WOKINGHAM
BOROUGH COUNCIL

A Meeting of the **WOKINGHAM BOROUGH HEALTH AND WELLBEING BOARD** will be held in David Hicks 1 - Civic Offices, Shute End, Wokingham RG40 1BN on **THURSDAY 8 FEBRUARY 2024** AT **5.00 PM**

Susan Parsonage
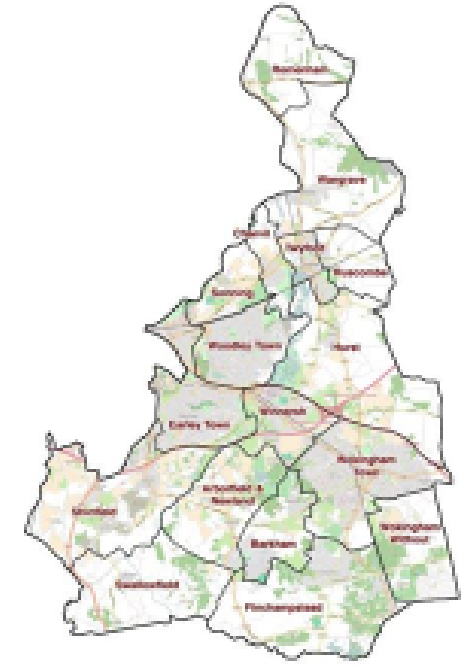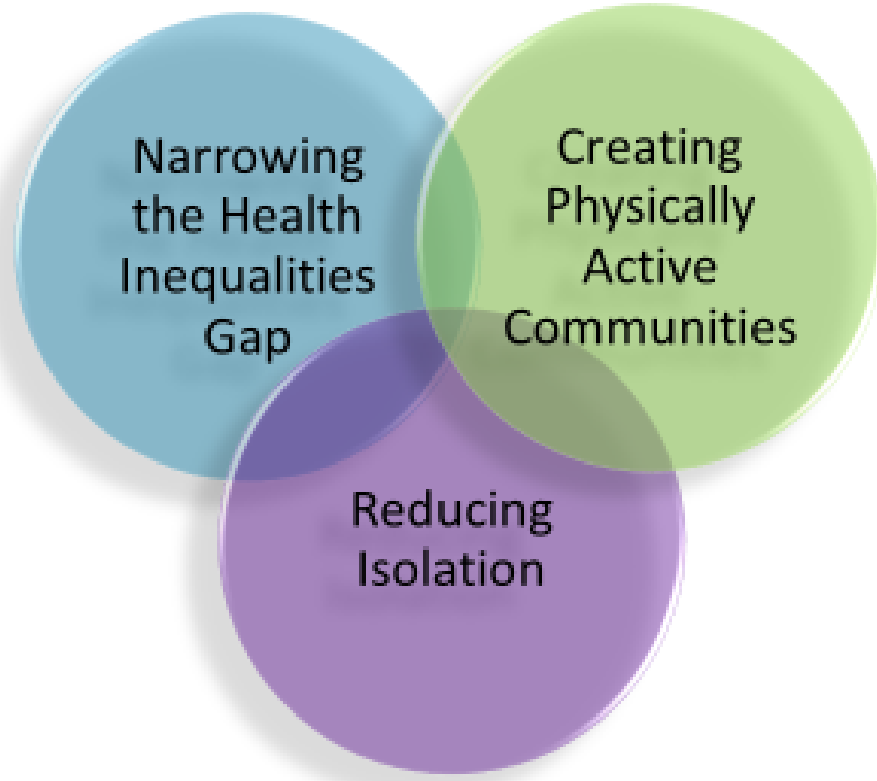Chief Executive
Published on 31 January 2024

Note: Members of the public are welcome to attend the meeting or participate in the meeting virtually, in accordance with the Council's Constitution. If you wish to participate either in person or virtually via Microsoft Teams, please contact Democratic Services: Democratic.services@wokingham.gov.uk

The meeting can also be watched live using the following link:
https://youtube.com/live/eKJuZVPk4l0?feature=share

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Creating Healthy & Resilient Communities

Key Priorities

Narrowing the Health Inequalities Gap

Creating Physically Active Communities

Reducing Isolation

WOKINGHAM
BOROUGH COUNCIL

MEMBERSHIP OF THE WOKINGHAM BOROUGH HEALTH AND WELLBEING BOARD

Debbie Milligan	NHS
David Hare	Wokingham Borough Council
Prue Bray	Wokingham Borough Council
Philip Bell	Voluntary Sector
Stephen Conway	Wokingham Borough Council
Graham Ebers	Deputy Chief Executive
Nick Fellows	Voluntary Sector
Giorgio Framalicco	Director Place and Growth
Nikki Luffingham	NHS England
Charles Margetts	Wokingham Borough Council
Susan Parsonage	Chief Executive
Matt Pope	Executive Director for Children, Adults and Health
Helen Watson	Interim Director Children's Services
Sarah Webster	BOB ICB
Ingrid Slade	Director Public Health
Andrew Statham	Royal Berkshire NHS Foundation Trust
Alice Kunjappy-Clifton	Healthwatch Wokingham Borough

39.   **MEMBER QUESTION TIME**
To answer any member questions

Any other items which the Chairman decides are urgent
A Supplementary Agenda will be issued by the Chief Executive if there are any
other items to consider under this heading

**MINUTES OF A MEETING OF THE
WOKINGHAM BOROUGH HEALTH AND WELLBEING BOARD
HELD ON 14 DECEMBER 2023 FROM 5.00 PM TO 6.40 PM**

Present

Debbie Milligan	NHS
David Hare	Wokingham Borough Council
Prue Bray	Wokingham Borough Council
Philip Bell	Voluntary Sector
Stephen Conway	Wokingham Borough Council
Nick Fellows	Voluntary Sector
Susan Parsonage	Chief Executive
Matt Pope	Executive Director for Children, Adults and Health
Sarah Webster	BOB ICB
Ingrid Slade	Director Public Health
Andrew Statham	Royal Berkshire NHS Foundation Trust
Alice Kunjappy-Clifton	Healthwatch Wokingham Borough
Narinder Brar (substituting Giorgio Framalicco)	Head of Enforcement & Safety
Ming Zhang (substituting Helen Watson)	Assistant Director Education and SEND

Also Present:

Madeleine Shopland	Democratic and Electoral Services Specialist
Robert Curtis	Transport Planning Team Manager
Hilary Lovie	Co-production and Engagement Officer
Callum Bell	Social care service user
Jay Dudakia	Social care service user
Stephen Bailey	Senior Transport Planner

75.   APOLOGIES
Apologies for absence were submitted from Karen Buckley, George Framalicco, Charles Margetts, and Helen Watson.

76.   MINUTES OF PREVIOUS MEETING
The Minutes of the meeting of the Board held on 12 October 2023 were confirmed as a correct record and signed by the Chair.

77.   DECLARATION OF INTEREST
There were no declarations of interest received.

78.   PUBLIC QUESTION TIME
There were no public questions.

79.   MEMBER QUESTION TIME
There were no Member questions.

80.   SOCIAL CARE FUTURES

The Board received a presentation about the future of social care in Wokingham Borough and were advised that a presentation would be made to Council in January.

During the discussion of this item, the following points were made:

- Social Care Futures was a vision of how the provision of social care could be different in the future. A charter describing how this could be achieved had been produced.
- The Board viewed a video which provided an introduction to the Social Care Futures vision.
- Social Care Futures was a national movement and was led by people with lived experience of social care, to help do things differently.
- Officers had been working with a small group of residents who drew on social care support, to develop a Social Care Future Vision.
- Callum Bell, service user, provided an update on his experience. He stated that the current Front Door System could be quite complicated, especially if you were moving between geographical areas. He also highlighted the difficulties he had faced when leaving college and suggested that there should be something in place like an Education, Health, and Care Plan to assist those leaving education. Callum indicated that his mum had, had to help him with the process, which had involved a number of different partners. At the time he had felt as if he had fallen through the cracks. Hilary Lovie, Co-production and Engagement Officer indicated that people often found times of transition to be a period of great anxiety.
- Callum outlined some of the existing challenges around transport. He stated that the current concessionary disabled persons bus pass system was unhelpful to those who were working or looking for jobs, as you could only travel outside peak periods. Many of the bus routes were not frequent enough. For instance, Callum indicated that he lived in Arborfield. Whilst service was good to Reading it was a poor service to Wokingham.
- Callum praised the support provided by Optalis in getting into the workplace. However, interviews could be made easier for those with learning disabilities. Employers needed to be encouraged to change their interview practices and to possibly offer trial shifts.
- Callum welcomed being involved in Social Care Futures.
- The Social Care Futures Group met monthly. Regular feedback was provided, and ideas were shared on how to make improvements locally.
- The Big Gathering had been held in July which had been attended by over 100 residents. This had been held to grow the Social Care Futures movement and had been very successful.
- Jay Dudakia, service user, indicated that he worked for Optalis one morning a week. He lived with his family and received support to undertake his job and the things that mattered to him. He also used the short break service to give him and his family a break. Jay commented that he had been involved with Social Care Futures from the start and attended the Group meetings. He felt that participants were treated with respect, that his views mattered, and that he was listened to. More people should become involved as it was a great way to work together to make things better. Jay indicated that Social Care Futures was about equal opportunities and an inclusive and accessible community.
- Matt Pope outlined new projects where the Social Care Futures lens was being applied, including how adults first accessed social care.

- Social care and its service users were often described using less positive language in the media. A move away from this was hoped for.
- Matt Pope indicated that a website would be launched alongside the Charter and that yearly progress updates would be provided to Full Council.
- Councillor Conway thanked Callum and Jay for their presentations. It had been very helpful to hear about their experiences. Susan Parsonage also thanked Jay and Callum for highlighting the issues that they had experienced. She and Councillor Conway indicated that they would be interested in attending the Social Care Futures Group.
- Alice Kunjappy-Clifton asked how the Social Care Futures message would be publicised so that it could be celebrated. Matt Pope indicated that after the Charter had been presented in January, there would be a communications launch where people could sign up to the Charter. Promotion of the Charter would be a focus of the next year.
- Andrew Statham questioned whether information about what action would be taken following listening to peoples' concerns, would be included in the Charter. Matt Pope indicated that a lot of action had already been taken, such as the new carers contract. However, having the Charter, going public with it, getting more people involved, and then updating Council on an annual basis, would help progress matters further.
- Councillor Bray indicated that she had attended the Big Gathering and the message that had come out clearly was that peoples' vision for Wokingham was a place where everybody belonged. This aligned with the wider Council Vision work. She emphasised that the connection between the two should not be lost.
- Dr Milligan praised the work being undertaken and the involvement of service users. Callum invited her to join the Social Care Futures Group.
- Philip Bell praised the ambition. He felt that the Board should champion the vision to ensure that the intended culture change was enacted.

RESOLVED: That

1) the commitment to the SCF vision be noted;

2) how the Health and Wellbeing Board may best support the delivery of the SCF vision and work with people who use adult social care and family carers to achieve positive outcomes for our community, be considered;

3) members of the HWB board to attend briefings (dates TBC);

4) the principles included within Wokingham Borough Council's SCF Charter be noted.

81.   LOCAL TRANSPORT PLAN - CONSULTATION

Robert Curtis, Transport Planning Team Manager, and Stephen Bailey, Senior Transport Planner, presented the Local Transport Plan – Consultation.

During the discussion of this item, the following points were made:

- The Department for Transport had removed the requirement to produce a Local Transport Plan every three years. However, the Local Transport Plan 3 had been adopted in 2011 so was quite out of date. Some time had been taken in drafting Local Transport Plan 4.

- Whilst there were significant changes from Local Transport Plan 3, many of the themes such as congestion and environmental issues, remained the same. Nevertheless, there had been a national shift in wanting to see greater use of cycling and walking, greater electric car use and increased public transport usage.
- Officers were wanting to hear peoples' views and any issues that they had. Robert Curtis highlighted Callum's reference in the previous presentation to buses running at the wrong times and the disabled bus pass being operational at inconvenient times.
- The Local Transport Plan had three key themes – to create healthy and safe places, grow the economy, and reduce the environmental impacts.
- The public consultation would run from 18 December 2023 for 9 weeks. One to one engagement would also take place with groups. Officers sought the Board's support in gathering the views of those who were hard to reach. In past consultations there had been little response from young people, those from different ethnic backgrounds, those with educational needs, or carers.
- Councillor Conway thanked officers for their work. He indicated that the Executive had approved the Plan going out to consultation. He went on to comment that the development of a representative citizens panel was possibly a long-term aspiration. Different parts of the Council may be able to assist in reaching different groups within the community.
- Councillor Bray commented that reducing the impact of roadworks, particularly when they were not instigated by the Council, and working with the utility companies, could be better addressed in the Plan. Robert Curtis indicated that there was ongoing work around roadworks.
- With regards to engaging with young people, Councillor Bray suggested that officers engage with the Youth Council, the SEND Youth Council and the Children in Care Council. She also suggested that parents could be better reached by sending a letter via the schools (including independent schools), nurseries and early years settings. The Board was informed that for the Reading Road consultation Engage had lowered the engagement age to 13 years old. The My Journey team also engaged with many schools.
- Philip Bell emphasised the importance of the consultation to the voluntary sector, who supported people to access care and support services. He committed to help get the message out that the consultation was starting on 18th December.
- Alice Kunjappy-Clifton asked about materials in different languages. She suggested a plug into the website to enable this.
- Sarah Webster commented that transport was an important building block for wellbeing. She asked about specific interventions regarding poor air quality. She was informed that the current guidance from the Council was less about a list of schemes and more about setting a policy framework from which more detailed studies and strategies would be produced at a later date. Robert Curtis indicated that there were Air Quality Action Plans for each of the Air Quality Management Areas, which were currently being refreshed.
- Sarah Webster asked how much accessibility to health services from particular areas such as retirement care homes, had been considered. Steve Bailey indicated that the Local Transport Plan was supported by data and reports from various areas. This evidence did not fully highlight peoples lived in experiences, which officers wanted to hear more of. Sarah Webster suggested that some analysis work also be undertaken to cover the eventuality of insufficient feedback being received around some areas.

- Sarah Webster offered use of the NHS communications routes to help reach wider audiences.
- Dr Milligan suggested that social prescribers within the Council and the surgeries were a good means of reaching different parts of the community. She also suggested engagement with the transport providers.

RESOLVED: That the content of the draft Local Transport Plan be noted, feedback provided, and any particular concerns regarding the current draft version that could be incorporated into the final draft, be highlighted.

82.   ROYAL BERKSHIRE NHS FOUNDATION TRUST PERFORMANCE UPDATE AND BUILDING BERKSHIRE TOGETHER UPDATE

The Board considered the Royal Berkshire NHS Foundation Trust Performance update and the Building Berkshire Together Update, presented by Andrew Statham, Director of Strategy, Royal Berkshire NHS Foundation Trust.

During the discussion of this item, the following points were made:

- Andrew Statham indicated that he was the Director lead for the work on the new hospital. He provided the Board with an update on the Building Berkshire Together project. Work had quietened which was reflective of the national programme focus which was focused on ordering schemes in light of being asked to take on those hospitals with RAAC concrete, and a focus on repeatable design.
- Securing alignment and support for a whole new hospital was important, and then understanding whether this could be constructed on the current site or what other possible sites were available.
- Work would be undertaken internally and also with the community to understand the potential impact to healthcare service users, to staff and partners, if the hospital did not remain on the existing site.
- Issues had been identified in reaching all the communities that used the services, to hear their views.
- There would be dates in January and February for site visits for Members to view the current estate.
- Councillor Hare questioned whether it was the case that the current site had a lot of underground works, and if so if it was a limiting factor. Andrew Statham commented that work was being carried out to understand what the site looked like and potential challenges. The presence of the hospital's repeatable design and how it could be done on a brownfield site with live working had to be carefully considered.
- Dr Milligan questioned how sufficient space could be made on the current site to enable construction to be undertaken whilst services continued to be provided. Andrew Statham agreed that there were complexities of building on a live site.
- Councillor Bray agreed that redeveloping a hospital on a live site would be very difficult. She questioned whether the rebuild would happen at all, such had been the delays in decision making at national level. She would support the move to a new site. Councillor Bray questioned when there would likely be more certainty, if at all. Andrew Statham commented that the New Hospital Programme was clear on creating a long term capability and plan to rebuild hospitals, regardless of the political environment. Local support would be required to highlight the importance of capital investment.

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- Work would be undertaken to understand the impact if the hospital was not located in its current location. It was currently located next to the most deprived part of the community it served.
- Councillor Bray asked whether leaving some facilities, for example an Urgent Care Centre, on the existing site and locating other facilities elsewhere, was a consideration. Andrew Statham indicated that it would be but that what facilities were located where would need to be considered.
- Ingrid Slade commented that Basingstoke and North Hampshire were also undergoing a consultation about moving their hospital to the other side of Basingstoke, which would have an impact on population boundaries. It was noted that Frimley Park Hospital was also part of the New Hospital Programme.
- Dr Milligan referred to learning from other areas that had been through the same experience. Andrew Statham indicated that the New Hospital Programme had produced 96 lessons for hospital trusts on what Trusts should do and what could potentially go wrong.
- Andrew Statham went on to update the Board on the Royal Berkshire NHS Foundation Trust performance up to October.
- Strong sustained progress had been seen in reducing staff turnover and improvements had been made with regards to vacancies. A focused campaign had taken place over a year.
- Some improvements were being seen in some of the diagnostic waits with new capacity being invested in, and additional work in Radiology.
- There were still areas of challenge such as the Emergency Department and performance relating to the volume of people seeking care and the challenges of discharging patients and creating capacity to admit them.
- There was a growing concern about the Trust's ability to meet the increased ambition around waiting targets next year – a combination of staff availability, demand and financial constraints that were expected. The Board was focusing on the settlement that the Trust would come to with ICS colleagues to support those challenges, and also the prevention agenda, which helped to mitigate demand.
- Dr Milligan stated that the Urgent Care Board had been looking at different ways of clinicians accessing urgent care, rather than everything going through the Front Door system, using Same Day Emergency Care, and also Same Day Surgical Care. Patients were being admitted straight to an acute ward rather than A&E. This was better for the patient and helped to reduce the number of patients visiting A&E. This had been well received. Work was also being undertaken with Out of Hours and Ambulance colleagues around Call before you Convey.'
- Councillor Bray commented that it appeared that sending patients to other centres such as Thatcham and Henley were viewed as negative, and questioned if it was in fact positive should the patients be seen quicker. Andrew Statham commented that the objective was around delivering care closer to home, and making use of other sites where appropriate. Whilst a lot of progress had been made during 2017-19, it had tailed off, so was a current area of focus. Dr Milligan commented that some patients did not want to travel to other sites and wanted to be seen more locally. Communication from GPs was important to help encourage patients to make greater use of the tertiary sites where appropriate.
- With regards to prevention, Andrew Statham commented that it was a key part of the system's joint forward plan work. He suggested that the Board may wish to keep updated on the work around primary care. Sarah Webster added that the Primary Care Strategy was currently being produced and feedback was being sought from the public on General practice, dentistry, optometry, and community pharmacy services. This was linked to the way that the Place Partnership was

looking to progress with the Community Wellness outreach work. The Board would be updated as this project rolled out further.

- Dr Milligan emphasised that people needed to be targeted at an earlier stage, for example educators talking about healthy lives, to ensure a successful prevention agenda.
- The Board was assured that health and Public Health worked closely together. Sarah Webster commented that Public Health involvement in the Strategy could be strengthened.

RESOLVED: That the Royal Berkshire NHS Foundation Trust Performance update and the Building Berkshire Together Update, be noted.

83. BERKSHIRE WEST HEALTH PROTECTION & RESILIENCE PARTNERSHIP BOARD (WEST BERKSHIRE, WOKINGHAM, READING)

The Board considered a report regarding the Berkshire West Health Protection and Resilience Partnership Board ("HPRPB").

During the discussion of this item, the following points were made:

- The Local Authority had statutory responsibilities around health protection and emergency preparedness, including all activities seeking to prevent and reduce harm caused by infectious diseases, and minimise impact from environmental hazards such as chemicals and radiation. The Director of Public Health worked on behalf of the local authority to discharge many elements of these responsibilities, working in collaboration with partners across the system.
- Temporary working arrangements had been established in Berkshire West during the pandemic, which provided a mechanism for delivering against national guidance on health protection (with a focus on COVID-19). There was now a need to establish a permanent governance structure to protect the health of residents across Berkshire West. The Berkshire West Health Protection and Resilience Partnership Board had been established. The Board would report into the Health and Wellbeing Boards and the United Executive of the ICS.
- Councillor Bray asked about the mechanism of keeping the Board updated with the work of the United Executive. Sarah Webster suggested an update from the Place Partnership at the Wellbeing Board's March meeting.

RESOLVED: That

1) the establishment of the HPRPB, chaired by a Director of Public Health, to provide assurance that robust arrangements are in place to protect the health of residents across Berkshire West (including West Berkshire, Wokingham, Reading) be noted;

2) the terms of reference for the HPRPB be noted;

3) it be noted that the HPRPB will meet quarterly and produce an annual report to both the Unified Executive and the HWB to provide a clear analysis of risk, mitigation, and incidents.

84. FORWARD PROGRAMME

The Committee discussed the forward programme for the remainder of the municipal year.

- An update from the Place Partnership would be brought to the Wellbeing Board's March meeting.

RESOLVED: That the forward programme be noted.

West of Berkshire
Safeguarding Adults Board

Reading, West Berkshire & Wokingham

Annual Report 2022-23

If you would like this document in a different format, contact Lynne.Mason@Reading.gov.uk

Concerned about an adult?

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

If you are concerned about yourself or another adult who may be being abused or neglected, in an emergency call the Police on 999.

If you think there has been a crime but it is not an emergency, call the Police on 101 or contact Adult Social Care in the area in which the person lives:

- **Reading** - call 0118 9373747 or email at CSAAdvice.Signposting@reading.gov.uk or complete an online form
- **West Berkshire** - call 01635 519056 or email safeguardingadults@westberks.gov.uk or complete an online form
- **Wokingham** -call 0118 974 6371 or email Adultsafeguardinghub@wokingham.gov.uk or complete an online form

For help out of normal working hours contact the **Emergency Duty Team** on 01344 351 999or email edt@bracknell-forest.gov.uk

For more information visit the West of Berkshire Safeguarding Adults Partnership Board website: http://www.sabberkshirewest.co.uk/

Message from the Independent Chair

This is my second year as Chair of the West of Berkshire Safeguarding Adults Board (2022/2023) and once again it has been my privilege to see the dedication and hard work of staff from across the health and social care sectors. These staff, including those from the formal, informal and voluntary sectors, are all committed to providing the very best health and social care possible.

Last year I commented on how staff were coping as we came out of the Covid pandemic and they were having to deal with a backlog of health and social care needs as a consequence of the pandemic. This past year has unfortunately been no easier and one of the great challenges facing the sector currently is recruitment and retention. Many parts of the health and social care sector continue to have very high and unsustainable vacancy rates which puts additional pressure on those staff within the system. This problem is outside of the Board's remit, but society as a whole does need to stand back and review how it values and appreciates staff working in this sector, particularly in the residential and domiciliary care sector for older people. They do amazing work under huge pressure, often on minimum wage or certainly low levels of pay. Society needs to review how we value these workers urgently if we are to have safe staffing levels, with experience and knowledge. Working in the care sector, though immensely rewarding, is hard work and requires great skill and ability.

However, despite all the pressures on the sector I am delighted to report that this Board has continued to function well during this past year to ensure that adults receive safe and appropriate health and social services in its area. The Board has undertaken and published a number of Safeguarding Adult Reviews in this year and also undertaken work to look at a Rapid Review process for SARs. This review has led to a tightening up of timelines to ensure that the process is completed as quickly as possible and we will be reviewing further the possibility of a more formal rapid review process in the coming year. One problem we are currently experiencing though is a lack of independent chairs to undertake the SARs. This is a national problem exacerbated by the fact that there are more reviews year on year. During the coming year we as a Board will be looking to strengthen our capacity to oversee SARs, and also to undertake even more quality and assurance work.

During the past year I am delighted to report on my involvement with organisations representing carers, people with lived experience and those working in the advocacy sector. This has been a growing and important development of our work.

Finally I want to offer my sincere thanks to the Board Staff and Board Members. Their commitment to safeguarding and high standards is really valued and appreciated. It is an area of work that continues to grow and is therefore of vital importance within our society in order to protect and support some of its most vulnerable members. It really is a privilege to work alongside these committed professionals and thus I want to say a sincere thank you for all you do.

Prof Keith Brown

Independent Chair, West of Berkshire Safeguarding Adults Board

About us

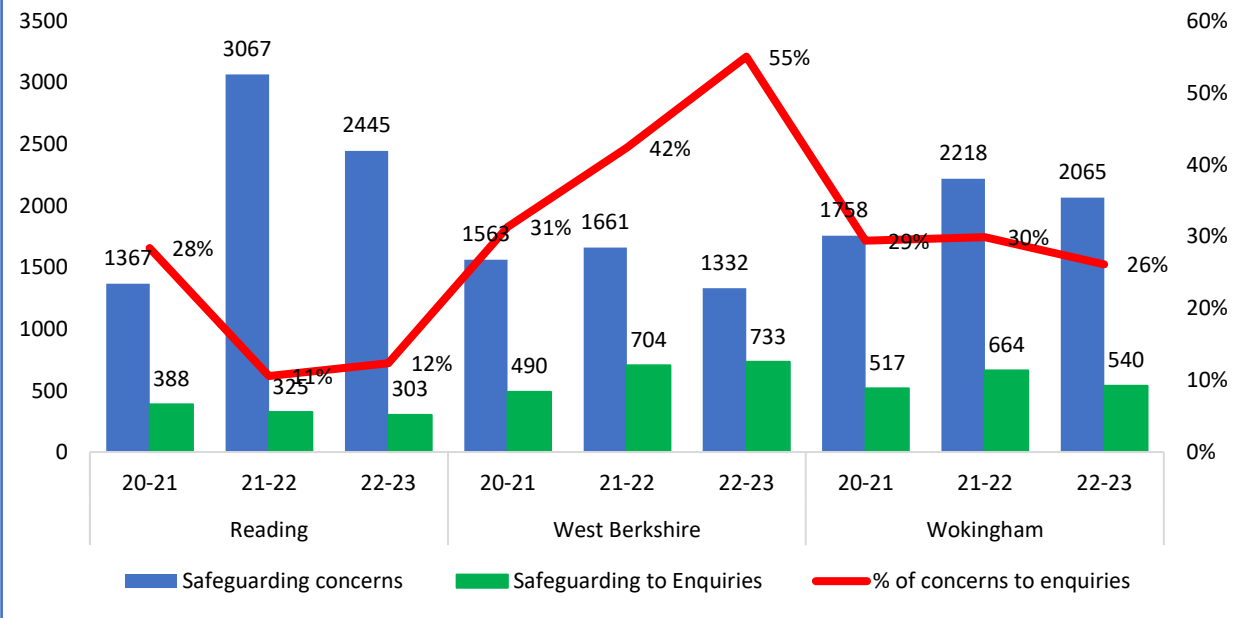|	
What is the Safeguarding Adults Board?	The West of Berkshire Safeguarding Adults Partnership Board (SAB) covers the Local Authority areas of Reading, West Berkshire and Wokingham. The SAB is made up of local organisations which work together to protect adults with care and support needs at risk of abuse or neglect. Mandatory partners on the SAB are the Local Authorities, Berkshire West Clinical Commissioning Group and Thames Valley Police. Other organisations are represented on the SAB such as health services, fire and rescue service, ambulance service, HealthWatch, probation and the voluntary sector. *A full list of partners is given in Appendix A and the SAB structure in Appendix B.* We work together to ensure there are systems in place to keep adults at risk in the West of Berkshire safe. We hold partner agencies to account to ensure they are safeguarding adults at risk and promoting their well-being. We work to ensure local organisations focus on outcomes, performance, learning and engagement.
Who do we support?	Under the Care Act, safeguarding duties apply to an adult who: • Is experiencing, or is at risk of, abuse or neglect; and • As a result of their care and support needs, is unable to protect themselves.
Our vision	Adult safeguarding means protecting people in our community so they can live in safety, free from abuse and neglect. Our vision in West Berkshire is that all agencies will work together to prevent and reduce the risk of harm to adults at risk of abuse or neglect, whilst supporting individuals to maintain control over their lives and make informed choices without coercion
What is safeguarding adults?	Safeguarding adults means protecting others in our community who at risk of harm and unable to protect themselves because they have care and support needs, regardless of whether or not they are receiving support for these needs. There are many different forms of abuse, including but not exclusively: Disability hate crime, Discriminatory, Domestic, Female genital mutilation (FGM), Financial or material, Forced marriage, Hate crime, Honour based violence, Human trafficking, Mate crime, Modern slavery, Neglect and acts of omission, Organisational, Physical, Psychological, Restraint, Self-neglect, Sexual and Sexual Exploitation,
Safeguarding Adults Policy and Procedures	Berkshire Safeguarding Adults Policy and Procedures are used in the West of Berkshire and their purpose is to support staff to respond appropriately to all concerns of abuse or neglect they may encounter: https://www.berkshiresafeguardingadults.co.uk/

Number of safeguarding adult concerns and enquiries 2022-23

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

We have spent a lot of time considering safeguarding adult concern numbers over the year, as the number of out of scope safeguarding concerns received by our Local Authorities, this resulted in Local Authorities having to adapt their pathways to ensure that their safeguarding pathway was not overwhelmed with concerns that were not safeguarding.

