Simon Warren
INTERIM MANAGING DIRECTOR

Civic Offices, Bridge Street,
Reading RG1 2LU
☎ 0118 937 3787

To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

Our Ref:
Your Ref:

Direct: ☎ 0118 937 2112
e-mail: nicky.simpson@reading.gov.uk

7 July 2016

Your contact is: Nicky Simpson – Committee Services

NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 15 JULY 2016

A meeting of the Health & Wellbeing Board will be held on **Friday 15 July 2016 at 2.00pm in the Council Chamber, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

Cont/..

../Cont

5. OUTCOMES AND RESPONSE TO LGA PEER REVIEW OF THE READING AND WEST OF BERKSHIRE HEALTH AND WELLBEING BOARDS 55

A report presenting the feedback letter from the LGA Peer Review of the Reading and West of Berkshire Health and Wellbeing Boards, which outlines the headline messages, key findings and recommendations contained in the review letter and a proposed draft framework to address the recommendations.

6. ALIGNING COMMISSIONING INTENTIONS WORKSHOP 75

Further to Minute 6 of the meeting on 22 January 2016, a report on the plans to run a workshop involving Commissioning leads from Reading Integration Board, partner authorities in West of Berkshire and Health and Wellbeing Board members, to share the critical themes to be built into organisations' commissioning intentions.

7. HEALTHWATCH READING ANNUAL REPORT 2015/16 77

Healthwatch Reading's annual report, giving details of the work carried out by Healthwatch Reading in 2015/16.

8. ANNUAL REPORT FROM THE DIRECTOR OF PUBLIC HEALTH 105

A report presenting the Strategic Director of Public Health's Annual Report for Reading, focusing on the health of children and young people.

9. DEVELOPMENT OF WELLBEING DASHBOARD 129

A report giving an update on the progress of the development of the Wellbeing Dashboard and presenting the latest draft Dashboard.

10. UPDATE ON THE JOINT HEALTH & WELLBEING STRATEGY REFRESH 144

A report giving details of progress to date in developing a 2nd Joint Health and Wellbeing Strategy for Reading.

11. BERKSHIRE WEST 10 LOCAL DIGITAL ROADMAP SUBMISSION 182

A report presenting the Berkshire West Local Digital Roadmap, which has been produced by local health and care systems and submitted to NHS England, setting out how they will achieve the ambition of 'paper-free at the point of care' by 2020.

Cont/..

../Cont

12. QUALITY ACCOUNTS: REVISED SCRUTINY ARRANGEMENTS 258

A report on plans for future scrutiny of Quality Accounts presented by healthcare providers, giving the Health and Wellbeing Board a clear overview and scrutiny lead in this area via a delegation from the Adult Care Children's Services and Education (ACE) Committee.

13. READING'S ARMED FORCES COMMUNITY COVENANT AND ACTION PLAN – MONITORING REPORT 261

A report giving a six monthly update on progress against the actions outlined in the Armed Forces Community Covenant action plan, and on the general development of the Community Covenant.

14. DATE OF NEXT MEETING -

Friday 7 October 2016 at 2pm

READING HEALTH & WELLBEING BOARD MINUTES – 18 MARCH 2016

Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Reading Borough Council (RBC)
Andy Ciecerski	Chair, North & West Reading Clinical Commissioning Group (CCG)
Councillor Eden	Lead Councillor for Adult Social Care, RBC
Wendy Fabbro	Director of Adult Care & Health Services, RBC
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Councillor Lovelock	Leader of the Council, RBC
Ishak Nadeem	Chair, South Reading CCG
David Shepherd	Chair, Healthwatch Reading

Also in attendance:

Adam Bevington	Digital & Website Manager, RBC
Andy Fitton	Acting Head of Early Help and Family Intervention, RBC
Jo Hawthorne	Head of Wellbeing, RBC
Kevin Johnson	Integration Programme Manager, RBC
Maureen McCartney	Operations Director, North & West Reading CCG
Eleanor Mitchell	Operations Director, South Reading CCG
Sally Murray	Head of Children's Commissioning, Berkshire West CCGs
Conor Nolan	Reading Youth Cabinet
Melanie O'Rourke	Head of Adult Social Care, RBC
Rachel Pearce	Director Commissioning Operations South Central, NHS England South
Veronica Reynolds	Intelligent Health
Nicky Simpson	Committee Services, RBC
Mandeep Sira	Chief Executive, Healthwatch Reading
Councillor Stanford-Beale	RBC
Cathy Winfield	Chief Officer, Berkshire West CCGs
Tom Woolmer	Participation & Accreditation Coordinator, RBC
Jen Young	Reading Youth Cabinet

Apologies:

Lise Llewellyn	Director of Public Health for Berkshire
Ian Wardle	Managing Director, RBC
Kim Wilkins	Senior Programme Manager, Public Health, RBC

1. MINUTES & MATTERS ARISING

The Minutes of the meeting held on 22 January 2016 were confirmed as a correct record and signed by the Chair.

Further to Minute 20, regarding the review of the Reading and West of Berkshire Health and Wellbeing Boards, Wendy Fabbro reported that the LGA Peer Review had taken place on 1-4 March 2016. Initial verbal feedback had been given by the LGA team and a written report was expected in a few weeks' time. A report would be submitted to the next Board meeting, to ensure that all parties had had a chance to receive the written Peer Review report and an action plan could be prepared.

Resolved - That the position be noted.

2. READING YOUTH CABINET UPDATE ON MENTAL HEALTH CAMPAIGN ISSUES

Further to Minute 4 of the meeting on 17 July 2015, when members of Reading Youth Cabinet had given a presentation on their campaigns on Mental Health and PSHE to the Board, Tom Woolmer submitted a report and Jen Young and Conor Nolan from Reading Youth Cabinet attended the meeting to give a presentation giving an update on the progress of the campaigns. Copies of the presentation slides had been included in the agenda.

The report and presentation explained that the Youth Cabinet had sought to raise the profile of mental health within schools, including the relaunch of a Mental Health Treaty (a copy of which was appended to the report) which had been sent to all schools in Reading, and the delivery of an event in November 2015, to which all schools had been invited.

The Treaty aimed to increase the amount of mental health education delivered, promote a consistent approach and continue to put pressure on schools to better support young people around mental health. The event in November 2015 had involved around 60 participants from five schools in workshops on the PSHE and Mental Health campaigns, to raise awareness of issues within these schools and look at ideas of how to tackle these issues and increase support; there had been good participation from those present at the event.

It was explained that engagement from schools in these opportunities had been mixed, so there was a continuing need to better engage schools consistently in this work. Mental Health had again been selected as one of the campaigns for the Youth Cabinet in 2016, for the fourth consecutive year. The other two campaigns were Anti-Discrimination (which had been voted for by the participants at the November event) and Right to Self-Expression.

Work in 2016 on the Mental Health campaign would focus on identifying gaps in service provision, ensuring an awareness of and accessibility to existing services, and supporting initiatives such as the School Link project to improve support within schools. This would go hand-in-hand with the continued work around the Mental Health Treaty.

The meeting discussed the challenges, which, even when schools did engage with mental health issues, could include lack of advertising of support for young people or advertising in places where they did not see it, and lack of training in mental health issues for those providing support for the young people. It was also noted that many young people with mental health issues did not think to go to their GP for support.

Sally Murray reported that there was a strand of work in a Future in Mind project which was about upskilling schools to enable them to help young people and increase communication and awareness with young people themselves. She said that this work needed reviewing to ensure that the work was reaching the right people and she also suggested that more use could be made of the Council's networks in working out the best ways of reaching young people generally.

It was also suggested that two ways for the campaign to be presented to schools was through the new REAP Reading Schools Partnership and the regular meetings of school Special Educational Needs Coordinators.

Councillor Hoskin said that he and the Lead Councillor for Education had made a commitment to support the Mental Health Treaty relaunch and it was important to think about how this could be supported through the Council's networks, as it was key to provide support to people with mental health problems at as early a stage as possible.

Resolved -

(1) That the presentation and progress of the Youth Cabinet on their campaigns, and their campaign plans for 2016, be noted;

(2) That Andy Fitton liaise with Tom Woolmer to organise for members of the Youth Cabinet to be invited to present their campaigns to the new REAP Reading Schools Partnership and to the meeting of school Special Educational Needs Coordinators;

(3) That members of the Board consider any further opportunities where they could work with the Youth Cabinet to further their campaign aims and ultimately services for young people.

3. UPDATE STATUS REPORT ON COMPREHENSIVE CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Further to Minute 5 of the Health and Wellbeing Board meeting on 9 October 2015, Andy Fitton and Sally Murray submitted a report giving an update on service development and improvement across the comprehensive CAMHS (Child and Adolescent Mental Health Services) system. Appendix 1 set out acronyms used in the report, Appendices 2 & 3 set out details of Tier 1-4 services and Appendix 4 set out details of progress to date against the Action Plan to Improve CAMHS Service Delivery.

The report explained that the system-wide CAMHS Local Transformation Plan for Reading, which had been approved in October 2015 (Minute 5 refers), was built around the national "Future in Mind" policy document and the comprehensive CAMHS engagement work undertaken in 2014 to identify local needs, and it had enabled additional recurrent funding to be released from NHS England to the Berkshire West CCGs. The report gave details of the themes included in the plan and stated that a joint meeting was held monthly to oversee and support the implementation of the Local Transformation Plans - the Berkshire West 'Future in Mind' group.

The report explained that the Action Plan had been updated with current progress since October 2015 and it highlighted key points of progress. The report noted that Berkshire West had committed an additional £1m recurrently and an additional £0.5m in the current financial year to Berkshire Healthcare NHS Foundation Trust to mainly address waiting times, and set out the associated targets. The report stated that it was recognised that these were challenging targets, which were not yet being met although waiting times were reducing, and contractual action was being taken to ensure that a robust recovery plan was in place to achieve the waiting time targets. However, there had been a number of quality improvements, details of which were set out in the report.

The report stated that there was close working across a network of partners, including the Council, Berkshire West CCGs, local Schools, the voluntary sector and other key partners to finalise the 2016/17 priorities in the Plan. The current priorities were:

- Reduce waiting times
- Develop the role of schools, primary care, early years settings and wider children's workforce to identify and respond to emerging mental health needs
- Plan how to make the system easier to navigate, through mapping the partnership collective resilience, prevention and early intervention offers
- Review current Common Point of Entry and access arrangements into CAMHs services, ensuring access for the most vulnerable
- Consider whether to commission a crisis home treatment or enhanced step up/step down service following the CAMHS CORE 24 Urgent Care Response Team pilot project
- Enhance provision across the system for children and young people with Autism Spectrum Disorder and Learning Difficulties
- Roll out of enhanced perinatal service
- Implement enhanced community Eating Disorders service

It was requested that the next update report also include metrics giving actual outcomes and measuring investment against outcomes in the action plan.

Resolved -

(1) That the progress made in CAMHS in terms of strategic direction and service improvement be noted;

(2) That a further update report be submitted to the Board in 12 months' time, to include metrics.

(Councillor Stanford-Beale declared an interest in the above item but remained in the room and took part in the debate. Nature of interest: Councillor Stanford-Beale was Chief Executive Officer of Autism Berkshire and also benefited from funding from Short Breaks.)

4. BEAT THE STREET READING 2015

Jo Hawthorne and Veronica Reynolds submitted a report providing feedback on the Beat the Street (BTS) Reading 2015 walking challenge project and giving an update on arrangements for the 2016 Beat the Street project. The report had appended:

- Appendix 1 – Beat the Street Reading Engagement Overview 2015
- Appendix 2 – Beat the Street Reading 2015 feedback – What do people get out of Beat the Street?

The report explained that BTS 2015 had been commissioned by Reading Borough Council Public Health and the North & West and South Reading CCGs, to increase physical activity levels, with a focus given to engaging people who had long term conditions and who had low levels of physical activity. The 2015 project had been developed based on the positive reception of the 2014 BTS project.

BTS had been carried out by Intelligent Health, a company which focused on promoting physical activity to improve health outcomes. Intelligent Heath's Beat the Street community initiative was designed to inspire people to walk more. People scanned a card or key fob onto 'Beat Box' scanners located around the community in order to indicate that they had walked between the boxes, earning points that added up to win prizes for their team or school.

The report stated that 23,992 people had taken part in BTS 2015 between 29 April and 24 June 2015 (as compared with 15,074 in 2014). 10,831 participants (8,416 in 2014) had been school children and 13,161 (6,658 in 2014) had been adults. The project had succeeded in engaging 11% of the population of Reading and 12% of participants had had a long term condition such as Chronic Obstructive Pulmonary Disease, arthritis or diabetes.

306,640 miles had been walked in total (244,537 in 2014). At the beginning of the project 40% of people had reported meeting the Department of Health's guidelines for levels of activity (30 minutes of physical activity for five or more days per week). By the end of the project, this had increased to 48%. 78% had said they would try to continue the changes they had made after Beat the Street had ended. A full evaluation of the 2015 BTS project was set out in the appendices to the report.

The report stated that, in order to build on the project outcomes, Public Health and North & West and South Reading CCGs would commission further projects over the next two years that would have higher participation rates, especially from GP practices engaging patients. The 2016 BTS project would cost £127,650, with 50% of the cost to be funded by Public Health and the remaining 50% funded equally from North & West and South Reading CCGs.

The 2016 project would run from 15 April – 27 May 2016, with the following expected benefits/outcomes:

- 15% of the population to participate (31,650)
- 25% of adults participating to have been referred by their GP and for 18% of adults participating to have a Long Term Condition
- 8% of participants to be referred through business workplaces
- 95% of primary schools participate
- 50% of secondary schools participate
- 10% increase in activity levels

As previously, monitoring of the BTS system and database would take place before, during and after the competition. Progress analysis and evaluation would be undertaken at inception, at the end of the live project and after six months and 12 months.

Veronica Reynolds gave a further update at the meeting on the way BTS projects had been taken up in other areas in the UK and across the world, following Reading's lead, and she also reported on the analysis of further follow-up data which had recently been collected on the Reading 2015 BTS project. She reported that the increase in activity had been sustained and there had been the greatest impact in those who had previously been least active. There had also been a sustained change in people choosing to walk more and it was hoped that each year these improvements in activity would be sustained and built upon. She said that, because of the large

numbers of people involved and the effectiveness of the project, there were expected to be significant healthcare savings, which justified the investment made.

Resolved -

(1) That the background to the Beat the Street walking initiatives and the feedback and evaluation results for the 2015 Beat the Street project be noted;

(2) That the arrangements for delivery of the Reading Beat the Street 2016 project be noted.

5. NHS PLANNING GUIDANCE & BERKSHIRE WEST CCGS DRAFT OPERATIONAL PLAN 2016-17

Cathy Winfield submitted a report on the draft Operational Plan 2016/17 for the four Berkshire West Clinical Commissioning Groups (CCGs) which had been submitted to NHS England on 2 March 2016, in line with NHS Planning Guidance issued in December 2015, and for which the final submission was due on 11 April 2016. A copy of the draft Executive Summary of the Operational Plan 2016/17 was attached at Appendix 1.

The report also set out the requirement within the Guidance for the development of a five year Sustainability & Transformation Plan (STP), which had to be submitted by the end of June 2016, and stated that the final versions of this and the Operational Plan would be reported to the Board's next meeting. Rachel Pearce attended the meeting and gave a presentation on the development of the STP. Copies of the presentation slides were circulated at the meeting.

The report explained that NHS England had issued planning guidance to CCGs "Delivering the Forward View: NHS Planning Guidance 2016-17 - 2020/21" in December 2015, which required CCGs to provide two separate (but connected) plans: A five year Sustainability and Transformation Plan (STP) and a one year Operational Plan 2016/17, as well as the submission of a Better Care Fund Plan for 2016/17 (see Item 10 below).

The report stated that the draft one year Operational Plan 2016/17 had been developed and aligned with the four goals and sub-objectives of the Reading Health and Wellbeing Strategy 2013-16 and the recent Reading JSNA, and the individual CCG Public Health profiles had informed its content for any Reading-specific areas of focus. The CCGs planned to develop a public facing "plan on a page" for each CCG in recognition that the Operational Plan was an "NHS" document, written in a format to meet the requirements of the NHS planning process and not intended as a public facing document.

The report stated that the guidance described the following "must do's" which had to be fulfilled by local systems:

- Develop a high quality, agreed STP & achieve local critical milestones for accelerating progress in 2016/17
- Return the system to aggregate financial balance
- Develop & implement local plan to address sustainability & quality of general practice (including workforce & workload issues)

- Achievement of access standards for A&E & ambulance waits (including through making progress in implementing the urgent & emergency care review)
- Improvement & maintenance of NHS Constitution standards (18 weeks Referral to Treatment Time (RTT) & patient choice)
- Deliver 62 day cancer waiting time standard & make progress in improving 1 year survival rates(including by securing adequate diagnostic capacity)
- Achieve & maintain 2 new Mental Health access standards (treatment of psychosis & referral to IAPT) & continue to meet dementia diagnosis rate
- Deliver actions to transform care for people with Learning Disabilities (including community provision & reducing inpatient capacity)
- Develop & implement plans for improving quality (providers to also participate in annual publication of avoidable mortality rates)
- **Plus** – three specific actions against roll out of 7 day services - consultant cover and diagnostics/improved access to Out of Hours care, and improved access to Primary care at evenings and weekends.

The appended Plan summary set out the Berkshire West CCG priorities for the coming year and plans to meet the "must do's". It explained that the Berkshire West system had been working as the Berkshire West 10, comprising four CCGs, three local authorities, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust and South Central Ambulance Service for some time, within a shared governance structure, and Berkshire West was proposing to establish a new Model of Care and operate as a local Accountable Care System (ACS), of which it gave more details. It also gave details of the development of a Thames Valley footprint STP.

Cathy Winfield explained at the meeting that, since the submission of the draft Operational Plan on 2 March 2016, discussions on the STP had moved on and the STP footprint was now expected to cover Berkshire West, Oxfordshire and Buckinghamshire (BOB).

Rachel Pearce's presentation on the STP covered the following:

With the resources provided in the Spending Review's £8.4 billion increase in funds for the NHS by 2020/21, a Five Year Forward View needed to be implemented to close a number of gaps. Health and care systems had to develop a five year Sustainability and Transformation Plan (STP) by June 2016. The STP was a place-based, strategic plan demonstrating how, as a health and social care system, it would:

1. Close the health and wellbeing gap
2. Drive transformation to close the care and quality gap
3. Unlock resources to invest in meeting the challenges of future demand, while achieving and maintaining financial balance and efficiency, whilst still delivering on the first two actions

The STP would require a step change in how the health and care system worked together, in having a common understanding of future service models and in identifying a level of collective saving over five years far higher than the NHS had ever delivered. There was an expectation that there would be a move away from thinking about organisations and their boundaries, towards looking at populations and patient flows at a very local level, whilst collaborating to find benefits of scale on issues such as estates or digital technology.

Buckinghamshire, Oxfordshire and Berkshire West CCGs had formed an alliance to develop STPs. The BOB alliance comprised ten CCGs and Provider Trusts operating through four local health economies - Buckinghamshire, Oxfordshire, Berkshire West and Berkshire East.

Providers, clinicians, patients and local authorities would be engaged in the local health economies, and the initial projects and workstreams being worked on included:

- Urgent and emergency care
- Specialised commissioning
- Workforce Resilience
- Digital Innovation
- PLCV/IFR/clinical thresholds
- Primary care provider development
- Central Support Unit procurement
- Provider landscape strategic oversight

The STP would cover a number of different footprints and the following examples were given of levels of service planning:

- Services designed/planned on an England-wide footprint (Highly Specialised Services) - eg liver transplant services, enzyme replacement therapy and secure forensic mental health services for young people
- Services designed/planned on an Buckinghamshire, Berkshire and Oxfordshire Alliance+ footprint (specialised commissioning) - eg chemotherapy, radiotherapy, complex rehabilitation
- Services designed/planned on a Buckinghamshire, Berkshire and Oxfordshire Alliance footprint - eg urgent and emergency care network; development of the integrated clinical hub and 111
- Services designed/planned on a CCG footprint - eg planned care, maternity
- Services designed/planned on a locality-footprint - eg new models of care; customisation of CCG models for long-term conditions

The meeting discussed the report and presentation and it was noted that the success of the STP would rely on leaders coming together to create an appropriate governance structure, especially if new resources would be fed into the STP level. The governance structure had not yet been signed off, but it was expected to build on existing structures rather than duplicate them.

Councillors expressed concern that the Council, and Social Care and Public Health particularly, had not been involved in the development of the STP, even though it was a health and social care system plan, and that there was a danger of losing local accountability, engagement, influence and decision-making.

Resolved -

(1) That the priorities identified by the CCGs as outlined in the "One Year Operational Plan 2016/17" be noted and the ongoing work of the CCGs in supporting the delivery of the Reading Health and Wellbeing Goals be supported;

(2) That the requirement for the development of a five year Sustainability and Transformation Plan across Berkshire West be noted;

(3) That it be noted that the final one year Operational Plan 2016/17 and five year STP would be reported to the next meeting of the Board;

(4) That further consideration be given to how the Council could be more involved in the development of the STP.

6. READING JOINT STRATEGIC NEEDS ASSESSMENT 2016-19

Jo Hawthorne submitted a report giving an update on the progress made to date on the redesign process with refreshed national and local data for the web-based Reading Joint Strategic Needs Assessment (JSNA). Adam Bevington attended the meeting and gave a presentation demonstrating the content and accessibility of the updated web-based Reading JSNA.

The report explained that the JSNA provided a local assessment of the current and future health, social care and wellbeing needs of the local population in Reading, so that the local system had the health and wellbeing intelligence it required to commission and provide the best services based on evidence of need. Following the launch of the Health and Social Care Act 2012, which had introduced significant changes to the health and social care system, a new approach to the production of the JSNA had been introduced in 2013/14. The report listed the key features of JSNA development and also examples of how the JSNA content had been used by health and social care partners to inform strategy and commissioning.

The report gave details of the work involved in the production of a comprehensive JSNA for 2016-19, to replace the existing one. It stated that content development, review and sign-off of a few final remaining JSNA sections was in progress and it was reported at the meeting that the new JSNA would be launched on 1 April 2016.

It stated that, throughout the year, individual JSNA modules would be reviewed following receipt of revised national and local sets of data, to ensure that the JSNA was updated as new data was released and reviewed appropriately, before being uploaded onto the JSNA website.

The report listed some of the key health and wellbeing needs in Reading which were emerging from the work on the JSNA and noted that the JSNA was a key source of information which would be used to develop the next iteration of the Reading Health and Wellbeing Strategy in collaboration with local key stakeholders. The new version of the Health and Wellbeing Strategy, as well as an implementation plan, would be submitted to the next meeting of the Board. A "dashboard" of key performance indicators would also be developed, to enable robust and transparent monitoring of progress on commitments and actions set out in the implementation plan (see Minute 7 below).

It was noted at the meeting that, unfortunately, some information available, such as that from the 2011 national census, was necessarily somewhat out of date, but that, where possible, local intelligence provided by partners had been used to provide more up to date figures, for example on the number of carers in Reading.

Resolved -

(1) That the proposal to move to in-year JSNA updates be endorsed and a schedule of planned updates be provided to members of the Board;

(2) That the JSNA be recommended to full Council for information and comment.

7. PROPOSAL FOR HEALTH & WELLBEING PERFORMANCE DASHBOARD

Jo Hawthorne submitted a report presenting a draft Health and Wellbeing Performance Dashboard for use by the Health and Wellbeing Board to enable monitoring of key performance indicators linked to the Health and Wellbeing Strategy. The draft dashboard was attached at Appendix 1.

The dashboard set out six priorities across the four goals of the Health and Wellbeing Strategy, listed indicators for each priority and gave a red/amber/green (RAG) status for each priority.

The report explained that it was proposed that the dashboard would contain key priorities, performance indicators and outcomes which would be monitored and reported on at the Health and Wellbeing Board by partners, who had the responsibility to develop and deliver specific outcomes. The Wellbeing Team would support this by providing data and intelligence through performance reports and it was envisaged that the dashboard would be viewed at each Health & Wellbeing Board as a pictorial aid, once developed.

The JSNA would provide the national and local context for the development of indicators, which had been drawn largely from the national NHS Outcome Framework, Public Health Outcomes Framework and Adult Social Care Outcome Framework. As the dashboard further developed, other appropriate quality measures might be identified and added, in collaboration with Reading Healthwatch and Commissioners.

A Task and Finish group with key stakeholders had been formed and had developed the first draft of the dashboard. The intention was for the Board to agree the principle and format of the dashboard in order for the Task and Finish Group to continue to develop, design and bring back to the Board a more detailed dashboard for approval.

The report stated that the outcomes and indicators contained within the dashboard would be reviewed in line with reviews of the Health and Wellbeing Strategy on an annual basis, or as indicated by the Board.

Resolved -

(1) That the format of the proposed Health and Wellbeing Performance Dashboard be endorsed;

(2) That the Task and Finish Group make further developments to the Health and Wellbeing Performance Dashboard and bring back a more detailed dashboard to the Board for approval.

8. QUALITY ACCOUNTS

Wendy Fabbro submitted a report on options for Health and Wellbeing Boards to comment on and advise on quality standards and performance to be achieved in the delivery of Health and Wellbeing strategic outcomes in NHS healthcare provider Quality Accounts (QAs). The report had appended QA consultation documents.

The report explained that a QA was a report about the quality of services delivered by an NHS healthcare provider. Reports were published annually by each provider, including the independent sector, and were an important way for local NHS services to report on quality and show improvements in the services they delivered to local communities and stakeholders. The quality of the services was measured by looking at patient safety, the effectiveness of treatments that patients received and patient feedback about the care provided.

The Department of Health required providers to submit their final QA to the Secretary of State by uploading it to the NHS Choices website by 30 June each year. Healthwatch should be provided with a copy to comment on prior to publication of the Quality Account, and had been asked to consider producing guidance that would enable them to effectively challenge QAs locally.

Foundation trusts and NHS trusts were only required by regulation to share their Quality Report with NHS England or relevant Clinical Commissioning Groups, Local Health Watch organisations and Overview and Scrutiny Committees (and have their reports audited). There was no regulatory requirement for foundation trusts or NHS trusts to share their Quality Account/Report with Health and Wellbeing Boards unless the Health and Wellbeing Board was fulfilling a scrutiny function, although the report stated that it was hard to see any reason why this would not be sensible given the remit of the Health and Wellbeing Board to oversee alignment and potential integration of health and care services. For Reading Borough Council, the Constitution identified the Adult Social Care, Children's Services & Education Committee (ACE) as the Health Scrutiny body, although in practice much of the reporting of developments was managed via the Health and Wellbeing Board.

The report stated that no central guidance had been issued to Health and Wellbeing Boards in terms of the expectation of comments, but comments might be made on the following areas:

- the degree to which local communities had been engaged in priority setting
- other priority areas that could have been included in the QA
- the approach the organisation had towards quality improvement overall

At the point of writing the report, a consultation document on QA priorities had been received and responded to from Royal Berkshire NHS Foundation Trust, but not the whole QA, and a draft QA had been received from Berkshire Healthcare NHS Foundation Trust, with a further QA expected from South Central Ambulance Service. However, the next Board meeting was planned for July 2016, after the deadline for publishing with NHSE. The received documents were attached as Appendices A and B.

Resolved -

(1) That a Task & Finish Group be set up from Board members and observers to evaluate Quality Accounts against strategic intentions and JSNA priorities;

(2) That a further report be submitted to the next meeting, setting out recommendations for ongoing monitoring of Quality Accounts as an essential element of Health Scrutiny.

9. PROGRESS REPORT ON HOW THE EX-GURKHA COMMUNITY ACCESS AND EXPERIENCE HEALTH AND SOCIAL CARE IN READING

Further to Minute 7 of the Board meeting on 17 July 2015, Wendy Fabbro submitted a report giving an update on progress on actions across health and social care as a result of recommendations from Healthwatch Reading's report on "How the ex-Gurkha community in Reading access and experience health and social care services".

The report explained that the original report had been commissioned in 2014 from Healthwatch Reading by Reading Borough Council, on behalf of a consortium of local authorities in the south-east of England, to gather feedback from members of the ex-Ghurkha Community on how they accessed health and social care services and their experience of those services. This had been presented to the Health and Wellbeing Board on 17 July 2015 (Minute 7 refers).

The report explained that the Healthwatch report had provided partners with a helpful understanding of the issues and experiences faced by the Nepalese community, which was a small but growing population in Reading, and had made a number of recommendations. The report gave details of information which had been gathered on the community and its health needs and stated that, based upon the recommendations within the Healthwatch report, health and social care had devised an action plan to address the key areas of development. Table 1 in the report described the recommended actions and the responses and the final column of the table demonstrated that all areas of the action plan had been completed.

The report stated that health and social care providers had also committed to making continued improvements, working in partnership, and the Reading Integration Board would lead on this programme, highlighting the need for greater community collaboration.

Resolved -

(1) That the progress made be noted;

(2) That the Reading Integration Board continue to track the progress of access to services for the ex-Gurkha community.

10. BETTER CARE FUND 2016/17 PLANNING AND SUBMISSION UPDATE

Further to Minute 13 of the previous meeting, Wendy Fabbro submitted a report giving an update on the 2016/17 Better Care Fund (BCF) submission requirements and timetable and the changes to the mandated National Conditions that would inform spending for 2016-17. It gave details of progress to date on 2016/17 BCF submission planning and requested officer authority to submit the final 2016/17 BCF plans by the deadline of 25 April 2016. Appendix 1 to the report contained a list of the projects

involved in the 2015/16 Reading BCF and Appendix 2 contained a diagram showing the Berkshire West 10 Integration Programme.

The report explained that the BCF was the biggest ever financial incentive for the integration of health and social care. It required Clinical Commissioning Groups (CCGs) and Local Authorities to pool budgets and to agree an integrated spending plan for how they would use their Better Care Fund allocation. For 2016/17, the BCF would continue with a mandated minimum fund of £3.9 billion to be deployed locally on health and social care. It was reported at the meeting that this translated to a local Reading fund of approximately £10.4 million (not £10.1 million as set out in the report).

The report listed the changes to the BCF Policy Framework for 2016/17, noting that in place of the performance fund, there were now two new national conditions, requiring local areas to fund NHS-commissioned out-of-hospital services (at a level in line with the 15/16 performance fund allocation) and to develop a clear, focused plan for management of delayed transfers of care (DTOC), including locally agreed targets. It stated that the national guidance had also given further advice on the alignment of BCF targets for reducing non-elective admissions to hospital (NEL) with the planning assumptions included in final CCG operational plans, and gave details of the current situation on NEL in Reading.

It explained that increased NEL in 2015/16 had led to system-wide pressures at discharge which the Council had experienced as significant financial pressure from the high numbers of additional people requiring support. The Council believed that there needed to be increased emphasis on BCF projects to tackle the increased admissions to hospital before the health and social care BCF was viable. During 2015/16 there had been a significant increase in NEL of 14.9% for North & West Reading CCG and 18.8% for South Reading CCG and an in-depth analysis was being undertaken to understand this cohort of patients and the financial impact on all partners. NHS England advice to the CCGs and the Council had been that in 2016/17 there could be a risk share to mitigate the cost pressure of extra hospital activity, but this was not required in the guidance. The details of the risk share were subject to further discussion between the Council and the CCGs so that a jointly agreed submission could be made on 21 March 2016.

The report stated that for 2016-17 the CCGs and Council would be required to collectively develop and agree through the Health and Wellbeing Board:

1. A short, jointly agreed narrative plan including details of how the national conditions were being addressed;
2. Confirmed funding contributions from the Local Authority and CCGs including arrangements in relation to funding within the BCF for specific purposes;
3. Spending plans broken down by each BCF scheme demonstrating how the fund would be spent;
4. Quarterly plan figures for the national performance metrics.

Due to the delays with the publication of the final 2016/17 BCF submission guidance and timetables from NHS England it had not been possible to fully anticipate all requirements. The final guidance had eventually been released on 23 February 2016 creating a challenging timetable with the first BCF submission having been due on 2 March 2016. This had not been submitted, due to outstanding issues relating to the

NEL targets and financial reconciliation as reported to Health and Wellbeing Board in June 2015, and further discussions were required on whether to include the risk share on BCF plans. The report gave a brief summary of the submission requirements and the related progress/position to date in the following areas:

- Narrative
- Funding Contributions
- Scheme Level Funding Plan
- Performance Metrics
- Engagement with: Patients and Service Users; Housing; Local NHS Providers and Local Adult Social Care Providers

The report set out the timetable that the BCF submission and assurance process would follow, which included first draft BCF submission by 2 March 2016, second draft submission by 21 March 2016 and final submission, having been signed off by the Health and Wellbeing Board, by 8 April 2016. The Section 75 agreements had to be signed and in place by 30 June 2016.

The meeting discussed the challenges of increased NEL and the work that was being done to prevent admissions, to analyse the existing data, and to look at risk sharing and providing a financial buffer within the BCF to protect social care, as it was noted that, although there was a significant impact on all parties of increased NEL, local authorities could not run deficit budgets.

Resolved -

(1) That the 2016/17 BCF submission be agreed in principle, subject to final revisions negotiated by officers;

(2) That the Director of Adult Care & Health Services be authorised to formally sign the agreement for the 2016/17 BCF submission, in line with the agreements in (1) above, in consultation with the Chair and members of the Board;

(3) That it be noted that the Chief Officer would sign off the agreement for the 2016/17 BCF submission on behalf of the CCGs.

11. DATES OF FUTURE MEETINGS

Resolved –

That the meetings of the Health & Wellbeing Board for 2016/17 be held at 2.00pm on the following dates:

- Friday 15 July 2016
- Friday 7 October 2016
- Friday 27 January 2017
- Friday 24 March 2017

(The meeting started at 2.00pm and closed at 4.55pm)

READING BOROUGH COUNCIL

REPORT BY CHIEF OFFICER, NHS BERKSHIRE WEST CCGs

TO:	**Reading Health and Wellbeing Board**		
DATE:	**15 July 2016**	**AGENDA ITEM:**	**4**
TITLE:	**NHS Berkshire West CCGs' Operating Plan 2016/17**		
LEAD COUNCILLOR:		**PORTFOLIO:**	
SERVICE:	**Health**	**WARDS:**	**All**
LEAD OFFICER:	**Cathy Winfield (NHS)**	**TEL:**	**0118 982 2732**
JOB TITLE:	**Chief Officer**	**E-MAIL:**	**cathywinfield@nhs.net**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This Operating Plan is being presented to the Health and Wellbeing Board for information, in order to provide additional detail to members on the CCGs' objectives and approach to the year ahead. The plan contributes to year one of our emerging Sustainability and Transformation Plan (STP), and builds on the Berkshire West CCGs strong track record of financial and non-financial performance.

The year ahead, however, reflects a dramatically increased set of challenges which include delivering higher levels of savings than ever before whilst also implementing the New Model of Care through the Accountable Care System. The size and scale of the challenge is reflected in our 'high' risk rating for delivery of a 1% surplus and over £17million savings. As contracts are not yet finalised the level of savings required may yet increase. The senior management team are currently establishing an in-house financial recovery process to mitigate the risk of failure to deliver a balanced financial plan.

The Berkshire West CCGs are collectively recognised as a high-performing and benchmark well nationally on a number of key performance measures, including non-elective admission rates and prescribing. For the last two full years, Berkshire West CCGs have been in the top 4% of CCGs for non-elective admission rates. We are also recognised across Thames Valley and nationally for leading the development of innovative approaches to improving clinical care and patient experience e.g. Diabetes Care, Stroke care, and Improving Access to Psychological Therapy services. Nevertheless, in line with other health and care systems we are facing increasing operational and financial challenges. Both elective and non-elective activity has increased significantly in recent months with significant spikes in emergency admissions. Our plan is focussed on addressing this pattern of activity in what can be a fragmented system experienced by patients, resulting in people being driven into treatment in hospital with higher and more costly levels of care than their needs determine. This fragmentation of care can impact on both the citizen's experience and outcomes, and is a poor use of public money.

Health and social care partners in Berkshire West are therefore committed to developing, testing and implementing innovative approaches to new ways of working and in delivering our shared vision for our system as a key foundation on which to build. By 2020/21, our vision is that enhanced primary, community and social care services in Berkshire West will have a developed service model which prevents ill-health within our local populations and supports people with much more complex needs to receive the

care they need in their community. People will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Care providers will share information, and use this to co-ordinate care in a way that is person centred, and reduces duplication and hand-offs between agencies. This vision is underpinned by the principle that people will only be admitted into hospital, nursing or residential homes when the services they require cannot be delivered elsewhere. All the services that respond to people with an urgent need for care will operate together as a single system, ensuring that people with urgent but not life-threatening conditions will receive responsive and effective care outside hospital.

1.2 The Operating Plan 2016/17 is attached at Appendix 1.

2. RECOMMENDED ACTION

2.1 Members are asked to note the content of the Berkshire West CCGs' Operating Plan for 2016/17 and consider how both NHS and Local Authority organisations can work together to deliver shared objectives.

Operational Plan 2016/17

Wokingham, Newbury and District, South Reading and North and West Reading Clinical Commissioning Groups

Table of Contents

1. Introduction

This document sets out Berkshire West CCGs high level Operational Plan for 2016/17. The plan forms year one of our emerging Sustainability and Transformation Plan (STP), and builds on the Berkshire West CCGs strong track record of financial and non-financial performance. The year ahead, however, reflects a dramatically increased set of challenges which include delivering higher levels of savings than ever before whilst also implementing the New Model of Care through the Accountable Care System. The size and scale of the challenge is reflected in our 'high' risk rating for delivery of a 1% surplus and over £17million savings. As contracts are not yet finalised the level of savings required

may yet increase. The senior management team are currently establishing an in-house financial recovery process to mitigate the risk of failure to deliver a balanced financial plan.

The Berkshire West CCGs are collectively recognised as a high-performing and benchmark well nationally on a number of key performance measures, including non-elective admission rates and prescribing. For the last two full years, Berkshire West CCGs have been in the top 4% of CCGs for non-elective admission rates. We are also recognised across Thames Valley and nationally for leading the development of innovative approaches to improving clinical care and patient experience e.g. Diabetes Care, Stroke care, and Improving Access to Psychological Therapy services.

Nevertheless, in line with other health and care systems we are facing increasing operational and financial challenges. Both elective and non-elective activity has increased significantly in recent months with significant spikes in emergency admissions. Our plan is focussed on addressing this pattern of activity in what can be a fragmented system experienced by patients, resulting in people being driven into treatment in hospital with higher and more costly levels of care than their needs determine. This fragmentation of care can impact on both the citizen's experience and outcomes, and is a poor use of public money**.** Health and social care partners in Berkshire West are therefore committed to developing, testing and implementing innovative approaches to new ways of working and in delivering our shared vision for our system as a key foundation on which to build.

By 2020/21, our vision is that enhanced primary, community and social care services in Berkshire West will have a developed service model which prevents ill-health within our local populations and supports people with much more complex needs to receive the care they need in their community. People will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Care providers will share information, and use this to co-ordinate care in a way that is person centred, and reduces duplication and hand-offs between agencies.

This vision is underpinned by the principle that people will only be admitted into hospital, nursing or residential homes when the services they require cannot be delivered elsewhere. All the services that respond to people with an urgent need for care will operate together as a single system, ensuring that people with urgent but not life-threatening conditions will receive responsive and effective care outside hospital.

This plan is supported by a suite of documents including our Financial Strategy, 16/17 Activity plans, Dementia Action plan, Cancer recovery plan, and the Systems resilience plan.

2. New Models of Care and Sustainability

2.1 Berkshire West Accountable Care System (ACS)

The Berkshire West system has been working together as the Berkshire West 10 (BW10) comprising 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) since 2013 within a shared governance structure. As BW10 we have recently prioritised joint work on a Frail Elderly Pathway which will report back in April 2016, with the findings and actions to be used to inform further pathway redesign and the exploration of new approaches to funding in the current Better Care Fund planning and health provider contracting round.

To meet our challenges and overcome the barriers to change in the current system, Berkshire West is proposing to establish a New Model of Care and to operate as an Accountable Care System (ACS). The ACS is a collective enterprise that will unite its members and bind them to the goals of the health system as a whole. In so doing we will hold ourselves collectively to account for delivering the necessary transformation of services and in getting the most out of each pound spent on the NHS within Berkshire West.

The key characteristics of our ACS:

- We will support our population to stay well through preventative care which considers the lives people lead, the services they use and the wider context in which they live
- We will improve patient experience and outcomes for our population through delivery of a Berkshire West Shared Strategy
- We will ensure optimal value from the 'Berks West £' by organising ourselves around the needs of our population across organisational boundaries, working collectively for the common good of the whole system
- Clinical decision-making and service developments will drive proactive management of care and provision of care in the most effective settings, underpinned by a payment system that moves resources to the optimal part of the system
- Deliver a financially sustainable plan; Finances will flow around the system in a controlled way that rewards providers appropriately and helps sustain financial balance by unlocking efficiencies in different parts of the system; incentives will be aligned and risks to individual organisations will be mitigated through the payment mechanism
- We will develop and use long term contracts to promote financial stability of the providers
- It will be governed by a unified leadership team comprising all commissioners and providers, with delegated powers from the constituent organisations.

The three Local Authorities in Berkshire West have given their support to health colleagues fast tracking the development of a new model of care which will enable further integration with social care over the medium term. The objectives of the ACS programme are aligned with the wider BW10 integration programme and support the delivery of Health and Well Being Strategies. The implementation of the Five Year Forward View requires the production of Sustainability and Transformation Plan (STP) and the development of an ACS for Berkshire West will be at the heart of the Thames Valley plan (see section 2.2) and will be the vehicle for delivering the service transformation locally that will lead to wider financial sustainability.

The key objectives of our ACS will be to:

1. Improve individual and population health, promoting primary and preventative care and reducing the requirement for more costly care. The ACS will require a strong public health and health promotion component to be effective in this area.
2. Improve people's experience of care by providing transformed, more integrated pathways of care with minimal hand offs between different parts of the system
3. Achieve financial balance at a system level through redesigned pathways and optimal models of delivery, supported by shared cost effective back office mechanisms, providing public confidence in the local NHS

In its first year the ACS will need to achieve two key deliverables: the production of a multiyear Berkshire West Shared Strategy and an underpinning system wide financial model which demonstrates how the transformation strategy will deliver financial sustainability.

The proposal is that social care could be included in the ACS in a subsequent phase of the programme and this has the support of all three Local authorities. This allows time for the three local authorities to pursue the development of a joint commissioning unit on the same Berkshire West footprint.

The ACS Programme will be managed against a clear documented project plan and a risk and issues log maintained. The programme management approach will be underpinned by partnership working and a communications and engagement plan to ensure all stakeholders are kept up to date.

2.2 Development of a Thames Valley Footprint STP

The CCGs, with colleagues from Buckinghamshire and Oxfordshire (BOB), are working together as requested by NHS England to scope an umbrella Sustainability and Transformation Plan (STP). The proposed footprint presents a number of risks, issues and opportunities which the respective Chief Officers and Chairs will consider over the coming weeks.

Organisations have finalised their submission to NHS E, setting out their analysis of current gaps across the domains of health and wellbeing, care and quality and finance and efficiency and identifying key priorities.

West Berkshire, Oxford and Buckinghamshire CCGs (BOB) remain committed to our main transformation programmes being at CCG or unit of planning levels, focussed on our key service providers of secondary, community, mental health and primary care as these cover the majority of demand from our local population's health needs. This has led to very different approaches across the wider STP footprint, including one devolution bid and one ACS model.

Whilst we clearly have very different approaches to our transformation programmes, we have identified key areas of our transformation that should be undertaken at BOB STP scale.

In summary, those are:

- The need to tackle lifestyle factors as the core business of all organisations, especially inactivity, obesity, alcohol, smoking and mental wellbeing across the life course. This will reduce disease and deaths across the board, but particularly CVD and cancers.
- The need to target all services at those most in need and differentiate the service offered accordingly so as to level up inequalities
- The need to coordinate all services around a 'better start in life' so as to reduce inequalities from the outset and reduce childhood obesity
- Tackling inefficiencies in patient experience of care to drive increased quality and productivity
- Urgent and emergency care – developing new integrated models of care
- Mental Health – to address as an emerging priority access to the full range and quality of mental health services, including specialist mental health
- Improving outcomes in cancer and maternity
- Supporting primary care, for example, developing 'at scale' provider entities
- Reducing variation in clinical practice and outcomes
- Focus on workforce challenges
- Safety improvement methodology

These have been mapped to the three identified gaps, for clarity and range from transformational work at scale (e.g. digital innovation and interoperability) through to areas where it makes sense to share learning to hasten wider implementation, such as primary care provider development.

BOB Alliance – Leadership Group

The BOB AOs and Chairs meet monthly and it is this meeting that will oversee the development of a robust STP. The roles, functions and membership will be kept under constant review as our plans are developed and then implemented. This group will ensure delivery of the key work-streams across the footprint.

3. Financial sustainability

3.1 Local context

The Berkshire West CCGs remain as some of the lowest funded commissioners in England on an allocation per person measure (£1,047 compared to a national average of £1,221), and remain underfunded when compared to their target allocations by approximately £20 a person (i.e. £10m in total). The target allocation of the Berkshire West CCG (if it existed) would be £1,067 per person, the second lowest in the South of England area.

Allocations and growth for 2016/17 are as follows:

	Newbury	N&WR	SR	Wok	BW CCGs total
Baseline 16/17 - £m	131.0	125.4	135.3	172.1	563.8
Primary care 16/17 - £m	14.0	13.7	18.2	18.1	64.0
Growth in above baseline - £m	3.8	5.6	7.2	5.0	21.6
% growth	3.05%	4.78%	5.75%	3.05%	4.07%

The key financial targets for the BW CCGs in 2016/17:

- Achievement of I&E surplus of 1%;
- Achievement of agreed QIPP plan;
- Commitment of only 99% of resource recurrently in 2016-2017, and for this budget to remain uncommitted at the planning stage.
- Contingency of 0.5% set aside.
- Commitment to an increase in funding for mental health in line with our percentage increase in allocation for 2016/17.
- Manage within our running cost allocation
- Payment to suppliers in line with the Better Payment Practice Code;
- Management within agreed cash limit; and
- Demonstrating value for money.

The four Berkshire West CCGs plan to comply with each of these requirements, recognising that this is a high risk plan and have begun an internal financial turnaround process. The size and scale of the financial challenge is greater than in previous years and may yet increase as contracts remain in negotiation. Added to this, previous financial positions have been achieved with the aid of reserves. In 2016/17 this flexibility will no longer be available.

3.2 Alignment with activity and growth assumptions

All trust contracts will as a starting point use estimated 2015/16 outturn as the starting point for 2016/17 contract negotiations.

The CCG has used the same activity assumptions for the finance and activity components of the plan. In 2016-2017, activity growth will be agreed with each provider based on local circumstances. Initial discussions with the main acute provider (RBFT) and on review of the Indicative Hospital Activity Model (IHAM), suggest that overall activity growth will be approximately 2% overall with some areas of emergency activity growing by up to 4%.

Assumptions have been applied on a Berkshire West basis to account for small number variations and to align to the way the CCG commissions services across Berkshire West. These assumptions still require further work and we continue to investigate further the non-recurrent elements of growth for elective care to enable us to reduce waiting

list backlogs, especially for cancer services. In addition, further testing of the growth assumptions is required for non-elective care with significant growth experienced compared to the prior year. The CCG has commissioned a specific piece of work to support this.

The CCGs have not modelled in the transformational QIPP changes into the activity models on the request of NHS England. However, QIPP has been applied in the financial plan which will require a reconciliation process between the two and a further reconciliation between activity and contracted activity levels on completion of contract negotiations. This matter has been highlighted to NHS England.

3.3 QIPP and Efficiency

It is recognised that the delivery of QIPP plans is a necessary lever to ensure real change to safeguard future financial stability and it is our intention to establish realistic and achievable levels of QIPP and efficiencies within the system. The QIPP gap has been identified for the CCGs for 2016/17, and amounts to £17m in total, which is 3% of allocation. Contracts are not yet finalised and may require additional savings to be identified.

In order to drive the achievement of QIPPs in 2016/17, a new Planning and Transformation team has been recruited (previously outsourced to the South Central and West CSU) and over the last 3 months the focus has been on developing new processes and governance structures which are now embedded across the organisation. In addition, an in-house financial turnaround process is being established. This includes revised documentation to introduce a focus on implementation and monitoring. The transformation team report to the relevant Operational Directors for each CCG and work is overseen through the new QIPP Operational Delivery Group and strategically through the CCGs QIPP & Finance Committee each month.

Schemes are being developed to meet the QIPP gap and these are shown in the table below. Other schemes are under development to close the financial gap, and currently the schemes yet to be identified amount to £2.1m.

Scheme name	Net saving £m
Frail Elderly	1.2
Care homes	1.2
Business rules	1.6
MSK	0.9
Placements	0.7
Meds management	0.7
Planned care	0.8
Better Care Fund	0.6
Ophthalmology provision	0.3
Referal variation	0.5
Urgent care	0.2
End of life	0.3
Respiratory	0.4
Other Long term conditions	0.6
CHC Review	1.0
Budget reviews	0.8
AQP review	0.2
Partnership Development Fund	0.7
Enhanced Services Review	1.3
Innovations in electives	0.2
Other schemes	0.6
	14.8

3.4 Parity of Esteem

Planning guidance set out the requirement for CCGs to invest further in mental health services to endure parity of esteem between mental and physical health services. Berkshire West CCGs have committed to investing in line with their increased allocation.

Any increased investment will be utilised in a number of organisations within the health economy including Berkshire Healthcare NHS FT, Royal Berkshire Hospital NHS FT, CCGs and Primary Care.

3.5 Moderating demand

Despite a number of initiatives and schemes being put in place during 2015/16 to reduce non-elective activity the system has seen unprecedented activity growth in non-elective activity. Although some of this can be explained by the introduction of a short stay Observation Unit at the RBFT this by no means explains growth of in excess of 10%. This activity has been in part paid for from the Performance Fund identified in the BCF and if not effectively managed and contained will increase financial unsustainability.

3.6 Improving health

The CCGs recognise the importance of prevention and health promotion in reducing the ultimate demand for healthcare. Effective, evidence-based prevention, addressing the lives people live, the services they access and the wider context in which they live will require co-ordinated action and the CCGs are working closely with Local Authority colleagues to ensure these services are delivered effectively across Berkshire West. This collaborative approach is exemplified by the Prevention Working Group, part of the BW10 Integration Programme, which will enable identification and sharing to develop best practice across the region and will support the development of health promoting health organisations.

3.7 Accountable Care System

The current profile of service provision in Berkshire West is not sustainable and this position will worsen unless action is taken to address the challenges set out above, promoting primary and preventative care.
In 2015/16 and 2016/17, our system is forecasting an overall deficit:

	2015/16 (deficit)/ surplus forecast (£m)	2015/16 (deficit)/ surplus as % of t/o	2016/17 (deficit) forecast (£m)
Royal Berkshire NHS FT	(9)	(2.40)	(11)
Berkshire Healthcare NHS FT	(2)	(0.85)	(8)
South Central Ambulance Service NHS FT	(4)	(2.10)	TBC
Berkshire West CCGs	5	0.90	(17) QIPP Gap
Total	**(10)**		**(36)**

NB This is prior to the control totals provided by NHSI to providers

The local health economy financial baseline shows that the size of the LHE financial challenge is set to grow significantly. Work undertaken across the health authority last year (currently being refreshed) shows the scale of the challenge by FY19.

	FY15	**FY16**	**FY17**	**FY18**	**FY19**
BHFT CIP cumulative total is **£41.5m**	£8.6m	£12.6m	£6.2m	£6.8m	£7.3m
BHFT CIP target as % of income	3.9	5.8	2.8	3.1	3.3
RBFT CIP cumulative total is **£77.9m**	£18.5m	£16.9m	£15.2m	£13.6m	£13.7m
RBFT CIP target as % of income	5.3	4.7	4.1	3.6	3.6
Commissioner cumulative net QIPP	£6.1m	£11.9m	£16.8m	£21.1m	**£24.8m**

(RBFT)					
Commissioner cumulative net QIPP (other)	£1.5m	£3.4m	£5.1m	£6.6m	**£8.0m**
Combined CIP and QIPP challenge (FY19)					**£152.2m**
Stranded costs at RBFT through alignment of plans					£4.3m
LHE challenge, assuming plans are aligned (FY19)					**£156.5m**

(Source: Berks West Clinical Strategy Programme LHE Financial Baseline, June 2014)

3.8 Primary Care

Berkshire West CCGs recognise that primary care will play a key role in the local ACS and as such have already invested £5m in primary care over the last two years in CESs to enhance extended hours provision (see above) and maximise the impact of care planning and ensure we provide proactive support to care homes. As we take on fully-delegated responsibility for commissioning primary medical services we will be working to ensure that the delegated budgets we receive are used to maximum effect to commission high quality care for our population. We are reinvesting PMS premium monies in a Quality CES which will be developed on an incremental basis over the next five years, reflecting the role that we need primary care to play in the delivery of our strategic objectives. We are exploring the affordability of commissioning such a CES in the CCGs which do not have PMS premium funding and have mirrored its requirements in our localised APMS contract offer which has been used for 3 procurements to date. This 'core contract plus' approach is described in our Berkshire West Primary Care Strategy and aims to ensure that all patients have access to a defined level of service and that incentives are aligned with the delivery of an expanded primary care offer by providers increasingly working at scale. The associated contractual arrangements will be reviewed as part of our response to the forthcoming national voluntary contract for GPs and our emerging local ACS financial model.

A priority for the delivery of our primary care strategy is ensuring investment in the premises schemes and technological developments. To deliver this we will work with NHS England through the PCTF bidding process and other capital allocation mechanisms. Other priority areas identified in our strategy include interoperability to enable integrated working between primary care and broader health and social care system and a number of key premises developments required to meet the needs of growing populations and accommodate larger providers offering an expanded range of services. Implementation planning to support the realisation of our strategy is currently taking place within the CCG and with our partners and wider stakeholders.

3.9 Better Care Fund (BCF)

Over £25m has been invested from health monies into the pooled budgets creating the Better Care Funds of the 3 Local Authorities, £15m of which was new investment in 2015/16. Section 75 agreements have been put in place for the management of the overall pooled budgets of £27m.

The CCGs have worked with local authority partners to agree their plans for the coming year. Local areas are expected to maintain the progress made around 2015-16 BCF metrics including admissions to residential and care homes, patient experience, effectiveness of reablement and delayed transfers of care. The final plans will be included in our planning submission on 21st March and in the final plans which will be submitted on 25th April. Approval of the final BCF plans will be via the individual Health and Wellbeing Boards.

Examples of achievements in 15/16 include:

- Working through the BCF Wokingham has supported the recruitment and training of 12 volunteer navigators to support patients to access the right services and reduce demand on GP appointments, by delivering social prescriptions and guiding patients to voluntary organisations who can support their needs

- In Reading the CCG have funded a Full Intake Model which aims to increase community reablement team capacity offering admission avoidance, reablement and support to the "discharge to assess bed base". The "Discharge to Assess" service has been expanded to 12 beds including for older people with mental health conditions such as dementia
- In West Berkshire the Joint Care Provider Project (incorporating seven day working and direct commissioning by specified health staff) has led to a more cohesive service which will reduce duplication, improve access and increase capacity.

4. Primary Care

As CCGs we were quick to recognise that a strong and effective primary care sector is a critical aspect of an effective and high performing out-of-hospital health care system. As set out above, we have invested £5m in primary care over the last two years and over the last 18 months have engaged the public, partners and member practices in the development of a detailed Primary Care Strategy. The resulting Berkshire West Primary Care Strategy clearly defines the following objectives for primary care:

- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
- Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.
- Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.
- Making effective referrals to other services when patients will most benefit.

The implementation of our Primary Care Strategy is overseen by our Primary Care Commissioning Committee which includes representatives of all four CCGs. A quarterly programme report incorporates progress on both Berkshire-West wide work streams and projects undertaken within individual CCGs. In this way, learning from local projects can be shared across the four CCGs and synergies and further opportunities for joint working can be identified. Similarly, we can engage existing providers at a local level whilst also maximising opportunities to deliver change across Berkshire West.

4.1 Sustainability and quality

The *Berkshire West Primary Care Strategy* recognises that the primary care sector needs to change to deliver these 'asks' and to respond to the challenges of increasing demand and workforce constraints. In 2015-16 we undertook a risk mapping exercise which considered the potential vulnerability of practices based on a range of metrics including CQC visit outcomes, staffing issues, the standard of practice premises and financial status. We are now developing this further into a Quality Dashboard which will allow improved comparison with local peers and national figures, thereby enabling a more detailed assessment of variation and inequalities. We have also reviewed the findings of the six-facet premises survey undertaken by NHS England. Taken together, this information gives us a clear understanding of the current state primary care locally and the 'gap' between this the vision for the sector as described in our primary care strategy.

Primary care in Berkshire West generally performs well against key quality markers and none of our practices are outliers on 6 or more high level indicators on GPOS. We have a range of premises from new, purpose-built facilities to smaller surgeries requiring modernisation. With the exception of the Reading Walk-in Centre which is run by Virgin Care, the majority of our providers are traditional GP partnerships. South Reading CCG's practices are generally smaller than those in the other CCGs. The *Berkshire West Primary Care Strategy* sets out the challenges

that are increasingly being faced by larger and smaller practices alike, particularly with regard to workforce and growing demand and the case for change in the sector.

We are using our risk assessment to support a dialogue with practices around options for future sustainability and in considering priorities for Primary Care Transformation Fund bids and other potential sources of investment. We are working particularly closely with a small number of practices identified as being particularly vulnerable at this time. These include practices rated as 'inadequate' by the CQC. We are supporting these practices to make the necessary improvements and are putting place contingency arrangements where required.
Over the coming year we will build upon this approach and use the Quality Dashboard to work with GP Councils to review variations in outcomes and share best practice, as well as following up any ongoing quality concerns identified. In addition to summary information from the national Primary Care Web Tool, the Quality Dashboard will incorporate a range of local indicators reflecting population need and CCG priorities which GPs can influence such as additional diabetes indicators, A&E attendance rates, non-elective admissions for ambulatory care sensitive conditions, utilisation of our DXS system, flu immunisation and prescribing indicators. It will also enable a focus on improving patient experience by incorporating data from the National Patient Survey and Friends and Family Test.

Further detail on our approach to improving quality in primary care is set out in the Quality section, below. In addition to the above four objectives, the *Berkshire West Primary Care Strategy* includes an enabling objective of addressing current pressures and creating a sustainable primary care sector. During 2016-17 we will be concentrating on this objective through the following work streams which constitute our local plan for addressing sustainability and quality in general practice.

Primary care at-scale

We are working with existing providers to explore new models of care and opportunities to work at scale, moving towards the anticipated future state described in our strategy where care will be provided by larger providers covering 10,000 or more patients, and potentially many more, using workforce models which look very different from those currently in place in most practices. We are also already using commissioning levers to underpin this upscaling, for example by commissioning CESs in such a way as to incentivise practices to provide them collaboratively. We believe that primary care operating at scale will be well-placed to take on the crucial role we envisage for it within the ACS model described above and therefore that by supporting the emergence of larger providers we can ensure that the potential of primary care to contribute to broader system sustainability is maximised. We anticipate a mixed economy with many existing practices merging or federating to form larger provider organisations and commercial providers continuing to run some contracts.

The *Berkshire West Primary Care Strategy* sets out this overall direction of travel which all four CCGs have endorsed, however its successful implementation will be reliant on the emergence of coherent local visions for primary care at an individual CCG level. The provider landscape is likely to vary somewhat across the CCGs given the different starting point of each. In South Reading CCG (where there are a large number of smaller practices) our vision for the future of primary care is that we will see a smaller number of providers, working in merged or federated arrangements likely to include hub and spoke models. We envisage that each of these will serve a population of 25,000 - 30,000 patients. Two such provider units are already emerging. We intend to use a proportion of released PMS premium funding, together with NHSE's vulnerable practice funding to progress this work. Wokingham CCG are supporting existing practices to explore opportunities to work together to create efficiencies and achieve sustainability. The Wokingham neighbourhood cluster model has created three clusters of practices, each serving a population of 40,000 - 60,000 patients, and practices within these clusters are now considering shared posts, pooled back office functions and a joint approach to meeting on-the-day demand. In North West Reading CCG it is our intention that current procurement exercises will stabilise two practices where there has been a turnover of providers; putting in place contracts that closely reflect our broader primary care strategy. Both Newbury and District and North and West Reading CCGs are also exploring opportunities for practices to work together to address current pressures particularly around workforce, and Newbury and District CCG are already training a new role called a GP administrative assistant intended to free up GP time as well as piloting clinical pharmacists in GP practices. In these CCGs it is anticipated that any changes to organisational form will evolve from successful collaboration on these key areas.

Workforce

We are currently developing a detailed programme of work to respond to primary care workforce issues, led by a working group reporting to the Primary Care Commissioning Committee. This will consider workforce planning, recruitment and retention of GPs and other staff, innovative approaches to training and CPD and workforce diversification, including scoping the opportunities for expanding the range of professionals offering primary care services. These might include pharmacists, a specialist GP role for care home patients, and extending the roles of health care assistants and practice nurses supported by appropriate accredited training and development programmes. As part of this we are exploring the potential to collaborate with Health Education England Thames Valley to develop a primary care training hub in Berkshire West. This will ensure we link effectively with 10 point plan for GP recruitment and retention. We will also give further consideration to how we can maximise the impact of retainer placements. We have also worked with the University of Reading, BHFT and RBFT to establish a local training programme for Physicians' Associates. A number of our practices are now hosting training placements and the first cohort of students will graduate next year. We envisage very different workforce models being in place in primary care in future, with a much more varied team working across practices, thereby underpinning the upscaling of provision described above. GPs will increasingly co-ordinate a multidisciplinary team incorporating a range of professionals, with their own attention focussed more strongly on the most complex patients. To achieve this we anticipate changes in the way that 'on the day' demand is managed, as described below.

Managing Demand

We recognise the need to develop a more robust approach to managing demand in primary care and therefore are creating a joint work stream between the Primary Care Commissioning Committee and the Innovation Technology and Information Systems Programme Board with the purpose of scoping and developing a work plan which aims to address this challenge in Berkshire West. This will include:

- Exploring how we utilise IT to maximum effect to give patients the opportunity to access primary care in new ways thereby enabling practices to better manage demand
- Exploring opportunities for greater self-management by patients, including automating elements of QOF as well as for joint working on urgent access.
- Maximising opportunities around self-care of self-limiting illness, including through the use of symptom-checker and GP triage apps.
- Considering the role of primary care as part of the broader urgent care system including piloting direct booking of GP appointments by NHS 111, developing urgent care metrics for primary care which will form part of the Alamac kitbag (see below), ensuring there is adequate on-the-day paediatric appointment capacity and that home visits are undertaken as early in the day as possible.
- Maximising the role of community pharmacy in treating minor ailments and supporting the management of 'on the day' demand.
- Exploring the potential for collaborative approaches to managing on-the-day demand and home visits, freeing up time to concentrate on providing proactive care for the most complex patients. This is a key element of the discussions around primary care at-scale.
- Benchmarking in-hours capacity and reviewing variation. Reviewing the impact of system resilience appointments in primary care and agreeing future commissioning arrangements.
- Reviewing the role of the Reading Walk-in Centre in preparation for re-procurement of the contract in 2017.

Premises

We are working to further develop the primary care component of our Estates Strategy which will underpin delivery of the models of care described above. As set out in the finance section above, our priorities for primary care premises investment reflect the need to respond to significant projected population growth, particularly in Wokingham CCG, and to ensure our 'up-scaled' providers work from modern, fit-for-purpose premises which support the delivery of an extended range of services in primary care. Our Primary Care Transformation Fund (PCTF bids) will reflect these priorities, focussing on a small number of larger schemes we expect to be required over the next 2-3 years. We will also be working closely with local authorities to maximise the benefit of CIL and S106

contributions, particularly in Wokingham where there is expected to be significant housing growth over the next five years.IT infrastructure

The *Berkshire West Primary Care Strategy* sets out the importance of interoperable IT systems as the foundation upon which we will build a modern, efficient and responsive primary care sector, enabling practices to work more closely together and with other services and to interact in new ways with patients through the new approaches to managing demand set out above. Section 13 of this document describes our Digital Roadmap as well as initiatives already underway in primary care to open up new ways for patients to access their practices, to support self-care and to ensure we make best use of existing tools such as online access, e-referrals and EPS.

4.2 Seven day working in primary care

Patients with urgent needs can already access primary care in the evenings and weekends through the Westcall Out of Hours (OOH) service. The Reading walk in centre is also open from 8am-8pm, seven days a week. In addition, the CCGs have jointly commissioned an Enhanced Access CES as an alternative to the Extended Hours DES. This has resulted in 1,321 additional routine bookable appointments per week on Saturday mornings and outside of core hours on weekdays (i.e. late evenings or early mornings), covering over 80% of the CCG's population. Some practices are working together to provide these sessions, however the majority are provided by patients' own practices. However, due to workforce constraints in primary care as described previously, as we work to improve coverage and expand availability to all day Saturday and Sundays, we envisage that practices will increasingly need to work together through 'hub' arrangements and alternative provider models.

4.3 Other key work-streams

The remaining three strategic objectives in the *Berkshire West Primary Care Strategy* relate to the role of primary care in preventing ill-health, delivering out-of-hospital care for patients with increasingly complex long-term conditions, co-ordinating integrated care for those who may be at-risk of admission and ensuring patients are referred to other services in accordance with best practice. The above work-streams around sustainability and access will ensure that primary care is able to play its part in the delivery of the CCGs' aspirations for patients in each of these areas which are described in more detail in the following sections of this document.

- Section 5 – Prevention
- Section 9 – Hospital Care
- Section 10 – Out of Hospital Care
- Section 11 – Mental Health

As set out above we are currently considering how we can expand extended access provision beyond current commissioned levels and will review premises and technological implications as part of this. As set out in our submission, our Connected Care procurement includes a patient portal which will underpin delivery of self-management and triage approaches. As we pilot NHS 111 direct booking and collaborative working around 7-day routine provision and meeting urgent care demand we will be considering the role of technology within this, including ensuring we maximise the benefit of online access, self-management and remote triage.

5. Prevention

Strong public health and health promotion are core components to delivering an effective ACS. We will place greater emphasis on prevention and putting patients in control of their own health; we will use the individual CCG Public Health profiles (see supporting documents) to inform local priorities in addressing health inequalities. These profiles show that life expectancy for both men and women are significantly better than the national average within 3 of the

4 Berkshire West CCGs. In contrast, South Reading CCG's life expectancy is significantly worse than the national average (2 years less for men, 1.2 years less for women).

Potential Years of Life Lost (PYLL) is an indicator of premature mortality and shows the number of years not lived by an individual from birth to 75. Both Newbury & District CCG and Wokingham CCG's rates were significantly better than the national level and the two Reading CCGs had similar rates. All of the Berkshire West CCGs had similar or better rates of PYLL to their respective CCG comparator groups. The main cause across all of Berkshire West CCGs was neoplasms, with ischaemic heart disease as the second main cause.

The BW10 Prevention Working Group will develop a comprehensive plan for prevention to support the sustainability of the Berkshire West Health and Social Care system. We will continue to promote healthy lifestyles and target the leading risk factors for ill-health in partnership with Public Health to decrease numbers of smokers and decrease levels of alcohol consumption, increase levels of physical activity, detect people with high blood pressure and cholesterol, and reduce obesity in children and adults by increasing the uptake of the NHS Health Check Programme and referring into local services e.g. Eat 4 Health. Local practices have been tasked with increasing referrals by 25% and are on track to deliver this target with 67 referrals in Q1, health walks, recording alcohol consumption and supporting a reducing alcohol intake through brief interventions and signposting.

