MINUTES OF A MEETING OF THE
HEALTH OVERVIEW AND SCRUTINY COMMITTEE
HELD ON 29 SEPTEMBER 2010 FROM 7.00PM TO 8.50PM

Present: Tim Holton (Chairman), Norman Gould (Vice Chairman), Alistair Corrie, Kate Haines, Charlotte Haitham Taylor and Emma Hobbs

Also present

Edward Donald, Chief Executive, Royal Berkshire NHS Foundation Trust
Bev Searle, Director of Partnerships and Joint Commissioning, NHS Berkshire West
Dr Stephen Madgwick, General Practitioner
Christine Holland, LINk Steering Group
Ella Hutchings, Interim Partnership Development Officer, Wokingham Borough Council
Mike Wooldridge, Development & Improvement Manager, Wokingham Borough Council
Dave Gordon, Senior Democratic Services Officer

28. MINUTES

The Minutes of the meeting of the Committee held on 27 July 2010 were confirmed as a correct record and signed by the Chairman.

29. APOLOGIES

Apologies for absence were submitted from Malcolm Armstrong, Andrew Bradley, Gerald Cockroft and Kay Gilder. In addition, Alex Gild (Berkshire Healthcare Foundation Trust) gave apologies.

30. DECLARATIONS OF INTEREST

Kate Haines declared a personal interest in the matter of a complaint she was pursuing with the Royal Berkshire Hospital which was proceeding through official channels at present.

31. PUBLIC QUESTION TIME

In accordance with the agreed procedure the Chairman invited members of the public to submit questions to the appropriate delegates to the Committee.

31.01 Question

Mrs Kathie Smallwood asked the Chairman of the Health Overview and Scrutiny Committee the following question, the reply to which is set out underneath:-

Are you aware that some health employees such as Occupational Therapists have had an effective pay cut by the removal of car allowances and free parking even though they are essential car workers and for them to use public transport would be unrealistic?

Answer

In common with all local authorities, Wokingham Borough Council is having to make significant in- year savings and will need to make savings in future years. We have looked very carefully at ways of achieving these savings from smarter procurement of goods and services, through income generation and by not filling vacant jobs whenever we can.

Whilst these contribute substantially to the savings required it does still leave us with some shortfall in savings. We are seeking to make good this shortfall by reducing overtime wherever possible, reducing the rate of mileage allowances for all staff and members,

reducing the number of staff receiving a high mileage car user allowance of £963 p.a. and ceasing to offer free car parking for staff and Members.

These measures are designed to reduce the need for redundancies. We have tried to do these things in as fair a way as possible and in ways that reduce the impact on lower paid staff where we can.

We are currently reviewing detailed aspects of those schemes to make them even fairer, if possible, whilst still meeting the savings that have to be made.

Supplementary Question
Was there no way of exempting essential workers, as they have no option as public transport would be impracticable?

Answer
A written response was sought after the meeting from Geoff Munday (Organisational Development Manager, Wokingham Borough Council).

31.02..Question
Mr Bill Smallwood asked the Chairman of the Health Overview and Scrutiny Committee the following question, the reply to which is set out underneath:-

In 2006 the Government gave a grant to all local authorities for Telecare. How has Wokingham Borough Council used this money?

Answer
Wokingham Borough Council used the Telecare Grant in several ways. Primarily it was used to provide equipment for Wokingham residents in their own homes. Just over 700 people received telecare equipment over the two years of the grant funding.

Examples of equipment included:
- Bed and chair occupancy sensors, designed to reduce the risk of falling.
- Property exit sensors and door alarms to reduce the risk of vulnerable people (particularly those with dementia) from leaving their homes and becoming lost.
- Telecare sensors such as smoke, CO2 and gas detectors provided to reduce the risk of harm to individuals from environmental dangers such as the presence of fire, carbon monoxide or natural gas.
- Monitoring systems like “Just Checking” and “Safer Walking” devices support informal carers looking after someone with dementia.

The grant also provided equipment into sheltered accommodation and care homes. This included:
- A flat dedicated for respite/short breaks fitted with the full range of telecare equipment to enable customers to experience its use as well as provide a demonstration function.
- Telecare equipment in our two residential care home to enhance internal communication between staff and provide specific sensors so that staff could respond quickly should a resident need attention.
- Telecare equipment in sheltered accommodation within the borough, for example, 80 carbon monoxide detectors.

In order to get the most out of the investment and make sure that the equipment was getting to those people who could benefit, some additional money from Supporting People

and prevention investment funded a specialist Occupational Therapist to run a two year Telecare AT Home Service.

The service offered people eligible to help from Community Care access to the equipment and its installation but also gave advice and information to the general public to help them access the benefits of telecare as a prevention measure. The postholder also promoted telecare by giving talks in the community and raising awareness among professionals in health, housing and social care.