The chart below demonstrates, in 2022-23 the total number of safeguarding concerns for individuals started in period - per 100,000 population, has decreased by 22% in the West of Berkshire, when comparing with 2021-22. The SAB understands that this decrease is due to the amended pathways adopted by Local Authorities to address out of scope concerns and that there has not been an actual reduction in the number of in scope safeguarding concerns received.

It is important to note that this indicator will only count an individual once during the reporting period and therefore does not account for any multiple safeguarding concerns raised for individuals over the year, therefore the number of safeguarding concerns received is much higher than this outturn.

The table below demonstrates the number of safeguarding concerns, safeguarding enquiries and conversion rate between safeguarding concern and enquiry over the last three years by local authority.

Number of safeguarding concerns for individuals started in period - per 100,000 of the population

	20-21	21-22	22-23
READING	1026	1753	1339
WEST BERKSHIRE	853	919	779
WOKINGHAM	1369	1755	1334

In 2022-23 there were a total of 1576 enquiries started
303 in Reading a decrease of 7% compared with 2021-22
733 in West Berkshire an increase of 4% compared with 2021-22
540 in Wokingham a decrease of 19% compared with 2021-22
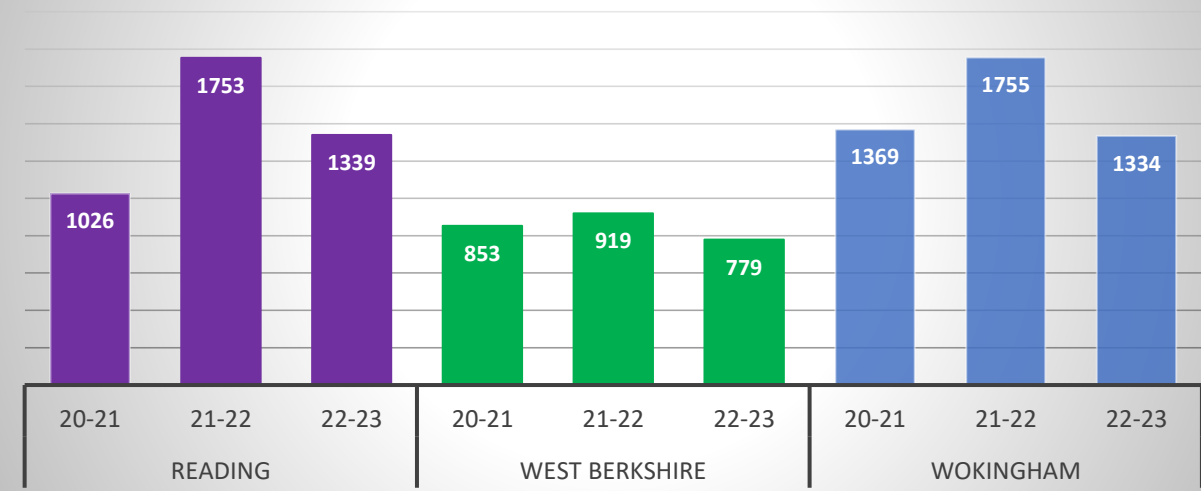
Types of Abuse

As in previous years neglect and acts of omission was the most frequent abuse type, equating to 34% of enquiries. This was followed by physical, psychological or emotional abuse and financial abuse. But all have seen a decrease when compared with 2021/22.

There is a 17% decrease in Domestic abuse which in the previous year had seen a 20% increase.

Organisational abuse has seen the biggest increase of 159% when compared with 2021/22. There were 29 enquiries in 2021/22 and 75 in 2022/23.

Modern Slavery has seen an increase of 25%, with 5 enquiries in 22/23
Self-Neglect has seen a 10% increase.

58% of enquires were in relation to women, this is consistent with previous years.

For the majority of enquiries (37%), the individual primary support reason was physical support, this however has decreased by 15% when comparing with previous years. This was followed by no support reason (30%), which saw a 5% increase when compared with last year.

85% of enquires were for individuals whose ethnicity is White, this consistent with last year. The ethnicity of the remaining 15% of individuals is as follows: Not Known 6%, Asian 3%, Black 3%, Other 3%, Mixed 1%.

The Performance and Quality Subgroup routinely consider the ethnicity data to ensure it is consistent with our demographics.

Location of alleged abuse

60% of enquiries completed were where the alleged abuse took place in the persons own home, this is a slight drop from 20/21 where it was at 62% and is the third consecutive year where this has dropped.

There has been a 7% decrease in enquiries completed where the location of abuse was in hospital, equating to a total of 87 enquiries.

Care Homes also saw an increase of 4%, with a total of 418 enquires.

There was a 52% increase in Service within Community (Commissioned service in community setting) with 47 enquiries.

62% of enquiries relate to people over 65 years in age, this is consistent with 2021/22

Challenges or areas of risk that have arisen during the year are recorded on our risk register, along with actions to mitigate the risks. These are some of the potential risks that we have addressed:

Risk	Consequence/Impact	Mitigation
The SAB does not know how individuals experience the Safeguarding Adults Process. Adults with care and support needs and their carers have no involvement or engagement with the Board.	Safeguarding Adults procedures and practices are not informed by people's experiences. Lack of community understanding to inform the work of the Board.	Voluntary Sector/Healthwatch Subgroup in place. Request made for the Advocacy people to deliver a presentation to the SAB in March 23, which was deferred to June 2023.
People who raise safeguarding concerns do not receive feedback	Impaired partnership working.	Key Performance Indicator (KPI) in place to monitor percentage of referrers that receive feedback. As reported in the 21/22 annual report Reading Borough Council are currently unable to supply this information. Repeated assurance has been provided to the Performance and Quality Subgroup that plans are in place to address this.
There is inconsistent use of advocacy services to support adults through their safeguarding experience.	The voice of the service user is not heard.	Improve oversight of advocacy offer in the West of Berkshire: • KPI on SAB's dashboard, • Advocacy representation at SAB and subgroups, • request made for the Advocacy people to deliver a presentation to the SAB in March 23, which was deferred to June 2023.
Responsibilities under the Mental Capacity Act (MCA) 2005 are not fully understood or applied in practice as a safeguard for people who may lack capacity (SAR finding)	Significant harm to adults as risk.	All work undertaken by the SAB partnership to ensure consideration of MCA so that it is embedded within practise. Good practice identified from the Pauline Safeguarding Adult Review (SAR) published Jan 23, but did evidence that practitioners are not evidencing their decision making in regard to MCA. MCA a SAB priority for 23/24.

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Challenges or areas of risk that have arisen during the year are recorded on our risk register, along with actions to mitigate the risks. These are some of the potential risks that we have addressed:

Risk	Consequence/Impact	Mitigation
There are capacity issues within the supervisory bodies to obtain timely DoLS assessments and provide appropriate authorisation.	Risks that vulnerable people do not have the opportunity to live within the least restrictive regime possible for their condition.	A KPI on the SAB dashboard, concerns around performance have been highlighted to the SAB for consideration.
Governance arrangements to support people who have Mental Health issues are not fully understood.	Significant harm to adults as risk.	Assurance obtained via Berks West Health Partners Strategic Safeguarding Committee.
Safeguarding People at risk of multiple exclusion, due to not meet safeguarding or care management pathways.	This is not a new issue but has been exacerbated as a result of lockdown, as people have been brought to the attention of services that wouldn't have previously been before.	Review and relaunch of Supporting Individuals to Manage Risk and Multi Agency Framework (MARM)took place in September 22.
Increase of out of Scope Safeguarding Referrals.	Capacity in Safeguarding Teams will be impacted on resulting in less time being available to spend on appropriate safeguarding concerns.	SAB sought assurance from partners that this issue was being addressed. In December 22 the SAB agreed that as LA's have updated their processes to limit the risk due to the increase in out of scope referrals, no further assurance is required for the SAB. The partnership can re-escalate to the SAB if the risk mitigation process is at risk of failure.
The impact the pandemic has had on domestic abuse.	People are more at risk of domestic abuse as a result of the measures put in place as a result of the pandemic, the partnership will need to consider how its approach will need to be adapted.	Safeguarding figures suggest that there had not been a significant increase in domestic abuse during the pandemic. However, agencies and the SAB continue to promote domestic abuse and ways in which to identify and support after the pandemic. Domestic abuse will be considered as part of the SAB priority on serious violence for 2023/24.
The SAB is not complying with its Quality Assurance Framework.	That the SAB do not have assurance in regard to the quality of safeguarding in its area.	Is a SAB priority for 2023/24.

Achievements through working together

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

Our priorities for 2022/23 and outcomes to those priorities were:

Priority 1: To expand on learning in regard to self-neglect; to offer the partnership with resources to support them to achieve effective outcomes for individuals that self-neglect.

- Created a Self-Neglect and Hoarding Toolkit for the partnership and launched via a webinar, where over 75 practitioners attended.
- Safeguarding Adults Week 2022 in November 2023 had 1 day which focused on self-neglect, there was webinars, briefing notes and social media posts that all highlighted self-neglect.
- Self-neglect Page created on SAB Website.
- Webinar on Mental Capacity Act and Self Neglect took place in October 2022.
- Review and relaunch of Supporting Individuals to Manage Risk and Multi Agency Framework (MARM) took place in September 22. Videos detailing how the MARM works in West Berkshire Council and Wokingham Borough Council launched and a KPI to monitor MARM usage and outcomes will be go live in April 2023.
- Work on an awareness campaign to highlight fire risks in regards to hoarding, started and will be launched in 2023/24.
- Self-Neglect bitesize session for Voluntary Sector took place in February 2023 a recording of this session is on our website.
- Published SARS and practice learning notes, podcasts where self-neglect was a concern.
- Published and promoted via newsletter and email the Mental Capacity Toolkit and Prof Keith Brown publications on MCA.
- Updated the MCA/DoLs Page of SAB website.
- Review of the Pan Berkshire Safeguarding Adults Policy and Procedure on self-neglect completed.

Priority 2: To seek assurance that quality of health and social care services delivered in the West of Berkshire or those commissioned out of area for West Berkshire residents is monitored effectively and there is a proportionate response to concerns.

- KPI to monitor quality of health and social care services in the West of Berkshire agreed and went live in April 2023.
- The following actions were not completed but have been carried over as SAB actions for 2023/24.
  - Assurance obtained from SAB Statutory partners on practice in regard quality monitoring of service provision.
  - Learning session to promote best practice when reviewing quality of care.
  - Create information source for volunteers on quality of service provision which includes details on pathways.
  - To consider any updates to the organisational safeguarding policy and procedure in light of SAB learning.

Priority 3: The SAB to review its Safeguarding Adult Review (SAR) process, in order to ensure that it is timely and good value for money

- Review of SAR process completed, SAB agreed that the SAR Panel should continue with its current SAR process.
- SARs continued to be delivered by the SAB as per its statutory requirements.
- Where suitable bitesize learning sessions on SARs have been delivered by the SAB.
- The following SAR action plans were signed off as completed: Michelle, P, Adam, John, Ken and Steven.

Priority 4: The SAB will continue to carry out its business as usual tasks to comply with its statutory obligations
Board Briefings, Annual Report, Website, Budget, Out of Scope Safeguarding Referrals, Joint Investigation Protocol, Safeguarding Adults Week, Pressure Care Awareness, Quality Assurance Framework.

Safeguarding Adults Week 2022

In November 2022, the West of Berkshire Safeguarding Adults Partnership Board is supported the Ann Craft Trust Safeguarding Adults Week. Each day of the week our partners hosted a wide variety of free webinars to cover the themes on: Responding to Contemporary Safeguarding Challenges, these were open to all health and social care practitioners and volunteers within the West of Berkshire. The partnership provided learning resources to support awareness on these key themes. The week was a great success with a total of 393 delegates attended the webinars and 5 learning briefs were created covering:

- Exploitation and County Lines
- Self-Neglect
- Creating Safer Organisational Cultures
- Elder Abuse
- Domestic Abuse in a Tech Society

Social media posts also went out daily to promote public awareness on these subjects. The SAB website has a page where copies of the learning.

Considered the impact the newly established Integrated Care Boards may have on the SAB and its arrangements with the East of Berkshire and our Pan Berkshire Safeguarding Adults Policies and Procedures.

Agreed options will be explored to relaunch the safeguarding train the trainer programme.

In response to learning identified in the Adam SAR the SAB:
- Created a best practice guide for out of area reviews
- Definition of 'relevant history' agreed and added to Pan Berkshire Policies and Procedures.
- Created and launched 'supporting agencies in the management of complex multi-agency enquiries – joint safeguarding and criminal investigations protocol'

Published a case study, which shares learning from a safeguarding enquiry where the use of clinical terminology led to confusion for individual and people supporting them.

Created a webpage dedicated to: fire risk awareness

Researched and agreed options for commissioning of a new SAB website.

Reviewed and relaunched our Allegations Management (PiPOT) policy.

Considered and agreed assurance arrangements in response to South Central Ambulances CQC Inspection rating of inadequate.

We said thankyou and goodbye to five Board members who are moving on from their organisations:

- Seona Douglas, Director of Adult Care and Health Services, Reading Borough Council
- Jo Lappin, Assistant Director for Safeguarding, Reading Borough Council
- Andy Sharp, Executive Director - People, West Berkshire District Council
- Simon Broad, Assistant Director - Adult Social Care at Wokingham Borough Council
- Abigail Mangarayi, Designated Safeguarding Lead (Adults) in Berkshire West - Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Celebratory Points

- Being able to address and be part of the SAB that **enables better understanding of advocacy**
- Being part of the **safeguarding week plans** and events that take place under the SAB banner.
- Knowing that SAB takes **issues that arise from SARs seriously** and acts on the recommendations that come from the reports
- **Commitment and agility of the Voluntary, Community and Social Enterprise Sector.** Despite the plethora of societal challenges facing communities, the determination to support those most in need continues. Within this, some charities have been able to build in additional offers of service delivery, for example grants to support the heating of the homes of local people.
- **More consortiums and partnerships.** Whist charities are having to work hard to support their own sustainability, many are realising the advantages of working in partnership. In the last year, Wokingham Borough has developed its Dementia Alliance and Carers Alliance. In both cases, three of more charities are working together to realise a collective ambition, utilising and sharing resources to best achieve for local people.

Emerging Issues

- Lack of enough **advocacy funding** to provide enough early intervention i.e. community advocacy to act as a prevention of escalating problems.
- Learning from SARs evidences there is **a gap in advocacy referrals**.
- **Support for Asylum Seekers**. There are many asylum seekers who are successfully receiving their leave to remain in the UK. Upon receiving this notification, these individuals are given 28 days-notice and are then required to move on from their temporary accommodation. This notification is often delayed in arriving with the individual in question which is then not allowing sufficient time for professionals and volunteers to help secure income, find housing and begin to build the lives of those who are often highly vulnerable.
- **Cost of Living.** There are an ever increasing number of residents who are presenting to our foodbanks and who are working. Following increases to mortgages, rent, utilities and other outgoings, those who have previously lived well or sufficiently within their means are now in financial hardship. Approximately a quarter to a third of those coming to the attention of food services have never had to use these facilities before.
- **Statutory Funding Pressures and Impact on Local Charities.** As statutory organisations come under increasing funding pressures, funds historically allotted to the Voluntary and Community Sector are under increasing scrutiny. Whilst we have not seen any cuts to funding at this stage, the prognosis of this happening is ever more present. This, alongside the increasing competition for funds from national and local funding organisations will see income to charities and other community assets go down which in turn will see services reducing their provision, with a potential risk of insolvency.

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Annual Budget and Financial Contribution, 2022/23

The 2022/23 annual budget for the Board was £75,705 the annual budget is established through a financial contribution from statutory partners, The SAB also had £34,399 carry over from previous years. The name of the agency and their contribution; shown as a percentage of the overall cost in the table below and the pie chart demonstrates where the money was spent.

Partner	Agreed % Contribution
Reading Borough Council	16.07%
West Berkshire Council	16.07%
Wokingham Borough Council	16.07%
Buckinghamshire, Oxfordshire, West of Berkshire ICB	16.07%
Berkshire Healthcare Foundation Trust	9.52%
Royal Berkshire Hospital	9.52%
Thames Valley Police	16.66%
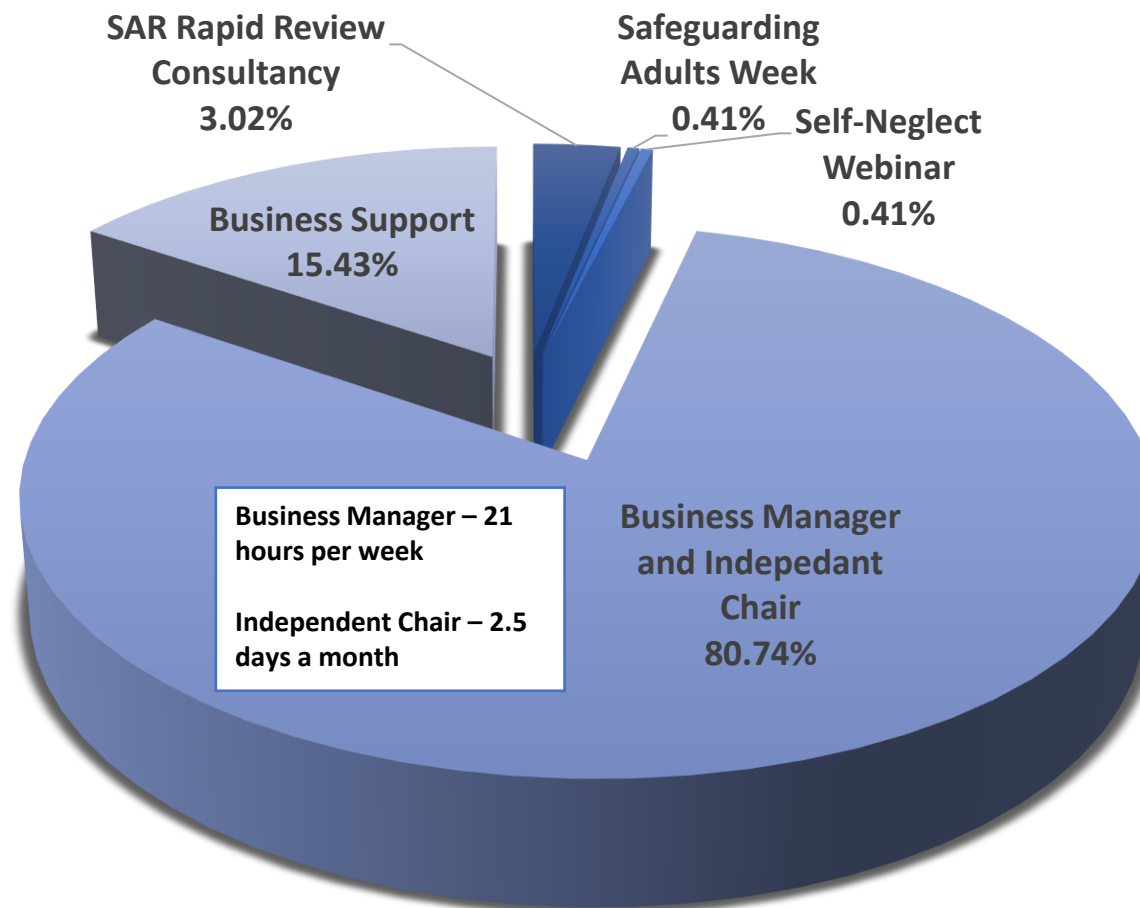
The 2022/23 expenditure was £71,745 and the SAB have carried over £43,859 into 2023/24. Which will be used to support the SAB to achieve its priorities.

SAR Rapid Review Consultancy 3.02%

Safeguarding Adults Week 0.41%

Self-Neglect Webinar 0.41%

Business Support 15.43%

Business Manager and Indepedant Chair 80.74%

Business Manager – 21 hours per week

Independent Chair – 2.5 days a month

Safeguarding Adults Reviews (SARs)

The SAB has a legal duty to carry out a SAR when there is reasonable cause for concern about how agencies worked together to safeguard an adult who has died, and abuse or neglect is suspected to be a factor in their death; or when an adult has not died but suffered serious abuse or neglect. The aim is for all agencies to learn lessons about the way they safeguard adults at risk and prevent such tragedies happening in the future. The SAB has a SAR Panel that oversees this work.

During the reporting year, the SAR Panel have worked on six SARs of which 3 have been endorsed and published and the remaining 3 SARs are due to go to SAB for endorsement and publication in 2023/24.

For each SAR that is completed a practice learning note is produced to help promote the learning across the partnership and webinars/podcasts are standard practice to further promote the learning.

The SAR Panel continues to promote reflective practice and feedback from learning events has been very positive.

The SAR Panel awaits the publication of the Safeguarding Adult Reviews in Rapid Time guidance that is being produced by the Social Care Institute for Excellence. Once available the panel will consider if this approach can be adopted by the SAB.

Adam Full Report and Practice Learning Note

Key learning identified from this review:

- Out of Area Placements – Understanding and Responding to Safeguarding Concerns Out of area placements make it more challenging to identify emerging safeguarding concerns and to provide an effective response. In order to improve this a person centred approach is required, in addition to a greater level of multi-agency working.
- Information Sharing The lack of information sharing affected the quality of safeguarding and reduced the ability of agencies to protect Adam from further abuse. A greater understanding of the need to share information is required for the effective management of future complex cases.
- Management of Complex Enquiries A new partnership protocol for the management of complex enquiries would greatly improve the efficacy of multi-agency safeguarding investigations. This should be supported with a training and development programme for professionals involved in such multi-agency enquiries.
- Family Engagement Professionals did not understand the underlying reasons for Adam's mother's concerns and why she had developed a different opinion to others about what was in Adam's best interests. This prevented a consensus being developed, affecting the services provided to Adam.

Published May 2022

Louise Practice Learning Note

Louise died in hospital when she was in her 40's. Louise had been living at home supported by two carers/personal assistants, one of whom lived in with her, this was managed by direct payments. Concerns had been raised over the years about the quality of care provided to Louise by the live-in personal assistant. Louise wanted to have weight loss surgery so that she could look after her son, who lived at his grandparents. Despite making changes in her life in preparation for surgery, Louise was told that it could not go ahead. Following this, Louise refused to allow district nurses to treat her pressure ulcers. Key Learning Points from this review were:

- There were unresolved concerns about the extent to which Louise's care and support needs were being met.
- Safeguarding processes did not identify patterns, themes or connections that might have alerted practitioners to the need to reconsider how well Louise's care and support needs were met or the extent to which Louise was feigning compliance and self-neglecting.
- No connection was made between the refusal of surgery and Louise's subsequent refusal of district nursing care. The impact of this was not recognised and no support was provided for Louise to cope with this disappointment.
- There was insufficient recognition that Louise was self-neglecting.
- Louise's mental capacity to make decisions about her care was assumed rather than assessed. This was despite a consistent pattern of "unwise decisions"
- There was insufficient consideration given to balancing Louise's wellbeing (Section 1 of the Care Act) and the obligation to protect her life (Article 2 of the Human Rights Act) with her right to make decisions (Article 8)

Published June 2022

Pauline Full Report and Practice Learning Note

Pauline lived alone in her own home. She was a local well-liked character; friendly, chatty and cooperative, but fiercely independent and someone who, despite increasing frailty associated with aging, remained very active and physically able. Pauline died at home in late 2021, having fallen resulting in fatal injuries. Pauline had several known conditions (including dementia) that impacted on her ability to manage daily living activities.

Concerns had been raised by Pauline's neighbours and a number of professionals over recent years that, as she had grown increasingly frail with age, and her choices which may have been present throughout her life.

The SAR clarified Pauline did not die because of abuse or neglect and partners had complied with their duties to assess and offer support in a manner that complied with her human rights. There was evidence of good practice from professionals throughout.

Key Learning Points from this review were:
- Balancing risks and rights: those working with Pauline demonstrated persistent, compassionate concern. The risks to Pauline remaining within her own home were well understood, but consideration was also given to the harm that compelling her to receive care against her will would cause.
- Caring Communities have a valuable role: People with dementia wishing to remain at home for as long as possible, have the easiest course when they have family, friends or neighbours supporting this choice.
- Good record keeping is essential to good risk enabling care: Whilst there was an agreed multiagency understanding of Pauline's capacity. Formal capacity assessment reports were not completed in line with policy. There are opportunities to improve recording and monitoring systems to ensure improved compliance with the Mental Capacity Act.
- Lessons learnt from Covid should not be forgotten: The pandemic was undoubtedly a very difficult time to have additional vulnerabilities, but there was also remarkable effort from volunteers and key workers to reduce harm to adults with care and support needs.

Published January 2023

How is learning from SARS embedded within in practice?

The SAB captures all recommendations from SARs on a Learning from SARS/Audit Implementation Plan where all recommendations from SARs and other SAB learning is added and tracked.

The SAB create and manage a SAR action plan and/or each partner agency involved in the SAR is required to submit a Learning from SAR Quality Check to the Business Manager within of 3 months of the SAR endorsement to demonstrate how learning from the SAR has been embedded within their organisations.

Learning events take place to share learning from reviews.

The SAB continually monitors themes in learning from SARs both locally and nationally and uses this to inform the SAB priorities.

The SAB are committed to ensuring that our priorities are current and have and will change priorities in order to support learning from its SARs.#
There is a dedicated page on the SAB's website for case reviews:
http://www.sabberkshirewest.co.uk/board-members/safeguarding-adults-reviews/

SAR Notifications

In 2022/23 the SAR Panel considered eight SAR Notifications of which three were identified as meeting the SAR criteria**.**

Under the Care Act each member of the SAB must co-operate in and contribute to the carrying out of a review. The Board has set out a process for Board members, managers and practitioners, in order to clarify the different roles and responsibilities of individual agencies, the Safeguarding Adults Board and its Subgroups. This includes a notification report template to be completed by anyone wishing to present a case for consideration by the SAR Panel.
Further information can be found here: Safeguarding Adults Reviews | West of Berkshire Safeguarding Adults Board (sabberkshirewest.co.uk)

Reflection

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

The SAB have reflected on its activity over the past 12 months and have identified 3 areas of success and 3 areas where we want to improve:

Success

Partnership	The SAB works in an atmosphere and culture of cooperation, mutual assurance, accountability and ownership of responsibility
Leadership	The SAB demonstrates effective leadership and coordinates the delivery of adult safeguarding policy and practice across all agencies, with representatives who are sufficiently senior to get things done.
Reporting Mechanisms	Reporting mechanisms (to the SAB and from the SAB to the LA's and the boards of partner organisations) are clear and effective.

