Public Document Pack

Notice of Meeting

Scan here to access the public documents for this meeting

Health and Adult Social Care Scrutiny Committee

Thursday 12 June 2025 at 10.00 am

in Roger Croft Room, Council Offices, Market Street, Newbury

You can view all streamed Council meetings here:
https://www.westberks.gov.uk/councilmeetingslive

Date of despatch of Agenda: 3 June 2025

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Vicky Phoenix (Principal Policy Officer - Health Scrutiny) on 07500 679060
e-mail: vicky.phoenix1@westberks.gov.uk

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

West Berkshire COUNCIL

To: Councillors Martha Vickers (Chairman), David Marsh (Vice-Chairman), Dennis Benneyworth, Nick Carter, Martin Colston, Owen Jeffery, Paul Kander, Stephanie Steevenson and Joanne Stewart

Substitutes: Councillors Adrian Abbs, Dominic Boeck, Billy Drummond, Janine Lewis, Ross Mackinnon, Alan Macro, Biyi Oloko, Clive Taylor and Carolyne Culver

Agenda

Part I

Sarah Clarke.

Sarah Clarke
Interim Executive Director - Resources

If you require this information in a different format or translation, please contact Gordon Oliver on telephone (01635) 519486.

This page is intentionally left blank

Health Scrutiny Committee – 12 June 2025

Item 1 – Apologies

Verbal Item

This page is intentionally left blank

DRAFT

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

HEALTH SCRUTINY COMMITTEE

MINUTES OF THE MEETING HELD ON TUESDAY 11 MARCH 2025

Councillors Present: Martha Vickers (Chairman), Jane Langford (Vice-Chairman), Nick Carter, Owen Jeffery, Stephanie Steevenson and Heather Codling

Also Present: Paul Coe (Executive Director – Adult Social Care), Dr Matt Pearce (Director of Public Health for Reading and West Berkshire), Steven Bow (Consultant in Public Health), Councillor Heather Codling, Jo England (Joint Interim Service Director - Adult Social Care), Vicky Phoenix (Principal Policy Officer - Scrutiny), Gordon Oliver (Principal Policy Officer), Fiona Worby (Healthwatch West Berkshire), Hugh O'Keefe (Head of Pharmacy, Optometry and Dentistry, BOB ICB), Nilesh Patel (Thames Valley Local Dental Network), Kirsten Willis (South Central Ambulance Service) and Caroline Morris (South Central Ambulance Service NHS Foundation Trust)

Apologies for inability to attend the meeting: Helen Clark (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board)

PART I

1 Minutes

The Minutes of the meeting held on 10 December 2024 were approved as a true and correct record and signed by the Chairman.

2 Actions from the previous Minutes

Members reviewed the updates on actions from the previous meetings:

- **34** – it was noted that the All Age Continuing Care Draft Dispute Policy had been with local authorities to comment. The final version would be progressed for approval with implementation by 1st April 2025. Paul Coe, Executive Director Adult Social Care and Public Health, confirmed that it was close to being signed off and would follow up with the BOB ICB.

3 Declarations of Interest

There were no declarations of interest received.

4 Petitions

There were no petitions received at the meeting.

5 Oral Health and Dentistry

Steven Bow (Consultant in Public Health, West Berkshire Council) gave an overview of the report on Oral Public Health. Steven Bow highlighted the role of local authorities in oral health, noting oral health surveys and prevention. Data on local population oral health was shared and it was highlighted that one in six children in West Berkshire had tooth decay. A number of initiatives including brushing for life in early years, as well as work in family hubs and in schools had been implemented. A national review of the oral health of people living in residential and nursing care homes found that untreated tooth

decay was higher among older people than the general adult population. It was advised that the next steps for public health included a local oral health survey focused on adults over 65 living in a care setting. Once completed the Public Health Consultant would work with the BOB ICB to provide support on an approach to build preventative care into treatment pathways.

It was advised that future work on oral health in West Berkshire could include an oral health needs assessment, a review of evidence and guidance and to develop partnership working.

During the debate the following points were discussed:

- There was a general downward trend for tooth decay among five-year-olds in West Berkshire. Fluctuations in the graph (Figure 1 in the Oral Public Health report) may have been explained by the smaller numbers locally being compared to larger national figures. It was noted that there was a slight increase in the graph between 2018 and 2022.
- It was noted that the number of tooth extractions in five- to nine-year-olds in West Berkshire were worse than the national average. It was asked if supervised brushing schemes in early years had helped. It was advised that there were limitations with up-to-date data.

Action: Steven Bow to provide up to date data on tooth decay and tooth extractions in children when available.

- The results of the national oral health survey in older people in residential and nursing care homes was noted and it was asked how this was being addressed in West Berkshire. Matt Pearce, Director of Public Health, advised the Committee that the local oral health survey planned would help to identify issues. Hugh O'Keeffe, Head of Pharmacy, Optometry and Dentistry BOB ICB, advised that there was a pilot underway in Oxfordshire with care homes that they would review the outcome of. It was a very complicated area that was a multiagency issue. There was a community dental service available, but it had limited capacity.
- It was noted that the data in the report was not up to date and made it more difficult for Public Health to respond to. A Public Health Analyst had been recruited recently and would work more closely with the BOB ICB to get data that would assist in informing a direction of travel in a timelier manner. Matt Pearce advised that the oral health survey sample size could be increased, however there were resource implications to this. It could be a recommendation of the Health Scrutiny Committee for Public Health to increase the budget to look at more granular detail for example an urban / rural comparison.
- It was noted that the national oral health survey found a number of factors affected the oral health of people living in residential and nursing care homes in England. It was highlighted that care home managers found it more difficult to access dental care for their residents than older adults living in their own home and that care plans were challenging to implement particularly for people who needed more support. Hugh O'Keefe agreed and noted that a pilot in Oxfordshire had also found this. There were sometimes mental health capacity concerns and a lack of priority given to seeking treatment. The BOB ICB wanted to raise the profile of oral health more generally in these environments.
- It was highlighted that levels of access to dental services in West Berkshire for both children and adults were significantly lower than England (p20 of the report on Oral public health). It was noted that access may be lower due to a lower level of need however, it could be indicative of difficulties accessing services.

Action: Steven Bow to consider and provide a response to the lower level of access to dental services in West Berkshire compared to England.

- The role of health visitors and family hubs was noted. It was asked how many children were accessing the nine month check and were those who missed appointments followed up with. It was highlighted that those most in need, may be those missing appointments and so it was important to reach the right cohorts. Councillor Heather Codling, Chair of the Health and Wellbeing Board, advised the Committee that new legislation was coming in 2025 along with a review of family hubs and services for 0 – 19-year-olds. Dentistry would be part of that. Steven Bow advised Members that in Quarter 3 of 2024/25 100% of children were offered the nine month check and 92.4% were seen. This was above target for the service.
- It was noted that fluoride varnishing was provided for children and more information on fluoride in water was asked for. It was advised that there was a consultation on this work in the North East of England which included public engagement. Evidence around fluoridation of water improving levels of tooth decay was robust. The outcome of the work in the North East of England was awaited.
- Matt Pearce noted that the Committee had highlighted a number of questions in response to the oral health report. A deep-dive into the data was needed to understand more detail. For example, a comprehensive health needs assessment would assist in this and in understanding what the public views were. This would provide direction in what was needed, including if an oral health strategy was needed to address some of the issues raised. This could include reviewing the use of fluoride varnishing in West Berkshire.
- It was asked how schools could assist particularly for vulnerable children. It was advised by Matt Pearce that the dilemma between personal and state responsibility, such as with childhood obesity, was difficult. A whole system approach was needed to reduce access to and advertising of sugary food and drinks, and to support parents in raising children. Matt Pearce advised the Committee that this not only included health visiting teams, but also other agencies engaged in supporting parents such as Home Start. The Director of Public Health report this year was focussed on the best start in life. It was noted that were was a great deal of help for parents, but it could be confusing to access.
- Concern was raised that there were pockets of deprivation in West Berkshire.
- The Chairman summarised some of the key discussions during the debate. Noting that targeted work was essential to reach those most in need. Information was needed that was up to date and detailed enough to identify groups for targeted work.

Hugh O'Keefe (Head of Pharmacy, Optometry and Dentistry BOB ICB) introduced Nilesh Patel (a Dentist and Chair of the BOB Local Dental Network). Hugh O'Keefe gave an overview of the report on NHS Dental Services in Buckinghamshire, Oxfordshire and Berkshire West. He advised that dental access was improving but still below pre-Covid levels. It was particularly challenging to support certain groups who weren't accessing services. Capacity was expanding but since 2021, 19 practices had left the NHS and 11 practices had reduced capacity. Overall, 6% of capacity had been lost. It was noted however that there had been recovery in recent years with an increase in 5000 Units of Dental Activity (UDAs) in West Berkshire. Areas of the report highlighted included changes to the NHS contract, the flexible commissioning team to target vulnerable patient groups and plans for new contracts in 2026 particularly for children's dental services. Substantial changes were expected to be made or a new contract formed.

During the debate the following points were discussed:

- The role of community dental nurses was discussed and it was asked whether they supported people with special needs. It was confirmed that community dental nurses were provided by Berkshire Healthcare NHS Foundation Trust (BHFT) and a clinic was held at West Berkshire Community Hospital. They were mainly provided for children but could also support those with anxiety or learning disabilities. There was criteria to meet for accessing the service.
- It was confirmed that levels of dental activity were lower in West Berkshire but it was recovering well. It was noted that when practices joined the Flexible Commissioning Scheme, the target UDAs were reduced and so some activity may be replaced by sessions for these targeted groups. In addition to this commissioning had increased.
- It was confirmed that people who used private dental practices were not included in the data provided. This was NHS data. It was noted that the Public Health report advised that 20% of people did not go to the dentist regularly and only attended when they had issues. There was a strong socio-economic link to this. It was also confirmed that people were not registered with a dental practice.
- It was advised that the Chairman and Councillor Steevenson attended the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Scrutiny Committee (BOB JHOSC) in November 2024. They asked if more funding was available for West Berkshire to help those not accessing dental services. Hugh O'Keefe advised that NHS provisions were highest in the most deprived areas and to a certain extent dental services were market driven.
- The Flexible Commissioning Scheme was an opt-in service for dentists to provide a flexible approach and to help keep them in the NHS.
- It was highlighted that the challenge for recovery since Covid was the increased treatment needs following a time when many people did not access dental services. There was increased need for urgent appointments and so the BOB ICB were addressing both patient needs and dental contracts.
- Hugh O'Keefe highlighted challenges around workforce. Some areas were harder to recruit for especially the further away an area was from London.
- It was confirmed that the BOB ICB worked with Public Health. For example, before the pandemic there was a national programme about starting well for children to attend a dental appointment before the age of one. This was to get families into the practice of regular attendance and was focused on deprived areas. They were now looking at a similar scheme again. It was advised by Matt Pearce that the partnership working could be better. There was no local oral health improvement board in West Berkshire but one was being set up in Reading. An opportunity to bring people together would be beneficial.
- It was advised that there was a concern about people being pushed to use private dentists. Dentists had concerns about the contract and there was action nationally around that over the last few years. The current contract was due for review. Some dentists were leaving the NHS and there were workforce challenges. Younger dentists were going straight into private practice and this all impacted on patients. Not all NHS practices would see all categories of patients. Hugh O'Keefe noted that there were 189 practices, of which were 75 accepting new NHS patients and 60 were not accepting new patients. This was tracked quarterly by the BOB ICB. Some practices may also be doing flexible commissioning.
- Nilesh Patel advised the Committee that he was a dentist who was seeing NHS patients. He advised that the fees provided did not cover the costs and he gave examples. The practice needed to not only cover appointment costs but also

infrastructure and staff costs. It was very difficult and despite this, some still provided NHS care. A yearly uplift in funding was needed that covered the increases in the cost of living. Last year the increase was 1.6% which made it progressively harder to keep the door open to NHS patients. It was almost impossible to run a dental practice entirely open to NHS patients. In addition, new National Insurance changes added pressure.

- Members requested this return in six months for a review.

Action: Vicky Phoenix to add this to the work programme for a six month review.

RESOLVED to note the report.

6 South Central Ambulance Service

Kirsten Willis-Drewett (Assistant Director of Operation) and Caroline Morris (Transformation Programme Director) presented the report from the South Central Ambulance Service NHS Foundation Trust (SCAS).

During the presentation the following points were highlighted:

- SCAS remained in the NHS Recovery Support Programme following the 2022 Care Quality Commission (CQC) rating of inadequate. However, significant improvements had been made across the organisation and they were focussed on longer term strategic and cultural change.
- In terms of patient safety and experience, significant improvements had been made to safeguarding, training in the approach to the Mental Capacity Act and in learning from patient safety incidents.
- An overview of operational performance was shared. This included reduced handover times at hospitals leading to faster call response times. This was in response to their Release to Respond initiative to reduce handover delays and had resulted in SCAS being the fastest responding ambulance service in the country in January 2025. There had also been improvements in ensuring patients got the right care as quickly as possible. It was highlighted that SCAS were responding to Category 2 and Category 3 calls better than the England average. Category 1 calls were not meeting target and so would be an area of focus for SCAS.
- It was advised that SCAS also provided the 111 call service. The demand for that had increased significantly. 111 used various pathways to direct patients to. The target was for less than 10% to be directed to 999 services.
- It was highlighted that SCAS had a strong working relationship with Royal Berkshire NHS Foundation Trust.

The following points were raised in the debate:

- It was noted how successful the Release to Respond initiative had been for ambulance response times and in reducing the queues of ambulances at hospitals across the SCAS operating area. It was noted that at peak times there were 25 ambulances operating in Berkshire West and about 15 during the night. If there were long queues at hospitals it was not viable for the ambulance service.
- Members noted there had been immense improvements since the CQC inspection and that the work undertaken was impressive. In particular, the work around culture and wellbeing was highlighted. It was confirmed that there was good evidence that an engaged workforce improved performance. SCAS had used evidence-based ways of making improvements.

- It was noted that there was a particular challenge around resourcing vehicles. There was a national procurement process, and the government mandate was for only two types of vehicles. They had to replace vehicles every five years and with only two products it was a challenge to get vehicles. A third provider would be beneficial, and it was a long process to acquire new vehicles. In addition, there were only two workshops in the SCAS area and so they were looking for a third workshop. Ambulances needed servicing every six weeks. Particularly during winter, there were fleet challenges.
- It was confirmed that the non-emergency patient transport service would no longer be provided by SCAS. A new provider had been commissioned by the BOB ICB starting from 1 April[t] 2025. The new provider was EMBED and they were the largest provider of non-emergency patient transport services in the UK. SCAS were working to ensure a smooth transition to the new provider.
- It was advised that the South East Ambulance transformation would involve the creation of a group model across six ICBs. SCAS currently covered four ICBs and was fairly small compared to other NHS organisations. This model worked along county boundaries and was built on current infrastructure, local accountability and local relationships. The South East Ambulance transformation would benefit from similar geographies and working together where it made sense to.
- It was advised by SCAS that they would be implementing Quality Improvement (QI) methodology and a continuous improvement approach to the transformation programme. SECamb had a great QI programme which would benefit SCAS as part of the South East Ambulance transformation. They would look at what each other did and compare to get collective improvements and to drive efficiency.
- It was highlighted that 5% of patients would never access digital services and asked how SCAS would ensure individuals were not excluded. It was advised that the use of artificial intelligence to support call handlers would benefit all through streamlining processes. They could also collect demographic data to reduce repetition for patients sharing information. Artificial intelligence could also be used to assist with training of call handlers and in particular the transition between the training environment and taking real calls. By improving the training environment, they were less likely to lose staff during that transition.
- It was noted that the Hampshire and IOW ICB were the lead commissioners of SCAS. It was advised that SCAS also met with the other three ICB's including the BOB ICB as well as working on specific programmes of work with each ICB.
- It was confirmed that SCAS were not in a rush to be reinspected by the CQC because although they had completed an enormous amount of work and made improvements, there was more work to be done. There was a new senior leadership team which needed time to settle. A reinspection would be better after a stable team was in place. However, it was noted that the CQC would visit when they would visit and that it could be at any time. It was advised that they were cautious to promote the improvements through communications at this time until they had the data and evidence to show that.
- It was asked that SCAS return to the Health Scrutiny Committee in 12 months times with an update and include information on their communications.

