Bracknell Forest Council

NOTICE OF MEETING

Health Overview and Scrutiny Panel
Thursday 14 June 2012, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

To: The Health Overview and Scrutiny Panel

Councillor Mrs Angell, Baily, Finch, Kensall, Mrs McCracken, Mrs Temperton, Thompson, Virgo and Ms Wilson

cc: Substitute Members of the Panel

Councillors Allen, Brossard, Ms Brown, Davison and Heydon

Co-opted Representatives

Terry Pearce, Bracknell Forest Local Involvement Network

ALISON SANDERS
Director of Corporate Services

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Published: 1 June 2012

Health Overview and Scrutiny Panel
Thursday 14 June 2012, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

AGENDA

Page No

1. **Election of Chairman**

2. **Appointment of Vice Chairman**

3. **Apologies for Absence/Substitute Members**

   To receive apologies for absence and to note the attendance of any substitute members.

4. **Minutes and Matters Arising**

   To approve as a correct record the minutes of the meeting of the Health Overview and Scrutiny Panel held on 26 April 2012. 1 - 10

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

   Members are asked to declare any personal or prejudicial interest and the nature of that interest, including the existence and nature of the party whip, in respect of any matter to be considered at this meeting.

6. **Urgent Items of Business**

   Any other items which, pursuant to Section 100B(4)(b) of the Local Government Act 1972, the Chairman decides are urgent.

7. **Public Participation**

   To receive submissions from members of the public which have been submitted in advance in accordance with the Council's Public Participation Scheme for Overview and Scrutiny.

8. **Treatment for Strokes**

   To receive a presentation from Frimley Park Hospital NHS Foundation Trust on medical strokes and their treatment. 11 - 14

9. **Dementia**

   To receive a briefing on the types of Dementia, its causes and effects and the respective roles of Health Service providers and local authorities. 15 - 54

10. **Quality Accounts**

    To note the letters sent to five NHS Trusts on their quality accounts for 2011-12. 55 - 66

11. **Working Group Updates**

To receive a report on the progress of the Panel's Working Groups. 67 - 68

12. **Date of Next Meeting**

Thursday 27 September 2012.

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HEALTH OVERVIEW AND SCRUTINY PANEL
26 APRIL 2012
7.30 - 9.45 PM

Bracknell Forest Council

Present:
Councillors Virgo (Chairman), Mrs Angell (Vice-Chairman), Baily, Finch, Kensall, Mrs Temperton, Thompson, Ms Wilson and Blatchford (Substitute)

Co-opted Representative: Terry Pearce, Bracknell Forest LINK

Also Present:
Councillor Birch, Executive Member for Adult Services, Health & Housing

Apologies for absence were received from:
Councillor Mrs Barnard

In Attendance:
Richard Beaumont, Head of Overview & Scrutiny
Glyn Jones, Director of Adult Social Care, Health & Housing
Mary Purnell, NHS Berkshire
Dr Pat Riordan, Director of Public Health
Philippa Slinger, CEO, Heatherwood & Wexham Foundation Trust
Dr William Tong, CCG Chairman

31. **Minutes and Matters Arising**

RESOLVED: that the Minutes of the Panel held on 2 February 2012 be approved as a correct record and signed by the Chairman.

Matters Arising

Minute 22: Views of Member of Parliament
The Chairman agreed to investigate if Dr Phillip Lee MP's model of healthcare for the local area had been published and if so, to circulate it amongst members of the Panel.

Minute 26: Frimley Park Hospital NHS Foundation Trust
The Head of Overview and Scrutiny confirmed that a visit to Frimley Park Hospital had now been arranged for members of the Panel on 15 May.

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

Terry Pearce declared a personal interest in Item 10: Heatherwood Hospital Birthing Unit as chairman of 'Defend Our Community Services', which was running a campaign concerning Heatherwood Hospital.

33. **Public Participation**

There were no items submitted under the Public Participation Scheme.

The Chairman encouraged members of the public to submit questions under the Scheme if they wished. The public could submit questions under the Scheme if they gave three clear working days notice and met the other requirements of the Scheme.

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

Dr William Tong, Chairman of the Bracknell Forest & Ascot Clinical Commissioning Group(CCG) gave a presentation to the Panel on the process for gaining authorisation of the CCG. In this, and in response to Members' questions, Dr Tong made the following points:

- The Bracknell and Ascot CCG comprised 15 practices, this incorporated 140,000 patients. 12 practices covered the Bracknell Forest area and in addition three practices were included in the Ascot area. There were 7 CCGs in Berkshire.
- All CCG's needed to be authorised by April 2013, this presented quite a challenge, a number of steps towards authorisation were required and there were six domains that had been specified by the Department of Health that would need to be addressed in order for CCG's to be authorised.
- The CCG had made good progress in its creation. Links had been built with Patient Reference Groups, the LINKs and the third sector. A 'federated' approach was being followed on various issues with other CCGs in Berkshire
- Dr Tong stated that authorisation would be a process and would not end in April 2013. The CCG needed to show it was fit for purpose by April 2013, and they were confident of doing so.
- The status of the CCG at present was that it was in shadow form and a sub committee of the PCT Cluster.
- Domains one and six demonstrated a requirement for clinical engagement, which included appointing a consultant from the local area. The CCG would be challenging this as it was felt that there could be advantages of appointing an external consultant as they would then be unbiased. A nurse and two lay people would also need to be appointed.
- The Health & Wellbeing Board and Healthwatch would need to demonstrate strong engagement with the public, to address domain two.
- Dr Tong stated that QIPP (Quality, Innovation, Productivity and Prevention) was at present the CCG's biggest challenge. The CCG were currently overspent.
- Domain five required the CCG to show how they were working collaboratively to deliver change, a good example of this was the Bridgewell Project.
- The Health O&S Panel would have a role in 360 degree stakeholder review and the CCG would be asking the Panel to contribute to this process. The turnaround time for this would be around eight weeks.
- Within Berkshire, all CCG's had agreed to attempt to gain authorisation in the first wave, however it was uncertain if this was possible and so the Bracknell Forest and Ascot CCG would be preparing for wave one, but likely to gain authorisation in wave two. There were advantages of being authorised in wave two as lessons could be learned from those authorities that had been authorised in wave one.
- Dr Tong confirmed that the CCG was absolutely committed to the screening of breast cancer and had increased the age range of women who qualified for screening.
- Dr Tong confirmed that the CCG would always seek the best provider and this would include providers in the private sector.

- Dr Tong apologised that the LINK representative felt that engagement had been poor to date and that this would improve under the auspices of the Health & Wellbeing Board.
- Dr Tong assured members that there was not a conflict of interest around the CCG being a provider and a commissioner as the CCG would only be commissioning services that it did not provide, it would not be commissioning its own primary care services.

The Chairman thanked Dr Tong for his informative presentation. Dr Tong agreed to attend a future meeting of the Panel to report the CCGs progress.

35. **Joint Strategic Needs Assessment**

The Director of Adult Social Care, Health and Housing reported that there was a statutory responsibility to produce a Joint Strategic Needs Assessment (JSNA), as a partnership endeavour. Work this year had identified a range of priorities; this included particular aspects of children's services. The Council had also been required to produce a Child Poverty Strategy.

A wide range of staff had been involved in identifying sources of information. The information now needed to be made more widely available.

The Director of Public Health, Dr Pat Riordan reported that it was important to recognise the importance of the JSNA and how it linked with the Health & Wellbeing Board and Health & Wellbeing Strategy. It would identify joint intelligence and define the health and wellbeing of the local population taking into consideration factors such as where you live, where you were born, your parents, education and life opportunities.

It was reported that the JSNA would be web based and interactive and provide information at Berkshire level, down to neighbourhood level. The JSNA would be used to define priorities in the Health & Wellbeing Strategy. The challenge would be to translate the issues in the JSNA into priorities. This would involve considering what needed to be achieved in Bracknell Forest over the next 3-5 years to bring about real changes in health and wellbeing of the local population.

In response to member's queries, the following points were made:

- Sources of information that would feed into the JSNA would include; GP registers of patients, QUAFF data, information relating to housing, education, the environment and the economy. Child poverty information would also be required. The JSNA was intended to provide a holistic view of an issue. It was acknowledged that the data sources would inevitably contain a degree of error.
- With regard to the data that had been produced to show an issue with asthma in the Binfield area, it was reported that each separate source of data should be subject to scrutiny.
- The Director of Public Health reported that the Health & Wellbeing Board would be responsible for commissioning in terms of public health and so any issues or concerns should be fed into it.
- The Executive Member for Adult Services, Health & Housing reported that if members wanted to raise issues concerning health and wellbeing there would be a number of ways of feeding these into the system and being dealt with.

- Dr Tong stated that the H&WB Board would have to take tough decisions going forward, and it was important that these were well informed,. He was keen to hear the views of all groups in terms of concerns or innovation; this would be a key part of the Health & Wellbeing Board's work as well as the CCG. A Health and Care Network would also provide a means of engaging the community and feeding into the work of the Health & Wellbeing Board.
- It was noted that there were currently gaps, possibly around Children's Services, but that these would be addressed and would have to be addressed as part of the CCGs authorisation process.

The Director of Adult Social Care, Health & Housing reported that the Panel's working group had already had a detailed briefing on the JSNA. The Long-Term conditions strategy was being re-visited, with Health partners. Once a draft of the Health & Wellbeing Strategy was complete, it would be submitted to the working group for comment and consideration. It would also be submitted to the Adult Social Care & Housing O&S Panel.

The Chairman thanked officers and the Executive Member for their contributions and stated that he was delighted that the Panel would be able to play a part in the process and have a say in policy and direction.

36. **Health and Wellbeing Board**

The Executive Member for Adult Social Care & Health reported that the Health & Wellbeing Board would become statutory in April 2013; it was currently operating in shadow form. The H&WB agenda is huge, and there was a great deal of work that would need to be completed before April 2013, in particular the Panel may be asked for its input on various aspects of work, but that a short response time would need to be given.

He reported that the Health and Social Care Act had received Royal Assent on 27 March, which required local authorities to set up Health & Wellbeing Boards. The Health & Wellbeing Board would be responsible for developing a joint Health & Wellbeing Strategy. The Council was well placed to achieve this, having produced an H&WB strategy in 2007, and in having an Executive portfolio which included all key elements for Health and Wellbeing.

The shadow Board had met three times to date; these meetings had been used to set up the Board's terms of reference and devising a work programme. A draft Health & Wellbeing Strategy was also being developed and an officer working group had been set up. Other tasks included determining governance issues such as whether meetings should be held in public.

The Board still needed to define the ambition behind the Health & Wellbeing Strategy and the Executive Member invited the Panel to propose a one page document around what they believed should be the vision of the Health & Wellbeing Board. This would need to be fed back to the Executive Member within the next few weeks.

