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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 TUESDAY 9 JUNE 2026

Councillors Present: Martha Vickers (Chairman), David Marsh (Vice-Chairman), Martin Colston, Alan Macro, Paul Kander, Stephanie Steevenson and Joanne Stewart

Also Present: Steven Bow (Consultant in Public Health), Dr Matt Pearce (Director of Public Health for Reading and West Berkshire) and Paul Coe (Executive Director – Adult Social Care), Vicky Phoenix (Principal Policy Officer - Scrutiny), Fiona Worby (Healthwatch West Berkshire), Daphne Barnett (Thames Valley Integrated Care Board), Dr Jane Bywater (Thames Valley Integrated Care Board), Elizabeth Rushton (Thames Valley Integrated Care Board:), Louise Lucio (Sue Ryder), Obiageli Okongwu (Berkshire Healthcare NHS Foundation Trust), Diane Utley (Thames Valley Integrated Care Board), Hannah Western (Sue Ryder) and Zoe Woods (Thames Valley Integrated Care Board)

Apologies for inability to attend the meeting: Councillor Dennis Benneyworth and Councillor Owen Jeffery

PART I

1 Minutes

The Minutes of the meetings held on 10 March 2026 and 14 May 2026 were approved as true and correct records and signed by the Chairman.

A Committee Member raised a matter arising from the 10 March 2026 minutes (Item 7: South Central Ambulance Service update), reporting a recent first-hand account of unacceptable response times for an elderly resident following a fall. It was noted that a complaint had been made to the Council. The Chair stated that further information would be received once the follow-up had been completed

2 Recommendations and Actions Tracker

The Committee noted the progress report on the recommendations and actions tracker. The Chair highlighted that the Children's Mental Health and Emotional Wellbeing Task Group response reports had gone to the Executive on 28 May 2026 (with responses to recommendations to be added to the tracker in due course). The Chair also corrected the recorded receipt date of an ICB response (amended from September 2026 to September 2025). No further comments were raised.

3 Declarations of Interest

There were no declarations of interest received.

4 Petitions

There were no petitions received at the meeting.

5 Palliative Care and Hospice Provision

Zoe Woods (Head of Palliative and End of Life Care (all age), Community Services and Section 117 (Berkshire West), Thames Valley Integrated Care Board (TV ICB)) presented the report on palliative care and hospice provision. The report provided assurance on the current system approach to end-of-life care; described progress to date and continuing areas for improvement; and set out the direction of travel towards a more integrated, community-focused model aligned to people's preferences for place of care and death. It reported West Berkshire deaths (2023) and described the system's expectation that a significant proportion of those approaching end of life would require specialist palliative care. It outlined recent service developments and partnership arrangements across the ICB, Berkshire Healthcare NHS Foundation Trust (BHFT) and Sue Ryder, including commissioning changes and expansions in community provision (including hospice at home), a 24/7 clinical advice line, virtual wards, rapid response, and inpatient bed capacity across local hospice and community hospital settings. It also identified ongoing challenges including coordination, digital infrastructure and consistent access/experience, and linked the work to wider strategic priorities (including a "Dying Well" approach across the Thames Valley).

During the debate the following points were discussed:

- It was raised that the table on page 21 was labelled "Preferred Place of Death" and clarification was sought as it appeared to reflect where people died. Zoe Woods advised the data was sourced from ONS. It was subsequently clarified in discussion that the table on page 3 was actual deaths rather than preferred place of death, and that the meeting should distinguish between preference and actual place of death.
- A question was asked about the reported figure that 56% of people would prefer to die at home, and whether this was a national figure or specific to the local area, as it did not appear to align with the table presented. Dr Jane Bywater explained that people do not always achieve their stated preferences due to service access, illness progression, unexpected events, and that preferences can change over time (often influenced by family support and carers' capacity).
- It was discussed that the key service question was the gap between what people say they want (e.g. dying at home) and what actually happens, and what "added value" the system can deliver. Dr Hannah Western (Palliative Care Consultant, Sue Ryder) noted that data can be difficult to interpret because it depends on when preferences are recorded; a preference expressed by the "well population" may change near end of life as care needs increase, symptoms become complex, or carers struggle. She also noted that changes in preference may reflect constraints in the level and responsiveness of home support, and that service developments aimed to make community provision more responsive across settings.
- Concern was raised about national reporting (a Marie Curie report) describing end of life care as "broken", with significant unmet need and out-of-hours gaps, especially in rural areas. It was also raised that a high proportion of deaths in West Berkshire occur in hospital compared with England, with implications for both patient choice and hospital bed pressures. Zoe Woods confirmed the system was aware of the report and described attendance at a national summit to understand implications. She set out that local work was at the start of a journey to improve integration and to enable more people to die where they wish, including investment in advance care planning via Respect and the Thames Valley Shared Care Record, and a focus on proactive early identification to reduce reactive hospital admissions.
- It was discussed that a national Modern Service Framework for palliative and end of life care was expected in the autumn and would set expectations for ICBs. Zoe Woods stated that the ICB had identified "Dying Well" as a priority, with activity

focused on proactive care, prevention of avoidable hospital admissions, and system-wide engagement.