Improvement

Links	Improve our links with Health and Wellbeing Board, Community Safety Partnership and Children's Safeguarding Board.
Engagement	Improve mechanisms to ensure that the views of people who are in situations that place them at risk of abuse and carers inform the work of the SAB.
Integration	Establish clear protocols that integrate different agency procedures.

Key Priorities for 2023/24

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

The SAB acknowledges that there are reoccurring themes from local and national learning from SARs that must be addressed. As in previous years we will continue to consider what the obstacles are in implementing recommendations and sustaining improvement and there will be a focus on good practice to promote learning, alongside an emphasis on good quality care principles and the role of effective support and supervision of the workforce to embed learning and inform future practice.

It is possible that changes to priorities will be made throughout the duration of this year in light of national and local learning in order to ensure that there is capacity within the partnership to deliver on the most pressing priorities for the West of Berkshire. Any change in priorities will be approved by the SAB.

Through its reflective learning practice, the SAB have identified the following priorities:

Priority 1	To seek assurance that quality of health and social care services delivered in the West of Berkshire or those commissioned out of area for West Berkshire residents is monitored effectively and there is a proportionate response to concerns.
Priority 2	Embedding a good understanding of Mental Capacity Act within the practice of our statutory partners.
Priority 3	Serious Violence and Exploitation, understanding the gaps from an adult safeguarding perspective.
Priority 4	Review and relaunch of the SAB Quality Assurance Framework

Appendices

Reference	Description	Link
Appendix A	SAB Member Organisations	[Click here]
Appendix B	SAB Structure	[Click here]
Appendix C	Achievements by partner agencies	[Click here]
Appendix D	2022/23 SAB Business Plan	[Click here]
Appendix E	2023/24 SAB Business Plan	[Click here]
Appendix F	Partners' Safeguarding Performance Annual Reports:	
	Berkshire Healthcare Foundation Trust	[Click here]
	West Berkshire Council	[Click here]
	Wokingham Borough Council	[Click here]
	Royal Berkshire NHS Foundation Trust	[Click here]
	Reading Borough Council	Not ready for publication
	South Central Ambulance	[Click here]

West of Berkshire
Safeguarding Adults Board

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Reading | West Berkshire | Wokingham

Berkshire West Safeguarding Children Partnership Annual Report 2022/2023

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Foreword/Executive Summary from the Berkshire West Safeguarding Executive

Welcome to the Berkshire West Safeguarding Children Partnership (BWSCP) Annual Report for 2022/2023, which provides an account of the work and progress undertaken by the multi-agency partnership to promote the safeguarding and wellbeing of children in Reading, West Berkshire, and Wokingham.

Our unique tri-borough partnership provides us with opportunities for collaborative working over a wider footprint. This can be challenging, and takes time, but throughout this document you will see examples of our progress. These include but are not limited to the alignment of Threshold Guidance to support continuity for practitioners working across Berkshire West, provision of support and training for schools (Alter Ego Productions) and clear and specific updated procedures and practice changes as a result of case reviews.

During this reporting year we have published an unprecedented six Local Child Safeguarding Practice Reviews. The Child Safeguarding Practice Review process requires significant resource from all our partner agencies, and it is a huge strength of our local safeguarding leads that they have, and continue, to commit to each review with openness, fully prepared to identify and respond to immediate learning. Please see section 3 for further information on these reviews and the learning identified.

We continue to reflect and scrutinise our multi-agency safeguarding arrangements to gain the benefits from working over a three local authority area footprint. Our new Independent Scrutineer, David Goosey, has been a huge help in enabling us to think more collaboratively and identify where our endeavours to work together are best focused. Please see the Governance and Accountability page below for more information. In addition, throughout the report you will see 'Scrutiny and Challenge' boxes that highlight where we need to focus our attention.

We would like to take this opportunity to acknowledge and say thank you to every member of the Partnership, our Subgroup Members, practitioners from all our partner agencies, education colleagues, volunteers, and those people out in the community, for their commitment and the work they continue to do to help keep children in Berkshire West safe and to improve their life chances. We would also like to thank our Partnership Business Unit, who manage all the partnership meetings, support the Chairs, and keep in communication with colleagues across the whole of Berkshire West. This is no mean feat, and we all appreciate the positive nature of the team, the high calibre of work produced, and their ability to keep the partnership on track.

Governance and Accountability – review and future arrangements

Our multi-agency safeguarding arrangements were created as a result of revised statutory guidance (Working Together to Safeguard Children 2018) and have been in existence as the Berkshire West Safeguarding Children Partnership (BWSCP) since June 2019. The Statutory Safeguarding Partners hold the oversight, governance, and responsibility of the partnership arrangements, with delegated responsibility to the BWSCP Safeguarding Executive.

The composition of the Safeguarding Executive from June 2022 is:
- Directors of Children's Services - Reading, West Berkshire, and Wokingham
- Chief Nursing Officer – Integrated Care Board (Buckinghamshire, Oxfordshire, and Berkshire West)
- Head Protecting Vulnerable People - Thames Valley Police
- Chief Superintendent, Local Policing Berkshire – Thames Valley Police
- Independent Scrutineer (Chair)

From the outset our multi-agency arrangements have been designed to be flexible, with the Safeguarding Executive acknowledging the need to review the structure and responsibilities if required. As such, we recognised there were some challenges and improvements required in our high-level accountability and governance, communication between subgroups, and our scrutiny model.

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The statutory responsibility for the partnership arrangements sits at the Chief Executive level of the safeguarding partners, who delegate this duty to the BWSCP Safeguarding Executive. It is vital that the Chief Executives remain informed of progress and are themselves curious about risks or improvements made, plus the potential or realised benefits of a tri-borough shared arrangement. We recognised that this link needed to be stronger, therefore we initiated regular joint meetings between the three Local Authority Chief Executive Officers and the three Directors for Children's Services. These meetings are being broadened to include the equivalent roles within Thames Valley Police and the ICB, and a new scheme of delegation is in the process of being agreed to ensure clear governance and line of sight for the statutory partners.

This year we have benefitted from the challenge, support, and advice of our new Independent Scrutineer. This role has been a critical part of our Safeguarding Executive discussions, enabling us to consider different viewpoints and think critically. David has also provided a consistent approach to the Chairing arrangements of the Executive Group and the three locality Independent Scrutiny and Impact Groups. We are clear that this role does not hold responsibility for the partnership, which firmly remains with the Safeguarding Executive, but Chairing these particular groups allows a vital communication link between them and provides a helicopter view across Berkshire West. Further links between the Safeguarding Executive and the wider subgroup structure will continue as we plan to invite Subgroup Chairs to periodically join the Executive meeting to discuss how the work of the groups can be better understood and shared.

For this reporting year the Safeguarding Executive met monthly to enable conversations and decisions to move quickly while our Independent Scrutineer settled into post. We have now agreed to return to a quarterly meeting timetable to enable work to progress in between meetings. Likewise, we have moved the Independent Scrutiny and Impact Groups to be quarterly and in line with the data availability, to support partnership colleagues to be able to complete work and auditing in between meetings and enable actions to be progressed and completed.

An area of focus for us going forward is the need to improve our multi-agency audit planning and delivery. This year, multi-agency auditing has continued to be driven on a locality basis through case review recommendations or inspection preparation. While the audits have been useful and learning is shared across the partnership, this still lacks clear coordination with no formally agreed multi-agency auditing process and is an area of development for the Independent Scrutiny and Impact Groups. We have, however, implemented a new Quality Assurance Framework, with the considerable help of our Independent Scrutineer. This provides clear purpose and focus for the partnership, detailing the safeguarding assurance processes we expect to follow (See section 4).

Our partnership structure allows us to promote partnership collaboration, which has enabled constructive independent scrutiny from partner agency colleagues. This has been evident locally in our subgroups but is also replicated in our pan-Berkshire work. Further details can be found in the following sections.

Scrutiny and Challenge:
Working over a Berkshire West footprint is complicated, and it requires continued engagement, ownership, discussion, and willingness for it to work at all levels and to be successful and provide added value. Our tri-borough partnership provides us with the opportunity to think more creatively, for example, the opportunity of cross boundary working allows us to identify common safeguarding issues and consider the strengths of joint discussion and co-working with partners. The examples above provide some evidence of the positive impact for our workforce of working in this coordinated way. However, much more could be done and should be done at pace to benefit from cross boundary working. This has to be a major part of the progress achieved in the coming year.

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During the 2021/22 year the BWSCP focused on some key themes identified by Local Child Safeguarding Practice Reviews and feedback from colleagues within our multi-agency safeguarding arrangements. This was undertaken in subgroups across our localities, Berkshire West, and Pan Berkshire. The BWSCP subgroup structure chart can be found in Appendix 1.
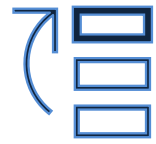
Whilst individual organisations respond to emerging and existing safeguarding concerns, the information below represents the partnership approach, work, and outcomes in relation to these themes.

OUR APPROACH TO EXTRA-FAMILIAL RISK – CONTEXTUAL SAFEGUARDING, EXPLOITATION, AND SERIOUS YOUTH VIOLENCE

We recognise the importance of practitioners understanding the local approach to 'contextual and complex' safeguarding and how this work needs a response often outside of our usual safeguarding frameworks.

There are regular multi-agency meetings in each of the three areas that discuss individual cases and separate strategic meetings to agree a joint agency response. These are routinely reviewed and changes to approach taken where necessary.

In Reading, an Independent Reviewer was appointed to review the Child Exploitation Missing Triage and Review (CETAR) and Child Exploitation and Missing Operational Group (CEMOG) Meetings following a recommendation in the Thematic Child Safeguarding Practice Review. There were a number of positive reflections including clear information sharing within the meetings, trauma informed compassion around the young person's experience, great relationship among colleagues attending the meetings and exploitation mapping was deemed important, and practitioners were pleased with the mapping work done.

There were recommendations for improvement also and these include better involvement with the young people and their parents, increasing the timeliness of referrals into these meetings, more effective meeting actions and timeframes (with an escalation route identified), introduction of a risk and issues log and more regular multiagency audits, where all agencies look at the arrangements for the young person. Including Adult Services to enable better transition planning is important, all 'red' raged cases should have a social worker and a problem profile is required. The review was completed in March 2023, and a multi-agency group is putting in place an action plan to support these recommendations.

In West Berkshire our Independent Scrutineer attended an Exploitation & Missing Risk Assessment Conference (EMRAC) and provided some useful feedback for development in the 2023/24 reporting year for the incoming chairs of the group. The feedback was mostly positive, noting that the meeting was well managed, the purpose was clear and understood by those present and the Child Exploitation/Child Sexual Exploitation criteria being used to good effect. There were close working relations between several different professionals and agencies which facilitated information sharing. A recommendation was to explore contexts further, including that of the impact of significant harm and ensuring that the young person's ethnicity is discussed and understood, as these will have an impact on the young person's identity.

Indicator Tool: To support our vulnerable young people, it is crucial that practitioners have the right tools and knowledge. Colleagues across Berkshire West continue to receive contextual safeguarding or similar training from their respective organisations. Colleagues are also supported to use the Pan Berkshire Exploitation Indicator Tool, which is regularly reviewed by the Pan Berkshire Exploitation Subgroup to ensure it is fit for purpose, ensuring a county wide approach. Locally, audits have shown the tool is well used and subsequent referrals are appropriate.

Audit: West Berkshire colleagues conducted an audit of indicator tools to establish if the relevant EMRAC thresholds were applied on a consistent basis, this concluded that in the vast majority of cases thresholds were

correctly applied. The type of factors that are most prevalent would commonly be present in young people working with children's social care. There has been a considerable increase in the number of young people identified at risk of exploitation where there is family relationship breakdown or conflict in comparison to the previous year.

Local Child Safeguarding Practice Review (LCSPR) Response:
In Reading, following the Thematic LCSPR into Serious Youth Violence, weapon crime continues to be a priority; Thames Valley Police Officers have a process in place to stop and search "habitual" knife carriers in the community. Thames Valley Police continue to provide safety arches in Secondary Schools when needed and the Neighbourhood Police Team have offered to support and undertake work with primary schools. Funding was secured by Thames Valley Police to provide assemblies from St Giles Trust in Reading schools. St Giles Trust helps vulnerable young people who are criminally exploited through gangs, serious violence, and offending. More than 20 assemblies were delivered to year groups seven, eight and nine across a number of Reading Schools and focused on debunking the myths and stereotypes around crime, weapons, gang involvement, county lines, exploitation, and violence.

Impact of LCSPR learning:
In Wokingham, following a LCSPR featuring serious youth violence, a pilot Exclusion Prevention Programme was initiated in September 2022 involving 5 schools in the area which had the highest exclusions rates. This programme is focused on exclusions related to offending type behaviour and works with the individual children and their schools to support the pupil to remain in school. In May 2023 the programme was working with 9 children and had evidence of success for a child who had been planned to move education settings but will now be staying at their current school given the noted improvements after they started working with the Prevention and Youth Justice Service.

Impact of Partnership working:
Adolescent Risk – Reading Festival – Concerns were raised by local services about the safeguarding and welfare of young people who attend large scale events such as festivals. Festival Republic alongside colleagues across the Partnership footprint undertake work in preparation for Reading Festival on an annual basis. The safeguarding practice at Reading Festival 2022 was effective and a Safeguarding Coordinator is always on site alongside welfare teams; there are key safeguarding partners in the welfare teams. There are also links with local hospitals, Thames Valley Police, and South-Central Ambulance Service.

Planning for 2023 will include a review of the visibility of services for young people and signage at the festival so any concerns can be responded to effectively. Festival Republic and local partners will be facilitating a project looking at the development of Help Hubs that will operate 24 hours a day throughout the festival period. These Hubs will be staffed by local safeguarding professionals and will be a one-stop hub where young people can come to talk, seek advice, and offer support.

Attending any large event, such as Reading Festival can be anxiety inducing; the Mental Health Support Team are considering hosting webinars and assemblies for the parents of Festival Goers to outline the range of safeguarding officers available at the festival.

Impact of Partnership working:
Starting Point – Navigator Programme - The Starting Point Navigator programme launched in June 2021. Based within the Royal Berkshire Hospital over the weekend it supports young people who come to the Emergency Department due to violence or risk-taking behaviours with the aim of reaching young people at a moment of crisis and to try to connect/divert them to other opportunities.

This programme format has been introduced in schools to engage with young people that are struggling in and need additional support. They offer support both in the education setting, but also ensure the young person is connected with a mentor in the community. So far, the programme has connected with 47 young people. Once they have made a connection, they work to understand their interests, what they want to achieve and explain to them the opportunities available via the Navigator Programme. Young People have an allocated mentor to accompany then throughout their journey and provide support as and when required.

STRATEGIC RESPONSE TO EXTRA-FAMILIAL RISK

We recognise the importance of practitioners understanding the local approach to 'contextual and complex' safeguarding and how this work needs a response often outside of our usual safeguarding frameworks. Locally, high profile incidents of serious youth violence have reminded us that a coordinated and consistent approach and response is crucial to support our families and practitioners.

In recent years, each locality area has produced a multi-agency strategy that relates to extra-familial Harm (using the terminology of either Adolescent Risk, Exploitation or Harm Outside the Home). While the detail and governance of these strategies is different for each locality, the BWSCP expectation is that there is general consistency in strategic approach and response, while recognising that the scale and breadth across local service delivery may differ. For example, we know that the Thames Valley Police response will be consistent across Berkshire West, but the preventative services provided by other agencies will vary, dependent on need.

While the three locality-based strategic groups have been continuing to provide direction within their locality, the BWSCP Safeguarding Executive have agreed that greater alignment of strategies is a key priority for 2023/2024.
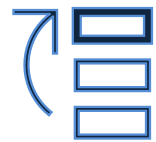
Our Strategic Intent: *To work towards locality-based strategies for Extra-Familial Harm that are more aligned, supporting a more combined and collaborative approach across Berkshire West.*

A task and finish group will be set up in in July 2023 to progress this work. For more information see the BWSCP Delivery Plan: BWSCP Website - Assurance Documents

Exploitation (Yellow YoYo) Project: To support the strategic intent for 2023/24, Thames Valley Police were able to offer additional funding to commission an organisation to review at the customer journey for all organisations that should either signpost or offer direct support in relation to exploitation. We want to ensure that, as far as possible, the public receive a consistent and user-friendly experience when they are looking for help – from the language used through to appropriate signposting and support. This work was commissioned at the end of the reporting year, and results will therefore be discussed and incorporated into the strategic work during 2023/24.

Scrutiny and Impact:
In each area there is a continued drive to ensure processes and strategic direction are improving through evaluation and review. Whilst changes have been implemented, the Child Safeguarding Practice Reviews have highlighted that more is required. These recommendations need to be acted upon quickly, and the learning shared widely. The Safeguarding Executive must work together to improve aligned responses and understanding across our Berkshire West footprint.

OUR APPROACH TO EXTRA-FAMILIAL RISK – ONLINE SAFETY AND SOCIAL MEDIA

To support schools, parents, and young people, we developed an Online Safety Page on the BWSCP website. It contains information relating to various types of online abuse that our young people can experience with links to guidance and agencies that can provide further information or support. There are also links to some useful articles for parents and carers about how to keep young people safe online. Online Safety features regularly in the BWSCP Facebook and Twitter posts.
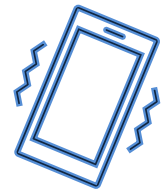
We recognise that social media has been highlighted as a significant concern within the Local Child Safeguarding Practice Reviews focussing on serious youth violence. Whilst the scope of the reviews could not evidence social media as harmful contributory factor, the criminal processes and a subsequent documentary did highlight the influential effects of pushed content and how social media can be used to organise and incite violence. As a result, our reviews have included recommendations for our local Partnership to both support practitioners and schools with current knowledge and information, whilst recognising that this is a national, if not global, issue.

Crest Advisory Report: The Dawes Trust commissioned Crest Advisory in 2019 to run a multi-year programme of work examining the underlying causes and drivers of serious youth violence including the use of technology, specifically social media. As part of the process, Crest Advisory interviewed a number of Reading Headteachers', Thames Valley Police and Metropolitan Police colleagues; Thames Valley Police Project Alpha has been created to assist with the disruption of harmful media content that could be seen to incite violence, specifically gang related content.

The report published in 2022 identified that online conflict is happening much younger than the current preventative work is aimed at and whilst primary schools are aware of the issues, other services do not engage until secondary school age. One of the key findings of the report outlines that violence is seen as an accepted response when it is not challenged; if a large group of individuals accept conflict escalating online it increases the expectation that it will be resolved physically. Crest Advisory are recommending that there is a roll out of "online active bystander" training for children and young people, delivered through PSHE lessons from key stage 3 to enable children and young people to understand that their actions online have real world consequences.

Effective reduction of the risk of violence from online activity cannot be achieved through any single group or organisation through a single solution, instead a wide range of mitigation strategies need to be deployed at varying scales: parents, public services, schools, technology companies and Ofcom.

**Local Child Safeguarding Practice Review (LCSPR) Response:**
Learning from our Child Safeguarding Practice Reviews has challenged us to understand how confident practitioners are in speaking to young people about their social media usage and online safety and understand how they use this information in their work with young people and any assessment of risk. We therefore undertook a practitioner survey in early 2023 to explore this further.

78% of respondents knew where to find their organisations online safety policy, and 79% did feel confident to speak to children about social media and how they use it. Respondents raised a number of barriers they felt they encountered to them regularly being able to have these discussions, and half reported that no clear training was available to them on this subject. While respondents were able to list a range of negative influences the social media can have, it did raise some questions about practitioners using a trauma informed approach. The results of this survey are due to be shared with the Learning and Development Subgroup in the first instance.

Theatre Productions in Schools:

To support our school community, in the Autumn of 2022, the Safeguarding Partnership funded Alter Ego's productions 'In the Net' and 'Unacceptable' for Primary and Secondary Schools across the Berkshire West footprint; these performances were well received and a positive experience for the schools involved.
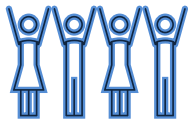
30 performances of the In the Net production were delivered to 43 Primary Schools (schools shared sessions), reaching approximately 3,500 pupils in Years 4-6.
Performances of the Unacceptable production were delivered to 29 Secondary Schools, reaching approximately 5,800 pupils in Years 9-11.

Following these performances, a survey with all participating Schools was undertaken in order to gain feedback on how engaging the sessions were and whether there was an increase and staff and student knowledge in relation to the subject matter.

Primary Schools reported that:
- children were able to list and give examples of how to stay safe online and use the internet responsibly
- children were able to talk confidently about what they learnt and understood that they should speak out if they see something scary, or someone says something unkind
- children were able to understand the importance of being kind and the repercussions of their actions

Secondary Schools reported that:
- the performances increased pupil's awareness of sexism, sexual harassment, and sexual violence and gave them the space to reflect on their views
- the performance promoted good 1:1 discussions
- the performance is being used as a tool as part of their restorative measures
- the real-life stories were very useful, and it sparked a discussion about sexism; and how to challenge the behaviours of the minority of students

EFFECTIVE UNDERSTANDING OF CHILD PROTECTION THRESHOLDS

Aligned threshold guidance
It is crucial to prevent escalating risk by supporting all partners to be able to respond to concerns and confidently hold responsibility for risk at an appropriate level. This should prevent our children and their families from having to access high level support or not be subjected to Children's Social Care involvement if not required.

In Berkshire West we have three locality-based Threshold Guidance documents, due to differences in relation to referral routes and service provision for each Local Authority Children's Services. However, a project was initiated towards the end of 2021/22 to fully align and standardise these three documents, which successfully concluded in the autumn of 2022.

The content and layout of the documents was updated to include:
- The issues highlighted by a local Domestic Homicide Review to ensure the content adequately reflected information in relation to the risks associated with domestic abuse, and the new Domestic Abuse Act.
- Improve the risk and protective factors in relation to exploitation, special educational needs and disabilities and sexual harassment in schools
- Alignment of the document detail across the three areas, with the only differences being referral information and some specific service detail
- An improved layout to enable practitioners to more easily access the important information
- Improved information and detail about consent requirements at each level of need.

These revised documents mean that whichever document a practitioner refers to they know that the detail within the levels of need is the same in each local authority area.   In addition, we have uploaded the document detail

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into a webpage. Practitioners can now easily review threshold guidance online, as well as download a pdf version is preferred. Details and links to the webpages and documents can be found here: BWSCP website - threshold guidance

Holding and managing risk for cases that don't meet the criteria for statutory intervention
Following an independent review of the 18 rapid reviews undertaken across Berkshire West from the beginning of 2020 until June 2021, a theme arose relating to professionals' confidence in holding risk for cases that fall below the statutory level. Education colleagues were asked to complete a short survey to coordinate a response to the findings.

The survey was sent out in early 2022/23 to Designated Safeguarding Leads across West Berkshire and Wokingham and 132 responses were received. The results of the survey have not yet been discussed at the Education Safeguarding Engagement Groups, but initial results indicate that 24% of respondents in Wokingham and 34% of respondents in West Berkshire were 'somewhat not confident in holding risk'. In addition, 43% of respondents in Wokingham were not aware of either the Threshold or Escalation Guidance documentation, compared to 22% in West Berkshire. However, most responders do feel confident to escalate safeguarding concerns within the multi-agency environment with only 6% and 11% not feeling confident in Wokingham and West Berkshire respectively.

Scrutiny and Impact:
There is clearly some awareness raising work to be considered with regards to the Threshold Guidance and support to be considered for education settings to enable them to feel more confident in working with some of their more challenging pupils.

Local Child Safeguarding Practice Review (LCSPR) Response:
In response to learning from our local Safeguarding Practice Reviews the Partnership produced guidance to support Professionals, Parents and Carers to understand the Child in Need process and the expectations when attending meeting. This guidance is easily accessible on our website and the links have been widely shared across the workforce.

- Guidance for Practitioners: BWSCP Website - Professionals: Child in Need meeting and plan
- Information for Parents and Carers: BWSCP Website: Parents and carers: Child in need meeting information

PRIORITY REVIEW FOR 2023/2024

Through the support of our Independent Scrutineer, the BWSCP Safeguarding Executive have reviewed and agreed some clear priorities for the year ahead. In addition to the 'Strategic Response to Extra-Familial Harm' (noted above) we have also specifically agreed the need for clarity and guidance in relation to our combined response to Neglect. This is also in response to one of our Local Child Safeguarding Practice Reviews. Neglect is a persistent safeguarding risk for children, and it can be difficult for professionals with safeguarding responsibilities to identify indicators of neglect, to assess whether what they have observed is sufficiently serious for them to take action, and to decide on the most appropriate course of action.

While each locality is working with a significant number of cases of neglect, with a variety of tools and approaches, there is currently no strategic strategy to tackle neglect either at a locality or Berkshire West level. This is where our tri-borough partnership can provide consistent strategic guidance, which will particularly benefit practitioners who work across Berkshire West.

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Our Strategic Intent: *To develop an agreed Berkshire West approach to neglect in relation to principles, training, and evaluation of service provision, enabling consistency but flexible enough to allow each area to deal with the issues relevant to their population.*

A task and finish group will be set up in in July 2023 to progress this work, building on the BWSCP Practitioner Guidance for Neglect that was agreed in 2023 (BWSCP Website - Neglect) to produce a Berkshire West Strategy.
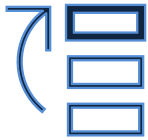
Other areas of focused work identified include the development of a Berkshire West MASH Oversight Group (more information in Section 3), actively respond to the Social Care Review and Working Together to Safeguard Children 2023 consultation when published, develop a comprehensive BWSCP Learning and Development offer (more information in Section 5) and embed the Quality Assurance Framework, providing assurance and evidence of progress and impact (more information in Section 4).

For more information see the BWSCP Delivery Plan: BWSCP Website - Assurance Documents

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RAPID REVIEW ACTIVITY AND LEARNING

During the 2022-2023 year, only one Rapid Review was undertaken at the beginning of the reporting year. This was a case in Reading of an unborn child who died unexpectedly in utero at 36 weeks gestation. This was initially notified to the National Child Safeguarding Practice Review Panel as both parents were well known to Children's Services. However, one outcome of the Rapid Review meeting was to agree that the death was not as a result of parental abuse or neglect, although there were co-morbidity factors recognised. This was reported to the National Child Safeguarding Practice Review Panel, who agreed that a formal Rapid Review Report was no longer required, however we decided to complete the Rapid Review and submit a report as there was learning identified. This included:

- The documentation of case history needs to be evident in records and considered in meetings and in planning. As a result Children's Social care reported that quality of practice was externally audited, to consider the use of history in assessments as part of accelerated improvement work. This practice would remain in place.
- Thames Valley Police information could have been shared and documented better, plus, the recording of requests for strategy meetings and conferences for all the children in the family concerned could be streamlined to make it more easily followed. This learning was shared with the MASH Manager and included in training across the area.

Scrutiny and Challenge:

It is notable that between March 2020 to June 2021, an unprecedented total of 22 Rapid Reviews were undertaken across Berkshire West. The case described above was the only case notified from July 2021 until March 2023. While there is no indication that cases have been missed, colleagues across the partnership must remain alert and ready to discuss cases which may meet notification threshold.