Health promoting schemes that we have funded in 15/16 and will continue to fund during 16/17 include the Eat4Health and 'Beat the Streets' programmes. This year 23,992 people took part in Beat the Streets (including 12% of patients with LTCs) and walked 306,599 miles. This is a 63% increase in participants from when the project was first piloted in 2014. At the beginning of the project 40% of people reported meeting the Department of Health's guidelines for levels of activity (30 minutes of physical activity for five or more days per week). By the end of the project, this had increased to 48%. 78% of participants said they would try to continue the changes they had made. In 2015/16 North & West Reading CCG commissioned Age UK to deliver a 'Living Well' pilot which provides upstream interventions for older people not requiring medical or nursing care to support improvements in wellbeing and reduce avoidable GP appointments, A&E attendances and 999 contacts. Results from the first 2 quarters of the pilot show that wellbeing has improved by 28% and that there has been a 30% reduction in GP appointments, 50% reduction in A&E attendances and 50% less 999 contacts.

5.1 Obesity and being overweight

Berkshire West CCGs have a recorded obesity prevalence rate of 7.0% in the registered population aged 16 and over, which is approximately 29,472 people. This prevalence rate varies between the CCGs, from 6.6% in Wokingham CCG to 7.4% in North & West Reading CCG. However, these are all lower than their respective comparator groups and the national prevalence rare of 9.0%.

Adults with a Body Mass Index over 25 are defined as being overweight. Figures collected through the Active People Survey (2012-2014) estimate that 64.6% of adults living in England are overweight or obese. All of the Berkshire West LAs have a lower level of adults with excess weight and Reading's is significantly lower at 61%.

Key objectives across Reading's Healthy Weight Strategy will be to ensure that people in Berkshire know how to achieve and maintain a healthy weight, are able to choose a healthy diet and can become more physically active in everyday life. A focus will be given within the strategy to evidence based interventions and recommendations for the prevention and management of childhood obesity across the CCG area, including schemes to improve facilities for cycling and walking; encouraging active play, minimising sedentary behaviour and the provision of healthy catering in early year's settings and appropriate referral to and endorsement of weight management, physical activity and healthy eating programmes.

We will commission during 2016/17 a Tier 3 weight management intervention service in line with the NICE guidance (CG 189, 2014). Tier 3 services form an important part of the weight management pathway and provide a more specialist intervention delivered by a multidisciplinary team with the aim of reducing mortality rates and levels of co-

morbidity associated with clinical obesity. The objective is to commission an effective and accessible weight management intervention service for patients (with or without co-morbidities) who have already been through an appropriate Tier 1 and Tier 2 weight loss service including nutrition and physical activity advice and psychological approaches to behaviour change.

In addition to obesity services those at risk of developing diabetes will be referred and managed under the National Diabetes Prevention Programme and working with Public Health we will be promoting a cross Berkshire digital campaign which builds on the successful Change for Life programme.

The prevalence of obesity in children as measured though the National Child Measurement Programme (2014/15) show that the prevalence of obesity in Reading is similar to the national average for both ages four to five and ten to eleven, while Wokingham and West Berkshire's are significantly better. The Reading CCGs have committed to working in partnership with the Public Health team to deliver the Beat the Street competition for the third year running, and to explore wider opportunities to collaborate with Primary Care, Maternity services, Health Visiting, School Nurses and Schools to address this issue. We have re-procured programmes to support children who are overweight (Let's Get Going) and within West Berkshire we are piloting an active schools programme from 0-19 years to increase levels of activity. In addition working with Public Health we will review the awaited children strategy and develop an action plan based upon this.

5.2 Alcohol

In 2013/14, there were over 333,000 alcohol-related hospital admissions in England, which equates to 645 admissions per 100,000 population. Three of Berkshire West's CCGs had significantly better rates of admission than the national figure, ranging from 366 in Wokingham CCG to 493 in Newbury & District CCG. South Reading CCG's admission rate was similar to England's at 597 per 100,000 population.

In 2016/17, we will be commissioning a new Alcohol Specialist Nursing Service for people who present and/or are admitted to hospital for alcohol related harm. This will support better management of patients presenting at the ED department at the RBFT with alcohol related problems by ensuring that there are clear pathways into both primary care and specialist drug and alcohol services, and provide a rapid response assessment and triage to avoid delayed discharges and avoidable hospital admission. The service will link with the appropriate community services for on-going community treatment and support to reduce re-attendances at ED. The service will also provide education and training to acute and Primary Care clinicians to enable better manage patients with chronic and acute alcohol problems.

In addition, we will be taking part in the Public Health England led improvement programme reviewing the current pattern of services against best practice.

5.3 Cholesterol and Blood Pressure

The national NHS Health Check Programme aims to prevent vascular disease, by inviting eligible people to an assessment of risk of developing a vascular condition. They are then given advice and support to help them manage or reduce any risks identified. GP Practices are the main providers of Health Checks nationally and all of the West of Berkshire LAs have Primary Care Contracts in place with their CCGs to provide this service.

Berkshire West CCG GP Practices completed 22,736 Health Checks from 1st April 2013 to 31st Dec 2015, which equated to 15% of the eligible registered population. The uptake in England over this time was 25%. The local uptake is lower than the national figure and also lower than the apportioned target for this time period (27.5%) and PHE ambition (37%). Working with Public Health we will continue to focus on health checks, including determining alternative ways and venues to find people with high blood pressure in the community.

5.4 Tobacco

In 2014 the national smoking prevalence rate for adults was 18.0%. Reading's rate was similar at 17%, while Wokingham and West Berkshire's were significantly better at 9.8% and 15.5% respectively. If we compare this to local smoking prevalence rates from 2010, this would suggest that there are now over 14,000 less smokers in Berkshire West than there were 5 years ago.

Stop Smoking Services operate to offer support to those people finding it difficult to quit. The service in Berkshire 'Smoke Free life Berkshire' is provided by Solutions 4 Health Ltd and jointly commissioned by all 6 Berkshire local authorities. The Stop Smoking Service and Public Health teams have worked closely with Berkshire Healthcare Foundation Trust to address smoking in certain priority groups. This includes people with mental health conditions among whom smoking rates are very high and quit smoking success rates are traditionally poor. The stop smoking service offer quit support on site at mental healthcare settings as well as work with BHFT to promote the service to people with mental health conditions resident in the community.

5.5 Screening and Immunisation

In a concentrated effort to address the inequalities in immunisation uptake in the 0-5 year cohorts in Berkshire, two Childhood Health Inequalities Nurses have been recruited to work within BHFT on a pilot project (Feb 2016 to April 2017). They will be working with child health records department, primary care, health visitors, local authorities, children's centres and other stakeholder agencies to improve timely childhood immunisation uptake in areas with historically low coverage, follow-up children with delayed or missing immunisation and facilitate access to immunisation services and target hard-to reach families.

Concerted effort is being made to maximise uptake of bowel cancer screening and reduce local variations in uptake. This includes Cancer Research UK's media campaign and screening enhancement kits and North and West Reading CCG quality premium initiative.

6. Improving quality of care through better outcomes and experience

Ensuring the quality of patient care provided by our commissioned services continues to be a primary focus in 2016/17. We have made significant progress in addressing key quality priorities to date, including reducing patient harm, such as a significant reduction in grade three and four pressure, reducing incidents of infection and reducing falls causing serious harm. The monitoring of quality performance is underpinned by robust governance processes, which include benchmarking our providers' performance with other Trusts across Thames Valley and holding them to account using tools such as Quality visits, clinical audits, and improvement plans to ensure improvements are made when standards fall below what is expected.

The contractual quality schedules set out our expectations for quality in 2016/17. These are based upon year to date performance in 2015/16, triangulated with feedback from our patients/ users and GPs gathered and reviewed through our Quality Committee, findings from the regulator and local intelligence.

The CCGs will continue to work with RBFT to monitor 104 day waits on the 62 day pathway with the expectation to move towards zero waits in this area in 2016/17. There is a clinical harm review process for all patients with a confirmed cancer diagnosis who have waited longer than 104 days. The CCGs will monitor the outcome of these in 2016/17. In addition, the CCGs will continue to monitor serious incidents that are a result of a failure to meet cancer targets and ensure learning is effectively captured and embedded.

In 2016/17 the CCGs will continue to monitor progress being made by our providers following recent CQC inspections, ensuring action plans are established to address any areas requiring improvement. The CCGs will continue with its programme of Quality Observational visits to our providers across 2016/17, gaining direct feedback from staff and patients and their families on the care they are receiving.

6.1 Primary Care

In 2016/17 the CCGs will continue to improve the quality of primary care provided across all of our practices. The CCGs have developed a quality dashboard for primary care to monitor performance and support continuous

improvement in quality against key quality indicators, which will be monitored through the Quality Committee and at CCG Council Meetings to support improvement. The dashboard will form part of a broader Primary Care Quality Report which will also incorporate information on complaints, significant events, safeguarding incidents and other information relating to managing the quality of services provided. In addition, the CCGs will continue to work with NHS England in supporting those practices in our area as rated by the CQC as requiring improvement, ensuring any decisions made are in line with our Primary Care Strategy and produce the best outcome for delivering the highest quality of care for our patients.

6.2 7 day services

The Berkshire West CCGs have made significant progress on achieving 7 day services access across a range of primary, community and acute services in line with the 10 clinical standards. This is underpinned and driven through several different work programmes including the delivery of the Systems Resilience High Impact Actions, the development of an integrated community care model supported through the BCF and in line with the BCF national conditions, and the development of relevant CQUINs and Service Development Improvement plans (SDIP) in both Provider contracts for 15/16.

In addition to investments made via the BCF, through systems resilience and into MH services all of which directly support 7 day access we have invested in an Enhanced Access CES for Primary Care, as described above in section 4.

Access to our community services is facilitated 24/7 via a Health Hub which is used by all discharging Acute Trusts as the single phone number for any health or social care referral. In 15/16 we agreed a service development improvement plan (SDIP) with the RBFT which covered standards 2, 5, 6, 7 and 9. RBFT is reporting compliance with standard 2 (Time to first consultant review), standards 5/6 partially compliant and the Trust have completed and agreed with commissioners a Quality impact assessment associated with this position in year. The Trust has met their agreed actions on standards 7 and 9.

We are in the process of finalising the requirements for Q4 15/16 and have already commenced as part of the contract build the development of the 16/17 SDIP to include standard 8 as well as 2, 5 and 6 which are the national priorities for the coming year. The Trust will be completing the self-assessment tool on 7 days as required by the end of April and we will use the results of this to support continued dialogue with the Trust on full achievement of all 10 standards.

BHFT also had an SDIP which covered the respective elements of standard 7(MH on acute admission, PMS) and 9 (transfer to Community, Primary and Social Care). BHFT have provided performance data for Q3 and our intention is also to use this to inform our 16/17 BCF planning.

The 10 Clinical Commissioning Groups in the Thames Valley are currently collaborating on the procurement of an Integrated NHS 111 urgent care service with the aim of delivering the Keogh vision

"If I have an urgent need, I can phone a single number (111) and they will, if necessary, arrange for me to see or speak to a GP or other appropriate health professional – any hour of the day and any day of the week"

The Urgent Care Service will offer patients immediate access to a wide range of clinicians, both experienced generalists and specialists. The model will also offer advice to health professionals in our local communities, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. Within Thames Valley this new integrated service will have access to a range of dispositions including, but not limited to, red and green ambulances dispositions and 24/7 primary care, and clinicians will be supported by the availability of clinical records through IT system interoperability which will support robust clinical decision making and the direct booking of appointments into other services. A key deliverable of the service is a contribution to the delivery of robust resilient urgent care services 7 days a week and the Providers planned approach to supporting resilience will be tested as part of the Invitation to Tender process.

6.3. Avoidable deaths

The CCGs have a robust Serious Incident process with monthly meetings to scrutinise investigation reports into any incident which has resulted in serious harm or death of a patient. The CCGs will continue to ensure that any lessons learnt from these investigations are fully embedded and will challenge robustly if there are any recurring themes, taking action as necessary if care falls below the quality standards we expect.

The CCGs will continue to encourage an open culture of reporting, which has seen a significant increase in reporting across all our providers in the past two years.

6.4 Sepsis

The CCGs acknowledge the risks associated with failure to diagnose and treat sepsis early to reduce mortality. In 2015/16 the CCGs supported a 'Sepsis Improvement Project' delivered by the Berkshire West GP Out of Hours provider WestCall. This project has involved the introduction of a screening and treatment toolkit to support GPs to diagnose potential sepsis and initiate treatment with appropriate antibiotic immediately. The CCGs plan to roll work with providers to expand this project into primary care and the ambulance service in 2016/17 and are exploring how best to do this, in collaboration with the Academic Health Science Network (AHSN). The CCGs plan to either continue the Sepsis CQUIN for a second year with our acute trust (depending on national CQUIN guidance), or transfer the requirements for screening and treatment within 1 hour to the Trusts quality schedule to ensure practice is embedded as business as usual.

6.5 Maternity

The CCGs Maternity Steering Group includes membership from all key partners including the MSLC. In 2016/17, we will continue to focus on supporting maternal choice through increasing the percentage of midwifery led deliveries, increasing the number of home births supported and reducing the need for RBFT to divert women in labour. The CCGs have several key performance indicators for maternity in the RBFT quality schedule and in addition monitor a comprehensive Trust maternity dashboard at quarterly Maternity Steering Group meetings, escalating any concerns through to the Berkshire West Quality Committee to agree any action required.

Following the recent publication of the National Maternity Review, a review will be undertaken, led by our CCG Maternity lead and the Maternity Steering Group to ensure its recommendations are implemented.

6.6 Medicines Management

The CCGs recognise that medicines form a significant part in addressing quality of care in terms of better patient experience, improving health outcomes and reducing patient harm. Optimising the use of medicines aims to ensure that the right drug is received in the right dose in the right place; that the most cost effective choices are made in line with national and local guidance; and that only those medicines that continue to benefit a patient are continued.

Work streams carried out by the CCG Medicines Optimisation Team to support these overarching aims include:

- A GP prescribing Quality scheme which has prescribing targets for practices to achieve.
- A prescribing support dietitian who reviews patients on gluten free foods, oral nutritional supplements and baby milks.

Both schemes above are delivering successfully with over £880k of efficiency savings delivered up to January 2016.

6.7 Antimicrobial stewardship

As part of the Primary Care Prescribing Quality Scheme (PQS) 2015-16, practices were asked to achieve three targets. Two of the targets were based on the national quality premium targets for CCGs which are to have an overall reduction in items (to date 37 of the 52 practices are now meeting this target) and also a reduction of specific broad spectrum antibacterials (to date 50 of the practices are now meeting this target). The last target requires practices to undertake an audit of all patients being prescribed an antibacterial for sore throat. Early results suggest there has been a reduction; however the data is in the process of being reviewed. It is expected that for 16/17, all of these targets will be in the PQS.

We are working with the local health economy to set up an Antimicrobial stewardship (AMS) group which will be looking all aspects of AMS, including having a joint strategy than spans primary, secondary and community care.

In addition, ambitions for reducing prescribing rates in secondary care will be added into the Provider contract in line with the expected Quality Premium.

6.8 CQUINS

We expect to reflect national guidance on CQUINs in our contract for 2016/17 and as we have done in previous years, securing mutually acceptable but challenging agreement around CQUIN that reflects national and local clinical commissioning priorities.

The CCGs have worked with our providers to agree a smaller number of local CQUINs schemes for 2016/17, providing a greater incentive and more intelligently focused on local health needs. The proposed CQUIN schemes are likely to include areas such as End of Life Care, 7 day working focused on weekend discharges, reducing contacts from high care homes users, and suicide prevention

6.9 Safeguarding

The CCGs will continue to be active members of three Local Safeguarding Children Boards (LSCB) and the Berkshire West Safeguarding Adult Partnership Board (SAPB) and will ensure our providers are fully engaged in delivering the safeguarding priorities of these boards. We will commit to improving safeguarding quality, by sustaining the improvement in compliance of delivering LAC Health Assessments within 20 days and continuing to improve GP report submission to child protection case conferences.

All contracts and SLAs require providers to adhere to the Berkshire-wide safeguarding policies. Contracts also require all providers to complete an annual section 11 audit (adapted to include safeguarding adults), and to provide assurance of compliance staff training levels, and continuing professional development covering topics such as their roles and responsibilities in regards to safeguarding children, adults at risk, Children Looked After, the Mental Capacity Act and Deprivation of Liberty Safeguards. Providers are required to inform commissioners of all incidents involving children and adults, including death or harm whilst in their care.

Our quality assurance reporting framework will monitor progress and contract compliance on the DH and Home Office Prevent strategy against NHS standard contract for all our providers. We will ensure quarterly reporting on training compliance and prevent referrals is submitted to our prevent lead. This training is in accordance with the NHS England prevent and training competencies Framework and as a CCG we have encouraged the use of both Home Office e-learning training and health wrap supported by the regional prevent co-ordinators forum. This is in accordance with the CCGs current status as a non-priority area.

6.10 Carers

The CCGs lead a Joint Health and Social Care Carers Commissioning forum which has been instrumental in the procurement of an Advice and Information service which is due to start on 1st April 2016. This forum is leading the development of a Joint Berkshire West Health and Social Care Commissioning Strategy.

We recognise the importance of Carers and the pressures that are often associated with those in a caring role. We have therefore continued our focus on identifying and supporting carers by ensuring that at least 90% of those registered with participating GP practices identified as carers are pro-actively contacted by way of phone or mail and given key information to help them including advice on NHS health checks, benefits, information on respite care and voluntary organisations providing specialist advice and services. We are also encouraging the role out of the use of 'carer champions' in some practices. In addition to expanding the role of Primary Care, the CCGs are also in the process of commissioning Carers Health and Wellbeing reviews with collaborative funding from Public Health West Berkshire. This will involve commissioning Carers Health and Wellbeing reviews being offered through Community Pharmacies, and active signposting by the voluntary sector and other health care professionals. The proposal is to pilot this service from April 2016 with evaluation by Reading University.

We have also engaged our main providers BHFT and the RBFT to ensure that their services are carer friendly.

7. Urgent and Emergency Care

7.1 Performance

The CCGs Urgent Care Programme Board will work to deliver a programme of improvements based upon the best practice as set out within the recently published NHSE 'Safer, Faster, Better' document and will take an oversight and scrutiny role in relation to performance; holding individual organisations to account for the role they have to play in an effective Urgent and Emergency Care system.

Reports generated from the Alamac kitbag support the Urgent Care Board to understand the drivers and constraints affecting A&E 4 hour performance. The CCGs have recently refreshed the measures collected in the kitbag and are working with Alamac to set what 'good looks like' so that from these standards automated alerts can be sent out to partners to prompt timely escalation.

In 2015/16 SCAS has been challenged in delivering the ambulance response time standards for the Thames Valley contract. All three of the national standards are at risk of being achieved on an annual basis for the year. During 2015/16, the CCGs served a contract performance notice for this performance and following this a remedial action plan was agreed. This action plan included a trajectory for recovering the standards, all of which should be achieved for the month of March and onwards during 2016/17. This remedial action plan is not on track and performance is not expected to achieve in March as set out in the recovery plan. The Trust had completed actions as per the remedial action plan; however two factors resulted in the failure to deliver in March:

- Unprecedented level of demand in the last quarter of 2015/16
- Continued workforce issues

  Performance will be challenged during 2016/17 due to the ongoing financial and resource pressures for the ambulance Trust. The contract negotiations are therefore key to ensuring sustainability of performance and achievement in 2016/17. The CCG is in the final stages of negotiating its contracts. Until contract negotiation is concluded the Trust will not confirm a trajectory and therefore CCG plans would potentially require further revision once contacts are finalised in order to ensure a consistent position.

In 2016/17 the Board work programme will be based on the best practice contained within 'Safer, Faster, and Better'.

In addition the Board will continue to focus on a number of general themes along the patient pathway including:

- Increased use of community alternatives pre-admission supporting higher non-conveyance rates for the ambulance service and more rapid response (admission avoidance) in the community
- Ambulatory care as the default pathway in the acute and a greater proportion of patients staying for 2 midnights or less through a relentless focus on straightforward discharges
- Discharge planning for patients in likely need of onward care starting at the point of admission with a fully integrated pathway for discharge reducing duplication/hand offs and delays
- A pull model operating at the back door at the hospital drawing patients out into the community, operating on the principles of Discharge to Assess and Trusted Assessment, moving patients out swiftly, maximising their rehab potential and reducing their long term dependence on care
- Smoothing of patient flow across the days of the week and hours of the day, minimising surges in demand.

Improvements will be targeted at delivering desired outcomes, aligned with the CCGs QIPP, and BCF, and their impact on urgent and emergency care performance will be rigorously monitored by the Urgent Care Programme Board.

7.2 Integrated NHS 111/Urgent Care Service

In line with "Safer Faster Better" and the recently published Commissioning standards for Integrated Urgent and Emergency Care, the Thames Valley CCGs are working jointly to commission an Integrated NHS 111/Urgent Care service to replace the current NHS111 service which will go live in April 2017. The service will via NHS111 offer a functionally integrated Urgent Care Service with immediate access for assessment and advice to a wide range of clinicians including mental health, pharmacy and dental. The model will also offer advice to health professionals so that no decision needs to be taken in isolation. The new integrated service will have access to a range of dispositions including, but not limited to, red and green ambulances dispositions, 24/7 primary care and direct booking into a wider range of urgent on the day services such as Walk In Centres and Minor injuries units. Clinicians in the Hub will have access to all relevant care records supporting robust clinical decision making.

During 2016-17 the Berkshire West CCGs will work with the incumbent NHS111 and Out of Hours Primary Care Provider to deliver improvements ahead of the establishment of the fully Integrated Service. Improvements will be aimed at delivered aspects of the new Commissioning Standards for Integrated Urgent Care including;

- Providing additional clinical expertise to the current NHS 111 service
- Direct booking from NHS 111 in the OOH service
- Special Patient notes, End of Life and Crisis Care plans to be available at the ideal point in the patient pathway
- Joint management of patient pathways and capacity across NHS 111 and OOH
- Early identification of callers who would benefit from speaking directly to a clinician
- Integrated governance arrangements.

7.3 System resilience

System resilience for the urgent & emergency care system operates year round, balancing demand and capacity, planning for expected surges, smoothing patient flow, and early and timely escalation and de-escalation. The Berkshire West system adheres to the Thames Valley Escalation Policy and uses this as a guide and reference point.

Resilience monitoring operates at a number of levels on daily, weekly and monthly basis and is underpinned by robust data and intelligence from the performance dashboard which is the Alamac urgent care kitbag. An analysis of 2015/16 measures has identified areas for improvement and is summarised below.

.

Worked well	Opportunity for improvement
• Patient flow was good during the two week holiday period • Conversion rates were high (40-50%) so system working effectively in terms of admission avoidance • Positive response from nursing and care homes • Good liaison between SCAS and RBFT with SCAS activity levels not as high as predicted • Primary Care with extended opening hours offering more capacity and focusing on early visiting	• Capacity in Domiciliary care became constrained by mid-January as the market was saturated (Councils responding by focusing on use of reablement services) • Pressure on the system built through January with RBFT tipping onto internal black by mid-month – different profile of demand compared to 14-15 • Difficulties arranging patient transport evenings and week-ends • Westcall extremely busy and challenges getting full shift cover • Lack of pharmacy cover as Oxford Road was the

• Fit List well maintained with a good flow out to adult social care services	only pharmacy commissioned to open on the Bank Holidays

Plans for the critical Christmas and New Year period will be scrutinised by the Urgent Care Programme Board. Alamac will be used proactively to predict emerging pressures so that organisations can respond accordingly.

In 2015-16 the CCGs invested recurrent resilience monies to BHFT to establish an Integrated Discharge Team with a view to expediting discharges and maintaining flow into community services seven days per week. The team have been hugely successful with a significant reduction in-year for the number of patients on the Medically Fit for Discharge list awaiting community services and patient being pulled out of the acute before they reach the list. The impact of the scheme is quantified by the number of bed days saved by the team and in the first three quarters of 2015-16 over 2,000 bed days have been saved.

The CCGs also invested in the SCAS SOS Bus which operates out of Reading Town Centre on week-end evenings. In the first three quarters of 2015-16 253 patients have presented at the bus of which 74% have been successfully treated on scene. The patient cohort that can be managed through this service are often under the influence of alcohol and often A&E is the wrong environment for them so it is of significant benefit to both the user and the health economy that they can be treated in this way.

8. Hospital Care (Elective care)

Our strategy for Planned Care is to enable patients to make informed decisions about their care and where secondary clinical interventions are necessary to have access to specialist assessment and treatment and in line with national performance standards. The CCGs will support local providers to improve their referral to treatment time performance, ensuring they can adhere to all NHS Constitution measures and access standards to provide patients with care in a timely manner.

Our vision includes the use of new technologies to enable our patients to interact with services in new ways; reducing attendances at hospital, lengths of stay and the number of follow up outpatient appointments required.

We are working with our providers to model the demand and capacity for all specialities including diagnostics to ensure we are commissioning the appropriate level of services and pathways are delivered efficiently. We will also explore other modalities to deliver follow ups in the hospital and work with primary care to reduce clinical variation in referrals through regular review of data and targeting practices with higher than average level of activity.

The work programme for planned care for 2015/2016 delivered a number of successful outcomes:

- The development of an Integrated Pain Assessment and Spinal Service (IPASS) service for patients with chronic pain. This service was launched in September 2015 and has recently won an award for Emerging Best Practice by the British Society for Rheumatology.

- Arthritis Care offers support for patients with hip and knee conditions as an alternative to surgery. The service was launched in June 2014 and feedback from patients and referring GPs has been positive and the programme is planned to continue in 2016/17.

- The CCGs worked with the RBFT to look at efficient methods of delivering elective follow up appointments and the Trust has successfully implemented telephone follow ups for T&O, urology and dermatology. The CCGs have also commissioned the Trust to set up a virtual fracture clinic, and see and treat clinics for Dermatology. The Trust are in process of implementing a one stop shop for Urology.

- Best practice pathways are continuing to be developed across several specialities including MSK, and Dermatology for utilisation in Primary Care and accessible via the DXS system with the aim of reducing unwarranted clinical variation.

Our Planned Care Programme work plan for 2016/2017 includes continuing work to redesign services and reduce clinical variation focusing on Orthopaedics and MSK, Ophthalmology, Dermatology, Diagnostics, Gynaecology, Gastroenterology, Urology and Pre-op assessments in primary care.

8.1 18 weeks RTT

The CCGs have achieved the national standard for the last 6 months but are not complacent and continue to focus on working with RBFT in 2016/17 to reduce the size of the backlog of patients waiting beyond 18 weeks yet to be treated, especially those with the longest waits beyond 40 weeks. In aligning our demand and capacity modelling we have factored in the capacity required to achieve the national performance standard, including diagnostic capacity. The CCG is expecting to agree a Data Quality Improvement Plan as part of contract negotiations, which will build on the improvements in 2015/16.

8.2 Cancer

We will continue to focus on delivering the national cancer standards especially in Dermatology and Upper and Lower GI pathways. Revised trajectories and remedial action plans have now been agreed for the 2 week and 62 day pathways. These plans have also been signed off by Monitor and NHS E. Two week wait pathways are expected to recover in quarter one. The remedial action plan is included as a supporting document to this plan. The 62 day performance is particularly challenged due to capacity constraints in the gastroenterology pathways. The CCG has been working with alternative JAG accredited hospitals to determine if there is any available capacity. To date, additional capacity has not been available and as a result RBFT have not been able to bring forward the expected recovery trajectory. The 62 day plan is attached as a supporting document and forecasts delivery for quarter 3.

The revised remedial action plans are currently being tested with RBFT to ensure that they are robust and achievable. Once contracts are agreed the plans will be monitored closely with the provider via assurance and challenge meetings already in place, including the RBFT Cancer Taskforce meeting where tumour site clinicians attend to review the factors limiting achievement of the cancer wait time standards.

The CCGs are working with the Trust to understand the demand and capacity required for diagnostics for year 1 and the 5 years forward planning considering the impact of:

1. Changes in demographics;
2. Increasing demands for diagnosis from cancer pathways (including current backlogs)from:
    a. Compliance with NICE Guidance on suspected cancers
    b. Diagnosis expected earlier in the pathway (as per the upcoming 28 day standard)
    c. Exploring GP direct access

An activity plan for year 1 for diagnostics is included within the CCGs activity plan submission. The CCGs have are also engaged in the SCN Diagnostics Demand and Capacity modelling workshop and we plan to utilise the Solutions for Public Health modelling for the 5 year plan when it is available.

In order to improve services and deliver improvements in Berkshire West CCGs have the following strategic priorities:

1. Reduce the mortality rate for cancer in Berkshire West compared to the rest of England.
2. Improve survival rates for cancer in Berkshire West compared to the rest of England.
3. Increase the number of patients supported to die in their place of choice
4. Increase access to diagnostics, ensuring faster access to treatment and shorter patient journey.
5. Prevention – achieve targets for Bowel, Cervical and Breast cancer screening.

6. Early detection for cancers
7. Prevent people from dying prematurely by decreasing the potential years of life lost (PYLL) from cancer related causes.
8. Prevent people from dying prematurely by decreasing the under 75 mortality rate from associated cancers.

The CCGs have established a Cancer Steering Group which includes all local stakeholders from the provider, Public Health and Voluntary Sector with the aim of developing a joint local Cancer Framework/Strategy to deliver the priorities as set out in the national Cancer Strategy and the local strategic priorities. The main focus is on prevention, earlier and faster diagnosis, improved survivorship and better aftercare. The survivorship programme has now been established with a dedicated programme manager which will provide additional drive and momentum to the delivery of the ambition of our strategy. Below are the proposed objectives to be delivered over the next 5 years. It is expected for the group to prioritise objectives for year 1 based on outlying areas identified in the CCGs public health profiles:

- To promote health lifestyle changes to reduce cases of preventable cancer
- To increase uptake of early screening especially focused in CCGs below national average
- Enable direct access tests for GPs including x-ray, ultrasound, brain MRI, CT and gastroscopy including clinical responsibility, the process of managing patients who need further review and who communicates results to patients.
- Increase referrals for suspected cancer ensuring adherence to the NICE Guidance utilising the DXS system,
- Develop a pathway to support and enable GPs to make urgent or 2WW referrals for patients with vague, atypical symptoms and no red flags
- Provide GP/health professional education as appropriate working with local consultants
- Review and agree local pathways for the four main tumour sties to deliver an efficient flow through the pathway including a review of current waiting times for direct access tests and agreement of when tests will be available within 2 weeks and review which 2 week wait referrals should go straight to test rather than to an outpatient appointment.
- Improve patient experience for the whole cancer pathway
- Further develop cancer rehabilitation as part of the cancer pathway including holistic needs assessment, risk stratified pathways, the completion of end of treatment summaries and patient education and support to transition to supported self-care
- Work with the Trust to progress recording of cancer stages.

Examples of work streams we have in place or are planned which support delivery of our local Cancer Framework will include:

- A formal survivorship programme with a dedicated programme manager to ensure the programme is appropriately resourced with a focus on delivery.
- A particular focus within South Reading CCG to deliver cancer equality working locally with Macmillan and Cancer Research UK we will focus on three main areas: improved prevention strategies, improve early diagnosis and tackling emergency cancer diagnosis presentations.

8.3 Reducing unwarranted variation in elective care

The CCG is seeking to reduce unwarranted variation in referrals and use of secondary care services by providing practices with their current activity, which can be peer reviewed against the CCG and Federation averages. The aim is for practices to review and utilise this data to learn from and manage clinical variation. By comparing performance, the CCGs will seek to reduce unwarranted variation, underpinned by the use of evidence based clinical pathways.

In signing up to the national Right Care Programme, we are utilising the tools to scope opportunities across all CCGs in Berkshire West to provide professional development solutions, data comparisons across the CCGs and help

promote services. The output of the initial scoping exercise, taking place currently, will help to convert potential opportunities into implementation plans for further cost savings and better integration of services. Clinical leaders have been assigned and the programme is aligned to our Primary Care Strategy, outlined in section 6 above.

9. Out of Hospital Care

Our Out of Hospital vision is underpinned strategically by the development of our ACS, and more operationally for 16/17 through the work of the CCGs Long Term Conditions (LTC) Programme Board, the BCF and the Frail Elderly Pathway Programme.

We will continue to work collaboratively across health and social care and the voluntary sector to provide quality care for patients; minimising the risk of an individual's health deteriorating and requiring increased service intervention, and maximising the opportunities for patient self-management. Within this programme of work are a number of key work streams, supported in many cases by the Strategic Clinical Network and AHSN to help drive transitional change.

We have made good progress in integrating local services – for example, our exemplary community-based multidisciplinary Diabetes service and we are in the process of applying the same principles to designing a community-based respiratory care pathway.

The CCGs will be implementing a project in 2016/17 for patients who have been diagnosed as at End of Life. The objective of the project is to increase the numbers of patients offered and able to achieve their choice of place to be cared for and subsequently die. We will be implementing a 24/7 advice and support service provided by specialist palliative care health professionals which will be available via a single number at the Hub for patients, families, carers, health and social care professionals.

The hub links directly with the appropriate support agency removing the requirement for patients to make multiple phone calls and using the expertise of the specialist palliative care clinical staff will avoid unnecessary admission to and end of life deaths in hospital.

9.1 Dementia

The CCGs have commissioned a Memory Clinic service which is now nationally accredited and is already achieving the contractual standard of 6 week waits. This best practice model of delivery has been shared and is being adopted across Thames Valley. In addition we commission an award winning service for young people with Dementia , which has demonstrated encouraging outcomes measures for the clients is has served.

During 16/17 our Dementia steering group will work with the AHSN to examine other possible models of delivery and assessment. This may include carrying out more assessments in a community setting e.g. through care home in reach teams , upskilling of the workforce to facilitate simple assessment where it is not appropriate to send the patient to a memory clinic service just for a diagnosis and a screening and triage process for appropriate access to memory clinic services. Outcome measures will include admission avoidance, reduction in requirements for respite /social care intervention as well as reductions in the need for medical intervention (e.g. measure reduction in mental Health practitioner and community support worker contacts). This information is invaluable to assessing the value for money these services offer but also to release funds to allow further investment in Dementia services. By the end of 2017 we will have identified and costed revisions to the current service to meet the future needs of the population.

We plan to continue delivery of our dementia action plan across Berkshire West to ensure maintenance of the 67% diagnosis of Dementia target in each CCG within Berkshire West. Currently the average across the 4 Berkshire West CCGs at December 2015 is 67.65%. Newbury & District CCG are implementing a specific 10 point action plan to improve diagnosis rates. Wokingham CCG with the highest proportion of elderly of the four CCGs also has a CCG specific action plan which will continue in 2016/17, piloting the use of the Dementia Care Advisors in GP practices

which will help support the identification of and provide ongoing support to dementia patients/carers. If successful , this can be rolled out across the other Berkshire West CCGs. Wokingham have also introduced a referral form specifically to facilitate "remote" confirmation of diagnosis of Dementia in existing care home patients who would not be deemed suitable or able to attend a memory clinic, simply to confirm diagnosis. This will increase the % diagnosis rates in many of the Wokingham practices in the next few months and could be a technique adopted, if successful, within Newbury CCG. We aim to have achieved the 67% target in Newbury and Wokingham CCGs by September 2016.

A key deliverable within our action plan will be the achievement of a dementia initial assessment within 6 weeks of GP referrals. This will require identification of variation in referral and diagnosis rates within primary care. We will provide dedicated support to those practices identified as outliers but also to allow us to share good practice between practices. Our current variation in primary care project and intelligent health dashboard will be key tools in measuring and addressing unwanted variation in the system. As well as building on the Prime Ministers challenge on Dementia in the 5 key areas of care, we will refocus on improving the quality of post-diagnosis treatment and support in line with the 2020 vision using benchmarking and best practice wherever possible.

Our current established dementia stakeholders group will meet monthly and by June 2016 will have agreed the Dementia action plan for 2016/17 and beyond.

We recognise that increasing demand will mean more people will be cared for by their GP practice and other models of delivery may include looking at the option to further integrate older people's mental health specialists within our practice GP clusters. We have already seen with our young people with dementia service is indicating that savings can be generated through reduced impact on health and social care spend when patients and their carers are supported and managed appropriately within the community. Our plans will focus on these identified areas of best practice.

10.2 Diabetes

Across Berkshire West CCGs, we recognise Diabetes as a significant issue with the prevalence and number of people at risk of developing Diabetes being very high in some areas (such as the south of Reading). It is already a strategic priority with a dedicated Federated Clinical lead and CCG locality clinical leads. QOF data indicates a gap between expected prevalence and recorded prevalence and we recognise that more can be done to build on the successful services in many GP practices, especially in identifying people at risk and referring them to risk-reduction services. We currently commission a community enhanced service for pre-Diabetes, which was commissioned in 2013 and further expanded in July 2014 across Berkshire West. Further investment of £51,000 has since been set aside for 2016/17 with agreement to fund the service for a further two years as a minimum. This builds on the pioneering Pre Diabetes Project which has been running within Newbury and District CCG through 2013-14, which has successfully identified Diabetics and Pre Diabetes as well as promoting lifestyle intervention for Diabetics prevention. The GP CES addresses the needs of those already identified with PreDM (coded with IGT, IFG, Resolved DM, h/o Gestational DM, at risk of Diabetes and those with previous HbA1c 42-47), with annual testing for progression, and lifestyle advice etc. As of October 2015, 2509 people had been invited for a review and 910 had taken up the offer.

Berkshire has been selected as a first-wave pilot site and will therefore receive funding for the National Diabetes Prevention programme (all 7 CCGs and 6 LAs). This programme will be locally led by Public Health working closely with the CCGs and will complement the local CES scheme. The lead partners will aim to deliver 3,800 referrals to providers of the Diabetes Prevention Programme across the two year timeframe. If a Diabetes prevention service was available to Berkshire from April 2016 we consider that we could refer at least 1,500 people with pre-diabetes and a further 1,500 with currently undiagnosed diabetes in the first year for risk reduction. Our reasoning is described in our expression of interest but builds upon the early success seen in our local community enhanced service which has been running across Berkshire West since July 2014. This provides us with a sound base to be early adopters within the national programme.

Diabetes Management

Within Berkshire West we have strong clinical leadership and an integrated approach to the management of diabetes, which has been widely recognised and acclaimed nationally.

Our vision is to enable people with diabetes in Berkshire West to live healthier lives by improving outcomes and reducing complications, and to do that efficiently. We aim to do this through informed , engaged patients , informed motivated Health Care Professionals, collaboration between stakeholders , supported by the of informatics and technology. An action plan is currently in place and we have made major progress since 2012 in achieving our objectives. This has included the commissioning of an innovative interactive database technology "Eclipse", to which all our practices have access.

In order to build on the current action plan, a comprehensive assessment of our performance against NICE Clinical Guideline guidance in type I and type II diabetes. Eclipse tells us that we have 1,829 type I diabetics and 16,763 type II diabetics currently registered in Berkshire West.

We have recently invested in a new service for the care of highly complex diabetic patients post discharge, which builds on the success seen in the virtual clinics and will see the implementation of new community based service for this patient cohort, aiming to reduce non-elective admissions and readmissions. The national Diabetic audit also tells us that more work is needed to avoid diabetics locally developing complications and progressing to renal replacement therapy.

Other local initiatives to reduce the numbers of patients with very badly controlled diabetes include the insulin intensification program for patients very badly controlled diabetes on insulin therapy. There is also a focus on managing patients with early diabetic nephropathy. There has been local focus on care of people with diabetes foot problems. This has involved reconfiguration of the diabetic foot clinic with increased vascular and orthopaedic surgical input. HES data and atlas of variation information also indicates we perform well against national benchmarking. Throughout 16/17 we will continue to build on our success and implement further actions where gaps have been identified through data sources and a self-assessment against NICE criteria of service delivery.

South Reading CCG are also one of eight CCGs in England participating in a CQC Diabetes thematic review which aims to identify to challenges in delivery of diabetes services in the community and to share best practice examples across the country.

10.3 Frail Elderly Pathway

Work on the development of a Frail Elderly Pathway first began in recognition of the need to improve the experience of older people in understanding the complex arrangement of services across our system, and the aspiration of being able to use resources more efficiently in the face of growing demand. Our aim is to develop a pathway that is centred on the needs of an individual person and their family, rather than the services themselves, professional boundaries or governance and structural requirements of individual organisations.

In 2014 the Kings Fund worked with the Berkshire West organisations to develop a new pathway for the provision of Frail Elderly Services. This was developed around the needs of a single service user 'Sam'. Work is now underway to assess the progress that has been made since 2014 in implementing the pathway and to model the activity changes and financial impact of its adoption.

In addition in 2015/2016 an evidence base on early prevention activities in older people was produced by Public

Health that was shared with each local integration board, this highlighted local strengths and weaknesses and will be used to develop priorities in each locality in 2016/2017. This evidence will inform changes in the way services are commissioned to ensure resources are allocated to those services which make the greatest contribution in supporting the Frail Elderly in Berkshire West.

The governance of the programme is into the Berkshire West 10 Integration Board and Delivery Group and the expected outputs of this programme including identified opportunities for "quick wins" will be used where possible to inform commissioning and contracting decision for 16/17. The final reports including an implementation plan will be produced by the end of March 2016.

10. Mental Health - Parity of Esteem

The Mental Health Taskforce has recently published their 'Mental Health Strategy Five Year Forward View'. The CCG's CMMV Programme Board is reviewing this document against our Commissioning ambitions for 16/17.

The CCGs are leading a local Mental Health Taskforce for Berkshire West and this will be the first time there has been a strategic approach to improving mental health outcomes for people of all ages in the health and care system, in partnership with the health arms-length bodies. Berkshire West CCGs is committed to work across the health and social care system in developing a joint mental health strategy to improve the experience of mental health service users and carers.

In Berkshire West we have already made significant investment in mental health services year on year to support the delivery of Parity of Esteem and we will continue to drive change to ensure all our mental health users and carers receive a high quality, outcome focus service to the same level as physical health care. The CCGs have invested in Primary Care education through our Training in Practice event, the latest event in January was specifically focused on Mental health and was adapted for not only to GPs but to practice nursing and reception staff.

We already have a well-established Crisis Care Concordat Steering Group in Berkshire (which will feed into the taskforce) that is hosted and co-ordinated by Berkshire West CCGs Director of Joint Commissioning, involving multi-agencies as part of the CCC Declaration Statement Signatories. A high level plan has been developed and is overseen by this group. As a result this has strengthened partnership working across multi-agencies i.e. Thames Valley Police, Ambulance Service, Local Authorities, CCGs, Mental Health & Acute Provider Trusts, Voluntary Sector Providers, Drug & Alcohol Services, Users/Carers and Public Health.

Berkshire CCGs jointly commission 3 places of safety (POS) with BHFT; these are based at Prospect Park Hospital. One of these is dedicated for Children and Young Person with facilities for parents to stay with their child during assessment period. The POS is managed by BHFT inpatient staff and has support system in place to effectively manage mental health patient with high risk presentation. The POS have significantly reduced mental health patients placed under Section 136 being detained in custody suite.

The Crisis Care Concordat plan includes steps to agree and implement a plan to improve crisis care for all ages, including investing in places of safety. For children and young people under the age of 18 years a CORE 24 compliant service is being piloted for 12 months. This builds on the existing CORE 24 compliant service for YP aged 16+. The pilot has been developed jointly by BHFT, RBFT and CCG commissioners.

In addition work with Public Health on a population wide approach to promoting good mental health and preventing mental illness and has included promoting Five Ways to Wellbeing messages across schools, businesses and local communities, and supporting local groups that work with people experiencing mental illness and social isolation e.g. Friends in Need, Pulling Together and Eight Bells.

10.1 Mental Health Standards

Working with our main provider, Berkshire Healthcare Foundation Trust (BHFT), we will lead service transformation to bring all its services in line with National Standards to meet the Parity of Esteem "Call to Action Framework" and we will be working with them to deliver on the Two New National Mental Health Standards as set out in the Planning Guidance.

IAPT – BHFT have been delivering on the IAPT trajectories (of 75% of people with relevant conditions accessing talking therapies in six weeks and 95% within 18 weeks).This is being reported quarterly and monitored in our contract monitoring meeting with the provider. The BHFT service has been recognised nationally as a high quality service with excellent wait times and access rates. This service has received national recognition for its achievements:

* Achieved a **r**ecovery rate of more than 50%
* Wait time of 4 weeks (against a national target of 18 weeks)
* 95% patients reporting a positive experience

Our priority for 16/17 is to ensure that current performance is maintained and that recovery rates are above 50% going the next contractual year. This service will continue to evolve and we are working with BHFT to roll-out the IAPT service in managing long term conditions i.e. COPD/Diabetes.

Berkshire West is part of the University of Reading CYP IAPT collaborative and has been for a number of years. (Wokingham CCG is the lead CCG for Berkshire). Many BHFT CAMHs Tier 3 staff and some local authority Tier 2 staff are undertaking CYP IAPT training. Learning from CYP IAPT has helped to shape care pathways and the development of outcomes framework in Berkshire West

CAMHS –In 15/16 the CCGs invested over £1 million in BHFT to reduce the lengthy waiting list for CAMHS services with a focus on prioritising those children assessed as being high risk, as well as reducing the overall waiting times to provide assessment and offer an appropriate treatment package if required. We will continue to work with the Trust to ensure that we have defined metrics for improvement in 16/17 and that performance is monitored closely through the contract with the Trust (see section on CAMHS transformation and supporting document).

Early Intervention Psychosis (EIP) – In 2015/16 we have an agreed Service Development Plan with our Mental Health Provider BHFT to implement 'A NICE compliant EIP' service that is able to offer and deliver the following NICE recommended treatments to more than 50% of people within 14 days of referral:

- CBT for Psychosis (CBTp)
- Individual Placement Support (IPS) for education and employment
- Family Interventions
- Medicines management
- Comprehensive physical assessments
- Support with diet, physical activities and smoking cessation
- Carer-focused education and support programmes

We are working closely with the South Region EIP Support Team to develop an EIP service that will meet the national accreditation criteria. We are working through our baseline figure with BHFT for 2016/17 and this will be agreed by the EIP Regional Team in the coming month, for reporting to start from April 2016.

BHFT have already started to develop the RTT Pathway for EIP Service for people aged between 14 and 35 and the completion of this pathway is expected by Q1 in 2016. The Referral to Treatment pathways on RiO (the BHFT IT Management System for Health Care Record) will support the reporting of EIP Activity Data from April 2016 using the new NHSE EIP reporting template.

Crisis Resolution Home Treatment Team (CRHTT) – We have increased our investment in this service line to improve workforce capacity to cover week-ends and night shifts to support those experiencing mental health crises out of hours, provide short term interventions and face to face contact. We have also invested in 'Street Triage' one year pilot in Berkshire West to work alongside Police Officers in responding to emergency mental health calls and/or assess individuals picked up by Police on the street to reduce the application of Section 136 under the Mental Health Act 1983. The CRHTT service now operates from Prospect Park Hospital and provides 24hr/7 days a week service in Berkshire West providing rapid response to manage mental health crisis in the community.

Liaison Psychiatry Service (Psychological Medicine Service) – Operating from Royal Berkshire Hospital the Psychological Medicine Service mirrors the 'RAID' (Rapid Assessment Intervention Discharge) model, providing rapid access to individuals presenting at Emergency Department with mental health problems and working with those admitted into an acute inpatient bed with co-morbid mental health conditions to reduce length of stay. This service is also supported by the Community Crisis Response teams and the Community Psychological Medicine Service working with frequent flyers and those with medically unexplained symptoms.

Male Mental Health - In Berkshire West there were 97 suicide/undetermined/open verdict deaths in 2012-2014 and males have a higher suicide rate compared to women in line with national figures (73% male; 26% female).As part of the Thames Valley network we are supporting the CALM project targeting information and support to men with mental illness to recognise signs of mental illness and access information and services.

Perinatal Mental Health – The Berkshire West Perinatal Service will be launched on the 1st April 2016. The service specification has been agreed including KPIs, Outcome Measures, Information Requirements and expected activity levels. The aim of the service is to provide a comprehensive range of community services for women requiring pre-conceptual counselling or who experience mental health problems or illness during pregnancy or in the first year after birth**.**

In 2016/17 we will continue to prioritise mental health investment, and will be considering recurrent investment in services such as the following:

- **Street Triage Service** – Improve the experience and outcomes for service users in crisis. There will be a professional mental health assessment undertaken by an experience healthcare worker (rather than for example a S136 applied by a police officer) and the person being taken to a Place of Safety, where a full MHA assessment is required. The number of Section 136's in Berkshire West will be reduced as a consequence.
- **Alcohol Specialist Nurse Service** – We have developed a business case to request funding for investment in the Alcohol Specialist Nurse Service to operate from RBH ED and Wards; this service will provide rapid assessment and treatment to all those presenting at ED with alcohol related problems and avoid hospital admission.
- **Recovery College** – We have set up a local project group to develop a recovery college service model to support mental health service users in their recovery journey from mental health problems and access education, training, vocational and paid employment. We also expect this service to support carers in accessing education and training.

Mental Health and Physical Activity – In 2015/2016 we supported Sport in Mind a local charity providing supported sports activity to users of mental health services to obtain a lottery grant for 3 years. Working with BHFT the project will widen participation in 2016/2017 using sport as part of recovery and ongoing health promotion for people experiencing mental health problems. Sport in Mind plan to deliver 1,750 sessions and expect to support 1,500 people in 2016/2017. In addition, working with Public Health, we have promoted the Activity for Health Scheme and Moving Forward; both schemes are designed for people experiencing both physical and mental health problems.

10.2 Transforming Care

The Berkshire West Transforming Care plan (see supporting documents) for people with Learning Disabilities is aligned to a regional 'Positive Living Model'. This plan provides the opportunity to develop integrated working, clear

lines of accountability and clinical engagement with adult social care to deliver high quality provision in a cost effective way through reducing the need for inappropriate admissions whilst releasing savings into the health and social are system.

Working with the best of local experience, skills and knowledge a new service model has been created that incorporates Positive Behavioural Support and increased level of community based provision through a reduction in beds. The CCG and 3 local authorities are planning to deliver intensive care support in the community as a viable alternative to hospital assessment and treatment beds. This will be achieved through specialist skills and knowledge to be transferred to community support settings and for the remaining beds to be redesigned as part of a challenging behaviour pathway. Cost savings will be released for investment into community intensive support.

BHFT has signed up to Berkshire West CCGs commissioning intentions to reduce the contracted bed based provision for people with a LD by 2017. The CCG is in the process of completing joint plans aimed at transforming services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, in line with *Building the Right Support – a national plan to develop community services and close inpatient facilities* (NHS England, LGA, ADASS, 2015). These plans will cover 2016/17, 2017/18 and 2018/19.

The CCG will work with BHFT to review the levels mortality in Berkshire in line with the recommendations of the Mazars report. The CCG will aim to develop a process for ensuring that there is good quality healthcare to achieve outcomes such as admissions avoidance. This process will be developed through understanding the current rate and reasons for mortality amongst people with learning disabilities. In parallel the Transforming Care Programme board will aim to identify how services will need to be commissioned and provided in the future to ensure that people with learning disabilities and/or autism with behaviours which challenge services are supported within their local community and only require in-patient services for clearly defined purposes.

The Berkshire West plan will aim to demonstrate how the national service model will be implemented by March 2019 that requires CCGs and local authorities to work together to reduce the reliance on in-patient beds through intensive intervention services in the community. The Director for Joint Commissioning will be leading this process for Berkshire as the Senior Responsible Officer for transforming care. The aim of this plan is to show where people are placed and how they are funded to provide opportunities for collaborating health and social care to resources to discharge people into community placements. A Pan Berkshire Business plan is also in the process of being finalised, that will show a phased reduction of in-patient beds and mobilisations plans for the intensive intervention service in the community.

Berkshire Healthcare staff, the 3 local authorities, Carers and Commissioners developed new patient care pathways to support phased closure on in-patient beds and utilise the resources to implement a 'Positive Living Model in the community.

10.3 CAMHS Transformation

The CCG has established a multiagency 'Future in Mind' group which includes all key stakeholders (e.g. Schools, Health Visitors, Local Acute and Community Providers and the three local authorities). This group will oversee the joint CAMHs transformation plan for Berkshire West. The focus of which is to improve early intervention and prevention services with the aim of improving outcomes for children and young people and reducing the demand on specialist CAMHS services.

We are putting additional training and support in place across the wider children's workforce (including schools and primary care) so that children and families can access help before problems reach the point where a specialist mental health service is required. We are working with the University of Reading to develop bespoke training for families who have a child with severe conduct disorder where Webster Stratten has been unsuccessful.

We are working with the voluntary sector, our community provider and Local Authorities to ensure appropriate support is provided to families who are awaiting Autism assessment. We are also developing a CAMHs outcomes framework which will be implemented by voluntary and statutory providers in all contracts from 16/17.

Following significant investment by the CCGs additional staff has been appointed into specialist CAMHs services in order to reduce waiting times, mitigate clinical risk and ultimately = minimise the number of children whose needs escalate into crisis. The CCGs are funding a 12 month pilot to improve access to urgent care CAMHs services for children aged less than 18 years, 7 days a week. By having more CAMHs staff available in the Royal Berkshire NHS FT (RBFT) it is hoped that length of stay will reduce, there will be fewer "frequent fliers" and that children and young people who are in crisis are able to access help more quickly, particularly over weekends.

We will be working with the Police and Crime Commissioner, voluntary sector and Health and Justice commissioning to ensure that the emotional and mental health needs of children who are victims of crime or are involved in the criminal justice system are being met.

We are also working with Berkshire East CCGs and our community provider to develop a community Eating Disorders service that meets the new standards. An enhanced perinatal mental health service has been commissioned. The SHaRON online platform is being expanded to include perinatal, carer and CAMHs support.

11. Patient Experience and Engagement

11.1 Patient Choice

The Berkshire West CCGs support Patient Choice by commissioning a range of accessible physical and mental health services from both the NHS and independent sector. Choice is facilitated by maintaining an extensive and up to date Directory of Services in collaboration with all the local service providers and accessed by the E-referral system.

Clinical pathways around Maternity services, End of Life and Ophthalmology are being investigated to assess feasibility of choice and will be added to the E-referral system where appropriate.

Providers continue to offer access to named consultants on e-referrals system.

11.2 Personal Health budgets

Berkshire West CCGs are committed to further rolling out Personal Health Budgets (PHBs) across our area for all patients who would benefit from them and have a programme of work for taking this forward.

Our next step is to take what we have learned from already offering PHBs to those with Continuing Health Care needs (CHC) and apply this in a new offer to people with learning disabilities. In doing so we confidently expect to further develop our processes and practice to facilitate the further roll out of PHBs to other patient groups.

We will develop this work jointly with appropriate local partners in particular the relevant Local Authorities (LAs). The three LAs that cover Berkshire West have already taken part in a public engagement exercise to launch this work and are signed up to being involved in joint delivery and sharing of resources where appropriate and practical.

11.3 Patient Engagement

Berkshire West CCGs Patient and Public engagement plans recognise that there are many different ways which people might participate in health depending upon their personal circumstances and interest. In addition to awareness raising, preventative health and system resilience messages throughout the year, topics that were explored in-depth with patients during 2015/16 included;

- Frail elderly pathway redesign
- Alternative Provider Medical Services (APMS) contract procurements
- Primary care strategy
- End of life care planning
- Digital behaviours
- NHS111

We have developed robust methods of listening, engaging and involving patients and the public which have ensured that their insight and experiences have been acted upon at all stages of the commissioning cycle and have influenced our commissioning decisions. We will now make this more systematic and consolidate our engagement and involvement to better empower patients to shape services and the care that they receive.

The engagement strategy for Berkshire West recognises that there are many different ways which people might participate in health depending upon their personal circumstances and interest. Hence CCG engagement ranges from simple awareness building activities for the general public, through to working with patient and community groups to ensure that their concerns and aspirations are understood and considered by commissioners:

- ***Awareness raising*** - Throughout the year a range of messages are shared via CCG and partner communication channels, online, offline and face to face.
- ***Surveys*** - The Berkshire Health Network (BHN) is used to target engagement activities to interested organisations and individuals, and to publish and invite feedback from surveys and discussion documents.
- ***Governing body meetings*** - Members of the public are invited to observe and attend CCG governing body and JPCCC meetings in public.
- ***Public meetings*** - CCG's host regular public meetings themed around a specific area, such as the primary care strategy or the frail elderly pathway. Such meetings create opportunity for group discussion and meeting outputs are documented for commissioners. Public meetings are also used to ensure the widest possible engagement in service change, such as new contract procurement for a GP surgery.
- ***Patient representatives*** - Patient representatives can be found on each programme board. CCG governing bodies are also supported by a lay member with an interest in patient and public participation.
- ***Patient groups*** - The CCGs are currently broadening work in this area to establish dedicated patient groups that engage with and support specific streams of work.

Patient engagement work during 2016/17 will focus on:

- Sharing of 16/17 CCG plans
- Areas of service change resulting from the implementation of the primary care strategy and QIPP plans
- The move towards the ACS
- The introduction of the new Frail Elderly Pathway.
- Development of a digital roadmap by Berkshire West CCGs and support for patients to engage with existing digital services.
- Work with seldom heard and hard to reach groups, encouraging them to become more involved in their local NHS.
- Work to map and engage PPGs directly in communications and engagement work.
- Build on an early trial in West Berkshire to set up and co-ordinate a communications and engagement network; bringing together providers and the unitary authorities, to share intelligence and look at ways in which partners can better engage with the public together.

11.4 Patient Activation and self-care

There are a number of measures in place across Berkshire West to support patient activation and self-care, including:

- Development of a self-care strategy to support reduction in urgent care demand
- Development of a self-management protocol enabling patients to enter their own data and remind them to attend appointments
- A social prescribing pilot in South Reading with Reading Voluntary Action group focusing on patients social needs
- Use of a diabetes online tool (ECLIPSE) – including a secure patient portal. In 2015/16 Berkshire West CCGs won first place for the most effective prescribing as a result of using Eclipse widely
- The use of risk stratification and care planning for patients aged 75 and over with input from patients

12. Technology

The CCG has been working with partners since 2013 on the innovative and exciting programme called Connected Care to develop a joint vision and strategy for information sharing, and the development of an integrated care record across the 10 Health and Social Care organisations in the Berkshire West community. This will enable delivery of a comprehensive electronic record at the point of care by 2018, including social care partners. Procurement processes for the information integration solution and single electronic care record will be complete by the end of the 2015/16 financial year, allowing the focus to shift to delivery in quarter 3 2016/17.

The Berkshire West Local Digital Roadmap will build on existing capabilities and governance structures already in place across Berkshire West. Our Connected Care Programme will deliver an integrated health and care record for our patients, following a successful procurement in 2015/16.

Our Practices predominantly use two system suppliers, with a third supplier used in a minority of practices. The CCGs have already implemented information sharing at the point of care with our unscheduled care provider and extended this through an integration pilot to A&E and our Health and Social Care Hub (implemented in quarter 3, 2015/16). As the roll out of Connected Care progresses we will be able to connect Social Care information to the integrated record; Wokingham Borough Council's information will be included by April 2017.

The procurement includes a patient portal which will allow patients and their carers to view the record and input self-care information; we expect this to come on stream in 2017/18. In the interim, practices are promoting the use of the patient on-line ability to view coded information in their general practice record where the system supplier has released the functionality. In March 2016, 92% of practices whose supplier offers the functionality had enabled care record viewing. In addition we are working with pilot practices across Berkshire West and patients with long term conditions to use enhanced web sites which allow for patient recorded observations to be measured by their GP and for e-consultations.

Using quality funding, in 2016, practices in Wokingham CCG will be able to share appointment books with NHS 111 and to allow clustered working to manage urgent on the day demand. We plan to start a pilot project in June 2016 to trial direct booking from 111 and for practices to receive a care summary about any patients booking an appointment from a neighbouring practice. We anticipate that this capability will deliver flexibility in urgent appointments, support extended practice and seven day working.

Delivery of the Local Digital Roadmap will be governed by the Berkshire West CCGs Innovation, Technology and Information Systems Programme Board; this forms part of the overall governance of the Berkshire West 10 Health and Care Integration Programme (BW10). The Connected Care Programme governance feeds in through the BW10 Integration Board and the Delivery Group. This ensures that digital priorities are identified collectively on a system

level, and are used as an integral enabler of clinical transformation and organisational priorities across the health economy.

Our system vision for Frail Elderly as described earlier has been used to inform the system requirements based on a local version of the "Sam's Story" narrative initially created by the Kings Fund. This has enabled us to model our requirements using a patient centred approach to pathway redesign. This work has highlighted how much more efficient and effective care would be by avoiding information silos and having a single integrated record.

Programme benefits are projected at approximately £2.5 million per annum on a Berkshire footprint against a Berkshire system wide investment of circa £10 million over the period of the contract (this includes all health and social care organisations). These benefits are focused on the following:

- Reductions in length of stay
- Reductions in admission
- Reductions in duplicate and unnecessary testing

The benefit values are conservative to avoid double counting against other service transformation programmes which are co-dependent on the delivery of the Connected Care Programme and the broader digital agenda across the Berkshire West 10 organisations.

Key activities outside the Connected Care Programme which will form part of the Digital Roadmap delivery for 2016/17 include:

- working with providers to support their use of electronic prescribing solutions and vital signs monitoring,
- maximising the use of existing clinical systems at the point of care.

In Primary Care, Wokingham CCG will be leading the development of a pilot with their practices and NHS 111 in relation to on the day bookings to commence early in 2016/17. We also envisage expanded access to planned extended hours appointments during 2016/17. A number of practices are already piloting Skype consultations and the use of emails and telephone consultation/triage is widespread amongst our practices. We are still working to further define work streams to expand and build upon these new modes of access and to increase self-care and the use of symptom checker and/or triage apps. Our initial priority will be to maximise the use of existing systems such as EPS2, e-referrals and existing patient online tools accessed through the GP record. Further detail will be set out in our Digital Roadmap.

There are a number of additional clinical systems which support decision support and care planning, and we will work to evaluate and rationalise these, ensuring that any duplicate functionality from any new systems allows the decommissioning of existing systems where appropriate.

As part of the integrated record the CCGs have procured a patient portal which will support projects increasing self-management and prevention. This will allow comprehensive patient access to their records across health and care in future, along with the ability to integrate information from wearable devices and self-monitoring tools. In the interim the CCGs will continue to work with practices to improve the digital services offered to patients through the existing patient online tools accessed through the GP record.

13. Research and Innovation

This statutory responsibility is incorporated into the terms of reference and business cycle of the CCG's Joint Quality committee. The CCGs are committed to and are engaged with the Oxford Academic Health science network, through attendance at the Clinical Innovation Adoption Oversight group and the Strategic Clinical Network (SCN). The AHSN

are routinely invited to attend the CCGs Clinical Commissioning committee and the relevant Programme Boards. Innovations are assessed on a case by case basis.

13.1 Genomics, precision medicine and diagnostics

As a result of increased molecular knowledge, disease classification will significantly improve over the next five years and will be more precise which will enable us to refine our diagnostic capability and apply a range of different therapeutic interventions. In turn, this will allow the identification of patient populations most likely to benefit from specific interventions and has the potential to improve the effectiveness and efficiency of the entire healthcare system.

In Thames Valley we are fortunate to have a very strong biomedical research centre and university and as well one of the strongest technology 'clusters' in Europe. Through our subscription to the AHSN we will be informed of developments in this field and will engage in opportunities to test new service models.

In the shorter term, we are aware that the capacity and demand gap for diagnostics is growing with the changing NICE guidelines. We are using the SCN support tools to help us quantify the gap and are participating in their programme of work that aims to jointly consider how this gap will be plugged. There are considerable work force issues that will need to be addressed and some consideration will need to be given to ensuring that going forward the work is done by a workforce fit for the future. This will be done in partnership with other health economies in Thames Valley.

14. Governance and Assurance

In line with the CCGs constitutions the Operating Plans will be signed off by the Council of Member Practices.

Progress against plans will be reported quarterly to Council of Practices and 6 monthly to CCG Governing Bodies. This process is underpinned by monthly reporting on delivery of quality and finance performance standards to the Berkshire West Federation of CCGs standing committees, and quarterly assurance meetings with NHSE area representatives.

The Berkshire West 10 system also has in place a formal governance structure which brings together the senior leadership from all partner organisations at both a strategic (Integration Board chaired by the CCG Federation CO) and operational level (Delivery Group, chaired by the Director of Adult Social Care for Reading Borough Council, and Vice Chair Director of Strategy for the BW CCGs) in support of the achievement of our overarching vision for Berkshire West. There is a direct link from these meetings through the membership to the three Health and Wellbeing Boards, and individual organisational Boards, Committees and Governing Bodies.

Supporting documents

1. Berkshire West CCGs – Public Health Profiles 16/17
2. Berkshire West CCGs Commissioning Intentions 2016/17
3. Berkshire West CCGs Finance Strategy 2016/17
4. Berkshire West CCGs Operating Plans on a Page
5. Cancer Treatment standard recovery plans, 2 week wait and 62 day plan
6. Berkshire West Operational Resilience Capacity Plan
7. Berkshire West Primary Care Strategy 2016/17 (attached)
8. Berkshire West CAMHs Transformation Plan (plans produced for each LA – copy of Wokingham plan attached)
9. Crisis Care Concordat Action plan
10. The Berkshire West Transforming Care plan
11. Connected Care Programme – Briefing document
12. Berkshire West CCG Dementia Action Plan
13. Berkshire West CCGs Communications and Engagement Plan

14. Berkshire West ACS PID

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	Health & Wellbeing Board		
DATE:	15th July 2016	**AGENDA ITEM:**	5
TITLE:	**OUTCOMES AND RESPONSE TO LGA PEER REVIEW OF THE READING AND WEST OF BERKSHIRE HEALTH AND WELLBEING BOARDS**		
LEAD COUNCILLOR:	COUNCILLOR HOSKIN /EDEN	**PORTFOLIO:**	HEALTH /ADULT SOCIAL CARE
SERVICE:	Wellbeing	**WARDS:**	ALL
LEAD OFFICER:	Jo Hawthorne / Jenny Scott	**TEL:**	0118 937 2072 0118 937 2275
JOB TITLE:	Head of Wellbeing / Senior Policy Officer	**E-MAIL:**	Jo.Hawthorne@reading.gov.uk /Jenny.scott@reading.gov.uk

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 In October 2015 Reading's Health and Wellbeing Board approved a review of the Board's effectiveness and efficiency by LGA Peer Challenge. This was undertaken collaboratively with Wokingham and West Berkshire Health and Wellbeing Boards, in order to identify any potential opportunities for future synergies or integrated working. All HWB'S are tasked with promoting the alignment and integration of health and care services in the sub region.

1.2 The LGA conducted 'on-site' visits from 1st – 4th March 2016. The feedback letter provides a summary of the peer team's findings specific to Reading and includes the collective feedback given to all 3 areas. In presenting this feedback, the peer challenge team acted as fellow local government and health officers and members, not professional consultants or inspectors. The review letter was circulated to Board Members for comments.

1.3 The report outlines the headline messages, key findings and recommendations contained in the review letter and a proposed draft framework to address the recommendations. The full review letter received from the LGA is attached at Appendix one and the draft framework in response to the recommendations is attached at Appendix two.

1.4 An update report on the Health and Wellbeing Strategy refresh is also being considered at today's meeting. The refreshed Health and Wellbeing Strategy will represent – in part - the Board's response to the recommendations of a health and wellbeing peer review carried out in March 2016, and will offer an outcome focused framework to drive the future agenda of the Health and Wellbeing Board.