- It was discussed that cultural and societal factors affect end of life outcomes, including end of life being a taboo subject. Zoe Woods described work with patient participation groups to explore what "dying well" means locally. Dr Jane Bywater (Consultant in Palliative Medicine, ICB Palliative and End of life Clinical Lead, TV ICB) described work in Reading to develop a Dying Well charter and a webinar series, prompted by inappropriate pathway use (people nearing end of life being placed in reablement pathways). She described aspirations for a more "compassionate community" where end of life is talked about more openly, reducing isolation and improving support for families and carers.
- It was raised that families and informal carers often provide a significant share of care at the end of life and may feel neglected and unsupported. Dr Jane Bywater referenced feedback from a focus group held by Newbury Cancer Care where relatives described themselves as part of the care "workforce" and noted the need for improved support for carers.
- A question was asked about training and development for GPs and community nursing staff given their role in identification, referral and ongoing support. Obi Okongwu (Head of Service, Community Nursing and Specialist Services, BHFT) stated that end of life training was essential training for community nursing staff, and that a specialist palliative care nurse supports care homes. She also stated that training was provided alongside the roll-out of digital Respect to support GPs to have conversations and record patient wishes so they can be shared appropriately.
- It was asked whether public debate about assisted dying was affecting patient trust or increasing anxiety and conversations. Zoe Woods stated that the NHS was awaiting Department of Health and Social Care policies and guidance before delivering further training or education on assisted dying. Dr Hannah Westernn stated that in her experience, conversations had not increased recently, despite expectations that they might.
- It was discussed that Sue Ryder had enabled patients to share their views on assisted dying and had "channelled" that voice to ensure patients had the opportunity to contribute to discussions (within the limits of current policy position).
- It was raised that workforce pressures were a national issue, including a stated community nursing turnover rate of 11.3% (reported as in line with NHS turnover) and expected future demand growth. It was welcomed that recruitment and retention were being prioritised. Obi Okongwu stated that work had reduced turnover from previously higher levels and addressed historical recruitment challenges in West Berkshire, including creating development pathways and opportunities (e.g. consultant nurse specialist for community nursing), providing robust induction, and supporting staff to develop specialist interests within a generalist community nursing field.
- It was discussed how the Council could assist with recruitment and awareness of community nursing careers. Obi Okongwu invited Council support through career fairs and outreach in schools, colleges and universities. She noted a misconception that ward experience is required before community nursing, and described the distinct skills needed for community work (including working with patients in their own homes where the patient has greater control and there is less "white coat syndrome").
- It was raised that since the enhanced partnership arrangements and community model changes commenced in January, an update on delivery and impact would be valuable after a full year of implementation. It was suggested this could be brought back to scrutiny around March 2027. Officers and partners indicated agreement in principle.

