Please note: amendments were made to these minutes at the meeting held on 29 November 2011

MINUTES OF A MEETING OF THE HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON WEDNESDAY 28 SEPTEMBER 2011 FROM 7.00PM TO 9.55PM

Present: *Tim Holton (Chairman), Charlotte Haitham Taylor (Vice Chairman), Annette Drake, Kate Haines, Lee Gordon-Walker and Sam Rahmouni*

Also present*:*
Nigel Davies, Chief Nurse, NHS Berkshire
Nigel Foster, Deputy Director Finance and Performance, NHS Berkshire
Alex Gild, Director of Finance, Berkshire NHS Foundation Trust
Christine Holland, LINk Steering Group
Tony Lloyd, LINk Steering Group
Janet Maxwell, Director of Public Health, NHS Berkshire West
Dr Richard Perry, Wokingham GP Consortia
Bev Searle, Director of Joint Commissioning, NHS Berkshire
Charles Yankiah, Senior Democratic Services Officer

28. MINUTES

The Minutes of the meeting of the Committee held on 2 August 2011 were confirmed as a correct record and signed by the Chairman.

29. APOLOGIES

Apologies for absence were submitted from Andrew Bradley, Gerald Cockroft, Kay Gilder, Mike Gore, Emma Hobbs and Philip Houldsworth.

30. DECLARATION OF INTEREST

Kate Haines and Tim Holton both declared personal interests in Minute No. 31 as users of GP Surgeries referred to in the responses to the public questions.

31. PUBLIC QUESTION TIME

In accordance with the agreed procedure the following members of the public have submitted questions.

31.01 Question

Mrs Kathie Smallwood has asked the Chairman for Health Overview and Scrutiny Committee the following question.

Since Woodley Centre & Parkside Surgeries have moved into new premises over Lidl there have been numerous problems with build quality, parking but mostly with access for the disabled. This is due to there being only one lift at this end of the building and no suitable spaces on the ground floor for consultations. With all the current problems this building is unfit for purpose. Is there any possibility of these premises being improved in the near future?

Answer

It is understood that Kathie Smallwood is a patient in the Woodley Centre Surgery and has already made this complaint verbally to the Practice Manager.

Berkshire Social Services have been aware of just three outstanding issues with the building all of which are now under control and will be resolved imminently now that they have accepted their offer of remedial work. The meeting to move forward was held on 12th

September when together with Lidl and Rydon, the 12 month snagging review was conducted.

The first issue is the main lift and it is a fact that there have been 17 breakdowns since the building was opened for business last October. There were a great number around Christmas time and Mike Hendy and Paul Rowley, the Managing Director of BSS, personally attended the site on several occasions to meet with the lift engineer to ascertain what the fault was and if there was a pattern. From then until June 2011 there were no further breakdowns and then a cycle started again with several in a short space of time. Stannah Lifts investigated this thoroughly using senior staff in their organisation. They issued a report to Rydon's (the builders) and Lidl which is summarised in an email from Rydons on 29th July:

"As you are aware, that since we met a further breakdown has occurred with the lift, and attached for your information and records is an email from Paul Ayers, Operations Director for Stannah detailing the cause of the latest problem and their companies subsequent actions, Mike Hendy has since spoken with Paul who confirms that all works were completed yesterday AM.

Stannah have now had the opportunity to analyse the information supplied via the "lift card engineer call outs" and we have been advised that the problems are all mainly due to the in retro installation of the "Pawl" new safety devise for stopping involuntary decent.

Stannah advise that they have had problems with this devise and with it's compatibility, which as mentioned has been the cause of the issues at the PCT.

They acknowledge and accept that they have had problems but they are confident that they and their Field Service Team are now in full control and they do not foresee any future problems with the lift"

There have been no further occurrences since this last 'fix'. Stannah have extended the warranty period on the lift to March 2012 and have agreed to provide 24/7 cover for breakdown at no cost to the PCT for the same period.

The second issue has been the high temperatures recorded in the entrance lobby noted by both the Woodley Centre Surgery Practice Manager and confirmed by Dr David Buckle, Senior Partner. BSS have been pursuing this issue with the builders and in the last few days they have confirmed that the reported temperatures do coincide with some data modelling they have run and now have now installed ante glare film to the whole entrance lobby glass which should significantly lower the temperatures. Dr David Buckle has been kept informed of developments

The only other issue is the suitability of the walls in the entrance where we suspect due to damage that has recently been caused by a mobility scooter that the lining does not meet the specification. Rydon have now admitted that the specification was not followed and have agreed to install wall protection to the whole of the ground floor area.

We can confirm that the building was built to and does conform to all NHS HTM's (Health Technical Memoranda) and complies with all requirements of the Disability Discrimination Act. In an emergency we do have the right to use the Residents Lift at the back of the building which was negotiated and agreed at the beginning of the lease negotiations – whilst not ideal as it is staff intensive, it does provide an alternative means of access and

egress for those with disability issues. It can take a normal wheelchair but not a stretcher as it was never specified for that unlike the main lift. Interestingly I quote from an email received from one of the Practice Managers today “We have an impressive surgery and we want to share this with the local community not just our patients” so obviously the staff are proud of the premises. It is also worth noting that the Parkside Family Practice was recently assessed for a training practice by the Oxford Deanery and they praised the GP facilities and the building

The comment about a ground floor consulting space are noted. We have always considered the area to be space wasted, we have expressed a view that it would have been desirable to have an interview room there especially when the lift breakdowns were frequent; however we understand that, as part of the condition of planning approval to comply with DDA requirements the ground floor entrance had to be designed as it is now. However that ground floor area will only take a few mobility scooters and bikes and soon fills up so it is doubtful whether a consulting road would have been able to have been built.

Finally there is a mention of parking which is nothing that the PCT would have any control of. We are aware that this continues to be an issue with staff but have never been aware that this is an issue with patients. Woodley Centre Surgery patients had to use Pay and Display parking when they were in Crockhamwell Road and this is no different now – in fact the Headley Road Car Park is marginally cheaper than the Waitrose one at 50p for 30 minutes as opposed to 70p!! Extra Disabled spaces were provided as part of the build so we really cannot see what the issue is anyway.

31.02 Question
Earley Neighbourhood Action Group has asked the Chairman of the Health Overview and Scrutiny Committee the following question.

By its inaction and public statements West Berkshire PCT is seen to have adopted a policy of tolerating use of 0844 telephone numbers by its contracted GPs. This policy stands clearly outside the terms of the contract revisions added in April 2010, with a deadline for compliance of 31 March 2011.

As the accountable officer, Mr Charles Waddicor, is thereby in breach of his statutory duty (under the Health Act 2009) to have regard to patient rights under the NHS Constitution when framing policy. The first of these rights is to access NHS services without a charge imposed by the provider.

The Earley NAG believes that the Committee should consider this breach of duty by the PCT in detail. As this applies to all of the Boroughs served by the clustered PCT, now covering all of Berkshire, it should consider doing so in conjunction with its sister Committees.

The NAG and other concerned citizens will be happy to furnish the Committee with evidence of the policy being followed by the PCT in the form of letters and statements to newspapers. There is also evidence of the effect on the people of Wokingham and other boroughs in the county.

The terms of the contractual requirement are clear and there is evidence of clarifications provided by government ministers. These clarifications counter the position of the BMA GPC which holds and promotes a policy that 0844 numbers should be retained.

Will the Committee use its authority to hold the PCT to account over this matter?

Answer
Thank you for giving me the opportunity to respond to the question that the Early Neighbourhood Action Group has asked at the Health Overview and Scrutiny Committee on 28 September 2011. The background to this is as follows -

On 1 April 2010 the National Health Service (Primary Medical Services) (Miscellaneous Amendments) Regulations 2010 came into force. These regulations amended GP contracts in respect of the use of 0844 telephone numbers. The regulations placed a responsibility on GP contractors to:

- Not enter into, renew or extend a contract or other arrangement for telephone services unless satisfied, having regard to the arrangement as a whole, that people will not pay more to make calls to the practice than they would to make equivalent calls to a geographical number, and

- That where a contractor was a party to an existing contact or other arrangement for telephone services under which people call a number which is not a geographical number, the contractor must:

    - before 1 April 2011 review the arrangement and consider whether, having regard to the arrangement as a whole, people pay more to make relevant calls than they would to make equivalent calls to a geographical number, and

    - if appropriate take all reasonable steps to ensure that, having regard to the arrangement as a whole, people will not pay more to make relevant calls than they would do to make equivalent calls to a geographical number.