Local Healthwatch would also need to be set up; this would be a much broader organisation than the LINK, which was to be abolished. A member of Local Healthwatch would then become a key member of the Board. A Health and Care Network would also need to be set up to support Healthwatch. This required widely drawn input, including from the Youth Parliament. The Director of Social Care, Health & Housing reported that Healthwatch would be a new organisation with new governance, constitution and members. Healthwatch although tendered by the Council would be independent from the Council.

Communicating to the public would be a key task for the Board and from April 2013 the Board would hold its meetings in public.

The Executive Member saw the Boards role as:

- Achieving and maintaining clear understanding between partner organisations
- Ensuring priorities were right
- Ensuring focus was on local needs
- Finding gaps in provision and resolving them
- Joining up all health and care services
- Driving quality improvement
- Resolving conflicts in commissioning
- Ensuring the patient voice is respected.

In response to questions, the Executive Member said that the H&WB had a meaningful and empowered role. Its membership should not be too large to prevent it making good progress, and its ethos was based on partnership.

The Executive Member stated that whilst the Borough had always made effective and best use of the resources available, he would continue to lobby for a fairer health funding allocation from Central Government for Bracknell Forest. Dr Riordan added that a recent letter jointly sent by the Chief Executives of both the Council and the PCT to the Department of Health challenged what was viewed as too small a budget allocation for public health.

37. **Transfer of Public Health Functions**

The Director of Adult Social Care, Health and Housing reported that a Berkshire-wide commissioning group had been established which comprised representatives from the six unitary authorities in Berkshire as well as the PCT Cluster Chief Executive. This Group had developed a model for Berkshire which comprised one Director of Public Health for Berkshire and local leaders for Public Health from each unitary council.

The main concern expressed by the Regional Director of Public Health was the time it would take to get to the transition model. The six unitary authorities were making progress and were in agreement in principle.

The Director of Public Health reported that the funding allocation from the Government would be ring-fenced and was likely to fund all current activity. She stated that the allocation would be based on a needs based weighted formula and consultation would be undertaken in the spring. To achieve the formula amount within a reasonable time, there may be a 'pace of change' element. She stated that it was important to get the allocation right, going forward from year one, the Department for Health would be calling to identify spend for 2012-13. Expenditure on public health varied from some £15 per head to over £100. Initially, all three boroughs in east Berkshire were due to receive £21 per head. In order to manage with fixed budgets and demand-led services, there may be a need for the councils to operate a form of risk sharing.

The Director of Adult Social Care, Health & Housing reported that currently work around the transfer of Public Health was being done within existing resources. The Berkshire unitary councils were collaborating to minimise costs, for example the

Director was taking the lead on Human Resources issues, and Reading BC on finance and contracting issues.

It was reported that there had been an exponential increase in sexually transmitted diseases, outstripping some of the contracts in place. Sexual health would be one of the major areas that would be transferring to local authorities. It was noted that data around sexual health was difficult to obtain, however the Council would have responsibility for new services and contracts and would need to manage this.

The Director of Social Care and Health reported that one of the opportunities that existed was to be creative around health promotion and consider how all Council services could contribute to the agenda. Leisure centres, health centres and other services could play a part in this. Every contact with the Council could have a public health dimension.

The Chairman highlighted mental health as another major area that needed consideration given the current economic climate. It was acknowledged that dementia diagnosis required improvement, and this was being attended to. Representatives of Berkshire Healthcare Foundation Trust reported that they were working with the CCG to make links stronger. The Memory Clinic had proved to be busy and was being invested in.

38. **Heatherwood Hospital Birthing Unit**

The Panel received an update from the Heatherwood & Wexham Park Hospitals NHS Foundation Trust on the closure of the Birthing Unit at Heatherwood Hospital.

Ms Slinger stated that it would not be possible to reopen the Heatherwood Birthing Unit for the reasons set out in the report before the Panel. In response to members' queries, she made the following points:

- Given the low demand for the service, fewer than 200 women a year were choosing Heatherwood as a birthing unit, the service had become unsustainable and unsafe. Further, there was a national shortage of midwives and it had become difficult to sustain staffing levels at Heatherwood. In addition, standards of care had massively increased leading to the need for much more qualified staff. All of these factors led to the birthing unit at Heatherwood becoming unsustainable.
- The decision to move community midwife services to Frimley Park had been based on patient choice and the hospital at which women were choosing to give birth.

In terms of the general health of the Trust itself, Ms Slinger reported that the Trust had ended the financial year at its re-forecasted level. This had included savings. There was now recognition that simply limiting expenditure did not always lead to overall savings.

Mrs Slinger reported that the Trust had significantly reduced the number of agency staff it used. An IT system was also now in place to allow more effective monitoring of patients.

Ms Slinger stated that she recognised that the Trust was more costly than other local hospitals for the same services and that this was being addressed.

39. **Working Group Updates**

The Head of Overview and Scrutiny reported that the Health Reforms Working Group and the Health & Wellbeing Strategy Working Group had not met since the last Panel meeting. He stated that now the Health & Social Care Act had received Royal Assent, a briefing could be arranged for members.

The Working Group on Health Reforms was focussing on the transfer of Public Health functions to local authorities. A draft of the Health & Wellbeing Strategy would be available in May, a detailed review would be made probably in a workshop format .

The Head of Overview and Scrutiny stated that the PCT consultation on Shaping the Future was due to take place in the autumn.

40. **Overview and Scrutiny Bi-Annual Progress Report**

The Panel noted the Overview and Scrutiny activity over the period September 2011 to February 2012, as set out in Section 5 of the report and appendices 1 and 2. The Head of Overview and Scrutiny reported that the annual report of Overview and Scrutiny had now been submitted to full Council.

41. **Date of Next Meeting**

14 June 2012.

CHAIRMAN

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ACTIONS TAKEN : HEALTH OVERVIEW AND SCRUTINY PANEL MEETING – 26 APRIL 2012

Minute Number	Action Required	Action Taken
31	The Chairman agreed to investigate if Dr Phillip Lee MP's model of healthcare for the local area had been published and if so, to circulate it amongst members of the Panel.	Dr Lee's report was circulated to Panel members on 16 May
36	The Executive Member invited the Panel to propose a one page document around what they believed should be the vision of the Health & Wellbeing Board.	Under preparation. The Panel's Working Group on the Health & Well Being Strategy is due to consider this at its next meeting on 6 June

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HEALTH OVERVIEW AND SCRUTINY PANEL
14 JUNE 2012

TREATMENT FOR STROKES
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report invites the Health Overview and Scrutiny (O&S) Panel to receive a presentation from Frimley Park Hospital NHS Foundation Trust on medical strokes and their treatment.

2 SUPPORTING INFORMATION

3.1 The presentation is expected to be delivered by Dr Brian Clarke, a Stroke Consultant at Frimley Park Hospital. Dr Clarke may be accompanied by Andrew Morris, Chief Executive, also possibly by a patient who has received stroke treatment at the hospital.

3.2 The Panel will also be invited to view the national TV broadcasts by the NHS on recognising the signs of strokes.

3.3 Background information on strokes, from the NHS Choices Website, is at Appendix 1.

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

Background Papers

None

Contact for further information

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Appendix 1

Information on Strokes from the NHS Choices Website[1]

A stroke is a serious medical condition that occurs when the blood supply to part of the brain is cut off.

Like all organs, the brain needs the oxygen and nutrients provided by blood to function properly. If the supply of blood is restricted or stopped, brain cells begin to die. This can lead to brain damage and possibly death.

Strokes are a medical emergency and prompt treatment is essential because the sooner a person receives treatment for a stroke, the less damage is likely to happen.

Types of stroke

There are two main causes of strokes:

- ischaemic (accounting for over 80% of all cases): the blood supply is stopped due to a blood clot
- haemorrhagic: a weakened blood vessel supplying the brain bursts and causes brain damage

There is also a related condition known as a transient ischaemic attack (TIA), where the supply of blood to the brain is temporarily interrupted, causing a 'mini-stroke'. TIAs should be treated seriously as they are often a warning sign that a stroke is coming.

Who is at risk from stroke?

In England, strokes are a major health problem. Every year over 150,000 people have a stroke and it is the third largest cause of death, after heart disease and cancer. The brain damage caused by strokes means that they are the largest cause of adult disability in the UK.

People who are over 65 years of age are most at risk from having strokes, although 25% of strokes occur in people who are under 65. It is also possible for children to have strokes.

If you are south Asian, African or Caribbean, your risk of stroke is higher. This is partly because of a predisposition (a natural tendency) to developing diabetes and heart disease, which are two conditions that can cause strokes.

Smoking, being overweight, lack of exercise and a poor diet are also risk factors for stroke. Also, conditions that affect the circulation of the blood, such as high blood pressure, high cholesterol, atrial fibrillation (an irregular heartbeat) and diabetes, increase your risk of having a stroke.

Strokes can be treated and prevented

Strokes can usually be successfully treated and also prevented. Eating a healthy diet, taking regular exercise, drinking alcohol in moderation and not smoking will dramatically reduce your risk of having a stroke. Lowering high blood pressure and cholesterol levels with medication also lowers the risk of stroke substantially.

[1] http://www.nhs.uk/Conditions/Stroke/Pages/Introduction.aspx

See the prevention section for more information about reducing the risk of having a stroke.

Strokes can be treated using a combination of medicines and, in some cases, surgery.

However, many people will require a long period of rehabilitation after a stroke and not all will recover fully.

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TO: HEALTH OVERVIEW AND SCRUTINY PANEL
14 JUNE 2012

DEMENTIA
Director of Adult Social Care and Health

1 PURPOSE OF REPORT

1.1 To inform members of the main causes of Dementia, and services available in Bracknell Forest to support people with dementia and their families.

2 RECOMMENDATION

2.1 That the attached report is noted.

3 REASONS FOR RECOMMENDATION

3.1 N/A – Information report.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 N/A – Information report.

5 SUPPORTING INFORMATION

5.1 The attached report (annex 1) gives information on the main causes of Dementia and the local services available.

5.2 Local services are developed within the framework of the National Strategy for people with dementia “Living Well with Dementia”

5.3 The Bracknell Forest Joint Commissioning Strategy for people with dementia was agreed in 2009, and is attached as annex 2. An update on progress on the action plan is also attached as annex 3. A recent review of progress has informed revised priorities in the light of the outcomes of the development programme “Next Generation Care” implemented by Berkshire Healthcare NHS Foundation Trust. Relevant information is attached as annexes 4-5.

Contact for further information
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Services and Support for People who have Dementia

1. Early Concerns

Often the first signs that cause concern for people and their relatives are when an individual becomes forgetful of confused. This is a difficult time for people who naturally may fear the worst, and may try to deny the problem, or put off doing anything about it. However, when they do seek advice, this is often from the GP. If appropriate, having screened out immediate physiological causes, the GP will refer the person to secondary health services for assessment and diagnosis.

2. Referral and Diagnosis

2.1. Non-emergency

Referral to the joint Community Mental Health Team – Older Adults (CMHT-OA) is through the BHFT Common Point of Entry (CPE), where referrals are screened to determine the most appropriate next steps for the individual. If it seems appropriate, the referral will then be passed to the locality team for assessment. Assessment and diagnosis is through the Memory Clinic.

