Bracknell Forest Council

NOTICE OF MEETING

Health Overview and Scrutiny Panel
Tuesday 7 January 2014, 7.30 pm
Function Room, Fifth Floor, Easthampstead House, Town Square, Bracknell

To: The Health Overview and Scrutiny Panel

Councillor Virgo (Chairman), Councillor Mrs McCracken (Vice-Chairman), Councillors Mrs Angell, Baily, Finch, Kensall, Mrs Temperton, Thompson and Ms Wilson

cc: Substitute Members of the Panel

Councillors Allen, Brossard, Davison, Ms Brown and Heydon

Observer: Clare Turner, Healthwatch Bracknell Forest

There will be a private meeting for members of the Panel at 7.00pm in the Function Room.

ALISON SANDERS
Director of Corporate Services

EMERGENCY EVACUATION INSTRUCTIONS

1 If you hear the alarm, leave the building immediately.
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3 Use the stairs not the lifts.
4 Do not re-enter the building until told to do so.

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Published: 6 January 2014

Health Overview and Scrutiny Panel
Tuesday 7 January 2014, 7.30 pm
Function Room, Fifth Floor, Easthampstead House, Town Square, Bracknell

AGENDA

Page No

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

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

2. **Minutes and Matters Arising**

   To approve as a correct record the minutes of the meeting of the Health Overview and Scrutiny Panel held on 3 October 2013. 1 - 8

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

   Members are requested to declare any Disclosable Pecuniary Interests and/or Affected Interests and the nature of those interests, including the existence and nature of the party whip, in respect of any matter to be considered at this meeting.

   Any Member with a Disclosable Pecuniary Interest or an Affected Interest in a matter should withdraw from the meeting when the matter is under consideration and should notify the Democratic Services Officer in attendance that they are withdrawing as they have such an interest. If the Interest is not entered on the register of Members interests the Monitoring Officer must be notified of the interest within 28 days.

4. **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.

5. **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.

6. **Departmental Performance**

   To consider the parts of the Quarter 2 2013/14 (July to September) quarterly service report of the Adult Social Care, Health and Housing department relating to public health, to include a progress briefing on Public Health activities and the Public Health Survey. 9 - 42

   Please bring the previously circulated Quarterly Service Report to the meeting. Copies are available on request and attached to this

agenda if viewed online.

7. **Integration of Health and Social Care**

To receive an update on the Government's plans for the further integration of health and social care. 43 - 70

8. **2014/15 Draft Budget Proposals**

To consider key themes and priorities for the Public Health element of the Council's draft budget proposals for 2013/14. 71 - 74

Panel members are asked to raise any detailed questions with finance officers in advance of the meeting.

9. **Applying the Lessons of the Francis Report for Health Overview and Scrutiny**

To consider and adopt the report of the Panel's Working Group which reviewed the lessons of the report by Robert Francis QC for Health Overview and Scrutiny. 75 - 124

10. **The Patients' Experience**

To consider the current information from the NHS Choices website, for the NHS Foundation Trusts providing most NHS services to Bracknell Forest residents. 125 - 130

11. **Working Group Update and 2014/15 Work Programme**

To receive a report on the progress of the Panel's Working Groups. 131 - 134

To propose items for inclusion in the Panel's work programme for 2014/15.

12. **Executive Key and Non-Key Decisions**

To consider scheduled Executive Key and Non-Key Decisions relating to Health. 135 - 140

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

To note the Bi-Annual Progress Report of the Assistant Chief Executive. 141 - 152

14. **Date of Next Meeting**

13 March 2014

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HEALTH OVERVIEW AND SCRUTINY PANEL
3 OCTOBER 2013
7.30 - 9.00 PM

Bracknell Forest Council

Present:
Councillors Virgo (Chairman), Mrs McCracken (Vice-Chairman), Mrs Angell, Kensall, Mrs Temperton, Thompson and Ms Wilson

Also Present:
Richard Beaumont, Head of Overview & Scrutiny (O&S)
Glyn Jones, Director of Adult Social Care, Health & Housing
Lisa McNally, Public Health Consultant
Chris Taylor, Local Healthwatch Co-ordinator
Clare Turner, Local Healthwatch

Apologies for absence were received from:
Councillors Baily and Finch

20. **Minutes and Matters Arising**

The minutes of the Panel held on 19 August 2013 were approved as a correct record and signed by the Chairman.

Matters Arising:

Minute 18: Heatherwood and Wexham Park Hospitals
The Panel queried whether the Care Quality Commission (CQC) should be invited to the Panel meeting on 7 January 2014 alongside the Heatherwood and Wexham Park NHS Trust to discuss progress with their action plan. It was noted that the CQC were planning an unannounced inspection at Wexham Park Hospital over the next 12 months. The Chairman agreed to give this further consideration and make a decision on whether to invite CQC to the next Panel meeting.

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

There were no declarations of interest.

22. **Urgent Items of Business**

There were no items of urgent business.

23. **Public Participation**

There were no submissions from members of the public.

24. **Local Healthwatch**

The Chairman welcomed representatives from Healthwatch Bracknell Forest to the meeting, Chris Taylor and Clare Turner, who would be presenting to the Panel

around their progress in fulfilling their role, with specific reference to engaging with NHS patients and working arrangements with the Health O&S Panel. Particularly on referrals and information on patients' complaints.

Chris Taylor, Co-ordinator at Healthwatch Bracknell Forest made the following points:

- He stated that The Ark had been commissioned to provide the Healthwatch service. The Ark was part of a consortium of organisations. Healthwatch had been operational since 1 October 2013. They had produced a leaflet detailing their role and contact details. They saw their role as improving health and social care for local people and to hold care providers to account on behalf of the public. The leaflet also set out the Health O&S Panel's role and how Healthwatch would work with the Panel.
- In terms of engaging with patients, their leaflet detailed all the ways in which Healthwatch could be contacted. Over the next three months they would be carrying out a large scale publicity exercise. They aimed to attend at least one public engagement each week to make sure that their presence was felt in all wards and neighbourhoods.
- They had met with the Chairman and the Head of Overview & Scrutiny and drafted a statement which set out how they would interact and work with the Health O&S Panel. They hoped to develop a close working relationship with the Panel.

Clare Turner stated that she worked for one of the consortium of organisations under The Ark, a charity called Kidz which provided play and leisure equipment for young children including disabled children. She had also worked in numerous positions within the community over her career. She had worked as a nursery nurse in Great Hollands as well as working in a number of children's centres and running her own local pre-school. She felt that over the years she had gained a wealth of knowledge about local communities and particularly families and what concerned them and what was important to them.

The Chairman stated that he welcomed this wealth of experience and looked forward to building a working relationship with Healthwatch.

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

- Healthwatch would cover social care and not just health. He suggested that Healthwatch may want to make representations to three of the Council's Overview and Scrutiny Panels but to use the Health O&S Panel as their conduit for doing this.
- He hoped to see a meaningful, open and trusting relationship develop with Healthwatch and for Healthwatch to become the organisation that represented the patient voice and the users of local health and social care services. He felt that one of the key strengths of The Ark were that they could call on numerous representative groups, as The Ark represented a consortium of organisations.
- He stated that referrals should work both ways, there may be a piece of work where the Panel feel it would be good to get Healthwatch's input. Healthwatch would be another resource to draw on and the Panel should take this into account.
- It was also key to remember that Healthwatch were a statutory board member of the Health & Wellbeing Board and so would influence an input to the work of the Board also. A workshop had been arranged for the Board

and Healthwatch later in October, to which the Panel Chairman and Deputy Chairman had also been invited.

The Panel asked how the Ark had been selected for this role. The Director explained that there had been a competitive procurement process and the contract award had been a competitive procurement process and the contract award had been a decision by the Executive Member for Adult Services, Health and Housing.

The Panel asked how many people were employed by Healthwatch.
The Healthwatch Co-ordinator reported that he was the only full time employee and reported to the Board of members. They also had access to a consortium of representative groups which would be invaluable.

The Panel asked how Healthwatch would reach those people who weren't represented on these groups.
The Healthwatch Co-ordinator reported that they would be attending a range of events in the community on a weekly basis in an attempt to reach a wide range of people. They had already attended an event at Great Hollands and they would be attending the Bracknell Forest Careers Event in the following week and also hoped to use volunteers to stand outside supermarkets and other locations to gather views from the community. Their publications were also available in a number of community locations, including surgeries and libraries. Some views had already been gathered around the difficulties of driving to Frimley Park hospital. Residents felt that signage was bad and there were too many roundabouts. The Healthwatch's Board would also be recruiting, through an open election, members of the public to sit on the Board. This opportunity would be advertised on Healthwatch's website and would be open to anyone who wanted to put their name forward. An election would then take place to make an appointment to the Board.

The Panel asked if Healthwatch had established its list of priorities.
It was reported that this hadn't yet been established.

The Panel asked if Healthwatch would essentially be a mailbox.
It was reported that Healthwatch would have the power to escalate things and move issues on. They could also be commissioned to carry out work by the Panel.

The Panel asked how Healthwatch would be opening up channels to ensure they had access to all complaints information from all the major hospitals in the area.
It was reported that Healthwatch had made arrangements to access all quality accounts. The Healthwatch Co-ordinator was keen to be clear that whilst Healthwatch could signpost they were not a complaints service. It was noted that the Panel would be receiving some complaints information from all major local hospitals.

The Panel asked if there would be a fee if Healthwatch called on the services of the organisations in their consortium.
It was confirmed that there would be no additional charge, for example one of the consortium organisations was 'Support, Empower, advocate, Promote (SEAP) and they were contracted to provide an NHS complaints advocacy service.

The Panel recognised Healthwatch's role as an advocate for residents and as a conduit to ensure residents got the help and support they needed from relevant organisations. The Panel asked what action Healthwatch would be taking directly themselves to support residents.
The Healthwatch Co-ordinator stated that it would depend on the severity of the issue; if it was a serious issue they would contact Healthwatch England and/or the Care Quality Commission.

The Public Health Consultant reported that she was happy to offer her help and support to Healthwatch particularly through the information and public views that would be collected for the Joint Strategic Needs Assessment.

The Head of Overview and Scrutiny reported that it was a legal requirement to adopt a statement to capture what the Panel would be aiming to achieve through its interaction with Healthwatch. With the assistance of officers and the Borough Solicitor, a statement had been drafted for members to consider. The draft statement had also be sent to the chairmen of the Adult Social Care & Housing O&S Panel and the chairman of the Children, Young People & Learning O&S Panel.

It was **AGREED** that the Panel:

i) considered the progress achieved to date by Healthwatch Bracknell Forest,

ii) endorsed the following draft protocol regarding O&S joint working with Healthwatch Bracknell Forest:

Healthwatch Bracknell Forest (HWBF) and Bracknell Forest Council's Overview and Scrutiny (O&S) are committed to the establishment of a mutually supportive and beneficial relationship through partnership working. The Council's Health O&S Panel (HO&SP) will take the lead on this relationship, referring matters to other O&S Panels as appropriate.

HWBF will provide evidence based feedback, attend HO&SP meetings as an observer, relevant workshops and working groups.

O&S may refer issues to HWBF for investigation or may commission HWBF to research evidence.

HWBF may refer matters to O&S for the purposes of securing information and expertise.

In accordance with The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 (SI 2021:3094), HWBF will escalate issues as necessary to the HO&SP. The respective O&S Panel has an obligation to acknowledge HWBF referrals within 20 working days of receipt.

25. **Departmental Performance**

The Panel were asked to consider the parts of the Quarter 1 2013/14 (April to June) quarterly service report (QSR) of the Adult Social Care, Housing and Health department relating to health. The Director of Adult Social Care, Health & Housing felt it was important that the Panel considered these performance reports in order to monitor the department's performance in terms of health.

The Director of Adult Social Care, Health & Housing reported that it had been an important quarter; much of the department's preparatory work around Public Health was now coming to fruition. He was genuinely pleased with the way this work was progressing; additional funding had been put into the budget for public health to pump

prime opportunities beyond those projects handed over by the former Primary Care Trust. A good set of projects had been funded from across Council directorates.

He reported that there had been a drive by the Minister for Health to encourage integration work. £9.6bn nationally had been dedicated to promoting integration, it was noted that some of this comprised existing funding. Pioneer status was being offered to authorities that participated in this work. It had been agreed locally that pioneer status would not bring any additional benefits locally and so was not being pursued.

He also reported that some work had been undertaken by the department to identify frequent users of social care and NHS services and then the department had worked with health partners to ensure these individuals were getting the best and most efficient use of overall resources. This had provided a strong basis and platform for beginning the journey of working together with these service users.

The Director expressed that he was grateful to health partners for their comments on in reach services. In addition, the team that delivered in reach services had been nominated for the South West team of the year award. He and the team were delighted about this and he would be drafting some publicity on this. The Chairman congratulated the Director and his staff for their excellent work in this area on behalf of the Panel.

The Chairman observed that asthma was very prevalent in the area and asked what preventative work was being undertaken to tackle this.
The Director reported that priorities would shape preventative work, for example, it was already clear that smoking was responsible for the premature death of significant numbers of local people. The Public Health Consultant added that they would be attempting to achieve a seamless delivery of preventative work. This would involve working jointly with NHS partners and colleagues in social care to ensure priorities for preventative work was in all their work streams.

The Chairman asked if members should consult the Joint Strategic Needs Assessment (JSNA) for information about health in their wards.
The Public Health Consultant reported that the Public Health Survey would provide a first hand source of live data and would provide ward level data. The JSNA would take an interactive web based format and contributions would be provided from across a range of partners. There would be a drive to ensure that the data was as complete as it possibly could be. The Panel welcomed this.

The Director agreed to provide the Panel with an interim report on the Public Health survey at their January 2014 meeting if the agenda permitted.

The Panel queried the timing of the QSR's as the report before them was April to June and members would have liked more current information.
The Panel queried the timing of the QSR's as the report before them was April to June and members would have liked more current information.
The Head of Overview and Scrutiny reported that this issue had been previoisly addressed by a Working Group of the O&S Commission. The QSR's needed to be reported to numerous places before publication and each one was put on the agenda for the next available Panel meeting. It was noted that members could ask questions when QSR's were published rather than wait for O&S meetings. The Director agreed to provide the Panel with a brief summary of activity/performance for the period between the QSR and the O&S meeting to ensure information was as current as possible.

The Chairman noted that rates of stroke and asthma remained high and cardiac problems were also high locally.

The Chairman thanked the Director and his team for their hard work and diligence.

26. **The Patients' Experience**

The report before members invited them to consider the current information from the NHS Choices website, for the NHS Foundation Trusts providing most secondary NHS services to residents.

The Head of Overview and Scrutiny invited the Panel's views on whether they would like to receive this information regularly at future meetings. This would provide a means of getting closer to the patient experience as encouraged by the Francis report. The NHS Choices website was regularly updated and provided a good high level summary of information.

The Panel agreed that some caution needed to be exercised around the information and careful attention given to the numbers of respondents for each indicator. The Panel also asked for further information around patient safety alerts; staff survey response rates, and Friends and Family test scores. The Panel also agreed it was important to understand the timeframe in which the information was gathered.

The Chairman agreed that caution needed to be exercised and that the Panel needed to become adept at considering this kind of data and forming a view.

27. **Working Group Updates**

The Lead member for the Francis Report O&S Working Group reported that the work of this group was progressing well. The outcomes from the working group would be crucial in shaping the way O&S around health scrutiny was taken forward. The working group had undertaken some valuable work and this would be shared with the Panel. At their next meeting in the upcoming week, the group would be meeting with the Chief Executive of the Heatherwood & Wexham Park NHS Trust, Philippa Slinger.

28. **Executive Key and Non-Key Decisions**

Panel members commented that the 'Healthy Voices' project had been hugely successful and had now been running for three years and it was hoped that funding could be secured for the project to continue. A bid had been submitted and partnership funding had already been secured from Lifelong learning, Adult Social Care and Public Health. If the bid was successful, funding would be secured which would be 3-4 times the amount put forward by partners.

29. **Date of Next Meeting**

7 January 2014.

CHAIRMAN

ACTIONS TAKEN : HEALTH OVERVIEW AND SCRUTINY PANEL MEETING – 3 OCTOBER 2013

Minute Number	Action Required	Action Taken
20.Minutes and Matters Arising	Invite CQC representatives to the 7 January Panel meeting alongside the Heatherwood and Wexham Park Trust to report progress.	Invitations sent on 4 October. Now being rearranged to Febuary meeting.
25. Departmental Performance	An interim report on the Public Health Survey to be submitted to the 7 January Panel meeting.	On agenda for 7 January Panel meeting
	Some slides be prepared to bring QSR data up to date at each Panel meeting, particularly when there is a large gap between the publishing of the QSR and the Panel meeting.	Ongoing
26. The Patients' Experience	Provide supplementary information on: patient safety alerts; staff survey response rates, and Friends and Family test scores	Information sent to members on 4 October

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Bracknell Forest Council

QUARTERLY SERVICE REPORT

ADULT SOCIAL CARE, HEALTH & HOUSING

Q2 2013 -14
July – September 2013

Portfolio holder:
Councillor Dale Birch

Director:
Glyn Jones

Contents

Section 1: Director's Commentary

There was significant activity in the second quarter of the year with further changes in legislation, particularly around benefits, starting to happen, as well as other developments across the department.

There have been a number of welfare changes that have been implemented in the first two quarters of the financial year. These include the benefit cap, reduction of housing benefit due to under occupation and the Council's council tax benefit scheme. Although these may have meant difficult decisions for households faced by these changes the Council continues to provide advice on managing finances and to date there has been no discernible impact on council tax arrears. As a result the risk of increased Council tax arrears has been downgraded in the Departments risk register.

In Housing, at the beginning of July the allocation policy change was implemented resulting in 330 households moving up a band as they have been waiting 6 years or more on the housing register.

The new Sensory Needs service is now up and running. The clinic was launched on 16th July. People are now able to attend and try out a wide range of specialist equipment before deciding upon what best meets their needs. Specialist visual needs assessments and rehabilitation programmes are being undertaken by preferred providers. Feedback on all aspects of the new service has to date been very positive.

The Department is delighted to report that the Community Response and Reablement (CR&R) In Reach Hospital Social Worker Team has been shortlisted for an award for the category Social Work Team of the Year, and that Linda Parsons, Registered Manager at Heathlands, is a finalist in the National Care Awards - Dementia Care Manager Category. Congratulations are due to both, and we wish them all every success at the award ceremony in November.

The Public Health teams have now fully recruited to their structures. A work program has been put in place prioritising those contracts inherited from the PCTs that should be recommissioned, with the Sexual Health contracts, as the biggest value contracts, taking precedence.

In September, the government launched the "Caring for our future" consultation document, providing much more detail on proposed changes to adult social care with the proposed introduction of the cap in social care costs for people. The Department will be responding to the consultation, and taking part in events with colleagues in other authorities to develop understanding, and start planning, for the changes.

Budget monitoring reports for the year are showing that the Department is managing early demand pressures that appeared, and although a small overspend is currently showing, the department is now on course to balance its budget. In previous years the Department produced significant underspends, aiding the Council's glidepath towards lower levels of expenditure, however a significant underspend is unlikely to be achieved this year. The department will continue to strive for efficiencies in year between budget setting rounds to help minimise the impact of budget reductions.

