Bracknell Forest Council

NOTICE OF MEETING

Health and Wellbeing Board
Thursday 11 April 2013, 2.00 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

To: The Health and Wellbeing Board

Councillor Dale Birch, Executive Member for Adult Services, Health & Housing
Dr William Tong, Bracknell Forest & Ascot Clinical Commissioning Group
Councillor Dr Gareth Barnard, Executive Member for Children & Young People
Glyn Jones, Director of Adult Social Care, Health & Housing
Dr Janette Karklins, Director of Children, Young People & Learning
Timothy Wheadon, Chief Executive, Bracknell Forest Council
Dr William Tong, Bracknell Forest & Ascot Clinical Commissioning Group
Mary Purnell, Bracknell Forest & Ascot Clinical Commissioning Group
Lise Llewellyn, Director of Public Health
Helen Clanchy, Thames Valley Area Team
Mrs Andrea McCombie-Parker, Local Healthwatch

ALISON SANDERS
Director of Corporate Services

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If you require further information, please contact: Priya Patel
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Published: 3 April 2013

Health and Wellbeing Board
Thursday 11 April 2013, 2.00 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

AGENDA

		Page No
1.	**Election of Chairman** The Board is asked to nominate a chairman.	
2.	**Appointment of Vice-Chairman** The Board is asked to appoint a Vice-Chairman.	
3.	**Apologies** To receive apologies for absence and to note the attendance of any substitute members.	
4.	**Declarations of Interest** Any Member with a Disclosable Pecuniary Interest or an Affected 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 Interest is not entered on the register of Members interests the Monitoring Officer must be notified of the interest within 28 days.	
5.	**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.	
6.	**Minutes from Previous Meeting** To approve as a correct record the minutes of the meeting of the Board held on 14 February 2013.	1 - 8
7.	**Matters Arising**	
8.	**Arrangements for Substitutes and Public Participation at Board Meetings** The Board became statutory on 1 April 2013, this report asks that the Board agree its arrangements for substitutes and public participation at Board meetings.	9 - 14
9.	**Link Final Annual Report** The LINK's final Annual Report for 2012/13 is attached for the Board to note.	15 - 38

10. **Francis Report into Mid Staffs**

To update the Health and Wellbeing Board regarding the Francis Inquiry and the Government's response to the Inquiry with the purpose that the Board discusses and agrees a mechanism to identify the partners' roles and responsibilities to implement the recommendations. 39 - 56

11. **Local Healthwatch Bracknell Forest Contract Award**

Following a procurement process, the contract for Local Healthwatch Bracknell Forest was awarded to the Ark Trust Limited, this information report provides further detail on this contract. 57 - 70

12. **Shaping the Future - Primary Care Trust Decision and Action Plan**

The Board of NHS Berkshire has approved recommendations relating to changes to four services used by patients living in east Berkshire and south Buckinghamshire which are currently provided at Heatherwood Hospital, Ascot. The decisions were taken following a three-hour discussion on 26 March 2013. The changes relate to maternity, minor injuries, stroke rehabilitation and general rehabilitation services. 71 - 82

13. **Relationship of the Board with NHS England**

This information report describes the new structures for commissioning health and care services for the people in the Thames Valley following the implementation of the Health and Social Care Act 2012. It details the new organisations that will be involved in commissioning from 1 April 2013. 83 - 92

14. **Pooled Budget Agreements**

To inform the Health and Wellbeing Board of the current pooled budget agreements and the new arrangements with the Clinical Commissioning Groups. 93 - 96

15. **Actions Taken Between Meetings**

16. **Forward Plan**

Board members are asked to make any additions or amendments to the Board's Forward Plan as necessary. 97 - 104

17. **Dates of Future Meetings**

4 July 2013
5 September 2013
12 December 2013
13 February 2014
10 April 2014
All meetings will be held at 2pm.

SHADOW HEALTH AND WELLBEING BOARD
14 FEBRUARY 2013
2.45 - 4.30 PM

Present:
Councillor Dale Birch, Executive Member for Adult Services, Health & Housing (Chairman)
Dr William Tong, Bracknell Forest & Ascot Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard, Executive Member for Children, Young People & Learning
Glyn Jones, Director of Adult Social Care, Health & Housing
Dr Janette Karklins, Director of Children, Young People & Learning
Dr Lise Llwellyn, Director of Public Health for Berkshire (East)
Mary Purnell, Bracknell Forest & Ascot Clinical Commissioning Group

Apologies for absence were received from:
Timothy Wheadon, Chief Executive, Bracknell Forest Council
Helen Clanchy, Thames Valley NHS Commissioning Board Representative

Also Present:
Kieth Naylor, Joint Commissioning Officer
Sandra Davies, Head of Performance Management & Governance
Zoe Johnstone, Chief Officer: Adults & Joint Commissioning
Lisa McNally, Consultant for Public Health
Kieth Naylor, Joint Commissioning Officer

1. **Declarations of Interest**

There were no declarations of interest.

2. **Urgent Items of Business**

The Chairman reported that there were two items of urgent business that had arisen since the publication of the papers for the meeting:

i) The Francis Inquiry Report into Mid Staffordshire NHS Foundation Trust. The Director of Adult Social Care, Health & Housing reported that the Francis report had been published in the previous week and it had included 290 recommendations. The Department of Health had yet to respond to the findings. Commissioning organisations locally were preparing to take action and commissioning arrangements in light of the recommendations would be reported back to the Board at the next meeting. Action plans were also being developed to ensure that acute care was in line with the recommendations.

Board members made the following comments:

- The recommendations were extremely important, the Board were clear that the unacceptable care provided at mid Staffordshire could not be repeated. Every stakeholder needed to engage with the findings to ensure patient safety and care.

- It was critical that the voice of the patient and carer was always heard and that performance and targets did not hinder patient care. The Board was keen to see a strong commitment to patient care in all plans and actions of partner organisations.
- The Chairman stated that it was clear that structures had failed at mid Staffordshire and that nobody seemed to want to take responsibility for these failures. He invited the chairman of the Health Overview & Scrutiny (O&S) Panel to comment.
- Cllr Virgo stated that they had already agreed to set up an O&S Working Group to look into this and in particular the scrutiny at mid Staffordshire and how it had apparently failed.
- Board members noted that at mid Staffordshire there seemed to be lots of reporting by patients and families expressing concerns, however little if anything was done in response. The Chairman stated that the Board would also be seeking input from Healthwatch on the report, their input would be invaluable.
- The Director of Public Health reported that CCG's and PCT's had been keeping a watchful eye on the emerging recommendations from the Francis Report over the last few months, particularly around areas where a higher than expected death rate existed. Quality monitoring and a robust complaints process would be critical in any new structure. GP's also had a contact number that they could use to report any concerns.

The Chairman stated that it was key that the Board continued to drive the agenda; he did not want to see the Board becoming bureaucratic in its function. If action needed to be taken between formal meetings of the Board, they should be completed as soon as possible and all members notified by email. If decisions were needed between meetings, this could be done by asking the Chairman or Vice Chairman for approval and then listing the decisions made between meetings at the next regular meeting of the Board for information and examination if necessary. It was agreed that the Board would conduct it business in this way to eliminate delays, particularly regarding issues around the Mid Staffs recommendations.

ii) The suggested possibility of a merger of the Frimley Park Trust with Heatherwood and Wexham Park Trust reported in the local media over the last few days. Dr Tong reported that Heatherwood & Wexham Park Trust had undergone a series of financial difficulties over the years and a suggested solution was for the Trust to merge with the Frimley Park Trust. It would be prudent for local commissioners to develop a plan locally rather than for there to be central intervention. Frimley Park and Heatherwood & Wexham Trust's had announced in the media that they would consider the possibility of merging and how this could be achieved. The Board agreed that if this did emerge into a local proposal, it would be one that the Board would support in principle.

The Chairman stated that he sincerely hoped that any proposals would consider the whole picture and what would be best for the population of Bracknell Forest and the surrounding area, based on sound clinical judgement and need. Proposals should not focus on location, but on quality, long term viability and not short term political fixes. If proposals were controversial, politicians and other partners would need to make some brave decisions to secure the best possible healthcare solution for

local people. He was keen to support the providers and looked forward to hearing their proposals.

The Director of Adult Social Care, Health & Housing stated that the Council would do whatever it could to assist the providers.

Board members were keen that quality of care and patient outcomes remained central to proposals; there existed a discrepancy between the two trusts in terms of quality.

3. **Minutes from Previous Meeting**

It was **RESOLVED** that subject to Minute 36, paragraph 4 being amended to 'CCG's Governing Body Nurse', the minutes of the Board meeting held on 6 December 2012 be confirmed as a correct record.

4. **Matters Arising**

Minute 35: Special Educational Needs (SEN) Arrangements
The Director of Children, Young People & Learning reported that work had now progressed, health colleagues had met with her officers to discuss areas where there had been changes to funding. A lead officer had now been confirmed for each area and another meeting with health colleagues was scheduled on 4 March.

Minute 38: The Health & Wellbeing Board: April 2013 Onwards: A Formal Statutory Committee – Protocols
Secondary regulations had been laid in Parliament and the Bracknell Forest Council's Legal team were in the process of determining governance arrangements for the Board. The Director of Adult Social Care, Health & Housing reported that Helen Clanchy had now been appointed by the NHS Commissioning Board as the Board's Local Area Team member for the purposes of section 197 of the Health and Social Care Act 2012.

Minute 40: Forward Plan
Dr Tong reported that the responsibility for the results of the Shaping the Future consultation would now rest with the CCG.

5. **Health & Wellbeing Strategy - Governance Arrangements**

The Board considered a report that sought to establish appropriate governance arrangements to ensure the implementation of the Health and Wellbeing Strategy (HWBS).

The Chief Officer: Adults and Joint Commissioning reported that the model strategy had been approved by the Board at the last meeting. The proposals included in this report set out to capitalise on existing structures to implement the strategy. It was proposed that three workstreams/groups be used to monitor and coordinate the implementation of the strategy:

- Prevention – Public Health Lead
- Intervention and Treatment – Clinical Commissioning Group (CCG) Lead
- Long Term Support – Children's Social Care Lead

She reported that a communications plan was being prepared for the Board that would incorporate communications for the Joint HWBS.

Board members made the following comments:

- The chairman reiterated the importance of using the latest available data and it was agreed that the wording of the report would be revised to reflect this.
- It was envisaged that the workstreams would report to the Board on a quarterly basis through performance reports. Information would also be sent to Overview and Scrutiny, Executive Members and the CCG.
- If any impediments or barriers to sharing information were identified, these would be brought back to the Board for resolution.
- The Director of Children, Young People & Learning requested that children's services be represented in the triangle of services presented on page 13 of the agenda papers.
- The Director of Adult Social Care, Health & Housing stated that the Board was charged with encouraging integration, the themed workstreams would contribute to this. The themes would entail a range of stakeholders coming together and undertaking cross cutting, joint work.
- The Director of Public Health stated that the Health & Wellbeing Strategy would be a key document when delivering improvements in public health. The Board would need to review the public health framework on a six monthly basis. The approach to governance was fine, the priorities would now need to be turned into action plans to implement the strategy. This would also address any concerns around children's services.
- The Board made preliminary suggestions for leads of each workstream as follows:
  - Public Health Lead, Lisa McNally
  - CCG Lead, Dr William Tong/Mary Purnell or Rohal Malik
  - Adult/Children's Social Care Lead, Zoë Johnstone/To be confirmed.

It was **RESOLVED** that;

i) the communications requirements in respect of the strategy be developed alongside those of the CCG and Health and Wellbeing Board, including consistent presentations at all relevant partnership boards and project/programme boards or equivalent. A provisional list of the relevant groups is attached at Annex A of the agenda papers.

ii) the implementation of the strategy be monitored and coordinated through three workstreams/groups, the focus of which will be:
- Prevention – Public Health Lead
- Intervention and Treatment – CCG Lead
- Long Term Support – Children's Social Care Lead

Progress will be reported to the Board via these workstreams/groups

iii) the leads/chairs of these workstreams/groups form the core of the group that will refresh/review the HWBS. This group to be chaired by a representative from Adult Social Care, Health & Housing.

iv) the relevant Board members nominate the chairs for the workstreams/groups and the strategy review group.

6. Draft Clinical Commissioning Group's Plan for 2013/14

The Board considered a report that detailed the latest draft plans for 2013/14 produced by NHS Bracknell and Ascot CCG and sought the views of the Board members to inform the final plan for 2013/14.

Dr Tong made the following points:

- The Area Team officers from the NHS Commissioning Board had now been appointed, Helen Clanchy had been appointed to the Bracknell Forest area.
- He referred the Board to the CCG's 'plan on a page' which the CCG had been required to produce.
- He reported that the three CCG's would work together in clinical forum as this would add strength.
- A single point of contact was available for GP's to put forward their concerns around any Trust or areas of failing around health. The facility was well used by the Bracknell and Ascot CCG which should be seen as a positive as it demonstrated that the CCG were on board with the idea and were keen to be a conduit, feed into the system with the overall objective of improving healthcare.
- Effective partnerships had been established; this included the Health & Wellbeing Board.
- The CCG would need to establish three priority areas as follows:
  - i) Public perception of primary care services, this was a local priority that the CCG would like to improve.
  - ii) Patients with long term conditions
  - iii) The third priority needed to be confirmed and would either be patient reported outcomes of hip and knee replacements, or local prevalence of depression. Local prevalence of depression was difficult to measure as baseline data was not at present available.
- The CCG had been subject to tight national deadlines to agree priorities and had based the three priorities on data taken from the Joint Strategic Needs Analysis, the Health and Wellbeing Strategy and Everyone Counts. The Board's input was welcomed.
- In response to members' queries, Dr Tong reported that local data around depression only showed prevalence and it was likely that this was an area affected by under-reporting. A marker for the data was necessary, for example, suicide rates could be used. Local psychiatrists and psychologists had been tasked with considering this further.

Board members made the following points:

- The Director of Public Health reported that it was important that there was sufficient alignment between the CCG Plan and the Health & Wellbeing Strategy and based on the CCG Plan before the Board there was sufficient alignment. She suggested that it may be difficult to quantify and/or impact upon the prevalence of depression and that it may be prudent to consider measures relating to experience of patients undergoing hip or knee replacements as this could be validated and measured and create a significant impact.
- The Director of Adult Social Care, Health & Housing noted that there was a healthy link between the CCG's core business and the Health & Wellbeing Strategy.
- Board members noted that priorities were based on outlying areas for the CCG and queried whether work was being undertaken around areas that were likely to become outlying areas. The Director of Public Health reported that this was the first time the CCG had been presented with the data and as a result it was difficult for the CCG to identify emerging issues at this early stage. Dr Tong reported that trend analysis and referral patterns would be monitored and used for priority setting.

- It was noted that there were a number of abbreviations and acronyms in the report and Board members agreed to refrain from using these, in order to ensure the reports could be easily understood by all.
- Board members were asked to feed through any other comments on the Plan to Mary Purnell.

It was **RESOLVED** that the Health & Wellbeing Board had reviewed the CCG Plan and asked that the comments made above be taken on board.

7. **Alignment of Service Plans with the Joint Health & Wellbeing Strategy**

The Board received a report that indicated the alignment of the proposed service plans for the Adult Social Care, Health & Housing and the Children, Young People & Learning department with the Joint Health & Wellbeing Strategy (JHWS). It was noted that at this stage with the Public Health function yet to transfer, the Adult Social Care, Health & Housing Plan was not sufficiently detailed in this area and this detail would be added in the first quarter of 2013/14.

The Director of Adult Social Care, Health & Housing reported that there was a requirement to ensure that the local authority's service plans were aligned to the JHWS. The report detailed this alignment for Adult Social Care, Health and Housing and Children, Young People and Learning. Further work would be necessary to align the Council's other departmental plans to the Strategy.

He stated that the report set out priorities for his department for the forthcoming year and included links to the JHWS.

The Director of Children, Young People & Learning stated that the report detailed main and underlying priorities for the department and there would be a crucial refresh of actions around the Plan coming up soon. She welcomed the opportunities for joint working and shared understanding. There would also be an opportunity to make better use of resources and to find synergies.

Recently there had been some work with young people around their emotional wellbeing in schools; this could potentially provide a useful starting point for joint working. In addition, the Children and Young People Partnership was a very active group.

Board members noted the need for clear priorities to ensure the voice of children and young people was heard.

It was **RESOLVED** that the Board;

i) endorsed the conclusion from the assessment that the service plans for Adult Social Care and Children's Social Care are aligned with the themes and priorities of the Joint Health and Wellbeing Strategy.

ii) on the basis of the analysis, will consider the opportunities for integrated working arrangements between partners and for the pooling of resources.

iii) Recommend the analysis be conducted for all local authority service plans and other commissioning plans for health and social care services.

8. **Funding Streams 2013/14**

The Director of Adult Social Care, Health & Housing presented a report that reviewed last year's expenditure in relation to NHS Funding for Social Care and set out proposals for the Board to comment on in relation to NHS Funding for Social Care for 2013/14. The report also set out details of bids, submitted to the Strategic Health Authority in relation to 'winter pressures' and Enhanced Intermediate Care.

The Director of Adult Social Care, Health & Housing made the following points:

- The Department of Health had issued a letter detailing 'what to expect' in terms of the funding transfer from Social Care in 2013/14. With the abolition of the Primary Care Trust, this transfer will be carried by the NHS Commissioning Board.
- The allocation for Bracknell Forest was £1,295,071 and the criteria were contained in the letter. There was a condition that local authorities agree with local health partners on how the funding was best used within Social Care, recognising the Health & Wellbeing Board as the natural place for these discussions.
- The funding in relation to managing demographic and system capacity pressures had ensured that the department had not overspent causing potential pressures for the Council and the need for further efficiencies. It had provided ongoing social care support for people and ensured that the capacity was available to respond to the pressures within the health system.
- The new proposed allocation for Public Health was expected to be £100k. It was expected that current contracts would be rolled over for one year to avoid disruption to services, this would limit early flexibility. No absolute plans would be agreed until the funding was confirmed. It was proposed that there would be additional funding for dementia support.
- The Department of Health had identified additional funding to 'Support Local Resilience during Winter and Maintaining Access in 2013/14'. This would be administered by NHS South of England; there was £82.5 million available and a minimum of £25 million to be invested in Social Care. The Council was notified by the CCG prior to Christmas following the Department of Health letter issued on 20 December 2012 and bids needed to be returned on 7 January 2013. A number of bids had been submitted as detailed in the report.
- Reporting of progress with bids and specific projects would be undertaken between Board meetings.

It was **RESOLVED** that the Board;

i) noted and supported the proposals in the report,
ii) endorsed the approach to utilising the NHS Funding for Social Care
iii) and agreed the reporting mechanisms back to the Board.

9. Forward Plan

Board members asked that:

- Pages 74 and 75 of the agenda papers relating to the Local Safeguarding Children's Board Annual Report to be incorporated into the programme of Board meetings as a single grouped item.
- Other items 'on the horizon' to be reviewed.