2. RECOMMENDED ACTION

2.1 **That the board note the observations and findings from the LGA Peer Challenge.**

2.2 **That the board endorse the recommendations of the LGA Peer Challenge. Listed in para 4.13.**

2.3 **A suggested framework, included at appendix two, in response to the review recommendations is agreed.**

2.4 **That a board member stocktaking event takes place and task and finish groups established to address the recommendations outlined in appendix two.**

3. POLICY CONTEXT

3.1 Health and Wellbeing Boards are statutory bodies introduced in England under the Health and Social Care Act 2012. According to the Act, each upper-tier local authority in England is required to form a Health and Wellbeing Board as a committee of that authority. The aim of Health and Wellbeing Boards is to improve integration between practitioners in local health care, Social Care, Public Health and related public services so that patients and other service-users experience more "joined up" care, particularly in transitions between health care and Social Care. The boards are also responsible for leading locally on reducing health inequalities.

3.2 Health and Wellbeing Boards have no statutory obligation to become directly involved in the commissioning process, but they do have powers to influence commissioning decisions made by CCGs. However, CCGs and local authorities may delegate commissioning powers to Health and Wellbeing Boards so that they can lead on joint commissioning. JSNAs and joint health and wellbeing strategies produced by the boards are key tools that CCGs use in deciding what public health services need to be purchased. In this sense the boards have a role in shaping the local public health landscape, and helping CCGs to commission services in an effective and targeted manner.

4. THE PROPOSAL

Scope and Focus of the LGA Peer Challenge

4.1 Peer challenge has been developed collaboratively for health and wellbeing. HWBs commission the challenge to focus on local system challenges and priorities within the overall framework.

4.2 The health and wellbeing peer challenges focused on the health and wellbeing board and the partners who form the local health and wellbeing system recognising that 2015/16 brings a window of opportunity to put Health and Wellbeing Boards in the driving seat of local system leadership; able to take on a place-based approach to commissioning Adult Social Care and health, and address the wider determinants of health. The peer challenges are focused on

enabling the leadership of HWBs to move into this space effectively. In this context the peer challenge focuses on the following elements:

- ensuring clarity of purpose of the board
- building a model of shared leadership within the board
- working with partners to develop the systems leadership role
- ensuring delivery and impact
- integration and system redesign

The peer challenge is fully subsidised by the Department of Health.

Comments received

4.3 The comments received relate to health inequalities and the inclusion of recommendations about engaging members of the public in the HWB strategy and ensuring the programmes of work in the strategy have good and robust engagement with the public and this means more communications with the public about its work. These have been included in the final letter.

Key Findings

4.4 The peer challenge focuses on a set of headline questions. A summary of the key observations and findings from the review are grouped under the headline questions and included in paragraphs 4.6 – 4.13. The more detailed review letter is included at appendix one. Areas referred to in the headline messages of the letter are shown in bold.

4.5 1. **To what extent is the purpose and role of the health and wellbeing board (HWB) established?**

- The board has carried out its formal duties and produced a JSNA, Health and Wellbeing Strategy and Better Care Fund Plan. Significant work is currently underway to revise the JSNA.
- The Better Care Fund Plan has been overseen by the HWB. The Plan for Reading is ambitious and it will be a hard stretch to implement it.
- Other areas of activity have not been performance managed in this depth, and this imbalance has been reflected in board agendas in relation to the more limited attention given by the board to other priorities.
- **The HWB does not feel to a number of its members like a properly-balanced partnership board**
- **The position of the HWB in the local system is unclear. It is currently not shaping and driving the improvement of the local health and wellbeing system.**
- **The appointment of a Vice Chair from a partner agency other than the Council might assist in emphasising that the HWB is a partnership bod**y.
- **The Health and Wellbeing Strategy (HWS) is not an integral part of the Council`s Plan**, nor is it reflected in the priorities of partner organisations (even though it is referenced in many of them). The agenda of the board does not reflect the content of the HWS.
- The above observations mean R**eading`s HWB is not really well-established in its role as the leader of the local health and wellbeing**

system. It is acting rather more as a "clearing house" for information, and a body that endorses work initiated and carried out elsewhere.

4.6 2. **How strong is work with key partners to develop system leadership?**

- The board has some evident strengths
  - It meets regularly and is well attended.
  - Board members have been working together for some time, many informal relationships are good and people seem to enjoy working together – up to a point!
  - The board has learned from its experience of the development of the previous strategy, when some partners felt they had been given little chance to influence it.
  - A good level of engagement with partners and key stakeholders is now being planned in the development of the new HWS.
- CCG and council relationships had improved and were working hard to make things better
- One outstanding issue seemed to be having a particularly unsettling effect – continuing healthcare payments.
- Relationship building requires time and the willingness to work together. In Reading, there isn't much time allowed for partners to work together informally so they can develop an appreciation of key issues before they are put into the formal arena of the HWB.
- Good committee services support to the HWB, there seems to be a gap in terms of support for business planning and board development.
- Not clear how the HWB is connected to providers as key stakeholders in the area. As the NHS Sustainability and Transformation Plan initiative is likely to have important consequences for the closer integration of health and community services providers with commissioners, the board might want to reflect on provider engagement, especially in relation to the Royal Berkshire, given its central role in the local health system.

4.7 **3. To what extent is the Health and Wellbeing Board ensuring the delivery of the health and wellbeing strategy?**

- The team noted a lot of good things happening in Reading. For example Living Well, Right for You, Beat the Street, HIV volunteers, and successful `flu and breastfeeding campaigns. South Reading CCG has met its dementia diagnosis target. The board is making good use of the Local Strategic Partnership to deliver work on FGM, and breaking down barriers related to information sharing. The Public Health Team is delivering well on its business plan, much of which reflects the HWS, and the Integration Board has a key role in driving improvement.
- The BCF has given attention to upstream prevention and the strengthening of community assets. The neighbourhood teams have a key role in building and mobilising community initiatives, with paid staff and volunteers. **Initiatives with BAME communities are well-developed**. The HWB has requested quarterly performance reports on BCF progress, and this has been seen as a positive development which has encouraged the timely delivery of key outputs.
- Similarly, when extra resource went into CAMHS, the HWB requested more detailed information about progress.
- However, there are some issues for the board to consider:

- Firstly, it does not have a performance review programme for the delivery of the HWS and it has received relatively little attention at the HWB.
- It is not clear which other people and groups have defined responsibilities for the delivery of parts of the HWS, nor how they report their progress to the HWB.
- As the HWS is being refreshed, it might be helpful for the board to consider designing a coherent performance management system, with an integrated dashboard of key indicators.
- Peer Challenge Team has not seen much evidence for a co-ordinated approach to building on community assets. Given the strength in the voluntary, community and faith sectors, and the local business world, the HWB may be missing useful opportunities.

4.8 4. To what extent is there a clear approach to engagement and communication?

- Strengths in relation to communications and engagement.
  - There is time at HWB meetings for public questions, in line with the Council`s policy
  - There is a dedicated resource now being provided for public health and social care communications, and this should make a difference. There are good examples of engagement with diverse communities
- However, the HWB does not engage with stakeholders and the public as a collective group. There is not yet a cohesive approach to communication and engagement led by the board and running across the health and wellbeing system.
  - The refresh of the HWS gives the board (as the body charged with leading the local improvement of health and wellbeing) an opportunity to engage with stakeholders, and become more visible and accessible to the public.
  - The board might want to use this opportunity to create a communications and engagement strategy closely related to the revised HWS.

4.9 5. To what extent is the Health and Wellbeing Board enabling closer integration and the change to a cohesive and effective health system?

- The HWB has endorsed the BCF programme, and is monitoring progress on integration. However, the board has not been driving this work, and needs to form a unified view of what integration should look like in Reading. The detailed work is being done by council and CCG staff, and considerable progress has been made on BCF objectives, but the board has not yet provided an agreed framework for local integration.
- The Integration Board provides quarterly performance reports but isn't a formally-designated sub-group of the HWB. This raises the question as to whether the HWB is leading the local integration agenda. If not, is there a risk that board members will become detached from the integration work?

4.10 Working together across Berkshire West

The three local authorities involved in this peer challenge asked for the team to look at the arrangements across Berkshire West and advise them on options for

improvement. The peer review team has endorsed the view that a good start has been made by the Berkshire West 10 Group, that more could and should be done to develop this dimension of the work, and that it needs to be linked more directly to the governance of the HWBs.

4.11 6. Are there any opportunities for the three boards to work together and if so do they meet clearly identified needs and can they be shown to be beneficial to local residents in all three area?

People from the three local authorities, their CCGs and other partners all said that it was important to work together on the wider footprint to tackle issues that could best be handled on that scale. Whilst there was certainly no appetite for the merger of the three HWBs across Berkshire West, the requirement for closer integration in the BCF, the development of Sustainable Transformation Plans (STPs) and the common agreement that there is a case for the three local authority areas to work more closely together on key themes, in order to maintain good governance, hold the system to account and drive change for the people in Berkshire West.

It was felt by the peer team that there were important differences in understanding about some key issues such as the meaning of integration, the depth of the shared work to be undertaken and the scope for local variety within shared programmes. More attention needs to be given to scoping and defining joint work programmes in future, and having in place a formal process of commitment. Operational delivery plans need to be tested for their congruence with strategies and assured for their feasibility before being approved by HWBs.

An example of good practice was cited for long-standing joint working arrangements in public health across Berkshire. Individual public health teams take on lead roles for the whole patch for specific themes. It would be helpful for these arrangements to be notified to the HWBs if this has not already happened. This is a source of strength for all three areas, which is probably almost invisible to the boards.

4.12 7 & 8. Are there opportunities for the three boards to work together to further develop their individual leadership roles for the integration of health and social care? Is there an opportunity for the three boards to frame and energise the integration agenda across the whole of Berkshire West?

The Integration Board and the Delivery Board have the potential to frame the agenda for cross-authority working on integration in the West of Berkshire. Participants spoke well of the Berkshire West 10 Group and was reported as tackling important issues. There was concern about governance and political accountability, especially the lack of a formal connection with the three HWBs, and through them with the councils.

There is a long list of practical issues for which a shared approach to problem-solving might be of value. However, in many cases the local arrangements currently in place might limit the options available.

The peer challenge team thought that the three HWBs might also need to be prepared to meet together (and with their CCGs) from time to time, for joint briefings and development sessions on the key emerging issues.

There is a similar point about the development of local leadership through sharing and learning with neighbouring HWBs. It is certainly possible that subject briefings

and development sessions could be done jointly, despite local differences in need, strategic approach and politics. There are a number of shared themes where there could be advantages in cost and convenience in running local workshops for board members from all three HWBs. Given the confusion that can often be found between the role of HWBs and Overview and Scrutiny, it might also be useful to hold a session on this particular theme. Other themes might include common mental health issues, loneliness, physical activity and health, and spatial planning – these illustrations are all of relevance for HWBs and local health improvement.

Finally, the 3 HWBs and their partners will need to consider whether the current joint delivery arrangements have sufficient capacity and are sufficiently robust to deliver these kinds of programmes across the West of Berkshire at appropriate pace and depth.

Next Steps

4.13 The key recommendations, below, from the review have been included in the proposed framework which is attached at appendix 2

- Develop the style of Reading's Health and Wellbeing Board and the way it operates:
    - Look at best practice and what works elsewhere
    - Alternate Venues: meet elsewhere from time to time
- Set aside time to develop the HWB as a team.
- Have some wide ranging debates about your vision and the emerging context for HWBs.
- Plan the board agendas around your strategic vision, health and wellbeing strategy and statutory priorities.
- Make time to develop the prevention theme and include child health and wellbeing.
- Define what is meant by "prevention" and "integration".
- Review and develop the partnership structure under the HWB in line with the new strategy and objectives of the board.
- Consider a vice chairing arrangement with CCG.
- Review policy and management support for the HWB.

It is proposed to hold a board member stocktaking event and establish task and finish groups to address the recommendations.

4.14 The peer challenge includes the option of follow-up support. This can involve all or part of the team engaging in an activity such as:

- Holding an action planning workshop with the HWB.
- Organising a workshop on a specific theme or area, involving experts or other peers as appropriate.
- Arranging a follow-up visit at a later time to look at progress.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Participation in the Peer Review supports the Corporate Plan priorities:

- Providing the best start in life through education, early help and healthy living; and
- Keeping the town clean, safe, green and active.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Section 138 of the Local Government and Public Involvement in Health Act 2007 places a duty on local authorities to involve local representatives when carrying out "any of its functions" by providing information, consulting or "involving in another way".

7. EQUALITY IMPACT ASSESSMENT

7.1 Under the Equality Act 2010, Section 149, a public authority must, in the exercise of its functions, have due regard to the need to—

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

7.2 An Equality Impact Assessment (EIA) is not relevant to this report.

8. LEGAL IMPLICATIONS

8.1 None

9. FINANCIAL IMPLICATIONS

9.1 The peer challenge is fully subsidised by the Department of Health.

10. BACKGROUND PAPERS

10.1 Review of the Reading and West of Berkshire Health & Wellbeing boards, report to Health & Wellbeing board, 9th October 2015.

10.2 Care and Health Improvement Programme (CHIP) Health and Wellbeing Peer Challenge: methodology and guidance, LGA, July 2015.

10.3 Health & Well Being Peer Challenge Letter, LGA

Cllr Graeme Hoskin, Lead Councillor for Health and Chair of the HWB
Ian Wardle, Managing Director
Reading Borough Council
Civic Offices
Bridge Street
Reading
RG1 2LU

March 2016

Dear Graeme and Ian,

Health and Wellbeing Peer Challenge 1st – 4th March 2016

On behalf of the peer team, I would like to thank you for the courtesy and support we received during the recent Health and Wellbeing Peer Challenge, as part of the LGA's Health and Wellbeing System Improvement Programme. The Peer challenge covered Reading individually, and in the context of the health and wellbeing system across Berkshire West.

The LGA programme is based on the principles of sector led improvement that:

- Councils are responsible for their own performance and improvement and for leading the delivery of improved outcomes for local people in their area
- Councils are primarily accountable to local communities (not government or the inspectorates) and stronger accountability through increased transparency helps local people drive further improvement
- Councils have a collective responsibility for the performance of the sector as a whole (evidenced by sharing best practice, offering member and officer peers, etc.)

Challenge from one's peers is a proven tool for sector led improvement. Peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge at Reading Borough Council were:

- Chris Bull, Lead peer & LGA Associate
- Cllr. Sue Woolley, Executive Member for NHS Liaison & Community Engagement, Chair, Lincolnshire Health & Wellbeing Board
- Cllr. Rory Palmer, Deputy Mayor Leicester City Council and Chair, Leicester City Health & Wellbeing Board
- Dr. Ian Orpen, Chair Bath and North East Somerset CCG and Co-Chair Health and Wellbeing Board

- Gill Moffett, Healthwatch Policy Lead, Department of Health
- Liam Hughes, LGA Associate
- Deb Watson, Director of Public Health peer & LGA Associate
- Kay Burkett, Programme Manager, LGA
- John Tench, Adviser, LGA

Scope and focus of the peer challenge

Health and wellbeing peer challenges focus on the health and wellbeing board and partners who form the local health and wellbeing system. They recognise that 2015/16 brings a window of opportunity to put health and wellbeing boards in the driving seat of local system leadership; able to take on a place-based approach to adult social care and health, and address the wider determinants of health. The peer challenges are focused on enabling the leadership of health and wellbeing boards to move into this space effectively.

In this context the peer challenge focused on five headline questions:

1. To what extent is the purpose and role of the Health and Wellbeing Board established?
2. How strong is work with key partners to develop system leadership?
3. To what extent is the Health and Wellbeing Board ensuring the delivery of the health and wellbeing strategy?
4. To what extent is there a clear approach to engagement and communication?
5. To what extent is the Health and Wellbeing Board enabling closer integration and the change to a cohesive and effective health system?

The peer challenge took place across Reading Borough Council, West Berkshire Council and Wokingham Borough Council with the peer team spending a day in each area and addressing the following questions the 3 health and wellbeing systems wanted to explore:

1. Are there any opportunities for the three boards to work together and if so do they meet clearly identified needs and can they be shown to be beneficial to local residents in all 3 areas?
2. Are there any opportunities for the three boards to work together to further develop their individual leadership roles in the integration of Health & Social care?
3. Is there opportunity for the three boards to frame and energise the integration agenda across Berkshire West?

It is important to stress that this was not an inspection. Peer challenges are improvement focused. The peers used their experience and knowledge to reflect on the information presented to them by people they met, things they saw and material they read.

This letter provides a summary of the peer team's findings specific to Reading building on the verbal feedback delivered by the team on 3rd March and includes the collective feedback given to all 3 areas. In presenting this feedback, the peer challenge team acted as fellow local government and health officers and members, not professional consultants or inspectors. We hope this will help provide recognition of the progress Reading Borough Council and its Health and Wellbeing Board (HWB) have made whilst stimulating debate and thinking about future challenges.

Headline Messages

The Reading Health and Wellbeing Board (HWB has made progress in a number of key area such as overseeing the development of Reading`s Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy (HWS). It has endorsed the Better Care Fund Plan and put its weight behind some neglected themes, especially autism and end of life care. It has provided a single forum for adult and children`s agendas to potentially come together, so that synergies can be identified. The board has also supported some important work on health inequalities, especially with black and minority ethnic communities (BAME).

There is a clear commitment, politically and from officers and clinicians, for the board to provide strategic leadership and to make a positive difference to improving the health and wellbeing of Reading`s people. However, the board has yet to show that it is leading the local system for health and wellbeing, and enabling the council, the Clinical Commissioning Groups and other partners to work better together.

The Health and Wellbeing Strategy (HWS) is not an integral part of the Council`s Plan, nor is it reflected in the priorities of partner organisations. The agenda of the board does not reflect the content of the HWS. Child health and wellbeing has had limited attention, perhaps because the JSNA was initially focused on adults. It is now being revised to cover children and young people in more depth. Health inequalities in Reading are more pronounced for men, with extremes of wealth and poverty in a small geographical area. Poor health outcomes reflect local patterns of deprivation. There is still a large gap in life-expectancy for men, and in this respect, Reading is an outlier in relation to similar areas. Although the vision for a healthier Reading refers to reducing health inequalities, the content of the HWS does not set out how this will be achieved and the agenda of the board does not reflect these key challenges.

The position of the HWB in the local system is constrained. It does not seem to be driving improvement in local health and wellbeing, but reacting to agendas set by others. Whilst it is a committee of the Council, it seems that its role has been primarily to receive information about decisions made elsewhere in the Council and CCG, and to endorse proposals made elsewhere. It has been given only limited delegated authority. The Council`s other committees and the CCG are the places where decisions about health and wellbeing seem to be made. The HWB does not feel to some of its members to be functioning like a partnership board with equal members.

Despite its limited scope for decision-making, it is a highly formalised Council committee, with little opportunity for members to meet informally, either in board development sessions or informal meetings where board members can extend their knowledge and appreciation of the key issues. Several board members do not see it as a place where difficult discussions can be held and issues sorted out. Some have reported that they feel uncomfortable both in the HWB and in the Health sub-committee that sets the board`s agenda. One way to help overcome this may be to consider appointing a Vice Chair from an organisation other than the council, such as a CCG.

It is clear that there is motivation for change from all of the partners that we spoke to on our visit. We know that the most effective HWBs are strong, place-based partnerships convened and enabled by councils. They are regarded by all board members as the place where agencies come together to improve the health and wellbeing of local people. They provide opportunities for board members to learn from each other and develop a shared culture and approach. They seek to ensure that health and social care work together to meet the needs of the local population. The HWB in Reading may wish to consider whether its current ways of working are consistent with fulfilling this

role. There is a good platform to build on given the strong statements of commitment that partners made about working together.

In relation to working on the Berkshire West footprint, there is common feedback to the three local authorities and HWBs that were part of the peer challenge. In summary, we found a consistent commitment from all organisations across the patch to work together, and there was a shared recognition of the potential benefits from doing this. However, there was not an agreed understanding about the nature of integration, nor about the scale of the local ambition. There was also concern about the extent to which the work taking place at the Berkshire West level was being properly connected to the HWBs and other governance bodies. There is a risk that proposals from the Integration Board might not be followed through when they reach the formal decision-makers for endorsement. For arrangements to be effective and to mitigate against the risk set out above, it seems to us that it would help to have appropriate political involvement at the joint Integration Board as well as protocols for involving individual HWBs, CCGs and related organisations at the right time in their business cycles. It would also help to have an agreed programme of work, and clear statements about the aims and scope of joint projects.

1. **To what extent is the purpose and role of the Health and Wellbeing Board established?**

The peer review team heard positive statements about Reading`s HWB. It has been established in shadow and statutory form for almost four years and it is a strength to have in one forum the responsibility for adult support, children and young people`s services and public health. The board has carried out its formal duties and produced a JSNA, Health and Wellbeing Strategy and Better Care Fund Plan. Significant work is currently underway to revise the JSNA. The revised JSNA will provide a comprehensive picture of local health needs and wellbeing issues. A high-level position statement on the health needs of the people in Reading is currently in place and the priorities that have emerged from the plan have been used to shape the Health and Wellbeing Strategy and its revision. The board has given emphasis to two additional themes, autism and end-of-life care, both of which were under-developed locally. It has also encouraged improvements related to black and minority ethnic communities, in order to reduce health inequalities. The work of the local hubs looks encouraging.

The Better Care Fund Plan has been overseen by the HWB, which has asked for regular and detailed reports. The Plan for Reading is ambitious and it will be a hard stretch to implement it. Other areas of activity have not been performance managed in this depth, and this imbalance has been reflected in board agendas in relation to the more limited attention given by the board to other priorities. There is still a big gap in male life-expectancy in Reading between the areas of greatest deprivation and affluence, and it is not clear how this gap is to be closed. The peer review team was told that there were also some concerns about support for asylum seekers who often have significant physical and mental health needs.

The HWB does not feel to a number of its members like a properly-balanced partnership board. Despite its limited scope for decision-making, it is experienced by all the members we spoke to as a highly formalised committee of the council, with little opportunity for members to meet informally, either in board development sessions or informal meetings where board members can extend their knowledge and appreciation of the key issues. Several board members were concerned that they had insufficient time to unpack issues or express their views in the public meetings, and that there was

significant scope for misunderstanding as a result. They reported that they did not see the board as a place where difficult discussions could be held and difficult issues could be sorted out. Some members said that they feel uncomfortable in the HWB, and also in the Health sub-committee that sets the board`s agenda. A great deal of attention was given to generating appropriate public messages from HWB meetings, and the presence of the press no doubt made HWB members cautious about their interventions in public board business. Several of them said that there was only limited opportunity for informal conversations and briefing sessions.

The position of the HWB in the local system is unclear. It is currently not shaping and driving the improvement of the local health and wellbeing system. This is being done in other places. Its role so far has been primarily to receive information about decisions and to endorse proposals made elsewhere. Board members reported that there were only a few initiatives that had had their origins in the board, e.g., end-of-life care, autism, BAME initiatives. Perhaps this was not so surprising, given that the board has only limited delegated authority to take decisions. The combination of a highly formalised approach to business, and limited scope for decision-making, has made some partners feel that the HWB is not well-placed to lead the local system for health and wellbeing. The appointment of a Vive Chair from a partner agency other than the Council might assist in emphasising that the HWB is a partnership body.

The Health and Wellbeing Strategy (HWS) is not an integral part of the Council`s Plan, nor is it reflected in the priorities of partner organisations (even though it is referenced in many of them). The agenda of the board does not reflect the content of the HWS. Child health and wellbeing has had limited attention – about safeguarding, Child and Adult Mental Health and the new public health nursing duties. Some board members felt that other public health issues need more attention at the HWB. The most important of these is probably the large gap in life-expectancy, particularly for men, in the area. In this respect, Reading is an outlier for men , even when measured against similar places.

The upshot of these observations is that Reading`s HWB is not really well-established in its role as the leader of the local health and wellbeing system. It is acting rather more as a “clearing house” for information, and a body that endorses work initiated and carried out elsewhere. Furthermore, whilst the scope of the peer challenge team did not include this issue, there did appear to be some confusion between the function of the HWB in receiving information about local developments, and challenging partners about them, and the Reading arrangements for Overview and Scrutiny.

2. How strong is work with key partners to develop system leadership?

The board has some evident strengths. It meets regularly and is well attended. Board members have been working together for some time, many informal relationships are good and people seem to enjoy working together – up to a point! The board has learned from its experience of the development of the previous strategy, when some partners felt they had been given little chance to have any influence on it. A good level of engagement with partners and key stakeholders is now being planned in the development of the new HWS. Elected members and GPs are well connected with local people in their neighbourhoods, and they share the daily experience of hearing about their lives and experiences at first hand. Healthwatch is finding its feet and making an important contribution. The voluntary sector forum is a positive way for the sector to influence health and wellbeing system. The police and fire-and-rescue services are involved in the work of the HWB. Reading officers are active participants in the Berkshire West 10 integration partnership which is seeking to deliver integration programmes across the patch.

However, there is an obvious 'clash of cultures' within the system between the CCG and the council. This should not be exaggerated - people said that relationships had improved when the CCG was established, and that they were working hard to make things better. However, they agreed that there is still more work to be done. It is difficult to have effective systems leadership when partners in the board do not feel entirely comfortable with the organisations represented around the table, and haven't fully agreed a shared vision for place and health and wellbeing. This challenge has become even more difficult under conditions of austerity.

The signs of this cultural unease can be seen in the arrangements for the working of the board. Partners have said they have sometimes received important information when it was too late to take any action, and that items often come to the board for information and endorsement when the real decisions have already been taken elsewhere – usually by a council committee or the CCG. There may be a lack of awareness of the timelines associated with processing formal business. It may also be the case that board members do not entirely understand one another`s duties and accountabilities, much less their cultures and constraints. Sometimes there has been a lack of clarity about the purpose behind items being presented to the board. The peer challenge team certainly saw examples of miscommunication and misunderstanding during the visit, most significantly in relation to funding discussions.

One outstanding issue seemed to be having a particularly unsettling effect – continuing healthcare payments. This has been settled in many other places but is still a problem in Reading, and it seemed to the peer challenge team that this was potentially an obstacle to productive partnership working.

Relationship building requires time and the willingness to work together. In Reading, there isn't much time allowed for partners to work together informally so they can develop an appreciation of key issues before they are put into the formal arena of the HWB. Without this opportunity, it is hard to develop trust and confidence, and local relationships are more likely to be brittle and less productive.

Whilst here is good committee services support to the HWB, there seems to be a gap in terms of support for business planning and board development. Other boards have reported that there is a delicate balance between operating as a committee of the council and as a unitary partnership board incorporating a wide range of partners. Many have taken time out to develop a shared board culture to handle this issue.

Finally, it was not clear how the HWB is connected to providers as key stakeholders in the area. As the NHS Sustainability and Transformation Plan initiative is likely to have important consequences for the closer integration of health and community services providers with commissioners, the board might want to reflect on provider engagement, especially in relation to the Royal Berkshire, given its central role in the local health system.

3. To what extent is the Health and Wellbeing Board ensuring the delivery of the health and wellbeing strategy?

There have been a lot of good things happening in Reading. Examples include initiatives such as Living Well, Right for You, Beat the Streets, HIV volunteers, and successful `flu and breastfeeding campaigns. South Reading CCG has met its

dementia diagnosis target. The board is making good use of the Local Strategic Partnership to deliver work on FGM, and breaking down barriers related to information sharing. The Public Health Team is delivering well on its business plan, much of which reflects the HWS, and the Integration Board has a key role in driving improvement. Clearly, there has been a great deal of activity aimed at the improvement of health and wellbeing in Reading.

The BCF has given attention to upstream prevention and the strengthening of community assets. The neighbourhood teams have a key role in building and mobilising community initiatives, with paid staff and volunteers. Initiatives with BAME communities are well-developed, and the work with the Gurkha and Polish families and communities is a source of strength. The HWB has requested quarterly performance reports on BCF progress, and this has been seen as a positive development which has encouraged the timely delivery of key outputs.
Similarly, when extra resource went into CAMHS, the HWB requested more detailed information about progress.

However, there are some issues for the board to consider. Firstly, it does not have a performance review programme for the delivery of the HWS and it has received relatively little attention at the HWB. It is not clear which other people and groups have defined responsibilities for the delivery of parts of the HWS, nor how they report their progress to the HWB. As the HWS is being refreshed, it might be helpful for the board to consider designing a coherent performance management system, with an integrated dashboard of key indicators. Finally, the Peer Challenge Team has not seen much evidence for a co-ordinated approach to building on community assets. Given the strength in the voluntary, community and faith sectors, and the local business world, the HWB may be missing useful opportunities.

4. To what extent is there a clear approach to engagement and communication

There are some strengths in relation to communications and engagement. There is time at HWB meetings for public questions, in line with the Council`s policy
There is a dedicated resource now being provided for public health and social care communications, and this should make a difference. There are good examples of engagement with diverse communities such as the engagement carried out by Healthwatch with the Gurkha community to identify need and help people gain access health and social care services. There are also apps in Polish and Nepalese to assist with access.

However, the HWB does not engage with stakeholders and the public as a collective group. There is not yet a cohesive approach to communication and engagement led by the board and running across the health and wellbeing system. The refresh of the HWS gives the board (as the body charged with leading the local improvement of health and wellbeing) an opportunity to engage with stakeholders and members of the public, and become more visible and accessible to the public. The board might want to use this opportunity to create a communications and engagement strategy closely related to the revised HWS and ensuring the programmes of work in the strategy have good and robust engagement which means more communication with the public about its work.

5. To what extent is the Health and Wellbeing Board enabling closer integration and the change to a cohesive and effective health system?

The HWB has endorsed the BCF programme, and is monitoring progress on integration. However, the board has not been driving this work, and needs to form a

unified view of what integration should look like in Reading. The detailed work is being done by council and CCG staff, and considerable progress has been made on BCF objectives, but the board has not yet provided an agreed framework for local integration. It was explained that in part, this was due to the complexity of the wider health and wellbeing system across Berkshire West, and the different assessment arrangements that are in use. The Integration Board provides quarterly performance reports but isn't a formally-designated sub-group of the HWB. This raises the question as to whether the HWB is leading the local integration agenda? If not, is there a risk that board members will become detached from the integration work?

Working together across Berkshire West

The three local authorities involved in this peer challenge asked for the team to look at the arrangements across Berkshire West and advise them on options for improvement. The peer review team has endorsed the view that that a good start has been made by the Berkshire West 10 Group, that more could and should be done to develop this dimension of the work, and that it needs to be linked more directly to the governance of the HWBs.

6. **Are there any opportunities for the three boards to work together and if so do they meet clearly identified needs and can they be shown to be beneficial to local residents in all three area?**

People from the three local authorities, their CCGs and other partners all said that it was important to work together on the wider footprint to tackle issues that could best be handled on that scale. Whilst there was certainly no appetite for the merger of the three HWBs across Berkshire West, the requirement for closer integration in the BCF, the development of Sustainable Transformation Plans (STPs) and the common agreement that there is a case for the three local authority areas to work more closely together on key themes, mean that the three boards may find that they need to work more closely together in order to maintain good governance, hold the system to account and drive change for the people in Berkshire West.

Although there were no dissenting voices, the peer challenge team felt that there were important differences in understanding about some key issues such as the meaning of integration, the depth of the shared work to be undertaken and the scope for local variety within shared programmes. Examples were given of shared commitments that had failed to materialise once more detailed work had been done into the feasibility of proposals. This suggests that more attention needs to be given to scoping and defining joint work programmes in future, and having in place a formal process of commitment to prevent the loss of trust that comes with the late abandonment of projects. Operational delivery plans need to be tested for their congruence with strategies and assured for their feasibility before being approved by HWBs.

There is already an example of good practice. There are long-standing arrangements for joint working in public health across Berkshire. Individual public health teams take on lead roles for the whole patch for specific themes. This seems to be working well, it concentrates expertise, and it makes best use of scarce resources. It would be helpful for these arrangements to be notified to the HWBs if this has not already happened. This is a source of strength for all three areas, which is probably almost invisible to the boards.

7 & 8. Are there opportunities for the three boards to work together to further develop their individual leadership roles for the integration of health and social care? Is there an opportunity for the three boards to frame and energise the integration agenda across the whole of Berkshire West?

The Integration Board and the Delivery Board have the potential to frame the agenda for cross-authority working on integration in the West of Berkshire. Participants spoke well of the Berkshire West 10 Group, and reported that it had picked up pace and was tackling important issues. There was concern about governance and political accountability, especially the lack of a formal connection with the three HWBs, and through them with the councils. It was understood that an elected member would soon be joining the Group to make a link with the local democratic system. However, as set out in the key messages section of this letter further measures are required to ensure that joint plans are properly held to account.

The new Prevention Board looks like an important initiative. Peer team members were interested in its relationship with the HWBs, and with the patch`s public health arrangements. There was insufficient time to follow this up.

There is a long list of practical issues for which a shared approach to problem-solving might be of value. However, in many cases the local arrangements currently in place might limit the options available. From the outside, the requirement for three different systems for access to assessment and care services at the Berkshire Royal looks like a confusing and expensive arrangement. For each local authority, of course, it makes sense in the light of local circumstances. The three councils and the CCGs will need to consider these kinds of issues with an open mind, look for common ground but be prepared to understand that single solutions may not always be possible given the nature of the area of Berkshire West.

The peer challenge team thought that the three HWBs might also need to be prepared to meet together (and with their CCGs) from time to time, for joint briefings and development sessions on the key emerging issues. Without this opportunity, they might find themselves ill-prepared for discussions in a bigger group covering a larger footprint. (There is a related question for Overview and Scrutiny Committees, which might need to combine for specific purposes such as the review of reconfiguration proposals if they do not do so already).

There is a similar point about the development of local leadership through sharing and learning with neighbouring HWBs. It is certainly possible that subject briefings and development sessions could be done jointly, despite local differences in need, strategic approach and politics. There are a number of shared themes where there could be advantages in cost and convenience in running local workshops for board members from all three HWBs. Given the confusion that can often be found between the role of HWBs and Overview and Scrutiny, it might also be useful to hold a session on this particular theme. Other themes might include common mental health issues, loneliness, physical activity and health, and spatial planning – these illustrations are all of relevance for HWBs and local health improvement.

Finally, the 3 HWBs and their partners will need to consider whether the current joint delivery arrangements have sufficient capacity and are sufficiently robust to deliver these kinds of programmes across the West of Berkshire at appropriate pace and depth.

9. Moving forward

In moving forward our key recommendations are:

- Develop the style of Reading's Health and Wellbeing Board and the way it operates:
  - Look at best practice and what works elsewhere
  - Alternate Venues: meet elsewhere from time to time
- Set aside time to develop the HWB as a team
- Have some wide ranging debates about your vision and the emerging context for HWBs
- Plan the board agendas around your strategic vision, health and wellbeing strategy and statutory priorities
- Make time to develop the prevention theme and include child health and wellbeing
- Define what is meant by "prevention" and "integration"
- Review and develop the partnership structure under the HWB in line with the new strategy and objectives of the board
- Consider a vice chairing arrangement with CCG
- Review policy and management support for the HWB

7. Next steps

The Council's political leadership, senior management and members of the HWB will undoubtedly wish to reflect on these findings and suggestions before determining how to take things forward. As part of the peer challenge process, there is an offer of continued activity to support this. If you wish to take this up then I look forward to finalising the detail of that activity as soon as possible.

In the meantime we are keen to continue the relationship we have formed with you and colleagues through the peer challenge to date. Mona Sehgal, Principal Adviser for the South East, is the main contact between your authority and the Local Government Association. Mona can be contacted at mona.sehgal@local.gov.uk (or tel. 07795291006) and can provide access to our resources and any further support.

In the meantime, all of us connected with the peer challenge would like to wish the Council and Health and Wellbeing Board every success going forward. Once again, many thanks for inviting the peer challenge and to everyone involved for their participation.

Yours sincerely,

Kay Burkett
Programme Manager
Local Government Association

Tel: 07909 534126 Email: kay.burkett@local.gov.uk

On behalf of the peer challenge team

Appendix 2 – HWB Peer Challenge Draft Framework

Activity	Outcome	Resources	Timescale	Progress
Develop the style of Reading's Health and Wellbeing Board and the way it operates: • To look at best practice and what works elsewhere • Alternate Venues: meet elsewhere from time to time	Place based partnership Shared culture and approach Agencies come together to improve health and wellbeing of local population	Policy Unit Committee Services	2016 2016	
Review Membership of the Board • Consider a vice chairing arrangement with CCG	Knowledge and appreciation of key issues across agencies	Wellbeing Team	2016/17	
Setting out the process for HWB to connect/ inform /report to other governing bodies	Shared common understanding	Wellbeing Team		
Review and develop the partnership structure under the HWB in line with the new strategy and objectives of the board	Fit for purpose structures in place	Wellbeing Team	2016/17	
Set aside time to develop the HWB as a team	Shared common understanding	Health and Wellbeing Board	2016/17	
Creating opportunities for 3 HWB to meet and discuss common themes of relevance (such as common mental health issues, loneliness, physical activity and health and spatial planning)	More closer working to maintain good governance, hold system to account and drive change	West of Berkshire Health & Wellbeing boards		
Facilitate wide ranging debates about vision and the emerging context for HWBs	Shared understanding of purpose and priorities based on the JSNA		Ongoing	
Plan the board agendas around • strategic vision • health and wellbeing strategy and statutory priorities	Agendas reflect partner priorities More focussed agendas	Chair / Vice Chair / Committee Services	ongoing	
Make time to develop the prevention theme and include child health and wellbeing	Holistic approach to improving health and wellbeing outcomes of the local population	Wellbeing Team / Partners	2016	
Define what is meant by "prevention" and "integration"	Shared understanding across the health and wellbeing system	Wellbeing Team / Partners	2016	
Review policy and management support for the HWB	Structures in place which support business planning and board development			

Appendix 2 – HWB Peer Challenge Draft Framework

Activity	Outcome	Resources	Timescale	Progress
Revised Health and Wellbeing strategy • Outline how reducing health inequalities will be achieved	Joint Health and wellbeing strategy in place	Wellbeing Team / partners	2016	Draft in progress
Developing our communications and engagement strategy, policy and procedure	Agreed communications and engagement strategy	Wellbeing Team / partners		
Procedure for managing the delivery of the Health and Wellbeing strategy	Clearly defined roles and responsibilities linked to delivery Robust agreed implementation plan	Wellbeing Team / partners		
Performance management system and integrated dashboard of key indicators	Functioning performance management system with integrated key indicators in place	Wellbeing Team / partners	2016	
Refresh statement about the role of Providers	Shows how the HWB connects to key stakeholders in the area	Wellbeing Team / partners	2016	
Building on our community assets involving voluntary, community, faith sectors and business	Coordinated approach	Stakeholder group		

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	HEALTH AND WELL BEING BOARD		
DATE:	15 JULY 2016	AGENDA ITEM:	6
TITLE:	ALIGNING COMMISSIONING INTENTIONS WORKSHOP		
LEAD COUNCILLOR:	COUNCILLOR EDEN	PORTFOLIO:	ADULT SOCIAL CARE
SERVICE:	ADULT SOCIAL CARE	WARDS:	ALL
LEAD OFFICER:	WENDY FABBRO	TEL:	0118 937 2072
JOB TITLE:	DIRECTOR OF ADULT SOCIAL CARE & HEALTH	E-MAIL:	WENDY.FABBRO@READING.GOV.UK

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 As agreed at Health and Wellbeing Board in January 2016, to update HWB partners on the plans to run a workshop to share the critical themes to be built into organisations' commissioning intentions plans so that:

- HWB can see the 'golden thread' from JSNA and HW Strategy to commissioning for solutions
- Plans can be worked up to build synergy and alignment without fear of potential conflict

2. RECOMMENDED ACTION

2.1 To endorse the plans for the workshop and to receive feedback at the October meeting

3. POLICY CONTEXT

4. THE PROPOSAL

4.1 Current Position: A workshop has been arranged for Sept 2nd 2016 in the Council Chamber. Commissioning leads from Reading Integration Board, partner authorities in West of Berks, and HWB members will be invited. The day will aim to receive succinct presentations on JSNA and Strategic intentions, Partner imperatives and expectations (eg NHSE requirements, Regulator (eg CQC/Monitor/Ofsted), in order to spend the majority of time

discussing and evaluating priorities. It is planned to have a “beauty parade” of the options at the end of the day for the workshop to vote on priorities they would like to ask commissioners to consider as they formulate the detail in plans.

Feedback from the day will be reported to the October HWB and could be used to evaluate the final submissions in January 2017.

healthwatch

Healthwatch Reading

Annual Report 2015/16

Contents

Message from our Chair

David Shepherd, Chair of Trustees

I am pleased to present this year's annual report. This year has seen great strides in ensuring local peoples voices are heard.

Over the past two years Healthwatch Reading had received an increasing number of calls about local GP services. Therefore, the Board decided they would focus the year's activities on primary care. The staff team carried out 31 Enter and View visits of GP surgeries and spoke to more than 500 patients. The report of the findings will go to inform the design and commissioning of primary care services. We have been able to achieve this through local people giving up their time to talk to us and by building strong working relationships with providers and commissioners, so that we are heard.

In addition, we published a report outlining the experience of women who were diverted from their preferred place of birth during labour. This led to our acute trust making more information routinely available to pregnant women about the possibility of this happening.

Our advocacy services have gone from strength to strength. In July 2015 we held the first ever local event of its kind, bringing together NHS and council complaints staff to compare how they handle concerns raised and discuss how complaint handling could be improved.

> **"We are working hard to listen to local people."**

The satisfaction with our service led to Healthwatch Reading being awarded a contract from April 1 2015, to co-ordinate Care Act Advocacy, under an arrangement we have called Reading Voice. We are delivering this contract in partnership with Age UK Reading, Reading Mencap and Talkback. This service involves giving a voice to some of the most vulnerable people in our community.

We also saw staff changes – saying farewell to Catherine Greaves, and welcoming Pat Bunch as new Healthwatch Officer.

Our trustees are still driving the vision of Healthwatch Reading forward and our Board remain strong in ensuring that we are working hard to listen to local people and influence the shape of local services.

As we enter our third year we are faced with a new challenge, including a 15% budget cut, which inevitably means we have to look at how best to support local people. We will work hard to ensure that we maintain the standards we have set.

We thank our local community, our partners and friends of Healthwatch Reading for making this another successful year.

The year at a glance

This year we've reached 2,589 people on social media

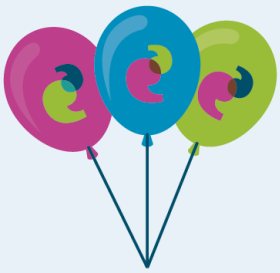
Our volunteers helped us crunch data, set up stalls and hand out leaflets

We've spent more than 1,500 hours helping people resolve concerns or complaints

We've visited 38 services to carry out 'Enter and View' activities

Our maternity report was based on in-depth stories from 19 women

We've engaged with hundreds of local people at community events



Who we are

Healthwatch is here to make health and social care better for ordinary people.

Everything we say and do is informed by our connections to local people and our expertise is grounded in their experience.

We are the only body looking solely at people's experience across all health and social care.

We are uniquely placed as a national network, with a local Healthwatch in every local authority area in England.

As a statutory watchdog, our role is to ensure that local health and social care services, and the local decision makers, put the experience of people at the heart of their care.

Our mission

Healthwatch Reading's mission is to campaign for better care for our community. We do this by:

- Advising people of their rights, giving them information, and signposting them to other services;
- Advocating on behalf of local people to raise concerns, make a complaint or support them to have their voice heard;
- Actioning, by listening hard to people, especially the most vulnerable, to understand their experiences and what matters most to them, and influencing those with the power to change things, now and in the future.

Our priorities

Our priorities are based on what the community says is important to them and are driven by the Healthwatch Board, a committed group of local volunteers.

Our priorities focus on the following key areas:

1. People are empowered to share feedback, complain or have their voice heard – we will work with individuals in our local community, the local voluntary and community sector, as well as statutory partners, to gather local people's views and support them in having their voice heard. This year we focused on visiting 31 GP surgeries to encourage people to have their say on primary care. We also helped build confidence of people, through our advocacy services, so they could express their needs about how they wanted their care delivered or have complaints about their care heard.

2. Ensuring everyone has an equal voice – we will work with the diverse community of Reading to understand how they experience local services. This year we brought together a panel of diverse people in Reading to carry out an 'equality and diversity' scoring exercise on a local health service.

3. People are involved in shaping services for today and the future. We used our seat on a commissioning committee to influence the shape of new primary care contracts.

Listening to people who use health and care services

Gathering experiences and understanding people's needs

One of the key ways we collected people's experiences this year was through visits to 31 GP surgeries across Reading. We wanted to reach a wide variety of people and our survey demographics showed:

- Around one-third of people we spoke to were from an ethnic minority
- Around one in five people we spoke to said they had a disability
- One quarter were aged over 64 and nine per cent were aged 11-24

We also worked with other partners and services to collect experiences. Our maternity services project involved us working with NCT groups, children's centres, midwives, health visitors and the local maternity forum, to identify women willing to share their in-depth birth stories.

We again worked with the Reading Youth Cabinet to connect with secondary school aged children. At the cabinet's annual priority-setting meeting, we gave a talk and encouraged their instant feedback on their smart phones to our e-survey. This helped to identify continued problems accessing help for mental health issues.

This year we moved into a new home - in the Elevate hub on the 3rd floor of Reading Central Library - which has given us further opportunities to work in partnership with other organisations to capture experiences. Elevate aims to support 16-24 years with jobs and health advice; and the hub also provides IT skills training for the whole community, promotes volunteering and provides meeting and training rooms for local organisations. So when a young group of people visited the hub as part of a 'challenge', programme, Healthwatch used the opportunity to run a short quiz to gain insight into their understanding of their rights when using NHS services. Our new location has also resulted in an increased number of 'drop-ins' from people who say we are easy to find.

Most of the time though, we believe the best way to gather experiences is by going out into the community. We have encouraged people to give us feedback from stalls we have held outside supermarkets, in shopping malls, in churches and at local events such as Armed Force's Day, Older People's Day, and Carers Rights Day.

And through our advocacy services, we have gone to the homes or institutions where many 'hidden' and vulnerable people live.

What we've learnt from our visits

Our visits to GP surgeries showed that most people were satisfied overall with their care but had concerns with appointment booking, and continuity of clinician, that they would like addressed. There was also very low use of online appointment booking. We also discovered that Reading people do not have equal access to extended opening hours (at weekends or early mornings/late evenings), and that many surgeries operate from old buildings not fit for purpose. We have used the intelligence to make a raft of recommendations to commissioners.

Giving people advice and information

Helping people get what they need from local health and care services

One of our key roles is to provide advice and information to the public about how to find services, how to resolve concerns, people's rights when using NHS or social care, and which other organisations might be able to help them.

The number of individuals who sought help from Healthwatch Reading with specific issues, totalled 223 in 2015-16.

These issues included:

- requests for details on which local GPs are taking on new patients
- queries about waiting times for outpatient appointments
- problems with hospital admin which had resulted in missed or changed appointments
- concerns about attitude, manner or comments made by NHS staff
- concerns about disjointed arrangements between hospital and social care before or after hospital discharge
- queries on entitlement to certain medications or referrals
- potential missed diagnosis of terminal illnesses
- complaints about errors that might have caused a person's death.

We provided information and advice on a staffed helpline, Monday-Friday 9am-5pm, and also through our website, and talks at local events. We also made home visits to people with mobility issues, and arranged interpreters for our conversations with non-English speakers.

ADVICE CASE STUDY

A person approached a Healthwatch Reading stall after listening to a Healthwatch staff member give a talk at a local event. The person was struggling to get help in coping with their child, diagnosed with ADHD. The person had limited ability to speak English.

The Healthwatch Reading staff member sat down with the person to have an informal chat, using short, simple sentences. Healthwatch discovered that the person had no nearby relatives and was not getting any breaks from a sometimes-stressful home situation. The person was unaware that they were entitled to have their needs looked into through a 'carer's assessment' from the local authority, or that the family might be able to access respite breaks, so Healthwatch described examples of what type of help the person could potentially get.

Healthwatch introduced the person to a local authority officer at the same event to see if an assessment could be arranged. Healthwatch also gave the person contact details for several voluntary sector organisations that could assist with peer support in coping with their child's needs.

Lastly, Healthwatch described to the person how interpreters could be arranged for NHS appointments, if the person felt this would assist in discussing their child's health needs - and their own - with clinicians.

The person said the information and advice had made them feel more confident they would now get help.

Top five contact themes:

1. 23% of people (52/228) contacted us about the Royal Berkshire Hospital or other acute hospitals
2. 19% of people (43/228) contacted us about GP Services
3. 18% of people (40/228) contacted us about Care Act Advocacy services
4. 1% of people (22/228) contacted us about mental health services
5. 1% of people (14/228) contacted us about social care

If information and advice was not enough to help people resolve their concerns, we carried out 'informal advocacy'. This might mean calling a service on a person's behalf to help broker a solution to their issue, or to point out their rights.

When informal advocacy had been exhausted, or when a person felt their concern was too serious, we acted as complaints advocates for them, using the NHS Complaints procedures. This involves a person submitting a written complaint, which might call for an apology, an explanation and/or assurances that changes have been made to prevent a similar issue being repeated. Once organisations investigate and respond, the person decides whether to accept the findings, request a resolution meeting or go to the Parliamentary and Health Services Ombudsman.

CASE STUDY: INFORMAL ADVOCACY

An elderly woman rang Healthwatch Reading to say she was still waiting for a repeat prescription from her GP surgery that she had submitted six days' beforehand. Repeat prescriptions were normally supposed to be turned around within 48 hours.

The woman said she had had the same problem the month before and despite writing to the practice, the problem was happening again. The prescription included vital blood pressure medication. With the woman's permission, Healthwatch Reading spoke to senior staff at the organisation and the repeat prescription was arranged straight away.

CASE STUDY: FORMAL COMPLAINT

An adult in their 20s contacted Healthwatch to complain that Royal Berkshire Hospital had made a mistake with a test result relating to a condition, which the hospital later said was wrong. The person said the initial information had had a major and distressing impact on their life. Healthwatch helped the person write a formal complaint letter, explaining the distress and calling for a full explanation of how the mistake happened and how it would be prevented in the future. The hospital responded to 'unreservedly apologise' to the person, and also to confirm that a machine had malfunctioned, leading to the wrong result. The supplier had been informed and all subsequent tests were now being double-checked.

The hospital had also reminded staff how to give test results in a timely and sensitive way.

How we have made a difference

Our reports and recommendations

We used our project and Enter & View reports to make recommendations to providers and commissioners of services, which have been acted upon. These include:

- Our project report on the experiences of the ex-Gurkha community in accessing health and social care, found that making appointments and communicating with clinicians, was difficult due to language barriers and lack of knowledge about NHS processes. This led to our local clinical commissioning groups agreeing to improvements, including the development of a Nepali/English card that people can show receptionists to request an interpreter for NHS appointments;
- Our project report on the experiences of women who were diverted from giving birth at their preferred place, has led to our local acute trust introducing routine information to women during midwife appointments and in leaflets, about the possibility of diversions and where they might be sent to outside of Reading. The trust has also had talks with out-of-area trusts about sharing information in a timely way to ensure seamless follow-up care, and also briefed staff about the importance of good communication to women when diversions are taking place, to help reduce stress on women;
- Our Enter and View report on a visit to the Royal Berkshire Hospital Eye Clinic, uncovered many concerns about administration problems, including appointments cancelled at the last minute by the hospital, or patient calls to the department going unanswered – the hospital said it would use the feedback to inform a wider restructure of the hospital's administration teams
- Our Enter & View visit reports of 31 individual GP surgeries, have prompted GP surgeries to agree to a range of actions, such as: greater promotion of online appointment bookings, better communication of appointment delays, information posters in other languages and improved privacy of front-desk conversations. Wider recommendations on themes from all the visits are now being considered by Reading's two clinical commissioning groups.

Working with other organisations

Healthwatch Reading is committed to a collaborative approach with service providers, commissioners, regulators and other local system partners to bring about change.

- We shared information about people's experiences of mental health, community and GP services, with the Care Quality Commission (CQC), ahead of their major inspection of Berkshire Healthcare NHS Foundation Trust in December.
- We sent a copy of each GP Enter and View visit report to the CQC and also took part in regular conference calls with the CQC about their rolling inspections of GP practices in Reading.
- We sent NHS England a copy of our maternity report to help inform its national review of maternity services.
- We assisted South Central Ambulance Service in grading some of its work, by convening an equality and diversity panel of local people to give direct feedback.
- We hosted a researcher from the Department of Health's Citizen Insight Team so she could see how a local Healthwatch collects feedback from the public.
- We raised safeguarding concerns with Reading Borough Council about adults at risk of harm or abuse.
- We assisted Reading Borough Council in giving a talk to 12 agencies it had approved to provide home care to local people, about what service users wanted to be treated, based on our past research.
- We gave advice to Reading Borough Council on communicating with and involving people and their families who will be affected by a planned move from the town's current day centre to a new location.
- We agreed to sit on CCG-run group drawing up plans for a new service on end-of-life care, and another group focusing on care homes.
- We chaired or hosted a regular meeting of Thames Valley local Healthwatch, to share ideas and intelligence.
- We gave a presentation to one of the regular training sessions held for all GPs in Reading, about ways their surgeries might better support unpaid carers.

Involving local people in our work

Healthwatch Reading continually called for local people to be involved in the commissioning and evaluation of local services during 2015-16 via its seats on the Reading Integration Programme Board, the Joint Primary Care Co-Commissioning Committee, the Urgent Care Programme Board, and the Health and Wellbeing Board.

We won greater involvement for local people by:

- Successfully arguing for commissioners to extend a consultation, so all patients at three practices facing new management, would be given an equal chance to influence the shape of future services
- Successfully arguing for Healthwatch Reading and patient participation groups to be included in commissioner-led workshops to set a new APMS contract for three GP practices, which helped give feedback about access to services;
- Taking part in scoring bids from providers wanting to take over the GP practices;
- Taking part in face-to-face questioning of shortlisted providers, so we could ask them how they would ensure good patient experiences.

In addition, Healthwatch Reading brought anonymised 'patient stories' to programme boards made up of commissioners and providers, to help keep improved patient experience, and not just cost savings, high on agendas.

We also used our monthly newsletter and social media to give updates on our projects and seek feedback for upcoming meetings we would be attending. For example, we invited local people to set questions that would be put to the new Royal Berkshire Hospital chief executive in the first of a regular set of meetings with local Healthwatch.

We supported our representative on the Health and Wellbeing Board to continue being effective, by giving them regular briefings on the staff team's work. Healthwatch staff also attended some HWBB meetings to give in-depth presentations on projects they had been working on.

We also regularly attended the North and West Reading Patient Voice and South Reading Patient Voice meetings to share intelligence and to hear their concerns.

And we worked to help develop a robust patient participation group network, by holding a training workshop and networking event for PPGs.

Our work in focus

Our work in focus: Reading Voice - the new Care Act advocacy service

Healthwatch Reading has this year forged stronger links with the voluntary sector organisations Reading Mencap, Age UK Reading, and Talkback to provide a vital new service to some of the most vulnerable people in our community.

Known as Reading Voice, the service matches people who have a statutory entitlement to 'Care Act advocacy', with the most suitable independent advocate from a local pool. These advocates help people who have learning disabilities, dementia, or other communication or physical needs, to express their views about how they want to live their lives and receive care, during social services care assessments or reviews.

The people who need this advocacy do not have anyone else in their lives, or anybody appropriate, who can support them through care planning processes.

The advocates are also assigned to people in safeguarding cases where abuse or neglect is suspected.

Advocates are not support workers, care workers, or counsellors. Their role is to empower people to have their say and express their wishes. They do this by:

- Focusing on what the person wants, not what professionals or relatives might prefer
- Spending time with the person to build up trust
- Encouraging people and building up their confidence to make their own choices
- Being non-judgemental – we do not tell people what to do
- Using different and creative methods to communicate
- Explaining and exploring different options about care and other choices about their lives
- Looking out for peoples' rights
- Challenging discrimination
- Celebrating diversity of people.

Care Act advocates have to undergo a new statutory qualification, involving training days, written assignments, and observations in practice.

It has been a big learning curve for the Reading Voice advocates but they have supported each other through monthly meetings hosted by Healthwatch Reading, sharing knowledge, skills, and case discussions. These regular meetings also mean we have gained a greater understanding of each other's other work within the charities, which has helped us to improve how we signpost members of the public with more general queries, to the most relevant local organisation for support.

Some of the advocacy cases have highlighted gaps in local safeguarding procedures, which we have raised with Reading Borough Council.

Overall, we have learnt that assumptions are often wrong about people being 'unable' to take part in care and wellbeing planning about their own lives. Spending more time with people, explaining all their options and communicating with them in a way that suits their needs, can make all the difference.

Reading age UK

healthwatch Reading

Reading mencap

Talkback

CARE ACT ADVOCACY CASE STUDY

Paul lives in a care home and has Parkinson's. He has low mood and has been saying he wants to move to another home.

His assigned advocate visits him regularly and he begins to trust her to talk about his wellbeing.

Paul tells the advocate he loves reading but his shaky hands make it hard to turn pages of books. The advocate describes other options (which haven't been discussed with him previously), like audio books and discusses with staff how this could be arranged.

The advocate observes that Paul is not fully dressed, his room feels cold and he says he feels chilly. The advocate raises this with staff. The advocate also observes that Paul cannot reach his drinks and has no way to ask staff for help if they are not in the same room.

On one visit she also notices a fresh bruise on his face and Paul tells her how he got it. The advocate makes a safeguarding referral. This eventually results in an occupational therapist working with the home on a falls prevention plans.

The advocate also helps Paul draw up a 'Wellbeing Plan' expressing in his own words, what would help improve his daily life. This plan is shared with the social worker and the home, and they begin taking steps to better meet Paul's needs.

Our work in focus: Helping providers learn from complaints

Another Healthwatch Reading innovation during 2015-16, was to hold the first event of its kind in Reading, bringing together staff from various complaints departments, PALS offices, or patient experience teams.

The aim of the event was to start a local conversation about how providers could better handle concerns or complaints raised by the public, and to improve understanding of the work of our complaints advocates.

We were pleased to have representatives attending from most major providers, including Royal Berkshire NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust, Reading Borough Council, and also GP practice mangers.

We mixed everybody up into small groups, asking them to describe to each other how their organisation's complaints procedures worked. It soon became clear to all how much these processes varied, and how tricky this must be for the public.

We also set the scene by sharing statistics on the number of people coming to us for help on complaints, and the most common themes they raised.

We then gave a talk about the role of advocates, our training and our values. This helped attendees understand, that as advocates, we speak 'as the person' rather than 'telling' people what to do. The groups then looked at case studies to discuss what actions could have been taken to avoid complaints escalating. We also discussed what makes a good written complaints response and also looked at how to hold effective face-to-face resolution meetings. Finally, we urged organisations to adopt the joint guidance from Healthwatch England, the Parliamentary and Health Services Ombudsman and Local Government Ombudsman *My expectations for raising concerns and complaints*.

We plan to hold a similar event in 2016-17 as part of our ongoing commitment to supporting local people with complaints.

Our plans for next year

Future priorities

Our plans for 2016-17 will build on our work in the third year of Healthwatch Reading. We will focus on:

- Ensuring patients are kept informed and involved of changes underway in primary care. Due to ongoing GP recruitment difficulties, different kinds of professionals are emerging in primary care teams such as physician's associates and prescribing pharmacists, and we hope to ensure patients are given full information to help them gain confidence about these professionals. We will also work in partnership with patient participation groups to check how patient care is delivered at Circuit Lane Surgery and Priory Avenue Surgery, which are being taken over by a company new to Reading, under a 10-year contract.
- Understanding the experience of people and their carers, when people are at the end of their life. Many national reports have highlighted that people often don't get to die in their preferred place, at home, and that there is still a taboo that prevents people discussing their wishes with their family. We will work in conjunction with hospices, palliative care teams, faith groups and other partners to conduct sensitive conversations with Reading people.
- Examining how the electronic prescription service is working in Reading - do people know about its benefits and use it, and do people encounter any problems with it at GP surgeries or pharmacies?
- Keeping a watching brief on how integration is working between health and social care services in Reading. We continue to hear from people about problems when they are transferred from one service to another as a result of issues such as contradictory or miscommunication between professionals.
- Calling for full public consultation on new plans being drawn up by new NHS regional bodies known as 'STP footprints'. This reorganisation involves Reading NHS organisations having to work with counterparts in Oxfordshire and Buckinghamshire on cost savings, efficiencies and transformation of services. This has led to concerns about money being taken from one area of the footprint to give to another area and we will speak up for Reading people to ensure they have a say on plans that affect their care.
- Improving the way, we give information to the public through the creation of a new staff post, of digital information officer.

Our people

How we make decisions

Our board and trustees are all volunteers and members of the local community.

The trustees are responsible for the strategic vision of the organisation and its governance. The trustees are also responsible for raising funds in order to fulfil the work plan.

The Board are responsible for the work plan and ensuring that we are listening to our local community, responding and ensuring change is happening.

We also involve our local community in decision making about our work plan. Before the Board decides what to focus on each year we ask our local community via our newsletter and a call out to our reference group about the issues that are of concern to them. Along with the information we collect from our contacts and the intelligence from the Board, the Board then compiles the work plan for the year.

We hold regular board meetings in public, to which we invite local speakers to update the public on matters of interest.

We also involve volunteers in our project work and Enter and View visits, including student volunteers.

Our people

Trustees:

David Shepherd - Chairman

Gurmit Dhendsa - financial and strategic development

Monica Collings – public health and mental health services

Our Board:

Sheila Booth – physical disabilities and sensory needs

Douglas Findlay – young people and pharmaceutical services

Tony Hall – care for the elderly and GP services

Sue Pigott – learning disabilities

Reverend John Rogers – engagement with the faith community and social care

David Shepherd – commissioning of services

Helena Turner – community engagement, young people and mental health

Co-opted members

Francis Brown – North and West Reading Patient Voice

Libby Stroud – South Reading Patient Voice

Our staff team:

Chief executive: Mandeep Kaur Sira

Team manager: Rebecca Norris

Advocacy services lead: Merlyn Barrett

Officers: Catherine Williams and Pat Bunch

Our finances

INCOME	£
Funding received from local authority to deliver local Healthwatch statutory activities	130,311
Additional income	94,012
Total income	224,323
EXPENDITURE	
Operational costs	8,239.84
Staffing costs	135,266.06
Office costs	15,871.17
Total expenditure	159,377.07
Balance brought forward	64,945.93

Contact us

Get in touch

Address:

Healthwatch Reading,

3rd floor, Reading Central Library

Abbey Square, Reading, RG1 3BQ

Phone number:0118 937 2295

Email: info@ healthwatchreading.co.uk

Website:www.healthwatchreading.co.uk

We will be making this annual report publicly available by 30th June 2016 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format, please contact us at the address above.

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE AND HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**15th July 2016**	**AGENDA ITEM:**	**8**
TITLE:	**ANNUAL REPORT FROM THE DIRECTOR OF PUBLIC HEALTH**		
LEAD COUNCILLOR:	**CLLR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**ADULT SOCIAL CARE & HEALTH**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**JO HAWTHORNE**	**TEL:**	**0118 937 3623**
JOB TITLE:	**HEAD OF WELLBEING**	**E-MAIL:**	**JO.HAWTHORNE@READING.GOV.UK**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of the report is to inform Health & Wellbeing Board members on the Strategic Director of Public Health's Annual Report. The Annual Report is written using information from the latest available needs assessment and evidence supplemented from other sources such as education and other community services.

2. RECOMMENDED ACTION

2.1 HWB members note the Annual Report from the Director of Public Health.

2.2 For HWB members to consider how the report will influence the work to reduce health inequalities.

3. POLICY CONTEXT

3.1 In general, the statutory responsibilities of the Director of Public Health (DPH) are designed to match exactly the corporate public health duties of their local authority. The exception is the annual report on the health of the local population, where the DPH has the duty to write a report; whilst the authority's duty is to publish it (Section 32 of the Health and Social Act 2012 Act refers).

3.2 The draft report in Appendix A therefore pulls together a snapshot of some of the key challenges and inequalities that exist within one group of the population – our children and young people. It describes the impact of these inequalities in later life and current service provision. The evidence shows

that children should be a key focus for attention if we are to address inequalities.

3.3 The report also highlights some of the issues that challenge our children as well as the inequalities that work within this group. It highlights that services can be too focused on clinical conditions and not recognise the huge impact that other issues contribute to outcomes. Education and health are interlinked, whilst Reading performs well to overall educational attainment in secondary schools and support children who are eligible for free school meals attainment is this group is lower than our neighbours.

4. THE PROPOSAL

4.1 The role of the DPH is to be an independent advocate for the health of our residents. Whilst the Annual Report is the independent report of the DPH and as such does not require public consultation, colleagues from Wellbeing and Reading Children's Services have added valuable expertise and assistant in shaping its content.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 Public Health interventions at a population level contribute to Corporate Priority 2: Providing the best life through education, early help and healthy living.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 The report will be available for information.

7. EQUALITY IMPACT ASSESSMENT

7.1 An equality impact assessment is not relevant.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications.

9. FINANICAL IMPLICATIONS

9.2 There are no financial implications.

Draft
Public Health
Annual Report
Reading Borough Council

Dr Lise Llewellyn
Strategic Director of Public Health
Public Health Services across Berkshire

Why children?

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

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

Additionally within each Local Authorities we can see that life expectancy varies according to the affluence of the ward – 10.2 years for men and 5.2 years for women within Reading.

Throughout the 20th century, infant mortality rates in England and Wales have steadily declined, largely due to 'improved living conditions, diet and sanitation, birth control, advances in medical science and the availability of healthcare'. 1 2 The reduction in infant mortality has been cited as the single greatest factor contributing to increased life expectancy over the past 100 years.

In his key report on health inequalities 2010 Marmot[1] identified 6 policy priorities that would have an impact on reducing health inequalities in England . Two of these priorities focused on children:

"Giving every child the best start" *and*

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

The report clearly shows that disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities therefore must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.. For this reason, giving every child the best start in life is the highest priority recommendation given in the report to address inequalities.

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

This year the commissioning responsibility of health visiting services has transferred into local government and this is an additional opportunity to support better outcomes for our children through fully integrating health and other early help services to support families and children. I hope this report shows the importance of addressing children's' health in relation to the public health duties in local government, and illustrates that whilst all families need support at some time services should recognise that some children and families need greater support.

Positively the evidence shows that if we give this support early we can make major improvements to the life chances of these families.

Infant Mortality

One of the most obvious measures of inequalities is in rates of death and additionally the level of childhood mortality can be seen as a major indicator of the health of a nation [1,2].

On a personal level the death of a child is the probably the most difficult time in any family.

