Bracknell Forest Council

NOTICE OF MEETING

Health Overview and Scrutiny Panel
Thursday 26 April 2012, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

To: The Health Overview and Scrutiny Panel

Councillor Virgo (Chairman), Councillor Mrs Angell (Vice-Chairman), Councillors Baily, Mrs Barnard, Finch, Kensall, Mrs Temperton, Thompson and Ms Wilson

cc: Substitute Members of the Panel

Councillors Blatchford, Brossard, Ms Brown, Davison and Heydon

Co-opted Representatives

Terry Pearce, Bracknell Forest Local Involvement Network

ALISON SANDERS
Director of Corporate Services

There will be a private meeting for members of the Panel at 7pm in the Board Room.

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If you require further information, please contact: Priya Patel
Telephone: 01344 352233
Email: priya.patel@bracknell-forest.gov.uk
Published: 17 April 2012

Health Overview and Scrutiny Panel
Thursday 26 April 2012, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

AGENDA

Page No

1. **Apologies for Absence/Substitute Members**

   To receive apologies for absence and to note the attendance of any substitute members.

2. **Minutes and Matters Arising**

   To approve as a correct record the minutes of the meeting of the Health Overview and Scrutiny Panel held on 2 February 2012. 1 - 6

3. **Declarations of Interest and Party Whip**

   Members are asked to declare any personal or prejudicial interest and the nature of that interest, including the existence and nature of the party whip, in respect of any matter to be considered at this meeting.

4. **Urgent Items of Business**

   Any other items which, pursuant to Section 100B(4)(b) of the Local Government Act 1972, the Chairman decides are urgent.

5. **Public Participation**

   To receive submissions from members of the public which have been submitted in advance and in accordance with the Council's Public Participation Scheme for Overview and Scrutiny.

6. **Bracknell and Ascot Clinical Commissioning Group**

   Dr William Tong, of the NHS Clinical Commissioning Group (CCG) for Bracknell Forest and Ascot has been invited to describe to the Panel the progress in establishing the Group, the timetable for gaining authorisation and the production of the Commissioning Strategy.

7. **Joint Strategic Needs Assessment**

   To receive a briefing from the NHS Berkshire East Director of Public Health and the Director of Adult Social Care & Health on the main issues arising from the updated Joint Strategic Needs Assessment (JSNA). 7 - 28

8. **Health and Wellbeing Board**

   To receive a briefing from the Executive Member for Adult Services, Health and Housing on the priorities of the shadow Health and Wellbeing Board, the funding of that work and the Board's 29 - 32

development.

9. **Transfer of Public Health Functions**

To receive further information from the Director of Adult Social Care & Health, also the NHS Berkshire East Director of Public Health on Public Health and the transition plan for its transfer to Bracknell Forest Council. The Chairman has asked that Panel members focus on their own ward priorities. 33 - 76

10. **Heatherwood Hospital Birthing Unit**

To receive an update from Heatherwood & Wexham Park Hospitals NHS Foundation Trust on the closure of the Birthing Unit at Heatherwood Hospital. 77 - 82

11. **Working Group Updates**

To receive a report on the progress of the Panel's Working Groups. 83 - 84

12. **Overview and Scrutiny Bi-Annual Progress Report**

To note the Bi-Annual Progress Report of the Assistant Chief Executive. 85 - 96

13. **Date of Next Meeting**

14 June 2012

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HEALTH OVERVIEW AND SCRUTINY PANEL
2 FEBRUARY 2012
7.00 - 9.30 PM

Bracknell Forest Council

Present:
Councillors Virgo (Chairman), Mrs Angell (Vice-Chairman), Baily, Mrs Barnard, Mrs Temperton and Davison (Substitute for Cllr Thompson)

Co-opted Representative: Terry Pearce, Bracknell Forest LINK

Also Present:
Councillor Birch, Executive Member Adult Services, Health & Housing
Councillor Mrs Hayes and Leake.

Apologies for absence were received from:
Councillors Finch, Kensall Thompson and Ms Wilson

In Attendance:
Dr Phillip Lee MP
Glyn Jones, Director of Adult Social Care & Health
Richard Beaumont, Head of Overview & Scrutiny
Alex Gild, Finance Director, NHS Berkshire
Andrew Morris, CEO, Frimley Park Hospital
Mary Purnell, NHS Berkshire
Charles Waddicor, CEO, NHS Berkshire PCT

21. **Declarations of Interest**

There were no declarations of interest.

22. **Views of Member of Parliament**

The Chairman welcomed Dr Phillip Lee MP for Bracknell to the meeting and invited him to address the Panel.

Dr Phillip Lee MP made the following points:

- He had been a GP for 11 years in the Thames Valley region, he had first started work at Wexham Park Hospital in 1999. A recent article that he had written in a national newspaper had provoked responses and letters from all parts of the Country. As a politician, he felt he had a moral obligation to tell it like it is.
- His view was that the local community had never been properly served by hospital services and that this needed to change, with a more strategic approach. He had worked at Heatherwood and Wexham Park hospitals and had plenty of experience of working in the NHS locally. He understood the history of Heatherwood and the emotional attachment that local people had for the hospital.
- The problem was that healthcare had changed significantly and health infrastructure needed to be designed to provide the very best care. For

example, the local area did not have a 24 hour manned stroke unit, the reality was that if someone had a stroke, they were not likely to recover as quickly as someone in another part of the Country.

- He stated that he could not defend services as they currently stood. A more strategic approach was required towards emerging services/chronic care. He added that Private Finance Initiatives were a national disgrace and he didn't want this happening on his patch.
- He stated that he was currently in the process of building a model for the future of healthcare for the local area. He was facing resistance from the NHS, he wanted to engage with the process but ultimately to provide the best care for his residents. Ultimately, his view was that a state of the art hospital was required and should be located at the M4 junctions eight and nine.
- It was important to maintain a strategic view, his model would be published at the end of the month and he encouraged panel members and the public to view it.
- In response to members' queries, he stated that funding would be difficult for a new hospital. Council's had realisable assets, and he would be querying why currently local residents were getting a lower rate per head spent on them on healthcare than other parts of the Country. He would be lobbying hard to change this.
- He stated that Wexham Park was teetering on the edge of financial difficulty almost daily, obstetric services were under great pressure, funding was being diverted to Slough. A new hospital would have a private wing which would help to fund it, he could not see how it could not be viable.
- He stated that he was concerned that if Heatherwood was closed that the proceeds of land sales would go to Slough, he did not want to see this happen. A significant amount of money could be secured from that land. He stated that healthcare had developed in a piece meal way locally and he wanted to see a more strategic approach.

The Chief Executive of NHS Berkshire stated that it was refreshing that politicians were saying the unsayable. He didn't necessarily believe that the way healthcare was funded was unaffordable.

The Chief Executive of Frimley Park Hospital stressed the need for hospitals to work closely with GPs to ensure that healthcare is given in the right place, and to minimise the time people spend in hospital.

The Executive Member for Adult Services, Health and Housing welcomed Dr Lee's interest in the long-term provision of health services, and stressed the need for good health services in the short term too.

23. **Minutes and Matters Arising**

RESOLVED that the Minutes of the Panel held on 3 November 2011 be approved as a correct record and signed by the Chairman.

Minute 18: Report of the Review of the Healthspace:
Mary Purnell reported that there had been considerable progress on the Section 106 issue, she was now awaiting confirmation that all issues had been resolved and agreed.

24. **Public Participation**

The clerk reported that no submissions had been received.

25. **NHS Berkshire Primary Care Trust**

The Panel received a progress report from the Chief Executive of NHS Berkshire (Primary Care Trust), Charles Waddicor, on the 'Shaping the Future' programme to find a long term solution for hospital and community health services in East Berkshire.

He made the following points:

- 'Shaping the Future' would shape acute services in East Berkshire, there were currently four proposals that were being consulted upon. In Ascot there had been considerable opposition against the closure of Heatherwood Hospital, these strong views needed to be taken into account. Proposals needed to be affordable and to serve the needs of the local population.
- Funding provision for the Healthspace had been made in the PCT's budget for 2012/13 of £0.5m per year. This was in addition to funding currently provided for commissioning of services. The case for the Healthspace had been made to the Strategic Health Authority.
- In 2010/11 the PCT had an £11m deficit, and in 2011/12 a small surplus was predicted. He reported that Heatherwood and Wexham Park Hospitals Trust were financially challenged, they had not been able to reduce their costs in line with commissioner's requests, they had between £12m and £13m deficit in 2011/12, and they were currently unable to repay their accumulated debt. It was an ongoing crisis. Prospective solutions to this were being explored.
- It was confirmed that the Commissioning Care Groups (CCGs) would not be responsible for this debt and that the debt would remain within Heatherwood and Wexham Park Trust. CCGs would be tasked with ensuring that the population had access to the health services they needed. He stated that he had great confidence in the interim Chief Executive, Philippa Slinger to bring changes forward.
- Whilst before GPs could make referrals without any responsibility for budgets, this would no longer be the case, this was a positive development. GP referrals were currently lower than previously, though this did not mean there is a worse service. Mr Waddicor stressed the need for everyone to take more responsibility for pursuing a healthy lifestyle.
- It was confirmed that 100% of stroke patients were receiving treatment in a timely manner. Patients were taken directly to Wycombe for screening and also referred to Frimley Park Hospital. The Chairman stated that he would like to look at stroke services in further depth at a future meeting of the Panel.

The Chairman thanked the Chief Executive for his comments and attendance.

26. **Frimley Park Hospital NHS Foundation Trust**

The Chairman welcomed the Chief Executive of Frimley Park NHS Foundation Trust, Mr Andrew Morris to the meeting and invited him to address the Panel on the provision of health services to Bracknell Forest residents. Mr Morris made the following points:

- He had been the Chief Executive at Frimley Park Hospital for 23 years and seen a lot of change in that time. Frimley Park served a collection of three towns that were very different and workload over the years had increased. In 23 years, the hospital had never overspent.

- Frimley Park Hospital had become a Foundation hospital in 2005 and had been rated highly through numerous inspections. The Care Quality Commission's spot checks had raised no concerns. The C. Difficile rate was the lowest in the south of England. Mortality rates were in the best decile nationally. Frimley Park's Maternity Services had been rated the second best in the Country and the National Patient Survey had placed the hospital in the top 20% of hospitals nationally. MONITOR is satisfied that the Trust's finances are sound. Frimley Park is a good hospital, the results spoke for themselves.
- Frimley Park served around 400 patients a month and staff at the hospital liked to work at the hospital. Happy staff equalled good care.
- The hospital strived to provide more consultant-led care and was currently trying to move towards 24/7 care. Maternity services had 8-9 hours of consultant cover daily, as well as a midwife led unit operating in close proximity.
- A new Trauma Unit was also to be developed which would include a helicopter pad on the roof of the hospital.
- Frimley Park had become the biggest provider for Bracknell Forest residents in recent times. The Chief Executive wanted to build contact with Bracknell Forest GPs, to respond to the interest shown by local residents. He was very committed to providing services to Bracknell Forest residents, particularly given current referral patterns. He was committed to the Healthspace and if GPs wanted a minor injuries unit, he would be happy to consider this.
- If patients had a bad experience at Frimley Park, he was keen to meet them personally or write to them.
- Frimley Park did currently experience problems with car parking, however they were working closely with Surrey Heath Borough Council to resolve this. It was hoped that another car park could be established at the back of the hospital.
- The hospital had an out of hours GP service that operated close to the hospital, patients could be sent there if they did not need A&E services. A local minor injuries unit in Bracknell would also take pressure away from A&E services.
- He stated that it was important that boundaries did not prevent Bracknell Forest residents from using Frimley Park.
- The hospital worked in close and successful collaboration with the Council's adult social care department, endeavouring to support and encourage people to remain in their own homes as much as possible.

The Chairman thanked the Chief Executive for his input and attendance and asked if it was possible for the Panel members to visit Frimley Park. The Chief Executive stated the Panel were welcome to visit the hospital.

27. **Public Health Update**

The Panel received a progress update from the Director of Adult Social Care and Health, the Director of Public Health had given her apologies for the meeting.

The Director of Adult Social Care and Health made the following points:

- Many Public Health responsibilities would be transferred to the Council and other upper tier councils across the Country from April 2013. The Government had set out roles and responsibilities for local authorities around Public Health. £5.2bn had been allocated overall to support Public Health, funding for upper tier councils had not yet been confirmed.

- There would be a Berkshire East learning event around Public Health, aimed at elected members on 8 February.
- It is possible that one Director of Public Health would work across the six Berkshire local authorities, this would be challenging and an effective way of working would need to be established. A good relationship had already been established with the Director of Public Health.
- A Transition Board had been established, an interim transition plan also needed to be developed. Subject to the Transition Plan being submitted to the shadow Health & Wellbeing Board, it would also be submitted to the Panel.
- In addition, the Health & Wellbeing Board would also be considering a draft Health & Wellbeing Strategy that would look to tackle a top ten of priority areas. This strategy could then be consulted upon, it was hoped that the Panel would contribute at this stage.
- There were some areas where it would be beneficial to work collaboratively where in other areas it would be advantageous to work individually.

The Executive Member stated that the Joint Strategic Needs Assessment (JSNA) would underpin all work around Public Health and the core data behind the JSNA needed to be sound. He stated that the Panel's involvement in this would be welcomed.

The Executive Member also stated that analysis of the JSNA needed to come from the data that underpinned it, which would then go into the strategy to be prioritised and commissioned. It was important to consider what was currently working and what was not.

The Chairman stated that Public Health should be revisited at a future Panel meeting, to consider the role of Public Health and effective pathways for Public Health. Mental Health issues, including depression, would also be followed up with the Berkshire Healthcare Trust.

28. **Working Groups Update**

The Head of Overview and Scrutiny updated the Panel on the progress of current working groups:

Health Reforms: This working group had gone as far as it could currently, it could not undertake any more work until the new legislation was clearer.

It was noted that the Health & Social Care Bill was currently being amended and patient involvement was included in this. This was something that the working group could look into, in particular the status of Healthwatch/LINks.

Health & Wellbeing Strategy: This working group had met twice and was arranging a third meeting.

Shaping the Future: This working group had not got off the ground, timescales had been put back for Shaping the Future and as a result there was less urgency. If a full consultation was initiated a working group would need to be formed, to date the only volunteer was Cllr Thompson.

In response to Members' questions, Alex Gild, Finance Director, NHS Berkshire said that no detailed plans were yet available on the planned use of £100,000 to support transport associated with the relocation of in-patient mental health facilities to Prospect Park Hospital. Implementation of this would take place over 18 months.

29. **Overview and Scrutiny Work Programme**

The Panel considered which topics should be included in their work programme for 2012/13:

It was agreed that:

- Strokes and treatment of strokes be considered at panel meetings.
- A seminar on Mental Health be arranged by the Director of Adult Social Care & Health and that all members of the Council be invited to attend. This was recognised as a growing problem that would impact all the Council's services as the recession began to set in. This might lead to an Overview and Scrutiny review. It was noted that the Chairman would be attending a Mental Health Conference. The Panel also considered the possibility of visiting Prospect Park.
- Consideration be given to how the JSNA should be built into the Panel's work programme.

The Chairman reported that he had been in discussions with chairmen of the Health Scrutiny committees of Buckinghamshire County Council, Slough BC and RB Windsor & Maidenhead concerning the 'Shaping the Future' consultation. To date there was shared agreement on the way forward , and this might lead to the resumption of the Joint East Berkshire Health Overview and Scrutiny Committee.

30. **Dates of Future Meetings**

26 April 2012
14 June 2012
27 September 2012
24 January 2013
18 April 2012

CHAIRMAN

TO: HEALTH OVERVIEW AND SCRUTINY PANEL
26 APRIL 2012

BRACKNELL FOREST JOINT STRATEGIC NEEDS ASSESSMENT REPORT
Director of Adult Social Care, Health and Housing and
Director of Public Health, NHS Berkshire East

1. SUPPORTING INFORMATION

1.1 The purpose of this report is to inform the Health Overview and Scrutiny Panel of the Joint Strategic Needs Assessment (JSNA) and to receive the Executive Summary of JSNA for 2011 set out as Annexe A. The statutory responsibility for the JSNA is a joint responsibility of the Director of Adult Social Care, Health and Housing, and Director of Public Health, together with the Director of Children's Services.

1.2 The development of the JSNA is a process that identifies the current and future health and well-being needs of the local population. It builds on work undertaken in both Health and the Council in relation to needs assessment pulling it together in one place. It is a snapshot of the needs of the local population. It signposts more detailed information that exists in determining either care group or partnership strategies.

1.3 The JSNA is not intended to set out the significant achievements that have been made in the Borough over recent years. The JSNA is an important source document for all of the various Partnership Boards and Scrutiny panels as they look at the outcomes the various strategies aim to achieve for the various parts of the population. In turn as evidence of need is developed throughout the year from the specific partnerships, it is anticipated that these will inform future JSNA development. This will include the any specific health and social care needs that relate to particular community groups, as this local knowledge is developed.

1.4 The Health Overview and Scrutiny Panel has set up a Working Group to look in detail at the JSNA and the emerging Health and Well Being Strategy. This has included a 2 hour workshop with Dr Angela Snowling (on behalf of the Director of Public Health) and the Director of Adult Social Care, Health and Housing so that members of the Working Group can spend more time looking at the issues this has raised for Bracknell Forest.

1.5 The Executive Summary is attached as Annexe A and will be accompanied by a short presentation on the key issues.

1.6 In future, since passing the Health and Social Care Bill, the production of the JSNA will be the responsibility of the Health and Wellbeing Board. There is a new statutory responsibility for Clinical Commissioning Groups in the joint development and implementation of the JSNA from 2013. In addition, their plans must be explicitly cognisant of the priorities in the JSNA and Health and Well Being Strategy which will be signed off by the National Commissioning Board.

2. RECOMMENDATION

2.1 It is recommended that the Health Overview and Scrutiny Panel note the content of the Executive Summary.

3. REASONS FOR RECOMMENDATION

3.1 The Local Government and Public Involvement in Health Act (2007) places a duty on upper-tier authorities and Primary Care Trusts to undertake a Joint Strategic Needs Assessment (JSNA).

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 N/A

Contact for further information

Glyn Jones, Adult Social Care, Health and Housing - 01344 351458
glyn.jones@bracknell-forest.gov.uk

Pat Riordan, Director of Public Health, NHS Berkshire East - 01753 636839
pat.riordan@berkshire.nhs.uk

Bracknell Forest Council

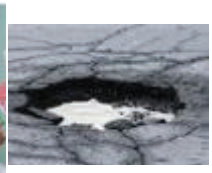
NHS Berkshire East

JOINT STRATEGIC NEEDS ASSESSMENT

2011-2012

A summary for the

Bracknell Forest Health and Wellbeing Board



Introduction

The requirement for Primary Care Trusts and upper tier Local Authorities to develop a Joint Strategic Needs Assessment (JSNA) for their local populations is contained in statutory regulation - the Local Government and Public Involvement in Health Act of 2007. The JSNA is a process by which the current and future health and social care needs of a population are identified in the light of existing services. Recommendations are made to address those needs.

The Local Government Improvement and Development Data Inventory (LGID 2011) was used this year as it provides a consistent and transparent way of comparing diverse priorities.

DH guidance released in December 2011 sets out the timetable (see Table 1) for ensuring the JSNA informs the development of local health and wellbeing strategies by May 2012 and commissioning plans prior to accreditation. Local shadow Health and Wellbeing boards are required to follow this timetable and to ensure that stakeholder engagement has occurred throughout 2012.