10. Date of Next Meeting

The Board agreed the following meeting dates for 2013/14:

11 April 2013
4 July 2013
5 September 2013
12 December 2013
13 February 2014
10 April 2014

CHAIRMAN

THE HEALTH & WELLBEING BOARD
11 APRIL 2013

ARRANGEMENTS FOR BOARD MEMBER SUBSTITUTES AND PUBLIC PARTICIPATION AT BOARD MEETINGS
Director of Corporate Services

1 PURPOSE OF REPORT

1.1 This report asks the Board to determine its arrangements for substitutes and public participation at Board meetings.

2 RECOMMENDATIONS

2.1 That the Board determine whether it wishes the Council to permit substitutes for each Board Member, subsequently to be agreed by full Council.

2.2 That the Board recommend to full Council that the Council and Committee Procedure Rules in the Council's Constitution be amended to permit the Board to implement a scheme of public participation.

2.3 That subject to the Council accepting the recommendation in 2.2 above, the Scheme of Public Participation set out at Annex A be approved.

3 REASONS FOR RECOMMENDATIONS

3.1 To enable the public to participate at Board meetings and for the Board to operate efficiently.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

Substitutes

5.1 If the Board wishes to nominate substitutes, these named substitutes must be formally appointed by full Council and each substitute will have full voting rights when attending a Board meeting on behalf of their substantive Board member.

5.2 It may be the case that some Board members may wish to nominate substitutes whilst others may not. It is advised that as a minimum the Local Healthwatch representative nominate a substitute to ensure that Board meetings are quorate.

5.3 Board members are asked to note that they must notify Democratic Services at least two hours before a meeting if they have asked a substitute to attend on their behalf. At present the Council's Constitution permits substitutes for councillors but not otherwise.

Public Participation

5.4 The Council's Procedure Rules and Committee Procedure Rules in the Council's Constitution provide that the Overview and Scrutiny Commission, the Licensing and Safety Committee, the Planning Committee and the Appeals Committee may make arrangements for public participation. Accordingly if the Board wishes to implement such a scheme the Council's Constitution will require amendment.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 Comments incorporated within the report.

Borough Treasurer

6.2 There are no financial implications directly arising.

Equalities Impact Assessment

6.3 N/A.

Strategic Risk Management Issues

6.4 None arising.

Other Officers

6.5 None.

7 CONSULTATION

Principal Groups Consulted

7.1 None.

Method of Consultation

7.2 Not applicable.

Representations

7.3 Not applicable.

Background Papers

None.

Contact for Further Information

Priya Patel – Democratic Services Officer: 01344 352233
Priya.patel@bracknell-forest.gov.uk

ANNEX A

Scheme for Public Participation for the Health & Wellbeing Board

The Board is committed to encouraging public participation in its work. This Scheme will give the public an opportunity to raise issues at Board meetings that concern them. All issues raised by the public under this scheme will be given careful consideration. While it will not be possible, in every case, to resolve an issue to the satisfaction of everyone, the Board will ensure that the issue is considered fairly.

1. What can the public do?

The public may use this Scheme to either submit a petition or ask a question at a Board meeting as follows:

(a) Petition:
A petition must be submitted at a minimum of seven working days before a Board meeting and must be given to Democratic Services by this deadline. This is to allow sufficient time for the petition to be added to the agenda papers for the Board meeting and circulated. There must be a minimum of ten signatures for a petition to be submitted to the Board.

(b) Question:
The Board will include a 15 minute slot for questions from the public (towards the end) near the beginning of its agenda. If a member of the public would like to ask a question they must arrive 15 minutes before the start of the meeting to provide the clerk with their name, address and the question they would like to ask. Alternatively, members of the public can provide this information via an email to Democratic Services or the contact officer listed on the front of the Board agenda papers at least two hours before of the meeting.

At the meeting, the Chairman will invite each member of the public to put their question at the appropriate point in the agenda. This may be addressed to the Chairman of the Board, who will decide which Board member is best placed to provide a response. The question must be about an issue that falls within the remit of the Board's work. A questioner who has put a question in person may also put one supplementary question, without notice, to the Board Member who has replied to his or her original question. A supplementary question must arise directly out of the original question or the reply. The Chairman may reject a supplementary question on any of the grounds in Section 3 below.

2. Relevance to the Board

The subject matter of a petition must be about something that is within the Board's responsibilities. This includes matters of interest to the Board as a key stakeholder in improving the health and wellbeing of communities. The subject matter of questions must relate to an item on the Board's agenda for that particular meeting. Democratic Services can provide advice to the public on the content of their submissions where requested.

3. What falls outside the scheme?

Some matters fall outside the scope of this scheme. These are:

- Individual's circumstances where it would not be appropriate for details to be aired in open session;

- Applications for legal consents where alternative procedures exist for the public to offer views; and
- Other proposals of any kind which have been formally published and where specific arrangements are made for the public to express their views.

The Chairman may also reject a submission if it:
- is not about a matter for which the Board has a responsibility or which affects the Bracknell Forest or Ascot area;
- is defamatory, vexatious, frivolous or offensive;
- is substantially the same as a submission which has already been put at that meeting or another meeting held within the preceding six months;
- Is about the subject of an appeal or review procedure that has not yet been concluded, or
- requires the disclosure of confidential or exempt information.

4. Number of submissions

If numerous submissions are made to any one particular meeting, no person may make more than **two** submissions and no more than two submissions may be made on behalf of one organisation or group. If numerous submissions are not submitted, three submissions may be made by any one person or group/organisation.

5. Support for the Public

The prospect of speaking at a formal meeting of the Board may be daunting for the public. Every help and support will be made available to those who wish to use this scheme. The Councillors and Officers present will treat members of the public with courtesy and respect.

6. Time Limits

No individual question will be allowed more than three minutes at a meeting. This rule will be strictly enforced in fairness to all those who wish to address the meeting. The overall time allowed at a meeting to hear and deal with submissions from the public will be decided by the Chairman, or by the meeting itself, but will not normally exceed 15 minutes. This will take into account the issues to be raised in the submissions, the number of submissions and the other business of the meeting.

Submissions will be heard in the order notice of them was received, except that the Chairman may group together similar matters. Where there is insufficient time to deal with all submissions received, the Chairman will decide which submissions should be dealt with at the meeting. Any submissions not dealt with will be formally received by the meeting and a written response will be given as soon as possible after the meeting.

7. Written Answers to Questions

Any question which cannot be dealt with during the allocated time, either because of lack of time or because of the non-attendance of the Board Member to whom it was to be put, will be dealt with by a written answer. Written answers shall be sent to the

Questioner and copied to all Board Members.

8. Action the Board May Take

In the case of a question, a written reply may be given where this is more convenient and can be circulated at the meeting. In the case of Petitions, the meeting will decide on the most appropriate course of action, which will be either to note the petition or to request an Officer report to a subsequent meeting of the Board on the issue raised.

9. General Information

The public are welcome to attend Board meetings where open business is discussed, but may not speak at the meeting unless via the Board's Public Participation Scheme.

This Scheme may be reviewed by the Board, as required.

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TO: **HEALTH AND WELLBEING BOARD**
11 APRIL 2013

LOCAL INVOLVEMENT NETWORK (LINk) ANNUAL REPORT
Director of Adult Social Care, Health and Housing

1 PURPOSE OF REPORT

1.1 To formally receive the Annual Report and Accounts (Annex 1) in accordance with the statutory requirements and agree arrangements for making it publicly available by the statutory deadline.

2 RECOMMENDATIONS

That the Board members

2.1 Receive the report

2.2 Agrees Local Healthwatch Bracknell Forest should, by 30 June 2013:

a. **Make the report publicly available on the Local Healthwatch Bracknell Forest website**

b. **Distribute the report to recipients as outlined in the body of the report**

3 REASONS FOR RECOMMENDATIONS

3.1 The Local Government and Public Involvement in Health Act 2007 (as amended by The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012) requires LINks to make publicly available an annual report and accounts and distribute it to Bracknell Forest Council, the health overview and scrutiny committee, the Bracknell Forest and Ascot Clinical Commissioning Group, the Secretary of State for Health and Healthwatch England by 30 June 2013.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None. The preparation and distribution of the report is a legal requirement.

5 SUPPORTING INFORMATION

5.1 The report complies with the "Directions on Matters to be Addressed in Local Involvement Network Annual Reports 2008" and the later Department of Health Guidance on "Changes to LINk annual reports 2012-13" and sets out:

- contact details for the LINk
- financial information
- names of individuals who have been authorised representatives and/or involved in making relevant decisions
- summary of activity detailing requests for information, enter and view, reports and recommendations and referrals to overview and scrutiny

- outline of LINk legacy

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 Not sought.

Borough Treasurer

6.2 Not sought.

Background Papers
Annex 1 – Annual Report
Directions on Matters to be Addressed in Local Involvement Network Annual Reports 2008
Changes to LINk annual reports 2012-13

Contact for further information
Glyn Jones, Adult Social Care, Health and Housing - 01344 351936
Glyn.Jones@bracknell-forest.gov.uk,

Bracknell Forest

Local Involvement Network

Annual Report

2012/13

Growing Stronger Communities

By joining together, many whispers become one voice

“Our Vision for the Bracknell Forest LINk is...making health and social care work for you by developing services that truly reflect the needs of people living and working in Bracknell Forest.

We have already established, and continue to develop, a diverse network of local people, communities, groups and organisations.

With your help we will create a stronger, more independent voice, to work together to help shape future services, strengthen and widen the influence of patients and service users in the planning, delivery and improvement of health and social care services for Bracknell Forest.”

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Hello and Welcome

As you will have seen from our last Annual Report (to 31 March 2012), the changes introduced by the Government's Health and Social Care Bill have resulted in the 152 Local Involvement Networks (LINks) around the country ceasing to exist from 31 March 2013.

In spite of the knowledge that 'we', the LINk, will not exist beyond March 2013, we have taken the view that it must be 'Bracknell Forest LINk business as usual' up until the latest date possible.

Locally, through its External Representatives, the LINk has continued to maintain an effective and constructive working relationship with statutory organisations – such as the Primary Care Trusts, soon to be Bracknell and Ascot CCG, NHS Hospital Trusts, the voluntary sector and the Shadow Health and Wellbeing Board. These are important for any 'consumer champion' as without them, the public / lay person's influence would be minimal or non-existent.

Nationally, the LINk has maintained its presence on groups such as the South East LINk Leaders Network (SELLNet) and the National Association of LINk Members (NALM). The LINk has also met its statutory obligation to comment on Quality Accounts reports produced by NHS Trusts operating in Bracknell Forest.

The Bracknell Forest LINk has continued its work on the projects started last year. In particular, we are making very good progress with two major projects looking at patient experience of hospital discharge and public attitude around Self-Care.

We hope that the new organisation will continue the good work undertaken so far by the LINk, whilst building on the excellent relationships that have already been formed. In this way, the people of Bracknell Forest will continue to have a voice in respect of the health and social care provision they receive.

Barbara Briggs
Chair, Bracknell Forest LINk

How can you contact us?

The offices for the Bracknell Forest LINk are based in Bracknell Town Centre

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Bracknell Forest Council
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Bracknell
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Telephone: 01344 352579

Email: info@bracknellforestlink.org

Website: www.bracknellforestlink.org

What does the LINK do?

Bracknell Forest LINk is focused on addressing local needs and priorities, by finding out what people want from their health and social carer services, monitoring the care that services provide and reporting our findings.

We offer everyone who lives or uses services in Bracknell Forest an opportunity to say what they think about health and social care services. The LINk aims to engage with as wide a cross-section of the public as possible to hear their views. Where possible individual issues received are signposted to further help and support. LINk actively look for trends which will then inform the LINk Work Plan.

The LINk makes recommendations to the people who plan and run services, and expects a response within a set period of time. It also asks for information about services, and again can expect a response within a specified timeframe. The LINk has the ability (via trained Authorised Representatives) to carry out Enter and View visits to see if services are working well. If it feels like action is required, issues can be referred to Bracknell Forest Council's Health Overview and Scrutiny Committee.

Who do we work with?

The LINk is an independent organisation but works in partnership with both local and national organisations. Most importantly we work with members of the public and the community to effectively represent their views to those organisations who purchase and commission services locally such as NHS Berkshire, Berkshire Healthcare Foundation Trust, Adult Social Care, independent regulators and of course all those who provide health and social care in the community.

Membership and Structure

You don't have to be a member of the Bracknell Forest LINk to get involved. Anybody can participate in the LINk and tell us about their experiences of health or social care services, even if they are not a member of LINk. For those people who would like to be more involved, membership of the LINk can range from being on the mailing list and receiving the newsletter, through to volunteering to serve on sub-groups or running for election to the Steering Group for those with more time to spare.

The number of LINk participants has continued to fluctuate this year as people opt out as they move jobs or out of the area. During the transition from LINk to Local Healthwatch, the LINk will be contacting all participants to ask permission to pass on their contact details to Healthwatch Bracknell Forest.

The LINk has a total of 266 people registered to hear about its work and the opportunity to get involved.

The LINk has had 8 active members on its Steering Group who have been involved in decision making and supported the progress of project work.

Bracknell Forest LINk registered participants:	
Total number of registered interested parties as of 31 March 2012	266
Total number of registered interested parties as of 31 March 2011	273
Number of persons requesting information only	60
Number of active participants involved in groups, work groups, representing the LINk externally etc.	10
Number of active participants that have participated in training events	0

The Steering Group

Bracknell Forest LINk is volunteer-led, with local volunteer residents supported by a paid Support Officer. The Bracknell Forest LINk has one main volunteer group that drive the work forward: the Steering Group. This group consists of selected members who come from many different backgrounds and experience, but all have an interest in local health and social care issues. We also have an Enter & View Team.

Steering Group: The Steering Groups is responsible for the overall governance of the LINk. It is responsible for making sure that things are done properly and that processes are in place to make the LINk fair and accessible to all. The current members of the Steering group are:

Barbara Briggs, Chair
Barbara is the chair of the Bracknell branch of Carers UK. Her organisation keeps carers issues high on the agenda for those providing services for carers and those cared for. Although she has a working knowledge of health issues, her expertise comes from social care; Barbara is involved in most areas appertaining to carers in Bracknell Forest.

Terry Pearce, Vice Chair
Terry has lived in Bracknell for nearly 40 years and for most of this time he has been involved in community activity. He had served as Councillor for his ward for a number of years. Terry was Chairman of Bracknell Forest University of the Third Age but still has a substantial involvement with the organisation.

Currently, Terry is a non-Executive Director of the Look-In Community Cafe and the Chair of the Over 50's Forum in Bracknell.

Adrienne Jones
Born in Bracknell, Adrienne is a fifth generation resident. Adrienne attended a LINk Information event and felt that she could contribute in the future development of health care in the borough and help bring more services to the increasingly elderly residents who are a vulnerable sector of the community. Adrienne has been active in the voluntary sector for many years especially with Age Concern (since 1971)

David Maxwell
Since 1995, David has been active in HAG (was Heatherwood Action Group, now Health Advisory Group). He has been elected as a Governor of Heatherwood and Wexham Park Hospitals Trust.

Linda Webdell
Linda is a 'first generation new-towner' having moved from London to Bracknell in 1958 as a child and currently four generations of her immediate family are resident in Bracknell Forest. She has therefore, a deep personal interest in Health and Social Care. For many years Linda has worked professionally in the community supporting and developing local groups and residents. She has a special professional interest in Mental Health and Learning Disability locally.

John Cattermole
John was a Nurse for thirty three years, spending the last seventeen years working as a Modern Matron at Broadmoor Hospital in Crowthorne. He took medical retirement in 2006, due to the ongoing disability of Multiple Sclerosis. After which he joined the Patient and Public Involvement in Healthcare (PPI) , which he remained for 2-3 years. This involved looking at mental health care in Berkshire, and completing announced visits to health care providers, which included Prospect Park in Reading and Thornford Park near Newbury. John has an ongoing interest in mental health, physical disability, learning disabilities and older peoples care, especially those requiring a residential care setting.

Anne Ruthven

Anne was co-opted on to the Steering in January 2012

Brenda Winch
Anne was co-opted on to the Steering in March 2012

What have we done this year?

The LINk's issues Sub-Group assesses issues brought to it against set criteria to determine the course of action for them to take. If it is deemed necessary for a project to be initiated, it is referred to the Steering Group who then allocate resources to the project. These are the projects that the LINk has taken forward since its last report to the Secretary of State.

Bracknell Forest Community Chest

Project Lead: Barbara Briggs
Project Support: Debra Ogles
Status:

The LINk made a fund of £5,000 available to local community groups and charities in order to undertake projects and research that promotes and reports the public's views about health and social care. A set of criteria for application of funds was created and a maximum limit of £1,000 per application was set. A group of LINks volunteers scrutinised the applications and decided which applicants should be awarded funding.

The successful applications were: Bracknell Forest Voluntary Sector Forum for a survey around people awareness of the new arrangements around health locally; Sandhurst and Owlsmoor PPG for a survey around Out of Hours; BADHOGs to buy new software for speech-to-text to ensure that all members can take part in their meeting; The Ark for a survey around GP access for people with learning disabilities and the Over 50s Forum on a survey on access to information about services, support and activities available from all agencies.

Bracknell Forest LINk Community Chest Projects: a snapshot

Over 50s Forum: The Over 50s Forum is an independent voluntary organisation set up in March 1998 to represent the views of the 50+ in the borough on matters arising locally which impact on their lives. This is achieved by liaison and discussion with public and voluntary bodies whose activities affect older people.

The aim of their report was to identify older people's attitude about accessing information and their views about: Given the opportunity would they like to access IT opportunities and have support to go online, the barriers to access/learning and of those not wanting to go online and the reasons why.

Sandhurst and Owlsmoor Patient Focus Group: provides a vehicle for patients in order to communicate concerns and find out their opinions about the services they are receive from the medical practices and then relate them back to the GPs who attend our meetings. We also carry out surveys and questionnaires. It helps the patients and the practice to improve its services.

The funded from the community chest allowed the PPG to carry out a survey on "out of hours services" along with questions relative to the Sandhurst and Owlsmoor practice.

The survey was sent out to over 300 people that are currently registered to the PPG but they also undertake face-to-face surveys at the surgeries.

Bracknell Forest Voluntary Sector Forum designed and conducted a survey to gather views on what local peoples knowledge is about the new arrangements under public health and commissioning.

In addition Bracknell Forest Voluntary Sector Forum would like to raise awareness and inform there new bodies of the vital services and support provided by VCFs groups in the health and wellbeing/social care field especially within the new commissioning arrangements.

The Ark Trust: The Ark Trusts aims to include, inform and inspire people with disabilities and young people not in education, employment or training across the South East of England. The organisation used the community chest fund to look at the experience of people with learning disabilities accessing their GP's.

Bracknell Area Deaf and Hard of Hearing Support Group (BADHOGs): BADHOGs used the community chest grant to develop a computer-based capability specifically for the very hard-of-hearing who, even when wearing hearing-aids, could not acquire sufficient content when someone else was speaking.

Although the prototype has now been installed it is still at a primitive level of operation. Work will continue on the speech analysis processor and it be more thoroughly trained to provide a higher level of accuracy and performance. At that point the whole capability will be ported across to a more powerful laptop which has been negotiated with DSL.

