READING HEALTH & WELLBEING BOARD MINUTES – 14 JULY 2017

Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Reading Borough Council (RBC)
Councillor Eden	Lead Councillor for Adult Social Care, RBC
Councillor Gavin	Lead Councillor for Children's Services & Families, RBC
Councillor Lovelock	Leader of the Council, RBC
David Shepherd	Chair, Healthwatch Reading

Also in attendance:

Corinne Dishington	Children's Centres Team Manager, RBC
Jo Hawthorne	Head of Wellbeing, Commissioning & Improvement, RBC
Jill Marston	Senior Policy Officer, RBC
Tony Marvell	Integration Programme Manager, RBC/CCGs
Maureen McCartney	Operations Director, North & West Reading CCG(CCG)
Lyndon Mead	Accountable Care System Programme Manager, Berkshire West CCGs
Melissa Montague	Public Health Programme Officer, RBC
Janette Searle	Preventative Services Manager, RBC
Mandeep Sira	Chief Executive, Healthwatch Reading
Nicky Simpson	Committee Services, RBC
Kim Wilkins	Public Health Programme Manager, RBC

Apologies:

Andy Ciecierski	Chair, North & West Reading CCG
Ann Donkin	Sustainability and Transformation Plan Programme Director, Oxfordshire CCG
Eleanor Mitchell	Operations Director, South Reading CCG
Sarita Rakhra	Commissioning Manager, Berkshire West CCGs
Elaine Redding	Interim Consultant, Safeguarding & Improvement, RBC
Councillor Stanford-Beale	RBC
Bu Thava	Chair, South Reading Clinical Commissioning Group
Graham Wilkin	Interim Director of Adult Care & Health Services, RBC
Cathy Winfield	Chief Officer, Berkshire West CCGs
Judith Wright	Strategic Director of Public Health for Berkshire

1. MINUTES

The Minutes of the meeting held on 24 March 2017 were confirmed as a correct record and signed by the Chair.

2. QUESTION IN ACCORDANCE WITH STANDING ORDER 36

The following question had been submitted by Tony Cowling in accordance with Standing Order 36. In his absence, a written reply was provided.

Men Dying Young in Reading

Why do men in Reading die younger than in any other town or city in the UK? (What is different about Reading?) I would like to see some effort being put in to sorting out why this is and some actions to mitigate the cause(s).

REPLY by the Chair of the Health & Wellbeing Board (Councillor Hoskin):

On average, men in Reading are expected to enjoy good health to the age of 66.4 years (CI 64.7-68.1). This is significantly better than the England average of 63.4 years and better than most similar Local Authority areas. Healthy life expectancy in Reading has remained consistently above the England average for the last five years.

The Slope Inequality Index in healthy life expectancy suggests a man living in the most well off areas of Reading could expect to live 12.8 years longer than a man in one of Reading's most deprived neighbourhoods (CI 9.4-16.2). The gap is 13.5 for women (CI 14.7-18.5). This is less than the gap seen between the most and least deprived local authority areas nationally (18.9 years for men and 19.6 years for women).

You are correct that premature mortality is an issue in Reading particularly amongst men.

Men in Reading have a life expectancy at birth of 78.7 years (Confidence interval 78.1-79.3) and those aged 65 can be expected to live for another 18.3 years on average (Confidence Interval 17.9-18.1). These are both significantly worse than the England average of 79.5 years at birth and 18.7 years at age 65, although not the worst in the UK (men in Blackpool have the lowest life expectancy at birth in England of 74.3 (CI 73.7-74.9) and men in Manchester aged 65 can be expected to live for another 15.8 years on average (CI 15.6-16.1).).

The mortality rate from preventable causes for males in Reading is 252.8 per 100,000 (CI 228.1-279.5), higher than the England average of 232.5 per 100,000 although not significantly so, but, again, not the worst in England (again, Manchester and Blackpool have the highest rates at 409.4 and 387.1 per 100,000 respectively).

The rates of premature mortality linked to cardiovascular disease and liver disease in men in Reading have consistently exceeded the national averages, although in some periods the differences have not been statistically significant. In the most recent period the number of men committing suicide in Reading has increased (rising from 33 in 2012-14 to 38 in 2013-15).

There is strong evidence that those living in more deprived areas are more likely to die prematurely and more likely to be affected by disability. Prevention interventions, especially those focusing on increasing physical activity and improving diet and weight management, reducing smoking and alcohol use are likely to be effective in addressing many of the common causes of disability and premature death.

