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.

ITEM NO: 46:00

TITLE	**Wokingham Joint Strategic Needs Assessment**
FOR CONSIDERATION BY	Health Overview and Scrutiny Committee on 24th November 2010
WARD	All wards
GENERAL MANAGER	Heather Thwaites, General Manager Policy and Partnerships

OUTCOME

The Joint Strategic Needs Assessment outlines the health and wellbeing needs of the community. It is developed as a tool and reference point from which to inform service planning and commissioning strategies. The JSNA covers all of the population of the Borough, both children and adults.

RECOMMENDATION

That the committee be informed of the process and development of the JSNA for 2010.

SUMMARY OF REPORT

The JSNA is a statutory requirement for local areas to develop and publish. The Public Health Team in the Primary Care Trust have taken the lead in project managing the development of the JSNA. Although the requirement to produce a JSNA is clear, there is little guidance as to what form it should take, with methodologies varying widely across the country.

In previous years the JSNA has been ostensibly about pulling together data that is currently available into one place to provide an overview of health and wellbeing across the borough. In 2010 the approach has been altered to a modular approach that provides key decision makers with specific information that they require in order to make effective commissioning decisions.

The new modular approach has been agreed and adopted by the Berkshire Commissioning Partnership (Directors and Chief Executives), which also sponsors the management and delivery of the JSNA. This partnership has set the programme of modules that are to be researched within the JSNA, with requested modules being lead in service areas and drafted with input from key staff.

Background

2010 will be the third year that the Council and Primary Care Trust have been required to complete a JSNA. In the two previous years, the process for producing the JSNA has focused on compiling a range of existing health related data under a range of different issues, which is then published with a brief piece of analysis from health and local authority professionals.

Whilst this approach did produce a clearly identifiable document, it was felt that it would prudent to investigate whether an alternative methodology would produce a more effective product. Contained within this view were two key questions; firstly, was the correct data available on which to complete an accurate analysis, and secondly, was the information produced actually for decision-makers making key commissioning choices?

In the early part of 2010, a small group of professionals from the three Berkshire unitary authorities and a selection PCT managers undertook to develop an alterative approach that would address the two key questions detailed above. The result of this is the modular approach that is now being undertaken.

Under the modular approach, the Berkshire Commissioning Partnership has identified a series of commissioning issues that it needs to address, and tasked each local authority area to undertake swift pieces of analysis to identify key local priorities. This evidence is then compiled into a summary report that is presented to the partnership.

The result of this approach is that the Commissioning Partnership is receiving the evidence it needs throughout the year when making commissioning decisions, and that each local authority area is able to input all of its local data and knowledge into the process. Appendix 1 to this report shows what modules have been requested by the Berkshire Commissioning Partnership and provides a summary of their findings and recommendations.

Analysis of Issues

Last year the Health Overview and Scrutiny Committee received a presentation from Dr Sallie Bacon about key issues that WBC and West Berks PCT needed to plan for. These were notably:

- The increase in the population of older people, including the increase in numbers of people with dementia
- The increase in numbers of people living with long term conditions and
- Tackling lifestyle factors such as smoking, obesity in adults and children and alcohol usage.

These issues continue to be the key strategic needs to consider in the Borough and require medium to long term strategies to address.

Reasons for considering the report in Part 2

List of Background Papers
JSNA 2010 final summary reports for Stroke, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease and Diabetes.

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Date 12th November 2010	**Version No.** 1

Appendix 1

NHS
Berkshire West

The Joint Strategic Needs Assessment process, 2010-11-10
Update for Berkshire West Commissioning Partnership.

Following the baseline document produced in 2008 and the three Local Authority focused JSNA reports finished in 2009, the JSNA has been proceeding as a joint modular development throughout 2010. Modules are developed involving a wide range of stakeholders and underpinned by bringing together the most up to date data and information available. Modules are developed on a rolling modular program, though the actual output documents will remain live so that new information and emerging issues can be included as required

Phase one modules completed are:

- Dementia
- Stroke
- Cardiovascular Diseases
- Diabetes
- Coronary Obstructive Pulmonary Disease

Phase two modules (scheduled to reach a final draft stage before Christmas) are:

- Children and Young People
- Demographic overview of Berkshire West.
- Long Term Conditions and Older People
- Mental Health
- Wellbeing and Prevention

Phase three modules for which background work is already going on, but which will become the mainstream development in January 2011 are:

- Cancers
- Inequalities
- Wider Determinants of health

In order to inform planning processes the emerging findings of each module are detailed into a comprehensive document, but are also summarised into short summary briefs and these have been reduced down to a key fact matrix. See below:

Summary of Recommendations for Commissioners in JSNA 2010 on Long Term Conditions

	Clinical area	Numbers	Prevention	Primary Care	Intermediate/Community Care	Secondary Care	Summary/Notes/Further work needed
1	Dementia	4,290 (exp) 1,536 (known) 5,800 by 2020	Vasc risk ie Smoking cessation Alcohol reduction	Early diagnosis/QOF Peer Support Information/Advice Social care support	Memory Clinics (BHCFT) Dementia Care Advisors EoI care	Dementia MH Liaison Team in RBH	Funding agreed. Going through CPMG
2	Diabetes	22,210 (exp) 15,517 (known) 29,452 by 2020	Weight management Physical activity BP Smoking cessation Increased awareness in at risk communities	Early identification Personalised Care plan Education/advice - Type 1 and 2 Medication (NICE) Renal function BP control Target at risk populations EoL	Community based services and Shared Care model National Diabetes Audit Insulin adjustment in primary care Insulin pumps Promote uptake of retinal screening IAPT services Training GPs and community/practice nurses	Think Glucose Move to Integrated model of care which is largely community based. Review services for children, adolescents and pregnant women with type 1	Some of this work already underway but much greater move to community based service needed
3	COPD	9,000 (exp) 4,579 (known) ? projected nos	Target deprived communities Smoking cessation	More equitable care across practices Increased awareness Early identification Information, advice Full respiratory service all areas Training for Primary care professionals Flu vaccination EoL	Workplaces awareness and spirometry Pulmonary rehab all areas Home oxygen service Oxygen alert cards End of Life Care Active case management severe cases (CMs) Integrated Care pathway Advanced care planning Audit referrals and admissions and EoL care	Inpatient include non invasive ventilation Out patient *domiciliary* ventilation and oxygen assessments Supportive care for end of Life with Clinical Nurse Specialist	

					Admission prevention schemes		
4	CVD	11,701 (known) 14,201 (exp) 16,201 by 2020 1,040 deaths 2008	Weight reduction Physical activity Smoking Alcohol reduction BP, cholesterol Health Checks Target deprived and BME communities Raise awareness Lifestyle interventions	Health Check programme LES Early identification of heart failure Prescribing Detection of AF Flu vaccination Improve quality across primary care New NICE guidance for chest pain Familial Hypercholesterolaemia service to be developed? EoL	Health Check programme community Cardiac Rehab review Review heart failure nursing team Ensure equity of access (HIA) Access for people with serious mental illness	Angiography Angioplasty CABG (UCL) Primary PCI Ensure services will meet needs of projected increase in numbers of people with CVD	Programme budgeting spend £105 per person on BW. Lowest spend in ONS cluster. Outcomes below cluster average (SMR, BP and cholesterol control)
5	Stroke/TIA	2,317 stroke/TIA known 2,829 in 2020 528 admissions 2008 110 stroke deaths in 2008	Weight reduction Physical activity Smoking cessation Alcohol reduction	Early identification risk factors – health checks Targeting at risk groups Good management of risk factors eg BP control, BS, Chol, renal function. Interventions eg smoking cessation, weight management, Physical activity Information and advice EoL	Community based services for rehabilitation and support Speech and language assessment after 12 weeks Early supported discharge Good transition between services Develop and implement guidelines for review Support for carers Information and support Expert patient programme Re-ablement services Health Impact assessment	Ensure compliance with national stroke strategy TIA clinics 7 days a week Admission to acute stroke unit for 90% of hospital stay. TIA access to carotid imaging in primary and secondary care within 24 hours Increase % access to scan to assess for thrombolysis following stroke	Better prevention Better integrated models of care and ongoing support in community

6	LTnC In progress	Includes Stroke as well as other neurological conditions including Parkinsons, epilepsy, Motor Neurone Disease	Not all preventable	Identification in primary care important eg for Parkinsons to optimise therapy Ongoing support for patient and carers Optimising treatment were appropriate. EoL	Multi-disciplinary care health and social care input Personalised care plans Personalised budgets? Support for carers Respite, residential care Re-ablement	Specialist care and advice and support where necessary	Joint working with health and social care

Janet Maxwell DPH, 11/10/2010

Visit to the RBH CDU department 11th October 2010. **ITEM: 48:00**

Representing WBC: Gerald Cockcroft, Emma Hobbs, Kate Haines and Norman Gould

Representing RBH: Mary Wells , Georgina Brown Matron for A&E, CDU, Nigel Davies Chief Nurse and John Simmons Clinical Service Director.