Death in childhood is measured in a number of ways:

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

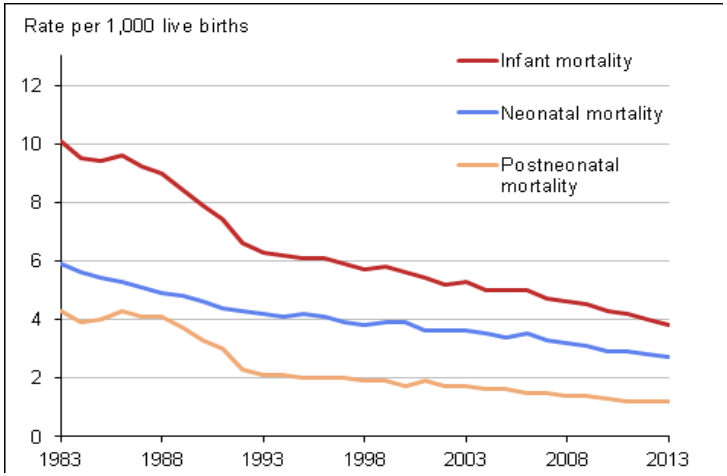
Neonatal mortality - deaths before age of 28 days per 1000 live births

Infant mortality - deaths between birth and one year per 1000 live births

Child mortality - deaths before age of 5 years

Infant mortality in the UK has decreased in the last 20 years - see figure

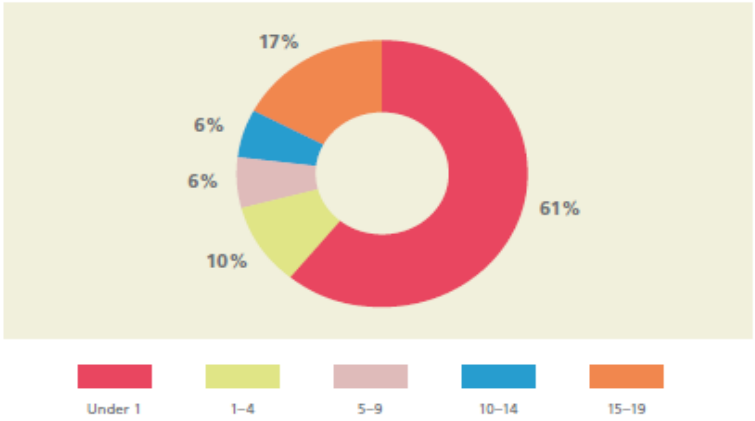
- 2011 - infant mortality rate - 4.2 deaths per 1,000 live births, the lowest level recorded in E&W
- 2010 - 4.3 deaths per 1,000 live births
- 1981 - 11.1 deaths per 1,000 live births [3]



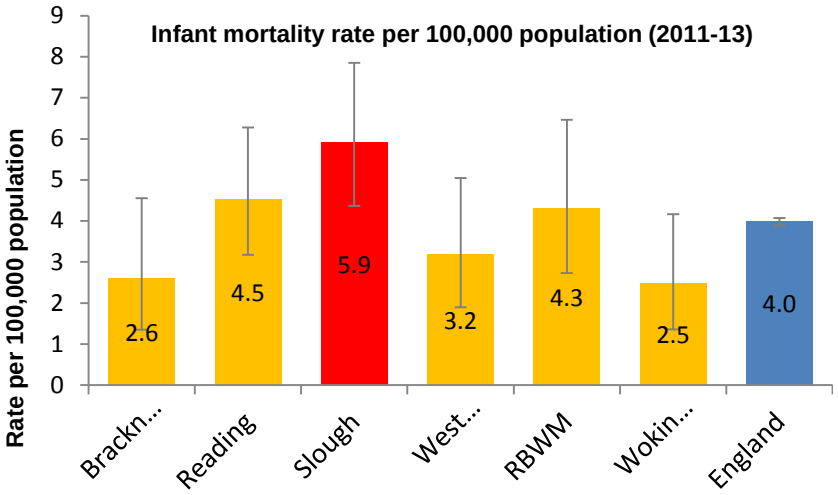
However for 20 years ago mortality in the UK for under 19 years compared favourably with the rest of Europe. Now we are among the highest and if we compare ourselves against Sweden **then every day 5 extra children under the age of 14 die in the UK .** [4 5]

Additionally there is considerable variation across the regions in the UK with deaths between the ages of 1 – 17 having a three fold variation (7-23 deaths per100,000) , similarly infant mortality (2.2 – 8 per100,000) and perinatal (4,2 – 12,2 per 100,000). [5]

As can be seen below across England most deaths occur under 1 years of age, with the next highest rate being between 15-19 years[5]



Data source: "Deaths by single year of age tables, England and Wales, 2012" ONS http://www.ons.gov.uk/ons/rel/vsob1/death-reg-sum-tables/2012/rft-deaths-syoa-tables--2012.xls



Causes of childhood deaths

Child death overview panels (CDOPs) are responsible for reviewing information on all unexpected child deaths. [6] They record preventable child deaths and make recommendations to ensure that similar deaths are prevented in the future.

Within Berkshire there is a CDOP that reviews cases across Berkshire and reports into each local safeguarding Board.

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

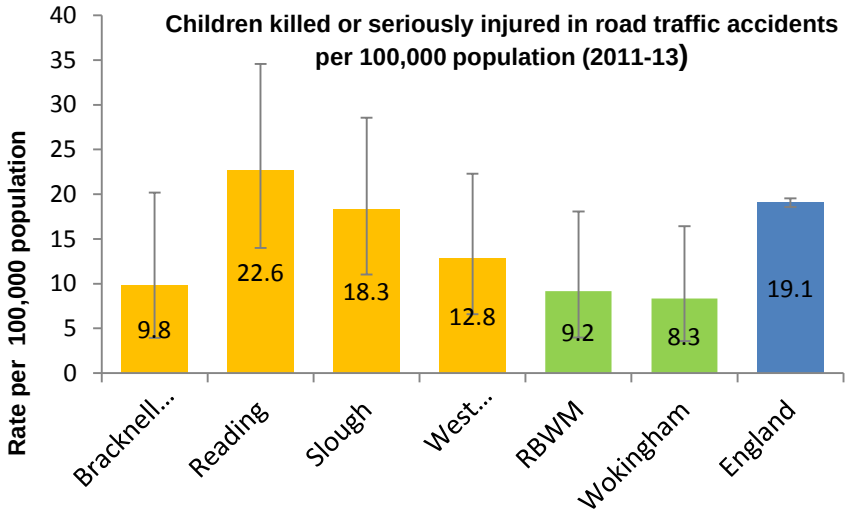
- any matters of concern affecting the safety and welfare of children in the area of the authority
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- putting in place procedures for ensuring that there is a coordinated response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

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

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

In 2011-13, 75 children were killed or seriously injured in road traffic accidents in Berkshire. The rate in England was 19 per 100,000 children (aged under 16). Wokingham and Royal Borough Windsor and Maidenhead's rates were significantly lower than England's, while the other Berkshire LAs were similar to the national rates

Childhood mortality

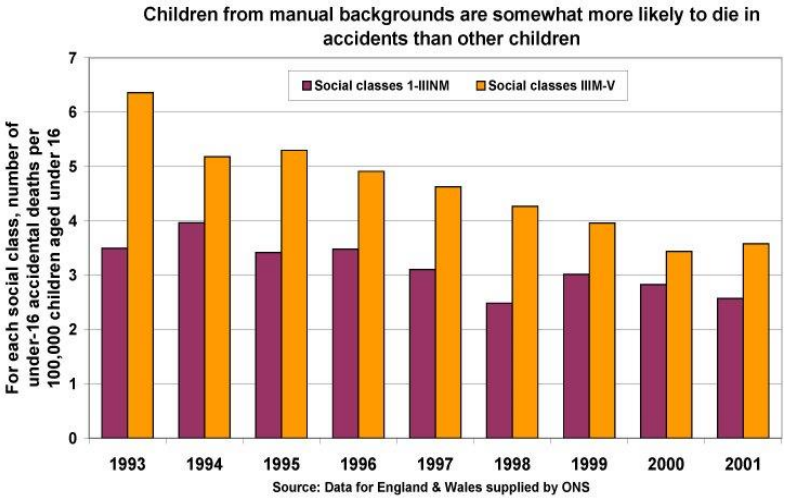


All children are exposed to injury as part of their everyday lives, but the burden is not evenly spread: injuries disproportionately affect some children more than others

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

- Lack of money (ability to buy safety equipment)
- Exposure to hazardous environments inside and outside the home (facilities for safe play; smoking parents; older wiring; lack of garden; small, cramped
- accommodation) [7]

- Ability of parents/carers to supervise children (single parent families; parents' maturity, awareness and experience; depression and family illness; large family size)
- Children's attitudes and behaviour (risk taking)



Deaths from accidents and injuries are reducing but at rates comparable to those European countries with lower childhood mortality. Therefore do not explain our worsening relative position in childhood death rates within Europe

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

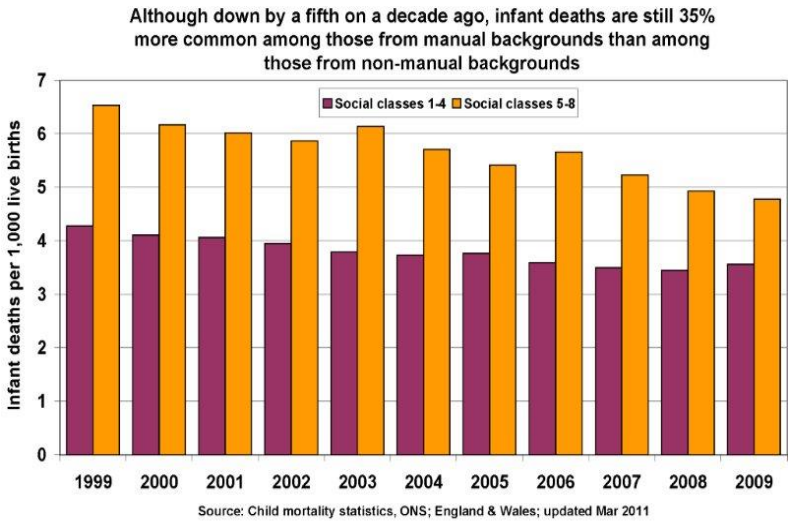
Wider influences

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

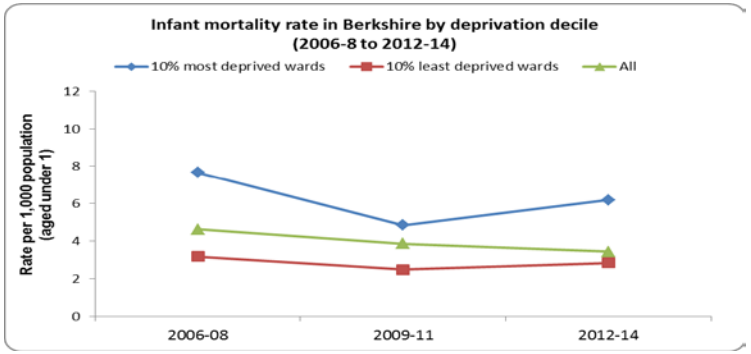
Infant mortality rates are highest for the routine and manual occupations with 5.4 deaths per 1,000 live births.

In contrast there were 2.2 deaths per 1,000 live births for higher managerial, administrative and professional occupations.
3.2 deaths per 1,000 live births for intermediate occupations.

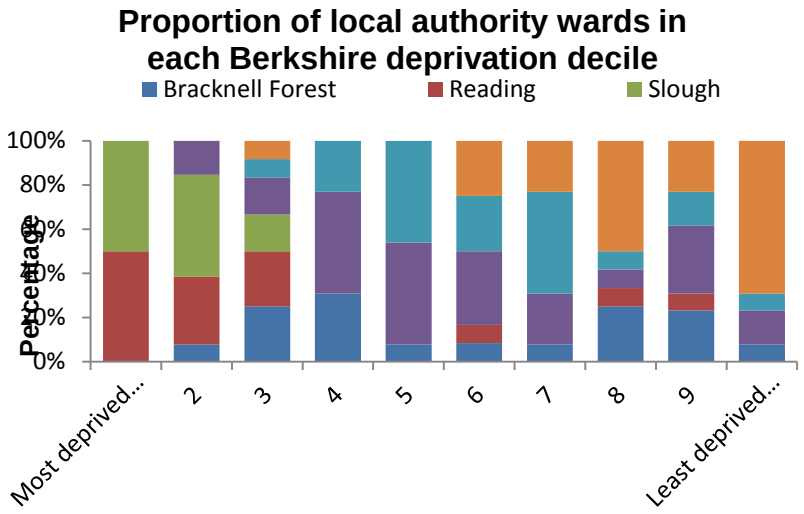
When the improvement in infant mortality is reviewed by ward then it is seen that wards which became relatively less deprived experienced a reduction in infant mortality rates greater than that for national rates in England and Wales. [1 8 9]



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



- Reading when compared to other authorities has average / just below average levels of deprivation being in decile 6 (where 10 is the most affluent) in the country. Therefore we would expect mortality levels to be around the England average, though the levels are slightly worse than the England average (4.5 v 4.0 deaths per1000 live births);
- In 2014 19.4% (5900) of our children in Reading live in poverty ' – defined as children living in families in receipt of out of work benefits or tax credits where their reported income is <60% median income';
- and 6000 children (16.8 %) live in the most deprived wards in Reading. [10]



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

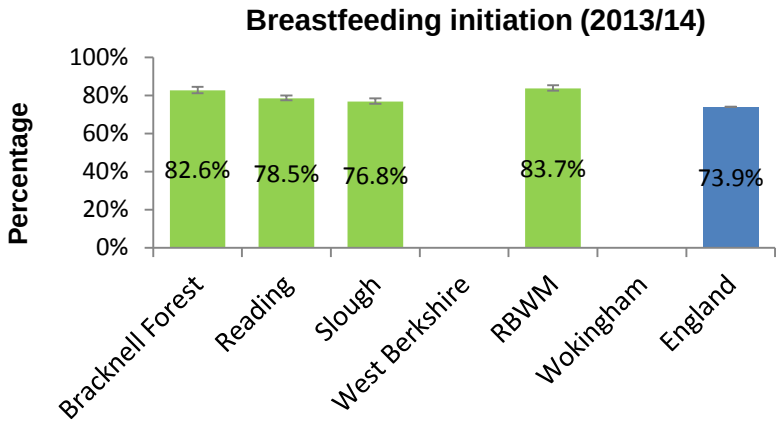
Rates of low birth weight are higher in less advantaged socio-economic groups [11] and are particularly linked to a number of negative health behaviours such as poor prenatal care, substance abuse, poor nutrition during pregnancy and smoking which are more common in these groups [7] .

Breast feeding

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

There is a clear association between reduced rates of breastfeeding and deprivation.

The Infant Feeding Survey published in 2012 reported that, in 2010 the prevalence of breastfeeding at all ages of baby up to nine months was highest among the highest SEC group , whilst the incidence of breastfeeding decreased as deprivation levels increased.



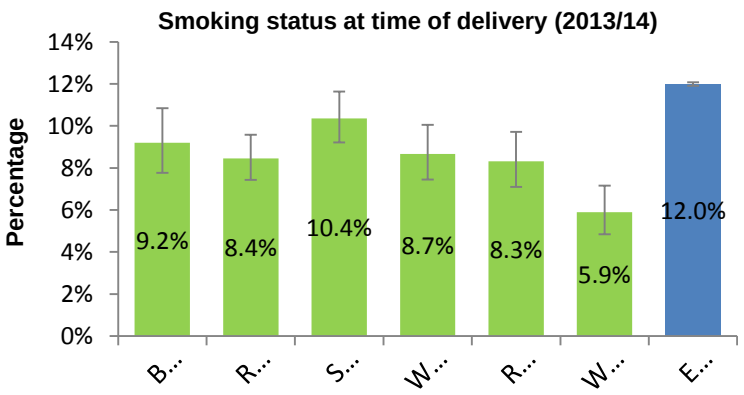
Other inequalities

Smoking

Smoking reduces the amount of oxygen available to the foetus during pregnancy and increases the risk of low birth weight, a key risk for infant mortality. [13] It has been shown that for first pregnancies smoking 20 cigarettes a day leads to a 56% increase in risk of infant death. [14]

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

But also smoking also as implications for the long term physical growth and intellectual development of the child. In 1999 WHO concluded, *"Parental smoking is associated with learning difficulties, behavioural problems and language impairment in children". Studies consistently report that high social class is linked to low smoking rates before pregnancy and high rates of smoking cessation during pregnancy (Graham 2003)*



Obesity

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

The Confidential Enquiry in maternal and Child Health CEMACH report for the period 2003-2005 identifies the risks of maternal obesity to the child as:[14]

- stillbirth
- neonatal death
- congenital anomalies
- Prematurity

National statistics for the prevalence of maternal obesity are not collected routinely in the UK. A national audit of extreme obesity during pregnancy between March 2007 and August 2008 identified that nearly one in every thousand women giving birth in the UK has a body mass index (BMI) of at least 50kg/m2 or weighs more than 140kg whilst a later audit showed that 5% of women had a BMI of over 35 or weighed at least 100kg (a higher threshold than usually used for obesity) . 2% had BMIs of over 4O – morbid obesity.

And unfortunately in line with the trend that over recent years there are increasing numbers of women who are obese UK studies within the last five years have shown an increase in the prevalence of obesity amongst pregnant women presenting to hospital for booking.

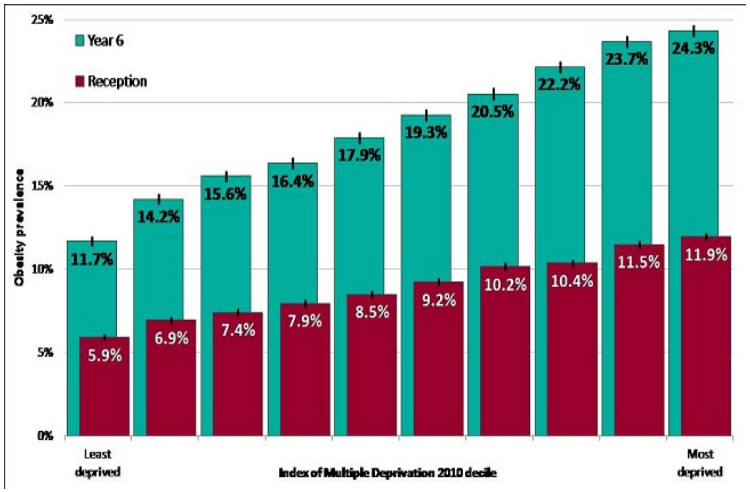
The impact of obesity on infant mortality and pregnancy complications is short term but the impacts continue through the life of the child.

Obesity during pregnancy continues to have an impact through the life of the child.. There is a significant relationship between maternal obesity, large birth weight babies and the subsequent development of childhood and subsequent adult obesity . A systematic review of the childhood predictors of adult obesity showed that maternal obesity and weight gain during pregnancy are related to higher BMI in childhood and subsequent obesity in adulthood. Children who are obese are more likely to have parents who are obese [15]

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

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

The well described national picture that children in more deprived areas are more obese, is mirrored in Berkshire

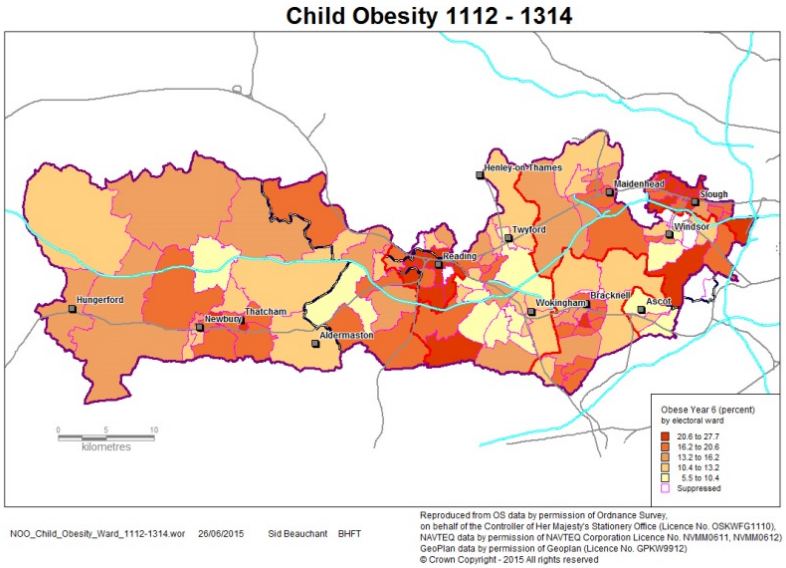


- Source: National Child Measurement Programme

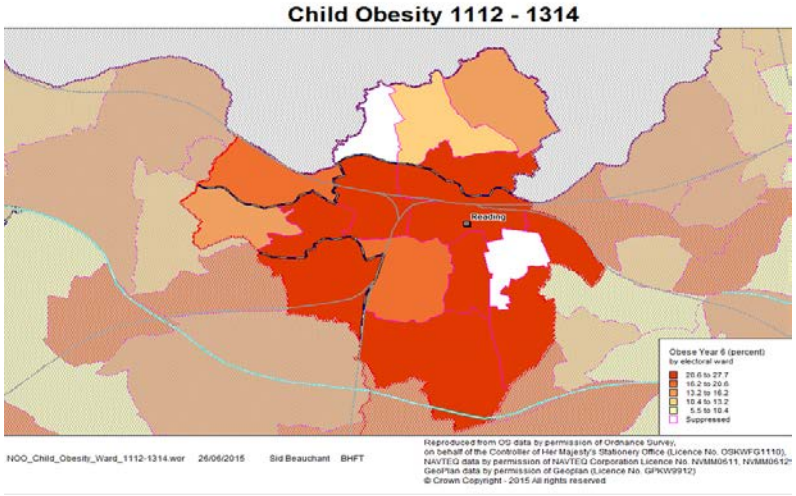
Across Berkshire we can easily see that more affluent local government areas have less obesity

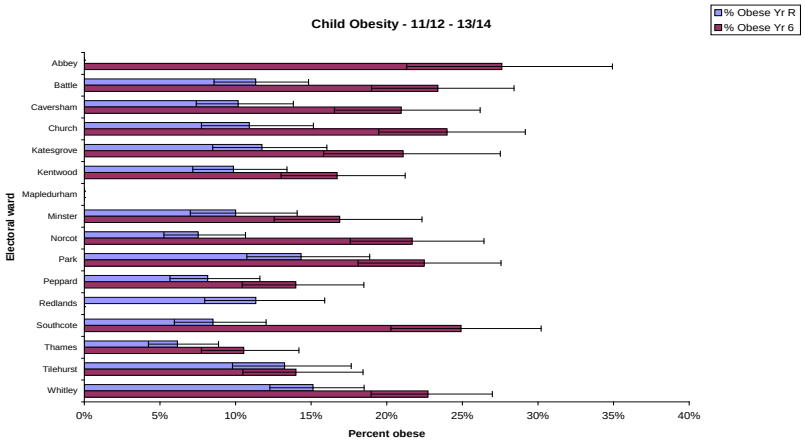
	4-5 year olds who are obese	
Local Authority Name	%	Number
Windsor and Maidenhead	6.8	130
West Berkshire	6.4	126
Reading	10.8	249
Bracknell Forest	6.4	109
Wokingham	6.6	143
Slough	11.9	300

And in year 6 the same pattern is repeated



Locally in within Reading the pattern is also shown across the wards, and as can be seen the rate of obesity almost Doubles between reception and year 6 .





The importance of this information is that obese children are more likely to have long terms health and other issues,: be absent from school due to illness, experience health-related limitations and require more medical care than normal weight children.[16]

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

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

Cardiovascular (CVD) **-** In Netherlands 62% of young (≤12 years of age) severely obese children already had one or more CVD risk factors. Whilst in the USA childhood obesity is associated with a quadrupled risk of adult hypertension . Obesity not only increases cardiovascular risk in adulthood, but it is also associated with cardiovascular damage during childhood.

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

Education and health

This relationship between health and education is complex.

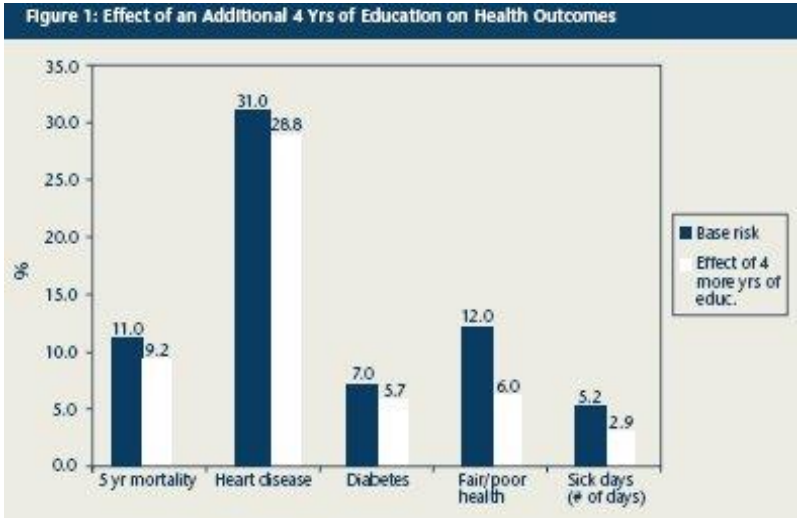
It is widely evidenced that in general those with higher educational attainment earn higher salaries. This may be the basis of the government policy which encourages more children to go to university as a route to promote economic growth.

Educational attainment is the most important of the factors examined in explaining poverty in both the UK and the other EU countries studied. In the UK, those with a low level of educational attainment are almost five times as likely to be in poverty now as those with a high level of education. [19]

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

International and UK evidence shows that education is strongly linked to better health . Those with more years of schooling tend to have better health and well-being and healthier behaviours. [17]

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



Cross country comparisons in Europe have produced similar findings. People with low education were more likely to report poor general health and functional limitations. Low education level has been associated with increased risk of death from lung cancer, stroke, cardiovascular disease and infectious diseases. Associations have also been found between education and a range of illnesses including back pain, diabetes, asthma, dementia and depression.

Evidence suggests that those who achieve a higher level of educational attainment are more likely to engage in healthy behaviours and less likely to adopt unhealthy habits. [18]

For women in the United States college education for a minimum of two years decreases the probability of smoking during pregnancy by 5.8 percentage points. This is a large effect given that on average only 7.8% of the women in the sample smoked during pregnancy.

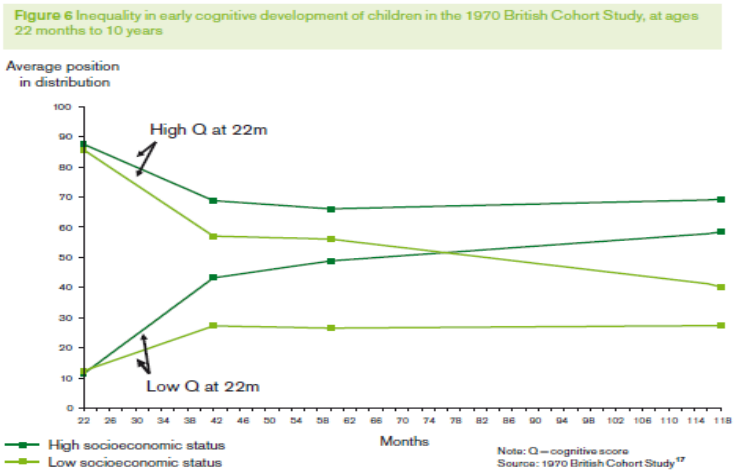
What influences education ?

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

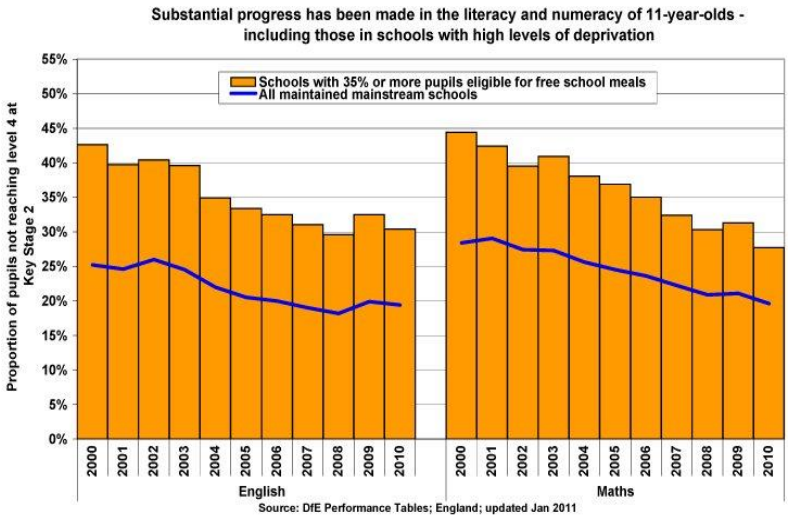
In the UK the largest influence, on a child success at school is father's education level. Young people are 7.5 times more likely to have a low educational outcome if their father has a low level of education, compared with a highly educated father. [10]

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

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



Whilst educational achievements have improved across all sectors of the community there is a persistent gap between the achievements of those children in with low income.

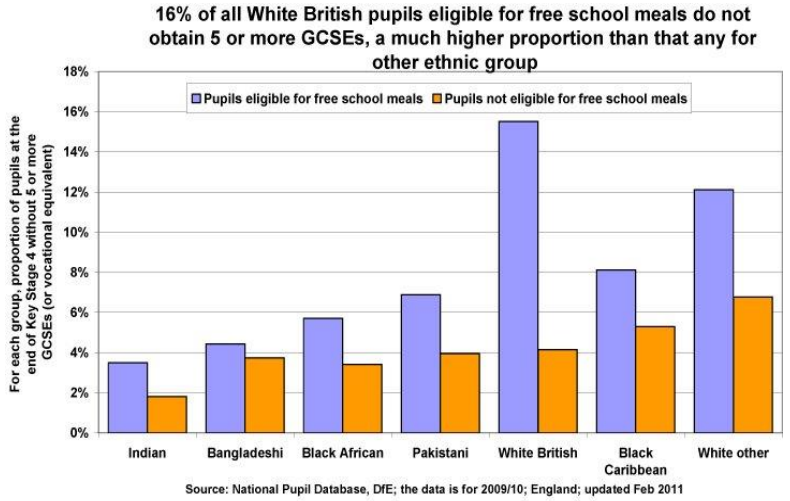


In the UK Children eligible for free school meals (FSM) are used as a proxy measure for families with lower incomes (since to be eligible their family must receive one of series of income support mechanisms).

Pupils eligible for FSM are more likely to be absent from school than non-FSM pupils. In secondary schools the absence rate of FSM pupils is around double that of non- FSM pupils between Years 8 and 11. [18]

15% of boys eligible for free school meals do not obtain 5 or more GCSEs. This compares with 10% for girls eligible for free school meals and 5% for boys not eligible for free school meals.

16% of White British pupils eligible for free school meals do not obtain 5 or more GCSEs. This is a much higher proportion than that for any other ethnic group.



Interestingly children eligible for FSM in cities generally enjoy a significant advantage over their peers who grow up in similar backgrounds, but in smaller cities and market towns – reversing assumptions that educational inequality is an inner city burden.
In inner London nearly 55% of pupils eligible for Free School Meals (FSM), achieve the 5 A* -C Grade GCSE almost 20% above the national average.

Across the UK there has been good progress over the last decade, with more pupils from disadvantaged backgrounds achieving 5 GCSEs at grades A* - C. The gap, however, between these pupils and their wealthier classmates has remained the same or widened. In 2013/14 71% of children in the south east not on free school meals achieved 5 GCSEs at grade A*-C – but for poorer children, this shockingly drops by 25% and even in in inner London there is a 20% gap.

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

% age of students achieving 5 A* - C grade GCSE - 2013/14		
Area	% Pupils eligible for FSM s	% All other pupils
South East	35.4	70.7
Bracknell Forest	27	71.3
Reading	38	74
Slough	50	78.5
West Berks	34	74.5
Windsor & m'head	43	72
Wokingham	44	77
London	56.4	74.5

Looked after children

As we have described in this report affluence / deprivation is a key factor that influences health. So improving the education of all our children should, by reducing the impact of low wages / poverty and also directly, improve the health of our children.

Only one or two studies have expressed these types of impacts in quantitative, costed terms. These have shown that the health benefit of education is in costed terms equivalent to an additional benefit of 15-60% of the effect due to increase in outcomes attributable to the increase in wages. This is a substantial additional benefit that may indicate a major under-investment in education.[20]

In a specific health area, an assessment of the monetary impact of the benefits of education for reduced depression was undertaken. Simulating the effects of taking women without qualifications to Level 2 in the United Kingdom would lead to a reduction in their risk of adult depression at age 42 from 26% to 22%. It is estimated that this would reduce the total cost of depression for the population of interest by GBP 200 million a year. [22]

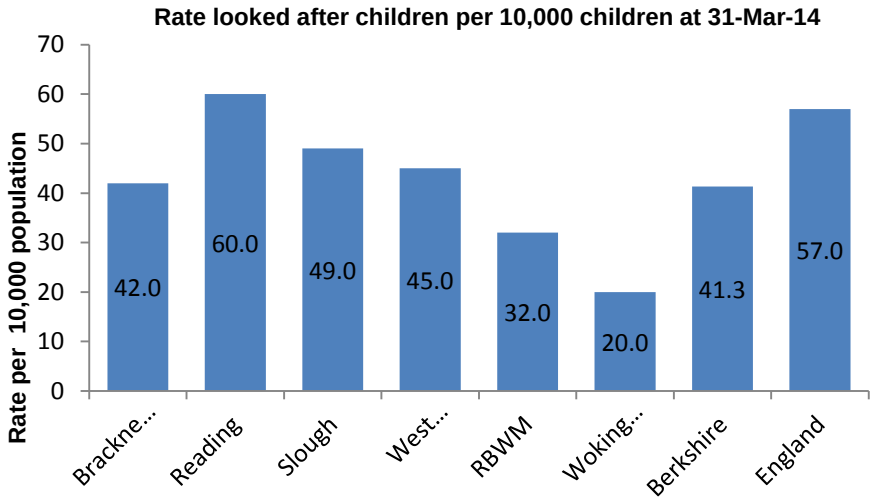
Inequalities in education and health drive a similar divide in the world of employment and later adult outcomes.

For example: The educational attainment gap often carries over into poor adult outcomes. - children on FSM in Year 11 were more likely than those not eligible FSM to become NEET (Not in Employment, Education or Training) in the following three years. Young people NEET are more likely to have grown up in social disadvantaged households including low levels of employment, single parent families and parents with low educational qualifications.

Children eligible for free school meals are not the only children that do less well in terms of educational attainment and health outcome

A child who is being looked after the local authority is known as a child in care. They might be living:

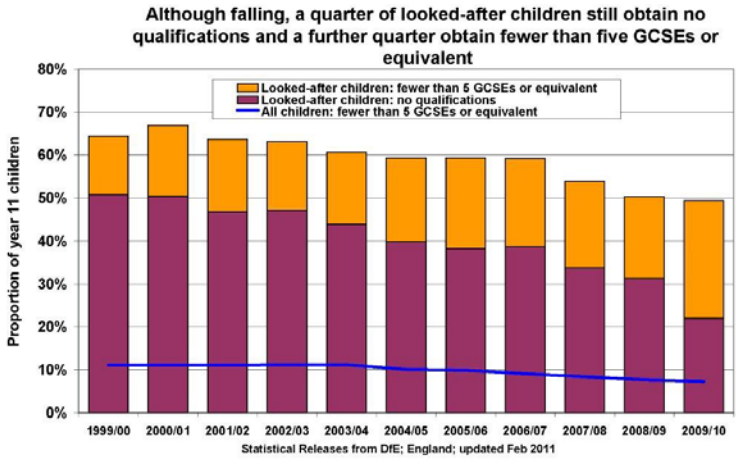
- with foster parents
- at home with their parents under the supervision of social services
- in residential children's homes
- other residential settings like schools or secure units.



Whilst the rate of looked after children in most of the unitary authorities in Berkshire is below the England average , this is to be expected since the risk of becoming a a looked after child is related strongly to deprivation – overcrowding, single parent families, reliance on income support.

Area	Number of LAC on 31-Mar-14
Bracknell Forest	115
Reading	210
Slough	190
West Berkshire	160
RBWM	105
Wokingham	75
Berkshire	855
England	64,470

However there are almost 900 children in this vulnerable group



The educational achievement of looked after children as a group remains low and the Children Act 1989 places a duty on local authorities to promote the educational achievement . Worryingly in the South East 32% of LAC achieved 5 GCSEs a*-c . (Local numbers cannot be shown as the numbers are too small.)

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

Locally we can seen that absence rates fluctuate quite markedly across the years which reflect the small and changing numbers of children in each Unitary authority

%age of sessions lost due to Unauthorised absence: LAC						
						Non-LAC
	2009	2010	2011	2012	2013	2013/14
England	1.6	1.5	1.5	1.2	1.1	1.1
South East	1.9	1.5	1.4	1.2	1.1	1.0
Bracknell Forest	1	1	1.1	0.5	1.7	0.9
Reading	0.5	0.6	0.8	1.6	1.8	1.3
Slough	1.3	2.6	0.7	0.5	0.5	1.1
West Berkshire	0.8	0.4	1	0.2	1.6	0.7
Windsor & M'head	2.2	0.8	1.7	0.7	0	0.7
Wokingham	4.6	1.4	1.3	0.3	1.2	0.7

Looked after children

Looked after children and young people share many of the same health risks and problems of their peers, but often to a greater degree. Children often enter the care system with a worse level of health than their peers, in part due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect. Longer term outcomes for looked after children remain worse than their peers [22]

Mental health disorder are more common:

- 5-10 year old LAC , 50% of boys and 33% of girls had an identifiable mental disorder.
- Among 11-15 year olds, the rates were 55% for boys and 43% for girls.
- This compares to around 10% of the general population aged 5 to 15

The major survey of LAC found that two thirds of all looked after children had at least one physical health complaint. Problems such as speech and language problems, bedwetting, co-ordination difficulties and eye or sight problems are more common

Young people leaving care are particularly vulnerable. Both young women and young men ire more likely than their peers to be teenage parents, 25-50% of young women leaving care became pregnant within 18 to 24.

in the year after leaving care health has been shown to worsen. almost twice as likely to have problems with drugs or alcohol and mental health problems and 'other health problems' such as asthma, weight loss, allergies, flu pregnancy..

One of the key duties of the children's act requires the local authority to assess the health of all their looked after children annually. [21]

	Number of LAC 31 march2013 - 12 months	% of LAC annual health assessment	% of LAC up to date imm'ns	% of LAC dental check
ENGLAND	47,200	87.3%	83.2%	82.0%
SOUTH EAST	5,960	85.6%	86.7%	85.4%
Bracknell Forest	75	93.3%	86.7%	93.3%
Reading	165	90.9%	84.8%	100.0%
Slough	115	91.3%	100.0%	91.3%
West Berkshire	95	89.5%	100.0%	78.9%
Windsor and Maidenhead	65	92.3%	100.0%	92.3%
Wokingham	45	88.9%	100.0%	100.0%

This includes a short behavioural screening questionnaire (SDQ) for each of their looked after children between the ages of 4 and 16 inclusive completed by the main carer.
It assesses:

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

So is an important measure of emotional distress in this vulnerable group

As is shown below completion of the SDQ varies between authorities

Percentage of children for whom a Strengths and Difficulties Questionnaire (SDQ) score was submitted by Local Authority			
	2011	2012	2013
England	70	71	71
South East	58	62	63
Bracknell Forest	54	64	82
Reading	86	87	96
Slough	70	97	100
West Berkshire	46	90	78
Windsor and Maidenhead	87	93	94
Wokingham	x	69	56

Mean scores for 5-15 yr olds across Britain are 8.4 but as could be expected from research findings SDQ scores are higher for LAC in England and the local scores show this increased score and level of distress . Higher scores are associated with poorer health experiences and highlight the particular and consistent health needs of this group.

Average score per child			
	2011	2012	2013
England	13.9	13.9	14.0
South East	15.0	15.2	14.8
Bracknell Forest	11.8	15.5	15.3
Reading	17.8	18.6	17.9
Slough	14.4	15.7	14.2
West Berkshire	15.7	15.8	16.4
Windsor and Maidenhead	13.5	15.4	13.9
Wokingham	x	16.6	16.1

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

The Children's Act clearly gives responsibility to local government and health services to work together to ensure that children receive the services they need in response to their health assessments [21]. However the national evidence shows that there is substantial local variation in the availability of services with a large focus on mental health services to meet the needs of children and young people, including those who are looked after. Increasingly, innovative Child and Adolescent Mental Health Service (CAMHS) partnerships are providing designated or targeted CAMHS provision for LAC.

However LAC are not the only at risk group for worsened mental health , there is well documented evidence that children in poverty are at increased risk of poor mental health . [23]

For example a recent survey in Scotland showed that people from the most deprived areas are more than three times as likely to be treated for mental illness . The report stated : "The more deprived an area, the higher its rate of psychiatric inpatient discharges [23]

Use of hospital services

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

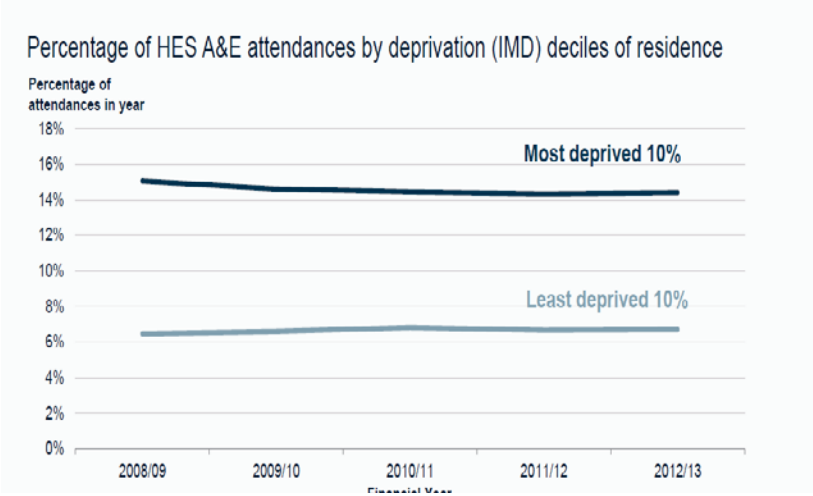
The consensus of the evidence available on the relationship of health service use in relation to deprivation, is that GP use is broadly equitable by social economic group, however it highlights a number of systematic differences between the use of secondary care by residents in deprived areas and compared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

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

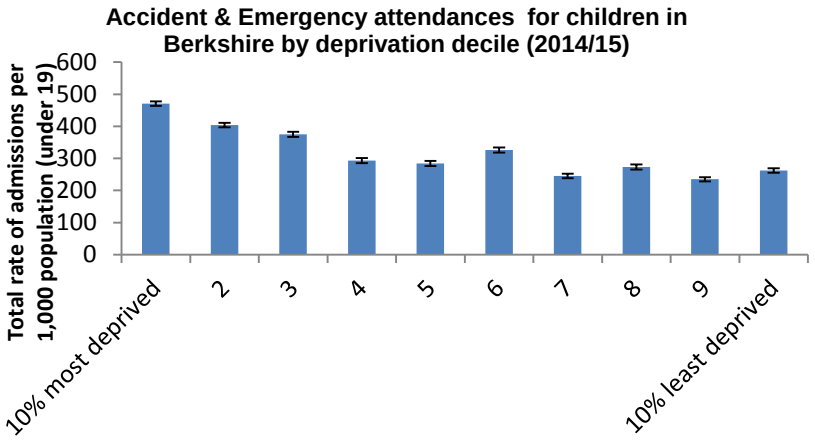
- used more emergency care
- used a similar amount of elective care
- attended A & E more frequently
- accessed outpatient care more via emergency channels
- failed to attend a larger proportion of outpatient appointments [24]

Pattern of A & E attendance has the steepest gradient, particularly in the relationships between attendance and the most deprived communities. [25]

In each of the last 5 years at least twice the number of attendances in all types of A & E departments have been by those living in the most deprived 10% of areas than those in the least deprived 10%.



This national picture is replicated in the pattern of children's attendances in Berkshire.



Studies demonstrate a relation between A & E use and deprivation for all assessed triage severities . This is most noticeable at the most severe end of the triage category (5x rate in most deprived communities) than for more minor illness / injury (rate is x2) .. [27]

The higher use of accident and emergency in more deprived communities can be partly explained by higher rates of illness and accidents with the rate of accidents being more prevalent in lower SEC groups but also shows differing behaviours in response to illness and injury.

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

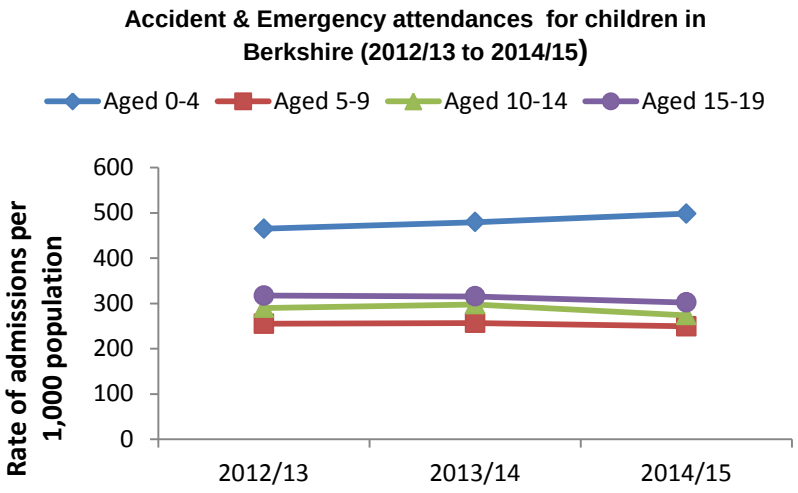
Nationally in recent years numbers of A & E attendances have risen faster than the growth in population : this is largely driven by more minor (type 3) types of attendances which have risen at 11 times the rate of population, though the recent trend has dipped . [26]
Nationally the highest percentage of A & E attendances are for very young children and those in their early twenties.

In 2012/13 there were at least 500 attendances at type 1 departments for every 1000 people aged under 2 or over 83 in England

If this aspect of care is reviewed in more depth nationally the proportion of attendances for over 64s at type 3 departments has decreased by 2.2 percentage points between 2008/09 and 2012/13 [26] .

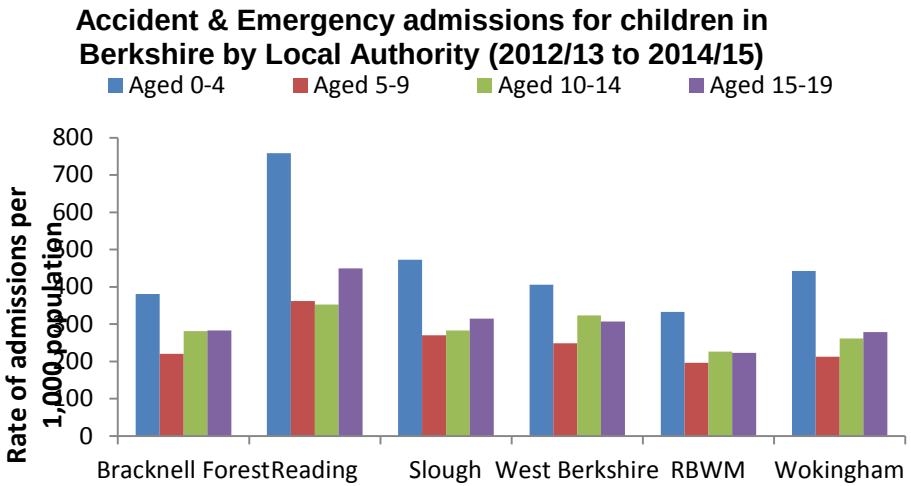
Whilst the proportion of attendances for under 10s has increased by 3.4 percentage points. [25]

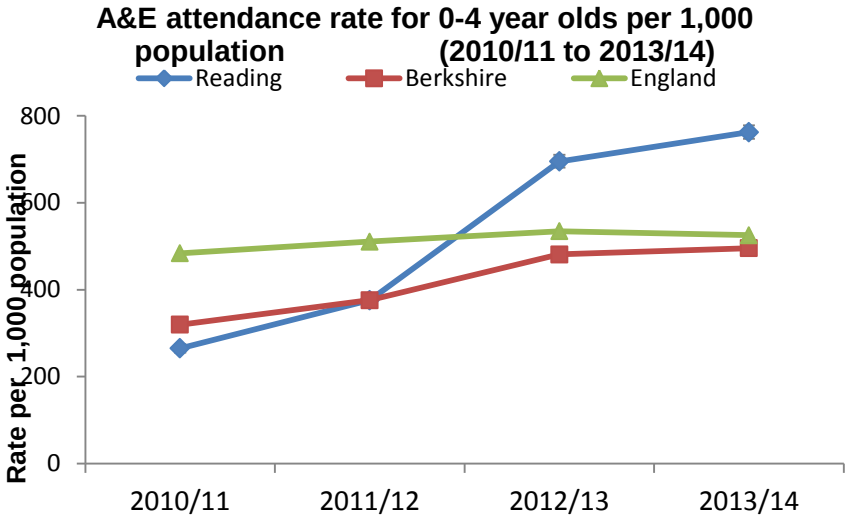
This pattern is also seen locally, driven by a rise in the 0-4 age groups.



In the past two years within Berkshire the total number for A & E attendances:

- In 0 – 10 year olds has increased as well - but by an increased amount 6% .
- 0-4 year olds are the age group that use A & E the most across the UK accounting for 3% of all attends.
- Similarly 0-5 year old age group has the highest number of emergency admissions - approximately 225,000 nationally which is a similar rate of attendances as that of 80 year olds .

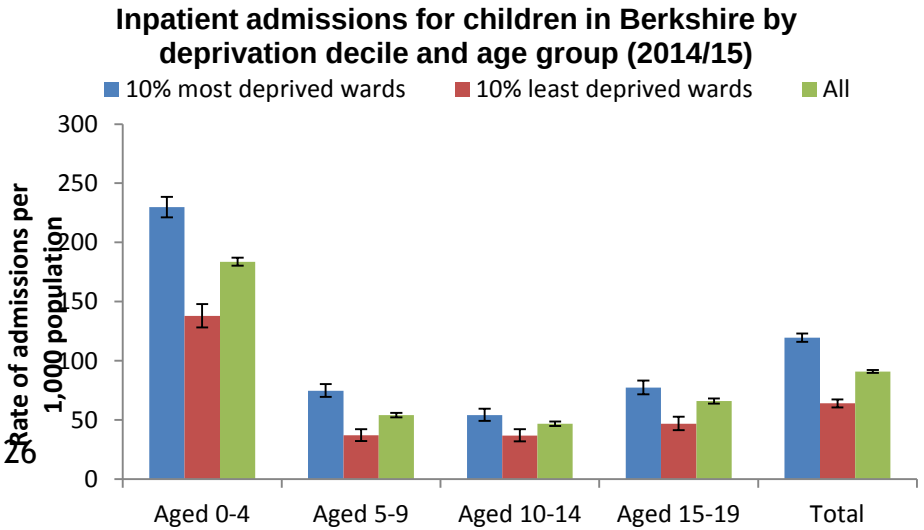




If we focus on the 0-4 year old group in 2013/14, there were 31,493 A & E attendances for children aged 0-4 years in Berkshire.
Reading and Slough show the highest rates but in Reading (not the most deprived local government area) the rate of attendances was significantly
worse than the national rate at 763 per 1,000 population. This higher rate could be driven by the local proximity of the A & E department as all rates of attendance are higher in this UA , however in each area we see the highest rate in 0-4 age groups. The other Berkshire LAs all had significantly better rates compared to England.

In addition whilst in the other UAs the rates of attendance in 0-4 yr olds is stable, in Reading the rates have increased over the past two years with a large increase in the past year.

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



Conclusions

The report tries to pull together a short snap shot of the inequalities that exist within our children currently but also to describe the impact of these inequalities in later life and on current services . The evidence shows that if we are serious in addressing inequalities in our communities then the early years period presents a key intervention point.

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

Babies are born with only 25 per cent of their brains developed, but by the age of 3 their brains are 80 per cent developed. If In that period, neglect, and other adverse experiences occur then it can profoundly effect on how children develop.

The mandated services for health visiting are :

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

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

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

In a time of budgetary constraints the tendency would be to focus services on children once they have presented with an issue to prevent escalation.

However return on investment studies on a range of well-designed early years' interventions show that the benefits significantly exceed their costs : ranging from 75% to over 1,000% higher than costs. In addition the early years foundation estimates that spending on 'late intervention' on children (i.e. spending which could have been prevented) costs the NHS £3bn per year.

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

Universal support to families will enable us to prevent issues developing and act quickly when problems occur.

However integrating services in communities is not the only opportunity to address the current inequalities in health that exist in our population.

The NHS tends to take a clinical / medical view of children and families. Whist local government is more adept at supporting at risk individuals and working in communities . If the NHS also adopted this approach then prevention could be targeted in a broader way and address a wider range of issues rather than specific clinical conditions and have a larger impact.

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

References

1 Geographical trends in infant mortality: England and Wales, 1970–2006 Paul Norman *University of Leeds* Ian Gregory *Lancaster University* Danny Dorling *University of Sheffield* Allan Baker *Office for National Statistics* Fair society Healthy Lives 2010 - Prof Marmot UCL et al

2 Woodroffe C, Glickman M, Barker M and Power C (1993) *Children, Teenagers and Health: the Key Data,* Open University Press: Milton, Buckingham.

3 12 Cooper N (2001) 'Analysis of infant mortality by risk factors and by cause of death, in England and Wales', in Griffiths C and Fitzpatrick J (eds), *Geographic variations in health. Decennial supplement.* Series DS no.16, The Stationery Office: London.

4 Wolfe Health servcies for chidlren in Western Europe Lancet 213 April6:381(9873):1224-34 3 (Oakley et. al. 2009 (720.5 Kb

Pdf)).Mortality 12 1 Blaxter M (1981) *The health of children: a review of research on the place of health in cycles of disadvantage,* Heinemann Educational: London.

5 Annual Report CMO 2012 Our Children Deserve Better

6 Woking together to safeguard children 2015

7 Injuries in children aged 0–14 years and inequalities *A report prepared for the Health Development Agency* Elizabeth Towner, Therese Dowswell, Gail Errington, Matthew Burkes, John Towner Community Child Health, Department of Child Health University of Newcastle upon Tyne

8 Why children die: death in infants, children and young people in the UKPart A May 2014 A REPORT BY: INGRID WOLFE ALISON MACFARLANE ANGELA DONKIN MICHAEL MARMOT
RUSSELL VINER

9 Childhood, Infant and Perinatal Mortality in England and Wales, 2013

10 PHE Outcomes Framework 2015

11 Spencer N J, Logan S and Gill L (1999) 'Trends and social patterning of birthweight in Sheffield, 1985–94', *Archives of Disease in Childhood Fetal & Neonatal Edition*

12 Breastfeeding and the Risk of Postneonatal Death in the United States Aimin Chen, MD, PhD, Walter J. Rogan, MD

13 Smoking, Low Income and Health Inequalities: Thematic Discussion Document Karen Richardson Report for Action on Smoking and Health and the Health Development Agency May 2001

14 The effects of maternal smoking on fetal and infant mortality. Kleinman JC[1], Pierre MB Jr, Madans JH, Land GH, Schramm WF.

15 Health risks of maternal obesity Public Health England

16 Wijga A, Scholtens S, Bemelmans W, de Jongste J, Kerkhof M, Schipper M, et al. Comorbidities of obesity in school children: a cross-sectional study in the PIAMA birth cohort. *BMC Public Health* 2010;10(1):184

17 What are the effects of education on health? By Leon Feinstein, Ricardo Sabates, Tashweka M. Anderson, Annik Sorhaindo and Cathie Hammond

18 Health Impacts of Education a review Claire Higgins Teresa Lavin Owen Metcalfe Institute of Public Health in Ireland November 2008

19 Part of Intergenerational transmission of disadvantage in the UK & EU, 2014 Released : 23 September 2014

20 Groot and van den Brink (2006)

21 Chevalier and Feinstein (2006)

22 Statutory Guidance on Promoting the Health and Well-being of Looked After Children

23 Child and Adolescent Mental Health – A Guide for Healthcare Professionals

24 The figures for Mental Health Inpatient Care, published by ISD Scotland

25 Are hospital services used differently in deprived areas? Evidence to identify commissioning challenges Barry McCormick, Peter-Sam Hill and Emmi Poteliakhoff

26 Focus on accident and emergency use HSCIC 2013

27 The association between deprivation levels, attendance rate and triage category of children attending a children's accident and emergency department T F Beattie, D R Gorman, J J Walker

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE AND HEALTH SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**15th July 2016**	**AGENDA ITEM:**	**9**
TITLE:	**DEVELOPMENT OF WELLBEING DASHBOARD**		
LEAD COUNCILLOR:	**COUNCILLOR GRAEME HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**WELLBEING**	**WARDS:**	**ALL**
LEAD OFFICER:	**JO HAWTHORNE**	**TEL:**	**0118 937 3623 (73623)**
JOB TITLE:	**HEAD OF WELLBEING**	**E-MAIL:**	**jo.hawthorne@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of the report is to update members of the Board on the progress of the development of the Wellbeing Dashboard.

1.2 The development of a Wellbeing Dashboard was agreed in principle at a previous Health and Wellbeing Board meeting on 18th March 2016. http://www.reading.gov.uk/media/4822/Item-10/pdf/item10.pdf

1.3 The latest draft of the Wellbeing Dashboard will be presented and demonstrated at the meeting and is attached at Appendix 1.

2. RECOMMENDED ACTIONS

2.1 To endorse the Dashboard and the initial indicator sets.

2.2 To recommend that the Dashboard is presented as a standing item at each Health and Wellbeing Board.

2.3 To consider arrangements for performance to be presented and scrutinised including leads for each area, pending the new Health and Wellbeing Strategy.

2.4 To endorse the proposed next steps (section 4.3)

3. POLICY CONTEXT

3.1 In January 2016, the LGA was appointed to complete a Peer Challenge review of Reading's Health and Wellbeing Board, which was conducted through 'on-site' visits in the following March. The recommendations from the Review included increasing accountability and transparency of progress against stated aims and objectives.

3.2 Reading's first Health and Wellbeing Strategy has now reached the end of its term and the Board has agreed next steps to refresh the strategy for the next period. A report commissioned to review the current strategy and the most recent Joint Strategic Needs Assessment (JSNA) has made a number of recommendations, including ensuring that the strategy objectives aligned with outcomes in the Public Health Outcomes Framework (PHOF).

3.3 Under the Health and Social Care Act 2012 Local authorities and clinical commissioning groups (CCGs) were given equal and joint duties to prepare Joint Strategic Needs Assessments and Health and Wellbeing Strategies through the local Health and Wellbeing Board. The Board's role is to be focused on improving outcomes when assessing needs, setting strategies and reviewing whether outcomes have changed as a result of agreed action/s, taking into consideration the long-term nature of achieving many public health outcomes.

4. THE PROPOSAL

4.1 Current Position

On 18th March 2016 Reading's Health and Wellbeing Board agreed to the draft 'Wellbeing Dashboard', which contained key priorities with associated performance indicators and outcome measures. It was suggested that these could be reported and monitored at Health and Wellbeing Board meetings by partners, providing transparent information on the delivery of the Health and Wellbeing Strategy. It was agreed that a group of key stakeholders would form a task and finish group to further develop the format of the dashboard to present to the next Health and Wellbeing Board.

4.2 Options Proposed

Key issues discussed by the group are set out below. Following the group meeting, the model for the dashboard has been developed further and the final version will be presented electronically and demonstrated at this meeting and is attached at Appendix 1.

- **Goals** – The task and finish group considered the four goals of the current Health and Wellbeing Strategy and the areas that the Board would need to take into account under each one. The group highlighted that the Board should be able to take a broad view of a wide range of areas under each goal that could then be investigated more closely where performance causes concern. These goals will be refreshed in order to reflect the development of a new Health and Wellbeing Strategy or new emerging data through the JSNA.

- **Indicators** – Indicators have been drawn from data published in one of three national outcome frameworks – the Public Health Outcomes Framework, the Adult Social Care Outcome Framework and the NHS Outcomes Framework, which largely cover all age groups. It is worth noting the Dashboard could also be used to capture any future recommendations emerging from the Ofsted Report. The use of published data will enable us to ensure that the data is robust and stable, along with demonstrating that objectives and outcomes are in line with national and local strategic aims. As described above, the indicators selected will be reviewed in accordance with the development of a new Health and Wellbeing Strategy.

- **Targets** – The group agreed that setting targets should be more ambitious than simply comparing to national or similar group average. Targets in the draft document are set at similar group average or better.

- **Format** – The group preferred that a broad range of indicators were presented in a compact format, but that fuller information was easily available. When viewed electronically, users can click on each goal for more detailed information, including comparison with the national average and similar local authority areas, and can also click on each indicator to see the full definition and data source. Users can also link to the published performance information online, including trend data where this is published.

- **Updates** – it is proposed that the HWB dashboard is updated with the most recent published data in advance of each Health and Wellbeing Board Meeting. However, once the dashboard is populated and approved by the Health Sub-Group, it will NOT then be updated before presentation to the board. This will ensure that members and other colleagues have sight of performance data before they are shared more widely.

- **Presentation to the board** – The proposal is that a lead will be identified for each indicator who will be able to provide basic background information when requested. Leads will also be able to raise any performance concerns with board members through the normal reporting channels. It is suggested that where there concerns are consistently highlighted a task and finish group can be convened to investigate.

4.3 Next Steps

Further recommendations for development will be taken into account and the model for the report will be refined further.

Development of mechanisms for ensuring sufficient background information is available to Board members on request to inform a practical oversight and understanding of performance and decision-making.

The most up-to-date version of the Wellbeing Dashboard will be presented as a standing item at the next Health and Wellbeing Board for discussion and action.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The new Health and Wellbeing Strategy with an accompanying action plan will be developed based on the needs of the local population, as determined by the Joint Strategic Needs Assessment, and provide a vision for improving the health and wellbeing of people in Reading. This project will play a vital role in ensuring that the Strategy is delivered effectively. Both the strategy and this project will support the delivery of Reading Corporate Plan Objectives, especially:

- Safeguarding and protecting those that are most vulnerable;
- Providing the best start in life through education, early help and healthy living; and
- Keeping the town clean, safe, green and active.

5.2 Further, by seeking to reduce health inequalities and promote healthy and independent living, both the Health and Wellbeing Strategy and this project will contribute directly to the Council's strategic aim of promoting equality, social inclusion and safe and healthy lifestyle for all and will contribute profoundly to the monitoring and improvement of the health of the people of Reading.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 A task and finish group with key stakeholders was used to develop the format and content of the current version of the Wellbeing Dashboard. Further consultation will be necessary to map the dashboard to the refreshed Health and Wellbeing Strategy.

6.2 Further consultation on the Dashboard will form part of the overall consultation on the Health and Wellbeing Strategy.

7. EQUALITY IMPACT ASSESSMENT

7.1 EIA is not relevant to a decision to continue to develop a Wellbeing Dashboard to monitor progress against the Health and Wellbeing Strategy.

7.2 Reading Borough Council must meet the Public Sector Equality Duty under the Equality Act 2010 and consideration will be given to this throughout any engagement activity. The Health and Wellbeing Strategy will be developed with an awareness of inequalities of health and the JSNA will continue to be a tool to support identification of inequalities across the goals.

8. LEGAL IMPLICATIONS

8.1 The Health and Social Care Act 2012 gives duties to local authorities and clinical commissioning groups (CCGs) to develop a Health and Wellbeing Strategy and to take account of the findings of the JSNA in the development of commissioning plans.

9. FINANCIAL IMPLICATIONS

9.1 Development and implementation will be delivered from existing resources with no additional expenditure. While no specific savings are forecast, closer monitoring of performance against PHOF and other outcome frameworks can be expected to ensure that commissioned services represent value for money for the locality.