Our latest Health and Wellbeing Strategy sets out how, over the next three years we aim to tackle some of the above issues, and how we aim to promote healthy lifestyles in a variety of settings so that every Reading resident has a chance to maximise their health and quality of life. We will focus on actions that:

- Deliver the priorities identified within the Healthy Weight Strategy (which sets out opportunities for children and adults to achieve and maintain a healthy weight by supporting them to make healthy dietary choices and choose an active lifestyle)
- Increase awareness of lifestyle and weight management services
- Promote walking and cycling both for leisure and active travel
- Prevent the uptake of smoking – by working with local stop services and promote smoke-free communities to support people to quit and remain smoke free in the long term.

3. BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST (BOB) NHS SUSTAINABILITY AND TRANSFORMATION PLAN (STP) - UPDATE

Maureen McCartney submitted a copy of a presentation by the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (BOB STP) Programme Director giving an update on the NHS BOB STP, similar to one which had been submitted to the Adult Social Care, Children's Services and Education Committee on 6 June 2017. The presentation covered the STP's background, footprint, finances, priorities, programme management, progress to date and next steps.

The presentation explained that the BOB five year STP set out the challenges and opportunities that the NHS and care services across the area faced. It showed how the NHS would work together to improve health and wellbeing within the funds available. The BOB STP was one of 44 STPs in England. The BOB STP area included six NHS Trusts, seven CCGs and 14 local authorities. Although the STP covered a large area the emphasis of the majority of proposals was on what could be achieved locally. However, the BOB STP was one of the largest 'non metropolitan' footprints in England.

The BOB STP approach was to develop STP plans in local systems where it made sense with key partners, and Maureen McCartney noted that the vast majority of work in Berkshire West would continue to be done at Berkshire West- or Reading-specific levels, but there would be a BOB-wide focus to include the following:

- Shift the focus of care from treatment to prevention;
- Access to the highest quality primary, community and urgent care;
- Collaboration of the three acute trusts to deliver quality and efficiency;
- Maximise value and patient outcomes from specialised commissioning;
- Mental Health development to improve the overall value of care provided;
- Establish a flexible and collaborative approach to workforce;
- Digital interoperability to improve information flow and efficiency.

Recent action and next steps included the following:

- In March 2017 NHS England and NHS Improvement had published a national Five Year Forward View delivery plan;
- The first quarter 2017 STP delivery plan was in development and incorporated the 2017/18 and 2018/19 CCGs and Trust two year operational plans;
- Formal consultations on significant variations in the range and location of services had commenced/continued, eg The Oxfordshire Transformation Programme;

- From April 2017 onwards implementation of the NHS Five Year Forward View had continued;
- In June 2017, an executive search process had been undertaken to appoint an STP lead via a competitive recruitment process with formal appointment anticipated in late summer;
- On 15 June 2017 both Buckinghamshire and Berkshire West had been confirmed by NHS England as first wave Accountable Care Systems.

David Shepherd and Mandeep Sira referred to the Stakeholder Engagement processes, noting that the STP was very Oxford-centric, and that the Healthwatches were set up with local rather than regional remits and had limited resources, so if for example Oxfordshire Healthwatch was on a forum or received communications about BOB STP matters, it was not necessarily possible for this work or information to be shared across other BOB Healthwatches.

Councillors Eden and Hoskin noted the £500m funding gap for health services by 2020/21 under the 'do nothing' scenario that was referred to in the presentation and expressed concern that until details of the cuts therefore required were known, health and social care partners could not plan for and mitigate against the effects of those cuts and there was uncertainty for both residents and organisations. They noted that the Adult Social Care, Children's Services and Education Committee was looking to be involved in scrutinising the plans once they were available, that it was important for there to be appropriate governance and accountability to local people, and that the Council would want to be involved in public consultation on the proposals as soon as possible. Lyndon Mead noted that the Berkshire West Accountable Care System would be looking at its share of the potential deficit and how this could be closed at a meeting in the following week.

Resolved - That the presentation be noted.

4. BERKSHIRE WEST ACCOUNTABLE CARE SYSTEM

Lyndon Mead submitted a presentation giving an update on the development of the Berkshire West Accountable Care System (ACS).

The presentation gave the history to partnership working in the health and social care system and explained that Local Authorities (LAs) had identified the opportunity to develop a joint commissioning function. Health partners had identified the opportunity to explore new models of delivery based on a single budget for the whole health system, with the ultimate aim to have a single programme for the whole health and care system delivering new care models and new business models - an Accountable Care System. The reporting mechanism for the ACS and LA joint commissioning programme would be via the Berkshire West 10 governance and through to Health and Wellbeing Boards.

In 2016, local NHS partners (the four Berkshire West CCGs and the two local NHS providers, Royal Berkshire NHS Foundation Trust (RBFT)and Berkshire Healthcare NHS Foundation Trust) had applied to NHS England for a system control total and in June 2017, the Berkshire West ACS had been selected as one of only eight systems nationally to operate as an ACS in shadow form for 2017/18, awarded 'exemplar' status.