In response to the regulation change, the PCT was required to issue a variation to each of the contracts that it has with GP Providers. This variation placed a responsibility on the GP Providers to ensure that they complied with the regulation change. We subsequently asked the providers currently using 0844 numbers to confirm their compliance and each of them submitted an assurance that their phone supplier (NEG) was charging rates in line with local geographical calls. The GP Providers consider that this means they are complying with their contract.

In response to concerns previously raised by Mr Mike Kennedy, of the Earley Neighbourhood Action Group and in order to assure itself further that the regulations were being complied with the PCT asked the Department of Health to clarify more precisely how the regulations were meant to be interpreted as it was recognised that there are many varied telephone tariffs available. In particular we sought clarification on:

- Whether the regulations only related to phone calls made from landlines, and

- Whether the wording in the regulations “having regard to the arrangement as a whole” meant that the majority of patients should not pay more than they would to make the equivalent call to a geographical number.

The Department of Health has advised that it is in the process of putting guidance together to clarify the interpretation of the regulations. Once this guidance is published, the PCT

will review again whether its GP contractors that use 0844 telephone numbers are compliant with the terms of their contract.

Supplementary Question
The Earley Neighbourhood Action Group thanked the Scrutiny the Committee for providing the response, however, we think that the response is inadequate and misleading.

Our original question was concerned with the matter of patients rights and it is our contention that NHS Berkshire West is failing to discharge its duty properly by not upholding those rights, not acting in accord with the NHS Constitution and allowing contravention of the fundamental principles of the NHS which are now repeated and enshrined within that Constitution The NAG is speaking on behalf of the 30,000 people who live in Earley, many of whom have expressed anger at the disgraceful continued use by GPs of premium charge expensive phone numbers, as reported in the Wokingham Times and on BBC Radio Berkshire recently. This response from NHS Berkshire West illustrates its failures as well as repeating inaccuracies and misrepresentations.

Accordingly we ask if this Committee will make available an appropriate resource to work with us to assemble and examine the evidence and prepare to hold NHS Berkshire West to account.

Supplementary Response
The Chairman said that he would make himself available to work with the Earley Neighbourhood Action Group to look into the issues raised.

32. MEMBER QUESTION TIME
There were no Member questions.

33. INFECTION CONTROL/CLEANING CONTRACTS
The Committee received a report from Nigel Davis, Chief Nurse Royal Berkshire NHS Trust in relation to Infection Control and Cleaning Contracts as included in the Agenda pages 10 to 13 and informed the Committee of the following –

- The Trust has an excellent record for infection prevention and control;
- The Trust is only 1 of 25 Trusts in the UK to remain MRSA free for more than a year;
- The Trust is 1 of 3 Trusts in the South Central region to remain MRSA free for more than a year;
- This has been achieved as a result of a zero tolerance approach and is based upon a more focussed approach to cleaning the patient environment and patient equipment and encouraging the use of the right hand cleaning methods and at the right point in time;
- The Trust now follows the national best guidance practices;
- The Trust made the decision to remove hand gel from some public areas such as entrances in responses to the National Patient Safety Agency issuing an alert in September 2008;
- Advice was that alcohol-based hand sanitisers are most beneficial if located at point of care;
- All Trusts have been required to undertake a risk assessment in relation to the positioning of these products;
- Alcohol-based sanitisers are still available at the entrances to clinical wards/departments and within the patient bed-space/room for use by anyone entering those areas;

- Clostridium Difficile (CDifficile) is spread primarily by the production of spores which are resistant to many antiseptics/disinfectants including alcohol;
- The best way to remove the spores from the hands is to physically wash them off with soap and water as the alcohol sanitiser does not kill the spores;
- Using chlorine releasing agents for all the routine decontamination of patient care associated equipment and the environment;
- This is also supported by the use of hydrogen peroxide "fogging" of the isolation room used by patients with C. Difficile;
- The cleaning schedule for public areas is also agreed by the Matron for Infection Prevention and Control and the Manager for Housekeeping;
- The Housekeeping team leaders allocated staff to the public areas according to frequency of the schedule covering 7 days per week;
- Daily, weekly and periodic cleaning activities are monitored according to the frequency of the cleaning activities;
- Auditing of the public areas is in line with the National Standards of Cleanliness;
- The Trust has embarked on a two cleaning initiatives this year;
    - The annual deep clean delivers a high level of cleanliness to support patient expectations and experience along with the reduction in hospital acquired infections.
    - The deep clean plus programme goes a step further and will see up to 10 wards not only achieve the same high level of cleanliness as a deep clean but will also receive a "mini make-over" in terms of general repairs, repainting the walls, update lighting, equipment testing and replacements.
- This is as a result of £750k of Capital Investment being set aside and used for this purpose; and
- The Trust takes both infection prevention and control and housekeeping seriously and these both have a direct impact on the experience of the patients and visitors and health outcomes of the patients.

Annette Drake congratulated the Trust for getting rid of MRSA for more than a year, but enquired about the amount of C.Difficile cases the Trust have had in a year.

Nigel Davis informed the Committee that it is currently about 35 cases a month, but these are in most cases referred to the Trust by GPs in the community. Only one third of cases are actually associated with the Trust. The Trust is currently working with communities and GPs to reduce these cases by improving and increasing cleaning measures and introducing the use of antibiotics.

Annette Drake enquired what the "fogging" cleaning method was and how was it done.

Nigel Davis informed the Committee that the "fogging" cleaning method was conducted in a sealed environment and involved the isolation of the room.

Kate Haines also congratulated the Trust for the report and for getting rid of MRSA for more than a year. She enquired if there was a way that the Trust knew how areas were being cleaned and despite the improvements in MRSA, there should still be hand gel dotted around the public areas.

Nigel Davis informed the Committee that it is difficult to place them in public areas given the current approach of the Trust in complying with National Guidance. He also stated that it would be very difficult to eliminate all contact with bacteria and micro-organisms, but the Trust was working hard to improve and increase its cleaning methods.

Kate Haines informed the Committee that she has made several complaints to the PALS Team in April and May but to date had not received a response.

Nigel Davis informed the Committee that he would look into it.

Dr Richard Perry commented that there were some concerns about the increase in C.Difficile and the numbers being referred to but asked what was being done to reduce it and even eliminate it.

Nigel Davis informed the Committee that there was an increase in signage in public areas to wash hands with soap and water. He also referred to the compliance with the National Guidance in adopting the cleaning methods.

Dr Richard Perry enquired if the alcohol-based hand gel could be made available from the reception areas and members of the public being signposted to ask for it, if they required to use it.

The Chairman enquired if everyone was able to use the alcohol-based hand gel.

Nigel Davis informed the Committee that he would look into Dr Perry's suggestion and also stated that some members of the public did not use the hand gel for religious reasons.

RESOLVED That –

1) the report be noted by the Committee and that the Trust be congratulated for the success in being MRSA free for over a year; and

2) Nigel Davis be thanked for the report and for attending the meeting.

34. BERKSHIRE HEALTHCARE FOUNDATION TRUST

The Committee received an update from Alex Gild, Director of Finance, Performance and Information Berkshire Healthcare NHS Trust in relation to the Next Generation Care (NGC) Implementation as included in the Agenda pages 14 to 21 and informed the Committee of the following –

- The Trust has been carrying out a major review of its Mental Health Services since September 2009;
- Its objective is to improve the quality of the services whilst staying within the financial constraints imposed on the NHS;
- The starting point was listening to people who use our services, general practitioners, staff and other stakeholders and hearing what they said;
- People said –
  - There was differing entry and exit criteria for services
  - It was difficult to get into services and access for some was not clear
  - Services appeared disjointed and difficult to navigate
  - Some patients found it difficult to understand what was happening in their treatment and there seemed to be poor co-ordination between services
  - Services seemed to create a dependency for some and had lost focus on recovery
  - Getting patients from primary care into the right service was complicated and unclear
- The NGC proposed changes in 3 strands –
  - The common point of entry;

  - The care pathway services; and
  - The 7 separate urgent care services being brought together
- The Common Point of Entry will –
  - Give advice to people about what services are provided
  - Allow GP's or other professionals to discuss with senior clinical staff the best treatment options
  - Triage and signpost where appropriate
  - Those requiring secondary mental health services – within 7 days to carry out an assessment of the person's needs
- Care Pathways will –
  - Allocate into an evidenced based pathway
  - Reduce the chance of services being disjointed
  - Make sure that people in the services have a care-co-ordinator who will not only be key in providing treatment and care but will also act as the person's guide
  - Ensure that people in the services are helped to develop a clear plan which is not only about their treatment but also about their overall recovery
- The Community Urgent Care Service will –
  - Provide a service to acutely unwell people in their own homes and will be available 24 hours a day, 365 days a year
  - Help people avoid admission to hospital where appropriate
  - Provide mental health assessment services into the Accident and Emergency Services in Berkshire
- Overall System Flow means –
  - New patients will be contacted quickly following a referral, usually within 24 hours and within 7 working days if an assessment is required
  - Face to face assessments will be carried out in the person's own community
  - People who do need services will be given advice and information
  - People who require services will have an allocated care co-ordinator who will act as their guide through services
  - There will be one Urgent Care service that will provide care for those in crisis and will be available 24 hours a day
  - People will have their own care plan which will focus on recovery
  - Community Mental Health Services will continue to be provided in partnership with Local Authorities
- The Common Point of Entry and Urgent Care will operate as a Berkshire wide service and will include the move of over 300 members of staff into new roles with no losses and majority of changes are planned to be implemented in mid-November;
- The Communication Plan and information to stakeholders will take place toward the end of October;
- A supporting structure will be in place to mitigate any risks and to support the decision making over a 30 day period and will include ongoing monitoring.

