Bracknell Forest Council

NOTICE OF MEETING

Health Overview and Scrutiny Panel
Thursday 27 September 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, Finch, Kensall, Mrs McCracken, Mrs Temperton, Thompson and Ms Wilson

cc: Substitute Members of the Panel

Councillors Allen, Brossard, Davison, Ms Brown and Heydon

Co-opted Representatives

Terry Pearce, Bracknell Forest Local Involvement Network

ALISON SANDERS
Director of Corporate Services

Please note there will be a private meeting for members of the Panel at 7pm in the Function Room.

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Health Overview and Scrutiny Panel
Thursday 27 September 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 14 June 2012. 1 - 8

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

   Members are requested to declare any Personal Interests 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.

   Any Member with a Disclosable Pecuniary Interest in a matter should withdraw from the meeting when the matter is under consideration and should notify the Democratic Services Officer in attendance that they are withdrawing as they have such an interest. If the Disclosable Pecuniary Interest is not entered on the register of Members interests the Monitoring Officer must be notified of the interest within 28 days.

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 in accordance with the Council's Public Participation Scheme for Overview and Scrutiny.

6. **Cardiac Arrest Survival Rates**

   To consider the South Central Ambulance Service's performance on out-of-hospital cardiac arrest survival rates. John Black, Medical Director and Keith Boyes, Operations Area Manager will be in attendance. 9 - 14

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

   Dr William Tong, Chair of the NHS Clinical Commissioning Group for Bracknell 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. Mary Purnell, Assistant Director of Commissioning, NHS Berkshire East will also be in attendance.

8. **Transfer of Public Health Functions**

To receive a progress report from the Director of Adult Social Care, Health & Housing on the transfer of Public Health responsibilities to Bracknell Forest Council. 15 - 22

9. **Response to Government Consultation on Local Authority Health Scrutiny**

To note the Council's response to the Department of Health's consultation over proposals for Local Authority Health Scrutiny. 23 - 26

10. **Responses to Pre-Consultation on Shaping the Future of Healthcare in East Berkshire**

To note the responses by the Council and the Joint East Berkshire Health Overview and Scrutiny Committee to the pre-consultation document on the 'Shaping the Future' proposals and the replies from the Primary Care Trust. 27 - 48

11. **NHS Commissioning Board Local Area Teams and Clinical Senates**

To note the new structure for the NHS National Commissioning Board Local Area Teams and Clinical Senates, following abolition of the Strategic Health Authorities and Primary Care Trusts in 2013. 49 - 76

12. **Working Group Update**

To receive a report on the progress of the Panel's Working Groups. 77 - 78

13. **Date of Next Meeting**

Thursday 24 January 2013.

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HEALTH OVERVIEW AND SCRUTINY PANEL
14 JUNE 2012
7.30 - 9.40 PM

Bracknell Forest Council

Present:
Councillors Virgo (Chairman), Baily, Finch, Kensall, Mrs Temperton, Thompson and Allen (Substitute)

Co-opted Representative: Terry Pearce, Bracknell Forest LINk

Also Present:
Councillor Leake

In Attendance:
Richard Beaumont, Head of Overview & Scrutiny
Glyn Jones, Director of Adult Social Care, Health & Housing
Zoe Johnstone, Chief Officer Adults and Joint Commissioning
Gerry Crawford, Locality Director, Berkshire Healthcare Trust
Mr & Mrs Gould, Local residents
Dr Brian Clarke, Consultant Physician Stroke & Elderly Care (Frimley Park)
Dr Tim Ho, Consultant Chest Physician and Clinical Director (Frimley Park)
Mrs Helen Coe, Associate Director, Urgent Care Services (Frimley Park)
Dr Paul Loughlin, Berkshire Healthcare Trust
David Williams, NHS Berkshire Primary Care Trust

Apologies for absence were received from:
Councillors Mrs Angell, Mrs McCracken and Ms Wilson

1. **Election of Chairman**

Upon the PROPOSAL of Councillor Kensall, SECONDED by Councillor Baily it was

RESOLVED that Councillor Virgo be elected as Chairman for the municipal year 2012/13.

2. **Appointment of Vice Chairman**

Upon the PROPOSAL of Councillor Baily, SECONDED by Councillor Thompson it was

RESOLVED that Councillor Mrs Angell be appointed as Vice-Chairman for the municipal year 2012/13.

3. **Minutes and Matters Arising**

RESOLVED that the minutes of the Panel held on 26 April 2012 be approved as a correct record and signed by the Chairman.

Matters Arising:

The Head of Overview and Scrutiny reported that details of actions taken since the last meeting were attached to the agenda papers at page 9. The draft vision document for the Health & Wellbeing Strategy had now been drawn up by the Working Group.

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

There were no declarations of interest.

5. **Urgent Items of Business**

In accordance with Section 100B(4)(b) of the Local Government Act 1972, the Chairman decided to take the following item as an urgent item, being a significant announcement by the Primary Care Trust after the agenda had been published:

Shaping the Future: Pre-consultation

The Head of Overview and Scrutiny advised that since the issue of the agenda, NHS Berkshire had issued a press release around a Shaping The Future Pre-consultation exercise and had publicised a number of events that would be taking place across the region related to this.

The Commissioning Director for Berkshire East, David Williams reported that the pre-consultation exercise had been publicised this week and focussed primarily on proposed plans for Heatherwood. He apologised to Panel Members that it had not been possible to include an item on the agenda papers but that he was keen to discuss the issues with Panel Members and the Council more widely. The Chief Executive of the Heatherwood and Wexham Foundation Trust, Philippa Slinger was also keen to discuss plans with the Panel.

The Chairman expressed disappointment that more information had not been provided to the Panel on the pre-consultation exercise, at an earlier stage. Panel members also asked to be informed of what services Heatherwood currently provided as well as any future plans.

It was reported that documentation relating to proposals would be provided on the Berkshire East website from Monday 18 June, this would include services that were currently provided at Heatherwood.

6. **Public Participation**

The Head of Overview & Scrutiny reported that a question had been submitted by a local resident, but that it was not deemed to be relevant to the work of the Panel. The resident had subsequently submitted a Freedom of Information request to which a response had been sent.

7. **Treatment for Strokes**

The Chairman welcomed Mrs Penelope Gould and her husband to the meeting and thanked them for agreeing to speak to the Panel about their experience of local health services following Mrs Gould's stroke in February 2012. The Chairman also welcomed the team of consultants and Associate Director from Frimley Park Hospital Trust.

The Panel viewed a TV advertisement titled F.A.S.T, which demonstrated what action should be taken if a stroke was suspected.

Dr Brian Clarke, Consultant Physician Stroke and Elderly Care and Dr Tim Ho, Consultant Chest Physician and Clinical Director gave a presentation to the Panel and made the following points:

- The best outcomes for stroke patients were achieved when patients could be treated within three hours of having a stroke, or ideally within an hour. This wasn't always possible as not all patients were brought immediately to hospital.
- In the past, strokes were often seen as a medical disaster for a patient however current stroke treatment had revolutionised care. Stroke care was no longer a neglected specialty, but active and interesting. Services were now seen to be at the cutting edge of medicine and strokes were considered to be a medical emergency.
- At Frimley, services were designed to be very proactive. This included:
    - a newly refurbished unit
    - first quartile of performance in SINAP
    - 7 day consultant ward rounds
    - 24/7 stroke consultant cover
    - 7 day TIA service available
    - Thrombolysis service 24/7

- Telestroke had been used for the past six months and this aimed to provide a consultant level decision via a TV screen and had been very successful in ensuring treatment was administered as quickly as possible.
- It was now recognised nationally that effective stroke treatment could prevent the need for intensive resources to care long term for a stroke patient with a disability.
- Consultants were pleased with the outcomes being achieved and the recovery of patients.

The Chairman thanked the team from Frimley Park for their presentation and invited Mrs Gould to speak to the Panel about her experience.

Mrs Gould made the following points:

- Mrs Gould described her symptoms when she had a stroke in February 2012, her husband had seen the TV advertisement and so knew that he needed to act quickly. An ambulance was called, and Mrs Gould was taken into Frimley Park Hospital where she was immediately given clot busting drugs following a CT scan. The hospital acted very quickly.
- Mrs Gould was then taken to the Stroke Unit and kept under close observation, after two days she was able to get out of bed and walk. After 3-4 days she went to the Rehabilitation Stroke area where she had physiotherapy. After a week or so, she was able to go home. Her husband had stayed with her throughout her treatment and had been kept informed at every stage.
- Mrs Gould had gradually got better, she still experienced minor problems such as slight memory loss and problems with fine motor skills, such as pressing buttons.
- Mr Gould added that his wife had been admitted to hospital within an hour and within 20 minutes of arriving at the hospital a consultant was in attendance and explaining the options available to them. Later on the same day, his wife was admitted to the Stroke Unit. He thanked Frimley Park for

all their work and support. Mr and Mrs Gould both felt that the service offered at Frimley Park was efficient, rapid and overall to be excellent.

The Chairman thanked Mr and Mrs Gould for their informative account of their experience of local stroke services.

The Associate Director – Urgent Care Services from Frimley Park, Mrs Helen Coe reported that the focus on hyper-acute strategy and stroke care had been 'front door and early discharge'. 40% of patients were able to attend the hospital on this basis. Much occupational therapy and speech therapy was now offered at home instead of at hospital.

Councillor Baily reported that having recently experienced a stroke, he concurred with Mr and Mrs Gould on their experience of services at Frimley Park and congratulated the hospital on their excellent service and treatment.

Members were informed that there was contact between ambulance crews and hospitals when stroke victims were being taken to hospitals, and these direct observations informed the planned treatment on arrival.

Members were informed that the Health and Wellbeing Strategy could usefully cover stroke risk factors such as hyper-tension, smoking cessation, obesity and lifestyle changes.

Members of the Panel agreed that the consultant led service offered at Frimley, with excellent management processes was outstanding. The Associate Director from Frimley Park reported that Frimley Park were happy to share their good practice and currently did so through national service frameworks and as part of the Stroke Network.

The Director of Adult Social Care, Health & Housing reported that good relationships existed between the Council's Intermediate Care team and Frimley Park to ensure that care was coordinated appropriately and effectively. The developments in stroke treatment had helped hugely to avoid institutional care, and assist people to return to normal life at home.

The Chairman thanked the team from Frimley Park for their attendance, informative presentations and engagement with the Panel.

8. **Dementia**

The Chief Officer, Zoe Johnstone reported that the Bracknell Forest Joint Commissioning Strategy which had been agreed in 2009, had clearly identified that local people wanted to be cared for in their own homes.

The Home Treatment Team provided a specialist multidisciplinary team that provided intensive support to individuals within their own homes Monday to Friday 9-7pm and weekends 9-3pm, outside of this care, urgent care services would be utilised. Other home support was provided by voluntary sector bodies and others.

Dr Loughlin reported that there were several diseases and conditions that resulted in dementia, these included Alzheimer's, Vascular, Dementia with Lewy bodies and Fronto-temporal dementia. Often dementia could be a combination of between three or four pathologies. The most common form of dementia was a combination of Vascular and Alzheimer's, however there were over 100 types of dementia, some yet to be identified. Dementia was defined as a gradual decline in the ability of the brain

to function on a daily basis and could affect the young or old. No cure was likely to be found for Dementia, but much could be done to alleviate its symptoms.

Younger patients with Alzheimer's were likely to have the condition as a result of genetics and family history. With patients over 65, lifestyle factors were much more important.

It was reported that the first access that a potential dementia patient would have with health services would be with a GP. A referral to the Memory Clinic may be made by a GP if appropriate. Early diagnosis was important. The Dementia Advisor worked with newly diagnosed patients who may not yet need the support of Social Care. Funding for the role of the Dementia Advisor had been extended.

It was reported that early diagnosis allowed individuals to plan ahead and make choices about their care, before they lost the capacity to make those choices. Generally, more early treatment was given now than previously, minimising the need for crisis treatment. There was an emphasis around encouraging patients to make decisions around their care, this included personalised budgets.

The Prime Minister's Dementia Challenge included developing dementia friendly services, the Council would be bidding for funding.

It was reported that in terms of priorities, it was important not to lose focus on dementia, the projected numbers for dementia were very real. It was crucial to consider how an integrated system of care for dementia could work well. The integration of health and social services was also crucial, the Alzheimer's Association had highlighted the need for respite care and the current gap in services that existed. Particularly as an individual's income dwindled, respite care would allow an individual to stay in their home for longer.

In response to members' questions, officers advised that:

- There was no research to prove the benefits of listening to music. However, efforts to improve cognitive issues are helpful, as were reminiscence groups.
- Obesity, smoking, and hyper-tension are contributory factors to having Dementia, and age is the main factor.
- The Healthcare Trust, having delivered its Transformation Programme, had the resources required. However, the position was tight, and there was a continuing need to improve integrated care and plan further efficiencies.
- Some people have a tendency to minimise symptoms of dementia, and early diagnosis and treatment is important.
- Integrated work between Adult Social Care, the Healthcare Trust and respite care is important.

It was noted that the findings of the Dilnott Enquiry was anticipated and it was hoped that adequate funding for adult care services would be proposed.

The Chairman thanked the team from the Healthcare Trust and officers for their attendance, informative presentations and engagement with the Panel.

9. **Quality Accounts**

The Head of Overview & Scrutiny reported that each NHS Trust was required to produce a set of Quality Accounts and invite comments from Overview and Scrutiny. Any comments made by Overview and Scrutiny Panels would then need to be incorporated by Trusts in their Quality Accounts.

The Panel noted the correspondence with the Trusts on their 2011-12 Quality Accounts and agreed to add consideration of Quality Accounts to their work programme for the following year.

10. **Working Group Updates**

The Head of Overview and Scrutiny reported that there were currently two active working groups, both of which had met recently:

Health Reforms Working Group: the primary focus of this working group was the transfer of public health responsibilities and creating Local HealthWatch. This group was likely to conclude its work in the autumn.

Health and Wellbeing Strategy: this group was contributing to the development of the Joint Health and Wellbeing Strategy and would monitor the work of the Health and Wellbeing Board as it moved from its shadow form into becoming a statutory body.

The Director of Adult Social Care, Health & Housing reported that the Health & Wellbeing Board was currently in shadow form and was actively considering how to move from its current arrangement to having meetings in public. It was anticipated that the Board would hold its meetings in public by the autumn. The shadow Board was currently looking into how it would engage with the local Health & Social Care network as well as a wider range of stakeholders. The Board had established effective working relationships with local partners.

The Director of Social Care, Health & Housing added that it was hoped that a draft Health & Wellbeing Strategy would be in place by the end of the summer recess. The end of the year would then be used to consult on the draft strategy.

