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Health and Wellbeing Board

Thursday 30 May 2019 at 9.30am

in Council Chamber Council Offices
Market Street Newbury

Please note that a test of the fire and lockdown alarms will take place at 10am. If the alarm does not stop please follow instructions from officers.

Date of despatch of Agenda: Wednesday, 22 May 2019

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jo Reeves / Jessica Bailiss on (01635) 519486/503124
e-mail: joanna.reeves@westberks.gov.uk / jessica.bailiss@westberks.gov.uk

Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire Health & Wellbeing Board

West Berkshire Council

To: Councillor Rick Jones, Dr Bal Bahia (Berkshire West CCG), Andy Sharp (Executive Director (People)), Councillor Lynne Doherty, Councillor Dominic Boeck, Councillor Graham Bridgman, Andrew Sharp (Healthwatch), Tessa Lindfield (Strategic Director for Public Health), Cathy Winfield (Berkshire West CCG), Superintendent Jim Weems (Thames Valley Police), Ian Mundy (Locality Director, BHFT), Mary Sherry (Chief Operating Officer, Royal Berkshire Hospital), Neil Carter (Group Manager - RBFRS), Luke Bingham (Divisional Director - Sovereign Housing), Garry Poulson (Volunteer Centre West Berkshire), Councillor Owen Jeffery and Councillor Steve Masters

Agenda

Part I

Page No.

1 **Election of the Chairman and Appointment of the Vice-Chairman for the 2019/20 Municipal Year**
To elect the Chairman and appoint the Vice-Chairman for the 2019/20 Municipal Year.

2 **Apologies for Absence**
To receive apologies for inability to attend the meeting (if any).

3 **Minutes** 5 - 12
To approve as a correct record the Minutes of the meeting of the Board held on 24 January 2019.

4 **Health and Wellbeing Board Forward Plan** 13 - 14
An opportunity for Board Members to suggest items to go on to the Forward Plan.

5 **Actions arising from previous meeting(s)** 15 - 16
To consider outstanding actions from previous meeting(s).

6 **Declarations of Interest**
To remind Members of the need to record the existence and nature of any personal, disclosable pecuniary or other registrable interests in items on the agenda, in accordance with the Members' Code of Conduct.

7 **Public Questions**
Members of the Executive to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution.

a **Question submitted by Mrs Aimee Thomas to the Executive Member for Health and Wellbeing**

"When will West Berks start to focus on improving oral health in children and adults, educating them about the importance of good oral health and preventing dental disease?"

8 **Petitions**

Councillors or Members of the public may present any petition which they have received. These will normally be referred to the appropriate Committee without discussion.

Items for discussion

Programme Management

9 **Update on Priority Two (Employment for Vulnerable People) for 2018/19** 17 - 18

To receive an update of progress made regarding Priority Two (Employment for Vulnerable People) for 2018/19.

Strategic Matters

10 **Healthwatch Voice Of Disability Report** 19 - 60

To report the feedback from the Voice of Disability consultation event held in November 2018 and update the Board on partners' responses to the recommendations identified in the report.

11 **Proposed Creation of Integrated Care Partnership** 61 - 130

To announce the launch of the Integrated Care Partnership.

Operational Matters

12 **Feedback from the Annual Health and Wellbeing Conference** 131 - 140

To share the outcomes of the conference with the Board.

13 **Health and Wellbeing Board Membership** 141 - 144

To make some amendments to the membership of the Health and Wellbeing Board.

Other Information not for discussion

14 **ICS Operational Plan 2019/10** 145 - 204
To ensure that the Operational Plan aligns with the aims of the Health and Wellbeing Board.

15 **Members' Question(s)**
Members of the Executive to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution.

16 **Future meeting dates**
The next public meeting of the Health and Wellbeing Board will be held on 4 October 2019.

Sarah Clarke
Head of Legal and Strategic Support

If you require this information in a different format or translation, please contact Moira Fraser on telephone (01635) 519045.

DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 24 JANUARY 2019

Present: Councillor Rick Jones (Executive Portfolio: Health and Wellbeing, Leisure and Culture), Dr Bal Bahia (Berkshire West CCG), Councillor Graham Jones (Leader of the Council), Councillor Lynne Doherty (Executive Portfolio: Children, Education & Young People), Tessa Lindfield (Strategic Director for Public Health), Cathy Winfield (Berkshire West CCG), Councillor Mollie Lock (Shadow Executive Portfolio: Education and Young People, Adult Social Care), Superintendent Jim Weems (Thames Valley Police), Ian Mundy (Locality Director, BHFT), Garry Poulson (Volunteer Centre West Berkshire) and Andrew Sharp (Healthwatch)

Also Present: Matthew Pearce (Head of Public Health and Wellbeing), Jo Reeves (Principal Policy Officer), Councillor Quentin Webb (Council Member), Tessa Ford (School Improvement Advisor), Sally Kelsall (Housing Strategy and Operations Manager) and Barry Stormont (Operations Manager Emotional Health Academy)

Apologies for inability to attend the meeting: Councillor Graham Bridgman, Councillor Richard Somner, Mary Sherry, Neil Carter and Luke Bingham

PART I

29 Minutes

The Minutes of the meeting held on 4 October 2018 were approved as a true and correct record and signed by the Leader.

30 Health and Wellbeing Board Forward Plan

The Forward Plan was noted.

31 Actions arising from previous meeting(s)

The list of actions arising from previous meetings was noted and updated as appropriate.

32 Declarations of Interest

Dr Bal Bahia declared an interest in all matters pertaining to Primary Care, by virtue of the fact that he was a General Practitioner, but reported that as his interest was personal and not a disclosable pecuniary or other registrable interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

Andrew Sharp declared an interest in any items that might refer to South Central Ambulance Service due to the fact that he was the Chair of Trustees of the West Berks Rapid Response Cars (WBRRC), a local charity that supplied blue light cars for ambulance drivers to use in their spare time to help SCAS respond with 999 calls in West Berkshire, and reported that, as his interest was personal and not a disclosable pecuniary or other registrable interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

Councillor Graham Jones declared an interest by virtue of the fact he was a pharmacy contractor, and reported that as his interest was personal and a disclosable pecuniary or

other registrable interest, he would leave the meeting during any discussion which might arise relating to pharmacy provision.

33 Public Questions

There were no public questions submitted.

34 Petitions

There were no petitions presented to the Board.

35 Delivering the Health and Wellbeing Strategy Q2 2018/19

The Board considered a report (Agenda Item 8) regarding progress made by the Health and Wellbeing Board's sub-groups at quarter two of 2018/19 to deliver the Health and Wellbeing Strategy. Jo Reeves particularly drew members' attention to section 6 of the summary report which stated:

(1) The Mental Health Action Group (MHAG) agreed its desired scope for the 'crisis review', but had not been clear how this review would be resourced. In Q3 the CCG made a commitment to undertake a coproduced review of the crisis care pathway.

(2) Performance relating to Delayed Transfers of Care was showing as 'green' for quarters one and two of 2018/19. It was likely, however, that performance would not be sustained into quarter three as actions were taken to mitigate the forecast overspend in the Council's Adult Social Care budget and health-attributable delays also increased.

(3) The Health and Wellbeing Steering Group had allocated £11,185 from the Health and Wellbeing Priority Fund. The remaining balance of the Fund was £84,815.

Andrew Sharp wished to record his thanks to Katrina Anderson and Rabia Alexander from the Clinical Commissioning Group (CCG) for attending the MHAG. A productive discussion had been held and it was clear that they understood the challenges in mental health services. Andrew Sharp added that the MHAG needed to consider its approach to public engagement and expressed concern that without future Thinking Together events the connection with service users might be lost. The CCG had committed to undertake a review of the crisis care pathway and Andrew Sharp expressed the view this should include both lower and higher levels of crisis. It should be aligned to a review of assets in the voluntary sector and ensure gaps were identified.

Ian Mundy advised that the CCG had recognised a system wide review of mental health crisis care was required. Cathy Winfield endorsed this viewpoint because too often people thought only of the Berkshire Healthcare Foundation Trust service when a broader approach was needed.

Councillor Lynne Doherty sought reassurance that the Board had robust processes in place to ensure that sub-groups updated their performance indicators and provided their data. Dr Bal Bahia advised that the Chairman had met one to one with sub-group chairs to help to hone down on what their groups were trying to achieve and present this information in a way which would be useful for the Board. There was a range of softer benefits which had been achieved. Councillor Rick Jones endorsed this viewpoint and noted that only a few groups did not have completed datasets; this was mainly due to personnel changes.

Andrew Sharp noted that in some instances it had been difficult to identify chairs for the Board's sub-groups. He thanked Matthew Braovac, the outgoing independent chair of the MHAG for his service over 2018.

RESOLVED that the Board noted the report.

36 Update on Priority One (Mental Health) for 2018/19

The Board considered a report (Agenda Item 9) regarding the update from the Mental Health Action Group (MHAG) on their work around the Board's annual priority for 2018/19 to 'promote positive mental health and wellbeing for adults'.

Councillor Rick Jones noted that as Matthew Braovac had stepped down as the Chair of the MHAG, he had asked Matt Pearce to take on the role in the interim.

In addition to the information contained in the report, Matt Pearce explained that the MHAG was in the process of formalising activity into project plans for its four workstreams:

- Celebrate, promote and connect existing resources especially those who provide Community Navigation and Peer Support
- Exploring the introduction of a digital community resource directory for prevention, recovery and self-care
- Investigating preventable deaths from physical health conditions of people with serious mental illness
- Work with users and BHFT to co-produce improvements to patients experience when in crisis

The MHAG had successfully bid for the Board's Priority Fund to support Eight Bells for Mental Health and Open for Hope, two peer support organisations. Work would be undertaken to clarify key performance indicators.

Matt Pearce also explained that the NHS Long Term Plan had many implications for mental health including smoking cessation support, psychological therapies and perinatal mental health.

Cathy Winfield noted the recent headlines regarding the impact of social media and mental health; she warned that the Emotional Wellbeing website, referred to on page 33 of the agenda, should be appropriately moderated.

Councillor Graham Jones sought more information on what measures of success the MHAG would be using. Matt Pearce advised that initially, outcome measures would be used for the projects which received funding but he was conscious that impact and not just activity should be recorded.

Tandra Forster asked whether the group had the capacity to take a formal project approach. Matt Pearce advised that it did, so long as effort was shared across the system.

Councillor Lynne Doherty enquired how the MHAG's activities would dovetail with mental health services for children. Matt Pearce noted that a common query arose at the Board regarding relationships between the sub-groups and that had yet to be resolved.

Tessa Lindfield praised the group's exciting work and asked whether the MHAG needed anything from the Board in order to help establish links across the system. Andrew Sharp suggested that it would be helpful to look at key metrics across the system such as mental health admissions. Jo Reeves reminded members that the Board formerly had a system resilience dashboard which included those kinds of indicators but the Board had decided that there was sufficient oversight on those in other parts of the system. It had therefore decided to focus on monitoring the performance of its own programme. Cathy Winfield suggested that the best approach would be to track inputs while keeping an eye on the outputs. She was also optimistic that the new population health management programme would support the production of live data. Dr Bahia noted that the Board's

Steering Group had a role to make links between different work areas and Board members had a role to deal with any blockages in the system.

Councillor Marigold Jacques asked how the MHAG worked with the community; Matt Pearce noted that there was a lot of input from the voluntary sector into the work of the group.

Councillor Rick Jones thanked everyone for the wide ranging inputs into the conversation which included some immediate and some strategic matters which would be considered as preparations for the next Health and Wellbeing Strategy commenced.

RESOLVED that the report be noted.

37 West Berkshire Vision 2036

The Board considered a report (Agenda Item 10) which presented the final version of West Berkshire Vision 2036 for the Board's approval.

Councillor Rick Jones advised that this document was not just a Council document but was to be shared and owned jointly between the partners of the Board. While the Strategy covered a four year period, this Vision took a longer term approach to considering the challenges and aspirations for West Berkshire. Amendments had been made to the draft based on the feedback received through the public consultation.

Andrew Sharp hoped that this was a living document and would be regularly monitored and refreshed. Councillor Rick Jones stated that while there was no detailed plan around the document, he hoped that it would be reviewed annually to ensure that the aspirations were still appropriate. Members supported reviewing the Vision annually.

Cathy Winfield highlighted that it would be useful for the CCGs if West Berkshire joined together with Reading and Wokingham in respect of their Health and Wellbeing Strategies.

RESOLVED that the West Berkshire Vision 2036 be approved and reviewed annually.

38 Homelessness Strategy Group Winter Plan Update

The Board considered a report (Agenda Item 11) which provided an update on the implementation of the Homelessness Strategy Group's (HSG) Winter Action Plan.

Councillor Rick Jones thanked Sam Headland for her time chairing the group and wished her well with her new job. The HSG would appoint a new chair at their next meeting.

Matt Pearce noted that the Winter Action Plan was agreed by the Board in October 2018 and some funding had been received from the government through the Rough Sleepers Initiative grant.

Sally Kelsall advised that the Council had commissioned winter provision from Two Saints to ensure that any individual with a local connection to West Berkshire at risk of rough sleeping between 1st November 2018 and 31st March 2019 could have access to shelter and daytime activities. The plan also included promotion of Streetlink, health and dental drop-in services and a dual-diagnosis worker. A 'make it happen' and a 'move on' fund had been established to enable people to move through Two Saints to independent accommodation and employment. The Homelessness Strategy Group meeting the following week would consider the Rough Sleeper Strategy.

Councillor Doherty stated that it was good to see the amount of work ongoing and asked for clarity regarding the official number of rough sleepers. Sally Kelsall advised that in November 2018 the official count was undertaken according to the government's prescribed methodology. In 2017 there were 20 rough sleepers, prior to the official count the number of known rough sleepers was 29 and in November 2018 the figure was 19.

As of January 2019, there were 15 rough sleepers. The Housing Service had worked hard to enable people to move through supported accommodation and the Homelessness Reduction Act had extended the Council's powers to offer discretionary accommodation. West Berkshire Homeless had also accommodated people in halfway houses. Rough sleeper numbers fluctuated daily.

Tandra Forster enquired whether rough sleepers who were offered accommodation would be able to sustain their tenancies. Sally Kelsall advised that it would depend on the individual's support needs. The Housing First project sought to offer accommodation first and then put support in place to enable people with complex needs to sustain their tenancies. The project was funded for 18 months so the Housing Service was looking at the longer term sustainability of the project.

Andrew Sharp stated that he disagreed with the November 2018 official number of rough sleepers and expressed the view that the methodology was deeply flawed. Sally Kelsall advised that the Council also hosted the Rough Sleepers Task and Targeting Group which monitored individuals known to be, or have a history of, rough sleeping. Tessa Lindfield noted that the official government figure was to enable comparison between local authorities.

Councillor Quentin Webb asked whether data regarding the length of time an individual slept rough was analysed. Sally Kelsall confirmed that this information was tracked.

Andrew Sharp commented that considerable progress had been made in comparison to the situation the previous year. He noted that the temperature was -4C the previous night and local knowledge suggested 13 people slept outside. He expressed disappointment that joint working was good until disagreements over alternative accommodation arose. Sally Kelsall responded that in accordance with the Winter Plan, the Council had commissioned 25 additional places over winter, plus bed and breakfast accommodation so there was capacity to accommodate anyone still sleeping rough.

Andrew Sharp advised that a draft version of the plan had made reference to an overspill facility and as it had not been realised it was removed before the plan was presented to the Board in October 2018. In November 2018, an overspill facility was identified. The Homelessness Strategy Group had always known that there would be a small number of people who would never accept accommodation at Two Saints. Andrew Sharp also requested a breakdown of the Rough Sleepers Initiative spending and challenged that none had gone towards voluntary groups who supported rough sleepers. He stated that the number of rough sleepers should be agreed with local charities. Andrew Sharp suggested that the Health and Wellbeing Board should consider what lessons it could learn from how statutory partners worked with the voluntary and community sector. Councillor Rick Jones advised that Andrew Sharp was correct to raise his concerns but would like the Homelessness Strategy Group to discuss these at their next meeting before Board members got involved.

Councillor Graham Jones noted that rough sleepers were a hard to reach group and while there was capacity to accommodate them, people were entitled to make their own choices. He asked how this situation could be resolved. Sally Kelsall advised that the Rough Sleeping Strategy would outline a person centred approach and acknowledge that solutions could not take a one size fits all approach. It was likely that there would be small number of people who would choose not to engage with any offers of support and accommodation.

Tessa Lindfield praised the impressive reduction in the number of rough sleepers that had been achieved and asked how evidence of best practice was being used to inform decision making. Sally Kelsall advised that 33 Councils had benefitted from the Rough

Sleepers Initiative funding and regular meetings were held with the other local authorities. The Housing Minister also made recommendations and the South East Public Health England team had supported the development of a longer term homelessness strategy.

Andrew Sharp noted that in the longer term, there was an opportunity to establish a health and wellbeing hub. The Homelessness Strategy Group should also look into hospital discharge arrangements for homeless people. Cathy Winfield advised that practice at the Royal Berkshire Hospital was good but other hospitals used by West Berkshire patients could be an area for improvement.

RESOLVED that the report be noted.

39 Educational Attainment of Children from Vulnerable Families

The Board considered a report (Agenda Item 12) regarding the 'red' performance for the action "to improve on 2015/16 Academic Year rankings for reading, writing and maths combined expected standard for disadvantaged pupils in KS2 in 2016/17 Academic Year."

Tessa Ford introduced the report which explained the reasons for the disappointing levels of performance, challenges around the definitions for 'disadvantaged pupils' and action being undertaken by Family Hubs, School Improvement and Public Health services to drive improved outcomes.

Councillor Mollie Lock noted that a school's rurality often made the provision of facilities more difficult. Registration for free school meals status was also challenging as this was a universal service until Key Stage 2. Tessa Ford advised that schools worked hard to encourage parents to take up Free School Meals status.

Councillor Mollie Lock expressed the view that the Family Hubs were not as effective as Children's Centres had been in ensuring early identification of issues, particularly in rural areas such as Lambourn.

Councillor Lynne Doherty thanked Tessa Ford for the detailed report and confirmed that improving educational attainment for disadvantaged children was a Council priority. She reported that Family Hubs were reaching more vulnerable families than Children's Centres had before them and ensured that there was coverage in rural areas. She was pleased to see alignment of activity to the wider determinants of health and noted that system working would be key to achieving success. While there had been positive progress at KS1 and KS4, West Berkshire was behind at KS2 despite efforts to make improvements. She thanked the Council's officers, head teachers and school staff for their hard work. Councillor Doherty asked the Board how they as system leaders might help a wider change to be achieved as 3000 children's social mobility was limited.

Andrew Sharp noted that CAMHS waiting times were an issue. Councillor Doherty noted that a larger proportion of West Berkshire's disadvantaged children had special educational needs (SEN), however support was provided when a need was identified, before a diagnosis was made. The Children's Delivery Group could consider how a whole family approach could be taken.

Cathy Winfield suggested that more links to the integrated health visiting service could be made.

Councillor Doherty noted that although the majority of children in West Berkshire achieved good outcomes, more focus was required on educational attainment and she hoped the Children's Delivery Group would prioritise this in future.

RESOLVED that the report be noted.

40 Future in Mind: Local Transformation Plan Refresh

The Board considered a report (Agenda Item 13) which sought approval of the Future in Mind Local Transformation Plan which was refreshed in October 2018.

Barry Stormont presented the report which outlined areas of strength and areas of challenge and development. He highlighted that West Berkshire had been successful in being selected alongside Berkshire West Clinical Commissioning Group (CCG), Reading Borough Council and Berkshire Healthcare NHS Foundation Trust to run a project to transform children's mental health.

Councillor Lynne Doherty supported the recommendation to approve the refreshed plan and was pleased to see the amount of work being undertaken, although she wished that it was not required. She referred to recent headlines regarding the use of social media by children and stated that legislative controls were required to safeguard children and young people. Participation in the national pilot for a mental health support team was testimony to the innovative work already being undertaken in West Berkshire. Garry Poulson supported the point about social media.

Councillor Mollie Lock advised that she had seen headlines that elsewhere in the country there was a problem at Key Stage One regarding children's violent behaviour; Barry Stormont advised that this was not a known problem in West Berkshire.

Andrew Sharp hoped that children's mental health would be considered as a priority for the Health and Wellbeing Board the following year.

Councillor Quentin Webb enquired upon the methodology used to select schools to participate in the trailblazer pilot. Barry Stormont advised that schools would be selected in order to compare and contrast results with schools involved in Reading's pilot.

RESOLVED that the report be noted.

41 Delayed Transfers of Care in Berkshire West: Report from the LGA Peer Review

The Board considered a report (Agenda Item 14) which set out the findings of the Local Government Association (LGA) Review into Delayed Transfers of Care and to update on current progress with implementing the recommendations.

Tandra Forster reported that the LGA had helped West Berkshire, Reading and Wokingham to identify ways in which they could collaborate, rather than compete, with each other. It had also helped that the previous year's target had been identified as incorrect. Consistent improvement had been seen as a result of implementing the recommendations made by the LGA including in the care market.

Councillor Quentin Webb noted that the Council's Overview and Scrutiny Management Commission had investigated performance around delayed transfers of care and was pleased to see that the problem had been identified as broader than just West Berkshire's actions. He was impressed that the solution was a more collaborative approach.

Ian Mundy noted that weekly hour long meetings were held between the local authorities and hospitals to 'sign-off' the delays. It ensured that system leaders had direct oversight.

In response to a question from Councillor Mollie Lock, Tandra Forster confirmed that the Council had a link worker at the Royal Berkshire Hospital in Reading and other hospitals used by West Berkshire patients.

Councillor Marigold Jacques enquired about seven day working in care homes. Tandra Forster confirmed that while patients were discharged at weekends it was an area of development for all partners.

Andrew Sharp noted the workforce challenges, market pressures and demographic pressures. He queried whether the Health and Wellbeing Board should look into capacity.

Councillor Rick Jones recognised that workforce issues were highlighted in the West Berkshire Vision 2036 and stated that as a system wide response was required, not everything was in the scope of the Board. He praised the DTOC work as a great example of collaborative working and asked what factors would determine continued performance improvements. Tandra Forster advised that the care market was still the primary challenge rather than timely patient assessment. The market was experiencing workforce and quality issues.

RESOLVED that the report be noted.

42 2017/18 Annual West of Berkshire Safeguarding Adults Annual Report

This item was not discussed. Members were asked to direct any queries to the Safeguarding Adults Board via Jo Reeves.

43 Members' Question(s)

There were no questions submitted by Members.

44 Future meeting dates

The next public meeting of the Health and Wellbeing Board would be held on 30 May 2019.

(The meeting commenced at 9.30 am and closed at 11.30 am)

CHAIRMAN …….

Date of Signature …….

Health and Wellbeing Board Forward Plan 2019/20 (All meetings are on a Thursday, starting at 9.30am in the Council Chamber except where otherwise stated)

There is a fire alarm and lockdown alarm in the Council Chamber at 10am on Thursdays.

Item	Purpose	Action required by the H&WB	Date Agenda Published	Lead Officer/s	Those consulted	Is the item Part I or Part II?
27 June 2019- Health and Wellbeing Workshop - JSNA development/ Primary Care Networks (Shaw House)						
11 July 2019 Informal Meeting						
Update on Priority One (tbc) for 2019/20	To receive an update of progress made regarding Priority Two (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Update on Priority Two (tbc) for 2019/20	To receive an update of progress made regarding Priority One (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Primary Care Networks	To share the latest progress on the development of Primary Care Networks including governance.	For information and discussion		tbc	Health and Wellbeing Steering Group	
WBC Cultural Strategy - how the strategy can support objectives for improving health & wellbeing	to share the draft Cultural Strategy with the Board	For information and discussion		Paul James	Health and Wellbeing Steering Group	
Delivering the Health and Wellbeing Strategy Q4	To provide the performance dashboard for the delivery of the health and wellbeing strategy and highlight any emerging issues.	For information and discussion	21st May 2019	Jo Reeves	Health and Wellbeing Steering Group	Part I
3 October 2019 - Board meeting						
Programme Management						
Update on Priority One (tbc) for 2019/20	To receive an update of progress made regarding Priority Two (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Update on Priority Two (tbc) for 2019/20	To receive an update of progress made regarding Priority One (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Delivering the Health and Wellbeing Strategy Q1	To provide the performance dashboard for the delivery of the health and wellbeing strategy and highlight any emerging issues.	For information and discussion		Jo Reeves	Health and Wellbeing Steering Group	Part I
Strategic Matters						
Annual Report of the Director of Public Health		For information and discussion		Tessa Lindfield	Health and Wellbeing Steering Group	Part I
West Berkshire Vision 2036 - Annual Review	To review the alignment of organisations' work to the West Berkshire Vision 2036.	For information and discussion		Jo Reeves	Health and Wellbeing Steering Group	Part I
Health and Wellbeing Workforce	To discuss workforce challenges across the health and wellbeing system and outline current strategies.	For information and discussion		Jo Reeves	Health and Wellbeing Steering Group	Part I
Feedback from the Multi Cultural Hub Event		For information and discussion		Alice Kunjappy-Clifton	Health and Wellbeing Steering Group	Part I
28 November 2019 Informal Meeting						
Update on Priority One (tbc) for 2019/20	To receive an update of progress made regarding Priority Two (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Update on Priority Two (tbc) for 2019/20	To receive an update of progress made regarding Priority One (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
30 January 2020 - Board meeting						
Programme Management						
Update on Priority One (tbc) for 2019/20	To receive an update of progress made regarding Priority Two (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Update on Priority Two (tbc) for 2019/20	To receive an update of progress made regarding Priority One (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Delivering the Health and Wellbeing Strategy Q2	To provide the performance dashboard for the delivery of the health and wellbeing strategy and highlight any emerging issues.	For information and discussion		Jo Reeves	Health and Wellbeing Steering Group	Part I
Strategic Matters						
No items at present						

Health and Wellbeing Board Forward Plan 2019/20 (All meetings are on a Thursday, starting at 9.30am in the Council Chamber except where otherwise stated)

There is a fire alarm and lockdown alarm in the Council Chamber at 10am on Thursdays.

Item	Purpose	Action required by the H&WB	Date Agenda Published	Lead Officer/s	Those consulted	Is the item Part I or Part II?
13 February 2020- Health and Wellbeing Workshop(Council Chamber)						
26 March 2020 Informal Meeting						
Update on Priority One (tbc) for 2019/20	To receive an update of progress made regarding Priority Two (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Update on Priority Two (tbc) for 2019/20	To receive an update of progress made regarding Priority One (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Delivering the Health and Wellbeing Strategy Q3	To provide the performance dashboard for the delivery of the health and wellbeing strategy and highlight any emerging issues.	For information and discussion	19th March 2019	Jo Reeves	Health and Wellbeing Steering Group	
2 April 2020- Health and Wellbeing Conference (venue tbc)						
21 May 2020 - Board meeting						
Programme Management						
Update on Priority One (tbc) for 2019/20	To receive an update of progress made regarding Priority Two (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Update on Priority Two (tbc) for 2019/20	To receive an update of progress made regarding Priority One (tbc) for 2019/20.	For information and discussion		tbc	Health and Wellbeing Steering Group	
Delivering the Health and Wellbeing Strategy Q4	To provide the performance dashboard for the delivery of the health and wellbeing strategy and highlight any emerging issues.	For information and discussion	21st May 2019	Jo Reeves	Health and Wellbeing Steering Group	Part I
Strategic Matters						
No items at present.						

Actions arising from Previous Meetings of the Health and Wellbeing Board

RefNo	Meeting	Action	Action Lead	Agency	Agenda item	Comment
121	22/11/18 (Development Session)	Ensure the CCG are represented on the Health and Wellbeing Strategy Task and Finish Group.	Matt Pearce	WBC	Proposal for a refresh of West Berkshire's Joint Health and Wellbeing Strategy	On hold to ensure alignment with plans for collaboration across Berkshire West.
126	22/11/18 (Development Session)	The subject to return for a fuller discussion another time – this includes understanding how PHM can align with the local joint strategic needs assessment.	Jo Reeves	WBC	Population Health Roadmap	PHM will link to the Board via the Locality Integration Board.
127	22/11/18 (Development Session)	Map current knowledge of adverse childhood experiences (ACEs) across the District and develop a plan to take forward.	Matt Pearce	WBC	Adverse Childhood Experiences	To form the action plan for the Children's Delivery Group
128	24/01/19	West Berkshire Vision 2036 to be placed on the Forward Plan for an Annual Review	Jo Reeves	WBC	West Berkshire Vision 2036	Completed.

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Report from the Skills and Enterprise Partnership

April 2019

Meetings and membership

The Skills & Enterprise Partnership seeks to support the HWBB in addressing the key priority of 'improving opportunities for vulnerable people to access employment, education, training and volunteering'. The group has recently increased its membership, to ensure a more inclusive coverage of key stakeholders. The current membership includes:

Alex Osterritter (West Berkshire Learning Disability Partnership)
Andrew Marmot (Parkway Shopping)
Andrew Sharp (Healthwatch West Berkshire)
Andy Murrill (Newbury Weekly News)
Chris Boulton (Greenham Common Trust)
Estefania Oliveira (Berkshire NHS)
Gabrielle Mancini (WBC - Economic Development)
Iain Wolloff (Newbury College- Chair)
Ian West (AWE)
Isabelle Denis (JCP)
Jane Hall (West Berkshire Mencap)
Joanna Reeves (WBC - Principal Policy Officer)
Kamal Bahia (Chair of PPE Group for the WB Health and Wellbeing Board)
Leila Ferguson (West Berkshire Mencap)
Mark Browne (WBC - Post 16 Advisor)
Matt Pearce (WBC - Public Health and Wellbeing)
Michelle Smith (EBP)
Patricia Marks (Newbury and District Agricultural Society)
Russell Downing (Newbury BID)
Shabana Mahmood, (JCP)

2018 – 2020 Delivery Plan

The delivery plan identifies four specific outcomes for the 2018 to 2020 period, with positive progress having been made in relation to each of these:

1. Business & Wellbeing Conference (Lead: Matt Pearce)

The Skills and Enterprise Partnership have been working with Buzz Connect to organise a 'work, worklessness and health event' on the evening of the 26th September. The event will be used to bring local organisations and businesses together to understand the link between work and health, and hear about some examples on how local employers have supported vulnerable people into work. The event will also hear about how the workplace environment can provide a unique opportunity to improve the health and wellbeing of employees and the benefits this can bring e.g. increased productivity, reduced absenteeism etc. The Keynote speaker will be Magdalene Mbanefo-Obi who is the National lead for Health and Work at Public Health England. The event will also be used to Launch the annual Director of Public Health Report for Berkshire which will this year be focusing on health and work. A Health and

Wellbeing Priority Fund Bid will be submitted over the coming weeks to cover the costs of the conference.

2. Work & Careers Fair (Lead: Iain Wolloff)

The Work & Careers Fair was held on 7th November 2018 at Newbury College. A total of 42 exhibitors took part, including large national employers, local businesses and education providers. Prior to the event, a Business Breakfast was held for all the exhibitors. A range of young people and adults attended the event including:

- Newbury College Students
- External Visitors (Adults)
- Students from special schools
- Schools - all local school sixth-forms were invited

The event was delivered at a total cost of £6,094.33 and an application has been submitted to the HWBB Priority Fund to meet these costs. Additional facilities and staffing costs were met by Newbury College.

3. Skills awareness day for vulnerable people (Lead: Iain Wolloff)

It is proposed to deliver a Skills Awareness Day for young people with learning disabilities at Newbury College in the autumn term 2019, working with the West Berkshire Learning Disability Partnership Board. The day will provide young people with practical insights into a range of training and employment pathways.

4. Toolkit for employers supporting vulnerable people in employment (Lead: Shabana Mahmood)

JCP have produced a live document 'Supporting Customers With Complex Needs In Newbury', which is regularly updated and provides a summary of services available for different groups. Relevant agencies are providing any updates to this information. JCP have also produced an employer toolkit, which is used to provide information about supporting vulnerable people in employment.

Iain Wolloff
April 2019

VOICE OF DISABILITY

A Healthwatch fact-finding conference

Workshop Report

15th November 2018

Photo: CC BY-NC 2.0/USAID U.S. Agency for International Development

CONTENTS

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INTRODUCTION

Healthwatch is an independent, statutory organisation responsible for ensuring the patient /public voice is heard as well as monitoring health and social care services on behalf of patients

The most important part of our role is listening to the views, experiences and thoughts of West Berkshire residents. We want to know what you have to say about local health and social care services, where things are going well as well as where they are not. We want everyone to be able to use us and especially groups that are hard to reach or those who are isolated by where they live, their age, medical condition, ethnicity, disability, traumatic event or poverty.

Co-produced events, like the Voice of Disability (VOD) are key to helping Healthwatch find out what you think. It is our way of gathering your views and taking it to those who deliver and commission services. We are committed members of the community who have the authority to make your views heard and campaign for change.

The Voice of Disability is such an event and was designed to seek the views across a range of disabled people, including individuals , carers and various agencies. It was arranged jointly with West Berkshire Independent Living Network (WBLIN), the Volunteer Centre and with support from West Berkshire Council Adult Social Care(WBASC) ,Berkshire West Clinical Commissioning Group (BWCCG), Department for Work and Pensions(DWP) and the Care Quality Commission (CQC).

This report contains the views of individuals and carers and information from key bodies. The appendices include points expressed and the Executive Summary tries to bring these points together. Where points are duplicated, they have not been included further times in the appendices although this emphasis is indicated in the main text.

This report is compiled under the headings of the workshop but organised under relevant questions and with relevant quotes from delegates added for support.

AUTHOR'S NOTE

The quotes that appear in this document are those of the participating delegates. Although some are mentioned in the apendices they may not be included in the body text. This is because an individual or group of individual's experience may not represent what is evidenced in general about a service.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

It is widely accepted that there are a lot of good things about West Berkshire for people with disabilities. The open spaces, the accessibility of the town centre and the number of voluntary services and support agencies are much appreciated. A number were mentioned specifically (see appendices)

1. In general, the NHS and local GP services were felt to be positive. Although clearly this is not the case for everyone and what came out very strongly were the difficulties that people had in making appointments at an appropriate time of day and in an appropriate timescale.

Recommendation – GP surgeries review accessibility of appointments with recognition that bus passes can only be used after 9.30 and some people with disabilities have fluctuating conditions that require a timely consultation.

2. There appears to be a recurring theme that people with disabilities do not know what services/activities are available to them. Regarding services, GPs are sometimes thought to know all and signpost people appropriately. However, in the current climate where recruitment and retention of GPs and lack of available appointments is problematic, other ways of bringing information to the fore are necessary.

Recommendation – West Berkshire Council and the Health and Wellbeing Board put efforts into publicising / marketing the West Berkshire Directory and having a hard copy in relevant public places that are fully accessible, eg library.

People were vocal in wanting to meet others and socialise. However, lack of information about what is available is resulting in people feeling lonely and isolated. This is particularly evident in rural locations.

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3. Secondary health services and specialists appear less understanding of disabilities than GPs.

Recommendation – The Health and Wellbeing Board considers how disability training for secondary care services is carried out and how this can be monitored, including consultants.

4. Waste disposal has mixed reviews. Some people felt that their assisted bin collection is good whilst for others this has been difficult to organise. There is a difficulty of insufficient capacity where a person uses incontinence supplies. Also, where bins are left on the pavement after collection, this can be obstructive for wheelchair users.

