Healthier Reading Partnership

Wednesday 19 January 2011, 6.00pm, NHS Berkshire West Headquarters, 57-59 Bath Road, Reading, RG30 2BA

1. **Apologies**
2. **Declarations of Interest**
3. **Minutes** of last meeting (5 October 2010) (Page 1)
4. **Matters Arising**
5. **Changing Policy Landscape** (Page 11) (Bev Searle)
   (Policy Implementation schematic and timeline to be tabled)
6. **Practice-Based Commissioning Perspective – PBC Leads**
   (Dr George Boulos and Dr Elizabeth Johnston will attend and present)
7. **Health and Well-being Action Plan: Priority Areas of Focus** (Page 23) (Grant Thornton/Bev Searle)
8. **NICE Guidance** (Page 26) (Kim Wilkins)
   - Four Commonly Used Methods to Increase Physical Activity
9. **Out of Cycle Meeting – to agree date and focus** (Bev Searle)
   possible dates:
   - 15 March 2011 suggest 4.30-8.00pm?
   - 17 March 2011 ”
   - 30 March 2011 ”
   - 31 March 2011 ”
10. **Communications**
11. **Forward Plan** (Page 28)
12. **Any Other Business**
13. **Date of Scheduled Meeting:** 12 April 2011

If you have any queries about this agenda, please contact Nicky Simpson in Committee Services, Reading Borough Council
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HEALTHIER READING PARTNERSHIP BOARD MINUTES – 5 OCTOBER 2010

Present:

Bev Searle (Chair)	NHS Berkshire West
Councillor Benson	Reading Borough Council
Councillor Ralph	Reading Borough Council
Sarah Gee	Reading Borough Council
Anne Laing	Reading Voluntary Action
Melani Oliver	Reading Borough Council
Sam Otorepec	NHS Berkshire West
Nina Sethi	Reading LINk
Grant Thornton	Reading Borough Council
Chris Turner	Reading Citizens' Advice Bureau

Also in Attendance:

Debra Cole	Reading Borough Council
Janette Searle	Reading Borough Council
Nicky Simpson	Reading Borough Council

Apologies:

Councillor T Harris	Reading Borough Council
Councillor Luckett	Reading Borough Council
Councillor Orton	Reading Borough Council
Kim Wilkins	NHS Berkshire West

1. MINUTES

The Minutes of the meeting held on 8 July 2010 were confirmed as a correct record and signed by the Chair.

2. MATTERS ARISING

Further to Minute 3 (2) of the last meeting, Sam Otorepec reported that she had circulated information on the Choose Well national campaign.

Further to Minute 3 (3) of the last meeting, Sam Otorepec reported that the Sexual Health Team were investigating the situation with regard to HIV testing. She said that it was true that the one-hour "Quicktest" was not currently offered in Berkshire, but there had been discussions about the efficacy of the test, and it was possible that pilot funding around the Quicktest would be available later in the year, so the Public Health team was doing further research on this matter.

Further to Minute 3 (4) of the last meeting, Sam Otorepec reported that she had spoken to Nick Buchanan, Commissioning Manager for Mental Health, who had said that there had been an extensive public relations process around Talking Therapies in the previous year and that, due to the high numbers of referrals already received, no formal launch was currently planned, as staff were working at full capacity dealing with the existing referrals. The meeting noted that, whilst the programme was welcome, there had been a gap in this area for a long time, and it was important that the IAPT (Improving Access to Psychological Therapies) teams were not so swamped that those in need were missed. The meeting discussed the importance of

coordinating partnership working to provide psychological support to people with long term health problems, in order to free up the IAPT teams to better target their resources, such as Talking Therapies, and maximise their benefit. Areas for investigation were suggested such as using the Children's Action Teams for facilitation, more involvement of the voluntary sector, and also the importance of providing advice to people coming out of Talking Therapies about what support was then available. It was suggested that discussions be held with Judith Williams and Nick Buchanan and then a task and finish group be set up to look at opportunities and develop recommendations.

Further to Minute 7 of the last meeting, Councillor Ralph said that, although as a result of funding cuts the core objectives for the Directorate of Education and Children's Services (DECS) had had to be revised and reduced from thirteen to eight as he had reported, he had been assured by officers that those objectives not in the key eight had not been deleted and progress was still being made in those areas. The Children & Young People's Plan still remained the same, although this might need to be reviewed once the results of the forthcoming Spending Review were known.

Further to Minute 8 of the last meeting, regarding alcohol harm reduction, Bev Searle reported that she was chasing the outstanding information requested at the last meeting, and that the providers had been asked to secure two detox beds at Prospect Park Hospital.

Further to Minute 9 of the last meeting, Sam Otorepec said that she had circulated information on the existing Practice Based Commissioning (PBC) Consortia and that three PBC Leads had agreed to come to the January 2011 HRP meeting.

Further to Minute 10 (2) of the last meeting, Sam Otorepec reported that she was making contact with Sally Swift, Head of Communications at the Council, regarding liaising with the NHS Berkshire West Communications Team. Bev Searle reported that there was to be a national Self Care week on 8-14 November 2010, which could provide partners with opportunities to publicise what they were doing – the PCT were planning to use it to advertise Choose Well further.

AGREED:

(1) That the position be noted;

(2) That Sam Otorepec talk to Judith Williams and Nick Buchanan and then set up a task and finish group to look at opportunities and develop recommendations for coordinating partnership working to provide psychological support to people with long term health problems, in order to free up the IAPT teams to better target their resources;

(3) That Bev Searle chase the outstanding information on alcohol harm reduction requested at the last meeting;

(4) That partners consider using the national Self Care week on 8-14 November 2010 to publicise their activities.

3. CULTURAL PARTNERSHIP BOARD REPRESENTATIVE

Bev Searle, Director of Partnerships and Joint Commissioning, NHS Berkshire West, explained that, in August 2010, she had been invited to nominate a representative from the Healthier Reading Partnership to the Cultural Partnership Board for Reading, an initiative set up to unite stakeholders from across sectors to support the delivery of the ambitious aims of the Cultural Strategy for Reading.

Due to the timescales involved, with the first meeting of the Cultural Partnership Board due to be held on 13 September 2010, members of the Board had been consulted about the nomination by email and it had been agreed that Kim Wilkins, Locality Public Health Lead - Reading, NHS Berkshire West, would be the HRP Board's representative, subject to formal ratification at the HRP Board's next meeting.

Bev said that Kim unexpectedly had had to send her apologies for tonight's HRP Board meeting, but would provide some information on the Cultural Partnership Board for circulation and give an update at the next meeting.