Table 1 Timetable to accreditation in April 2013

	Jan 12	April 12	May 12	July 12	Oct 12
Health and wellbeing board	Continuous engagement with stakeholders, users and public	Non statutory operation			
JSNA	Underway				
Joint Health and Wellbeing strategy		JSNA priorities inform strategy	Strategy informs commissioning plans		
Clinical commissioning groups				Start of authorisation process	Formal process begins

Public health commissioning responsibilities set out under the Health and Wellbeing Bill (2011) include the commissioning responsibilities for Public Health England, the NHS Commissioning board, clinical commissioning groups and local authorities. These are set out clearly in a recent DH publication available at

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131901.pdf

Local authorities will be responsible for a great range of contracts currently managed by the Primary Care Trust. The contracts will need to be safely transferred by April 2013 and any future changes must be informed by the JSNA findings set out in summary form here and in greater detail in the electronic guide.

Key findings shown here are therefore related to commissioning responsibilities as well as themes identified in the JSNA described in this summary and the board is requested to note;

- The strategic issues which require resolution at PCT and Health and Wellbeing board level
- that stakeholder engagement will commence to further inform the local views sections and the commissioning cycle to 2013 as shown above in Table 1 - from new DH guidance for developing health and wellbeing strategies
- that staff and partners will have electronic access to the JSNA once approved by the board.
- that this report includes a short summary of progress made against the Marmot Themes as required for establishing the local health and wellbeing strategy
- that sections 5 and 7 of the full guide include programme budgeting and Personal, Social Services expenditure data to inform commissioners of the key areas of spend that can be used to recommission services

Process and governance

The process followed reflects feedback from the 2010 JSNA. The local JSNA working group was established with membership representing NHS Berkshire East (NHSBE), Bracknell Forest Borough Council, Bracknell and Ascot CCG and the voluntary sector. This year there was strong representation from commissioners who requested equality impact information from provider services for children and older adults.

The Assistant Director of Public Health for Bracknell led the process on behalf of the Director of Public Health and the Director of Adult Social Care. Informatics support was provided by NHSBE and Bracknell Forest Borough Council. Data transfer was managed in accordance with the Data Protection Act - aggregate level data only was shared and many of the data sources are nationally available (as set out in the LGID guidance).

Themed templates and local reports were supplied by working group members for each of the locality versions. Evidence based templates for each theme have been collated for the Health and Wellbeing board to enable them to select priorities under the six headings of: numbers affected, potential severity or harm averted, projected future position is no action is taken, scope for improvement, resource impact, contribution to reducing inequalities and local views (public, patient and other stakeholder perspectives of needs).

A key development this year is that service templates and activity data were supplied for services for children and young people and for older adults, with a focus on those that will become the responsibility of local authorities or clinical commissioning groups to commission from 2013. These comply with equality impact monitoring requirements and can be further developed by commissioners throughout 2012. This will aid transparency as contracts move to local authority control in 2013.

A first draft (without electronic links to the datasets or templates) was sent to the local working group, to approve the structure and content in early December. Final feedback was received on 3.01.2012. Hyperlinks were then inserted into the electronic guide to the underlying datasets and templates. These are now live and the electronic guide is a substantial public health resource for all commissioners to use once approved by the board.

The guide, datasets and powerpoints of key findings will now be transferred to the local authority information lead for use by members of the Health and Wellbeing board and partners and for commissioners. They cover

- the health and wellbeing needs of local people
- the evidence base for each determinant of health and wellbeing
- key outcomes which are statistically worse or better than the Southeast
- a directory of commissioned services for children and older people
- the scope for future improvement
- a local views section* for each chapter which will be developed through further stakeholder engagement
- information on health inequalities

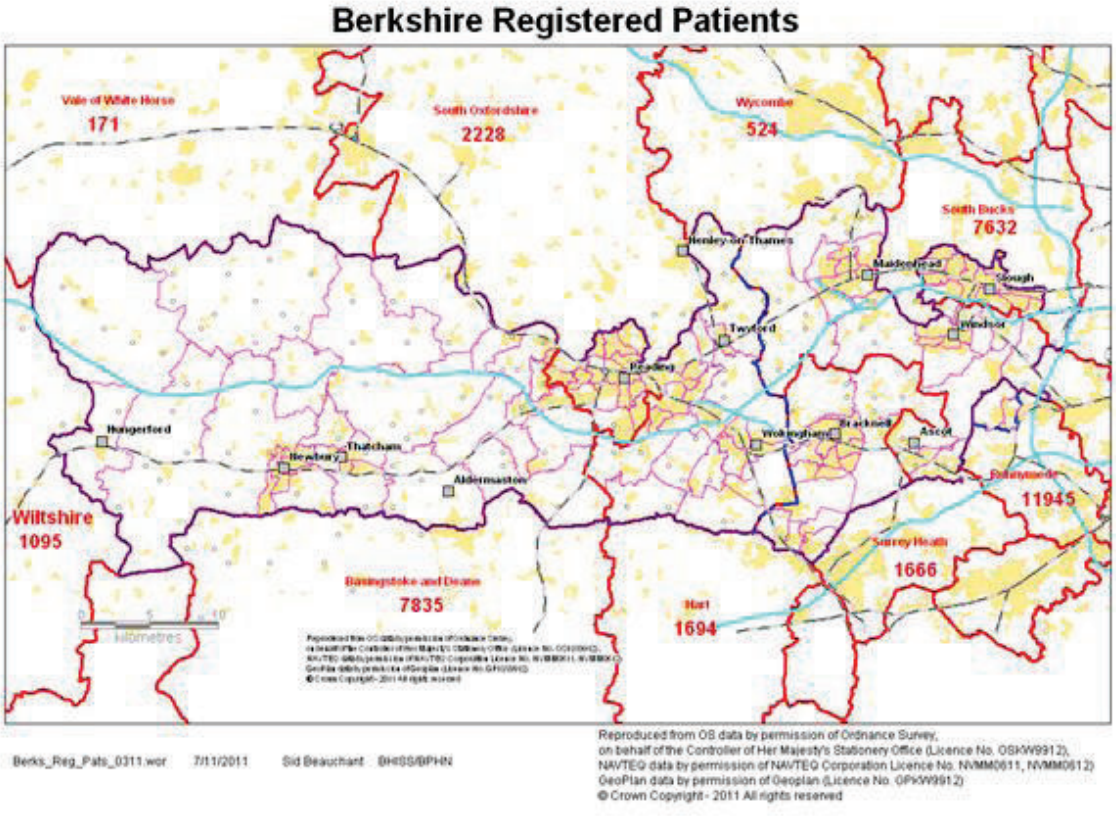
(*)The **next steps** are set out in the timetable in Table 1

Wider stakeholder engagement must now commence to further inform the 'Local Views' sections and 2013 commissioning plans. This will ensure JSNA is aligned with the commissioning cycle for the local authority, clinical commissioning group and NHS Commissioning board

Strategic issues - population differences

The area covered by Berkshire East comprises the three Unitary Authority areas of Slough, Bracknell Forest and Royal Borough of Windsor and Maidenhead (RBWM). Figure 1 shows how many patients live outside the geographic boundary of the existing PCT in adjacent counties.

Figure 1Registered patients living in neighbouring counties outside the geographic boundary of Berkshire



The Office of National Statistics ONS 2010 estimated *resident* population of NHS Berkshire East at July 2011 was 406,700 (202,800 males and 203,900 females). This is considerably larger than the sum of all three local authority areas which was 393,800 (based on ONS mid

year estimates for 2010). This is because the resident population includes the two Englefield wards. No ONS mid year estimates have been released for 2011 as the census results will reshape local estimates substantively in July 2012.

The Attribution Dataset population for NHS Berkshire East called the registered population was 396,378 in 2010 (196,552 males and 199,826 females). This is calculated by constraining the GP lists to the resident population i.e within the geographic boundary of the region which is then apportioned to each PCT – it is the population for which the PCT is funded. PCT resident populations refer to the people living within the geographic boundary covered by the PCT i.e. in the case of Berkshire East the area covered by the three local authorities plus two wards in North Surrey.

Key population issues relevant to Bracknell Forest (for resolution prior to CCG accreditation), which relate to non coterminous boundaries include:

- How joint funded health and social care services will be delivered to the patients in the Ascot area that are now part of the Bracknell and Ascot clinical commissioning group. (Three out of five practices in Ascot ward have joined leaving a main and a branch practice within Windsor and Maidenhead CCG)
- The need to agree a consistent population for joint funding purposes in the shadow year.

Future population projections – to 2030

Bracknell Forest currently has a younger population profile than the UK average with a higher proportion of those aged 0-18 and a lower proportion of those aged 65 plus as illustrated in Table 2 below.

Table 2 Numbers and proportions of ADS resident population 2010 in Berkshire East compared to the UK

Age group		Number males	Number females	Total	Proportion
0-18	UK	5,982,768	5,712,926	11,732,580	22.3%
	Bracknell Forest	14,800	14,000	28,800	24.7%
65+	UK	3,701,265	4,730,414	8,756,400	16.7%
	Bracknell Forest	6,300	8,100	14,300	12.3%

Source – The Health and Social Care Information Centre 2011. Lists extracted from the ADS2010 and reconciled to ONS mid 2009 estimates for local authorities (minus special populations)

For young people the 10-14 age band projected to increase most to 2030

Within the area covered by the local authority of Bracknell Forest the population is currently younger than the Southeast. Projections show the gap will close to meet the Southeast average trend by 2030 as the population ages. The greatest growth in Bracknell Forest is projected to be in the age bands 55-59 and 70-74 years

For the Royal Borough of Windsor and Maidenhead (RBWM) the population projections to 2030 are estimated to remain in line with the Southeast average. For RBWM the peak age band for growth is expected among those aged 50-59

Ethnicity

Until the 2011 Census results are published (expected in July 2012) overall the proportion of the population in Bracknell Forest which is from non white ethnic groups is estimated to be 10.4% (source ONS 2009 ethnic estimates). South Asian men are more likely to develop CHD at younger age, and have higher rates of myocardial infarction. Black people have the highest stroke mortality rates. Heart disease, diabetes and learning disabilities are more prevalent nationally in Asian communities and these together with African and some Mediterranean communities have a higher prevalence of sickle cell anaemia.

Birth rates in Bracknell Forest show that in line with national trends one in four new births are now to women not born in the UK. Results of the January school census in Bracknell Forest primary schools show that 16.1% children were from 'non white' ethnic groups, whereas in RBWM 17.9% of resident children were from non white ethnic origins.

Deprivation

Bracknell Forest is one of the least deprived areas of the country - ranked 291 out of 326 local authorities in England on the Index of Multiple Deprivation 2010 (IM2010). The overall picture of deprivation in Bracknell Forest masks variations at Lower Super Output Area (LSOA) level (an area containing a minimum of 1000 people).

For instance, eleven primary schools have free school meal eligibility in excess of 10%. 11% of 0-16 year olds in the borough are living in poverty, compared to a national average of 21.6%. However, there are six wards in the borough that have child poverty rates higher than the regional average with the highest ward rate being 23% in line with the national average.

Life Expectancy

Life expectancy is the number of years that a person of a specific age can expect to live on average in a given population. It is a commonly used summary measure based on death rates in the population in a given year. Life expectancy at birth is defined as an estimate of the number of years a new-born baby would survive, were he or she to experience the particular area's age-specific mortality rates for that time period throughout his or her life.

The average life expectancy for Bracknell in 2007-2009 was above the Southeast average for males at 79.7 compared to 79.4 the Southeast average and statistically above the national average at 78.25 years

For females the average life expectancy was 83.8 years but was not statistically different from the Southeast average of 83.3 years or the national average of 82.31.

It is important to note that the Health Profile 2010 spine chart used life expectancy estimates based on a three year rolling average from 2006-8 data. Yet when calculating differences in life expectancy between quintiles of deprivation the 2011 Health profile used five years (2005-9). Life expectancy gaps between the most affluent and the most deprived *therefore provide different estimates based on the years used.* It is likely that three year estimates will be used in the Public Health Outcomes framework when published.

Using five year estimates from the Health Profiles for 2011 there was a gap between the most affluent and the most deprived wards for males of 4.02 years and for females of 1.21 years in Bracknell Forest (based on 2005-9 data)

Births and deaths

The population of Bracknell Forest and Ascot will continue to rise to 2030. The population pyramid for Bracknell Forest was estimated in 2010 (ONS MYE 2010) to be overrepresented compared to the Southeast by those aged under 59 with the exception of the age band 20-24 and underrepresented over the age of 60. This will change over the next twenty years as the population ages and increases to match that of the Southeast profile.

23.5% of new births in Bracknell Forest are to women whose country of origin is not the UK.

Cause of death codes on death certificates are very variable and it is particularly important to know which years are being pooled to calculate mortality percentages or to draw inference about mortality rates by age or gender that might be statistically higher than national.

Using three year averages (based on all 2008-10 mortality data shown in the 2011 End of Life profiles) the percentage of deaths from all cancers was statistically above national in Bracknell Forest at 29.57% compared to 27.71% nationally. The RBWM rate was 27.88 but not statistically above national. Cancer deaths in Bracknell were statistically higher among females in the 65-84 year age band. Analysis of single year annual district death data from 2010 shows that within 'all cancers' colorectal cancers in males and females are ranked the highest.

In addition in Bracknell Forest deaths from other causes were statistically higher than national in males aged 65-84.

Cardiovascular disease mortality rates were statistically lower than national in Bracknell Forest yet cardiovascular disease in males and females remains among the top three categories in the CCG area – based on a single year extract from Annual District Deaths for 2010.

Groups that might have additional needs

Estimates of need and projections of future need are provided for a wide range of vulnerable groups and include local views expressed by users of services. Groups covered include: those with learning disability, special educational needs, children who are on child protection plans, children in need, looked after children, veterans, older people living alone, those not in education employment or training, carers, teenage parents, those with physical disability or sensory needs, gypsies and travellers, migrant workers and their children. These can now be compared with actual service activity levels shown in chapter 5.

Update on the Marmot recommendations (Chapter 6 of the guide)

To enable the board to produce a Health and Wellbeing Strategy in line with the Marmot themes (as recommended in recent guidance from DH 2011 and as used in the 2010 JSNA) Chapter 6 of the electronic guide reviews key indicators in the Marmot report. There are connections to each theme throughout the document as shown below

- Theme A – giving every child the best start in life. (Chapters 2.3 and 4.2 of the guide). The key indicator explored this year at a local level was the performance of children on entry to school. The measure nationally is the whole Early Years Foundation Stage score. This is a composite of the communication and language scores, the emotional health and wellbeing scores and others. The first two have been analysed separately and show important findings in relation to where pupils live and then go to school. The key finding is that in order to reduce inequalities before entry to school the work of the early years

teams, speech and language teams and others will need to be directed outside of the borough boundaries, as residents in the borough take their children to schools in Bracknell or Slough and in-migration of pupils from those areas is significant. This has implications for commissioning for example the Family Nurse Partnership, speech and language services and various parenting programmes.

- Theme B – enabling all children, young people and adults to maximise their capabilities (Chapter 2.3 and 4.3 of the guide). The results for those not in education employment and training are covered in 2.4 as is the underperformance of boys and some BME groups - a local and national issue.
- Theme C – fair employment and good work for all (chapter 2.2 and 4.4 in the guide). This reviews employment rates and claims which are similar to last year
- Theme D – ensuring a healthy standard of living for all (chapters 1.5 and 2.2 in the guide). The small increase in the numbers of claims by carers and those with a disability is not statistically significant
- Theme E – create and develop healthy and sustainable places and communities (chapter 2.1, 2.3, 2.5, 2.6 in the guide). It is too early to show impact in a single year – the 2010 BMG local resident surveys is referenced in section 2.1
- Theme F - strengthen the role and impact of ill health prevention (chapters 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 4.5, 4.6, 4.7, 4.8 in the guide). Improvements in disease specific outcomes are shown in section 4.6, 4.7. Reductions in the adverse health outcomes of problem drug use and the social and economic costs of drug related crime are shown in section 3.3. Reductions in preventable and avoidable death and disability across the social gradient are shown in section 5.2.

COMMISSIONING PRIORITIES

IMPROVING OUTCOMES FOR CHILDREN LIVING IN POVERTY

This is an ongoing national and local priority for Bracknell Forest. A child poverty strategy has been developed and an Early Intervention Strategy is being developed across the council which will tackle the determinants of health inequalities set out in the Marmot report (DH, 2010). The results published in the Health profile show 2595 children were living in poverty based on 2008 data from Her Majesty's Revenue and Customs (HMRC). The results for 2009 will be published in the 2012 Health Profile. More recent quarterly Directorate of Work and Pensions data (Dec 2011) can however be used as a worst case scenario to target services until revised HMRC data is available. These indicate that 7500 families are claiming although not all will meet the definition HMRC use which is 'The proportion of children living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income'

Gaps identified

- That the gap between the median and the bottom 20% for the Early Years Foundation profile is narrowing and that the overall score is rising in each area. There is still scope to improve this in the central wards of Bracknell Forest.
- Referrals from health visitors to early years teams are viewed as vital for vulnerable children and families. Increasing the capacity of the health visitor workforce is essential

to ensure that pre birth visits and two year review assessments can be systematically implemented and used to measure the impact of early interventions.

- Improved targeting of the Family Nurse Partnership is required in areas of deprivation where low emotional health and wellbeing scores have been identified (from local analysis of the early years foundation stage indicator).
- Cross boundary commissioning of early interventions is required (such as speech and language and parenting programmes) as children are entering schools from adjacent boroughs. Examples include the Every Child a Talker programme to prevent language delay
- Family members and day care provide just over half of all childcare. Ensuring childminders gain 'good' or better OFSTED grading is a key priority.

IMPROVING MENTAL HEALTH ACROSS THE LIFECOURSE

There are 12943 patients (12.4%) on depression registers in the Bracknell and Ascot CCG. This prevalence rate is statistically above the national average and above the Berkshire East average of 11.2%. Mental health registers show there are 777 people on local CCG registers. Overall QoF prevalence remains at 0.6% for the CCG i.e below the national rate of 0.7%. Wards identified as most likely to have higher than national values on the Mental Health Needs Index (2007) are Crowthorne and Old Bracknell in Bracknell Forest. NB no area in RBWM is estimated to be above national reflecting lower levels of deprivation.

There is scope to redesign services before the contracts transfer to local authority control as the Programme Budget information for 2010 for the PCT has identified that both expenditure on Child and Adolescent Health Services and on psychotic disorders is higher than comparator areas and second highest in England. Standardised outpatients attendances are also significantly higher than England.

Gaps identified

- Best practice post natal depression estimates (BMJ 2011) vary from 7-19% among mothers yet there is no systematic recording to inform commissioning and the current thresholds for referral are high. Improved reporting needs to be implemented to inform lower levels of targeted support
- The rates of children becoming looked after is increasing – since April 2007 a 21% increase in Bracknell Forest and a 15% increase in RBWM. There is under representation of looked after children (a group in whom 45% are estimated to have a psychiatric disorder, and 38% a conduct disorder) and of children and young people with conduct disorder in local CAMHS services compared to estimated need.
- There is currently no provision of a court Divert service - a gap compared to the west of Berkshire
- GPs have identified there is a gap in provision of low level anger management programmes although perpetrators of for example domestic abuse are offered access to anger management programmes
- Standardised mental health admissions are below the expected rate in the CCG area but conversely standardised outpatients attendances are above the England average at 13807 compared to 4657 in Bracknell Forest and 14944 compared to 5278 in RBWM.
- Despite the higher prevalence in two practices overall dementia prevalence in local practice registers is below the national average in the CCG area. Using PANSI and POPPI

Oct 2011 estimates together there are 1067 patients in 2011 rising to 2084 in 2030 in Bracknell Forest yet just under half (458) are listed on 2010-11 quality and outcomes registers. Intensive work is underway to ensure early diagnosis and support is in place to prevent unnecessary admissions as part of the dementia strategy. This includes prescribing reviews and the provision of a dementia care advisor

- .A review of reporting requirements for both the child and adult mental health contracts is required (prior to transfer of the budget to local authorities) to ensure that information is reported for the resident population in each unitary authority rather than simple counts of attendances at bases within those areas.