Action: Vicky Phoenix to add an update to the work programme for March 2026.

RESOLVED to note the report.

7 Social Care Inquests

Jo England (Service Lead – Adult Social Care) presented the Social Care Inquests Annual Report. During the presentation the following points were highlighted:

- There was a monthly inquest review panel looking at requests for information from the Coroner and at incidents that may or may not go to the Coroner.
- This was the second annual report following the initial report shared with the Committee in March 2023. Since that report, there had been a levelling off of requests for information from the Coroner. There had been only three requests in the last year.

RESOLVED to note the report.

8 Healthwatch Update

Fiona Worby (Lead Officer from Healthwatch West Berkshire) advised the Committee that Healthwatch West Berkshire were in the process of creating their work plan for next year. They were closing some projects and writing up their reports. A full report would be provided for the Health Scrutiny Committee in June 2025.

It was advised there was concern raised regarding funding for a women's health hub which they were pursuing. This had been raised with the ICB and with the Health and Wellbeing Board.

RESOLVED to note the report.

9 Task and Finish Group Updates

The Chairman advised Members that the Task Group looking at Children's Mental Health and Emotional Wellbeing had carried out two sessions with partners from health, education, the Council and the voluntary sector. One further session was scheduled for later in March.

A report with recommendations would follow and be presented at a future Health Scrutiny Committee.

10 Health Scrutiny Committee Work Programme

The Chairman invited Members to review the draft work programme for the 2025/26 municipal year. It was noted that Dementia and All Age Continuing Care were on the agenda for the Health Scrutiny Committee in June 2025.

Paul Coe advised Members that the CQC visited West Berkshire Council in February 2024 to look at Adult Social Care. It was agreed a report would be brought to the Health Scrutiny Committee in September or December 2025.

RESOLVED to note the work programme.

(The meeting commenced at 1.30 pm and closed at 3.55 pm)

CHAIRMAN ……

Date of Signature ……

This page is intentionally left blank

DRAFT

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

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

MINUTES OF THE MEETING HELD ON THURSDAY 15 MAY 2025

Councillors Present: Dennis Benneyworth, Martin Colston, Owen Jeffery, Paul Kander, Alan Macro (Substitute for Councillor Stephanie Steevenson), David Marsh, Joanne Stewart and Martha Vickers

Also Present: Sarah Clarke (Monitoring Officer and Interim Executive Director for Resources), Joseph Holmes (Chief Executive), and Darius Zarazel (Principal Democratic Services Officer)

Apologies for inability to attend the meeting: Councillor Nick Carter and Councillor Stephanie Steevenson (Substituted by Councillor Alan Macro)

PART I

1 Election of the Chairman

RESOLVED: That Councillor Martha Vickers be elected as Chairman of the Health and Adult Social Care Scrutiny Committee for the 2025/26 Municipal Year.

2 Election of the Vice-Chairman

RESOLVED: That Councillor David Marsh be elected as Vice-Chairman of the Health and Adult Social Care Scrutiny Committee for the 2025/26 Municipal Year.

(The meeting commenced at 9.40pm and closed at 9.42pm)

CHAIRMAN …….

Date of Signature …….

This page is intentionally left blank

Actions arising from previous HSC Meetings HSC is requested to consider the following list of actions and note the updates provided.				
Ref No:	**Date**	**Item/Action**	**Member/Officer**	**Comments/Update**
32	10/12/2024	**Eastfield House Proposed Relocation** The Health Scrutiny Committee be kept updated	Liz Pope - Eastfield House Surgery and Helen Clarke - BOB ICB	**Ongoing** - Planning Permission for the new surgery was granted on 22 January 2025 subject to resolution regarding drainage. The Outline Business Case will be submitted to the BOB ICB. Not yet submitted as of 2 June 2025.
33	11/03/2025	**Oral Public Health** To bring back up to date data tooth decay amongst 5 years olds (2018/19 – 2021/22) and tooth extractions for 5 -9 year olds (2022/23) when available.	Matt Pearce - Director of Public Health	**Ongoing** - to be brought back when available. Not available as of 2 June 2025.
36	11/03/2025	**Oral Public Health** Public Health to consider undertaking an oral health needs assessment to include a deep-dive into the data, to form an understanding of the public's views and to identify groups for targeted work.	Matt Pearce - Director of Public Health	**Ongoing.**
37	11/03/2025	**Oral Public Health** A review of partnership working and consideration of an Oral Health Improvement Board or other improvement suggestions for West Berkshire in relation to partnership working	Matt Pearce - Director of Public Health	**Ongoing.**

Last updated: 02/06/25

This page is intentionally left blank

Health Scrutiny Committee – 12 June 2025

Item 4 – Declarations of Interest

Verbal Item

This page is intentionally left blank

Health Scrutiny Committee – 12 June 2025

Item 5 – Petitions

Verbal Item

This page is intentionally left blank

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Paper to West Berkshire Health Overview and Scrutiny Committee

Date of Meeting: 12th June	**Agenda item:**

Title of Paper: Prevention & Health Inequalities Update for W Berkshire – BOB ICB

Paper is for: (Please ✓)	**Discussion**	x	**Decision**		**Information**	x

Purpose and Executive Summary

These slides provide some detail and an update position of some key Prevention & Health Inequalities activities currently taking place with West Berkshire.

These include Long Term Conditions, Core20Plus5 Framework and activities, Community Wellbeing Programme, Vaccination Programme.

These are to encourage understanding and discussion about improved delivery and outcomes within West Berkshire.

Action required

Members are asked to note and discuss/ raise questions re the services covered.

Author: Steve GoldenSmith, Associate Director of Prevention & Health Inequalities, BOB ICB

Date of Paper: 30th May 2025

This page is intentionally left blank

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Health Inequalities

Prevention & Health Inequalities

Steve GoldenSmith

The NHS can play a role in reducing Health Inequalities in four distinct ways.

1. **Influencing / Supporting / Promoting multi-agency action to address social determinants of health**
   The role of integrated care systems (ICSs) working with local authorities and local communities is particularly critical here. (Housing/ Welfare Benefits / Green Spaces / Employment / Education / Health Services)
2. **The NHS as an Anchor Organisation**
   The functions, processes, investments and the choices we make as a strategic commissioner, employer, partner, purchaser will impact on inequalities.
3. **Tackling the existing inequalities in Healthcare**
   The enduring mission of the NHS is high quality care for all. That means tackling existing disparities in access to services, patient experience and healthcare outcomes.
4. A focus **on Ill Health Prevention and influencing Healthy Lifestyle Behaviours**

Making the case for change: in BOB there is higher prevalence of many conditions particularly CVD, cancer and depression than the national average at sub-place level

Below national | In line with national | Above national

Conditions		Cardiovascular disease						Respiratory diseases		Other			
		AF	CHD	HF	HYP	PAD	S/TIA	Asthma	COPD	Obesity	Cancer	Dementia	Depression
Buckinghamshire	Buckinghamshire	2.44%	2.96%	0.95%	14.82%	0.45%	1.78%	6.51%	1.21%	9.91%	4.12%	0.75%	0.89%
Oxfordshire	Cherwell	2.21%	2.54%	0.96%	13.68%	0.51%	1.85%	6.36%	1.42%	12.72%	4.33%	0.74%	1.05%
	Oxford	1.33%	1.56%	0.63%	9.10%	0.34%	1.20%	4.70%	1.00%	7.31%	2.68%	0.49%	0.95%
	South Oxfordshire	2.66%	2.55%	1.09%	14.83%	0.48%	1.94%	6.85%	1.36%	10.79%	4.82%	0.82%	1.17%
	Vale of White Horse	2.56%	2.67%	1.05%	15.19%	0.49%	2.39%	6.80%	1.53%	12.95%	4.78%	0.81%	1.09%
	West Oxfordshire	2.97%	2.88%	1.30%	17.15%	0.52%	2.07%	7.06%	1.50%	12.79%	5.33%	1.08%	1.15%
Berkshire West	Reading	1.40%	1.78%	0.84%	11.99%	0.29%	1.18%	5.41%	1.08%	10.55%	2.58%	0.54%	1.05%
	West Berkshire	2.40%	2.53%	1.09%	15.34%	0.44%	1.74%	7.19%	1.48%	11.61%	4.22%	0.78%	0.98%
	Wokingham	2.17%	2.27%	0.99%	13.47%	0.30%	1.51%	6.34%	1.02%	8.80%	3.96%	0.78%	0.92%
BOB		2.19%	2.46%	0.85%	13.78%	0.41%	1.68%	6.25%	1.24%	10.36%	3.93%	0.73%	1.50%
Peer average		2.38%	2.86%	1.05%	14.66%	0.50%	1.11%	6.58%	1.58%	11.67%	3.93%	0.80%	1.28%
National		2.18%	2.97%	1.06%	14.79%	0.56%	1.86%	6.53%	1.86%	12.80%	3.64%	0.76%	1.48%

REDUCING HEALTHCARE INEQUALITIES

NHS

The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Target population

CORE20 PLUS 5

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

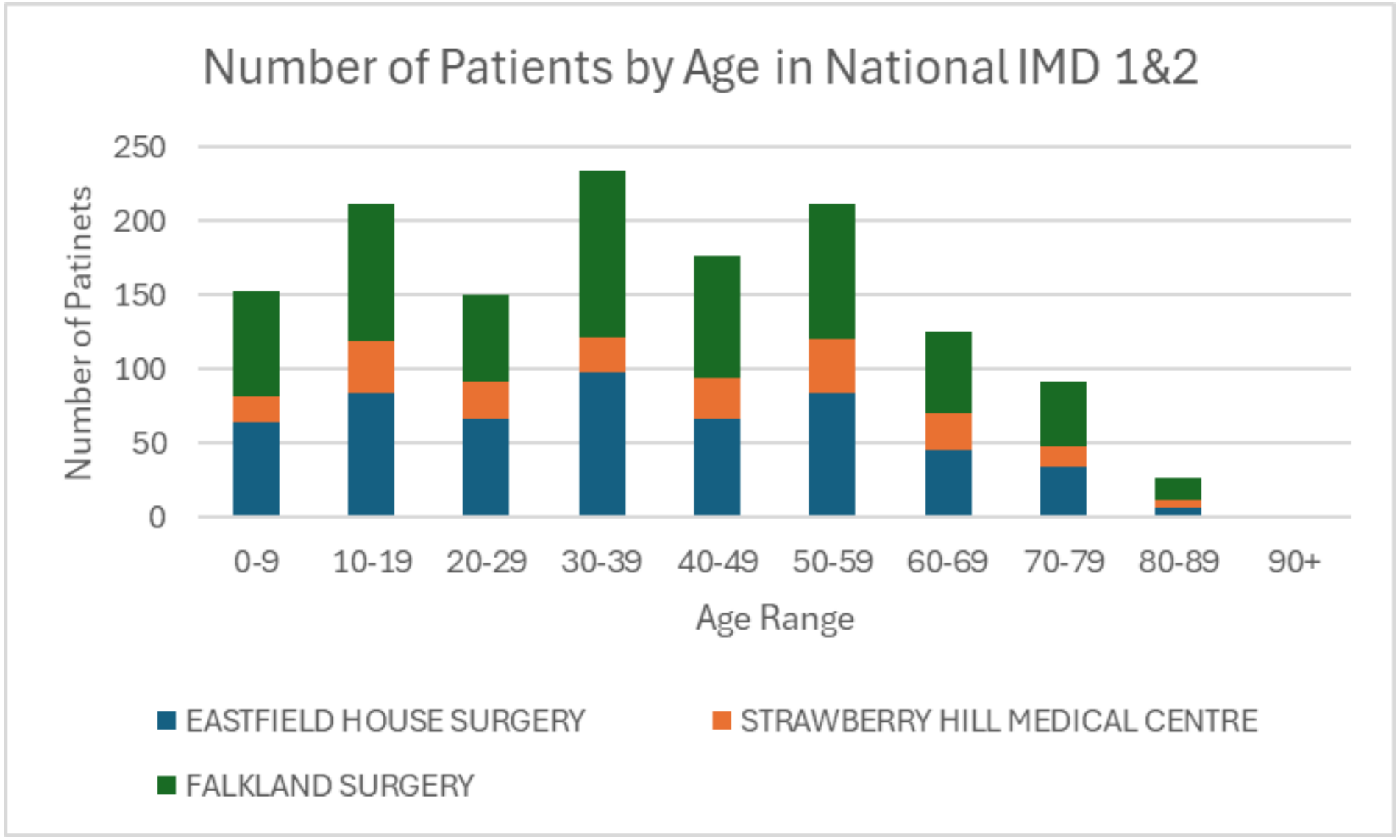
2. **SEVERE MENTAL ILLNESS (SMI)**
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

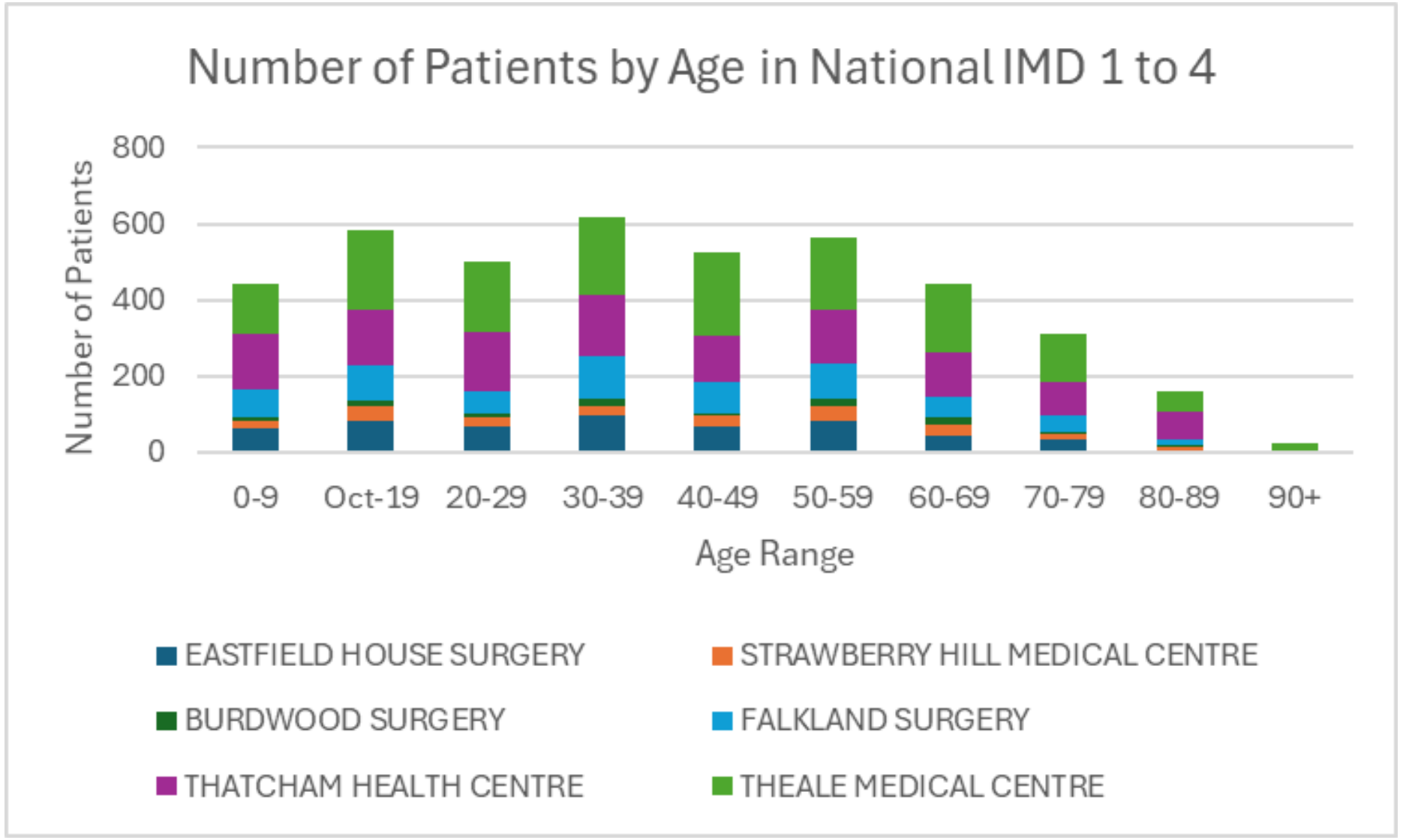
5. **HYPERTENSION CASE-FINDING**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas



