MINUTES OF A MEETING OF THE HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON TUESDAY 31 MAY 2011 FROM 7.03PM TO 9.10PM

Present: Tim Holton (Chairman), Charlotte Haitham Taylor (Vice Chairman), Andrew Bradley, Gerald A Cockroft, Mike Gore, Kate Haines, Emma Hobbs and Philip Houldsworth

Also present:
Councillor Annette Drake
Bev Searle, Director of Partnerships and Joint Commissioning, NHS Berkshire West
Christine Holland, LINk Steering Group
Tony Lloyd, LINk Steering Group
Rachel Masters, Partnership Development Officer, Wokingham Borough Council
Nicola Wessa, Assistant Director PR, Royal Berkshire NHS Foundation Trust
Lisa Glynn, Interim Director or Operations, Royal Berkshire NHS Foundation Trust
Kenny Noughton, Service Development Manager, South Central Specialised Services Commissioning Group
Madeleine Shopland, Senior Democratic Services Officer
Charles Yankiah, Senior Democratic Services Officer

Prior to the meeting, the Chairman Tim Holton wished to record his thanks to last year's Committee and welcomed the Committee members for 2011/12 including the new members on the Committee.

5. MINUTES
The Minutes of the meetings of the Committees held on 23 March 2011 and 19 May 2011 were confirmed as a correct record and signed by the Chairman.

6. APOLOGIES
An apology for absence was submitted from Kay Gilder.

7. DECLARATION OF INTEREST
Charlotte Haitham Taylor declared a personal interest in Item 13 – LINk Update as an epilepsy patient and being in receipt of medical treatment.
Kate Haines declared a personal interest in Item 13 – as a wheelchair user and as a user of a specific department of the Neurological Dept.

8. PUBLIC QUESTION TIME
There were no public questions.

9. MEMBER QUESTION TIME
There were no Member questions.

10. HEALTH CONSULTATION – CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND
The Committee received a presentation from Kenny Naughton, Service Development Manager, South Central Specialised Commissioning Group in relation to the Health Consultation – Children's Congenital Heart Services in England as attached to these minutes at Appendix 1.

Kenny Naughton also informed the Committee of the following: -

- The benefits were to ensure the best possible care and outcomes for children, regardless of where people live
- The development of congenital heart networks would strengthen collaboration in the interests of patients based upon the District Children's Cardiology Centres being led by PECs, the Children 's Cardiology Centres being led by the Cardiologists and the Specialist Surgical Centres leading the network
- The four areas of consulting were the Standards of Care, the Congenital Heart Networks, the Larger Surgical Centre and Measuring the Quality.

The Chairman, Tim Holton enquired as to what the advantages were in choosing the London centre over the Southampton centre and vice versa.

Kenny Naughton informed the Committee that based upon the results table both centres have good quality services and their standards were expecting to be raised in the future from all accounts. He also commented that there will still be patient choice no matter what option centres are chosen or preferred.

Emma Hobbs enquired as to what is going to happen when the increase in housing accommodation in Wokingham brings an increase in the population of Wokingham.

Kenny Naughton informed the Committee that the increase in population in Wokingham won't have an impact on the services being provided by any of the option centres.

Philip Houldsworth enquired as to whether or not any of the option centres had identical services or specialist services to take into consideration.

Kenny Naughton informed the Committee that the Southampton centre had a strong case for co-locating both the adult and children heart services centres.

The Chairman, Tim Holton sought the views of the Committee in agreeing what option centres would be preferred.

RESOLVED: That

1) the Health Overview and Scrutiny Committees (HOSC) preferred choice is Option B.

2) the HOSC's preferred choice of London Centres are Evelina and Great Ormond Street Hospital.

3) the Chairman collates the response on behalf of the HOSC and submits it by 1 July 2011.