Recommendations - West Berkshire Council considers:

- how the service can be better publicised
- whether integrated Health and Social Care services can work together so that additional bins can be provided where incontinence supplies are used.

5. People also commented on the difficulty in following through a complaint.

   The energy needed to complete the complex process means that complaints are often dropped.

Recommendation - West Berkshire Council considers how making complaints can be made easier and fully accessible.

6. CAMHS (Child and Adolescent Mental Health Service) attracted a great deal of criticism with some carers becoming desperate. It is unreasonable that the need for a diagnosis and thence support and medication if appropriate, requires a waiting time of up to two years.

Recommendation – The Health and Wellbeing Board undertakes an URGENT review of CAMHS waiting times, with special reference to children with a disability and how this affects the carer and the family, and looks at priority funding.

7. Referrals to Health and Social Care are often problematic and waiting time can be up to a year.

Recommendation – The Health and Wellbeing Board undertakes an URGENT review of integrated services (Health and Social Care) referral waiting times in relation to people with disabilities and considers priority funding.

8. People generally feel that those with disabilities are accepted in the area, that there is support from peers and support in crisis is good. There are many voluntary groups and the Volunteer Centre is appreciated. However, in contrast the lack of respite care is of particular concern.

Recommendation – The Health and Wellbeing Board undertakes an URGENT review of respite in line with the Local Offer.

9. Parking is a known issue at Royal Berkshire Hospital and must be mentioned, but it is recognised by Healthwatch that there may be development planned at the site. However, the lack of access for large wheelchairs to toilet facilities is of concern as is the availability of **appropriate** wheelchairs.

Recommendation – Royal Berkshire Hospital undertakes an updated access review of the Hospital, including toilet facilities, and ensures that there is appropriate wheelchair access and signage to locations- in light of the size of modern powered wheelchairs. As this may highlight expensive capital requirements, short term mitigation of issues highlighted should be considered. For example, a greeter with specialist knowledge to aid wheelchair users and people with disabilities.

10. Transport is the area where people have the most difficulty even though there is acknowledgement that the town pedestrianisation has been very positive. The three aspects that were positive included volunteer drivers, all buses now announcing the next stop audibly / on screen and Reading to Newbury buses ability to carry wheelchairs.

However, access to other buses is problematic with little or no wheelchair provision and scheduling to rural areas often at inappropriate times, resulting in residents feeling cut off. The location of 'dropped' kerbs not being adjacent is also a problem.

Bus drivers also come under criticism, particularly moving off too quickly before people are seated. This is a safety issue and should be addressed urgently. Drivers are also often unaware of the difficulties that disabled people have.

Vegetation around bus stops can also presents a problem for access and safety and restricts the view so bus driver misses the person at the bus stop.

Recommendation – West Berkshire Council assist with representation to local bus companies to review:

- scheduling to rural areas
- carry out URGENT staff training regarding disabled passengers
- cutting back vegetation that restricts access to bus stops .

Additionally, if passengers experience problems they could be encouraged to ask for a driver's name, number and the person to whom to report issues and this publicised. The person is believed to be Julia O'Brien, West Berkshire Council Licensing.

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11. There is generally a lack of wheelchair taxis with some drivers refusing to take a wheelchair even if they have the facility to do this. One person said they must book all their trips a month in advance to ensure they can get to appointments. This is a key issue as are the lack of suitable drivers.

Recommendation - West Berkshire Council jointly undertake a service user review to ensure services are operating appropriately in line with the Equality Act 2010 and look to ease issues with lack of suitable drivers (recruitment, training, etc).

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12. Financial difficulties remain a serious difficulty for disabled people. When claiming a Personal Independence Payment (PIP), it is felt to be fairer for a person to be assessed on what they are unable to do rather than what they can do. This is because people have good days and bad days and difficulties fluctuate. There is also a feeling that the Department of Work and Pensions (DWP) needs to fit people into a category so that forms can be filled in, so people are known by their diagnosis not as a person.

    Additionally, a disability reduction in Council Tax is difficult to get. The cancellation of home to school transport for anyone with SEND is causing hardship to some families and Housing Associations are not always felt to be helpful or sympathetic.

Recommendation – Healthwatch West Berkshire requests the local DWP to look at how a more accurate view of a person's condition can be assessed and the whole person considered. Healthwatch West Berkshire requests the local MP to take this back to the relevant Ministers to ask for a 'sea-change' on looking at the whole person as the client not the condition.

13. Of major concern is the inaccessibility of one of the DWP offices in Reading where some PIP reviews are heard. The room is located on the second floor with no lift and there is no notification before attending. If a person is then late for an appointment because of these access problems an immediate sanction is applied.

    Addtionally there is a lack of disabled parking nearby.

Recommendations - The Health and Wellbeing Board request that the DWP undertake an immediate review of accessibility at the Reading office, as this was highlighted as far back as 2003 by a member of the West Berkshire Disability External Scrutiny Board (WBDES). Additionally, that the DWP undertake an accessibility review of their local offices and consider the following:

- making alternative arrangements and/or moving the office without lift access to one that complies with the Equality Act 2010(previously known as DDA 1995)
- offering accessible alternatives or home visits as a matter of policy .

14. The lack of support for people whose disability fluctuates is a problem as the support needs are only necessary when there is an episode. The system does not accommodate this fluctuation.

    Additionally the long wait for repairs from the wheelchair clinic means that a person whose only way of community access is removed becomes isolated and their life restricted.

Recommendation - The Health and Wellbeing Board urgently locates the responsible service and requests a review of its compliance with the Equality Act 2010 (previously known as DDA), its procedures and waiting times. This to be reported back to the Board.

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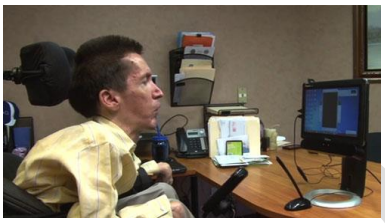
15. There was great enthusiasm to use good assistive technology and many good ideas were proposed including 'talking' utility meters and talking aids such as Google Home.



Recommendation – The Health and Wellbeing Board support the roll out of assistive technology from its partners to aid the quality of life for people with disabilities and ensures that key staff are trained appropriately i.e. 'Tech Savvy' Occupational Therapists.

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16. West Berkshire External Disability Scrutiny Board currently only reports to West Berkshire Council. It covers a range of issues that are covered in this report, including health/well being/transport/access issues.

Recommendation – The Health and Wellbeing Board requests reports from the West Berkshire External Disability Scrutiny Board.

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17. It is clear there are still many challenges for those with disabilities in West Berkshire though currently there is no co-ordianted response or if the Health and Welll Being Board (H&WBB) even has sight of the disabled.

Recommendation – The Health and Wellbeing Board(H&WBB) assesses how it manages disability issues and reviews the successes and/or challenges with particular reference to issues affecting health and wellbeing inequalities.

RESPONSES

Adult Social Care

In response to recommendation 7:

'From an Adult Social Care perspective, waiting times are an area of focus because we know that the sooner people can access support the better it is for them and for the services which support them. There has been significant progress over the last year, with a 40% reduction in the number of people waiting for an assessment by the community teams. There is too much variation in waiting times depending on where people live and this is something that we are working to address. Teams do prioritise their response based on the perceived level of risk so people with an urgent need are seen more quickly than others.'

In response to recommendation 8 :

'Adult Social Care does commission respite care for people with a range of needs, but agrees that it can be difficult to source. Providers are often reluctant to offer respite because it is a less predictable source of income than permanent placements. Another challenge is that some people want to plan respite far in advance but others may need respite on an emergency basis, creating another practical challenge. Our experience this year is also that we saw a large amount of scheduled respite for people (based on assessments) which was still unused at year-end and this makes the picture more complex.'

Paul Coe - **Service Manager - Adult Social Care**

DRAFT

Royal Berkshire Hospital

'The RBFT recognises the challenges encountered by our patients, caused mainly by our patchwork of old estate built to a different code and challenging to alter.

As recommended by the VOD report we will undertake an access review across our site during 19/20. Due to the age and restrictions of our current site making the hospital fully accessible may be challenging. We will ensure that signage and information regarding facilities are improved and made available at key points such as the reception and welcome desks. During 19/20 we are working on a long term Master plan to develop our estate that will consider the needs of our services and our patients. As we develop designs for our new and refurbished hospital buildings we will be keen to engage with patients and visitors to ensure that our buildings meet their needs as far as is practical.

In addition, this year we have a focus on reducing the need for patients to attend the RBH site through the use of technological solutions as well as more clinics at our modern estate in Townlands, Bracknell and West Berkshire.'

Caroline Ainslie - Executive Director of Nursing

Richard Benyon

'Richard has noted the three points you raise – and should the H&WBB want him to raise these issues with the appropriate bodies at some point he would be happy to do that.'

Catherine Haig - Senior Researcher for The Rt Hon Richard Benyon MP

DRAFT

WHAT IS GOOD AND WHAT CHALLENGES ARE THERE OF SERVICES FOR PEOPLE WITH DISABILITIES IN WEST BERKSHIRE HEALTH AND SOCIAL CARE?

It is widely accepted that there are a lot of good things about West Berkshire for people with disabilities. The open spaces, the accessibility of the town center and the number of voluntary services and support agencies is much appreciated. A number were mentioned specifically (see appendices).

Health

In general, the NHS and local GPs came out well.

I am exceedingly thankful for the NHS. In all probability I would have died by now without the many ways they have helped me. This is a burning issue because there is so much negative talk about it"

Healthcare good – I feel very supported and receive good care.

West Berks community Hospital and Red Cross Ambulance Service very good

GP atmosphere very good (Thatcham Medical Centre)

Thatcham dentist very good

Pain clinic is starting to treat people holistically

Empathy of practitioners and staff generally

There are highly trained professionals in adult social services

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Clearly this is not the case for everyone and it came out very strongly the difficulties that people had in making appointments at an appropriate time of day and in an appropriate timescale.

GP surgeries only open a few days a week (rural locations)

Waiting times for appointment is poor, three weeks is too long

No support from GP to manage meds reviews (long term condition) – advised to make appointment three months in advance to see own GP

There is also concern about on-going health provision and services following on from GPs.

Good relationships with local GPs, for clients with LD. But not so good when you get into specialist services and consultants

Beyond GP and broader health services, specialists are less understanding

No after care after seeing NHS professionals, I called an ambulance, they treated me, then I was left alone

Challenge to see a psychiatrist at Hillview House community hospital. I got diagnosed and was told to see a psychiatrist on a regular basis and that my GP would follow-up, but GP knew nothing and said he would investigate it but didn't. I am now lost back in the system. I have suffered from mental health issues since 16 and now at 31 a carer for a disabled child and I can't get help

DRAFT

Child and Adolescent Mental Health Service (CAMHS) are severely criticised with people informed that there is a waiting time of two years and some carers struggling to cope

CAMHS waiting list. Been told to wait 2 years

Waiting times for mental health in young people poor

My children are on the CAMHS waiting list and I have been told to expect a wait of approximately two years.

I am having a nightmare and will continue to do so until my kids receive some sort of diagnosis. This is NOT acceptable. We as a family are struggling. Medication cannot be prescribed without a diagnosis through CAMHS

Referrals to Health and Social Care are often problematic and waiting time can be up to a year. The list is based on need, so anyone added to the list with a greater need takes priority. There is a wish that the way things used to be would return. People used to phone in and speak to a social worker who made an immediate appointment.

When I was 16, I had mental health problems. I am now 32. I have tried to commit suicide. There was no help. I was taken by ambulance to Prospect Park but the referral back to the GP never arrived

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Carers / Support

People generally feel that people with disabilities are accepted in the area, that there is support from peers and support in crisis is good. There are many voluntary groups and the volunteer centre is appreciated

General acceptance in the local community of disabled people

Once under crisis, the support is good

Thatcham Volunteer Bureau

Goodwill. People making a difference in voluntary groups

However, in contrast the lack of respite care is of concern.

Lack of respite options for adults. Funding has been cut for short stay respite

But everyone on this table said lack of respite for carers or mental health support for them

We need support for parents with children that have poor mental health

I don't get any respite as I can't buy it in, can't afford it. The direct payment rate is £10 an hour but Mencap charge £18 per hour. I want a two-week holiday, which is what I'd get if I was an employee

DRAFT

The Local Offer sets out provision which is available for children and young people with Special Educational Needs and Disabilities (SEND), aged 0 to 25, including education, health and social care services, but some people find accessing this difficult.

I can't access respite. I get a carers allowance of £50 a week and for overnight care it costs £900. I want some sleep.

Personal Independence Payments for carers with health issues are poor. No income or support for medications and dentist

Payments for carers and lack of information are real problems. Additionally, agency carers often have a lack of language skills or training for complex communication needs. This can mean there is a lack of empathy and can have major time issues for carers. For example, a lack of understanding can result in food / drinks being left out of reach.

It is accepted that there is a lot of help (other than respite) but people are not informed and don't know what information they need. People don't know what they don't know.

I need carer training – how to lift safely, First Aid – updated regularly

I lack knowledge about what to do as a carer

I don't know what is available – no support to sort out mobility scooters and wheelchairs, GP has no information

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Access

West Berks Community Hospital is a valued service as it means less travelling. Where hospital visits are further afield there is transport support although this is not known by everyone and there is a cost.

CAB is fantastic. I pay £12.50 for transport to RBH when I need to get there

DRAFT

The built environment is felt to be good in Newbury with the pedestrianisation of Northbrook Street and trip hazards removed, but this is not the case in villages and people can feel isolated. The town disabled facilities are generally good.

The Kennet Centre has good changing facilities in toilets

Vue is ok with spaces but can't book online

Parking is a known issue at Royal Berkshire Hospital, however it is a further difficulty for people with disabilities as there is limited parking and no prior information about whether the disabled spaces are full. Late arrivals at appointments are often the case. Changes to South Central Ambulance Service (SCAS) bookings for hospital transport to/from out-of-area are problematic. People with disabilities are often told to use public transport or drive themselves when this is inappropriate, impossible or dangerous for the patient.

Not enough disabled parking at RBH and you must enter the car park to find out disabled spaces are full – you then have to pay to get out of the car park

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The toilets at RBH are also difficult to access in a wheelchair and there are also issues with the accessibility of ward shower rooms

Took my relative to RBH. I can't manage a large wheelchair but had to transfer to a large wheelchair at the hospital. Large chair won't go into the toilets for the disabled so had to transfer to smaller one just for the toilet. Made a complaint. Letter back saying thanks for bringing to our attention. then nothing.

RBH changing facilities, difficult for LD and wheelchair user

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There is an acknowledgement that West Berks is trying to get better with sensitivity to people with autism, but there is more needed in shops etc.

There is often an expectation that GPs should have the knowledge of all services and be able to signpost. One person pointed out that she had difficulty with being examined by her GP because of lack of equipment.

Some GPs appear to have no knowledge of their patients. Do not know their medical history. Do not offer support regarding a child with special needs or help with regards to mental health.

A specialist will recommend talking to a GP regarding services (nappy pickups) but GP's do not know what services are available or how these can be requested / put in place

There are no hoists at GP surgeries, so I can't be examined

Other access problems

Signs are written rather than any images, for people who can't read

Communication aids are necessary for children and should be more accessible. Our 9-year-old child cannot talk. We do not have the money to pay for different apps (£300 - £400) to "try" and buying communication aids that can cost £1000's

I'm registered blind and have a walking stick. Get vehicles parking on the pavement (cars, vans, lorries, motorbikes) so I must get off the pavement then get the driver shouting at me for being on a road. When I speak to WBC Highways, they say, 'I don't know what we can do'. Same with police: they say I have to speak to WBC. Hit my head against a brick wall every time. Can't usually walk from my house to the bus stop. Would like to see a law, that people parking on pavement are fined.

Changes within West Berkshire Council and legislation means that disabled people cannot now attend Planning Meetings, Transport Meetings or many other statutory public meetings. Therefore, representation has been reduced, or is no longer available.

Transport

Transport is one area where people have the most difficulty even though there is acknowledgement that the town pedestrianisation has been very positive.

The three aspects that were positive included volunteer drivers, all buses now announcing the next stop audibly and, on a screen, and Reading to Newbury buses ability to carry wheelchairs.

However, access to other buses is problematic with rural areas feeling cut off and buses that do run scheduled at inappropriate times.

Handy Bus difficult to access

Large wheelchairs don't fit on buses

Buses to college no good I need to use 'mum's taxi

In Mortimer there is no transport on Sundays and Bank Holidays, they have been removed

No transport to WB Council offices at Calcot

Public transport from Cold Ash v poor

There is a bus service to the rural areas. But only 3 buses a day at not the most convenient of times / within the school day

No late-night buses generally and assistance service problematic

Lack of public transport in West Berkshire, ie Compton has limited service. Does not help with employment

DRAFT

Bus drivers come in for criticism:

Bus drivers don't give people a chance to sit down (Jet Black 1). As a result, passengers have fallen over

Drivers often not aware of disabilities, e.g. don't put ramp down

Drivers make excuses not to take disabled people

Bus drivers don't park close enough to the pavement

There is a need for training for bus drivers and taxi drivers in the requirements and show of respect to disabled people

Bus drivers drive past even when a disability is visible

Buses have a seat where a disabled person should have priority. However, they are more often occupied by people, mostly women, and most of them use the seat for their shopping and don't move although they can see you need the seat

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However, there are two sides to most things!

There are two sides to the issue re bus drivers. It is true that some drivers are rude and inconsiderate, however (a) so are passengers and (b) the employer puts constraints on the driver which puts makes for difficult situations for him. Eg I was a bus driver in Bristol for two years and was allowed 28 seconds for a stop. Taking on a woman with a pram and toddler takes over the allocated time.

Physically accessing buses when they do run at convenient times can then be difficult. Getting on and off with walking aids can be difficult and kerbs are difficult to traverse if a person uses a wheelchair or is unsteady on their feet. Dropped kerbs can help but are often in the wrong place and/or don't line up with similar on the other side of the road.

I tried to get dad on a wheelchair taxi but he said he couldn't take that wheelchair. He said he'd been on a course, there needed to be hard back and attachment points. Means everyone will have to change their wheelchair.

No drop curbs and some pavements rough especially on A4 between Church Hall and ½ mile East

Any complaints or suggestions relating to bus difficulties should be directed to the bus company in the first instance and then to the council (details on website). 90% of bus services are operated by Reading buses. Mathew from West Berks Transport services will feed back on issues raised at the workshop.

DRAFT

Taxis are also sometimes problematic:

Wheelchair users – booking a taxi is a nightmare – availability, cost, refusal to take – West Berks are investigating incident where a taxi driver refused to take my dad in a wheelchair

Lack of wheelchair taxis

Trains have issues too:

Theale Station is inaccessible to wheelchair users such that disabled users need to travel to Basingstoke and return to the other Theale platform, incurring additional cost, more inconvenience and is discriminatory.

I can't use public transport unless I book 24 hours in advance if a ramp is needed

Trains – access for disabled people, ie not have to go to the next station to have help to get off the train with the right help

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Other points relating to transport include:

My husband was dying of cancer. Had to get to RBH. Not nice conversation to book in. Dr said could have transport. Person on the desk said needed to fit box. 'Isn't dying enough?

Loss of companion bus passes for carers

Hospital transport – I was recently told it is NOT available to Personal Independence Payment /

Disability Living Allowance recipients and Blue Badge holders in the future

Barrier to getting Blue Badge – I receive a care package but no badge

Thatcham football club - not disabled friendly - no parking and no covered area for wheelchair users. Toilet has a slight step too

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Social

There are a number of clubs and social groups for people with disabilities (see appendices). People were vocal in wanting to meet others and socialise. However, there appears to be a general lack of information getting to people and people living in rural villages felt isolated. There is also a lack of age appropriate activities for those with complicated needs.

Education

Views were expressed for Newbury College to have more activities with animals and sports and a need to have access to working computers. There are also allegations of 'bullying' behaviour towards people with learning disabilities from other students were expressed- but not felt serious enough to warrant immediate action at the event.

Financial

Financial difficulties remain a serious difficulty for people with disabilities. When claiming a Personal Independent Payment, it is felt to be fairer to be assessed on what they are unable to do rather than what they can do. This is because people have good days and bad days such that difficulties fluctuate.

There is also a feeling that the Department of Work and Pensions need to fit people into a category so that forms can be filled in, so people are known by their diagnosis not as a person.

Additionally, a disability reduction in council Tax is difficult to get. The cancellation of home to school transport for anyone with SEND is causing hardship to some families and Sovereign Housing is not always felt to be helpful.

Disability reduction on Council Tax is hard to get

Of note is the fact that one of the DWP offices in Reading where PIP reviews are heard is on the second floor with no lift.

This is not known prior to attending. If a person is then late for an appointment, because of access problems, there is an immediate sanction applied.

PIP waiting times for assessments and appeals cause real difficulties

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Technology

There appears to be an assumption that everyone has a computer or can navigate sites easily. Several people (particularly those over 60) may not have a computer and may feel they can't learn IT skills or simply may not wish to.

WBC rely too much on people having access to email for information. Not everyone has or can use a computer

Carers Rights day needs webinar access, so I can attend

Services / Facilities

When known about people generally feel that charities and services are positive

However, there appears to be a recurring theme that there are a lot of services/activities for people with a learning disability but that these are not known about.

Information is not available re voluntary service

When accessed, charities and services encountered are positive

Making sure there's information about where to get support. E.g. cancer charity could give lifts but only found out about it ad hoc with 3 Frogs

A central resource where it is easy to find voluntary and statutory services in your local area. There are lots of services that people aren't aware of. I have just found out about a directory – westberks.gov.uk. Make sure that ALL services are listed

DRAFT

Waste disposal has mixed reviews.

Some people felt that their assisted bin collection is good whilst for others this has been difficult to organise. There is also a difficulty where a person uses incontinence supplies and replacing bins after collection can be obstructive.

Assisted bin collection, will go to back door. But [another group said] people emailed about it and then had a large form to fill in and it takes 12 weeks to get in place

Bins are needed if an adult is incontinent

Langley Hall Drive is often blocked by waste operatives' replacements of bins

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People also commented on the difficulty in complaining about a service. The energy needed to carry on following through with a complaint meant that they are often dropped.

West Berks complaints procedure is awful – you get no results

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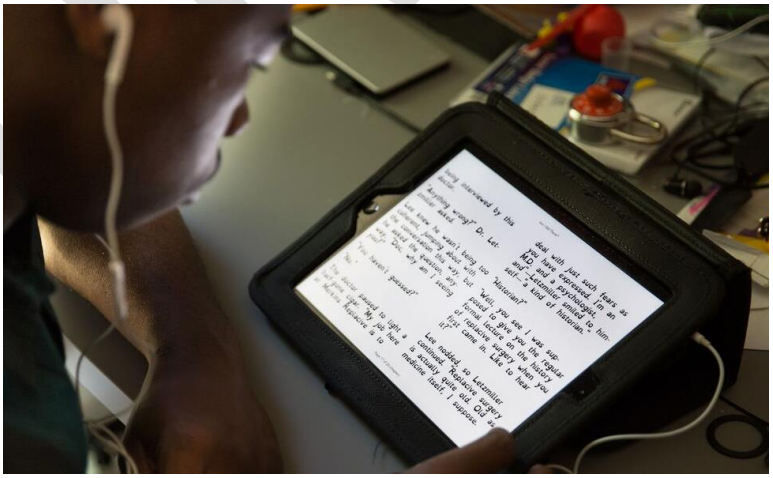
The lack of support for people whose disability fluctuates is a problem and the long wait for repairs from the wheelchair clinic means that a person whose only way of community access is removed become isolated and their life restricted.

There is no home help for occasional need. I am told to go to hospital, but I can be looked after at home when needed

Children's wheelchair clinic – a long wait to be seen; a long wait for repairs; a reluctance to give wheelchairs at the level needed resulting in people being restricted and isolated



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Adult Social Care – How does it work with you?

Mike Harling (Principal Social Worker for Adult Social Care) and Alex Barrow (Social Care Practitioner from West Team)

West Berks has reorganised the support teams. Where previously teams were organised by condition, ie a disability team, a dementia team, now they are organised by locality. This means each team is responsible for all needs in their area and there is a one-stop-shop to get in touch.

There are offices at West Street, Hillcroft and Turnhams Green where parking is a problem. It is routine that social workers visit people in their own home or other convenient place. There is a carers assessment and a current push to support carers as the council is aware of the vital role that they play.

However, someone commented: ***"not everyone knows about the assessment or the Carers Hub."***

A local resident disclosed in a conversation with her social worker that she was being treated badly by her husband. The social worker was able to work discretely and supported the woman to move to her own safe accommodation with support.

Social Care make sure carers have all the information and support they need as a carer.

Carers not supported by GPs. Heard about carers hub by accident. Had been caring for mother-in-law for 11 years. Only found out as stamped my feet and shouted

There is now also a West Berks Directory of groups, clubs, societies, organisations, etc. An internet search for West Berkshire Directory should get you there.

Currently loneliness is a big issue for the Council, as it is nationally.

50-year-old Alex presented at the Council distressed. His wife had a stroke and had difficulty walking meaning that going out was problematic for them both. Alex also had health problems, and both felt isolated. An adult care social worker visited the couple and, through conversation, found that Alex's wife had a long interest in horses and riding. The social worker arranged an hour of riding each week and this improved her walking and wellbeing and support was arranged for Alex.

Some don't know about carers hub

When I have a bad episode there is no one to help me. My GP says I must call the paramedics, but they don't want to take me to hospital. They get me downstairs but must leave me. My children live away. I do not have constant problems but episodes, so I can't have a carer. I don't know what to do. I have tried incontinence pads when I can't get to the toilet, but they don't work. I am not considered disabled enough to get PIP.

Anyone who rings in to the Council who is a carer is given information in compliance with Care Act requirements.

Reading and West Berkshire Carers Hub provide information and advice to unpaid carers to help support their physical and emotional wellbeing. They offer carer-specific advice on a host of topics, such as finding a carers support group, helping make contact with others in the same situation, or helping to access information on carers breaks.

They're also able to advise on financial help (such as grants, benefits and discounts) and rights in employment. They also signpost to a host of other relevant services.

To access support from Reading and West Berkshire Carers Hub complete the Reading and West Berkshire Carers Hub Referral Form or ring 0118 324 7333

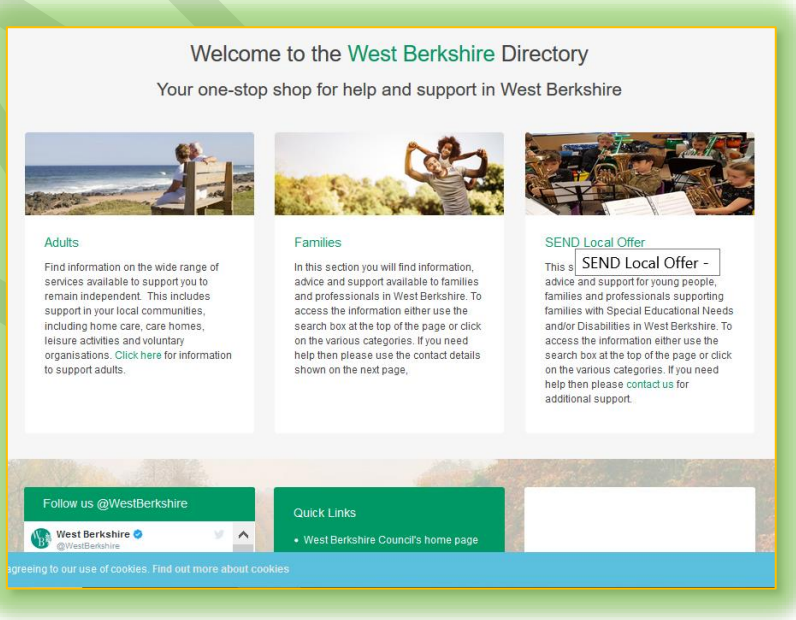
GP – will often refer to village agents who will call on you and tell you about the services.

Village Agents can provide support and information and be contacted through the Volunteer Centre (1 Bolton Place, Newbury RG14 1AJ Phone: 01635 581 001). www.villageagentswb.org.uk

Adult Social Care can signpost to available services and make referrals (01635 50 30 50)

Access to information is problematic where people have no access to the internet or a mobile phone and some GPs are unable to support carers by signposting to a relevant contact or service.

There's a lot of good stuff out there but you need to communicate this.



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Overview on Transforming Care for People with Learning Difficulties, Mental Health Issues and Autism

Sarita Rakhra (Lead Commissioning Manager – Transforming Care, Carers/Voluntary Sector/Mental Health – Berkshire West Clinical Commissioning Group

Transforming Care has grown from the Winterbourne View. It has five work streams. Finance and Activity, Children and Young People, Autism, Workforce Development and Housing and Accommodation.

Where people are in long stay hospitals Care and Treatment Review visits are carried out to check if a person is safe and their treatment is appropriate. Where they are transferred from long stay provision after 5 years their funding allocation of £180k per patient goes with them.

In West Berkshire 7 beds have been closed and reinvested into an intensive support team set up with funding from NHS England. However, there is a need for the right infrastructure as some people need intensive wrap around services.

33 people have been seen and provided with support to go into their own homes and 31 still remain so. Five people have been funded through grants from Central Government of £1.2m to buy their own home.

This programme ends Nationally in March 2019 when the target is for a 50% closure of beds, but West Berks is committed to continuing with the service.

The emphasis is now on preventing people going into long stay provision and remaining in the community and training for those involved in support.

NHS Berkshire West Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

Although West Berks is emphasising prevention of long stay/residential care there are some people with complex disabilities for whom 24-hour care in a specialist home is appropriate. Residential placements are costly and with the move away from these, local authorities are reducing provision so there is less of it and it becomes more costly. Placements now are becoming more expensive and this is further reducing a decline in available placements.

Carers express concern about the future for their cared-for and have the stress of keeping themselves healthy. Sadly, they hope that they will outlive their cared-for.

My 18-year-old non-verbal son has been in John Radcliffe Hospital. He requires a carer to stay with him all the time. There was no provision for a carer to stay so I had to sleep on a chair and they left me to do everything as if I was a member of staff. He is at the College and leaves at 19 but his assessment has been delayed and I don't know what will happen What then? If someone can no longer care, who then takes over

Carers also reported difficulties when transitioning between children's services and adult social care

There is a black hole at transition as people move from children's services to adult services

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GPs across West Berkshire are signed up to the Direct and Enhanced service to provide health checks for 70% of people with learning disabilities by 2020. The aim being to detect any underlying issues early and for which they receive an additional payment.

I am concerned this is pump priming money and will then be a cliff edge

Why target of only 70% for health checks"

Sarita says" I'm a commissioner and am surprised to hear people don't know about the services, so I'd like to hear more".

What would you like to see to improve your wellbeing?

Matt Pearce (Head of Public Health and Wellbeing, consultant in Public Health

People were clear that they wanted access to services and activities and to be treated equally in respect of their physical, social and mental wellbeing. They wanted to be able to be happy, saying that loneliness is a big barrier to their health.

Keeping fit and healthy. Healthy eating

I want to be the best person I can

When I feel I'm understood. I have an invisible condition – one that isn't immediately shown and there needs to be customer training in equality

For me wellbeing is accessibility, transport, healthcare etc.

What makes me happy is when I do something nice for other people

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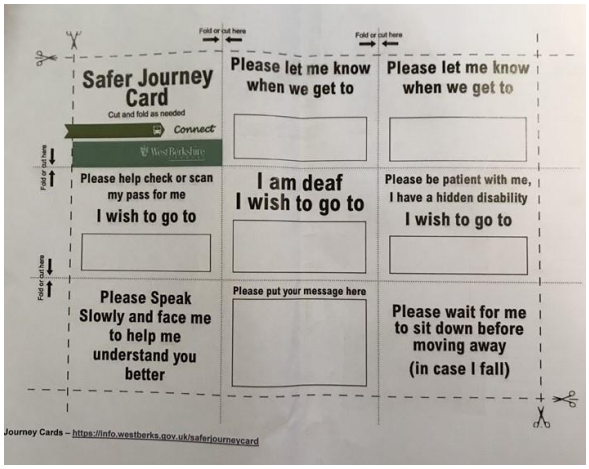
There are a number of things that West Berks Council is trying to do to improve services for people with learning disabilities. Regarding transport for example, there is a safe journey card which can be shown discretely to a bus driver, e.g. 'please wait for me to sit down before you move away', although drivers should do that anyway! Or it could say where you want to get off.



However, there is a severe lack of getting information to the right people at the time they want/need it.

Information from Volunteer Centre West Berks

Garry Poulson, Director

Community transport is very good in this area.

There are 10 volunteer car schemes in West Berks, information about which can be best found through an internet search for 'voluntary car schemes'. Schemes are in Lambourn, Kintbury, Thatcham, Hungerford, Downland (Compton), Newbury, Chapel Row/Bucklebury, Bradfield, Theale. Pangbourne/Streatley/Goring. If there is no access to the internet ring 01635 49004.

There is also a Handybus that runs between Newbury and Thatcham and this takes group bookings. Contact Trevor on 01635 37111.

To book the car scheme or Handybus it is necessary to contact with information about disabilities and what is required.

In Newbury there is a shop mobility service. For £3 a day a scooter or wheelchair can be hired from the Northbrook Street multistorey car park (and you get to park for free).

Technology and Innovation

Technology is developing fast and technological innovation is helping people with disabilities to be more independent. Computers and internet technologies are helping people to access information and have social contact with others. However, it must not be assumed that everyone has access to a computer or wishes to learn how to use one.

Not everyone has smart phones and internet, so include everyone. A one-stop-shop of information. A lot of the services are there but people don't know how to access them

.

There is a need for occupational therapists to be 'technologically savvy' so that people can be helped to use technology aids. Voluntary technology advice is also suggested.

People with disabilities have lots of ideas about how technology could be used to help maintain positive health and wellbeing. E.g. if a person is unable to lift a kettle, a hot water machine that dispenses one cup at a time can make making a cuppa possible.

Call systems, Alexa and the like, can be programmed to respond to voice commands, for example to call a named person or the emergency services in a fall.

The need for adequate lighting for people with sight impairments is often missed and back lighting heating dials would be a simple way of enabling access as would lighting in meter cupboards. Or perhaps electricity and gas meters and dials could *'speak'* the readings.

Other technological support spoken about include:

A crisis phone app

A sensor mat something to let someone know if partner has got out of bed, e.g. risk of fall.

Using technology reminders

Age UK has a telephone shopping service when the internet cannot be used but I would like it directly with the supermarket as online shoppers do

Communications device for child to communicate. They're £10-20k.

I have a non-verbal child. Could use eye gaze, look at pix and it speaks. Or tap and say a phrase. Speech and language therapists say, 'try this', but £400 to just try it.

Physical education helps my children, can't afford clubs, activities, no time to walk in the woods. I need low cost activities.

WBC will fund telecare

Red Cross loan out equipment.

I asked, (Mencap), for a ramp but couldn't help.

Hospital appointment – if big delays problem with ADHD. Give device to keep you up to date with when likely to be seen

Some restaurant beeps when food ready

Something to keep children occupied while having to wait.

An app for parking, so you know where there are disabled parking facilities.

Then, not just parking, but where there are seats, where disabled toilets are, where shop mobility scooters are.