It was noted that representations could be made to the Board through the LINks representative and eventually through Local HealthWatch as it emerged. The Panel noted that the membership of the Board was set out in the Health & Social Care Act.

It was noted that a vision for the Health & Wellbeing Board had been drafted on behalf of the Panel and would be circulated to all members of the Panel.

It was agreed that a working group be set up to consider the Shaping The Future: Pre-consultation work. It was noted that the pre-consultation would be complete by the end of July and the full consultation exercise would take place in the autumn. The working group would therefore need to meet before the end of July. Once the Health Reforms Working Group had concluded its work, this working group could begin its main work.

Councillors Virgo, Finch, Kensall and Mrs Temperton stated that they would be interested in participating in the working group around Shaping The Future.

11. **Date of Next Meeting**

Thursday 27 September 2012

CHAIRMAN

ACTIONS TAKEN: HEALTH OVERVIEW AND SCRUTINY PANEL MEETING – 14 JUNE 2012

Minute Number	Action Required	Action Taken
9. Quality Accounts	To add consideration of Quality Accounts to the work programme for the following year.	In work plan for April 2013 meeting
10. Working Group updates	Circulate draft suggestions on the vision for the Health & Wellbeing Board to all members of the Panel for comment.	Sent to members on 15 June. Finalised and sent to Executive Member on 22 June.
	A group of members be set up to consider the 'Shaping The Future': Pre-consultation work.	Meeting held on 16 July, and single Council response produced jointly with the Executive

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South Central Ambulance Service NHS
NHS Foundation Trust

Clinical Excellence within South Central Ambulance Service

South Central Ambulance Service (SCAS) continues to remain very focused on achieving excellent clinical outcomes for all of our patients. Over the last few years, we have developed our capability to audit our clinical performance in a number of key areas of our emergency clinical practice. Since the introduction of national Clinical Performance Indicators, which have included clinical care bundles for the management of heart attack, acute asthma, acute stroke, diabetic emergencies, and cardiac arrest, we have maintained an impressive track record of continuous improvement in the standards of care that we deliver to our patients. One of the key areas that we have invested in has been our ability to capture the high quality clinical care that our staff deliver from their clinical records, and for the first time, our staff now have the ability to be able to track and monitor their own clinical performance to inform their own future clinical practice and development.

Within the last twelve months, Ambulance Services in England have for the first time been monitoring the clinical outcomes of patients who have sustained a cardio-respiratory arrest in the community and we have been collecting data on the number of our patients that have arrived at hospital with a restored pulse, and equally as importantly, but more challenging, we have been collecting data on the survival of these patients to hospital discharge. This latter measure is a marker for the quality of care the patient receives from the whole emergency care system, including specialist care delivered in hospitals.

Over the last six months we have recognised that we need to do further work to improve the quality of our clinical data, particularly in the area of survival to hospital discharge data, and we have been working closely with our acute hospital trusts to ensure that SCAS obtains this date in a timely manner. We have also modified the design of our clinical records to facilitate this data capture and have emphasised the importance of staff maintaining high quality clinical records. The position is improving and we are receiving more data, quicker from our acute hospital trust partners.

The latest data we have from the National Department of Health Dashboard, confirms that for the month of April 2012 36.8% of our patients who had sustained a cardiac arrest in the community in whom resuscitation has been attempted had a pulse on arrival at hospital and that 13% of all patients who had survived a cardiac arrest survived to hospital discharge. The proportion of patients who had ‘witnessed’ cardiac arrests, in which the underlying cardiac arrest rhythm was more favourable (ventricular fibrillation or ventricular tachycardia), is even higher, although the numbers of patients are small. The current overall cardiac survival to discharge rate is reported in the United Kingdommedical literature as approximately 7%.

It is important that the limitations of this data are understood as the absolute numbers of patients who have been treated in cardiac arrest month on month is small, but the data will become more robust with the passage of time as the size of the dataset increases. At this time, we have good evidence that the quality of care we currently deliver to our patients is good, but we are not complacent.We have had a number of initiatives in place to further improve the clinical care of patients in cardiac arrest, this includes our front line staff using up to date evidenced based cardiac resuscitation algorithms that are approved by the Resuscitation Council UK. All of our staff continues to receive regular refresher update training and performance review.

We are continuing to develop our community first responder's schemes in community areas to enhance the first link of the cardiac chain of survival, namely to try and ensure that basic life support and compressions are initiated as quickly as possible, and to facilitate access to early defibrillation. To complement the growth of our community first responder schemes, we are working with a number of charities to improve the distribution of semi-automatic defibrillators throughout the community at pre-determined locations based on probability of cardiac arrest risk, for example sports centres, shopping centres and railway transport hubs. We are also working on improving the visibility of these assets to our emergency control room staff in the event of reported cardiac arrest, again to improve access to early defibrillation by the public, prior to the arrival of our highly trained and experienced ambulance staff.

We will continue to monitor our clinical performance very closely and we are determined to achieve the best possible outcomes following cardiac arrest, and indeed for all emergencies that we manage in the community.

John Black
Medical Director
SCAS
September 2012

The Ambulance Clinical Quality Indicators in more detail

Providing a fast response in an emergency is vital – but it is only one part of the treatment process. In April 2011, a new method of measuring ambulance service performance was introduced. Ambulance Care Quality Indicators don't just reflect how long it took to travel from "A" to "B" they also show the standard of care delivered from the moment the patient dials 999 so we can better monitor all of the factors which go into providing the best service possible. We know the importance of listening to what people have to say when it comes to identifying possible improvements. That's why we publish the Ambulance Care Quality Indicators each month.

1) Indicator: Outcome from acute ST-elevation myocardial infarction (STEMI)

STEMI is a type of heart attack. This is determined by an electrocardiogram (ECG) test. We know that a patient is more likely to recover if they receive early treatment.

Performance: There is no identified target for this but the desired outcome is for a high proportion of patients to have received early reperfusion (timely thrombolysis and primary angioplasty; delivery of care bundle) and all components of assessment have been consistent during the early months of the financial year. Our performance is 83% for Primary angioplasty and for delivery of the STEMI care bundle 40.64%.

Action: The Trust will continue to scrutinise all cases, and break each incident down into its constituent elements. Staff have been issued with advice to help with keeping on scene times to a minimum. Processes in the Emergency Operations Centre will be reviewed as part of the ongoing improvement in reducing on scene and journey times. SCAS is working closely with the South Central Cardiovascular Network to improve the pathways with the Acute Trusts for direct access to Hyperacute Stroke Units.

Work is currently being undertaken to understand which elements of the patient journey are likely to prevent the patient reaching a hyperacute stroke centre within 60 minutes. This involves looking at each incident to look at the initial call and how the incident has been prioritised within the Emergency Operations Centre (EOC) and then what resource has been sent.

- **STEMI (ST Elevation Myocardial Infarction) Call to Needle**

This clinical practice has been withdrawn with patient receiving primary angioplasty (PPCI), which is more effective for the patient. SCAS does not record data for this measure as the trust no longer undertakes thrombolysis.
All stocks of thrombolytic drugs have now been removed from the trust's vehicles with good access to heart attack centres across South Central the best practice is to deliver the patient direct to the catheter lab with as much pre-alert notice as possible reducing the call to balloon time.

- **STEMI (ST Elevation Myocardial Infarction) Call to Balloon**

The trust has improved its performance against this measure throughout the year. The trust's performance is far exceeding the CQC target and above the national average for all ambulance trusts in England. The trust is now working with acute hospital trusts to reduce the Door to Balloon times.
The trust is currently working towards improving pre-alerts, especially out of hours, so as to help the acute trusts to reduce the door to balloon times. This is a joint target for ambulance and acute trusts to work in seamless partnership to achieve the reduction in call to balloon times. Call to door times has been improved significantly by education and feedback between the ambulance service and acute hospital trusts.

- **STEMI Care Bundle**(Proportion of cardiac patients who received all elements of the optimal care package)

Following analysis of its processes, and delivering improvement in its analgesia (pain relief) administration, SCAS has continued to improve in this area. There are discussions at the National Ambulance Directors of Clinical Care meetings around reviewing the care bundle for STEMI patients, in the light of new evidence which will further enhance the care of this group of patients.
The care bundle focuses on only two forms of analgesia, morphine and Entonox, where as SCAS has a much larger formulary of analgesia. This causes us to have a reduced score for analgesia administration as SCAS staff use a stepwise approach to the management of pain by using more appropriate medicines that reduce risk or by using a combination of analgesics managing pain more effectively.
The use of GTN, which is a vaso-dilator is being reviewed by the national ambulance Medical Directors group as there is evidence that it has no benefit to patients that do not have chest pain, even if they are having a STEMI. The trust is waiting for the evidence to be reviewed and will make any changes to practice if required.

2) Indicator: Outcome from cardiac arrest: return of spontaneous circulation (ROSC)

This indicator will measure how many patients who are in cardiac arrest have been helped to regain a pulse/heartbeat by the time they arrive at hospital. The aim of this indicator is to reduce the proportion of patients who die from out of hospital cardiac arrest. The return of spontaneous circulation is calculated for two patient groups: The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out of hospital cardiac arrest patients; the rate for the Utstein comparator group applies to a subset of all cardiac arrest patients and provides a more comparable measure of management of cardiac arrest for patients where timely and effective clinical care can particularly improve survival.

ROSC for Utstein group (Proportion of patients whose cardiac arrest was witnessed and arrived at hospital with a pulse)

Performance*:*There is no specified target for this indicator but SCAS is continuing work to improve performance in these areas. Our current performance for the Utstein group is 52.54%. Our overall ROSC performance is 31.13%. The higher the ROSC rate the better.

Due to the small sample size involved, SCAS will continue to review its performance. SCAS's overall ROSC rate is consistent with existing published UK survival rates and there are initiatives to improve the early intervention to greatly improve outcomes.

Action:SCAS are increasing the number of community responders that have an important role to improving the outcome for patients that have a cardiac arrest. The success that is seen in London can be attributed to the vast number of defibrillators that are placed in the offices and buildings which give very early access to defibrillation, significantly improving the outcome for the patient. Our Community Responders are trained and live within the community to provide the same such early defibrillation in towns and villages across South Central, working with the ambulance crew to increase the chance of achieving a Return of Spontaneous Circulation on arrival at hospital.
Defibrillators in the community project is also being expanded, placing defibrillators where large groups of people gather, such as shopping centres, cinemas or village shops, so early defibrillation can be achieved on the spot.

3) Indicator: Outcome from cardiac arrest to discharge indicator –

It is important to understand the effectiveness of the whole system in managing patients who suffer a cardiac arrest. That's why this indicator measures the rate of those who recover from cardiac arrest and are then discharged from hospital alive.

Survival to discharge for Utstein group
(Proportion of patients whose cardiac arrest was witnessed and survived to leave hospital alive)

Performance:
There is no identified target but the desired success is that the higher survival rate the better. SCAS will continue to review and improve its performance in this area, which remain at expected levels from published literature. SCAS is participating in a cluster randomised control trial using a mechanical chest compression device for patients in cardiac arrest that may further improve ROSC and survival to discharge from hospital. Obtaining timely mortality and survival data from acute hospitals continues to be challenging and is contributing to delays in reporting of survival to hospital discharge data.

A patient's survival to discharge from a cardiac arrest is very complex as it has a significant number of factors that need to be taken into account. The most obvious is what has caused the cardiac arrest in the first place. If the arrest is due to a chronic condition such as cancer then the likelihood of a successful resuscitation is very low for instance.

Action:SCAS has made significant effort to build relationships with acute trusts to obtain this information but is reliant on good will at the moment. Steps have been taken at Board level to formalise this process and these are starting to improve the flow of data.

4) Indicator: Outcome following stroke for ambulance patients

We know that prompt emergency treatment can reduce the risk of death and disability from a stroke. This is why people at the scene should act quickly. This indicator will require ambulance services to measure the time it takes from the 999 call to the point where a F.A.S.T-positive stroke patient arrives at a specialist stroke centre.

Stroke care bundle (Proportion of stroke patients who received all elements of the optimal care package)

Performance: There is no identified target but the desired outcome is for the highest percentage of FAST positive stroke patients to arrive at a hyperacute stroke centre within 60 mins. Our current performance is 52.34%. Our current performance for the indicator requiring the highest percentage possible of suspected stroke patients receiving a care bundle, is 60.65%.

SCAS has very good performance in the care of Stroke patients but re-enforces the need to maintain the level of care at any opportunity to avoid any drop in performance.

Action: Training has recently been given to ensure that stroke patients are cared for in line with best practice guidelines.

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TO: HEALTH OVERVIEW AND SCRUTINY PANEL
27 SEPTEMBER 2012

PUBLIC HEALTH UPDATE
Director of Adult Social Care, Health and Housing

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide a further update to the Health Overview and Scrutiny Panel on the emerging arrangements for the transfer of Public Health functions to Local Authorities in April 2013. The last update was on 26 April 2012, although the Working Group on NHS Reforms has had a progress report.

2. RECOMMENDATION

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

3. BACKGROUND AND CONTEXT

3.1 The Health and Social Care Act 2012 confirms the relocation of Public Health functions, resources and commissioning responsibilities from the NHS into Local Government. Local authorities will be required to discharge their statutory public health responsibilities, detailed in the Public Health Outcomes Framework 2012 from 1 April 2013.

3.2 The framework identifies four specific domains that local authorities are required to focus on:

- Domain 1 - Improving the wider determinants of health;
- Domain 2 - Health improvement;
- Domain 3 - Health protection;
- Domain 4 - Healthcare public health and preventing premature mortality

3.3 The Act has major implications for the local health system and the relationship between that system and local government. In particular it provides for the:

- Abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) and the establishment of Clinical Commissioning Groups (CCGs), led by GPs, to commission health services locally;
- Transfers responsibility for public health to local government; and
- Places a responsibility on Local Government to provide Public Health advice and intelligence back to CCGs and the NHS Commissioning Board;
- Requires councils to establish Health and Wellbeing Boards;
- GPs will have responsibility for commissioning a wide range of healthcare services, with some exceptions. The Act allows GPs to join together in consortia, and to commission services in the ways that they judge will deliver the best outcomes for patients

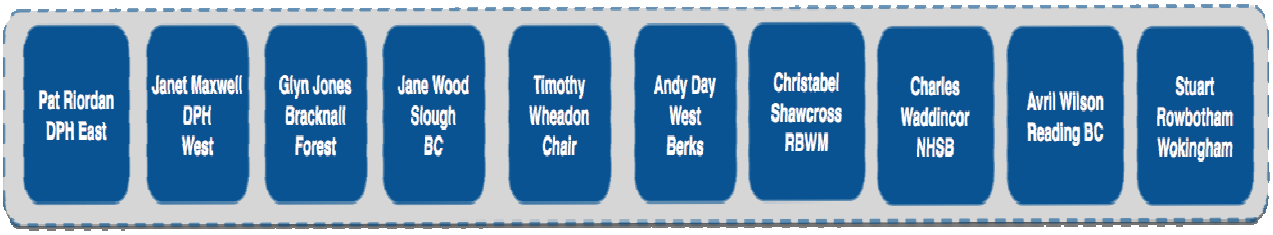
4. PROGRESS SO FAR

4.1 Members of the Panel will be aware that early consideration was given to a model based upon a single Strategic Director of Public Health (SDPH) across Berkshire. The preferred position of the Unitary Authorities was for a single SDPH, this was communicated to Charles Waddicor, Chief Executive of the PCT in a letter from Timothy Wheadon dated 14 February 2012. Since this, it has been agreed by the six UAs that Bracknell Forest Council will host the SDPH and Care Team on behalf of the partnership.