Memory Clinic staff are-

- Consultant in Psychiatry of Old Age
- Staff Grade Psychiatrist
- 2 specialist nurses
- Psychologist

Assessments can be carried out at Church Hill House where the team is based, or in the person's home.

When a referral is received, the information is considered at the weekly allocations meeting, and the most appropriate workers are assigned to complete the assessment.

The assessment will consider a range of potential causes for the symptoms presented, and will test for these to rule our any causes that are reversible or indicate causes other then dementia. Often physical illnesses such as infections can give rise to confusion and forgetfulness, and treatment can see the person return to full health. These tests will include full blood screening, and may also include scans. This service is also available to younger people who may have a dementia, and these individuals should always be referred to Neurology.

2.2. Emergency

There are occasions where a more urgent response is required, and it is inappropriate to wait for the weekly allocations meeting. This may be, for example, where an individual has been found wandering, or has become distressed. In these circumstances, prioritisation is made and allocation takes place immediately.

3. Causes of Dementia

There are several diseases and conditions that result in dementia. These include:

- **Alzheimer's disease** − The most common cause of dementia. During the course of the disease the chemistry and structure of the brain change, leading to the death of brain cells. Problems of short-term memory are usually the first noticeable sign.
- **Vascular dementia** − If the oxygen supply to the brain fails due to vascular disease, brain cells are likely to die and this can cause the symptoms of vascular

dementia. These symptoms can occur either suddenly, following a stroke, or over time through a series of small strokes.

- **Dementia with Lewy bodies** − This form of dementia gets its name from tiny abnormal structures that develop inside nerve cells. Their presence in the brain leads to the degeneration of brain tissue. Symptoms can include disorientation and hallucinations, as well as problems with planning, reasoning and problem solving. Memory may be affected to a lesser degree. This form of dementia shares some characteristics with Parkinson's disease.
- **Fronto-temporal dementia** (including Pick's disease) − In fronto-temporal dementia, damage is usually focused in the front part of the brain. At first, personality and behaviour changes are the most obvious signs.

Rarer causes of dementia

There are many other rarer diseases that may lead to dementia, including progressive supranuclear palsy, Korsakoff's syndrome, Binswanger's disease, HIV/AIDS, and Creutzfeldt−Jakob disease (CJD). Some people with multiple sclerosis, motor neurone disease, Parkinson's disease and Huntington's disease may also develop dementia as a result of disease progression.

Mild cognitive impairment

Some individuals may have noticed problems with their memory, but a doctor may feel that the symptoms are not severe enough to warrant a diagnosis of Alzheimer's disease or another type of dementia, particularly if a person is still managing well. When this occurs, some doctors will use the term 'mild cognitive impairment' (MCI). Recent research has shown that individuals with MCI have an increased risk of developing dementia. The conversion rate from MCI to Alzheimer's is 10-20 per cent each year, so a diagnosis of MCI does not always mean that the person will go on to develop dementia.

Who gets dementia?

- There are about 800,000 people in the UK with dementia.
- Dementia mainly affects people over the age of 65 and the likelihood increases with age. However, it can affect younger people: there are over 17,000 people in the UK under the age of 65 who have dementia.
- Dementia can affect men and women.
- Scientists are investigating the genetic background to dementia. It does appear that in a few rare cases the diseases that cause dementia can be inherited. Some people with a particular genetic make-up have a higher risk than others of developing dementia.

After Diagnosis – "Living Well with Dementia"

Fig 1: Summary of support

4. Support in the Community

4.1. Support from CMHT-OA

Mental Health Practitioners

- Community Psychiatric Nurses (CPN's)
- Social Workers (SW's)
- Occupational Therapist (OT)
- Community Support Workers (CSW's)
- Speech & Language Therapist (SALT)
- Psychology team
- Home Treatment Team (short term care management) (see below)
- Dementia Advisor

4.1.1. Dementia Advisor

Many people newly diagnosed with dementia do not yet need support from Social Care. However, they have access to the Dementia Advisor, whose role is to give information, advice, and support, and signpost people to where they can find other support available. Further information on this role will be available. The role was first funded as part of a National pilot, and has proven so useful and so popular that permanent funding has been secured, and other localities are following the model.

4.1.2. Care Co-ordination: (by any practitioner in the team)

Assessment, diagnosis and treatment of mental health conditions for older adults are the core business of the team. In addition, those people who have a clinical need for specialised integrated support will be eligible for care management (i.e. where psychiatric knowledge and expertise is essential to achieve effective Care Co-ordination).

Examples of people needing Care Coordination:

- A person with a severe mental illness/dementia with challenging behaviour who is at risk due to a lack of insight into their condition
- Resistant to attempts to provide care/support

Individuals and their families are encouraged and supported to consider a wide range of ways in which their social care needs can be met, in line with the personalisation agenda, and many families have been able to have support arrangements that meet their very individual needs and circumstances.

4.1.3. Support for Carers

Carers are entitled to an assessment and there are a range of options for support, including voluntary organisations. (see Fig.1). As part of the approach to personalised support arrangements carers can have a direct payment to organise support or activities that help them in their caring role. They can also use the Timebank (further information to be circulated).

4.1.4. Occupational Therapy:

Occupational Therapist runs weekly Cognitive-Stimulation Therapy groups and carries out assessments of functional ability in individuals' own homes. Following assessments, recommendation will be made to support individuals to regain or retain skills for as long as possible.

4.1.5. Speech & Language Therapy:

This involves assessment of communication skills or memory, and feeding/swallowing difficulties, and development of programmes to support retention of skills.

4.1.6. Psychology:

Can provide in-depth neuropsychological assessments where required, also psychological based interventions on an individual or group basis

4.1.7. Memory Clinic reviews

These can be led by the nurse, doctor or psychologist, and monitor the individual and their treatment to ensure that it is as effective as possible, as the dementia progresses. The work of the Consultant Psychiatrist contributes to national research into the treatment of Dementia.

4.1.8. Understanding Dementia Carers Courses

The memory clinic staff run a course for carers of people with dementia. This is 8 sessions over 8 weeks, and is run at Heathlands, where the individual with dementia can receive day care if necessary. Aware of the fact that it may be difficult for some carers to attend, the team are intending to run an alternative course over one day.

4.2. Home Treatment Team (HTT)

'A specialist, multidisciplinary mental health team which aims to provide short-term, intensive, home based assessment and treatment as an alternative to inpatient care'

This differs from the Community Mental Health Team in the following ways:-

- It has the capacity to visit up to 4 times per day, for up to 12 wks
- It operates 7 days a week, 365 days per year
- It provides support outside of office hours

HTT and CMHT OA are key elements of the wider Community Mental Health Services for Older People. Both work together very closely and share a work base.

Main Functions of HTT:

- Crisis response
- Person-centred risk assessment and management
- Provide community treatment during most severe phase of illness
- Provide telephone advice and support
- Monitor mental well-being and response to treatment
- Support patients to take active part in decisions about their mental health care and recovery
- Educate and empower people/carers to manage symptoms
- Help people maintain links with their social support network

4.3. Home Support

If individuals and their families need day to day support with tasks of daily living, or personal care, then this can be provided by:-

- Regular visits by support workers from a domiciliary care agency, either arranged by the Council or through a Direct Payment.
- The council's specialist dementia home support team (usually for people with more complex needs)
- Having a live-in carer which can also be arranged through an agency or Direct Payment
- Employment of personal assistants using a Direct Payment
- Using the befriending scheme run by BFVA
- Using the Timebank

4.4. How to refer

Referrals detailing personal, medical and psychiatric history, any screening results and the presenting problem/reason for referral, should be sent to the Common Point of Entry for all Mental Health Services across Berkshire.

The number to contact is: 0300 365 0300

5. Residential Care

People are supported to remain in their own homes for as long as possible. However, for some people there may come a time when this is no longer possible, for example because:-

- Family carers are no longer able to provide the level of care required, even with additional support
- The individual has no family, and the risks of living alone have become too great even with a package of support.

In these circumstances, the practitioner from the team will, in consultation with the individual and family and friends, identify a suitable care home. All care homes where people are funded by the Council have rigorous checks for quality, and are monitored closely through the Care Governance arrangements.

6. Hospital Care

6.1. Charles Ward

The Older Adults inpatients wards in the East have historically remained under-occupied for a number of years. This has resulted in an inefficient use of the available resources for older adult's inpatient provision. BHFT reviewed the opportunity to consolidate ward 14, Heatherwood Hospital with the current activity on Charles Ward by June 2011.

6.2. Support in Acute Hospitals

The fact that people with dementia do not always receive good care in acute hospitals has been well publicised.

Heatherwood and Wexham Park Hospital Trust have undertaken a programme of work to determine what they need to do to address this, and as a result have instigated a range of initiatives, including the following:-

- Established a team with particular expertise in dementia, to advise staff on surgical and medical wards how they should support individuals. They are alerted whenever a person who is known to have dementia, or who appears may have dementia, and they visit and tailor their advice accordingly
- Use a discrete system to identify to ward staff when a person has dementia to indicate that they need specific support
- specialist dietetics advice
- Liaison Psychiatry service: this service carries out urgent old-age psychiatric assessments, and will assess before hospital discharge if it is inappropriate to wait for a memory clinic appointment.
- Staff training for local care homes

Royal Berks Hospital Trust also has a liaison psychiatry service

Frimley Park Hospital Trust has a specialist liaison nurse who works with individuals to facilitate safe hospital discharge

6.3. Discharge from Hospital (for people living in their own homes)

Individuals may have been in hospital for one of two main reasons:-

- Assessment and treatment of dementia
- Treatment for a physical condition

and may require reablement or intensive support for a period of time after they are discharged.

6.3.1. Physical reablement – Intermediate Care

The Council manages the intermediate care service for people with physical reablement needs. This is run in partnership with Berkshire Healthcare NHS Foundation Trust (BHFT), and has two main components:-

- The Bridgewell Centre, which offers reablement in a care home setting, and
- the domiciliary team, which provides reablement service in people's own home.

Bridgewell will soon be opening a separate wing, which will offer physical reablement for people with dementia. The domiciliary will shortly be receiving specialist training to ensure that they can respond appropriately to the physical reablement needs of people with dementia.

Both Bridgewell and the domiciliary intermediate care team also provide intensive support to people who need it to prevent hospital admission.

6.3.2. Dementia-related hospital discharge

The Home Treatment team will provide the short term intensive support that may be required following hospitalisation because of dementia. See 4.2 above.

7. Safeguarding

People with Dementia are among the most vulnerable in the community. The Council leads the local approach to safeguarding adults in partnership with other agencies. Further detail is available, and the Annual Report for 2011-12 will be published in June.