AGREED:

(1) That Kim Wilkins be confirmed as the HRP Board's representative on the Cultural Partnership Board;

(2) That Kim Wilkins provide some information on the Cultural Partnership Board for circulation and give an update at the next meeting.

4. EQUITY & EXCELLENCE – LIBERATING THE NHS

Bev Searle, Director of Partnerships & Joint Commissioning, NHS Berkshire West, gave a presentation on the proposals for healthcare reform in the recent White Paper "Equity & Excellence – Liberating the NHS". Copies of the presentation slides had been circulated with the agenda.

Some of the key proposals in the White Paper and points highlighted in the presentation were:

- Putting patients first and extending patient choice over providers and treatment
- Replacing LINks with HealthWatch
- Reducing inequalities and improving health outcomes, focusing on outcomes rather than targets and using NICE (National Institute of Clinical Excellence) to inform commissioning
- Establishing an independent national NHS Commissioning Board by April 2011 to allocate resources and commission primary care, and appointment of National and Regional Directors of Commissioning and Provider
- All NHS Trusts to become Foundation Trusts by 2013 and to be given greater freedoms
- All GPs to be part of consortia and to be responsible for local commissioning (some consortia to be selected to be early adopters to help inform the shape of future systems)
- The abolition of Strategic Health Authorities in 2012 and Primary Care Trusts in 2013

- The creation of a new Public Health Service and the transfer of the responsibility and a ring-fenced budget for public health to local authorities, including the responsibility to lead on Joint Strategic Needs Assessments and local health improvement and prevention activity
- Monitor to become the economic regulator of providers and promote competition
- The Care Quality Commission to be the inspectorate for Health and Social Care

Bev gave details of some of the potential risks involved in the proposals and the processes being put in place to mitigate them. She said that NHS Berkshire West had not had budget cuts, but had flat costs and increasing demand, so needed to find around £60m savings over three years. She gave details of the existing and some possible future partnership structures, noting that partnership structures would need to be reviewed as it would become increasingly difficult for the PCT to keep doing things three times, once for each of the local authority areas covered. For example, there was some interest in having a common Health & Wellbeing Board across the three areas, but it was not yet clear if this would work.

Bev said that a further White Paper on Public Health was expected in December 2010. She said that, in Berkshire, relationships with the Practice Based Commissioners (PBCs) were good and they were working with the PCTs on plans for the transition to PBC. In Reading, there were currently four GP consortia, and this was likely to change to two consortia, but these were unlikely to be co-terminous with Local Authority boundaries as there was an area around Theale and Pangbourne which had historically been included in a Reading consortium. It was expected that the two GP consortia in the Berkshire West area likely to be nominated as early adopters would probably be in the Wokingham area, as the consortia there had been established for longer.

She also reported that Charles Waddicor had been appointed on secondment as the Regional Director of Commissioning at the Strategic Health Authority, and Helen McKenzie was acting up as Interim Chief Executive at NHS Berkshire West.

Bev said that work was ongoing with GPs in engaging them in clinical issues and in creating a development plan to prepare them for their commissioning role. The meeting noted that a need for increased education of GPs in their clinical role about various issues had also been identified in a number of separate strategies, eg alcohol harm reduction (referred to at the last meeting - Minute 8 refers), and there might be an opportunity to achieve joined-up multi-disciplinary training on such issues in the development of PBC.

Grant Thornton said that he would circulate a copy of a recent Local Government Information Unit briefing on the British Medical Association's response to the White Paper.

AGREED:

(1) That the position be noted;

(2) That Grant Thornton circulate a copy of the recent Local Government Information Unit briefing on the British Medical Association's response to the White Paper.

5. HEALTH & WELLBEING ACTION PLAN

Further to Minute 7 of the last meeting, Bev Searle, Director of Partnerships and Joint Commissioning, NHS Berkshire West, submitted the latest draft of the Reading Health & Wellbeing Action Plan.

It was suggested that the Priority 4 section of the plan regarding children and young people should be updated by adding in appropriate objectives from the results of the Children's Health Scrutiny (see Minute 11 below), and that the plan should be used to inform the Board's forward plan.

Nina Sethi reported that this would be her last meeting of the HRP Board, as she was stepping down from the LINk Board and her replacement would be elected in November 2010, but said that she was willing to continue to be involved in working on the BME part of the Priority 1 section of the plan on reducing health inequalities, and to be used as a resource by the Board as needed.

AGREED:

(1) That Sam Otorepec circulate by email the latest draft of the Reading Health & Wellbeing Action Plan to all members of the Board for comments;

(2) That the Management Group look at the recommendations from the Children's Health Scrutiny and add in appropriate objectives to the Action Plan;

(3) That the Management Group use the updated Action Plan to inform the forward plan for the HRP Board meetings;

(4) That Nina Sethi be thanked for her hard work for the Partnership and for her offer of continued availability to the Board for advice.

6. DRAFT SUSTAINABLE COMMUNITY STRATEGY

Grant Thornton, Head of Community Planning, submitted a report giving an update on the development by the Local Strategic Partnership (LSP) of the new Vision and Sustainable Community Strategy (SCS) for Reading, to be published by April 2011 when the current strategy expired, and seeking input from the HRP Board.

The report had appended the first draft of the new SCS (Appendix A), an outline of the proposed mechanisms for taking forward the fairly raw current draft to a version suitable for broader public consultation, including a request for initial feedback from thematic partnerships by 22 October 2010 on key areas and principles (Appendix B), and a draft list of key "levers for change" around which broader consultation could crystallise (Appendix C).

The report stated that the LSP Board would approve a draft for further consultation at its meeting on 3 November 2010 and wider public consultation would be carried out between 8 November and 17 December 2010, including the LSP Forum on 16 November 2010. The SCS would then need to go through sign-off processes in each of

the main stakeholder organisations in time for publication and implementation from April 2011.

It was reported that the latest draft of the Local Transport Plan for Reading (2011-2026) was also out for consultation and available on the LSP website.

AGREED:

(1) That any comments on the draft Sustainable Community Strategy be submitted to Grant Thornton, for consideration by the HRP Management Group and submission by the 22 October 2010 deadline;

(2) That it be noted that the LSP Board would approve a draft for further consultation at its meeting on 3 November 2010.

7. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Further to Minute 5 of the last meeting, Bev Searle, Director of Partnerships & Joint Commissioning, NHS Berkshire West, updated the Board on the development of the Joint Strategic Needs Assessment (JSNA).

She said that the JSNA chapters on Dementia, Diabetes, Chronic Obstructive Pulmonary Disease, Cardio Vascular Disease and Stroke were about to be uploaded to the Local Strategic Partnership (LSP) website for comments and feedback and for other groups such as the Older People's Partnership to consider them and check that they described their needs. Work was continuing on the chapters on Children & Young People and Mental Health & Wellbeing and on refreshing the current core data sets. Final details of the JSNA publication had yet to be decided.

