Peter Sloman
CHIEF EXECUTIVE

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

To: All Members of the Health and Wellbeing Board

Our Ref:
Your Ref:

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

4 July 2019

Your contact is: Nicky Simpson - Committee Services

NOTICE OF MEETING - HEALTH AND WELLBEING BOARD 12 JULY 2019

A meeting of the Health and Wellbeing Board will be held on **Friday, 12 July 2019 at 2.00 pm** in the **Council Chamber, Civic Offices, Bridge Street, Reading RG1 2LU**. The Agenda for the meeting is set out below.

AGENDA Page No

CIVIC OFFICES EMERGENCY EVACUATION: If an alarm sounds, leave by the nearest fire exit quickly and calmly and assemble on the corner of Bridge Street and Fobney Street. You will be advised when it is safe to re-enter the building.

A report giving an update on the Action Plan as a result of the Care Quality Commission (CQC)-led Local System Review that the Reading system across Health and Social Care was subject to during October 2018.

7. INTEGRATED CARE PARTNERSHIP GOVERNANCE PROPOSALS 45 - 126

A report on a set of proposed strategic integration objectives for Health & Social Care partners across Berkshire West; together with proposals for redesigned governance and staffing arrangements (collectively titled the Berkshire West Integrated Care Partnership (BWICP) that will help to deliver these strategic objectives.

8. RESPONSE TO THE HEALTHWATCH READING REPORT 'LGBT+ YOUR EXPERIENCES AS LESBIAN, GAY, BISEXUAL, TRANSGENDER PEOPLE ACCESSING HEALTH & SOCIAL CARE SERVICES IN READING' 127 - 130

A report on the joint response of Reading Borough Council and Berkshire West CCG to a report 'LGBT+ Your experiences as Lesbian, Gay, Bisexual, Transgender people accessing Health & Social Care Services in Reading', presented by Healthwatch Reading to the 12 October 2018 meeting of the Reading Health and Wellbeing Board.

9. NHS LONG TERM PLAN - PUBLIC ENGAGEMENT REPORT 131 - 174

A report by Healthwatch, presenting a summary of views collected from nearly 1,250 people living in the Buckinghamshire, Oxfordshire and Berkshire West (BOB) NHS area, in April and May 2019. This project was part of a simultaneous exercise by all 152 local Healthwatches in England, to inform implementation of the NHS Long Term Plan published in January 2019.

10. HEALTHWATCH READING ANNUAL REPORT 2018/19 175 - 200

Healthwatch Reading's annual report, giving details of the work carried out by Healthwatch Reading in 2018/19.

11. READING'S ARMED FORCES COVENANT AND ACTION PLAN - MONITORING REPORT 201 - 214

A report presenting an annual update on progress against the actions outlined in the Reading Armed Forces Covenant Action Plan, in particular the heath-related actions, and on the general development of the covenant.

12. INTEGRATION PROGRAMME UPDATE 215 - 220

A report giving an update on the Integration Programme, as well as progress made against the delivery of the national Better Care Fund (BCF) targets.

13. HEALTH AND WELLBEING DASHBOARD AND ACTION PLAN - JULY 2019 221 - 312

A report presenting an update on delivery against the Health and Wellbeing Action Plan (Appendix A), alongside the Health and Wellbeing Dashboard (Appendix B), which sets out local trends in a format previously agreed by the Board. Taken together, these documents provide the Board with an overview of performance and progress towards achieving local goals as set out in the 2017-20 Health and Wellbeing Strategy for Reading.

14. DEVELOPING A BERKSHIRE WEST SHARED JOINT HEALTH & WELLBEING STRATEGY 313 - 318

A report outlining the reasoning for a Joint Health & Wellbeing Strategy across Berkshire West and seeking support from the Reading Health & Wellbeing Board for a methodology to develop the strategy.

15. ROYAL BERKSHIRE FIRE & RESCUE SERVICE - MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD 319 - 330

A report proposing that the Health and Wellbeing Board co-opt a representative from Royal Berkshire Fire & Rescue Service as a non-voting additional member of the Board and agree the resultant changes to the membership and therefore terms of reference and powers and duties of the Board.

16. DATE OF NEXT MEETING - FRIDAY 11 OCTOBER 2019 AT 2PM

This page is intentionally left blank

Present:

Councillor Hoskin (Chair)	Lead Councillor for Health, Wellbeing & Sport, Reading Borough Council (RBC)
Andy Ciecierski	North & West Reading Locality Clinical Lead, Berkshire West CCG
Councillor Jones	Lead Councillor for Adult Social Care, RBC
Sarah Morland	Partnership Manager, Reading Voluntary Action
Emily Roberts	Thames Valley Policy (substituting for Stan Gilmour)
David Shepherd	Chair, Healthwatch Reading
Councillor Terry	Lead Councillor for Children, RBC
Councillor R Williams	RBC (substituting for Councillor Lovelock)
Cathy Winfield	Chief Officer, Berkshire West CCG

Also in attendance:

Councillor David Absolom	Chair of the Adult Social Care, Children' Services & Education Committee (ACE Committee), RBC
Mandeep Bains	Chief Executive, Healthwatch Reading
Michael Beakhouse	Integration Programme Manager, RBC & Berkshire West CCG
Michelle Berry	Neighbourhood Coordinator – Wellbeing, RBC
Gwen Bonner	Clinical Director, Berkshire Healthcare NHS Foundation Trust (BHFT)
Alice Boon	Senior School Standards Officer, Better Futures for Children
Gerry Crawford	Regional Director, BHFT
Jon Dickinson	Deputy Director for Adult Social Services, RBC
Andy Fitton	Service Redesign & Transformation Manager, Berkshire West CCG
Marion Gibbon	Consultant in Public Health, RBC
Paul Gresty	Strategic Lead for Partnership, Prevention & Early Intervention, Brighter Futures for Children
Elin Jones	Director for Provider Efficiency & Performance, Department of Health & Social Care
Kim McCall	Health Intelligence Officer, Wellbeing Team, RBC
Lynne Mason	Business Manager, West of Berkshire Safeguarding Adults Board
Jayne Rigg	Commissioning & Social Care Manager, RBC
Janette Searle	Preventative Services Manager, RBC
Nicky Simpson	Committee Services, RBC

Apologies:

Seona Douglas	Director of Adult Care & Health Services, RBC
Stan Gilmour	LPA Commander for Reading, Thames Valley Police
Deb Hunter	Principal Child & Education Psychologist, Brighter Futures for Children
Tessa Lindfield	Strategic Director of Public Health for Berkshire
Councillor Lovelock	Leader of the Council, RBC
Sally Murray	Head of Children's Commissioning & Designated Clinical Officer for SEND, Berkshire West CCG

1. MINUTES

The Minutes of the meeting held on 18 January 2019 were confirmed as a correct record and signed by the Chair.

2. CARE QUALITY COMMISSION (CQC) REVIEW OF READING HEALTH AND SOCIAL CARE SYSTEM – FINAL REPORT & DRAFT ACTION PLAN

Further to Minute 4 of the previous meeting, Cathy Winfield presented a report by the Director of Adult Care & Health Services with, attached, the final report by the Care Quality Commission (CQC) on the Review of the Reading Health and Social Care System that had been carried out by the CQC between 29 October and 2 November 2018. The report also had appended a draft Reading Action Plan drawn up by system leaders following a summit on 16 January 2019 to address the CQC report's recommendations, for the Board's approval.

The report explained the CQC Review had considered the Reading health and social care system performance along a number of pressure points on a typical pathway of care, with a focus on older people aged 65 and over. The Reading health and social care system comprised Reading Borough Council, Berkshire West CCG, Royal Berkshire NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust and the South Central Ambulance Service, as well as the providers of health and social care services within the wider marketplace, including voluntary and community sector organisations.

Following agreement of a draft report of the review on 17 December 2018, health and social care system leaders had held a summit on 16 January 2019 and had worked together to create the attached action plan, which outlined how the recommendations made by the CQC Review team would be addressed.

The review report set out its summary of findings, which included many examples of good practice, addressing the following questions:

- What are older people's experiences of care in Reading?
- Is there a clear shared vision and common purpose, underpinned by a credible strategy to deliver high-quality care which is understood across the system?
- Are there clear governance arrangements and accountability structures for how organisations contribute to the overall performance of the system?
- Are there arrangements for the joint funding, commissioning and delivery of services to meet the needs of older people?
- Are people who work in the system encouraged to collaborate and work across organisational boundaries to meet the needs of older people?

It also set out 13 key areas for improvement, and Cathy Winfield explained that a lot of work had already been done on many of the areas since the review, which was reflected in the draft action plan.

The draft action plan divided the areas for improvement into four groups, setting out the actions required, action owners and timescales for completion, as well as identifying risks and mitigating actions and providing notes on progress on the actions and RAG (red/amber/green) ratings for each area. The four groups were

- Strategic Development, Governance and System Alignment

- Operational Delivery and Workforce
- Commissioning and Market Management
- Communication and Engagement

It was reported that the draft action plan still needed more work to make it more succinct and to tighten the objectives so that they could be tracked and measured. It was suggested at the meeting that there needed to be more focus in the action plan on the role of public and patient involvement in the system.

The report proposed that monitoring of the action plan should be carried out by the Reading Integration Board, which would then report progress to the Health and Wellbeing Board.

Resolved –

(1) That the final CQC Review report be noted and received;

(2) That the draft action plan be endorsed;

(3) That the proposed arrangements for the Reading Integration Board to monitor the action plan and report progress to the Health and Wellbeing Board be agreed.

3. THE NHS LONG TERM PLAN

Cathy Winfield submitted a report and gave a presentation setting out the contents of the NHS Long Term Plan which had been published in January 2019. The presentation slides were appended to the report.

The plan described a new model of care that strengthened services in primary and community care. This model was characterised by groups of GP practices working together in Primary Care Networks (PCNs) or "neighbourhoods." The NHS had been asked to work at locality level with partners in local government, community health services, the voluntary sector and communities themselves to develop PCNs. The intention was that all local services would operate on a neighbourhood footprint, increasing the coordination and integration of care for residents. This fitted well with the current priority in Berkshire West to "Design Our Neighbourhoods".

The additional capacity in primary care would enable the shift to more pro-active care, identifying people at risk and intervening pro-actively to stop them developing new conditions, such as diabetes, or deteriorating further.

The NHS Long Term Plan placed new emphasis on the prevention agenda and on the reduction of health inequalities. It also set specific targets for improvements in care and clinical outcomes for key conditions such as cancer, cardiovascular disease, children's health, and mental health. The plan also talked about the future organisation of services with the ambition that all areas were working as Integrated Care Systems by 2021.

The report stated that much of the plan aligned very well with the work already happening locally as the Berkshire West ICS and the Berkshire West 7. Commitment had already been made to strengthening the links between these two programmes

with the leadership and support of the three Health and Wellbeing Chairs across Berkshire West.

The Integrated Care System would need to produce a five year strategy by the Autumn in response to the NHS Long Term Plan, and the recommendation was that the Berkshire West system produced a single plan that brought together the three Health and Wellbeing Strategies and the response to the Long Term Plan. The delivery of the strategy would reflect the needs of each of each of the localities and be locally-driven. This approach would also deliver the recommendations of the CQC to develop a single strategy.

Resolved –

(1) That the contents of the NHS Long Term Plan and the alignment with the local Berkshire West work programme be noted;

(2) That the work to develop neighbourhoods in Reading be endorsed;

(3) That the development of a single plan across Berkshire West be endorsed.

4. MAKING READING A PLACE WHERE PEOPLE CAN LIVE WELL WITH DEMENTIA: UPDATE ON PRIORITY 6 FROM THE HEALTH AND WELLBEING ACTION PLAN

Further to Minute 11 (b) of the previous meeting, Michelle Berry submitted a report giving an update on delivery against the Health and Wellbeing Action Plan Priority 6 – *Making Reading a place where people can live well with dementia*. It included an overview of performance and progress towards achieving goals which contributed to making Reading a place where people could live well with dementia, as well as upcoming activities which supported the strategic objectives. The report had appended the latest version of the relevant section of the Health & Wellbeing Strategy Action Plan, on Making Reading a place where people can live well with dementia, and the Berkshire West CCG's Berkshire West Dementia Action Plan 2018-21.

The report stated that the Health and Wellbeing Board had agreed to review progress in this area, as recommended by Healthwatch Reading in the 'Conversations About Care' report which had been presented to the previous meeting of the Board (Minute 11 (b) refers). It set out progress on raising awareness of dementia, on diagnosis and support and on future planning.

Councillor Jones said that he had recently become aware of the eligibility, with GP sign-off, for a 100% Council Tax discount for those with severe mental impairment, but apparently the knowledge of and application of this was patchy across the country, and he queried whether this was promoted in Reading. Michelle Berry explained that the Carers' Hub, Alzheimer's Society and other similar agencies would know about this discount and people were likely to be signposted towards this benefit through them, but she could investigate what the Council was doing and what further work could be done on promoting this.

Sarah Morland said that those in the social prescribing service often saw dementia clients, but often carers also needed additional support and she queried whether GP practices were proactively supporting carers, as carers did not seem to know that

they could have a carer's assessment and get support from the Carers' Hub. Michelle Berry said she would feed this back to Rabia Alexander, the Dementia Lead at Berkshire West CCG, to feed into the Berkshire West Dementia Steering Group.

Resolved –

(1) That the progress made to date against Reading's Health and Wellbeing Strategy Action Plan Priority 6 be noted;

(2) That Michelle Berry investigate what the Council was doing and could do further on promoting the Council Tax discount for those with severe mental impairment;

(3) That Michelle Berry feed back to Rabia Alexander the encouragement for GP Practices to proactively support carers and refer them for assessment and support, to feed into the Berkshire West Dementia Steering Group.

5. HOW ADVERSE CHILDHOOD EXPERIENCES AFFECT THE DEMAND AND TYPE OF SERVICES REQUIRED IN COMMUNITIES

Marion Gibbon, Paul Gresty and Emily Roberts presented a report seeking commitment to achieving a system-wide approach to raising awareness of ACEs (Adverse Childhood Experiences), Trauma-Informed Communities (TICs) and Trauma-Informed Practice (TIP), and of the inter-linkages of ACEs with substance misuse, suicide prevention and other adverse health and societal outcomes, in order to enable a robust approach to prevention and dealing with trauma within communities. The report also looked at how childhood trauma (ACEs) affected the development of children, young people and families, and impacted both on the demand for, and type of, public and community services and identified ways of working in partnerships to support communities and the national Policing, Health and Social Care Consensus.

The report explained that, in September 2018, the strategic partners and other key enablers that delivered preventative and early intervention approaches to children and families in Reading, had committed to establish a Reading Prevention & Early Intervention Partnership, which would ensure shared accountability for early help arrangements; and strategic governance to the Reading Prevention & Early Intervention Strategy, of which the Partnership had oversight. A report providing a summary of progress, priorities and governance had been presented to the Adult Social Care, Children's Services and Education Committee on 14 February 2019, a copy of which was attached at Appendix 1.

In order to deliver shared outcomes and priorities around early help, and ensure improved outcomes for children, young people and families in Reading, a number of 'Partnership Delivery Groups' had been established – including ACEs. On 24 October 2018, the first meeting of the 'Trauma-informed & Emotional Health and Wellbeing' delivery group had taken place. The vision for the group was that Reading became a 'trauma-informed' town and that schools and other key partners took a 'therapeutic approach' to supporting young people with ACEs.

The report explained how trauma and ACEs could have a big and long-lasting effect on people's lives, activities, behaviour and health and wellbeing, resulting in trauma survivors being disproportionately represented in public and community services clients, those with substance abuse problems or mental health conditions and those in

the criminal justice system. It stated that a Trauma-Informed Community (TIC) was one where members of the community relied less on a clinical diagnosis of mental health issues or descriptions of criminal behaviour, for example, but first asked 'What is your life story?' This led to compassion from service providers and self-compassion by the public, which in turn led to better understanding and engagement with services. One study had shown that, simply by the raising of education and awareness of what was meant by trauma within a community, this had led to 33% fewer visits to GPs and 11% fewer visits to Accident and Emergency departments by frequent attenders. The report gave details of work already being carried out to embed the trauma-informed approach and set out proposals for the next steps.

It was reported at the meeting that the process of recruiting a trauma-informed practitioner was currently under way. RVA were hosting an event on 2 April 2019 showing the Resilience film referred to in the report and leading a discussion on how Reading could become more trauma-informed.

The meeting welcomed the approach and discussed the importance of appropriate review and evaluation of the planned work, so as to allow evidence-based decision making for future work.

Resolved –

(1) That the proposal to undertake a mapping exercise to gauge current knowledge around trauma-informed thinking (Adverse Childhood Experiences), and work being delivered across Reading, with a view to developing a vision and trauma-informed framework to bring consistency to embedding trauma in practice, via the One Reading Prevention & Early Intervention Partnership, be endorsed;

(2) That the proposal to operationalise the framework to deliver the vision by embedding trauma-informed thinking in service delivery via a dedicated practice lead, funded by partners, be endorsed;

(3) That the proposal to put in place a network of therapeutic champions across Reading be endorsed.

6. DEVELOPING THE JOINT STRATEGIC NEEDS ASSESSMENT

Marion Gibbon presented a report describing a new approach to developing the Joint Strategic Needs Assessment (JSNA) for local authorities across Berkshire and requesting that this approach was approved to be taken forward from April 2019.

The report explained that the JSNA was a joint duty between the local authority and the CCG on behalf of each Health and Wellbeing Board. The JSNA provided a common view of health and care needs for the local community, focusing on health inequalities. It was used by health and social care commissioners to plan services, as an evidence base for preparing bids and business cases, by the voluntary and community sector to ensure that community needs and views were represented, by service providers to assist in future development of their services and by the public to scrutinise local health and wellbeing information, plans and commissioning recommendations.

In 2018, the Consultants in Public Health had reviewed current arrangements and had noted the following:

- The JSNAs were taking a disproportionate amount of staff time to produce in relation to its use by commissioners and impact on evidence-based decision making.
- The format of pdf documents was rigid, not searchable and difficult to navigate.
- Commissioners were requesting information that was already in the JSNA. They were not turning to the JSNA as the first port of call for information because they felt that it was not timely or relevant when they were redesigning and recommissioning services.
- Not all elements were recognised as being part of the JSNA – for example the CCG profiles.
- The Berkshire JSNAs were out of step with developments across the country.

In July 2018, a lighter touch JSNA refresh for 2018/19 had been proposed to free capacity to re-examine the model of JSNAs across the Berkshire Local Authorities and recommend improvements. Concurrently, NHS bodies had been developing Population Health Management, a potentially powerful data and information system to inform clinical service design and delivery. There was a risk of duplication of effort and confusion of intelligence for commissioners.

In order for the JSNA to evolve to be more efficiently produced, complement population health management and better meet the needs of its users with timely and useful information and intelligence, a new model was proposed. Whilst each Authority's JSNA would be individual, a unifying vision supported by a set of principles was proposed for JSNAs in Berkshire Unitary Authorities as follows:

- "Local public health teams; the shared public health team; commissioners; health and wellbeing boards will actively work together to develop and promote the use of JSNAs as a suite of tools to identify health and wellbeing priorities and guide decision making, in order to reduce health inequalities and enable communities to live healthy lives."

The report set out the principles for the new JSNA model and detailed the shifts in focus that would be required.

The new JSNA would be a suite of resources covering the following six areas: Data, Reports, Health Needs Assessments, Self-serve Analytical & Visualisation Tools, Bespoke Analyses and Other Sources of Information.

Many of these were already in place in some shape or form, but work would be needed to develop a new range of local routine reports, to roll out the self-serve tool and build the library of resources. A key new area of work would be the inclusion of data from patients and residents. The work would be led by Public Health, delivered by Local Teams and supported by the Public Health Shared Team, using existing budgets. The JSNA steering group had been refreshed and invitations had been extended to partner organisations.

Resolved – That the new JSNA approach be approved to be taken forward from April 2019.

7. THE BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST MENTAL HEALTH STRATEGY 2016-21 – UPDATE

Further to Minute 4 of the meeting held on 13 July 2018, Gwen Bonner and Gerry Crawford submitted a report giving an update on progress on the Berkshire Healthcare NHS Foundation Trust's (BHFT's) Mental Health Strategy 2016-21.

The report gave an overview of changes since July 2018, including:

- Developments in national policy and the local operating context
- Results of the 2018 Care Quality Commission Inspection of Mental Health Services
- What had been done in terms of:
    - Taking forward key initiatives and strategic intentions
    - Progress against national targets

It also set out the next steps planned in terms of activities to deliver the strategy.

Resolved - That the report be noted.

8. REFRESHED FUTURE IN MIND (LOCAL TRANSFORMATION PLAN FOR CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH & WELLBEING)

Further to Minute 6 of the meeting held on 19 January 2018, Alice Boon and Andy Fitton submitted a report giving an overview and seeking approval of the refreshed Future in Mind Local Transformation Plan (LTP) for Children and Young People's Mental Health and Wellbeing, which had been co-produced with partners, children and young people, and had been published in October 2018 in accordance with national Future In Mind requirements. The LTP provided an update on service development and improvement across the comprehensive Child and Adolescent Mental Health Service (CAMHS) system.

The report had appended a summary version of the refreshed LTP and a young person-friendly version summary. It explained that the full document built upon the 2017 LTP and provided an update on what had been achieved so far, the commitment to undertake the further work required, local needs and trends and resources required.

The report stated that a wide range of initiatives across the system was under way to improve emotional health and wellbeing of children and young people. Further details were given at the meeting of the progress of the successful bid to become a Trailblazer site for setting up a multi-disciplinary Mental Health Support Team for schools and of schools' involvement in the Therapeutic Thinking Schools Approach to behaviour management to reduce the risk of exclusions, as examples of initiatives linked to the LTP. 42 schools had volunteered to be trainers for changing the culture to the Therapeutic Thinking School Approach and it was hoped that changes to the numbers of children being excluded might be seen by the end of the year.

Resolved - That the refreshed Future in Mind Local Transformation Plan be approved.

9. WEST OF BERKSHIRE SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2017-18

Lynne Mason submitted a report presenting the West of Berkshire Safeguarding Adults Board (SAB) Annual Report 2017-18, which was attached to the report, for the Health and Wellbeing Board to consider the report, to meet statutory requirements.

The report stated that the SAB had to lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. The overarching purpose of a SAB was to help and safeguard adults with care and support needs. It did this by: assuring itself that local safeguarding arrangements were in place as defined by the Care Act 2014 and statutory guidance; assuring itself that safeguarding practice was person-centred and outcome-focused; working collaboratively to prevent abuse and neglect where possible; ensuring agencies and individuals gave timely and proportionate responses when abuse or neglect had occurred; and assuring itself that safeguarding practice was continuously improving and enhancing the quality of life of adults in its area.

The Annual Report presented what the SAB had aimed to achieve on behalf of the residents of Reading, West Berkshire and Wokingham during 2017-18, both as a partnership and through the work of its participating partners. It provided a picture of who was safeguarded across the area, in what circumstances and why and outlined the role and values of the SAB, its ongoing work and future priorities.

Lynne Mason highlighted some of the key points from the report, noting that not as much progress had been made as expected on some actions due to a significant number of staff changes across the partnership and the absence of an SAB Business Manager for six months. She explained the learning process from Safeguarding Adult Reviews and how this had led to changing to a three year live business plan, which could be adapted to ensure that learning was prioritised appropriately. She noted that there had been a 22% reduction in the number of safeguarding concerns since the previous year, and partners were working together to understand the reasons for this and see if any further work was required.

Resolved - That the West of Berkshire Safeguarding Adults Partnership Board (SAPB) Annual Report 2017-18 be noted.

10. INTEGRATION PROGRAMME UPDATE

Michael Beakhouse submitted a report giving an update on the Integration Programme and on progress made against the delivery of the national Better Care Fund (BCF) targets.

The report stated that, of the four national BCF targets, performance against one (limiting the number of new residential placements) was strong, with projected overall performance for the year in line with its target. It stated that partners had not met the target for reducing the number of non-elective admissions (NELs) but work against this goal remained a focus for the Berkshire West-wide BCF schemes.

Performance on reducing the number of delayed transfers of care was currently not on target for the year, but initiatives were in place that, if successful and reflected in the Quarter Four performance, would bring performance in line with the target.

Progress against the target for increasing the effectiveness of reablement services remained in line with the decreased performance reported in the last report, but this was due to revised guidance around the methods of measuring their impact and did not reflect a drop in actual performance.

The report gave further details of BCF performance and gave details of items progressed since January 2019 and the next steps planned for April to June 2019.

Resolved - That the report and progress be noted.

11. HEALTH AND WELLBEING DASHBOARD – MARCH 2019 UPDATE

Kim McCall submitted a report giving an update on the Health and Wellbeing Dashboard (attached at Appendix A), to keep Board members informed of local trends in priority areas identified in the Health and Wellbeing Strategy.

Paragraph 2.1 of the report set out details of updates to the data and performance indicators which had now been included in the Health and Wellbeing dashboard and Paragraph 2.2 summarised performance against the eight priority areas.

It was noted at the meeting that, whilst Reading was unlikely to meet the NHS healthcheck targets in Priority 1 in the current year, the work on the new Primary Care Contract and Quality Outcomes Framework was likely to have a positive effect and there was also targeted work going on to get healthchecks for people with long term mental health conditions and unpaid carers.

Resolved - That the report be noted.

12. ADULT SOCIAL CARE & HEALTH SERVICES – DIRECTION OF TRAVEL – "SUPPORTING OUR FUTURE"

Councillor Jones presented a report by the Director of Adult Care & Health Services setting out the draft strategic direction of travel for supporting adults, entitled "Supporting Our Future 2019-2022". The report had appended the draft strategy and the consultation document on the draft strategy.

The report provided an overview of the context and rationale for the development of Supporting Our Future for Adults, and of the approach set out under the prevention agenda.

The draft strategy set out the Council's vision and approach and the priorities in the delivery with partners in early intervention and prevention across Reading. It reflected changes from the Care Act 2014, and the current context of increasing demand and reducing finances, and emphasised to all involved the importance in supporting people to remain at home and independent. The strategy set out joint opportunities to work across the health and social care system economy in better supporting people to receive a seamless service at home.

The strategy included a workforce best practice "Five Ps" framework, which would enable the workforce to remain focused on prevention and independence at every stage in a person's journey. This stated that "Adult Social Care and Wellbeing through Supporting Our Future will focus on preventing the need for care, so to support maintain people to live a healthy, independent life at home longer, by having

in place the right support, at the right time, in the right place". The framework also set out details of the things that would be done to provide the five ps of "Best People, Best Place, Best Pound, Best Partner and Best Performance".

Public consultation on the draft strategy had been going on since January 2019 and would finish at the end of March 2019, with the final strategy expected to be published in April 2019. It was reported at the meeting that the online consultation had closed in error on 1 March 2019 and officers said that this would be investigated and rectified.

Resolved –

(1) That the national and local context in which the Council was undertaking its statutory duties in the provision of adult social care, and in meeting the needs of children who transitioned to adult services, be noted;

(2) That the Supporting Our Future Consultation Document, the outcome of consultation on which would influence the final strategy, be noted;

(3) That the workforce practice Five Ps be noted.

13. DRUG AND ALCOHOL STRATEGY AND ACTION PLAN AND RE-PROCUREMENT UPDATE

Further to Minute 5 of the meeting on 12 October 2018, Marion Gibbon submitted a report giving an update on the Reading Drug and Alcohol Commissioning Strategy and Action Plan for Young People and Adults from 2018-22 and on the drug and alcohol treatment service re-procurement exercise.

Reading's Drug and Alcohol Commissioning Strategy for Young People and Adults – 2018-2022 had been approved by the Policy Committee on 24 September 2018 and the Board on 12 October 2018, following a public consultation exercise, and approval had been given to recommission Reading's Drugs and Alcohol Treatment service in line with the Strategy (Minutes 32 and 5 refer respectively).

Three priorities had been identified in the draft Strategy: Prevention (reducing the amount of alcohol people drink to safer levels and reducing drug related harm), Treatment (Commissioning and delivering high quality drug and alcohol treatment systems) and Enforcement and Regulation (tackling alcohol and drug related crime and anti-social behaviour). The public consultation exercise had shown high level of agreement with the priorities and the responses would be used to develop a local action plan to support each of the three priorities.

The report explained that the outcome of consultation on the Strategy had enabled public health and social care commissioners to design a new treatment service specification. Reading Public Health had carried out a procurement exercise from October 2018 to February 2019 to re-procure a new drug and alcohol treatment service, the winning provider of which would be announced in spring 2019 once all the procurement regulations had been met. There would be a six month implementation period and the winning provider would start the new treatment service from 1 October 2019.

A Drug and Alcohol Strategy Action Plan would be developed in line with the new tendered service and a revised action plan would be presented to the Health and Wellbeing Board in July 2019.

Resolved – That the report and the next steps in the development of the action plan be noted;

14. READING LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) ANNUAL REPORT 2017/18

The Board received a report presenting the Reading Local Safeguarding Children Board (LSCB) Annual Report for 2017/18 on the work of and achievements of the LSCB for the 2017/2018 financial year, which was appended to the report.

The report explained that the Reading LSCB was the key statutory partnership whose role was to oversee how the relevant organisations co-operated to safeguard and promote the welfare of children in Reading and to ensure the effectiveness of the arrangements, as outlined in statutory guidance Working Together to Safeguard Children 2015.

The LSCB Chair was required to publish an Annual Report on the effectiveness of child safeguarding and promoting welfare of children in Reading. The report had to be presented to the Health and Wellbeing Board in line with statutory guidance.

The report explained that the Annual Report contained information on activities and achievements that demonstrated the partnership working and scrutiny in the LSCB and the impact this had on practice, and listed the achievements and ongoing challenges for the LSCB and partners against the following priorities identified for the 2017/18 year:

- Neglect;
- Domestic Abuse from a Child's Perspective;
- Children with Special Educational Needs and/or Disability (SEND)
- Child Sexual Exploitation and Missing, including Trafficking, Slavery and Online Exploitation;

The report explained that, during 2017/18, and in line with recommendations made by partners involved in the three West of Berkshire LSCBs (Reading, West Berkshire and Wokingham), the LSCB Chair had overseen the merger of the three Boards into one Berkshire West Safeguarding Children Board. This had been developed as a transitional year, to establish how well a shared Board arrangement could work, and how this arrangement could morph into future multi-agency safeguarding arrangements, as required by Working Together 2018.

Working Together 2018 required a significant range of changes for LSCBs, including the removal of the statutory requirement to have an LSCB, an Independent LSCB Chair and a requirement for the three Safeguarding partners (Local Authority, Clinical Commissioning Groups and Police) to agree and publish multi-agency safeguarding arrangements. The three safeguarding partners would be expected to jointly ensure safeguarding practices were maintained, monitored and improved. In addition, Working Together 2018 included the establishment of a new national Child Safeguarding Practice Review Panel to undertake reviews of serious cases and the

transfer of responsibility for child death reviews from LSCBs to new Child Death Review Partners under the governance of the Department of Health.

The statutory partners from across Berkshire West had been meeting as a Programme Board and planned to publish their local multi-agency safeguarding arrangements by 31 March 2019.

Resolved –

(1) That the annual report of the Reading Local Safeguarding Children Board 2017/18 be noted;

(2) That a report be submitted to a future meeting by the statutory safeguarding partners on the future multi-agency safeguarding arrangements required by Working Together 2018.

15. DATE OF FUTURE MEETINGS

It was requested that the possibility of Health and Wellbeing Board meetings being webcast be investigated.

Resolved –

(1) That the meetings for the Municipal Year 2019/20 be held at 2.00pm on the following dates:

- Friday 12 July 2019
- Friday 11 October 2019
- Friday 17 January 2020
- Friday 13 March 2020

(2) That the possibility of the meetings being webcast be investigated.

(The meeting started at 2.00pm and closed at 4.35pm)

This page is intentionally left blank

healthwatch Reading advice • advocacy • action

NHS Berkshire West Clinical Commissioning Group

Reading Borough Council Working better with you

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12th July 2019**		
REPORT TITLE:	**PRIMARY CARE NETWORKS**		
REPORT AUTHOR:	**Helen Clark**	**TEL:**	**0118 9822922**
JOB TITLE:	**Director of Primary Care**	**E-MAIL:**	**Helen.clark23@nhs.net**
ORGANISATION:	**Berkshire West CCG**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To provide the Health and Wellbeing Board with a briefing on the establishment of Primary Care Networks in Reading.

2. RECOMMENDED ACTION

2.1 To note the progress made in establishing Primary Care Networks and the intention for the new networks to work collaboratively with partners to develop neighbourhood services through the Reading Locality Integration Board.

3. POLICY CONTEXT

The *NHS Long Term Plan* describes Primary Care Networks as key component of delivering integrated care. Primary Care Networks (PCNs) are groupings of GP practices and other services working together to plan and co-ordinate care within local neighbourhoods typically serving 30-50,000 patients. PCNs are being established through the GP contract arrangements for 2019-24 which has meant that initial discussions have focussed around GP practices coming together. From the outset PCNs will however be expected to work closely with community services, social care and the voluntary sector to improve the wellbeing of the population they serve and provide integrated services.

4. SUMMARY

Following engagement with partners and in accordance with a process set out in the GP contract settlement for 2019-24, Berkshire West CCG has agreed the formation of 14 PCNs which went live on 1st July 2019. Six of these are in Reading:

Network name	Clinical Director	Practices	Total population
Tilehurst	Dr Caverna Tiwari	Westwood Road Grovelands Tilehurst Village	35,766
Whitley	Dr Bu Thava	London Street Milman Road South Reading/Shinfield Longbarn Lane	34,964
Reading Central	Dr Aman Bindra	Abbey Medical Centre Eldon Road Chatham Street	50,789

		Russell Street Pembroke Kennet Melrose Reading WIC	
University	Dr Elizabeth Johnston	University Medical Practice	31,034
Caversham	Dr Tom Back	Balmore Park Surgery Emmer Green Surgery	31,356
Reading West	Dr Anil Chauhan	Western Elms/Circuit Lane Tilehurst Surgery	41,438

Primary Care Networks bring together GP practices and others to plan and deliver care to populations of 30-50,000 on a neighbourhood footprint. In applying to form PCNs, practices had to demonstrate that their geographical footprint would make sense to other services and to the communities they would serve. Each PCN also had to nominate a Clinical Director to lead their work including interfacing with partners and the broader Integrated Care System and had to sign up to a mandatory network agreement which sets out ways of working between practices. As the commissioner of primary care services, the CCG had to ensure 100% of the Berkshire West population would be covered by a Primary Care Network and that any practice that wanted to join one had an opportunity to do so.

Primary Care Networks are funded through the Network Contract Directed Enhanced Service (DES). This is an optional service which sits alongside the core GP contracts between practices and the NHS. Primary Care Networks are eligible for the following funding under the Network Contract DES:

- £1.50 per head of population for the running of the network.
- Funding to individual practices of £1.76 per registered patient to support their participation in the network
- Funding for the clinical director role at the equivalent of 0.25 whole time equivalent for a network of 50,000 patients
- Investment in additional workforce for primary care for posts which will work across networks. In Year 1 this will fund one social prescribing link worker and 70% of the cost of a clinical pharmacist per PCN. Going forward PCNs will receive funding based on weighted capitation to cover 70% of the cost of employing further staff including physicians' associates, physiotherapists and paramedics thereby further diversifying the primary care workforce and enabling practices to work together to meet workforce challenges.

The current key requirements of the Network Contract DES in are as follows:

- Engaging primary care in shaping and supporting local system plans.
- Leading and supporting quality improvement and performance across member practices.
- Supporting implementation of agreed service changes and pathways.
- Working with the CCG and others to develop, support and deliver local improvement plans.
- Developing local initiatives to deliver the PCN's agenda. This is expected to include taking a lead role in integration work within the neighbourhood(s) the PCN covers (see below).
- Facilitating practice participation in research studies.
- Engaging, liaising and communicating with patients including 'seldom heard' groups.
- Delivery of extended hours appointments, replacing the current DES provided by individual practices. This is in addition to the Enhanced Access arrangements commissioned separately by the CCG.

The requirements of PCNs will build over time; in the first year there is a focus is on establishing effective relationships with partners with a view to requiring PCNs to put in place more formal

relationships in later years which could include other services joining PCNs. The Reading PCNs are now starting to consider how they can work closely with social care and the voluntary sector at neighbourhood level to support integration and improve care for residents. Initial discussions to develop this vision of integrated neighbourhood working will take place through the Reading 'Design our Neighbourhoods' event scheduled for 10th July 2019 at which the six Reading PCN Clinical Directors will be joined from colleagues across the Reading health and social care system to start to think about how services can work better together at a local level to better meet people's needs. Following this, the Clinical Directors will look to take forward joint working with partners by joining the Reading Locality Integration Board which will lead on the local delivery of neighbourhood working approaches.

Early opportunities will include considering how social prescribing link workers in PCNs may interface with existing social prescribing schemes and/or build links with voluntary sector organisations already working within the community. Later iterations of the Network Contract DES are also expected to introduce mandatory service specifications focussed on areas where PCNs can make a difference to patient care by working with partners, in particular:

- Structured medication reviews
- Enhanced care home support
- Anticipatory care
- Supporting early cancer diagnosis
- Personalised care
- CVD prevention and diagnosis
- Tackling neighbourhood inequalities

The CCG will also be able to add to these specifications by using the DES as a means of commissioning other 'supplementary' services from PCNs.

Delivery of these service specifications and broader PCN objectives will be underpinned by a focus on identifying and responding to population needs and working proactively to maintain health and wellbeing. To this end the CCG is providing each PCN with analytical support to take forward the actions and learnings identified through the recent Population Health Management programme.

The ongoing development of PCNs in Berkshire West will be overseen by the newly-established Primary Care Programme Board and work to ensure that the PCNs work with partners at a local level to deliver maximum benefit for the communities they serve will be led by Locality Integration Boards of which the new Clinical Directors will now become members as set out above.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 PCNs will look to work with partners to ensure delivery of the Reading Health and Wellbeing Strategy's eight priorities:

1. Supporting people to make healthy lifestyle choices (with a focus on tooth decay, obesity, physical activity and smoking)
2. Reducing loneliness and social isolation
3. Promoting positive mental health and wellbeing in children and young people
4. Reducing deaths by suicide
5. Reducing the amount of alcohol people drink to safe levels
6. Making Reading a place where people can live well with dementia
7. Increasing breast and bowel screening and prevention services
8. Reducing the number of people with tuberculosis

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 Primary Care Networks are expected to engage with patients through their constituent practices' Patient Participation Groups (PPGs) and other routes.

7. EQUALITY IMPACT ASSESSMENT

7.1 Not applicable

8. LEGAL IMPLICATIONS

8.1 Primary Care Networks are commissioned through the Network Contract DES (see above) which sits alongside core GP contracts.

9. FINANCIAL IMPLICATIONS

9.1 Primary Care Networks are funded through the GP Contract settlement for which the CCG receives delegated funding from NHS England. In addition, the 2019-20 NHS planning guidance requires CCGs to make available £1.50 per head of population to PCNs to support delivery of the Network Contract DES requirements.

10. BACKGROUND PAPERS

10.1 None

DATE OF MEETING:	**12th July 2019**		
REPORT TITLE:	**Care Quality Commission (CQC) Reading Local System Review - Action Plan Quarterly Update**		
REPORT AUTHOR:	**Seona Douglas**	**TEL:**	**0118 937 2094**
JOB TITLE:	**Executive Director for Social Care and Health**	**E-MAIL:**	**seona.douglas@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To provide an update of the Action Plan as a result of the Care Quality Commission (CQC) led Local System Review that the Reading system across Health and Social Care was subject to during October 2018. The focus of the Review was on older people 65 and over.

1.2 The Reading Health and Social Care System comprises of Reading Borough Council, Berkshire West CCG, The Royal Berkshire Hospital, Berkshire Healthcare Foundation Trust (BHFT) and the South Central Ambulance Service. In addition to the providers of health and social care services, Healthwatch, the Voluntary and Community-Sector organisations have been fully engaged.

1.2 The requirement of the Health and Social Care system is to devise an Action Plan in response to the recommendations of the Report. (Annexe A) .

2. RECOMMENDED ACTION

2.1 To note the Reading Health and Social Care System Action Plan.

2.2 To note the quarterly update of that action plan.

3. POLICY CONTEXT

3.1 It is important to note that the Reading System was selected for a Review, based on the significant improvements that it has made to its performance in reducing delayed transfers of care (DTOC) across the last year.

3.2 The Review was carried out under Section 48 of the Health and Social Care Act 2008. This gives CQC the ability to explore issues wider than their usual regulatory work.

3.3 The Reading Review followed on from 20 System Reviews carried out between August 2017 and July 2018. The findings from these were published in a report called

"Beyond Barriers: How older people move between health and social care in England."

3.4 The review process consisted of analysis of the local area performance data, an analysis of a range of information available from National Data collections, as well as CQC's own data.

3.5 The Reading System was also asked to provide a System Overview Information Return. (SOIR) The SOIR was submitted prior to on the on-site fieldwork and provided and enabled system leaders to give their own perspective on the challenges faced in their local area, as well as an opportunity to share the value of the positive outcomes for service users.

The Local System Reviews explored how people moved between health and social care organisations, and the mechanisms that are in place to achieve a timely response to the health and social care needs.

The final report was published by CQC on their website on 17th January 2019.

4. THE PROPOSAL

4.1 The Action Plan combines a number of agreed tasks and outcomes that were either in the planning stages at the time of the Review, or were a response to suggestions and findings of the Review inspection team.

4.2 The Report made a number of suggested areas for improvement and these are addressed and prioritised in the action plan. (Appendix A)

4.3 The Action Plan was built at a workshop in January 2019 and was signed off by the senior leadership team of the 5 lead organisations. The agreement of those key actions was also further contributed to by a wider range of stakeholders at two further workshops at which there were a full range of partner representatives, including those from our voluntary sector partners and Healthwatch.

4.4 The action plan for this quarter has been update to show the progress against each of the actions in the period since it was agreed. The update has been provided by the named action owner as nominated by their organisation.
The progress column details the work to date and the relationship between the actions and who is responsible. The RAG rating column details the progress so for example 1c is now showing as a fully completed action that has been related to actions at 1a.
Where an action remains rated as Red then this is due to the agreed timescale for completion being someway in the distance and the remaining work. e.g. at 2c there is an explanation that the action is awaiting other work detailed above at 2b to be completed.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The Reading Health and Wellbeing Strategy priorities that relate to the Reading Review:

1. Supporting people to make healthy lifestyle choices
2. Reducing loneliness and social isolation
3. Making Reading a place where people can live well with dementia

5.2 Strategic Aim 6. Making Reading a place where people can live well with dementia.
The system overview return that the 5 key organisations submitted to CQC made reference to the strategy and policy context that is relevant to both the individual

organisations involved along with joint working initiatives. However it specifically focussed on those over 65 and with Dementia and so provided a useful reflection for the system, highlighting what works well and where there are opportunities for improving how the system works for people using services.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

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".

6.2 The CQC Reviewers used a variety of methods to ensure full engagement was undertaken across the area. Areas of the community were involved in specially arranged focus groups. One of these was with the local voluntary sector partners and another with groups of carers. The Reviewers visited services such as lunch clubs and sheltered housing and day centres that are accessed by Reading's older population and so will have direct contact with individuals who use these services. The case tracking evidenced an individual's interactions with all of the organisations involved in the review. The Review also included a relational audit which was a questionnaire sent out to a wide range of partners and users of services to establish how relationships were working between the partner organisations. Healthwatch, Voluntary, Community and Social Enterprise partners (VCSE) were involved in the interviews and focus groups.

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 All aspects of the Adult Services teams undertake Equality Impact Assessments, however this was not required in this instance CQC and the Review Team were mindful of the equality framework and how it impacts on their visits and meetings. As well as qualified inspection staff they are always accompanied by experts by experience who were involved in the visits and focus groups. There was also a Relational Audit send out by CQC across a wide range of user groups to ensure a wider proportion of people were given an opportunity to express their opinions and share their experiences.

8. LEGAL IMPLICATIONS

8.1 Care Quality Commission (CQC) were commissioned to carry out a targeted programme of Local System Reviews under section 48 of the Health and Social Care Act (2008).

8.2 This particular review process was commissioned by the Secretaries of State of Health and Social Care and for Housing, Communities and Local Government.

8.3 CQC has powers under section 63(2) (b) of the Health and Social Care Act 2008, that allow them to access peoples' medical and care records. They do not need a person's consent in order to do this. All personal and confidential information reviewed as part of their onsite activity will be handled in line with CQC's information governance code of practice.

9. FINANCIAL IMPLICATIONS

9.1 The potential for any increased costs of any proposals and recommendations are minimal as this Action Plan's main focus is about strengthening the strategic development of joint working, and improvements in services already in situ. Consideration will need to be given to any changes alongside each organisations financial envelope.

10. BACKGROUND PAPERS

10.1 CQC Local System Review - Reading

Action Plan

10.2 The findings from the 20 previous reviews that have been completed to date, nation-wide, can be found in the CQC publication "Beyond Barriers", which is available at: https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england

Reading Action Plan

Care Quality Commission Local System Review of Reading

January 2019

Background to the review and development of this Action Plan

The Local System Review in Reading looked at the services provided by the following organisations:

- Reading Borough Council
- Berkshire West Clinical Commissioning Group
- Royal Berkshire Hospital
- Berkshire Healthcare Foundation Trust
- South Central Ambulance Service

Local System Reviews are carried out following a request by the Secretary of State for Health and Social Care and the Secretary of State for Housing, Communities and Local Government.

The Care Quality Commission were asked to carry out a programme of targeted reviews of local authority areas, of which Reading was one.

The main purpose of this review was to understand how people move through the Health and Social Care System in Reading with a focus on the interface between services. The Local System Review considered system performance along a number of pressure points on a typical pathway of care with a focus on people aged 65 and over.

This action plan is a response to the findings of the Reading System CQC review carried out between 6th September and 2nd November 2018 and in the report published by CQC on the 16th January in CQC'S published report dated January 2019.

This Action Plan will be monitored and progressed via a pre-existing multi-agency Reading Integration Board, this is made up of key senior representatives of all of the above organisations and led and chaired by the Director of Adult Care and Health Services at Reading Borough. .

NB. Mostly the CQC report makes reference to the Berkshire West 10 (BW10) this was a name used to describe the number of organisations involved In the joint working programme and Integrated Care System. However due to the amalgamation of the 4 CCG's into 1 and forming of the new GP Alliances this action plan for clarity now makes reference to the renamed BW7.

Action Owner	Role	Organisation
Seona Douglas	Director of Adult Care and Health Services	Reading Borough Council
Jon Dickinson	Deputy Director Adult Care and Health Services	Reading Borough Coucil
Peter Sloman	Chief Executive	Reading Borough Council
Cathy Winfield	Berkshire West CCG	Berkshire West CCG's
Cllr Graeme Hoskins	Chair of Health and Wellbeing Board	Reading Borough Council
Cllr David Absolom	Chair of ACE Committee	Reading Borough Council
Sam Burrows	Deputy Chief Officer & Director of Strategy	Berkshire West CCG's
Debbie Simmons	Director of Nursing	Berkshire West CCG's
Maggie Neale	Integrated Care System Workforce Manager	Berkshire West CCG's
Maureen McCartney	Director of Operations, CCG Urgent Care Lead	Berkshire West CCG
Melissa Wise	Head of Transformation	Reading Borough Council
Katrina Anderson	Interim Director of Joint Commissioning	Berkshire West CCG's
Liz Rushton	Assistant Director for Berkshire NHS Continuing Healthcare (Adults and Children)	Berkshire West CCG's
Tessa Lindfield	Strategic Director of Public Health	Public Health Services for Berkshire
Steve McManus	Chief Executive	Royal Berkshire Hospital Foundation Trust
Janette Searle	Preventative Services Development Manager, Wellbeing Team	Reading Borough Council
Reva Stewart	Divisional Director, Adult Community Health Services West	Berkshire Healthcare Foundation Trust

Key for RAG priority rating:

RED		Not started or priority to complete
AMBER		Work in progress to deadline
GREEN		Work Complete

Group 1 - Strategic Development Governance and System Alignment						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
1a) The vision for the delivery of health and care services in Reading was set out in the Health and Wellbeing Strategy however we did not find this to have strong engagement and agreement by all system partners. The Health and Well Being Strategy had a strong public health focus but was not driving the future direction of health and care for the city. The delivery of health and care services in Reading was influenced by the work of a collaboration of organisations, known as the Berkshire West 7 (BW7).	1. Review of Governance across: Berks West Integrated Care System , Berkshire West 7, Health and Well Being Board across 3 West Berkshire Local Authorities to ensure stronger engagement across the system. 2. Agree the Strategic Principles and statement across Berkshire West 7 through the Chief Officers Group. 3. Agree with Chairs of the 3 Berkshires West Health and Well Being Board's political commitment to the Strategic Vison and table at Health and well Being Boards to inform the public.	Seona Douglas		1st July 2019	**Risks** • National drivers e.g. Integrated Care System/Strategic Transformation Partnership change. Chief Executive Priorities change. e.g. national and local issues e.g. Brexit/local critical incident. **Mitigations** • Programme Management Office needs strong leadership. • Partnership accountability via the Health and Well Being Boards in the Berkshire West 7	The report and this action plan will be presented to Reading Health and Well Being Board on 15th March 2019. May 2019 An Integrated Care Partnership across BW7 is being presented to Members over June and July 2019 which sets out the New Governance arrangements to benefit from the joined up projects with clear leadership and Boards in relation to subject areas reporting to a delivery group / Executive and ICP Leadership Team.

1b) The strategic direction of the Berkshire West 7 was set out by Chief Officers representing the member organisations. There were strong relationships between the Chief Officers, however the strategic vision for the Berkshire West area, including Reading, had not yet been articulated into a credible strategy that was agreed by and understood by all partners. As a result, it was not clear to people who use services and staff, how the strategy for the delivery of health and care services in Reading was aligned to the vision for the Berkshire West area.	1. Co-design Strategy at Stakeholder events in the Reading Locality to inform the Integrated Care Strategy. 2. Multi System Staff Awareness events to be held across all agencies to deliver the agreed strategy as part of the sign up to fully integrate health and social care. 3. Publicise the Strategy in local areas such as Primary Care Hubs organisations internet, local forums and each organisations to use social media to spread the understanding of the commitments of Berkshire West linked with Reading .	Sam Burrows		31st October 2019	**Risks** • Lack of engagement of partner agencies in terms of Communication assistance. • Unable to release staff due to day to day demands. • Impact on other public interest issues as a result of an incident or changing priorities. • Local Adult Social Care strategies need to be linked. **Mitigation** • Chief Officers driving priorities	Progress detailed in 1a and 1c no delay anticipated

Group 1 - Strategic Development Governance and System Alignment (cont)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
1c) Health partners had led the development of the Berkshire West Integrated Care System in 2016 and were in support of merging the work of the BW7 into the INTEGRATED CARE SYSTEM. Historically there had been reluctance from some local authority partners for this direction of travel, however opportunities for alignment were being explored, supported through recent meetings between the Chairs of the Health and Wellbeing Boards in the three unitary authorities.	1. Meetings and engagement with Chairs of the Health and Well Being Boards with Local Authority and Health representatives to agreed strategy across Berkshire West 7. 2. Chief Executive Group to clarify and agree joint strategy alignment	Seona Douglas		31st May 2019		See response to 1A above The Chief Officers group meets monthly to drive the work detailed above.

1d) System leaders should evaluate governance boards and processes to ensure that there is not duplication. System leaders should also ensure that people working in the system are clear on where decisions are taken, and where accountability lies for system performance.	1. Map all Governance systems, meetings and projects to decide upon cohesive agreement regarding streamlining and averting duplication of priorities. 2. Create / update diagram of current decision making to understand the link within and across the System. 3. Make decisions on duplication across BW7 in consultation with other LA's to effect 1D (2).	Seona Douglas		30th June 2019	**Risks** • Loss of organisations autonomy. • Sufficient time allocated to complete tasks • Organisational cooperation • Production of accurate data **Mitigation** • Changes are appropriately communicated. • Chief Officer Commitment and scheme of delegation.	Work detailed in response 1a determines the direction of travel. Berkshire West 7 group details the proposed Governance in relation to the whole system
1e) The Health and Wellbeing Board should play a greater role in scrutinising health and care decisions taken at an Integrated Care System (ICS) and BW7 level to ensure that plans are aligned with Reading's Health and Wellbeing Strategy. The Health and Wellbeing Board should also review its membership and ensure greater representation of health and social care providers, including independent providers.	1. Review Health and Wellbeing Board Membership in line with the Health and Social Care Act 2012 – Chapter2 section's 194 – 199 to ensure representative membership for scrutiny and challenge. 2. Decisions of the boards mapped out at 1d need to be reported at Health and Wellbeing Board	Seona Douglas		30th October 2019	**Risks** • Failure to comply with the legislation and benefits from the wider membership and what this has to offer to progress outcomes for residents of Reading **Mitigation** • Support from the LGA Health and Wellbeing Board Support Team/Social Care Institute for Excellence to engage with relevant organisations with us if required to gain sign up	Following the agreement to 1abc and d above a review will need to be completed for submission to the Autumn Health and Wellbeing Board meeting. Original June target date amended accordingly to reflect that.

Group 1 - Strategic Development Governance and System Alignment (cont)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
1f) The Adults, Children and Education (ACE) Committee should better embed its scrutiny function and play a more significant role in holding partners to account for common goals and scrutinising future strategic plans. The ACE Committee should call health leaders to account for decisions that impact on the delivery of health and care services to people in Reading.	1. Chair of Adults, Children and Education Committee (ACE) has arranged visits with partners NHS Chief Executives to open communications and set out expectations for the scrutiny programme and future agenda setting.	Seona Douglas		31st May 2019	**Risks** • Visits do not take place in a timely way. • Lack of sign up from the Partner organisation to presentation and attendance at Adults Children's and Education Committee.	**6/2/2019:** Cllr Hoskin and Cllr Absolom along with Director of Adult Care and Health Services have agree roles of Adult Children and Education Committee (ACE) and Health and Wellbeing Board (HWBB) to assist with agenda setting **10/2/2019:** Chief Executives and Adults Children's and

	2. Meeting held to determine respective roles of Health and Wellbeing Board (HWBB) and Adult Children and Education (ACE) Committee 3. Consider other Reading needs and support for a Health Scrutiny function to consider the role of Healthwatch in that task.				**Mitigation** • Director of Adults Care and Health Services to facilitate meetings to support Elected Member.	Education Committee chair are arranged for dates over the next 6 weeks **22/5/19** The Reading Children's services are now in a company arrangement "Brighter Futures for Children" Therefore new arrangements are now in place for member reporting from them as an organisation Meetings have taken place with Cathy Winfield CCG, Will Hancock SCAS, Julian Emms BHFTr. Last of those meetings is arranged with Steve McManus RBH for June.

<u>Group 2</u> - Operational Delivery and Workforce						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**

2a) The modelling work undertaken by Integrated Care System workforce leads should be developed into a system workforce strategy and they should ensure that the local authority and the VCSE sector are involved in its development as partners and not just as providers.	1. Develop a Workforce strategy for Social and Health Care across Reading and secure the future staffing requirements to meet the needs of the system. 2. Revise Terms of reference to include all system partners alongside current workforce leads so that there is clarity of the task required. 3. Engagement event of the relevant system partners to ensure all have contributed to the strategy to ensure meets need of area and looks at integration. 4. Reports form the Workforce group need to be included in updates to Reading Integration Board	Debbie Simmonds		30th April 2020	**Risks** • Social care partners may not engage or understand the relevance of the Integrated Care System Workforce Group to their workforce so need to be informed. • Engagement with seniors managers who are able to contribute and participate in the work. • Day to day priorities and/or emergency situations occur • Individual organisations workforce priorities and strategy need to be aligned with core principles. • Previous Workforce planning undertaken by Health Education England was not fully engaged with or embedded in Berkshire West. **Mitigation** • Escalation to the Chief Officers Group to direct as required	Since CQC met with Workforce Focus Group leaders Integrated Care System Workforce Group has put into the March Meeting a 'Deep Dive' of social care workforce issues. This has led to higher engagement which will hopefully embed the social care issues within Integrated Care System Workforce Structure. Berkshire West Integrated Care System Workforce Group have agreed across the Integrated Care System a workforce methodology, Skills for Health '6 Step'. Social Care alongside all health providers and has been offered support in engaging with this model. Workshops to facilitate this are currently in development. .

Group 2 - Operational Delivery and Workforce (cont)						
CQC Findings / Suggested Area for Improvement	**Action**	**Action**	**RAG**	**Timescale for**	**Identified Risks and Mitigating**	**Progress and Recommendations**

	Required	Owner	Rating	Completion	Actions	
2b) Although people received high-quality care and support in hospital, people aged 65+ were more likely to attend hospital in an emergency when compared to the national average, there was also a higher chance than the England average that that they would be admitted.	1. Ensure that the Optum Population Health Management work programme provides the intelligence we need to identify the underlying reasons for the higher number of non-elective admissions for patients aged 65 plus. 2. Working with clinical leads and other partners, including Primary Care Networks and service users, use this intelligence to develop an action plan to help address the issues contributing to this higher than average number. 3. Reading Integration Board to oversee the implementation of the actions in this plan and to provide reassurance of progress to the Health and Wellbeing Board.	Maureen McCartney		30th September 2019	**Risks** • A focus on patients aged 65 plus may detract from work needed to address NEL's in other age groups • Need to ensure alignment with priorities of system partners • Commitment from all partners to delivery of the action plan • Resources to implement all actions identified **Mitigation** • RIB to ensure the Optum findings are used to support .an overall reduction in NELS's across all age groups and timescales for this agreed action • RIB membership to ensure joined up working and commitment across partner agencies • RIB to prioritise actions	Health and Social Care Partners have actively engaged with the Optum Population Health Management Programme and an analysis of the Optum and CCG data in relation to Non Elective Admissions has now been completed. This includes age, frailty, deprivation levels, prevalence of long term conditions and mental health and length of hospital stay. The key findings from this analysis and a list of recommended actions will be sent to members of the Reading Integration Board in the first week of June and is due to be discussed in detail at the July Integration Board meeting following which an action plan will be developed. The outputs of this will be shared with the Primary Care Networks and partners in the wider Berkshire West System.
2c) While there was extensive support for people living in care homes, the support offer in the wider community was less well developed. Schemes such as the Falls and Frailty Service and the Rapid Response Service were in place to meet people's needs at a point of crisis, however there was not an effective system risk stratification to identify people at high risk of deterioration in their condition which meant that early targeted interventions could not be put in place.	1. Address the gap identified in the work in 2B above 2. Develop an action plan to address the gaps in support to reduce risk of non-elective admissions from a community setting. 3. Include the external providers of domiciliary care and identify support for early supported discharge planning	Reva Stewart		31st December 2019	**Risks** • Funding priorities • Sufficient allocated resource to undertake the task. • Lack of System/partner engagement **Mitigation** • Chief Officer group mandate	**June 2019** No update available until Optum work detailed above at 2b has concluded

Group 2 - Operational Delivery and Workforce (cont)

CQC Findings / Suggested Area for Improvement	Action Required	Action Owner	RAG Rating	Timescale for Completion	Identified Risks and Mitigating Actions	Progress and Recommendations
2d) Two primary care alliances had recently formed – the Reading Primary Care Alliance and the North & West Reading Primary Care Alliance. The formation of the two alliances covered 25 GP practices in Reading and would allow for a more cohesive and collaborative approach to workforce planning and would represent and contribute towards a strategy for primary care within the Integrated Care System. It was expected that through the alliances, GP practices would work closer together in the development of a system risk stratification tool that would identify people at the highest risk of hospital admission.	1. Ensure the GP Workforce Group is linked in to wider system workforce strategy 2. CCG to work with GP providers to use outputs from Optum public health management work to further develop risk stratification and MDT care planning for patients at risk of a deterioration in their health, linking to care navigators as appropriate.	Helen Clark		31st December 2019		The CCG has engaged with ICS partners on the workstreams that the new Primary Care Networks (PCN) Programme Board will cover and the wider membership will ensure a broader approach to workforce planning can be taken. The first PB meeting is scheduled to take place in June, and will be followed up by a PCN Summit Meeting in July. The existing Primary Care Workforce Group will now operate as a sub-group of the new Primary Care Networks Programme Board. In addition to this, the new PCN Clinical Directors will be invited to a Workforce Workshop in July that will help them understand how the new PCN workforce funding can support ICS objectives e.g. implementing a strategic approach to Social Prescribing. The Optum work has resulted in three pilot projects for Reading practices that are due to be implemented shortly: • Caversham - Provide proactive intervention to prevent the >65 with 2-3 LTCS from becoming the >85 in health crisis. • Melrose – Housebound patients with CPOD and /or diabetes aiming to reducing A & E visits and admission by half • South Reading PCN - Improved performance on treatment outcome measures for Nepalese patient with Diabetes to prevent /reduce future attendances to services PHM leads will join the new Primary Care Networks Programme Board to ensure the roll-out of these projects and the broader PHM approach is embedded within PCNs from the outset.

Group 2 - Operational Delivery and Workforce (cont)

CQC Findings / Suggested Area for Improvement	Action Required	Action Owner	RAG Rating	Timescale for Completion	Identified Risks and Mitigating Actions	Progress and Recommendations
2e) Connected Care, an information sharing platform was already improving connectivity between services, with ambulance and A&E staff accessing GP summary care records, enabling them to make more informed decisions about a person's care. Connected Care had been rolled out within the acute and community trusts but was yet to be established in social care – plans were in place for a phased roll out in December 2018. Social care staff told us that this will make a big difference for them as they will be able see the conversations that have taken place with a person before the point that they make contact, saving time and informing better assessments	1. Deliver the currently agreed implementation plan.	Melissa Wise		31st June 2019	**Risk** • There is a risk that these projects will not Go Live as planned due to technical challenges. This risk will be robustly monitored through the Connected Care Implementation Board to ensure the project delivers to plan. **Mitigation** • To maintain reporting through the Connected Care Implementation Board.	We are on track to deliver portal access to agreed list of front line staff and managers which started May 2019.

Group 2 - Operational Delivery and Workforce (cont)

CQC Findings / Suggested Area for Improvement	Action Required	Action Owner	RAG Rating	Timescale for Completion	Identified Risks and Mitigating Actions	Progress and Recommendations
2f) System leaders told us that processes for CHC had been reviewed and extra training had been provided for frontline staff. Despite this frontline staff still did not feel processes were still clear and consequently this was continuing to cause delays. We heard how this was impacting on people being able to die in their preferred place and were given examples of people dying in hospital before the funding was approved. A progress report given to the BW7 on the CHC Quality Premium in March 2018 showed that the CCG was still not reaching the terms of the Quality Premium.	1. Evidence of dissemination through the System of the Interim funding paper agreed by the CCG. This will enable agreement for interim funding so that someone can be placed while assessment and decision regarding Continuing Heath Care are completed to prevent delay in a hospital. 2. Process redesign of the Continuing Heath Care Discharge to assess pathway and process. 3. Interim funding paper – wider communication needed of desired outcomes when the process is redesigned to ensure achieving the outcome. 4. A focus on more assessments happening in the community.	Katrina Anderson		31st July 2019	**Risks** • People wait unnecessarily for a Continuing Health Care determination. • Potentially Health Care needs are not identified early enough and may impact upon resident if they fund their own care. • Adult Social Care potentially provide for Health care needs inappropriately. • Need to review training needs against the framework agreements **Mitigation** • Multidisciplinary Team Meeting need terms of reference sharing • CHC senior manager now attending DASC Wednesday 8 am meetings to • discuss/agree DTOC issues. • Adult Social Care have received training and support from Michael Mandelstam in relation to Continuing Health Care	These communication plan and these tasks will be allocated across all the organisations by Reading Integration Board when the pathway and process are signed off.