Packaging with a sell by date, but if can't read them

Nottingham Rehab Services (NRS), nationwide; but locality based. So, if person needs equipment visiting Manchester, still must pay for it there too – no co-ordination by this NRS service. If visit, difficult to get equipment in vehicle but they have depots all over. Was in Hull last year and cost £1400 to hire all the equipment that needed

Philip been trying to get a phone with big numbers. Vodafone said they don't do that. But their head office is up the road they've just joined the H&WBB, so could ask them there

What if want to speak to someone. Why not ring WBC and they will tell you who you need to speak to? That should go for all services. Too often directed to a website.

Helping YP (young people) with disabilities to have more of a social life.

Link Eye Gazer with the internet so they could Skype, access the internet etc. So you can have some independence

Can't book a wheelchair space at theatres online, though can for cinemas. Corn Exchange have to talk them.

Disabled tickets in theatres the more expensive.

London theatres – maximum you pay is £35 and you get a free carers ticket. Ensure they know if you don't need a wheelchair or you'll just be given a space. You get set up for that on the system and then don't need to prove things.

Also, for gigs, your essential companion goes free.

Andrew Sharp – should talk to Corn Exchange and Watermill also.

I am a dental inspector for CQC. If you have problems with dentist, contact them first. Also have Healthwatch West Berkshire. They talk to us. But if you're really desperate don't hesitate to contact us, e.g. whistleblowing.

If you need advocate with dentists, SEAP provide statutory advocacy.

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THANKS

Thanks must go to:

Jackie Wilkinson, Chair of West Berkshire Independent Living Network

Facilitators

- Sharon Briggs
- Ann Standen
- Amerie Bailey
- Garry Poulson
- Jo Reeves
- Adrian Barker
- Mike Harling
- Sam Dalton
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- Colin Bibby

Adrian Barker for taking notes

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Special thanks to Karen Swaffield, Healthwatch West Berkshire for compiling this report.

Going forward

Healthwatch West Berkshire may host future events focusing on specific issues. It would be good to hear from you more about any health and/or wellbeing issues you may experience.

Healthwatch West Berkshire

Broadway House
4-8 The Broadway
Northbrook Street
Newbury
RG14 1BA

T: 01635 886 210

E: contact@healthwatchwestberks.org.uk

www.facebook.com/HealthwatchWestBerkshire

twitter.com/HealthWWBerks

APPENDICES

Appendix 1

Attendees

73 people attended the workshop of which 34 were service providers (including the voluntary sector). Representatives came from:

Service Providers
Voluntary
BCT (BetterCommunities Together)
seAp
Newbury College
Berkshire West CCG
AllTogether
Public Health
H&WBB members
Webcas
WB Commissioner
Volunteer Centre
WB Adult Social Care
West Berks Mencap
DWP
Swings and smiles
WB Transport Service
Open for Hope
CQC (Care Quality Commisssion)
Thatcham Council –Mayor
WBILN (West Berks Independent Living Network)

Appendix 2

What is good and what challenges of services for people with a disability are there in West Berkshire Health and Social Care?

What's Good?

Health

- Health. Good support, from surgery and ongoing
- Social care and district nurses when needed
- All therapists available Castle School
- Pain clinic is starting to treat people holistically
- Good relationships with local GPs, for clients with LD. But not so good when get into specialist services and consultants
- Support from different therapist at Castle School is excellent
- I am exceedingly thankful for the NHS. In all probability I would have died by now without the many ways they have helped me. This is a burning issue because there is so much negative talk about it

- Empathy of practitioners and staff generally
- Highly trained professionals in adult social services
- Duty social worker always available
- Annual reviews and health checks – good communication and support and chance to set goals and get more support
- Swindon outpatients very good
- West Berks community Hospital very good
- Red Cross Ambulance Service very good
- GP atmosphere very good (Thatcham Medical Centre)
- Thatcham dentist very good
- Sport in Mind
- Wiltshire Farm Foods
- Park run
- Brilliant NHS
- Healthcare good – I feel very supported and receive good care
- District nurse and Adult Social Care brilliant when my husband died in 2013
- GP referral to fitness for health
- Stroke Club
- Steady Steps keeps me moving

Carers / Support

- Peer support and access to town
- centre
- Once under crisis, the support is good
- Goodwill. People making a difference in voluntary groups. E.g. Cameo, people
- General acceptance in the local
- community of people with disabilities
- Volunteer Bureau
- Community Furniture Project

Access

- Built environment is good in Newbury, pedestrianisation, but not so good in the villages, isolated
- Built environment pretty good, flat and accessible with trip hazards removed
- Kennet Centre has good changing facilities in toilets
- Vue ok with spaces but can't book online

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Transport

- Volunteer drivers
- Reading / Newbury buses can take wheelchairs

Social

- 3 Frogs club for young people with autism but want more places to go
- Young learning-disabled people Social clubs
- Diamond dining centre at Greenham Business Park, very good
- MENCAP Gateway Club
- Phoenix Centre sessions
- New Horizons Club for people with disabilities and good trips
- Aquadrome special session, disabled swimming
- Open for Hope every Tuesday in Thatcham Memorial Hall
- Eight Bells for Mental Health mates

Education

- Mix abilities
- Excellent support from Winchcombe school
- Recovery in Mind

Services / Facilities

- WBC Disability Scrutiny Board is unique in that anyone disabled can be a board member and this is supported by the WB CEO
- Services, groups, not always relevant to our needs
- Kennet good changing facilities, with a hoist
- Active, thriving voluntary sector
- Assisted bin collection
- Good social workers / occupational therapists
- When accessed, charities and services encountered are positive
- Most of Berkshire is a good place to live. Lots of open space. Healthwatch good and we have a Health and Wellbeing Board
- Good services, eg Volunteer Centre, but now everyone is aware of them

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Other

- This event is good
- Healthwatch events
- I want to register I'm here on the system so can be sent more information about events

What's Not Good/ Challenges?

Health

- CAMHS waiting list. Been told to wait 2 years
- My children are on the CAMHS waiting list and I have been told to expect a wait of approximately two years. I am having a nightmare and will continue to do so until my kids receive some sort of diagnosis. This is NOT acceptable. We as a family are struggling. Medication cannot be prescribed without a diagnosis through CAMHS
- Lack of resources so timely intervention at Low level doesn't come and increases to big problems needing more input
- Waiting times for mental health in young people poor
- Is there an OT unit for people under 60 but none for over 60s? I can't access a bath and need a wet room. (Answer) OTs work for WBC as well as health, and if need for equipment they can come out and assess
- OT Service
- RBH changing facilities, difficult for LD and wheelchair users
- Support needed for carers of adults with disabilities in hospital, they are treated as staff
- Waiting list – lack of resources in Adult Social Care, mental health, NO timely intervention
- GP specialist service poor
- Communication especially with social care. Moved to Thatcham, health good but not heard from social care, e.g. for help and advice. Want to be recognised and heard and in the system
- When I moved here in 1987, I got a welcome pack from the Council but this time nothing. I've now lived her for 12 weeks and received no social care support.
- Understanding NHS language: acronyms, terminology, definitions

DRAFT

- Beyond GP and broader health services specialists are less understanding
- GP appointments in three weeks
- No communication between GP surgeries and buses eg Handybus for timely appointments
- GP surgeries only open a few days a week
- No communication between providers
- Repetitive requests for Information
- Waiting times for appointments too long
- Lack of respite for carers: support for mental and physical health needs – better carer support
- Child – adult transition ill prepared for
- No support from GP to manage meds reviews (long term condition) – advised to make appointment three months in advance to see own GP
- The Local Offer sets out provision which is available for children and young people with Special Educational Needs and Disabilities (SEND), aged 0 to 25, including education, health and social care services but I can't access it. I get a carers allowance of £50 a week and for overnight care it costs £900. I want some sleep.
- No after care after seeing NHS professionals, I called an ambulance, they treated me, then I was left alone
- People with disabilities avoid making GP appointments because of problems getting there
- One size does not always fit all adult respite facility for wheelchair users once they are adult and have complex medical needs
- Challenge to see a psychiatrist at Hillview House community hospital. I got diagnosed and was told to see a psychiatrist on a regular basis and that my GP would follow-up, but GP knew nothing and said he would investigate it but didn't. I am now lost back in the system. I have suffered from mental health issues since 16 and now at 31 am a carer for a child with disabilties and still I can't get help
- Adult Social Services, children's services, GPs, mental health all lack resource

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Carers / Support

- Lack of respite options for adults. Funding has been cut for short stay respite
- Lot of groups helping people but challenge as information not being passed down

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- Everyone on this table said lack of respite for carers or mental health support for them
- Personal Independence Payments for carers with health issues are poor. No income or support for medications and dentist
- I need carer training – how to lift safely, First Aid – updated regularly
- I lack knowledge about what to do as a carer
- We need support for parents with children that have poor mental health
- I don't know what is available – no support to sort out mobility scooters and wheelchairs, GP has no information
- I don't get any respite as I can't buy it in, can't afford it. The direct payment rate is £10 an hour but Mencap charge £18 per hour. I want a two-week holiday, which is what I'd get if I was an employee

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Access

- W Berks, trying to get better and sensitive to people with autism, but more needed in shops etc.
- Took my relative to RBH. I can't manage a large wheelchair but had to transfer to a large wheelchair at the hospital. Large chair won't go into the toilets for the disabled so had to transfer to smaller one just for the toilet. Made a complaint. Letter back saying thanks for bringing to our attention. then nothing.
- No hoists at GP surgeries so I can't be examined
- I need assistance for putting questions to the Council
- Some GPs appear to have no knowledge of their patients. Do not know their medical history. Do not offer support regarding a child with special needs or help with regards to mental health.
- A specialist will recommend talking to a GP regarding services (nappy pickups) but GP's do not know what services are available or how these can be requested / put in place
- People with hearing aids often have problems with indistinct recorded messages
- Lack of accessible toilets
- Wheelchair access in shopping areas
- Thatcham Football Club refuse to provide a covered area for wheelchair users
- Time constraints on equipment hire, eg if going to family for the weekend need to pay for a day's hire
- Understanding NHS language and abbreviations. E.g. CCG

DRAFT

- Communication aids are necessary for children and should be more accessible. Our 9-year-old child cannot talk. We do not have the money to pay for different apps (£300 - £400) to "try" and buy communication aids that can cost £1000's

Transport

- There is a bus service to the rural areas. But only 3 buses a day at not the most convenient of times / within the school day
- I am registered blind and pavement parking makes walking unsafe – Council and police response poor
- In supermarkets and shops, it's hard to find things because all the signs are written rather than any images, for people who can't read
- I have to travel to Swindon for hospital appointments, couldn't consultant hold clinics at WBCH?
- Barrier to getting Blue Badge – I receive a care package but no badge
- Main challenge, transport funding cuts, creating isolation
- Lack of accessible parking in many car parks
- Drivers often not aware of disabilities, e.g. don't put ramp down
- Drivers make excuses not to take people with disabilities
- Buses to college no good I need to use 'mum's taxi'
- Can't use public transport unless book 24 hours in advance
- Bus drivers don't park close enough to the pavement
- No drop curbs and some pavements rough especially on A4 between Church Hall and ½ mile East
- Incident: bus driver not giving people time to sit down
- Drop curbs not lined up
- Handy Bus difficult to access
- Bus drivers don't give people a chance to sit down (Jet Black 1). As a result, passengers have fallen over
- Bus drivers drive past even when a disability is visible
- No late-night buses generally and assistance service problematic
- Lack of public transport in West Berkshire, ie Compton has limited service. Does not help with employment
- Loss of companion bus passes for carers
- Road crossing between College and Tesco's
- Care home, hospital transport, changing rules. Fewer groups eligible for hospital transport (need PIP, DLA, blue badge?
- I have trouble getting on and off with my trolley walker

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- My husband was dying cancer. Had to get to RBH. Not nice conversation to book in. Dr said could have transport. Person on the desk said needed to fit box. 'Isn't dying enough?'
- I tried to get dad on wheelchair taxi but said couldn't take that wheelchair. Said had been on course, needed to be hard back, and attachment points. Means everyone will have to change their wheelchair.
- In Mortimer there is no transport on Sundays and Bank Holidays, they have been removed
- There are two sides to the issue re bus drivers. It is true that some drivers are rude and inconsiderate, however (a) so are passengers and (b) the employer puts constraints on the driver which often puts makes for difficult situations for him. Eg I was a bus driver in Bristol for two years and was allowed 28 seconds for a stop. Taking on a woman with a pram and toddler takes over the allocated time.
- There are overgrown hedges around bus stops
- Lack of wheelchair taxis
- Cannot use disability bus pass until after 09.30 – this is a disadvantage for hospital appointment
- No transport to WB Calcot offices
- Booking a train – passenger assist – ok but not accessible at a times. Eg Thatcham station unmanned on Saturday after 12 noon.
- Additional dropped kerbs often do not marry up
- Cars blocking pavements
- Public transport from Cold Ash v poor
- Hospital transport – I was recently told it is NOT available to Personal Independence Payment / Disability Living Allowance recipients and Blue Badge holders in the future
- Buses have a seat where people with disabilities should have priority. However, they are more often occupied by people, mostly women, and most of them use the seat for their shopping and don't move although they can see you need the seat
- Disabled parking spaces are often taken over by builders skips and equipment or mobile X-Ray units
- Trains – help 24 hours for those in a wheelchair
- Trains must be booked 24 hours in advance for wheelchair users if a ramp s needed
- Wheelchair users – booking a taxi is a nightmare – availability, cost, refusal to take – West Berks are investigating incident where a taxi driver refused to take my dad in a wheelchair
- Trains – access for people with disabilities, ie not have to go to the next station to have help to get off the train with the right help
- Bus and taxi drivers need training in the requirements and show of respect to people with disabilities
- Large wheelchairs don't fit on buses
- Langley Hall Drive is often blocked by waste operatives' replacements of bins

DRAFT

- Taxi drivers are reluctant to take wheelchair users and it is difficult to get one. Many lifts are too small to get a wheelchair as well as a carer in
- Not enough disabled parking at RBH and you must enter the car park to find out disabled spaces are full – you then must pay to get out
- Thatcham football club - not disabled friendly - no parking and no covered area for wheelchair users. Toilet has a slight step too

Social

- Being aware what's out there
- Need for age appropriate activities for people with high needs
- I'm recently bereaved and loneliness
- Difficult meeting new people and getting to know them
- Age appropriate activities needed for those with complicated needs
- No drop-in centre for vulnerable and lonely people
- Isolation in rural communities

Education

- Alleged 'bullying' behaviour towards people with a learning disability from other students
- Newbury College: more activities with animals, more computers that work, more sports activities, eg football, longer lunchbreak

Financial

- People should be assessed on what they can't do not what they can do for PIP, because people have occasional good days and fluctuating difficulties
- DWP fit you into a category in order to tick a box. You are known by your diagnosis
- PIP waiting times for assessments and appeals cause real difficulties
- Personal assessment
- Disability reduction on Council Tax is hard to get
- The threshold for earnings is too low
- Cancellation of home to school transport for anyone with SEND
- Sovereign Housing not always helpful
- Expenses difficult that come with living with chronic and serious illness

Technology

- WBC rely too much on people having access to email for information. Not everyone has or can use a computer
- Internet access for people on benefits – may not have / often do not want to learn (as they fear looking silly).

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- The council expect that everyone has access to or own a computer for information
- Carers Rights day needs webinar access, so I can attend
- Breakdowns in communications for GP urgent referral to optician cause delay

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Services / Facilities

- Assisted bin collection, will go to back door. But [another group said] people emailed about it and then had a large form to fill in and it takes 12 weeks to get in place
- Voluntary sector not well supported financially so people with a learning disability are losing out
- The geographical spread of the area makes it difficult to provide services to individual families
- Thatcham MEP - so difficult to get an appointment as a carer. If the carer becomes ill things can fall apart
- There is no home help for occasional need. I am told to go to hospital, but I can be looked after at home when needed
- Bins – family of five – larger bins but the same as other
- West Berks complaints procedure is awful – you get no results.
- Children's wheelchair clinic – a long wait to be seen; a long wait for repairs; a reluctance to give wheelchairs at the level needed resulting in people being restricted and isolated
- Bins are needed if an adult is incontinent
- Need for changing facilities for older children who are incontinent in public places
- Information is not available re voluntary service
- Making sure there's information about where to get support. E.g. cancer charity could give lifts but only found out about it ad hoc with 3 Frogs

Other

- Need more comprehensive ombudsman over and above SEAP (adult social care)
- Raise awareness of how local councillors can help

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Appendix 3

What does wellbeing mean to you?

- Wellbeing is being happy, having boyfriends, a quiet time, good food, listening to music, going to college and help from learning support assistants. Being with animals, sport and football
- Healthwise it is healthy eating, more exercise, going outside and being active and being active inside (sports)
- Challenges to wellbeing are too much sugary stuff, not seeing family every day and not wanting to go for walks.
- Pain management
- Being able to get out and about and meet people
- Being mobile
- Accessing what I need when I need it
- Being able to access sports/exercise venues
- Kerbs, bus companies, more parking
- Not being dizzy, able to breathe
- Being supported by those around us, professional and personal
- See same GP each time
- Feeling safe and happy in your own home
- To be able to live life as you want
- To feel comfortable
- To have help when you need it
- Not to feel or be threatened by others
- Independence
- Helpful neighbours / community support
- Links to others and wanting to be part of a wider community

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Appendix 4

What would you like to see to improve your wellbeing?

- More resources for CTPLD (Community team for People with a Learning Disability) - only two staff left!
- I don't know about the different groups that are available
- Better training for frontline staff – empathy
- Funding support to access groups, cost is a barrier
- Not feeling lonely or isolated
- More information about what is available
- Prompt access to treatment when you have a problem
- Not having to pay for physiotherapy
- Help with motivation to keep fit if you have a mental health issue
- More cycle/pedestrian paths where there are no cars
- Information in hard copy as well as on line
- To be able to carry on working
- To be able to manage my disability in everyday life
- Suitable time slots for activities, eg an autism hour for shopping
- Treating mental health and physical disabilities in a holistic manner
- Waste collection assistance for moving full bins over uneven ground. I called, emailed, filled in form but nothing for three months
- More accessible clubs/activities
- Supermarket phone for shopping where cannot access the internet

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Appendix 5

How might innovation and technology help me in the future?

- Improved customer digital systems eg can't book wheelchair space online
- Access to volunteers to show people how to use Google/iPad etc. in my home
- Training on the use of mobility scooters
- A lot of technology available but need help in choosing which is the most appropriate for the person. Difficult to keep up with advancements. Need a technology advisor
- Linking Eye Gazer with the internet to enable Skype and email and communicate with friends
- More human voice technology
- Trains with ramps to not have to book.
- Car club vehicle that can take a wheelchair
- Automated vehicles

- Bring back the Welcome Pack when move to the area, on line with dial in for more information
- Supposed to be one dial in number, someone answer the actual phone
- Skype GP appointments
- Find my Phone so I know where my child/partner is
- GP app on phone
- Disabled persons app: parking locations and availability of disabled spaces, public transport appropriate stops, toilet facilities/with hoist, shopping area, etc
- Email facility for my GP
- An exercise program with specific exercises for me – a lightweight box.
- Tablet talking reminder, text, call
- Emergency network of volunteers for support in a crisis
- Shopping app
- App to give information if appointment is on time/running late
- Communication device so that my daughter can communicate with me that doesn't cost £20 - £30k
- Alexa link to call emergency services
- Pads for older people to engage/entertain to reduce isolation
- Heating dials back lit as sight impaired people can't see to adjust
- Electricity and Gas meters too small and often located in difficult situations
- More companies to send audio disks rather than letters
- Larger fonts on packaging
- Bigger number mobile phones at affordable price – Vodafone a local company that could sort
- Scales that read out measurements
- Where pavements/kerbs have knobbly bits are not obvious (most) could use lights or colours.
- Coloured bicycle lanes as difficult to see what is pedestrian and what cycle
- Supermarket phone for shopping where cannot access the internet
- Picker gadget/revolving shelves where cannot reach shopping shelves
- Signage with pictures as well as words
- Smart houses tailored to individual needs

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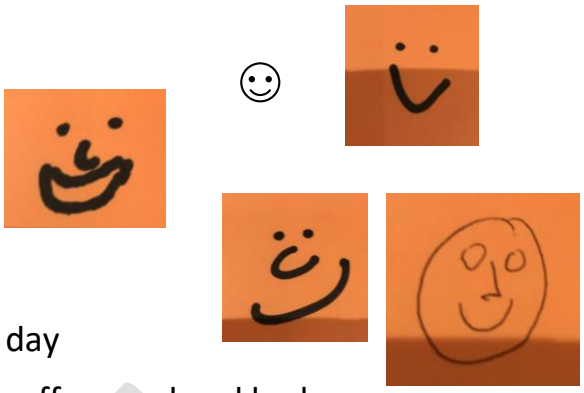
Appendix 6



What people thought about the day?

1. Very interesting ☺
2. Excellent day ☺
3. I was very happy what came out of the day
4. Very helpful, food great, opportunity to offer good and bad
5. It was really good and interesting. I'm going to feedback to the It's My Life group
6. Good day. Good to be listened to. Let's hope these things are worked out.
7. Really good. Proves that 'conversations' and networking equal a great sharing of information which is needed. Great, into sharing.
8. Good time keeping.
9. Excellent participation by ALL
10. Great lunch
11. Good networking
12. but quite long!

Proposed Creation of Integrated Care Partnership - Summary Report

Committee considering report:	Health and Wellbeing Board
Date of Committee:	30 May 2019
Item for:	Decision
Report Author:	Nick Carter

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. 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.

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

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

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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.

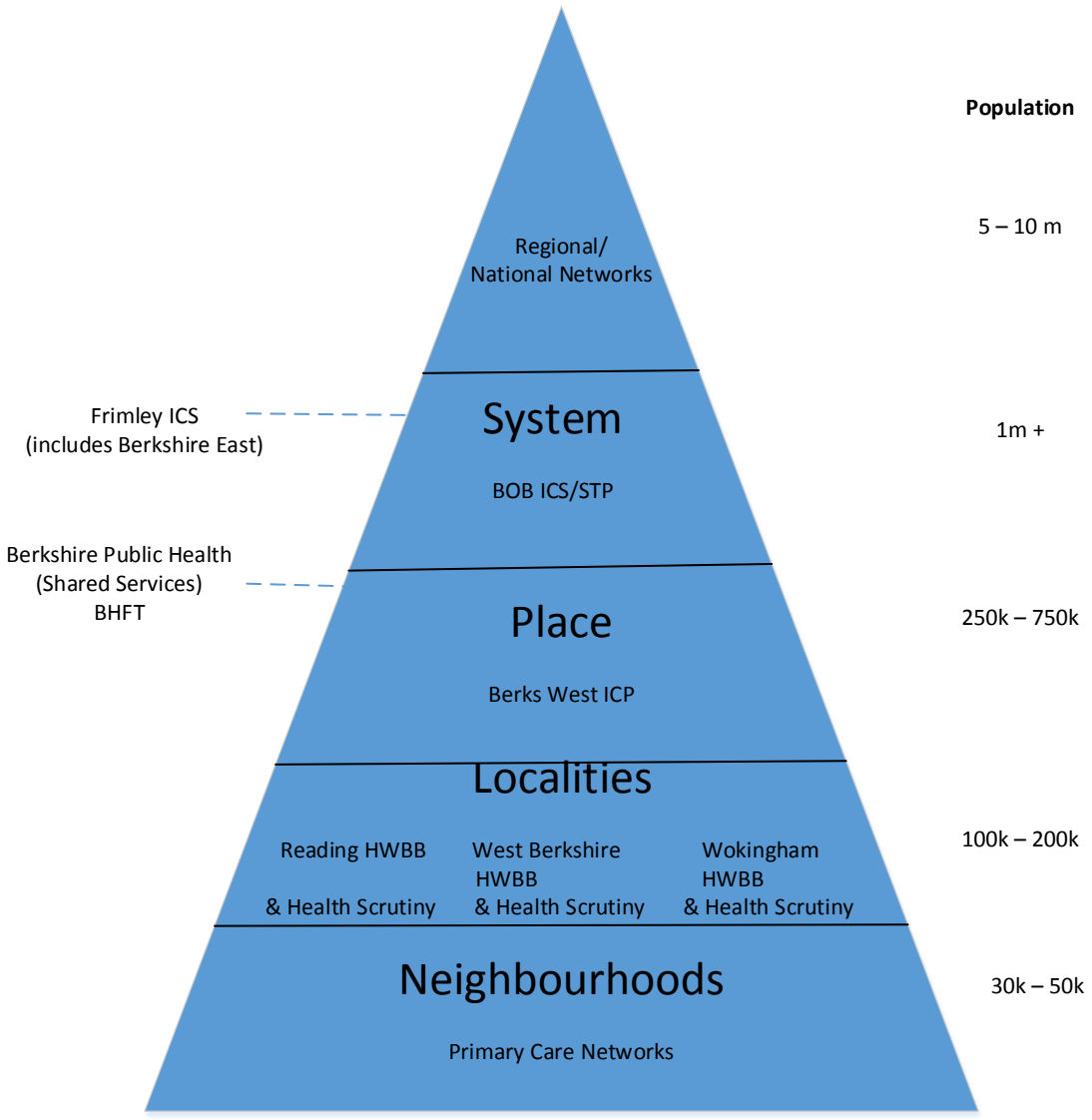
(4) The terms of reference for the BWICP Leadership Board, BW10 Executive and BW10 Delivery Group as set out in Appendices 5a-c of the main report are agreed.

(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

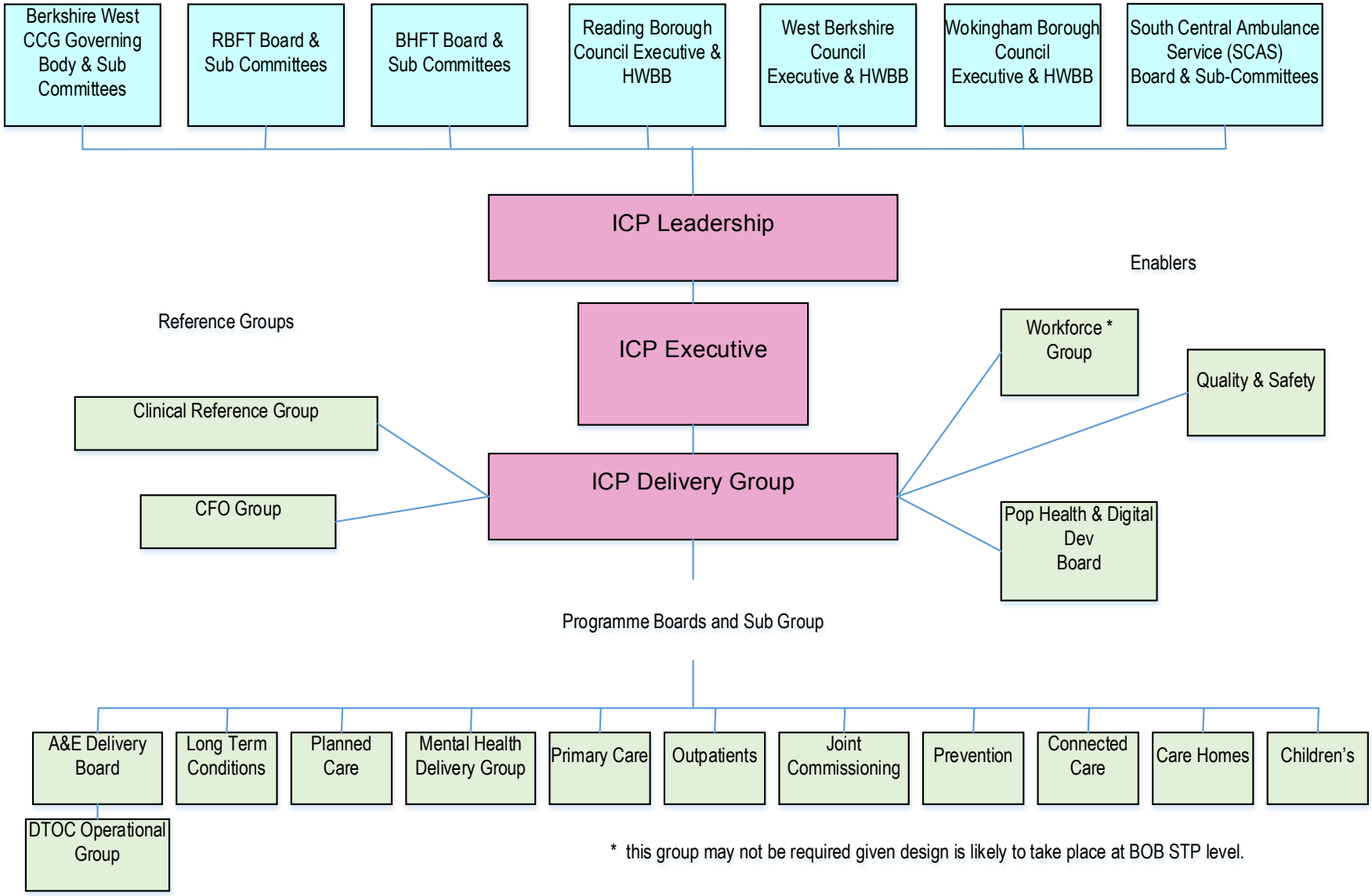


Note: Delivery will also be provided by organisations which will not necessarily align with this taxonomy

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 (February 2019)



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

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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.

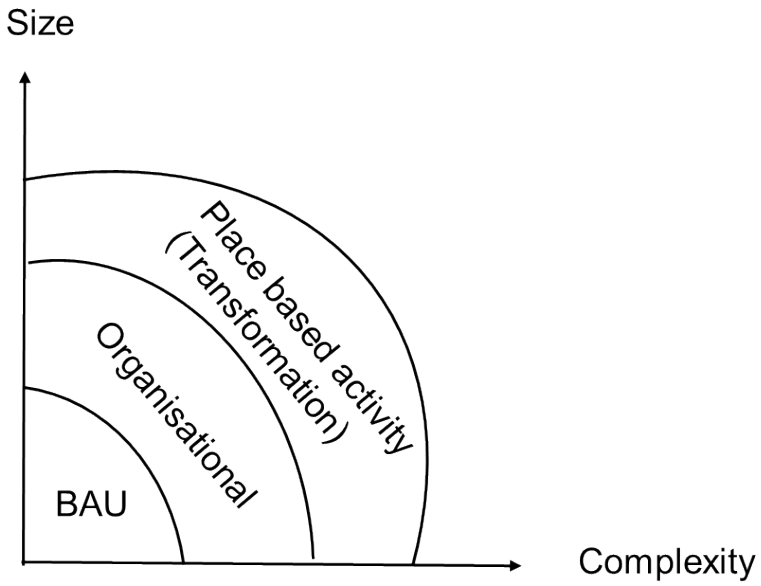
4.13 Appendix 3b highlights five strategic priorities for 2018/19 which were used to frame BWICS activity during that year. At this point it is not intended to include these but

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.