AGREED: That the progress on the JSNA process to date be noted.

8. SOUTH READING SURVEY – VOLUNTARY & COMMUNITY SECTOR

Anne Laing, Partnership Development Manager, Reading Voluntary Action (RVA), submitted a table showing the results of a survey of Voluntary and Community Sector organisations working in South Reading which had recently been carried out.

She explained that the information had been gathered on the basis of sharing between agencies to support cross-sector working, initially in health, and it was hoped that this would be a useful tool for workers in the area and for the HRP and others to use the information to help fulfil their strategic targets.

The meeting discussed the survey, noting that it provided two useful strands of information – a directory giving information on services provided and a list of existing and potential partners to work with and from whom work might be commissioned in the future. The HRP would also need to consider how the work contained in the list could contribute to the HRP Action Plan.

It was noted that the information was useful but it would be important for it to be shared appropriately and kept up to date to retain its usefulness. It also needed to be reconfigured for each audience, and information on the capacity of the services listed would be helpful. It was noted that resource directories for adult and

children's social care had been developed and it was suggested that the Council needed to carry out a corporate review of information and advice services and develop different resource directories to capture information on services available, whilst ensuring that there was not duplication of effort.

It was noted that the information would also be useful for Councillors, particularly those involved in South Reading.

AGREED:

That the Management Group consider the two strands of information provided by the survey and come up with proposals for using, circulating and maintaining the information to make the best use of both strands.

9. PROGRESS REPORT ON DELIVERY OF "A BIG VOICE IN OUR LIVES" – THE READING LEARNING DISABILITY PARTNERSHIP'S STRATEGY 2009/14

Janette Searle, Partnership & Service Development Manager and Debra Cole, Learning Disability Partnership Manager, submitted a report giving an update on progress against the Reading Learning Disability Partnership's Strategy 2009/14.

The report explained that the Reading Learning Disability Partnership (LDP) was formally accountable to the Local Strategic Partnership via the Healthier Reading Partnership, with parallel reporting lines into the two commissioning bodies represented on the LDP, the Council and NHS Berkshire West.

The LDP had published its first strategy "A Big Voice in Our Lives" in June 2009 (an easy-read summary was attached at Appendix 1), which had localised the priorities identified in the national learning disability strategy "Valuing People Now". In March 2010, the LDP had published an annual report as required by the national Valuing People Team (an easy-read summary was attached at Appendix 2). The report supplemented the annual report by offering further commentary on progress in relation to the most significant local priorities for Reading, of housing, health, employment and transport.

It was reported that, although most of the Reading GP surgeries had now signed up for training for GPs and nurses on learning disability health checks, and at the time of the appointment of the Health Action Plan coordinator there had been an increase in the number of surgeries offering health checks, progress had subsequently stalled and the number of actual health checks completed was disappointing, with a wide variation in how proactive GP surgeries were in following up health checks. Bev Searle said that the development of learning disability health checks was on the Learning Disability Commissioning Group's Action Plan and so any problems in this area should be reported to the Group via Arthi Squires. The Clinical Executive Committee would be receiving a report on learning disability in November 2010.

It was queried whether all the people with learning disabilities who were parents had been identified to the Young Carer leads, in order to ensure that appropriate support was given to any children acting as carers.

AGREED:

(1) That the progress to date in delivering the Reading Learning Disability Partnership's Strategy 2009/14 be noted;

(2) That Debra Cole tell Sam Otorepec which GP practices were not following up on learning disability health checks so that Sam could liaise with Arthi Squires regarding taking this forward;

(3) That Janette Searle and Debra Cole check that all parents with learning disabilities had been reported to the Young Carer Leads.

10. NICE GUIDANCE

Further to Minute 6 of the last meeting, Bev Searle, Director of Partnerships and Joint Commissioning, NHS Berkshire West, submitted a response to the two sets of guidance from the National Institute of Clinical Excellence (NICE) in relation to School-Based Interventions to Prevent the Uptake of Smoking Among Children and Interventions in Schools to Prevent and Reduce Alcohol Use Among Children and Young People.

She also submitted two further sets of recently-published NICE guidance on Social and Emotional Wellbeing in Primary Education and Social and Emotional Wellbeing in Secondary Education.

It was noted that the Healthy Schools programme was not continuing and so meeting the requirements in the NICE guidance would become increasingly challenging, given the resource constraints the programme's removal would bring.

AGREED:

(1) That the response to the NICE guidance in relation to School-Based Interventions to Prevent the Uptake of Smoking Among Children and Interventions in Schools to Prevent and Reduce Alcohol Use Among Children and Young People be noted;

(2) That Kim Wilkins speak to Karen Reeve to identify an appropriate person to review the two sets of NICE Guidance on Social and Emotion Wellbeing in Primary and Secondary Schools and bring a response back to the Board.

11. SCRUTINY REVIEW OF CHILDREN'S HEALTH

Melani Oliver, Head of Extended Services, submitted a report setting out the recommendations that had been approved by Cabinet on 12 July 2010 (Minute 34 refers) from a Scrutiny Review of Children's Health.

A joint meeting of the Education and Children's Services and Housing, Health and Community Care Scrutiny Panels had been held on 14 October 2009 to consider the correlations between poverty and deprivation and children's learning and health. The scrutiny process had resulted in a set of recommendations which had been presented to Cabinet on 12 July 2010, along with a response to the recommendations compiled by officers from the Council and NHS Berkshire West. Cabinet had approved the recommendations from the scrutiny review, as amended by the suggestions in the

officer response. The report summarised the 17 recommendations approved by Cabinet and sought support of the HRP in actioning and taking these forward.

Melani reported that work was being carried out on all the recommendations, and that the Local Strategic Partnership (LSP) would be considering Children's Health issues at its next meeting. She asked the Board to consider which of the areas covered by the recommendations it particularly wished to focus on, where the HRP could "add value" using its strategic role.

It was noted that it had already been decided to update the objectives in Priority 4 of the Health & Wellbeing Action Plan by adding in appropriate objectives from the results of the Scrutiny Review (see Minute 5 above).

The meeting discussed the recommendations, noting that two key issues for HRP to focus on were areas of embedded health inequalities and how early health interventions could add value in children's early years to help to reduce the gap in educational performance across the Borough (whilst not replicating the work of the Children's Trust). It would also be important that the needs of the Black & Minority Ethnic (BME) population were considered in whatever was chosen to focus on.