7.1. Mental Capacity Act 2005 (MCA)

The MCA consolidates common law, and sets out the requirements for making decisions about care and treatment for people who lack capacity to make their own decisions. The MCA is quite complex but in brief:

Key principles of MCA are:

- The assumption of capacity unless determined otherwise
- Every possible step must be taken to enable the individual to make their own decisions
- Unwise decisions do not indicate lack of capacity
- Decisions made on behalf of the individual must be made in their best interests
- The least restrictive course of action must be followed.

The Act established the role of IMCA (Independent Mental Capacity Advocate) to act as an advocate for those individuals who lack capacity, but have no relatives or friends to advocate for them. They also have a specific role if consideration is being given to depriving an individual of their liberty in a care home or hospital for the purposes of receiving care or treatment. There are very clearly prescribed processes for this call the Deprivation of Liberty Safeguards (DoLS).

7.1.1. Assessment of Capacity

If it is thought that an individual may lack capacity to make a particular decision, then their ability to do so must be assessed. To demonstrate capacity in relation to the **specific decision** in question, the individual must be able to:-

- Understand the relevant information
- Retain the relevant information
- Weigh up the information and understand the implications to the decision in question
- Communicate that decision.

7.1.2. Best Interests Decisions

If an individual is assessed as lacking capacity to make a specific decision then the "Best Interests decision" must be made on their behalf.

The complexity and seriousness of the decision will determine who needs to be involved. Some decisions will require information and expertise from multi-disciplinary teams.

7.1.3. Lasting Powers of Attorney (LPA)

Whilst an individual still has capacity, they can authorise another individual to make decisions on their behalf. There are two kinds of LPA:

- Personal welfare, including healthcare
- Property and affairs (financial matters)

7.1.4. Advance Decisions

Before losing capacity individuals should be encouraged to consider making Advance Decisions. This usually relates to refusing treatment in certain circumstances. If an advance decision is properly written, signed and witnessed, then it must be honoured.

7.2. Court of Protection

In circumstances where there is disagreement in relation to whether an individual has capacity, or what decision id in their best interests then the matter can be referred to the Court of Protection for a ruling. They may request independent expert assessments, to assist in making their determinations, and may appoint a deputy to act for someone who is unable to make their own decisions. The Council hosts the Deputyship function for individuals who may not have other people available to take on this role.

8. End of Life Care

Wherever possible, people are supported to receive end-of-life care in accordance with their wishes. Where people have made an advance decision to refuse treatment (see 7.1.4) then this must be respected.

Often the final cause of death is a physical illness, rather than the dementia. Palliative care can be provided in individuals' own homes, or in appropriate care home settings, supported by input from appropriate community nursing services such as Marie Curie, or Macmillan or specialists in Parkinson's disease.

Carer Support

Alzheimer's Society 0845 306 0868 www.alzheimers.org.uk

Alzheimer's Dementia Support (Local):

Terrie: 07516165647; Christine: 07516165665
www.alzheimersdementiasupport.co.uk

Princess Royal Trust for Carers: 0800 988 5462 / 01628 777217; Email: helpline@prtberks.plus.com; Web: www.carers.org

Counsel and Care (Advice Service): 0845 300 7585; Web: www.counselandcare.org.uk

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Commissioning strategy for people with dementia 2009-2014

Bracknell Forest Council

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Contents

1. Introduction

'Strategic commissioning has the potential to change the shape, volume and quality of care services to meet the needs of local people. Understanding people's needs and aspirations by seeking the views and involvement of people of all ages, children and families, and ongoing dialogue with every community is the basis for effective commissioning'. [1]

Bracknell Forest Council through its Adult Social Care branch is committed to enabling people with dementia and their carers to access effective support that promotes independence, well-being and choice.

This Dementia Commissioning Strategy sets out the strategic direction for support for people with dementia, including younger people with dementia, from 2009-2014. It has been developed based on an analysis of need in Bracknell Forest.

The Commissioning Strategy is set in the context of outcome-based commissioning, where support available must demonstrate improved outcomes for individuals. These outcomes can be grouped into 7 main areas [2] .

- Improving health and emotional well-being
- Improving quality of life
- Making a positive contribution
- Increasing choice and control
- Freedom from discrimination or harassment
- Economic well-being
- Maintaining personal dignity and respect.

As well as support being outcome focused, the values, vision and principles of offering effective support to people who have dementia and their carers are illustrated below.

- Planning support and services from the experience/perspective of the people who use services and their carers
- Equality of access to high quality and appropriate support, information and advice
- Enabling choice through creative support options, such as providing personalised budgets, to maximise independence

[1] The Commission for Social Care Inspection (2006) The state of social care in England 2005-2006. Newcastle: Commission for Social Care Inspection (p65)
[2] Department of Health (2006) Our health, our care, our say: a new direction for community services. London: Department of Health

- Shifting from services provided directly by the Council to community based activities and support, enabling people to maintain independence and a 'normal' life
- Working in partnership with health, voluntary organisations, people who use services and their carers
- An honest and transparent approach to all aspects of work
- Increased understanding and awareness in society and a recognition that dementia is not an inevitable part of old age
- Timely diagnosis and intervention
- Providing care to people with dementia that is outcome based, not time or task oriented.

2. National context

Dementia is a key local priority with the number of people living with dementia expected to rise substantially over the next 25 years. The Government's recently published National Dementia Strategy supports the direction of travel we had embarked on. The three main themes nationally for dementia support are:

- Improving awareness: increased public and professional awareness of dementia and an informed and effective workforce for people with dementia
- Early diagnosis and intervention: good quality early diagnosis and intervention for all; good quality information for those with dementia and their carers and enabling continuity of support and advice
- Living well with dementia, by improving the quality of care for people with dementia from diagnosis: in general hospitals; home care; respite care/short breaks; joint commissioning strategy for dementia; intermediate care; improved dementia care in care homes and improved registration and inspection of care homes.

The Transformation of Adult Social Care and commitment to personalised support also influences this Dementia Commissioning Strategy, as does other evidence of good practice in dementia support. Underpinning all recent social care and health national guidance is the importance of choice, and the power to make decisions, for people who use social care and health services.

Key messages from national policy

- Earlier diagnosis and intervention
- Increasing public and professional understanding of dementia and reducing the stigma and discrimination associated with dementia
- An emphasis on living well with dementia
- More emphasis on the 'whole journey' of dementia, from early diagnosis through to end of life care
- Promoting social inclusion, social capital and community cohesion
- Provision of appropriate accommodation and technologies to enable people to remain in their own homes
- Improving access to, and quality of, support for people with dementia and their carers
- Providing information that is timely and accessible
- A focus on how support will improve people's outcomes
- Developing stronger peer support networks to help people cope
- Supporting carers
- More choice and a louder voice for people with dementia and carers and fully involving people in their support options
- Introducing personalised budgets in social care to enable a transparent approach to entitlement and greater choice of support options
- Reducing inequalities and improving access to support in the community
- Ensure that people, regardless of ethnicity, race, disability, sexual orientation, age, gender or religion, receive fair treatment
- Partnership working, with people who use services, their carers and other agencies, to provide effective support
- Joint commissioning between Social Care and Health to provide high quality support that meets individual needs in a flexible, responsive way.

3. Needs analysis

What is a needs analysis?

Needs analysis is a way of estimating the extent and nature of the needs of a population so that appropriate support can be planned accordingly. The needs analysis can

- Help estimate the current and future needs of a population
- Indicate the geographical distribution of need
- Identify those people who are at greatest risk
- Help identify the gap between met and unmet need.

A comprehensive needs analysis is based on a balance of national and local data and consists of demography, incidence and prevalence, risk factor data and local and service user data.

Summary of quantitative data

Demography [3]

- Over the next five years the population of Bracknell Forest aged 18-64 is expected to rise by 2.3%, and for those aged 65 and over, by 20%
- There are marginally more women then men (18+ years) (51% women, 49% men) and this difference will increase slightly over the next five years to 52% women
- The average life expectancy of women is 82.6 years and men, 78.6 years, which is slightly higher than the average for the South East and 1.3 years higher than the national average
- The ethnic profile of the borough is changing. Whereas the census 2001 showed 4.9% were from non-white minority groups, 2008 data from schools shows 10.5% are from non-white groups. This rises to 11.5% when taking data from primary schools only. [4]

Incidence and prevalence [5]

- In England and Wales there are estimated to be 165,000 new cases of people with dementia each year. This suggests an incidence rate in Bracknell Forest of approximately 280 new cases each year
- Using national prevalence figures and the latest estimated population figures, there are approximately 936 people with dementia living in Bracknell Forest
- At any point in time, approximately a third of the people with dementia living in Bracknell Forest are receiving support paid for by Adult Social Care

[3] Office for National Statistics, data extract July 2008

[4] Bracknell Forest local schools data

[5] http://ageing.oxfordjournals.org/cgi/content/full/35/2/154 and backing figures from Mental Health Observatory figures for dementia, 2008

- Just over two thirds (69%) of people with dementia are aged over 80
- There are more men than women with dementia in the 65 to 74 age range. After this age there are more women. This may be due to the longer life expectancy of women
- Dementia affects a third of all people who are 95 years of age or older
- There are proportionately more people from BME communities with early onset dementia but this is due to the younger age profile of the BME community
- There is a larger proportion of older people living in Bullbrook, Priestwood and Garth and Ascot. Therefore these wards are most likely to have a higher proportion of people with dementia. Priestwood and Garth is the ward most likely to have the highest number of people with dementia as it has the highest number of older people living there out of all the wards in Bracknell Forest
- The number of people with dementia receiving support from Adult Social Care is likely to rise by 20% over the next five years.

Risk factors

A study by the Medical Research Council showed the following as key risk factors in the incidence of dementia:

- Age- the older you are, the more at risk you are
- Gender- more women than men, although this may be due to the longer life expectancy of women
- Stroke- those who have a history of strokes appear to be at more risk. However, this was disputed in a further evaluation of the data which showed no difference across areas with greater incidence of strokes
- Parkinson's disease- those with the disease were more at risk.

This study also identified some protective factor, that is, factors that are associated with a lower incidence of dementia:

- Self-perceived health- the incidence of dementia was lower amongst those stating their health was 'good' or 'excellent'
- General anaesthetic- the incidence of dementia was lower amongst people who had received a general anaesthetic. This effect was consistent with increasing exposure to anaesthesia; the risk of dementia got lower as the number of exposures to a general anaesthetic got higher.

Local data

- This data was extracted from our Adult Social Care database
- There were 315 people with dementia with an open referral to Adult Social Care on 9th September 2008
- There are around 100 new referrals to Adult Social Care each year. This is approximately a third of the estimated new cases of people with dementia each year in the Borough. This proportion appears low but this could be for reasons such as people may not have a diagnosis of dementia, people may already be receiving services from another team so would not count as a new referral or they may not access social care
- As the numbers of people aged 65+ from the non-white BME groups is very small in Bracknell Forest (national census 2001 showed only 137 people), it is difficult to draw firm conclusions from the ethnic monitoring analysis. The analysis, such as it is, does show the proportion of people from BME communities receiving support from Adult Social Care, is broadly in-line with the proportion of people in the borough
- Approximately two-thirds of people being supported by Adult Social Care are receiving support at home in the community, and one third are in residential or nursing care homes
- The number of people supported is set to rise from 315 to 378 (20% increase) over the next five years.