4.2 The six UAs are working in a spirit of collaboration to develop a framework that would lead to an effective and efficient Public Health model that would have two key objectives:

- To provide real focus and interventions for the local issues and concerns, not only around the health element but also to consider the wider determinants of health as highlighted in the Marmot Report published in February 2010;
- To establish a public health function that could work across Berkshire and deliver real collaborative sustainable change and efficiencies that would make a real difference to health outcomes and demonstrate real value for money.

4.3 The Transition Board has led the transition programme since its inception. The structure of the Board is described in Fig 1 below, which is chaired by Timothy Wheadon, Chief Executive, Bracknell Forest Council:



4.4 The Board has been supported by two Programme Managers who were engaged to support the transition programme on an East and West basis:

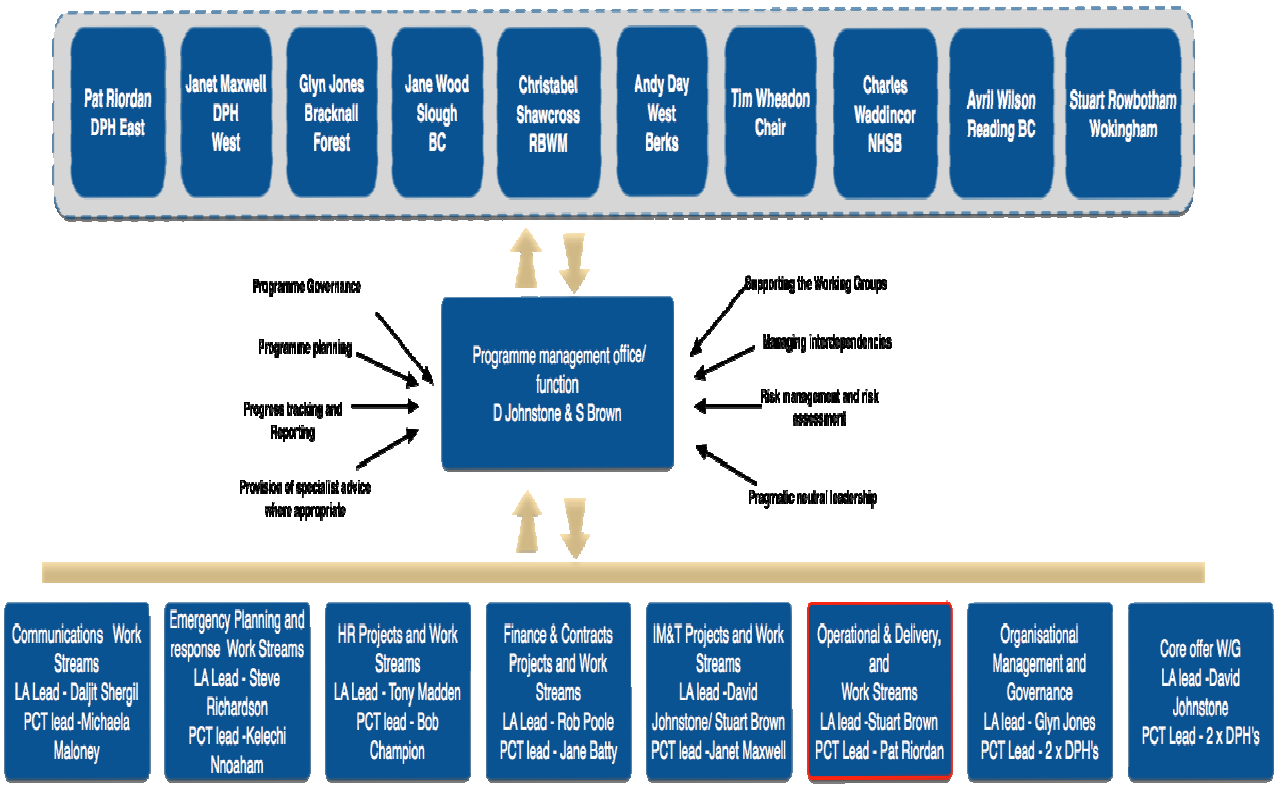
- David Johnstone - supporting the UAs in the West of Berkshire
- Stuart Brown - supporting the UAs in the East of Berkshire

4.5 The CCGs are also represented on the Transition Board as key stakeholders and partners in the new world. They first attended the Transition Board meeting on the 8 May and have been continuously represented since.

4.6 The Working Group Approach

4.6.1 Because of the complexity and the enormity of the tasks that needed to be undertaken if we were to deliver ***a safe and stable public health service*** into local authorities by 31 March 2013, it was decided to establish a number of working groups. The membership of the groups is drawn from all six UAs and includes at least one representative from Public Health.

4.6.2 This approach has proved to be a success with each of the UA assured that they are more than adequately represented. Fig 2 below describes the Board and the sub structure Working Group:



4.7 Governance and Structures Working Group

4.7.1 This group was established following the Transition Board meeting in April and tasked with designing the proposed structures for the PH teams that will be embedded in each of the UAs as of the 1 April 2013.

4.7.2 The group, consisting of the two DPHs, The Director of Adult Social Care, Health and Housing at Bracknell Forest Council and the two Programme Managers has held a series of workshops and meetings and has developed a proposed structure which was presented to the Transition Board on 12 June for formal approval. This then also formed the basis for discussions at the Chief Executive's Forum and the Berkshire Leaders Forum.

4.7.3 The group also completed the production of the Job Descriptions and Person Specifications for the Strategic Director of Public Health for Berkshire and the Lead Consultant role that will be located within each of the Unitary Authorities. Formal consultation on the proposed roles and the core structure commenced on the 23 July 2012.

4.7.4 Detailed work to define the specialisms and capacity that would be required within each of the Unitary Authorities began in early August and will complete in time for staff consultations to commence on 1 October.

4.8 Information Management & Technology Working Group

4.8.1 This workstream has made good progress since its inception and has already started to take on additional work around the core offer of Public Health advice to the NHS as the programme gathers momentum. A high level product breakdown structure has been completed which will define the deliverables and allow proper planning. Sub

workstream leads and working groups have been established for the following areas:

- Information governance & security and its dependencies;
- Identification and recording of information/intelligence assets and liabilities ;
- Information and intelligence allied to commissioning cycles;
- Supporting information/intelligence infrastructure and standards;
- Core offer to the NHS

4.8.2 One of the challenges for local government with the transfer of Public Health services is that in some instances they are in possession of and working with patient identifiable data. The access to and use of which is governed by the NHS clinical information governance framework. This is recognised as a national problem and there is a Public Health task force in the NHS currently looking at this, lead by Professor John Newton.

4.8.3 There are indications that the public health data and intelligence databases will transfer to the new Commissioning Support Units (CSUs) - this has raised some concerns in local government about the possibility of CSUs wanting to charge for the provision of this information in the future - with local authorities having a mandatory duty to supply the Core Offer to CCGs free of charge this places a financial burden on local authorities because the substance of the core offer is dependent on the provision of reliable and accurate data and intelligence which Public Health currently have access to as part of the public health functions and resources.

4.8.4 It is anticipated that we will be able to resolve the issues around patient identifiable data and access the other challenge is around the IT infrastructure required to provide the intelligence service. Initial discussions with Berkshire Shared Services have explored the possibility of extending the current service level agreement.

4.9 Finance and Contract Working Group

4.9.1 During the last period, the following sub groups have been established and are undertaking a more detailed analysis of the contracts and spend using the 2011/12 data (this is the program spend and not staffing spend). These work groups are as follows:

- Acute Contracts
- Community Contracts
- GP provided services
- Other (inc. Drug, smoking etc.)

4.9.2 Each workstream is being led by one of the six UAs and has Finance, contracts/ commissioning (from PCT and UA) and Public Health as part of the group membership.

4.9.3 The initial data for 2011/12 has been produced by the PCT and this has been converted into a data pack (in the same formats that were produced for the 2010/11 data returned to DH) for each of the sub groups to use to ensure that the control total is maintained. Each of the working groups will be completing a detailed template (which has been reviewed and slightly amended following feedback from the working groups) to capture the required information in a consentient format. This may not capture all the data required, but should provide a more detailed picture of the likely commitments and contracts.

4.9.4 Currently work is progressing as planned, but with some slippage in terms of timescales has occurred which is causing some concern at Transition Board level. Based on this, the SHA are able to provide resource support funding, a mini business

case to the SHA was submitted in support of a request for funding to the tune of £30K which will be used to deliver a number of specific objectives around the finance/budgets and the contracts that we will inherit in 2013. The SHA have contacted the Programme Manager and given an assurance that they will indeed underwrite this amount.

4.10 Emergency Planning Working Group

4.10.1 The Emergency Planning Working Group was, at the time of submission of the transition plan, deemed to be of a lower priority for the UAs whilst planning and testing of plans for London 2012 was reaching a critical stage.

4.10.2 This Working Group has now been implemented and the vast majority of the work plan has been completed and the necessary transfer arrangements are identified and either implemented or ready to be implemented.

4.11 Finance & Funding

4.11.1 Clarity is still some way off about what the final allocations will be for each of the UAs for 2013/14. Some work has been done by the SHA around identifying a fairer and more realistic set of allocation figures which would rebalance the initial proposed allocations to give greater fairness and to some degree a figure based on some consideration of needs in each borough. It is anticipated that by December, we will be notified of final allocations.

5. FORWARD PLANNING 2013/14

5.1 Commissioning Intentions

5.1.1 Local government will need to play an important role in defining commissioning intentions for health services in their localities. The majority of the responsibility for this will sit with CCGs but local authorities will have an important role to play in ensuring that CCGs commission services that will improve the outcomes for their populations.

5.1.2 This will be achieved in a number of ways, not least of all through the JSNAs and Health and Wellbeing Boards, but also via the mainstream public health functions on a day to day basis.

5.1.3 The relationship(s) with the CCGs will play a critical role in ensuring that we get the right service in the right place for the right price. The seven Berkshire CCGs have already federated into East and West federations, which may or may not continue to be the alignment going forward.

5.2 Core Offer

5.2.1 The core offer is a range of services and/or information that has been defined as a necessary and important input from the public health service that is currently provided to NHS commissioners and other service areas within the NHS. Therefore, there is a clear need to continue to provide this service to the new commissioning structures post 31 March 2013.

5.2.2 A Working Group was established and a number of key principles proposed. Recently, progress accelerated and a draft Memorandum of Understanding (MOU) has been produced by David Johnstone and will be discussed in detail at the next Core Offer

working group meeting towards the end of September.

5.2.3 Following which, a formal paper and draft MOU will be presented to the October Transition Board meeting.

5.3 Joint Strategic Needs Assessment (JSNA)

5.3.1 The JSNA is a statutory requirement that public health are tasked with leading on and publishing, this document should identify and inform the commissioning intentions based on the locality priorities. This statutory duty will transfer to local authorities on the 31 March 2013

5.3.2 This document often works on a 2-3 year cycle, but should be refreshed every year to ensure that it stays current and relevant. However, it is a matter for each Unitary Authority to determine the exact timing of these cycles so as to ensure that they provide the necessary and accurate input to CCG annual commissioning plans.

5.3.3 Public Health England (PHE) will support local communities by providing services, expertise, information and advice in a way that is responsive to local needs. It will support local authorities, CCGs and health and wellbeing boards by providing the most up to date information and evidence on what works to improve the public's health, including research and good practice. In addition, PHE will provide a public health service to the NHS Commissioning Board, and will support directors of public health and their teams in advising CCGs as required in the commissioning and delivery of health care services and programmes.

5.4 Risks and Issues

5.4.1 Overall a number of the risks have been identified and are being managed by the individual work stream leads although all risks have been escalated to programme level. Whilst some risks around contracts being novated in 2013, and taking into account the current stage we are at in the programme the trend is a reducing one. However, the fact that an agreement to extend existing provider contracts by 12 months from March 2013 has embedded and inherent risk that UAs may have to implement post transition contract adjustments to ensure that services are delivered in an affordable way for UAs.

6. CONCLUSION

6.1 Considerable progress has been made on the arrangements for transfer via the Working Groups.

6.2 It is a very sensitive time for staff as we prepare to consult on the detailed arrangements of posts and grades in the new structure. The next period will also continue to recruit to roles in the structure.

6.3 The priority remains as set out in 4.6.1 to ensure a safe and stable Public Health Service on 1 April 2013. Once this has been achieved then it will be possible to look at the synergies of being in local government, and how this can provide opportunities for further collaboration and improved commissioning.

Contact for further information

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HEALTH OVERVIEW AND SCRUTINY PANEL
27 SEPTEMBER 2012

RESPONSE TO GOVERNMENT CONSULTATION ON LOCAL AUTHORITY HEALTH SCRUTINY

Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report invites the Health Overview and Scrutiny Panel to note the Council's response to a consultation over proposals for Local Authority Health Scrutiny.

2 RECOMMENDATION

2.1 That the Health Overview and Scrutiny Panel notes the Council's response to the Department of Health's consultation over proposals for Local Authority Health Scrutiny.

3 SUPPORTING INFORMATION

3.1 The Department of Health published its proposals on Local Authority Health Scrutiny[1] on 12 July 2012, with a closing date for responses of 7 September. The consultation sought views on whether health service reconfiguration and referrals should also include a:

- requirement for local authorities and the NHS to agree and publish clear timescales for making a decision on whether a proposal should be referred;
- new intermediate referral stage to the NHS Commissioning Board for some service reconfigurations;
- requirement for local authorities to take account of the financial sustainability of services when considering a referral, in addition to issues of safety, effectiveness and the patient experience; and
- requirement for health scrutiny to obtain the agreement of the full council before a referral can be made.

3.2 The attached response was agreed with Members of the Panel, also with the Executive Member for Adult Services, Health and Housing.