10. BACKGROUND PAPERS

10.1 Proposal of a Wellbeing Dashboard – report to Reading's Health and Wellbeing Board 18th March 2016. http://www.reading.gov.uk/media/4822/Item-10/pdf/item10.pdf

10.2 Reading Health and Wellbeing Strategy – Next Steps - report to Reading's Health and Wellbeing Board 22nd January 2016. http://www.reading.gov.uk/media/4506/Item-12-Report/pdf/Item_12_Report.pdf

10.3 LGA Peer Review of the Reading and West of Berkshire Health and Wellbeing Boards Methodology and Process – report to Reading's Health and Wellbeing Board 22nd January 2016. http://www.reading.gov.uk/media/4566/Item-18-update/pdf/Item_18_update.pdf

10.4 Dr Andrew Terrell - Rapid Review of Reading Joint Strategic Needs Assessment (JSNA). 10th June 2016.

Goal	Indicator	Target Met/Not Met	Direction of Travel
Goal One - Promote and protect the health of all communities, particularly those most disadvantaged	One-year vaccinations	NOT MET	WORSE
	Two-year vaccinations	NOT MET	WORSE
	Five-year vaccinations	NOT MET	WORSE
	TB Incidence rate	NOT MET	WORSE
	HIV late presentations	NOT MET	WORSE
	Cancer early diagnoses	*NOT AVAILABLE*	*NOT AVAILABLE*
	Breast cancer screening	NOT MET	NO CHANGE
	Cervical cancer screening	NOT MET	WORSE
	Bowel cancer screening	NOT MET	*NOT AVAILABLE*
	Health check	NOT MET	*NOT AVAILABLE*
Goal Two - Increase the focus on early years and the whole family to help reduce health inequalities	Children in poverty	MET	BETTER
	Low birth weight	NOT MET	WORSE
	Infant mortality	NOT MET	NO CHANGE
	Breastfeeding initiation	MET	BETTER
	School readiness	NOT MET	BETTER
	NEET	NOT MET	WORSE
	Homelessness	NOT MET	WORSE
	Domestic violence	NOT MET	WORSE
Goal Three - Reduce the inpact of long term conditions with approaches on specific groups	Reablement	MET	BETTER
	Dementia Diagnoses	*NOT AVAILABLE*	*NOT AVAILABLE*
	Permanent admissions	NOT MET	WORSE
	Post-diagnosis care	*NOT AVAILABLE*	*NOT AVAILABLE*
	Learning disability - Employment	NOT MET	WORSE
	Learning disability - Accommodation	NOT MET	BETTER
	Mental Health - Employment	MET	WORSE
	Mental Health - Accommodation	MET	WORSE
	Suicide rate	MET	NO CHANGE
	Carers - Satisfaction	MET	*NOT AVAILABLE*
	Carers - Involvement	NOT MET	*NOT AVAILABLE*
	Carers - Social Contact	NOT MET	WORSE
	Delayed Transfers of Care	NOT MET	*NOT AVAILABLE*
Goal Four - Promote Health Enabling behaviours and lifestyle	Smoking - Adults	NOT MET	NO CHANGE
	Smoking - 15 year olds	MET	*NOT AVAILABLE*
	Smoking Cessation - quitters	NOT MET	WORSE
	% eating five a day	NOT MET	WORSE
	Obesity - Adults	MET	*NOT AVAILABLE*
	Physically Active Adults	NOT MET	WORSE
	Obesity - 10-11 year olds	NOT MET	WORSE
	Injuries due to falls	MET	WORSE
	Alcohol related hospital admissions	MET	BETTER
	Drug treatment - opiate	NOT MET	WORSE
	Drug treatment - non-opiate	MET	BETTER

Goal One	Promote and protect the health of all communities, particular those most disadvantaged									
Sub-heading	**Indicator Title**	**Framework**	**Good performance low/high**	**Most recent reporting period**	**Most recent performance**	**Target**	**Met/Not Met**	**DOT**	**England Average**	**2015 Deprivation Decile Average**
Childhood Vaccinations	One year vaccinations (Population vaccination coverage - Dtap/IPV/Hib (1 year old) and PCV (1 year old)) (%)	Public Health Outcome Framework	High	2014-15	92.8	94.0	NOT MET	WORSE	94.0	94.4
	Two year vaccinations (Population vaccination coverage - Dtap, IPV, Hib (2 year old); Hib/Men C booster; MMR for one dose; and PCV booster) (%)	Public Health Outcome Framework	High	2014-15	91.2	93.5	NOT MET	WORSE	93.0	93.5
	Five year vaccinations (population vaccination coverage - Hib/MenC (5 years old; MMR one dose (5 years old and MMR two doses (5 years old)) (%)	Public Health Outcome Framework	HIgh	2014-15	89.9	92.0	NOT MET	WORSE	91.8	92.2
Infectious Diseases	TB incidence (rate of new reported cases per year per 100,000 population)	Public Health Outcome Framework	Low	2012-14	36.3	15.0	NOT MET	WORSE	13.5	8.8
	People presenting with HIV at a late stage of infection (%)	Public Health Outcome Framework	Low	2012-14	48.5	47.5	NOT MET	WORSE	42.2	47.3
Cancer Diagnoses	Cancer diagnosed at early stage (%)	Public Health Outcome Framework	High	2014	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE		
Screening	Cancer screening coverage - breast cancer (%)	Public Health Outcome Framework	High	2015	73.4	75.0	NOT MET	NO CHANGE	75.4	NOT AVAILABLE
	Cancer screening coverage - cervical cancer (%)	Public Health Outcome Framework	High	2015	69.2	70.0	NOT MET	WORSE	73.5	75.4
	Cancer screening coverage - bowel cancer (%)	Public Health Outcome Framework	High	2015	55.3	58.0	NOT MET	NOT AVAILABLE	57.1	58.4
	% offered a health check who received a health check in a five year period	Public Health Outcome Framework	High	2013-14 - 2014-15	49.9	51.0	NOT MET	NOT AVAILABLE	48.9	51.2

Back to HWB Dashboard

Goal Two Increase the focus on early years and the whole family to help reduce health inequalities

Sub-heading	Indicator Title	Framework	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	Deprivation Decile Average
Children in poverty	Children in poverty (under 16s) (%)	Public Health Outcomes Framework	Low	2013	18.4	18.4	MET	BETTER	18.6	NOT AVAILABLE
Infant health and breastfeeding	Low birth weight of term babies (% births)	Public Health Outcomes Framework	Low	2014	3.0	2.5	NOT MET	WORSE	2.9	2.5
	Infant mortality (per 1,000 births)	Public Health Outcomes Framework	Low	2011-13	4.5	4.0	NOT MET	NO CHANGE	4.0	3.6
	Breastfeeding initiation (%)	Public Health Outcomes Framework	High	2014-15	79.0	75.0	MET	BETTER	74.3	74.7
School and education	School readiness: children achieving a good level of development at the end of reception (%)	Public Health Outcomes Framework	High	2014-15	67.1	68.0	NOT MET	BETTER	66.3	68.4
	16-18 year olds not in education , employment, or training (%)	Public Health Outcomes Framework	Low	2014	8.1	4.5	NOT MET	WORSE	4.7	4.3
Stable Family Environment	Homelessness acceptances per 1,000 households	Public Health Outcomes Framework	Low	2014-15	5.7	2.1	NOT MET	WORSE	2.4	2.1
	Rate of domestic abuse incidents reported to the police per 1,000 population	Public Health Outcomes Framework	Low	2014-15	22.7	20.5	NOT MET	WORSE	20.4	NOT AVAILABLE

Back to HWB Dashboard

Goal Three Reduce the impact of long term conditions with approaches on specific groups

Sub-heading	Indicator Title	Framework	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	Deprivation Decile/Similar LAs Average
Long term conditions	Proportion of older people (65 and older) who were still at home 91 days after discharge from hospital into	Adult Social Care Outcome Framework and NHS Outcome Framework	High	2014-15	91.5	85.0	MET	BETTER	82.1	81.4
	Estimated diagnosis rate for those with dementia	Public Health Outcomes Framework	High	2013-14	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE	52.5	NOT AVAILABLE
	Placeholder A measure of the effectiveness of post-diagnosis care in sustaining indepence and improving quality of life	Adult Social Care Outcome Framework			NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE	NOT AVAILABLE
	Permanent admissions to residential and nursing care homes per 100,000 population	Adult Social Care Outcome Framework	Low	2014-15	936.1	712.5	NOT MET	WORSE	668.8	712.5
Learning Disability	Adults with a learning disability who live in stable and appropriate accommodation (%)	Public Health Outcomes Framework	High	2014-15	68.3	73.3	NOT MET	WORSE	73.3	73.7
	Gap in the employment rate between those with a learning disability and the overall employment rate (%)	Public Health Outcomes Framework	Low	2014-15	68.4	66.0	NOT MET	BETTER	66.9	NOT AVAILABLE
Mental Health	Adults in contact with secondary mental health services who live in stable and appropriate accommodation (%)	Public Health Outcomes Framework	High	2014-15	80.7	60.0	MET	WORSE	59.7	NOT AVAILABLE
	Gap in the employment rate between those in contact with secondary mental health services and the overall	Public Health Outcomes Framework	Low	2014-15	64.0	66.0	MET	WORSE	66.1	NOT AVAILABLE
	Suicide rate per 100,000 population	Public Health Outcomes Framework	Low	2012-14	8.8	8.8	MET	NO CHANGE	8.8	NOT AVAILABLE
Carers	Overall satisfaction of carers with social services (%)	Adult Social Care Outcome Framework	High	2014-15	41.8	41.8	MET	NOT AVAILABLE	41.2	41.7
	The proportion of carers who report that they have been included or consulted in discussions about the person they care for	Adult Social Care Outcome Framework	High	2014-15	71.0	71.4	NOT MET	NOT AVAILABLE	72.3	71.4
	% of carers who have as much social contact as they would like	Public Health Outcomes Framework	HIgh	2014-15	36.6	38.0	NOT MET	WORSE	38.5	NOT AVAILABLE
Delayed transfers of care	Delayed transfers of care from hospital, and those which are attributable to adult social care (per 100,000 population)	Adult Social Care Outcome Framework	Low	2014-15	6.4	4.8	NOT MET	WORSE	3.7	4.8

Back to HWB Dashboard

Goal Four Promote health-enabling behaviours and lifestyles

Sub-heading	Indicator Title	Framework	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT (up= better, down=worse)	England Average	Deprivation Decile Average
Smoking	Smoking prevalence in adults (%)	Public Health Outcome Framework	Low	2014	17.0	17.0	MET	NO CHANGE	18.0	NOT AVAILABLE
	Smoking prevalence at 15 years old - current smokers (survey data) (%)	Public Health Outcome Framework	Low	2014/15	8.2	8.2	MET	NOT AVAILABLE	8.2	NOT AVAILABLE
	Stop Smoking Service provider performance (number of quitters)	Public Health Outcome Framework	High	Q3 2014/15	615	645	NOT MET	WORSE	NOT AVAILABLE	NOT AVAILABLE
	Proportion of the population meeting the recommended '5 a day' (%)	Public Health Outcome Framework	High	2015	49.4	54.0	NOT MET	WORSE	52.3	54.1
Obesity	Excess weight in adults (%)	Public Health Outcome Framework	Low	2012-14	61.0	64.6	NOT MET	NOT AVAILABLE	64.6	NOT AVAILABLE
	% of adults who are physically active	Public Health Outcome Framework	High	2014	54.7	57.0	NOT MET	WORSE	57.0	NOT AVAILABLE
	Excess weight in 10-11 year olds (%)	Public Health Outcome Framework	Low	2014-15	35.6	32.0	NOT MET	WORSE	33.2	32.0
Falls	Injuries due to falls in people aged 65 or over (rate per 100,000)	Public Health Outcome Framework	Low	2014-15	1,851	2,000	MET	WORSE	2,125	NOT AVAILABLE
Alcohol	Alcohol-related hospital admissions per 100,000 population	Public Health Outcome Framework	Low	2014-15	541	597	MET	BETTER	641	597
Drugs	Successful completion of drug treatment (opiate users) (%)	Public Health Outcome Framework	High	2014	5.6	7.4	NOT MET	WORSE	7.4	7.4
	Successful completion of drug treatment (non-opiate users) (%)	Public Health Outcome Framework	High	2014	44.0	44	MET	BETTER	39.2	36.7

Back to HWB Dashboard

SMOKING IN ADULTS - INDICATOR DEFINITION

Back to Goal One
Back to HWB Dashboa

Indicator numl	**2.14**
Indicator full r	**2.14 - Prevalence of smoking among persons aged 18**
Rationale	Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart In 2008/09, some 463,000 hospital admissions in England among adults aged 35 and over were attributable to smoking, or some 5 per cent of all hospital admissions for this age group (NHS Information Centre (2010). Statistics on Smoking: England, 2010, NHS Information Centre, Leeds). Illnesses among children caused by exposure to second-hand Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population.The Government's Tobacco Control Plan (Health Lives, Healthy People: A Tobacco Control Plan <p>The Government’s Tobacco Control Plan (Healthy Lives, Healthy People: A Tobacco Control Plan for England, <a href="http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124960.pdf" title="Tobacco Control Plan" target="_blank">http://www.dh.gov.uk/prod_consum_dh/gr
Definition	Prevalence of smoking among persons aged 18 years and
Data source	Integrated Household Survey. Analysed by Public Health
Indicator sourc	Integrated Household Survey.
Indicator produ	Public Health England Knowledge and Intelligence Team
Definition of nu	The number of persons aged 18+ who are self-reported smokers in the Integrated Household Survey. The number of respondents has been weighted in order to improve
Source of nume	Integrated Household Survey
Definition of de	Total number of respondents (with valid recorded smoking status) aged 18+ in the Intergrated Household Survey. The number of respondents has been weighted in order to
Source of deno	Integrated Household Survey
Value type	Proportion
Methodology	The prevalence is calculated by dividing the weighted number of self-reported smokers aged 18+ by total number 95% confidence intervals have been calculated based on simple random sampling. The complexity implied by the various survey designs means that sampling errors calculated
Unit	%
Age	18+ yrs
Sex	Persons
Year type	Calendar
Frequency	Data are updated annually.
Benchmarking	Confidence intervals overlapping reference value
Benchmarking	95%
Confidence int	Normal approximation

SMOKING IN ADULTS - INDICATOR DEFINITION

Indicator numl	**2.14**
Indicator full r	**2.14 - Prevalence of smoking among persons aged 18**

Back to Goal One
Back to HWB Dashboa

Confidence int	A confidence interval is a range of values that is used to quantify the imprecision in the estimate of a particular indicator. Specifically it quantifies the imprecision that results from random variation in the measurement of the Normal approximation methods can be used to calculate approximate confidence intervals for a wide variety of indicators. Any indicator value which is calculated as a mean of the observed values can be approximated with a Normal distribution as long as the sample size is sufficiently large. Distribution-specific methods should be used whenever possible, especially when the indicator is a rate with very The general form of all Normal approximation methods is: A 100(1 − α)% confidence interval for an indicator value, x, is where α is the significance value specifying the width of the confidence interval, SE(x) is the standard error of the indicator value (estimated by different methods according to For example for a 95% confidence interval, α = 0.05 and z = 1.96 (the 97.5th percentile value from the Standard Normal For proportions, SE(x) is estimated by: √(x(1 − x)/n) where x is the indicator value (the observed proportion) and
Confidence lev	95%
Confidence int	95% confidence intervals have been calculated based on simple random sampling. The complexity implied by the various survey designs means that sampling errors calculated For City of London, the lower confidence limit has been calculated as less than zero as the observed proportion and denominator are small. As negative values of this indicator are not valid, the lower confidence limit has been set to
Disclosure cont	Data for Isles of Scilly have been included in the total for Cornwall. The data are subject to standard disclosure
Caveats	Each eligible participant (18 years and over) in the Integrated Household Survey (IHS) was asked whether they had ever smoked a cigarette and whether they currently These data have not been age-standardised and, therefore, variation between area values may be a result of differences in population structure. IHS data are currently experimental The numerator and denominator accounts (which have been weighted to improve representativeness) are based on a sample of the population and, as such, are not true counts. Where the estimate is based on a sample size of less than 30
Notes	The Integrated Household Survey is a composite household survey combining the answers from a number of ONS

SMOKING IN ADULTS - INDICATOR DEFINITION

Indicator numl	**2.14**	Back to Goal One
Indicator full r	**2.14 - Prevalence of smoking among persons aged 18**	Back to HWB Dashboa
	Inequalities data is available at England level only. All inequalities dimensions were calculated using the Household Weight (HH141R14) in the Integrated Household Survey dataset, with the exception of sexual identity which uses the	
Data re-use	Data may be re-used referencing the Integrated Household	
Links	Integrated Household Survey User Guides	

(2C) Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population

Back to Goal Three
Back to HWB Dashboard

Domain / Outcome

2. Delaying and reducing the need for care and support.

When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

Rationale

This measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population. It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

Definition / interpretation

This is a two-part measure that reflects both the overall number of delayed transfers of care (2C part 1) and, as a subset, the number of these delays which are attributable to social care services (2C part 2).

A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.

A patient is ready for transfer when:

(a) a clinical decision has been made that the patient is ready for transfer AND
(b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND
(c) the patient is safe to discharge/transfer.

Set out below is a table showing UNIFY2 definitions for the attribution of different reasons for delay:

Attributable to NHS
Attributable to Social Care
Attributable to both
A. Awaiting completion of assessment
B. Awaiting public funding
C. Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
Di). Awaiting residential home placement or availability
Dii). Awaiting nursing home placement or availability
E. Awaiting care package in own home
F. Awaiting community equipment and adaptations
G. Patient or family choice
H. Disputes
I. Housing – patients not covered by NHS and Community Care Act

Interpretation

Using a two-part measure means that we can maintain a focus on joint working, while balancing this with a measure that focuses more closely on the specific contribution of social care services.

Alignment

ASCOF measure only

Risk adjustment

(2C) Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population

Risk adjustment does not seem appropriate for this measure since the objective is that delayed transfers of care are minimised. The factors affecting whether this is achieved should largely be within the control of local health and care services.

Formula x100,000

Where, for 2C part 1 (total delayed transfers):

X: The average number of delayed transfers of care (for those aged 18 and over) on a particular day taken over the year. This is the average of the 12 monthly snapshots collected in the monthly Situation Report (SitRep).

Source:Unify2

Y: Size of adult population in area (aged 18 and over)

Source: ONS mid year population estimates26

For 2C part 2 (delayed transfers attributable to social care):

X: The average number of delayed transfers of care (for those aged 18 and over) on a particular day taken over the year, that are attributable to social care or jointly to social care and the NHS. This is the average of the 12 monthly snapshots.

Source: UNIFY2

Y: Size of adult population in area (aged 18 and over)

Source: ONS mid year population estimates27

26 If a population estimate does not exist for the current year then the previous year's estimate will be used.

27 If a population estimate does not exist for the current year then the previous year's estimate will be used.

Worked example

Suppose the total number of delayed discharges from the 12 monthly snap shots is 812.

Divide this by 12 for a monthly figure.

And if the ONS mid-year population estimate = 570,562

Therefore the average rate of delayed transfers is calculated as:

((812 /12) /570,562) *100,000

11.9

If the total number of delays attributable to social care or jointly to social care and the NHS is 271, the average rate of delayed transfers of care attributable to social care or social care and the NHS jointly is calculated as:

((271 /12) /570,562) *100,000

4

Disaggregation
available

Equalities: Age (18+)

Client groups: Adults aged 18+

Frequency of collection

Annual

Data source

UNIFY2 (DH)

Office of National Statistics

Return format

Numeric

(2C) Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population

Decimal places

One

Longer-term development options

None identified

Further guidance

Guidance for 2012/13 onwards can be found via the social care collection page at http://www.ic.nhs.uk/services/social-care/social-care-collections by clicking on the year.

Guidance on UNIFY2 can be found at: http://transparency.dh.gov.uk/2012/06/21/dtoc-information/

Delayed discharges data can be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AcuteandNon-AcuteDelayedTransfersofCare/index.htm

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT CARE & HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**15 JULY 2016**	**AGENDA ITEM:**	**10**
TITLE:	**UPDATE ON THE JOINT HEALTH & WELLBEING STRATEGY REFRESH**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN / COUNCILLOR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**ALL**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**JO HAWTHORNE**	**TEL:**	**0118 937 3623**
JOB TITLE:	**HEAD OF WELLBEING**	**E-MAIL:**	**Jo.Hawthorne@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report sets out progress to date in developing a 2nd Joint Health and Wellbeing Strategy for Reading.

1.2 Members of the Health and Wellbeing Board have worked with stakeholders to review the 2016 Joint Strategic Needs Assessment (JSNA) and performance against the 2013-16 Health and Wellbeing Action Plan. There will be further involvement with partners and communities to develop proposed priorities for the new strategy which will then go through a period of formal consultation in the autumn. The new strategy will reflect Board members' agreed priorities for health and social care integration, and the need to develop a framework to drive co-commissioning across the Board's membership. The 2017-20 strategy will incorporate wellbeing responsibilities towards residents with current or emerging care and support needs so as to be comprehensive and Care Act compliant.

1.3 The refreshed Health and Wellbeing Strategy will also represent – in part - the Board's response to the recommendations of a health and wellbeing peer review carried out in March 2016, and offer an outcome focused framework to drive the future agenda of the Health and Wellbeing Board.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board agrees to the proposals for development of Reading's 2017-20 Health and Wellbeing Strategy, and requests a further report to the Board's October 2016 meeting on the commencement of a formal consultation.

3. POLICY CONTEXT

3.1 The primary responsibility of Health and Wellbeing Boards, as set out in the Health and Social Care Act 2012, is to produce a Joint Strategic Needs Assessment (JSNA) to identify the current and future health and social care needs of the local community, which will feed into a Joint Health and Wellbeing Strategy (JHWS) setting out joint priorities for local commissioning. Through these key tools, the Health and Wellbeing Board will develop plans to:

- improve the health and wellbeing of the people in their area;
- reduce health inequalities; and
- promote the integration of services.

Local authority and CCG commissioning plans should then be informed by the JSNA and the Joint Health and Wellbeing Strategy.

3.2 Responsibility for the Joint Health and Wellbeing Strategy falls on the Health and Wellbeing Board as a whole and the delivery of an effective strategy depends upon all members working together throughout the process. Boards also need to work with a wider range of local partners and the community beyond the Board's membership. Working with local partners supports the Board to develop a thorough and broad assessment of local needs by using the evidence and expertise which partners can provide, and also to build on community assets in a co-ordinated way.

3.3 The Care Act in 2014 created a new statutory duty for local authorities to promote the wellbeing of individuals. This duty – also referred to as 'the wellbeing principle' - is a guiding principle for the way in which local authorities should perform their care and support functions. It is not confined to the Council's role in supporting those who are eligible for Adult Social Care, however, but includes all assessment functions, the provision of information & advice, and the local offer of 'preventative' services. The Care Act gives the local authority a responsibility to provide or arrange services that reduce needs for support among people and their (unpaid/family) carers in the local area, and contribute towards preventing or delaying the development of such needs. This is a corporate responsibility, and needs to be considered alongside the general duty of co-operation (with partners outside the local authority).

3.4 The Care Act requires councils to have a strategy for meeting their wellbeing responsibilities under the Act. In January 2016, Reading Borough Council launched a draft Adult Wellbeing Position Statement intended to cover this responsibility whilst a revised JSNA and then updated Health and Wellbeing Strategy were in preparation. Feedback from a public consultation on the Adult Wellbeing Position Statement will inform the development of Reading's 2016-19 Health and Wellbeing Strategy.

4. READING'S JOINT THE HEALTH AND WELLBEING STRATEGY

4.1 Reading's 2013-16 Health and Wellbeing Strategy identifies four goals to achieve the vision of a healthier Reading.

- Goal 1: Promote and protect the health of all communities particularly those disadvantaged
- Goal 2: Increase the focus on early years and the whole family to help reduce health inequalities
- Goal 3: Reduce the impact of long term conditions with approaches focused on specific groups
- Goal 4: Promote health-enabling behaviours & lifestyles tailored to the differing needs of communities

4.2 Health and wellbeing are broad issues which are supported by a wide range of services – from acute and community health through to the quality of our environment, access to housing, education, transport and leisure, and the wide range of formal and informal supports which help people feel involved with and part of their local communities. The Health and Wellbeing Board recognises the need to focus its oversight on those areas where the Board as a collective entity can have the greatest impact. In this regard, the Board will take into consideration the recommendations of the LGA Health and Wellbeing Peer Challenge carried out in March 2016. In considering the goals to adopt for Reading's 2nd Joint Health and Wellbeing Strategy, the Board is conscious of the need to consolidate its role as leading the local system for health and wellbeing and bringing stakeholders together in a strong place-based partnership.

4.3 Reading's first Joint Health and Wellbeing Strategy has been reviewed against:

- the refreshed JSNA, launched in April 2016;
- performance against the 2013-16 Health and Wellbeing Action Plan;
- Reading's programme for health and social care integration, including the Berkshire West 10 Integration Programme and the 2016 Reading Better Care Fund Plan; and
- the priorities identified in Reading's Adult Wellbeing Position Statement for meeting the Care Act wellbeing duty.

4.4 An independent analysis of the 2016 JSNA key findings against the 1st Joint Health and Wellbeing Strategy for Reading highlighted the following areas for review in the development of the 2nd Joint Health and Wellbeing Strategy.

<u>Goal One – Promote and protect the health of all communities particularly those disadvantaged</u>

- In Berkshire, TB services are of high quality with good treatment completion rates. However, there is a wide variation in BBV screening and Hepatitis B vaccination uptake among high-risk groups, and a lack of clarity regarding referral pathways for Hepatitis B and C. There is also currently no Berkshire TB strategy, although this is being developed during 2016 as part of the work-stream of the newly formed South East TB Control Board.

- Reading has a Child Sexual Exploitation strategy which has identified the need to work better within communities.

- Downs screening is below target at 92%.

Goal Two – Increase the focus on early years and the whole family to help reduce health inequalities

- It is important that all women access the antenatal care pathway by the recommended stage of pregnancy. The percentage of women in Reading who were smoking at time of delivery is below the national rate. Breast feeding rates are generally above average in Reading, but there is considerable inter-ward variation.

- In 2015 there were 156 people with autism in Reading who were receiving support. Reading now has an Autism Strategy.

- 17.8% of children in Reading are in low income families.

- The oral health of 5 year old children in Reading is markedly worse than the national and regional populations as a whole.

Goal Three – Reduce the impact of long term conditions with approaches focused on specific groups

- The population of Reading aged 65 years and over is predicted to rise by 11,500 from 2016 to 2037. The number of Reading residents aged 65 years and over with dementia is predicted to increase by 749 people over the same period.

- As the proportion of elderly residents rises, it is predicted that the number of Reading residents with diabetes (diagnosed and undiagnosed) will rise from 6.1% in 2015 to 7.3% in 2030. Reading is part of the diabetes prevention pilot and this should be actively promoted to address the known risk factors.

- NICE recommends the promotion of a healthy lifestyle in mid-life to reduce the risk of or delay the onset of disability, dementia and frailty in later life.

- NICE recommends that health and social care staff should aim to promote and maintain the independence, including mobility, of people with dementia.

- It is estimated that around 590 Reading residents have moderate or severe learning disability. There is large variation in the cost-effectiveness of residential services and services provided may not reflect individual needs.

- Reading has a sufficient number of nursing dementia beds to cater for expected demand through to 2030, but there is little resilience.

- Respiratory conditions are the most common reason for GP consultation or emergency admission. All patients with chronic respiratory conditions should be identified and entered on a chronic disease register.

- 12,315 Reading residents identified themselves as a Carer in the 2011 Census – 291 of these carers were aged 0-15 years and 2,324 were aged over 65 years.

<u>Goal Four – Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities</u>

- It is estimated that at least 30,000 Reading residents are drinking to hazardous levels and 4,500 are drinking to harmful levels.

- There are very many more people in Reading who could benefit from specialist alcohol misuse services than are currently able to receive them.

- There are many people in Reading with either (or both) 'early' misuse of alcohol and drugs who could benefit from specialist intervention.

- The prevalence of overweight and obesity amongst adults and children in Reading by far exceeds the capacity of intervention programmes. Reading mirrors national trends in terms of the relationship between obesity prevalence and deprivation.

- 54.7% of Reading adults are classified as physically active whilst 25.5% are inactive. These are broadly on par with national rates but slightly below the regional rates. Reading has a wide range of projects promoting physical activity but these need to ensure access to those most at need.

4.5 In addition, the 2016 JSNA identifies a number of areas of health inequality which are not addressed in the 1st Joint Health and Wellbeing Strategy:

- **Cancer** is the commonest cause of death in people aged under 75 years in Reading.
- Reading is ranked 13th of 15 similar localities for **premature death**
- Reading is ranked 15th of 15 similar localities for **heart disease & stroke**
- More can be done locally to support residents to reduce **risks for CVD** related to lifestyle.
- There are some key areas of **high deprivation** in Reading, and most areas with high levels of overall deprivation also have a high level of health deprivation.
- Reading has high employment & high earnings - but there are still areas of deprivation and a large student population.
- Reading has an increasingly diverse population with those from BME groups most likely to live in central areas of the borough.
- For Reading residents aged over 85 the rate of excess winter deaths was 32%, compared to 24% nationally, although this rate has been gradually improving since 2006.

The full analysis appears at Appendix 1.

4.6 The JSNA also references the evidence base on the outcomes of early intervention, prevention and enablement activities in various areas, and so has helped the Board to identify where there are clear causal links between targeted wellbeing interventions and improved health or care outcomes. This will drive the Board's consideration of where to focus its efforts in terms of promoting health and wellbeing. It remains important, however, to develop local schemes against clear criteria which will enable us to evaluate these and so develop our understanding of what works and where the benefits clearly outweigh the costs.

4.7 Performance against the 2013-16 Health and Wellbeing Action Plan has been strong in the following areas:

- Sexual health services are performing well in general and an information website has been developed.
- The Drug & Alcohol Treatment service has launched 'Reading IRiS Phased and Layered Treatment Model'. Successful treatment completions rates are improving.
- Compliance visits completed for early years settings and any identified actions are been delivered.
- Breastfeeding initiation rates continue to exceed regional and national averages.
- A Domestic Abuse strategy is agreed and in place.
- Long term conditions are managed by multiple support activities and relevant boards.
- A new Carers Information and Advice service is in place.
- Opportunities for active travel have increased by implementing schemes to encourage more cycling and walking.

- NCMP 3 year aggregated data is available to help target future weight management offers to local school children.
- Smoking prevalence is just below national averages.

4.8 However, progress has been slower than envisioned in some other areas:

- HIV testing and diagnoses rates need to improve.
- New information pathways for residents from BME communities need to be explored and adopted.
- The uptake of NHS health checks need to increase.
- Work is needed to increase cancer screening rates from existing levels.
- Work needs to continue to improve access to services for residents with physical and learning disabilities.

4.9 The Health and Wellbeing Board has overseen the development of Reading's Better Care Fund plans – now in their second phase - and will continue to receive regular progress reports on delivery against those plans. The Board also receives reports from the wider Berkshire West Integration Programme (the 'BW10') which has joint accountability to the Reading, Wokingham and West Berkshire Health and Wellbeing Boards. The Reading Board will review its priorities for health and social care integration to determine how the Board will interface with local integration plans during the lifetime of the 2nd Joint Health and Wellbeing Strategy.

4.10 Feedback on the Council's Adult Wellbeing Position Statement has demonstrated that the Council's seven key aims for promoting wellbeing for adults with current or emerging care and support needs are supported by the local population and by partners, and these are therefore contained in the 2nd Joint Health and Wellbeing Strategy. However, people wanted to see these same aims applied to children's services too and so their reach has been broadened in the Strategy. These key aims are to:

- Embed the wellbeing principle throughout the Council's functions
- Ensure Reading homes support wellbeing
- Harness the assets Reading has to prevent care and support needs from increasing
- Empower people with care needs to self-care and to make positive lifestyle choices
- Support people to prevent their care and support needs from increasing
- Promote a re-abling approach across care services
- Ensure people with emerging care needs and unpaid carers can access services that work well together to support people's independence

4.11 Feedback on the Adult Wellbeing Positon Statement also showed that many health and wellbeing services need to be publicised more effectively – either through broader awareness raising or more targeted approaches to reach people who are less likely to be familiar with what is available. Board members will therefore collaborate to develop more effective information and advice tools. The full consultation report appears at Appendix 2.

4.12 A "dashboard" of key performance indicators has been developed to enable robust and transparent progress monitoring of commitments and actions set out in the refreshed Health and Wellbeing Action Plan. This dashboard will be finalised when the final implementation plan is presented back to the Health and Wellbeing Board in October.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 In January 2016, the Health and Wellbeing Board received a report summarising the commissioning intentions of both the local authority and the CCGs. These outlined each partner's strategic plans to improve the commissioning, review and transformation of local services. The CCG Commissioning Intentions were based on the NHS Five Year Forward View and 5 year Strategic Plan. The local authority intentions were based on the Council's Corporate Plan and Service Plans.

5.2 Decisions relating to the commissioning of health services are made currently by the CCGs (co-commissioning with NHSE for Primary Care, and via NHSE for Specialised Services), and decisions relating to the delivery of Public Health, Adult Social Care, Children's Services and Education (and many services identified as the wider determinants of health) are made by Reading Borough Council and its sub committees. Key themes emerge from the current Commissioning Intentions documents prepared by the different local commissioners, albeit interpreted in different ways. These could be summarised as:

- Prevention
- Choice and control
- 7 day working
- Community resilience/ social capital
- Efficient use of resources

5.3 There is potential for greater synergy if all commissioning authorities and stakeholders work together more closely to develop joint commissioning plans and to operationalise these plans jointly. The Health and Wellbeing Board has therefore resolved to convene a workshop in early autumn 2016 to ensure the future co-creation of commissioning intentions based on the Board's strategic aims and priorities. Following wider stakeholder engagement and refinement of the document, Reading's 2nd Joint Health and Wellbeing Strategy will provide the framework to progress this co-commissioning agenda in Reading.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 Refreshing the Joint Health and Wellbeing Strategy for Reading has begun with a workshop (the Health & Wellbeing Involvement Group) bringing together members of the Health and Wellbeing Board and other key stakeholders representing public services, local providers and Reading's voluntary sector. This stakeholder group has brought a range of knowledge and expertise into a collaborative review of local need, and past performance against agreed health and wellbeing goals.

6.2 Members of the Involvement Group welcomed the opportunity to be involved in the development of the 2017-20 strategy at an early stage and so shape the draft strategy prior to a formal consultation period. In future, the Involvement Group would like to see:

- a clear plan to shift our emphasis onto prevention rather than care;
- an approach which takes a holistic view of people rather than looking at health conditions in isolation;
- stronger collaboration around providing people with the information they need to take charge of improving their own health;
- recognition that different approaches are needed to reach different communities;
- better use of technology to empower people, support independence and make the most efficient use of limited resources;
- a strategy which focuses our collective effort on fewer priorities, and so targets the biggest risks for Reading.

6.3 The Involvement Group was particularly keen to ensure a very wide cross section of Reading in involved in the further development of Reading's 2nd Joint Health & Wellbeing Strategy. There is a particular need to involve the people of Reading's different communities, the providers of local services, and our various faith and community groups. These are the people who hold the detailed knowledge which we need to draw on in order to build on Reading's assets and meet the challenges ahead.

6.4 Over the next few months, the Health and Wellbeing Board will be reflecting on the findings of the Peer Review, and considering how to align Commissioning Intentions across members of the Board more closely in future (see above). Throughout these discussions, the Board will consider how the new Health & Wellbeing Strategy can steer the Board in the direction it needs to take, including providing the best foundation for health and social care integration.

6.5 There has already been a 12 week consultation on the Council's Adult Wellbeing Position Statement (see Appendix 2) and this feedback will inform the development of the new Health and Wellbeing Strategy. This will ensure that the new strategy includes Reading's approach to meeting the specific wellbeing duties detailed in the Care Act and relating to adults with current or emerging care needs.

6.6 The Health and Wellbeing Board is committed to working with partners and local residents, and will develop a draft 2nd Health and Wellbeing Strategy with stakeholders, which will then be subject to a formal public consultation. People will be invited to comment on the Board's proposed priorities to drive improvement in local health and wellbeing over the next 3 years, and to co-produce an Action Plan to deliver on those priorities. Consultation will include stakeholder and community meetings, supported by an online survey.

7. LEGAL IMPLICATIONS

7.1 The Health and Social Care Act (2012) gives duties to local authorities and clinical commissioning groups (CCGs) to develop a Health and Wellbeing Strategy and to take account of the findings of the JSNA in the development of commissioning plans. In addition, the Council has a duty under the Care Act (2014) to develop a clear framework for ensuring it is meeting its wellbeing and prevention obligations under the Care Act.

7.2 Members of the Health and Wellbeing Board are under a legal duty to comply with the public sector equality duties set out in Section 149 of the Equality Act (2010). In order to comply with this duty, members must positively seek to prevent discrimination, and protect and promote the interests of vulnerable groups. Many of those intended to benefit from the priorities set out in the draft Health and Wellbeing Strategy will be in possession of 'protected characteristics' as set out in the Equality Act, and the Strategy therefore has the potential to be a vehicle for promoting equality of opportunity.

8. EQUALITY IMPACT ASSESSMENT

8.1 The consultation will provide an opportunity to develop an understanding of how the draft Strategy might impact differently on protected groups, and will also highlight any concerns or impacts any changes may have. As a vehicle for addressing health inequalities, it is expected that any such differential impact would be positive. However, an equality impact assessment will be prepared to accompany the final strategy presented to the Board for approval.

9. FINANCIAL IMPLICATIONS

9.1 This engagement exercise will be met using existing resource and will not in itself require additional capital or revenue investment.

9.2 Consultation feedback will inform the development of the Health and Wellbeing Action Plan, at which point the financial implications of adopting the Strategy will be presented to the Health and Wellbeing Board. It will be an imperative that the Strategy drives the efficient use of resources and identifies clear health benefits on investment so as to protect a sustainable local health and care system.

10. SUPPORTING PAPERS

Appendix 1 – Analysis of Reading 2016 JSNA – Dr Andrew Tyrell – May 2016
Appendix 2 - Adult Wellbeing Position Statement: consultation report May 2016

APPENDIX 1

Friday 10th June 2016
Author: Dr Andrew Terrell

RAPID REVIEW OF READING JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Introduction

The Joint Strategic Needs Assessment (JSNA) presents an analysis of the local population's health status, assets and needs. It is used to inform the development of the local Health & Wellbeing (HWB) Board's strategy to improve the health and wellbeing of the people of Reading.

The Reading JSNA was recently updated; taking advantage of the latest national and local information on the health and wellbeing of Reading residents. This rapid review was commissioned to inform the updating of the Reading Health and Wellbeing Strategy and plan. The approach adopted was to review the findings of the JSNA against the objectives of the existing Health and Wellbeing Strategy (Annex A). These were then reviewed with reference to the latest national data on the health and wellbeing of Reading residents.

This paper does not reflect the totality of the actions required to improve the health and wellbeing of Reading residents. Instead it highlights those areas where the health and wellbeing fall below expectations and which should be specifically considered in the development of the future Health and Wellbeing Strategy. There is a lot of good work that is going on to improve the health and wellbeing of Reading residents and the majority needs to continue. However, the opportunity should be taken to review existing projects to ensure that they continue to meet the needs of Reading residents and that they are cost effective.

How we have done

Reading's first HWB Strategy has been supported by an action plan which was developed and put in place to monitor progress against specific goal and objective areas. Updates have been incorporated where these have been provided by key partners and action leads. Completed activities and performance measures have been included where available. The full action plan is available on request from the Wellbeing team, however key points to note are:

Good progress

- Sexual health services are performing well in general and an information website has been developed.
- The Drug & Alcohol Treatment service has launched 'Reading IRiS Phased and Layered Treatment Model'. Successful treatment completions rates are improving.
- Compliance visits completed for early years settings and any identified actions are been delivered.
- Breastfeeding initiation rates continue to exceed regional and national averages.
- Domestic abuse strategy agreed and in place.
- Long term conditions managed by multiple support activities and relevant boards.

- A new carers information and advice service is in place.
- Opportunities for active travel increased by implementing schemes to encourage more cycling and walking.
- NCMP 3 year aggregated data available to help target future weight management offers to local school children.
- Smoking prevalence just below national averages.

Further work needed

- HIV testing and diagnoses rates need to improve.
- New information pathways for residents from BME communities to be explored and adopted.
- Uptake of NHS health checks need to increase.
- Work to increase cancer screening rates from existing levels.
- Continue work to improve access to services for residents with physical and learning disabilities.

A dashboard of key performance indicators has now been developed to enable robust and transparent progress monitoring of commitments and actions set out in the refreshed Health and Wellbeing Action Plan.

National Context

The Department of Health paper *Public Health Outcomes Framework 2013 to 2016*[1] sets out the desired outcomes for public health in England. The government's vision is "*to improve and protect the Nation's health and well-being and improve the health of the poorest fastest."* The framework has four broad objectives and for each a number of indicators have been identified which allow progress to be monitored. These are summarised at Annex B.

The results for local authorities in England are updated on a regular basis and they are publically and freely available at: http://www.phoutcomes.info/. Given this degree of public scrutiny, it is logical that the future Reading Health & Wellbeing plan align with the metrics that will monitor improvements in health and wellbeing in Reading and across England.

It is recommended that the objectives of the 2016-2019 Health & Wellbeing Strategy align with the Public Health Outcomes Framework (PHOF).

It is recommended that existing health and wellbeing activities be reviewed and the value of those not contributing to a PHOF outcome measure challenged.

If these recommendations are accepted, the future Reading health and Wellbeing Strategy could have the following four objectives:

- Tackle the wider factors that adversely affect health and wellbeing in Reading.

[1] https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

- Protect Reading residents from major incidents and other health threats.
- Support Reading residents to live healthy lifestyles and to make healthy lifestyle choices.
- Reduce the number of Reading residents living with preventable ill health and dying prematurely.

From 2015, the Council acquired a new statutory duty to promote the wellbeing of individuals under the Care Act. This duty underpins all care and support functions - including all assessment functions, the provision of information & advice, and the local offer of 'preventative' services to reduce needs for support among people and their (unpaid/family) carers. Reading has identified seven key aims for promoting wellbeing for adults with current or emerging care and support needs.

- Embed the wellbeing principle throughout the Council's functions
- Ensure Reading homes support wellbeing
- Harness the assets Reading has to prevent care and support needs from increasing
- Empower people with care needs to self care and to make positive lifestyle choices
- Support people to prevent their care and support needs from increasing
- Promote a re-abling approach across care services
- Ensure people with emerging care needs and unpaid carers can access services that work well together to support people's independence

It is recommended that the 2016-2019 Health & Wellbeing strategy incorporates the aims set out in the draft Adult Wellbeing Position Statement (published January 2016).

Local Context

The financial situation in Reading is challenging. Despite having to make savings of over £115m between 2011 and 2020 the Council has a positive vision for the future of Reading. The Council aims to become even more entrepreneurial, working in partnership, innovating, improving services to help those that are vulnerable and to reduce inequalities. In doing so, Reading's service priorities remain:

- Safeguarding and protecting those that are most vulnerable
- Providing the best life through education, early help and healthy living
- Providing homes for those in most need
- Keeping the town clean, safe, green and active
- Providing infrastructure to support the economy
- Remaining financially sustainable to deliver these service priorities

Improving the health and wellbeing of Reading residents is a fundamental element of the first two of these priority areas, but it is essential in the current financial climate that health and wellbeing activities also deliver value for money.

It is recommended that existing health and wellbeing activities be reviewed in order to confirm that they provide value for money.

Review of Joint Strategic Needs Assessment (JSNA)

The updated Reading JSNA has been reviewed and the key messages identified. These are summarised in Annex B by Health and Wellbeing Strategy objective. These key messages are discussed further below, together with the implications for services in Reading. For the sake of clarity these are grouped by PHOF objective.

In general, the objectives in the current Strategy relating to Goal 3 (Reduce the impact of long term conditions with approaches focused on specific groups) are concerned with the provision of care and the support of carers rather than reducing the impact of long term conditions through reducing their incidence. These objectives relate more to the local authority's wellbeing duties under the Care Act (2014) than to PHOF.

It is recommended that the objectives relating to reducing the impact of long term conditions be refocused to reflect consultation feedback on the draft Adult Wellbeing Position Statement, and expanded to include objectives focused on reducing the incidence of long term conditions.

Overarching Indicators.

PHOF Outcome 0.1 Healthy Life Expectance at Birth measures the average number of years an individual can expect to live in good health based upon contemporary mortality rates and prevalence of self-reported good health.

In 2012/4 the Healthy Life Expectancy at birth for Reading males was 66.2 years (which is above expectations), whilst overall life expectancy at birth for males was 78.5 years (which was below expectations and one year below the national average). This would suggest that reading males maintain their good health well into older years, but then fade rapidly. This would suggest a need to target health improvement activities in middle to later years.

It is recommended that health improvement activities are targeted on middle to later years.

At birth Reading women have a healthy life expectancy of 64.6 years and an overall life expectancy of 82.9 years. Both are in line with expectations.

Life expectancy in Reading males varies from 84.7 years in Mapledurham to 73.6 years in Minster. For females the range is 88.0 years in Mapledurham to 79.3 years in Minster.

It is recommended that health improvement activities are targeted at those living in the more deprived areas in Reading.

Improving the wider determinants of health

These indicators track progress in improving the wider factors that affect health and wellbeing.

In 2013, 18.4% of children aged less than 16 years in Reading were in low income families. With the exception of phonics screening tests in Year 1, all indicators of school readiness

were in line with expectations. Reading schools appear to be delivering early years support at around the level expected of them.

In 2014, 8.1% of 16-18 year olds in Reading were not in education, employment or training. This was the worst figure in the region and is an area where further action may be required.

> **It is recommended that action is taken to increase the education, employment and training opportunities for 16-18 year old residents.**

In 2012/4, 28.3 per 100,000 Reading residents were killed or seriously injured on the roads and 21.5 per 100,000 were admitted to hospital as an emergency following a violence incident. Both of these were amongst the best in the region and better than expected.

In 2014/5, 0.36% of Reading households were in temporary accommodation, the second worse area in the South East region and an area where further work may be required.

> **It is recommended that action is taken to reduce the number of Reading households held in temporary accommodation.**

Health improvement

These indicators track progress in helping people to live healthy lifestyles and to make healthy lifestyle choices.

In 2012/4 54.9% of Reading residents who were assessed for substance dependence on entering prison were found to require treatment which they had not already received in the community. This would suggest that Reading residents do not access the substance misuse services that they require.

> **It is recommended that action is taken to improve access to substance misuse services for Reading residents who require them.**

In 2014/5 4.7% of Reading residents over 17 years of age were recorded by their GP as having diabetes. This is below expectation and may suggest that many cases of diabetes are not recognised by their GPs.

> **It is recommended that action is taken to better record cases of diabetes in primary care chronic disease registers.**

PHOF outcome 2.20 measures the uptake of adult cancer screening services. As at 2015 73.4% of women had been adequately screened for breast cancer and 69.2% for cervical cancer. Only 55.3% of eligible Reading residents had been screened for bowel cancer. All three were below expectations and as a result cancer is the commonest cause of death in those less than 75 years in Reading.

> **It is recommended that action be taken to increase uptake of adult cancer screening services by Reading residents.**

PHOF outcome 2.21 measures the uptake of adult non-cancer screening services. In 2012/13 it is estimated that only 73.3% of Reading residents with diabetic retinopathy who were invited to a digital screening event actually did so. This was below expectations.

It is recommended that action be taken to increase uptake of digital screening by Reading residents known to have diabetic retinopathy.

Health protection

These indicators track progress in protecting the population's health from major incidents and other threats.

PHOF outcome 3.02-Chlamydia detection rate (15-24 year olds) is a measure of increased control activities and PHE recommend that Local Authorities work towards a detection rate of at least 2,300 per 100,000. Only 48.5% of adult HIV cases were diagnosed late in Reading, but this falls short of the national target of 25%. That said sexual health services in Reading are performing well in comparison with their regional peers.

It is recommended that action be taken to reduce the number of adult HIV cases who are diagnosed late in the course of their disease.

PHOF outcome 3.03 measures how well local vaccination services meet national targets. In Reading these targets were met in 9 out of the 13 areas assessed, but more can be done.

At 36.3 new cases per 100,000 the incidence of TB in Reading is high. This is probably the result of cases imported from high risk countries overseas and reflects the increasingly diverse nature of Reading's population. 90% of those diagnosed with TB completed treatment within one year. Whilst this is in the top 1/3rd of areas in the region it is still well below the national target.

It is recommended that action be taken to work with high risk communities to identify new cases of TB and to improve treatment completion rates.

Healthcare public health and preventing premature mortality

These indicators track progress in reducing the number of people living with preventable ill health and people dying prematurely.

PHOF outcome 4.02 is a measure of tooth decay in children. In 2011/12 children aged 5 years in Reading had on average 1.14 teeth that were decayed, missing or filled. This was above expectations and the second worst area in the region.

It is recommended that action be taken to improve the oral health of children aged less than 5 years.

PHOF outcome 4.03 is a measure of preventable deaths. In 2012/14, 269.3 per 100,000 Reading male residents died from causes that were considered to be preventable. This was above expectations. For Reading residents aged over 85 years the rate of excess winter deaths was 32%. This has been gradually improving since 2006, but still compares poorly to the national rate of 24%. Most excess winter deaths are due to circulatory and respiratory disease.

It is recommended that action be taken to reduce smoking amongst elderly residents of Reading.

PHOF outcome 4.05 is a measure of under-75 mortality due to cardiovascular diseases. In 2012/14, 92.0 per 100,000 Reading males aged less than 75 years died from cardiovascular diseases that were considered to be preventable. This was above expectations.

It is recommended that action be taken to reduce smoking and obesity in middle-aged Reading males.

PHOF outcome 4.06 is a measure of under-75 mortality from liver disease. In 2012/14, 29 per 100,000 Reading males aged less than 75 years died from liver disease that was considered to be preventable. This was above expectations and the majority were due to harmful alcohol consumption.

It is recommended that action be taken to reduce harmful and dangerous alcohol consumption amongst middle-aged Reading males.

PHOF outcome 4.07 is a measure of under-75 mortality from respiratory disease. In 2012/14, 51.5 per 100,000 Reading males aged less than 75 years died from respiratory disease. This was above expectations and the majority were due to smoking.

It is recommended that action be taken to help middle-aged Reading males to stop smoking.

It is recommended that action be taken to help middle-aged Reading males to adopt healthy lifestyles.

PHOF outcome 4.08 is a measure of mortality from communicable diseases. In 2012/14 87.4 per 100,000 Reading residents died from a communicable disease. It is not clear why this is so, but for both males and females living in Reading the rate is above expectations.

It is recommended that further work be undertaken to determine why more Reading residents die from communicable diseases than would be expected.

General observations

In 2014, the population of Reading was estimated to be around 160,800 of whom around 19,200 (11.9%) were aged 65 years or over. By 2037 the population of Reading is predicted to be around 176,000 of whom around 31,300 (17.8%) will be aged 65 years or over. A large proportion of these will be in BME communities. The JSNA would suggest that the biggest threat to the health & wellbeing of Reading residents is the more than 50% increase in the number of residents over 65 years of age over the next 20 years or so.

It is recommended that action is taken to work with local communities to promote a healthy lifestyle in middle aged residents in order to reduce the risk of or delay the onset of disability, dementia and frailty in later life. This is particularly important for difficult to reach communities.

Annex A

ANALYSIS OF JSNA KEY POINTS BY HWB STRATEGY OBJECTIVE

2013 HWB Strategy Objective	JSNA Key Point
Goal One – Promote and protect the health of all communities particularly those disadvantaged	
Objective 1 – Protect health and reduce the burden of communicable diseases by targeting services more effectively	• There is a wide variation in BBV screening and Hepatitis B vaccination uptake among high-risk groups. • The Chlamydia detection rate amongst young people aged 15 to 24 years of age was 2,799 per 100,000 and only 48.5% of adult HIV cases were diagnosed late[2]. Reading has good sexual health & HIV services. • The incidence of TB in Reading is 36.3 per 100,000 and 90% completed treatment within one year.[3]
Objective 2 - Ensure effective support is available to vulnerable and BME groups to protect their own health.	• Reading has a Child Sexual Exploitation strategy which identified the need to work better within communities.
Objective 3 – Increase awareness and uptake of Immunisation and Screening programmes	• Antenatal & newborn screening - Downs screening = 92% (below target) but no specific action required. • General vaccination rates are good and on a par with expectations.[4]
Goal Two – Increase the focus on early years and the whole family to help reduce health inequalities	
Objective 1 – Ensure high quality maternity services, family support, childcare and early years education is accessible to all	• The number of births in Reading is predicted to fall slightly from around 2,600 per year in 2013 to around 2,400 in 2037.[5] • The number of children in Reading aged under 5 years is predicted to fall slightly from around 12,000 in 2016 to around 11,000 in 2037.[6]

[2] PHOF Health Protection indicator: 3.02: Chlamydia detection rate (15 to 24 year olds). Available at: http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000043/pat/6/par/E12000008/ati/102/are/E06000038

[3] PHOF Health Protection indicators: 3.05ii: Incidence of TB and 3.05i: Treatment completion for TB. Available at: http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000043/pat/6/par/E12000008/ati/102/are/E06000038

[4] PHOF Health Protection indicators: 3.03: Population vaccination coverage. http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000043/pat/6/par/E12000008/ati/102/are/E06000038

[5] ONS 2012-based Subnational Population Projections – Table 5: available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/componentsofchangebirthsdeathsandmigrationforregionsandlocalauthoritiesinenglandtable5 (accessed 17 May 16).

[6] ONS 2012-based Subnational Population Projections – Table 4: available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2 (accessed 17 May 16).

2013 HWB Strategy Objective	JSNA Key Point
	• The number of children in Reading aged 5 to 9 years is predicted to fall slightly from 10,800 in 2016 to 9,900 in 2037. • Effective delivery of the 0-5 Healthy Child programme is needed to ensure a good start to life. • Neonatal Mortality rate fluctuates above/below national rate due to very small numbers. 7.4% of new mothers in Reading were smokers, well below national rate. • Breast feeding generally above average in Reading, but considerable inter-ward variation. • In 2014/15 7.4% of women in Reading were smoking at time of delivery. This is below the national rate. • It should be ensured that all women access the antenatal care pathway by the recommended stage of pregnancy. • Reading's absolute level of attainment in secondary education is above the national average levels.
Objective 2 – Reduce inequalities in early development of physical and emotional health, education, language and social skills	• In 2015 there were 156 people with autism in Reading who were receiving support. 62 (39.7%) of were aged 19 years or younger. • Reading has an autism strategy. • 19.4% of children in Reading are in low income families. • Insufficient data on child development until PHOF report in Apr 17. • Reading schools appear to be delivering early years support at around national average. • The oral health of 5 year old children in Reading is markedly worse than the national and regional populations as a whole.
Objective 3 - Improve identification and reduce the effects of domestic violence on emotional wellbeing for the whole family	• The number of alerts and referrals is increasing as the requirement to safeguard adults is being recognised by all professionals and agencies. • Of the estimated 35,900 children aged 0-17 years in Reading in 2014, 1,673 (4.7%) were referred to the Multi-Agency Safeguarding Hub.
Goal Three – Reduce the impact of long term conditions with approaches focused on specific groups	
Objective 1 - Assist and support ability to self-care in all adults and young people with existing long term conditions	• Little information on the prevalence of long term conditions in children and young people in Reading. Key issue is ensuring that all are recognised and have access to high quality care

2013 HWB Strategy Objective	JSNA Key Point
Objective 2 - Ensure high quality long term condition services are available to all including those with a learning disability	• The population of Reading aged 65 years and over is predicted to rise from around 19,800 in 2016 to 31,300 in 2037. • The number of Reading residents aged 65 years and over with dementia is predicted to rise from 1,446 in 2015 to 2,195 in 2030. • NICE recommends the promotion of a healthy lifestyle in mid-life to reduce the risk of or delay the onset of disability, dementia and frailty in later life. • NICE recommends that 'Health and social care staff should aim to promote and maintain the independence, including mobility, of people with dementia. • As the proportion of elderly residents rises, it is predicted that the number of Reading residents with diabetes (diagnosed and undiagnosed) will rise from 6.1% in 2015 to 7.3% in 2030. • It is estimated that around 590 Reading residents have moderate or severe learning disability. There is large variation in the cost-effectiveness of residential services and services provided may not reflect individual needs. • Reading has a sufficient number of nursing dementia beds to cater for expected demand through to 2030, but there is little resilience. • The expected loss of 18% of nursing beds for the over 65 has put pressure on the Council to continue to meet placement demand. New facilities may be required to provide additional capacity and competition in the current market. • Respiratory conditions are the most common reason for GP consultation or emergency admission. All patients with chronic respiratory conditions should be identified and entered on a chronic disease register.
Objective 3 - Build on and strengthen the quality and amount of support available to adult and young carers in Reading	• In the 2011 census, 12,315 Reading residents identified themselves as a carer. This was 7.9% of the local authority's resident population. • In 2011 there were 291 young and young adult carers (0-15 yrs) in Reading. • In 2011 there were 2,324 elderly carers (over 65 yrs) in Reading. • The percentage of the population who are carers varies between wards, from 4.4% in Abbey to 12.4% in Mapledurham. • In 2014/15 only 9% of carers in Reading were dissatisfied with the support or services they had received from Social Services, whilst 75% expressed some degree of satisfaction. • Reading is part of the diabetes prevention pilot and this should be actively promoted to address the known risk factors.

2013 HWB Strategy Objective	JSNA Key Point
Goal Four – Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities	
Objective 1 – Improve tobacco control and reduce harm due to alcohol and drug misuse in Reading	• It is estimated that at least 30,000 Reading residents are drinking to hazardous levels and 4,500 are drinking to harmful levels. • There are very many more people in Reading who could benefit from specialist alcohol misuse services than are currently able to receive. • There are many people in Reading with either (or both) 'early' misuse of alcohol and drugs who could benefit from specialist intervention. • The estimated smoking prevalence in Reading in 2014 was 17.0%, broadly in line with the national average, but the rates of smoking attributable mortality and hospital admission are slightly below the national rates.
Objective 2 – Enhance support and target causes of lifestyle choices impacting health for adults and children	• Life expectancy at birth for males varies from 73.6 years in Minster to 84.7 years in Mapledurham. For females life expectancy at birth varies from 79.3 years in Minster to 88.0 years in Mapledurham. • Biggest unmet need is ensuring access to and take up of healthy lifestyles. • Teenage pregnancy rate has fallen over past 5 years, but the rate in Reading is still higher than national and regional rates.
Objective 3 – Reduce the prevalence, social and health impacts of obesity in Reading including targeting key causes	• Reading mirrors national trends in terms of the relationship between obesity prevalence and deprivation. • Berkshire has seen a 32% increase of spending over the last 5 years (10/11 to 14/15) on initial bariatric surgery procedures. • The prevalence of overweight and obesity amongst adults and children in Reading by far exceeds the capacity of intervention programmes. • 61% of adults in Reading are classified as overweight or obese, although this is better than the national rate and on a par with the regional rate.[7] • 54.7% of Reading adults are classified as physically active whilst 25.5% are inactive. These are broadly on par with national rates but slightly below the regional rates. Reading has a wide range of projects promoting physical activity but these need to ensure access to those most at need.

[7]PHOF Health Improvement indicator: 2.12: Excess weight in adults. Available at: http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000042/pat/6/par/E12000008/ati/102/are/E06000038/iid/90362/age/1/sex/1 (accessed 25 May 16).

Areas Not covered in HWB Strategy objectives

- **Air quality** is generally good, with just a few hotspots around roads
- **Cancer** is the commonest cause of death under 75 years in Reading.[8]
- Reading is ranked 13th of 15 similar LAs for **premature death**[9]
- Reading is ranked 15th of 15 similar LAs for **heart disease & stroke**
- More can be done locally to support residents to reduce **risks for CVD** related to lifestyle.
- Key areas of **high deprivation** in Reading are found:
    - in the far south of Whitley ward and the Northumberland Avenue area in the south of the borough;
    - throughout Abbey ward and around the town centre;
    - around Dee Road in Norcot ward;
    - around Coronation Square in Southcote ward; and
    - around Amersham Road in Lower Caversham.
- Although there are some exceptions, most areas with high levels of overall deprivation also have a high level of health deprivation (high risk of premature death and impairment of quality of life through poor physical or mental health)
- Reading has high employment & high earnings - but there are still areas of deprivation & lots of students.
- The "white British" **population of Reading** has decreased from 86.8% in 2001 to 66.9% in 2011. Reading has an increasingly diverse population with those from BME groups most likely to live in central areas of the borough.
- 25% of Reading population born outside the UK
- 48% of West Berkshire residents die in hospital and 45% in their normal place of residence (24% at home and 21% in a care home).
- For Reading residents aged over 85 the rate of **excess winter deaths** was 32%, compared to 24% nationally. This rate has been gradually improving since 2006.
- Reading has a very small **traveller population** and little is known of their health needs.
- There is a need to develop a sustainable, connected community in order to create a socially-inclusive Reading that promotes social networks and environmental engagement. More support should be provided to employers to promote workplace wellbeing. This was identified as an unmet need under mental health services, but would appear to be equally **valid for the population as a whole**.

[8] http://www.phoutcomes.info/public-health-outcomes-framework#page/4/gid/1000044/pat/6/par/E12000008/ati/102/are/E06000038 (accessed 17 May 16).
[9] http://healthierlives.phe.org.uk/topic/mortality/area-details#are/E06000038/par/cat-2-6/ati/102/pat/ (accessed 17 May 16).

Public Health Outcomes Framework 2016–2019
At a glance

VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

Outcome measures

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life

Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System

* Indicator shared with the NHS Outcomes Framework.

** Complementary to indicators in the NHS Outcomes Framework

† Indicator shared with the Adult Social Care Outcomes Framework

†† Complementary to indicators in the Adult Social Care Outcomes Framework

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.01 Children in low income families
1.02 School readiness
1.03 Pupil absence
1.04 First time entrants to the youth justice system
1.05 16-18 year olds not in education, employment or training
1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H)* **(NHSOF 2.5ii)*
1.07 Proportion of people in prison aged 18 or over who have a mental illness
1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services *(i-NHSOF 2.2) ††(ii-ASCOF 1E) **(ii-NHSOF 2.5i) †† (iii-ASCOF 1F)*
1.09 Sickness absence rate
1.10 Killed and seriously injured casualties on England's roads
1.11 Domestic abuse
1.12 Violent crime (including sexual violence)
1.13 Levels of offending and re-offending
1.14 The percentage of the population affected by noise
1.15 Statutory homelessness
1.16 Utilisation of outdoor space for exercise / health reasons
1.17 Fuel poverty
1.18 Social isolation † *(ASCOF 1I)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.01 Low birth weight of term babies
2.02 Breastfeeding
2.03 Smoking status at time of delivery
2.04 Under 18 conceptions
2.05 Child development at 2 – 2 ½ years
2.06 Child excess weight in 4-5 and 10-11 year olds
2.07 Hospital admissions caused by unintentional and deliberate injuries for children and young people under 25
2.08 Emotional well-being of looked after children
2.09 Smoking prevalence – 15 year olds
2.10 Self-harm
2.11 Diet
2.12 Excess weight in adults
2.13 Proportion of physically active and inactive adults
2.14 Smoking prevalence – adults (over 18s)
2.15 Drug and alcohol treatment completion and drug misuse deaths
2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
2.17 Estimated diagnosis rate for people with diabetes mellitus
2.18 Alcohol-related admissions to hospital
2.19 Cancer diagnosed at stage 1 and 2** *(NHSOF 1.4v 1.4vi)*
2.20 National Screening Programmes
2.22 Take up of the NHS Health Check programme – by those eligible
2.23 Self-reported well-being
2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

3.01 Fraction of mortality attributable to particulate air pollution
3.02 Chlamydia diagnoses (15-24 year olds)
3.03 Population vaccination coverage
3.04 People presenting with HIV at a late stage of infection
3.05 Treatment completion for TB
3.06 Public sector organisations with board approved sustainable development management plan
3.08 Antimicrobial Resistance

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.01 Infant mortality* *(NHSOF 1.6i)*
4.02 Proportion of five year old children free from dental decay** *(NHSOF 3.7i)*
4.03 Mortality rate from causes considered preventable **(NHSOF 1a)*
4.04 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*
4.05 Under 75 mortality rate from cancer* *(NHSOF 1.4)*
4.06 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*
4.07 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*
4.08 Mortality rate from a range of specified communicable diseases, including influenza
4.09 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5i)*
4.10 Suicide rate** *(NHSOF 1.5ii)*
4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*
4.12 Preventable sight loss
4.13 Health-related quality of life for older people
4.14 Hip fractures in people aged 65 and over
4.15 Excess winter deaths
4.16 Estimated diagnosis rate for people with dementia * *(NHSOF 2.6i)*

APPENDIX 2:

Adult Wellbeing Position Statement

Consultation Report – May 2016

Reading Borough Council
Working better with you

Executive Summary

In January 2016, Reading Borough Council published a draft Adult Wellbeing Position Statement. This set out a framework for developing Council services to meet the local authority's wellbeing duties under the Care Act and so prevent, reduce and delay care and support needs across the local population.

The Council was keen to engage with residents and partner agencies about its approach to supporting those residents who have current or emerging care needs, and also its approach supporting the unpaid or family carers who are helping to keep people well and independent. This meant the Adult Wellbeing Position Statement had a particular focus. It included a wide range of Council services but only detailed those likely to be of particular relevance to adults with a care or support need or a clear risk of having these needs in future.

A twelve week public consultation demonstrated that the Council's seven key aims for adult wellbeing were supported by the local population and by partners. However, people wanted to see these same aims applied to children's services too. People welcomed the recognition that supporting wellbeing needs to be based on holistic approaches.

Many people were pleasantly surprised to discover how much the Council already offers to support wellbeing, but under each key aim people identified areas where support could be strengthened or made more widely available. People with care or support needs not access services in the same way as others, and reaching those are at risk of poor health and more likely to require social care must be a priority within programmes that promote people's capacity to maintain an independent lifestyle.

The most common theme running throughout the feedback was that services need to be publicised more effectively – either through broader awareness raising or more targeted approaches to reach people who are less likely to be familiar with what is available.

Background

In common with other local authorities, Reading Borough Council is facing challenging budget pressures, including increased demand across many service areas. The Council recognises the need to achieve a cultural shift so that its investment is increasingly directed at improving the wellbeing of Reading residents - that is, helping people to prevent ill-health and disability that is avoidable - rather than just treating the effects of poor wellbeing.

The wellbeing duty (a new statutory responsibility under the Care Act) sets a framework for how local authorities should meet the needs of those who meet Adult Social Care eligibility criteria. It also directs how the Council should interact with local residents who have lower care or support needs, or who have a risk of developing care and support needs, in order to reduce the likelihood of their developing avoidable illness and disability.

Reading Borough Council set out its proposed aims to meet its wellbeing responsibilities under the Care Act in the form of a draft Adult Wellbeing Position Statement published in January 2016. This was based on a vision to narrow the wellbeing gaps in Reading so that residents affected by care and support needs can access early help and enjoy healthy and fulfilling lives.

A public consultation on the draft Adult Wellbeing Positon Statement was carried out so that:

- stakeholders would have a better appreciation of the range of Council policies and services which promote adult wellbeing, and understand how to influence their further development;
- the Council's approach to adult wellbeing could be developed on the basis of stakeholder feedback; and
- across the Council and partner agencies, Reading could offer a more joined up approach to supporting adult wellbeing.

What we consulted on

We asked people to give us their views on the seven key aims identified to help us realise our vision for adult wellbeing, and so meet our Care Act responsibilities:

- Embed the wellbeing principle throughout the Council's functions

- Ensure Reading homes support wellbeing
- Harness the assets Reading has to prevent care and support needs from increasing
- Empower people with care needs to self care and to make positive lifestyle choices
- Support people to prevent their care and support needs from increasing
- Promote a re-abling approach across care services
- Ensure people with emerging care needs and unpaid carers can access services that work well together to support people's independence

We wanted to know if people agreed that these were important areas to address in promoting wellbeing, where Reading already had a strong offer in these areas, and where there is a need to improve.

How we consulted

The consultation ran from 25 January to 15 April 2016 (extended from the initial close date of 18 March 2016 so as to take in feedback from some key forums scheduled for late March and early April).

The consultation was designed to involve:

- local adults with current or emerging care needs (whether or not eligible for social care support)
- Unpaid or family carers who are helping to keep people well and independent
- Organisations and services across all sectors (including voluntary and community groups) that support the prevention/re-ablement agenda.

The emphasis was on taking discussion out to community groups, and bringing people together to debate what wellbeing means to different people, and what role the Council should play in promoting wellbeing.

The Adult Wellbeing consultation was discussed at 7 public, community or interest group meetings, as listed below. It was also raised as an information item at 3 further meetings to encourage individual members to respond.

Table 1: Adult Wellbeing consultation discussions

Meeting	audience	Number of people attending

Reading Voluntary Action Wellbeing Forum – 28.01.2016	Voluntary & community sector groups	38
Learning Disability Carers Forum – 02.03.2016	Carers of people with a learning disability (all ages)	8
Learning Disability Partnership Board – 08.03.2016	Adults with a learning disability, carers and providers (all sectors)	18
Access & Disabilities Working Group – 10.03.2016	People with long term conditions, carers and VCS groups	16
Care & Support Conference workshop – 07.04.2016	Care and support providers (all sectors)	22
Talkback 'Matters' sessions – April and March 2016	Adults with a learning disability	50
TOTAL CONTRIBUTORS (approx.)		**152**

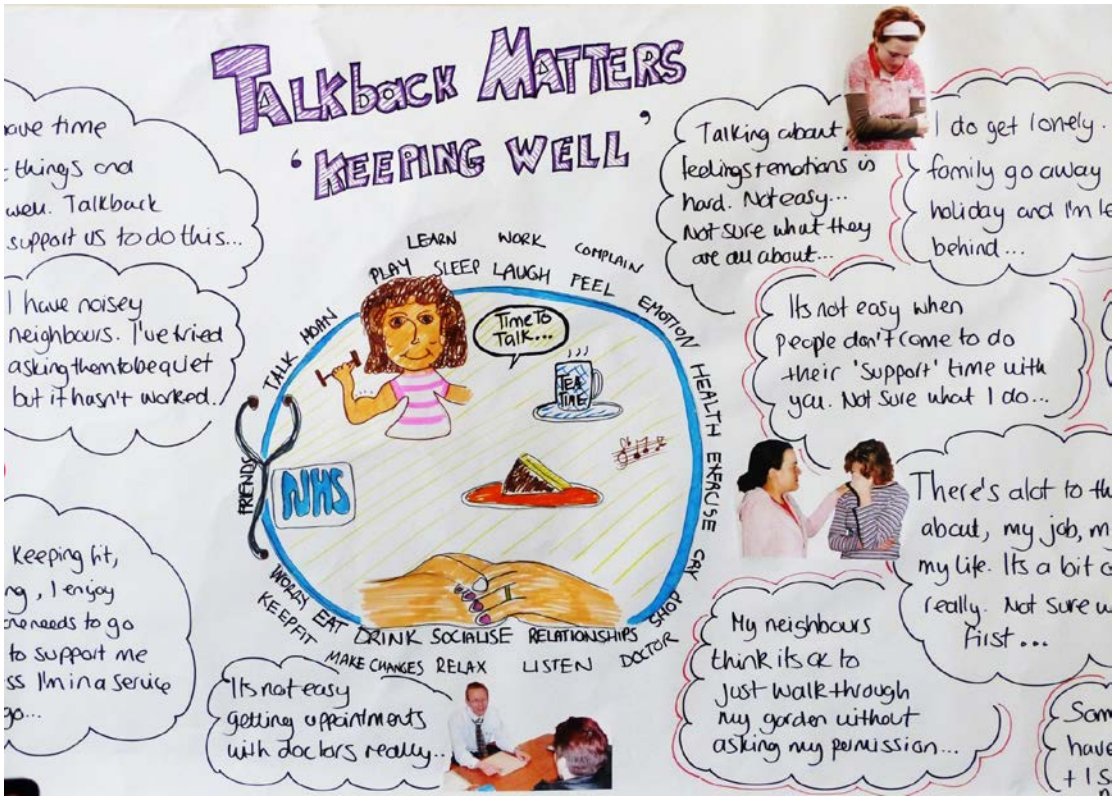
The consultation was also promoted at meetings of:

- the Older People's Working Group – 05.02.2016
- the Physical Disability & Sensory Needs Network – 22.02.2016
- the Reading Carers Steering Group – 21.03.2016

Consultation material

A consultation draft of the Adult Wellbeing Position Statement was published on the Council's website at the start of the consultation alongside a consultation questionnaire which could be completed online or in hard copy. Printed copies of the draft Statement and the questionnaire were available on request, and were offered at all meetings where the Adult Wellbeing consultation was discussed or promoted.