Supplementary Question
Will this investment in infrastructure be continuing to assist those in difficulty requiring services?

Answer
This was the intention, although the absence of a grant would make this more difficult. The use of a consultation was vital in boosting the level of service available to users.

32. MEMBER QUESTION TIME
There were no Member questions

33. CHIEF EXECUTIVE, ROYAL BERKSHIRE NHS FOUNDATION TRUST
Edward Donald gave the presentation outlined on the papers circulated to members prior to the meeting. Having been in post for six months, he was now in a position to start making some judgements as to where the Trust was and what plans it should have for the future. In addition, the context of the 'Equity and Excellence: Liberating the NHS' White Paper was discussed, as well as the areas of interest identified by Councillors which had been sent to Edward Donald.

In terms of the Trust, once constant in its history had been a commitment to innovation. However, this was also linked to a desire to keep matters as simple as possible, and ensure that the focus remained on the basic aims of the best possible patient experience, the best possible health outcomes and the lowest possible cost. Examples of innovation included the Copeland shoulder (which now had international recognition) and the Harold Hopkins lymphoscope. In addition, the Children's Services team had done much work on bicycle helmet design and the Trust had received a CHKS award for quality of care, as well as receiving national recognition regarding its response time for heart incidents. A series of shortlists also had representation from the Trust (e.g. best patient experience, 'Get It on Time' Parkinson's campaign), but there were also still areas of concern. The most expensive issue was the slow discharge of patients, with Berkshire West PCT estimated to have spent over £1 million on the matter. However, this issue was not of great concern on Trust premises in the Wokingham Borough Council area. The Trust was also committed to engaging with patients' groups and the local LINk, with one main aim being to improve the book-in service for patients. In terms of ophthalmology, the level of cancellations was a positive but work was being undertaken to lower the number of complaints being made. At present, Martin Leyland was involved in establishing a protocol to ensure the safe signing off of patients from the Prince Charles Eye Unit.

A recent joint review of maternity services (held in conjunction with Berkshire West PCT) had recommended that the amount of intervention in births was a matter of concern; the Trust supported this, and was committed to raising the number of natural births taking place. On hospital acquired infections, a zero tolerance policy had been put in place, with Clostridium Difficile rates now amongst the lowest in the country with better tracking

measures now being implemented. As mentioned previously, the corporate focus on simple measures had been enacted here; thorough hand washing policies, for example, had made significant inroads on this matter.

However, the strategic challenges facing the Trust were similar to those faced across the NHS. At present, the Trust faced a £153 billion gap between receipts and expenditure; despite budgets being ringfenced, £20 billion of savings had to be made by the NHS, with a total of £60 million in the next three years being trimmed from the Royal Berkshire budget. In the wider context of the 'Equity and Excellence' White Paper, the Trust had already been moving from an administration-led organisation to a clinically-led one, and this was reflected in the Government's proposals. The desire to put patients at the heart of the process, with the phrase 'no decision about me without me' being a keynote theme in the White Paper, fitted with the Trust's recent ethos and led to Edward Donald's desire to become a beacon organisation. However, there were also some areas where the Trust would seek clarification; firstly, the role of Monitor. Their position could lead to some confusion, as it seemed possible that they could be in charge of both the setting of prices and regulation of Foundation Trusts. In addition, the matter of patient care from the point of hospital discharge to the first four weeks back home raised questions; would this be the responsibility of the NHS or local authorities?

In terms of models of care, recent research by The King's Fund estimated that, should the NHS budget have an average annual inflation rate of 2% until 2080, by this date it would be consuming 80% of the United Kingdom's Gross Domestic Product; this was also envisaged to be a global phenomenon. As a result, partnership working to tackle problems such as heart conditions and diabetes was being built into the system, with home based care to be a major element; here, electronic patient records would be of paramount importance. Vascular and hyperacute treatments would be organised in a new fashion. Management would become as lean as possible, with an urgent focus on ensuring that funding reached frontline services. The Trust was committed to working through international best practice models to find the best solutions for the area.

Committee Members made comments as follows:

- At present, Clostridium Difficile and MRSA were having data on them published. Wee other hospital acquired diseases subject to the same monitoring?
  The overall picture was good at present, but the need to identify other areas of concern was pressing. The White Paper in general terms has spoken of the need to go beyond data, and we shall continue to publish the data on this and extend the focus beyond Clostridium Difficile and MRSA. Dr Foster Intelligence was compiling work on clinical outcomes which would be used to benchmark services.
- With reference to Caesarean sections, did women have a choice as to whether to pursue natural birth or not? If so, how would the Trust persuade pregnant women to give birth naturally?
  There was a major debate around this matter, as childbirth had been a major killer and Caesarean sections had lowered mortality rates. However, a major element in this matter was a suitable environment in which to give birth naturally; if this was not in place, then mothers did not have a real choice. Midwives also needed to be able to lead the environment in which they worked; however, the Trust faced a challenge here as Caesarean section rates were relatively high. Home childbirth was provided as an option by the Community Team.
- How would the Trust work to ensure that the elderly avoided thrombosis?