Access to GP appointments for the deaf and hard of hearing community - Revisits

Project Lead: David Maxwell and BADHOGs
Project Support: Debra Ogles
Complete

In September 2011, the Deaf and hard of hearing subgroup decided to revisit the 12 surgeries that took part in the original survey to see if there had been any improvements since the initial report was published. Revisits showed that very few improvements were made since our initial visits in 2009/2010. In a few surgeries the only way to make an appointment is by telephone or in person: The former is no use to a person with hearing difficulties and it is difficult for communication to be established between a hearing and hearing impaired person in the latter. Fortunately, electronic communication (i.e. email, text) is now available at several surgeries. These are not yet widely used for making appointments. We were pleased to note that several surgeries now send information to patients by email.

The project highlighted that there is still some work to be undertaken around raising awareness of the needs of Deaf and hard of hearing people accessing health services, including pharmacists, hospitals and dentists.

Satisfaction of the Direct Payment Process

Project Lead: Debra Ogles
Project Support: Debra Ogles
Complete

At the beginning of 2012, the Bracknell Forest LINk carried out an independent evaluation of Direct Payment recipient's satisfaction of the support given by the Self Directed Support team within Bracknell Forest Council. This piece of research came about from issues raised to the LINk from the public about vulnerable individuals becoming employers.

The project was commissioned by the LINk with the support from the Self Directed Support team at the local authority, after LINk steering group members received issues from members of the public about vulnerable individuals becoming employers. The LINk wanted to find out whether this concern was replicated with people's who currently receive a direct payment.

The survey was sent out to 158 people who were in receipt of a Direct Payment from the Council. This number excluded people who receive a Direct Payment for Shopping or House Work.

The LINk received back 56 responses to the survey which was a statistically viable 35% response rate.

The project highlighted that the majority of respondents were happy with the support and information provided by the self directed support team at Bracknell Forest Council.

Patient Experience of Hospital Discharge

Project Lead: Barbara Briggs
Project Support: Debra Ogles
Complete

During 2011/12, the LINk carried out an independent evaluation of Patient Experience of Hospital Discharge from the three acute hospital trusts that cover Bracknell Forest.

Patient Experience surveys were distributed to local residents at events, carers, and the main acute hospitals, Frimley Park Hospital, Royal Berkshire Hospital and Heatherwood and Wexham Park.

The findings of this project highlighted different ways that different people experience hospital discharge at different hospitals, with some trusts being more patient centred than others. It is clear that good practice exists, and this report may be useful evidence for more research and further partnership working/relationship development.

Homeless Project

Project Lead: Linda Webdell
Project Support: Debra Ogles
Complete

The aim of the project was to record the number of people that are currently homeless in Bracknell Forest under the definition of homelessness 'a person with no fixed, regular or adequate abode' to include sofa surfers and the hidden homeless living in the woods.

During the project the LINk made contact with the local Foodbank – a national network who give out nutritionally balanced emergency food to people in crisis who have nowhere else to turn - based at the Kerith centre, the LINk made contact with them to find out statistics, which show the amount of homeless people who are receiving food parcels from them.

Public Attitude to Self Care

Project Lead: Debra Ogles
Project Support: Dave Rossiter
Complete

During Self-Care Week which ran from 12th November – 16th November 2012 the LINk teamed up with key partners including Bracknell Forest Council and Stroke Association to promote and encourage a healthy lifestyle.

Throughout the week the LINk, with partners, had a display in Princess Square, a shopping centre in Bracknell town centre, which enabled people to find out how they can help themselves in staying fit and healthy for life, in some cases taking the first steps in Self-Care. Fruit (provided by Waitrose), pedometers and information were all given away throughout the week by staff from LINk, Bracknell Leisure Centre, Stroke Association and Bracknell Forest Council.

To capture local people's attitude around Self-Care, the LINk encouraged local people to complete a survey which entered them in a prize draw. Over 100 people completed the LINk survey and it is estimated that a further 300 people visited the stall over the week, taking away valuable information about looking after themselves and the people they care for.

The report presents 8 recommendations to local health and social care organisations.

Review of Information for NHS Dental Patients

Project Lead: Debra Ogles
Project Support: Debra Ogles
Complete

NHS Berkshire, Dental Communications Group asked Reading and Slough LINks to carry out a review of information for patients held by NHS Dental Practices. The project was then extended to include Wokingham, Bracknell and West Berkshire LINks.

The project looked at the range of services offered by practices, the charges relating to those services and entitlement to receive certain services on the NHS. This involved members of the LINk enter and view team carrying out visits to 9 NHS dental practices in Bracknell Forest to speak to staff and look for patient information and following this reviewing patient leaflets and practice websites.

NHS Berkshire believes that improved information to patients via leaflets, websites, and within the practices would help address theses issues, and improve the service patients are receiving from their NHS dental practice.

An interim report with recommendations and completed questionnaire's with LINk findings was sent to each of the practices visited and a final joint report with 'key themes' from each of the Berkshire LINks that took part in the project was sent to NHS Berkshire. The report is to be used to share best practice and improve the information provided for NHS dental patients

Bracknell Forest LINk Legacy

Project Lead: Debra Ogles
Project Support: Debra Ogles
Complete

The Bracknell Forest LINk is keen to ensure that all of its work, processes, systems, volunteer efforts and resources are not lost during the transition to the new Local Healthwatch body. The Host worker is committed to ensuring that this is achieved and that the new Local Healthwatch organisation is in the best possible place to continue, in a seamless way, the functions of the LINk. The legacy document, which will be handed over to LHW, aims to ensure the voices of local people continue to be heard and opportunities for influencing decisions within health and social care continue to be available to the public.

The LINk legacy is the story and impact of Local Involvement Networks. When it ceases to exist as a statutory network in April 2013, it will be the LINk's benefits, lessons and achievements that will be passed on.

This legacy will continue the journey of promoting the voice of local people across Bracknell Forest in the future of health and social care. Many of these benefits will have particular relevance for community engagement initiatives going forward but there will also be wider significance to commissioners, service providers and local accountability mechanisms.

Representatives from the LINk's Steering Group were invited to discuss the legacy that the Bracknell Forest LINk will leave behind. The legacy included, for example, recommendations to Local Healthwatch following the results of LINk project work, NHS and social care issues that LINk

participants consider Healthwatch should address in the future, and LINk Authorised Visitor training packages.

Enter and View

The LINk has the right to Enter and View certain premises where health and social care services are provided (excluding Children's Social Services). Enter and View visits will take place following evidence-based research, and may be announced or unannounced. However, the LINk endeavours to address any issues at a 'grass-roots' level before the need for Enter and View arises.

The Enter & View Team comprises trained representatives who are responsible for our Enter & View visits of health or social care premises. The current Enter & View Team are:

- Barbara Briggs
- Terry Pearce
- Margaret Camp
- Adrienne Jones
- David Maxwell
- Isabel Fernandez – Grandon

During 2012/13, The LINk carried out 10 Enter and View visits as part of their dental review project.

Quality Accounts

All NHS service providers are required to publish Quality Accounts each year, to provide the public with information on the quality of care they provide. Bracknell Forest LINk is given a copy of these Quality Accounts for each provider in our area, and invited to comment upon it. Any statement that the LINk chooses to make must be included verbatim in the final Quality Account.

This year, the LINk was invited to comment on 3 Quality Accounts:

- Berkshire Healthcare Foundation Trust
- Royal Berkshire NHS Foundation Trust
- Heatherwood and Wexham Park Hospital

LINk members provided informed statements for the Quality Accounts for Berkshire Healthcare Foundation Trust and Royal Berkshire NHS Foundation Trust.

Involvement, Engagement & Networking

The Health and Social Care Act 2012 abolishes LINks with effect from 31 March 2013 and a new organisation, Local Healthwatch, will replace LINks.

Despite this, the LINk has continued to engage with local people through its networks, projects, Bulletins, quarterly newsletters, website, and through attendance at local events. However, the LINk has reduced its programme of major Community Engagement Events so that it can concentrate its resources (key LINk participants and the support team) on completing all of its projects before the LINk ends, alongside producing a Legacy to hand over to the new Local Healthwatch organisation.

LINk Roadshow

People across Bracknell Forest were encouraged to give their local health and social care services, as Bracknell Forest LINk went out and about during its summer roadshow.

The roadshow visited various locations and provided local people with an easy method to have their say on services in the community.

Newsletter and E-bulletin

The LINk Newsletter continued to share key information and updates with participants, health and social care organisations and providers.

The e-bulletin continued to share LINk updates, ensuring information and outcomes of LINk activity, surveys and involvement opportunities were shared in a timely fashion between newsletter publications.

LINk at Local events

The LINk has supported local events whilst also promoting its role. We have also had a presence at local partnerships including; Bracknell Forest Adult Safeguarding Board, Bracknell Forest Older People's Partnership, Integrated Care Partnership Board and Heatherwood Stakeholder meeting.

Shaping the Future of Healthcare in East Berkshire

The 'Shaping the Future' programme is a joint commitment by all elements of the local NHS to find long-term solutions for hospital and community health services to meet local health needs.

Working together on the Shaping the Future programme are:

- NHS Berkshire (Berkshire East PCT)
- Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- Clinical Commissioning Groups (CCGs) led by GPs covering Bracknell & Ascot, Slough, Windsor & Maidenhead and South Bucks.

The programme was designed to:

- Establish a financial and clinically sustainable model of care for east Berkshire
- Improve care pathways
- Ensure improved outcomes for patients
- Make the most efficient use of estates
- Ensure that every available pound is spent on patient care.

A clinically and financially sustainable model of care was required that meets the needs of local people. That will mean changes in both the location of services and the way they are provided.

A regular series of ‘Shaping the Future’ meetings have been held through this year at six to eight weekly intervals with LINk representatives from this LINk and those of Slough, Buckingshire and Windsor, Ascot and Maidenhead.

The LINk representatives have pressed four main issues:

- The need for a clearly articulated vision of future services
- The need for integrated care
- Access to patients, including transport issues
- Patient involvement in shaping services.

This resulted in a fundamental review of the proposals by Heatherwood & Wexham Hospital Trust for development of services currently based at Heatherwood Hospital.

The development of the new strategy is being managed with LINk representation on the Stakeholder Reference Group of the Programme Board. Whilst there is general agreement that treating patients at home backed up by hospital services is a good idea, we remain concerned that community services need to be fully involved and then properly resourced to support such changes where this is possible and clinically appropriate.

Public meeting: new responsibility for the CCG

The Bracknell and Ascot CCG together with the LINk hosted a public meeting in June 2012

Dr Martin Kittel, executive member of the CCG discussed with attendees the development of CCG and the subsequent new responsibilities. Discussion also took place relating to the CCG commissioning strategy and local Patient Participation Groups

The meeting was well attended and feedback indicated a high satisfaction rate.

Shadow Health and Wellbeing Board

The Health and Wellbeing Board (HWBB) will play a very important part in the future by leading on improving the strategic coordination of commissioning across NHS, social care and related children’s and public health services.

In the future and when established, the new Local Healthwatch will have a statutory seat on the HWBB to represent the community’s interest.

In the interim, the Bracknell Forest LINk is in the fortunate position of sitting on the Shadow HWBB. The LINk’s representative is Barbara Briggs, Chairman of the LINk Steering Group.

South East LINk Leaders Network (SELLNet) and the National Association of LINk Members (NALM)

This year, the Bracknell Forest LINk Steering Group has continued to regularly attend the quarterly meetings of SELLNet, which brings together representatives of LINks across the South East region.

As the Bracknell Forest LINk moves towards the transition to Local Healthwatch, the Steering Group have been working very closely with the relevant organisations to ensure that the LINk’s Legacy and expertise are not overlooked during this critical stage. This has included attending the NALM Annual

General Meeting in October 2012, where Healthwatch England was launched, and various meetings of SELLNet in Newbury and Guildford.

Relationship & Representation

Relationship with Bracknell Forest Council

The LINk has continued to build upon its relationship with the council. The LINk has supported the joint commissioning team in carrying out Quality Assurance Assessment and has been used as an independent facilitator for people unable to complete the annual adult social care survey.

Relationship with organisations

The notion of what a LINk is has been difficult for organisations to grasp. As Bracknell Forest LINk is not seen as an organisation it has, therefore, been hard for the LINk staff to engage with the public by explaining the concept of a network in the context of LINk.

When the host contract ended, a support worker was put in place and has widely been regarded as being critical to the LINks current and ongoing success, not least by the LINk Steering Group. Through active engagement, across a range of communities of interest, the support worker has developed a level of trust with people and demonstrated that changes can be made to services, regardless of size.

Relationships with children and young people

The LINk Steering Group understands that more work should have been done to engage with younger people to understand their views on health and social care. Whilst the LINk Steering Group invited members of the youth parliament at the beginning of 2009, they stopped attending and it was recognised that the set up of the meeting was inappropriate for youth involvement.

LINk relationship with the PPG/PRGs

Whilst the LINk has developed individual relationships with some of the Patient Participation Groups (PPG) and Patient Reference Groups (PRGs) in the borough, a relationship has never been formed with the Bracknell and Ascot Joint Patient Forum (BAJPF), the overarching group attended by the Borough PRGs and which would have been the most effective way to communicate and engage with the all the local PPGs together.

Feedback from the PRGs themselves has led the LINk to identify local PPGs playing a key role in Local Healthwatch representing the patient voice at neighbourhood level. However, before this a working relationship needs to be developed and protocols need to be put in place; the current setup does not allow for the widest representation of views to be gathered and heard which means that genuine outcomes for health improvement and reducing health inequalities could be missed for the wider community.

LINk relationship with Bracknell and Ascot CCG

The LINk relationship with the Bracknell and Ascot CCG has developed rapidly over the last six months, as the CCG has emerged and developed. The LINk support worker has worked hard to raise the profile of the LINk and secure involvement in CCG planning and development, successfully providing input into the CCG workplan. As the landscape of the NHS changes, LHW will need to be focussed and tenacious in developing relationships with the new NHS.

Though a relationship has been formed, more work needs to be carried out to ensure that all CCG members have a clear understanding of the role of LINk/Local Healthwatch and the expertise is has to offer to support its commitment to patient involvement which could be helpful at the early steps of CCG development, and how our statutory powers can support them with their project planning, service delivery and quality assurance. In the short-term, this could involve developing a quarterly meeting with the CCG chair for operational matters alongside the strategic relationship that LINk and LHW will soon play on the Health and Wellbeing Board.

LINk relationship with NHS Berkshire

The LINk relationship with NHS Berkshire is developing into a positive one. NHS Berkshire has involved the LINk in the development of the “Shaping the Future” consultation by meeting regularly to discuss proposals and asking for LINk input. The LINk is kept informed about changes in services and is able to raise concerns to the designated contact.

As PCTs will be abolished on 1 April 2013, a new relationship will need to be brokered with the NHS Commissioning Board, both nationally and with local area teams, Commissioning Support Units, local public health teams and other organisations and groups emerging from the modernisation of the NHS. This relationship was limited because:

LINk relationship with other LINks

The LINk host workers in Berkshire have developed a very good and strong working relationship. This relationship has proved invaluable and would strongly encourage LHW Bracknell Forest to engage and connect with peers, Berkshire-wide and within the new NHS Commissioning Board local area team configuration, as soon as possible after establishment for the added-value such a relationship can bring for strategic and operational issues.

The Chair and Vice Chair of the Steering Group attend quarterly SELLnet (South East LINk network) meetings, where they meet other LINks chairs across the south East. Whilst LINks had many different national and regional networks to choose from, LHW will be supported by Healthwatch England. Whilst the value of this organisation cannot yet be determined, the national and regional perspective is a useful one to secure.

LINk relationships with health and social care agencies

The LINk has provided lay representation on a wide range of committees and boards which has been positive in raising its profile and ability to influence but not necessarily providers. However, representatives have been drawn from a relatively small pool of volunteers and the extent to which they have been able to represent the wider views of service users and the public has been limited.

Berkshire Healthcare NHS Foundation Trust

Since becoming responsible for providing community based health services in April 2011 in addition to mental health services for Berkshire the Trust have undergone some changes in staff but the LINk have maintained a strong relationship

Patient and Public Involvement

Liz Daly joined the trust as Head of Service Engagement & Experience and subsequent patient experience reports improved to make sure the learning from customer complaints is captured. Jo Gilbert has continued to support the LINk in keeping us informed on the Shaping the Future consultation and changes in services and responding to our requests.

Royal Berkshire NHS Foundation Trust (RBHFT): Patient and Public Involvement work

A member of the LINk attended the Trust's Patient Partnership Standing Conference in November where excellent presentations were given by staff on patient care and included projects planned to improve care.

LINk relationship with the CQC

CQC and the LINk had begun to develop regular meetings, to share information and identify current issues and mutual concerns. Changes in staffing have created some challenges however it is anticipated that these links will continue and be strengthened with the development of Healthwatch England.

Referrals to Health Overview & Scrutiny Panel

No referrals to the Health Overview & Scrutiny Panel were made in 2011/12, but the relationship has been maintained. The LINk Vice Chair, Terry Pearce, continues as the representative for LINk on the Health Overview & Scrutiny Panel.

Developing Local Stakeholder Relationships

Host staff and LINk Participants shared LINk work and provided key health and social care updates throughout the year, gathering views on services and experiences where appropriate.

Some of the Groups Bracknell Forest LINk have engaged with	
Rethink	Bracknell CAB
Bracknell and Wokingham Mencap	Voluntary Sector Forum
Over 50s Forum	Just Advocacy
Berkshire Youth	Arthritis Care
BADHOGs	Princess Royal Carers Trust
Deaf Positives	Stroke Association
The Ark	Alzheimers Society
Bracknell and Ascot Branch Blind Social Club	U3A
The Challenge Club	Sandhurst Stroke Club
Age Concern	Red Cross
Dementia Support Group	Berkshire County Blind Society
Health Advisory Group	Age UK

Healthwatch Bracknell Forest

The setting up of Healthwatch Bracknell Forest is the responsibility of Bracknell Forest Council. However, to enable the seamless transition from LINk to Healthwatch as stated in the Health and Social Care Act, LINk has worked with Bracknell Forest Council wherever possible.

The LINk steering group has helped Bracknell Forest Council in highlighting key issues that needs to be observed in the development of the Local Healthwatch specification. Our organisational knowledge and the importance of securing a local provider have been key to this.

The LINk has also supported and took part in the “vision for Local Healthwatch” exercise. Publishing the final report on our website and with our participants.

How was it paid for?

