APPENDIX 1

NHS
Berkshire West

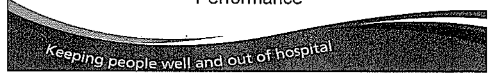
NHS Berkshire West - Performance & Finance Update

Wokingham Health Overview & Scrutiny Committee

28th September 2011

Nigel Foster

Deputy Director of Finance & Performance



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Agenda

- Financial Overview
- Key Performance Indicators

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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)

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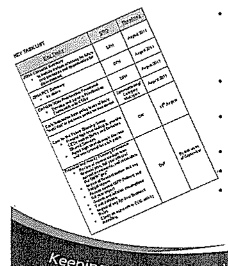
Budget Comparison

Area	2010-11 Annual budget £000s	2010-11 Outturn variance £000s	2011-12 Annual budget £000s	2011-12 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

Keeping people well and out of hospital

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

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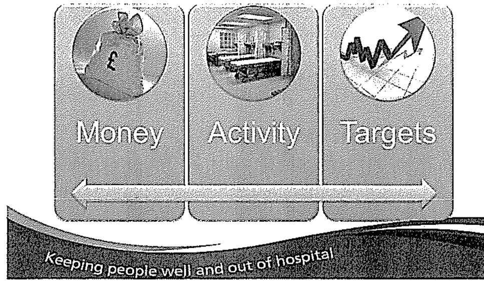
Where do we need to get to...



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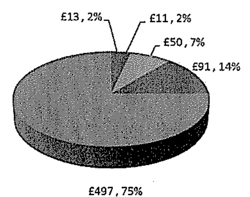
Where will the money go in 2013?



- Local Authoroties (Public Health)
- National Commissioning Board (Public Health)
- National Commissioning Board (Specialist)
- National Commissioning Board (Primary Care)
- Clinical Commissiong Groups

Total Budget = £662m

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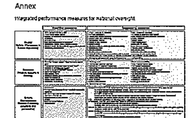
Performance Requirements 2011-12

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.



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Patient Safety & Experience

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	^		
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	
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	38.6%			
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% 93.6%	^	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%	v	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%	v		

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Cancer

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	93.3% 93.0%	^	Green	Green
HQU14: 2 week wait services - % seen in 2 weeks of all symptomatic breast referrals	93%	M4 YTD	91.0% 91.8%	v		
HQU15: 62 day wait - % treated in 62 days from GP referral	85%	M4 YTD	88.6% 84.4%	^	Green	Amber
HQU15: 62 day wait - % treated in 62 days from consultant referral	No Target	M4 YTD	100% 92.0%	^		
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	97.0% 98.4%	^	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 ⊕	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%	v	Amber	Green

⊕ Age Expansion - Funding has been agreed by the PCT, it is expected that implementation will begin around October 2011

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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
SQU18: Prevalence of Breastfeeding at 6-8 Weeks	Q1-55.8%, Q2-58.3%, Q3-60.6%, 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%	^		
SQU27: % people aged 40-74 who have received a health check	Total for 11/12-10,500. Each Quarter-2625	Q1	1360	v		
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%	<>		
24 Month Hib/Men C			92.5%	<>		
24 Month MMR			92.4%	<>		
5 Year DTB			87.1%	^		
5 Year MMR2			84.9%	<>		
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	30 182	^		

Elective Access

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	<18233 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	5.8	<>	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)	^		

Emergency Access

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	v		
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

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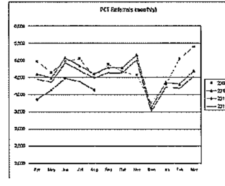
GP Referral Activity



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

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

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

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

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

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

<u>Liberating the NHS</u>
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

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

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)

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

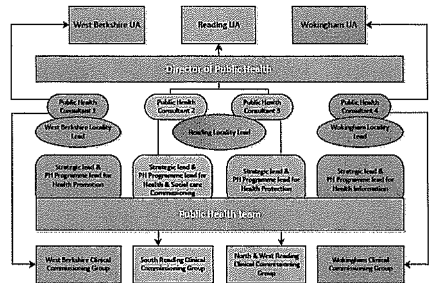
Transition of public health functions to LA

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



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.

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.

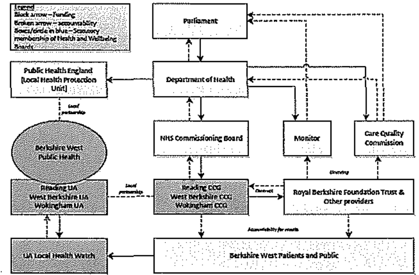
Other PH functions

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.



Next steps

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

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.

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.

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