Group 3 - Commissioning and Market Management

CQC Findings / Suggested Area for Improvement	Action Required	Action Owner	RAG Rating	Timescale for Completion	Identified Risks and Mitigating Actions	Progress and Recommendations
3a) Health and care commissioners should work together to develop the new Joint Strategic Needs Assessment and ensure that in its development it is aligned with the Integrated Care System's Population Health Management approach.	1. Engage partners and service users to join existing boards to influence and contribute to meeting the needs in the Joint Strategic Needs Assessment (JSNA). 2. Ensure all partners are involved in decisions regarding Joint Strategic Needs Assessment (JSNA and Public Health Monies 9PHM). 3. Make best use of IT to present and share the information across the various organisations and staff groups.	Tessa Lindfield for Joint Strategic Needs Assessment Maureen McCartney for Population Health Management		31st December 2019	**Risk** • There is a continued risk that organisations will continue to use the outputs of the Joint Strategic Needs Assessment and Public Health Monies work separately given the differing timescales of delivery. **Mitigation** • This is mitigated by both TL and MM being part of both working groups	
3b) Health and care commissioners should develop a joint commissioning strategy. Health and care commissioners should agree on commissioning intentions across health and social care and work together to develop a joint market position statement.	1. Directors across Berkshire West set high level commissioning priorities for a joint commissioning strategy across Berkshire West and this will now be progressed to agree joint commissioning programme. 2. Develop and agree Joint Market Position statement across the 3 Local Authority's and Clinical Commissioning Group for areas that are common to all partners	Seona Douglas		31st December 2019	**Risks** • Commissioning capacity in all partner organisations remains a risk to this work. **Mitigation** • Additional capacity is being explored through the Better Care Fund to expedite this work.	An initial meeting of BW7 Commissioners have agreed scope to progress work. A further meeting in March will develop a work plan.

Group 3 - Commissioning and Market Management (cont)

Appendix A

CQC Findings / Suggested Area for Improvement	Action Required	Action Owner	RAG Rating	Timescale for Completion	Identified Risks and Mitigating Actions	Progress and Recommendations
3c) System leaders should focus on developing prevention and early intervention services that increase the support offer in the community. A system approach to risk stratification and active case management should be developed to identify people at the highest risk of hospital admission.	1. MDT Risk stratification progressing as part of care planning, but will be accelerated and broadened in order for partners and other projects to benefit from understanding this risk profiling approach. 2. The Neighbourhood Care Planning Group (NCPG) pilot project needs to be reviewed to ensure the outcomes are aligned with the CQC outcomes. Consider if the information GP's hold in their GP frailty register could link into the pilot.	Maureen McCartney		31st September 2019	**Risks** • There is a risk that the National Care Planning Group work is completed in isolation of the planned system wide neighbourhood work. **Mitigation** • All planned work related to Neighbourhoods is cited through the Reading Integration Board	Health and Social Care Partners have actively engaged with the Optum Population Health Management Programme and the outputs from this and the analysis and recommendations in the Paper referred to in Action 2b) support the action required for 3C .
3d) The role of the Reading Integration Board should be further developed to enable joint commissioning outside of the Better Care Fund and be more closely aligned to the Health and Wellbeing Board	1. Review Terms of Reference and membership. 2. RIB chair and PMO to engage with HWBB Chair to identify options for better alignment. 3. As Joint Commissioning develops utilise the Reading Integration Board as the appropriate Governance vehicle for monitoring	Melissa Wise		31st March 2020	**Risks** • Lack of sufficiently experienced Programme Management capacity. • Joint commissioning develops at a slower pace than expected. **Mitigation** • Identify internal resources if required to undertake required work.	Further to discussion with RIB Chair a 5 minute recurring item will be added to the Reading Integration Board (RIB) agenda for May 2019 onwards to discuss and monitor progress made / opportunities arising at the Berkshire West 7 Joint commissioning board and consider ongoing conversations re joint commissioning opportunities. Meeting to be planned for late June to allow Director and Chairs of both boards to discuss better alignment of Reading Integration Board (RIB) and Health and Wellbeing Board (HWBB). To also agree any necessary changes to terms of reference and membership.
3e) Market management was undertaken by the local authority and the CCG separately although system leaders stated an intention to move towards a more joined up approach. The local authority had a robust market position statement and were undertaking work to update this.	See 3b above	Seona Douglas pending appointment of new Asst. Director Commissioning		30th September 2019	**Risks** • Commissioning capacity in all partner organisations remains a risk to this work **Mitigation** • Additional capacity is being explored through the Better Care Fund to expedite this work.	**22/5/2019** A Joint Commissioning Group as a part of the new Governance arrangements described above in 1A has been set up across the Berkshire West 7 group to address the commissioning issues more widely than Reading BC and the CCG. The group will be informed by the JSNA work, the Optum project and the 3 LA's (Reading Wokingham and West Berkshire) Market Position Statements.

Group 4 - Communication & Engagement

CQC Findings / Suggested Area for Improvement	Action Required	Action Owner	RAG Rating	Timescale for Completion	Identified Risks and Mitigating Actions	Progress and Recommendations
4a) In developing the next Health and Wellbeing Strategy, due for publication in 2020, the local authority should engage system partners and ensure greater alignment with the wider Berkshire West Integrated Care System strategic intentions and those of the Buckinghamshire, Oxford and Berkshire West STP	1. Using the Health & Wellbeing Board as the vehicle for discussion undertakes early scoping with partners to develop the strategic intentions for the strategy. 2. Ensure System Leaders are engaged in approving the strategy and associated action plan. Ensuring alignment to the Integrated Care System (ICS) strategic intentions as appropriate. Joint ownership of the Action Plan is secured.	Tessa Lindfield		30th September 2019	**Risks** • As the Integrated Care System work evolves there is a risk that developments will not be included in the Health & Wellbeing Strategy as it has a finite publish date. • Ensure sufficient time is allowed to capture service user voice through partnership groups	The chairs of the Wokingham, Reading and West Berks Health and Wellbeing Boards agreed in April 2019 to pursue having a Berkshire West shared joint health and wellbeing strategy. This will be one strategy that covers the Berks West footprint thus aligning with the Berks West ICS (ie what was BW7/ BW10 footprint). There would still be borough specific sections to the strategy to ensure a sufficient local focus remains. After being published a Borough specific action plan would then be developed to sit under the strategy. The Reading HWB will receive a paper on 12th July 2019 that outlines a proposed process for the development of this shared joint HWB strategy. The same paper is going to the Wokingham and West Berks HWBs at a similar time point to ensure progress occurs across all 3 LAs within the same timeframe
4b) While relationships between system leaders are strong, improvements in relationships between health and local authority partners could be improved. As the system moves towards greater integration at a Berkshire West level, system leaders should ensure that staff are engaged in the process and that health partners and working with colleagues in the local authority to progress plans.	1. Public Health Consultants are working at a Berkshire West level to create the Framework needed to coordinate and bring groups together on a more formal basis. 2. Action plan to decide how we really engage with each other and the wider stakeholders and public. 3. Staff from all organisations are involved in the further development of the Integrated Care System work to ensure alignment and a joined up approach.	Cathy Winfield		31st August 2019	**Risks** • Potential changes to elected members and senior leaders with a subsequent reduction in commitment to joint working • Lack of capacity to deliver the ICP work programme • Lack of resource to support the development of the joint strategy **Mitigation** • Secure full organisational support for joint working and embed robust governance at locality and system level to reduce the impact of loss of specific individuals • Review the resource	1. Reading Health and Well Being Board to agree and implement revised governance for Berkshire West ICP by August 2019. This will create the framework needed to coordinate the joint working and engage staff. 2. All ICP partners agree to develop a joint strategy for Berkshire West by July 2020, coordinated by public health, with clear identification of specific priorities for each local authority area (see 4a). RAG rating is now Amber as we have ICP proposals and joint strategy proposals now worked up and going to HWB with this plan..

(4b continued)					associated with the current BW10 so that this can be deployed on agreed priorities and makes more efficient use of current capacity by doing things once and sharing. Each ICP partner to agree how the development of the new strategy will be resourced.	

Group 4 - Communication & Engagement

CQC Findings / Suggested Area for Improvement	Action Required	Action Owner	RAG Rating	Timescale for Completion	Identified Risks and Mitigating Actions	Progress and Recommendations
4c) There were opportunities to make better use of the VCSE sector services market. Health and care commissioners should work with VCSE sector providers to support in the development joined up service offers.	1. Linked to 3B above 2. Refresh mapping exercises previously undertaken across the Clinical Commissioning Group and Reading Borough Council to align existing Voluntary Sector and Social Enterprise Commissioning and ensure Voluntary sector groups included across board.	Seona Douglas pending appointment of new Asst. Director Commissioning		30th September 2019	**Risks** • Capacity in commissioning teams across partner organisations is proving challenging. **Mitigation** • A realistic approach to be adopted to what can be achieved and maximise the resources available.	The Joint Commissioning Board described in 3e has a sub group focussed on Voluntary Sector commissioning led by the Public Health Consultant in West Berkshire and will report to the Joint Commissioning Board.
4d) Carers had varying experiences of accessing support in Reading. Statutory services were not always well linked to VCSE sector services that could provide support to carers. The Reading Carers Hub provided information and advice for unpaid carers however carers felt that they were not always well supported to access services and many felt they had to reach crisis point before they were offered support.	1. Raise awareness of third sector support for carers amongst all organisations across the system 2. Promote Carers Week (June) and Carers Rights Day (November) activities to create network opportunities	Jon Dickinson		30th September 2019	**Risks** • Lack of understanding legislation and local services **Mitigation** • Utilise local HUB's GP surgery's and on-line solutions to inform as widely as possible	

Group 4 - Communication & Engagement (cont)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
4e) Carers we spoke with were concerned about the availability of respite care and that those who did not fund their own care had limited choice and control over what respite services were available. Carers felt that carers issues are not well understood and more could be done to join services together and promote common issues	1. Carers needs to be incorporated in to the roll out of the new strength based model work – Conversations Count within Reading Borough Council see in 2 c above Further training to be rolled out across the department and partners re identifying carers who may have significant caring role. 2. System partners to understand the joined up carers strategy – and to align in the future. 3. Develop the 'getting a break' section of the 'Caring in Reading' information pack which is disseminated online within Reading Services Guide) and in hard copy so as to improve awareness of respite services	Jon Dickinson		31st March 2020	**Risks** • Further analysis and identification work if needed. **Mitigation** • Explore involvement from Healthwatch and Carers Hubs	
4f) Strategic provider forums which bring together staff from across health and social care providers should be established to enable staff to discuss operational processes and overcome barriers to joint working.	1. RBC will facilitate provider forums across all service areas ensuring representatives from partner organisations are represented.	Seona Douglas pending appointment of new Asst. Director Commissioning		31st September 2019	**Risks** • Attendance at the sessions • Partaking and absorbing the messages to champion in the workplace. • Day to day priorities **Mitigation** • Inclusive workshop style to encourage understanding. • Commitment of Managers to release staff to participate.	This is a wider matter in relation to response for 1a above therefore the timescale has been adjusted from the original July date to enable this to be considered further and established across the wider footprint.

Group 4 - Communication & Engagement (cont)						
CQC Findings / Suggested Area for Improvement	**Action Required**	**Action Owner**	**RAG Rating**	**Timescale for Completion**	**Identified Risks and Mitigating Actions**	**Progress and Recommendations**
4g) In the establishment of pathways care, operational leads should ensure they are understood and signed up to by staff across the system and that they are clearly communicated to people so that they understand what options are available to them when they are discharged from hospital	1. To Review all the care pathways to provide a clear understanding of the hospital discharge journey for residents. 2. To provide public information in relation the pathway so that there is clarity in relation to a range of options.	Mark Robson		30th September 2019	**Risks** • Allocated time • Day to day priorities. **Mitigation** • Commitment to improve the resident experience of hospital discharge.	A Task and Finish Group 1t meeting was commenced in March 2019 and is working to review and revise pathways.

READING BOROUGH COUNCIL

REPORT BY EXECUTIVE DIRECTOR SOCIAL CARE AND HEALTH

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**12th JULY 2019**		
TITLE:	**Integrated Care Partnership Governance proposals (covering report)**		
LEAD COUNCILLOR:	**CLLR G HOSKIN**	**PORTFOLIO:**	**HEALTH, WELLBEING & SPORT**
SERVICE:	**SERVICE DEVELOPMENT & PARTNERSHIPS TEAM**	**WARDS:**	**ALL**
LEAD OFFICER:	**MICHAEL BEAKHOUSE**	**TEL:**	**01189 373170**
JOB TITLE:	**INTEGRATION PROGRAMME MANAGER**	**E-MAIL:**	**MICHAEL.BEAKHOUSE@READING.GOV.UK**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report seeks approval for a set of proposed strategic integration objectives for Health & Social Care partners across Berkshire West; together with proposals for redesigned governance and staffing arrangements (collectively titled the Berkshire West Integrated Care Partnership / BWICP) that will help to deliver these strategic objectives.

1.2 The proposed governance structure would merge the current Berkshire West Integration Programme and the Berkshire West Integrated Care System into a new, single governance system for driving integration across Berkshire West. It is important to note that Local Authority transparency and public accountability will be retained as part of the Governance.

1.3 The important drivers behind this proposal include a recommendation arising from the CQC Local System Review, which highlighted the need to ensure greater synergy between the (currently disparate) integration programmes.

1.4 Reading would wish to ensure that the Voluntary Community Social Enterprise organisations are part of the Boards and work groups due to the critical role they play in the community.

1.5 The following documents are appended:

- Appendix A - Berkshire West Governance (Executive Summary)
- Appendix B - Berkshire West Governance (Summary Report)

- Appendix C - Berkshire West Governance (Main Report)

2. RECOMMENDATION

The Adult Education and Children's Committee held on 1st July 2019 endorsed the recommendations:

2.1 That the strategic objectives outlined in the Main Report (Table 3) be approved as the basis of the BWICP work programme in 2019/2020.

2.2 That Reading Borough Council agree to adopt the Governance arrangements and structure outlined in the Main Report (Figures 1 & 2 respectively) for the BWICP.

2.3 That Reading Borough Council adopt the Terms of Reference for the Governance Boards and Groups, as outlined in appendices 5a-5c of the Main Report.

2.4 That Reading Borough Council adopts the principles for resourcing the BWICP, as outlined in Section 5 of the Main Report at the same level as the other Local Authorities in the partnership.

The Health and Well Being Board is requested to note the Report and Decisions above.

3. POLICY CONTEXT

3.1 This decision is being made within the context of Reading Borough Council's Health & Wellbeing Board Strategy (2017-2020), which has been aligned to local integration plans and aims to promote seamless care by the right agency at the right time and in the right place. The proposal supports this strategy by refining existing governance arrangements into a new formulating that is better-able to deliver integration across Berkshire West.

3.2 While it is not a formal policy, the proposals do reflect the direction of travel set by the new NHS Long Term Plan (LTP). The LTP will refocus future activity most notably for Health partners although there will be an impact on local government, since the LTP will shape future health and social care activity – for example, it places a requirement upon health partners to develop Primary Care Networks, which in turn may well accelerate further integration at a Locality and Neighbourhood level.

4. THE PROPOSAL

4.1 Current Position:

There are currently a range of governance boards and bodies across Berkshire West in respect of integration; these are laid out in detail in Appendix 3 (Section 3, "Current Context").

It was agreed by the Chief Officers Group (in late 2018) that the Berkshire West 10 Integration Programme (BW10) and the Berkshire West Integrated Care

System (BWICS) would be combined. This was further reinforced by the CQC System Review in Reading, finalised late 2018, which also concluded that there was a need to integrate the two Programmes. The Chief Officers Group workshop on 19th November 2018 agreed that as one of its emerging three priorities, the governance of the two Programmes should be combined. This appended documents set out the proposals for how this might be done. The papers have already been considered by a number of extant groups across Berkshire West, and are now being brought through the relevant Boards/Executives of the relevant organisations for final approval.

4.2 Options Proposed

The proposed governance structure would merge the current Berkshire West Integration Programme and the Berkshire West Integrated Care System into a new, single governance system for driving integration across Berkshire West.

While full details are contained within Appendix 3 (Section 4, "Governance", and Section 5, "Support Arrangements"), the following key points should be noted:

- The proposals envisage a greater role for Elected Members, with their attendance being required at meetings of the proposed Leadership Board (with 6, bi-weekly meetings per year).

- The proposed staffing changes would (while releasing funds for reallocation, at an amount to be confirmed) reduce Reading's Integration staffing establishments from 3x FTE posts to 1x FTE post, potentially limiting the number of integration projects undertaken at a local level.

4.3 Other Options Considered

The Chief Officer's Group gave consideration to maintaining the current governance arrangements. However, as this would not address the CQC's finding (referenced in 4.1) or the publication of the NHS Long Term Plan, this was not deemed to be a viable option.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The proposals align with the following Corporate Plan priority area:

1. To protect and enhance the lives of vulnerable adults and children

Closer alignment and joint working with health and social care partners from across Berkshire West will support exploration of joint commissioning opportunities for health and social care services. This has the potential to create more services that are better-wrapped around the health and social care needs for local residents.

5.2 The proposals align with the following strategic aim for Reading Borough Council:

- To promote equality, social inclusion and a safe and healthy environment for all

Closer alignment and joint working with health and social care partners from across Berkshire West will help to ensure that an equitable offer is provided to residents in Berkshire West, by aligning the services offered by Reading with the standards and practices delivered by neighbouring West Berkshire and Wokingham Borough Councils. It will also help to ensure equity of practice in health settings (such as Royal Berkshire Hospital and Berkshire Health Foundation Trust), where historically they may have had to support residents from the three local authority areas according to three different sets of procedure.

6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 In the course of writing the appended reports, the author (Nick Carter, Chief Executive Officer for West Berkshire Council) explored and developed the proposals with a number of extant groups (such as the Berkshire West 10 Delivery Group, which includes Reading's Healthwatch representative, and members of partnerships organisations such as Berkshire Healthcare Foundation Trust, Royal Berkshire Hospital, Berkshire West CCG, West Berkshire Council and Wokingham Borough Council). Feedback was requested from board members and consideration at the Chief Officers Group about how best to incorporate the proposals in order to reflect the information received to ensure that any approach continue to deliver clear outcomes for residents of each of the 3 Local Authority areas.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equalities Impact Assessment is not relevant to the decision; the changes proposed are purely internal for the organisations involved, and do not directly impact on the service offer to local residents. No change to the service offer is planned as a result of these proposals.

8. LEGAL IMPLICATIONS

8.1 There are no legal implications to the proposal; Reading Borough Council has already made the legal decision to be an active member of the Berkshire West 10 partnership, and these proposals relate to the naming and structuring of this partnerships.

9. FINANCIAL IMPLICATIONS

9.1 Reading currently has a Programme Management Office budget of £150,000 per annum (sourced from the Better Care Fund), which funds 3 x full-time equivalent posts. Under this proposal, the staffing levels would be reduced which may release funding that could be redeployed to other initiatives. However, the proposals have not yet identified the level or nature of these reductions, and consequently at this stage it is not possible to identify the full financial implications or risks. There are no capital implications identified as part of the proposals.

9.2 The proposals include a set of strategic priorities for integration which would form the basis of the Berkshire West Integrated Care Partnership's integration efforts. These include a focus on exploring joint commissioning opportunities. This has the potential to generate value for money by (for example) reducing contract costs by jointly commissioning services with Berkshire West partners.

10. BACKGROUND PAPERS

10.1 Reading Better Care Fund (BCF) Submission 2017-2019 (September 2017).

10.2 Care Quality Commission (CQC) Local System Review: Reading (October – November 2018).

This page is intentionally left blank

Proposed Creation of Integrated Care Partnership - Summary Report

Committee considering report:	Health and Wellbeing Board
Date of Committee:	
Portfolio Member:	Please select:
Date Head of Service agreed report *(for Corporate Board)*	
Date Portfolio Member agreed report:	
Report Author:	Nick Carter
Forward Plan Ref:	

1. Purpose of the Report

1.1 To set out the arrangements for the proposed creation of an Integrated Care Partnership across Berkshire West

2. Recommendation(s)

(1) The strategic objectives outlined in the main report (Table 3) are approved as the basis of the BWICSs work programme in 2019/20 noting that these are likely to change as a new strategy is developed.

(2) The taxonomy summarised in Fig 1 is used to frame the governance arrangements for the BWICP.

(3) The governance structure as set out in Fig 2 is adopted for the new BW ICP.

(4) The terms of reference for the BWICP Leadership Board, BW10 Executive and BW10 Delivery Group as set out in Appendices 5a-c of the main report are agreed.

(5) The principles for resourcing the ICP as set out in section 5 are agreed.

2.2

3. Implications

3.1 **Financial:** The new governance arrangements will deliver a saving in programme management costs. These are likely to be most apparent to the three local authorities which currently fund the project management costs through the Better Care fund. Any saving in project management costs can be used to fund other activities within the BCF. NHS costs through use of the NHS Transformation Fund are likely to be less

affected.

3.2 **Policy:** This report has no policy implications as such although it does reflect on the direct now set by the new NHS Long Term Plan (LTP). This will refocus future activity most notably for Health partners although there will be an impact on local government since the LTP will inevitably shape future health and social care activity. The development of Primary Care Networks may well accelerate further integration at a Locality and Neighbourhood level.

3.3 **Personnel:** There will be some rationalisation in the current staffing supporting programme and project management activity. A number of staff are currently contracted on an interim basis or are on short term contracts so exit costs will not be a consideration. The proposals do envisage a greater role for Elected Members. This is seen as overdue but it will require Members to attend meetings of the Leadership Board.

3.4 **Legal:** There are no legal implications associated with this report. The proposed Integrated Care Partnership is not a legal entity in its own right.

3.5 **Risk Management:** Prior to the emergency of the LTP early in 2019 it had already become clear that the current governance arrangements which involved the Berkshire West 10 and the Berkshire West ICS were unsustainable. It was recognised both across the partners and externally that the two needed to be consolidated. The publication of the LTP has effectively changed the wider landscape so the opportunity has been taken to address both at the same time. Doing nothing was not an option.

3.6 **Property:** This report has no property implications.

3.7 **Other:**

4. Other options considered

4.1 A wide ranging discussion has taken place with Health and NHS Partners regarding the governance moving forward. This has involved considering a number of proposals. The conclusion of all these discussions in the Paper now before you. Some work, most notably around the work programme and supporting Programme Boards is still ongoing and will continue to be refined over the coming months.

Executive Summary

In this section please provide any necessary background information that explains why you are asking for this decision to be made and a summary of any key information that is essential for Members to enable them to make a fully informed decision i.e. background, proposals, options, key issues, conclusions. Please do not add any additional headings to this section.

5. Introduction / Background

5.1 Attached at Appendix A and Appendix B are two reports which have both been written to provide a detailed explanation of the governance proposals supporting the new Berkshire West Integrated Care Partnership (ICP). The second main report provides a more detailed background for those who have not been involved in the previous partnership arrangements and who are not fully sighted on the new NHS Long Term Plan.

5.2 In essence both reports cover the following;

(1) a description of the health and social care partnership arrangements that have been in place since 2013 and a review of their effectiveness;

(2) an explanation as to why the governance needs to change;

(3) proposals regarding the new governance for the suggested Integrated Care Partnership (ICP) which include proposals to increase Elected Member representation.

(4) comments regarding future programme management costs which should fall

6. Conclusion(s)

6.1 The recommendation reflect each of the above.

7. Appendices

7.1 Appendix A – Proposed Governance Arrangements for a Combined Berkshire West ICS and Berkshire West 10 – Executive Summary

7.2 Appendix B – Proposed Governance Arrangements for a Combined Berkshire West ICS and Berkshire West 10 – Main Report

7.3

Corporate Board's recommendation:

*(add text)

To be completed after the Corporate Board meeting.

Proposed Governance Arrangements for a Combined Berkshire West ICS and Berkshire West 10 – Executive Summary – Final Draft

1. Introduction

1.1. It was agreed late last year that the Berkshire West 10 Integration Programme (BW10) and the Berkshire West Integrated Care System (BWICS) would be combined. This was further reinforced by the CQC System Review in Reading, finalised late last year, which also concluded that there was a need to integrate the two Programmes. The Chief Officers Group workshop on 19th November 2018 agreed that as one of its emerging three priorities, the governance of the two Programmes should be combined. This Paper sets out the proposals for how this might be done. The paper has already been considered by a number of extant groups and is now being brought through the relevant Boards/Executives of the relevant organisations for final approval.

2. Background

2.1. The BW10 was formed in 2014. Its primary purpose was to set a future direction for the integration of health and social are across Berkshire West, and then oversee the implementation of the resulting Programme. The BW10 comprised the four CCGs (at that time), Berkshire Health Care Foundation Trust (BHFT), the Royal Berkshire Hospital Foundation Trust (RBH), the South Central Ambulance Service (SCAS) and the three Unitary Authorities.

2.2. Much of the initial focus of the BW10's work was focused on the Elderly Frail and overseeing the introduction of the Better Care Fund (BCF). Initial governance was focused around the Chief Officers Group (COG) which had been established in 2013 following the implementation of the Health and Social Care Act (2012). As the work of the BW10 grew so did the governance needed to support an increasing scope. A BW10 Integration Board was subsequently established with a supporting BW10 Delivery Group and three Locality Boards based on the boundaries of the three Unitary Authorities.

2.3. The BW10 Integration Board subsequently developed a Vision and work programme which went beyond the Elderly Frail work but this proved difficult to establish for a number of reasons. By 2018 attendance at the BW10 Integration Board had become an issue and it was agreed that its function would merge with that of the Chief Officers Group. The BW10 Delivery Group has continued to meet, as have the three Locality Boards in some form.

2.4. Reflections on the BW10 governance suggest that there have been issues sustaining senior leadership commitment particularly in light of the emergence of the BW10 Integrated Care System (BWICS). The BW10 governance arrangements have also not included Elected Members – they were never formally part of the structure. It is also unclear the degree to which the BW10 governance has linked effectively with the Health and Wellbeing Boards in Reading, West Berkshire and Wokingham.

2.5. The Berkshire West ICS (BWICS) emerged in 2016. From the beginning it was agreed that Health partners alone would start the agreed Integration Programme and that local government partners would join the ICS after two years. The focus to date has been on integrating within Health not integrating Health and Social Care. This has left the ICS very much a Health entity. The only non Health representation on BWICS is the Chair of the BW10 Integration Board who is currently one of the Unitary Authority Chief Executives. The BWICS has progressed well on a number of its objectives and is seen to be one of the more advanced in the country.

3. Governance Proposals

3.1. Before considering future governance proposals it is perhaps worth reflecting on the current strengths and weaknesses of the existing governance arrangements across Berkshire West.

(1) Strengths

(a) Strong lasting relationships most notably amongst Health partners where there has been less churn in senior leadership.

(b) Commitment to partnership working which in some areas has borne improved outcomes.

(c) An effective BWICS governance structure which appears to have supported progress at some pace.

(d) An active and engaged BW10 Delivery Group that has some notable achievements under its belt.

(e) Some effective sub groups within both the BW10 and BWICS structure which have also delivered significant achievements.

(2) Weaknesses

(a) Current lack of agreed vision and strategic plan.

(b) Capacity - most notably at senior leadership level.

(c) Lack of engagement with Elected Members and with Health and Wellbeing Boards.

(d) Complex local arrangements with potential duplication.

(e) Strategic direction is fluid and subject to change – most notably within the NHS. This could undermine the effectiveness and sustainability of any agreed governance arrangements.

3.2. When this Paper was originally conceived late last year it was based on the expectation that the two existing Programmes (BW10 and BWICS) simply needed to be combined. The publication of the NHS Long Term Plan (NHS LTP) in January 2019 has however changed that. It has heralded a shift in the landscape over which NHS services will be planned and delivered over the next 10 years. This has potentially significant implications for Berkshire West and it would seem appropriate to shape this Paper around this new emerging landscape. Quite how some of these

proposals will finally emerge has yet to be clarified so some assumptions have had to be made. That said there is an opportunity now to shape something that both reflects national expectations whilst at the same time protecting the strong partnership arrangements that have already developed across Berkshire West. This will hopefully provide the foundation to strengthen joint working going forward and ensure Berkshire West has a strong and effective voice within the new Buckinghamshire, Oxfordshire, Berkshire West (BOB) ICS (BOB ICS) whilst also reflecting the Localities and Neighbourhoods that lie within Berkshire West.

3.3. Reflecting both the proposed direction in the NHS LTP and some of our own local architecture it would seem appropriate to base our future governance around the following taxonomy:

(1) *System* – the ICS will be the local Health and Social Care System. NHSE have determined that this should be Buckinghamshire, Oxfordshire and Berkshire West (BOB), the same footprint as the current Sustainability and Transformation Partnership (STP). The ICS will therefore no longer be based on Berkshire West. There is also a discussion around the future arrangements for Clinical Commissioning Groups (CCGs). There is a suggestion that there will be one CCG for each ICS: (the remainder of this Paper therefore refers to two ICSs - the current Berkshire West ICS (BWICS) and the newly emerging Buckinghamshire, Oxfordshire and Berkshire West ICS (BOB ICS) which it is assumed will replace the BWICS in time. In the context of this Paper the BOB STP and the BOB ICS should be assumed as one and the same thing!):

(2) *Place* – Berkshire West would be the focus for Place based planning. At this point there would appear to be an expectation that Place will be an important element of the new BOB ICS. A function of this Paper is to start the discussion as to what this Place based planning might look like:

(3) *Locality* – this would be each unitary authority area. The Health and Wellbeing Boards would remain the main planning unit at this level along with the Health Scrutiny function.

(4) *Neighbourhoods* – Primary Care Networks (PCNs) feature prominently within the NHS LTP. Work has already started on developing these across Berkshire West. The expectation is that as planning units PCNs would support a population of between 30,000 – 50,000 residents. Little has been done yet to consider the governance arrangements at Neighbourhood level and this Paper only comments superficially on this level of governance. The area of work is one of the other three priorities agreed by the Chief Officers Group in November last year.

3.4. Fig. 1 shows diagrammatically how this would work locally. It has been adapted from a diagram produced by the BOB STP.

3.5. Given this context some guiding principles have been set for the newly proposed governance arrangements:

(1) They should be built on the 'four level taxonomy' as already outlined providing clarity as to what each level is responsible for and how coordination will be effected between the different levels. Planning and delivery need to be differentiated as two different things.

(2) The new arrangements should be no more burdensome than the existing ones - ideally less so:

(3) The arrangements need to directly support the strategic direction adopted across Berkshire West and provide an effective means of working within the new BOB ICS.

(4) What is in place should be inclusive most notably with regard to Elected Members.

3.6. The absence of a vision and strategic plan creates something of a vacuum in terms of trying to shape governance around what needs to be achieved. Ultimately the work programme will be a combination of;

(1) what needs to be done to support the BOB ICS. (The BOB ICS has already produced an overview plan which highlights that it will delegate a significant amount of planning responsibility to Place – see Table 1);

(2) aspirations at a Berkshire West level (some of which have been articulated through the Chief Officers Group) alongside the existing aspirations of the BWICS and BW10. This requires further work;

(3) a consideration of the aspirations of each Locality as expressed through their Health and Wellbeing Strategies and;

(4) the emerging aspirations of Neighbourhoods largely through Primary Care Networks.

3.7. Table 1 highlights how the BOB ICS currently sees the role of Place. This is summarised below using the seven themes within the NHS LTP (subject to change);

(1) *Integrated Care* - Designed and delivered at Place. The System role would be to share good practice and encourage collaboration.

(2) *Prevention and Inequalities* - Designed and delivered at Place. As above the System role would be too share good practice and encourage collaboration.

(3) *Care Quality and Outcomes* - Designed and delivered at System level but delivered at Place or Organisational level

(4) *Workforce* - Designed by system with delivery left to Place or Organisation.

(5) *Digital* - Designed and delivered at Place. The System role would be to share good practice and encourage collaboration.

(6) *Efficiency* - Designed and delivered at Place Level and amalgamated / added to at System level.

(7) *Engagement and Partnerships* - Designed and delivered at Place level with STP / ICS sharing good practice and encouraging collaboration.

3.8. The main report attempts to do a similar exercise using the same themes from the NHS LTP. This time a Place perspective is taken analysing the relationship between Place and Locality and then a Locality perspective which analyses the relationship between Locality and Neighbourhood. This will require more discussion but it is an important consideration for these governance proposals.

3.9. With regard to the governance of Place the following are proposed and are shown in Fig.2;

(1) An Integrated Care Partnership (ICP) is created for Berkshire West given the titles ICS and BW10 are now no longer appropriate. The term ICP has been used elsewhere as a sub grouping of the ICS. It is felt the term implies a direct link to the BOB ICS which is seen to be important.

(2) The Leadership and Executive Boards within the existing Berkshire West ICS governance are retained. Their terms of reference are broadened to reflect the agreed strategic direction of the ICP. Membership would also need to be broadened and the following is suggested:

(a) ICP Leadership Board – the current membership would be expanded to include the Chief Executive and Elected Members from each local authority in the form of an Executive Member and the Chair of the Health and Wellbeing Board. The Board would retain an Independent Chair:

(b) ICP Executive Board – the current membership of this Group will need to be rationalised if it is to remain effective. The three Unitary Authority Chief Executives would join this Group along with the existing Chief Executives. It is proposed that each CEO would also be accompanied by one of their Directors. The Group would also contain the existing clinical representation. The Independent Chair of the ICP Leadership Board would also be invited to attend as an observer. The Executive Board would be chaired by a Chief Executive which would be revolved annually between the NHS and local government.

(c) The BW10 Delivery Group would become the ICP Delivery Group. The Chair of this Group would be a Chief Executive drawn from the Executive Group and rotated on an annual basis. The nominated Chief Executive would be from the opposite sector to the Chief Executive chairing the Executive Board. The expectation would be that this Group would be represented by Directors of Strategy (NHS), Directors of Adult Social Care (DASS), Children's Services (DCS) or their equivalents. It is proposed that the existing Programme Boards and Enabling Groups would report through the ICP Delivery Group going forward and not directly to the Executive as at present. The

Chairs of the Programme Boards and Enabling Groups would therefore also be expected to be represented on the ICP Delivery Group.

(d) Members of the Executive Board are already Members of the BOB STP Chief Executive's Group and this should provide an effective link at a strategic level to the BOB ICS. The BOB ICS is currently reviewing its own governance to ensure that it is 'fit for purpose' given the roles and responsibilities that the BOB ICS will assume. A watching brief will need to be maintained on this.

(3) Consideration needs to be given as to how Locality based planning interacts with Place based planning in this new arrangement. A stronger relationship needs to exist between the Health and Wellbeing Boards and the ICP. There will be a direct link at the ICP Leadership Board. It is also proposed to create a Prevention Programme Board which may be an appropriate place to take forward the joint working that has already been initiated between the three Health and Wellbeing Boards. This issue is reflected on in greater detail within the Main Report.

(4) No proposals are made in this Paper concerning the governance of the emerging Primary Care Networks. Once agreed this will need to fit appropriately with the 'four level taxonomy' outlined in this Paper. At this point it is proposed that a strong link is created between Neighbourhoods and Locality.

(5) There will be a need to expand the number of Programme Boards given that the work of the existing COG and BW10 work streams will need to be incorporated within the new ICP governance. This is reflected in more detail within the Main Report.

(6) The Chief Officers Group would be disbanded given its role would be assumed by the ICP Executive Board.

(7) It would be for Localities to decide whether they retained their BW10 Locality Integration Board and if so in what form and what its terms of reference would be.

5. Resourcing the new arrangements

5.1 The Chief Officers Group has already assumed that the support for this new governance will be found from within existing resources. There are in effect two sources;

(1) The Berkshire West ICS – there is a Programme Office in existence which includes 2 FTE with a total budget of £105k (staff costs only)

(2) The Berkshire West 10 – there is a BW Programme Office which includes 2 fte and has a budget of £730k. In addition to this each locality also has dedicated resource. In total the Locality resource comes to 5.4 fte (Wokingham 1.4 fte; Reading 3 fte and West Berkshire

1 fte. The BW10 resource is directly funded from the Better Care Fund (BCF).

5.2 In the future the ICS will move from Berkshire West to BOB. It is assumed however that the current BWICS staff funding will remain in Berkshire West. In terms of BW10 the level of project activity at a Locality level has fallen in recent years as projects have become 'business as usual' and the funding available for BCF related work has increasingly been moved into operational activity. It is therefore timely that the current arrangements are reviewed and reshaped around any newly emerging governance. The following is proposed;

(1) The Locality programme monitoring and management resource is moved to Place. The focus of the new resource would be on programme management and supporting the new ICP governance. At its heart will be the Leadership Board, Executive and Delivery Group but the ICP Programme Management Office (ICP PMO) would also need to support the ICP Programme Boards as well. If some ongoing Locality support was needed then this could be drawn from the ICP PMO but under the new governance arrangements the expectation would be that Health and Wellbeing Boards would provide this in Localities and that the resourcing will come directly from the three Unitary Authorities. At this point it is assumed that it would cover the following;

(a) Programme management for the ICP;

(b) Project management coordination;

(c) Performance management and data management;

(d) Forward planning for Leadership Board, Executive and Delivery Group

(e) Agenda management and distribution;

(f) Minuting meetings.

(2) Provision of specific Programme Manager resource to promote delivery of the agreed work programme. The current 'Integration Programme' has within it a number of existing work streams and some potential new ones. The development of the BOB ICS is likely to create new ones. Areas that have already been identified as in need to additional resource include;

(a) development of a vision and strategic plan for Berkshire West;

(b) joint commissioning;

(c) children's services integration;

(d) development of primary care networks although this is likely to be driven by Localities not Place;

5.3 The current view is that to enable this a Programme Office of 2 fte is required which will be funded by NHS Transformation Funding. In addition to this it is suggested

that each locality has 1 fte Project Officer post funded through the BCF. These Locality posts would report to the Programme Office and are likely to support both Place and Locality based work. Overall there will be a notable saving in Programme and Project Management costs compared to the current position.

6. Conclusions

6.1 The original objective of this Paper was to propose governance arrangements for a combined BW10 and BWICS Programme. There has been widespread acceptance that the two Programmes needed to be brought together however the publication of the NHS LTP in January this year has introduced a number of complications.

6.2 The future ICS seems unlikely to be based on Berkshire West but on BOB. A new taxonomy is now beginning to emerge based around BOB being seen as the System with Berkshire West, Oxon and Bucks each being designed as Place. In addition to this the terms Locality and Neighbourhood have also been defined creating a hierarchy in the governance of health and social care. In many respects this new taxonomy is helpful and will hopefully lead to much needed clarity as to who is doing what and where. The BW10 would most probably have made greater progress if such clarity had been forthcoming in 2014.

6.3 Aside from the new taxonomy the new NHS LTP has also provided a set of themes which are being used more widely by the BOB STP to frame its own objectives. This has been continued in this Paper to provide some continuity.

6.4 The focus on the NHS LTP should however be treated with some caution. It is a NHS document seemingly written almost entirely for the NHS. It says little about Local Government, Public Health or the community and voluntary sector and therefore does little to embrace true health and social integration. The NHS LTP also brings significant new resources for the NHS over the medium term. At the time of writing the Government had yet to do anything to address the funding challenges in Social Care nor the ongoing reductions in Public Health Grant. A growing disparity in the funding positions of NHS and Local Government partners will not be conducive to productive joint working and integration and will require effective leadership.

6.5 All that said the NHS LTP shifts the emphasis from Berkshire West to BOB. NHS funding will now be channelled through the BOB ICS and it will be essential for Berkshire West to play a strong role within this new system.

6.6 The proposal to create a Berkshire West ICP reflects this need to establish a strong link with the BOB ICS. The new governance seeks to take the best from the existing BWICS and BW10. Importantly the arrangements should reduce and certainly not increase the time commitments of senior managers which has become a major issue in recent years. It is also set to enable a reduction in the current programme management costs.

6.7 Importantly the new governance arrangements seek to establish a clear role for Elected Members and also establish closer links with Health and Wellbeing Boards. The new ICP will still have an agenda dominated by Health. This will in part be a reflection of the agenda driving by the BOB ICS which in turn will be driven by the NHS LTP. If the new ICP is to be truly a partnership between Health and Local Government then the blending of work streams and a recognition of the work to be

done at Locality and Neighbourhood will be essential. Creating agendas and a debate that can properly engage all partners will be a real challenge. If participants become spectators to an alien unfamiliar and largely irrelevant debate they will soon depart.

6.8 The history of the BW10 and BWICS suggests that balancing transformation with organisational objectives and the day to day 'business as usual' activity will remain challenging. There will be a need for the ICP to have a handle on the performance of the Berkshire West Health and social care system. At the same time it will need to ensure its own Programme of activity is being delivered and that all of the partners are playing their part in delivering it.

6.9 Berkshire West does not have a vision or strategic objectives which sit comfortably with the new world within which it now resides. Neither does the BOB ICS. It is currently shaping its new strategy. The BWICP will need to do likewise. For the purposes of this document a working set of strategic objectives have been established on which the governance proposals in this Paper have been shaped. At the same time various assumptions have been made about what is best done at System, Place, Locality and Neighbourhood. At this point the strategic objectives largely reflect those of the BWICS, BW10 and Chief Officers Group. They have been framed within the seven themes of the NHS LTP and where appropriate are reflective of the emerging strategy being developed by the BOB ICS. By definition they will change and the BWICP governance, most notably the Programme Boards, will need to change to reflect it.

6.10 The bringing together of the current arrangements under a new BWICP will also necessitate the bringing together of the staff that will need to support and the Paper makes a number of proposals in this regard.

7. Recommendations

(1) The strategic objectives outlined in the main report (Table 4) are approved as the basis of the BWICSs work programme in 2019/20 noting that these are likely to change as a new strategy is developed.

(2) The taxonomy summarised in Fig 1 is used to frame the governance arrangements for the BWICP.

(3) The governance structure as set out in Fig 2 is adopted for the new BW ICP.

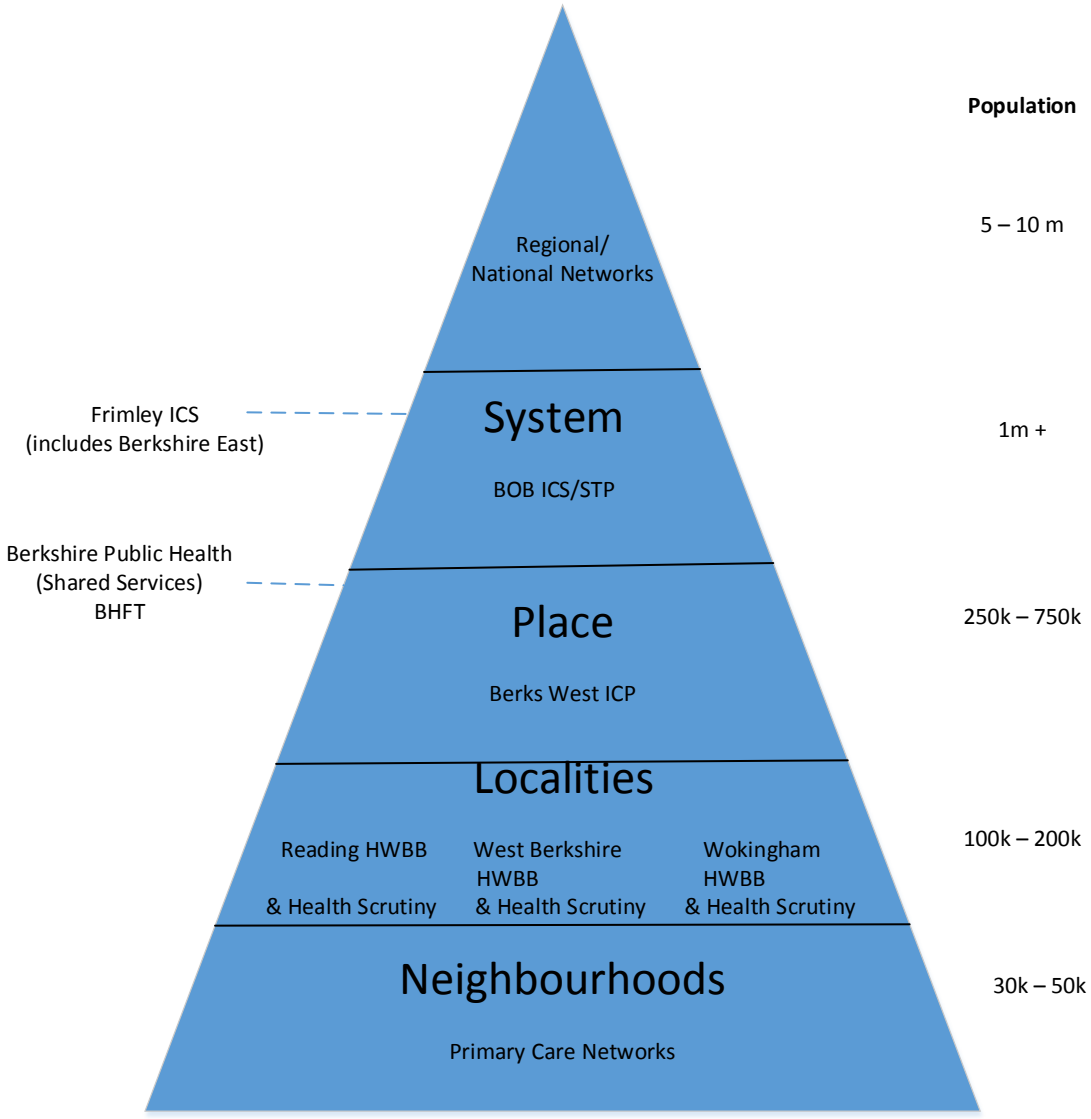
(4) The terms of reference for the BWICP Leadership Board, BW10 Executive and BW10 Delivery Group as set out in Appendices 5a-c of the main report are agreed.

(5) The principles for resourcing the ICP as set out in section 5 are agreed.

Nick Carter

April 2019

Fig. 1 – The proposed Health and Social Care Planning Taxonomy on which Berkshire West governance is based

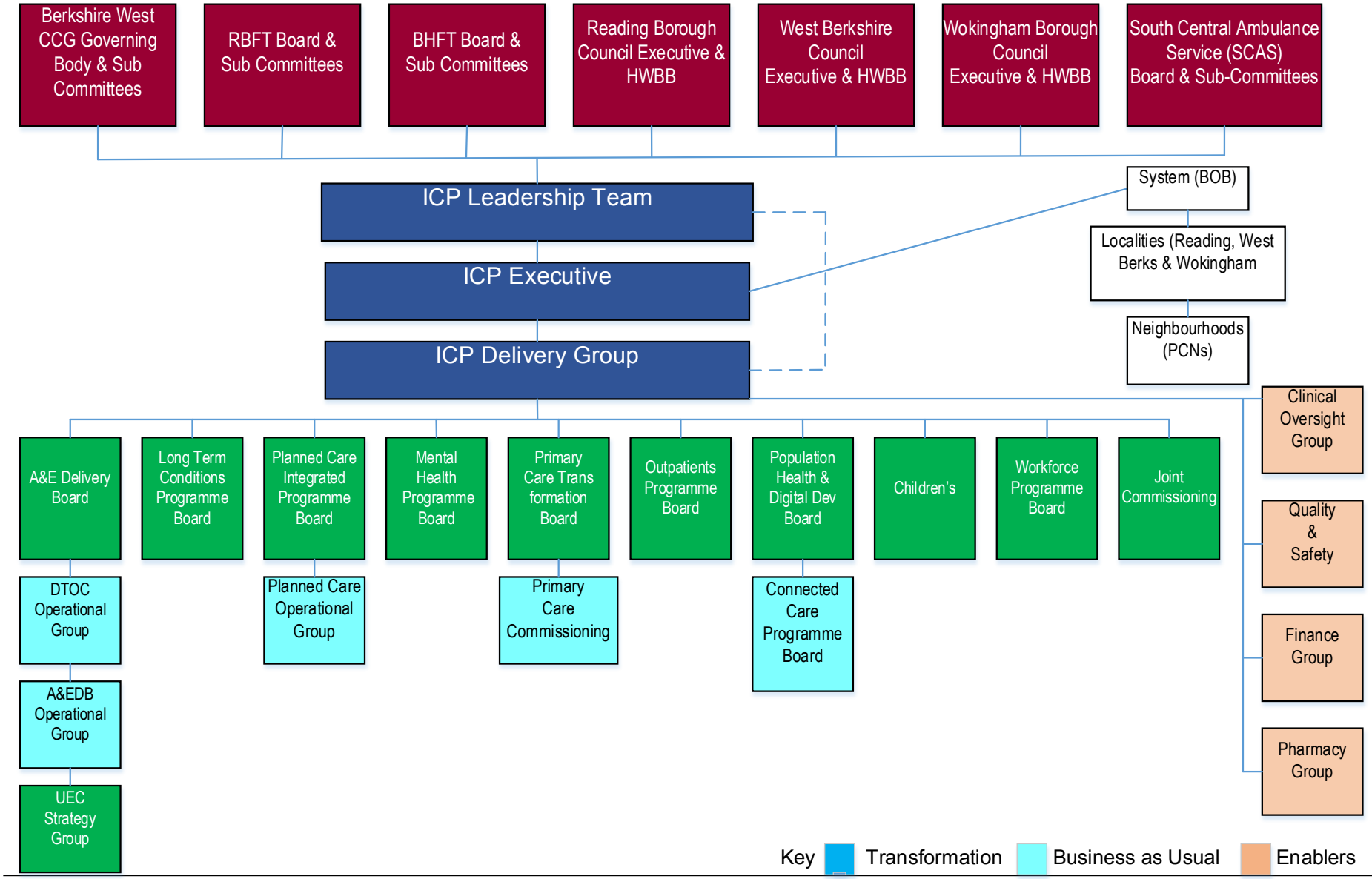


Note: Delivery will also be provided by organisations which will not necessarily align with this taxonomy

Table 1 - Proposed allocation of roles and responsibilities between System and Place as proposed in the BOB STP

LTP Theme	Primary Responsibility for design	Primary responsibility for delivery	Proposed System role under current approach	How role could develop to something more ambitious if desired
1. Integrated care	Place	Place	Coordinates/share good practice/encourage collaboration	Elements of system design and delivery (e.g. digital primary care). Ambition and accountability
	Much of System LTP section to be developed at Place and amalgamated. Some elements at System			
2. Prevention & Inequalities	Place	Place	Coordinates/share good practice/encourage collaboration	Elements of system design (e.g. related to population growth or border localities).
	System LTP section to be developed at Place and amalgamated			
3. Care Quality & Outcomes	System (or wider)	Organisation	System design, leave delivery to Place/Organisation	Possibly system delivery e.g. clinical support services. Ambition and accountability
	LTP section to be developed at System level and added to by Organisations			
4. Workforce	STP	Organisations	Some system design, leave delivery to Place/Organisation	System design e.g. shortages. System delivery e.g. regional bank or leadership academy
	LTP section to be developed at System level and added to by Places/Organisations			
5. Digital	STP (or wider)	Place & Organisations	System design, leave delivery to Place/Organisation	System delivery provider for all organisations
	LTP section to be developed in Place and amalgamated/added to at System			
6. Efficiency	STP	Organisations	Some system design, leave delivery to Place/Organisation	System design –STP efficiency plan. System delivery – for scale
	LTP section to be developed in Place and amalgamated/added to at System			
7. Engagement & Partnerships	Place	Place	Coordinates/share good practice/encourage collaboration	System design on engagement, especially with big employers/housebuilders
	LTP section to be developed in place and amalgamated/added to at System			

Fig 2 - Proposed ICP Governance & Leadership (March 2019)



This page is intentionally left blank

Proposed Governance Arrangements for a Combined Berkshire West ICS and Berkshire West 10 - Main Report – Final Draft

Table of Contents

Tables

Figures

Appendices

Introduction

1.1. It was agreed at the Chief Officers Workshop held at the Hilton Hotel in Reading on 19th November 2018 that one of the three priorities moving forward should be a review of the governance structures for the Berkshire West Integrated Care System (BWICS) and the Berkshire West Integration Programme (BW10). The aim was to produce a single governance structure for both. At the same time the workshop also agreed that project resourcing for any new combined governance structure should also be considered. It was agreed that existing BCF funding should be looked at as a potential source for this along with current NHS Transformation funding.

1.2. The need to potentially integrate the BW10 and ICS governance structures began to emerge early in 2018. It was becoming clear that the two governance structures were seen as increasingly difficult to support. Churn in senior staff, most notably within local government, was also exacerbating capacity constraints in senior leadership teams. The need for change was seen if only because the existing arrangements were viewed as unsustainable. A start towards the bringing together of the two governance regimes was made in August 2018 with the combination of the BW10 Integration Board and the Chief Officers Group.

1.3. The purpose of this Paper is to set out a set of proposals for bringing the two current governance arrangements together. In doing so a review is undertaken of the current arrangements but also of the newly emerging NHS architecture which is beginning to form following the publication of the NHS Long Term Plan (NHS LTP). Having considered the governance arrangements, the Paper moves on to consider how the new integrated Programme might best be supported across Berkshire West.

2. Background - Overview

2.1 The Berkshire West Integration Programme (BW10) was established in 2014 and brought together both local Health partners and local government. It was a natural development of the Chief Officers Group which was established in 2013 following the implementation of the Health and Social Care Act (2012). Its initial focus was heavily geared towards improved integration of Elderly Frail services alongside management of the Better Care Fund (BCF). Latterly it developed a more expansive vision which proved more challenging to implement.

2.2 When the BWICS was originally conceived in 2016 there was an agreement that the initial focus would be on the three main health partners, the then four clinical Commissioning Groups which are now one (CCG), the Berkshire Healthcare Foundation Trust (BHFT) and the Royal Berkshire Hospital (RBH) moving forward a programme of Health integration. The expectation was that the three Unitary Authorities would join the BWICS some two years later. Whilst this did not become a formal discussion during 2018 it was evident that the agendas of the BW10 and BWICS two groups were beginning to merge. Indeed at the Chief Officers Group workshop in November 2018 a venn diagram was produced which highlighted the agendas of the two Groups and the areas of common interest (see Appendix 1).

2.3 The issue was further highlighted in the Reading Local System Review which was conducted in October/November 2018 by the CQC. Whilst focused on Reading, the

Review also considered the work of the BW10 and BWICS and made the following observations;

(1) the strategic direction of the Berkshire West 10 was set out by Chief Officers representing the member organisations. There were strong relationships between the Chief Officers, but the strategic vision for the Berkshire West area, including Reading, had not yet been articulated into a credible strategy that was agreed by, and understood by, all partners. As a result it was not clear to people who use services (or staff) how the strategy for the delivery of health and care services in Reading was aligned to the vision for the Berkshire West area;

(2) health partners had led the development of the Berkshire West Integrated Care System (ICS) in 2016 and were in support of merging the work of the BW10 into the ICS. Historically there had been reluctance from some local authority partners for this direction of travel, but opportunities for alignment were being explored and supported through recent meetings between the Chairs of the Health and Wellbeing Boards in the three unitary authorities;

(3) in terms of the key areas for improvement the CQC cited the following which are relevant to this Paper;

(a) in developing the next Health and Wellbeing Strategy, due for publication in 2020, the local authority should engage system partners and ensure greater alignment with the wider Berkshire West ICS's strategic intentions and those of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Partnership (STP);

(b) health and care commissioners should work together to develop the new Joint Strategic Needs Assessment (JSNA) and ensure that its development is aligned with the ICS's Population Health Management approach;

(c) health and care commissioners should develop a joint commissioning strategy. Health and care commissioners should agree on commissioning intentions across health and social care and work together to develop a joint market position statement (this is being taken forward as a separate work stream by the Chief Officers Group (COG));

(d) system leaders should focus on developing prevention and early intervention services that increase the support offer in the community. A system approach to risk stratification and active case management should be developed to identify people at the highest risk of hospital admission;

(e) while relationships between system leaders were strong, relationships between health and local authority partners could be improved. As the system moves towards greater integration at a Berkshire West level, system leaders should ensure that staff are engaged in the process

and that health partners are working with colleagues in the local authority to progress plans;

(f) system leaders should evaluate governance boards and processes to ensure that there is no duplication. System leaders should also ensure that people working in the system are clear on where decisions are taken, and where accountability lies for system performance (the latter point is a particular focus for this Paper).

2.4 A key point to take from these comments is that the future direction of the BW10/BWICS work needed to be clarified before any meaningful decisions could be taken on future governance and resourcing. This is reflected on later in the Paper.

2.5 It is also important to realise that Berkshire West does not exist in isolation. There are three local authorities within Berkshire West and each has its own Health and Wellbeing Board and BW10 Locality Board. In the past, links between the BW10/BWICS and Health and Wellbeing Boards have been tenuous. This has led to something of a deficit in Elected Member engagement which also needs to be addressed as part of this Paper. Primary Care Networks (PCNs) are also now being discussed and these are being taken forward at a geography smaller than each of the three unitary authorities.

2.6 The BOB STP has already been mentioned and is an important dimension to consider when determining what should be planned and delivered at a Berkshire West level. There is an ongoing debate at the STP regarding what activities are best co-ordinated at scale across BOB and what are best managed more locally. As this Paper is being written this debate continues and has now been crystallised to a degree through the publication of the NHS Long Term Plan (NHS LTP). This newly emerging context is now an important element to consider in the development of any new integrated governance arrangements locally.

3. Current Context

3.1 Before considering how to move forward across Berkshire West it is perhaps worth providing some further context to the wider health and social care system and the potential impact of ongoing announcements at a national level. What are seen as the most significant developments are set out below.

The NHS Long Term Plan (NHS LTP)

3.2 The new NHS Long Term Plan (NHS LTP) was published in January 2019. It followed on from the Five Year Forward View (5YFV) which was published by the NHS in October 2014 and which set out a blueprint for the future provision of care in England and introduced the concept of Integrated Care models which have subsequently developed into Integrated Care Systems (ICSs).

3.3 The new NHS LTP sets out a proposed direction for the NHS over the next 10 years. A set of priorities are laid out within the Plan which will undoubtedly be the subject of future discussion. The key points that are perhaps relevant to this Paper are;

(a) there is an expectation that there will be ICSs in place across the country by 2021;

(b) it appears that future ICSs are expected to have a minimum population footprint of 1 million or more. This rules out Berkshire West and the assumption going forward is that BOB will be the geography for the new ICS;

(c) additionally, it is suggested that commissioning arrangements will typically involve a single CCG for each ICS area. It remains unclear how this will be organised.

3.4 Late last year the NHS released a proposed infrastructure which would be used to help shape future health and social care governance arrangements. This was essentially based on three layers within a local architecture – namely, System, Place and Neighbourhood. Locally, the term Locality has also been introduced into this new taxonomy. It is important to bear in mind that this new taxonomy or architecture is for planning not necessarily delivery purposes and the NHS appear to accept that organisations may continue to be based on a geography that that does not align with what is set out below. The suggested local interpretation of this new planning taxonomy is shown in Fig. 1 and summarised below:

(a) *System* – the ICS is seen to embrace the 'System'. At the moment it appears to be assumed that this will be BOB. Currently the ICS is based on Berkshire West. There is also an ICS for Buckinghamshire. Both sit within BOB:

(b) *Place* – it is assumed that this would be Berkshire West. Roles and responsibilities between System and Place are only now being formally discussed:

(c) *Locality* – it is assumed that in a local context the three localities will be Reading, West Berkshire and Wokingham. These reflect the boundaries of the three unitary authorities. Each Locality also has its own Health and Wellbeing Board and its own BW10 Locality Board. Partners are engaged in both. This is also the geography at which the Health Scrutiny currently takes place.

(d) *Neighbourhoods* – these are assumed to be the new Primary Care Networks which are at an early stage of being established. Neighbourhoods are optimally seen to support a population of between 30,000 – 50,000 and so are smaller than the Berkshire West defined Localities. These Neighbourhoods have yet to be defined.

3.5 As stated earlier delivery is likely to be achieved through individual organisations or through various 'partnership' arrangements. There is no expectation that these will align to the above taxonomy and there are a number of examples of this;

(1) RBH serves a population that is not coterminous with Berkshire West. There is a relatively good fit but some residents of West Berkshire are served by the North Hants Hospital in Basingstoke and the Great Western Hospital in Swindon. The RBH also serves Bracknell.

(2) BHFT provides services across Berkshire.

(3) Public Health, whilst being organised in part at a Locality level, is established as a shared service for the whole of Berkshire.

3.6 If the architecture in Fig.1 is being prescribed then the future governance will need to reflect it. We are not however starting from a blank sheet of paper so in terms of a new approach it is important to be mindful of what is already in place. A brief review is set out below.

The System - BOB

3.7 STPs emerged as Sustainability and Transformation Plans (plans were replaced by Partnerships in 2017) in the NHS Planning Guidance published in December 2015. This followed publication of the 5YFV. Berkshire West was placed within the Buckinghamshire, Oxfordshire and Berkshire West STP known locally as the BOB STP. There was a general feeling that this geography was unnatural and that it brought together three local areas that previously had little history in working together, in particular Berkshire West.

3.8 The original concept behind STPs was that NHS organisations and local authorities in different parts of England would come together to develop 'place-based plans' for the future of health and care services in the area. Draft plans were produced by June 2016 and final plans were submitted in October of that year. The original expectation was that the plans would cover;

(a) improving quality and developing new models of care;

(b) improving health and wellbeing;

(c) improving efficiency of services.

3.9 They were expected to cover the period October 2016 – March 2021.

3.10 The BOB STP Plan was published in 2016 and set out the following priorities;

(1) shifting the focus of care from treatment to prevention;

(2) providing access to the highest quality primary, community and urgent care;

(3) collaboration between acute trusts to deliver equality and efficiency;

(4) developing mental health services to improve the overall value of care provided;

(5) maximising value and patient outcomes from specialised commissioning;

(6) establishing a flexible and collaborative approach to workforce;

(7) making better use of digital technology to improve information flow, efficiency and patient care.

3.11 In July 2018 the BOB STP in terms of overall progress was judged as Category 2 'Advanced' whilst System Leadership was described as Category 3 'Developing' (1 = High scoring 4 = Low).

3.12 The STP governance arrangements as at November 2018 are set out in Appendix 2. There are a number of work-streams some driven by the STP Plan and others by the national 5YFV. The work-streams are;

(1) Population Health Management (STP)

(2) Prevention (STP)

(3) Capacity planning (STP)

(4) Digital (STP)

(5) Estates (STP)

(6) Workforce (STP)

(7) Cancer (FYFV)

(8) Urgent and Emergency Care (FYFV)

(9) Maternity – Better Births (FYFV)

(10) Mental Health

3.13 The BOB STP is supported by a Team of 7 staff including an Executive Chair. Governance is primarily through the Chief Executive's Group which in the context of Berkshire West includes the Accountable Officer from the CCG, the Chief Executives of BHFT and RBH and the Chief Executive of West Berkshire Council who represents all three West Berkshire Unitary authorities.

3.14 As stated earlier the NHS LTP clearly sees an ongoing role for the STP. The BOB STP is currently seen as the future System and also as the future ICS. At this point the STP is aligning its activity very closely to the new NHS LTP. In some respects this is helpful but the LTP is very NHS focused and there is a risk that the BOB STP agenda becomes dominated by Health matters and increasingly irrelevant to the other partners.