Delivery against actions in the Service Plan is looking very strong. Of 84 actions, 29 were already completed at the end of the second quarter, with 54 expected to be met and 1 action delayed, namely the dementia training to be provided to retailers, leisure centres and transport providers by 31 October.

There were difficulties in transferring the money to the Local Authority, following the demise of the Strategic Health Authority. This led to a significant delay to the start of this project. The provider has now selected and commissioned to deliver dementia awareness training. The project start date was 1st September 2013 with a revised completion date of April 2014.

The one action that was reported as delayed at the end of quarter 1, namely development of The Prevention and Early Intervention Guide, is now complete, and the Guide will be presented to Health and Well Being Board in December.

There was 1 indicator in quarter 2 with a current status of red:

NI 178 - Indicator NI 178 (number of household nights in B&B across the quarter): There were a higher number of homeless households who required emergency accommodation during the month of August than predicted. It is increasingly difficult to secure homes in the private rented sector for households so they can avoid homelessness. The Council will take ownership of two properties in September/ October which it has purchased to provide accommodation for homeless households and this will go some way towards meeting the increased homeless demand.

There is an apparent drop in the numbers of people receiving a Direct Payment since 2012/13. In fact the drop in reported numbers is the result of changes in what is reported as a Direct Payment, which has resulted in those carers who receive a grant from the Carers' Grant via Berkshire Carers' Service no longer being included in this figure. There has been no change to the service that these people receive.

Every quarter the department reviews its risks, in the light of events, and also in the light of management action taken, and updates its risk register accordingly.

One risk has disappeared as a result of management action, and two new risks have been placed on the risk register to be managed. One risk has diminished that of increased council tax arrears due to the cumulative effect of the welfare reforms mentioned above.

The risk that has disappeared is that of pre-employment checks not being properly applied, resulting in staff being employed without such checks having happened. New recruitment processes have been put in place, and one result of this is that it is more likely that Human Resources would pick up at an earlier stage if the necessary checks had not taken place. The reduction in risk is such that this disappears from the risk register.

The first new risk is in respect of the integration agenda announced in the last spending review. This creates risks that the Council and the Clinical Commissioning Group (CCG) will not meet the agenda, with attendant financial risks, as some of the NHS money for social care will be linked to meeting certain key targets. The failure of IT systems in the NHS and Social Care to talk to each other is one barrier to closer integration. This Council and the NHS locally have been at the forefront of integration, and these risks will be managed by working with the CCG to ensure that plans for integration do meet the council's and Department of Health's requirements.

The second new risk is in relation to proposed changes to how sexual health contracts in Berkshire are paid for. The current joint arrangement provides for such costs to be shared between authorities pro rata to their public health grant. It is proposed that this

changes to each authority paying for its cases. This creates some financial risk, although it is also possible this will be of financial benefit to the Council. This will be closely monitored as part of normal budget monitoring.

There is a statutory complaints process for Adult Social Care, as part of which compliments are also recorded, which culminates in an Annual Report. For this reason the numbers of complaints and compliments are recorded, and reported, separately for Adult Social Care and for Housing, with Housing complaints dealt with via the Corporate Complaints process. In addition, there is a separate, statutory, process for Public Health complaints.

In the second quarter, Adult Social Care received 6 complaints, of which 3 were not upheld, and 3 are ongoing. This compares to the previous quarter when 4 complaints were received. Of these, 1 was partially upheld, 2 were not upheld, and 1 is on-going. An additional complaint received in quarter 1 was referred to the Local Government Ombudsman, and remains on-going. There were in addition 29 compliments received in the quarter, a reduction compared to 39 in the previous quarter.

In Housing, there were 4 new complaints, 3 at stage 2 and 1 at stage 4, 3 of which were partially upheld and 1 not upheld. The number of complaints is less than quarter 1, when there were 6 (2 at stage 2 and 4 at stage 3) of which 1, at stage 3, was partially upheld and 5 were not upheld. There were 5 compliments in the quarter, compared to 8 in the previous quarter.

No complaints have yet been made in respect of Public Health.

Section 2: Department Indicator Performance

Ind Ref	Short Description	Previous Figure Q1 2013/14	Current figure Q2 2013/14	Current Target	Current Status	Comparison with same period in previous year
ASCHH All Sections – Quarterly						
NI132	Waiting times for assessments (Quarterly)	91.5%	88.0%	90.0%	G	⇨
NI133	Waiting times for services (Quarterly)	95.3%	Data not available	90.0%	N/A	N/A
NI135	Carers receiving needs assessment or review and a specific carer's service, or advice and information (Quarterly)	10.6%	20.3%	18.8%	G	↘
OF2a.1	Permanent admissions to residential or nursing care per 100,000 population 18-64 (Quarterly)	1.40	2.70	6.8 (for the year)	G	⇨
OF2a.2	Permanent admissions to residential or nursing care per 100,000 population 65 or over (Quarterly)	210.30	343.40	750.6 (for the year)	G	↘
L137	Number in residential care (quarterly)	168.00	167.00	No target set	N/A	↗
L138	Number in nursing care (Quarterly)	136.00	141.00	No target set	N/A	↘
L159	People receiving Self-Directed Support as a percentage of Eligible People (Quarterly)	97.5%	99.2%	98.0%	G	↗
L172	Timeliness of financial assessments (Quarterly)	96.80%	97.50%	95.00%	G	↗
Community Mental Health Team - Quarterly						
OF1f	Adults receiving secondary mental health services in employment (Quarterly)	15.9%	Data not yet available	13.0%	N/A	N/A
OF1h	Adults receiving secondary mental health services in settled accommodation (Quarterly)	75.9%	Data not yet available	84.0%	N/A	N/A
Community Response and Reablement - Quarterly						
OF2c.1	Delayed transfers of care - total delayed transfers per 100,000 population (Quarterly)	2.3	3.9	10.0	G	⇨
OF2c.2	Delayed transfers of care - delayed transfers attributable to social care per 100,000 population (Quarterly)	0.0	1.4	7.0	G	↗
L135.1	Percentage of Intermediate Care Referrals seen with 2 hours (quarterly)	100.00	100.00	97.00	G	↗
L135.2	Waiting time for OT support (Quarterly)	88.40	90.60	90.00	G	⇨
Community Support & Wellbeing - Quarterly						
L136.1	Number in receipt of direct payments (Quarterly)	187.00	218.00	No target set	N/A	↘
L136.2	Number in receipt of community support excluding direct payments (Quarterly)	1,130.00	1,192.00	No target set	N/A	↗

Ind Ref	Short Description	Previous Figure Q1 2013/14	Current figure Q2 2013/14	Current Target	Current Status	Comparison with same period in previous year
Community Team for People with Learning Difficulties - Quarterly						
OF1e	Adults with learning disabilities in employment (Quarterly)	16.4%	16.3%	15.0%	G	↗
OF1g	Adults with learning disabilities in settled accommodation (Quarterly)	84.9%	85.4%	86.0%	G	⇨
Housing - Benefits - Quarterly						
NI181	Time taken to process Housing Benefit or Council Tax Benefit new claims and change events (Quarterly)	9.0	10.0	11	G	⇨
L033	Percentage of customers receiving the correct amount of benefit (Sample basis) (Quarterly)	96.6%	96.4%	96.5%	G	⇨
L177	Average time from when customer first seen to receipt of benefit payment (Quarterly)	6	13	14	G	N/A
Housing – Forestcare - Quarterly						
L030	Number of lifelines installed (Quarterly)	109	139	120	G	⇨
L031	Percentage of lifeline calls handled in 60 seconds (Quarterly)	98.03%	96.42%	97.50%	G	⇨
L180	Time taken for Forest Care customers to receive the service from enquiry to installation (Quarterly)	12	12	15	G	N/A
Housing - Options - Quarterly						
NI155	Number of affordable homes delivered (gross) (Quarterly)	53	82	77	G	↗
L178	Number of household nights in B&B across the quarter (Quarterly)	455	607	475	R	N/A
L179	The percentage of homeless or potentially homeless customers who the council helped to keep their home or find another one (Quarterly)	92.64%	92.00%	90.00%	G	N/A

Traffic Lights

Compares current performance to target

G Achieved target or within 5% of target

A Between 5% and 10% away from target

R More than 10% away from target

Comparison with same period in previous year

Identifies direction of travel compared to same point in previous year

↗ Performance has improved

⇨ Performance sustained

↘ Performance has declined

The following are annual indicators that are not being reported this quarter:

OF3a - Overall satisfaction of people who use services with their care and support (Annual)
OF3b - Overall satisfaction of carers with social services (Every two years)
OF3c - The proportion of carers who report that they have been included or consulted in discussion about the person they care for (Every two years)
OF3d - Proportion of people who use services or carers who find it easy to find information about services (Every two years)
OF4a - The proportion of people who use services who feel safe (Annual)
OF4b - The proportion of people who use services who say that those services have made them feel safe and secure (Annual)
OF2b - Achieving independence for older people through rehabilitation or intermediate care (Annual)
OF1a - Social Care Related Quality of Life (Annual)
OF1b - Proportion of People who use services who have control over their daily life (Annual)
OF1c.1 – Percentage of social care clients receiving self-directed support (Annual)
OF1c.2 – Percentage of social care clients receiving Direct payments (Annual)
OF1d - Carer – reported quality of life (Annual)
L032 - Number of benefits prosecutions and sanctions in the year (Annual)

Section 3: Compliments & Complaints

Compliments Received
34 compliments were received by the Department during the quarter which were distributed as follows within the following teams:

Adult Social Care
29 compliments were received in Adult Social Care which consisted of:

Community Response & Reablement (CR&R) Team – 18 compliments (9 of which were about Bridgewell)
Older People & Long Term Conditions (OP&LTC) Team – 3 compliments (2 of which were about Heathlands)
Community Team for People with Learning Disabilities (CTPLD) – 8 compliments

Housing
5 compliments were received in Housing which consisted of:

Benefits team – 2 compliment
Housing Options team -1 compliment
Forestcare team – 2 compliments

Complaints Received

There were a total of 10 complaints received in the Department in the quarter.

Adult Social Care Complaints:

Stage	New complaints activity in quarter 2	Complaints activity year to date	Outcome of total complaints activity year to date
Statutory Procedure	6	10	1 Partially Upheld, 5 not upheld and 4 ongoing.
Local Government Ombudsman	0	1	Ongoing

There were 7 concerns received in Adult Social Care.

Nature of complaints/ Actions taken/ Lessons learnt:

The nature of the 6 complaints received in quarter 2 about Adult Social Care was as follows:

- Concerning care provided following respite – 1 complaint
- Concerning care provided following discharge from Hospital – 1 complaint
- Regarding attitude of members of staff - 2 complaints
- Regarding communication received from someone with learning disabilities – 1 complaint
- Regarding charges for home care – 1 complaint

There are regular meetings within Adult Social Care to ensure learning from complaints is disseminated and acted on. The data is collated as the year progresses and is reported annually within the Complaints Report for Adult Social Care.

Housing Complaints:

4 complaints were received in the quarter in Housing.

Stage	New complaints activity in quarter 2	Complaints activity year to date	Outcome of total complaints activity year to date
New Stage 2	3	5	2 partially upheld, 3 not upheld
New Stage 3	0	4	1 partially upheld, 3 not upheld
New Stage 4	1	2	1 partially upheld
Local Government Ombudsman	0	1	1 ongoing

Nature of complaints/ Actions taken/ Lessons learnt:

The nature of the 4 complaints received in quarter 2 about Housing was as follows:

- Housing Strategy & Needs / Benefits - 2 complaints
- Benefits – 1 complaint
- Housing Options – 1 complaint

There is no discernible pattern to the nature of the complaints although what is clear is that the complex housing and benefit complaints do progress to stage 2 in the procedure. The key learning point is that it may be better to offer a meeting with complainants if they are prepared to accept this as it should be easier to explain different interpretations of the service provided in person rather than via correspondence. Following the meeting, written confirmation of what was agreed during the meeting is sent to the complainant.

Section 4: People

Staffing Levels

Section	Total Staff in Post	Staffing Full Time	Staffing Part Time	Total Posts FTE	Vacant Posts	Vacancy Rate
Directorate Management Team / PAs	12	10	2	11	0	0
Older People and Long Term Conditions	203	92	111	131.83	9	4.24
Adults & Joint Commissioning	94	63	31	81.04	5	5.05
Performance & Resources	27	21	6	24.39	0	0
Housing	70	51	19	58.16	3	4.1
Public Health Shared	11	8	3	9.08	0	0
Public Health Local	4	4	0	4	0	0
Department Totals	**421**	**249**	**172**	**319.50**	**17**	**3.88**

Staff Turnover

For the quarter ending	30 September 2013	2.19%
For the year ending	30 September 2013	8.76%

Total voluntary turnover for BFC, 2011/12: 12.69%
Average UK voluntary turnover 2011: 9.3%
Average Public Sector voluntary turnover 2011: 6.7%

(Source: XPertHR Staff Turnover Rates and Cost Survey 2012)

HR Comments:
Staff Turnover has decreased this quarter from 2.8% to 2.19%. There have been fewer voluntary leavers during this quarter which explains the reduced number of vacancies.

Staff Sickness

Section	Total staff	Number of days sickness	Quarter 2 average per employee	2013/14 annual average per employee
Directorate Management Team / PAs	12	4	0.33	0.83
Older People and Long Term Conditions	203	383	1.89	8.21
Adults & Joint Commissioning	94	74	0.79	6.25
Performance & Resources	27	21	0.78	1.78
Housing	70	77.5	1.11	4.98
Public Health Shared	11	0	0	0
Public Health Local	4	0	0	0
Department Totals (Q2)	**421**	**559.5**	**1.33**	
Actual Totals	**421**	**2,662**		**6.32**

Comparator data	All employees, average days sickness absence per employee
Bracknell Forest Council 12/13	5.56 days
All local government employers 2011	8.1 days
All South East employers 2011	6.4 days

(Source: Chartered Institute of Personnel and Development Absence Management survey 2012)

N.B. 20 working days or more are classed as long term sick.

HR Comments:
Staff Turnover has decreased this quarter from 2.8% to 2.19%. There have been fewer voluntary leavers during this quarter which explains the reduced number of vacancies.

Section 5: Progress against Medium Term Objectives and Key Actions

Progress has been monitored against the Key Actions from the Adult Social Care Health & Housing Service Plan for 2013/14. This contains 84 Key Actions detailed actions in support of 7 Medium Term Objectives. Annex A provides detailed information on progress against each of these detailed actions:

29 actions have been completed () with 54 on schedule (). No actions are reported as potentially delayed (), and 1 action was reported as delayed ().

Section 6: Money

Revenue Budget
The cash budget for the department is £31,991k, and a breakdown of this is attached in Annex B1. The forecast outturn in the latest budget monitoring is £32,116k, an overspend of £125k. Action plans are in place to address this overspend, and the department is confident that the budget will breakeven at the end of the financial year.

The department has identified a number of budgets that can pose a risk to the Council's overall financial position, as they are vulnerable to significant changes in demand for a service, which has to be met. The current position with regard to each of these budget areas is as follows:

Service Area	Net Budget £000	Forecast Outturn £000	Comments
People with Physical Disabilities – residential care	188	280	Volatile, demand led area of expenditure but current trends indicate an overspend at year end due to increased demand.
Older People Residential Care including EMI	568	591	Volatile, demand led area of expenditure but current trends indicate an over spend at year end due to changes in demand arising after budget development.
Mental Health - Supported Living	226	479	The demand for the service and the cost of individual support is significantly higher than budgeted.
Older People - Homecare	1,547	1,611	Volatile, demand led area of expenditure but current trends indicate an overspend at year end.

Housing - Homeless Families, B&B costs	85	94	Volatile, demand led area where current estimates suggest a small overspend but the overspend could increase significantly if historical trends are followed as well expenditure in the most recent month continues for the remainder of the year.

The current forecast is based on current commitments plus any known changes that will arise prior to the year end. The significant risks that may impact on this reported position are outlined below:

Ordinary residence risk and Continuing Health Care
Previous reports to CMT have highlighted as an emerging issue the ongoing ordinary residence risk arising from plans to de-register local residential homes and the potential additional costs from changes initiated by the now defunct Primary Care Trust in its approach to Continuing Health Care, and continued by the CCGs in Berkshire. These issues remain, although the risk has diminished to an extent.

Capital Budget
The approved capital budget for the department is £5.7m and it is projected to spend the full amount by year end. In most cases programmes are being forecast as fully spent until the picture becomes clearer as the year progresses. A detailed list of schemes together with their approved budget and forecast spend is available in Annex B2.

Section 7: Forward Look

ADULTS & JOINT COMMISSIONING

Approach to Assistive Technology
Staff guidance and an e-learning package have been developed available to all front line teams: all front line staff members are expected to undertake the training. An information leaflet for the public will be developed.

Autistic Spectrum Disorders (ASD)
Through the 3rd quarter the remaining staff will be supported to either undertake or book the appropriate training.

Joint Commissioning
A workshop will be held for members and advisers to the Health and Wellbeing Board along with Elected Members from the Health Overview and Scrutiny Panel and colleagues from NHS providers. The purpose of the workshop is to clarify the role of the Health and Wellbeing Board, and the wider partnership with the NHS providers and Scrutiny, in order to implement the recommendations made in the Francis report and to inform the way in which the Board conducts its business.

The Commissioning Strategy for people with dementia will be presented to the Executive.

Learning Disabilities
Over the next quarter, the learning disability service in partnership with the CCG will be co-ordinating and developing a response to the annual DH Learning disability self assessment. This assessment is about how the needs of people with a learning disability are being responded and met.

Mental Health
A training provider has been selected and commissioned to provide dementia awareness training in the community. A meeting is taking place in early October to plan delivery, aiming for training to commence in November.

Safeguarding Adults
The Safeguarding Board is developing its own website. This will contribute to the actions set out in the empowerment strategy. The website is due to 'go live' by the end of December 2013.

Staff from the learning disability services are working with colleagues in the Contracts Team to develop a consistent approach to quality assurance for people with learning disabilities. This work will inform the development of the Departmental review of the Quality Assurance Framework which will commence in Q3.

HOUSING

Housing Strategy & Housing Options
The development of the Santa Catalina site, previously owned by the Council will begin the quarter. The development will provide 6 flats for people with learning disabilities with the ground floor flats being fully wheelchair accessible. The Council has provided £394,000 towards the cost of the development.

The second low cost home ownership evening will be held on the 23rd October. This will promote the Council's BFC my home buy scheme, cash incentive scheme and mortgages. It will also offer the opportunity to consult on potential changes to the Council's mortgage offer.

Benefits
There will be three consultations happening during the period.

First consultation will take place on the introduction of fixed civil penalties for those people who have an overpayment of housing or council tax benefit due to failing to inform the Council of a change of circumstance without good cause or through negligence. The penalty is proposed to be a £50 fine for any overpayment up to £500. Overpayments above £500 are referred to the Council's fraud team to investigate.

Secondly, consultation will take place on revising the Council's discretionary housing payment policy. The proposed revisions are to remove the set amounts for paying for removals when it is in a customer's interest to move and also to introduce the ability to make awards conditional upon customers undertaking agreed actions. Following and subject to consultation responses the Executive member will be asked to consider the revisions.

Lastly, it will be necessary to consult on changes in the Council's local council tax benefit scheme so that charges such as non-dependent charges for working age households are in line with those set in the national pensioner schemes.

Work will begin during the quarter on preparing for year end and billing for the next financial year. The Council will need to test and install necessary software changes.