Annette Drake commented that it was a very ambitious programme and hoped that it would go smoothly. She enquired about who the care co-ordinators would be and how the self referral would work.

Alex Gild informed the Committee that the care co-ordinators could be any professional e.g. Psychiatrists or Psychologists and that self referrals would be done through advertising of services and by patients themselves referring themselves for additional services.

Charlotte Haitham Taylor commented that she welcomed the changes was a bit concerned that patients could still be lost in the system and enquired as to how this could be prevented.

Alex Gild informed the Committee that there was a focus from the beginning to assess the needs through the pathways and that there would also be assignments for co-ordinations of care and at the common point of entry. He also stated that all the records would be electronic and live with no paper trail and less danger with the technology improvements.

Charlotte Haitham Taylor enquired as to how the self referrals would be promoted.

Alex Gild informed the Committee that this would be done through GP surgeries and practices and through a public advertising campaign.

RESOLVED That –

1) the update be noted by the Committee; and

2) Alex Gild be thanked for the update and for attending the meeting.

35. NHS BERKSHIRE WEST PERFORMANCE AND FINANCE UPDATE

The Committee received an update (see attached as Appendix 1 to these minutes) from Nigel Foster, Deputy Director of Finance and Performance Berkshire West NHS in relation to the financial overview and the key performance indicators and informed the Committee of the following –

- Core allocation was approximately £1,367 per person from the population of about 482,000;
- Including the recurrent and non recurrent allocations, Berkshire West is the lowest funded Primary Care Trust (PCT) in the country per head;
- Berkshire West is the most stable financially in Berkshire with a total budget of around £662m and a surplus of around £1.6m;
- Planning for 2012-13 includes –
  - a review of the current medium term financial plan
  - full year effect of current investments
  - recalculating the Quality, Innovation, Productivity and Prevention (QIPP) “gap”,
  - impact of forecast outturn and any budget repairs
  - assess current QIPP delivery and full year impact
  - growth and inflation assumptions
  - tariff deflation
  - Clinical Commissioning Groups (CCGs) to be driving the process
- Berkshire West will be looking at money, activity and targets;
- NHS Operating Framework sets out the indicators and milestones to be used for planning and to assess how PCTs are delivering; and
- There are approximately 125 indicators and milestones grouped under 3 domains –
  - Quality – covering safety, effectiveness and experience
  - Resources – covering finance, workforce, capacity and activity
  - Reform – covering commissioning, provision, partnership building, putting patients first and development of a new public health infrastructure

Charlotte Haitham Taylor enquired if there was any monitoring of the money that was spent on patients who had received Private Operations funded by the NHS and then subsequently required more NHS Treatment like for example physiotherapy.

Nigel Foster informed the Committee that there is no monitoring of resources for those patients which made it difficult to follow up, however, the quality of care remains the same.

Charlotte Haitham Taylor enquired if anything was being done to improve the pathways and reduce the waiting times.

Nigel Davis informed the Committee that patients were being signposted appropriately to the right services which prevented and reduced second referrals or second moves which had a knock on effect to reduce waiting times.

Annette Drake enquired about where the money came from for Berkshire West and how often did Berkshire West have to bid for it.

Nigel Foster informed the Committee that it was not a bidding process, but money came through the PCT using a funding formula which included a range of indicators with health and social needs. He also stated that it was varied and mainly over a 2 or 3 year period and some on an annual basis like currently.

Annette Drake enquired why Chlamydia positive testing rate in relation to the Health Promotion and Prevention indicators was the only STD that was being tested.

Janet Maxwell informed the Committee that all STDs were done as a matter of course, but because it was a specific indicator it was included in the Promotion and Prevention Indicators.

Kate Haines enquired as to how they knew who the likely ones were to test for STDs.

Janet Maxwell informed the Committee that a series of promotions are done throughout the year at University fresher's week, festivals and at sexual health centres offering various services including screenings.

Lee Gordon Walker enquired as to where the indicators came from and if there was any scope for it to be changed.

Janet Maxwell informed the Committee that the indicators were national and were meant to improve services and increase access for the population and there was very little that could be done to change it.

Lee Gordon Walker enquired as to what the charging policy was for visitors from other countries and if any money is recovered.

Nigel Foster informed the Committee that the health service was free for EU visitors and that there was a national policy in place to re-charge other foreign visitors. He also stated that the onus was left to the hospital to recover any money and that the PCT would not get involved.

Nigel Davis also commented that there was a specific team that dealt with re-charging and recovery, but it was based upon the accuracy of the information provided by the patient at the time e.g. address and contact details.

Charlotte Haitham Taylor enquired if all staff were aware of the charging policy and practices and if they promoted the information.

Nigel Davis informed the Committee that all staff were obligated to treat all patients in A&E and were aware of the policy and practices.

The Chairman enquired if it was fair that Berkshire West was one of the lowest funded PCTs and if there was anything can could be done.

Nigel Foster informed the Committee that someone had to be at the bottom of the table and unfortunately it was Berkshire West. He stated that the population was educated and knew what to ask for and when and that it was also an aging population that had something to do with it. He also stated that because of the changes in the funding formula and the demands on healthcare and emergency services there was a move in money fro healthcare to social care funding as well.

RESOLVED That –

1) the update be noted by the Committee; and

2) Nigel Foster be thanked for the update and for attending the meeting.

36. GP CONSORTIA

The Committee received an update (see attached as Appendix 2 to these minutes) from Dr Richard Perry in relation to the recent developments of the GP Consortia and informed the Committee of the following –

- The Council will become the governing body of the Clinical Commissioning Group (CCG)
- Membership includes 2 lay-members, consultants and nurses;
- The Executive will include 5GPs, 2 practice managers and 1 director, however, there was still no prescription from Government;
- Discussions are being held to develop a federation at a Berkshire West level with over 150,000 patients in the region;
- Some proposed federation functions include –
  - Royal Berkshire, North Hampshire and Great Western contracts
  - IT and data analysis
  - London Trusts
  - Stroke, cancer and vascular networks
  - South Central Ambulance Service
- Local CCG functions included –
  - Developing relationships with the local health and wellbeing board and the local authority
  - Developing patient and public engagement
  - Developing clinical engagement within primary and secondary care – to develop and generate sensible pathways
  - Working with public health and the Joint Strategic Needs Assessment (JSNA) to address local health needs and inequalities
- Currently the pot is £165m and Wokingham is the lowest funded CCG, however, working towards understanding the following budgets –
  - Acute Services
  - Community and Mental Health
  - Long term health care
  - Prescribing
  - Management costs
- Wokingham pressures include –
  - the deficit and pace of change

  - the elderly population with long term conditions and dementia
  - nursing care homes (significant proportion of care homes in the Berkshire area and orthopaedics
- Current areas of activities include –
  - reducing practice variation – elective referrals, non elective admissions, pathology use
  - musculoskeletal (MSK) Service and
  - Practice prescribing
- This means for patients –
  - An increase in high quality community based services
  - More people managed in their own home when unwell
  - No significant changes to their GP surgery

Annette Drake thanked Dr Perry for the update and commented that she didn't understand the logic before, but now she understood what was happening. She enquired as to how the £165m is agreed to be spent.

Dr Perry informed the Committee that the GP Consortia will replace the PCT, however, support will be put in place for PCT staff. He stated that there is currently no disagreement with the proportions of the £165m and everything is currently done on consensus, but if it came to it, there could be a vote.

Lee Gordon Walker enquired as to what happens if the CCG is over budget.