NHS

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)

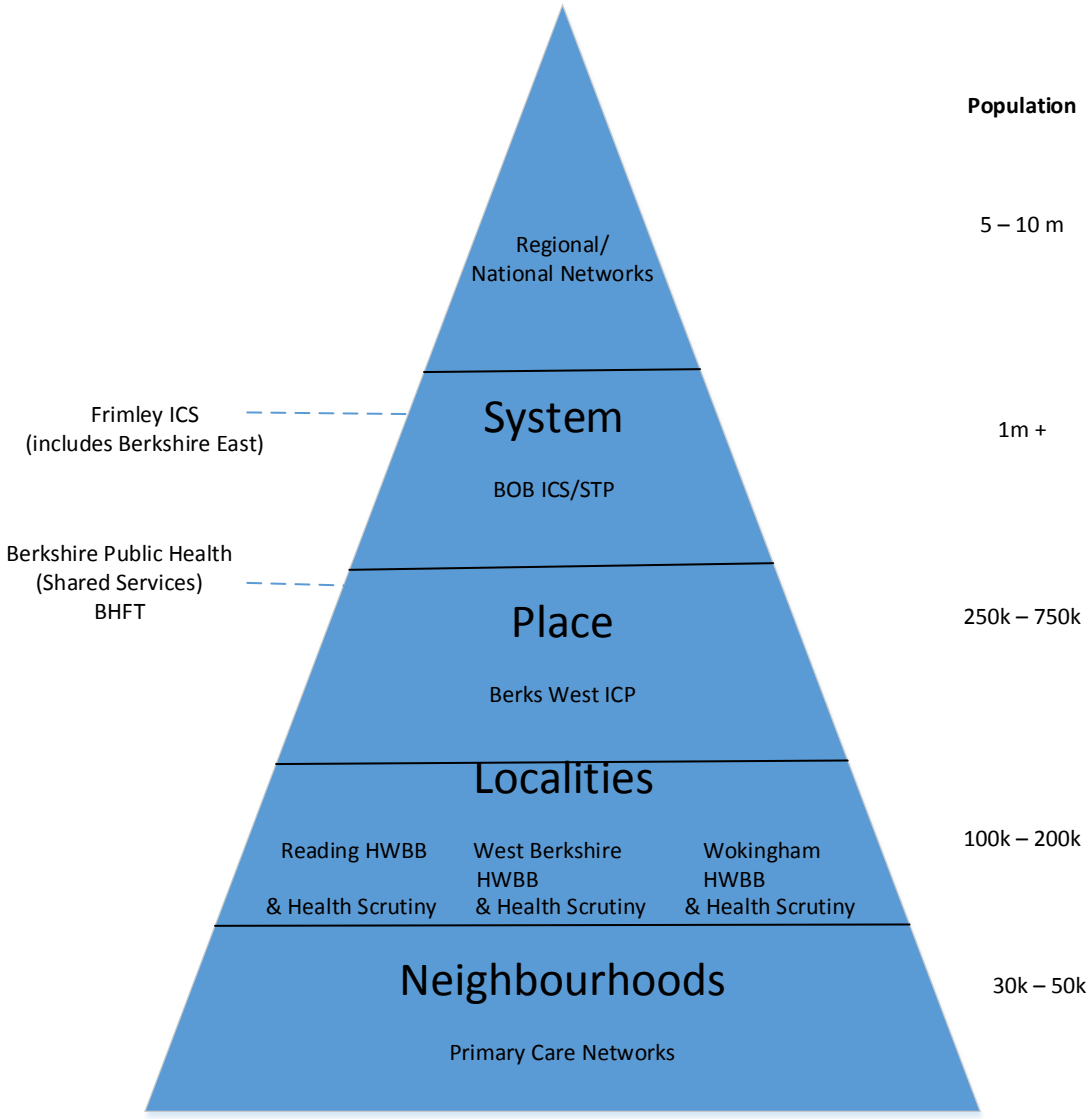
Berkshire West – Programme	£181	
Projects		£169
Reading Programme Office		£150
West Berkshire Programme Office		£100
Wokingham Programme Office		£130
Total		£730

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

Place based objectives

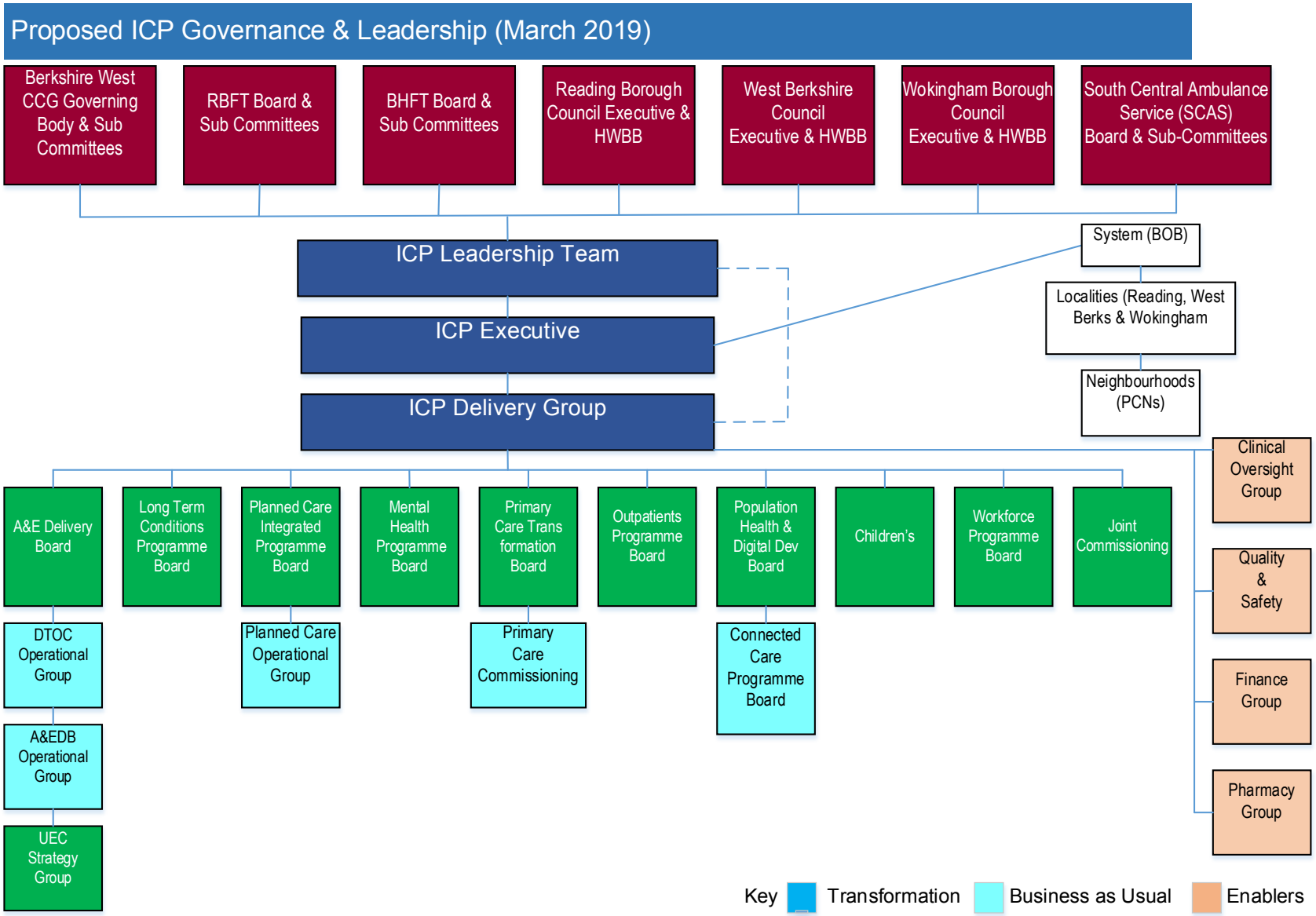
1. An improvement in the health and wellbeing of our population
2. Enhancement of patient experience and outcomes
3. Financial sustainability for all constituent organisations

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

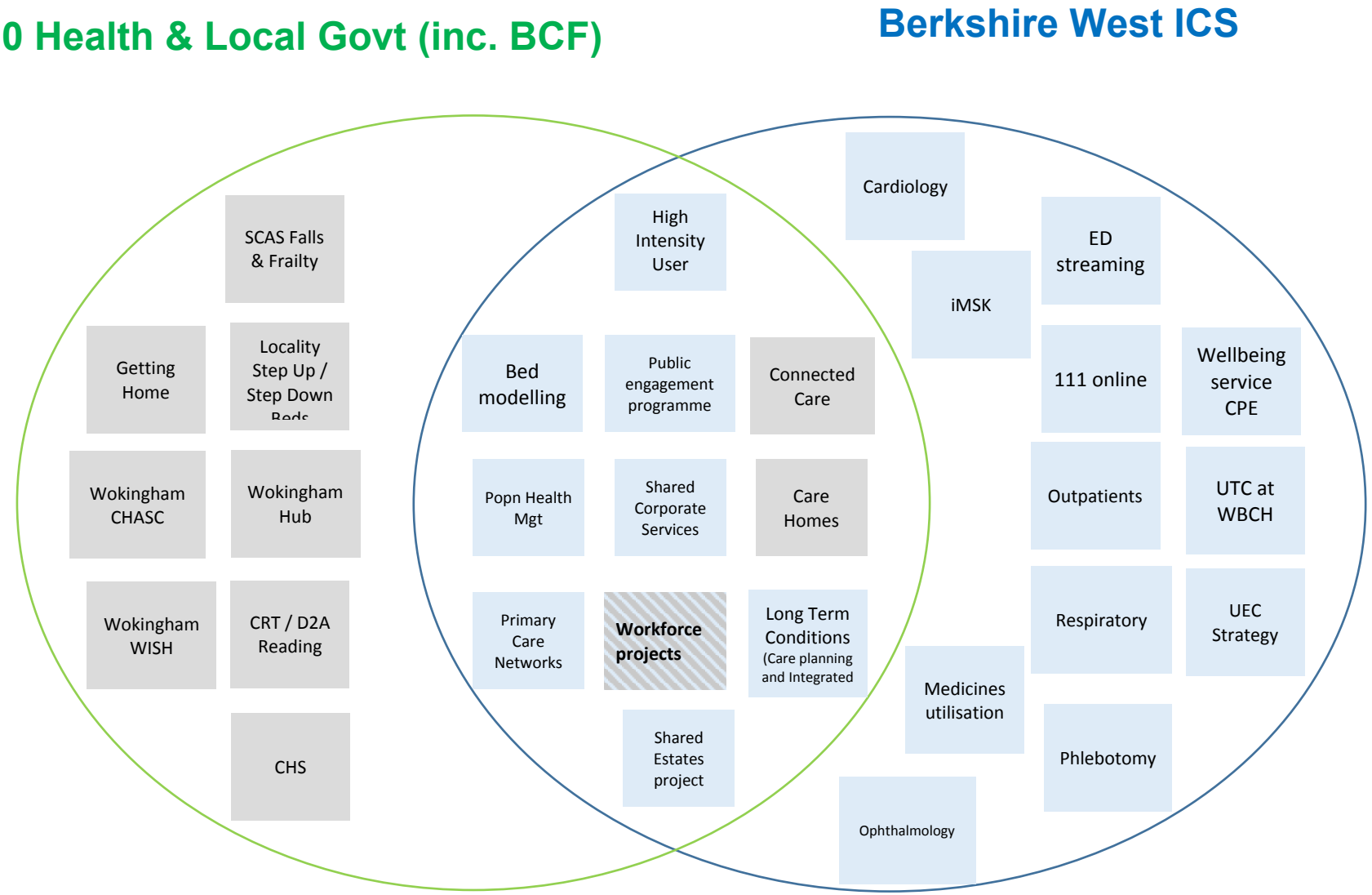


Note: Delivery will also be provided by organisations which will not necessarily align with this taxonomy

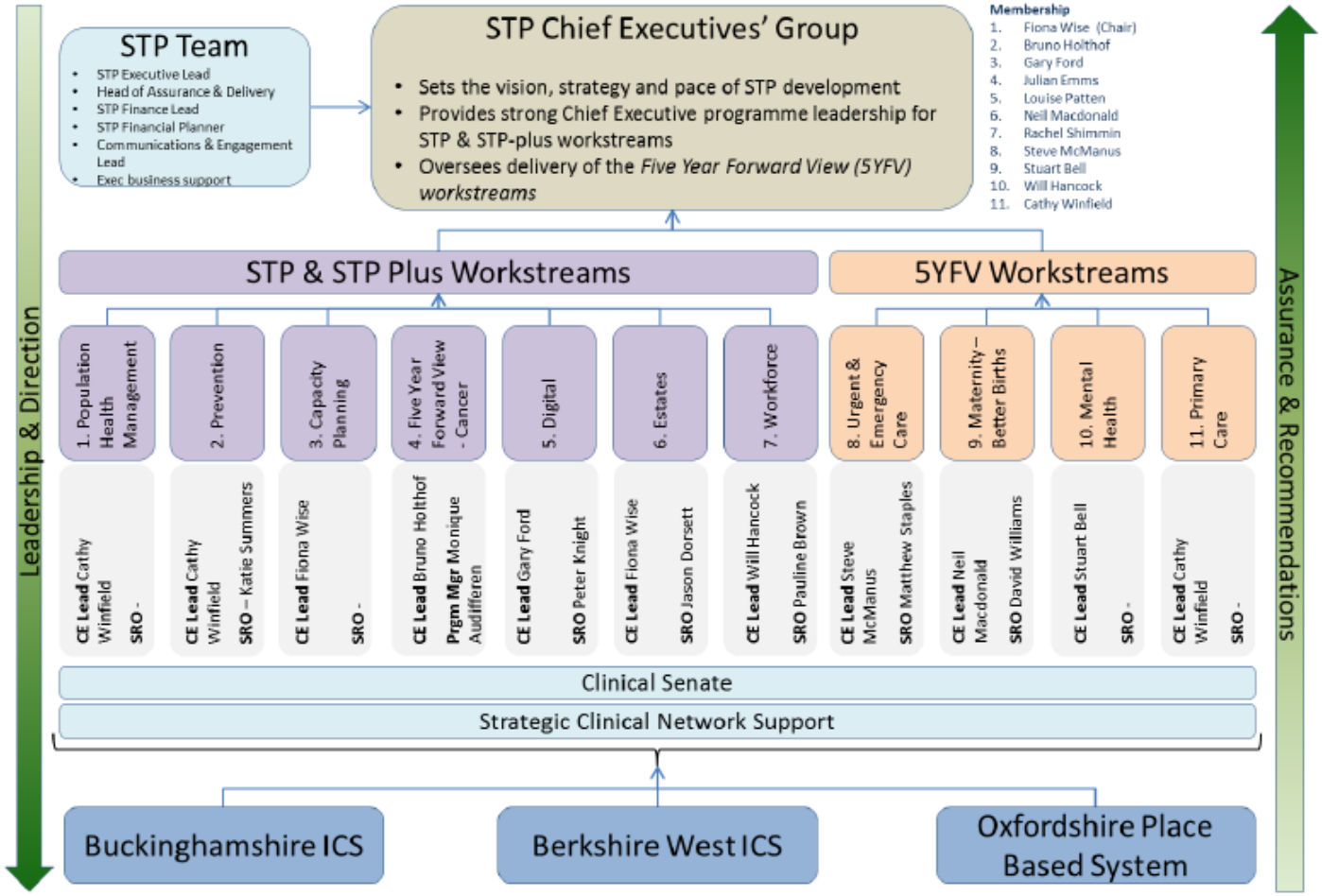
Fig 2 – Proposed BWICP Governance Structure



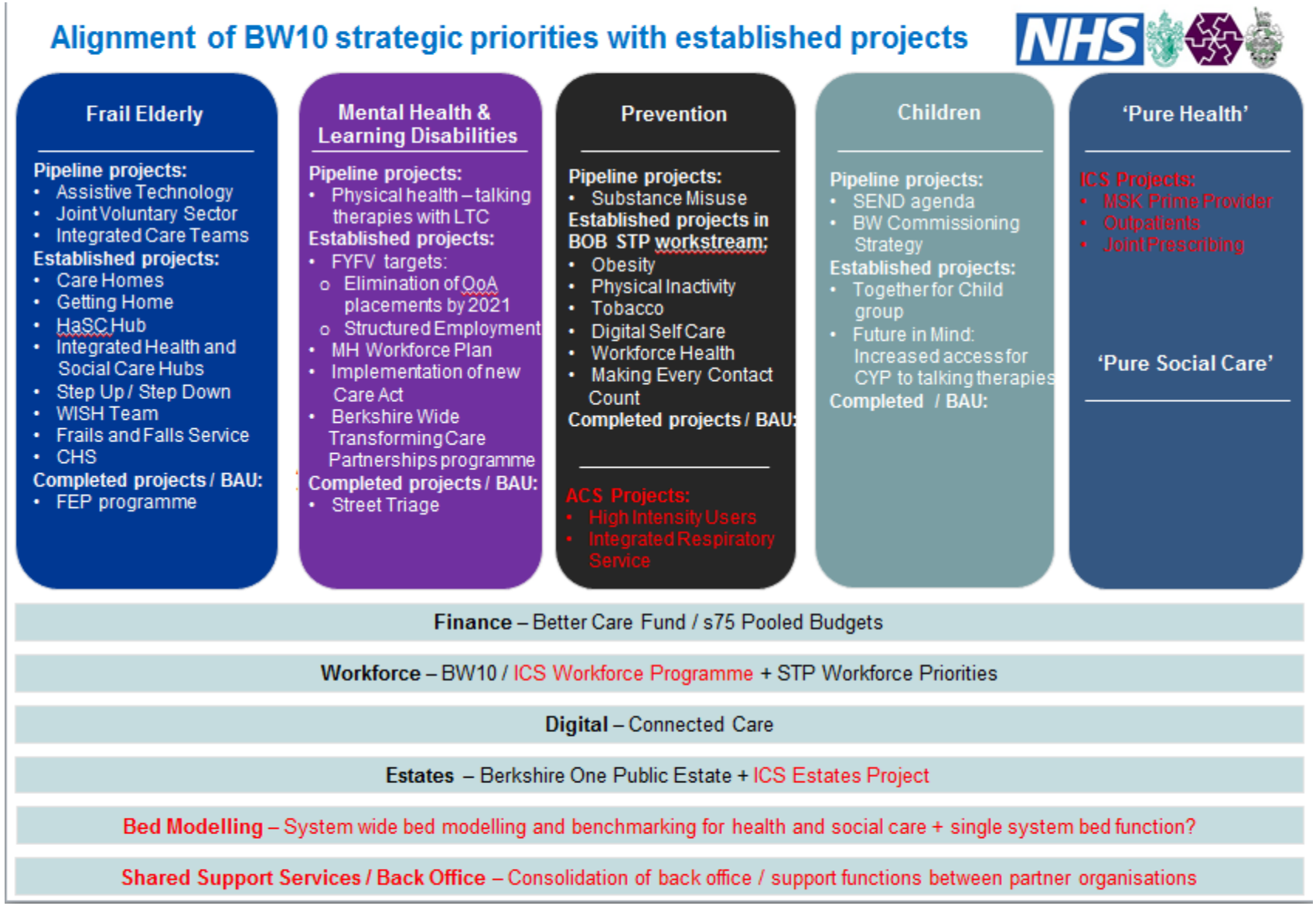
Appendix 1 – BW10 and BW10 ICS - Roles & Responsibilities and areas of common interest



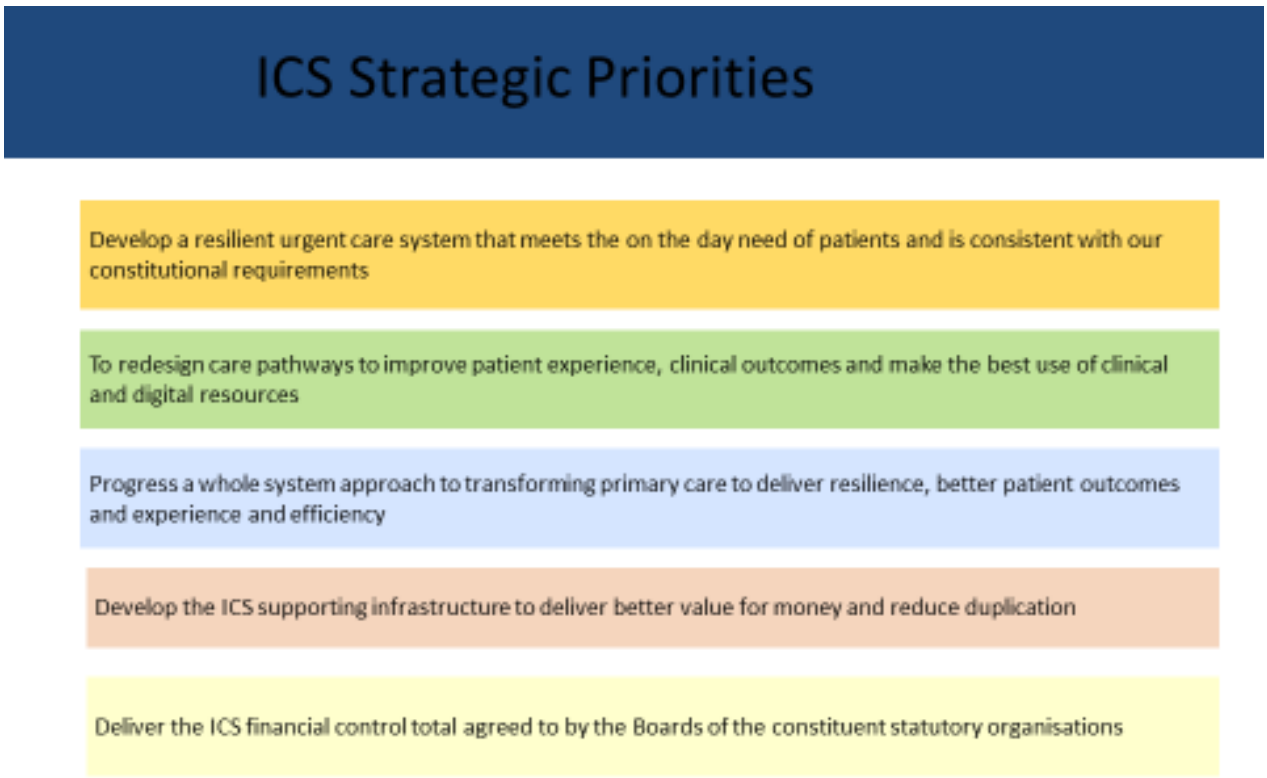
Appendix 2 – BOB STP Governance Chart – November 2018



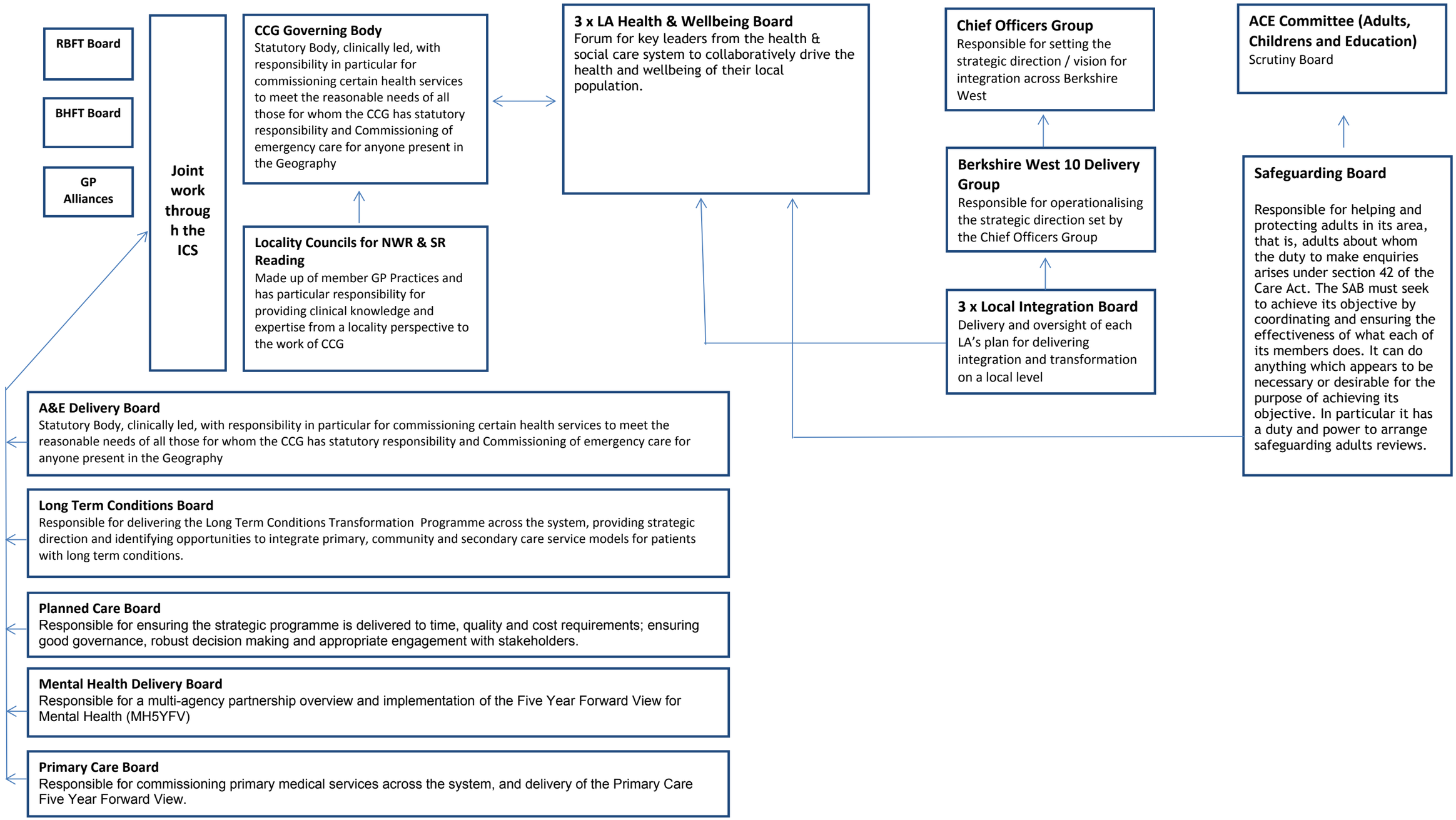
Appendix 3a – The Vision Framework for Berkshire West 10 (October 2018)



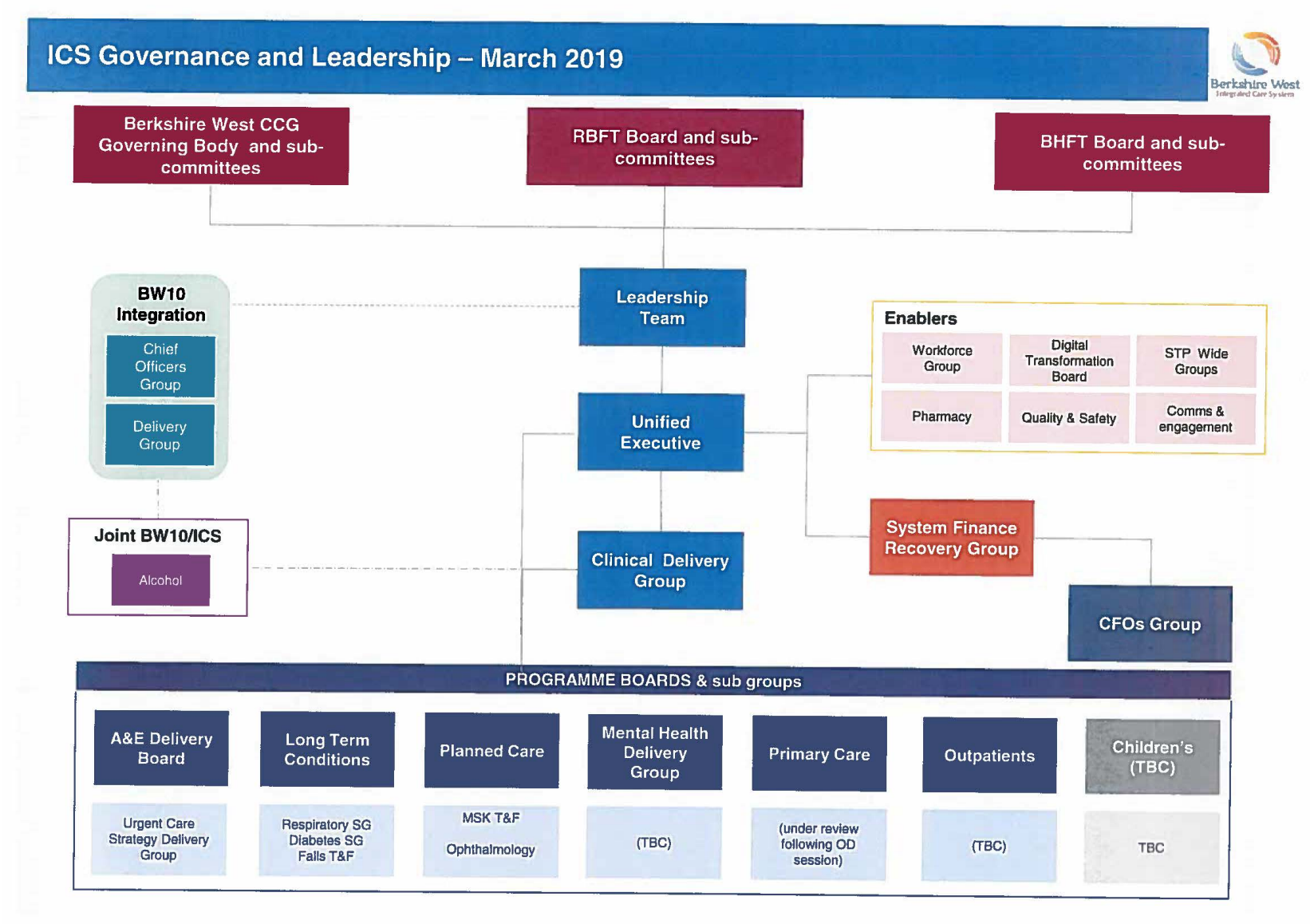
Appendix 3b – The Strategic Priorities of the Berkshire West ICS



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



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 ICS Strategy.

2 Standing

2.1 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.

3 General Responsibilities of the Leadership Team

3.1 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.

(b) to ensure alignment of all partners to the Berkshire West ICP strategy

(c) to promote and encourage commitment to the principles and strategic priorities

(d) to ensure that Berkshire West is effectively represented within the BOB ICS

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

(b) 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;

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

4 Independent Chair / Programme Director / Programme Manager

4.1 An independent non-voting chair has been appointed by the partners to oversee the Leadership Board.

5 Members and Alternate Members of the Leadership Board

5.1 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 Federation 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 ACS

(h) Two GPs who represent a minimum of two GP Provider alliances from within the Berkshire West system.

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

5.3 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.

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

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

- The BWICP Programme Manager

6 Proceedings of Leadership Board

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

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

6.3 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).

7 Attendance of third parties at Leadership Board meetings

7.1 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.

8 Administration for the Leadership Board

8.1 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

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

8.3 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.

9 Review

9.1 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 ACS 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 ICS Leadership Group 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 Manager.
- Meeting dates to be agreed annually.
- Meetings should be scheduled for two hours each.
- The ACS 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 LG members. This is for information/context only and should not repeat/over-lap with papers for the LG.

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 LG quorate, with Chair able to nominate his replacement in event of unavoidable absence.

Scope and philosophy

- The ICS Leadership Group (LG) represents all parties constructed within the ICS framework and within the scope of the MoU. It is instrumental in developing and implementing the BWICS strategy.
- LG will consider the capacity, resources, transformation, operations and reputation of, and risks to, the BWICS as a whole relation to agreed strategy and the wider system as a whole. As such it (LG) will endeavour to ensure cohesion, integration and collegiate working practices and behaviours to deliver the strategy and objectives of the BWICS and amongst providers, commissioners and work-groups.
- Under no circumstances should the LG 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 LG should focus solely on “full width" ICS matters - strategy, transformation 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 BWICS is identified by the Chair.
- 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 BWICS. Where changes necessary to meet an improvement to BWICS 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 ICS objectives.

LG 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 ICS' strategy and oversee delivery of programmes and commitments.
- **Ensure** delivery of the requirements set out in the MoU agreed between the BWICS leaders and NHSE/I.
- **Create** a shared understanding of the 'vision' and 'end point' for the ICS 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 BWICS.

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 Standing

2.1 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.

3 General Responsibilities of the ICP Executive

3.1 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

4 Reviews/Reporting

4.1 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.

5 Members and Alternate Members of the Executive Team

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

5.2 The Executive Members will be

(a) Chief Officer 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 ACS Clinical Strategy Group

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

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

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

(h) Strategic Director for Public Health (Berkshire)

(i) BWICP Programme Manager

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

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

5.4 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.

5.5 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 the CCG Leadership Board members are in attendance.

5.6 The following will be non voting members of the Executive

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

- The ACS Programme Manager
- NHS England's 'Sponsor for the Berkshire West ACS who will attend on a regular basis when appropriate.

6 Proceedings of Executive Meetings

6.1 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")

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

6.3 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.

7 Attendance of third parties at Executive Team meetings

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

8 Administration for the Executive Team

8.1 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

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

8.3 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.

9 Review

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

Appendix A - Principles of Collaboration (extract from the Berkshire West ACS 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 ICS

(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 SOPH 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 the 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.

Report from the Annual Health and Wellbeing Conference

Report being considered by:	Health and Wellbeing Board
On:	30 May 2019
Report Author:	Jo Reeves
Item for:	Discussion

1. Purpose of the Report

1.1 To summarise the outputs from the annual Health and Wellbeing Conference held on 4 April 2019 at Thatcham Rugby Club. The focus of the conference was to explore how to achieve the aspirations outlined in West Berkshire Vision 2036 which was adopted by the Board in January 2019.

2. Recommendations

2.1 Later in the year a paper should be presented to the Board which articulates the alignment of all partners' current and emerging strategies with the ambitions in the West Berkshire Vision 2036.

3. How the Health and Wellbeing Board can help

3.1 Continue to lead culture change in your organisations which emphasises collaboration with partners and communities.

3.2 Ensure that your strategies and plans are compatible with the West Berkshire Vision 2036 and work together to fill any gaps.

Will the recommendation require the matter to be referred to the Executive for final determination?	Yes: ☐	No: ☒

4. Introduction/Background

4.1 The Health and Wellbeing Board has held a conference annually for the past few years in order to engage with its wider stakeholders outside the confines of an ordinary public meeting. It serves to inform attendees of the Board's activities over the previous year and encourage their continued participation through an activity.

4.2 In 2019, a slightly different approach to organising the conference was taken with a group of volunteers being drawn from the Board's Patient and Public Engagement Group. The group determined that the audience would be professionals linked to the Board or its sub-groups and Patient Participation Groups. The agreed purpose of the conference was to celebrate success, encourage participation in the West Berkshire Vision 2036 and consider best practice for public engagement.

4.3 The group of organisers included Jo Reeves – WBC, Cecily Mwaniki - BHFT, Andrew Sharp –Healthwatch, Sharon Briggs – BCT, Kamal Bahia – CCG and Adrian Barker and Karen Swaffield – volunteers.

4.4 The diversity of the organising team led to a creative and collaboration focussed agenda.

5. Agenda

Update on the Board's Activities over 2018/19

5.1 Jo Reeves, Principal Policy Officer - WBC, provided an update on the Board's activities over 2018/19, including some highlights from its sub-groups. The following infographic was used to demonstrate some of the main headlines:

Where are we now?

5.2 Matt Pearce, Head of Public Health and Wellbeing - WBC, gave his personal reflections on the work of the Board following a year. He also presented a video

which had been commissioned to demonstrate the impact of the Health and Wellbeing Board, including how its activities already aligned with the aspirations in the West Berkshire Vision 2036.

5.3 An abridged version of the video is available on YouTube: https://www.youtube.com/watch?v=2uYTaXTiO_A&t=3s

5.4 Kamal Bahia, Chair of the Patient and Public Engagement (PPE) Group, gave an overview of the range of partners and groups the PPE had engaged with over the year. She also announced the official launch of the improved West Berkshire Directory, an online resource which lists a wide range of services, groups and activities.

5.5 The Directory is available here: https://directory.westberks.gov.uk

West Berkshire Vision 2036

5.6 Nick Carter, Chief Executive – WBC, gave a summary of the five key themes in the West Berkshire Vision 2036; a partnership document created by the Health and Wellbeing Board to outline the challenges and opportunities that the District will face over the next 17 years.

5.7 Some interesting queries were raised around whether the Board had the necessary governance in place in order to implement the Vision, what the 'quick-wins' were that could be achieved and how the public would be engaged.

Community Led Transformations

5.8 Susan Powell, Building Communities Together Team Manager, described examples of community-led transformations using examples from abroad in Denmark and Australia and closer to home in Purley on Thames. She emphasised that communities must be part of the Vision if it is to be effective.

6. Activities

What does the Vision 2036 mean to you?

6.1 Attendees were asked to produce a word cloud using the outline of West Berkshire which captured thoughts, ideas and feelings about what the Vision meant for them in their roles as professionals and volunteers. A large proportion identified the ways in which all partners would need to work together in order to realise the ambitions articulated in the document.

6.2 Examples of the word clouds are in Appendix A1.

What is the path to the Vision 2036?

6.3 After break, attendees were asked to draw the path to the Vision 2036, or the 'yellow brick road'. Attendees drew and wrote on a yellow brick road graphic, demonstrating the barriers and enablers, milestones and stakeholders that would be involved.

6.4 Examples of the 'yellow brick roads' are in Appendix A2.

7. Closing Remarks

7.1 Councillor Rick Jones closed the conference by informing attendees of the potential priorities for the Board over 2019/20. He outlined three options under consideration:

(1) Giving children the best start in life

(2) Primary Care Networks (PCN's)

(3) Supporting vulnerable people into work

7.2 Further work would be undertaken to establish what expectations the Board would have of any group leading on one of these priorities.

8. Feedback

8.1 Attendees were invited to use postcards to record their feedback. Of those who chose to provide feedback, the response was overwhelmingly positive. Some constructive feedback was also received regarding the clarity of the activities. Examples of comments are provided below:

"Excellent input from all members – interesting topics and ambitions. Coordination and communication needed."

"I found the discussions very useful and inspirational. It was also good to see what has happened over the last year and to work on the visions for the future."

"Very well done! Good turnout and engagement with a cross section of people and groups."

8.2 Attendees were also invited to describe what they would do differently as a result of the conference. Common themes regarding actions were around community engagement and aligning work to the ambitions in the West Berkshire Vision 2036.

"Engage with diverse groups to accrue benefit for all."

"Promote more coproduction of system working."

"We will be better at working together, making the effort to share resources and talk about what we do. We will remain connected and keep in touch!"

8.3 Where an address was provided, the postcards will be posted to the attendees in early July.

9. Conclusion

9.1 The annual Health and Wellbeing Conference held on 4 April 2019 was attended by over 40 professionals and volunteers linked in some way to the Health and Wellbeing Board's work. Good feedback was received for the lively and creative event.

9.2 The presentations and discussions at the conference have raised some issues for consideration by the Board.

(1) What governance arrangements are required for the Board to oversee the 'implementation' of the Vision 2036?

It is expected that a governance review will be undertaken alongside the development of the new Joint Health and Wellbeing Strategy. This might need to include a membership review. Any necessary changes will be identified and brought back to the Board for discussion.

(2) How will the Board's partners encourage the necessary culture change to achieve the aspirations as set out in the Vision 2036?

The Board has long had a commitment to working together in order to overcome barriers and improve opportunities for everyone to enjoy the best possible health and wellbeing. Specific opportunities for joint working should continue to be explored.

(3) How will the Board engage with the public to inform them what the Vision 2036 is, how it effects them and how they can get involved?

The Patient and Public Engagement Group refreshed their strategy in 2018 and have recently refreshed its membership and objectives. The Board needs to maximise use of this group, whilst acknowledging that the members of the group are either volunteers or participating on top of their day jobs.