Feedback was welcomed in alternative formats. Talkback, a local self advocacy provider, captured group feedback on a giant paper roll and sent in photographs of that.



Who responded

By the close of the consultation, feedback had been gathered from approximately 174 contributions. This figure was made up of approximately 152 contributors[1] to consultation discussions plus 22 returned questionnaires (all online – no paper copies were returned).

The makeup of audiences at the various consultation discussions is summarised in Table 1. More detailed demographic information was collated only from people who chose to answer these questions in the consultation survey.

- Around one third of the returned questionnaires were from men, and two thirds from women.
- Almost half of the returned questionnaires (43%) came from people aged 65 or over, and none were returned by anyone aged under 35.
- Exactly half of the questionnaires were completed by someone who considered themself to have a disability, long term health condition or care and support needs, but only 5% were receiving social care services.
- Two thirds of returned questionnaires came from someone providing unpaid or informal care.

[1] Some people may have attended more than one of these meetings, so total attendance at consultation meetings is only indicative of the number of contributors.

- One third of people who returned questionnaires carry out some form of voluntary work.

Has the Council chosen the right aims for adult wellbeing?

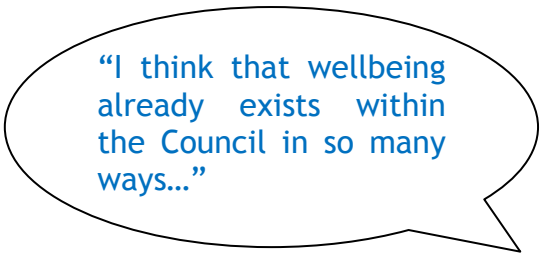
Most people agreed that all of the seven aims for adult wellbeing set out in the draft Position Statement were important. However, a small minority believed the Council should not include museums and libraries in its wellbeing strategy.

Several people challenged the focus on adult wellbeing, and were keen to see the Adult Wellbeing Position Statement extended to include children. This was particularly important to adults caring for a disabled child: they pointed out that their own wellbeing (as adults) depends on good whole family approaches.

Aim (1): Embedding the wellbeing principle throughout the Council's functions

We asked people to comment on our plans to:

- monitor the various Council services which contribute to wellbeing in a more holistic way;
- promote wellbeing through our commissioning activity; and
- work across Council departments and with our partners to make more of a range of contacts with residents as opportunities to promote wellbeing.



People welcomed the prospect of Council departments working together more cohesively, and skilling up staff to be able to tell people about support available to them from other services. They felt the Council had good foundations to work on.

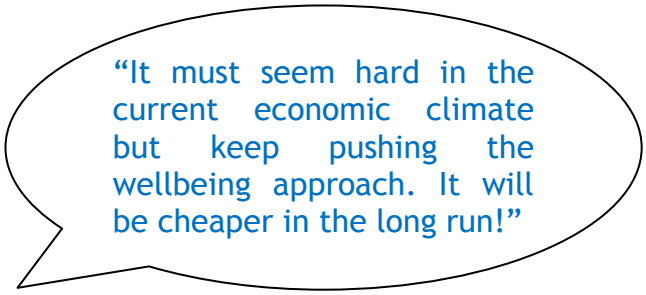
People supported the principles of the 'Making Every Contact Count' (MECC) programme, but wanted the Council to start working with other agencies on this at an early stage and not confine it to Council departments. As far as the Council was concerned, though, people wanted assurance that MECC training would include children's teams and not just be focused on adults.

People expressed the hope that promoting a wellbeing approach would encourage more staff to see the 'whole person' they're working with, and think about what people have to offer as well as what they need help with. Some older people, in particular, felt that they were too often seen as a nuisance by Council staff and their experience went unrecognised.

Providers from the voluntary sector felt that few Council staff understood what they were doing very well, and groups were looking for more opportunities to explain to RBC employees what they can do to support wellbeing. Some suggested the idea of secondments into and from the voluntary sector.

People pointed out that being able to call on a range of services based on individual need does require a particular set of skills. They were keen to see the Council's wellbeing plans supported by a workforce development plan which recognises this. In future, there needs to be more emphasis on networking, with staff supported to understand how to go about this effectively. Individual and team targets need to include meaningful wellbeing outcomes, and people should be encouraged to share stories of what's worked to bring statistics alive and show what's possible.

There was some concern about how staff would manage to take on new wellbeing duties with workloads already heavy, but strong support that this is the right way to go.



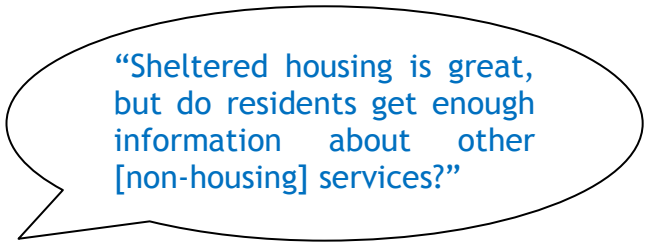
Aim (2): Ensure Reading homes support wellbeing

We asked people to comment on our plans to:

- support elderly or vulnerable people to maintain private sector homes
- support residents with home adaptations and repairs
- tackle fuel poverty
- work in partnership with the Royal Berkshire Fire and Rescue Service to offer vulnerable adults a home safety check
- tackle homelessness

Many people commented that the Adult Wellbeing Position Statement showed them there was more support available than they had realised previously to support people to live in safe and secure homes.

Again, people wanted the Council to do more to make this information easier to access, though, including sharing the information across different teams as well as housing staff. Similarly, they would like housing staff to be supported to understand other services so they can signpost people.



A lot of different agencies talk to people who need help to understand their housing options, and voluntary sector partners would welcome training from the Council in how to manage these queries.

There was a plea for more thought to be given to the fact that adaptations are often needed to a family home and not just the home of a single person – so other family members' needs have to be considered as well. In particular, children's needs change as they grow.

Several people remarked that both individuals and families make important community connections, and it can be very harmful to people's wellbeing if these connections are broken when someone needs to move into some form of supported accommodation. People also want to feel safe in the area where they live as well as the actual property, and hate crime is a real worry for some residents with disabilities.

People acknowledged that it's a challenge to achieve this, but felt that Reading needs more permanent housing, including more single storey properties. Having an insecure tenancy can be very stressful, all the more so for someone living with a disability or long term health condition which makes moving harder.

People particularly valued the fire safety checks and the assisted refuse collection, and were keen to see both of these continue as important contributions to residents' wellbeing. However, people felt there was a shortage of practical help services to help people manage in their own homes when their mobility or strength is limited.

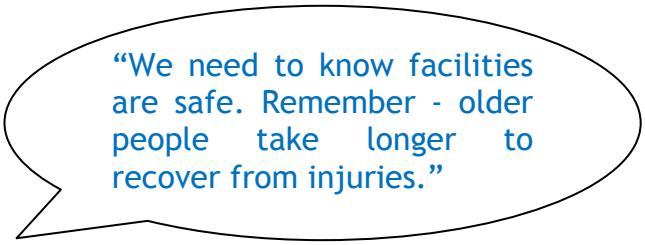
Aim (3): Harness the assets Reading has to prevent care and support needs from increasing

We asked people to comment on the services offered by:

- Reading Sports & Leisure
- Sport in Mind
- Rivermead Leisure Centre

- Reading Museum
- Reading Libraries

People said that Reading needs more sports and leisure facilities for the disabled, and suggestions for additional facilities included clubs for trampolining and adapted games. People also wanted clearer information about the support available to use sports and leisure services. Others asked for more real time information about facilities, so that people can be reassured about safety and don't have wasted journeys if facilities like hoists are temporarily unavailable, for example.

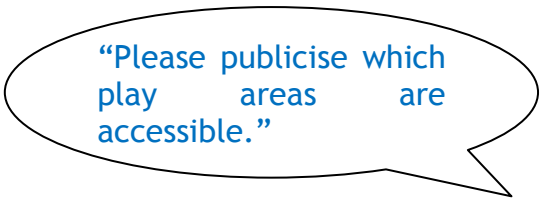


Some people also felt that there was a training need within sports and leisure providers around accessibility.

People liked the 'relaxed' shows at the Hexagon, particularly suited for people with autism, and wanted to see more of these.

People welcomed the plan to move the Council's day centre for older people and people with physical disabilities to the Rivermead site with the possibilities this offers to give people access to a wider range of activities. Several people commented that this was one example of the potential there is for sharing assets across sectors and providers to offer more holistic wellbeing services.

There was a request for more thought to be given to accessibility when designing play areas, as areas surfaced with woodchip or sand can't be accessed in a wheelchair. Reading does have play areas which are accessible, but some families felt they had struggled to get information about these.



Without knowing things are going to be accessible for disabled children, some families felt they had no option but to leave their disabled child at home while their siblings go out to play.

There was a concern expressed that while Reading has some excellent facilities, many of them are starting to look a bit shabby, so not as welcoming as they could be.

Aim (4): Empower people with care needs to self care and make positive lifestyle choices

We asked people to comment on Reading's approach to:

- Access to preventative health services
- emotional wellbeing
- Self care and peer support
- Lifelong learning offered by New Directions
- Reducing loneliness
- Transport (including the 'walkability' of Reading)

Most comments on this part of the Position Statement were about the importance of personal relationships – the need to support people who have too little contact with others, and the need to understand the range of issues which can lead to vulnerable adults becoming more and more isolated. Some people need support to find community groups while others need help to join them – assistance with transport, someone to go with the first time, or help in developing the skills needed to enjoy relationships.

"Loneliness is a huge issue."

People felt that the community navigator model was a good one to ensure that people could get one-to-one support to address all the issues relevant to them. People want to take part in social activities which are interesting and meaningful, and the range of courses offered by New Directions is an important part of this.

On the whole, people felt that Reading is well served by transport services – particularly the bus service. However, some people felt that disabled parking facilities were inadequate in some parts of the town, such as by the railway station.

"Reading's bus service is first class. It made me feel ok about giving up driving."

There was a lot of recognition of the health benefits of walking. However, people felt that pavement maintenance needed to be improved, and cycling on pavements tackled more robustly. There were also requests for more pedestrian crossings in busy areas.

People felt that access to preventative health services, like NHS health checks, was patchy. Some commented that this put positive lifestyle choices are out of reach for some, such as residents with communication needs. Some other respondents pointed out that self care depends on being given

information about your condition, and this isn't always done well or at an early enough stage.

People recognised links between physical and emotional wellbeing from their own experiences, and welcomed the holistic approach the Council was proposing to wellbeing. Waiting times for the Child and Adolescent Mental Health Service (CAMHS) are a worry, and people would like to see more support for young people dealing with anxiety, for example, within schools. People also felt there was a gap in mental health provision between the Talking Therapies service (typically 6 sessions) and crisis management.

Aim (5): Support people to prevent their care and support needs from increasing

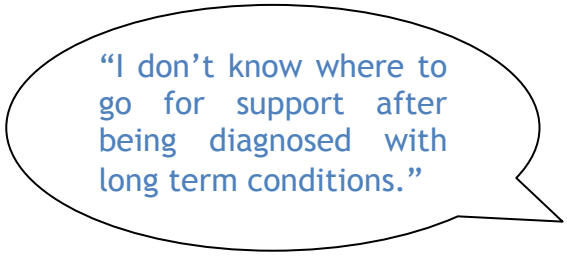
We asked people to comment on the Council's approach to:

- Information and advice services
- Assistive technology
- Supporting carers

People fed back that information and advice for people with care needs is delivered by a very wide range of providers in Reading. The Council's own services are an important but relatively small part of the picture. Rather than necessarily providing more direct services, some people felt a more important role for the Council could be to have an overview and facilitate networking between organisations, especially the smaller ones in the voluntary sector. Information for people with sensory needs was seen as a current gap.

Some people felt the Council should develop its website and use of social media to promote wellbeing, whilst recognising, though, that these channels wouldn't be suitable for everyone. In terms of website offers, people queried why there wasn't more information about Council services on the Reading Services Guide.

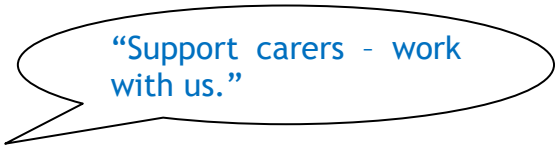
The Council commissions information and advice from a number of voluntary sector groups who are particularly well placed to reach into communities less able to make direct use of the Council's information services. These providers include Healthwatch Reading and a number of providers commissioned under the Narrowing the Gap Bidding Framework. Newly commissioned providers from mid 2016 onwards were not named in the Adult Wellbeing Position Statement. People asked that the Council publish this information (again – as successful bidders were announced during the consultation) so as to encourage more people to make use of these services.



People were generally supportive of assistive technology being part of the Adult Wellbeing Position Statement, and keen to know more but unsure where to go for clear advice.

A large proportion of responses to the consultation came from carers. There was some very positive feedback on how carers assessments can be really valuable in helping people to manage caring. However, it was clear that one area in which the Council needs to improve is in delivering carer assessments when the family is in contact with different parts of the local authority. For example, when a young person is caring for a disabled adult or an adult is caring for a disabled child, there is quite a lot of confusion about routes into the social care system.

Carers also felt that more needs to be done to ensure their role is considered by *all* services, although some are very good at involving carers.



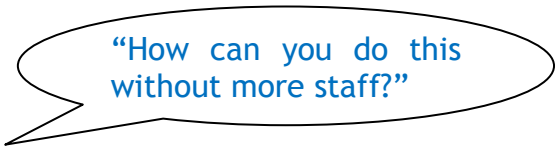
Carers also asked for a broader range of training to be made available to help them manage caring.

Aim (6): Promote a re-abling approach across care services

We asked people about:

- Our new approach to social care – the Right 4 You pilot schemes
- Re-ablement
- Home from hospital services
- End of life care

There was very positive feedback about the focus on the individual in the Council's proposals in this section. People felt it was right to invest time in getting to really understand a person's situation, but felt that this wasn't always happening at the moment. They were generally surprised to learn how many people had been spoken to



and how quickly by the Right 4 You teams. There were concerns about whether the Council could afford enough staff to take this approach across all teams.

People who had used re-ablement services were very positive about them, and people who hadn't had generally heard good things about the service. Some wondered whether 6 weeks was enough, and whether everyone who could get something out of a re-ablement service was being offered it at the moment. Several people thought that more could be done to link people up with voluntary sector support when they come out of hospital. Some people also thought there needed to be more focus on people's emotional wellbeing at this time as 'getting back on your feet' is about more than practical support sometimes.

"Having choices at the end of your life is so important."

A lot of people were particularly pleased to see end of life care included in the Position Statement. Some people commented that this seems to be the area where there's the biggest breakdown in communication between agencies at the moment.

Many of the people who contributed to the consultation through Talkback's 'Matters' sessions said it was a relief to be able to talk about dying. These were adults with a learning disability, often with elderly parents. They had often tried to ask questions about what would happen when their parents died but felt they'd been 'fobbed off'. Of course, some people do find talking about death difficult and people at the 'Matters' group were able to leave the room if they didn't want to take part in this bit of the conversation.

Aim (7): Ensure people with care needs and unpaid carers can access services that work well together to support people's independence

We asked people about the principles behind our plans for health and social care integration. The Adult Wellbeing Position Statement set out the schemes which made up Reading's first (2014) Better Care Fund plan. However, the second phase of the Better Care Fund plan was in development at the time of the consultation on the Position Statement, so people weren't asked to comment on particular integration schemes.

Most comments on this area were about how people working in some services don't seem to now very much about other services available locally, although there

"Seating areas [in GP surgeries] should be set up more like information centres rather than just waiting rooms."

were exceptions to this.

When asked about what improvements people hoped to see from better integrated services, most people were hoping that they would get to see a health or social care worker more quickly when they needed help. Carers wanted to see a care system which took them into account at *every* stage.

READING BOROUGH COUNCIL

REPORT BY INTERIM DIRECTOR OF OPERATIONS, WOKINGHAM CCG

TO:	**Reading Health and Wellbeing Board**		
DATE:	**15 June 2016**	**AGENDA ITEM:**	**11**
TITLE:	**Berkshire West 10 Local Digital Roadmap submission**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**HEALTH**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**Lois Lere**	**TEL:**	
JOB TITLE:	**Interim Director of Operations, Wokingham CCG**	**E-MAIL:**	**lois.lere@nhs.net**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 Last September NHS England began a three-step process began to enable local health and care systems to produce Local Digital Roadmaps (LDRs), setting out how they will achieve the ambition of Paper-free at the Point of Care by 2020.

1.2 The first step was the organisation of local commissioners, providers and social care partners into LDR footprints, in our case across the Berkshire West 10.

1.3 The second step was for NHS providers within LDR footprints to complete a Digital Maturity Self-assessment. Both of these steps have now been completed.

1.4 Each LDR footprint is now asked to develop and submit an LDR by **30 June 2016**.

1.5 LDRs will be reviewed in July within the broader context of Sustainability and Transformation Plans (STPs). A signed off LDR will be a condition for accessing central investment for technology enabled transformation.

1.6 An LDR is expected to include the following elements:

- A five-year vision for digitally-enabled transformation
- A capability deployment schedule and trajectory, outlining how, through driving digital maturity, professionals will increasingly operate 'paper-free at the point of care' over the next three years
- A delivery plan for a set of universal capabilities, detailing how progress will be made in fully exploiting the existing national digital assets
- An information sharing approach

1.7 The attached report is the final submission to NHS England on the 30th June 2016. We have the opportunity to refine the submission before it is published on NHS England's public facing internet site in September.

2. RECOMMENDED ACTION

2.1 ***The Health and Wellbeing Board is asked to note the current content of the Local Digital Roadmap and the collaborative effort that will be required to deliver the "Paper-free at the point of care" requirements***

3.0 **Policy Context**

3.1 The Five Year Forward View makes a commitment that, by 2020, there would be "fully interoperable electronic health records so that patient's records are paperless". This was supported by a Government commitment in Personalised Health and Care 2020 that "all patient and care records will be digital, interoperable and real-time by 2020".

3.2 In September 2015, a three-step process began to allow local health and care systems to produce Local Digital Roadmaps (LDRs) by 30 June 2016, setting out how they will achieve the ambition of 'paper-free at the point of care' by 2020. As outlined above, these steps have now been completed and Local Digital Roadmaps will be reviewed in July 2016 within the broader context of STPs.

3.3 Further details on the process will be published in due course. A signed off LDR will be a condition for accessing investment for technology enabled transformation.

4.0 **The Proposal**

4.1 All organisations participating in the Berkshire West 10 agreed in 2013, that to ensure safe and effective care the patient's information required to be available, wherever whenever they are treated and the Berkshire West Connected Care programme was conceived.

4.2 This programme has helped our health and care economy to work more collaboratively and we have developed a robust governance framework to support the delivery of this complex initiative. We are now seeing the benefits of these good working relationships deliver across the system, supporting new pathways of care to develop uninhibited by the constraints of information silos and allowing new ways of working across the public estate which would not have been delivered without our experience of collaboration and joint working.

4.3 The Connected Care and other collaborative digital projects are essential to delivering transformation and are also essential enablers of our health and care change priorities. This has been recognised by the agreement to fund Connected Care through the Better Care Fund, allowing us to radically change out of hospital care to meet the challenges of our growing elderly population and people with complex needs. Through Connected Care we will deliver:

- Interoperability and information exchange between health and social care organisations – with all ten organisations sending and receiving information by 2020.
- A person held record for health and social care for the citizens of Berkshire, to support prevention of ill health the promotion of wellbeing and promote self-care and self-management for those who become unwell.

4.4 Our history of collaborative working includes initiatives with neighbouring health economies which has enabled us to bring together a network of digital leaders across the Sustainability and Transformation Plan (STP) footprint. Chief Information Officers from NHS Commissioners, providers and Local Authorities from Buckinghamshire, Oxfordshire and Berkshire West (BOB) have agreed to work collaboratively with the aim of implementing fully integrated records across the footprint by 2020. Key priorities for 2016/17 include:

- Sharing best practice from across the three health and care communities.
    - e-Consultations in Urgent Primary Care in Buckinghamshire.
    - Connected Care Integrated Records in Berkshire.
    - Person Held records in Oxfordshire.

  Joining forces where we can demonstrate efficiency.
- Developing our Digital Transformation capabilities.
- Delivery of projects and programmes.
- Procurements.

- Developing population health and risk stratification tools.
- Creating a single set of information sharing agreements.
- Agreeing a clear direction for patient portals and self-management, with a joint approach to citizen identity across health and local government.
- Ensuring integrated records are available where patient flows cross borders.

4.5 These are the initial priorities agreed by the technology leaders at the BOB STP level. We are also working with a number of clinical programmes to ensure that the digital priorities which flow from their work are reflected in ours.
Although Berkshire West is starting from a robust baseline we recognise there is work to do to ensure that:

- All our information is electronic.
- All our information is shared.
- Our patients are empowered with their health and care information.

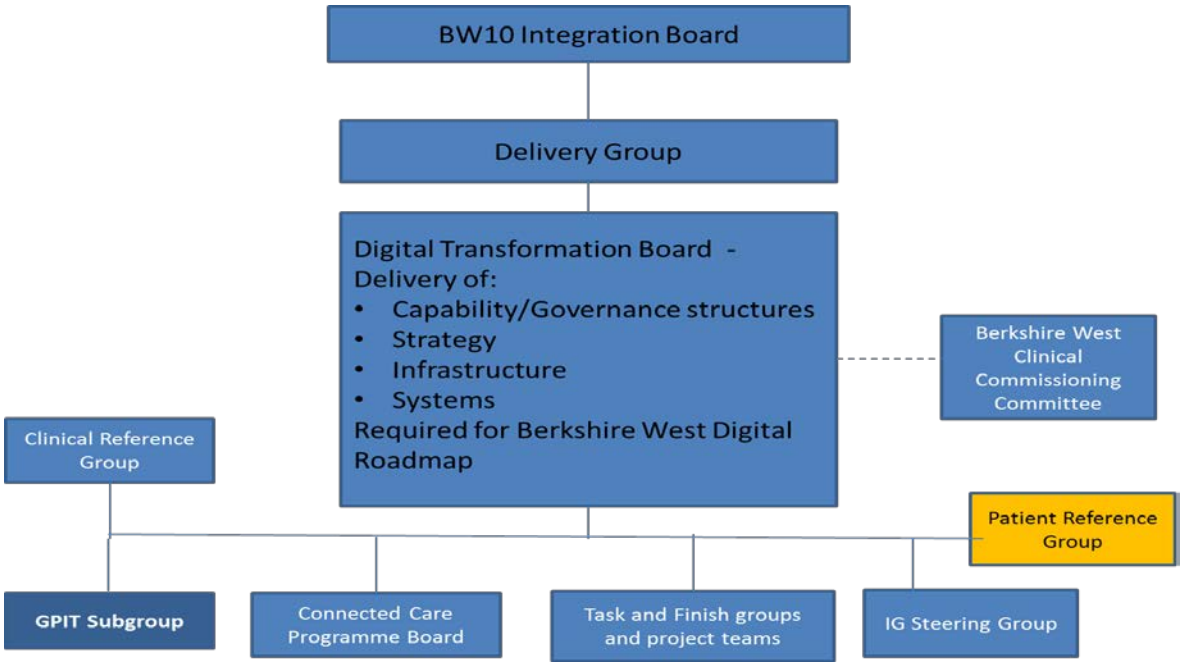
4.6 We are passionate advocates of developing system leadership in technology and digital services and we will continue to support our providers to deliver individual digital strategies and investment plans which will lead to the whole system being greater than the sum of its parts.

5. CONTRIBUTION TO STRATEGIC AIMS

Connected Care and supporting technology is a key enabler for the delivery of the Berkshire West 10 priorities. The proactive digitalisation of the patient record and other technology advancements will allow the people of Berkshire and our wider STP footprint to become more actively involved in their care encouraging active partnership across health and social care ensuring the person is at the centre of their own care. This personalisation may encourage the culture shift necessary in order to promote service sustainability in the future.

6. COMMUNITY ENGAGEMENT AND INFORMATION

A patient reference group forms part of the governance structure and the development of the Local Digital Roadmap:



7. **Equality Impact Assessment**

An Equality Impact Assessment has been carried out for the Connected Care Programme Procurement. Once the Local Digital Roadmap has been accepted by NHS England, a similar exercise will be carried out to ensure that the needs of those without access to digital services are protected, by maintaining access to existing communication channels for our population, while focusing on the "Digital First" government priority for health services.

8. LEGAL IMPLICATIONS

There are no legal implications of Local Digital Roadmap

9. FINANCIAL IMPLICATIONS

9.1 We are currently working with partners to identify their existing capital and revenue plans for technology investment. We will be creating a business case, for submission to NHS England, to fund any gaps in existing capability and capacity required to deliver the roadmap. These submissions will take place in late 2016/17 (once the timescale has been advised) for delivery in subsequent years.

10. BACKGROUND PAPERS

The full Berkshire West Local Digital Roadmap is attached.

Local Digital Roadmap for Berkshire West (Wokingham with partners)

Version : 1.0, SUBMISSION DRAFT
Date : 30th, June 2016

Document History

Revision History
Date of this revision: 30/06/2016

Revision date	Previous revision date	Summary of Changes
30/06/2016	1.0	Submission document

Contents

Preface

The organisations contributing to the Berkshire West local Digital Roadmap have an established history of working together on cross health economy projects. The ten organisations in our footprint are:

- 4 CCGs comprising 57 GP practices.
- 3 Unitary Authorities.
- 1 Acute trust.
- 1 Community and Mental Health Trust.
- South Central Ambulance Trust.

All organisations agreed in 2013 that to ensure safe and effective care, the patient's information required to be available wherever and whenever they are treated and the Berkshire West Connected Care programme was conceived. This programme has helped our health and care economy to work more collaboratively and we have developed a robust governance framework to support the delivery of this complex initiative. We are now seeing the benefits of these good working relationships deliver across the system, supporting new pathways of care to develop uninhibited by the constraints of information silos and allowing new ways of working across the public estate which would not have been delivered without our experience of collaboration and joint working.

The Connected Care and other collaborative digital projects are essential to delivering transformation and are also essential enablers of our health and care change priorities. This has been recognised by the agreement to fund Connected Care through the Better Care Fund, allowing us to radically change out of hospital care to meet the challenges of our growing elderly population and people with complex needs. Through Connected Care we will deliver:

- Interoperability and information exchange between health and social care organisations – with all ten organisations sending and receiving information by 2020.
- A person held record for health and social care for the citizens of Berkshire, to support prevention of ill health the promotion of wellbeing and promote self-care and self-management for those who become unwell.

Our history of collaborative working includes initiatives with neighbouring health economies which has enabled us to bring together a network of digital leaders across the Sustainability and Transformation Plan (STP) footprint. Chief Information Officers from NHS Commissioners, providers and Local Authorities from Buckinghamshire, Oxfordshire and Berkshire West (BOB) have agreed to work collaboratively with the aim of implementing fully integrated records across the footprint by 2020. Key priorities for 2016/17 include:

- Sharing best practice from across the three health and care communities.
    - e-Consultations in Urgent Primary Care in Buckinghamshire.
    - Connected Care Integrated Records in Berkshire.
    - Person Held records in Oxfordshire.
- Joining forces where we can demonstrate efficiency.
    - Developing our Digital Transformation capabilities.
    - Delivery of projects and programmes.
    - Procurements.
- Developing population health and risk stratification tools.
- Creating a single set of information sharing agreements.
- Agreeing a clear direction for patient portals and self-management, with a joint approach to citizen identity across health and local government.
- Ensuring integrated records are available where patient flows cross borders.

These are the initial priorities agreed by the technology leaders at the BOB STP level. We are also working with a number of clinical programmes to ensure that the digital priorities which flow from their work are reflected in ours.

In addition to the technology priorities there is also a critical link with the workforce workstream to ensure that we develop our existing and future workforce to maximise the opportunity digital transformation offers.

Although Berkshire West is starting from a robust baseline we recognise there is work to do to ensure that:

- All our information is electronic.
- All our information is shared.
- Our patients are empowered with their health and care information.

We are passionate advocates of the role the Commissioner can play in supporting integration, contracting for change, developing system leadership in technology and digital services and we will continue to support our providers to deliver individual digital strategies and investment plans which will lead to the whole system being greater than the sum of its parts.

Lois Lere, Director of Operations, NHS Wokingham Clinical Commissioning Group

30th June 2016

A Executive Summary

A1 The case for change

A1.1 Berkshire West serves a population of 521,000 patients and comprises of a number of organisations:

- CCGs: Wokingham, Newbury and District, North and West Reading, South Reading
- Unitary Authorities: Reading Borough Council, West Berkshire Council, Wokingham Borough Council
- Ambulance Trusts: South Central Ambulance Service Foundation Trust
- Mental health and community providers: Berkshire Healthcare Foundation Trust
- Acute care provider: Royal Berkshire Foundation Trust

A1.2 The Berkshire West Local Digital Roadmap is closely aligned to the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (the BOB STP). The BOB STP footprint serves a population of 1.8 million people registered with GPs in seven CCGs: Berkshire West (four CCGs), Oxfordshire, Aylesbury Vale and Chiltern.

A1.3 There is broad alignment between providers and commissioners on the size of the challenge and a realisation that current ways of working and providing care are not sufficient to bridge the projected financial gap. It is accepted that commissioners and providers planning in isolation will not bring the system into balance and could worsen provider positions. A whole system approach is required.

A1.4 The BOB STP has identified six priorities to help drive forward the whole system approach, they are:

- Improve wellbeing through prevention
- Redesigning urgent and emergency care
- Realignment of acute care
- Mental Health Vanguard
- Workforce – leadership, capability and capacity
- Digital Transformation

A1.5 The BOB STP includes a number of initiatives that will support these priorities across the footprint. The priorities described in the BOB STP are reliant on the development and utilisation of a number of technological innovations to enable improvement in outcomes, support of self-care and provide a greater proportion of care in a community setting. The Berkshire West Local Digital Roadmap is aligned to the BOB Sustainability and Transformation Plan and includes a roadmap to achieve:

- Paper-free at the point of care.
- Digitally enabled self-care.
- Real-time data analytics at the point of care.
- Whole systems intelligence to support population health management and effective commissioning, clinical surveillance and research.

A2 Leadership, governance and engagement

A2.1 The delivery of the Local Digital Roadmap is being overseen by the Berkshire West Digital Roadmap Board. This group was originally the Connected Care Board, but has taken on additional responsibilities for the workstreams associated with the delivery of the broader roadmap. The Board includes representation from each of the health and social care partners involved in the footprint, has been operating since mid-2013 and has overseen significant cross system digital developments. The Senior Responsible Officer (SRO) is the Director of Operations for Wokingham CCG.

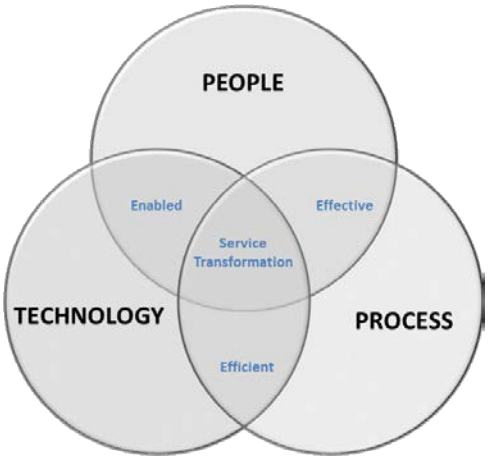


Figure [A1] - Transformation Model

A2.2 Berkshire West have been very clear that "digitally enabled transformation" should not focus on the

technology alone but must be driven by the end-users, i.e. those at the front line of delivering care. To this end, over 50 members of staff across health and social care were involved in the development of Sam's story - a fictional journey used to illustrate some of the issues facing care professionals in obtaining patient/citizen centric data in relation to individuals under their care. Sam's story was completed in September 2015 and was one of the key inputs to the shared care record (Connected Care) requirements that were published as part of the Invitation To Tender (ITT) process which started in October 2015.

In many cases the level of transformation of business processes is under estimated. In order to maximize the benefits of technology and innovate new models of care, transformational change must be given equal attention and resources.

A2.3 Clinical and care professionals were involved in the Connected Care ITT marking and selection process.

- Clinicians and care professions were involved in the marking and moderation of the functional and operational requirements.
- 71 clinical and care professionals attended the two day supplier demonstrations (January 2016) and were actively involved in the final selection process. Suppliers involved in the process commented that this was the best clinical engagement they had seen during a procurement exercise.

A2.4 The Connected Care Programme Board has patient representation since inception in early 2014 and was involved in the ITT marking and selection process.

- Patients were involved in the marking and moderation of the patient portal requirements.
- Patients attended the two day supplier demonstrations (January 2016) and were actively involved in the final selection process.

A2.5 In September 2015 Berkshire initiated an Information Governance steering group comprising of the Caldicott guardians (or delegates) from each of the organisations involved in digital transformation. The purpose of this group was to ensure a strong IG management framework was developed to demonstrate that all personal confidential data will be processed, used and shared lawfully and that all data protection requirements are being effectively satisfied. The steering group is chaired by the Local Medical Committee (LMC). Following the production of 12 key principles (and supporting collateral) the LMC wrote to all Berkshire West GPs in April 2016 to endorse the sharing of data and the Connected Care programme.

A2.6 Since the LDR and STP footprints were formed, the complexity of multiple LDR's being involved in multiple STP's has become apparent. It is imperative that the BOB STP is supported with consistent digital strategies from the multiple LDR's and an STP Digital Group is being established to bring together the LDR's. This will have representation from Berkshire West, Oxfordshire, Aylesbury Vale and Chiltern CCG's, as well as providers and councils.

A2.7 In summary, in terms of leadership, governance and engagement Berkshire West is well prepared to implement the Local Digital Roadmap thereby achieving; paper-free at the point of care, digitally enabled self-care, real-time data analytics and whole systems intelligence.

A3 Implementation capability

A3.1 The organisations across Berkshire West have been working together for the past 30 months, developing solutions, investigating options and learning how to work successfully with each other. The relationships developed during this time are critical to the successful implementation of the Local Digital Roadmap.

A3.2 All organisations have agreed that the NHS number will be the primary identifier. Wokingham Council is currently in the process of installing a connection to the N3 spine (preparing to test the Demographic Batch Service and Patient Demographic Service) and the other two councils are in the process of completing their IG Toolkit submission to begin the process (anticipated Q4 2016).

A3.3 Significant advances have been made in terms of cross organisational information sharing however, to-date, these have been mainly technology led.

- Phase 1 of the Connected Care project enabled the sharing of (selected) primary care data from the 54 GP surgeries in Berkshire West with Westcall Out of Hours Service, Reading Walk In centre and approximately 200 pilot users in Berkshire Health Foundation Trust and the Royal Berkshire Hospital. Phase 1 went live in December 2015.
- Phase 2 of the Connected Care project implemented a "proof of concept" integrated portal which extended the data provider organisations and the data consumers. In addition to the primary care information the pilot portal also included Admissions/Discharges/Transfers from the Royal Berkshire Hospital and community information from Berkshire Health Foundation Trust – in effect this was one of the first stages in moving towards paper-free at the point of care. The proof of concept ran for 6 months and was decommissioned in April 2016. Phase 2 also included the procurement process for the full interoperability solution.
- The implementation of reablement, intermediate and integrated care teams including but not limited to the Out of Hospital Transformation team, Integrated Cardiac Prevention Programme and End of Life sitting service.
- Care & Support @ home – This initiative encourages closer working and data sharing between the local authority, the domiciliary care provider and the person to develop a person centric plan to keep the person safe, well and in their own home. This is a significant move towards digitally enabled self-care.
- Multi Agency Safeguarding Hub (MASH) - Inter-agency initiative between the Council, NHS and Police services, requiring secure communications and data transferred.

A3.4 Many of the organisations across Berkshire West are undergoing major system upgrades while at the same time facing severe budgetary constraints. These two factors are driving behaviours that are detrimental to the long terms success of the LDR, they are:

- Organisations are focussing on "run the business" functions as opposed to cross organisational initiatives.
- Technical staff with highly desirable integration skills are being asked to perform other roles or are being released, i.e. it is more difficult to get the people with the right technical skills.
- Front line clinicians and carers are less able to participate in design, configure and testing.
- The focus on Cost Improvement Plans (CIPs) and short term savings can impede the ability to achieve greater efficiencies in savings that could be achieved from a longer term view.

Berkshire West is looking at pragmatic solutions to these problems including shared resource pools across organisations, however It is essential that funding is made available to assist in this area.

A3.5 Berkshire West has successfully implemented a number of information sharing projects. The cross organisational relationships are in place and mature, there is clarity in terms of organisational interdependencies and there is a shared vision. There is a proven mechanism for managing information governance, all organisations are fully supportive and the LMC has endorsed our approach. In terms of deployment capability Berkshire West is well prepared to implement the Local Digital Roadmap.

A4 Change and benefits management

A4.1 The Connected Care Full Business Case contained a detailed benefits realisation section and the final Key Performance Indicators will be part of the Board updates. Berkshire West has already had discussions with organisations outside the STP footprint to learn lessons and better prepare for this work. During the initiation phase (June/July 2016) baseline measures will be made and the data required to perform the appropriate analysis will be determined. Results will be reported to the Berkshire West Digital Roadmap Board.

A4.2 In addition to use and utilisation, the Connected Care and supporting technology solutions will also be used to monitor progress against specific benefits realisation, for example:

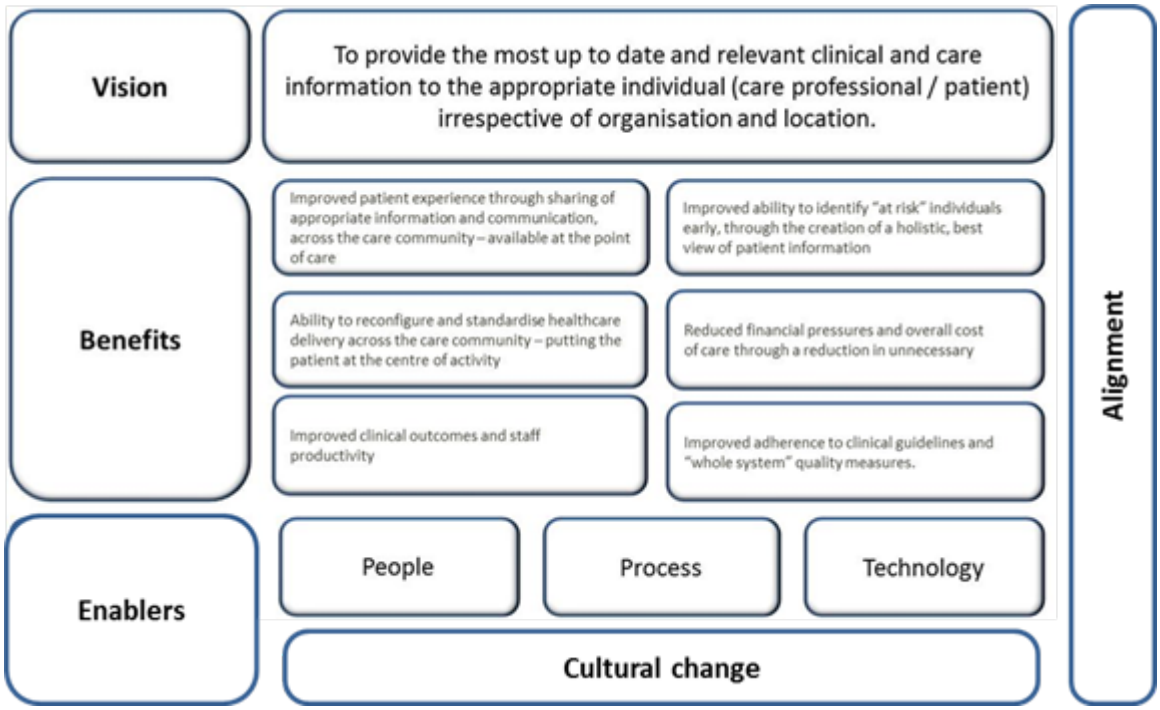
- Reduction in length of stay.
- Reduction in unnecessary admissions.
- Reduction in unnecessary and duplicate tests.

From a system strategy perspective, Connected Care and supporting technology is a key enabler for the delivery of the STP priorities. The proactive digitalisation of the patient record and other technology advancements will allow the people of Berkshire and our wider STP footprint to become more actively involved in their care encouraging active partnership across health and social care with the person at the centre of their own care. This personalisation may encourage the culture shift necessary in order to promote sustainability in the future.

A4.3 Benefits management and the change management work that delivers the desired patient, staff and financial benefits are identified, planned, delivered and monitored on a system-wide basis and using a combination of input and output metrics and performance indicators. This integrated approach ensures that the change initiatives are consistent across the dimensions of people, process and technology and coordinated across all participating organisations, projects and programmes. The methodology to be employed in delivering and managing the benefits and transformational changes has evolved from pioneering work done in NHS IM&T in the early 1990s drawing on and enhanced by Managing Successful Programmes (MSP) and by work done with Cranfield University and the former NHS Institute for Innovation and Improvement.

A4.4 Within the technology space, lessons have been learned about the importance of culture and change management when implementing new technology. The below vision will support us in bringing patients and health and social care professionals along with the digital transformation agenda.

Figure [A2] - Transformation Alignment



A5 Digital maturity

A5.1 Each NHS trust has recently completed the national Digital Maturity Self-Assessment (DMA), which evaluates how well-developed different aspects of readiness, capability and infrastructure are. The DMA baseline for provider organisations in health shows that, broadly speaking, each trust is well-placed regarding strategic alignment, leadership, resourcing, governance, asset optimisation, standards and enabling infrastructure. The table shows that significant work needs to be done but overall the health organisations are starting from a sound base.

Figure [A3] - Footprint Organisation Digital Maturity

Issue	National Average Health	BHFT	RBH	SCAS	National Average LAs	Reading	West Berkshire	Wokingham
Strategic Alignment	76%	100%	60%	56%	78%	71%	71%	75%
Leadership	77%	90%	80%	85%	79%	78%	78%	88%
Resourcing	66%	95%	45%	75%	75%	58%	63%	67%
Governance	74%	100%	65%	75%	76%	79%	88%	83%
Information Governance	73%	96%	50%	75%	82%	77%	81%	92.31 %
Records, Assessments & Plans	44%	56%	26%	57%	47%	50%	50%	44%
Transfers Of Care	48%	59%	42%	61%	35%	55%	55%	41%
Orders & Results Management	55%	49%	66%	14%	-	-	-	-
Medicines Management & Optimisation	30%	4%	17%	29%	-	-	-	-
Decision Support	36%	30%	33%	22%	62%	0%	0%	25%
Remote & Assistive Care	32%	92%	25%	50%	56%	61%	61%	61%
Asset & Resource Optimisation	42%	81%	45%	56%	65%	68%	68%	86%
Standards	41%	46%	44%	75%	62%	0%	0%	25%
Enabling Infrastructure	68%	80%	48%	75%	70%	81%	81%	72%

A national DMA tool has been designed for social care (adult and children) providers. It follows the same broad headings as the NHS assessment but has specific questions which are more pertinent to social care. The Digital Maturity Assessment for Social Care was not compulsory to complete and it is testament to the overall commitment to service transformation that all three Local Authorities in Berkshire West have made submissions and demonstrate a consistently high standard in comparison to the national standards.

A5.2 The DMA baseline for social care shows that, broadly speaking, all Local Authorities demonstrate a consistently high standard in comparison to the national standards. Strategic alignment, leadership, remote & assistive care and enabling infrastructure are key areas where Local Authorities are developing and investing, i.e. where they can potentially see significant benefits with the emphasis on a person being more self-reliant, prevention strategies, reablement and keeping a person out of residential care for as long as possible. This is done through investment in new technologies, moving towards digital platforms, movement away from paper and development of remote and assistive technology strategies.

A5.3 It should also be noted that the digital maturity assessments were self assessments and the questions were open to interpretation, e.g. are systems available, or are they actually used. The cross system working and new governance structures will therefore be more important to this LDR, than using the DMA to assess how individual trusts are developing to achieve paper free at the point of care.

A5.4 In terms of digital maturity Berkshire West is well prepared to implement the Local Digital Roadmap. The ambition of each organisation is to improve their digital maturity and they all have board level support as long as it maps to the STP priorities and the LDR initiatives of paper-free at the point of care, digitally enabled self-care, real-time data analytics and whole systems intelligence. The challenge will be if funding is not available to support their ambitions.

A6 Capability

A6.1 The Local Digital Roadmap guidance identifies 10 “Universal Capabilities” with 25 associated “Aims” which focus on fully exploiting the existing national digital assets. The following table summarises the current position for the footprint in relation to each of the Capabilities with two columns indicating the anticipated position in terms of percentage delivery for each Universal Capability at the end of 2016/17 and 2017/18 based on plans agreed by footprint partners.

Capability	2016/17 Goal	2017/18 Goal	Aim	Current
Cross care settings access to GP held information			Secondary, emergency and triage views of GP information	25%
			Pharmacy views of GP information	60%
U & EC access information for patients most likely to present			GPs compiling enhanced SCR information for key patient groups	5%
			Secondary, emergency and triage views of enhanced GP information	5%
Patients can access their GP record			Access to detailed coded GP records actively offered to key patient groups	2%
			Patients who request it are given access to their detailed coded GP record	2%
GPs can refer electronically to secondary care			Every referral created and transferred electronically	72%
			Every patient presented with information to support their choice of provider	50%
			Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability)	50%
			By Sep 17 – 80% of elective referrals made electronically	60%
GPs receive timely electronic discharge summaries			All discharge summaries sent electronically from all acute providers to the GP within 24 hours	60%
			All discharge summaries shared in the form of structured electronic documents	25%
			All discharge documentation aligned with Academy of Medical Royal Colleges headings	10%
Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care			Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care	20%
Clinicians in unscheduled care settings - access CPI / social care professionals notified accordingly			Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting	0%
			Indication of child protection plan, looked after or unborn child protection plan flagged to clinician, along with social care contact details	0%
			The social worker of a child on a child protection plan receives a notification when that child presents at an unscheduled care setting	0%
Professionals across care settings made aware of end-of-life preference information			All patients at end-of-life able to express their preferences to their GP and know that this will be available to those involved in their care	30%
			All professionals from local providers involved in end-of-life care of patients access recorded preference information	50%
GPs and community pharmacists can utilise electronic prescriptions			All permitted prescriptions electronic	44%
			All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic	44%
			Repeat dispensing done electronically for all appropriate patients	7%
			By end 16/17 – 80% of repeat prescriptions to be transmitted electronically	57%
Patients can book appointments and order repeat prescriptions from their GP practice			By end 16/17 – Minimum of 10% of patients registered for, and actively accessing, one or more online services	14%
			All patients registered for online services use them above alternative channels	1%

♦

A6.2 In summary the key points are

♦ Many relevant digital enablers are in place (e.g. SCR, MIG, patient access from GP systems to summary and to detailed record, booking, prescriptions, EPS, ERS)

♦ However Capabilities that are driven largely by patient awareness and adoption e.g. view record online appear to demonstrate relatively low rates of utilisation. (e.g. only 14% patients are registered for online GP booking, etc and only 1.3% patients currently are registered to access their detailed GP records; Although 20% ED staff have access to SCR / MIG, there is moderate usage). Hence more communication, awareness, education is required amongst the workforce and citizens. However it should be noted that in primary care only a proportion of registered patients (est.30%) actively use their GP services and benefit from engagement with these digital servicesClear accountability is also required to ensure that these capabilities are delivered. To achieve this, workstreams will be developed that will have a mandate and responsibility for progressing the aims. These workstreams will bring together end users and the relevant professionals from all organisations. The workstreams will report into the appropriate Board, but will often have "dotted line" links to multiple organisational and systems boards to give the appropriate assurances.

- ♦ Trusts / GPs do not yet have access to the Child Protection Information Sharing service, although trusts do receive a weekly extract by secure email
- ♦ Social Care currently receives between 61-80% of their referrals through electronic means where the remainder are still made via a telephone conversation

A7 Infrastructure, Standards and Information Sharing

A7.1 The LDR is acting as a vehicle to ensure collaboration between organisational IT teams and already there have been discussions to explore where existing systems can be linked to enable stronger collaboration between partners. This includes linking networks to enable health and social care professional to access their core systems from any NHS site and exploring opportunities for the standardisation of mobile working solutions. It also ensures that future, provider specific, procurements will take the wider LDR aims into consideration thus ensuring the systems are compatible with wider procurements while achieving economies of scale and making best use of the local IM&T professionals across the health and social care system.

A7.2 In determining overall priorities it is essential to ensure current and future ongoing information and IT operational needs are adequately resourced, along with more general enabling activities such as addressing the "digital culture" through change management and benefits realisation programmes and basic digital skills of the workforce.

A8 Conclusion

A8.1 Analysis of the identified strategic LDR priorities and the existing situation across the footprint indicates that the individual organisations and the footprint as a whole have made considerable progress in relation to many of the issues considered in this LDR especially with regard to inter organisational operations and whole system intelligence. The main areas of strength are:

- Leadership and governance is strong with mature working relationships, a willingness to share experience/information and transparency regarding the decision making process.
- Clinical and care engagement is high and the solution delivery team (technical) is embedded into the clinical/care decision making process.
- Berkshire West has successfully delivered multiple projects that span organisational boundaries.
- The digital maturity is starting from a strong baseline with clarity as to how to move this forward.

A8.2 Although Berkshire West is starting from a solid baseline position there are a number of key factors which are currently considered to be constraining the rate of progress towards the goal of paper-free at the point of care / digitally enabled self-care / real-time data analytics / whole systems intelligence and the vision for digital transformation in general. The following limiting facts have been categorised using the People – Process – Technology theme discussed in Section C3:

People

- Pace of change – organisational and individual capacity to deal with change fatigue
- Work force development – skills development, recruitment (IM&T and other) and retention.
- Risk aversion/risk tolerance
- Resourcing in times when both health and Local Authorities are under significant funding pressure and where resources are being stretched by competing priorities
- Capacity in relation to the scale of ambition

Process

- Funding availability: programmes will require investment to enable benefits to be delivered in other transformation projects.
- Service user acceptance – normalising a paper-free at the point of care service is a significant cultural shift that will impact adoption rates.

- Change management - varying levels of engagement across the workforce
- The rate at which individual and all organisations will move to a fully digital technology solution
- The ability to get timely responses from organisations such as NHS Digital which prevents further delays to ongoing pieces of work

Technology

- Older provider legacy systems and main social care systems are not easy to integrate with and/or do not support "to be" processes.
- Multiple networks / multiple systems / multiple out-of-footprint flows – no enterprise architecture.
- Lack of vendor engagement due to over commitment of resources

A8.3 The issues listed above clearly show that the majority of the concerns relate to transformation activities associated with people and process. It is important to re-iterate that in order to maximise the benefits of technology and innovate models of care, transformational change must be given equal attention and resources.

A8.4 IM&T is listed as a key enabler to the STP, and it is imperative that the digital priorities are aligned to the priorities set out in the STP. There is a strong belief, that technology can have a significant impact on each of the priority areas and that the building blocks are in place to take exciting and ambitious steps.

A8.5 The alignment of the Berkshire West LDR and BOB STP provides an integrated approach that has the commitment to realise the vision for health delivery across the footprint.

B About the Berkshire West Digital Roadmap

B1 Background and Context

B1.1 NHS England's *Five Year Forward* View (October 2014) set the context for transformation of healthcare delivery. Many of the changes envisaged are critically dependent on the transformative power of information and technology (summarised as information management and technology (IM&T) throughout this document). One key commitment is that, by 2020, there would be "fully interoperable electronic health records so that patient's records are paperless".

B1.2 In response NHS England's National Information Board (NIB) set out a series of IM&T priorities (in *Personalised Health and Care 2020. Using Data and Technology to Transform Outcomes for Patients and Citizens. A Framework for Action,* (November 2014)). Amongst its recommendation, the NIB identified the need for "development of local roadmaps for digital interoperability to be published in 2016". Commissioners have been tasked with coordinating the development of local digital roadmaps (LDRs).

B1.3 A signed-off LDR is a condition for accessing investment for technology enabled transformation. Progress in delivering the commitments and aspirations in the LDR will become part of commissioner and provider assurance, assessment and inspection regimes.

B1.4 Berkshire West serves a population of over 500,000 and comprises a number of organisations:

- CCGs: Wokingham, Newbury & District, North & West Reading and South Reading (52 General Practices)
- Unitary Authorities: Reading Borough Council, West Berkshire Council, Wokingham Borough Council
- Ambulance Trusts: South Central Ambulance Service NHS FT

- Mental Health and community providers: Berkshire Healthcare NHS FT
- Acute care provider: Royal Berkshire NHS FT

B1.5 The Berkshire West Local Digital Roadmap is closely aligned to the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (STP). The STP footprint serves a population of over 1.8m people registered with GPs in 7 CCGs: Berkshire West (4 CCGs), Aylesbury Vale, Chiltern and Oxfordshire. The Berkshire West LDR is one of 4 LDRs associated with the above mentioned STP.

- Given that this LDR needs to support the vision and aims of the Buckinghamshire, Oxfordshire and Berkshire West STP it is important to understand some of the associated complexities across the wider geography. Due to its geographic reach, the South Central Ambulance Service has responsibilities across the three regional STPs.
- Frimley Health (STP No34)
- Hampshire and the Isle of Wight (STP No42)
- Buckinghamshire, Oxfordshire and Berkshire West (STP No44)This engagement involves the collaborative working across 19 CCG's and input into 7 LDR's. Alignment across so many service providers will be difficult.
- Similarly, Berkshire Healthcare NHS FT covers across 2 regional STPs – Frimley Health (STPNo34) and Buckinghamshire, Oxfordshire and Berkshire West (STP No44). This engagement involves the collaborative working across 7 CCG's and input into 2 LDR's.

The Berkshire West LDR is part of a much wider and extremely complex environment.

B2 Purpose

B2.1 Production and agreement of the LDR is intended to be the first stage towards supporting the health economy to become 'paper-free at the point of care' with systems interoperability across multi-agency provider organisations. By definition achieving fully interoperable electronic health records requires high levels of collaboration and coordination amongst local stakeholders. The LDR is the vehicle through which the necessary collective milestones and issues become codified and agreed.

B2.2 Locally the need for e-sharing of patient/client records has long been recognised as fundamental to achieving many of the goals set out in the CCGs' strategic and operational plans. Hence this requirement is a major component of the CCGs' IM&T Strategy (first developed in 2013). Section [F] outlines the local approach and plans for interoperability across the health and care community. The LDR allows these plans to be further aligned with each organisation's current status, priorities and plans with regard to e-records.

B3 Local Digital Roadmap Scope

B3.1 The scope of the LocalDigitalRoadmap is broader than just the original remit to address Paper-free at the Point of Care. It now encompasses the following topics:

- Paper Free at Point of Care for information used both within and shared between organisations
- Digitally enabled self-care
- Real-time data analytics at the point of care
- Whole systems intelligence to support population health management and effective commissioning, clinical surveillance and research.

B3.2 In prioritising the topics identified above Berkshire West has focussed on Paper Free at Point of Care ensuring that the immediate needs (12 – 24 months) associated with the Universal Capabilities are described in considerable detail while the broader, longer term (3 years) capabilities are documented at a slightly higher level (appropriate to the timescale involved). For those topics not directly related to Paper Free at Point of Care the direction of travel over the next 5 years will be described but they are not documented in any depth.

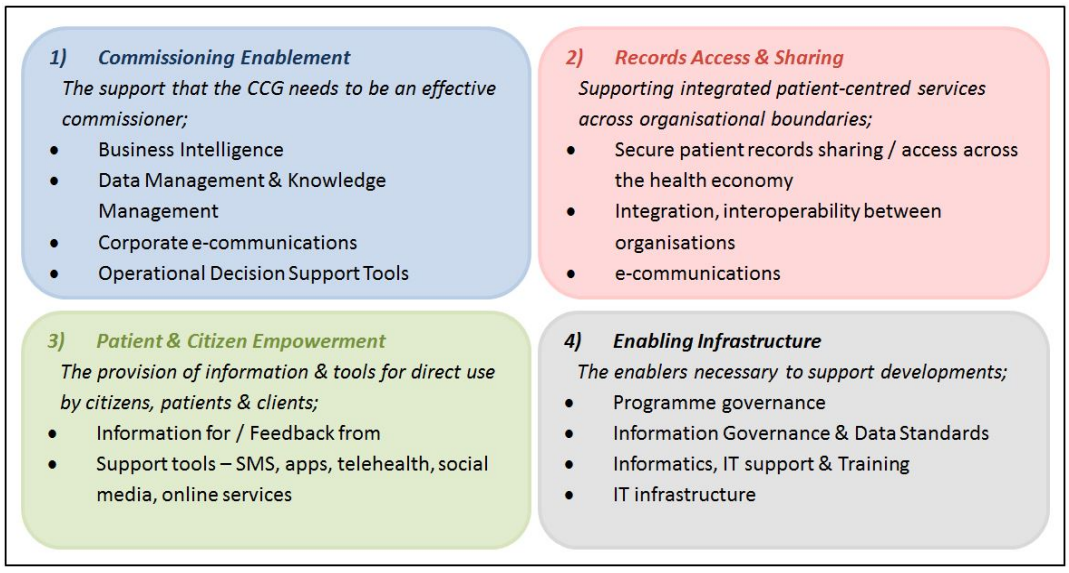
B3.3 It is not intended that the LDR replaces or replicates the IM&T strategies and plans of individual organisations. Rather, the LDR focuses on the common themes across the footprint where collaboration is either desirable (e.g. to achieve economies of scale, to share scarce resources, to share best practice) or essential (e.g. cross-organisational data sharing and interoperability).

B3.4 It is understood that Berkshire West's LDR will need to be aligned with those from the neighbouring regions in order that they form a cohesive technical strategy across the Buckinghamshire, Oxfordshire and Berkshire West STP. With this in mind it is anticipated that this LDR will be refined and expanded in subsequent iterations. Development and endorsement of the Roadmap

B3.5 Whilst, in some respects, the LDR is a new concept, it builds on the CCGs' existing IM&T Strategy. Figure [B1] illustrates the scope and focus of the CCGs' existing IM&T Strategy. Most of the themes in the strategy have been developed as workstreams within an overarching CCG IM&T Programme.

B3.6 The Strategy addresses issues of direct relevance to the LDR, such as sharing of patient records amongst local organisations, utilisation of national systems and infrastructure, clinical decision support and whole system analytics. Where the scope differs from that of the LDR is that there is less emphasis on the status and plans for, for example, Paper Free at Point of Care within the trusts and Local Authorities, and there is more focus on the internal information and IT needs of the CCGs (Figure [B1], Box 1). Also, the CCGs' Operational Plan and Strategic Plan were the drivers, rather than the STP.

Figure [B1]. Scope of existing CCGs' IM&T Strategy



B3.7 This roadmap has been developed by the NHS Wokingham CCG,NHS Newbury and District CCG and NHS North and West Reading CCG, with support from South Central and West Commissioning Support Unit (SCWCSU), in consultation with representatives from each of the main health and social care organisations within the footprint. For each organisation, the development involved provision and analysis of documentation, completion of pro-formas, participation in workshops, bilateral discussions, review of draft LDR documentation.

B3.8 Alignment of the Local Digital Roadmap with the developing STP has been ensured through dialogue with those responsible for development of the STP / whole system transformation plans, as well as the informatics communities. Key suppliers have been consulted as part of this work and the interoperability workstream to ensure that the ambitions set out in this roadmap are achievable. These include primary care system suppliers, Servelec, Microsoft, System C/Graphnet and Adastra.

B3.9 This version of the Local Digital Roadmap has been endorsed and signed-off by the Digital Transformation Programme Board which has representatives from all partners.

C Strategic context

C1 The case for change

C1.1 Berkshire West serves a population of 521,000 patients and comprises of ten organisations: Wokingham CCG, Newbury and District CCG, North and West Reading CCG, South Reading CCG, Reading Borough Council, West Berkshire Council, Wokingham Borough Council, South Central Ambulance Service NHS FT, Berkshire Healthcare NHS Foundation Trust and Royal Berkshire NHS Foundation Trust.

C1.2 The Berkshire West Local Digital Roadmap is closely aligned to the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (the BOB STP). The BOB STP footprint serves a population of 1.8 million people registered with GPs in seven CCGs: Berkshire West (four CCGs), Oxfordshire, Aylesbury Vale and Chiltern.

C1.3 There is broad alignment between providers and commissioners on the size of the challenge and a realisation that current ways of working and providing care are not sufficient to bridge the projected financial gap. It is accepted that commissioners and providers planning in isolation will not bring the system into balance and could worsen provider positions. A whole system approach is required.

C1.4 The BOB STP has identified four priorities to help drive forward the whole system approach, they are:

- Improve wellbeing through prevention.
- Redesigning urgent and emergency care.
- Development of specialist services.
- Workforce – leadership, capability and capacity.

C1.5 The BOB STP includes a number of initiatives that will support these priorities across the footprint. The priorities described in the BOB STP are reliant on the development and utilisation of a number of technological innovations to enable improvement in outcomes, support of self-care and provide a greater proportion of care in a community setting. The Berkshire West Local Digital Roadmap is aligned to the BOB Sustainability and Transformation Plan and includes a roadmap to achieve:

- Paper-free at the point of care.
- Digitally enabled self-care.
- Real-time data analytics at the point of care.
- Whole systems intelligence to support population health management and effective commissioning, clinical surveillance and research.

C2 Digital technology as change enabler

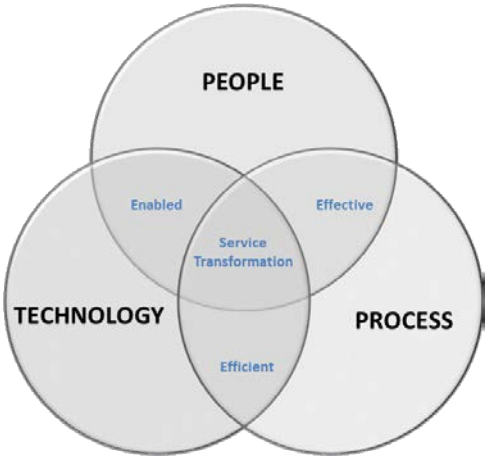
C2.1 It is recognised locally and nationally that the kinds of transformative change set out in the STP cannot be achieved without realising many of the opportunities afforded through extensive deployment of digital technology..

C2.2 More recently NHS England's *General Practice Forward View* (April 2016) emphasises the importance of greater use of technology to connect primary care with others, for the sharing of best practice, for greater online access for patients and to deliver new modalities for provision of advice and support for patients and the public.

C3 Vision for digitally enabled transformation

C3.1 Digitally enabled transformation is an essential component for addressing the challenges faced by the local health system. Berkshire West have been very clear that "digitally enabled transformation" should not focus on the technology alone but must be driven by the end-users, i.e. those at the front line of delivering care. Often the level of transformation of business processes is significantly under estimated. Figure [C2] shows the relationship between technology, people and process that lies at the heart of successful transformation.

Figure [C2]. Key enablers for successful service transformation



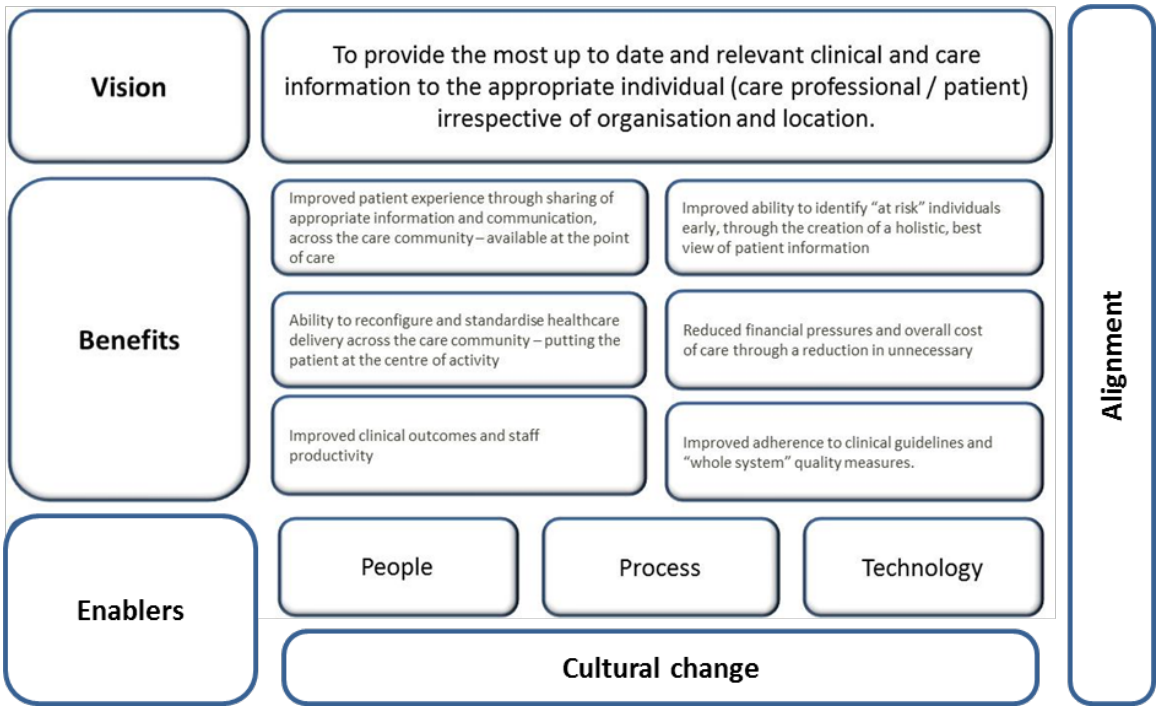
The theme of People, Process and Technology appears throughout Berkshire West's approach to whole system transformation.

Figure [C2] shows that technology is a key component and requires close coordination with the business in terms of strategic direction and process redesign. Cross organisational service transformation requires changes to corporate culture and re-alignment at an individual level. People have to come together to redefine processes that are not only significantly different to their current situation but that may be to their personal detriment.

C3.2 Berkshire West is committed to technology being an enabler for whole system transformational change as referenced in the BOB STP, however in order to maximize the benefits of technology and innovate models of care, transformational change must be given equal attention and resources.

C3.3 Our vision is summarised in Figure [C3] with investment in technology to support self-care through digital tools and enablers, data and information sharing across organisations and the development of a predictive urgent care model across the footprint.