The presentation explained why an ACS was needed, due to financial and demand challenges, different parts of the health system currently being funded differently and the commissioner/provider split creating unhelpful consequences for joint planning of patient care and managing the "Berkshire West Pound".

An ACS would provide a more collaborative approach to the planning and delivery of services with collective responsibility for resources and population health, operating on a single budget for the whole health care system, with funds following the patient to support pathway and service redesign. It would be underpinned by a system financial model, managing risk and aligning incentives, with organisations working more closely in partnership, with system-wide governance arrangements. This should provide joined-up, better-coordinated services with more control and freedom over the total operations of the health and social care system in the area.

The ACS would involve new ways of working, including: shared, non-statutory governance; joint clinical improvement projects; a system control total for financial management; a cost-recovery model rather than volume; a stronger voice for primary care, and would enable further social care integration. The ACS would fit within the well-established health and social care Berkshire West 10 integration programme which oversaw joint investments and improved system working, the ACS members were part of the BOB STP and they would also continue to work with partner organisations at the Thames Valley level to plan for and deliver services effectively at larger scales.

The presentation gave details of progress to date, stating that new governance arrangements had been established in June 2016 and for 2017/18 a marginal rate with RBFT had been introduced to share risk. A stocktake had been undertaken, as part of the Five Year Forward View, of Accident & Emergency, Mental Health, Cancer and Primary Care services, and the ACS Transformation Programme had commenced, setting up new care models and new business models. The work of the ACS overlapped with the joint Berkshire West 10 programme and the two together formed a health and social care transformation continuum.

The High Intensity Users Project was given as an example of a new care model, looking at how better to manage the healthcare needs of patients who used systems a lot. Representatives from the hospital, GPs, mental health services and the police were looking at how to de-medicalise the issues, for example by looking at coaching for the patients involved.

The next steps for the ACS would be to agree a performance contract with NHS England, get transformational funding for the ACS and start managing to a system pound control total, with collective decision-making and governance. The ACS would work with emerging primary care providers, and in year two it was planned to start to bring the Berkshire West 10 and the ACS together. Nick Carter, Chair of the Berkshire West 10 Integration Board, was joining the ACS Leadership Group to provide a link between the two programmes. Lyndon reported that the template for the performance contract was being signed off nationally in the current week, but targets and funding were not yet known.

The presentation listed the areas in which the ACS would have implications for the way things worked, including: partnerships within the ACS and horizontal networks with other health providers; a new approach to the independent sector; an integrated health and local government system-wide strategy for clinical, digital, estates and

workforce; combined teams/shared leadership, being agnostic about "who" and "where"; a single-system view of performance and quality; fundamental changes in the commissioner/provider relationship; and collective, clinically-led decision making on optimal care models/pathways and allocation of the Berkshire West Pound.

By moving to an ACS model it was planned to: work more collaboratively to transform services such as Outpatients; cover the challenge of lower real-terms allocations; ensure each organisation had a stake in the system financial position rather than each constituent standing alone; better position the local NHS for wider integration opportunities with local government; provide Primary Care with a greater platform in the design and evolution of service models; and flow resource to the parts of the system where it was needed, such as primary and social care.

During the discussion on the ACS, the points made included:

- The people of Berkshire had not yet been told the details of the system. There were patient representatives on joint working groups, but patient involvement was also needed at higher levels. The ACS was at an early stage of development and it was acknowledged that it would be important to engage with patients and the voluntary sector, so that it was communicated clearly what the new system would mean for them.

- Concern was expressed that a lower control total was going to mean cuts and also about how open and transparent the details of the financial control total would be. There had been limited public engagement so far, and it would be important to not just look at clinical governance, but to engage people in designing services. The local authority could assist through its existing systems and local knowledge , for example in reaching people for consultation, such as getting in touch with parents through libraries.

- It was clarified that, whilst there had been discussions about the future of health and social care, Reading social care had not yet joined the ACS, further discussions were needed about local democratic accountability, and it would be important for there to be a Reading Borough Council representative at the ACS meetings to help with communication and get genuine partnership working.

- It was agreed that it was an appropriate time to expand the ACS Leadership Group membership to include local authority representatives and that this would be raised at the Group's next meeting.

- It was suggested that it was unhelpful to describe people as patients and there should be a change in focus in health to seeing residents as people rather than just patients, and to make links with the wider community, the voluntary sector and public health.

- Opportunities for public involvement and co-production would best be achieved by working together but it was noted that there had been limited opportunities for feedback so far.

