MINUTES OF A MEETING OF THE HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON 24 JANUARY 2011 FROM 7.00PM TO 8.52PM

Present: Tim Holton (Chairman), Norman Gould (Vice Chairman), Malcolm Armstrong, Gerald A Cockroft, Alistair Corrie, Kay Gilder, Kate Haines and Charlotte Haitham Taylor

Also present:
Bev Searle, Director of Partnerships and Joint Commissioning, NHS Berkshire West
Nigel Foster, Acting Director of Finance and Performance, NHS Berkshire West
Sue Sheath, Compliance Manager, Care Quality Commission
Mike Wooldridge, Development and Improvement Team Manager, Community Care Services, Wokingham Borough Council
Alex Gild, Berkshire Healthcare Foundation Trust
Christine Holland, LINk Steering Group
Tony Lloyd, LINk Steering Group
Kathy Small, Member of the Public
Bill Small, Member of the Public
Ella Hutchings, Principal Democratic Services Officer, Wokingham Borough Council

55. MINUTES

The Minutes of the meeting of the Committee held on 24 November 2010 were confirmed as a correct record and signed by the Chairman.

56. APOLOGIES

There were no apologies for absence submitted.

57. DECLARATION OF INTEREST

Kate Haines declared a personal interest with regards to her ongoing complaint with the Royal Berkshire Hospital.

58. PUBLIC QUESTION TIME

There were no public questions.

59. MEMBER QUESTION TIME

There were no Member questions.

60. CARE QUALITY COMMISSION – REGISTRATION OF HEALTH PROVIDERS

Sue Sheath, Compliance Manager, Care Quality Commission (CQC), attended the Committee to give them an update on current work, since her last presentation to the Committee in July 2007.

The Committee were given an update on the registration of health providers, of which there were 25,000 locations that needed registering which meant 11,500 providers. There were still 1,000 providers that needed registering because of various issues such as timescales or because some were now out of scope. Those who were out of the scope of the CQC included nursing agencies who only placed staff rather than managed those staff in placements and cosmetic laser surgeries. Most of the providers who had been registered had received their notice of decision and any conditions that may have been applied to them. Their certificates were being processed currently. CQC had just recently started registering dental practices and independent ambulance services as well and would welcome feedback from the committee on any providers of concern.

One Member of the Committee had raised a query in advance of the meeting about the changes to the old 'five star' rating system for social care which had been discussed at the July 2007 meeting. Sue Sheath reminded the Committee that due to a change in legislation, CQC had stopped awarding quality ratings under the Care Standards Act from July 2010 and explained that they were currently trying to develop a new system. A consultation process would be launched once that had been done and Sue had hoped that it would have been launched by the time she attended the Committee, however this had still not happened and so far there was still no date for this. Once the consultation was launched Sue would let the Committee know and urged Members to take part so that they could feed into the process.

At the current time the old rating system was still on the website where it applied, but some newly registered providers would not have a rating. The website made it clear when the rating had been applied so that viewers knew they were looking at the most recent information. If a provider had received a good rating in the past but had slipped, the old rating would remain on the website but CQC would put a statement on their website to say they were concerned that the provider may not be complying with one or more of the essential standards. At present Sue did not believe there were any plans to remove the old ratings.

It was confirmed that every provider had to have a planned review at least every two years. Previously providers had been reviewed at varying times depending on the previous rating received, e.g. those given 'excellent' were then reviewed again in three years time, those who had been awarded 'good' were reviewed in two years time and those that had been given lower ratings were reviewed more often. The new legislation required that a planned review be done of each provider every two years, assessing them against the 16 key standards. This could start as a desktop review looking at any reports or comments received about a provider, then they may decide to visit depending on the outcomes of that research (and largely they did) and then they would report on all the information they had gathered giving a broader review. This would be very challenging in terms of capacity as there were so many more providers registered than had been in the previous system. The providers considered of most concern would be looked at first.

Regarding ongoing compliance, CQC had spent significant time identifying those providers they had concern with, either because they had applied conditions at registration or had received reports of concern from elsewhere such as members of the public. The Committee were informed that CQC had been into a number of locations in the South East region in the last three months to assess them and that reports were in the process of being compiled, once they had been checked with the provider for accuracy only, they would be placed on the website for viewing. The website would flag up where there might be an issue that was being investigated.

Members discussed the information and thanked Sue Sheath for the update. The Committee felt it would be useful to continue to be kept informed about the progress on these matters and it was suggested that Sue Sheath attend the Committee again in six months time to provide a further update. The Committee were informed that more information could be brought at that time about trends emerging from CQC reviews and about the registration of dental practices and private ambulance services.

RESOLVED: That:
1) the update be noted;

2) Sue Sheath, Compliance Manager, Care Quality Commission, be invited back to the Committee in six months time to give an update on progress.

61. COMMUNITY CARE SERVICES ANNUAL PERFORMANCE ASSESSMENT REPORT 2009/10

Mike Wooldridge, Development and Improvement Team Manager, Community Care Services, Wokingham Borough Council, gave the Committee a presentation about the Community Care Services Annual Performance Assessment 2009/10. A report had also been included in the Agenda on pages 8 to 11.

The Committee were informed that the judgment of the Annual Performance Assessment was made in consideration of the evidence provided to the Care Quality Commission on how well the Adult Social Care service was performing. This was in respect of the commissioning of services in the Borough to meet the needs of the community which in turn promoted independence, provided choice, were cost effective and supported the whole community by promoting health and wellbeing. This was the last year that they would be assessed in this way though.

The Annual Performance Assessment for Community Care Services for 2009/10 had four possible assessment judgment ratings:-

- Poorly performing
- Performing adequately
- Performing well
- Performing excellently

The assessment was made against criteria and performance characteristics which were outcome focused.

Within the overall assessment there were seven outcomes of delivery. This year the service had been required to self assess and declare its performance ahead of the submission of evidence. The accuracy and clarity of the self declaration informed CQC's view of the quality of leadership and management.

Where Community Care Services were 'performing well' in any outcome of 2008/09 they were able to declare continued performance at that level without submitting a full self assessment. Where they believed they were now performing excellently they were required to complete the self assessment for that outcome. Wokingham declared it was performing at the higher outcome grade of 'excellent' for 'Improved Health and Emotional Wellbeing' and 'Choice and Control'. For the rest of the outcomes they declared they were still 'performing well'. CQC agreed with all of the self assessment levels that Community Care Services submitted.

CQC fully assessed and reported on Outcome 7 'Maintaining Personal Dignity and Respect' for every Council regardless of the previous year's grade as this primarily related to Adult Safeguarding. There were also two domains of 'Leadership' and 'Commissioning and Use of Resources'. These were judged via the self assessment, data returns and ongoing engagement with CQC.