Total 1379

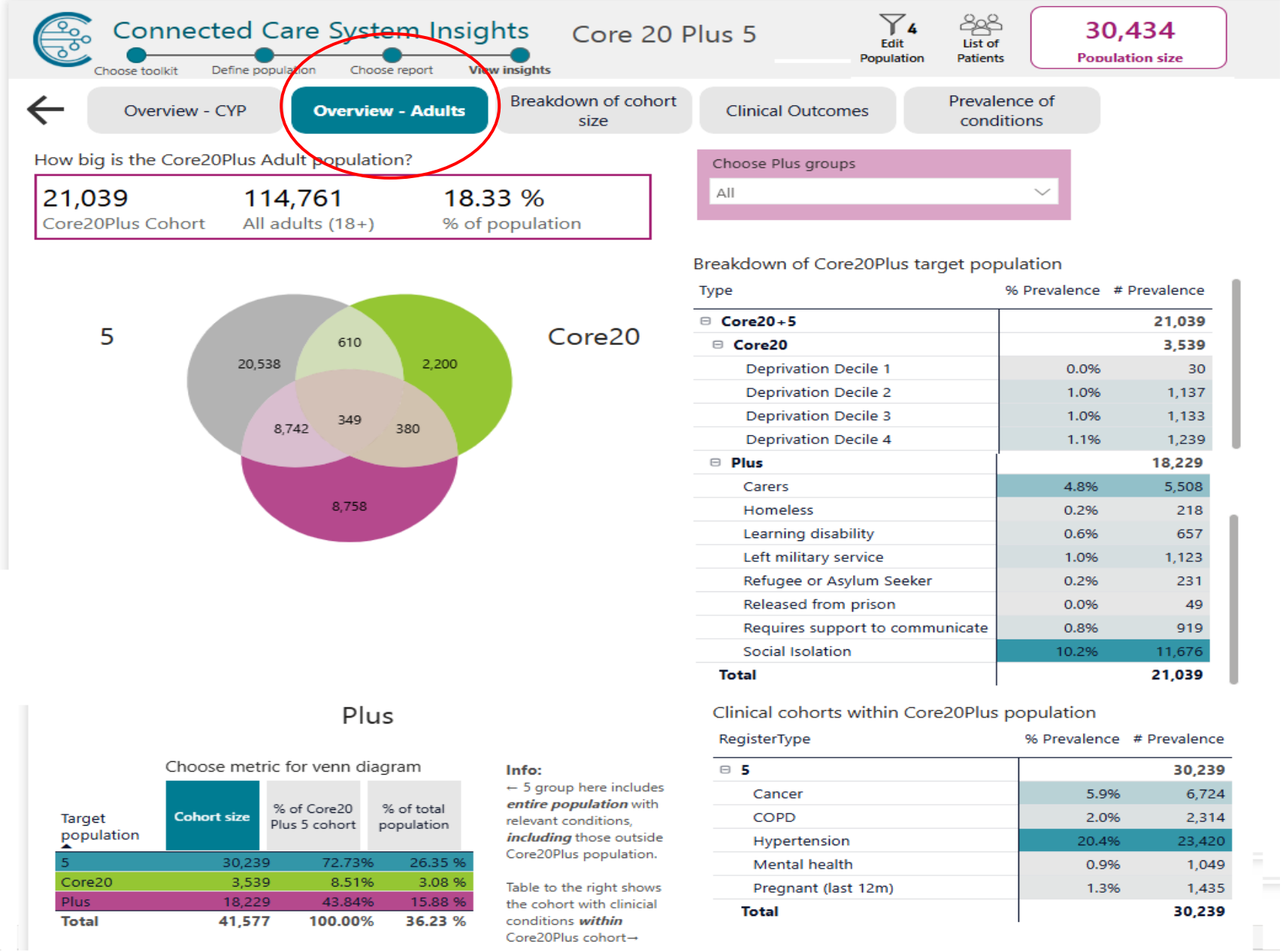
16 non White



Total 4168

234 non White

Over 18s


Connected Care System Insights
Choose toolkit
Define population
Choose report
View insights
Core 20 Plus 5
4
Edit Population
List of Patients
30,434
Population size
Overview - CYP
Overview - Adults
Breakdown of cohort size
Clinical Outcomes
Prevalence of conditions
How big is the Core20Plus Adult population?
21,039
Core20Plus Cohort
114,761
All adults (18+)
18.33 %
% of population
Choose Plus groups
All
5
Core20
20,538
610
2,200
8,742
349
380
8,758
Breakdown of Core20Plus target population
Type
% Prevalence
# Prevalence
Core20+5 21,039
Core20 3,539
Deprivation Decile 1 0.0% 30
Deprivation Decile 2 1.0% 1,137
Deprivation Decile 3 1.0% 1,133
Deprivation Decile 4 1.1% 1,239
Plus 18,229
Carers 4.8% 5,508
Homeless 0.2% 218
Learning disability 0.6% 657
Left military service 1.0% 1,123
Refugee or Asylum Seeker 0.2% 231
Released from prison 0.0% 49
Requires support to communicate 0.8% 919
Social Isolation 10.2% 11,676
Total 21,039
Plus
Choose metric for venn diagram
Target population
Cohort size
% of Core20 Plus 5 cohort
% of total population
5 30,239 72.73% 26.35 %
Core20 3,539 8.51% 3.08 %
Plus 18,229 43.84% 15.88 %
Total 41,577 100.00% 36.23 %
Info:
← 5 group here includes entire population with relevant conditions, including those outside Core20Plus population.
Table to the right shows the cohort with clinicial conditions within Core20Plus cohort→
Clinical cohorts within Core20Plus population
RegisterType
% Prevalence
# Prevalence
5 30,239
Cancer 5.9% 6,724
COPD 2.0% 2,314
Hypertension 20.4% 23,420
Mental health 0.9% 1,049
Pregnant (last 12m) 1.3% 1,435
Total 30,239

REDUCING HEALTHCARE INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE

NHS

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

Target population

CORE20 PLUS 5

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Key clinical areas of health inequalities

1. **ASTHMA**
Address over reliance on reliever medications and decrease the number of asthma attacks

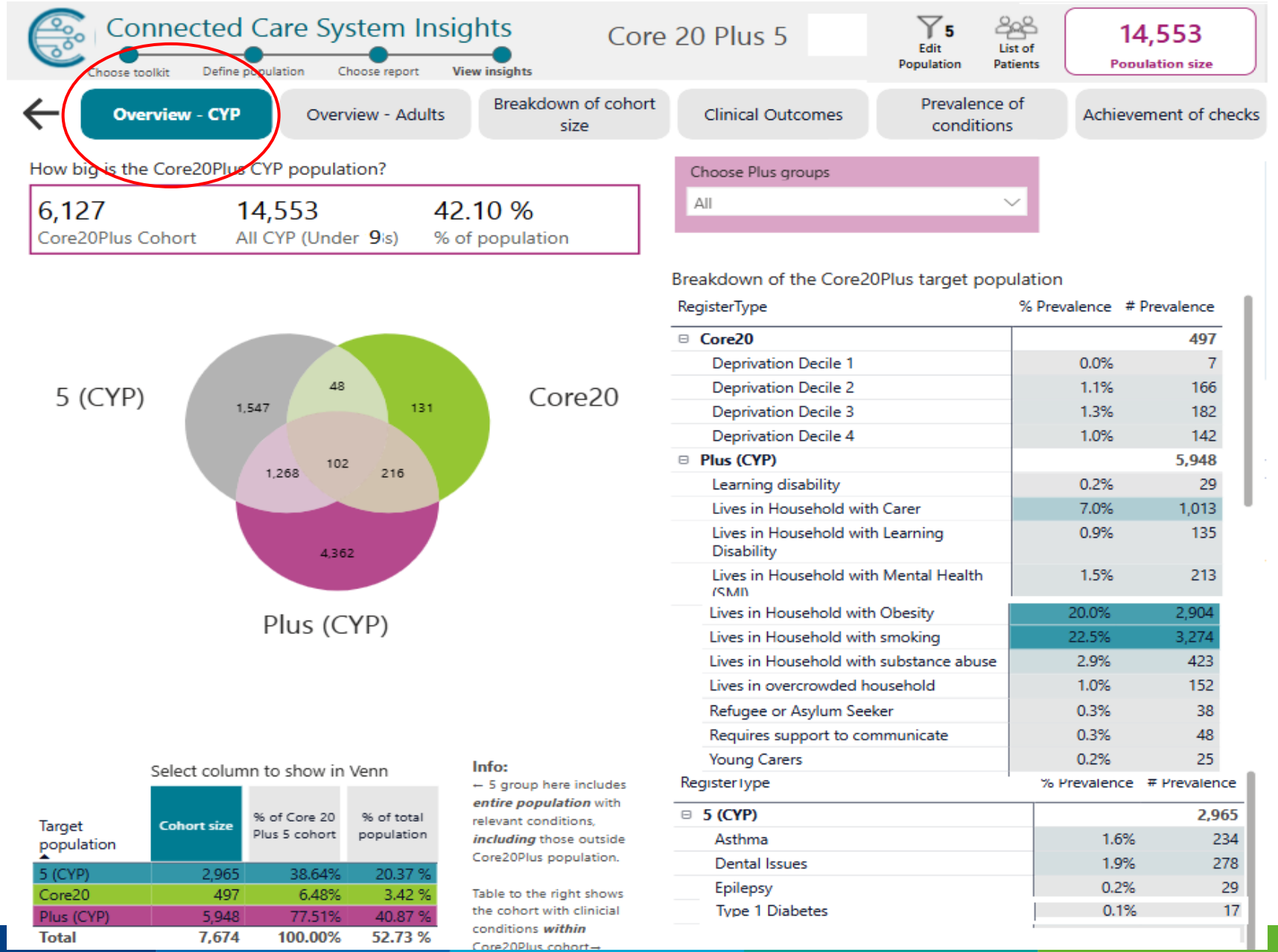
2. **DIABETES**
Increase access to Real-time Continuous Glucose Monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds & increase proportion of children and young people with Type 2 diabetes receiving annual health checks

3. **EPILEPSY**
Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism

4. **ORAL HEALTH**
Address the backlog for tooth extractions in hospital for under 10s

5. **MENTAL HEALTH**
Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

Under 10s


Connected Care System Insights
Choose toolkit
Define population
Choose report
View insights
Core 20 Plus 5
5
Edit Population
List of Patients
14,553
Population size
Overview - CYP
Overview - Adults
Breakdown of cohort size
Clinical Outcomes
Prevalence of conditions
Achievement of checks
How big is the Core20Plus CYP population?
6,127
Core20Plus Cohort
14,553
All CYP (Under 9s)
42.10 %
% of population
Choose Plus groups
All
5 (CYP)
Core20
Plus (CYP)
1,547
48
131
1,268
102
216
4,362
Breakdown of the Core20Plus target population
RegisterType
% Prevalence
# Prevalence
Core20 497
Deprivation Decile 1 0.0% 7
Deprivation Decile 2 1.1% 166
Deprivation Decile 3 1.3% 182
Deprivation Decile 4 1.0% 142
Plus (CYP) 5,948
Learning disability 0.2% 29
Lives in Household with Carer 7.0% 1,013
Lives in Household with Learning Disability 0.9% 135
Lives in Household with Mental Health (SMI) 1.5% 213
Lives in Household with Obesity 20.0% 2,904
Lives in Household with smoking 22.5% 3,274
Lives in Household with substance abuse 2.9% 423
Lives in overcrowded household 1.0% 152
Refugee or Asylum Seeker 0.3% 38
Requires support to communicate 0.3% 48
Young Carers 0.2% 25
RegisterType
% Prevalence
# Prevalence
5 (CYP) 2,965
Asthma 1.6% 234
Dental Issues 1.9% 278
Epilepsy 0.2% 29
Type 1 Diabetes 0.1% 17
Select column to show in Venn
Target population
Cohort size
% of Core 20 Plus 5 cohort
% of total population
5 (CYP) 2,965 38.64% 20.37 %
Core20 497 6.48% 3.42 %
Plus (CYP) 5,948 77.51% 40.87 %
Total 7,674 100.00% 52.73 %
Info:
– 5 group here includes entire population with relevant conditions, including those outside Core20Plus population.
Table to the right shows the cohort with clinicial conditions within Core20Plus cohort→

The inequalities work we have undertaken to date around CYP Long Term Conditions has been across the whole CYP age spectrum and *not specifically been for the under 5 age group*.

There are several initiates in place across the system:

Asthma:

An Asthma Pilot runs in Royal Berkshire Hospitals to improve patient access to an asthma nurse specialist, with the aim of reducing the over reliance on reliever medications and decrease the number of asthma attacks. One of the Key Performance Indicators (KPIs) is to target CYP with asthma living in areas of deprivation with the aim of increasing engagement and improving outcomes. *Asthma is not usually diagnosed before the age of 5, and so this does not specifically target children in their Early Years'.*

Epilepsy:

We are hosting an Epilepsy Nurse Specialist Pilot on behalf of NHSE for the southeast region. This is to provide access to Epilepsy Nurse Specialists to address the variation in care. One of the targets is to improve support to CYP with a Learning Disability or Autism. *This would include children in their early years*.

Diabetes:

We have recently hosted the CYP Diabetes Technology Pilot for the Southeast region, with the aim of improving access to Diabetes technologies, again specifically targeting those CYP in areas of deprivation and from ethnic and minority backgrounds. The Pilot also provided education to health professionals and the Thames Valley and Wessex Diabetes Network have provided Poverty Proofing Training to all three acute providers, including RBH. *This again was all ages of CYP and so includes CYP in their Early Years*.

Dental

Presently, we have 475 children waiting a new patient consultation (approximate waiting time or new patient consultation is 13-14 weeks).

Those who have been assessed and are awaiting extraction under general anaesthetic for children is approx. :

- 160 Royal Berkshire Hospital, a 6-7 month wait,
- 82 Wexham Park Hospital, an 8 month wait

For those with special needs awaiting general anaesthetic

- 105 Royal Berkshire Hospital, a 9-10 month wait.

