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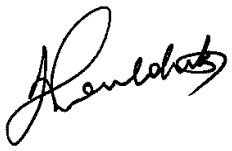
WOKINGHAM
BOROUGH COUNCIL

A Meeting of the **HEALTH AND WELLBEING BOARD** will be held at the Civic Offices, Shute End, Wokingham RG40 1BN on **THURSDAY 11 FEBRUARY 2016** AT **5.00 PM**



Andy Couldrick
Chief Executive
Published on 3 February 2016

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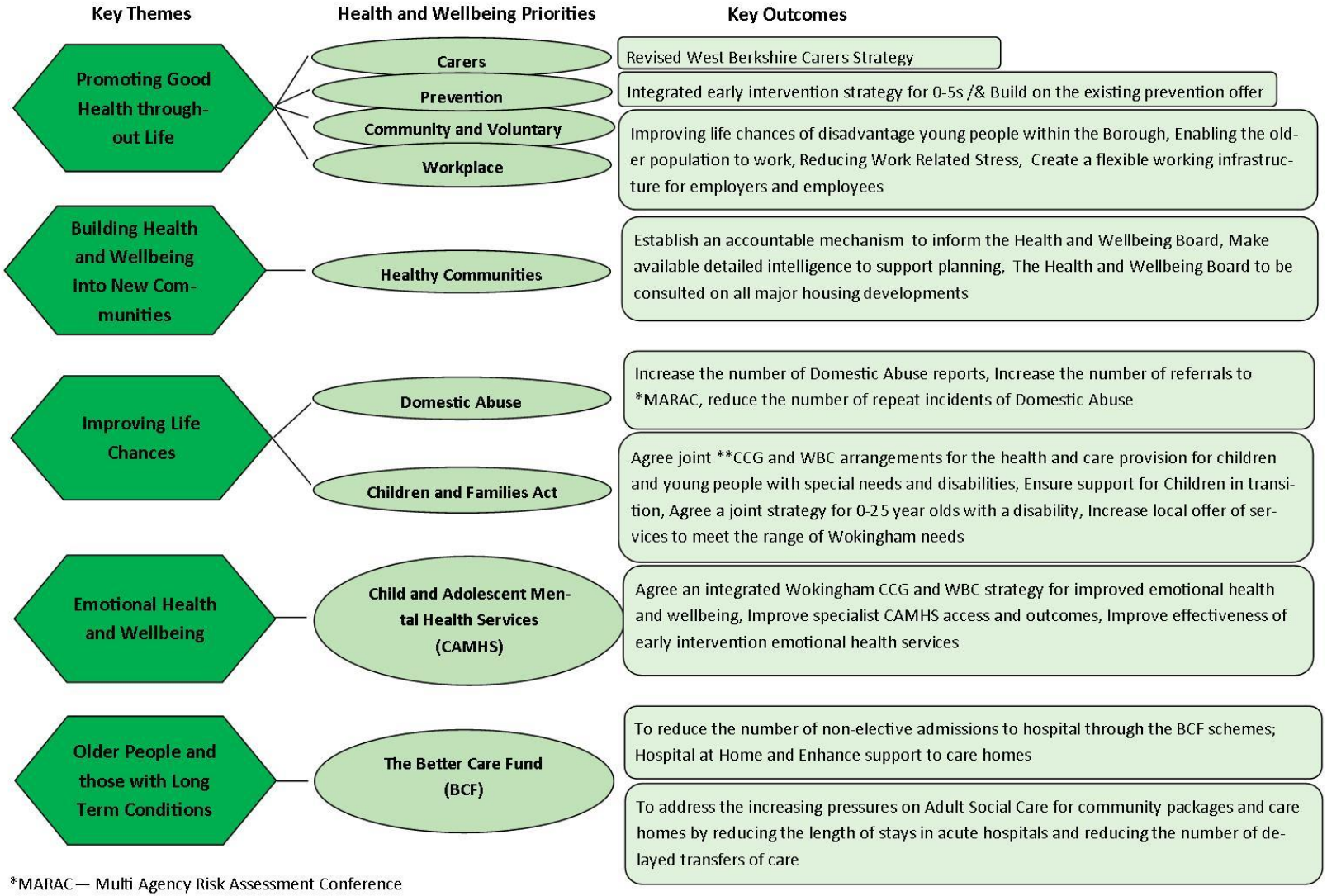
Wokingham's Health and Wellbeing Strategy 2014-2017



*MARAC— Multi Agency Risk Assessment Conference

**CCG and WBC—Clinical Commissioning Groups and Wokingham Borough Council

MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

Julian McGhee-Sumner	WBC
Dr Johan Zylstra	NHS Wokingham CCG
Keith Baker	WBC
Prue Bray	WBC
Charlotte Haitham Taylor	WBC
Superintendent Rob France	Community Safety Partnership
Beverley Graves	Business Skills and Enterprise Partnership
Dr Lise Llewellyn	Director of Public Health
Lois Lere	NHS Wokingham CCG
Nikki Luffingham	NHS England
Judith Ramsden	Director of Children's Services
Stuart Rowbotham	Director of Health and Wellbeing
Nick Campbell-White	Healthwatch
Katie Summers	NHS Wokingham CCG
Dr Cathy Winfield	NHS Wokingham CCG
Kevin Ward	Place and Community Partnership Representative
Clare Rebbeck	Voluntary Sector representative

ITEM NO.	WARD	SUBJECT	PAGE NO.
75.		**APOLOGIES** To receive any apologies for absence	
76.		**MINUTES OF PREVIOUS MEETING** To confirm the Minutes of the Meeting held on 10 December 2015.	**7 - 14**
77.		**DECLARATION OF INTEREST** To receive any declarations of interest	
78.		**PUBLIC QUESTION TIME** To answer any public questions A period of 30 minutes will be allowed for members of the public to ask questions submitted under notice. The Council welcomes questions from members of the public about the work of this Board. Subject to meeting certain timescales, questions can relate to general issues concerned with the work of the Board or an item which is on the Agenda for this meeting. For full details of the procedure for submitting questions please contact the Democratic Services Section on the numbers given below or go to www.wokingham.gov.uk/publicquestions	

79.		**MEMBER QUESTION TIME** To answer any member questions	
80.		**HEALTH AND WELLBEING**	
81.	None Specific	**JOINT STRATEGIC NEEDS ASSESSMENT** To consider the Joint Strategic Needs Assessment. *(10 mins)*	**15 - 18**
82.	None Specific	**DRAFT PUBLIC HEALTH ANNUAL REPORT** To receive the Draft Public Health Annual Report. *(15 mins)*	**19 - 44**
83.		**PERFORMANCE**	
84.	None Specific	**PERFORMANCE METRICS** To receive updates on performance against the following: • Better Care Fund; • Public Health Outcomes Framework, NHS and Adult Social Care; • Health & Wellbeing Strategy 2014-17. Please note that this will be by exception only. *(15 mins)*	**45 - 46**
85.		**ORGANISATION AND GOVERNANCE**	
86.	None Specific	**URGENT & EMERGENCY CARE REVIEW - PROGRESS REPORT** To receive a progress report on the Urgent and Emergency Care Review. *(15 mins)*	**47 - 56**
87.	None Specific	**BERKSHIRE WEST PRIMARY CARE STRATEGY** To discuss the Berkshire West Primary Care Strategy. *(15 mins)*	**57 - 102**
88.	None Specific	**HEALTH AND WELLBEING BOARD SUB-COMMITTEE - PRIMARY CARE** To receive a report regarding the dissolution of the Health and Wellbeing Board Sub Committee. *(10 mins)*	**103 - 110**
89.	None Specific	**CHILDREN'S SAFEGUARDING OFSTED REPORT AND THE LOCAL SAFEGUARDING CHILDREN'S BOARD OFSTED REPORT** To discuss the Children's Safeguarding Ofsted report and the Local Safeguarding Children's Board Ofsted report. *(15 mins)*	**Verbal Report**

90.	None Specific	**UPDATE FROM BOARD MEMBERS** To receive updates on the work of the following Health and Wellbeing Board members: • Business, Skills and Enterprise Partnership • Community Safety Partnership • Place and Community Partnership • Voluntary Sector *(15 mins)*	**Verbal Report**
91.	None Specific	**FORWARD PROGRAMME** To consider the Board's forward programme for the remainder of the municipal year. *(5 mins)*	**111 - 114**

Any other items which the Chairman decides are urgent
A Supplementary Agenda will be issued by the Chief Executive if there are any other items to consider under this heading

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MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 10 DECEMBER 2015 FROM 5.00 PM TO 6.50 PM

Present

Julian McGhee-Sumner	WBC
Dr Johan Zylstra	NHS Wokingham CCG
Prue Bray	WBC
Charlotte Haitham Taylor	WBC
Superintendent Rob France	Community Safety Partnership
Beverley Graves	Business Skills and Enterprise Partnership
Dr Lise Llewellyn	Director of Public Health
Judith Ramsden	Director of Children's Services
Stuart Rowbotham	Director of Health and Wellbeing
Dr Cathy Winfield	NHS Wokingham CCG
Clare Rebbeck	Voluntary Sector representative
Hilary Turner	NHS England

Also Present:

Madeleine Shopland	Principal Democratic Services Officer
Darrell Gale	Consultant in Public Health
Sally Murray	Head of Children's Commissioning Wokingham CCG
Louise Noble	Interim Head of Service, Berkshire CAMHS
Mark Sellman	Programme Manager, NHS Central Southern Commissioning Support Unit

55. APOLOGIES

Apologies for absence were submitted from Nikki Luffingham, Nick Campbell-White, Helen Power, Jim Stockley, Katie Summers and Kevin Ward.

56. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Committee held on 8 October 2015 were confirmed as a correct record and signed by the Chairman.

57. DECLARATION OF INTEREST

There were no declarations of interest made.

58. PUBLIC QUESTION TIME

There were no public questions.

59. MEMBER QUESTION TIME

There were no Member questions.

60. ORGANISATION AND GOVERNANCE

61. CAMHS TRANSFORMATION PLANS-IMPLEMENTING "FUTURE IN MIND" ACROSS BERKSHIRE WEST CCGS AND WOKINGHAM BOROUGH COUNCIL AND WOKINGHAM CCG EMOTIONAL HEALTH AND WELLBEING STRATEGY ACTION PLAN

The Board considered the CAMHs Transformation Plans-Implementing "Future in Mind" across Berkshire West CCGs and Wokingham Borough Council and Wokingham CCG Emotional Health and Wellbeing Strategy Action Plan.

During the discussion of this item the following points were made:

- The Board was reminded that there was a requirement for system wide transformation over 5 years with plans signed off by Health and Wellbeing Boards before additional recurrent funding was released to the CCGs. The Transformation Plan had been submitted to the regional team and had received assurance.
- Funding for the Eating Disorders work had already been released to the CCGs.
- 30 WTE were being recruited to the current specialist CAMH service across Berkshire. These would be a mixture of highly skilled and junior staff to meet the identified skill mix needs. 21.4 WTE new staff had been recruited so far, not all of whom were in post yet.
- New staff were beginning to take caseloads and a reduction was starting to be seen in wait times for the Common Point of Entry and the ADHD pathway. Councillor McGhee-Sumner questioned when the public would start to see a difference. Louise Noble advised that the time taken to see a first contact was already reducing and that those who had waited the longest were being allocated to new staff. It was likely that a difference would be seen in the new financial year.
- Sally Murray commented that substantial work had been carried out regarding risk mitigation and young people on the wait lists. Support packages were arranged around some of those young people most at risk to reduce the likelihood of A&E attendance and the length of stay in A&E should they end up there and also to reduce those going into Tier 4 (in patient).
- In Berkshire West there had been a 25% reduction in young people attending A&E due to self-harm. The number of young people in Tier 4 had also reduced overall from 30 to 21.
- Next year the University of Reading would be undertaking research to build evidence bases for the management of conduct disorder in children. Wokingham schools and families would be asked to participate.
- In response to a question from Dr Llewellyn regarding the longest waiter for the Common Point of Entry, Louise Noble explained that some young people in the Common Point of Entry were waiting beyond 42 days but that they were in contact with the service.
- The Board discussed Tier 2 resources. Funds had been released and volunteer organisations would be able to make bids for funding. Clare Rebbeck commented that the outcome framework had been published a week prior to the deadline for bids to be submitted which had been challenging for the voluntary sector.
- Clare Rebbeck went on to state that a meeting had been held recently with 18 organisations to discuss support available for parents and guardians.

RESOLVED: That the CAMHs Transformation Plans-Implementing "Future in Mind" across Berkshire West CCGs and Wokingham Borough Council and Wokingham CCG Emotional Health and Wellbeing Strategy Action Plan be noted.

62. WEST OF BERKSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT

The Service Manager, Adult Safeguarding and the Director of Health and Wellbeing took the Board through the West of Berkshire Safeguarding Adults Board Annual Report.

During the discussion of this item the following points were made:

- With the introduction of the Care Act 2014, the Safeguarding Adults Board was now based on a legal framework.
- The Service Manager, Adult Safeguarding highlighted Wokingham's contribution to the Safeguarding Adults Board goals. This included:
    - Care Act training had been delivered to adult social care front line staff, providers and forums, including information about the Board and its statutory responsibilities.
    - The prevention worker in conjunction with the Chartered Trading Standards Institute had developed a toolkit for Trading Standards to aid understanding of Adult Safeguarding and provide examples of good practice.
    - A mandatory safeguarding e-learning module for staff had been developed.
    - The Wokingham Forum had continued, its profile had been raised and it now had 60 members.
    - Quality Assurance framework and audit programmes had been implemented to meet the requirements of the Care Act and Making Safeguarding Personal. Performance information was reported quarterly to management teams.
    - Awareness of the Safeguarding Adults Board was being raised.
    - The promotion of the Safer Places Scheme. There had been a drop in the number of participating premises with the closure of several businesses. Further venues would be identified next year.
    - Good outcomes had been achieved by the 'Choice Champions' project.
    - Members of Wokingham's CLASP (Caring Listening and Supporting Partnership) had supported the production of 'easy read' formats for awareness raising publicity material.
    - The findings of two Safeguarding Adults Reviews had been delivered by Wokingham.
- During 2014-15 there were 868 safeguarding alerts of which 499 were referred. 61% of referrals started in the year were for females and 39% were for males. In 2014-15, 71% of referrals were from people aged 65 years or over, an increase from the previous year where 62% of referrals were from the 65+ age group.
- Neglect and physical abuse were the most common types of alleged abuse. Reports of financial abuse were lower than the national average.
- It was noted that care homes were the second highest location of alleged abuse.
- Councillor Bray questioned why Wokingham had a greater number of requests for Deprivation of Liberty Safeguards (DoLS) and a higher proportion of requests authorised, than either Reading or West Berkshire. The Director of Health and Wellbeing commented that Wokingham had a greater number of care homes than its neighbouring authorities. A lot of work regarding safeguarding had been carried out with the care homes, the CQC and partnership organisations and reporting rates were good. In addition assessment timescales were being met.
- With regards to alleged cases of sexual abuse, Rob France questioned how many of the cases had become criminal cases and was informed that it was hopefully all cases.

- Board members discussed how awareness of the Safeguarding Adults Board could be further raised. The Director of Health and Wellbeing suggested that the shape of the Safeguarding Adults Board be discussed at a future meeting.

RESOLVED: That the West of Berkshire Safeguarding Adult Board Annual Report be noted.

63. PERFORMANCE

64. PERFORMANCE METRICS

The Board considered the Performance Metrics.

During the discussion of this item the following points were made:

- The Board discussed non-elective admissions. It was suggested that further context, such as whether performance was good or otherwise, would be helpful. Hilary Turner asked whether an analysis of the ages of those attending A&E was available. Dr Zylstra commented that the under 3's and over 70's were the biggest attending age groups.
- Dr Winfield advised that it was unlikely that the Q3 A&E target would be achieved and that there needed to be a step up in moving those on the medically fit lists.

RESOLVED: That the Performance Metrics update be noted.

65. ADULT SOCIAL CARE OUTCOMES FRAMEWORK

The Director of Health and Wellbeing presented the Adult Social Care Outcomes Framework.

During the discussion of this item the following points were made:

- The Adult Social Care Outcomes Framework was published annually and overall Wokingham had performed well.
- Wokingham was performing above the national average for 8 indicators and slightly below or on the national average for 9 indicators.
- Wokingham was performing slightly below average with regards to the perception carers have of the services that they received.
- Board members requested benchmarking information from Wokingham's statistical neighbours in future.

RESOLVED: That the Adult Social Care Outcomes Framework be noted.

66. INTEGRATION

67. CONNECT CARE PROGRAMME

Mark Sellman, Programme Manager NHS Central Southern Commissioning Support Unit, updated the Board on the Connected Care Programme.

During the discussion of this item the following points were made:

- Mark Sellman explained that Connected Care was person held health and social care records for Berkshire residents. This would be across commissioners and health and social care providers so that the individual held and managed their care

and gave consent to providers of care to view their record based on an agreed data set.

- The Connected Care Programme would enable the flow of data between two or more organisations for the benefit of co-ordinating service provision across care pathways, thereby improving patient care.
- Mark Sellman outlined some of the benefits of the programme including giving staff more time with the patient, better decision making, reduced administration and job satisfaction. Citizens would have better engagement with the care process and a better care experience. Time efficiency savings would also be made.
- Board members were assured that only those involved in the individual's care process would be able to access the records and they would have access only to areas of the record appropriate to their role.
- A phased approach was being taken to the roll out. Since Summer 2014 the primary care provider had been sharing agreed data with Westcall. Recently Phase 2, a proof of concept portal, had been implemented. Phase 3 would be the implementation of the full portal solution for the Berkshire Partnership community, including the local authorities and the Ambulance Trust. Procurement was underway and it was anticipated that a preferred provider would be selected by January and the contract signed by March.
- Councillor Haitham Taylor asked whether it would be a statutory requirement for partners to make their data available and was informed that it was not but it was important for the success of the programme.
- Dr Winfield emphasised that it was important that the Board were kept updated on the project milestones as it was a key enabler to integration.
- Clare Rebbeck questioned whether Community Hospitals and Pharmacies would be included in the Connected Care programme and was informed that Pharmacies were not included.
- Dr Llewellyn asked whether enough had been done to publicise the programme. Clare Rebbeck commented that information could be included as part of the Community Awareness event being held in June. Dr Winfield indicated that many people at Call to Action events had assumed that records were already shared.
- It was emphasised that staff would also need to be kept informed of project milestones.

RESOLVED: That the presentation on the Connected Care Programme be noted.

68. BETTER CARE FUND QUARTERLY RETURN

The Board considered the Better Care Fund Quarterly Return to Department of Health Quarter 2 2015.

During the discussion of this item the following points were made:

- Steady progress was being made against the Better Care Fund programmes.
- Councillor Bray asked about central guidance for 2016/17. It was anticipated that guidance would be released on 18 December. Hilary Turner commented that following the Q1 returns NHS England had asked localities for information on what support they required. She informed the Board that a self-assessment framework was available.

RESOLVED: That the content of Wokingham's Better Care Fund quarterly return to the Department of Health (DoH) for Quarter 2 of 2015 be noted.

69. SECTION 75 FINANCE UPDATE

This item was deferred to the Board's meeting on 11 February 2015.

70. UPDATE FROM HEALTH AND WELLBEING BOARD MEMBERS

Updates were provided by several Board Members.

Business, Skills and Enterprise Partnership:

Beverley Graves updated the Board on progress against the following objectives within the Health and Wellbeing Strategy; 1d) *Improving the life chances and wellbeing of disadvantaged young people (Not in Employment Education or Training (NEET), aged 16-25 years) in the borough* and 1e) *'Enabling the older working population to work in fulfilling, productive employment for longer - Including volunteering.'* Elevate Wokingham had indicated that between April-October 2015 67 had accessed advice and 9 apprenticeships had started. The target for NEETs was 3.2%. In October the level of NEETs had been 2.3%. The Board was informed that 11 people had attended a workshop on career information aimed at over 50s. Elevate had seen 49 new clients who were over 50.

Beverley Graves went on to comment that a Thames Valley Local Enterprise Partnership report on skills and skills shortage had highlighted a skills shortage in the care industry. The Director of Health and Wellbeing commented that a pilot project regarding key worker housing was under consideration.

Community Safety Partnership:

Partnership working was strong locally. In response to a question Councillor Bray, Rob France indicated that there would be an anti-drink driving campaign over the Christmas period.

RESOLVED: That the updates from the Health and Wellbeing Board members be noted.

71. PROPOSED S106 FOR WOKINGHAM MEDICAL CENTRE

The Board received a report regarding a proposed S106 payment for Wokingham Medical Centre.

The support for increased infrastructure provision in primary healthcare through the release of capital funding from Section 106 and Community Infrastructure Levy contributions was one mechanism that the Council could use to ensure existing and new residents had access to the high quality primary healthcare provision that met their needs.

RESOLVED: That the Board agrees to recommend that the Executive approves the capital payment of £150,000 to Wokingham Medical Centre as specified in this report.

72. FORWARD PROGRAMME

The Board considered the Forward Programme for the remainder of the municipal year.

- Judith Ramsden suggested that the Children's Safeguarding Ofsted report and the Local Safeguarding Children's Board Ofsted report be requested for the Board's February meeting.
- Councillor Bray requested an update on Public Health funding at the Board's February meeting.

- Dr Winfield indicated that the Wokingham CCG Co-Commissioning Delegation and Primary Care Strategy would be taken to the February meeting.
- It was requested that the new Better Care Fund Plan and CCG Operating Plan be presented at the Board's meeting in April.
- Clare Rebbeck asked that the Voluntary Sector be included under on the list of Board Members providing updates in future.

RESOLVED: That the Forward Programme be noted.

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TITLE	**Joint Strategic Needs Assessment (JSNA)**
FOR CONSIDERATION BY	Health and Wellbeing Board on 11 February 2016
WARD	None Specific
DIRECTOR	Stuart Rowbotham, Director of Health and Wellbeing

OUTCOME / BENEFITS TO THE COMMUNITY

A comprehensive, user friendly and "live" assessment of the Borough's health, care and wellbeing needs is essential for effective and efficient commissioning of services, not just by Wokingham Borough Council (WBC) itself but also our Clinical Commissioning Group (CCG) colleagues and the wide range of partners and stakeholders in all sectors.

Ensuring priority is given to commissioning services that meet need; are evidence-based and offer good value will be crucial to improving and maintaining the good health of the Borough's population, whilst taking into account our changing demographic.

The Joint Strategic Needs Assessment (JSNA) seeks to be a user friendly product for professionals and the community to use and make informed decisions that tells the 'One Truth' for Wokingham Borough.

RECOMMENDATION

That the Health and Wellbeing Board:

1) endorse the new JSNA and the microsite, specifically the navigation, content and structural design;

2) support the finalisation of the content upload and chapter synthesis;

3) support the launch of the JSNA in March 2016 through social media, newsletters etc.

SUMMARY OF REPORT

The JSNA microsite is nearing completion, chapters are in the process of being uploaded and the remaining chapters are waiting to be written. The Health and Wellbeing board is asked endorse the new JSNA microsite. All functional aspects of the JSNA microsite are set and cannot be changed. Very minor changes can be made to the cosmetic aspects of the site however, these may require further resources.

The Health and Wellbeing Board is asked to support the publication of the new JSNA microsite in the Borough News.

Background
The JSNA situated on the Wokingham Borough Council website was viewed as outdated and difficult to navigate and understand. Following this feedback and the need to update the content on the website it was decided to create a new microsite to host the JSNA data and content. This gave the Council the opportunity to create a JSNA that was up-to-date and one that put the user at the centre of the design.

Following consultation across the council, a focus group focused on usability with Health and Wellbeing Leadership team and studying data relating to the use of the JSNA the new microsite, found at jsna.wokigham.gov.uk was created.

The new microsite has improved navigation and usability. Whilst the microsite has allowed some freedom of design it has been restricted by the use of corporate colours and the corporate content management system. The navigation, content and usability of the microsite have been optimised to its fullest potential. The overall design of the site is a time consuming process however there is some flexibility with regards to colours and minor cosmetic changes, specifically there is some potential to changes some colours providing they fall within the corporate guidelines. There is also scope to make adjustments to the facia on the home page.

Content has been created and is being uploaded currently. Once all content has been created and uploaded the priorities will be presented in the summary section of the microsite. It will be made clear that the priorities highlighted are not to the detriment of the other data and issues identified in the JSNA, however that the priorities have been highlighted as the greatest opportunities to make a difference at this moment in time.

Work has also begun on the continuing update schedule for the JSNA to ensure that it stays up-to-date and Wokingham Borough Council employees are able to work the chapter updates into their workload.

The public release date for the JSNA is scheduled in March 2016. This is will be achieved through the Borough News article that is framed as a quiz ‘How well do you know your Borough’. This will be supported by social media promotion and talks are currently being had with partners on how they can support the launch.