The CDU Dept is an admission department where referrals have taken place from a GP. On admittance, the patient will be assessed by a nurse or practitioner and will either be moved to a bed or after advice be sent home. If a patient is brought in by ambulance and is not required to go through A&E, the patient will be taken directly to a bed. There the patient will be assessed and where required for further long-term treatment, moved on to a main ward.

There is a consultant on the CDU unit 24 hours a day, 7 days a week. This includes a daytime visit Kidney specialists, Urology and Cardiac Unit specialists.

Staffing levels for the unit consist of Matron, Nurses, Doctors and Consultants offering a full service to the unit. Staffing rotas are provided and the unit caters for extra staffing during the afternoon and evening as this has proved to be the busiest time for CDU.

Patients have just completed a survey from RBH, asking if the patient felt they received enough information whilst on going treatment. This survey came back very positive. The attendees did not view the outcome of this.

In the event patients become violent or start abusing staff, security will be called. This may result in the patient being allocated to a main ward.

The main problem that CDU currently have, is Bed Blocking. This currently runs at approximately 50 patients at any one time.

We asked what the staff of CDU would like to happen under the new structure of the NHS. The main problems highlighted were:

- Lack of communication between Boroughs, Districts and Unitary
- Every area has a different telephone number
- Communication systems do not join up around Berkshire and Oxfordshire
- Outside services need to work closer with Emergency Care

<u>A cost effective solution to Bed Blocking:</u>

The four main areas within RBH's area is to have one telephone number to feed information requirements for home care, nursing care, care homes. From that one point of contact, staffing is then distributed between areas. This could be as little as four. It would be their responsibility to seek out the appropriate requirements for that patient, put them in place and confirm information back to the manager, who in turn will contact the hospital.

The CDU staffs then are free to do their jobs instead of spending and wasting a great deal of time ringing around.

We as a committee suggest under the new GP's authorisation that HOSC approach Dr Stephen Madgwick Head of Practice Based Commissioning and System Reforms to look into a practical cost effective solution to this problem.

CDU Ward:
The ward is split with male and female areas; all have separate male and female bathrooms and toilets.

There is one joint male and female area this being the xxIDU unit and extra staff are placed there.

Each ward holds 6 beds, which are well positioned to allow access around them and still giving the patient privacy.

3 assessment rooms, in the event a bed is not needed.

1 waiting room.

Several private rooms for the more accute

The corridors of the unit are cleared to the best of their ability. There is a number of machine equipment held down the corridor, but this is kept well up against a wall leaving the centre free for walking.

Two main desks are within the unit, fully manned.

One restricted staffing room where this holds the computers etc and all information and telephone calls can be made.

The wards and corridors were clean and kept free of debris, staff had their hair tied up. However, it was noted that some scrub trousers were too long and dragging on the floor. The uniform maybe needs looking at so staffs keep themselves free from infection and dirt to the best of their ability.

There is a strict conduct of dress code; clothing must be kept free to elbows and all jewellery and watches removed. There are a number of liquid hand washes and staff and visitors are to use these on entering and exiting at all times.

Georgie, the matron, has an enormous job with A&E and the CDU unit; it was nice to see the matron back on duty.

Catering for ethnic groups and the elderly is of a good standard and there is a ratio of 2-8 to help with feeding and all personal needs.
Patients are well informed about the care they are to receive on an ongoing basis.

The unit has a target of 2-3 hours for patients to be seen by a doctor and this target is well achieved.

ITEM NO: 50:00

TITLE	**Help & Care update on Local Involvement Network (LINk)**
FOR CONSIDERATION BY	Health Overview & Scrutiny Committee – 24 November10
WARD	All wards
LEAD OFFICER	Nicola Strudley, Regional Manager, Berkshire LINks

PURPOSE OF REPORT
To review the progress that was made by the Wokingham LINk over the last quarter

RECOMMENDATIONS
Members are recommended to note the progress update on the Wokingham LINk and begin to think about arrangements for the transition to HealthWatch.