11. CARE QUALITY COMMISSION UPDATE

RESOLVED: That in the absence of Sue Sheath, Compliance Manager, Care Quality Commission, the item be deferred to the next meeting of the Health Overview and Scrutiny Committee and that she be invited to provide the update on the work of the Care Quality Commission.

12. LOCAL INVOLVEMENT NETWORK (LINk) ANNUAL REPORT

The Committee considered the LINk Annual Report that had been included in the Supplementary Agenda regarding the Local Involvement Network Annual Report for

2010/11. Christine Holland presented information regarding the Annual Report and highlighted the following -

- The Community
- Local Health Care Services
- Local Social Care Services
- The Wokingham LINk
- Achievements of the Wokingham LINk
- Monitoring and Scrutinising Services
  - Carers Respite Funds
  - Patient Environment Action Team visit to Wokingham Hospital
  - Berkshire West Primary Care Trust (PCT) Pharmacy Commissioning Group
  - Survey on the Ease of Access to General Practitioner(GP) Surgeries by People with Disability
  - Survey on Patient Access to Appointments with GPs
- Community Engagement Survey 2010
- Services for People with Neurological Condition
- Experience of Parents of Children with Autistic Spectrum Disorders when using the Child and Adolescent Mental Health Service (CAMHS) in Wokingham
- Involvement in National or Local Consultations
- Developing Local Stakeholder Relationships
- Supporting User Lead Organisations (ULOs) in Wokingham
- Year in figures

Andrew Bradley sought clarification on whether there were 14 or 15 general practices in the Wokingham Borough.

Christine Holland informed the Committee that there were 15 general practices in the Borough.

Charlotte Haitham Taylor congratulated the LINk, on the details of the annual report and the work and content gone into the: -

- Survey on the Ease of Access to GP Surgeries by People with Disability;
- Child and Adolescent Mental Health Service (CAMHS); and
- Community Engagement Survey (CES) 2010.

Christine Holland informed the Committee that as a result of the CES improvements had been made to Wokingham Direct and that copies of the CES were available and if the Committee wanted she could circulate them in the future.

The Chairman, Tim Holton enquired as to what the LINk would be unable to do as a result of a reduction in funding.

Christine Holland informed the Committee that as a result of the reduced funding there would be less support of office time and assisting with reports, there would need to be a revision of other organisations. She also informed the Committee that the LINk would be happy to submit a financial update at the next meeting after it had done its assessment.

RESOLVED: That -

1) Christine Holland and the Wokingham LINk be thanked for the Annual Report 2010/11 and for the effort gone into the production and detail of the report.

2) A copy of the Community Engagement Survey 2010 be made available and circulated to the Committee.

3) A financial assessment of the Wokingham LINk be submitted to the next HOSC meeting.

13. LINk UPDATE, INCLUDING SUPPORT ARRANGEMENTS AND WORK PROGRAMME FOR 2011/12 AND NEUROLOGICAL CONDITIONS REPORT SUMMARY

The Committee considered the LINk Update that had been included in the Agenda pages 18-28 that included the support arrangements, the work programme for 2011/12 and a presentation relating to the Neurological Conditions in Berkshire West. Tony Lloyd presented information regarding the LINK update and highlighted the following –

PROJECTS -

- Hosting contract with Help and Care ended on 31 March 2011, however, it was extended for one month to 30 April 2011;
- New hosting contract with Support Horizons began on 1 May for 11 months till 31 March 2012;
- The Neurological Survey Project – replies were received from the stakeholders and the University of Leeds has produced a report on the results;
- Parents experience of the CAMHS - The Steering Group are awaiting an invitation to be involved in the review of this service, jointly commissioned by Wokingham Borough Council (WBC) and Berkshire West PCT; and
- Pharmaceutical Service provided by Community Pharmacists – people involved in this service who have spoken to groups has produced some invitations which are being met.

