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Notice of Meeting

Health Scrutiny Panel

Tuesday, 27th March, 2012 at 6.30 pm

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Monday, 19 March 2012

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Kate Phipps (01635) 519695
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Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To:	Councillors Howard Bairstow, Dominic Boeck, Sheila Ellison, Carol Jackson-Doerge, Tony Linden, Alan Macro, Gwen Mason (Vice-Chairman) and Quentin Webb (Chairman)
Also to:	Jan Evans and Jo Naylor (Principal Policy Officer) and Kate Phipps
Substitutes:	Councillors George Chandler, Roger Hunneman, Andrew Rowles and Julian Swift-Hook

Agenda

Part I

Page No.

1 **Apologies for Absence**
To receive apologies for inability to attend the meeting (if any).

2 **Minutes of Previous Meeting** 1 - 8
Purpose: To approve as a correct record the Minutes of the meeting of this Panel held on 17th January, 2012.

3 **Declarations of Interest**
To receive any Declarations of Interest from Members.

4 **Actions from Previous Minutes**

5 **Update on Progress of NHS Continuing Health Care Programme** 9 - 12
Purpose: To receive an update from Jan Evans (Head of Service, Adult Social Care, West Berkshire Council) on the progress of NHS Continuing Health Care Programme.

6 **Interim Report on Dignity and Nutrition at the Royal Berkshire Hospital** 13 - 32
Purpose: To review the interim report on Dignity and Nutrition at the RBH by Tony Lloyd, Chair of West Berkshire LINk.

7 **Health Scrutiny Panel Work Programme** 33 - 36
Purpose: To consider and review as necessary the Work Programme for the Panel as at Year end 2011/12 and for consideration of additions to the Work Programme from the Members prior to referral to the OSMC for the Work Programme for 2012/13.

Andy Day
Head of Policy and Communication

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HEALTH SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON

TUESDAY, 17TH JANUARY 2012

Councillors Present: Councillors Howard Bairstow, Dominic Boeck, Sheila Ellison, Tony Linden, Gwen Mason (Vice-Chairman), Quentin Webb (Chairman) and George Chandler.

Also Present: Councillor Joe Mooney, Mr Charles Waddicor (NHS Berkshire), Ms Helen Mackenzie (NHS Berkshire), Margaret Goldie (Corporate Director), Janet Golder (Continuing Healthcare Specialist Worker), Dr Abid Irfan (Newbury & District Clinical Commissioning Group), Samantha Ward (South Central Strategic Health Authority), Junes Graves (Head of Social Care Commissioning & Housing), Leigh Hogan (Team Leader, Legal Services), Alison Coles, (Solicitor), Keith Ulyatt (Public Relations Manager) and Jo Naylor (Principal Policy Officer).

18. Apologies

Apologies were received from Councillors Jackson Doerge and Macro. Councillor Chandler substituted for Councillor Jackson-Doerge.

19. Minutes of the previous meeting.

The minutes of the meeting held on the 4th October, 2011 were agreed as a true and correct record and signed by the Chairman.

20. Declarations of Interest

Councillor Mason declared a personal interest in Agenda Item 4. She reported that as her interest was personal and non-prejudicial she determined to remain to take part in the debate and vote on the matter.

21. Scrutiny Review of NHS Continuing Healthcare

(Councillor Mason declared a personal interest in Agenda Item 4 by virtue of the fact that she was an Associate Member of the West Berkshire Disability Alliance and Independent Living Network. As her interest was personal and not prejudicial she was permitted to take part in the debate and vote on the matter).

The Chairman then invited Mr Charles Waddicor (Chief Executive of NHS Berkshire) to describe if there were any particular reasons why West Berkshire would have less equitable access to NHS Continuing Healthcare (CHC) compared to elsewhere in the country.

Mr Waddicor said his general belief was that the Primary Care Trust (PCT) was doing more than fine with a complex set of directions and guidance. He explained the guidance sometimes conflicted with the directions and in these instances the Primary Care Trust (PCT) would follow the directions as these were the law.

Berkshire West PCT was the lowest funded PCT in the country. The level of funding was based on a Government calculation that takes into account the healthcare needs of the population. He explained that as a consequence he would have expected to see expenditure at the lower end across all services.

He reported that in terms of actual expenditure on CHC the PCT was 126 out of 150 PCTs nationally. He explained that on a prima facie case there was not any evidence which showed the rules had not been applied fairly in West Berkshire.

He explained that the directions were derived from the Acts of Parliament and these had the basis of law. The PCT considered the guidance but during times

when the guidance conflicted with the directions the PCT would ultimately follow the directions.

Mr Waddicor responded to the nine questions published at Item 4, Appendix B (reprinted as headings below).

How does the PCT explain the inconsistency in approach whereby only 3.3 per 10,000 patients received Continuing Healthcare funding in the NHS Berkshire area, when as many as 29.3 people per 10,000 received funding in other parts of the country?

Mr Waddicor explained that whilst the Berkshire West PCT area was 150 out of 150 in terms of Government funding for healthcare that actual expenditure on CHC was ranked as 126 out of 150 PCTs for these funding awards.

He could not comment on how other PCTs applied the rules and regulations but he was not aware of major differences around the country. He added there was not any national formula for calculating CHC spend.

Councillor Boeck asked Mr Waddicor about the perception of medical practitioners that health care needs were not being met and that fewer patients received CHC in West Berkshire than elsewhere in the country.

Mr Waddicor responded by saying the PCT would deny they were not meeting healthcare needs where the evidence demonstrated they should have been. He would not accept this assertion. He said that as the PCT as the lowest funded body in the country it would be expected to spend at that level otherwise the organisation would have been in financial difficulty.

He explained that even though the numbers were lower the PCT spend more than they should on CHC and he did not see the evidence for any assertion that needs were not being met.

What budget build process has been taken and has there been a policy decision taken around the Continuing Healthcare budget to bring down budget spends? What has been the expenditure on Continuing Healthcare over the last 5 years?

The budget build process was based on expenditure from the previous years and made allowances for inflation. This would also include an assessment as to whether growth was required based on changes to the legislation or demographical changes. Mr Waddicor said he categorically guaranteed there was not any requirement for the CHC Team to deliver cost savings.

Mr Waddicor explained that complete data was not available over 5 years only for the last 4 years. Over this time, records showed that broadly the expenditure had remained the same.

During 2007-08 the PCT funded £13.8m of the NHS costs for CHC with a further £3.8m of jointly funded care costs or £17.7m for Berkshire West PCT area overall.

During 2010-11 the NHS funding for CHC was £13.4m. This figure was only £400k different from the total for 2007-08 and when the joint funding for cases was included (just over £3m) the total annual expenditure was reported as £16.5m. This showed that the total figures were only £1.2 million pounds lower in 2010-11 compared to the budget figures from 2007-08.

Mr Waddicor noted that there had been a significant reduction in the NHS funding for certain client groups most notably for those with Learning Disabilities. A series of reviews undertaken in 2008-09 had shown the PCT was incorrectly funding certain individuals and he explained this might be the reason

for the reduction in expenditure which was seen. He reported that there was not any evidence of significant change over the last 5 years.

How many individuals were in receipt of Continuing Healthcare funding, year on year, and what are the implications for West Berkshire Council?

Mr Waddicor explained the figures were for the Berkshire West PCT area as a whole. During the 2007-08 the NHS funded 378 people (for NHS and joint CHC costs) compared to the financial year 2010-11 when 465 individuals received funding which demonstrated that the PCT was funding more people in 2010-11. He reported that the process was not about reducing costs but ensuring the proper assessment of individuals' needs.

How many applications are submitted for Continuing Healthcare funding and how many of these are successfully awarded funding each year?

Mr Waddicor explained that he does not have the complete picture but he supplied figures for 2009-10 and 2010-11 for the number of new requests for CHC assessments. In the Berkshire West area 128 applications were granted during 2009-10 which represented 68% of all applications received. Whilst in 2010-11 it was reported that 123 assessments were awarded funding this equated to 63% of all applications received.

On what grounds can the NHS Continuing Healthcare Checklist be declined?

Ms Helen Mackenzie (Deputy Chief Executive, NHS Berkshire) responded by explaining that the directions indicated that the CHC checklist can be used as a screening tool to inform the decision as to whether a full assessment was required.

The PCT had been alerted to the fact there had been issues around the return of inappropriately completed checklists. She referred to national Ombudsman reports which instructed PCTs that checklists needed to be completed in full to provide sufficient evidence for an informed decision and to document the rationale behind any decision.

She mentioned that the PCT undertook a proportionate approach to ensure resources were directed to those who were most likely to be eligible for CHC funding. There was not any requirement to complete the checklist.

Under the directives and framework the PCT applied their expertise and knowledge in determining when to complete a full assessment and providing an explanation for the cases that fail to progress to a full assessment.

How many NHS Continuing Healthcare Checklists are received and how many go on to have a full assessment completed?

Mr Waddicor apologised that the PCT did not record data in such a way that would have allowed him to answer this question. The stored records only reported on the assessments received as opposed to checklists received and this response had already been provided to answer Question 4, Appendix B.

For those patients that require "Fast Track" care due to the urgency of their needs, and where the form is appropriately completed by a clinician, how many of these have been declined Continuing Healthcare funding and on what grounds have these decisions been made?

Mr Waddicor explained that although a patient might apply for a "Fast Track" assessment this did not mean they had any automatic entitlement to funding. Only a clinician can apply for a "Fast Track" assessment and should the criteria be met the PCT would provide funding in these cases.

He added that a patient with a terminal illness does not have an automatic right to CHC funding as the NHS provided a whole range of other services that are free at the point of delivery which could meet their needs.

Were all types of patient (e.g. End of Life, Learning Disabilities, those with complex needs) equally eligible for Continuing Healthcare funding?

Mr Waddicor reported that all types of patients were indeed eligible for CHC funding and there was not any discrimination between the groups, however he explained that there was not any automatic entitlement to funding either. He described that the needs of the individual would be considered and a decision made on entitlement in a similar way to Adult Social Care funding awards.

How many cases that were assessed for Continuing Healthcare funding took longer than the 28-day statutory time period to determine the application?