The loading of data onto the benefit ICT system for those eligible for free school meals will be complete and the module turned on so that when households apply for housing benefit and are eligible for free school meals they will automatically receive a letter confirming their entitlement.

The redesign of the housing and benefit service has reached an important point. The service now deals with all customer demand either via telephone or face to face contact and as such customer services are no longer providing the initial face to face contact with customers. The service redesign has demonstrated faster responses to customer demand and increased customer satisfaction, delivered from the existing staff resource. The service will continue to be redesigned on an on going basis against 7 core operating principles,

- Remove functional splits;
- Take expertise / decision making as close to the customer as possible;
- Take a holistic approach;
- Maximise initial face to contact with customers;
- Set up customers service requests clean;
- Learn from customer demand and design against it;
- Develop case ownership so that staff support/ "bat for the customer".

The housing and benefit service staff will be consulted on the restructure of the service to deliver a service the purpose of which is to maximise customers income and independence. This will involve new generic job descriptions that reflect the service purpose for front line staff.

Forestcare
Forestcare will begin a new contract supporting Berkshire women's aid. The service now has dedicated installers of lifeline equipment and this is showing dividends in the number of installations that are provided each month. The service will continue to deliver the new services for vulnerable people to prevent admission to hospital or enable early discharge.

OLDER PEOPLE & LONG TERM CONDITIONS

Business Support
The team has supported the Assistant Care Manager for Carers and Berkshire Carers Service (BCS) to ensure that carers' assessments are being recorded in a timely manner, whilst one member has taken on responsibility for organising appointments with the Sensory Needs and Falls Clinics. The team will also attend team meetings to ensure that staff understand the demands and complexities of work undertaken.

Bridgewell
The team will be recruiting to the post of Registered Manager for the Bridgewell Centre.

Carers
The Big Partnership continues to meet to review local and national carers support. The new Carers Information Booklet has been launched and the aim now is to encourage GP practices to refer carers to BCS as a matter of course.

Community Response and Reablement (CR&R)
A tendering exercise will commence regarding the employment of staff with health contracts who work exclusively for CR&R. The team are working with health to co-locate a nurse with Duty Officers in Time Square in order to ensure that people's Social Care and Health needs are met in an integrated way.

Drug and Alcohol Action Team (DAAT)
Following the review of the mephedrone strategy it has been agreed that this group will be merged with the Drug & Alcohol Strategy Group in order to maintain an overview of the work around mephedrone and legal highs. The terms of reference and membership of the strategy group will be reviewed in quarter 3 to ensure that they take into account the expanded remit of the group.

A second Berkshire-wide Drug and Alcohol Learning Set will take place in quarter 3 with a focus on alcohol. This Berkshire event will also be used as an opportunity to feedback on the first session and make recommendations on how to take forward a proposal around improving services and knowledge in respect of Child Sexual Exploitation, sexual health and the links between sex workers and substance misuse.

Emergency Duty Services (EDS)
The EDS database upgrade will be completed. It will be tested for 1 month with all staff receiving 1 days training on new system.

Heathlands
Refurbishment of individual's bedrooms is on-going and should be completed in early December. Volunteers have been recruited to assist in decorating the home for the holiday period and a range of activities are planned, including a trip to see a pantomime and carol performances. Heathlands Day-Centre's sensory room is available to the younger adults group as well as attendees. The centre is also now hosting a monthly carer's meeting for people caring for loved-ones or friends with memory loss.

Older People and Long Term Conditions team
The community team are participating in a project which will "pilot" the use of an external agency to provide support for people to plan and arrange their own support. The comparison of people's experiences, outcomes and costs will inform options for future commissioning.

PERFORMANCE & RESOURCES

Finance
In addition to the core functions of accounting, budget monitoring and financial advice, the Accountancy team will be focussed on preparation of the Housing Benefit mid-year subsidy claim. The team will also be working on implementing the "Finance Manager" module of Electronic Monitoring, which will link the data on call times to automatically produce invoices.

In the last quarter of the calendar year the finance team will be preparing the detailed budgets for 2014/15 and supporting the implementation of Zero Based Review.

HR
The revised recruitment process has been operating since 1 August 2013 and seems to be working well with recruitment managers having access to all the necessary documents early and being able to seek help from HR as needed. There will be a monitoring meeting toward the end of October to see how it is going. HR continues to provide support to Chief Officers, Heads' of Service and Team Leaders as necessary for Organisational Change and Employee Relations issues.

IT
The Electronic Social Care Record IT systems Replacement Functional Specification has been drafted and further discussions around the gap between what the system currently provides and what tendering at this stage could hope to achieve is taking place. The major shortcoming is on integrating with health systems, and at this stage the Council and partners are not in a position on integration to draw up a specification in the timeframe required for implementing in February 2015. What is done in various places around the country is being looked at to see if anyone has successfully integrated their health and social care systems. The team is waiting for further information on the replacement of the Health Community system.

The VISA Prepaid Card project will be progressing with a pilot commencing in November. Further work will be ongoing around the processes, electronic transfer of information, training plan and marketing documentation that is required for implementation.

Performance
Work will continue in implementing the changes within the Zero Based Review, with IAS system testing taking place in November and December. Teams will also be involved in providing the data input for Primary Support Reasons and Health Conditions as outlined in the guidance. Public Health indicator outturns will be reported in Q3, and it is proposed that they will include 4 week quits (local smoking indicator) and Health Checks.

PUBLIC HEALTH

A set of proposed Public Health priorities for 2013/14 was presented and agreed by the Health & Well-Being Board at the start of July 2013. Quarter 2 saw all of these projects get underway and make progress towards their aims. In Quarter 3 the Public Health team will focus on ensuring that these projects continue to develop. As in previous reports, the work will be considered under three key headings:

Public Health Intelligence

The substantial work involved in refreshing the Joint Strategic Needs Assessment (JSNA) and moving it to a web-based format is well underway. A 'beta' version will be ready for consultation and comment in December. Since the availability of health information at a ward level is often not available from central sources the, Bracknell Forest Public Health Survey will be also be completed by December.

Health Protection

Work will continue on the MMR 'catch up' campaign with the aim of vaccinating as many unvaccinated and partially vaccinated 10-16 year olds as possible. Efforts to improve the uptake of immunisation against the seasonal flu virus will also continue, including work with front-line health and social care staff, as well as promotion of the new vaccination schedule aimed at young children.

Health Improvement

The delivery of NHS Health Checks improved significantly from quarter 1 to quarter 2. In quarter 1, there were 232 invites sent and 164 Health Checks undertaken compared to 768 invites sent and 601 Health Checks undertaken in quarter 2.

This upward trend will be maintained in quarter 3 by the delivery of community based Health Checks via pharmacies and other settings. In addition, two key campaigns are already underway that will generate health improvement outcomes in quarter 3: a Berkshire-wide promotion of 'Stoptober', the 28-day stop smoking challenge, and also a alcohol harm reduction campaign being run in community pharmacies in partnership with Drink Aware.

Annex A: Progress on Key Actions

Progress on Key Actions				
MTO 1: Re-generate Bracknell Town Centre				
Sub-Action	**Due Date**	**Owner**	**Status**	**Comments**
1.9 Implement an Accommodation Strategy to rationalise the number of buildings used by the Council.				
1.9.10 Move ASCHH to final locations in Time Square.	31/10/2014	ASCHH	G	Phase 2 - 2N to 3N completed smoothly. Detailed plans for final moves to 1S under development.
1.9.12 Implement flexible and mobile working across all town centre offices.	31/03/2014	ASCHH	G	Ongoing.
MTO 4: Support our younger residents to maximise their potential				
Sub-Action	**Due Date**	**Owner**	**Status**	**Comments**
4.8 Ensure all children and young people feel safe, are protected from harm and abuse, have their views respected and gain confidence as a member of the local community.				
4.8.4 Commission a full range of substance misuse services which ensure that young people, their families and friends have access to advice, information and support.	31/03/2014	ASCHH	G	The Family & Friends Group continues to be well attended. A Parents Group is now delivered once a week specifically aimed at parents who are engaged with treatment and aims to highlight the impact of their substance misuse on their child. This group is currently attended by up five new parents, 3 of whom do not currently look after their child.
MTO 6: Support Opportunities for Health and Wellbeing				
Sub-Action	**Due Date**	**Owner**	**Status**	**Comments**
6.2 Support the Health and Well Being Board to bring together all those involved in delivering health and social care in the Borough.				
6.2.1 Develop the mechanism and timescales to renew the Joint Health and Wellbeing Strategy.	31/03/2014	ASCHH	G	The group is meeting regularly to review implementation and renewal.
6.2.2 Work with the Clinical Commissioning Group to improve outcomes for residents.	31/03/2014	ASCHH	G	Presentation to Health and Well Being Board in Q2 saw establishment of integration task force. Active involvement in "Winter Pressures" work around Wexham system.
6.3 Continue to support the development of a local Healthwatch to provide local patients with a voice.				
6.3.1 Monitor local Healthwatch and review to ensure successful delivery.	31/10/2013	ASCHH	G	Contract compliance meetings have been taking place and will continue.
6.5 Integrate the new responsibilities for Public Health within the Council.				

Progress on Key Actions				
6.5.1 Develop a Public Health action plan for the Borough.	31/12/2013	ASCHH	B	Completed. Report Agreed. Progress of priorities to be monitored.
6.5.2 Establish the necessary governance frameworks for hosting the Public Health structure in Berkshire.	30/04/2013	ASCHH	B	Completed. Public Health advisory Board established and chaired by SDPH. Links to Berkshire Chief Executives (3 monthly) and Leaders (6 monthly) Groups.
6.5.3 Ensure that the local authority has the ability to report on the Public Health Outcomes framework in conjunction with the core Public Health Team.	30/09/2013	ASCHH	B	Completed. Initial Public Health outcomes to be reported will include the local indicator for smoking (4 week quits) and NHS Health checks completed (from the Public Health Outcomes Framework). Profiles of performance of these indicators will appear in the Q3 Quarterly Service Report.
6.5.4 Establish and embed Public Health teams into the local authority workforce.	31/05/2013	ASCHH	B	Completed. All staff successfully transferred. Vacancies are being recruited to.
6.5.5 Absorb and induct Public Health Teams into Adult Social Care Health & Housing and wider council.	31/05/2013	ASCHH	B	Completed. Consultant in Public Health now part of DMT. All departments have been part of Inductions for staff
6.5.6 Develop monthly budget monitoring for Public Health.	31/05/2013	ASCHH	B	Completed. This is now in place.
6.8 Preserve and promote Public Health.				
6.8.5 Improve the quality of the information in the Joint Strategic Needs Assessment (JSNA) by collecting new, local health related data from residents.	31/12/2013	ASCHH	G	This project is on schedule and we still aim to complete the work by the end of December 2013. The interview and methodology have been designed in consultation with council colleagues from all departments, CCG Directors, Health & Well-Being Board and Overview & Scrutiny Chairs. The methodology was finalised with the research team and the start date is set for data collection (9th October).
6.8.6 Increase the number of people accessing an NHS Heath Check or specialist health improvement programmes such as Stop Smoking Services.	31/03/2014	ASCHH	G	This work is on schedule. The number of Health Checks delivered in Q2 was increased by over 300% on Q1. The initiatives in community settings are underway.
6.8.7 Deliver a range of programmes aimed at improving mental health in the local population, including training for staff across a range of agencies in supporting people with mental health issues and outreach work focused on at-risk, older people in the community.	31/03/2014	ASCHH	G	This work is on schedule. The Mental Health First Aid courses have begun. The first intensive (12-hour course) has delivered (September 2013). The first 'Mental Health First Aid- Lite' (3 hours) course was also delivered in September with 3 more scheduled for the rest of the year. The Older People's Health project is also on schedule with the first event scheduled for 14th October in

Progress on Key Actions				
				Owlsmoor.
6.8.8 Carry out specific assessments of the services we commission including sexual health services, stop smoking services and other health improvement programmes.	31/03/2014	ASCHH		The sexual health needs assessment has been completed as has a local consultation with young people. This information is being fed into the re-tendering process which is led by Angela Snowling in Slough BC. A report on the Stop Smoking Service is also underway which is scheduled for November. Finally, we have successfully renegotiated the contract for weight management services and switched to a programme that offers more detailed data returns from the provider.
6.8.9 Work with the Clinical Commissioning Group to assess how well hospital and community NHS services are performing.	31/03/2014	ASCHH		Working with Director Nursing to look at implications of CQC report on HWPT.
6.9 Support people who misuse drugs and/or alcohol to recover by providing appropriate interventions.				
6.9.1 Ensure that people who misuse substances have access to blood-borne virus services and to monitor the effectiveness of these services.	31/03/2014	ASCHH		Quarter 2 figures are not yet available.
6.9.2 Provide training to local pharmacies to improve the level of advice offered on reducing harm caused by drugs and alcohol abuse.	31/07/2013	ASCHH		Completed. The training has now been provided.
6.9.3 Work with all relevant agencies and departments to increase access to housing, employment, and training to improve outcomes for people who misuse substances.	31/03/2014	ASCHH		Bracknell Floating Support provide a housing drop in once per week at New Hope which is accessible to people who are homeless or are at risk of becoming homeless due to their substance misuse.
6.9.4 Evaluate the effectiveness of the Payment by Results project by monitoring successful delivery of outcomes.	31/03/2014	ASCHH		Payment by Results is still working well and outcomes are improving in most areas. Abstinence from alcohol is still lower than the national and baseline figures as are successful completions. For drug users the percentage of people successfully completing treatment is higher than the national and local baseline figures. The national evaluation is still ongoing.
6.10 Support the Bracknell & Ascot Clinical Commissioning Group to focus on improving local health services for our residents.				
6.10.1 Work with health and the voluntary sector to improve hospital discharge for people living with dementia.	30/11/2013	ASCHH		The hospital Social work team and the Community Mental Health Team for Older People are working closely together to facilitate discharge into the community for people with

Progress on Key Actions				
				dementia.
6.10.2 Monitor delivery of End of Life Care to ensure high standards of care.	31/03/2014	ASCHH	G	End of Life training has been commissioned from Learning and Development who will be delivering a bespoke course for the Bridgewell Centre.
6.10.3 Work with Health and the voluntary sector to develop robust and early supported discharge for people suffering from stroke.	31/03/2014	ASCHH	G	The new Community Stroke Worker continues to support people who have been deemed suitable for early supported discharge following stroke. This ensures that individuals and carers are made aware of available support networks, provided advice on benefits and encouraged to be active partners in their recovery.
6.10.4 Work with health agencies as part of the 'shaping the future' programme to establish sustainable local health trusts.	31/03/2014	ASCHH	G	Working with the CCG to assist in implementing Shaping the future requirements and the acquisition of HWPT by Frimley.
6.10.5 Work with partners to improve the sustainability of Brants Bridge Health Facility.	31/03/2014	ASCHH	G	Urgent Care Tender underway - Council involved in selection of approved provider.
6.10.6 Work with the Stroke Association to ensure that people who have had a stroke, have a review every 6 months to make sure that their needs and the needs of their carers are met	31/07/2013	ASCHH	B	Completed. Adult Social Care continues to work closely with the Stroke Association to ensure that individuals are reviewed every six months and that carers and the wider family are supported with information, advice and signposting to Carer's services.
MTO 7: Support our older and vulnerable residents				
Sub-Action	**Due Date**	**Owner**	**Status**	**Comments**
7.1 Secure preventative and early intervention measures to ensure residents have the maximum choices to allow them to live longer in their own homes.				
7.1.1 Work with housing, health and community groups to provide extra care housing for 65 households.	31/03/2014	ASCHH	G	Ground has now broken on the new scheme of 65 extra-care sheltered flats with completion planned for early 2015. ASCHH will be leading on developing a service specification and preparing tender documents for the planned 24 hour support service over the coming months.
7.1.2 Monitor and report on the action plan within the Long Term Conditions Commissioning Strategy.	31/12/2013	ASCHH	G	The Long-term conditions Strategy is on target for a December launch. Meantime, consideration will be given to offering further support for the NICE plans to develop social care guidance for supporting older people with long-term conditions.
7.1.3 Review of the Long Term Conditions Joint	31/06/2013	ASCHH	B	Completed. The review is complete and the Long Term Conditions Joint

Progress on Key Actions				
Commissioning Strategy.				Commissioning Strategy has been approved by the Executive.
7.1.4 Review the Prevention and Early Intervention Guide.	31/07/2013	ASCHH		Completed. The draft has been presented to Departmental Management Team for approval. It was decided to present the guide to the Health and Wellbeing Board meeting in December.
7.1.5 Assist in developing the Joint Strategic Needs Assessment.	31/03/2014	ASCHH		The first stage of the JSNA has been submitted.
7.1.6 Review of Older Person's Joint Commissioning Strategy.	31/05/2013	ASCHH		Completed.
7.1.7 Develop Action Plan following development of Older People Commissioning Strategy and subsequent monitoring arrangements.	30/06/2013	ASCHH		Completed. Action plan approved by Older People Partnership Board and delivery will be monitored through Older Partnership Board.
7.1.8 Participate in Dementia Awareness Week.	31/05/2013	ASCHH		Completed. The Bracknell memory clinic along with the Alzheimer's Society held two information events at local supermarkets. Both events were successful and generated a lot of requests for information (on dementia, diagnosis, services, benefits etc). An evening drop in session was arranged at Church Hill House but no-one attended this.
7.1.9 Undertake the Dementia Friendly Community consultation of people affected by dementia.	31/07/2013	ASCHH		Completed. Feedback from the consultation has informed the development of the dementia strategy as well as the dementia training project as detailed in action 7.1.10.
7.1.10 Dementia training to be provided to retailers, leisure centres and transport providers.	31/10/2013	ASCHH		There were difficulties in transferring the money to the Local Authority, following the demise of the Strategic Health Authority. This led to a significant delay to the start of this project. The provider has now been selected and commissioned to deliver dementia awareness training. The project start date was 1st September 2013 with a revised completion date of April 2014.
7.1.11 Review of the Dementia Joint Commissioning Strategy.	31/12/2013	ASCHH		The consultation has now closed and almost 600 comments were received from people, carers and other stakeholders. The strategy will be presented to the Executive in December.
7.1.12 Development of Carers Education Course for carers of people with dementia	31/10/2013	ASCHH		Completed. Carers Education course delivered as a one day event to target carers who are in employment. This is in addition to the rolling 6 week programme.