The report highlighted the key strengths and areas for improvement identified by the Annual Performance Report, and Mike explained these further through his presentation.

The Committee discussed the report and presentation and made a number of comments. There was some concern from Members about grants to some providers being cut to the people being given Personal Budgets. Mike Wooldridge explained the thresholds for charging people and that some grants would have to be tapered, but that hopefully providers would make themselves commercially viable and desirable to clients so that they would choose to use those services, paid for out of their Personal Budget. The impact of the charging changes would be reviewed in April/May. If people were turning down services on a financial basis that was of concern though and would need to be considered further.

One Member said that they had been told that Stroke aftercare had been cut across the whole area for people coming out of hospital which was very worrying. Mike Wooldridge said that he was not aware that this was the case and would look into the matter and report back.

The reasons for the delay for discharge from hospital was also queried. Mike Wooldridge explained that since the report had been published they had continued to make improvements in this area and had achieved many months of zero or just one or two delays. This improvement had been down to partnership working between the agencies involved and Bev Searle, Director or Partnerships and Joint Commissioning, NHS Berkshire West, said that Wokingham were very proactive and were the front runners for this in the area. The reasons for delay were sometimes down to providers, such as availability of beds, and sometimes down to the families, such as issues of paying for care outside of hospital. Domiciliary Care issues were very rarely a reason for a delay. It was confirmed that the Social Care Team saw patients before they left hospital and then provided up to six weeks of reablement support from the START team after they had been discharged home. There was no charge for this service. If they still needed ongoing care after that then a financial assessment would be carried out.

After the meeting Mike Wooldridge also supplied further information about discharge from hospital: '*If a patient did not have care needs but would benefit from short term social and practical help to return home there was also the Home from Hospital service which the Council commission through Age UK Berkshire. It was supported by volunteers and had a capacity for up to 40 people at any one time.*'

One Member of the Committee asked about the number of people currently using and the targets for Personal Budgets or Direct Payments. Mike Wooldridge was unsure about the numbers but gave the answer he thought was correct. However, following the meeting he looked into the matter with colleagues and was able to provide further information, as follows:

- *'There was currently a national target in place for numbers of people Self Directing (people with Personal Budgets or Direct Payments) and this was 30%. This was National Indicator 130. Community Care Services were confident they would achieve this in this year as their December figure for NI130 was 27.7% and 698 people had already received self directed support in the year. They were seeing continuous improvement throughout 2010/11 and this was currently increasing by over 40 people per month. NI130 performance for 2009/10 was 16.8% for comparison.*

  However, they did have some issue with the definition for NI130 as the denominator in the calculation required that they included people that would not currently receive self directed support (e.g. people who were receiving short-term packages of care or one-off equipment, reablement services, professional support). This issue was recognised

nationally and so in order to have something more meaningful locally they also collected and reported on a local indicator which was slightly different in the way it was calculated as it was as a percentage of the total number of people receiving services. Their target for this was 40% by the end of the financial year and they were at 29.6% at the end of December.'

RESOLVED: That:

1) the presentation, report and results of the Community Care Services Annual Performance Assessment 2009/10 be noted;

2) Mike Wooldridge follow up the query about Stroke aftercare in Wokingham and information be feed back to the Committee at its next meeting.

62. NHS BERKSHIRE WEST ANNUAL PERFORMANCE AND FINANCE UPDATE

Nigel Foster, Acting Director of Finance and Performance, NHS Berkshire West, gave the Committee a presentation; copies of the slides were handed out at the meeting.

The Committee were informed that Annual Performance was measured against Performance Indicators that were based on four main areas: Reducing Health Inequalities; Children and Young People; Older People and Long Term Conditions; and Wellbeing and Prevention. Some of the Indicators were nationally set and some were agreed locally between the Strategic Health Authority and the Primary Care Trust. Nigel Foster explained some of the Indicators and the reasons why some were not on target at present.

Members commented on some of the measurements, such as the number of children being weighed, which made it look like there were no problems of childhood obesity. Bev Searle, Director of Partnerships and Joint Commissioning explained that in the future measurements would be on outcomes, but currently it was more process driven.

One Member queried why there was a target for the number of teenage pregnancies and wanted to know more about the work undertaken in that area. Bev Searle said that this could be an item for a future meeting if the Committee wanted to look at it further.

The 'Overarching Target Measures' were also tabulated in the presentation and Members were informed that although the target for Clostridium Difficile was showing as red/amber, there were a number of ways to test for this and the Royal Berkshire Hospital used very sensitive testing methods, which picked up more cases. This was very good as a treatment regime could be put in place, but it did mean that the figures being picked up rose and so it looked negative against target. There was also a graph in the presentation showing the number of referrals to secondary care.

The Committee were informed about the performance requirements for 2011-12, funding, the budget for 2010-11 which was currently fairly on target, the operating framework which came out before Christmas and shown a slide looking at the financial overview and the challenge ahead, which demonstrated the predicted spending gap and savings of £115 million that would be needed by 2014/15.

There was one element of the presentation that was of particular concern to the Committee and that was about budget performance at Practice Level. It showed that compared to the rest of Berkshire West, Wokingham had more practices in the bottom quartile for spend on referrals and prescribing and for non elective work they were in the second, third and bottom quartiles fairly evenly. Nigel explained this was about budget

performance and not clinical quality but spending was disproportionately high. These figures were of particular importance in the light of the new GP Commissioning. Currently some areas across Berkshire West spent more, some spent less and overall it evened out. However, if as was looking likely, there were four separate GP Commissioning Consortia in Berkshire West, funding in Wokingham would not meeting the current spending levels and GPs would need to make some savings. Some of the possible reasons for this could be that more expensive procedures were needed, or that the percentage of funding per population received by Wokingham was very low and so it was hard to stay within that figure.

Members asked a number of questions on this matter. Nigel explained that if this did prove an issue in the future, the challenge for the Consortia would be how to provide care in different ways to achieve savings or how to manage overspends by looking at spend in other areas. GP Commissioning Consortia's will be expected to live within funding. Members asked if they could be provided with further information about this matter and were informed that arrangements and figures were only just being looked at. A discussion would be best left for a few months, at which point the GP Consortia may also be able to come along to talk about the situation further.

It was also suggested that Nigel Foster be asked to come back to the Committee in three or four months time but that he be contacted in two months time to discuss when would be appropriate.

RESOLVED: That:

1) the presentation be noted;

2) Nigel Foster be asked to attend a future meeting when appropriate to give the Committee an update;

3) the issue of budget performance at practice level/GP Commissioning Consortia budget management be brought to a future meeting when appropriate.