Mr Waddicor explained that delays in determining the applications might occur for a variety of reasons; there were often family requests, delays awaiting medical reports or difficulties finding a suitable time to meet which could result a longer time period than might ordinarily have been expected.

During 2010-11 there were 48 out of 123 applications that took longer than the statutory 28-day requirement.

The Chairman asked how many assessments had not been done and whether patients were being denied access to the full assessment. Mr Waddicor acknowledged that sometimes the necessary paperwork was not completed properly and this was the cause of returned assessments.

Councillor Linden described how other local authority areas also received low levels of healthcare funding but remained able to fulfil their necessary obligations. He was concerned that the figure of £400k (reduction of NHS CHC in 2010-11) showed an overall funding reduction despite continuing demand for CHC funding.

Mr Waddicor mentioned there was a substantial reduction in NHS funding in CHC from the assessment of adults with learning disabilities (LD) during 2008-09 which contributed to a significant reduction in expenditure. He explained that he had shown that the PCT was supporting more people with CHC needs now than compared to several years ago. He had to apply the rules equitably across the area and he did not see any evidence that people in West Berkshire were disadvantaged compared to other parts of Berkshire. The PCT was the lowest funded in the country and lower expenditure across all services would be expected.

The Chairman asked Mr Waddicor to explain the reason for the difference between local authority areas and whether this might indicate a stricter application of the guidance.

Mr Waddicor said he could not comment on the situation in other areas. He repeated how an organisation that was the lowest funded in the country based on a calculation of healthcare needs would have been expected to spend accordingly.

The Chairman asked whether there were cases where the PCT should be responsible for providing the funding and that perhaps the low figures of those receiving CHC indicated the local authority might be paying for some of these individuals instead.

Mr Waddicor mentioned a difficult session two years ago where the Council had felt strongly that the PCT was making the wrong decisions in relation to the

assessment of those with Learning Disabilities (LD). He recollected that when the disputed cases went to arbitration the PCT won every single one of those cases. Therefore he did not see the evidence that the PCT had applied things incorrectly or inappropriately.

In other parts of the South Central SHA region there was wider variation in the figures for numbers accessing CHC funding which might suggest different stringency and application of the rules. For Berkshire West the rules had been applied consistently and there was not any reduction to funding.

The Chairman asked how differences of opinion in relation to CHC funding cases would be resolved and what dispute resolution process was followed.

Ms Mackenzie responded by confirming that there was not any dispute procedure currently in place. However, consultation was underway on a draft procedure with the Berkshire local authorities. She acknowledged the importance of formalising this procedure.

The Chairman enquired whether the draft document covered the creation of a Committee of officers to determine decisions and whether an independent panel for the resolution of disputes would be established.

Ms Mackenzie described how a suggestion had been made for managing the disputes process as part of the draft procedure which was currently the subject of consultation.

Councillor Mooney reported his surprise that Mr Waddicor could not supply the specific figures for the West Berkshire local authority area. He expressed his concern there had been a 20% increase in the numbers receiving CHC funding yet there was reduced expenditure on CHC overall, per person per annum. He was concerned that West Berkshire Council might be covering end of life care costs particularly on occasions when a patient made a request to die in their own home.

Mr Waddicor responded by explaining that the PCT did pay for some terminally ill patients who were being treated at home. He explained that just because an individual was terminally ill this does not give an individual an automatic entitlement to funding. He reiterated that during 2007-08 the PCT funded 378 individuals and that during 2010-11 this figure was higher with 465 individuals receiving funded. He did not see that there was any evidence for the concerns that had been raised.

Councillor Mooney also asked why data could not be analysed by local authority area or by postcode. Ms Sam Ward (South Central Strategic Health Authority (SHA)) responded by explaining that the published Department of Health figures and benchmarking data for CHC funding could only be extracted by PCT area. There was not any ability to collate the data by local authority area.

The Chairman asked whether this data on CHC applicants could be collected and analysed by different means in the future.

Mr Waddicor responded by explaining how he would not ask for this to be done, due to the huge organisational pressures that the PCT was facing at this time. He reported that in the future the local authority would be in receipt of CHC assessments and might wish to conduct retrospective reviews.

Councillor Mason asked whether “Fast Track” applications can be denied if a clinician had made the funding request and whether “Fast Track” applications were possible from all types of patients.

Ms Mackenzie clarified that “Fast Track” related to a separate funding stream which can only be requested by a clinician. She explained that a “Fast Track” application could be made in situations when there is a primary need for health care and this was a completely separate process from the 28-day statutory deadline for CHC assessment requests. A “Fast Track” assessment form would still be returned if this was not completed satisfactorily.

Dr Abid Irfan (Newbury & District Clinical Commissioning Group Chairman) said that from April 2013 the Clinical Commissioning Groups would have the responsibility for managing the budget for CHC funding. He reported that the PCT process appeared to have been consistent from the figures he had seen and suggested however in the future better record management of the data was advisable. He added that the guidance suggested decisions over “Fast Track” applications should be made within 48 hours and he reassured Members that from the data he had seen this had happened in the vast majority of all cases.

Councillor Boeck asked about the management tools and PCT measurements which were used which might give reassurances that the needs of patients’ were being met.

Ms Mackenzie explained that the assessment process gave the PCT this information and also by following the expectations as outlined in the directions and guidance.

Mr Waddicor said data showing a wide variation in expenditure or in numbers over a period of time might have highlighted there was an issue. However, the PCT has not had any evidence of complaints or situations where their processes have been challenged or overturned in a court of law.

Councillor Boeck asked Mr Waddicor how the PCT is convinced that the 3.3 per 10,000 population figure demonstrated all the need was being met.

Mr Waddicor said he did not know specifically but the evidence suggested that overall the PCT was correct in their approach as the numbers were consistent, the policy had not been altered and the expenditure was consistent.

Ms Ward (South Central SHA) mentioned how the SHA was the organisation responsible for the next stage review and the Independent Review Panel. She explained she would have expected to see a significant number of complaints regarding the PCT decisions if there had been a problem.

The Chairman invited Ms Janet Golder (WBC Continuing Healthcare Specialist Worker) to give her view. She explained that more needed to be done in terms of providing more evidence-based analysis. She felt the low numbers awarded funding were a reflection of the low numbers of applications that were processed through to completion and consequently the absence of any referrals to the IRP. She explained that the process was further hampered by the absence of any dispute resolution procedure.

Ms Golder said the critical issue remained the actual number of completed CHC applications that were progressed to completion. The PCT had given numerous reasons why current applications were delayed and had not been processed, some of which had now been outstanding for several months. The Council officers had been challenging the PCT on cases where they believed the individual had an entitlement to CHC funding.

Councillor Boeck stated that a quarter of all applications for CHC funding fall outside the timeframe for determining applications and one-third do not actually receive this funding was evidence enough that the process needed investigating more thoroughly.

Councillor Bairstow requested the need for better data management so the PCT would know exactly how many applications were received, refused and the outcome of every application.

Mr Waddicor responded by saying that even by gathering data it might not fully explain the picture about meeting needs. He reiterated he did not see any evidence that the PCT was applying the rules in a stricter or more lenient fashion than other PCTs. He explained that he felt the consistency of approach was a good indicator. The SHA had not received considerably more appeals from the PCT's decisions and he does not see numerous Ombudsman complaints.

Mr Waddicor reminded the Panel Members that this was not a PCT that wanted to work in opposition to the Council. Ms Mackenzie emphasised that although there were different viewpoints it was important to agree a way forward.

Councillor Mooney reported that it was not lawful for local authorities to provide, fund or charge for care which should be provided by a PCT.

Mr Waddicor felt he had already answered this question and was confident that he was applying the regulations and guidance appropriately.

The Chairman summed up the discussion and explained this was the beginning of the Review on this subject. He said that the dispute resolution and the consultation process needed to be explored further. He welcomed the roundtable meeting between the PCT and Council officers as a useful way forward. He explained that there would be a further meeting of WBC officers once the written submission from Mr Waddicor and the benchmarking data from the South Central SHA had been received.

RESOLVED that:

(i) NHS Berkshire should formalise a dispute resolution process as a critical part of the fairness and equality of determining Continuing Healthcare funding across Berkshire.

(ii) An independent appeals panel should be established to arbitrate on cases where there is disagreement between the local authority and NHS Berkshire on Continuing Healthcare (CHC) awards.

(iii) There should be further investigation into the process of Continuing Healthcare (CHC) applications to establish the impact on West Berkshire residents.

(iv) NHS Berkshire should supply a written submission for the questions listed at Item 4, Appendix B.

(v) The South Central Strategic Health Authority (SHA) should supply benchmarking data to help support the Scrutiny Review with comparator data on Continuing Healthcare (CHC) awards.

22. Health Scrutiny Work Programme

Members considered the existing Work Programme for the Municipal Year 2011/12. Ms Naylor reported that the Day Centre scrutiny had not yet taken part due to a lack of resource and explained that the request would need to be considered and re-prioritised with all other work programme items.

Tony Lloyd (West Berkshire Local Involvement Network (LINk) Chairman) reported on the Review of "Dignity and Nutrition in Hospitals". He explained the difficulties encountered in the dispatch of questionnaires to those patients that had been treated in hospital over the last 12 months. He had been in contact with Crossroads and the Princess Carers' Trust to get their assistance. There

was a 20% response rate to the questionnaire which had been circulated and this included scope for some qualitative feedback. Some of the comments received showed some concerns to be followed up however overall the majority of the feedback was very positive about care within Berkshire's hospitals.

It was confirmed that the update on outcomes following the "Six Lives" Report had previously been considered by the Health Scrutiny Panel in October and there was no further work underway.

RESOLVED that:

(i) the "Six Lives" Report and "GP Commissioning" be removed as items from the Health Scrutiny Panel work programme.

The meeting commenced at 6.30pm and closed at 8.15pm.