Resolved -

(1) That the progress by local NHS organisations towards the establishment of an Accountable Care System be noted;

(2) That it be noted that, whilst Reading Borough Council had yet to take a decision on whether, and in what way, it might become involved in the ACS, it was committed to exploring further opportunities for integrated services with Health where this would be to the benefit of Reading residents.

5. MEETING THE NEEDS OF VULNERABLE PEOPLE IN READING: JOINT LOCAL AUTHORITY/CCG RESPONSE TO FINDINGS OF HEALTHWATCH READING

Janette Searle submitted a report setting out the joint response of Reading Borough Council (RBC), and North and West Reading Clinical Commissioning Group and South Reading Clinical Commissioning Group ('the Reading CCGs') to the report presented by Healthwatch Reading to the 24 March 2017 meeting of the Reading Health and Wellbeing Board on 'Meeting the needs of vulnerable people in Reading' (Minute 8 refers).

The report explained that the Healthwatch report had summarised the observations of 13 local voluntary sector organisations on delivering services to vulnerable adults in the current economic climate and had invited the statutory commissioner members of the Health and Wellbeing Board to consider, amongst other things, how more effective joint working could help to address some of the issues raised in the report.

The report listed the eight findings of the Healthwatch report and set out the joint responses to the findings from RBC and Reading CCGs. It noted that Reading needed a sustainable and thriving third sector to help meet the challenges ahead, that the sector was operating under pressure currently, and that the Healthwatch report had highlighted the reasons for needing to work together across statutory and third sector services to pool resources for residents' benefit.

Resolved -

That the joint response be noted and Healthwatch Reading be asked to share it with those organisations which had contributed to the 'Meeting the needs of vulnerable people in Reading' report presented to the Board on 24 March 2017.

6. HEALTHWATCH REPORT: HOW HOMELESS PEOPLE IN READING EXPERIENCE HEALTH CARE SERVICES

David Shepherd and Mandeep Sira submitted a report presenting the findings of a project carried out by Healthwatch Reading collecting information on how homeless people in Reading experienced Health Care Services.

The report explained that members of the public had told Healthwatch that they were concerned about an apparent rise in the number of homeless people in Reading. Healthwatch was committed to ensuring that 'unheard groups' got the chance to describe their experiences of local health and social care services in the same way as other citizens and so it had run an engagement project with homeless people.

Healthwatch had also wanted to collect experiences that could complement the findings of a Reading health audit of homeless people, led by Reading Borough Council

and carried out in January-March 2017 (the findings from which were yet to be published), and so it ran focus groups in parallel to the audit, to elicit more personal stories and experiences to complement the audit findings.

The project involved Healthwatch meeting and collecting experiences of 19 people in three focus groups, each lasting one hour, at community locations used by those clients. A £10 Tesco voucher had been offered to people for their time and involvement (an engagement method used in past projects). Participants had given their consent for Healthwatch to take photos and share their stories.

The main findings from the project were:

- Access to dental care was the most common and significant problem and evidence was heard of people removing their own teeth.

- Access to timely appointments with a known GP was difficult (which echoed concerns of the general population from Healthwatch's 2016 primary care project). People could also run out of phone credit while on hold to surgeries. People appreciated reception staff (such as those at the Reading NHS Walk-In Centre) who showed them respect regardless of their circumstances.

- Administration problems (such as last-minute outpatient appointment cancellations) were an issue for people using hospitals. Again, this was a problem also reported to Healthwatch previously by the general population. People also described issues with hospital discharge, and some felt they were denied painkillers due to assumptions about being 'addicts'.

- Sporadic Internet access meant some people could not access up-to-date information or might miss the benefits of online services.

The report urged NHS and social care commissioners to use the findings, together with results of the RBC health audit (due out later in 2017), to inform how they would address care gaps, and consider innovations such as mobile dentistry services.

Maureen McCartney said that the CCGs welcomed the report and would respond to the issues raised regarding the services they commissioned. She reported that she had spoken to the Practice Manager at the Western Elms Surgery, which had a protocol for registration which could be shared as good practice with other GP surgeries and the CCGs would facilitate appropriate discussions.

Jo Hawthorne noted that poor dental health was a problem for people in poverty generally as well as those who were homeless and that Public Health was coming to the end of a two year survey of child oral health it had commissioned, which she expected also to show poor oral health linked to deprivation. NHS England commissioned dental services, rather than RBC or the CCGs, so this issue needed looking at in more detail to see how change could be effected, using information from the Healthwatch report, the child oral health survey and the CCGs.

Resolved -

(1) That the report be noted and commissioners use the findings and recommendations to inform how care gaps could be addressed;

(2) That Jo Hawthorne investigate further the issues of dental care in Reading, including those issues raised in the report, once the results of the child oral health survey were known.