9.3 The Board needs to ensure that the Vision 2036 is a live document; it is proposed that a report is presented later in the year to map alignment of existing and emerging strategies of all partners with the West Berkshire Vision 2036.

10. Consultation and Engagement

10.1 Matt Pearce – Head of Public Health and Wellbeing has been consulted in the preparation of this report.

11. Appendices

Appendix A1 – Word Clouds

Appendix A2 – Yellow Brick Roads

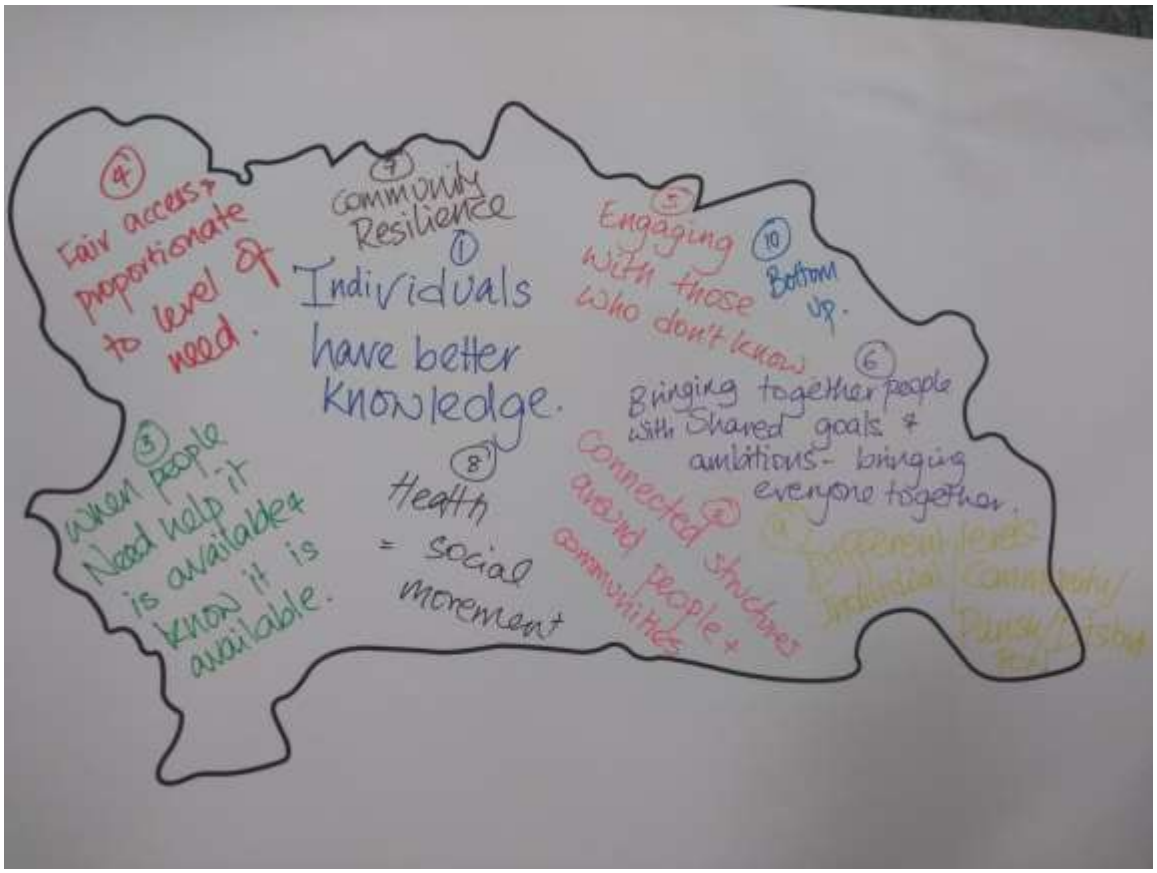
Background Papers:

West Berkshire Vision 2036:
https://info.westberks.gov.uk/CHttpHandler.ashx?id=46989&p=0

Officer details:

Name:	Jo Reeves
Job Title:	Principal Policy Officer (Executive Support)
Tel No:	01635 519486
E-mail Address:	joanna.reeves@westberks.gov.uk

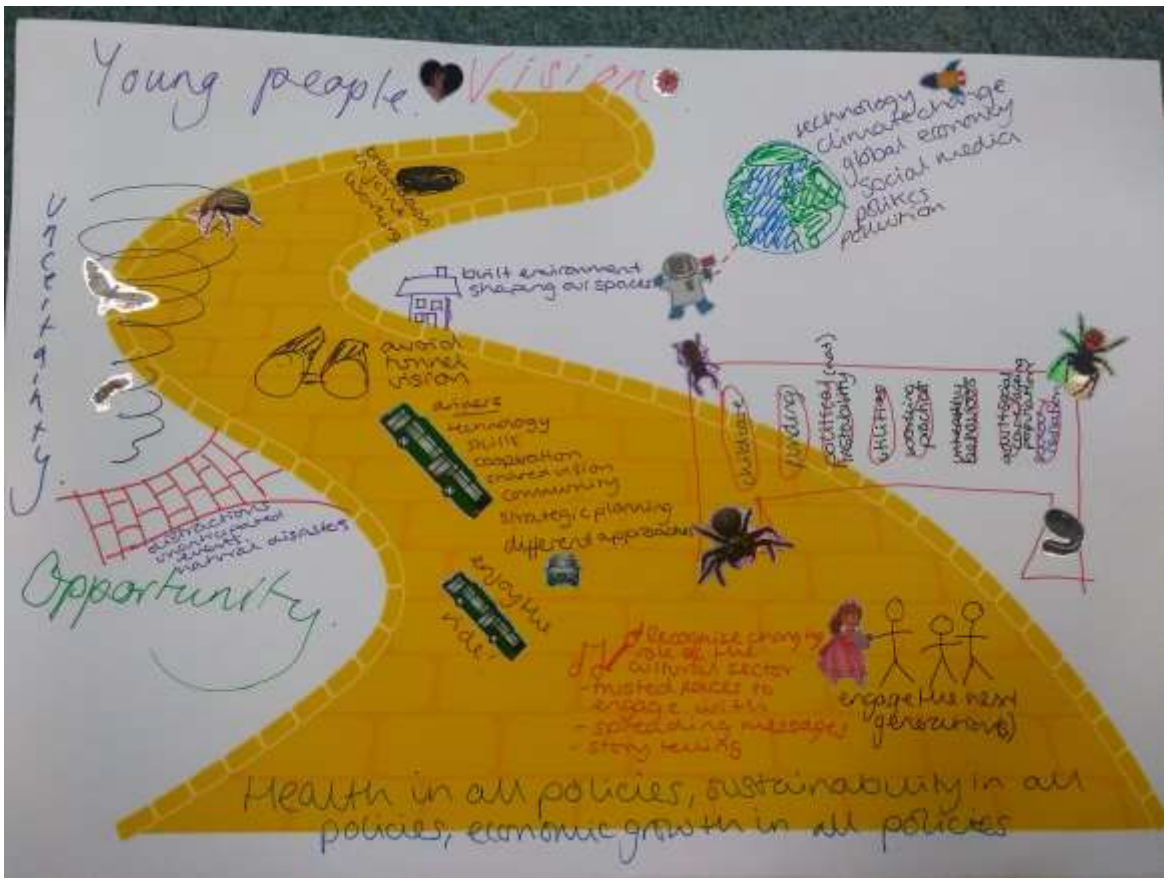
Appendix A1- Word Clouds




TOP DOWN
HOUSING
COMMUNITY DRIVEN
AMBITION
WORK FORCE
SAFE
EQUALITY
LONG TERM
INCLUSIVE
DATA DRIVEN
FOCUS
HAPPY


GEOGRAPHY
WHO(PEOPLE)
FOUNDATION
Facilitating
ENGAGEMENT
Flexible
WHAT (ACTION)
Recognition
INCLUSION
Diversity
Language
MILESTONES
AMBITION
EQUALITIES
HOW(PROCESS)
Challenge
OUTREACH
Encouragement
Journey/Path
Review
DIRECTION
Adjust
QUALITY OF SERVICES
Aspiration
Opportunity
Catalyst

Appendix A2 – Yellow Brick Roads


Young people Vision
technology
climate change
global economy
social media
politics
pollution
built environment
shaping air spaces
natural human vision
drivers
technology
skills
cooperation
shared vision
community
strategic planning
different approaches
Uncertainty
Opportunity
engage the next generation
Health in all policies, sustainability in all policies, economic growth in all policies


Plan
Do
Study
Act
10 Year Plan
Review + Reinform
DRIVER
If we don't do this it will break - we need to improve now
Reduced health inequalities
INTEGRATION
Aligning what we are doing & why
small steps/milestones
Cross collaborative working
Stay Positive. Resilience in the community + Planning ahead
Engage schools + YP
Physical Activity
'Move more'
Who is our Hugh?
Health + Wellbeing Board → People
Joint Health + Wellbeing Strategy
JSNA
SHARE THE VISION
166,120 pops
120 responses
small pebbles, share, share
SHARE!

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Health and Wellbeing Board Membership

Report being considered by:	Health and Wellbeing Board
On:	30 May 2019
Report Author:	Jo Reeves
Item for:	Decision

1. Purpose of the Report

1.1 To provide an update on the current status of the Board's membership, following the appointment of new members to represent employers and major healthcare providers in January 2018.

2. Recommendations

2.1 That the Health and Wellbeing Board appoint the Head of Public Health and Wellbeing at West Berkshire Council as a member.

2.2 That the number of named CCG representatives is reduced to two following the Berkshire West CCG merger.

2.3 That the Board clarifies that one shadow portfolio holder for health and wellbeing from each Political Group on the Council may be a member of the Board.

2.4 That one seat for employer representatives is removed and one maintained pending feedback from Vodafone. Further employer engagement to take place through the Skills and Enterprise Partnership.

2.5 That a representative from the arts and culture sector be invited to join the Board.

Will the recommendation require the matter to be referred to the Executive for final determination?	Yes: ☐	No: ☒

3. Introduction

3.1 The Health and Social Care Act 2012 established Health and Wellbeing Boards. The legislation prescribes the core membership of the Health and Wellbeing Board and gives the Board permission to appoint additional members as it deems appropriate.

3.2 The Health and Wellbeing Board last updated its membership in January 2019 when it resolved to invite two employer representatives, Berkshire Healthcare Foundation Trust and Royal Berkshire NHS Foundation Trust to join the Board.

3.3 The Chairman of the Health and Wellbeing Board and the Strategic Director for Public Health have determined that it is timely to adjust the membership.

4. Update

4.1 The report presented to the Board in January 2018 proposed the appointment of a representative of Vodafone, as the District's largest employer. The Board discussed the matter and resolved that two employer representatives should be appointed to represent large and smaller employers. They also agreed a role description for an employer representative.

4.2 It was thought that engagement through an umbrella organisation representing small and medium sized enterprises was appropriate. To that end a conversation was held with the Thames Valley Chamber of Commerce to seek representation for smaller employers in the District. The conversation was not successful and no smaller employer representative was identified.

4.3 Vodafone nominated a representative to join the Board. However, in the past twelve months no one has attended any of the Board's formal or informal meetings on Vodafone's behalf. Vodafone have been asked if they still wish to nominate a representative to the Board and are trying to identify a representative.

4.4 Tessa Lindfield, Strategic Director of Public Health covers the six Berkshire Unitary Authorities and as such is a member of six Health and Wellbeing Boards. Matt Pearce, Head of Public Health and Wellbeing, is her nominated substitute and attends the Board in her place when she is unable to attend. He is also a member of the Health and Wellbeing Board Steering Group and attends several of the subgroups. Tessa has requested that in order to aid continuity they are both full members of the Health and Wellbeing Board.

4.5 In April 2018 the four CCGs in Berkshire West merged. Previously, the CCGs had three 'seats' on the Board to ensure representation of the Newbury and District and North and West Reading localities, plus the Chief Officer. As a result of the merger and streamlined leadership team, the Chief Officer has confirmed that the CCG are only able to provide two representatives to occupy seats on the Board.

4.6 The outcome of the District Election saw a third party elected to the Council for the first time. The current terms of reference specify that "the Shadow Portfolio Holder for Health and Wellbeing" will be a member of the Board. In light of the election results, it is recommended that the Board clarifies that one shadow portfolio holder for health and wellbeing from each Political Group on the Council may be a member of the Board.

4.7 The link between culture, the arts, health and wellbeing has long been recognised. Increasingly as attention shifts towards preventative approaches, the culture and arts sector has a developing role in supporting health and wellbeing. Further, the Chairman of the Board has been approached by a representative from a local cultural organisation who has requested to become a member of the Board.

5. Proposals

5.1 That the Health and Wellbeing Board appoint the Head of Public Health and Wellbeing at West Berkshire Council as a member.

5.2 The number of named CCG representatives is reduced to two following the Berkshire West CCG merger.

5.3 That one seat for employer representatives is removed and one maintained pending feedback from Vodafone.

5.4 That the Board clarifies that one shadow portfolio holder for health and wellbeing from each Political Group on the Council may be a member of the Board.

5.5 That one seat for employer representatives is removed and one maintained pending feedback from Vodafone. Further employer engagement to take place through the Skills and Enterprise Partnership.

5.6 That a representative from the arts and culture sector be invited to join the Board.

6. Conclusion

6.1 The proposals above would lead to the number of members on the Health and Wellbeing Board going from 19 to 20.

6.2 A further review of the Board's membership will be required following production of the new Health and Wellbeing Strategy in 2020 to ensure the Board is in a position to deliver it. Thought also needs to be given to ensure that the correct stakeholders required to deliver the aspirations in the West Berkshire Vision 2036 are involved.

7. Consultation and Engagement

7.1 Matt Pearce - Head of Public Health and Wellbeing, Councillor Rick Jones – Chairman of the Health and Wellbeing Board.

8. Appendices

Appendix A – Health and Wellbeing Board full membership list at January 2018

Background Papers:

Health and Wellbeing Strategy 2017-2020 and appendices

The proposals contained in this report will help to achieve the above Health and Wellbeing Strategy aim by ensuring the Board is able to broaden its reach to deliver the Health and wellbeing Strategy.

Officer details:

Name:	Joanna Reeves
Job Title:	Principal Policy Officer (Executive Support)
Tel No:	01635 519486
E-mail Address:	joanna.reeves@westberks.gov.uk

Appendix A – Health and Wellbeing Board Membership (January 2018)

Statutory members of the Health and Wellbeing Board

1. the Leader of the Council or their nominee
2. the director of adult social services for the local authority,
3. the director of children's services for the local authority,
4. the director of public health for the local authority,
5. a representative of the Local Healthwatch organisation for the area of the local authority,
6. a representative of each relevant clinical commissioning group

Additional members appointed upon the creation of the Health and Wellbeing Board

7. a representative of the voluntary sector
8. the Portfolio Holder for Public Health and Wellbeing
9. the Portfolio Holder for Children and Young People
10. the Portfolio Holder for Adult Social Care
11. the Shadow Portfolio Holder for Health and Wellbeing

Additional members appointed in November 2016 to cover the wider determinants of health

12. A representative from Royal Berkshire Fire and Rescue Service
13. A representative from Thames Valley Police
14. A representative from the housing sector
15. The Portfolio Holder for Community Resilience and Partnerships.

Additional members appointed in January 2018 to support delivery of the Health and Wellbeing Strategy

16. Employer representative (small and medium sized)
17. Employer representative (large)
18. Berkshire Healthcare Foundation Trust
19. Royal Berkshire NHS Foundation Trust

Royal Berkshire NHS Foundation Trust

Berkshire West Clinical Commissioning Group

Berkshire Healthcare NHS Foundation Trust

BERKSHIRE WEST INTEGRATED CARE SYSTEM

OPERATING PLAN: 2019/20

1 INTRODUCTION

This document is the 2019/20 Operating Plan for the Berkshire West ICS and the NHS organisations that are part of the ICS. It will form the foundation for a five year strategy that will be developed later this year in response to the NHS Long Term Plan. The ICS will work with its three local authority partners and Health and Well Being Boards to develop a single strategy for Berkshire West and this, in turn, will contribute to the development of the strategy for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) shadow ICS.

To meet the challenges faced by the local health and care economy, the constituent NHS organisations have joined together to form the Berkshire West Integrated Care System (ICS). The ICS is currently made up of:

- Berkshire West Clinical Commissioning Group (CCG)
- Royal Berkshire Hospital Foundation Trust - an acute hospital (RBFT)
- Berkshire Healthcare NHS Foundation Trust - a community and mental health provider (BHFT)
- Providers of GP services in Berkshire West

The ICS also works closely with South Central Ambulance Service (SCAS) and the three local councils in West Berkshire, Wokingham and Reading to drive integration between health and social care through the Berkshire West 7 programme. During 2019/20 we will align the two programmes and create a single set of governance arrangements for the NHS and local government in order to take on joint responsibility for the health of the local population, providing joined up, better coordinated care and making best use of the Berkshire West pound.

1.1 Our Vision

At its inception the ICS identified three strategic objectives which are shared by the Berkshire West 7 programme:

- An improvement in the health and wellbeing of our population
- Better patient experience and outcomes
- Financial sustainability for all organisations across the ICS.

The ICS has a clear vision for the Berkshire West health and social care system which will comprise:

- A resilient urgent care system that meets the “on the day” needs of patients and meets national standards
- Redesigned care pathways that improve patient experience and clinical outcomes and make the best use of clinical and digital resources
- A transformed and resilient primary care sector which supports GPs to care for more patients at home and in their communities
- A shared infrastructure and capability that supports delivery of the vision
- A financially sustainable system that provides best value for the taxpayer

The ICS has developed programmes which support the delivery of its vision and 2019/20 will be our third year of operation as an ICS. The system will seek to build on the successes of the previous years, which include:

- Improvements to service quality and access, including the provision of additional GP appointments at evenings and weekends

- The establishment of four Primary Care Alliances which have provided a strong foundation for the development of Primary Care Networks serving neighbourhoods of around 50,000 people
- Publication of our first *Population Health Management Roadmap* (PHM), and the launch of our initial PHM programme which has identified opportunities to provide support to “at risk” individuals in our population
- Development of a robust urgent and emergency care system which has reduced Delayed Transfers of Care (DTOC) in conjunction with BW7 partners, and reduced non elective admissions from care homes to below the national average.
- Working with the Thames Valley Cancer Alliance to increase the uptake of cancer screening amongst individuals who were not previously coming forwards
- Implementing a nationally recognised Increasing Access to Psychological Therapies service which is an early implementer for targeting people with Long Term Conditions
- Delivery a psychiatric liaison service in the Royal Berkshire to support people in crisis who attend the Emergency Department
- Expanding the Individual Placement Support employment model to support people with mental health and addictions to gain and keep paid employment.
- The development of a new contracting mechanisms and a joint approach to managing the system’s financial resources

1.2 About us

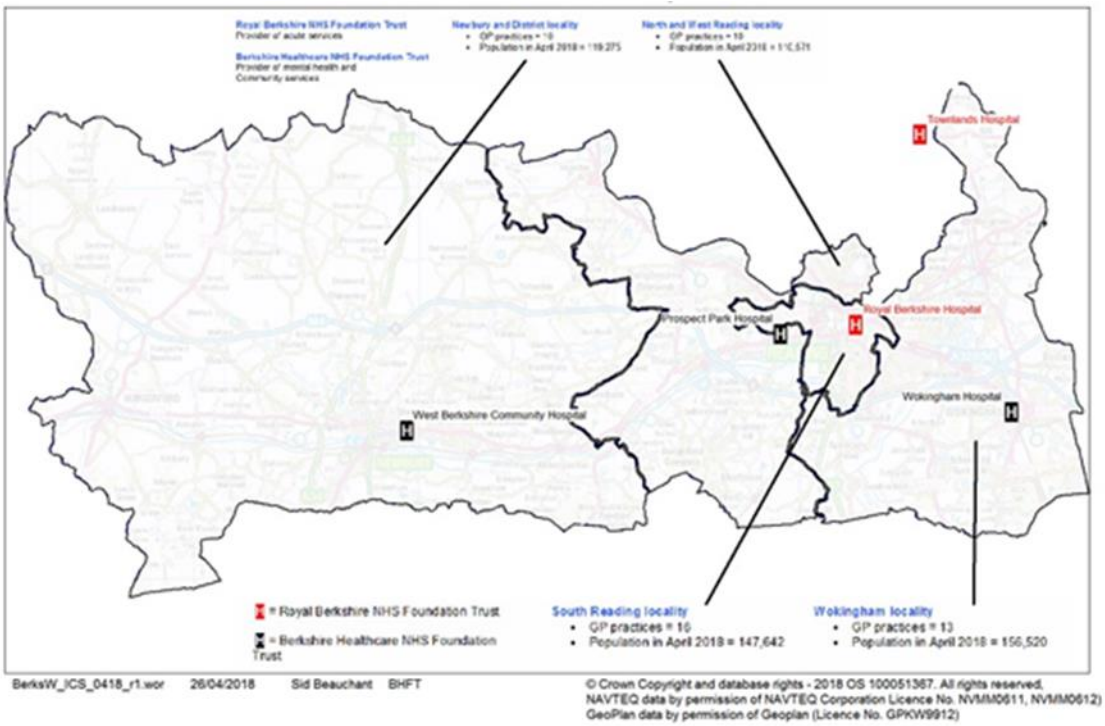
The ICS is collaboration between health organisations to improve services for our local population, delivering consistent high quality and safe care, ensuring the best possible outcome and experience for patients, whilst returning our system to financial sustainability.

Together with our Local Authority partners the ICS are responsible for the health and wellbeing of 528,000 residents living across three Local Authority Areas.

- West Berkshire;
- Reading; and
- Wokingham.

Along with South Central Ambulance Service (SCAS) the three local authorities and 3 NHS organisations make up Berkshire West 7 (BW7)

Map 1.1: Berkshire West Geographical Footprint



The BW7 footprint is a self-contained health economy with approximately 80% of patient activity, and the majority of funding, being with the constituent organisations. The three local authority areas have some notable differences in terms of their demographic and health profiles. Reading has a much younger population with typical characteristics of an inner city diverse population, Wokingham is suburban with rapid housing expansion under way, whilst West Berkshire has an older population and significant rurality.

Generally, the health of residents of Berkshire West is good; however, there are some clear differences between the populations in each of the local authority areas and this is reflected in the differing health needs.

For most of Berkshire West the smoking rates are lower than the national rate in England, however in Reading the rates are higher. The number of people drinking alcohol above the recommended levels is fairly high, particularly in South Reading, and along with smoking is an area of focus for the ICS and BW7. Obesity levels across the area are similar to the national figure as are rates of physical inactivity. The ICS works closely with public health colleagues to monitor and improve these levels with targeted interventions in place to support healthy eating and promoting healthy lifestyles.

Overall the health and well being priorities for Berkshire West include:

- Reducing childhood obesity
- Reducing alcohol consumption to safe levels and alcohol related harm
- Promoting positive mental health and well-being
- Preventing and reducing early deaths from cardiovascular disease, diabetes, COPD, chronic kidney and cancer
- Reducing levels of infectious diseases e.g. Tuberculosis
- Promoting self-care and empowerment

1.3 Our 2019/20 Strategic Priorities and Transformation programme

Despite good progress in previous years the system faces a significant financial challenge in 2019/20. Berkshire West continues to be one of the lowest funded health economies in the country and has already delivered many of the recognised approaches to system efficiency. In recent years the control total has been achieved by a series of non-recurrent mitigations, both within the provider and the commissioner sector. The underlying deficit has reduced but remains and there are no further short term non recurrent mitigations available to address this.

The ICS's focus is therefore on delivering a robust shared cost improvement programme and a broader transformation programme that will deliver medium term service redesign. This is a mature system that now operates on a system wide cost model, as opposed to price and income, but the limiting factor is the rate at which cost can be taken out of the system, mainly from the acute sector. The ICS therefore has put itself into voluntary turnaround and proposes a two year financial recovery plan. The current plan shows recovery of c.50% of the financial gap in 2019/20 and there is work underway to develop a plan during Q1 19/20 that closes the gap completely by 2020/21.

The ICS have identified a number of transformation programmes that will deliver the ambitions of the Long Term Plan and contribute to financial recovery. These have been identified by reviewing Population Health Management (PHM) data, NHSE/I best practice toolkits, Rightcare, New Model Hospital and the Bronze Diagnostic. Proposals are robustly tested by the clinical and financial leadership before they are approved to begin. The list of programmes can be found in Table 1.

A system financial recovery plan at Table 2 shows the full gamut of activity organisations are planning to take this year to improve the financial position and includes the impact of the transformation programmes.

In light of the NHS Long Term Plan and the challenges faced by the local health and care system Berkshire West ICS has identified 7 strategic priorities for the year ahead:

- **Implement the ICS financial recovery plan –** Given the highly challenged financial position of the Berkshire West health economy the partner organisations will work together through a joint Financial Recovery Group to complete and deliver a systems savings plan**.**

- **Design Our Neighbourhoods** – The ICS will work with the newly established Primary Care Networks, the three local authorities, community services, the voluntary sector, patients and communities to integrate services at neighbourhood level around clusters of GP practices. The ICS will invest around £3m in primary care services in 19/20 providing new workforce to improve urgent access to primary care and provide proactive more co-ordinated support to people with complex problems.
- **Development of a new Urgent & Emergency Care delivery model** – following the development of an urgent care strategy for Berkshire West, the ICS have identified a number of key design principles such as access to same day urgent primary care, the development of community hubs, 24/7 mental health support, ambulatory care at the front door of A&E. This means all patients will get a timely and appropriate response to their needs but only the highest acuity patients will need to go to A&E.
- **Outpatient transformation** –The ICS will continue with the objective of reducing the number of outpatient appointments at the RBFT by 50% which will see many patients offered the opportunity to have their outpatient appointment closer to home through a range of approaches including the use of technology
- **Design and development of an Integrated MSK service** – The ICS will introduce new staff whose role is to support patients early on in the pathway and maintain and improve their condition so that fewer people require surgery.
- **Develop a strategy for the future provision of diagnostic equipment and associated care pathways –** The ICS will have a shared understanding of current comparative provision, performance and cost of Berkshire West diagnostic services, an understanding of future demand and an implementation plan to deliver identified gaps
- **Implement and embed our approach to Population Health Management and Digital transformation –** Complete an evaluation of the programme commenced in 2018/19 and identify ongoing PHM priorities, which will support the identification of transformation opportunities at system level and support PCNs in the pro active management of their population. Take steps to develop a shared ICS Business intelligence function

These, along with other programmes of work, are supported by key enablers including a review of shared functions and estate, understanding and modelling our collective bed base, and workforce development.

As a strong component of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) shadow ICS, Berkshire West will contribute to the BOB operating plan which will describe how the wider system will deliver shared programmes at scale.

1.4 Oversight and delivery of Transformation and Financial Recovery

The ICS will have oversight of these programmes via monthly reports from the programme boards to the Unified Executive on progress against agreed deliverables and trajectories. The ICS have an agreed Quality Improvement and Transformation methodology and staff working on the transformation programmes have, or will have, training on these quality improvement methodologies. The system will utilise a set of reporting processes and templates that support the successful delivery of quality improvements.

All significant transformation programmes across the ICS have or will undertake a Quality Impact Assessment (QIA) to understand the impact on patients and staff of the potential change. These are reviewed by the respective organisational or ICS wide Quality Committees with recommendations as to how to mitigate any negative quality impacts.

Efficiency savings are verified by Chief Finance Officers ahead of being agreed by the Unified Executive. A joint Finance Recovery Group will track progress on delivery of the overall Financial Recovery Plan and identify mitigations as required. Risks to delivery will be captured by the individual programme boards and escalated to the Finance Recovery Group and Unified Executive where necessary.

To increase the delivery capability across Berkshire West in 19/20 the CCG will continue its programme of in housing functions from the CSU and the ICS partners will establish a shared transformation function. Dedicated turnaround resource will be secured and located in RBFT.

Table 1.1 – Summary table of ICS Programmes

Berkshire West ICS Strategic Priorities – 2019/20

ICS Objectives

An improvement in the health and wellbeing of our population

Enhancement of patient experience and outcomes

Financial sustainability for all constituent organisations and the ICS

19/20 Strategic Priorities

Develop a resilient urgent care system that meets the on the day need of patients and is consistent with our constitutional requirements	To redesign care pathways to improve patient experience, clinical outcomes and make the best use of clinical and digital resources	Progress a whole system approach to transforming primary care to deliver resilience, better patient outcomes and experience and efficiency	Develop the supporting infrastructure to deliver better value for money and reduce duplication	Deliver the financial control total agreed to by the Boards of the constituent statutory organisations

Key Projects for Delivery

Develop new UEC delivery model; to include:

- Completion of UEC Strategy
- Bed capacity optimisation
- Establish an Urgent Treatment Centre at West Berkshire Community Hospital
- Develop the Reading Walk in Centre
- Refine the approach to ED Streaming
- High Intensity Users

Joint pathway redesign work to include:

Outpatients Transformation

Integrated MSK Service

Diagnostic Strategy

Delivery of national Cancer ambitions

Delivery of MH FYFV and Long Term Plan ambitions

Audiology

Diabetes

Ophthalmology

Respiratory

Implement Primary Care Networks;

- Design of PCN neighbourhoods in partnership with community health, social care and voluntary sector
- DES contracts signed by end of June to achieve 100% PCN coverage across BW
- Increased digital support to reduce workload, offer alternative consultation modes and increase self management by patients
- Completion of primary estates strategy to ensure needs arising from housing growth are met and best use is made of BW estate
- Strengthen the primary care workforce in partnership with BOB shadow ICS and through recruitment of new roles to PCNs
- Support PCNs to adopt a PHM approach and engage with urgent and planned care transformation programmes

Development of integrated Place-based shared functions

- Options appraisal and implementation of an Integrated Place based functions:
  - Transformation,
  - Analytics,
  - Business Intelligence
  - Compliance
- Redesign of governance to integrate the ICS and BW 7 programme and create an Integrated Care Partnership.
- **Develop and implement the ICP Digital Strategy**
- **Evaluate the 18/19 PHM programme and agree the 19/20 deliverables to support PCNs and embed system wide PHM capability**

Credible financial recovery plan for 20/21 and beyond

Progressing transparency of cost information at SLR level

Benefits

- Patients being seen in the most appropriate setting in a timely manner
- Fewer patients needing to access on the day services from the acute hospital
- Constitutional standards achieved

- Patients to receive more of their care closer to home
- Greater reliance on technology to free up clinical time for more complex tasks
- Unlock estate capacity through fewer F2F appts
- Services provided at a lower cost to the taxpayer

- Networked based delivery of additional services and improved access for patients
- Greater resilience and capacity within the primary care sector
- Development and deployment of new care models which are more integrated and delivered closer to patients' homes

- Shared capacity targeted at system priorities
- Improved integration and joint decision making between the NHS and local government
- Digital technology supporting optimal efficiency
- PHM driving pro active care of patients to reduce demand on hospital and identify further transformation opportunities

- Delivery of the financial trajectory agreed with regulators

Table 1.2 – Berkshire West Two-Year Financial Recovery Plan

ID	Org	Scheme	Y1 Total £k	Y2 Total £k	Two Year (Cumulative)
BH01	BHFT	Bed Optimisation (Acute/PICU overspill beds)	1,000	-	1,000
BH02		Papist Way Contract	191	-	191
BH03		Cloisters Contract - Income Loss Avoidance	272	-	272
BH04		Cloisters Contract - Bed Reduction	560	-	560
BH05		Sexual Health Tender	432	-	432
BH06		Court L&D Hampshire	621	-	621
BH07		Veterans Expansion	271	-	271
BH08		19/20 Procurement Programme	301	-	301
BH09		NHS Supply chain Margin Removal	152	-	152
BH10		NHS Supply chain Profit Share	44	-	44
BH11		NHS Supply chain Category Towers	48	-	48
BH12		Medicines Optimisation	52	-	52
BH13		CRHTT	100	-	100
BH14		LD Patients	300	-	300
BH15		NHSPS VAT saving	614	-	614
BH16		SLT (Slough)	60	-	60
BH17		PFI Benchmarking / Review	129	-	129
BH18		Corporate Benchmarking Target	150	-	150
BH19		Admin / Estates Agency Trade Out	200	-	200
BH20		E-Roster Efficiencies (Carter)	100	-	100
		TOTAL Berkshire Healthcare FT	**5,597**	**-**	**5,597**
RB01	RBFT	Procurement Transformation-UCG	175	-	175
RB02		Medicines Optimisation -NCG	507	-	507
RB03		Commercial Income and Opportunities -PCG	331	-	331
RB04		Digital Hospital -NCG	62	-	62
RB05		Digital Hospital -Trustwide	342	-	342
RB06		Patient Flow Bed Base -NCG	329	-	329
RB07		National Procurement - PCG	1,000	333	1,333
RB08		Commercial Income and Opportunities -UCG	495	-	495
RB09		National Procurement -EFM	200	-	200
RB10		National Procurement -NCG	100	-	100
RB11		BSPS CIP- Pathology -NCG	710		710
RB12		Networked Care Pay Schemes -NCG	353	-	353
RB13		Networked Care Non-Pay Schemes -NCG	456	-	456
RB14		Urgent Care Pay Schemes -UCG	394	51	445
RB15		Urgent Care Imaging -UCG	500	167	667
RB16		Digital Hospital -Transcription Service -UCG	25		25
RB17		Procurement Transformation -PCG	951		951

RB18		Planned Care Pay Schemes -PCG	1,052		1,052
RB19		Planned Care Non - Pay Schemes PCG	96		96
RB20		EFM Non Pay Schemes	709		709
RB21		EFM Income Schemes -EFM	100		100
RB22		IM&T Non Pay schemes-IM&T	102		102
RB23		Procurement Transformation - NCG	170		170
RB24		Medicines Optimisation -PCG	435		435
RB25		Patient Flow Bed Base -PCG	35		35
RB26		Patient Flow Bed Base - UCG	844		844
RB27		Patient Flow Bed Base -EFM	214		214
RB28		Digital Hospital Non Pay - CROWN -PCG	113		113
RB29		Digital Hospital Pay Scheme -PCG	370	177	547
RB30		Outpatients - PCG	288	96	384
RB31		Outpatients - NCG	118	40	158
RB32		Women and Children Services - UCG	874		874
RB33		Medicines Optimisation -UCG	40		40
RB34		Outpatients-UCG	86	29	115
RB35		Digital Hospital Transcription - PCG	188		188
RB36		National Procurement - UCG	100		100
RB37		Urgent Care - Non Pay	10		10
RB38		Procurement Transformation - corporate	144		144
RB39		Demand and Capacity	340	73	413
RB40		Operating Theatres Improvement Scheme	250	2	252
		TOTAL Royal Berkshire FT	**13,610**	**968**	**14,578**
CCG01	CCG	SCAS non conveyance	94	31	125
CCG02		Urgent Care Centre Activity	375	125	500
CCG03		MSK	1,050	350	1,400
CCG04		Referral Management	225		225
CCG05		Non-local acute challenges	503		503
CCG06		PLCVs/IFR	475		475
CCG07		Prescribing	1,140		1,140
CCG08		Long term placements	1,075		1,075
CCG09		Community Equipment	190		190
CCG10		Primary Care Networks	150	50	200
CCG11		Running costs general	950	500	1,450
		TOTAL Berkshire West CCG	6,227	1,056	7,283
		TOTAL	**25,434**	**2,024**	**27,458**

1.5 Our Governance

Whilst the members of the ICS remain statutory organisations, the ICS has developed governance arrangements that support full system working. The ICS Leadership Group is led by an independent Chair

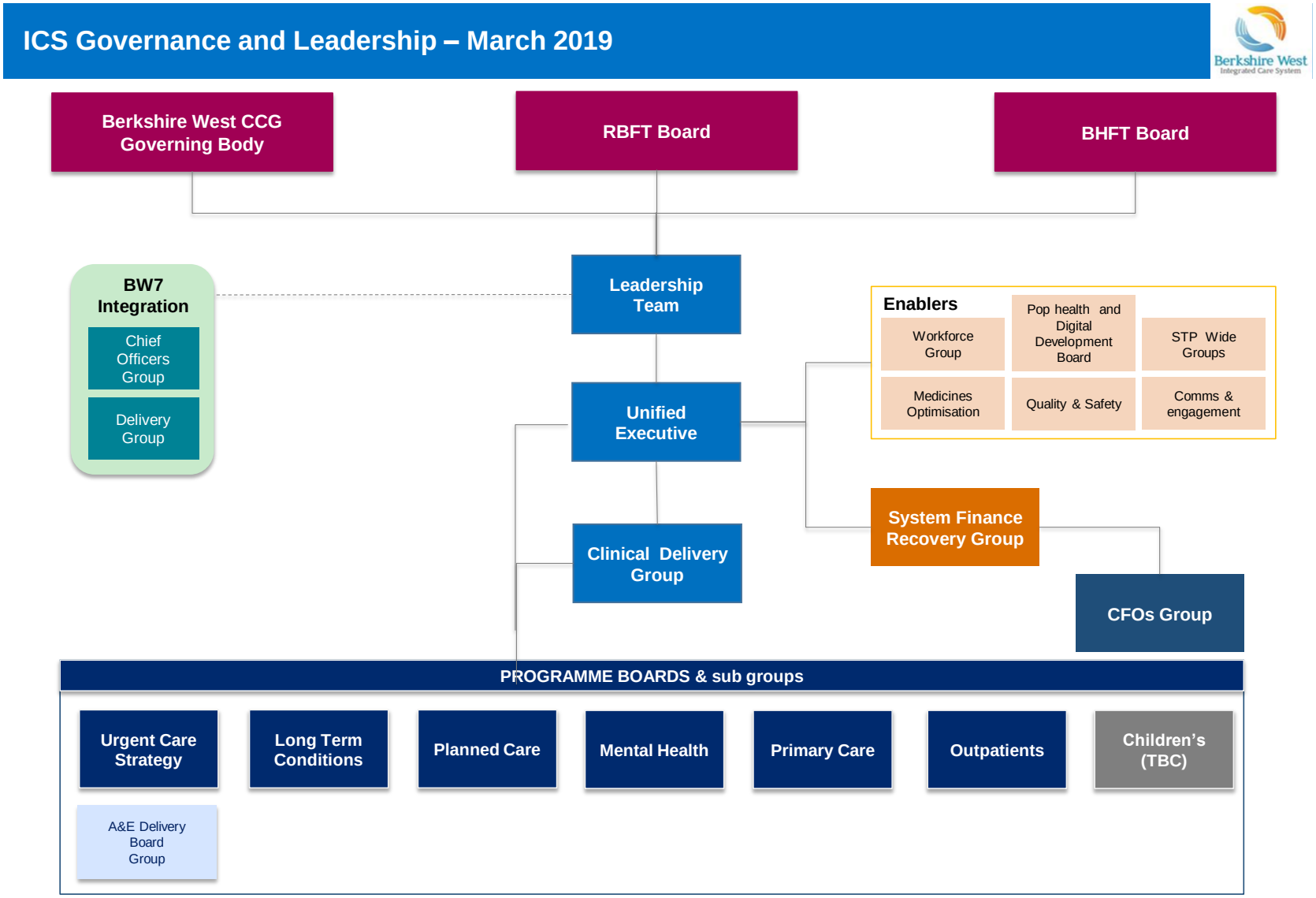
and the membership comprises the Chairs and Chief Executives of three member organisations and the Chief Executive of West Berkshire Council in his capacity as Chair of the BW7. During 2019/20 this group will expand to include the Chief Executives of the other two local authorities in Berkshire West and the elected members who chair the three Health and Well Being Boards. This will present a further opportunity to integrate the work of the NHS and local government. The Leadership Group sets the ICS strategy and holds the executive to account for delivery of the ICS programme. (Proposed new governance arrangements are currently being developed subject to further review and ratification)-

The ICS Unified Executive comprises the three NHS Chief Executives and key members of their executive teams who oversee the design and drive delivery of the programme. During 2019/20 the governance will be reviewed to align the work of the Berkshire West 7 Delivery Group and create a single PMO. The ICS has undertaken an Organisational Development programme supported by the King's Fund which has contributed to the strengthening of our governance arrangements.