Refreshments	389
Printing/photocopying	1982.99
Postage	102
Interpreting	687
Volunteer expenses	105
Room hire	891
Travel costs	141
Community Chest Funding	3,250
Self Care Project	351
Events	15

Summary of Activity

Requests for Information in 2011-12		
How many requests for information were made by your LINk?		20
Of these, how many of the requests for information were answered within 20 working days?		9
How many related to social care?		0
Enter and View in 2011-12		
How many enter and view visits did your LINk make?		10
How many enter and view visits related to health care?		10
How many enter and view visits related to social care?		0
How many enter and view visits were announced?		10
How many enter and view visits were unannounced?		0
Reports and Recommendations in 2011-12		
How many reports and/or recommendations were made by your LINk to commissioners of health and adult social care services?		0
How many of these reports and/or recommendations have been acknowledged in the required timescale of 20 working days?		0
Of the reports and/or recommendations acknowledged, how many have led, or are leading to, service review?		0
Of the reports and/or recommendations that led to service review, how many have led to service change?		0
How many reports/recommendations related to health services?		0
How many reports/recommendations related to social care?		0
Referrals to Overview & Scrutiny Committee in 2010-11		
How many referrals* were made by your LINk to an Overview & Scrutiny Committee?		0
How many of these referrals did the OSC acknowledge?		0
How many of these referrals led to service change?		0

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TO: HEALTH AND WELLBEING BOARD
11 APRIL 2013

FRANCIS INQUIRY
Director of Adult Social Care, Health and Housing

1 PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board regarding the Francis Inquiry and the Government's response to the Inquiry with the purpose that the Board discusses and agrees a mechanism to identify the partners' roles and responsibilities to implement the recommendations.

2 RECOMMENDATIONS

That the Board:

2.1 Agrees to take responsibility for oversight of the implementation of the recommendations.

2.2 Proposes a workshop to clarify roles and responsibilities for all organisations with a responsibility for implementing the recommendations.

3 REASONS FOR RECOMMENDATIONS

3.1 In order to implement successfully the recommendations from the report (Appendices 1 and 2), partners must take a co-ordinated approach.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 There is no alternative to implementing the recommendations made by the report following the Francis Inquiry.

5 SUPPORTING INFORMATION

5.1 The Francis Inquiry followed a series of investigations and report, including an investigation by the Healthcare Commission in 2009 and an independent inquiry also conducted by Robert Francis.

5.2 The Francis Inquiry report attributes accountability for the appalling care at Stafford Hospital to the Trust Board, but also points to a systemic failure by a range of national and local organisation to respond to concerns. The report indicated that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS.

5.3 The Inquiry looked at the hospital itself and the roles of the main organisations with an oversight role; it made 290 detailed recommendations. Many respondents to the inquiry indicated that they were not aware of the extent of the problems at the hospital and that failings had not been brought to their attention. The report disagrees with this stance, indicating that clear warning signs were available.

5.4 The overall picture from the report was that the Trust Board operated with a "culture of self-promotion rather than critical analysis and openness" and that organisations with a role in assessing performance at the hospital all too often accepted the hospital's version of events at face value.

5.5 The overall recommendation is that all organisations involved in NHS commissioning, provision and regulation and "ancillary organisations" should consider the findings and recommendations from the report.

5.6 There is a role for the Health and Wellbeing Board to clarify and oversee the responsibilities of all the partners in implementing the recommendations.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 Not sought.

Borough Treasurer

6.2 Not sought.

Equalities Impact Assessment

6.3 An Equality Impact Assessment will be completed for any changes to policies and structures arising from implementing the recommendations.

Strategic Risk Management Issues

6.4 There is a risk to people in the community and a reputational risk to partner organisation should the recommendations not be responded to appropriately.

Other Officers

6.5

7 CONSULTATION

Principal Groups Consulted

7.1 The Health and Wellbeing Board.

Method of Consultation

7.2 It is proposed to hold a workshop for all organisations with a responsibility to implement the recommendations made by the report.

Representations Received

7.3 Representations will be incorporated into an action plan.

Background Papers

None

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LGiU LOCAL GOVERNMENT INFORMATION UNIT

POLICY BRIEFING

The Francis Inquiry into Mid Staffordshire NHS Foundation Trust – messages and implications

Author: Christine Heron, LGiU Associate

Date: 8 February 2013

Summary

The Francis Inquiry report attributes accountability for the appalling care at Stafford Hospital to the Trust Board, but also points to a systemic failure by a range of national and local organisations to respond to concerns. The report indicates that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS.

Repeated NHS restructuring was identified as an important element in the background to the failures, and with the most substantial changes to the NHS since its inception now taking place there is clearly potential for further major failings in NHS providers. This policy briefing summarises the report and identifies some significant messages for local authorities in their health responsibilities.

Briefing in full

Background

In June 2010 the then Secretary of State for Health Andrew Lansley charged Robert Francis QC with undertaking a public inquiry into the failures of Mid Staffordshire NHS Foundation Trust. The terms of reference were to:

- examine the operation of commissioning, supervisory, regulatory and other agencies in their monitoring role of Mid Staffordshire NHS Foundation Trust (Stafford Hospital) between January 2005 and March 2009 to identify why problems were not identified and addressed sooner
- identify relevant lessons for how any future failing regimes can be identified as soon as practicable within the context of NHS reforms.

The Francis Inquiry followed a series of investigations and reports, including an investigation by the Healthcare Commission in 2009 and an independent inquiry also conducted by Robert Francis.

The failings at Stafford Hospital have been well reported in the media and will not be repeated in detail here. The number of excess deaths between 2005 and 2008 is

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estimated at 492 people. Examples of poor care include patients being left in soiled bedclothes for lengthy periods, lack of assistance with eating and drinking, filthy wards and toilets, lack of privacy and dignity such as people left naked in a public ward, and triage in A&E undertaken by untrained staff. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'.

The Inquiry looked at the hospital itself and the roles of the main organisations with an oversight role including the Department of Health, the strategic health authority, the PCT, national regulators, other national organisations, local patient and public involvement, and health scrutiny. It made 290 detailed recommendations.

What organisations knew or should have known

Many respondents to the Inquiry indicated that they were not aware of the extent of problems at the hospital and that failings had not been drawn to their attention. The report disagrees with this stance, indicating that clear warning signs were available. These include:

- star ratings reduced from three-star to zero by the Commission for Health Improvement in 2004
- poor peer reviews, auditor reports, and Healthcare Commission reports including staff and patient surveys
- staff concerns reported to management and instances of whistleblowing ignored
- financial recovery plan not consistent with maintaining quality and safety.

The overall picture was that the Trust Board operated with a 'culture of self promotion rather than critical analysis and openness' and that organisations with a role in assessing performance at the hospital all too often accepted the hospital's version of events at face value.

Stafford Hospital

Hospital leaders failed to appreciate the enormity of failings, downplayed their significance, and sought to explain away problems. There was a culture of accepting poor standards and isolation from good practice elsewhere. The leadership prioritised financial issues, meeting targets and achieving foundation trust status rather than quality of care. There was no culture of listening to patients or acting on complaints or poor surveys; information from patients was probably seen as of low importance. Some clinicians raised concerns but did not pursue these 'with vigour' and are described as 'passive'. Evidence to the Inquiry described an environment in which professional staff were in conflict with each other. Clinical governance was not introduced effectively. Due to poor leadership and staffing levels the standard of nursing on some wards was 'completely inadequate'.

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The PCT, GPs and the strategic health authority

The report indicates that at the time PCTs were subject to constant reorganisation and followed national guidance that focused on financial control and access targets. However, PCTs were also under a duty to monitor and improve the quality of services they commissioned and had significant resources. The report indicates that the local PCT experienced a dilemma about potentially destabilising a provider when no alterative provider was available. It criticises the PCT for the time taken to address issues, insufficient focus on developing systems to monitor performance and a willingness to accept that clinical safety was not compromised. Local GPs only expressed 'substantive concern about quality of care' after the announcement of the Healthcare Commission investigation.

The Strategic Health Authority was also operating under extensive financial challenges, organisational restructuring and lack of role clarity. While it did not actively seek out concerns it was willing to intervene if necessary. However all too often it judged concerns as not warranting exceptional action. Overall, it was too ready to trust providers and too remote from patients. The SHA failed to provide information to the DH on the application for foundation trust status and did not consult with the Healthcare Commission.

The report points to the new commissioning systems of NHS Commissioning Board and clinical commissioning groups (CCGs). It indicates that there is an 'urgent need to rebalance and refocus commissioning' on standards of services for patients.

The regulators

Monitor and failure of the foundation trust authorisation process

Monitor is the NHS financial regulator and responsible for foundation trust authorisation. Stafford Hospital was granted foundation trust status in 2008 and the report is swingeing in its criticism of this decision. 'An elaborate, resource-consuming process failed to achieve what should have been its primary objective; ensuring that the only organisations authorised were those with the ability and capacity to deliver services compliant with minimum standards on a consistent and sustainable basis' (Executive Summary 1.51). The report also indicates that there was an 'undue delay' in Monitor intervening when problems were identified. The major factor in the 'erroneous authorisation' was the dissonance between regulation of finance and quality – Monitor and the Healthcare Commission did not co-ordinate their regulatory roles.

The Healthcare Commission

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The report points out that the HC was the regulator at the time of the failings, but it was the first organisation to identify serious concern and take action. It suggests that the top-down design and confusion of the NHS Annual Healthcheck – the process of self-assessment on compliance against standards – contributed to failure to detect problems sooner.

The Care Quality Commission

The report supports the new regulatory model which collects a wide range of information to identify risk of non-compliance. It points to the multitude of organisational challenges the CQC has had to face in a short period of time (merging three organisations, new system of regulation and standards, new registrations). However, it indicates that while the CQC aspires to be an open organisation it has exhibited defensiveness and 'instinct to attack' in the face of criticism. While it is improving and becoming more responsive, it still needs to focus on information from patients.

Professional bodies/regulation

The report describes an inadequate response from organisations including the General Medical Council, the Nursing and Midwifery Council, university/deaneries, the Health Protection Agency, and the Health and Safety Executive. It describes the Royal College of Nursing as 'ineffective both as a professional organisation and a trade union' with failure to uphold professional standards or address problems identified by members. It suggests a potential conflict between its professional and trade union roles.

Department of Health

The report indicates that the DH was genuinely concerned about the failings at Stafford Hospital and has a sincere aim to improve quality for patients. However, over successive governments there have been struggles between rhetoric and implementation. Reforms aimed at improving quality for patients have been imposed too quickly and followed by further reform without being given time to succeed. Clinical leaders were not always at the heart of decision making and officials were sometimes too remote from patients and front-line staff. While it is not fair to say that there is a culture of bullying, action has been interpreted as bullying and instructions may have been applied locally 'in an oppressive manner'.

Voice of the local community

Patient and public involvement

The report identifies that failure to engage with patients and the public is a major factor in the problems at Stafford Hospital. It also indicates that formal patient and

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public involvement mechanisms were not operating well, leaving the campaigning patients' group Cure the NHS as the only effective local voice.

Patient Opinion (a not for profit social enterprise that allows patients and carers to anonymously share their health service experiences in order to receive feedback and improve services) commented on the Francis report that patients themselves need to speak up about their care or nothing will change as a result of the inquiry and that patient stories can make a difference - being an early warning of systemic failings that needs to be urgently redressed. Councils will be interested that a similar scheme will be launched soon for adult social care users and their families.

Most of the respondents to the Inquiry suggested that the organisational model of Community Health Councils, with their mix of officers and board would have been a more effective structure than the models that replaced it.

On Staffordshire Patient and Public Involvement Forum, the report describes 'mutual acrimony' between members and between members and the host, a preoccupation with constitutional and procedural matters and a 'degree of diffidence towards the Trust' as leading to a failure to be effective. Local Involvement Networks (LINks) were described as an 'even greater failure'. 'The albeit unrealised potential for consistency represented by the Commission for Patient and Public Involvement in Health was removed, leaving each local authority to devise its own working arrangements. Not surprisingly, in Stafford the squabbling that had been such a feature of the previous system continued and no constructive work was achieved at all' (Executive Summary 1.22).

On Local Healthwatch (LHW), the report says that without a national framework to provide consistency there is a 'danger of repetition of the arguments that so debilitated Staffordshire LINks'.

Health overview and scrutiny committees (HOSCs)

On health overview and scrutiny, the report says the following. 'The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust. The evidence before the Inquiry exposed a number of weaknesses in the concept of scrutiny, which may mean that it will be an unreliable detector of concerns, however capable and conscientious committee members may be.' (Executive Summary1.25)

Recommendations

The Inquiry makes 290 recommendations of which many are detailed proposals for changes to aspects of policy or process. The overall recommendation is that all organisations involved in NHS commissioning, provision and regulation and 'ancillary organisations' should consider the findings and recommendations of the report. The DH should publish regular reports on how they have responded, and the Commons

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Health Select Committee should consider including this issue in their work programme.

This section presents some of the high profile recommendations and those that relate to the work of local authorities.

- Prioritising the needs of patients in the NHS, with caring, compassionate and committed staff working within a common culture; for example:
  - developing the NHS Constitution so there is greater commitment to staff putting patients before themselves.

- Clear responsibility for, and effectiveness of, healthcare standards and governance, for example:
  - there should be a single regulator dealing with corporate governance, financial competence, viability and compliance with patients' safety and quality standards
  - a merger between Monitor and the CQC should be undertaken incrementally and after thorough planning. CQC would take on responsibility for foundation trust authorisation, incorporating relevant departments from Monitor
  - zero tolerance for failure to meet fundamental standards – organisations who fail should not allow to continue. Criminal liability should follow where serious harm or death results from a breach of fundamental standards
  - any 'wilfully or recklessly false' statement about compliance with safety or essential standards in provider quality accounts should be made a criminal offence.

- Complaints handling should be improved with sensitive, responsive and accurate communication and learning, for example:
  - a facility should be available to Independent Complaints Advocacy advocates and their clients to access expert advice in complicated cases
  - overview and scrutiny committees and LHW should have access to information about complaints (confidentiality maintained).

- Commissioners should incorporate standards and monitor compliance, for example:
  - GPs need to take a monitoring role on behalf of their patients who receive acute hospital or other specialist services
  - commissioners need wherever possible to make available alternative sources of provision
  - greater involvement of patients and the public in commissioning.

- Patient, public and local scrutiny should be improved, for example:

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- there should be a consistent national structure for LHW
- local authorities should be required to pass over their funding allocation for LHW
- respect for the independence of Local Healthwatch should not be allowed to inhibit a local authority – or Healthwatch England as appropriate – intervening
- guidance should be given to promote coordination and cooperation between LHW, health and wellbeing boards and scrutiny committees
- proper training and, where necessary, expert advice should be available to the leadership of LHW
- scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role including easily accessible guidance and benchmarks
- scrutiny committees should have powers to inspect providers rather than relying on patient involvement structures, or should actively work with those structures to trigger and follow up inspections rather than receiving reports without comment or suggestions for action
- MPs are advised to adopt a simple system for identifying trends from individual complaints.

- Greater openness, transparency and candour, for example:
  - a statutory obligation for healthcare providers and professionals to observe a duty of candour
  - criminal liability relating to dishonesty about incidents when informing a regulator or commissioner.

- Nursing – a number of recommendations relating to culture of care and practice, training, national standards and leadership.

- NHS leadership – a number of recommendations relating to training, code of ethics and standards. Serious breaches of the code could result in managers being disqualified from senior positions in future. However, the report falls short of recommending regulation for NHS managers.

- Care for the elderly – there should be specific approaches for older people, such as effective teamwork between disciplines, ward management, and discharge coordination.

Next steps

The fall-out from the Francis report is ongoing. There have been calls, most prominently from Cure the NHS, for the resignation of Sir David Nicholson the NHS

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and NHS Commissioning Board Chief Executive who was previously a strategic health authority chief executive in the West Midlands.

NHS Medical Director Sir Bruce Keogh will investigate five trusts with high death rates. David Cameron has announced that trust boards could be suspended for quality failures as well as financial problems, with a 'single failure regime' implemented. He has asked the CQC to create the post of chief inspector of hospitals with a new inspection regime to begin in the autumn. The man who led President Barack Obama's US healthcare reforms has been engaged to introduce 'zero-harm' into the NHS culture. South Tees Hospitals Foundation Trust Chief Executive Tricia Hart and Labour MP Ann Clwyd have been asked to advise on how NHS hospitals should handle patient complaints.

The government will respond to the 290 recommendations in full next month. LGiU will produce a further policy briefing at that time.

Comment

Robert Francis has produced a fair and balanced report which sets the actions of organisations within the context of organisational pressures and limitations. Nevertheless, most organisations involved are criticised for failure to act and there are severe criticisms of the Trust and its leadership. According to Patient Opinion the problems of Stafford Hospital continued for so long and were not identified or fixed by the trust, commissioners or external agencies because no-one was listening.

Local commissioning

One of the key themes is that reorganisation is generally well-meaning but usually undertaken too quickly without adequate planning and without a thorough assessment of the impact on patients and families. 'Structural reorganisations have made implementing policies for quality and safety very difficult in practice.' (Executive summary 1.104) Clearly, this message resonates with the current round of restructuring.

The report indicates that any system must have a 'relentless focus' on patient safety and quality standards. The role of health and wellbeing boards does not figure prominently in the report, but it would seem that they have an important role in ensuring that local commissioning maintains a focus on quality and safety through difficult financial times.

Merging regulators

Another important recommendation is to merge the CQC and Monitor to plug the gap between their separate roles. Anyone following health policy in recent years will have seen continuing disputes between Monitor and the Healthcare Commission. A

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complete division between economic and quality regulation would seem to inevitably lead to problems. It is disappointing therefore to read in the Health Service Journal that Health Secretary Jeremy Hunt indicates that Monitor will continue as the economic regulator and will probably run the 'single failure regime' for providers announced by the Prime Minister. HSJ further reports that the CQC does not seek to merge with Monitor.

Patient and public involvement

Chapter 6 of Volume 1 of the report provides a detailed account of the development and activity of patient and public involvement at Stafford Hospital. Anyone involved in commissioning or working with LHW will find this an interesting and salutary account.

While it is important not to slide between problems in a specific patient and public involvement mechanism to general comments about the model itself – there are some excellent LINks – there is no doubt that some of the problems identified will be immediately recognisable to anyone involved in developing patient involvement.

One of the dilemmas for local authorities is that intervening in the work of a LINk or LHW as the commissioning organisation may be viewed as oppressive and controlling. For this reason, there has been a reluctance to get involved and a tolerance of poor performance. The report's recommendation that local authorities, or Healthwatch England, should intervene should be built into LHW arrangements.

Also, it is important to recognise that LHW involves people who are volunteers. LHW members need to understand the responsibility of the role they have taken up; the Inquiry report which goes into detail about the action of named individuals should be used as an example for this.

Health overview and scrutiny

Chapter 6 of Volume 1 sets out the role and responsibilities of overview and scrutiny and describes the activity of Stafford Borough Council HOSC and Staffordshire County Council HOSC. Those involved in overview and scrutiny may wish to read this to identify potential lessons.

The role of health scrutiny has been recognised by the Government as effective and important, with increased responsibilities in the NHS reforms. However, scrutiny at Stafford Hospital concerned the specific issue of identifying bad performance, and the dilemmas identified in the report may be familiar to many HOSCs.

Some points that may be of interest to HOSCs can be drawn from the report's conclusions about the role of scrutiny.

- lack of detail in notes in some meetings about Stafford Hospital
- the need to be more proactive in seeking information

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- over-dependency on information from the provider rather than other sources, particularly patients and the public
- lack of resources, particularly in small borough committees
- questions about expertise of some members of HOSCs
- need for clarity in the roles of borough/district and county HOSCs
- scrutiny better conducted at arms-length rather than as a 'critical friend'.