The trimming of staff levels had arisen early into Edward Donald's tenure of office; it did seem that they had gone too far on this matter. If staff levels were to reduce across the board, then prioritisation would be imperative.

- Should the return of Matrons become a reality, would this assist the Trust's work?
  The Royal Berkshire Hospital had a significant number of matrons, whose responsibilities were the running of wards and monitoring of budgets. However, Edward Donald had commented internally regarding a decline of standards during night shifts, and matrons were working to improve this; this had become a major priority.
- What were the listed areas for specialisms?
  A written response from Edward Donald would be received after the meeting.

RESOLVED: That

1) A written response from Edward Donald regarding specialisms be requested.

2) That the presentation be noted.

34. PRACTICE BASED COMMISSIONING AND THE FUTURE ROLE OF GP CONSORTIA

Dr Stephen Madgwick introduced the report, as outlined in the agenda pages seven and eight. In Wokingham, 14 GP practices operated as a consortium; representatives from each of the practices met one per month at a meeting under one chair. The situation across West Berkshire was similar, with 4 localities being represented by their lead GPs at a joint meeting for the area. Up until the publication of 'Equity and Excellence' the Primary Care Trust had been in charge, with GPs offering input; however, the White Paper has accelerated change in that relationship considerably. Views amongst GPs may be mixed, but support for the greater role of GPs was widespread.

Health Secretary Andrew Lansley has outlined a future where GPs are to replace PCTs as the commissioning bodies by April 2013. Not all PCT functions will be transferred to GPs, but a majority will; local authorities will inherit some new powers, with public health one area which may also be transferred to them (a paper clarifying this was due for publication in autumn 2010). GPs would be working with local authorities, public health bodies and the wider public to ensure that all parties were represented in discussions and offered assistance as required. The matter of aligning services to cope with the financial situation was also being considered. In summary, GPs felt that the situation was one in which a clean slate would be in place; if competence, expertise and financial awareness could be demonstrated, then fewer constraints would be in place under this Government than the last.

In practical terms, GPs were organising themselves into a commissioning body; it was possible that these would not respect the boundaries of local authorities but rather extend across West Berkshire. To respect current localities may not make sense in the new environment; for example, to maintain 4 financial officers across the whole of West Berkshire would quadruple this cost compared to appointing one. Despite this, it was likely that localities would maintain some autonomy. The current plan would be for each locality to sit on the West Berkshire GP Board and plan strategy collaboratively. In addition, meetings would be held with the PCT as they would have to shadow the PCT's responsibilities during and after the handover. Once this had been resolved, collaboration with colleagues and Wokingham Borough Council would take place to initiate the culture change. Patient representatives (e.g. LINk) would also be consulted to ascertain how best to represent 'the patient voice'. Work with the Royal Berkshire Hospital was also ongoing;

a meeting with consultants had been held in September 2010 to discuss care issues (e.g. rehabilitation) and a number of ideas were emerging. In terms of Wokingham Borough Council, Dr Madgwick took the opportunity to highlight its work in housing those in need of residential care. This helped with delayed discharges from the Royal Berkshire Hospital, and would be beneficial if continued (despite funding issues having the potential to complicate matters). At present, much work was taking place and the environment for GPs was dynamic and evolving.

Committee Members made comments as follows:

- At an NHS event in September 2010, one Councillor attended a workshop on public health. The role of Councils in preventative care and rehabilitation had some omissions and few guidelines; however, healthcare professionals seemed to expect that local authorities would increase in prominence. Did Dr Madgwick have a view on this?
  The Public Health Paper would have to be awaited for detailed answers on this question. Local authorities would see funding to undertake prevention campaigns (e.g. anti-smoking, exercise), but dialogue would be paramount on this. Bev Searle added that resources would be transferred over, with some public health professionals being transferred over to assist local authorities.
- Would accountants with NHS knowledge be employed?
  This would be essential; as management costs are cut, a higher quality of staff would be required to fill any emerging skills gap.
- How would the public be represented given the wide divergence in their views? How would 'hard to reach' sections of society be represented?
  These would have to be channelled via bodies such as LINks, but work would be undertaken to respect the diversity of views and interests amongst the public. In terms of the 'hard to reach', GPs already had significant links with these parts of society; the need for a wide spectrum of respondents was noted within the NHS.
- How does the market fit into the new system? Given the increased competition, how would under achievement be managed?
  This would have to be monitored; one area where Wokingham Borough Council area practices were struggling was the use of resources. Here, problems were named and investigated; GPs who under performed would be noted and educated, but the exact mechanics of any new system were still unclear.
- Was there a risk that one effective monopoly was being replaced with another?
  This was recognised as an issue; any willing service provider who could meet standards should be supported.
- Would the dynamic of communications within smaller practices be translated effectively into the new larger structures?
  It was not yet clear whether consultation with Wokingham Borough Council or GP consortia would be required; local authorities faced similar issues with the future of public health.