Dr Perry informed the Committee that there risk sharing takes place and CCGs knows that a bail out would be put in place. He also stated that there is access to those who over-spend and they are spoken to and there would come a time then they would be officially notified and in some instances "asked to leave" the CCG.

RESOLVED That –

1) the update be noted by the Committee; and

2) Dr Richard Perry be thanked for the update and for attending the meeting.

37. PUBLIC HEALTH

The Committee received an update (see attached as Appendix 3 to these minutes) from Janet Maxwell in relation to the proposed changes for public health across Berkshire West and informed the Committee of the following –

- Four domains for Public Health – health improvement, health protection, health and social care commissioning, public health intelligence and knowledge management;
- Major health issues including health and wellbeing, health inequalities and social influences;
- Moving back to Local Authorities helps bring health and its wider determinants closer together;
- Public health practitioners are trained in a range of skills including epidemiology, health promotion skills, health protection skills, health economics, sociology and psychology skills, management techniques and understanding research evidence;
- Current policy and key guidance –
  - Liberating the NHS – NHS White Paper – July 2010
  - Healthy Lives, Healthy People – White Paper – November 2010/July 2011
  - Our Health and Wellbeing – November 2010
  - Health and Social Care Bill – January 2011

- Public Health System – due late 2011
  - Public Health Outcomes Framework
  - Public Health England operating model
  - Public Health in Local Government
  - Public Health Funding
  - Workforce Strategy
- Transition of Public Health Functions to Local Authorities
  - Key elements of new system – based on outcomes, ring fenced grant, prescribed services
  - Role of Director of Public Health – principal advisor on health
  - Locally led system – NHS contribution to public health, co-ordinating role of Health and Wellbeing Board
  - Public Health Commissioning responsibilities moving to Local Authority
- The move of Public Health to Local Authorities will take place formally in April 2013
  - During 2012/13 – operate in shadow form
- 18 months to understand and agree the structures needed to develop in order to achieve optimum delivery of the public health function
- The funding formula has yet to be agreed nationally – shared budget based on 2010/11 outturn figures
- Discussions need to take place with each Unitary Authority to gain a better understanding of the issues and the options for delivery of the public health function.

Lee Gordon Walker enquired as to once the implementation has taken place, what options will the Local Authority have in relation to what is being proposed.

Janet Maxwell informed the Committee that there would be some flexibility regarding what is being proposed, however, it should be noted that a lot of the grants will be ring-fenced.

Annette Drake thanked Janet Maxwell for the presentation and commented that the information sharing among the organisations should continue as there have been many examples of good practice and partnership working especially with the smoking cessation and obesity campaigns.

Janet Maxwell informed the Committee that she was totally in agreement and that she hoped that the partnership working and information sharing among organisations will continue after the transition.

Charlotte Haitham Taylor enquired if the Health and Wellbeing Boards had been set up in Berkshire West and if so, how were they going.

Janet Maxwell informed the Committee that some had already been set up and were starting to gel, there were the obvious problems of agenda setting and working together, but these issues are being dealt with as the HWBB continues to meet and move forward.

RESOLVED That –

1) the update be noted by the Committee;

2) Janet Maxwell be thanked for the update and for attending the meeting; and

3) Janet Maxwell be invited back to the Committee in January 2012 to provide an update in relation to Public Health and the progress and developments of the Shadow Health and Wellbeing Boards.

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

38. LINks UPDATE

The Committee received an update from Christine Holland in relation to the LINk as included in the Agenda pages 22 to 24.

Charlotte Haitham Taylor enquired about the project relating to the Referral of the Pharmacy waiting times at the Royal Berkshire Foundation Trust Hospital.

Christine Holland informed the Committee that the project was making good progress and would keep the Committee up to date with any developments.

Annette Drake commented that she hoped the project relating to the Residential Care Homes grows and progresses well. She also stated that she had concerns about Homecare Assistants and their lack of training despite being used by the hospitals. She enquired if the LINk would be looking into it in the future.

Tony Lloyd informed the Committee that a similar project had just gotten underway in Berkshire West and he would look into whether the project could be extended to the Wokingham/Reading area.

RESOLVED That –

1) the update be noted by the Committee; and

2) Christine Holland and Tony Lloyd be thanked for the updates and for attending the meeting.

39. HEALTH CONSULTATIONS

The Chairman informed the committee that the current “live” consultations that were detailed in the briefing paper were for the attention of the Committee and that they should pay particular attention to Consultation 6 – Developing Safe and Sustainable acute services in South Central Stroke, major trauma and vascular surgery as it involved NHS Berkshire. He also stated that the online response, actually takes a few minutes to complete as he had completed it earlier.

RESOLVED: That the briefing paper be noted by the Committee.

40. WORK PROGRAMME 2011/12

The Committee considered the proposed Work Programme for 2011/12 as included in the Agenda pages 31 to 43 and raised the following issues –

- The agenda for the next meeting on 29 November has a lot of agenda items and the agenda needed to be a bit more focussed given the attendance of the Chief Executive Royal Berkshire Hospital;
- Community Care Connect update can be moved to the January 2012 meeting;
- Update on Public Health can be deleted; and
- PALS just needs to submit a report for consideration by the Committee.

The Chairman thanked the members who attended the site visit to Age Concern Woodley on 23 September 2011 and informed the Committee that it was a worthwhile visit, seeing the staff and customers utilising the services.

Kate Haines submitted a report to the Committee (attached as Appendix 4 to these minutes) regarding the site visit to Age Concern Woodley on 23 September 2011.

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Charlotte Haitham Taylor also submitted a report to the Committee (attached as Appendix 5 to these minutes) regarding her attendance at the Berkshire Healthcare NHS Foundation Trust AGM.

The Chairman reminded the Committee about the importance of attending planned activities and events organised and approved by the Committee including the Site Visits and the Working Group meetings and requested that members fulfil their commitments.

RESOLVED That –

1) the reports submitted by Kate Haines and Charlotte Haitham Taylor be noted by the Committee; and

2) the proposed amendments to the Work Programme 2011/12 be updated accordingly.

41. HOSC DEVELOPMENT

The Chairman informed the Committee that he thought it was very important for the Committee to look at the development of HOSC over the next year and possibly make some changes to the agenda items and work programme items. He suggested that a working group be established to look into in more detail and that a report be submitted to the Committee in January 2012, reporting its findings and a way forward.

RESOLVED That –

1) a Working Group be established to look at the development of HOSC and includes the following members – the Chair, Charlotte Haitham Taylor, Sam Rahmouni, Bev Searle (NHS Berkshire) and Charles Yankiah (Democratic Services);

2) the Working Group submits a report to the HOSC in January 2012 reporting its findings and proposing a way forward; and

3) the proposed amendments to the Work Programme 2011/12 be updated accordingly.

42. ANY OTHER BUSINESS

Mental Health Task and Finish Working Group

The Committee received an update from Charlotte Haitham Taylor in relation to the Mental Health Task and Finish Group as included in the Supplementary Agenda pages 54 to 58.

RESOLVED That –

1) the Draft Terms of Reference and the Draft Review Schedule be approved by the Committee; and

2) the Task and Finish Working Group keeps the Committee up to date with its progress.

……

The Chairman, 29 November 2011

These are the Minutes of a meeting of the Health Overview and Scrutiny Committee
If you need help in understanding this document or if you would like a copy of it in large print please contact one of our Team Support Officers.

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

APPENDIX 1

NHS Berkshire West

NHS Berkshire West - Performance & Finance Update

Wokingham Health Overview & Scrutiny Committee
28th September 2011

Nigel Foster
Deputy Director of Finance & Performance

Keeping people well and out of hospital

NHS Berkshire West

Agenda

- Financial Overview
- Key Performance Indicators

NHS Berkshire West

Funding

Recurrent allocations (95%):

- Core allocation = £1,367 per person
- Raw population = 482,000
- Weighted population = 393,000 (minus c20%)

- Including recurrent and non recurrent allocations, lowest funded PCT in country per head (was 7th in 2010/11)