Analysis of Issues

The speed in which the first iteration of the JSNA can be completed depends on the capabilities of the officers writing the remaining chapters.
The JSNA microsite is able to be tweaked and any additional user experience improvements or arising issues can be addressed on an ongoing basis.

FINANCIAL IMPLICATIONS OF THE RECOMMENDATION
The Council faces severe financial challenges over the coming years as a result of the austerity measures implemented by the Government and subsequent reductions to public sector funding. It is estimated that Wokingham Borough Council will be required to make budget reductions in excess of £20m over the next three years and all Executive decisions should be made in this context.

	How much will it Cost/ (Save)	Is there sufficient funding – if not quantify the Shortfall	Revenue or Capital?

Current Financial Year (Year 1)	Set up Staff Time	n/a	n/a
Next Financial Year (Year 2)	Maintenance Staff Time	n/a	n/a
Following Financial Year (Year 3)	Maintenance Staff Time	n/a	n/a

Other financial information relevant to the Recommendation/Decision
n/a

Cross-Council Implications
The JSNA has the potential to effect major change in the way the Council undertakes commissioning and discharges its legal responsibilities for health and wellbeing. It has the potential to enable all departments to contribute to working as “One Council” to deliver its vision and priorities for all our residents.

Reasons for considering the report in Part 2
n/a

List of Background Papers
JSNA – Wokingham Borough Council Website JSNA Microsite

Contact Darrell Gale	**Service** Public Health
Telephone No 0118 908 8195	**Email** darrell.gale@wokingham.gov.uk
Date 25/01/2016	**Version No.** 1

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Draft
Public Health
Annual Report
Wokingham Borough Council

Dr Lise Llewellyn

Strategic Director of Public Health

Public Health Services across Berkshire

Why children?

The Public Health role of local government is to improve the life expectancy of its residents and reduce health inequalities.

Across Berkshire, Wokingham, West Berkshire, Bracknell Forest and Windsor and Maidenhead have high levels of affluence and in line with this affluence have good life expectancy. Whereas Reading and Slough are less affluent and see more premature deaths (deaths before the age of 75 years).

Additionally within each LA we can see that life expectancy varies according to the affluence of the ward – 4.8 years for men and 5.6 years for women within Wokingham.

Throughout the 20th century, infant mortality rates in England and Wales have steadily declined, largely due to 'improved living conditions, diet and sanitation, birth control, advances in medical science and the availability of healthcare'.[1] The reduction in infant mortality has been cited as the single greatest factor contributing to increased life expectancy over the past 100 years.

In his key report on health inequalities, Professor Marmot identified six policy priorities that would have an impact on reducing health inequalities in England. Two of these priorities focused on children:

"Give every child the best start in life"

and

"Enable all children, young people and adults to maximise their capabilities and have control over their lives" [2]

The report clearly shows that disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities therefore must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.

For this reason, giving every child the best start in life is the highest priority recommendation given in the report to address inequalities.

This Annual Report presents some of examples across England and Berkshire of how health and other experiences of our children varies according to where they live. It also summarises some of the reasons for this pattern, and touches on other circumstances that alter the outcomes for children.

This year the commissioning responsibility of health visiting services has transferred into local government and this is an additional opportunity to support better outcomes for our children through fully integrating health and other early help services to support families and children.

I hope this report shows the importance of addressing children's health in relation to the public health duties in local government, and illustrates that whilst all families need support at some time, services should recognise that specific children and families need greater support. The evidence shows that if we give this support early we can make major improvements to the life chances of these families.

Infant Mortality

One of the most obvious measures of inequality is the rate of deaths in childhood. The level of childhood mortality can also be seen as a major indicator of the nation's heath as a whole. On a personal level, the death of a child is also probably the most difficult time in any family.

Death in childhood is measured in a number of ways.

Still births *- children born after 24 weeks gestation where the child showed no signs of life*

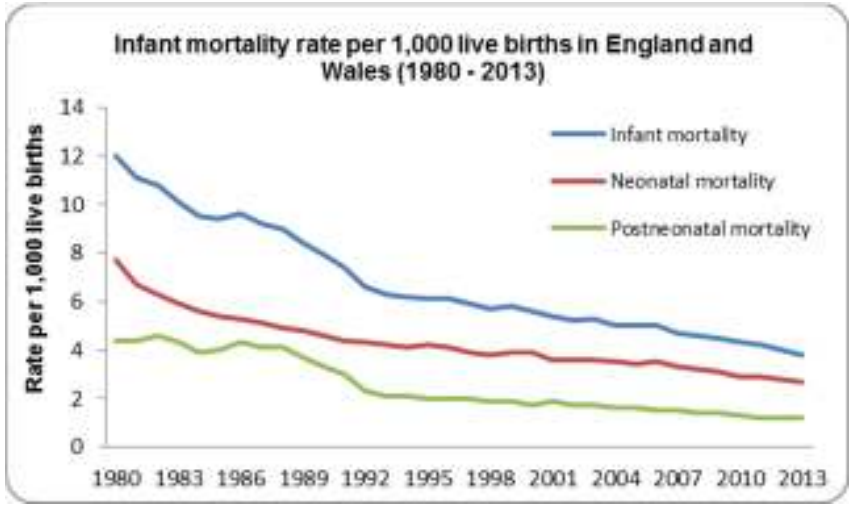
Neonatal mortality - *deaths before age of 28 days per 1,000 live births*

Infant mortality - *deaths between birth and one year per 1,000 live births*

Child mortality - *deaths before age of 5 years*

Infant mortality in England and Wales has decreased over the last 20 years.

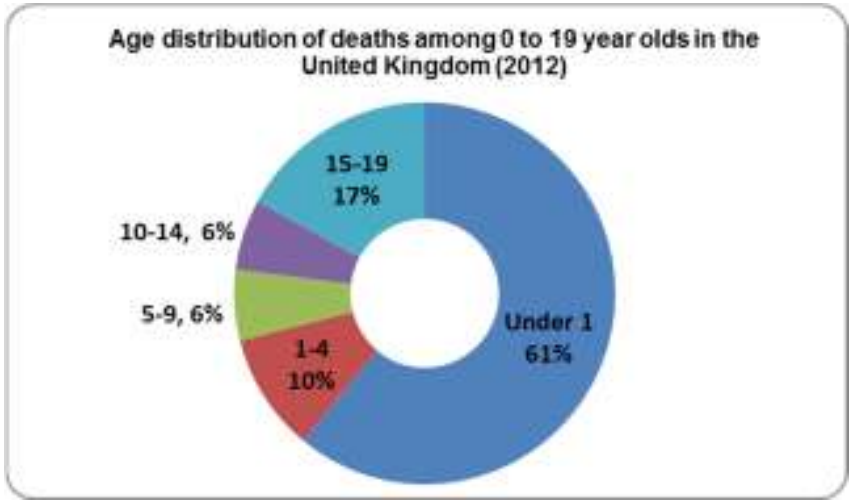
In 1980, there were 12.0 deaths per 1,000 live births and in 2013 there were 3.8 deaths per 1,000 live births. This was the lowest level recorded in England and Wales .[3]

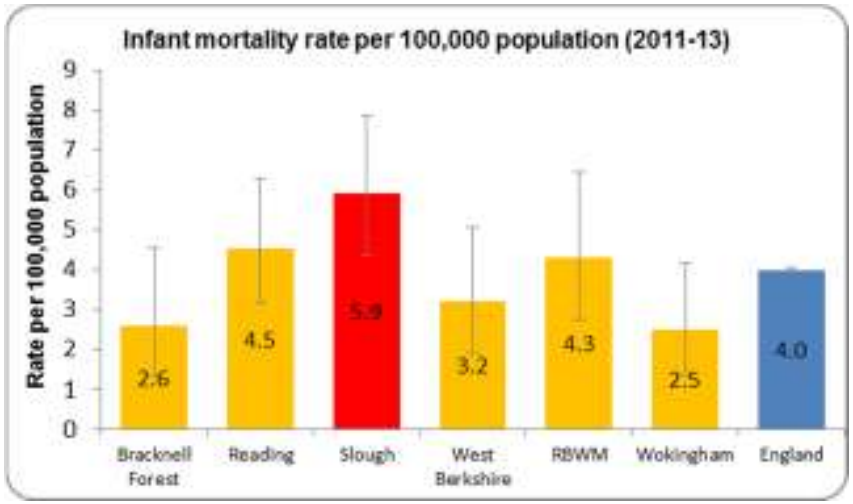


In contrast, 20 years ago mortality in the UK for under 19 years compared favourably with the rest of Europe. However, now we have one of the highest rates. If we compare ourselves against Sweden then **every day 5 extra children under the age of 14 die in the UK.** [4, 5]

Additionally there is considerable variation across the regions in the UK with deaths between the ages of 1 to 17 having a three fold variation (7 to 23 deaths per 100,000 population), similarly infant mortality (2.2 to 8 per 1,000 live births) and perinatal mortality (4.2 – 12.2 per 1,000 live births).[5]

Most childhood deaths in England occur under 1 year of age, with the next highest rate being between 15-19 years. [5]





Causes of childhood deaths

Child death overview panels (CDOPs) are responsible for reviewing information on all unexpected child deaths.[6] They record preventable child deaths and make recommendations to ensure that similar deaths are prevented in the future. Within Berkshire there is a CDOP that reviews cases across he county and reports into each Local Safeguarding Board.

CDOPs main functions are to collect and review details of children's deaths to identify :

- any matters of concern affecting the safety and welfare of children in the area of the authority
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death

Within Wokingham the main causes of children's deaths in 2015 were chromosomal, genetic and congenital anomalies perinatal and neonatal.

In older age groups accidents and injuries becoming increasingly important as causes of deaths and disability. Within this group road traffic accidents account for over a third of all incidents.

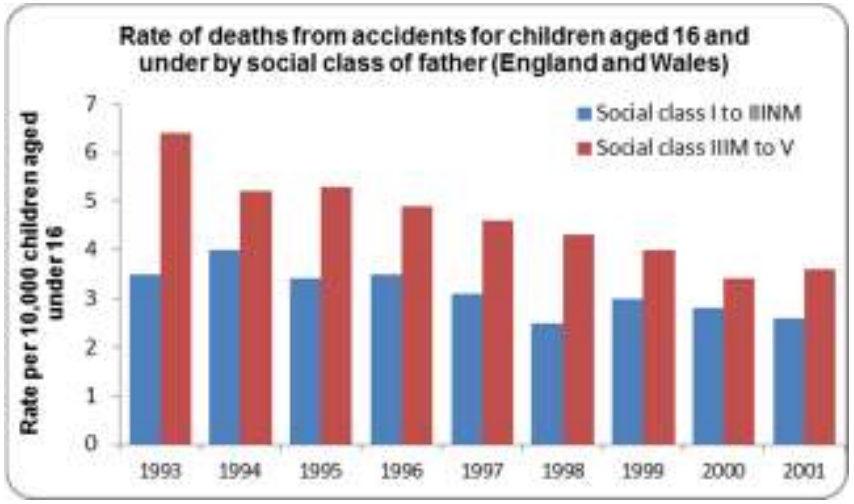
In 2011-13, 75 children were killed or seriously injured in road traffic accidents in Berkshire. The rate in England was 19 per 100,000 children (aged under 16). Wokingham and RBWM's rates were significantly lower than England's, while the other Berkshire LAs were similar to the national rate.

Childhood mortality

All children are exposed to injury as part of their everyday lives, but the burden is not evenly spread. Injuries disproportionately affect some children more than others.

Patterns of injuries vary by age, gender and also socio-economic class. The latter is complex, but key factors underpinning this relationship include :

- Lack of money (ability to buy safety equipment)
- Exposure to hazardous environments inside and outside the home (facilities for safe play; smoking parents; older wiring; lack of garden; small, cramped accommodation)
- Ability of parents/carers to supervise children (single parent families; parents' maturity, awareness and experience; depression and family illness; large family size)
- Children's attitudes and behaviour (risk taking)[7]



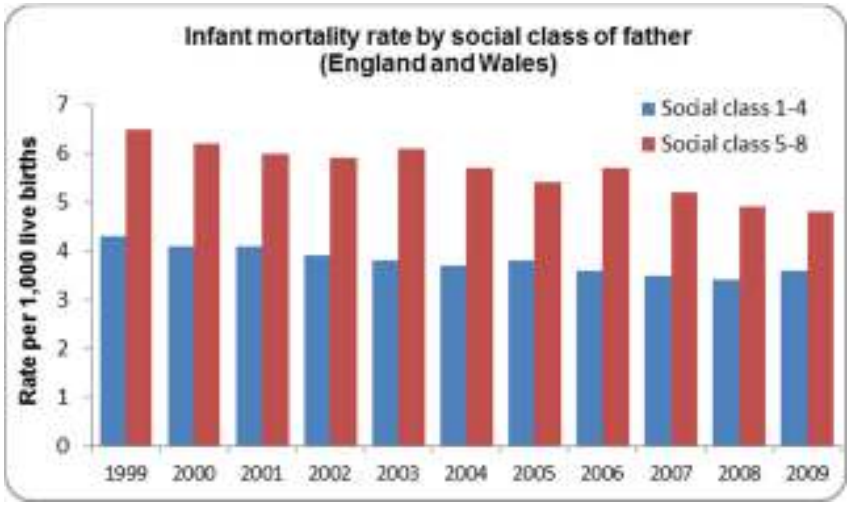
Deaths from accidents and injuries are reducing, but at rates comparable to European countries that already have lower childhood mortality. This does not, therefore, explain our worsening relative position in childhood death rates within Europe.

The key areas where the UK rates appear to be relatively high are infant deaths and deaths among children and young people who have chronic conditions.[8] The rate of improvement is relatively low in these key areas.

Wider influences

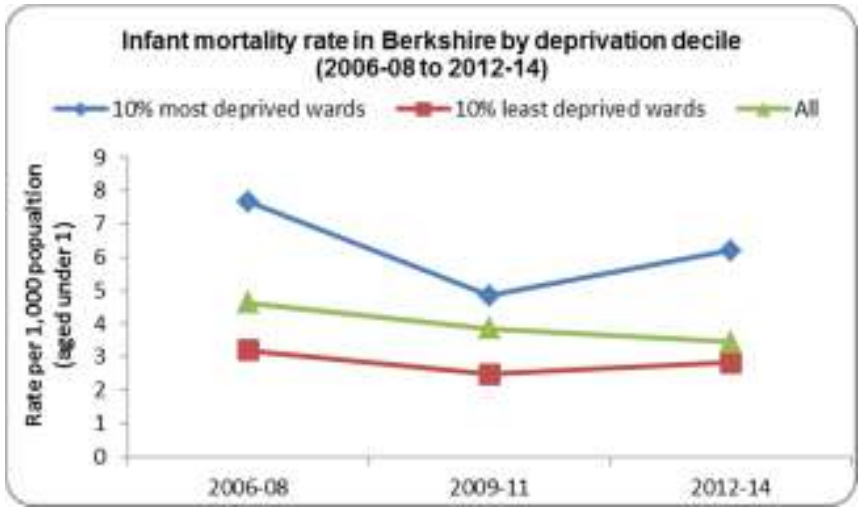
The link between deprivation and death rates are seen in infant deaths.

Infant mortality rates are highest for routine and manual occupations in England and Wales. In 2013, there were 5.4 deaths per 1,000 live births for these occupations, compared to 2.2 deaths per 1,000 live births for higher managerial, administrative and professional occupations and 3.2 deaths per 1,000 live births for intermediate occupations. [9]



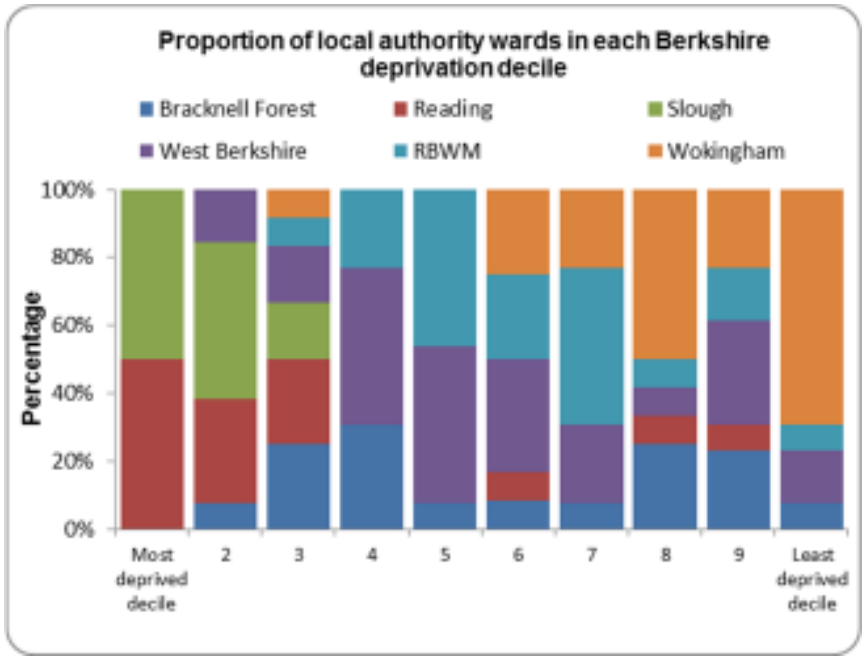
When the improvement in infant mortality is reviewed by ward, it is possible to see that wards that were relatively less deprived experienced a greater reduction in infant mortality rates compared to the national rates in England and Wales [1, 8].

Likewise when one looks at infant mortality across Berkshire, the differences in infant mortality according to deprivation can be seen.



Wokingham is one of the most affluent areas in the country and we would therefore expect infant mortality to be lower than the England average. This is the case, as in 2011-13 there were 2.5 infant deaths per 1,000 live births compared to the England average of 4.0 per 1,000 live births.

In 2014, 6.6% (2,000) of our children in Wokingham lived in poverty (defined as 'children living in families in receipt of out of work benefits or tax credits where their reported income was <60% median income').[10] 13% of children (4,600) lived in the 10% most deprived wards in the Borough.



The UK's higher infant mortality rates are partly explained by the high numbers - nearly two thirds - of deaths that occur before a child's first birthday that were born preterm and/or with low birth weight. UK rates of low birth weight and preterm births are higher than some other European countries, including the Nordic countries.

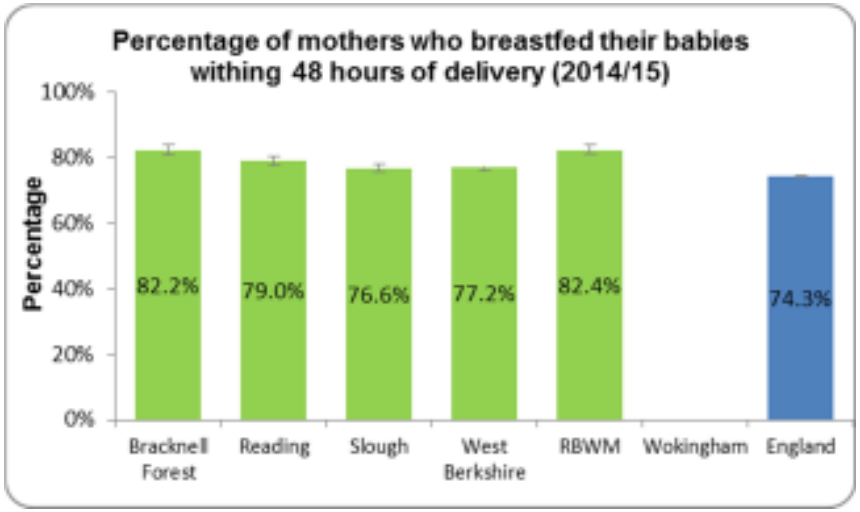
Rates of low birth weight are higher in less advantaged socio-economic groups[11] and are particularly linked to a number of negative health behaviours such as poor prenatal care, substance abuse, poor nutrition during pregnancy and smoking which are more common in these groups. [7]

Breastfeeding

Studies have shown that babies who are breastfed have a 21% lower risk of death in their first year, compared with babies never breastfed. The reduction in risk rises to 38% if babies are breastfed for 3 months or more.[12]

There is a clear association between reduced rates of breastfeeding and deprivation. The Infant Feeding Survey (2012) reported that in 2010 the prevalence of breastfeeding at all ages of babies up to nine months was highest among the highest Socio-Economic Classification group, whilst the incidence of breastfeeding decreased as deprivation levels increased. [13]

In 2014/15, 74.3% of women giving birth initiated breastfeeding within the first 48 hours after delivery in England.[10] Bracknell Forest, Reading, Slough, West Berkshire and RBWM all had significantly higher levels of breastfeeding initiation. Data for Wokingham was not been published for data quality reasons.



Other inequalities

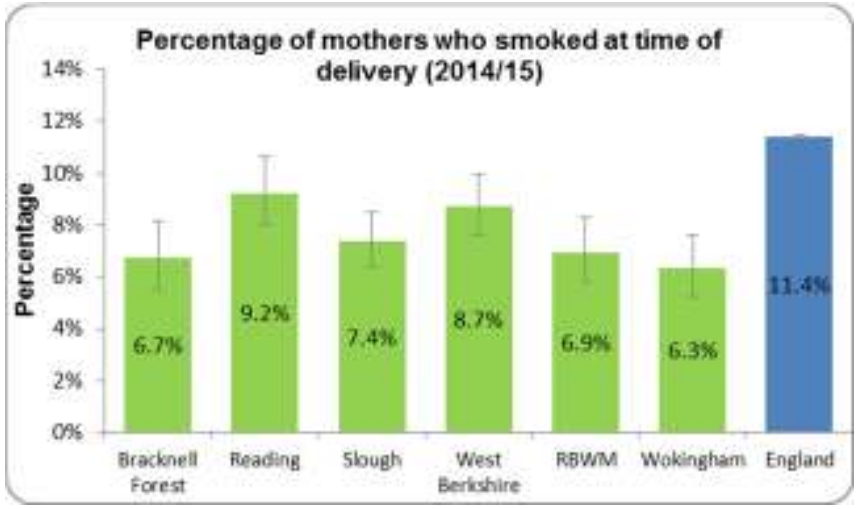
Smoking

Smoking reduces the amount of oxygen available to the foetus during pregnancy and increases the risk of low birth weight, a key risk for infant mortality.[14] It has been shown that for first pregnancies smoking 20 cigarettes a day leads to a 56% increase in risk of infant death. [15]

In the USA it was estimated that if all pregnant women stopped smoking, the number of foetal and infant deaths would be reduced by approximately 10%.

Smoking also has implications for the long term physical growth and intellectual development of a child. In 1999 the World Health Organisation concluded, *"Parental smoking is associated with learning difficulties, behavioural problems and language impairment in children".* Studies consistently report that high social class is linked to low smoking rates before pregnancy and high rates of smoking cessation during pregnancy. [14]

In 2014/15, 11.4% of mothers in England were smokers at the time of delivery. All of the Berkshire local authorities had a significantly lower level of smokers, from 6.3% in Wokingham to 9.2% in Reading. [10]



Obesity

Maternal obesity is a significant risk to both the mothers' health and that of the child.

The Confidential Enquiry in maternal and Child Health CEMACH report for the period 2003-2005 identified the risks of maternal obesity to the child as:

- stillbirth
- neonatal death
- congenital anomalies
- prematurity [16]

National statistics for the prevalence of maternal obesity are not collected routinely in the UK. A national audit of extreme obesity during pregnancy between March 2007 and August 2008 identified that nearly one in every thousand women giving birth in the UK had a body mass index (BMI) of at least 50kg/m2 or weighs more than 140kg, whilst a later audit showed that 5% of women had a BMI of over 35 or weighed at least 100kg (a higher threshold than usually used for obesity). 2% had BMIs of over 40, which is morbidly obese. [17]

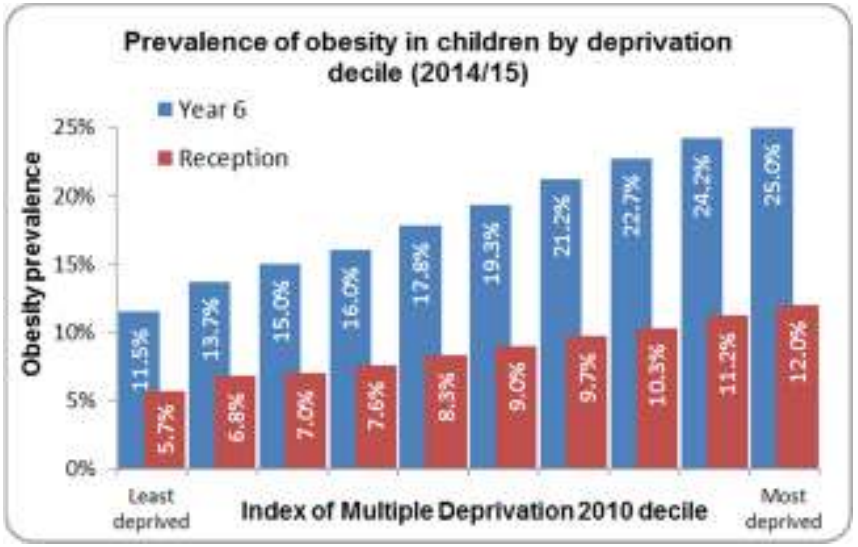
UK studies within the last five years have shown an increase in the prevalence of obesity amongst pregnant women presenting to hospital for booking. [17]

The impact of obesity on infant mortality and pregnancy complications is short term, but the impacts continue through the life of the child. There is a significant relationship between maternal obesity, large birth weight babies and the subsequent development of childhood and subsequent adult obesity.