Title of Report:	**Update on NHS Continuing Health Care Implementation in West Berkshire**
Report to be considered by:	Health Scrutiny Panel
Date of Meeting:	27 March 2012

Purpose of Report: **To update the Health Scrutiny Panel on the progress of the NHS Continuing Healthcare programme.**

Recommended Action: **To consider the information supplied by Jan Evans (Head of Service, Adult Social Care, West Berkshire Council) and agree the next steps for the Review process.**

Health Scrutiny Chairman	
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Executive Report

1. Introduction

1.1 Members were concerned that Berkshire receives some of the lowest levels of Continuing Healthcare funding when compared to other Primary Care Trusts nationally.

1.2 Since the last Health Scrutiny Panel, the Council has continued in its robust approach
with the PCT with regard its interpretation and implementation of the NHS Continuing Healthcare Framework.

1.3 Janet Golder conducted a review of existing CHC delivery and this has resulted in an agreement to an independent review to be conducted April/May 2012 commissioned by the SCHA.

2. Recommendations

It is recommended that Members consider the information supplied by Jan Evans (Head of Service Adult Social Care) at the Panel meeting on 27 March 2012 and agree the next steps for the Review process.

Appendices

Appendix A – NHS Continuing Healthcare Update Briefing

Item 5 - Appendix A

HEALTH SCRUTINY PANEL – 27 March 2012
BRIEFING – NHS CONTINUING HEALTH CARE UPDATE

Introduction;

Since the last Health Scrutiny Panel, the Council has continued in its robust approach with the PCT with regard its interpretation and implementation of the NHS Continuing Healthcare Framework.

Actions
Impact of the CHC specialist worker
Janet Golder has;

- held a programme of training events across staff and managers to raise awareness and knowledge of CHC
- continuously supports and advises staff to progress applications
- conducting individual reviews to progress CHC funding
- engaged legal services in challenging the PCT's decisions and processes
- conducted a review of the whole process, analysing where in her view the PCT is not adhering to statute and the spirit of the CHC Directions and Guidance.
- this review was the basis of a briefing meeting with WBC Health Scrutiny
- the review has been the basis of discussions with the SCHA

Health Scrutiny Panel

Charles Waddicor attended the last Panel and answered a range of questions from the Scrutiny members. This emphasised to the PCT how seriously this Council was taking these matters and its intention to progress their concerns with other organisations.

Legal Services

Due to the position taken by the PCT on a number of individuals and with no dispute resolution process in existence, legal services are regularly used to support staff in challenging the PCT. Currently they are working with over 20 individual cases.

Independent Review

The Council has discussed with the SCHA the findings of Janet's review. This has resulted in an agreement to an independent review to be conducted April/May 2012 commissioned by the SCHA. 2 senior managers are to be involved. Currently one is SWHA Continuing Healthcare lead and the other an ex

NHS CEO with significant expertise in this area. She also comes from the South West where there has been established an accord between the Councils and NHS on CHC matters.

The aims of this review will be;

1. To review the application of Continuing Healthcare Policies by NHS Berkshire across the six local authority areas, including any specific NHS Ombudsman guidelines currently used to inform local decision making.

2. To review the way in which the Directions, National Framework and Practice Guidance are being implemented by NHS Berkshire; review current local operational policies and procedures, and to determine the extent to which these are compliant with the national requirements.

3. To review how the eligibility criteria for NHS CHC are being applied (using the Decision Support Tool), and whether the Framework and National Practice Guidance are being interpreted correctly. To review this specifically in relation to decisions about eligibility for CHC for people with learning disability/challenging behaviour, people with mental health/substance misuse problems, and children.

4. To review the work of the CHC Panels, specifically in relation to timeliness of decision making and communication of outcomes, and the relationship between MDT recommendations and Panel decisions.

The reviewers will review existing written procedures in place across Berkshire, the advice and guidance provided to CHC Leads, and to Panel members, by NHS Berkshire and any written evidence relating to specific cases provided by the six Councils.

They will meet with both NHS and Council staff. Timescales and reporting arrangements will be agreed. The critical issue will then be how the review's recommendations are implemented in practise, with a robust monitoring framework in place.

Berkshire Local Authorities

Margaret Goldie has contacted the other 5 Councils, who have all expressed similar concerns at the approach of the PCT to this matter. They have agreed that WBC will lead for the 6 Councils, but are all supplying examples to contribute to the independent review.

Jan Evans - Head of Service

Title of Report:	**Review of the Interim Report on Dignity and Nutrition at Royal Berkshire Hospital**
Report to be considered by:	Health Scrutiny Panel
Date of Meeting:	27 March 2012

Purpose of Report: **To review the provision of Nutrition and Dignity at RBH.**

Recommended Action: **To consider the information supplied by Tony Lloyd (Chair of West Berkshire LINk) on Dignity and Nutrition at the RBH.**

Health Scrutiny Chairman	
Name & Telephone No.:	Councillor Quentin Webb – Tel: 01635 202646
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Executive Report

1. Introduction

1.1 Members were concerned about the lack of up to date information available to councillors on Dignity and Nutrition at the Royal Berkshire Hospital.

1.2 It was understood that whilst the CQC had undertaken a series of visits at 100 hospitals across England on these topics, the RBH was not included.

1.3 At the HSC meeting on October 4th, the West Berkshire LINk undertook to investigate these topics and to provide an interim report to the HSC by mid January 2012.

2. Recommendations

It is recommended that Members consider the information supplied by Tony Lloyd (Chair, West Berkshire LINk) at the Panel meeting on 27 March 2012 and agree the next steps for the Review process.

Appendices

Appendix A – Dignity and Nutrition at local acute Hospitals – Interim report by the West Berkshire Local Involvement Network (LINk).

Dignity and Nutrition at local acute Hospitals (Item 6 - Appendix A)

Interim report for the West Berkshire Council Health Scrutiny Panel – 27 March 2012

Background

Concern had been expressed by the West Berkshire Council Health Scrutiny Panel on July 19th 2011 about the lack of up to date information available to councillors on Dignity and Nutrition at the Royal Berkshire Hospital. This was in part due to the fact that the CQC had undertaken a series of visits at 100 hospitals across England on these topics which did not include the RBH.

At the HSC meeting on October 4th, the West Berkshire LINk undertook to investigate these topics and to provide an interim report to the HSC by mid January 2012.

Executive Summary

The Independent Living Network, acting as the host organisation for the LINk, made a number of attempts to assemble focus groups in September and October 2011 but experienced a great many late cancellations. One was held but only two people turned up. Focus Groups were therefore abandoned in favour of a questionnaire based survey.

Working in collaboration with the Princess Royal Trust and Crossroads, 250 questionnaires were despatched and we had 51 valid responses (20%)

32 responses related to inpatient episodes at the RBH with the remainder relating to Basingstoke (7), Swindon (4) Oxford (2) and a variety of other hospitals. The bulk of the responses (65%) were from people in the RG14, RG19, RG31 and RG18 postcodes

We asked people to score their experiences of the following on a scale of 1 to 10

1) The standard of nursing care on weekdays.
2) The standard of nursing care at evenings and week ends.
3) Dignity and Respect.
4) Nutrition and hydration
5) The information that they were given.
6) Hygiene and hand washing standards.
7) The admin relating to their admission, treatment and discharge.

We also asked

8) Whether due note was taken of whether they were carers.
9) Whether they would recommend the hospital.

The **RBH** results (numbers and percentages) based on 32 returns are summarised below :

	0 to 3	**4 to 6**	**7 to 10**	**Total**
Nursing care - weekdays	1 (3%)	6 (19%)	24 (78%)	31 (100%)
Nursing care –evenings etc	2 (6%)	7 (23%)	22 (71%)	31 (100%)
Dignity and respect	2 (6%)	5 (16%)	24 (78%)	31 (100%)
Nutrition	2 (7%)	9 (31%)	18 (62%)	29 (100%)
Information	3 (10%)	6 (19%)	22 (71%)	31 (100%)
Hygiene	2 (6%)	4 (13%)	25 (81%)	31 (100%)
Administration	2 (6%)	4 (13%)	25 (81%)	31 (100%)
		Yes	**No**	**Total**
Carer status		16 (52%)	15 (48%)	31 (100%)
	No	**Unlikely**	**Probably**	**Yes**
Recommendation?	2 (6%)	3 (9%)	9 (28%)	18 (56%)

The results for the full cohort of responses (51) relating to all hospitals are as follows:

	0 to 3	**4 to 6**	**7 to 10**	**Total**
Nursing care - weekdays	3 (6%)	15 (31%)	31 (63%)	49 (100%)
Nursing care –evenings etc	4 (9%)	16 (34%)	27 (57%)	47 (100%)
Dignity and respect	4 (8%)	10 (21%)	34 (71%)	48 (100%)
Nutrition	4 (9%)	15 (33%)	26 (58%)	45 (100%)
Information	5 (11%)	9 (19%)	33 (70%)	47 (100%)
Hygiene	2 (4%)	5 (11%)	38 (85%)	45 (100%)
Administration	2 (4%)	13 (27%)	33 (69%)	48 (100%)
		Yes	**No**	**Total**
Carer status		20 (41%)	29 (59%)	49 (100%)
	No	**Unlikely**	**Probably**	**Yes**
Recommendation?	5 (10%)	5 (10%)	14 (29%)	25 (51%)

The results at the RBH are consistent with recently published internal satisfaction measures and are as good or better than the average for all responses apart from hygiene in all categories.

Although the sample sizes are low and although it cannot be claimed that the sample is representative, there is still some evidence within this sample of dissatisfaction amongst a sizeable minority of patients about the standards of care that they have experienced at local hospitals.

We would, however, issue a caveat regarding the findings in that two of the more critical returns relating to the RBH concern hospital episodes prior to 1st October 2010.

We have asked the RBH if they would be prepared to distribute an amended but similar questionnaire to a random selection of elderly patients that had been discharged in the last six months. Thus far, despite reminders, this has yet to take place but we recognise that the RBH has been in the throes of a huge reorganisation over the last few months and that certain recent events have added to their difficulties. This survey, however, underlines the need to do such a survey in order to reassure the community that recent initiatives to improve standards there are being effective and to help refute some very strongly held views in the community that standards of care at the RBH, particularly for older people, are very poor.

We have also made a request to John Shaw, the CEO of the PRT in Reading, to extend the survey to the Wokingham area but again this request has not yet been responded to.