LONG TERM CONDITIONS

The World Health Organisation (WHO) defines long term conditions (also called chronic conditions) as health problems that warrant continuous management over a prolonged period, usually years or decades. The term "chronic diseases" includes an array of conditions including heart disease, stroke, diabetes, chronic respiratory diseases and cancer.

Depending on the severity of the condition risk reduction and self management are the primary goals but where health or social care services are needed such as intermediate care the aim is to increase a person's ability to manage personal care, daily living tasks, or achieve outcomes such as maintaining independence and reducing dependency on statutory services

CARDIOVASCULAR DISEASE, CORONARY HEART DISEASE, DIABETES, STROKE AND CHRONIC KIDNEY DISEASE

Due to the way in which each cancer is coded separately cardiovascular disease (CVD) is the biggest cause of death in the UK, accounting for one in three deaths each year. CVD is the main cause of premature deaths – deaths under 75 years. It is a major cause of health inequalities as it more commonly affects people living in deprived communities. Heart attacks and strokes are the most common form of CVD.

Cardiovascular disease in males and females was the leading cause of death in Bracknell Forest in 2010, accounting for 108 males and 97 female deaths. Within this CHD was the next most common with 56 males and 39 female deaths whilst stroke was the third with 26 males and 30 female deaths.

There are 14907 patients on the CCG hypertension register and 3460 patients on the CHD register. The biggest contributing factors to the development of coronary heart disease are high blood cholesterol (46%) and physical inactivity (37%). CHD admissions were statistically higher than the Berkshire average in Crown Wood (based on 2007-10 HES data).

There are 4946 patients registered with diabetes in the CCG. Diabetes prevalence at 4.7% was below the PCT and national average of 5.5%. Diabetes is a major cause of ill health and premature mortality, mainly due to cardiovascular complications such as heart attacks, stroke, peripheral vascular disease, eye disease and kidney disease. Approximately 75% of patients with diabetes develop cardiovascular disease. South Asian and Black people are at greater risk of type II diabetes, with cases occurring from the age of 25, compared to from 40 years in the general population (Diabetes UK). Diabetes is more common in deprived populations. There are 144 children diagnosed with type 1 diabetes but as yet this has not been disaggregated to local authority boundaries.

There are 2831 patients with chronic kidney disease in the CCG a prevalence of 2.7% - below the national rate of 2.9%.

There are 1752 patients registered with a stroke on CCG QoF 2010/11 registers. Stroke admissions in the wards of Ascot, Crown Wood and Harmanswater were above the Berkshire average in 2007-10. The Projecting Older Peoples Population (POPPI) estimates that there are 338 people aged 65 and over with long term health needs following stroke. This is predicted to rise to 602 by 2030 an increase of 78.1%. The premature mortality rate under 75 years for stroke in Berkshire East was 15 per 100000 in 2007-9, higher than England (12.8) and significantly higher than South Central (10.6). Male mortality rates exceed female mortality rates Stroke emergency admissions were above the Berkshire average in Ascot, Crown Wood and Harmanswater (based on 2007-10 HES data)

There are 1563 patients with atrial fibrillation in the CCG a leading risk factor for stroke. Atrial fibrillation admissions were higher than the Berkshire average in Ascot, Bulbrook and Central Sandhurst (based on 2007-10 data extracted from HES)

There are 676 patients with heart failure in the CCG.

Gaps identified

- To fully commission the NHS Health Checks screening programme
- To increase uptake of diabetic retinopathy screening to national standards
- To embed the roll out in primary care of the atrial fibrillation locally enhanced service
- To provide Myquest support to ensure that practices can load and use the Guidance on Risk Assessment & Stroke Prevention tool (GRASP)
- To follow the South Central post stroke care pathway recommendations in the community

CANCERS

There are now 2028 people on cancer registers in local practices in the CCG. Cancer mortality trends for 2007-9 were noted in the 2010 JSNA and will be updated when new data is available.

Cancer mortality percentages for each local area are available in the End of Life profiles for 2011. For Bracknell 29.57% of deaths in 2008-10 were due to cancer and 27.88% in RBWM. The only statistically significant age bands were in Bracknell for females aged 65-74 (a rate of 32.95% compared to 32.8% nationally) and for males aged 8% plus in RBWM (a rate of 23.3% compared to 19.52% nationally).

No indicator on the 2011 cancer profile for the PCT as a whole is statistically better or worse than England. Urological cancer incidence is however higher in RBWM.

END OF LIFE CARE

There has been widespread adoption of the gold standard framework for care management. Apart from acute provision the following community services currently provided include: community initiatives in each local authority, a night sitting service, medicines management, care homes education, practice nurse education programmes and voluntary sector bereavement support.

Gaps identified

- Palliative care codes in all three major acute providers remain statistically significantly above the England average (at between 20-30% of all deaths). Further work will be needed to evaluate whether the level of community provision is sufficient to meet the need identified.

RESPIRATORY DISEASE

There are 7824 patients registered with asthma in the CCG (QoF 2010-11). Rates are just below national in Bracknell Forest yet emergency admissions for asthma and other respiratory conditions are higher in Binfield with Warfield and Central Sandhurst for those aged under five years. The coding of asthma in such a young age group is more likely to be due to viral wheeze according to local clinicians. Ensuring one day length of stay admissions from accident and emergency are reduced in both in the Royal Berkshire Hospital and in Frimley is a priority.

COPD is an umbrella term covering a range of respiratory diseases. Men in unskilled manual occupations are 14 times more likely to die from COPD than men in professional roles. There were 1360 people registered with COPD in 2010/11 on the CCG QOF registers, a prevalence of 1.0% compared to 1.6% nationally. Emergency admissions for COPD were higher than the Berkshire average in the wards of Harmanswater and Warfield Harvest Ride (HES extract 2007-10). Emergency admissions for other respiratory diseases (including influenza) were higher in College Town and for pneumonia were higher in Central Sandhurst and Harmanswater. Bronchiolitis emergency admissions were higher in Wildridings and Central and College Town.

Gaps identified

- The need for a pulmonary rehabilitation service which targets areas of excess admissions reported in the JSNA and frequent attenders
- Wards with excess admissions compared to expected admissions have been identified for: asthma, bronchiolitis, upper and lower respiratory and chronic obstructive pulmonary disease. Further investigation is required as there are multiple potential triggers including: poor self management, housing conditions, smoking etc

LIFESTYLE INTERVENTIONS - SMOKING

Smoking has been identified as the single greatest cause of preventable illness and premature death in the UK. It is known to be a major risk factor in many diseases including cardiovascular disease, respiratory diseases, and many cancers. Passive smoking has also been shown to be harmful to health and is a particular concern in the children of smokers.
Smoking accounts for half of the difference in life expectancy between social classes I and V (Acheson Report 1998). Following last years JSNA a re-tendering process is underway based on an outcomes based tariff to improve the local service. This is being undertaken in partnership with all local authorities in Berkshire.

ALCOHOL

The 2009 Report on Alcohol statistics (IC) estimated 1 in 3 men and 1 in 6 women were hazardous drinkers and 6% of males and 4% of females were harmful drinkers. PANSI estimates (Oct 2011) estimated 4529 people were alcohol dependent. Among those in treatment the level of drug users who also have an alcohol dependency is reported as 21% nationally. Local alcohol profiles for 2011 show an increase in hospital admissions in Bracknell to 1332 per 100000 – the second highest rate in the county.

No indicator was red at local authority level in the 2011 Local Alcohol Profile for England yet. According to the North West Public Health Observatory, the level of binge drinking in the local authority is estimated to be 19.0%. (Violence related to binge drinking is not treated in the same way as alcohol dependency. Criminal justice system interventions include Thinking Skills training).

Local drug and alcohol teams commission a range of services. The numbers in tier 4 residential services across the area were low (reported as 25 in 2010-11). Payment by results information is being monitored nationally and is restricted. It can be provided to commissioners.

Gaps identified

- Further development of Identification and Brief Advice in pharmacies and in tier 1 settings in particular GP surgeries and among staff in Adult & Children's Services.
- The payment by results service is being evaluated locally and nationally and will inform future delivery.
- The need for Alcohol Liaison Nurses in Accident and Emergency departments.
- The need to ensure access to alcohol treatment services is consistent for all local practices in the CCG.

SUBSTANCE MISUSE

The JSNA contains new estimates of adults with a drug dependency. Bracknell is being monitored as part of a national payment by results pilot. Detailed performance information and projections showing financial impact have been produced by the National Drug Treatment agency to support JSNA commissioning decisions. Most of this information is restricted but can be provided to commissioners.

OBESITY

In Bracknell Forest 81% of reception year children and 68.2% of young people at age 10/11 are a healthy weight compared to England rates of 76.4% and 65.3% respectively as shown in the latest National Child Measurement programme (2010/11). The reception result is significantly higher than England.

In Bracknell Forest the prevalence of obesity among children entering school in reception and at year 6 remains just below national rates at 7.6% and 15.6% respectively compared to 9.4% and 19% nationally.

The prevalence of adult obesity in Bracknell Forest and the CCG (and associated costs to the NHS and social care) is projected to rise. Synthetic estimates show 28% of the adult population eat healthily and the adult obesity prevalence is estimated to be - slightly lower than the England average. Yet the prevalence of adult obesity recorded in local practices in Bracknell Forest in quality and outcomes registers show a prevalence of 9.5% i.e below the national rate of 12.5% (QoF underestimates true prevalence as it is only recorded for those on disease registers).

Gaps identified

- The lack of a dedicated psychosocial support programme for morbidly obese children
- A clear documented strategic approach for addressing adult obesity at tier 3 and 4 should be developed.

PHYSICAL ACTIVITY

The latest Active People Survey (Dec 2011) noted that 24.7% of adults in Bracknell undertook the minimum exercise of three sessions a week of at least 30 minutes. This places them in the highest quartile however this is less than the number of sessions recommended for health.

Gaps identified

- The need to promote the new early years guidance on appropriate activity levels throughout all childrens centres
- Increase commissioning of physical activity programmes in line with the national No Health without Mental Health strategy
- Map and align existing provision for those identified via the vascular risk check (a national health check screening programme for those aged 40-74 who are not on any existing disease registers) who meet the referral criteria from the NHS health check programme

SEXUAL HEALTH

Poor sexual health is an important cause of health inequalities, with a higher risk of poor sexual health and barriers to services among young people, with a particular additional risk for those who are looked after, those not in education, training or employment; BME groups, asylum seekers and refugees; gay and bisexual men; sex workers; and drug mis-users. Rising rates of all sexually transmitted infections are noted although none are statistically higher than England in 2010. Whilst current provision is therefore considered good yet there is scope to improve as follows

Gaps identified

- The need to resolve shared care pathways in advance of the introduction of a national tariff in 2013 when commissioning responsibility moves to local authority control. This is a strategic health authority led programme.
- The HIV burden is underestimated by one third and commissioning should be informed by the outcomes of an early identification pilot for HIV in Slough
- Almost half of the teenage conceptions in the PCT area in 2010 ended in abortions and the reasons for repeat abortions need further investigation.
- There are no data on the extent of psychosexual problems in the CCG area, or on local psychosexual service provision or uptake.
- Local LINks reports show a continuing demand for sex and relationships education in schools

HOUSING

Detailed analysis from the local templates shows increasing demand for homes among young families with waiting lists of 3478 in Bracknell Forest.

The prevention of homelessness is a key priority as there has been a rise in temporary placements which has a detrimental effect on children who may be placed out of the area in which they attend school.

Increasing supported living options for those with learning disabilities and mental health problems is a priority.

Extra Care Housing is a priority. Extra Care Housing is designed with the needs of frailer older people in mind and with varying levels of care and support available on site. People who live in Extra Care Housing have their own self contained homes, their own front doors and a legal right to occupy the property. Extra Care Housing is also known as very sheltered housing,'assisted living', or simply as 'housing with care'. It comes in many built forms, including blocks of flats, bungalow estates and retirement villages. It is a popular choice among older people because it can sometimes provide an alternative to a care home and supports independent living.

CQC information extracted shows the difference between the numbers of beds and the numbers of care homes in the area. Two practices have responsibility for a number of care homes and as a result have a dementia prevalence that is significantly above the England average

Table 2 Beds and care homes provided by locality

Bracknell	RBWM
485 beds 23 homes	1,412 beds 48 homes

Gaps identified

- The highest areas of joint expenditure for both the NHS and councils are in nursing and residential care placements (as well as for assessment and care management) yet differences in the way in which NHS funding is recorded within local councils' 'Personal Social Services Expenditure' make interpretation difficult. Further work is needed once final figures are released for 2010 to ensure that support is proportionate to need.

The scope for improvement suggested in the themed templates underpinning this section include the provision of extra care housing such as

- Examining how extra care housing can support people with dementia and widen the scope beyond frailty
- Working with housing associations to look at tenure options - leasehold can be appealing for people who wish to rent where extra care housing units are at a lower cost to the tenant.
- Increasing the stock of private extra care housing and social rented extra care housing

Other recommendations include the use of joint health and social care assessment tools to ensure thresholds do not differ between agencies especially where health agencies work across different localities.

There is also scope to re-commission using the current PCT contribution in section 256 agreements (formerly called section 28A agreements) where high level need is identified.

EDUCATION AND SKILLS DEVELOPMENT

Key indicators recommended in the Marmot report and the 2010 JSNA have been monitored again this year. The JSNA examines outcomes at each life stage from entry into school, through transition to secondary school and work based learning.

Bracknell Forest is in the process of agreeing the local action plan for their Children and Young Peoples partnership priorities. These will be included in the electronic version when ready and will include actions for enhancing outcomes for boys at GCSE and for vulnerable groups.

Gaps identified

- There are opportunities to further promote local childcare and childcare provision in those Children's Centres that will remain following restructuring. Local parents, including teenage parents benefit from a wide range of parenting programmes, health and wellbeing advice and access to education, training and employment opportunities. Welfare and benefits advice is also available to maximise benefit take up, and links with Jobcentre Plus to encourage and support labour market participation by parents.

- Along with schools and community venues, Children's Centres provide a number of adult learning and English as an Other Language (ESOL) classes to develop skills and employability amongst the adult population. With the current review of chidrens centres local commissioners will need to plan services according to need and accessibility. The findings of the analysis for early years foundation scores should be shared with local schools and actions identified at a local level as well as a commissioning level
- Commissioners should work together to ensure that plans are for the delivery of the school nursing services link to plans for the child health service when future commissioning responsibility moves to local authorities for those aged above five years (after April 2013).
- Those not in education employment or training and those in transition remain priorities although the method of recording outcomes will be challenging as local services report in different ways and now offer targeted support. Early identification of those young people at risk of becoming NEET may help to target resources / support more effectively.

DOMESTIC ABUSE

Much work has been done by local Safer Communities Partnerships in each area and yet repeat rates of abuse remain the same. NICE guidance is awaited in 2012 on the evidence base for a range of interventions. Work with local safeguarding children boards shows the pressure community nursing teams are under as this now comprises 60% of their workload. Recommendations from Berkshire and Buckinghamshire Womens' Aid about how women access medical services are included in the local views section.

SAFEGUARDING ADULTS

The recommendations in the JSNA relate to safeguarding children (which have a separate section in Chapter 1 and looked after children which are discussed in Chapter 5).
A recent Association of Directors of Social Services report which makes reference to many commissioning recommendations that are already in place in service specifications, invitations to tender and contracts. The goal will be to ensure that governance arrangements are in place to identify trends and ensure that the outcomes of referrals are known.
Local adult safeguarding reports include a key recommendation i.e to redress the under-reporting by health services. All general practices should have access to the Berkshire East wide adult safeguarding policy and procedures which can be found on line.

HEALTH PROTECTION

The recommendations in the JSNA overlap with those already outlined under the sexual health section (see HIV and Chlamydia recommendations). Reducing the rise in cases of Clostridium difficile is now a corporate priority.

AUTHOR DR ANGELA SNOWLING, Assistant Director of Public Health Version 2: 29.Jan 2012

Appendix 1 Navigating the JSNA – guide to key findings

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APPENDIX 2 Public Health Commissioning Responsibilities

Local authorities will be responsible for:

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- 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 and screening programmes
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)

- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

Only some are mandated and in 2012-13 these are marked in bold. There is flexibility to make local determination for the remainder

(By 2015 local authorities should be prepared to commission health visiting services in accordance with health visiting expansion plans currently underway)

CLINICAL COMMISSIONING GROUPS

- Abortion services

NHS COMMISSIONING BOARD

- Sexual assault and referral centres
- Campaigns to promote the diagnosis of cancer
- Commission effective child health systems for transfer to local authorities in 2015.

Public Health England

- To specify child health systems
- To commission the increased health visiting workforce and new health visiting service model until the local arrangements for the Healthy Child Programme is in place

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TO: HEALTH OVERVIEW AND SCRUTINY PANEL
DATE: 26 APRIL 2012

REPORT ON STATUS OF SHADOW HEALTH AND WELLBEING BOARD
Director of Adult Social Care, Health and Housing

1 INTRODUCTION

1.1 This paper sets out the progress towards establishing a statutory Health and Wellbeing Board in Bracknell Forest which is a requirement of the Health and Social Care Act 2012 ("the Act").

2 RECOMMENDATION

2.1 The Panel is asked to note the arrangements.

3 REASONS FOR RECOMMENDATIONS

3.1 To ensure Overview and Scrutiny Panels are aware of the progress being made through the Shadow Health and Wellbeing Board to prepare for the statutory responsibilities in April 2013.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None. Although it must be noted that this report will need to be reviewed following commencement orders, regulations and guidance relevant to the Act.

5 SUPPORTING INFORMATION

5.1 In the NHS White Paper, "*Liberating the NHS: Legislative framework and next steps*", (14 December 2010) the Government set out a requirement for health and wellbeing boards to be set up in every upper tier local authority by April 2013 to bring together local NHS services, social care and public health commissioners to:

- develop a Joint Strategic Needs Assessment (JSNA) and new statutory Health and Wellbeing Strategy (JHWS)
- transfer to the local authority specific public health functions defined in the Bill
- secure the integration of commissioning across health, public health and social care and all other functions and services with a health related outcome including planning, leisure, community safety, employment and criminal justice agencies
- ensure patient and public involvement in health, public health and social care commissioning
- facilitate and enable the pooling of funds under Section 75 of the NHS Act 2006

5.2 Ahead of the April 2013 deadline, interim bodies are to be set up described nationally as "Shadow Health and Wellbeing Boards". The purpose of the shadow boards is to put in place those arrangements necessary to deliver the statutory requirements.

5.3 The Bracknell Forest Shadow Board met for the first time in September 2011 with the following membership which reflects the statutory requirement in Section 194 of the Act:

Cllr. Dale Birch	Executive Member for Adult Services, Health and Housing (Chairman)
Cllr. Dr. Gareth Barnard	Executive Member for Children and Young People
Timothy Wheadon	Chief Executive, Bracknell Forest Council
Glyn Jones	Director of Adult Social Care and Health, Bracknell Forest Council
Dr Janette Karklins	Director of Children, Young People and Learning, Bracknell Forest Council
Dr Pat Riordan	Director of Public Health for Berkshire (East)
Dr William Tong	Representative of the Bracknell Forest and Ascot Clinical Commissioning Group (Vice Chairman)
Mary Purnell	Representative of the Bracknell Forest and Ascot Clinical Commissioning Group
Barbara Briggs	Patient and Public Involvement Representative from the Local Involvement Network

5.4 The structure of the Board is emerging and a format has been discussed such that a small overarching executive group, comprising local health, social care and public involvement representatives will oversee a work programme supported by four sub-groups:

- Adult Social Care & Safeguarding
- Children's Partnership Arrangements & Safeguarding
- GP Commissioning & Public Health
- Patient and Public Involvement

5.5 The Shadow Board will meet every two months, the next meeting is to be held on 26 April 2012.

Progress to date

5.6 The Board is undergoing a process of relationship building which has not hindered progress. Terms of Reference have been agreed by the constituent members of the Board and an online community of practice has been created to allow for collaborative discussion between meetings across the different sectors and participants.