AGREED:

(1) That the approved recommendations from the Scrutiny Review of Children's Health be noted;

(2) That it be noted that the LSP would be considering Children's Health issues at its next meeting;

(3) That the Management Group and Melani Oliver consider the recommendations and how they related to the Health and Wellbeing Strategy and Action Plan and identify specific strategic actions for the HRP to take forward, where it could provide "added value" without replicating the work of the Children's Trust.

12. FORWARD PLAN

The meeting considered the latest draft forward plan of items to be considered at future meetings of the Board. It was noted that the Management Group would be looking at the forward plan at its next meeting, in order to coordinate the agenda for the next Board meeting.

Bev Searle reported that Jackie Lonsdale would be reporting to the Board's next meeting on Re-ablement.

AGREED:

That the Management Group consider the Board's forward plan further, including adding an item on Re-ablement for the next meeting.

13. OTHER BUSINESS

a) World Mental Health Day

Sam Otorepec, Head of Partnerships, NHS Berkshire West, circulated information on activities to be held locally to celebrate World Mental Health Day on 10 October 2010, and said that she could provide an electronic copy if anyone needed it.

AGREED: That the position be noted.

b) Community Engagement Survey Analysis Summary Report

Nina Sethi, from Reading LINk Board, tabled copies of a summary report analysing a Community Engagement Survey on health and social care services that had been carried out by Reading LINk from February to July 2010. She explained that the results of the survey had not yet been shared with statutory partners, as the LINk Board had only received the report on 4 October 2010 and had also not yet produced its action plan from the report.

The report gave details of the survey and the responses received, and concluded that, whilst many individuals felt that their local health and social care needs were being met, the research suggested that mental health services, access to NHS Dental Services and being seen on time for hospital outpatient and GP appointments were priority issues which cut across different communities and affected individuals of all ages. Many residents would like to see improvements across social care provision, but particularly in respect of helping carers access the services and financial assistance to which they were entitled. Therefore, improved access to information using a range of different media, specifically for social service provision, but also in healthcare services for some elderly, disabled, special needs and non-English speaking communities, were also identified as a priority for action.

AGREED:

That the Management Group consider the report and how to address the issues raised.

14. DATE OF NEXT MEETING

AGREED: That the next scheduled meeting of the Healthier Reading Partnership be held on Wednesday 19 January 2011.

(The meeting started at 6.00pm and closed at 8.30pm)

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Policy Landscape briefing info for Healthier Reading Partnership (HRP) December 2010

Introduction

This paper provides a brief overview of the policy changes impacting on the NHS in order to inform the short term priorities of the HRP. The first section is taken from the Department of Health website, followed by a brief description of local implications and sources of further detail. Two factsheets have been included in the briefing pack, along with this paper to provide further detail about Health and Wellbeing Boards and GP Commissioning in particular.

1.0. Quick guide to health and care reform. (From Department of Health Website)

Why is it happening?

Much of the health and social care system is excellent but England falls behind many of its European neighbours on a number of key health measures, such as cancer survival rates. Out health and care system needs to deliver an improved service with better results for patients:

- there needs to be more focus on improving quality, as poor quality care costs more money – if hospital acquired infections are not tackled, or if there are no steps to prevent falls among older people, it can cost the NHS billions of pounds every year
- services need to be joined up more effectively – patients who need support from both health and care professionals too often find their needs aren't met, because health and social care professionals don't work together locally
- about half of all deaths in this country are preventable, so more needs to be done to encourage people to look after their own health by eating well and exercising more
- health costs are rising because of an ageing population and advances in medical technology so steps need to be taken now to cut waste and improve performance.

What does it mean for the patient?

'No decision about me without me' will be the principle behind the way in which patients are treated – patients will be able to make decisions with their GP about the type of treatment that is best for them. Patients will also have more control and choice over where they are treated and who they are treated by. They will be able to choose their:

GP
consultant
treatment
hospital or other local health service.

Patients will be able to get the information they need, such as how well a hospital carries out a particular treatment, to help them decide on the best type of care. If patients are unhappy with their local hospital, or other local services, they will be able

to choose another one to treat them. Patients will be able to rate hospitals and clinics according to the quality of care they receive, and hospitals will be required to be open about mistakes and always tell patients if something has gone wrong. Patients will have a strong collective voice through a national body, HealthWatch, and in their communities through arrangements led by local authorities.

What does it mean for the public?

The public will be able to have more influence over what kind of health services should be available locally. They will also have greater opportunities for holding to account local services that are not performing well. They will be able to get more information about how their local health services are performing, such as how well their local hospital carries out a particular operation or treatment. There will be more focus on preventing people from getting ill – the Public Health Service will pull together services locally to encourage people to keep fit and eat more healthily.

What does it mean for GPs and other primary care clinicians?

GPs will be responsible for designing local services for patients – they will decide, for example, what services are needed for patients with asthma or diabetes or how pre- and post-operative care can be best organised. Working with other local clinicians, GPs will take over from managers in Primary Care Trusts as the people who buy health services for patients. GPs will also be more directly accountable to patients, who will be able to choose any GP practice they like, regardless of where they live.

What does it mean for hospitals and other health service providers?

Providers of hospitals and other services will have greater freedom and fewer centrally set targets. They will be paid according to their performance and payment will reflect results – this will provide an incentive for greater quality. If they provide a good service that is popular with patients, they'll be able to grow and expand. Providers will also be able to make more money from different sources of revenue and reinvest it into NHS services.

What does it mean for local authorities?

Councils will have a much greater leadership role in local health services – they will be responsible for local health care priorities, joining up health and care services and ensuring they meet the needs of their local communities. They will work with GPs and others to define what local health priorities should be – whether that's reducing smoking rates, improving stroke care or maternity services. They will also have a much more clearly defined role in leading the development of public health services in their area.

How will the new health and care system be run?

Local authorities will be responsible for local health care priorities, while central government will have much less control over health services.

The NHS will be measured by how successfully it treats patients – for example, whether it improves cancer survival rates, enables more people to live independently after having a stroke or reduces hospital acquired infection rates. An independent and accountable NHS Commissioning Board will be established to:

lead on the achievement of health results
allocate and account for NHS resources
lead on improvements in quality
promote patient involvement and choice.

The Board will also have a duty to promote equality and tackle inequalities in access to healthcare. Monitor will become an economic regulator to promote effective and efficient providers of health and care, encourage competition, regulate prices and safeguard the continuity of services. The role of the Care Quality Commission will be strengthened as an effective quality inspectorate covering both health and social care. HealthWatch will represent the views of patients, carers and local communities.

