HEALTH OVERVIEW AND SCRUTINY PANEL
27 SEPTEMBER 2012
7.30 - 9.50 PM

Bracknell Forest Council

Present:
Councillors Virgo (Chairman), Mrs Angell (Vice-Chairman), Baily, Finch, Mrs Temperton and Thompson

Co-opted Representative: Terry Pearce, Bracknell Forest LINk

In Attendance:
Richard Beaumont, Head of Overview and Scrutiny
John Black, Medical Director of the South Central Ambulance Service
Glyn Jones, Director of Adult Social Care, Health and Housing, BFC
Dr William Tong, Chairman of the Bracknell Forest and Ascot Clinical Commissioning Group
Steve West, Operations Director North, Ambulance Service

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

12. **Minutes and Matters Arising**

RESOLVED that the minutes of the Panel held on 14 June 2012 be approved as a correct record, and signed by the Chairman.

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

There were no declarations of interest.

14. **Public Participation**

There were no items submitted under the Public Participation Scheme.

15. **Cardiac Arrest Survival Rates**

John Black, Medical Director of the South Central Ambulance Service (SCAS), and Steve West, Operations Director North attended the meeting to comment on the Trust's performance on out-of-hospital cardiac arrest survival rates.

Data collection for the SCAS in the South East had been more recent than data collection in London and was expected to improve in the future. One in three patients were taken to hospital with a pulse after a cardiac arrest, which was an improvement on the earlier position. Survival rates in relation to out-of-hospital cardiac arrests were expected to be better in the South East when compared to other regions of the country.

There was a focus on achieving best clinical outcomes and all ambulance crews had received refresher training on new devices and clinical systems. The aim was to despatch ambulances more quickly and community responder teams were being

developed. Work was being undertaken with sports teams and there was close working with clinical colleagues. Quality of care in hospitals and direct access to cardiac care was important.

There were challenges regarding information sharing, and there was an indicator for the whole health system in relation to discharges. There was an aim to have an emergency care team at SCAS to assist in improving survival rates for patients.

In response to Members' questions, the following points were made:

- Ambulance services were required by national standards to respond to calls in 8 minutes, and the SCAS responded to 78% of calls in 8 minutes.
- Questions asked from the control room at SCAS did not delay the despatch of an ambulance. The location of a call was confirmed at the same time as questions were asked. Around 95% of calls were answered within 10 seconds and maximum response times were also monitored. SCAS was a national leader in ambulance response times. The control room could advise members of the public or relatives who were with a person who had a cardiac arrest on how to deal with the situation; initial actions by people did help.
- There had been approximately a 6% increase in the number of calls to the call centres which had been amalgamated into one main call centre, and an 8% increase in calls in Berkshire. This had started in February 2012 and was mainly occurring in the evenings and on weekends, and was putting pressure on resources.
- The transfer of staff from Wokingham to Bicester had been seamless and there was now an increased number of staff. Previous call handling had not been as quick but work was being undertaken to improve this and the team of call handlers had been increased to twenty people. Calls were now being answered in approximately 10 seconds. Some staff were redeployed to places other than Bicester. There was a knowledge gap once the merger of call centres had been undertaken and performance had been challenged over the summer months but this had improved now and staff were responding well to the change.
- Capability to progress calls for urgent cases or people requiring community care was being addressed.
- London was a different area to the South East and there was rapid access to defibrillators in many locations in London which made a difference to cardiac arrest survival rates.
- Better quality data was expected in future; just two months of reliable data had been received from hospitals and the way percentages were calculated could make survival rate data look inflated.
- Training was offered to members of the public who wanted to be community responders and ambulance control rooms could instruct people on how to use defibrillators. Signposting to these kits was also important and tracking the location of semi-automatic defibrillators.
- SCAS worked with some 1,400 volunteer Community Responders, and training was refreshed every three months. Anyone interested in becoming a community responder should contact SCAS and they would be put in contact with a local community responder team. Community responder teams were funded by different means including the local community, British Heart Foundation, and public funding. A link would possibly be made with Parish Councils.
- Data was collected using a paper based system which paramedics handed over to hospital staff on arrival to hospital with a patient. Care pathways were well developed and hospital staff used data from electronic systems. The aim

was for there to be electronic links to enable data to be sought directly from hospitals.