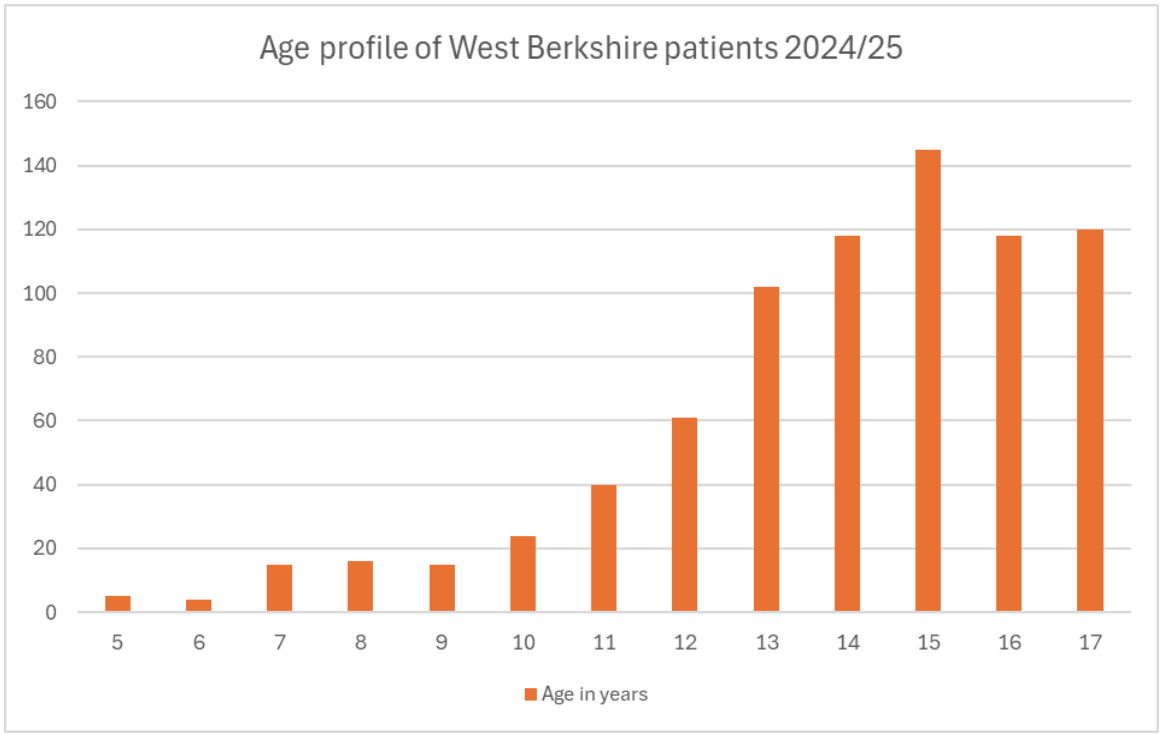
Issues

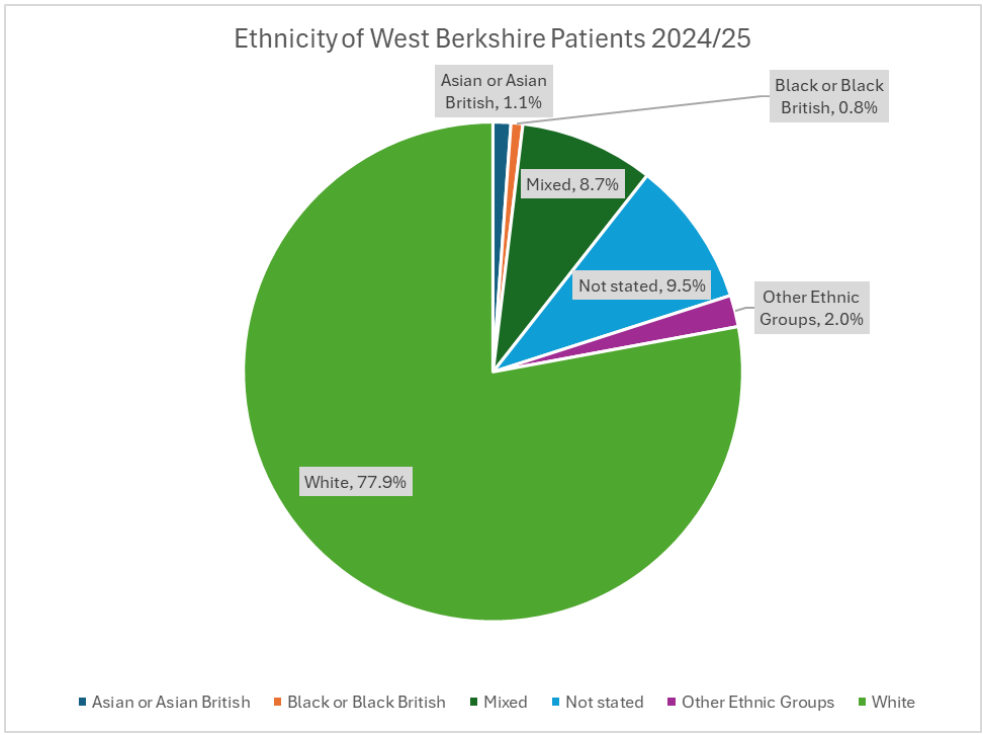
Children are seeming to be increasingly anxious,

More neurodivergence identified (or on a pathway for possible diagnoses),

Potential changes to how anaesthetists prefer to manage the airway in theatre, plus other hospital level challenges, such as increasing demand but no more theatre space/staff.

Children & Young Peoples Mental Health Services





The ethnicity profile is not significantly adrift to the ethnicity profile for West Berkshire. Starting to utilise improved data to understand where unwarranted variation in access /experience /outcomes lie.

Inequality is a golden thread through the Reimagining Community CAMHS transformation programme.

We don't provide specific mental health services for the under 5's. That is reflected in the low numbers of referrals to that age group.

Mental Health

- *Our data tells us that there do not seem to be major inequalities between ethnicity groups for young people once they get into the service, but there is under-representation in some communities being referred in.*

- *Targeted work is being undertaken in these areas, through our MHST & Getting Help level teams, but also some specialist services e.g in adult ED we have identified that in some cultural groups people do not seem to seek help until they are very unwell, with higher levels of acuity and risk. We are working up a QI project with representatives from those communities to seek to understand the reasons for this & work together to address it.*

- *In terms of deprivation, there does seem to be a correlation between the level of deprivation and how likely referrals are to be 'urgent' and how likely patients are to not attend appointments.*

- *Our least deprived patients are more likely to be seen quickly, with a higher proportion seen within 6 weeks.*

Berkshire West Summary

Community Wellbeing Outreach Programme

Community Wellbeing Outreach Programme

What does the programme do?

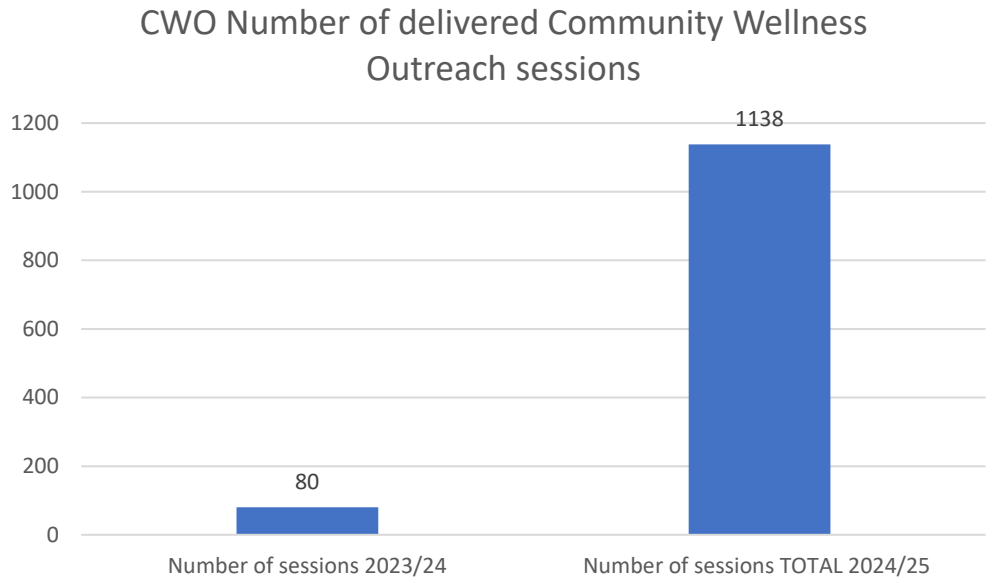
We are delivering enhanced NHS Health Checks to priority population groups within community settings, detecting CVD risk and supporting behavioural change.
By using population health management data, we are targeting communities disproportionately affected by inequalities in access and health outcomes. The project partnership involves local authorities, primary care, the voluntary sector, the ICB and our acute trust.

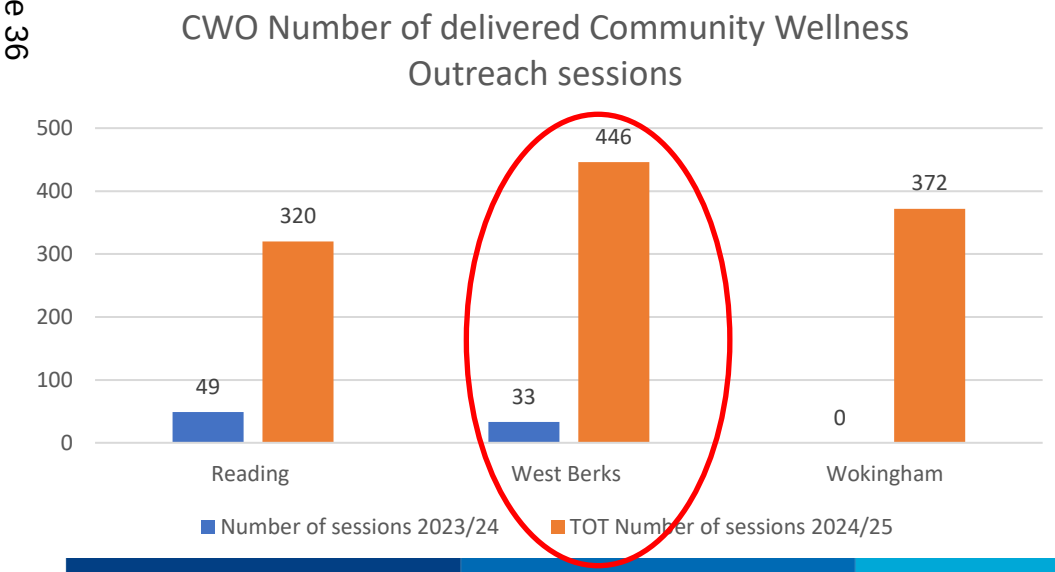
What does the programme provide to residents?

It helps inform residents of their risk of getting certain health conditions, such as heart disease, diabetes, kidney disease, & stroke. If you are over 65, you will also be told about symptoms of dementia to look out for. During the check you will discuss how you can reduce your risk of these conditions.

The health check takes about 30 minutes and includes:

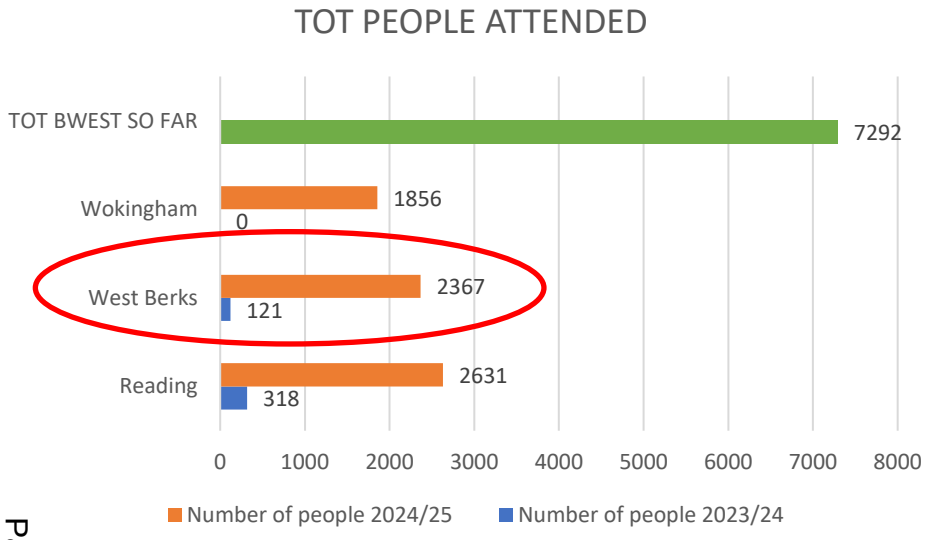
measuring your height and weight
measuring your waist
a blood pressure check
a cholesterol test
a blood sugar test

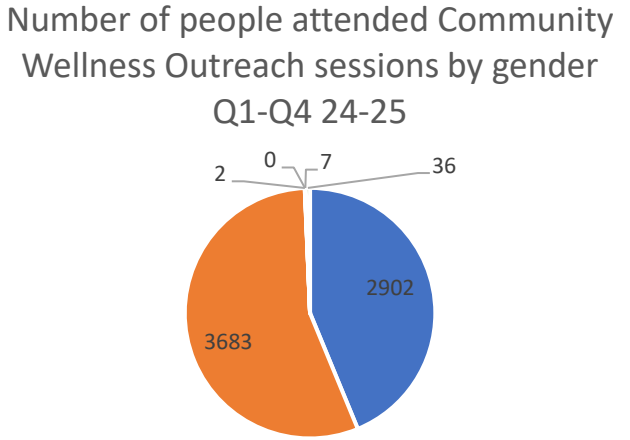




Activity – Sessions delivered

The number of sessions delivered continues to grow



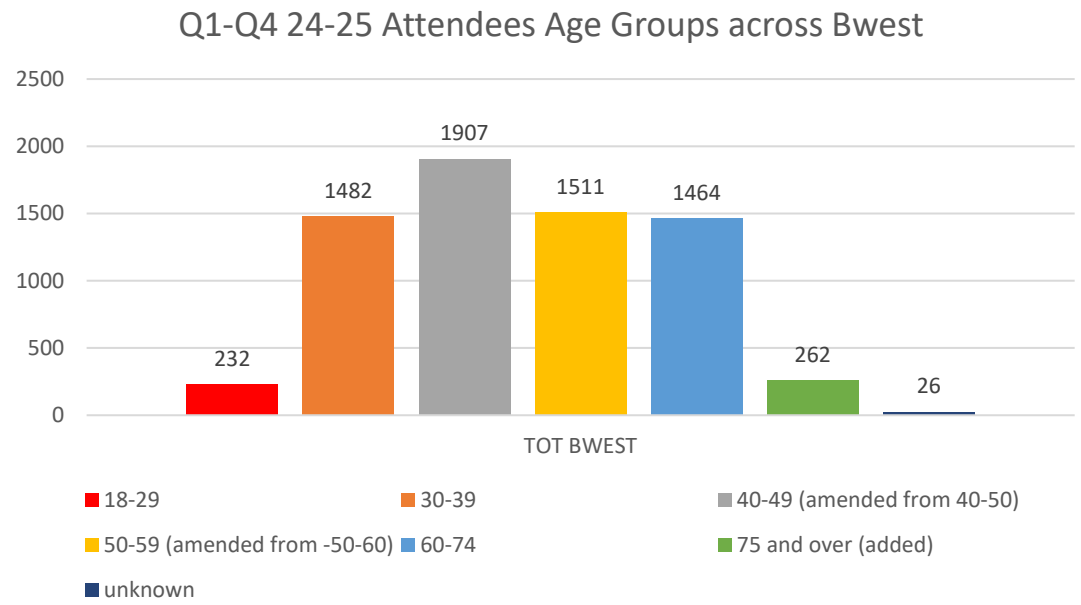


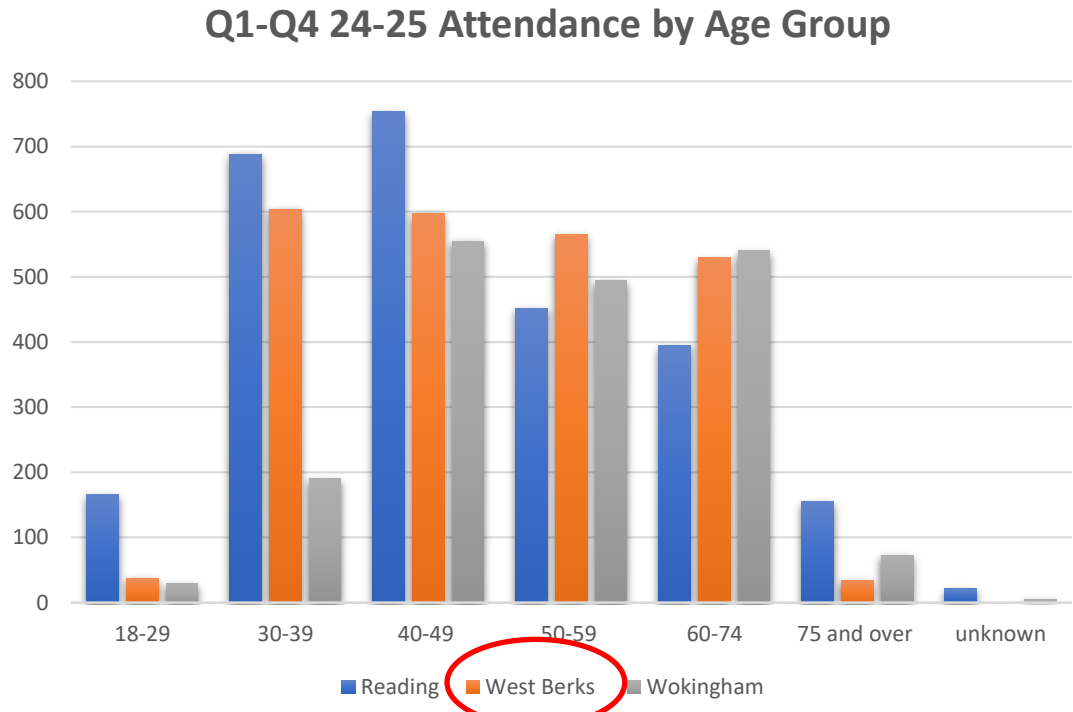
Targeted Activity – Number of people who attended the Community Wellness Outreach sessions

3989 are in the priority cohorts, 71% of Reading's activity, **73% of West Berks activity** and 22% of Wokingham's activity. We know that Wokingham are missing data on invites sent by GP practices and have not been able to count priority cohorts against this.