A systematic review of the childhood predictors of adult obesity showed that maternal obesity and weight gain during pregnancy are related to higher BMI in childhood and subsequent obesity in adulthood. Children who are obese are more likely to have parents who are obese. [17]

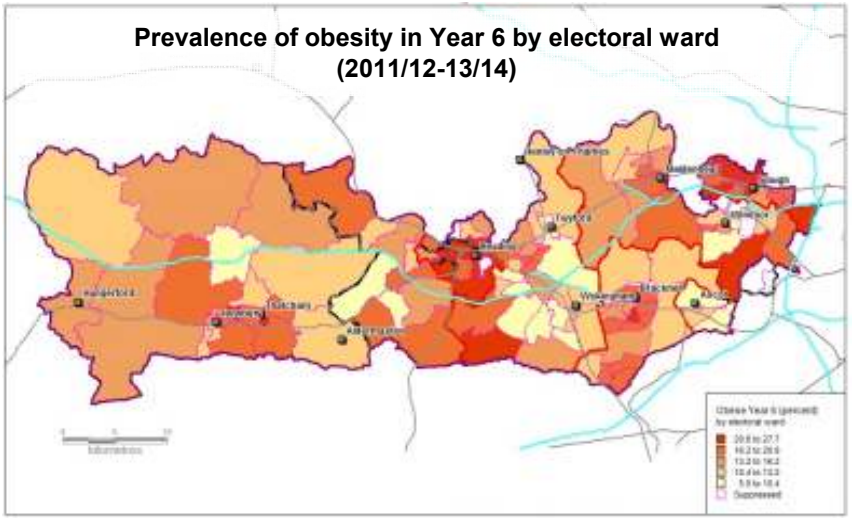
We have tried to describe in this report a 'social gradient' in health – that is a pattern in outcomes that show how outcomes get worse as the level of deprivation increases, such as infant mortality.

Sadly in the UK, socioeconomic inequalities have increased since the 1960s and this has led to wider inequalities in both child and adult obesity, with rates increasing most among those from poorer backgrounds. This worsening of health inequalities in relation to obesity is more marked for women. This pattern is repeated in children, with the socioeconomic inequalities in obesity being stronger in girls than boys. [18]

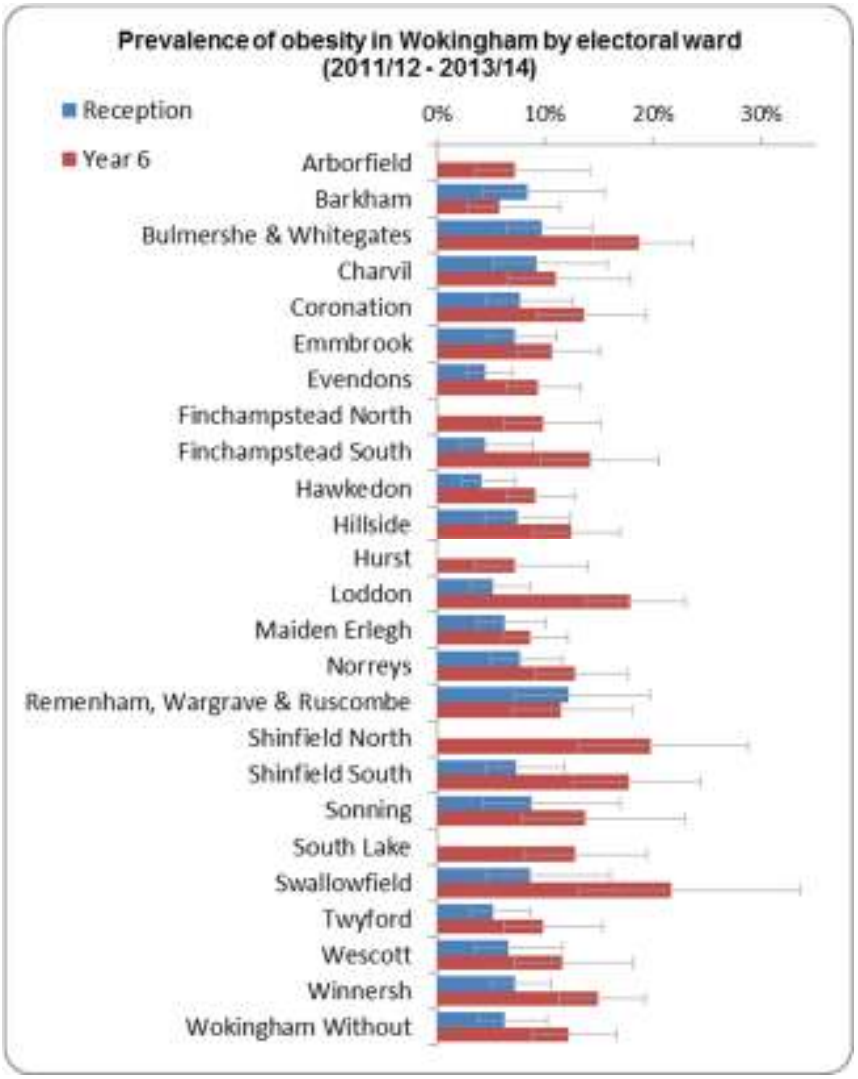


The well described national picture that children in deprived areas are more obese is also mirrored in Berkshire. The more affluent local authority areas have lower levels of obesity in Berkshire, as shown in the table and map below. [18]

Prevalence of childhood obesity in Berkshire based on National Child Measurement Programme (2014/15)			
	Local Authority	**Reception**	**Year 6**
Most deprived ↑	Slough	10.0%	24.5%
	Reading	10.0%	19.8%
	West Berkshire	7.2%	14.9%
	Bracknell Forest	7.2%	14.6%
	RBWM	5.6%	16.6%
Least deprived ↓	Wokingham	6.7%	13.8%



Locally within Wokingham the pattern is shown across the wards and, as can be seen, the rate of obesity almost doubles between reception and year 6. [18]



Obese children are more likely to have long terms health and other issues, such as being absent from school due to illness, experience health-related limitations and require more medical care than children of a normal weight. [19]

Type 2 diabetes - Usually an adult illness, children as young as 7 are now being diagnosed with Type 2 diabetes in the UK. 95% of children diagnosed are overweight and 83% are obese. The rate of increase is higher in children from minority ethnic groups.

Asthma - a recent study has quantified that overweight and obese children are at a 40-50% increased risk of asthma compared to children of a normal weight.

Cardiovascular (CVD) - In the Netherlands, 62% of severely obese children aged under 12 years old have one or more CVD risk factors. Whilst in the USA, childhood obesity is associated with a quadrupled risk of adult hypertension.

Obesity not only increases cardiovascular risk in adulthood, but it is also associated with cardiovascular damage during childhood.

Mental Health - Strong evidence to suggest that by adolescence, there is increased risk of low self-regard and impaired quality of life .

Education and health

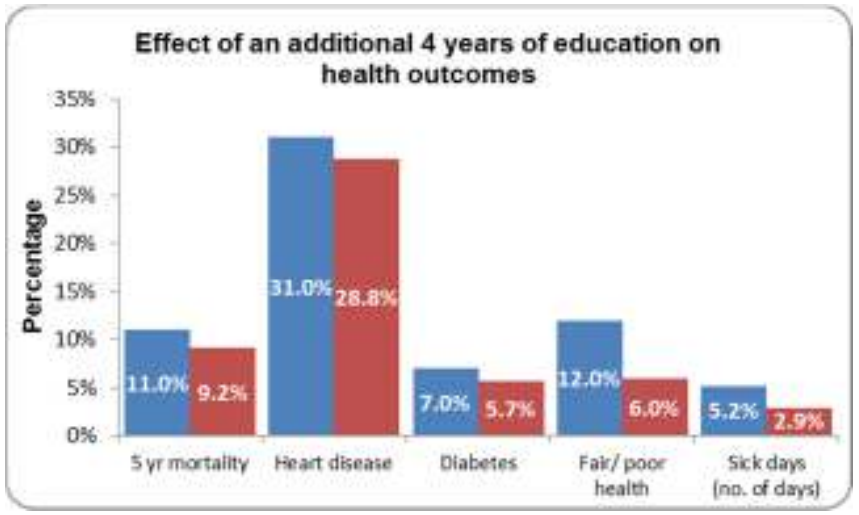
The relationship between health and education is complex. It is widely evidenced that in general those with higher educational attainment earn higher salaries. This may be the basis of the government policy which encourages more children to go to university as a route to promote economic growth.

Educational attainment is the most important of the factors examined in explaining poverty in both the UK and other EU countries studied. In the UK, those with a low level of educational attainment are almost five times as likely to be in poverty now as those with a high level of education. [20]

However, the effect of education is not simply an increase in income. The association between education and health remains substantial and significant even after controls for income, job characteristics and family background are taken into account. The relationships of health and differences in valuing the future, access to health information, general cognitive skills, individual characteristics, rank in society, and social networks have also been tested. No single factor explains the relationship seen between education and improved health, however undoubtedly education has the potential to substantially improve health.

International and UK evidence shows that education is strongly linked to better health . Those with more years of schooling tend to have better health and well-being and healthier behaviours. [21]

A substantial body of international evidence clearly shows that those with lower levels of education are more likely to die at a younger age and are at increased risk of poorer health throughout life than those with more education. [22]



Cross country comparisons in Europe have produced similar findings. People with low education were more likely to report poor general health and functional limitations. Low education level has been associated with increased risk of death from lung cancer, stroke, cardiovascular disease and infectious diseases.

Associations have also been found between education and a range of illnesses including back pain, diabetes, asthma, dementia and depression.

Evidence suggests that those who achieve a higher level of educational attainment are more likely to engage in healthy behaviours and less likely to adopt unhealthy habits. For women in the United States, college education for a minimum of two years decreases the probability of smoking during pregnancy by 5.8% points. This is a large effect given that on average only 7.8% of the women in the sample smoked during pregnancy. [23]

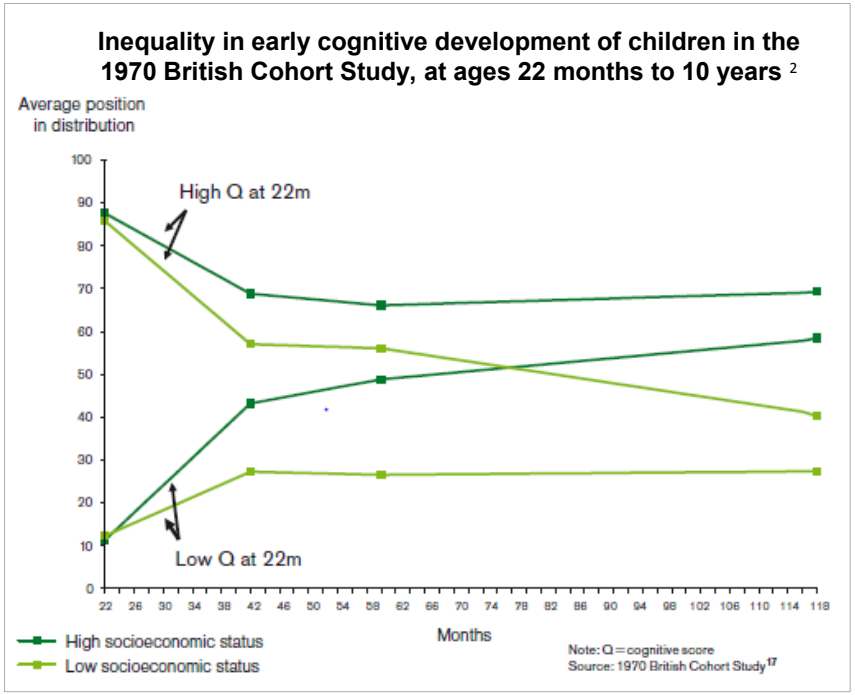
What influences education?

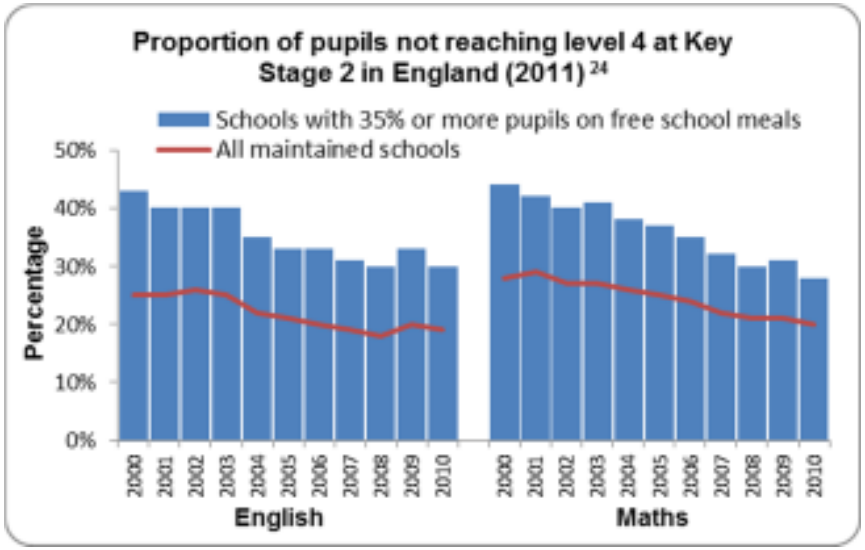
So if education has such a powerful impact on health, do all our children have the same educational success or the same chances of this success?

In the UK, the largest influence on a child's success at school is their father's education level. Young people are 7.5 times more likely to have a low educational outcome if their father has a low level of education, compared with a highly educated father. [19]

The UK has a low level of earnings mobility across the generations, meaning that there is a strong ongoing relationship between the economic position of parents and that of their children. It could be inferred that improving educational attainment will have a lasting impact on the community in many aspects including health.

Lower income and social class does have a marked impact on educational attainment. Social class has a rapid impact on a child's attainment . Children with higher cognitive ability but from lower socio economic class in testing are overtaken in test results by children of lower ability but higher social background by the age of 7. [2]

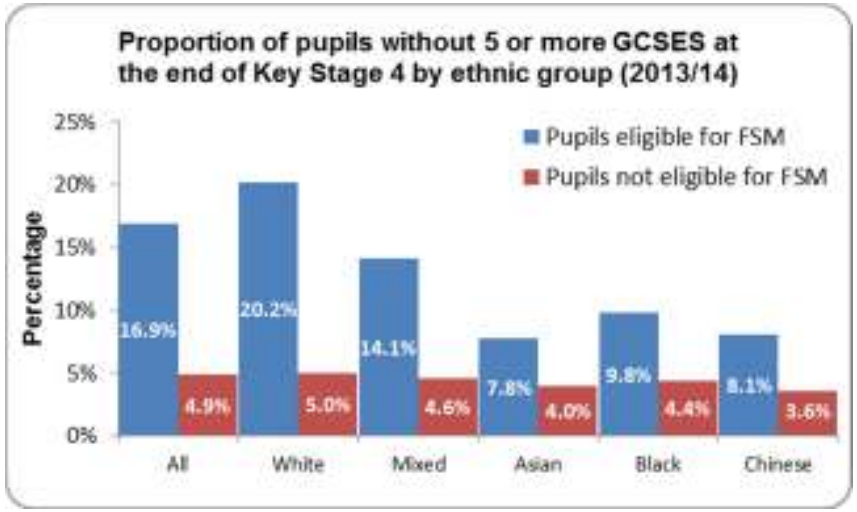




In the UK, children eligible for free school meals (FSM) are used as a proxy measure for families with lower incomes. To be eligible for FSM, the family must receive one of a series of income support mechanisms.

Pupils eligible for FSM are more likely to be absent from school than non-FSM pupils. In secondary schools the absence rate of FSM pupils is around double that of non- FSM pupils between Years 8 and 11. [23]

20% of boys eligible for free school meals did not obtain 5 or more GCSEs in 2013/14. This compares with 14% for girls eligible for free school meals and 6% for boys not eligible for free school meals. 10% of White British pupils eligible for free school meals did not obtain 5 or more GCSEs. This is a much higher proportion than that for any other ethnic group. [25]



Interestingly , children eligible for FSM in cities generally enjoy a significant advantage over their peers who grow up in similar backgrounds, but in smaller cities and market towns. This reverses assumptions that educational inequality is an inner city burden.

In 2013/14, over 60% of pupils in Inner London who were eligible for Free School Meals achieved 5 A*-C grades at GCSE, which was almost 20% above the national average. [25]

There has been good progress over the last decade across the UK, with more pupils from disadvantaged backgrounds achieving 5 A*-C grades at GCSE. However, the gap between these pupils and their wealthier classmates has remained the same or widened. In 2013/14, 71% of children in the South East who were not eligible for FSM achieved 5 A*-C grades at GCSE, but for poorer children this shockingly drops by 25% and even in in inner London there is a 20% gap. [25]

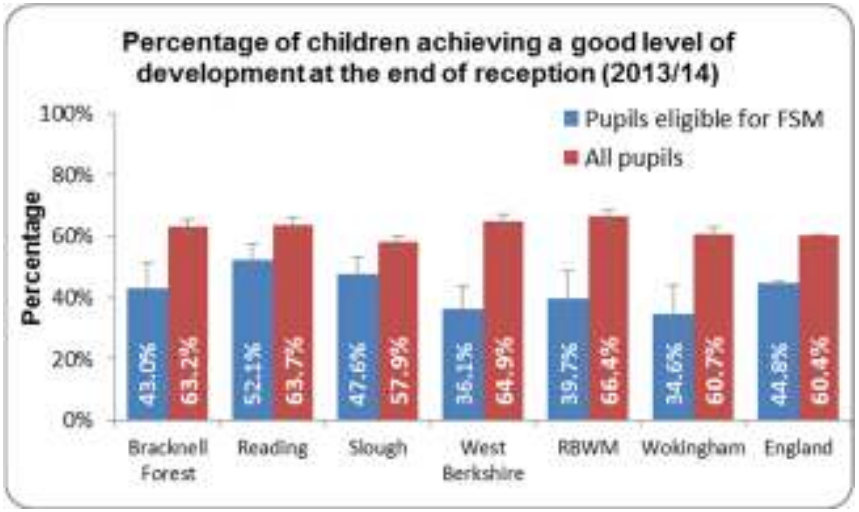
This 'narrowing the gap' issue is replicated in each of the local authorities in Berkshire. Bracknell Forest has the largest gap and, together with West Berkshire, is under the South East average attainment. In Slough we see the greatest success with exams in children eligible for FSM , where success is approaching the inner London achievement rates. In all are authorities we must persist in tackling this enduring inequality.

Percentage of students achieving 5 A*-C grades at GCSE (2013/14) [25]

Area	Pupils eligible for Free School Meals	All other pupils
Bracknell Forest	27%	71%
Reading	38%	74%
Slough	50%	79%
West Berkshire	34%	75%
RBWM	43%	72%
Wokingham	44%	77%
London	56%	75%
South East	35%	71%

The difference in school attainment for children who receive Free School Meals is also evident in primary school. The Public Health Outcomes Framework includes 2 measurements of school readiness for children who are in Reception and Year 1 (ages 4 to 6). Evidence shows that gaps in attainment emerge early in life for children from different social backgrounds. [10]

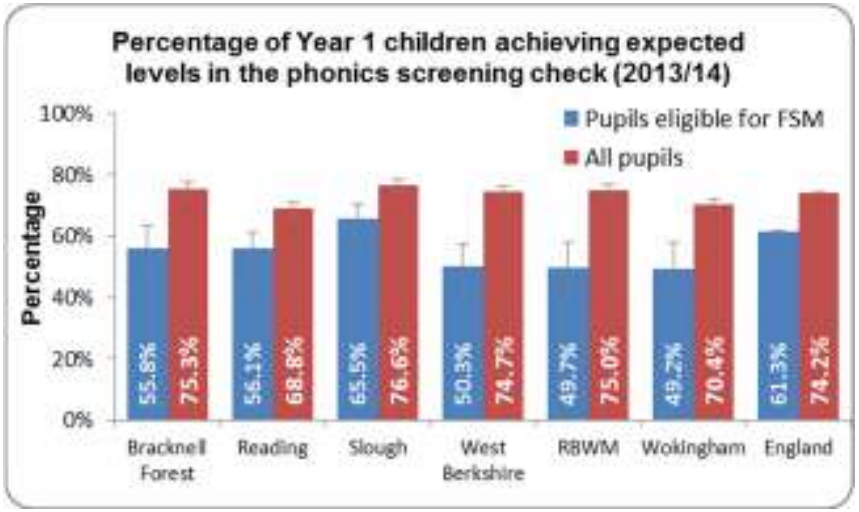
Children are defined as having reached a good level of development at the end of Reception if they achieve the expected level in the early learning goals of personal, social and emotional development, physical development, communication and language and specific areas of maths and literacy. In 2013/14, 60.4% of children achieved a good level of development by the end of reception in England. This compared with 44.8% of children who were eligible for Free School Meals and was a gap of 15.6% points.



Wokingham's achievement gap was notably higher at 26.1% points and this was significantly worse than the England average.

In 2013/14, only 34.6% of children eligible for free school meals in Wokingham achieved a good level of development at the end of reception. While the cohort of eligible children in Wokingham was low (104 children in Reception), this was one of the lowest achievement rates in England and was also the lowest in Berkshire.

Children complete a phonics screening check at the end of Year 1. In 2013/14, 74.2% of pupils achieved the expected level in England. This compared to 61.3% of pupils who were eligible for Free School Meals, which was a 12.9% point gap.



Wokingham's gap between pupils eligible for Free School Meals and all children was significantly worse than England's at 21.2% points. Again the cohort in Wokingham was quite small (122 children in Year 1), however this remains one of the lowest rates in England.

Looked after children

As we have described in this report, affluence and deprivation are key factors that influence health. Improving the education of all our children should therefore improve the health of our children, by reducing the impact of low wages and poverty.

Only one or two studies have expressed these types of impacts in quantitative and costed terms. These have shown that the health benefit of education is equivalent to 15-60% of the wage effect. This is a substantial additional benefit that may indicate a major under-investment in education. [21]

In a specific health area, an assessment of the monetary impact on the benefits of education for reducing depression were undertaken. This found that by taking women without qualifications to Level 2 (GCSE or equivalent) would reduce their risk of adult depression from 26% to 22% at the age of 42. It is estimated that this would reduce the total cost of depression for the population of interest by £200 million a year in the UK. [21]

Inequalities in education and health drive a similar divide in the world of employment and later adult outcomes. The educational attainment gap often carries over into poor adult outcomes. For example, - children on Free School Meals in Year 11 were more likely than those not eligible FSM to become NEET (Not in Employment, Education or Training) in the following three years. NEETs are more likely to have grown up in social disadvantaged households including low levels of employment, single parent families and parents with low educational qualifications.

Children eligible for free school meals are not the only children that do less well in terms of educational attainment and health outcomes. A child who is being looked after by the local authority is known as a child in care. They might be living:

- with foster parents
- at home with their parents under supervision of social services
- in residential children's homes
- other residential settings like schools or secure units

The rate of looked after children in Berkshire is below the England average. This is to be expected, since the risk of becoming a looked after child is related strongly to deprivation – overcrowding, single parent families, reliance on income support. However, there are still 850 children in this vulnerable group.

	Number and rate of Looked After Children on 31-Mar-2015 [26]	
Area	**Number**	**Rate per 10,000 population**
Bracknell Forest	105	37.0
Reading	205	57.0
Slough	195	49.0
West Berkshire	170	47.0
RBWM	100	30.0
Wokingham	75	20.0
Berkshire	850	40.3
England	69,540	60.0

The educational achievement of looked after children as a group remains low and the Children Act 1989 places a duty on local authorities to promote their educational achievement. Worryingly, only 15% of looked after children in the South East achieved 5 GCSEs graded A*-C in 2014 (Local numbers cannot be shown as they are too small to publish.) [27]

Whilst each looked after child must have a personal educational plan that promotes the quality of support and personal achievement, attendance at school in this vulnerable group of children is often worse than their counterparts and has been so for a significant period.

Locally we can seen that absence rates fluctuate quite markedly across the years, which reflect the small and changing numbers of children in each Local Authority.