Progress on Key Actions				
7.1.13 Develop and Implement Workforce Development Strategy to ensure efficient delivery of personalised approaches.	31/03/2014	ASCHH		Meetings have taken place with consultant's decision - October 2013.
7.1.14 Review of the Learning Disability Joint Commissioning Strategy.	31/12/2013	ASCHH		The consultation has now closed and the strategy will be presented to the Executive in December.
7.1.15 Roll out of the Integrated Care Team pilot.	31/03/2014	ASCHH		Completed. The cluster meetings continue to take place every three weeks. Further evaluation of the effectiveness of this process is ongoing.
7.2 Work with all agencies to ensure people feel safe and know where to go for help.				
7.2.1 Ensure the safe and effective transfer of increased DoLS responsibilities from the PCT.	30/04/2013	ASCHH		Completed. The Deprivation of Liberty Safeguards (DoLS) function was transferred to the Council on the 1st April. Appropriate applications have been received from local NHS provider trust, which is indicative of the success of the detailed transfer plan.
7.2.2 Develop and implement a Quality Assurance programme to ensure social care assessments continue to be compliant with the Mental capacity Act.	31/07/2013	ASCHH		Completed. Analysis of the audit is due to be presented to senior managers in the first week of Q3. Learning from the audit will be embedded into practice following this.
7.4 Continue to modernise support and include new ways of enabling the delivery of that support.				
7.4.1 Implement the Assistive Technology Strategy.	31/03/2014	ASCHH		During the second quarter the steering group developed assistive technology guidance and an e-learning training package for staff as part of raising awareness and ensuring the opportunities assistive technology offers to support people are maximised.
7.4.2 Develop Learning Disability Commissioning Strategy.	31/01/2014	ASCHH		The consultation has now been completed and analysis of the feedback is underway to help determine the priorities for the strategy.
7.4.3 Develop a market position statement in order to improve choice and quality for people who need support.	31/07/2013	ASCHH		Completed. The Market Position Statement has been developed. The Developing Care Market for Quality and Choice programme is being supported by the Institute for Public Care (IPC). The IPC will be supporting the council in the next stages of the programme.
7.4.4 Carry out assessments of all applicants not automatically eligible for Blue	30/06/2013	ASCHH		Completed. Changes to Blue Badge eligibility have prompted an increase in appeals. The Department has an

Progress on Key Actions				
Badges and develop suitable appeals systems.				appeals panel with a clinical lead. Physiotherapy assessments are available to anyone who is not automatically eligible or who has appealed a decision not to issue a badge.
7.4.5 Review of carers' services provided at Waymead.	31/08/2013	ASCHH		Completed. Reviews have been completed with information being used as part of the feedback for the development of the Learning Disability strategy.
7.4.6 Further develop and expand support for carers known only to their GPs in partnership with health, carers and the voluntary sector.	31/01/2014	ASCHH		The new Carers Information has been finalised and first copies have been distributed. Berkshire Carers Service is working with local GP practices to encourage more referrals. Meanwhile the Integrated Care Team members are reminded that Carers need to be included in treatment plans whenever possible.
7.4.7 Provide support and training to enable carers to return to paid or voluntary work.	31/03/2014	ASCHH		Carers are able to apply for grant funding for training to gain skills that can enable them to return to the workplace. Both Berkshire Carers Service and Bracknell Forest Voluntary Action offer opportunities for carers to undertake voluntary work to gain experience and enhance prospects for employment.
7.4.8 Identify training needs to enable the service to deliver new ways of working by analysing the calls that come into the service.	31/03/2014	ASCHH		Call Facilitators have now undertaken a Training day focusing on data protection and sharing of information. Further training day booked for customer skills in December 2013.
7.4.9 Evaluate the implementation of the new operational model in the Emergency Duty Service.	31/01/2014	ASCHH		Customer Survey results have now been received. These are being analysed and results will be incorporated into the Annual Report.
7.4.10 Review the needs of people who receive out of hours services and develop a model that meets these needs.	31/03/2014	ASCHH		Work continues to identify an appropriate model.
7.4.11 Expand the function of Bridgewell to include establishment of a Community Dentistry clinic and a Telecare clinic.	31/03/2014	ASCHH		The sensory needs clinic is proving effective. This includes the use of telecare. One bedroom in Bridgewell has been set up with some telecare sensors to help care for people with dementia.
7.4.12 Continue to work towards establishing a separate Autistic Spectrum Disorder Community Team within Adult Social Care & Health.	31/03/2014	ASCHH		Assessment and review has established a continued increase in demand necessitating in the recruitment of a part-time Team leader and Personal Facilitator.
7.4.13 Monitor delivery of domestic support provided for	31/10/2013	ASCHH		Completed. Contract compliance meetings have taken place and are

Progress on Key Actions				
compliance against contract.				ongoing.
7.5 Improve the range of specialist accommodation for older people which will enable more people to be supported outside residential and nursing care.				
7.5.1 Improve the range of specialist accommodation for older people by developing the Extra Care Housing scheme which will enable more people to be supported outside residential and nursing care.	31/03/2014	ASCHH	B	Completed. The extra care scheme is on site.
7.6 With partners develop a culture that does not tolerate abuse, and in which older and more vulnerable residents are safeguarded against abuse.				
7.6.1 Implement an Empowerment Strategy to enable people to safeguard themselves and feedback on people's experiences of the process.	31/03/2014	ASCHH	G	An update on the strategy and associated action plan was provided to the safeguarding board in Q2. The action plan remains on track to be fully implemented within the agreed timeframe.
7.6.2 Monitor and evaluate advocacy contract and guidance in relation to the Advocacy Policy and Best Practice Safeguarding guidance.	30/11/2013	ASCHH	B	Completed. The monitoring framework is now in place, with compliance with the policy and relevant practice guidance being monitored throughout the year.
7.6.3 Promote better understanding of Autistic Spectrum Disorder by delivering training and awareness across the department.	31/12/2013	ASCHH	G	The review during the 2nd quarter has reflected continued uptake of the training by front and non-front line staff.
7.7 Target financial support to vulnerable households.				
7.7.1 Implement the Council's local council tax benefit scheme.	31/01/2014	ASCHH	G	Modelling complete and the 2014/15 scheme can be delivered within available resources without the need for any further changes.
7.7.2 Review the financial advice and support provided to households in Bracknell Forest by the Council and voluntary organisations.	30/09/2013	ASCHH	B	Completed. Further meetings are being arranged with a view to providing the basis for the local support service for universal credit introduction.
MTO 8: Work with the police and other partners to ensure Bracknell Forest remains a safe place				
Sub-Action	**Due Date**	**Owner**	**Status**	**Comments**
8.1 Continue to seek to reduce overall crime levels, focusing particularly on domestic violence, sexual crimes and burglary.				
8.1.3 Deliver assertive outreach services offered by SMART in order to engage with hard to reach groups in order to reduce their levels of offending.	31/03/2014	ASCHH	G	1 Operation Ladybird initiative was undertaken in quarter 2. Staff have reported that the operation was quiet in terms of people with substance misuse issues. Weekly outreach sessions are still being delivered and are being particularly

Progress on Key Actions				
				well attended at Holly House and Rainforest Walk.
MTO 10: Encourage the provision of a range of appropriate housing				
Sub-Action	**Due Date**	**Owner**	**Status**	**Comments**
10.1 Ensure a supply of affordable homes.				
10.1.1 Ensure a supply of affordable homes by enabling affordable housing development at Jennets Park, the Parks, Broughs and Rothwell house (funded by HCA and the RPs)	31/03/2015	ASCHH	G	There are no revised completions dates for the affordable housing schemes.
10.1.2 Work with partners to identify a suitable location to enable the relocation of the Bridgewell Centre.	31/03/2014	ASCHH	G	Discussions are taking place.
10.1.3 Develop a new sensory needs service for Bracknell Forest by working in partnership with people who use our services and voluntary organisations.	31/01/2014	ASCHH	B	Completed. The Sensory Needs Clinic was launched on 16th July. People are now able to attend and try out a wide range of specialist equipment before deciding upon what best meets their needs. Specialist visual needs assessments and rehabilitation programmes are being undertaken by preferred providers. Feedback on all aspects of the new service has to date been very positive.
10.2 Support people who wish to buy their own home.				
10.2.1 Enable a programme of support for households to buy their own home on low cost basis.	31/03/2014	ASCHH	G	Another promotional drop in meeting is being arranged in October for the low cost home ownership schemes. Take up is still not at programme level.
10.2.2 Support the provision of the cash incentive scheme and BFC MyHome buy schemes	31/03/2014	ASCHH	G	Following on from last quarter, funding has been defrayed for the Rainforest Walk scheme.
10.3 Continue to find ways to enable people to secure a suitable home.				
10.3.1Support those households who need to move home due to welfare changes through financial support and advice.	31/03/2014	ASCHH	G	Financial advice and support continues for households.
10.3.2 Redesign the housing and benefit service so that household's income and independence is maximised.	31/03/2014	ASCHH	G	The services redesign is now at the stage to consider full implementation.
MTO 11: Work with our communities and partners to be efficient, open, transparent and easy to access and to deliver value for money				
Sub-Action	**Due**	**Owner**	**Status**	**Comments**

Progress on Key Actions				
	Date			
11.1 ensure services use resources efficiently and ICT and other technologies to drive down costs.				
11.1.4 Implement Electronic Monitoring within Community Intermediate Care and monitor the financial and activity impact.	31/12/2013	ASCHH		Electronic call monitoring systems are now in place for most people supported. Implementation of finance modules to enable payments to be made on the basis of electronic monitoring is scheduled for Quarter 3, and so this is still on track.
11.1.5 Complete options appraisal and undertake tender process for IAS Contract.	31/03/2014	ASCHH		Gap Analysis complete and waiting further discussion within the Department on next steps.
11.2 ensure staff and elected members have the opportunities to acquire the skills and knowledge they need.				
11.2.4 Deliver appropriate training within the department in relation to adult safeguarding.	31/03/2014	ASCHH		A detailed analysis of the current position across the department has taken place. Plans are in place to further ensure that all staff within the department have received the appropriate level of training.
11.2.5 Ensure that the local workforce is appropriately trained to identify substance misuse issues in order to offer information and advice.	31/03/2014	ASCHH		Four training courses were delivered in quarter two. A total of 19 Bracknell Forest Staff attending the training as follows: Drugs & Alcohol Level 1 - 1 person attended Drugs & Alcohol Level 2 - 4 people attended Dual Diagnosis - 8 people attended Mephedrone - 8 people attended
11.3 publish information about the Council to promote openness and cost-effectiveness and accountability.				
11.3.3 Publicise advice and information options for people who fund their own support.	31/01/2014	ASCHH		The council has now entered into a partnership arrangement with My Care, My Home to provide information, advice (including financial advice) and brokerage support to people who are paying for their own support.
11.5 develop appropriate and cost effective ways of accessing council services				
11.5.4 Maintain the i-hub to enable people in the community to access relevant and up-to-date information to plan their support and activities and also enable providers to maintain their own records on the system to ensure accuracy.	28/02/2014	ASCHH		The i-hub continues to be updated on an ongoing basis. Some providers are taking the opportunity to update their own records, which are then moderated by the council staff before appearing on the live i-hub.
11.5.5 Plan and implement changes to the cost centre structure brought about by both the Zero Based Review	31/03/2014	ASCHH		Proposed changes to cost centre structure have been discussed and agreed with chief officers with detailed discussions on

Progress on Key Actions				
and the transfer of responsibilities to Public Health to ensure compliance with new reporting requirements.				implementation the new structure due to take place by the end of October.
11.5.6 Review Forestcare services to ensure they meet customer demand.	31/03/2014	ASCHH		The Public health funded scheme has provided the Forest care service to 6 people who have been discharged from hospital and 10 existing customers have been refereed to the falls service.
11.7 work with partners and engage with local communities in shaping services.				
11.7.4 Work with Wexham Park, Frimley Park and Royal Berkshire Hospitals to create a whole systems approach to hospital discharge.	30/06/2013	ASCHH		Completed. We now have membership on Urgent Care and Transformation Board for all 3 acute trusts to ensure a whole system approach to hospital discharge.
11.7.6 Contribute to the Dementia Service Directory.	31/01/2014	ASCHH		First draft is going through initial approval processes.
11.7.7 Work in partnership with the Bracknell and Ascot Clinical Commissioning Group and Bracknell Healthcare Foundation Trust to create an integrated service for adults with long term conditions.	31/05/2013	ASCHH		Completed. Initial evaluation has been completed a further evaluation will take place in March 2014.
11.7.8 Establish a clinical governance post which ensures that intermediate care services operate safely and effectively and to a high standard.	30/06/2013	ASCHH		Completed. The post was successfully recruited to and filled in September.
11.8 implement a programme of economies to reduce expenditure				
11.8.7 Develop proposals to help the Council produce a balanced budget in 2014/15.	31/03/2014	ASCHH		Initial proposals have been developed and considered by the Council's Corporate Management team, before presentations to members to happen in quarter 3.

Annex B: Financial Information

Annex B1

ADULT SOCIAL CARE HEALTH & HOUSING BUDGET MONITORING - August 2013									
	Original Cash Budget	Virements & Budget C/fwds	NOTE	Current aproved cash budget	Spend to date %age	Department's Projected Outturn	Variance Over / (Under) Spend	Variance This month	NOTE
	£000	£000		£000	%	£000	£000	£000	
Director	746	(971)		(225)	840%	(216)	9	(29)	
	746	**(971)**	1	**(225)**	**840%**	**(216)**	**9**	**(29)**	1
Adults and Commissioning	(126)	14		(112)	0%	0	112	0	
Mental Health	1,936	(52)		1,884	35%	2,205	321	52	
Mental Health EMI	2,290	48		2,338	36%	2,321	(17)	31	
Learning Disability	13,573	154		13,727	22%	13,452	(275)	(114)	
Specialist Strategy	199	10		209	26%	200	(9)	0	
Joint Commissioning	490	77		567	33%	552	(15)	1	
Autism	259	136		395	15%	347	(48)	0	
	18,621	**387**	2	**19,008**	**25%**	**19,077**	**69**	**(30)**	2
Housing									
Housing Options	320	8		328	16%	139	(189)	9	
Strategy & Enabling	250	14		264	22%	229	(35)	5	
Housing Management Services	(58)	27		(31)	32%	-9	22	4	
Forestcare	(16)	16		0	0%	46	46	(4)	
Supporting People	1,065	35		1,100	27%	1,056	(44)	0	
Housing Benefits Payments	98	0		98	-162%	102	4	(4)	
Housing Benefits Administration	284	43		327	-54%	178	(149)	0	
Other	17	(65)		(48)	-14%	17	65	0	
	1,960	**78**		**2,038**	**-3%**	**1,758**	**(280)**	**10**	3
Older People and Long Term Conditions	(199)	(93)		(292)	0%	0	292	0	
Long Term Conditions	2,122	115		2,237	35%	2,349	112	(16)	
Older People	5,589	403		5,992	35%	5,896	(96)	69	
Community Response and Reablement - Pooled Budget	1,658	14		1,672	54%	1,732	60	(11)	
Emergency Duty Team	41	(3)		38	-3%	29	(9)	0	
Drugs Action Team	92	(35)		57	-154%	57	0	0	
	9,303	**401**	3	**9,704**	**38%**	**10,063**	**359**	**42**	4
Performance and Resources									
Leadership Team and Support	(31)	0		(31)	0%	0	31	0	
Information Technology Team	277	1		278	42%	337	59	7	
Property	173	0		173	20%	107	(66)	8	
Performance	221	0		221	35%	207	(14)	(1)	
Finance Team	503	38		541	29%	498	(43)	(4)	
Human Resources Team	184	0		184	29%	185	1	1	
	1,327	**39**		**1,366**	**32%**	**1,334**	**(32)**	**11**	5
Public Health									
Bracknell Forest Local Team - Gross Expenditure	0	2,872		2,872		2,872	0	0	
Bracknell Forest Local Team - Public Health Grant	0	(2,772)		(2,772)		-2,772	0	0	
	0	**100**	4	**100**	**98%**	**100**	**0**	**0**	
TOTAL ASCHH	**31,957**	**34**		**31,991**	**35%**	**32,116**	**125**	**4**	
Memorandum item:									
Devolved Staffing Budget				**12,860**	**42%**	**13,111**	**251**	**36**	
Non Cash Budgets									
Capital Charges	642			642	0%	642	0	0	
FRS17 Adjustments	433			433	0%	433	0	0	
Recharges	2,839	66		2,906	0%	2,906	0	0	
	3,914	**66**		**3,981**		**3,981**	**0**	**0**	

Annex B2

Adult Social Care Health and Housing
Virements and Budget Carry Forwards

Note	Total	Explanation
	£'000	
		DEPARTMENTAL CASH BUDGET
	22	**Total previously reported**
		Budget Carry Forwards
	0	**LINKS Budget into the Director Budget**
		Virements
1	-110	**Director** Budget for Public Health moved out of Directorate, transfer of winter pressures funding to Adults and Commissioning and transfer of Broadband Allowance and Telephony Budget from Corporate.
2	13	**Adults and Commissioning** Transfer of winter pressures funding from directorate and transfer of Broadband Allowance and Telephony Budget from Corporate.
	0	**Housing** None to report
3	9	**Older People and Long Term Conditions** Funding for severance payment transferred to Corporate reserve to department and transfer of Broadband Allowance and Telephony Budget from Corporate.
	0	**Performance and Resources** None to report
4	100	**Public Health** **Net** Budget transferred from Director
	34	**Total**
		DEPARTMENTAL NON-CASH BUDGET
	66	**Total previously reported**
		Virements
	0	none to report
	66	**Total**
	100	**Total**

Annex B3

Adult Social Care Health and Housing
Budget Variances

Note	Reported Variance over/ (under)	Explanation
	£'000	
		DEPARTMENTAL BUDGET
	121	**Total previously reported**
1	(29)	Due to the separate reporting of the shared Public Health team there is now an additional £36k of income being the administration recharge to the shared team this is partially offset by increased costs (£10k) associated with carers costs
2	(30)	There has been an decrease in the projected overspend in Adults and Joint Commission, the key reasons are as follows :- Mental Health shows an adverse movement of £63K due to three new packages being added. Mental Health EMI has an monthly adverse variance of £31k where the projected number of recipients for the year has increased further. There is postive montly movement on Learning Disability of £114k adverse due to a number of packages being closed.
3	10	There has been a small adverse movement in the variance for Housing, the key reasons are as follows:- Housing Options is showing a small pressure on B&B costs (£5k) and communal cleaning costs for Banbury (£2k), for Strategy and Enabling a £5k debt write-off, Housing Management Services a continued increase in projected water costs and income adjustment £4k, offset by the reduction in project overtime costs for Forestcare £4k and a reduction in irrecoverable overpayments payments in Housing Benefits £4k.
4	42	There has been a small adverse movement in the OP & LTC, the key reasons for the movement are as follows:- LTC a positive movement of £16k due to one less recipient projected for the year, Older People an adverse movement in projected Home Care costs (£58k) based on profile year to date and agency costs at Heathlands (£21k) and CR&R a positive movement in staff costs across various cost centres (£11k).
5	11	For Performance and Resources there is an adverse movement due to revised projections for staff costs.
	125	**Grand Total Departmental Budget**
		DEPARTMENTAL NON-CASH BUDGET
	0	**Total previously reported**
	0	No variances to report
	0	**Grand Total Departmental Non-Cash Budget**

Annex B4

CAPITAL MONITORING 2013/14

Dept: Adult Social Care, Health and Housing

As at: 31st August 2013

Cost Centre	Cost Centre Description	2012/13 Brought Forward £000's	2013/14 Budget £000's	Virements Awaiting Approval £000's	Total Virements £000's	Approved Budget £000's	Cash Budget 2013/14 £000's	Expenditure to Date £000's	Current Comm'nts £000's	Estimated Outturn 2013/14 £000's	Carry Forward 2014/15 £000's	(Under) / Over Spend £000's
	Housing											
YP260	Help to Buy a Home (Home Affordability Scheme)	**816.1**	**17.6**		0.0	**833.7**	833.7			833.7	0.0	
YP261	Help to Buy a Home (Cash Incentive Scheme)	**532.4**	**0.0**		0.0	**532.4**	532.4			532.4	0.0	
YP262	Enabling More Affordable Homes (Temp to Perm)	**255.7**	**679.2**		0.0	**934.9**	934.9	1.7		934.9	0.0	
YP304	Mortgages for Low Cost Home Ownership Properties	**137.4**	**0.0**		0.0	**137.4**	137.4			137.4	0.0	
YP316	BFC My Home Buy	**688.9**	**0.0**		0.0	**688.9**	688.9	-22.0		688.9	0.0	
YP440	Garth Extra Care Scheme	**0.0**	**1,567.2**		0.0	**1,567.2**	1,567.2	1,567.2		1,567.2	0.0	
YP441	Rainforest Walk Scheme	**0.0**	**0.0**		0.0	**0.0**	0.0			0.0	0.0	
	Adult Social Care & Health											
YS429	Mental Health	**22.1**	**0.0**		0.0	**22.1**	22.1	21.6		22.1	0.0	
YS430	Social Care	**29.2**	**0.0**		0.0	**29.2**	29.2			29.2	0.0	
YS527	Social Care Reform Care	**43.7**	**0.0**		0.0	**43.7**	43.7			43.7	0.0	
YS528	Care Housing Grant	**15.4**	**0.0**		0.0	**15.4**	15.4			15.4	0.0	
YS529	Community Capacity Grant	**298.8**	**195.0**		0.0	**493.8**	493.8	0.7		493.8	0.0	
YH126	Improving Info for Social Care (Capital Gr)	**64.7**	**0.0**		0.0	**64.7**	64.7			64.7	0.0	
YS418	ASC IT Systems Replacement	**130.3**	**180.0**		0.0	**310.3**	310.3			310.3	0.0	
		3,034.7	**2,639.0**	**0.0**	**0.0**	**5,673.7**	**5,673.7**	**1,569.2**	**0.0**	**5,673.7**	**0.0**	**0.0**

TO: HEALTH OVERVIEW AND SCRUTINY PANEL
7 JANUARY 2014

INTEGRATION TRANSFORMATION FUND
Director of Adult Social Care, Health and Housing
Bracknell and Ascot Clinical Commissioning Group (CCG)

1. PURPOSE OF REPORT

1.1 The purpose of this report is to explain the background, details and conditions of the Integration Transformation Fund and to propose an approach and timescale for developing the Integration Plan.