5.7 A JSNA has been produced and arrangements are in place to begin the development of the JHWS. A lead officer has been nominated by the Board who is Zoë Johnstone, Chief Officer: Adults and Joint Commissioning. The initial development meeting will take place on April 11. The purpose of the group in the shadow year is to determine robust arrangements for developing a JHWSA and the intention is to develop a "model" plan by July 2012. Members of the Health Scrutiny Panel will be involved in its development.

5.8 The Act prescribes enhanced patient and public involvement in health and social care commissioning. Two strands have emerged:

5.8.1 A new organisation called Local Healthwatch ("LHW") must be commissioned by the local authority to assume the statutory functions of the Bracknell Forest LINk and new functions by April 2013. LHW will be the independent consumer champion of users

of health and adult social care services. A lead officer has been nominated who is Mira Haynes, Chief Officer: Older People and Long-term Conditions. Arrangements to support statutory LINk functions until April 2013 are in place. With regard to LHW development, an independent specialist in health and social care patient and public involvement will assist in the development of a visioning exercise to shape LHW in Bracknell Forest in line with published guidance.

5.8.2 Patient and public involvement must also be hardwired into the commissioning arrangements of the Health and Wellbeing Board and its partners. An outline proposal to meet this requirement was submitted to the Board in February. Subsequent collaboration between the local authority and the health service will see a detailed paper going to the next Board meeting setting out a "Health and Care Network"

5.9 A number of public health functions will return to local government from April 2013. Inherent in this change is potentially the transfer of people, information assets and financial commitments. A comprehensive plan for the transition of functions was developed by the PCT and local authorities and in place by April 2012. There is a Berkshire-wide Transition Board chaired by the Chief Executive and supported by the Director of Adult Social Care, Health & Housing. There is a more detailed report being presented to members of the Health Scrutiny Panel at its April's meeting.

Next steps

5.10 Additional regulations and subsequent guidance are expected which should clarify the requirements for holding meetings in public.

5.11 Arrangements for working with and within the new NHS architecture are also to be developed. The timetable for this work will emerge as new bodies are established.

5.12 How members of the board will support the Clinical Commissioning Group authorisation process must also be explored and final guidance is expected in this regard.

5.13 Mapping of the new outcomes frameworks for health, public health and adult social care across the work of the Board is also to be undertaken.

5.14 Due to non-coterminosity of the Clinical Commissioning Group and the local authority area, information protocols and working relationships with the Royal Borough of Windsor and Maidenhead are to be established.

5.15 In the light of an emerging outcomes strategy for children and young people, how these and children's trust arrangements are to be integrated into the work of the board must also be reviewed.

5.16 Establishing the necessary communications messages and media to create awareness of the Board, its purpose and intended outcomes

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 Not applicable

Borough Treasurer

6.2 Not applicable

Strategic Risk Management Issues

6.3 The potential NHS Reforms are identified in the Council's Strategic Risk Management Plan.

Contact for further information

Glyn Jones, Adult Social Care, Health & Housing - 01344 351458
glyn.jones@bracknell-forest.gov.uk

Kieth Naylor, Adult Social Care, Health & Housing - 01344 351587
kieth.naylor@bracknell-forest.gov.uk

TO: HEALTH OVERVIEW AND SCRUTINY PANEL
26 APRIL 2012

PUBLIC HEALTH UPDATE
Director of Adult Social Care, Health and Housing and
Director of Public Health, NHS Berkshire East

1. PURPOSE OF REPORT

1.1 The purpose of this report is to further update the Health Overview and Scrutiny Panel on the emerging arrangements for the transfer of Public Health functions to Local Authorities in April 2013.

2. RECOMMENDATION

2.1 The Health Overview and Scrutiny Panel are asked to note this update report.

3. SUPPORTING INFORMATION

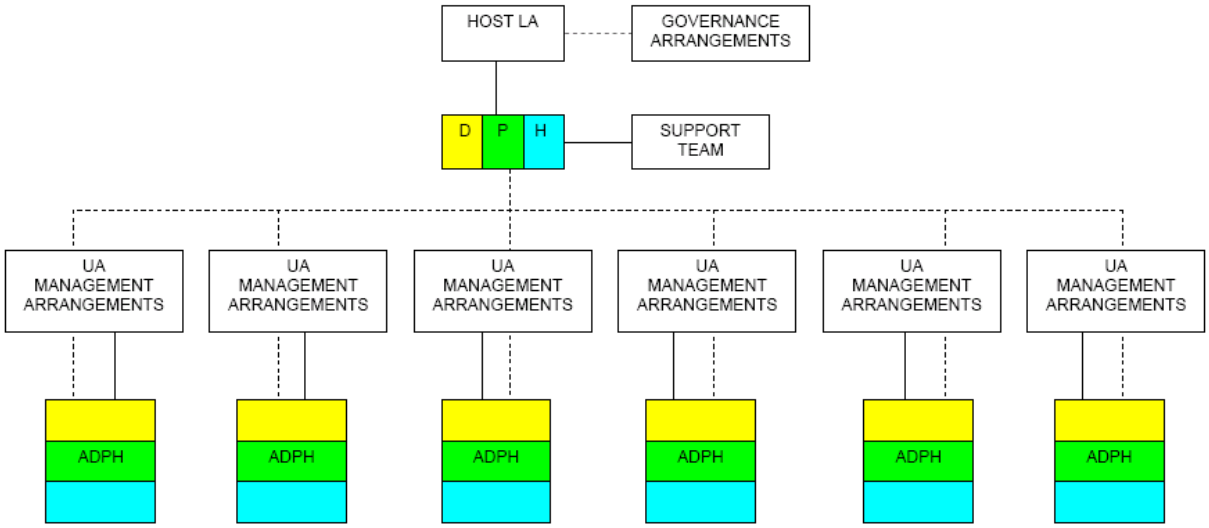
3.1 Members will be aware from the last meeting that by 5 April a Transition Plan should be formally submitted to the Strategic Health Authority (SHA). At the beginning of March, Local Authority Chief Executives were written to by the SHA advising the deadline was 16 March 2012.

3.2 The six Berkshire Unitary Authorities are working together with the PCT Cluster to determine an effective Public Health solution for Berkshire.

3.3 There is no doubt that the organisational challenge within Berkshire is greater than in many authorities who have co-terminus PCT and Local Authorities. This has been reflected in the fact that there is a formal Transition Board. This is chaired by Timothy Wheadon, Bracknell Forest Chief Executive.

3.4 At their meeting in February, the Berkshire Chief Executives supported the view that there should be one Director of Public Health for Berkshire, with local leadership in the form of an 'Assistant Director of Public Health' in each Local Authority to provide local leadership. In Bracknell Forest, the function is to be within Adult Social Care, Health and Housing as determined by the Executive in February 2012.

3.5 The diagram on the next page sets this out. The workstream regarding organisation structure and governance is working on the detail of what activities will be undertaken in each section.



The shading reflects the 3 elements of the role:-

- Strategic Public Health activity
- Local Authority role
- Public Health advice to the NHS

3.6 Once the structure is complete then there is a requirement to follow the Department of Health's organisational change protocol.

3.7 The final package of measures will need to be formally approved by each Council, through their own procedures.

3.8 The Transition Plan submitted to the SHA as Annexe A to this report. It has set the foundation of activity for the Transition Board. It is anticipated that the work of that Board will be regularly reported to this Overview and Scrutiny Panel. Given the timing of meetings, the Director of Adult Social Care, Health and Housing will verbally update from the latest meeting as it will take place after the deadline for Panel papers.

3.9 Since the last Panel meeting, the Government has announced funding arrangements following an exercise undertaken by the PCT, submitted to the Department of Health. The allocation is intended to be based on current spend, however, the initial allocation is less than the current spend. Representations are being made to the Department of Health.

3.10 One of the workstreams is looking in detail at all of the financial and contractual implications.

3.11 Berkshire East Local Authorities will receive one of the lowest allocations for Public Health at £21 per head, whilst Berkshire West Authorities will receive £25 per head.

3.12 There is wide national variation in Public Health spend and the Department of Health and various ministers have indicated that the current spend will be given to the Local Authorities and that there will also be a 'pace of change' element. This is the target budget that authorities should receive over time. This is the mechanism used in the NHS to change allocations. It operates in a similar way to 'floors' and 'ceilings' in Local Authority finance terms.

3.13 As reported at the last meeting, the Director of Public Health (NHS Berkshire East) in conjunction with Local Authorities and the LGA established an education event for Elected Members of Scrutiny Panels. Given the wide ranging aspects of Public Health, the invite was made to all members of this Panel, the Chairman and Vice Chairman of all other Panels. As well as the Director of Adult Social Care, Health and Housing, Portfolio Holder and Head of Scrutiny, this was attended by Cllr Virgo and Cllr Mrs Temperton.

4. NEXT STEPS

4.1 It is intended to brief this Panel on progress towards transfer at each of the Panels' meetings.

Contact for further information

Glyn Jones, Adult Social Care, Health and Housing - 01344 351458
glyn.jones@bracknell-forest.gov.uk

Pat Riordan, Director of Public Health, NHS Berkshire East - 01753 636839
pat.riordan@berkshire.nhs.uk

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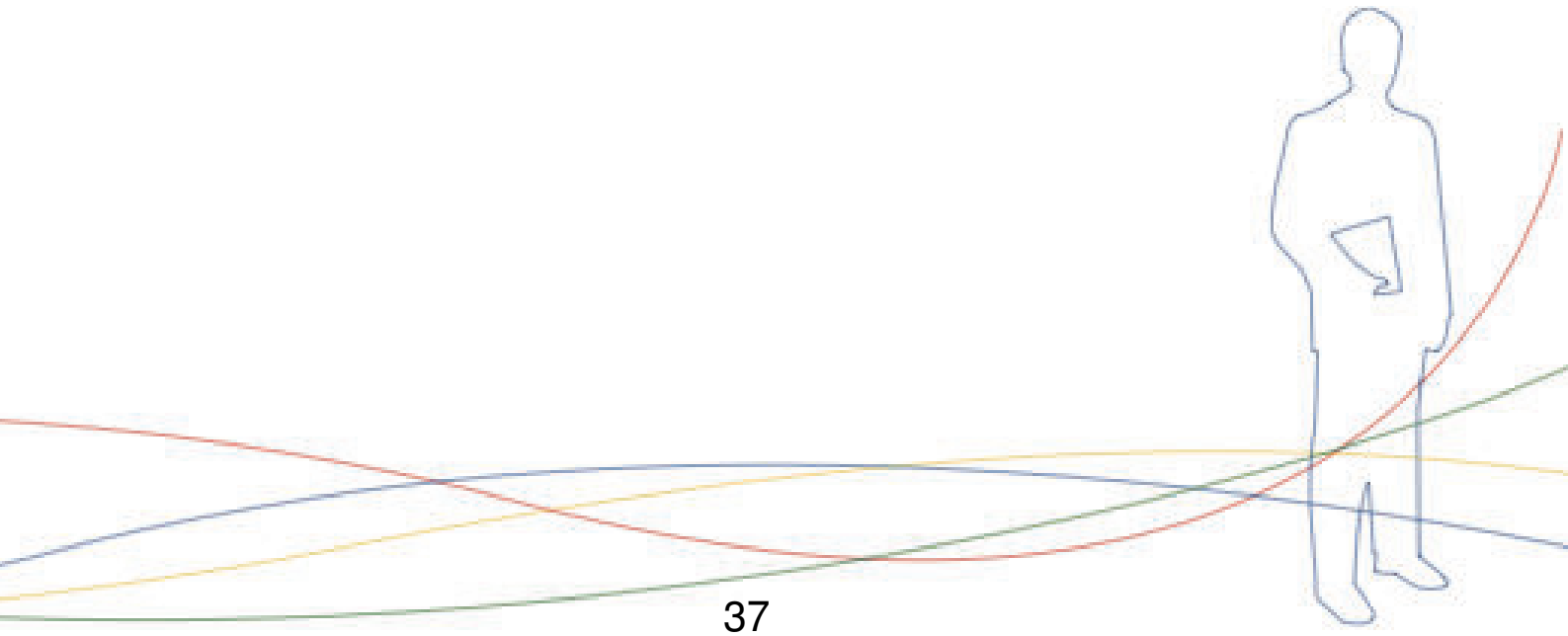
Berkshire
Public Health Transition Plan

presented to:

South Central Strategic Health Authority

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Document Control

Distribution

Name	Title	Version and Date	Date of Issue
Timothy Wheadon	Chief Executive - Bracknell Forest	Version 1	16th March 2012
Ruth Bagley - OBE	Chief Executive - Slough	Version 1	16th March 2012
Ian Trenholm	Chief Executive - RBWM	Version 1	16th March 2012
Andy Couldrick	Chief Executive - Wokingham	Version 1	16th March 2012
Chris Waddicor	Chief Executive - NHS Berkshire	Version 1	16th March 2012
Michael Coughlin	Chief Executive - Reading	Version 1	16th March 2012
Nick Carter	Chief Executive - West Berkshire	Version 1	16th March 2012
Caroline Vass	Public Health Transition and Performance Manager - South Central SHA	Version 1	16th March 2012
Jane Woods	Director of Community and Wellbeing - Slough Borough Council	Version 1	16th March 2012
David Johnstone	Interim Strategic Commissioner at Wokingham Council	Version 1	16th March 2012
Pat Riordan	Director of Public Health - NHS Berkshire (East)	Version 1	16th March 2012
Janet Maxwell	Director of Public Health - NHS Berkshire (West)	Version 1	16th March 2012
Rob Poole	Head of Finance and Performance at Reading Council	Version 1	16th March 2012
Jane Batty	Interim Asst Director of Finance at NHS Berkshire	Version 1	16th March 2012
Liz Steel	South Central SHA	Version 1	16th March 2012

TABLE OF CONTENTS

1. Organisational goals

The white paper "Liberating the NHS" and subsequent Coalition & Department of Health (DH) publications require Local Authorities (LA) to assume the responsibility of delivering the Public Health (PH) functions effective from April 1st 2013. This coincides with legislation to transfer of commissioning responsibilities from Primary Care Trust's (PCT's) to the General Practitioner (GP) led Clinical Commissioning Groups (CCG's).

There are a number of proposed changes resulting from the above mentioned legislation including:

- Responsibility for strategic planning and commissioning of NHS services will transfer to the NHS Commissioning Board and locally based CCGs;
- Local Authorities (LA's) will be given a statutory duty and a ring fenced budget[1] to improve and protect the health and wellbeing of their populations by delivering effective public health initiatives and programmes;
- Strategic Health Authorities (SHA's) and PCT's will cease to exist beyond April 2013;
- A number of Commissioning Support Units (CSU's) will be established by the NHS Commissioning Board to provide the necessary skills and expertise to local CCG's;

Berkshire Unitary Authorities (UA's) are intent on delivering the transition of PH from the PCT(s) to councils in a structured and controlled manner whilst ensuring that commissioned PH programmes and initiatives for 2012/13 (the shadow year) are delivered effectively and efficiently.

Berkshire UA's have put in place two programme managers who will lead the development and delivery of the transition plan - on a Berkshire wide approach as part of a collaboration across the County. The programme management approach will be based on the former Office of Government Commerce's[2] Managing Successful Programmes (MSP) Framework.

The transition plan will be assured by the SHA, as part of a national process overseen by the Department of Health (DH).

The revised submission date for the detailed iteration of the plan is 16th of March 2012.

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[1] The budget has still to be quantified

[2] **OGC** (former owner of Best Management Practice) functions have moved into the Cabinet Office, part of HM Government -www.cabinetoffice.gov.uk.

2. Context and Background

In 2010 the general election resulted in the forming of a coalition government and the appointment of the Rt Hon Andrew Lansley as Secretary of State for Health (SoSH). Early announcements on the health agenda included an intention to transfer the responsibility for the delivery of Public Programmes and initiatives from the NHS Commissioning bodies into Local Authorities.

Some, not all, PH departments and LA's acted very quickly, immediately transferring staff and support functions into local authority buildings and infrastructure. The ring fenced budgets that have been proclaimed have yet to be finalised and as a result there are still a number of PH Departments that have not yet commenced any physical transition of staff and support functions - or the intelligence that underpins the development of the public health delivery agenda.

Berkshire is one of the areas where the transition/transfer is yet to be delivered and there are a number of complex issues to be worked through as part of the transition - this plan seeks to address some of those issues, and where solutions are not immediately obvious, develop processes and actions that will lead to the resolution of those complex issues.

Berkshire consists of six UA's supported by two NHS PCT's (BerksEast and BerksWest which have clustered to form a single management board. This in itself presents a number of difficulties that are being worked through relating to structure of the PH function within the local authorities across the County. - There is agreement from the Chief Executive's of the six UA's that there will be one Director of Public Health, the structure that sits underneath the single DPH is still to be fully defined.

It is against the backdrop of these unanswered questions that we are trying to develop a detailed and deliverable transition plan for the transfer of PH. As a consequence we have are making certain planning assumptions that may need to change over time as things become clearer.

3. Structure of the Plan

This document is one of a suite of documents that makes up the detailed transition plan for Berkshire comprising of:

This document - describing;

- the audience

- the strategic context for the transition
- governance arrangements for the transition plan
- the approach to planning
- the processes that will be used to deliver specific work streams
- stakeholder management of groups and individuals
- risks and issues
    - transitional risks which could materialise during the transition phase
    - legacy risks and issues that arise as a consequence of the transfer of the public health function to the LA
- transition arrangements and programme management
- budgetary assumptions[3]
- commissioning intentions, headlines describing the priority projects and work streams for 2012/13
- high level delivery plan for 2012/13
- commissioning intentions for 2013/14
- delivery plan for 2013/14
- key transition dates

A detailed Schedule of Events (SoE)

Describes the milestones, activities, resources required to deliver them, the effort and duration required to deliver them and the interdependencies;

Programme communications strategy;

Detailing what we will communicate, to whom, how we will communicate and how frequently

Stakeholder map and profiles;

Describes who the key stakeholders are, their area of influence and their level of interest. It also describes how we plan to communicate with them.

Programme documentation including;

- Risk, Issues, Opportunities and Actions log;

[3] This may be high level assumptions if the detail is not available at the time of publication

- Programme Terms of Reference (ToR's) ;
- Project briefs and Project Initiation Documents (PIDS);
- Reporting templates for - Highlight reports, Exception reports, Change control and Risk assessment, Business case (where applicable);
- Programme document register.

Cash flow forecast . (not included as part of this submission)

Our approach will be to deliver the transition collaboratively and efficiently whilst supporting and maintaining momentum around the delivery of 2012/13 Public Health priorities.

4. Purpose of this document

This document, which is focused on a Berkshire wide approach (consisting of the six Unitary Authorities (UA's) and NHS Berkshire), describes the specific processes and framework that will be used to deliver the transfer of the PH function from the NHS into the LA's. The document itself forms part of the wider suite of documents that make up the full transition plan.