3.15 Work has already began at the BOB STP / ICS to determine its future strategy and governance arrangements. These are still at a formative stage and are expected to be concluded towards the end of 2019. For the purpose of this report the BOB STP and the BOB ICS are essentially the same thing. The former is expected to morph into the latter over the coming months.

3.16 The proposal at the moment is to align the future BOB STP/ICS strategy to that set out in the NHS LTP. The latter is seen to have seven distinct themes;

(1) Integrated care:

(2) Prevention and inequalities:

(3) Care quality and outcomes:

(4) Workforce:

(5) Digital:

(6) Efficiency:

(7) Engagement & partnerships.

3.17 As can be seen there is a strong alignment with the existing work streams that were highlighted earlier. Additional work has also suggested that these work streams also align well with the Place based strategies that have been developed within BOB. However there are a small number of areas where it is felt the Place based strategies have a particular emphasis which is yet to be replicated at a BOB STP level. These include;

(1) Reducing inequalities;

(2) Clinical priorities e.g. long term conditions, learning disabilities, maternity etc;

(3) Patient experience/voice;

(4) Prevention.

3.18 Table 1a sets out some early thoughts as at February 2019 from the BOB STP on how these NHS LTP themes are best taken forward and in particular how roles and responsibilities might be allocated between System and Place. This clarifies the role that the STP currently sees Place as having with each of the seven themes shown in paragraph 3.16. It is noteworthy that in many instances the role of the STP is to bring together what has been created at Place or to act in a quality assurance capacity. In summary;

(1) *Integrated Care* - Designed and delivered at Place. The System role would be to share good practice and encourage collaboration.

(2) *Prevention and Inequalities* - Designed and delivered at Place. As above the System role would be too share good practice and encourage collaboration.

(3) *Care Quality and Outcomes* - Designed and delivered at System level but delivered at Place or Organisational level

(4) *Workforce* - Designed and delivered largely at System with delivery left to Place or Organisation.

(5) *Digital* - Designed and delivered at Place level. The System role would be to encourage collaborations. Delivered at Place or Organisation level.

(6) *Efficiency* - Designed and delivered at Place Level and amalgamated / added to at System level.

(7) *Engagement and Partnerships* - Designed and delivered at Place level with System sharing good practice and encouraging collaboration.

3.19 If taken forward this would leave a significant role for Berkshire West both in terms of design and in delivery. This is helpful in clarifying what Berkshire West is likely to have to govern going forward. What Table 1a does not do is clarify what would be done at Locality and Neighbourhood level. This has not been considered by the BOB STP but is reflected later on in this Paper.

The Place – Berkshire West

3.20 Berkshire West is seen as the boundary for the local health economy although it is by no means an impermeable boundary with significant patient flows both out of and into the area. The Clinical Commissioning Group (CCG) is based on the Berkshire West boundary as is the current BW ICS.

3.21 At first sight it would seem that the focus on Berkshire West may diminish somewhat with the future ICS being based on the BOB boundary and the future structure of CCGs also being potentially aligned to this boundary. However, as noted in Table 1a the BOB STP/ICS is already moving towards a highly delegated structure where many of the essential building blocks going forward will remain at the Place level. Mention has already been made of the BW10 and BWICS arrangements which underpin health and social care planning across Berkshire West. These are now being brought together but it is important to review their current work activities prior to any consideration as to future governance.

Berkshire West 10

3.22 The Berkshire West 10 Partnership was established in 2014. It brought together the then four CCGs, three unitary authorities, two NHS providers and the South Central Ambulance Service. The governance eventually settled around an Integration Board which provided strategic direction and oversight, a Delivery Group which focused on co-ordinating operational delivery and three Locality Boards aligned to the boundaries of the three unitary authorities (see Appendix 4a). Links to the Health and Wellbeing Boards have not been particularly strong. Neither has Elected Member engagement. Both need addressing going forward.

3.23 The initial work of the BW10 was focused on the Elderly Frail and the coordination of the Better Care Fund (BCF). The latter emerged in 2015.

3.24 A more developed Vision emerged in 2017 (see Appendix 3a) which embraced four distinct strands:

(1) Frail elderly:

(2) Mental health and Learning Disabilities:

(3) Prevention:

(4) Children:

3.25 Progress with implementing this wider Vision proved problematic and limited progress was made. In August 2018 the BW10 Integration Board was effectively abolished and merged with the extant Chief Officers Group.

3.26 The BW10 Delivery Group has continued to meet and remains well attended. It has a number of active work streams most notably:

(1) Care Homes Project for which there is a separate Project Board:

(2) Trusted assessor:

(3) Connected care for which there is now a new Project Board:

(4) CHS (Provider for self funder discharge from hospitals):

(5) SCAS falls project:

(6) CHASC working:

(7) Step up beds – Wokingham:

(8) WISH Team – Wokingham:

(9) Integrated Hub – Wokingham:

(10) Integrated Care Team – West Berkshire:

(11) Additional Capacity – West Berkshire:

(12) Step down beds – West Berkshire:

(13) Discharge to assess (Willows) – Reading:

(14) Community Reablement Team – Reading.

3.27 The above reflects what is currently being supported in part by BCF funding across Berkshire West. A number of the above projects are now becoming 'business as usual' and can now be removed from this list.

3.28 Table 2 sets out in more detail the staffing resources that are being used within the BCF budget to manage the current BW10 programme. The general view is that it is these resources which need to reshaped to support an integrated Berkshire West Programme moving forward. This is reflected on later.

Berkshire West ICS

3.29 The Berkshire West Integrated Care System (BWICS) was established in 2015, and was recognised by NHSE as an ICS Exemplar Area in June 2017. It is one of 10 ICSs across England. It was agreed from the outset that the ICS would focus on Health integration and therefore it has not included Local Government to date. The expectation was that local authorities would join after 2 years but in practice this has not happened.

3.30 The main objective of the BWICS is cited as ensuring that the population's experience of healthcare services:

- continues to improve;
- continues to benefit from improved health and wellbeing outcomes, and that;
- the local NHS is financially sustainable for the future.

Specifically this is seen to mean;

(1) making faster progress in transforming the way care is delivered, as set out in the 5YFV, and in particular making tangible progress in urgent and emergency care reform, strengthening general practice and improving mental health and cancer services;

(2) managing these and other improvements within a shared financial control total and to deliver the system wide efficiencies necessary to manage the local NHS budget;

(3) integrating services and funding, operating as an integrated health system and manage the health of the local population, keeping people healthier for longer and reducing avoidable demand for healthcare services;

(4) demonstrating what can be achieved with strong local leadership and increased freedom and flexibilities, and share learning with the wider NHS.

3.31 The current strategic priorities and key projects for the BWICS are set out in Appendix 3b. The priorities are set out as to:

(1) Develop a resilient urgent care system that meets the on the day need of patients and is consistent with constitutional requirements:

(2) Design care pathways to improve patient experience and clinical outcomes, and make the best use of clinical and digital resources:

(3) Progress a whole system approach to transforming primary care to deliver resilience, better patient outcomes and experience and efficiency:

(4) Develop the ICS infrastructure to deliver better value for money and reduce duplication:

(5) Deliver the ICS financial control total agreed to by the Boards of the constituent statutory organisations.

3.32 The governance arrangements for the BWICS comprise a Leadership Board, and Executive along with supporting Programme Boards, Reference Groups and Enabling Groups. This is set out in Appendix 4b.

The Localities

3.33 The three Localities (Reading, West Berkshire and Wokingham) each have a Health and Wellbeing Board. The Boards were created through the Health and Social Care Act 2012. Health and Wellbeing Boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. They have a statutory duty, with CCGs, to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population. The Boards have very limited formal powers being constituted as a partnership forum rather than an executive decision making body. The Board must include a representative of each relevant CCG and local Healthwatch as well as local authority representatives. The local authority has considerable discretion in appointing Board members and some have over time sought to broaden the remit of the Board to something akin to that of previous Local Strategic Partnerships which were created in the early 2000's under the Local Government Act 2000.

3.34 The degree to which HWBBs have linked effectively to BW10 and BWICS is a moot point. Elected Members have not been represented within either Programme and the BWICS has no formal Locality focus. The Better Care Fund (BCF) which has been a major driver behind the BW10 does link that Programme to HWBB's through the Locality Boards but how effective that link is remains unclear.

3.35 The BW10 Locality Boards are, as the name suggests based around Localities. They are strongly linked to the BW10 Delivery Group less so to the HWBBs. Their focus has been almost entirely on managing the Better Care Fund (BCF). Most of this BCF funding has now been absorbed into operational budgets with activity now increasingly becoming business as usual. There is a question over the role of the Locality Boards moving forward.

3.36 Localities are also the geographical level at which Health Scrutiny takes place. This is a responsibility of the local authority through Overview and Scrutiny Committees.

3.37 Table 1b provides some thinking on what the responsibilities of Locality might be contrasted with those of Place. Once again the NHS LTP themes have been used to help frame this but areas where it is felt Localities should lead include;

(1) development and support for Primary Care Networks (Neighbourhoods);

(2) some prevention work and a strong focus on health inequalities;

(3) engagement and partnerships including the patient experience and voice;

(4) the development of health and wellbeing strategy (to be amalgamated at Place);

The Neighbourhoods

3.38 Primary Care Networks (PCNs) are seen as building blocks for Neighbourhoods. It is currently estimated that there will be 13 PCNs or Neighbourhoods across Berkshire West (Place). It is unclear at this point whether PCNs will be coterminous with the three Localities. Whilst still at an early stage in development PCNs are a

key feature of the NHS LTP and are seen as clusters of existing GP surgeries which will work towards (note in some cases some of this work is already underway);

(1) the establishment of integrated care teams;

(2) delivery of evening and weekend appointments;

(3) shared staff e.g. clinical pharmacists;

(4) shared back office;

(5) same day access models;

(6) the development of hubs.

Neighbourhoods are at an early stage of development but it is felt that the Localities should have a key role in shaping their development.

3.39 Before considering future governance proposals it is perhaps worth reflecting on the current strengths and weaknesses of our existing governance arrangements across Berkshire West.

(1) Strengths

(a) Strong lasting relationships most notably amongst Health partners where there has been less churn in senior leadership.

(b) Commitment to partnership working which in some areas has borne improved outcomes.

(c) An effective BWICS governance structure which appears to have supported progress at some pace.

(d) An active and engaged BW10 Delivery Group that has some notable achievements under its belt.

(e) Some effective sub groups within both the BW10 and BWICS structure which have also delivered significant achievements.

(2) Weaknesses

(a) Current lack of agreed Vision and strategic plan.

(b) Capacity - most notably at senior leadership level.

(c) Lack of engagement with Elected Members and with Health and Wellbeing Boards.

(d) Complex local arrangements with potential duplication.

(e) Strategic direction is fluid and subject to change – most notably within the NHS. This could undermine the effectiveness and sustainability of any agreed governance arrangements.

4. Governance Principles

4.1 The Kings Fund identifies ten design principles for place based systems of care. These are worth reflecting on prior to the design of a new governance for a combined BWICS/BW10. The 10 design principles are;

(1) define the population group and the system's boundaries. The proposed taxonomy in Fig 1 frames this very well and the articulation of what might be done at what level within that taxonomy is a very helpful step forward. This is an issue which has hampered integration work locally in the past;

(2) identify the right partners and services. The Kings Fund states 'while place-based systems of care will have a strong focus on the NHS they should also involve local authorities, the third sector and other partners'. This is particularly the case where the aim is to focus on population health and not just health and care services. The inclusion of both providers and commissioners is also seen as important. The Locality is probably the level at which this wider level of engagement is likely to be best secured and is where broader discussions about health and wellbeing are best promulgated;

(3) develop a shared vision and objectives. The commentary here states 'the initial focus is likely to be on achieving the financial and clinical sustainability of local services as well as the development of new care models that cut across organisational and service boundaries'. Areas that have more experience in partnership working may chose to focus on the broader aim of improving population health and wellbeing from the outset. The BWICS/BW10 approach is still largely in the former camp although more recent developments highlight a broader approach is developing although more is needed to embed this. It would appear necessary to create a new more holistic vision and set of strategic objectives going forward;

(4) develop an appropriate governance structure – this is the purpose of this paper but the opening comment from the Kings Fund states 'governance arrangements must reflect existing accountabilities while also creating a basis for collection action. To do this successfully they must be inclusive enough to ensure that those involved in delivering and receiving services are meaningfully involved in decision making. They must also be strong enough to be able to coordinate the range of activities involved in meeting the group's objectives – something that is far easier said than done!'

(5) identify the right leaders and develop a new form of leadership – the Kings Fund states that 'ensuring that the right leaders are involved in managing the system of care at the appropriate level of seniority, including Chairs and Board members where appropriate, is essential. Much will depend on the strength of relationships between organisational leaders and the extent to which there is mutual trust and respect. The need for collaborative leadership is stressed as is the need for clinical leadership and the engagement of front line clinical teams if change is to be realised. Relationships at some levels are well

developed but there has also been significant churn. Engagement of Elected Members and Health and Wellbeing Boards at Place is a significant current deficit;

(6) agree how conflicts will be resolved – the commentary states 'wherever possible, conflict should be viewed as a healthy reflection of the state of collaborative working and the ability of the organisations involved to disagree and move on. At the same time, partners should be clear about the consequences for organisations that fail to play by the agreed rules and behaviours of the system.' This is probably an area where some further work is required;

(7) develop a sustainable financing model – this has been advanced under the BWICS with some notable success. The work is far from complete but it has been a key objective of the BWICS agenda to date;

(8) create a dedicated team – teams are in place to support both BWICS and BW10. Resources also exist at the BOB STP and Locality Level. Part of the purpose of this paper is to reshape these teams to support the new integrated governance;

(9) develop systems within systems – there is an expectation that different programmes will develop within the Place based governance. It is stated that 'the important task is to ensure that activities of different groups from a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives;

(10) develop a single set of measures. The BWICS and BW10 both have their own sets of measures. These now need to be reviewed not only because BW10 and BWICS are being combined but also because they need to be fit for purpose. It is suggested that;

- there should be a small set of metrics to assess the overall performance of the Place, including how they will be circulated and reported to the public;
- a larger set of metrics should also be collected to allow partners to understand how they are contributing to the overall goal of the system and identify areas of improvement;
- this area requires further work locally.

(11) it is also suggested that measures should be used to test whether the Place is behaving in a way that aligns with its agreed values and behaviours e.g. how well teams are collaborating to deliver more coordinated services or how well shared decision making is embedded in the way that care is delivered. It is also stated that one of the risks in developing systems of care is that of adding further complexity to an already complex system. While this cannot be avoided entirely, the design of governance arrangements needs to be done in a way that minimises transaction costs and seeks to keep these arrangements as simple as possible.

4.2 There is as yet no clear vision and strategic plan for Berkshire West as a Place. The original Vision of the BW10 proved unachievable although there are undoubtedly elements of it that would remain relevant in any Programme aimed at improving patient outcomes and reducing cost across health and social care. There may be a need to retain some oversight of the BCF programme and in particular the work on reducing DTOCs which has proved successful in recent months. Some projects remain ongoing and need to be retained in any new governance arrangements others can, or have become business as usual. The BWICS has an active work programme and despite the NHS LTP much of what is currently in place would appear relevant in terms of any future arrangements.

4.3 The emerging BOB STP/ICS governance discussion does however highlight some current gaps in their proposed arrangements and these will need further consideration.

4.4 The Chief Officers Group identified three priorities late last year. One is being progressed through this Paper but the other two need to be picked up by the new arrangements most notably;

(1) Joint commissioning

(2) Effective neighbourhood working

4.5 Berkshire West also has a range of existing governance arrangements based around operational management. These include;

(1) A&E Delivery Board

(2) Planned Care Operational Group

(3) Finance Group

4.6 Many of these are effective and need to the retained within the new arrangements as well.

4.7 Consideration also needs to be given to how Locality and Neighbourhood working will relate to Place based planning and delivery based on Berkshire West. The BOB STP/ICS appears to be adopting a principle of subsidiarity in its relationship with the three Place based areas within it. Such a principle may not be appropriate in the Place's relationship with the three localities of Reading, West Berkshire and Wokingham but an understanding of what is best done at Place and at the Locality would seem essential if the new governance arrangements are to work effectively. Confusion and dispute on this particular issue has not served the BW10 well since 2014.

4.8 Given this context some guiding principles have been set for the newly proposed governance arrangements:

(1) They should be built on the 'four level taxonomy' as already outlined in Fig.1 providing clarity as to what each level is responsible for and how coordination will be effected between the different levels. Planning and delivery need to be differentiated as two different things.

(2) The new arrangements should be no more burdensome than the existing ones - ideally less so:

(3) The arrangements need to directly support the strategic direction adopted across Berkshire West and provide an effective means of working within the new BOB ICS:

(4) What is in place should be inclusive most notably with regard to Elected Members.

Towards a Vision and Strategic Plan

4.9 The absence of a vision and strategic plan creates something of a vacuum in terms of trying to shape governance around what needs to be achieved. Ultimately the work programme will be a combination of;

(1) what needs to be done to support the BOB ICS. (The BOB ICS has already produced an overview plan which highlights that it will delegate a significant amount of planning responsibility to Place – see Table 1a);

(2) aspirations at a Berkshire West level (some of which has been articulated through the Chief Officers Group). This requires further work;

(3) a consideration of the aspirations of each Locality as expressed through their Health and Wellbeing Strategies, and;

(4) the emerging aspirations of Neighbourhoods.

4.10 It is not the purpose of this governance paper to set out a clear Place based vision for the future although the latter is something of a prerequisite for the former. The following are however being assumed at this stage;

(1) an interim strategy will emerge later in 2019 which will be aligned to the strategy work being undertaken by the BOB ICS;

(2) a new Health and Wellbeing Strategy will be prepared collectively by each of the Localities which will then be aggregated at Place level. This will seek to bring together not only the collective ambitions for the area in respect of prevention, population health and health inequalities but will also seek to embrace the Place's overall ambitions with regard to integration and its response to the NHS LTP.

4.11 Whilst there is currently something of a strategic void to help guide this governance Paper it is necessary to create some form of strategic framework on which a new governance structure can be constructed. The following have been used to try and help achieve this;

(1) the themes set out in the NHS LTP;

(2) the plans of the three current Health and Wellbeing Boards;

(3) the existing programmes of activity that are being sponsored and delivered by the BW10, BWICS and the Chief Officers Group.

4.12 The three objectives of the current BWICS align very closely to those which were originally adopted by the BW10. It is proposed that these are retained for the ongoing Place based work. They are;

(1) an improvement in the health and wellbeing of our population;

(2) an enhancement of patient experience and outcomes;

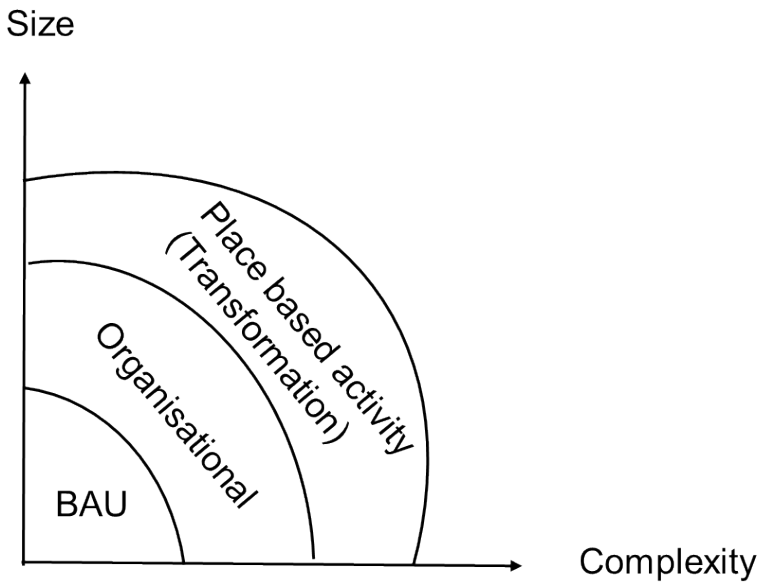
(3) financial sustainability for all constituent organisations.

4.13 Appendix 3b highlights five strategic priorities for 2018/19 which were used to frame BWICS activity during that year. At this point it is not intended to include these but rather list a number of proposed and existing projects which it is felt should be pursued during 2019/20. These are set out within the seven themes of the NHS LTP and highlighted in Table 3.

4.14 It must be stressed that this is very much an initial and provisional set of strategic objectives and projects aimed at seeking to provide an initial framework over which the governance can be shaped.

4.15 The earlier chapter highlighted the need to focus the governance around a clear understanding of what is seen as transformational activity as opposed to 'business as usual' activity. The approach adopted by BWICS is set out below and the same approach has been adopted here to aid the development of appropriate governance.

Fig 2 – Differentiating levels of activity



4.16 In framing the future governance the emphasis has been on the transformational element but it also has to be recognised that it is important that an oversight of the performance of Place is maintained and for this reason some oversight of business as usual and organisational change is also important

The Development of a Berkshire West Integrated Care Partnership

4.17 BW10 is no longer a correct term given that the 4 CCGs that made up BW10 in 2014 are now just one. At the same time the ICS looks set to move from Berkshire West to BOB so the term ICS also no longer seems appropriate. It is felt a new description is needed to embrace the new collective governance. Integrated Care Partnership or ICP is proposed since the term has been used elsewhere in the country to describe Place based structures. It also provides a clear link to the emerging BOB ICS which is seen a appropriate partly because Berkshire West was an ICS but also because it demonstrates Berkshire West's position within the wider ICS.

4.18 It is also proposed that the main building blocks of the current BW ICS and BW10 governance are retained although in all cases the membership will need to be broadened. Consequently the following are being recommended;

(1) ICP Leadership Board:

(2) ICP Executive:

(3) ICP Delivery Group.

4.19 The former two have their origins in the BWICS and the latter in BW10. The inclusion of the ICP Delivery Group is seen as essential to ensure that the ICP Executive is not swamped by reports from the supporting Programme Boards and other groups. Fig. 2 sets out the proposed structure including a range of supporting Programme Boards and enabling groups. These are currently provisional and subject

4.20 The Terms of Reference for each of the three main groups is set out in Appendices 5a-c but the key elements of each are set out below.

(1) BWICP Leadership Board – this would be drawn from all seven organisations making up the BWICP (see Fig.2). Alongside the existing membership Elected Members would be included along with the Chairs of the Health and Wellbeing Boards who would sit on the Group in an observational capacity. The Chief Executives of the unitary authorities would also become Members. The Board would continue to have an Independent Chair given the wide range of interests and scale of the agenda. The primary purpose of the Board would be to;

(a) act to optimise the ICP in delivering improved health and wellbeing outcomes and delivering better care for patients with increased cost effectiveness and;

(b) concentrate on the creation of strategy, building confidence with all Partners, approving of programmes, resolving strategic blockers, delegating to executives for implementation, and providing direct challenge where there is under delivery/performance;

(c) lead the development and articulation of the ICP strategy and oversee delivery of programmes and commitments;

(d) create a shared understanding of the vision and ensure that this is aligned with the objectives;

(e) intervene robustly to address shortfall in delivery and performance of programme boards and working groups;

(f) maintain an effective oversight of the performance and risks relating to the Berkshire West health and social care system.

(2) BWICP Executive – the current membership of this Group will need to be rationalised if it is to remain effective. The three Unitary Authority Chief Executives would join this Group along with the existing Chief Executives. It is proposed that each CEO would also be accompanied by one of their Directors. The Group would also contain the existing clinical representation and the Berkshire Strategic Director of Public Health. The independent Chair of the ICP Leadership Board would also be invited to attend as an observer.

The Chair of the Executive would rotate between Health and Local Government.

The primary purpose of the Executive would be to;

(a) deliver and have oversight of the ICP programme taking management decisions where required to ensure strong performance;

(b) receive exception reports and an overall evaluation of progress with the ICP Programme from the ICP Delivery Group;

(c) consider reports from and issues arising from the BOB ICS including preparing responses to wider issues concerning the BOB ICS;

(d) provide clinical, professional and managerial leadership;

(e) prepare a quarterly report for the ICP Leadership Board with regard to overall performance across the Berkshire West health and social care system and for the Programme overall;

(f) approve the appointment, removal or replacement of programme and project management personnel.

(3) BWICP Delivery Group – the membership of the Delivery Group might need to be reviewed but this grouping already draws its membership from Health and Local Government across Berkshire West. Membership would primarily be drawn at the Director level alongside programme and project management resources. It is proposed that the Chair of the Delivery Group is drawn from the Executive membership and is from the sector which is not chairing the Executive at that time. The Chair would rotate at the same time as the Executive. The purpose of the BWICP Delivery Group would be;

(a) act as the Programme Board for the BW ICP. As such the Group will be responsible to the Executive for implementing the agreed programme of joint work;

(b) coordinate the allocation of resources to ensure that the Programme can be delivered;

(c) provide effective challenge and peer review in considering and approving PIDs and Business Cases relating to the Programme;

(d) review progress against the agreed critical success factors for the Programme which enable assurance of the expected impacts;

(e) on behalf of the Executive provide a quarterly report setting out performance of the Berkshire West health and social care system;

(f) maintain an overview of relevant activity across the three Localities providing support and co-ordination where appropriate;

(g) provide support where required to the BOB ICS in support of its work programme and related activity required across Berkshire West as agreed with the ICP Executive;

4.21 Fig.2 provides an overview of the governance arrangements which include;

(1) the linkages to System, Locality and Neighbourhood;

(2) the Programme Boards and Enabling Groups that are seen as necessary to take forward the ICPs strategic objectives for 2019/20.

Appendix 6 provides more detail on the membership of the Programme Boards and Delivery Groups that it is currently proposed will be in operation during 2019/20. (in preparation)

4.22 It will be important to ensure that the meetings of each of the main three Groups are managed effectively. This is likely to be less of an issue for the Delivery Group who will retain a health/local authority membership similar to that at present. The Executive will function with a similar representation to the current Chief Officers Group although it is also proposed that one Director from each partner organisation is also invited. This will therefore become a larger meeting.

4.23 The biggest change will be at the Leadership Board which has to date been almost entirely Health representation and with an agenda devoted entirely to the BWICS. With the advent of the BOB ICS this work programme will shift. It will also be increasingly influenced by the Localities and hopefully a greater emphasis on health and wellbeing and prevention. As important will be the change in membership. Elected Members with their local authority Chief Executives will join this meeting and it will be important to ensure that the agenda remains relevant to all.

4.24 The risk is that the future agenda of the Leadership Board is dominated by Health matters. The link to the BOB ICS is likely to reinforce this as is a focus on a Health dominated NHS LTP. The BW ICS Programme outlined in this Paper is itself Health dominated so there is a real danger of Local Authority officers and Members

becoming spectators at the Leadership Board meeting. It is likely that the agenda will need to be managed accordingly with the potential to have a Part A meeting which involves Health and Local Authority partners meeting separately followed by a Part B meeting in which the Partners meet together to discuss issues of mutual interest. The agenda would need to be ordered appropriately.

4.25 The timing of the three meetings would need to be co-ordinated given that the Delivery Group needs to feed the Executive and the Executive, the Leadership Board. Links to the System and Locality governance also need to be considered.

5. Support Arrangements

5.1 A significant amount of project and programme management staffing resource is currently deployed to support the BWICS and BW10 Programme. This excludes senior management time which is spent in meetings supporting the existing governance. Taken together the current cost is likely to exceed £1m per annum.

5.2 The BWICS programme management team costs £105k (staffing costs only) and is supported by NHS Transformation Funding. This is linked directly to Berkshire West's status as an aspirant ICS. It is unclear at this point how the move to create the ICS at BOB will change this but for the purposes of this report it has been assumed that this funding will continue.

5.3 The BW10 Programme Management Team costs are funded through the Better Care Fund (BCF). These funds are held by each of the three Local Authorities. The funding is used to fund a Berkshire West Programme Office and Project support in each of the Unitary Authorities. The costs are set out in Table 2 and total £730k per annum.

5.4 Given the bringing together of BW10 and BWICS it seems logical to now bring the Programme support together in one place. The new single Programme Office will be responsible for;

(1) programme management of the ICP's Transformation Programme with the allocation of appropriate project officer support to assist the Programme Boards and Delivery Groups;

(2) supporting the ICP governance including the preparation of a forward plan and agenda management including preparation, despatch and minute taking;

(3) performance management for the ICP including data collection, analysis and report preparation;

(4) liaison where appropriate with BOB ICS and Localities re HWBBs etc.

5.5 At this point it is proposed that the new single Programme office would comprise;

(1) Programme Manager;

(2) Administrative Assistant;

(3) Up to three Project Officers;

5.6 Further consideration needs to be given to the work programme before considering how many Project Officers are required. It is anticipated at this stage that the Programme Office will continue to be funded by a combination of NHSE Transformation and BCF Funding. It would seem appropriate to have the Programme Manager and administrative support based at the CCG Officers in Reading. The physical location of the Project Officers would be more flexible. They are likely to work at both a Place based and Locality level and would be located locally. Current estimates suggest that savings in staffing costs will be made in moving to the single ICP. These are likely to be within the ringfenced BCF budget.

6. Conclusions

6.1 The original objective of this Paper was to propose governance arrangements for a combined BW10 and BWICS Programme. There has been widespread acceptance that the two Programmes needed to be brought together however the publication of the NHS LTP in January this year has introduced a number of complications.

6.2 The future ICS seems unlikely to be based on Berkshire West but on BOB. A new taxonomy is now beginning to emerge based around BOB being seen as the System with Berkshire West, Oxon and Bucks each being designed as Place. In addition to this the terms Locality and Neighbourhood have also been defined creating a hierarchy in the governance of health and social care. In many respects this new taxonomy is helpful and will hopefully lead to much needed clarity as to who is doing what and where. The BW10 would most probably have made greater progress if such clarity had been forthcoming in 2014.

6.3 Aside from the new taxonomy the new NHS LTP has also provided a set of themes which are being used more widely by the BOB STP to frame its own objectives. This has been continued in this Paper to provide some continuity.

6.4 The focus on the NHS LTP should however be treated with some caution. It is a NHS document seemingly written almost entirely for the NHS. It says little about Local Government, Public Health or the community and voluntary sector and therefore does little to embrace true health and social integration. The NHS LTP also brings significant new resources for the NHS over the medium term. At the time of writing the Government had yet to do anything to address the funding challenges in Social Care nor the ongoing reductions in Public Health Grant. A growing disparity in the funding positions of NHS and Local Government partners will not be conducive to productive joint working and integration and will require effective leadership.

6.5 All that said the NHS LTP shifts the emphasis from Berkshire West to BOB. NHS funding will now be channelled through the BOB ICS and it will be essential for Berkshire West to play a strong role within what seems likely to be a highly delegated system.

6.6 The proposal to create a Berkshire West ICP reflects this need to establish a strong link with the BOB ICS. The new governance seeks to take the best from the existing BWICS and BW10. Importantly the arrangements should reduce and certainly not increase the time commitments of senior managers which has become a major issue in recent years. The proposals set out in this Paper are also expected to lead to a reduction in staffing costs.

6.7 Importantly the new governance arrangements seek to establish a clear role for Elected Members and also establish closer links with Health and Wellbeing Boards. The new ICP will still have an agenda dominated by Health. This will in part be a reflection of the agenda driving by the BOB ICS which in turn will be driven by the NHS LTP. If the new ICP is to be truly a partnership between Health and Local Government then the blending of work streams and a recognition of the work to be done at Locality and Neighbourhood will be essential. Creating agendas and a debate that can properly engage all partners will be a real challenge. If participants become spectators to an alien, unfamiliar, and largely irrelevant debate they will soon depart.

6.8 The history of the BW10 and BWICS suggests that balancing transformation with organisational objectives and the day to day 'business as usual' activity will remain challenging. There will be a need for the ICP to have a view and perspective on the performance of the Berkshire West Health and social care system. At the same time it will need to ensure its own Programme of activity is being delivered and that all of the partners are playing their part in delivering it.

6.9 Berkshire West does not have a vision or strategic objectives which sit comfortably with the new world within which it now sits. Neither does the BOB ICS. It is currently shaping its new strategy. The BWICP will need to do likewise. For the purposes of this document a working set of strategic objectives have been established on which the governance proposals in this Paper have been shaped. At the same time various assumptions have been made about what is best done at System, Place and Locality. At this point the strategic objectives largely reflect those of the BWICS, BW10 and Chief Officers Group. They have been framed within the seven themes of the NHS LTP and where appropriate are reflective of the emerging strategy being developed by the BOB ICS. By definition they will change and the BWICP governance, most notably the Programme Boards, will need to change to reflect it.

6.10 The bringing together of the current arrangements under a new BWICP will also necessitate the bringing together of the staff that will need to support and the Paper makes a number of proposals in this regard.

7. Recommendations

(1) The strategic objectives outlined in Table 4 are approved as the basis of the BWICSs work programme in 2019/20 noting that these are likely to change as a new strategy is developed.

(2) The taxonomy summarised in Fig 1 and further developed in Tables 1a-b is used to frame the governance arrangements for the BWICP.

(3) The governance structure as set out in Fig 2 is adopted for the new BW ICP.

(4) The terms of reference for the BWICP Leadership Board, BW10 Executive and BW10 Delivery Group as set out in Appendices 5a-c are agreed.

(5) The principles for resourcing the ICP as set out in the report are agreed.

Nick Carter

April 2019

Supporting Information

CQC – Reading System Review

Table 1a - Proposed allocation of roles and responsibilities between System and Place as proposed in the BOB STP

We have pulled out where the STP can play a stronger design and delivery role. As a minimum, we think the STP can play a system design role in care quality and outcomes; workforce; digital; and best use of resources. But there are options for a stronger role if desired.

Organisational priorities to move us from first to second column?

	Primary responsibility for design	Primary responsibility for delivery	Proposed STP role under current approach	How role *could* develop to something more ambitious if desired
1. Integrated Care	Place	Place	Coordinate/share good practice/ encourage collaboration.	Elements of system design and delivery (e.g. digital primary care) Ambition and accountability
	Much of STP LTP section to be developed at place and amalgamated. Some elements at STP			
2. Prevention & Inequalities	Place	Place	Coordinate/share good practice/encourage collaboration.	Elements of system design (e.g. related to population growth or border localities).
	STP LTP section to be developed at place and amalgamated			
3. Care Quality & Outcomes	**STP (or wider)**	Organisation	**System design, leave delivery to place/ organisation**	Possibly system delivery e.g. clinical support services Ambition and accountability
	LTP section to be developed at STP level and added to by organisations			
4. Workforce	**STP**	Organisations	**Some system design, leave delivery to place/organisation.**	System design e.g. shortages System delivery e.g. regional bank or leadership academy
	LTP section to developed at place and amalgamated/added to at STP			
5. Digital	**STP (or wider)**	Place & Organisations	**System design, leave delivery to place/ organisation**	System delivery provider for all organisations
	LTP section to be developed at STP level and added to by places/orgs			
6. Efficiency	**STP**	Organisations	**Some system design, leave delivery to place/organisation**	System design – STP efficiency plan System delivery – for scale
	LTP section to be developed in place and amalgamated/added to at STP			
7. Engagement & Partnerships	Place	Place	Coordinate/share good practice/ encourage collaboration.	System design on engagement, especially with big employers/ housebuilders
	LTP section to be developed in place and amalgamated/added to at STP			

25

Table 1b – Proposed allocation of roles and responsibilities between Place and Locality

LTP Theme	Primary responsibility for design	Primary responsibility for delivery	Notes
1. **Integrated Care**			
Primary Care Networkers	Locality	Neighbourhood with oversight from Locality	
Joint Commissioning	Place	Place and organisations	
Population Health Management	Locality	Locality with oversight from Place	
Urgent and Emergency Care	Place	Place and Organisations	Effective governance already in place
Personalised care; • Personal health budgets • Social prescribing	Place Locality	Neighbourhoods with oversight of Locality	
2. Prevention and Inequalities			
• Smoking • Alcohol • Obesity • Antimicrobial resistance • Air Pollution • Health inequalities	Place Locality	Place Locality	

LTP Theme	Primary responsibility for design	Primary responsibility for delivery	Notes
3. Care Quality and Outcomes			
• Maternity and neo natal • CYP • Cancer • Cardiovascular • Stroke • Diabetes • Respiratory • Adult Mental Health • Short waits for planned care • Research and innovation	Place	Place	System will have a role in design as well
4. Workforce			
• Recruitment • Retention • Productivity • Leadership and management • Volunteers	Place	Place/organisation	Same design by system
5. Digital			
• Empowering people • Supporting professionals • Supporting clinical care • Improving population health • Improving efficiency/safety	Place	Place/organisation	Design is currently largely seen to be at system level

LTP Theme	Primary responsibility for design	Primary responsibility for delivery	Notes
6. Efficiency			
• Cash releasing productivity • Procurement • Pathology • Estates etc • Reducing variation • Capital	Place	Place/organisation	Efficiency Plan will also be produced at system level for working at scale
7. Engagement and Partnerships	Locality/ Neighbourhood	Locality/Neighbourhood with some 'light touch' coordination at Place if needed	Engagement and partnership activity will be driven at Locality and Neighbourhood level
8. ICP Strategy			
• Development of an ICP strategy to incorporate the Health and Wellbeing Strategy	Locality	Locality	Strategy will be bought together at Place and will reflect where appropriate system strategy

Table 2 – Current Programme Management Costs for the BW10 and BWICS

1. BWICS (source NHS Transformation Funding)

Staffing	-	£105k
Other	-	£unknown
Total		£105k

2. BW10 (source: BCF)

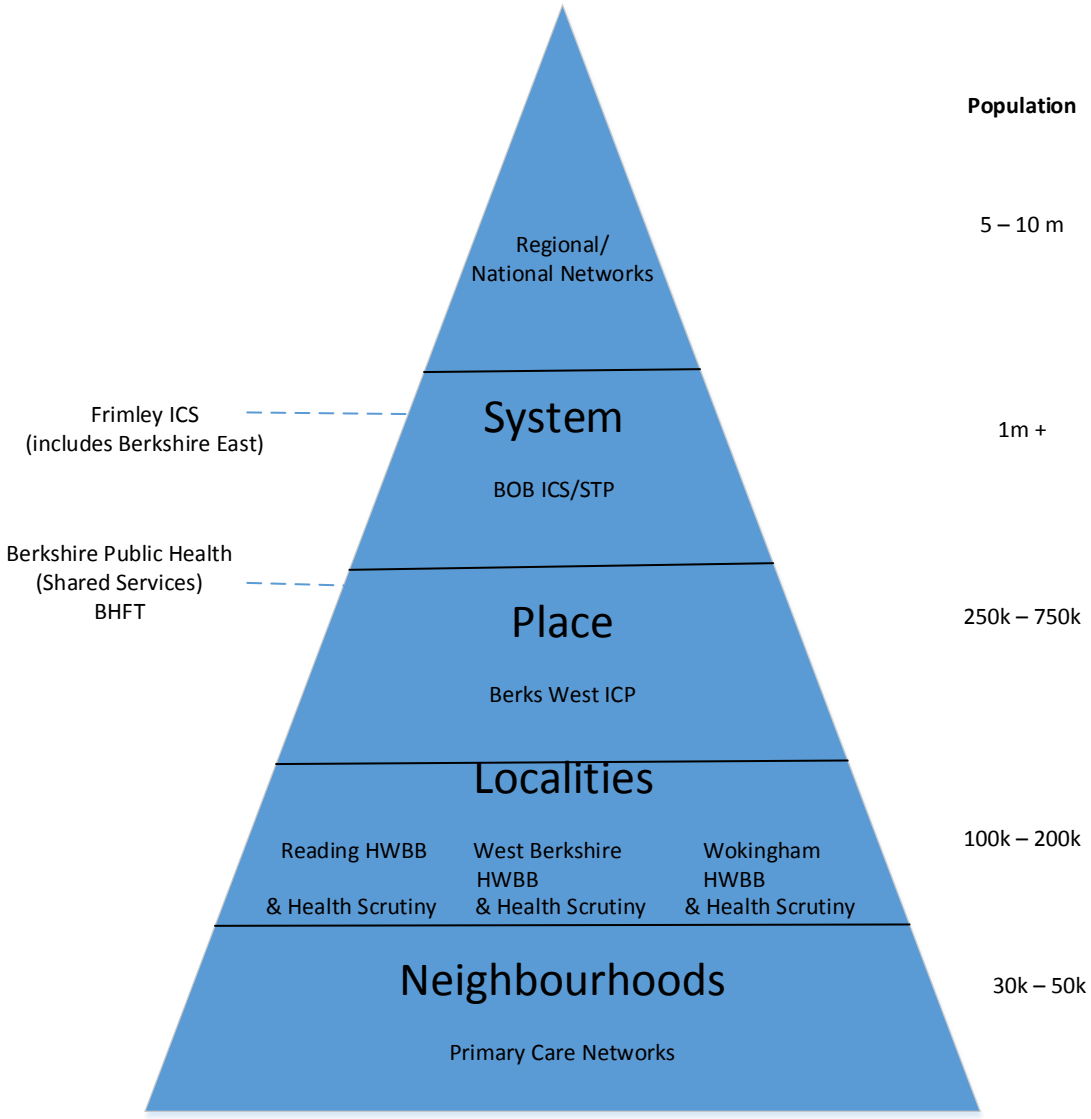
Berkshire West – Programme Projects	£181	£169
Reading Programme Office		£150
West Berkshire Programme Office		£100
Wokingham Programme Office		£130
Total		£730

Table 3 - Proposed Berkshire West Place based activity during 2019/20

Place based objectives

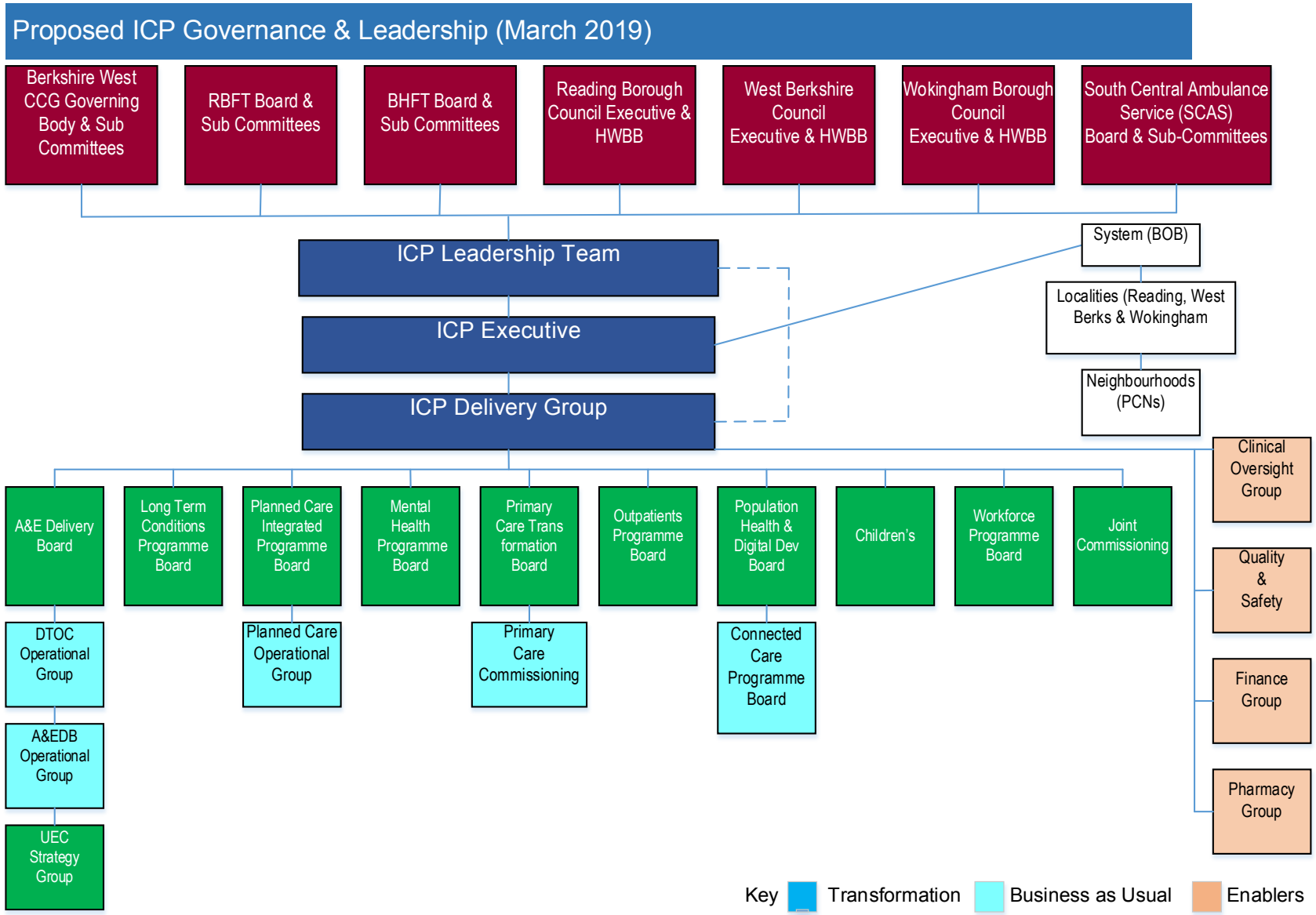
1. An improvement in the health and wellbeing of our population
2. Enhancement of patient experience and outcomes
3. Financial sustainability for all constituent organisations

Fig. 1 – The proposed Health and Social Care Planning Taxonomy on which Berkshire West governance is based

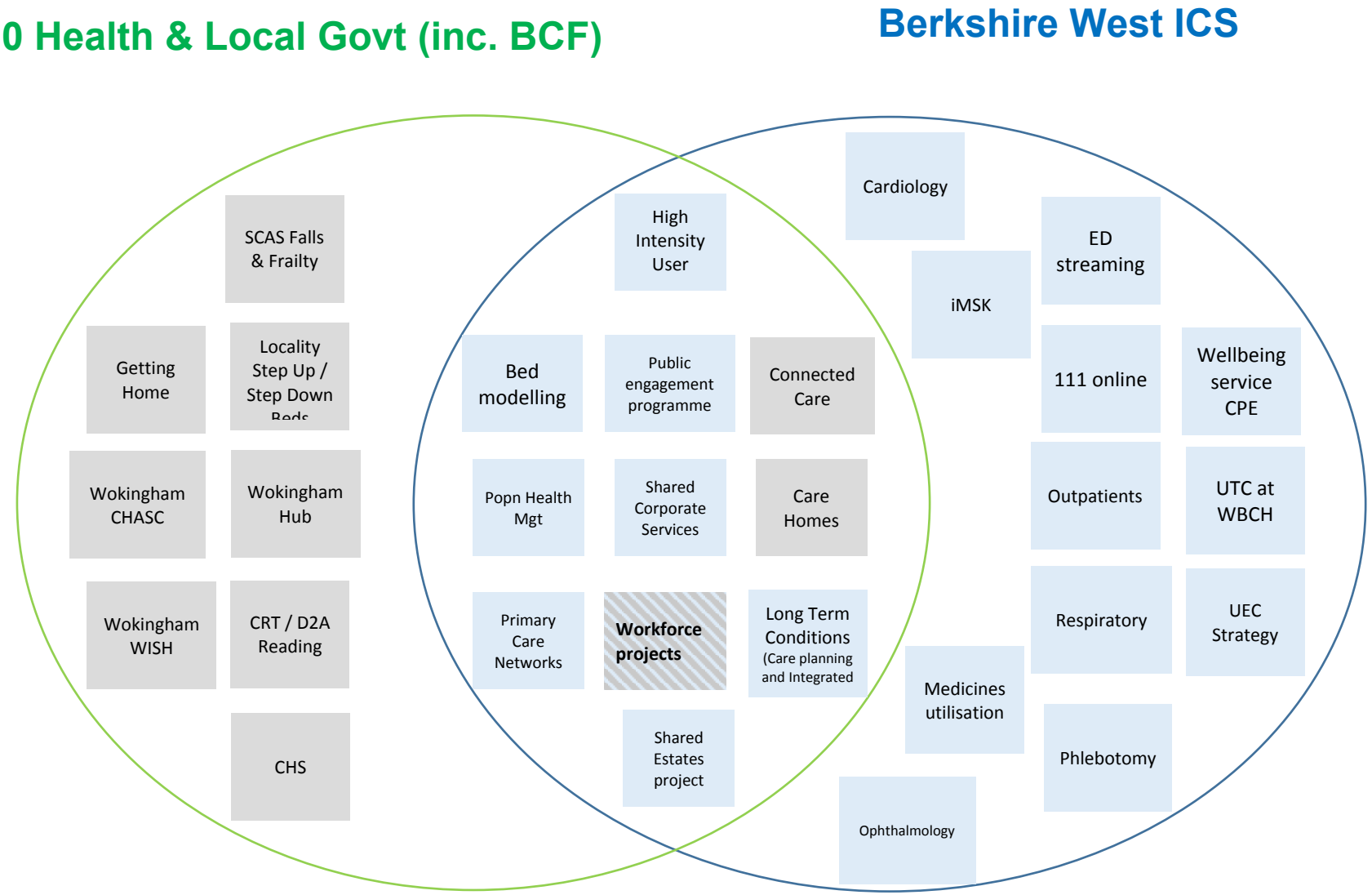


Note: Delivery will also be provided by organisations which will not necessarily align with this taxonomy

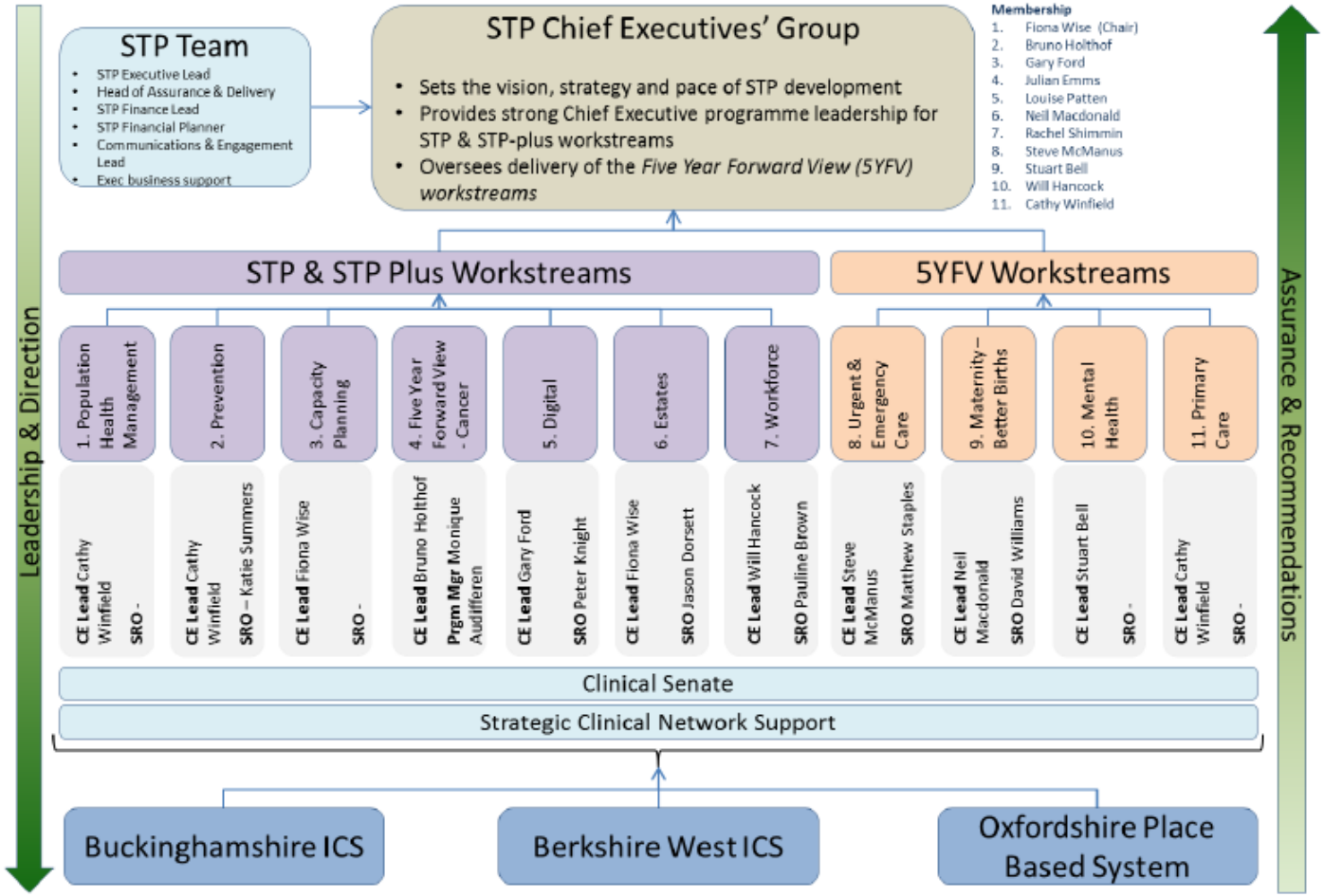
Fig 2 – Proposed BWICP Governance Structure



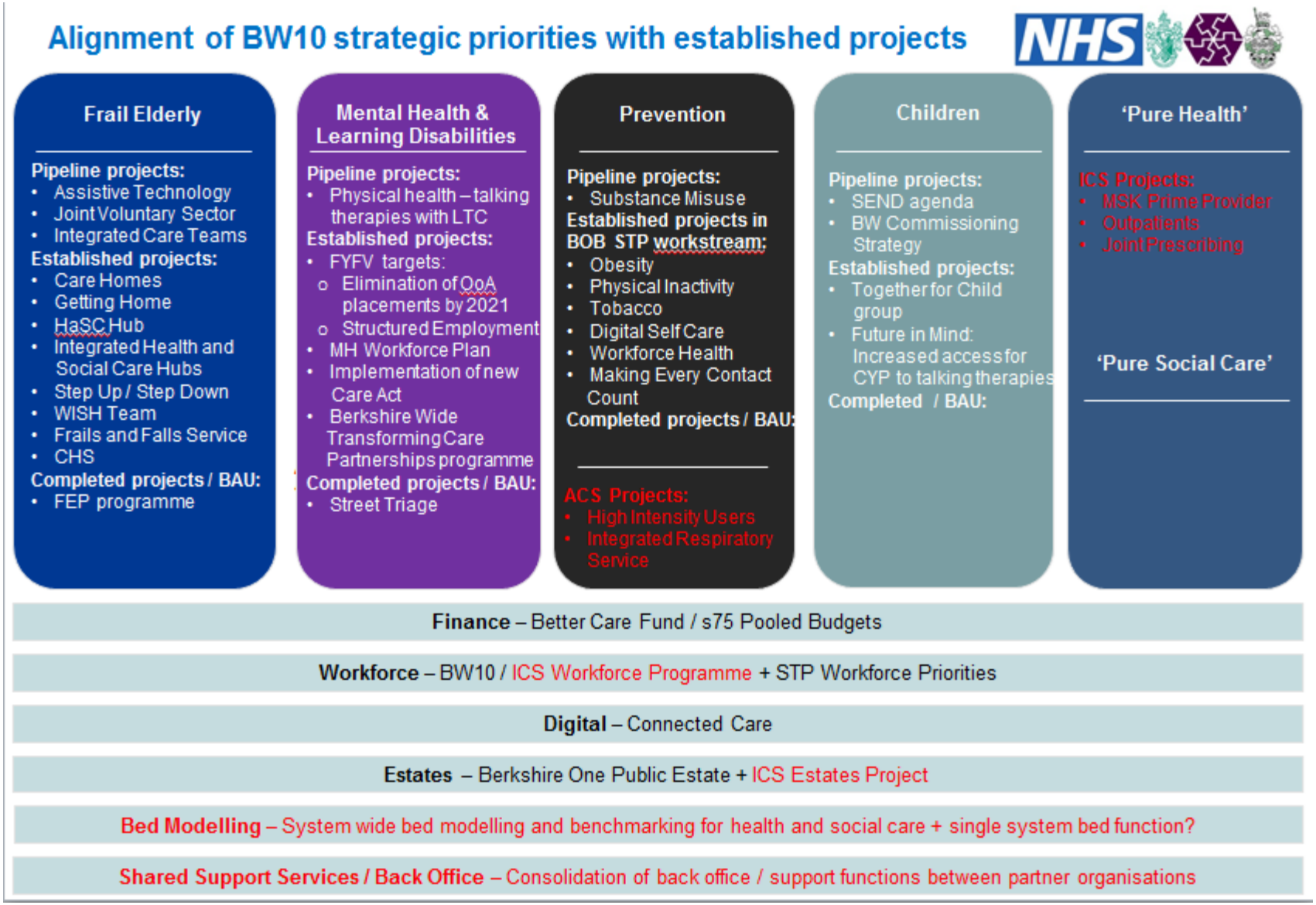
Appendix 1 – BW10 and BW10 ICS - Roles & Responsibilities and areas of common interest



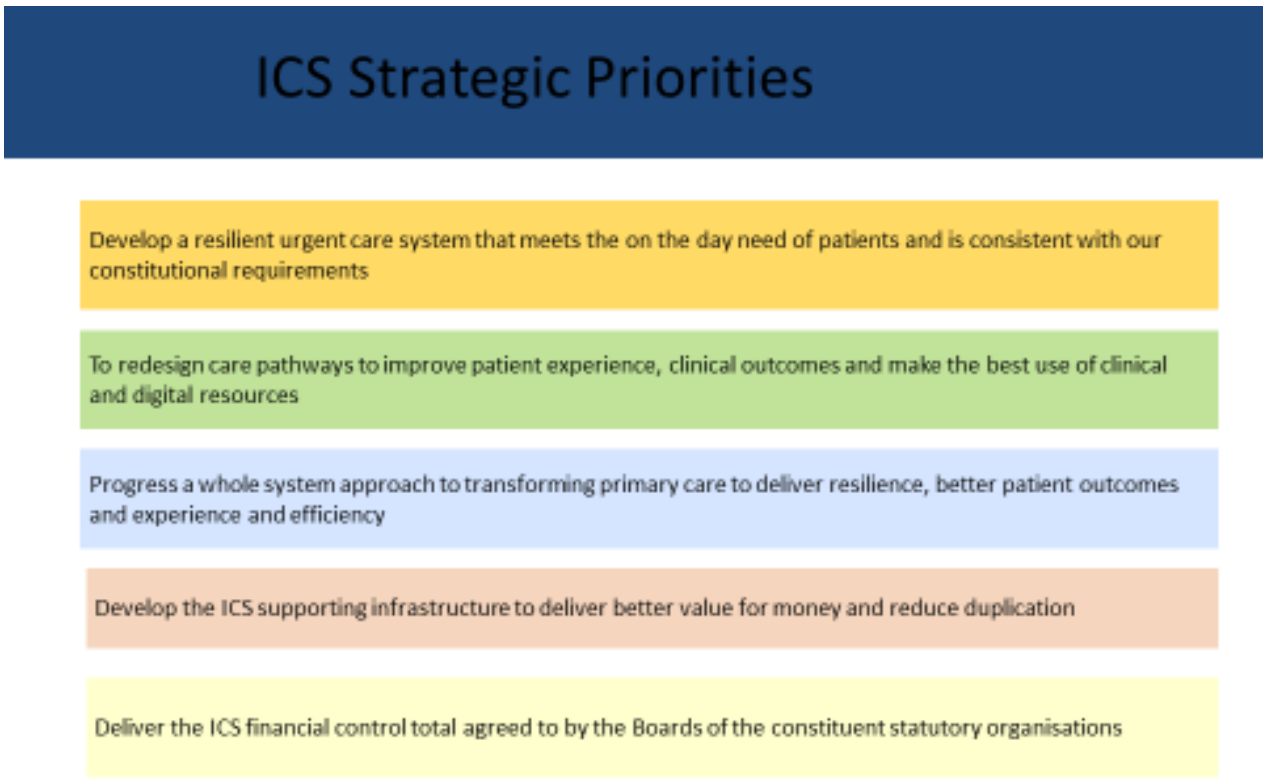
Appendix 2 – BOB STP Governance Chart – November 2018


STP Team
STP Executive Lead
Head of Assurance & Delivery
STP Finance Lead
STP Financial Planner
Communications & Engagement Lead
Exec business support
STP Chief Executives' Group
Sets the vision, strategy and pace of STP development
Provides strong Chief Executive programme leadership for STP & STP-plus workstreams
Oversees delivery of the Five Year Forward View (5YFV) workstreams
Membership
1. Fiona Wise (Chair)
2. Bruno Holthof
3. Gary Ford
4. Julian Emms
5. Louise Patten
6. Neil Macdonald
7. Rachel Shimmin
8. Steve McManus
9. Stuart Bell
10. Will Hancock
11. Cathy Winfield
Leadership & Direction
Assurance & Recommendations
STP & STP Plus Workstreams
5YFV Workstreams
1. Population Health Management
CE Lead Cathy Winfield SRO -
2. Prevention
CE Lead Cathy Winfield SRO – Katie Summers
3. Capacity Planning
CE Lead Fiona Wise SRO -
4. Five Year Forward View - Cancer
CE Lead Bruno Holthof Prgm Mgr Monique Audifferen
5. Digital
CE Lead Gary Ford SRO Peter Knight
6. Estates
CE Lead Fiona Wise SRO Jason Dorsett
7. Workforce
CE Lead Will Hancock SRO Pauline Brown
8. Urgent & Emergency Care
CE Lead Steve McManus SRO Matthew Staples
9. Maternity – Better Births
CE Lead Neil Macdonald SRO David Williams
10. Mental Health
CE Lead Stuart Bell SRO -
11. Primary Care
CE Lead Cathy Winfield SRO -
Clinical Senate
Strategic Clinical Network Support
Buckinghamshire ICS
Berkshire West ICS
Oxfordshire Place Based System

Appendix 3a – The Vision Framework for Berkshire West 10 (October 2018)



Appendix 3b – The Strategic Priorities of the Berkshire West ICS



Appendix 4a – Health & Social Care Governance Arrangements for BWI0

RBFT Board

BHFT Board

GP Alliances

Joint work through the ICS

CCG Governing Body
Statutory Body, clinically led, with responsibility in particular for commissioning certain health services to meet the reasonable needs of all those for whom the CCG has statutory responsibility and Commissioning of emergency care for anyone present in the Geography

Locality Councils for NWR & SR Reading
Made up of member GP Practices and has particular responsibility for providing clinical knowledge and expertise from a locality perspective to the work of CCG

3 x LA Health & Wellbeing Board
Forum for key leaders from the health & social care system to collaboratively drive the health and wellbeing of their local population.

Chief Officers Group
Responsible for setting the strategic direction / vision for integration across Berkshire West

Berkshire West 10 Delivery Group
Responsible for operationalising the strategic direction set by the Chief Officers Group

3 x Local Integration Board
Delivery and oversight of each LA's plan for delivering integration and transformation on a local level

ACE Committee (Adults, Childrens and Education)
Scrutiny Board

Safeguarding Board

Responsible for helping and protecting adults in its area, that is, adults about whom the duty to make enquiries arises under section 42 of the Care Act. The SAB must seek to achieve its objective by coordinating and ensuring the effectiveness of what each of its members does. It can do anything which appears to be necessary or desirable for the purpose of achieving its objective. In particular it has a duty and power to arrange safeguarding adults reviews.