2. RECOMMENDATIONS

The Health Overview and Scrutiny Panel is asked to:-

2.1 Note the requirements of the Integration Transformation Fund.

2.2 Note the timescale and support the approach to developing the Integration Plan for sign off by the Council's Executive, Bracknell and Ascot Clinical Commissioning Group Governing Body and the Health and Wellbeing Board.

3. REASONS FOR RECOMMENDATIONS

3.1 The Integration Plan for Bracknell Forest must be agreed and submitted to the NHS England Area Team by 15 February 2014.

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 All options for the integrated provision of services will be considered in developing the Integration Plan.

5. SUPPORTING INFORMATION

Integrated Care and Support: Our Shared Commitment

5.1 Following the publication of the Care Bill, the Government announced, in "Integrated Care and Support: Our Shared Commitment", that local areas must develop integrated health and social care services over the next five years. It is recognised that there is no blue print for integrated care, and while elements of different models will be transferable, every locality is unique and needs to develop a different model to suit the needs of local people. A national collaboration will drive progress and provide support, and a national programme of integration pioneers will share solutions and identify barriers to integration, some of which will be addressed at a national level.

5.2 The statement from Government sets out the following expectations for local areas:

- Local leaders should joint together to develop innovative models for integration
- There should be Health and Wellbeing Board level commitment to integration and an agreed action plan
- Integration should adhere to the principles of the Caldicott Report and the NHS Constitution on data sharing
- Solutions to integration should be co-produced with local people who are supported by health and social care services
- Progress against the definition and personal narrative for integrated care to be measured
- That care should be co-ordinated around the needs of the individuals not diseases or dependency scores
- Individual's data to be shared where this is important for the quality or safety of care
- Opportunities are to be identified for frontline staff to build relationships with colleagues who provide parallel forms of care
- Organisations should avoid retreating into familiar silos as the financial climate toughens
- Organisations should be ambitious in planning person centred care and jointly allocating resources

5.3 Implementation of further integrated working will be funded by a £3.8bn Integration Transformation Fund.

NHS Funding for Social Care and the Integration Transformation Fund

5.4 The actual NHS Funding for Social Care for 2013/14 and planned ITF funding for 2014/15 and 2015/16 is as follows:

2013/14 (£1,295K for Bracknell Forest)

		£	£
(i)	Community Equipment and Adaptations		10k
	Demographic and System Capacity Support	*10k*	
(ii)	Telecare		
(iii)	Integrated Crisis and Rapid Response Services		71k
	Additional Support for LTCs	*71k*	
(iv)	Maintaining Eligibility Criteria		620k
	Demographic and System Capacity Support	*620k*	
(v)	Reablement Services		86k
	Demographic and System Capacity Support	*60k*	
	Stroke Care	*26k*	
(vi)	Bed-Based Intermediate Care Services		60k
	Demographic and System Capacity Support	*60k*	
(vii)	Early Supported Hospital Discharge Schemes		20k
	Demographic and System Capacity Support	*20k*	

(viii)	Mental Health Services		108k
	Dementia Adviser	*35k*	
	Dementia Support	*73k*	
(ix)	Other Preventative Services		100k
	Public Health Projects	*100k*	
(x)	Other Social Care		220k
	Support for Carers	*100k*	
	Supporting People with autism	*80k*	
	Programme Development Capacity	*40k*	
	Total		**1295k**

2014/15 (£1.1bn nationally)

a. The £900m funding the NHS planned to transfer to fund social care in 2014/15
b. An additional £200m investment in 2014/15

2015/16 (£3.8bn nationally)

a. £1.9bn NHS funding
b. £1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. Composed of:

- £130m Carers' Breaks funding
- £300m Clinical Commissioning Group (CCG) Reablement funding
- £354m capital funding (including c£220m of Disabled Facilities Grant)
- £1.1bn existing transfer from health to social care (as 2014/15)

5.5 The funding for 2015/16 of £3.8bn is comprised of £3.45bn revenue and £0.35bn capital. It is unclear how allocations will be made, and it is also unclear what conditions attach to the money – for example, £1bn of the £3.8bn will be paid when local results are achieved. This creates considerable uncertainty for both the Council and the CCG.

If the allocation was made on the same basis as the 2013/14 money, the £3.8bn would break down as follows:

	£m Nationally	£000 BFC (possible)
Continuation of existing NHS transfer to social care	900	1,357
Funding to accelerate transformation	200	302
New NHS funding for integration	2,000	3,015
Further funding for carers and people leaving hospital who need support to regain independence	350	528
Capital funding for projects to improve integration locally, including IT funding to facilitate secure sharing of patient data and improve facilities	350	528
Total	3,800	5,729

BFC Allocations are on the basis that the money is shared on the basis of relative needs formula, and that the formula does not change

Current social care allocations, including NHS Money for Social Care, has been on the basis of relative needs formula (RNF). The Government is currently undertaking a review of RNF for adult social care.
£1bn of the money – or about £1.5m of Bracknell's possible allocation – is dependent on achieving local results.

5.6 The fund does not in itself address the financial pressures faced by Councils and CCGs. The £3.8bn funding brings together NHS and Local Government resources that are already committed to existing core activity. Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that will deliver better outcomes for individuals. This calls for a shared approach to delivering services and setting priorities and presents the NHS and Councils, working together through the Health and Wellbeing Board, an opportunity to shape sustainable health and care (Annex A).

5.7 Part of the fund will be linked to performance. The detail on how this element will work is yet to be decided by Government. It is likely that that the performance metrics to be used will be determined by data that is already available. The Spending Review agreed that £1bn of the £3.8bn will be linked to achieving outcomes. In summary, 50% of the pay-for-performance element will be paid at the beginning of 2015/16, contingent on the Health and Wellbeing Board adopting a plan that meets the national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. Whilst the exact measures are still to be determined, the areas under consideration include:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Admissions to residential and nursing care
- Individuals' experience

5.8 It is essential that CCGs and Councils engage from the outset with all providers, both NHS and social care, that are likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Councils should also work with providers to help to manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the fund includes agreement to the service change consequences.

5.9 In 2015/16 the fund will be allocated to local areas, where it will be put into pooled budgets under joint governance between CCGs and Councils. A condition on accessing the funding is that CCGs and Councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

5.10 Councils will receive their detailed funding allocation following the Autumn Statement. When allocations are announced later this year, they will include two-year allocations for 2014/15 and 2015/16 to enable planning.

Local Agreement and Planning for the Integration Transformation Fund

5.11 Each Health and Wellbeing Board is required to sign off the plan for the Council and

the CCG area. The plan to be signed off by the Bracknell Forest Health and Wellbeing Board will cover the Bracknell Forest Local Authority Area. The Government has published a template which is expected to be used to develop, agree and publish integration plans (Annex B). The template sets out the information and metrics that are needed to ensure the conditions of the fund are being met. Local areas are asked to provide a shared risk register, with agreed risk sharing and mitigation covering, as a minimum, steps to be taken if activity volumes do not change as planned.

5.12 The plan must outline how the following conditions of the fund are to be met:

- The plan must be jointly agreed
- Protection for social care services (not spending)
- 7 day services in health and social care to support people being discharged from hospital and to prevent unnecessary admissions at the weekend
- Better data sharing between health and social care, based on the NHS number
- A joint approach to assessments and care planning and assurance that, where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of changes on the acute sector.

5.13 Health and Wellbeing Boards are required to submit the agreed planning template by 15 February 2014.

Draft Outline Project Plan

5.14 The Council and the CCG have begun to establish mechanisms for developing integrated plans. The Health and Wellbeing Board agreed to establish an Integration Task Force and a working group to:

- undertake detailed analysis of current expenditure
- identify opportunities for integration
- develop plans for investment and dis-investment and service re-design
- Analyse the impact on other organisations e.g. acute hospital trusts
- Propose a risk sharing plan for the Council and the CCG

5.15 Membership of the Integration Task Force is as follows:

Glyn Jones – Director for Adult Social Care, Health and Housing, BFC
Zoë Johnstone – Chief Officer: Adults and Joint Commissioning, BFC
Lynne Lidster – Head of Joint Commissioning, BFC
William Tong – Chair of Bracknell and Ascot Clinical Commissioning Group
Mary Purnell – Head of Operations, BACCG
Eve Baker – Deputy Accountable Officer, CCG Federation

5.16 Membership of the Working Group includes:

- Public Health, Finance and Commissioning staff from Bracknell Forest Council
- Commissioning and Finance staff from Bracknell and Ascot CCG
- Project Support staff from the Commissioning Support Unit

5.17 The following timetable has been proposed:

Integrated Taskforce –Planning Phases

Phase	Task	Milestone	Outcome	Support
Scoping Nov-Dec	Scope current spend Agree values and principles for ITF Identify challenges and risks	Workshop mid Nov	Agree understanding of current position	CCG and BFC Officers. CSU Team
Prioritisation Dec-Jan	Agree priority areas for joint work, based on analysis and benchmarking	HWBB report 12 Dec	Prioritised work plan for short, medium and long term	BACCG, BFC, Kings Fund, CSU, HWBB
Commissioning Feb 2013-March 2014	Detailed plans for newly specified and commissioned services	TBC for each work stream	Commissioned services ready to start by April 2015	Joint teams with CSU support
Implementation	New services commissioned and contract monitoring in place	April 2015	Commissioning plans implemented	Joint teams with CSU support

Governance

5.18 The plan must be approved by the Council's Executive, the CCG Board and the Health and Wellbeing Board in February 2014.

Approach to identifying funding and indicative priorities

5.19 An early list of opportunities has been established which looks to take the development of integrated work further and builds on areas of success to date. These include:

- Community Response and Reablement and Urgent Care
- Linking the Innovation Fund and Public Health Grant (£100k)
- Continuing Healthcare
    - A) Opportunities for integrating assessment functions (within the National Framework)
    - B) Providing integrated ongoing support
    - C) Pooling budgets
- Joint Commissioning and Procurement
- Dementia
- Personalisation, particularly in Health
- Communications and public engagement
- Exploring Housing Options for Vulnerable People
- Services for children and young people
- Leisure and wellbeing services

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The relevant legal implications are identified within the main body of this report.

Borough Treasurer

6.2 There are considerable financial implications for the Council from the expansion of the NHS money for Social Care, and the introduction of the ITF.

In 2014/15 the increase of NHS money for social care equates to approximately £300k, based on Bracknell's current share of the national transfer, which is as per the funding formula for adult social care. In respect of 2015/16 it is unclear precisely how much money will need to go into the fund, as highlighted in the body of the report in paragraphs 5.4 and 5.5, but initial estimates suggest approximately £5.7m. The allocation mechanism has yet to be determined by the NHS England, but it is worth noting that the funding formula for adult social care will potentially change to coincide with the introduction of the Care Cap.

It should be noted that £1bn of the total national fund of £3.8bn is payable on results, which on current formula allocations amounts to £1.5m for Bracknell. There is a risk that money to this value will be spent on efforts to achieve outcomes, but will not be reimbursed if those outcomes, are not achieved. The current judgement is that Bracknell performs well on the outcomes that are likely to be used as a basis for awarding the performance element of the money, for example delayed discharges from hospital, but the risk should not be ignored.

However, this should be regarded as an opportunity to achieve better outcomes for people locally, and potential efficiencies locally.

Equalities Impact Assessment

6.3 An Equalities Impact Assessment will be completed for each service change that is proposed as a result of the Integration Plan.

Strategic Risk Management Issues

6.4.1 Elements of existing BFC and CCG funding will be transferred to the ITF. Early indications show that this will include the Disabled Facilities Grant alongside existing NHS funding to social care e.g. for Intermediate Care and demographic pressures. Securing budgetary provision for existing services will be critical to the development of the Integration Plan.

6.4.2 It is a requirement of the ITF that Clinical Commissioning Groups and Councils understand the implications of decommissioning services from NHS providers, both Acute and Community Foundation Trusts. CCGs and Councils must agree the sharing of risk around the destabilisation of NHS Acute Sector and Community Services. The ITF guidance states, “CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services”.

6.4.3 Both the CCG and the Council must be in agreement to the priorities for funding from the ITF. This will require a shared understanding of the needs of the population and future demand.

6.4.4 The performance framework for the ITF is still to be determined. Bracknell Forest Council is a high performing authority. It is not yet clear whether the implementation of the performance related part of the ITF will require meeting "stretch targets". Sufficient funding must be allowed in the ITF to improve performance relating to existing services.

6.4.5 In developing the Integration Plan, it is critical to ensure that services are planned to meet the needs of the people in Bracknell Forest. This will require local pathways and services that are tailored for the area rather than generic services across the east of the county.

7. CONSULTATION

Principal Groups Consulted

7.1 Consultation will be undertaken with appropriate organisations and people as a result of proposed service changes. It is a requirement of the ITF to consult.

Method of Consultation

7.2 To be determined, dependent on the service changes proposed.

Representations Received

7.3 All representations will be considered in developing the Integration Plan.

Background Papers

Annex A – ITF Letter
Annex B – Draft Integration Plan Template

Contact for further information

Glyn Jones, Adult Social Care, Health and Housing - 01344 351458
glyn.jones@bracknell-forest.gov.uk

Mary Purnell, Heads of Operations, Bracknell and Ascot CCG – 01753 636176
Mary.purnell@nhs.net

17 October 2013

To: CCG Clinical Leads
Health and Wellbeing Board Chairs
Chief Executives of upper tier Local Authorities
Directors of Adult Social Services

cc: CCG Accountable Officers
NHS England Regional and Area Directors

Dear Colleagues

Next Steps on implementing the Integration Transformation Fund

We wrote to you on 8 August 2013 setting out the opportunities presented by the integration transformation fund (ITF) announced in the spending review at the end of June. While a number of policy decisions are still being finalised with ministers, we know that you want early advice on the next steps. This letter therefore gives the best information available at this stage as you plan for the next two years.

Why the fund really matters

Residents and patients need Councils and Clinical Commissioning Groups (CCGs) to deliver on the aims and requirements of the ITF. It is a genuine catalyst to improve services and value for money .The alternative would be indefensible reductions in service volume and quality.

There is a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund. We encourage Health and Wellbeing Boards to extend the scope of the plan and pooled budgets.

Changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five year strategy for health and care. Accordingly the NHS planning framework will invite CCGs to agree five year strategies, including a two year operational plan that covers the ITF through their Health and Wellbeing Board.

A fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. There is excellent practice in some areas that needs to be replicated everywhere. The ingredients are the same across England; the recipe for success differs locality by locality.

Integrated Care Pioneers, to be announced shortly, will be valuable in accelerating development of successful approaches. We are collaborating with all the national partners to support accelerated adoption of integrated approaches, and will be launching support programmes and tools later in 2013.

Where does the money come from?

The fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16, which remain very challenging. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. (The requirements of the fund are likely to significantly exceed existing pooled budget arrangements). Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

Working with providers

It will be essential for CCGs and Local Authorities to engage from the outset with all providers, both NHS and social care, likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the fund includes agreement to the service change consequences.

Supporting localities to deliver

We are acutely aware that time is pressing, and that Councils and CCGs need as much certainty as possible about how the detail of the fund will be implemented. Some elements of the ITF are matters of Government policy on which Ministers will make decisions. These will be communicated by Government in the normal way. The Local Government Association and NHS England are working closely together, and collaborating with government officials, to arrive at arrangements that support all localities to make the best possible use of the fund, for the benefit of their residents and patients. In that spirit we have set out in the attached annex our best advice on how the Fund will work and how Councils and CCGs should prepare for it.

The Government has made clear that part of the fund will be linked to performance. We know that there is a lot of interest amongst CCGs and Local Authorities in how this “pay-for-performance” element will work. Ministers have yet to make decisions on this. The types of performance metrics we can use (at least initially) are likely to be largely determined by data that is already available. However, it is important that local discussions are not constrained by what we can measure. The emphasis should be on using the fund as a catalyst for agreeing a joint vision of how integrated

care will improve outcomes for local people and using it to build commitment among local partners for accelerated change.

Joint local decision making and planning will be crucial to the delivery of integrated care for people and a more joined up use of resources locally. The ITF is intended to support and encourage delivery of integrated care at scale and pace whilst respecting the autonomy of locally accountable organisations.

This annex to this letter sets out further information on:

- How the pooled fund will be distributed;
- How councils and CCGs will set goals and be rewarded for achieving them;
- Possible changes in the statutory framework to underpin the fund;
- The format of the plans for integrated care and a template to assist localities with drawing up plans that meet the criteria agreed for the fund;
- Definitions of the national conditions that have to be met in order to draw on the polled fund in any locality; and
- Further information on how local authorities, CCGs, NHS England and government departments will be assured on the effective delivery of integrated care using the pooled fund.

Leads from the NHS and Local Government will be identified to assist us to work with Councils and CCGs to support implementation. More details on this can be found in the annex. We will issue a monthly bulletin to Councils and CCGs with updates on the Integration Transformation Fund.

Yours faithfully

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

NHS England Publications Gateway Ref. No.00535

Annex

Advice on the Integration Transformation Fund

What is included in the ITF and what does it cover?