It is positive that there have been cases of potential concern brought to the Case Review Group for discussion throughout this period, and examples of cases that may meet notification threshold being discussed between statutory partners. However, this discussion process did not have a clear escalation or sign off route, which has been rectified through revisions to the BWSCP Case Review Process document described below.

CASE REVIEW GROUP ACTIVITY

The Case Review Group continues to promote active discussion about any cases that colleagues may feel meet criteria for a level of multi-agency review. This was particularly important considering the significant drop in cases being identified that met the criteria for making a notification of a serious child safeguarding incident. Due to the reduction, consideration was given to the process in place and challenging discussions took place to review whether any cases may have been missed. During this period the Case Review Group continued to review cases of concern, that didn't meet the criteria for notification, to ensure that there was a multi-agency view and to consider if any further local-based work was required.

An outcome of the case review process discussion and the Independent Review report referenced in the previous Annual Report, was that the Safeguarding Executive had not been fully sighted on all the Rapid Reviews from across Berkshire West, at the different stages of review. This inadvertently meant a lack of clear ownership and direction at the Executive level which subsequently impacted on the ability of the Safeguarding Executive to be fully assured about the process, learning identified and the impact. A thorough review of the process has been undertaken, to ensure that appropriate Safeguarding Executive members are informed or involved at key stages of decision making. The latest version of the BWSCP Case Review Process document can be found here: BWSCP Website - Child Safeguarding Practice Reviews

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LOCAL CHILD SAFEGUARDING PRACTICE REVIEWS

The purpose of a Child Safeguarding Practice Review (LCSPR) is to look at the multi-agency response of organisations working alongside children and families, to identify any improvements that can be made to the services they provide; and as a partnership for us to understand and share good practice and learning to improve and promote the wellbeing of our children and young people.

Published LCSPRs:

The BWSCP have published six LCSPRs in the 2022/2023 year. These relate to two cases of known or suspected non-accidental injury of a young child (Reading 'Aiden' and West Berkshire 'Bobby'), one case of sexual abuse (Wokingham 'Aisha and Ciara'), two individual CSPRs for two perpetrators of serious youth violence (Wokingham 'Harry' and 'David' and a Thematic Review into the same topic for Reading). All our LCSPR reports are published on this page: BWSCP Website - Safeguarding Practice Reviews.
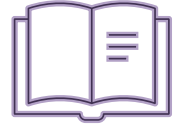
Some of the key areas of learning from the cases include:

- Assessments should recognise and take account of the multiple risk factors, analyse statements of fact about a parent/adult with what impact the issue may have on a child's safety and welfare, ensure records reflect this thinking process, management oversight promotes clear rationale for decisions.
- Recognising and understanding patterns of behaviour through the use of chronologies (single or multi-agency) to support assessment and risk management work.
  - Ensuring safe step down of intervention - to include a clear, multi-agency process to support these cases once higher level of intervention is removed and re-assessment of risk if the family circumstances change, or parental disengagement is a cause for concern.
  - All cases reiterate areas for improved information sharing at different stages in safeguarding processes, plus the need for empowering practitioners to escalate if they have a concern or difference of opinion.
  - It is important to find out and understand if family members have any learning needs or borderline learning difficulties - professionals must make sure that family members understand what meetings they are asked to attend, why the meeting is happening, and what is expected of them.
- The importance of Child Focused Practice - professionals should always try to understand and record children's views where possible, even if they are young with limited verbal skills, with due consideration of different communication styles, including issues of disability, age, and language.
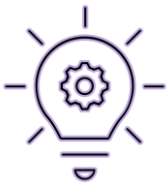
Learning specifically in relation to serious youth violence:

- Recognition that this cohort are likely to have a range of complex needs and are at risk of school exclusion.
- Improve information sharing with schools about pupils at risk of exploitation.
- The need for appropriate alternative education provision to support a multi-agency response.
- Earlier referral and engagement with CAMHS for children at risk of exclusion and understanding the role of speech and language services.
- Development of diversionary support to avoid entry into the criminal justice system.
- The need to reduce the number of professionals involved, whilst enabling consistency and continuity of workers to build relationships with the young people and their family.
- Improving data to understand the problem profile more accurately.
- Ensure that the needs of children and young people with special educational needs and disabilities are really understood by all professional working with them.

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As part of the Child safeguarding Practice Review process, we also identify and highlight the positive work undertaken by practitioners. Many examples of this were identified, including:

- Clear identification of vulnerabilities in families and multi-disciplinary discussions being undertaken.
- Early referrals when concerns identified, and examples of quality assessments.
- Swift responses after an incident to safeguard children and their siblings.
- Practitioners effectively sharing information and communicating, and examples of cultural sensitivity.
- Positive examples of practitioners being child focussed and challenging decisions when they felt it was appropriate.
- Significant support was initially put in place for a family, which was appropriately reduced when good progress was made.
- Examples where the multi-agency response when some new information was received was timely and coordinated.

Recommendations and action plans are in place for these reviews; they are being actively monitored and acted upon through the Berkshire West Case Review Group and the locality based Independent Scrutiny and Impact Groups. A number of partnership actions have been completed which include:

- A BWSCP webpage has been created using the best practice resources developed by the Centre of Expertise on Child Sexual Abuse. These resources, and other guidance, have been shared widely across the safeguarding network
- Review and update of the Threshold Guidance (noted above)
- Review and update of the Escalation Guidance and procedures
- Produce and share Child in Need Meeting Guidance for practitioners, and parents/carers (noted above)
- A range of locality and agency specific, plus Berkshire Wide procedures and processes have been reviewed and updated as a direct result of CSPR learning.

Local Child Safeguarding Practice Review (LCSPR) Response:
There are examples of our response to LCSPR recommendations throughout this report, but in addition:

- In Wokingham Children's Services, following CSPR recommendations, there has been significant improvement in process, practice and information sharing when a child with an Education, Health, and Care Plan (EHCP) moves into the area. Multi-disciplinary meetings are arranged to share any relevant information between new professionals and those formerly involved, providing continuity for the children/young people moving between Local Authorities and mitigates the risk of important information being missed, or the family 'repeating their story'. Social Workers are now routinely invited to annual reviews of children/young people with an EHCP, and if there is no Social Worker involvement, consideration is given to whether a referral to Children's Social Care or Early Help would be beneficial to the family.

- Thames Valley Police has a vulnerability and risk annual programme and, as a result of LCSPRs, child criminality, and the appropriate trauma informed and partnership approach to children suspected of crime, was covered in the 2022 training delivered to Incident Crime Response and Neighbourhood teams. A Vodcast has also been developed with family members involved in a serious youth violence incident that triggered two of our LCSPRs. The Vodcast will be mandatory training for all front-line officers, student officers, PCSO's, Child abuse and MASH staff.
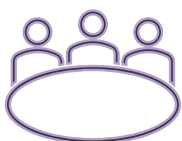
- In West Berkshire Children and Family Services, Conferences Chairs received refresher training to ensure that 'respectful curiosity' is maintained, and self-reporting is regarded with due weight. The Service Manager has carried out observations and confirmed that the issues which arose within the case review are considered as part of this process and that reflective discussions occur where these factors are considered. The Service Manager reads all feedback provided by attendees of conferences and where necessary these are acted upon and used to inform service development.

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- Brighter Futures for Children initiated a review of the Pupil Referral Unit (PRU) and alternative provision, focusing on their potential contribution to work to combat extra-familial harm and exploitation. The review has concluded, and actions are being implemented. The report commented that there had been a recent change in leadership at the PRU, and interviewers were encouraged with their level of planning and training around areas of safeguarding concern. Relationships need to be strengthened with the borough's alternative provision and they need to be considered by all professionals as a key partner in the safeguarding network around a child. Priorities include ensuring consistent information for schools and internal Local Authority staff to ensure monitoring, quality and review is in place, Alternative Provision safeguarding policies need to be developed more in respect of Extra-Familial Risk and Harm through training, engagement, and local offers of Continual Professional Development.

Audit:

In response to LCSPR learning Wokingham Children's Services have undertaken an audit of cases where the Early Help service has been tasked to support young people with special educational needs and disabilities. This included feedback from parents and identified that a better understanding of what constitutes 'Early Help' in Wokingham - including thresholds and the full range of early help activity on offer is required; reiterated the need for shared knowledge, co-ordination, and oversight for the group of children who have SEN support needs and EHCPs, but also that when a family receives an appropriate Early Help service that feedback is positive and the family find the support beneficial.

Sharing learning:

Along with ensuring processes and procedures are effective, once of the key outputs from any case review is to share learning to improve practice. Whilst there is much learning for practitioners involved in a case review, while the process in ongoing, we also produce a two-page learning brief for each case published. This focusses on the learning identified, the recommendations, and information and guidance for practitioners. Along with the full report, we share these widely with the expectation that these are used and discussed within agencies and teams.

In addition, details of the learning and recommendations from the Rapid Reviews and recently published CSPRs have been collated and shared widely, particularly at sessions with School Designated Safeguarding Leads and nearly 100 GPs across Berkshire West. Along with common themes and learning from previous case reviews the presentation slides, published reports, learning briefs and 7-minute briefings can be found here: BWSCP Website - Safeguarding Practice Reviews

Local Case Review Process:

While previous feedback from the National Child Safeguarding Practice Review Panel and the independent review conducted in February 2022 concluded that the local process for Rapid Reviews has been effective, one LCSPR (not yet published) identified some weaknesses in our LCSPR panel process and another. As a result, a review of our Case Review Process Guidance and Documentation has been undertaken, with key areas regarding the expectation of the LCSPR Chair and Panel, and escalation processes strengthened. The revised document can be found on our website: BWSCP Website - Safeguarding Practice Reviews

Review of National Cases of Local Interest

The Berkshire West Case Review group regularly reviews recently published national cases. Information is collated and shared with regards to learning and recommendations that would benefit from further consideration locally.

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As an example, following the tragic death of Arthur Labinjo-Hughes and subsequent National Child safeguarding Practice Review and Joint Targeted Area Inspection, colleagues across Berkshire West initiated a project to review local services against the report findings. The project focused on the different approaches and multi-agency support into the MASH arrangements in the three local authority areas. Some of the key findings were:

- Multi-agency input into the MASH varies between the three areas.
- MASH processes are not consistent across the three areas.
- While there are good examples of strong multi-agency response and decision making, this is not consistent and in one area there were significant concerns regarding decision making resting solely with Children's Social Care.

The results of this work identified how different the MASH approaches are in each area, which was surprising considering the three areas share the same police and health partners. This has directly led to the Safeguarding Executive agreeing that this is a priority area of work and the need to establish a Berkshire West MASH Oversight Group with the remit to provide scrutiny, advice, and challenge on how the MASH arrangements are working in each locality and identify improvements.

Impact of Partnership Working:

Learning from local and national safeguarding case reviews highlighted the need for a clear escalation policy that all practitioners felt confident to use. To support our local practitioner's additional escalation guidance was produced to explain how to work towards the best outcome for a child, particularly in complex cases, local contact information for each agency was included so that contact can be made should an escalation reach a stage where formal resolution is required. A briefing note template was also included for practitioners to complete, to allow them to outline their concerns and describe the solution they are looking to achieve. Our solution focused approach to the escalation process has been replicated in the Pan Berkshire Policy.

Scrutiny and Challenge:

There is considerable independent scrutiny built into the case review process, with multi-agency partners scrutinising information at the Rapid Review stage and Independent Reviewers brought in for Child Safeguarding Practice Reviews. The Case Review Group continues to scrutinise any cases of concern to ensure the appropriate decision has been made. In addition, as Independent Scrutineer, I now have a significant involvement with the subgroup bringing an independent perspective.

The partnership has recognised that improvements needed to be made to the LCSPR process, to increase oversight and management. The revised documentation should support this. It is important that colleagues involved in LCSPRs understand the remit and their responsibility to achieve a proportionate and effective review.

There also remains a need to establish the sharing of learning across a tri-borough arrangement, utilising the new Quality Assurance Framework, and to ensure there is clear responsibility for plans and a method of identifying impact.

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SAFEGUARDING EXECUTIVE: ESCALATIONS, CHALLENGES AND RESPONSES

We are aware that we have challenged ourselves locally by forming a tri-borough safeguarding partnership arrangement but recognise that we can work more coherently and collaboratively across the three borough boundaries. Throughout the document are examples of decisions taken and topics discussed by the Safeguarding Executive, but some other examples include:

Looked After Children Initial Health Assessments (IHA): The Safeguarding Executive were alerted to the local challenges around completion of LAC Health Assessments within the statutory timeframe. Timeliness of health checks is critical because any delay results in the child's care plan not being able to include the child's health needs at the first looked after child review.

Health colleagues were invited to the Safeguarding Executive Meeting to discuss and consider the steps to resolve the issue. A subsequent report from the Integrated Care Board with the provider agency provided assurance that there had been no specific safeguarding concerns resulting from an IHA not being completed within the 20-day period. There were either legitimate reasons for the delay, which enabled a more effective assessment, or process issues were identified which colleagues agreed to resolve. The local Independent Scrutiny and Impact Groups continued to received data and no further issues have been escalated.

Health Visiting Provision: In early 2023, it was identified locally that the unprecedented number of vacancies within the Health Visiting Service led to the need to implement a business continuity plan and develop a remedial action plan with adjustments to the service provision. It was highlighted that even with a full complement of staff there would still be insufficient numbers of HV's to provide a comprehensive service.

Mitigating actions included (but were not limited to) prioritising targeted contacts for vulnerable families, all antenatal notifications being triaged to ensure that targeted face to face antenatal appointments are offered when needed, in the family home, and continued attendance at safeguarding meetings.

There is an LGA review underway into Public Health in Berkshire so hopefully this will provide a clearer picture moving forward in relation to the commissioning position. The Safeguarding Executive agreed that they will wait until the Public Health review has concluded and, in the meantime, regular updates of assurance will be provided to the ISIGs. In recent months the position has improved considerably.

Arrival of families from Ukraine: During 2022 the Safeguarding Executive regularly discussed this situation to ensure organisations were working together and in alignment across Berkshire West. A particular issue relating to accompanied minors was identified as the messaging from Government to Local Authorities seemed not to be complaint with the suggested framework. The Safeguarding Executive agreed that there was merit in aligning the processes across the 3 areas so that practice across Berkshire West was consistent.

QUALITY ASSURANCE FRAMEWORK

In 2022 our Independent Scrutineer highlighted that the partnership was lacking a Quality Assurance Framework to support the understanding of the quality of practice to safeguard children and young people. The Independent Scrutineer has provided us with a framework that combines various data sources (qualitative and quantitative) and is designed to help generate a culture where the best standards of practice are expected, by providing high challenge and high support. The challenge comes via rigorous scrutiny of practice and delivered using skilled feedback across the professional system, which is informed by strong values of openness, transparency, honesty and of never setting out to harm others, whether fellow professionals or children and families. The new Quality Assurance Framework is published on our website: BWSCP Website - Quality Assurance

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BWSCP Dataset Improvements: Reviewing our local data is a key element of the Quality Assurance Framework. Our three areas have very different demographics, and as such are never in the same group of statistical neighbours. However, our children and families regularly cross the borders and as a Berkshire West area we obviously share many safeguarding risks. When we came together as a partnership, we produced a combined Berkshire West dataset that included the same information from all three Children's Services to provide a comparison, as well as data from other key partners. This dataset has been discussed at each Independent Scrutiny and Impact Group (ISIG) meeting during the reporting year. A selection of the data included in the dataset can be found in Appendix 2.

The combined dataset provided some interesting points of comparison between the three local authority areas, but more frequently the natural differences between the data (due largely to demographics, economics, different reporting mechanisms and local procedures) meant that time was spent unnecessarily reviewing these differences rather than understanding what the data was telling us for each locality. The Independent Scrutineer has been supporting the development of an enhanced dataset, which will be locality specific, and more comprehensive. Each locality ISIG will receive data pertinent to them, enabling focussed and relevant discussion. More effective analysis of the data is a priority for the ISIGs and feedback on the new dataset and how it has been used can be provided in the next annual report.

Scrutiny and Challenge:
The existing dataset was not fit for purpose and proved more of a distraction than a mechanism to understand the local picture. The three Independent Scrutiny and Impact Groups need to use and analyse the information within the new enhanced and locality specific datasets more effectively to drive discussion, risk identification and improvement.

SUPPORTING THE EDUCATION SECTOR

We have three locality-based Education Safeguarding Engagement Groups, with Headteacher and Local Authority Safeguarding Leads/representatives, which provides a mechanism for education leaders to identify and inform the development of safeguarding and improvement across schools and ensure that issues specific to the school/education community have a voice and can be escalated for discussion to the Statutory Safeguarding Partners.

Alongside these meetings are locality-based learning sessions for Designated Safeguarding Leads (DSL) where we can share consistent but tailored safeguarding messages. The DSL sessions have continued to develop with a range of key speakers from local services but also regional or national organisations. This year this has included:
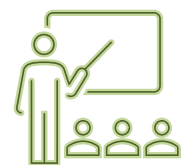
- Royal Berkshire Fire and Rescue Service attended the 3 DSL meetings to provide an overview of the sessions they have on offer for young people. Fire Safe is a programme that schools can refer young people who are showing an interest in or have displayed fire setting behaviours; the programme looks at the consequences of fire setting, provides fire safety information and diverts to alternative activities. They also provide Fire Safety Training along with Road and Water Safety Sessions for children in Years 5 to 7.

- The NSPCC Schools Coordinator attended the 3 DSL meetings to present the range of training and resources that are on offer to Schools. For Early Years Foundation Stage children, they use the 'PANTS' resources as a simple way to talk to young children about staying safe from sexual abuse. For KS1 and KS2 pupils they offer 'Speak Out, Stay Safe' assemblies that teaches young people about all forms of abuse and where to get help. For secondary and further education pupils they offer the 'It's Not Ok' resources and lesson plans that help young people recognise concerning behaviour and identify characteristics of positive relationships as well as the 'Love Life' resources which provides strategies for staying safe as young people grow up and gain independence.

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To support our Education colleagues the BWSCP also developed a briefing for their return after the summer break. It provided safeguarding updates in relation to revised Threshold Guidance, Escalation Guidance, CSPR Learning, Training Links and Private Fostering.

School Safeguarding Audit: The Section 175/157 (school safeguarding audit) process continues to be aligned across the three authority areas using the NSPCC audit tool. The audit request was sent to Schools in the Autumn of 2022 with a 6-week timeframe for completion. In Reading there was a 98.51% return rate, up 7.5% on last year's returns. In West Berkshire and Wokingham there was a 100% return rate.

It is a requirement that schools confirm that they have completed the audit with their Safeguarding Governor and that it is seen by the Local Governing Body, to promote awareness and responsibility for safeguarding within the school governance structure. The returns are analysed by safeguarding leads locally to identify any areas of concern. The results are shared between the local authority leads across Berkshire West to enable the learning to be shared across the three areas, but also with the Education Safeguarding Engagement Group in each locality.

The audits highlighted some local areas of focus however the common areas of attention were:
- Governor and Trustee CP Training
- Parents and carers understanding of child protection and safeguarding policy and procedures
- Visitors understanding of how they are able to raise concerns for a child's welfare.
- Supporting unaccompanied asylum-seeking children
- Online Safety
- Safer Recruitment

Action plans in each locality are in place and will be monitored through the Section 175/157 Subgroup.

Op Encompass: A challenge was raised in the local education safeguarding Engagement Groups that Schools were not receiving timely or accurate notifications of Domestic Abuse via the Op Encompass System. Following this concern, a meeting was held with local Op Encompass leads from Thames Valley Police who advised that they are continuing to develop and improve their automated reporting processes for domestic abuse notifications. However, it was recognised that the police school lead/email details had not been updated since the original request for schools to sign the information sharing agreement in 2017 and some were therefore likely to be out of date. The BWSCP Business Unit has been liaising with colleagues to obtain up-to-date school contact lists which have been shared with Thames Valley Police. This topic needs to be re-addressed in the autumn of 2023 to establish if issues remain.

Scrutiny and Impact:
Domestic Abuse is another example of a high-risk concern where the responsibility for a coordinated response lies with multiple partnership arrangements. It is vital that BWSCP members engage fully with the three new Domestic Abuse Partnership Boards to ensure the risk to children is appropriately included in their agendas and remains a robust challenge within the safeguarding partnership.

Child Death Overview Panel Bereavement pack: Whenever a child or young person dies it is a tragedy. First and foremost, for the child and the family, but also for those around them including school professionals who may have worked with them. Following discussions at the Pan Berkshire Child Death Overview Panel a Bereavement Guide was produced for school professionals on how to respond to a sudden or unexpected death of a child or young person; this document was finalised in the Autumn of 2022. The guidance outlines the Child Death process and other statutory functions that need to be considered as well as providing useful contacts, resources, and links to local support services. This has been shared with schools across Berkshire West and is available on our website: BWSCP Website - Child deaths

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PAN BERKSHIRE ARRANGEMENTS

BWSCP has continued to support the Pan Berkshire safeguarding arrangements through the Section 11 Panel, Pan Berkshire Policy and Procedures Subgroup and Pan Berkshire Exploitation Subgroup. These groups are well respected by colleagues from across the county and are crucial to effective partnership arrangements.

The **Section 11 Panel** requests that representatives from key agencies who work across two or more Berkshire local authority areas attend the panel to present their Section 11 self-assessment return. A tool is provided to enable agencies to demonstrate and provide evidence that they are fulfilling their safeguarding duties under the Children Act 2004. Panel members scrutinise the return, ask questions of the presenter and provide feedback on areas for improvement. Agencies value this process, but our new Quality Assurance Framework is clear that we should expect more challenge and practitioner feedback int eh process to provide greater assurance.

The **Pan Berkshire Policy and Procedures** subgroup is also a multi-agency group with representatives from agencies across the county. The meetings scrutinise chapter amendments suggested by the procedure's provider, but also has a timetable of chapters for local review. This cross border and multi-disciplinary approach enable all Berkshire Safeguarding Partnerships to maintain up-to-date localised on-line procedures that are easily accessed by all practitioners.

Subgroup members remain willing to take responsibility for, and be proactive in, reviewing chapters outside of the schedule provided by Tri.x and in line with our local forward planner. Out of a total of 48 chapters, 30 (62.5%) have been reviewed since early 2022, and all bar two have been reviewed between March 2021 and May 2023.

It is difficult to quantify the impact of this subgroup, however, there remains confidence in the group processes and accuracy of the procedures provided. Any errors are quickly resolved, and good relations with our Tri.x representative has supported us to achieve this. The tone of the group and the strong multi-disciplinary and countywide attendance is a good foundation for multi-agency working. Plus, having a pan county arrangement is helpful for all practitioners working across boundaries.

Impact of Partnership Working: This group also reacts to findings from local case reviews, an example being revisions in the Child Protection Conference chapter following a West Berkshire Child Safeguarding Practice Review. The chapter is now clear that when a case is stepped down from a child protection plan that a child in need plan is in place for at least three months and be subject to management scrutiny and review before closure.

Following a Wokingham Child Safeguarding Practice Review the Children of Parents with Learning Disabilities Procedure was reviewed and refreshed to incorporate the learning from the review, with a specific focus on those parents who do not have a formal diagnosis, in line with the Equalities Act 2010, and signposting the best practice guidance from the Centre of Expertise on Child Sexual Abuse.

It is positive that an issue raised in one local authority area can positively impact procedures that are accessed by six local authority areas.

Scrutiny and Challenge:

Development work is required within the Section 11 process to improve and test the level of assurance provided. This requires improved attendance at the Section 11 Panel from key partners within Berkshire West to enable discussion and support change.

WEBSITE AND MULTI-MEDIA LEARNING

Website: The main mechanism for sharing information with the wider workforce and our families continues to be via the BWSCP website, which is updated regularly and contains a wide range of safeguarding information, guidance and links for support and training.

From April 2022 to March 2023 there were 130762 views on 73 pages. The most accessed page was eLearning with over 5,800 views; this is where the Universal Safeguarding Training is hosted alongside various other learning opportunities, and it is positive that the workforce knows where and how to access this.

The second most accessed page on the BWSCP website was the Child Safeguarding Practice Review page. This page contains the Overview Reports and Learning Briefings for all of the published Reviews. It was anticipated that this page would receive more coverage due to the publication of several reviews; this increase suggests that the ongoing publicising of this page is helping professionals access this information and learning.

This year we have added or improved key information pages on topics identified through audit and case review. These have included, but are not limited to:
- Threshold guidance
- Child in Need process and meeting guidance
- Neglect guidance

Social Media: We have increased our social media presence with regards to promoting safeguarding campaigns, posting on Facebook and Twitter every two to three days. Statistics show that engagement with our posts has increased significantly this year, with the most popular topics being exploitation, mental health, and safe sleep/co-sleeping. Some of the identified areas of focus for this year have been:
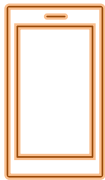
- Summer campaigns on water safety
- Safe sleeping
- Weapon crime and Exploitation
- Online Safety
- Mental health
- Healthy relationships and domestic abuse

E-Learning: Across Berkshire West we continue to provide a free online level 1 universal safeguarding training module that is available to anyone working with children and young people via our website.

It has always been our aim to retain this element of training for our workforce as free to access; over the past 12 months 4008 people have successfully completed the online Universal Safeguarding Training, an increase of 500 from the previous year. This year we updated the case example provided to ensure more recent and pertinent cases of national importance are highlighted.

Newsletters: The Learning & Development Subgroup published a number of newsletters that were developed to help support all professionals in their self-guided learning. Learning and Development is not just about attending training courses, it can include reading, researching, online sessions & webinars, shadowing and looking at useful tools, resources, and websites. The newsletters are available on the BWSCP website (BWSCP Website - Newsletters) and relate to: Transitional Safeguarding, Safer Internet, Effective Engagement and Trauma Informed Practice.

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BWSCP VIRTUAL FORUMS

The Partnership have successfully hosted a number of online multi-agency forums; these are open to everyone whose service works with the children, young people, parents/carers, and families. Each Forum provides professionals the opportunity to gain information about local & national learning, current initiatives, network and share good practice.

Working with Dads – Working with Dads has been a theme in several safeguarding practice reviews. The aim of this session was to help professionals understand the importance of working work more inclusively with Dads to allow professionals to gain the bigger picture of the families they are working with. The Forum was attended by more than 80 professionals from several agencies.

Child on Child Abuse – An area of improvement from the completion of the Schools S175 Audit in 2021/2022 related to the measures in place to prevent and respond to Child-on-Child abuse. As a result, Child-on-Child abuse is now included in the Universal Safeguarding training and DSL training. The Partnership also hosted a multi-agency forum that outlined what child-on-child abuse is, what it looks like, when to be concerned and how to respond. The Forum was attended by more than 75 professionals from several agencies.

Words Matter - The language that professionals use can have a significant and potentially lifelong impact on victims of abuse and exploitation. This forum enabled us to come together and discuss victim blaming language and how we can accurately and sensitively record and report on victim experience. Colleagues had the opportunity to consider unconscious bias, remodeling their language and barriers.

The Forums are recorded and made available via our YouTube channel: BWSCP YouTube Channel and our website: BWSCP Website - Multi-agency Forums

SAFEGUARDING ASSURANCE

The BWSCP Learning and Development (L&D) Subgroup need to ensure that all partner organisations are providing single and multi-agency training, and that there is the required uptake of such provision. In addition, the subgroup wants to ensure that organisations are appropriately and adequately assessing their learning needs and using the information to determine learning priorities. This in turn should enable the BWSCP to identify any gaps or additional learning needs across the workforce.