OTHER MATTERS -

- Participants on the database transferred to the new Host is 579;
- Allocation of financial support to the Steering Group for 2011/12 is 36.5% of that used last year and the Support Officer time of 2 days per week is ££.3% of that assigned for 2010/11 – this will reduce the work significantly that the Steering Group can undertake for and with Wokingham residents; and
- An invitation to volunteer to work with the LINk Steering Group on areas of people care was circulated in the last LINk Newsletter circulated in March that is being followed up with 5 volunteers who have responded.

NEUROLOGICAL CONDITIONS IN BERKESHIRE WEST –

- Questionnaires were designed by West Berkshire Neurological Alliance (WBNA) and approved by local support group leaders
- Questionnaire packs were provided to the support groups from January to August 2010, which was funded entirely by the LINks;
- Analysis and reports were completed by the LINk and the transcriptions of patient's comments were completed by the Voluntary Action West Berkshire (VAWB) volunteers;
- Report prepared by the LINk and was reviewed by Professor Gillian Parker of York University;
- Response rate was 19.1%, which was considered quite low, possibly mainly due to questionnaire fatigue or returned questionnaires not getting back to the LINk;

- Resources were accessed by 254 patients which meant approximately 7,334 episodes of care which averaged about 29 visits per year;
- Comparison of service providers highlighted that consultants received a high rating in relation to being helpful in comparison to GPs and Community Nurses;
- The Voluntary Sector scored higher than all other services;
- Physiotherapists, though much in demand and intensively used, scored poorly for knowledge and helpfulness in relation to the number of visits in comparison to the Nurse Specialists and Consultants;
- 7 general recommendations have been made with 19 specific recommendations;
- A full response was received from Royal Berkshire Hospital Foundation Trust. 5 additional questions have been asked;
- PCT and 4 consortia had only responded to the 7 general recommendations but an additional response to the other recommendations had just been received;
- Berkshire Health Care NHS Foundation Trust (BHCFT) had not responded at all; but again a response from Julian Emms had been received just prior to this meeting;
- Wokingham and West Berkshire Councils have provided responses but they are limited in scope compared to Reading.

Tony Lloyd informed the Committee that Professor Gillian Parker, Director of the NHS R&D Service Delivery, Department for Health had agreed to review the draft report. She had commented that the language in one of the sub-reports was quite combative where it criticised the PCT and GPs. It was pointed out that the language was that used of the patients themselves. She also commented that the report and its findings were consistent with other surveys that had been conducted nationally.

Emma Hobbs enquired as to the reason behind the Community Nurses and the GPs performing low in the comparison of service providers was it mainly due to a lack of training and why was Wokingham's response limited and not detailed as much as Reading's, it is possible to have a copy of the response.

Tony Lloyd informed the Committee that the Community Nurses and the GPs have no specialist training in comparison to the Specialist Nurses which could be the reason. He also commented that Reading provided a more detailed response, in comparison to Wokingham's response that just answered the questions.

Rachel Masters commented that Community Care in responding to the questionnaire were of the view that they could not comment on matters that WBC were not directly responsible for and as a result only responded to matters directly related to their areas of responsibility.

RESOLVED: That the update be noted and that the Authority's (Reading, West Berkshire and Wokingham) responses to the LINk's Neurological Services report be circulated to the Committee.

14. ROYAL BERKSHIRE HOSPITAL CLINIC WAITING TIMES REPORT

The Committee considered a report regarding the delays in the Outpatient Clinic at the Royal Berkshire NHS Foundation in response to information requested by HOSC at a previous meeting.