- The Department of Health published in May the information from the data collected in relation to cardiac arrest survival rates and this could be shared with members of the Panel.
- There were eleven Ambulance Trusts nationally and clinical indicators were being developed. The aim was to identify good practice and share it.
- There was a national digital system called 'Airwave'. The next system of digital radio was being jointly procured by the Fire, Police and Ambulance Services.
- Mr Black thanked Bracknell Forest Council for its support towards, for example, the Chiltern Air Ambulance Service.

The Chairman thanked Mr Black and Mr West for appearing before the Panel, and indicated that the Panel may wish to review progress on cardiac arrest survival rates in around six months time.

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

Dr William Tong, Chairman of the Bracknell Forest and Ascot Clinical Commissioning Group (CCG) gave a presentation to the Panel on the progress in establishing the Group, the timetable for gaining authorisation, and the production of the Commissioning Strategy. Mary Purnell had given apologies for not being able to attend the meeting.

Issues in relation to the CCG for Windsor, Ascot and Maidenhead had been resolved. Authorisation documents would be submitted tomorrow to enable a site visit. Each applicant CCG would have a one day site visit for the NHS National Commissioning Board to meet the applicant CCG leaders, assess their capability to deliver, and test points arising from earlier phases of assessment.

The Chair of the Governing Body, Dr Tong, and Accountable Officer would sign the application on behalf of the applicant CCG to certify that the applicant was ready and had plans in place to discharge its duties and responsibilities in key areas. The Accountable Officer, Alan Webb from 8 October 2012, would have different responsibilities and would work across three CCGs. Eve Baker, Financial Officer, would share a post to achieve economies of scale across three CCGs.

There were nineteen authorisation core documents, the 360° stakeholder survey had been completed and the report had been received. The main documents included the draft Joint Strategic Needs Assessment (JSNA), the draft Joint Health and Wellbeing Strategy (JHWS), the draft commissioning intentions for 2013-14 and joint commissioning draft agreements or plans, and the Communications and Engagement Strategy.

Another project was being undertaken in relation to maternity and the Community Midwifery Service (CMS). A different team was in place in the CMS and this was working well, making sure that patients were seen in the right place by the right service. There had been positive 360° feedback and some issues highlighted, such as the response rate from the upper tier seemingly not being as high as it could be.

The CCG would be a clinical organisation with different clinical domains and multi-professionals. Governance arrangements needed to be strong and the CCG would not be responsible for commissioning primary care. The CCG would measure the quality of the hospital service through a committee. There would be outcome based services and patient and public involvement. Once the decision had been made

regarding authorising a CCG it was final and all CCGs needed to be authorised. Lay posts were being recruited and a designated nurse role was needed in the CCG.

In response to Members' questions, the following points were made:

- Public Health triangulated data from a population model with the data which was available to them and this could be improved. Some data was coded differently and there was a Payment by Results book. It was now possible to see where services were most used.
- Asthma was a JSNA priority for primary care.
- The scope for innovation depended partly on the resources available to the CCG.
- The JSNA should inform where to focus but it was not known yet how budgets would be assigned. Additional funding may be needed or funding may be moved depending on priorities.
- The CCG had to make a difficult decision regarding HealthSpace but the main aim was to provide services.
- The CCG would not be replicating the Primary Care Trust (PCT), there would be efficiencies of scale and other stakeholders would need to be taken into account. There would be dialogue with other CCGs as changes would impact on more than one CCG.
- Two lay members on the CCG would ensure that patient and public involvement was present, not just from 1 April 2013. There was a perception issue where involvement was concerned as people needed to know how to contribute. Social networks would be used in the Involvement Strategy.
- The aim was for patients to see outcomes.
- If one CCG in the Federation did not achieve accreditation, the other two CCGs would progress independently.
- The Children's Evening Clinic was due to start in Bracknell from 1 September 2012 but there had been some difficulty in finding doctors with the right skills. The finance and room were arranged but it was important to deliver a service of good quality.
- Cancer screening was a JSNA priority and prevention work was needed. Some patients declined screening tests offered, for example for bowel cancer. There would be more focus on preventative work in the JSNA.