NHS Berkshire West

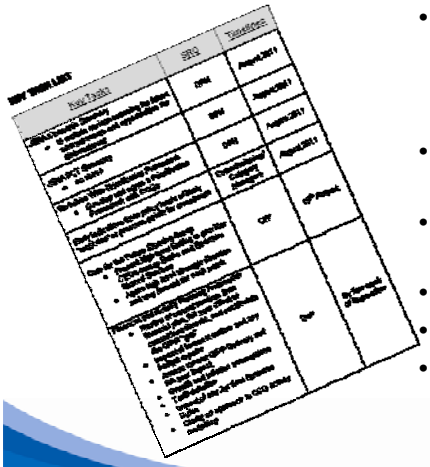
Budget Comparison

	2010-11		2011-12	
Area	**Annual budget £000s**	**Outturn variance £000s**	**Annual budget £000s**	**Forecast variance £000s**
Secondary care SLAs	251,600	(16,701)	249,698	(2,804)
Mental health SLAs	47,928	84	47,450	0
Community Health SLA	54,985	798	59,070	0
Specialist commissioning SLA	37,574	(144)	46,282	382
Non Contracted Activity	3,777	(451)	4,200	0
Other commissioned services	26,693	(2,647)	25,634	161
Primary care commissioning	152,558	595	153,148	1,588
Out of hospital care	44,259	546	29,478	661
Other	39,127	19,566	47,366	1,578
Total	**658,501**	**1,646**	**662,326**	**1,566**

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

NHS Berkshire West

Planning for 2012-13



- Review of current medium term financial plan, full year effect of current investments, and recalculate the QIPP "gap"
- Impact of forecast outturn and any budget repairs
- Assess current QIPP Delivery and full year impact
- Growth and inflation assumptions
- Tariff deflation
- CCGs to be driving the process

Keeping people well and out of hospital

NHS Berkshire West

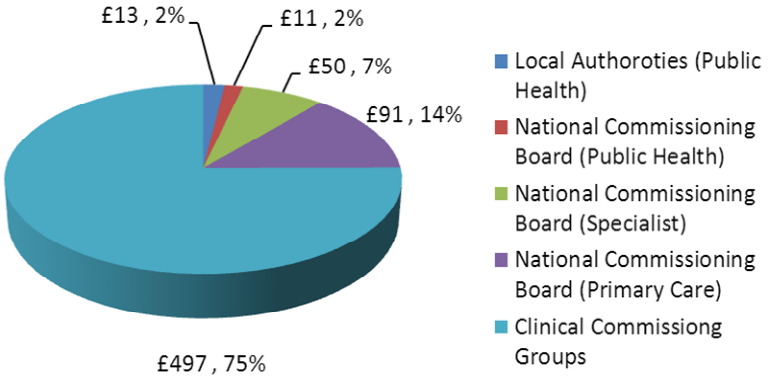
Where do we need to get to…

Keeping people well and out of hospital

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

NHS Berkshire West

Where will the money go in 2013?



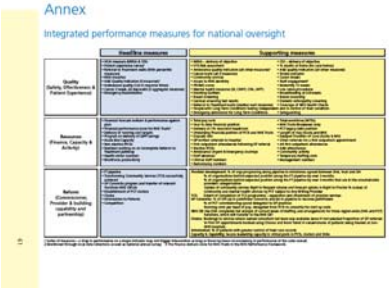
Total Budget = £662m

NHS Berkshire West

Performance Requirements 2011-12

NHS Operating Framework sets out the indicators and milestones to be used for planning and to assess how PCTs are delivering. Approx 125 indicators and milestones grouped under three domains:

- **quality**, covering safety, effectiveness and experience;
- **resources**, covering finance, workforce, capacity and activity; and
- **reform**, covering commissioning, provision, partnership building, putting patients first and development of the new public health infrastructure.


Annex

Integrated performance measures for national oversight

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Patient Safety & Experience

NHS Berkshire West

Description	11/12 Target	Reported Period	Current Actual	DoT	Current Actual Rating	FOT rating
HQU01: Number of MRSA bacteraemia	7	M5 YTD	0 3	▲	Green	Amber
HQU02: Number of Clostridium Difficile	194	M5 YTD 11/12 YTD 10/11	30 159 144	▲	Red	Red
Number of E-Coli bacteraemia	2011-12 is the baseline year for next year's target	M5 M3-M5	13 51	▲		
Number of MSSA bacteraemia	2011-12 is the baseline year for next year's target	M5 M3-M5	3 13	▲		
HQU08: Numbers of unjustified Mixed Sex Accommodation (MSA) breaches	0	M5 YTD	0 4	▲	Green	Red
SQU01: % of all adult inpatients who have had a VTE risk assessment	90%	M4	97.8%	◄►	Green	Green
SQU02: No reg deaths at usual place of residence/no. registered deaths	Q1-37.1%, Q2-40.0%, Q3-45.0%, Q4-50.0%. Total Yr 43.0%	2009	36.6%			
SQU06_01: Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit	80%	Q1 (M5 RBFT Only)	77.5% 93.8%	▲	Green	Amber
SQU06_02: Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours	60% Apr 11, 75% Sept 11, 90% Apr 12	Q1 (M5 RBFT Only)	80.0% 89.5%	▲	Green	Green
SQU12: % women who have seen a midwife by 12 weeks and 6 days of pregnancy	90%	Q1	90.6%	▼	Green	Green
HRF05 & SRF13: Trend in volume of NHS-funded patients being treated at independent sector (non-NHS) facilities (Treatment centres and hospitals)	No Target	M5	6.8%	▼		

Cancer

NHS Berkshire West

Description	11/12 Target	Reported Period	Current Actual	DoT	Current Actual Rating	FOT rating
HQU14: 2 week wait services - % seen in 2 weeks of all urgent referrals	93%	M4 YTD	96.3% 93.6%	▲	Green	Green
HQU14: 2 week wait services - % seen in 2 weeks of all symptomatic breast referrals	93%	M4 YTD	91.8% 91.8%	▼	Red	Red
HQU15: 62 day wait - % treated in 62 days from GP referral	85%	M4 YTD	88.8% 84.4%	▲	Green	Amber
HQU15: 62 day wait - % treated in 62 days from consultant referral	No Target	M4 YTD	100% 92.9%	▲		
HQU15: 62 day wait - % treated in 62 days from screening programme	90%	M4 YTD	95.0% 89.4%	▲	Green	Amber
SQU05: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	96%	M4 YTD	97.6% 96.4%	▲	Green	Green
SQU05: Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is Surgery	94%	M4 YTD	97.5% 97.8%	◄►	Green	Green
SQU05: Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is an Anti-Cancer Drug Regime	98%	M4 YTD	100% 98.9%	▲	Green	Green
SQU05: Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	94%	M4 YTD	93.4% 95.7%	◄►	Amber	Green
SQU20: Extension of breast screening program to women aged 47-49 and 71-73 ❶	Not live until October 2011					
SQU21: Extension of bowel screening programme to men and women aged 70 up to 75 birthday	30% of population invited by Mar 2011	M3	70.8%	▲	Green	Green
SQU22: All women to receive results of cervical screening tests within 2 weeks	98% in 2 weeks	M5 M2-M5	99.5% 99.4%	◄►	Green	Green
Previous Year Indicator: Cervical Screening 25-64 years	80%	Q1	81.2%	◄►	Green	Green
Previous Year Indicator: Breast cancer screening 53 to 70 years	80%	Q3	79.5%	▼	Amber	Green

❶ Age Expansion - Funding has been agreed by the PCT. It is expected that implementation will begin around October 2011

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Health Promotion & Prevention

NHS Berkshire West

Description	11/12 Target	Reported Period	Current Actual	DoT	Current Actual Rating	FOT rating
SQU18: Number of smoking quitters	11/12 Target-Q1-544, Q2-559, Q3-544, Q4-827, Total for 11/12-2474	Q1	578	^	Green	Green
SQU19: Prevalence of Breastfeeding at 6-8 Weeks	Q1-55.8%, Q2-58.3%, Q3-60.8%, Q4-63.2%, Total for Yr-59.5%	Q1	56.7%	^	Green	Green
SQU19: Coverage of Breastfeeding at 6-8 Weeks	95%	Q1	95.1%	^	Green	Green
SQU23: Diabetic Retinopathy Screening: Of those offered % of patients screened	80%	Q1	71.1%	^	Red	Red
SQU27: % people ages 40-74 who have received a health check	Total for 11/12-10,500. Each Quarter-2625	Q1	1360	v	Red	Red
Previous Year Indicator: Individuals who complete routine immunisation:						
12 Month DTPPHib	95% for All	YTD	94.9%	v	Amber	Green
24 Month PCV			91.1%	<>	Red	Red
24 Month Hib/Men C			92.5%	<>	Red	Red
24 Month MMR			92.4%	<>	Red	Red
5 Year DTB			87.1%	^	Red	Red
5 Year MMR2			84.9%	<>	Red	Red
Chlamydia positive testing rate (15 – 24 year olds)	To achieve rate of 2,000/100,000 it is expected that 680 positive screens will be required from the screening programme	M5 YTD	36 182	^	Red	Red