Lisa Glynn presented information regarding the Outpatient Clinic and highlighted the following -

- that the intention was to assist members to understand how the clinics are organised

- to explain why delays may sometimes occur and how they were working to improve the experience for the patients
- each year over 500,000 patients are seen for appointments
- clinics take place at 5 sites – Royal Berkshire Hospital, Prince Charles Eye Unit Windsor, West Berkshire Community Hospital, Townlands Hospital in Henley and Wallingford Community Hospital
- clinics are hosted by a number of staff including consultants, registrars and nursing staff depending on the type of clinic
- clinics are mainly made up of appointment, however some do include slots for urgent referrals, or emergency patients
- an established Working Group whose remit includes how the outpatients experience can be improved is also looking at the pathway patients follow for planned care that includes outpatient clinic
- areas of focus for the working group were identified from the National Outpatient Survey, audit work completed within the Trust looking at how outpatient clinics are used and feedback from the staff running those clinics
- the team are never complacent about delays and are constantly trying to manage the balance between responding to urgent patient needs either in clinic or in the wards and delivering timely care to those with scheduled appointments
- Actions being taken cover 3 main areas – the environment, the appointment process and keeping patients informed and gathering feedback from patients.
- National Outpatient Survey with produce their findings in about 4/5 months.

Charlotte Haitham Taylor enquired if any improvements were being made as a result of all the reviews, surveys and working group focus.

Lisa Glynn informed the Committee that improvements were being made, but it was still early days and a lot more improvements would be seen later on.

Andrew Bradley commented that he has had personal experience with the outpatient x-ray department in that he had to wait a considerable amount of time to be seen and enquired if that was being looked into as well.

Lisa Glynn informed the Committee that it was being looked at in some depth and that the whole area was going to be re-designed and a new model adopted with regards to the flow of patients through the system and the waiting areas.

Gerald Cockroft also commented that he had a more positive experience in the Neurology Department and enquired if their system could be adopted elsewhere as it worked really well.

Lisa Glynn informed the Committee that is does work well, but it has not yet been adopted and it is a measure of good practice that needed to be replicated across other service areas.

Annette Drake addressed the Committee and enquired of the representatives of the RBHFT the following: -

- Slotting in patients as referred to in part 2 of the report - can this not be changed to be inserted before the clinic begins so that emergency and new patients are seen first so that those who have scheduled appointments are not interrupted and the day runs smoothly; and

- The working group as referred to in part 3 of the report – what do they do, there is no clear indication as to what they do or what their focus is.

Lisa Glynn informed the Committee that slotting in of patients was probably the incorrect terminology to be used, as they are really not "slotted in", but what happens is that specific times in the daily diaries are held and kept clear in the event that there are emergencies, however, this works well as it is done in partnership with the GP clinics. She also commented that what really happens is that patients want to come in, be seen and then go home, so reviewing the schedule and is quite important.

Kate Haines enquired as to whether or not there was going to be any improvement with the disabled parking.

Lisa Glynn informed the Committee that there had been improvements with the disabled parking, but there issues around allocation, access and numbers in general.

Bev Searle commented that though there had been an increase in the number of appointments being made, what they didn't want to happen was people attending un-necessarily and that there were good innovative ways of improving that were being looked at.

Kate Haines commented that in relation to appointments she knows of a particular situation where the consultant has been told that they should try to have just one appointment with the patient and then try and sign them off and she has a lot of concerns in relation to this method as many people could "slip through the net" as it were.

Lisa Glynn informed the Committee that it was all about trying to keep a balance and working toward the benchmarks. She also commented that it is understandable that patients feel a bit frustrated about the process but it is being encouraged that patients access the service for as long as possible where necessary. She also informed the Committee that patients are the representatives of the Consultant and that the Consultants are not forced to do anything.

RESOLVED That:

1) Lisa Glynn and her team be thanked for attending and providing the information as requested by the HOSC.

2) The National Outpatient Survey Action Plan (NOSAP) be submitted to the Committee within 4/5 months.

3) The Steering Committee be invited to attend the HOSC when the NOSAP is being presented.