- It was discussed that some residents regard a care home as their home and may prefer to die there, and that end-of-life choices should reflect that reality (including care home as “ordinary residence” for some people).
- A question was asked about what “hospice at home” entails and whether it is realistic for everyone, including equipment and home adaptation needs. Louise Lucio (Regional Director of Healthcare Operations – Sue Ryder South East, Sue Ryder) explained that the pathway includes community nurse specialist assessment and care planning, access to occupational therapy and physiotherapy, provision of equipment via community equipment services (including delivery, safe set-up and support for carers), and hospice at home provided by senior healthcare assistants (described as a specialist domiciliary care component). She stated the hospice at home service operates 8am-8pm, and overnight support is provided via partnership arrangements with other community services, supported by the 24/7 clinical advice line.
- It was asked whether inpatient hospices were becoming “unfashionable” and how their role fits alongside the shift to home-based care. Zoe Woods stated there is a mix of NHS and independent hospice provision across the wider area, and that Berkshire West includes hospice-related inpatient capacity delivered through NHS providers with specialist hospice elements. Louise Lucio and Dr Hannah Western confirmed that inpatient hospice beds remain an essential part of the pathway for patient choice and for complex symptom control (including complex pain and medication management), and for step-down from hospital to hospice and onward to community where appropriate. They stated that inpatient hospice care is more expensive due to the 24/7 model, but that cost does not determine access where hospice care is clinically appropriate or chosen.
- It was discussed that some younger patients may choose hospice rather than dying at home to avoid the family home becoming the place associated with death, particularly where children are involved.
- A question was asked about the status and need for a proposed 20-bed hospice development in the Sandleford / Newbury area (planning permission previously granted as part of a wider development). Zoe Woods stated the ICB had reviewed the proposal; questioned whether a 20-bed inpatient hospice was needed given existing bed capacity (described as 18 beds across Berkshire West) and the strategic direction towards supporting more people to die at home; and indicated that from the ICB perspective the proposal had been rejected, although she was not able to provide complete confirmation of the current “live” planning/development status beyond that.
- A question was asked about the direction of travel (more people wanting to die at home) and whether capacity would be sufficient. Zoe Woods stated projected need would increase and that the ICB’s “Dying Well” priority includes work on access and capacity across hospice provision, community nursing, primary care, social care, and ambulance services, aligning with wider system planning and recovery priorities.
- It was discussed that dementia prevalence is expected to rise and that dementia end of life care presents particular challenges (including uncertainty about timing and when to initiate end of life planning). Dr Hannah Western stated that specialist palliative symptom needs in dementia are not always the most complex aspect, but overall care needs are complex and multi-provider, requiring strengthened system integration. Dr Jane Bywater stated that work on frailty provides an opportunity to identify people likely to be in the last year of life (advanced frailty), which would capture many people with advanced dementia and enable earlier conversations and planning. Obi Okongwu stated that community teams would support dementia patients as complex cases, using multidisciplinary approaches, and involving family conversations and wider Voluntary, Community and Social Enterprise (VCSE) partner support where needed.

- It was discussed that earlier identification and advance care planning is a priority, particularly to capture wishes while capacity allows. Zoe Woods stated this underpinned investment in Respect as the preferred approach for documenting "what matters" to individuals earlier.
- A question was raised about Sue Ryder funding sustainability, noting that a substantial proportion of funding is raised through charitable sources. Louise Lucio stated that Sue Ryder had entered into a new seven-year contract (with possible extension to ten years) providing greater stability for planning and service development. She stated that approximately 43% of funding is received from the ICB and the remainder is supported through charitable fundraising and other income streams (including retail, fundraisers, sponsorships, grants, and continuing healthcare funding for hospice at home). She also stated that the charity is contributing to national work to influence sustainable funding through the modern service framework, and that service demand was increasing (citing a 2.5% year-on-year increase in the number of Newbury patients requiring specialist care over three years). Zoe Woods stated that the ICB recognised national variation in hospice commissioning and funding and that this remained a commissioning priority as part of the "Dying Well" agenda.
- It was discussed that further scrutiny could include a future item on children and young people's palliative care, and collaborative work to support wider community conversation about end of life and "dying well", including potential Council actions to support such a shift.

Action: Vicky Phoenix to add an item to the committee work programme for partners to return with an update in March 2027.

6 Health in all Policies

Steven Bow (Public Health Consultant, West Berkshire Council) presented the report on the Council's Health and Wellbeing in All Policies (HiAP) approach and programme update, supported by a short slide presentation. The report set out a shared understanding of HiAP as an organisational approach (rather than a discrete service), explained why it was needed, summarised progress in phases one and two (foundations, tools, skills and processes), described the projects funded to date, and outlined phase three priorities focused on embedding HiAP as business-as-usual, strengthening governance and decision-making, and improving measurement of impact and sustainability.

During the debate the following points were discussed:

- It was raised that embedding HiAP required a training and education approach for both officers and elected members, as people can be focussed in their own workstreams and may find it difficult to apply a health lens to routine decisions; Steven Bow confirmed training and workshops had been delivered (including LGA leadership workshops and systems thinking workshops) and that phase three would focus on embedding the approach through organisational change.
- It was raised that planning policy and the built environment are critical levers for health, and that historically it had been difficult to influence the local food environment (e.g., fast food outlets) because of planning constraints; Steven Bow responded that progress had been made by including health and wellbeing requirements in the Local Plan, and that further work was underway to provide clearer guidance to developers and strengthen implementation.
- A question was asked whether a tracker could be provided for HiAP-funded projects, including timelines and how the committee would know whether individual initiatives

are progressing and whether they are successful; Steven Bow stated that tracking projects was an aim for the year and that a performance workstream had been established to balance local ownership of projects with central oversight and reporting.