63. CHANGES TO PROVIDER SERVICES

The Chairman informed the Committee that this item had been deferred.

Bev Searle, Director of Partnerships and Joint Commissioning, NHS Berkshire West, explained that Provider Services was currently transferring to Berkshire Healthcare Foundation Trust in an 'as is' state and that it would be important for the Committee to hear more about the changes once they had been in place for a while. It was therefore suggested that the item be brought to the Committee, in conjunction with Berkshire Healthcare Foundation Trust and Wokingham Borough Council, in two meetings time so that they could talk about how things had been working and changes going forward.

RESOLVED: That the item on 'Changes to Provider Services' be added to the Committee's Work Programme and brought to the meeting on 31 May 2011.

64. LINK UPDATE

The Committee considered a report from the Wokingham LINk that had been included in the Agenda on page 12 and gave an update on the current work of the LINk. Christine Holland, Chair, and Tony Lloyd, Finance Officer, from the Wokingham LINk Steering Group also gave some further information about the projects they had been working on.

Members asked a number of questions about the projects and noted the progress being made.

RESOLVED: That the update be noted.

65. COMMITTEE WORK PROGRAMME

The Committee considered the work programme, as detailed on Agenda pages 13-16.

It was confirmed that Charlotte Haitham Taylor would be leading on the visit to the Maternity Unit at the Royal Berkshire Hospital and would provide a report to the next meeting of the Committee about the visit. Members who were not attending were asked to supple Charlotte with any questions they had.

Norman Gould raised an issue about the cross over of the work programmes and membership of the Health Overview and Scrutiny Committee and the Community Partnerships Overview and Scrutiny Committee and that it might be worth looking into this further. The Committee discussed the issue and the Chairman suggested that Norman Gould compile a short report for the next meeting for Members to consider.

RESOLVED: That:

1) the Work Programme and Agenda for the meeting on 23 March 2011 be agreed;

2) Norman Gould bring a short report to the next meeting of the Committee on the work programmes and membership of the Committee and that of the Community Partnerships Overview and Scrutiny Committee with proposed recommendations.

66. HEALTH CONSULTATIONS

The Committee considered the consultation document included in the Agenda on pages 17-60 entitled 'Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health'. The Committee were informed that the consultation closed on 31 March 2011.

As the consultation closed after the next meeting on 23 March 2011, it was suggested that Members take the document away to consider it further and that the item be placed on the Agenda for the next meeting when the Committee could discuss it and form a response for submission by 31 March 2011.

Bev Searle, Director of Partnerships and Joint Commissioning, NHS Berkshire West, suggested that a Public Health colleague might be available to attend the next meeting to help lead the discussion if the Committee felt that would be useful.

The Committee discussed the proposed suggestions.

RESOLVED: That:

1) The 'Healthy Lives, Healthy People' consultation be added to the Agenda for the next meeting;

2) A Public Health representative from NHS Berkshire West be invited to attend the next meeting to participate in the discussion about the consultation;

3) A response to the consultation be agreed at the next meeting and submitted by 31 March 2011.

These are the Minutes of a meeting of the Health Overview and Scrutiny Committee

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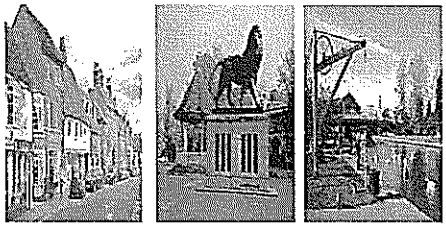
ITEM NO: 75.00

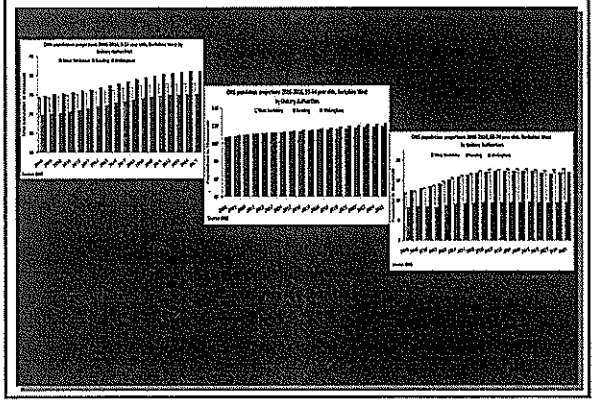
Berkshire West JSNA 2010-2011



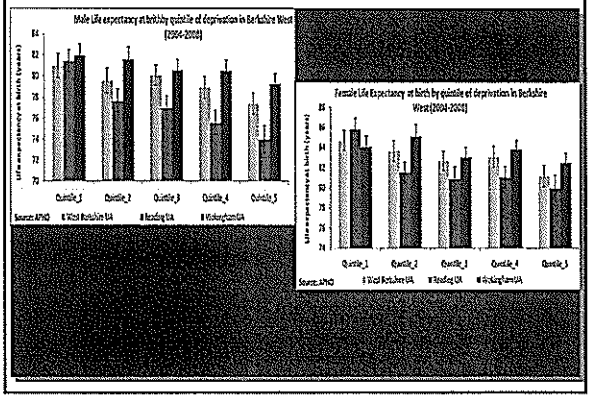
Key Findings and
Commissioning Priorities

- Demography
- Burden of ill-health
- Children and Young People
- Health Inequalities
- Behaviour and Lifestyle
- Findings & priorities for commissioning

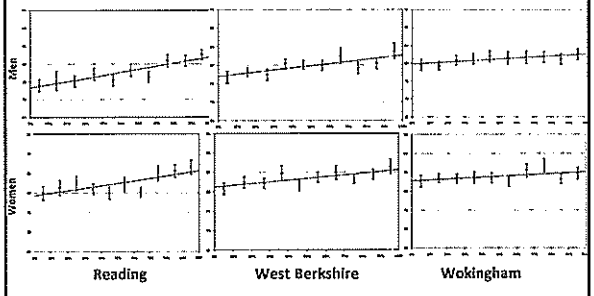
Future population change



Life expectancy & deprivation



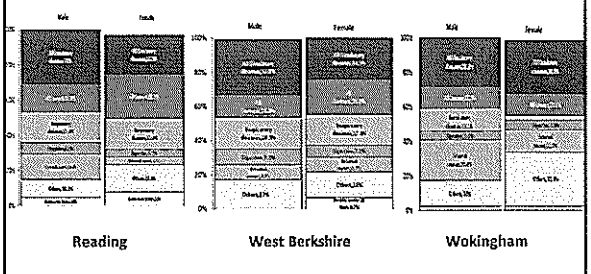
SII for life expectancy



The Slope Index of Inequalities (SII) represents the gap in LE between the least and most deprived