Figure [C3].Berkshire West vision



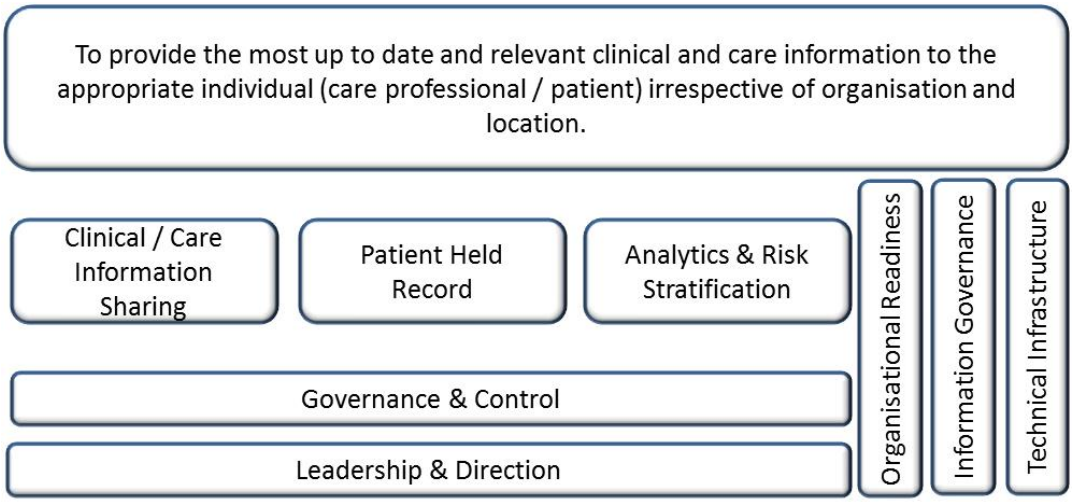
C3.4 IM&T is listed as a key enabler for the BOB STP and it is imperative that the digital priorities are aligned to the priorities set out in the STP. There is a strong belief that technology can have a significant impact on each of the priority areas and that the building blocks are in place to take exciting and ambitious steps.

C3.5 The alignment of the LDR and BOB STP provides an integrated approach that has the commitment to realise the vision for health delivery for those we serve.

C3.6 The technology enablers of our digital vision need to meet a broad set of requirements across a number of care settings, however collectively, they need address three high level objectives:

- **Interoperability and information exchange between health and social care organisations** to allow the flow of real time data between two or more organisations for the benefit of co-ordinating current and future service provision across care pathways, improving care and data analysis. This is a major step towards paper-free at the point of care and real-time data analytics at the point of care.
- **Having a person / patient held record (PHR) for health and social care for the citizens** of Berkshire West, that contains accurate real time data and information from commissioners, health and social care providers and citizens, enabling the individual to hold and manage their care (digitally enabled self-care) and give consent to providers of services and carers to view their record based on an agreed data set.
- **Whole systems intelligence** to bring together financial, operational and clinical outcome data centred around patients providing an opportunity for deriving whole system intelligence to support population health management, effective commissioning, outcome based contracting, planning, clinical surveillance, service re-design and research.

Figure [C4]. Key Enabling Components - Technology



C3.7 From a strategic point of view, sections C4, C5 and C6 outline the anticipated benefits and options being considered or currently under way.

C3.8 The current state and the next steps associate with each of these components is more fully detailed later in this document.

C4 Information sharing between health & social care organisations

C4.1 Multi-organisational, real-time (or near real-time) patient-level data available at the point of care is a pre-requisite for many of the Berkshire West STP initiatives. Detailed analysis has indicated that success in this area contribute towards:

- Reduction in Length of Stay
- Reduction in admission
- Reduction of unnecessary and duplicate tests
- Improvements in clinical outcomes
- Adherence to end of life preferences
- Reduction in citizen anxiety due to delayed communication
- Increased trust and confidence in the service.
- Greater staff confidence due to complete day access.
- Improved care experience - the patient only has to repeat their story once.
- Reduction in effort – improved time efficiency
- Reduction in diagnostic and treatment errors
- Reduction in adverse patient incidents
- Reduction in unnecessary referrals
- Reduction in readmissions
- Reduction in unnecessary follow up appointments
- Reduced ambulance conveyances
- Reduction in prescribing errors and adverse drug reactions (ADRs)

C4.2 Point of care clinical decision support has been used for many years within primary care (e.g. for prescribing) and is becoming more widespread in trusts as EPR capabilities are deployed.

C4.3 As well as supporting patient-level clinical decisions (paper-free at the point of care, real-time data analytics), integrated real-time data offers opportunities for real-time demand management by tracking activity across the whole system to, for example, raise alerts when urgent care capacity is likely to be breached. These are new application areas which will increasingly become feasible as the scale and scope of real-time digital records becomes reality.

C4.4 Section H provides information relating to what we are doing to recognise this vision.

C5 Person / patient held record and associated client facing services

C5.1 Appropriate use of technology for direct access by citizens / patients / clients (digitally enabled self-care) has the potential to:

- Reduce demand on services by better informing citizens about healthy choices and appropriate use of services
- Empower patients / clients to become partners in choices concerning their healthcare and social care (no decision about me without me)
- Enable patients / clients to take great responsibility and control for managing their own health and care
- Citizens get a greater sense of shared decision making, feel part of the care process and increased confidence in the service as they have access to a greater range of information.
- Offer a wider range of channels through which support and advice can be provided, which are more convenient, accessible and efficient than conventional face to face contacts, allowing the possibility of new models and settings of care.

C5.2 The range of relevant information services and technologies is wide. They include:

- Patient / client access to / ability to view and to add to their own records
- On-line appointment booking and repeat prescriptions
- Telehealth in support of self-management, especially for those with chronic conditions
- Online tools, smartphone apps which can provide tailored advice and support
- SMS text alerts such as appointment reminders
- Social media, e.g. peer group support networks
- Websites to provide information about and signposting to services available
- E-consultations, video-consultations
- Telecare, including the “internet of things”, i.e. alerts from smart household appliances of vulnerable people.

C5.3 There is a significant emphasis on self-care and self-management in the STP. One of the most important areas that can support this is person-held records and preliminary discussions are taking place to explore this further. We have looked at other areas in the NHS that are using patient portals, and there are pockets of real innovation but generally at a trust level.

C5.4 The provision of universal free WiFi for patients across the NHS estate may act as an enabler for patients to become more engaged in digital tools generally, and specifically those that support health and well-being including condition specific support groups and social networks, apps that help monitor conditions and support the concept of a 'digital prescription'. The funding referenced in *The General Practice Forward View* will be key to delivering this across the footprint. The scale of ambition within Berkshire West is significant, with trusts stopping procurement of patient portals so that they can join with a system-wide implementation. All organisations understand the benefits of having a single portal for all health and social care requirements.

C5.5 This, aligned with ambitious plans to harness the power of health and social care websites, apps and wearable devices will all help support patients at home and support them being healthier.

C5.6 Discussions are taking place with Microsoft Health who is one of the world leaders in patient portals and we have already procured their platform through the Connected Care programme. This ensures we have the best building blocks to design a portal with patients and health and social care professionals.

C5.7 Given the emphasis placed in the BOB STP and in local plans regarding greater self-care and self-management, this aspect of the LDR Programme will acquire much greater focus and increased scale than currently is the case.

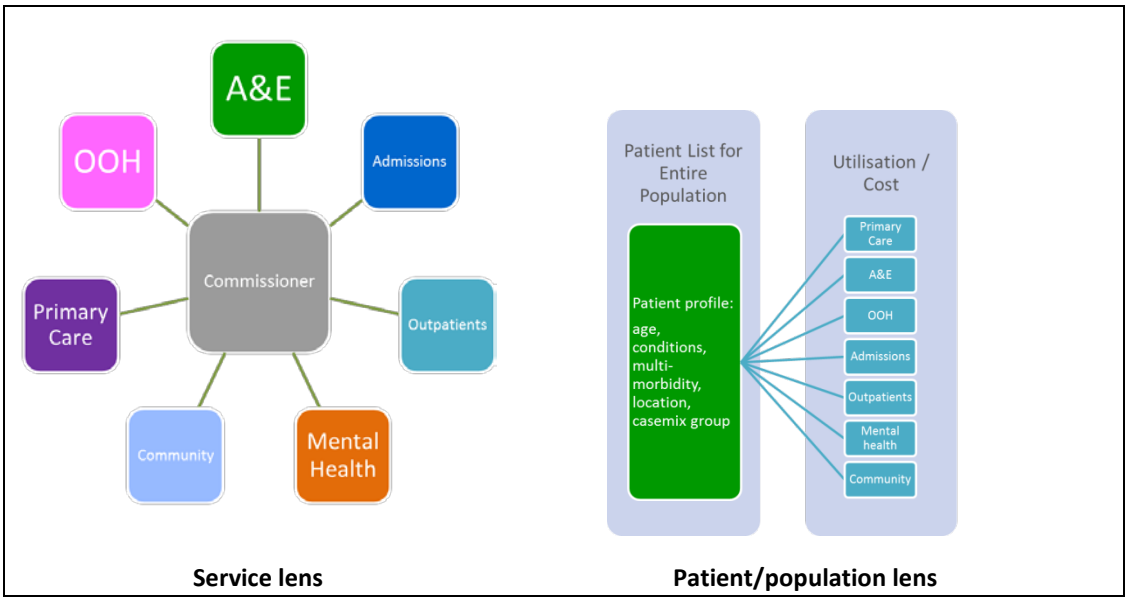
C5.8 Section H provides information relating to what we are doing to recognise this vision.

C6 Whole systems intelligence

C6.1 The bringing together of financial, operational and clinical outcome data centred around patients provides an opportunity for deriving whole system intelligence to support population health management, effective commissioning, outcome based contracting, planning, clinical surveillance, service re-design and research. This, in turn, should enable more effective prioritisation and targeting of resources, increased opportunities for joint initiatives, common solutions and shared expertise.

C6.2 A core goal of the Buckinghamshire, Oxfordshire and Berkshire West STP is to improve the integration of services around the patient, and whole systems intelligence is critical to this. To this end, West Berkshire CCGs in 2013 commissioned the "Eclipse" project, using a risk stratification and analytics system of the same name that extracts data from GP systems to allow benchmarking and audit in long term conditions (LTCs), as well as identifying those at risk of emergency admissions This can be supported by refocusing analysis of service use and resources around the patient, rather than on services.

Figure [C5]: Analysis of service use and cost: service versus patient and population lens



C6.3 Within a secure data repository, pseudonymised patient level data is already available for secondary care services and the ID POC will add a one-off extract of pseudonymised primary care data to this existing repository. The data repository also holds demographic and public health datasets, performance information and contract monitoring reports. Within the Data Services for Commissioners Regional Office (DSCRO) the CSU is able to obtain identifiable data and undertake linkage between data sets (subject to appropriate data sharing arrangements being in place). The CSU repository provides a rich source of information which is already used to support population based analytics. There are a number of examples where this is already happening across Berkshire West.

- A current application of population based analytics is the use of risk stratification to identify patients at high risk of hospital admission thereby enabling CCGs to prioritise segments of the population with costly health needs. The risk stratification tool provided by the CSU uses the Adjusted Clinical Groups (ACG) risk stratification algorithm developed by the Johns Hopkins University (calibrated using local data). The tool supports GPs and community teams with case management of high risk patients.
- The "Eclipse" project started in 2014, initially with a focus on improving diabetic care, which has since extended to include a wider range of LTCs patient groups. It is a tool analysing prescribing and screening data extracted from primary and secondary care, generating automatic safety reports and alerts enabling clinicians to identify patients at risk from their medications, and patients not fulfilling local guidelines. This presents the opportunity for improved patient healthcare and admission avoidance.
- Furthermore, clinicians are able to remotely monitor patient clinical profiles and access extensive analysis, allowing interventions that have improve the safety of "at-risk" patients and optimise prescribing efficiencies.

C6.4 There is considerable scope to extend the use of these linked data sets and these form part of the LDR strategy, for example;

- Build meaningful patient cohorts (segments) based on demographic and clinical features, and use these cohorts as a lens through which to understand current and future activity, financial impact and long term outcomes
- Better engage clinicians whilst still delivering the information that commissioners need
- As a basis for proactive case management of high risk/cost patients
- Total vertical and horizontal data integration: every person and every activity – this data set can be used for analysis at each level of the health system: federation/locality, CCG, STP
- Basis for developing capitated budgets and new contracting models

- A primary component of BAU analytics support for commissioning
- Services and contracts better aligned with populations and their needs – not just with providers / activity / precedent
- Strategic planning e.g. based on projections of the distribution of segments / cohorts e.g. long-term multi-morbidity projections
- Future scenario / cost modelling Cohort flagging / marking and then monitoring e.g. monitoring frail elderly patients, or use of services by care home residents
- Opportunity identification for Operational planning / QIPP, etc. – via case-mix adjusted benchmarking

C6.5 The future development of integrated population analytics can build on the existing integrated data repositories as patient level data sets are developed for further service sectors such as community and mental health. In parallel, the development of clinical interoperability solutions has the potential to enable integrated population analytics using data which has been brought together for use at the point of care. This offers the potential to feed the results of predictive analytics back into clinical solutions, and to develop analytics within interoperability solutions. As commissioning and planning of services becomes more focused on the patient, there is likely to be a convergence of strategic analysis based on analysis of repository data and real-time analytics.

C6.6 The Berkshire interoperability initiative, Connected Care, will enable greater opportunities for real-time information and data sharing across health and social care. This level of data integration will enrich the central data repository empowering the risk stratification algorithm in identifying certain high risk patient groups and provide the linkage to social care dataset thereby defining a more complete depiction of an individual's need. Instead of being patient-centric care it will become more person-centric, allowing these people being offered preventive health and social care today aimed at averting costly, unpleasant health and social problems tomorrow.

D Current Situation

D1.1 This section documents the baseline position for West Berkshire in embarking on the Local Digital Roadmap. It is from this baseline position that the roadmap will be identified to transform West Berkshire from its current state to the future state identified in Section C Strategic Context.

D1.2 The baseline position of the digital maturity of each of the Primary and Secondary Care providers and Social Care organisations are documented in section D1. Section D2 reviews the current digital projects and programmes that are currently in flight across the footprint. Section D3 reviews where new models of care are being piloted or deployed across Primary and Secondary Care providers and Social Care organisations. Section D4 reviews the recently completed digital projects and programmes. Section D5 documents the factors that are or will limit progress in completing the Local Digital Roadmap.

D2 Digital Maturity

D2.1 Each NHS trust and Local Authority has recently completed the national Digital Maturity Self-Assessment (DMA), which evaluates how well-developed their different aspects of readiness, capability and infrastructure are. The findings are summarised in Table [D1]. Although too much emphasis should not be placed on the actual percentage score, the green shading is used to highlight where organisations are above the national average.

D2.2 The LDR is especially concerned with the current maturity for each of the seven Paper Free at Point of Care capabilities (highlighted in bold in Table [D1]) – explained further in Section [E2].

D2.3 The DMA baseline shows that each trust is generally well-placed regarding readiness / governance / leadership / strategy, etc, although some issues possibly need to be addressed at RBFT regarding resourcing and IG.

D2.4 For Paper Free at Point of Care capabilities, there is a mixed picture. BHFT is mostly close to or above national averages, whereas the baseline for RBFT indicates progress has been more limited, to date, in several areas. e-Medicines Management is generally a weak area across both RBFT and BHFT. This reflects the fact that neither trust has yet deployed a e-PMA as part of their EPR - RBFT is planning for deployment in 2017/18 (or possibly later), BHT will review the business case, in 2016/17, for investing in an e-PMA solution.

D2.5 SCAS currently appears to have little digital support for orders/results and medicines management, but these areas are possibly less relevant for ambulance services. Of these areas, SCAS has included Medicines management and optimisation and Decision support as opportunities for improvement and reflected in the initiatives identified.

Table [D1]. DMA scores for the Berkshire West footprint

Issue	National Average Health	BHFT	RBFT	SCAS	National Average LAs	Reading	West Berkshire	Wokingham
Strategic Alignment	76%	100%	60%	56%	78%	71%	71%	75%
Leadership	77%	90%	80%	85%	79%	78%	78%	88%
Resourcing	66%	95%	45%	75%	75%	58%	63%	67%
Governance	74%	100%	65%	75%	76%	79%	88%	83%
Information Governance	73%	96%	50%	75%	82%	77%	81%	92.31 %
Records, Assessments & Plans	44%	56%	26%	57%	47%	50%	50%	44%
Transfers Of Care	48%	59%	42%	61%	35%	55%	55%	41%
Orders & Results Management	55%	49%	66%	14%	-	-	-	-
Medicines Management & Optimisation	30%	4%	17%	29%	-	-	-	-
Decision Support	36%	30%	33%	22%	62%	75%	75%	25%
Remote & Assistive Care	32%	92%	25%	50%	56%	61%	61%	61%
Asset & Resource Optimisation	42%	81%	45%	56%	65%	68%	68%	86%
Standards	41%	46%	44%	75%	62%	0%	0%	25%
Enabling Infrastructure	68%	80%	48%	75%	70%	81%	81%	72%

D2.6 A national DMA tool has been designed for social care (adult and children) providers. It follows some of the same broad headings as the NHS assessment, but has specific questions which are more pertinent to social care. The Digital Maturity Assessment for Social Care ran from 4th April 2016 until the 20th May 2016 and was not compulsory to complete. All 3 Local Authorities in West Berkshire have made submissions and Table [D1] demonstrate the results.

D2.7 All Local Authorities demonstrate a consistently high standard in comparison to the national standards.

D2.8 The main area of concern is in relation to the Standards section of the assessment. The reason for the results not just locally but nationally being low is 2 fold:

- Firstly in relation to the vendors of Social Care IT rather than the organisations themselves. The limitations around the IT solutions available and their lack of the use of Open APIs severely restricts the Local Authorities from progressing significantly in this area until the available solutions are developed in line with existing and new technologies.

- Secondly around the use of the NHS number and the ability to accurately capture record and validate the NHS number has historically been difficult. With the implementation of the Connected Care project all Local Authorities are working towards 100 % compliance with the NHS number and the connection to the N3 spine for the use of the Demographic Batch Service (DBS) and the Person Demographic Service (PDS). At present we have two Local Authorities that are undertaking IG Compliance against Version 14 of the IG Toolkit and one Local Authority who have submitted their Local Connection Architecture (LCA) to NHS Digital for approval before ordering the BT Connection.

D2.9 Areas where we see consistently high figures are around Remote & Assistive Care and Enabling Infrastructure as these are the key areas where Local Authorities are developing and investing in where they can potentially see significant benefits, with the emphasis on a person being more self-reliant, prevention strategies, reablement and keeping a person out of residential care for as long as possible. This is done through investment in new technologies and developing more integrated and closely working teams across health and social care.

D2.10 A similar systematic national exercise will be conducted for primary care in the near future. Meanwhile, much is already known, locally, about the availability and usage of systems and IT infrastructure within general practices. The current status in relation to provision of digital services for patients and other initiatives is summarised in Table [D2]. NB This table does not provide information on the take-up and usage of these services by patients, which currently is generally modest.

Table [D2]. Primary Care Current Status

Issue	Description	N&D CCG	N&WR CCG	SR CCG	W CCG	Total
Number Of Practices		11	10	19	13	53
Digital Services for Patients						
Prescriptions	EPSr2 live	64%	70%	84%	77%	74%
	EPSr2 average utilisation	67%	47%	36%	40%	44%

	Repeat prescriptions online	100%	90%	89%	100%	94%
Appointments	Book / Cancel Appts. online	100%	90%	100%	100%	98%
Patient Access to Electronic Records	Access to Summary Info. Available - Medication, Allergies/Adverse reactions	100%	86%	100%	100%	97%
	Access to Detailed Record available -Results	82%	60%	68%	62%	68%
	Access to Detailed Record available -View letters	45%	10%	58%	31%	40%
Reminders / Alerts	SMS Text messaging - Appt reminders	100%	100%	100%	100%	100%
Other Developments	Data submitted to SCR	100%	100%	100%	100%	100%
	Practice WiFi	27%	20%	58%	31%	38%
	Data sharing via interop	100%	100%	100%	100%	100%

D2.11 Overall, general practices are considerably more mature than are NHS trusts in their use of electronic patient records, decision support systems, order communications, e-prescribing, and the other capability areas. For example, it is rare for a GP to need to access / refer to the patient's paper notes for a consultation, or to check a test result or current medications, or any other routine clinical process. The Paper Free at Point of Care shortcomings for primary care relate, largely, to where they are dependent on another organisation to provide them with information in an appropriate format.

D3 Current initiatives

D3.1 Many local initiatives are underway which are of direct relevance to the vision set out above. Some of the key ones with whole-system implications include:

- Implementing digital tool (DXS) for pathway / referrals decision support for GPs
- Implementing single domain and WiFi across all general practices. It is planned that this will be extended beyond enabling practice staff access to corporate systems, to allow Health and Social Care staff access their corporate systems and patient access to public wifi
- RBFT – further deployment of EPR (Millennium) e.g. to cover ED, e-PMA, and continue to integrate EPR with other internal IT systems
- Further deployment and improved utilisation of nationally-developed systems such as SCR, EPS, ERS, PAERS (primary care)
- Further deployment / benefits realisation from use of Open Rio; Wider usage of SCR and MIG in urgent care, pharmacy and other departments (BHT)
    - SCAS LiveLink to Care Homes, currently undertaking a small scale pilot providing a servise of virtual see and treat between the Clinical Contact Centre and participating Care Homes.
    - SCAS LiveLink to Patient / Caller, project to provide visual communications with the public that contact the service which will support the decision of what course of action needs to be taken.
    - SCAS 111 Clinical Call Handling System, project that has been scoped to implement the Adastra system to strategically align the SCAS service for improved interoperability and improved working with other service providers.

- Carers integrated commissioning – To validate and refine plans for commissioning carers services and assessments
- Step Up/Step Down – Delivering a comprehensive reablement service as well as an ongoing assessment service of someone's needs prior to going home.
- Night Responder service – Working with Domiciliary Care Plus service provide options where a person requires 24 hrs support without the need of going into hospital or residential home
- Neighbourhood clusters, self-care and prevention (Wokingham) – integrating long term social care, community health services and third sector organisations in local communities. The third sector is expected to provide support in accessing appropriate services and provide social support to people living in the community

D4 Local transformation pilots / initiatives

D4.1 There are several examples of where new care models are being developed to transform care delivery, both at a whole-system scale and at a more local / specialist level, where IM&T dependence is recognised. These include:

- Establishment of an "Accountable Care System" (ACS) serving the population around Reading and West Berkshire. This is a major transformation initiative which aims to move to a more preventative model of care, to improve quality and outcomes and to become financially sustainable. These aims clearly overlap with those of the STP, as do the many IM&T dependencies. It is considered that (lack of appropriate) technology is a barrier to change towards an ACS. The sharing of patients' health and care records across organisations is at an early stage – but without this progressing at apace and at scale, it will inhibit continuity of care across complex pathways and limit our ability to affect their redesign - resulting in a duplication of assessments and diagnostics as well as gaps and delays in the provision of care.
- Primary Care Transformation initiatives are supporting federated working and extended hours. These in turn depend upon solutions for shared access to records and robust, secure flexible IT infrastructure.
- Wokingham Integrated Service Hub (WISH) is developing an integrated "front door" for health and social care. Although members of this team will initially use existing technology, detailed plans are underway to provide links between the various organisations' IT systems
- Wokingham Council has embarked upon a "21st Century Council" work stream to bring change management and IT together across all services, and the Better Care Fund Connectivity programme is an integral part of this project
- RBFT clinical service transformation initiatives, e.g. establishing a T&O Virtual Clinic, use of Tele-Dermatology.
- Rapid Response & Treatment for Care Homes – Provide a consistent and coordinated health and social care multi-disciplinary team.
- Integrated Hub – A single point of access for the Integrated Short Term team, which is also accessible by the public and professionals.
- Integrated short term team – The WISH team joins up the social care hospital liaison team, the START reablement team, the Council's social care assessment team and BHFTs intermediate care team.
- Workforce planning – Inter organisational workforce planning across health and social care to deliver more integrated and efficient services
- Integrated short term team – The WISH team joins up the social care liaison team, the START team and BHFTs intermediate care team
- Neighbourhood clusters, self-care and prevention (Wokingham) – integrating long term social care and community health services.
- Joint Care Pathway/7 Day Working – Integrated hospital discharge service staffed by both health and social care to deliver prompt responses to referrals and avoid delays in discharge from hospital
- Patient Recovery Guide (West Berkshire) – To develop a dedicated personal support service to assist patients through the care pathway so patients do not remain in hospital longer than they should do.
- Multi Agency Safeguarding Hub (MASH) - The implementation of an Inter-agency initiative between the Councils, NHS and Police services, requiring secure communications and data transferred aiming at the safeguarding of Children across West Berkshire

D5 Recent digital achievements

D5.1 In summary, key recent IM&T achievements that are contributing to the overall vision and aims of the LDR are:

- Berkshire West has benefited from cross-organisational working on IM&T for many years. The current Berkshire West Innovation, Technology and Information Systems (ITIS) Programme Board co-ordinates an ambitious programme of IM&T projects which address topics within each of the 4 areas of the CCGs' IM&T Strategy (see Figure [B1])
- Connected Care is a multi-organisational programme which has piloted limited sharing of patient information. Following a successful procurement, it now is deploying an interoperability solution, at scale, to enable information and data sharing across health and social care, providing immediate access to real time data
- SCAS - roll out of mobile access to the NHS Summary Care Record for ambulance crews. It is the first ambulance trust in England to give paramedics electronic access to the SCR, ensuring they have constant access to real-time patient information at the scene. The SCR will be embedded into the Trust's Ortivus EPR, allowing crews to view the patient's record using mobile devices once the patient has given their consent
- Reading Borough Council was one of the first authorities in Berkshire to set up and run a Multi-Agency Safeguarding Hub (MASH) with the Police and Health and Social Care.
- BHFT has implemented a fully managed mobile solution deployed across the whole mobile workforce. This is sufficiently flexible to allow it to be updated as care delivery models change and as new usability features become available
- GPs receive electronic correspondence from BHT via their DocMan solution (now 10,000+ documents per month)
- Partner organisations have direct access (where appropriate) to BHFT's EPR records
- The use of Glasscubes which is also used by Health for secure information sharing and collaboration.
- GCSX email for secure email connection across PSN network to other authorities and @nhs.net addresses
- The use of Global Certs Secure email for secure email communications outside of PSN email domains with standard @reading.gov.uk email domain
- Integrated team having access to both social care and RIO from same laptop - as an interim measure until Connected Care can facilitate better sharing arrangements
- Publication of data to the Child Protection Information System (CP-IS)
- 21st century council – move towards more sophisticated use of IT linked to cloud computing and reorganisation of local authority services away from old "Directorate" structure

D6 Rate limiting factors

D6.1 The key factors which are currently considered to be constraining the rate of progress towards the vision for digital transformation across the whole system are:

- Varying levels of clinical engagement across the workforce
- Keeping up with the pace of change in some clinical areas
- The culture of paper dependency
- The capacity of staff, both front-line and support, in relation to the scale of ambition for change, whilst ensuring ongoing operational activities
- Poor network access / mobile connectivity in some areas
- The main social care systems are not easy to integrate

- Costs vs likely capital and revenue funding availability.
    - Resources in times when both health and Local Authorities are looking at making cost savings and therefore key staff being unavailable with too many conflicting priorities
    - The ability to get timely responses from organisations such as NHS Digital which prevents further delays to ongoing pieces of work
    - A culture amongst service users of not engaging with digital services as well as poor communication of features, functionality and benefits of these services
    - Lack of vendor engagement due to over commitment of resources

  Some of these issues are examined further in the sections below.

E Capabilities

E1 Universal capabilities

E1.1 The LDR guidance identifies 10 "Universal Capabilities" with 25 associated "Aims" which focus on fully exploiting the existing national digital assets (See Table [E1]). For each of these capabilities, NHS England expects plans to show "clear momentum" in 2016/17 and "substantive delivery" in 2017/18.

Table [E1]. Universal Capabilities & Associated Aims

Capability	Aim
1)Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions	a) Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients) b) Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions
2) Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)	a) Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations b) Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients)
3) Patients can access their GP record	a) Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition b) Patients who request it are given access to their detailed coded GP record
4) GPs can refer electronically to secondary care	a) Every referral created and transferred electronically b) Every patient presented with information to support their choice of provider c) Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability) d) By Sep 17 – 80% of elective referrals made electronically
5) GPs receive timely electronic discharge summaries from secondary care	a) All discharge summaries sent electronically from all acute providers to the GP within 24 hours b) All discharge summaries shared in the form of structured electronic documents c) All discharge documentation aligned with Academy of Medical Royal Colleges headings
6) Social care receive timely electronic Assessment, Discharge & Withdrawal Notices from acute care	a) All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act
7) Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly	a) Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children) b) Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details c) The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record
8) Professionals across care settings made aware of end-of-life preference information	a) All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care b) All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected
9) GPs and community pharmacists can utilise electronic prescriptions	a) All permitted prescriptions electronic b) All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic c) Repeat dispensing done electronically for all appropriate patients d) By end 16/17 – 80% of repeat prescriptions to be transmitted electronically
10) Patients can book appointments and order repeat prescriptions from their GP practice	a) By end 16/17 – Minimum of 10% of patients registered for, and actively accessing (per NHS Mandate 2016/17), one or more online (or through apps) services (repeat prescriptions, appointment booking or access to record) b) All patients registered for online services use them above alternative channels

E1.2 Appendix [B] summarises the current baseline position and plans in relation to each Universal Capability / Aim. Figure [E2] summarises the current position for the footprint in relation to each of the Capabilities with two columns indicating the anticipated position in terms of percentage delivery for each Universal Capability at the end of 2016/17 and 2017/18 based on plans agreed by footprint partners. Each Aim related to the Capabilities is shown in terms of current delivery status (an estimated overall % across all providers), and the status of current improvement plans (Green – plans in place, existing initiatives underway, Aim achieved; Amber – plans developed, new initiatives required; Red – further planning required, significant new initiatives required). The final (Note: further detail of the footprint plans can be found in the Universal Capability Delivery Plan templates).

Figure [E2]. Summary of Universal Capability Baseline and Plans

Capability	2016/17 Goal	2017/18 Goal	Aim	Current
Cross care settings access to GP held information			Secondary, emergency and triage views of GP information	25%
			Pharmacy views of GP information	60%
U & EC access information for patients most likely to present			GPs compiling enhanced SCR information for key patient groups	5%
			Secondary, emergency and triage views of enhanced GP information	5%
Patients can access their GP record			Access to detailed coded GP records actively offered to key patient groups	2%
			Patients who request it are given access to their detailed coded GP record	2%
GPs can refer electronically to secondary care			Every referral created and transferred electronically	72%
			Every patient presented with information to support their choice of provider	50%
			Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability)	50%
			By Sep 17 – 80% of elective referrals made electronically	60%
GPs receive timely electronic discharge summaries			All discharge summaries sent electronically from all acute providers to the GP within 24 hours	60%
			All discharge summaries shared in the form of structured electronic documents	25%
			All discharge documentation aligned with Academy of Medical Royal Colleges headings	10%
Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care			Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care	20%
Clinicians in unscheduled care settings - access CPI / social care professionals notified accordingly			Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting	0%
			Indication of child protection plan, looked after or unborn child protection plan flagged to clinician, along with social care contact details	0%
			The social worker of a child on a child protection plan receives a notification when that child presents at an unscheduled care setting	0%
Professionals across care settings made aware of end-of-life preference information			All patients at end-of-life able to express their preferences to their GP and know that this will be available to those involved in their care	30%
			All professionals from local providers involved in end-of-life care of patients access recorded preference information	50%
GPs and community pharmacists can utilise electronic prescriptions			All permitted prescriptions electronic	44%
			All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic	44%
			Repeat dispensing done electronically for all appropriate patients	7%
			By end 16/17 – 80% of repeat prescriptions to be transmitted electronically	57%
Patients can book appointments and order repeat prescriptions from their GP practice			By end 16/17 – Minimum of 10% of patients registered for, and actively accessing, one or more online services	14%
			All patients registered for online services use them above alternative channels	1%

E1.3 In summary, the key points are:

- Many relevant digital enablers are in place (e.g. SCR, MIG, patient access from GP systems to summary and to detailed record, booking, prescriptions, EPS, ERS)

- However Capabilities that are driven largely by patient awareness and adoption e.g. view record online appear to demonstrate relatively low rates of utilisation. (e.g. only 14% patients are registered for online GP booking, etc and only 1.3% patients currently are registered to access their detailed GP records; Although 20% ED staff have access to SCR / MIG, there is moderate usage). Hence more communication, awareness, education is required amongst the workforce and citizens. However it should be noted that in primary care only a proportion of registered patients (est.30%) actively use their GP services and benefit from engagement with these digital services
- Utilisation amongst practices of ERS is relatively high at 72%, whereas EPS utilisation is currently about 44%. About 60% discharges from RBFT have an accompanying e-discharge summary sent within 24 hours
- Opportunities exist for more innovative use of existing digital enablers to improve capabilities. For example the use of enhanced SCR to record End of Life preferences.

- Unscheduled care setting are currently able to view Child Protection data through the Child Protection Information Service however at present only 23 organisations are publishing data to CP-IS
- Trusts / GPs do not yet have access to the Child Protection Information Sharing service, although trusts do receive a weekly extract by secure email

E1.4 Social Care currently receives between 61-80% of their referrals through electronic means where the remainder are still made via a telephone conversation. Broader capability deployment

E1.5 This section describes, for each of the seven capabilities directly relevant to Paper Free at Point of Care, the expected trajectory over a three year horizon to March 2019. Figure [E3] summarises what is covered by the seven capabilities, and Table [E4] provides examples of some elements which are mainly dependent on functionality *within an individual organisation*, and those that require action *across organisations*. Note that of the seven, three capabilities have fairly weak or no dependence on whole system working.

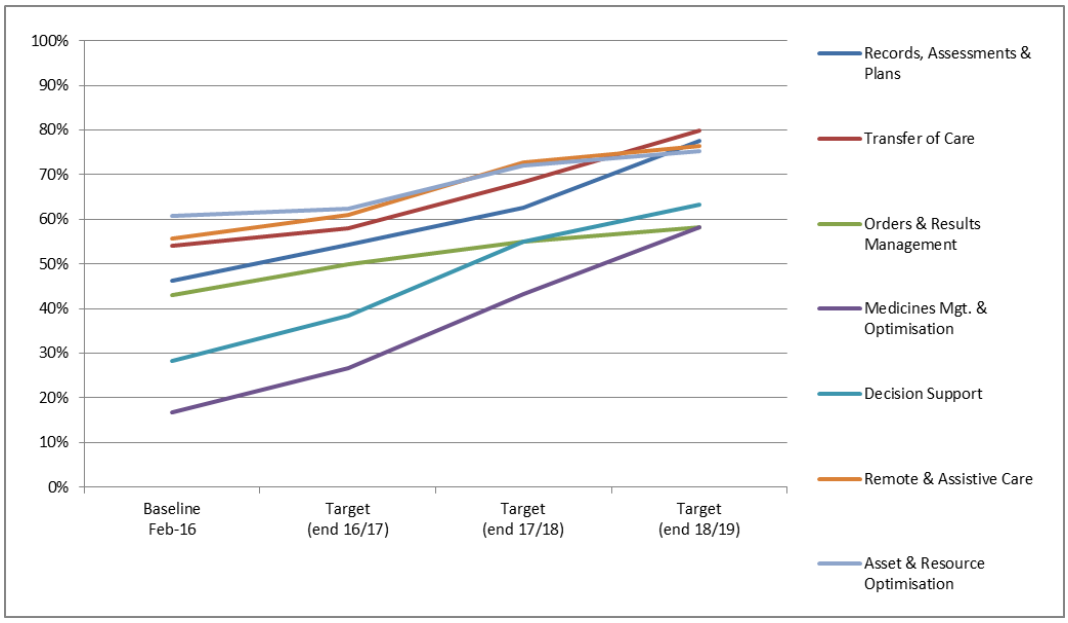
Figure [E3]. Scope of Paper Free at Point of Care Capabilities

Table [E4]. Organisational and Whole System Dependencies

Capability	Organisation-specific dependency, e.g.	Whole system dependency, e.g.
Records, Assessments & Plans	Structured digital records accessed and updated in own systems	Access to clinical information from other organisations The capability to match NHS number
Transfers Of Care	Systems able to generate and integrate referral and discharge information	Standardised approach for transfer / receipt of referrals and discharges
Orders & Results Management	Digital ordering of tests and access to results	May cover to/from primary care
Medicines Management & Optimisation	Digital prescribing by the organisation's clinicians	Limited
Decision Support	Digital alerts concerning patients under the care of the organisation	Limited
Remote & Assistive Care	Remote/virtual clinical consultations between clinician and patient	Remote/virtual clinical consultations between clinicians from different organisations The investment in assistive technology Promotion of assistive technology The development of support and training in the use of assistive technology
Asset & Resource Optimisation	Digital tracking and management of internal resources, such as beds, staff, equipment	Limited

E1.6 Figure [E5] provides a high-level view of the capability trajectory for secondary care across the whole system, and the current baseline position. (Systematic data is not yet available for primary care nor for social care. The baseline scores are from the DMA. The prospective scores have been estimated by each organisation, based on their proposed systems and capability deployment plans. The whole system scores are derived by aggregating scores from individual organisations. Capability trajectory scores and deployment schedules for each trust, explaining what lies behind the forecast trajectories, are provided in Appendix [C].

Figure [E5]. Secondary Care Capability Trajectory

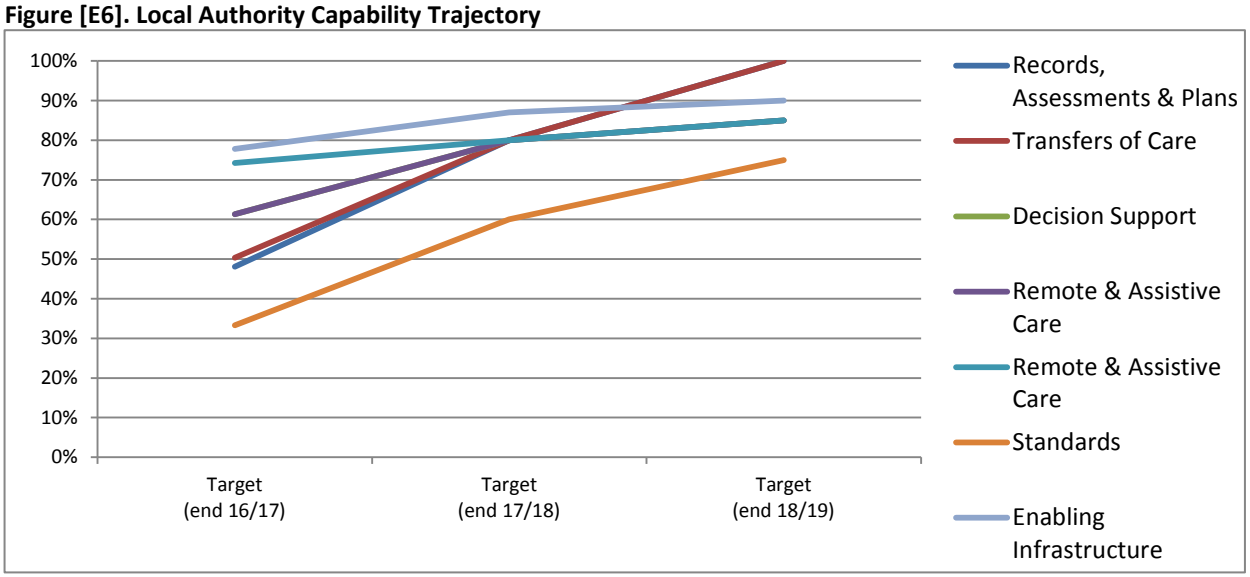


E1.7 Figure [E5] shows that:

- The overall capability trajectory (BHFT, RBFT and SCAS combined) indicates steady and relatively rapid progress is planned over next 3 years across all Paper Free at Point of Care capability areas
- No capability is expected to reach 100% by 2019, indeed only 1/7 categories (transfers of care) is expected to reach 80% by 2019 (*cf* national target of paperless working in primary, urgent and emergency care by 2018)
- Appendix [C] shows that for most capabilities, RBFT is anticipating a gradual increase, year on year, whereas there is a much more mixed picture for BHFT. SCAS is expecting a rapid improvement in relation to decision support and medicines management over the next two years, but only modest change for orders/results.
- Appendix [C] also suggests, for example, there will be big differences in the extent of deployment for orders/results amongst the three trusts. By 2019, RBFT expects to achieve 85% deployment, BHFT 60% and SCAS 30%.

E1.8 Figure [E6] provides a high level overview of the capability trajectory for Local Authorities across West Berkshire across the whole system and the current baseline position which have been provided as part of the output of the DMA. The prospective scores have been estimated by each organisation, based on their responses to the DMA, proposed systems and capability deployment plans. The whole system scores are derived by aggregating scores from individual organisations and agreeing realistic targets for the next 3 years based on work either ongoing or planned over that period of time

Figure [E6]. Local Authority Capability Trajectory



E1.9 There are a number of capabilities that are not expected to reach 100% within the next 3 years and potentially in the next 5 years. This is due to a number of reasons including financial investment, limitations in the current technology available and organisational changes.

E1.10 Most areas will see gradual changes in the capabilities over the next 3 years except in the standards area where the Local Authorities are currently undertaking work with connection to the N3 spine service and NHS number matching.

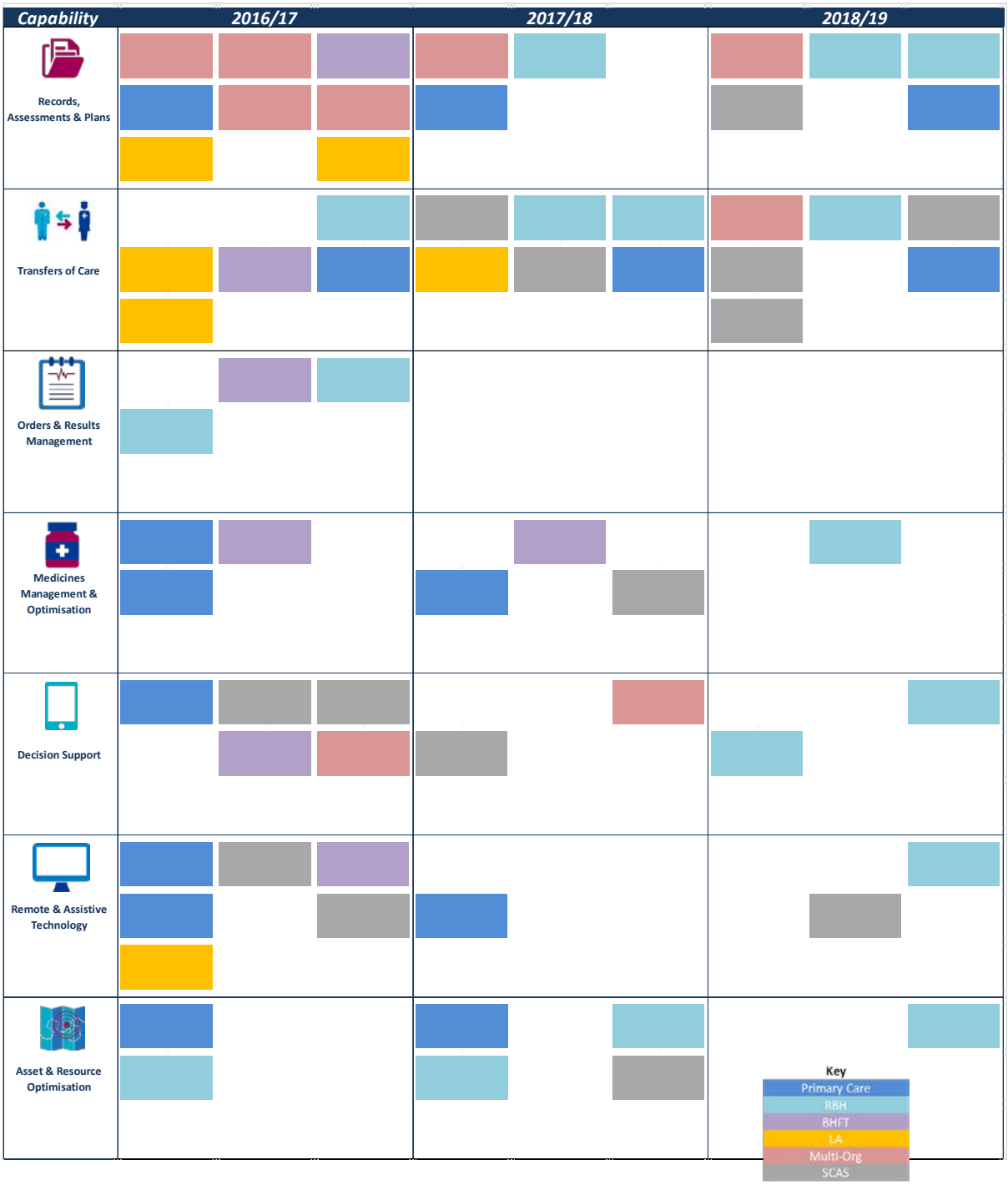
E1.11 A wide range of developments relevant to the Paper Free at Point of Care capabilities are proposed across all organisations. Figure [E7] shows, in outline only, when key aspects of deployment are expected in relation to each capability category: a) by organisation, and b) for the whole system, classified by status (active, committed, aspirational). The capabilities cover primary care and local authorities, as well as secondary care. For reasons of readability these diagrams do not contain details of what specifically will be deployed – this detail is provided in Appendix [D].

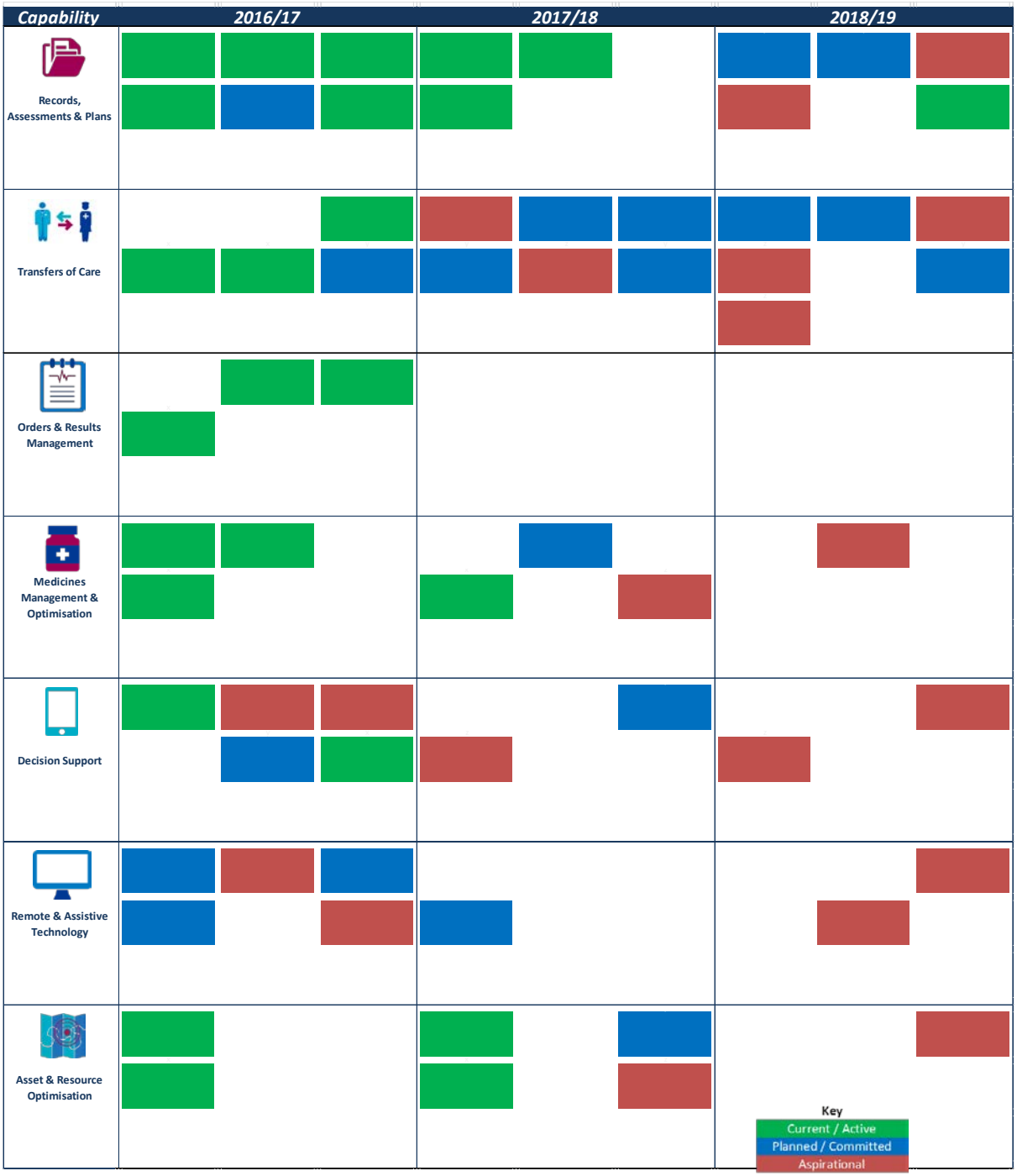
E1.12 Figure [E7] and Appendix [D] allow some of the secondary care capability trajectories to be explained in terms of planned deployments. For example:

- Figure [E7] suggests there will be more activity in the early years than later – but this probably reflects levels of certainty. Furthermore, Figure [E7] suggests that many of the deployments for 2018/19 are "aspirational", rather than being current/active or planned/committed.
- The detailed deployment charts in Appendix [D] provide insight into some of the major milestones for each organisation / sector over the next three years. For example RBFT expects that by the end of 2017/18 no paper records will be required in outpatients and e-prescribing will have been deployed by 2018/19. BHFT expects, by the end of 2016/17, to have e-access to RBFT diagnostic services for orders/results and deployment of telemonitoring for patients of the heart failure team.

E1.13 More generally, Appendix [D] indicates further deployments / uptake / utilisation during 2016/17 and 2018/19 in relation to the various universal capabilities (e.g. use of SCR and/or MIG, e-referrals, e-discharges, wider access to EoL information, access to CP-IS), all of which will support further progress towards goals for both paperless working and for information sharing.

Figure [E7]. Capability deployment chart by organisation and status




Capability
2016/17
2017/18
2018/19
Records, Assessments & Plans
Transfers of Care
Orders & Results Management
Medicines Management & Optimisation
Decision Support
Remote & Assistive Technology
Asset & Resource Optimisation
Key
Current / Active
Planned / Committed
Aspirational

F Information sharing

F1 Background

F1.1 It is recognised locally and nationally that the kinds of transformative change set out in the STP[1] cannot be achieved without realising many of the opportunities afforded through extensive deployment of digital technology.

F1.2 Efficient, effective, secure patient / client information sharing across organisations is fundamental to achieving many of the whole system transformation priorities set out in the STP, as well as to the ambition of paper free at the point of care (Paper Free at Point of Care).

F1.3 Information sharing amongst clinicians / care workers can take many forms, e.g. the sharing of documents at the transfer of care (such as discharges, referrals), real-time access to specific parts of the clinical record (such as medications), sharing of information such as tasks or notifications as part of the workflow, self-care enablers and population health management. These can be summarised as follows:

- **Interoperability and information exchange between health and social care organisations** to allow the flow of real time data between two or more organisations for the benefit of co-ordinating current and future service provision across care pathways, improving care and data analysis.
- **Having a person / patient held record (PHR) for health and social care for the citizens** of Berkshire West, that contains accurate real time data and information from commissioners, health and social care providers and citizens, enabling the individual to hold and manage their care and give consent to providers of services and carers to view their record based on an agreed data set.
- **Whole systems intelligence** to bring together financial, operational and clinical outcome data centred around patients providing an opportunity for deriving whole system intelligence to support population health management, effective commissioning, outcome based contracting, planning, clinical surveillance, service re-design and research.

F1.4 The Berkshire interoperability initiative, the "Connected Care" Programme was established in 2013 as a collaboration amongst all the main organisations within the footprint and latterly (since 2015) as a joint development with Berkshire East. The aim of the overall programme is to improve clinical effectiveness and patient experience by providing clinicians, carers and patients with a comprehensive view of patient medical/care history irrespective of source, moving away from separated information systems and data silos to a multi-system cross care setting landscape.

F1.5 The Connected Care approach has been to introduce increasing levels of functionality and an extended set of data through a controlled, phased approach:

- Phase 1 of the project enabled the sharing of (selected) primary care data from the 54 GP surgeries in Berkshire West with Westcall Out of Hours Service, Reading Walk In Centre and pilot users in Berkshire Health Foundation Trust and the Royal Berkshire Hospital. Phase 1 went live in October 2014.
- Phase 2 implemented a "proof of concept" integrated portal which extended the data provider organisations and the data consumers. In addition to the primary care information the pilot portal also included Admissions/Discharges/Transfers from the Royal Berkshire Hospital and community information from Berkshire Health Foundation Trust. The proof of concept ran for 6 months and was decommissioned in April 2016 (following the procurement of a different supplier for the final solution). Phase 2 also included the procurement process for the full interoperability solution.
- Phase 3, the implementation of the full solution began in June 2016. The approach will be to deploy multiple releases (in line with the STP initiatives) during the five year contract duration.

[1] Section C1.

F1.6 In addition to sharing data and records amongst professionals, collaboration between professionals from different organisations may involve more interactive digital technologies. Alongside existing methods, i.e. telephony and email, opportunities exist to use instant messaging, video / web-conferencing and enterprise collaboration tools. Berkshire West will use a mixed economy of solutions to meet the needs of the business.

F2 Leadership and governance

F2.1 The delivery of the Local Digital Roadmap (LDR) is being overseen by the West Berkshire Digital Transformation Programme Board. This group was originally the Connected Care Board, but has taken on additional responsibilities for the workstreams associated with the delivery of the broader roadmap. The Senior Responsible Officer (SRO) is the CIO for NHS Wokingham CCG.

F2.2 The West Berkshire Digital Transformation Programme Board includes representatives from each of the health and social care partners involved in the footprint. The Board has been operating since November 2013 and has overseen significant cross system digital developments.

F2.3 The West Berkshire Digital Transformation Programme Board reports into the Berkshire West Clinical Commissioning Committee and the Delivery Group which reports into the Berkshire West Integration Board (acting on behalf of the four West Berkshire CCGs Governing Bodies. The CIO for NHS Wokingham CCG attends all meetings therefore ensuring continuity.

F2.4 The West Berkshire LDR is one of three LDR's within the Berkshire West, Oxfordshire and Buckinghamshire STP footprint. To ensure that the STP has a consistent digital input, Lois Lere has been designated as the digital lead for the STP and has established a CIO forum to start linking the LDR's. Some early priorities that have been identified include patient portals, integrated digital clinical records and IG. Opportunities are already being explored to work at scale and to best support the STP.

F3 Clinical engagement

F3.1 Digitally enabled transformation is an essential component for addressing the challenges faced by the local health system. Berkshire West have been very clear that "digitally enabled transformation" should not focus on the technology alone but must be driven by the end-users, i.e. those at the front line of delivering care.

F3.2 Similar to a number of organisations in the UK who are working to implement "joined up" care across the health and social care, Berkshire (West and East) created a fictional person (Sam) to illustrate some of the issues facing care professionals in obtaining patient/citizen centric data in relation to individuals under their care.

F3.3 Sam was created for the purpose of developing "real life" scenarios for many of the cross organisational service lines that will care for Sam during his journey. These scenarios were focussed on defining the following:

- Identification of the key issues currently facing care professionals when Sam (or a real life equivalent) presents him/herself
- What information is required by the care professionals involved to be able to make a more informed decision
- What are the anticipated benefits of having the relevant information available at the point of care

F3.4 The journey, associated scenarios and information requirements were developed by front line staff and provide a broad range of issues currently facing the delivery teams and their respective organisations.

F3.5 Over 50 members of staff across health and social care were involved in the development of Sam's story and this document acted as a focal point for clinical and care engagement. Sam's story was completed in September 2015 and was one of the key inputs to the requirements that were published as part of the Invitation To Tender (ITT) process which started in October 2015.

F3.6 Clinical and care professionals were also involved in the ITT marking and selection process.

- Clinicians and care professions were involved in the marking and moderation of the functional and operational requirements.
- 71 clinical and care professionals attended the two day supplier demonstrations (January 2016) and were actively involved in the final selection process. Suppliers involved in the process commented that this was the best clinical engagement they had seen during a procurement exercise.

F3.7 To ensure on-going alignment to the needs of front line staff, the Connected Care delivery team and the chosen interoperability supplier are members of the Clinical Advisory Group for data-set definition and Care Planning. Embedding the technology team into the transformation workstream not only ensures that the business drives the use of technology but also that changes to processes take account of experience gained from other customers and any "best practice" solutions adopted.

F4 Patient engagement

F4.1 The Connected Care Programme Board has patient representation since early October 2014.

F4.2 Patients were involved in the ITT marking and selection process.

- Patients were involved in the marking and moderation of the patient portal requirements.
- Patients attended the two day supplier demonstrations (January 2016) and were actively involved in the final selection process.

F4.3 A patient group has been identified to assist the Connected Care Programme in terms of developing the requirements of the patient portal.

F4.4 This patient group will evolve to support the wider digital transformation agenda and will play a vital role in supporting with the design, implementation and communication. This group will communicate with broader patient groups to get as broader engagement as possible.

F4.5 Patient journeys were mapped from a clinical perspective and further work will be done to map this from the patient perspective. This is so important when designing services or technology that will have a direct impact on patients. Information governance

F4.6 The range of service areas and the required support structures suggest that the challenge of delivering co-ordinated care should not be underestimated. It requires an integrated service model to deliver joined up care across different provider boundaries, where providers operate under different service objectives and performance criteria.

F4.7 Information sharing is a key enabler for any integrated service model and this sharing must be implemented in conjunction with the best practice principles associated with Information Governance.

F4.8 In September 2015 the Connected Care Programme initiated an Information Governance steering group comprising of the Caldicott guardians (or delegates) from each of the organisations involved. The purpose of this group was to ensure a strong IG management framework was developed in order to demonstrate to all partner organisations that all personal confidential data will be processed, used and shared lawfully and that all data protection requirements are being effectively satisfied. The steering group is chaired by the LMC and it represents both West and East Berkshire.

F4.9 The steering group has developed a set of 12 key principles that all participating organisations have signed off. These principles are evidenced by a documentation suite that that supports and ensures these principles are being adhered to.

F4.10 In April 2016 the LMC wrote to all Berkshire West GPs to endorse the Connected Care programme.

F4.11 The IG steering group will remain in place for the duration of the project.

F5 Data-set definition and agreement

F5.1 The Berkshire ITT identified 20 information feeds (in addition to all GP practices) that would be required by an interoperability solution across health and social care.

F5.2 The key determining factors in specifying what can be achieved per information feed are:

- Availability of a unique identifier across all provider solutions (health and social care)
- What's information is required by the clinical and care professionals
- What's stored within the existing provider solutions

F5.3 All organisations have agreed that the NHS number will be the primary identifier. Local authorities have plans in place for an initial batch update and on-going maintenance of the NHS number within their systems.

F5.4 The primary care data set has initially been determined by the standard information made available via Health Care Gateways MIG solution (F1.5, phase 1). Although adequate and signed-off for current purposes this data-set will be monitored and updated based on clinical and care professional feedback (via the Clinical Advisory Group).

F5.5 The proof of concept pilot (F1.5, phase 2) helped to identify and supply key data sets from secondary care providers (ADT, community) which will be reused as we move to the full solution. Although adequate and signed-off for current purposes this data-set will be monitored and updated based on clinical and care professional feedback (via the Clinical Advisory Group).

F5.6 An analysis of the Local Authority data-set was completed in June 2016. This identified a common set of data stored across all Local Authority systems and verified it's appropriateness with health professionals. Although adequate and signed-off for current purposes this data-set will be monitored and updated based on clinical and care professional feedback (via the Clinical Advisory Group).

F5.7 The development of new services is being led by the Berkshire West 10 Delivery Board. Going forward, all data-sets will be reviewed by this group to ensure alignment to new working practices/processes and the long term vision of care. Any gaps in the data-sets required will be identified and solutions will be developed.

F5.8 Patients are involved in the definition of information that will be made available through the patient portal.

F5.9 Berkshire (West and East) is at an advanced stage of understanding and extracting the data sets required for effective interoperability. It is Berkshire's intention to make this information available to surrounding geographies in order to help standardise data sharing across boundaries.

F6 Progress and plans

F6.1 Implementation of the full Connected Care programme is scheduled to start in June 2016. Initial planning has been completed and the lessons learned (including existing data feeds) from the initial pilot will be incorporated to ensure quick wins are achieved and momentum gained.

F6.2 Detailed plans for Connected Care will be developed on an annual basis. These will include a detailed in-year plan and a year+1 high level plan. Plans are in place for FY2016-17 and FY2017-18.

- FY2016-17: includes data available from all GP practices, RBFT, BHFT and two Local Authorities, data consumption by all organisations, alerting and notification, patient portal design and care planning design.
- FY2017-18: includes data available from the remaining organisations, extending exiting data-sets, implementation of the patient portal (limited cohort of patients), care plan implementation (limited) and mobile use.

F6.3 In addition to Connected Care, a number of other initiatives contribute to the sharing of patient information between organisations:

- SCAS has plans to implement: Two-way sharing of "special patient notes", e.g. updating records and notifying GP of adverse reaction to medication; e-Booking of appointments from 111 call into GP / OOH /minor injuries services ; e-Discharge messages 111 and 999 to GP Practices
- WBC social care automatically receives e-assessment, e-referrals, e-discharge and e-withdrawal notices from acute care via the Health Hub
- BHT and RBFT (for inpatients and ED only) send discharge summaries digitally, and all correspondence via the EDT/Docman hub for auto-uploading into GP records
- End of life care plans, currently held within the Out of Hours system, are able to be viewed by authorised clinicians from trusts and elsewhere
- End of life – Provide a single point of contact through a centralised hub, for patients, families, carers, health and social care professionals
- OHMS Self Service Module – Citizen online services
- Social Care Information Point – Internal and external facing repository which provides details of services, organisations and activities to support adults help live independently.
- Family Information Service Directory – Information, advice and guidance on Ofsted Registered Childcare and other family services NB All authorities have to provide these, along with a 3rd type for SENDD children to support EHCP decisions
- Discharge to Assess/Time to decide – DTA is a step down rehab and reablement service with the primary aims being to reduce the number of patients on the fit to go register, reduce length of stay and reduce permanent admissions.
- Reducing delayed transfers of care
- Neighbourhood clusters, self-care and prevention (Wokingham) – integrating long term social care delivered by Optalis, community health services and third sector organisations.
- Community Reablement Team – A domiciliary care service which works jointly with BHFT to provide short term support
- Step up and step down care (Wokingham), with people being actively diverted from hospital care
- Enhanced 24 hour emergency support in a person's home to aid late discharge from hospital and divert people from attendance at A&E as a risk prevention measure
- Proposed co-location of teams working in Wokingham Children's Services and BHFT to improve Education, Health & Care Planning arrangements

- Carers integrated commissioning – To validate and refine plans for commissioning carers services and assessments
- Step Up/Step Down (Wokingham) – Delivering a comprehensive reablement service as well as an ongoing assessment service of someone's needs prior to going home.
- Night Responder service (Wokingham) – Working with Domiciliary Care Plus service provide options where a person requires 24 hrs support without the need of going into hospital or residential home
- Neighbourhood clusters, self-care and prevention (Wokingham) – integrating long term social care, community health services and third sector organisations in local communities. The third sector is expected to provide support in accessing appropriate services and provide social support to people living in the community
- Child Protection Information Service (CP-IS) – Local authorities to share child protection information electronically to CP-IS for use in unscheduled care settings.
- National systems including Choose & Book / ERS, SCR, GP2GP, EPS, Spine.

F6.4 Appendix [E] plots, for the next few years, the potential deployment of information sharing solutions and their usage.

F6.5 Digital technology is being used to support improved collaboration between professionals and more efficient cross organisational working. Examples of current initiatives and planned developments include:

- Tele-conferencing is already in place and most organisations plan to expand its use.
- Secure email is used to support the exchange of confidential patient / client data between organisations, examples include child protection information shared by LAs with trusts and notifications of assessment and discharge from trusts to LAs.
- The Multi-Agency Safeguarding Hub (MASH) (a forum for secure collaborative working and information gathering/sharing across multiple agencies/partners (Social Care, Police, Education, Health etc) provides a single, secure repository for shared information.
- Collaborative working tools such as Huddle and GlassCubes are mainly used within organisations rather than between.
- The implementation of N3 connections in all LAs this year will allow validation of NHS Numbers and publication of CPIS data.
- The Connected care Project will provide a range of tools to support cross-organisational working and process, examples of the functions to be implemented include a shared dynamic care plan, a holistic patient record capturing core data from all health and social care organisations, and a business intelligence suite that will help identify patients that are at risk or need an intervention.

G Infrastructure and standards

G1 Mobile working

G1.1 Providing a robust, secure mobile IT infrastructure not only enables flexible information access for professionals within their normal place of work, but also supports their ability to work in other care settings, patient homes, residential homes, etc.

G1.2 The necessary mobile infrastructure components include mobile devices (laptops, handhelds, tablets, smartphones), authentication / security, device-specific user interfaces, connectivity (WiFi, 4G), mobile device management.

G1.3 The current status and plans for the mobile working infrastructure across the footprint are summarised here, with further detail provided in Appendix [F]:

- Mobile devices – the trust DMA scores for healthcare professionals being equipped with mobile devices to access clinical applications and information at the point of care are: 75% (BHFT), 25% (RBFT), 75% (SCAS), 63% (National). Currently a variety of devices (laptops, tablets, mobile phones) are in use, with differences both within and across organisations.
- Local Authorities are working towards mobile solutions for their workers with investment in new laptops and smartphones, application upgrades to support mobile working, improvement in WI-FI at council offices and sites along with a superfast Berkshire Broadband Infrastructure with 100% availability for 2018/2019.
- Connectivity – The extent to which healthcare professionals have WiFi access to clinical applications across each trust has been assessed for trusts as part of the DMA – scores are: 75% (BHFT), 25% (RBFT), 50% (SCAS), 78% (National). The GP WiFi project is due to complete by October 2016. Remote connectivity with primary care systems is enabled for most practices via EMIS Mobile or INPS Vision Anywhere. Health and Social Care workers are able to access networks / systems in their own organisation from offsite locations, such as general practices, via VPN. Councils have a well-developed mobile infrastructure, but front-line social care staff are not necessarily mobile enabled.
- Different mobile authentication / security solutions are currently deployed across each organisation, with different mobile device management (MDM) products in use or under consideration. Appendix [F] provides further detail.

G1.4 System-wide initiatives to further develop and exploit the mobile working infrastructure include:

- Work has started across healthcare providers on providing access to Trusts applications irrespective of NHS West Berks location.
- Further opportunities for sharing facilities and best practice will be examined. This could include evaluation of different mobile devices or MDM solutions; Ensuring any health / care professional can have secure WiFi access from any site, irrespective of organisation.

G2 Comms/Networking/etc

G2.1 Currently, all NHS organisations have full access to the NHS secure network, N3. All three LA's are in the process of implementing an N3 connection whether this is through the indirect route of the Public Service Network (PSN), or directly through the BT connection. All organisations will migrate from the existing N3 service by end of March 2017, to the successor Health and Social Care Network (HSCN) services, capable of supporting both the health and social care system.

G2.2 In terms of offering free WiFi to patients, the position across the footprint can be summarised as follows;

- BHFT - Currently offer free WiFi to long stay patients. Offering at all 200 community sites will require additional funding to upgrade bandwidth
- RBFT - Currently available at main hospital site.
- Primary care - Planned to be available by October 2016 as part of the GP WiFi Project.