Please see **appendix A** for the full quantitative needs analysis.

Summary of qualitative data

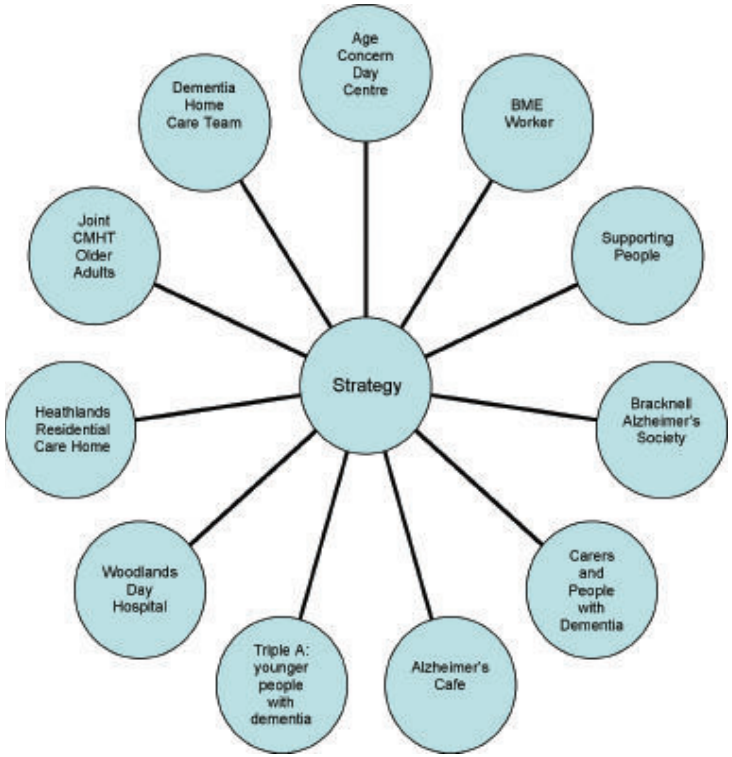
Ways we engaged with people to inform the consultation paper

Exploratory work with key individuals and groups (May- July 2008)

- 1:1 interviews with stakeholders conducted by members of project team
- Focus groups with service providers
- Attending voluntary sector activities

In the exploratory work to develop the dementia commissioning strategy, it was essential that the key stakeholders in dementia care and support were involved. Views of people and groups who may be seldom heard in the Council's planning processes were actively sought, such as views regarding dementia support for Black and Minority Ethnic communities and for people with a learning disability. We also engaged with people who have dementia, carers, people who work in Social Care, Health, the voluntary sector and other stakeholders, to obtain a wide range of views and perspectives on the future direction of support.

The figure below illustrates some of the groups and individuals we engaged in the qualitative needs analysis.



Key points from analysis of interview data

- Generally, services and support currently available work well and the aspects that make them work well should be integral to all future service provision
- The support available from the voluntary sector is highly regarded and enables people to maintain independence and quality of life
- People working in dementia care should be aware of safeguarding issues
- Home care services need to effectively meet the needs of people with dementia
- People value the service provided by the Bracknell Forest in-house Dementia Home Care Team
- Day care options need to be varied, with longer hours, flexible to meet individual needs and with a range of stimulating and meaningful activities to be available
- The general public and health and social care workers need to be more aware of dementia
- A range of respite care options should be available
- People would like emergency support to be available
- Carers and families of people with dementia play a crucial role and need to be well-supported, both emotionally and practically
- Some people experience financial worries, particularly families of younger people with dementia
- Access to support can sometimes be difficult. People may not know about available support, support may not be available when required and transport is a big challenge
- People from BME groups may not be receiving appropriate diagnoses or care
- People with learning disabilities are at a higher risk of developing dementia and services need to be able to support people with complex needs
- Younger people with dementia should have age appropriate services
- There are accommodation and housing related support issues for people with dementia
- Statutory services could encourage people to volunteer and help provide care and support for people with dementia
- Existing resources could be used in new and creative ways
- The dedication and skill of staff is very important in providing effective care.

The findings from the qualitative needs analysis were summarised in a consultation paper. The consultation document, as well as summarising the key findings, incorporated other drivers behind the development of the Commissioning Strategy. A wide range of people were invited to comment on the proposed priorities for dementia support offered by Bracknell Forest Council.

Summary of consultation

Ways we engaged with people to inform the commissioning strategy

Consultation (October 2008- January 2009)

- Consultation paper and feedback form sent to people who expressed an interest after the qualitative needs analysis
- Events attended and facilitated discussion of consultation paper held
- People and groups identified who had not participated in the needs analysis approached for feedback.

Key points from analysis of consultation feedback

- Overall, respondents to the consultation paper gave positive feedback about the paper
- People generally agreed with the proposed priorities
- An ongoing theme that emerged throughout the feedback was the lack of detail in the paper concerning how the priorities would be achieved
- Three new issues arose as a result of the consultation, specifically
  - Emphasis on the importance of involvement of families and providing feedback on what is happening in dementia support, including the impact of the new transforming adult social care agenda
  - Need to acknowledge the provision of telecare and assistive technologies for people with dementia
  - People often have more than one condition, and services need to respond to specialised concerns of these people

The findings from the qualitative needs analysis and the consultation have informed and influenced the priority setting in this Dementia Commissioning Strategy.

Please see **appendix B** for the full qualitative needs analysis and findings from the consultation.

4. Financial overview

Specialist support provided directly by Adult Social Care to those with dementia is managed by several teams:

- Joint Health and Social Care support is offered by the Community Mental Health Team for Older Adults (CMHT OA)
- Specialist home care support is provided by the Dementia Home Support Team
- Residential care is provided by the Council at Heathlands
- Day support is available at Heathlands day centre.

The Older People and Long Term Conditions Team and the Community Response and Re-ablement Team within Adult Social Care also provide support for people with dementia. Data available does not currently allow us to estimate the expenditure from these support services directly for people with dementia.

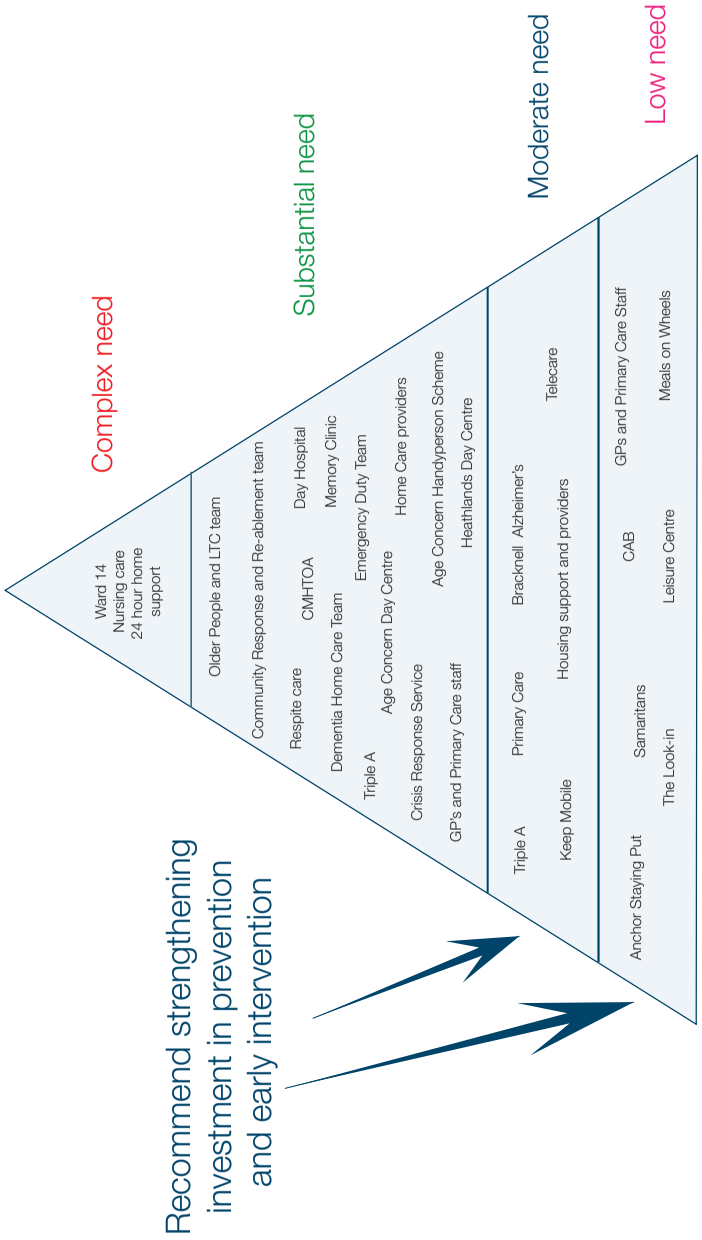
The Council also contracts with independent providers of home care support, residential care homes and nursing homes and supports voluntary sector organisations by providing grants to the Ascot Area Alzheimer's (Triple A) support group and Age Concern.

The major financial concerns will be the impact in the medium or longer term of increasing service demand from demographic changes upon services. The Council's overall budget strategy for the next three financial years 2009/10 to 2011/12 recognises pressures of a demographic nature.

Key financial messages

- The financial impact of increased demand from demographic changes will impact in the medium and longer term. Provision for this will need to be considered as part of the Council's overall annual budget setting process.
- Need to work towards ways of monitoring the proportion of the Adult Social Care budget specifically spent on people with dementia.

5. Current support in Bracknell Forest



6. Our priorities

The national policy context and comprehensive needs assessment have informed the priorities for future dementia support in Bracknell Forest. The needs analysis identified the population trends, incidence, prevalence and risk factors for dementia, as well as how social care support is currently offered and utilised.
People's views and experiences were also collected and analysed and are central to the vision and development of the priorities for dementia support in Bracknell Forest. This section demonstrates how the priorities work towards improving people's outcomes as identified in 'Our health, our care, our say'[6] .