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

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[1] http://www.dh.gov.uk/health/2012/07/health-scrutiny

Bracknell Forest Council Response to Department of Health Consultation on Local Authority Health Scrutiny

General

Bracknell Forest Council welcomes the Government's commitment to increase accountability and enhance the public voice on the National Health Service, and the commitment to make the new NHS bodies subject to effective scrutiny and accountability. The Council believes that the provision of good health services depends on effective scrutiny of health service providers by democratically elected representatives of the local community. We provide below the Council's comments on the Department of Health consultation proposals for health scrutiny.

Q1. Do you consider that it would be helpful for regulations to place a requirement on the NHS and local authorities to publish clear timescales? Please give reasons

We support this proposal in principle. However, it would be unreasonable to require local authorities to immediately notify the NHS body of the date by which they intend to make a decision (as to whether to refer the proposal). In practice, referrals are rare and a decision to embark on that route would only be taken after careful consideration. Consequently, and given that most consultations run for at least 8 weeks, we suggest that local authorities are encouraged to notify an indicative decision date within three weeks of receiving consultation proposals.

Q2 Would you welcome indicative timescales being provided in guidance? What would be the likely benefits and disadvantages of this?

No. Whilst indicative timescales can sometimes be useful, as the consultation document recognises (paragraph 52), every reconfiguration scheme is different, and any prescribed timescale would risk undermining the value of the scrutiny process which the government is trying to strengthen. Instead, the guidance could usefully state that it is incumbent on local authorities to work constructively with NHS bodies to complete the consultation process expeditiously, with no undue delays.

Q3. Do you consider it appropriate that financial considerations should form part of local authority referrals? Please give reasons for your view.

Yes. Costs, savings, clinical outcomes and safety – as well as wider impacts e.g. on social care - must all be properly considered in any local authority referral concerning reconfiguration proposals. However, we do not think there should be any obligation on local authorities to put forward alternative proposals (paragraph 60). Whilst local authorities should be free to suggest alternatives, the onus should always be on the NHS to determine options and financially assess them.

Q4. Given the new system landscape and the proposed role of the NHS Commissioning Board, do you consider it helpful that there should be a first referral stage to the NHS Commissioning Board?

We consider that the NHS Commissioning Board's real influence over local commissioners will be extensive, such that a first referral stage to them would not be appropriate in all cases. Accordingly, we favour the alternative approach set out in paragraph 67, whereby local

authorities would have the discretion to raise concerns with the Commissioning Board, whilst retaining the right to make referrals directly to the Secretary of State.

Q5. Would there be any additional benefits and drawbacks of establishing this intermediate referral?

An intermediate referral offers the prospect of faster resolution to concerns, but this would be uncertain. Possible drawbacks would include the additional time and cost of having another stage in the referral process. Clarity over timescales and decision making is very important.

Q6. In what other ways might the referral process be made to more accurately reflect the autonomy in the new commissioning system and emphasise the local resolution of disputes?

The Council suggests that there might be a valuable role for Health and Wellbeing Boards in the local resolution of disputes. This forum offers the potential to achieve an informed consensus among representatives of bodies with the strongest local knowledge, responsibility and influence. This could be a discretionary referral mechanism for the local authority health scrutiny, as an adjunct to their right to make referrals directly to the Secretary of State.

Q7. Do you consider it would be helpful for referrals to have to be made by the full council? Please give reasons for your view.

This additional requirement would not be consistent with the expressed aim of the Government to strengthen and streamline health scrutiny, and would add a procedural delay. Neither would it accord with the Local Government framework whereby full Council determines the policy framework and other high level decisions, entrusting more detailed issues to individuals and committees appointed by them. Nor are the arguments in the consultation paper on assembling evidence convincing. Furthermore, it would slow down the process as full Council meets relatively infrequently (once every two months is the norm). It should also be noted that referrals are rare, indicating that in practice local authorities use this referral power very sparingly.

An alternative, preferable approach would be to require that any referral by local authority scrutiny must be accompanied by a statement by the Council's Executive; the presumption being that the referral will be treated much more seriously by the SoS if the Council's leadership are supportive of the case made for the referral.

Q8. Do you agree that the formation of joint overview and scrutiny arrangements should be incorporated into regulations for substantial service developments or variations where more than one local authority is consulted? If not, why not?

No. This would reduce the mandate for local decision making and would not reflect practical reality at local level, where different configurations of health providers result in differing boundaries geographically. Furthermore:

- There should be no sanctions for failing to form a joint committee. The reason for this is that one or more councils in the area may be unwilling to become involved in a joint committee, and it would unfair to punish those which are prepared to be involved;
- Individual councils must retain the right to make their own responses to a consultation. This is because consensus might be achievable between members of a joint committee on some aspects of the consultation response, but it is inevitable that individual councils may hold differing views on reconfigurations that

hold out differing benefits/disadvantages between the council areas making up the joint area.

Q9. Are there additional equalities issues with these proposals that we have not identified? Will any groups be at a disadvantage?

None that we are aware of.

Q10. For each of the proposals, can you provide any additional reasons that support the proposed approach or reasons that support the current position? Have you suggestions for an alternative approach, with reasons?

Our views are incorporated in the responses to the questions above.

Q11. What other issues relevant to the proposals we have set out should we be considering as part of this consultation? Is there anything that should be included that isn't?

It would be useful to set out more fully the government's aspirations on the interaction of Healthwatch with the local authority scrutiny arrangements.

HEALTH OVERVIEW AND SCRUTINY PANEL
27 SEPTEMBER 2012

RESPONSES TO PRE-CONSULTATION ON SHAPING THE FUTURE OF HEALTHCARE IN EAST BERKSHIRE

Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report invites the Health Overview and Scrutiny Panel to note the responses by the Council and the Joint East Berkshire Health Overview and Scrutiny Committee (JEB) to the pre-consultation document on the 'Shaping the Future' proposals for changing healthcare in east Berkshire, and the replies from the Primary Care Trust (PCT).

2 RECOMMENDATION

2.1 That the Health Overview and Scrutiny Panel notes the responses by the Council and the Joint East Berkshire Health Overview and Scrutiny Committee to the pre-consultation document on the 'Shaping the Future' proposals, and the replies from the Primary Care Trust.

3 SUPPORTING INFORMATION

3.1 NHS Berkshire Primary Care Trust, together with various NHS partners, issued its 'Vision Document' for Shaping the Future of Healthcare in East Berkshire[1] in June 2012. This sought views on ideas for a full public consultation on suggested changes to health services in east Berkshire, to take place in autumn 2012.

3.2 The response by the Executive Member for Adult Services, Health and Housing, to the PCT's pre-consultation vision document, attached at Annex 1, was agreed with Members of the Panel.

3.3 The response by the JEB Committee, attached at Annex 2, was agreed by the Councillors from Bracknell Forest and other councils' representatives on that Committee. The response is consistent with the Council's response at Annex 1.

3.4 The PCT's replies to the points raised by the Council and the JEB Committee are at Annexes 3 and 4. The JEB Committee is due to meet next on 1 October.

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

Contact for further information

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[1] http://www.berkshirewest.nhs.uk/page-stf.asp?fldArea=11&fldMenu=4&fldSubMenu=1&fldKey=343

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Bracknell Forest Council

Our Ref: DB/GJ/am

30 July 2012

Shaping the Future Team
FREEPOST RSYL-KEKG-URGC
NHS Berkshire
57-59 Bath Road
Reading
RG30 2BA

Dear Sir or Madam

This response has been prepared by Bracknell Forest Council, through the Executive, Scrutiny and Officers. The Council would like to make some general points about the content of the pre-consultation and raise some concerns that are not addressed in the documentation.

The vision document is entitled “Shaping the Future in East Berkshire” and yet there is scant mention of Frimley Park Hospital or the Royal Berkshire, which we understand from the PCT’s own figures are the major acute hospitals serving the population of Bracknell Forest. It also fails to mention the role of independent hospitals which we understand patients can choose to secure their treatment from. Certainly the Council can provide evidence through its own Adult Social Care, Health and Housing department of how patient flows have impacted on the running and focus of the department in responding to hospital discharge.

Prior to the launch of the consultation, the PCT and HWPT declared that all sites were in effect safe. The Council is interested to learn if there was a mandate determined elsewhere for this position being established ahead of the consultation and from whom this mandate came. In doing this the Council believes this has served to fashion the consultation in a particular way and to this Council, it seems that this is about the future of Heatherwood and Wexham Park Trust and not about healthcare in East Berkshire. It is also known that the Heatherwood and Wexham Park Trust has begun the costly process of disposing of part of the Heatherwood site with the establishing of a project board to remodel the Heatherwood site and at its first meeting declared that Heatherwood would remain even though a consultation is still outstanding.

The document talks about the lack of capital and yet proposes to keep all current hospital sites open. This we believe cannot make economic sense in the climate we are in and given all of the advances in healthcare. The fact that there is already an NHS facility which has been purchased at considerable expense to the tax payer at Brants Bridge is not mentioned in any significant way in the document. Surely the use of this facility must be maximised given its location to the population prior to other investments being considered.

ADULT SOCIAL CARE, HEALTH AND HOUSING
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The Council has experience of taking difficult decisions in relation to building based services and responding to care and economic arguments. Much in the consultation hinges on the sale of surplus land on the Heatherwood site. The Council is aware how complex land sales can be and the associated planning arrangements. This can be a lengthy process. It would be helpful to know that the planning authority will be able to support the proposals and its views of the likely timescale and that the likely sale value will meet the contribution required to support the HWPT rescue package. The Council is aware of the arrangements that NHS property should be handled by a new organisation "PropCo" The Council believes the consultation should be clear about the role of PropCo particularly as any land matters will not be determined prior to April 2013.

The Council feels that the development of Urgent Care in Bracknell Forest should not be formally considered as part of this consultation. It has already been the subject of a consultation and Health Service Commissioners agreed the case for 'Healthspace' in Bracknell Forest. However, this has not been delivered to the detriment of the local population. We note that on p1 the PCT has placed HealthSpace on the map, presumably in recognition of the fact that is not part of the consultation.

If there is a decision on the MIU that should be a separate one, it is misleading in its current form and could leave people thinking that all Urgent Care Services could be at Heatherwood. The Council urges the PCT to ensure that the Healthspace proceeds at pace now that it should be at Brants Bridge and is happy to assist in that objective.

Finally, the Council is anxious that the development of the proposals may significantly disadvantage the Bracknell Forest and Ascot Clinical Commissioning Group. It is essential that the contracts are constructed in such a way to reflect patient flows. Anything other than this would put the CCG under financial pressure as it is clear that patients are exercising their right to choose which acute healthcare provider they want. This comment is in line we believe with the four key 'tests' set out by the Secretary of State for service change. If contracts are tied up to promote H&WP Trust sustainability then we are not convinced that the test in relation to 'consistency with current and prospective patient choice' will be met.

It must be recognised that HWPT is no longer the preferred service provider in Bracknell Forest and that any attempts to manipulate the local market and inhibit patient choice or place the CCG in financial difficulty will be resisted at the highest possible level.

Turning to the questions set out in the consultation document.

In the light of the general comments made earlier.

1) What do you think about our idea to develop a modern surgical hospital at Heatherwood?

The Council looks forward to examining the business case and a comparison with costs if other providers were to undertake this activity. It is assumed that there would be a natural limit to the activity given that ICU facilities would not be part of this service. We remain concerned about the extent of activity on all of the sites, within the proposals. In addition to this, there is no clarity on how the funding streams will be organised to deliver this ambition. We are sceptical that the assumptions of land value at the site can be realised.

2) What are your views on our plans for a new Urgent Care Centre in Bracknell with enhanced services to replace <u>services provided at the Heatherwood Minor Injuries Unit?</u>

The Urgent Care Centre must be separated from the consultation. The Council believes the PCT is already mandated to develop this and has failed to do so. It would be helpful to have a clear timeline from the PCT on when work will begin to establish the Healthspace.

The only questions that remains in our view is, should MIU remain at Heatherwood and more strategically the links between that MIU in Maidenhead and the Walk In Centre in Slough and the A&E service in Wexham, including Urgent Care.

Given the proximity of the population, the MIU should be moved to the Healthspace.

3) <u>What are your views on our ideas for the rehabilitation services and related inpatients beds?</u>

The Council supports the principle of this proposal and urges the PCT to consider more innovative approaches to rehabilitation similar to that agreed between the CCG and the Council, to improve efficiency and outcomes for individuals. There needs to be more clarity about the relationship between these services and acute rehabilitation. The document is silent on plans for other rehabilitation services in the other sites.

4) Do you think we are offering the right choices for women in terms of where they give birth?

The Council supports the proposals if the choices are real, Members have expressed concern about whether these are possible. The financial analysis will be helpful in this regard.

5) What is important to you about where outpatient services are delivered from?

- ☒ Access
- ☒ Transport
- ☒ Parking
- ☒ Other (please explain)

It makes economic sense to have outpatient clinics in population centres that will generate the demand.

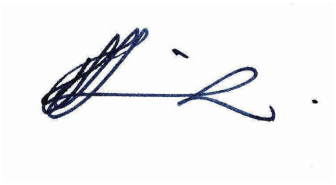
6) We will fully evaluate all proposals against best clinical evidence, quality outcomes, patient choice, patient experience, patient access, sign-up from doctors and other clinicians and financial viability. Do we need to take anything else into account?

The extent to which NHS providers can collaborate to deliver the commissioning vision and provide best outcomes. There are serious questions about the viability of healthcare in its current configuration and we believe there is further to go than is set out in the document. The investment at Brants Bridge as 'healthcare/taxpayers' money must be fully utilized to maximise the value of the asset to deliver improved services before incurring additional expenditure as we have already set out.

The Council is happy for its response to be published and would ask that due notification is given prior to that occurring. Likewise, if the Council needs to publish comments in relation to the consultation, we would notify the PCT.

If you require any points of clarification, please do not hesitate to contact me or my Director of Adult Social Care, Health and Housing.

Yours sincerely



Councillor Dale Birch
Executive Member for Adult Services, Health and Housing
Dale.Birch@bracknell-forest.gov.uk

Date: 26 July 2012

Joint East Berkshire Health Overview and Scrutiny Committee
c/o Scrutiny Office
Slough Borough Council
1st Floor West
St Martin's Place
51 Bath Road
Slough
SL1 3UF

Charles Waddicor
Chief Executive
NHS Berkshire
57 - 59 Bath Rd
Reading, Berkshire
RG30 2BA

Dear Mr Waddicor,

Shaping the Future of Healthcare in East Berkshire: Vision Document (June/July 2012)

The Joint East Berkshire Health Overview and Scrutiny Committee would like to submit the following points in response to the pre-consultation document on the Shaping the Future proposals.