	Percentage of sessions lost due to unauthorised absences for looked after children [27]				
Area	**2010**	**2011**	**2012**	**2013**	**2014**
Bracknell Forest	1.0	1.1	0.5	1.7	1.0
Reading	0.6	0.8	1.6	1.8	0.7
Slough	2.6	0.7	0.5	0.5	0.6
West Berkshire	0.4	1.0	0.2	1.6	0.8
RBWM	0.8	1.7	0.7	0.0	0.3
Wokingham	1.4	1.3	0.3	1.2	1.1
South East	1.5	1.4	1.2	1.1	1.2
England	1.5	1.5	1.2	1.1	1.0

Looked after children and young people share many of the same health risks and problems as their peers, but often to a greater degree. Children often enter the care system with a worse level of health than their peers, in part due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect. Longer term outcomes for looked after children remain worse than their peers. [28]

Mental health disorders are more common in looked after children

- 50% of boys and 33% of girls aged 5-10 have an identifiable mental disorder.
- 55% of boys and 43% of girls aged 11-15 have an identifiable mental disorder.
- This compares to around 10% of the general population aged 5 to 15

A major survey of looked after children found that two thirds had at least one physical health complaint. Problems with speech and language, bedwetting, co-ordination difficulties and eye or sight problems were more common.

Young people leaving care are particularly vulnerable. Both young women and young men are more likely than their peers to be teenage parents. Studies have shown that 25-50% of young women leaving care become pregnant within 18 to 24 months of leaving care.

The health of care leavers also worsens in the first year after leaving care. They are almost twice as likely to have problems with drugs or alcohol and report mental health problems. 'Other health problems' such as asthma, weight loss, allergies and flu are also far more likely. [28]

One of the key duties of the Children's Act requires the local authority to assess the health of all their looked after children annually. This includes arrangements for mental and dental care, such as immunisations and dental check-ups, as well as a short behavioural screening questionnaire (SDQ).

The SDQ should be completed for each looked after child between the ages of 4 and 16 and is completed by the main carer. It assesses:

- emotional symptoms
- conduct problems
- hyperactivity/inattention
- peer relationship problems
- prosocial behaviour

The SDQ is an important measure of emotional distress in this vulnerable group. In 2014, 68% of looked after children had an SDQ score submitted in England, but the submission rate across Berkshire did vary significantly from 29% in West Berkshire to 93% in Bracknell Forest. Wokingham submitted SDQ scores for 49% of looked after children in 2014.

Higher SDQ scores highlight concerns with the emotional and behavioural health of children. The average score for all 5 to 15 year olds in England is 8.4, however the scores for looked after children are higher at 13.9 in 2014. This is as the research findings would suggest. Higher scores are associated with poorer health experiences and highlight the particular and consistent health needs of this group.

Area	Number of LAC at 31-Mar-15 who had been looked after for at least 12 months	Percentage of LAC at 31-Mar-15: [27]		
		whose immunisations were up to date	who had their teeth checked by a dentist	who had their annual health assessment
Bracknell Forest	75	93.3%	86.7%	93.3%
Reading	160	93.8%	84.4%	87.5%
Slough	120	100.0%	95.8%	95.8%
West Berkshire	105	100.0%	71.4%	85.7%
RBWM	70	85.7%	92.9%	100.0%
Wokingham	55	81.8%	81.8%	81.8%
South East	**6,030**	**84.4%**	**83.4%**	**85.2%**
England	47,670	87.1%	84.4%	88.4%

Area	Average Strengths and Difficulties (SDQ) scores for looked after children [27]			
	2011	2012	2013	2014
Bracknell Forest	11.8	15.5	15.3	14.6
Reading	17.8	19.6	17.9	17.1
Slough	14.4	15.7	14.2	14.9
West Berkshire	15.7	15.8	16.4	16.8
RBWM	13.5	15.4	13.9	14.8
Wokingham	x	16.6	16.1	16.6
South East	15.0	15.2	14.8	14.6
England	13.9	13.9	14.0	13.9

So far in this report the evidence shows that deprivation is linked to medium and longer term poorer health outcomes and educational attainment. However, the SDQ scores in the health assessments of looked after children clearly show that there are immediate mental health issues health issues for this vulnerable group.

The Children's Act clearly gives responsibility to local government and health services to work together to ensure that children receive the services they need in response to their health assessments. [28] National evidence shows that there is substantial local variation in the availability of services with a large focus on mental health services to meet the needs of children and young people, including those who are looked after. Increasingly, innovative Children and Adolescent Mental Health Service (CAMHS) partnerships are providing designated or targeted CAMHS provision for looked after children.

Looked after children are not the only at risk group for worsened mental health. There is well documented evidence that children in poverty are also at increased risk of poor mental health.

For example, a recent survey in Scotland showed that people from the most deprived areas are more than three times as likely to be treated for mental illness. The report stated : "The more deprived an area, the higher its rate of psychiatric inpatient discharges". [29]

Use of hospital services

So far in this report we can see that not only does deprivation have an impact on longer term health outcomes, but also effects educational levels, which is a key way to actually reduce deprivation. We can now explore how deprivation also effects immediate use of health and other services.

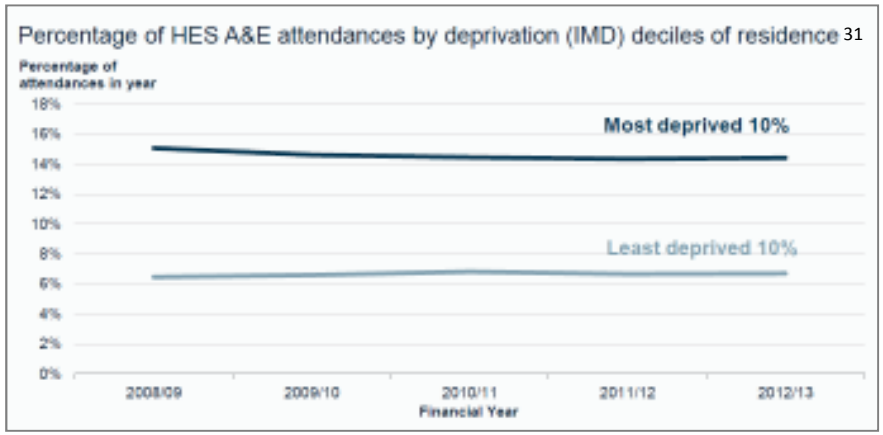
The consensus of the evidence available on the relationship of health service use in relation to deprivation is that GP use is broadly equitable by social economic group. However, evidence highlights a number of systematic differences between the use of secondary care by residents in deprived areas and compared to those in more affluent areas.

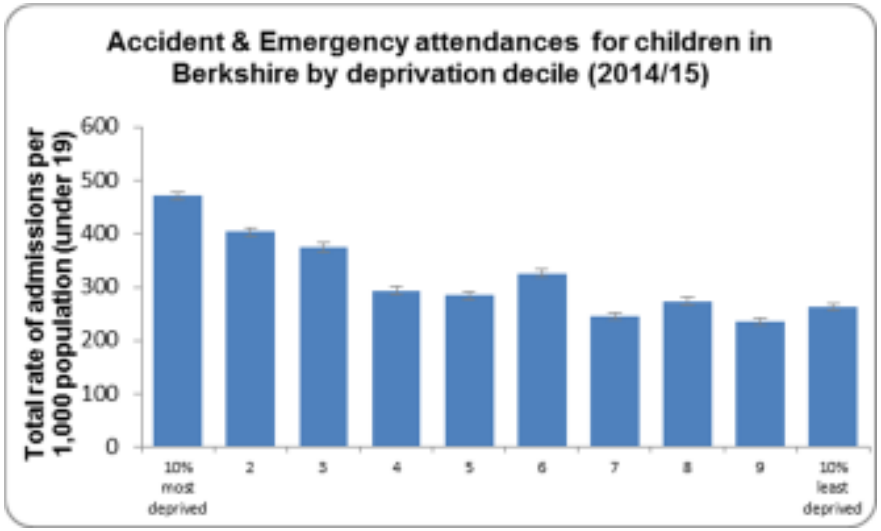
Compared with people in more affluent area, those living in deprived areas:

- use more emergency care
- use a similar amount of elective care
- attend A & E more frequently
- access outpatient care more via emergency channels
- fail to attend a larger proportion of outpatient appointments [30]

The pattern of A & E attendance has the steepest gradient, particularly in the relationship between attendance and the most deprived communities.

From 2008/09 to 2012/13, twice the number of attendances in all types of A & E departments have been by those living in the most deprived 10% of areas, compared to those in the least deprived 10%. [31] This national picture is replicated in the pattern of children's attendances in Berkshire.





Studies demonstrate a relationship between A & E use and deprivation for all assessed triage severities. This is most noticeable at the most severe end of the triage category, with five times the rate in most deprived communities. This compares to twice the rate for more minor illnesses and injuries. [32]

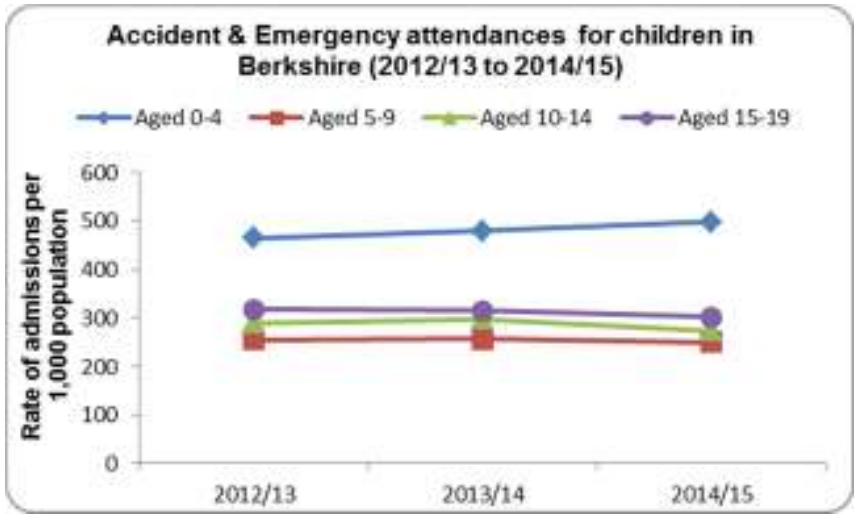
The higher use of A & E in more deprived communities can be partly explained by higher rates of illness and accidents, with the rate of accidents more prevalent in lower SEC groups. This also shows differing behaviours in response to illness and injury.

It is not just the relationships between deprivation and A & E use that is of relevance here. Children are key users of services, especially A & E, and are a key area of pressure in the NHS currently.

In recent years, numbers of A & E attendances have risen faster than the growth in the population nationally. This is largely driven by more minor (type 3) types of attendances which have risen at 11 times the rate of population, though the recent trend has dipped. [31] Nationally the highest percentage of A & E attendances are for very young children and those in their early twenties.

In 2012/13, there were at least 500 attendances at type 1 departments for every 1,000 people aged either under 2 or over 83 years in England. If this aspect of care is reviewed in more depth nationally, the proportion of attendances for over 64s at type 3 departments decreased by 2.2% points between 2008/09 and 2012/13. [31] The proportion of attendances for under 10s increased by 3.4% points. [30]

This pattern is also seen locally, driven by a rise in the 0-4 age groups.



The total number of A & E attendances in Berkshire has increased over the last two years. Children aged 0 to 10 have seen an increase of over 6% in this time period.

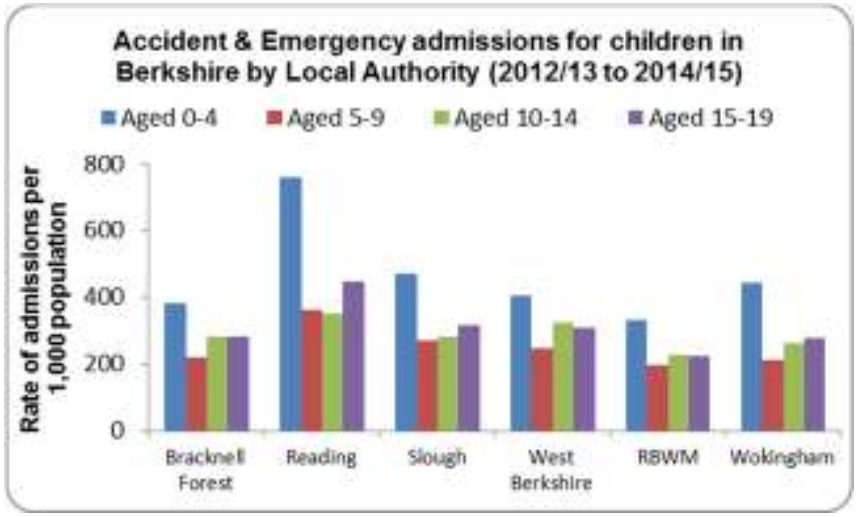
0-4 year olds use A & E the most across the UK, accounting for 3% of all attendances. People aged 80 account for less than 1% of all attendances.

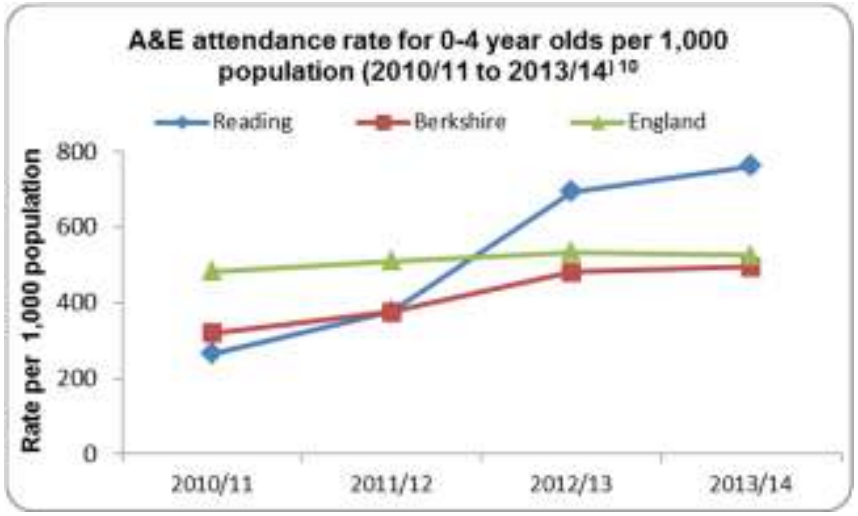
Similarly, the 0-4 age group has the highest number of emergency admissions, with approximately 225,000 nationally. This is a similar rate of attendances as 80 year olds . [31]

In 2013/14, there were 31,493 A&E attendances for children aged 0-4 years in Berkshire. Reading and Slough had the highest rates, and Reading's were significantly worse than the national rate at 763 per 1,000 population. This higher rate could be driven by the local proximity of the A&E department , as all rates of attendance are higher in this local authority. [10]

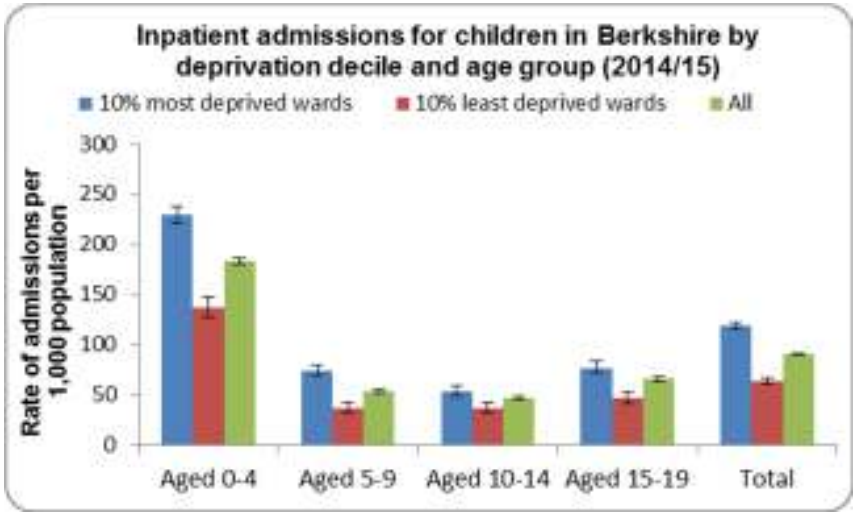
In each local authority, the highest rate of admissions were in the 0-4 year old age band. Other Berkshire local authorities had significantly better rates compared to England.

The rate of A & E attendances for 0-4 year olds is stable in all of the Berkshire local authorities, apart from Reading where it has increased over the past two years with a large increase from 2012/13 to 2013/14.





Finally whilst national data shows less of a relationship between inpatient admissions and deprivation, across all of the Berkshire local authorities it can been that children in more deprived communities are admitted more than their counterparts in more affluent areas.



Conclusions

The report pulls together a snapshot of the inequalities that exist with our children currently, and also describes the impact of these inequalities in later life and on current services. The evidence shows that if we are serious in addressing inequalities in our communities then the early years period presents a key intervention point.

The change of responsibility in commissioning health visiting services provides an opportunity to integrate how we support families and communities. Local authorities know their communities and understand local need, so links can be made with established wider services, such as housing and early years services, to enable the integration of children's services.

Babies are born with only 25% of their brains developed, but by the age of 3 their brains are 80% developed. If neglect and other adverse experiences occur in this period, it can profoundly effect a child's development. [33]

The mandated services for health visiting are :

- antenatal check at 28 weeks
- new born visit;
- 6 to 8 week review;
- 12 month assessment;
- 2 to 2½ year assessments

As the only universal service, health visitors can develop close working relationship with families and identify any support required. This can then be delivered through the community or multi disciplinary services.

In addition, health visitors are trained in recognising the risk factors, triggers of concern, and signs of abuse and neglect in children. They also know what needs to be done to protect them

In a time of budgetary constraints the tendency would be to focus services on children once they have presented with an issue to prevent escalation. However return on investment studies on a range of well-designed early years' interventions show that the benefits significantly exceed their costs: ranging from 75% to over 1,000% higher than costs. In addition the early years foundation estimates that spending on 'late intervention' on children (i.e. spending which could have been prevented) costs the NHS £3bn per year. [34]

A recently published OFSTED Chief Inspector's report identifies the important role that health visitors have in school readiness and the take up of free childcare for disadvantaged children has on system wide economic and societal benefits. [35]

Universal support to families will enable us to prevent issues developing and act quickly when problems occur. However integrating services in communities is not the only opportunity to address the current inequalities in health that exist in our population. The NHS tends to take a clinical/medical view of children and families, whilst local government is more adept at supporting at risk individuals and working in communities. If the NHS also adopted this approach then prevention could be targeted in a broader way and address a wider range of issues rather than specific clinical conditions and have a larger impact.

"Building their essential social and emotional capabilities means children are less likely to adopt antisocial or violent behaviour throughout life. It means fewer disruptive toddlers, fewer unmanageable school children, fewer young people engaging in crime and antisocial behaviour. Early intervention can forestall the physical and mental health problems that commonly perpetuate a cycle of dysfunction."

Graham Allen Early Intervention: The Next Steps [33]

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Health and Wellbeing Board Performance Report

Reporting Period: April to December 2015

Key:	⇧	Performance Improving compared to previous period
	⇩	Performance Deteriorating compared to previous period

HWB Priority	HWB Strategy Objective	Performance Indicator (Better Care Fund Indicator are in BOLD)	Year End Target 2015-16	Benchmark	Provenance of Benchmark	Reporting Frequency	Period	Expected Performance this Period	Actual Performance this Period	RAG this Period	Direction of Performance (see key)	Expected Performance to Date	Actual Performance to Date	RAG to Date	Projected Year End Performance	Commentary
BCF	5a	**Total non-elective admissions in to hospital (general & acute), all-age**	Q3 (Oct 15 - Dec 15) 2,977	1,695	Berkshire West CCG Average per 1,000 population. Wok is 1,650 per 1,000 population	Quarterly	Quarter 3	2,977	2,817	Green	⇩	2,977	2,817	Green	2,977	Jan 16 Updated to include November 2015, Q3 incomplete. 15% less activity compared to November 2014 - RBFT had a partial submission of non elective data which will be corrected. Q3 forecast to be 5% under plan.
BCF	5a	**Permanent admissions of older people (aged 65 and over) to residential and nursing care homes**	167 (619 per 100,000)	588 per 10,000 population	National Data published by HSCIC for the Adult Social Care Outcomes Framework. 588 per 100,000 is the 2014/15 average for SE Region and 669 nationally	Monthly	Dec-15	14	5	Green	⇨	125	80	Green	107	January 16 YTD Nov - 35 less permanent admissions compared to 2014-15.
BCF	5a	**Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**	70% (2013/4 outturn was 65.6%)	SE Region 80.1% in 2013/4	SE Region 80.1%, English average 82.5% in 2013/4. Collected in the annual SALT return, published by HSCIC	Annual	January to March 15	70%	77.9%	Green	⇧	70%	77.9%	Green	NA	From December 1st this has been recorded in FWi. The performance team has monitored the data quality and found issues which have been fed back to the team. NH to work with Ros Edwards to ensure this is captured accurately
BCF	5a	**Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).**	4,265	269	NHS Statistics website: Monthly average for Berkshire Unitary Authorities for September 2015. (Monthly average for SE region 1,536)	Monthly	Nov-15	255	305	Green	⇩	3,060	2,619	Green	3,929	Jan 16 November by sector: NHS 148 Social Care 117 Both 40 YTD 572 fewer days compared to 2014-15. Indicator is reported in arrears and December data is not yet available.
BCF	5b	**Number of patients going through reablement**	900	105	National Data published by HSCIC for Short & Long Term Services 2014/15. Berkshire Unitary Authorities average figure for end of year snapshot for those receiving short term rehabilitation	Monthly	Dec-15	75	84	Green	⇧	675	741	Green	998	Whilst START's capacity is below where it should be, START is actually delivering in excess of the block contract. There is an on-going recruitment programme to build capacity.
BCF	5b	**Adult Social Care User Experience Survey: Q3b Do care and support services help you in having control over your daily life?**	87.2%	89.1%	National data published by HSCIC of the Adult Social Care Survey 2014/15. South East Region average	Annual	2014-15	87.2%	89.0%	Green	⇧	87.2%	89.0%	Green		Because of changes to the cohort and methodology it is not possible to make direct comparisons between data for 2014-15 and previous years. The survey for 2015/16 is underway and will be submitted by 11th May 2016
		National GP survey is Section 8 Question 32: In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health services.	Not set	64%	England	Annual	2014-15	66%	Survey currently being undertaken	NA	NA	66%	Survey currently being undertaken	NA	Not set	Data is based on collection during July-September 2014 and January-March 2015. Current performance is 66% which consists of fieldwork from January-March 2014 and July-September 2014.
		Adult Social Care User Experience Survey: Question 2. Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?	89.9%	92.4%	National data published by HSCIC of the Adult Social Care Survey 2014/15. South East Region average	Annual	2014-15	88%	91.5%	Green	⇧	88%	91.5%	Green		This indicator is a percentage of all respondents to the survey who said their quality of life was 'So good, it could not be better', 'Very good', 'Good' or 'Alright'. The 2015/16 survey is in progress and is due to be submitted to HSCIC in May 2016.
		Number of Adult Safeguarding Referrals	Not set	257 Berkshire average for individuals	In 2013/4 the English average was 246 per 100,000 population) . Taken from the Annual Safeguarding Adults Return, published by HSCIC	Monthly	Dec-15	43	26	NA	⇩	387	370	NA	634	This is an area of significant concern and impact nationally and is something we need to monitor closely as a Board.
CCG - Local quality priority		Increase the number of referrals to the BHFT memory clinic	612	None	This is a local measure based on the capacity of the local service to see more patients	Quarterly	Quarter 2	130	129	Green	⇧	505	238	Green		Local target, to support increase in diagnosis of Dementia - 10% increase of referrals. Quarter 3 15-16 data is not yet available.
CCG - Local quality priority		Dementia Diagnosis Rate: Diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence	67.0%	66.7%	Based on the Prime Ministers Dementia Challenge	Annual	Aug-15	66%	62.1%	Green	⇧	63%	62.1%	Green	NA	Figures relate to 14/15. methodology changed in 15/16. Expectation to achieve 67% for March 2016. Data will be published in October by National Team
CCG national quality priority		IAPT Access: The proportion of people with depression /anxiety that have entered psychological therapies	15.9%	15.0%	Based upon National standard	Quarterly	Quarter 1	4.0%	4.2%	Green	⇩	15.9%	4.2%	Green	15.9%	Increased investment from the CCG to the IAPT service in 2014-15.
CCG national quality priority		IAPT recovery rate	50%	50.0%	Based upon National standard	Quarterly	Quarter 4	50%	54%	Green	⇩	50%	54%	Green	50%	Increased investment from the CCG to the IAPT service in 2014-15.

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TITLE	**Urgent & Emergency Care Review - Progress Report**
FOR CONSIDERATION BY	Health & Wellbeing Board on 11 February 2016
WARD	None Specific
DIRECTOR	Dr Cathy Winfield

RECOMMENDATION

1) That the Health and Wellbeing Board notes the report and the action being taken nationally and locally to deliver the objectives of the "Urgent and Emergency Care Review".

2) The Board is also asked to note how the local health and social care system currently works in partnership to support good patient flow around the system, which is critical is to the success of our local urgent and emergency care system.