7. HEALTHWATCH READING ANNUAL REPORT 2016/17

David Shepherd and Mandeep Sira submitted the 2016/17 Annual Report for Healthwatch Reading, which gave details of the work carried out by Healthwatch Reading in 2016/17.

The report outlined the mission of Healthwatch Reading and gave details of Healthwatch Reading's priorities in 2016/17, which had focused on:

1. Empowering people to share feedback, complain or have their voice heard, by working with individuals, the local voluntary and community sector, and statutory partners. In 2016-17 Healthwatch Reading had engaged with more than 1,600 local people through a range of projects, including a week-long exercise in the emergency department of Royal Berkshire Hospital, a survey in pharmacies and GP practices, on people's experiences of electronic prescribing, and ongoing evidence-gathering from some of the 17,000 patients affected by underperformance at two local GP surgeries.

2. Ensuring everyone had an equal voice by working with the diverse community of Reading to understand how they experienced local services. This included understanding the needs of people with learning disabilities, mental health needs or in old age, refugees and those in poverty, by convening a roundtable of local charities who provided frontline support to the most vulnerable people in society. Healthwatch Reading had also developed relationships with BME organisations such as Jeena.

3. People being involved in shaping services for today and the future. Healthwatch Reading had brought a public perspective as new services were developed, through involvement in a local End of Life Care steering group, and also campaigned for better communication about transformation of services, through its seats on the Berkshire West Primary Care Commissioning Committee, Berkshire West A&E Delivery Board, and Reading Integration Board.

The report also gave details of how experiences were gathered, what had been learnt from visiting services and how Healthwatch had made a difference, how it had provided advice and information, worked with other organisations, championed the role of public involvement and involved local people in its work. It also set out plans for the work of Healthwatch Reading in 2017/18.

It was reported at the meeting that Healthwatch Reading had discovered on 7 July 2017 that they were winners of the 'Engagement in Service Change' category of Healthwatch England's annual awards 2017, for the project on why people went to the Emergency Department of the Royal Berkshire Hospital.

Resolved -

(1) That the report be noted;

(2) That the Health and Wellbeing Board's thanks to the Healthwatch Reading team for their work, and congratulations for their award, be recorded and passed to the team.

8. A HEALTHY WEIGHT STATEMENT FOR READING - IMPLEMENTATION PLAN UPDATE

Further to Minute 11 of the meeting held on 27 January 2017, Melissa Montague submitted a report giving an update on the development of an implementation plan for the Healthy Weight Strategy for Reading. The report had appended a draft Healthy Weight Strategy Action Plan.

The report explained that the Healthy Weight Statement for Reading had been endorsed by the Health and Wellbeing Board on 27 January 2017. Between March and June 2017, a multi-agency task and finish group had held four meetings to further develop the implementation plan, which set out actions to deliver on the key areas listed below, both through work led by the Council and that of partners:

- Provision of information and support to help people manage their weight.
- A continued focus on helping the least active members of the population to move more.
- Strengthening work with schools and families to help more children be a healthy weight.
- Provision of support for parents in early years settings to help family members be a healthy weight.
- Supporting/encouraging teenagers to eat healthily and have active lifestyles.

Since its establishment, the multi-agency task and finish group had already been instrumental in overseeing and driving forward progress across these key areas, and the report highlighted areas of progress.

Resolved -

(1) That the implementation plan, which had been developed with partners to deliver against the priorities set out in the Healthy Weight Statement, be endorsed;

(2) That a further report giving an update on progress on the Healthy Weight Strategy Implementation Plan be submitted to the Board in 12 months' time.

9. URGENT AND EMERGENCY CARE DELIVERY PLAN

Maureen McCartney submitted a report on plans for a modernised and improved Urgent and Emergency Care Service as described in the "Urgent and Emergency Care Delivery Plan" which had been published by NHS England in April 2017.

The report listed the seven key areas of change set out in the plan and set out, where appropriate, a summary of the steps which had been taken locally to date to support the delivery of the plan. The seven areas were:

1. NHS Online in 2017

2. NHS 111 – Increase the number of 111 calls receiving clinical assessment to a third by March 2018, so that only patients who genuinely needed to attend A&E, or use the ambulance service, were advised to do this.
3. Expanding evening and weekend GP appointments to 50% of the public by March 2017, then 100% by March 2019
4. Roll out of around 150 standardised 'urgent treatment centres' to offer diagnostic and other services to patients who did not need to attend A&E
5. Comprehensive front-door clinical screening at every acute hospital by October 2017
6. Hospital to Home: Hospitals, primary care, community care and local authorities working together to address delayed transfers of care
7. Ambulances: Implementing the recommendations of the Ambulance Response Programme by October 2017

The report explained that the Berkshire West A&E Delivery Board was responsible for developing and ensuring implementation of a local action plan in response to the requirements of the Delivery Plan. There was also an STP-wide Urgent & Emergency Care Plan currently being developed to deal with those aspects that required a BOB-wide (Berkshire West, Oxfordshire and Buckinghamshire) response. These were primarily around ambulance services and NHS 111 and were listed in the report.