Details of the ITF Fund

The June 2013 SR set out the following:	
2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the ITF will be created from the following:
£1.9bn NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. Composed of:
• £130m Carers' Breaks funding
• £300m CCG reablement funding
• £354m capital funding (including c.£220m of Disabled Facilities Grant)
• £1.1bn existing transfer from health to social care

1. The Integration Transformation Fund will be £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users. In 2014/15 an additional £200m transfer from the NHS to social care in addition to the £900m transfer already planned will enable localities to prepare for the full ITF in 2015/16.

2. In 2014/15 use of pooled budgets remains consistent with the guidance[1] from the Department of Health to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

3. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

4. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

5. *In line with our responsibilities under the Health and Social Care Act, NHS England is also making it a condition of the transfer that local authorities and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

6. *NHS England is also making it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

7. In 2015/16 The fund will be allocated to local areas, where it will be put into pooled budgets under joint governance between CCGs and local authorities. A condition on accessing the money in the fund is that CCGs and local authorities must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

How will the ITF be distributed?

8. Councils will receive their detailed funding allocation following the Autumn Statement in the normal way. When allocations are made and announced later this year, they will be two-year allocations for 2014/15 and 2015/16 to enable planning.

9. In 2014/15 the existing £900m s.256 transfer to Local Authorities for social care to benefit health, and the additional £200m will be distributed using the same formula as at present.

10. The formula for distribution of the full £3.8bn fund in 2015/16 will be subject to ministerial decisions in the coming weeks.

11. In total each Health and Wellbeing Board area will receive a notification of its share of the pooled fund for 2014/15 and 2015/6 based on the aggregate of these allocation mechanisms to be determined by ministers. The allocation letter will also specify the amount that is included in the pay-for-performance element, and is therefore contingent in part on planning and performance in 2014/5 and in part on achieving specified goals in 2015/6.

How will Councils and CCGs be rewarded for meeting goals?

12. The Spending Review agreed that £1bn of the £3.8bn would be linked to achieving outcomes.

13. In summary 50% of the pay-for-performance element will be paid at the beginning of 2015/16, contingent on the Health and Wellbeing Board adopting a plan that

meets the national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. We are still agreeing the detail of how this will work, including for any locally agreed measures.

14. In practice there is a very limited choice of national measures that can be used in 2015/6 because it must be possible to baseline them in 2014/5 and therefore they need to be collected now with sufficient regularity and rigour. For simplicity we want to keep the number of measures small and, while the exact measures are still to be determined, the areas under consideration include:

    - Delayed transfers of care;
    - Emergency admissions;
    - Effectiveness of re-ablement;
    - Admissions to residential and nursing care;
    - Patient and service user experience.

15. In future we would hope to have better indicators that focus on outcomes for individuals and we are working with Government to develop such measures. These can be introduced after 2016/7 as the approach develops and subject to the usual consultation and testing.

16. When levels of ambition are set it will be clear how much money localities will receive for different levels of performance. In the event that the agreed levels of performance are not achieved, there will be a process of peer review, facilitated by NHS England and the LGA, to avoid large financial penalties which could impact on the quality of service provided to local people. The funding will remain allocated for the benefit of local patients and residents and the arrangements for commissioning services will be reconsidered.

Does the fund require a change in statutory framework?

17. The Department of Health is considering what legislation may be necessary to establish the Integrated Transformation Fund, including arrangements to create the pooled budgets and the payment for performance framework. Government officials are exploring options for laying any required legislation in the Care Bill. Further details will be made available in due course. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the fund?

18. Each upper tier Health and Wellbeing Board will sign off the plan for its constituent local authorities and CCGs. The specific priorities and performance goals are clearly a matter for each locality but it will be valuable to be able to:

    - Aggregate the ambitions set for the fund across all Health and Wellbeing Boards;

- Assure that the national conditions have been achieved; and

- Understand the performance goals and payment regimes have been agreed in each area.

19. To assist Health and Wellbeing Boards we have developed a draft template which we expect everyone to use in developing, agreeing and publishing their integration plan. This is attached as a separate Excel spread sheet.

20. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the ITF. We strongly encourage Councils and CCGs to make immediate use of this template while awaiting further guidance on NHS planning and financial allocations.

21. Local areas will be asked to provide an agreed shared risk register, with agreed risk sharing and mitigation covering, as a minimum, steps that will be taken if activity volumes do not change as planned. For example if emergency admissions increase or nursing home admissions increase.

What are the National Conditions?

22. The Spending Review established six national conditions:

National Condition	Definition
Plans to be jointly agreed	The Integration Plan covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and Local Authorities should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 2 to 6,

National Condition	Definition
	above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The forthcoming national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England will provide guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas will be asked to: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas, and will make this available alongside the planning template. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas will be asked to identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning.
Agreement on the consequential impact of changes in the acute sector	Local areas will be asked to identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient engagement in this planning, as well as plans for political buy-in.

How will preparation and plans be assured?

23. Ministers will wish to be assured that the ITF is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

24. To maximise our collective capacity to achieve these outcomes and deliver sustainable services we will have a shared approach to supporting local areas and assuring plans. This process will be aligned as closely as possible to the existing NHS planning rounds, and CCGs can work with their Area Teams to develop their ITF plans alongside their other planning requirements.

25. We will establish in each region a lead local authority Chief Executive who will work with the Area and Regional Teams, Councils, ADASS branches, DPHs and other interested parties to identify how Health and Wellbeing Boards can support one another and work collaboratively to develop good local plans and delivery arrangements.

26. Where issues are identified, these will be shared locally for resolution and also nationally through the Health Transformation Task Group hosted by LGA, so that the national partners can broker advice, guidance and support to local Health and Well Being Boards, and link the ITF planning to other national programmes including the Health and Care Integration Pioneers and the Health and Well Being Board Peer Challenge programme. We will have a first review of readiness in early November 2013.

27. We will ask Health and Well Being Boards to return the completed planning template (draft attached) by 15 February 2014, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the ITF.

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Integration Transformation Fund

Draft Plan Submission Template

Local Authority	<Name of Local Authority>
Clinical Commissioning Groups	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
Boundary Differences	<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>
Date agreed at Health and Well-Being Board:	<dd/mm/yyyy>
Date submitted:	<dd/mm/yyyy>
Minimum required value of ITF pooled budget: 2014/15	£0.00
2015/16	£0.00
Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£0.00

Authorisation and Sign Off

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
date	<date>

Signed on behalf of the Clinical Commissioning Group	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Local Authority	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

Signed on behalf of the Health & Wellbeing Board	
By Chair of the HWB:	<Name of Signatory>
Position	<Job Title>
date	<date>

Service provider engagement

Please describe how health and social care providers have been involved in the development of this pla, and the extent to which they are party to it

Patient, service user and public engagement

Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it

Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition

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Outcomes and metrics

Please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Outcome measures- Examples only	Current Baseline (as at....)	14/15 Projected delivery (full year?)	15/16 Projected delivery (full year?)
Delayed transfers of care			
Emergency admissions			
Effectiveness of reablement			
Admissions to residential and nursing care			
Patient and service-user experience			
<Local measure>			
<Local measure>			
<Local measure>			

Finance

Please summarize the total health and care spend for each commissioner in your area. Please

Organisation	2013/14 spend	2013/14 benefits	2014/15 spend	2014/15 benefits	2015/16 spend	
Local Authority Social Services						
CCG						
Primary Care						
Specialised commissioning						
Local Authority Public Health						
Total						

Please summarize where your pooled budget will be spent. NB the total must be equal to or more than your total ITF allocation

ITF Investment	2014/15 spend	2014/15 benefits	2015/16 spend	2015/16 benefits
Scheme 1				
Scheme 2				
Scheme 3				
Scheme 4				
Scheme 5				
Total				

Approximately 25% of the ITF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully		
	Maximum support needed for other		
Outcome 2	Planned savings (if targets fully		
	Maximum support needed for other		

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Key Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk Rating	Mitigating Actions
Risk 1		
Risk 2		
Risk 3		
Risk4		

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TO: HEALTH OVERVIEW AND SCRUTINY PANEL
7 January 2014

DRAFT BUDGET PROPOSALS 2014/15
(Borough Treasurer and Director of Adult Services, Health & Housing)

1 INTRODUCTION

1.1 The Executive agreed the Council's draft budget proposals for 2014/15 at its meeting on 10 December 2013 as the basis for consultation with the Overview and Scrutiny Commission, Overview and Scrutiny Panels and other interested parties. The consultation period runs until 21 January 2014, after which the Executive will consider the representations made at its meeting on 11 February 2014, before recommending the budget to Council.

2 SUGGESTED ACTION

2.1 That the Overview and Scrutiny Panel comments on the Council's draft budget proposals for 2014/15.

3 SUPPORTING INFORMATION

3.1 Attached to the reports to the other Overview and Scrutiny panels were relevant extracts from the 2014/15 Revenue Budget and Capital Programme reports. These are less relevant to this panel, as the Public Health budget is almost entirely funded from ring-fenced specific grant, with the additional input to the budget being a contribution within the NHS Money for Social Care transfer.

3.2 Public Health is the most significant specific grant received by the Council. The Council has previously been notified of ring fenced grant allocations of £2.772m in 2013/14 and £3.049m in 2015/16. Announcements suggest that the ring fencing of public health grant will continue into 2015/16, although no indication of the likely grant amount has been received at this stage. A further £100k is earmarked from the NHS Money for Social Care transfer for local public health projects.

3.3 For planning purposes, it is assumed that the 2015/16 grant, and contribution from the NHS Money for Social Care transfer, will be the same as in 2014/15. Attached to this report therefore is a detailed breakdown of the Public Health budget for 2013/14, with proposals for 2014/15 following through into 2015/16.

3.4 The full 2014/15 Revenue Budget and Capital Programme reports are available on the Council's public website as part of the wider budget consultation (http://consult.bracknell-forest.gov.uk/portal).

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

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	2013/14	2014/15	2015/16
	£000	£000	£000
Public Health Available Funds			
Public Health Grant	2772	3049	3049
Contribution from NHS Transfer	100	100	100
Available Funds	**2872**	**3149**	**3149**
Expenditure within the Berkshire Joint Arrangement			
Contribution to Public Health Berkshire Shared Team	97	97	97
Smoking Cessation	268	268	268
Sexual Health	805	805	805
Childrens Health	237	237	237
Weight Management	33	33	33
Total within Joint Arrangement	1440	1440	1440
Local Public Health Expenditure			
Bracknell Public Health Team	268	268	268
Contribution to Drug and Alcohol Action Team	744	744	744
Health Checks	83	83	83
Sexual Health	68	68	68
Projects to generate early public health outcomes through joint working across the Council and the CCG	100	100	100
Other Local Schemes	169	321	321
Aligning the outcomes of existing services to achieving Public Health outcomes	0	125	125
Total Local Team expenditure	**1432**	**1709**	**1709**
Total Public Health Expenditure	**2872**	**3149**	**3149**

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Agenda Item 9

HEALTH OVERVIEW AND SCRUTINY PANEL
7 JANUARY 2014

APPLYING THE LESSONS OF THE FRANCIS REPORT FOR HEALTH OVERVIEW AND SCRUTINY

Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report presents the attached report resulting from the review of the lessons of the Francis Report for Health Overview and Scrutiny, undertaken by a working group of the Health Overview and Scrutiny Panel.

2 RECOMMENDATIONS

That the Health Overview and Scrutiny Panel:

2.1 Adopts the attached report and recommendations of the Working Group which reviewed the lessons of the Francis Report for Health Overview and Scrutiny.

2.2 Stands down the working group.

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

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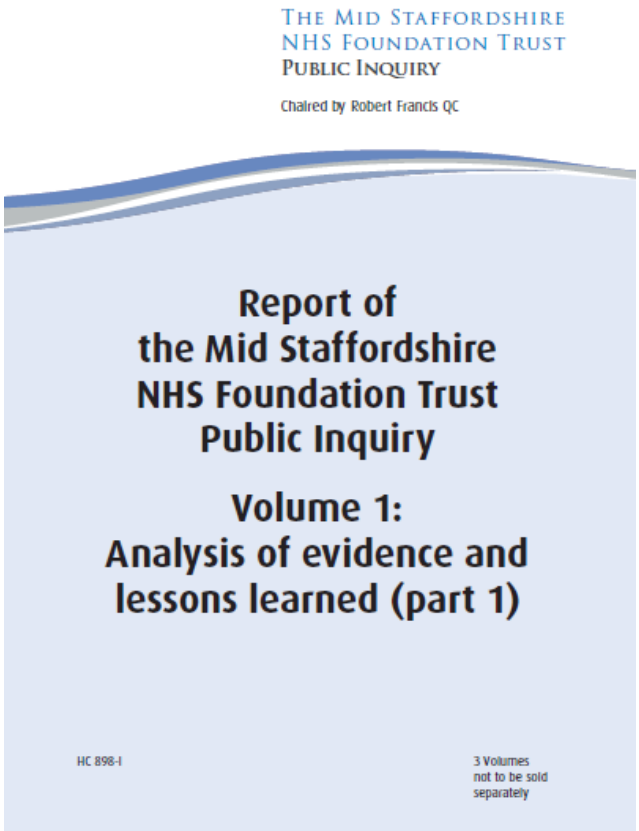
Bracknell Forest Council

DRAFT 09.12.2013

Applying the Lessons of the Francis Report to Health Overview and Scrutiny

by a Working Group of the Health Overview and Scrutiny Panel



December 2013

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Acknowledgements

The Working Group would like to express its thanks and appreciation to the following people for their co-operation and time. All those who have participated in the review have been thanked for their contribution and have been sent a copy of this report.

Bracknell and Ascot Clinical Commissioning Group
Dr William Tong Chairman
Sarah Bellars Director of Nursing

Centre for Public Scrutiny
Avril Davies Health Scrutiny Adviser

The Royal Berkshire NHS Foundation Trust
Ed Donald Chief Executive Alistair Flowerdew Medical Director
Caroline Ainslie Director of Nursing

Frimley Park Hospital NHS Foundation Trust
Nicola Ranger Director of Nursing

South Central Ambulance Service NHS Foundation Trust
Deirdre Thompson Director of Quality and Patient Care

Heatherwood and Wexham Park Hospitals NHS Foundation Trust
Philippa Slinger Chief Executive Dr Rob Loveland Medical Director
Thomas Lafferty Director of Corporate Affairs

Healthwatch Bracknell Forest
Clare Turner Chris Taylor

Bracknell Forest Council
Councillor Dale Birch Executive Member for Adult Services, Health and Housing
Glyn Jones Director of Adult Social Care, Health & Housing
Richard Beaumont Head of Overview and Scrutiny

1. Foreword by the Lead Member

1.1 This review was brought about as a direct result of the Francis report into the Mid-Staffordshire Hospital crisis and the deficiencies it highlighted in the Health Overview and Scrutiny function of the local authorities.

1.2 I must stress that this review was not convened through any concerns that our arrangements were in any way lacking but rather to determine whether there were areas where our Overview and Scrutiny practices could be enhanced in light of the Francis report and recommendations.

1.3 What this review has highlighted is that members must take an active role in Health Overview and Scrutiny in order to be fully aware of, and challenge when necessary, any changes that occur in the NHS and its agencies.

1.4 Not surprisingly I have a number of people to thank for their open, frank and incisive input to the discussions that have gone to making up a large part of this review, which I now do unreservedly.

In particular I would like to thank Richard Beaumont for all the work he has put into this review, it is fair to say that the review would not be what it is without his dedication to detail and ability to just get on with the job .

To Glyn Jones our Director of Adult Social Care, Health & Housing, our thanks for your input and attending so many of our Working Group meetings.

To Cllr Birch, Executive portfolio holder for Adult Services, Health and Housing for his input to this review.

To the numerous contributors from the NHS and its agencies which I have listed in the acknowledgements, on the contents page above.

Last and by no means least to my colleagues on the Working Group who applied themselves to the enormous amount of data coming out of the Francis report together with the lengthy meetings that they participated in.

Councillor Mrs Jennie McCracken
Lead Working Group Member

2. Executive Summary

2.1 The Inquiry by Robert Francis QC into the failings of the Mid Staffordshire Foundation NHS Trust concluded that the large number of excess deaths between 2005 and 2008 at Stafford Hospital and the incidence of very poor patient care there constituted a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'. In the Government's interim response to the Inquiry report, the Secretary of State for Health said *'This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.'*

2.2 Bracknell Forest Council's Health Overview and Scrutiny (O&S) Panel set up a Working Group to help ensure that the failures at Mid Staffordshire do not happen in our borough. This report describes the work of the Working Group Between May and November 2013, and it is organised in the following sections:

Part 3 Gives background information in respect of the Francis report, and summarises how we set about our review.

Part 4 Summarises the information and evidence gathered by the Working Group.

Part 5 Contains our analysis and the conclusions we have reached following our review, on which we have based a number of recommendations to the main NHS organisations providing emergency and inpatient health services to Bracknell Forest residents; to the Council's Executive; to the O&S Commission; and to the Health O&S Panel.

At the end of our report is a glossary of terms used and an appendix containing the approach we took to our review.

2.3 Our overall conclusions are that

- The NHS Trusts which provide most of the hospital, ambulance and other inpatient health services to Bracknell Forest residents are showing a seriousness of purpose in learning and applying the lessons from Francis. They were all clearly shaken by the appalling failures at Mid Staffordshire. The real changes and improvements they have embarked upon demonstrated to us their determination not to let similar failures happen in their Trust.
- Although the Council's Health O&S function has been active and effective, there are a number of improvements which can and should be made if the shortcomings in local authority O&S found by Mr Francis are not to be repeated in Bracknell Forest. Implementing these recommendations would require significantly more time commitment by Members and officers; this cannot be accommodated without hard choices being made by the O&S Commission and Panel.

2.4 Our recommendations to the NHS Trusts are in paragraph 5.7 and are in summary:

a) To include in their welcome pack for patients a brief guide to how to make a complaint or compliment.

b) **To publish detailed information on complaints, at least equal to the level used by the Royal Berkshire and the Berkshire Healthcare Trust. The published information on complaints should also include the outcome for the complainant and any learning points.**
c) **To give publicity to the role of local authority O&S.**

2.5 Our recommendation to the Council's Executive are in paragraph 5.28:

The Executive Member for Adult Services, Health and Housing should carry out a stock take of all the Council's external positions on NHS bodies, and works with Members to ensure that all suitable opportunities are taken up.