15. WORK PROGRAMME 2011/12

The Committee considered the proposed Work Programme for 2011/12 as included in the Agenda pages 35 to 41 and suggested the following amendments –

NEXT MEETING – date to be confirmed

- Care Quality Commission Update – be included on the agenda
- Consultations - The Seasonal Influenza Immunisation Programme – A review of the procurement of seasonal vaccine - consultation link to be emailed to members in advance of the meeting so it can be viewed

- Age UK Woodley - A report on the services provided by Age UK Woodley to be received at the next meeting, with a follow up visit to be arranged

29 NOVEMBER

- Chief Executive of Royal Berkshire Hospital to be invited as a follow up to his last visit to the Committee in September 2010.
- The National Outpatient Survey Action Plan be submitted to the November meeting and that someone from the Patient Improving Steering Group be invited to attend as well.

25 JANUARY 2012

- CAMHS – be included on the agenda for the 25 January meeting. This review will focus on the transition of patients from CAMHS to adult social services. The review will be conducted in two parts, with the first part taking the form as a visit to the Berkshire Healthcare Trust in December to discuss this transition, with a focus on eating disorders.

The Chairman, Tim Holton requested that the Committee Clerk inform the Committee of the proposed Tracking Note.

Charles Yankiah, Senior Democratic Services Officer, Wokingham Borough Council informed the Committee that he had produced the Tracking Note to ensure that actions and resolutions did not fall off the agenda or be forgotten in the future and that items from the Tracking Note could only be deleted or removed with the approval of the Committee or the Chairman or when those items had been satisfactorily dealt with or reported back to the Committee.

RESOLVED That:

1) the amendments to the Work Programme 2011/12 be updated.

2) the Tracking Note be produced and kept up to date by the Clerk and it be included on the agenda in the future as part of the Work Programme Item.

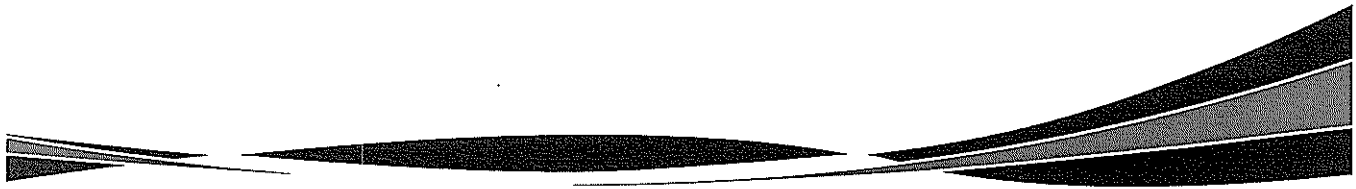
3) the changes to the Public Health system be kept on the work programme together with an invitation to Professor John Newton, Regional Director Public Health, NHS South Central.

Safe and Sustainable: Review of Children's Congenital Heart Services in England

Health Impact Assessment:

Key emerging findings - Phases 1 & 2

June 2011



Mott MacDonald

Confidential

Appendix 1

Introduction

The NHS is currently consulting on *Safe and Sustainable*: a vision to improve children's congenital heart services in England. Clinicians and parents have asked for this review and the NHS is currently consulting on four areas:

- **Standards of care:** Are they the right standards?
- **Model of care:** Fewer, larger surgical centres and the development of congenital heart networks. Is this the right model of care for England?
- **Larger surgical centres:** Do you agree on the proposed number and location of surgical centres?
- **Measuring quality:** Do you agree that new systems for analysing and reporting outcome data are necessary and beneficial?

More information about the review and the public consultation, which closes on 1 July 2011, can be found here: www.specialisedservices.nhs.uk/safeandsustainable

10

Health Impact Assessment (HIA)

In parallel with the consultation, an independent HIA is being undertaken to consider the impacts on health; equality and vulnerable groups; travel and access; and carbon emissions of the potential reconfiguration options for services.

The purpose of this document is to share with the HOSCs, patients and the public **key emerging findings on the HIA** to date to inform their response to the consultation. It is important to stress that the findings outlined here are preliminary because they are based only on the work to date. As a result, firm conclusions cannot be drawn until all of the research tasks have been completed and findings analysed and considered.