The report stated that the local A&E Board had had a workshop in June 2017 to develop the local plan and the final version of the Berkshire West Delivery Plan would be presented to the October 2017 meeting of the Health and Wellbeing Board.

Resolved -

That the report, and the fact that the final version of the Berkshire West Urgent and Emergency Care Delivery Plan would be presented to the next meeting, be noted.

10. TUBERCULOSIS (TB) & ANTIMICROBIAL RESISTANCE (AMR) PROGRAMME UPDATE

Jo Hawthorne submitted a report giving an update on Tuberculosis (TB) and Antimicrobial Resistance (AMR) programme activities and seeking continued support for TB and AMR public engagement.

The report explained that recent data from Public Health England showed that the incidence of TB in Reading between 2002 to 2015 had been consistently higher than the England and South East average and so a TB Advocacy, Communication and Social Mobilisation plan had been developed and implemented by a multi-agency group of local stakeholders to improve awareness of active and latent TB locally, reduce stigma and improve access to testing and treatment. The report gave details of work that had been carried out so far.

It explained that a strong TB pathway with good treatment completion would contribute to prevention and control of multi-drug resistant TB and would also preserve antimicrobials for where they were most needed. Strong antimicrobial stewardship should help to ensure that antibiotics could continue to effectively treat latent and active TB.

The report concluded that there was a need for continued professional and public engagement and the Board was asked to support stakeholders to promote hand hygiene and increase understanding of the need for good antimicrobial stewardship by continuing to encourage members of all Board partners to pledge as Antibiotic Guardians and to support wider engagement with young people through schools, colleges and other settings in 2017.

Resolved -

That the Board continue to support public engagement for Tuberculosis (TB) and Antimicrobial Stewardship (AMS) programmes.

11. 0-19 (25) PUBLIC HEALTH NURSING SERVICE – PROCUREMENT UPDATE

Further to Minute 9 of the previous meeting, Jo Hawthorne submitted a report on progress made on the procurement of the integrated Public Health Nursing Service for 0-19 (25) year olds.

The report explained that the Adult Social Care, Children's Services and Education Committee, on 13 December 2016, had agreed to bring the health visitors service and school nursing service together into a single Public Health Nursing Service, to start on 1 October 2017(Minute 47 refers).

A full procurement had been undertaken, which had commenced on 13 March 2017 and closed on 18 April 2017. Following contract selection, internal approval to award the contract to Berkshire Healthcare Foundation Trust (BHFT) had been secured and BHFT had acknowledged the formal award of the Reading 0-19 (25) contract letter issued to them.

The project team were currently making the necessary arrangements with Legal Services to process the contract between Reading Borough Council (RBC) and BHFT. The contract would start on 1 October 2017 for a period of two years, with the option to extend for a further 12 months. Mobilisation meetings had been arranged with representatives from RBC and BHFT to discuss implementation of the new contract arrangements.

The Reading 0-19s service would be integrated with the early intervention children's service. This would develop coherent, effective, life course services for children and young people. The model would maximise opportunities for health visitors and school nurses to be a part of the RBC priorities for keeping children safe, achieving their maximum potential and staying healthy.

Resolved -

That the progress on the development of an integrated 0-19 (25) Public Health Nursing Service be noted.

12. DEVELOPMENT OF THE HEALTH AND WELLBEING BOARD DASHBOARD

Jo Hawthorne submitted a report on the development of the Health and Wellbeing Dashboard, to be used to keep Board members informed on local trends in priority areas identified in the Health and Wellbeing Strategy, and asking the Board to

consider recommendations for frequency of the report and for setting targets for each indicator.

Development of a Health and Wellbeing Dashboard had been agreed in principle in July 2016 and the final version of the Health and Wellbeing Strategy had been approved by the Health and Wellbeing Board on 27 January 2017 (Minute 4 refers). The report stated that a draft version of the dashboard had been partially developed and decisions about targets and frequency of reporting were now required. Indicators reflecting each priority area had been identified and included in the draft dashboard.

The Dashboard would have three levels – a high level showing performance of all indicators against targets (met or not met and direction of travel), a second level showing more detailed information and benchmarking for the indicators in each priority area, and a third level showing more detailed trend data and source information for each indicator (An example was included in Appendix 1).

While each performance framework benchmarked each indicator against national performance and performance of similar Local Authority or CCG areas, and while a small number might be subject to a nationally-set target, there were currently no locally agreed targets for the indicators that would be included in the Dashboard.