2.0. Health and Social Care Bill

The Bill is anticipated in January 2011, and will provide further detail regarding the current statutory functions of PCTs – some of these will be stopped altogether, with others being transferred to either the NHS Commissioning Board, GP Commissioning Consortia or Local Authorities.

3.0. Policy Changes - Local Implications

3.1. GP Commissioning

There are currently 4 GP Commissioning Consortia in the area served by Berkshire West Primary Care Trust: 2 in the Reading Borough Council area (with some overlap into the West Berkshire Council area) 1 in West Berks and 1 in Wokingham. GP Commissioning leads already work in a collaborative way, with work streams and projects in place across the whole area, while maintaining a strong focus on their own locality.
Discussions are currently underway about the nature of the commissioning support arrangements required by the consortia.

3.2. Public Health

Responsibility for Public Health will be transferring from PCTs to Local Authorities, with Directors of Public Health being joint appointments between Local Authorities and “Public Health England” a new body to be established in shadow form in 2011. A ring fenced budget will transfer in 2013, following shadow arrangements in the previous year.
Discussions are in progress between Berkshire Unitary Authorities, the Regional Director of Public Health and the 2 Directors of Public Health for Berkshire West and East PCTs about locally appropriate arrangements.

3.3. Health and Wellbeing Boards

These will be established by 2013 to achieve effective strategic commissioning across NHS, Social Care, and related children’s and public health services.

Discussions are underway about the most appropriate approach locally – in order to achieve an effective balance between locally focussed activities within a single Council area, with local accountability and governance, as well as a strategic approach across the Berkshire West area. In order to achieve an effective functioning system, there is a requirement to establish shadow arrangements at the earliest opportunity.
Health and Wellbeing Boards will be required to develop a joint health and wellbeing strategy that spans the NHS, social care, public health and potentially other wider health determinants such as housing.

3.4. HealthWatch

The NHS White Paper proposed that HealthWatch becomes the national champion for health and social care consumers. At a national level, it is expected that HealthWatch England would aim to be a strong, independent body that can represent the views of patients and communities as the independent consumer arm of the Care Quality Commission (CQC).
To strengthen the voice of communities, it is proposed that Local Involvement Networks (LINks) would evolve to become local HealthWatch organisations.Local organisations would be able to feed information into HealthWatch England, as well as local Health Scrutiny and the Health and Wellbeing Board
Local arrangements are yet to be confirmed, but it is expected that the Local Authorities will take a lead in this, in partnership with existing groups.

3.5. PCT Clusters

In order to maintain the capacity required to enact the continuing statutory duties of PCTs prior to their closure in 2013, while at the same time, supporting the development of effective GP Commissioning consortia, PCTs will form into clusters by June 2011.
Locally, Berkshire East and Berkshire West will form a cluster, with Milton Keynes, Oxfordshire and Buckinghamshire forming another, and Southampton, Hampshire, Isle of Wight and Portsmouth the final cluster in the South Central Strategic Health Authority area.

4.0. Papers for Further Details of Policy Changes

The following documents are all available from the Department of Health website.

Liberating the NHS:
Legislative Framework and Next Steps.
Published 14.12.10

Healthy Lives, Healthy People: Our strategy for public health in England.
Published 30.11.10

Healthy Lives, Healthy People:
Consultation on the funding and commissioning routes for public health.
Published 21.12.10

The Operating Framework for the NHS in England 2011/12.
Published 15.12.10

Achieving equity and excellence for children:
How liberating the NHS will help us meet the needs of children and young people.

Published 16.09.10

The NHS Outcomes Framework 2011/12.
Published 20.12.10

Bev Searle, Director of Partnerships and Joint Commissioning. NHS Berkshire West.

LOCAL DEMOCRATIC LEGITIMACY: FACTSHEET
Gateway reference: 15320

1. Introduction

The NHS and Public Health white papers together provide local authorities with an enhanced role in supporting the delivery of health and social care services.

Local authorities will take on the major responsibility of improving the health and life-chances of the local populations they serve, and will lead others to work together to improve health and wellbeing.

Local authorities will lead on public health, using a new ring-fenced budget and health premium, which will reward areas who make the most progress. Directors of Public Health will move from the NHS to local authorities.

2. Mutually respecting partners

Better health and wellbeing will only come from the NHS and local authorities working together, with high quality local leadership and relationships being an essential foundation for achieving better health and wellbeing outcomes.

3. Statutory health and wellbeing boards

There is a need to improve the strategic coordination of commissioning services across NHS, social care, related childrens and public health services. To support this, the Health and Social Care Bill will require the establishment of a health and wellbeing board in every upper tier local authority by April 2013.

Health and wellbeing boards will bring together elected representative and the key NHS, public health, social leaders and patient representatives to work in partnership. This will ensure services are joined up around the needs of people using them, and that resources are invested in the best way to improve outcomes for local communities.

4. Flexible geographical scope

The Health and Social Care Bill will give flexibility for health and wellbeing boards to choose to do their work at whatever level “makes sense locally”. This means they might choose to work together to set up a board covering more than one local authority area, or to carry out some of their work more locally, focussing on the needs of a specific district or neighbourhood.

5. Core membership

To achieve the most effective integration and joint action, core members of the board must include GP consortia, the director of adult social services, the director of children’s services, the director of public health and a representative from local HealthWatch. To increase local democratic legitimacy and to represent the interests of the public the Bill prescribes there must be a minimum of at least one local elected representative.

Local authorities can decide to invite and include other members, for example other groups or stakeholders who can bring in particular skills or perspectives, such as the voluntary sector, clinicians or providers.

By making the boards statutory and specifying a core membership health and wellbeing boards provide the forum for public accountability.

The role of the boards will be to improve joint working and commissioning and increase local democratic engagement with the commissioning of services, alongside patient engagement through local HealthWatch.

6. Enhanced joint strategic needs assessment

The core purpose of health and wellbeing boards is to join-up commissioning across NHS, social care, public health, children's services and other services that the board agrees have an impact on the wider determinants of health – for example leisure or housing.

The aim is to achieve better health and wellbeing outcomes for their whole population and a better quality of care for patients and other people using services.

Through new health and wellbeing boards, local government will lead in bringing together the NHS, social care, public health and children's services to understand local needs through a joint strategic needs assessment (JSNA) and to create a joint health and wellbeing strategy (JHWS) to address them. Local authorities and GP consortia will have an equal responsibility to develop the strategy.

The Bill will place a legal obligation on NHS and local authority commissioners to refer to the JSNA in exercising their commissioning functions.

7. The new joint health and wellbeing strategy

The ambition is for health and wellbeing boards to go further than analysis of common problems to deep and productive partnerships that develop solutions to challenges (rather than just commentating on them).