We would recommend that the survey be extended. The LINk will notify the CQC of our interim findings

Detailed Report

Methodology

Focus Groups

Sharon Jones, the development officer for the LINk and the ILN, liaised with the Princess Royal Trust during September and early October 2011 to try to assemble some focus groups. On two occasions the planned meeting was called off at the last minute due to people pulling out.
Eventually, a focus group was assembled but only two people attended and neither of them had been in a local acute hospital in the previous year.
A decision was taken to defer the use of focus groups in favour of adopting a questionnaire approach.

Questionnaire

A questionnaire (see Appendix 1) was developed with the help of the ILN and Nigel Owen of West Berkshire Council. Two additional questions relating to Carers were added at the request of the Princess Royal Trust (PRT).

Questionnaire packs including SAEs were prepared for the PRT and later for Crossroads so that they could add address labels for their members. At no stage did the LINk have access to the names and addresses of the recipients.

It was noted that there was no guarantee that those in receipt of the questionnaires would have been an inpatient at an acute hospital though the probability of this was likely to be greater than it would be amongst the general population.

190 Questionnaires were provided to the PRT and 60 to Crossroads. We had 51 returned questionnaires.

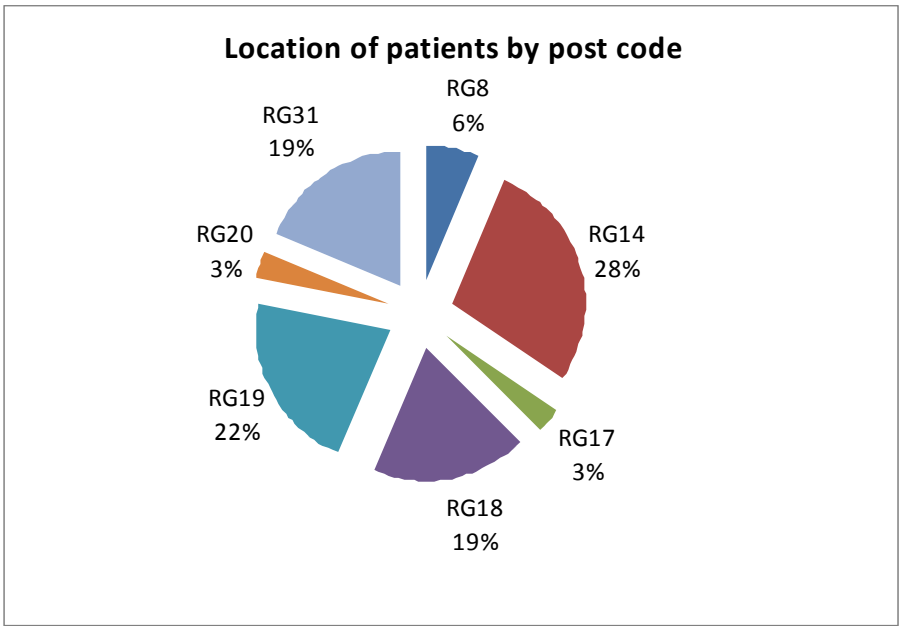
The returned questionnaires were analysed and transcribed by Sharon Jones and Man Lui of the ILN / LINk support team and this report is based on their work.

Findings at the Royal Berkshire Hospital

Demographics

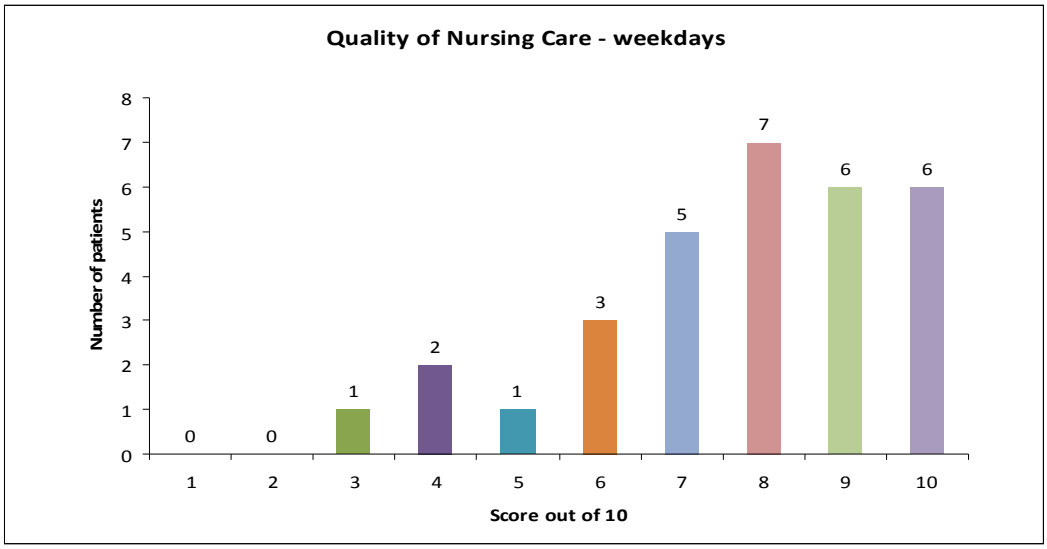
There were 32 people who responded re the RBH of whom 24 were carers.
Of these 12 were the patients themselves, 20 were close friends or relatives of the patient and 1 was the carer of a patient that was neither a close friend or relative.
24 of the in patient episodes occurred in the 12 months to 30 Sept 2011. 8 were earlier than that.
All but one of the patients were aged 65 or over with 11 being 81 or over. The majority of the patients (70%) were male (23)

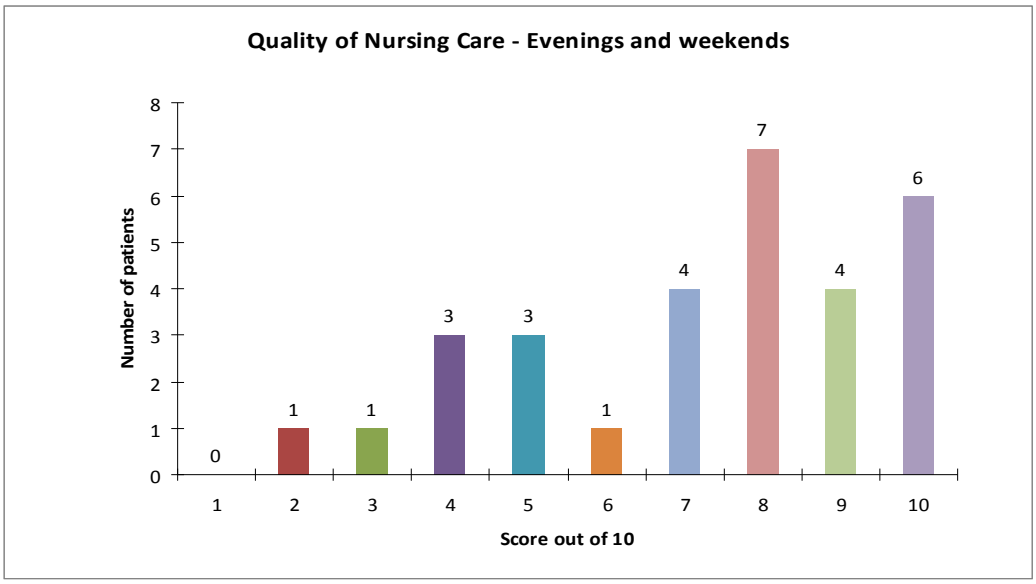
The post codes of the patients are shown in the diagram below



Nursing Care

As can be seen from the charts below the majority of patients felt that the standard of Nursing Care on both weekdays and evenings and weekends was in the range of 7 out of 10 or better.





Comments varied from compliments such as

1) Nothing was too much trouble.

2) I cannot fault the level of nursing care during these times for 39 days' stay.

to some more worrying ones that chime with some current hospital internal reporting

3) Nurses' attitudes were very caring but hard pressed. Time from ringing care 'bell' to getting attention varied, could be 10 minutes or more.

4) Rarely saw a nurse weekends very thin on the ground.

Dignity and respect

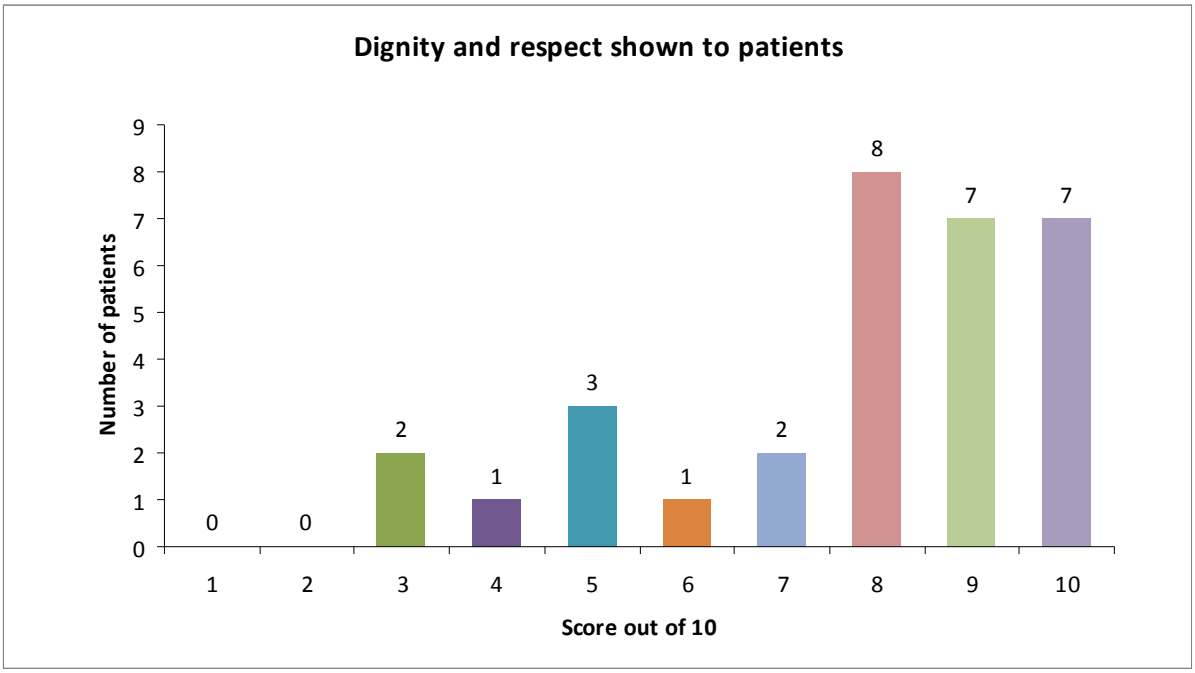
As indicated in the questionnaire, dignity and respect in a hospital context can be defined as below:

Dignity is the result of being treated with respect. It is internal and often associated with a sense of worth, well-being, being valued and having a sense of purpose

Respect is about the staff at the hospital being polite, being thoughtful and caring, keeping you informed, meeting your needs and ensuring your privacy, etc. and not treating you as an object of service..