Improving health and emotional well-being

"Services promote and facilitate the health and emotional well-being of people who use the services"

Our priorities for the next 5 years	How we will know this has been achieved
Continue to build on successful support and services and change and adapt support available, as appropriate, to meet people's needs	Internal care pathways and support arrangements will be reviewed
Address barriers to accessing support: information; timely support; transport and finances	Service use data will demonstrate equality of access to support
Investigate opportunities for using existing resources in creative ways to meet people's needs	New and innovative support options will be available
Continue to invest in staff development and training, including specialist dementia training	Training data will demonstrate this and outcomes for people using services will improve
Work more closely with the NHS to fund and provide support for people with dementia and their carers	A joint dementia commissioning strategy will be in place
Work with the NHS towards good quality early diagnosis and intervention	Numbers of people receiving an early diagnosis will increase
Provide accessible support for people with dementia to enable them to stay in their own homes for longer and to help with timely discharge from hospital	Data will demonstrate a greater proportion of people with dementia staying in their own homes for longer

[6] Department of Health (2006) Our health, our care, our say: a new direction for community services. London: Department of Health

Improving quality of life

"Services promote independence and support people to live a fulfilled life making the most of their capacity and potential"

Our priorities for the next 5 years	How we will know this has been achieved
Investigate opportunities for commissioning specialist dementia home care provider services	Specialist home care providers will be in place
Support current home care providers to increase staff skills and awareness of dementia	Home care providers will access training offered by the Council
Recruit staff to increase the capacity of our specialist home care	The Dementia Home Care Team will support more people
Investigate how to improve day options for people with dementia	There will be a range of day options for people with dementia
Investigate new opportunities for provision of a range of flexible respite care	There will be various respite options available
Increase awareness for carers of who to contact in an out-of-hours emergency	Emergency Duty Team will be responding to more people with dementia
Work with housing providers and other teams within the Council to address accommodation needs of people with dementia	Appropriate accommodation will be available
Provide more options of specialist dementia residential care	There will be more specialist residential care available

Making a positive contribution

"Councils ensure that people who use their services are encouraged to participate fully in their community and that their contribution is valued equally with other people"

Our priorities for the next 5 years	How we will know this has been achieved
Continue to support and value carers and their families and involve carers and people using services in the development of new initiatives	People will be involved in the Council's planning processes
Continue to support and value the work of the voluntary sector; looking at new ways to work with the voluntary sector to improve people's lives	The Council will continue to support voluntary sector organisations
Work towards increasing the number of people volunteering in dementia care, for example, by making new partnerships with colleges	There will be more volunteers working in this area
Implement a system within the Council of involving carers and people with dementia, as appropriate, in the development, monitoring and evaluation of dementia support and services, including the transforming adult social care agenda	An involvement and engagement strategy will be in place

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Increasing choice and control

"People, and their carers, have access to choice and control of good quality services, which are responsive to individual needs and preferences"

Our priorities for the next 5 years	How we will know this has been achieved
Work with carers, providers and our partners to implement supported self-assessment and individualised budgets for people with dementia and their carers	People will have personalised budgets
Promote uptake of direct payments to enable more choice for people who use dementia services and their carers	The numbers of people with dementia receiving direct payments will increase
Increased provision of Telecare and assistive technologies to enable people with dementia to stay at home	More people will have assistive technologies

Freedom from discrimination or harassment

"Those who need social care have equal access to services without hindrance from discrimination or prejudice; they feel safe & are safeguarded from harm"

Our priorities for the next 5 years	How we will know this has been achieved
In partnership with health services, work towards tests for dementia that are appropriate for people from all background and that dementia care is culturally sensitive	More people from BME groups will have an early diagnosis of dementia and have appropriate support
Improve partnership working between learning disability and dementia services	The teams will be working together to provide appropriate support
Expand the options for support for younger people with dementia	There will be more support options available
Investigate the options for having a Dementia Care Adviser role, which could be a single point of contact for people to access advice and support	A Dementia Care Adviser role will be in place at CMHTOA
Investigate ways to increase people's awareness of dementia, both in the general population and in health and social care workers	Awareness raising activities will take place and be evaluated
Develop a strategic approach to inclusion and equality in dementia care, including addressing the needs of Lesbian, Gay, Bisexual and Transgender people (LGBT)	Equality impact assessments will be conducted on all new services and plans
Specialist support to continue to be available to people with multiple/complex diagnoses or sensory loss and dementia	Different teams will be working together to provide appropriate and flexible support

Economic well-being

"People are not disadvantaged financially and have access to economic opportunity and appropriate resources to achieve this"

Our priorities for the next 5 years	How we will know this has been achieved
Be aware of the financial hardships families can face and promote benefits and financial advisory services	People will access advisory services
Help people to find out different ways that social care and housing support can be funded	Measure take up of different funding streams available

Maintaining personal dignity and respect

"Adult social care provide a confidential, secure setting which respects the individual, helping to preserve people's dignity"

Our priorities for the next 5 years	How we will know this has been achieved
Wherever possible, make sure support is available in community settings and be designed to help people to maintain social contacts and a 'normal' life	Continue to support voluntary sector activities which advocate this ethos. More people will access support in the community
Encourage all providers of dementia support to access safeguarding training and we will require all providers we contract with to sign up to the adult safeguarding policy and access safeguarding training	More providers will access safeguarding training
Work to improve dementia care in care homes by working in partnership with providers	Contracts will be monitored and support plans in place where necessary
Promote high quality care for people with dementia at the end of life	End of life care strategy will be in place and implemented

This commissioning strategy will give rise to a detailed implementation plan that will clearly demonstrate how and when the priorities will be achieved. Relevant stakeholders will be involved in this process.

The strategy, appendices and a summary of the strategy are available at www.bracknell-forest.gov.uk/dementiacommissioningstrategy2009-2014 or from the Commissioning Team on 01344 351796.

Copies of this booklet may be obtained in large print, Braille, on audio cassette or in other languages. To obtain a copy in an alternative format please telephone 01344 352000.

Nepali

यस प्रचारको सक्षेपं वा सार निचोड चाहिं दिइने छ ठूलो अक्क्षरमा, ब्रेल वा क्यासेट सून्नको लागी । अरु भाषाको नक्कल पनि हासिल गर्न सकिने छ । कृपया सम्पर्क गनूहोला ०१३४४ ३५२००० ।

Tagalog

Mga buod/ mga hango ng dokumentong ito ay makukuha sa malaking letra, limbag ng mga bulag o audio kasette. Mga kopya sa ibat-ibang wika ay inyo ring makakamtan. Makipag-alam sa 01344 352000

Urdu

اس دستاویز کے خلاصے یا مختصر متن جلی حروف، بریل لکھائی یا پھر آڈیو کیسٹ پر ریکارڈ شدہ صورت میں فراہم کئے جا سکتے ہیں۔ دیگر زبانوں میں اس کی کاپی بھی حاصل کی جا سکتی ہے۔
اس کے لیے براہِ مہربانی ٹیلیفون نمبر **01344 352000** پر رابطہ کریں۔

Polish

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Portuguese

Podemos disponibilizar resumos ou extractos deste documento em impressão grande, em Braille ou em audiocassete. Podem também ser obtidas cópias em outros idiomas. Por favor ligue para o 01344 352000.

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Bracknell Forest Dementia LIT: Action plan. COMPLETED PRIORITIES

Introduction

National context

The National Dementia Strategy, Living Well with Dementia, was published in February 2009 and is the first ever national strategy document focussing solely on Dementia. The strategy envisions people with dementia and their carers being helped to live well with dementia at all stages of their condition and/or wherever they are within the health and social care system.

In September 2010 the Department of Health published *Quality Outcomes for people with dementia: building on the work of the National Dementia Strategy***. This publication suggests a revised implementation plan for health and social care localities and their delivery partners. This includes four priority objectives:

- good quality early diagnosis and intervention for all
- improved quality of care in general hospitals
- living well with dementia in care homes
- Reduced use of antipsychotic medication

In March 2012, the Prime Minister's Challenge on Dementia sets out 3 key commitments

- Driving improvements in Health and Care
- **Creating dementia friendly communities (The action plan looks at how Bracknell Forest can achieve this)**
- Better research

Local context

The Bracknell Forest commissioning strategy for people with dementia 2009 – 2014 was developed in light of the National Dementia Strategy. This local strategy demonstrates how we are working towards improving people's outcomes as identified in '*Our health, our care, our say'*. The headings highlighted in blue relate to the outcomes identified in '*Our health, our care, our say'* and the Bracknell Forest Dementia Strategy.

The Bracknell Dementia Sub LIT has been meeting to implement the actions in Bracknell Forest's dementia strategy for three years and many significant outcomes have been achieved. This re-freshed action plan aims to detail what has been achieved so far and what actions are needed to meet the remaining needs as identified by the local strategy and takes into account the four identified themes from the September 2010 publication.

Those tasks and priorities which have been addressed can be found on a separate document entitled "Dementia LIT actions April 2012"

Bracknell Forest Dementia LIT: Action plan. COMPLETED PRIORITIES

Priority identified in BF strategy	Outcome	Actions	Target Date	Lead
1. Improving health and emotional wellbeing				
1.1Continue to build on successful support and services and change and adapt support available, as appropriate, to meet people's needs	Home Treatment Team fully operational.		Complete	
1.2 Address barriers to accessing support: information; timely support; transport and finances **NDS objective 3,4**	No waiting list Home Treatment Team in place Dementia Advisor is a substantive post – people able to access accurate information easily and early on. Duty Officer in place		complete	
1.3 Use existing resources in creative ways to meet people's needs and increase day activity hours **NDS objective 6**	Personalisation/ Personal budgets Direct Payments accessible to older adults. Timebank up and running Heathlands – doubled day activity hours.		Complete	
1.4 Continue to invest in staff development and training, including specialist dementia training **NDS objective 1,13**	As per routine practice: All CMHT (OA) staff undertake Dementia training.		Complete	
1.5 Work more closely with the NHS to fund and provide support for people with dementia and their carers **NDS objective 14**	CMHT (OA) is an integrated team Dementia Advisor post		Complete	

1.6.Work in partnership towards good quality early diagnosis and intervention **NDS objective 2**	Dementia Advisor in place offering advice and support soon after diagnosis. *This is high on the Next Generation Care agenda.*		Complete	
1.7 Provide accessible support for people with dementia to enable them to stay in their own homes for longer and to help with timely discharge from hospital (intermediate care/re-ablement) **NDS objective 6,9**	Dementia Advisor in post Dementia Home Treatment Team established Community Support and Wellbeing (Dementia) Team established Telecare helps people to remain in their own homes for longer.		Complete Complete Complete Complete	
2. Improving quality of life				
2.1 Commission specialist dementia home care provider services **NDS objective 6**	Community Support and Wellbeing Team – Dementia. Team fully operational.		Complete	
2.2 Support current home care providers to increase staff skills and awareness of dementia **NDS objective 1,6,13**	Dementia training is available to providers through the council. This is no longer a free provision. Extended handover is part of common practice when people stop receiving support from Community Support and Wellbeing (Dementia) Team and start receiving support from an agency. Ladybank and Heathlands have purchased specialist dementia training and this is made available to providers who are asked to cover the cost of the workbooks (£2 each). Completion of this training is worth credit towards a diploma.			
2.3 Recruit staff to increase the capacity of BF in-house specialist home	Recruited 3 new staff since October 2009		Complete	