This split has been consistent throughout the project

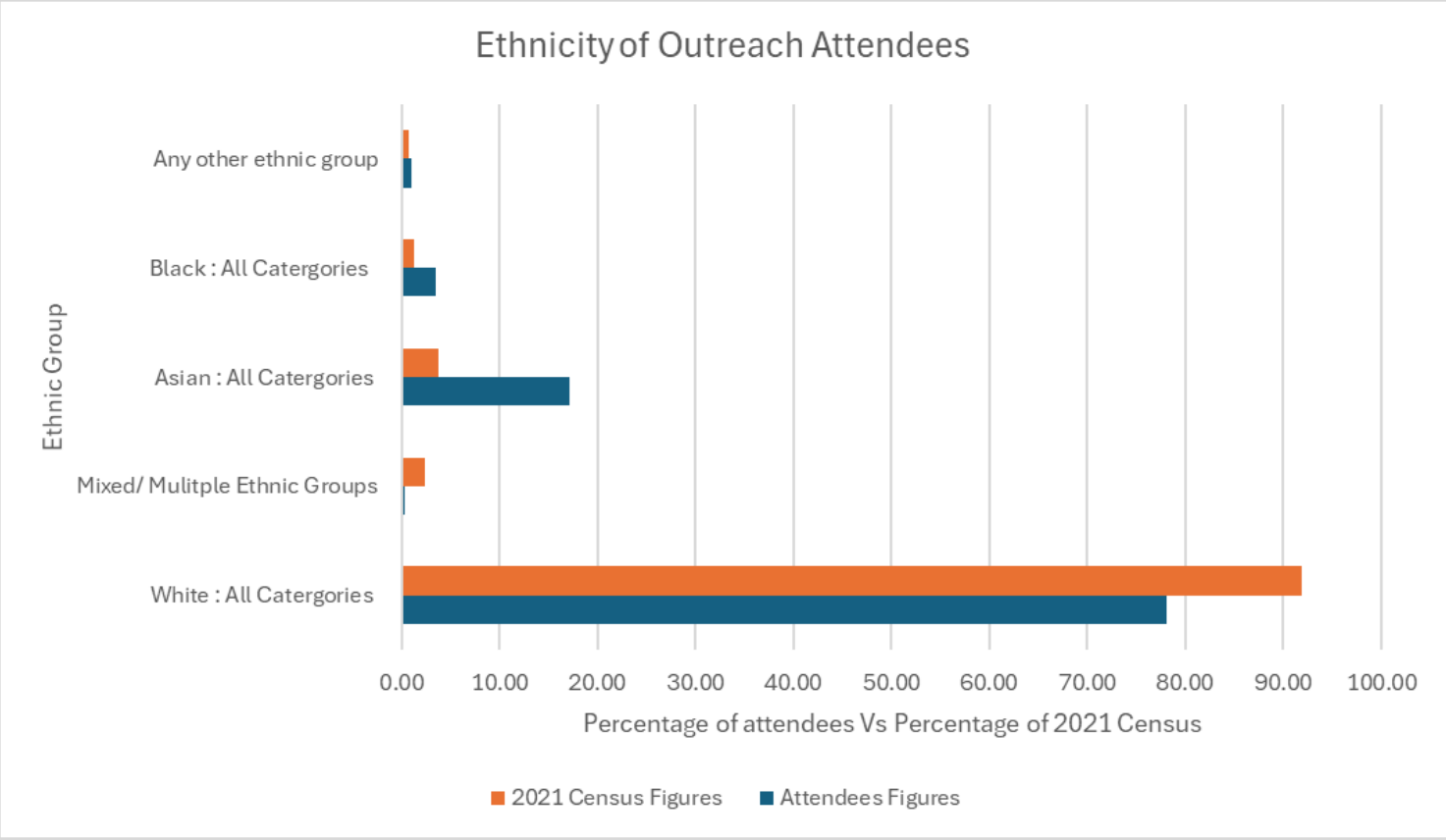
Activity – Number of people who attended the Community Wellness Outreach sessions





In Reading highest attendance is for the 40-59 age groups. We have a high number of people attending for the 30-39 age group in West Berks and Reading. **In West Berks 30-39 is the group with highest attendance.** Wokingham's highest attendance is for the 40-59 followed closely by the 60-74 age group.

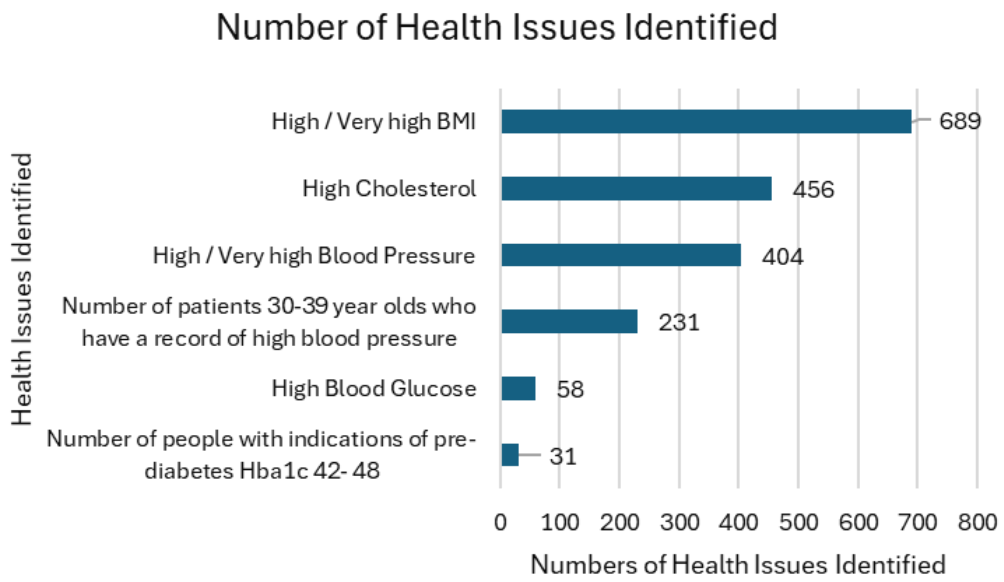
Ethnicity of those attending sessions based on place - West Berkshire

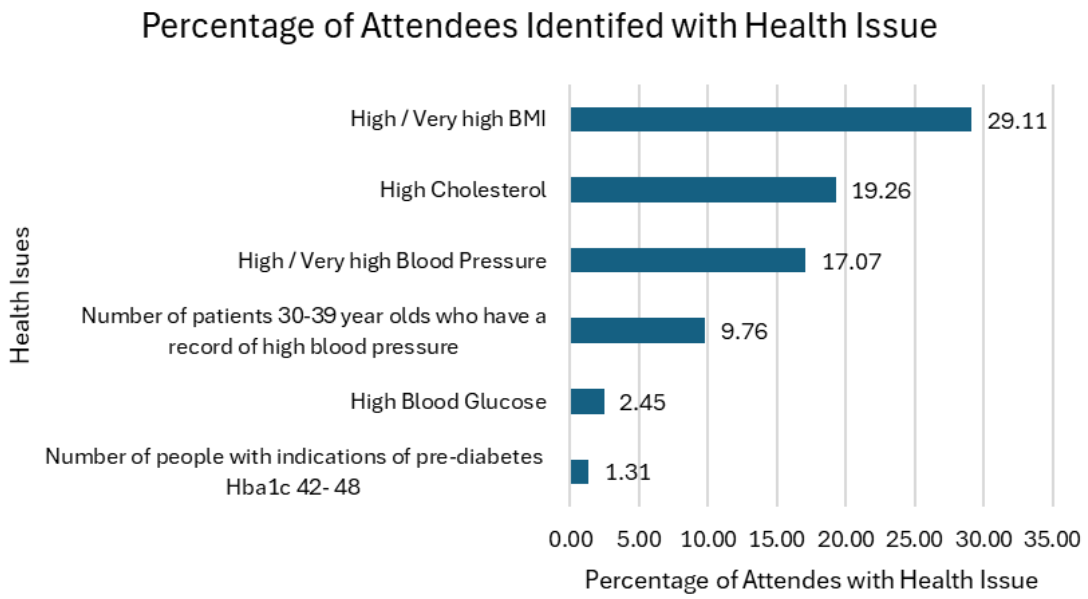


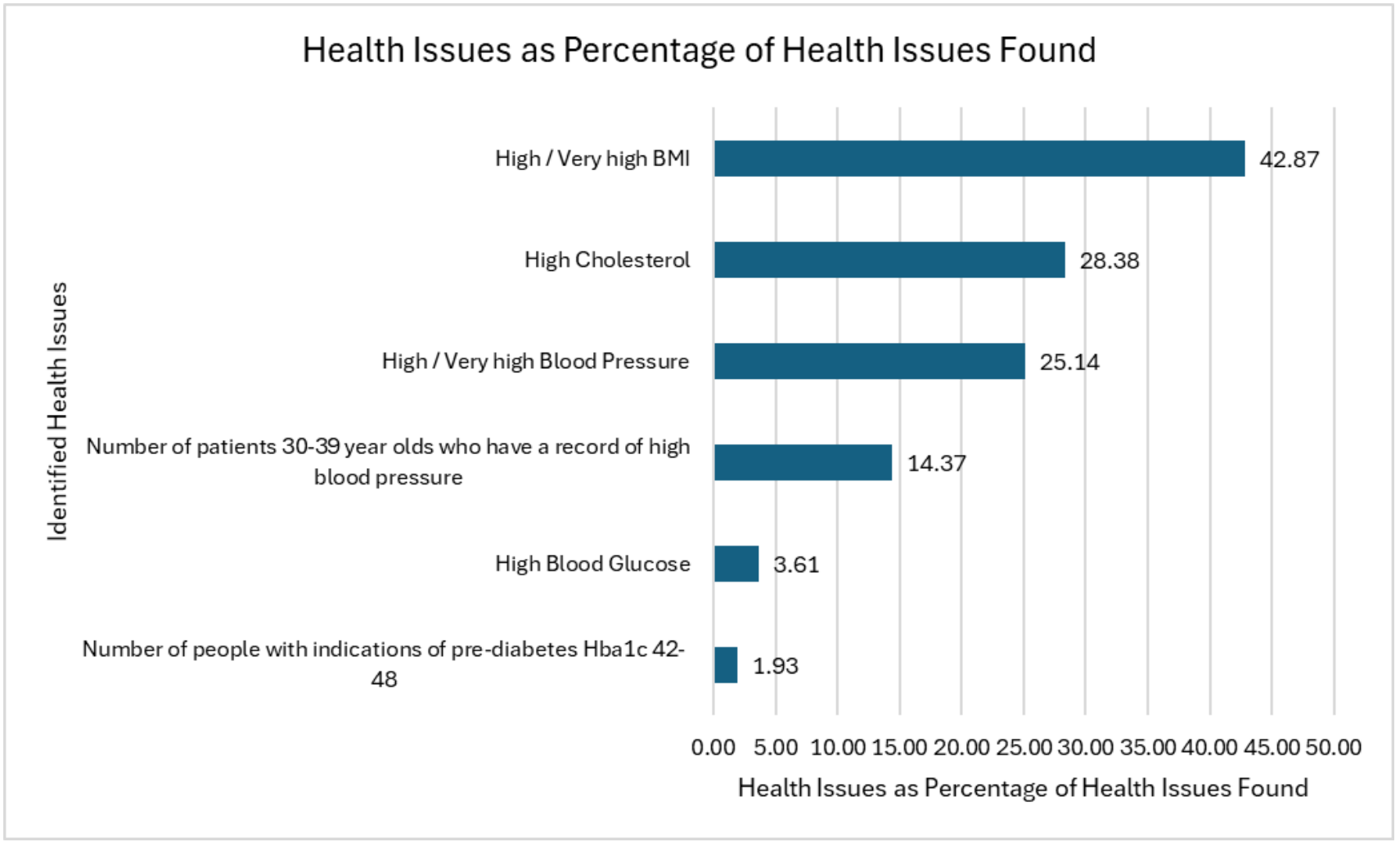
In addition to the standard groups (30-74, IMD 1-4 and haven't accessed general practice in last 12 months), West Berkshire are focussing on minority ethnic groups men in routine and manual occupations, carers, people with disabilities, people with drug or alcohol dependencies and Gypsy Roma and Traveller communities.

There is also a particular focus on residents of wards including IMD 1-3 decile.