The question that was asked was “Were you treated with respect as a person, when you were in hospital? How would you rate this?”

The results are shown in the chart below and again show that the majority of patients rated the RBH well on this issue. However 6 out of 31 (19%) scored this as 5 or below which is a cause for concern



Comments, as for other issues, varied from complimentary such as

1) Treatment good

2) On the whole, I was treated with respect but I realised that I had to 'think ahead' if I needed care or help in order to save nurses extra work.

through to more thoughtful ones

3) Could I have done any better? (or as well?) Perhaps not. But nursing staff and even doctors seemed a little 'busy' at times, but trying their best. Some patients struck me as very 'demanding' which could make difficulties.

Down to more distressing ones

4) I felt as though I couldn't possible know my mothers requirements or her problems even though I tried to explain her needs and confusion. I trusted them knew better but turned out I shouldn't doubt myself and I had to step in and help when mum got upset. I don't want her or me to go again.

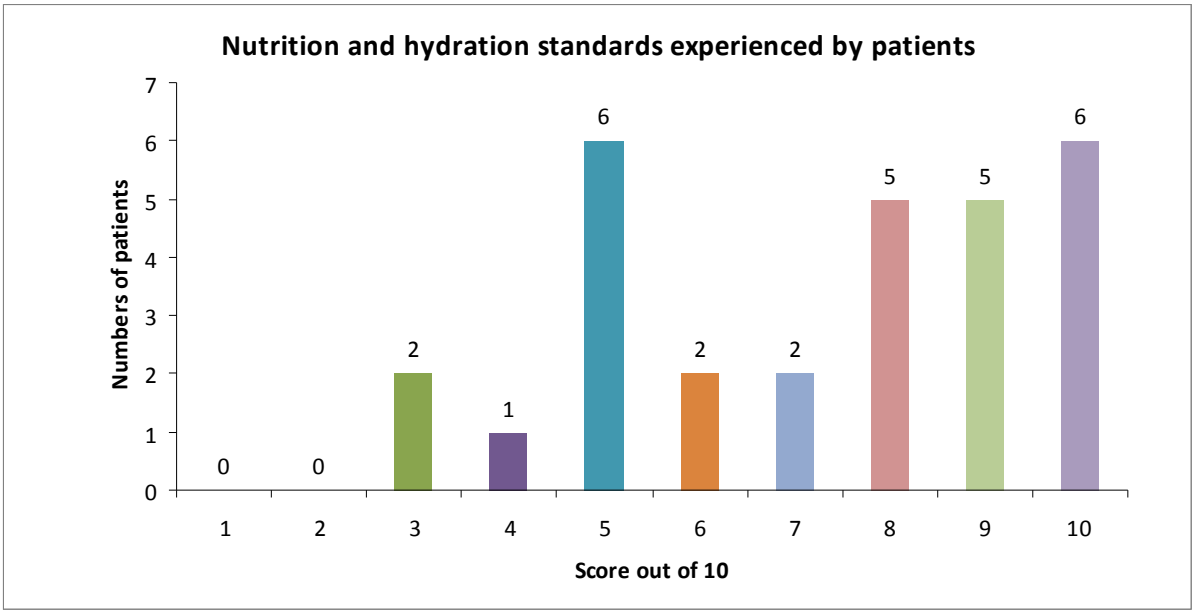
5) My mother was left in a chair, ignored by staff for more than six hours following a period when drugs had caused her to became mentally confused.

Nutrition and hydration

We asked the patients the following question

Were you able to get the food and drinks you needed, when you were in hospital? How would you rate this?

It will be noted that there is some evidence that there is a somewhat higher level of dissatisfaction regarding this issue than for the previous ones (nursing care and dignity and respect).



In comparison to the comments that we received from other units, the RBH fared quite well with a number of compliments

1) Food was good

2) Food always hot and as you wanted it.

3) The nursing staff sat at length with patients unable to feed themselves. In some cases they refused to eat so food and water left on tables within easy reach.

Though there were some adverse comments

4) On the first day after my operation my meals were put on the table where I could not reach them (as I could not sit up). I also had to ask for a mug and straw for my drink as I could not drink from a cup. If it hadn't been for one very kind young nurse who fed me, I could have missed out on lunch.

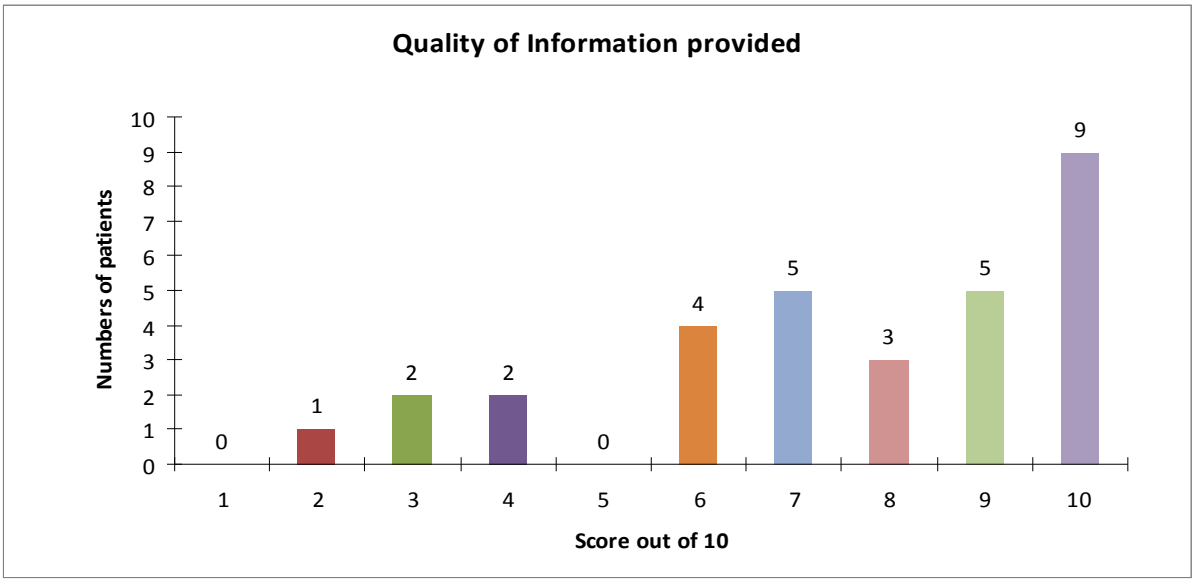
5) No. He was forgot sometime to get a drink. Was not good at all.

Information

The question that was asked was “How would you rate the information that you received about your treatment from consultants and junior doctors?

The findings were as follows:-

Despite the fact that 70% of those responding scored the RBH at 7/10 or greater, the outcome is not as good as it should be and a significant number of patients were dissatisfied with this aspect of their stay.



Comments were mainly complimentary such as

1) The consultant and doctors gave us all the information without us asking for it.

2) . Always excellent.

3) I was seen by the consultant and registrars after the operation and gave all the details I wanted about the success of the operation. The physio saw me a) to fit conset b) to check I was fit to leave hospital.

The one adverse comments was

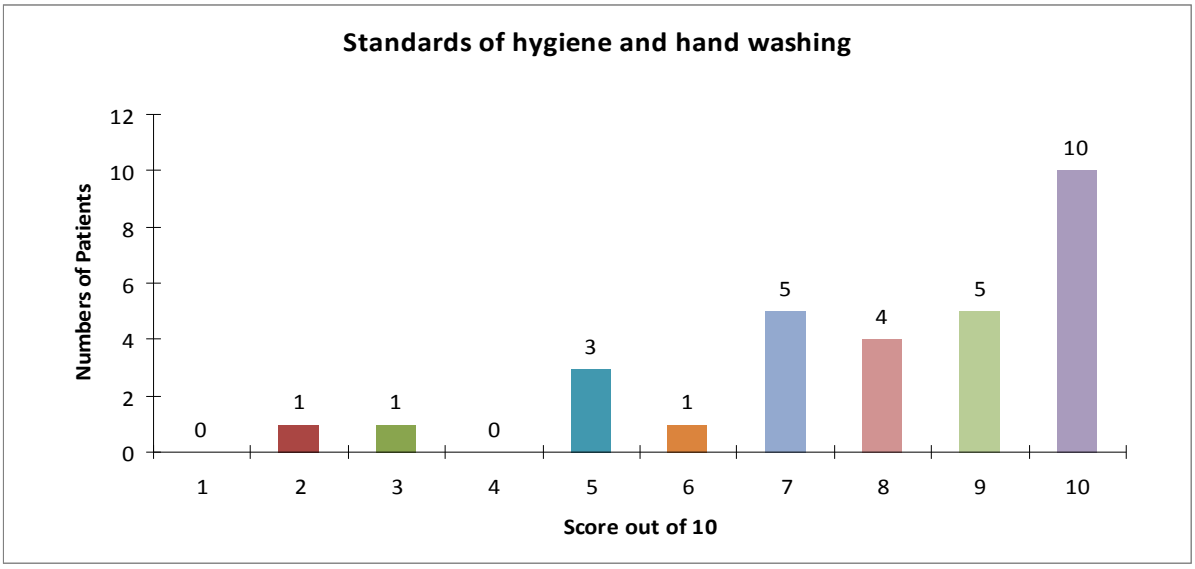
4) On discharge was Diagnosed wrong, eventually diagnosed correctly, but too late.