1. Having reviewed the document, it is clear that the programme is primarily focusing on Heatherwood and Wexham Park Foundation Trust (H&WPT), and therefore the title of the document in referring to "Healthcare in East Berkshire" is misleading. The proposals, as a whole, are not strategic, do not provide any significant changes to the provision of healthcare, and reflect something of the status quo, which we had been led to believe was not a viable option. Connected to this, we believe that more detail of how other public and private health service providers neighbouring facilities, including those at Frimley Park and the Royal Berkshire, fit within these proposals is required.

2. We are deeply concerned that there is a complete lack of detail on the financial model. The JEBHOSC recognised the significant development required at all three of the primary sites in East Berkshire (Wexham Park, Heatherwood and Bracknell), alongside the Community Health teams, yet there is no clear understanding of how the financial investment to meet these requirements will be settled. A fundamental element of this is the sale of land at the Heatherwood site, of which much more information is needed on who holds the land and what covenants exists and how these impact on any proposals, specifically whether this can realistically deliver the funding required for the development of H&WPT on time. In addition, the JEBHOSC would seek confirmation from the NHS that a portion of currently unused land Heatherwood will not be included in the sale in order to support any future healthcare needs at the site.

3. We also feel that the plans are missing details of the anticipated benefits realisation plan, which we feel is fundamental to allowing a reasoned judgement to be made on the proposals.

4. We will also add that we feel that the proposals would have the effect of committing the new Clinical Commissioning Groups to contracts which may hinder their future work towards improving competition and patient choice.

5. JEBHOSC is very disappointed that the document did not provide sufficient information for them to fully respond to the questions posed. In particular, greater clarity is needed about the future provision of rehabilitation beds. The JEBHOSC understands that there will be a provision held at Heatherwood but this is not clearly articulated in the document, nor is how rehabilitation beds at the Community Hospitals will effectively meet requirements. The JEBHOSC asks that detailed information is provided in the main consultation document, which gives exact provision numbers.

6. Following the 'Right Care Right Place' major consultation in 2007/08, Health Service Commissioners committed to providing the 'Healthspace' in Bracknell Forest. Despite that promise and funds having been allotted to its creation some years ago, the document proposes consulting afresh on whether it is a good idea. We do not see any case for this to be included in the consultation. Instead, efforts need to be concentrated on the delivery of the Healthspace, which is long overdue.

7. The JEBHOSC also feels that the reference to maternity services fails to fully show how patients' preferences will be met. It also fails to indicate how staff capacity will be ensured, in what is already a difficult national picture.

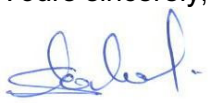
8. The JEBHOSC would like to see more information in the main consultation document on what transport provisions will be put in place to support residents with mobility issues when they may need to travel further to receive services in the future; as well as how the capacity to the Ambulance Service will be taken into consideration with the potential of a greater number of residents than currently requiring transportation to facilities at Frimley Park and the Royal Berkshire.

9. The JEBHOSC would like to see details of how the engagement of the public will be undertaken during the consultation process. The Committee welcomed the public engagement that has been undertaken during the pre-consultation, but questioned how well these events had been advertised. The JEBHOSC requests details of the Communication Plan that the NHS will be using during this period.

In addition to the above, the JEBHOSC also asks that the PCT provide confirmation as to who will be taking the Shaping the Future proposals forward after the PCT is abolished in April 2013.

The JEBHOSC looks forward to receiving a response from the PCT on the points made above, and reviewing how these issues will be reflected in the draft of the full consultation document.

Yours sincerely,



Councillor S Dhaliwal
Chairman
Joint East Berkshire Health Overview and Scrutiny Committee

cc. All Members of Joint East Berkshire Health Overview and Scrutiny Committee
Shaping the Future Team, FREEPOST RSYL-KEKG-URGC, NHS Berkshire, 57-59 Bath Road, Reading, RG30 2BA

Response to feedback on StF consultation from BRACKNELL FOREST COUNCIL

Ref	Feedback	Our response
1.	The vision document is entitled "Shaping the Future in East Berkshire" and yet there is scant mention of Frimley Park Hospital or the Royal Berkshire, which we understand from the PCT's own figures are the major acute hospitals serving the population of Bracknell Forest. It also fails to mention the role of independent hospitals which we understand patients can choose to secure their treatment from. Certainly the Council can provide evidence through its own Adult Social Care, Health and Housing department of how patient flows have impacted on the running and focus of the department in responding to hospital discharge.	This is a perfectly fair point. The four proposals we are now planning to formally consult on are specific service changes that we are ready to discuss with local people. The overall Shaping the Future programme involves developing clinical models of care and working locally to develop changes in services that go well beyond these specific proposals. The Bracknell and Ascot Clinical Commissioning Group (CCG) is leading a process to develop an integrated care workstream where it is inviting all its acute providers to work with it to shape services in the south of Berkshire. We propose to make it more explicit in the consultation that we are focussed on a relatively small number of changes that are important for some specific services currently provided by the Heatherwood and Wexham Park NHSFT at Heatherwood. Our wider planning processes will include all key providers when relevant
2.	Prior to the launch of the consultation, the PCT and HWPT declared that all sites were in effect safe. The Council is interested to learn if there was a mandate determined elsewhere for this position being established ahead of the consultation and from whom this mandate came. In doing this the Council believes this has served to fashion the consultation in a particular way and to this Council, it seems that this is about the future of Heatherwood and Wexham Park Trust and not about healthcare in East Berkshire. It is also known that the Heatherwood and Wexham Park Trust has begun the costly process	We received significant feedback from the public and many clinicians in our engagement exercise in 2011 that they believed all of our main sites had an important future role to play, even if some of the service on them might change. This was particularly strong for the Heatherwood site. As our financial plans developed it became clear that the savings from major site closure were not sufficiently large to merit the continued pursuit of closure options. In formal governance terms there is no need for a "mandate" not to close an existing site or service. The approach was, however, agreed by the Berkshire East PCT and has the support of CCGs.

Ref	Feedback	Our response
	of disposing of part of the Heatherwood site with the establishing of a project board to remodel the Heatherwood site and at its first meeting declared that Heatherwood would remain even though a consultation is still outstanding.	It is entirely true that the consultation focuses on some services currently provided by the Heatherwood and Wexham Park Foundation Trust – but it goes well beyond this to include new community services provided by the Berkshire Healthcare Foundation Trust, and the integration of some services with primary care in the new Urgent Care Centre in Bracknell. Heatherwood and Wexham Park Hospitals NHS Foundation Trust has established a project to improve the hospital facilities given the public and commissioner view that Heatherwood should remain. The project has a Programme Board that includes the three CCG Chairs and a Stakeholder Reference Group that includes the Bracknell Forest Lead Member for Health together with councillors from the three other Local Authorities. The group has met once and will be involved in all the detail of any proposed improvements, including consideration of any land sale that may be proposed in the future.
3.	The document talks about the lack of capital and yet proposes to keep all current hospital sites open. This we believe cannot make economic sense in the climate we are in and given all of the advances in healthcare. The fact that there is already an NHS facility which has been purchased at considerable expense to the tax payer at Brants Bridge is not mentioned in any significant way in the document. Surely the use of this facility must be maximised given its location to the population prior to other investments being considered.	We are actively pursuing options that make best use of capacity at Brant's Bridge. This is a key rationale for why we are proposing it should be the location of the Urgent Care Centre, MIU and outpatient services for the Bracknell population. The plan is for Brants Bridge to replace the HealthSpace scheme as far as is possible so it is also envisaged that some outpatients will also be delivered from the building, in particular those that are currently provided from Fitzwilliam House and any that the CCG would wish to be relocated from Heatherwood.

Ref	Feedback	Our response
4.	The Council has experience of taking difficult decisions in relation to building based services and responding to care and economic arguments. Much in the consultation hinges on the sale of surplus land on the Heatherwood site. The Council is aware how complex land sales can be and the associated planning arrangements. This can be a lengthy process. It would be helpful to know that the planning authority will be able to support the proposals and its views of the likely timescale and that the likely sale value will meet the contribution required to support the HWPT rescue package. The Council is aware of the arrangements that NHS property should be handled by a new organisation "PropCo" The Council believes the consultation should be clear about the role of PropCo particularly as any land matters will not be determined prior to April 2013.	In our engagement document we tried to cover all of the plans we have affecting Heatherwood Hospital so that people could understand what the changes meant as a whole. This included the proposed new elective hospital and related land transactions as these are plans the Trust is actively pursuing. However, it is not a substantial service change as the proposal for a new elective hospital is not moving significant services away from the site. The Trust is exploring the detail of how it will deliver the new hospital under the constituted programme board, and the issues you identify will all be tackled by the Trust and Board. The Trust is the freehold owner of the Heatherwood site and therefore the ownership will not be by the newly established NHS PropCo - this was created to take ownership of property that is owned by PCTs across the country in readiness for the dissolution of PCTs in March 2013. However, these plans do not form part of the formal consultation, and we are not intending to provide significant detail on them within it.
5.	The Council feels that the development of Urgent Care in Bracknell Forest should not be formally considered as part of this consultation. It has already been the subject of a consultation and Health Service Commissioners agreed the case for 'Healthspace' in Bracknell Forest. However, this has not been delivered to the detriment of the local population. We note that on p1 the PCT has placed HealthSpace on the map, presumably in recognition of the fact that is not part of the consultation.	This is primarily a matter of presentation – and we quite agree that the Urgent Care Centre has been long planned and agreed. The critical point is that when those plans were first developed it was not clear that it would result in a better and more financially viable service if the full MIU at Heatherwood was integrated into this Urgent Care Centre. As you will see in the consultation we are now making it clearer that the consultation is focussed on the aspect of moving the MIU services from Heatherwood to Bracknell.

Ref	Feedback	Our response
6.	If there is a decision on the MIU that should be a separate one, it is misleading in its current form and could leave people thinking that all Urgent Care Services could be at Heatherwood. The Council urges the PCT to ensure that the Healthspace proceeds at pace now that it should be at Brants Bridge and is happy to assist in that objective.	We are grateful for the offer of assistance in helping the Urgent Care Centre move forward quickly. However, we do need to work within a framework which ensures plans are not later delayed because we have not consulted correctly, and the advice we have received is that we do need to finalise the issue on the MIU transfer before we go ahead otherwise we could well be subject to legal challenge.
7.	Finally, the Council is anxious that the development of the proposals may significantly disadvantage the Bracknell Forest and Ascot Clinical Commissioning Group. It is essential that the contracts are constructed in such a way to reflect patient flows. Anything other than this would put the CCG under financial pressure as it is clear that patients are exercising their right to choose which acute healthcare provider they want. This comment is in line we believe with the four key 'tests' set out by the Secretary of State for service change. If contracts are tied up to promote H&WP Trust sustainability then we are not convinced that the test in relation to 'consistency with current and prospective patient choice' will be met.	We have no intention of restricting patient choice and under the NHS financial regime money will inevitably follow patient flows. It is true that the three CCGs have made a commitment within a Memorandum of Understanding to provide temporary support to the Heatherwood and Wexham Park Hospitals NHS Foundation Trust to help it regain a stable financial footing. We are confident that local people support the CCGs in their desire to ensure we retain the Trust as key provider of local healthcare services in the area, and that we should be giving it the temporary support needed to ensure this. The biggest reduction in local choice possible would take place if this was not done. The Memorandum does not restrict patient choice and we fully expect that patients, in consultation with their physicians, will be choosing to use a number of different acute providers.

Ref	Feedback	Our response
8.	It must be recognised that HWPT is no longer the preferred service provider in Bracknell Forest and that any attempts to manipulate the local market and inhibit patient choice or place the CCG in financial difficulty will be resisted at the highest possible level.	It is true that Bracknell Forest patients have the choice to attend a number of different local hospitals and also that a substantial number of Bracknell patients currently access Heatherwood and Wexham Park services. We expect there to be a continuing competitive market for healthcare provision throughout east Berkshire, and the maintenance of this market will support the CCG's financial position. We do not believe any of the substantial service changes we are consulting on will impact on this.
1)	**What do you think about our idea to develop a modern surgical hospital at Heatherwood?** The Council looks forward to examining the business case and a comparison with costs if other providers were to undertake this activity. It is assumed that there would be a natural limit to the activity given that ICU facilities would not be part of this service. We remain concerned about the extent of activity on all of the sites, within the proposals. In addition to this, there is no clarity on how the funding streams will be organised to deliver this ambition. We are sceptical that the assumptions of land value at the site can be realised.	All of these issues are important. In the NHS it is the role of provider Trusts to determine the affordability of capital developments and to take any risk involved in building them taking into account commissioner plans. As indicated above, these issues will be tackled by the Programme Board for the new hospital development, which has representation from CCGs and local stakeholders. They are not formally part of the consultation on substantial service changes.

Ref	Feedback	Our response
2)	**What are your views on our plans for a new Urgent Care Centre in Bracknell with enhanced services to replace services provided at the Heatherwood Minor Injuries Unit?** The Urgent Care Centre must be separated from the consultation. The Council believes the PCT is already mandated to develop this and has failed to do so. It would be helpful to have a clear timeline from the PCT on when work will begin to establish the Healthspace. The only questions that remains in our view is, should MIU remain at Heatherwood and more strategically the links between that MIU in Maidenhead and the Walk In Centre in Slough and the A&E service in Wexham, including Urgent Care. Given the proximity of the population, the MIU should be moved to the Healthspace.	We will include our most up-to-date estimate on the timescales for the UCC within the consultation document. We have already addressed some of these points. We agree that it is important to have clarity on links with hospital A&E departments to ensure safe delivery of service. Our aim is to have a consistent set of urgent care services across all of east Berkshire.
3)	**What are your views on our ideas for the rehabilitation services and related inpatients beds?** The Council supports the principle of this proposal and urges the PCT to consider more innovative approaches to rehabilitation similar to that agreed between the CCG and the Council, to improve efficiency and outcomes for individuals. There needs to be more clarity about the relationship between these services and acute rehabilitation. The document is silent on plans for other rehabilitation services in the other sites.	We look forward to the opportunity of working with you as we implement the proposals on the innovative approaches you mention. We know that the CCG and Council have recently commissioned a new joint health and social care service at the Bridgewell Centre to enhance intermediate care services for the population. We are not consulting on changes to other sites within this process. As Clinical Commissioning Groups develop the detail of their plans they will work with local people and their councils on any changes in rehabilitation services that may be needed.