- It was discussed that measuring public health success was inherently difficult because prevention benefits may not be visible for years and because it is hard to demonstrate "what was prevented". Steven Bow acknowledged the challenge and confirmed phase three included a focus on measuring performance/impact of funded projects and building a stronger approach to evidencing outcomes.
- It was raised that the "health in all policies" approach should not become purely theoretical and needed to translate into tangible benefit for residents; Matt Pearce (Director of Public Health, West Berkshire Council) acknowledged the recurring challenge of "bringing it to life", noted that some impacts were "soft influence" (e.g., health inequalities being actively discussed in decision-making), and stated that further work was needed on an outcomes framework.
- It was raised that the report referenced environmental interventions in homes with damp and mould and that there had previously been issues with outdated measurement equipment compared to private providers; Steven Bow stated the project was led by Environmental Health and he could seek further information on the technology/equipment being procured, as he did not have the detail to hand.
- A question was asked about the new Public Health Planning Liaison Officer post (two-year fixed term): whether the officer would see every planning application, and how applications that may not support healthy, sustainable communities would be escalated to that role—particularly concerns about HMOs and older/converted properties rather than new developments; Steven Bow responded that the current focus is on new developments and reviewing health impact assessments, but that the role also included broader planning policy work and that there was a recognised gap/complexity in influencing existing stock.
- Steven Bow reported collaborative work with the University of Reading to explore what legal and policy levers are available locally to influence planning and health outcomes, reflecting the need to bring planning and public health expertise together.
- Matt Pearce reinforced that Health Impact Assessments (HIAs) were forward-looking by nature, and that retrospective application to existing environments was challenging; he emphasised the importance of understanding available levers, particularly for more deprived wards where limited new build may occur.
- It was raised that climate change was altering housing risks and that overheating (particularly in flats and office-to-residential conversions) should be considered alongside damp and mould; Matt Pearce responded that HIA criteria include factors such as connectivity/active travel, access to green space, garden size, trees, and insulation, and stated that the key was ensuring HIAs were validated rather than treated as a "tick-box" exercise.
- It was discussed that the Council needed to determine the threshold for when developers must submit HIAs, given the workload and volume of developments; Matt Pearce indicated that the threshold question was still under consideration (e.g., whether it should apply from a certain number of homes), noting the potential burden if applied to very small developments.
- It was noted that national planning policy (National Planning Policy Framework) was increasingly moving in the direction of healthier development expectations, including the emerging approach to restricting fast food outlets near schools; Matt Pearce stated that national policy was "starting to catch up" but there is still significant local shaping that can be done.

- A question was asked about how the Low-Income Family Tracker (LIFT) worked and where the data came from; Matt Pearce stated he did not have the full details to hand but described that outcomes data was being produced showing identification of residents eligible for benefits who were not receiving them and subsequent signposting leading to increased uptake, including improved Healthy Start voucher access (noting he did not want to quote figures without certainty).
- A question was asked what "GPAW" refered to (referenced in the report in relation to the remit of the new prevention board); Paul Coe (Executive Director, Adult Social Care and Public Health, West Berkshire Council) explained the Council's four strands of work; Growth , Prevention , Assets , and We Can (culture/organisational attitude and capability for change).
- It was suggested that planning-related thresholds should consider not only the number of dwellings but also the type of development (e.g., HMOs, conversions to flats, properties not designed for residential use), given associated health risks; Matt Pearce agreed there was a need to strengthen the evidence base and understanding to influence decisions and withstand planning inspection challenge.
- A specific local example was discussed where a fast food outlet application was said to be impossible to resist on the basis of distance from schools, despite large numbers of pupils passing the site daily; Matt Pearce responded that public health needed to strengthen evidence to support refusal/conditions and suggested options such as a supplementary planning document on fast food takeaways, noting other areas had developed such approaches.
- It was discussed that while fast food outlet density was not high in West Berkshire compared with national benchmarks, that does not mean localised issues do not exist; Matt Pearce also noted national interest in other environmental harms such as gambling outlet concentration.
- A question was asked about the status of "HiAP champions" and whether members should be more aware; Matt Pearce stated the champions approach was still in development, with scoping underway for a short training programme at service director level to build shared understanding, improve access to and use of data, and identify relevant service pipeline projects, with the ambition to cascade throughout the organisation over time.
- It was discussed that current HiAP-funded projects appeared to focus on underserved/needier communities, and it was asked whether there was scope for broader prevention initiatives that benefit the whole population, including:
    - working with schools on citizenship education/resilience so young people better understand systems, rights and how to seek help, thereby improving confidence and long-term wellbeing; and
    - improving children's access to and confidence in using the local countryside (e.g., orienteering and mapping skills) to encourage physical activity and nature access; and
    - making access to leisure centres more affordable for people on benefits and increasing youth access.
- Matt Pearce responded that schools delivered PSHE (personal, social, health and education) and that there may be a role for public health to support it further; he explained that the previous HiAP project list arose from a council-wide call for proposals aligned to public health outcomes, and similar calls could be repeated; he suggested potential partnership with Get Berkshire Active and referenced existing walking programmes and partner organisations (e.g., ramblers). He also stated that leisure services were exploring increased access for younger people and that concessionary rates for those on benefits likely exist, but he would need to confirm details.