To support this discussion the L&D Subgroup run a Training Needs Assessment. This survey was undertaken in Spring 2023 and at the time of writing this report, not all required responses had been received, meaning that a discussion of the results has not yet taken place. However, of the responses received, almost all organisations confirmed that they provide regular safeguarding children training for their staff which is regularly reviewed and updated, and that the majority of staff who require training have received it. A range of safeguarding children training at all levels has been delivered by a number of different training providers.

Some gaps in training have been highlighted within the responses including domestic abuse. Whilst domestic abuse appears to be embedded within other areas of training, there are no standalone training resources specifically for the subject. The results also highlighted a mix of responses regarding the delivery of training; the majority of responses are in favour of a mixed method including both face-to-face and virtual.

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Challenge from the Independent Scrutineer has highlighted to the Safeguarding Executive that there is no current multi-agency training offer other than the BWSCP Forum Sessions described above. The majority of the decision making, direction and organisation has been placed on the outgoing L&D Subgroup Chair and the BWSCP Business Unit. While the current offer complies with the requirements of Working Together to Safeguard Children 2018, it falls short of a comprehensive and cohesive programme of training. This is now an element of the BWSCP Delivery Plan for 2023/2024.

Scrutiny and Challenge:

As noted above, the current L&D multi-agency programme is not fit for purpose and a new L&D Subgroup Chair needs to be identified. The new Chair must be given the support of key partnership colleagues who understand the locality learning requirements. A Learning and Development Strategy is required to provide clear direction and expectation in this area of partnership working. Finally, resources must be made available to ensure the learning and development offer is credible and sustainable.

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SECTION 6: ENGAGEMENT AND FEEDBACK

Our multi-agency safeguarding arrangements recognise the need to improve our partnership engagement with children and families, ensuring that their voice and experiences are part of our discussions and decision making. Whilst this remains a work in progress, colleagues have undertaken surveys that we have considered in our partnership meetings. Some of the below have been referenced directly in other sections of this report.

Attitudinal Survey: This survey was distributed across all West Berkshire Secondary School; there were a total of 6353 responses with the majority of responders being aged between 11 and 18 years. Young People were asked a series of questions relating to how happy they are to the concerns they are faced with and whether the feel safe in the area they live.

When asked what the most important concerns are 62.9% of young people selected mental health and wellbeing, 6.7% selected domestic abuse and only 4.4% selected exploitation and grooming. There are ongoing projects with young people to raise awareness of exploitation including the Risking it All theatre production, posters, and online information. However, this topic generally expected to be covered by schools as part of the PSHE curriculum, therefore local RSHE forum will review this further to ensure that the material is up to date and informative. In addition, the missing children coordinator is working more closely with youth workers to create a half a day, during school holidays, where they work with a cohort of young people of concern around online exploitation.

'Taking illegal drugs' was highlighted by quite several young people as an issue in the area; however, when asked if any of them had someone close affected by the highlighted issues, the number of responses dropped. Similarly, 26% of young people reported 'carrying a weapon' as a problem in the area they live in; however, when asked whether they or anyone close to them was personally affected by this issue, the percentage dropped to 4.5%. This highlights the difference between perception and experience of an issue and Thames Valley Police confirm that they are not finding many weapons in their stop and searches. The Serious Violence Steering Group will be focusing on addressing how to communicate these statistics to young people to provide some reassurance ad highlight that there is more risk of harm if you are carrying a knife.

Due to the success of this survey in West Berkshire, the Police and Crime Commissioner have funded it to being undertaken in Reading and Wokingham for the first time.

Reading Extra-Familial Harm Workshop: In March 2023, the BWSCP delivered the Reading Extra-Familial Harm Workshop; the purpose of this being:
- To review and refresh the Extra-Familial Harm Strategy Action Plan
- To build in links with the Community Safety and Serious Violence Strategy
- Take the opportunity to learn from the Child Safeguarding Practice Reviews (CSPRs) published in Berkshire West recently
- To support the completion of relevant Reading Thematic Child Safeguarding Practice Review (CSPR) actions

The workshop was productive, and it provided detail about what the focus should be going forward. Workshop attendees were divided into different groups, each of which was given a topic to discuss relating to the recommendations from the recently published Thematic CSPR. This exercise provided analysis around what is working well, where further development is required works well, and ideas about how progress can be made. An action plan is currently being developed and work will be progressed in the coming months.

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Crest Advisory Report: The Dawes Trust commissioned Crest Advisory in 2019 to run a multi-year programme of work examining the underlying causes and drivers of serious youth violence including the use of technology, specifically social media. As part of the process, Crest Advisory interviewed a number of Reading Headteachers', Thames Valley Police and Metropolitan Police colleagues. More information can be found in Section 2.

Practitioner Engagement: Our engagement with practitioners has predominantly continued through auditing and case review work. We have ensured that all our Child Safeguarding Practice Reviews (CSPRs) have included a practitioner event, where the independent reviewer has had a chance to ask questions and hear directly from those involved about their experiences and what they feel is the key learning. This has been particularly challenging in an environment of online meetings, and these sessions would always be preferable as face-to-face, however we have endeavoured to make sure practitioners are supported through the process and feel comfortable to speak.

Auditing is also a key area where practitioners are able to reflect and feedback on areas of work or practice. Multi-agency and single agency audit (where there is a safeguarding element) findings are reported back to the Independent Scrutiny and Impact Groups with audit topics including (but not limited to) pre-birth assessments, first time entrants into the Youth Offending Service, referrals from the Royal Berkshire Hospital Foundation Trust to the three Children's Services, vulnerable caseload audit from Health Visiting and School Nursing, and the Berkshire West Child in Need audit.

In addition, we have surveyed sections of the workforce on specific topics. These have been referenced within the report and include:

- Practitioner confidence in speaking to young people about their social media usage and online safety and using this information in their work with young people and any assessment of risk (Section 2)
- Feedback from the Alter Ego Theatre Productions in Schools (Section 2)
- Education professionals' confidence in holding risk for cases that fall below the statutory level (Section 2)
- Agency Training Needs Assessment (Section 5)
- School Safeguarding Audit using the NSPCC audit tool (Section 4)

Scrutiny and Challenge:
This continues to be an area of challenge for the BWSCP. It is positive to receive the results of surveys from our children and young people and practitioners, but there is not yet enough direct evidence of subsequent decision making by the partnership as a result. Any plans to engage young people more directly within our partnership arrangements needs to be done with care and clear purpose.

Appendix 1 – Berkshire West Safeguarding Children Partnership Sub-group structure chart

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┌─────────────────────────────────────────────────────┐
│          Berkshire West Chief Executive Group         │
└─────────────────────────────────────────────────────┘
                                              ┌──────────────────────────────────────┐
                                              │ Links to other key partnerships,       │
┌─────────────────────────────────────────────┐ │ including:                             │
│          BWSCP Safeguarding Executive Group   │─ │ West of Berkshire Safeguarding Adults  │
└─────────────────────────────────────────────┘ │ Board                                  │
                                              │ Community Safety Partnerships x 3      │
                                              │ Domestic Abuse Partnership Boards x 3  │
                                              └──────────────────────────────────────┘
            ┌──────────────────────────────────────┐
            │      Operational/Project Steering Group │
            └──────────────────────────────────────┘
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PAN BERKSHIRE SUBGROUPS

- Child Death Overview Panel
- Policy & Procedures
- Section 11
- Child Exploitation

LOCAL SUBGROUPS

Reading Independent Scrutiny & Impact Group	West Berkshire Independent Scrutiny & Impact Group	Wokingham Independent Scrutiny & Impact Group
Reading Adolescent Risk Strategic Group	West Berkshire Child Exploitation Group	Wokingham Serious Violence and Exploitation Strategic Board
Reading Education Safeguarding Engagement Group	West Berkshire Education Safeguarding Engagement Group	Wokingham Education Safeguarding Engagement Group
Reading Education Designated Safeguarding Leads	West Berkshire Education Designated Safeguarding Leads	Wokingham Education Designated Safeguarding Leads

BERKSHIRE WEST SUBGROUPS - Substantive

- MASH Steering Group
- Case Review Group
- Learning & Development
- Section 175
- Child Death Review Panel
- Health Safeguarding Committee

BERKSHIRE WEST SUBGROUPS – Task and Finish @ May 2023

- Neglect Strategy Group
- Extra-Familial Harm Strategy Group

Appendix 2 – Knowing our children

West Berks	
West Berks Under 19 Population (Census 2021)	**37,122**
Children Subject to Child Protection Plan (Rate per 10,000) March 2023	**95**
Number of Children in Need (Rate per 10,000) March 2023	**421**
Children in Care (Rate per 10,000) March 2023	**55**
Domestic Crimes involving Children Q4 2022/2023	**250**
Total number of children 0-18-year-olds admitted to RBFT (including MH & Self-Harm) - Q4 2022/2023	**25**

Reading	
Reading Under 19 Population (Census 2021)	**41,808**
Children Subject to Child Protection Plan (Rate per 10,000) March 2023	**50.2**
Number of Children in Need (Rate per 10,000) March 2023	**430.3**
Children in Care (Rate per 10,000) March 2023	**72**
Domestic Incidents involving Children Q4 2022/2023	**310**
Total number of children 0-18-year-olds admitted to RBFT (including MH & Self-Harm) - Q4 2022/2023	**30**

West Berkshire
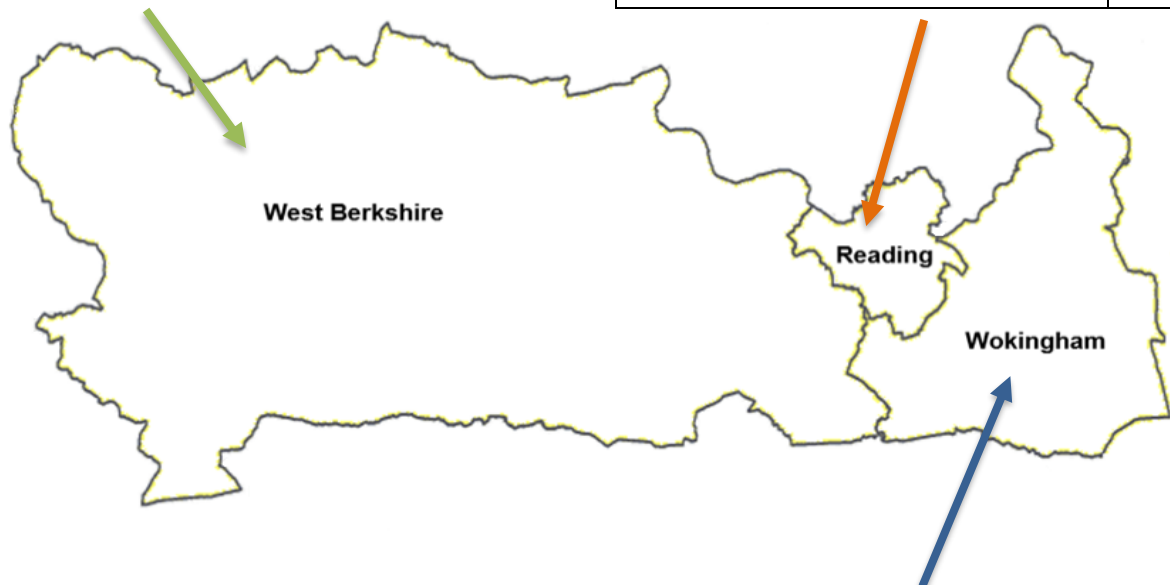
Reading

Wokingham

Wokingham	
Reading Under 19 Population (Census 2021)	**44,375**
Children Subject to Child Protection Plan (Rate per 10,000) March 2023	**37.8**
Number of Children in Need (Rate per 10,000) March 2023	**146.6**
Children in Care (Rate per 10,000) March 2023	**33.2**
Domestic Incidents involving Children Q4 2022/2023	**168**
Total number of children 0-18-year-olds admitted to RBFT (including MH & Self-Harm) - Q4 2022/2023	**23**

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Wokingham Inequalities Project

Understanding what will make a difference so that everyone in Wokingham can be healthy, happy and safe.

Sarah O'Connor, Head of Communities and Partnerships
Anna Richards, Consultant in Public Health

February 2024

WOKINGHAM
BOROUGH COUNCIL

It's a matter of life and death

In our most deprived neighbourhoods people are dying 5 years earlier than people who live in our least deprived neighbourhoods

5 years

WOKINGHAM
BOROUGH COUNCIL
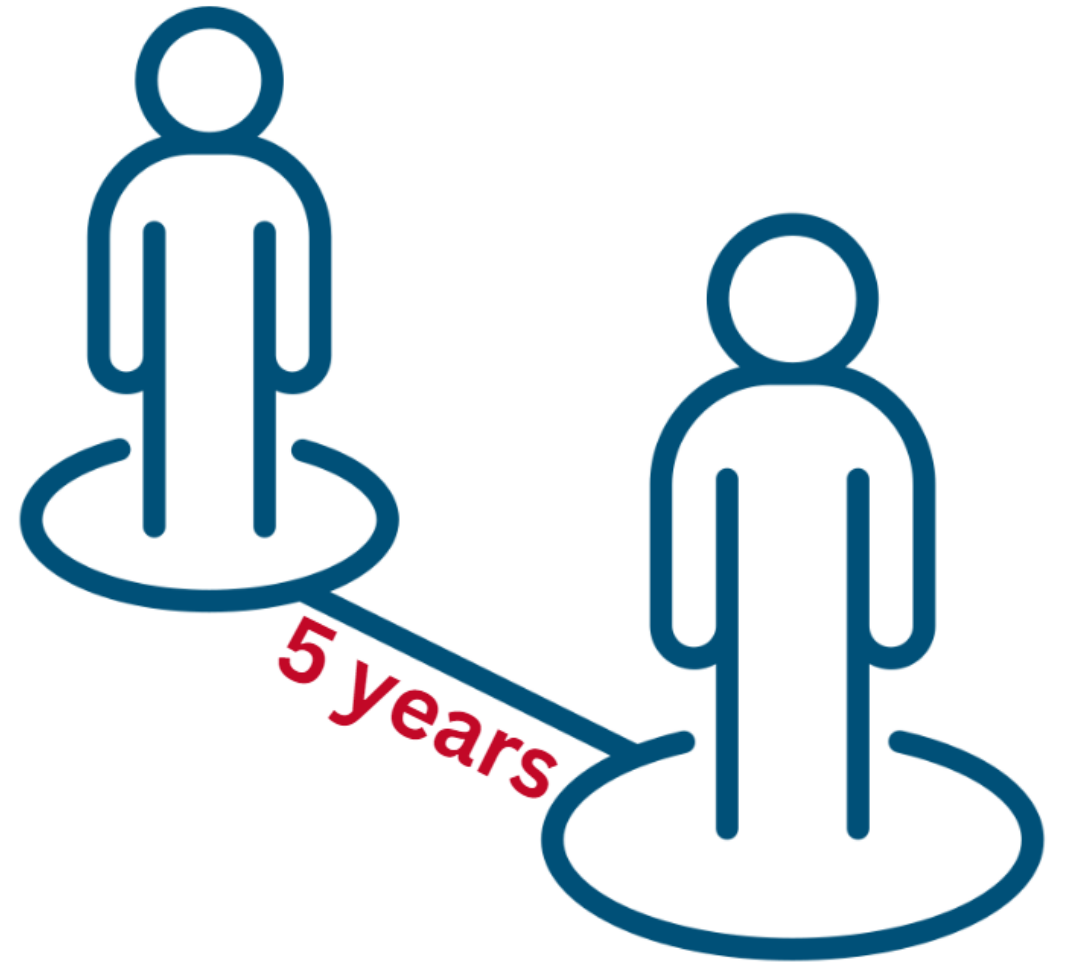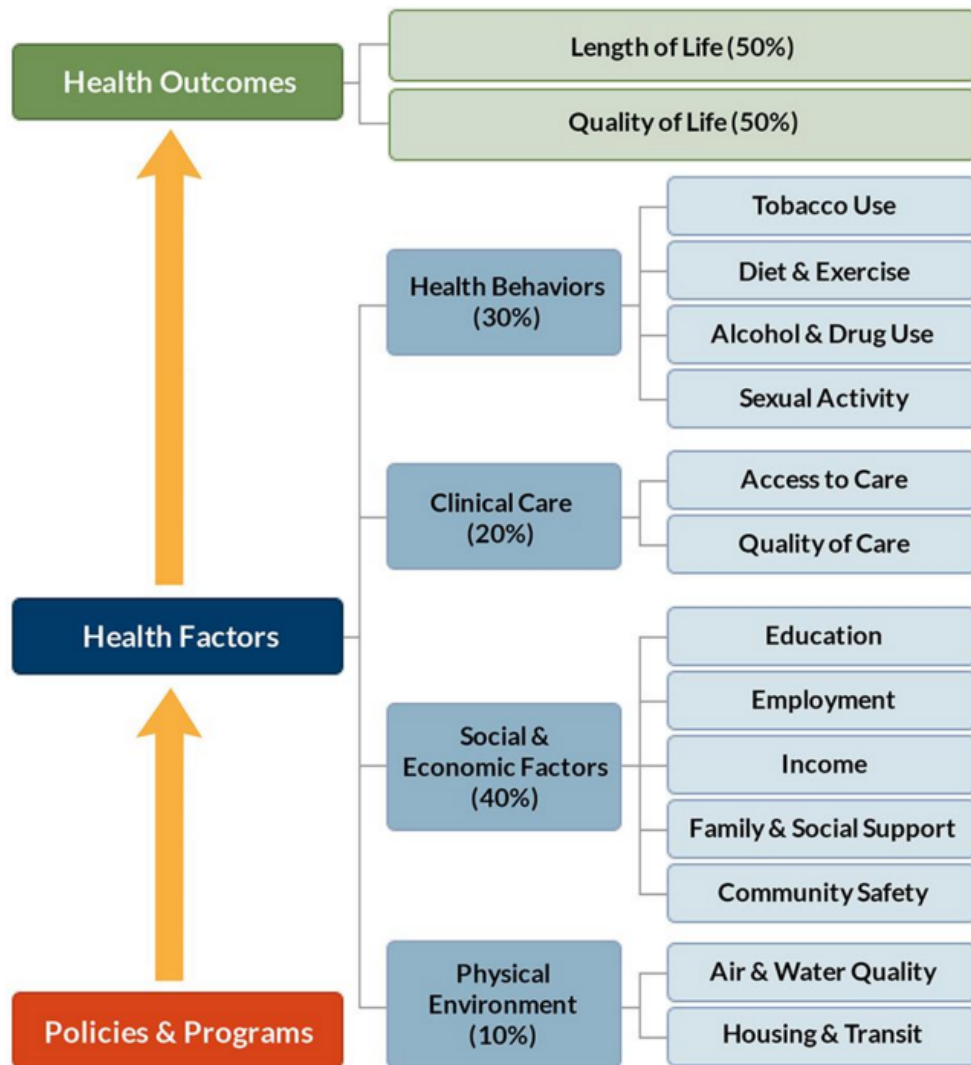
The University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, 2022. www.countyhealthrankings.org

The environment people live in and the opportunities they experience throughout their life are the factors that are most likely to have the biggest impact on their health and wellbeing

The building blocks of health and wellbeing

- To create a society where everybody can thrive, we need all of the right building blocks in place: access to secure housing, good jobs with fair pay, quality education and much more.

- But right now, in too many of our communities, the blocks are unstable. It's time to fix the gaps.

- Public services can make a big difference in supporting these building blocks.
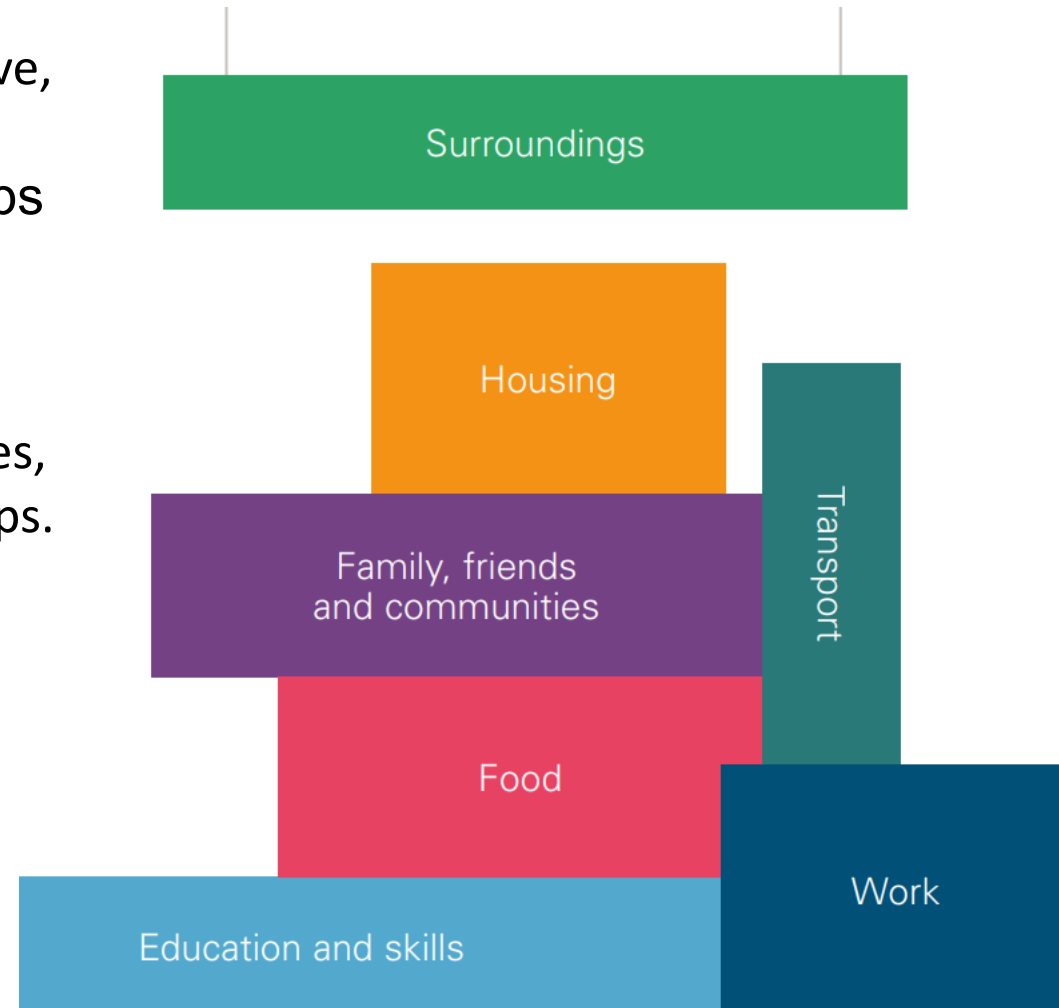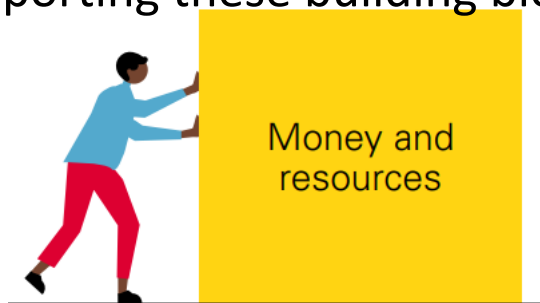
Reference: How to talk about the building blocks of health. The Health Foundation; 2022 (health.org.uk/publications/how-to-talk-about-the-building-blocks-of-health).

Change is possible

- It is important that we understand the building blocks of health and wellbeing in Wokingham. Where are the blocks that are missing for some residents and how can we work together to fix the gaps?

WOKINGHAM
BOROUGH COUNCIL

Project on a page

Aim

To understand what building blocks of health and wellbeing are missing for some residents in Wokingham and how we can work together to fix the gaps so that everyone can be happy, healthy and safe.

Timeline

12 months (August 2023 – August 2024)

Goals

1. To bring together intelligence, including insights from those with lived experience and from front-line staff, to create a common understanding
2. To support the development of the council plan so that change happens fastest for those with the greatest need
3. To improve applied research skills within the council
4. To work towards becoming a "Marmot Place"

Approaches

Talk to people

Look at what the data in Wokingham are telling us

Learn from others

Inequalities Project | Workstreams

Inequalities Project – Workstreams Structure

Data & Intelligence	Literature & Research Review	Insights from Frontline Workers	Lived Experience Conversations	Working with the Institute of Health Equity
Collate high-level data to describe existing inequalities across the building blocks of health	Reviewing the literature to understand the impact of relative deprivation and effective interventions to reduce inequalities	To hold discussions with frontline staff to understand their perspectives on relative deprivation	To hold discussions with residents to gain direct insight on their lived experiences of inequality	To investigate becoming a Marmot Place, and to understand and define requirements

WOKINGHAM BOROUGH COUNCIL

The Steering Group have identified two key existing Wokingham strategies which highlight those residents who are at greater risk of experiencing inequalities. They would like to invite these residents to participate in the discussion groups.

Wokingham Tackling Poverty Strategy (2022-2026)
- **People in persistent hardship** - these are people on low income, Universal Credit or other benefits
- **People who are just about managing** - these are people who don't have much money left at the end of the month
- **People who are asset rich, cash poor** - these are people who own a home or a car, which is an asset, but they don't have much money

Wokingham Health and Wellbeing Strategy into Action
- People with learning disabilities
- Unpaid carers
- Young people in contact with the criminal justice system
- People with lived experience of substance misuse
- People with lived experience of domestic abuse

WOKINGHAM
BOROUGH COUNCIL

Frontline staff will be invited to share their perspectives on how the building blocks of health and wellbeing look and feel for those residents at greater risk of experiencing inequality.

The project steering group would like to invite people working in these areas to participate:

- **Voluntary and community sector**
- **Housing**
- **Adult Social Care**
- **Debt Support**
- **Education and skills** – adults and children
- **Children's services**
- **Health visiting**
- **Community nursing**
- **Refugee Service**
- **Customer Service** (Wokingham Borough Council)
- **Community Engagement**
- **Libraries**
- **Sports and Leisure**

Governance

Project Sponsors:
- Sally Watkins (Chief Operating Officer, Wokingham Borough Council)
- Ingrid Slade (Director of Public Health, Wokingham Borough Council)

Governance:
- A **Steering Group** has been set up to oversee the project
- The Steering Group will report to the **Joint Equalities and Tackling Poverty Programme Board** (which meets every 6 weeks) and will update the **Wokingham Health and Wellbeing Board** (which meets every 2 months).

WOKINGHAM
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Wokingham SEND Partnership - Strategy Development

Update for Health & Well-Being Board

Strategy Development - Process so far...

- Initial discussion at SEND Partnership in May 2023

- Consensus that whilst the strategic and financial context had changed, priorities identified in the 2021-24 SEND Strategy remained valid

- Therefore agreed that the strategy required relatively 'light touch' updating and refreshing rather than comprehensive 'root and branch' change

- Data gathering process - through surveys and wider discussion:

  - Survey for schools between June - July 2023

  - SEND Voices Parents and Carers - Annual Wokingham Borough SEND Survey 2023

  - Me2 Club surveyed young people's views June - September 2023

- Pulled together initial draft of plan in the Autumn / Winter term

- This is the version that has been circulated – conscious that there are gaps in terms of input particularly from health colleagues

Strategic Vision

- Wokingham is a great place for children and young people to grow up. The area is vibrant and has a strong local economy. Most families in Wokingham benefit from high quality housing and access to good community services. Schools in Wokingham are excellent. Healthcare provision across the Berkshire West area is accessible and high quality.

- It must be recognised, however that for children and young people with SEND, that positive picture is not always shared, with a range of barriers preventing and restricting access to opportunities and services.