Elective Access

NHS Berkshire West

Description	11/12 Target	Reported Period	Current Actual	DoT	Current Actual Rating	FOT rating
HQU05: RTT - admitted 95th centile	<23 Weeks	M4	22.7	^	Green	Green
HQU06: RTT - non-admitted 95th centile	<18.3 Weeks	M4	14.0	^	Green	Green
HQU07: RTT - incomplete 95th centile	<28 Weeks	M4	22.8	v	Green	Green
HRS07: Total numbers waiting at the end of the month on an incomplete RTT pathway	<16233 a month	M4	15074 (Of which 1347 18+ Weeks)	v	Green	Green
SQU24: RTT - admitted median	<11.1 Weeks	M4	7.9	^	Green	Green
SQU25: RTT - non-admitted median	<6.6 Weeks	M4	1.6	^	Green	Green
SQU26: RTT - incomplete median	<7.2 Weeks	M4	5.6	<>	Green	Green
Previous Year Indicator: <18 Wks RTT: % admitted	>=90%	M4	91.0%	^	Green	Green
Previous Year Indicator: <18 Wks RTT:% non-admitted	>=95%	M4	99.1%	^	Green	Green
Previous Year Indicator: Diagnostics: maximum wait	0 over 6 weeks SHA upper limit is 100 for whole year	M4	40 over 6 weeks) (out of 3190 total tests)	^	Red	Red

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

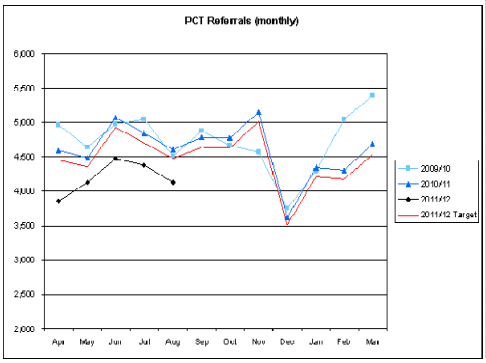
Emergency Access

NHS Berkshire West

Description	11/12 Target	Reported Period	Current Actual	DoT	Current Actual Rating	FOT rating
HQU03_01: Ambulance Cat A response within 8 mins	75%	M5	80.1%	▲	Green	Green
HQU03_02: Ambulance Cat A response within 19 mins	95%	M5	97.4%	◄►	Green	Green
HQU09: Unplanned re-attendance rate - Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)	<5%	M4 (RBFT Only	2.3%	▲	Green	Green
HQU10: Total time spent in A&E department - 95th centile – Admitted Patients	<240 minutes	M4 (RBFT Only	337 minutes	▼	Red	Red
HQU10: Total time spent in A&E department - 95th centile – Non-Admitted Patients	<240 minutes	M4 (RBFT Only	239 minutes	◄►	Green	Green
HQU11: Left department without being seen rate	<5%	M4 (RBFT Only	3.0%	▲	Green	Green
HQU12; Time to initial assessment - 95th centile	< 15 minutes	M4 (RBFT Only	0 minutes	◄►	Green	Green
HQU13: Time to treatment in department – median	< 60 minutes	M4 (RBFT Only	61 minutes	▲	Amber	Amber
SQU03_01: Ambulance Call Abandonment Rate	<0.5% abandoned	Data source currently being determined				
SQU03_03: Outcome from Cardiac Arrest	Baseline Year	Data source currently being determined				
SQU03_04: Ambulance Clinical Quality - Service Experience	Baseline Year					
SQU03_05: The percentage of patients suffering a STEMI and who, following direct transfer to a PPCI centre , primary angioplasty commences within 150 minutes of call	TBC	Q1 (RBFT Only)	97.1% (34/35)	▲	Green	Green

GP Referral Activity

NHS Berkshire West



MONTH	2009/10	2010/11	2011/12	2011-12 Target
April	4,963	4,598	3,854	4,458
May	4,648	4,493	4,136	4,361
June	4,977	5,075	4,471	4,930
July	5,050	4,849	4,378	4,703
August	4,506	4,607	4,136	4,476
September	4,883	4,791		4,646
October	4,669	4,776		4,633
November	4,574	5,152		5,012
December	3,747	3,624		3,512
January	4,295	4,351		4,218
February	5,049	4,310		4,174
March	5,395	4,691		4,538
Grand Total	56,756	55,317	20,975	53,659

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

APPENDIX 2

Wokingham Clinical Commissioning Group
Dr Richard Perry

Structure

- Council
  - This will become the governing body of the CCG
  - Membership
- Exec
  - This is the workhorse of the council
  - Membership

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Federation

- Discussions are in progress to develop federating at a West Berkshire level and a Berkshire wide level
- Federation membership

Important local CCG functions

- Developing relationships with our local health and wellbeing board and the Local Authority
- Developing patient and public engagement
- Developing clinical engagement within primary and secondary care
- Working with public health and the JSNA address local health needs and inequalities

Some Federated Functions

- Royal Berkshire, North Hampshire and Great Western contracts
- IT and data analysis

- London Trusts
- Stroke, cancer and vascular networks
- SCAS

Budgets

- Currently working towards understanding the following budgets
  - Acute Services (elective, NEL)
  - Community and Mental health budgets
  - Long term health care
  - Prescribing
  - Management costs

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Wokingham Pressures

- The deficit and Pace of Change
- Elderly population
  - Long term conditions
  - Dementia
- Nursing and care homes
- Orthopaedics

Current areas of activity

- Reducing Practice Variation
  - Elective referrals
  - NEL admissions
  - Pathology use

- MSK Service
- Practice Prescribing

What does this mean for Patients?

- An increase in high quality community based services
- More people managed in their own home when unwell
- No significant changes to their GP surgery

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

APPENDIX 3

Future of Public Health in Berkshire West

Janet Maxwell DPH

28th September 2011

What is public health?

- **Faculty of Public Health definition:**

'The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society'

(Sir Donald Acheson,1988)

- **Four domains of public health**
  - Health improvement
  - Health protection
  - Health and social care commissioning
  - Public health intelligence and knowledge management

Four sections

- What is public health?
- Brief overview of national guidance and policies for public health
- Public health roles and responsibilities that will move to LA
- Opportunities for delivery of PH across the three Unitary Authorities

What is public health?

- Major health challenges
- Health and Wellbeing
- Health Inequalities
- Social influences/wider determinants of health

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

How public health operates

- Public health as a discipline originated in Local Authorities but in 1974 the role of the Medical Officer of Health was abolished and the speciality of Community Medicine created, changing again to Public Health Medicine in 1986, and the profession became part of the NHS.
- The move back to LAs brings us back to our roots and helps bring health and its wider determinants closer together again.
- Public health practitioners are trained in a range of skills including epidemiology (the study in populations of who gets diseases and why they do), health promotions skills, health protection skills, health economics, sociology and psychology skills, understanding research evidence, management techniques, and managing and analysing data.
- Some public health services are commissioned and some are delivered or developed locally. In other areas, public health advises and supports other commissioners or partners and acts as advocates for population health by providing intelligence to help influence decisions to improve health outcomes.

Key National guidance

Liberating the NHS
NHS White paper - July 2010

- Putting patients and the public first
- Focus on improvement in quality and healthcare outcomes
- Autonomy, accountability and democratic legitimacy
- Cutting bureaucracy and improving efficiency
- Public Health moves to Local Authorities
- Ring fenced Public Health budget allocated to reflect relative population health outcomes with new health premium to promote action to reduce health inequalities
- New Public Health Service (Public Health England), an Executive Agency of the Department of Health incorporating Health Protection Service and other health improvement bodies
- Director of Public Health jointly appointed between LA and Public Health England

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Healthy Lives, healthy people

White paper - PH strategy for England – Nov 2010

- Public Health to have higher priority and dedicated services
- Life course framework for tackling wider social determinants of health
- Stronger support for early years
- Personalised, preventive services
- Better outcomes, innovative approaches, professional leadership
- Local government and local communities at the heart of improving health and wellbeing
- Public Health England – incorporating Health Protection

Our Health and Wellbeing today

Nov 2010

- Summary of evidence base on health and wellbeing informing the white paper
- Importance of population view and health inequalities
- Improve maternal health, better children's health, improved working age health – life course approach
- Changing adults behaviour – reduce risk of heart disease, cancer, alcohol related ill health and premature death. Reduce excess winter deaths
- Partnership working across social care, the NHS and public health

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Health and Social Care Bill

January 2011

- 350 pages
- Listening exercise – the pause
- Passed by House of Commons Sep 2011
- Now going through the House of Lords
- Various amendments