2.6 Our recommendations to the O&S Commission are in paragraphs 5.20, and 5.32-33 and are in summary:

a) **That public engagement mechanisms are kept under review, with the underlying aim of learning about residents' healthcare concerns as directly as possible, and – in concert with Local Healthwatch - by giving the public a voice.**
b) **Recognising that officer resources are already fully stretched, to decide, in consultation with the Health O&S Panel, how to meet the new demands on officer time arising from our recommendations.**
c) **To consider reviewing, and asking the other O&S Panels to review, the scope for replicating the improvements to Health O&S throughout the Council's O&S function.**

2.7 Our recommendations to the Health O&S Panel are in paragraph 5.9 onwards and are in summary:

a) **To agree on a refreshed statement of the aim and objectives of Health O&S, and the role of Members.**
b) **To adopt a selective and tiered approach to scrutiny of the local NHS service providers, which does not cover all services.**
c) **Each Member to have a specialist area of NHS activity to develop knowledge of, and to lead the Panel's O&S work on, including scrutiny of complaints information.**
d) **That members should receive induction, annual refresher and targeted training.**
e) **That a panel of people with clinician experience be recruited in a voluntary 'pro-bono' capacity and used to provide independent expert advice to the Panel.**
f) **To improve the information flow to members, concentrating on exception reporting, flagging of issues of possible concern, and to prioritise quite ruthlessly on where O&S should focus its efforts.**
g) **All Members should be encouraged to outreach into their respective wards to relay properly prepared and approved health information and issues to residents.**
h) **The Parliamentary and Health Services Ombudsman should be asked to re-consider their decision not to provide information to the Panel on complaints to the NHS Trusts.**
i) **The Panel's terms of reference are amended to recognise Healthwatch Bracknell Forest (HWBF) as an Observer, that regular feedback is sought from HWBF, and that the Panel assists in spreading awareness of HWBF.**

j) **To maintain regular contact with those BFC councillors on Trust Boards/Governing Bodies, including asking each councillor representative to report to the Panel at least once annually.**

k) **Inviting input from all Members including the Executive Member, also the Director, and the Public Health Consultant before commenting on the annual NHS Quality Accounts.**

l) **The specialist members concerned should maintain contact with the local CQC Manager, and attend any CQC 'Listening Events' with patients of the three hospitals and Berkshire Healthcare Trust in advance of their inspections. The Panel's specialist member should also actively engage in the CQC 'Quality Summits' for those Trusts we are focussing on.**

m) **The running of Panel meetings should be improved through: better forward planning and monitoring, better preparation for meetings, making discussions more conclusive, continuing the improved format of the record of meetings, and more systematic follow-up.**

n) **Not to agree the recommendations in this report unless all its Members are personally committed to putting in the time to deliver what is recommended as new responsibilities.**

o) **The Working Group's report is sent, together with our thanks to their representative for her input, to the Centre for Public Scrutiny for sharing widely.**

2.8 Members of the Working Group hope that this report will be well received and we look forward to receiving responses to its recommendations.

2.9 The Working Group comprised:

Councillor Mrs McCracken(Lead Member)
Councillor Mrs Angell
Councillor Angell
Councillor Baily
Councillor Kensall
Councillor Mrs Temperton
Councillor Virgo

From left to right rear: Richard Beaumont, Councillors Virgo, Baily and Angell

From left to right front: Councillors Kensall, Mrs McCracken, Mrs Temperton and Mrs Angell

3. Background

3.1 On 9 June 2010 the Secretary of State for Health announced a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. The Inquiry was established under the Inquiries Act 2005 and was chaired by Robert Francis QC.

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

3.3 The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on Wednesday 6 February 2013. The number of excess deaths between 2005 and 2008 at Stafford Hospital was estimated at 492 people. Examples of poor care include patients being left in soiled bedclothes for lengthy periods, lack of assistance with eating and drinking, filthy wards and toilets, lack of privacy and dignity such as people left naked in a public ward, and triage in A&E undertaken by untrained staff. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'.

3.4 The Francis Inquiry report recommended that a fundamental change in culture was required which put patients and their safety first. Mr Francis made 290 recommendations, framed around:

- A structure of fundamental standards and measures of compliance
- A requirement for openness, transparency and candour
- Improved support for compassionate, caring and committed nursing
- Stronger, patient centred healthcare leadership, with increased accountability
- Accurate, useful and relevant information to allow effective comparison of performance by patients and the public.

3.5 The Francis Inquiry attributed accountability for the appalling care at Stafford Hospital to the Trust Board, but also pointed to a systemic failure by a range of national and local organisations – including the Health Overview and Scrutiny Committees of both the County and District councils concerned - to respond to concerns. The report indicated that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS. On O&S specifically, Mr Francis said, '*The Overview and Scrutiny Committees in Stafford were happy to take on a role scrutinising health services but did not equate this with responsibility for identifying and acting on matters of concern; and they lacked expert advice and training, clarity about their responsibility, patient voice involvement, and offered ineffective challenge.'*

3.6 In the Government's initial response to the Francis report, the Secretary of State for Health said in March 2013: *'The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry makes horrifying reading. At every level, individuals and organisations let down the patients and families that they were there to care for and protect. A toxic culture was allowed to develop unchecked which fostered the normalisation of cruelty and the victimisation of those brave enough to speak up. For far too long, warning signs were not seen, ignored or dismissed. Regulators, commissioners, the Strategic Health Authority, the professional bodies and the Department of Health did not*

* All documentation relating to the Francis Inquiry can be found at http://www.midstaffspublicinquiry.com/

identify problems early enough, or, when they were clear, take swift action to tackle poor care. They failed to act together in the interests of patients. This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again….Every individual, every team and every organisation needs to reflect with openness and humility about how they use the lessons from what happened at Mid Staffordshire NHS Foundation Trust to make a meaningful difference.'

3.7 An O&S officer attended the Centre for Public Scrutiny's annual conference on 11 June 2013, at which Mr Francis was one of the speakers. Mr Francis stressed the potential value of local authority O&S in safeguarding against similar failures to those in Mid Staffordshire. He drew particular attention to the need to make full use – and ensure the transparency - of performance information, to elicit information from various sources, and not to ignore the messages to be drawn from patients' complaints. At the same conference, Tim Kelsey, a Director of NHS England, suggested that Health O&S Committees needed professional support in interpretation of data, and they should not rely solely on information given by NHS Trusts.

3.8 At its meeting on 18 April 2013, the Health O&S Panel decided there was a compelling need to safeguard against the failings in Mid Staffordshire occurring in Bracknell Forest. The Panel decided to commence a Working Group ('the Group') with two main purposes:

- To review the steps being taken to implement the lessons of the Francis report by those nearby NHS organisations providing emergency and inpatient health services to Bracknell Forest residents.
- To recommend to the Panel what changes are needed to the Health O&S practices at Bracknell Forest in the light of the weaknesses in the Mid Staffordshire local authorities found by Mr Francis.

3.9 The Group held its first meeting on 9 May 2013, and subsequently agreed its key objectives and its scope as set out at Appendix 1. Mr Francis had identified a number of weaknesses in O&S and in order to complete our review in good time, we grouped these into five separate workstreams, with each councillor in our Group leading the detailed work on one of these:

- Redefining the objectives for health O&S and specifying which NHS trusts are to be routinely scrutinised
- Members' role and improving their effectiveness (including training, advice and support)
- Prioritising issues for O&S attention, and getting the right information
- Patients' complaints – systems and information flows
- Working with partners
- Preparing for, conducting and recording meetings of the Health O&S panel.

3.10 The Group gathered information from various sources, as set out in Section 4 of this report. We used that to arrive at a set of conclusions on which we then make a number of recommendations, as set out in Section 5.

4. Investigation And Information Gathering

Introductory Review Work

4.1 On **9 May 2013** the Working Group ('the Group') commenced its work. We elected Cllr Mrs McCracken as our Lead Member and we received an introductory briefing from the Council's Director of Adult Social Care, Health & Housing, and the Head of Overview and Scrutiny. The Group reviewed the relevant extracts from the Francis report, the government's response, and related briefing material.

4.2 The Group confirmed its overall purpose, as set by the Health Overview & Scrutiny (O&S) Panel at its meeting on 18 April 2013, as being to:

- recommend to the Panel what changes are needed to the Health O&S practices at Bracknell Forest in the light of Mr Francis' extensive findings and recommendations regarding inadequacies in local authority health scrutiny at Mid Staffordshire;
- participate in the workshop envisaged by the Health and Wellbeing Board (Glyn Jones (GJ) advised that a date for this had yet to be arranged);
- review the steps being taken to implement the lessons of the Francis report by those NHS organisations serving Bracknell Forest residents.

Members agreed that this would require a thorough review of the weaknesses in O&S highlighted by Francis, showing that the Council had responded properly to the lessons it offered. The Francis report clearly showed that Staffordshire Council's O&S had barely 'touched the surface' of the problems at that hospital. The Group recognised at the outset that it should reach a view on a methodical way for the Panel to decide what pertinent health data it needed, and to interpret and use that information to hold health service providers to account. Other matters arising in discussion were:

a) There is a complex range of NHS Trusts providing health services to Bracknell Forest residents. To make the task manageable, it would be necessary to concentrate attention and scrutiny coverage only on those NHS organisations which are significant local providers.

b) In deciding what level of review was needed of NHS organisations, care must be taken not to over-step the role of O&S into Local Healthwatch's (LHW) for example. Also, as it could be argued that the primary responsibility for O&S follow-up lay with the Health scrutiny committee of the local authorities where the NHS trusts are based, we decided to enquire of those councils what review work they planned to do.

c) The Group agreed to frankly reappraise what the objectives of Health scrutiny in Bracknell Forest are, and what the role and contribution of councillors should be.

d) The type and volume of complaints, and the systems around complaints were another focus of the Group's review. We considered that people tended not to complain unless it was important to them, so it would be important for Health O&S to take careful note of complaints made. This might involve reviewing individual complaints (with names erased), and seeing whether there was any connection for example with complaints about safeguarding. The Group recognised the need to be sensitive to and protect confidential patient information.

e) It could be argued that there should be a duty on General Practitioners (GPs) to follow through the experience of their patients when at hospital.

f) The NHS comprised a huge field of activity thus there was a great need for O&S to prioritise the issues it wanted to cover; which in turn required a flow of relevant information.

g) Historically, NHS managers had largely determined what information was provided to the Health O&S Panel. This needed to change with the Panel taking the initiative more in setting out what its requirements are and, for example, requiring that information be provided in advance of Panel meetings, to allow for proper preparation – which also needed, for example: forward agenda planning; Members thoroughly reading the material; and a pre-meeting to agree which Members would lead on which lines of questioning.

h) A key message of the Francis report was seen to be that Health O&S needs to get closer to the patients' experience. Visits to wards might well be in breach of patient confidentiality. There would be a need to work in collaboration with LHW.

i) The WG might well conclude that there were wider lessons for O&S beyond Health O&S, particularly on gaining a better understanding of residents' experience of using council services.

j) That as other councils would be similarly considering changes to their O&S practices in the light of Francis, we should seek input from the Centre for Public Scrutiny (CfPS) on the best way to approach the task, and experience elsewhere in local government

4.3 The Group discussed the approach to take to the review, and – following our meeting in June - this was subsequently finalised in the standard scoping document at Appendix 1. At the centre of our approach, we analysed each of the comments in the Francis report concerning O&S. These were then grouped under a number of headings. To make our work manageable, each Member of the Group then took responsibility for progressing – with O&S Officer assistance - one or more heading, and reported back to the Group on how they had pursued the issue, with their recommended actions on the way forward.

4.4 On **3 June**, the Group met **Avril Davies (AD), Health Scrutiny Adviser, Centre for Public Scrutiny** (CfPS), to explore any suggestions for emerging good practice, in terms of councils' O&S response to actions arising from the Francis report. AD summarised the CfPS's involvement through the Healthy Accountability Forum and elsewhere in interacting with councils endeavouring to respond appropriately to the lessons from the Francis report. That response was still at an early stage, with no obvious leaders of best practice, and most councils were trying to form a view on what information they should be seeking from the NHS, not falling into the trap of trying to micro-manage the NHS, and trying to build robust lines of questioning whilst recognising that elected Members are not health professionals. The Care Quality Commission (CQC) were similarly applying themselves to the task of learning from the Francis report, and AD encouraged Health O&S to engage with the CQC and get a fuller understanding of the CQC's outputs.

4.5 AD said the Francis report presented O&S with an opportunity to 'raise their game', particularly in terms of not taking entirely on trust information presented by NHS Trusts, and to look more closely at quality of service issues – and giving this priority over, e.g. real estate matters. Staffordshire Council had constructed a confusing arrangement of sharing health scrutiny responsibilities with the District councils, a complication which did not arise with unitary authorities. A central message from Francis is the need to understand better what issues are of concern to residents, and most councils needed a better 'public platform'. Members acknowledged that the

Council's Public Participation scheme for O&S was not generating any public engagement, and additional accessibility would be useful (we return to this in paragraph 5.18 below). Anecdotal cases can sometimes point towards wider service failures. The Director pointed out that the Clinical Commissioning Group (CCG) have a process by which doctors can raise concerns about hospital services; and the Council worked with the NHS on individual concerns such as inappropriate admissions from care homes to hospitals.

4.6 AD stressed the need to understand and examine Standardised Mortality Rates for local hospitals, and to make a start it might be advisable to have skilled advice on the make-up of these rates and the comparative position of each of the hospitals. A related issue was to look at the hospitals' wider clinical governance, particularly in drawing attention to service failures, also the health prevention agenda. Further information was available in the NHS Trusts' published Board papers. AD also encouraged the Group to consider inviting independent experts from 'Clinical Networks' to advise Members on topics under review. Other matters arising in discussion were:

a) It might be worth building and maintaining contact with the PALS service, though the limitations on patient confidentiality meant that they might not be very forthcoming. The dignity of patients is important.
b) Establishing a comprehensive picture of patients' experience required 'triangulation' of information from several sources, for example: the 'inpatient surveys', CQC reports, information provided by the NHS Trusts (such as Quality Accounts), anecdotal information from councillors' Ward surgeries, etc.
c) There is a vast range of issues around NHS services, well beyond the capacity of Member and officer time and resources to examine. This demanded rigorous prioritisation of the most important issues to devote O&S attention to. The number of Panel meetings could only be increased at the expense of other O&S activity, or if extra resources became available, neither of which are likely.
d) Presentations should be obtained in advance of meetings, to allow Members to prepare the questions they wanted to raise.
e) Preparation through pre-meetings was useful, and this could be built on, for example through making fuller use of the support from Council officers. It might also be worth having a de-briefing meeting shortly after each panel meeting.
f) Some Members saw a need for training on the interpretation of statistics, though it needed to be remembered that Members were not required, or expected to be health experts.

<u>Surrey County Council's Health Scrutiny Committee</u>

4.7 On **4 July** two Members of the Group participated in a meeting of Surrey County Council's Health Scrutiny Committee. Representatives of the NHS Hospital Trusts serving Surrey residents described their progress in addressing the lessons from the Francis report, and there was a discussion on the Committee's access to information on complaints by patients of those Trusts. As Frimley Park Hospital was included and Bracknell Forest has a clear interest in that, it was agreed that a partnership approach with Surrey would be worthwhile.

4.8 All representatives showed that their Trusts were taking Francis seriously and their work had identified the need for various improvements. They all showed a

commendable sense of responsibility, for example the Chief Executive of Epsom and St Helier made it very plain that 'the buck stops with me'. Recurring themes were:

a) responding to the cultural change
b) ensuring all staff understood the key points in Francis, e.g. through printing a message on their payslips about Francis
c) engaging all staff, e.g. by seeking their ideas about how to improve quality of care
d) reviewing/reorganising complaint handling processes. There is no national guidance on hospital complaints handling, making the sharing of consistent information challenging.
e) ensuring the 'duty of candour' is achieved
f) marshalling the work into workstreams, each led by a senior officer, and with Trust Board involvement/oversight
g) overall clinical leadership
h) the role of Ward Sisters is pivotal
i) a need to improve on listening to patients' experience and concerns, and to get regular feedback from them, e.g. through evening and week-end 'walk-arounds' aimed at seeing things from the patients' perspective.

4.9 The Chairman of Surrey's Scrutiny Committee requested that complaints data be shared with the Committee and Healthwatch when appropriate. The provider representatives confirmed their full detailed reports were being shared with their Boards of Governors, but there would be issues in sharing the complaints data due to the personally identifiable information these contained, and that there was not currently a consistent approach to the presentation and information Trusts made available. They would, however, look into how best to share this information with the Committee when required.

4.10 Our impressions of Surrey's Health O&S Committee were that:

a) It had been a well-run meeting, and holding it in the morning probably helped people's alertness. The good quality and incisiveness of the Surrey CC Members' questions suggested that each might have a specialist area of interest. One co-opted member is a GP.
b) The Trusts appeared to be taking a similar approach to applying the learning from the Francis report, and the approach to whistleblowing was of widespread interest.
c) It was appropriate that LHW were present (though apparently not co-opted).
d) Reference had been made to Surrey CC councillors being on the Boards of the local hospital trusts.
e) The regular item on 'action tracking' showed that the Committee were systematically following matters up, including previous recommendations. The WG recognised that Surrey has two officers supporting Health O&S, whereas in BFC there are fewer than two officers for all O&S support.

<u>Royal Berkshire Hospital NHS Foundation Trust</u>

4.11 On **5 July 2013** the Group met **Ed Donald (ED), Chief Executive, and Alistair Flowerdew (AF), Medical Director, of the Royal Berkshire NHS Foundation Trust (RBH).** This meeting – also the subsequent meetings with other hospital trusts and the Ambulance Service - had been arranged principally to learn about the Trust's progress in applying the lessons from the Francis report; and to explore the provision of routine information from the Trust for Health O&S on complaints and other related matters.

4.12 The Group was told that the RBH Trust puts emphasis on teamwork and a constant, balanced focus on four key factors:

Patient Experience – giving time to establishing the patient experience, and drawing directly on the knowledge of the Local Involvement Network and local patients groups. The RBH tracks the patient experience through 'NHS Choices' and other means. The latest survey (of c.4,000 patients annually) showed a continuing improvement, currently with 97% of respondents saying they would recommend the Trust to their family and friends. The NHS 'Patient Direct' site showed the RBH had moved from 3 stars to 4.5 (the same as Frimley Park Hospital).

Health Outcomes – and particularly survival rates. Professor Jarman had developed Summary Hospital-level Mortality Indicator (SHMI) rates, using data sets based on population and other factors. It was seen as alarming if a hospital has an SHMI rate in excess of two standard deviations above its standard rate. Each hospital's actual mortality rate could be analysed in detail, to individual patient level. The RBH actual mortality rate is closely in line with its standard rate, and the Trust aspired to significantly improve that position.

Value for Money – with reference to financial performance and stability. Indicators of soundness here were: achieving a risk rating of 3 from the regulator; having an affordable capital programme; and that the payroll costs should not exceed 60% of the whole (RBH are currently at 59%). Equally, payroll costs should not fall so low that there are insufficient staff frontline - it is a balance.

Staff Experience – Staff can be relied upon to give an honest assessment in their survey responses. Some 450-500 staff at the RBH have completed the survey (out of c.5,000 staff). Historically, the RBH had been in the lowest quartile for staff recommending the hospital, but had improved greatly and they are now in the top quartile. This was testament to moving away from a top-down management approach, towards staff empowerment, engagement and more teamwork.

ED stressed the need to achieve balance when pursuing these four aims, citing the error of Mid-Staffordshire NHS Trust in giving undue prominence to finance/value for money, at the expense of patient safety.

4.13 Mr Flowerdew (AF) gave a presentation on the key failures of Mid-Staffordshire as revealed in the Francis reports, together with a summary of the approach taken by the RBH to the lessons from Francis. The Chief Executive is the 'accountable officer', however the Board has accountability too. Various functions are delegated to the Medical Director, the Finance Director, and other specified senior postholders. The NHS had been undergoing a major transformation, with the drive to convert to Foundation Trusts. It had been crucially important to bring clinicians into the management process, and the RBH had moved a long way on that path.

4.14 AF described how all NHS organisations had been required to examine the recommendations in the Francis report, and to state the actions they were taking, as a consequence. The RBH Board was strongly committed to this, and a high-level steering group had been established. All the 149 recommendations pertinent to the Trust had been examined, and a gap analysis had been carried out on these to determine any new actions required. For the vast majority, the current position is positive. The proposed actions were to be presented to the Board in a published report later in July.