The impact of the social gradient on LE is greater for men and women in Reading (SII=8.5yrs in men; SII=6.3yrs in women) than West Berkshire (SII=5.6yrs in men; SII=4.4yrs in women) and Wokingham (SII=2.7yrs in men; SII=2.4yrs in women)

Causes of death & their contribution to LE gap



Circulatory disease, cancer and respiratory disease are the major causes of LE gaps between most and least deprived quintiles in Berkshire West

Relative significance of 'Other' causes of death in Wokingham women is notable

Dementia

1,536 diagnosed (QOF) vs. 4,290 expected
2,754 (64%) 'missing'
5,800 predicted by 2020
Prevalence ↑ to 5.6% from 2015
Fewer cases in Reading reflecting younger population

Priorities for prevention
- CVD risk factors
- Blood pressure control
- Smoking
- Cholesterol
- Alcohol

Commissioning recommendations
- Joint commissioning strategy
- Dementia awareness training across H & S care
- Early identification in primary care
- Improve quality of care in care homes
- Put in place early onset dementia services
- Memory Clinics in three localities
- Implement findings of national hospital audit

Key gaps and challenges
- Education and training
- Peer support
- Dementia care advisors
- Mental health liaison service
- Housing/ accommodation with care
- Needs of the BME community
- Impact of rising number of people with learning disability and dementia
- Impact of alcohol dependency

Summary of key issues

- Will double from 35,000 to 60,000 in 10yrs in Berkshire West
- Associated with high and rising costs for health and social care
- Most are preventable by lifestyle change
- Much can be achieved through joint working of PH and social services in UA
- GPs are well positioned to advise and support
- Primary Care can be remodelled to provide care
- Secondary care to support care in the community
- End of Life care of significant importance

Early intervention - maternity

Reading
1. Age profile of mothers similar to national profile
2. 42% of births are to women born outside the UK (much high than UK average)

West Berkshire
1. Mothers tend to be older than national average

Wokingham
1. Mothers significantly older than national average

Good progress made:
1. Fewer women smoking in pregnancy
2. Breast feeding initiation increasing

Key issues and gaps
1. Early access to antenatal care especially teenagers, older mothers, BME groups
2. High proportion of Caesarean sections and instrumental deliveries

Commissioning recommendations
1. Increase availability of midwife-led care
2. Review maternity provision in primary care
3. Ensure comprehensive assessment and management of risk: rising maternal obesity; mental health problems; social risk; Hep B and BCG vaccination; smoking and breast feeding.

Infant Mortality

Reading
1. Infant mortality rates significantly higher in Reading cf. rest of BW, national & regional rates.
2. In 2006/08 Infant Mortality Rate was 6.8 per 1000 live births

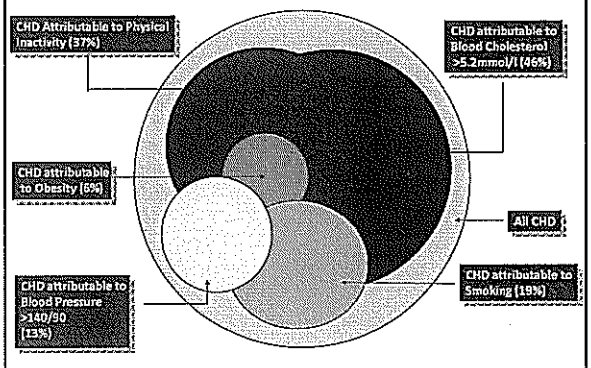
West Berkshire
1. In 2006/08 the Infant Mortality Rate was 4.2 per 1000 live births
2. Similar to the national and regional rates

Wokingham
1. In 2006/08 the Infant Mortality Rate was 3.2 per 1000 live births
2. Lower than the national and regional rates

Key issues and gaps
1. Significant levels of child poverty remain, particularly in Reading
2. Breastfeeding rates remain lower in deprived areas
3. Rates of maternal obesity are increasing
4. Continuing high rates of teenage pregnancy in Reading
5. Disparities in the uptake of immunisations

Commissioning recommendations
1. Work underway to tackle the underlying determinants of infant mortality. Further work is needed in:
2. Reducing number of children in relative low income households
3. Ensure that the evidence based interventions to prevent SUDI are widely understood in target groups
4. Implementation of recommendations from NHS Berks West Maternity Review 2010

Related risk factors for CHD under 75 death



Source: Britton A and McPherson K 2000 – A Report to the Chief Medical Officer

Physical Activity

The annual cost of physical inactivity for NHS Berkshire West is estimated at £2.84 million per annum *(BHF 2007)*

19.2% of the Reading population participate in moderate physical activity at least 3 times per week

25.3% of the West Berkshire population participate in moderate physical activity at least 3 times per week

6.5% of the Wokingham population participate in moderate physical activity at least 3 times per week

Key issues and gaps
1. Over 60% of all car journeys under 2 miles in length
2. Advice and support for physical activity not given on a systematic basis

Commissioning recommendations
1. Support projects that encourage active travel
2. Support Primary Care and Local Authority providers in delivering the "Lets Get Moving" Physical Activity care Pathway
3. Continuation and expansion of projects that encourage lifelong participation in sport, leisure and recreation activities

Key Findings and Recommendations for Commissioning

- Ageing population
- Inequalities in morbidity and mortality
- Rising prevalence of LTC
- Unhealthy lifestyles
- Focus on prevention
- Increase in primary and community care
- Invest in good start to life
- Invest in good end to life

Thank you

Funding and Commissioning routes for Public Health

Consultation Dec-Mar

3 routes for funding:

PH services will be funded by a new PH budget through Public Health England via three principal routes:

- Allocated funding to Local Authorities
- Commissioning Services via the NHS Commissioning Board
- Providing services itself

Local Authorities

- LA already carry out a range of health protection functions and many other responsibilities that bear on public health such as leisure, housing, education and social care.
- These separate functions will be treated separately from the ring fenced public heath budget though in practice LAs will be free to integrate management of these functions with their new public health responsibilities.

Commissioned through NHS

- PH services currently provided by primary care are funded by PH England and commissioned by the NHS commissioning Board. PHE will have influence on how these services are commissioned.
- GP practices currently provide a range of public health services under the GP Contract such as childhood immunisations, contraceptive services, cervical cancer services and child surveillance.
- These will continue and be funded from the public health budget. There is scope for greater flexibility of provision of these services

NHS funded and commissioned

- Some services are an integral part of services provided in primary care and will continue to be funded from within the overall resources of the NHS Commissioning Board. These may be services carried out in general practice, dental services or by community pharmacists.
- Public health expertise will inform the commissioning of NHS funded services, facilitating integrated pathways of care for patients.
- The DPH will be able to advise GP consortia on public health issues for example through the H&WB Boards or through the provision of public health intelligence or data on population health issues. Public health advice will need to be part of designing whole pathways of care.