care **NDS objective 6**	Community Support and Wellbeing Team (Dementia) up and running.			
2.4 Improve day options for people with dementia **NDS objective 6**	Dementia Advisor 'user-led' group. Woodlands closed. All people with dementia will have a personal budget – this can be managed on their behalf if necessary. The revamp at Heathlands Day Centre has doubled the amount of day care places available		Complete	
2.5 Enable new opportunities for provision of a range of flexible respite care **NDS objective 6**	Carers able to access respite drop in service Carers able to use personal budgets to access identified respite need. Princess Royal Trust Carer's Service in place	6 month pilot @ Heathlands	Complete Complete Complete	
2.6 Increase awareness for carers of who to contact in an out-of-hours emergency **NDS objective 3,4**	Information given on care plan Answer phone message gives Emergency Duty Team number		Complete	
2.8 Provide more options of specialist dementia residential care.	Heathlands Residential Home registered and in use for Dementia Care.		Complete	
2.9 Improve quality of general hospital care for people with dementia **NDS objective 1,8**	*Linked to Next Generation Care* Berks East – Mental health liaison service (2 specialist nurses) in place at Heatherwood and Wrexham park. Berks West – Mental health liaison service at Royal Berks		Complete Complete	
3. Making a positive contribution				
3.1 Continue to support and value	Carers members of the Local Implementation Team,		Complete	

carers and their families and involve carers and people using services in the development of new initiatives **NDS objective 7**	Dementia Advisor sub-lit group. Carer's able to access 'Understanding Dementia' courses. Carers instrumental in running of User Led Group. Carer aware, e-learning tool available. Carer's drop in respite service available at Heathlands.			
3.2 Continue to support and value the work of the voluntary sector; looking at new ways to work with the voluntary sector to improve people's lives	Voluntary sector representatives within Local Implementation Team. Team supports Alzheimer's Café and other voluntary carer's groups.		Complete	
3.4 Implement a system of involving carers and people with dementia, as appropriate, in the development, monitoring and evaluation of dementia support and services, including the transforming adult social care agenda **NDS objective 5,7**	Terms of Reference detail the membership of carers and people with dementia within the Local Implementation Team. Patient experience tracker. People who access services and their carer's evaluating Dementia Advisor service.		Complete	
4. Increasing choice and control				
4.1 Work with carers, providers and our partners to implement supported self assessment and individualised budgets for people with dementia and their carers.	All new referrals and people at point of review complete an SSAQ, giving them access to personal budgets		Complete	
4.3 Increased provision of Telecare and assistive technologies to enable people with dementia to stay at home	Telecare champion in place within CMHT (OA). Telecare lead in OP LTC team Telecare explored as an option when supporting people with arranging their support through their personal budget.		Complete	
5. Freedom from discrimination or harrassment				

5.1 In partnership, work towards tests for dementia that are appropriate for people from all backgrounds **NDS objective 2**	Variety of test formats in use – no service deficit reported		Complete	
5.4 Investigate the options for having a Dementia Advisor role	Dementia Advisor in post		Complete	
5.6 Develop a strategic approach to inclusion and equality in dementia care, including addressing the needs of LGBT people **NDS objective 2**	Met through holistic assessment		Complete	
5.7 Specialist support to continue to be available to people with multiple/complex diagnoses or sensory loss and dementia	Available through CMHT (OA) and Sensory Needs Service		Complete	
5.8 Ensure dementia care is culturally sensitive **NDS objective 2**	Met through holistic assessment		Complete	
6 Economic wellbeing				
6.1 Be aware of the financial hardships families can face and promote benefits and financial advisory services **NDS objective 3,4**	Holistic assessment by all of team gives this information. Dementia Advisor gives this information to newly diagnosed. Financial team also advises Publication available for self funders and their families considering residential care – financial advice re how to pay for this.	 Establish working group Produce publication	Complete Complete Complete Complete Complete	
6.2 Help people to find out different ways that social care and housing	Holistic assessment by all of team gives this information.		Complete	

support can be funded **NDS objective 3,4,10**	Dementia Advisor gives this information to newly diagnosed. Financial team also advises.			
7. Maintaining personal dignity and respect				
7.2 Encourage all all providers of dementia support to access safeguarding training and we will require all providers we contract with to sign up to the adult safeguarding policy and access safeguarding training.	This is now a contractual requirement of all providers.		Complete	
7.3 Work to improve dementia care in care homes by working in partnership with providers **NDS objective 1,11,13**	Regular monitoring of individual's wellbeing whilst in a care home by CPNs and Social Workers. Care homes phone duty team for advice on dementia issues.		Complete	
7.4 Promote high quality care for people with dementia at the end of life **NDS Objective 12**	Care home staff, District Nurses and CR&R staff attend End of Life training		Complete	

** Quality outcomes for people with dementia: building on the work of the National Dementia Strategy
First published: September 2010

1. Good quality early diagnosis and intervention for all - Two thirds of people with dementia never receive a diagnosis; the UK is in the bottom third of countries in Europe for diagnosis and treatment of people with dementia; only a third of GPs feel they have adequate training in diagnosis of dementia.

2. Improved quality of care in general hospitals - 40% of people in hospital have dementia; the excess cost is estimated to be £6m per annum in the average General Hospital; co-morbidity with general medical conditions is high, people with dementia stay longer in hospital.

3. Living well with dementia in care homes - Two thirds of people in care homes have dementia; dependency is increasing; over half are poorly occupied; behavioural disturbances are highly prevalent and are often treated with antipsychotic drugs.

4. Reduced use of antipsychotic medication - There are an estimated 180,000 people with dementia on antipsychotic drugs. In only about one third of these cases are the drugs having a beneficial effect and there are 1800 excess deaths per year as a result of their prescription.

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Bracknell Forest Dementia Strategy

The story so far!

Bracknell Forest Council

What we have achieved

Improve access to personalised support in the community where appropriate.

- Holistic assessment
- Home Treatment Team
- Community Support and Wellbeing (Dementia) Team
- Dementia Advisor
- Duty Officer
- Personalisation
- Healthlands revamp = Doubled the amount of day centre places
- Woodlands closed
- The Forgetters
- Telecare

Bracknell Forest Council

What we have achieved

Skilled and experienced support in all settings

- All CMHT (OA) staff undertake specialist Dementia training
- Extended handover from Community Support and Wellbeing (Dementia) Team to agencies
- Specialist Dementia training available being rolled out internally (Council and Trust)
- Heathlands now registered as Dementia Care Home

Bracknell Forest Council

What we have achieved

Support for carers

- Carers' drop in respite at Heathlands
- Personal budgets for carers
- The Forgetters
- 'Carer aware' e-tool available
- 'Understanding Dementia' course
- Carers members of LIT
- Carers key to Dementia Advisor evaluation

Bracknell Forest Council

What we have achieved

Support to access financial advice

- Dementia Advisor
- Financial Team
- ‘Funding your own care’ booklet

Bracknell Forest Council

What we are still working on

- Specialist dementia training available for providers
- 3 step down beds within East Berkshire
- Extra sheltered housing (target 2014)
- Permanent funding of mental health liaison service at Heatherwood and Wexham Park
- Frimley – specialist dementia ward for people receiving general treatment
- Increase number of volunteers at Healthlands
- One day for younger people with dementia at Healthlands
- Care home and community staff to complete End of Life training
- All agencies contractual obligation to train staff in dementia awareness and adult safeguarding

Bracknell Forest Council

Priorities for 2012 – 2014?

- Improve statistical recording and joint working
- Roll out Dementia Training to other teams
- Become a recognised ‘Dementia Friendly Community’
- Increase number of people with dementia and carers with a personal budget
- Develop the market to encourage use of personal budgets
- Dementia resources
- Reduce use of antipsychotic medication
- Develop Dementia Advisor website

- And….?

Bracknell Forest Council

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HEALTH OVERVIEW AND SCRUTINY PANEL
14 JUNE 2012

QUALITY ACCOUNTS
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report invites the Health Overview and Scrutiny (O&S) Panel to note the letters sent to five NHS Trusts on their Quality Accounts for 2011-12, and the three responses received.

2 RECOMMENDATIONS

2.1 That the Health Overview and Scrutiny Panel notes the letters sent to five NHS Trusts on their quality accounts for 2011-12, and the responses received.

3 SUPPORTING INFORMATION

3.1 All providers of NHS healthcare services in England, whether they are NHS bodies, private or third sector organisations must publish an annual Quality Account. Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement.

3.2 Quality Accounts are published on the NHS Choices website and providers also have a duty to display a notice at their premises with information on how to obtain the latest Quality Account; and to provide hard copies on request.

3.3 Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the O&S Committee (or Panel) in the local authority area in which the provider has its registered office, inviting comments on the report from O&S prior to publication. This gives O&S the opportunity to review the information contained in the report and provide a statement on their view of what is reported. Providers are legally obliged to publish this statement (of less than 1000 words) as part of their Quality Account.

3.4 A Working Group of the Health O&S Panel considered the Quality Accounts of the NHS Trusts servicing Bracknell Forest Residents and decided to send the letters attached at Appendices 1-5. Three NHS Trusts responded, reproduced at Appendix 6.

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

Background Papers

'Quality Accounts: a guide for Overview and Scrutiny Committees' – Department of Health, 2011

Contact for further information

Richard Beaumont – 01344 352283
e-mail: richard.beaumont@bracknell-forest.gov.uk

Appendix 1

Bracknell Forest Council

Julian Emms
Acting Chief Executive Officer
Berkshire Healthcare NHS Trust
Fitzwilliam House
(2nd/3rd Floors)
Skimped Hill Lane
Bracknell
RG12 1LD

By email to:
Julian.Emms@berkshire.nhs.uk

Date: 24/04/2012

Dear Julian,

TRUST'S QUALITY ACCOUNT 2011/12

Thank you for inviting the views of Bracknell Forest Council's Health Overview and Scrutiny Panel on the Trust's Quality Account for 2011/12.

The Panel has the following comments:

1. We would like to see more about how the Trust proposes to respond to the higher incidence of mental health problems, as highlighted in the recent Joint Strategic Needs Assessment.
2. Given the recent consultation process and changes to concentrate in-patient care at Prospect Park in Reading we would have thought that this merited inclusion in the Trust's priorities for improvement in the coming year. Also, there should be a clear way forward on the mitigation of additional travel costs for patients and their visitors.
3. In the draft report at 2.1.3a there is a significantly lower offer rate at Bracknell. This 15% below target has not been commented on and we would be interested in the reasons for it.
4. Working with the Clinical Commissioning Groups is increasingly important. The priority focuses on initiatives to better meet the mental health needs of people with long term physical health conditions such as respiratory disease, heart disease and musculoskeletal problems. It also seeks to enhance the physical health care of

people with mental health problems. It is vital to work effectively with GPs to better meet these objectives.

5. The Panel would welcome the Trust providing more facilities for addressing Autism needs.
6. The Panel is concerned that Berkshire Healthcare Foundation Trust's Information Governance Assessment Report overall score for 2011/12 was 68% and was graded amber (unsatisfactory).