As well as the seven key themes that were identified in the original submission in January 2012 this document sets out the programme management arrangements and additional subject matter that arises from new recently issued guidance for transition planning. The plan will be used to manage and assure delivery of the transition upto the 31st of March 2013. The programme will formally close shortly after that with activities and responsibility pass to "Business as Usual" functions.

5. The audience.

The audience that this programme will reach and interact with is diverse and spans a number of partner organisations as well as the general population of Berkshire, including but not limited to:

- Directors, Managers and other staff members of Berkshire UA's;
- Elected members of Berkshire;
- The Berkshire Clinical Commissioning Groups (BCCG's);
- NHS Berkshire East (NHSBE) Commissioners;
- NHS Berkshire West (NHSBW) Commissioners;
- Public Health Staff at NHSBE & W;

- The residents of Berkshire;
- Slough Borough Council;
- Royal Borough of Windsor and Maidenhead;
- Reading Borough Council;
- Bracknell-Forest Borough Council;
- West Berkshire Borough Council;
- Wokingham Borough Council;
- Reading Borough Council;
- Public Health England Transition Team (PHETT) at NHS South Central Strategic Health Authority;
- PHETT at DH;
- Shadow Health & Wellbeing Boards (SHWB)
- LINK's and Shadow Healthwatch structures;
- Providers of Acute Services;
- Providers of Mental Health Services;
- Providers of Community Care;
- DAAT Teams
- GP's;

6. Governance arrangements for the transition plan

The six Unitary Councils in Berkshire operate Executive and Scrutiny forms of governance, in accordance with the Local Government Act 2000. Although there is one model of governance in place the way in which these governance arrangements operate will vary from one Local Council to another.

The transition of Public Health into Local Councils will require a number of "Key Decisions" to be made at meetings of the Executive. In addition, each Council's constitution and, in particular, the way in which decision making can be delegated and Management Structures will need to be changed to reflect the new responsibilities that Local Councils will have for Public Heath. There may also be a need to review Financial and Contract Rules of Procedure. These constitutional changes can only be authorised by a meeting of the Full Council.

The involvement of Scrutiny will vary in each Local Council, some wishing to review the transition of Public Health before decisions are made by the Executive and some deciding to review these decisions after meetings of the Executive.

The lead in times for Executive and Full Council meetings can be extensive and complex and a list of “Key decisions” will be identified by the Berkshire Public Health Transition Group to enable each Local Council to synchronise, where possible, their decision making. In addition to the Council’s decision making structures, there will also be a significant decision making role for Health and Well Being Boards and these meetings will need to be programmed to synchronise with Council decision making timetables.

NHS Berkshire responsibilities

The PCT is responsible for oversight and assurance of the quality and timely delivery of the information and activities within the sender organisation that are required to achieve a successful and timely transition of the Public Health functions that are transferring over to LA’s.

The PCT is also responsible for providing appropriate support and resourcing to support the transition programme.

7. The approach to transition planning.

Whilst we are describing this as plan it is in reality a programme of work containing a number of distinct projects and initiatives that are required to deliver the successful transfer of the PH functions and responsibilities from NHS control to LA control and accountability.

Berkshire UA’s have identified seven key themes around which we have planned the activities and engagement that will be required to deliver the transfer of public health from the PCT into the LA. These themes are:

- Identification of the PH responsibilities of the LA;
- Identification and understanding of the PH functions and commitments that are transferring from the NHS to LA’s;
- Identification and understanding of the core skills required to deliver the PH function;
- Governance and management structure options for PH within the LA(s);
- Ensuring the role of the DPH is appropriately defined and a process for assimilation into the LA(s);
- The smooth transition of Public Health staff and resources is carefully planned and managed;

- Information Management &Technology (IM&T) - ensuring the safe and secure transfer of data, information and systems, processes and technologies.

A programme board has been established, Fig 1 below describes the structure of the programme board, that brings together and co ordinates the specific working groups, key stakeholders and stakeholder groups that are required to deliver the plan itself.

The programme board is the overarching authority across the Berkshire UA's for the delivery and approvals sign off of the transition plan(s) to the South Central Strategic Health Authority.

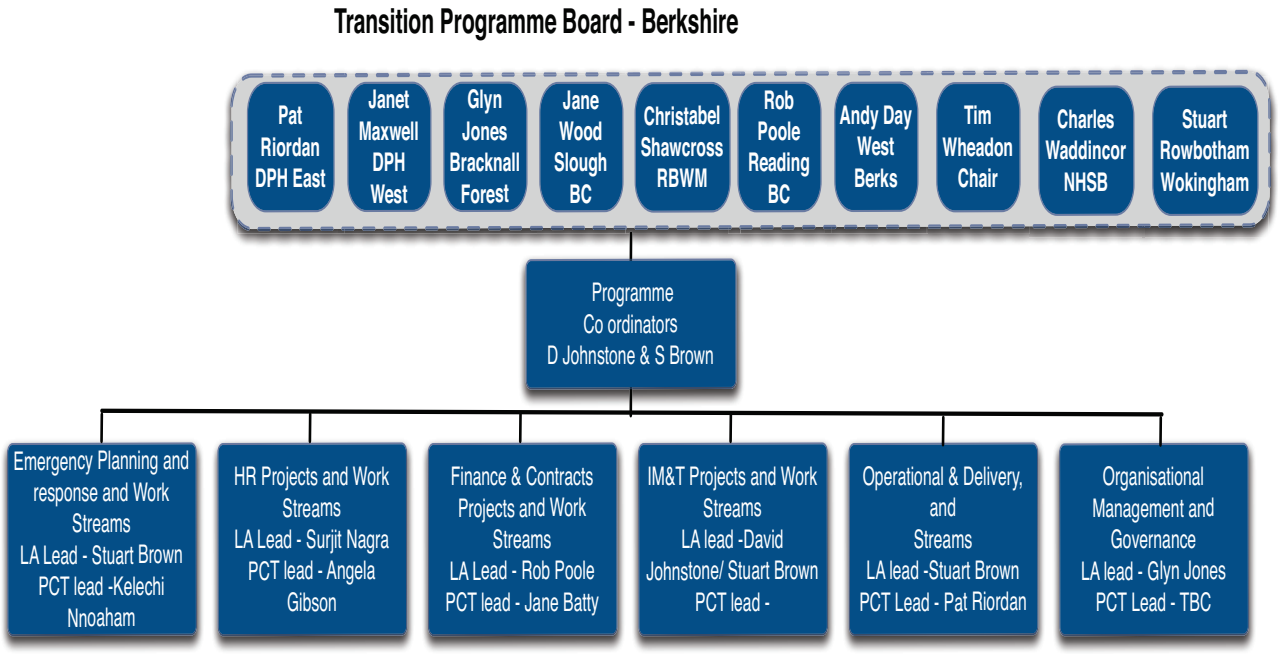

Fig 1 - Programme Board Structure

As well at the programme board each of the key areas has a working group that will support and drive the delivery of the activities that will be required to ensure that the desired outcomes are realised in a timely and effective manner.

8. Risks and Issues

Risks and issues will be present during the transition and after the transition, it will be important to record, track and manage the risks in the most appropriate manner so that we minimise the exposure and reputation of the respective organisations.

Each work stream group will be responsible for identification and recording of risks that are specific to their work streams. Once a risk or issue has been identified and recorded in the risks and issues log it is the responsibility of the Work Stream lead to apply the most appropriate method of risk assessment to determine the likelihood of the risk occurring and the potential impact if it does occur. This could be as simple as a discussion with the

project area affected or it could be appropriate to convene a risk workshop facilitated by the programme manager. The objective of the assessment is determine what the appropriate risk response should be, i.e. Transfer, Tolerate, Terminate, Treat, etc and what the appropriate risk mitigation action should be. Mitigation actions should be undertaken based on the Berkshire's UA's and the PCT's risk appetite as defined by Standing Financial Instructions and other relevant governance.

Once the assessment has been completed the risks will be re-rated if necessary and the risk log updated. Risks will be reviewed on a regular basis (at least monthly) to determine if likelihood or impact has changed. The following diagram (fig 2)describes the level of detail that should be entered in the risk and issues log

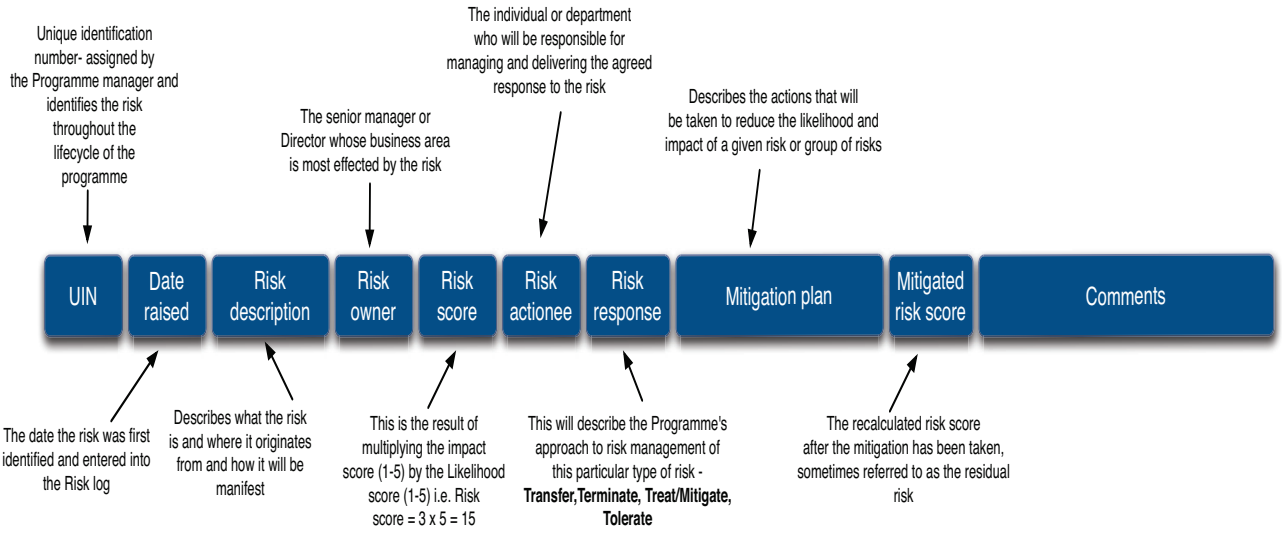

Fig 2 - Risk log entry

9. Key Stakeholder Groups and Individuals.

The complexity of the PH transition indicates that the number and diversity of the key stakeholders and their interests and influences will be equally as complex as the programme itself. This means that the programme needs to have an effective methodology for stakeholder management and communication supported by an agreed Communications Strategy[4].

Each stakeholder or stakeholder group will be profiled to map their interest and influence level(s) in the programme. The results of the profiling will be captured in a stakeholder matrix that records their :

- name;
- organisation & department;

[4] The communications strategy is the subject of a separate document which forms part of the suite of documents that is the Public Health Transition plan

- title;
- email address;
- contact telephone number(s);
- interest level in the programme on a scale of 1 for low level of interest to 4 for a high level of interest in the programme and it's anticipated outcomes;
- level of influence that they are likely to have on the programme on a scale of 1 for low level of influence and 4 for a high level of influence - the matrix should will also record whether the particular stakeholder or stakeholder group's influence is likely to be positive or challenging.
- once each individual or group has been profiled a stakeholder communications plan will be developed that takes account of the individual or groups level of interest and influence on the programme.

The stakeholder matrix and the stakeholder engagement plan will be reviewed on a regular basis, at least quarterly given the length of the transition itself. This will ensure that changes and movements of personnel are captured and that communications are being delivered efficiently and to the right person or group.

Regular reviews will also ensure that if a change to the communications channels and the frequency of communication needs to change as the programme develops it will be captured in a timely fashion

The following graphic (Fig X) illustrates visual representation that will be used for stakeholder mapping:

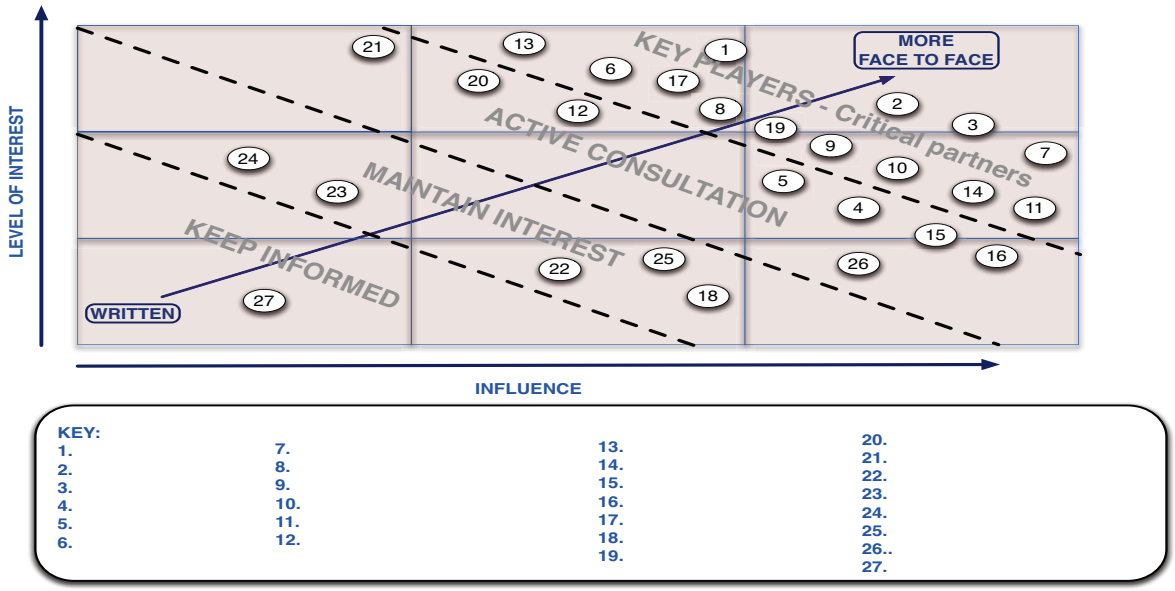

Fig 3 - Stakeholder mapping template

10. Identification of the Public Health responsibilities of the Local Authority

There are a number of business as usual PH functions that will transfer to LA control and management as well as a number of mandatory functions. There is also the matter of the Commissioning Support offer to the BCCG's and CSU's which will be addressed in a separate section of this document.

The key areas are:

Health Improvement

- Development of appropriate strategies and prioritisations;
- Development, commissioning and/or provision of healthy lifestyle services;
- Leading partnerships and developing the strategies to tackle the underlying wider determinants of health such as Crime and Housing issues as well as health behaviour;
- Embracing and contributing to the wider health economy and the application and delivery of the QIPP[5] programmes.

Health Protection

- Taking the lead role in Emergency preparedness, resilience and response;
- Leading, co-ordinating, commissioning and reporting on the take up of immunisation programmes;
- Leading, co-ordinating and quality control and reporting outcomes of screening programmes;
- Outbreak management i.e. Pandemics.

Governance arrangements for emergency planning and resilience are contained in a separate section in this document.

Health Service Improvement

- Leading and Supporting the annual development of the Joint Strategic Needs Assessment (JSNA)
- Supporting the GP Clinical Commissioning Group, GP Federations and joint commissioning bodies

[5] QIPP = Quality, Innovation, Performance and Prevention

- Leadership, engagement and facilitation of care pathway redesign where such action will improve patient experience in line with the QIPP agenda
- Lead on the development of evidence based strategies and policies and prioritisation processes for the overall improvement in the local populations health

As mentioned previously there will also be a number of mandatory functions transferring in 2013 which the local authority will assume responsibility for:

- sexual health[6];
- health protection;
- population healthcare advice to the NHS;
- health Checks;
- national Child Measurement Programme (NCMP).

Further detailed guidance on the transfer of responsibility can be found in :

- The Public Health Outcomes Framework 2012;
- NHS Outcomes Framework;
- Adult Social Care Outcomes Framework
- (Draft) Guidance to Support the Provision of Public Health Advice to CCGs;
- NHS Operating Framework 2012/13;
- Fair Society Healthy Lives (Marmot review 2010);
- Public Health in Local Government Fact sheets (Dec 2011);
- The White Paper - Equity and Excellence.

Transition Process

Each of the functions will be jointly reviewed in detail to understand;

- The strategic context and importance of the function;
- The operational resources required to assure successful delivery of the function and it's constituent projects and initiatives;
- Whether it will be delivered in each individual unitary, review whether it should or could be a shared service across multiple LA's that delivers better outcomes within a smaller financial envelope;

[6] The specifics are still under discussion but it is not expected that commissioning for treatments will transfer

- What KPI's will be used to determine the success or otherwise of Public Health programmes commissioned for 2012/13;

The Health and Wellbeing Board is the body with overall responsibility for the successful implementation of these functions. The Joint Strategic Needs Assessment will provide the information needed to identify needs and priorities. The Joint Health and Wellbeing Strategy will describe the programmes necessary to implement improvement programmes.

11. Budgetary Assumptions.

At the time of publication budgetary information is still not clear in terms of what the ring fenced budgets will be that are coming to the LA's for the purpose of delivering PH.

There has been suggestions that it will be in the region of £21-£25/patient - we would expect to be closer to the highest spine point than the lower one.

There is a lack of clarity around the PH 2010/11 financial outturn for the County, this is further complicated by the need to break it down into spend by unitary. There appears to have been no formal business planning around the PH budget forecast for 2010/11 but instead it was based on the previous year's outturn and then factored for inflation and financial recovery requirements.

The complexity exists for a number of reasons such as:

- "block" contracts where PH programmes, projects and initiatives are commissioned within a much larger service specification making it a difficult exercise to unbundle the contracts;
- other complications revolve around the differences in the providers being used on an East and West basis that has been taken over a number of years;
- understanding what the true impact will be if decisions to decommission services are taken with individual providers which could de-stablize them;
- a further risk is that because the contracts are "block" the overheads are aggregated across the full range of services at the provider, past precedent has dictated that the provider must be given sufficient time to follow the approved termination procedures and time to identify and commission replacement services - as a consequence we have a stranded overheads liability issue.

Transition process

- A financial working group has been established and is working with the PCT Finance Directorate to identify:
    - the value of contracts by unitary;

- the terms and conditions attached to contracts;
- the service specification of contracts and where available linked to activity data;
- the possible penalties associated with terminating contracts and/or serving notice of termination to provider organisations.

(See Appendix II for Remit and Terms of Reference of the Finance Work stream drafted by Rob Poole.)

12. Workforce

Transferring staff from the NHS into Local Authorities will be a complex work stream that needs to be managed with some amount of sensitivity as it is possible that some members of staff will be put at risk by the process and redundancies may prove to be necessary.

The working group that will deliver this work stream will need to be very closely aligned across the PCT and the UA's. There is a high level of risk around this work stream with people being at risk and the potential for negative publicity that may arise as a consequence.

The process that we will follow is designed to provide assurance to staff, unions and management that the process itself is open and transparent and unequivocally fair and legal.

We currently have an issue around organisational design and running costs that is preventing us from building the model for the transfer which delays us being able to identify personnel for transfer, personnel that could be put at risk and where personnel transferring will be located within the local authority community. Essentially this means that we cannot commence any staff consultations or Union consultations that relate to the transfer of PH personnel.

This is expected to be resolved by June 2012 which will allow for a 3 month period until September 2012 to prepare all necessary paperwork, plans and communication strategies for the actual consultation. By June 2012 a final milestone and key activity plan will be signed off by all parties. Between June 2012 and September 2012 the PCT, working with LA's will complete all preparatory paperwork for the consultation. This will include a final consultation HR Plan and a detailed communication documentation for delivery of a transparent Consultation. Consultation with Public Health Staff will start no later than 1st October 2012 and is expected to last for 90 days. A final milestone and key activity plan is expected to be in place by end of June 2012 or shortly after the new structure is agreed, formal and final agreement of the structure will be subject to the approval of UA Cabinets.