Local Authorities

Will be the lead commissioner for:

- Childhood obesity measurement
- Dental public health
- Fluoridation
- Medical inspection of school children

Proposed areas of public health within Local Authority for consultation			
	Topic		Public health/Local authority role
1	Sexual health	LA to commission comprehensive open access sexual health services including testing and treatment of STI including opportunistic chlamydia screening, fully integrated TOP services and contraceptive services as alternative to GPs	LA to commission all sexual health services - apart from contraceptive services commissioned by NHS Commissioning Board via GP Contract
2	Immunisation against infectious disease		LA to commission all school programmes such as HPV and teenage booster
3	Radiation, chemical and environmental hazards, including the public health impact of climate change		Public Health England supported by LAs
4	Seasonal mortality	Local initiatives to reduce excess deaths	LA to commission
5	Accidental injury prevention	Local initiatives such as falls prevention	LA to commission

	Public mental health	Mental health provision, mental illness prevention and suicide prevention	LA to commission
7	Nutrition	Running national nutrition programmes including Healthy Start would be responsibility of PH England	LA to commission locally led initiatives
8	Physical Activity	Local programmes to address inactivity and other interventions to promote physical activity such as improving the built environment and maximising PA opportunities offered by the natural environment	LA would commission work though brief interventions such as in LGM would be funded through NHS primary care budget
9	Obesity programmes	Local programmes to prevent and address obesity eg delivering the national Child measurement programme amnd commissioning weight management services	LA to commission

10.	Drug Misuse Services	Drug misuse services prevention and treatment	LA to commission Opportunity to join up drug and alcohol services for intervention and recovery services locally
11.	Alcohol misuse services	Alcohol misuse services, prevention and treatment	LA to commission
12.	Tobacco control	Tobacco control local activity, including stop smoking services, prevention activity, enforcement and communications	LA to commission but brief interventions will be provided in primary care, secondary, dental and maternity care
13.	NHS Health Check Programme	Assessment and Lifestyle interventions. Includes design, piloting and roll out of any extension to programme	LA to commission supported by PHE. Primary care will provide NHS funded treatment and ongoing risk management
14.	Health at Work	Local initiatives on workplace health	LA to commission. NHS continue to provide NHS occupational health

15.	Reducing and preventing birth defects		LA and PH England Primary care to provide pre-pregnancy counselling or smoking cessation programmes and secondary care to provide specialised genetic services
16.	Prevention ad early prevention of cancer and LTC	Behavioural/lifestyle campaigns to prevent cancer, LTC, campaigns to prompt early diagnosis via awareness of symptoms	LA supported by PH England
17.	Dental Public health	Epidemiology and oral health promotion including fluoridation	LA supported by PH England
18.	Emergency preparedness and response and pandemic flu preparedness		PH England supported by LAs
19.	Health Intelligence and information	Health Improvement and protection intelligence and information including data collection and management, analysing, evaluating and interpreting data, modelling, and using and communicating data	PH England and LA Includes existing functions of PH Observatories, Cancer Registries and Health Protection Agency. NHS will continue with data collection and information reporting systems eg SUS and HES

20.	Children's public health 0-5 Children's public health 5-19	NHS Commissioning Board to fund services for Children age 0-5 including Health Visiting Services, leadership and delivery of the Healthy Child Programme for the under 5s, prevention interventions by the multiprofessional team and the Family Nurse partnership Healthy Child Programme for school age children including school nurses and including health promotion and prevention interventions by the multiprofessional team	PH England to fund through NHS Commissioning Board LA to commission services for 5-11s
21.	Community Safety and violence prevention and response	Specialist domestic violence services in hospital settings and voluntary and community sector organisations that provide counselling and support services for victims of violence including sexual violence and non confidential information sharing	LA to commission
22.	Social exclusion	Support for families with multiple problems such as intensive family interventions Prison healthcare or for those in custody	LA to commission NHS Commissioning Board

Any questions?

Public Health Outcomes Framework

Consultation
Dec 10 – Mar 11

Vision for Public Health

'To improve and protect the nation's health and to improve the health of the poorest fastest'

5 Domains

- Health Protection and Resilience
- Tackling the wider determinants of health
- Health Improvement
- Prevention of ill health
- Healthy Life Expectancy and preventable mortality

5 Domains

- Domain 1- Health Protection overarching
- Domains 2 and 3 - Inequalities and health improvement focus on determinants of ill health
- Domains 4 and 5 – Ill health prevention and healthy life expectancy focus on outcomes of ill health

Measurement

- Outcomes measured by indicators supported by centrally collated and analysed data sets
- Include indicators that target different age groups and different communities that experience differentia outcomes in health
- Local areas determine how they wish to use indicators in JSNA and strategies

Domain 1 – Health Protection

- Interagency plans to public health incidents
- Systems in place to ensure effective and adequate surveillance of health protection risks and hazards
- Life years lost from air pollution as measured by fine particulate matter
- *Population vaccination coverage*
- Treatment completion rates for TB
- Public Sector organisations with Board approved sustainable development management plan

Domain 2- Wider determinants

- Children in poverty
- School readiness
- Housing overcrowding
- NEET rates
- Truancy rates
- People with mental illness/disability in employment
- People in long term u/e
- People with LTC and u/e
- Domestic abuse incidence
- Violent crime rates inc sexual violence
- Statutory homeless households
- Fuel poverty
- Access and utilisation of green space
- RTA casualties
- Neighbourhood noise pollution
- Community safety perception for OP
- Reduction in proven re-offending
- Cycling participation

Domain 3- Health improvement

- Prevalence healthy weight 4-5, 10-11 yrs
- Prevalence healthy weight in adults
- Smoking prevalence in adults
- Rate of hospital admissions per 100,000 fo alcohol related harm
- Hospital admissions caused by unintentional and deliberate injuries 5-18yr
- Under 18 conception rates
- Rate of dental caries in 5yrolds
- Self reported well being

Domain 4 - Prevention of ill health

- Hosp adm due to acc/ non acc inj <5s
- Self harm hospital adm
- Low birth weight
- Breastfeeding
- Prevalence recorded diabetes
- Sickness absence rates
- Chlamydia diagnosis rates 15-24
- Late pres HIV
- Child development 21/2
- Maternal smoking rates
- Smoking severe mentally ill
- Em readmissions under 28 days
- Health related QOL OP
- Falls over 65s hosp adm
- Health Check take up by eligible
- Cancer diagnosis stage 1 and 2 as proportion of all cancer diagnosed