A&E Delivery Board
Statutory Body, clinically led, with responsibility in particular for commissioning certain health services to meet the reasonable needs of all those for whom the CCG has statutory responsibility and Commissioning of emergency care for anyone present in the Geography

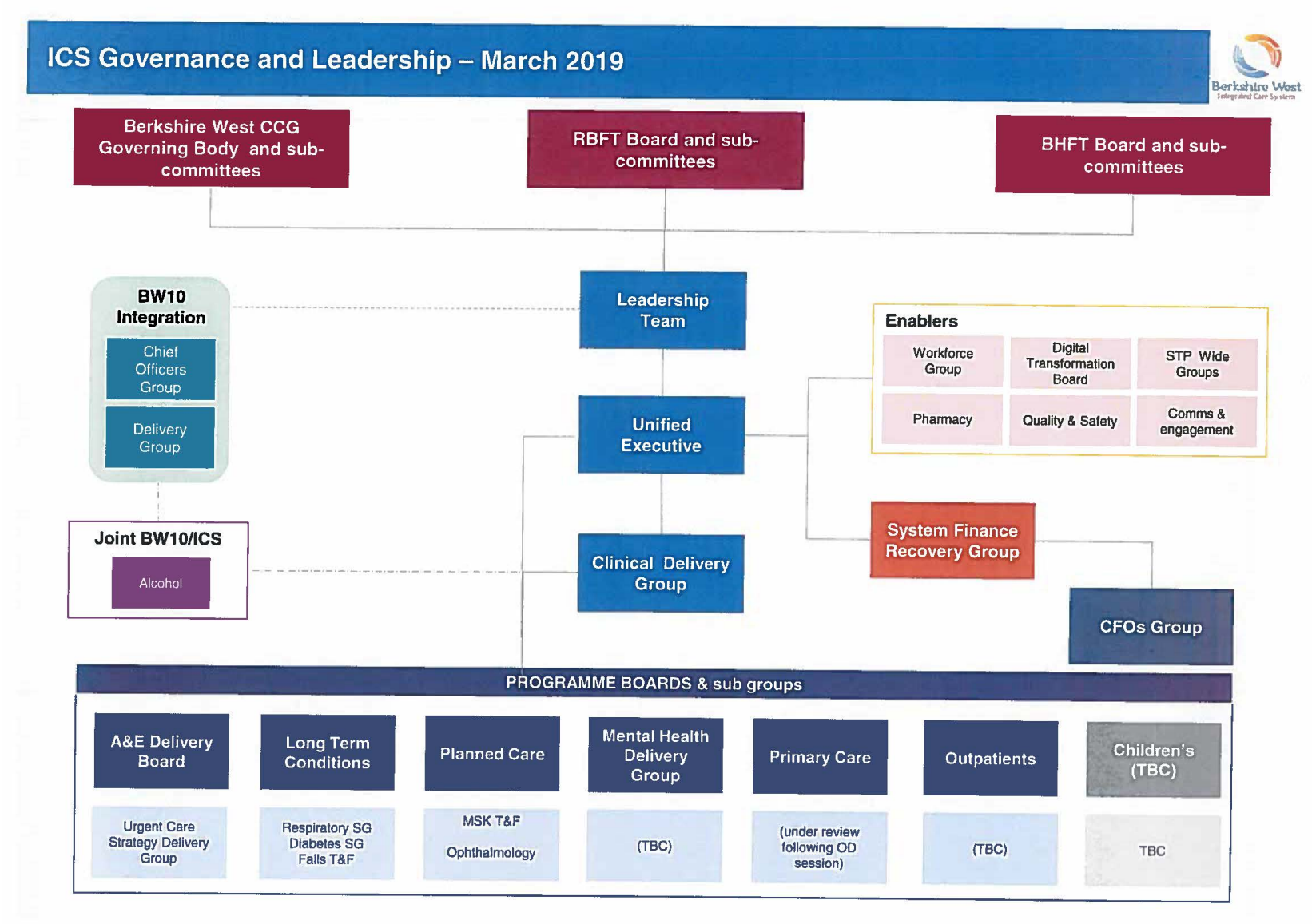
Long Term Conditions Board
Responsible for delivering the Long Term Conditions Transformation Programme across the system, providing strategic direction and identifying opportunities to integrate primary, community and secondary care service models for patients with long term conditions.

Planned Care Board
Responsible for ensuring the strategic programme is delivered to time, quality and cost requirements; ensuring good governance, robust decision making and appropriate engagement with stakeholders.

Mental Health Delivery Board
Responsible for a multi-agency partnership overview and implementation of the Five Year Forward View for Mental Health (MH5YFV)

Primary Care Board
Responsible for commissioning primary medical services across the system, and delivery of the Primary Care Five Year Forward View.

Appendix 4b – Governance arrangements for BWICS



Appendix 5a – Proposed ToR

Berkshire West ICP Leadership Board

Terms of Reference

1 Scope

1.1 The ICP Leadership Board will be responsible for leading the development of the ICP strategy and oversee delivery of the ICP programme aligned as required to the BOB ICP Strategy.

2 Frequency

2.1 The Leadership Board will meet six times per year.

3 Standing

3.1 The meeting of the ICP Leadership Board provides the vehicle for the partners to work as a single partnership. The current sovereignty of the participating organisations is unaffected; however, members of the Leadership Board will be expected to act in accordance with the responsibilities which are vested in them through being Members of the Board.

4 General Responsibilities of the Leadership Team

4.1 The general responsibilities of the ICP Leadership Board are:

(a) to formulate, agree and implement a strategy for the Berkshire West ICP (BWICP) which delivers the objective of stated objectives of the ICP.to ensure alignment of all partners to the Berkshire West ICP strategy to promote and encourage commitment to the principles and strategic priorities

(b) to ensure that Berkshire West is effectively represented within the BOB ICP

(c) to seek to determine or resolve any matter referred to it by the Executive or any individual party; and

(d) the review of the performance of the partners within the Berkshire West ICP Memorandum of Understanding and determining interventions to improve performance or rectify poor performance – recommending remedial and mitigating actions across the system;

(e) review and approve the BWICP programme governance at appropriate intervals
(f)

5 Independent Chair / Programme Director / Programme Manager

5.1 An independent chair has been appointed by the partners to oversee the Leadership Board.

6 Members and Alternate Members of the Leadership Board

6.1 The following will be the Leadership Members:

(a) the current Chief Executive and Chair of RBFT;

(b) the current Chief Executive and Chair of BHFT;

(c) the Berkshire West CCG Chair and Accountable Officer.

(d) the Managing Director and an Executive Member from Reading Borough Council

(e) the Chief Executive and an Executive Member of West Berkshire Council

(f) the Chief Executive and an Executive Member from Wokingham Borough Council

(g) the independent chair of the ICP

(h) A GP who represents GP Provider alliances or Primary Care Networks from within the Berkshire West system.

6.2 An appropriate deputy may be appointed to attend a meeting on behalf of one of the members

6.3 The partners will each ensure that, except for urgent or unavoidable reasons, their respective member (or their appointed deputy) attends and fully participates in all of the meetings of the BWICP Leadership Board.

6.4 No matter will be recommended at any meeting unless a quorum is present. A quorum will not be present unless at least one ICP Leadership Board Member from BHFT, RBFT, GP providers, the three local authorities and the CCG Leadership Board members are in attendance.

6.5 The following will be the non-voting Leadership Board members:

- The BWICP Programme Director

7 Proceedings of Leadership Board

7.1 The Leadership Board will meet on a bi-monthly basis and may call extraordinary meetings as required

7.2 If unavoidable, members may join by telephone conference or video link by exception.

7.3 Each Leadership Board member will have an equal say in discussions and will look to agree recommendations on the basis of the Principles of collaboration (attached).

8 Attendance of third parties at Leadership Board meetings

8.1 The Leadership Board shall be entitled to invite any person to attend but not take part in making recommendations at meetings of the Leadership Board.

9 Administration for the Leadership Board

9.1 Papers for each meeting will be sent to Leadership Board members no later than five days prior to each meeting by the Programme Manager via the Chair. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to Leadership Board members earlier if possible

9.2 The minutes of the ICP Executive meeting will be made available to the ICP Leadership Board on a monthly basis

9.3 Minutes, or where considered appropriate, the action points of the Leadership Board meetings will be circulated to all Leadership Board members as soon as reasonably practical.

10 Review

10.1 The Leadership Board will review these Terms of Reference annually.

(Need to agree a position on this)

Appendix A - Principles of Collaboration (extract from the Berkshire West ICP MoU)

1.1 The Parties agree to adopt the following principles when carrying out the development of the Accountable Care System (the "**Principles**"):

1.1.1 address the vision. In developing the Accountable Care System the Parties seek to address the triple aims of the Forward View: increasing the emphasis on primary prevention, health and wellbeing; improving quality of care by improving outcomes and experience for patients and achieving constitutional standards; delivering best value for the taxpayer and operating a financially sustainable system;

1.1.2 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with the three Berkshire West local authorities and the wider NHS ;

1.1.3 be accountable. Take on, manage and account to each other, the local authorities, the wider NHS and the Berkshire West population for performance of the respective roles and responsibilities set out in this MoU;

1.1.4 be open. Communicate openly about major concerns, issues or opportunities relating to the Accountable Care System and be transparent adopting an open book approach wherever possible (acknowledging the Parties requirements under paragraph 4.1.5 below);

1.1.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection, information governance and freedom of information legislation;

1.1.6 act in a timely manner. Recognise the time-critical nature of the Accountable Care System and respond accordingly to requests for support;

1.1.7 manage stakeholders effectively with a clear intention to engage with all relevant stakeholders in the development of the Accountable Care System and to look towards the future inclusion of social care and the local authorities as parties to the arrangements;

1.1.8 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

1.1.9 act in good faith to support achievement of the Key Objectives and compliance with these Principles and to develop appropriate "Rules of Engagement" between stakeholders in the Accountable Care System

Proposed amendments to ICP Leadership Board Terms of Reference

Timing

- The Leadership Board should meet six times per year 2 weeks after the Executive; the Chair to determine agenda in collaboration with the Programme Director.
- Meeting dates to be agreed annually.
- Meetings should be scheduled for two hours each.
- The ICP Chairs will meet in intervening months for an informal catch-up and alignment discussion

Pre-read and interim-read

- Executive minutes to be copied to LB members. This is for information/context only and should not repeat/over-lap with papers for the LB.

Attendees

- As per proposal except;
    - Only "minute-taker" and Programme director needed to support every meeting.
    - Any external/mgt. group contributors should attend only for their discussion and only with prior approval from the Chair.
    - One GP provider representative as a permanent and consistent attendee
    - Quorum – at least one representative from all of BH, RB, CCG, GP and Chair make LB quorate, with Chair able to nominate his replacement in event of unavoidable absence.

Scope and philosophy

- The ICP Leadership Board (LB) represents all parties constructed within the ICP framework and within the scope of the MoU. It is instrumental in developing and implementing the BWICP strategy.
- LB will consider the capacity, resources, transformation, operations and reputation of, and risks to, the BWICP as a whole relation to agreed strategy and the wider system as a whole. As such it (LB) will endeavour to ensure cohesion, integration and collegiate working practices and behaviours to deliver the strategy and objectives of the BWICP and amongst providers, commissioners and work-groups.
- Under no circumstances should the LB concern itself with day to day operations. Subsidiarity should apply albeit with the joint rights to challenge a decision if it is felt by other members that a wider intervention/opportunity is possible.
- All members of the LB should focus solely on “full width" ICP matters - strategy, transformation sustainability and delivery. It should focus on and be prepared to act together to intervene on unambitious, slow or weak performance where a risk to the BWICP is identified by members of the Board.
- A mantra might be that, we all leave our organisation out of the room when we come in.
- Support proposals which benefit the whole system, where there is agreed evidence that the proposal will materially improve the care of patients achievable within available funding for the

whole BWICP. Where changes necessary to meet an improvement to BWICP is a detriment to one provider, the members agree to identify mitigations in an equitable way through an agreed risk share.

- The Chair must be willing to meet key stakeholders and regulators on a regular basis to support our ambitions and promote external relations, including contact with other similar bodies and those representing ICP objectives.

LB primary purpose and responsibilities

- **Act** to optimise the Berkshire West health and social care system in delivering better care for patients with increased cost effectiveness.
- **Concentrate** on the creation of strategy, building confidence with all partners, approval of key efficiency programmes, resolution of strategic blockers, delegation to executives for implementation and direct challenge where there is under delivery/performance.
- **Lead** the development and articulation of the ICP' strategy and oversee delivery of programmes and commitments.
- **Ensure** delivery of the requirements set out in the MoU agreed between the BWICP leaders and NHSE/I.
- **Create** a shared understanding of the 'vision' and 'end point' for the ICP and ensure this is aligned with the Principles and objectives.
- **Intervene** robustly to address shortfall in delivery and performance of mgt groups, work-streams for individual members of BWICP.

Appendix 5b – Proposed ToR

Berkshire West ICP Executive

Terms of Reference

1 Scope

1.1 The Executive will be responsible for the day to day leadership, management and support of the activities of the BWICP work programme of the Executive is to have a tactical level of detail, ensuring processes are in place to support high quality outcomes for services and the population of Berkshire West.

2 Frequency

2.1 The ICP Executive shall meet twelve times per year, on a monthly basis.

3 Standing

3.1 The meeting of the Executive provides the vehicle for the Partners to work as a singe alliance. The current sovereignty of these organisations is unaffected; however, members of the Executive will be expected to act in accordance with the responsibilities which are vested in them by virtue of their formal roles within their organisations.

4 General Responsibilities of the ICP Executive

4.1 The general responsibilities of the Executive are:

(a) to deliver and have oversight of the BWICP programme, taking management decisions where required to ensure strong performance

(b) monitoring the achievement of the objectives and receiving reports from the ICP Delivery Group on progress in the development of the ICP work programme.

(c) to manage and have oversight of the use of the nationally allocated Transformation Fund and to have oversight of the Better Care Fund (BCF)

(d) providing clinical, professional and managerial leadership with regard to the services

(e) ensuring compliance with the governance regime and leading the parties behaviour in accordance with the principles of the BWICP

(f) approve the appointment, removal or replacement of programme management

5 Reviews/Reporting

5.1 The ICP Delivery Group streams will report to the Executive and the Executive may request that SROs of the agreed attend Executive meetings where appropriate.

6 Members and Alternate Members of the Executive Team

6.1 Each partner will appoint and will at all times maintain the following Executive member(s) on the Executive

6.2 The Executive Members will be

(a) Chief Officer and one Director of Berkshire West CCG

(b) Chief Executive and one Director from the Royal Berkshire Foundation Trust

(c) Chief Executive and one Director from Berkshire Healthcare Foundation Trust

(d) Chair of the ICP Clinical Strategy Group

(e) A CFO to represent the CFO Group (can be fixed or rotated at the discretion of the CFO Group)

(f) Managing Director and one other Director from Reading Borough Council

(g) Chief Executive and one Director from West Berkshire Council

(h) Chief Executive and one Director from Wokingham Borough Council

(i) Strategic Director for Public Health (Berkshire)

(j) BWICP Programme Manager

(k) Any two GP members of the four GP provider alliances.

6.3 An appropriate deputy may be appointed to attend a meeting on behalf of one of the members

6.4 The Partners will ensure that, except for urgent or unavoidable reasons, their respective Executive member (or their appointed alternative) attends and fully participates in all of the meetings of the Executive.

6.5 No matter will be recommended at any meeting unless a quorum is present. A quorum will not be present unless at least one (1) Executive Team Member from BHFT, RBFT, GP providers and each of the Local Authorities are in attendance

7 Proceedings of Executive Meetings

7.1 The Executive members shall agree and appoint a unified Executive Team member (or in his absence his Alternate Executive Team member) to be the chairman of the Executive Team (the "Executive Team Chairman")

7.2 If unavoidable members may joint by telephone conference or video link by exception

7.3 Each Executive Team member (or its alternate) will have an equal say in discussions and will look to agree recommendations on the basis of the Principles.

8 Attendance of third parties at Executive Team meetings

8.1 The Executive Team may invite any person to attend but not make recommendations at meetings of the Executive Team.

9 Administration for the Executive Team

9.1 Papers for each meeting will be sent to Executive Team members no later than five days prior to each meeting by the Programme Manager via the Chair. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to Leadership Board members earlier if possible

9.2 The minutes of the Executive Team meeting will be made available to the Executive Team members as soon as reasonably practicable

9.3 Minutes, or where considered appropriate, the action points of the Leadership Board meetings will be circulated to all Leadership Board members as soon as reasonably practical.

10 Review

10.1 The Executive Team will review these Terms of Reference annually.

Appendix A - Principles of Collaboration (extract from the Berkshire West ICP MoU)

1.2 The Parties agree to adopt the following principles when carrying out the development of the Accountable Care System (the "**Principles**"):

1.2.1 address the vision. In developing the Accountable Care System the Parties seek to address the triple aims of the Forward View: increasing the emphasis on primary prevention, health and wellbeing; improving quality of care by improving outcomes and experience for patients and achieving constitutional standards; delivering best value for the taxpayer and operating a financially sustainable system;

1.2.2 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with the three Berkshire West local authorities and the wider NHS ;

1.2.3 be accountable. Take on, manage and account to each other, the local authorities, the wider NHS and the Berkshire West population for performance of the respective roles and responsibilities set out in this MoU;

1.2.4 be open. Communicate openly about major concerns, issues or opportunities relating to the Accountable Care System and be transparent adopting an open book approach wherever possible (acknowledging the Parties requirements under paragraph 4.1.5 below);

1.2.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection, information governance and freedom of information legislation;

1.2.6 act in a timely manner. Recognise the time-critical nature of the Accountable Care System and respond accordingly to requests for support;

1.2.7 manage stakeholders effectively with a clear intention to engage with all relevant stakeholders in the development of the Accountable Care System and to look towards the future inclusion of social care and the local authorities as parties to the arrangements;

1.2.8 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

1.2.9 act in good faith to support achievement of the Key Objectives and compliance with these Principles and to develop appropriate "Rules of Engagement" between stakeholders in the Accountable Care System

Appendix 5c – Proposed ToR

Berkshire West ICP Delivery Group

Terms of Reference

1. Scope

The ICP Delivery Group will have programme management of the ICP work programme. It will report to the BWICP Executive primarily in the form of exception reporting. The Group will oversee where appropriate the work of the Programme Boards and supporting groups. The Delivery Group has a key co-ordinating role within the ICP governance.

2. Standing

The meeting of the ICP Delivery Group provides the vehicle for the partners to work as a single partnership and to coordinate work across the whole ICP.

3. General responsibilities of the Delivery Group

3.1 The general responsibilities of the ICP Delivery Group are;

(a) Act as a Programme Board with regard to the ICP. As such the ICP DG will be responsible for overseeing the implementation of actions focussed on the delivery of the BWICP objectives and in support of the BOB ICP

(b) Co-ordinate the allocation of resources to ensure that the IIP work programme can be delivered

(c) Provide effective challenge and peer review in considering and approving PIDS and business cases relating to projects and schemes relevant to the work programme.

(d) Review progress against the critical success factors and put in place appropriate performance management arrangements which enable assurance of expected impact.

(e) Review the governance arrangements for the ICP as required and to act as custodian and guardian of them to ensure that governance and decision making arrangements are consistent and effective.

(f) Prepare a regular review of the Berkshire West system performance for consideration both by the BW ICP Executive and the BW ICP Leadership Board.

(g) Provide assurance to the Executive on progress highlighting any risks and issues.

(h) The BW ICP DG will amend the ICP work programme as programmes, resources and strategies dictate.

4. Members and Alternate Members of the Delivery Group

4.1 The following will be the Delivery Group Members

- Directors of strategy with the NHS
- Directors of Adult Social Services and Directors of Children's Services
- Programme Board Chairs and the Chairs of other supporting groups
- The SDoPH or his/her Deputy

4.2 An appropriate deputy may be appointed to attend a meeting on behalf of one of the Members.

4.3 The BWICP DG will be chaired by a Chief Executive from the BWICP Executive. The Chief Executive will be drawn from the sector (NHS or local government) that is not chairing the BWICP Executive. The Chair will rotate annually as at the BWICP Executive.

4.4 The partners will each ensure that, except for urgent or unavoidable reasons, their respective Member/or appointed deputy) attends and fully participates in all of the meetings of the BWICP Delivery Group.

5. Proceedings of the Delivery Group

5.1 The Group will meet on a monthly/bi-monthly basis and may call extraordinary meetings as required.

5.2 If unavailable, Members may join by telephone conference or video link by exception.

5.3 Each Delivery Group member will have an equal say in discussions and will look to agree recommendation on the basis of the Principles of Collaboration (attached).

6. **Attendance of third parties at Delivery Group meetings**

6.1 The Delivery Group shall be entitled to invite any person to attend but not take part in making any recommendations at meetings of the Delivery Group.

7. Administration for the Delivery Group

7.1 Papers for each meeting will be sent to Delivery Group members by the ICP Programme Office no later than five days prior to each meeting. The agenda and papers will have previously been agreed by the Chair. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effect will be made to circulate papers to Delivery Group members earlier if possible.

7.2 Minutes and action points of the Delivery Group meetings will be circulated to all Delivery Group members as soon as reasonably practical.

8. Review

8.1 The Delivery Group will review these Terms of Reference annually.

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12 JULY 2019**		
REPORT TITLE:	**RESPONSE TO THE HEALTHWATCH READING REPORT ' LGBT+ Your experiences as Lesbian, Gay, Bisexual, Transgender people accessing Health & Social Care Services in Reading'**		
REPORT AUTHOR:	**CLARE MUIR/DEBBIE SIMMONS**	**TEL:**	**0118 937 2119 /**
JOB TITLE:	**POLICY AND VOLUNTARY SECTOR MANAGER/ NURSE DIRECTOR BERKSHIRE WEST CCG**	**E-MAIL:**	**clare.muir@reading.gov.uk/ debbie.simmons2@nhs.net**
ORGANISATION:	**READING BOROUGH COUNCIL / BERKSHIRE WEST CLINCAL COMMISSIONING GROUP**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This is the joint response of the local authority, Reading Borough Council (RBC), and the local clinical commissioning group (Berkshire West CCG) to a report 'LGBT+ Your experiences as Lesbian, Gay, Bisexual, Transgender people accessing Health & Social Care Services in Reading', presented by Healthwatch Reading to the October 2018 meeting of the Reading Health and Wellbeing Board.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board notes this joint response and asks Healthwatch Reading to share it with Support U and others who contributed to the report.

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 requires local authorities to establish a Local Healthwatch in their areas as a consumer champion for healthcare and social care services. Healthwatch Reading is commissioned to deliver this service for the Reading locality, which includes promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of local health and social care services.

3.2 Healthwatch Reading prepared a report which was the outcome of an online survey undertaken in partnership with Support U a charity providing a resource service for those needing help with Lesbian, Gay, Bisexual and Transgender issues, based in the Thames Valley. The survey aimed to collect the views and experiences of Reading people who are Lesbian, Gay, Bisexual, Transgender, and other people identifying as

members of this community (LGBT+) accessing health and social care services in Reading.

3.3 It should be noted that the report is based on the replies of 35 people who responded to the survey.

4. REPORT RECOMMENDATIONS

4.1 Healthwatch Reading and SupportU made 4 recommendations:

1. NHS and social care services should ensure that the training of their staff is up to date regarding the health needs of LGBT+ people and working with diverse groups. It should take account of the advice given which includes:

    - Do not make judgemental comments
    - Do not ask questions about gender and sexual orientation beyond what they need to know to provide care or help
    - Do not make assumptions about the relationship between any person and the person(s) accompanying them

1.

2. NHS and social care services should take steps to be more clearly welcoming to and respectful of diversity e.g. using posters, LGBT+ pins on their lanyards – and ensure greater ease of access to LGBT+ related information and points of contact for any LGBT+ concerns or issues patients/service users may wish to raise

3. Reading Borough Council should explore supporting social care provision that is sensitive to the needs of LGBT+ people

4. Local commissioners and providers should ensure that they use 'Out Loud: LGBT Voices in Health and Social Care' a national resource, published in 2016 by The National LGBT Partnership and based on the views of more than 200 people identifying as LGBT+ ; 'Sexual Orientation, a guide and toolkit for the NHS' from Stonewall; the Healthwatch Reading report and other resources mentioned in the discussion section of the report, to inform the commissioning of LGBT+ inclusive local health and social care services, and staff training in these services.

5. JOINT RESPONSE TO THE RECOMMENDATIONS

5.1 Berkshire West CCG (Clinical Commissioning Group) and Reading Borough Council welcome the report and have had positive discussions regarding the benefits of joint working and sharing of learning for patients and clients locally. In response the Berkshire West CCG has set up an ICS (Integrated Care System) Equality and Diversity Committee to bring together the Equality and Diversity leads from the local system to ensure a consistent approach.

Attendees include Equality and Diversity leads from:

- Berkshire West CCG
- Berkshire Healthcare NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- Reading Borough Council
- West Berkshire Council
- Wokingham Borough Council
- Healthwatch Reading

The initial meeting was held in January 2019 at which the Healthwatch LGBT+ report was discussed.

The Terms of Reference for the Committee were agreed at its meeting April. The Committee will monitor, discuss and collectively take action to drive improvements in ensuring and promoting Equality and Diversity across the Berkshire West ICS. The aims of the Committee are as follows:

- Support partners in having due regard to the Public Sector Equality Duty
- Embed the use of Equality Impact Assessments in all decisions and policies
- Receive assurance on the use of the NHS Equality Delivery System (EDS2), and NHS Workforce Race Equality Standards (WRES,) along with any associated action plans
- Drive closer partnership working on Equality and Diversity
- and meetings are being held on a quarterly basis.

5.2 Recommendation 1 - Training

All providers currently require all staff to undertake Equality and Diversity training which includes elements relating to LGBT+ clients/patients. There was agreement that both the content of the training and the provider of the training could be reviewed as part of the future work of the committee. It was also agreed that consideration would be given to using patient story videos as these can be more relatable and memorable for staff. **A** Task & Finish Group has been set up to explore best practice with engaging and supporting the bisexual and transgender elements of the LGBT+ community.

5.3 Recommendation 2 - Welcoming

All providers will explore the ways in which services can be seen as more clearly welcoming to LGBT+ patients and service users. SupportU and Healthwatch Reading will support by providing posters and information to be used on the screens within GP practices; a short article will also be provided to be included within the newsletter sent to all GP Practices in Berkshire West.

5.4 Recommendation 3 – Sensitive Social Care

Reading Borough Council supports social care provision that is sensitive to the needs of LGBT+ people by providing all staff, on induction, with Equality and Diversity training and a further specific Trans Awareness – E-Learning course. This is supplemented by an e-link to further resources such as information from the JSNA. This has recently been augmented by the addition of the resources in para 5.5.

5.5 Recommendation 4 – Use of National Guidance

The resources 'Out Loud: LGBT Voices in Health and Social Care'; 'Sexual Orientation, a guide and toolkit for the NHS' from Stonewall and the Healthwatch Reading report have been added to Reading Borough Council's Equality and Diversity training module.

6. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

6.1 The issues raised in the report are relevant across the priorities from the Reading Health and Wellbeing Strategy 2017-20 and particularly relate to the building blocks of the strategy to safeguarding vulnerable adults and children.

7. COMMUNITY & STAKEHOLDER ENGAGEMENT

7.1 The report outlines that Healthwatch Reading partnered with local charity SupportU and created an online survey, which was promoted on Twitter and on Facebook. The project ran from 27th February to 3rd April. Healthwatch Reading also contacted large local businesses and other local organisations to share the survey link. Paper copies of the survey were available to attendees at an event in Reading Central Library during LGBT+ Awareness Week in February 2018 and were also available at SupportU events during the survey period. SupportU circulated the survey link to a wide range of LGBT+ groups, including Reading Pride and MyUmbrella, and to other local groups including ACRE.

8. EQUALITY IMPACT ASSESSMENT

8.1 Under the Equality Act 2010, Section 149, a public body 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.

8.2 The findings and recommendations of the Healthwatch Reading Report contribute to positive equality impact.

9. LEGAL IMPLICATIONS

9.1 There are no direct legal implications arising from this report.

10. FINANCIAL IMPLICATIONS

10.1 There are no direct financial implications arising from this report.

11. BACKGROUND PAPERS

11.1 HEALTHWATCH READING REPORT ' LGBT+ Your experiences as Lesbian, Gay, Bisexual, Transgender people accessing Health & Social Care Services in Reading, 2018

healthwatch

NHS Long Term Plan

Public engagement report

Buckinghamshire, Oxfordshire, and Berkshire West (Reading, West Berkshire and Wokingham)

---

what would you do?

It's your NHS. Have your say.

Contents

Executive summary

About this report

This report presents a summary of views collected from nearly 1,250 people living in the Buckinghamshire, Oxfordshire and Berkshire West (BOB) NHS area, in April and May 2019.

This project was part of a simultaneous exercise by all 152 local Healthwatch in England, to inform implementation of the NHS Long Term Plan published in January 2019.

The five local Healthwatch within BOB - Buckinghamshire, Oxfordshire, Reading, West Berkshire, and Wokingham, engaged with communities in person and online to collect:

- 938 responses to a general survey supplied by Healthwatch England (HWE)
- 219 replies to a HWE-supplied survey about care of specific conditions such as cancer
- In-depth views of 87 people via 10 focus groups (four on adult mental health, and one each on learning disabilities, older people, Asian women, young onset adult dementia, young carers, and people living in a neighbourhood with high deprivation.

Healthwatch Reading acted as the coordinator, analysing and compiling the BOB-wide findings and submitting them to the BOB Integrated Care System (ICS), previously known as the BOB Sustainability and Transformation Partnership. The aim is to ensure patient experience informs an upcoming BOB ICS report on how it will implement the Long-Term Plan. The five Healthwatch will also publish findings on their own websites.

About BOB and the local population

Around 1.8m people live across BOB, in a mix of urban centres in Aylesbury, Oxford and Reading, as well as market towns, villages and more rural areas. The general population is expected to significantly increase due to waves of new homes being built, and the number of over-75s who need more health and care support will also grow. There are also significant pockets of deprivation, and ethnically diverse populations, in Oxford and Reading.

Three NHS trusts run major hospitals across BOB (John Radcliffe, Royal Berkshire and Stoke Mandeville), while two other trusts provide community and mental health services, and a single trust provides ambulance services. However, for most people, their main contact with the NHS is with a GP: 18,000 patients are seen every day by the 175 GP surgeries across BOB.

Funding and planning of health and care is undertaken by multiple bodies across BOB:

- the BOB ICS sets strategy on workforce and NHS buildings, allocates some NHS funds, and holds organisations to account on cancer, maternity, mental health, urgent and emergency care, primary care and digital developments;
- seven, GP-led clinical commissioning groups (CCGs) spend NHS budgets and plan care for their local populations;
- 14 local authorities fund social care and public health services for their residents; elected councillors also scrutinise local decisions on health and care services
- two integrated systems in Berkshire West, and Buckinghamshire, involve partnership working between CCGs and healthcare providers.

Key themes and findings

Access to healthcare

The public's number one priority is getting healthcare when needed, without delay.

- → 85% of people say it is 'very important' to access help and treatment when needed
- → 54% say it is more important to see any available health professional when first seeking help, rather than waiting longer to see a professional they know
- → 47% of people with a specific condition, said the wait for their initial assessment or diagnosis was 'slow or very slow'

Communication

People value health professionals who listen, give options, answer questions, have a caring manner, and adapt communication methods for those with extra needs.

- → 84% of people say it was 'very important' that professionals listen when they speak to them about health concerns
- → 67% say it was 'very important' that choosing the right treatment is a joint decision between them and the health professional
- → People with learning disabilities told us they need professionals to explain things simply and be patient with them
- → Some people with mental health needs want professionals to show more empathy
- → People want to be offered interpreters if they cannot speak English

Managing ongoing conditions

People with conditions value the relationship they have with expert teams as it helps them better manage their care and stops them having to repeat their story.

- → For long-term support, 62% of people would prefer to wait to see a health professional they know, than to see an available health professional more quickly

Mental health care

Mental health services need urgent investment and improvement.

- → The largest number of negative comments collected in our project was on this topic

Healthy lifestyles

People want personalised goals from the NHS to become or stay healthy but also think government, business, schools and councils should also play a part.

Care in later life

People want to keep their independence for as long as possible.

- → 77% say it is 'very important' to stay at home for as long as it is safe to do so.
- → People told us they want access to high quality, and affordable, or free, social care

Digital technology

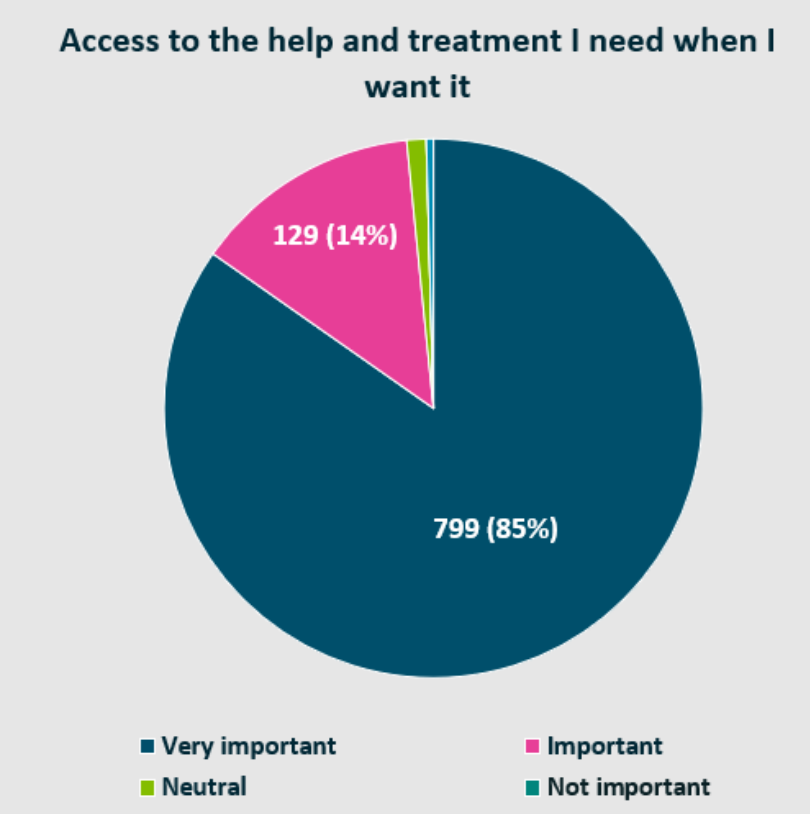
People who are happy with digital technology want it more widely used by the NHS, while those who can't use it (due to lack of skills or equipment, or poor broadband coverage) don't want to become 'second-class' NHS citizens.

Chapter 1: General survey findings

This section sets out findings to all questions in the general survey, completed by 938 people. The pie chart for each question shows the BOB ICS-wide findings and a breakdown is also given for the top finding for each of the five local authority/Healthwatch areas, and for the Berkshire West area (Reading, West Berkshire and Wokingham combined), to specifically inform the commissioners and providers who work together as a system there.

Question 1: What is important to people to help them live a healthy life?

Respondents were asked to rate the importance of five separate statements. Most people said it was very important to have access to help and treatment they needed, when they wanted it, followed by wanting health care professionals to listen to them.



BOB-wide finding on access to care

Local breakdown

Buckinghamshire (Bucks): 87%

Oxfordshire: 86%

Reading: 85%

West Berkshire (West Berks): 85%

Wokingham: 81%

Berkshire West partnership of Reading, Wokingham and West Berkshire: 85%

Many of the comments we received on the theme of access were about difficulties in contacting their doctor's surgery or getting timely appointments with GPs:

"Not having to spend ages on the phone trying to get through to my GP surgery - most online appointments are for weeks in advance so you still have to ring if it's urgent."

"Make it possible to see my own GP in less than four weeks as it is at the moment."

"GP open in the evening and weekend for people who work Mon-Fri."

More findings on helping people to live a healthy life

- **84% of people (788) across Buckinghamshire, Oxfordshire and Berkshire West (BOB) say is very important to them, that professionals 'listen to me when I speak to them about my concerns'**

Local breakdown:

Bucks: 85%	Oxfordshire: 90%	Reading:85%
West Berks: 84%	Wokingham: 79%	Berkshire West: 83%

People told us they wanted professionals to hear them fully rather than 'jump in' and make assumptions or be dismissive. People told us they were aware of the pressure that professionals were under and that consultation times were often too short.

"To be listened to and taken seriously."

"The time limit on my GP appointment was too short to talk about my concerns."

"When I first went to see my GP to talk to someone about my diminishing mental health, I was dismissed. After repeated visits to no avail, I saw a different GP who signposted to me to Talking Therapies."

"I had to go to the GP two times before they listened to me about what I thought was wrong. I know my body so when I was told it was a just a muscular problem, I knew that was incorrect."

- **65% of people (609) say it is very important to have easy access to the information they need to help them make decisions about their health and care**

Local breakdown:

Bucks: 58%	Oxfordshire: 68%	Reading:71%
West Berks: 67%	Wokingham: 67%	Berkshire West: 66%

People told us they want to feel that professionals or services are not trying to withhold information from them about potential care options. They also want easy access to up-to-date information they can look up about themselves.

"A one-stop-shop type service where I can find all the info I need at the click of a button."

"My experience of asking for information is 'we know better, you don't need to know'."

"More information at the time, about long-term effects and options for treatments."

More findings on helping people to live a healthy life

- **62% of people (581) say it is very important to have the knowledge to help them do what they can to prevent ill health**
  Local breakdown:

Bucks: 60%	Oxfordshire: 68%	Reading:64%
West Berks: 59%	Wokingham: 63%	Berkshire West: 62%

People want specific goals tailored to them as individuals, rather than just blanket public health messages, in a way that is simple to understand, potentially backed up by short courses that give them any new skills they need on managing their own health, recognising symptoms and changing their lifestyle. Ongoing encouragement is also important.

"The NHS is big on giving 'knowledge' but often this is full of jargon and not personalised. Many people need support to gain skills to change."

"Told in layman's terms."

"Information about eating healthier that's easy to understand. Advice on exercise I can do on my own. Appointments with a nurse to talk over difficulties."

"Advice sessions re diet and exercise. Possible sessions for groups to meet and discuss needs with professionals."

- **61% say it is very important for every interaction with health and care services to count; for their time to be valued**
  Local breakdown:

Bucks: 58%	Oxfordshire: 64%	Reading:63%
West Berks: 61%	Wokingham: 57%	Berkshire West: 61%

People told us they want health care professionals to be enabled to give enough time during appointments and they also want services to do more to prevent the hospital appointments or operations being changed at the last minute.

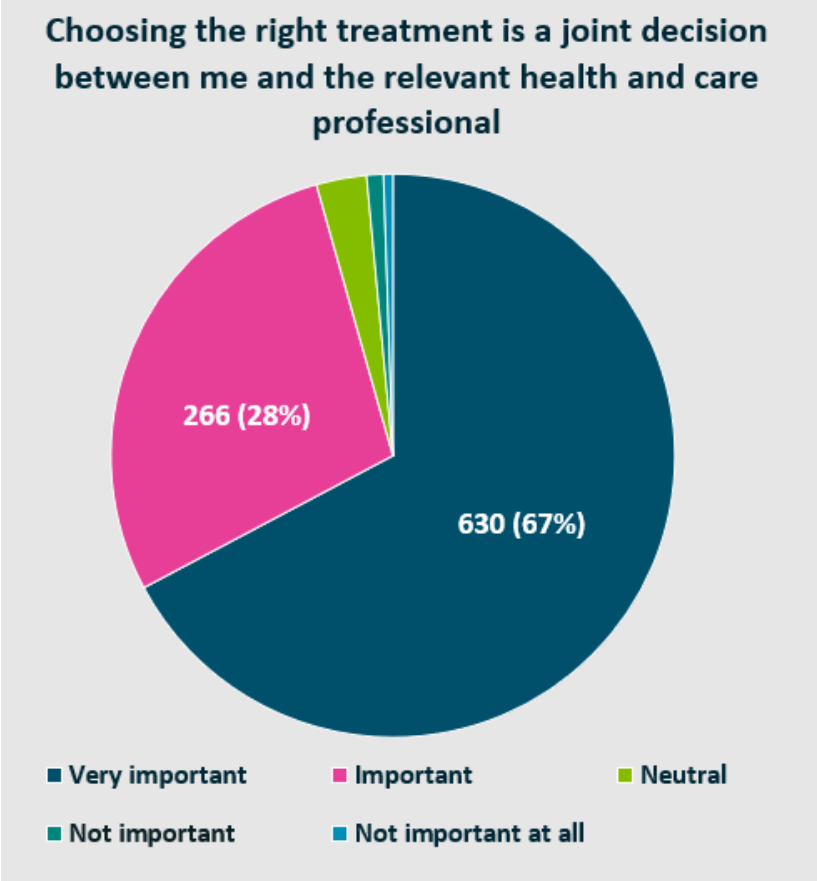
"Important to have time to talk and listen to healthcare professionals so that I can make a considered choice re my care."

"Health care professionals need time to offer and discuss treatment options and not be rushed by appointment times."

"I think consultants should be trained on the effects of changing appointments to a patient's mental health."

Question 2: What is important to people when it comes to managing and choosing support?

Respondents were asked to rate the importance of eight separate statements in helping them to manage and choose support. Replies showed that most people across the BOB ICS valued the ability to work with healthcare professionals to jointly decide the best course of action. Timely communications from services were also very important.



BOB-wide finding on decision-making

Local breakdown

Bucks: 68%
Oxfordshire: 68%
Reading: 68%
West Berks: 70%
Wokingham: 57%
Berkshire West:67%

People told us they wanted health care professionals who discussed their options, rather than just told them what to do. They also wanted doctors to see the 'whole person'.

"More transparent and honest information and doctors and consultants that speak to me like an educated, informed human - who don't patronise, and who treat me like an equal."

"That all available options are explained, including advantages and disadvantages."

"Nowadays there is so much online that patients know more about their condition and they know their own bodies better than doctors….I believe in order to manage a condition, health care professionals and patients need to start working together."

"Common sense seems to be severely rationed and the sight of grey hair reduces most people to baby talk. The most effective consultant I have met recently took a look at me, a look at test results on her computer screen, correctly diagnosed that I was all right and the tests were wrong. She looked at the person - not the screen - retesting proved her right."

More findings on people managing and choosing their support

- **66% of people (612) say it is very important that communications are timely**
  Local breakdown:

Bucks: 58%	Oxfordshire: 68%	Reading:68%
West Berks: 69%	Wokingham: 66%	Berkshire West: 68%

People described their frustration at administration delays or hold-ups, and of having to be proactive in chasing up information themselves and wanting the NHS to become more efficient in getting back to people.

"Information being added to NHS systems in a timely manner by consultants and admin staff, and communications sent to patients in a timely manner and when promised – in any other business it is not acceptable to wait 3-4 weeks for an 'urgent' letter."

- **54% of people (496) say it is very important that they have time to consider their options and make the choices that are right for them.**
  Local breakdown:

Bucks: 48%	Oxfordshire: 55%	Reading:58%
West Berks: 58%	Wokingham: 43%	Berkshire West: 55%

Extra time was particularly important for people with learning disabilities:

"Talking to other people such as my support workers to help me understand what my options are. I need extra time to decide."

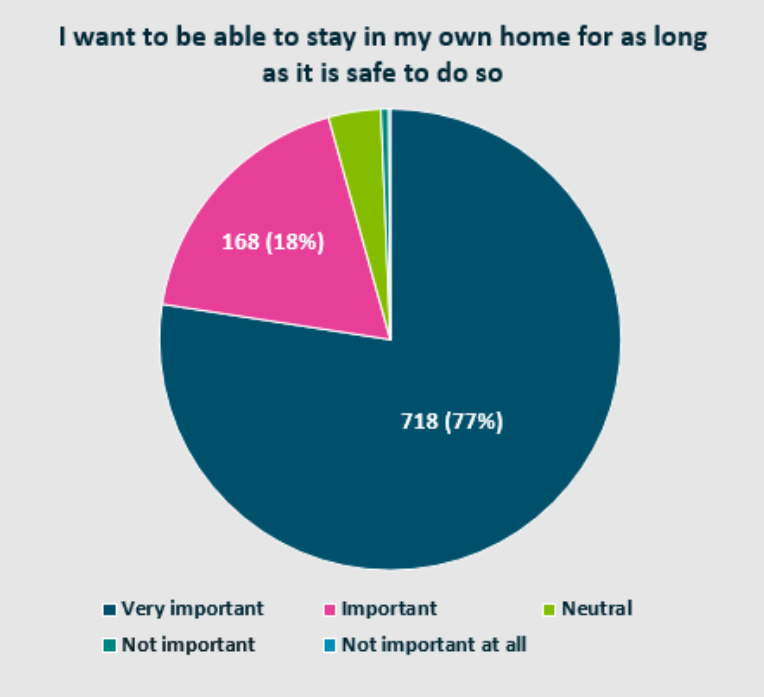
Answers to other questions, showed around 50 per cent of respondents or fewer found it vital to be in total control of decisions about managing and choosing care. In extra comments they gave, they said it was important that the NHS was transparent about what treatments or operations were available and funded in their local area, that professionals helped guide them on which consultant or hospital had a good reputation and that professionals were honest about waiting times.

- **50% (466) say it is very important, their opinion on what's best for them, counts**
- **48% (444) say it is very important that they should be offered care and support in other areas if their local area can't see them in a timely way**
- **47% (436) say it is very important they decide where to go for care/treatment**
- **42% (394) say it is very important that they decide when they receive health and care support**
- **38% of people say it is very important that, if they have a long-term condition, they decide how the NHS spends money on them**
- **38% of people say it is very important that, if they have a long-term condition, they decide how the NHS spends money on them**

"Knowing what care and treatment is truly funded in my area, rather than a NICE guideline that says one thing, then finding out my GP can't refer because 'we don't fund that in our area'."

Question 3: What is important to people to help them keep their independence and stay healthy as they get older?

Respondents were asked to rate the importance of five separate statements about their health as they get older. Staying in their own home for as long as possible was very important for more than three-quarters of respondents. People told us this was dependent on access to high quality social care in the home, and support for family and friends that will or do care for them. Good public transport is also important.



BOB-wide findings on remaining at home

Local breakdown

Bucks: 78%
Oxfordshire: 81%
Reading: 77%
West Berks: 74%
Wokingham: 79%
Berkshire West: 76%

"Reliable care workers who are allowed enough time to ensure I have what I need without it being rushed."

- **76% (707) say it is very important that they and their family feel supported at the end of the person's life**
  Local breakdown:
  Bucks: 75% Oxfordshire: 74% Reading: 81%
  West Berks: 75% Wokingham: 72% Berkshire West: 77%

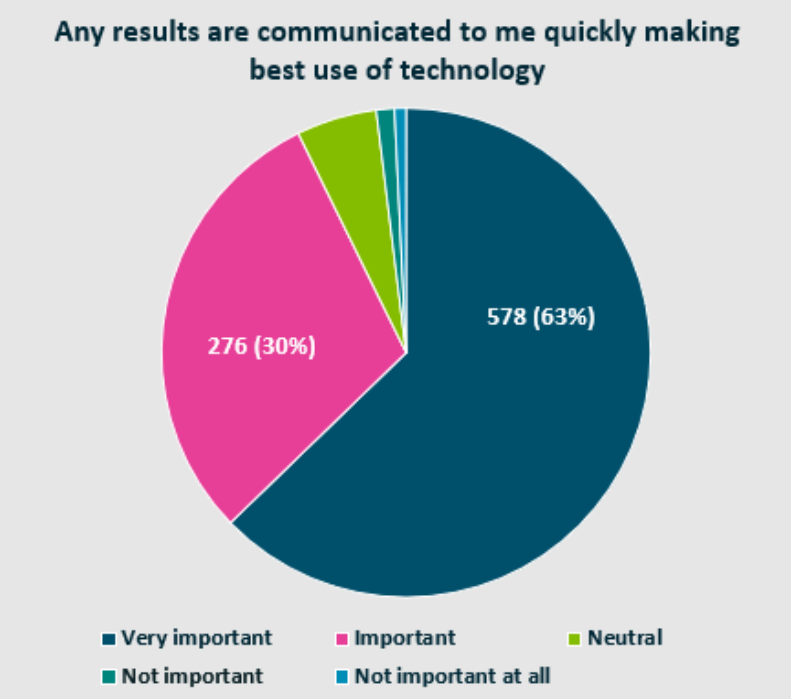
- **69% 639) say it is very important to have convenient ways to travel to services**
  Local breakdown:
  Bucks: 66% Oxfordshire: 74% Reading: 71%
  West Berks: 68% Wokingham: 67% Berkshire West: 69%

- **59% (543) say it is very important their family has knowledge to support them**
  Local breakdown:
  Bucks: 52% Oxfordshire: 47% Reading: 65%
  West Berks: 64% Wokingham: 53% Berkshire West: 62%

- **50% of people (459) say it is very important for their community to support them**
  Local breakdown:
  Bucks: 45% Oxfordshire: 52% Reading: 56%
  West Berks: 48% Wokingham: 40% Berkshire West: 50%

Question 4: What is important to people when they are interacting with the local NHS?

Respondents were asked to rate the importance of seven separate statements about communication between themselves and health services. For most people, receiving any results related to their health in a timely way, was very important.



BOB-wide findings on receiving results

Local breakdown

Bucks: 57%
Oxfordshire: 51%
Reading: 69%
West Berks: 64%
Wokingham: 64%
Berkshire West: 66%

"The NHS needs to make use of digital resources such as sharing blood results…online."

Other findings on how people interact with the NHS

- **59% of people (543) say it is very important to have absolute confidence that their personal data is managed well and kept secure**
  Local breakdown:
  Bucks: 52% Oxfordshire: 59% Reading: 63%
  West Berks: 61% Wokingham: 62% Berkshire West: 61%

- **52% of people (476) say it is very important to be able to talk to their doctor or other health care professional, wherever the patient is.**
  Local breakdown:
  Bucks: 48% Oxfordshire: 48% Reading: 58%
  West Berks: 52% Wokingham: 46% Berkshire West: 54%

- **51% of people (470) say it is very important that they can make appointments online and for their options not to be limited**
  Local breakdown:
  Bucks: 57% Oxfordshire: 45% Reading: 48%
  West Berks: 56% Wokingham: 55% Berkshire West: 53%

"Please make online booking of appointments…available to the local HIV clinic."

More findings on how people interact with the NHS

- **48% of people (450) say it is very important that they can access services using their phone or computer**
  Local breakdown:

Bucks: 45%	Oxfordshire: 44%	Reading: 50%
West Berks: 50%	Wokingham: 52%	Berkshire West: 50%

- **People had mixed feelings about managing their own personal records: 37% (343) think it is very important to manage their own personal records so they can receive continuity in care; while 34% (309) say it is important and 23% say they are neutral on this point.**

  If records are made more widely available online, people want to know that they will be presented in a way that they can understand:

  "To be able to have my records online and easily readable in easy terms as well as medical terms."

- **32% of people (297) say it is important to be able to talk to others who are experiencing similar health challenges; 31% feel neutral, and 28%, very important**

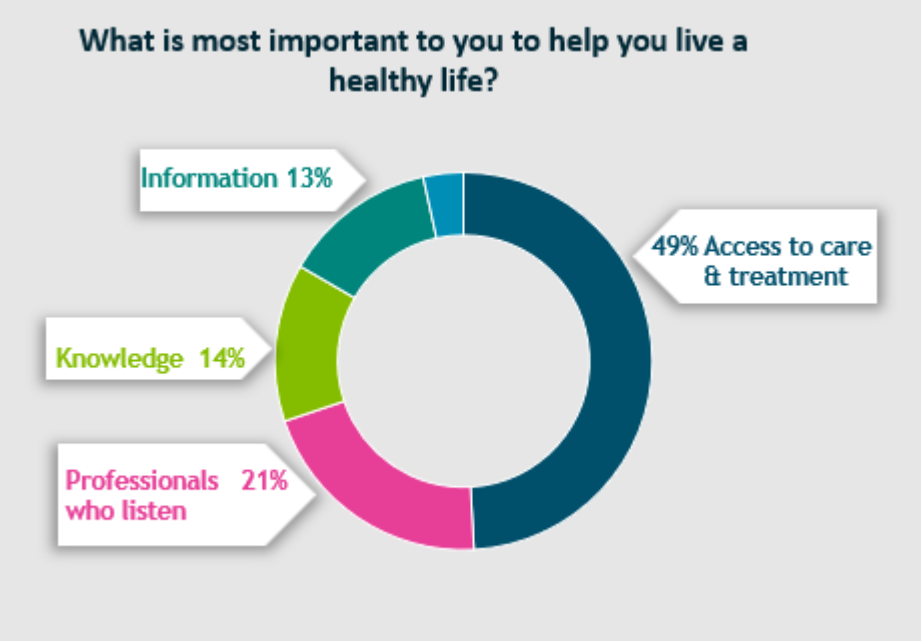
  "Following a recent total knee replacement…I would have felt better being in a support group with other people instead of feeling isolated at times when progress was initially slow and painful."

Question 5: What is *most* important to people to help them live a healthy life?

Respondents were asked to choose *only one* of the following five options:

- Access to the help and treatment when they need it
- Easy access to the information to help them make decisions about their health and care
- For every interaction with health and care services to count and for their time to be valued
- Professionals that listen to them when they speak to them about their concerns
- The knowledge to help them do what they can to prevent ill health

Nearly half of all people (433) across the BOB ICS say access to care and treatment is the single most important thing to help them live a healthy life



BOB-wide ranking on healthy living

Local breakdown, for top finding of access to care:
Bucks: 57%
Oxfordshire: 44%
Reading: 49%
West Berks: 49%
Wokingham: 42%
Berkshire West: 48%

As well as many comments from people wanting easier and quicker access to GP appointments, many people called for services to remove access barriers for people who have physical impairments and learning disabilities.

"Text phone numbers for Deaf BSL users to access GPs."

"For interpreters to be accessible for GP appointments and other health service appointments and not to have to wait two weeks for an interpreter to be available."

"Budgets provided for care agencies to be trained in BSL to care for deaf patients after they leave hospital – there are none in this area!"

When people were also asked to suggest *one more thing* that would help them live a healthy life, they suggested a variety of personal, NHS, community and state-led solutions.

People's ideas for healthy living:

Healthy eating

"Let someone come up with a good grow-your-own incentive. Make better use of allotment sites. Schools could grow veg and have a weekly market stall and earn income; corporates could have roof gardens where staff could grow fruit and veg - good for team building, stress relief, mental and physical health. Housing development companies should be made to include such a space on their development sites - perhaps one metre square per household, at least. Parents could grow veg whilst watching children in the plan area, instead of just… flicking through social media."

"Having companies like Gousto or HelloFresh, perhaps subsidised in a way to make it more affordable for busy, working people to have access to good, organic, fresh, healthy food."

"Cheaper fruit and vegetables."

Healthy environments

"Less traffic, so I could feel safe to cycle with my children around our neighbourhood."

"General reduction in pollution, especially from cars."

State intervention

"Cigarettes should be outlawed and irresponsible alcohol usage should be discouraged more robustly."

"The NHS should be proactive in tackling causes and treating conditions rather than relying on long-term ill health, dependence on medication and accepting declining quality of life."

"Why is public health funding being cut?"

Social interaction

"That as part of any treatment involving medicines and pills - or better still, instead of - patients are encouraged to join a group, club or activity relevant to their condition. I suspect that a good proportion of conditions presented stem from a lack of social interaction or activity."

"More support for lonely people."

Health checks

"Since my wife passed away…my health has deteriorated as I am far more reluctant to contact my GP when not feeling well - basically I am suffering from the lack of a concerned 'nag' factor. I suspect that the health system needs to get ahead of the curve by proactively keeping an eye on my health, possibly by a proper annual…check-up."

"Regular full check-ups and advice. The so-called 'MOT'."

"More early preventative checks on possible inherited conditions."

Exercise advice and facilities

"Easy, low cost access to exercise facilities for the over-60s. Gyms often appear to be promoted towards the fit and active younger set."

"Exercise for disabled and people who have long-term conditions."

"More affordable facilities."

"For exercising to be more fun. I already exercise a lot (swimming, running) and build in exercise to daily activities (cycle to town rather than drive) but often exercise is a slog. This is not particularly a request for help from statutory authorities: it's up to me to find fun ways to exercise but if I feel like that, others may too, so it may be worth thinking of ways to encourage more fun exercise. That could be coming up with different ways of doing it (accepting that a lot already exists, from sports clubs to the use of electronic trackers) and helping local people come up with new arrangements. So perhaps some research, information dissemination and some local facilitation."

"Free gym memberships."

more group (mixed ability) sport sessions organised and available on a drop-in basis

"Free, self-guided walks all around [our town] that we could download and follow. But they would need to be extensive, i.e.no more than a few minutes from everyone's house so those of us who are disabled/poorly/overweight etc could do them."

Education

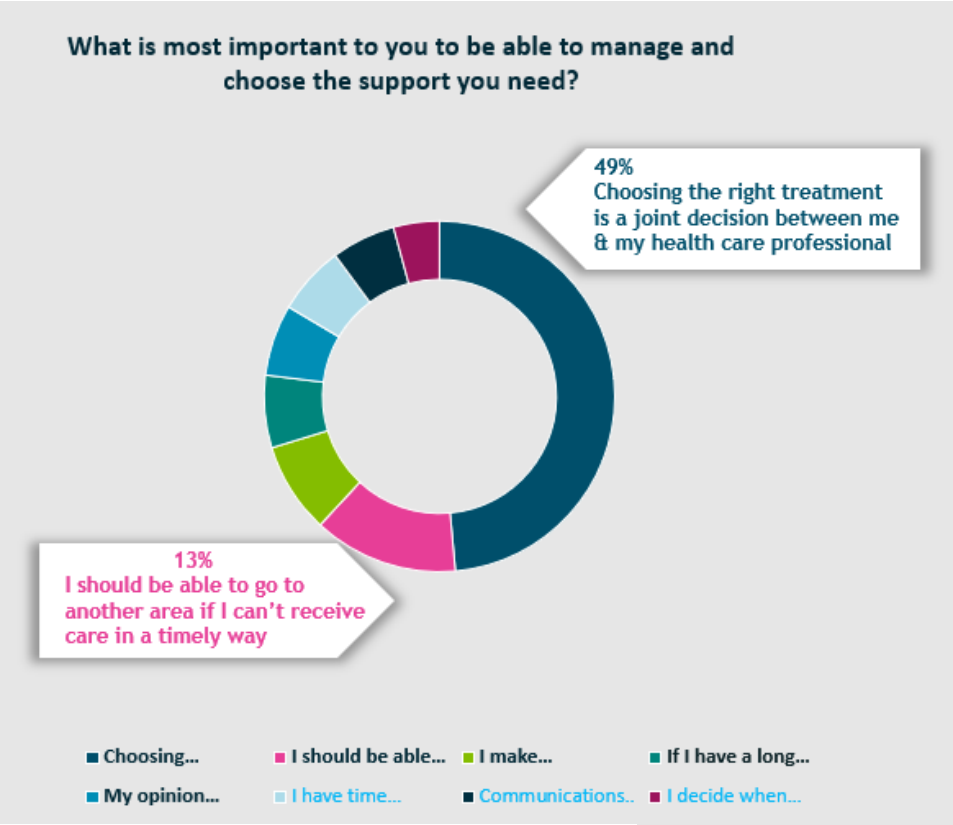
"Education from nursery age, simple healthy life messages that can build through the years."

Question 6: What is *most* important to people to enable them to manage and choose the support they need?

Respondents were asked to select just one of the following eight options:

- Choosing the right treatment is a joint decision between me and the relevant health and care professional
- Communications are timely
- I have time to consider my options and make the choices that are right for me
- I make the decision about when I will receive health and care support
- I make the decision about where I will go to receive health and care support
- I should be offered care and support in other areas if my local area can't see me in a timely way
- If I have a long-term condition, I decide how the NHS spends money on me
- My opinion on what is best for me, counts

Nearly half of people (436) said that working jointly with a health professional to make the right decision about their treatment, was the single most important factor.



BOB-wide ranking on managing and choosing support

Local breakdown for the top finding, of choosing treatment jointly with professionals:

Bucks: 49%
Oxfordshire: 43%
Reading: 46%
West Berks: 55%
Wokingham: 45%
Berkshire West: 49%

When people were also asked to suggest *one more thing* that would help them manage and choose how the NHS supports them, they suggested:

- Being given clear information on symptoms, diagnosis and options
- Being given consistent advice by different health professionals
- Better communication with people with extra needs such as learning disabilities
- Having consistency of clinician at follow-up appointments
- Involve carers/family or advocates when someone lacks mental capacity
- Services that are integrated

People's ideas for managing and choosing their own support:

Clear, expert advice

"That I am provided with support/advice by multi-disciplinary staff who are skilled and trained on, prevention, behaviour changes where necessary and have knowledge of other wrap-around services."

"Frank talks with my GP or healthcare professional."

Consistency of care and options

"Being able to speak to the same doctor consistently."

"A more consistent approach to treatments as opposed to where you live and if a consultant has a different approach to other consultants."

Integrated services

"Single point of contact, person or centre which has all the relevant information about me and my health rather than the confusing different channels which don't join up - GP, physio, nurse, pharmacist, outpatients' clinics."

"Being able to have treatment across borders with sharing of information. Cross border issues for Newbury and outlying areas is a real problem. E.g. if I have treatment at North Hampshire, I cannot get blood test or follow up appointments locally."

Accessible information

"Information that is easily understandable, particularly for people whose first language is not English."

"The NHS should not expect everybody to be able to read - 'tell' people about it as well."

"Ensure there is an advocate who can communicate in BSL to explain and discuss options."

"Easy read information. Talk to my family so they can help me understand what my choices are."

Involvement of carers

"Let family and carers be involved in discussions and decisions for people who lack mental capacity."

"Medics should accept that family carers know patients and what is their 'normal' healthy state."

Question 7: What is *most* important to people to help them keep their independence and stay healthy as they get older?

Respondents were asked to select only one of the following five options:

- I want my family and friends to have the knowledge to help and support me when needed
- I want my community to be able to support me to live my life the way I want
- I want my family and me to feel supported at the end of life
- I want there to be convenient ways for me to travel to health and care services when I need to
- I want to be able to stay in my own home for as long as it is safe to do so

BOB-wide ranking on keeping independence and staying healthy as you get older

Local breakdown

Bucks: 54%	Oxfordshire: 54%	Reading: 57%
West Berks: 55%	Wokingham: 70%	Berkshire West: 58%

Many suggestions were given by people when asked what else could support them:

- Not becoming a financial or personal burden to relatives
- Cheaper or free social care
- Opportunities to stay mobile as long as possible via support from physios and OTs
- Cheap or free transport, and/or bus services restored to small villages
- Adaptations/technology and high-quality home care workers to stay safe at home
- A care coordinator to fully join up health and social care
- The ability to choose when to end their life, through assisted dying

People's ideas for staying independent and healthy as they get older

Support to stay mobile

"Maintaining my health and mobility, if I could have other types of treatment like hydra therapy pool, assisted exercise machines. That would help keep me healthier and remain mobile for longer, which in the long term be less of a burden for the NHS."

"Access to appropriate exercise classes or physio-led exercise close to where I live."

"More needs to be done to get elderly people moving when they have broken something, otherwise they end up not being able to move and might not be able to move back to their house."

Access to social care

"I don't want my family to have to give up their quality of life to support me. Having paid my taxes, I feel the state should pay for my care."