Maintaining patient flow through hospitals relies on a dynamic equilibrium between admissions and discharges. It is therefore imperative that staff in the Royal Berkshire Hospital, Berkshire Healthcare Foundation Trust and Wokingham Social Care work closely together to prioritise activities aimed at achieving the earliest possible discharge of patients from hospital.

SUMMARY OF REPORT

This report is to inform the Health & Wellbeing Board about the "Urgent and Emergency Care Review" and the action being taken at national and local level in implementing this.

1. Introduction

Urgent and emergency care is one of the new models of care set out in the NHS Five Year Forward View (FYFV). "*The Urgent and Emergency Care Review*" (referred to as the *Review)* proposes a fundamental shift in the way urgent and emergency care services are provided, and will be the first major practical demonstration of these new models of care.

"…. the NHS will begin joining up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that patients know where they can get urgent help easily and effectively, 7 days a week…" . Simon Stevens, Chief Executive of NHS England.

The patient offer for 2020 will be:

i. A single number – NHS 111 – for all your urgent health needs
ii. Be able to speak to a clinician if needed
iii. That your health records are always available to clinicians treating you wherever you are (111, 999, community, hospital)
iv. To be booked into right service for you when convenient to you
v. Care close to home (at home) unless need a specialist service
vi. Provide specialist decision support and care through a network

2. Background

Urgent and emergency care is one of the new models of care set out in the Five Year Forward View. The Urgent and Emergency Care Review proposes a fundamental shift in the way urgent and emergency care services are provided, and will be the first major practical demonstration of these new models of care.

In November 2013 the NHS set out its vision for a future system which is safer, sustainable and capable of delivering care closer to home, helping to avoid unnecessary journeys to, or stays in hospital unless clinically appropriate. The *Review* is harnessing an approach of developing urgent and emergency care networks which rely on different parts of the system working together to create a completely new approach to delivering urgent care for physical and mental health.

The vision is simple:

- Firstly, for those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families;
- Secondly, for those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

To do this requires change across the urgent and emergency care system by:

- Providing better support for people to self-care
- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital
- Ensuring that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery; and
- Connecting all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

3. Implementation of the Review

Since November 2013 NHSE has been working with stakeholders from across the urgent and emergency care system to translate the *Review* vision into practical pieces which, when combined, will deliver the objectives of the Review. This is being done through a Delivery Group (which includes NHS England, Monitor, Trust Development Agency, Public Health England and CCGs), the majority of the work being led directly by NHS England, and the rest by system partners such as Monitor and Health Education England.

Implementing this vision is not a 'quick fix' but will instead be a transformational change that will take several years to effect. Delivering safe and effective urgent and emergency care cannot be done from within organisational or commissioning silos. It requires cooperation between and within numerous organisations and services, and collaboration between clinicians and supporting staff who place patient care at the centre of all they do. It is also recognised that this transformation will be occurring in the face of significant demand pressure in general practice, primary care and across the wider health and social care system.

Urgent and Emergency Care Networks: The establishment of Networks, which give strategic oversight of urgent and emergency care and connect all services within the urgent care system, is a key enabler for delivering the objectives of the *Review*. Nationally twenty-four networks have been agreed and are now meeting, bringing together representatives of their constituent system resilience groups (which locally we call the Berkshire West Urgent Care Programme Board), CCGs, acute receiving hospitals, ambulance services, NHS 111, mental health, community healthcare, local authorities, community pharmacy, Local Education and Training Boards and other key stakeholders.

Urgent and Emergency Care Route Map: NHSE has developed a route map that outlines high-level expectations to support networks and System Resilience Groups in prioritising their delivery of the Review. This route map (attached as **Appendix A**) signals the supporting products on offer from NHS England and partners alongside the expectations on networks and SRGs. This route map will be supported by a detailed implementation plan.

As an initial step in the route map, a stocktake of urgency and emergency care services has been undertaken by NHSE to understand:

- all urgent and emergency care services that are available in the network;
- the commissioning and service arrangements for these services; and
- Operational hours, case mix and facilities.

New commissioning standards for integrated urgent care: Published in October 2015 these support commissioners in delivering a fundamental redesign of the NHS urgent care 'front door'. The standards are built on evidence and what is known to be best practice.

Currently around the country, commissioners have adopted a range of models for the provision of NHS 111, OOH and urgent care services in the community. In most cases, however, there are separate working arrangements between NHS 111 and OOH services, and a lack of interconnectivity with community, emergency departments and ambulance services. This no longer fully meets the needs of patients or health professionals. The new commissioning standards required commissioners to take necessary steps to ensure that functionally integrated 24/7 urgent care access, treatment and clinical advice services are commissioned.

Urgent and Emergency Care Vanguards: Nationally eight urgent and emergency care (UEC) vanguards have been selected to accelerate delivery of the objectives of the *Review,* acting as test beds for new urgent and emergency care initiatives including clinical decision support hubs, a focus on liaison psychiatry, implementing a new payment model and testing new systemic outcome indicators.

Potential New Payment Model: NHS England and Monitor have published "*Urgent and emergency care: a potential new payment model"*, which sets out potential payment options and provides detailed guidance on how a new payment approach might be implemented in practice. This will be tested in Vanguard sites.

Workforce: NHSE is also working with Health Education England to review the UEC workforce and make sure that it is fit for purpose and there is a clear supply of staff to meet future demands. This includes describing and ensuring the supply of a trained alternative workforce out of hospital and on the interface with emergency departments to support the urgent and emergency care agenda. This involves the development and promotion of roles such as: physician associates, paramedics, pharmacists, and advanced clinical practitioners. They are working to enhance the role of paramedics to support the ambulance service as a treatment service, in line with the paramedic evidence-based education project (PEEP) report. A new single accredited curriculum for paramedics is in development., which academic institutions will begin to deliver from 2016 and will markedly enhance skills for paramedics to 'hear and treat', 'see and treat', as well as to work independently and in wider urgent care, such as primary care, as an alternative to A&E and ambulance conveyance.

Support Products: To support Networks and SRGs, a range of enablers have been, or are being, developed. These include:

- *Safer, Faster, Better: good practice in delivering urgent and emergency care* (published September 2015).
- *Guidance for Commissioners regarding Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services*.
- *Integrated Urgent Care Commissioning Standards* (published October 2015)
- *Ambulance service: new clinical models*.
- *Improving referral pathways between urgent and emergency services in England*.
- New system-wide indicators and measures.
- *Urgent and emergency care: a potential new payment model* (published August 2015).
- Standards for commissioning of 24/7 mental health crisis services
- Information technology that supports patients and clinicians to access the right care.
- *Urgent and emergency care: financial modelling methodology*.
- Local capacity planning tool.
- Self-care initiatives.

"'Safer, Faster, Better': good practice in delivering urgent and emergency care: a guide for local health and social care communities":

https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

This important document was published on 1st September. It is one of a suite of documents and tools being produced to support local health systems to implement the recommendations of the Review. It sets out design principles drawn from good practice

which have been tried, tested and successfully delivered by the NHS in local areas across England. It's clear that the guide should not be taken as a list of instructions or new mandatory requirements and that implementation should be prioritised taking into account financial implications and local context.

Current position in relation implementation of the *Review* at a local level

Thames Valley Urgent and Emergency Care Network: The Network which is chaired by Dr Annet Gamell, Chief Officer of Chiltern CCG had its inaugural meeting on 21st October 2015. Berkshire West CCGS are represented by Dr Andy Ciecierski, Cathy Winfield and Maureen McCartney. There is also Director of Adult Social Services representation. It meets on a monthly basis and is responsible for delivering key elements of the Urgent and Emergency Care Route Map at **Appendix A**.

Procurement of a Thames Valley wide Integrated NHS 111/ Urgent Care Service: In 2014 CCGs in Thames Valley agreed to work together to commission the NHS 111 service. Following publication of the new commissioning standards for integrated urgent care in Oct 2015 it was agreed that this work should move to the commissioning of an integrated NHS 111/Urgent Care Service for Thames Valley. This will offer patients who require it immediate access to a wide range of clinicians, both experienced generalists and specialists. This model will also offer advice to health professionals in our local communities, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. Within Thames Valley this new integrated service will have access to a wider range of dispositions including, but not limited to, ambulances, 24/7 primary care, pharmacists, mental health professionals and midwives. Clinicians will be supported by the availability of clinical records through IT system interoperability which will support robust clinical decision making and the direct booking of appointments into other services. This work is being led by the Berkshire West CCGs and it is expected that the new service will be in place by April 2017.

How the local Health and Social Care System works in partnership to support implementation of the Review and the earliest possible discharge of patients from hospital : The Berkshire West Urgent Care Programme Board which has senior level representation from health and social care is responsible for ensuring whole system resilience, the planning and delivery of urgent and emergency care improvement at a local level and delivering the NHS constitutional target that 95% of patient should be admitted, transferred or discharged within 4 hours of their arrival at A&E. There is a system wide strong focus on partnership working to achieve joint discharge planning and timeliness of post-acute transfer with the principle of a "pull" system of discharge.

The Board is supported in its work by an Urgent Care Operational Group made up of key operational managers which meets monthly. Its purpose is to deliver operational improvements and tackle blocks and issues along the urgent care pathway.

Both the Board and the Operational Group have been successful in helping establish and maintain very good working relationships between partner organisations.

The Board has begun the process of assessing where we are as an urgent care system against the best practice listed in "Safer Faster Better" and this was the subject of an Urgent Care Programme Board workshop on 17th December. The outputs of this will also help inform the further development of our local strategy for urgent care services.

Good patient flow around the system is critical to the success of our local urgent and emergency care system. The general principles of good patient flow are described in the document. Maintaining patient flow through hospitals relies on a dynamic equilibrium between admissions and discharges so it is really important that our local health and social care communities prioritise activities aimed to achieve the earliest possible discharge of patients. Numbers of patients on the *"Fit List"*, i.e. those clinically fit to leave the hospital who are awaiting onward health and/or social care are reviewed on a daily basis and are currently the subject of a daily system wide telephone conference call chaired by the CCG Urgent Care Lead/On call Director. The Berkshire West Health and Social Care system has set itself a target that each Local Authority and the Community Health Trust should have no more than 5 patients on the list with each having an average length of stay on the list of no more than 5 days.

The Wokingham locality Integrated Short Term service (WISH) which provides reablement, social care assessment and domiciliary care packages is an important enabler in helping our local system achieve this target. The CCGs have recently provided system resilience funding to support additional capacity in this team and the opening of a 3rd 'step up step down' flat in order to prevent unnecessary admissions and promote timely discharge thus maximising patients' independence and reducing reliance on long term care.

Appendices

Appendix A - Key elements of the Urgent and Emergency Care Route Map

Urgent and Emergency Care Route Map (1)

Appendix A

NHS England

1 System Architecture	Deliverable	Supporting product publication	Timescale for implementation
Establishing U&EC Networks	• Principles of governance to support membership structure and ToRs • Stocktake of U&EC services by networks. • Support for overarching network U&EC plan agreed with regions; Networks to develop plans. • Networks to define consistent pathways for urgent care with equitable access	• Safer Faster Better published	• August 2015 • Nov 2015 • Jan 2016 • Dec 2016
Identifying and piloting system wide outcome metrics	• Development of a single framework for measuring and reporting on system outcomes (nationally, with local trial) • Toolkit to support measurement	• 2016 • 2016	• 2017
Develop a new payment system	• Local payment model for pilot sites, taking into account mental health outcomes (Monitor) • Roll-out of shadow testing model in pilot areas / vanguards • Implementation nationally	• August 2015 – Local payment example produced by Monitor • Sites to be confirmed as part of vanguards	• April 2016 • April 2018
Enhanced summary care record	• Urgent and emergency care services to have greater electronic access to records including summary care record, end of life care records, special patient notes and mental health crisis plans (including patient held plans)		• June 2016
Workforce	• Underpinning work programme with Health Education England		• Ongoing
Accessing the UEC system			
2 **Accessing the UEC System**	• Align or novate existing NHS111 and OOH contracts to deliver a more functionally integrated Urgent Care Access, Treatment and Clinical Advice Service model **or** plan for migration to full integration when contracts allow • New NHS 111 commissioning standards published nationally • Guidance on the establishment of clinical hubs (within standards) • Guidance on specialist advice (within standards) • Clinical triage of green ambulance calls established (within standards) • Development of Access to Service Information (next generation of the DoS) for timely access to service information and the technical links with ERS to support booking across the urgent care system.. • Deliver the Clinical Triage Platform (next generation of clinical decision support) to reflect an integrated urgent care system • NHS 111 online platform integrated into NHS Choices, with a clear expectation of digital first	• Oct 2015 • Oct 2015 • Oct 2015 • Oct 2015 • OBC March 2016 • OBC March 2016 • OBC March 2016	• Nov 2015 • TBD in local plans • TBD in local plans • TBD in local plans • June 2018 • June 2018 • December 2016

Urgent and Emergency Care Route Map (2)

3	UEC Centres	Deliverable	Supporting product publication	Timescale for delivery
	Direct booking from 111 to urgent care centres	• SRG to drive adoption of and greater provision of direct appointment booking into UCC, ED and primary care. National support, local delivery		• Ongoing
	Local Directory of Services (DoS)	• Networks / SRGs to ensure maintenance of local DoS	• N/A	• Ongoing
	Ensure **UCCs provide a consistent service**	• Specification to support move to ensure local care centres are consistently called Urgent Care Centres and offer consistent service	• Q4 2015/16 – Spec for UCC and Emergency Centres	• 2016 – 2020 in line with local plans
4	**Paramedic at Home**			
	More patients more appropriately dealt with at **home by paramedics**	• Clinical models to support increase in proportion of calls to 999 dealt with via 'see and treat' • Referral pathways set between paramedics and other providers	• Guidance on clinical models – Q3 2015 /16 • Guidance on referral pathways –Q3 2015 /16	• In line with local implementation plans
	Ensure a **clinically appropriate response by ambulance services to 999**	• Ambulance dispatch on disposition evaluated and national standards reviewed • Implementation of recommendations	• Final recommendations by Autumn 2016	• Autumn 16 – Spring 17
5	**Emergency Centres and Specialist Services**			
	Analytical activity	• Analysis of non-elective activity and capacity	• Capacity and demand tool Aug-Dec 2015	• Aug- Dec 2015
	Hospitals providing 7 day services across ten identified specialties	• Compliant with 7DS clinical standards as per NHS Standard Contract • All urgent network specialist services compliant with four mortality clinical standards on every day of the week	• Standard Contract	• Ongoing
	Discharge from hospital	• DTOC plans submitted • Support packages for CCGs and SRGs	• 7DS standards to include discharge planning and consultant review of patients.	• 2017
	Ensure patients are treated in the right networked facilities	• Facility specifications and advice to support designation of network facilities and definition of consistent care pathways	• Q4 2015/16 – Spec for UCC and Emergency Centres	• 2017

Urgent and Emergency Care Route Map (3)

6 Mental Health Crisis	Deliverable	Supporting product publication	Timescale for delivery
An access and waiting time standard will be introduced for 24/7 crisis assessment	• Access and waiting time standard for 24/7 crisis assessment response (community based) • Improving access to health-based places of safety following Section 136	• Introduced 16/17 • Prepared in 15/16	• 2017/18 implementation • 16/17 introduction
An access/ waiting time standard will be introduced for liaison mental health services in A&E	• Access and waiting time standard for assessment by liaison mental health services in A&E (as per 7DS standard)	• Introduced 16/17	• 2017/18 implementation
An assessment standard for those with Mental Health needs	• A next generation clinical assessment system specifically designed to support mental health needs and crisis. This will cover Multi – channel access; i.e. voice, face to face/ telephone and online.	• Prepared in 16/17	• 2017/18 implementation
7 Supporting Self Care			
Personalised care and support planning	• People who are most at risk of needing emergency care, including mental health crisis care, will have the option of a person centred care and support plan	• Guidance published January 2015	• 2017
Support for self-management	• Supported self-management guide published with Age UK based on 11 principal risk factors associated with functional decline in older people living at home • Consensus statement and practical guidance to support commissioners and Fire and Rescue Services to use the 670k home visits carried our annually by the FRS to keep people 'safe and well' • Tools to support implementation of key approaches, including self-management education and peer support e.g. commissioning tool / economic model underpinned by a clear evidence base • A series of innovative tools / training packages to support culture change for health and care professionals • An overview and assessment of the levers, barriers and enablers of person-centred care – and a set of recommendations for the future	• Published January 2015. Revision in October 2015 • October 2015 • Beta versions from Spring 2016 • Final products to be developed nationally Autumn 2016	• 2015/16 publication. 2016/17 integration within frailty pathway approach • Implementation support from 2015/16 • Implementation in line with local plans 2016 / 2017
Personalised Health Budgets	• CCGs are developing their local personal health budgets offer and will be introducing PHBs beyond NHS continuing healthcare in line with the 2015/16 planning guidance.	• National roll out from April 2015	• Implementation in line with local plans 2017

Urgent and Emergency Care Route Map (4)

8 Independent Care Sector	Deliverable	Supporting product publication	Timescale for delivery
Local Commissioning Practice	• Guidance to CCGs and LAs on working with the ICS, including encouraging joint winter and future capacity planning • Clarification guidance to be made available on Continuing Healthcare processes – within Quick Guide: Improving Hospital Discharge • Guidance for acute trusts on how to support self-funders (choice protocols)	• Guidance published Q3 2015/16 • Guidance published Q3 2015/16 • Guidance published Q3 2015/16	• Q3 – Q4 2015/16 • Q3 – Q4 2015/16 • Q3 – Q4 2015/16

Better use of care homes	• Guidance for best practice clinical input required for care homes:
	  • Quick Guide: Clinical input into care homes
	  • Phase II – long term models including cost benefit analysis
	• Quick Guide: Identifying local care home placements
	• Quick Guide: Technology in care homes
		Guidance published:
		• Q3 2015/16
		• 2016/17
		• Guidance published Q3 2015/16
			• Q3 2015/16 – Q4 2016/17
			• Q3 – 2015/16

Improving Hospital Discharge	• Quick Guide: Improving Hospital Discharge to the care sector • Quick Guide: Sharing Patient Information	• Q3 2015/16	• Q3 2015/16
Better use of care at home	• Quick Guide: Better use of care at home	• Guidance published Q3 2015/16	• Q3 – Q4 2015/16
9 Primary Care			
Improved access to primary care	• 18 million people will have access to weekend and weekday appointments, and/or different modes of accessing general practice • Routine access to GP appointments at evenings and weekends	• Phase 2 PMCF • Primary Care Infrastructure Fund	• March 2016 • 2020
Increased role for pharmacy in urgent care	• Pharmacy access to Summary Care Record • Seasonal Influenza Vaccination Advanced Service for community pharmacy • Quick Guide: Extending the role of Community Pharmacy in UEC	• Refreshed guidance Autumn 2015 • Q3 2015/16	• Autumn 2015-17 • Autumn 2015 • Q3 – 2015/16
Improving oral and dental health	• Quick Guide: Best use of unscheduled dental care services	• Guidance published Q3 2015/16	• Q3 – 2015/16

TITLE	**Berkshire West Primary Care Strategy**
FOR CONSIDERATION BY	Wokingham Health and Wellbeing Board on 11th February 2016
WARD	None Specific
DIRECTOR	Dr Cathy Winfield, Chief Officer, Berkshire West CCGs

OUTCOME / BENEFITS TO THE COMMUNITY

The Primary Care Strategy sets out our vision for sustainable, enhanced primary care services which will play a key role in delivering out-of-hospital care for patients as described in the CCG's Strategic Plan.

RECOMMENDATION

The Health and Wellbeing Board is asked to note and endorse the Berkshire West Primary Care Strategy.

SUMMARY OF REPORT

This report follows previous Health and Wellbeing Board papers on the development of the Berkshire West Primary Care Strategy. Following further engagement with the public, the strategy has now been signed off by the Joint Primary Care Co-Commissioning Committee on which the Health and Wellbeing Board is represented. The wider Health and Wellbeing Board are now asked to endorse the principles set out in the strategy, a copy of which is included with this paper.

The four Berkshire West CCGs have engaged with the public throughout the development of the Strategy. This has intensified in recent months with the distribution of a summary document for patients, a programme of public events and meetings and online engagement through the CCGs' websites. A full engagement report is available on our websites alongside the strategy itself. This sets out how patients' views have influenced the development of the strategy. It is intended that this initial engagement now develops into an ongoing dialogue with the public regarding specific projects and initiatives as we move towards implementation. Should specific changes to individual practices be proposed the CCGs will also ensure that practices fulfil their responsibility to consult with their registered patients.

The CCG would also like to highlight that we have applied to move to a fully-delegated co-commissioning arrangement with effect from 1st April 2016. We believe that this will have a positive impact on the development of local primary care services, putting us in a stronger position to implement the vision described in the strategy.

FINANCIAL IMPLICATIONS OF THE RECOMMENDATION

The Council faces severe financial challenges over the coming years as a result of the austerity measures implemented by the Government and subsequent

reductions to public sector funding. It is estimated that Wokingham Borough Council will be required to make budget reductions in excess of £20m over the next three years and all Executive decisions should be made in this context.

	How much will it Cost/ (Save)	Is there sufficient funding – if not quantify the Shortfall	Revenue or Capital?
Current Financial Year (Year 1)	N/A	N/A	N/A
Next Financial Year (Year 2)	N/A	N/A	N/A
Following Financial Year (Year 3)	N/A	N/A	N/A

Other financial information relevant to the Recommendation/Decision
N/A

Cross-Council Implications
N/A

Reasons for considering the report in Part 2
N/A

List of Background Papers
N/A

Berkshire West Primary Care Strategy

2015 – 2019

1. Introduction

The Berkshire West CCGs' 5 Year Strategic Plan describes how, by 2019, enhanced primary, community and social care services in Berkshire West will work together to prevent ill-health within our local populations and support patients with complex needs to receive the care they need in the community, only being admitted to hospital where this is absolutely necessary.

The overriding aims of our overarching Berkshire West CCGs plan which underpin this strategy are:

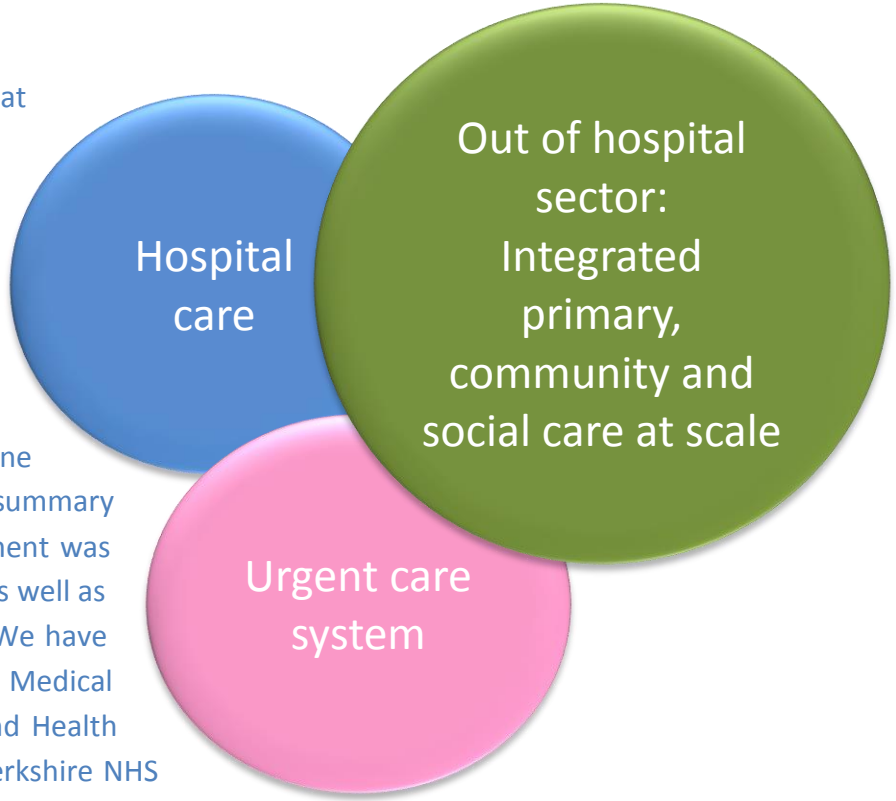
- Placing a greater emphasis on prevention and putting patients in control of their own care planning.
- Moving away from disease specific services to the commissioning of person centred care.
- Implementation of new models of care which support better integration, and which expand and strengthen primary and out of hospital care.
- Development of new payments mechanisms which incentivise the delivery of outcome focused care and which support the future sustainability of the local system.
- Commissioning highly responsive services urgent care services which ensure patients get the right care at the time in the right place.
- Better use of technology and innovation to achieve better outcomes for patients and improved demand management.
- Achieving parity of esteem for people with mental health problems and learning disabilities.