Ref	Feedback	Our response
4)	**Do you think we are offering the right choices for women in terms of where they give birth?** The Council supports the proposals if the choices are real, Members have expressed concern about whether these are possible. The financial analysis will be helpful in this regard.	We do believe the choices are real – there are three local hospitals providing care for women in the Bracknell area offering a wide variety of choice.
5)	**What is important to you about where outpatient services are delivered from?** ✓ Access ✓ Transport ✓ Parking ✓ Other (please explain) It makes economic sense to have outpatient clinics in population centres that will generate the demand.	We agree with the core principle expressed.

Ref	Feedback	Our response
6)	**We will fully evaluate all proposals against best clinical evidence, quality outcomes, patient** **choice, patient experience, patient access, sign-up from doctors and other clinicians and financial viability. Do we need to take anything else into account?** The extent to which NHS providers can collaborate to deliver the commissioning vision and provide best outcomes. There are serious questions about the viability of healthcare in its current configuration and we believe there is further to go than is set out in the document. The investment at Brants Bridge as 'healthcare/taxpayers' money must be fully utilized to maximise the value of the asset to deliver improved services before incurring additional expenditure as we have already set out. The Council is happy for its response to be published and would ask that due notification is given prior to that occurring. Likewise, if the Council needs to publish comments in relation to the consultation, we would notify the PCT.	We have addressed your points on working with other providers and the use of Brants Bridge above. Thank you for agreeing that your response may be published. We would like to include it as part of the information available to the public when we start the formal consultation in October.

Response to feedback on StF consultation from JOINT EAST BERKSHIRE HOSC

Ref	Feedback	Our response
1.	Having reviewed the document, it is clear that the programme is primarily focusing on Heatherwood and Wexham Park Foundation Trust (H&WPT), and therefore the title of the document in referring to "Healthcare in East Berkshire" is misleading. The proposals, as a whole, are not strategic, do not provide any significant changes to the provision of healthcare, and reflect something of the status quo, which we had been led to believe was not a viable option. Connected to this, we believe that more detail of how other public and private health service providers neighbouring facilities, including those at Frimley Park and the Royal Berkshire, fit within these proposals is required.	These proposals are one part of the overall Shaping the Future Programme. The four proposals we are now planning to formally consult on are specific service changes that we are ready to discuss with local people. The overall Shaping the Future programme involves developing clinical models of care and working locally to develop changes in services that go well beyond these specific proposals. As part of this, the Bracknell and Ascot CCG is in the process of developing an integrated acute sector workstream where it is inviting all its acute providers to work with it to shape services. We propose to make it more explicit in the consultation that we are focussed on a relatively small number of changes that are important for some specific services currently provided by the Heatherwood and Wexham Park NHSFT at Heatherwood. The "substantial" service changes on which we are consulting in this particular consultation are focussed on services provided by Heatherwood and Wexham Park NHSFT - and we will make this clearer. Our wider planning processes will include all key providers when relevant. It is true that in 2011 our analysis was that it was likely we needed to look at closing hospital sites. However, the public and clinicians were strongly opposed to this and more detailed work since then has made it clear that this is not the right way to address our deficit and CCGs and our provider Trusts are identifying important functions for all our key hospitals.

Ref	Feedback	Our response
2.	We are deeply concerned that there is a complete lack of detail on the financial model. The JEBHOSC recognised the significant development required at all three of the primary sites in East Berkshire (Wexham Park, Heatherwood and Bracknell), alongside the Community Health teams, yet there is no clear understanding of how the financial investment to meet these requirements will be settled. A fundamental element of this is the sale of land at the Heatherwood site, of which much more information is needed on who holds the land and what covenants exists and how these impact on any proposals, specifically whether this can realistically deliver the funding required for the development of H&WPT on time. In addition, the JEBHOSC would seek confirmation from the NHS that a portion of currently unused land Heatherwood will not be included in the sale in order to support any future healthcare needs at the site.	The pre-consultation engagement Vision document was intended to be a high level presentation of our ideas, and naturally did not include significant detail on some areas. In our engagement document we tried to cover all of the plans we have affecting Heatherwood Hospital so that people could understand what the changes meant as a whole. This included the improved elective hospital and related land transactions as these are plans the Trust is actively pursuing. However, it is not a substantial service change as the proposal for the hospital is not moving significant services away from the site. The Trust is exploring the detail of how it will deliver the new hospital under the constituted programme board, and Stakeholder Reference Groups that have CCGs and Local Authorities as members and the issues you identify will all be tackled by the Trust and that Board. The Trust is the freehold owner of the site and details about its use will be discussed and examined through the Groups described above. However, these plans do not form part of the formal consultation, and we are not intending to provide significant detail on them within the consultation.
3.	We also feel that the plans are missing details of the anticipated benefits realisation plan, which we feel is fundamental to allowing a reasoned judgement to be made on the proposals.	We are including benefit realisation plans in our business case for the consultation which will be available as part of the consultation.

Ref	Feedback	Our response
4.	We will also add that we feel that the proposals would have the effect of committing the new Clinical Commissioning Groups to contracts which may hinder their future work towards improving competition and patient choice.	We have no intention of restricting patient choice and under the NHS financial regime money will inevitably follow patient flows. It is true that the three CCGs have made a commitment through a Memorandum of Understanding to provide temporary support to the Heatherwood and Wexham Park NHS Foundation Trust to help it regain a stable financial footing. We are confident that local people support the CCGs in their desire to ensure we retain the Trust as key provider of local healthcare services in the area, and that we should be giving it the temporary support needed to ensure this. The biggest reduction in local choice possible would take place if this was not done. The Memorandum does not restrict patient choice and we fully expect that patients, in consultation with their physicians, will be choosing to use a number of different acute providers
5.	JEBHOSC is very disappointed that the document did not provide sufficient information for them to fully respond to the questions posed. In particular, greater clarity is needed about the future provision of rehabilitation beds. The JEBHOSC understands that there will be a provision held at Heatherwood but this is not clearly articulated in the document, nor is how rehabilitation beds at the Community Hospitals will effectively meet requirements. The JEBHOSC asks that detailed information is provided in the main consultation document, which gives exact provision numbers.	We have not indicated that in the future there will be rehabilitation beds at Heatherwood and we will be very clear in the public consultation documents that our proposals would close the stroke and general rehabilitation beds at Heatherwood. The rationale for this closure is not that the patients would go to other community hospitals, but that we will reinvest the resources that were paying for patients to stay in hospital into community based services that will allow patients to be cared for at home. We are confident that this will mean in the future that there is significant reduction in the number of people staying too long in hospital. We are therefore not providing a detailed analysis of community hospital bed numbers. What we will do is describe resource we are putting in place which will deliver the reduction we need to enable the closure of beds at Heatherwood.

Ref	Feedback	Our response
6.	Following the 'Right Care Right Place' major consultation in 2007/08, Health Service Commissioners committed to providing the 'Healthspace' in Bracknell Forest. Despite that promise and funds having been allotted to its creation some years ago, the document proposes consulting afresh on whether it is a good idea. We do not see any case for this to be included in the consultation. Instead, efforts need to be concentrated on the delivery of the Healthspace, which is long overdue.	This is primarily a matter of presentation – and we quite agree that the 'Healthspace' has been long planned and agreed. The critical point is that when those plans were first developed it was not clear that it would result in a better and more financially viable service if the full MIU at Heatherwood was integrated into the Urgent Care Centre within the 'Healthspace'. As you will see in the consultation we are now making it clearer that the consultation is focussed on the aspect of moving the MIU services from Heatherwood to Bracknell.
7.	The JEBHOSC also feels that the reference to maternity services fails to fully show how patients' preferences will be met. It also fails to indicate how staff capacity will be ensured, in what is already a difficult national picture.	We believe we have shown that patients will be able to choose any of a) obstetric led services in any of the three major local acute hospitals b) midwife led units based alongside those obstetric services but very much with the non-medical ethos that makes people want midwife led services c) midwife led births at home We would like to know what additional information you require. In a challenging national climate for the numbers of midwives it would be very difficult to demonstrate definitively how staff capacity would be ensured. However, all our local providers are committed to policies of recruitment and retention which will ensure they attract enough of the best midwives. What we are certain of is that in that challenging climate is not right to keep open a unit which is not well used.

Ref	Feedback	Our response
8.	The JEBHOSC would like to see more information in the main consultation document on what transport provisions will be put in place to support residents with mobility issues when they may need to travel further to receive services in the future; as well as how the capacity to the Ambulance Service will be taken into consideration with the potential of a greater number of residents than currently requiring transportation to facilities at Frimley Park and the Royal Berkshire.	We will continue to discuss opportunities to improve transport with local councils for all of our hospital sites. However, we do not think any of the changes will result in large numbers of people needing to travel significantly further and this is evidenced by the analysis we are including in the consultation. Most of the proposals will reduce travel, particularly where they are to provide support in people's own homes. We do not expect greater number of residents to require transportation to Frimley Park and Royal Berkshire as a result of these proposals. If anything we expect the Urgent Care Centre to reduce the number of those journeys. Overall we expect the proposals together will reduce the number of patients needing to travel to Wexham Park hospital.
9.	The JEBHOSC would like to see details of how the engagement of the public will be undertaken during the consultation process. The Committee welcomed the public engagement that has been undertaken during the pre-consultation, but questioned how well these events had been advertised. The JEBHOSC requests details of the Communication Plan that the NHS will be using during this period.	We welcome the chance to discuss this at the meeting with you on 28 August, and your views will influence our approach.
10.	In addition to the above, the JEBHOSC also asks that the PCT provide confirmation as to who will be taking the Shaping the Future proposals forward after the PCT is abolished in April 2013.	This will primarily be the responsibility of the local Clinical Commissioning Groups in east Berkshire who have agreed to work together on Shaping the Future.

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HEALTH OVERVIEW AND SCRUTINY PANEL
27 SEPTEMBER 2012

NHS COMMISSIONING BOARD LOCAL AREA TEAMS AND CLINICAL SENATES

Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report invites the Health Overview and Scrutiny Panel to note the new structure for the NHS National Commissioning Board Local Area Teams and Clinical Senates, following abolition of the Strategic Health Authorities and Primary Care Trusts in 2013.

2 RECOMMENDATION

2.1 That the Health Overview and Scrutiny Panel notes the new structure for the NHS National Commissioning Board Local Area Teams and Clinical Senates.

3 SUPPORTING INFORMATION

3.1 The structure, role and geographical coverage of the new National Commissioning Board Local Area Teams and Clinical Senates are set out in the attached briefing paper from the NHS Commissioning Board.

3.2 There will be 27 local area teams with staff working from a number of office bases across their geographical area. All local area teams will have the same core functions around clinical commissioning group (CCG) development and assurance, emergency planning, resilience and response, quality and safety, configuration, system oversight and partnerships and stakeholder engagement, with the senior leadership of the local area team participating as a full partner on health and wellbeing boards.

3.3 Clinical senates are intended to help Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards and the NHS CB to make the best decisions about healthcare for the populations they represent by providing advice and leadership at a strategic level. They will be made up of a range of clinicians and professionals from health, including public health and social care alongside patients, public and others, as appropriate.

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

Contact for further information

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NHS
Commissioning Board
A special health authority

20 June 2012

Dear Colleague

NHS COMMISSIONING BOARD LOCAL AREA TEAMS AND CLINICAL SENATES

Following on from the letter sent at the beginning of June, we are now writing to update you on the outcome of the work to agree the geographies that the NHS Commissioning Board (NHS CB) local area teams will serve and also on the outcome of related work that has been going on to confirm the number and coverage of clinical senates.

Local area teams
We recognise that there is no single, ideal model or geographical footprint for a local area team. Since the NHS CB's four Regional Directors were appointed they have been working with colleagues locally and in the NHS Commissioning Board Authority (NHS CBA) to develop proposals which take account of related local geographies, service patterns and relationships to achieve a sustainable solution that will establish the definitive local presence of the NHS CB.

The proposals have considered a range of factors including the NHS CB's direct commissioning responsibilities; the number and nature of local relationships which will need to be maintained; the boundaries of clinical commissioning groups (CCGs); the interface with local government; and the relationship of local area teams to the pattern of other local footprints such as clinical networks and senates and Local Resilience Forums / Local Health Resilience Partnerships.

As a result of this work, proposals for 27 local area teams were put to the May meeting of the NHS CBA, and we wrote to you to confirm these arrangements and to indicate that the final details of the areas covered would be shared shortly. A full list of the teams will be published on the NHS CBA website, along with a map outlining the geographical boundaries for each. A background briefing pack containing these details is attached for you to share and cascade as appropriate.

Arrangements in London
In London there will be a more integrated structure with three area teams working as an essential part of the overall pan-London arrangements for direct commissioning and functions supporting the delivery of service innovation. These arrangements reflect both the distinct nature of the London Region and the need to ensure effective working with partners at both a Borough and London-wide level.

Clinical Senates
Clinical senates will help Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards (HWBs) and the NHS CB to make the best decisions about healthcare for the populations they represent by providing advice and leadership at a strategic level.

On our behalf, Dr Kathy McLean has led discussions with SHA Cluster Medical and Nursing Directors, local clinical leaders and the NHS CB's Regional Directors to determine the most appropriate number and coverage of clinical senates. As a result of this work it has now been confirmed that there will be a total of 12 senates. A map outlining their geographical boundaries is also available at the link above.

Geographical Alignment
A key principle of the design work for both local area teams and clinical senates has been that there should be alignment of boundaries between structures wherever relationships are important.

The 27 local area teams have boundaries which are largely aligned within those of the clinical senates. There are only three areas where the senate boundaries cut across those of the local area teams. This has been necessary to ensure that the senate boundaries recognise the pattern of patient flows, particularly with tertiary centres.

For example, patient flows and clinical relationships for the north of Cumbria are primarily with the north east, whereas those for the south of the county are predominantly with north Lancashire. The clinical senate boundary reflects these differences, whereas the local area team includes the whole of Cumbria as well as Northumberland, Tyne and Wear, to provide the best alignment with CCGs and local government.

Similarly, close alignment has been sought between the NHS CB's specialised commissioning arrangements and the clinical senates. As a result, the boundaries of the 10 specialised commissioning hubs will be aligned entirely with the 12 senates.

Next steps
Roles in the local area teams will be advertised to eligible candidates within the next few days so that the detailed design of the corporate team, regions and local area teams can now progress in earnest.

Please share this update with colleagues.