SUPPORTING INFORMATION

1. **Project update**

   Please see attached slideshow

2. **General update:**

   2.1 The 3 West Berkshire LINks met with governance director's at Berkshire Healthcare to discuss serious untoward incidents and how information is recorded around this to ensure better partnerships with cross services. It has been agreed that information is to be shared with the LINk.

   2.2 The LINk organised a public meeting where the CQC compliance manager for Wokingham spoke about the CQC role and held a question and answer session. 20 attendees found the session worthwhile and informative.

   2.3. The LINk sit on the Wokingham ULO project board

   2.3 LINk participants numbers are up again and now stand at 605 people in Wokingham borough.

Corporate Implications (this must include Financial Implications)
Host contract expires 31.03.10, transition to HealthWatch to be considered

Contact Nicola Strudley	**Service** Berkshire LINks
Telephone No 0118 936 0090	**Email** Nicola.Strudley@helpandcare.org.uk
Date 12 November 2010	**Version No.** 1

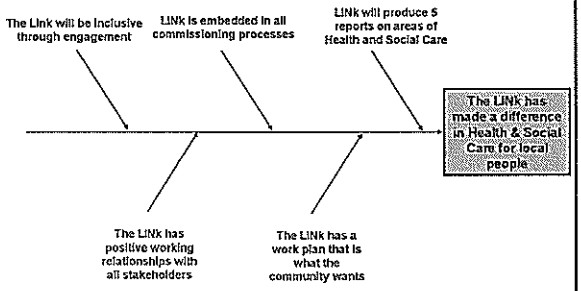
Appendix A

Berkshire LINks
Your voice on local health and social care

How the Wokingham LINk has made a difference over the last 3 months

Berkshire LINks
Your voice on local health and social care

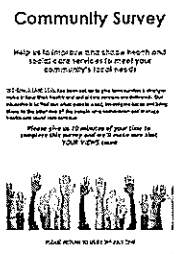
The 5 Outcomes.....



Berkshire LINks
Your voice on local health and social care

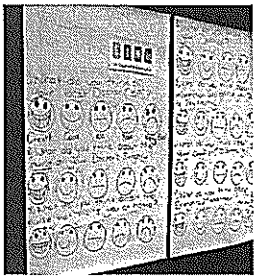
Wokingham LINk Community Survey

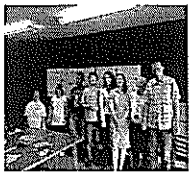
What health and social issues do local people think are important?



Take Notice

Berkshire LINKs — Your voice on local health and social care





LINk's role in the consultation on Day Services at Westmead Centre

Berkshire LINKs — Your voice on local health and social care

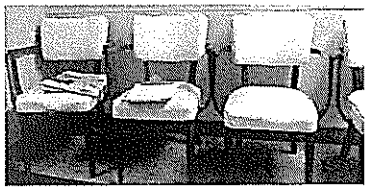

Wokingham News and Crowthorne & Sandhurst Newsweek

AXE FALLS ON WESTMEAD

LINk GP Appointment Survey

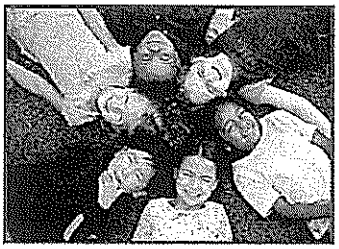
Berkshire LINKs — Your voice on local health and social care

65% of 403 Wokingham residents surveyed were satisfied, however 30% of surgeries made patients ring back



Partnership work with the Liberty of Earley House

Child and Adolescent Mental Health Services review



Responding to the Autism Act 2009 statutory guidance

- Diagnosis
- Training for professionals
- Training & Support (parents/families)
- Integration of Services
- Evidence of good practice highlighted

Partnership work with Wokingham Area Access Group

Berkshire LINKS — Your voice on local health and social care

Norrey's; helping to build a healthy community

Berkshire LINKS — Your voice on local health and social care

Follow up from July's street party to investigate any shift in eating habits

The future.....

Berkshire LINKS — Your voice on local health and social care

The White Paper made it clear that the patient voice will continue to be a central part of the department of health and social services
Transformation of LINks into local HealthWatch organisations will have additional roles.