With best wishes,

Councillor Tony Virgo
Chairman, Health Overview & Scrutiny Panel

Copies to: Councillor Birch; Director of Adult Social Care, Health & Housing
Email Copy to Amanda.Mollett@berkshire.nhs.uk

Appendix 2

Bracknell Forest Council

Andrew Morris
Chief Executive
Frimley Park Hospital NHS Trust
Portsmouth Road
Frimley
Surrey
GU16 7UJ

By email to:
andrew.morris@fph-tr.nhs.uk

Date: 24/04/2012

Dear Andrew,

TRUST'S QUALITY ACCOUNT 2011/12

Bracknell Forest Council's Health Overview and Scrutiny Panel has the following views on the Trust's Quality Account for 2011/12:

1. We were delighted to hear of the developments and standards of the Trust when the Panel was addressed recently by CEO Andrew Morris. The Panel will shortly be taken on a tour around the hospital and see the new A and E suite being constructed.
2. The Strategic Health Authority should endeavour to spread the best practice from this highly performing Hospital Trust to other NHS establishments across the South of England.
3. Working with the Clinical Commissioning Groups is increasingly important, and we would welcome more information on how the Trust will embrace that change.

With best wishes,

Councillor Tony Virgo
Chairman, Health Overview & Scrutiny Panel

Copies to: Councillor Birch; Director of Adult Social Care, Health & Housing
Email Copy to James.Taylor@fph-tr.nhs.uk

Appendix 3

Bracknell Forest Council

Philippa Slinger
Chief Executive
Heatherwood & Wexham Park NHS Trust
Wexham Street
Slough
Berkshire
SL2 4HL

By email to:
Philippa.slinger@HWP-tr.nhs.uk

Date: 23/04/2012

Dear Philippa,

TRUST'S QUALITY ACCOUNT 2011/12

Thank you for inviting the views of Bracknell Forest Council's Health Overview and Scrutiny Panel on the Trust's Quality Account for 2011/12.

The Panel has the following comments:

1. We remained concerned about the acute financial situation of the Trust and the condition of the building and facilities at Heatherwood hospital. While the Panel is totally committed to the creation of a Healthspace at Bracknell with an urgent care facility, we want to encourage the Trust to find suitable partners to make a much needed investment to the Heatherwood site and commission service that are sustainable services that are cost effective and complementary to the Healthspace.
2. We want to see the Trust reduce further the reliance on agency staff and build a more stable workforce that encourages leading clinicians in their particular field to join the team.
3. The Panel also wants to see the Trust commission consultants to be available during the weekend.
4. Perhaps it would also be helpful in the report if the Trust could distinguish the specific work carried out at individual sites to help us understand the whole picture. The breakdown of services at individual sites is listed on page 5.
5. We are encouraged to see the Trust improving their IT systems in order to respond more quickly to demand and a fast changing picture of activity. We are also delighted

that the priories include a better booking system and rates of cancelled hospital generated appointments have reduced.

6. We are also delighted to see infection rates decline (page 27/28).
7. Working with the Clinical Commissioning Groups is increasingly important, and we would welcome more information on how the Trust will embrace that change.

We are pleased to see the improved communications with the Trust since you took up post and we look forward to continuing working with you to improve services.

With best wishes,

Councillor Tony Virgo
Chairman, Health Overview & Scrutiny Panel

Copies to: Councillor Birch; Director of Adult Social Care, Health & Housing
Email Copy to penny.coventry@hwph-tr.nhs.uk

Appendix 4

Bracknell Forest Council

Edward Donald
Chief Executive
Royal Berkshire NHS Foundation Trust
London Road
Reading
RG1 5AN

By email to:
Edward.donald@royalberkshire.nhs.uk

Date: 24/04/2012

Dear Ed,

TRUST'S QUALITY ACCOUNT 2011/12

Thank you for inviting the views of Bracknell Forest Council's Health Overview and Scrutiny Panel on the Trust's Quality Account for 2011/12.

The Panel has the following comments:

1. We warmly welcome the opening of the Trust's clinic at Brant's Bridge, Bracknell, and we look forward to it being used more by Bracknell Forest residents.
2. We are concerned that the turnaround time for ambulances attending the Royal Berkshire Hospital in Reading is sometimes slow, particularly when A&E is at capacity and we would like to see improvements made to reduce this delay.
3. We would like to see as priority *Clostridium Difficile* infection rates reduced. On page 6, it states that current rates are above target.
4. Working with the Clinical Commissioning Groups is increasingly important, and we would welcome more information on how the Trust will embrace that change.

With best wishes,

Councillor Tony Virgo
Chairman, Health Overview & Scrutiny Panel

Copies to: Councillor Birch; Director of Adult Social Care, Health & Housing
Email Copy to Hester.Wain@royalberkshire.nhs.uk

Appendix 5

Bracknell Forest Council

William Hancock
Chief Executive
South Central Ambulance Service NHS Foundation Trust,
Unit 7 and 8, Talisman Business Centre
Talisman Road
Bicester
Oxfordshire
OX26 6HR

By email to: Will.Hancock@scas.nhs.uk

Date: 24/04/2012

Dear Will,

TRUST'S QUALITY ACCOUNT 2011/12

Thank you for inviting the views of Bracknell Forest Council's Health Overview and Scrutiny Panel on the Trust's Quality Account for 2011/12.

The Panel has the following comments:

1. The Panel congratulates the Trust on achieving Foundation Trust status. This was a major achievement.
2. We are pleased to see the continued improvements and areas of excellence from the Trust.
3. The Panel was concerned that the Trust was still relying on the availability of freelance staff and vehicles for its operations including emergency call outs. We would like to see this figure reduced (paragraph 1.1 page 25).
4. We are encouraged to see ambulance call out time continued to improve.
5. We commend the drive to reduce hospital handover delays, led by SCAS.
6. Working with the Clinical Commissioning Groups is increasingly important, and we would welcome more information on how the Trust will embrace that change.

With best wishes,

Councillor Tony Virgo
Chairman, Health Overview & Scrutiny Panel

Copies to: Councillor Birch; Director of Adult Social Care, Health & Housing
Email Copies to duncan.burke@scas.nhs.net; fizz.thompson@scas.nhs.uk

Appendix 6

From: Wain Hester [mailto:Hester.Wain@royalberkshire.nhs.uk]
Sent: 24 April 2012 12:22
To: Richard Beaumont
Subject: RE: Quality Accounts - Observations by Bracknell Forest Council

Dear Richard,

Thank you for your comments. I will add these verbatim to the Quality Accounts, where we will respond to the areas you have raised.

Yours sincerely,
Hester

From: Mollett Amanda [mailto:Amanda.Mollett@berkshire.nhs.uk]
Sent: 24 April 2012 15:24
To: Richard Beaumont; Emms Julian
Cc: Wilson Justin
Subject: Quality Accounts - Observations by Bracknell Forest Council

Dear Richard

I would like to thank the panel and chair for reviewing the Draft Trust Quality Account.

Following verbal feedback received last week, the draft Trust Quality Account has been updated to reflect the following two points which were raised (attached):

1. Reference to the plans for Prospect Park Hospital in terms of a centre for excellence, this is now included within the statement section of the document.
2. Concerns around the offer rate for physical health checks in 2.1.3a for Bracknell being lower than other localities, the year end data for physical health checks has now been updated, the table 2.1.3a on page 14 now demonstrates that 99% of Bracknell clients were offered a physical health check exceeding the target of 80%.

With regards to the other points included within the Chairs formal comments received today, we will review and consider them prior to the final Trust Quality Account being received and signed off by the Board on 8th May.

Best Wishes

Amanda

Amanda Mollett
Head of Clinical Effectiveness and Audit
Berkshire Healthcare NHS
Foundation Trust

South Central Ambulance Service NHS
NHS Foundation Trust

Chief Executive Office
Northern House
Units 7&8, Talisman Business Centre
Talisman Road
Bicester
OX26 6HR

will.hancock@scas.nhs.uk
Tel: 01869 365031

2 May 2012

Health Overview and Scrutiny Panel
Bracknell Forest Council
East Hampstead House
Town Square
BRACKNELL
RG12 1AQ

Dear Councillor Virgo,

Thank you for your response to the Trust's Quality Account 2011-12. It is important to us that we include your views and comments.

I, the Chairman and all of our teams in the organisation are delighted that we achieved Foundation Trust status. Driving our quality agenda and making continuous improvements to care delivery, patient experience and clinical effectiveness is a key element of our commitment to ensuring the highest quality pre-hospital healthcare.

We do know, however, that there is work to do with our acute trust partners around delays at hospitals and we are actively involved in reducing these delays in the interest of patient experience and safety.

South Central Ambulance Service NHS Foundation Trust will be working proactively with the new Clinical Commissioning Groups to plan and commission the delivery of health services which are responsive to patients' needs.

If you require any further information please do not hesitate to contact either Duncan Burke at duncan.burke@scas.nhs.uk or Fizz Thompson, Executive Director of Patient Care at fizz.thompson@scas.nhs.uk

Yours sincerely

Will Hancock
Chief Executive

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HEALTH OVERVIEW AND SCRUTINY PANEL
14 JUNE 2012

WORKING GROUPS UPDATE REPORT
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report provides an update on the Working Groups of the Health Overview and Scrutiny Panel.

2 RECOMMENDATIONS

2.1 That the Health Overview and Scrutiny Panel notes the progress achieved to date by the Panel's Working Groups.

3 SUPPORTING INFORMATION

Health Reforms

3.1 The Working Group comprises Councillors Finch (Lead Member), Mrs Angell, and Virgo. It has been formed to monitor the implementation of the major changes from the 2010 NHS White Paper and the Health and Social Care Bill, with a particular focus on the transfer of public health responsibilities to the Council. The Working Group has held two meetings to date, most recently on 17 November 2011. The Group decided to suspend further meetings of the Working Group until the legislative changes became known. Following enactment of the Health and Social Care Act, a further meeting of the Working Group has been arranged for 7 June.

Health and Well Being Strategy

3.2 The Working Group comprises Councillors Virgo (Lead Member), Baily, Finch, and Mrs Temperton; and Mr Pearce. It has been formed to make an input to the Council's statutory 'Health and Well Being' strategy, and to monitor the creation of the Health and Well Being Board. The Working Group has held two meetings to date, most recently on 6 December 2011. The Group are due to meet next on 6 June, to further engage in the development of the new Health and Well Being Strategy.

'Shaping the Future' of Health Services in East Berkshire

3.3 The Chairman has decided to form a Working Group to consider the forthcoming major consultation by NHS Berkshire (Primary Care Trust) and Heatherwood & Wexham Park Hospitals Trust on 'Shaping the Future'. This is aimed at reconfiguring healthcare services in response to the changing national and local clinical priorities. The planned timetable for the consultation has been deferred by the NHS, and the Working Group has not yet been formed. Meanwhile, the Chairman and Vice Chairman have continued informal discussions with the Chairmen of the Health Scrutiny Committees for Buckinghamshire County Council, Slough BC, and RB Windsor & Maidenhead, the PCT and Heatherwood and Wexham Park Hospitals Trust on developments.

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

Background Papers

None

Contact for further information

Richard Beaumont – 01344 352283
e-mail: richard.beaumont@bracknell-forest.gov.uk