- It was noted that some secondary schools delivered GCSE Citizenship Studies and that the Council has hosted Year 10 citizenship groups in the council chamber (with more planned), demonstrating existing links with schools and civic education.
- The committee noted the recommendations in the report: to note current status and proposed phase 3 priorities, to provide comments/advice on oversight and development, and to request further information if needed to assure effective embedding and sustainability of the HiAP approach.

Action: Steven Bow to seek and provide further information on whether the damp and mould project includes investment in up-to-date measurement equipment/technology.

Action: Public Health bring back a report once they have developed improved oversight of HiAP-funded projects and an outcomes/impact framework so performance can be monitored and reported back.

7 All Age Complex and Continuing Care

Daphne Barnett (Interim Head of Neuro Transformation and Complex Cases, Thames Valley Integrated Care Board (TV ICB)) presented the report on all-age continuing care and complex care. The presentation set out: the establishment of the new Thames Valley ICB (from 1 April 2026) and its governance arrangements across “places”; work to improve joint working between health and social care (including disputes processes and joint reviews); policy alignment across the new ICB footprint (including further work on a draft healthcare contribution policy); performance and activity data for Continuing Healthcare (CHC) and Fast Track CHC; and key priorities for future delivery including a more centralised operational model, improved consistency and timeliness, and performance reporting to NHS England.

During the debate the following points were discussed:

- It was discussed that the data being presented had only recently become available at the requested granularity; a caveat was raised by Daphne Barnett that reliability was still improving due to system merging and inconsistent historic recording, and that a new process was being introduced to ensure consistent recording going forward.
- It was raised by Paul Coe (Executive Director, Adult Social Care and Public Health, West Berkshire Council) that the committee valued receiving local authority-level data and noted that ICB colleagues had done extra work to provide this. It was suggested that embedding this granularity into routine reporting would be beneficial going forward.
- It was discussed that commentary within the slides about proportionality across Buckinghamshire, Oxfordshire, Berkshire West and the newly-added East Berkshire needed careful interpretation; It was noted that some comparisons were expressed “per 50,000 population” and that would slightly challenge the proportionality point as expressed.
- It was discussed that, on formation of the new larger Thames Valley ICB, CHC was understood to be an area “protected” within the new organisation, giving some confidence about continuity and focus.
- It was discussed that quarter-to-quarter data could fluctuate; Paul Coe advised that, for scrutiny purposes, a longer time period (e.g., a full year / four quarters) would provide a more reliable sense of trend and direction of travel than isolated quarterly snapshots.
- A question was asked about the clarity and internal consistency of the data visualisations and narrative on “slide 3” (standard CHC referrals per 50,000 and eligibility metrics). It was raised that:

    - The narrative referred to specific figures (e.g., 13.6, 16.75, and 9.7 rising to 12.8) that were difficult to reconcile with the charts shown.
    - Some lines/bars appeared not to clearly correspond to the narrative values, making it hard to interpret without confusion.
    - It was suggested that the presentation might be improved by showing data over a longer run (e.g., four quarters), with clearer "before/after" comparisons and/or clearer depiction of means/trends, rather than complex multi-line charts that were hard to map to stated figures.
- Daphne Barnett responded that she had noted the feedback and would take it back to the data team who produce the figures and slides, with the intention of improving representation and clarity next time. It was also offered that a councillor was willing to make themselves available to discuss the reporting/visualisation issues with the ICB data team.
- It was raised that a labelling error appeared on "slide 6" where the title referred to "West Berkshire AACCC" but the data were for "Berkshire West"; the point was made that the slide title should reflect "Berkshire West" rather than "West Berkshire".
- A question was asked about the conversion rate figure stated in the narrative (21.8% described as the national average / higher end), noting that West Berkshire's figures shown (2 eligible out of 19) equated to approximately 10.5%, which appeared materially below the national conversion rate. A response was provided by Liz Rushton (Head of Delivery, Neighbourhood Teams / All-Age Continuing Care, Thames Valley ICB) that:
    - CHC reporting to NHS England was done at "Berkshire West" (place/area) level rather than by individual local authority, so the conversion rate quoted related to Berkshire West across West Berkshire, Reading and Wokingham combined.
    - If calculated only for West Berkshire as a local authority area, the conversion rate would indeed be lower, but this was not how performance is routinely reported nationally.
- A further question was asked specifically why West Berkshire's local-authority-specific conversion rate might be much lower even if Berkshire West overall aligns with the national range. In response, Liz Rushton discussed possible contributing factors, including:
    - Differences in local care home markets (e.g., areas with more nursing and dementia care homes may see different assessment profiles and volumes).
    - The impact of placements and GP registration: responsibility for CHC assessment is driven by GP registration. If individuals are placed out of area and become registered with GPs across borders (e.g., Wiltshire/Hampshire), they may be assessed by other areas and would not appear in Berkshire West figures, potentially affecting local-authority-level counts.
    - It was noted in the exchange that these factors may explain differences in volumes coming into the assessment process; the questioner indicated that while that might explain lower numbers of assessments, it did not fully explain why the proportion found eligible was lower.
- It was discussed that West Berkshire repeatedly appeared "at the bottom" of columns in the data tables (e.g., West Berkshire 2 eligible vs Reading 6 vs Wokingham 13), and that it was not clear whether this was solely a function of population size or reflected other systemic factors. It was suggested that the committee may need a clearer "bigger picture" view to interpret whether West Berkshire is improving relative to others.
- Paul Coe reiterated that:
    - This was an area the committee should continue to monitor regularly.