To support this ambition the Bill specifies boards should develop a joint health and wellbeing strategy that spans the NHS, social care, public health and potentially other wider health determinants such as housing. Through the strategy, the council, NHS and other partners will agree, at a high level, how they will address the health and wellbeing needs of their community, giving the overarching framework for developing plans for the NHS, social care, public health and other relevant services.

The Bill will place a legal obligation on NHS and local authority commissioners to have regard to the JHWS in exercising their commissioning functions.

This new way of working is not about one partner on the health and wellbeing board having the power to overrule others' decisions – it's about fundamentally changing the dynamic to one of collaborative leadership. The work of the health and wellbeing boards is about influencing, shaping and driving services.

8. Increased joint commissioning and pooled budgets

Health and wellbeing boards will be able to look at the totality of resources available to support local people's health and wellbeing, across the budgets the NHS, council and other partners hold. The Health and Social Care Bill and health and wellbeing boards are intended to encourage local authorities and their NHS partners to make more use of the flexibilities already available to them – such as pooling budgets or having lead commissioning arrangements – when drawing up the joint health and wellbeing strategy.

Health and wellbeing boards will be expected to consider how the mechanisms for integration already included in the NHS Act, such as pooled budgets or lead commissioning arrangements, could be used to provide more integrated commissioning across health and social care.

9. Health and wellbeing boards as an open-ended vehicle
Local authorities will have freedom to delegate additional functions to the health and wellbeing board. For example, housing or other wider determinants of health could be considered by the board, with the aim of providing better (and more integrated) services to communities

GP consortia will be able to develop voluntary arrangements with a local authority to deliver services on their behalf. For example, local authorities, with their commissioning expertise may be well placed to support GPs in developing new arrangements.

10. Referral and enhanced security
The Department of Health listened to feedback about the importance of having independent scrutiny functions and reconsidered its proposals. We are therefore persuaded that health and wellbeing boards will not have a health scrutiny function.

Rather than placing a duty on the health and wellbeing board, the Bill will place the powers for health overview and scrutiny with the local authority itself. Local authorities can then choose how to exercise these functions, whether through current Health Overview and Scrutiny Committees or alternative arrangements.

11. Implementation framework
Subject to Parliamentary approval, health and wellbeing boards will become a statuary committee of local authorities at the same time GP consortia taken on responsibility for the NHS budget.

Although boards will only formally assume powers and duties in April 2013, the new partnership arrangements are critical to developing the new system for health and care, and need to be hardwired into it from the start. That means developing them alongside other parts of the system like GP consortia, starting now.

Legislating for change is not the same as making it happen. The benefits for local communities cannot be achieved without developing the right local relationships and leadership.

Leaders in local authorities, emerging GP consortia and PCTs need to work together now to consider and establish the right local arrangements.

In the first phase, a network of early implementers – areas who want to start work on new arrangements now – will be supported by DH to share experience and expertise. The outputs of this work will be shared with other councils and GP consortia. We will be writing to all local authorities in January, inviting them to engage in this network.

The second phase of implementation will be the establishment of “shadow” health and wellbeing boards in every upper-tier authority by the end of 2011, with shadow running during 2011/12.

The final phase will be in April 2013 onwards, when statutory duties and powers will take full effect – this will be supported by enhanced scrutiny powers for local authorities

To be successful, it is important that all key partners in a local area take this work forward together, recognising that not everybody is starting from the same point, and that some GP consortia or councils will already be further on with their plans than each other. Partners will need to build learning and share skills together as they go, investing time, effort and commitment in building relationships.

Date issued: 16 December 2010

COMMISSIONING FOR PATIENTS: FACT SHEET

Gateway reference: 15318

1. Introduction

The Government's ambition is for an NHS that puts patients first and continually improves the quality and outcomes of care for everyone. This improvement will come from devolving power to professionals, patients and carers.

By April 2013, there will be a comprehensive system of GP commissioning consortia, supported by and accountable to a new independent NHS Commissioning Board.

2. The principle of GP commissioning

Key decisions affecting patient care should be made by healthcare professionals in partnership with patients and the wider public, rather than by managerial organisations.

GP commissioning builds on the key role that GP practices already play in coordinating patient care and acting as advocates for patients. It gives groups of GP practices financial accountability for the consequences of their decisions.

3. Granting GP consortia statutory powers and duties

The purpose of consortia being statutory bodies is to ensure that they have a separate identity from that of their member practices.

Being a statutory body means that consortia can have clear powers and duties. This will not affect the status of GPs and GP practices as providers of primary care.

The legislative framework will be designed to make sure that consortia are able to focus on improving quality of care within the resources available to them.

4. Composition of GP consortia

All holders of primary medical contracts will have a duty to be a member of a consortium for each contract they hold, i.e. for each GP practice.

Individual GPs or GP practices will not have to take commissioning and financial decisions on their own. The majority of GPs will continue focusing on providing primary care.

Membership of consortia will be flexible, with consortia able to expand, contract, dissolve or merge.

The precise size of a consortium is less important than the ability to scale up or scale down depending on the nature of the activity being undertaken.

The NHS Commissioning Board will need to be satisfied that prospective consortia, when applying to be established, have made appropriate arrangements to ensure that they can discharge their functions.

5. Robust governance arrangements

Commissioning decisions will need to reflect the healthcare needs of the practice's registered patients together with the needs of unregistered patients for whom the consortium is responsible.

All consortia should have an Accountable Officer who need not be a GP or clinician. However, strong clinical leadership is a critical component of successful commissioning, and clinical experience will be essential in understanding how best to improve quality and outcomes.

The consortium's Accountable Officer will be responsible for ensuring that a consortium promotes continuous improvements in the quality of services it commissions, complies with its financial duties, and provides good value for money.

All consortia will be required to have a published constitution.

Consortia will be required to make remuneration arrangements and commissioning plans public, to hold an open annual general meeting, and to publish an annual report showing the results of patient and public consultations.

6. Partnership working and public involvement

There will be increasing focus given to partnership working and the importance of multi-professional involvement in commissioning.

The NHS Commissioning Board will hold consortia to account for financial performance and outcomes, but there will also be a stronger role for local authorities in helping shape commissioning priorities, and in promoting a joint approach to improving the health and wellbeing of local communities.

There is a commitment to greater patient and public involvement within emerging GP consortia. The Health and Social Care Bill will place a duty on GP consortia and the NHS Commissioning Board to ensure that people who may receive a service are involved in its planning and development. Local Healthwatch will strengthen the patient's voice, and the enhanced role of local authorities will increase the democratic legitimacy of NHS commissioning decisions.