West Berks - 2367 Checks	Total Ind April - March 2367	Percentage of Patienst with Issue Issue	Percentage of Issues
2024/25	Totals	a	a
High / Very high BMI	689	29.11	42.87
High Cholesterol	456	19.26	28.38
High / Very high Blood Pressure	404	17.07	25.14
Number of patients 30-39 year olds who have a record of high blood pressure	231	9.76	14.37
High Blood Glucose	58	2.45	3.61
Number of people with indications of pre-diabetes Hba1c 42- 48	31	1.31	1.93

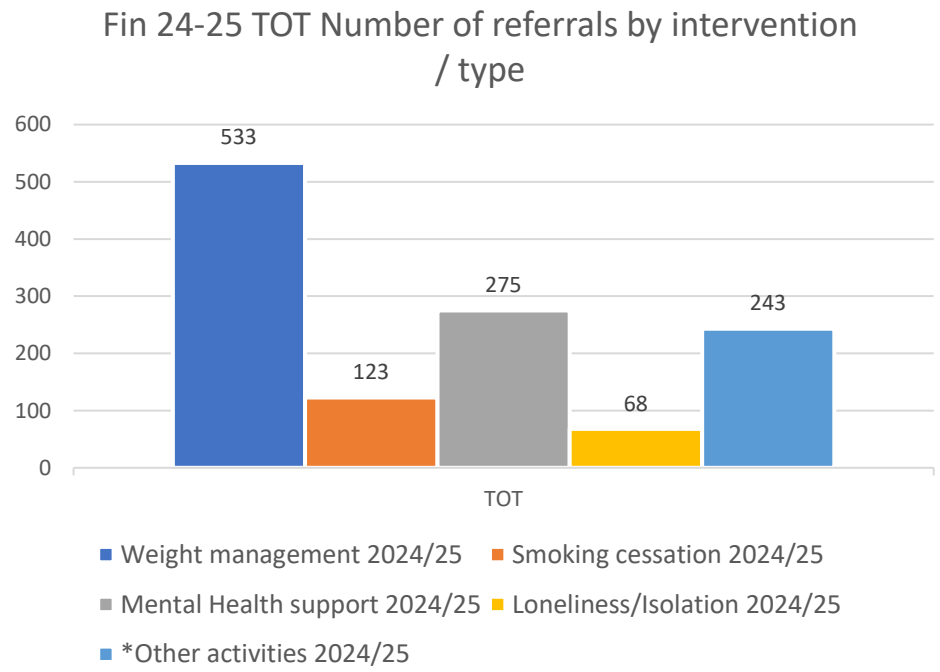


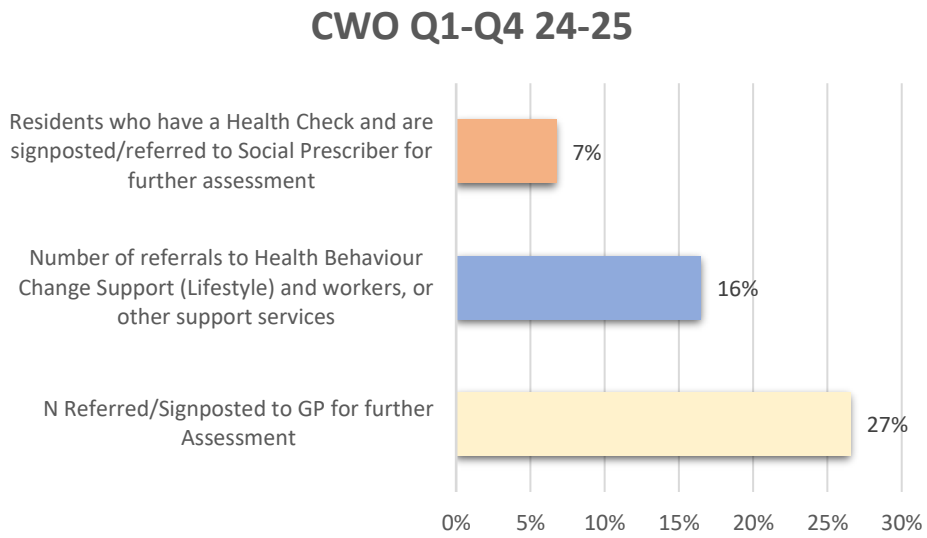



Health Issues as Percentage of Health Issues Found
Identified Health Issues
High / Very high BMI
42.87
High Cholesterol
28.38
High / Very high Blood Pressure
25.14
Number of patients 30-39 year olds who have a record of high blood pressure
14.37
High Blood Glucose
3.61
Number of people with indications of pre-diabetes Hba1c 42-48
1.93
0.00 5.00 10.00 15.00 20.00 25.00 30.00 35.00 40.00 45.00 50.00
Health Issues as Percentage of Health Issues Found

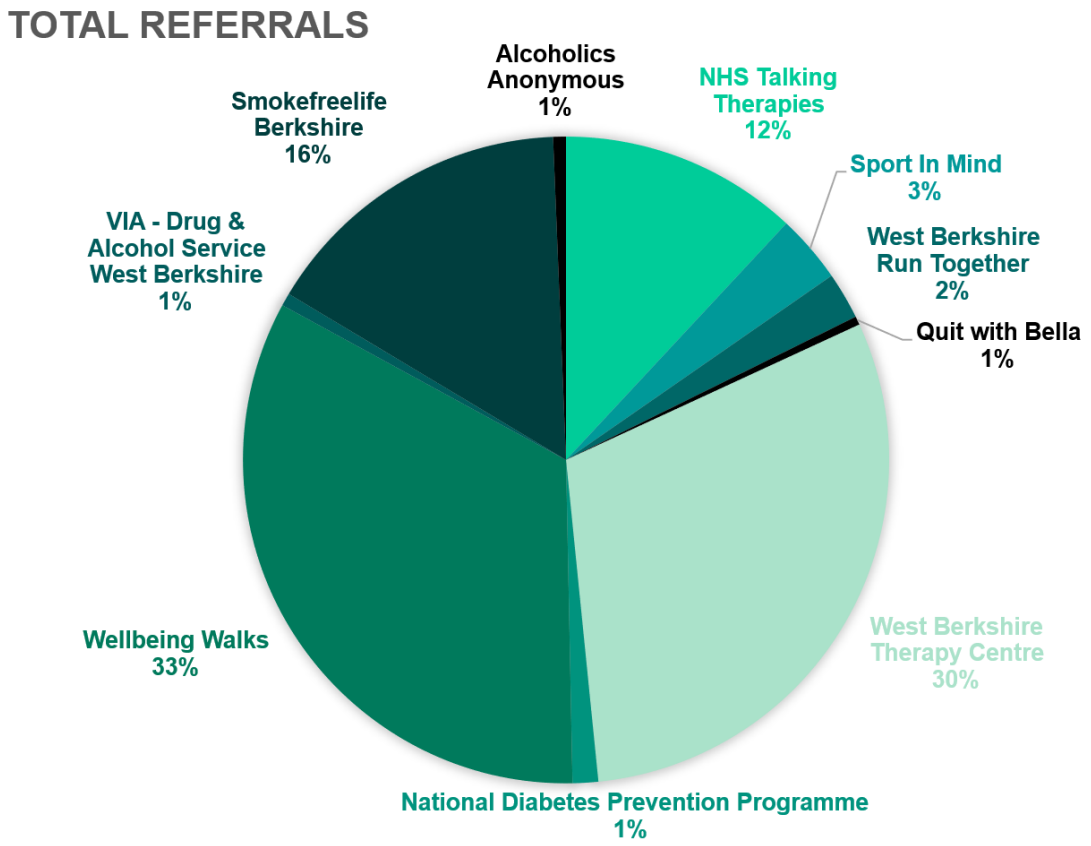
Onwards Referrals and Signposting

There are some challenges within data but the known data indicates that the highest number of referrals was made to Weight Management services, followed by Mental Health Support Services.





Who are people being referred to?



PCN	Eligible Population	Vaccinations	% Uptake
A34	5,484	3,469	63.26%
Kennet	5,466	3,537	64.71%
West Berkshire Rural	3,491	2,213	63.39%
West Reading Villages	5,890	3,545	60.19%
BOB	228,421	129,065	56.50%

Ethnicity	Average Uptake
Unknown	16.13%
P: Black or Black British - Any other Black background	21.73%
N: Black or Black British - African	23.26%
R: Other ethnic groups - Chinese	24.24%
J: Asian or Asian British - Pakistani	29.17%
K: Asian or Asian British - Bangladeshi	30.56%
F: Mixed - White and Asian	34.38%
H: Asian or Asian British - Indian	36.43%
99: Not known	38.58%
E: Mixed - White and Black African	39.64%
L: Asian or Asian British - Any other Asian background	44.38%
M: Black or Black British - Caribbean	46.33%
S: Other ethnic groups - Any other ethnic group	48.76%
G: Mixed - Any other mixed background	49.70%
D: Mixed - White and Black Caribbean	52.50%
B: White - Irish	55.60%
C: White - Any other white background	56.48%
A: White - British	64.48%

COVID Vaccination Summary Spring 25 updates for West Berkshire

Deprivation Decile is 07, 08, 09, or 10 / Age Band is 0-9		
RegisterType	RegisterDescription	% Prevalence
Measles, Mumps, Rubella (MMR)	Vaccinated - 1 dose	86.9%
Measles, Mumps, Rubella (MMR)	Vaccinated - 2 doses	64.0%
Meningitis B - MenB (Child Imms)	Vaccinated - 1 dose	92.4%
Meningitis B - MenB (Child Imms)	Vaccinated - 2 doses	89.9%
Meningitis B - MenB (Child Imms)	Vaccinated - 3 doses	82.1%
Pneumococcal (PCV - Child Imms)	Vaccinated - 1 dose (under 2yo)	93.8%
Pneumococcal (PCV - Child Imms)	Vaccinated - 2 doses (under 2yo)	86.0%
Rotavirus (Child Imms)	Vaccinated - 1 dose	92.2%
Rotavirus (Child Imms)	Vaccinated - 2 doses	89.7%

Deprivation Decile is 01, 02, 03, or 04 / Age Band is 0-9		
RegisterType	RegisterDescription	% Prevalence
Measles, Mumps, Rubella (MMR)	Vaccinated - 1 dose	85.6%
Measles, Mumps, Rubella (MMR)	Vaccinated - 2 doses	63.5%
Meningitis B - MenB (Child Imms)	Vaccinated - 1 dose	94.5%
Meningitis B - MenB (Child Imms)	Vaccinated - 2 doses	92.1%
Meningitis B - MenB (Child Imms)	Vaccinated - 3 doses	84.0%
Pneumococcal (PCV - Child Imms)	Vaccinated - 1 dose (under 2yo)	95.3%
Pneumococcal (PCV - Child Imms)	Vaccinated - 2 doses (under 2yo)	87.2%
Rotavirus (Child Imms)	Vaccinated - 1 dose	91.9%
Rotavirus (Child Imms)	Vaccinated - 2 doses	89.2%

Deprivation Decile is 01, 02, 03, or 04 / Ethnicity L0 is White / Age Band is 0-9		
RegisterType	RegisterDescription	% Prevalence
Measles, Mumps, Rubella (MMR)	Vaccinated - 1 dose	86.9%
Measles, Mumps, Rubella (MMR)	Vaccinated - 2 doses	65.3%
Meningitis B - MenB (Child Imms)	Vaccinated - 1 dose	96.0%
Meningitis B - MenB (Child Imms)	Vaccinated - 2 doses	93.8%
Meningitis B - MenB (Child Imms)	Vaccinated - 3 doses	86.7%
Pneumococcal (PCV - Child Imms)	Vaccinated - 1 dose (under 2yo)	95.5%
Pneumococcal (PCV - Child Imms)	Vaccinated - 2 doses (under 2yo)	88.8%
Rotavirus (Child Imms)	Vaccinated - 1 dose	93.3%
Rotavirus (Child Imms)	Vaccinated - 2 doses	90.7%

Deprivation Decile is 01, 02, 03, or 04 / Ethnicity L0 is BAME/ Age Band is 0-9		
RegisterType	RegisterDescription	% Prevalence
Measles, Mumps, Rubella (MMR)	Vaccinated - 1 dose	86.5%
Measles, Mumps, Rubella (MMR)	Vaccinated - 2 doses	57.7%
Meningitis B - MenB (Child Imms)	Vaccinated - 1 dose	86.5%
Meningitis B - MenB (Child Imms)	Vaccinated - 2 doses	80.8%
Meningitis B - MenB (Child Imms)	Vaccinated - 3 doses	71.2%
Pneumococcal (PCV - Child Imms)	Vaccinated - 1 dose (under 2yo)	98.1%
Pneumococcal (PCV - Child Imms)	Vaccinated - 2 doses (under 2yo)	82.7%
Rotavirus (Child Imms)	Vaccinated - 1 dose	82.7%
Rotavirus (Child Imms)	Vaccinated - 2 doses	80.8%

Ethnicity is White Age Band is 0-9		
RegisterType	RegisterDescription	% Prevalence
Measles, Mumps, Rubella (MMR)	Vaccinated - 1 dose	87.8%
Measles, Mumps, Rubella (MMR)	Vaccinated - 2 doses	64.8%
Meningitis B - MenB (Child Imms)	Vaccinated - 1 dose	94.6%
Meningitis B - MenB (Child Imms)	Vaccinated - 2 doses	92.2%
Meningitis B - MenB (Child Imms)	Vaccinated - 3 doses	84.4%
Pneumococcal (PCV - Child Imms)	Vaccinated - 1 dose (under 2yo)	94.6%
Pneumococcal (PCV - Child Imms)	Vaccinated - 2 doses (under 2yo)	86.7%
Rotavirus (Child Imms)	Vaccinated - 1 dose	93.5%
Rotavirus (Child Imms)	Vaccinated - 2 doses	90.9%

Ethnicity BAME / Age Band is 0-9		
RegisterType	RegisterDescription	% Prevalence
Measles, Mumps, Rubella (MMR)	Vaccinated - 1 dose	82.0%
Measles, Mumps, Rubella (MMR)	Vaccinated - 2 doses	59.5%
Meningitis B - MenB (Child Imms)	Vaccinated - 1 dose	75.6%
Meningitis B - MenB (Child Imms)	Vaccinated - 2 doses	71.2%
Meningitis B - MenB (Child Imms)	Vaccinated - 3 doses	63.3%
Pneumococcal (PCV - Child Imms)	Vaccinated - 1 dose (under 2yo)	87.2%
Pneumococcal (PCV - Child Imms)	Vaccinated - 2 doses (under 2yo)	77.4%
Rotavirus (Child Imms)	Vaccinated - 1 dose	81.9%
Rotavirus (Child Imms)	Vaccinated - 2 doses	79.1%

This page is intentionally left blank

All-age Complex and Continuing Care (AACCC)

Berkshire West Health Scrutiny Committee

June 2025

Daphne Barnett – Interim Associate Director of Nursing
Sarah Flavell – Associate Director of Nursing (AACCC)

All Age Complex & Continuing Care Executive Summary

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

All Age Complex and Continuing Care (AACCC) is an umbrella term that brings together Continuing Healthcare, (CHC) Children and Young Peoples Continuing Care (CYPCC) and Complex Care. Since the start of the year the ICB AACCC team have been working to develop and implement a hub and spoke model to align and bring constancy to the AACCC service under one strategic clinical leadership team, led by a Director of Nursing. This paper gives an update to the presentation made in December 2024 setting out the key priorities for each service line and the overall governance to enable review, improvement and reporting oversight.

CHC referral and eligibility.

The data in December showed that Berkshire West has variation when compared to other systems for referral and eligibility. Work is ongoing to review if the variation is warranted or unwarranted. Early indications are that the referral and eligibility rates have increased with Berkshire West being nearer to national benchmark quality standards. Further work is planned as we refine our delivery model working in collaboration with the LAs across East and West Berkshire.

CYPCC consistency in process

The ICB CYPCC team have developed jointly with the Local Authorities across West Berkshire a CYP funding panel that has been operating within Berkshire West since December 2024, early evaluation is positive with an ambition to take the learning into other place-based team to strengthen consistency. The pack includes slides provided by the Local Authority setting out the successes.

Complex Care

Processes are in development for interim and joint funding for individuals who do not meet the eligibility criteria for CHC or CYPCC, but have unmet health needs, not provided through core NHS service provision. A health care contribution policy has been developed and shared through Strategic partnership Board. Berkshire West have been part of the "testing" of this policy to gain learning with a view that a fila policy will be taken to the next Strategic Partnership Board for sign off.

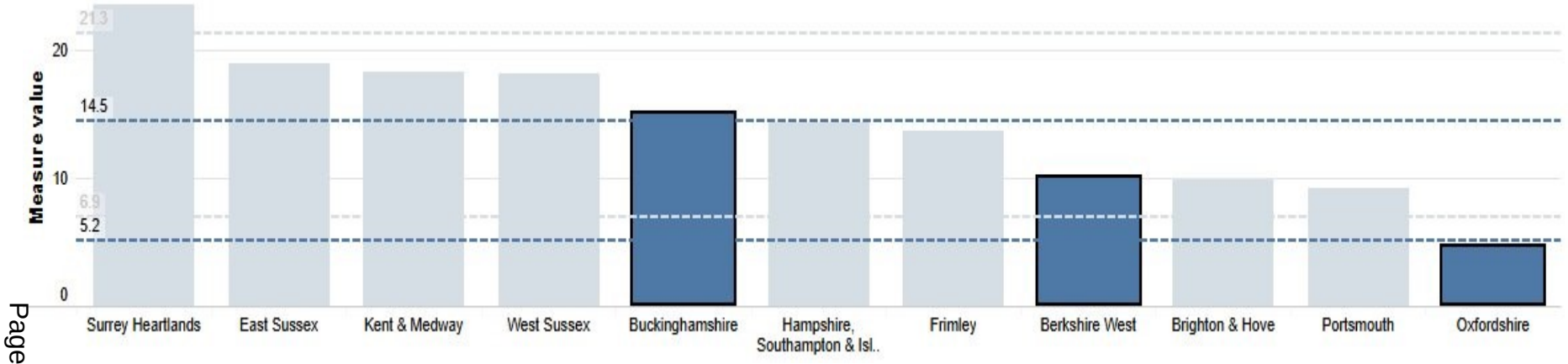
Governance

Each place base have partnership forums in place to develop and coproduce local neighbourhood services. It is recognised that there remains a need to strengthen relationships and communication at operational level to enable appropriate escalation through Strategic Partnership Board where issues cannot be resolved at operational level. The recent development of a disputes and health care contribution policy are good examples of where the Strategic Partnership Board can influence and enact change and improvement.