Finally, the recommendation for scrutiny committees to possibly have inspection powers needs further thought, since it has previously divided opinion in the scrutiny community.

Related LGiU policy briefings

Winterbourne View and the state of care

Consultation on extending the NHS Constitution

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk

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Press release

Putting Patients First - Government publishes response to Francis Report

Organisation: Department of Health
Published: 26 March 2013

The quality of patient care will be put at the heart of the NHS in an overhaul of health and care in response to the Francis Inquiry.

The quality of patient care will be put at the heart of the NHS in an overhaul of the health and care system in response to the Francis Inquiry. Health Secretary Jeremy Hunt announced today how a culture of compassion will be a key marker of success, spelling an end to the distorting impact of targets and box ticking which led to the failings at Stafford Hospital.

Hospitals and care homes will be encouraged to strive to be the best, the basic values of dignity and respect will be central to care training and, if things go wrong, patients and their families will be told about it.

Radical new measures will be introduced to achieve this including Ofsted-style ratings for hospitals and care homes, a statutory duty of candour for organisations which provide care and are registered with the Care Quality Commission, and a pilot programme which will see nurses working for up to a year as a healthcare assistant as a prerequisite for receiving funding for their degree.

The response is accompanied by a statement of common purpose signed by the chairs of key organisations across the health and care system. It renews and reaffirms the commitment to the values of the NHS, as set out in its Constitution, and includes pledges to work together for patients, always treat patients and their families with compassion, dignity and respect, to listen to patients and to act on feedback.

Jeremy Hunt said:

The events at Stafford Hospital were a betrayal of the worst kind. A betrayal of the patients, of the families, and of the vast majority of NHS staff who do everything in their power to give their patients the high quality, compassionate care they deserve.

The health and care system must change. We cannot merely tinker around the edges – we need a radical overhaul with high quality care and compassion at its heart. Today I am setting out an initial response to Robert Francis' recommendations. But this is just the start of a fundamental change to the system.

I can pledge that every patient will be treated in a hospital judged on the quality of its care and the experience of its patients. They will be cared for in a place with a culture of zero harm, by highly trained staff with the right values and skills. And if something should go wrong, then those mistakes will be admitted, the patient told about them and steps taken to rectify them with proper accountability.

I and the chairs of key organisations involved in care have pledged to do this and make our health and care system the best and safest in the world.

The Government's response to the Francis report includes plans to:

Put in place a culture of zero-harm and compassionate care.

- There will be a new regulatory model under a strong, independent Chief Inspector of Hospitals.
- The Chief Inspector will introduce single aggregated ratings. The Nuffield Trust rightly said that in organisations as large and complex as hospitals a single rating on its own could be misleading. The Chief Inspector will also develop ratings of hospital performance at department level. This will mean that cancer patients will be told of the quality of cancer services, and prospective mothers the quality of maternity services.
- The Chief Inspector of Hospitals will assess hospital complaints procedures.
- The CQC will move to a new specialist model based on rigorous and challenging peer-review. Assessments will include judgements about hospitals' overall performance including whether patients are listened to and treated with dignity and respect, the safety of services, responsiveness, clinical standards and governance.
- A new Chief Inspector of Social Care will ensure the same rigour is applied across the health and care system. The merits of having a Chief Inspector of Primary Care are also being explored.
- The NHS Confederation will review how we can reduce the bureaucratic burden on frontline staff and NHS providers by a third.

Detect problems quickly.

- A new statutory duty of candour will ensure honesty and transparency are the norm in every organisation overseen by the CQC.
- The new Chief Inspector of Hospitals will be the nation's whistleblower- in-chief. • Publishing survival results improves standards, as has been shown in heart surgery. Survival rates for a further 10 disciplines, including cardiology, vascular and orthopaedic surgery will now be published.

Deal with problems quickly. * A new set of fundamental standards will be introduced to make explicit the basic rights that anyone should expect of the NHS. They will be produced by the Chief Inspector of Hospitals, working with NICE, patients and the public. * Where these standards are breached, a new failure regime will ensure that firm action is taken swiftly. If it is not, the failure regime could lead to special administration with the automatic suspension of the Board.

Accountability for wrongdoers.

- Health and social care professionals will be held more accountable.
- We will consider the introduction of legal sanctions at a corporate level for providers who knowingly generate misleading information or withhold information from patients or relatives.
- The General Medical Council, the Nursing and Midwifery Council and the other professional regulators have been asked to tighten and speed up their procedures for breaches of professional standards.
- The Chief Inspector of Hospitals will also ensure that hospitals are meeting their existing legal obligations to ensure that unsuitable healthcare assistants are barred.

Leadership and motivation of NHS and social care staff.

- NHS-funded student nurses will spend up to a year working on the frontline as healthcare assistants, as a prerequisite for receiving funding for their degree. This will ensure the people who become nurses have the right values and understand their role.
- Nurses' skills will then be revalidated, as doctors' are now, to ensure their skills remain up to date and fit for purpose.
- Healthcare support workers and adult social care workers will now have a code of conduct and minimum training standards, both of which are published today: www.skillsforhealth.org.uk/codeofconductandtrainingstandards
- The Chief Inspector will ensure that hospitals are properly recruiting, training and supporting healthcare assistants, drawing on the recommendations being produced by Camilla Cavendish.
- The Department of Health will become the first department where every civil servant will gain real and extensive experience of the frontline.

The Government is also today publishing a revised NHS Constitution following a recent public consultation. It incorporates many of the changes that were consulted on and, where possible, further changes resulting from additional suggestions heard through consultation. A copy can be found at www.gov.uk/dh

It is likely there will be a further consultation later in the year on further changes to the NHS Constitution, with the aim of incorporating further recommendations made by Robert Francis QC.

Notes to editors

1. For further information, media should contact the Department of Health Media Centre on 020 7210 5738 / 5707 / 5282 / 5896 / 5947.
2. The public can contact public enquiries on 020 7210 4850.

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INFORMATION REPORT

**TO: HEALTH AND WELLBEING BOARD
11 APRIL 2013**

**LOCAL HEALTHWATCH BRACKNELL FOREST CONTRACT AWARD
Director of Adult Social Care, Health and Housing &
Chief Executive Officer, The Ark Trust Limited**

1 INTRODUCTION

1.1 Following a procurement process, the contract for Local Healthwatch Bracknell Forest ("LHW") was awarded to the Ark Trust Limited, a local organisation based in Crowthorne, that was able to demonstrate:

a. Knowledge and understanding of Local Healthwatch placed within the context of Bracknell Forest and therefore aligned most closely with the expressed needs of local stakeholders sourced from independent engagement activity undertaken in 2012
b. Knowledge and practical examples of involving supported and vulnerable individuals in decision making from the ground up
c. Reflective knowledge, understanding and appreciation of the mechanics and relationships in the local voluntary and community sector landscape and potential barriers to collaborative working
d. A clear understanding of the principles of branding and marketing communications using traditional and new media channels
e. Existing partnership arrangements covering key health and social care groups and upon which the broader service could be built within a specified timeframe
f. Evidence of broad and creative mechanisms for engaging with and securing the views of local people
g. Evidence of an ability to support people to lead the lives the way they wish in a non-judgemental way
h. A comprehensive approach to safeguarding adults and children and young people

2 SUPPORTING INFORMATION

Legal requirement for Local Healthwatch

2.1 Subject to the Health and Social Care Act 2012, Local Healthwatch organisations must be established by local authorities responsible for social care to ensure all local people have:

- access to an organisation that will act as their independent consumer champion and ensure they have access to advice and information (signposting) about health and social care services and support so that they can make informed choices relevant to their needs

- a strong collective voice which is heard by commissioners of services and which will inform the development or improvement of services taking into account the needs and experiences of local people

Procurement process

2.2 A procurement team with representatives from Adult Social Care, Heath and Housing and Children, Young People and Learning was established and supported by corporate procurement.

2.3 A single open tender process was advertised on the South East Business Portal on Friday 1st June 2012. All interested organisations were able to download:

- Invitation to Tender
- Service Specification
- All associated appendices

2.4 Interested organisations were able to ask for clarifications, in writing, by Friday 11th January 2013. No questions were received.

2.5 The tender documentation included a set of Entry Level Questions. Potential bidders self-evaluated whether they met the Council's minimum criteria for being able to provide the service before completing and submitting their bids.

2.6 The deadline for bids was Monday 21st January 2013. To accommodate issues relating to the weather, this deadline was extended to Wednesday 23rd January 2013. A total of 3 bids were returned. Tenders were assessed by the Tender Evaluation Team, details of which are set out in the Confidential Annexe to this report. Evaluation criteria had been agreed by the Team prior to the tender invitations, with a price:quality weighting of 50:50. Also agreed were a number of qualitative criteria relating to the three core elements of the service, operational sustainability, accessibility and learning from past experience.

2.7 Reference checks have been undertaken in order to ascertain, as far as reasonably possible, the suitability and viability of the three Tenderers. The references for The Ark Trust Ltd were positive recommendations.

2.8 Emails were sent on 25 January 2013 to all organisations inviting them to give a presentation to the Council on their vision of LHW, how people would interface with the service, how the service would operate within a network of local networks, and how the service would use commercial and non-commercial opportunities for sustainability followed by questions from the Evaluation Team on their proposals. Presentations took place on 1st February 2013. Following all presentations, the Tender Evaluation Team finalised the tender evaluation.

Decision to award contract

2.9 As the contract does not exceed £400k in total value, the decision to award the contract is one that falls to the Director and Executive Member for Adult Social Care, Health and Housing in accordance with the requirements of the councils Contract Standing Orders 2012.

Next steps

2.10 The Council and the Ark have meet to review and revise the initial implementation plan submitted at the point of tender to take into account new secondary legislation and additional requirements of the contract which have come about whilst the procurement process was in train. Subject to signing of contracts, next steps comprise:

- Establishing Transition Managing Team
- Governance and operational procedures
- Recruitment of chair, staff and volunteers
- Agreement of licensing terms for Healthwatch brand and website

- Agreeing operations plans for Business Development Plan, Communications, Training, Engagement, Partnership development, training etc.
- Establishing a Forward Plan

3 EQUALITIES IMPACT ASSESSMENT

3.1 The procurement process was subject to an equalities screening process. Attached in Annex A.

4 **STRATEGIC RISK MANAGEMENT ISSUES**

Funding period and shortfall

4.1 The contract has been awarded for 2 years (from 1st April 2013) with an option to extend for a further year if required. There is budget availability for the funding of the contract from the Local Healthwatch budget and Local Reform & Community Voices grant.

4.2 Please note that there is provision within the contract to vary it according to budget availability and the Ark Trust is aware of this provision. This risk is further mitigated as the incoming provider, classified as a social enterprise, will have trading powers allowing Local Healthwatch to charge for services for which it can develop a market. A business plan is already in development to maximise its commercial and non-commercial income streams.

Ongoing change in the NHS and the social care economy

4.3 LHW will develop against a backdrop of ongoing change in the NHS and social care. To mitigate against this, Local Healthwatch will be part of Healthwatch England which will provide central support for the national network of Local Healthwatch organisations. LHW will also be represented on the Bracknell Forest Health and Wellbeing Board directly connected to discussions between the key stakeholders in the health and social care economy and will be expected to be equally and jointly involved in the influencing and informing of decisions relating to local commissioning.

Partnership working

4.4 A risk to LHW would be the failure to work effectively with key partners or to involve patients and the public in the development of the service which may result in a service that does not meet the needs of the community or deliver better outcomes for their area. This will be mitigated by independent development work commissioned through RAISE, a regional voluntary and community infrastructure support organisation that has been involved in LHW development from policy to implementation.

4.5 An identified strength of the Ark bid was that it set out an existing, viable arrangements of a manageable size with other local organisations (including advocacy services) that could be developed over time and which covered a range of health and social care groups as follows:

- Pan-disability / Long-term conditions and young people — The Ark (as contract lead)
- Sensory impairment — Deaf positives
- Young people — Kids.org
- Older People — Age Concern Slough and Berkshire East
- Mental Health — SEAP
- Autistic spectrum — Berkshire Autistic Society

- Learning disabilities Mencap

4.6 The Ark recognised the need to expand this network over time and it would be hard for any organisation that is committed to person-centred outcomes for the people they engage with to justify any position which does not support or collaborate with LHW as it develops.

Past iterations of patient and public involvement

4.7 Responsibilities for patient and public involvement under the Local Government Act 2007 have transferred from Local Involvement Networks to Local Healthwatch organisations under the Health and Social Care Act 2012 along with additional responsibilities. This risk is mitigated as the outgoing LINk has been actively involved in the LHW development process and has provided a comprehensive legacy document of learning and analysis to support the development of the incoming provider.

Delays establishing the service

4.8 The procurement of LHW organisations has taken place against the backdrop of emergent legislation and the establishment of the national Healthwatch England body which has yet to confirm in detail, the working relationship it will have with the LHW network. To mitigate the issues of the past and develop an organisation that is fit for purpose, the desire to establish the service as soon as possible must be balanced against legal, economic, political, technological and environmental factors which have yet to be fully identified and defined. For this reason, the LHW service has been given a maximum 6 month window to become fully operational, the details of which must be set out against a detailed implementation plan.

Background Papers
Annex 1 – Equality Screening Record

Contact for further information
Glyn Jones, Adult Social Care, Health and Housing - 01344 351936
Glyn.jones@bracknell-forest.gov.uk
Andrea McCombie Parker, Local Healthwatch Bracknell Forest – 01344 755528
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Equalities Screening Record Form

(File reference: LHW Procurement EIA v5 0 UNRESTRICTED.doc)

Date of Screening: 19 September 2012	Directorate: ADULT SOCIAL CARE, HEALTH AND HOUSING	Section: JOINT COMMISSIONING
1. Activity to be assessed	Procurement process for Local Healthwatch Bracknell Forest (LHW)	
2. What is the activity?	☐ Policy/strategy ☐ Function/procedure ☐ Project ☐ Review ☒ Service ☐ Organisational change	
3. Is it a new or existing activity?	☒ New ☐ Existing	
4. Officer responsible for the screening	Kieth Naylor, Joint Commissioning Officer: NHS Modernisation Projects	
5. Who are the members of the EIA team?	Kieth Naylor, Joint Commissioning Officer: NHS Modernisation Projects (Adult Social Care, Health and Housing) Lynne Lidster, Head of Joint Commissioning (Adult Social Care, Health and Housing) Kim Helman, Joint Commissioning Officer (Adult Social Care, Health and Housing) Dave Rossiter, Joint Commissioning Officer (Adult Social Care, Health and Housing) Graham Symonds, Policy and Commissioning Manager (Children, Young People and Learning) Service Efficiency Group	
6. What is the purpose of the activity?	To ensure that a new contract for the supply of LHW is established before 1 April 2013 and that it is ready to assume the statutory functions of Local Involvement Networks (LINk) that it will replace. The reasons behind the national decision to replace Local Involvement Networks with LHW organisations is documented nationally and which have been echoed to a greater or lesser extent within Bracknell Forest including: • significant variance in effectiveness from area to area • poor demographic representation • limited capacity due to a reliance on the good will of individuals and community groups • lack of public awareness and poor accessibility • lack of national leadership and therefore fragmented action and impact • unclear accountability caused by the tripartite arrangement between Hosts, the local authority and LINk • poor governance and management • internal disputes and poor relationships leading to limited influence in commissioning and service delivery **Context**	

	The procurement of the Service will take place within the context of significant change to the NHS as a whole. Because of the bulk of changes will affect social care services, the commissioning lead for the transformation of the NHS has been devolved to local authority social care departments. In Bracknell Forest, the lead is the Adult Social Care, Health and Housing (ASCH&H) department. The project lead has been delegated to the Chief Officer: Older People and Long-Term Conditions, supported by a designated member of the (ASCH&H) Joint Commissioning Team. A project team with representatives from the commissioning teams of both adult and children's social care with responsibility for local authority and joint commissioning with the NHS was identified to establish options and recommend a preferred solution. **Community involvement** As part of the procurement process, a programme of community engagement and involvement activity was undertaken by independent consultants to gather the views of local stakeholders and their findings are documented in a separate Vision Report available from http://www.bracknellforestlink.org/LocalHealthwatch and which has been used extensively in the preparation of the procurement plan and specification for services. The activities took the form of focus groups to elicit the qualities of a good consumer champion for health and social care and a second stakeholder event to elicit views on the potential delivery options for the Service. Where highlighted through community engagement, specific issues relating to equalities are addressed in the body of the screening report and is supported by other evidence brought to bear by the procurement team. This document should be read in conjunction with the EIA screening record for the LHW service for detailed analysis of need by equalities group and other communities of geography, identity and interest. **Options appraisal** A number of options were appraised by the community as the principle customer of the service. *Model 1 – A single contract with a supplier established specifically for the delivery of LHW* Issues of power, control and over concentrated influence permeated the discussions of all options at the stakeholder event and there appears to be widespread tensions around these issues, directed at the local authority and the bigger players in the sector. This model emerged as the least favoured option in stakeholder discussion. There was also concern that a single organisation would not be able to provide all the LHW services adequately or be flexible enough to adapt to the emerging requirements of LHW anticipated over time. The scale of LHW functions and the ongoing discussion around LHW functions, roles and responsibilities would require a more flexible option for delivery to accommodate change. *Model 2 – A single contract with a supplier, LHW delivered as an extension of an existing remit* The concerns raised around this model echoed those of model 1 with only marginally fewer risks to benefits and the added issue of conflict of interest. This could be a real issue in a small provider market with organisations already delivering health, social care or services with a health related outcome and which would be subject to enter and view powers for which it would be responsible. *Model 3 – A single contract with a supplier that sub-contracts to deliver specialist services* This model was the only model to secure equal comment relating to benefits and risks. The praise focussed on the potential for provision through a wider range of organisations allowing for small organisations to participate with less pressure to take on a leading role without the burden of immediate changes to governance or constitutions. The option would also provide lead in time for development of sector infrastructure to meet social enterprise criteria and would allow for the setting up of LHW functions over time in a planned, piece-meal basis. This builds in flexibility for the lead organisation particularly as more

	information emerges on the delivery of LHW functions. From a LA contracting perspective and the timeline for procurement, having a single contract to establish and monitor would be desirable in the short- to medium-term. Furthermore, section 183 of the Health and Social Care Act 2012 allows for the primary provider to be a social enterprise without the need for sub-contractors to comply with these regulations, thereby affording the wider sector greater opportunity to support or deliver LHW functions. However, clarity on the accountabilities within the framework would need to be a requirement of the contract and monitoring arrangements, particularly where there may be conflicts of interest. *Model 4 – A single contract with a consortium arrangement including organisations who could provide specialist services* The primary risk of this model appears to be the ability of the local market to combine and to work up a collaborative arrangement capable of delivering LHW functions within the timescale. Implications for governance and constitutional arrangements emerged as key concerns from stakeholders which is an alarming echo of the disabling debate around governance which prevented the early development of the LINk. *Model 5 – Separate contracts with single suppliers required to work in partnership to deliver a Healthwatch brand* The timescale is too contracted to accommodate this option and it unclear as to the capacity of the market to deliver services in this way. It is one of the highest risk options to the local authority. In addition, the governance, constitutional and operational burdens on voluntary and community sector organisations would be onerous under this model, forcing change with no guarantee of winning bids. *Model 6 - A pan-Berkshire contract to provide back office and some specialist services with a local delivery arms* This option was suggested at the stakeholder event and was not subject to the same level of discussion and debate as the other models. It is therefore NOT recommended because it has not been robustly assessed by community stakeholders and furthermore, LHW organisations are at various stages of development and are not yet viable. There is provision within the legislation for LHW organisations to work together and this collaborative approach should be applied in the first instance before considering any joint delivery until such time as models in different localities are established and tested. *Preferred options* Having taken into account the general desire of stakeholder groups to ensure the active participation of a wider range of voluntary and community groups in the delivery of LHW functions, models 3, 4 and 5 emerge as leading options, but the onus will be on bidding organisations to highlight their chosen model would deliver the outcomes of the service specification and mitigate risks to delivery.
7. Who is the activity designed to benefit/target?	The service is designed for local people who use health and social care services defined in the Health and Social Care Act 2012 as follows: a. people who live in the Bracknell Forest area b. people who get health and care services provided in Bracknell Forest c. people from Bracknell Forest who get social care services provided in any other place, and; d. people who are representative of the people mentioned in (a) to (c)