G2.3 In terms of Unified Communications e.g. the integration of real-time communication services such as instant messaging, presence information, voice (telephony), video conferencing, shared desktops and interactive whiteboards with non-real-time communications services such as voicemail, email, SMS and fax. NHS Mail2 is currently being deployed as a replacement to NHS Mail and will offer standard features such as:

- Instant Messaging and Presence
- Mobile Device Management
- And additional or top-up features such as:
- Audio and Video calling
- Desktop Sharing
- Advanced Mobile Device Management

It is anticipated that all Primary and Secondary Care organisations will replace their email systems with NHS Mail2 to take advantage of at least the basic features offered.

As new and updated workflows and pathways are developed that demand the additional functionality of unified communications such as desktop sharing and video calling these could be added from the functions available from NHS Mail 2 or other 3rd party solutions could be procured.

SMS capability is not part of NHS Mail2 and is provided via 3rd party solutions, such as iPlato or Mjog.

Fax is being phased out.

- Maytech secure file Transfer – Secure File Transfer Protocol solution to share documents electronically and securely
- Glass Cubes Migration - It provides teams with a strategic and efficient way to collaborate, by sharing and storing information in the cloud that's secure, accurate and accessible from anywhere

G3 Standards & Policies

G3.1 The implementation of certain standards and agreed policies across the footprint are essential enablers for sharing information. The current coverage of NHS number in key systems across organisations in summarised in Table [G1]. The current status and plans for the adoption of other key national standards (SNOMED-CT, GS1, Dictionary of Medicines and Devices) is summarised in Appendix [G].

Table [G1]. % patient / client records which have NHS number

Organisation	% coverage	Comments
BHFT	99%	On-going data quality audits & monitoring
RBFT	>95%	In EPR & Spine linked systems. Ongoing batch tracing & audit
SCAS	86% 98.2%	999 Matching NHS Number to Patient Records 111 Matching NHS Number to Patient Record
Primary Care	100%	
RBC	63%	Initial matching was completed in 2015 and process in place to capture NHS numbers. A further matching to be completed prior to connecting to the N3 network
W Berks C	98%	Process in place to capture NHS numbers and once upgrade to new social care system is complete then will be looking at a direct connection to N3.
WBC	75%	Initial matching exercise completed (Autumn 2015) and another bulk matching exercise planned. In process of data cleansing involving the NHS numbers.

G3.2 Each organisation has plans, policies and procedures in place to minimise risks associated with increasing dependence upon technology. The summary, below, outlines the current status, identifies important gaps and some of the proposed steps to address these for each of the relevant areas. Further detail is provided in Appendix [H]. (Organisations are aware that the National Data Guardian Review of Data Security is underway, and that this is likely to require a review of local plans, especially in relation to responsibilities and data security standards.)

G3.3 IG, Data Protection and Privacy - DMA scores relating to IG are summarised in Table [G2]. This shows that RBFT, in particular, needs to make further progress – one area of concern being assurance in relation to suppliers' assets security. The Connected Care Programme Board for interoperability has an Information Governance subgroup which develops and recommends for approval policies in relation to the sharing of information, including Information Sharing Agreements and patient consent (to sharing) models.

Data Security - Footprint healthcare organisations follow the DH guidance *"Information Security: NHS Code of Practice"* in all processes, both those deployed and managed internally and those from managed service providers. Managed service providers have a formal information security risk assessment and management programme covering key information assets, including a documented information security incident reporting and management procedure. Procedures to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error and business continuity plans are up to date and regularly tested for all critical information assets.
All systems have appropriate access control functionality and documented, managed access rights are in place for all users of these systems with monitoring and enforcement processes to ensure NHS national application Smartcard users comply with the terms and conditions of use. Transfers of hardcopy and digital person identifiable and sensitive information are mapped and risk assessed and technical and organisational measures adequately secure these transfers.

Managed service providers have successfully completed the IG Toolkit at the level required to retain Accredited Safe Haven (ASH) status, allowing the processing of Personal Confidential Data.

Cyber security status and threat levels are continuously monitored and policies and procedures including education and awareness communication programmes are regularly reviewed and updated.

G3.4 Business Continuity and Disaster Recovery (BC&DR) – DMA scores relating to this area are summarised in Table [G2]. This shows that each trust, except RBFT, is above the national average, but none are at 100%, indicating that further work is required in developing and testing BC&DR plans, as described in Appendix [H]. For example, RBFT has about 300 IT applications and systems in use. Of these, only 31 remain to be transformed to a fully resilient platform.

G3.5 Clinical Safety - Clinical risk management is mandated by HSCIC in order to promote and help embed clinically safer working practice methods and patient safety solutions, enabled by IT, applied consistently across the NHS.

Berkshire West organisations commissioning Health IT systems follow a rigorous and robust clinical risk management cycle and conduct all required clinical safety activities. The commissioning organisations must be in receipt of a clinical safety case report from any Health IT system supplier. This is in compliance with the requirements of ISB 0160: management of clinical risk relating to the deployment and use of health software.

All identified hazards, including any residual hazards handed over by a supplier, must be documented in a hazard log. Any hazards are assessed according to their likelihood and severity and allocated a risk score, using the standards set down by the National Patient Safety Agency.

G3.6 Where there may be residual clinical risk, evidence must be provided that mitigation has reduced that risk to be as low as is reasonably practicable. The clinical risk management cycle builds upon and contributes to an overall clinical risk safety case for any IT health system project. This report must be reviewed by senior clinical leads and must be formally approved before deployment of any IT Health system is undertaken

G3.7 Data Quality and Information Standards – it is recognised that robust, standardised data must underpin most of the strategic objectives that this LDR aims to address (e.g. sharing of information across organisations, enabling patients / clients to view and add to their own health records). Each organisation has its own data quality improvement procedures. In addition, Connected Care will begin to identify areas where data are not fit for purpose, which will need to be fed back to the supplying organisation. Wherever these exist, organisations will, increasingly, adopt national / international standards of data recording / coding, and standardised data sets for transactions such as referrals and discharges.

Table [G2]. DMA scores for IG and business continuity / disaster recovery

Standard	Description	National	BHFT	RBH	SCAS
Information Governance	IGTK accred., IG understanding by Board, workforce, 3rd party suppliers, cyber security, active monitoring	73%	96%	50%	75%
Business Continuity & Disaster Recovery	BC&DR plans, processes, procedures; Multi-site redundancy for business-critical systems	71%	100%	50%	92%

G3.8 In respect to the Local Authorities the results are displayed in the table beneath:

Table [G3] DMA score for IG and business continuity/disaster recovery for the Local Authorities

Issue	Description	National Average	RBC	WBBC	WBC
Information Governance	IG Understanding by board, workforce, 3rd party suppliers, cyber security with active monitoring	76.33%	79.17%	87.5%	83.33%
Business Continuity & Disaster Recovery	Business continuity/disaster recovery processes & procedures have been tested and audited.	61.78%	75.00%	75.00%	100%

G3.9 SNOMED-CT – Within West Berkshire we recognise that the use of SNOMED-CT standards will enable improved sharing of information between Primary and Secondary Care providers. BHFT systems currently partially support the standard, it should be noted that the areas where they do not support the standard are due to their systems suppliers roadmaps not including the standard adoption in those areas. RBFT have aspirational plans to adopt the standards, but do not have any fixed plans currently. Primary Care systems suppliers are planning to implement in 2017/2018. This standard is not applicable to Local Authorities.

G3.10 GS1standards – Within West Berkshire, we recognise that the use of GS1 standards will enable, through standard identifiers and bar codes, the local health and care system to identify, capture, and share information on medicine, medical devices, consumables, assets and returnable equipment automatically.

The standards will help identify patients and staff as well as delivery and requisition locations to improve patient safety and supply chain efficiency, whilst saving on costs and enabling recording the full service line costing of procedures and patient care.

Across West Berkshire only RBFT has aspirations to implement RFID and this is dependent on funding. RBFT are currently using bar coding.

G4 Opportunities for shared infrastructure

G4.1 It is recognised that there are potential economic, strategic and operational benefits from further sharing of the IT infrastructure across the footprint or beyond.

The LDR has already acted as a vehicle to ensure collaboration between organisational IT teams. This has led to exploration of where existing systems can be linked to enable stronger collaboration between partners. This includes linking networks to aim for any health and social care professional being able to access their core systems from any NHS site. It also ensures that future, provider specific, procurements will take the LDR into consideration. This will ensure the systems are compatible with wider system procurements.

A final benefit is that joint procurements can be explored to achieve economies of scale, and make best use of the local IM&T professionals across the health and social care system. This could include cloud based data storage, Sharepoint, Microsoft Office 365, teleconsultations and other IT solutions where there are clear advantages of procuring at a system level.

G4.2 SCAS are working on a couple of initiatives:

- to implement NHS Mail 2, which not only brings a secure mail solution but adds Skype for Business, which both will introduce cost savings relating to cost and time of off-site meetings;
- to implement SCAS Clinical Cloud, which is a project that has been scoped to introduce Cloud hosting technologies that will improve remote system access for off-site working and reduce capital expenditure on hardware.

H Roadmap

H1 Whole System Transformation

H1.1 The preceding analysis of the identified strategic LDR priorities (see Section C) and Current Situation (see Section D) indicates that the individual organisations and the footprint as a whole have made considerable progress in relation to many of the issues considered in this LDR especially with regard to inter organisational whole system intelligence. However there are opportunities to target and accelerate the closure of the gaps and facilitate user engagement to move from the current state to delivering the strategic LDR priorities:

- Strategic goals of Paper Free at Point of Care and of universal information sharing capability – to achieve the planned capability trajectories outlined in Figure [E5] and [E6], and to execute and realise the benefits of the interoperability initiatives outlined in Section [F]
- Universal capabilities - mainly by realising further benefits from existing systems, increased utilisation, initiatives, and through improved organisation and patient awareness and benefits communication.
- Other strategic needs - especially citizen / patient / client-facing technologies, and whole system analytics
- Investment in essential underpinning infrastructure components, e.g. mobile capabilities.

H1.2 Table [H1] summarises some of main gaps that appear to exist between the current situation and the strategic goals (not just the shorter-term Universal Capability targets) outlined in Section C.

Table [H1]. Gaps in relation to strategic goals

Patient / Client Records (includes Universal Capabilities, PAPER FREE AT POINT OF CARE, Information Sharing / Interoperability, professional digital collaboration)	• Several Universal Capabilities requirements to be addressed (see above) • Limited digital support, currently, for many Paper Free at Point of Care capabilities (see DMA) • Comprehensive interoperability solution in development and yet to be deployed(Connected Care) • IT solution for federated working across practices to be deployed for South Reading • NHS Number Compliance and verification not yet at 100%
Citizen / Patient / Client-facing Digital	• Use of remote & assistive care technologies limited in scale, uniformity of solutions and deployment • Diversity of apps deployed in different sectors, but no overarching strategy/plan • Limited use by patients of online services such as appointment booking • Very limited access by patients to their detailed digital records • Diverse person demographics across West Berkshire and therefore skills and ability to use technology will differ
Analytics & Decision Support	• Not routinely using primary care data for whole system intelligence • ACG risk stratification tool available, not universally used (?) • DXS pathway support tool available, level of usage varies per practice/GP • Limited digital clinical decision support in trusts (see DMA scores)

Infrastructure	• Mobile IT access limited for some – e.g. no firm plans to provide mobile working to practitioners in social care (Wokingham BC); Poor mobile signal in some patches • Wi-Fi generally available, but not yet in every general practice (but final rollout underway) • Unified communications across Health & Care professionals to be developed. • Little sharing of technical resources / expertise across organisations • All Local Authorities are currently working towards the N3 Connection and are at different stages of implementation
Readiness, Governance	• LDR Implementation Programme not yet defined (to be based on this LDR) • workflow/pathways layered over digital platform • General digital awareness and familiarity of workforce need development

H1.3 Many different current and proposed initiatives are referenced in this report and its appendices. Although each has a role to play in meeting the stated goals, they need to be prioritised and strategically aligned as part of a multi-agency whole systems intelligence approach across the entire footprint.

H1.4 The criteria for agreeing priorities across the footprint include:

- Universal capabilities - is this initiative a significant contributing factor to the successful realisation of these?
- STP – are there specific objectives that will rely upon this initiative?
- Whole system working – will this initiative directly or indirectly facilitate a shared approach across the footprint (and possibly beyond)?
- Paper Free at Point of Care - is this initiative an essential enabler within a single organisation? Across several organisations?
- Will this initiative deliver significant patient/client/citizen benefit?

H1.5 Furthermore, in determining overall priorities, clearly it is essential to ensure current and future ongoing information and IT operational needs are adequately resourced, along with more general enabling activities such as addressing the "digital culture" through change management and benefits realisation programmes and basic digital skills of the workforce.

H2 Emerging Priorities

H2.1 With reference to the identified gaps to achieve the roadmap and by applying the above criteria, those initiatives that are considered particularly high priorities within the LDR Implementation Programme for 2016/17 and for 2017 and beyond are summarised in Figures [H2] and [H3] respectively.

H2.2 The proposed LDR Implementation Programme structure is summarised in the next Section.

Figure [H2]. 2016/17 Priorities

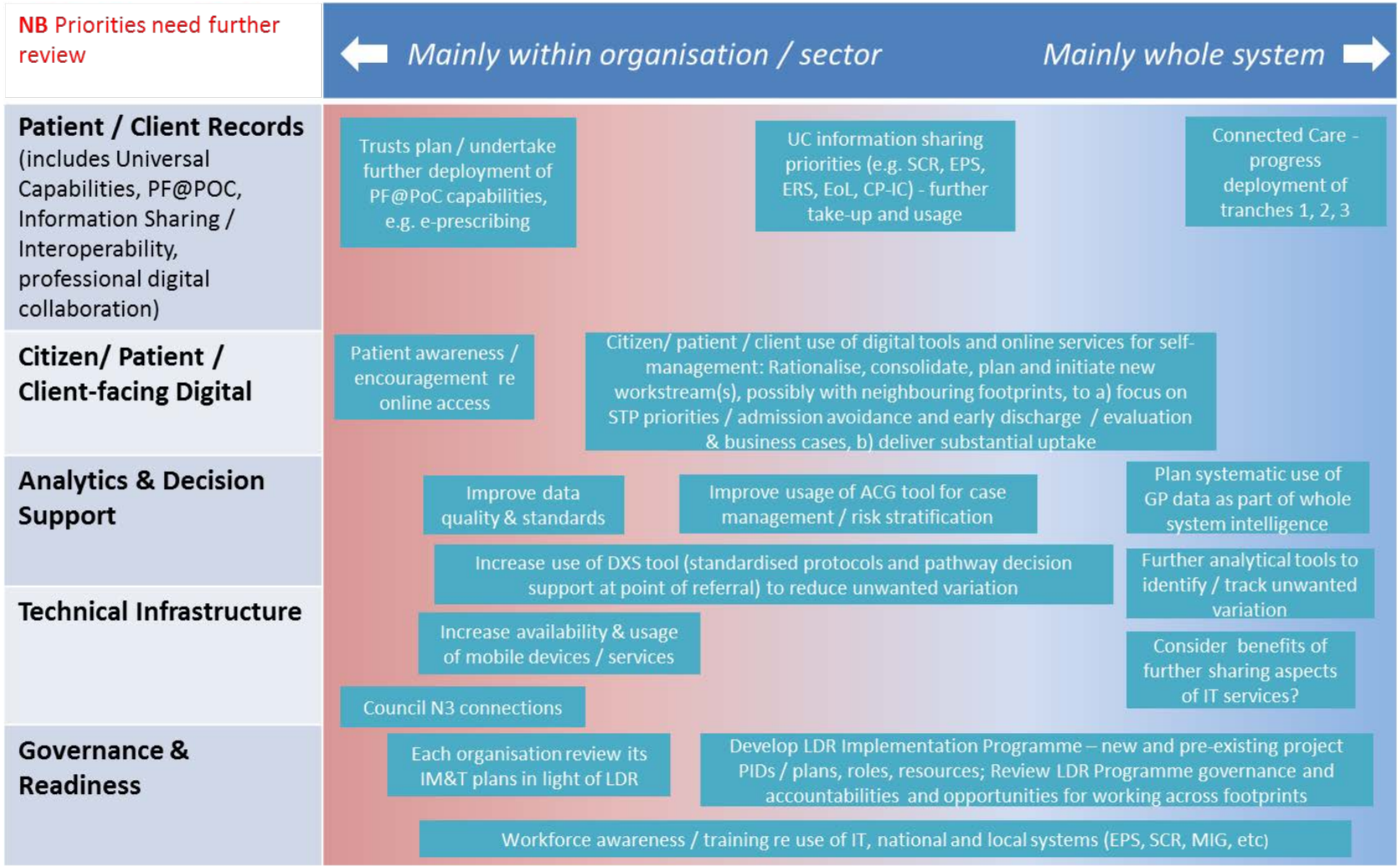
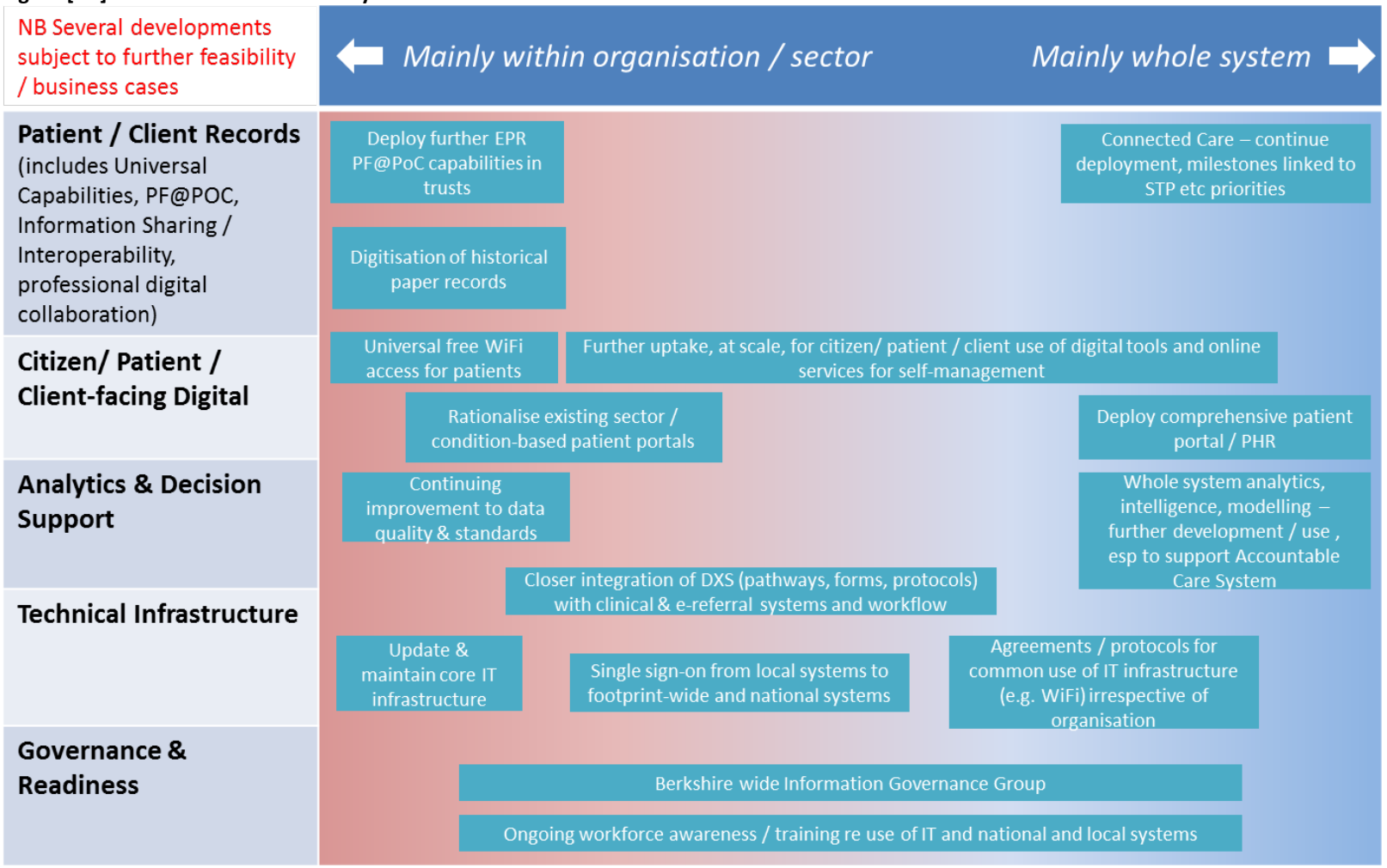


Figure [H3]. Priorities for 2017 and beyond



I Readiness

I1 Introduction

I1.1 This report outlines ambitious plans and identifies several likely challenges in meeting the plans. Therefore, to succeed the LDR Implementation Programme requires strong leadership and clarity regarding governance and accountabilities.

I1.2 In order to deliver the anticipated benefits, there needs to be a robust approach to change management and to benefits management.

I1.3 This section outlines the approach that will be taken to these issues, as well as highlighting overall resource requirements / funding priorities.

I2 Leadership, engagement and governance

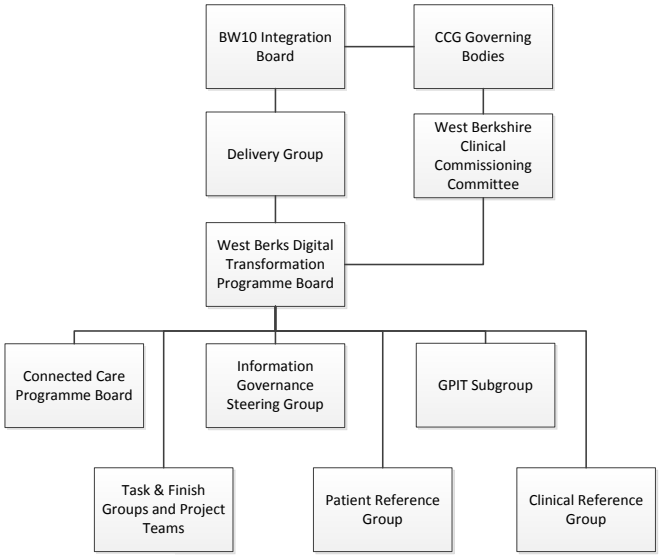
I2.1 The delivery of the Local Digital Roadmap (LDR) is being overseen by the West Berkshire Digital Transformation Programme Board. The Senior Responsible Officer (SRO) is the Interim Director of Operations for the Berkshire West Federation.

I2.2 The West Berkshire Digital Transformation Programme Board includes representatives from each of the health and social care partners involved in the footprint. The Board has been operating since October 2014 and has overseen significant cross system digital developments.

I2.3 The West Berkshire Digital Transformation Programme Board reports into the Berkshire West Clinical Commissioning Committee and the Delivery Group which reports into the Berkshire West Integration Board (acting on behalf of the four West Berkshire CCGs Governing Bodies. The CIO for NHS Wokingham CCG attends all meetings therefore ensuring continuity.

I2.4 The Board meets bi-monthly and by exception, if required. The accountability and links for the group are shown in Figure [I1]. The Patient Reference Group set up to provide support to the Connected Care programme has agreed to take an overview of the Digital Roadmap as a whole. The LDR SRO is the Interim Director of Operations / Chief Information Officer (Wokingham CCG, South Reading CCG, North and West Reading CCG, Newbury and District CCG) and the LDR Lead is the Head of Digital Transformation, South Central & West CSU.

Figure [I1]. LDR Programme Management Arrangements



I2.5 The proposed structure for the LDR Implementation Programme, which will be the vehicle for delivering the whole system Paper Free at Point of Care goals, along with other priorities for 2016/17 and beyond, is summarised in Figure [I1]. NB Those Paper Free at Point of Care goals which relate primarily to developments within an organisation will continue to be managed as part of that organisation's IM&T Programme with the intention of aligning workstreams through oversight by board level structures formed by the LDR and STP processes. Figure [I2] summarises the programme structure for the delivery of initiatives under way in 2016/17 that are key enablers for the realisation of the paper free at Point of Care ambition.

Figure [I2]. LDR Implementation Programme Structure

LDR Implementation Programme 2016/17				
	Capability	Workstream	Focus	Governance
Records, Assessments and Plans	Cross care access to GP held information	SCR	Communications, change management	CCG IM&T Committee
		Connected Care	Deployment	Connected Care Board
	Cross care access to enhanced GP held information	Enhanced SCR	Communications, change management	CCG IM&T Committee
		Connected Care	Deployment	Connected Care Board
		Cerner	Upgrade	RBH Transformation Board
	Electronic Referral	DXS	Deployment	CCG IM&T Committee
	Electronic Discharge Summaries	EDT	Deployment	RBH Transformation Board
		EDS to social care	Deployment	Connected Care Board
		Fax decomissioning	Deployment	RBH Transformation Board
	Social care integration	CPIS	Deployment	Connected Care Board
		SCR	Deployment	CCG IM&T Committee
		Connected Care	Deployment	Connected Care Board
	End of Life preferences access	Enhanced SCR	Communications, change management	CCG IM&T Committee
		EoL care plans	Communications, change management	CCG IM&T Committee
Patient/client Services	Patient access to transactional GP services	Patient Online	Communications	CCG IM&T Committee
		Patient Portal (CC)	Deployment	Connected Care Board
	Patient access to medical records	Patient Online	Communications, change management	CCG IM&T Committee
		Patient Portal (CC)	Deployment	Connected Care Board
	Electronic Prescription	EPSr2	Communications, change management	CCG IM&T Committee
Infrastructure	Single Sign On	Single Domain	Deployment	CCG IM&T Committee
	Mobile Working	Wi-Fi	Deployment	CCG IM&T Committee
	Local Authority N3 Connection	IT N3 PSM	Deployment, communications	Connected Care Board
Analytics and Decision Support	Risk stratification	Eclipse	Expansion	CCG IM&T Committee
		ACG Tool	Communications	CCG IM&T Committee

I2.6 The self-assessment of IM&T leadership and governance of trusts, as defined in the recent DMA exercise, is summarised in Table [I3].

Table [I3]. Trust DMA scores for Leadership and Governance

Standard	Description	National	BHFT	RBH	SCAS
Leadership	Board level ownership, clinical leadership, digital tech horizon-scanning	77%	90%	80%	85%
Governance	Board-led IM&T programme, project management, business cases, follow best practices	74%	100%	65%	75%

Table [I4] Local Authority DMA Scores for Leadership and Governance

Issue	Description	National Average	RBC	WBBC	WBC
Leadership	Board level ownership	78.52%	78.13%	78.13%	87.50%
Governance	Board led IM&T programme, project management, business cases and follow best practice	76.33%	79.17%	87.50%	83.33%

I2.7 All organisations have a Chief Information Officer (CIO) or equivalent, with the exception of RBC where the functions of a CIO are fulfilled by the ICT & Technology Services Manager, Digital & Website Manager and Social Care Heads of Service.

I2.8 There is a patient representative on the West Berkshire Connected Care Workstream and a patient group has been established to link with Digital Transformation Programme Board. Patients will be involved in establishing priorities and the delivery against the strategy. Patients were involved in the Connected Care ITT marking and selection process.

- Patients were involved in the marking and moderation of the patient portal requirements.
- Patients attended the two day supplier demonstrations (January 2016) and were actively involved in the final selection process

I2.9 Engagement with the Programme of clinicians and other care professionals will build on existing arrangements. Each NHS organisation has appointed a Chief Clinical Information Officer (CCIO), and the Heads of Adults & Children's Services fulfil an equivalent role for the LAs.

I2.10 Over 50 members of staff across health and social care were involved in the development of Sam's story (see F3 for more details) and this document acted as a focal point for clinical and care engagement. Sam's story was completed in September 2015 and was one of the key inputs to the requirements that were published as part of the Invitation To Tender (ITT) process which started in October 2015. Clinical and care professionals were also involved in the ITT marking and selection process.

- Clinicians and care professions were involved in the marking and moderation of the functional and operational requirements.
- 71 clinical healthcare and Social care professionals attended the two day supplier demonstrations (January 2016) and were actively involved in the final selection process. Suppliers involved in the process commented that this was the best clinical engagement they had seen during a procurement exercise.

I2.11 In terms of leadership, governance and engagement Berkshire West is well prepared to implement the Local Digital Roadmap.

I3 Implementation capability

I3.1 The organisations across Berkshire West have been working together for the past 18 months, developing solutions, investigating options and learning how to work successfully with each other. The relationships developed during this time are critical to the successful implementation of the LDR.

I3.2 In September 2015 the Connected Care Programme initiated an Information Governance steering group comprising of the Caldicott guardians (or delegates) from each of the organisations involved. The purpose of this group was to ensure a strong IG management framework was developed in order to demonstrate to all partner organisations that all personal confidential data will be processed, used and shared lawfully and that all data protection requirements are being effectively satisfied. The steering group is chaired by the LMC. The steering group has developed a set of 12 key principles that all participating organisations have signed off. These principles are evidenced by a documentation suite that that supports and ensures these principles are being adhered to. Information Governance will continue to be actively managed throughout the duration of the LDR implementation.

I3.3 All organisations have agreed that the NHS number will be the primary identifier. All Local Authorities have a process for capturing NHS number in their databases and are actively working towards acquiring the N3 Connection in order to connect to the Person Demographic Service (PDS) and the Demographic Service (DBS) to be able to update and validate NHS numbers.

I3.4 Significant advances have been made in terms of cross organisational information sharing however, to-date, these have been mainly technology led.

- Phase 1 of the Connected Care project enabled the sharing of (selected) primary care data from the 54 GP surgeries in Berkshire West with pilot users in Berkshire Health Foundation Trust and the Royal Berkshire Hospital. Phase 1 went live in December 2015.
- Phase 2 of the Connected Care project implemented a “proof of concept” integrated portal which extended the data provider organisations and the data consumers. In addition to the primary care information the pilot portal also included Admissions/Discharges/Transfers from the Royal Berkshire Hospital and community information from Berkshire Health Foundation Trust. The proof of concept ran for 6 months and was decommissioned in April 2016. Phase 2 also included the procurement process for the full interoperability solution.
- Multi Agency Safegaurding hub (MASH)- Inter-agency initiative between the Council, NHS and Police services, requiring secure communications and data transferred.
- Rapid Response & Treatment for Care Homes – Provide a consistent and coordinated health and social care multi-disciplinary team.
- Integrated Hub – single point of access for adult services which is also accessible by the public and professionals.
- Integrated Hub – single point of access for the Integrated Short Term team, which is also accessible by the public and professionals.
- Integrated short term team – The WISH team joins up the social care hospital liaison team, the START reablement team, the Council’s social care assessment team and BHFTs intermediate care team
- BW10 Workforce planning – Inter organisational workforce planning across health and social care to deliver more integrated and efficient services
- Neighbourhood clusters, self-care and prevention – integrating long term social care delivered by Optalis, community health services and third sector organisations.
- Joint Care Pathway/7 Day Working – Integrated hospital discharge service staffed by both health and social care to deliver prompt responses to referrals and avoid delays in discharge from hospital
- Patient Recovery Guide – To develop a dedicated personal support service to assist patients through the care pathway so patients do not remain in hospital longer than they should do.

Community Reablement Team – A domiciliary care service which works jointly with BHFT to provide short term support

Many of the organisations across Berkshire West are undergoing major system upgrades while at the same time facing severe budgetary constraints. These two factors are driving behaviours that are detrimental to the long terms success of the LDR, they are:

- Organisations are focussing on "run the business" functions as opposed to cross organisational initiatives.
- Technical staff with highly desirable integration skills are being asked to perform other roles or are being released, i.e. it is more difficult to get the people with the right technical skills.
- Front line clinicians and carers are less able to participate in design, configure and testing.

Berkshire West is looking at pragmatic solutions to these problems including shared resource pools across organisations, however It is essential that funding is made available to assist in this area.

I3.5 Berkshire West has successfully implemented a number of information sharing projects. The cross organisational relationships are in place and mature, there is clarity in terms of organisational interdependencies and there is a shared vision. There is a proven mechanism for managing information governance, all organisations are fully supportive and the LMC has endorsed our approach. In terms of deployment capability Berkshire West is well prepared to implement the Local Digital Roadmap.

I4 Change management & benefits management

I4.1 The Local Digital Roadmap identifies a number of capabilities that have been identified as enabling and assisting in the delivery of better care. The achievement of the aims set out at the beginning of this report is critically dependent upon changes to relationships, to workflows and to pathways, with appropriate clinical engagement, training and support.

Only by looking at people, process and technology will we be able to drive usage and utilisation across the capability areas.

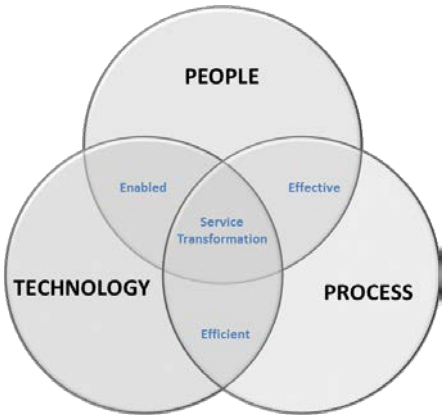


Figure [I5] Transformation Dependency Components

I4.2 "Technology will only succeed if it supports new ways of working. Interventions have failed where technology has simply been layered on top of existing structures and work patterns, creating additional workload for health care professionals", Delivering the Benefits of Digital Health Care, Nuffield Trust (Feb 2016)

I4.3 Hence achievement of the aims set out at the beginning of this report is critically dependent upon changes to relationships, to workflows and to pathways, with appropriate clinical engagement, training and support.

I4.4 Benefits management and the change management work that delivers the desired patient, staff and financial benefits are identified, planned, delivered and monitored on a system-wide basis and using a combination of input and output metrics and performance indicators. This integrated approach ensures that the change initiatives are consistent across the dimensions of people, process and technology and coordinated across all participating organisations, projects and programmes. The methodology to be employed in delivering and managing the benefits and transformational changes has evolved from pioneering work done in NHS IM&T in the early 1990s drawing on and enhanced by Managing Successful Programmes (MSP) and by work done with Cranfield University and the former NHS Institute for Innovation and Improvement.

I4.5 A key driver that has been proven to drive usage is the ability to access cross organisational information from within a clinician/care professional's source system, i.e. not having to log in to a 3rd party system. The Connected Care solution has a specific requirement to ensure that this functionality is enabled in 13 different source systems within the first 24 months of deployment.

I4.6 The Connected Care solution along with the other supporting technology solutions will monitor a number of standard measures and report these back to the West Berkshire Digital Roadmap Board, these include:

- Total number of active users.
- Active users split by profession, organisation, etc.
- Total number of records accessed.
- Trend analysis.

I4.7 In addition to use and utilisation, the Connected Care and supporting technology solutions will also be used to monitor progress against specific benefits realisation, for example:

- Reduction in length of stay.
- Reduction in admissions.
- Reduction in unnecessary and duplicate tests.

The Connected Care Full Business Case contained a detailed benefits realisation section and the final Key Performance Indicators will be part of the Board updates. Berkshire West has already had discussions with organisations outside the STP footprint to learn lessons and better prepare for this work.

During the initiation phase (June/July 2016) baseline measures will be made and the data required to perform the appropriate analysis will be determined. Results will be reported to the West Berkshire Digital Transformation Board.

I4.8 All organisations have arrangements in place to ensure that IM&T / digital developments are driven by, and aligned with organisational and service transformation priorities, and linked to change management and benefits management programmes. These include ensuring business cases clearly identify benefits and change management arrangements, that benefits are assigned to business owners, strong project and programme management for all developments, rigorous approval and gateway processes at key stages in the project/programme lifecycle, user involvement from concept to delivery and utilising qualified change management professionals to redesign processes and support implementation.

I4.9 Organisations provide a range of training opportunities for users focussed on the digital agenda, covering usage of systems and services, core PC skills (including ECDL or equivalent), Information Management, Security & Confidentiality. Training delivery methods include traditional courses and one-to-one training, floor walking, e-Learning portals and NHS England online training resources (including "medaiwikis" developed to cover main system functions and usage). Training & Development programmes are informed by Training Needs Analyses which are completed annually in organisations. As well as developing the skills of the existing workforce, organisations ensure that sufficient levels of IT competency are included in job descriptions and recruitment processes for new staff.

I4.10 Given that the analysis in sections D and E has identified workforce readiness and change management as critical to delivering the required outcomes, the approach to these issues across the whole footprint should be re-evaluated, and opportunities for collaboration considered, e.g. shared resource pools.

I4.11 Due consideration must also be given to the significant challenges around patient/citizen readiness and acceptance of the major changes that will affect how they communicate and interact with their healthcare and social services and start to take a greater role and responsibility in managing their own wellbeing with digitally enabled self-care.

I5 Resources

I5.1 The plans outlined in this LDR clearly will require substantial further financial investment. Each organisation has an IM&T capital programme, with supporting revenue streams. The CCGs manage capital and revenue funding for IT on behalf of general practices, and for certain whole-system initiatives. These resources are summarised in Appendix [I]. It is anticipated that the majority of core organisation-specific developments will be funded through these existing programmes.

I5.2 However, this LDR has identified several new priorities, and has brought forward the required investment timescale for some pre-existing priorities, leading to a likely substantial funding gap. For some of the priorities highlighted in Section H which will require substantial investment, Table [20] identifies likely capital and revenue funding requirements, along with known, anticipated and target sources of investment.

Table [I6][2]. Funding requirements and sources for key priorities

Berkshire West LDR finance schedule Organisation	2016/17 £(000)			2017/18 £(000)			2018/19 £(000)			Funding sources (see note)
	Capital	Revenue one-off	Revenue recurrent	Capital	Revenue one-off	Revenue recurrent	Capital	Revenue one-off	Revenue recurrent	
Berkshire Healthcare Foundation Trust[3]	569	14	562	0	0	562	0	0	562	Funded
Berkshire Healthcare Foundation Trust	248	0	178	519	281	208	2,025	185	335	Unfunded
CCGs (GPIT and other commissioner led projects)		1,000	1,150			1,150			1,150	Funded
CCGs (GPIT and other commissioner led projects)			600		2,500	1,000		1,500	1,000	Unfunded
Royal Berkshire Foundation Trust				3,200			3,200			Funded
Royal Berkshire Foundation Trust			500	3,000		800	3,000		800	Unfunded
SCAS Foundation Trust										Funded
SCAS Foundation Trust		**800**	**100**	**4000**	**12600**	**3050**	**4000**	**13800**	**3880**	Unfunded
Reading Council	815		304							Funded
Reading Council	800			1,000		100	1,400		250	Unfunded
West Berkshire Council	1,400		462							Funded
West Berkshire Council	700			1,500		250	1,300		400	Unfunded

[2] These figures are draft and will be ratified and signed off over the following 2 months

[3] BHFT – only initiatives that will deliver Paper Free at Point of Care

Wokingham Council	733	101	1,065							Funded
Wokingham Council	700			1,200		200	1,200		300	Unfunded
Total across footprint	**5,965**	**1,915**	**4,921**	**14,419**	**15,381**	**7,320**	**16,125**	**15,485**	**8,677**	

Note: Potential funding sources include - each organisation's budget, re-investment of benefits, GPIT / GPSoC funds, CCGs' whole system project funds, Estates Transformation & Technology Fund (ETTF), Better Care Fund, other national funds and Not Known.

I6 Equality and Diversity

I6.1 Promoting equality and equity are at the heart of our values – ensuring that we exercise fairness in all that we do and that no community or group is left behind in the improvements that will be made to health outcomes across the country.

We will continue to work internally, and in partnership with colleagues within the Department of Health and the wider NHS, to ensure that advancing equality and diversity is central to how we conduct our business as an organisation

I6.2 Public bodies were required to prepare and publish objectives by 6 April 2012 to meet the general equality duty as outlined in the Equality Act 2010. These objectives need to be specific and measurable and refreshed at least once every four years. The primary purpose of the objectives is to focus organisations on the outcomes to be achieved through advancing equality, rather than the written documents and processes to evidence legal compliance.

We have set ourselves four Equality Objectives for the period April 2014 to March 2016:

- We will oversee and support the implementation of the Equality Delivery System (EDS2), so that by 31 March 2016 there is a minimum of 95% implementation across all NHS Trusts, NHS Foundation Trusts, and Clinical Commissioning Groups across England.
- During 2014/15, we will help support CCGs to plan and commission for equality by embedding equality at the heart of key system levers identified by the Equality and Diversity Council, including the CCG assurance regime and the corporate governance statement.
- By March 2015, we will have developed an Accessible Information Standard to help disabled patients, service users and carers to receive accessible information and appropriate communication support when in contact with healthcare services, to be implemented by March 2016.
- NHS England is committed to implementing the Equality, Diversity and Inclusion in the Workplace Strategy 2013 to 2015, to ensure an engaged workforce that is more representative at all levels

The Equality Objectives set above will help to ensure that our policy-making, decisions and activities are compliant with the public sector Equality Duty, and will provide system leadership to Clinical Commissioning Groups and other parts of the NHS.

Appendices (in separate document)

Appendix A – Glossary

Appendix B - Summary of universal capability baseline and plans

Appendix C - Capability deployment trajectory – secondary care

Appendix D - Capability deployment

Appendix E - Information sharing approach

Appendix F - Use of mobile technologies

Appendix G – Use of national standards

Appendix H - Addressing risks associated with increasing dependence upon technology

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE AND HEALTH SERVICES

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**15 JULY 2016**	**AGENDA ITEM:**	**12**
TITLE:	**QUALITY ACCOUNTS: REVISED SCRUTINY ARRANGEMENTS**		
LEAD COUNCILLOR:	**CLLR HOSKIN**	**PORTFOLIO:**	**HEALTH**
SERVICE:	**ADULT SOCIAL CARE & HEALTH**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	**WENDY FABBRO**	**TEL:**	**0118 937 2072**
JOB TITLE:	**DIRECTOR OF ADULT CARE & HEALTH SERVICES**	**E-MAIL:**	**WENDY.FABBRO@READING.GOV.UK**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report updates the Health and Wellbeing (HWB) Board on plans for future scrutiny of Quality Accounts presented by healthcare providers, giving the HWB Board a clear overview and scrutiny lead in this area via a delegation from the Adult Care Children's Services and Education (ACE) Committee.

2. RECOMMENDED ACTION

2.1 HWB Board members agree membership of a Task and Finish Group to evaluate Quality Accounts against strategic intentions and JSNA priorities.

2.2 HWB Board requires the Task and Finish Group to present Quality Accounts received together with Group's response – prepared on behalf of the HWB Board – at the next available HWB Board after receipt of each Quality Account.

3. POLICY CONTEXT

3.1 A Quality Account is a report about the quality of services delivered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. They aim to give confidence that the relevant board is being open and honest about the quality of services being provided across the organisation and is committed to driving continuous quality improvement.

3.2 The quality of the services is measured in the Quality Account by looking at patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided.

3.3 Health and Wellbeing boards are intended to shape and drive the improvement of the local health and wellbeing system. A recent peer review of Reading's Health and Wellbeing Board noted a clear commitment, politically and from officers and clinicians, for the board to provide strategic leadership and to make a positive difference to improving the health and wellbeing of Reading`s people. However, the peer reviewers also observed that that the Board's role to date has been primarily to receive information about decisions made elsewhere in the Council and CCGs. Giving the Reading Health and Wellbeing Board a clear lead in receiving and responding to Quality Accounts will help to consolidate its leadership role in relation to local healthcare.

4. QUALITY ACCOUNTS

4.1 The Department of Health requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year. The requirement is set out in the Health Act 2009. Amendments were made in 2012, such as the inclusion of quality indicators according to the Health and Social Care Act 2012. NHS England or Clinical Commissioning Groups (CCGs) cannot make changes to the reporting requirements. Additionally Healthwatch should be provided with a copy to comment on prior to publication of the Quality Account, and Healthwatches have been asked to consider producing guidance that will enable them to provide an effective challenge to Quality Accounts locally.

4.2 Foundation trusts and NHS trusts are only required by regulation to share their Quality Account with NHS England or relevant clinical commissioning groups (as determined by the NHS Quality Accounts Amendment Regulations 2012), local Healthwatch organisations, and Overview and Scrutiny Committees (and have their reports audited). There is no regulatory requirement for foundation trusts or NHS trusts to share their Quality Account/Report with Health and Wellbeing Boards unless the Health and Wellbeing Board is fulfilling a scrutiny function; although it is hard to see any reason why this would not be sensible given the remit of the Health and Wellbeing Board to oversee alignment and potential integration of health and care services. For Reading Borough Council, the Constitution identifies the Adult Social Care, Children's Services & Education (ACE) Committee as the Health Scrutiny body, although in practice much of the reporting of developments is managed via the Health and Wellbeing Board.

4.3 No central guidance has been issued to Health and Wellbeing Boards setting expectations as to the comments they may make on Quality accounts. However, comments may be made on the following areas:

- the degree to which local communities have been engaged in priority setting
- other priority areas that could have been included in the Quality Account
- the approach the organisation has towards quality improvement overall

5 PROPOSALS FOR FUTURE HANDLING OF QUALITY ACCOUNTS

5.1 ACE Committee has been asked to delegate its health scrutiny function in relation to Quality Accounts to the HWB Board. Transferring responsibility for responding to Local Accounts to the Health and Wellbeing Board in this way will then enable the HWB Board to bring together from its membership representatives of all bodies required to comment on Quality Accounts. Quality Account responses can then be prepared collaboratively across the local authority, CCGs and Healthwatch. In the case of the CCGs as commissioners of the services concerned, they would continue to engage their Quality Committee in the HWB Quality Accounts Group in order to agree the form of response from the Partnership.

5.2 This transfer of responsibility will give the Reading HWB Board a clearer mandate to take on a leadership role in relation to health improvement locally. In future, all Quality Accounts received for local NHS healthcare providers will be received and responded to by the Reading HWB Board. The HWB Board ordinarily meets four times a year, however, and this may not be sufficiently frequent to facilitate discussion of each Quality Account response by the full Board. The HWB Board will therefore establish a Quality Account Task and Finish Group including representatives of:

- Director of Adult Care & Health Services
- Director of Children Education & Early Help Services
- Healthwatch Reading
- North and West Reading CCG
- South Reading CCG

and empower this Group to prepare and submit Quality Account responses on behalf of the HWB Board.

5.3 Members of the Task and Finish Group will be appointed by but need not be members of the HWB Board.

6. BACKGROUND PAPERS

6.1 ‘Quality Accounts’ report to Health and Wellbeing Board - March 2016

READING BOROUGH COUNCIL

REPORT BY MANAGING DIRECTOR

TO:	**HEALTH & WELLBEING BOARD**		
DATE:	**15th July 2016**	**AGENDA ITEM:**	**13**
TITLE:	**READING'S ARMED FORCES COMMUNITY COVENANT AND ACTION PLAN – MONITORING REPORT**		
LEAD COUNCILLOR:	**Cllr Lovelock**	**PORTFOLIO:**	**Leader of the Council**
SERVICE:	**Corporate Policy**	**WARDS:**	**All**
LEAD OFFICER:	**Jill Marston**	**TEL:**	**0118 937 2699**
JOB TITLE:	**Senior Policy Officer**	**E-MAIL:**	**jill.marston@reading.gov.uk**

1.0 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Community Covenant is a voluntary statement of mutual support between a civilian community and its local armed forces community.

1.2 Reading's Community Covenant was launched on 7th July 2012 at the Afghanistan Homecoming Parade at Brock Barracks.

1.3 This report presents a six monthly update on progress against the actions outlined in the action plan, and on the general development of the Community Covenant.

2.0 RECOMMENDED ACTION

2.1 To note the progress against the actions set out in the Armed Forces Community Covenant action plan.

2.2 To agree to future reporting on an annual basis, rather than six monthly.

3.0 POLICY CONTEXT

3.1 In 2011, the Government published a new Armed Forces Covenant, as a tri-Service document which expresses the enduring, general principles that should govern the relationship between the Nation, the Government and the Armed Forces community.

3.2 The Community Covenant complements the Armed Forces Covenant but enables service providers to go beyond the national commitments. It allows for measures to be put in place at a local level to support the Armed Forces and encourages local communities to develop a relationship with the Service community in their area.

4.0 THE PROPOSAL

Background

4.1 A Community Covenant is a voluntary statement of mutual support between a civilian community and its local armed forces community. It is intended to complement the Armed Forces Covenant, which outlines the moral obligation between the nation, the government and the armed forces, at the local level.

4.2 The aims of the Armed Forces Community Covenant are to:

- encourage local communities to support the armed forces community in their areas
- nurture public understanding and awareness amongst the public of issues affecting the armed forces community
- recognise and remember the sacrifices faced by the armed forces community
- encourage activities which help to integrate the armed forces community into local life
- to encourage the armed forces community to help and support the wider community, whether through participation in events and joint projects, or other forms of engagement

4.3 The Reading Armed Forces Community Covenant was launched at the Afghanistan Homecoming Parade at Brock Barracks on 7th July 2012.

4.4 In addition to the Council, the covenant has been signed by 7 Rifles on behalf of the Armed Forces, and a range of other key partners.

4.5 Reading doesn't have a large military 'footprint', with no regular forces stationed in the town. However, Brock Barracks is the headquarters for the Territorial Army unit 7th Battalion The Rifles, and Reading is home to a large ex-Gurkha community. Reading's Community Covenant therefore focuses on Veterans and Reservists and aims to be proportionate in its scope to the size of the Armed Forces community in Reading.

Further development of the Community Covenant and action plan

4.6 The Community Covenant working group with key stakeholders meets on a six monthly basis, the most recent held on 16th March 2016.

4.7 Progress to date against the actions in the action plan is shown in Appendix A. Several of the actions in action plan have now been completed. Successes to date include:

- Reading was awarded £21,730 from the Community Covenant grant scheme for an integration project for Veterans, aimed at raising awareness of health and social care services amongst the ex-Gurkha community in particular; health weeks have been delivered in August and December 2013 (both attended by at least 90 people), and February 2014 (attended by 60), including workshops and health checks.

- The Museum service was awarded £10,000 from the Community Covenant grant scheme to support their exhibition, 'Reading at War', to mark the centenary of the beginning of the First World War in 2014, along with a leaflet on Reading's military heritage and the commissioning of a poet to deliver workshops in primary schools.

- Reading Ex-British Gurkha Association was awarded £14,500 under the new Covenant Fund for two Nepalese community development workers.

- Armed Forces personnel can now be given extra priority when applying for social housing on the Housing Register, as part of the Council's Housing Allocations Scheme.

- A domestic violence protocol is in place between the Service and the Police, to recognise military needs and ensure equitable service.

- A leaflet on accessing health services has been translated into Nepalese and is being used by SSAFA to run classes.

- Reading Borough Council now has a protocol in place for employment of Reserve Forces personnel.

- 'Operation Reflect' activities to mark the centenary of the beginning of the First World War included 7 Rifles visits to 5 primary schools.

- Job Centre Plus staff now receive regular briefings from 7 Rifles.

<u>New Community Covenant fund</u>

4.8 A new Community Covenant fund has recently been launched, with £10 million available every year.

4.9 The following four priorities have been set for the financial years 2016/17 and 2017/18:

1. Veterans' Gateway
2. Families in Stress
3. Improving Local Covenant Delivery (clusters of LAs only)
4. Community Integration / Local Service Delivery

4.10 Under priority 4, the MOD will fund projects of up to £20,000 that respond to the local needs of the Armed Forces Community and improve recognition of the Armed Forces Covenant, and that:

- help integrate Armed Forces and civilian communities across the UK
- deliver valuable local services to the armed forces community.

4.11 There are two application rounds this year for priority 4, with deadline dates of 22 June and 2 November 2016. The next working group meeting in Sept 2016 will discuss any potential bids for November submission.

5.0 CONTRIBUTION TO STRATEGIC AIMS

5.1 The development of an Armed Forces Community Covenant for Reading contributes in particular to the Council's strategic aim to 'promote equality, social inclusion and a safe and healthy environment for all' by working to ensure that both serving and ex-Armed Forces personnel can access appropriate support and are able to integrate well into the community.

5.2 This work also relates particularly well to the Sustainable Community Strategy's 'people' theme where 'we look after each other' and the 'prosperity' theme by aiming to ensure that veterans and reservists are not excluded from the economy.

6.0 COMMUNITY ENGAGEMENT AND INFORMATION

6.1 Two of the key aims of the Armed Forces Community Covenant are to:

- encourage local communities to support the armed forces community in their areas
- encourage the armed forces community to help and support the wider community, whether through participation in events and joint projects, or other forms of engagement

7.0 EQUALITY IMPACT ASSESSMENT

7.1 The covenant is intended as a vehicle for partners across Reading to help enable Veterans or Reservists to access health services, particularly mental health services, training and employment opportunities.

8.0 LEGAL IMPLICATIONS

8.1 The general power of competence, introduced as part of the Localism Act 2011, replaces the well-being power from February 2012. The Act gives local authorities the power to do anything which an individual generally may do, which they consider is likely to be of benefit (directly or indirectly) to the whole or any part of their area. It therefore gives local authorities the power to do anything they want, so long as it is not prohibited by other legislation.

9.0 FINANCIAL IMPLICATIONS

9.1 £30m of central government funding was allocated over four years to 2014/15 to financially support Community Covenant projects at the local level which strengthen the ties or the mutual understanding between members of the armed forces community and the wider community in which they live. Reading has submitted bids in three bidding rounds. £10m per annum has now been made available in perpetuity from 2015/16 onwards through the new Armed Forces Covenant fund.

10.0 BACKGROUND PAPERS

10.1 Armed Forces Community Covenant guidance notes, July 2012, www.gov.uk/government/publications/community-covenant-pledge

10.11 Armed Forces Covenant Fund
www.gov.uk/government/collections/covenant-fund

READING ARMED FORCES COMMUNITY COVENANT
ACTION PLAN, JUNE 16

The Armed Forces Community Covenant's key objectives:
Recognise, Remember, Integrate and Support

Armed Forces community comprises serving personnel (regular and reserves) and their dependants; and veterans and their dependants.

HQ 11 Infantry Brigade Workstrands:

- Health and Wellbeing
- Economy and Skills
- Education, Children and Young People
- Environment and Infrastructure
- Safer & Stronger Communities

Ref	Outcome	Responsibility	Timescale	Progress/ key actions
HEALTH AND WELLBEING - *To ensure that the wellbeing of the Armed Forces community is not undermined by the nature of service life*				
Recognise: *Map and identify veterans status and represent special requirements of Armed Forces community in order to allow NHS to meet needs*				
1	Feedback and input to Health and Wellbeing Board	ROSO 7 Rifles	ongoing	ROSO 7 Rifles attended meeting in Oct 2015; Regimental Medical Officer to attend future meeting
3	Devise protocol for GPs to register Veteran status	Clinical Commissioning Groups	ongoing	GPs currently being encouraged to record status and a number of measures have been designed by the CCGs, and introduced in the run-up to Armed Forces Day in June 2016: • CCGs have developed guidance for practices on registering patients from the armed forces community • A new armed forces page of the CCGs' websites sets out why

Ref	Outcome	Responsibility	Timescale	Progress/ key actions
				Veterans should register themselves as such with their GP • A simple form is available on websites that veterans can take to their practice to ensure they are recorded as a Veteran • Veterans will also be encouraged to register via the information screens in practice waiting rooms
4	Raise awareness of and signpost to Veteran's mental health service for the South Central region	Covenant partnership/ Armed Forces charities/other partners	ongoing	• JCP, SSAFA, RBL promote the service • SSAFA and RBL working with South Central Veterans mental Health Service within current casework • Veterans Mental Health Service to attend next 7 Rifles 'health fair' • CCGs have been raising awareness at council of practice meetings, on CCG websites, and on social media.
5	Development of a leaflet on accessing health services to be translated into Nepalese	Clinical Commissioning Groups/SSAFA/RBC	Spring 2014	**ACHIEVED** SSAFA running classes using leaflet
6	Develop and promote a discount scheme for serving personnel (both full time and reservists) for arts and leisure facilities in Reading	RBC/ ROSO 7 Rifles	Promotion summer 2013	**ACHIEVED** • Scheme developed and in place for leisure centres • Delivery via the Defence Discount Scheme being considered for leisure centres • Use of 'tickets for troops' by Hexagon
7	Consolidation of appropriate contact/ support lists in order to provide better signposting	ROSO 7 Rifles/ RBC	2014	**ACHIEVED** Reading Borough Council website includes key support contacts at: http://www.reading.gov.uk/article/7300/Reading-Armed-Forces-Community-Covenant

Ref	Outcome	Responsibility	Timescale	Progress/ key actions
ECONOMY AND SKILLS - *Enhance the economic prosperity of Service personnel (including reservists), their families, and Veterans whilst benefitting the local economy wherever possible*				
Integrate: *Ensure Armed Forces benefit from ongoing economic development in county*				
Support: *Facilitate a sustainable pathway for Service leavers into civilian employment*				
8	Keep local authorities and business updated on re-structuring of Defence	ROSO 7 Rifles	ongoing half yearly	• Briefing provided at March 2016 working group meeting; 7 Rifles actively recruiting
9	Work with local businesses to encourage employment of Service leavers and Reservists	Reading UK CIC/ Jobcentre Plus/	ongoing	• Tesco Distribution and Veolia Environmental Services are keen to employ ex-forces personnel; Tesco have recently launched the Armed Forces Network • JCP promoting Veterans Interview Programme to employers; promoting relevant employer events; circulating requests from employers for Service leavers • Reading UK CIC collaborating with other local authorities on business lunch at Sandhurst in Feb 2015 • MOD employer engagement strategy to promote to employers the value of employing Reservists • 7 Rifles work with Gravity Personnel to promote the benefits of recruiting Reservists • UK CIC and Business Improvement District newsletters have promoted benefits of employing Reservists • 7 Rifles to attend First Friday Club on 1st July • Contact made with Oracle shopping centre and recruitment presence planned for 2016 • 7 Rifles briefed JCP staff in March and planned again for June 2016
10	Encourage Jobcentre Plus to register Veterans	Jobcentre Plus	ongoing	Jobcentre Plus systems allow recording of Veteran status, though for JSA claimants only, but advisors are finding that interview times are

Ref	Outcome	Responsibility	Timescale	Progress/ key actions
				becoming shorter with less opportunity to ask additional questions, therefore monitoring is incomplete 7 Rifles briefed JCP staff in March and planned again for June 2016
11	Promote the Armed Forces (Regular and Reserve) as a career for the residents of Reading, particularly young people Not in Education, Training or Employment	Reading UK CIC/ 7 Rifles/ Jobcentre Plus	ongoing	• Almost daily recruiting activities in Oxon, Bucks and Berks in support of Operation Fortify recruiting initiative • JCP advisors kept up to date with Armed Forces vacancies, and promote Army Reserve generally • MOD employer engagement strategy • Armed Forces exhibited at successful job fair in Broad St Mall in June 2015 • Annual Reading jobs fair in Hexagon • 7 Rifles briefed JCP staff in March and planned again for June 2016
12	Support Service leavers, former Armed Forces personnel and reservists to access careers guidance, CV support and interview preparation courses	Jobcentre Plus / New Directions/ other partners	ongoing	• Reading University involved in Troops to Teachers programme to train ex-forces personnel as teachers once they leave the Services • SERFCA have set up jobs4reservists website, promoted via Reading UK CIC e-news • New Directions offer employability course in partnership with JCP, covering employability and essential IT skills -for Universal Jobmatch/ CV creation • Royal British Legion's CivvyStreet (online resettlement, learning and work service at https://www.civvystreet.org) • National Careers Service promoted via RBC Armed Forces Covenant web page
13	Defence discount service/ card	Reading UK CIC	2014/15	Article in Sept 15 Business Improvement District newsletter to raise awareness amongst businesses
14	Promotion of relevant events to businesses/ employers	Reading UK CIC/ROSO 7 Rifles/Jobcentre Plus	ongoing	• JCP and Reading UK CIC general promotion of relevant events e.g. Sandhurst business lunch in Feb 2015 • Pop up 2 week 'start your own business' school, Feb 2016 and ongoing (Reading UK CIC)

Ref	Outcome	Responsibility	Timescale	Progress/ key actions
15a	Development of Reading Borough Council protocol for employment of Reserve Forces personnel	RBC	March 2014	**ACHIEVED** Agreed at Personnel Committee March 2014
15b	Promotion of Corporate Covenant scheme	RBC/ Reading UK CIC/ Covenant partnership	ongoing	Article in Feb 2015 edition of Reading UK CIC e-News
EDUCATION, CHILDREN AND YOUNG PEOPLE - *Develop a comprehensive understanding of the needs of Service children; remove and negate disadvantage which results from the mobility of Service life. Develop youth opportunities across the community, supporting the Cadet Forces.*				
Integrate: *Promote an understanding of the needs of Service children so that they are not disadvantaged in the state education system*				
Support: *Enable optimal educational opportunity for Service children within the context of the state education system*				
16	Survey schools to determine numbers of Service family pupils and ensure schools maximise the value of the Service Pupil Premium by encouraging registration and promoting best practice in utilisation of	RBC/ Schools in Reading Borough area/ 7 Rifles	annual survey (next due Jan 15)	• Latest figures (Jan 16) - 12 service children in Reading schools • Reminder to encourage parents to inform school of Armed Forces status sent to schools in first term of academic year 15-16 • 7 Rifles promotion

Ref	Outcome	Responsibility	Timescale	Progress/ key actions
	funding			
17	Being sensitive and supportive to the possible emotional and psychological needs of some Service children	RBC/ Schools in Reading Borough area/ 7 Rifles	ongoing	• Reminder to encourage parents to inform school of Armed Forces status sent to schools in first term of academic year 15-16
ENVIRONMENT AND INFRASTRUCTURE - *Ensure that the wider Armed Forces' infrastructure requirements (inc Housing) are met in synchronisation with the Defence Infrastructure Organisation (DIO) and cognisant of the requirements of the local community. Where possible, create efficiencies with the local community*				
Support: *Develop a common understanding of infrastructure needs of the Armed Forces community, in order to inform Local Authority planners to optimise provision. This incorporates a common, equitable housing protocol for Veterans within the local area.*				
18	Develop and implement a plan for the identification of Veterans locating to the Reading area in order to ensure that they are informed and included in relevant initiatives	ROSO 7 Rifles / RBC/ charities	ongoing	● Some Veterans claiming JSA can now be identified and support offered ● Support, initiatives and opportunities disseminated via charities' existing mechanisms (SSAFA, RBL, Reading Ex-British Gurkha Association, Forgotten British Gurkhas)
19	Ensure Veterans receive equitable treatment in allocation of social	RBC	ongoing	**ACHIEVED** Incorporated into Reading Borough Council's Housing Allocations Scheme

Ref	Outcome	Responsibility	Timescale	Progress/ key actions
	housing			
20	Explore options for facility sharing in line with local needs and Defense Infrastructure Organisation plans	PSAO HQ Coy 7 Rifles/ RBC	ongoing	• Greater use of Brock Barracks for community purposes agreed and promoted via alternativevenues.org • Promoted to community groups via Reading Voluntary Action newsletter and Reading Borough Council website
SAFER AND STRONGER COMMUNITIES - *Develop a stable and robust Armed Forces community which integrates into the wider society, whilst retaining a sense of itself*				
Integrate: *Promote common understanding and closer integration between military and civil communities*				
21	Ensure that appropriate links are in place between the Local Authority and Armed Forces in order to allow the effective activation of Military Aid to the Civil Community (MACC) in the event of a civil emergency (e.g. severe weather event) and/ or community projects where manpower is required	RBC/ TM or TM(V) 7 Rifles	ongoing	Civil emergency liaison in place; Armed Forces assistance during flooding events in 2014
Support: *Support civil agencies in their dealings with members of the Armed Forces community, in order to optimise outcomes and use resource more efficiently*				
22	Establish and implement domestic violence protocol between Service and Civil Police, agencies and charities to recognise	ROSO 7 Rifles	ROSO to advise	**ACHIEVED** Protocol in place

Ref	Outcome	Responsibility	Timescale	Progress/ key actions
	military needs and ensure equitable service			
23	Identify key areas for application of Community Covenant grant funding which will benefit both the civil and Armed Forces communities	RBC/Covenant partnership/ ROSO 7 Rifles	Ongoing	• Grant fund promoted on RBC website and via Reading Voluntary Action ● Successful bid for £21,730 for 'health weeks' project aimed at raising awareness of health and social care services amongst the ex-Gurkha community, December 2012 • Successful bid for £10,000 for museum centenary project, December 2013 ● Meeting with ex-Gurhka groups and organisations working with the Nepali community to discuss issues and needs in Feb 15 ● New Covenant grant fund launched Aug 2015 ● Successful bid from REBGA for two Nepalese community development workers (£14,500)
24	Encourage organisations and communities to sign up to the Armed Forces Community Covenant	RBC/ Covenant partnership/ ROSO 7 Rifles	Ongoing	Latest signatories include Thames Valley Chamber of Commerce, Reading College and University of Reading
RECOGNISE AND REMEMBER - *Encourage recognition and remembrance of the unique sacrifices made by Armed Forces personnel in defence of society*				
Recognise*: Support civil events that allow the community to recognise the Armed Forces*				
25	Support the annual Armed Forces Day	PSOA HQ Coy 7 Rifles/RBC	Annual (June)	• Freedom of Reading March May 8th 2016 • Armed Forces Day planned for 22nd June 2016 in Broad St and Forbury Gardens, including concert from Waterloo Band
26	Armed forces participation in public events as appropriate	RBC/ PSAO HQ Coy 7 Rifles (PSOA HQ Coy)	ongoing	Numerous recruiting and other community events throughout the year including: • 01 May – Tilehurst Festival

Ref	Outcome	Responsibility	Timescale	Progress/ key actions
				• 08 May – Freedom of Reading parade and recruiting stand in Broad St • 10 June – Tescos Queens birthday tea party (7 Rifles providing tables and chairs) • 22 June - Reserves Day • 2 June – 2 July - Reserve Officers Campaign Week • 28 June – Open evening at Brock Barracks
Remember: *Commemorate those members of the Armed Forces who have made the ultimate sacrifice*				
27	Plan and conduct remembrance event at Brock Barracks as focal point for annual armistice event in Reading	PSAO HQ Coy 7 Rifles	ongoing	Event planned for Nov 2016 in Forbury Gardens
28	Plan and conduct appropriate event(s) in support of the centenary anniversary of the outbreak of the First World War	RBC/ Adjt 7 Rifles/ communities	Aug 2014	● Successful bid submitted to Community Covenant Grant Fund by Museum service for funding to support their forthcoming exhibition,' Reading at War', to mark the centenary of the beginning of the First World War ● As part of this work, a poet was commissioned to work with 7 Rifles ● Royal British Legion commemoration services on 6th July and 4th Aug 2014 at Reading Minster ● Operation Reflect activities including 7 Rifles visits to 5 primary schools ● Commemorative paving slabs for home towns of Victoria Cross winners, placed with Trooper Potts VC Memorial ● Trooper Potts VC Memorial unveiled in October 2015 outside the Crown Courts in Reading

List of abbreviations

SSAFA – Soldiers, Sailors and Airmen Families Association
SERFCA – South East Reserve Forces and Cadets Association
ROSO – Regimental Operations Support Officer

RBC – Reading borough Council
NHS – National Health Service
GPs – General practitioners
JCP – Jobcentre Plus
CCGs – Clinical Commissioning Groups
MOD – Ministry of Defence
JSA – Job Seekers Allowance
TBC – to be confirmed
AF – Armed Forces
BID – Business Improvement District
PSAO HQ Coy – Permanent Staff Admin Office HQ Company
TM or TM(V) – Training Major
CCRF- Civil Contingency Reaction Force
CIMIC – Civil Military Corporation
Adjt - Adjutant