"Make access to information more readily available. For example, I had no knowledge that I could remain at home with live-in care home rather than a care home. I now know from a few friends…this is possible with live-in Care supported by the district nurses and MacMillan nurses all working in a co-productive fashion."

"To have home care integrated with healthcare provision and provided by central funding."

Care closer to home

"Having supported neighbours, it is blatantly obvious that Wycombe, and other areas, needs something like an elderly overnight care facility for the elderly with conditions like COPD. A&E at Stoke Mandeville is clogged up…and it is such a difficult journey driving back from Stoke at 2am (I have done it on several occasions to support a neighbour)."

"Bring back day centres in Oxfordshire as they help to stop carer burden thereby enabling older people to live in their homes longer."

"Regarding end of life, it would be appropriate to have a hospice locally."

Greater support for carers

"Family members who spend more time with elderly relatives than social workers, should be listened to. Mine were ignored with regards to my dementia-suffering grandmother and she was left in a 3-bed house too long suffering so they could save money."

"Support for those around me if I choose to stay at home for end of life."

Better transport

"If you need to go to a medical appointment you do not want to be jolted around the area for a couple of hours and have to change buses. There is no direct bus from Winnersh to RBH [Royal Berkshire Hospital]."

"Organise a park-and-ride from the Madejski Stadium to the RBH [Royal Berkshire Hospital]."

"NHS was great, all tests done and treatment provided but having to travel large distances to get to the Royal Berks and the lack of parking, meant long bus journeys both ways, which, when you're having chemo is not a great experience. Taxis cost £70. Unsustainable."

"Better transport in rural areas, especially when getting to doctors' surgeries and hospitals. It is also important to have transport that enables people to visit people when they are in hospital, which can help them remain positive and so aid their recovery."

"Better local transport for when driving is no longer safe."

Care coordination

"One person, a key worker who is responsible for taking a holistic view and who can coordinate agencies to provide thorough care from a medical and social model, a bit like a EHC plan that is put in place for SEN [special education needs] children but is a plan for elderly provision."

Changes to the law

"I would strongly support provisions for dignity in dying including a right to choose when to die in the event serious terminal illness."

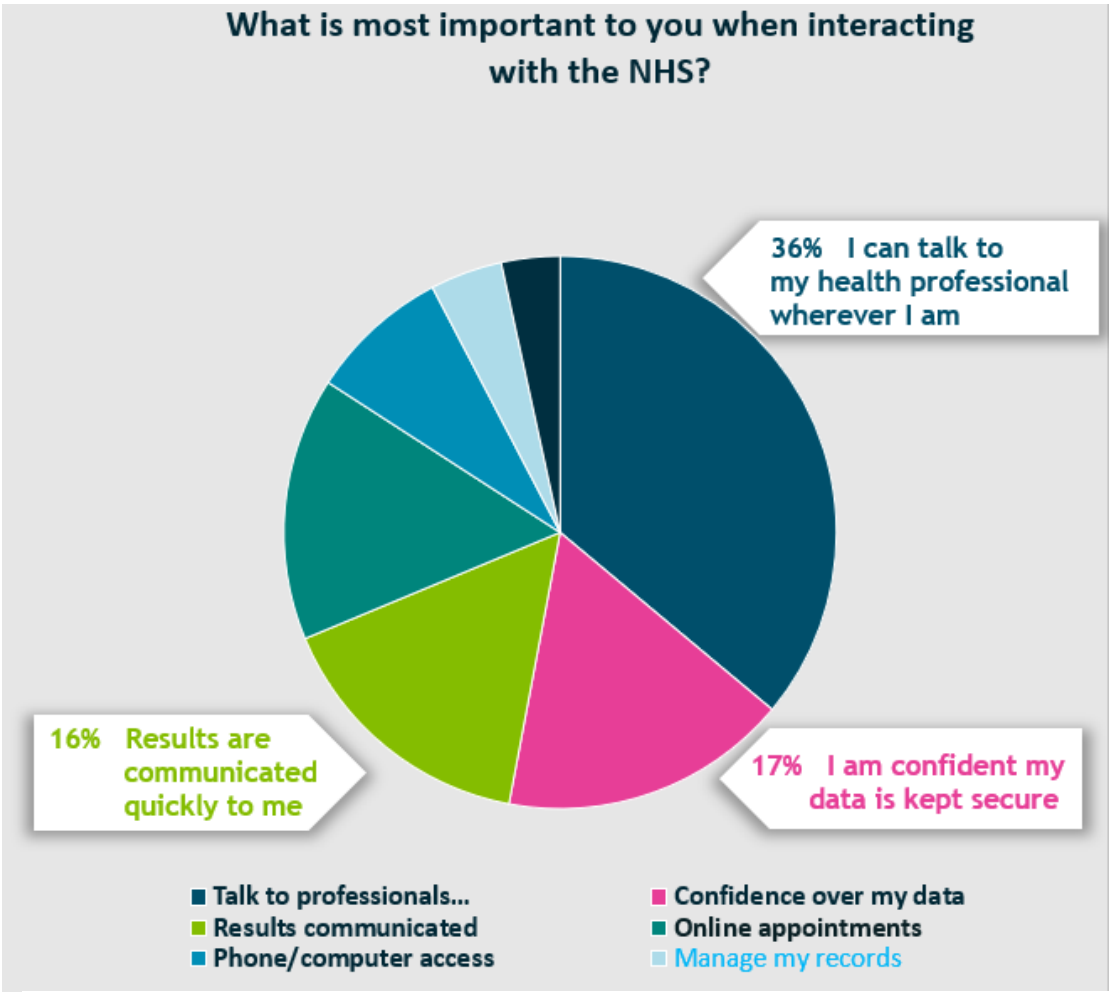
"The ability to decide when to die."

Question 8: What is *most* important to people when they are interacting with the NHS?

Respondents were asked to choose only one of seven options most important to them:

- Any results are communicated to me quickly making best use of technology
- I am able to talk to other people who are experiencing similar challenges to me to help me feel better
- I can access services using my phone or my computer
- I can make appointments online and my options are not limited
- I can talk to my doctor or other professional where-ever I am
- I have absolute confidence that my personal data is managed well and kept secure
- I manage my own records so that I can receive continuity in care

There was a spread of opinion about which factor was most important:



BOB-wide ranking on interaction with the NHS

Local breakdown, for the top finding of being able to talk to health professionals:

Bucks: 43%	Oxfordshire: 30%	Reading: 29%
West Berks: 43%	Wokingham: 32%	Berkshire West: 35%

Respondents' views on the role of technology in the NHS:

Use technology to its fullest capability

"I have to have regular blood tests - why can't I book these online?"

"Ensure every professional interacting with me has access to my full health records (at least the current situation and data for 2 years) and every aspect of my health management. I do not want to repeat everything to each professional I see."

"Enable the messaging function [to GP] in the Patient Access App."

"As a patient with myeloma (a blood cancer) I would like to be able to access my blood results online and not have to wait for clinic appointments. It can be an anxious wait at crucial times in my disease."

"Make it easier to book online. At the moment it is difficult to register - you have to have lots of information and go to the surgery first. Then when you do book a GP appointment online you are given one slot on one day with one doctor, which isn't your own doctor. There is no choice, no other slots."

"Patient Access [for booking GP appointments] is a waste of time. Had to drive 4 miles to book an appointment as nothing available on Patient Access this morning."

Technology helps those with extra needs

"Access via my computer is important to me, because I am hearing impaired and the telephone is very difficult for me."

"Text phone numbers. Deaf and hard of hearing people cannot use telephones. Minicoms are not used anymore."

Technology has its limitations

"Face to face still important as cannot hide true feelings/symptoms."

"There are many places in Bucks where you can't get a good signal /adequate broadband so people could miss vital information."

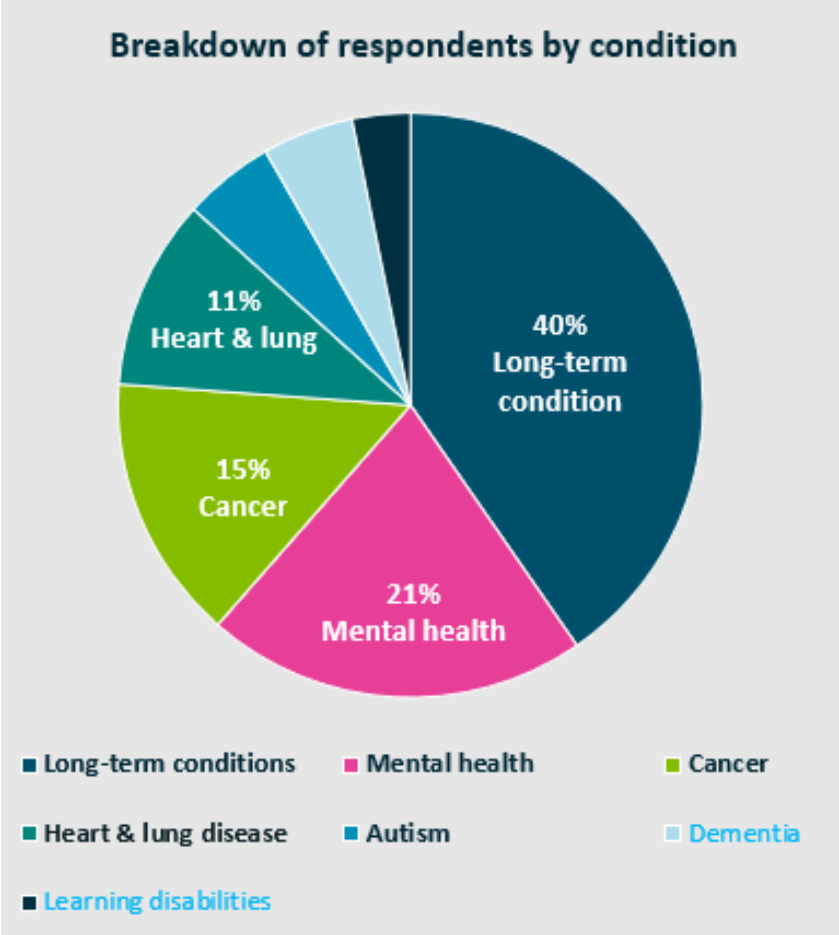
"Personal interaction between patient and practitioner is vital."

"It is no help to the NHS, its staff or patients if the healthiest patients who rarely see a GP are given a high tech video link GP service which leads to less money being available to their previous GP surgery to manage the needs of the patients who need more frequent care."

Chapter 2: Specific conditions survey findings

We received 219 responses to the second survey Healthwatch England supplied for this engagement project, to obtain people's experiences of conditions that are set out as priorities in the NHS Long-Term Plan. These seven conditions are:

- Autism
- Cancer
- Dementia
- Heart & lung disease
- Learning disabilities
- Long-term conditions (like diabetes or arthritis)
- Mental health



BOB breakdown of survey 2 respondents by specific conditions

The findings show that 45% of respondents said their condition had started within the last three years.

The key themes and findings were that:

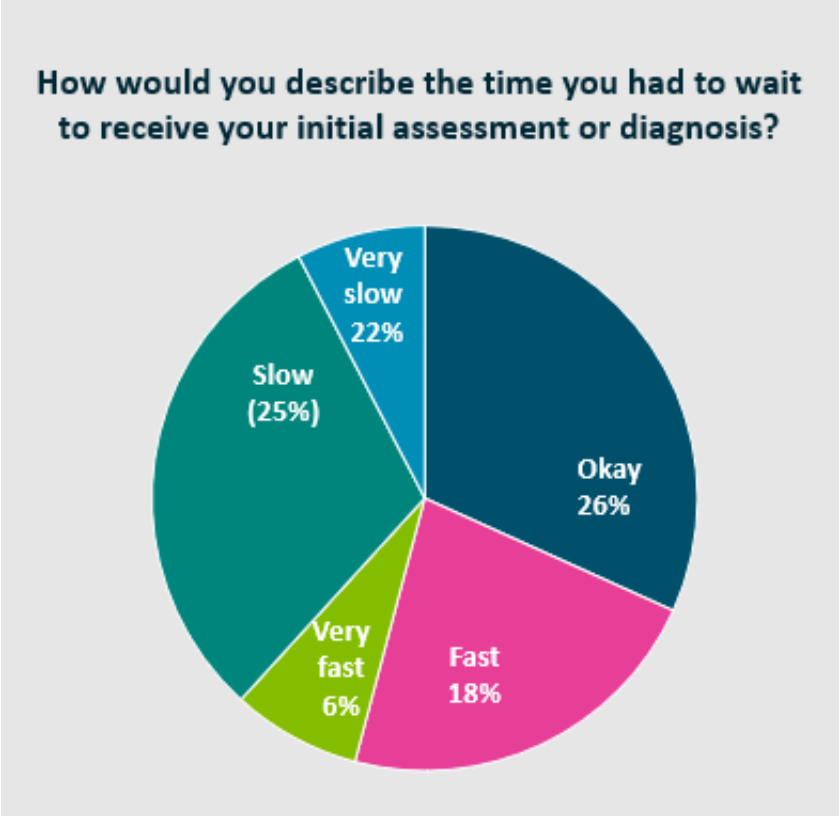
- The wait to get an initial assessment or diagnosis was too slow
- Continuity of care from a known professional for ongoing follow-ups was important in helping people manage their condition
- People who had multiple conditions found it harder to get the support they needed
- People had mixed experiences of receiving support they needed and consistent communications

The largest number of free text comments we received were about mental health care, mostly negative.

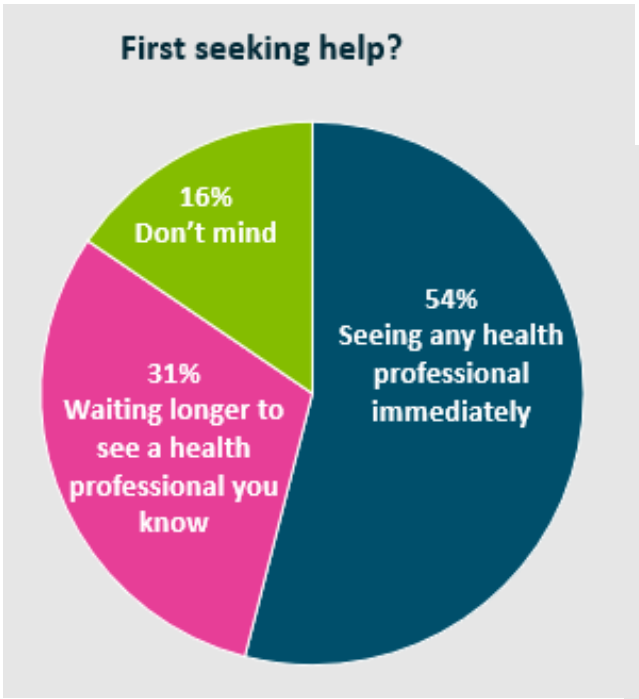
The rest of this chapter highlights some key statistics and then focuses on each of the seven conditions and the experiences that people shared with us. Full findings for the specific condition survey can be found in Appendix 3, on pages 41-42 of this report.

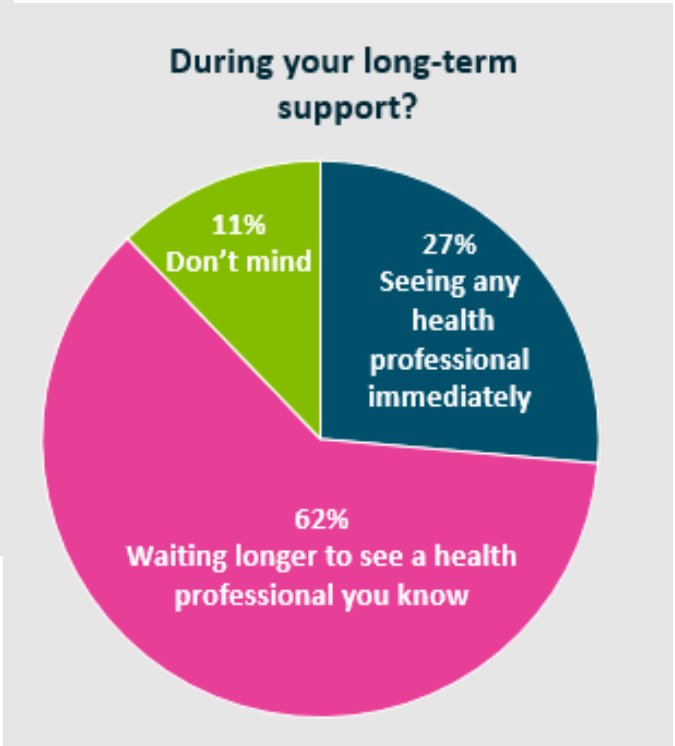
Due to the smaller sample size of this second survey, we have not provided a breakdown of findings for the five local areas.

Key findings from the specific conditions survey



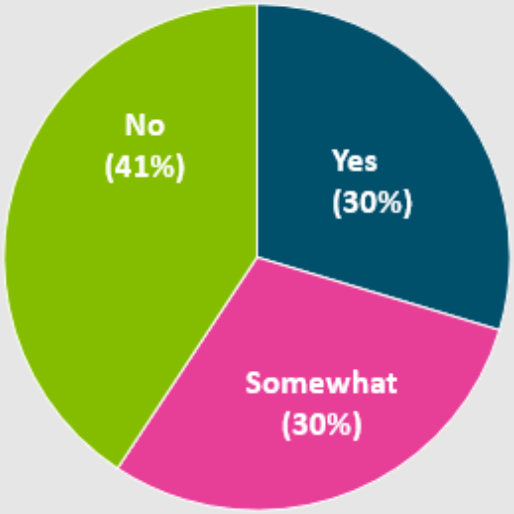
What was most important to you when……



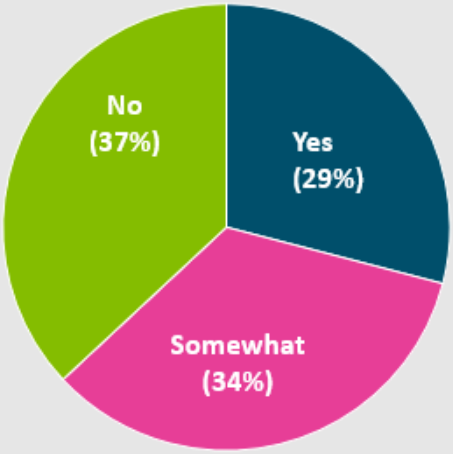


More key findings from the specific conditions survey

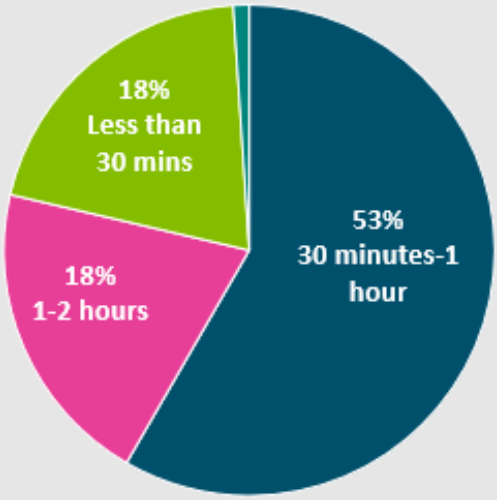
Did the support options you were offered, after initial assessment or diagnosis, meet your expectations?



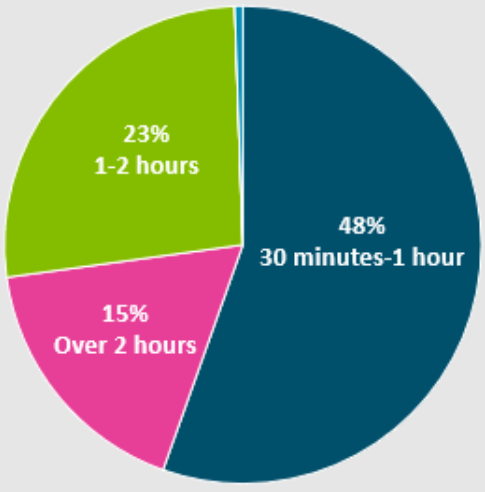
During your whole experience of getting support, did you receive timely and consistent communication from all the services that you came into contact with?



How much time would you be willing to travel for a quick and accurate diagnosis?



How much time would you be willing to travel to receive specialist treatment or support?



People's experiences about the specific conditions

Autism

Feedback themes:

- Long wait to get children diagnosed
- Little support for adults with autism
- Health professionals and teachers need training on supporting people with autism
- Delays in mental health referrals due to professionals only seeing autism needs

"The child…should have been diagnosed and statemented for school earlier and without having to write to all parties to get this as he got lost in the system. Once diagnosed…extra help was provided to keep him in mainstream education."

"I am an Adult with Autism. There is no support available…there is no Community Adult Autism Team and the Adult Community Learning Disability Team excludes people with Autism."

"Access to mental health help extremely slow and often issues bounced back to autism."

Cancer

Feedback themes:

- Medical care for cancer praised
- People really value the support of specialist cancer nurses
- Some said improvements were needed to after care or emotional support

"The cancer nurses were brilliant."

My friend…is having to travel…to Oxford for treatment that cannot be delivered in Reading which is adding more pressure to both him, his wife and…children. The charity Maggie's is in place at Churchill Hospital and they often travel to Oxford when they need support. It appears there is nothing of a similar nature in the area and is something that would benefit patients, families and friends enormously in so many ways."

"I am happy that my oncology department are giving me the best treatment. I feel a more holistic approach to living with Stage 4 cancer would be better, as the emotional issues in my case were huge. I did get support from a psychologist who is excellent, but this is for a limited number of sessions. When it is finished, I feel I have no ongoing support other than my GP. There are a team of specialist nurses, but you are not allocated one person, so it is difficult to build the relationship of trust and understanding that would be useful in my situation - so I do not use them other than for very practical issues."

Dementia

Feedback themes:

- Delays in getting diagnosis
- Family feel their evidence about relatives' behaviour is not always taken into account

"I struggled to get GP to understand the issue with my mother and her dementia and this severely delayed referral."

"Took months to get the help needed for my mother's dementia."

Heart and lung disease

Feedback themes:

- Praise for medical care
- People value support and advice from heart failure nurses
- Some people want better follow-up care
- Society should make adjustments for people with lung conditions in the same way as disabilities

"The heart failure nurses are brilliant."

"Great heart failure team and amazing GP."

"I do not have a disability, but my quality of life is affected by my Arthritis, Bronchiectasis and Asthma. I think being classed as 'disabled' should not be the only measure of how your life is affected by your health. Being able to park in disabled spaces when being admitted and discharged [at the Royal Berkshire Hospital] would have helped enormously as I was in considerable pain and had limited mobility (I needed a wheelchair to reach my car). Is there a short-term disabled permit that could be issued?"

"Great to start with, but now just left to get on with it. More access to a heart consultant to discuss medication would be helpful."

Learning disabilities

Feedback themes

- Health care professionals need training on learning disabilities, including communication
- Relatives want health professionals to take their views into account

"Understanding of disability and learning difficulties, communication difficulties, by staff at all levels, particularly GPs as first point of call."

"They need to be patient and explain things easier to me."

"Not to assume, if nonverbal, unable to feel pain or communicate."

Long-term conditions

Feedback themes

- Some people had experienced long delays in getting a diagnosis and/or treatment
- It is important to have continuity of care from the same team of professionals
- Services should be aware of the fatigue, stress and financial burden of conditions

Delays

"I was originally diagnosed as having migraine; however, years later, after moving into a new area and going to a new surgery, I got the correct diagnosis [of epilepsy], and treatment that could help me."

"Initially I seemed to get lost in the system and was left having been given some terrible news about a long-term condition with an appointment three months down the line and absolutely no support. I had to fight to get some answers…"

"For my arthritis I was left waiting a long time from referral to treatment. Referral was in April… treatment [the following] January - however this was partly due to intervening diagnosis of [another condition] but included a delay due to last minute cancellation."

Consistency of care

"I have to get regular appointments at the GP, but am not allowed to book in advance, [only] on the day; this makes it hard to see my [own] GP and penalises me for having a long-term condition."

"I have had lupus for [many years] and even though I live in Reading I still make the appointments at Guys in London as I feel my consultants know the history but also have taken the time to get to know me as a person. I always know that they are an email or a phone call away and have received great treatment."

Accessibility

"Long-term conditions make it difficult to get around without feeling tired all the time. More telephone support would be useful."

"I cannot keep taking off time from my job to travel, find parking, pay for parking and then to walk all the way through the hospital to the blood clinic each month."

Care costs

"Make inhalers for asthmatics free."

"I was offered four physiotherapy sessions but told I needed many more. I since paid thousands of pounds on treatment."

Mental health

We received more comments about mental health care than any other specific condition

Feedback themes:

- Delays in diagnosis or treatment
- Inadequate or limited care options for ongoing symptoms
- Inadequate support in a crisis situation
- Professionals who are overworked, and/or not empathetic
- Not getting the same level of support as for physical conditions

Delays

"I kept going to see my GP about my symptoms and was wrongly diagnosed with depression and anxiety. After two years and nearly committing suicide - my GP finally listened. I was sent to a psychiatrist and waited a month and was diagnosed with PTSD and then discharged from the mental health team. I've struggled for over 2.5 years now with PTSD but the mental health team and my GP won't help me."

"I had to wait nine months to see a therapist to start CBT. When you are struggling to get through each day this is a horrendous wait. It's very hard to pluck up the courage to ask for help and then to be left in limbo for so long is not right. There needs to be more funding for mental health services to reduce waiting times."

"I received very basic support. GP couldn't help. Took them months to get through to mental health services and even then, I had to wait longer for help. Took about eight months and they weren't very understanding, spoke over me a lot and I felt they didn't listen."

"I took a friend to A&E as she was having suicidal thoughts and had the resources to carry the action out. I tried to contact the crisis centres and various other organisations and was eventually told to take her to A&E - we waited for 4 hours in the waiting room, another 1-2hrs in a second waiting room and then she told the mental health consultant what she'd already told me, she was then advised to go to her GP surgery the next day - I could've told her that myself."

"After a serious suicide attempt and subsequent referral to the home crisis team, it took six weeks to be seen by a psychiatrist."

"When she turned 18, she then had to register with the adult mental health team, which took a while, then moving to…university she had to see a psychiatrist all over again before getting counselling, when it is supposed to be a NATIONAL health service. The wait was too long there, and she had another suicide attempt, so we paid for private treatment."

Attitude of NHS staff

"Medics treat anyone with mental health issues like a nuisance and I've fought 2.5 years for a correct diagnosis and it led to me nearly committing suicide before anyone actually listened to me. It also makes me getting help for my asthma extremely difficult as the GP blames my mental health for it."

"I often felt unimportant during my process with CAMHS. I felt like they believed that my mental health needs were not severe enough to be worth their help and felt concerns were not taken seriously. There was a long wait time and appointments were sporadic at the best of times. The care did not feel person centred and I felt that CAMHS were too desperate to follow the NICE guidelines rather than take into account individual needs. I do think that individual practitioners are not to blame for this and their hands are tied. They are underfunded and overworked."

"Have empathy and understanding."

Quality of care

"There was an excellent first assessment in the Emergency Department - the nurse and doctor were very good, started medication immediately and gave both me and the patient a safety plan which was very useful. But the follow-up in the mental health system was really not as good."

"The NHS only offers certain types of therapy and CBT online is not effective for someone with severe and enduring mental health problems. I needed face-to- face counselling, not computer course and fortnightly (sometimes monthly) telephone appointments."

"More options for mental health support - medication and CBT is not a one-size-fits-all solution to complex long-term mental health issues."

"You would not half treat cancer or a broken leg, so why half treat mental health conditions."

Investment

"What is most obvious is the desperate underinvestment in mental health services - all the staff are willing, but there are too few of them and they all seem overstretched and unhappy. There is little access to psychological therapies and long waiting times to see a consultant."

"The NHS should have mental health casualty services just as they have for physical health these services will be the signpost to other support and health and guide people who don't have the capacity at that time to help themselves."

Chapter 3: Focus group findings

This chapter sets out a summary of the views of 87 people collected during 10 focus groups held by the five local Healthwatch.

Four of the focus groups were with people with experience of mental health needs. This reflects the level of ongoing concerns reported to local Healthwatch about mental health services. The focus group findings build on the extensive library of patient experience that local Healthwatch across BOB have produced, including reports on the experiences of people admitted to acute hospital wards, people who have self-harmed, people who use crisis services, and the mental health needs of young people.

Other focus group topics were chosen by local Healthwatch to allow engagement with seldom heard groups: women from ethnic minority backgrounds, young carers, people with learning disabilities, and carers of adults with young-onset dementia. A further two of the focus groups explored how services and/or neighbourhoods should be designed to meet the needs of older people, or a population in a deprived ward.

The full report on each focus group can be found on the five local Healthwatch websites. (See page 43 of this report for contact details).

The findings summarised in this report only relate to the views expressed by that particular focus group and should not be seen as being representative of the wider population.

Summary of focus group findings

Bucks	Mental health focus group	
What people said works well	What people said doesn't work well	What people said matters most or needs to change
• Support from mental health charities • Day centre • Those GPs that specialise in mental health • Police respond well to mental health crisis	• GP appointment times not long enough to talk about mental health • Stressful having to tell receptionists symptoms • Timely GP appointments not always available • Some acute beds are too far away, takes people away from family • Feel like you're on your own after discharge from community team	• Need more staff • Every GP surgery should have a doctor specialising in mental health • Need more information about local community support and activities • Need walk-in services like those run by charities

Oxfordshire	Mental health focus group	
What people said works well	What people said doesn't work well	What people said matters most or needs to change
• Holistic support from voluntary sector within Oxfordshire Mental Health Partnership • Other social and leisure activities run by charities	• Some people felt that A&E was the only place to go in a crisis • Long waits from referral to therapy • Not enough support after working hours • Only crisis support is A&E • GPs don't always recognise the severity of symptoms • Potential disparity between services available in city & county **"I called the Warneford [hospital] trying to make contact with a care coordinator, but no one got back to me. So I had to phone the police. The police are a great help, they take the slack for mental health services."**	• Getting more support at the right time • Expert mental health support based in A&E • More evening or weekend social clubs or activities • More training for GPs on recognising key signs of mental health problems

Reading	Mental health focus group	
What people said works well	What people said doesn't work well	What people said matters most or needs to change
• Support from mental health charities	• Mental health needs aren't given the same priority as physical needs • GPs not always skilled on mental health • Long waits after being referred • Negative experiences with community mental health team staff – puts people off seeking help **"They deal with crisis much better than they deal with ongoing support and prevention."**	• Need empathetic staff who see the person holistically • Information about available community support needs to be better distributed among professionals • Install a bus stop outside Prospect Park Hospital to make it easier & safer to attend appointments • Invest more in preventative services • More funding of peer-led groups

West Berkshire	Mental health focus group	
What people said works well	What people said doesn't work well	What people said matters most or needs to change
• Support from mental health charities • GP support is generally good despite their workload and funding pressures	• Long waiting time for the NHS mental health crisis helpline to be answered • Waiting times too long from GP referral to see a mental health specialist • Not enough follow-up after hospital discharge • Stress of dealing with council or DWP • Poor transport **"For someone who is in a mental health crisis there is not a direct line for them in Newbury. They have a switchboard…and you end up waiting 20 minutes on the phone."**	• Engagement with service users need to be constant and used to make changes • Mental health resilience needs to be taught at school • Need to see the same GP • Locate specialist support nearer people's homes, such as charities/GP's • Make information on local support available offline, too

Bucks	Young onset dementia focus group	
What people said works well	What people said doesn't work well	What people said matters most or needs to change
• Help & support from local carers organisation • Some health professionals who proactively make adjustments **"We couldn't manage without support from Carers Bucks."**	• Delays in diagnosis due to GPs not considering it in young people • Relatives don't feel their evidence is listened to • Respite service for younger patients closed in 2012 • Some professionals who don't know how to communicate with dementia patients • Social services not responsive enough • Not qualifying for CHC	• Carers should be more involved in initial diagnosis process • Use other assessments than just the memory test • Fast-track for support when needed • CPNs should be available • Professionals need more experience of interacting with people with dementia • More information aimed at children of patients • Evening and weekend appointments are better for carers, who often work

Oxfordshire	Asian women's perspectives on GP services, focus group	
What people said works well	What people said doesn't work well	What people said matters most or needs to change
• Showing health promotion videos on the GP surgery waiting room screen (e.g. NHS Sugar Smart)	• Repeatedly asking for help but not getting it • Expectations for medication aren't met • Not being offered translators if needed • GPs making assumptions **"I went to the GP feeling tired and my hair was falling out. The GP said, 'All Asian people have vitamin D deficiency' and told me to buy vitamins from the chemist. When they finally [checked my blood] my Vitamin D level was [very low] and I needed a high dose only the GP could give, not over the counter."**	• An outreach talk by a clinician to their group on diabetes would be useful • Culturally appropriate dietary information • GPs need to give information about antibiotics and prescribing in an easy-to-understand manner • Promote the availability of translators at the point you book GP appointments • Education at school on healthy eating
Reading	**Designing a healthy neighbourhood, focus group**	
Current issues	**Questions raised about primary care networks**	**What matters most or needs to change**
• Difficult to make a same-day GP appointment unless you can phone at 8am • Some people resort to using Reading Walk-In Centre when they can't get an appointment at own surgery • GP surgeries aren't near other services • Telling people to stop unhealthy habits doesn't work	• Won't the plan for 'digital first' primary care leave behind those not online? • Where will 111 helpline get all the staff needed to do direct GP appointment booking? • Do GPs have time to set up new networks? • Why haven't our surgeries talked to us about primary care networks? • Will the networks just be based on GP business relationships rather than what's best for patients?	• Build on existing community resources like local allotments to tie into healthy eating plans • Create fun activities at the community hub which already has a library, parent & children groups, advice sessions & café • Merge GP surgeries into one, large health centre within community hub • Set up services closer to home for people with poor mobility • Improve public transport • Engage with patients on plans **"You've just got to make it enjoyable and sociable - come here learn to cook, all eat together."**

West Berkshire	Learning disabilities focus group	
What people said works well	What people said doesn't work well	What people said matters most or needs to change
• When health professionals make reasonable adjustments **"He [the dentist] understood that I don't like needles and gave me the choice of going to the RBH [for wisdom teeth extraction] and being knocked out."**	• When services overlook a person's written care plan as vital communication tool, and risk their safety • When people use jargon, acronyms and terminology that they can't understand	• Health professionals need to communicate in a way people understand • Accessible transport is needed to and from appointments (most people with LDs do not drive, have limited income for paying support staff or have restrictions on bus pass times) • Make sure follow-up letters are in Easy Read format • Women want to see female doctors/nurses • People want to be honestly told if treatment will hurt • People want to feel safe at the service they are attending

Wokingham	Young carers focus group	
What people said works well	What people said doesn't work well	What people said matters most or needs to change
• GPs are caring, empathetic, listen, focus on them as individuals and understood the pressure of being a young carer • A&E staff are kind, compassionate and explain things clearly	• 10 minutes isn't enough time for GP appointments • They didn't always feel heard by CAMHS professionals – or too much time was spent talking with the parent • Things weren't always explained clearly by hospital staff (outside of A&E) **"Why did my parents get a letter and not me? This is my issue, my treatment. If they have to send a letter to my parents, then okay, but send one to me as well."**	• Young people want to feel heard • Young people want to be treated as individuals • Young people want to feel like their opinions are valued • Young people want information about treatment, before, during and after • Young people want to be asked views on current or new services and be told later how these have shaped changes

Wokingham	Older people ageing healthily, focus group	
What people said works well	What people said doesn't work well	What people said matters most or needs to change
• GPs listen and are caring • Referrals for diseases like cancer or heart disease are swift • Treatment from cancer and heart specialist teams was excellent • MacMillan staff were exemplary	• Two week waits for GP appointments • Having to visit hospitals can cause anxiety about driving into city centres, lack of parking or walking around large buildings • There hasn't been enough engagement with public about previous changes to local NHS services	• A community healthspace of various services would be welcome • The excellent cancer care from doctors or nurses should be replicated for other diseases/conditions • Carers want quick access to GPs, fall services & nurses • Carers don't want to have transport unwell relatives to far away services **"I've used the Brants Bridge Healthspace in Bracknell, it's excellent at providing services, we need something like that in the Wokingham area."**

Next steps

This major public engagement exercise has collected a substantial amount of views from people in communities across Buckinghamshire, Oxfordshire and Berkshire West. The key messages that we urge commissioners and providers within BOB STP to consider, are:

- *The public's top priority is to access healthcare when needed, without delay*
- *People can choose and manage their support when they have access to professionals who truly listen, set out options and answer their questions*
- *A caring and empathetic manner in health care professionals is as important as medical skills and knowledge*
- *Health professionals must use a variety of communication methods, particularly with people with disabilities, and those who do not speak English as a first language, so these people can be fully involved and informed about their care and kept safe*
- *People who care for those who are vulnerable, such as people with dementia, want to be seen as 'experts' on their needs and be fully consulted about their options*
- *People with long-term conditions value relationships with trusted, familiar health professionals; it helps them manage conditions and stops them repeating their story*
- *People who are happy to use technology, want the NHS to enable it to its full extent (such as making all GP appointment slots bookable online)*
- *People who can't or don't want to use online services, do not want to become 'second-class citizens' in terms of accessing NHS services*
- *People want personalised goals from the NHS to stay or become healthy, but they also call for more action by government, industry, schools and local authorities*
- *People are keen on health hubs that bring together multiple services closer to home*
- *Transport can be a major barrier to accessing services, if village bus routes are closed, hospital carparks are expensive or full, and if people have limited mobility*
- *At the end of life, people's main wish is to stay at home; they need help beyond the NHS to do this, in the form of affordable (or free), high quality social care*
- *Mental health services are in urgent need of investment and improvement, not least to stop people feeling they need to be contemplating suicide before they get help.*

We asked the BOB ICS to respond to our report. On June 24 2019 it sent us a statement:

"We welcome the work carried out by Healthwatch and are grateful to those who took the time to talk about their experiences, concerns and priorities. All of the feedback provided will be carefully considered by colleagues and leaders working to plan for and implement the ambitions of the NHS Long Term Plan.

"It has been helpful to see that the issues raised chime with those areas that we have identified as our priorities, through our work in recent months to analyse local health and care needs and reflect on what communities tell us about what matters to them.

"The Healthwatch survey and focus groups both complement and supplement the on-going engagement and conversations continuing in local health and care systems and more locally still in neighbourhoods. In addition to this on-going work, we expect to do further engagement work specific to our strategy for BOB and the Long Term Plan. The timeline and next steps for this will be informed by national guidance, which we expect to be published in the coming weeks."

Appendix 1: Methodology

Representatives of five local Healthwatch met at the beginning of the project with the BOB ICS lead on communications and engagement, to discuss the aims of the survey:

- To survey up to 250 people per local Healthwatch area, using two Healthwatch England-supplied surveys (one for the general public and one for people with specific conditions)
- To run two focus groups of up to 10 people per local Healthwatch
- To compile the findings on a BOB-wide basis to inform the BOB ICS response to the NHS Long-Term Plan

From the beginning of April 2019, all five local Healthwatch promoted the surveys, which people could complete online on the Healthwatch England site.

However, all the local Healthwatch found that good response rates relied more on printing and bringing out paper copies of the surveys to community groups and organisations, hospitals, and GP waiting rooms. Local Healthwatch then input the findings into the online survey form.

Healthwatch England supplied Excel files of the raw survey data back to the coordinating Healthwatch (Reading) to analyse fully.

All survey responses were anonymous.

For the focus groups, local Healthwatch in most cases worked in partnership with local voluntary groups or support services to set up and run sessions, ranging from one to several hours.

Participants signed consent forms to confirm their anonymous views could be used.

In some cases, people were thanked for their time in taking part, with a small gift voucher and/or lunch and refreshments.

Appendix 2: Demographics

General survey respondents:

Total: 938 people

Gender: 69% of respondents were women, 30% men, two people said 'other' and 10 people said they preferred not to say

Age: The biggest age group (26%) was 65-74; followed by 55-64 (20%), 75+ (18%), 45-54 (16%), 35-44 (10%), 25-34 (8%), 18-24 (3%) and five respondents aged under 18

Ethnicity: Most people (89%) said they were White British, followed by Any Other White Background (4%), and 'Other' (2%). Nine people said they were from Any Other Mixed Background; 8, Asian British; 7, Indian; 4, African; 3 each for Arab, Bangladeshi and Black British, 2 Pakistani, and 1, Caribbean. 41 people left this question unanswered

Disability: 21% of people said they considered themselves to have a disability; 75% said no, 4% said they preferred not to say; and 37 people left this unanswered.

Carer: 12% of people said they were a carer, 88% said no, 53 left this unanswered.

Sexual orientation: 89% of people said they were heterosexual; 2% said 'Other', 1% said Gay or Lesbian, 1% said Bisexual; two people said they were Asexual, two Pan-Sexual, and 6% said they preferred not to say.

Religion: 51% of people said they were Christian; 36% said No Religion; 7% said they preferred not to say; 23 people said 'Other', 11 said Muslim, 7, Hindu; 6, Buddhist; 4, Jewish; 2, Sikh.

Specific conditions survey:

Total: 219

Gender: 66% of respondents were women, 32% men, three people said 'other' and one person said they preferred not to say

Age: The biggest age group (22%) was 55-64; followed by 45-54 (20%), 65-74 (19%), 35-44 (14%), 75+ (12%), 25-34 (7%), 18-24 (4%) and five respondents aged under 18

Ethnicity: Most people (86%) said they were White British, followed by Any Other White Background (12 people), Asian British (6 people), Any Other Mixed Background (5 people), Caribbean (3 people), 'Other' (3 people), African (1 person), Indian (1 Person), and four people left this question unanswered

Disability: 41% of people said they considered themselves to have a disability; 56% said no; 8 people said they preferred not to say; and 7 people left this unanswered.

Carer: 15% of people said they were a carer, 85% said no and 8 people left this unanswered.

Sexual orientation: 87% of people said they were heterosexual; 8% said they preferred not to say, followed by 3 who said they Bisexual; 3 people said they were Asexual, 2 people who said 'Other', 2 said Gay or Lesbian.

Religion: 47% of people said they were Christian; 36% said No Religion; 10% said they preferred not to say; 11% people said 'Other', 4 people said Hindu; 2 said Buddhist, 1 said Muslim.

Appendix three: Full findings of the specific conditions survey

Q1: When you first tried to access help, did the support you received meet your needs?

Yes: 33% **Somewhat:** 29% **No:** 32%

Q2: How would you describe your overall experience of getting help?

Very positive: 17% **Positive:** 27% **Average:** 25%
Negative: 17% **Very negative:** 10%

Q3: Do you have any other/additional conditions including long term conditions or disabilities?

Yes: 56% **No:** 44%

Q4: If so, how would you describe the experience of seeking support for more than one condition at a time?

It made it easier: 8% **No difference:** 38% **It made it harder:** 46%

Q5: How would you describe the time you had to wait to receive your initial assessment or diagnosis?

Very fast: 6% **Fast:** 18% **Okay:** 26%
Slow: 25% **Very slow:** 22%

Q6: How would you describe the time you had to wait between your initial assessment/diagnosis and receiving treatment?

Very fast: 28% **Fast:** 18% **Okay:** 27%
Slow: 22% **Very slow:** 20%

Q7: After being diagnosed or assessed, were you offered access to further health and care support?

Yes: 56% **No:** 44%

Q8: Were you referred to a specialist? For example, a hospital consultant, psychiatrist or physiotherapist

Yes: 73% **No:** 27%

Q10: How would you describe the time you had to wait between initial appointment and seeing the specialist?

Very fast: 5% **Fast:** 19% **Okay:** 29%
Slow: 26% **Very slow:** 17%

Q11: If you needed it, how easy did you find it to access ongoing support after you were diagnosed or assessed?

Very Easy: 5% **Easy:** 13% **Okay:** 30%
Difficult: 23% **Very difficult:** 17%

Q12: Did the support options you were offered meet your expectations?

Yes: 30% **Somewhat:** 30% **No:** 41%

Q13: During your whole experience of getting support did you receive timely and consistent communication from all of the services that you came into contact with?

Yes: 29% **Somewhat:** 34% **No:** 37%

Q14: What is your main means of transport?

Another person's car: 15% **Bus:** 10% **Own car:** 67%

Q15: How much time would you be willing to travel to receive a quick and accurate diagnosis?

Over 2 hours: 4% **1-2 hours:** 18% **30 mins-1 hr:** 53% **Less than 30 mins:** 18%

Q16: How much time would you be willing to travel to receive specialist treatment or support?

Over 2 hours: 15% **1-2 hours:** 23% **30 mins-1 hr:** 48% **Less than 30 mins:** 14%

Q17: What is most important to you….

When first seeking help?

Seeing a health professional you normally see but you may have to wait: 31%
Seeing any medically appropriate health professional who is free immediately: 54%
Don't mind: 16%

When you received a diagnosis and explanation of treatment or support options?

Seeing a health professional you normally see but you may have to wait: 40%
Seeing any medically appropriate health professional who is free immediately: 47%
Don't mind: 13%

During your initial treatment or support?

Seeing a health professional you normally see but you may have to wait: 42%
Seeing any medically appropriate health professional who is free immediately: 46%
Don't mind: 12%

During your long-term support?

Seeing a health professional you normally see but you may have to wait: 62%
Seeing any medically appropriate health professional who is free immediately: 27%
Don't mind: 11%

What level of support do you want the NHS to provide to help you stay healthy?
A lot: 22% **Some:** 63% **I don't need support:** 10% **Don't know:** 5%

Acknowledgements

Local Healthwatch in Buckinghamshire, Oxfordshire, Reading, West Berkshire, and Wokingham would like to thank members of the public who took the time to answer the survey.

We are also grateful for the voluntary and community groups who allowed us to come and speak with their service users and who helped spread the word about the project.

Lastly, we thank our volunteers who helped us to undertake the surveys.

Contact details

Healthwatch Bucks:

https://www.healthwatchbucks.co.uk/

Tel: 0845 260 6216

Healthwatch Oxfordshire:

https://healthwatchoxfordshire.co.uk/

Tel: 01865 552 0520

Healthwatch Reading:

https://healthwatchreading.co.uk/

Tel: 0118 937 2295

Healthwatch West Berkshire:

http://www.healthwatchwestberks.org.uk/

Tel: 0163 588 6210

Healthwatch Wokingham:

https://www.healthwatchwokingham.co.uk/

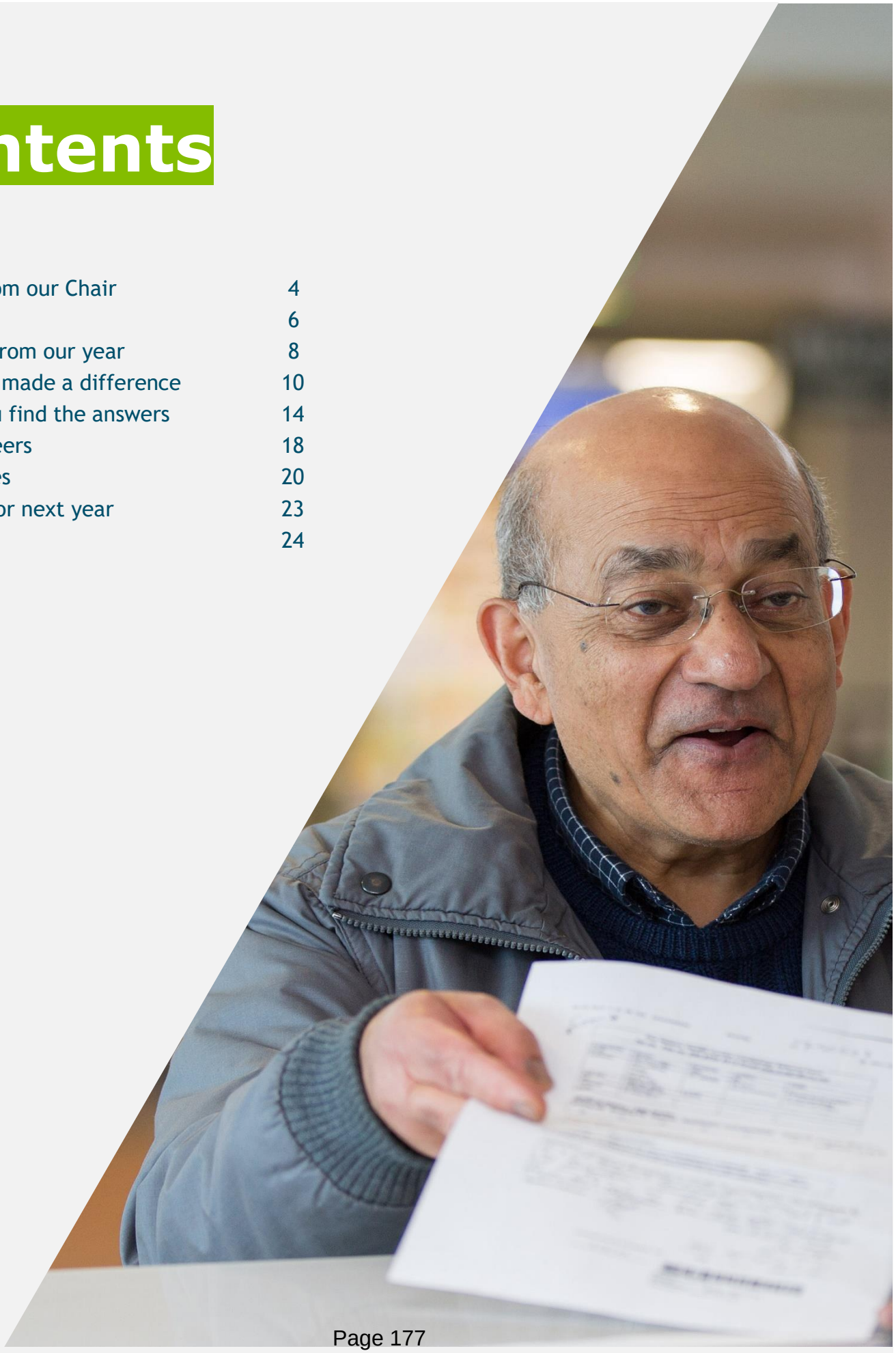
Tel: 0118 418 1418

healthwatch Reading
'Making your voice count'

Home of ReadingVoice
Your local advice & advocacy hub

Annual report 2018-19

Contents



Message from our Chair

The 2018-2019 year began with a joint celebration to mark our 5th birthday, and also commemorate 70 years of the NHS. Despite challenges in funding and increasing demand for our services, Healthwatch Reading is going from strength to strength as this coming year we mark another birthday, the first anniversary of the Reading Voice Advocacy service we manage.

Reading Voice works hand in hand with local Healthwatch by providing four different advocacy services: Care Act, NHS Complaints, Social Care complaints and Independent Mental Health Advocacy. We deliver this service in partnership with Age UK Reading and the learning disability charity Talkback, to harness the expertise and empathy they have in working with vulnerable people. Our advocates have worked with over 300 people in the first year.

To celebrate our success and to plan for the future, we carried out a stakeholder audit looking at how influential Healthwatch Reading has been.

The results were very positive, praising our work reaching seldom heard groups and the benefits of an independent organisation working local people – as one respondent told us: "Healthwatch Reading has a strong influence in the planning and delivery of health and social care services in Reading. They are a very strong voice for patients and are highly regarded within the health and social care system."

This year we also led some important and innovative projects. These included gathering the views of our LGBT+ community, speaking to young people about whether they know how to find the health and care they need when they arrive in Reading to study, and collecting the views of local people living in care homes.

These projects have demonstrated the depth of our work and our ambition to give a voice to those who often go unheard.

We have also been ambitious about ensuring we can influence decision-makers at the highest level. Working with our local Healthwatch colleagues in West Berkshire and Wokingham, we successfully bid for funding to test out a new role of Healthwatch Integrated Care System Officer. The aim is to ensure a single point of contact and liaison between the three local Healthwatch and the Berkshire West Integrated Care System as it seeks to transform local health services.

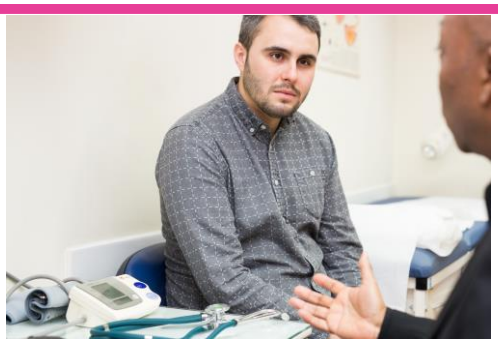
Finally, we thank our community for trusting us with their experiences so we can help make care better in Reading.

David Shepherd, chair of trustees

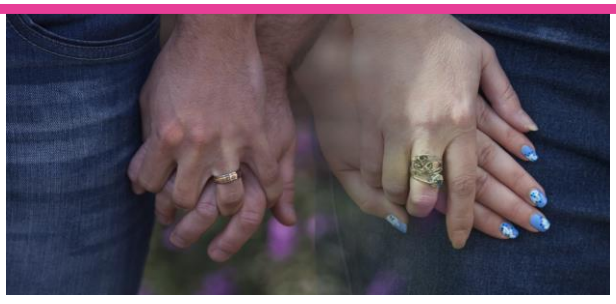
Changes you want to see

Last year we heard from almost 1,000 people who told us about their experience of a number of different areas of health and social care. Here are some examples of the changes that you want to see.

+ Care homes should provide a good choice of activities and food, and better access to dentists



+ Health staff should allow more time when they see people with learning disabilities



+ People want health and care professionals to be trained on LGBT+ issues to avoid prejudice

+ Students want more information on how to cope with stress and mental health needs

About us

Healthwatch is here to make care better

We are the independent champion for people using local health and social care services. We listen to what people like about services and what could be improved. We share their views with those with the power to make change happen. People can also speak to us to find information about health and social care services available locally.

Our sole purpose is to help make care better for people.

As Chair of Healthwatch England, it's my role to make sure your Healthwatch gets effective support and that national decisions are informed by what people are saying all over England.

If you were one of the 400,000 people who shared their experiences with us last year, I want to say a personal thank you. Without your views, Healthwatch wouldn't be able to make a difference to health and social care services, both in your area and at a national level. One example of this is how we shared 85,000 views with the NHS, to highlight what matters most, and help shape its plans for the next decade.

If you're part of an organisation that's worked with, supported or responded to Healthwatch Reading, thank you too. You've helped to make an even bigger difference.

None of this could have been possible without our dedicated staff and volunteers, who work in the community every day to understand what is working and what could be better when it comes to people's health and care.

If you've shared your views with us then please keep doing what you're doing. If you haven't, then this is your chance to step forward and help us make care better for your community. We all have a stake in our NHS and social care services: we can all really make a difference in this way.

Sir Robert Francis QC
Healthwatch England Chair

Our vision is simple

Health and care that works for you. People want health and social care support that works – helping them to stay well, get the best out of services and manage any conditions they face.

Our purpose

To find out what matters to you and to help make sure your views shape the support you need.

Our approach

People's views come first – especially those that find it hardest to be heard. We champion what matters to you and work with others to find solutions. We are independent and committed to making the biggest difference to you.

People are at the heart of everything we do

We play an important role bringing communities and services together. Everything we do is shaped by what people tell us. Our staff and volunteers identify what matters most to people by:

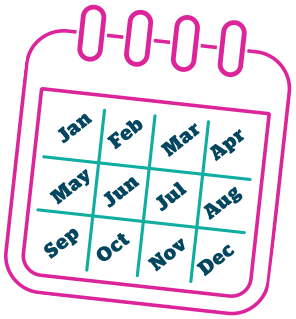
+ Visiting services to see how they work
+ Running surveys and focus groups
+ Going out in the community and working with other organisations

Our main job is to raise people's concerns with health and care decision-makers so that they can improve support across the country. The evidence we gather also helps us recommend how policy and practice can change for the better.

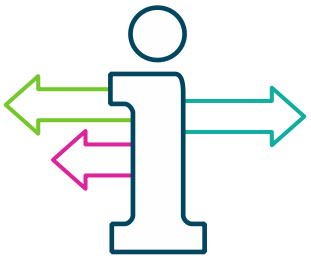
Highlights from our year

Find out about our resources and the way we have engaged and supported more people in 2018-19. **Our resources:**

Almost 1,000 people shared their health and social care story with us



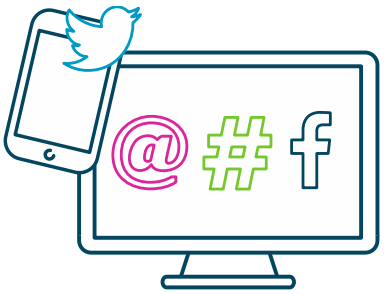
We have 11 volunteers helping to carry out our work. In total, they gave up more than 200 hours of their own time.



More than 200 people accessed Healthwatch advice and information online or contacted us with questions about local support, 20% more than last year

We visited 19 services via Enter and View and engagement visits to understand people's experiences of care.

We made 19 specific recommendations to decision-makers that they have said they will act on to improve health and care for our community



8% more people than the previous year engaged with us through our social media.

How we've made a difference

Changes made to your community

Find out how sharing your views with your Healthwatch Reading has led to positive changes for a wide variety of people in our community.

We show that when people speak up about what's important, and services listen, care is improved for all.

Take a look at how we have made a difference.

Amplifying the voices of 'seldom heard' groups

When we visited a diverse range of local charities in Reading to hear first-hand the experiences of staff and the people they support, we found many common themes.

So we brought the findings together in a 'Seldom Heard' report and challenged both the NHS and local authority to do better.

Our project allowed us to understand and voice the 'top three priorities' for people with learning disabilities, recently arrived refugees and asylum seekers, women from ethnic minority backgrounds learning English, and people who had experienced homelessness. While each group had unique experiences, they also faced common barriers, leading us to call for:

+ People to get information, at the right time, in a format that is suitable for their needs
+ People to know their individual rights and have these rights respected
+ People to receive good quality and culturally sensitive care.

As well as being formally considered at Reading's Health and Wellbeing Board, our report led to new opportunities for people with different needs to connect with decision-makers.

Staff and service users of Reading Learning Community Centre, and the Reading Refugee Support Group were invited to Patient Voice group meetings run by Berkshire West Clinical Commissioning Group, to share their experiences and work directly.
Reading Borough council has also said the Healthwatch findings will be taken into account as part of its review of community services commissioning in 2019.

Healthwatch Reading visited Reading Refugee Support Group to find the 'top three priorities' of staff and people to help improve experiences of accessing health and social care

LGBT+ project leads to action on equality for all

Thanks to our project to understand the experiences of people who identity as lesbian, gay, bisexual or transgender (LGBT+), an equality and diversity committee has been set up to shine a light on actions the NHS and local authorities take for a wide range of people.

We partnered with local LGBT+ charity SupportU to carry out a survey to find out whether gender identity or sexuality affects people's experience of using the NHS or care services.

We found:

+ Nobody felt they had been discriminated against by the NHS but 17% had experienced some prejudice, due to professional's lack of knowledge or respect
+ 37% of people had sought help for depression, a much higher rate than the general population (this has been confirmed in national studies too)
+ People called for services to have more visible signs to show they are LGBT+-aware and friendly.

In response to our report, the Berkshire West Integrated Care System (a partnership of health and care providers and decision-makers), created an equality and diverse committee that now meets every three months to not only look at LGBT+ issues, but also race, disability, and other characteristics protected by law. Healthwatch Reading attends as permanent member and the committee is already looking at representation of different people among staff and leadership of organisations, as well as care and attitudes towards service users.

"The Committee will monitor, discuss and collectively take action to drive improvements in ensuring and promoting Equality and Diversity across the Berkshire West Integrated Care System." RBC/BWCCG

Healthwatch Reading at the Reading Pride Festival in September 2018, to share our project findings with revellers

Healthwatch Reading with residents at St Luke's care home

Views of care home residents to inform new standards

Conversations about Care was our biggest project of the year, involving visits to 14 Reading care homes over 10 months to listen to 213 older people talk about their wellbeing and daily lives.

As a result, Reading Borough Council says it will use the findings to inform work it has begun on redrafting standards for the care it expects in the residential homes where it places people who are eligible for social services-funded support.

The NHS is also going to take action on care planning, and access to dentists and eye health care.

Our visits found that the top three things that matter most to people in care homes are:

+ Food choices
+ The way staff respond to them
+ Access to activities.

Three quarters of residents said they could see a GP when needed but only 26% could see an optician and even fewer, 21% could see a dentist when needed. Many people also told us they felt lonely, despite being surrounded by other people:

Our report also highlighted examples of good practice, such as stimulating environments and activities at care homes such as St Luke's in Emmer Green.

"The findings of the Healthwatch Reading report can positively influence standards of care going forward." RBC

Have your say

Share your ideas and experiences and help services hear what works, what doesn't, and what you want from care in the future. Staff are based at our central Reading office (pictured) from Monday to Friday.

t: 0118 937 2295

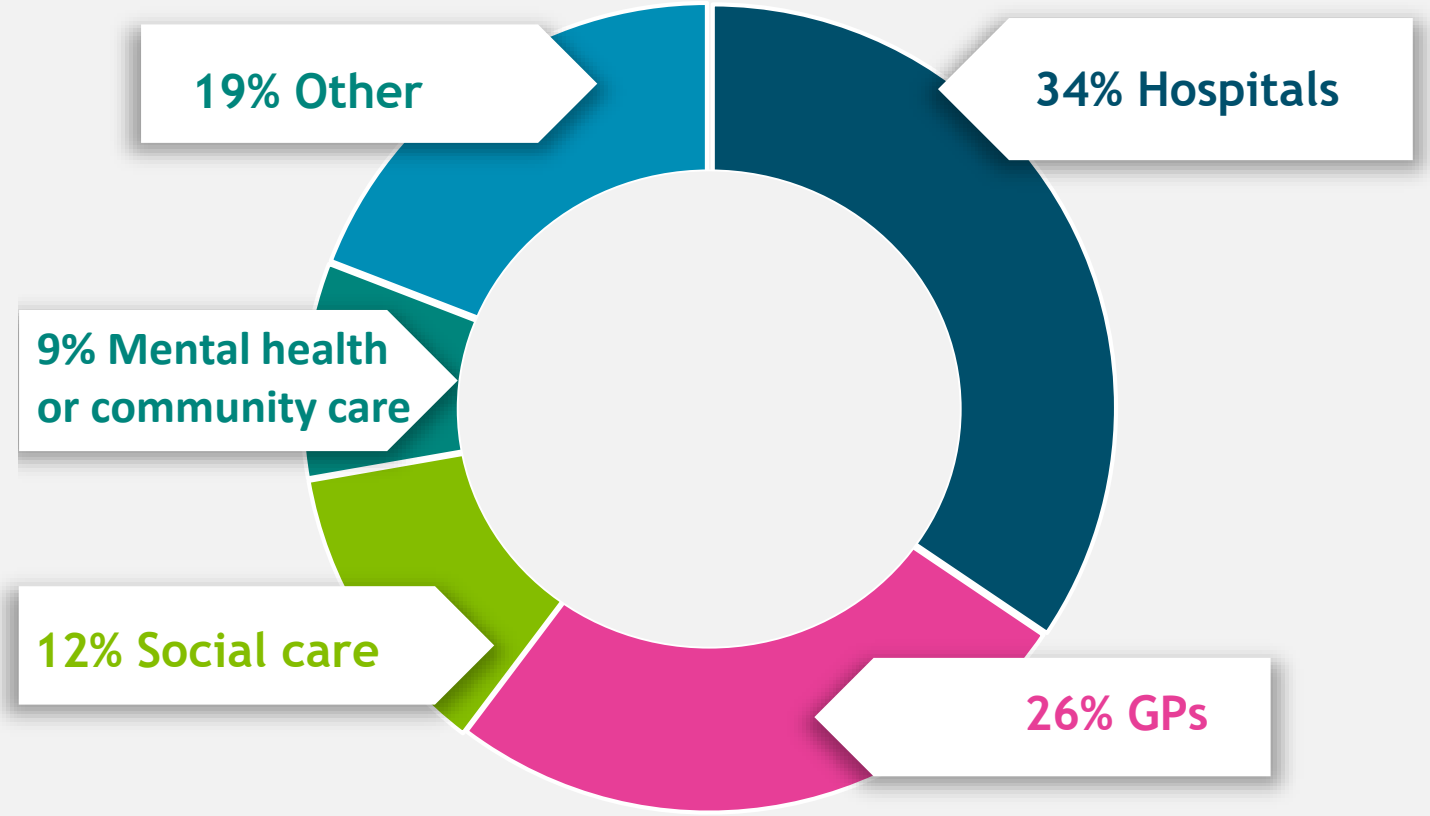
e: info@healthwatchreading.co.uk

Helping you find the answers

What services do people want to know about?