- The aspiration and vision set out in this Strategy is that **Wokingham should be great place for ALL children and young people, including those with SEND, to grow up with voices that are heard, access to opportunities, and who are well prepared for an independent and fulfilled adult life.**

Key Principles underpinning the SEND Strategy

Co-Production is central - We will ensure that the voices of children, young people and their families shape our services

We will ensure that children and young people with SEND are valued, visible and included in their communities

We will ensure the local SEND system is focused on early support and prevention

SEND is Everyone's business - We will ensure that all services are supported and challenged to play their part in delivering the SEND Strategy

We are ambitious for Children and Young People with SEND and will support and encourage their high aspirations

Support will be needs-led NOT label-led - Services will respond quickly to address needs rather than await diagnoses

Honesty, integrity and trust will be hallmarks of the local system

SEND Partnership Strategic Priorities

PRIORITY	AIMS
Priority 1 – Inclusion, Access and Early Intervention	Ensuring that C&YP with SEND are visible, valued and included as part of their local communities and that every provider plays their part in meeting these needs through positive and proactive inclusion and early intervention
Priority 2 – Sufficiency of SEND Services	Ensuring there is access to sufficient high-quality education, health and care provision to address the special educational needs and disabilities of the local 0-25's population
Priority 3 – Joint Commissioning	To maximise the reach and impact of education, health, and social care support across the system, at both SEN Support and EHCP levels through effective commissioning and contract management
Priority 4: Effective Transitions	Ensuring we are able to target resources and support at key stage transfers and other points of tension and system failure
Priority 5 – Communication and Co-Production	Develop a more consistent approach to engaging with young people with SEND to ensure their views and experiences contribute to shaping the local SEND System Address stakeholder frustrations around communication regarding SEND processes and provision

SEND Strategy Development Timetable

- Initial Draft released for feedback early December

- This had been developed with input from schools, parents and carers of young people with SEND and young people themselves

- Following a request from health colleagues seeking more opportunities to input into the Strategy we are currently in the process of holding three Co-Production workshops in the first quarter of 2024 (January, February and March)

SEND Strategy Co-Production Workshops
Thursday 25th January 10:30-12:30
Monday 19th February 15:00-17:00
Thursday 28th March 12:00-14:00

- These sessions are focused on identifying and addressing barriers to progress on our shared priorities

- This will culminate in the final draft being presented to Executive for approval 30 May 2024

Integrated Performance Report

December 2023

Improving together to deliver outstanding care for our community

Improving Together

December 2023 performance summary

The data in this report relates to the period up to 31st December during which the Trust experienced significant pressures across non-elective care and 3 days of Junior Doctor Industrial Action undertaken.

Despite these pressures, the Trust currently continues to perform well on the RTT **elective care standard**, with under 20 patients waiting over 52 weeks on those pathways. However, the sustained challenges are impacting on performance and, there is a significant risk that this and the combination of workforce and financial pressures will continue to challenge performance into 2024-2025.

The Trust remains challenged across other **Deliver in Partnership** objectives. We remain significantly behind the 99% within 6-week **diagnostic waiting standard** with Endoscopy and Echocardiography driving our long wait position. **Cancer performance** standards continue to fall below national standards, with 70% of patients meeting the 62-day standard in December.

The Trust's **rate of turnover** (page 6) has continued to improve, reflecting the increased focus on this area from across the organisation. The Trust's vacancy rate now sits at 7.91%, rapidly approaching the breakthrough priority target of 7%.

Financial performance as at Month 9 YTD is £1.84m behind plan driven by continued spend on workforce. We are currently preparing for the formal reforecast requested across the NHS at Month 10, we are currently on track albeit, with risks to deliver our budgeted full year financial position of £10.05m deficit. Efficiency savings are on track and due to be delivered in full by year end.

As in previous months, a number of **watch metrics** are outside of statistical control. Most relate to the operational pressures experienced in the Trust and are expected to improve in line with strategic metrics. A final set relate to mandatory training and appraisal completion which have been a focus of performance meetings with directorates.

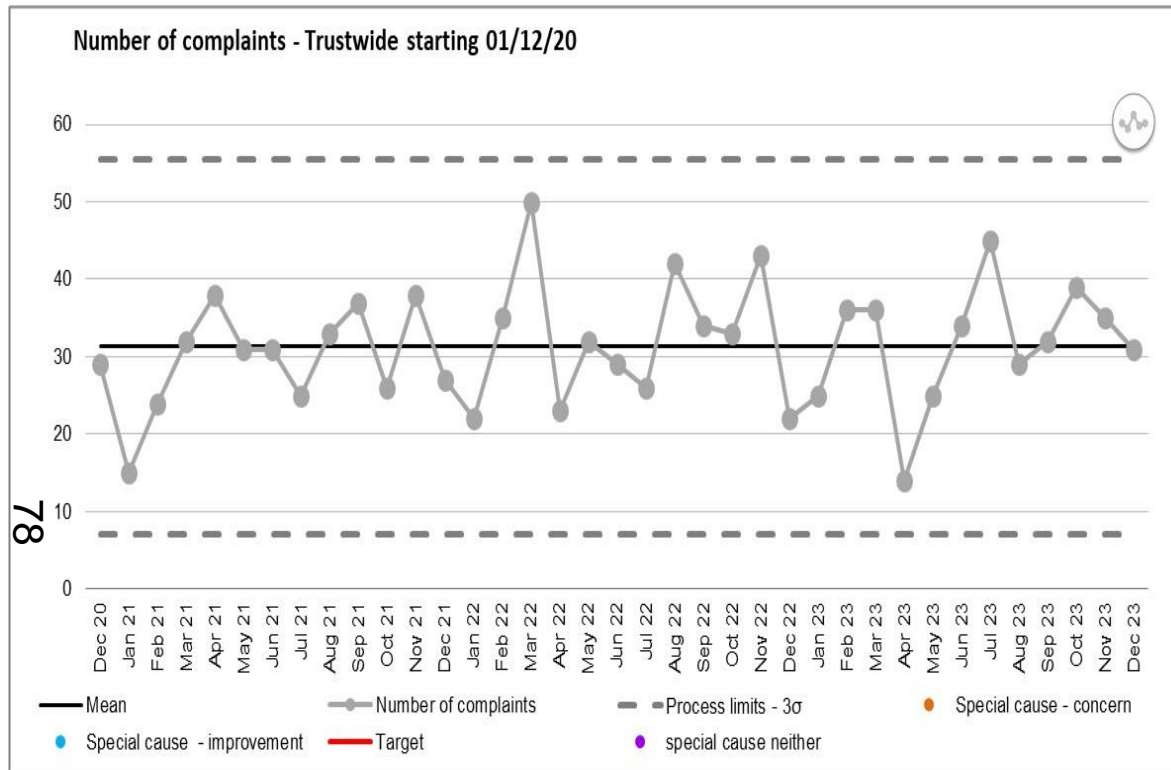| Strategic Objectives	Page	Strategic Metric	SPC flag
Provide the highest quality care for all	4	**Improve patient experience:** Number of complaints	
	5	**Reduce harm:** Number of serious incidents	
Invest in our people and live out our values	6	**Improve retention:** Turnover rate	
Delivering in partnership	7-9	**Improve waiting times:** Reduce Elective long waiters Average wait times for diagnostic services Emergency Department (ED) performance against 4hr target	
	10	**Reduce inpatient admissions:** Rate of admission (LoS>0)	
Cultivate innovation and improvement	11	**Increase care closer to home:** Proportion of activity delivered at RBH	
Achieve long-term sustainability	12	**Live within our means:** Trust income and expenditure	
	13	**Reduce impact on the environment:** CO_2 emissions	
Breakthrough priorities	15	**Recruit to establishment** (Vacancy %)	
	16	**Improve flow:** Average LOS for non-elective patients (inc. zero length of stay)	
	17	**Support patients with cancer** Reduce 62 days cancer waits incomplete	
	18	Delivery of £15m efficiency target	
Watch metrics	20-29		N/A

Strategic Metrics

Board Committee: Quality committee	Assurance	Variation
SRO: Katie Prichard-Thomas	N/A	

NHS Royal Berkshire NHS Foundation Trust

Number of complaints - Trustwide starting 01/12/20

This metric measures:
Our objective is to improve the experience of receiving care within the Trust. We are working towards developing a holistic measure of patient experience that can provide regular timely information on how we are performing. Whilst that is in development, we are using the number of complaints received by the Trust within the calendar month.

How are we performing:
The Trust received 31 formal complaints this month with the top two themes being clinical treatment and communication.
Hotspots:
Complaints – Gastroenterology 2, Paediatrics 2
Patient Advice and Liaison Service (PALS) - Emergency Department (32) and Ophthalmology (15)
Overdue Complaint Responses / Reopened Complaints:
23 overdue complaints for Urgent Care and 12 reopened complaints outstanding
4 overdue complaints for Networked Care and 3 reopened complaints outstanding
6 overdue complaints for Planned Care and 5 reopened complaints outstanding
Complaint Action Tracker:
Currently we have 178 open actions on the tracker with 76% of those actions overdue. The team are working with the care groups to reduce this number. Please note the reporting has changed to open actions rather than complaints with an open action, hence the increase in numbers. Each complaint has at least 3 actions.

	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Number of complaints received	45	29	32	39	35	31
Complaints turnaround time within 25 days (%)	61%	70%	65%	50%	52%	50%
No. of Vulnerable persons complaints	0	2	3	3	1	2

Actions:
• Continuous PALS monitoring to gauge current issues
• Weekly CNO, CMO, Patient Experience & Safety Huddles to identify Trust wide theme
• Feed into communication working group **(Q4 23/24)**
• Complaint structure review completed, increase complaints senior leadership **(Q4 23/24)**
• KPMG review action plan **(Q3 24/25)**
• Transformation rerun complaints response data to highlight delays & plan **(Q4 24/25)**
• CNO/Care Group overdue complaints meetings & CNO driver metric **(Q4 24/25)**

Risks:
• Care Group capacity - the impact of Investigating Officers (IOs) to undertake responses and completion of actions in a timely manner due to ongoing capacity within the Trust

Strategic objective: **Provide the highest quality care for all**

Strategic metric: All declared serious incidents (SI's)

Board Committee: Quality committee

SRO: Katie Prichard-Thomas

Assurance	Variation
N/A	(variation icon)

NHS Royal Berkshire NHS Foundation Trust

Number of serious incidents - Trustwide starting 01/12/20

Legend:
— Mean
—●— Number of serious incidents
– – Process limits - 3σ
● Special cause - concern
● Special cause - improvement
— Target
● special cause neither
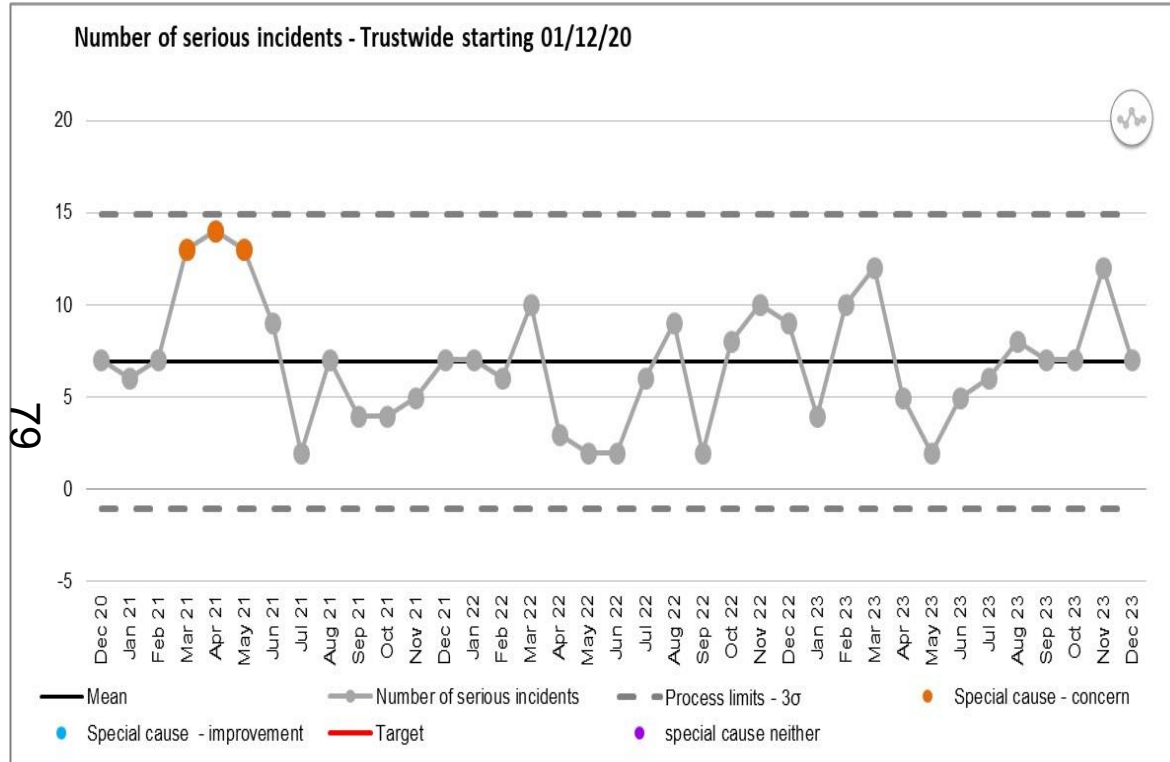
	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Number of serious incidents reported	6	8	7	7	12	7
Serious Incidents related to vulnerable persons	0	0	0	0	1	1

This metric measures:
Our objective is to reduce avoidable harm across all our services. The metric we have chosen to assess or progress in this measures the number of reported serious incidents in the Trust in the month. The data relates to the date we are reporting date rather than the incident date.

How are we performing:
- 7 Serious incidents (SI's) were reported in December 2023, 2 in Planned Care, 1 in Networked Care and 4 in Urgent Care which includes 1 Maternity and of which 1 Never Event with no patient harm
- Treatment delay featured in 3 of the SI's reported in December which is a continuing theme.
- Duty of Candour was met in all cases and learning shared
- Key learning themes from December SI's include EPR system usability and the refinement of a digital escalation process, raising awareness through safety huddles of post falls management, embedding of the new maternity care cards which support the triage midwife to give appropriate advice, and a continued focus on assurance and improvement of the World Health Organisation (WHO) checklist with a themed learning 'celebration day' planned in January.

Actions:
- Transition from SI Framework (2015) to Patient Safety Incident Review Framework (PSIRF) implementation continues with a target transition by **1st April 2024.**
- RBFT PSIRF draft plan and policy have been completed in collaboration with the ICB, and a pilot with PSIRF pilot areas will be undertaken in the next 4 weeks.
- Actions including a refined process for digital escalation and WHO checklist audit and education activities are ongoing in response to the Never Event thematic analysis
- Responsive and pro-active improvement work continues across the Trust including Falls and Pressure Ulcers, Hypoglycaemic awareness, the Deteriorating Patient workstream and Venous thromboembolism (VTE) education and awareness.

Risks:
- Patient safety team resource constraints – additional workload created by PSIRF implementation
- Risk of patient harm following the most recent industrial action, in addition to current winter pressures.
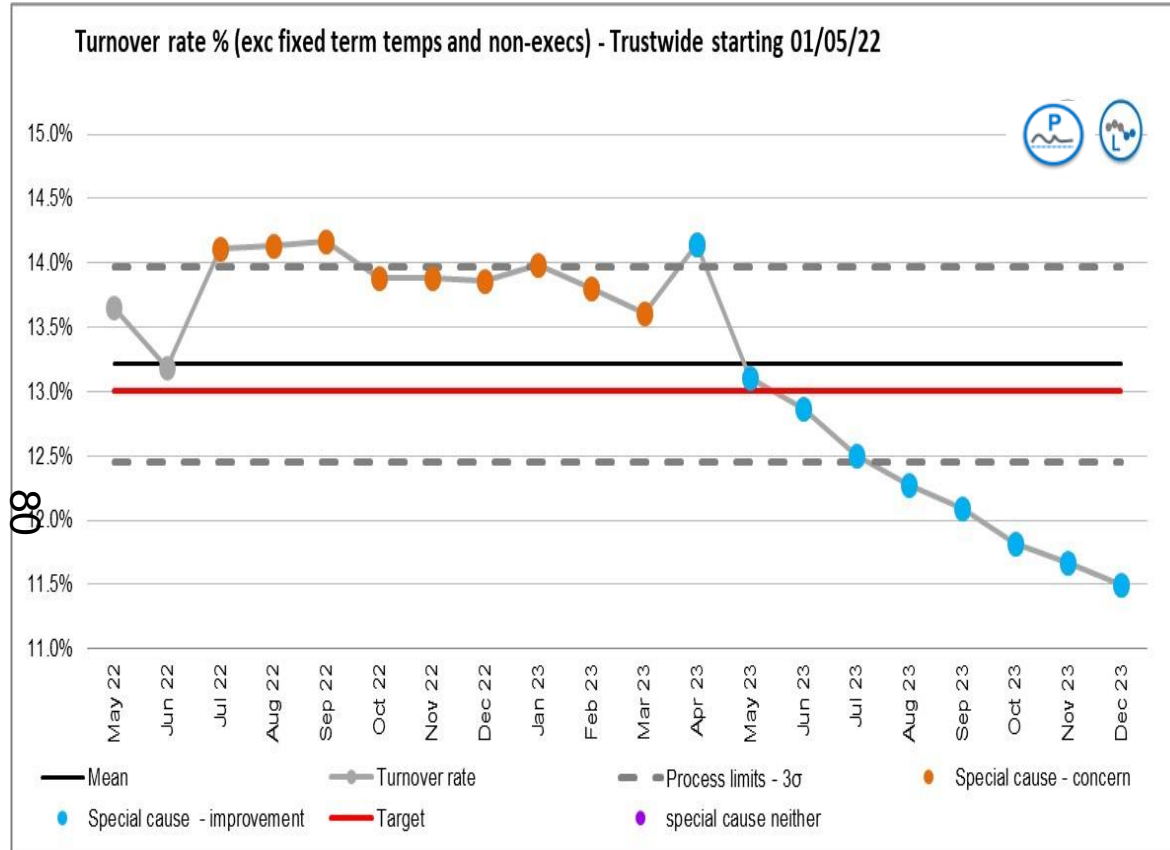
Strategic objective: **Invest in our people and live out our values**

Strategic metric: Improve retention

Board Committee: People Committee

SRO: Don Fairley

Assurance	Variation
P	L

NHS Royal Berkshire NHS Foundation Trust

Turnover rate % (exc fixed term temps and non-execs) - Trustwide starting 01/05/22

Legend: Mean | Turnover rate | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither

This metric measures:
Our vision is to improve the retention and stability of staff within the Trust as we know this helps us to avoid the use of bank and agency staff (which impacts on both quality and financial objectives). We have chosen to measure Turnover Rate which is defined as number of Whole Time Equivalent (WTE) leavers in the month divided by the average of the WTE of staff in post in the month. The Trust has an ambition to reduce turnover to 11.5 in 2024/25. This will be continually monitored and reviewed.

- **How are we performing**:
- Turnover has continued to reduce over the last eight months to reaching our ambition of 11.50% (excluding fixed term/temp)
- New starter 4 & 8month questionnaire report now circulated to PCP and Care Groups.
- Care Group turnover performance improvements have been sustained for several months and therefore turnover driver metrics at Care Group level are being closed out.
- Turnover in OT will continue to be a local driver metric for Specialist Medicine
- RISE beginning to have an impact at Care Group level, bringing greater focus to appraisal conversations and mini talent review boards.

- **Actions:**
- Actionable themes from 4&8month survey being developed and incorporated into care group people plans.
- Work underway on probationary reviews and clarity around developmental posts
- Retention work/interventions under evaluation and SOP's being developed.
- Focus on staff health and wellbeing including recent Health check data and financial support across Care Groups.
- EM Aspiring Leaders Programme, over 10 placements currently confirmed..

- **Risks:**
- Lack of financial influence on retention
- Environmental factors a constant challenge i.e. cost of living

	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Staff turnover rate	12.50%	12.28%	12.09%	11.82%	11.67%	11.50%

Strategic objective: **Deliver in partnership**

Strategic metric: Reduce Elective long waiters

Board Committee:
Quality Committee
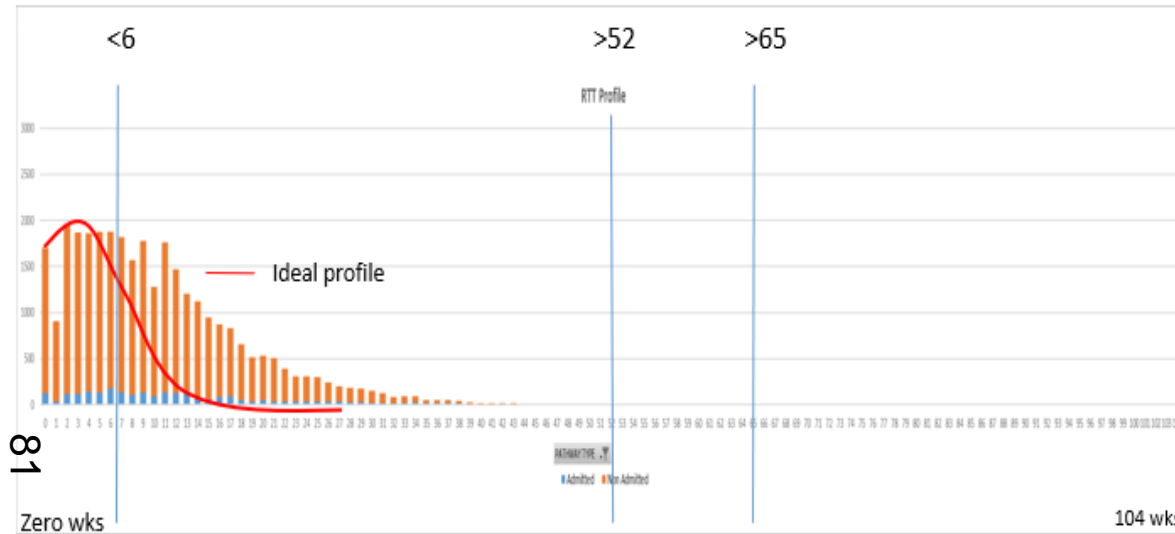
SRO: Dom Hardy

Assurance	Variation
P	N/A

NHS Royal Berkshire NHS Foundation Trust

Median LOW by specialty: 12 months to December 23 - Trustwide for the IPR

This metric measures
Our objective is to reduce the number of patients experiencing excess waiting times for elective care as measured by the national Referral to Treatment Time standards. Nationally there is an expectation that we eradicate >65 week waits by March 24. We want to exceed these standards and eradicate waits over 52wks consistently during 2023-24.

How are we performing:
- The Trust is maintaining a low number of >52 week wait RTT pathways (<20)
- However, whilst the Patient Tracking List (PTL) size is comparable to 2019 we are seeing the impact of IA and local rate card extending the waiting time profile. The <18 PTL volume is now 55% higher than Jan 23 and continuing to increase. Without intervention we expect to see the numbers >18 and >52 begin to increase through Q4 and an increase in tip over volume for >52 and >65 from May 24
- First outpatient appointment (OPA) and diagnostic waiting times are the primary drivers for extended waiting times against the RTT standard. Maintaining our position and making further improvement to the RTT profile will be achieved through shortening **stages of treatment** across the elective pathway, in particular waiting times to 1st OPA

Actions:
- 6 month targeted programme of work to improve EPR encounter information underway as part of the Master-WL programme – expected completion **Apr 24**
- Investigating opportunities to increase capacity to support whole pathway transfers in order to decrease first OPA demand
- Work with each specialty to understand capacity and identify where alternative delivery methods can add value and where appropriate convert slots from follow-up to first
- Deployment of fully integrated e-Triage and referral management solution has been delayed. Sign off of the technology with NHSE has now been confirmed and early user deployment is underway.

Risks:
- Repeated industrial action is significantly impacting the elective programme – continuing loss of activity resulting in longer waits for routine OP appointments and an increase in 52 week waits
- Sustained increased demand across the cancer pathway (Urology, Dermatology and Gastro) displacing routine workload
- Implementation of capped rates having significant impact on Trust's ability to provide additional capacity
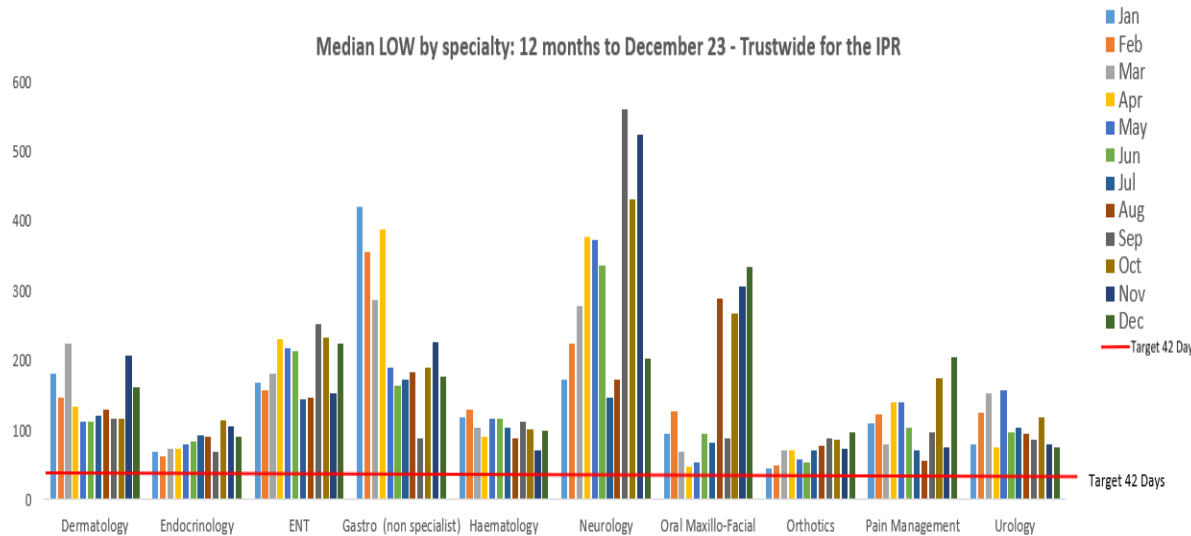
Strategic metric: Average waiting times in diagnostics DM01

Board Committee:
Quality Committee

SRO: Dom Hardy

Assurance	Variation
(F)	(H)

NHS Royal Berkshire NHS Foundation Trust

Average waiting times in diagnostics - Trustwide starting 01/07/21
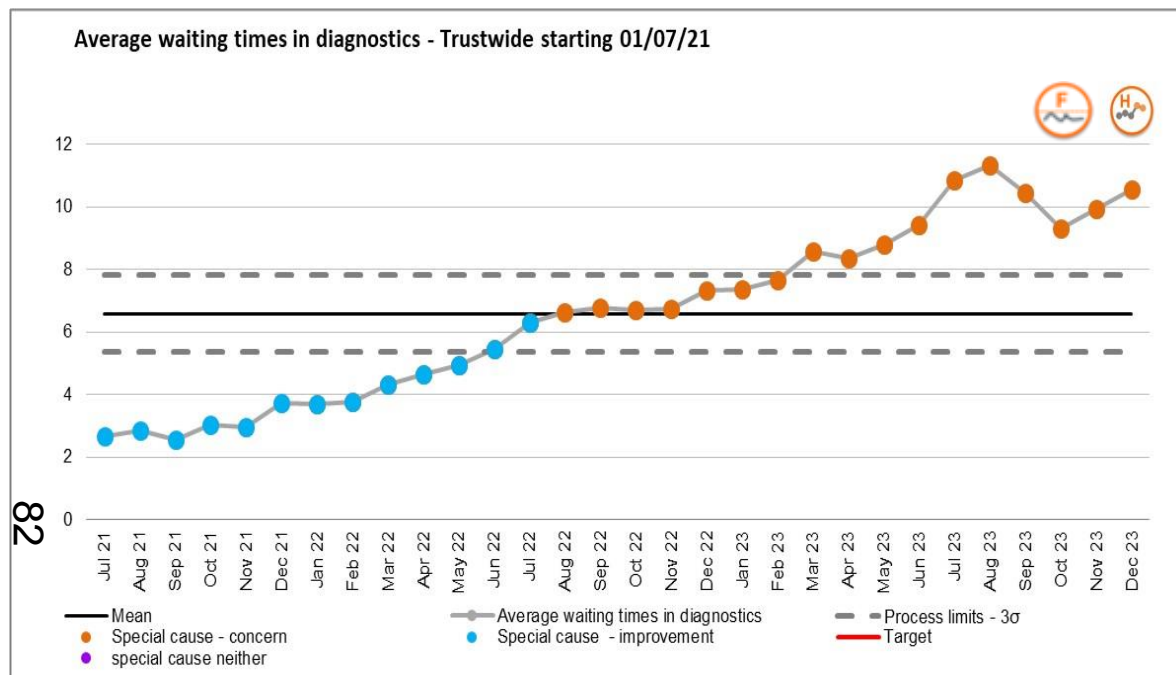
	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Average wait all modalities (wks)	**10.84**	**11.33**	**10.44**	**9.32**	**9.94**	**10.55**
Imaging	3.80	3.96	3.18	2.57	2.14	3.14
Physiological Measurement	7.47	7.33	8.04	6.78	9.73	10.67
Endoscopy	27.58	28.15	27.51	27.70	29.06	28.78
Cancer	3.66	2.77	2.29	2.02	1.85	3.27
Urgent	16.83	17.25	15.39	14.80	15.28	15.69
Routine	9.65	10.30	9.83	8.39	8.99	9.49

This measures:
Our objective is to reduce the number of patients experiencing excess waiting times for diagnostic services, which is a key driver for cancer, RTT, post inpatient procedure and surveillance pathways. We measure our performance through the average length of time patients have been on the waiting list and the end of each reporting month.