The Berkshire West local health economy is innovative and high performing, benchmarking well on key measures such as non-elective admission rates and prescribing. However it is recognised that the system faces significant operational, clinical and financial challenges to sustainability going forward. The CCGs are therefore working with partners to define a new model of care reflecting the triple aims of the *NHS Five Year Forward View* which are to increase the emphasis on primary prevention, health and wellbeing, to improve the quality of care by improving outcomes and experience for patients and achieving constitutional standards, and to deliver best value for the taxpayer by operating a financially sustainable system. There is an emerging consensus locally that a clinically and financially sustainable health economy can best be delivered through the creation of an Accountable Care System (ACS), bringing together commissioners and providers to assess population need, determine priorities,

redesign services, agree and measure outcomes and allocate resources along care pathways and in such a way as to incentivise all organisations to work towards the same goals. Such a system would ultimately function on the basis of a place-based capitated budget incorporating all aspects of healthcare including primary medical services with providers and commissioners jointly incentivised to deliver specified outcomes in a cost-effective way.

This Strategy builds upon the CCGs' overarching Strategic Plan to describe a detailed vision for primary care services in Berkshire West; anticipating that primary care will play a pivotal role in delivering new models of care and in ensuring the sustainability of the broader health and social care system in the light of increasing demand and financial pressures.

To ensure primary care is able to function in this way, this Strategy also describes what we intend to do to address the current challenges facing the sector including financial issues, growing workload pressures and increasing challenges in recruiting and retaining GPs and other key healthcare professionals.



The Strategy has been jointly developed by the four Berkshire West CCGs, working together with NHS England as the statutory commissioners of primary care services, and with patients and members of the public. Further details of our engagement with the public are included at Appendix 1. This has included a combination of online surveys, public meetings and targeted discussions, as well as the publication of a summary version of this strategy aimed at a patient audience. The development of the document was also guided by a Task and Finish Group including GPs, Practice Managers and Nurses, as well as by discussions in each of the four GP Councils and with the four Governing Bodies. We have also discussed the Strategy with our statutory partners, Healthwatch and the Local Medical Committee through our Joint Primary Care Co-Commissioning Committee (JPCCC) and Health and Wellbeing Board meetings, and have shared it with our local trusts; the Royal Berkshire NHS

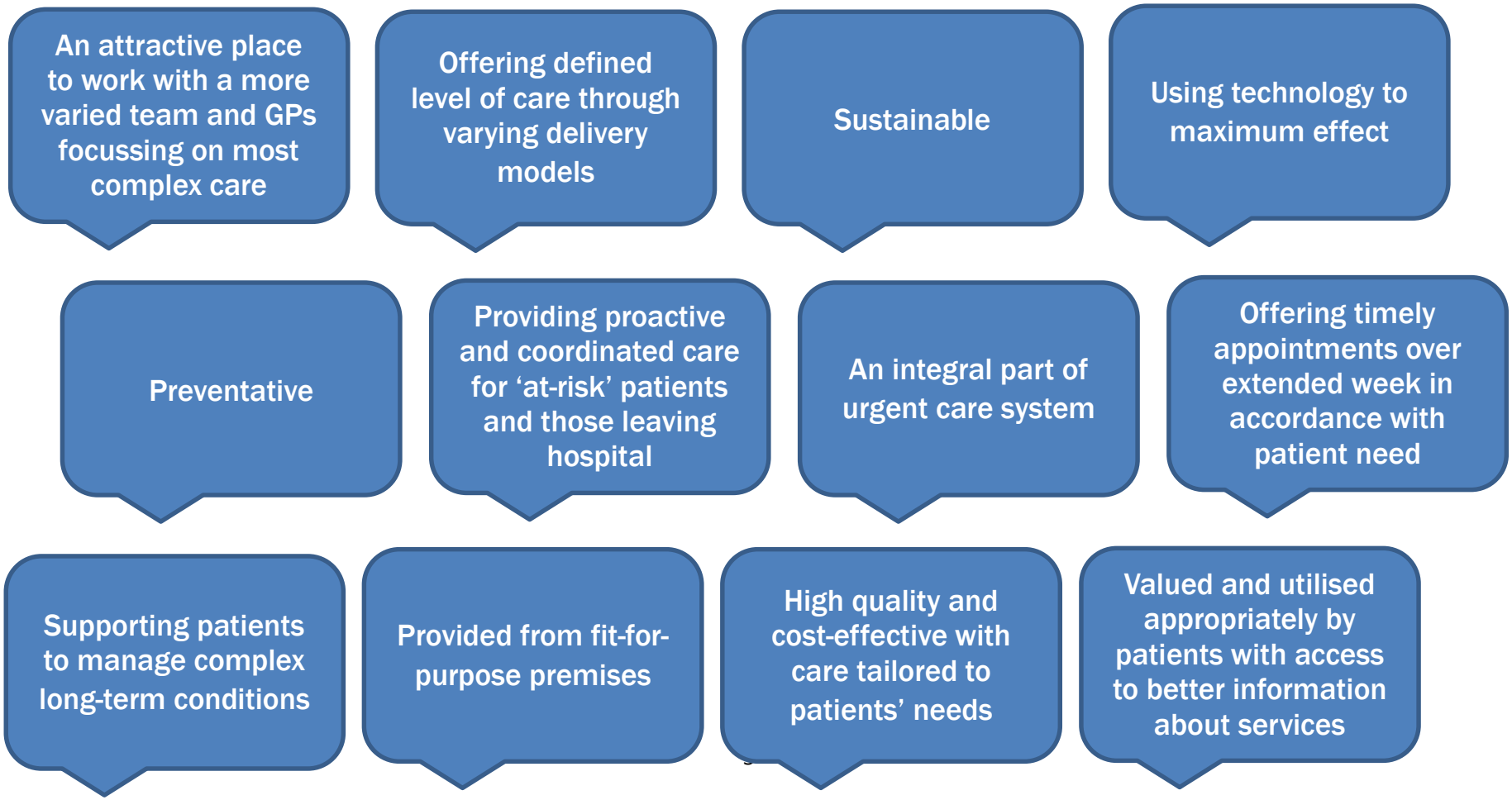
Foundation Trust and the Berkshire Healthcare NHS Foundation Trust.

At this stage the Strategy focuses on primary medical services, and to a lesser extent on community pharmacy, but the opportunities and importance of integrated working with other community services is also a key theme.

Implementation of the Strategy will be overseen by the Joint Primary Care Co-Commissioning Committee (JPCCC), linking with the CCGs' other Programme Boards as appropriate. The Terms of Reference for the Joint Primary Care Co-Commissioning Committee are available at http://www.wokinghamccg.nhs.uk/joint-primary-care-co-commissioning-committee.

2. Our Vision for Primary Care

By 2019, primary care in Berkshire West will be:



3. The Case for Change

There are currently 53 GP practices in Berkshire West, providing care to approximately 520,000 patients from 75 surgeries. For 2015-16, the total budget for general practice services in Berkshire West was £66.9m, made up of £61.2m NHS England funding for contractual payments including QOF and enhanced services, and £5.7mm invested by the CCGs in community enhanced services including Admissions Avoidance (care planning for Over 75s), support to care homes, early identification of diabetes and extended hours.

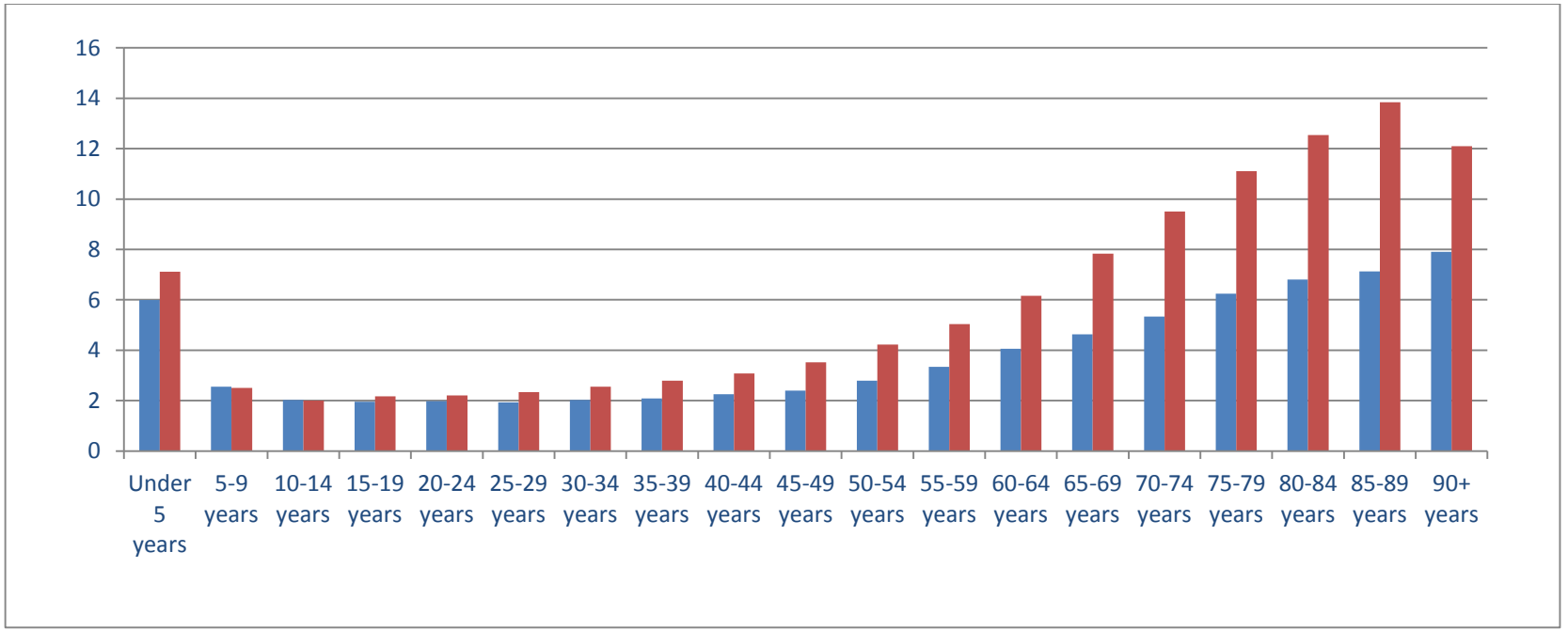
All practices in Wokingham CCG and all but one in Newbury and District CCG hold GMS contracts. In North and West Reading and South Reading CCGs, the majority of practices hold PMS contracts. There are currently four APMS contracts in place in Berkshire West, one of which includes a Walk-in Centre component and two of which are one-year interim contracts held by Berkshire Healthcare NHS Foundation Trust (BHFT). The Walk-in Centre contract will be re-procured during 2016-17 whilst the other three APMS contracts are currently being re-procured with the intention of new contracts commencing from July 2016.

The quality of primary care provision in Berkshire West is generally high. Average QOF achievement exceeded the England average for three of the four CCGs and was also above average in 11 practices in the remaining CCG. The Primary Care Web Tool collates key primary care quality data such as QOF achievement and prevalence, prescribing, screening and immunisation uptake rates, A&E attendances, non-elective admissions for patients with long-term conditions and National Patient Survey results. Practices that are outliers on more than six indicators are identified as requiring further investigation to understand the reasons behind this. No Berkshire West practices are in this group although some are outliers on a smaller number of indicators. There is also some local variation between practices serving similar populations which needs to be understood and addressed as appropriate. 25 practices have so far been visited by the Care Quality Commission (CQC) of which 61% have been rated as good or outstanding. Where practices have been rated as 'Requires Improvement' many of the issues identified have been procedural matters which have been relatively easy to address. A small number of local practices have been placed in special measures in recent months and the CCGs and NHS England have worked closely with the practices on Quality

Improvement Plans which are proving successful in addressing the issues identified. Going forward the CCGs are now working to support all practices to better understand the CQC requirements and inspection process.

Out-of-Hours services are provided by Westcall (part of the Berkshire Healthcare NHS Foundation Trust). Westcall is recognised as being a high quality provider of out-of-hours care and is staffed to a large extent by local GPs. This knowledge of local services and care pathways, together with access to patient records through the Medical Interoperability Gateway and to care plans via Adastra, ensures that the service is able to work effectively to meet urgent care needs and avoid unnecessary admissions to hospital during the out-of-hours period.

It is becoming increasingly evident that pressures affecting the wider UK primary care system are starting to impact upon Berkshire West practices. The national increase in consultation rates, reflecting an ageing population increasingly suffering from one or more long-term conditions (see Figure 1, below), is being replicated in Berkshire West where over the 2014-15 Winter period, practices reported a 25% increase in consultation rates when compared with the previous year. We are undertaking further work locally to understand levels of capacity and demand in primary care which will inform our future commissioning decisions.



Changes in consultation rates 1995-2008 (HSCIC)

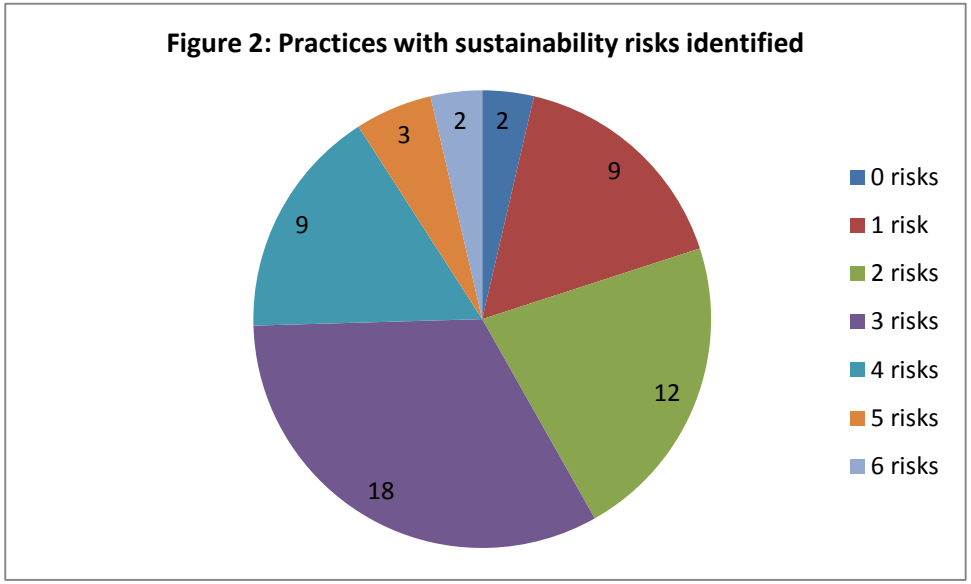
A further pressure relates to GP recruitment and retention. The Royal College of General Practitioners (RCGP) reports that the number of unfilled GP posts has quadrupled in the last three years and that applications to undertake GP training have dropped by 15%.[1] The Nuffield Trust reports that a third of GPs aged under 50 are considering leaving the profession in the next five years due to workload pressures.[2] There is an increasing trend towards part-time posts with 12% of general practice trainees now working in this way, and towards salaried employment with just 66% of GPs now working as partners compared to 79% in 2006.[i] 27 of the 55 Berkshire West practices have indicated that they are currently experiencing issues with recruiting GPs and other

[1] http://www.rcgp.org.uk/news/2014/october/over-500-surgeries-at-risk-of-closure-as-gp-workforce-crisis-deepens.aspx
[2] *Is Primary Care in Crisis?,* The Nuffield Trust, November 2014

clinical staff and with a high proportion of Berkshire West GPs and Practice Nurses aged over 50 these issues are expected to become more acute over time.

Patients have told us that they are generally happy with the standard of care provided but would like services to be better co-ordinated so that they only have to 'tell their story once'. Around 60% of patients say that current surgery opening times meet their needs. Where weekend access is provided the preference is for Saturdays mornings. Waiting times for appointments and continuity of care are frequent concerns but people are increasingly willing to consider alternative access models such as speaking to GPs over the telephone or seeing different members of the practice team such as pharmacists or physicians' associates. There is also consistent across all age groups feedback that people want to interact with their surgery online although some indicate that they would need help to register for online services. Patients would welcome being supported to take a greater role in their care and also believe that primary care could work more effectively with other organisations including in the voluntary sector to promote health and wellbeing. Further information about the priorities identified through patient engagement, together with details of how these are reflected in the Strategy are included in Appendix 1.

The CCGs recently undertook a 'risk mapping' exercise aiming to assess the stability of the CCGs' GP practices in order to work with them proactively to address risks and avoid potential contract failures. In addition to recruitment and retention and workload pressures associated with serving a deprived or growing population, this took into account CQC risk ratings, practice size, condition of premises and the potential financial impact of contractual changes. Eight measures were considered in total and Figure 2 summarises the level of 'sustainability risks' identified. This data is now being triangulated with quantitative data from other sources such as the national Primary Care Web tool, other CCG reporting tools and demographic information to establish a dashboard of quality and risk relating to primary care contracts.



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The remainder of this document describes the strategic objectives and key workstreams which will enable us to realise our vision for primary care.

4. Strategic objectives

In order to deliver our vision, we have set the following five strategic objectives for primary care:

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- Addressing current pressures and creating a sustainable primary care sector.
- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
- Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.
- Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.
- Making effective referrals to other services when patients will most benefit.

The following sections describe in more detail the models of care that we intend to develop in relation to each of these strategic objectives or 'asks' of primary care. In delivering these models, we will also address other aspects of our vision, such as ensuring that primary care in Berkshire West is sustainable, cost-effective and an attractive place to work, and that patients value the services provided and are supported to access them appropriately.

- **Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector.**

Innovative solutions will be employed to address the challenges currently facing the primary care sector. We will work to address the current workforce crisis at all levels; improving pre-registration training provision, building job satisfaction through more rewarding continuing professional development processes and working to improve retention of mid-career GPs and others by working with practices to offer more varied and flexible employment opportunities. We will also look to maximise the potential of new roles in primary care including Physicians' Associates, practice-based pharmacists and enhanced administrative and care co-ordination roles. Alongside this we will work to enable practices to respond to demand in new ways (see Strategic Objective 3) and to ensure that the expansion of the role of primary care is accompanied by an increase in primary care investment (see Strategic Objective 2).

Digital systems are the foundation upon which we will build a modern, efficient and responsive primary care sector. Enabling information to flow between care providers within and beyond organisational boundaries, and between care providers and patients, is a key means by which we will achieve a sustainable primary care sector. GP IT systems sit at the heart of primary care technology facilitating and recording thousands of interactions with patients every week. GP practices have led the way in the move from paper to digital record-keeping and recently begun offering online transactions, such as appointment bookings, repeat prescriptions, and online access for patient to their GP- held records.

In a challenging financial environment, IT services must not only improve the quality of care through enhancing the patients' experience of services, but also enable the practice to realise efficiency benefits and reduce administrative burden. Building on the solid foundations which are already in place in primary care, our vision is to support practices to develop IT functionality which responds to the evolving needs of patients and underpins integration across care pathways.

It is our view that addressing workforce challenges, capitalising on IT developments and providing the models of care set out under the following strategic objectives will require primary care providers to operate at scale. Single-handed and small practices are unlikely to be able to provide the range and breadth of services described, or to manage the communication and relationships required to operate as part of a truly integrated system. Similarly, investment in IT and premises infrastructure is only likely to be cost effective where it serves a large patient population. There is evidence that encouraging the emergence of larger providers is likely to result in sustainable provision and improved outcomes for patients going forward.[3] Our intention is therefore to make commissioning and investment decisions that support the development of providers with at least 6,000 registered patients, and ideally 10,000 or more and to support collaborative working between practices through federations, networks and joint provider organisations.

- **Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting**

Existing community-based care pathways, such as that developed for diabetes, will form the starting point for expanding similar models to other specialties. Virtual outpatient clinics and community-based consultants will become the norm and technology will be used to maximum effect to support self-care and timely liaison between clinicians working in primary and secondary care. Where additional services are commissioned from primary care, the associated investment must follow.

The implications of providing a greater range of services in primary care must be fully factored in to all levels of workforce and premises planning. Larger primary care providers will be better placed to take on expanded roles, and in any case collaboration will be required so that specialists can interface across practices.

[3] *Securing the future of general practice: new models of primary care,* Nuffield Trust and the King's Fund (2013)
Primary Care: Today and tomorrow – Improving general practice by working differently, Deloitte Centre for Health Solutions (2012)
Breaking Boundaries – a manifesto for primary care, NHS Alliance (2013)
Primary Care for the 21st Century, Nuffield Trust (2012)
Does GP practice size matter?, Institute of Fiscal Studies (2014)

- **Strategic Objective 3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.**

Primary care will take a more active role in working to improve the health of the population it serves. Practices will provide more primary and secondary prevention services, linking extensively with public health, the voluntary sector and other community organisations to prevent ill-health and promote wellbeing.

Primary care should work as part of the broader health and social care system to avoid patients going into crisis and requiring emergency admission and to support effective discharge from hospital. Proactive care planning for patients with complex needs who may be at risk of admission, including those in care homes, will be further developed to become a core element of primary care provision. A multidisciplinary approach will be taken, with technological solutions supporting the sharing of care plans so that patients only have to 'tell their story' once and different organisations can work together in a co-ordinated way to meet their needs.

Supporting the broader health and social care system will be our programme for information sharing and connecting the health and social care system - "Connected Care". This has already commenced with the introduction of static interoperability, between practices and Out of Hours primary care, and through a proof of concept testing process connecting GP practices with secondary care. Over the next 18 months all practices will join a wider dynamic programme connecting, practice systems with acute, community and social care systems.

- **Strategic Objective 4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.**

New technology will enable practices to respond to demand in different ways such as through greater use of the telephone, online consultations and email advice systems (with safeguards in place to ensure these systems are used appropriately), as well as technology enhanced mobile working. Patients

will be supported to self-care where appropriate and to access the right services at the right time. Community pharmacy may also play a greater role in providing advice, guidance and treatment to patients.

The CCGs will encourage practices, especially smaller ones, to work together to respond to same day requests for appointments in a different way, thereby freeing up time for staff to focus on planning care for at-risk patients and on managing long-term conditions. The potential for NHS 111 to take an enhanced role in managing same day demand will be explored through the forthcoming Thames Valley procurement of an Integrated Urgent Care Service. . This service will work with GP practices, out-of-hours, the Walk-in Centre, A&E and other services to meet the needs of people with urgent care needs in accordance with the *Safer, Faster, Better* guidance.[4]

We will continue to commission extended hours primary care provision, reflecting NHS England planning guidance. Currently we are focussing on improving patient experience through bookable appointments to be provided across an extended weekday and at weekends by single providers or through collaborative models. Additional capacity will also continue to be commissioned at peak times in-hours over the Winter period thereby working to reduce demand on other services, particularly A&E.

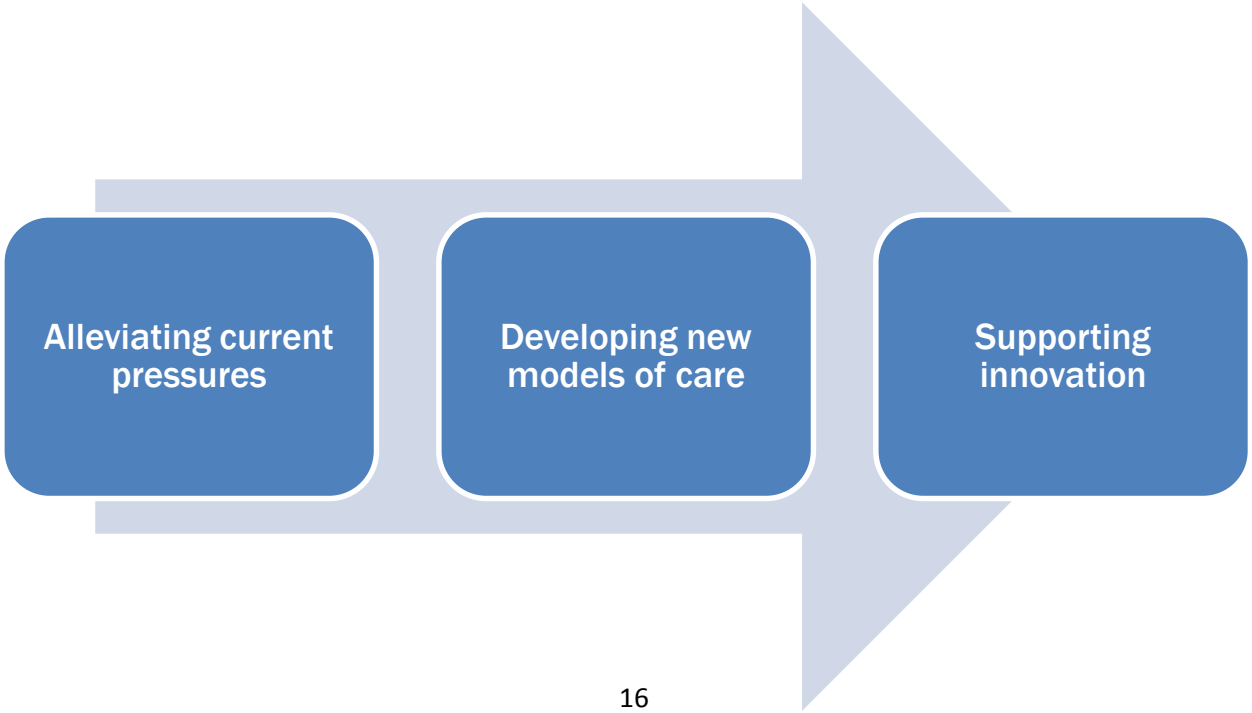
- **Strategic Objective 5: Making effective referrals to other services when patients will most benefit**

The CCGs will work with practices through peer review and closer liaison with secondary care colleagues to reduce unexplained variation in levels of referral between practices and individual clinicians, thereby ensuring that patients are referred to the services that will most benefit them and at the most appropriate stage of their treatment. Support to referrals will be strengthened through the further development of the DXS system which works as an integral part of practice clinical IT systems, providing a directory of services and detailed information on agreed care pathways and local referral criteria.