In preparation during March – June 2012 the following activities will be undertaken.

- Quarterly Public Health Staff Mapping exercise;
- Assessment of current skills and abilities held within the Cluster Public Health Departments;
- Draft an impact assessment with resolution plans for PCT during transition period;
- Start staff formal communications & engagement activities which will involve an organic Q & A document, staff briefing and support during 1:1 for staff;
- Draft HR Transition Plan with detailed milestones and activities that will be delivered;
- Set up of HR/workforce work stream.

Transition process

Once we have clarity on the design of the organisation we will be able to move forward with the process which includes but is not limited to the following steps:

- Finalise Consultation & Communication milestone and key activity plan.Identification of the staff group(s) involved;
- Develop an agreed set of staff values for the new structure.Identification of the skill sets that will be required for the functions transferring Development of the detailed Employer Liability (TUPE);
- Developing and baselining the future core skills mix, which will also inform a gap analysis when assessed against current skill mix ;
- Developing a clear understanding of the new structure and where it will sit within local government;
- Presentation to and approval by Cabinet(s) of the organisational model;
- Developing and baselining the future core skills mix, which will also inform a gap analysis when assessed against current skill mix ;
- Presentation to and approval by cabinet of the size and running costs of the final organisational structure;
- Prepare consultation documentation and communication plans;
- Informing Unions about the proposed organisational structure across the Cluster and Local Authorities;
- Assessment of consultation team members will be made against an agreed set of skills and competencies required to support staff through a change process; and their understanding and ability to work within the overall PH transition framework, communications policies and governance;

- Work with Occupational Health departments (LA & PCT) to ensure the wellbeing of staff is monitored and that staff receive the appropriate support;
- Advance notification of staff consultation period;
- Consultation period;
- Organise and agree information and data to be transferred and method of transfer.
- Agree the process for staff transfer, pension, general PAYE logistics;
- Develop and agree the accommodation requirements;
- Procurement/Relocation of any additional logistical requirements;
- Scheduling of LA inductions

13. IM&T

Soft - Data/Intelligence

Detailed and accurate information about health and wellbeing needs of the population is at the heart of the Health and Social Care bill. It is an essential requirement for local authorities, CCGs and NHS organisations in order to meet their statutory responsibilities. The transfer of Public Health information services and their integration with local government so that the sum is greater than the parts is a key part of the Transition Plan.This part of the project will, to some extent, depend on the Public Health Staffing model adopted by each Local Council

" The Government has set out a new vision for the leadership and delivery of health and care services. This includes building upon progress with establishing JSNAs as a fundamental part of the planning and commissioning cycle at a local level. Central to this vision is that decisions about services should be made as locally as possible, involving people who use them and communities to the maximum degree. The positioning of JSNAs and Joint Health and Wellbeing Strategies within health and wellbeing boards underpin this vision." JSNA Draft Guidance, Dept Health 2011

Development and delivery of Public Health programmes, projects and interventions is heavily dependent on the supply of detailed accurate health informatics. This data and intelligence is used to identify the demographic health issues that are impacting on the local community, from this the programmes, projects and public health initiatives, of varying duration and size and complexity, are developed

Much of the intelligence relied on by Public Health is sourced from either the NHS Information Centre (NHS IC) or from external agencies such as the HPA, WHO, etc,etc

Fig 5 below describes some of the key sources of data and intelligence that Public Health rely on.

Some sources of data/intelligence are accessed via NHS accounts or require an N3 Server connection in order to access the data direct. Other sources of intelligence used by the Public Health function comes from external agencies and this is likely to be less problematic in transferring access to local authorities.

The IM&T Working Group will establish a process and evaluation criteria to review all sources of data/intelligence and the service level agreements that relate to them where applicable.(see Appendix 3 for Remit and Terms of Reference for Information Management and Technology work stream.

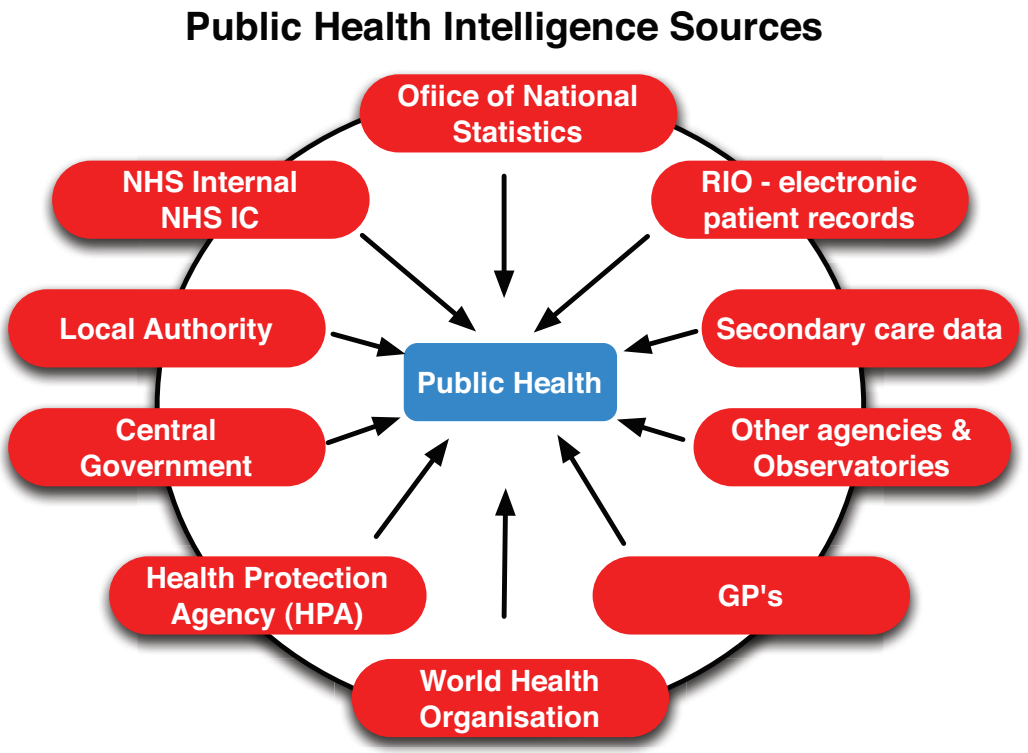

Fig 5 - High level data and intelligence map for Public Health

Hardware and Systems

Depending on the type of data and the source of the data/intelligence that will be used by the public health function when it transfers will determine the requirements around hardware and systems.

In a number of cases the data and intelligence used by PH is supplied from an external source/provider. The IM&T Working Group will review the sources and, where they exist, the service level agreements to ensure that the flow of information, data and intelligence continues during both the shadow year and when PH functions transfer by April 1st 2013.

The IM&T working group will review the systems of the sender organisation and the receiver organisation to establish whether the respective systems can communicate and if they have the compatibility to:

a. Export and Import the data;

b. Store the data;

c. Manipulate the data.

The system review will be based on whether LA's are going to have to produce the data/ intelligence or whether they will just be the recipient. The two scenarios may conclude that different solutions are required which may have an impact on any costs incurred.

Transition process

- Working Group is convened
- Audit of all intelligence sources to determine options for sourcing, current service level agreement status;
- Review of future storage status of data and intelligence streams - i.e remain outsourced , or bring in house;
- Audit of all hardware and systems in use on the PCT sites and the LA sites;
  - Are they compatible with each other, can they communicate?
  - Will we need to build new links/couplings?
  - Do we need to build separate links to other external agencies i.e. HPA?
- Determine current suitability and "fit for purpose" going forward;
- Undertake a cost impact analysis;
- If required, develop outline business case (OBC) to support and approve investment;
- Report to Transition Board.

14. Commissioning Intentions 2012/13.

PCT's commence work on commissioning intentions around November with a view to having contracts in place by April 1st. Therefore the PCT currently has discretion and autonomy around commissioning for services to be delivered in the 2012/13 financial year.

Notwithstanding this, the LA's need to have an in-depth understanding of what services are being commissioned, at what cost and how the outcomes will be measured. They also need to be familiar with the contractual implications and what liabilities will be transferred

and carried over into 2013/14. More importantly all contractual commitments should be within the approved base budget.

The PCT, specifically the DPH's, have put in place a group that will oversee the development and delivery of the sender organisations responsibilities under the transition requirements.

Berkshire UA's and the PCT already collaborate in a number of areas around PH so we are proposing that we establish a formal commissioning review panel that will address the elements mentioned previously but also will form one level of a commissioning assurance function going forward.

This panel will not be charged with determining strategy or policy for the county but will be a delivery focussed group that reviews and approves programmes, projects and initiatives from a commercial viability perspective i.e. is it affordable within the budget we have been allocated, is it evidence based, is it deliverable within the stated timescale, is it appropriately resourced, does it have Key Performance Indicator's (KPI's) and can the outcomes be effectively measured, does it fit with the stated strategic direction of the councils?.

The review panel will be jointly resourced by the LA's and the PCT during the shadow year to provide a balanced approach and ensure that it has appropriate public health; expertise. We are also proposing that we invite a local GP or other suitable clinician to sit on the panel to provide additional clinical input. This may be a new structure or it could be a combination of existing structures across the various organisations.

Provisional service review panel

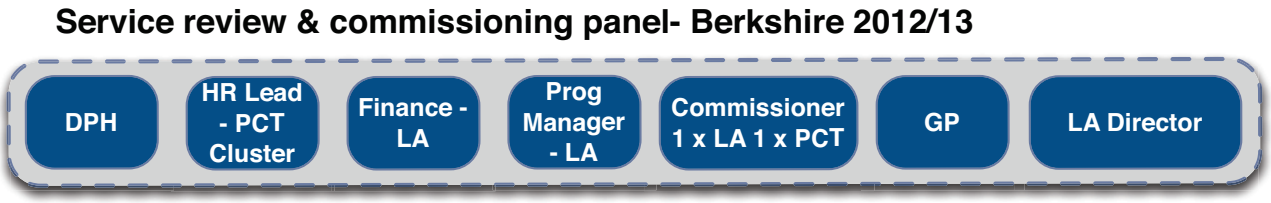

Fig 4 - Proposed service review and commissioning panel

Transition Process

- Agree the membership of the panel;
- Develop, agree and publish the Terms of Reference (ToR's) for the panel;
- Agree a set of common review templates and distribute to function/project leads;
- Develop and publish the schedule of reviews;

It is likely that the reviews will be informed by the development of outline business cases that should include the necessary options appraisals. Once approved, or rejected, for continuation or commissioning the business case will go back to the function lead for continuation/commissioning or decommissioning.

15. Delivery Plan 2012/13.

Maintenance of high quality PH quality delivery of Public Health programmes and services will be a key feature during the transition which will be monitored by Council Scrutiny arrangements and Health and Wellbeing Boards.

Berkshire UA's will work with the PCT to understand the contents and complexity of the delivery requirements for 2012/13. Since commissioning intentions are usually baselined in November though to January it is likely that most of the programmes and projects are well advanced in terms of initiation so the Berkshire UA's may not be able to have too much influence the budgets that have already been approved, for those projects and initiatives that have not already initiated, however there may be an opportunity jointly review to see if efficiency opportunities exist in terms of doing things differently or collaboratively across borders and organisations.

The pressures that the transition is likely to place on the personnel in both organisations as a result of increased workloads on top of people's day jobs clearly identifies the 2012/13 delivery plan as a key risk. There will not be any relaxing of PH target outcomes so it is critical that the PCT and the LA(s) work closely together to pool resources to support the delivery plan.

Therefore it would seem a logical approach to use the proposed Review Panel to lead this work stream as well.

In line with good practice we will seek to develop a structured approach to delivery based on best practice project management. Because as previously stated the extra stresses may prevent much of the plan being delivered under normal business as usual approaches.

This approach, working closely with the PCT PH will lead to a natural and familiar approach to delivery when PH transfers and delivery of the 2013/14 plan commences.

Transition process

PCT to evaluate their project management capability and capacity to lead and support the development of the following:

- an overall programme plan for PH;
- a project brief;

- risk log;
- KPI's
- an investment plan;
- a milestone plan;

There will be a clear reporting structure to track progress against forecast, report risk and issues, measure outcomes against the original plan, a feed into the LA reporting architecture that goes to the Shadow Health and Wellbeing Board(s) (SHWBB), Corporate Management Teams and Executive Boards (Cabinet) as appropriate.

Other key priorities for 2012/13 include:

- Development of the Health and Wellbeing Strategy[7];
- Development of the Health and Wellbeing Board that will assume it's duties on the 31st of March 2013
- Development of the JSNA that will inform the 2013/14 commissioning intentions and delivery plan

16. Commissioning Intentions for 2013/14

The commissioning intentions for 2013/13 will be dependent on a range of issues, requiring input from a number and variety of different sources.

Amendments to the Health and Social Care Bill will, once it has completed it's passage through Parliament, lead to additional duties and accountabilities being placed on the LA's and their PH departments. One of these will be the requirement for PH departments to continue to provide advice and guidance to CCG's & NHS Commissioners(see section 10).

Being a year of significant and complex change it would make sense to develop a plan that brings forward the timetable for developing and communicating commissioning intentions for 2013/14. This is not an unreasonable approach, it is unlikely that unless we experience major climate change, pandemics, epidemics or major disasters in the county that our health priorities are likely to change significantly in a couple of months[8].

Transition process

As part of transition planning the sender organisation working group will, in collaboration with the LA's and CCG's, develop and agree a revised commissioning timetable for 2013/14;

[7] A joint undertaking with the PCT and CCG's

[8] This approach will necessitate an acceleration of the JSNA production timetable

As part of the sub-programme a detailed project plan will be developed within the SoE that will deliver the revised timetable.

17. Delivery plan 2013/14

The delivery plan for 2013/14 will be developed from the commissioning intentions for 2013/14.

Once these have been developed the delivery plan will be baselined using similar processes and methodology to that which we will use for the 2012/13 delivery plan – using a programme management approach to delivery whilst the new arrangements for the PH functions bed in.

18. Emergency Planning & Health Protection

The Public Health department has a clear duty and responsibility to provide leadership and expertise in the area of outbreak management for infectious diseases such as influenza pandemics as seen in 2009.

In some health economies the Public Health Department often co-ordinates the PCT's overall emergency planning functions. This includes co-ordinating the health response to major incidents such as rail disasters, major road traffic accidents and other such events.

Under the current PCT Cluster arrangements the responsibility for Emergency Planning sits with the Assistant Director Public Health (Health Protection) who is responsible to the Cluster Chief Executive via the DPH's

With the impending transfer of public health responsibilities there is a need to ensure that robust arrangements and processes are put in place to continue to be able to provide this expertise and support.

Local authorities have emergency planning responsibilities and they have expertise in a number of areas of disaster planning. However there is an admission that the focus of much of the emergency planning undertaken in local authorities tends to be focussed on the recovery elements of a disaster as opposed to prevention, which is usually the preserve of other departments.

However, the transfer of Public Health into Local Councils does provide an opportunity to review how Emergency Planning is delivered.

Transition planning process

This being the case we are proposing that an additional working group is established to review:

- what impact the transition will have on the health economy's ability to respond to health focussed events and incidents;
- how effective are the current arrangements (are plans up to date?);
- what type of expertise is required in order to transfer capability to SBC;
- what the resource requirement might be;
- is it affordable;
- what other options are available - i.e. a shared service across multiple LA's

Due to the current workload described by the Emergency Planning Officer as a result of London 2012 we propose that this work stream is led by the Programme Manager for PH transition at Slough Borough Council.

19. Commissioning arrangements

The constraints around the shape of destination organisational model are providing a challenge when developing the commissioning arrangements post March 2013. The LA already has commissioning capability and capacity, some of which will naturally integrate some the PH commissioning functions.

Further work is required to determine exactly what the final governance arrangements will be for commissioning PH services and programmes. It is clear that we will need to involve a number of bodies and individual from key areas across the health economy to identify the criteria for commissioning, the sources of information and intelligence that will be used and who will lead.

20. Provision of Healthcare Public Health Advice to Clinical Commissioning Groups

The Government are planning, by way of an Act of Parliament, to make it incumbent on LA's to provide a core service of PH expertise and advice to NHS Commissioners (this includes CCG's and NHS CSU's. This is expected to be entered into legislation in time for the PH transition and Commissioning transition on the 1st April 2013.

DH have issued guidance to help LA's and PCT's to define what the offer should be and what resource capacity is likely to be required. The detailed specialist advice/inputs and the expected outputs are contained in Appendix 1 of this document

The following list represent the key stages in the commissioning cycle where LA/PH support is required:

- Strategic planning - Assessing Needs;

- Reviewing Service Provision;
- Deciding Priorities;
- Procuring Services;
- Designing shape and structure of supply/suppliers;
- Planning capacity and managing demand;
- Evaluation
    - Supporting patient choice
    - Managing performance
    - Seeking public and patient views

Much of what is included in the “core offer” are functions that PH already deliver to various audiences so the main consideration is how much time and resource will need to be provided to deliver this support to the new recipients.

Transition process

- Review against current practice and provisions in LA and PCT;
- Review against proposed organisation structure[9];
- Identify gaps and analyse potential solutions;
- Options appraisal of potential solutions;
- Report to Transition board;
- Transition Board communicates preferred option and approves .

21. Key transition plan dates

This is the high level copy of the SoE which is attached with this document in MS Project form. This table identifies activity groups only not specific detailed activities.