Domain 5 –Life Exp and mortality

- Infant mortality rate
- Suicide rate
- Mortality from Communicable diseases
- Mortality rate from all cardiovascular disease under 75s
- Mortality rate chronic liver disease under 75s
- Mortality rate chronic resp disease uner 75s
- Mortality rate people with mental illness
- Excess seasonal mortality

12 Questions for consultation

1. How can we ensure that the Outcomes framework enables local partnerships to work together on health and wellbeing priorities and does not act as a barrier?
2. Do you feel these are the right criteria to use in determining indicators for public health?
3. How can we ensure that the Outcomes Framework and the health premium are designed to ensure that they contribute fully to health inequality reduction and advancing equity?
4. Is this the right approach to alignment across the NHS, Adult social Care and public health frameworks?
5. Do you agree with the overall framework and domains?
6. Have we missed out any indicators that you think we should include?

7. We have stated in this document that we need o arrive a a smaller set of indicators than we have had previously. Which would you rank as most important?
8. Are there indicators here that you think we should not include?
9. How can we improve indicators we have proposed here?

10. Which indicators do you think we should incentivise? (Consultation on this will be through the accompanying consultation on public health finance and systems).
11. What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes frameworks
12. How well do the indicators promote a life course approach to public health?

Any more questions?

Next steps

ITEM NO: 77.00

TITLE	***Healthy Lives, Healthy People:* consultation on the funding and commissioning routes for public health – Committee Response to Consultation**
FOR CONSIDERATION BY	Health Overview and Scrutiny Committee on 23 March 2011
WARD	None Specific
STRATEGIC DIRECTOR	Susanne Nelson-Wehrmeyer, Head of Governance and Democratic Services

OUTCOME

To consider the response to this consultation prepared by Councillor Charlotte Haitham Taylor and Madeleine Shopland (Democratic Services).

RECOMMENDATION

Members are asked to discuss the consultation and agree a response to be submitted by Officers, in consultation with the Chairman, on behalf of the Committee following comments made at the meeting, by the deadline of 31 March 2011.

SUMMARY OF REPORT

The Committee considered this consultation at it's last meeting and agreed to do more work on it before considering it again at this meeting. Charlotte Haitham Taylor and Madeleine Shopland attended various briefings and together compiled some suggested responses based on the information they received. These comments are put forward in order to start the discussion and are only draft at this stage.

Background

The Committee consider relevant consultations and form responses where they feel it is appropriate to do so. This consultation was felt an important matter and so the Committee wanted to fully consider the issue before submitting a formal response.

Analysis of Issues

N/A

Reasons for considering the report in Part 2
n/a

List of Background Papers
Full consultation paper in previous agenda.

Contact Ella Hutchings	**Service** Governance & Democratic Services
Telephone No 0118 974 6013	**Email** ella.hutchings@wokingham.gov.uk
Date 15 March 2011	**Version No.** 1

***Healthy Lives, Healthy People:* consultation on the funding and commissioning routes for public health**

Q1 Consultation question: Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

- Unusually, Berkshire is in the situation of having 6 unitary authorities. Will there be a pan Berkshire Health and Wellbeing Board, one per authority, or a West Berkshire Board and an East Berkshire Board?
  Comment from Mike Wooldridge: This has not been determined yet but other Unitary Authorities are pursuing having a Board for their Authority.
- Currently the Health and Wellbeing Board is part of the Wokingham Borough Strategic Partnership (WBSP) and is called the Health and Wellbeing Partnership – it is unclear yet whether there would be a need to separate from the WBSP to avoid becoming bogged down with the other functions of the Partnership. The HOSC appreciate where the board is placed will differ between Local Authorities.
- Health and Wellbeing Boards bring together elected representatives and key NHS, Public Health, social leaders and patient representatives to work in partnership. This should be a good means of joint working. However, is there a danger some factors may be underrepresented – mental health? Learning disabilities?
  Comment from Mike Wooldridge: Yes, potentially, but would wish to adjust membership and Terms of Reference to address this.
- What are the possible difficulties of pooled budgets?
- What would the alternative be?

Q2 Consultation question: What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

- Joint Strategic Needs Assessment needs to feed into Health and Wellbeing Board.
- GP consortia need to be inclusive towards voluntary sector and User Led Organisations.
- Commissioning process needs to be watertight but accessible so as not to put off smaller organisations. Minimising barriers would help ensure widest possible range of providers.
- Possible improvements to commissioning and procurement process? – widen advertising.
- Publicise "joint health and wellbeing strategy." Comment from Mike Wooldridge: And produce the strategy with engagement and involvement across the sector.
- If the Health and Well Being Boards sit within a Strategic Partnership then the partnership needs to have a wide and varied membership to encourage diversity and good joint working to achieve best outcomes.

Q3 Consultation question: How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

- The voluntary sector is possibly a source of untapped resources.
- The Bill will place a legal obligation on NHS and Local Authorities commissioners to refer to Joint Strategy Needs Assessment in exercising commissioning functions – this will need to be as robust as possible to ensure the maximum outcomes.

- Formalise relationship between Public Health England and the NHS Commissioning Board.
- There may be 'grey areas' in the early period – need to be firm on which organisations are responsible for what areas and ensure that nothing is allowed to fall by the wayside.

Q4 Consultation question: Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

- Would greater involvement blur the role of Public Health England and in what instances would they need to become more involved? How would they judge when may need to be more flexible? Would they step in should there be problems with commissioning services provided through the GP contract?
- GP consortia would presumably be most aware of local needs and requirements.

Q5 Consultation question: Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

- Comments from Mike Wooldridge: Not quite sure how the allocation or funding formula would work but one of the things we would be concerned about it is where there are some small but significant areas of deprivation in a relatively affluent borough (or shire) where there will also be significant health inequalities. Relates to both this question and question 16. In Wokingham we know this to be the case but overall we are one of the healthiest areas of the country.

Q6 Consultation question: Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

- Mostly.
- Sexual health – a very large portion of responsibility of this has been proposed to be provided by Local Authorities. Under these proposals there will be a crossover of responsibly between the different commissioning routes and there may be some areas that therefore may be not covered sufficiently. Some services may be better commissioned by either the NHS Commissioning Board (via GP contract) or Public Health England.
- Prevention and early presentation – suggest add Public Health England to the Commissioning route.
- Reducing and preventing birth defects – suggest add GP contract to the Commissioning route.

Q7 Consultation question: Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:
a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
b) reduce avoidable inequalities in health between population groups and communities? If not, what would work better?

- On the whole yes.