People don't always know how to get the information they need to make decisions about their own health and care. Healthwatch Reading plays an important role in providing advice and pointing people in the right direction for the support they need.

Here are the most common services that people ask us about:



How we provide people with advice, information or advocacy

Finding the right care or support can be worrying and stressful. There a number of organisations that can provide help, but people don't know where to look.

Last year we gave specific information to 209 individuals as well as targeted advice to specific groups.

You can come to us for advice and information in a number of ways including:

+ Specific advice and information blogs online
+ Our 'contact us' form on our website
+ At community events
+ Our social media channels
+ Over the phone
+ Or drop in to our central Reading base

Helping students find their way

At Fresher's Fairs in September 2018 we handed out a free A5 card guide to students starting their studies at Reading College or the University of Reading, after they had filled in one of our surveys.
Our aim was to ensure students – many from overseas or outside of the borough - could get all the information they needed in one place, about local GPs, dentists, sexual health services, mental health support and more.
The University Health Centre now keeps a stock of the cards on its reception to hand out to students. We also have an online guide for students on our website.

Timely advice for patients affected by GP surgery closure

When 6,500 patients were told that Priory Avenue Surgery in Caversham was closing at the end of June 2018, we used all our available channels to ensure people were fully informed about their rights and options.
This included posting advice on a local Facebook group (see below) where more than 200 people raised concerns; visiting the surgery six times to assist people with knowing their choices and completing forms; attending two public meetings held by NHS leaders overseeing the closure, taking phone calls, publishing comparison tables of other local GP practices, and distributing our own one-page guide on how to choose a new GP surgery.
Afterwards we gave feedback to an NHS-led review on how it manages future surgery closures.

Our Reading Voice service is run by advocacy services manager Carl Borges (pictured).

Providing statutory advocacy via our Reading Voice service

Since 1 April 2018 we have been official providers of four types of advocacy that people are entitled to for free as part of an all-in-service known as Reading Voice.

Advocacy is separate to our statutory Healthwatch remit, but the work is often related, so we share staff, information and expertise so that people can get help from the same place. We work with Age UK Reading and the charity Talkback, to provide this service.

The four types of advocacy are:

+ Statutory NHS Complaints Advocacy: to help any Reading resident resolve their concern or complaint about health services
+ Statutory Care Act Advocacy: to help isolated vulnerable adults such as people to have their say on care needs and plans during discussions with social workers
+ Statutory Independent Mental Health Advocacy: to help any Reading person who is detained for mental health treatment at Prospect park Hospital, to know their rights, understand their care and have their say
+ Social Care Complaints Advocacy: a non-statutory service to help Reading adults with a complaint about social care that has been arranged for them by the council.

Statutory advocacy is funded by central government via local authorities, who must contract with an organisation that is independent of the NHS or council and whose staff who have completed mandatory training.

Are you looking for help?

If you have a query or need help with where you can go to access further support, get in touch. Don't struggle alone. Healthwatch is here for you.

w: www.heealthwatchreading.co.uk
t: 0118 937 2295
e: info@healthwatchreading.co.uk

Our volunteers

How do our volunteers help us?

At Healthwatch Reading we couldn't make all of these improvements without the support of our volunteers who help us in a wide variety of ways:

+ Raise awareness of the work we do in the community
+ Visit services to make sure they're meeting people's needs
+ Support our day to day running by e.g. governance
+ Share views and experiences at our regular board meetings which we use to set our work

Our volunteer board members share local intelligence, help set our projects and give feedback on our reports, at the regular meetings we hold at Reading Central Library.

Every little bit helps…

We're grateful to the unpaid time and effort our volunteers give – we couldn't do our work without them. So here's a big thanks to….

Trustees:

+ Monica Collings
+ Gurmit Dhendsa
+ David Shepherd, chair, and our representative of the Reading Health and Wellbeing Board

Board members:

+ Sheila Booth
+ Francis Brown
+ David Cooper
+ Douglas Findlay
+ Tony Hall
+ Karen Hampshire (North and West Reading Patient Voice)
+ James Penn (South Reading Patient Voice)
+ David Shepherd (chair of trustees)
+ Helena Turner

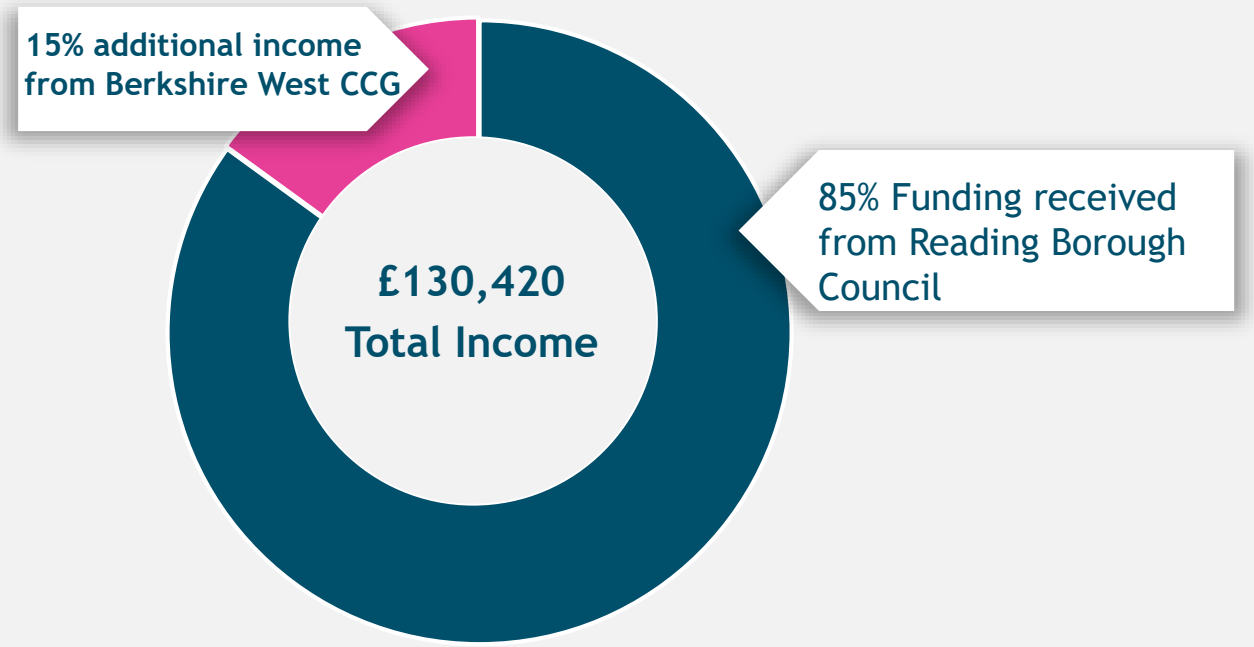
Our finances

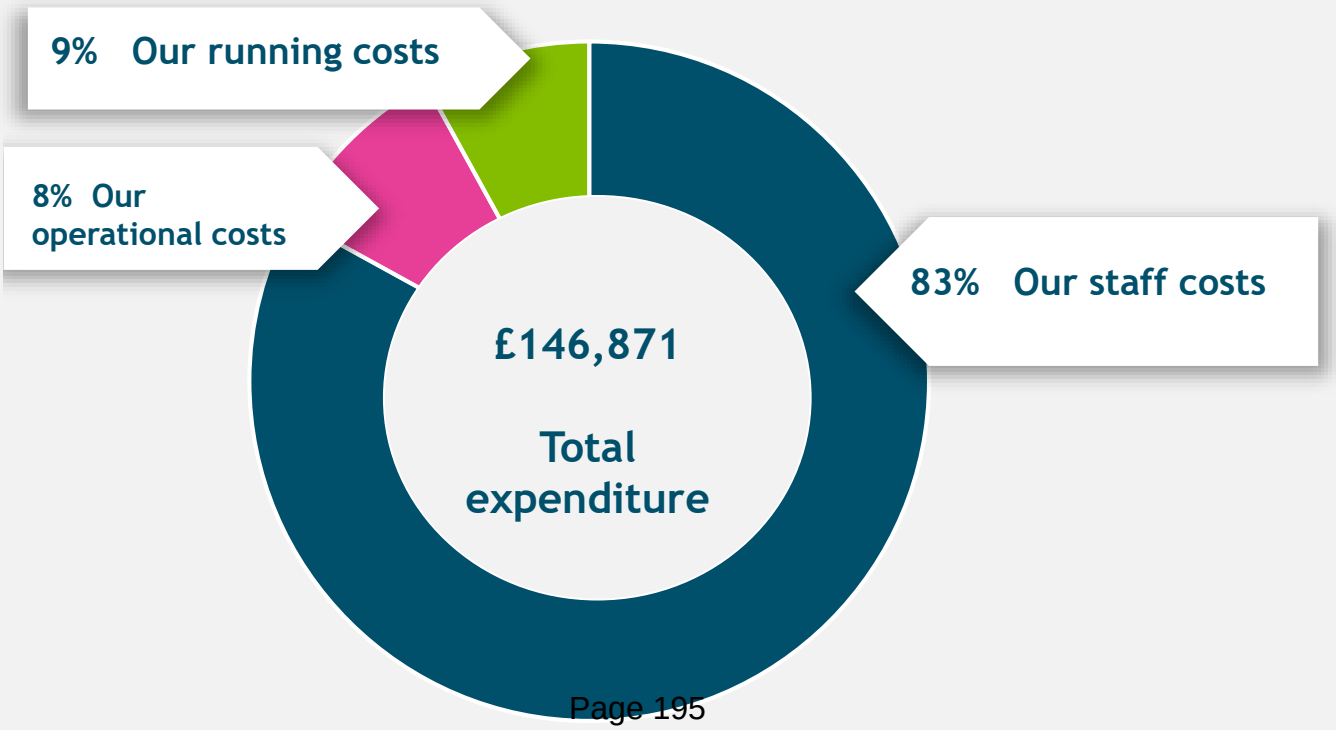
How we use our money

To enable us to fulfil our Healthwatch contract, we are funded by our local authority.

In 2018-19 we spent £146,871.

We also received £19,920 of additional income from Berkshire West Clinical Commissioning Group.





Our plans for next year

Message from our CEO

Time never stands still for local Healthwealth, as our staff and volunteers can testify. We continue to hear wide-ranging issues from the public, while local services undergo yet more government-led reorganisation.

Looking back on 2018-19, we have:
+ amplified the voices of seldom heard groups, such as LGBT+ people, which has led to a renewed local focus on equality and diversity
+ revealed quality of life issues in care homes as the council prepares to write new standards
+ expanded our advocacy provision, including Independent Mental Health Advocacy at Prospect Park
+ and relaunched our website.

Looking ahead to 2019-20, we plan:
+ To influence the new integrated care system and GP-led primary care networks, with findings from a major engagement project on how extra NHS funding should be spent
+ To visit the local NHS Walk-In Centre and emergency department, to see if the way people use these, has changed as GPs offer more appointments outside working hours
+ To explore views of digital advances, like video consultations with doctors and the new NHS App.

Underpinning our role as an independent champion for people, is our philosophy of using constructive challenge to help improve local services.

Thank you to Reading people, our voluntary sector partners, and organisations that fund and provide health and social care.

Mandeep Kaur Bains
Healthwatch Reading chief executive

Contact us

Healthwatch Reading
3rd floor, Reading Central Library
Abbey Square
Reading
RG1 3BQ

Charity number: 1151346

+ 0118 937 2295
+ info@healthwatchreading.co.uk
+ http://twitter.com/HealthwatchRdg
+ https://healthwatchreading.co.uk/

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 need this in an alternative format please contact us.

Healthwatch Reading
3rd floor, Reading
Central Library
Abbey Square
Reading
RG1 3BQ

w: www.healthwatchreading.co.uk
t: 0118 937 2295
e: info@healthwatchreading.co.uk
tw: @HealthwatchRdg
fb: facebook.com/HWReading

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12th July 2019**		
REPORT TITLE:	**READING'S ARMED FORCES COVENANT AND ACTION PLAN – MONITORING REPORT**		
REPORT AUTHOR:	**Jill Marston**	**TEL:**	**72699**
JOB TITLE:	**Senior Policy Officer**	**E-MAIL:**	**Jill.marston@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Armed Forces Covenant is a voluntary statement of mutual support between a civilian community and its local armed forces community.

1.2 This report presents an annual update on progress against the actions outlined in the Action Plan, in particular the heath related actions, and on the general development of the Reading Armed Forces Covenant.

2. RECOMMENDED ACTION

2.1 To note the progress against the actions set out in the Reading Armed Forces Covenant Action Plan (appendix A), in particular the section on Health and Wellbeing.

3. POLICY CONTEXT

3.1 In 2011, the Government published the 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 'Covenant for Communities' 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. THE PROPOSAL

Background

4.1 The aims of the Armed Forces 'Covenant in the Community' 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

4.2 The Reading Armed Forces Community Covenant was launched at the Afghanistan Homecoming Parade at Brock Barracks on 7th July 2012.

4.3 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.

4.4 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 Armed Forces 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 Armed Forces Covenant and Action Plan

4.5 The Reading Armed Forces Covenant working group with key stakeholders meets on a six monthly basis, the most recent held in March 2019. Partners continue to report that the meeting is valuable.

4.6 Progress to date against the actions in the Action Plan is shown in Appendix A. A number of the actions have now been completed. Significant successes since 2012 include:

- Reading was awarded £21,730 from the 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.

- The Museum service was awarded £10,000 from the Covenant grant scheme to support their exhibition, 'Reading at War', to mark the centenary of the beginning of the First World War in 2014.

- Reading Ex-British Gurkha Association was awarded £14,500 under the new Covenant Fund for two Nepalese community development workers.

- Soldiers, Sailors and Airmen Families Association (SSAFA) was awarded £1,000 to further update their leaflet on accessing health services, which has been translated into Nepalese and is being used by SSAFA to run classes; leaflet now updated and printed.

- 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 ensure service and civilian families/individuals are supported and treated equitably.

- 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.

Health related actions

4.7 The Action Plan includes a section on health and wellbeing with the following actions:

- Feedback and input to the Health and Wellbeing Board
- Devise protocol for GPs to register Veteran status
- Raise awareness of and signpost to Veteran's Mental Health Service for the South Central region
- Development of a leaflet on accessing health services to be translated into Nepalese
- Develop and promote a discount scheme for serving personnel for arts and leisure facilities in Reading
- Consolidation of appropriate contact/ support lists in order to provide better signposting

4.8 Progress on each of these is summarised in the attached Action Plan. In particular, re GPs recording Veteran status, a number of measures have been put in place by Clinical Commissioning Groups (CCG's) regarding the recording of Veteran status by GPs:

- CCGs have developed guidance for practices on registering patients from the Armed Forces community
- Information on CCG web sites and social media
- 308 Veterans currently recorded in Reading practices as at Dec 2018
- As part of the NHS Long Term Plan, Military Veteran Aware accreditation will be rolled out nationally to practices over the next 5 years
- Discussions between the Reading branch of the Royal British Legion and the lead for Veterans at Berks West CCG re Veterans and NHS services

Covenant Grant Fund Trust

4.9 The national Covenant grant fund was launched in 2015 by the Ministry for Defence, with £10 million available every year. Since April 2018, the fund has become the independent Armed Forces Covenant Fund Trust and makes grants to support members of the Armed Forces community.

4.10 Under the 'local grants and digital developments programme', the trust will fund projects of up to £20,000 that support community integration or local delivery of services. Applications are open to charities, local authorities, schools, other statutory organisations, Community Interest Companies or Armed Forces units.

4.11 Applications can be made at any time for this programme in 2019/20, but the following timetable applies:

- Applications submitted by 9 September 2019 will be decided before the end of November 2019.
- Applications submitted by 2 December 2019 will be decided before the end of February 2020.

4.12 There have been some initial discussions about a potential bid to improve visibility of the Royal Berks Cenotaph from Oxford Rd via the keep entrance.

4.13 An application was made to the Covenant Fund by New Directions in Sept 2018 for a project to deliver adult learning to Reading's Gurkha community, combining English language teaching with classes to teach life skills and leisure interests – e.g. cooking and gardening. Unfortunately, the bid was unsuccessful.

5.0 CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The work on the Armed Forces covenant is in line with the overall direction of the Reading Health and Wellbeing Strategy and contributes to a number of the Strategy's

eight priorities, including the following as they relate to the Veteran community, through strengthening the support provided to Veterans and service leavers:

1. Supporting people to make healthy lifestyle choices
2. Reducing loneliness and social isolation
3. Reducing deaths by suicide
4. Reducing the amount of alcohol people drink to safe levels

5.2 The proposal recognises that plans in support of Reading's 2017-20 Health and Wellbeing Strategy should be built on three foundations - safeguarding vulnerable adults and children, recognising and supporting all carers, and high quality co-ordinated information to support wellbeing. The proposal addresses these by providing support to the Armed Forces community and their families, including Veterans.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

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. 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. 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. 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 submitted bids in three bidding rounds. £10m per annum was made available in perpetuity from 2015/16 onwards through the new Armed Forces Covenant fund.

10. BACKGROUND PAPERS

10.1 Armed Forces Covenant Fund https://www.gov.uk/government/collections/covenant-fund

Appendix A

READING ARMED FORCES COMMUNITY COVENANT
ACTION PLAN MAY 2019

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.

Ref	Outcome	Responsibility	Timescale	Progress 2019
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	• Annual report on health related actions to Health & Wellbeing Board in July 2019 • Regimental Medical Officer to be invited to future meetings once in post
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: • 'READ' codes provided to practices from Spring 2016. • CCGs have developed guidance for practices on registering patients from the armed forces community • Information on CCG web sites and social media • 308 Veterans currently coded in Reading at their practices as at Dec 2018 • As part of the NHS Long Term Plan, Military Veteran Aware accreditation will be rolled out nationally to practices over te next 5 years • Discussions between Reading branch of the Royal British Legion and the lead for Veterans at Berks West CCG re Veterans and NHS services

Appendix A

Ref	Outcome	Responsibility	Timescale	Progress 2019
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 • CCGs have been raising awareness at council of practice meetings, on CCG websites, and on social media • Hotline number included on Council's web page for support for Veterans http://www.reading.gov.uk/reading-armed-forces-community-covenant
5	Development of a leaflet on accessing health services to be translated into Nepalese	Clinical Commissioning Groups/SSAFA/RBC	Spring 2014	**ACHIEVED** • SSAFA runs classes with ex-Gurkha community using leaflet • Funding gained from covenant fund to develop the booklet further and to print and translate into Nepalese; revision version now complete and printed • Royal Berks Hospital now running 6 weekly meetings with ex-Gurkha community on diabetes, blood pressure etc, using the booklet
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 • 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/reading-armed-forces-community-covenant

Appendix A

Ref	Outcome	Responsibility	Timescale	Progress 2019
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 2019 at partnership meeting; 7 Rifles actively recruiting; Army re-structure now complete
9	Work with local businesses to encourage employment of Service leavers and Reservists	Reading UK CIC/ Jobcentre Plus/	ongoing	• MOD employer engagement strategy to promote to employers the value of employing Reservists • Ongoing briefing sessions between 7 Rifles and JCP (including Back to Work Programme and Armed Forces Employment Pathways Scheme) • 7 Rifles work with Gravity Personnel to promote the benefits of recruiting Reservists • UK CIC and Business Improvement District newsletters promotion of benefits of employing Reservists • 7 Rifles presence at Hexagon job fair Autumn 2018, due again 2019; Reading College and University of Reading job fairs Autumn 2018.
10	Encourage Jobcentre Plus to register Veterans	Jobcentre Plus	ongoing	• Jobcentre Plus systems allow recording of Veteran status at start of Universal Credit claim; JCP to promote more widely • Ongoing briefing sessions between 7 Rifles and JCP
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	• Regular 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 • Ongoing briefing sessions between 7 Rifles and JCP • 7 Rifles presence at Hexagon job fair Autumn 2018, Reading

Appendix A

Ref	Outcome	Responsibility	Timescale	Progress 2019
				College and University of Reading job fairs Autumn 2018 • Armed Forces Employment Pathways scheme for NEETs with DWP
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	• SERFCA have set up jobs4reservists website, promoted via Reading UK CIC e-news • New Directions offer an employability course in partnership with JCP, covering employability and essential IT skills - for Universal Jobmatch, CV creation, job applications and interview preparation • Advice and support contacts promoted via RBC Armed Forces Covenant web page: http://www.reading.gov.uk/reading-armed-forces-community-covenant and new Armed Forces Covenant website: (www.armedforcescovenant.gov.uk)
13	Defence discount service/ card	Reading UK CIC	2014/15	• Awareness raised with Business Improvement District businesses • A number of large companies with Reading branches already signed up to scheme
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 • Sandhurst Leadership Challenge (employers) Sept 2018 and March 2019 • Hexagon job fair Autumn 2018, Reading College and University of Reading job fairs Autumn 2018
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 Armed Forces Covenant to employers	RBC/ Reading UK CIC/ Covenant partnership	ongoing	• Article in Reading UK CIC e-News • Ongoing work with MOD Defence Relationship Management to engage employers • RBC awarded Employer Recognition Scheme bronze award July 2017

Appendix A

Ref	Outcome	Responsibility	Timescale	Progress 2019
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 funding	RBC/ Schools in Reading Borough area/ 7 Rifles	annual survey (next due Jan 15)	• 12 service children in Reading schools (Jan 19, School Census) • Best practice examples of how service pupil premium spent in other areas circulated to schools
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 Autumn 16.

Appendix A

Ref	Outcome	Responsibility	Timescale	Progress 2019
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 benefits can be identified and support offered • Support, initiatives and opportunities disseminated via charities' existing mechanisms (e.g. SSAFA, RBL, Reading Ex-British Gurkha Association, Forgotten British Gurkhas) • Total number of veterans in Reading difficult to ascertain; around 380 residents are in receipt of Armed Forces pension (a proxy measure for Veteran numbers).
19	Ensure Veterans receive equitable treatment in allocation of social housing	RBC	ongoing	**ACHIEVED** • Incorporated into Reading Borough Council's Housing Allocations Scheme • 69 households have been given additional priority for housing via the Housing Register since 2011; to date, 12 have been re-housed and 10 applications are currently live on the register (July 2019)
20	Explore options for facility sharing in line with local needs and Defence 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

Appendix A

Ref	Outcome	Responsibility	Timescale	Progress 2019
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/ X0 7 Rifles	ongoing	• Civil emergency liaison in place, and protocol for civil emergency funding has been improved • 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 military needs and ensure equitable service	ROSO 7 Rifles	ROSO to advise	**ACHIEVED** Protocol in place
23	Identify key areas for application of Community Covenant grant funding	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

Appendix A

Ref	Outcome	Responsibility	Timescale	Progress 2019
	which will benefit both the civil and Armed Forces communities			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 • New Covenant grant fund launched Aug 2015 • Successful bid from REBGA for two Nepalese community development workers (£14,500) • Successful bid from SSAFA for funding to update, develop and print copies of a health booklet translated into Nepalese (£1,000)
24	Encourage organisations and communities to sign up to the Armed Forces Community Covenant	RBC/ Covenant partnership/ ROSO 7 Rifles	Ongoing	• Signatories include Thames Valley Chamber of Commerce, Reading College and University of Reading • Ongoing work with MOD Defence Relationship Management to engage employers
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)	• Armed Forces Day planned for 29th June 2019 in Broad St and Forbury Gardens; flag raising at the Civic Offices • Reserves Day 26th June 2019
26	Armed forces participation in public events as appropriate	RBC/ PSAO HQ Coy 7 Rifles (PSOA HQ Coy)	ongoing	• Carol concert at St Georges church in December 2018 • Numerous recruiting and other community events throughout the year
***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 2019 in Forbury Gardens

Appendix A

Ref	Outcome	Responsibility	Timescale	Progress 2019
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 - 2018	• Successful bid submitted to Community Covenant Grant Fund by Museum service for funding to support the 'Reading at War' exhibition' in to mark the centenary of the beginning of the First World War • 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

This page is intentionally left blank

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12 JULY 2019**		
REPORT TITLE:	**INTEGRATION PROGRAMME UPDATE**		
REPORT AUTHOR:	**LEWIS WILLING**	**TEL:**	**01189 372477**
JOB TITLE:	**INTEGRATION PROJECT MANAGER**	**E-MAIL:**	**LEWIS.WILLING@READING.GOV.UK**
ORGANISATION:	**READING BOROUGH COUNCIL / BERKSHIRE WEST CCGs**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an update on the Integration Programme – notably, progress made within the Programme itself, as well as performance against the national BCF targets for the entirety of financial year 2018/2019.

1.2 Of the 4 national BCF targets:

- Performance against one (limiting the number of new residential placements) is strong, with the target for the financial year met & exceeded.
- We have not met our target for reducing the number of non-elective admissions (NELs), but work against this goal remains a focus for the Berkshire West-wide BCF schemes and a paper has been written exploring trends within the NELS data & making recommendations for driving reductions in NELS.
- We have met our target DTOC for almost 50% of the financial year, with incredibly strong reductions in the number of social care delays compared to performance in previous years. Initiatives are in place that it is believed will continue to drive further reductions in DTOC rates across the financial year 2019/2020.
- Progress against our target for increasing the effectiveness of reablement services remains in line with the decreased performance discussed at January's HWB, but this is due to revised guidance around the methods of measuring their impact and does not reflect a drop in actual performance (see section 4.9 – 4.11 for further detail) and further activities are planned to align our reablement offer with emerging national best practice.

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing Board are asked to note the general progress to date.

3. POLICY CONTEXT

3.1 The Better Care Fund (BCF) is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups (CCG) and Local Authorities to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation to promote / deliver on integration ambitions.

3.2 As in previous years, the BCF has a particular focus on initiatives aimed at reducing the level of avoidable hospital stays and delayed transfers of care (DTOCs) as well a number of national conditions that partners must adhere to (including reducing the number of non-elective admissions to hospital; reducing admissions to residential accommodation; and increasing the volume of individuals remaining at home 91 days after receiving reablement services).

4. BCF PERFORMANCE UPDATE

DTOC

4.1 Under our revised target for 2018/2019, we aspire to have no more than 419.75 bed days lost per month broken down as follows:

- Health attributable – no more than 211 bed days lost
- ASC attributable – no more than 175 bed days lost
- Both attributable – no more than 33 bed days lost

4.2 Our results across the financial year to date are as follows:

- April = 421 (of which 315 Health, 106 ASC, 0 joint)
- May = 322 (of which 250 Health, 62 ASC, 10 joint)
- June = 272 (of which 236 Health, 2 ASC, 34 joint)
- July = 348 (of which 210 Health, 63 ASC, 75 joint)
- August = 480 (of which 254 Health, 132 ASC, 94 joint)
- September = 403 (of which 183 Health, 127 ASC, 93 joint)
- October = 471 (of which 305 Health, 97 ASC, 69 joint)
- November = 544 (of which 260 Health, 229 ASC, 55 joint)
- December = 657 (of which 282 Health, 306 ASC, 69 joint)
- January = 332 (of which 203 Health , 55 ASC, 74 joint)
- February = 560 (of which 456 Health, 95 ASC, 9 joint)
- March = 462 (of which 374 Health, 48 ASC, 40 joint)
- April 2019 = 224 (of which 160 Health, 29 ASC, 35 joint)

4.3 Within each month (except December), there has been a greater volume of Health delays (exceeding the health-attributable days delayed target set by NHSE in all months except July and September and January).

4.4 In terms of our local schemes' impact on the DTOC rates:

- *Community Reablement Team (CRT)* – In the financial year 2018/19, the service appears to have prevented 1787 delayed days in hospital. Assuming a cost of £400 per NHS bed/day, this would equate to a cost avoidance of £714,819. For this financial year (April & May 2019), the service appears to have prevented 205 delayed days in hospital, this would equate to a cost avoidance of £82,180.

- *Discharge to Assess (D2A)* – In the financial year 2018/19, the service appears to have prevented 617 delayed days in hospital. Assuming a cost of £400 per NHS bed/day, this would equate to a cost avoidance of £246,685. For this financial year (April & May 2019), the service appears to have prevented 78 delayed days in hospital, this would equate to a cost avoidance of £31,200.

4.5 We continue to proactively address DTOC performance by:

- Holding a weekly Directors' meeting – during which the ASC Directors from the 3x Berkshire West Local Authorities, the Director of Berkshire West CCGS, and senior managers from Berkshire Healthcare Foundation Trust and Royal Berkshire Hospital review and sign-off the weekly delays. Trends in delays are discussed and remedial actions agreed. A paper summarising the key findings within identified delays (along with associated remedial actions) was brought to the May meeting of the Berkshire West 10 Delivery Group for discussion and approval.

- Working with the Berkshire West 10 Delivery Group to implement the High Impact Model across the Berkshire West system. As part of this work, the integration leads for Berkshire West will undertake visits to key health & social care sites to review further activities that might help to drive further reductions in delay.

<u>Residential Admissions</u>

4.6 Our target is to have no more than 116 new residential admissions for older people.

4.7 The year-end position for 2018/2019 was a total of 88 new residential admissions in the financial year. So far for 2019/2020, a total of 13 new residential admissions in this financial year.

4.8 In terms of our local schemes' impact on the rate of residential admissions:

- *CRT* – 429 clients were living at home prior to entering the service, and subsequently returned home rather than progressing to a residential or nursing placement upon leaving the service. The service could therefore be argued to have prevented 429 entrances into residential care. Taking the average cost of a residential / nursing placement, this could equate to full-year effect cost avoidances of around £7,945,053

- *D2A* – 34 clients were living at home prior to entering the service, and subsequently returned home rather than progressing to a residential or nursing placement upon leaving the service. The service could therefore be argued to have prevented 34 entrances into residential care. Taking the average cost of a residential / nursing placement, this could equate to full-year effect cost avoidances of around £905,426.

<u>Reablement</u>

4.9 Our target is to maintain an average of 93% of people remaining at home 91 days after discharge reablement / rehabilitation services (having entered these services following a stay in hospital).

4.10 Based on our performance to date (within our CRT and D2A service), within the financial year 2018/2019 we have achieved an average of 82% of service users remaining at home 91 days after discharge from hospitals into our Community Reablement Service and Discharge to Assess service.

4.11 This is due to revised guidance being issued by NHS England. Previously, any clients who passed away following discharge from reablement services were not included in the count, as it was felt that clients with terminal conditions and/or severe ill health could not be reabled. However, NHS England have asked for these clients to be included in the count moving forward, which has decreased our performance accordingly. Please note that:

- Were the clients in question not included, performance would be on-target.

- Had the clients in question not been referred to reablement services, it is potentially likely that they would've remained in hospital and become DToCs, and could potentially have passed away in hospital. Therefore whilst their inclusion in the count has decreased performance against the national target, the practice that has caused this is arguably in the clients' best interest, and has played a significant role in avoiding higher DToC rates.

- Further actions to better-align our reablement offer with emerging national best practice are outlined in sections 5.1 and 5.2 below.

<u>Non-Elective Admissions (NELs)</u>

4.12 Our BCF target is to achieve a 0.97% reduction (expressed as 149 fewer admissions) against the number of NEL admissions seen in 2017/2018. This equates to a target of no more than 15,190 NELs in 2018-2019 (or no more than 1266 per month).

4.13 Based on our final end of year performance data, we acheived a total of 16,642 NELs across 2018-2019. This equates to an increase of 9.45% compared to the target reduction of 0.97%.

4.14 However, in terms of the local versus national position on NELs, Berkshire West CCG are in the top 10 out of 211 CCGs for lowest numbers of NELs.

4.15 In terms of our local schemes' impact on the rate of NELs:

- *CRT* - by engaging with 163 "rapid referrals" (clients who are seen prior to hospital admission, hopefully negating the need for a non-elective admission), the service has potentially prevented up to 163 NELs[1].

- *D2A* - by engaging with 12 "rapid referrals" (all of which did not progress onwards to hospital following discharge from the service), the service appears to have prevented 14 NELs.

4.16 Further actions to improve NEL performance are detailed in section 5.1 below.

[1] Please note that further analysis is required to determine how many of these clients were subsequently admitted to hospital, in order to calculate the exact impact the service has had on NELs.

5. PROGRAMME UPDATE

5.1 Since January, the following items have been progressed:

- **Launching the pilot of the Neighbourhood Care Planning Group,** a joint working initiative between Adult Social Care (ASC) and North/West and South Reading GP Alliances. The pilot brings together key professionals to provide a forum for multi-disciplinary discussion, risk assessment and comprehensive care planning. Three meetings have been held to date, with input from Adults Social Care, 6 voluntary sector organisations, 2 GP surgeries, community matrons, community nurses, and community mental health team workers.

- Designing a project to implement the findings of the **review of Reading Borough Council's BCF-funded Community Reablement Team (CRT) service**, which will seek to align the team with emerging best practice.

- **Analysing NELs performance** and exploring further opportunities for driving performance improvements. The CCG have led on writing a paper summarising the findings of this review, which will be brought to the July Reading Integration Board meeting for sign-off along with three proposed projects that aim to drive reductions in Reading's NELS performance.

6. NEXT STEPS

6.1 The planned next steps for July - September include:

- **Completing the Neighbourhood Care Planning Group pilot** between Adult Social Care and the North/West and South GP Alliances (the last of the 6 multi-disciplinary team meetings comprising the pilot will take place in September) – the outcomes of this pilot will be brought to the next Health Wellbeing Board.

- Continue progressing approved recommendations relating to **aligning the Community Reablement Team with emerging best practice.**

- **Revising the design and operation of the Reading Integration Board** to reflect emerging best practice in West Berkshire and Wokingham; and to reflect the actions as stated in the **CQC Local System Review**, namely to ensure greater linkages between the Board and the Health & Wellbeing Board.

7. CONTRIBUTION TO STRATEGIC AIMS

7.1 While the BCF does not in itself and in its entirety directly relate to the HWB's strategic aims, Operating Guidance for the BCF published by NHS England states that: *The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners* […] *HWBs also have their own statutory duty to help commissioners provide integrated care that must be complied with.*

8. COMMUNITY & STAKEHOLDER ENGAGEMENT

8.1 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".

8.2 In accordance with this duty, the integration leads for Berkshire West met with Healthwatch to develop a proposal that would have seen Healthwatch potentially receive additional funding to gather service user feedback. This feedback would have been gathered from service users who had utilised more than 1 service within the health and social care system, and would have focused on the quality of joined-up care that they received (in line with the approach, and questions, recommended by the Social Care Institute for Excellence in their "Logic Model" for integration, which is expected to underpin the forthcoming Health and Social Care Green Paper). However, whilst Reading and Wokingham Council were able to meet their share of the cost of this proposal under BCF funding, West Berkshire could not source the required amount. Accordingly, the integration leads have reviewed existing service user mechanisms in place across the Berkshire West system and have identified two (one delivered by the Royal Berkshire Hospital, the other by Berkshire Healthcare Foundation Trust) that could potentially replicate the proposed system that Healthwatch might otherwise have delivered. Further meetings are planned for Summer 2019 to develop this proposal further. Any qualitative and quantitative feedback gathered would be fed into the respective integration boards' performance dashboard, to ensure that stakeholders were able to understand and plan responses to any themes identified within the data.

9. EQUALITY IMPACT ASSESSMENT

9.1 N/A – no new proposals or decisions recommended / requested

10. LEGAL IMPLICATIONS

10.1 N/A – no new proposals or decisions recommended / requested.

11. FINANCIAL IMPLICATIONS

11.1 At the end of March 2019 the combined forecast outturn across the RBC and CCG hosted schemes forecast outturn for 2018/19 is an underspend of £298.3k.

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	12 July 2019		
REPORT TITLE:	Health and Wellbeing Dashboard and Action Plan - July 2019		
REPORT AUTHOR:	Kim McCall / Janette Searle	TEL:	0118 937 3245 / 3753
JOB TITLE:	Health and Wellbeing Intelligence Officer / Preventative Services Manager	E-MAIL:	kim.mccall@reading.gov.uk / Janette.searle@reading.gov.uk
ORGANISATION:	Reading Borough Council		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report presents an update on delivery against the Health and Wellbeing Action Plan (Appendix A), alongside the Health and Wellbeing Dashboard (Appendix B), which sets out local trends in a format previously agreed by the Board. Taken together, these documents provide the Board with an overview of performance and progress towards achieving local goals as set out in the 2017-20 Health and Wellbeing Strategy for Reading.

1.2 The appended documents give the Board a context for determining which parts of the Health and Wellbeing Strategy it wishes to review in more depth, such as by requesting separate reports. Identifying priorities from the Health and Wellbeing Strategy to provide themes for Health and Wellbeing Board meetings is in line with the 2016 Peer Review recommendation that the Health and Wellbeing Strategy should be used to drive the agenda of the Health and Wellbeing Board.

2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board notes the progress to date against the 2017-20 Reading Health and Wellbeing Strategy Action Plan as set out at Appendix A.

2.2 That the Health and Wellbeing Board notes performance a set out in the dashboard at Appendix B, and in particular the following performance measures which have been updated since the dashboard was last brought to the Board:

- **Estimated dementia diagnosis rate (aged 65+) has been updated with monthly snapshots.**
- **% of those eligible for an NHS health check who were offered and received a health check**
- **% of adults overweight or obese**
- **% of adults physically active**
- **Number of dementia friends**

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 sets out the requirement on Health and Wellbeing Boards to use a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) to develop plans which:

- improve the health and wellbeing of the people in their area;
- reduce health inequalities; and
- promote the integration of services.

3.2 Reading's 2017-20 Health and Wellbeing Strategy sets out local plans as required under the Health and Social Care Act, and also addresses the local authority's obligations under the Care Act 2014 to promote the wellbeing of individuals and to provide or arrange services that reduce needs for support among people and their (unpaid/family) carers in the local area.

3.3 The current strategy is founded on three 'building blocks' – issues which underpin and are expected to be considered as part of the implementation plans to achieve all of the strategic priorities. These are:

- Developing an integrated approach to recognising and supporting all carers
- High quality co-ordinated information to support wellbeing
- Safeguarding vulnerable adults and children

3.4 The Strategy then sets out eight priorities:

- Supporting people to make healthy lifestyle choices (with a focus on tooth decay, obesity and physical activity)
- Reducing loneliness and social isolation
- Promoting positive mental health and wellbeing in children and young people
- Reducing deaths by suicide
- Reducing the amount of alcohol people drink to safe levels Making Reading a place where people can live well with dementia
- Increasing breast and bowel screening and prevention services
- Reducing the number of people with tuberculosis

3.5 In July 2016, Reading's Health and Wellbeing Board agreed to introduce a regular Health and Wellbeing Dashboard report – at each meeting - to ensure that members of the board are kept informed about the Partnership's performance in its priority areas, compared to the national average and other similar local authority areas. The updated Health and Wellbeing Action Plan is presented to the Board in full twice a year.

4. CURRENT POSITION (July 2019)

Priority 1 – supporting people to make healthy lifestyle choices

4.1 A greater or similar proportion of Reading's population continues to make healthy lifestyle choices. There are more people than average whose weight is within the recommended range; a greater number than average who meet criteria for being physically active; and a smaller proportion of adults who smoke. Smoking amongst those in routine and maintenance professions in Reading continues to be higher than elsewhere, but this has reduced in line with targeted reduction.

4.2 Despite fluctuations in the proportion of primary school children classified as overweight or obese, these have stayed close to the England average. Four Let's Get Going programmes have been commissioned for 2019-20 with a mix of term-time and holiday

provision to enable a comparison of performance. The Eat4Health service has now been re-instated, and widely promoted.

4.3 Reading is unlikely to meet local or national targets for the delivering NHS health checks to eligible residents (those aged 40-74 without certain specified diagnoses). The healthcheck assesses people's risk of stroke, heart disease, kidney disease, diabetes and dementia, and leads to targeted advice. However, the proportion of Reading residents who go on to receive a health check after being offered one is higher than the England average. In Quarter 3, performance has begun to increase following a fall in the proportion of the eligible population who were offered or received a health check in Quarter1, but the change is not significant and is not restored to previous levels.

4.4 There is now an active Train the Trainer programme to prepare for a Making Every Contact Count (MECC) rollout so as to engage the wider workforce in promoting healthier lifestyles.

Priority 2 – Reducing loneliness and social isolation

4.5 Currently, there are very few national indicators which facilitate tracking progress against this priority, However, in *A Connected Society: a Strategy for Tackling Loneliness* published in October 2018 the Government signalled plans to trial some new measures of loneliness in 2019.

4.6 There is a local steering group and action plan to support an all age approach to reducing loneliness and social isolation. The group has supporting local research to develop understanding and identify solutions relevant to different groups of residents, and the launch of a toolkit by Reading Voluntary Action.

4.7 Results from the 2017/18 Adult Social Care survey tell us that a higher proportion of respondents to the survey than previously have reported that they have less social contact than they would like. Furthermore, a larger proportion of respondents in Reading reported less social contact than they would like compared with elsewhere in England and amongst residents of councils similar to Reading. Healthwatch Reading has carried out some research to develop understanding of this issue for care home residents, in particular.

Priority 3 - Promoting positive mental health and wellbeing in children and young people

4.8 The number and proportion of primary school children with social, emotional or mental health need has increased very slightly between 2017 and 2018, both in Reading and across England. The proportion in Reading continues to be very slightly higher than the national average and the average amongst local authority areas with similar levels of deprivation and above, but the difference is not large enough to be statistically different. In the same period, the proportion of secondary school children with social, emotional or mental health needs has fallen very slightly, but not significantly enough to bring it in line with the national average.

4.9 The Future in Mind plan covering the whole of Berkshire West is refreshed annually. An in-depth report on the current plan was last brought to the Health and Wellbeing Board in March 2019.

Priority 4 – Reducing deaths by suicide

4.10 At the time of the latest release the mortality rate for suicide and undetermined intent in Reading was in line with the national average and average for local authority areas

with similar levels of deprivation, and showed continuing improvement in line with targets. However, provisional national data suggests an increase during 2018 which may be reflected in local figures.

4.11 A Suicide Audit has now been completed covering inquest findings for the period 2014-18. Some patterns emerge from this which help indicate who faces a greater risk of death by suicide and what services or points of contact might be the most effective ways of offering support.

4.12 Issues which were commonly noted in the inquest findings covered by the audit were relationship issues (mostly with an intimate partner/spouse or former intimate partner / spouse), financial issues, physical health conditions, a mental health diagnosis, work-related stress, and a recorded history of self-harm. The services which the audit found that most people who died by suicide had been in contact with were GPs, mental health services and substance misuse services.

4.13 The Berkshire-wide Action Plan and the six supporting locality Action Plans are now being refreshed, to include responses to the audit findings. The refreshed Reading plan was approved by the Reading Mental Wellbeing Group in May 2029.

Priority 5 – Reducing the amount of alcohol people drink to safer levels

4.14 At the end of 2017/18, the proportion of people receiving alcohol treatment who successfully completed treatment fell below the national average for the first time since 2015 and has remained below the locally set target of 38.3% throughout 2018/19. This proportion is slightly lower than the average for England. Alcohol-related hospital admissions, after a steady increase over the last few years, have fallen back below England and statistical neighbour averages in 2017/18.

4.15 There is an action plan to use education and campaigns to promote responsible drinking, to create responsible market behaviour through licensing measures and partnership approaches, and to encourage people into treatment as necessary. The action plan will be reviewed and refreshed in 2019.

Priority 6 - Making Reading a place where people can live well with dementia

4.16 Reading has an active Dementia Action Alliance (DAA) bringing partners together across sectors to raise awareness and understanding of dementia, and promote equity of access to health and social care. The aim is to make more services become dementia friendly so that people living with dementia in Reading are able to access and stay part of their community. The DAA leads on delivering Dementia Friends sessions to secure individual commitments to taking action on dementia, and has agreed a revised stretch target after exceeding the previous local target. 7,859 dementia friends had been trained by the end of June 2019, compared to 5,000 that were expected to be trained by this date in order to meet the target of 10,000 by January 2020.

4.17 Taking action on dementia was selected as a priority for the current Health and Wellbeing Strategy part because of low diagnosis rates in parts of the borough, indicating low awareness and recognition of the benefits if a diagnosis. The estimated diagnosis rate for people aged 65+ with dementia is reported monthly and in the last six months has gradually risen above the target of 67.7%, to 71.1% of cases diagnosed.

Priority 7 – Increasing take up of breast and bowel screening and prevention services

4.18 Locally set targets for breast and bowel cancer screening have been met. Coverage in Reading is in line with the England average and the average for local authorities with

similar levels of deprivation. Volunteer cancer champions have been successful in driving up screening rates where previously these were low for particular practice areas, and in supporting a range of awareness-raising activities and events.

Priority 8 – Reducing the number of people with tuberculosis

4.19 Although incidence of TB continues to be much higher in Reading than elsewhere, the latest published data confirms ongoing improvement in line with targets. There is an ongoing programme of awareness-raising around screening and treatment via pubic events, engagement with community groups and targeted sessions to reach higher risk groups.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 The 2017-20 Health and Wellbeing Strategy and accompanying Action Plan draw on the findings of the Joint Strategic Needs Assessment (JSNA) for Reading to identify priorities. The Strategy complements plans for health and social care integration, and supports the drive towards co-commissioning across the Health and Wellbeing Board's membership. The 2017-20 strategy also incorporates wellbeing responsibilities towards residents with current or emerging care and support needs so as to be comprehensive and Care Act compliant.

5.2 This proposal supports Corporate Plan priorities by ensuring that Health and Wellbeing Board members are kept informed of performance and progress against key indicators, including those that support corporate strategies.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 A wide range of voluntary and public sector partners and members of the public were encouraged to participate in the development of the Health and Wellbeing Strategy and a draft of the proposed Strategy was made available for consultation between 10th October and 11th December 2016. The indicators included in this report reflect those areas highlighted during the development of the strategy and included in the final version.

6.2 Delivery of the Health and Wellbeing Action Plan is through a range of multi-agency forums which bring together representatives of the Health and Wellbeing Board with other local partners. These are referred to in the appendixed update.

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.

8. EQUALITY IMPACT ASSESSMENT

8.1 An Equality Impact Assessment is not required in relation to the specific proposal presented to the Board through this report. However, the Health and Wellbeing Strategy and Action Plan are vehicles for addressing health inequalities, and accordingly delivery is expected to have a differential impact across groups, included those with protected

characteristics. This differential impact should be positive, and so delivery of the Action Plan supports the discharge of Health and Wellbeing Board members' Equality Act duties.

9. FINANCIAL IMPLICATIONS

9.1 There are no new financial implications arising from this report. The proposal to note the report in Appendix A offers value for money by ensuring that Board members are better able to determine how effort and resources are most likely to be invested beneficially in advance of the full Health and Wellbeing Dashboard.

10. APPENDICES

APPENDIX A – Health and Wellbeing Action Plan update July 2019

APPENDIX B – Health and Wellbeing dashboard July 2019

Appendix A: Reading Health and Wellbeing Strategy 2017-20 - Action Plan - updated July 2019

PRIORITY No 1	**Supporting people to make healthy lifestyle choices – dental care, reducing obesity, increasing physical activity, reducing smoking**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update – July 2019**
To Prevent Uptake of Smoking - Education in schools - Health promotion - Quit services targeting pregnant women/families - Underage sales	Wellbeing Team; Trading Standards; CS; S4H; Youth Services; Schools;	From April 2017	Maintain/reduce the number of people >18 years who are estimated to smoke in Reading Improve awareness of impact of smoking on children Reduce the illegal sale of tobacco to >18 years Increase uptake of smoking cessation >18 years	PHOF 2.03 - Smoking status at the time of delivery PHOF 2.09i – Smoking prevalence at age 15-current smokers (WAY survey) PHOF 2.09ii – Smoking prevalence at age 15 – regular smokers (WAY survey) PHOF 2.09iii – Smoking prevalence at age 15 – occasional smokers (WAY survey) PHOF 2.09iv – Smoking	3 Reading schools took part in the young person's smoking and drinking attitudinal survey (across Berkshire West). 6 presentations in Reading 2ry schools Community Alcohol Partnership will be funding 10 Youth Health Champions in Reading 2019-20 – two schools are participating

				prevalence at age 15 – regular smokers (SDD survey) PHOF 2.09v – Smoking prevalence at age 15 – occasional smokers (SDD survey)	
To provide support to smokers to quit - Health promotion - Referrals into service - VBA training to staff - Workplace and community smoking policies	S4H; RBC; CCGs;	From April 2017	Achieve minimum number of4 week quits - 722 Achieve minimum number of 12 week quits Supporting national campaigns – 463 Achieve minimum of 50% quitters to be from a priority group Increase referrals to S4H by GPs; Increase self-referrals to S4H	PHOF 2.03 - Smoking status at the time of delivery PHOF 2.14 – Smoking prevalence in adults – current smokers (APS) PHOF 2.14 – Smoking prevalence in adults in routine and manual occupations – current smokers (APS) NHS OF 2.4 - Health related quality of life for carers	643 successful quits measured at 4 weeks in 2018-19 – 65% from target populations 411* successful quits measured at 12 week in 2018-19 – 63% from target populatons (* provisional data – final figure expected to be higher Reduced capacity within the smoking cessation service planned for 2019-20 requires a review of health promotion activity to rive referrals into the service. Smokefreelife Berkshire continues to operate a mobile service in communities of high deprivation, and high footfall, e.g. Tesco on Portman Road in

					Battle ward
To take action to tackle illegal tobacco and prevent sales to <18 - Health promotion - Act on local intelligence - Retailer training – challenge 25 - Test purchasing	Tobacco Control Co0rdinator, Trading Standards; S4H	From April 2017	Increase awareness of impact of illicit/illegal sales have on community Improve the no of successful completions of Retail Trainer Training (challenge 25) Reduce the number of retailers failing test purchasing		A Southeast region hotline is planned to report illegal tobacco and underage sales. Once this is live, the Tobacco Control Alliance will review promotion opportunities. The 'Challenge 25' campaign continues locally.
Local Smoking Policy – workplace, communities - Update workplace smoking policy (wellbeing policy) - Smoking ban in community (RBC sites, school grounds; RSL; Broad Street)	Wellbeing Team; Health & Safety; Trading Standards; Environmental health;	From April 2017	Increase referrals to S4H smoking cessation services Prevent harm to community through restriction of exposure to second hand smoke.		RBC Workplace Health Review is progressing and will include local smoking policy. A draft Berkshire Wet Tobacco Control Delivery Plan 2019/20 has now been prepared. CLeaR tobacco self-assessment has been completed and best practice shred with colleagues across the BOB STP area.

Commissioned weight management/physical activity services targeting: - Adults - Children	Wellbeing Team	2017/18 – Contract for Tier 2 course runs until August and October 2018.	To contribute to halting the continued rise in unhealthy weight prevalence in adults. To contribute to halting the continued rise in unhealthy weight prevalence in children and young people. To promote a 'whole family approach' to healthy eating and physical activity.	2.21 Excess weight in adults. 2.13i Percentage of physically active and inactive adults – active adults. 2.13ii Percentage of physically active and inactive adults – active adults. 2.11i - Proportion of the adult population meeting the recommended '5-a-day' on a 'usual day' (adults). 2.06i - % of children aged 4-5 classified as overweight or obese. 2.06ii - % of children aged 10-11 years classified as overweight or obese. 2.11iv – Proportion of the population meeting the recommended "5-a-	4 X Let's Get Going programmes have been commissioned for 2019-20. Two programmes will be run as holiday clubs to enable a comparison of performance and take-up with term-time provision. 11 X Eat 4 Health courses have been commissioned in Reading. A new Eat 4 Health Open course will be piloted to increase capacity and offer greater flexibility.

				day" at age 15	
To undertake local health promotion of healthy eating and physical activity across different local settings & groups including: - Children's 0-19's service - Promotion of oral health messages - Early years settings - Troubled families programme - Mental Health Services - Workplace Health - Community & Voluntary - General Population - National Diabetes Prevention Programme	Joint partnership working across RBC directorates and with partners and providers to broaden the reach of health promotion messages.	Health Promotion is an ongoing action required to support the consistent delivery of health promoting messages.	To promote understanding of the benefits of health eating and physical activity and what recommended guidelines are. To provide people with information, advice and support on how to maintain/improve diet and or physical activities. To promote local services and/or open spaces	2.21 Excess weight in adults. 2.13i Percentage of physically active and inactive adults – active adults. 2.13ii Percentage of physically active and inactive adults – active adults. 2.11i - Proportion of the adult population meeting the recommended '5-a-day' on a 'usual day' (adults). 2.06i - % of children aged 4-5 classified as overweight or obese. 2.06ii - % of children aged 10-11 years classified as overweight	NHS Diabetes Prevention Week campaign was widely promoted across Reading including VCS partners. Re-launch of Eat4Health promoted through GP and RBC communications networks. #MovingIs promotion via RBC's social media raised awareness of getting active and promoting offers through Get Berkshire Active. NHS Live Well Seated Exercise Plan linked to the #MovingIs campaign. A comprehensive review of services and support available which impact on healthy weight and physical activity is being undertaken by Wokingham BC on behalf of the 3 Berkshire West authorities to inform

				or obese. 2.11iv – Proportion of the population meeting the recommended "5-a-day" at age 15	future priorities.
Promotion and use of local leisure services, green spaces and active travel - Local cycling and walking - Walking volunteer recruitment workshops - Work with partners to supporting bidding for funding Neighbourhood initiatives	Joint partnership working across RBC directorates and with partners and providers to broaden the promotion of local RSL, green spaces and active travel.	Ongoing	Increase in the number of people walking and cycling to work Increase in the number of children benefitting from Bikeability. Increase in the number of children walking or cycling to school Reduce congestion Increase the local capacity to deliver health walks to people who have low physical activity levels. Support planned bid in development by Reading museum linking local heritage and walking.	1.16 - % of people using outdoor space for exercise/health reasons. 2.13i Percentage of physically active and inactive adults – active adults. 2.13ii Percentage of physically active and inactive adults – active adults.	2018-19 performance shows: • 1,108,163 leisure centre attendances and hires • 280,225 parks and sports hire attendances • 546 programmed event days (parks & open spaces) • 3,534 families engaged in Reading Play • 8.801 child accesses to Reading Play after school clubs • 27,750 Reading Play educational support sessions run • 140 Pathway GP referrals (78 male /62 female)

					• 5 X weekly walks, attracting 5,286 participation sessions (367 individual walkers)
To offer Making every Contact Count (MECC) training to the local voluntary and community sector	Wellbeing Team	From January 2018 – March 2019	To increase knowledge, skills and confidence to make appropriate use of opportunities to raise the issue of healthy lifestyle choices and signpost to sources of support.	Potentially all PHOF indicators highlighted in this section relating to healthy weight, healthy eating and physical activity.	MECC Train the Trainer sessions are being run in May, June and July to develop local capacity for rollout of a Reading MECC programme
To oversee and implement the local delivery of the National Child Measurement Programme	Wellbeing Team	Ongoing	Weight and height measurements offered to all children attending state funded primary school children who are in Reception Year (age 5) and Year 6 (aged 10,11) in accordance with NCMP guidance	2.06i - % of children aged 4-5 classified as overweight or obese. 2.06ii - % of children aged 10-11 years classified as overweight or obese.	NCMP Progress Quarter 4 (January–March 2019): 1,413 children screened (71.6% of cohort) - two families contacted school nurses for support and advice - 20 further families accepted support when telephoned after a 'very overweight' or 'underweight' letter
To develop an oral health strategy based on the need of local residents	RBC Wellbeing Team & Shared Public Health Team (Bracknell)	2020	Partners will have access to dental epidemiological data in order to be able to monitor progress in relation to Public Health Outcomes Framework	PHOF 4.2: tooth decay in 5 year old children	RBC has commissioned a Dental Epidemiology Survey from PHE to be undertaken in the 2018/19 academic year. Full results will be available in Dec 2019 and a

			indicators on oral health		strategy that is informed by this data will be developed in early 2020.

PRIORITY No 2	**Reducing Loneliness and Social Isolation**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update - July 2019**
i. Establish a Reducing Loneliness Steering Group	Health & Wellbeing Board	February 2017	A cross-sector partnership is in place to oversee an all-age approach – covering prenatal, children and young people, working age adults and later life		COMPLETED - Steering Group now meeting bi monthly representing a range of interests.
ii. Develop a reducing loneliness and social isolation module as part of the Reading Joint Strategic Needs Assessment	Wellbeing Team, RBC	April 2017	We will understand the local loneliness issue, in particular which groups of Reading residents are at greatest risk of experiencing health inequalities as a result of	PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who	COMPLETED - The Loneliness and Social Isolation Steering Group has overseen the development of an in-depth local loneliness analysis, which has now been published as JSNA module.

			loneliness	have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing	
iii. Refresh the Loneliness and Social Isolation JSNA module annually	Wellbeing Team, RBC	annually	We will understand the local loneliness issue, in particular which groups of Reading residents are at greatest risk of experiencing health inequalities as a result of loneliness	PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing	Loneliness & Social Isolation module published at: http://www.reading.gov.uk/jana/loneliness-and-social-isolation Further literature analysis plus interviews and focus groups took place over summer 2018, and a report will be published in 2019.
iv. Map out community notice boards, including owners and access criteria	Ebony George (Neighbourhood Intiatives), Matt Taylor (AUKR), Steph Francis	Nov 2019	Partners will be enabled to share information about services and resources to reduce loneliness and		45 boards mapped as at Sep 2018: ○ 20 are RBC owned ○ 25 are managed by community groups

	(CCGs)		social isolation.		○ For 23 out of 45 notice board, we do not known who is key holder – including those owned by RBC A volunteer has been recruited to take this forward under AUKR's leadership.
v. Map local Facebook pages	Sarah del Tufo (RCLC)	Nov 2019	Partners will be enabled to share information about services and resources to reduce loneliness and social isolation.		Mapping commenced – administrator details to be collated across the group
vi. Raise Adult Social Care staff awareness of services to reduce loneliness and social isolation	Sarah Hunneman (Wellbeing Team, RBC)	ongoing	Adult Social Care staff will have up to date knowledge of local services so as to signpost or refer people at risk of social isolation.		The Neighbourhood Wellbeing Team is now working alongside the ASC 'Front Door' to raise awareness of community services, including running networking events and using RiPFA resources.
vii. Develop a plan for regular awareness raising with local NHS staff about services to reduce loneliness and social isolation.	Steph Francis (CCGs) Sarah Morland (RVA)		NHS staff will have up to date knowledge of local services so as to signpost or refer people at risk of social isolation.		SF/SM have arranged to include a 'VCS focus' section in the weekly newsletter to GP practices, with a focus on support to reduce loneliness and social isolation.

viii. Collate and share partner experiences of supporting peer support / social groups and community champions to develop and become self sufficient Review and promote tools to assess and evaluate services' impact on social connectivity	Rhiannon Stocking-Williams (RVA) / Michelle Berry (RBC Wellbeing Team)	May 2019	Tools are available to promote sustainable solutions		RVA Toolkit launched at Befriending Forum 14.05.2019 setting out how people can help themselves and other people to reduce loneliness. There is a printed summary and longer online toolkit. Being promoted through a series of roadshows.
ix. Develop and raise the profile of community transport solutions , and explore buddying options to encourage more people to use public transport	Reducing Loneliness Steering Group	Ongoing	At-risk individuals know how to access transport as needed to join in social networks		All members of the Steering Group committed to promoting: • the accessibility of general public transport in Reading • consideration of travel companions as part of service provision • Readibus's volunteer driver training scheme Readibus and Reading Buses represented on the Steering Group Age UK Berkshire exploring expansion of the Caversham Good Neighbours model across

					Reading.
x. Support the neighbourhood Over 50s groups to grow and be self-sustaining	Michelle Berry & Sarah Hunneman (Wellbeing Team, RBC)	Ongoing	Older residents are able to be part of developing opportunities for neighbours to know one another better	PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like PHOF 2.23 i-iv – self-reported wellbeing	There are now four thriving Over 50s clubs – in Caversham, Southcote, Whitley and Coley.
xi. Support access to employment as a way of addressing loneliness and social isolation	Marc Murphy (Oracle)	Ongoing			Ongoing confidence building, interview skills and work experience programme at the Oracle for single parents Ongoing work shadowing programme for people who face challenges to work / integration The Step Into Retail network has so far assisted 60 people and supported 16 adults to secure employment

					Partnership developing with RCLC's pre-employment group- Supporting DWP's partner forum to get feedback on their services and how they can improve.
xii. Develop volunteering and employment opportunities for adults with care and support needs	Sarah Hunneman (Wellbeing Team, RBC) / Sarah Morland (RVA) / Kirsty Wilson (Connect Reading)	Ongoing	There will be more opportunities for adults with care and support needs to enjoy supportive and enabling social connections through work	PHOF 1.18i / ASCOF 1.i - % of adult social care users who have as much social contact as they would like PHOF 1.18ii / ASCOF 1.1 - % of adult carers who have as much social contact as they would like	New volunteering and employment opportunities have been created as part of: - The relocation and reshape of The Maples Day Service - The development of the Recovery College - The development of the Over 50s clubs RVA has an officer who specialises in volunteering opportunities for people with additional needs. Berkshire West Your Way commenced delivery under a new contract 01.06.2018 which includes supporting people with mental health needs into

					employment RBC has made a 'Time to Change' pledge to end mental health discrimination – this campaign to be promoted to other Reading employers Connect Reading is promoting Mental Health First Aid as workplace training with Reading businesses Mental Health Week 2019 event received very positive feedback – provided good opportunities for volunteers to speak and gain confidence, and people have requested a similar event again.
xiii. Raise awareness of services to reduce loneliness and social isolation with people who are not literate or who speak little or no English	Sarah del Tufo (RCLC)	ongoing	People who are not literate or who speak little or no English will be enabled to access groups and services to reduce loneliness and social isolation.		RCLC, Reading Refugee Support and Communicare commenced delivery 01.06.2018 on a new contract for people facing language or cultural barriers to social contact. Independent report into the needs of ethnic minority

					women in Reading and how RCLC meets those needs published 19.07.2018. RCLC now runs a food sharing group regularly attracting 12-30 attendees. There is now a twinning arrangement with Swallowfield coffee mornings.
xvi. Raise awareness of services to reduce loneliness and social isolation with people who are not literate or whose first language is BSL	To be discussed following further analysis				Deaf people to be a priority group for further analysis within ongoing research
xvii. Raise awareness of loneliness and social isolation amongst and services to support children and young people	To be discussed following further analysis	ongoing			Children and young people to be a priority group for further analysis within ongoing research

PRIORITY No 3	**Promoting positive mental health and wellbeing in children and young people**

The Local *Future in Mind* (Transformation Plan for Children and Young People's Mental Health and Wellbeing) was last refreshed in October 2018.
This Plan is owned by the Berkshire West CCG working in partnership with the West Berkshire and Wokingham local authorities, and with Brighter Ftures or Children in Reading.