Healthy Lives, Healthy people: update and way forward

July 2011

- Policy statement which sets out progress made in developing the vision, identifies where further development needed and provides a timeline and next steps
- Local authorities take responsibility, with Directors of Public Health leading the work as principal advisers to the local authority
- Local Authorities supported by Public Health England which will provide access to expert advice, intelligence, evidence and focus for development of new approaches including those from behavioural sciences and providing health protection service.
- Stronger focus on public health outcomes. Outcomes framework to be published later this year following consultation period.
- Public health seen as a core part of business across government supported by resources
- Commitment to reduce health inequalities as priority for all parts of the public health system, drawing on the Marmot Review (Fair society, Healthy Lives: Strategic review of health inequalities in England. 2010)

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Public Health System Reform Updates

due late 2011

- Public Health Outcomes Framework – will detail how we track public health outcomes and improvements in health and wellbeing
- Public Health England Operating Model – to describe how PHE will work, its relationships, and how it can support improved health outcomes.
- Public Health in local government and the Director of Public Health – final detailed operational design building on the role set out in the update policy paper
- Public Health funding regime – to establish baseline public health spend and details of the allocation methodology, health premium and shadow allocations
- Workforce strategy – will address concerns relating to terms and conditions and regulation of public health professionals

Transition of public health functions to local authorities

Key elements of the new system

- Based on outcomes (yet to be published)
- Locally-led system based in local government
- Flexibility in use of ring-fenced grant
- Prescribed services to include:
- Access to sexual health services
- Health Protection
- Support to NHS Commissioners
- National Child Measurement Programme
- NHS Health Check assessment
- Elements of the Healthy Child Programme

Role of Director of Public Health

- The principal adviser on health to elected members and officials
- The officer charged with delivering key new public health functions
- A statutory member of the health and wellbeing board
- The author of an annual report on the health of the population

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Transition of public health functions to LA

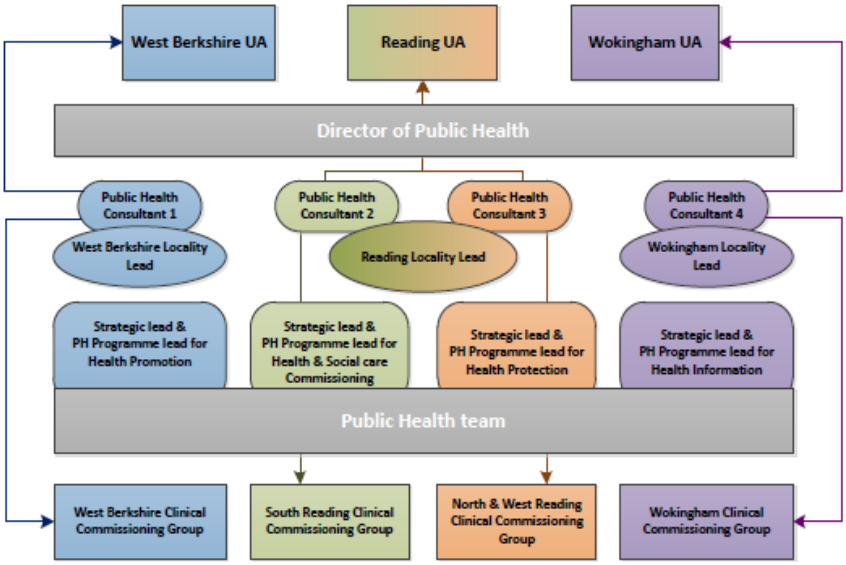
Locally-led system supported by:

- NHS contribution to public health – includes quality healthcare provision, maximising public health impact of clinical care, health protection, disease prevention and emergency planning.
- The co-ordinating role of Health & Wellbeing Boards – bringing whole local system together, driving integration of NHS, public health and social care and promoting joint commissioning to secure population health improvement.
- Public Health England – includes functions of Health Protection Agency, National Treatment Agency, Public Heath Observatories, Cancer Registries, National Cancer Intelligence Network, National Screening Committee and Cancer Screening Programmes and Regional Directors of Public Health
- Clear national leadership

PH Commissioning responsibilities moving to Local Authority

- Tobacco Control
- Alcohol and Drug Misuse services
- Obesity and malnutrition services
- Increasing levels of physical activity in the local population
- Assessment and lifestyle interventions through NHS Health Check Programme
- Public mental health services
- Dental public health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long term conditions
- Local initiatives on workplace health
- Supporting, reviewing and challenging delivery of key public health-funded and NHS delivered services such as immunisation programmes
- Comprehensive sexual health services
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Role in dealing with health protection incidents and emergencies
- Promotion of community safety, violence prevention and response
- Local initiatives to tackle social exclusion

Please note: amendments were made to these minutes at the meeting held on 29 November 2011



Strategic roles for PH Consultants

PH Consultant lead for Health and Social Care Commissioning

The PH Consultant with a strategic lead for Health and Social Care commissioning will be a key part of the 'core offer' from the LA-based public health team to support clinical commissioning of health care and joint health and social care commissioning. This is a key role to ensure clinical commissioners' priorities and agendas link closely with the identified needs in the Joint Strategic Needs Assessment and there is a good understanding of the shared priorities agreed at the Health and Wellbeing Boards in order to achieve improved health outcomes for our populations.

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

PH Consultant lead for Health Protection

- The PH Consultant with a strategic lead for Health Protection will be responsible for the public health role in emergency planning and preparedness across Berkshire West and will work closely with the Health Protection Unit (part of Public Health England) currently based at Didcot and serving the Thames Valley area and providing a link Consultant in Communicable Disease Control for Berkshire West. Emergency planning, resilience and response (EPRR) also covers disasters relating to extreme weather conditions, chemical and other environmental hazards and nuclear and radiation threats. We are still awaiting details of how the health EPRR function will operate across the Local Authority PH structure and NHS but it is currently being proposed that there is shared leadership. Clinical Commissioning Groups will be expected to become more visible players in local health EPRR in the future and support with this function may be part of the core LA Public Health offer to the Clinical Commissioning Groups.

- As the core LA public health offer will include a defined role in supporting the delivery of screening and immunisation programmes, the responsibility for cancer (bowel, cervical and breast) and non-cancer (antenatal & newborn and diabetic retinopathy) screening programmes will be part of the remit in this area. It will also cover responsibility for immunisation programmes (e.g. Children 0-5 years, HPV, pneumococcal and seasonal flu). Sexual health commissioning is part of the health protection responsibility and this will include access to comprehensive contraceptive services, young people's services, Chlamydia screening and services for sexually transmitted infections including HIV. The other major area is infectious disease control which includes hospital acquired infections such as MRSA and Clostridium Difficile, TB control and pandemic influenza.

PH Consultant lead for Public Health Intelligence and Knowledge Management

The PH Consultant with a strategic lead for Public Health Intelligence and Knowledge Management will have responsibility for the Joint Strategic Needs Assessment and the team will work closely with the information leads in each Local Authority to ensure a shared understanding and use of data and information from the different areas of work such as children's services, community safety, transport etc. This will enable a comprehensive analysis of populations' needs and the links with the wider determinants of health can be drawn on to inform strategy and policy for commissioning decisions across health and local government to improve health outcomes for our populations. The team will be supported by work nationally through Public Health England who will take on the work of the Public Health Observatories who produce the health profiles for a range of health issues, the Health Protection Agency, National Treatment Agency, Cancer Registries, National Cancer Intelligence Network, National Screening Committee and Cancer Screening

PH Consultant lead for Health Improvement

- The PH Consultant with a strategic lead for Health Improvement will have responsibility for ensuring a strong focus on the key areas of lifestyles and behaviour which impact on wellbeing. The public health team will have responsibility for commissioning in the areas of Tobacco Control, Alcohol and Drug Misuse services, obesity and malnutrition services, increasing levels of physical activity in the local population and the assessment and lifestyle interventions through the NHS Health Check Programme. They will work closely with colleagues in clinical commissioning to ensure that there is a strong focus on prevention of long term conditions and will help with ensuring quality of commissioning of pathways of care for people at risk of or living with long term conditions including cardiovascular disease, stroke, respiratory disease, diabetes, dementia and long term neurological conditions.

- There is also a growing emphasis on improving mental health and wellbeing. The area of public mental health will be included here, addressing issues for children, adults and older people and promoting understanding of the different environments within which mental wellbeing can be addressed such as the home, school, workplace and community. The role will cover promotion of community safety, violence prevention and response including work on domestic violence and offender health. Addressing health inequalities is a major issue that cuts across all public health work and the team will be involved in identifying these in all areas of our work and in promoting local initiatives to tackle social exclusion.