The report set out the advantages and disadvantages of different options for setting targets and of different frequencies for presenting the dashboard report, recommending that Priority/Action Plan leads be tasked to use their expert knowledge to set appropriate targets for each indicator in their priority area jointly with key stakeholders, and that an annual dashboard report be presented at the end of each year to the Board, with quarterly performance updates on specific indicators to be presented by exception or on request.

Whilst the Health and Wellbeing Dashboard was still in development, two reports on Reading's performance against key indicators and Health and Wellbeing Strategy priorities were appended to the report as Appendices 2 (Performance Update) and 3 (Reading's PHE Health Profile, 2017).

The meeting welcomed the involvement of all stakeholders in the production of the dashboard targets and noted the importance of timely reporting of any problems with performance on specific indicators. It was noted that the Board would also be receiving regular reports on progress against the Health and Wellbeing Strategy Action Plan (see also Minute 13 below).

Resolved -

(1) That the latest progress in development of a Health and Wellbeing Dashboard be noted;

(2) That Priority/Action Plan leads agree appropriate targets for indicators with key stakeholders;

(3) That the Health & Wellbeing Dashboard be presented annually to the Board, with more regular updates on specific indicators by exception or on request.

13. READING HEALTH AND WELLBEING BOARD ACTION PLAN 2017-20 – PROGRESS REPORT

Jo Hawthorne submitted a report giving an update on progress against delivery of the Health and Wellbeing Action Plan which supported the 2017-20 Health and Wellbeing Strategy as at June 2017. Full details were set out in Appendix A to the report.

The report explained that, alongside the Health and Wellbeing Dashboard (see Minute 12 above), the Health and Wellbeing Action Plan update provided the Board with an overview of performance and progress towards achieving local goals. It also gave the Board a context for determining which parts of the Action Plan it wished to review in more depth at its future meetings, in line with the recent Health and Wellbeing Peer Review recommendation that the Health and Wellbeing Strategy should be used to drive the agenda of the Health and Wellbeing Board.

The appendix gave details of performance in the following eight priority areas of the Strategy:

1) Healthy lifestyle choices;
2) Loneliness and isolation;
3) Safe use of alcohol;
4) Mental health and wellbeing of children and young people;
5) Living well with dementia;
6) Breast and bowel cancer screening;
7) Incidence of tuberculosis;
8) Suicide rate.

The report stated that, as priorities (2), (3) (4) and (5) formed a natural cluster around emotional wellbeing and with a planned focus on priority (4) in the autumn to align with an international awareness day, this grouping was suggested for the first set of in-depth progress reports. The 6 October 2017 Health and Wellbeing Board would also take place shortly before World Mental Health Day (10 October 2017).

Resolved -

(1) That the progress to date against the 2017-20 Reading Health and Wellbeing Strategy Action Plan, as set out in Appendix A, be noted;

(2) That in-depth reports on progress towards achieving priorities (2), (3), (4) and (5) of the Health & Wellbeing Strategy be brought to the next meeting.

14. UPDATE ON BOB STP PREVENTION WORKSTREAM

Jo Hawthorne submitted a report giving an update on the work of the Prevention Workstream that was part of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability Transformation Plan (BOB STP), working on shifting the focus of care from treatment to prevention.

The report set out the six themes that were the focus of this work, giving the vision, deliverables and progress to date. The six themes were: obesity, physical activity, tobacco, Making Every Contact Count, Digital self-care and improving workforce health. It explained that the work going on in the BOB STP Prevention Workstream

was variable across the themes, but there had been considerable progress made and collaboration across the three geographical areas within BOB and the different disciplines. The Prevention Workstream was chaired by an Operational Director for the Berkshire West CCGs and there was a presence of Directors of Public Health and their representatives from Buckinghamshire, Oxfordshire and Berkshire West.

The report had appended:

Appendix 1 – Tiers of weight management interventions
Appendix 2 – London Clinical Senate – Helping smokers quit campaign
Appendix 3 – Making every contact count stocktake
Appendix 4 – BOB STP Prevention Workstream Update Presentation – April 2017

Jo Hawthorne said that a workshop for local authority and CCG colleagues was due to be held in the next few weeks to look at the next steps and so they would be able to report back to the next meeting on what the Prevention Workstream meant for Reading.

Resolved -

(1) That the progress against delivery of the six themes within the BOB STP Prevention Workstream be noted;

(2) That further joint feedback be given to the next meeting setting out what the Prevention Workstream meant for Reading.