During 18/19 Berkshire West ICS became a self-assuring system and monitors its performance through an Integrated Quality and performance Report which is also shared with regulators. Progress on the ICS Transformation Programme is reviewed monthly. Financial assurance is achieved through the Directors of Finance producing a group account of the year-to-date position and forecast at system level.

An ICS Finance Recovery Group has been established to manage the challenging financial position faced by the ICS in 2019/20. This will track delivery of organisational CIPs and the system wide savings plan. The ICS will augment its capabilities with additional finance turnaround support based in the RBFT.

Table 1.3 – ICS Governance and Leadership



2 A NEW MODEL OF CARE FOR BERKSHIRE WEST IN 19-20

Berkshire West ICS has assessed the challenges it faces and the opportunities available to deliver its vision, transform services and achieve financial recovery. This section of the plan describes our strategic priorities and the new model of care we intend to adopt, with partners and stakeholders, to meet these challenges and begin delivery of the NHS Long Term Plan.

Our priorities for 2019/20 were described in section 1 and build on the work undertaken in previous years and are:

- **Implement the ICS financial recovery plan**
- **Development of a new Urgent & Emergency Care delivery model**
- **Outpatient transformation**
- **Develop a strategy for the future provision of diagnostic equipment and associated care pathways**
- **Design Our Neighbourhoods**
- **Design and development of an Integrated MSK service**
- **Implement and embed our approach to Population Health Management and Digital transformation**

These priorities also reflect the visions of the constituent organisations in the system notably RBFT's vision of 'Working together to provide outstanding care for our community,' supported by its Clinical Services Strategy, and BHFT's vision "to be recognised as the leading community and mental health service provider by our staff, patients and partners", supported by its Quality Strategy.

The priorities support delivery of the long term plan by developing a robust primary and community care sector to provide local, accessible services for patients and reduce the pressure on hospital services. The ICS will work with GP practices, the existing primary alliances, community and voluntary services, patients and communities to design primary care networks operating at neighbourhood level. We have already started on a programme of community engagement and partners across Berkshire West are committed to Design our Neighbourhoods as our shared priority in 19/20.

A well supported and resilient primary care sector will play a key role in responding to "on the day" demand in support of the wider urgent and emergency care system in Berkshire West. During the coming year the ICS will identify community hubs. In particular it will seek to upgrade the current MIU to an urgent treatment centre that is linked to NHS 111 and local GP practices. The ICS will review the role of the Walk In Centre in Reading and ensure that there is a good service for children who are currently brought to A and E but do not require this service and for homeless people. The redesign of services will draw on the helpful work of Healthwatch which helped us to understand why people attended A and E and what alternative services we could offer to meet their needs.

Finally a robust primary and community sector enables us offer services that were traditionally provided in hospital in community settings closer to where people live. The ICS has identified a number of areas for transformation in relation to planned care. During 19/20 we will continue with our ambition to transform outpatients and reduce the number of appointments happening at the Royal Berkshire Hospital by 50% and implement the redesigned pathway for people with musculo skeletal conditions. The ICS will also undertake modelling of its diagnostic capacity to ensure that it can meet the needs of patients who may have can cancer in a timely way.

Our 2019/20 transformation programme is underpinned by the implementation of a comprehensive population health management approach. During 18/19 we have commenced a 20 week externally supported programme to increase the capability of the ICS in this area, identify further opportunities for system transformation and provide support to primary care networks to identify and pro actively manage individuals who are risk of deteriorating health in the future.

The diagram below describes our overall transformation strategy for 2019/20.

Diagram 2.1 – ICS Transformation strategy

2.1 Primary Care

A major part of the 2019/20 plan will be the development of primary care networks as the delivery vehicle for a number of related transformation programmes. The ICS will deliver improvements in Primary Care by:

- Building upon existing GP provider configurations to actively supporting the establishment of Primary Care Networks (PCN) including by investing £1.50 per head in accordance with the planning guidance to achieve 100% coverage by July 2019.
- Working with PCNs to develop new models of same day access as part of the broader urgent care system.
- Continuing to provide extended access to general practice services, including at evenings and weekends, for 100% of the population.
- Working with PCNs to embed multidisciplinary integrated care team working at a neighbourhood level, driven by PHM intelligence and ensuring PCNs are able to deliver the national service specifications outlined in the new GP contract.
- Ensuring that clinical pharmacists and social prescribers are recruited into primary care networks to increase their capacity and capability
- Work with community health services, social care the voluntary sector to identify the “wrap around” services for each PCN such as District Nursing, community geriatricians, diabetic nurse specialists, and the Rapid Response and Treatment service to support people in care homes.
- Offering PCNs access to primary care data analytics for population segmentation and risk stratification enabling an in depth understanding of the network’s populations’ rising health and care needs. This will build on the work commenced in 2018/19.
- Providing managerial support and subject matter expertise to PCNs to assist with their development and evolution
- Continuing work on the refreshing of the primary care estates strategy, working closely with the three local authorities to understand and meet the requirements of local housing growth.

- Continuing to support delivery of initiatives to manage workload in primary care e.g. care navigation, workflow optimisation and other High Impact Actions.
- Building the capacity of Primary Care to support the Outpatients Transformation programme
- Working with partners in BOB shadow ICS, implement the Wessex workforce planning tool to inform the primary care workforce strategy
- Build on the implementation the International GP Recruitment programme and support the current international recruits to ensure that they are retained.
- Work with partners in BOB shadow ICS to implement the GP retention programme and support two Berkshire West GPs with GP Fellowships.
- Working with HEE and higher education institutions to support nurses to choose primary care as a first destination and to retain experienced nurses already working in primary care
- Further developing the Berkshire West Training Hub to deliver practice manager development and clinical leadership development and work with partners in BOB to review the optimal model for Training Hubs going forwards
- Increasing the use of digital technology to enable patients to book appointments and order prescriptions on line, have different modalities of consultation such as telephone or skype, and increase the remote monitoring of patients with long term conditions.

Arrangements for managing all delegated responsibilities, will continue unchanged with oversight provided by the Primary Care Commissioning Committee. As part of the process of providing assurance to NHSE these arrangements have been reviewed by internal audit and provided “Substantial Assurance”.

2.2 Urgent Care

During 2018/19 the ICS undertook work to establish how we can better manage the demand for Urgent Care in Berkshire West and avoid the need to expand the acute and community bed base as the population ages. The review demonstrated that the ICS have the correct mix of beds in our system, with some further efficiency opportunities, providing we implemented a new model of care. This new model would provide people with timely and appropriate services to meet their needs and reduce the need to attend A&E. If people do need emergency admission then the aim is to get them back out of hospital and home as soon as possible.

Our work identified a number of key design features for the new model:

- Single point of access/triage – this will build on the work already underway with the Integrated Urgent Care alliance to position NHS 111 as the entry point for patients who are unsure of which service to access
- Prevention and self care at home – supporting patients and their families to maintain wellness and signpost to self care wherever possible
- Proactive management of health
- Voluntary sector support – building on our successful social prescribing and winter schemes during 18/19
- Access to same day urgent primary care
- Access to hospital consultants for GPs to support them to manage patients by ensuring telephone access to specialists to support alternatives to acute admission
- Enhanced NHS 111 Clinical Assessment Service to incorporate secondary care expertise
- Community services tailored to the neighbourhood’s needs and able to respond rapidly
- Paramedics and ambulance services delivering treatment to avoid hospital admission – further enhancing the work delivered through the non-conveyance CQUIN
- Urgent Treatment Centres to provide local alternatives to A&E
- Ambulatory care at the front door of the hospital – delivering the national aspiration for 30% of patients to be treated as same day emergency care
- 24/7 specialist mental health support for all ages
- Tiered provision of community beds
- Services aimed at children with minor ailments – to meet a recognised need in the Reading area.

The ICS will use these principles to complete the Berkshire West Urgent Care Strategy by the end of quarter one and commence implementation.

Working across Thames Valley, the ICS will further develop the Clinical Assessment Service (CAS) underpinning Integrated Urgent Care (NHS 111). During 18/19, the service expanded to include palliative care expertise, access to third sector agencies including the Samaritans and direct booking into GP Out of Hours and the Minor Injury Unit. This approach has enabled the system to channel patients to definitive treatment in the community. Services within the NHS 111 Directory of Services are reviewed regularly, with recent improvements to search limits and mapping of symptom discriminators across Thames Valley, ensuring patients are directed to the most appropriate service, particularly out of hours and for minor injuries.

111 Online is now well established across the Thames Valley with patients receiving direct calls from clinicians after an initial online assessment. As part of a continued development of the CAS this will expand to include call backs from dentistry in 19/20, following a successful pilot in Oxfordshire.

During 2019/20, the ICS plans to:

- Maintain a 50%+ proportion of NHS 111 calls receiving clinical assessment by ensuring there is sufficient clinical workforce available at all times
- Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment with another service,
- Continue to ensure that patients provided with advice by NHS 111 are supported to access an array of services away from the Emergency Department by regularly reviewing the Directory of Services and addressing any commissioning gaps which may be identified"
- Work with commissioners across Thames Valley and the ambulance service to achieve a single Clinical Assessment Service across 999, 111 and GP out of hours
- Expand direct booking into in hours general practice in line with the new contract for Primary Care Networks
- Scope NHS 111 disposition to rapid response community services
- To complete the business case for an Urgent Treatment Centre at West Berkshire Community Hospital, building on the current Minor Injuries Unit
- Develop the role of the Walk In Centre in Reading
- Ensure 100% of ambulance handovers occur within 30 minutes and that Ambulance Response Programme (ARP) waiting time standards continue to be achieved
- Undertake further work with SCAS to improve non conveyance rates with increased access to out of hospital pathways and access to shared care plans to support alternative management of patients
- Build on the successes of the existing Royal Berkshire Hospital Frailty Service and ring fenced Ambulatory Care Unit to increase the number of non elective admissions discharged on a same day basis
- Build on existing good work in relation to national pathways for stroke, heart attack, and sepsis
- Continue to closely monitor and reduce the number of stranded patients in hospital beds by addressing both internal and external reasons for delay and continue to make progress on reducing delayed transfers of care (DTOC).
- Embed the use of the local code to identify causes of delay and identify trends which can then be used to drive further improvements particularly in health attributable delays and delays in mental health beds.
- During 2019/20 the ICS will resume its focus on High Intensity Users – those people with high use of urgent care services. This will be done by reviewing frequent adult, children and mental health patients who attend the Emergency Department; reviewing people who call 999 and 111 frequently and taking the learning from GP reviews of High Intensity Users. The ICS will build on the pilot it implemented to identify an appropriate response to support people and the Oxford AHSN will support the ICS with this work.

As part of the new model of care for Berkshire West there will be a move towards people getting more control over their own health and receiving more personalised care when they need it. During 2019/20 the ICS will achieve this by:

- Introducing social prescribing as part of Primary Care networks so that people have access to a wide range of local support services that help to keep them well and living in their communities.
- Increasingly patients will be involved in making informed decisions about their care. 85% of people who have musculoskeletal (MSK) problems will have the opportunity to work with a voluntary sector provider to support them in managing their condition.
- The ICS will increase the number of patients with complex problems and those at the end of life who have personal care plans that are developed with them and shared by all those involved in their care
- The ICS will learn from the good practice demonstrated by our local authority partners and increase the number of people who have personal health budgets (PHBs). The ICS will ensure that the delivery of all new Continuing Healthcare home-based packages (excluding fast track) use the personal health budgets model as the default delivery process. We also plan to expand the CCG's PHB offer to users of wheelchairs and people entitled to S117 Aftercare. Our submitted trajectory shows an increase of 70 PHB's for 19/20 in recognition of the baseline position and the work required.

2.3 Planned care

Our strategy for Planned Care will improve patient experience and productivity by redesigning services to improve health outcomes for patients, reducing lengths of stay in hospital and the number of outpatient appointments required. Our vision includes the use of new technologies to enable our patients to interact with services in new ways; we will implement virtual clinics and other modalities to deliver follow ups.

Our ICS work programme for 2019/20 includes continuing work to redesign and streamline pathways and reduce clinical variation focusing on Orthopaedics and Musculoskeletal problems, Dermatology, Ophthalmology, Adult Hearing and Diagnostics; efficiencies in outpatients including exploring other modalities for follow ups (e.g. virtual clinics, telephone follow ups), access to consultant advice and guidance for GPs, patient initiated clinics and Pre-op assessments.

A key priority for the ICS in 2019/20 is the transformation of outpatient pathways and the redesign of musculo-skeletal services to improve patients' experience of care. The ICS has drawn on national work to identify best practice in developing its programme. The ICS will achieve these improvements by:

- Designing a new end to end MSK pathway to deliver care closer to patients' homes by preventing unnecessary hospital procedures and investing in conservative treatment. The pathway will incorporate up skilling GPs and peer to peer reviews in primary care, First Contact Physiotherapists in primary care, the introduction of clinical triage service (key national 'must do') for patients that cannot be managed in primary care but require some additional management from a multi disciplinary team of clinicians before considering treatment in secondary care, and increased Shared Decision Making to help patients make informed choices about their care.
- The redesigned service will deliver the following benefits:
    - Ensuring appropriate referrals to secondary care in line with clinical need
    - Reducing clinical variation and duplication through pathway coherence
    - Ensuring that every MSK practitioner is consistent in their approach
    - De-medicalising MSK presenting symptoms and promoting self-care and healthy living such as exercise and healthy eating as enablers to have a positive impact on MSK issues
    - Addressing the issues and concerns identified by patients and improving the quality of patient experience
    - Delivering best value for the Berkshire West pound
- Redesigning the Dermatology service at RBFT to address the shortage of dermatology consultants. The ICS is working together to produce a new and innovative clinical model which will optimise primary care and community providers to support the Dermatology service with consultant oversight. The NHSE Elective Care Handbook for Dermatology has informed the clinical redesign of the service.

- Reviewing the ophthalmology pathway by incorporating triage and redesigning pathways for the three main conditions: Wet AMD, cataracts and glaucoma. We are also maintaining failsafe prioritisation processes and policies in all areas to manage the risk of harm to ophthalmology patients, and act on the outcomes from the eye health capacity reviews
- The ICS performs well in relation to seven-day services and has adopted the Hospital Services Board Assurance Framework to support oversight. The focus in 2019/20 will be on consultant review within 14 hours.

- The ICS generally performs well in relation to Referral to Treatment Times (RTT). Processes have been in place for over two years to manage RTT and proactively review long waits as a result RBFT have not had any patients waiting over 52 weeks in 2018/19.

- To ensure patients make an informed choice of provider a project is being developed to train GP practice staff to educate patients where they can be treated and utilise the information on the electronic Referral Service (eRS) correctly. (The ICS has considered implementing Capacity Alerts however due to pressures within the Thames Valley system this is not an effective tool).

3 ACTION ON PREVENTION AND REDUCING HEALTH INEQUALITIES

Preventing ill health and reducing health inequalities will be key priorities for the NHS in the next decade, with the focus on supporting people to live healthy lives becoming increasingly important.

At present the ICS is working with Local Authority partners to align the Joint Strategic Needs Assessment (JSNA), the Population Health Management Programme, the Health and Wellbeing Strategies and BOB STP prevention programmes. During 2019/20 the ICS will build on the existing programmes of:

- Obesity – working with our local authority partners we will undertake a comprehensive review of our children and adult obesity care pathways. This will aim to improve equity and access across Berkshire West and ensure sufficient support is in place.
- Physical activity – maximise opportunities to engage the least active through the implementation of social prescribing and Making Every Contact Count (MECC) to signpost individuals to local physical activity opportunities. This will be supported by working in partnership with local authorities to build on the learning of the NHS Healthy Towns Initiative to develop a joint health and planning protocol across Berkshire West
- Smoking – work with our local authority partners to undertake a review of our stop smoking services and the implementation of the 19/20 CQUIN across community, mental health and acute providers. This will include improving data quality on those individuals who smoke and ensure brief advice is given
- Alcohol – develop early identification and support for heavy and harmful drinkers, as distinct from those seriously dependent on alcohol that visit A&E frequently, with the aim of targeting people earlier in their alcohol journey support implementation of the 19/20 CQUIN.
- Making Everyone Contact Count – we will continue to roll-out a train-the-trainer model of MECC that will be supported by a behaviour change training in partnership with the University College of London (UCL)

We will continue to work with our partners to ensure a continued focus on reducing health inequalities across the system. Tackling the wider determinants will be important as these are known to strongly influence people's resistance to illness and disease, as well as their ability to self-care. Therefore, we will support the adoption of a "health in all policies" approach to improve population health and health equity. This will be supported through working in partnership with the three local authorities to develop a joint health and wellbeing strategy. The development of our primary care networks, supported by a population health management approach, and social prescribing will also provide more holistic models of care that can help tackle the root causes of ill health.

4 IMPROVING CARE AND QUALITY OUTCOMES IN BERKSHIRE WEST

The purpose of this section of the plan is to set out how the ICS will support the reduction of disease burden across Berkshire West in key areas and improve care and quality outcomes

4.1 Cardiovascular Disease

Preventing cardiovascular disease is one of the biggest opportunities for the ICS to save lives over the next 10 years.

The previous chapter described our prevention strategy which addresses a number of risk factors and in addition the ICS will:

- Work with Primary Care networks to improve the detection and management of high blood pressure, raised cholesterol and Atrial Fibrillation in primary care, support more people to understand their own results and work with health care professionals to improve the management of these conditions.
- Work with Primary Care Networks to improve the management of patients with heart failure and ensure that all high risk patients have personalised care plans

4.2 Stroke Care

Berkshire West ICS performs well in the delivery of Stroke Care but will ensure that the service model is delivered consistently across the 24 hour period. The ICS will work with partners across BOB to plan for the implementation of post hospital stroke rehabilitation models. During 2019/20 the ICS will review its capacity for neuro rehabilitation.

4.3 Cancer

In light of the national cancer strategy and the Long Term Plan the ICS is refreshing its Cancer Framework and plans to:

- Continue to show improvement in the proportion of cancers diagnosed at stage 1 and 2, as progress towards the ambition of 75% cancers diagnosed at stage 1 and 2 by 2028/29. Currently the system is at 54% and the ICS Cancer Steering Group and TV Cancer Alliance (TVCA) are working together to increase this by working with hard to reach groups, Primary Care and Public Health teams.
- The ICS has implemented a Quality Improvement Scheme (QIS) which aims to increase cancer screening across three major tumour sites of Breast, Prostate and Bowel Cancer.
- It will also increase 2WW referrals by providing in-depth and expert advice to GPs on when to refer patients to secondary care for testing.
- The QIS is running alongside a specific patient engagement project to improve knowledge of screening programmes in the community of South Reading where outcomes are some of the worst in the country. The project, delivered by the charity Rushmoor Healthy Living, aims to raise awareness of the signs and symptoms of cancer
- Maintain the 25 cancer champions have been recruited and made over a thousand contacts with our most hard to reach communities to increase early detection and treatment and increase survivorship.
- Continue to ensure that all providers collect mandatory data items for the 28-day faster diagnosis standard cohorts and work with TV Cancer Alliance to use this data to improve time to diagnosis,
- Redesign pathways to enhance the existing services for breast and prostate cancer to provide high quality, efficient, accessible, effective and safe follow up care. The ICS has already fully implemented the risk stratification of follow-up protocols for Breast and is looking to roll out prostate and colorectal follow ups in 2019/20. Work with TVCA and PHE to implement bowel FIT screening testing, HPV and consider lung health checks.

- Review our demand and capacity modelling to ensure the capacity required to achieve the national performance standard, including diagnostic capacity are fulfilled and work with TVCA to consider a local Rapid Diagnostic Centre

4.4 Respiratory Conditions

Berkshire West ICS have identified respiratory as an area of focus using Right Care data and agreed the following areas of focus for19/20:

- the provision of Spirometry in a consistent way across the system and
- the development of a clearer pathways for COPD patients, particularly those with exacerbating conditions, across primary, community and secondary care, building on our existing pulmonary rehabilitation services
- a prescribing Quality Incentive Scheme that includes the review of inhaler provision and support for inhaler technique for asthmatic patients.

4.5 Diabetes

Diabetes continues to be an area for improvement within Berkshire West therefore in 2019/20 the ICS plans to:

- Support Primary Care Networks to reduce variation in achievement of the diabetes treatment targets between GP practice through data sharing and support from the Diabetes Clinical Leads.
- Ensure individuals with Non-Diabetic Hyperglycaemia are referred to the NHS Diabetes Prevention Programme (NDPP) to reduce the risk of Type 2 diabetes, with support to practices frm the programme coordinator.
- In 2019/20 the CCG's pre-diabetes Community Enhanced Service (CES) will have an explicit requirement to refer to NDPP.

4.6 Mental Health

Improving mental health is a fundamental part of the CCGs' operating plan with the need to integrate care to meet the needs of a changing population both for adults and for children and young people. During 2019/20 the ICS plans to:

- meet the mental Health investment standard; as part of the 2019/20 financial planning, all budgets and investment have been through the CCG's governance processes
- continue focus on early intervention and improving outcomes for people with mental health problems, supporting them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality.
- address the challenge of increased demand and ensure children and young people get the right help they need, building capacity and capability across the whole system is critical to improving access to community mental health services.
- In line with our Local Transformation Plan significantly improve access to emotional wellbeing and mental health support by reducing waiting times and strengthening pathways for our most vulnerable children. This will ensure that 34% children and young people with a diagnosable mental health condition will receive treatment from an NHS-funded community mental health service.
- As one of 25 national trailblazer sites, set up two Mental Health support teams in 2019 that will increase capacity to both identify and intervene earlier as well as strengthen the knowledge and response of local schools. These teams will contribute another 1000 intervention as year when fully operational as well as provide highly valuable training and consultation to local school leaders in order to get children, young people and families the right support at the right time.
- develop the current community eating disorder service and ensure that the service is compliant against NICE standards and will meet national standards on access and waiting times for children
- work with partners to identify cases earlier in order to support children and young people at an earlier stage of eating disorder with mild-moderate presentations.

- review the mental health services for adults with the intention to redesign core community mental health services by 2023/24 to deliver better outcomes and meet the new four-week waiting time target, underpinned by a systematic focus on prevention and supported self-care, with the aim of reducing unplanned hospital admissions .
- reinforce the Psychological Therapies pathway particularly for people with long-term conditions by integrating the psychological pathway across IAPT and the Acute hospital, increasing access to IAPT services to 25% by 2021 and ensuring that the recovery rate of 50% continues to be met.
- continue to develop plans for the IAPT workforce by having an integrated service for people with mental health and physical health needs, as well as creating a workforce trained to deliver talking therapies for children and young people.
- continue to engage with the BAME community and with people over 65 to promote the service and increase access for these groups
- develop CMHTs to work in partnership with drug and alcohol teams to support individuals with dual diagnosis.
- review the crisis pathway with the intention of building on the current expansion of crisis care that incorporates a single point of access and timely, universal mental health crisis care for the residence of Berkshire West, 24/7 community support, alternatives to admissions (such as crisis houses and sanctuaries) and work with the ambulance service to better respond to people with MH needs through increased access to mental health training
- develop a Primary Care Mental Health model as a key part of the vision for transformation in 2019/20, ensuring more accessible and extensive mental health support within primary care which will also allow individual to transition from secondary care into primary care in a timely manner.
- focus on addressing the physical health risks and reducing premature death for our patients in both mental health and learning disabilities by ensuring Mental Health clinicians have a range of skills and knowledge
- work with GPs to deliver physical health checks by offering incentive to carry out an enhanced health check service, in addition to the current QOF arrangement, with a target of reaching at least 60% of those on SMI registers having a physical health check.
- continue to develop our Psychiatric Liaison Service to be an all-age mental health liaison service in A&E and inpatient wards by 2020/21 that will enable it to meet the Core 24 standard.
- carry out a full needs assessment of the section117 cohort to ensure we commission services that meets the needs of this group in a cost effective manner. The ICS will work collaboratively with the market to develop new solutions for meeting the needs of service users to increase the local supply and provide greater choice. This will allow the ICS to reduce out of areas placements and enable people to be closer to their family.
- continue to work in partnership with BHFT and the Councils to develop a process to regularly monitor requests for out of area placements, the application of the Care Programme Approach (CPA) and progress towards repatriating people placed out of area.
- Building on the committed investment in Perinatal Mental Health, ensure increased access to community-based specialist perinatal mental health services and delivery of the 5YFV targets. Continue to developing the service ensuring that at least 4.5% of the target population receive dedicated psychiatric and psychological support to in line with NICE guidance
- make good progress against the OAP baseline of 476 bed days for 2017-18 with the aim of reducing the numbers by 33.3% in 2019-20.
- continue to meet the national EIP standard of 50% people experiencing a first episode of psychosis begin treatment within two weeks of referral and work towards the increased target of 60% in 2021.

4.7 Dementia

Increasing the identification of people with dementia so that they can receive appropriate support is a key priority for the ICS. During 2019/20 the ICS will:

- focus on maintaining the dementia diagnosis rates across Primary Care.
- deliver the Dementia Action Plan with partners to improve dementia diagnosis rates, access to services and outcomes for people living with dementia and their carers.

Dementia Strategy for Learning Disability

The ICS Dementia Action Plan also focuses on the needs of people with learning disabilities. The priorities for 2019/20 are:

- increase access to assessment / diagnosis and treatment by working with primary care and Learning Disabilities Team to identify the cohort at risk of early onset Dementia from the Learning Disability registers.
- GPs will complete assessments on people identified as having early signs of Dementia.
- Deliver more training on Learning Disability and early onset Dementia for primary care and social care staff.
- Work with providers to ensure that reasonable adjustments are made to referral and assessment pathways for people with learning disabilities
- Work with colleagues in Adult Social Care to ensure that people with learning disabilities have a regular assessment of their care needs

4.8 Self-harm and suicide

A partnership Berkshire wide Suicide Prevention Strategy has been developed and approved by all six Berkshire Local Authority Health and Wellbeing boards. The implementation of the strategy plans to meet the national target to reduce suicide rates by 10% by 2020/21 against the 2016/17 baseline. The ICS will support the concept of “zero suicide” which facilitates the belief that suicide is preventable and all health and social care partners can make a positive contribution to this work.

To support this within Berkshire Healthcare progression against the zero suicide ambition will focus on self-harm and suicide of those under the care of in-patient and Crisis teams, ensuring that all of these patients have a safety plan in place.

4.9 Transforming Care for people with learning disabilities

The key focus for the ICS in 2019/21 will be to continue to deliver the regional and local Transforming Care plans with local government partners, enhancing community provision for people with learning disabilities and/or autism. This will enable a reduction in occupancy within inpatient beds; reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism. This will be achieved by:

Transforming Care

- develop the services to deliver significant changes in community services that will enable support to be delivered to people with Learning Disabilities and/or Autism and Challenging Behaviour to enable care closer to home.
- ensure every one with a Learning Disability/ASD has a Care and Treatment Reviews (CTRs) and routinely review the care of all people in in-patient beds and or at risk of admission
- scope the development of the children’s intensive support service will enable delivery of Community Care Education and Treatment Reviews to support admission avoidance.

Annual Health Checks

- focus on improving our progress with the Directed Enhanced Service annual health check sign up by primary care to improve access to healthcare for people with learning disability so that by 2020 75% of people on a GP register are receiving an annual health check and

improve flu immunisation uptake rate.

Housing Plan

- working with partners, develop a housing plan for people with a learning disability or autism or both who display behaviour that challenges, including those with a mental health condition. The Berkshire approach is to increase housing options for people to improve choice, support person centred care and meet the requirements of the national strategy for 'Building the Right Support'

Workforce development Plan

Berkshire Transforming Care Programme's workforce plan supports the changes in service provision and engagement with people with learning disabilities and/or autism and their parents and carers. It has been produced on a multi-agency basis and is supported by an action plan with clear governance and responsibilities.

Learning Disability Mortality Review (LeDeR) Programme

The ICS will maintain its well established steering group which has clear governance and accountability both to the to the Quality and Governance leads and the Health and Well Being Boards.

Children & Young People

A work stream targeted at Children & Young People in 52 week placements is ongoing to ensure that there are robust transition plans in Berkshire for this cohort of patients.

4.10 Maternity

Maternity transformation and quality assurance is delivered through a Berkshire West Maternity Steering Group (MSG) that reports directly to the BOB Local Maternity System Board. Building on the progress made since the publication of *Better Births* and the *Five Year Forward View*, the ICS will continue to deliver improvements for maternity care provision. The BOB LMS action plan, sets out the ambitions and priorities for maternity transformation, with separate implementation plans for each locality. The Berkshire West MSG is responsible for the delivery of our local implementation plan, overseen by the BOB LMS Board. To date, RBFT data for stabilised and adjusted perinatal death rate per 1000 births shows a 10.3% decrease from 2015 to 2016 (the latest available data) The ICS aims to:

- Continue against trajectory to deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025.
- Deliver full implementation of *Saving Babies' Lives Care Bundle version 2.* At present the ICS is 93% compliant with the set standards and work is in progress to meet the remaining requirements, which will be monitored through the Berkshire West MSG
- Increase the number of women receiving continuity of the person caring for them during pregnancy, birth and post-natally. By June 2019 a trajectory will be shared with the MSG for achieving 20% of women booked onto the continuity pathway
- Continue to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 all women have a personalised care plan. In Berkshire West all women carry handheld antenatal notes which include an in-depth plan of care. The ICS have appointed a Midwife project lead for 'Better Births, who will lead to deliver all of the recommendations and work with similar midwives leads across the STP who are progressing this work.
- Continue to deliver improvements in choice and personalisation through Local Maternity Systems so that by March 2021 more women can give birth in midwifery settings. So far year to date 30.4% of women are under midwife led care at home and the Home Birth Team are demonstrating increase in last quarter of home births. It is envisaged that the Continuity pathways will enable more women to access services in midwifery settings; this will be monitored as part of the ongoing project evaluation and reported through the MSG

- Through the LMS Digital work stream, build on the findings of the local Digital Maturity Assessment Report, which outlines the vast amount of work required to deliver interoperability across BOB. RBFT are global digital exemplars (GDE), which means that they are digital fast followers and have subsequently received investment to support their digital programme development. In addition, RBFT have appointed a Digital Midwife Lead to progress this key work programme.

4.11 Children's Health

Alongside improvements to children's mental health services the ICS will establish a Children's programme board with local authority partners and NHS providers which will seek to ensure improvements in children's wider needs by:

- Improving on the current performance in relation to childhood immunisations to deliver the standards required by public health
- Supporting childhood vaccination by monitoring uptake as part of the CCG Practice visits and through commissioning of a Quality Enhanced Service
- Reducing the need for children to attend A&E by ensuring that there is access to a range of NHS and local authority services to meet their needs.
- Improving the care of children with asthma, epilepsy and diabetes
- Working with partners across the BOB STP to establish paediatric networks to ensure a co-ordinated approach to critical care and surgical services for children
- Supporting the development of a Children and Young people's strategy within the acute trust to create a culture change across the organisation and change how services are shaped around the child.