Thank you

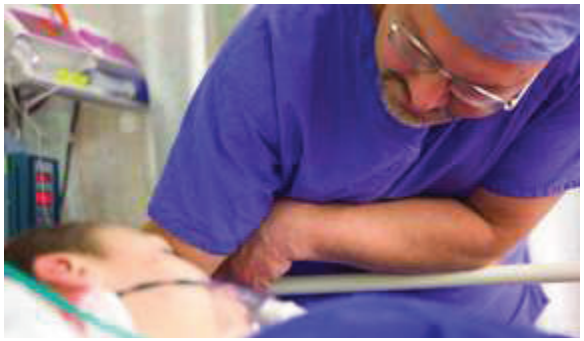
Yours faithfully

Ian Dalton CBE
Chief Operating Officer
and Deputy Chief Executive

Professor Sir Bruce Keogh
National Medical Director

NHS Commissioning Board
A special health authority

NHS Commissioning Board: Local area teams



Staff briefing pack

20 June 2012

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Background

- Regional directors have been working with PCT and SHA clusters, emerging CCG leaders and local government partners to co-design optimal geographies of local area teams within each region.

- The work considered a range of factors including
  - direct commissioning responsibilities;
  - the number and nature of local relationships which will need to be maintained;
  - the boundaries of clinical commissioning groups (CCGs);
  - the interface with local government; and
  - the relationship of local area teams to the pattern of other local footprints such as clinical networks and senates and Local Resilience Forums / Local Health Resilience Partnerships.

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Outcome

- There will be 27 local area teams, with local staff of the operations directorate working from a number of office bases across their geographical area.
  - North of England: 9 local area teams
  - London: 3 local area teams
  - Midlands and East: 8 local area teams
  - South of England: 7 local area teams
- The naming convention has been revised from ‘sectors’ to ‘regions’ and from ‘local offices’ to ‘local area teams’ to recognise the multitude of office bases for local staff.
- The conclusions take account of related local geographies, service patterns and relationships to achieve a sustainable solution that will establish the definitive local presence of the NHS CB.

North of England

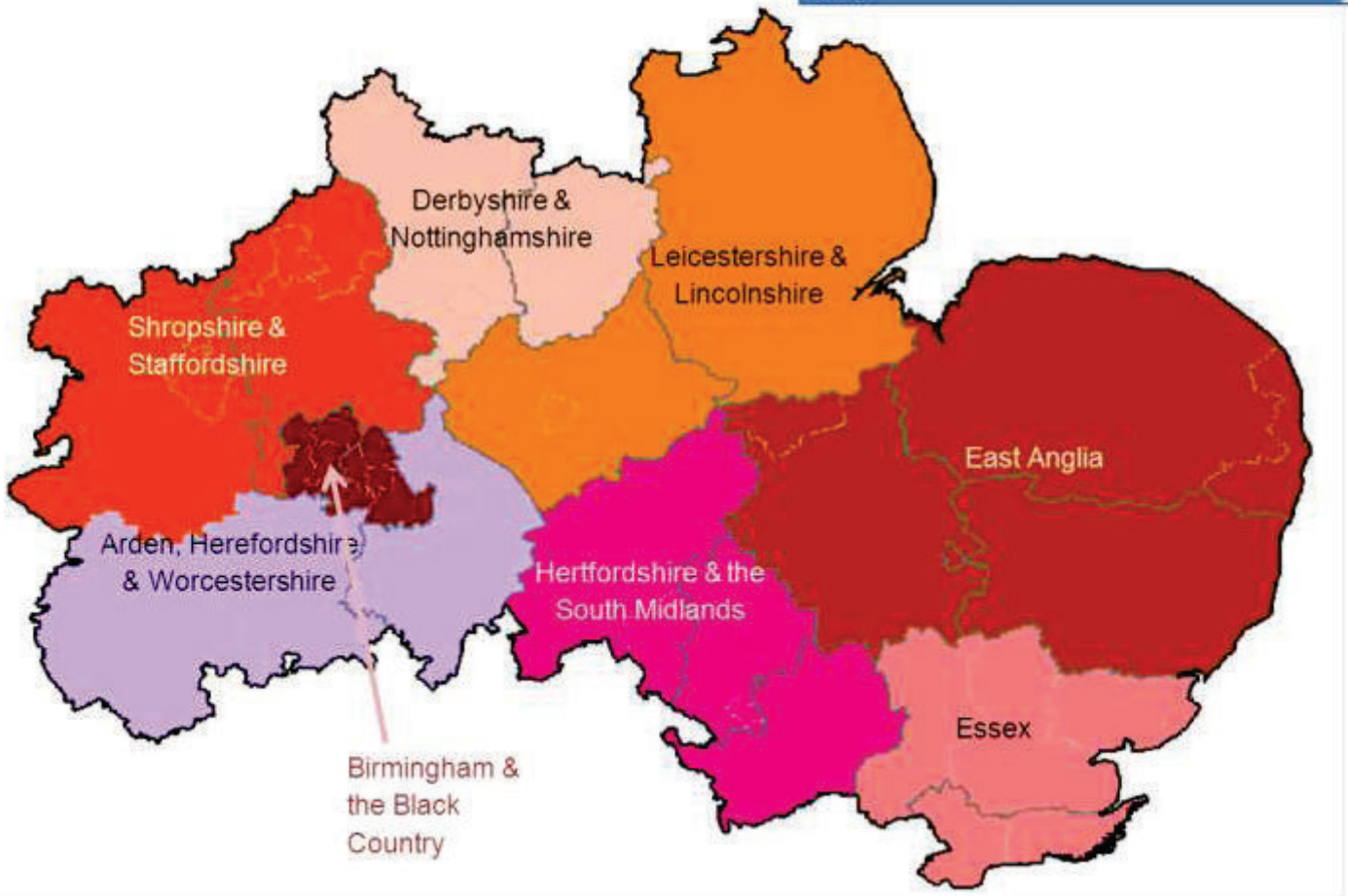
North of England	Popn (1,000s)	CCGs	HWBs
Cheshire, Warrington and Wirral	1195	6	4
Durham, Darlington and Tees	1167	5	6
Greater Manchester	2636	12	10
Lancashire	1424	8	3
Merseyside	1170	6	5
Cumbria, Northumberland, Tyne and Wear	1910	8	7
North Yorkshire and Humber	1690	8	6
South Yorkshire and Bassetlaw	1427	5	4
West Yorkshire	2235	10	5
Total	**14853**	**68**	**50**

London

London	Popn (1,000s)	CCGs	HWBs
North East London	2897	12	13
North West London	1890	8	8
South London	2971	12	12
Total	**7758**	**32**	**33**

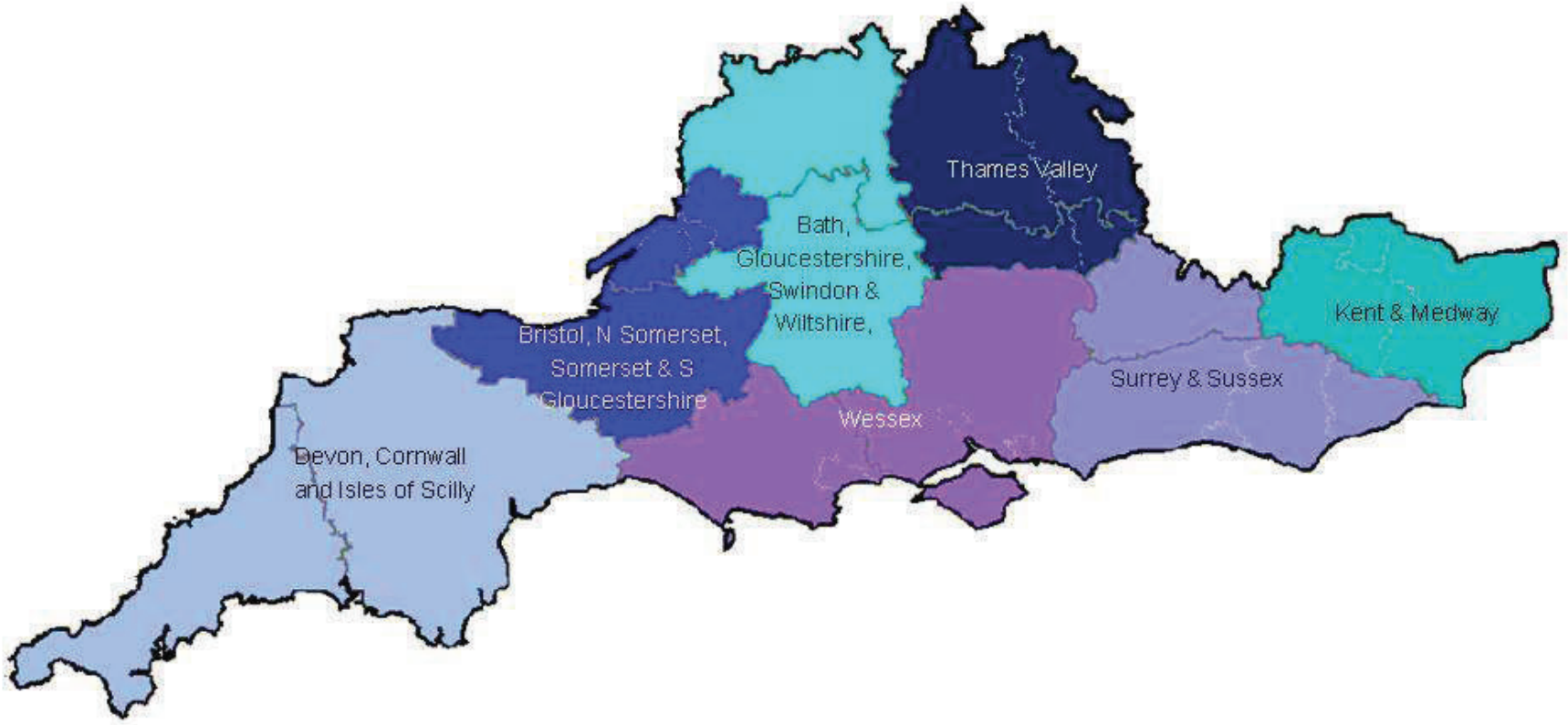
Midlands and East of England

Midlands and East of England	Popn (1,000s)	CCGs	HWBs
Arden, Herefordshire and Worcestershire	1575	7	4
Birmingham and the Black Country	2350	8	6
Derbyshire and Nottinghamshire	1933	10	4
East Anglia	2294	8	4
Essex	1699	7	3
Hertfordshire and the South Midlands	2628	7	6
Leicestershire and Lincolnshire	1674	7	4
Shropshire and Staffordshire	1496	8	4
Total	15649	62	35

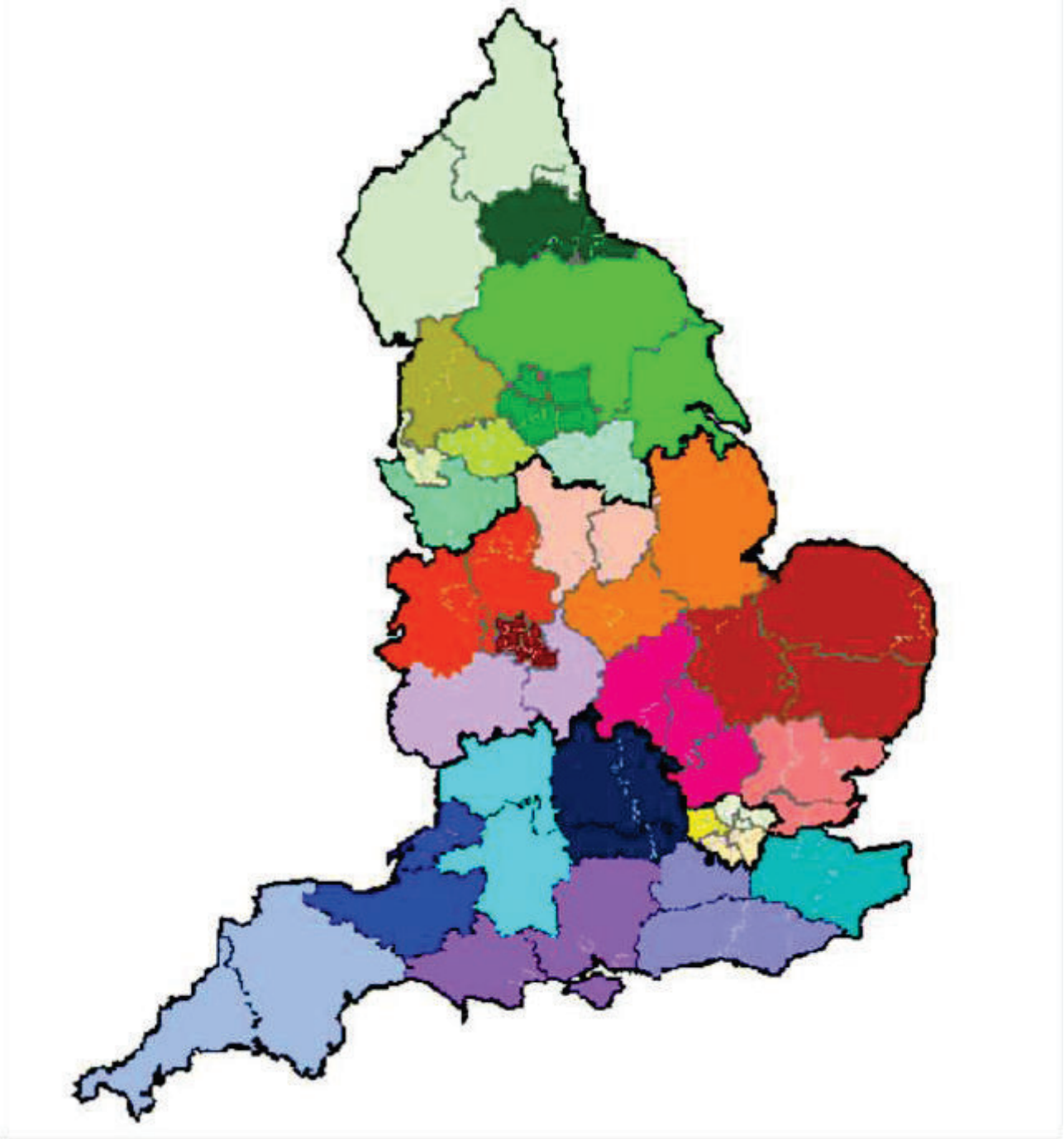


South of England

South of England	Popn (1,000s)	CCGs	HWBs
Bath, Gloucestershire, Swindon and Wiltshire	1411	4	4
Bristol, N Somerset, Somerset and S Gloucestershire	1413	4	4
Devon, Cornwall and Isles of Scilly	1652	3	5
Kent and Medway	1662	8	2
Surrey and Sussex	2640	12	4
Thames Valley	1985	10	8
Wessex	2550	9	7
Total	13313	50	34



England



Local Area Teams

Population, number of CCGs and number of Health and Wellbeing Boards

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Wessex	2550	9	7
Total	**13313**	**50**	**34**