Hygiene and hand washing

The question asked was : -

How would you rate the hygiene standards in the ward? Was it clean? Did staff wash their hands before physical contact?

The responses are shown in the chart below. Again, bearing in mind the emphasis on this aspect of hospital care over the last two or three years it would have been anticipated that there would have been even better outcomes.



Comments on hygiene varied from the complimentary and reassuring

1) Ward always clean

2) The ward was spotless. Staff always washed their hands.

3) Staff always washing hands, always changing beds, especially incontinent patients.

to the worrying

4) There was a layer of thick dust at the back of my bed (on the floor). The shower was filthy - waters and hairs on the floor. Also the emergency bell did not work.

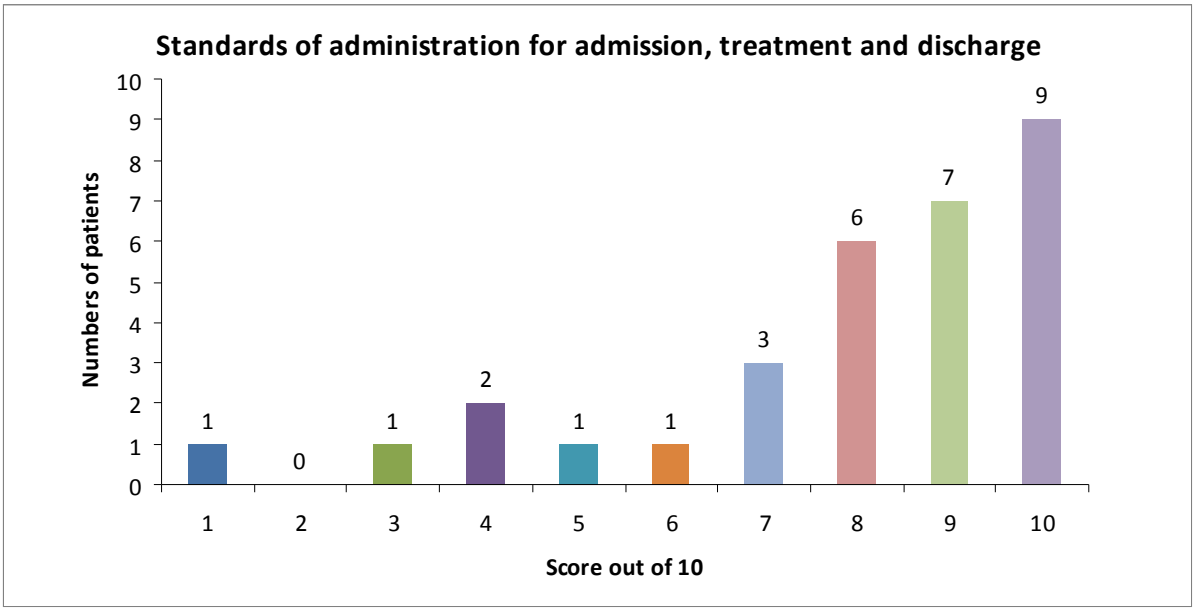
5) People visiting saw that some did not wash their hands and they had very little time to do this. but had time to laugh about their evenings and days off.

6) I never actually saw them washing their hands from my bed position. I was aware they sometimes used alcohol gel wash gloves.

Administration

The question asked was "How would you rate the hospital administrative processes – admission, discharge, communications etc? Was it well organised and trouble free?"

The outcomes are shown in the chart below:



Comments varied from compliments such as

1) We were met at door and given immediate attention.

To disturbing ones such as

2) . They couldn't wait to get rid of my husband and I had to fight for any care package.

3) Husband drove for emergency on 7.12.10. Hospital telephoned at 6.12pm and told us to go to SDU at 4.30 for admission. We duly arrived - no one knew anything about us and we were directed to A&E, I refused to go, asked to see a manager. Eventually a bed was found for my husband.

4) Waited a long time without seeing anyone eventually saw someone, to be told we would have to come back another day

Carer status

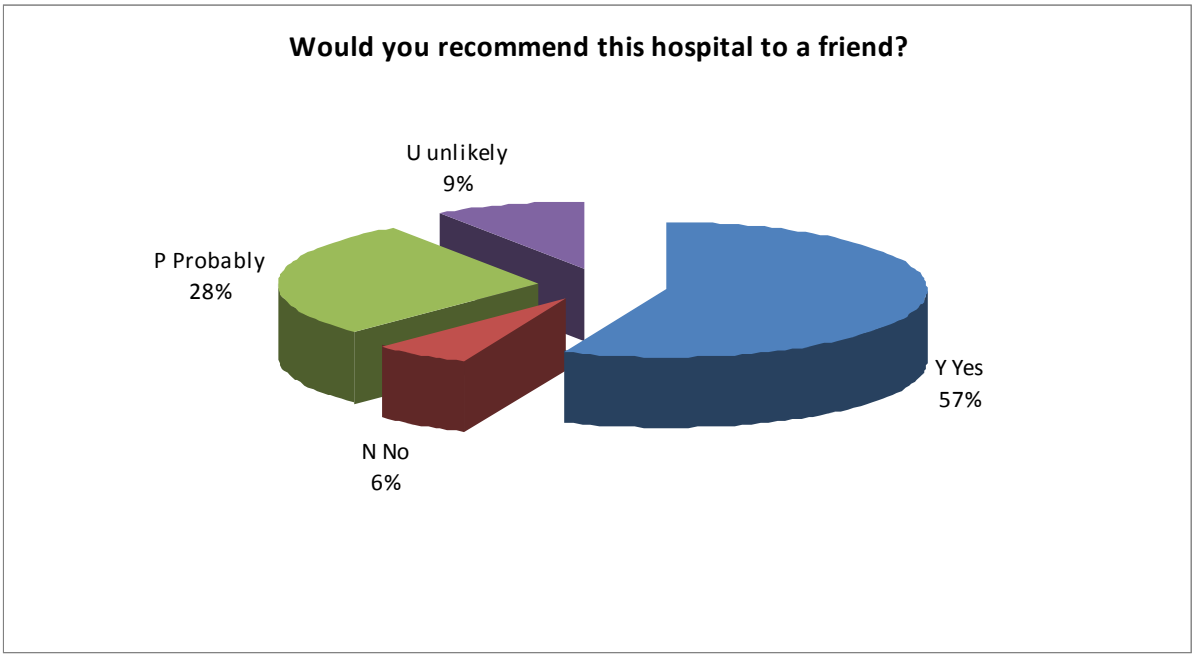
The Princess Royal Trust requested that we ask patients whether they were asked if they were carers during the admission process. Clearly there are circumstances where such information would need to be acted upon very quickly and there is a good argument for this question to be asked of all patients (that are capable of answering) as soon as possible after admission.

Approximately half of the patients (16 out of 31) indicated that they had not been asked

Recommendation

One of the best questions to ask people that have experienced hospital services as either a patient or as a member of hospital staff is " Would you recommend this hospital to a friend or relative?"

The people responding to the questionnaire were not unanimous in their response as may be seen from the chart below. With 15% saying that they either wouldn't or would be unlikely to recommend the RBH to a friend, this must give rise to concern. Certainly more work should be done to establish whether a more scientific study would yield similar results.



Comments made at the end of the questionnaire and relevant to this question about recommendation again covered the entire spectrum of views from

1) Maybe I was lucky. I also have private medical insurance but in this case it was necessary to use the NHS. Couldn't have had better service, Lodden Ward.

2) Husband has Alzheimer's and austin moore hemiarthroplasty. Excellence, wrote to the Chief Executive Officer.

through to

3) My husband went to the RB at the end of October 2007. He died four weeks later. The nursing was appalling, as his eyesight was failing, no one saw that he was fed. The ward was filthing. There was urine on the floor, no one bother to mop up. They put all the old people in nappies, then didn't bother to change them. So if they got out of bed urine just out of the nappy. My husband was

not treated with respect. The nurses just stood around talking.
Please God if I'm ill don't send me to the RB, let me die at home.
The ward my husband was in was SIDMOUTH.

4) I have seen Royal Berks in better health also where people cared more for people they looked after over the years. I have seen linen in black plastic bags left for clear in areas and not many chairs for visitors to sit on. Good and bad.

Findings at the other hospitals attended

Scope

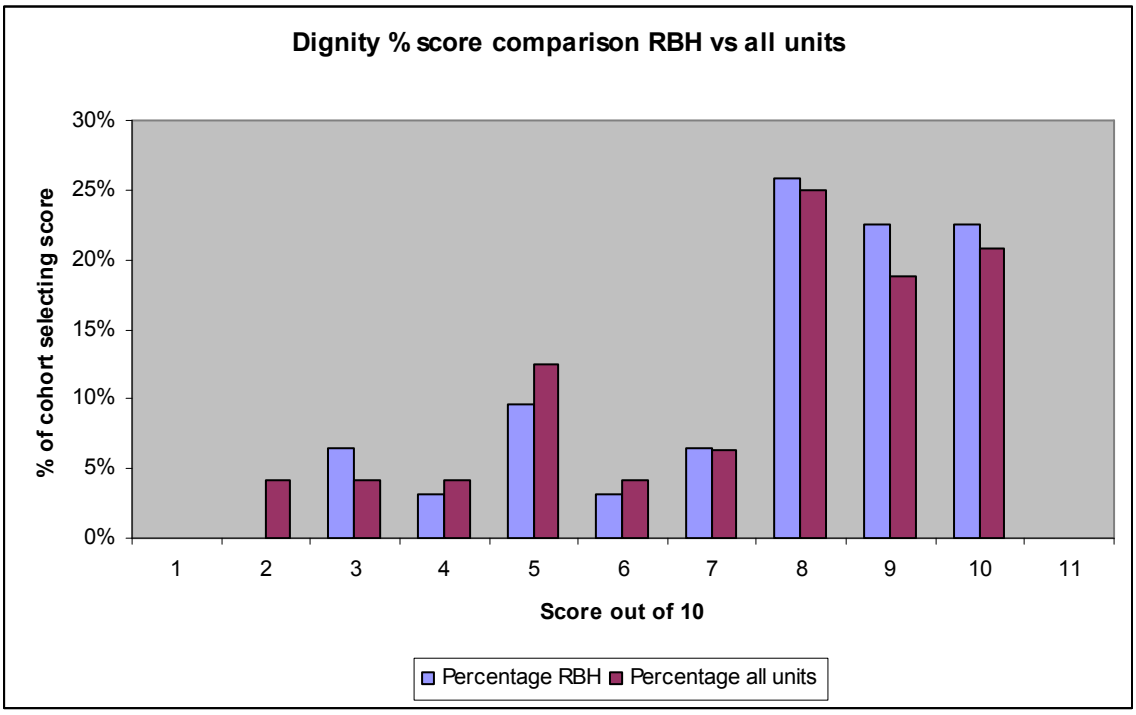
Rather than repeating the previous section relating to the RBH, it has been decided to limit the detailed commentary in this report to the dignity and nutrition sections and the recommendation section

If required, a more detailed report can be provided on request.