15. READING'S ARMED FORCES COVENANT AND ACTION PLAN – MONITORING REPORT

Jill Marston submitted a report on the Armed Forces Covenant, a voluntary statement of mutual support between a civilian community and its local armed forces community, giving an annual update on progress against the actions outlined in the associated action plan, in particular the health-related actions, and on the general development of the Covenant. The Action Plan was attached at Appendix A.

The report stated that the Council had nominated itself for the bronze award of the Defence Employer Recognition Scheme, and it was reported at the meeting that the award had been achieved.

It was reported that officers from the CCGs were working on the registration of veterans in GP practices.

Resolved –

(1) That the progress against the actions set out in the Armed Forces Covenant Action Plan (Appendix A) be noted;

(2) That it be noted that the Council had received the bronze award of the Defence Employer Recognition Scheme.

16. INTEGRATION AND BETTER CARE FUND

Tony Marvell submitted a report giving an update on the progress of the Integration programme, including Better Care Fund (BCF) Performance.

The report gave details of progress to date against the four key BCF performance indicators that each Health & Wellbeing Board was required to report on:

- Reducing delayed transfers of care (DTOC) from hospital
- Avoiding unnecessary non-elective admissions (NEA)
- Reducing inappropriate admissions of older people (65+) into residential care
- Increase in the effectiveness of reablement services

It also summarised performance to date on the following key integration/BCF schemes:

- Discharge to Assess – Willows
- Community Reablement Team
- Enhanced Support to Care Homes
- Connected Care

The report stated that the final BCF policy framework had been released in March 2017, but the technical guidance had not formally been released by NHS England, although a draft copy of the technical guidance had been received from the Local Government Association. This meant that the final funding and planning requirements for the 2017/18 & 2018/19 BCF were still not confirmed and there was a risk of abortive work should the final guidance differ from the draft version.

The report stated that planning sessions including CCG and RBC representatives were continuing but information about timescales for the delivery of the technical guidance or the final submission date had not been received and the report noted that the Board had agreed at its previous meeting for authority to be delegated to officers to submit the BCF, in consultation with the Chair of the Board, as it had been anticipated that timescales were unlikely to fit with the Board's meetings.

It was reported at the meeting that the technical guidance had now been received, as well as information on the timescales for submission of reports to NHS England and DCLG. Refreshed BCF plans for the next two years had to be submitted by 11 September 2017, which would then be rated as approved, approved with conditions, or not approved.

It was also reported at the meeting that the April and May 2017 performance data on DTOC had now been received, showing that the Reading BCF continued to improve and that Reading had moved up from 137th to 99th out of 150 in national performance comparisons.

The meeting discussed the importance of public involvement in the development of the BCF and the challenges of achieving something meaningful in the timescales involved, and it was agreed that further work was needed on this issue. It was also noted that all stakeholders should be considering how to engage with the public on the wider STP and ACS issues.

Resolved -

(1) That the progress on integration and the BCF be noted;

(2) That Tony Marvell work further with partners on how to involve the public in the development of the BCF.

17. PHARMACEUTICAL NEEDS ASSESSMENT 2017

Jo Hawthorne submitted a report from the Berkshire Shared Public Health Team briefing Berkshire Health and Wellbeing Boards on their role in the three-year refresh of the Pharmaceutical Needs Assessment (PNA).

The report explained that, since April 2013, every Health & Wellbeing Board in England had had a statutory responsibility to publish, and keep up to date, a statement of the needs for pharmaceutical services in their area, or Pharmaceutical Needs Assessment (PNA). Each Health & Wellbeing Board had had to publish their first PNA by 1 April 2015, and was required to undertake a revised assessment at least every three years. The refreshed PNAs needed to be signed-off and published by 31 March 2018.

The report explained that the Berkshire Shared Public Health Team would lead on the development and delivery of the PNAs on behalf of the Berkshire Health and Wellbeing Boards, using the results of two surveys – one survey of residents using local pharmacy services and the other of pharmacy staff in each borough, to be carried out in 2017 in June, July and August. They would be electronic and managed through the Health and Wellbeing Board partner organisations' usual dissemination channels for a public survey.

The report also gave details of actions which needed to be undertaken at a local level to ensure success of the project, including promotion to local residents, explaining that the draft PNA would need to be signed off in October 2017 for public consultation between October and December 2017. HWBB members were asked to add this to their corporate consultation schedule for this period and to identify any processes that needed to be completed to ensure this consultation occurred.

Mandeep Sira noted that Healthwatch Reading had a number of communication channels which were available to be used for public consultation.

Resolved -

(1) That the report be noted;

(2) That a report on the draft PNA be submitted to the next meeting.

18. DATE OF NEXT MEETING

Resolved – That the next meeting be held at 2.00pm on Friday 6 October 2017.

(The meeting started at 2.10pm and closed at 4.30pm)