Total	51573	212	152

Local Area Teams

Current PCT cluster to Local Area Team mapping

Region	Local Area Team	Current PCT Cluster
NORTH		
	Cheshire, Warrington and Wirral	Cheshire, Warrington and Wirral
	Cumbria, Northumberland, Tyne and Wear	Cumbria North of Tyne South of Tyne and Wear
	Durham, Darlington and Tees	County Durham and Darlington Tees
	Greater Manchester	Greater Manchester
	Lancashire	Pan Lancashire
	Merseyside	Merseyside
	North Yorkshire and the Humber	Humber North Yorkshire & York
	South Yorkshire and Bassetlaw	South Yorkshire and Bassetlaw
	West Yorkshire	Airedale, Bradford and Leeds Calderdale, Kirklees & Wakefield
MIDLANDS AND EAST		
	Arden, Herefordshire and Worcestershire	Arden West Mercia
	Birmingham and the Black Country	Birmingham Black Country
	Derbyshire and Nottinghamshire	Derbyshire Nottinghamshire
	East Anglia	Cambridgeshire and Peterborough Norfolk, Great Yarmouth and Waveney Suffolk
	Essex	North East Essex South Essex
	Hertfordshire and the South Midlands	Bedfordshire and Luton Hertfordshire Northamptonshire and Milton Keynes
	Leicestershire and Lincolnshire	Leicestershire Lincolnshire
	Shropshire and Staffordshire	Shropshire Staffordshire West Mercia

Local Area Teams

Current PCT cluster to Local Area Team mapping

Region	Local Area Team	Current PCT Cluster
LONDON		
	North East London	Inner North East London North Central London Outer North East London
	North West London	North West London
	South London	South East London South West London
SOUTH		
	Bath, Gloucestershire, Swindon and Wiltshire	Bath, North East Somerset and Wiltshire Gloucestershire and Swindon
	Bristol, North Somerset, Somerset and South Gloucestershire	Bristol, North Somerset and South Gloucestershire Somerset
	Devon, Cornwall and Isles of Scilly	Cornwall and Isles of Scilly Devon and Torbay
	Kent & Medway	Kent & Medway
	Surrey and Sussex	Surrey Sussex
	Thames Valley	Berkshire Oxfordshire and Buckinghamshire
	Wessex	Bournemouth, Poole and Dorset Southampton, Hampshire, Isle of Wight and Portsmouth

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Functions

- All LATs will have the same core functions around:
  - CCG development and assurance
  - emergency planning, resilience and response
  - quality and safety
  - partnerships
  - configuration
  - system oversight

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Functions

- There will be variations around the scope of direct commissioning responsibilities:
  - all local area teams taking on direct commissioning responsibilities for GP services, dental services, pharmacy and certain aspects of optical services;
  - 10 local area teams leading on specialised commissioning across England;
  - smaller number of local areas teams carrying out the direct commissioning of other services such as military and prison health;
  - the model for the commissioning of NHS public health services and interventions still to be finalised.

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London region

- In London there will be a more integrated structure with three area teams working as an essential part of the overall pan-London arrangements for direct commissioning and functions supporting the delivery of service innovation.
- These arrangements reflect both the distinct nature of the London Region and the need to ensure effective working with partners at both a Borough and London-wide level.

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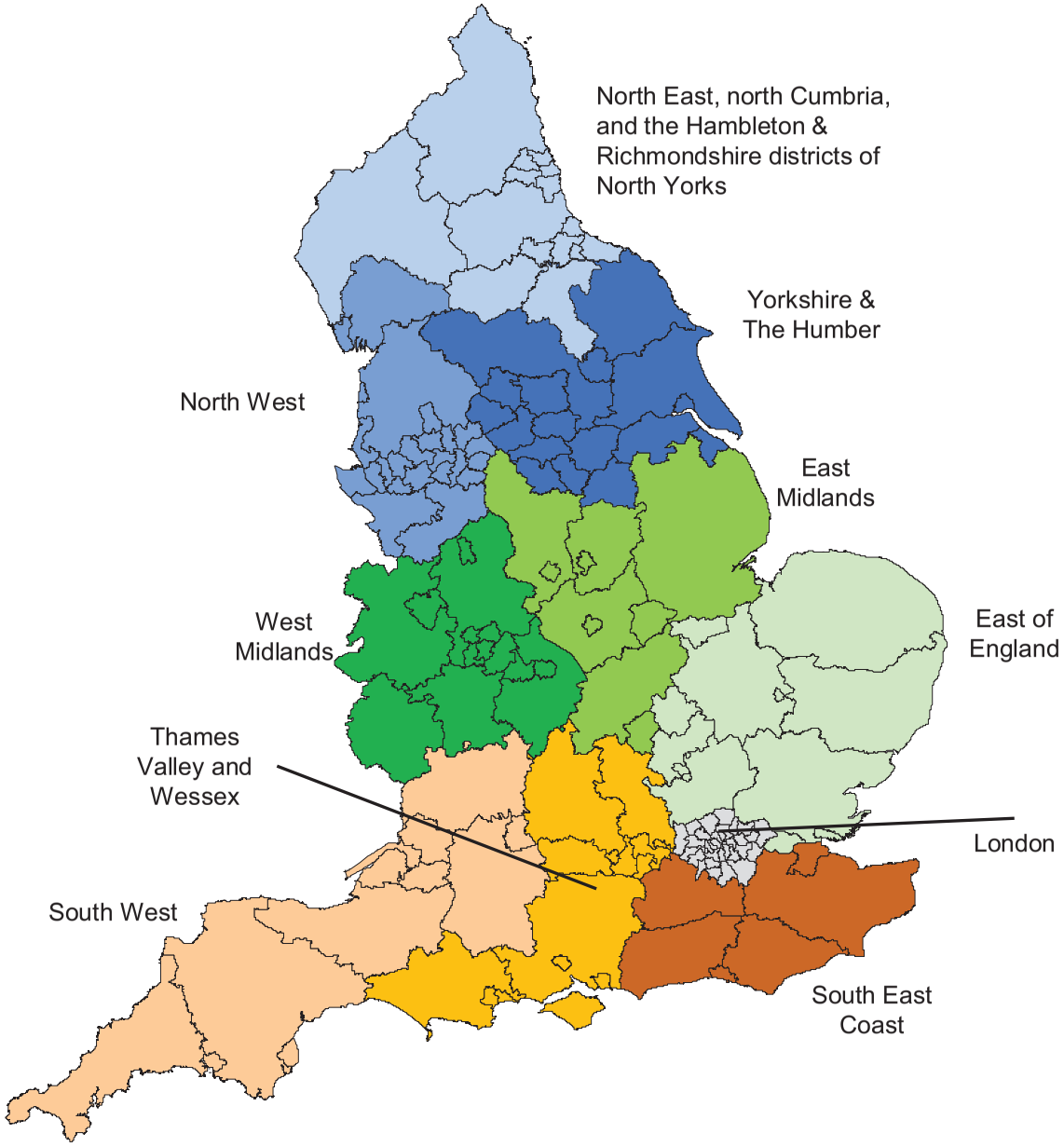
Specialised commissioning

10 of the local area teams will be responsible for specialised commissioning hubs:

- Cumbria, Northumberland, Tyne and Wear
- South Yorkshire and Bassetlaw
- Cheshire, Warrington and Wirral
- East Anglia
- Leicestershire and Lincolnshire
- Birmingham and the Black Country
- Bristol, North Somerset, Somerset and South Gloucestershire
- Wessex
- Surrey and Sussex
- London

Specialised commissioning hubs



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Next steps

- **June – July 2012:** the next steps will be to recruit to the very senior manager (VSM) posts in the Directorate, including:
  - two director level posts in central roles
  - local area team directors; and
  - direct reports to the regional directors

- **July – December 2012:** recruitment to direct reports to the local area team directors and all Agenda for Change posts as part of a rolling programme. This is likely to start with AfC band 8-9 posts.

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Next steps

- We are working across the system, moving as quickly as we can at the same time as aiming to align the recruitment and transfer of staff at similar grades and levels.
- By working in a coordinated way we aim to maximise opportunities for staff and minimise uncertainty and disruption in the current system.

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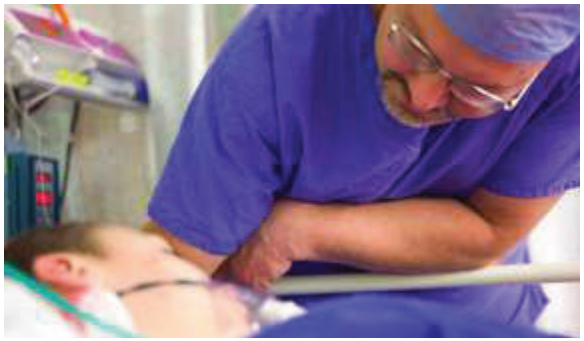
NHS Commissioning Board: Clinical senates



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Background

- Clinical senates will help Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards (HWBs) and the NHS CB to make the best decisions about healthcare for the populations they represent by providing advice and leadership at a strategic level.

- Dr Kathy Mclean has been working with SHA Cluster Medical and Nursing Directors, clinical leaders locally and the NHS CB's Regional Directors to determine the most appropriate number and coverage of clinical senates. As a result of this work it has now been confirmed that there will be a total of 12 senates.

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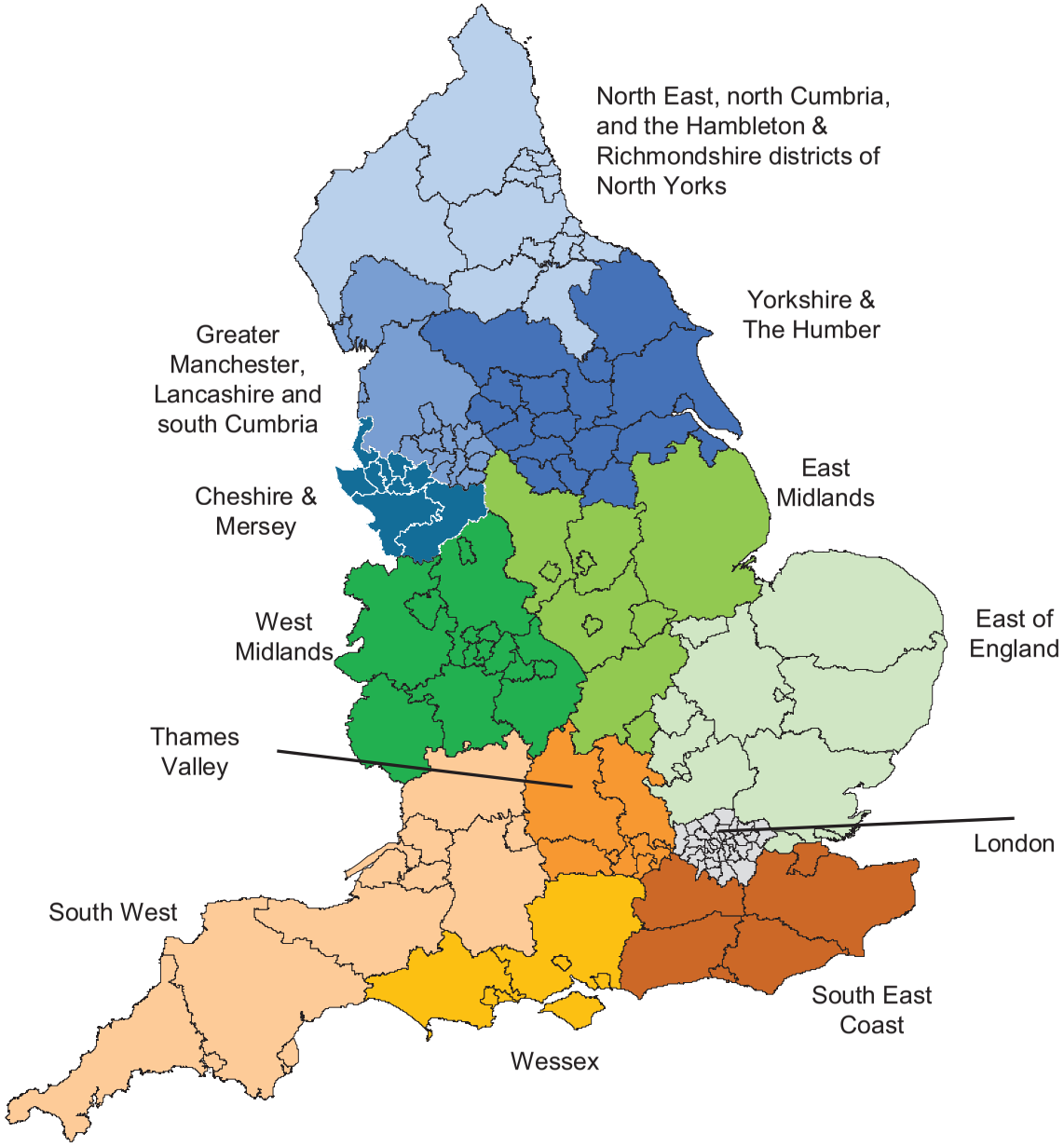
Establishing Clinical Senates

- The detail of who will be part of clinical senates, and the roles they may have will be shared for discussion over the next few weeks.
- They will be made up of a range of clinicians and professionals from health, including public health and social care alongside patients, public and others, as appropriate.
- The NHS Commissioning Board is working with clinicians and stakeholders on the exact makeup of clinical senates, and there will be opportunities for engagement and co-production within this work.
- Further details will be circulated in the coming weeks
- Details will also be shared shortly on the future arrangements for clinical networks

Clinical senates map



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Geographical Alignment

- A key principle of the design work for both LATs and clinical senates has been that there should be alignment of boundaries between structures wherever relationships are important.
- The 27 local area teams have boundaries largely aligned within those of the clinical senates. There are only three areas where the senate boundaries cut across those of the local area teams. This has been necessary to ensure that the senate boundaries recognise the pattern of patient flows, particularly with tertiary centres.
- Similarly, close alignment has been sought between the NHS CB's specialised commissioning arrangements and the clinical senates. As a result, the boundaries of the 10 specialised commissioning hubs will be aligned entirely with the 12 senates.

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HEALTH OVERVIEW AND SCRUTINY PANEL
27 SEPTEMBER 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 RECOMMENDATION

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, 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 three meetings to date, most recently on 7 June 2012. A further, possibly final meeting of the Working Group has been arranged for 12 October.

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, and to monitor the creation of the Health and Wellbeing Board. The Working Group has held four meetings to date, most recently on 29 August 2012. Further meetings of the Group will be arranged, to maintain engagement in the development of the new Health and Wellbeing Strategy.

'Shaping the Future' of Health Services in East Berkshire

3.3 A Working Group is planned 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. This has included responding to the pre-consultation document (see item 10 on the Panel's agenda).

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

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