Because of a number of adverse comments relating to aspects of the care at both Basingstoke and Swindon, some of these comments have been incorporated into a separate section below.

Dignity and respect (all hospitals)

The first chart below shows the dignity and respect scores for all 48 units that repondents had experienced (including the RBH) and the second chart shows the comparative percentage scores for the RBH in comparison to the 48 units. As can be seen there is little difference though the RBH scores slightly greater than the average across the 48



Regarding the other units, some additional comments are set out below.

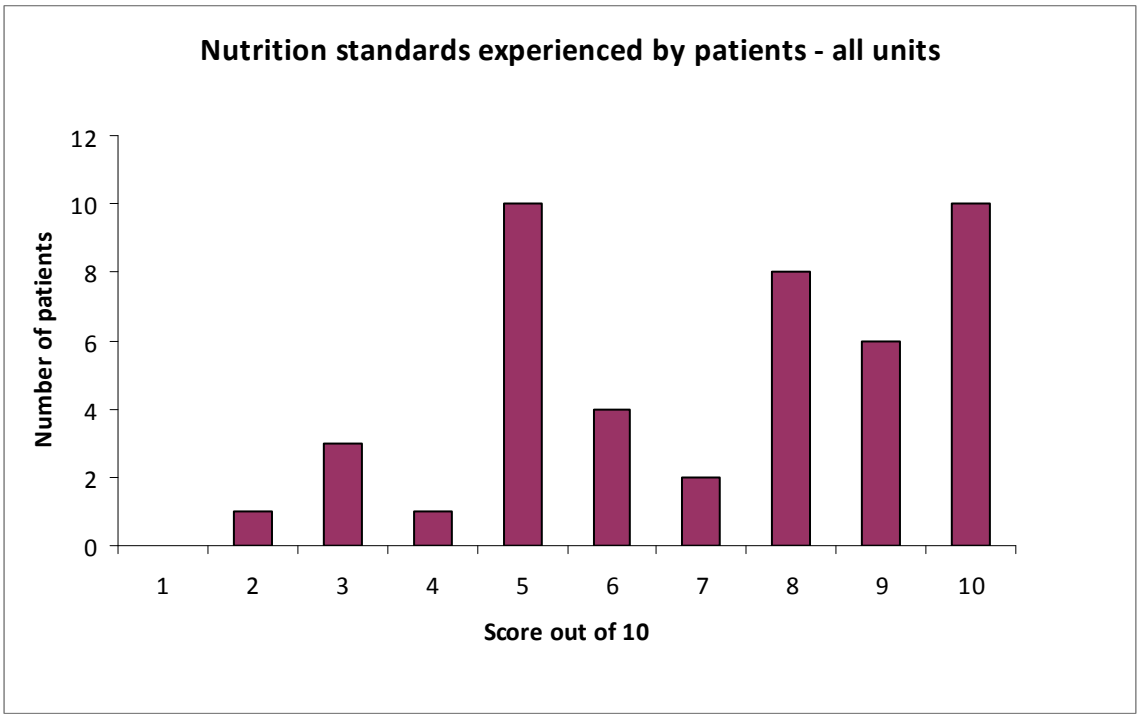
1) I was treated with respect and informed of the procedures involved throughout. (Elsewhere)

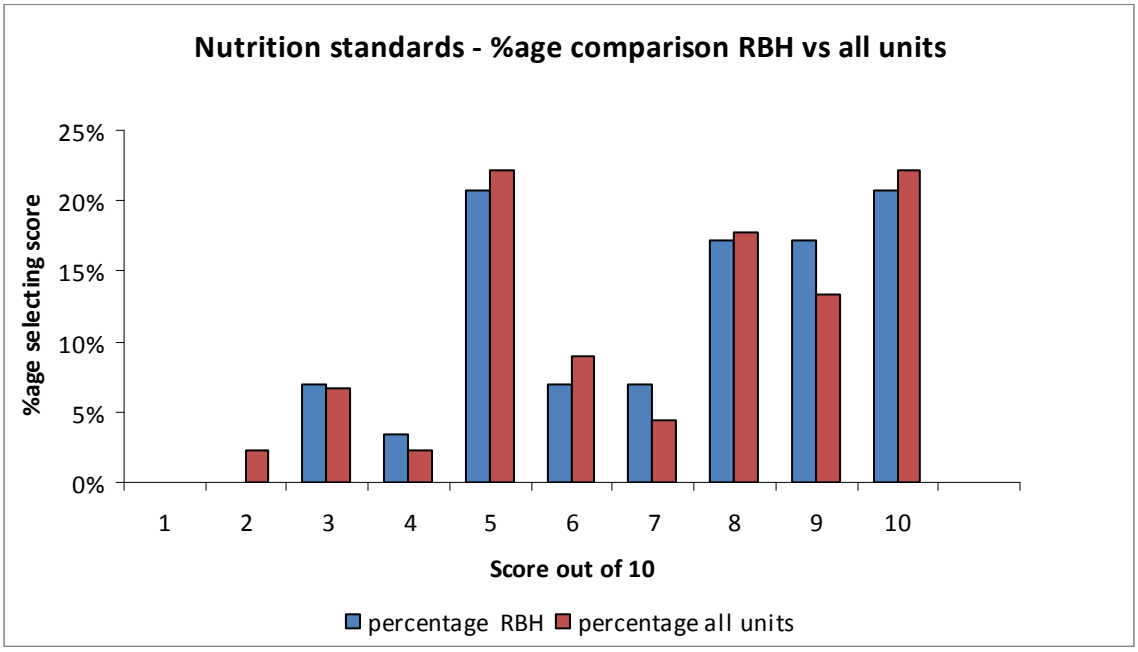
2) No real problems with dignity etc (Basingstoke)

3) Some doctors treat you as an object, refused to let me have tablets prescribed by my doctor. Had rows with nurses as doctor told that I had to have all tablets in the morning not like I have been doing some morning some night. (Swindon)

4) Acute assessment ward really needs a shake up or more staff (re Swindon)

Nutrition and hydration (all hospitals)





Comments specific to other units are as follows:-

1) When you got your meals they were warm or cold, and for us old people not what we are used to.

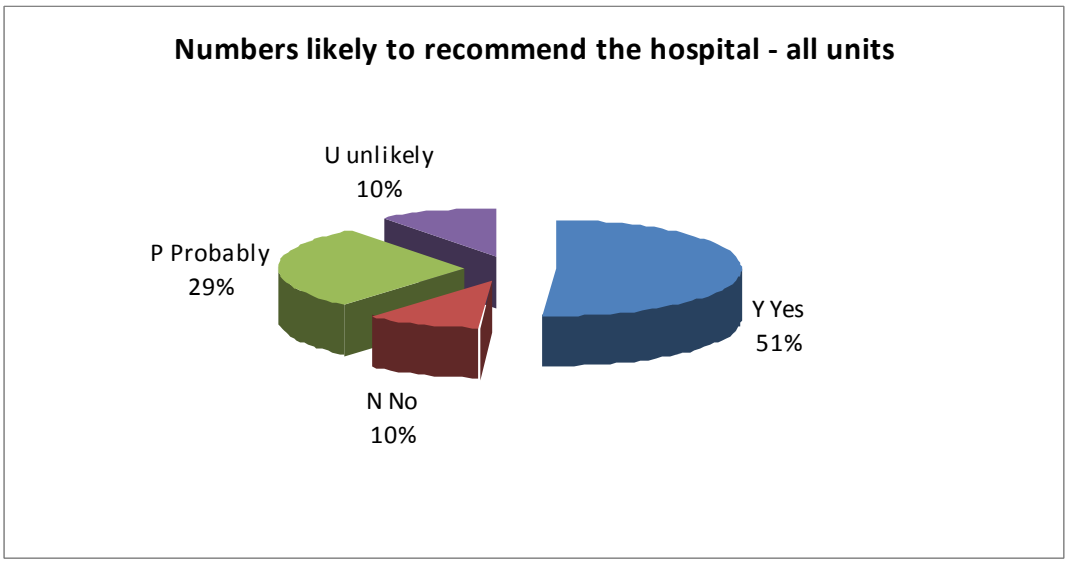
2) My mother was extremely unwell we had to ask for my mother to be prescribed drink supplements as her eating was so poor due to the food not being served that she could not eat.

(Both comments relate to Swindon)

Recommendation (all hospitals)

It will be noted that the proportion of people that would definitely or probably recommend the hospital that they had received treatment at has dropped from 57% and 28% (RBH only) to 51% and 29% respectively when looking at the full cohort of responses.

This would seem to indicate that peoples experiences of other local hospitals is worse than they experienced at the Royal Berks



Comments regarding recommendations from people who used hospitals other that the RBH include :-

1) Only that was the easiest hospital to get to, and parking was no problem. (Basingstoke)

2) First class treatment through out my two stays in North Hants Hospital. To be recommended. (Basingstoke)

Through to

3) Would rather be looked after at home, better care. Hospital food rubbish and cold breakfast cereal and leather toast every day. No proper breakfast. Have asked not be sent to Swindon to stay in hospital. (Swindon)

4) As my husband is suffering from dementia they completely ignored him. Shocking. Which meant me visiting him every day from Newbury.