[4] *Safer, Faster, Better: good practice in delivering urgent and emergency care,* NHS England, 2015, www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

5. Our Strategic Approach

The previous sections have highlighted that there is a real opportunity to build upon the high standards of provision in Berkshire West to create an expanded primary care sector as described in our Strategic Plan, but also a risk that this may be stifled by the pressures currently facing general practice. This strategy therefore takes a maturation approach whereby we will first look to support primary care providers to address the very real challenges they are facing, moving on to develop the new models of care described above, with a view to the primary care sector as a whole then being in a position to take a lead role in the new integrated model of care we envisage operating in Berkshire West by 2019. The outline workstreams and investment plan set out below span these three areas and will inform the development of a more detailed Implementation Plan. The following section also describes how co-commissioning arrangements agreed with NHS England will underpin the delivery of this Strategy.



a) Workstreams to deliver our Strategic Objectives

Strategic objective for primary care	Anticipated workstreams
1: Addressing current pressures and creating a sustainable primary care sector.	Four sets of inter-related workstreams will aim to achieve sustainability for the local primary care sector: Workforce: • Supporting new roles in primary care, e.g. Physicians' Associates, prescribing pharmacists, AHPs. • Development of generic primary care nurse role allowing greater flexibility around where care can be delivered. • Expansion of training provision and development of network of multi-professional training practices or training hubs. • Offering student nurse placements in primary care • Shared training programmes for existing staff including clearer career structures for e.g. practice nurses and administrative staff. Greater sharing of training with other providers / across disciplines. • Development of new roles around care planning and signposting e.g. care navigators, voluntary sector co-ordinators and enhanced case co-ordinator roles • Supporting collaborative approaches to recruitment and development of shared posts and portfolio careers. Shared locum arrangements. • More effective linking with HETV and other appropriate organisations around workforce planning and training provision. • More co-ordinated appraisal system and CPD arrangements including a structured programme to support nursing revalidation and care certification for HCAs. • Further development of specialist nursing and medical roles working across networks of practices. IT (see also other objectives, below): • Maximising potential of self-care/triage apps • Installation of new servers, single domain and Wi-Fi in every practice. This is the biggest upgrade to GP Practice IT in 20 years and will mean Berkshire West has one of the most advanced infrastructures in the country.

	Premises: • Systematic planning for population growth • Maximising investment from housing developments • Maximising investment from national funding streams such as Primary Care Infrastructure Fund • Planned investment in premises which will enable delivery of the models of care described in this document, including underpinning the 'upscaling' of provision as described above. Organisational form: • Developing commissioning approaches that support upscaling and collaborative working between practices e.g. through federations, networks and joint provider organisations as a means of sustaining primary care by achieving economies of scale and efficiencies. This work will also put providers in a better position to take up opportunities to develop an extended role for primary care as part of the broader new model of care we are looking to develop in Berkshire West.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Roll out of existing community-based pathways to other specialties e.g. respiratory medicine. • Development of virtual outpatient clinic model and more community-based clinics • Expansion of community-based consultant roles, building on community geriatrician and community diabetologist models • Improving interface between primary and secondary care clinicians, e.g. greater provision of advice via Choose and Book, E-referral and telephone , using technology to share information between clinicians electronically, psychiatrists to visit practices to jointly review patients with complex mental health needs. • Further developing GP specialist roles working across clusters of practices, including in mental health in order to support effective management of mental health conditions within primary care. • Risk stratification of patients with long-term conditions • Supporting self-care for patients with long-term conditions including through technological means, remote monitoring and wearable devices.

3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Systematic development and implementation of risk profiling and multi-disciplinary care planning for Over 75s and patients with complex health needs, including improved sharing of information and using technology to further develop the role of patient in managing their care. Anticipatory Care CES to support face-to-face care planning, medications review and sharing of information through Adastra. Improving care planning and systematic annual reviews for patients with chronic mental health needs and improved processes to review the health needs of patients with a learning disability. GP job plans to include care planning as a core component of their regular workload. • Improving interface between primary care, community services, social care and the voluntary sector through the development of neighbourhood clusters based around groups of GP practices. • Building on existing preventative work e.g. targeted screening for diabetes and exercise schemes to focus more strongly on promoting health and wellbeing amongst the practice population and ensure such work is appropriately reflected in contractual arrangements. • Supporting practices to better meet the needs of carers, including through provision of Directory of Services enabling improved signposting to voluntary sector support. • Supporting information sharing between practices and the wider health and social care system through the Berkshire West Connected Care Programme.
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	• Practices to be commissioned to offer more bookable appointments in the evenings/early mornings and at weekends , reflecting NHS England planning guidance. Additional capacity to be commissioned at peak times in-hours to support system resilience. Smaller practices to be encouraged to work collaboratively to increase appointment availability, sharing patient records as appropriate. Empowering patients to self-care where possible and to access services appropriately. • Enabling practices to utilise technology to maximum effect to offer patients different options for accessing services e.g. via telephone or online consultations or through email advice portals. • Supporting practices to work together to respond to same-day demand in new ways thereby meeting urgent needs more efficiently and freeing up capacity for other aspects of primary care. To include considering shared call handling / urgent clinic models and potential role of NHS 111 in triaging in-hours calls. • Further exploration of potential role of community pharmacy as part of urgent care response. • Establishing clearer standards and expectations of practices with regard to capacity based on review of current local practice and patient feedback.

	• Supporting practices to deliver care through mobile working • Ensuring availability of a same day primary care response to patients in mental health crisis as part of the implementation of the local action plan linked to the Mental Health Crisis Care Concordat.
5: Making effective referrals to other services when patients will most benefit	• Roll-out of the DXS system and the associated service directory to be available to all practices and to include information on voluntary sector provision and carer support. • QIPP scheme to reduce variation in referrals and non-elective admissions where there is no clinical rationale behind this. To be delivered through peer review, CCG support and education sessions.

b) Co-commissioning

Co-commissioning will be a key enabler for the delivery of this Strategy. The CCGs were approved to jointly commission primary medical services with NHS England with effect from 1st May 2015. Responsibilities are discharged through the Joint Primary Care Co-Commissioning Committee (JPCCC) which follows national guidance with regard to the scope of joint commissioning, governance requirements and arrangements for managing conflicts of interest. We are now considering taking on fully delegated responsibility for commissioning primary medical services from 1st April 2016.

Co-commissioning will enable CCGs to influence the content and management of core and enhanced primary care contracts (within national parameters) and to align the commissioning of primary care with the organisations' broader commissioning intentions, thereby enabling care to be commissioned across the full extent of the patient pathway, and supporting the move towards place-based budgeting as set out above.

The following opportunities and priorities have been identified:

- Through co-commissioning we will work to further develop our local definition of what high quality primary care looks like, what level of service patients can expect and our anticipated outcomes, linking back to the strategic objectives set out in this document. We will then work to reflect this in contractual arrangements including our APMS service specifications and an associated 'contract plus' offer for GMS and PMS practices. This will ensure that providers are paid the same rate where they provide the same level of service irrespective of the type of contract that they hold and that

patients have access to a defined level of service even though delivery models may vary. This 'contract plus' offer will be funded initially through re-invested PMS premium funding but we are committed to working towards aligning funding levels for all practices by also commissioning it from practices that do not have access to this source of investment.

- We will take every opportunity to ensure that the commissioning decisions we make support delivery of strategic objectives for primary care, for example with regard to future practice changes. This will include encouraging 'upscaling' and collaboration between practices as we have recognised that this will best support delivery of the models of care described in this Strategy.

- Linked to this, the CCGs will look to develop a framework for further improving quality and addressing unwarranted variation in primary care. This will be based upon CCG-led peer support and sharing of best practice but will also incorporate arrangements to identify and address any ongoing performance issues. By risk mapping practices on an ongoing basis we will also be able to ensure that we offer targeted support to practices experiencing particular issues and work with those most under pressure to develop plans for the future. We will also support practices to prepare for CQC inspections and to make improvements to services where these are identified as a result of visits.

- Over time we will explore the potential to re-design QOF and directed enhanced services to better reflect local needs. We will look to consolidate enhanced services commissioning to reduce the bureaucracy associated with managing multiple contracts.

- We will work to develop a strategic plan for primary care premises, ensuring that investment is targeted towards premises developments which will underpin delivery of the new models of primary care described in this strategy and that the system is able to respond proactively when national funding streams are made available

c) CCG-level planning

The four GP Councils have engaged with the development of this strategy through a series of workshops and the strategic objectives set out in this document reflect the collective output of these sessions. However whilst the associated workstreams (see above) will span the four CCGs, it is envisaged

that implementation arrangements will vary between them, reflecting their differing population needs and the nature of their existing models of primary care provision.

The following table shows how the emerging local vision of each CCG aligns with the broader strategic objectives for primary care identified in this document by identifying key priorities identified for each CCG area. .

	Newbury & District	North and West Reading	South Reading	Wokingham
1: Addressing current pressures and creating a sustainable primary care sector.	• Supported self-care and automating QOF. Using technology to support self-care for long-term conditions; enabling patients to enter their own data and reminding them to attend for appointments. • New 'GP Personal Assistant' admin role • Freeing up GP time to focus on most complex patients and work that can only be done by them personally, thereby ensuring they are working 'at the top of their licence'. • Multidisciplinary training environment; learning environment enabling everyone in the team to	• Increase use of pharmacists • Shared approach to multi-disciplinary training, appraisal and CPD, utilising where possible existing programmes run by local trusts • Maintain and develop Nurse and HCA training programme • Explore the potential of the voluntary sector in supporting the needs of patients • Continue to explore the potential of collaborative working arrangements across practices and proactively plan for future provision of services for patients in North	• Discussions have focussed on potential for practices to work more closely together through hub and spoke model thereby creating efficiencies. These 'clusters' would share back office functions and provide services jointly where appropriate, thereby creating efficiencies and improving choice for patients. • Part of PMS premium funding to be used to establish Transformation Fund to support service developments aimed at achieving sustainability. Plan for use of this funding being developed across	• Discussions have focussed on how practices can work together to deliver efficiencies. Federated and networked models have been considered but progress to date has been focussed on the neighbourhood cluster model. This would enable practices to work together to create back office and other efficiencies, to jointly address workforce issues and to improve the interface with other services. There will be three clusters, each serving a population of 40-60,000 people. • Key priority is planning for population growth – it is estimated Wokingham will

	benefit from shared expertise, to keep up to date and to develop their skills. • Development of pharmacist roles. • Consideration to be given to collaborative recruitment approaches. • Fostering collaboration between practices as providers to achieve economies of scale and support sustainability.	Caversham. • Work with BHFT to pilot new ways of working across Community Nursing and Practice Nurse services • Support GP manpower by encouraging retiring GPs to join 'bank' arrangements	three key areas of IM&T infrastructure, workforce and premises. • Premises strategy being developed in line with clustering approach.	have an additional 32,000 residents by 2022.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Direct access diagnostics and new ways of working with consultants to reduce the need for referrals. • Geriatrician to support GPs in looking after care homes • Care closer to home using West Berkshire Community Hospital as a hub. Outpatient appointments provided in community by community-based consultants. Aspiration to develop West Berkshire Community Hospital as a Diagnostic and Treatment Centre, avoiding the need for travel to acute hospitals.	• As lead commissioner of urgent care across Berkshire West we will review patient pathways to identify potential improvements in a community setting.	• Hubs (likely to service around 25,000 patients) would have critical mass to offer new services and interface with consultants and others in new ways.	• Clusters would have critical mass to offer new services and interface with consultant and others in new ways. There will be opportunities to further develop GP specialist roles working across practices and linking in new ways with secondary care clinicians.

	• Supporting collaboration between practices as providers to expand the range of services offered by primary care.			
3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Continuity when it matters – implemented by an extended team(see above) led by an accountable clinician such as a GP or community matron, focussing on patients from whom continuity is important and could affect clinical outcomes (e.g. those with complex multi-morbidity, enduring mental illness or requiring end-of-life care). • Further development of anticipatory care planning • Personal recovery guide jointly with social care and the voluntary sector.	• Explore potential of care planning for other long-term conditions • Work with Public Health to increase preventive work, including increasing physical activity rates through Beat the Street . • Ensure that all practices utilise the Living Well pilot and evaluate its benefits • Consider the benefits of introducing a specialist GP role for care home patients and the frail/elderly • Instigate/participate in coproduction opportunities as they arise	• Hubs would act as point of interface with other organisations, thereby supporting cluster working as set out in BCF plan. •	• Cluster Care planning working with Care Navigators • Social workers, housing officers etc. would be aligned to clusters enabling services to work together more effectively to meet people's needs in the community. • Voluntary Sector Co-ordinator role being piloted. This role supports practices to signpost patients to the range of voluntary sector services available to them, with a particular focus on reducing social isolation amongst older people and supporting new families moving into Wokingham.
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring	• Different length appointments according to patient need • Extended Hours capacity commissioned in accordance with patient need and linked	• Ensure that 80% of practices provide extended access • Discuss and agree how an integrated urgent care system could best support practices to manage patient	• Hub and spoke model would offer flexible approaches to extended hours provision and potentially in-hours requests for same day appointments.	• Considering collaborative approach to call handling and meeting on the day demand through cluster-based urgent care centres. Over time this should ensure GPs have the

urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	to the Out of Hours provision • Exploring triage to prioritise appointments using a combination of the most experienced clinician and enhanced reception roles • Develop collaborative working to deliver improved access across the 11 practices, including exploring potential of shared call handling through hubs (involving GPs, minor illness nurses and Nurse Practitioners) and/or a locally-agreed protocol and thresholds for on-the-day appointments. This would give GPs in practices more control over their day and enable them to focus on most complex or those needing continuity (see above). • Exploring utilising technology to obtain succinct patient history prior to appointments and more use of Skype and telephone consultations.	demand for urgent care	• Practices could collaborate to meet on the day demand thereby freeing up time for care planning for patients with the highest needs.	capacity to focus on providing proactive, community-based care for patients with higher levels of need.

5: Making effective referrals to other services when patients will most benefit	• Directory of Services likely to be delivered as part of DXS system. To facilitate direct access to other professionals (e.g. IAPT, Social Services, Physiotherapy) and to incorporate a service navigation function which will support patients and practices to access the services they need.	• Ensure practices are aware of voluntary sector services available to support their patients and that these are included on DXS • Continue to provide practices with referral benchmarking information at practice visits and as routine every quarter • Through regular reporting of referral benchmarking information reduce levels of variation between practices.		• DXS information will improve co-ordination of care and links with voluntary sector. • Considering how to reduce variation in referral rates for some time and now working with other CCGs on BW QIPP scheme.

6. Investment plan

Core primary care services are funded through NHS England's GP commissioning budgets. A high-level summary of 2015-16 budgets is provided below. Further enhanced services are commissioned by unitary authority Public Health departments.

CCG	GP Contract Payment £0	QOF and Aspiration £0	PCO Admin £0	GP Drugs Payments £0	GP Premises £0	Misc. Items £0	Enhanced Services £000s	Total Area Team £0
Newbury and District	8,624	1,141	448	914	1,143	339	850	13,459
North and West Reading	8,997	1,170	427	386	1,109	315	669	13,073
South Reading	12,750	1,101	418	74	1,781	300	849	17,273
Wokingham	11,191	1,549	596	442	1,954	438	1,108	17,278
Total	**41,562**	**4,961**	**1,889**	**1,816**	**5,987**	**1,392**	**3,476**	**61,083**

CCG budgets relating to primary care in 2015-16 are set out below. In addition to GPIT funding of £1.3m and established enhanced services funding of £0.5m, we have used the £5 per head funding to support the care of the Over 75s (as per the 2014-15 planning guidance) to invest in an Anticipatory Care CES designed to significantly advance our third Strategic Objective (Managing the health of a population in partnership with others). In addition, we have invested £2.5m to extend GP access into the evenings and weekends as well as at peak times in-hours over the Winter period, following a £1m pilot scheme in 2014-15. These two schemes combined equate to an 8.4% increase in investment in primary care. Further information about current IT investment plans are included in Appendix 3, below.

	CCG Budgets				
CCG	£5 per head "anticipatory care" £000	Enhanced Access £000	Other Enhanced Services £000	GPIT £000	Total CCG £000
Newbury and District	576	576	101	299	1,552
North and West Reading	560	560	116	279	1,515
South Reading	643	643	94	352	1,732
Wokingham	722	722	187	406	2,037
Total	**2,500**	**2,500**	**498**	**1,336**	**6,836**

In addition, the CCG is responsible for commissioning the Westcall Out-of-Hours service provided by the Berkshire Healthcare NHS Foundation Trust. For 2015-16, £5.02m was spent on commissioning this service.

Further investment in primary care may follow where it is identified that this will result in overall cost savings in other parts of the CCGs' commissioning budgets. It is also intended however that the strategy will be delivered through the re-alignment of existing commissioning budgets to better reflect the strategic objectives described. As set out in the above co-commissioning section, key priorities will include:

- Development of an APMS offer that reflects our strategic objectives with KPIs aligned to local patient need.
- Redesign of QOF to reflect local priorities.
- Ensuring infrastructure investment furthers our strategic aims.

- Re-investment of released PMS premium funding in service models which reflect this strategy, and with the intention of aligning GMS and PMS funding levels in the future. The mechanisms for doing this require further discussion.

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7. Delivering the Strategy

The following table summarises the types of outcomes that would result from successful delivery of our strategic objectives for primary. More specific outcomes will be developed as we move towards implementation and progress against these will be monitored by the Joint Primary Care Co-Commissioning Committee. The Committee will also take oversight of the delivery of the Strategy as a whole and will assess progress and review this document periodically in the light of developments in co-commissioning and the broader health and social care economy's approach to integration and sustainability.

Strategic objectives	High-level outcome measures
1: Addressing current pressures and creating a sustainable primary care sector.	• Decreased number of vacancies within practices, application rates improved as primary care is seen as a more attractive place to work. • Staff satisfaction improved • Smaller practices working in federation or other collaborative forms from fewer/better premises serving populations of at least 6,000 but ideally 10,000 patients • No new contracts awarded to single-handed practitioners or practices that would have a list size of less than 6,000 • All primary care premises are fit-for-purpose • Primary care workforce diversified to include pharmacy, nursing, therapists and physicians associates. • Multidisciplinary and joined up arrangements in place for pre-registration training and continuing professional development • Practices receive a consistent level of funding for a defined level of service so that patients in Berkshire West have access to a consistent level of provision. PMS premium funded reinvested to support delivery of models of care set out in this Strategy. • Services provided outside of core contracts are resourced appropriately. • Contractual arrangements simplified and bureaucracy reduced. • Quality standards are maintained or improved and unexplained variation between practices is addressed.

	• Patients supported to access practices online. • Patients are supported to use self-care apps • Opportunities to interface with patients in different ways e.g. through telephone and Skype consultations, patient history-taking apps etc. are utilised to full effect thereby enabling practices to manage growing demand.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• New care pathways in place between primary and secondary care resulting in fewer visits to hospital. • Improved control of long-term conditions e.g. reduced HbA1C level etc. • Positive feedback from patients with long-term conditions
3: Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Directory of Services in place supporting improved links with the voluntary sector and increased signposting to voluntary services. • Risk stratification actively used to identify and develop care plans for at-risk individuals thereby reducing avoidable hospital admissions • Preventative work in place with lower risk groups. • Improved patient feedback regarding co-ordination of care • Interoperability achieved and services therefore able to share information with patient consent
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	• Bookable GP appointments available from 8am-8pm in the week and at weekends, reflecting NHS England planning guidance • Improved patient survey results / Friends and Family test responses • Practices utilising shared call handling and/or on-the-day provision where appropriate to create efficiencies which free up time for GPs to focus on more complex patients.

5: Making effective referrals to other services when patients will most benefit	• Unwarranted variation in referral and non-elective admission rates reduced for specialties where this has been identified. • DXS utilised to maximum effect to support delivery of agreed care pathways and signposting to other services as appropriate.

8. Next steps

Delivery of the strategy will be overseen by the Joint Primary Care Co-Commissioning Committee. The Committee will develop an implementation plan which will form the basis of a strategic programme for primary care for which it will take lead responsibility, identifying and working to mitigate risks as appropriate. It will also link extensively with the CCGs' other Programme Boards around specific workstreams.

Further engagement with patients around the workstreams set out in this Strategy will be undertaken as part of the CCGs' broader Communications and Engagement Strategy. A communications plan will be developed for each workstream which will aim to build upon the useful information already obtained with regard to many of the themes covered in this Strategy document.

Appendices

Appendix 1: Patient Engagement

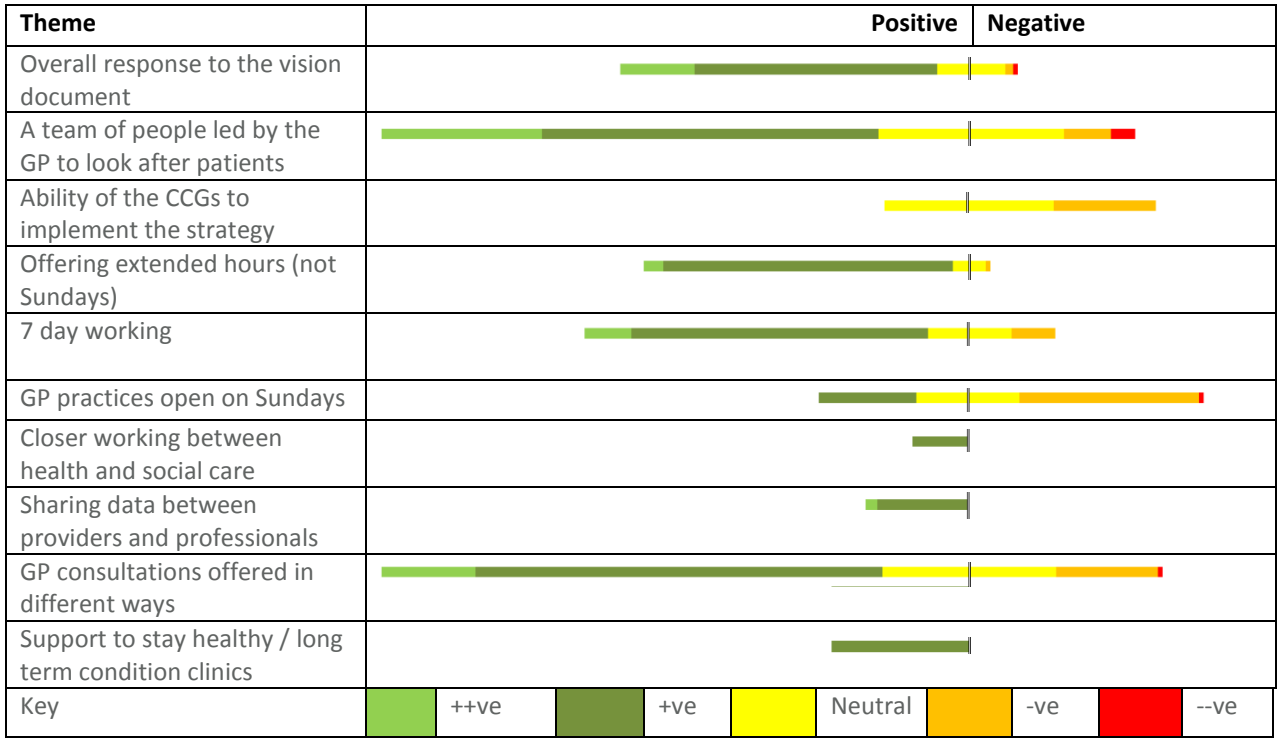
The CCGs' engagement with the public regarding primary care began with the Call to Action events held in 2014. Since this time we have developed an ongoing dialogue with individual Patient Voice Groups and have raised primary care through broader engagement work undertaken as part of the CCGs' overall Communications and Engagement Strategy.