Q8 Consultation question: Which services should be mandatory for local authorities to provide or commission?

- Obesity, physical activity, nutrition, drug misuse, alcohol misuse, NHS checks programme, children's public health.
- Seasonal mortality – the proposed Commissioning route is through Local Authorities so this will require considerable partnership working with Hospitals and other partners to created better outcomes.
-

Q9 Consultation question: Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

- What services should or should not be provided using the grant. Comment from Mike Wooldridge: Or if there is a ring fence that is 'flexible' enough e.g. addressing underlying causes of poor public health.
- There will be a need to demonstrate value for money although this can be difficult with regards to prevention work.
- Greater involvement of Local Authorities – potentially more 'visible' to the public – need for transparency and to demonstrate are providing value for money.
- Ring-fencing grant - However, this should not lead to the voluntary or independent sector experiencing difficulties in accessing the funds.

Q10 Consultation question: Which approaches to developing an allocation formula should we ask ACRA to consider?

- Different areas of provision – value for money vs need.
- Population health measures - Multitude of factors need to be taken into consideration such as population levels (are there any bulges in particular age groups?), ageing population, birth rate, level of deprivation etc.

Q11 Consultation question: Which approach should we take to pace-of-change?

- Provision of shadow budget is helpful – needs to be flexible to allow changes to be made if necessary before system goes live.

Q12 Consultation question: Who should be represented in the group developing the formula?

- As per 5.2 of consultation – the group needs to be fully representational making use of key partners, representatives of local government, both officers and elected members, public health experts and a variety of academics.
- There needs to be a mechanism in place to allow smaller groups to feed in to the group and have a voice.

Q13 Consultation question: Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

- Joint Strategic Needs Assessment.

- Feedback from Local Authorities.
- Feedback from GP Consortia.

Q14 Consultation question: How should we design the health premium to ensure that it incentivises reductions in inequalities?

- Need to maintain and build on existing assessments.
- Agree should not automatically receive less funding if successful in improving health of local community as many projects will require ongoing funding. Comment from Mike Wooldridge: Performance targets set locally. Agree should not be penalised where already performing highly. Some outcome measures around reduction and prevention will be longer term.

Q15 Consultation question: Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

- Comment from Mike Wooldridge: Links to above and below. Some improved outcomes will only be demonstrated over the medium, long term and this would need to be considered rather than say 3 year LAA type arrangement.

Q16 Consultation question: What are the key issues the group developing the formula will need to consider?

- Covered in 5.7 of consultation (sensitivity of indicators and outcomes to public health interventions, possibility of changes of in indicators and outcomes for reasons unconnected with public health interventions; relative focus on the long-term outcomes and progress in the shorter term on those factors that drive these outcomes, frequency of reporting and relative ease of making a difference to an indicator or outcome, and how this varies between areas with different characteristics).
- The general approach that will be taken – either utilisation, cost-effectiveness or population health measures.
- Comment from Mike Wooldridge: See answer to question 5 above.

ITEM NO: 78.00

Changes to Health and Social Care Provision

Transforming Community Services – Transfer of PCT Provider Services into BHFT

Transforming Adult Social Care – New Adult Social Care Pathway and creating the Adult Social Care Local Authority Trading Company

Report for Wokingham Borough Council Health Scrutiny Committee

March 2011

Transforming Community Services – Transfer of PCT Provider Services into BHFT

Introduction

In response to operating plan guidance in 2008, the PCT had at the outset of this work created an internal separation of its commissioning and providing functions. This included the formation of a Community Health Oversight Committee and a formal contract with the provider arm being put in place and performance managed.

In January 2009, the Department of Health published guidance entitled Enabling New Patterns of Provision, setting out the requirement for PCTs to go further than simply separating out their commissioning and community provision functions; by describing their 5 year strategy for community services including how they would be divested from PCTs in that time period. PCTs were required to complete their strategy by October 2009.

The Operating Framework for 2010/11 published in December 2009 introduced a faster and mandated pace for the divestment of community services from PCTs and gave a steer as to the most likely options.

The Transforming Community Service Committee was originally set up to oversee the production of the 5 year strategy, but subsequently has had a role in the governance of the transaction to transfer the PCTs community services to another provider.

Three specific outputs were required to be delivered by the group :-

- The production of a commissioning strategy for community services
- The production of an estates strategy for community services
- An assessment of organisational form options to best fit the commissioning strategy

In addition to the committee, a Collaborative Commissioning group was established to engage with GP Commissioners and Local Authorities relating to the service transfer. However, much of the work to support the transaction was completed within a weekly commercial meeting between the two Berkshire PCTs and Berkshire Healthcare Foundation Trust.

Commissioning Strategy for Community Services

The approach taken for the development of the strategy was to segment the services into the categories set out in the national guidance. These are :-

- Health and Wellbeing
- Children's and Family Services
- Acute Care Closer to Home
- Long Term Conditions and Rehabilitation (combination of 2 segments in national guidance)

- End of Life Care

The strategy was compiled from these sections and submitted to the Strategic Health Authority (SHA) by the required deadline of end of October 2009. The strategy was approved by the SHA and the PCT was commended for its integration of market management within the sections and those sections were circulated to the Department of Health as an example of good practice.

Estates Strategy
The national guidance also required that PCTs set out an interim estates position by October 2009 and a full estates strategy by April 2010.

Strategy Implementation
Following the completion of the strategy, the focus of work was on agreement of the destination of community services by the end of April 2010 and to complete the divestment of the provider arm functions from the PCT by 1st April 2011. The Transforming Community Services Committee has maintained the oversight for this more transactional process in its governance role to the Board.
The PCT took the decision at the board meeting in April 2010 to transfer its specialist Palliative Care Services to Sue Ryder Care, and to run a process to select one or more of the local foundation trusts to integrate community services into.
A selection process commenced on 1st April 2010 and following a panel selection day including representatives from the PCT, Local Authorities, LINKs and staff side; Berkshire Healthcare Foundation Trust was elected as the preferred bidder for all services except Specialist Palliative Care. (Please see appendix 1 for details of the transfer of Palliative Care services)
A business case setting out the transaction was submitted to the SHA in June 2010 and following additional information requirements and assurances was approved by the SHA Board.

Completion of Arrangements for Transfer
The next steps for the transaction were the completion of the Integrated Business Plan and Long Term Financial Model by Berkshire Healthcare Trust to enable assessment by Monitor in January 2011.
The PCT has to complete a commissioner due diligence exercise to the same timetable and will formally sign the contract and management transfer agreement in March 2011.