The full document describes how as a local system partners are improving the emotional wellbeing and mental health of all Children and Young People across Reading, West Berkshire and Wokingham in line with the national ambition and principles set out in the government document "*Future in Mind– promoting, protecting and improving our children and young people's mental health and wellbeing*" (2015).

This is an ambitious partnership with collaboration at its centre. Over recent years there has been a marked culture shift to a mature thriving system which has a collaborative solution focussed approach to improving services for children, young people and families. The local partners are bidding to become a trailblazer site for the Green Paper Reforms, having already being cited by the Children's Commissioner for England as an area of good practice. The intention is to build on well-established joint working arrangements between the CCG and local authorities to achieve further sustainable whole system change. Bids are being submitted for 2 Trailblazer lots- creating new local Mental Health Support Teams (MHSTs) and reducing waiting times for Specialist CAMHs and the Anxiety and Depression pathway.

The Local Transformation Plan is reviewed, refreshed and published annually in line with the requirements of Five Year Forward View for Mental Health and the Green Paper. The full document is available on the CCG website at:
https://www.berkshirewestccg.nhs.uk/media/2516/berkshire-west-future-in-mind-ltp-refresh-oct2018.pdf

The new plan builds on the 2017 plan and provides an update through a THRIVE lens of
What we have achieved so far
Our commitment to undertake the further work that is required
Local need and trends
Resources required

PRIORITY 4	**Reducing Deaths by Suicide**

What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update – July 2019**
Map local services and contact points relevant to people experiencing relationship difficulties, including third sector services	RBC Wellbeing Team	Nov 2019	Local suicide prevention communications and support can be targeted more effectively on people at risk through relationship breakdown	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Identify key partners who are in communication with people in financial difficulty, including third sector services	RBC Wellbeing Team	Nov 2019	Local suicide prevention communications and support can be targeted more effectively on people at risk through financial difficulty	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Review access to support for work-related stress within key employer organisations	Time to Change Champions & partners	Nov 2019	Strengths and gaps will be identified to support targeting suicide prevention support to complement existing resources	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	new
Identify networks and forums through which support can be offered to people who are self	RBC Wellbeing Team	Nov 2019	Strengths and gaps will be identified to support targeting suicide	4.10 Age-standardised mortality rate from suicide and injury of	New

employed or working in small organisations without a formal HR service			prevention support to complement existing resources	undetermined intent	
Through the Compass Recovery College, develop and deliver a range of recovery-focused courses for people living with mental health challenges and/or supporting others with experience of mental health challenges	Compass	ongoing	People living with or affected by mental health challenges are able to access support to develop self-management skills	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Review Compass enrolment and feedback data to identify any gaps in reaching groups at higher risk of suicide and use this to develop the college	Compass	Ongoing	Compass is accessible to groups which face a higher suicide risk.	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Map local services and contact points relevant to reaching men who may face a raised suicide risk, and identify suitable resources to offer targeted awareness raising	RBC Wellbeing Team	Nov 2019	Men have greater awareness of support available to help reduce suicide risk	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	new

Support the delivery and evaluation of a 12m 'Support After Suicide' pilot	RBC Wellbeing Team	Sep 2020	Availability of one-to-one support for people bereaved by suicide; improved understanding across partners of how to support those bereaved by suicide	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Support colleagues of people who die by suicide by sharing information and resources with relevant employers and HR departments as identified	RBC Wellbeing Team	Ongoing	People affected by the suicide of a work colleague have greater awareness of support available.	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Map local services and contact points to reach those bereaved by suicide, e.g. funeral directors, places of worship, community settings and counselling services	RBC Wellbeing Team	Nov 2019	People bereaved by suicide have greater awareness of support available.	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New
Promote a media summit to refresh awareness of the Samaritans Responsible Suicide Reporting guidelines across Reading media partners	RBC Wellbeing Team	Jan 2020	Improved awareness across Reading media of how to report suicide in a sensitive way	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	new

Incorporate the Berkshire Suicide Audit findings into the Reading Joint Strategic Needs Assessment	Public Health Intelligence	July 2019	Local suicide prevention planning can be informed by Berkshire Suicide Audit findings being made public	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	New

PRIORITY No 5	**Reducing the amount of alcohol people drink to safer levels**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update – July 2019**
Treatment					
Increase the number of people receiving support at the appropriate level to address risky, harmful and dependent use of alcohol. Review current alcohol pathways to enable the specialist service to gain capacity to work with more risky, harmful and dependent drinkers.	All Partners required to support an alcohol pathway Drug and Alcohol Commissioner, CCG Leads, IRIS Reading Borough Manager, GP Lead	Ongoing	Lower level drinkers understand the risks to their drinking and prevent become more harmful/ hazardous drinkers. Other Stakeholders become a part of the alcohol pathway and understand their role in preventing people becoming harmful/ hazardous drinkers.	PHOF 2.15iii – Successful completion of alcohol treatment PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	Alcohol Pathway under review.
Promote knowledge and change behaviour by promoting understanding of the risks of using alcohol and	All partners	Ongoing		PHOF 2.15iii – Successful completion of alcohol treatment	NHS Health Check provides opportunistic conversation around alcohol use as Audit C is part of a check. Number of

by embedding screening and brief intervention in primary care, social care and criminal justice settings, housing and environmental health contacts.				PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	invites and health checks completed by GPs (providers) have declined from 2015/17 to 2016/17. 250 staff received Alcohol Brief Intervention training in the last year, including Royal Berkshire Hospital and Police Community Support Officers. Chemist IBA training to take place over summer 2019
Deliver IBA Training across all sectors – Need to encourage uptake of more Alcohol Champions	CAP Lead and Source Team Manager	Ongoing	More individuals trained to deliver an intervention – Making every contact count approach to managing alcohol issues/ signposting		Ongoing See above Providing IBA referral packs to wards that have been trained to allow them to refer to for future use. 510 pupils attended alcohol awareness sessions across schools in the last year. Work is ongoing with the Parental Substance Misuse Team to deliver joint alcohol awareness sessions within children's centres.

					Community Alcohol Partnership to offer IBA training to all Reading services alongside a Prospect Park nurse.
Peer Mentors to be on the (selective) Wards at RBH Alcohol Peer mentors – to visit clients on hospital wards and assist in transition into community (including following detox).	IRIS Reading Borough Manager/ Peer mentors	ongoing	Peer mentors can advise patients on specialist community services and alcohol service available locally. To prevent re-admissions to hospital.	PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	Peer mentors are supporting patients on Sidmouth Ward at RBH – Complete and ongoing CAP working with IRIS and the Trust CQUIN Lead to ensure all RBH staff are aware of the process is now complete.
Alcohol CQUIN - preventing ill health caused by alcohol. RBH to identify and support inpatients who are increasing or higher risk drinkers	RBH/ Public Health/ IRiS Reading/ CAP	June – Sept 2018	Reduction in alcohol admissions to hospital.	PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M and F)	Specialist drug and alcohol services and CAP lead to support RBH in training Trust staff in IBA and ensuring referral pathway into specialist treatment services is robust. Completed October 2018 (See above for stats)
Licensing					
A community free of alcohol related violence in homes and in public places, especially the town centre.	CAP Lead	Ongoing	Reduction in alcohol admissions to hospital. Responsible drinking in	PHOF 2.18 – Admission episodes for alcohol-related conditions (narrow) (Persons, M	Street drinking initiative underway and ongoing Retailer conference organised,

Create responsible markets for alcohol by using existing licensing powers to limit impact of alcohol use on problem areas and by promoting industry responsibility. Address alcohol-related anti-social behaviour in the town centre and manage the evening economy Address alcohol-related anti-social Neighbourhoods			public spaces.	and F)	which saw 24 retailers from across Reading attend. 4 presentatioms to include: CAP Alcohol awareness, Licensing re the importance of the 4 licensing objectives, Trading standards – Business improvement and CAP Reginal officer – Illicit alcohol and tobacco. Test purchases across the last two quarters had a 33% failure rate. There is now a focus on 'high harm areas' with 'Check 25' and Under 18 test purchase follow-ups if required. Performance or licence reviews may follow, or training and healthcheck visits.
Review all extended new applications under the Licensing Act – Public Health review and consider all new applications. Make representations for anything that is of concern and attend Licensing Hearings, Performance review or Licence reviews. Reading Festival - work with	Public Health/ Licensing CAP/ Licensing	Ongoing July- Aug 18	Control of licensed outlets and review of Reading's late night economy.		Ongoing Reading Festival discussions taking place regarding onsite test purchasing

Festival Republic, the organisers of Reading Festival, in preparation for this year's event and consider how best to tackle the issue of alcohol (and illegal drug use)	Team/ Public Health				Send out Newsletter before Reading Festival to all Retailer's in the area to remind them of their 4 Licensing objectives and laws around Underage drinking and proxy purchases.
Licencing to promote responsible retailing, 4 Licensing objectives. CAP to increase Test Purchasing – Challenge 25, Under 18. Training Log to be rolled out to all retailers. Retailer Training to commence.	CAP / Licensing	Ongoing	Stricter licensing restrictions will be in place. There is a minimum price for a unit of alcohol as a mandatory condition of a License.		Commenced – CAP arranged joint retailer visits with licensing to complete the licensing surveys, licensing checks and Training log.

Encourage retailers to restrict the sale of higher ABV % cans					
Encourage neighbourhoods to report street drinking to the Police via NAG meetings	All	Ongoing	Reduce street drinking and ASB		Ongoing. RSG to include a link for reporting alcohol issues. Promote CAP Role within the community to build relationships and encourage reporting.
Education					
Education if for all ages. Alcohol awareness sessions for all.	CAP Lead	Ongoing	Educating everyone on the risks of alcohol and promote drinking responsibly.		Developed a Needs assessment and sent out to all Secondary schools with the CAP Young Peoples survey.; to be able to give Alcohol awareness sessions that fit the schools and pupils needs. Distributed June 2019 CAP to offer joint IBA training sessions to Reading Services with Prospect Park Misuse Nurse. Ongoing School children at Katesgrove Primary School benefitted from alcohol awareness sessions (

Mini Police Project - a fun and interactive volunteering project for children in Years 5 and 6. The aim is for children to work with neighbourhood police teams on local issues. The pupils will also spread the word among their school friends about the work they are involved in and gain awareness of a variety of issues. CAP to expand on this and set up new project 'Young CAP Champions' to encourage YP to promote important messages about alcohol amongst their peers (Primary schools in Reading).					age appropriate awareness of alcohol, including risks, health impacts and associated laws), as part of a 'Mini Police' project. Primary Schools being encouraged to sign up to this initiative. Third round being organised for summer 2019 CAP are part of the RVA Youth Partnership Working Group to review youth provision in Reading. Funding secured for 5 X Youth Health Champions across Reading Girls and Reading Boys schools

Commence a Youth Health Champion role – encourage youngsters to be active in tackling alcohol and understanding the risks of drinking alcohol. Work in partnership with Colleges and University to promote alcohol awareness to students Volunteers from the Specialist Treatment Service to visit school age children to educate them about the risks of alcohol and how their lives have been affected.					
Promote diversionary activities to all – via schools, colleges, website	CAP Lead	Ongoing	Promote social activities and exercise as alternatives to drinking alcohol.		

			Resolve the “boredom” and social issues associated with alcohol.		
Prevention					
Promotion of Dry January campaign. Promotion of January alcohol detox via IRIS Reading as part of the Dry January campaign	CAP Lead, DAAT Contract & Project Manager, IRIS Reading IRIS Reading Borough Manager & RBC Press team	December 2017 and January 2018	Encourage awareness of effects of alcohol on staff, clients and local community. Promote drinking responsibly.		New programme to be developed in Nov / Dec for 2019
Explore with the street care team whether we can promote drinking responsibly at recycling depots.	DAAT / Street Care Team		Encourage drinking responsibly and increase public awareness of the risks of alcohol		To be reviewed. Additional recycling bins to be in place in and around Reading Festival Site in summer 2019.
New Reading University Community Alcohol Partnership	CAP	Ongoing	Better working relationships with students and young people		Action plan being developed – will address issues and support objectives across Reading i.e. night time economy and health and wellbeing of young people

PRIORITY NO 6	**Making Reading a place where people can live well with dementia**

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators	Progress Update – July 2019
Establish a Berkshire West Dementia Steering Group to implement the Prime Ministers Dementia 2020 challenge and ensure up-to-date local information about dementia can be reflected into dementia care services and that there is an opportunity to influence and inform local practice			The Berkshire West Dementia Steering Group will report to the three Berkshire West Health and Wellbeing Boards as required from time to time, contributing updates and commentary on performance in relation to local dementia priorities and issues identified by those Boards. The Berkshire West Dementia Steering Group will also report to the Berkshire West Long Term Conditions Programme Board and will in addition keep the Thames Valley Commissioning Forum updated		Berkshire-wide dementia steering group set up comprising representatives from the three unitary authorities in Berkshire, a GP, Berkshire West CCGs and voluntary sector groups. The Reading DAA is also represented on this group to ensure a working partnership

Raise awareness on reducing the risk of onset and progression of dementia through building on and promoting the evidence base for dementia risk reduction (including education from early years/school age about the benefits of healthy lifestyle choices and their benefits in reducing the risk of vascular dementia) and health inequalities and enhancing the dementia component of the NHS Health Check.	Public Health (LAs), GPs, Schools	May 2017	By 2020 people at risk of dementia and their families/ carers will have a clear idea about why they are at risk, how they can best reduce their risk of dementia and have the knowledge and know-how to get the support they need. This will contribute towards the national ambition of reduced prevalence and incidence of dementia amongst 65-74 year olds, along with delaying the progression of dementia amongst those that have been diagnosed.	PHOF 4.16 and NHS 2.6i– Estimated diagnosis rate for people with dementia PHOF 4.13 – Health related quality of life for older people ASCOF 2F and NHS Outcomes Framework 2.6ii – effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia. ASCOF 1B – People who use services who have control over their daily life NHS OF 2.1 - Proportion of people feeling supported to manage their condition	The Dementia Action Alliance organised an event to mark Dementia Action Week 2019, promoting the benefits of physical activity, singing and social engagement and attracting over 100 people livening with dementia, mostly younger people with dementia and their carers. The event also showcased the benefits of community connections, volunteering and services to support people to live well with dementia. The Wellbeing Team has provided 2 public information sessions at Dementia Awareness Week (town centre) and Southcote May Fayre, both raising awareness of preventative health services specifically around dementia and the links to alcohol, exercise and general health.

Identify patients early including those from Black, Asian and Minority Ethnic origin and other seldom heard groups enabled through greater use by health professionals of diagnostic tools that are linguistically or culturally appropriate; encourage self-referral by reducing stigma, dispelling myths and educating about benefits of obtaining a timely diagnosis	Primary care, Social Care (LAs), Memory Clinics, Care homes	March 2018	More people diagnosed with dementia are supported to live well and manage their health	ASCOF 2F - a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence for people with dementia	There is an ongoing programme of outreach and engagement with BME groups. The DAA includes ACRE which hosts annual dementia forums and invites speakers to help break down the barriers and discrimination around a dementia diagnosis.
Play a leading role in the development and implementation of personalised care plans including specific support working in partnership with memory assessment services and care plan design and implementation.	Primary Care/BWCCGs/BHFT	March, 2018	GPs ensuring everyone diagnosed with dementia has a personalised care plan that covers both health and care and includes their carer. This will enable people to say "I know that services are designed around me and my needs", and "I have personal choice and control or influence over decisions about me"	PHOF 4.13 - Health related quality of life for older people ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life NHS OF 2.6ii - effectiveness of post-	Care Plans are uploaded on DXS, easily accessed by GPs and practice staff.

				diagnosis care in sustaining independence for people with dementia ASCOF 1B - People who use services who have control over their daily life NHS OF 2.1 - Proportion of people feeling supported to manage their condition	
Ensure coordination and continuity of care for people with dementia, as part of the existing commitment that everyone will have access to a named GP with overall responsibility and oversight for their care.	BWCCGs	March, 2018	Everyone diagnosed with dementia has a named GP as well as a personalised care plan that covers both health and care and includes their carer.	PHOF 4.13- Health related quality of life for older people ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life NHS OF 2.6ii -	Every diagnosed dementia patient has a named GP

				effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia. ASCOF 1B - People who use services who have control over their daily life NHS OF 2.1- Proportion of people feeling supported to manage their condition	
Provide high quality post-diagnosis care and support, which covers other co-morbidities and increasing frailty.	Primary care/ Memory Clinics/ Social Care (LAs),	Ongoing	Reduced: unplanned hospital admission, unnecessary prolonged length of stay, long-term residential care	ASCOF 1B - People who use services who have control over their daily life NHS OF 2.1- Proportion of people feeling supported to manage their condition	Patients and carers are routinely supported and sign-posted to services for on-going support. Post-diagnostic support is mainly provided by Alzheimer's society, BHFT and other voluntary sector organisations. The Dementia Action Alliance is developing a signposting pathway for all stages of

					dementia. This will be a comprehensive guide to maintaining relationships, employment and finances as well as finding equipment and services to support people with dementia ad their carers.
Target and promote support and training to all GP practices, with the aim of achieving 80% Dementia Friendly practice access to our population	BW CCGs project Lead/ DAA co-ordinators	March, 2018	80% of practices in Berkshire West will have adopted the iSPACE and sign up to the Dementia Action Alliance to become dementia-friendly.	PHOF 4.16 - Estimated diagnosis rate for people with dementia NHS 2.6ii- effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia PHOF 4.13 – Health related quality of life for older people	Tier 1 training has been offered to all Practice staff across South Reading and North & West Reading CCGs. All practices in Reading have put plans in place to become dementia friendly. This will be further assessed using the iSPACE model and supported by the Dementia Action Alliance
Work with local organisations, care homes and hospitals to support more providers to achieve Dementia Friendly status	DAA/ LAs/ Alzheimers society/BHFT	Ongoing - reviewed in December 2017, 2018 and 2019	More services will be staffed or managed by people with an understanding of dementia and the skills to	PHOF 4.16 - Estimated diagnosis rate for people with dementia NHS 2.6ii - effectiveness of post-	DAA has a total of 24 local businesses and partners signed up to the Reading Dementia Action. A partnership has been formed with Thames Water,

			make practical changes to make their service more accessible to those with dementia	diagnosis care in sustaining independence and improving quality of life for people with dementia PHOF 4.13 – Health related quality of life for older people	the Oracle shopping centre and MERL. Work for the coming year will focus on town centre locations including all shops and services in the Oracle to ensure dementia friendly shopping for all. The Dementia Action Alliance is supporting St Lukes and The Oaks to develop a dementia friendly café on site. This service will be available to the wider community.
Maximise the use of Dementia Care Advisors & training opportunities & roll out a training package/train the trainer model for NHS & Social Care staff and other frontline workers	BWCCGs/Alzheimers Society/ HEE/BHFT	March, 2018	People with dementia and their carers will be supported by health and care staff in all types of service that will have the appropriate level of dementia awareness and training.	NHS OF 2.1- Proportion of people feeling supported to manage their condition	All DCAs are trained in Tier 1 dementia training. BWCCGs offered Tier 1 dementia training to all GP practice staff and social care staff in December 2016.

Ensure commissioned services contractually specify the minimum standards of training required for providers who care for people with dementia including residential, nursing and domiciliary care settings.	Local authority and NHS commissioning teams	March, 2018	People with dementia and their carers will be supported by health and care staff in all types of service that will have the appropriate level of dementia awareness and training.	NHS OF 2.1- Proportion of people feeling supported to manage their condition	Dementia training is offered by RBC to all private voluntary and independent providers, although it is not compulsory for domiciliary care providers to ensure staff are trained in dementia
Review benchmarking data, local JSNA , variation, & other models of Dementia Care to propose a new pathway for Dementia Diagnosis/Management.	BWCCGs/ Public Health/BHFT – not clear who leads on what here-	March, 2017	National dementia diagnosis rate maintained at two-thirds prevalence, and reduced local variation between CCGs following agreement and implementation of an appropriate and affordable plan to bring services into line within the national framework for treatment and care.	PHOF 4.16 - Estimated diagnosis rate for people with dementia NHS 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia	The current pathway is still being used. A review of the local JSNA data will inform the proposal of a new pathway for diagnosis/management A dementia friendly community pathway is being designed by the DAA for 2019. This pathway will be post diagnosis support and activities that will improve health and wellbeing for persons diagnosed with dementia and their carers.

Identify & map opportunities, learning from similar and neighbouring CCGs, Providers and Local Authorities, for future service delivery to meet the 2020 Challenge. e.g. annual assessment, shared care, carer identification & support	BWCCGs/ BHFT	April, 2017	Diagnosis rate maintained at two-thirds prevalence, and reduced local variation between CCGs following agreement and implementation of an appropriate and affordable plan to bring services into line within the national framework for treatment and care	PHOF 4.16 - Estimated diagnosis rate for people with dementia NHS 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia	An on-going quarterly Dementia Commissioners forum enables sharing and learning from national and regional initiatives to improve dementia diagnosis rates and post-diagnostic care and support. The DAA is currently mapping services and support. Age UK Berkshire is seeking funding to address gaps. Early analysis indicates a need to support those likely to receive a dementia diagnosis ahead of that diagnosis being given.
Raise awareness of and ensure that at least 80% of people with dementia and their carers have a right to a social care assessment.	LAs/ Memory Clinics/ Primary Care/ CMHT/ DCAs	March, 2018	At least, 80% of people with dementia and their carers are able to access quality dementia care and support.	PHOF 4.13– Health related quality of life for older people ASCOF 2F- a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of	Awareness raising is ongoing. Anyone with the appearance of a care or support need is entitled to a social care assessment.

				life NHS OF 2.6ii - effectiveness of post-diagnosis care in sustaining independence and improving quality of life for people with dementia ASCOF 1B- People who use services who have control over their daily life NHS OF 2.1- Proportion of people feeling supported to manage their condition	
Provide opportunities for people with dementia and their carers to get involved in research through signposting them to register with joint dementia research (JDR)	BHFT/Alzheimers Society /LA/BWCCGs/ University of Reading	March, 2018	More people being offered and taking up the opportunity to participate in research and to support the target that 10% of people diagnosed with dementia are registered on JDR by 2020. Future treatment and services to		The DAA is supporting Amanda Walsh, Clinical Research Assistant at The Berkshire Memory and Cognition Research Centre, University Of Reading. The DAA is recruiting individuals who have a diagnosis of Alzheimer's or mixed Alzheimer's who

			be based on and informed by the experiences of people living with dementia		showed symptoms of the disease between the ages of 66-70 years. The purpose of the Study is to learn more about the genetics that may affect the risk of developing Alzheimer's before the age of 70, with the hope that this leads to improved treatments and diagnosis in the future. Individuals need to be of Caucasian origin, and have no current diagnosis of substance abuse or psychosis and should also be willing to provide a blood sample.
Enable people to have access to high quality, relevant and appropriate information and advice, and access to independent financial advice and advocacy, which will enable access to high quality services at an early stage to	BHFT/LAs	March, 2018	People with dementia and their carers are able to access quality dementia care and support, enabling them to say "I have support that helps me live my life", "I know that services are designed		This happens routinely

aid independence for as long as possible.			around me and my needs", and "I have personal choice and control or influence over decisions about me"		
Evaluate the content and effectiveness of dementia friends and dementia friendly communities' programme.	AS/DAA/UoR	March, 2018	More research outputs on care and services.		The DAA has exceeded the target to reach 6000 dementia friends during 2018 by achieving over 7000 and is on track to meet or exceed a target to train 10,000 dementia friends by January 2020. The DAA is continuing to support Southcote to work towards being a dementia friendly community and has now created a dementia friendly – memory café running every week, offering mental stimulation and activities to support mental wellbeing. The group is run by the Grange Café volunteers.

PRIORITY NO 7	Increasing take up of breast and bowel screening and prevention services				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update July 2019**
Identify Practices where screening uptake is low and target initiatives and practice support visits to increase uptake.	NHSE/PHE Screening Team Cancer Research UK Facilitator		Improved Screening Coverage and detection of cancers in early stages.	PHOF 2.19 Cancer Diagnosed at early stage 2.20iii Cancer Screening coverage-bowel cancer 2.20i Cancer screening coverage- breast cancer 4.05i Under 75 mortality rate from cancer (persons) 4.05ii Under 75 mortality rate from cancer considered preventable (persons)	South Reading Cancer Education Project extended to 30.06.2019, linking volunteer champions (the Reading Cancer Support Group) to 16 general practices Bowel screening & breast screening were above the Thames Valley Alliance and England averages at Sep 2018 Most Reading surgeries have now singed up to the bowel screening non-responder alert. Teachable moment pilot project for South Reading rolled out from August 2017 (see below). Pilot ended in January after implementation by only two practices. Lack of time, workload constraints and capacity of the team to support

					the implementation were seen as barriers. Tailored GP Surgery bowel screening letters are now sent to patients from the Hub. The Cancer Research UK Facilitator has offered to visit all South Reading practices to improve cancer screening uptake
To work in partnership with key stakeholders to increase public /patient awareness of signs and symptoms and screening programmes	Public Health Berkshire Macmillan		Patients seek advice and support early from their GP Increase uptake of screening programmes		Reading Cancer Champions organised multiple events to mark World Cancer Day 2019 (February 4th) South Reading Cancer Educator has delivered 24 Cancer education and awareness sessions in South Reading Cancer awareness event organised by Cancer Champions on 29th September 2018. Local authority is supporting the promotion and engagement

					of the Macmillan Cancer Education Project, led by Rushmoor Healthy Living with funding from Macmillan Cancer Support. Macmillan Cancer Educator has been appointed to raise awareness of the signs and symptoms of cancer among hard to reach groups in South Reading, Over 23 people from the community have signed up to become cancer champions. A number of community events and meetings have been held. Fifteen community volunteers from South Reading have completed their training as Cancer Champions. Macmillan Cancer Champion training have been organised for volunteers from different community groups. These champions will now organise

					cancer awareness sessions for their community groups CRUK bowel screening promotional video has been shared through local authority web pages. Wellbeing team has been promoting various cancer awareness campaigns including PHE's Be Clear on Cancer: Breast Cancer in women over 70 by sharing key messages via local authority webpages, digital media and during community events Wellbeing team in partnership with CCG promoted bowel screening among Southcote over 50s group. Participants completed questionnaires around bowel cancer screening and they were provided information on using the test kit

To plan and implement a pilot project that provides motivational behaviour change interventions to patients who have had a 2WW referral and a negative result ("teachable moments")	Public Health Berkshire Cancer Research UK Facilitator		Patients motivated to make significant changes to lifestyle behaviours that will help to reduce their risk of developing cancer		See above – take up too low for a formal evaluation

PRIORITY NO 8	**Reducing the number of people with tuberculosis (TB)**				
What will be done – the task	**Who will do it**	**By when**	**Outcome – the difference it will make**	**Supporting national indicators**	**Progress Update – July 2019**
Offer training in Reading for health professionals , community leaders and other professionals who come in contact with at risk populations	FHFT & RBH TB service /South Reading CCG	Jan-17	Increase awareness about TB amongst local health and social care professionals as well as third sector organisations	PHOF 3.05ii - Incidence of TB (three year average)	A year on year decrease in TB incidence in Reading has been achieved, this is in line with national and South East trends. TB incidence in the 2015-2017 period was 20.9 per 100,000 compared to 36.4 per 100,000 in 2012 .

					Reading's ongoing work has been acknowledged by PHE and TB control Boards. TB awareness sessions are for housing colleagues and partners took place in January and April 2019. Workshops were held for health professionals and for RBC staff during 2018-19 A workshop led by the TB Team and Berkshire Shared PH Team for Looked After Children's nurses and link workers across Berkshire West was held in May 2019 with a similar session for Community Paediatricians in June 2019 Sessions have also been delivered to other groups by the New Entrant Screening Nurse / TB nurse team from RBH with support from Public Health.
Develop resources / training materials for wide range of LA staff to enable them to discuss TB and signpost to local services	Berkshire shared PH team / TB Alert		Increase awareness about TB amongst local authority staff working with those at increased risk of TB	PHOF 3.05ii - Incidence of TB (three year average)	Training materials developed previously continue to be used in awareness sessions and community events

Develop and run a joint public-facing communications / social marketing campaign to raise awareness of TB, latent TB and the local New Entrant Screening Service in order to reduce stigma and encourage those invited for LTBI screening to attend	Berkshire shared PH team / CCG comms / NESS nurses	March 2017	Address social and economic risk factors related to TB	PHOF 3.05ii - Incidence of TB (three year average)	TB awareness sessions have been run during community events including Reading University Fresher's Fayre, Disability Awareness Day, Older People's Day, Carers Rights Day, and a Health and Wellbeing event at Royal Berkshire Hospital. A TB awareness session for the Zambian community took place in January 2019. For World TB Day 24th March a joint news release between the CCG, RBH and Reading Borough Council was featured on local TV, newspapers and on social media sites and included interviews with a TB patient praising the treatment from RBH. Information was shared via GP practice screens and RBH TB Nurses & Public Health also hosted an information stall at Whitley Community Centre.
Include TB data and service information in JSNA	Reading Wellbeing team	February 2017	Address social and economic risk factors related to TB	PHOF 3.05ii - Incidence of TB (three year average)	Key information on active and latent TB and a map of high risk countries has been made available on the Reading Services Guide and JSNA profile to facilitate public access to TB information. TB data will be refreshed in 2019 as part of the JNSA rolling update

					schedule. Data on all TB Strategy Monitoring Indicators is available on PHE Fingertips https://fingertips.phe.org.uk/profile/tb-monitoring
Provide service users with a means to feed into service design discussions	PH / TB Teams	Ongoing	Future treatment and services are based on and informed by the experiences of people living with TB Repeat service user survey annually	PHOF 3.05ii - Incidence of TB (three year average)	The TB team utilises the Friends and Family test
Continue to work closely with PHE health protection colleagues to ensure robust and effective contact tracing takes place as standard	TB Nurses / Berkshire TB Strategy Group		Contract tracing is monitored through the Thames Valley TB Cohort Review	PHOF 3.05ii - Incidence of TB (three year average)	Public Health England is routinely notified of cases of Tuberculosis (TB) and implements public health actions to prevent and control onward transmission, including identification of close contacts of active TB cases and offer of appropriate TB testing. Eight cases of TB infection that were notified to the Thames Valley Health Protection Team over the previous two years have been found to be linked by genetic testing. Further genetic testing of all cases is being undertaken using an alternative technique that can provide higher discriminatory power. Investigation is ongoing to further

					explore any links.
Maintain robust systems for providers to record and report BCG uptake	NHS England		Monitor provision and uptake of BCG vaccination as new policies are implemented	PHOF 3.05ii - Incidence of TB (three year average) Local indicator on BCG update could be developed in partnership with NHSE	A risk-based strategy to offer BCG to infants at increased risks of TB (based on National Guidance) has been adopted by RBH Maternity Services and is supported by the Berkshire TB Strategy Group
Ensure processes are in place to identify eligible babies, even in low-incidence areas	Midwifery teams in FHFT and RBH	Ongoing	Midwifery Teams use agreed service specification to identify eligible babies	PHOF 3.05ii - Incidence of TB (three year average)	A risk-based strategy to offer BCG to infants at increased risks of TB (based on National Guidance) has been adopted by RBH Maternity Services and is supported by the Berkshire TB Strategy Group.
Tackle the clinical and social risk factors associated with development of drug resistance in under-served	Reading Wellbeing Team / Reading	Jan-17	Work to develop the provision of appropriate and accessible information and support to under-	PHOF 3.05ii - Incidence of TB (three year	Reading Healthwatch has conducted a Knowledge and Behaviours Survey. Over 300 people have taken part indicating their views and knowledge towards TB. The results of this will

populations by maintaining high treatment completion rates and ensuring thorough contact tracing around MDR cases	Reading Housing Team / NESS nurses/CCGs		served and high-risk populations.	average)	provide a baseline to measure impact of communication and engagement work. This information will also be used to further shape engagement with under-served and other at-risk groups Resources shared with providers including IRIS A TB awareness session was delivered to IRIS staff in 2018
Ensure patients on TB treatment have suitable accommodation	Reading Wellbeing Team / Reading Reading Housing Team / NESS nurses/CCGs		Development of robust discharge protocol	PHOF 3.05ii – Treatment completion for TB	PHE have developed Thames Valley guidance to inform the process for assessment and discharge of homeless TB patients - both with and without recourse to public funds. This guidance has been used to inform process across the Berkshire LAs during 2017, demonstrating it is fit for purpose. Work is in progress to develop an MOU between the CCGs and local authorities across Berkshire West to ensure provision of accommodation to homeless TB patients with no recourse to public funds

Develop and promote referral pathways from non-NHS providers	LA public health / NESS nurses/CCGs		Align local service provision to these groups as per NICE recommendations	PHOF 3.05ii - Incidence of TB (three year average)	Work with under-served continued to be priority for the CCG and RBC Wellbeing Team in 2018-2019 The RBC Wellbeing Team worked with TB nurses and CCG colleagues to promote World TB Day on 24.03.2019 by engaging with local residents World TB Day was promoted by the local authority via web pages and digital media. A TB awareness session was organised for the Nepalese community in partnership with the charity Communicare The RBC Wellbeing Team has developed links with different community groups to identify TB Champions who could raise awareness of TB and NESS within their groups
Engagement with SE TB Control Board to share best practice	DPH / PHE CCDC		Work to decrease the incidence of TB in Berkshire through investigating how co-ordinated, local latent TB screening processes can be improved	PHOF 3.05ii - Incidence of TB (three year average)	The SE TB Control Board held a workshop in Reading in November 2017 to review its objectives for 2018. There are 2 face to face board meetings a year, and 2 TB network lead meetings to share work streams. There is a public facing website with links to general information, and a TB

					nurse forum
Fully implement EMIS and Vision templates in all practices in South Reading	South Reading CCG	Ongoing	Ensure that new entrants are referred routinely to local services for screening through addressing issues with local pathways	PHOF 3.05ii - Incidence of TB (three year average)	Templates are installed in all practices. The majority of 16 South Reading practices are returning monthly lists to NESS and practices have been offered training/support to continue this. 563 patients were screened from April-2018 - March 2019 compared with 382 in the previous year. DNA rates have reduced substantially during 2018-19 following changes in follow up process with invited patients and implementation of an evening clinic.

Appendix B

Priority	Indicator	Target Met/Not Met	Direction of Travel
1. Supporting people to make healthy lifestyle choices	2.12 Excess weight in adults	Met	Better
	2.13i % of adults physically active	Met	Better
	2.06i % 4-5 year olds classified as overweight/obese	Not Met	Better
	2.06ii % 10-11 year olds classified as overweight/obese	Met	Worse
	2.03 Smoking status at the time of delivery	Met	Better
	2.14 Smoking prevalence - all adults - current smokers	Met	Better
	2.14 Smoking prevalance - routine and manual - current smokers	Met	Better
	2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2014-2019	Not Met	No change
	2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2014-2019	Met	No change
	2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2014-2019	Not Met	No change
2. Reducing loneliness and social isolation	1.18i/1l % of adult social care users with as much social contact as they would like	Not Met	Worse
	1.18ii/1l % of adult carers with as much social contact as they would like	Not Met	No change
	Placeholder - Loneliness and Social Isolation	*NA*	*NA*
3.Promoting positive mental health and wellbeing in children and young people	Pupils with social, emotional and mental health needs (primary school age)	Not Met	No change
	Pupils with social, emotional and mental health needs (secondary school age)	Met	Better
	Pupils with social, emotional and mental health needs (all school age)	Met	No change
4. Reducing deaths by suicide	4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	Met	Better
5.Reducing the amount of alcohol people drink to safer levels	2.15iii Successful treatment of alcohol treatment	Not Met	Better
	2.18 Admission episodes for alcohol related conditions (DSR per 100,000)	Met	Better
6.Living well with dementia	4.16/2.6i Estimated diagnosis rate for people with dementia	Met	Better
	No. Dementia Friends (Local Indicator)	Met	Better
	Placeholder - ASCOF measure of post-diagnosis care	*NA*	*NA*
7.Increasing take up of breast and bowel screening and prevention services	2.20iii Cancer screening coverage - bowel cancer	Met	No change
	2.20i Cancer screening coverage - breast cancer	Met	No change
8.Reducing the number of people with tuberculosis	3.05ii Incidence of TB (three year average)	Met	Better

PRIORITY 1: Supporting people to make healthy lifestyle choices

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
2.12 Excess weight in adults	Public Health Outcomes Framework	Active People Survey	Annual	Low	2017-18	55.7	63.4	Met	Better	62.0	63.5
2.13i % of adults physically active	Public Health Outcomes Framework	Active Lives Survey	Annual	High	2017-18	68.8	64	Met	Better	66.3	67.0
2.06i % 4-5 year olds classified as overweight/obese	Public Health Outcomes Framework	National Child Measurement Programme	Annual	Low	2017-18	22.3	22.0	Not Met	Better	22.4	Not available
2.06ii % 10-11 year olds classified as overweight/obese	Public Health Outcomes Framework	National Child Measurement Programme	Annual	Low	2017-18	34.3	36	Met	Worse	34.3	Not available
2.03 Smoking status at the time of delivery	Public Health Outcomes Framework	Smoking Status At Time of Delivery (SSATOD) HSCIC	Annual	Low	2017-18	6.3	8.0	Met	Better	10.8	12.0
2.14 Smoking prevalence all adults	Public Health Outcomes Framework	Annual Population	Annual	Low	2017	13.6	14.8	Met	Better	14.9	13.2
2.14 Smoking prevalance - routine and manual - current smokers	Public Health Outcomes Framework	Annual Population Survey	Annual	Low	2017	27.6	28.9	Met	Better	25.7	23.7
2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2014-2019	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2014-2019 Q3	52.1%	100%	Not Met	No change	81.0%	Not available
2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2014-2019	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2014-2019 Q2	50%	50%	Met	No change	48.3%	Not available
2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2014-2019	Public Health Outcomes Framework	www.healthcheck.nhs.uk	Annual	High	2014-2019 Q2	26%	50%	Not Met	No change	28.9%	Not available

Back to HWB Dashboard

PRIORITY 2: Reducing Loneliness and Social Isolation

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
1.18i/1l % of adult social care users with as much social contact as they would like	Public Health Outcomes Framework/Adult Social Care Outcomes Framework	Adult Social Care Survey - England	Annual	High	2017-18	41.4	45.4	Not Met	Worse	46.0	NA
1.18ii/1l % of adult carers with as much social contact as they would like	Public Health Outcomes Framework/Adult Social Care Outcomes Framework	Carers Survey	Bi-Annual	High	2016-17	36.2	38.5	Not Met	No change	35.5	32.4
Placeholder - Loneliness and Social Isolation	NA	TBC	Annual							NA	NA

Back to HWB Dashboard

Priority 3: Promoting positive mental health and wellbeing in children and young people

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
Pupils with social, emotional and mental health needs (primary school age)	Children and Young People's Mental Health and Wellbeing	DFE Special Needs Education Statistics	Annual	Low	2018	2.4%	2.3%	Not Met	No change	2.2%	2.0%
Pupils with social, emotional and mental health needs (secondary school age)	Children and Young People's Mental Health and Wellbeing	DFE Special Needs Education Statistics	Annual	Low	2018	3.2%	3.3%	Met	Better	2.3%	2.1%
Pupils with social, emotional and mental health needs (all school age)	Children and Young People's Mental Health and Wellbeing	DFE Special Needs Education Statistics	Annual	Low	2018	3.0%	3.0%	Met	No change	2.4%	2.2%

Back to HWB Dashboard

Priority 4: Reducing deaths by suicide

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	Public Health Outcomes Framework	Public Health England (based on ONS)	Annual	Low	2015-17	8.0	8.25	Met	Better	9.6	9.6

Back to HWB Dashboard

PRIORITY 5:Reducing the amount of alcohol people drink to safer levels

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
2.15iii Successful treatment of alcohol treatment	Public Health Outcomes Framework	National Drug Treatment Monitoring System	Quarterly	High	Q2 2018-19	36.4%	38.3%	Not Met	Better	38.5%	Not available
2.18 Admission episodes for alcohol related conditions (DSR per 100,000)	Public Health Outcomes Framework	Local Alcohol Profiles for England (based on HSCIC HES)	Annual	Low	2017-18	534	599	Met	Better	632	600

Back to HWB Dashboard

Priority 6: Living well with dementia

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
4.16/2.6i Estimated diagnosis rate for people with dementia	Public Health Outcomes Framework/NHS Outcomes Framework	NHS Digital	Monthly	High	Oct-18	71.1	67.7	Met	Better	68.7	68.3
No. of Dementia friends	NA (Local only)	Local Report	Quarterly	High	Jun-19	7859	5000	Met	Better	Not available	Not available

PLACEHOLDER - Post diagnosis care

Back to HWB Dashboard

Priority 7: Increasing take up of breast and bowel screening and prevention services

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
2.20iii Cancer screening coverage - bowel cancer	Public Health Outcomes Framework	Health and Social Care Inf	Annual	High	2018	56%	52%	Met	No change	60%	61%
2.20i Cancer screening coverage - breast cancer	Public Health Outcomes Framework	Health and Social Care Information Centre (HSCIC)	Annual	High	2018	71%	70%	Met	No change	75%	77%

Back to HWB Dashboard

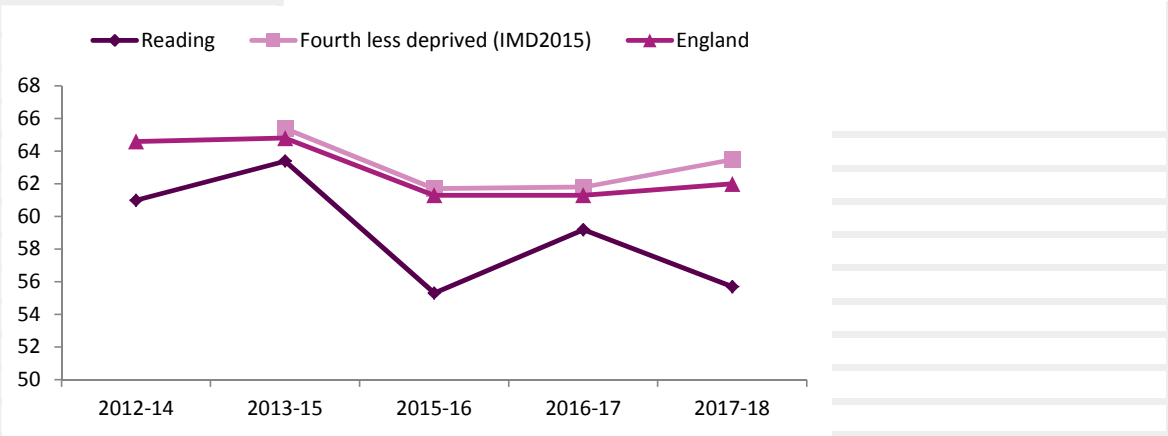
Priority 8: Reducing the number of people with tuberculosis

Indicator Title	Framework	Source	Frequency updated	Good performance low/high	Most recent reporting period	Most recent performance	Target	Met/Not Met	DOT	England Average	2015 Deprivation Decile Average
3.05ii Incidence of TB (three year average)	Public Health Outcomes Framework	Public Health England.	Annual	Low	2015-2017	20.9	30	Met	Better	9.9	6.3

Back to HWB Dashboard

Indicator number	**2.12**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Excess weight in adults**
[Back to Priority 1](#)	
[Back to HWB Dashboard](#)	
Data source	Active Lives Survey (previously Active People Survey) Sport England
	* Note change in methodology in 2015-16
Denominator	Number of adults with valid height and weight recorded. Active lives Survey. Historical (before 2015-16) Number of adults with valid height and weight recorded. Data are from APS year 1, quarter 2 to APS year 3, quarter 1
Numerator	Number of adults with a BMI classified as overweight (including obese), calculated from the adjusted height and weight variables. Active Lives Survey. Previously (before 2015-16) from Active People survey. Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m2.

Period	Reading	Fourth less deprived (IMD2015)	England
2012-14	61		64.6
2013-15	63.4	*65.4*	64.8
2015-16	55.3	*61.7*	61.3
2016-17	59.2	*61.8*	61.3
2017-18	55.7	*63.5*	62

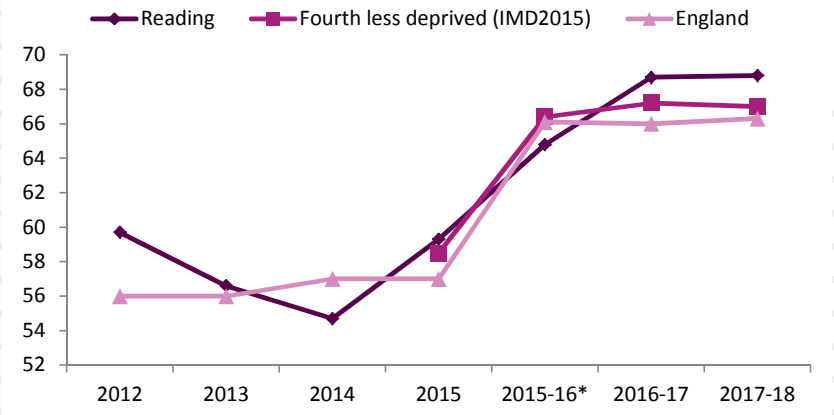


Indicator number	**2.13**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**% Physically Active Adults**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Data source	Until 2015 - Active People Survey, Sport England
	2015-16 onwards - Active Lives, Sport England
	* Note change in methodology in 2015-16
Denominator	Weighted number of respondents aged 19 and older with valid responses to questions on physical activity
Numerator	Weighted number of respondents aged 19 and over, with valid responses to questions on physical activity, doing at least 150 MIE minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days.

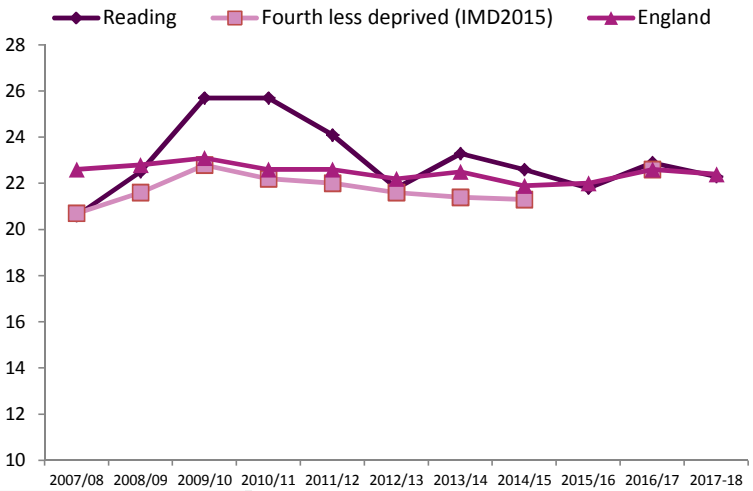
Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	59.7	55.3	64.2		56
2013	56.6	52.3	60.8		56
2014	54.7	50.4	58.9		57
2015	59.3	55	63.6	*58.5*	57
2015-16*	64.8	61.7	67.7	*66.4*	66.1
2016-17	68.7	65.8	71.5	*67.2*	66
2017-18	68.8	64.5	72.7	*67*	66.3



Indicator number	**2.06i**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Child excess weight in 4-5 year olds**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Data source	National Child Measurement Programme
Denominator	Number of children in Reception (aged 4-5 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Numerator	Number of children in Reception (aged 4-5 years) classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

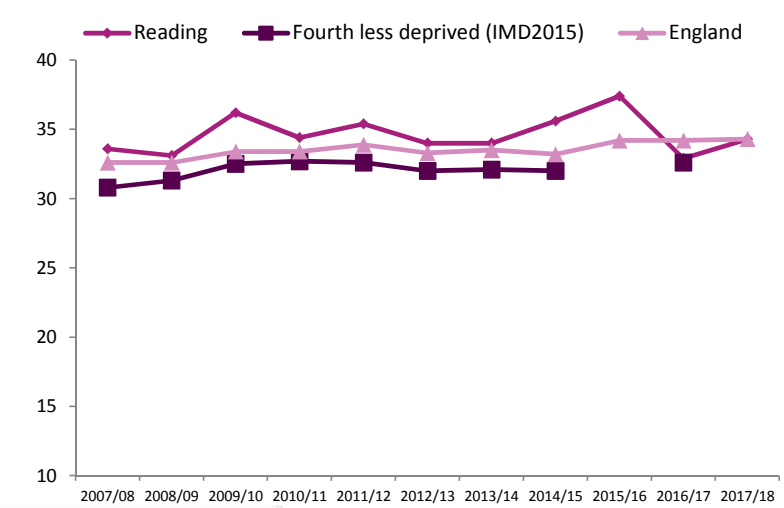


Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2007/08	20.6	18.5	22.9	*20.7*	22.6
2008/09	22.5	20.5	24.6	*21.6*	22.8
2009/10	25.7	23.7	27.9	*22.8*	23.1
2010/11	25.7	23.7	27.8	*22.2*	22.6
2011/12	24.1	22.1	26.1	*22*	22.6
2012/13	21.8	20	23.9	*21.6*	22.2
2013/14	23.3	21.3	25.5	*21.4*	22.5
2014/15	22.6	20.9	24.5	*21.3*	21.9
2015/16	21.8	20.1	23.6	-	22
2016/17	22.9	21.1	24.7	*22.6*	22.6
2017-18	22.3	20.6	24.1		22.4

Indicator number	**2.06i**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Child excess weight in 10-11 year olds**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Data source	National Child Measurement Programme
Denominator	Number of children in Year 6 (aged 10-11 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Numerator	Number of children in Year 6 (aged 10-11 years) classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.



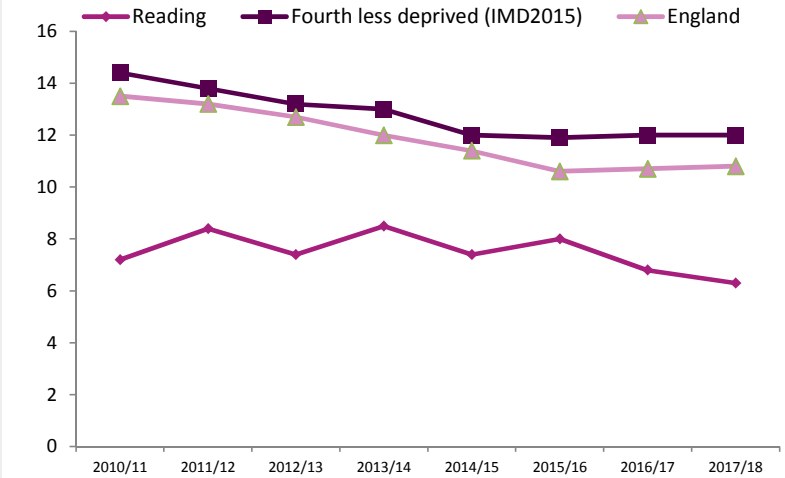
Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2007/08	33.6	31	36.2	*30.8*	32.6
2008/09	33.1	30	35.7	*31.3*	32.6
2009/10	36.2	33.6	38.8	*32.5*	33.4
2010/11	34.4	32	36.9	*32.7*	33.4
2011/12	35.4	32.9	37.9	*32.6*	33.9
2012/13	34	31.6	36.5	*32*	33.3
2013/14	34	32.2	37.1	*32.1*	33.5
2014/15	35.6	33.2	38	*32*	33.2
2015/16	37.4	35.1	39.7	-	34.2
2016/17	32.9	30.7	35.2	*32.6*	34.2
2017/18	34.3	32.1	36.6		34.3

Indicator number	**2.03**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**% of women who smoke at the time of delivery**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Data source	Calculated by KIT East from the Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SSATOD)
Denominator	Number of maternities (estimated based on counts for CCGs)
Numerator	Number of women known to smoke at time of delivery (estimated based on counts for CCGs)

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2010/11	7.2	6.1	8.2	*14.4*	13.5
2011/12	8.4	7.4	9.6	*13.8*	13.2
2012/13	7.4	6.3	8.2	*13.2*	12.7
2013/14	8.5	7.4	9.6	*13*	12
2014/15	7.4	6.4	8.5	*12*	11.4
2015/16	8	7	9.1	*11.9*	10.6
2016/17	6.8	5.9	7.9	*12*	10.7
2017/18	6.3	5.4	7.4	*12*	10.8

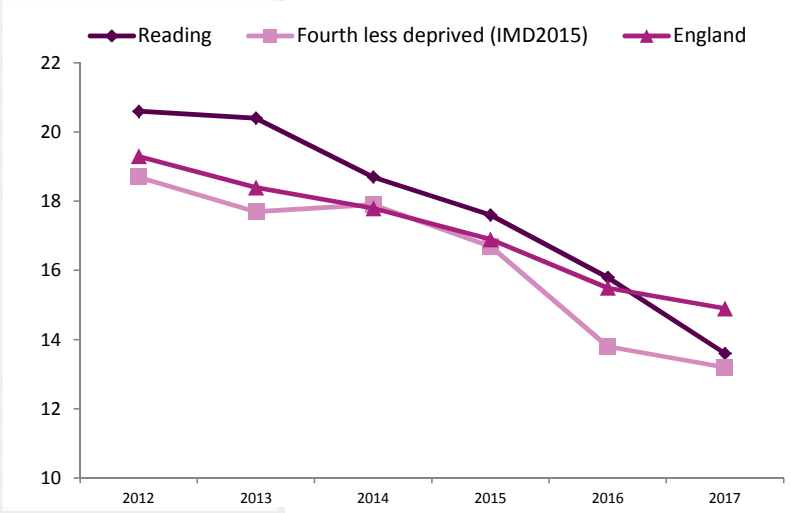


Indicator number	**2.14**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Smoking Prevalence in Adults - Current Smokers**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Data source	Annual Population Survey
Denominator	Total number of respondents (with valid recorded smoking status) aged 18+ from the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Numerator	The number of persons aged 18 + who are self-reported smokers in the Annual Population Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	20.6	18.4	22.8	*18.7*	19.3
2013	20.4	18.2	22.6	*17.7*	18.4
2014	18.7	16.7	20.7	*17.9*	17.8
2015	17.6	15.5	19.8	*16.7*	16.9
2016	15.8	13.5	18.1	*13.8*	15.5
2017	13.6	10.9	16.3	*13.2*	14.9

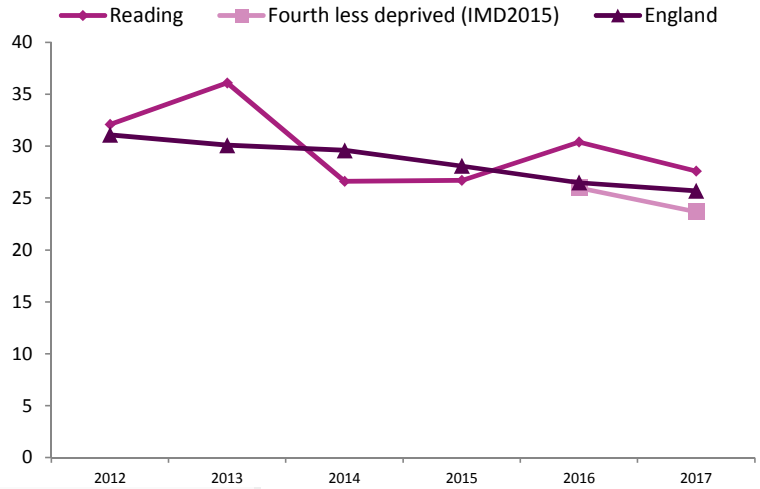


Indicator number	**NA**
Outcomes Framework	**Local Tobacco Control Profiles**
Indicator full name	**Smoking prevalence in routine and manual occupations - Current smokers**

[Back to Priority 1](#)
[Back to HWB Dashboard](#)

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012	32.1	26.4	37.8	*NO DATA*	31.1
2013	36.1	30.1	42.1	*NO DATA*	30.1
2014	26.6	21.2	32	*NO DATA*	29.6
2015	26.7	20.6	32.7	*NO DATA*	28.1
2016	30.4	23	37.9	*26*	26.5
2017	27.6	19.4	35.8	*23.7*	25.7

Data source	Annual Population Survey
Denominator	Total respondents with a self-reported smoking status aged 18-64 in the R&M group. Weighted to improve representativeness.
Numerator	Respondents who are self-reported smokers in the R&M group. Weighted to improve representativeness



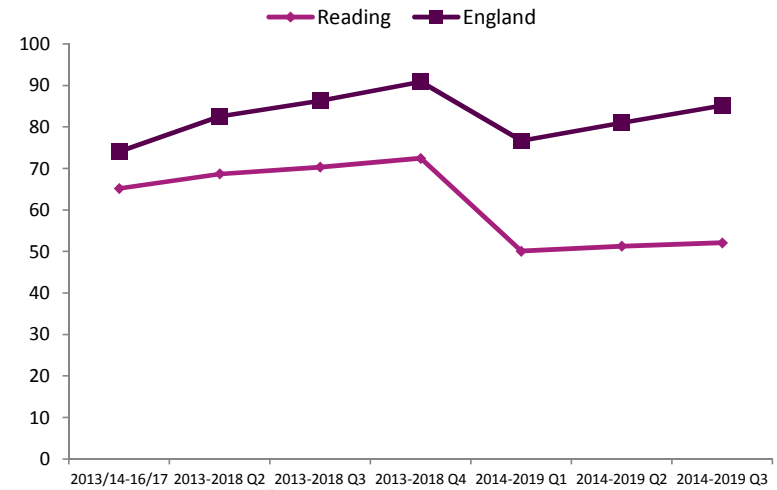
Indicator number	**2.22ii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check**

[Back to Priority 1](#)

[Back to HWB Dashboard](#)

Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who were offered an NHS Health Check in the five year period

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2013/14-16/17	65.2	64.8	65.7	75.7	74.1
2013-2018 Q2	68.72				82.54
2013-2018 Q3	70.33				86.36
2013-2018 Q4	72.44				90.91
2014-2019 Q1	50.08				76.67
2014-2019 Q2	51.28				81.05
2014-2019 Q3	52.07				85.21



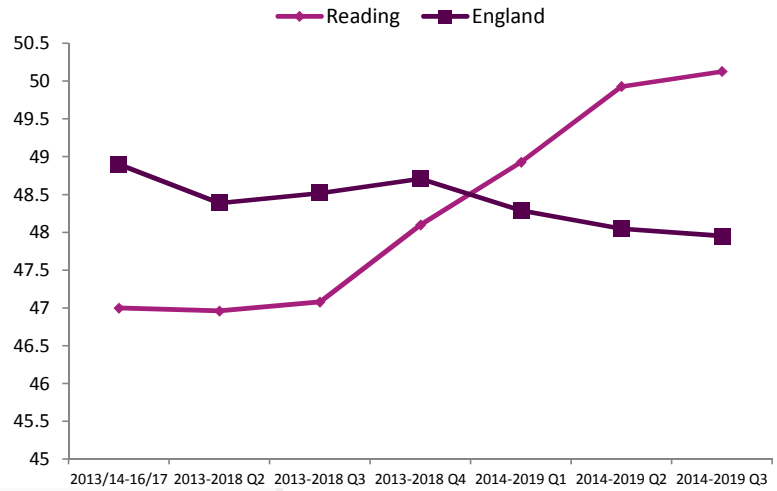
Indicator number	**2.22iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received a Health Check**

[Back to Priority 1](#)

[Back to HWB Dashboard](#)

Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 offered an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check received an NHS Health Check in the five year period

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2013/14-16/17	47	46.1	47.8	*50.7*	48.9
2013-2018 Q2	46.96				48.39
2013-2018 Q3	47.08				48.52
2013-2018 Q4	48.1				48.71
2014-2019 Q1	48.93				48.29
2014-2019 Q2	49.93				48.05
2014-2019 Q3	50.13				47.95



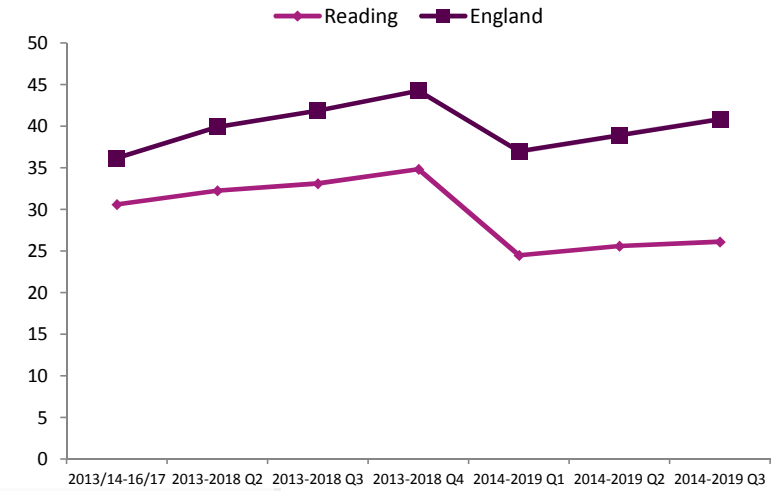
Indicator number	**2.22iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cumulative percentage of the eligible population aged 40-74 who received a Health Check**

[Back to Priority 1](#)

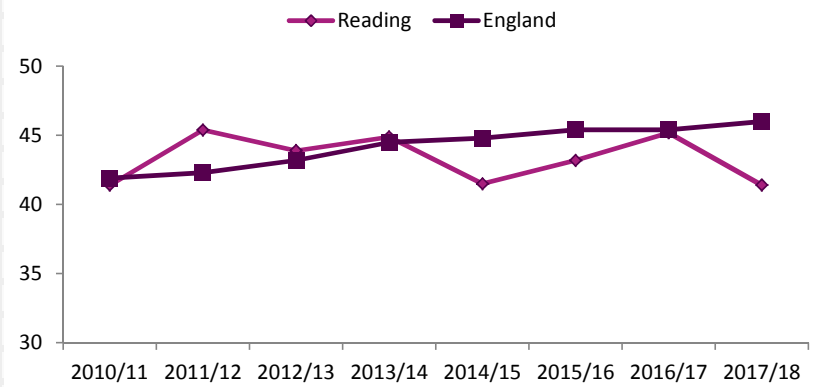
[Back to HWB Dashboard](#)

Data source	Public Health England - www.healthcheck.nhs.uk
Denominator	Number of people aged 40-74 eligible for an NHS Health Check in the five year period
Numerator	Number of people aged 40-74 eligible for an NHS Health Check who received an NHS Health Check in the five year period

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2013/14-16/17	30.6	30.2	31.1	*38.4*	36.2
2013-2018 Q2	32.27				39.94
2013-2018 Q3	33.11				41.91
2013-2018 Q4	34.84				44.28
2014-2019 Q1	24.5				37.02
2014-2019 Q2	25.6				38.94
2014-2019 Q3	26.1				40.86



Indicator number	**1.18i/1l**
Outcomes Framework	**Public Health Outcomes Framework/Adult Social Care Outcome Framework**
Indicator full name	**% of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey**
Back to Priority 2 Back to HWB Dashboard	
Data source	Adult Social Care Survey - England
	http://content.digital.nhs.uk/catalogue/PUB21630 - Annex Tables
Denominator	The number of people responding to the question "Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?"
Numerator	All survey respondents who responded to the question (adult social care users identified by LA) NHS Digital - Personal Social Services Adult Social Care Survey England