Protected Characteristics	Please	Is there an impact?	What evidence do you have to support this?

	tick yes or no		What kind of equality impact may there be? Is the impact positive or adverse or is there a potential for both? If the impact is neutral please give a reason.	E.g equality monitoring data, consultation results, customer satisfaction information etc Please add a narrative to justify your claims around impacts and describe the analysis and interpretation of evidence to support your conclusion as this will inform members decision making, include consultation results/satisfaction information/equality monitoring data
8. Disability Equality	Y	N	Positive The procurement process identified positive benefits from the new service to people in this group.	The existing LINk has secured good representation from people with disabilities. The LINk database, secured the involvement of people with disabilities and organisations representing people with disabilities in stakeholder engagement and involvement activity. Their comments are captured in the community Vision Report and are in tune with evidence from people with disabilities about their information and advice and support needs. However, the representation and active involvement of the diversity of disabilities is limited within the LINk. Evidence of under representation has emerged from people with dementia and their carers who need improvements to the accessibility and availability of information about health and social care as an integral part of the care and support package; feedback from the Bracknell Forest Mental Health Strategy Consultation in Summer 2012 demonstrates that people accessing mental health support welcome opportunities to influence service development and want better access to information about support in the local area; “Speaking Up, Speaking Out and Taking Action”, the strategy for advocacy in Bracknell Forest highlighted specific issues relating to access to information for people with visual and hearing impairments, people with long-term conditions, people with autism and learning disabilities. The Provider will be required to monitor and evidence the needs of this group in contract monitoring arrangements.
9. Racial equality	Y	N	Positive The procurement process identified positive benefits from the new service to people in this group.	The representation of the diversity of different ethnic, linguistic and cultural groups and their active involvement in LINk business cannot be adequately demonstrated compared to the population as a whole. Although people and organisations representing different

				ethnic, cultural and religious groups participated in the stakeholder event, from this engagement and involvement activity, it was not possible to identify benefits or disbenefits to people purely on the basis of racial equality. Yet it is understood that a gap exists from other evidence. The Joint Strategic Needs Assessment suggests that there will be positive outcomes relating to sexual health for men of African origin is they were to receive better information and also earlier detection of HIV. Council research into advice, information and advocacy provision has indicated issues relating to accessible information for people of different ethnic or linguistic backgrounds, this is specifically the case for the growing number of families from minority ethnic families with children with autism. The involvement of such communities would also help determine the most appropriate communications methods to reach these vulnerable communities. The Provider will be required to monitor and evidence the needs of this group in contract monitoring arrangements.
10. Gender equality	Y	N	Neutral The procurement process was unable to identify benefits from the new service to people on the basis of gender equality alone.	The Provider will be required to monitor and evidence the needs of this group in the Specification and Contract arrangements.
11. Sexual orientation equality	Y	N	Positive The procurement process identified benefits from the new service to people on the basis of sexual orientation and gender re-assignment equality.	The representation of the LGBT communities and their active involvement in LINk business cannot be adequately demonstrated compared to the population as a whole. Engagement and involvement activity did not identify benefits or disbenefits to people purely on the basis of sexual orientation equality. However, the procurement process does reference council research into deficits in relation to advice, information and advocacy provision specifically to older people for health and social care issues in general and men who sleep with men of all ages in relation to early HIV diagnosis.

				The Provider will be required to monitor and evidence the needs of this group in contract monitoring arrangements.
12. Gender re-assignment	Y	N	See comments above for sexual orientation equality	See comments above for sexual orientation equality
13. Age equality	Y	N	Positive The procurement process identified positive benefits from the new service to people in this group.	Older people, particularly those with disabilities or long-term conditions are well represented on the LINk, but people of working age and children and young people are not adequately represented compared to the population as a whole.
14. Religion and belief equality	Y	N	Neutral	There is no evidence at this time to suggest an adverse or positive impact on health improvement or reducing health inequalities is experienced on the basis of religion or belief alone. The Provider will be required to monitor and evidence the needs of this group in contract monitoring arrangements.
15. Pregnancy and maternity equality	Y	N	Positive The procurement process identified positive benefits from the new service to people in this group.	This group is not well represented on the LINk, although engagement and involvement activity did not specifically identify benefits or disbenefits to people purely on the basis of sexual orientation equality. Other evidence, from the national outcomes frameworks and the JSNA suggest early interventions and securing the views of individuals to design services appropriate to need could be beneficial in this area specifically in relation to ante- and post-natal healthy lifestyles, breastfeeding, smoking during pregnancy and at birth and post natal depression. The Provider will be required to monitor and evidence the needs of this group in contract monitoring arrangements.
16. Marriage and civil partnership equality	Y	N	Neutral	There is currently no evidence at this time to suggest an adverse or positive impact on health improvement or reducing health inequalities is experienced on the basis of marriage and civil partnership alone.

				The Provider will be required to monitor and evidence the needs of this group in contract monitoring arrangements.

17. Please give details of any other potential impacts on any other group (e.g. those on lower incomes/carer's/ex-offenders) and on promoting good community relations.	**Carers** The Provider will be required to evidence need and opportunities for engagement with carers who suffer both financial and social disadvantage because of their caring role and which limits their access to information and their involvement in the commissioning of services which affect them. **People in prison** A need to determine how the Service will engage with prison services will be built into the specification and contract in order to meet the needs of people in the criminal justice system who have have inequitable access and varied experiences of health and social care. **Other accessibility consideration relating to the procurement process** **Promoting and Advertising the Opportunity** Advertising the opportunity will be key to ensuring that that any organisation has the ability to see when the council is tendering for a particular product or service. The opportunity will be visible on a number of websites, including the South East Business Portal which is accessible, free of charge, to any organisation. As there is a desire to ensure opportunity for the widest range of civic society organisations to deliver or support the delivery of LHW either as a main provider or as a sub-contractor, the specification will be written in a plain English style to make it accessible to organisations that would not normally consider tendering for such work. Limitations on the organisational model put in place by legislation such that the provider must be a social enterprise will be addressed by market development activity to support potential organisations and create capacity in the voluntary and community sector. The social enterprise criteria has been identified as a risk to local bidders coming forward and a voluntary OJEU advert will be placed. Documents in relation to the tender will be available in a number of formats, available free of charge and widely available in online and hard copy formats.
18. If an adverse/negative impact has been identified can it be justified on grounds of promoting equality of opportunity for one group or for any other reason?	No negative impact has been identified.
19. If there is any difference in the impact of the activity when considered for each of the equality groups listed in 8 – 14 above; how significant is the difference in terms of its nature and the number of people likely to be affected?	No negative impact has been identified.

20. Could the impact constitute unlawful discrimination in relation to any of the Equality Duties?	Y	N	No negative impact has been identified
21. What further information or data is required to better understand the impact? Where and how can that information be obtained?	The current LINk arrangements have not been able to demonstrate adequate representation and involvement of different communities in its business. The current legal arrangements for LINks are to some extent at fault, relying wholly on volunteering and good will, it has not been possible to reach out to the extent that has been desired to ensure that it meets the needs of the widest possible range of stakeholders. Whilst knowledge and experience of health and social care issues has not been wholly at fault, the lack of capacity has extended beyond human resource to limitations in skills and expertise in business areas with failings to create awareness of the service and promote itself. A number of specific actions have been determined to address the issues raised in the screening: • The new organisation will be required to use national branding (promoted via central government) to address the issue of identity • Requirements will be placed on LHW organisations to identify and engage with existing networks (and build new ones were required) to extend its reach to the widest and most representative extent to organisations, groups and individuals • Lack of capacity and guidance will be addressed not only by the asset based approach in the point above, but also by the new organisation being part of a nationally coordinated network under Healthwatch England which will be in place to support the development of LHW organisations. • The Service will be legally bound by Equalities Duties and will be monitored against these duties under under the terms of contract to ensure all staff and volunteers have undertaken training relating to the needs of all communities and monitoring arrangements will be put in place that will require the Service to gather data that can be disaggregated by protected characteristics criteria and sub-categories, including carers. • Accountabilities of the Service will be determined by Regulation which will require it to publicly disclose the effort is has made to ensure that the service is accessible to all sectors of the community and the outcomes it has achieved as a result. • Specific requirements will placed on the Provider by virtue of its membership of the Health and Wellbeing Board to provide robust evidence of local need and experience for the purposes of service commissioning and decommissioning • The Provider will also be required to work collaboratively with service commissioners, and will be held to account through the Health and Wellbeing Board for the actions it proposes to take to address the needs of people of all age groups in relation to areas of need identified in the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. • As part of the bidding process, prospective suppliers will be expected to demonstrate a sound understanding of local needs in relation to health and social care.		

22. On the basis of sections 7 – 17 above is a full impact assessment required?	Y	N	It is a further recommendation of the procurement process to specify that service will be subject to a full Equality Impact Assessment 18 months after the start of the contract to ascertain a detailed analysis of information, advice, signposting, communication, engagement, involvement, etc. needs of local people on the basis of the protected characteristics and other factors as they emerge on the basis of regular reporting.

23. If a full impact assessment is not required; what actions will you take to reduce or remove any potential differential/adverse impact, to further promote equality of opportunity through this activity or to obtain further information or data? Please complete the action plan in full, adding more rows as needed.

Action	***Timescale***	***Person Responsible***	***Milestone/Success Criteria***
Specific actions for the service are outlined in the service specific EIA			

24. Which service, business or work plan will these actions be included in?	*In the service contract and monitoring arrangements.*
25. Please list the current actions undertaken to advance equality or examples of good practice identified as part of the screening?	*LHW will be provided with access to Council training on equalities.*
26. Chief Officers signature.	*Signature:* *Date:*

When complete please send to abby.thomas@bracknell-forest.gov.uk for publication on the Council's website.

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Shaping the Future

The service changes

The service changes approved by the NHS Berkshire Board on 26 March 2013 are:

1. Moving the Minor Injuries Unit at Heatherwood to the planned new Urgent Care Centre at Brants Bridge in Bracknell
2. Improving rehabilitation services for both stroke and general medical patients, providing care and therapy to them in their own homes or communities, in line with best practice and national clinical guidance (Ward 8 at Heatherwood to close)
3. Permanently closing the Ascot Birth Centre at Heatherwood

Shaping the Future of Healthcare in East Berkshire

Board backs changes to services at Heatherwood Hospital

The Board of NHS Berkshire has approved recommendations relating to changes to four services used by patients living in east Berkshire and south Buckinghamshire which are currently provided at Heatherwood Hospital, Ascot. The decisions were taken following a three-hour discussion at its meeting at the Holiday Inn, Maidenhead, on 26 March 2013.

The changes relate to maternity, minor injuries, stroke rehabilitation and general rehabilitation services.

The Board made informed decisions after thorough debate which went on for more than an hour longer than scheduled to ensure all issues were properly explored. They also considered the contents of a Decision Making Business Case and Independent Consultation Analysis Report.

Dozens of questions were taken and responded to – both written ones submitted in advance and others asked at the meeting by members of the public and by the Board's non-executive directors.

The proposals were measured against key criteria including the impact on patient choice, access, service quality and support from clinicians.

Sally Kemp, the Chairman of NHS Berkshire, said: "As these proposals affect healthcare provided to patients across east Berkshire it was our responsibility to make our decisions looking at the needs of the population as a whole. We have made what we believe to be the right decisions, with some important conditions, to improve healthcare for the population and represent value for money within the resources available."

The decisions followed extensive public engagement dating back to 2011, including public consultation from October 2012-January 2013.

We have listened and taken on board all the feedback we received before, during and after the consultation. That feedback helped to shape the final recommendations. We want people to continue to work with us as we put these changes in place.

The implementation plan will be led by local Clinical Commissioning Groups which take over responsibility for commissioning local health services from 1 April 2013.

Dr Adrian Hayter, the Chairman of the Windsor, Ascot and Maidenhead CCG, said: “The four new local CCGs in east Berkshire and south Buckinghamshire have been working closely together to ensure that the needs of our patients are best served. Doctors and nurses have very much been part of the process and the development of the proposals. We are clear that these changes will bring long-lasting improvements for the population.”

The Heatherwood and Wexham Park Hospitals NHS Foundation Trust is developing plans to secure the long-term future of Heatherwood Hospital as a centre for high quality, planned surgery.

Shaping the Future team, FREEPOST RSYL-KEKG-URGC,
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Windsor Ascot and Maidenhead
Clinical Commissioning Group

NHS Berkshire
King Edward VII Hospital
St Leonards Road
Windsor
SL4 3DP

18th March 2013

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

Dear Charles

Shaping the Future consultation regarding changes to services currently provided at Heatherwood Hospital.

The Windsor, Ascot and Maidenhead CCG shadow Governing Body met on 6th March 2013 and discussed the working draft of the Shaping the Future Decision Making Business Case and the working draft of the Independent Consultation Analysis Report.

The CCG discussed in detail the proposals for change, the detailed responses and each of the draft recommendations in the Decision Making Business Case.

The Shadow Governing Body provides the following comments for consideration by the PCT Board at its meeting on 26th March 2013.

Recommendation 1 - The Board should confirm that the process undertaken has effectively engaged the local population, stakeholders and affected groups.

The importance of learning lessons from the consultation process to increase knowledge, awareness and involvement in the future of healthcare service provision in Windsor, Ascot and Maidenhead was raised. The Shadow GB were aware that as they take over responsibilities from April 2013 involving patients in decisions affecting their health will need to be a systematic and on-going process. Governing Body members noted the highly polarised public support for the consultation proposals, including the expressions of concerns beyond the scope of the consultation. It felt work needed to continue to explain these changes to the public before they were enacted and local community leaders should be fully engaged in the site's long term service planning process by HWPFT.

Recommendation 4
That the Board approves the proposal to enhance the service model so that the MIU is integrated with primary care in an Urgent Care Centre.

The Shadow Governing Body felt that this recommendation needed to be expanded to capture the changed service model from a minor injuries unit to an urgent care centre. A suggested rewording is provided below:-

That the Board approves an urgent care centre model which provides:-

- An enhanced primary care service for minor ailments as well as minor injuries
- A booked GP appointment service for patients across Bracknell, Ascot, Windsor and Maidenhead.
- Strong integration with primary care out of hours services on the same site to provide 24/7 coverage

The Shadow GB outlined a strong requirement to integrate the centre with Windsor and Maidenhead GP practices as well as those from Bracknell and Ascot to ensure continuity of primary care services for patients across the area.

The CCG noted particular comments from the Joint Overview and Scrutiny Committee on the importance of communicating effectively with the public on access routes into urgent and emergency care services. An effective communication plan will need to be implemented prior the move to ensure the public are fully aware of what emergency and urgent care services are available where, and at what times of the day. This did not just relate to the UCC but to other urgent and emergency care services accessed by WAM residents.

The CCG noted national work taking place on the definition and specification of urgent and emergency care services. Any new service will need to be consistent with emerging national definitions for different elements of urgent care.

Subject to the above points the Shadow GB supports recommendation 4 and provides the Board with assurance that it will work with the other CCGs and Unitary Authorities to ensure effective implementation, including addressing the points above on communications.

Recommendation 5 - That the urgent care centre, including the MIU should be located at Brant's Bridge NHS clinic. This recommendation is subject to the following caveats:

- **It is dependent on the negotiation of an appropriate lease with the owner of the facility**
- **Assurance that the future of the Brant's Bridge facility as the host of the UCC can be secured.**
- **Assurance that sufficient parking will be available**

The CCG discussed the Brant's Bridge location option for the urgent care centre. It was understood that initially a new build solution in Bracknell was proposed within the initial business case proposals, but that that was later rejected and replaced with the proposal to move to Brants Bridge. The CCG has not had information on the rationale for this decision, and would wish the NHS Berkshire Board to have assurance that there were good reasons for it.

The Governing Body noted the merits of the location of the urgent care centre in Bracknell, 2 miles from the Heatherwood site in terms of patient access and transport. It was further noted that transport was a repeated concern in the consultation and recommends a comprehensive travel plan is produced, promoted and implemented.

Subject to successful lease negotiations for the proposed building and the assurance regarding the original new build option, the Shadow Governing Body supports recommendation 5.

Recommendation 6 - That the Board approves the proposal to close ward 8 at Heatherwood and replace it with the following range of services in East Berkshire:

- **Eight additional stroke rehabilitation beds at Wexham Park**
- **An early supported discharge service for recovering stroke patients**
- **Community based packages of care for general medical rehabilitation**

The Shadow Governing Body noted national evidence and wide clinical support for the early discharge support service for stroke patients. The improvements this brings in quality of care for patients were evident. The CCG fully supported the proposal to implement the service in East Berkshire.

The Shadow Governing Body noted the concerns raised in the consultation by patients and the WAM OSC on providing appropriate community packages of care before the Heatherwood ward closure. The Shadow GB supported firm agreements and sufficient 'lead in' time to ensure social and community support packages were in place and the community informed before the changes were enacted.

The Shadow GB confirms support for the recommendation and can provide the Board with assurance that it will work with the other local CCGs and RBWM to ensure that appropriate community-based services are put in place prior to the closure of the ward.

Close liaison with the Unitary Authorities and all relevant providers to ensure the full package of health and social care is in place for discharged patients.

Recommendation 7 - That the Board approves the proposal not to reopen the Ascot Birth Centre.

The Shadow GB supported the proposal and will continue to ensure that there are clear choices for women who want to choose a midwife led birth. The CCG will work with providers to ensure that there is sufficient capacity of the right type in the system to provide for the future number of births projected.

In terms of overall assurances for the PCT Board the clinical leadership within the CCG and its members are committed to the implementation of the decisions of the PCT on 26th March from April 2013 as the statutory body who will be responsible for commissioning these services for patients of Windsor, Ascot and Maidenhead.

In terms of overall assurances for the PCT Board, the Shadow WAM CCG Board supports the recommendations given the above caveats and is committed, within the parameters outlined in this letter, to the implementation of the decisions of the PCT on 26th March from April 2013 as the statutory body who will be responsible for commissioning these services for our patients.