However, some preliminary observations can be drawn and are outlined here.

The HIA is undertaken in four phases:

Phase	Application to the proposals for children's heart surgery and cardiology services
1: Scoping (Oct 2010 – Jan 2011)	• Strategic overview of potential effects of reconfiguration • Identification of vulnerable groups who need to be the focus of HIA • Identify impacts on populations and areas that need to be particularly considered during the main HIA.
2: Data capture and engagement (Feb 2011 – Jul 2011)	In-depth analysis of each option, including: • Travel and access analysis, identifying those who are disproportionately impacted by longer journey times • Stakeholder engagement, with particular focus on patients and families from vulnerable groups • Carbon assessment Phase 2 will result in: • Identification of positive impacts, who experiences these and opportunities for further improvement • Identification of potential adverse impacts, who experiences these and ways in which to mitigate these • Integrated assessment of each option with emerging conclusions
3: Review of HIA in light of consultation outcomes (Sept 2011)	Update the report to fully consider and integrate relevant consultation findings.
4: Incorporation of HIA into decision-making (Late 2011)	HIA is considered by the JCPCT so that it can inform decision-making.

Activity to date

Between October 2010 and January 2011, phase 1, a scoping , was undertaken and a report produced. The scoping phase has analysed available clinical and equality evidence to understand which groups were more likely to require paediatric cardiac surgical services. The tasks undertaken included:

•desk –top research to provide a qualitative baseline of key issues relating to children's heart surgery services and identify groups within the population which will demand focus in later assessment phases;

•socio-demographic data collection and mapping to develop a clear understanding of the characteristics of the population of England and Wales; the profile of communities around each of the existing surgical centres; and the distribution of residents from different equality strands and deprived groups; and

•interviews with NHS Regional Directors of Public Health to corroborate and build on the evidence gathered through desk research and socio-demographic analysis and further understand the potential effects on health outcomes, inequalities and equality groups.

The scoping report and further work undertaken since the scoping phase has revealed several patient groups which are, proportionally, more likely to be in greater demand for paediatric cardiac services than the wider population. These are:

•Those who experience socio-economic deprivation;

•Black, Asian and Minority Ethnic (BAME) groups, particularly those related to Indian, Pakistani, Bangladeshi and other Indian subcontinent populations;

•Mothers who smoke during pregnancy; and

•Mothers who are obese during pregnancy.

Phase 2 has built on the initial findings through undertaking Health and Equality Impact forums, inviting almost 2,000 organisations and individuals across England and Wales (the lists of invited stakeholders are attached, please note that these are not final as the HIA continues). In addition to this, we are undertaking one-to-one telephone interviews with vulnerable patients and their families from those areas most likely to be affected as a result of the proposals, based on journey times, access and socio-demographic analysis. However, while there may be a higher relative incidence among some Asian populations for a small number of congenital heart conditions, overall numbers are very small.

Overview of key emerging findings

The impact assessment considers that the proposals for change in children's cardiac surgery services will lead to improvements in clinical care and outcomes for patients.

Through improved clinical network arrangements, there will also be benefits from proposals to provide most non-surgical services more locally, across all areas. These changes will ensure that children can receive good quality care nearer to home, meaning that there should be less need to attend specialist centres. This is likely to benefit more deprived and vulnerable communities who find it difficult to meet the financial costs of private or public transport to attend follow up care, which often is a long-term commitment rather than a one-off visit that surgery is in most cases. Local care, therefore, will deliver considerable benefits to these communities.

A number of potential negative impacts had also been identified, some of which would have more impact on vulnerable groups. Some of these issues have already been identified by *Safe and Sustainable* and are in the process of being addressed through mitigation strategies. Further potential adverse impacts which have been considered include the disruption to the continuity of care for some patients requiring surgery and longer and more complex journeys to specialist surgical centres for a small proportion of patients and families.