Standard CHC: Regional Data for Q4 2024/25

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Number of new referrals for Standard CHC - per 50K Population



- In December 2024 we reported that Berkshire West regional data gave a value of **6.3** for new referrals for Qu1 2024/25. Following a review and alignment of our ICB internal processes Berkshire West has is reporting **10.1** at the end of Qu4, representing a marked increase in the numbers of referrals coming into the team.

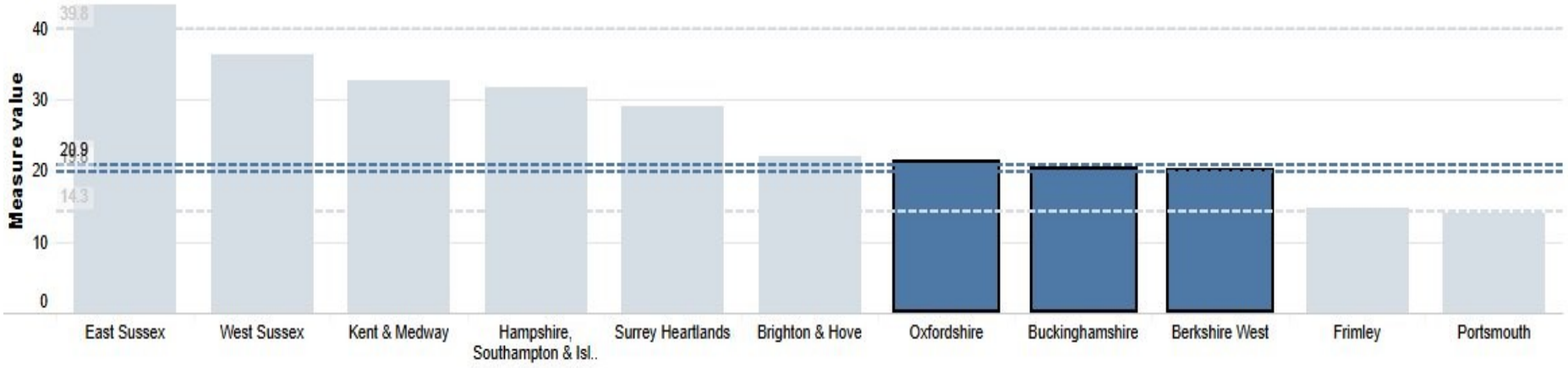
Number eligible at the end of the quarter for Standard CHC (Snapshot) - per 50K Population

- Berkshire West reported a value of **9.7** for eligibility at the end of quarter for the first quarter of 2024/25 this is now **11.5** at the end of Qu4 (remaining below the 5th percentile for the region). This figure continues to reflect lower than expected eligibility per 50K population compared to other organisations in the region however shows an increase in individuals found eligible at Qu4.

Fast Track: Regional Data for Q4 2024/25

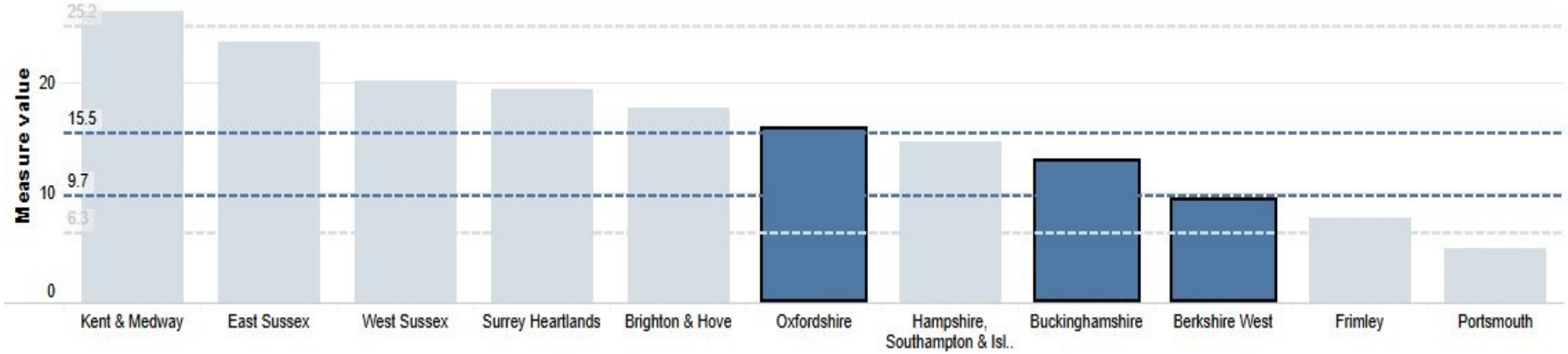
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Number of new referrals for Fast Track - per 50K Population



- In December 2024 we presented that Berkshire West was reporting a value of **18.6** for new referrals for the first quarter of 2024/25. As at Qu 4 this metric has increased to **19.8**. This figure reflects a position in line with the average referral rates per 50K population compared to other organisations in the region.

Number eligible at the end of the quarter for Fast Track (Snapshot) - per 50K Population



- Berkshire West reported a value of **8.0** for eligibility at the end of Qu1 2024/25. This figure is now at **9.3** for Q4.This figures reflects expected eligibility per 50K population compared to other organisations in the region.

Berkshire West (CYPCC) Joint Funding Panel

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

The CYPCC (Children and Young People's Continuing Care) funding panel is a collaborative initiative involving Wokingham, Reading, and West Berkshire councils.
The panel aims to streamline the funding process for continuing health care, ensuring timely and effective support for individuals with complex health needs.

Key Objectives:

- Improve joint working and funding arrangements across the three local authorities.
- Enhance the decision-making process for CYPCC funding applications.
- Address historical backlogs and streamline case progress.

Panel Structure:

- Jointly chaired by local authority service directors and representatives from BOB Integrated Care Board (ICB).
- Regular pre meetings to review assessment and approve CHC funding applications.
- Collaborative approach involving health commissioners and acute trust representatives.

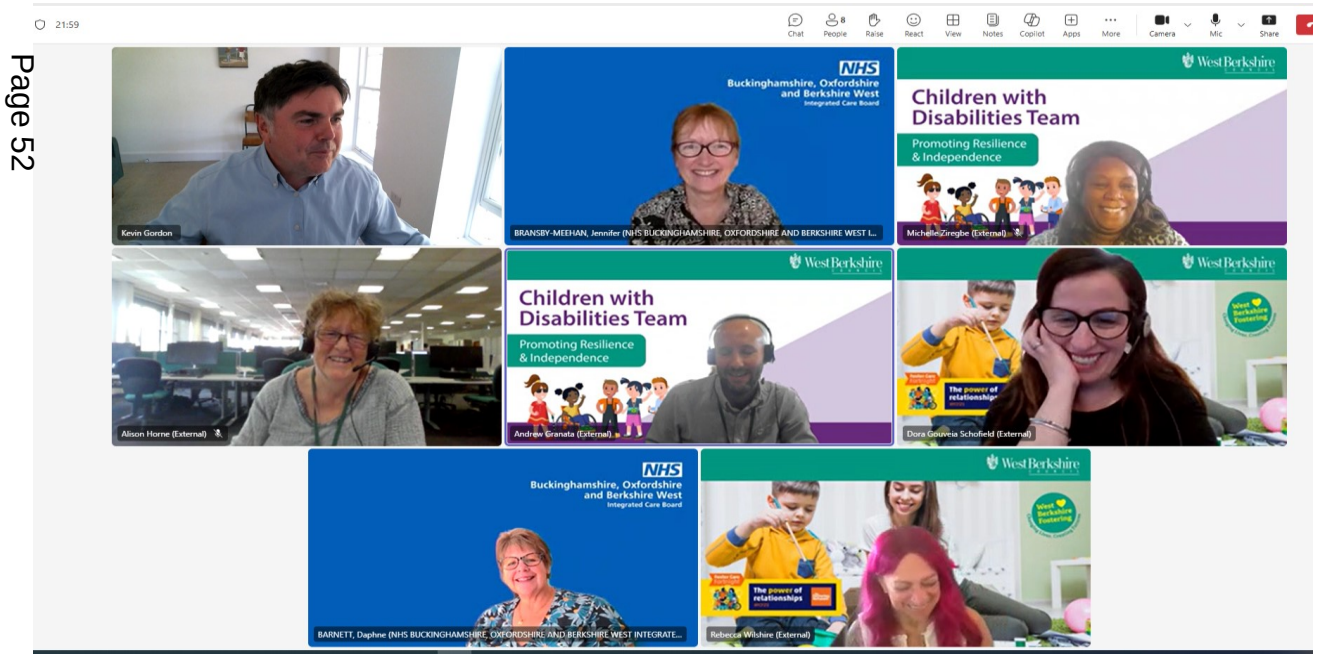
Success

Improved Collaboration: The panel has fostered a culture of collaborative working among the three local authorities and health partners.

Efficient Decision-Making: Streamlined processes have led to quicker decision-making and reduced delays in funding approvals.

Addressing Backlogs: Significant progress in resolving historical backlogs, ensuring timely support for individuals in need.

Test and Learn Approach: The panel has adopted a 'Test and Learn' approach, continuously refining processes based on feedback and outcomes.



Impact

Enhanced Support: Individuals with complex health needs receive timely and appropriate care, improving their quality of life.

Positive Feedback: The initiative has received positive feedback from stakeholders, highlighting the benefits of joint working and efficient funding processes.

Future Plans: Ongoing commitment to refining the panel's processes and expanding collaborative efforts to further improve CHC funding and support.

Summary

As AACCC navigates it way through the current national change programme the team remain committed to work collaboratively and alongside the Local Authorities to ensure that we meet the needs of individual with complex and continuing care needs to include the following action points.

- Executive level oversight and leadership with strategic partnership boards chaired by ICB CEO
- Aligning consistency in process across the ICB and with our neighboring ICB in Frimley
- Establishing a pilot to consider the unmet health needs for children and young people who do not meet the threshold for CYPCC.
- Desk top review of historical disputed cases.
- Agreed disputes policy in place.
- Trialing of joint funding / health care contribution process for individuals not eligible for CHC.
- Pathway development for complex care with clear protocols for decision making, patient review and evaluation.
- Continued working with Beacon advocacy service to improve the experience of individuals accessing CHC services.
- Developing joint training for health and social care teams.
- Development of a central “hub” for quality assurance verification process to enable peer review check and challenge to decision making working “with regard” to the National Framework.
- Phase 1 central process for Appeals, PUPOC and Ratification to go live 1st July 2025
- Phase 2 central process for Fast Track, Referrals and Disputes to go live 1st September 2025 .

This page is intentionally left blank

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Paper to West Berkshire Health Overview and Scrutiny Committee

Date of Meeting: 12th June 2025	**Agenda item:**

Title of Paper: Developing our foundation for neighbourhood health

Paper is for: (Please ✓)	**Discussion**		**Decision**		**Information**	X

Purpose and Executive Summary

The attached Board paper sets out the ICB's current thinking and progress on Neighbourhood Working as described in the NHS Operating Planning guidance for 2025/26 and associated Neighbourhood Health Guidelines. It is expected the publication of the NHS 10-Year Plan will set out a fuller vision for neighbourhood working as a foundation for reform across the NHS and six core components have been identified.

The paper describes preparatory work undertaken in advance of the 10-Year Plan's publication. There is an immediate focus for the NHS on preventing long and costly admissions to hospital and improving timely access to urgent and community care by focussing on people with the most complex needs. At a local level consideration is being given to how current work programmes and services sit within a Neighbourhood Working approach and an update on West Berkshire discussions will be provided at the meeting.

Action required

No action identified

Author: Helen Clark, Associate Director of Place (Berkshire West), BOB ICB

Date of Paper: 30th May 2025

This page is intentionally left blank

BOB ICB BOARD MEETING

Title	BOB ICB Developing our foundation for neighbourhood health		
Paper Date:	05 May 2025	**Meeting Date:**	13 May 2025
Purpose:	Information and approval	**Agenda Item:**	11
Author:	Angela Jessop, Programme Lead, Transformation and Improvement. Robert Bowen Director of System Transformation and Development	**Exec Lead/ Senior Responsible Officer:**	Dr Ben Riley, Chief Medical Officer

Executive Summary

The 2025/26 Planning Guidance and associated NHSE Neighbourhood Guidelines asks ICBs to work towards the delivery of a neighbourhood health model. This will bring together statutory health and care services alongside the voluntary sector to create healthier communities, helping people of all ages live healthy, active, and independent lives while improving their experience of care, and increasing their agency in managing their own care.

This paper provides and update to the Board on how the neighbourhood agenda is progressing across BOB and proposes the establishment of a BOB System Neighbourhood Programme.

The Board are asked to:

- Note the progress that has already been made by the place teams who have been driving the multi-disciplinary approach to neighbourhood working for several years.
- Agree the direction of travel and the establishment of a BOB System Neighbourhood Programme that will coordinate the progress and support the accelerated implementation of the neighbourhood working across the ICB footprint.

Conflicts of Interest:	Conflict noted: conflicted party can participate in discussion and decision

The ambition outlined in this paper describes the organisation of NHS services which will impact on organisations that members of the Board lead/work for. The perspective of these members is an important aspect to development and delivery of our plans

Date/Name of Committee/ Meeting, where last reviewed:	Not Applicable

BOB ICB Developing our foundation for neighbourhood health

The Context

1. In 2024, the newly elected Government set out a mandate for reform of the NHS which included a commitment that the NHS must evolve into a neighbourhood health service[1] with care available closer to people's homes enabling three key shifts of hospital to community, treatment to prevention and analogue to digital.
2. In January 2025, both the NHS Operating Planning guidance for 2025/26 and associated Neighbourhood Health Guidelines recognised a neighbourhood health approach will reinforce new ways of working in the NHS, local government, social care and their partners, where integrated working is the norm and not the exception.
3. It is expected the publication of the NHS 10-Year Plan will set out a fuller vision for neighbourhood working as a foundation for reform across the NHS. The guidance asks ICBs and partner organisations to progress neighbourhood health in 2025/26 in advance of the publication of the NHS 10 Year Health Plan and defines the steps that the NHS must take to deliver the new model of care. It sets out the expectation for systems to develop neighbourhood health models.
4. There are six '**core components'** that the local systems are expected to consider in 2025/26:
    a. *Population health management (PHM):* Systems should create a linked dataset for population health outcomes, risk stratification and strategic resource allocation which includes health and social care data.
    b. *Modern general practice:* ICBs should implement the modern general practice model that involves streamlining access, making it easier to connect with the most appropriate healthcare professional or service.
    c. *Standardised community health:* Community health services should address physical, mental health and social care needs in a joined-up way. Services should be commissioned and integrated as part of a neighbourhood health plan that improves access and overall experience for people and carers.
    d. *Neighbourhood multi-disciplinary teams (MDTs)*: MDTs will deliver proactive, planned, and responsive care based on individual need and the opportunity for greatest impact. Using a care coordinator, teams are often organised around population cohorts with specific, often complex needs. Together they offer a range of coordinated services. Team composition will vary according to need and skill mix.
    e. *Integrated intermediate care with a 'Home First' approach:* Systems should provide therapy led short-term rehabilitation and reablement services. Access will be directly from community or as part of discharge planning using a 'home-first' approach. Good case management systems and outcome evaluation will underpin service change.
    f. *Urgent neighbourhood services*: For people with escalating or acute health needs, systems should have a standardised and scaled urgent neighbourhood service, aligned and planned around local demand to ensure integrated support to local

[1] Build an NHS Fit For the Future - GOV.UK

populations, managed through a single point of access (SPOA). This service will link with urgent and emergency care services and link with local step-up and step-down pathways.