Transforming Adult Social Care – New Adult Social Care Pathway and creating the Adult Social Care Local Authority Trading Company

Putting People First', outlined the government's policy for the transformation of social care services based on a system of self directed support and Personal Budgets. Local Authorities are expected to lead the transformation which sets out an ambitious programme to completely transform the social care system for adult social care. The emphasis is on shifting the balance of power and control away from professionals working in social care to the individual and his/her support network. This will enable a more 'person-centred' approach to providing support – the 'personalisation' agenda.

The fundamental mechanism to achieving this shift is through the use of 'Personal Budgets'. Essentially a Personal Budget is an identified cash sum relative to the individual's assessed need. The individual is then free to plan how to use the cash sum to meet his/her needs. The national transformation programme ends on the 31 March 2011. The original target is that 30% of all who use adult social care will be in

receipt of a personal budget. Wokingham expects to exceed that target by the deadline by around 5%. Over time, everyone who has eligible social care need will have his/her needs met through a personal budget.

This new social care offer has meant that the council has needed to reconfigure its services to align to the new system. Previously, the council operated a care management system in which the council would assess eligibility and identify need, provide services to meet need and review periodically that need was continuing to be met. Often this was all done by the care manager and although individuals were able to influence outcomes, in reality they had limited choice and control.

The new pathway is predicated on linking assessed need to a personal budget. It splits out the assessment and resource allocation as one function, and help to put together a personalised support plan (including choosing the services the person wants) as a separate function. The new social care pathway is shown diagrammatically at Appendix 2. Of the two functions, only the assessment function is reserved to social services authorities – in other words the council cannot delegate its assessment and resource allocation duty to a third party. Support planning (often called care brokerage) can be outsourced and the creation of a mixed economy of care brokerage should lead to greater choice and control for individuals.

To align to the new pathway, adult social care had to be restructured. Essentially the care management workforce had to be re-designated to: -

- Those who undertook statutory assessment, resource allocation (personal budget) and statutory review
- Those who undertook care brokerage – working with individuals and their families to use their personal budget to get the services that they needed and which best suited their individual lifestyle

In February 2011, after a full consultation with all stakeholders and a formal consultation with the workforce, the restructure was implemented and the new pathway to social care services became our operating model for all new and existing clients.

A second effect of the change to adult social care is that the council's directly provided services (homecare, day services, residential care services) have had to become much more transparent about their unit costs – because personal budget holders now have to 'buy' the service from the council. For the first time our clients are able to make judgements about the value of those services and to seek alternatives, potentially putting the directly provided services at risk. It is clear that a new commercial reality is at play, which existing council run services need to be able to respond to. It is also clear that the bureaucratic necessity of the public service environment is a real impediment to those services being able to respond.

For this and other reasons, the council took the decision in Feb 2011 to create a Local Authority Trading Company (LATC - a company wholly owned by the council as sole shareholder for the purposes of carrying out council business, but which has its own separate board of directors). The working name for the LATC is *'Connect Community Care'* and it is due to be launched in June 2011.

The services transferring to Connect Community Care are: -

- Suffolk Lodge and Fosters residential care homes
- Westmead day service
- Learning disability day service
- Cockayne Court supported housing and day service for older people
- Oakfield Court supported housing for people with learning disability
- Home care services (START team and the dedicated dementia homecare service)
- Care brokerage
- Wokingham Borough Employment Support Service

Formal staff consultation has begun and will conclude in early April.

The objectives of creating the company are; -

- To be the 'provider of last resort' for the council so that the council can guarantee to be able to discharge its duty to meet eligible need
- To ensure the services can evolve and respond to the personal budget era
- To improve efficiency within the services (mainly back office)
- To offer services to private fee payers and other statutory agencies with the aim of making a surplus for the council as shareholder

As well as being owned by the council, the company will be contractually obliged to provide care services to the council, safeguarding both the volume and quality of services.

Bev Searle
Director of Partnerships and Joint Commissioning
NHS Berkshire West

Stuart Rowbotham,
Strategic Director Commissioning,
Wokingham Borough Council

Appendix 1.

Transforming Community Services: A progress report on Specialist Palliative Care

1. Background

Following previous consultation as part of its Transforming Community Services Strategy NHS Berkshire West is transferring its specialist palliative care service to Sue Ryder Care from April 1st 2011. The main driver for this proposal was to support the PCT's strategy to make choice of place of death a reality by providing more community services for patients requiring palliative care.

2. Changes to Service:

Hitherto the PCT has commissioned six palliative care beds from Sue Ryder in Nettlebed and twelve beds at Duchess of Kent in Reading. Because of the geographical location the Nettlebed beds were often not used because of access issues for patients and relatives. The Nettlebed beds have therefore been decommissioned and the beds in Duchess of Kent have been increased to fifteen to provide a specialist palliative care "hub" in the centre of Berkshire West.

The day care services at the Charles Clore Unit, Newbury and Wokingham Macmillan House have also transferred to Sue Ryder, providing the "spokes" of the service. These services remain unchanged.

There has been additional investment in community services: Community Nurse Specialist (formerly MacMillan Nurses), and night district nursing. Additional funding has also been received from the SHA for a nurse educator post to support Nursing and residential homes to improve the management of specialist palliative care patients.

The new service model increases the consultant capacity in Berkshire West enabling improved support to GPs who are caring for palliative care patients at home and more capacity for consultant home visits.

There will also be more consultant input to the Royal Berkshire Hospital, ensuring that palliative care patients are not inappropriately admitted to an acute hospital and that patients are transferred to their choice of place for ongoing care as soon as possible.

The staff will transfer to Sue Ryder Care on NHS terms and conditions and they are positive about the change. Formal consultation commences in January.

The transition is progressing well and it is anticipated that the service will transfer on April 1st as planned.

3. Key benefits:

- An increase in accessible specialist palliative care beds in Berkshire West

- An increase in community services to make care at home a genuine choice for palliative care patients
- Increased consultant support to GPs and community nurses enabling more patients to be cared for at home
- Improved management of palliative care patients in nursing and residential homes
- Reduced occupation of acute hospital beds by patients with specialist palliative care needs
- Improved management of palliative care patients who are in the acute hospital.
- An increased opportunity for the charitable sector (Sue Ryder, Duchess of Kent charity, Marie Curie, MacMillan, Wokingham District Cancer Care Trust and Newbury District Cancer Care Trust) to work together in a co-ordinated way to support the development of local palliative care services
- More focused and specialist management. The service will now be run by an organisation whose core business is palliative care provision rather than being a small service within a much larger general community health unit.
- Better use of NHS resources. The amalgamation of the two existing services has enabled a saving of £300k to be made as a contribution to the NHS efficiency target as well as increasing investment in the areas outlined above.

Appendix 2

New Adult Social Care Pathway