PH Consultant in Dental Health

- The PH Consultant in Dental Health works as part of a Thames Valley-wide Dental Public Health Network with Buckinghamshire, Berkshire East and Oxfordshire (and currently Milton Keynes though this may change). They provide advice and support on dental public health measures locally such as the Brushing for Life campaign for under 5s identifying areas where there is unmet need through data on poor dental health in children. They also work with the clinical commissioners ensuring there is good access to dentistry and oral surgery for the population.

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

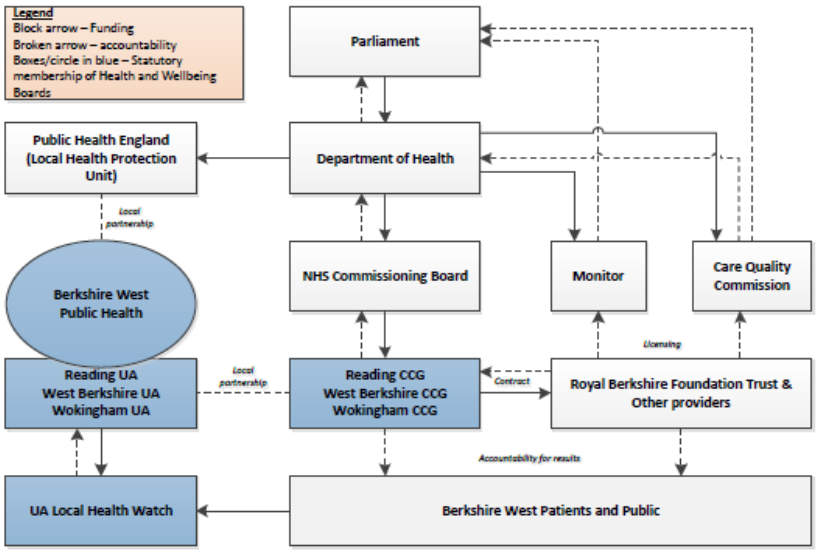
Other PH functions

Health and Wellbeing Boards

- The government proposes that these statutory boards at the level of top tier Local Authorities should have three main functions:
- To assess the needs of the local population and lead the statutory joint strategic needs assessment
- To promote integration and partnership across the areas, including through promoting joined up commissioning plans across the NHS, social care and public health
- To support joint commissioning and pooled budget arrangements, where all parties agree this makes sense

Joint Strategic Needs Assessment (JSNA)

- The JSNA is a joint statutory requirement of PCTs and upper tier UAs enshrined in the Local Government and Public Involvement in Health Act 2007. Locally, these needs assessments have been carried out since 2007, currently led by Public Health working in partnership with local authority colleagues. The process aims to provide a comprehensive analysis of local current and future health, wellbeing and social care needs for adults and children to inform commissioning and service planning.



Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Next steps

- Share knowledge of each others organisations
- Agree working arrangements for shadow year 2012/13
- Shadow year

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

APPENDIX 4

REPORT ON A VISIT TO WOODLEY AGE CONCERN ON 23 SEPTEMBER 2011 BY CLLRS TIM HOLTON, SAM RAHMOUNI AND KATE HAINES

Following a recent presentation by Ann Parr MBE of Woodley Age Concern to HOSC, three members took the opportunity to visit the Centre last Friday.

We were welcomed at reception and all staff knew that we were coming. A visitor's book was signed.

Ann Parr met us and showed us around. The building is 33 years and in pretty good condition and at present, the numbers of visitors are 35, 7 of whom have dementia.

Firstly we visited the Brightside room where the visitors were enjoying a lively session of singing. This room is very nicely decorated and also has a bar which is open over lunchtime.

Overall, there was a lovely social feeling emanating from the Brightside room.

The Garden Room speaks for itself really! Nicely laid out with a dartboard, piano, TV. and much to my wonder, an old radiogram identical to the one my parents had when I was a child! Doors lead out to the garden which the visitors look after and there are vases of flowers on all the tables grown by their own fair hand.

Sunnyside is the specialised dementia unit. I thought initially we were in the wrong place as there was a lady in a wedding dress! I was quickly assured this was part of the everyday life in the centre. Every day, the visitors make cakes which are shared with the whole centre for afternoon tea.

There are 3 bedrooms for overnight stays which again, felt like a home from home, nicely furnished and a very welcoming feel to them.

It is very evident that all the staff loves the work they do and their aim is to keep it very much a residential setting.

Overall, we had a very pleasant visit and thank the Centre for allowing us to share part of their day with them.

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

APPENDIX 5

Summary of Berkshire Healthcare NHS Foundation Trust AGM
21st September 2011

Received a verbal Annual Report for the Chairman – John Hedger

Trust is made up of over 8,000 members

The Governors consist of:

- 6 Local Authority Appointed Governors
- 19 Publicly elected Governors
- 4 staff elected Governors
- 2 PCT elected Governors
- 4 Partnership elected Governors

They have 4 Full Council meetings per annum which are open to the public

2 meetings per year with the Board of Directors

As well as their Committee meetings with cover a wide range of topics:

- Strategy
- Membership and Communication
- Recovery
- Annual Health check
- Appointments and Remuneration
- Ad hoc Groups – i.e. Health and Social Care Act
- Reference Groups

The key activities of the Trust are:

- Appointing New Non-Executive Directors
- Engagement in priority setting for Quality Accounts
- Approval of constitutional amendments – related to merger with community Health Services
- Consideration of impacts of Health and Social Care Bill
- Engagement in annual planning process
- Initiated development of carer strategy
- Involved in supporting annual staff awards
- Involved in assessment of clinical excellence awards

The AGM also received a presentation from Phillippa Slinger, Chief Executive, and Director of Finance, Berkshire Healthcare NHS Foundation Trust

This presentation was about the **Next Generation Care, Community Service Transfer, Mental Health Location and Care Quality Commission** looking at it from 2010-2011.

She talked about 3 quality objectives:

1. easy access to services
2. not getting bounced around the service i.e. Smooth treatment paths
3. making sure that the patients were treated with respect - not rude or discourteous treatment

There will be new monitoring systems in place from November 2011.

She reported that through the Care Quality Commission there had been a small number of things that needed addressing on the Charles Ward

Examples:

- There had not been full employment histories on all of the staff employed – this has now been addressed
- There were some issues regarding data – it was not being processed in a timely manor therefore allowing it to be uploaded to the central database in time – again this has been addressed through some changes to the Governance structure.

2011-2012 Objectives

1. Safe effective services
2. Commissioners provider of choice
3. Financially sustainable services
4. Working with other providers
5. Services that offer alternatives to hospital admissions
6. Working with others to provide services
7. To offer services to private patients

(Objective 7 could potentially raise £300,000 for the Trust but could only be achieved if the Health and Wellbeing bill is past)

Finance –
At the end of this financial year 2010-11– the trust had a surplus of £400,000
They spent £3m on infrastructure (on upgrading IT and property)
£654,000 of debt was paid off to PFI on a finance lease on Prospect Park Hospital (23 years still to go), the asset is worth £30m.

Then the AGM had a presentation on **Urgent Care (integrated) Pathways - Community and inpatient services for Acute Mental Health** by Mark Hardcastle – Clinical Director, Adult Mental Health and Older People (East Berkshire).

Talked about providing care in the home environment and what the advantages of this are versa care in a hospital.

Advantages of Home treatment
Visiting on regular basis, building up of trust / relationship with carers, carers can see the patient in home environment, less disruptive to patient's life than having to go to clinic, no hospital rules to obey, home feels safe and comfortable.

In-patient care is provided for in a number of locations: Prospect Park, Heatherwood, Hexham and home care can be provided by Community teams, Crisis Response and Home teams.

Please note: amendments were made to these minutes at the meeting held on 29 November 2011

Looking at Mental Health Hospital Admission numbers:

April 05/06	April 10/11
Numbers of patients: 1124	Number of patients: 1040
Length of stay: Median 18 days	Length of stay: Median 15 days
Length of stay: Mean 33 days	Length of stay: Mean 33 days

The community services around Berkshire are all different leading to inefficiencies but they are still very busy. They had 6,287 meetings of 1,606 different people using their service last year.

Urgent Care Pathway
Want integrated pathway for adults who are acutely mentally ill.

New Service –
Seamless 24 hour care
Cross boundary working
Shared working
Best practice

Organised with 2 hubs - one in the East and one in the West of Berkshire.

It will operate a traffic light system to manage care. Home visits can be:
0-2 or 3 times a day
0-1 times a day
0-2 or 3 times a week

They will also provide out of hours service for children and older people so there will be less gaps in the service. It is key to remember though that this is a treatment service.

Charlotte Haitham Taylor
28.09.11