However, across all of the options, the majority of the overall population (around 65%) would not experience a change in journey times to access surgical services. The numbers of those who would experience a disproportionate increase in journey times are small. Between 1.9% (Option A) and 2.8% (Option C) of the population would experience a significantly longer journey time by private car (over 3 hours) and between 4.3% (Option D) and 5.6% (Option B) by public transport (over 4 hours), to access surgical services. In relation to vulnerable communities, longer travel times would be experienced by some but the numbers are again small; representing between 1.2% (Options A, B and D) and 1.8% (Option C) of the total population when travelling by private car or between 2.2% (Option B and D) and 3.0% (Option C) of the total population when travelling by public transport. For all options, deprived areas of Norfolk and Cornwall would continue to have journey times (by car) of over 3 hours.

Currently, we are finalising detailed travel analysis to identify the exact proportion of patients from vulnerable groups who would be disproportionately impacted in each of the four options.

Positive Impacts

The most important positive impact is improved health outcomes. There was general consensus within the research and amongst the stakeholders consulted that concentrating surgery onto fewer sites will be beneficial; particularly for those vulnerable communities with a higher prevalence of congenital heart defects. This major strand of the proposals will lead to higher levels of safety and quality of care for patients. It will be important for improved clinical networks to be built up to achieve the full benefits to patients that should potentially follow from the proposed changes.

There was general acceptance amongst stakeholders that the provision of cardiology care in more local settings could bring with it considerable benefits. This proposed model of care would particularly benefit patients and families from deprived areas and from certain ethnic groups; reducing travel time for routine follow -up care and the inconvenience this can cause; and improve attendance rates.

Centralising services onto fewer sites will also provide safer and sustainable surgical services: ensuring that there are improved arrangements for 24/7 surgical cover; reducing cancellations and rejection of referrals; and supporting the retention and recruitment of cardiac surgical skills. Centralisation will also provide opportunities to use clinical facility and staffing resources more productively. Proposed improvements in monitoring and reporting on the patients' morbidity and mortality will lead to supporting the improvements in outcomes; particular relevant to those vulnerable communities with higher prevalence rates.

Proposed clinical standards are expected to deliver benefits for children; and in particular those from vulnerable communities. This includes the benefit from the opportunity to be seen by a Clinical Psychologist who will also support them during the decision-making process , a Children's Specialist Nurse being present at all outpatient appointments to help explain the diagnosis, and an immediate 24-hour access to a member of the clinical team for advice and support. The BAME groups in particular will benefit from the requirement in the standards that all information needs to be culturally sensitive. Those on low incomes in particular will benefit from the proposed standards around improving facilities for families, such as access to accommodation.

Negative Impacts

As with any major reconfiguration of services, during the transition period to the new service configuration, it is recognised that there will be change in the continuity of care provided to children. However, these impacts are short-term and would only affect those children who have a relationship with a current surgical centre and who may require a surgical procedure or interventional procedure in the future. To mitigate against these, it is important that children and families receive appropriate information about the changes and continue to be involved in the changes to their care.

As a result of the reconfiguration, NHS should explore, before implementation, which surgical centres may be treating children from different communities which have not previously presented at the centre. Therefore, it will be important that centres and commissioners give careful consideration to the provision of culturally specific facilities and services in the specialist centres, particularly those from Asian communities.

As mentioned previously, for a small proportion of children and families there will be longer and more complex journeys to specialist surgical centres, with between 1.9 – 2.8% of the population experiencing a significantly longer journey time by private car and between 4.3 – 5.6% by public transport. This will also result in increased travel costs but financial assistance will continue to be provided to those families with low incomes. For those children and families affected by the reconfiguration, clear guidance and advice about different travel access options should be made available in a variety of formats and languages. Journey times for patients and families could also be considered when scheduling planned surgical procedure appointments.