Description	Task or Milestone	Start date	End date
Submission of 2nd draft transition plan	Milestone	16th March 2012	16th March 2012
Staff Quarterly staff mapping	Task	14th May	1st June

[9] Constrained currently by lack of clarity around final structure of PH in Berkshire

Description	Task or Milestone	Start date	End date
Assessment of current skills mix	Task	1st April 2012	1st June 2012
Establishment of HR/Workforce work stream	Milestone		16th April 2012
Draft HR Transition plan	Task	1st March 2012	1st June 2012
PH Staff formal comms & engagement activity	Task	20th March 2012	31st March 2013
Presentation of the structure of the DPH for Berkshire to Cabinet(s)	Milestone		July 2012
Start of staff consultation	Task	Oct 2012	December 2012
Implementation of the workforce plan	Task	Jan 2013	March 2013
Detailed cost breakdown of staff and resources is developed	Milestone		30th March 2012
Develop detailed breakdown of financial resources/ contracts and assumptions used to arrive at the 2010/11 allocations	Task	9th March 2012	30th March 2012
Initial plan is developed	Milestone		11th May 2012

Description	Task or Milestone	Start date	End date
Revised Finance and Commissioning proposal	Milestone		1st June
Final report and options for approval delivered to the Transition Board	Milestone		June Board
Approvals process	Task	June	Aug 30th
Stress testing transition plans to provide assurance to SHA and DH that processes and resources are in place to deliver mandatory PH initiatives	Milestone		October 2012

22. Appendices

Appendix I - Core offer to Commissioners

Stages in the commissioning cycle	Core Specialist Healthcare Public Health Service	Examples of Outputs
Strategic planning - Assessing Needs	Using and interpreting data to assess the population's health, this may include	
	– Supporting CCGs to make inputs to the Joint Strategic Needs Assessment and to use it in their commissioning plans.	JSNA and joint health and wellbeing strategy with clear links to CCG commissioning plans
	- Development and interpretation of neighbourhood/locality/ practice health profiles, in collaboration with CCGs and local authorities	Neighbourhood/locality /practice health profiles, with commissioning recommendations
	- Providing specialist public health input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality	Clinical commissioners supported to use health related datasets to inform commissioning
	- Health needs assessments (HNA) for particular conditions/ disease groups – including use of epidemiological skills to assess the range of interventions from primary/ secondary prevention through to specialised clinical procedures.	HNA for condition/disease group with intervention / commissioning recommendations

Stages in the commissioning cycle	Core Specialist Healthcare Public Health Service	Examples of Outputs
Reviewing Service Provision	- Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups, including the protected population characteristics covered by the Equality Duty	Vulnerable and target populations clearly identified; PH recommendations on commissioning to meet health needs and address inequalities.
	-- Support to CCGs on interpreting and understanding data on clinical variation in both primary and secondary care. Includes PH support to discussions with primary and secondary care clinicians if requested	PH recommendations on reducing inappropriate variation
	- PH support and advice to CCGs on appropriate service review methodology	PH advice as appropriate

Stages in the commissioning cycle	Core Specialist Healthcare Public Health Service	Examples of Outputs
Deciding Priorities	- - Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence-base for the setting of priorities	Review of programme budget data Review of local spend / outcome profile
	- Advising CCGs on prioritisation processes - governance and best practice.	Agreed CCG prioritisation process
	- Work with CCGs to identify areas for disinvestment and enable the relative value of competing demands to be assessed	Clear outputs from CCG prioritisation
	- Critically appraising the evidence to support development of clinical prioritisation policies for both populations and individuals	Clinical prioritisation policies based on appraised evidence for both populations and individuals.
	- Horizon scanning: identifying likely impact of new NICE guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation	PH advice to clinical commissioners on likely impacts of new technologies and innovations

Stages in the commissioning cycle	Core Specialist Healthcare Public Health Service	Examples of Outputs
Procuring Services	- Taking into account the particular characteristics of a specified population:	
Designing shape and structure of supply	Providing PH specialist advice on the effectiveness of interventions, including clinical and cost-effectiveness (for both commissioning and de-commissioning)	PH Advice on focussing commissioning on effective/ cost effective services
	Providing PH specialist advice on appropriate service review methodology	
	Providing PH specialist advice on medicines management	PH advice to medicines management eg ensuring appropriate prescribing policies
Planning capacity and managing demand	- Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes	PH advice on development of care pathways/ specifications/
	PH advice on modelling of the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs	PH advice on development of care pathways/ specifications/ quality indicators

Stages in the commissioning cycle	Core Specialist Healthcare Public Health Service	Examples of Outputs
Monitoring and Evaluation Supporting patient choice Managing performance Seeking public and patient views	- PH advice on the design of monitoring and evaluation frameworks, and establishing and evaluating indicators and benchmarks to map service performance	Clear monitoring and evaluation framework for new intervention/ service PH recommendations to improve quality, outcomes and best use of resources
	Working with clinicians and drawing on comparative clinical information to understand the relationship between patient needs, clinical performance and wider quality and financial outcomes	
	Providing the necessary skills and knowledge, and population relevant health service intelligence to carry out Health Equity Audits and to advise on Health Impact Assessment and meeting the public sector equality duty	Health equity audits. PH advice on Health Impact Assessments and meeting the public sector equality duty.
	Interpreting service data outputs, including clinical outputs	PH advice on use of service data outputs.

Appendix II - Finance and Commissioning Work stream Terms of Reference (ToR's)

Introduction

The Health and Social Care Bill will bring in the changes set out in the White Paper Healthy Lives, Healthy People: Our strategy for public health in England. This briefing paper sets out the work of the Finance and Commissioning Sub Group and seeks a formalisation of how the Transition Board wishes this work stream to progress the various issues.

Part a - Process

Proposed Remit of the Group:

- To identify the Public Health baseline budget transferring to the local authority, to include the identification of any non-recurring funding, for both sides of the county. This information will be produced in a similar format (for east and west), identifying where there are specific differences in terms of the services being delivered;
- To identify the potential contractual commitments, risks associated with these contracts and any potential financial shortfalls against the baseline;
- To define how the funding being transferred to the local authorities is likely to meet the outcomes of the Health and Social Care Bill (mandatory and non-mandatory);
- To identify for the Board possible options to meet the set-out objectives (from the Berks CEOs) in terms of structure (working with the HR work stream) and a smooth transfer of services (safe delivery of services) and potential delivery options (i.e. pooled budgets, lead authority etc);
- To identify potential governance and risks associated with the transfer. Specifically, once the overall baseline and contracts are identified, what approvals will be required by each local authority and timings for this;
- To identify how the current proposed Department of Health allocation of budgets to individual Councils may impact the effective transfer of the Public Health function. (that is will the funding covered the commitments in the various local authority areas – assuming it is possible to identify the splits of activity on a local authority basis).

Membership

Overview: Phase 1 - the finance and commissioning work stream will act as a single group until we have clearly established the baseline of finance and the contracts that are available to meet the outcomes of the current public health service, this will be achieved by the PCT, Public Health East and West and each local authority nominating a senior Finance and Commissioning lead to participate in the working group.

To deliver the work stream it is suggested (initially) that a small sub group works directly with the PCT Finance/Commissioning/Public Health team and then reports back initially to an East/West work stream (this is only due to the way that services are commissioned and budgeted differently by the PCT on the two sides of the County). This would be two or three people from the sender and receiver organisations as a larger group will not be able to get into the real detail. This will be led from the receiver organisation for the county by Robert Poole (Reading).

Phase 2 - Once we have a clear baseline then:

- Create two sub streams, one to concentrate on the financial details and one to examine in detail the contractual and commissioning issues. It will be essential that these two groups continue to work closely and consolidate their work to provide the overall final service transfer offer;
- Consideration will need to be given to how this is then managed either on the current east/west basis or another option (i.e. county wide). This will include options around pooled budgets etc.

Working Arrangements:

- The working group will nominate joint lead coordinators from the sender and receiver organisations;
- Establish project plan for implementation of work programme;
- Liaise with other work stream groups as necessary through Transition Programme Steering Group.

Reporting Arrangements:

- Regular reporting schedule to Transition Programme Steering Group;
- Reporting, informing and advising as necessary West and East Berks implementation work streams, and working groups where established in each of the sender and receiver organisations.

Part B - Progress and Issues

Overview and Current tasks

The current financial and service information was produced using/following Department of Health guidance on the actual public health spend for 2010/11, (which was then used to produce the draft allocations from the DH to individual Councils in February), however it is now widely acknowledged that there are issues in how this information has been produced across the country due to different interpretations of the guidance, difficulties with availability of data (financial and activity) and due to the limited time available for this work to be undertaken. The “recommendation” currently coming from the Department is that

local Councils and their NHS partners should be working together to review the baseline information and to seek to identify and agree solutions for any specific issues.

Following the Berkshire CEO meeting and the West Berkshire Workshop, a detailed discussion was held with the PCT finance lead around the above issues and how a revised baseline could be established.

- A detailed breakdown is produced of the costs/budgets of the staff affected by the transfer (this detailed data will need to be restricted to a small group due to confidentiality issues) to support the HR work stream in organisation design options. Attached to this will need to be the assumptions around the overhead allocations. (Target date 30th of March);
- A breakdown is produced (in a similar format for both the East and West) that provides a detailed breakdown of the financial resources/main contracts and services and assumptions used to arrive at the resource allocation for 2010/11. (There is an acceptance that in arriving at this figure there are a number of assumptions due to the difficulties in extracting data from the main NHS provider block contracts) (Target date 30th March). This would then be presented to the two working groups w/c 16th April and then back into the various councils (possible H&WBs);
- The above data is then re-based to the 2011/12 outturn, this would then also pick up contracts which are outside of this data collection (e.g. where specific new schemes have been agreed for 2012/13) for discussions with the CCGs around continuing this funding into 2013/14. Establishing this revised baseline will enable the two finance and contract sub groups to commence their work in developing the options for the transfer;
- Targets:
    - Initial draft/plan Friday 11th May 2012;
    - Revised Finance and Commissioning proposal Friday 1st June;
    - Final report and options for approval to the Transformation Board early June to then allow for further discussions with PCT/CCGs and individual Council approval processes June-August. This would allow for implementation process to happen in qtrs 3 and 4 (at this stage as it is unclear what these will be, but could be section 75 etc, but could need an amount of time to establish and have in place for the 1st April 2013).

The above is a rough guide to timescales and will require some further work if this basis is approved. It currently has not factored-in any commissioning activities which may need to happen during 2012/13 or any work that may need to happen with any NHS shared service changes.

It is also at this stage not possible to comment on any impact of formula allocation proposals or the impact of the Department of Health review on dealing with transitional costs. The work of this work stream will need to take account of these possible issues and they will be factored-in as and when further details become available.

Key Decisions - Approved in the principle by the Transition Board on the 13th March 2012

Appendix III - Information Management and Technology Work stream -Terms of Reference

Remit

- To identify the Public Health management information functions transferring to the local authority;
- To define the management information responsibilities of local authorities required to promote the values, principles and outcomes of the Health and Social Care Bill;
- To provide guidance on the development of effective;
    - Joint Strategic Needs Assessment;
    - Joint Health and Wellbeing Strategies;
    - Joint Health and Wellbeing Strategies;
    - Alignment and avoidance of duplication in strategic plans intended to:

Promote health and wellbeing;
Improve health outcomes;
Reduce health inequalities;
Promote community safety

- To identify information governance and data security requirements in relation to protection of data and information transfer;
- To identify information and technology requirement to enable communication and information exchange between NHS and local government information systems.

Membership:

PCT, Public Health East and West, each local authority will nominate a senior management information lead to participate in the working group.

(Note that organisations might need to identify lead person with expertise in information and another with technical expertise in order to support the scope of this work stream. However, only one person from each organisation be nominated for membership of the work stream.)

Working Arrangements:

- The working group will nominate joint lead coordinators from the sender and receiver organisations;
- Establish project plan for implementation of work programme;
- Liaise with other work stream groups as necessary through Transition Programme Steering Group.

Reporting Arrangements:

- Regular reporting schedule to Transition Programme Steering Group;
- Reporting, informing and advising as necessary West and East Berks implementation work streams, and working groups where established in each of the sender and receiver organisations.

Heatherwood and Wexham Park NHS Foundation Trust
Ascot Birthing Centre – Trust Board Decision Paper

23 February 2012

Introduction

This paper provides an update on the current position of the Ascot Birthing Centre (ABC) and sets out the issues in relation to the long term sustainability of the unit.

Context

Up to 2008 Heatherwood Hospital (HH) had a full obstetric unit able to provide full maternity care to women who chose to give birth from that site. As the quality and safety of Obstetric Services improved, national guidance increased the number of hours any obstetric unit needed to provide full Obstetrician cover (Consultant). These changes made it impossible for the Trust to provide 2 fully functional obstetric units (1 at Wexham Park and 1 at Heatherwood) and Heatherwood became a standalone midwifery led unit (MLU) offering a maternity service to those Mothers considered to be very low risk as rapid emergency Consultant led intervention could not be provided. Maternity standards continue to improve nationally and the latest guidance requires a further extension to the hours of Obstetric cover required up to 98 hours per week. This means the Trust will be recruiting a further 2 Consultant Obstetricians to ensure the unit at Wexham remains fully compliant.

In September 2011 the Trust had to take an emergency decision to close the MLU due to unprecedented levels of staff sickness that occurred in addition to planned maternity leave meaning the Trust could not provide the midwife cover required to provide the service in the ABC. Women could continue to receive their ante natal and post natal care from ABC staff but are offered alternative choices for the actual birth that include homebirth, the ISIS birthing centre (a MLU) on the Wexham Park site, the Labour Ward at Wexham Park, or transferring to a neighbouring Trust, the Royal Berkshire, Ashford and St Peter's or Frimley Park.

The ABC remains closed for birthing and the Board need to decide if it considers the centre should be re-opened, or that it should recommend to the Commissioners (NHS Berkshire and the Clinical Commissioning Groups)[1] that it be closed permanently.

[1] NHS Services are "bought" on behalf of the population by Primary Care Trusts from NHS Hospital providers. Commissioners determine what services should be provided and then ask, through a contract, the hospital to deliver the service. In Berkshire the commissioner for the service is NHS Berkshire who take the final decision about whether a service should be provided.

The Ascot Birthing Centre

The ABC is a standalone maternity unit. This means it is not on the same site as any major acute hospital that has emergency facilities. As a standalone facility it can only offer care to women who are expected to have very low risk deliveries. Any Mother with a higher level of risk is advised to deliver in one of the major acute hospitals that are within the area (mentioned above). If a low risk Mother is within the ABC and starts to show signs of developing complications such as abnormal fetal heartbeat, stained liquor or slow progress with labour they must be transferred to one of those acute hospitals.

In 2010 there were 294 births in the ABC, 5.39% of the total births in the Trust (5069 at Wexham). In 2011 there were 210 births in the ABC. Of those 210, 45 women needed to be transferred in labour to the Maternity unit at Wexham Park.

Staffing

The ABC is staffed by the Midwives that provide community midwifery services to Bracknell, Ascot, Windsor and Maidenhead. The total staffing allocation is 16.7 wte[2] posts, primarily all qualified midwives but with some midwifery support posts. The staff provide all the ante and post natal care to women in that area and offer the birthing service.

At the time of the emergency closure there was unexpected sickness amongst the staff and maternity leave. Since then the Trust has transferred a further 3.8 wte midwives to the community service; however some staff have resigned and others remain on sick leave resulting in the team still working on less than 60% capacity. This means the Trust can not reopen the birthing facility as it simply can not cover the staffing demand at present. Staff turnover and the national shortage of Midwives mean that it is very difficult to predict if the Trust will be able to fill all vacant posts and maintain staffing once fully established.

[2] WTE = whole time equivalent (37.5 hours) it is possible to have more people that posts as there may be part time staff within the team.

Costs

The unit is staffed by the Community Midwives and costs £800,000 a year. Those costs include the community service together with the birthing service. The Trust receives £1,639 per birth at the ABC with the remainder of the costs within a single block payment. If we are not offering births we will not incur costs and therefore the financial effect on the Trust is neutral.

Further Issues

Last August The Bracknell and Ascot Clinical Commissioning Group (CCG[3]) decided that they wish their community midwifery service to be provided by Frimley Park Hospital and the service is due to move from us to Frimley Park within the next 2 months. That means that we will no longer be providing community midwifery services to women from those GPs. This will result in a far smaller community midwifery team providing for the Windsor and Maidenhead area and therefore a smaller number of midwives available to man the ABC and if the ABC were to reopen it would provide for less births as that population would be far more likely to use Frimley Park for their delivery given their ante and post natal care would come from Frimley Park midwives. It is difficult to assess the impact on the deliveries within the ABC, however, in 2010/11 the Trust had 288 women from those areas deliver in our care. Making an assumption that 5% of all births in the Trust were within the ABC, 5% of 288 is 14, so the ABC would lose a further 14 births a year taking the numbers to below 200. However the main issue is that we will only have a very small community midwifery team to cover Windsor and Maidenhead and a team of 16 has proven too small to provide continuity and therefore the problem will be worse in a smaller team.

The funding we will lose in the transfer is £250,000 from the block we currently get and £30,000 from the 14 births that we may expect in the ABC. We will lose all costs so the financial effect will be neutral.

The funding we should get to provide the community midwifery service in Windsor and Maidenhead will be approximately £150,000 to provide community midwifery. This would not provide sufficient

[3] A Clinical Commissioning Group is a group of GP practices who work together to determine how best to ensure their patients receive services from the providers they choose. The Bracknell and Ascot CCG includes all the GP practices in Bracknell with the Green meadows, Kings Corner and Magnolia House Practices in Ascot covering a population of 149,000.

funds to ensure that a sustainable service could be provided in the ABC as the critical mass of midwives would be very small.

Midwife Led Maternity Units

As far as is possible to determine there are 47 standalone MLUs in the country[4]. There are others in our region in Oxford and Hampshire. The Oxford units are provided for in 2 ways, one on a rotational scheme from the John Radcliffe Hospital and the other through midwives on call from home. Midwife recruitment is not an issue.

In Hampshire the New Forest unit is fully staffed 24 hours a day with approximately 450 births and was developed as the consolidation of 3 smaller MLUs. There is a further centre in Andover (200 births) that also has its service currently suspended due to recruitment issues.

A key feature of success seems to sufficient numbers of births to have 24 hour midwifery or to have a large pool of Midwives to call upon with no recruitment issues.

Safety

There is no evidence that suggests standalone MLUs are any less safe that home births, therefore, as long as women understand the risk is the same there would be no reason to close the unit on safety grounds.

- It is generally acknowledged that there is no difference in safety between a home birth and a birth in a MLU. The available information suggests that there is a higher likelihood of a normal birth with less intervention among women who give birth at home or in a MLU. It does not make a distinction between standalone MLUs and those on the sites of major acute hospitals.
- The issues of safety are the same for home births and standalone MLUs. Pool births, pain relief options and emergency equipment are of the same type whether at home or in a standalone unit and can be offered at home or in the MLU.

[4] Conservative Party FOI Request, March 2008

- If a transfer due to complications is required, again this is the same for home birth or standalone MLU and may involve an ambulance and Midwife escort.

- If the MLU is on the same site as a major acute hospital (as it is with the ISIS centre at Wexham Park) if there are complications transfer may be as simple as moving a bed from one room to another, or may mean bringing additional expertise into the MLU very rapidly.

Considerations

- The ABC is a standalone MLU with a small and decreasing number of births due to personal choice as women choose other venues for delivery and because the community midwifery services for Bracknell and some parts of Ascot will no longer be provided by the Trust. Women are most likely to choose to give birth where their community midwives can follow them through and so it is likely that the vast majority of women from that area will choose a home birth or Frimley Park as their venue.

- The move of service provider to Frimley Park leaves the Trust providing a midwifery service only to Windsor and Maidenhead from the Heatherwood site resulting in a very small number of midwives operating in the area.

- The Trust does experience difficulty in recruiting Midwives, much like many in the country as there is a recognised national shortage. The issue is about a dependable, sustainable service. Can the Trust guarantee that it can offer a standalone MLU in Ascot for the foreseeable future?

- The Trust can and does offer women in our area a number of choices for the place of birth that include their own home, MLU (the ISIS Centre at Wexham), and full Labour Ward, and there are other Trusts that offer maternity services very close to the area.. Those choices are all available in 15 to 40 minutes travel time from the area depending on which hospital may be chosen (not assuming public transport is used as this would be unlikely for a woman in labour).

- There is no evidence that patient safety is any different at home to a standalone MLU and the Trust will continue to offer home births for the population it will serve in the area.

- 23% of women who laboured in the ABC needed transfer to an acute setting and the Trust's Obstetricians believe a standalone MLU creates unnecessary clinical risk through the need to transfer.

- Informal discussion with the Bracknell and Ascot GPs suggests they support the view that the Trust cannot provide a sustainable stand alone MLU.

- There is a softer and subjective side to this point that should be considered. Women are properly informed that the ABC is no safer than a home birth and choose it on that basis. However, some may still think that it provides a higher level of safety than home simply by the fact it is in a building called a "hospital". This may mean that some that are transferred are shocked that it happens and it may cause even greater anxiety at a time of stress.

Options

There are 2 options:

1. Re-open the ABC

2. Permanently close the ABC

Option 1

To deliver this option the Board must conclude that it can guarantee a dependable, sustainable service.

Option 2

To deliver this option the Trust must recommend to the Commissioners that it does not consider it can provide a dependable, sustainable service.

Philippa Slinger

Chief Executive

HEALTH OVERVIEW AND SCRUTINY PANEL
26 APRIL 2012

WORKING GROUPS UPDATE REPORT
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report provides an update on the Working Groups of the Health Overview and Scrutiny Panel.