Following production of the draft of this Strategy, a patient-facing version was produced which has formed the basis of an intensive programme of engagement over the last few months, as well as an online survey. Specific engagement has also been undertaken in relation to the three APMS contracts we are procuring in 2015-16 which has elicited useful feedback in terms of our overall direction of travel for primary care commissioning. The following table summarises key recent engagement events and activities which have had a primary care focus:

Date	Event
November 2014	Reading 'GP Question Time' event
March 2015	Wokingham 'Have your say'
March 2015	Newbury Primary Care Event
July 2015	North and West Reading CCG annual meeting and engagement event
August to December 2015	Primary Care Strategy survey live on Berkshire Health Network.
September 2015	South Reading CCG annual meeting and engagement event
July – August 2015	NHS111 engagement
September 2015	APMS engagement: Circuit Lane
September 2015	APMS engagement: Priory Avenue
October 2015	APMS engagement: Shinfield Medical Practice
October 2015	Woosehill Surgery PPG survey
October 2015	Wokingham PCS engagement event
November 2015	South Reading Patient Voice PCS engagement
November 2015	Trinity School, Newbury – sixth form
November 2015	Mailout to more than 70 residential care homes across Berkshire West to promote feedback on the strategy

The heat map below demonstrates the key areas of interest for patients reading the vision document and responding to the online survey. The length of line indicates the volume of responses and the bar colour the sentiment of respondents. The heat map below represents 988 statements (83% of total). The map tells us that respondents were overwhelmingly positive towards the ideas set out in the vision document, welcome a wider range of professionals offering care and are enthusiastic for new styles of GP consultation – including Skype video consultations.

Some online respondents were concerned about our how we will implement the vision. We intend to address this concern through the implementation plans that we put in place to support delivery of the Strategy which will include mechanisms for identifying and addressing risks to delivery. Seven day working was seen as beneficial overall, though many of those in favour felt that Sundays should not be used for routine appointments.



The following table summarises the key themes identified through all of the engagement activities we have undertaken as part of the development of this Strategy (including the online consultation above), and how these are reflected in the final document. A full *Primary Care Strategy Engagement Report* is available on the CCG websites. Further information on the strategy and its development, including an online version of this document, is also available at Primary Care Strategy.

Key themes identified through patient engagement	How these are reflected in Strategy
People want better co-ordination of care between organisations so that they only have to tell their story once and they are supported to navigate the care system. There is a view that this should be achieved through shared IT system, and should include working to avoid admissions from care homes. Patients with the most complex needs should be prioritised and plans should be in place to ensure they do not have to explain their illness at every consultation. These patients most value continuity of care. IT systems should ensure confidentiality of data. Technological solutions should not be a substitute for good face-to-face care but respondents did recognise the potential of wearable technology. *See also Goals 2 and 3 in Primary Care Strategy Engagement Report.*	• Integration with social care and other services through neighbourhood clusters will improve communication between organisations • Patients identified as being most at risk of admission will have care plans in place which can be accessed by other organisations through Adastra. This will incorporate specific care planning processes for care home residents. • Berkshire West Connected Care Programme currently allows the out-of-hours GP service to access patients' records with their consent. Over time this will be expanded to cover A&E and other organisations. Data confidentiality and information governance are key considerations in all initiatives being progressed under this programme. The programme aims to ensure that technology is used to maximum effect to support patient consultations and enhance patients' overall experience of care. Other elements of our IT programme will ensure we maximise the potential of self-care and monitoring apps and gathering data from wearable devices. • Wokingham and NWR CCGs are piloting voluntary sector co-ordinator roles which will support patients to navigate the system. Learning from these

	pilots will be shared across Berkshire West.
Whilst satisfaction with opening hours is generally high, a significant proportion of patients would like their GP practice to be open more in the evenings and at weekends, or would be willing to access another surgery at these time. Others felt that good access in-hours with an ability to see their own GP was as important as extended opening. There is limited appetite for Sunday opening. Appointments could also be different lengths according to patient need. People are generally positive about accessing their GP surgery in new ways (email, Skype etc) although some said they would need support to do this and others expressed concerns that it must be voluntary and shouldn't substitute face-to-face care. *See also Goal 4 in Primary Care Strategy Engagement Report.*	• We will commission practices to provide extended hours opening across weekday evenings and on Saturday mornings, in some cases working together to maximise access for patients. Maintaining and expanding capacity in-hours, particularly at peak times, will also be a focus. • Under the 2015-15 GP contract, practices are required to offer patients a named GP responsible for co-ordinating their care. This now applies to all patients; addressing the concerns expressed by some around this previously being limited to Over 75s. • GP practices will make best use of technology such as email, texting, online services such as repeat prescriptions and consultations. Information and support will be available for patients from practices to enable then to get started. • NHS 111 will play an integral role for patients to be able to access the NHS locally out of hours.
People recognise that there is a need to promote self-care and to ensure that patients access services appropriately. There is general support for the concept of the NHS 111 service. *See also Goal 4 in Primary Care Strategy Engagement Report.*	• We will use new technology to support self-care as a component of care for patients with long-term conditions. • Our Communications plan will provide more information about self-care for minor ailments and appropriate usage of A&E and other services. • As part of implementing the Strategy the JPCCC will work with the Urgent Care Programme Board to consider the future potential of NHS 111 to

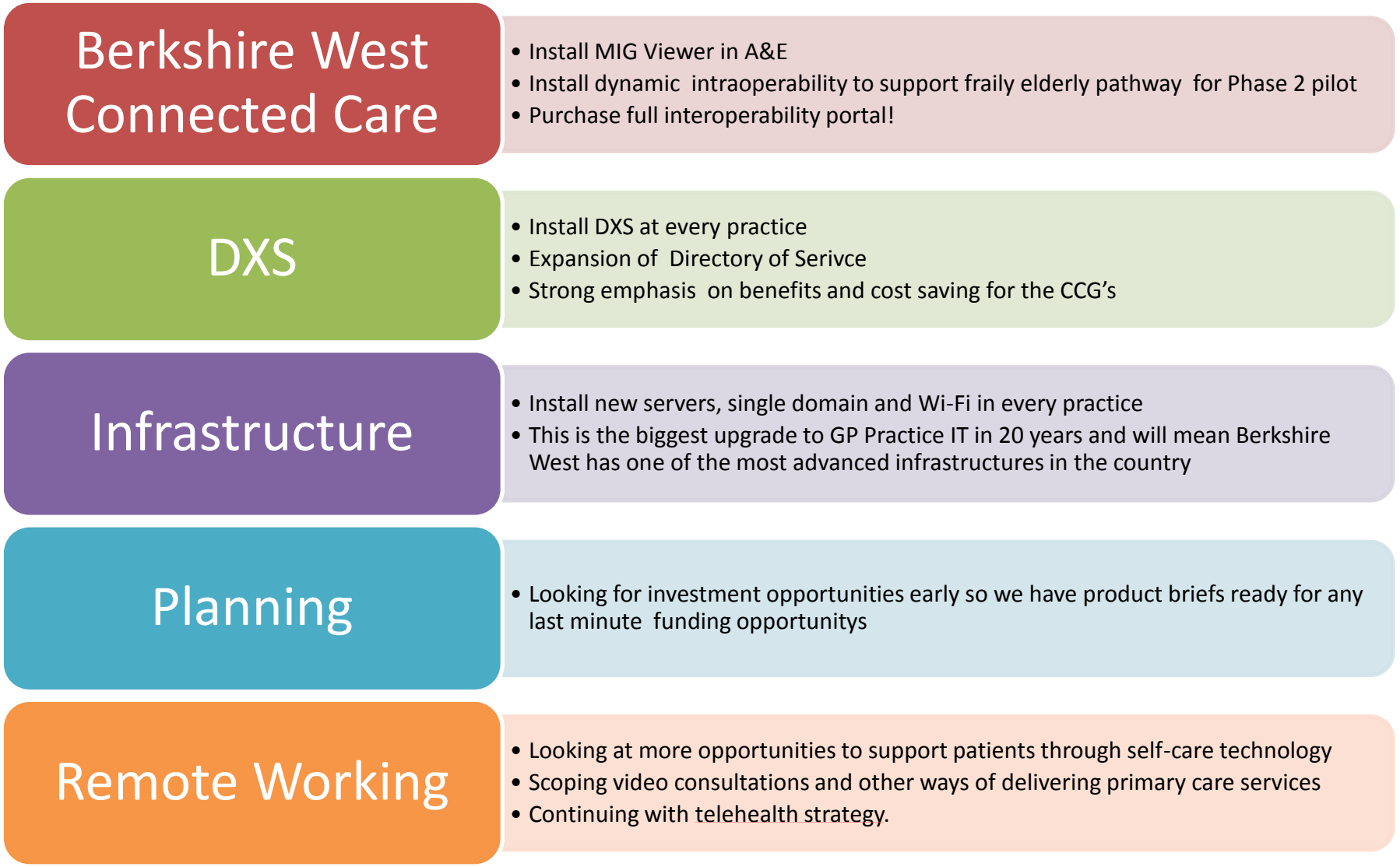
	respond to on-the-day demand for primary care services.
People believe that the voluntary sector could play a greater role in meeting peoples' needs, although there it is important to assure the quality of the services offered and to fund these organisations appropriately. GPs need to be more aware of voluntary sector provision. *See also Goal 3 in Primary Care Strategy Engagement Report.*	• Wokingham CCG are piloting a Voluntary Sector Co-ordinator role as part of their cluster working project. • We are working to improve signposting to voluntary sector provision for example through the Directory of Services linked to the new DXS system and through pilot roles such as the Voluntary Sector Co-ordinator in Wokingham. The provision of information about support to carers through this system is also being explored.
People identified the need for primary care to work with other agencies to support wellbeing and help prevent mental health issues. A particular focus should be ensuring that young families have access to the support they need. Young people were also identified as a priority group. Staff should be supported to understand the needs of particular groups attending practices such as those with learning disabilities. GP practices should work with and support carers; signposting them to other services where appropriate. *See also Goals 1 and 3 in Primary Care Strategy Engagement Report.*	• Our vision for primary care involves practices working at the heart of the communities they serve and with other agencies to prevent both physical and mental ill health and to work as proactively as possible to minimise the impact of illness. • Wokingham's pilot Voluntary Sector Co-ordinator role will have a particular focus on the needs of young families moving to the area. • Information on support services and organisations will be better available to practices through the DXS system (see above). Specific action will be taken to ensure GP practices support carers effectively. • We intend to continue to work closely with practices around continued professional development. This could include providing training around the needs of particular groups.

There is also a view that GP practices should routinely offer more information on the benefits of exercise and how to prevent diabetes and that young families need more support. It was recognised that practices should work in partnership with other organisations to enable early intervention and prevention of more complex health issues. Some patients also indicated that they would welcome more general health advice and health checks. *See also Goal 3 in Primary Care Strategy Engagement Report.*	• NWR and Wokingham GPs are promoting physical exercise through the 'Beat the Street' initiative. We have also commissioned practices to provide support to patients identified as being at risk of diabetes or in the early stages of diabetes. Through this Strategy we will work with Public Health to further build the role of primary care in preventing ill health (see above).
It is recognised that practices will increasingly involve teams of different healthcare professionals, thereby widening the workforce. Patients feel that this is appropriate as they recognise that they do not always need to see their GP but do want to be assured that appropriate leadership arrangements are in place and there is clarity of roles. Most people were positive nurses and pharmacists in particular taking on enhanced roles. Generally people welcomed the idea of more services being available in their GP surgery from a mixed skill-set team and it was felt that this would also make primary care careers more attractive. *See also Goal 1 in Primary Care Strategy Engagement Report.*	• The workforce sections of this Strategy describe how different professionals such as Physicians' Associates, pharmacists and emergency care practitioners may increasingly become involved in the delivery of primary care, with a wider practice team working to support the specific needs of different groups of patients. We will support practices to diversify their teams with clear lines of accountability and information for patients about different professional groups. • The Strategy describes how practices will in future work differently with secondary care consultants and other professionals to provide a much broader range of services in primary care.
People want more planned care for long-term conditions, including continuity of care where possible. Having substantive staff in post supports this. *See also Goals 2 and 3 in Primary Care Strategy Engagement Report.*	• The CCGs recognise that continuity of care is important to patients with complex needs and where this improves outcomes practices should endeavour to provide this. Where different professionals are involved in a patient's care, care planning and better sharing of information will improve communication between them (see above). GPs are also now required under their contracts to identify a named GP for all patients. • The Strategy sets out a range of actions that will be taken to support

	practices to address difficulties in recruiting to substantive posts. We recognise that recruitment is a key challenge for the primary care system and that we need to work as proactively as possible to address this.
People want to understand how the Strategy will play out in rural areas and for smaller GP surgeries which may not be able to host multidisciplinary teams. *See also Goal 1 on Primary Care Strategy Engagement Report.*	• The CCG elements of the Strategy above starts to set out how the vision might be implemented at a local level. This may include smaller practices working together to provide some services, thereby ensuring that patients in all areas have access to the same range of services and supporting practice sustainability. Practical considerations such as a rurality would be taken into account in any such approaches.

We recognise that engagement with the public is an ongoing process. Going forward we intend to undertake specific engagement around key workstreams resulting from the implementation of this Strategy. This will be in addition to any formal consultation required with regard to service changes. We will build upon our successful approach of combining public meetings, focussed discussions with key groups and online publications and surveys to engage with as broad a range of patients as possible; also working through established mechanisms such as our Patient Voice and PPG Forum groups, the Berkshire Health Network and practice-based participation groups. If you would like to know more please contact the CCGs Patient and Public Involvement Team on 0118 9822709 (8.30am-4.30pm, Monday-Friday) or on ppiteam.berkshirewest@nhs.net. Information about how to register with the Berkshire Health Network is also available at https://www.healthnetwork-berkshire.nhs.uk/consult.ti/system/register.

Appendix 2: IM&T investment plans



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TITLE	**Health and Wellbeing Board Sub-Committee – Primary Care**
FOR CONSIDERATION BY	Health and Wellbeing Board on 11 February 2016
WARD	None Specific
DIRECTOR	Stuart Rowbotham, Director of Health and Wellbeing

OUTCOME / BENEFITS TO THE COMMUNITY

To ensure transparency of decision making through the correct governance

RECOMMENDATION

To dissolve the Health and Wellbeing Board Sub-Committee – Primary Care.

SUMMARY OF REPORT

The Health and Wellbeing Board Sub-Committee's Terms of Reference are misdirected; the sub-committee has no locus to carry out its purported aims. The Department of Health has determined that Clinical Commissioning Groups shall be responsible for commissioning Primary Care and a local NHS Joint Primary Care Co-Commissioning Committee has been established for that purpose and has published a Primary Care Commissioning Strategy. The sub-committee's continued involvement would confuse governance and add bureaucracy without adding value.

Background and Analysis of Issues

The Health and Wellbeing Board established a sub-committee to consider issues regarding the development of primary care services within the context of the Council's land development Core Strategy. On review, the Terms of Reference for the sub-committee (Appendix 1) appear to be a misdirection in that it purports to *'act as a Programme Board to manage the planning of local primary care infrastructure to 2026'.* The committee has no standing to co-opt such powers, which are statutorily vested within the NHS, working with the Local Planning Authority.

Additionally, since the sub-committee's inception the landscape for Primary Care Commissioning has changed. The commissioning of Primary Care is now the responsibility of Clinical Commissioning Groups. An NHS Primary Care Co-Commissioning Committee has been established covering the four Berkshire West CCG's as the recognised Unit of Planning for NHS commissioning. Each Health and Wellbeing Board has a representative on the Committee. The Committee has approved a Primary Care Commissioning Strategy, which has been the subject of consultation at each of the Berkshire West Health and Wellbeing Boards.

With regard to Primary Care infrastructure and estate, the responsibility for drafting and agreeing plans sits with the CCG, working with the Council as a Planning Authority. Pre-planning considerations form part of the Council's planning function and the Council executes its planning responsibility through its statutory Planning Committee. It is through these pathways that Primary Care infrastructure is properly governed.

The Health and Wellbeing Board is a key consultee for Primary Care commissioning matters, both with regard to the Primary Care Commissioning Strategy and primary care infrastructure planning consent applications. It is proposed that it is through these mechanisms that the Health and Wellbeing Board exercises its influence with regard to the development of primary care services in Wokingham.

FINANCIAL IMPLICATIONS OF THE RECOMMENDATION

The Council faces severe financial challenges over the coming years as a result of the austerity measures implemented by the Government and subsequent reductions to public sector funding. It is estimated that Wokingham Borough Council will be required to make budget reductions in excess of £20m over the next three years and all Executive decisions should be made in this context.

	How much will it Cost/ (Save)	Is there sufficient funding – if not quantify the Shortfall	Revenue or Capital?
Current Financial Year (Year 1)	N/A	N/A	N/A
Next Financial Year (Year 2)	N/A	N/A	N/A
Following Financial Year (Year 3)	N/A	N/A	N/A

Other financial information relevant to the Recommendation/Decision
None

Cross-Council Implications
Clarifies governance with regard to the Council's planning duties

Reasons for considering the report in Part 2
N/A

List of Background Papers
HWB Sub-Committee Terms of reference (Appendix 1)

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Date 02/02/2016	**Version No.** 1

HEALTH AND WELLBEING BOARD SUB-COMMITTEE

4.4.48 Introduction

The Core Strategy sets out the location and vision for community developments across the Borough to 2026. In taking forward the Core Strategy the Council recognises its responsibility with other stakeholders to meet the health needs of a growing and changing population.

The Health and Wellbeing Board Sub Committee will act as a Programme Board to manage the planning of local primary care infrastructure up to 2026.

4.4.49 Membership

The membership of the Health and Wellbeing Board Sub-Committee will be as follows:

a) Two Elected Members who sit on the Health and Wellbeing Board;

b) Two representatives from the Wokingham Clinical Commissioning Group;

c) One representative from NHS England;

d) One representative from local Healthwatch;

e) Wokingham Borough Council Consultant in Public Health;

f) One Wokingham Borough Council Director;

g) One senior Wokingham Borough Council Planning Officer working on the Strategic Development Location's delivery;

h) One representative representing the Health and Wellbeing Board Partnership Groups;

The Health and Wellbeing Board Sub Committee may appoint such additional persons to be members of the Sub Committee as it thinks appropriate. The appointment of any additional members to the Health and Wellbeing Board Sub Committee will take place at Sub Committee meetings.

4.4.50 Co-optees

With the agreement of the Health and Wellbeing Board Sub Committee individuals may be co-opted to the Health and Wellbeing Board Sub Committee for an agreed period.

Representatives from other key partners may be invited to attend the Health and Wellbeing Board Sub Committee meeting where there is a specific agenda item which would benefit from their engagement. Representatives attending in this capacity will be non-voting attendees.

4.4.51 Appointment of Health and Wellbeing Board Sub Committee

Health and Wellbeing Board Sub Committee members will be appointed at the first meeting of the Health and Wellbeing Board of the municipal year.

4.4.52 Voting
The Health and Wellbeing Board Sub Committee will generally reach decisions by consensus. However, in the event that a vote is required the Chairman will have the casting vote.

4.4.53 Substitutes
Named substitutes are permitted to cover for representatives if they are unable to attend a meeting. Elected Member substitutes should be a member of the Health and Wellbeing Board.

Organisations will appoint a substitute for their representative(s) at the beginning of the municipal year. Appointment as a substitute to the Health and Wellbeing Board Sub Committee may be renewable.

If sub committee members are unable to attend a Sub Committee meeting they may ask the nominated substitute to act in their place (including vote on their behalf if applicable) at the meeting.

Substitute Members will have all the powers and duties of any Ordinary Member of the Board Sub Committee but will not be able to exercise any special powers or duties exercisable by the person they are substituting.

4.4.53.1 Changing Substitutes
Organisations represented on the Health and Wellbeing Board Sub Committee will inform Democratic Services should they change the substitute for their representative(s) on the Board Sub Committee during the municipal year.

4.4.54 Chairman and Vice Chairman
The Chairman of the Health and Wellbeing Board Sub Committee will be appointed at the first meeting of the Health and Wellbeing Board Sub Committee of the municipal year.

The Vice Chairman of the Board Sub Committee will be appointed at the first meeting of the Health and Wellbeing Board Sub Committee of the municipal year and can be any other member of the Board Sub Committee.

4.4.55 Functions
The Health and Wellbeing Board Sub Committee will:

a) bring together relevant stakeholders and partners to ensure effective discussion of the commissioning of local health services as the Borough's population grows and changes;

b) effect decision making regarding the commissioning of local health services by providing recommendations to the Health and Wellbeing Board and other commissioning partners, how and where investment, resources and improvements could be made within the Borough.

4.4.56 Meetings
The Health and Wellbeing Board Sub Committee shall meet on a basis agreed by the Health and Wellbeing Board Sub Committee.

Additional (extraordinary) meetings may take place with the agreement of the Chairman. Dates, times and locations of meetings will be agreed by the Health and Wellbeing Board Sub Committee and published.

4.4.57 Reporting Lines
The Health and Wellbeing Board Sub Committee will report and make formal recommendations to the Health and Wellbeing Board as appropriate, in accordance with functions described in 4.4.55.

4.4.58 Attendance of Public and Press
The Health and Wellbeing Board Sub Committee will meet in public, unless confidential or exempt information is to be discussed, and the Access to Information Rules contained in Chapter 3.2 of this Constitution set out the requirements covering public meetings. The principles of decision making set out in Chapter 1.4 will apply to meetings of the Board Sub Committee.

4.4.59 Public and Member Questions
Public and Member questions can be asked in relation to items under their remit in accordance with the requirements set out in Chapter 4.2 of this Constitution.

The total time allotted questions from the public will be limited to 30 minutes and Member questions will be limited to 20 minutes. The total time allotted to public and Member Questions may be extended at the discretion of the Chairman.

At meetings after each main presentation, members of the public present will be allowed to ask questions (through the Chairman). Any questions from the floor must be relevant to the item or presentation just received, and not relate to personal cases. Question time would be limited to 5 minutes per item at the discretion of the Chairman.

4.4.60 Speaking Rights
A Member of the Council who is not a member of the Board Sub Committee shall be entitled to attend and speak (but not vote) at any full public meeting of the Health and Wellbeing Board Sub Committee at the discretion of the Chairman.

4.4.61 Quorum
The quorum of a meeting of the Health and Wellbeing Board Sub Committee shall be three.

If there is no quorum at the published start time for the meeting, a period of no more than 10 minutes will be allowed, and if there remains no quorum at the expiry of this period, the meeting will be declared null and void.

Where a meeting is inquorate those members in attendance may meet informally but any decisions shall require appropriate ratification at the next quorate meeting of the Board Sub Committee.

4.4.62 Code of Conduct
All voting members of the Health and Wellbeing Board Sub-Committee will be subject to the Code of Conduct for Councillors set out in Chapter 9.2 of this Constitution.

When recommending a course of action that, if acted upon by the Health and Wellbeing Board, will either positively or negatively directly affect any organisation or business

which provides services under contract to the NHS, sub committee members from these bodies will either need to declare a personal interest or in the case of a Disclosable Pecuniary Interest, receive a dispensation.

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HEALTH AND WELLBEING BOARD

Forward Programme from June 2015

Please note that the forward programme is a 'live' document and subject to change at short notice.

The order in which items are listed at this stage may not reflect the order they subsequently appear on the agenda / are dealt with at the scrutiny meeting.

All Meetings start at 5pm in the Civic Offices, Shute End, Wokingham, unless otherwise stated.

HEALTH AND WELLBEING BOARD FORWARD PROGRAMME 2015/16

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
14 April 2016	**Performance metrics**	To receive an update on performance regarding: • Better Care Fund • Implementation of Care Act • Health and Wellbeing Strategy • NHS, Adult Social Care and Public Health Outcomes Framework	To monitor performance	Health and Wellbeing Board	Performance
	CCG Operating Plan	For approval	For approval	CCG	Organisation and Governance
	National Information Board – Local Digital Roadmap	For approval	For approval	CCG	Organisation and Governance

	Children's Disability Strategy	For information	**Strategy Theme**: Improving Life Chances **H&W Priority**: Children and Families **Objective**: 3d, Agree joint WBC / CCG arrangements for the education, health and care provision for children and young people with special educational needs and for those with disabilities and difficulties	Judith Ramsden, Director of Children's Services	Organisation and Governance
	Local Account	To endorse the Local Account	To endorse the Local Account	Stuart Rowbotham, Director of Health and Wellbeing	Organisation and Governance
	Children and Young People's Partnership – Early Health and Innovation Project	Update	Update	Judith Ramsden, Director of Children's Services	Health and Wellbeing\
	Health and Wellbeing Strategy	To sign off refreshed Health and Wellbeing Strategy	To sign off refreshed Health and Wellbeing Strategy	Health and Wellbeing Board	Health and Wellbeing
	Better Care Fund 2016	To discuss the Better Care Fund for 2016	To discuss the Better Care Fund for 2016	Stuart Rowbotham, Director of Health and Wellbeing	Integration

	Update on Neighbourhood Clusters	To inform the Board of progress made regarding the Neighbourhood Clusters	Update on progress	Stuart Rowbotham, Director of Health and Wellbeing	Integration
	Emotional Health and Wellbeing Strategy performance scorecard update	To receive an update on the progress of the Emotional Health and Wellbeing Strategy performance scorecard	Update on progress	Judith Ramsden, Director of Children's Services/CCG	Integration/ Organisation and governance
	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance
	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	

Site visits:

- Wokingham Hospital - TBC