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5 QUALITY

Prioritisation of quality – including delivery of safe care, and ensuring a good experience for patients and their families – is at the centre of our ICS. Partners have a strong track record of delivery of good quality services, with well-established leadership, governance and monitoring systems.

The Royal Berkshire's current Care Quality Commission rating is "*outstanding*" for the Royal Berkshire Hospital, with an overall Trust rating of "*good*". Berkshire Healthcare's overall Trust rating is "*good*" with an "*outstandin*g" rating for "*well-led*". The four GP Provider Alliances have a strong foundation of good quality general practice, and have developed leadership and governance arrangements, enabling them to work effectively together as well as at local neighbourhood level.

The Quality Strategies (Appendix B) of both Foundation Trusts are strongly linked to the 5 CQC domains of *safe, effective*, *caring*, *responsive*, and *well-led*, and align well with both the ICS strategic priorities as well as with individual organisational strategies. Quality Accounts and providers' plans for 2019/20 ensure clarity of focus on key quality priorities, supported by a strong focus on Quality Improvement.

5.1 Summary of Quality Priorities for 2019/20

- Reduction in the numbers of pressure ulcers in our hospitals
- Reduction in infections acquired due to a lapse in care (gram negative bacteraemia and e-coli)
- Reduction in medication errors
- Reduction in self-harm and suicide
- Reduction in harm from falls

Alongside these, mortality reviews, mortality review for people with a learning disability, implementation of NEWS2, and Sign Up To Safety have been established and will continue to provide a strong framework for the ICS safety culture**.**

The ICS work continues to be informed by national policy guidance – including the *Long Term Plan* – which will continue to shaper local plans alongside the developing work on population health management and the views of local people.

As Executive leads for quality improvement, Directors of Nursing from the CCG and provider trusts have worked together to develop a collaborative approach to quality improvement, with an ICS Quality Framework which retains robust scrutiny, builds greater transparency and reduces duplication. This new approach to quality assurance, shares responsibility and accountability for delivery of high quality care with both providers and commissioners. The ICS has developed an Integrated Quality and Performance Dashboard (IQPR), which includes a quality section; divided into patient safety, clinical effectiveness and patient experience and a performance section. The IQPR is scrutinised at the ICS Quality Committee, where providers present by exception, any risks to patient safety and mitigating actions taken. The ICS are continuing to build on this, through the development of a common ICS quality improvement/transformation methodology using local experience and international best practice, ensuring a culture of healthy challenge from provider to provider in addition to the usual commissioner to provider arrangement. The ICS Quality

Committee is an enabling committee within the ICS governance structure and reports formally through the CCG Quality Committee to the Governing Body.

The ICS has retained named quality leads for provider contracts within the CCG and a collaborative approach to the development of quality schedules and confirmation of quality priorities between commissioners and all providers.
The ICS Clinical Delivery Group is chaired by the Royal Berkshire's Medical Director, and includes senior leaders from all partner organisations. It has played a key role in identifying strategic priorities where the ICS can demonstrate value in terms of improved quality and use of our collective resources.

National priorities are reflected in the ICS strategy, and Berkshire West leads are also well engaged with work taking place at STP level on Urgent Care, Mental Health, Cancer and Maternity Services.

Our Quality Concerns are largely linked to high demand and workforce shortages, and are also focussed on work required to mitigate key risks linked to avoidable deaths – all of which are set out below in summary form.

Table 2 – Quality Concerns and actions to address

Challenge	Actions to address
Clinical Staff Shortages	Retention, recruitment and workforce transformation initiatives within local organisations, at "place" and "system" level to reduce vacancies and turnover and increase workforce stability. Monitoring of progress is maintained within each of the Foundation Trusts, enabling Board overview and assurance that risks have been properly identified and mitigation put in place, under the leadership of Directors of Nursing and Human Resources. There is also oversight through the ICS Workforce Committee, which reports into the BOB Local Workforce Action Board
Capacity and flow within Trusts and across the local healthcare economy	The A&E Delivery Board, chaired by the Chief Operating Officer of the Royal Berkshire, is well established and supported by all local health and social care organisations. There are strong arrangements in place to manage demand and capacity across acute, community and mental health inpatient services. A programme of work is in place within Berkshire healthcare to optimise bed use, improve patient flow and reduce Out of area placements. Urgent Care system, Acute Medicine Pathway and Primary Care Alliance development are focussed on provision of safe and effective care, with good use of resources. The Urgent Care Strategy, development of Primary Care Networks, Outpatient Transformation and Digital Development are all priority initiatives for the ICS. The ICS has a specific focus on children and young people in ED and CAMHs in individual organisations, as well as the use of SAFE improvement programmes– recognising that reducing avoidable harm reduces bed days and delivers more efficient care.
Treatment of serious infections in the context of increasing antimicrobial resistance	The Royal Berkshire and Berkshire Healthcare both have a strong focus on reducing harm to patients in their plans for 2019/20, with specific targets and programmes of work in place for their quality priorities. Sepsis and antimicrobial stewardship work programmes within individual organisations and across the ICS include the review and implementation of a "catheter passport", developing urinary tract infection management guidelines for community patients (inpatient and in own home) and standardised approaches to nutrition and hydration in care homes.

A Mortality Review Group has been established at ICS level, linked to robust arrangements within each of the Foundation Trusts and CCG. Along with the joint ICS Serious Incident Panel, these facilitate learning

and development across our local system. One recent example of this is the joint work undertaken to plan implementation of *Pressure Damage Guidance* from NHSI.

The learning and experiences from major issues, initiatives and reports (such as NHS Improvement's drive towards providing 7-day hospital services; and implementation of the National Quality Board's "*Guidance on Learning from Deaths*", Gosport Inquiry) are used to guide local work – and are reported through Executive and Board governance processes, as well as through our ICS structures.

NEWS2 has been implemented within the Royal Berkshire and is being rolled out to community inpatient services within Berkshire Healthcare, supported by training around the deteriorating patient and electronic patient record systems.

Quality Impact Assessment processes are established within both Foundation Trusts, including approval processes relating to major cost improvement or transformation programmes. These include a structured assessment of potential impact, as well as a formal sign off process including Medical and Nursing Directors. Monitoring of key safety and experience metrics within provider organisations is enhanced by the ICS Quality Framework and Dashboard outlined above, process, which enables a system wide overview of potential impacts of major programmes. The Clinical Delivery Group supports our ICS Unified Executive in understanding the quality implications of ICS priority initiatives as part of our prioritisation and performance monitoring processes.

Berkshire Healthcare has implemented a significant, multi-year Quality Improvement Programme, including external support from internationally recognised experts. As well as including the tools and techniques used to support quality improvement in patient facing services, the programme includes a significant focus on strategy, leadership and development of a whole organisation culture focussed on quality improvement. Berkshire Healthcare also has a Quality Strategy which is set out in summary form in Appendix B.

The Royal Berkshire has established a quality improvement initiative and full details of this can be found in Appendix B.

6 ACTIVITY PLANNING

6.1 Overview

The purpose of this section is to summarise the activity assumptions that have been agreed across the ICS for 2019/20 as required to deliver on constitutional standards and the intentions of this plan. They have been developed following detailed modelling by providers and commissioners and are supported by the detailed activity returns from our constitutional organisations. The section also seeks to summarise the action we are taking to ensure that capacity exists in providers to deliver on these assumptions and the specific action we have planned to ensure service continuity during Winter 2019/20.

6.2 Activity assumptions

Bottom up modelling by providers and commissioners has indicated a limited need for growth in services for the year ahead. This continues the trend seen during 2018/19 and is reflective of the strong performance of the system with respect to operational standards.. A high level summary of our assumptions is provided in table X below which highlights the limited growth expected by all parties save for the growth in zero length of stay Non-elective admissions which is linked to the growth trend as seen since 2017/18 and work to embed ambulatory care pathways and improve patient flow in support of same day emergency care. .

Table 6.1 – Forecast growth 19/20

Code	Activity Line	Forecast Growth from CCG Adjusted 18/19 FOT to 19/20 Plan (Total)*
E.M.7	Total Referrals (General and Acute)	0.5%
E.M.7a	Total GP Referrals (General and Acute)	0.5%
E.M.7b	Total Other Referrals (General and Acute)	0.5%
E.M.8+9	Total Consultant Led Outpatient Attendances	0.4%
E.M.8	Consultant Led First Outpatient Attendances	0.5%
E.M.9	Consultant Led Follow-Up Outpatient Attendances	0.3%
E.M.21	Consultant Led Outpatient Procedures	1.0%
E.M.10	Total Elective Admissions	1.2%
E.M.10a	Total Elective Admissions - Day Cases	1.2%
E.M.10b	Total Elective Admissions - Ordinary	1.2%
E.M.11	Total Non-Elective Admissions	3.2%
E.M.11a	Total Non-Elective Admissions - 0 LoS	10.0%
E.M.11b	Total Non-Elective Admissions - +1 LoS	0.0%
E.M.12	Total A&E Attendances excluding Planned Follow Ups	1.2%
E.M.12a	Type 1 A&E Attendances excluding Planned Follow Ups	2.0%
E.M.12b	Other A&E Attendances excluding Planned Follow Ups	0.0%

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6.3 Capacity to deliver constitutional standards

Given the limited growth planned for 2019/20 and our existing performance the constituent members of the ICS are assured that there is sufficient capacity available to deliver the level of activity agreed in the plan. Key actions already in train to support this are detailed below.

RTT:

For elective procedures the main acute provider (RBFT) has been a strong performer on access targets (RTT) and therefore has an ability to absorb some fluctuations in demand. Should there be concerns that develop during the year in relation to ability to manage capacity there is significant capacity in the Berkshire West system through a large independent provider presence, although it is not anticipated that additional activity is required at this stage and indeed there is an ambition to repatriate some activity to RBFT.

Where there are agreements in place with local independent sector providers, these providers are agreed with commissioner partners as permitted subcontractors, through the usual contractual process. When demand spikes are experienced, over and above the locally agreed demand and capacity plans, there remains the operational and associated financial risk of any associated increases in capacity. Work will continue, as in 2018/19, to mitigate the risks of such instances.

Cancer:

The ICS remains committed to the delivery of the national cancer access standards and we continue to work closely across both primary and secondary care to identify opportunities for further improve and access to treatment for patients referred with a suspicion of cancer. Through 2018/19 the main acute provider has performed well across all standards cancer standards with the two 14 day and five 31 day standards expected to achieve above target performance for the year. The Cancer 62 day standards have been more challenging through 18/19 following a significant unexpected increase in referral demand within one tumour site which when combined with the low volume nature of the 62 day standards has resulted in lower than targeted performance. However whilst performance has not been as high as we would like the Trust has robust processes in place to ensure that high quality care is maintained and wait times are kept to a minimum. The Trust remains significantly above the national average for the 62 day standard and will be targeting a compliant 62 day position through 2019/20..

As an ICS we work closely across the sectors and with the Thames Valley Cancer Alliance (TVCA) to manage our adherence to the national standards but importantly there is a strong collaboration in place to identify areas for improvement and transformation across a range of pathways and enabling programmes. We continue to target opportunities to deliver improvements that will support;

- Shorter waiting times
- Earlier diagnosis (both identification and access to diagnostic tests)
- Support and management of patients ‘Living with and Beyond Cancer
- Care Closer to Home
- The use of Digital technology to support improvements in care delivery and support.

Looking forward to 2019/20 the ICS will remain focused on delivering the highest quality care to patients with or suspected of having cancer and will continue to work towards our goal of all patients being seen, diagnosed and communicated with quickly and effectively, and where cancer is diagnosed, ensuring treatment is started as quickly and effectively as is clinically appropriate. The ICS will continue to work closely with the TVCA and NHS England in relation to changes to the national cancer standards that are under discussion (e.g. 28 day diagnosis) to ensure we are able to respond effectively for the benefit of our patients.

Diagnostics:

The ICS is conscious that performance against the diagnostic access standard has been a challenge through 2018/19 as a result of workforce and equipment challenges at different points of the year. Through 18/19 the Trust has address the cause of these issues and is targeting a return to compliance in 19/20. Looking forwards, as detailed elsewhere in this plan, the ICS will be commencing a programme of work to inform planning for diagnostic services across the ICS for the next five years. This work will be undertaken in close communication with wider footprint stakeholder via the STP and Thames Valley Cancer Alliance.

Urgent Care:

During 2018/19 the system was successful in securing capital to increase acute medical capacity in the hospital in order to better manage urgent care demand. This investment alongside associated revenue funding and other investments across the system has supported a 39% reduction in 4hr breaches in Q4 of 2018/19 when compared to the same period last year and has allowed us to support the best possible care for increasingly complex patients.

During 2018/19 work was completed on a system wide bed modelling exercise to ensure that the ICS can appropriately size system capacity. This work demonstrated that with the investment above the system had sufficient near term capacity but that work was required to develop a new model of care in order to avoid the need for future investment. Progressing this work is a key priority for the ICS in the year ahead.

6.4 Winter planning and escalation/planning

The ICS A&E Delivery Board has partners working together to plan, address issues and support robust winter planning arrangements. The ICS is a comparatively high performer against urgent and emergency care metrics and have undertaken a number of improvement programmes through 2018/19, for example Patient Flow Improvement with the support of the Emergency Care Intensive Support Team (ECIST). In addition during winter 18-19 RBFT have tested arrangements to open additional short stay and HMU capacity at times of escalation and temporarily convert elective orthopaedic beds to medicine.

Winter resilience planning for 19-20 will be based on an evaluation of the 18-19 system wide plan and will adopt the same key principles of;

- Providing safe, quality care for patients aiming to reduce multiple moves in patient pathways and maintaining privacy and dignity
- Streaming as many patients as possible across front door locations to same day emergency care services
- Treating patients in short stay facilities wherever safe to do so
- Robust approach to targeting all delays in patient pathways across the system
- Supporting staff at times of pressure
- Communication and escalation with system partners as necessary to support system flow.

6.5 Mental Health Targets

BHFT and the CCG are working together to ensure that BHFT have the resources to deliver key operational standards during 2019-20. These include:

- timely access to IAPT treatment to specified outcome measures,
- early intervention for people with first episode of psychosis,
- an increase in the number of children receiving timely mental health treatment,
- physical health checks for people with mental health conditions,
- reduced number of suicides
- The required additional clinical workforce.

There is a need to ensure sufficient capacity and resource to reduce the number of out of area placements (OAPS). Whilst BHFT have been able to achieve their target trajectory, the position remains volatile. The ICS have invested in a Bed Management Team and will review opportunities for the use of alternative

provision including crisis beds and "safe haven" models. NHSE capital funding will enable a 12 bedded unit for General Adolescent Services, including specialist eating disorder services to open in the summer of 2020, which should reduce OAPs and support young people closer to home.

BHFT, working with The Berkshire Transforming Care Partnership, has closed an inpatient service (7 beds) and developed a community based Intensive Support Team for people with learning disabilities who are at risk of inpatient admission. There is a focus on enabling a small number of people in specialist OAPS to be discharged back into local community based services – and to work with partners to support the development of sufficiently robust services locally to reduce admissions, and new OAPs.

As highlighted in our quality section one of the risks to future performance is, in common with much of the rest of the NHS, the challenges around workforce. However, given the work outlined in the workforce section the ICS believe that it is making steps to reduce this risk.

7 SYSTEM FINANCIAL PLAN

7.1 System Financial Sustainability

Introduction

Financial sustainability continues to be one of the strategic priorities of the ICS. In 2017/18 the ICS achieved its control total and in 2018/19 there will be a small (0.5%) underachievement. Good in year financial performance has been achieved by non-recurrent mitigations whilst the underlying run rate has remained unresolved. Although, the allocations for 19/20 provide welcome additional funding for both providers and commissioners much of the new funding is committed to cover inflation, in particular the impact of the Agenda for Change pay award, alongside supporting delivery of the requirements of the Long Term Plan. The focus of the ICS is to deliver a robust shared cost reduction programme, with medium term service redesign through transformation.

Table 7.1 – Per Capita Funding

CCG Allocation 2019/20 (raw population)

Per Capita Funding*	**£**
Berkshire West CCG	1,175
SE England average	1,397
England average	1,460

As a result of changes to allocation methodology, Berkshire West CCG has moved on its core allocation from being 4.65% below target allocation in 2018/19 to 0.81% above target funding in 2019/20. The system continues to be one of the lowest funded in the country.

7.2 Gap Analysis and Efficiency

There is evidence to support the success that the ICS has had in flattening demand and as a result the underlying deficit has reduced, but this has been offset by inability to take cost out of the system at the same pace. The system wide gap has reduced from £50m to £45m over the 2 year period from April 2017 to March 2019 and while this is encouraging, the key focus for the system going into 19/20 is to increase the pace of change as the ability to mitigate a significant deficit has been eroded over time.

The ICS system financial gap is calculated to be £45.2m for 2019/20 and is made up from commissioner and provider positions as outlined in the bridge analysis below.

Table 7.2 – Bridge Analysis

	RBFT* £000s	BHFT^ £000s	CCG £000s	Total £000s
2018/19 Surplus/(deficit)	(3,684)	2,522	(3,000)	(4,162)
Non-recurrent Funding		(3,531)	(5,500)	(9,031)
Other non-recurrent action	(14,305)	(1,565)	(8,500)	(23,670)
Recurrent position	(17,989)	(2,574)	(17,000)	(37,563)
Allocation increase		240	33,000	
Price/tariff inflation	21,170	4,510	(15,750)	
Other inflation	(19,341)	(5,095)	(1,800)	
Investments	(5,500)	(450)	(2,900)	
MH and community commitments	0	837	(1,750)	
Growth	1,887	3,930	(6,800)	
Cost pressures/cost associated with growth	(2,052)	(4,040)	(2,150)	
Rebuild contingencies/reserves	0	0	(5,600)	
2019/20 Gap	(21,825)	(2,642)	(20,750)	(45,217)

**RBFT figures for all contracts. ^BHFT figures represent 60% of total*

Individual and system efficiencies linked to flattening demand and containing costs are summarised as follows for 19/20. The residual gap is £21.4m split between RBFT £9.4m and the CCG £12m. It is expected that the CCG will be able to mitigate some of the residual gap non-recurrently and this will leave £7m net risk as per the detailed financial templates.

Table 7.3 – Summary of Individual/System Efficiencies

Programme	RBFT £000s	BHFT £000s	CCG £000s	Total £000s
Gap	(21,825)	(2,642)	(20,750)	(45,217)
RBFT	13,930			13,930
BHFT		2,400		2,400
CCG			6,227	6,227
Net Position	**(7,895)**	**(242)**	**(14,523)**	**(22,660)**
Control total	1,503	(242)	0	1,261
Gap before mitigations	**(9,398)**	**0**	**(14,523)**	**(23,921)**
Enhanced Access Allocation			2,500	2,500
Residual Gap	**(9,398)**	**0**	**(12,023)**	**(21,421)**

7.3 Growth and Inflation

The high level **combined** growth and inflation assumptions used in planning are given below.

Commissioning segment	%
Royal Berkshire FT (based on detail projections)	6.1
Other Acute	5.4
Prescribing (as per guidance)	2.5
CHC (as per guidance)	5.7
BCF (as per guidance)	1.8
Mental health	6.2
Community	5.5
Ambulance (9s contract as per guidance)	5.2

In addition to growth and inflation, further investment will be made in Primary Care Networks and specific pathway development as proposals are agreed throughout 2019/20.

7.4 Compliance with Financial Rules

The system's ability to comply with the financial rules is assessed below, with the main risk highlighted around the achievement of individual control totals.

Table 7.4 – ICS compliance with financial rules

Financial Rule	Current Rating		
	RBFT	BHFT	CCG
Break-even in year within their overall allocation.			
Have a cumulative surplus of at least 1% of allocation.			
Set aside a contingency which is 0.5% of overall allocation.			
Invest into Mental Health services to ensure spend in 19-20 is 6.2% more than spend in 18-19			
Achievement of control total			

Given the scale of the underlying financial deficit and the more limited in year options for mitigation, the system has put itself into voluntary turnaround. Work is underway to redesign the collective transformation resource into a fit for purpose function spanning the entire ICS with a dual aim of demand flattening and cost efficiency. Linked to this, we are in-housing key services from SCWCSU to release significant cost and improve effectiveness of support functions with resource being aligned to the ICS programme boards. This has been made possible as much of the non-value added activity related to PBR and associated contractual challenge has been removed. A joint Financial Recovery Group has been established with executive level representation and a wide remit to focus on both system and individual plans.

For RBFT there is a requirement to improve financial control and forecasting, with the following programme of work agreed by the Board in March and supported by partners:

- A full review of financial governance and control is underway, led by the Chief Finance Officer.
- This will include governance over the operation of the procurement cycle, management of contracts, approval mechanisms over variable pay, delegated spending controls, budget management training and a review of financial reporting across the organisation, with the aim of improving the accuracy of forecasting, reporting, and the effectiveness of cost control.
- This programme will encompass corporate and care group areas. It will also include supporting a Trust wide demand and capacity review with the required cost, income and activity information.
- Internal Audit and some targeted external expertise will be assisting in this work. Including an external review of the financial bridge for 19/20.

The key transformation areas which will deliver system sustainability are described in Chapter 2 of this document, with the following identified as having the greatest potential benefit from 20/21 onwards:

- Outpatient Transformation
- iMSK
- Development of Primary Care Networks

To this list is added our Berkshire West First programme which aims to minimise leakage out of the system and maximise the ROI on existing healthcare assets.

Following the receipt of the Bronze Diagnostic and using other data that becomes available to the system in year e.g. output from the Population Health Management trial, it is hoped that the number of areas for transformation can be increased.

7.5 Creating the Right Environment for Transformation

The ICS has a Chief Finance Officers' Group which has been working together since September 2016 to develop a number of work streams to support our sustainability:

- **New payment mechanisms:** The ICS moved away from PbR in 2018/2019 using an innovative "blended payment" approach working closing with the NHSE/I joint pricing team. The ICS is seen as a trailblazer in this respect. The payment mechanism includes a fixed payment and an innovative risk sharing agreement with different interpretations to reflect the different starting points and risk appetites of the 2 main providers. *Ambition for 2019/20: Extend the risk share to BHFT (subject to further discussion and agreement).*
- **Cost of system delivery:** In order to further the ICS payment journey ICS finance leads have identified the need to better understand the cost of system delivery and the interplay between demand and cost. Close work with the NHSE/I Joint Pricing team has enabled the ICS to have access to support from KPMG to develop a system costing model which will enable us to assess the cost impact of proposed transformation. It is expected that this model will be fully operational from the end of Q1 with 60% system cost coverage (and 40% using price as a proxy for cost). By the end of 2019/20 the model will have been enhanced with primary care cost data linked to an innovative primary care patient level costing project. This model will link to our PHM interventions and will give visibility of cost across pathways with the ability to summarise at PCN and individual practice as required. *Ambition for 2019/20 and beyond: move to an efficient cost model for the fixed element of the blended payment.*
- **System control total:** The ICS signed up to a control total linked to the additional PSF in 2018/19. Berkshire West was the first ICS to request and secure an in year offset between providers. The control total will be at BOB STP level in 19/20 so there are no opportunities to develop this further at place on a formal basis.
- **Group Accounts** – the development of a consolidation model for group accounts gave visibility of system income and costs through the early months of 2018/19 and has now been replaced by the BWICS system risk and mitigation monitoring and sharing methodology which will be further

developed in 2019/20. This is ensuring alignment throughout planning and for forecast outturn reporting.

- **Contractual form:** The ICS will continue to use the Standard NHS Contract which has been supplemented with an Alliance Agreement setting out the risk share arrangements for the year ahead. No further development work is planned for 2019/20.
- **New ways of working:** The joint contract and finance team is being supported to develop 6 focus areas with the dual theme of creating capacity and efficiency. These compliment the 4 focus areas already developed by the CFOs' Group.

Table 7.5 - New Ways of Working & Focus Areas

Focus areas from CFO Group	Focus areas from joint team
ICS Finance Team Development	Eliminate provider to provider recharges
Cost of system delivery	Joint contract review meetings
Internal audit and governance	Improve intra BW recharge processes
Adopting the Best Possible Value Framework	Development of joint business case group and processes
Communication	
Berkshire West First Project	

7.6 Agency Rules

In 18/19 the RBFT Agency Ceiling was £9,502k and the Trust expects to spend c£9,600k. For 19/20 the Ceiling is again £9,502k which the Trust does not expect to exceed.

BHFT has been operating below its agency cap for the last two years and plans further cost and quality improvements in 19/20 related to non-clinical agency usage and more effective use of our existing e-rostering system by increasing volumes of planned roster at 8 weeks in advance, reducing unused contracted staffing capacity, and better manage absence to reduce agency costs.

7.7 Use of Capital

RBFT: A high quality, modern, accessible and welcoming estate along with the presence of modern digital infrastructure and medical equipment is critical to our collective ability to serve our patients. Like many hospitals, the RBFT estate is a patchwork of bespoke buildings built in a range of different eras across multiple sites a number of which are beyond their useful life and or require investment or replacement. During 19/20 RBFT is seeking to develop a master plan for its estate that will set the long-term direction for its facilities. This plan will explore ways the Trust can to utilise estate away from RBFT site, alongside evolving digital and technological solutions. While this plan is in development the Trust will prioritise investment in infrastructure (physical and digital) and will look to deal with required backlog maintenance issues through the planned £37m of capital spend in 19/20.

BHFT: Through a £12.4m total capital programme two key estate developments will commence in 19/20. The first is the move of our inpatient learning disability service on the Prospect Park Hospital site into an improved environment for patients, releasing capacity to relocate our Wokingham based Tier 4 CAMHS inpatient service onto the hospital site in Reading (Tier 4 service move funded by wave 4 STP capital expected to be drawn in 20/21). The second scheme is to commence refurbishment of our leased property on the Reading university Whiteknights campus to move and co-locate Reading community based mental health and physical health services from poor dispersed sites, including specialist childrens services provided by Royal Berkshire FT (capital and lease funded by RBFT for their wing of the building). During 19/20 BHFT will continue major investment in IT infrastructure (cloud, 0365 etc.), PDC funded GDE programme delivery and HSLI community worker mobile device upgrade, to improve productivity and digital experience of the clinical workforce.

8 WORKFORCE

The workforce challenges remain significant in our ICS particularly with regard to recruiting and retaining staff; this is most acute in relation to the front line nursing, allied health professional groups and primary care staff. Workforce presents the greatest risk to the delivery of our strategy, and the ICS recognises that failure to recruit and retain an appropriately qualified skilled and experienced workforce will directly impact our ability to maintain quality outcomes and deliver the transformation agenda. The ICS recognises the importance of sustaining an engaged and motivated workforce and adopting technological and digital solutions to address workforce pressures and support front line staff.

In Berkshire West, the workforce supply challenges are compounded by the high cost of living locally; Reading is the sixth most expensive place to live in the UK, and local employment levels are high. The ICS also have above average numbers of workers aged over 50 in a number of services/specialities, which may reflect the impact of the high cost of living and alternative employment options available to younger workers.

The ICS has identified its ambition in relation to workforce:

- To fully engage our staff in the development of our ICS – using their talents and creativity to develop innovative solutions to the challenges of increasing demand and finite resources
- To work together as partners to share good practice and expertise to respond effectively to our workforce challenges
- To provide increased opportunities for career development through the new ways of working that are incorporated within our ICS priority initiatives, alongside cross-organisational leadership
- To develop a shared methodology for transformation and quality improvement as part of an ICS approach to organisational development

The ICS had identified five key strategic objectives to deliver its ambition and address the workforce challenge, working both within the ICS and with partners across the STP, and the RBFT and BHFT HR Directors provide leadership to the BOB work programme via the Local Workforce Advisory Board (LWAB).

8.1 Collaboration

The STP working group collaborate through regular meetings and the sharing of best practice, polices, training courses and campaigns. They have engaged in developing a People Strategy for the BOB STP, ensuring where appropriate things are done once and all can benefit from the activity. The group has worked together on the EU settlement scheme as well as leadership courses and recruitment expertise. The NHS Trusts have also collaborated on streamlining areas such as recruitment, statutory training and occupational health provision to ensure it is easier for staff to move around the NHS and reduce costs.

8.2 Recruitment and Resourcing

The ICS held an event to share recruitment and resourcing expertise between the NHS Trusts and other health and social care providers including GP surgeries. The Trusts are able to share ways of recruiting, such as using advertising campaigns, writing engaging job descriptions and using social media, that result in successful applications.

8.3 Organisational Development

At BOB level the People Strategy development and engagement of all parts of the system is a good example of OD at its best. Providers have worked on the development of a joint strategy to identify where better links and closer working would lead to better services and higher recruitment levels. This activity included conversations on the values each provider has and ways of working required by leaders and staff going forwards.

8.4 Staff Engagement

ICS partners run the NHS Staff Survey annually and use the results to make changes to how it feels to be an NHS employee in Berkshire. The feedback has led to improvements in the health and wellbeing offer, the way in which appraisals are done and development for managers to ensure they have the skills to manage well and in accordance with our values. 68% of NHS staff in the ICS would recommend the NHS as a place to work. Together we will work on the interventions to make this a great place to work including developing career paths across the system, improving the training available and recruiting more people to support our current workforce.

8.5 Retention and Wellbeing

The ICS a retention plan which includes initiatives such as reviewing the working environment, IT support, career path options, introducing flexible and agile working practices, and building a network of mental health first aiders and health, wellbeing and engagement champions to improve the support to staff. All of this work will be part of the Great Place to Work For All campaign to be launched later in 2019.

8.6 Workforce design

The ICS is working together on building the skills to design and plan the workforce for the future. A number of staff across the ICS have attended training on workforce planning and will attain a formal qualification with the aim of having internal expertise to support projects where health and social care are working together to improve workforce design.

8.7 Planning and Productivity

The current workforce data is used to predict future requirements in the light of planned changes to services. In addition ways of working and delivering services are linked to contractual renewal or bid cycles to ensure the best value for money. The Global Digital Exemplar programme has also led to the introduction of technology which has impacted on the way people work and the type of roles required. For example, community nurses are benefitting from the introduction of IPADS and smart technology allowing them to update patient records without having to travel to a fixed base.

The constituent organisations of the ICS are working to deliver an efficient, effective and sustainable workforce model to support the delivery of services. Whilst temporary staffing remains an important resource, to allow for flexible delivery, the work described above will improve staff recruitment, retention and capability which will reduce the need for temporary staffing.

Job planning and e-rostering are in place to see a better match between workload and staffing at RBFT and BHFT. Both trusts have been able to manage agency costs below the NHSI ceiling, and utilise more bank than agency shifts. RBFT has reviewed its temporary staffing policy which sees priority being given to lower costs sources over higher cost, in the first instance. Since September 2018 a joint staff bank has been established between RBFT and BHFT. RBFT believes it has been successful in achieving very competitive agency rates from providers, however there have been some issues in finding staff to cover shifts, which

may in part be linked to the rate that is being offered and therefore there may be limited future scope in this direction. Both providers have successfully implemented a “bank only” approach to temporary staff required for staff at Bands 2 and 3.

In addition both Foundation Trusts within the ICS have Board approved workforce strategies which include a focus on workforce planning, recruitment, development and retention. The ICS have recruited from both the EU and beyond and continue to see overseas recruitment as part of our workforce plans. Steps have been taken to retain existing EU staff, including regular communication with them about their importance to our success, and to address their concerns and issues.

The development of new roles, including apprenticeships across clinical, support services and leadership roles are a key part of our plans. RBFT has been highlighted as an area of best practice for their use of apprenticeships. The ICS is also developing shared functions in key areas to increase capability and make best use of the collective resource.

The CCG leads a BOB wide primary care workforce group which is developing workforce analytical and modelling capability. This group allocates the national funding available to support recruitment, retention and upskilling in primary care and works with the three place based Training hubs. The group will also have oversight of the diversification of the primary care workforce and the recruitment of new roles to Primary Care Networks.

An analysis of specific workforce challenges, risks and initiatives are set out below by sector.

	Workforce challenge	**Impact**	**Initiatives**
Primary Care Workforce	Reducing supply of registered GPs and increasing numbers of registered patients Berkshire West has higher than average numbers of GPs and Practice Nurses aged over 50.	Poor access to primary care, resulting in patients accessing less appropriate services	Current Work Streams: Time to Care Initiative, Social Prescribing, development of Footfall system use, GP Retention Scheme, International GP Recruitment, GP Locum Chambers, GP Fellowships, Upskilling and Development of the Primary Care Workforce. Development and employment of increased numbers of supporting roles within primary care including: Physicians Associates; Paramedics; Apprenticeships: (GP Assistant posts); Pharmacists
	Fewer Practice Nurses entering training since the removal of the nurse training bursary.		HEE funding is supporting the development of an integrated model of community and practice nursing.
	GP workforce data is not as robust as other sectors	Inadequate understanding of work force pressures and key skill shortages	Implementation of the Wessex Workforce Planning Tool and support from HEE

		which impedes workforce planning	Workforce Data Intelligence Team
Acute hospital	**Workforce challenge**	**Impact**	**Initiatives**
	Shortage of staff in specific services/roles including elderly care and paediatric nurses, Theatre Practitioners.	Difficulty in offering flexibility in working patterns, higher use of temporary staffing, increased workload for other staff. Challenges in filling on call rotas	Incentive schemes, rotational posts, review of shift patterns, development of new roles, retire and return initiatives. Specific review of Paediatric Consultant requirements based on demand forecasting
	Long term vacancies in Dermatology, Pharmacy and ED Consultant roles	Use of locum and agency staff to maintain service provision. Increased waiting times.	Updating of job roles and consideration of new ways of working with primary care. Redesign of roles within a workforce transformation programme and consideration of rotation scheme with private providers. New employment offering with flexibility options. Joint working with other acute trusts in BOB.
	Transformation initiatives are potentially compromised by workforce issues	Benefits of initiatives may not be fully realised or are delayed.	Employment of a Head of Workforce Transformation Use of a workforce planning template to enable integration of workforce, activity and financial planning
Community and mental health	**Workforce challenge/risk**	**Impact**	**Initiatives**
	Difficulty in recruiting to Band 5,6 and 7 Nursing and Allied Health Professional roles (particularly podiatrists and physiotherapists) This is most significant in Mental Health Inpatient, Community Inpatient and Community Nursing Services. Supply of Learning Disability Nurses is also	Use of temporary staff (targets for reduced use of agency staff are being met) and vacancy rate are both higher than BHFT wants to achieve. Adverse impact of staff wellbeing as a result of increased workload	Specific Workforce Plans and initiatives are in place for areas of highest risk. BHFT aims to increase permanent staffing recruitment, targeting Band 5 Nurses (MH, LD and DN), band 3 and 4 nursing associates to deliver national Long Term Plan targets and meet forecasted demand, and to recruit more

	limited, with reducing numbers of training courses available.		apprentices both into clinical and non-clinical roles. Improving data for workforce planning, reviewing job role design and content, and better forecasting. Recruitment of specialist support to improve health, wellbeing and engagement to reduce sickness levels and increasing engagement Recruitment of a social media expert to develop innovative recruitment channels

9 DIGITAL TRANSFORMATION

Digital Transformation underpins almost all of the ICS transformation programmes. According to *The Long Term Plan* '*Technology will play a central role in realising the LTP, helping clinicians use the full range of their skills, reducing bureaucracy, stimulating research and enabling service transformation'*

The NHS Foundation Trusts within our ICS have *Global Digital Exemplar* and fast follower GDE status – which provides a strong basis for our system focus on digital transformation: our Connected Care Programme is our largest individual work programme within the ICS, and is well established, with shared leadership from partner organisations. A digital "summit" meeting of ICS partners held in September 2018 achieved alignment of digital priorities – and reaffirmed our shared commitment to Connected Care. This meeting also provided an important organisational development opportunity for our ICS – with senior leaders summarising and reflecting the perspectives of other partners into the debate – thus modelling system rather than organisational leadership in service of our population.