    - Berkshire West has historically (over a long period) shown disparity in CHC eligibility decisions compared with other areas; it had not always been clear whether that disparity was warranted or unwarranted.
    - Centralising processes should, in principle, help reduce unwarranted variation and improve equity of experience for residents.
    - More granular local authority data, combined with a longer time series, will help scrutiny assess whether the situation is improving, worsening, or static.
- A question was asked requesting that future data be normalised by population size (e.g., rates per 100,000), so comparisons can be made "like for like" rather than relying on absolute numbers that may simply reflect differing population sizes. Daphne Barnett confirmed that this could be done for future reporting.
- It was discussed that CHC can feel opaque to residents and potentially even to some professionals; a question was asked about what happened to individuals when CHC was refused (i.e., where the checklist/assessment result was negative / ineligible). Paul Coe responded that:
    - If an individual was not eligible for NHS-funded CHC, responsibility was likely to fall to the local authority to organise care, and the individual may then be financially assessed and charged according to their resources.
- It was noted that Fast Track CHC related to people who needed end-of-life care (raised by the Chair in clarifying the purpose/intent of the Fast Track route).
- It was discussed that, while the update was useful, the committee wanted improved comparability and interpretability in future, including (as themes across the questions):
    - Longer trend reporting (e.g., annual/four-quarter views) rather than single-quarter snapshots.
    - Clearer visuals and consistent narrative-statistic alignment.
    - Population-normalised rates to support direct comparison.

Action: Thames Valley ICB to work with its data team to resolve the issues raised about CHC charts/narrative alignment and provide clearer, population-normalised and longer-run (e.g., four-quarter) trend reporting, and to arrange a meeting with Councillor Paul Kander to discuss the data presentation and interpretation issues. To return to the committee in December 2026 with the improved dataset and updated reporting format.

8 Adult Social Care Strategy Consultation

Paul Coe (Executive Director, Adult Social Care and Public Health, West Berkshire Council) presented the report on the draft Adult Social Care Strategy consultation. He explained that the strategy was in draft form and had been published for consultation, with active engagement under way to gather views before finalising. He outlined that officers had been engaging adult social care staff, partner agencies (including health partners and other statutory services), the independent provider market, and representative forums including the Learning Disability Partnership Board and carers' groups. The consultation closing date was confirmed as 22 June 2026. It was stated that feedback was ideally submitted via the formal online consultation route to support collation, although comments made in the meeting would be noted.

The following points were discussed:

- It was raised that the strategy included an easy read option, and a question was asked how people with learning disabilities and others who need accessible formats were being supported to provide feedback, particularly if responses were expected to be submitted online; it was explained that the Learning Disability Partnership Board had received a presentation (delivered by the strategy lead, Melanie O'Rourke), an

easy read version was available, and printed copies had also been circulated so engagement was not solely dependent on online access.