RESOLVED: That

1) Dr Stephen Madgwick be invited back to address the Committee on future progress on GP commissioning.

2) That the report be noted.

35. FUTURE OF HEALTH SCRUTINY FOR LOCAL AUTHORITIES

Dave Gordon gave the presentation outlined on agenda pages 9 to 11. The presentation focused solely on the implications for local government health scrutiny, although also touched upon general themes as these would have an impact on the matter. Members were directed to Section 4 (Autonomy, Accountability and Democratic Legitimacy) of the 'Equity and Excellence' White Paper for further details, and in particular page 35 which specifically discussed Health Overview and Scrutiny Committees.

The phrase 'no decision about me without me' highlighted the greater role intended for patients, and the movement of powers from Whitehall to Town Hall also featured heavily in this White Paper, as with many other recent Government documents. Additionally, as central targets and bodies such as PCTs and Strategic Health Authorities lost influence, local authorities stood to inherit many of these roles. HealthWatch England was also being put forward as a 'consumer champion', which would sit within the Care Quality Commission. The future of LINks had been under discussion, but the move for them to become 'local HealthWatches' may extend their lifespan.

In terms of Health Overview and Scrutiny Committees, it did appear that they may soon become obsolete. However, Councillors and local authorities may be inheriting more powers, but may have to refocus. In particular, work in conjunction with a range of external providers and also other local authorities in the region could become increasingly prevalent. The Committee would be updated as details emerged on these matters. It was hard to generalise as to whether this would increase or decrease the ability to scrutinise health matters, although it would certainly seem possible that Wokingham Borough Council's autonomy to decide its own workload might increase. The new bodies in charge of the regime would be Health and Wellbeing Boards; there would be an 18 month transitional phase during which details would become clearer. In summary, the Government's legislative and economic programme, as to be outlined during the autumn of 2010, would clarify matters and give the first clear indications as to precise policy measures which would have an impact.

RESOLVED: That the report be noted.

36. LINk UPDATE

Christine Holland updated the meeting, talking to the report included on the agenda pages 12 and 13. As with other partners of Wokingham Borough Council, funding had been reduced for Wokingham LINk. Ongoing discussions would value the input from the voluntary sector and other relevant parties; in terms of 'Equity and Excellence', Wokingham LINk had provided a response but was disappointed with the impact of their recommendations.

RESOLVED: That the update be noted.

37. REPORTS ON 'CARE FOR THE FUTURE' AND PALLIATIVE CARE

The reports, on agenda pages 14 to 16, were discussed by Bev Searle. The paper on 'Care for the Future' was a high level briefing regarding East & West Berkshire and Buckinghamshire and their long term plans to meet the needs of local populations. This was still at an early stage, with the overall vision still under development. The Health Overview and Scrutiny Committee's input would be vital, and consultation on the matter should be put on the Committee's Forward Plan. The Chief Executive of NHS Berkshire West would be involved in making the best use of available resources. The Berkshire Healthcare Trust had taken forward plans on the scope of work for mental health; this work

was separate from the 'Care for the Future' programme. Consultations on plans for Berkshire East were being monitored by Wokingham LINk.

The report on palliative care related to public engagement and working to ensure that all patients' needs were met. The model was 'hub and spoke', as there was some concern that services had been too focused on in-patients, with those in the community (particularly in rural areas) not receiving the same attention. This focus was being changed, and the document had been provided to inform the Committee that this work was underway. Bev Searle would bring this matter back to the Committee once feedback from local residents had been obtained.

RESOLVED: That the Committee place consultation on the vision for 'Care for the Future' on the Work Programme for the next meeting.

38. COMMITTEE WORK PROGRAMME 2010 – 11

After discussions, the following requests were made for the Work Programme.

RESOLVED: That:

1) Overview of consultations to be placed on the agenda as a standing item;

2) Care for the Future to be placed on the Programme for 24 November 2010;

3) Dr Stephen Madgwick be asked to return to the Committee on 24 January 2011 to discuss GP commissioning;

39. ANY OTHER ITEMS WHICH THE CHAIRMAN DECIDES ARE URGENT

Tim Holton distributed copies of the response given to the Committee regarding medication errors occurring during day and night shifts. In addition, the Committee were informed that 2 new NHS dentists had received contracts; they would cover Finchampstead and Lower Earley, and would start around the turn of 2010 / 11.