5. There is an immediate focus for the NHS on preventing long and costly admissions to hospital and improving timely access to urgent and community care by focussing on people with the most complex needs.
6. The publication of the Model ICB Blueprint also helpfully clarifies the opportunity for ICBs to lead on the commissioning of neighbourhoods – working with local teams to confirm population needs, setting a strategy to inform appropriate resource allocation to improve local outcomes, and agreeing and evaluating a contractual framework that supports change.

An evidence base for change

7. In addition to the national context, recent analysis completed as part of the *Pathway to Sustainable Healthcare* project, has identified further benefits for accelerating the existing work on neighbourhood health already underway across the BOB system. The analysis identified opportunities to:
    a. Reduce unwarranted variation in our current models of care and deliver outcomes that could, in part, be achieved through a more standardised approach to interventions that support a shift to a community and primary care based models. This includes the implementation of multi-disciplinary, proactive and coordinated care for people with complex care needs; and improved home and community support models such as proactive rehabilitation schemes, remote monitoring, and early interventions.
    b. Developing a more systematic approach to prevention by slowing or stopping deteriorations in health. The analysis pointed towards a particular focus on cardiovascular disease (CVD), obesity and diabetes.
8. The analysis shows there will be increased costs associated with increases in demand if proposed interventions are not adopted. A neighbourhood approach will be one of the important ways to progress these ambitions over the medium term (5 years) and develop services that target specific local population needs or pressures, thereby reducing or avoiding forecast costs over the medium term.

Building on good practice across BOB

9. The introduction of Primary Care Networks (PCNs) in 2019, and the subsequent ambition for Integrated Neighbourhood Teams (INTs) as part of the Fuller Stocktake in 2022 means that the concept of neighbourhood working is not new. The BOB Primary Care Strategy, published in 2024 set an ambition to roll out INTs more comprehensively across our population.
10. Recognising that each Place team had taken a different approach to the implementation of INTs and Integrated working, we have recently undertaken a local scoping exercise to understand local progress and achievements. As part of the scoping exercise, we have met with a multi-disciplinary group, representing a range of organisations in each area to understand both progress and plans to implement the six components of the Neighbourhood model.

11. The scoping exercise has shown valuable progress and variation across Buckinghamshire, Oxfordshire and Berkshire West Places, summarised below:

Current neighbourhood working in BOB – a summary
Buckinghamshire
• 6 neighbourhoods have been defined with circa 100,000 population. • Population health assessments are underway, led by public health colleagues mostly using Thames Valley and Surrey (TVS) Shared Care Record data. • Various MDT pilots have been running allowing for learning and shared good practice. MDTs have focussed on children and young people, CVD and frailty. • Multiple rapid response, intermediate care, home independence teams in place. Work completed on discharge process has strengthened relationships.
Oxfordshire
• Significant experience of developing neighbourhood MDTs, focussed on areas with greatest health inequalities. Working closely with Public Health colleagues to use data to support decision on neighbourhood footprints. • Currently 7 active MDTs for frailty focused on urgent care. Other active INTs. Current model is funded through Better Care Fund (BCF). Less than 50% population covered. • Health and Wellbeing workers employed in areas of greatest deprivation. • Undertaken extensive work on Discharge to Assess and Home First.
Berkshire West (BW)
• Currently convening partners to collectively agree a common approach • TVS insights tool is available in 100% of practices, making PHM a possibility. Focus has been on segmentation to support triage. Ambition to increase usage an increase coordination with social care. • MDT working has been in place in parts of BW for more than 4 years. Different models in place. Community wellness programme is seen as good practice • Berkshire Healthcare Foundation Trust (BHFT) are actively involved in discussions about neighbourhood MDT approach.

12. The scoping exercise also identified areas where system support would be valuable. These included:
    - Access to consistent health data set and corresponding analysis
    - Facilitating data sharing between organisations
    - Brokering clarity of vision for Neighbourhoods in BOB, recognising local variation according to local needs.
    - Clarity on expected outcomes and success measures for neighbourhoods
    - Support for Organisation Development such as relationship building, defining roles and responsibilities.
    - Resources to support mapping of existing services, funding flows, workforce capacity to support closer alignment a reduced duplication.

Establishing a BOB Neighbourhood Health programme

13. We are proposing to initiate a programme to support the consistent implementation of the ambition of the national neighbourhood health guidance, and to coordinate the realisation

of the expected benefits. Dr Ben Riley, Chief Medical Officer will be the SRO for the system programme.

14. A formal Programme Board will be established to support the coordination of system activities and the existing Place project teams. The Programme Board will have a cross organisation and multidisciplinary membership to ensure a holistic approach. The first meeting is expected to take place in mid-May.

15. It is expected that priorities for neighbourhood working in 2025/26 will be developing and planning the infrastructure, information flows and ways of working required to support cohorts of people with complex health and social care needs who require support from multiple services and organisations at a neighbourhood level. This focus aims to prevent people from spending unnecessary time in hospitals or care homes (as per national guidance).

16. Where possible, neighbourhoods may also focus on opportunities to prevent the deterioration of health and may wish to identify specific population cohorts that will benefit from the coordinated multidisciplinary approach.

17. The purpose of the Neighbourhood Programme will be to accelerate a more integrated neighbourhood level approach to coordinating and delivering services that meet local needs. Specifically, the Programme Board will:

    a. Provide governance, a programme scope, common vision, frameworks for stakeholder co-production and outcomes, as well as system level evaluation for neighbourhood working, including clarification of a common language.
    b. Convene the three places to share and cascade best practice and lessons learnt, and serve as a coordination point for stakeholder communication, co-production and engagement.
    c. Support the organisational development of neighbourhood teams to enable the development of effective relationships across the health and care system, including NHS, social care, local authority, voluntary, community and social enterprise (VCSE) and academic partners, and the cultural shift required to work together in a new way.
    d. Seek to identify and align existing data reporting and funding flows, commissioning models and contractual mechanisms across NHS and local authority to enable this work.
    e. Work with partners to steer and support the development of new data and insight tools required to facilitate neighbourhood co-production, tackle health inequalities and evaluate preventative health interventions.
    f. Support the asset mapping work which includes, services, roles, funding, pathways, and estates.
    g. Provide a framework for shared responsibility of assurance.

18. Terms of Reference will be agreed before the end of May.

Next steps

19. The BOB ICB Board are asked to note the progress that has already been made by the place teams who have been driving the multi-disciplinary approach to neighbourhood working for several years.

20. As we seek to make our approach more consistent across BOB, the Board are asked to agree the direction of travel and the establishment of a BOB System Neighbourhood Programme that will coordinate the progress and support the accelerated implementation of the neighbourhood model across the ICB footprint.

21. Updates on progress of the Neighbourhood model will be shared formally with the ICB executive. The proposed system governance is still to be defined. Meanwhile we commit to updating the ICB Board on progress regularly.

Executive Summary

The Royal Berkshire NHS Foundation Trust (RBFT) is refreshing our Trust Strategy and invites the council to share their views and help develop our organisational strategy for the next five years.

The West Berkshire Health Scrutiny committee plays a key role in the strategic direction of RBFT as a local authority partner organisation whose responsibilities include or ensuring the need of our local residents are considered as we plan, develop and operate local health services.

This paper provides West Berkshire Health Scrutiny Committee with the background and context to the strategy refresh at RBFT and an update on engagement thus far, before opening a discussion to seek committee members recommendations and ideas.

1. Background and Context

1.1. The Trust Strategy was last reviewed in 2022 (a summary of the current high level aims and objectives is shown in Appendix 1), and the key drivers for a 2025 refresh are as follows:

- **Change in health landscape** with the legislation of Integrated Care Boards/Systems in 2022 and increased appetite/ask for collaboration over competition.
- **Stronger partnerships** further to the above across both Berkshire West place and the system via the Acute Provider Collaborative provide a new lens for our work.
- **National NHS review** following the arrival of a new government at the General Election including the Darzi independent investigation and upcoming 10 Year Plan.

1.2. The Trust Board has set the below timeline:

1. **Exploration and Planning** (from now until February 2025)
2. **Engagement phase** (March – July 2025)
3. **Strategy development and refinement** (July – August 2025)
4. **Finalisation and approvals** (September – November 2025)
5. **Key enabler delivery plan development** (post approval)

1.3. Key highlights from some of the exercises undertaken as part of the exploration and planning exercise are shown below.

- **Evaluation against our existing Trust Strategy**
  We have undertaken a review against the 86 ambitions set out in our existing Trust Strategy. It showed that we have made significant progress in several areas of our current strategy, particularly in developing our continuous quality improvement methodology. This has led to enhanced care, improved patient safety, and stronger workforce development.

However, whilst we've worked well with our partners and improved how patients move through the system, progress has been slower in areas including resource sharing, adopting a unified digital approach, and fostering greater collaboration with partners outside of heath. These are areas we want to explore further in the engagement and our new Trust Strategy.

- **Policy platform exercise**
  So far, we've analysed over 50 local, regional, and national policy documents and reviews that may inform our strategy – including the Darzi report, BOB Joint Forward Plan and Core20PLUS5 alongside the Elective Care Plan published 5 January 2025. Several key themes emerged from this, including a greater national and local focus on addressing health inequalities, increased collaboration with partners and delivering more care closer to patients' homes in the community.

- **'What Matters 2024'**
  'What Matters' is an organisation-wide conversation about our values and what they mean to our staff. Thematic analysis of the 4637 contributions to the 2024 What Matters conversation revealed the key areas identified by staff to enhance compassion, aspiration, resourcefulness and excellence (our CARE values) were as follows: maximising our use of digital where appropriate; improving our estate and digital infrastructure; and continuing our work on staff health and wellbeing, reward and recognition.

- **NHS Change Programme response**
  The Department of Health and Social Care and NHS England are developing the 10 Year Health Plan with the public and health and care staff. For this, we hosted an engagement session with 100 RBFT Senior Leaders as part of our Senior Leaders Forum. The session focused on three outlined themes: making better use of technology; moving more care from hospitals to communities; and preventing sickness not just treating it.
    - *Preventing sickness not just treating it*: Leaders highlighted that they felt there was significant opportunity to maximise earlier intervention with children, young people and maternity; the influence (both positive and negative) of social media amongst other information sources; and the role of legislative and policy action in removing barriers to healthier choices.
    - *Moving more care from hospitals to communities*: Leaders strongly support delivering more care in the community and working with place and system partners to enable this. Key challenges to overcome will likely include logistical and workforce changes and effective risk management. The RBH virtual wards are seen as a local success story from which there is learning to share around technological enablers.
    - *Making better use of technology*: Leaders conversations for this theme centred primarily around data and how we can maximise our Health Data Institute to assist with improving patient outcomes and planning our services.

2. Engagement

2.1. Our refreshed Trust Strategy will be co-produced with our staff and volunteers, our patients and community, and our partner organisations. With engagement tailored to each group to ensure ideas and inputs are captured across all RBFTs roles: as a provider of healthcare; a partner; an employer.

2.2. In our engagement, we recognise that several people will fall into multiple groups (e.g. many of our 6500 staff members live in our local community and use our services). The engagement will allow participants to engage in multiple roles.

2.3. The last Trust Strategy was developed in 2021 during the COVID-19 pandemic, with restrictions and pandemic response reducing the engagement. This latest refresh will comprise of thorough engagement across all three groups.

2.4. In collaboration with the RBFT Patient Engagement and Experience Team and the Communications and Engagement team, we have undertaken an extensive stakeholder mapping exercise to maximise our engagement and ensure all voices can be heard and to plan engagements around other calendared Trust communications.

2.5. We have also identified several accessibility needs including translation services, easy read formatting and paper-based options to avoid digital exclusion.

2.6. Patients and communities across West Berkshire have been involved so far via an extensive engagement campaign including social media posts, posters in the local community, parish council newsletters across West Berkshire, pop-up stands in the community and in West Berkshire Community Hospital, and at Meet PEET (Patient Experience Engagement Team) health checks. Focus groups with GP's and other health partners across West Berkshire are being organised to engage with our local partner organisations.

3. Committee Discussion

3.1. West Berkshire Health Scrutiny Committee are asked to provide their recommendations and input for RBFT's strategic objectives and aims for the next 5 years.

3.2. This work is a refresh of our current strategy, and in their thinking, the committee are recommended to consider RBFT's current strategic objectives (see Appendix) in the context of:

- their relevance for the next five years;
- future aims;
- opportunities for further partnership working.

3.3 The committee should also not feel constrained by the current strategic objectives and are also invited to comment beyond the existing strategic framework.

Appendix: Our current Strategic Objectives and Aims (2022)

SO1: Providing the highest quality of care for all

Safety and quality for every patient is our top priority. We will continuously improve so that all our services are outstanding for every patient every day.

Our Aims:

- We will enhance the patient experience.
- We will achieve optimal outcomes.
- We will minimise harm.

SO2: Invest in our people and live out our values

We will recruit, support, motivate and develop our people to become one of the best and most inclusive places to work in the NHS.

Our Aims:

- We will recruit, retain and develop our people to their highest potential.
- We will foster an inclusive and supporting culture that connects all staff with our purpose and empowers them to live out our values every day.
- We will prepare our workforce for tomorrow.

SO3: Deliver in Partnership

We will work with partners locally and regionally to bring care closer to home, provide a seamless service for patients and support improvements in wellness and prevention.

Our Aims:

- We will work together with our partners to promote wellbeing and prevention-working to prevent the onset of disease and support those living with long-term conditions to stay well.
- We will proactively drive the development of integrated pathways of care that cross boundaries, are joined up, are led by the right provider and deliver seamless transitions in care for a “one NHS” experience of care.
- We will work with partners to improve access to care for all patients.

SO4: Cultivate Innovation and Improvement

We will encourage the development and adoption of advancements in medical practice and technology to enhance outcomes and experiences for our patients and staff.

Our Aims:

- We will improve through insights that inform clinical and operational decision-making.
- We will unlock new and better ways for our staff to deliver care and for our patients to co-manage their health.
- We will transform the user experience of digitally-enabled care for both patients and staff.

SO5: Achieve long-term sustainability

Using resources efficiently and responsibly allows the Trust to invest in developing and improving our services for patients, look after our environment and renew the infrastructure supporting our operations.

Our Aims:

- We will live within our means.
- We will minimise our impact on the environment.
- We will upgrade our infrastructure in line with our ambitions.

This page is intentionally left blank

Health Scrutiny Committee – 12 June 2025

Item 10 – Healthwatch Update

Verbal Item

This page is intentionally left blank

Health Scrutiny Committee – 12 June 2025

Item 11 –Task & Finish Group Updates

Verbal Item

This page is intentionally left blank

Health Scrutiny Committee Work Programme

Ref	Item	Purpose	Health Body / Responsible Officer
23 September 2025 (Report Deadline 5 September)			
3	Dementia	To receive an update on dementia diagnosis rates, pathways and the BOB ICB strategy on Dementia pathways since attending the Health Scrutiny Committee in June 2023.	Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and West Berkhisre Council
4	Health In All Policies	To review the implementation of Health in All Policies.	West Berkshire Council
5	DPH Annual report	To receive the Director of Public Health Annual Report.	Director of Public Health
16 December 2025 (Report Deadline 28 November)			
6			
7			
10 March 2026 (Report Deadline 20 Februrary)			
8			
9	South Central Ambulance Service	To recieved an update on the progress made on their improvement programme.	South Central Ambulance Service NHS FoundationTrust
10	Oral Health and Dentistry	To receive an update on the System approach to oral health and dentistry. Including the preventative approach and commissioned services.	West Berkshire Council Public Health and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board
Other Items to be programmed			
Other Items for consideration by the Health Scrutiny Committee			

Standing Items			
	Healthwatch West Berkshire Report	To receive an update from Healthwatch West Berkshire on patient feedback received, reports prepared and other activities.	Healthwatch West Berkshire
	Director of Public Health Annual Report	To review the Director of Public Health Annual Report	Public Health
	Inquest Review Panel	To receive the annual report from the Inquest Review Panel	West Berkshire Council