There could also be increased travel for ambulance services, which could in turn cause capacity constraints. During implementation, local commissioners need to ensure that ambulance services are fully integrated into the clinical network and that capacity requirements are considered and planned.

Adult Safeguarding Annual Report 2010/2011

Linda MacEachen
Adult Safeguarding Service Manager

WOKINGHAM BOROUGH COUNCIL

Changes in national and local policy

- No Secrets – No update until 2013
- May 2011
  - Law commission recommendations
  - DH guidance
  - ADASS advice note

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Proposed changes

- Definitions:
  - Adult at risk for Vulnerable Adult
  - Harm and Significant harm for abuse
- Safeguarding Boards to be statutory requirement for all agencies and duty to co-operate in investigations
- Local authority to continue to lead plus duty to cause investigation/assessment to happen when significant harm is suspected
- Significant harm to include self neglect and self harm

WOKINGHAM BOROUGH COUNCIL

Health services

- New adult safeguarding clinical governance and best practice guidance with audit tool.
- Royal Berks Hospital appointed lead nurse for adult safeguarding. Improved communication and follow up of concerns

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Police

- Proposed changes to Protecting Vulnerable People Unit
- One referral centre for Berkshire
- Risk of losing specialist police officer for vulnerable adults in the West of Berkshire
- Ongoing consultation led by Superintendent Richard List

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Referrals to Wokingham Borough Council

- 380 - 80% increase on last year
- 192 Older People
- 152 Learning Disability
- 32 Physical and Sensory needs
- 15 Mental Health
- 12 Substance misuse
- 2 Other

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Reasons for increase?

- Greater awareness of abuse
- Improved reporting
- Change in definition of abuse to include significant risk of harm from self neglect
- Better recording of concerns by Adult Social Care staff
- Rise is consistent with other local authorities of similar size
- Still less than prevalence found in Department of Health study

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Who refers from our partners

- 38 from NHS partners
  - 22 Primary/Community
  - 9 Mental Health Trust (decrease)
  - 7 Secondary/Hospital
- 22 Police
- 6 from Housing (decrease)
- 147 Care Providers

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Who else refers

- 38 Self
- 56 Family
- 7 Friend/ Neighbour
- 35 Other
- 24 Social Worker

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Type of abuse

- 181 Physical
- 106 Neglect
- 79 Psychological
- 62 Financial
- 45 Sexual
- 17 Institutional
- 4 Discriminatory

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Alleged perpetrators

- 88 Other vulnerable adults
- 65 Family
- 37 Partners
- 27 Friend/Neighbour
- 118 paid staff (92 care staff) resulting in 14 being disciplined.

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Outcomes

- 72% substantiated
- Partly substantiated
- 15% not substantiated
- 13% Not determined

- Action taken to safeguard vulnerable people with only 28 needing no further action following assessment

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Action needed

- Better collection and reporting of data to inform operational and strategic action
- Work through West of Berks Safeguarding Adults Partnership Board to improve development of response from Health and Police.
- ASC staff to refresh Safeguarding Training
- Continue to develop Care Governance protocol to improve practice in care provided.

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Prevention Strategy – Preventing abuse

- In people's homes and in the community
  - Bogus callers/Rogue Traders, Campaigns, Safer Places, Hate Crime prevention
- In services provided to vulnerable adults
  - Safeguarding Forum, Care Governance, Support with Confidence, Safe Recruitment, Training
- Raising awareness of abuse and how to safeguard self and others
  - Publicity, Training

WOKINGHAM BOROUGH COUNCIL

Adult Safeguarding Service

- Prevention Advisor – Johan Baker Support to voluntary sector and vulnerable people to prevent abuse
- At Risk Co-ordinator – Jo Betenson links with police and Community Safety, MAPPA and MARAC
- Service Manager – Linda MacEachen links with West of Berks partnership board. Quality assurance of WBC response to concerns about abuse

WOKINGHAM BOROUGH COUNCIL