17. **Transfer of Public Health Functions**

The Director of Adult Social Care, Health and Housing presented a progress report on the transfer of Public Health responsibilities to Bracknell Forest Council (BFC).

Public Health functions would be transferred to local authorities in April 2013. There would be collaborative working with all six local authorities in Berkshire and PCTs supported by a small team and a consultant in public health. There would be consultation with senior staff in public health, then with those in posts below them.

There was a transition board and the Director of Adult Social Care, Health and Housing at BFC was the lead Director across the six authorities. Considerable progress had been made in partnership with other organisations, and there were different work streams. Work was being undertaken on communications and emergency planning, contracts were being inherited from the PCT and systems were being transferred. The aim was for operational delivery and work streams to be fully operational from 1 April 2013.

Consultation was being undertaken with CCGs on detail, governance issues, finance and contracts. Funding was due to be allocated by the Department of Health and

there would be different funding per head in a county depending on the area, ranging from approximately £21 per head to £100 per head. There would be organisational changes and Berkshire had a different composition with two PCTs and six local authorities compared to other counties.

Close working was being undertaken with health colleagues to access preventative work. The aim was to ensure a safe and stable public health service on 1 April 2013 but other changes after the transfer would take time.

In response to Members' questions, the following points were made:

- Consideration would be given to which services were best delivered in Bracknell and which services were best delivered in other areas of Berkshire, such as specialist services. Emergency protection was delivered across the country. Work would be undertaken with providers and consideration given to the most efficient way of procuring services.
- All parties were working to make the transition as smooth as possible, and it was recognised that it was a time of uncertainty for staff.
- The Government had said that current funding for public health would transfer to local authorities. BFC was not aware of any additional funding or reduction in funding due to the transfer of public health functions. How much funding BFC would receive would be announced soon. BFC would expect to be advised of what their funding allocation was and what it should be, the presumption being that in time the target figure would be reached. If there was any underspend during a financial year Borough Councillors could help to decide whether funding should be carried forward into the next financial year.
- Funding for transitional costs was being announced by government, meanwhile the Strategic Health Authority had already provided some financial support.
- The Government was going to introduce health premium with aim of reducing inequalities. There was an opportunity to earn additional funding as a result of this.

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

The Panel noted the Council's response to the Department of Health's consultation over proposals for Local Authority Health Scrutiny.

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

The Panel noted 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.

This would be discussed further at the next meeting of the Panel once the consultation had been completed. Work was being undertaken with the Council's Executive on the approach to the meeting in relation to the urgent care centre.

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

The Panel noted the new structure for the NHS National Commissioning Board Local Area Teams and Clinical Senates, following the abolition of the Strategic Health Authorities and Primary Care Trusts in 2013.

The Board was national and there would be four regions in the country. Bracknell would be in the South region, Thames Valley, comprising of Berkshire,

Buckinghamshire and Oxfordshire. There would be ten specialist commissioning areas, for example, for cancer care, and for renal care.

Members expressed concern at the cost of the new 'layers' in the NHS, their cost and bureaucracy.

Once more clarity was available, a more detailed report would be brought to the next meeting of the Panel regarding the changes in 2013.

21. **Working Group Update**

The Panel noted the progress achieved to date by the Panel's Working Groups. The Health Reforms Working Group had last met in June 2012 and was due to meet again. The Health and Wellbeing Strategy Working Group would continue to meet to monitor the development of the Health and Wellbeing Strategy.

The 'Shaping the Future' consultation would run until January 2013 and a Working Group of the Panel would consider this consultation. Councillors Virgo, Finch, Kensall and Mrs Temperton had expressed an interest in participating in the Shaping the Future working group at the last meeting of the Panel on 14 June 2012.

22. **Date of Next Meeting**

Thursday 24 January 2013

CHAIRMAN