7. The NHS Commissioning Board

The NHS Commissioning Board will be established in shadow form as a Special Health Authority in April 2011, and as a full non-departmental public body from April 2012.

The Board will be responsible for establishing GP consortia, and in doing so will ensure that there is a comprehensive system of consortia across England. The Board will hold consortia to account, but will only have the power to intervene where there is evidence that consortia are failing or are likely to fail to fulfil their functions.

The NHS Commissioning Board will have a vital role in providing national leadership for driving up the quality of care, including safety, effectiveness and patients' experience, and promoting choice and patient and public involvement.

The Board will need to be able to demonstrate good clinical evidence in support of its decisions, maintain effective relationships with professional bodies, and have strong internal professional leadership.

The Board will publish a business plan setting out how it intends to achieve its statutory duties, and the objectives or requirements that have been set for it by the Secretary of State. It will also publish an annual report setting out progress against both its duties and objectives and requirements.

8. Clear accountability

GP consortia will have a stronger focus on improving the quality and outcomes of care for patients. They will be under a statutory obligation to seek to reduce inequalities in access to healthcare.

The NHS Commissioning Board will draw on the national outcome goals in the Outcomes Framework to develop a Commissioning Outcomes Framework, to help hold consortia to account for promoting improvements in quality.

GP consortia will also be required to ensure that their expenditure does not exceed the commissioning budget allocated to them. There will be a clear line of financial accountability from consortia to the NHS Commissioning Board and in turn to the Secretary of State. The Board will have the powers to intervene where there is a significant risk of financial failure.

There is a need to ensure a fair approach to handling current deficits and surpluses. The expectation is that any debt will be fully resolved by the end of 2012/13. Further detail is included in the NHS Operating Framework for 2011/12.

9. Commissioning primary care

The NHS Commissioning Board will commission primary medical care services, but we are planning an explicit duty for all GP consortia to support the Board to improve the quality of these services.

The NHS Commissioning Board will be able to ask GP consortia to carry out some commissioning functions in relation to primary medical care on its behalf. This will mean that consortia have a core role in improving patient care across the system.

The NHS Commissioning Board will retain formal responsibility for ensuring that a practice is meeting its core contractual duties. The Care Quality Commission will be responsible for ensuring that GP practices are meeting standards of safety and quality.

10. Commissioning specialised and complex services

The NHS Commissioning Board will commission national and regional specialised services, drawing on engagement with GP consortia. The specialised services portfolio will be kept under regular review. There will be a criteria-based approach to deciding which services are 'specialised'.

The NHS Commissioning Board will have responsibility for health services for those in prison or custody, high security psychiatric services and the current PCT duties in relation to healthcare for the armed forces and their families.

GP consortia are likely to work collaboratively with each other on particular aspects of commissioning, such as commissioning low volume services. The NHS Commissioning Board will also be able to commission some services on behalf of consortia, where this is agreed by both parties.

Responsibility for commissioning maternity services will lie with GP consortia, but with a strong role for the Board in promoting quality improvement.

11. Autonomy for the NHS with national leadership

The functions of the NHS Commissioning Board will be defined in primary legislation, rather than being at the discretion of the Secretary of State through legal delegation.

Instead, the Secretary of State will set a mandate for the Board, which will include the totality of the Government's requirements and expectations for the NHS over a three year period, updated annually.

Each year the Secretary of State will be obliged to undertake a formal public consultation on the priorities within the mandate for the NHS Commissioning Board.

In the event of emergencies, it is vital for the Government to be able to act decisively. The Board will be under a duty to ensure NHS preparedness and resilience by assuring that clear arrangements are in place.

12. GP pathfinders and managing the transition to consortia

Consortia pathfinders will test out design concepts for GP commissioning and explore how emerging consortia will best be able to undertake their future functions.

Pathfinders and other emerging consortia will work closely with PCTs to deliver the QIPP agenda.

The NHS Commissioning Board will start to establish consortia from April 2012. Once established as statutory bodies, consortia will be able to take on staff from PCTs.

In the autumn of 2012, consortia will receive notification of the budgets for which they will be statutorily accountable in their own right from April 2013 onwards.

15. Conclusion

Our proposals for GP commissioning and the NHS Commissioning Board are intended to transform the quality of care and health outcomes for patients. Day-to-day decision making will be more sensitive and responsive to their needs and wishes.

A clear framework established and developed by the NHS Commissioning Board will promote quality, choice, patient and public involvement, and effective stewardship of public resources.

The plans are intended to unlock the benefits of GP-led commissioning, focussing on achieving a step-change in the quality of patient care, delivering better value for the taxpayer and improving the health of local communities.

Date issued: 16 December 2010

TO:	**HEALTHIER READING PARTNERSHIP BOARD**		
DATE:	**19TH JANUARY 2011**	**AGENDA ITEM:**	**7**
TITLE:	**(DRAFT) SUSTAINABLE COMMUNITY STRATEGY AND THE HEALTH & WELL-BEING ACTION PLAN**		
LEAD OFFICER:	**GRANT THORNTON**	**TEL:**	**0118 937 2416**
JOB TITLE:	**HEAD OF COMMUNITY PLANNING**	**E-MAIL:**	**grant.thornton@reading.gov.uk**

1. EXECUTIVE SUMMARY

1.1 This report summarises the key elements of the draft Sustainable Community Strategy (SCS), including the priorities for delivery that are emerging through public consultation, and those of the current Health & Well-being Action Plan. The Partnership Board is asked to consider how the Health and Well-being Strategy should be taken forward in the context of the SCS and changing legislative and organisational landscape.

2. RECOMMENDED ACTION

2.1 That the Board reviews the priorities in the current Health & Well-being Action Plan in the context of the emerging SCS.

2.2 That the Board considers re-focusing the Action Plan around a smaller number of interim key priorities.

2.3 That the Board tasks the Management Group to reframe the Action Plan in the context of the SCS to inform further discussion at the proposed out of cycle meeting.

3. DRAFT SCS

3.1 The draft SCS links the Reading of today with the agreed vision for Reading in the future organised across the key themes of People, Place and Prosperity. It is not a detailed delivery plan but provides a strategic context and overarching priorities for all of the delivery plans to be developed by the family of partnerships and organisations under the auspices of the Local Strategic Partnership (LSP).