Paul Streets, NHS Director of Public & Patient Engagement and Experience wrote to all Local Authority Chief Executives on 27.10.10 outlining points to consider in relations to contracting support in 2011-12
Department of Health's view is that, prior to any changes made through legislation, local authorities should consider extending existing LINks host contracts for a year, unless there are strong operational reasons not to do so.

Berkshire LINKs

Your voice on local health and social care

helpcare

www.facebook.com/BerkshireLINks

www.twitter.com/BerkshireLINk

Visit: www.makesachange.org.uk

Phone: 0300 111 0102

Text: LINKs+ Area+ your message to 80039

GOOD OR BAD? YOU TELL US

APPENDIX B

Department of Health

Skipton House
80 London Road
London SE1 6LH
Tel: 020 7972 2000

27 October 2010

See attached list

Dear Colleague

Gateway Reference: 14845

Contracting for support to Local Involvement Networks in 2011-2012: supporting the possible transition to Local HealthWatch

In 2008 the Department of Health provided £84 million in funding for Councils with Social Service Responsibilities in England to enable them to commission support to Local Involvement Networks (LINks) for 2008-2011.

This funding enabled the establishment and development of LINks and enabled local authorities to discharge their statutory responsibilities as set out in Sections 221 and 222 of the Local Government and Public Involvement in Health Act (2007).

Following the Spending Review, allocations to Local Authorities were set out in the letter from the Secretary of State for Communities and Local Government on 20 October. This includes the Department of Health's grants (which will roll into formula grant from 2011/12) which include LINks.
ttp://www.communities.gov.uk/documents/localgovernment/pdf/1745945.pdf

This letter sets out some points which local authorities may wish to consider in relation to contracting support in 2011-2012.

- The White Paper 'Equity and excellence: Liberating the NHS' sets out the Government's vision for transforming health and social care. A key part of that vision is to give consumers a stronger voice through establishing HealthWatch England and by building on the current role of LINks to create local HealthWatch organisations.
- Subject to the White Paper consultation, legislation to establish HealthWatch is likely to be introduced as part of the forthcoming Health Bill and local HealthWatch would be in place, subject to legislation, by 2012. Local authorities would have a vital role in ensuring local HealthWatch organisations are supported and successful
- The responsibility of local authorities to commission support to LINks during 2011/12, as set out in the 2007 Act, remains.

- The White Paper proposes that from 2012 local HealthWatch would retain existing LINks' responsibilities and have additional functions. Subject to the Spending Review, there would be additional funding for additional functions such as providing complaints advocacy services and supporting individuals to exercise choice.

Extending contracts

In order to ensure that the vision for a stronger voice for consumers set out in the White Paper is met the Department of Health's view is that, prior to any changes made through legislation, local authorities should consider extending existing LINks host contracts for a year – where existing contracts allow for this – to run to March 2012, unless there are strong operational reasons not to do so.

This would minimise disruption and maintain continuity; allow the development of local HealthWatch organisations if applicable; and reduce costs incurred in tendering.

Alternative arrangements

Your authority will reach its own judgement on tendering through its contract monitoring and feedback from LINks participants.

Some authorities will not wish to continue current support arrangements and some current LINks host organisations may also not wish to extend contracts. In these circumstances there may be alternatives to a full re-tendering exercise for one year support, such as working in partnership with neighbouring authorities to obtain support from host organisations they have commissioned.

Contractual issues

Your authority will form its own view in the light of its own legal advice on any contractual issues arising from this approach.

However, many contracts to provide support to LINks have provisions for the extension of contracts, which should be invoked to ensure continuation of service. Where extension provision has not been stated, you will need to take local advice regarding ensuring continuation of service.

Authorities may wish to take this approach to ensure the continuity and stability of service provision and discharge their statutory duties. A similar approach was used in 2007 by the Commission for Patient and Public Involvement in Health to extend contracts to provide support to Patient and Public Involvement Forums prior to their abolition and replacement by LINks in April 2008.

Yours sincerely,

Paul Streets
Director of Public and Patient Engagement and Experience

To: The Chief Executive

County Councils)
Metropolitan District Councils) England
Shire Unitary Councils)
London Borough Councils
Common Council of the City of London
Council of the Isles of Scilly

The Director of Adult Social Services

Councils with Social Service Responsibilities in England

Copied to: Chief Executive – Strategic Health Authorities
Local Government Association
Government Office Directors
Deputy Regional Directors for Social Care and Partnerships