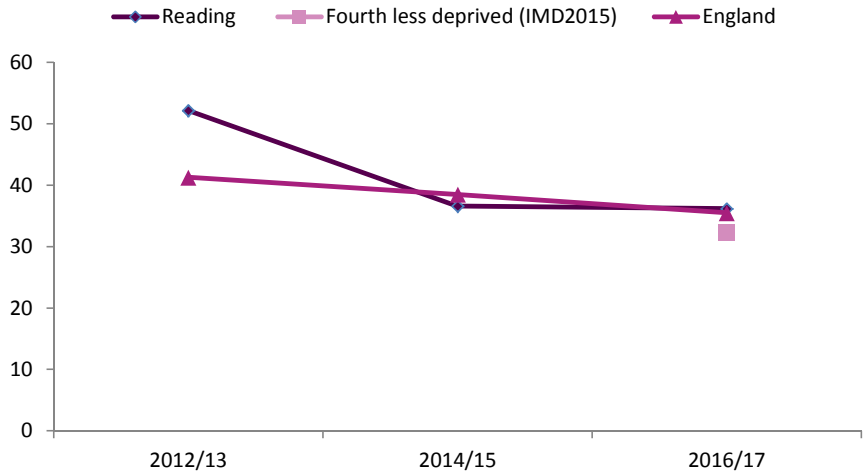
Period	Reading	Fourth less deprived (IMD2015)	England
2010/11	41.4	-	41.9
2011/12	45.4	-	42.3
2012/13	43.9	-	43.2
2013/14	44.9	-	44.5
2014/15	41.5	-	44.8
2015/16	43.2	-	45.4
2016/17	45.2	-	45.4
2017/18	41.4		46

Indicator number	**1.18ii/1l**
Outcomes Framework	**Public Health Outcomes Framework/Adult Social Care Outcome Framework**
Indicator full name	**% of adult carers who have as much social contact as they would like according to the Adult Social Care Users Survey**

[Back to Priority 2](#)
[Back to HWB Dashboard](#)

Data source	Carers Survey
Denominator	The number of people responding to the question "Thinking about how much contact you've had with people that you like, which of the following statements best describes your social situation?", with the answer "I have as much social contact as I want with people I like" divided by the total number of responses to the same question.
Numerator	All survey respondents who responded to the question (adult social care users identified by LA) NHS Digital - Personal Social Services Adult Social Care Survey England

Period	Reading	Lower CI	Upper CI	Fourth less deprived (IMD2015)	England
2012/13	52.2	48.1	56.3		41.3
2014/15	36.6	31.8	41.4		38.5
2016/17	36.2	30.4	42.4	*32.4*	35.5

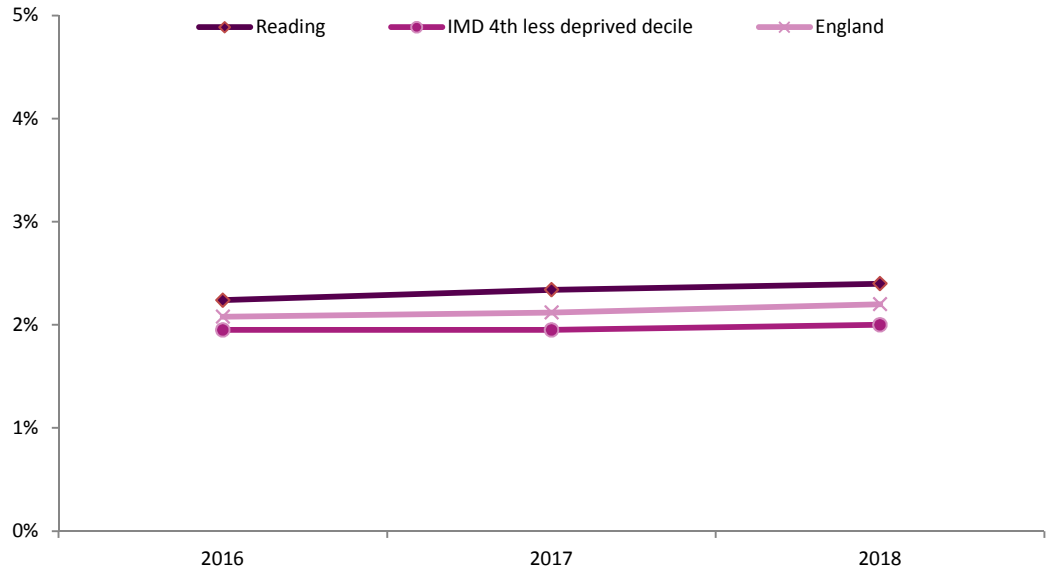


Indicator number	**NA**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (primary school age)**

[Back to Priority 3](#)
[Back to HWB Dashboard](#)

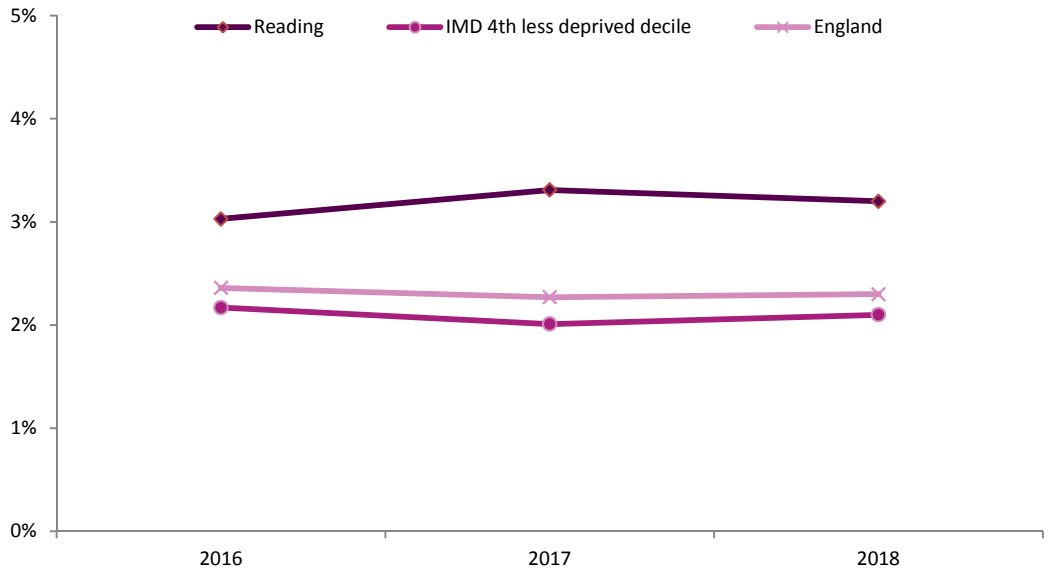
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations) https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health

Period	Reading	IMD 4th less deprived decile	England
2016	2%	2%	2%
2017	2%	2%	2%
2018	2%	2%	2%



Indicator number	**NA**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (secondary school age)**
[Back to Priority 3](#) [Back to HWB Dashboard](#)	
Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations) https://www.gov.uk/government/collections/statistics-special-educational-needs-sen
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health

Period	Reading	IMD 4th less deprived decile	England
2016	3%	2%	2%
2017	3%	2%	2%
2018	3%	2%	2%

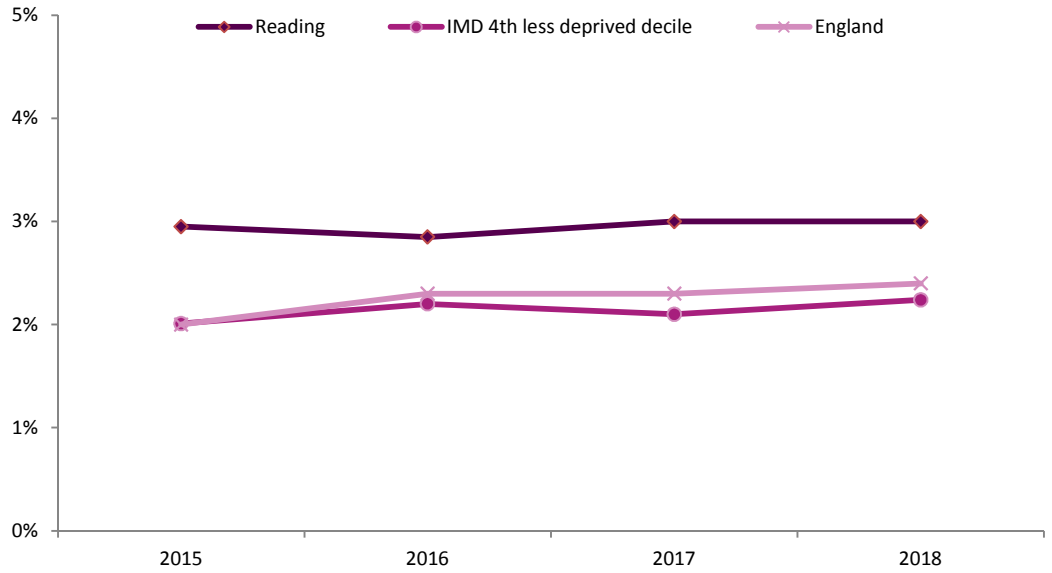


Indicator number	**NA**
Outcomes Framework	**Children and Young People's Mental Health and Wellbeing**
Indicator full name	**Pupils with social, emotional and mental health needs (all school age)**

[Back to Priority 3](#)
[Back to HWB Dashboard](#)

Data Source	DFE Special Needs Education Statistics
Denominator	Total pupils (LA tabulations)
Numerator	Number of pupils with statements of SEN where primary need is social, emotional and mental health https://www.gov.uk/government/collections/statistics-special-educational-needs-sen

Period	Reading	IMD 4th less deprived decile	England
2015	3%	2%	2%
2016	3%	2%	2%
2017	3%	2%	2%
2018	3%	0.0224	0.024



Indicator number	**4.10**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population**

[Back to Priority 4](#)
[Back to HWB Dashboard](#)

Data Source	Public Health England (based on ONS)
Denominator	ONS 2011 census based mid-year population estimates
Numerator	Number of deaths from suicide and injury from undetermined intent ICD10 codes X60-X84 (age 10+), Y10-34 (age 15+).

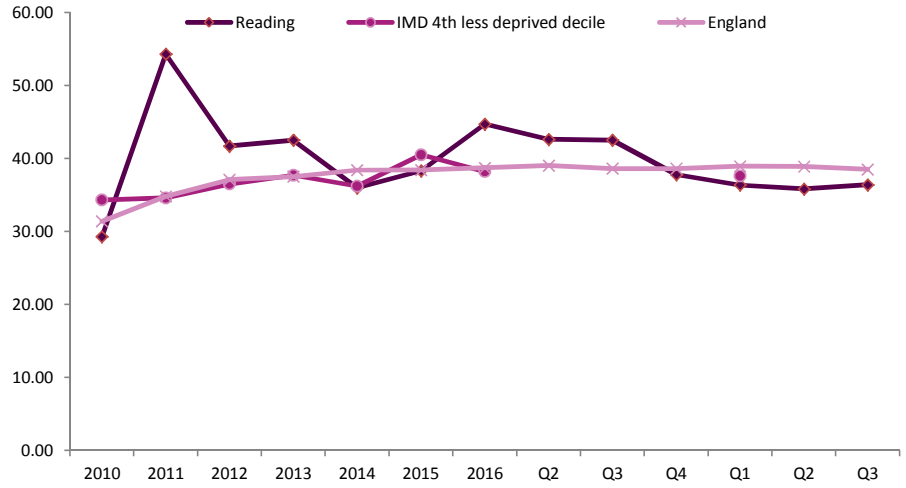
Period	Reading	4th less deprived IMD 2015	England
2001 - 03	11.5	-	10.3
2002 - 04	10.7	-	10.2
2003 - 05	10.4	-	10.1
2004 - 06	10	-	9.8
2005 - 07	9.6	-	9.4
2006 - 08	11.2	-	9.2
2007 - 09	10.9	-	9.3
2008 - 10	8.8	-	9.4
2009 - 11	7.4	-	9.5
2010 - 12	7.7	-	9.5
2011 - 13	9.3	-	9.8
2012 - 14	9.8	-	10
2013 - 15	11	10.5	10.1
2014 - 16	9.9	10.2	9.9
2015 - 17	8	9.6	9.6

Indicator number	**2.15iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Successful completion of alcohol treatment**

[Back to Priority 5](#)
[Back to HWB Dashboard](#)

Data Source	National Drug Treatment Monitoring System
Denominator	Total number of adults in structured alcohol treatment in a one year period
Numerator	Adults that complete treatment for alcohol dependence who do not re-present to treatment within six months

Period	Reading	IMD 4th less deprived decile	England
2010	29.30	34.30	31.40
2011	54.30	34.60	34.80
2012	41.70	36.50	37.10
2013	42.50	37.70	37.50
2014	36.00	36.20	38.40
2015	38.30	40.50	38.40
2016	44.70	38.20	38.70
Q2	42.60		39.00
Q3	42.50		38.60
Q4	37.80		38.60
Q1	36.36	37.60	38.92
Q2	35.80		38.90
Q3	36.40		38.50



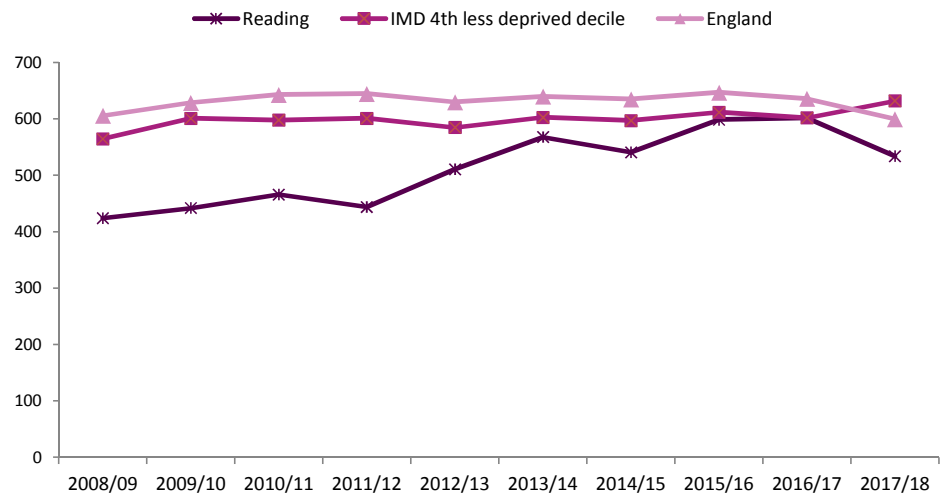
(NDTMS DOMES)

Indicator number	**2.18**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Admission episodes for alcohol-related conditions per 100,000 people**

[Back to Priority 5](#)
[Back to HWB Dashboard](#)

Data Source	Health and Social Care information Centre - Hospital Episode Statistics. Via Local Alcohol Profiles for England
Denominator	Mid-Year Population Estimates (ONS)
Numerator	Admissions to hospital where primary diagnosis is an alcohol-related condition or a seconday diagnosis is an alcohol-related external cause. Uses attributable fractions to estimate.

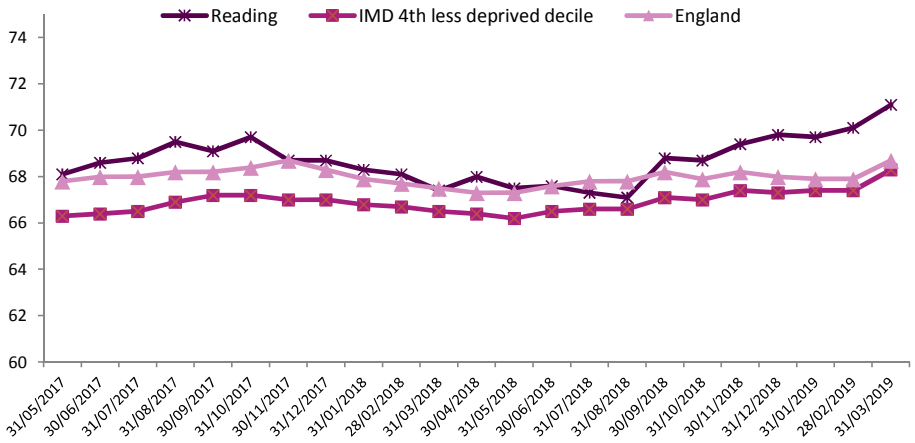
Period	Reading	IMD 4th less deprived decile	England
2008/09	424	565	606
2009/10	442	601	629
2010/11	466	598	643
2011/12	444	601	645
2012/13	511	585	630
2013/14	568	603	640
2014/15	541	597	635
2015/16	599	612	647
2016/17	602	602	636
2017/18	534	632	600



Indicator number	**4.16 / 2.6i**
Outcomes Framework	**Public Health Outcomes Framework / NHS Outcomes Framework**
Indicator full name	**Estimated diagnosis rate for people with dementia**

[Back to Priority 6](#)
[Back to HWB Dashboard](#)

Data Source	NHS Digital
Denominator	Applying the reference rates to the registered population yields the number of people aged 65+ one would expect to have dementia within the subject population where:
Numerator	**Registered population** Patients aged 65+ registered for General Medical Services, counts by 5-year age and sex band from the National Health Application and Infrastructure Services (NHAIS / Exeter) system; extracted on the first day of each month following the reporting period end date of the numerator. **Reference rates: sampled dementia prevalence** Age 65+ age and sex-specific dementia prevalence rates. Source: MRC CFAS II.

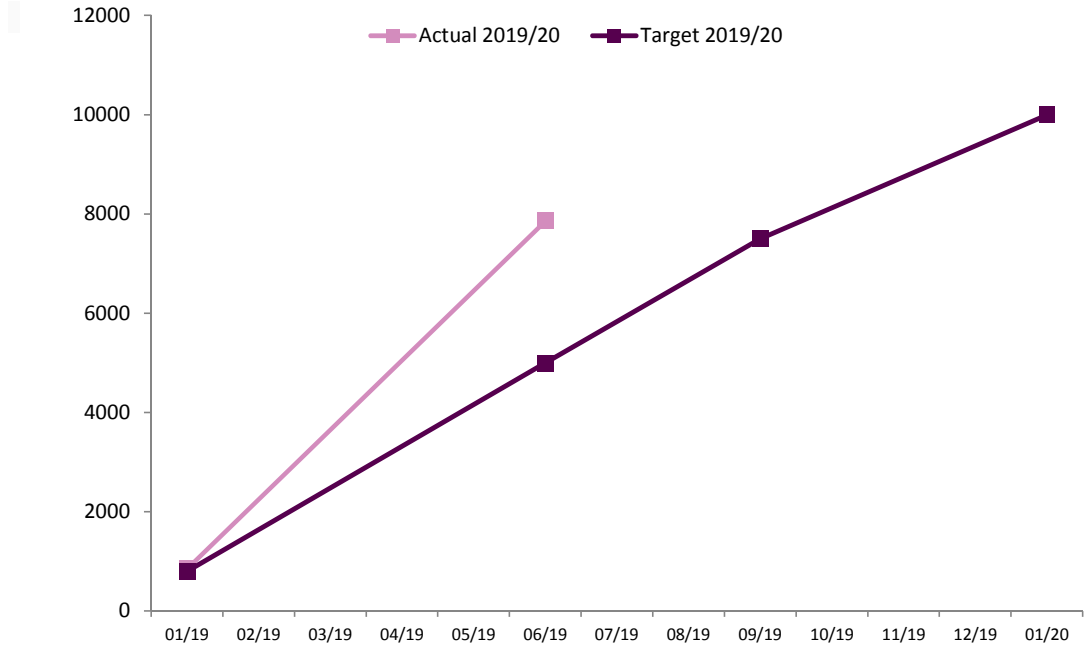


Period	Reading	IMD 4th less deprived decile	England
42886	68.1	66.3	67.8
42916	68.6	66.4	68
42947	68.8	66.5	68
42978	69.5	66.9	68.2
43008	69.1	67.2	68.2
43039	69.7	67.2	68.4
43069	68.7	67	68.7
43100	68.7	67	68.3
43131	68.3	66.8	67.9
43159	68.1	66.7	67.7
43190	67.4	66.5	67.5
43220	68	66.4	67.3
43251	67.5	66.2	67.3
43281	67.6	66.5	67.6
43312	67.3	66.6	67.8
43343	67.1	66.6	67.8
43373	68.8	67.1	68.2
43404	68.7	67	67.9
43434	69.4	67.4	68.2
31/12/2018	69.8	67.3	68
31/01/2019	69.7	67.4	67.9
28/02/2019	70.1	67.4	67.9
31/03/2019	71.1	68.3	68.7

Indicator number	**NA**
Outcomes Framework	**NA**
Indicator full name	**No. of Dementia Friends**

[Back to Priority 6](#)
[Back to HWB Dashboard](#)

Data Source	Locally Recorded
Definition	No. of people who have completed a 45 minute training session and agreed to be a dementia friend



Period	Actual 2019/20	Target 2019/20
Jan-19	857	800
Jun-19	7859	5,000
Sep-19		7500
Jan-20		10,000

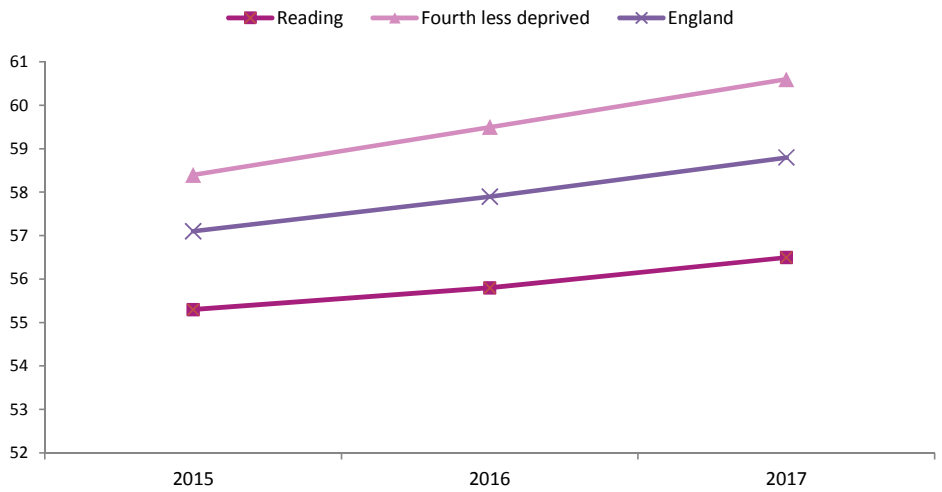
Indicator number	**2.20iii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cancer screening coverage - bowel cancer**

[Back to Priority 7](#)
[Back to HWB Dashboard](#)

Period	Reading	Fourth less deprived	England
2015	55.3	58.4	57.1
2016	55.8	59.5	57.9
2017	56.5	60.6	58.8

Data Source	Health and Social Care Information Centre (Open Exeter)/Public Health England
Denominator	Number of people aged 60-74 resident in the area (determined by postcode of residence) who are eligible for bowel screening at a given point in time (excluding those with no functioning colon (e,g, after surgery) or have made an informed decision to opt out.
Numerator	Number of people aged 60-74 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous 2½ years

Target is the NHS England minimum coverage standard
https://www.england.nhs.uk/wp-content/uploads/2017/04/service-spec-26.pdf

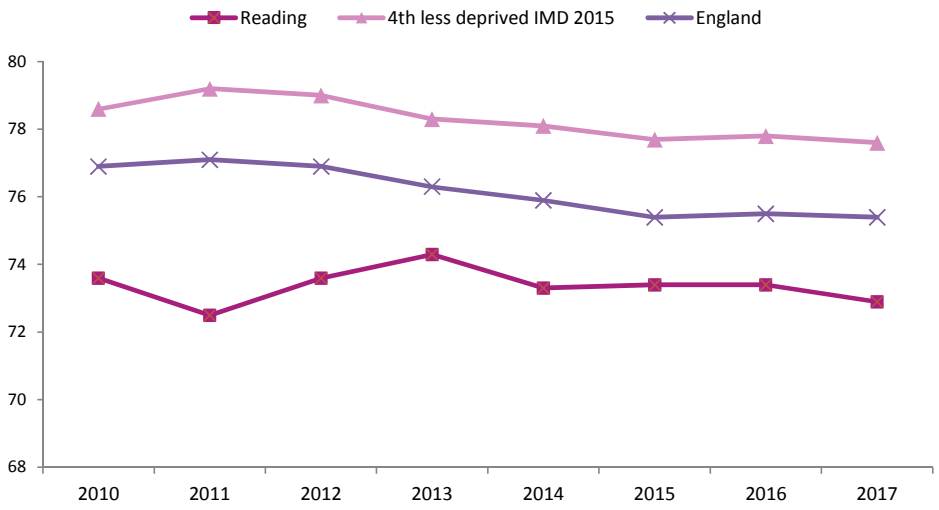


Indicator number	**2.20i**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Cancer screening coverage - breast cancer**

[Back to Priority 7](#)
[Back to HWB Dashboard](#)

Data Source	Health and Social Care Information Centre (Open Exeter)/Public Health England
Denominator	Number of women aged 53-70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time.
Numerator	Number of women aged 53-70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years Target is the NHS England minimum coverage standard https://www.england.nhs.uk/wp-content/uploads/2017/04/service-spec-24.pdf

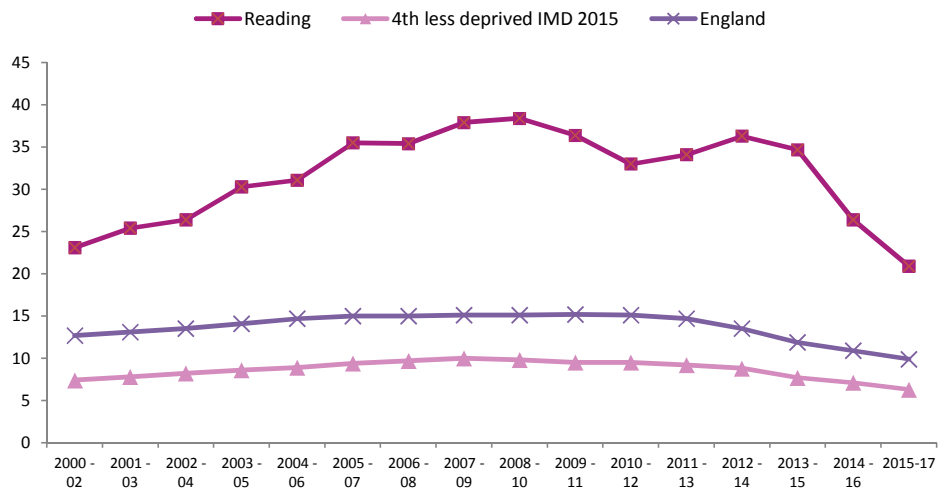
Period	Reading	4th less deprived IMD 2015	England
2010	73.6	78.6	76.9
2011	72.5	79.2	77.1
2012	73.6	79	76.9
2013	74.3	78.3	76.3
2014	73.3	78.1	75.9
2015	73.4	77.7	75.4
2016	73.4	77.8	75.5
2017	72.9	77.6	75.4



Indicator number	**3.05ii**
Outcomes Framework	**Public Health Outcomes Framework**
Indicator full name	**Incidence of TB (three year average)**

[Back to Priority 8](#)
[Back to HWB Dashboard](#)

Data Source	Enhanced Tuberculosis Surveillance system (ETS) and Office for National Statistics (ONS)
Denominator	Sum of the Office for National Statistics (ONS) mid-year population estimates for each year of the three year time period
Numerator	Sum of the number of new TB cases notified to the Enhanced Tuberculosis Surveillance system (ETS) over a three year time period



Period	Reading	4th less deprived IMD 2015	England
2000 - 02	23.1	7.4	12.7
2001 - 03	25.4	7.8	13.1
2002 - 04	26.4	8.2	13.5
2003 - 05	30.3	8.6	14.1
2004 - 06	31.1	8.9	14.7
2005 - 07	35.5	9.4	15
2006 - 08	35.4	9.7	15
2007 - 09	37.9	10	15.1
2008 - 10	38.4	9.8	15.1
2009 - 11	36.4	9.5	15.2
2010 - 12	33	9.5	15.1
2011 - 13	34.1	9.2	14.7
2012 - 14	36.3	8.8	13.5
2013 - 15	34.7	*7.7*	11.9
2014 - 16	26.4	*7.1*	10.9
2015-17	20.9	*6.3*	9.9

Indicator	Expected date of update (PHOF Indicators)	Local/Quarterly data available?
2.12 Excess weight in adults	May	No
2.13i % of adults physically active	May	No
2.06i % 4-5 year olds classified as overweight/obese	February	No
2.06ii % 10-11 year olds classified as overweight/obese	February	No
2.03 Smoking status at the time of delivery	November	No
2.14 Smoking prevalence - all adults - current smokers	August	No
2.14 Smoking prevalance - routine and manual - current smokers	August	No
2.22iii Cumulative % of those aged 40-74 offered a healthcheck 2013/14 - 16/17	NA	Updates are published quarterly
2.22 iv Cumulative % of those offered a healthcheck who received a healthcheck 2013/14 - 16/17	NA	Updates are published quarterly
2.22 v Cumulative % of those aged 40-74 who received a healthcheck 2013/14 - 16/17	NA	Updates are published quarterly
1.18i/1l % of adult social care users with as much social contact as they would like	November	Local data but collected annually
1.18ii/1l % of adult carers with as much social contact as they would like	November	Local data but collected bi-annually
Placeholder - Loneliness and Social Isolation	NA	
2.15iii Successful treatment of alcohol treatment	NA	Updates are published quarterly
2.18 Admission episodes for alcohol related conditions (DSR per 100,000)	May	No
% pupils with social, emotional and mental health needs (primary, secondary and all schools)	August	No
4.16/2.6i Estimated diagnosis rate for people with dementia	August	Monthly
No. Dementia Friends (Local Indicator)	NA	Yes
Placeholder - ASCOF measure of post-diagnosis care	NA	
2.20iii Cancer screening coverage - bowel cancer	February	No.
2.20i Cancer screening coverage - breast cancer	February	No.
3.05ii Incidence of TB (three year average)	November	No.
4.10 Age-standardised mortality rate from suicide and injury of undetermined intent	November	No.

This page is intentionally left blank

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**Health and Wellbeing Board**		
REPORT TITLE:	**Developing a Berkshire West Shared Joint Health & Wellbeing Strategy**		
REPORT AUTHOR:	**Tessa Lindfield**	**TEL:**	**01344 352776**
JOB TITLE:	**Strategic Director of Public Health**	**E-MAIL:**	**Tessa.Lindfield@bracknell-forest.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This paper outlines the reasoning for a Joint Health & Wellbeing Strategy across Berkshire West and seeks support from the Reading (Health &) Wellbeing Board for a methodology to develop the strategy.

1.2 In April 2019 (Health &) Wellbeing Board Chairs from West Berkshire, Reading and Wokingham agreed to propose development of a Shared Joint Health & Wellbeing Strategy (JHWS) across the three Local Authorities. This move was supported by the CCG and ICS leadership. It was acknowledged that while a strategy would be shared, there would be room for local priority setting within it. There was an ambition that the strategy would also set the direction of travel for the Integrated Care Partnership

2. RECOMMENDED ACTION

2.1 ***The Board is asked to:***

a. Support the concept of a Shared JHWS
b. Agree the timeline for the strategy development
c. Agree to identify dedicated capacity for strategy development
d. Agree to delegate the development of the strategy to a Strategy Development Group

3. POLICY CONTEXT

3.1 The production of a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) are a joint statutory duty for Local Authorities and CCGs, discharged through the Health and Wellbeing Board. Once it is published, the organisations have a duty to have regard to the strategy in their own planning and service delivery.

3.2 The purpose of a JHWS is to set priorities for collective action to improve the health and wellbeing of the population; an important part of this is enabling commissioners to plan and commission integrated services that meet the needs of their whole local community.

3.3 The duty to produce a JHWS is shared between local government and the CCG. The three local authorities share one CCG and together form the geography for the Berkshire West Integrated Care Partnership, part of the Berkshire West, Oxfordshire and Buckinghamshire Integrated Care System. The authorities also have a range of NHS delivery services in common including the Royal Berkshire Hospital and Berkshire Healthcare Foundation Trust which delivers mental health and community health services.

3.4 Although each HWB is responsible for its own residents, there are some populations in common. Children are educated across borough boundaries and people travel to work, shop and socialise in different boroughs from where they live. Having a shared strategy will support a settings-based approach, to take health improvement to where people are - at work, at school and in places where they gather, such as parks and shopping centres.

3.5 There has been recent progress in integrating public services around the customer, for example coordinating health and social care interventions to get people home from hospital faster or directing early help to prevent people's health and wellbeing worsening. Integration has the potential to improve the efficacy of the service model and to improve efficiency for the customer and the delivery organisations. There is further benefit to be had from integration and embedding prevention in our integration work locally. Promotion of integration is a core duty of the HWB and because of our shared partners, will be facilitated by a shared strategy.

3.6 Building on this the governance of the integration work is being reformed with closer governance supporting the closer integration of local public services. A shared strategy supports this direction of travel and that expressed within the NHS Long Term Plan.

3.7 There are also efficiencies to be gained by working together as a Berkshire West group of Health and Wellbeing Boards as well as opportunities provided by the shared JSNA function supported by the Berkshire Shared Public Health Team.

3.8 Timelines mean that this is a good time to start developing a joint strategy - West Berkshire and Reading have strategies that run from 2017 to 2020 and Wokingham a strategy that runs from 2018 to 2021.

3.9 There is already synergy between the priorities identified in the existing Joint Health & Wellbeing Strategies for each borough and so it is likely that in developing a joint strategy it will be possible to identify shared priorities.

3.10 It is important to note, however, that each Health and Wellbeing Board will require an individual action plan consisting of both shared actions against these priorities as well as their local actions to meet local priorities.

4. THE PROPOSAL

4.1 The production of a shared JHWS will require a commitment to shared principles and an agreed process supported by some dedicated resource, either in the form of current staff's work plan or financial resource

4.2 The following principles are proposed:

- The overall aim of the strategy is to improve health and wellbeing for residents which include reducing health inequalities.
- The strategy is developed in close collaboration and consultation with residents and local partners, including the voluntary sector
- The strategy will set the direction for health and wellbeing partners working at the place level.
- The strategy will focus on areas where partnership action adds value.

- The strategy will have a shared direction and local priorities, which may vary from locality to locality.
- The priorities in the strategy will be based on need, supported by actions based on evidence of effectiveness

4.3 It is proposed that the production of the strategy is delegated to a Task & Finish Strategy Development Group operating under the terms of reference included at Appendix 2. The process and the group will be supported by a staff with dedicated capacity for developing the strategy.

4.4 The timescale for the development are set out in Appendix 1. The timescales set out would result in the publishing of the strategy in September 2020. It is acknowledged that this is an indicative timescale only and that there may need to be some flexibility agreed to allow for small changes to timings. It is proposed that the HWB is updated quarterly with the progress of the strategy development to ensure appropriate governance is in place.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 This proposal clearly contributes to Reading's HWB aims by developing a new joint strategy to inform the priorities of the board in the coming years

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 Engagement and consultation with the public is an intrinsic part of this proposal. This would occur in both the Strategy development phase (July to Dec 2019) and in the draft strategy consultation phase (Feb to April 2020). See Appendix 1. Engagement will need to include the breadth of stakeholder organisations relevant to Health and Wellbeing locally as well as with the residents across Berkshire West. The detail of how engagement and consultation will take place will be delegated to the Task & Finish Strategy Development Group who will work according to the principles listed in section 4 and the ToR (currently draft) in Appendix 2.

7. EQUALITY IMPACT ASSESSMENT

7.1 Not applicable

8. LEGAL IMPLICATIONS

8.1 The production of the Joint Health and Wellbeing Strategy (JHWS) are a joint statutory duty for Local Authorities and CCGs, discharged through the Health and Wellbeing Board. Once it is published, the organisations have a duty to have regard to the strategy in their own planning and service delivery.

9. FINANCIAL IMPLICATIONS

9.1 Identification of a small amount of resource to support development of the strategy. This could be financial or within work plan of existing officers.

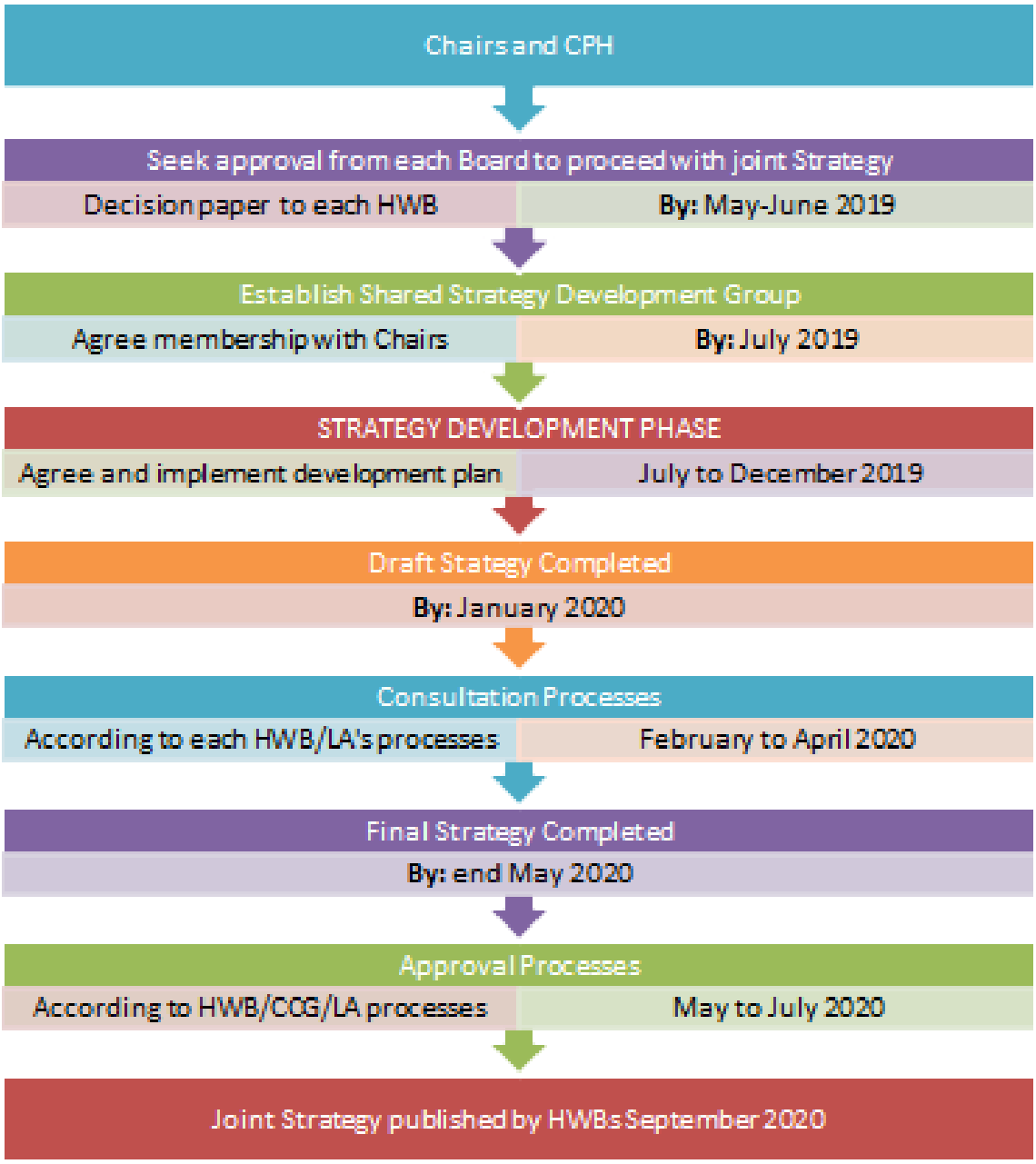
10. BACKGROUND PAPERS

10.1 Health and Social Care Act 2012

11. APPENDICIES

APPENDIX 1

Indicative timetable for development of a Shared Joint Health and Wellbeing Strategy



APPENDIX 2

BERKSHIRE WEST SHARED JOINT HEALTH & WELLBEING STRATEGY

STRATEGY DEVELOPMENT GROUP

TERMS OF REFERENCE

Purpose of the Group

This is a time limited group to produce the Shared Joint Health & Wellbeing Strategy across West Berkshire, Reading and Wokingham Local Authorities, the area covered by the Berkshire West Integrated Care Partnership.

Objectives

To produce the Shared JHWS by September 2020 in accordance with the following principles:

a. The overall aim of the strategy is to improve health and wellbeing for residents which includes reducing health inequalities.

b. The strategy is developed in close collaboration with residents and local partners.

c. The strategy will set the direction for health and wellbeing partners working at the place level.

d. The strategy will focus on areas where partnership action adds value.

e. The strategy will have a shared direction and local priorities, which may vary from locality to locality.

f. The priorities in the strategy will be based on need, supported by actions based on evidence of effectiveness.

g. The structure of the strategy will take inspiration from the Kings Fund's overlapping pillars of population health[1] as illustrated below, with inequalities a theme throughout.

To keep the (Health&) Wellbeing Boards and the ICP Delivery Board fully engaged in the process.

Ways of Working

To meet monthly, chaired by the Strategic Director of Public Health. Meeting agenda and papers to be sent in advance, minutes to be taken.

To provide regular reports to Health & Wellbeing Boards and the ICP Delivery Board.

Membership - TBC

[1] https://www.kingsfund.org.uk/sites/default/files/2018-11/A%20vision%20for%20population%20health%20online%20version.pdf

Strategic Director of Public Health
Consultants in Public Health, West Berks, Reading & Wokingham
Project Manager
CCG Director of Strategy
Healthwatch
Adult Social Care leads
Children's services representative

READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**12 July 2019**		
REPORT TITLE:	**Royal Berkshire Fire & Rescue Service - Membership of the Health and Wellbeing Board**		
REPORT AUTHOR:	**David Munday**	**TEL:**	**0118 937 4538**
JOB TITLE:	**Acting Consultant in Public Health**	**E-MAIL:**	**david.munday@reading.gov.uk**
ORGANISATION:	**Reading Borough Council**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To agree the following change to the membership and therefore terms of reference and powers and duties of the Reading Health & Wellbeing Board:

1) To co-opt a representative from Royal Berkshire Fire & Rescue Service as a non-voting additional member of the Health and Wellbeing Board.

1.2 The terms of reference and powers and duties and operational arrangements of the Board are set out at **Appendix A.** These have been updated in a number of places, to show the changes proposed above – the changed text is shown *in italics and highlighted*. If the changes are agreed, the terms of reference and powers and duties will be amended.

2. RECOMMENDED ACTION:

2.1 That a representative from Royal Berkshire Fire & Rescue Service be co-opted as a non-voting additional member of the Reading Health and Wellbeing Board;

2.2 That the relevant amendments to the terms of reference and powers and duties of the Health and Wellbeing Board be agreed;

2.3 That the representative from RBFRS be invited to give a presentation to the next meeting of the Board on the Service's Prevention Work.

3. POLICY CONTEXT

3.1 The Health and Social Care Act 2012 sets out the required membership for Health and Wellbeing Boards. The terms of reference and powers and duties of the Reading Health and Wellbeing Board have been set up since 2014 in line with these requirements and are approved each year at the Annual Council Meeting. They were last amended in March 2018, to co-opt representatives from Reading Voluntary Action and Thames Valley Police onto the Board, and in May 2019, along with other committees. to add responsibility for contributing to and adopting relevant parts of the Climate Change action plan (Minute 8 of the Health and Wellbeing Board on 13 March 2018 and Minute 9 of the Council on 22 May 2019 refer, respectively).

4. CHANGES TO MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

4.1 The Health and Wellbeing Board agreed its membership in 2014, in line with the requirements set out in the Health and Social Care Act 2012 (the Act). Section 194 (2) of the Act says that the Board will consist of, as well as specified representatives of the local authority and the local Healthwatch set out in (a) to (f):

(g) such other persons, or representatives of such other persons, as the local authority thinks appropriate.

4.2 On 16 March 2018, the Board agreed to co-opt a representative from Reading Voluntary Action (Sarah Morland) and a representative from Thames Valley Police's Reading Local Police Area (Stan Gilmour) as non-voting additional members of the Reading Health and Wellbeing Board.

4.3 Sam Mortimore, the Prevention Lead for Reading and West Berkshire from Royal Berkshire Fire & Rescue Service (RBFRS) has asked if Reading Health and Wellbeing Board would like to have a representative from RBFRS on the Board, in order to help RBFRS to assist partners in achieving their health and wellbeing goals and to promote the Prevention Service. Neil Carter, Group Manager Service Delivery West at RBFRS, is already a member of the West Berkshire Health and Wellbeing Board and Sam Mortimore is his substitute.

4.4 RBFRS is a key partner in the prevention work that can protect and improve people's health and wellbeing. The service has demonstrated its commitment to this agenda by engaging with other agencies to deliver home safety checks in an innovative way to incorporate healthy lifestyle messages and connect vulnerable residents into relevant support services. RBFRS has also partnered with others to promote mental wellbeing and address the health risks of loneliness. The service has invested in Making Every Contact Count (MECC) training for its staff to help embed a preventative approach to public health and wellbeing throughout the organisation.

4.5 Following discussions with the Chair and Vice-Chair, it is proposed that the Reading Health and Wellbeing Board co-opt a representative from RBFRS onto the Board membership, as a non-voting additional member, and that they be invited to give a presentation on the Service's Prevention work to the next meeting of the Board.

4.6 The Health and Social Care Act 2012 sets out that a Health and Wellbeing Board is a committee of the local authority which established it and, for the purposes of any enactment, is to be treated as if it were a committee appointed by that authority under section 102 of the Local Government Act 1972. It also states that, at any time after a Health and Wellbeing Board is established, a local authority must, before appointing another person to be a member of the Board under subsection (2)(g), consult the Health and Wellbeing Board.

4.7 If the Health and Wellbeing Board agrees the proposed change, the terms of reference and powers and duties of the Board will be updated and the relevant changes will be made where these are set out in Article 8 of the Constitution – Regulatory and Other Committees.

5. CONTRIBUTION TO READING'S HEALTH AND WELLBEING STRATEGIC AIMS

5.1 This proposal recommends changes to the membership of the Health and Wellbeing Board to strengthen the Board by allowing the Fire and Rescue Service to be more closely involved as part of the Board. This will assist the Board in its role of encouraging all partners in their delivery against the eight shared priorities set out in Reading's Health and Wellbeing Strategy 2017-20.

The Board's agreed priorities are:

1. Supporting people to make healthy lifestyle choices (with a focus on tooth decay, obesity, physical activity and smoking)

2. Reducing loneliness and social isolation
3. Promoting positive mental health and wellbeing in children and young people
4. Reducing deaths by suicide
5. Reducing the amount of alcohol people drink to safe levels
6. Making Reading a place where people can live well with dementia
7. Increasing breast and bowel screening and prevention services
8. Reducing the number of people with tuberculosis

5.2 These priorities are underpinned by three guiding principles which the Board has agreed ought to form part of the implementation plans for each strategic priority. These are:

a. Developing an integrated approach to recognising and supporting all carers
b. High quality co-ordinated information to support wellbeing
c. Safeguarding vulnerable adults and children

5.3 A Fire & Rescue Service voice on the Health and Wellbeing Board will strengthen the Board's ability to support people to make healthy lifestyle choices, and to reduce loneliness and social isolation, in particular, although the service's public engagement around wellbeing also puts it in a position to offer insights which could help deliver across all of the Board's priorities.

5.4 The proposal recognises that plans in support of Reading's 2017-20 Health and Wellbeing Strategy should be built on three foundations - safeguarding vulnerable adults and children, recognising and supporting all carers, and high quality co-ordinated information to support wellbeing. The proposal specifically addresses these by recognising the RBFRS role in identifying possible safeguarding risks, and in delivering information to support wellbeing.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 Not applicable.

7. EQUALITY IMPACT ASSESSMENT

7.1 This report has no decisions which require an Equality Impact Assessment.

8. LEGAL IMPLICATIONS

8.1 The Board is set up under Section 194 of the Health & Social Care Act 2012 (the 2012 Act). Under S194(11), the Board must be treated as if it were a committee appointed by the authority under S102 of the Local Government Act 1972. This is subject to the application of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (the 2013 Regulations), which have been issued under S114(12) of the 2012 Act.

8.2 The Board's powers and duties are those given to it by statute, primarily SS195-196 of the Health & Social Care Act 2012 and SS116 and 116A of the Local Government & Public Involvement in Health Act 2007 (as amended by the 2012 Act) (the 2007 Act).

9. FINANCIAL IMPLICATIONS

9.1 There are no financial implications arising from this report.

10. BACKGROUND PAPERS

Article 8 of Council Constitution – Para. 4 – Terms of reference and Powers and Duties of Health & Wellbeing Board

HEALTH AND WELL-BEING BOARD
TERMS OF RERERENCE AND OPERATIONAL ARRANGEMENTS
READING BOROUGH COUNCIL

This is set up under section 194 of the Health and Social Care Act 2012. Under section 194(11), the Board must be treated as a committee appointed by the authority under Section 102 of the Local Government Act 1972.

The profile of Reading Health Wellbeing Board
The Health and Well-being Board (HWB) aims to improve health and well-being for people in Reading. It is a partnership that brings together the Council, the NHS, the voluntary sector, the local Police, *the local Fire & Rescue Service* and the local Healthwatch organisation.

By working together on the delivery of national and local priorities, the Board's purpose is to make existing services more effective through influencing future joint commissioning and provision of services. The Board will be responsible for overseeing the production of a Joint Strategic Needs Assessment (JSNA) for Reading, and for developing a Health and Well-being Strategy and Delivery Plan as the basis for achieving these aims. The focus will be on reducing health inequalities, early intervention and prevention of poor health and promotion of health and well-being.

The Board is responsible to the Council and will reflect the need to promote health and well-being across health and Council departments, including housing, social care, schools, community services, environment, transport, planning, licensing, culture and leisure.

The Board will be expected to improve outcomes for residents, carers and the population through closer integration between health services and the Council. Stronger joint commissioning offers scope for more flexible, preventative and integrated services for children and adults with long-term conditions and those living in vulnerable circumstances.

The Joint Strategic Needs Assessment (JSNA) provides the framework for considering the wider determinants of health, including employment, education, housing and environmental factors that impact on the health and well-being of people in Reading. The JSNA will inform the development of the Health and Well-Being Strategy and Action Plan and alongside other intelligence, especially the views of local people, help define priorities for the strategy that in turn will influence commissioning priorities.

The powers and duties of the Board are set out in Article 8 of the Council's Constitution, and are attached as an appendix to this Terms of Reference. The Health & Wellbeing Board is a Committee of Reading Borough Council. It is subject to Article 8, and the Standing Orders for Council and Committees and the Access to Information Procedure Rules in Part 4, of the Council' Constitution. Subject to Standing Order 23, it has delegated authority from the Council to discharge the functions set out in the Appendix to these terms of reference.

ROLE AND PURPOSE OF THE BOARD:

The Health and Well-Being Board (H&WB) acts as the high-level strategic planning partnership to develop the provision of integrated health and social care services in Reading Borough. The H&WB for Reading is established to oversee the health improvement and well-being of those who live and work in the Borough.

1. To identify key priorities for health and local government commissioning and develop clear plans for how commissioners can make best use of their combined resources to improve local health and well-being outcomes

2. To provide the collective leadership to improve health and well being across the local authority area, enable shared decision making and ownership of decisions in an open and transparent way
3. To achieve democratic legitimacy and accountability, and empower local people to take part in decision-making
4. To address health inequalities by ensuring quality, consistency and comprehensive health and local government services are commissioned and delivered in the local area.

KEY FUNCTIONS

1. Ensure the preparation and publication of a JSNA for the area.

2. Develop an action plan to deliver the health and well-being strategy with clear priorities, objectives for delivery and measurable milestones.

3. Support the participation of the community and voluntary sectors, and other non-statutory agencies in the delivery of health and social care outcomes as a shared endeavour.

4. Ensure health & social care improvement in Reading is developed within the context of Best Practice and Clinical Governance.

5. Establish time limited working groups to assist it to deliver any of its key responsibilities.

6. Work with key providers to provide strategic 'problem solving' to unlock potential, resources or improved practice

7. Co-ordinate work with neighbouring H&WBs where appropriate to ensure effective commissioning decisions that deliver value for money in support of improved outcomes.

TIMING AND MEETINGS

The Board will, as a minimum, meet four times a year and may meet more often if the Board so decides.

The Board is subject to the access to information provisions of Section 100A of the Local Government Act 1972. It is committed to the principles of transparency and all meetings will be open to the public.

In order to accommodate confidential and exempt matters, particularly regarding commercially sensitive issues linked to commissioning and providers, the Board will hold two-part meetings with such matters being considered in Part 2 (without the press and public present) as necessary. The Council's Access to Information Procedure Rules will apply, to ensure that the principles of transparency remain central to these arrangements.

Agendas and papers for Board meetings will be made public no less than 5 working days prior to the date of the meeting.

Quorum

The quorum of the board will be no fewer than three of its voting membership; if fewer voting Members than this attend, then the meeting will be deemed inquorate.

Decision Making

Decisions at meetings will be achieved by consensus of those present. If a vote is required then, if there is an equal number of votes for than against the proposal, the Chair will have a second, casting vote.

MEMBERSHIP

The Council may co-opt additional persons or representatives to be members of the Board as it thinks appropriate, either as voting or non-voting Members, subject to the Council consulting beforehand with the Board.

The membership of the Board, under Section194(2) of the Health & Social Care Act 2012, is as follows:

- 4 Councillors – ie the Leader of the Council, and the Lead Councillors for Health, Wellbeing & Sport, Adult Social Care, and Children (the Act requires at least 1 Councillor to be on the Board)
- The Director of Adult Social Care & Health *
- The Director of Children's Services *
- Director of Public Health for the Local Authority or his/her representative *
- Two representatives from the Berkshire West Clinical Commissioning Group (CCG) (the Act requires a representative of each relevant CCG)
- A representative from the Local Healthwatch organisation

(* the Members asterisked will not have voting rights, as explained below)

Voting rights
Under the provision of Regulations 6 and 7 of the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013, the Council, following consultation with the shadow Health & Wellbeing Board, has decided as follows:

- To disapply the duty to allocate seats to political groups under Sections 15 and 16 of the Local Government & Housing Act 1989

- To treat the following as non-voting members of the Board:
    - The Director of Adult Social Care & Health (or his/her representative)
    - The Director of Children's Services (or his/her representative)
    - The Director of Public Health (or his/her representative)

The voting membership of the Board must be named by the body they are representing. It will therefore be as follows:

- 4 Councillors by relevant office, ie the Leader of the Council, and the Lead Councillors for Health, Wellbeing & Sport, Adult Social Care, and Children
- 1 named Local Healthwatch representative
- 2 named local CCG representatives

The bodies appointing voting Members to the Board may, in addition, appoint named substitute Members who may attend as voting Members in the place of their named Member.

Voting Members will be subject to the Council's local Member Code of Conduct, and will be required, under the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012 to register with the Monitoring Officer, and to declare at meetings, any disclosable pecuniary interest that both they and/or their spouse/partner has in the business of the Board.

Co-opted Members

The following will be co-opted as non-voting additional members:

- The Chief Executive of Reading Borough Council (or his/her representative)
- A representative from Reading Voluntary Action
- A representative from Thames Valley Police's Reading Local Police Area
- *A representative from Royal Berkshire Fire & Rescue Service*

Observers

The following observers may attend and participate but not vote at Board meetings:

Chair - Local Safeguarding Adults Board
Chair - Local Safeguarding Children Board

One relevant shadow Lead Councillor for each opposition group on the Council (up to three in total).

A named representative of NHS England will join the Board to help in the preparation of the Joint Strategic Needs Assessment or Joint Health and Well-being Strategy.

CHAIR

The Lead Councillor for Health, Wellbeing & Sport will chair the Board.

VICE-CHAIR

A Clinical Commissioning Group member of the Health and Wellbeing Board will be Vice-Chair.

ACTIONS TO BE TAKEN BY MEMBERS OF THE BOARD

The Board is a decision-making body of the Council. Therefore the voting Members from other organisations must have authority from the bodies that they represent to make decisions at Board meetings. Accountability should be clear, without superseding the responsibilities of any participating agency. Board Members attending any working group should have the delegated authority to commit the body they represent to specific courses of action, including committing resources.

As a Statutory Board of Reading Borough Council the H&WB may report to Council as appropriate including recommending the Health and Wellbeing Strategy for approval and support the alignment of the Council's plans with the priorities identified in the Health and Well-being Strategy and Action Plan.

GP Clinical Commissioning Groups will consult with the H&WB when drawing up their own annual plans.

The H&WB will include a statement in CCG's plans confirming whether or not the plans align with the JSNA and the priorities identified in the Health and Well-being Strategy and Action Plan.

The Board should receive the input and information it needs from partner bodies to support effective prioritisation and strategic decision making.

Members of the Board will hold themselves and partners to account for the delivery of agreed outcomes as set out in the action plan.

The Board will inform local commissioners of key decisions that may impact on the provision of services.

Appendix

The Powers and Duties of the Health and Wellbeing Board were agreed at the Council's Annual General Meeting on 22 May 2019 *(without the highlighted & italicised amendment now proposed)*.

Powers and duties of the Health and Well Being Board

This is set up under Section 194 of the Health & Social Care Act 2012. Under Section 194(11), the Board must be treated as a committee appointed by the authority under Section 102 of the Local Government Act 1972.

(1) To discharge the functions of the Health & Wellbeing Boards as set out in Sections 195-196 of the 2012 Act, ie:

- Duty to encourage integrated working in health and social care under the National Health Service Act 2006
- Power to encourage closer working in relation to wider determinants of health
- Power to give its opinion to the authority on whether the authority is discharging its duty to have regard to the Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy for its area
- Duty to provide an opinion – to its partner clinical commissioning groups CCGs and/or the NHS Commissioning Board - about whether the local commissioning plans have taken proper regard of the Joint Health & Wellbeing Strategy

(2) To discharge any other health functions delegated to it by the authority.

(3) To ensure that the authority meets its duties as a relevant authority, under Section 116 of the Local Government & Public Involvement in Health Act 2007 ("the 2007 Act"), as amended by Sections 192 and 193 of the Health & Social Care Act 2012:

(a) to prepare, with its partner CCGs, and publish a Joint Strategic Needs Assessment for the area, involving the local Healthwatch and local people living or working in the area;

(b) to prepare, with its partner CCGs, and publish a Joint Health & Wellbeing Strategy to meet the health needs of the area included in the Joint Strategic Needs assessment, relating to the exercise of public health functions by the authority, the NHS Commissioning Board or the CCGs, involving the local Healthwatch and local people living or working in the area;

(c) to ensure that the local authority, and its partner CCGs, have regard to these documents.

(4) To promote health care, health improvement and the reduction of health inequalities for all local people, including children and vulnerable adults, and to exercise the following statutory duties on behalf of the authority:

(a) To improve the health of people in its area under Section 28 of the National Health Service Act 2006, including:

- any public health functions of the Secretary of State which s/he requires local authorities to discharge on his/her behalf
- dental health functions of the Council
- the duty to co-operate with the prison service to secure and maintain the health of prisoners
- the Council's duties set out in Schedule 1 of the National Health Service Act 2006, which include medical inspection of pupils, the weighing and measuring of children and sexual health services

- arrangements for assessing the risks posed by violent and sexual offenders

(b) To improve public health under Sections 2B and 111 of the National Health Act 2006 (as amended by Section 12 of the Health & Social Care Act 2012), including:

(i) under Section 2B(3):
- Providing information and advice
- Providing services or facilities designed to promote healthy living (including helping individuals address behaviour that is detrimental to health or in any other way)
- Providing services for the prevention, diagnosis or treatment of illness
- Providing financial incentives to encourage individuals to adopt healthier lifestyles
- Providing assistance (including financial) to help individuals minimise any risks to health arising from their accommodation or environment
- Providing or participating in the provision of training for persons working or seeking to work in the field of health improvement
- Making available the services of any person or any facilities

(ii) Under Section 2B(4), providing grants or loans on such terms as the local authority considers appropriate.

(iii) Under Section 111 and Schedule 1:
- Dental public health (S111)
- Medical inspection of pupils (Paras 1-7B)
- Research for any purpose connected with the exercise of the authority's health functions (Para 13)

(5) To discharge health and social care functions identified by the Government and/or the National Health Service for exercise by the Board, including the integration of health and social care functions within Reading;

(6) To approve and publish a Pharmaceutical Needs Assessment for Reading

(7) To oversee and implement the following joint arrangement and partnerships in which the authority is involved:
- Berkshire Public Health Joint Arrangement
- Berkshire Public Health Joint Advisory Board

(8) To make representations to the Adult Social Care, Children's Services and Education Committee as the authority's health scrutiny committee.

(9) Climate Change Strategy - To contribute to and adopt the relevant parts of the Climate Change action plan

Membership

The Council may co-opt additional persons or representatives to be members of the Board as it thinks appropriate, either as voting or non-voting Members, subject to the Council consulting beforehand with the Board.

The membership of the Board, under Section194(2) of the Health & Social Care Act 2012, is as follows:

- 4 Councillors – ie the Leader of the Council, and the Lead Councillors for Health, Wellbeing & Sport, Adult Social Care and Children(the Act requires at least 1 Councillor to be on the Board)
- The Director of Adult Social Care & Health *

- The Director of Children's Services *
- Director of Public Health for the Local Authority or his/her representative *
- Two representatives from the Berkshire West Clinical Commissioning Group (CCG) (the Act requires a representative of each relevant CCG)
- A representative from the Local Healthwatch organisation

(* the Members asterisked will not have voting rights, as explained below)

Voting rights

Under the provision of Regulations 6 and 7 of the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013, the Council, following consultation with the shadow Health & Wellbeing Board, has decided as follows:

- To disapply the duty to allocate seats to political groups under Sections 15 and 16 of the Local Government & Housing Act 1989

- To treat the following as non-voting members of the Board:
    - The Director of Adult Social Care & Health (or his/her representative)
    - The Director of Children's Services (or his/her representative)
    - The Director of Public Health (or his/her representative)

The voting membership of the Board must be named by the body they are representing. It will therefore be as follows:

- 4 Councillors by relevant office, ie the Leader of the Council, and the Lead Councillors for Health, Wellbeing & Sport, Adult Social Care, and Children
- 1 named Local Healthwatch representative
- 2 named local CCG representatives

The bodies appointing voting Members to the Board may, in addition, appoint named substitute Members who may attend as voting Members in the place of their named Member.

Voting Members will be subject to the Council's local Member Code of Conduct, and will be required, under the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012 to register with the Monitoring Officer, and to declare at meetings, any disclosable pecuniary interest that both they and/or their spouse/partner has in the business of the Board.

Co-opted Members

The following will be co-opted as non-voting additional members:

- The Chief Executive of Reading Borough Council (or his/her representative)
- A representative of Reading Voluntary Action
- A representative from Thames Valley Police's Reading Local Police Area
- *A representative from Royal Berkshire Fire & Rescue Service*

Observers

The following observers may attend and participate but not vote at Board meetings:

Chair - Local Safeguarding Adults Board
Chair - Local Safeguarding Children Board

One relevant shadow Lead Councillor for each opposition group on the Council (up to three in total).

A named representative of NHS England will join the Board to help in the preparation of the Joint Strategic Needs Assessment or Joint Health and Well-being Strategy.

This page is intentionally left blank