3.2 Although all of the SCS themes have some relevance to health issues the primary focus of addressing health needs of the population fall

within the People chapter. The key identified areas of focus in the SCS are: to reduce inequality; create more capable communities; and positively embrace diversity. Key priorities for addressing these challenges are as follows:

a. Reducing Inequality

- Further development and delivery of the Thriving Neighbourhoods Programme to improve outcomes in our poorest neighbourhoods and reduce the inequality gap.
- Development and delivery of an anti-poverty strategy to focus on significantly reducing child poverty. A concerted and co-ordinated effort by all sectors and agencies to address the consequences and causes of poverty. Ultimately breaking the cycle of deprivation.
- Re-focus resources on preventative and early interventions that improve outcomes and reduce downstream costs, e.g. through tackling unhealthy lifestyles. Using evidence of risk factors to identify those at risk and intervening earlier to prevent more crisis interventions, be this in relation to educational outcomes for young people, preventing re-offending, reducing hospital admissions for the elderly, improving mental health.
- Recognise and value the importance of work for people with fewer skills so that they feel an equal part of society.

b. Capable Communities

- Increasing personalisation of services so that service users have greater choice and control over the services they receive and greater influence over what and how they are provided.
- Development and delivery of more holistic family support services designed around the needs of whole families irrespective of agency or provider.
- Further developing models of co-production where individuals, families and communities as a whole have greater and more direct influence and control over services that are provided.
- Developing the capacity for individuals, families and communities to take greater responsibility for their own lives and for others. Professionals as facilitators to encourage self-reliance, volunteering, peer support networks and mutual support.

c. Embracing Diversity

- Improving shared understanding of the changing nature of the population and developing appropriately responsive services that address age- specific, cultural or ethnic barriers.
- Continue to invest in and develop cultural activities that embrace and celebrate Reading's diversity whilst challenging all forms of discrimination.
- Celebrate and build on the contribution to society that all young people bring to Reading. The most diverse section of the population is our future generation that can embed tolerance, integration and cohesion.

3.3 In addition to establishing these priorities the LSP is seeking to identify a limited number of key drivers for change or building blocks that will help catalyse progress. These have been widely consulted on with the top 3 areas identified as:

- Breaking the cycle of poverty;
- Capable Communities;
- Skills for all.

These potentially have implications on the Health & Well-being Action Plan's priorities both in terms of what and how issues are addressed.

4. Health and Well-being Action Plan

4.1 The current Action Plan is organised across 4 high level priorities:

- Reduce health Inequalities;
- Achieve more people living healthier lives and preventing more ill-health;
- Enable more older people & people with long-term conditions to live at home;
- Give children & young people the best start in life through improving their own & their families' well-being.

There are a range of detailed action areas linked to each priority with an attempt to focus on practical actions that add value, e.g. maximising the benefits of the talking therapies programme. In reality there has as yet been limited opportunity or capacity to drive strands of activity and performance measurement is weakly defined. In no small part this is attributable to the scale of change impacting on the health / public sector in relation to legislation, organisational responses and budget pressures.

PUBLIC HEALTH NICE GUIDANCE IMPLEMENTATION FORM

Title of Guidance	**Four commonly used methods to increase physical activity**
Type of Guidance	**Public Health Intervention Guidance**
Date of Guidance	**March 2006**
Ref No	

Relevant Service Areas	*NHS Commissioners, Local authority Leisure Services, Transport policy, Childrens Trust, parks and Open spaces*
Form completed by	*Jeremy Speed*
Date initially completed	04/01/2011
Date last updated	

Summary of Key Points

Local policy makers, commissioners and managers, together with primary care practitioners, should monitor the effectiveness of local strategies and systems to promote physical activity. Practitioners, policy makers and commissioners should endorse exercise referral schemes to promote physical activity that are designed to measure outcomes such as knowledge, attitudes and skills, as well as measures of physical activity levels.

Relevance to PCT

Primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on 5 days of the week (or more) . They should use their judgement to determine when this would be inappropriate (for example, because of medical conditions or personal circumstances). They should use a validated tool, such as the general practitioner physical activity questionnaire (GPPAQ), to identify inactive individuals.

Relevance to Partners

The guidance is aimed at professionals working in the NHS, local authorities and the voluntary sector who have either a direct or indirect role and/or responsibility for physical activity or health improvement more generally. Within the NHS, this includes: directors of public health, public health advisers, commissioners of services, general practitioners (GPs), other primary healthcare professionals. In local authorities it includes: those working in Healthy Living Centres, leisure service managers, walking and cycling officers, exercise and leisure professionals and community development workers. In the voluntary sector it includes: those developing and delivering walking or cycling schemes or pedometer loan schemes.

PUBLIC HEALTH NICE GUIDANCE IMPLEMENTATION FORM

Summary of Key Points
Actions Required
Consider commissioning appropriately designed Exercise Referral Schemes. Support the promotion of Walking and cycling schemes through Transport, open spaces and schools initiatives.
Recommendations
Local policy makers, commissioners and managers, together with primary care practitioners, should pay particular attention to the cultural needs of hard to reach and disadvantaged communities, including minority ethnic groups, when developing service infrastructures to promote physical activity. PHIAC determined that there was insufficient evidence to recommend the use of pedometers and walking and cycling schemes to promote physical activity other than as part of research studies where their effectiveness can be evaluated. However, professionals should continue to promote walking and cycling (along with other forms of physical activity) as a means of incorporating regular physical activity into people's daily lives. Overall, brief interventions in primary care were found to be cost effective.

Healthier Reading Partnership -Forward Plan

updated 11.1.11

unallocated items

- Mental Health (agreed 8.7.10)
- ?Dementia (Kim Wikins) (deferred 5.10.10)

Standing items for each meeting as follows:

- Health and Well-being Action Plan – progress/update (Bev Searle/Sam Otorepec)
- NICE Guidance (Kim Wilkins)
- JSNA Update (Bev Searle)
- Communications (to include consultation activity)

(Suspended items originally down for 19 January:

- Re-ablement (Jackie Lonsdale)(agreed 5.10.10)
- BME community health needs overview
- Sustainable Community Strategy (Grant Thornton)
- Older People's Partnership
- Anti-poverty
- Draft Joint Commissioning Strategy for Physical Disabilities, Long-term Conditions and Sensory Needs
- Healthy lifestyles

12th April 2011 (final report deadline 4 April)

- LINK Annual review and work programme (Sheila Booth)
- Thriving Neighbourhoods Programme – Annual Report
- Children's Trust
- Think Family – presentation on work in South Reading (Melani Oliver)
- Independent living
- response to NICE guidance on social & emotional wellbeing in primary & secondary schools (Kim Wilkins) (from 5.10.10 mtg)

N.B. 2 out of cycle meetings to be arranged as follows:

- ~~November – review priorities in context of budget and policy changes (links into health component of delivering new SCS) (cancelled due to current changing health climate)~~

- Feb/March – to review and roll forward Health and Well-being Strategy and develop work programme linked to budgets and priorities for 11/12.