- It was discussed that some service users may not be able to respond directly even with accessible formats, and a question was asked whether the council would place weight on feedback provided by representatives; Paul Coe stated that the council intended to gather views through valid proxies, including family members and informal carers (as "experts" in the lived experience of their loved ones), advocacy organisations and voluntary sector partners, and that such representative input was considered legitimate and important.
- It was raised that one of the "areas to improve" in the draft strategy was to increase uptake of direct payments, and a question was asked why West Berkshire was at around 12% when the England average was more than double, and whether this reflected a lack of trust in residents; Paul Coe responded that it was not a trust issue, but an area where the council had tried repeatedly to increase uptake without successfully shifting the position.
- It was discussed what direct payments were intended to achieve and why people might not choose them; Paul Coe explained that direct payments provide people with funding to arrange their own care rather than having the council arrange provision, aiming to increase autonomy and flexibility, but there were practical trade-offs that may deter uptake.
- It was discussed that council processes could influence direct payment take-up, and it was raised that the current process may be too "sticky" or complicated; Paul Coe stated that this was likely a contributing factor and that the council had a small specialist direct payments team, while social workers and care management teams were expected to make the initial offer, and the council had been working to shift resources so the specialist team could engage faster when someone expressed interest.
- It was discussed that direct payments can result in different costs and administrative burdens, and it was raised that people may decide council-commissioned care is preferable; Paul Coe stated that individuals arranging care via direct payments may face higher costs than local authority block purchasing, and individuals may also face administrative responsibilities (for example National Insurance, holiday arrangements and cover), which can make the decision a genuine "toss-up" between flexibility and added administration.
- A question was asked about the draft strategy's reablement outcome metric and whether West Berkshire's reported figure (62.8%) compared with England (77.1%) meant that reablement outcomes were poorer; Paul Coe explained that the reablement service experience and satisfaction were described as exceptionally good, but the metric referred specifically to the proportion of people who required no ongoing care after reablement ended, and West Berkshire achieved this less frequently.
- It was discussed why the reablement metric might be lower in West Berkshire; Paul Coe stated that a possible reason was that the service may be more optimistic and inclusive in attempting reablement, taking cases forward where independence without care was uncertain, whereas other areas might decide earlier that someone is not suitable for reablement, and that the council needed to find a balance between optimism and realism.
- A question was asked whether, once the strategy was implemented, it would be more widely publicised to residents, given reports that people do not understand adult social care criteria, assessments and funding arrangements; Paul Coe agreed that explaining what adult social care is, what it is for, and how to access it is an ongoing

challenge, and stated that communications would continue and the strategy itself was intended to help provide clarity.

- It was discussed that effective communication about adult social care requires multiple routes and that people may not see or read some channels, and it was raised that professionals who come into contact with residents (such as GPs and community nurses) need to understand what support is available and how to signpost.
- A question was asked about the meaning of adopting a “waiting well” approach for anyone awaiting assessment; Paul Coe explained that this was intended to make waiting more manageable through proactive communication, information and practical tools, including providing clearer information about likely timescales so people could plan.
- It was discussed what safeguards applied while people were waiting for assessment and how changes in need would be identified; Paul Coe stated that the council triages all contacts and responds quickly to those at greatest risk, that people waiting were judged lower risk at the point of triage, but that ongoing communication was important because circumstances can change.
- It was raised that workforce status, recruitment and retention in adult social care remain important, and it was discussed that care roles are skilled and should be promoted as such to attract staff; it was noted that the strategy included reference to a skilled workforce and that ongoing promotion of care as a valued profession was important.
- It was discussed that committee members were encouraged to respond directly to the consultation; Paul Coe stated that the preferred approach was to submit feedback via the formal online consultation route to enable coherent collation, while noting that comments made in the meeting would be taken away and recorded.

9 Healthwatch Update

Fiona Worby (Lead Officer, Healthwatch West Berkshire) presented the report on Healthwatch West Berkshire’s current activities. She explained Healthwatch’s statutory role in relation to health and social care and how it gathered and represented the public voice through outreach, visits and events. She also reported that the team was preparing its statutory annual report (due by 30 June) and outlined key ongoing and planned projects (patient transport experiences; experiences of young people after turning 18; and women’s health), along with emerging themes from resident contacts (including access, communication, and public understanding of adult social care). She additionally updated the committee on the national proposal to abolish Healthwatch and the lack of formal communication received from Government on that issue.

The following points were discussed:

- It was advised that Healthwatch was facing a proposed abolition progressing through Parliament (reported as being in the House of Lords, with a second reading occurring that week), and it was noted that Healthwatch had received no direct update from Government and was learning developments at the same time as the public; Fiona Worby advised that, if the abolition proceeded, implementation would likely take time and she anticipated Healthwatch could remain in place until around mid-2027 due to the legislative process and Parliamentary timings.
- It was raised that the committee and wider scrutiny structures had significant concerns about the proposal to abolish Healthwatch, particularly regarding the loss of an independent voice for service users; the Chair stated that concerns had been raised at the Joint Health Overview and Scrutiny Committee and that senior health leaders had been present to hear those concerns.