Yours sincerely

Adrian Hayter
Clinical Chair
Shadow Windsor, Ascot and Maidenhead CCG

NHS

Slough

Clinical Commissioning Group

NHS Berkshire
King Edward VII Hospital
St Leonards Road
Windsor
SL4 3DP

18th March 2013

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

Dear Charles

Shaping the Future consultation regarding changes to services currently provided at Heatherwood Hospital

The Slough CCG shadow Governing Body met on 26th February and discussed the working draft of the Shaping the Future Decision Making Business Case and the working draft of the Independent Consultation Analysis Report. The shadow Governing Body discussed the feedback from the consultation process and assessed each of the recommendations in turn. Given the numbers of Slough patients affected by the proposed changes to Maternity and Urgent Care services are minimal the discussion centred on the early supported discharge and general rehabilitation proposals.

1. The shadow Governing Body supports the three proposals for service change described in the DMBC related to the Minor Injuries Unit/Urgent Care Centre, rehabilitation services, and midwife led maternity services at Heatherwood hospital. It therefore would support approval of recommendations 4, 5, 6 and 7 within the DMBC (these are the recommendations in the DMBC which directly apply to the service changes).

2. The clinical leadership within the CCG and its members are committed to the implementation of the proposals especially in relation to early supported discharge for stroke patients and general rehabilitation services.

3. I can confirm that if the PCT Board decides to approve the proposals listed above, the CCG will actively work to ensure their implementation. I also can provide the following assurances and comments on implementation.

To reflect the feedback in the consultation we support that the name of the Urgent Care Centre should be reviewed. In particular, as national guidance emerges on the naming of the different kinds of emergency/urgent care facility to ensure greatest

public understanding of their role and function we will reflect that guidance. This will apply for all urgent and emergency care services accessed by Slough patients.
In addition, an effective communication plan will need to be put in place at the time of the move to ensure the public are fully aware of what emergency and urgent care services are available where, and at what times of the day across the East Berkshire system.

Rehabilitation implementation
We will ensure that appropriate community and social care based services are commissioned in Slough prior to the closure of the ward if the proposals are supported by the PCT Board.

We will work closely with the Slough Unitary Authorities and all relevant providers to ensure the full package of health and social care is in place for discharged patients to ensure patients are only discharged where effective community and social care support can be provided in the home.

Maternity implementation
We will continue to ensure that there are clear choices for Slough women who want to choose a midwife led birth.

We will work with providers to ensure that there is sufficient capacity of the right type in the system to provide for the future projected number of births in Slough CCG.

Yours sincerely

Dr Jim O'Donnell
Clinical Chair
Slough CCG

NHS
Bracknell and Ascot
Clinical Commissioning Group

NHS Berkshire
King Edward VII Hospital
St Leonards Road
Windsor
SL4 3DP

18th March 2013

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

Dear Charles

Shaping the Future consultation regarding changes to services currently provided at Heatherwood Hospital

The Bracknell and Ascot CCG Shadow Governing Body met on 13th March and discussed the working draft of the Shaping the Future Decision Making Business Case and the working draft of the Independent Consultation Analysis Report. The Shadow Governing Body discussed the feedback from the consultation process and supported the recommendations highlighted in the draft business case. The following comments are provided for PCT Board consideration:-

Recommendation 1 - The Board should confirm that the process undertaken has effectively engaged the local population, stakeholders and affected groups.

The CCG reflected that the public consultation had effectively engaged the Bracknell and Ascot population with good engagement at deliberative events, focus groups and through individual and organisational responses. The Governing Body commented however that in future consultations the use of social media could be employed to greater effect.

The CCG noted that whilst the majority of respondents were negative in respect to the changes that the concerns mainly focussed on the future of the Heatherwood hospital site and recognised that the CCG needed to focus on the three substantive proposals linked to the consultation criteria as part of its deliberations.

Recommendation 4 - That the Board approves the proposal to enhance the service model so that the MIU is integrated with primary care in an Urgent Care Centre.

Recommendation 5 - That the urgent care centre, including the MIU should be located at Brant's Bridge NHS clinic. This recommendation is subject to the following caveats:

- **It is dependent on the negotiation of an appropriate lease with the owner of the facility**
- **Assurance that the future of the Brant's Bridge facility as the host of the UCC can be secured.**
- **Assurance that sufficient parking will be available**

The CCG strongly supports the above recommendations. The delivery of an Urgent Care centre in Bracknell is critical to its plans for developing primary and community care services for its population and meeting its commitments through the 'Right Care, Right Place' consultation in 2008.

The Governing Body noted feedback from the consultation on the clinical model of care for the UCC including opening hours and levels of GP support. The CCG is committed to reviewing the service offering with local people as changing services and needs dictate. We were especially mindful of the confusion in the public as to access points to urgent and emergency care services. An effective communication plan will be put in place at the time of the move to ensure the public are fully aware of what emergency and urgent care services are available where, and at what times of the day. Additionally, as national guidance emerges on the naming of the different kinds of emergency/urgent care facility to ensure greatest public understanding of their role and function - we will reflect that guidance in the new service.

The Governing Body recognises the importance of linking the Urgent Care Centre to practices in Windsor, Ascot and Maidenhead CCG to ensure continuity of service as well as those in Bracknell and Ascot.

Recommendation 6 - That the Board approves the proposal to close ward 8 at Heatherwood and replace it with the following range of services in East Berkshire

- **Eight additional stroke rehabilitation beds at Wexham Park**
- **An early supported discharge service for recovering stroke patients**
- **Community based packages of care for general medical rehabilitation**

The CCG supports the above recommendation. We will ensure that appropriate community and social care based services are commissioned in Bracknell and Ascot prior to the closure of the ward. The CCG are aware that discharge arrangements into community service are linked to three acute hospitals serving the CCG area.

We will work closely with the Bracknell Forest Council and the Royal Borough of Windsor and Maidenhead and all relevant providers, to ensure that safe and appropriate discharge arrangements are in place that meet individual needs, and fulfil their potential for rehabilitation.

Recommendation 7 - That the Board approves the proposal not to reopen the Ascot Birth Centre.

The CCG supports the above recommendation. We will continue to ensure that there are clear choices for Bracknell and Ascot women who want to choose a home, midwifery led or obstetric led birth.

We will work with providers to ensure that there is sufficient capacity of the right type in the system to provide for the future projected number of births in Bracknell and Ascot CCG.

In terms of overall assurances for the PCT Board the clinical leadership of the CCG and its members are committed to the implementation of the decisions of the PCT on 26th March from April 2013 as the statutory body who will be responsible for commissioning these services for people resident in Bracknell and Ascot CCG's catchment area.

Yours sincerely

Dr William Tong
Clinical Chair
Bracknell and Ascot CCG

Chiltern
Clinical Commissioning Group

NHS

NHS Chiltern Clinical Commissioning Group
Chiltern District Council Offices
King George V Road
Amersham
Bucks

Phone: 01494 586600
Fax: 01494 732035
Website: www.chiltern.nhs.uk

15th March 2013

Charles Waddicor
Chief Executive
NHS Berkshire

Dear Charles

Shaping the Future consultation regarding changes to services currently provided at Heatherwood Hospital.

I am writing on behalf of Chiltern CCG to confirm that we support recommendation six (quoted in the box below) in the draft Decision Making Business Case you have shared with us.

> "That the Board approves the proposal to close ward 8 at Heatherwood and replace it with the following range of services in East Berkshire:
>
> Eight additional stroke rehabilitation beds at Wexham Park
>
> An early supported discharge service for recovering stroke patients
>
> Community based packages of care for general medical rehabilitation"

I confirm that we have also gained assurances from our provider of acute and community services that they have adequate commissioned resources to meet the needs of South Buckinghamshire patients affected by the change.

Yours sincerely

Dr Annet Gamell
Chief Clinical Officer

NHS
Commissioning Board

NHS Commissioning in Thames Valley
March 2013

This briefing note describes the new structures for commissioning health and care services for the people in the Thames Valley following the implementation of the Health and Social Care Act 2012. It details the new organisations that will be involved in commissioning from 1 April 2013.

The following organisations are all taking on functions, and in some cases receiving staff, from the primary care trusts (PCTs) and Strategic Health Authority (SHA) in Oxfordshire, Buckinghamshire and the Berkshire.

Clinical commissioning groups (CCGs)

CCGs are commissioning organisations formed from general practices. All practices are required to join a CCG. Practices will shape commissioning decisions and hold the CCG to account for decisions made on their behalf. Many CCGs cover a smaller area than the previous PCTs. They are intended to ensure a closer relationship between local people, GPs and commissioning decisions.

CCGs will formally take on their new responsibilities on 1 April 2013. There are seven CCGs in Berkshire (3 CCGs in East Berkshire & 4 CCGs in West Berkshire. They have formed 2 federations West and East) within which he CCGs share posts (including Chief Finance Officer and Chief Officer/Accountable Officer).
In Buckinghamshire there are two CCGs: Chiltern CCG; population 326K and Aylesbury Vale; population 198K and Oxfordshire has one that covers a population of 696k.

Clinical leaders (usually the chair but sometimes the accountable officer) provide clinical leadership for each CCG, representing the clinical voice of members (the individual practices), overseeing governance and relationships with partners.

Commissioning support units (CSUs)

CSUs will provide CCGs with many of the commissioning support functions and services that were previously carried out by PCTs such as business intelligence and procurement. Some CCGs will also call upon CSUs to provide other functions such as transactional HR and finance.

CSUs are currently hosted by the NHS Commissioning Board (now known as NHS England) and CCGs within the Thames Valley have identified which CSUs they would like to buy functions and services from. Most are buying services from the Central Southern CSU.

CCGs vary in the amount and type of commissioning support they are buying (for example Oxfordshire as a relatively large CCG (688k population) has chosen to employ a higher proportion of support staff ‘in-house’.

Thames Valley Area Team (AT)

This is the local arm of NHS England (the NHS Commissioning Board), responsible for:

- Commissioning primary care (GPs, dentists, optometrists and pharmacists) across Oxfordshire, Buckinghamshire and Berkshire
- Some Public Health functions, on behalf of Public Health England: screening, immunisation and the health child programme for under 5's
- Specialist commissioning (this is for relatively rare and specialist treatments that need to be commissioned across higher population numbers). This will be Led by Wessex Area Team
- The Thames Valley AT will also lead on Offender Health commissioning on behalf of Wessex AT.
- Armed Forces health care is commissioned by Bath Gloucestershire, Swindon and Wiltshire AT on behalf of the South of England and London.
- CCG development and assurance
- Emergency preparedness, resilience and response
- System oversight; partnerships; and quality and safety

Public Health

The public health function is transferring from PCTs to local authorities and to Public Health England which will promote health protection and prevention.

Health and wellbeing boards

Health and wellbeing boards have been established to set a joint health and wellbeing strategy (JHWS) for each upper tier council area (for example county and city councils). They are designed to promote joint working and integrated services across health and social care.

Each board includes an elected member of the local council; the council's directors of adult services, children's services and public health; a member of the local Healthwatch; and representatives of each CCG in the local area. Each board is free to expand their membership to include a wide range of perspectives and expertise and they will seek to engage a wide range of partners, such as police, housing, education and transport as well as service providers and the voluntary sector.
NHS England will have a non-voting seat on each HWBB.
Health and wellbeing boards have been working in shadow form since April 2012 and will take on their full responsibilities in April 2013.

Healthwatch

Healthwatch will be commissioned by local authorities as the independent consumer champion for health and social care, gathering and promoting the views of local people. It will provide people with information and advice on local services and finding the right advocacy organisation, speaking out and getting involved.

Healthwatch will replace Local Involvement Networks (LINks) in April 2013. Each local Healthwatch will be an independent organisation, able to set its own agenda and work programme, employ its own staff and involve volunteers.

Healthwatch England was established in October 2012 to provide leadership, guidance and support to local Healthwatch organisations and influence national policy. It will be a statutory committee of the Care Quality Commission (CQC).

Clinical senate

Across the country, 12 clinical senates will provide advice and leadership to help CCGs, health and wellbeing boards and the NHS Commissioning Board make the best decisions about healthcare for local populations. The senates will be made up of clinicians and health professionals including public health and social care, alongside patients, the public and others. There will be a senate to cover the Thames Valley.

Strategic clinical networks

Strategic clinical networks, hosted and funded by the NHS Commissioning Board, will cover conditions or patient groups where improvements can be made through an integrated, whole system approach. These networks will help local commissioners to reduce unwarranted variation in services and encourage innovation in the following areas:

- Cancer
- Cardiovascular disease (including cardiac, stroke, diabetes and renal disease)
- Maternity and children's services
- Mental health, dementia and neurological conditions.

Strategic clinical networks will cover the same 12 areas as the clinical senates.

Thames Valley Local Education and Training Board (T.V. LETB)

T.V. LETB has been established in shadow form and, subject to successful authorisation, will be established by April 2013 as a sub-committee of Health Education England, the new national leadership body for education, training and development of the healthcare and public health workforce.

T.V. LETB is led by local NHS service providers. Their priorities for the next five years have been identified and a skills development strategy is currently being developed. This will take account of the operating plans of service commissioners, incorporating the joint strategic needs assessments developed by local authorities and public health.

Thames Valley Academic Health Science Network (AHSN)

There will be 15 AHSNs across England, bringing together NHS organisations, higher education, local government and business. All CCGs and NHS England direct commissioners should be members of an AHSN.

They aim to align clinical research, informatics, innovation, training and education and healthcare delivery. Their goal is to improve patient and population health outcomes by translating research into practice and developing and implementing integrated healthcare services. Working with Academic Health Science Centres they will identify innovations and spread their use through their networks.

NHS Trust Development Authority (NTDA)

The NTDA will be established from April 2013 to provide governance and oversight of NHS provider trusts that are not yet foundation trusts. The functions of the NTDA have previously been carried out mainly by strategic health authorities and the Department of Health. There is a strong expectation that the majority of trusts will achieve foundation status by April 2014.

NHS Property Services Ltd

The majority of the PCT estate will transfer to this new national organisation which will maintain, manage and develop facilities ranging from GP practices to administrative buildings. It is a limited company but will remain wholly owned by the Secretary for State for Health. PCT estates staff will transfer directly to this organisation.

HC 28/3/13

MILITARY HEALTH

MILITARY HEALTH	
Summary information on 2013/14 plan	
Key risks and mitigation	• Getting agreement nationally to the risk share to be mitigated through national agreement on funding • Historic poor data collection and collation mitigated through the CSU support service. • Inaccurate baselines / CCG contribution may be inaccurate – mitigated through review in 2013/14 • Developing the Armed Forces networks ready for transfer to CCGs – mitigated through working with CCGs in 2013/14 in Co-hosting arrangements • Working with Providers and CCGs to ensure that the ill and injured are transferred back into the community in a safe and timely manner with care package in place • Vascular services reconfiguration – need to work with CCGs; HWBs; Public and providers • Thresholds for care – mitigated by stating clearly NHSCB levels and using evidence base • Prosthetics – (a) funding of prosthetics – expectations may differ (Murrison report) (b) transition plan to transfer prosthetics to an AT in future • Governance arrangements – responsibility and accountability to be clarified – mitigated by review of governance arrangements underway
Outstanding issues to resolved before final plan	• The risk share model needs to be resolved before contracts can be agreed. • Agreement to revisit the baselines in 2013/14 to be agreed with CCGs

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Direct Commissioning plans on a page

Area Team: Thames Valley

Primary Care Programme

Values and Principles	Common core offer of high quality patient centred primary care	Continuous improvement in health outcomes across the domains	Patient experience and clinical leadership driving the commissioning agenda	Balance between standardisation and local empowerment

Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13

- Managing list size growth to reach the 5% target
- Existing QIPP plans to be completed
- Delivering increased access to NHS dentistry to individual PCT target
- Safe transition of all contracts and quality handover including any outstanding quality and performance issues, performer list issues
- Communication to contractors and performers
- Ensure end of year processes are in place and capacity to manage
- Implement new orthodontic contract across Thames Valley

Strategic Context and Challenges

- Implement Securing Excellence Single Operating model
- Implement strategy for quality improvement in primary medical services
- Implement GMS contract changes for 2013/14 to secure further health improvements
- Delivery of LPN work plans for pharmacy. dental and eye care

QIPP Improvements

- Ensure all contracts deliver core elements to the highest standard and efficiency
- Ensuring accuracy of GP registered lists by routine activity to identify patients who may have left
- Implement changes to QOF – NICE recommendations, increased upper thresholds for exiting indicators to reflect achievement of 75th centile to benefit more patients, public health domain set up so that 15% of the value of QOF devoted to prevention, Quality and Productivity indicators continue
- Implement new DES for improving diagnosis for dementia, care of frail elderly and seriously ill patients, support those with LTCs, on-line access to practice services

Organisational Development

- Training to implement Single Operating Model
- Developing Stakeholder and partner engagement
- Clinical Leadership Development Strategy

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Assurance	• Ensure steady state and transfer of contracts on 1 April 2013 • Ensure safe transfer of contracts to CCG's and LA's • Lift and shift FHS function •Implement national assessment frameworks across 4 contractor groups	• Continuity for primary care services • Local enhanced services reviewed by commissioners to ensure local health needs and priorities are in line with Health and Wellbeing Board strategies • Steady state as business critical functions and processes transferred	• Greater consistency in General Medical Services contract models based on improving outcomes and reducing health inequalities • Assurance frameworks will ensure efficiencies and value for money
Quality	• Introduction of the national quality framework including strategy for quality improvement, web-enabled database of general practice indicators and national performance assessment framework	• Established partnership and processes with CCGs for improving quality of primary care medical services and benchmarking across member practices	•Continuous quality improvement and positive experience of care
Single Operating Model	• Implement single operating framework • Implement single national performers list • Implement performers support services to manage performers whose practice raises concern	• More efficient and effective use of primary care team resource to enable increased focus on improving quality and providing support to improve	• Consistency in ways of commissioning and contract management balanced with local empowerment/flexibility • Clinical leadership and engagement in operational and strategic commissioning • Patient engagement
Securing Excellence-Dentistry	• Implement Securing Excellence in commissioning NHS dental services •Develop and implement the national dental care pathway commissioning framework • Implement and support Dental LPN	• Greater consistency in contract performance management to improve outcomes and reducing health inequalities • Efficient use of resources and improved quality of service • Clinical leadership and engagement in operational and strategic commissioning of NHS dental services	• Continuous quality improvement and positive experience of care • Clinically led, evidence based commissioning
FHS	• Ensure safe transition and steady state for business critical functions by lift and shift	• Transformation and cost reduction programme to improve efficiency and meet QIPP requirements •Implementation of common service specification	• Efficiency savings met and FHS services steam-lined to meet Area Team direct commissioning function requirements

Area Team …Thames Valley

Public Health Programme

Values and Principles	Services are patient centred and outcome based	Improved outcomes are delivered across each of the domains	Fairness and Consistency – patients have access to services regardless of location	Productivity and efficiency improves

Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13

Immunisations:
Implementation of Pertussis programme for pregnant women
Cancer Screening programmes:
Breast screening: Implementing full digital mammography (Buckinghamshire)
Bowel screening: Implementation of age extension in Bucks and Oxon
Cervical screening: Yr1 implementation of HPV triage and test of cure
Non Cancer screening (adults): Aligning Diabetic eye screening services to new national pathway
AAA: launching AAA screening programme is Thames Valley
AN & NBBS screening: Collecting robust chart data for Bucks AN screening

Strategic Context and Challenges

Challenges:
Implementation of Securing Excellence and the SOM across all PH programmes in the Thames Valley
Capital investment programmes in provider trusts e.g. impact on breast screening services converting to full digital mammography
Transition and workforce capacity (commissioner and provider)
Risks associated with co-terminosity and cross boundary issues working in new geographical footprint
Data collection and IT system risk impact on accuracy of performance data
Increase the number of health visitors and transfer of 0 – 5 PH programmes to local authorities by 2015

QIPP Improvements

Areas for further investigation:
Modernising pathology services (joint with CCGs)
Review of CHIS (currently 3 in TV)
General review of commissioning of screening programmes

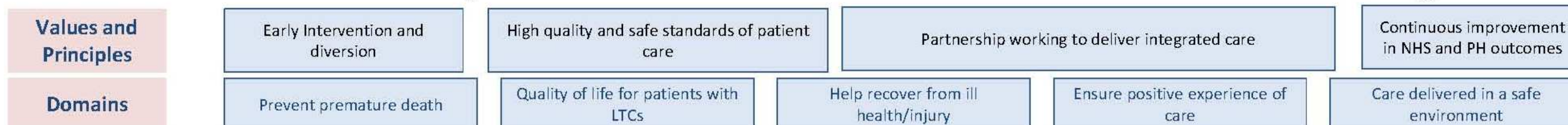
Organisational Development

Screening and Immunisation workforce training
Developing new working relationships with partners including CCGs, Local Authorities and providers
Working with LAs to prepare for handover of PH services 0 – yrs.