How are we performing:
• We remain significantly behind the 99% within 6-week standard
• Average waits remain significantly extended, driven primarily by Endoscopy and Echocardiography
• These modalities make up c. 85% of total >6 week waits. The majority of these being in the longest wait backlog (90% of total >13 weeks), however this decreased slightly in the most recent months report
• Clinical triage and prioritisation is in place. However, improvement to performance is linked to substantial increases in capacity and resource over 24/25

Actions:
• As previously reported at public Board, the Endoscopy service have a comprehensive plan for recruitment, capacity and utilisation that is being worked through. However, these are focused upon the long term
• In the short term, work is being insourced for gastroenterology, with medium term options being explored i.e., use of theatres and CDC
• We have also introduced a time-limited additional sessional rate for the remainder of this year and this is enabling additional clinics to be undertaken

Risks:
Endoscopy
  • Cancer pathway demand is continuing to grow, and expected to grow further
  • Waiting times for non-cancer work grow as a result or prioritising cancer work
  • Capped rates for additional consultant sessions

Physiological Measurements (PM)
  • Cardiology may see continued decline in DM01 performance due to workforce capacity

82

Strategic objective: **Deliver in partnership**

Strategic metric: Performance against 4hr A&E target

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
(F)	(L)

NHS Royal Berkshire NHS Foundation Trust

ED Trust Performance against 4 hour target - Trustwide starting 01/12/20

Legend:
- Mean
- ED Trust Performance
- Process limits - 3σ
- Special cause - concern
- Special cause - improvement
- Target
- special cause neither
- Constitutional Standard

	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
4hour Performance (%)	75.83%	72.60%	69.66%	66.74%	66.80%	66.21%
Total Attendances	14864	13984	14606	15133	14832	14411
Total Breaches	3592	3831	4431	5033	4924	4869
4hour Performance (%) 2022	71.19%	75.85%	69.64%	67.08%	63.23%	62.65%
Total Attendances 2022	14444	13872	14182	15533	15196	15352
Total Breaches 2022	4162	3350	4306	5114	5587	5734

This measures:
Our objective is to reduce the number of patients experiencing excess waiting times for emergency service. We measure this through the percentage of patients who attend the Emergency Department (ED) and are seen within 4 hours of their arrival. Delivering against this standard requires cooperation across both the hospital and with partners in the wider health and care system. While the constitutional standard remains at 95%, NHS England has set Trusts a target of consistently seeing 76% of patients within 4 hours by the end of March 24

How are we performing:
- In December 66.21% of patients were seen within 4 hours. High daily attendances continue with an average of 399 per day and greater than 400 attendances for over half the month
- ED Minors Unit activity reduced to an average of 79 patients per day in December
- The team achieved the quality performance standard for 29/31 days. Actively pushing to increase use of EDMU and throughput to alleviate main department challenges
- >60 & >30min handover performance show improvement. >60min breaches have significantly reduced in month. Further improvement challenged with decision to admit (DTA) capacity issues

Actions:
- Reading Urgent Care Centre appointment booking via EMIS® fully functioning. With greater focus on utilisation.20% increase of slot utilisation
- ED Triage collaborative work with KPMG to be translated in to workstreams for further improvement opportunities. Triage 2 now open
- Single Point of Access programme continues focus on GP referrals via ED with further roll out planned for January
- Continued focus on streaming patients to Results chairs to relieve pressure in main department.
- Focus on improving ambulance handover times

Risks:
- Significant increase in Mental Health demand as well as incidences of Violence & aggression towards staff
- Significant space constraints of the current ED facility
- Demand continues to grow in excess of population growth and funding
- Dependence on specialties to see referred patients in a timely manner

Strategic metric: Reduce inpatient admissions

Board Committee: Quality Committee

SRO: Dom Hardy

EL Variation	NEL Variation

NHS Royal Berkshire NHS Foundation Trust

EL bed based admission (admits with LOS > 0) as % of all admissions - Trustwide starting 01/12/20

NEL bed based admission (admits with LOS > 0) as % of all admissions - Trustwide starting 01/12/20

% of admissions with Los>0	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Elective	6.5%	7.1%	7.4%	6.8%	6.7%	6.4%
Non-elective	31.6%	32.3%	32.9%	31.5%	30.5%	37.3%

This measures:
Our objective is to reduce the need for patients to be admitted to a hospital bed as we know that unnecessary admission impacts on patient outcomes. We are seeking to progress this through a combination of improving the underling health of our population, working in partnership with community providers to maximise admission avoidance programmes and implementing change to our non-elective and elective pathways such as same day emergency care and day-case procedures.
We are measuring our progress by monitoring the proportion of our elective and non-elective admissions that result in an overnight stay in the hospital and are looking for this metric to decline overtime.

How are we performing:
This metric is a work in progress. There are several factors which require further investigation (e.g. variability of bed numbers (elective/non-elective) and occupancy).

However, volume analysis of the past 12 months shows daycase volume, overnight stays volume, daycase rate (average 85%) and non-elective overnight rate (average 31%) are all relatively stable.

Actions:
• For elective admissions, review GIRFT data as part of Theatres Efficiency programme and ensure day case rates are at optimal levels
• For non-elective admissions, continue to pursue Same Day Emergency Care (SDEC) and virtual hospital work to increase numbers of admissions avoided; and develop a hospital-wide patient flow programme to reduce inpatient length of stay and expedite timely discharge

Risks:
• Theatre utilisation work does not have sufficient impact on increasing day case rates, resulting in more and longer inpatient stays for patients on elective pathways
• Admission avoidance work and patient flow programmes do not sufficient impact on avoiding admissions and reducing length of stay, resulting in high bed occupancy, slow flow, and delays for patients at all stages

10

Board Committee
Quality Committee

SRO: Andrew Statham

Assurance	Variation
F	H

NHS Royal Berkshire NHS Foundation Trust

Proportion of outpatient activity delivered F2F at the RBH site - starting 01/12/20

Legend:
— Mean
● Special cause - concern
● special cause neither
—— Proportion of activity delivered F2F at RBH
● Special cause - improvement
-- Process limits - 3σ
—— Target

85
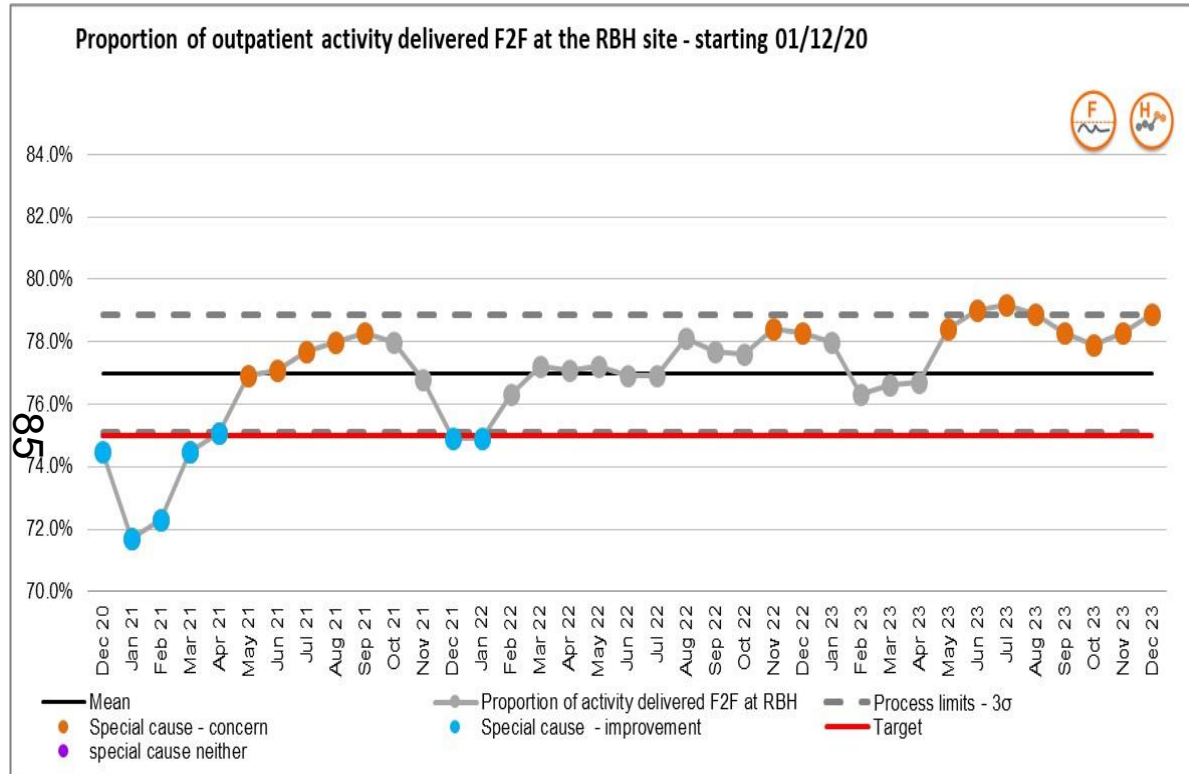
This measures:
Our objective is to deliver as much care as possible at locations close to patients own homes or places of residence. This will in ensure that all our communities benefit from high quality care, we will be able to reduce unnecessary journeys and we will make best use of our digital and built infrastructure.

We are tracking the volume of outpatient care that is delivered face to face (F2F) at the RBH site as we believe that delivery of our clinical services strategy should result in this proportion falling as we take advantage of our investments

How are we performing:
Since 2017 the proportion of the Trust's activity delivered from the RBH site has fallen from 95% to under 80% driven by increased use of our sites in Henley, Bracknell and Newbury and because of an expansion in digital services such as virtual hospital and remote consultations

In December, 78.9% of all contacts in the Trust were delivered face-to-face from the RBH site – a small increase in performance from November and still above the 75% target. In recent (and coming) months, this metric is likely to have been impacted by industrial action.

Actions:
The Executive Management Committee are progressing a range of measures as part of the planning for 24/25 to support the delivery of our clinical services strategy including:
• Progressing Community Diagnostics Centres
• Extending our work with the patient portal
• Space review at Bracknell, Windsor, Henley and Newbury
• Exploring opportunities for MDT delivery with primary care
• Identification of service improvements aligned to our CSS with system partners

Risks:
• Our drive to increase the number of first Outpatient appointments to support delivery of elective waiting times is likely to result in a higher volume of face-to-face activity
• Digital and telephone appointments create additional requirements for clinicians
• Capacity within primary care to support demand for urgent care from patients
• Impact of ongoing Industrial action on activity across the Trust

	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
% of all care provided from RBH site	79.2%	78.9%	78.3%	77.9%	78.3%	78.9%

Board Committee
Finance & Investment

SRO: Nicky Lloyd

Assurance	Variation
F	••••

NHS Royal Berkshire NHS Foundation Trust

Performance against budget 2023/24 (£m)

Cash Summary - minimum cash position
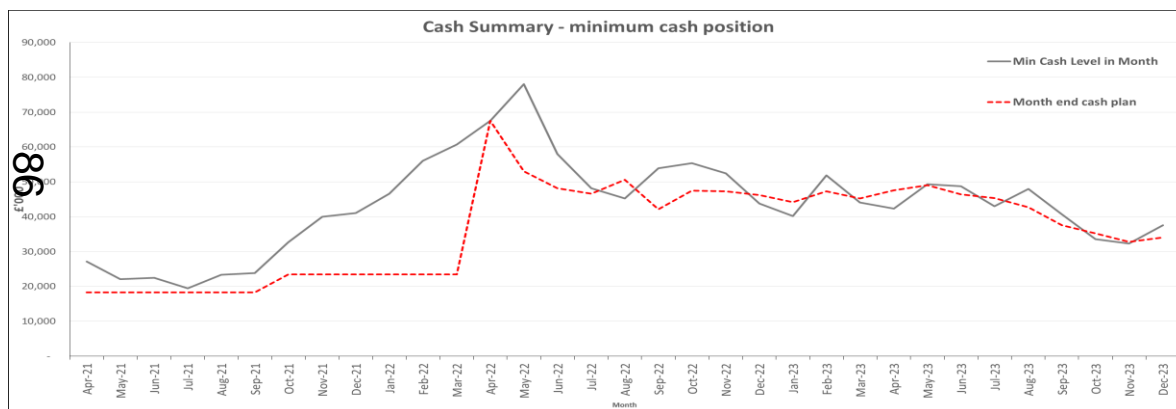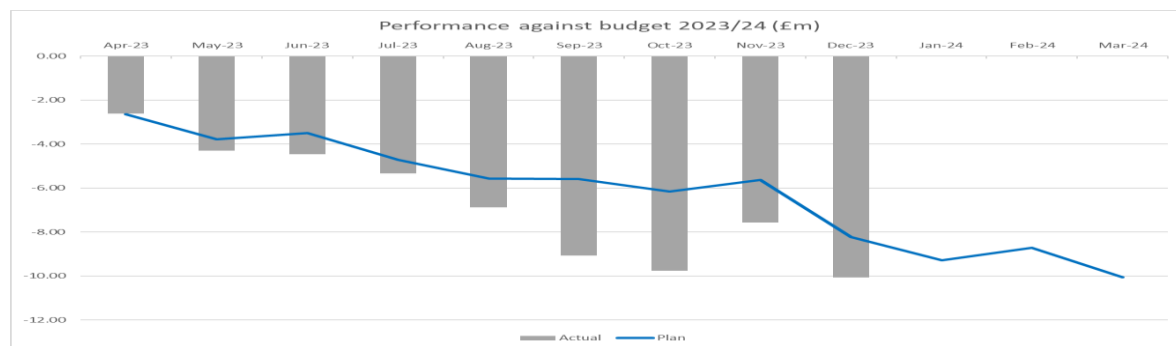
	Year to date				Full Year
	Actual	Plan	Variance against plan	RAG	Plan
Income (incl pass through)	£449.20m	£434.24m	£14.97m	▲	£579.11m
Pay	£267.94m	£259.44m	-£8.50m	▲	£345.31m
Non Pay (incl pass through)	£185.88m	£176.77m	-£9.11m	⬥	£235.53m
Other	£5.09m	£6.25m	£1.16m	⬥	£8.32m
Surplus/(Deficit)	-£10.05m	-£8.22m	-£1.83m	⬥	-£10.05m
Exclude donated Asset Effect, centrally funded PPE and Impairment	-£0.01m	£0.00m	-£0.01m	⬥	£0.00m
Adjusted Financial Performance (NHSE Plan)	-£10.06m	-£8.22m	-£1.84m	⬥	-£10.05m

This measures:
Our objective is to live within our means. We have set a budget of a £10.05m full year 2023/24 deficit as the first step on our return to a break-even position.

How are we performing:
Month 09 YTD, financial performance is a £(10.06)m deficit, £(1.84)m worse than plan. Income is ahead of plan by £14.97m, the variance is primarily driven by £4.77m income from NHSE to cover the impact of industrial action to M07 YTD, the over performance in high-cost drugs £3.28m, in addition, £4.74m is accrued income for the incident (Insurance settlement).

The Pay position is £(8.50)m adverse to plan YTD, this includes the Lighthouse costs of £1.51m (this is offset by income), and the additional cost of industrial action of £1.24m YTD that has been incurred from April to October 2023, and netted off with the income received in M09. In addition, the Trust has incurred £0.17m in December 23 relating to industrial action which is currently unfunded.

Non-Pay costs are £(9.11)m at M09 YTD, after excluding the April power outage costs of £4.71m , Lighthouse cost of £2.16m and £1.63m of pass through drugs (offset by income), the residual net non-pay overspend is £0.61m.

Actions:
- Focus is needed to make run-rate reductions in pay expenditure
- We continue to identify further savings delivery across specific contracts and spend areas
- Workforce controls have been implemented for several months and are ongoing
- We now have identified the £15m of risk adjusted efficiency savings delivery in year, of which £11.30m has been delivered at M09 YTD – further savings are now needed to offset the expenditure running in excess of budget
- The focus is now to identify schemes that are recurrent and could be taken forward to the next financial year 2024/25

Risks:
- Prolonged and further Industrial Action across different staff groups, as well as no resolution yet achieved for Junior Doctors' dispute
- Sourcing further savings to address the YTD overspend and absorb any further spending in excess of budget levels between now and the end of the year

Strategic objective: **Achieve long-term sustainability**	Board Committee Finance & Investment	Assurance	Validation	NHS Royal Berkshire NHS Foundation Trust
Strategic metric: CO2 emissions	**SRO:** Nicky Lloyd	P	N/A	

Royal Berkshire Foundation Trust Scope 1 & 2 Carbon Emissions

2021/2022 old, 14,374
2021/2022 corrected, 15,677
2022/2023, 11,496
2029/2030, 3,511
2039/2040, 1,567
2044/2045, 1,090

Tonnes of CO₂

■ Total Scope 1&2 CO2e   ■ Landmarks   — Path to 2045 Net Zero
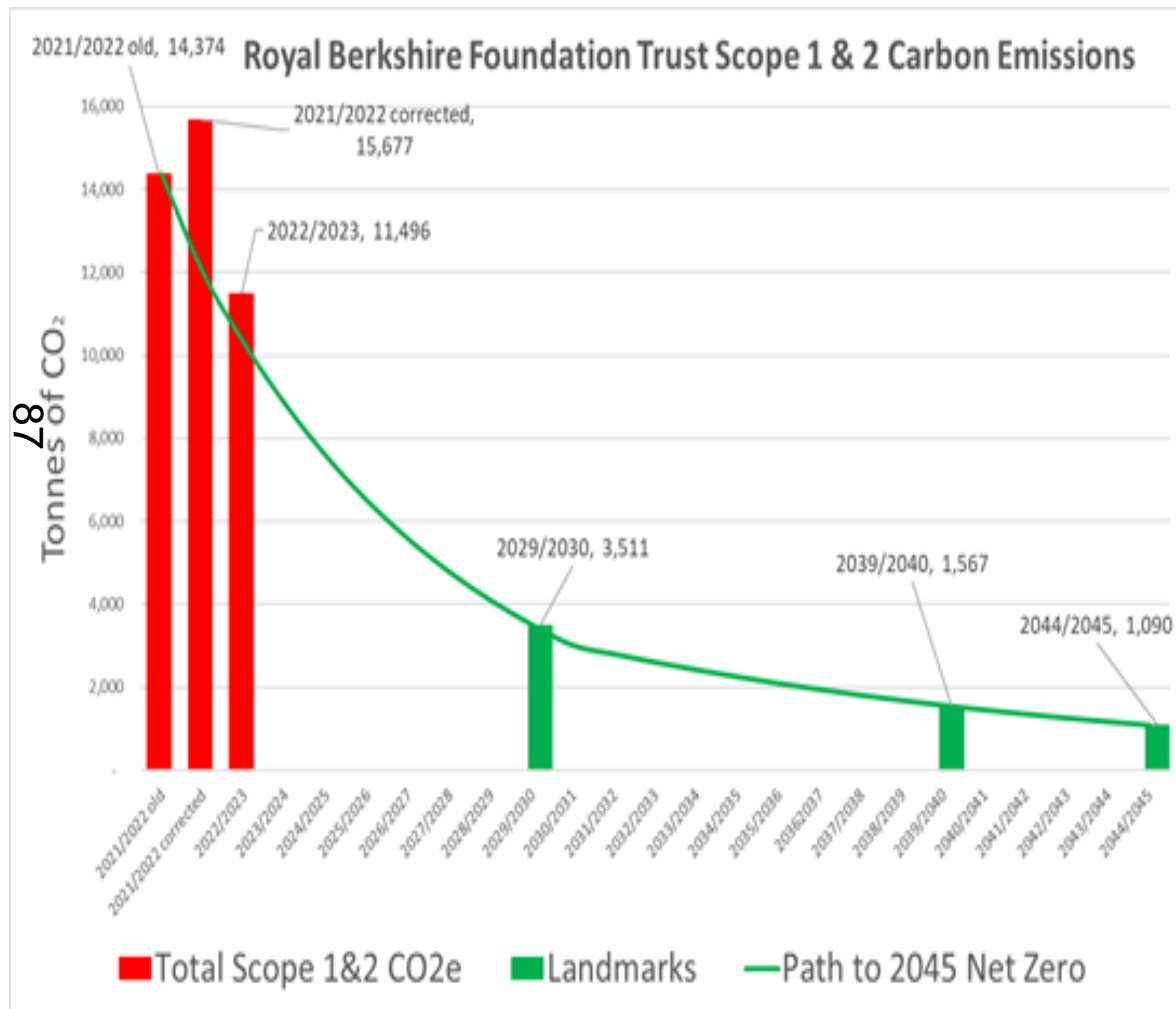
This measures:
Our ambition is to reduce the impact we have on the environment and deliver on our net zero goal for 2040. We have finalised the 2022/23 full year report and are progressing establishing quarterly in year reporting. We are exploring how we benchmark our performance against other organisations and our own planned trajectory, in conjunction with other organisations across BOB ICS.

How we are performing:
The data for energy use has been collated from the properties owned by the Trust. The total 2022/23 RBFT carbon footprint for scope 1 and 2 emissions (The NHS Carbon Footprint) was calculated as 11,496 tonnes of CO2, compared to the updated, 15,677 tonnes for 2021/2022. These emissions included electricity imported, Energy Centre (main site) and wider Trust estates gas utilisation accounting for Combined Heat and Power (CHP), generators, medical gases; inhalers; refrigerant Fugitive F-Gas and fleet vehicles.

Battle and North Block are now back on mains power, so no longer on generator power fueled by diesel from the power outage from the 23rd April 23 which has adversely impacted on the Trust total Carbon footprint compared to prior years where the majority of power has been generated by the CHP.

Actions:
Executive Management Committee (EMC) has considered a strategic filter of programmes of work for the year ahead and endorsed its support to prioritise supporting our Net Zero Carbon ambition
The CEO has commissioned a proposal for resourcing environmental sustainability work and the Chief Finance Officer (CFO) is progressing this ahead of Q4

Risks:
• Lack of in year reporting poses a risk on certainty as to achievement of our Green Plan
• Achievement at pace of major net zero actions requires investment
• Dedicated PMO resource is required to continue momentum and funding for this is not yet secured

Breakthrough Priorities

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Breakthrough priority metric:
Vacancy rate

Assurance	Variation
(F)	(H)

NHS Royal Berkshire NHS Foundation Trust

Vacancy rate - Trustwide starting 01/12/20

Legend:
— Mean
— Vacancy rate (grey line with markers)
— Process limits - 3σ (dashed)
● Special cause - concern (orange)
● Special cause - improvement (blue)
— Target (red)
● special cause neither (purple)

	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Trust Performance	9.38%	8.74%	8.03%	7.86%	7.67%	7.91%

please note: there was an increase in establishment between FYs 21/22 & 22/23 which is why there is a significant increase in the vacancy rate from March 22 to April 23

This metric measures:
We are seeking to make significant inroads into our vacancy rate as we know that having substantive staff in role will provide quality and financial benefits across the organisation. We are tracking our progress by monitoring the unfilled substantive full time equivalent (FTE) as a percentage of the total staffing budgeted FTE.

- **How are we performing:**
- 73 vacancies went to advert, a total of 112 candidates were shortlisted for interviews
- 101 offers were made across the Trust through domestic recruitment
- No internationally recruited nurses were on boarded in December the final 25 of the 2023/24 cohort will arrive in Q4
- December has shown a slight increase caused by increase in WTE due to winter pressures

- **Actions:**
- Work to align ESR to Budgets discussed and workplan being drawn up between Finance and Workforce Information teams
- Work has started to align TRAC with current vacancies underway using Care Group trackers initially working with Directors of Nursing (DONs) due to discrepancy in budgets and ESR
- Discussions to look at recruitment processes and capacity/capability of recruitment team supported by the Transformation Team – work to commence January 2024
- Incentive Payment Guidance has been drafted and shared with Care Groups to be discussed at January Operational Management Team (OMT)
- Formal escalation process now in place for placement of internationally recruited staff to meet the Trust's pastoral requirements
- Review of HCA pipeline – waiting list has been cleansed 20 waiting to be placed. Wards continue to place individual adverts to be discussed at January R&R Meeting
- Nursing Open Days for 2024 arranged starting in March 2024
- Hot spot areas to be highlighted to focus on in 2024 – People & Change Partner (PCPs) and Retention Team

- **Risks:**
- Environmental factors – High cost of living
- Neighbouring Trusts paying incentives for specialist roles and High Cost Area Allowance (HCA) payments making moves to RBHFT less attractive

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Breakthrough priority metric:
Average Length of Stay (LOS) for non-elective patients (inc. zero LOS)

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
N/A	(variation icon)

NHS Royal Berkshire NHS Foundation Trust

Average LOS for NEL patients (inc. zero LOS) - Trustwide starting 01/12/20

Legend:
- — Mean
- - - Process limits - 3σ
- ● Special cause - improvement
- ● Average LOS for NEL patients (inc. zero LOS)
- ● Special cause - concern
- — Target

	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Ave LOS for NEL patients (inc. zero LOS	5.5	5.7	5.7	5.8	6.0	5.9

This metric measures:

Our objective is to reduce the average Length of Stay (LOS) for non-elective patients to:

- Maximise the use of our limited bed base for the patients that need it most
- Reduce the harm caused to patients due to unwarranted longer stays in hospital, including from infection
- Positively impact ambulance handover times and Emergency Department performance
- Minimise the costs associated with excess stays in hospital beyond what is clinically appropriate

How are we performing:

- Following a recent increase, the LOS for non-elective patients has reduced to 5.9 days on average. This is a return to pre-COVID norms
- This recent change is driven primarily by an increased number of patients with a short stay of 1-2 days.