Working in collaboration with Berkshire East CCGs and the Frimley Health and Social Care ICS, the Berkshire West system has led the way in the provision of integrated digital platforms which enable the sharing of information across health and social care organisational boundaries. As well as combining information held in different IT systems across the county, the shared record allows care professionals to create and update care plans, creating co-ordinated multi-agency care for individual patients and enables new ways of delivering services.

To ensure delivery of our ambition, we recognise the importance of strong foundations in a number of key functions – and our Connected Care programme includes the following priority projects.

Table 9.1 - Connected Care programme

Cloud based infrastructure Building system resilience, scalability and alignment with LHCRE	**ePMA** Including medication items within Connected Care, phased over time by provider	**Pathology** Enabling view of test results through Connected Care sent in real time by pathology service providers
Enhanced acute feeds Providing an enhanced, standard data set across Royal Berkshire and Frimley Health services	**Next generation social care** Ensuring social care data feeds can migrate to a cloud based infrastructure	**Documents** Ensuring document forms in secondary care can integrate into Connected Care

Our overarching objectives with the full deployment of new digital technologies will be to:

- Facilitate the sharing of information between professionals to support the coordination and delivery of care, regardless of which NHS organisation(s) the patient is interacting with
- Continue our work on the development of Population Health Intelligence (PHI) to support the identification and proactive support of people with complex needs and to identify pathways that could benefit from redesign across the ICS
- Provide different modalities of care – such as online service delivery (already established within IAPT, Eating Disorder, Perinatal and other mental health services), remote monitoring, Skype consultations, smart home technologies to drive efficiencies and improve patient experience. Other examples include online appointment bookings, e-prescribing and the digital front door to general practice
- Empower and supporting patients to manage their own health through access to their records and information, through the NHS app and NHS login, as well as self-access to high quality self-care information and signposting (e.g. further development of NHS 111 Online). The ICS anticipates that

the patient portal within our shared record system will develop over time to be a significant driver in the development of our ICS.

The ICS are working at organisational, place, system and regional levels, focussing on what scale or population size is required to add greatest value in digital transformation – illustrated in the following table.

Table 9.2 - Overview of digital transformation

Regional/Sub regional	BOB STP work streams with digital focus	ICS/Place	Organisation
LHCRE Programme - Thames Valley and Surrey Pathology Network Thames Valley Cancer Network Oxford Academic Health Science Network	Information Governance Steering Group Digital Work Stream including capital investment Cancer and Maternity work streams	Bucks Digital Transformation Group Oxfordshire Digital Strategy Group Berkshire West PHM Development Board	Berkshire Healthcare GDE Royal Berkshire GDE fast follower

As our ICS moves into 19/20 the momentum on this vital programme of work has been maintained by the formation of the *Population Health and Digital Development Board*. Members of this board include Chief Information Officers of partner organisations, Directors of Strategy and Director of Public Health, thus ensuring that our work is fully embedded within our overall strategic plans – both as a system and within individual organisations.

This board will oversee the continued development of the Connected Care Programme and will be the lead for Population Health Management approach (PHM). As set out in the *Long Term Plan*, it is expected that this approach will become; *increasingly sophisticated in identifying groups of people who are at risk of adverse health outcomes and predict which individuals are most likely to benefit from different health and care interventions, as well as shining a light on health inequalities.*

The board plan for 2019/20 is to:

- Work with the ICS Programme Boards to enable delivery of the ICS Strategic Priorities
- Hold the Strategic focus for ICS digital / infrastructure development
- Lead and deliver the Connected Care programme
- Design and deliver enhanced Information sharing between ICS and Local Authority partners
- Develop an Analytics and Information Governance Group which will provide the system with '*one version of the truth'* for Planning and Business Intelligence
- Drive and deliver the accelerated *Population Health Management* programme

10 NEW WAYS OF WORKING

Berkshire West ICS is entering its third year of operation and has maximised the opportunities this way of working has brought, along with additional support from NHSE. However, the Long Term Plan identifies the requirements for ICSs to operate at a larger footprint to have the scale required for some of the necessary transformation in the NHS.

Berkshire West ICS has been an active member of the Buckinghamshire, Oxfordshire and Berkshire West STP (BOB) and will use its experience to work with colleagues in BOB to achieve ICS status. Partners in BOB have recognised that transformation will continue to be delivered in each of the 3 places in partnership with local authorities and other stakeholders. The ICS will work with NHSE and BOB partners to describe how each of the three places in BOB might operate as part of a larger ICS to optimise the NHS across the system. It should be noted that Berkshire Healthcare Foundation Trust (BHFT) is also a constituent of the Frimley STP / ICS and are fully engaged with the ICS in both geographies.

As part of our work to strengthen how the Berkshire West system operates the ICS has already begun to introduce shared leadership and shared posts between the organisations. In 2019/20 partners will transfer organisational planning and transformation functions into a shared place based function, develop more robust joint commissioning arrangements with the three local authorities and provide support to emerging Primary Care Networks.

The ICS is working jointly with officers and elected members in the three local authorities to develop and implement new governance arrangements that will integrate the ICS and BW7 programmes.

In preparation for working at scale the CCGs in BOB have begun to review commissioning arrangements in three areas:

- Specialised commissioning,
- NHSE direct commissioning
- CCG commissioning.

This will enable the ICS to take opportunities to integrate the different commissioning activities to ensure aligned commissioning intentions and commission services along patient pathways.

The ICS will also contribute to the design of the BOB ICS governance and support the recruitment of a non-executive chair by the end of quarter 1 and a substantive executive lead by the end of quarter 2. The governance in BOB will need to be flexible to recognise the three places and will need to address partnership working with local authorities and clinical involvement in the design of services. BOB partners are working together to develop a clear road map to achieve ICS status by April 2020.

11 SUMMARY

In summary, the Berkshire West ICS is a high performing health system which is looking to build on the achievements of 2018/19. However, the financial challenge faced by the health system is 2019/20 is particularly significant and the ICS will be in voluntary turnaround to address this challenge.

The 2019/20 plan outlines the key transformation programmes that will deliver the first year of the Long Term Plan although it should be noted that lack of available financial headroom will constrain the ability to invest further in new models of care to accelerate these changes.

Despite this financial challenge, the ICS is in a strong position and as it moves into the next 10 year phase of the NHS. Working together the with local government, the third sector, partners and our local communities the ICS will continue to drive system transformation to ensure that the local NHS improves health outcomes and improves the experience patients have of NHS care.

12 APPENDICES

A COUNCIL OF GOVERNORS AND ELECTIONS

A.1 Berkshire Healthcare Foundation Trust

The Council of Governors comprises 32 representatives and has enjoyed an engaged membership since our foundation trust authorisation in 2007. The 19 public governors on the Council of Governors are elected by thirds. This ensures that there is a balance between new and experienced governors.

During 2018/19 BHFT appointed 4 governors, with 1 position currently vacant. Our membership strategy is designed to ensure BHFT exceed our required 10,000 membership (currently 11,900) which reflects the diversity of Berkshire's population. There will be elections for 7 new public governors in 2019/20. The Council of Governors' Membership and Engagement Committee is planning to promote the role of Governor by attending local community groups and events to encourage interested people to put themselves forward as candidates for governor elections. The Committee, together with our Chair and Company Secretary, routinely reviews and responds to best practice in attracting potential governors.

All new Governors are invited to attend an induction session facilitated by the Chair and the Company Secretary. The sessions provide an overview of the work of the Trust and an introduction to the statutory roles of Governors. This is supplemented with attendance on the core module of the Governwell development programme delivered by NHS Providers. Governors with specific responsibilities, such as recruitment of non-executive directors, have access to the relevant specialist Governwell module. Locally delivered training is also arranged to address any development needs. Development also features regularly within the quarterly joint meetings held between the Council and the Board.

The Trust is part of two Integrated Care Systems (Berkshire West and Frimley Health). During 2018-19, the Trust hosted two ICS Engagement events in the East and the West. This provided an opportunity for governors, clinical commissioning groups, voluntary sector, councillors and senior health and local government staff across the two systems to network and to discuss the development of the ICSs.

Governors use a variety of opportunities to engage with members and the public. This includes attendance at the Trust's Annual Members' Meeting, attending local community engagement events, such as World Mental Health Day, and attending Reading Pride. Governors also draw on their own community links to engage with members, the public and service users and carers.

A.2 Royal Berkshire Foundation Trust

The Trust has 9,256 members with public governors representing five local geographic areas, as well as volunteer, staff and partner governors. The Trust has recruited five new governors during 2018/19. There are currently five vacancies on the Council of Governors and elections will be held during May 2019 to fill these seats. All governor vacancies are advised via the Trust's Pulse magazine, as well via internal briefings to staff

The Trust, and its governors, has been raising the profile of governors with members and the public through a number of methods including sessions for people to meet their governors at all membership events. The Trust has also refreshed its membership magazine, Pulse, using an electronic platform in which the Lead Governor has a standing article in each edition, as well as featuring an article from other governors. RBFT have also sought to engage staff members to promote the role of staff governors. Proposed dates for membership events have been circulated to the governors. In 2018/19 all membership events were oversubscribed and these events were used to encourage people to become members, apply to become a governor as well as engaging our members on the development of Trust Strategy. The Trust held its third Open Day in September 2018 which was well attended. This is now an annual event.

Where there has been an under-representation of groups from the local community , the Trust has engaged with Governors to address this issue, identifying alternative ways of recruitment, including Governors attending patient engagement events in the community as well as Trust recruitment events. Members aged between 16-29 years are currently underrepresented and the Trust is due to hold a joint membership event with South Central Ambulance

Service specifically aimed to engage and recruit younger members. The Trust is also in discussions with our Integrated Care System (ICS) partners about holding joint membership events during 2019/20.

To help Governors fulfil their role the Trust has strengthened its induction programme and sought to develop them through the committees with which they engage. In addition, Governors are provided with regular updates via the NHS Providers newsletters. A Governor training and development programme continued in 2018/19 including sessions on NHS finance, commissioning, quality governance and patient experience.

The Trust is committed to meaningful engagement with its members. The membership strategy for the next 12-24 months will focus on ensuring that the Trust's membership is representative of the population served.

B QUALITY STATEMENTS FROM RBFT AND BHFT

B.1 RBFT approach to quality improvement, leadership and governance

Ensuring safety and quality of care for every patient is RBFT's top priority. RBFT aims for all its services to be outstanding every day of the week, and to maintain its position as a top performer in delivering NHS access standards. RBFT strives to be the one of the safest and most caring NHS organisations in the country.

Our high-quality clinical care is based on a strong research and development culture, being one of the most research active district general hospitals in the country. We are committed to continual learning and improvement, with a strong desire to ensure that every day is better than yesterday.

RBFT's Quality Strategy (2018-2023) provides the framework for the quality improvement work taking place across the Trust, based around the 5 CQC domains of safe, effective, caring, responsive, and well-led. The Quality Strategy sets out our quality aims and targets to help us to maintain our position as an 'outstanding' quality organisation at the Royal Berkshire Hospital site and aligns with our actions to achieve outstanding across the rest of our services. The Trust's Medical Director and Director of Nursing are the lead Executives for quality.

Our assessment of our quality of care and our chosen priorities reflects a balanced view of:

- The action taken to deliver ever improving standards of quality in the care we provide (including CEO transformation projects; "Learning from Excellence" feedback programme; and staff engagement in the 'What Matters' campaign)
- The learning and experiences from major issues, initiatives and reports (such as NHS Improvement's drive towards providing 7-day hospital services; and implementation of the National Quality Board's "Guidance on Learning from Deaths", Gosport Inquiry)
- The views and conclusions of our regulators such as the Care Quality Commission and NHS Improvement
- Feedback received from patients, partners and stakeholders in the community
- Analysis of themes arising from internal quality indicators (complaints, incidents, clinical audits, mortality reviews, outcomes data);

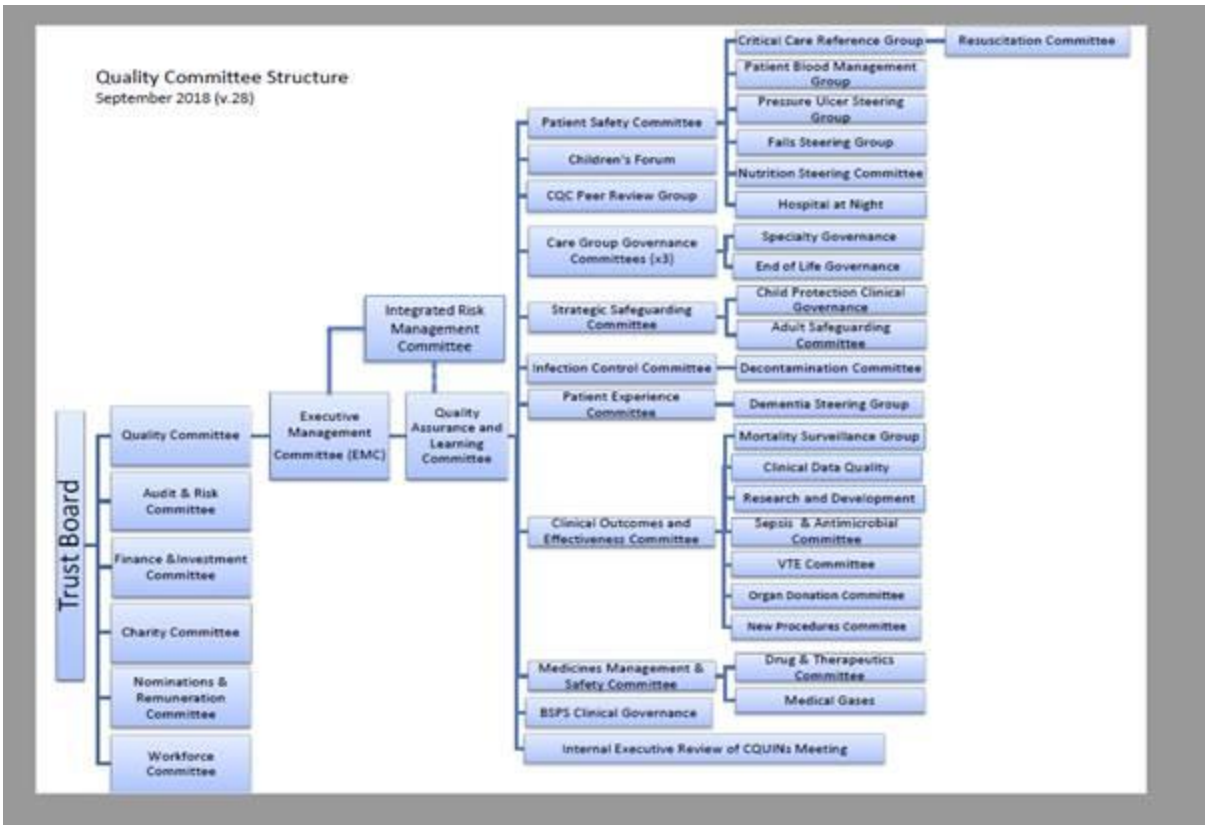
As a result, RBFT is confident that the quality priorities selected are those which are meaningful and important to our community.

Our quality priorities will be monitored to ensure that our ambitions are turned into reality. Underpinning this will be a comprehensive monitoring process to ensure that we know we are delivering quality care. This will encompass:

- the Executive and Care Groups meeting monthly to discuss and monitor progress against our quality indicators
- the monthly quality performance report to the Board
- periodic quality and safety reports
- regulatory assurance
- patient feedback

This is supported by an extensive governance infrastructure, see diagram below.

B.1.1 RBFT's Quality Governance Infrastructure



B.1.2 Summary of the quality improvement plan

Learning from Deaths

RBFT has a robust process of mortality surveillance and learning from deaths, and this is shared system wide. Our processes ensure that every adult, inpatient death receive an initial screen at the point of death certification to check if there were any concerns against an approved checklist of standards. All deaths which 'trigger' are subject to a full review by a consultant. Any avoidable deaths identified are presented in detail and considered for potential serious incident reporting and investigation. In addition plans are underway to implement the Medical Examiner role.

Reduction of Gram-negative Bloodstream (GNB) Infections

NHS and Public Health England's (PHE) ambition is to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021. RBFT, as part of the wider Berkshire West health economy, has implemented a Gram Negative Bacteraemia reduction action plan and work-streams that enhances the existing Infection Prevention & Control surveillance of E.coli Bacteraemia. Within the RBFT, progress against the action plan is monitored by, and reported to the Trust Infection Prevention & Control Committee

Development of safety culture

- To work with the Academic Health Science Network (AHSN) Patient Safety Collaborative to share learning across the region
- To be within the top decile of NRLS incident reporters
- To achieve an "outstanding" CQC rating for safety
- To develop new roles and career opportunities to meet emerging healthcare needs and to respond to national shortages of key clinical staff, such as Physician and Nursing Associates

Reduction of avoidable harm

- 50% reduction in avoidable grade 2 pressure ulcers
- Zero avoidable grade 3/4 pressure ulcers

- Reduction of avoidable hospital acquired Escherichia coli bloodstream infections
- Zero avoidable falls with harm
- Reduction in avoidable, hospital-acquired venous thromboembolisms (VTEs)

Maternity improvement programme

- To improve the maternity safety culture by working with NHS Improvement on Wave 2 of the Maternity and Neonatal Safety Collaborative.
- Zero never events relating to retained swabs
- To develop Quality Improvement (QI) coaching for maternity staff to enable a culture of continuous learning and improvement.

Mental Health

- To improve safety and outcomes for mental health patients through increased partnership working with community services

The four priority standards for 7-day hospital services

In April, 2018 the Trust was compliant with 3 of the 4 standards with standard 2, consultant review within 14 hours for all emergency admissions, not being met in all areas. In order to address this, issues were investigated at a service level and an improvement plan developed.

The Trust is preparing for the introduction of the new Board assurance self-assessment framework The Trust completed the "dry run" self-assessment which was signed off by the Trust Board and submitted to NHSI. Good progress has been made in developing our EPR system to enable reporting against both Standards 2 and 8. It is envisaged that systems and processes will be in place for full implementation of the framework by 28th June.

B.1.3 NEWS2

NEWS2 has been implemented within the Trust, facilitated by the development and go-live of the Trust's EPR system.

B.1.4 Risks to Quality

There are significant challenges facing the NHS in the delivery of high quality patient care that we will address locally through this strategy. These include:

Challenge	Actions to address
Clinical Staff Shortages	Retention, recruitment and workforce transformation initiatives
Capacity and flow within the Trust and across the local healthcare economy	Acute medicine pathway: GP Streaming and Paediatric ED "SAFER" Patient Flow Programme 7 day working programme Development of innovative outpatient services Digital Hospital work programme
Treatment of serious infections in the context of increasing antimicrobial resistance	Sepsis and antimicrobial stewardship work programmes
Increased financial pressures	SAFE improvement programmes– reducing avoidable harm reduces bed days and delivers more efficient care

The key issue for RBFT are largely reflected across the NHS, balancing high quality care against increasing demand and constrained financial resources. To support the delivery of our quality and access standards we continue to drive improvement through innovation, change and recognition of good practice.

B.1.5 Summary of quality impact assessment process and oversight of implementation

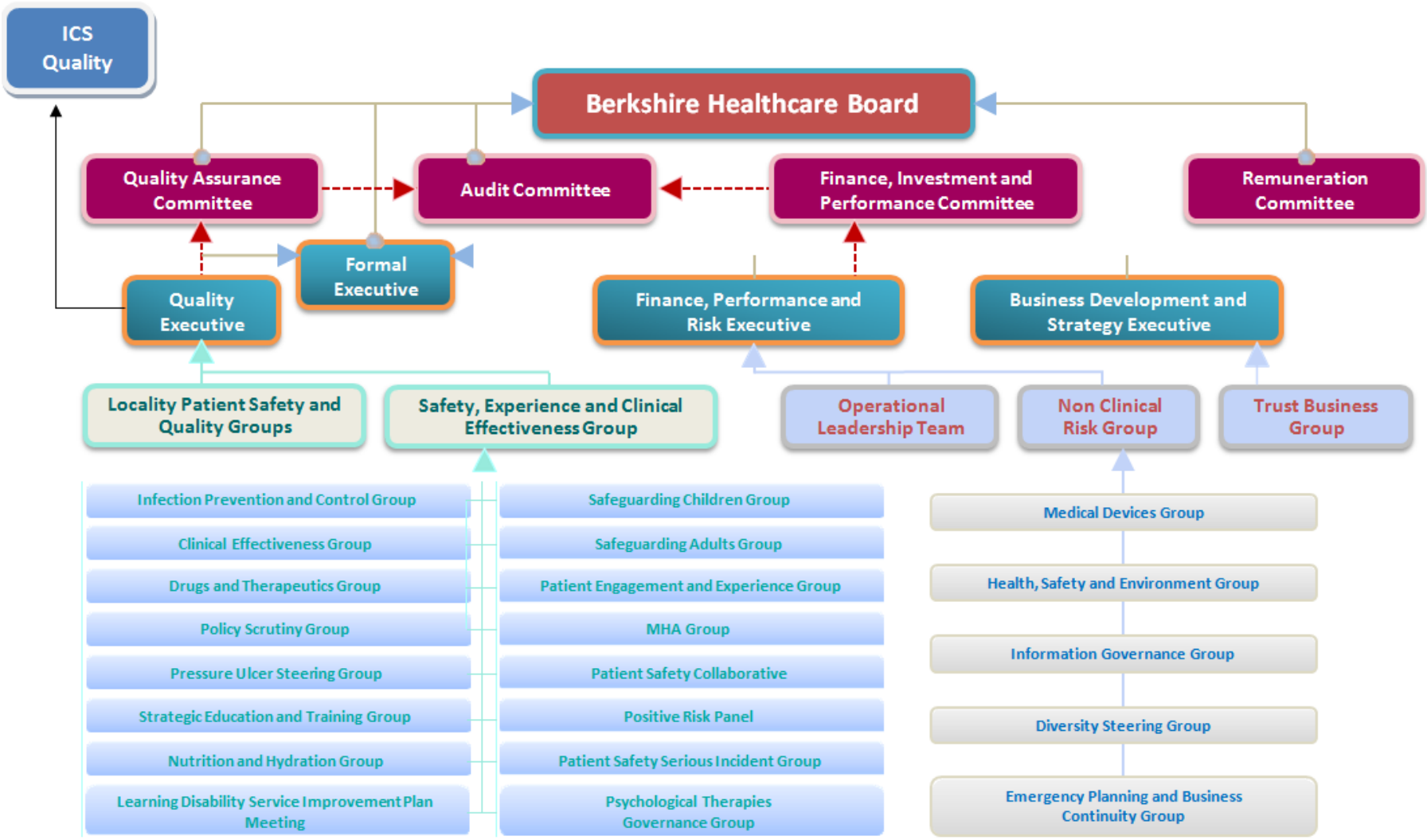
The Trust has a robust Quality Impact Assessment which is carried out on efficiency schemes over a certain value and on ones where the value maybe small but there is likely to be a negative impact on staff or the quality of the service provided. There is a standard template that reviews the quality impact of schemes on patients and staff. There is a clear scoring criteria and if any of the criteria scores over 8, the quality impact assessment is escalated to the Director of Nursing and the Medical Director for a decision to assess whether the project should continue, continue with amendments, pause and review the scope or the project should not be progressed. A quarterly update on quality impact assessments is also provided to the Quality Committee.

The following table shows RBFT's quality domains against which the QIA is scored.

Area of Quality	Impact question
Duty of Quality	Did the proposal impact negatively on any of the following - compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?
Patient Experience	Did the proposal impact negatively on any of the following - positive survey results from patients, patient choice, personalised & compassionate care, patient complaints or waiting times?
Patient Safety	Did the proposal impact negatively on any of the following – safety, systems in place to safeguard patients to prevent harm, including infections, medication errors, slips/trips/falls or adverse events?
Staff Safety	Did the proposal impact negatively on – safety, safe systems of work, or introduce further risks into the environment?
Education	Did the proposal impact negatively on the number of training placements provided by the Trust?
Clinical Effectiveness	Did the proposal impact negatively on evidence based practice, clinical leadership, clinical engagement, high quality standards, readmission rates or mortality rates?
Prevention	Did the proposal impact negatively on promotion of self-care and health inequality?
Productivity and Innovation	Did the proposal impact negatively on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?

B.2 BHFT approach to quality improvement, leadership and governance

B.2.1 BHFT's Quality Governance Infrastructure



B.2.2 Summary and oversight of implementation

The Trust Board has overall responsibility for setting strategy and ensuring its implementation across the organisation. This is undertaken through the structure described in B.2.1.

Furthermore:

- Each meeting of the Trust Board starts with a focus on service quality, and all members of the Board make “quality visits” to our services to ensure that they stay in close touch with patients, their families and our staff.
- The Quality Assurance Committee undertakes detailed consideration of quality issues, and is complemented by the Audit and Finance Investment and Performance, Committees of the Trust Board, to collectively provide a strong Board governance structure.
- The Quality Executive includes all Clinical Directors, Executive and Regional Directors, and is the senior executive level body for decision making and scrutiny in respect of service quality and in addition, reports into the Berkshire West ICS Quality Committee. The structure diagram in B.2.1. shows the groups that are accountable to the Quality Executive, which include:
- Locality Patient Safety and Quality Groups which are chaired by our Clinical Directors and are responsible for identification and monitoring of key risks and associated action plans concerning patient experience, quality and safety across all service areas within and hosted by the locality.
- Safety, Experience and Clinical Effectiveness Group which is responsible for development and monitoring work of specified subcommittees, supporting the development of the Annual Quality Account, receiving standard reports for example serious incidents requiring investigation and undertaking work delegated by the Quality Executive.

The Finance, Performance and Risk Executive Meeting oversees performance against key quality priorities including falls, pressure ulcers, reduction of prone restraint and assaults to staff. This is supported by our Quality Improvement methodology which has enabled detailed root cause analysis and development and implementation of targeted countermeasures. This Executive meeting also receives safe staffing reports along with performance monitoring across all the Trusts “true north” priorities of: Harm Free Care, Supporting our Staff, Good Patient Experience and Money Matters.

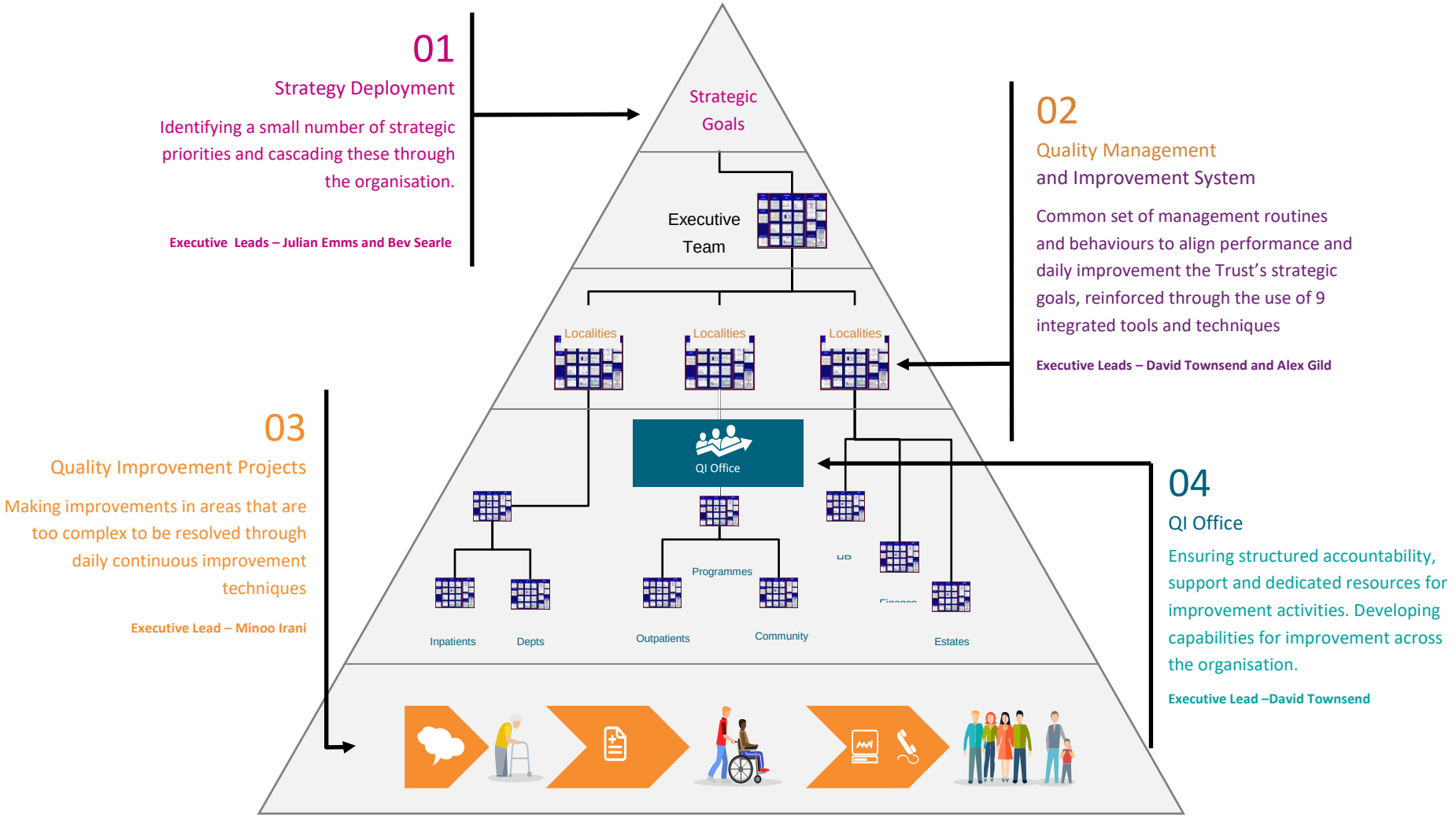
The Business and Strategy Executive oversees progress of major projects - and uses a strategic prioritisation approach developed as part of the Quality Improvement Programme. This enables an overview of all major projects in one place, and consideration of their resource impact on patient facing and corporate services.

Quality Impact Assessments are carried out for major projects – including our cost improvement plans. These are signed off by the Trust’s Director of Nursing and Governance and Medical Director and reported through to the relevant Executive meeting.

Implementation of the Quality Strategy (summarised in B.2.3) is supported by our Quality Improvement Programme, which is outlined in B.2.4 and includes setting of True North patient safety metrics which are outlined in B.2.5.

B.2.3 Summary of the quality strategy

B.2.4 Quality Improvement Programme Overview



B.2.5 Berkshire Healthcare True North Patient Safety Metrics

Metric	Threshold/baseline	Reduction target for 2019/20	comments
1. Self-harm	87/ month	30%	baseline unchanged from 2018/19
2. Suicides	no current threshold	10% reduction by 2021	Unchanged from 2018/19
3. Falls	8/1000 bed days	50%	baseline unchanged from 2018/19
4. Medication errors (moderate and above categories)	less than 5 per 12 months	20%	new
5. Pressure ulcers acquired due to lapse in care (Community Nursing East & West; Community Inpatient wards)	180 days without category 3 and 4 pressure ulcers— reported individually by Community IP wards and Community Nursing East & West	10%	new
6. Gram negative bacteraemia (due to lapse in care)— Inpatient Community wards	Less than 2 GNB per 12 months	50%	new

C STRATEGIC PRIORITY RISK REGISTER

Risk Ref. No.	ICS Strategic Priority	Risk description, source and owner	Inherent risk score			Required controls and actions to reduce/mitigate risk (with dates)	Review Dates: (monthly, quarterly)	Monitor/ Review body	Residual Risk Score and Rating			Is risk/ rating accept-able
			L	I	IRR				L	I	RRR	Yes/No
01	SP1	**Financial Recovery Plan 19/20** - there is a risk that unless the work required to identify opportunities for future years is completed more quickly the ability to produce a robust plan which delivers financial balance will be missed.	5	5	25	System to enter formal financial turnaround. System Financial Recovery Group initiated. Scope for external support and challenge at RBFT being drafted.	Monthly	ICS Unified Executive	4	5	20	No
02	All	**Workforce** – The largest risk to delivery and sustainability of the Berkshire West health economy is access to new workforce, both of established and new clinical roles. This risk extends to both recruitment and retention and will significantly impact the ability to deliver transformation of, and ongoing high quality services.	4	5	20	Time to Care programme Wessex workforce planning tool HEE integrated community nursing project Organisation and system level incentive schemes	Monthly	ICS Workforce Group and ICS Unified Executive	3	4	12	Yes
03	SP2	**Design our Neighbourhoods** – there is a risk that elements of this work (such as the agreement of the new DES) have short delivery timescales which are both challenging to meet and may impact on what can be achieved in year one.	2	4	8	Priority workstream for CCG Primary Care Team. Monitoring, support and oversight provided by system wide Programme Board.	Monthly	ICS Unified Executive	1	3	3	Yes
04	SP3	**Development of a new UEC delivery model** – there is a risk that the implementation of any significant changes to the delivery of UEC services will either require unavailable investment or are slow to realise due to their complexity.	3	4	12	Further mitigating actions are required for this work, including the production of a new local strategy, programme plan, resource plan and timelines. This risk has not yet been mitigated.	Monthly	ICS Unified Executive	3	4	12	Yes

05	SP4	**Outpatient Transformation** – there is a risk that the piecemeal / service-by-service change model does not release a high enough volume of activity to reduce acute hospital costs. Additional risks exist around the data and information available to track the impact of the change(s).	3	4	12	Outpatients Programme Board is continuing to work on an improved suite of programme reports, including more granular level of data and information. ICS Unified Exec will take a deepdive in April 2019 to understand outstanding issues and provide further support.	Monthly	ICS Unified Executive	2	3	6	Yes
06	SP5	**iMSK** – there is a risk that the amount of investment required to establish the new clinical pathway is unaffordable. An additional risk exists to the achievability of the cost out requirements within the acute sector.	4	4	16	Project teams are working with CFOs from all three organisations to refine the financial modeling and better understand delivery risks. Timeline for production of business case has been agreed, culminating in a final decision expected at the May meeting of the ICS Unified Executive.	Monthly	ICS Unified Executive	3	3	9	Yes
07	SP6	**Develop a strategy for the future provision of diagnostics** – there is a risk that there is a constrained level of both capital and revenue to achieve the full ambition of this work. There is also constrained transformation capacity to scope and manage this work and external support may be required which may not be affordable given the system financial position.	3	3	9	Further mitigating actions are required for this work, including the production of a new local strategy, programme plan, resource plan and timelines. This risk has not yet been mitigated.			3	3	9	Yes
	SP7	**Implement and embed our approach to PHM & Digital** – there is a risk that the level of cultural and resource change required to achieve this goal is so significant that realisable delivery is only possible in future years.	3	3	9	The Population Health and Digital Development Board are continuing to manage this risk which will be further addressed through the production of the system wide Digital Strategy.			2	2	4	Yes