- A point was made challenging the Government's stated rationale for abolition (that fewer organisations would create a clearer path for feedback), and it was argued that removing Healthwatch would reduce, rather than improve, routes for people to share views.
- Fiona Worby reported that she had supported a mapping exercise requested by MP Lee Dillon's team because they were receiving high volumes of constituent contacts and were uncertain where to signpost people; Healthwatch identified more than 157 pathways for feedback in health and social care in West Berkshire (including some national routes) and fed this back to the ICB, suggesting that streamlining may be needed.
- It was noted that Healthwatch's statutory powers to hold services to account were important, though Fiona Worby indicated she did not consider formal escalation was often necessary because issues could frequently be progressed through constructive discussion; she reiterated that the key concern was the removal of an independent public voice if Healthwatch were abolished.
- Fiona Worby outlined a live project on patient transport following receipt of multiple resident contacts; it was discussed that dissemination was challenging, so Healthwatch had used its website and social media, asked partners (including carers' networks) to share the survey, and planned press coverage in the Newbury Weekly News to reach residents who are not online.
- In relation to patient transport, it was discussed that feedback included both positive and negative experiences; concerns reported by residents included missed collections and/or non-attendance for booked transport, patients being taken to appointments but not collected for the return journey, and people having to pay for taxis home; Fiona Worby also reported concerns about kindness and consideration in some interactions; she stated the survey would remain open for a further couple of weeks and Healthwatch would then determine next steps.
- It was discussed that Healthwatch was developing a project on the experience of young people after turning 18 (including those transitioning out of Children and Young Peoples Mental Health Services (CAMHS)) where families reported young people struggling with adulthood, including social withdrawal, not going out, not working, and remaining isolated at home. Fiona Worby stated the project would consider experiences of both young people and those supporting them (including parent carers and professionals) and that it would launch shortly, having been developed carefully over time.
- It was discussed that women's health remained a priority concern for Healthwatch and that West Berkshire had no women's health hub (in contrast to Oxfordshire and Buckinghamshire). Fiona Worby reported that earlier NHS funding and intended developments had not progressed as expected, that a draft strategy required further work, and that the women's health strategy was understood to be on hold. She confirmed she would request an update from the Thames Valley ICB. The Chair confirmed that the committee would scrutinise women's health at its September meeting, and it was noted that patient transport was already included on the forward work programme for a future meeting.
- Fiona Worby reported emerging themes from resident contacts, and it was discussed that recurring issues include access to services (especially where multiple organisations are involved), the need for clearer communication and information about pathways and available support, and recurring questions about adult social care—particularly public understanding of eligibility, assessment processes, and funding arrangements.

- It was discussed that engaging with diverse communities remained challenging, with some groups reluctant to come forward; Fiona Worby stated Healthwatch would continue proactive outreach and engagement while it remains in place.
- It was noted that the council's adult social care strategy consultation was ongoing and that issues raised by Healthwatch—particularly around understanding adult social care and how decisions were made—were relevant; it was discussed that residents approaching Healthwatch should be encouraged to also feed views into the formal consultation process so that feedback is captured in a structured way.

10 Health and Adult Social Care Scrutiny Committee Work Programme

The Chair (Cllr Martha Vickers) introduced the draft work programme for 2026/27 and reminded members that proposals for scrutiny items are submitted through a prioritisation tool and then considered by the Chair and Vice-Chair ahead of the next meeting. She noted that the September agenda was already full (including women's health strategy, carers strategy and the Better Care Fund), and that women's health had been delayed from the current meeting due to timing of reports.

It was discussed that the committee should consider scheduling a future update on the new integrated palliative care and hospice provision model, once the partnership arrangements have had time to embed; Cllr Stevenson suggested March 2027 as an appropriate point for an update (after approximately a year of operation), and the Chair indicated this could potentially be strengthened by also including an update on children and young people's palliative care.

It was discussed that there was now a meeting end time extension to 4:30pm, which may provide slightly more capacity to accommodate additional agenda items, though the forward plan is already busy.

Cllr Stewart proposed that the committee should consider scrutiny of the vaccination programme, prompted by recent local concerns about meningitis and wider issues relating to immunisation uptake (including the observation that second-dose uptake can be lower than first-dose uptake, e.g., measles); the Chair advised the suggestion should be put through the prioritisation tool to assess how and when it could be scheduled.

Action: Vicky Phoenix to put the proposed scrutiny item on the vaccination programme (including meningitis and wider immunisation uptake issues) through the committee's prioritisation tool for scheduling consideration.

(The meeting commenced at 1.30 pm and closed at 4.18 pm)

CHAIRMAN …….

Date of Signature …….