Actions:

A holistic patient flow programme is underway, involving various workstreams to tackle the key elements of the pathway including:

- Minimising admission rates and unwarranted variation
- Reducing unnecessary moves between the wards
- Improving processes that facilitate discharge, through training days and communications
- Identifying and tackling the cultural changes required to support effective patient flow

Risks:

- Patient flow is impacted by many factors that are difficult to control and this means that while progress can be made it does not always result in observable change to the metric
- It will take time to embed any changes to patient flow which can then be sustained for the long term. The risk is therefore a loss of momentum and motivation from wider teams
- There are a wide variety of stakeholders to bring on board with this project and the capacity of the team is limited. The challenging aim is for Trust-wide changes in culture and practice

Breakthrough Priority metric:
Reduce 62 days cancer waits

Board Committee:
Quality Committee

SRO: Dom Hardy

Assurance	Variation
(F)	(H)

NHS Royal Berkshire NHS Foundation Trust

Cancer 62 day incomplete - No. on PTL over 62 days- Trustwide starting 01/12/20

This measures:
We have identified our cancer waits as a breakthrough priority because of the underlying performance challenges in this areas and the impact on patient care delays to this pathway can cause. We are tracking our progress by measuring the total number of patients on an incomplete cancer patient tracking list (PTL) waiting >62 days. This is also the principal metric NHS England are using nationally and the target is 161 patients by March 2024. We are also tracking the proportion of patients treated within 62 days. The national target is 85%

How are we performing:
- In Nov, 69% of patients on a cancer pathway were treated within 62days (85% standard)
- Dec performance is un-validated at 70%
- The total number of patients on the PTL >62 days is very high, predominantly within skin, gynae and gastro (100, 102 & 141 patients respectively, cum. 75% of the total >62)
- Overall PTL size has increased following the Cancer Waiting Times (CWT) updated guidance as reported to the board last month. (impact c. 90 pathways)
- 31 day is unlikely to pass with several additional lists via the Risk assessed targeted initiatives (RATI) process coming on stream which will address backlog but will result in more breaches in Jan and Feb
- Skin and gastro are largely driving poor cancer performance across Thames Valley Cancer Alliance (TVCA) in Swindon, Buckinghamshire and Oxford too

	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Trust Performance	75.10%	70.70%	62.00%	63.90%	69.10%	70.10%
Total Cancer PTL list	2325	2379	2377	2451	2219	2207
No. on PTL > 62 days	194	244	270	299	294	327
Incomplete - % on PTL over 62 days	8.3	10.3	11.6	12.2	13.2	14.8
Cancer 28 day Faster Diagnosis	78.1	79.9	75.2	74.8	75.7	77.5

Actions:
- Insourcing capacity in Gastrointestinal (GI) and urology
- RATI process in place – additional activity agreed for skin, gynae, GI and urology
- 2ww demand tool developed and shared to inform business planning
- Head and Neck (H&N) one stop US is live to help meet the 28 day target
- New Cancer Action Group (CAG) process started 16th Jan following the process review and feedback from teams/fishbone review
- Exploring locum support in skin and additional OUH capacity for plastics

Risks:
- RATI process seems to have traction, may not have sufficient funds to meet all needs
- Funding from TVCA is non-recurrent and will add pressure to budgets next year
- Limited recovery after industrial action within skin and gynaecology particularly

Breakthrough Priority metric:
Living within our means - Delivery of £15m efficiency target

Board Committee
Finance & Investment

SRO: Nicky Lloyd

Assurance	Variation
?	•••

NHS Royal Berkshire NHS Foundation Trust

Efficiency saving by Care Group - £m

Area	Target	Full year	In year	Risk adjusted	Gap	M01 planned £m	M02 Planned £m	M03 Planned £m	M04 Planned £m	M05 Planned £m	M06 Planned £m	M07 Planned £m	M08 Planned £m	M09 Planned £m	M01 actual £m	M02 actual £m	M03 actual £m	M04 actual £m	M05 actual £m	M06 actual £m	M07 actual £m	M08 actual £m	M09 actual £m	YTD_M09 delivered
Urgent Care	4.14	5.38	5.05	4.00	(0.14)	0.27	0.27	0.26	0.30	0.31	0.32	0.32	0.32	0.32	0.29	0.18	0.51	0.35	0.47	0.23	0.15	0.56	0.12	2.86
Planned Care	4.53	4.34	3.94	3.31	(1.22)	0.09	0.10	0.21	0.47	0.25	0.24	0.23	0.19	0.18	0.09	0.09	0.21	0.46	0.28	0.38	0.55	0.34	0.38	2.78
Networked Care	3.70	2.25	2.09	1.75	(1.95)	0.08	0.08	0.08	0.26	0.08	0.14	0.14	0.14	0.14	0.08	0.12	0.08	0.28	0.08	0.11	0.16	0.09	0.06	1.07
CEO	0.09	0.06	0.05	0.05	(0.04)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	-	0.01	0.01	0.00	0.00	0.01	-	0.01	0.02
COO	0.01	0.01	0.01	0.01	0.00	-	-	-	-	-	-	0.00	0.00	0.00	-	-	-	-	-	-	-	-	-	-
CMO	0.08	0.44	0.44	0.31	0.23	0.04	0.04	0.04	0.04	0.04	0.04	0.02	0.02	0.02	-	-	-	0.03	-	0.14	0.02	0.07	0.26
CNO	0.22	0.42	0.42	0.18	(0.04)	-	-	-	-	-	-	-	-	0.14	-	-	-	-	-	-	-	0.14	0.14
Estates and Facilities	1.02	1.52	1.47	1.13	0.11	0.06	0.06	0.07	0.05	0.17	0.09	0.09	0.09	0.09	0.07	0.06	0.09	0.05	0.20	0.18	0.16	0.08	0.08	0.93
IM&T	0.64	1.09	0.91	0.96	0.32	0.02	0.02	0.02	0.02	0.17	0.04	0.04	0.04	0.04	0.05	0.02	0.02	0.01	0.25	0.05	0.15	0.08	0.07	0.70
Finance	0.17	0.27	0.22	0.16	(0.01)	0.02	0.01	0.00	0.00	-	0.01	0.02	0.02	0.02	0.02	0.01	-	-	-	-	-	-	-	0.03
CPO	0.17	0.22	0.20	0.20	0.03	0.00	0.00	0.00	0.01	0.01	0.03	0.03	0.03	0.03	0.00	0.00	0.00	0.00	0.02	0.14	0.03	0.04	0.25
Strategy & Transformation	0.07	0.31	0.31	0.24	0.17	0.01	0.01	0.01	0.01	0.01	0.02	0.02	0.02	0.02	0.01	0.01	0.01	0.01	0.00	0.01	0.08	0.01	0.01	0.16
R&D	0.06	0.29	0.24	0.24	0.18	0.06	-	-	-	0.13	-	-	-	-	0.06	-	-	-	0.13	-	-	-	-	0.19
Trustwide	0.10	4.28	4.37	2.44	2.34	0.02	0.02	0.15	0.14	0.25	0.26	0.25	0.25	0.25	0.19	0.17	0.16	0.03	0.24	0.05	0.12	0.31	0.06	1.31
Travel and Transport	-	0.42	0.34	0.11	0.11	-	-	-	-	0.01	0.01	0.01	0.01	0.01	-	-	-	-	0.03	-	-	-	-	0.03
Other procurement				0.04											-	-	-	-	0.01	0.02	0.08	0.08	0.08	0.08	0.10	0.15	0.57
Total	15.00	21.29	20.05	15.13	0.09	0.67	0.62	0.86	1.30	1.44	1.21	1.17	1.13	1.27	0.88	0.68	1.16	1.23	1.70	1.16	1.75	1.61	1.14	11.30

Efficiency saving by Care Group – £m

Area	Risk adjusted	YTD_M09 delivered	M10 forecast £m	M11 forecast £m	M12 forecast £m	Total forecast £m
Urgent Care	4.00	2.86	0.27	0.27	0.26	0.79
Planned Care	3.31	2.78	0.01	0.05	- 0.31	- 0.24
Networked Care	1.75	1.07	0.13	0.13	0.16	0.43
CEO	0.05	0.02	0.01	0.01	0.01	0.03
COO	0.01	-	-	-	0.01	0.01
CMO	0.31	0.26	0.02	0.02	0.01	0.05
CNO	0.18	0.14	0.01	0.01	0.02	0.04
Estates and Facilities	1.13	0.93	0.08	0.08	0.03	0.19
IM&T	0.96	0.70	0.02	- 0.09	0.02	- 0.05
Finance	0.16	0.03	0.02	0.02	0.07	0.10
CPO	0.20	0.25	0.02	0.02	- 0.09	- 0.05
Strategy & Transformation	0.24	0.16	0.03	0.03	- 0.01	0.05
R&D	0.24	0.19	-	-	0.05	0.05
Trustwide	2.44	1.31	0.28	0.28	0.33	0.89
Travel and Transport	0.11	0.03	0.03	0.03	0.03	0.08
Other procurement	0.04	0.57	0.44	0.44	0.44	1.33
Total	15.13	11.30	1.37	1.30	1.03	3.70

RBFT - Efficiency savings 2023/24 - Cumulative forecast (£m)

Legend: Efficiency Saving - achieved; Efficiency Saving - forecast; CIP target
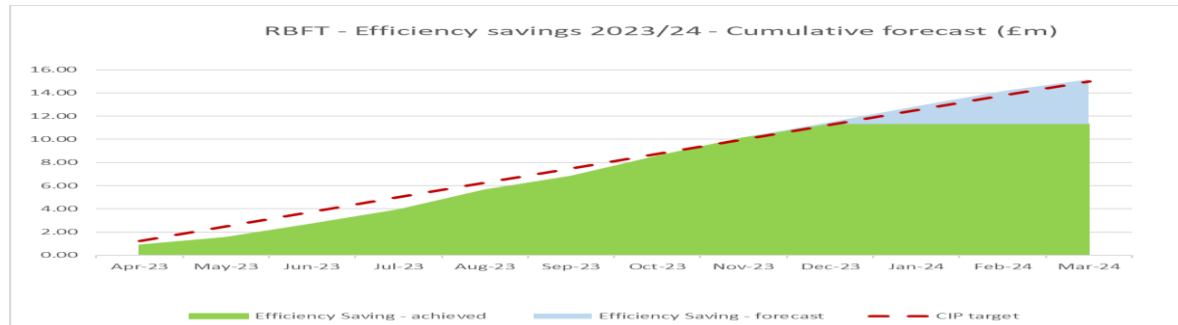
This measures:
Our objective is to live within our means, in order to achieve this objective, the Trust has set an efficiency target of £15m for the financial year 2023/24.

How are we performing:
The plan is to deliver £15m of cash releasing efficiency savings in 2023/24, of which £21.29m is so far identified for the full year and £20.05m of in year effect. We have risk assessed this at £15.13m, £11.30m has been delivered in YTD M09, compared to straight line phased plan of £11.25m..

Actions: .
- Scheme leads continue to work on additional programmes to improve the In year and risk assessed values
- The focus has shifted to identifying recurrent schemes to deliver impact in 2024/25
- While we have identified the financial level of savings required to meet the assumptions of our 2023/24 plan, these to date have been largely opportunistic/one off savings achieved by mechanisms such as holding or delaying filling vacancies. We are working with budget holders to explore how these savings can be sustained into the following financial year and beyond through permanent workforce/transformation redesign

Risks:
- Given the level of overspend at month 9 YTD, there is a requirement to recover the 2023/24 financial position to achieve the £10.05m deficit plan
- Developing recurrent savings to underpin 2024/25 budgets is an area of focused

Watch Metrics

Summary of alerting watch metrics

NHS
Royal Berkshire
NHS Foundation Trust

Introduction:

Across our five strategic objectives we have identified 127 metrics that we routinely monitor, we subject these to the same statistical tests as our strategic metrics and report on performance to our Board committees.

Should a metric exceed its process controls we undertake a check to determine whether further investigation is necessary and consider whether a focus should be given to the metric at our performance meetings with teams.

If a metric be significantly elevated for a prolonged period of time we may determine that the appropriate course of action is to include it within the strategic metrics for a period.

Alerting Metrics December 2023:

In the last month 20 of the 127 metrics exceeded their process controls. These are set out in the table opposite.

A number of the alerting relate to the operational pressures experienced in the Trust and the focus being given to enhancing flow and addressing diagnostic and cancer performance is expected to have impact on these metrics as well as the strategic metrics covered in the report above, this includes those relating to cancer, stroke and mixed sex accommodation.

Other alerting metrics are aligned to strategic metrics including patient experience, delivery of OP by telephone or digital and financial performance.

A final set relate to mandatory training and appraisal completion. In addition to the focus on recruitment, the Trust has put in place a number of interventions to support improvement action in this area.

For this month there are 2 new alerting metrics:
* Abuse/V&A (Patient to Staff)
* Conflict Resolution

Provide the highest quality of care for all

* VTE inpatient compliance
* Never Events
* Ecoli
* Mixed sex accommodation breaches
* FFT Response – OPA
* Abuse/V&A (Patient to Staff)
* Conflict Resolution
* FFT Response – Maternity

Invest in our staff and live out or values
* Ethnicity progression disparity ratio
* Rolling 12 month sickness absence
* Appraisal rates

Deliver in Partnership
* 12 hrs from arrival in ED
* Ambulatory care NEL admissions
* % of patients seen by a stroke consultant within 14 hours of admission
* % patients with high TIA risk treated within 24 hours
* Cancer 2 week wait: cancer suspected
* Cancer Incomplete 104 day waits

Cultivate innovation and improvement
* % OP treated virtually

Achieve long term sustainability
* Pay Cost vs Budget
* Non Achievement of Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice

Strategic Objective: **Provide the highest quality care for all**

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS
Royal Berkshire
NHS Foundation Trust

Metric	Variation	Assurance	Target	Trending	Oct-23	Nov-23	Dec-23	Dec-22
Never Events			0		1	1	1	1
Patient Safety incidents/100 admissions			7.00%		10.06%	10.82%	11.59%	10.99%
Pressure ulcer incidence per 1000 bed days			1.00		0.09	0.00	0.10	0.09
Category 2 avoidable pressure ulcers			5		4	13	2	2
Category 3 or 4 avoidable pressure ulcers (SI)			0		0	0	0	0
Patient Falls per 1 000 bed days			5.00		4.01	4.91	3.04	4.36
Patient falls resulting in harm (SI) avoidable			-		0	1	0	1
No. of DOLS applications applied for			-		16	35	24	21
No. of detentions under the MH act to RBH			-		5	2	2	6
% of staff: Safeguarding children L1 training			90.00%		94.40%	95.10%	95.20%	94.70%
No. of child safeguarding concerns by the Trust			-		116	100	121	119
No. of adult safeguarding concerns by the Trust			-		29	33	30	24
No. of safeguarding concerns against the Trust			-		0	2	3	7
Unborn babies on child protection (CP) / child in need plans (CIP)			-		44	54	41	34
C.Diff (Cumulative)			44		24	28	31	33
C.Diff lapses in care			-		0	1	1	1
MRSA			0		0	0	0	0
Ecoli (trust acquired) infections			-		6	11	12	12
Ecoli (trust acquired) infections (Cumulative)			92		80	91	99	85
MSSA surveillance (trust acquired)			-		5	4	3	2
Hand Hygiene			-		97.67%	97.02%	96.39%	
VTE inpatient (excluding short stay/maternity) risk assessment / prescription compliance			95.00%		81.00%	Arrears	Arrears	
Hospital Acquired Thrombosis (HAT) rate / 1000 inpatient admissions			0		1	Arrears	Arrears	

Strategic Objective: **Provide the highest quality care for all**

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS
Royal Berkshire
NHS Foundation Trust

Metric	Variation	Assurance	Target	Trending	Oct-23	Nov-23	Dec-23	Dec-22
No. of compliments			-		35	50	36	23
FFT Satisfaction Rates Inpatients: i.Inpatients	H	?	99%		98%	96%	96%	99%
FFT Satisfaction Rates Inpatients: ii.ED		?	99%		81%	79%	81%	80%
FFT Satisfaction Rates Inpatients: iii.OPA	L	F	99%		95%	95%	95%	95%
Mixed sex accommodation - breaches	H	?	0		366	363	256	410
Crude mortality	L		-		1.40	1.50	1.60	2.20
HSMR	L		-		Arrears	Arrears	Arrears	87.0
SMR	L		-		Arrears	Arrears	Arrears	87.7
SHMI	L		-		Arrears	Arrears	Arrears	0.97
Myocardial Ischaemia National Audit Project (MINAP): Door-to-Balloon target of less than 90 minutes		?	97%		93%	94%	Arrears	92%
Myocardial Ischaemia National Audit Project (MINAP): Call-to-Balloon target of less than 120 minutes		?	86%		57%	73%	Arrears	64%
Myocardial Ischaemia National Audit Project (MINAP): Call to Balloon target less of than 150 minutes		?	82%		71%	87%	Arrears	73%

NHS
Royal Berkshire
NHS Foundation Trust

Metric	Variation	Assurance	Target	Trending	Oct-23	Nov-23	Dec-23	Dec-22
RIDDOR reportable Incidents	⟳		-		0	1	0	0
Abuse/V&A (Patient to staff)	⟳		-		43	66	61	59
Body fluid exposure/needle stick injury	⟳		-		15	28	20	14
Environment Related Incidents	⟳		-		12	25	24	15
Manual Handling non patient every 3 years	H	?	90%		92%	93%	95%	91%
Conflict Resolution	H	F	90%		88%	87%	88%	87%
Fire (Annual)	H	F	90%		91%	92%	92%	88%
Nursing and AHP Manual handling training every 3 years	⟳	?	90%		89%	89%	90%	85%
Doctors manual handling training every 3 years	H	F	90%		92%	93%	95%	55%
Health and Safety Training	H		-		95%	95%	95%	92%
Slips and Trips	⟳		-		1	1	6	3
Musculoskeletal - Inanimate object	L		-		3	2	2	2
Total non clinical incidents reported	H		-		285	222	284	266

Strategic Objective: **Provide the highest quality care for all**
Maternity Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS
Royal Berkshire
NHS Foundation Trust

Metric	Variation	Assurance	Target	Trending	Oct-23	Nov-23	Dec-23	Dec-22
FFT Satisfaction Maternity			99.0%		86.5%	87.2%	95.0%	99.0%
FFT Response Maternity		F	50.0%		4.0%	6.0%	4.0%	6.2%
Complaints - % response in 25 days			78.0%		25.0%		33.0%	100.0%
Number of Serious Incidents in the Maternity Service			1		0	2	1	0
% bookings with ethnicity documented / recorded			-		86.1%	91.7%	100.0%	99.2%
% women with a documented CO result at booking	H		95.0%		91.2%	90.0%	89.2%	81.7%
% women with a documented CO result at 34-36 weeks			95.0%		87.2%	92.0%	91.0%	96.9%
% of pre-term (less than 34+0),singleton, live births receiving a full course of antenatal corticosteroids, within seven days of birth			80.0%		100.0%	33.0%	0.0%	16.6%
Post Partum haemorrhage>1500mls			3.5%		2.6%	3.3%	3.3%	3.0%
Percentage of term babies admitted to Neonatal Unit			5.0%		4.0%	5.2%	Arrears	5.2%
Percentage of Perinatal Deaths			0.5%		0.2%	0.4%	0.4%	0.4%
Number of occasions MLU service suspended for 4 hours or more			-		28	21	13	25
Midwifery staffing vacancy rate	L		-		10.1%	8.5%	7.5%	14.4%
Midwifery staffing turnover	L		14.0%		8.1%	8.9%	8.1%	14.1%
Education and training - MIDWIFERY annual attendance at maternity specific mandatory training days: Fetal Monitoring			90.0%		95.9%	91.2%	93.2%	95.1%
Education and training - MEDICAL annual attendance at maternity specific mandatory training days: Fetal Monitoring			90.0%		81.4%	89.5%	93.5%	98.1%
Education and training - MEDICAL annual attendance at maternity specific mandatory training days: PROMPT			90.0%		85.7%	73.7%	81.8%	94.5%
Education and training - MIDWIFERY annual attendance at maternity specific mandatory training days: PROMPT	L	P	90.0%		94.2%	90.9%	91.1%	97.9%
Education and training - ANAESTHETISTS annual attendance at maternity specific mandatory training days: PROMPT	H	F	90.0%		92.6%	85.7%	86.8%	92.7%

Strategic Objective: **Invest in our people and live out our values**

Watch metrics:

SRO: Don Fairley

NHS
Royal Berkshire
NHS Foundation Trust

Metric	Variation	Assurance	Target	Trending	Oct-23	Nov-23	Dec-23	Dec-22
Ethnicity Progression Disparity ratio between middle and upper pay bands			1.66		1.95	1.98	1.99	
Stability rates %			-		84.4%	84.1%	99.0%	81.8%
Rolling 12 month Sickness absence			3.3%		3.5%	3.5%	Arrears	4.3%
% Fill rate of Registered Nurse Shifts (RN)			90.0%		98.0%	100.1%	99.2%	96.9%
% Fill rate of Care Support Worker Shifts (CSW)			90.0%		102.3%	115.2%	111.8%	95.7%
Completed Mandatory Training			90.0%		92.3%	91.4%	92.8%	89.0%
Appraisals			90.0%		81.7%	83.5%	87.5%	78.4%
Nurse Staffing Red Flags			-		64	55	43	59

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Strategic Objective: **Delivering in partnership**
Watch metrics

SRO: Dom Hardy

NHS
Royal Berkshire
NHS Foundation Trust

Metric	Variation	Assurance	Target	Trending	Oct-23	Nov-23	Dec-23	Dec-22
12 hours from arrival in ED (%)	H	?	2%		5%	5%	6%	4%
12hr DTA (Trolley Waits)			-		0	0	0	0
Percent of Ambulatory Care of Non elective Admissions	L		-		1.0%	0.5%	0.5%	2.3%
Average non-elective length of stay - excluding 0 day LOS (Length of Stay)			-		6.7	6.5	6.0	6.6
Urgent Operations Cancelled 2nd time			-		0	0	0	0
Fractured Neck of Femur: Surg in 36 hours		?	75.0%		62.0%	Arrears	Arrears	40.4%
Seen by Stroke Consultant within 14 hours		F	95.0%		52.0%	52.0%	54.0%	65.0%
Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	L	?	90.0%		67.0%	61.0%	53.0%	63.0%
Proportion of stroke patients scanned within 12 hours of hospital arrival		P	90.0%		100.0%	100.0%	100.0%	96.0%
Proportion of patients spending 90% of their inpatient stay on a specialist stroke unit (national target)		?	80.0%		92.0%	85.0%	80.0%	87.0%
Proportion of people with high risk TIA fully investigated and treated within 24hrs (IPM national target)	L	F	90.0%		17.0%	19.0%	14.0%	30.0%
Average Length of Stay (LOS) from admission to discharge (days)		?	14		17	8	16	14
Door to needle time <60mins		?	95.0%		83.0%	92.0%	100.0%	100.0%
No. of weekend discharges		?	783		546	516	680	545
Rate of Emergency readmissions within 30 days of discharge	L		-		Arears	Arears	Arrears	16.1
Rate of Emergency readmissions within 30 days of discharge - Paediatrics (<16ys)	H		-		Arears	Arears	Arrears	9.8
Rate of Emergency readmissions within 30 days of discharge - Adults (16yrs+)	L		-		Arears	Arears	Arrears	17.4

Strategic Objective: **Delivering in partnership**
Watch metrics

SRO: Dom Hardy

NHS
Royal Berkshire
NHS Foundation Trust

Metric	Variation	Assurance	Target	Trending	Oct-23	Nov-23	Dec-23	Dec-22
Cancer 2 week wait: cancer suspected	L	?	93.0%		61.3%	60.8%	66.3%	92.4%
Cancer 2 week wait: breast patients		?	93.0%		98.0%	98.3%	96.6%	100.0%
Cancer 31 day wait: to first treatment		?	96.0%		90.2%	91.5%	98.8%	97.1%
Cancer 31 day wait: drug treatments	L	?	98.0%		100.0%	98.0%	95.5%	100.0%
Cancer 31 day wait: surgery	L	?	94.0%		81.0%	90.2%	71.8%	85.7%
Cancer 31 day wait: radiotherapy		?	94.0%		95.5%	94.7%	96.3%	87.1%
62 day consultant upgrade: all cancers			-		74.1%	73.8%	79.7%	77.3%
62 Day screen Ref		?	80.0%		54.5%	79.5%	91.7%	73.3%
Incomplete 104 day waits	H	F	0		118	91	120	93

Watch metrics

SRO: Andrew Statham

NHS
Royal Berkshire
NHS Foundation Trust

Metric	Variation	Assurance	Target	Trending	Oct-23	Nov-23	Dec-23	Dec-22
Cancelled Ops not re-scheduled < 28 days (%)			5%		0%	0%	0%	0%
% OP appointments done virtually			-		22.1%	21.6%	21.1%	21.9%
New to follow up ratio			-		1.9	1.9	2.1	1.9
Number of OPPROC			-		9410	9721	7325	7454
Number of MDT OP			-		719	717	529	
Clinic room utilisation (esp utilisation at non RBH sites)			-		35%	36%	29%	
Number of PIs			-		89	96	100	50
Number of active research trials			-		104	111	118	98
Number of projects supported by HIP			-		54	54	54	50

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Strategic Objective: **Achieve long-term sustainability**
Watch metrics

SRO: Nicky Lloyd

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Trending	Oct-23	Nov-23	Dec-23	Dec-22
Pay cost vs Budget (£m)			-		-0.39	-1.77	-1.11	-0.53
Non pay cost vs Budget (£m)			-		-1.31	-1.20	-1.58	-1.82
Income vs Plan (£m)			-		1.48	4.54	2.74	0.49
Daycase actual vs Plan (£m)			-		-0.13	0.18	-0.23	-0.16
Elective actual vs Plan (£m)			-		-0.21	0.16	0.06	0.01
Outpatients actual vs Plan (£m)			-		0.25	0.60	-0.51	-0.23
Non-elective actual vs plan (£m)			-		-0.52	-0.26	0.48	1.04
A&E actual vs plan (£m)			-		0.14	0.21	-0.12	0.84
Drugs & devices actual vs plan (£m)			-		0.12	0.27	0.07	0.51
Other patient income (£m)			-		0.14	0.25	0.12	-0.15
Delivery of capital programme (£m)			-		2.25	2.29	1.22	1.32
Cash position (£m)			-		33.58	32.29	37.89	43.81
Agency spend % of total staff cost (%)			-		2.2%	2.2%	2.2%	4.0%
Creditors (£m)			-		-72.60	-72.83	-75.15	-74.48
Debtors (£m)			-		24.09	26.64	24.15	16.22
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) YTD			95.00%		57.45%	58.40%	58.30%	
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) In Month			95.00%		65.72%	66.45%	56.80%	

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WOKINGHAM BOROUGH WELLBEING BOARD

Forward Programme from June 2023

Please note that the forward programme is a 'live' document and subject to change at short notice.

The order in which items are listed at this stage may not reflect the order they subsequently appear on the agenda.

All Meetings start at 5pm in the Civic Offices, Shute End, Wokingham, unless otherwise stated.

WOKINGHAM BOROUGH WELLBEING BOARD FORWARD PROGRAMME 2023/24

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
7 March 2024	Local Pharmaceutical Committee update			Local Pharmaceutical Committee	
	ICB Pharmacy Optometry and dentistry leads			ICB	
	Community Wellness			Public Health	
	Marmot			Public Health	
	Royal Berkshire NHS FT	Standing update	Standing update	Andrew Statham	
	Place Partnership	Update	Update	ICB	
	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	

To be scheduled –

- Wellbeing – impact of Borough's leisure provision on residents' wellbeing
- Annual Report Director Public Health
- Harm outside the Home Strategy – consultation