5) We did make a complaint about the treatment, food and discharge of our mother who subsequently had to be admitted as an emergency to the Argyles nursing home.

6) The Trauma ward was not set up for patients who could not do the basic things for themselves. What was needed was help from a number of health care support workers (auxilliary staff where the cost should not be a problem). (Basingstoke)

7) Although junior doctors and consultants try hard after this the system falls down, maybe due to organisation or staff shortage or information, but there are problems for patients. (Swindon)

Adverse comments about nursing care and hygiene in non RBH units

1) Very poor at times not enough nurses. Patients seemed to be pushed to one side. Catheter not cleaned each day. (Swindon)

2) Couldn't care less (Other)

3) After 2 days my husband was in a room on his own, and I am sure that he did not get all the care and attention he needed. (Basingstoke)

4) My wife is doubly incontinent but her pad was only changed very infrequently resulting in a pressure sore which she had not had during all the time in palliative care at home. It took a day or two for a ripple mattress to be used. (Basingstoke)

5) Asked to be taken to the toilet several times, when carer arrived she had to take me, and not only on one occasion. Also physio could have been better. (Basingstoke)

6) During the weekend my daughter and I did all feeding and changing clothes etc. What the situation would have been if we had not done this I hate to think. (Basingstoke)

7) Poor night care when called for took ages, result was soiled bed linen which was then commented upon. (Swindon)

8) Medically P**** was taken care of but nursing quite poor. Bedding didn't look as clear as it should be (spilling of food). Being unable to open liquid food drinks that were imposible to open. P**** died after 3 weeks in Hospital. (Basingstoke)

9) Used plasters under bed. Didn't change mattress for new patient or disenfect it. (Other)

C**onclusions**

This was a relatively small sample that was not randomly selected. As such conclusions based on this sample should be regarded with some caution

Some of the evidence (25%) gathered related to episodes of care that took place more than 12 months prior to Sept 30 2011.

Bearing in mind those caveats, there is evidence that many people using the RBH are content with the standards of care that they experienced. However 15% of our sample would not recommend it to a friend which is a concern. It will be noted that this rises to 20% if the other hospital episodes are taken into account. The RBH, by way of contrast, report that their performance on recommendations has improved from 89% to 94% from 2010 to 2011 on the basis of their internal rolling monthly survey

It is recommended that this survey be expanded to a wider group of patients preferably by obtaining the direct cooperation of the Royal Berkshire Hospital in sending out similar questionnaire packs to a random sample of people aged 65 or over that have been discharged from any ward in the last 6 months.

West Berkshire LINk (HealthWatch)
Bridging Gaps In Health and Social Care Services

DIGNITY IN CARE - INPATIENTS AT ACUTE HOSPITALS

There have been a few reports reaching us from patients and carers about poor care experienced at local acute hospitals like the Royal Berks in Reading and similar units in Basingstoke, Swindon and Oxford. As a precaution we would like to ask you about any specific period of care that you or a close relative or friend have experienced as an in-patient in the year to Sept 30th 2011.

Before we start, we need to ask you about yourself so that we can analyse the responses properly.

Q1 Who?

In completing this questionnaire are you describing the experiences of

A) Yourself as a patient or
B) Those of a close friend or relative or
C) Someone else for whom you provide care services

Please insert A, B or C in the box ☐

Q2 Carer?

Are you a carer? **Please insert Y (yes) or N (No) in the box**. ☐

Q3 When?

Did the episode of care that you are describing take place during the 12 months to Sept 30 2011? **Please insert Y (yes) or N (No) in the box**. ☐

If not, when did it take place? ☐

Q4 Where?

At which acute hospital did this episode occur? **Please insert A,B,C,D or E in the box** ☐

A) Royal Berkshire - Reading, B) Basingstoke C) Swindon

D) John Radcliffe in Oxford E) Elsewhere

If E) then please specify ☐

Q5 Age?

What was the age of the patient ?

A 65 or less B 66 to 80 C 81 or over

Please insert A, B or C in the box ☐

Q6 Gender?

What was the gender of the patient? **Please insert M or F in the box** ☐

Q7 Home Location?

What are the first four characters of the patient's home postcode (e.g. RG17) ☐

Main Questionnaire

Please rate your experiences on a scale of 0 to 10 where 1 is Very Poor and 9 is Very Good. Scores of either 0 or 10 would be exceptionally good or bad and therefore unlikely but not impossible in practice.

Please try to answer all of the questions.

For the purposes of the questionnaire we use the term “you” to describe the patient whose experiences are being commented on whether it be yourself or your relative or friend.

Q8 Hospital administration

How would you rate the hospital administrative processes – admission, discharge, communications etc? Was it well organised and trouble free?

Please insert score (0 to 10) in the box

Comments

Q9 Support administration

Did the hospital ask if you were a carer and ensure that the person for whom you provide care was being looked after appropriately?

Please insert Y (yes) or N (No) in the box.

Q10 Nursing Care – Days

How would you rate the nursing care that you received during peak hours (7am to 7pm Monday to Friday) ? **Please insert score (0 to 10) in the box**

Comments

Q11 Nursing Care – Evenings and Weekends

How would you rate the nursing care that you received during the evening / night time and at weekends ? **Please insert score (0 to 10) in the box**

Comments

Q12 Dignity and Respect

Were you treated with respect as a person, when you were in hospital? How would you rate this?

Respect is about the staff at the hospital being polite, being thoughtful and caring, keeping you informed, meeting your needs and ensuring your privacy, etc. and not treating you as an object of service. Dignity is the result of being treated with respect. It is internal and often associated with a sense of worth, well-being, being valued and having a sense of purpose.

Please insert score (0 to 10) in the box

Comments

Q 13 Nutrition and hydration

Were you able to get the food and drinks you needed, when you were in hospital? How would you rate this?

Please insert score (0 to 10) in the box

Comments

Q14 Information

How would you rate the information that you received about your treatment from consultants and junior doctors?

Please insert score (0 to 10) in the box

Comments

Q15 Hygiene and hand washing

How would you rate the hygiene standards in the ward? Was it clean? Did staff wash their hands before physical contact?

Please insert score (0 to 10) in the box

Comments

Q16 Recommendation?

Would you be likely to recommend the hospital to a friend on the basis of your experiences?

Please insert Y (yes), P (probably), U (unlikely) or N (No) in the box

Comments

Please return to : West Berkshire LINk (HealthWatch), Broadway House, 4-8 the Broadway, Newbury, Berks, RG14 1BA

Title of Report:	**Health Scrutiny Panel Work Programme**
Report to be considered by:	Health Scrutiny Panel
Date of Meeting:	27 March 2012

Purpose of Report: **To consider and prioritise the work programme for the remainder of the municipal year 2011/12.**

Recommended Action: **To consider the current items and discuss any future areas for scrutiny.**

Health Scrutiny Panel Chairman	
Name & Telephone No.:	Councillor Quentin Webb – Tel (01635) 202646
E-mail Address:	qwebb@westberks.gov.uk

Contact Officer Details	
Name:	Kate Phipps
Job Title:	Policy Officer
Tel. No.:	01635 519695
E-mail Address:	kphipps@westberks.gov.uk

Executive Report

1. Introduction

1.1 Members are requested to consider the latest work programme attached at Appendix A. In addition, Members are asked to give consideration to future areas for scrutiny.

Appendices

Appendix A – Health Scrutiny Panel Work Programme

Consultees

Local Stakeholders:

Officers Consulted: Head of Adult Social Care, Head of Policy and Communication

Trade Union: N/A

HEALTH SCRUTINY PANEL WORK PROGRAMME 2011/12

Item 7 - Appendix A

Reference	Subject/purpose	Methodology	Expected outcome	Review Body	Dates	Lead Officer(s)/ Service Area	Portfolio Holder(s)	Status: In Progress Completed	Comments
OSMC/11/102	**Day Centres** To examine the provision of day centres across the District.	Task group review with information supplied by, and questioning of.		HSP	Start: TBD End: TBD	Jan Evans – 2736 Adult Social Care	Councillor Joe Mooney	To be scheduled	
OSMC/11/104	**Anti-Child Poverty Strategy**	To monitor the strategy	Monitoring item	HSP	Start: On-going End: March 2012	Julia Waldman – 2815 Children and Young People	Cllr Irene Neill	In Progress	Lead Officer on leave -request for update at next meeting- 19 June 2012
OSMC/11/105	**Dignity and Nutrition – Hospitals** To review the Care Quality Commission report on Dignity and Nutrition - Hospitals	To survey and hold focus groups detailing information		HSP	Start: July 2011 End: April 2012	Nigel Owen, West Berkshire LINk, Age UK	Cllr Joe Mooney	In Progress	Update report received.Circulated and to be presented at 27 March 2012 meeting.
OSMC/11/106	**Update on the Health and Wellbeing Board** To receive updates from the Health and Wellbeing Board	To update members on Health and Wellbeing Board	Monitoring item	HSP	Start: Mar 2012	Andy Dayl/June Graves	Cllr Joe Mooney	In Progress	Update report to be presented at next meeting- 19 June 2012
OSMC/11/107	**Update on the Health Service in West Berkshire**	To update members on the changes to Health Service in West Berkshire	Monitoring item	HSP	Ongoing	Bev Searle - Director Joint Partnerships and Commissioning	Cllr Joe Mooney	In Progress	
OSMC/11/119	**Continuing Healthcare (CHC)** To examine the operation of the NHS CHC scheme in the NHS Berkshire West area	In meeting review		HSP	Start: Jan 2012 End: April 2012	Jan Evans – 2736 Adult Social Care	Councillor Joe Mooney	In Progress	Update report received . Circulated and to be presented at 27 March 2012 meeting
OSMC/12/122	**Home Care** To understand and critically appraise the systems and process in place for the provision of Home Care	TBD		HSP	Start: TBD End: TBD	Jan Evans – 2736 Adult Social Care	Councillor Joe Mooney	To be scheduled	Item incoroprated at OSMC meeting of 2012-02-21

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