2 RECOMMENDATIONS

2.1 That the Health Overview and Scrutiny Panel notes the progress achieved to date by the Panel's Working Groups.

3 SUPPORTING INFORMATION

Health Reforms

3.1 The Working Group comprises Councillors Finch (Lead Member), Mrs Angell, Mrs Barnard and Virgo. It has been formed to monitor the implementation of the major changes from the 2010 NHS White Paper and the Health and Social Care Bill, with a particular focus on the transfer of public health responsibilities to the Council. The Working Group has held two meetings to date, most recently on 17 November 2011. The Group decided to suspend further meetings of the Working Group until the legislative changes became known. With the recent enactment of the legislation, a further meeting of the Working Group will be arranged soon.

Health and Wellbeing Strategy

3.2 The Working Group comprises Councillors Virgo (Lead Member), Baily, Finch, and Mrs Temperton; and Mr Pearce. It has been formed to make an input to the Council's statutory 'Health and Wellbeing' strategy. The Working Group has held two meetings to date, most recently on 6 December 2011. The Group are likely to meet next in May to engage in the development of the new Health and Wellbeing Strategy.

'Shaping the Future' of Health Services in East Berkshire

3.3 The Chairman has decided to form a Working Group to consider the forthcoming major consultation by NHS Berkshire (Primary Care Trust) and Heatherwood & Wexham Park Hospitals Trust on 'Shaping the Future'. This is aimed at reconfiguring healthcare services in response to the changing national and local clinical priorities. The planned timetable for the consultation has been deferred by the NHS, and the Working Group has not yet been formed. Meanwhile, the Chairman and Vice Chairman have continued informal discussions with the Chairmen of the Health Scrutiny Committees for Buckinghamshire County Council, Slough BC, and RB Windsor & Maidenhead, the PCT and Heatherwood and Wexham Park Hospitals Trust on developments.

ALTERNATIVE OPTIONS CONSIDERED/ ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS/ EQUALITIES IMPACT ASSESSMENT/ STRATEGIC RISK MANAGEMENT ISSUES / OTHER OFFICERS/ CONSULTATION – Not applicable

Background Papers

None

Contact for further information

Richard Beaumont – 01344 352283
e-mail: richard.beaumont@bracknell-forest.gov.uk

TO: HEALTH OVERVIEW AND SCRUTINY PANEL
26 APRIL 2012

OVERVIEW AND SCRUTINY PROGRESS REPORT
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report highlights:

(i) Overview and Scrutiny (O&S) activity during the period September 2011 to February 2012.
(ii) Significant national and local developments in O&S.

2 RECOMMENDATIONS

2.1 To note Overview and Scrutiny activity over the period September 2011 to February 2012, set out in section 5 and Appendices 1 and 2.

2.2 To note the developments in Overview & Scrutiny set out in section 6.

3 REASONS FOR RECOMMENDATIONS

3.1 The Chief Executive has asked for a six monthly report to be produced on O&S activity.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

Health Scrutiny

5.1 Health Scrutiny Chairmen from the three East Berkshire councils together with Buckinghamshire County Council are considering resuming the Joint East Berkshire Health Overview and Scrutiny Committee, which has been formally suspended since February 2011; this would be to receive a prospective formal consultation by the Primary Care Trust (PCT) later in 2012, regarding prospectively significant changes to health services.

Overview and Scrutiny Membership

5.2 The membership of the O&S Commission and Panels was last set by Council and the Commission respectively at their annual meetings on 25 May 2011. Subsequently, the two Parent Governor and Catholic Diocese vacancies have been filled, and the vacancy of the Church of England representative remains to be filled.

Overview and Scrutiny Work Programme

5.3 The programme continues the increased focus on contributing to policy development and pre-decision scrutiny, through short reviews; with fewer major reviews reviewing important

topics in depth, over several months. The table at Appendix 1 sets out the current status of the O&S Working Groups, along with the list of completed reviews. Work is well underway to refresh the work programme for the coming civic year.

Overview and Scrutiny Commission

5.4 The O&S Commission met on 15 September, the main items being: to review the progress of a number of O&S Working Groups and their reports; the responses received to an O&S report; the quarterly performance reports; and considering the work programme and the approach to budget scrutiny. An additional meeting was arranged on 21 September to consider the Call-In of an Executive decision relating to land at Binfield. At the Commission's meeting on 24 November the main items were a presentation on the work of the Economic and Skills Development Partnership, considering the Executive responses to two O&S reports, and to review the progress of the Commission's various Working Groups. At its last meeting on 26 January, the main items included: appointment of Mrs Carol Murray as new Parent Governor Representative; considering the draft budget for 2012-13; reviewing the latest performance reports; receiving a report on Superfast Broadband; and considering the progress of Panels, Working Groups and the future O&S work programme.

5.5 The O&S Commission's next meeting is on 29 March. Meanwhile, the Commission is running two Working Groups, as described in Appendix 1. The Commission's working groups which have concluded, listed in Appendix 1, included the review of the new Medium Term Objectives; on that review the Council's Leader's letter of 21 Sept, accepting many of the recommended changes by the O&SC Working Group, said *'Executive colleagues, senior officers and I have certainly found the Working Group's views positive in helping to sharpen the document'.*

Environment, Culture and Communities O&S Panel

5.6 The Panel met on 18 October and 10 January. The main items considered at the meetings included: Quarterly Service Reports for the relevant quarters; the 2012/13 budget proposals; the Supporting People Strategy; relevant Executive Forward Plan items; briefings in respect of the Community Infrastructure Levy and the impact of the Localism Act 2011; and progress updates concerning the Borough's Local Development Framework, the re-surfacing of the A322 Bagshot Road, the energy management of the Borough's schools, proposed highway works, winter preparations and monitoring the progress of the Panel's working groups (see Appendix 1). The Panel's next meeting is on 24 April.

Health O&S Panel

5.7 The Panel met on 3 November and 2 February. The main items considered at those meetings included: receiving the views of the Member of Parliament for Bracknell on secondary health services in the locality; reviewing progress on the establishment of the new Clinical Commissioning Group; receiving presentations from the Chief Executives of South Central Ambulance Service and Frimley Park Hospital on the work of their NHS Trusts; meeting the Chief Executive of NHS Berkshire PCT on progress on the reforms to health arising from the Government's Health and Social Care Bill and the 'Shaping the Future' programme for health services in East Berkshire; monitoring the Bracknell Healthspace project; receiving briefings on the transfer of public health functions to the Council; and monitoring the progress of the Panel's Working Groups (see Appendix 1). The Panel's next meeting is on 26 April.

5.8 The work outside formal panel meetings has included the Panel Chairman attending the Royal opening of the Royal Berkshire Hospital's Brants Bridge Clinic, visiting Frimley Park Hospital, and attending various NHS seminars.

Children, Young People and Learning O&S Panel

5.9 Meetings of the Panel were held on 5 October and 18 January when it: viewed a domestic violence DVD created by the Bracknell Forest Youth Council; received the minutes of the Corporate Parenting Advisory Panel; was briefed on school places and the school admissions process, the Education Act 2011 and a Serious Case Review; and considered relevant Executive Forward Plan items, its work programme, Quarterly Service Reports for the relevant quarters, the 2012/13 budget proposals, the report of the O&S review of the Common Assessment Framework, and the 2010/11 annual reports of the Local Safeguarding Children Board, of School and Children's Centre Inspections, of the Ofsted Assessment of Children's Services and of the Independent Reviewing Officer for Children's Social Care. Future review work is described in Appendix 1. The Panel's next meeting is on 18 April.

5.10 The work outside formal Panel meetings has included some Panel members and an O&S officer meeting with OFSTED inspectors in November 2011 on the role and activities of the Panel and its working groups. OFSTED and the Care Quality Commission were inspecting safeguarding and looked after children services in Bracknell Forest and subsequently commented on O&S in the report[1] of their Inspection. The inspectors said:

> *'The council's overview and scrutiny process is outstanding and has led to a thorough and comprehensive review of safeguarding in 2011 with clear and measurable recommendations.'*
>
> *'The internal scrutiny of performance is outstanding, with strong evidence of senior managers being held to account for service quality, performance and the actions to be taken in order to meet specific targets.'*

Additionally, following the issuing of a press release on the report of the Working Group which reviewed the Common Assessment framework, a local radio station interviewed the Lead Member of the Working Group.

Adult Social Care O&S Panel

5.11 The Panel met on 11 October and 17 January. The main items considered at the meetings included: the 2010/11 Adult Safeguarding Annual Report; the Adult Social Care and Health Local Account for 2010/11; Quarterly Service Reports for the relevant quarters; the 2012/13 budget proposals; the Panel's work programme, relevant Executive Forward Plan items; briefings in respect of the Emergency Duty Team, Carers' Conference outcomes, substance misuse and Blue Badge disabled parking scheme reforms; and progress updates regarding the personalisation of Adult Social Care and the Older People's Partnership. The Panel also received a petition with 973 signatories asking for Ladybank Residential Care Home to remain open and updates on its working groups (see Appendix 1). The Panel's next meeting is on 17 April.

Other Overview and Scrutiny Issues

5.12 The O&S Annual Report for 2011-12 is being produced, and this is planned for presentation to Council on 25 April.

5.13 Responses to the feedback questionnaires on the quality of O&S reviews are summarised in Appendix 2, showing a consistently high score across the various questions posed.

[1] The report was published on 16 December 2011 and can be seen at http://www.ofsted.gov.uk/local-authorities/bracknell-forest

5.14 Quarterly review and agenda setting meetings between O&S Chairmen, Vice-Chairmen, Executive Members and Directors are taking place regularly for the Panels (every two months for the O&S Commission).

5.15 The O&S Commission Chairmen and Vice Chairmen are meeting on a regular basis to consider cross-cutting O&S issues. Their next meeting is planned for 16 April.

5.16 External networking on O&S in the last six months has included an O&S officer attending the South East Employers Local Democracy and Accountability network events; Members and an O&S officer attending an O&S public health conference; and an O&S officer attending a Home Office conference on the new Police and Crime Panels scrutiny arrangements.

6 Developments in O&S

6.1 The Government's Health and Social Care Bill, currently going through its Parliamentary stages contains some proposed changes to strengthen Health O&S provisions, and is being monitored. The governance implications of the Localism Act relating to scrutiny are under consideration by members.

6.2 Council approved the introduction of a Public Participation scheme for O&S, and this is now a standard item for all O&S meetings in public.

6.3 Member training on O&S in the period included three training events delivered by the Centre for Public Scrutiny on questioning skills, and on leadership of O&S.

6.4 The O&S Officer team pursued a number of developments, including adding O&S questions to the all-Member survey in January 2012. Of the applicable answers from respondents, 96% said they were satisfied with the support provided by officers, and 81% said they were satisfied with the training provided to members on O&S. Other development work by the O&S team included regularly delivering Corporate Induction Training on O&S; and improving the O&S pages on the Council's website. Also, the Head of O&S met the Youth Council on 26 September, at the initiative of the Executive Member for Children and Young People, to explain the role of O&S, and to explore whether the Youth Council would like to become involved.

7 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Statutory Scrutiny Officer

7.1 The monitoring of this function is carried out by the Statutory Scrutiny Officer on a quarterly basis. Good progress has been made on the agreed programme of work by Overview and Scrutiny for 2011/12. Scrutiny Panels have continued to focus on areas of importance to local residents, and the quality of the work done continues to be high.

Borough Solicitor

7.2 Nothing to add to the report.

Borough Treasurer

7.3 There are no additional financial implications arising from the recommendations in this report.

Equalities Impact Assessment

7.4 Not applicable. The report does not contain any recommendations impacting on equalities issues.

Strategic Risk Management Issues

7.5 Not applicable. The report does not contain any recommendations impacting on strategic risk management issues.

Workforce Implications

7.6 Not applicable. The report does not contain any new recommendations impacting on workforce implications.

Other Officers

7.7 Directors and lead officers are consulted on the scope of each O&S review before its commencement, and on draft O&S reports before publication.

8 CONSULTATION

Principal Groups Consulted

8.1 None.

Method of Consultation

8.2 Not applicable.

Representations Received

8.3 None.

Background Papers

Minutes and papers of meetings of the Overview and Scrutiny Commission and Panels.

Contact for further information

Victor Nicholls, Assistant Chief Executive
Victor.nicholls@bracknell-forest.gov.uk
Tel: 01344 355604

Richard Beaumont, Head of Overview & Scrutiny
Richard.beaumont@bracknell-forest.gov.uk
Tel: 01344 352283

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Appendix 1

OVERVIEW AND SCRUTINY CURRENT WORKING GROUPS – 2011/12
Position at 23 February 2012

Overview and Scrutiny Commission								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
ICT Strategy	Heydon (Lead) Angell, Ms Brown, Brunel-Walker and Gbadebo	Pat Keane	Richard Beaumont	√	Completed	√ Views given at meeting on 22 February 2012		Final strategy awaited (Note: 15 March strategy submitted)
Community Infrastructure Levy	Leake (Lead), Angell, Mrs Birch, Heydon, Virgo and Worrall	Bev Hindle	Richard Beaumont	Being drafted				First meeting held on 23 February

Health Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
New Health and Well-being Strategy	Virgo (Lead), Finch, Mrs Temperton, and Baily. Mr Pearce	Glyn Jones	Richard Beaumont	Under development	Information gathering underway			Two meetings held to date
Implementation of the major NHS reforms	Finch (Lead), Virgo, Mrs Angell and Mrs Barnard	Glyn Jones	Richard Beaumont	√	Started. On-hold pending legislation			Two meetings held to date

Environment, Culture and Communities Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Review of Highway Maintenance	Mclean (Lead), Mrs Angell, Brossard, Leake and Parish & Town Councillors: Mrs Cupper (Sandhurst), Mrs Doyle (Binfield), Kensall (Bracknell), Paxton (Winkfield) and Price (Crowthorne)	Steve Loudoun	Andrea Carr	√	Around 80% completed	Interim report issued	Response received to interim report	The working group has resumed to complete the review and will be next considering the Highways Asset Management Plan.
Member Reference Group – Commercial Sponsorship	Finnie (Lead), Brossard, Dudley, Gbadebo and Ward	Vincent Paliczka	Andrea Carr	√	Around 60% completed			To provide views and advice on prospective commercial sponsorship income.
Site Allocations Development Plan Document (SADPD)	Finnie (Lead), Mrs Angell, Brossard, Finch and McLean	Bev Hindle / Max Baker	Andrea Carr	√	Completed	Views submitted to the Executive as part of the DPD consultation.	Not applicable	Work completed and no further meetings proposed.

Public Transport Subsidies & Concessionary Fare Support	Brossard, Finnie, Gbadebo and Leake	Bev Hindle / Sue Cuthbert	Andrea Carr	Scope drafted	The first meeting will take place on 29 February 2012			Review requested as part of the 2012/13 budget proposals.

Children, Young People and Learning Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Common Assessment Framework	Mrs Birch (Lead), Mrs McCracken, Ms Hayes and Mrs Temperton. Mrs Mitchell	Sandra Davies	Richard Beaumont	√	Completed	√		Executive response awaited. Group re-forming to provide input to the Early Intervention Strategy.

Adult Social Care Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Substance Misuse	Virgo (Lead), Blatchford and Brossard	Jillian Hunt / Mira Haynes	Andrea Carr	√	Third meeting is being arranged.			Information and evidence gathering.
Modernisation of Older People's Services	Allen (Lead), Brossard, Harrison and Mrs Temperton	Mira Haynes	Andrea Carr	√	Second meeting taking place on 20 March.			Information and evidence gathering.

Completed Reviews

Publication Date	Title
December 2003	South Bracknell Schools Review
January 2004	Review of Adult Day Care Services in Bracknell Forest (Johnstone Court Day Centre & Downside Resource Centre)
May 2004	Review of Community & Voluntary Sector Grants
July 2004	Review of Community Transport Provision
April 2005	Review of Members' Information Needs
November 2005	The Management of Coronary Heart Disease
February 2006	Review of School Transfers and Performance
March 2006	Review of School Exclusions and Pupil Behaviour Policy
August 2006	Report of Tree Policy Review Group
November 2006	Anti-Social Behaviour (ASB) – Review of the ASB Strategy Implementation
January 2007	Review of Youth Provision
February 2007	Overview and Scrutiny Annual Report 2006
February 2007	Review of Library Provision
July 2007	Review of Healthcare Funding
November 2007	Review of the Council's Health and Wellbeing Strategy
December 2007	Review of the Council's Medium Term Objectives
March 2008	2007 Annual Health Check Response to the Healthcare Commission
April 2008	Overview and Scrutiny Annual Report 2007/08
May 2008	Road Traffic Casualties
August 2008	Caring for Carers
September 2008	Scrutiny of Local Area Agreement
October 2008	Street Cleaning
October 2008	English as an Additional Language in Bracknell Forest Schools
April 2009	Overview and Scrutiny Annual Report 2008/09

Publication Date	Title
April 2009	Healthcare Commission's Annual Health Check 2008/09 (letters submitted)
April 2009	Children's Centres and Extended Services in and Around Schools in Bracknell Forest
April 2009	Older People's Strategy
April 2009	Services for People with Learning Disabilities
May 2009	Housing Strategy
July 2009	Review of Waste and Recycling
July 2009	Review of Housing and Council Tax Benefits Improvement Plan
December 2009	NHS Core Standards
January 2010	Medium Term Objectives 2010/11
January 2010	Review of the Bracknell Healthspace (publication withheld to 2011)
January 2010	14-19 Years Education Provision
April 2010	Overview and Scrutiny Annual Report 2009/10
July 2010	Review of Housing and Council Tax Benefits Improvement Plan (Update)
July 2010	The Council's Response to the Severe Winter Weather
July 2010	Preparedness for Public Health Emergencies
October 2010	Safeguarding Adults in the context of Personalisation
October 2010	Review of Partnership Scrutiny
December 2010	Hospital Car Parking Charges
January 2011	Safeguarding Children and Young People
March 2011	Review of the Bracknell Healthspace (Addendum)
April 2011	Overview and Scrutiny Annual Report 2010/11
June 2011	Office Accommodation Strategy
June 2011	Plans for Sustaining Economic Prosperity
July 2011	Review of Highway Maintenance (Interim report)
September 2011	Performance Management Framework

Publication Date	Title
October 2011	Plans for Neighbourhood Engagement
October 2011	Regulation of Investigatory Powers

Appendix 2

Results of Feedback Questionnaires on Overview and Scrutiny Reports

Note – Departmental Link officers on each major Overview and Scrutiny review are asked to score the key aspects of each substantive review on a scale of 0 (Unsatisfactory) to 3 (Excellent)

	Average score for previous 15 Reviews[2]
PLANNING Were you given sufficient notice of the review?	**2.8**
Were your comments invited on the scope of the review, and was the purpose of the review explained to you?	**2.9**
CONDUCT OF REVIEW Was the review carried out in a professional and objective manner with minimum disruption?	**2.7**
Was there adequate communication between O&S and the department throughout?	**2.7**
Did the review get to the heart of the issue?	**2.7**
REPORTING Did you have an opportunity to comment on the draft report?	**2.9**
Did the report give a clear and fair presentation of the facts?	**2.5**
Were the recommendations relevant and practical?	**2.5**
How useful was this review in terms of improving the Council's performance?	**2.6**

[2] Road Traffic Casualties, Review of the Local Area Agreement, Support for Carers, Street Cleaning, Services for Adults with Learning Disabilities, English as an Additional Language in Schools, Children's Centres and Extended Services, Waste and Recycling, Older People's Strategy, Review of Housing and Council Tax Benefits Improvement Plan, 14-19 Education, Preparedness for Public Health Emergencies, Safeguarding Children, Safeguarding Adults, and the Common Assessment Framework.