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Immunisation	• implementation of new immunisation programmes • Adjustments to schedules of existing imms programmes • improve uptake of seasonal flu vaccination programme in <65s in clinical risk groups and pregnant women •Agreement on management of outbreaks within new NHS/LA architecture	• vaccine programmes rotavirus and shingles and pre school influenza fully implemented in line with national guidance • Improved uptake of seasonal flu vaccination in <65s in clinical risk groups and pregnant women •Agreed TV outbreak management plans in place	• roll out of influenza vaccine for school age children • Cross sector working arrangements well established with CCG, LA, Area Team • A reduction in variations in uptake of imms and vaccs programmes •Robust data collection and analysis of imms programmes in place •Single operating model for imms programmes fully embedded
Screening Programmes (Cancer)	• Ensure that screening programmes are delivered in line with new national service specifications & gaps addressed • implement flexi-sigmoidoscopy pilots for bowel screening • Year 2 implementation of HPV testing in cervical screening • Integrating surveillance of high risk women in breast screening	• All local gaps in the provision of screening programmes against national service specs have been identified and plans in place to address, with local contract arrangements confirmed • Planning completed to implement Flexi sig pilot in Berks in 2015 • Year 2 implementation of HPV testing in cervical screening complete • Surveillance of high risk women integrated within breast screening	• All screening services delivered as per national specs across TV and achieving national QA standards and performance targets • A reduction in local variations in uptake across screening programmes •Single operating model for screening programmes fully embedded
Screening Programmes (Non-Cancer)	• Ensure that screening programmes are delivered in line with new national service specifications & gaps addressed • Full year roll out of AAA screening programme • Ensure that all diabetic eye screening services align with new national pathway	• All local gaps in the provision of screening programmes against national service specs have been identified and plans in place to address, with local contract arrangements confirmed • Full year roll out of AAA complete •Age extension of all bowel screening services in TV complete • all diabetic eye screening services fully aligned with new national pathway •Robust data collection systems for AANB screening across TV	• All screening services delivered as per national specs across TV and achieving national QA standards and performance targets • A reduction in local variations in uptake across screening programmes •Single operating model for screening programmes fully embedded
0-5 years Programme (including HV and FNP)	• Increase the number of health visitors working in local areas •Ensure that newly trained HVs are effectively deployed •Improve support for families through the Healthy Child Programme •Maintain & expand provision of FNP •Ensure new offer is delivered in an integrated way	•Local service specifications mapped against national specification and plans in place to address gaps • Increase in number of wte. HVs in line with trajectory •Increase in number of training places to meet demand for student HVs : 120 commissions •Improved coverage of HCP in Bucks and east & West Berks	• Target will have been met for increasing numbers of HVs in Thames Valley •Achieve a safe handover of responsibility for commissioning for PH services for 0 – 5 to Local Authorities • Single operating model for health visiting services fully embedded
NHSCB and PHE agreements	• •	• •	• •

Area Team : Thames Valley and Wessex

Offender Health Programme



Pre-existing Priorities 12/13

NHSCB transition: seamless transfer of contracts and provisions.
Assurance that offenders, detainees and young people (SCH) will continue to receive high quality equivalent healthcare services that are to the same standard as those provided in the community, as far as is possible within the constraints of a custodial environment.
Review existing Liaison/ Diversion and police custody pilots to inform future commissioning decisions.
Supporting and progressing existing procurements

Strategic Context and Challenges

Improving the health and social care outcomes and reducing health inequalities for adults and children in contact with the CJ system
Implement a single operating approach
Focus on early intervention, liaison and diversion as components in reducing reoffending, promoting resettlement (Bradley Report)
Challenges: Financial and Physical resource, IT systems incompatible, conflicting organisational priorities and cultural difference impacts.
Draw on area and regional support for robust clinical commissioning

QIPP Improvements

Ensure all contracts deliver core elements to the highest standard and efficiency
Review emerging opportunities to implement QIPP in Criminal Justice settings.
Greater service user involvement to inform quality

Organisational Development

Develop and implement suitable governance structures
Work with new commissioning support arrangements to develop procurement timescales, plans and provision
Work with Clinical Reference Groups (CRG's) to continue to develop contract products, in particular service specifications and service policies
Link with clinical networks for consistency
Develop relationships with CCGs and LA's for community pathways
Review and develop partnership structures

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
General Prison Healthcare	Single operating model approach- Consistency not centralisation. Improved partnerships to facilitate opportunities to reduce reoffending, and promote resettlement. Prison Health Performance and Quality Indicator reporting and HMIP/ CQC recommendation implementation	Alignment of existing contracts where appropriate for greater efficiency Adherence to national standards and governance requirements. Successful local interface between the NHS commissioners and LAs involved in the Criminal Justice system.	Quality delivery / planning across services and commissioners. Seamless integration and transfers between custody and the community A flexible commissioning model that can respond to emerging strategy. Contract Alignment
Secondary Care	Work with CCGs for seamless commissioning Engage key stakeholders to develop a planning process to ensure that services meet the needs of the population	Implementing common operating procedures Clinical leadership and local engagement in commissioning for custody and community based offenders.	Comparable standards and quality of care across community and criminal justice settings with CCG champions Seamless secondary care provisions for offender
Substance Misuse	Integrated, evidence based clinical and psychosocial SMS provision SMS based on need with outcome and recovery focus Services based on national good practice and quality standards	Value for money , greater quality, innovation and efficiency. Robust data reporting via the National Drug Treatment Monitoring System (NDTMS) Identification of recovery champions' (Patel Review)	End to end approach to case management across prison and the community. PBR contracts informed by effective NDTMS data reporting Single point of contact developed by SMS service providers.
Secure Training Centres	Not applicable to Thames Valley or Wessex	Not applicable to Thames Valley or Wessex	Not applicable to Thames Valley or Wessex
Secure Children's Homes	Establish partnerships with the Youth Justice Board and Hampshire CC to support the migration of commissioning responsibilities	Equity and consistency of care provision	Services for children and young people in Secure Children's Homes (SCH) improve Child Health Outcomes
Immigration Removal Centres	Equivalence of care and access for foreign nationals patients. Migration of care from the Home Office to the NHSCB Recognition of deportation constraints and foreign policy conflicts.	Engagement of UK Boarders Develop specifications to deliver best quality and outcomes for IRCs Implementation of SMS psychosocial and clinical provisions	Value and support diversity and greater service user input Continuity of care across boundaries Ensure contracts are inline with NHS standard
Sexual Assault Services (* linked to Public Health)	Improved continuity of care and equitable access to care for offenders and victims of sexual assault Access to a range of healthcare services that meet NHS standards	Close alignment between the NHS and Police to deliver services, which address both the patient's health needs and forensic enquiry to support any criminal investigation.	Sexual Assault services involving children Integrated with paediatric and community mental health services Services meet NHS standards and Public Health Outcomes
Liaison & Diversion	Roll out L&D schemes, designed to identify direct individuals with mental health, learning disabilities and substance misuse problems away from the criminal justice system to appropriate services	Early interventions and liaison and diversion schemes in all courts and police custody suites. Service model based on evidence and experience of pathfinders.	Diversion of offenders to appropriate modes of care as recommended by the 2009 Bradley report Delivering change through partnerships
Police Custody Suites	Implementation of healthcare into all local Tier 3 police custody suites.	Support local transfer of healthcare develop statement of readiness Draw on evidence compiled from wave 1 and 2 early adopters schemes (33 of 39 forces)	Services are delivered in-line with standard operating procedures and expectations of the independent police complaints commission

TO: HEALTH AND WELLBEING BOARD
11 APRIL 2013

POOLED BUDGET AGREEMENTS
Director of Adult Social Care, Health and Housing

1 PURPOSE OF REPORT

1.1 To inform the Health and Wellbeing Board of the current pooled budget agreements and the new arrangements with the Clinical Commissioning Groups.

2 RECOMMENDATION

2.1 That the board endorses the approach to pooled budget agreements and joint working arrangements between the council and health bodies.

3 REASONS FOR RECOMMENDATION

3.1 Partnership arrangements support more effective commissioning of existing or new services through the identification of synergies and efficiencies.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 Further opportunities for joint working may be suggested by the Board.

5 SUPPORTING INFORMATION

5.1 Section 75 of the National Health Service Act 2006 allows the pooling of funds between health bodies and health-related local authority services. It further allows for functions that can be delegated and resources and management structures to be integrated. Partnership arrangements support more effective commissioning of existing or new services through the identification of synergies and efficiencies.

5.2 The council is a partner to a Section 75 agreement, specifically for the provision of a community equipment service, with the other Local Authorities in Berkshire and with the Primary Care Trusts (PCT) for Berkshire. The lead agency for this arrangement is Slough Borough Council; SBC holds the community equipment contract with Nottingham Rehab Supplies Ltd. The agreement was approved by the council's Executive in November 2011 and commenced in April 2012 for a period of five years. The agreement provided that successor organisations to the PCT may replace the PCT as partners to the agreement. On behalf of the partnership, Slough Borough Council is drafting a document to assign the PCTs' responsibilities and benefits under the agreement to the Clinical Commissioning Groups across Berkshire.

5.3 In September 2012, the council's executive approved an overarching Section 75 agreement with Berkshire East Primary Care Trust for the 2012/13 financial year. This agreement commits partners to a set of principles and working arrangements that ensure effective delivery, management and governance. The agreement is appended with service specific schedules which will amongst other things, reflect the exact nature of the service, its deliverables, perceived impact and performance measures. The service schedule for Intermediate Care Services has been approved by the partners. The service schedule for the Community Team for People with a

Learning Disability is in development and is subject to negotiation regarding future commissioning leads. The department is exploring opportunities for further joint arrangements, for example pooling purchasing budgets between health and social care.

5.4 An overarching Section 75 agreement between the Bracknell and Ascot Clinical Commissioning Group and the Council, to succeed the 2012/13 agreement between the Council and the PCT, is in draft form and is currently being considered by the CCG's legal services. The Health and Wellbeing Board is named in the draft agreement to provide governance to the pooled budget arrangements.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The legal issues are described within this report.

Borough Treasurer

6.2 The Borough Treasurer is satisfied that no significant financial implications arise directly from this report. The services covered by the Agreement will continue to be funded from within existing identified budgets.

Equalities Impact Assessment

6.3 Equalities Impact Assessments were completed for both Section 75 Agreements and presented to the Executive. These are available on request.

Strategic Risk Management Issues

6.4

Other Officers

6.5 None

7 CONSULTATION

Principal Groups Consulted

7.1 The PCT, Adult Social Care, Health and Housing Departmental Management Team and legal and finance services.

Method of Consultation

7.2 Meetings and documents for consultation.

Representations Received

7.3 All representations were incorporated into the Section 75 agreements.

Background Papers
None

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HEALTH & WELLBEING BOARD: FORWARD PLAN 2013/14

Detailed below are overarching issues that the Board will need to take a view or inform. Scheduling of agenda items may change, if necessary.

Last meeting of the Board: 14 February 2013

Item	Decision	Responsibility	Submitted to Board:
ASCH&H and CYP&L Service Plan Alignment	To **formally assess and comment** upon the ASCH&H Service Plan and its alignment with the JHWS	Glyn Jones	**SUBMITTED**
HWBS – Governance Arrangements	To establish appropriate governance arrangements to ensure the implementation of the strategy.	Glyn Jones	**SUBMITTED**
Draft CCG's Plan for 2013/14	To seek the views of Board Members to inform the final plan for 2013/14.	William Tong/Mary Purnell	**SUBMITTED**
Funding Streams 2013/14	To set out proposals for the Board to comment on in relation to NHS funding for Social Care for 2013/14.	Glyn	**SUBMITTED**
Local Healthwatch Progress Report	To review progress.	LHW Rep	**SUBMITTED**
SEN Arrangements	To **review** progress.	William Tong/Janette Karklins	To be reported under action between meetings.
Assisted Conception	Ensure alignment with JHWBS.	Zoe Johnstone	To be reported under action between meetings.
Arrangements during Election Periods	To agree arrangements for representation at the Board for members who are subject to election processes	Priya Patel	Will be covered by the Council Constitution.

11 April 2013

Item	Decision	Responsibility	Submitted to Board:
Francis Report into mid Staffs.	To receive and comment on the plans of local commissioners to take on board the recommendations of the Francis Report.	William Tong/Mary Purnell /Glyn Jones	**SUBMITTED**
LINk Final Annual Report	To receive and comment upon the Local Healthwatch Annual Report and Accounts	Debra Ogles	**SUBMITTED**
Shaping the Future Results	To be considered by the Board	William Tong/Mary Purnell	**SUBMITTED**
Relationship of the Health and Wellbeing Board with the NHS Commissioning Board	To agree protocols for working with the NHS Commissioning Board	Mary Purnell / William Tong	**SUBMITTED**
Pooled Budget Arrangements (Section 75 agreements)	To agree protocols for establishing section 75 agreements	Glyn Jones	**SUBMITTED**
Local Healthwatch Bracknell Forest Contract Award	Information item	Kieth Naylor	**SUBMITTED**
Terms of Reference & Constitutional Arrangements of the HWB.	To agree arrangements.	Priya Patel/Kieth Naylor	**SUBMITTED**

4 July 2013

Item	Decision	Responsibility	Submitted to Board:
Local Healthwatch Forward Plan	To **assess and comment upon** the Local Healthwatch Forward Plan and its alignment with the JHWS	LHW Representative	
Bracknell Forest Partnership Risk Analysis	To **agree** the risk register prior to submission to the partnership in relation to the Act and subsequent regulations	Glyn Jones	
Serious Case Review Learning	To monitor learning from SCR	Janette Karklins/ Sandra Davies	
LSCB report on the	For consideration	Janette Karklins/	

Item	Decision	Responsibility	Submitted to Board:
performance of partner organisations on safeguarding and LSCB Business Plan.		Sandra Davies	

5 September 2013

Item	Decision	Responsibility	Submitted to Board:
HWB Annual Report	To **agree** to publish the HWB Annual Report	Dale Birch / William Tong	
Integrating Commissioning Strategies	To **agree** arrangements to receive and provide comment upon commissioning strategies to connect, integrate and resource outcomes	Glyn Jones / Janette Karklins	
Cross-border working	To **agree** protocols for working across boundaries with identified partners	BF HWB and RBWM HWB??	

12 December 2013

Item	Decision	Responsibility	Submitted to Board:

13 February 2014

Item	Decision	Responsibility	Submitted to Board:

10 April 2014

Item	Decision	Responsibility	Submitted to Board:

Work in Progress/Outstanding Issues:

- Memorandum of Understanding between HWB and CCG (Mary/Kieth) – work in progress.

Other Areas the Board may need to consider:

Health and Social Care Act - Issues subject to commencement

Item	Decision	Responsibility
Charges for specific health services	To **receive information** on section 50 regulations relating to the application of application of Charges to Health Improvement and Health Protection Measures and to **decide** future action	CCG / LA
Personal health budgets	To **receive information** on section 55 regulations relating to personal health budgets and to **decide** future action	CCG
Mental Health Advocacy	To **receive information** on section 55 regulations relating to mental health advocacy and to **decide** future action	LA
Pharmaceutical Needs Assessment	To **agree** the process of developing, updating and publishing the Pharmaceutical Needs Assessment	LA
Enhanced Joint Strategic Needs Assessment	To **agree** the process of refreshing the JSNA	LA/CCG
Application of the duty to integrate to health-related services	To **agree** a process to assess the commissioning of decisions of executive bodies against the JHWS	
Establishment of Care Trusts	To **agree** the protocols for establishing Care Trusts between the LA and the CCG	

New or draft legislation

From April 2013

Item	Decision	Responsibility
Draft Care and Support Bill	To **agree** arrangements for the joint working of the NHS CB, CCG, LA and carers' organisations and agreeing plans and budgets to support carers	William Tong/ Glyn Jones/Janette Karklins/NHS CB Representative

BF Local Safeguarding Children Board Annual Report 2011/2012 – Subject to approval of document

Item	Decision	Responsibility
??? Section 11 Safeguarding Assessments	To **agree** protocols for ensuring the Clinical Commissioning Group and other health providers commissioned through the Health and Wellbeing Board adhere to Bracknell Forest LSCB minimum safeguarding standards	Janette Karklins
??? Serious Case Review Recommendations	To **agree** protocols for ensuring the Clinical Commissioning Group and other health providers commissioned through the Health and Wellbeing Board are sighted on Serious Case Reviews and lessons learned are integrated into CCG and General Practice quality assurance systems	Janette Karklins
General Practice, Health Visiting and Midwifery Case Review Recommendations	To **agree** protocols for ensuring the Board and Clinical Commissioning Group and other health providers commissioned through the Health and Wellbeing Board are sighted on Case Reviews and lessons learned for General Practice, Health Visiting and Midwifery Case Review	

Item	Decision	Responsibility
	Recommendations are integrated into CCG and General Practice quality assurance systems	
Co-sleeping and bed-sharing for infants and small children	For the Board **to give a view** on community health professionals' advice on co-sleeping and bed-sharing for infants and small children	Janette Karklins
Child protections practice of health economy providers	For the Board **to give a view** on the potential application of the Exemplar Safeguarding Audit Tool to audit the child protections practice of health economy providers	Janette Karklins
Single and Inter-agency Training	*There is covered in section 4 – does the Board need to take a view on extending this throughout the new health economy?*	

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