4.15 Other matters arising in discussion, and in response to Members' questions were:

a) ED did not see the Mid-Staffordshire faults being repeatable at the RBH. Patient experience and other information showed that the position is sound. The RBH has traditionally attracted high quality staff, also the General Medical Council give extremely good reports about the RBH. The stable workforce enhances safety and assists excellence, and there is limited use of agency staff. The Trust considers it is strong, without being complacent. ED added that the Francis report had made a difference, both at the RBH and across the NHS.
b) ED suggested that he most relevant information to be routinely reviewed by Health O&S should include:
    - On patients' experience, the percentage who would recommend the hospital to their friends and family
    - The staff recommendation rate (it being important to recognise the extended team, necessarily working together)
    - Related information beyond the Trust, for example discharge performance, and the capacity of Berkshire Healthcare Trust.
    - The extent to which the NHS Constitution standards are being achieved.
    - Information on complaints. ED suggested that the routine report to the RBH Board on complaints should suffice.
c) The Patient Advice and Liaison Service (PALS) concentrated on customer care. Any patient or their relative could take a concern to PALS. They aimed for early resolution to issues of concern, in collaboration with the doctors and nurses concerned. The Director of Nursing had identified areas of necessary improvement to PALS, such as the need to telephone the patient about their complaint, and to be less bureaucratic.
d) A Member of the RBH Executive telephones two patients each week, chosen at random, to check on their experience of the RBH's services.
e) The RBH's Francis action plan included some red and amber ratings on the complaints handling arrangements. The number of complaints rises when the hospital is under pressure. Complaints are examined by the relevant team, and ED personally signed all responses to complaints.

4.16 On **9 October**, a member of the Group met **Caroline Ainslie, Director of Nursing**, at the Royal Berkshire Hospital to enquire about the detailed arrangements for the trust's handling of complaints by patients. This was used to inform our conclusions and recommendations at paragraph 5.24.

<u>Examples Of Good And Less Effective Health Overview & Scrutiny</u>

4.17 The Group considered the factors which influenced the achievement of good and less effective Health Overview & Scrutiny, by reference to two examples from the Health O&S Panel 'archives':

- On 27 September 2012, the Panel met senior staff of the South Central Ambulance Service, concerning the Trust's performance on out-of-hospital cardiac arrest survival rates. There had been adverse media reports on survival rates in relation to out-of-hospital cardiac arrests in the South East when compared to other regions of the country.
- The Panel meeting on 26 April 2012, which had included substantive 'visitor items' on:
    1. A progress update from a Clinical Commissioning Group
    2. A briefing on the Joint Strategic Needs Assessment
    3. A briefing on the shadow Health and Wellbeing Board,
    4. A briefing on the transfer of Public Health Functions
    5. An update from an NHS Trust on a change to NHS services

4.18 The Group considered that the factors which had made the Ambulance Service meeting on 27 September 2012 good scrutiny had been:

- O&S officers keeping their 'ear to the ground' and spotting a media report on the topic, bringing it to the Panel chairman's attention, who agreed it should go on the Panel agenda
- Looked at an issue of public concern (people dying in ambulances when they might have had their lives saved by improvements in service) and use of volunteer 'Community Responders'
- All Members of the Panel had engaged in questioning
- Probing questions – Trust representatives clearly felt they had been held to account for their performance
- A commitment was given by the Ambulance Trust to action
- The Panel decided to return to the issue in six months, to see whether the position had changed
- There had been some pre-meeting preparation by Panel Members on the questions to raise with the Trust.

We did, however, think that the effectiveness could have been greater if:

- Information had been sought in advance from the Trust, particularly on differences of view on how data is collected
- Time permitting, there had been some research and briefing to Members regarding the national position and data issues before the meeting
- Clearer conclusions and recommendations had been reached by the Panel
- The Panel had not delayed its follow-up (which had been due to competing pressures on the Panel's agenda).

4.19 By contrast, the Group considered that the factors which had made the meeting on in April 2012 not very effective scrutiny had been:

- The items were more about receiving information rather than challenging something of concern
- The Panel could not really do justice to so many major issues at one meeting, consequently none were covered in sufficient depth
- Limited preparation
- Some visitors were kept waiting for quite a long time while other visitors presented their material
- Less than full Member participation
- Witnesses seemed to find the questioning relatively un-challenging
- The Panel had not been sufficiently assertive
- No clear outcomes from the Panel discussion, nor any conclusion on 'where do we go next'.

<u>Work of Other Councils' Overview and Scrutiny on Francis</u>

4.20 So as to avoid duplication, the scrutiny officer supporting our review notified the O&S officers of those adjoining councils where the three principal hospitals are sited that the Group would be approaching those hospitals to establish what their response to the Francis report had been. None of the councils raised any objections to that. We also enquired about their O&S approach to learning from Francis. The responses indicated that the other councils were not approaching this in similar depth to our approach, so we did not see any need to revise our approach.

Bracknell and Ascot Clinical Commissioning Group

4.21 On **9 August**, the Group met **Dr William Tong (WT), Chairman, and Sarah Bellars (SB), Director of Nursing, of the Bracknell and Ascot Clinical Commissioning Group** (CCG), to discuss the CCG's progress in applying the lessons from the Francis report, and their views on the progress by the local hospitals and the Ambulance Service, also the routine information needed for effective Health O&S, on complaints and other matters.

4.22 WT said that the Francis report pointed to a multi-level lack of patient care in Mid-Staffordshire. Many of the failings were basic, and various doctors, nurses, managers and others had failed in their duties. For the NHS, it raised the question of whether the failings were isolated, also what could be learnt to prevent similar failures occurring elsewhere. The CCG saw Francis as being highly relevant and were monitoring the quality of service by providers. Particular diligence was needed with Heatherwood & Wexham Park hospitals (H&WPT) due to current concerns there. The CCGs were to hold a workshop at the end of September with the local hospital trusts, with Local Healthwatch (LHW) present, to receive presentations from each Trust on their responses to Francis, and to have a challenge process on them, in an open forum. Local Authority representatives were also to join in the workshop. That workshop should enable the CCG to achieve satisfaction that the actions being taken by the three nearby hospitals, and Berkshire Healthcare Foundation Trust (BHT) and the Ambulance Service were properly applying the lessons of the Francis report. Following the workshop, the assessments and actions would be reported to the governing bodies in October, afterwards being sent to the Department of Health (DoH).

4.23 SB described how the CCG had reviewed all the Francis recommendations applying to CCGs. This had included a workshop to agree on actions needed, and that action plan was in the course of being agreed between the three East Berkshire CCGs. Some of the Francis recommendations would be challenging to implement without DoH support, for example concerning safe staffing levels. Drawing on her experience as a former Ward Sister, SB described how staffing needs should be properly assessed with reference to the presenting symptoms/conditions of each patient, and a standard minimum level could be insufficient at times of high demand from very sick patients. In reality, the staffing needs of individual wards varied from ward to ward, and from day to day. The particular staffing concern at H&WPT was the balance between permanent and temporary staff - the CCG did not see an insufficiency of staff numbers in total, neither were they aware of any restrictions on staffing numbers; the H&WPT financial position is not preventing them from engaging the staff they need. SB said that all hospital staff had a shared duty to uphold standards, and this was not solely the responsibility of Matrons (who have a distinct policing role in that regard). All staff need to challenge each other in a professional and courteous way, and the cultural environment should provide for that.

4.24 The CCG representatives told us that the 'Friends and Family' survey gives a valuable insight into privacy and other non-measurable aspects of the patient experience. WT said that the council could help the CCG by communicating knowledge of patients' experience, for example in relation to discharge from hospital. The positive 'Friends and Family' results for H&WPT were at odds with the clinical concerns about that Trust. SB commented that complaints to the CQC by H&WPT patients had peaked in February, tailing away in April-May.

4.25 Other matters arising in discussion, and in response to Members' questions were:

a) At Mid-Staffordshire, inspectors had failed to detect what had been going wrong. The position was now greatly changed, for example the CCG had been increasingly concerned about services at H&WPT from January 2013. A Quality Surveillance Group had been established with CQC, and this had triggered the CQC inspection of that Trust in May.
b) SB cautioned against relying too much on standardised mortality rates, even though they are a useful and important indicator. Being lagging annual figures, they are always dated, neither do they identify mortality 'hot spots' within a hospital.
c) SB stressed the importance of maintaining standards at all times, regardless of how heavy the pressure is on a hospital.
d) The Accident and Emergency pressure at Wexham Park had been exacerbated by

- The 'case mix' of A&E patients from South Buckinghamshire being more demanding than anticipated;
- Nationally, a much greater winter surge in A&E demand than normal.

e) Planning for the next winter's A&E demands was already in progress. H&WPT was in line to receive a good proportion of the recently - announced additional funding from the DoH for A&E.
f) Regarding the concern about the impact of weather extremes on the mortality of the elderly, WT said the emphasis should be on reducing all avoidable deaths.
g) NHS capacity constraints meant that GP's could not simply stop referring patients to under-performing hospitals. Instead, CCGs worked with hospital trusts to encourage and support them to perform to the required level. WT added, whilst not condoning in any way the poor quality found by CQC, that the position at H&WPT was not unsafe for patients, though it had been unacceptable and high-risk.
h) Patients' right of choice had resulted in some movement away from H&WPT, though there is no patient choice on A&E location. The right of choice already extended to three hospitals and private providers, and it is set to widen further.
i) The CCG is working to gain more information on the complaints made to the hospitals, and their resolution. The CCG welcomed BHT's initiative in giving thought to publishing summary details of complaints they receive. Hospital service providers were expressing difficulty in divulging confidential patient information in complaints. WT added that primary care providers were also thinking about how to achieve greater openness about complaints they receive.
j) Prescription errors can occur for a variety of reasons, such as: poor record keeping; lack of clarity about who is responsible for determining medication; hospital pharmacy opening hours; and uncertainty over the current medication of patients who are unconscious on arrival in hospital.
k) The CCG had established contact with LHW, who are undergoing an authorisation process. The CCG welcomes LHW as a critical friend, and regards them to be an integral part of their public forum.
l) The CCG was monitoring quality at H&WPT more closely and frequently than other trusts (Bracknell and Ascot CCG work with NE Hants and Surrey Heath CCGs around Frimley Park Hospital), and this included talking to patients directly about their experience of the service.
m) All doctors and nurses have a responsibility to ensure that drugs are kept secure.

Hospital Inpatient Survey Results

4.26 The Group reviewed the results of the CQC survey of 2,550 inpatients at FPH, RBH, and H&WPT hospitals, in the period September 2012 – January 2013, to which 1,244

people had responded. This gave very comprehensive and direct feedback on the patients' experience of various aspects of the hospitals' service to them. It was noted that the H&WPT responses would have been mainly from Wexham Park patients. The WG agreed that there was a need to present the in-patient survey results routinely to the Health O&S Panel, as a primary source of information about the patient experience, to be used to hold service providers to account. The WG was concerned to see the low satisfaction ratings for H&WPT, and we followed this up with that Trust at our Panel meeting with them in August.

Frimley Park Hospital NHS Foundation Trust

4.27 On **23 August** the Group met **Nicola Ranger, Director of Nursing, Frimley Park Hospital NHS Foundation Trust** (FPH), to discuss the Trust's progress in applying the lessons from the Francis report; and routine information for Health Overview and Scrutiny on complaints and other matters.

4.28 Nicola Ranger (NR) said that the Francis report had had an impact, particularly around the focus on nursing care, and summarised the FPH work to date flowing from Francis. NR described the new hospital inspection regime, noting that FPH, as a designated low risk hospital is to be subject to a full review in November, when 20 experts will examine a range of outcomes and other matters connected with the running of the hospital.

4.29 NR explained that a major issue of Francis concerns nurse staffing levels; Frimley Park has strengthened the nursing numbers, particularly on care of the elderly. FPH had been recruiting nurses including some from Portugal. English language ability is tested during the recruitment process. Some 70 newly qualified and good calibre nurses were due to commence in September, and mentors are provided to help them settle in to their role. New staff are given very clear information on the names and responsibilities of team Members. FPH employ some 3,000 staff of whom around 1,700 are nurses, midwives and nursing assistants.

4.30 NR regarded FPH to be performing well on the management of the complaints, though the process was being further improved. The Chief Executive and Director of Nursing read every complaint received, and NR personally met complainants when the matter involved poor care, so as to fully understand the issues. The 'Duty of Candour' was being worked on, with the aim of achieving complete honesty and openness. NR said that there is a standard NHS complaints procedure, and a recent audit of FPH's complaints process concluded that it was excellent. FPH are trialling a meeting with former complainants where they had similar themed complaints, to see whether they had been satisfied with any remedial actions taken. The PALS service, which had started 10 years ago, should be used for less serious complaints and enquiries. Occasionally, ward staff wrongly advised patients to contact PALS, instead of sorting out the patients' issues at source. A serious complaint – for example a miss-diagnosis – would be immediately referred to the Medical Director or NR, for a full investigation to be done within 25 days.

4.31 Board and staff engagement was assisted by monthly ward walk-abouts by non-Executive board Members, and by the presentations of performance information to the Board by clinical staff. This gave an opportunity for face to face discussions about matters of concern. In order to continue to improve this, the Trust was experimenting with a 'question time' session for staff. The Trust's Chief Executive continued to deliver monthly staff briefings. Other matters arising in discussion and in response to Members' questions were:

a) Staff are openly encouraged to raise any concerns they might have, and the whistleblowing facility had been used occasionally. NR has an 'open door' policy, and Staff Forums had also been used to help staff feel more able to raise concerns.
b) The role of Ward Sisters is being improved through a leadership programme, run jointly with the British military presence at FPH. This reinforced the Sister's role as being visibly in control and respected, and aimed to relieve them of bureaucracy as much as possible. Every ward will have a Ward Sister, visible and accountable for everything in the ward, assisted by a deputy. Each Matron will cover 5-6 wards. The title of Ward Manager will be changed to Ward Sister/Charge Nurse.
c) The military previously had a dedicated ward at FPH. Their work was now spread across A&E, Orthopaedics, surgery, etc, (though not in elderly care, for example). This was a huge benefit for FPH, bringing additional staffing resilience, as well as a 'fresh set of eyes' and extra objectivity.
d) The new form of reports from the CQC should be very useful assurance material for O&S. Other useful information was from patient and staff surveys. FPH responded to themes from these, for example in response to the low score on disruption to sleep, the Trust was considering issuing patients with ear plugs.
e) Information on complaints received would also be helpful to O&S, and a high level summary could be made available. Complaints sent to the Health Services Ombudsman would give an indication of how well complaints had been resolved locally.
f) NR suggested that the best assurance could be gained from seeing how well Ward Sisters carried out their duties, and offered to arrange a 'ward walk-around' for councillors. O&S might also consider meeting the FPH Executive Team and Governors occasionally.
g) NR expressed the view that the Francis report had helped to stop the continuous reduction of nursing numbers across the NHS.
h) A growing challenge is caring for the elderly, and dementia cases. A common source of complaints was from patients who had been unable to sleep due to other patients making noise throughout the night.
i) NR considered that the Local Health Watch (LHW) role should be useful and give a different viewpoint, but she had some concern about the proliferation of accountability routes. It would be important to achieve two-way communications with LHW.
j) NR considered that factors influencing FPH's success included: self-belief; an excellent long term post-holder of the Chief Executive position; the hospital being genuinely clinically-led; and high staff motivation. By contrast, poorly performing NHS organisations were often characterised by external agencies putting them under a deal of pressure, and the Chief Executive being driven too much by targets and finance issues.

'NHS Choices' Information

4.32 The Group reviewed the summary information available on the 'NHS Choices' website. This is the UK's biggest health website. It provides a comprehensive health information service, including more than 20,000 regularly updated articles. There are also hundreds of thousands of entries in more than 50 directories that can be used to find, choose and compare health services in England. The WG considered that the summary information relating to mortality, patient and staff recommendations, the current assessments of the Trusts by the CQC and MONITOR and other matters available on the NHS Choices website for the principal, local NHS Trusts and decided it would be useful to regularly provide this summary information to the Panel.

South Central Ambulance Service NHS Foundation Trust

4.33 On **9 September** the Group met **Deirdre Thompson, Director of Quality and Patient Care, South Central Ambulance Service NHS Foundation Trust** (SCAS), to discuss the Trust's progress in applying the lessons from the Francis report; and routine information for Health Overview and Scrutiny on complaints and other matters.

4.34 Deirdre Thompson (DT) described the significant work carried out by SCAS arising from the Francis Report, delivering a presentation covering:

- The area covered by SCAS, its background, the achievement of Foundation Trust status in 2012, its structure and staffing (some 2,900 and growing).
- The range of SCAS services, which extend well beyond the traditional emergency calls, to include commercial training, for example.
- The principal questions from Francis which had been addressed,
- Progress on SCAS's five improvement and change themes: Standards; Openness; Care and Compassion; Leadership; and Information
- The position on patient and staff satisfaction
- The high-level SCAS commitments
- Examples of feedback from patients on the impact of SCAS services

4.35 SCAS, in common with the whole NHS, had been shaken by the findings of the Francis report, and it had caused them to fundamentally re-visit what the ambulance service's role was. DT added that the report was timely, coming after the impact on the NHS of a severe winter. The failings in Mid-Staffordshire bore some relation to: the new NHS architecture shifting the focus away from patients; the combined effects of various reductions in public services; and some confusion over the service offerings of different NHS institutions. DT said that SCAS had moved quickly to respond to the lessons from Francis, and she was confident that the local hospitals also had Francis at the top of their agendas. For SCAS, the main change brought about was to talk more about culture and patient care. There was a realisation that services are not perfect, and there is a stronger commitment to do one's best for patients. SCAS was also moving the focus away from processes towards more openness, commitment to learning, and determination not to repeat mistakes.

4.36 DT said that SCAS had deliberately avoided the traditional action plan approach to the tasks flowing from Francis, instead mainstreaming this in their everyday work. An update on this was provided monthly to the Trust Board, as part of the standards and quality report. The integrated performance report to the Board brings together all the pertinent information, and a lot of attention is given to this to identify where any further actions are necessary.

4.37 DT described 'Openness' as being a large and important field of work. There had previously been a widespread tendency across the NHS to give priority to organisational reputation, financial position, etc. over patients' interests. The 'duty of candour' now required of all NHS Trusts meant that there had to be greater openness about things that had gone wrong. There was a nervousness about sharing such matters publicly, nevertheless SCAS was moving towards publication of suitably measured, balanced and anonymised information in this field. Internally within SCAS, there was traditionally good information sharing at local level of matters which had gone wrong. This was now being built on, for example to develop a more continual process of learning from complaints and compliments.

4.38 DT explained that recruiting, managing and appraising staff is central to improving Care and Compassion. SCAS had adopted the national 'Friends and Family' test for use in all their patient surveys. In that regard, much higher response rates had been obtained from telephone surveys, which supplement the postal surveys. SCAS were striving to learn more about individual patient 'journies', as much can be learnt from their overall service experience. On 'Leadership', DT mentioned that a local authority councillor had recently 'third manned' on an ambulance. That, and section visits are very powerful, and proceeding well, as is stakeholder engagement. The SCAS leadership is striving to ensure that customer-facing staff have sufficient time to spend with patients. DT explained that SCAS are giving more attention to the qualitative aspects of 'Information'. For example, more granular detailed information on patient experience is being presented to the SCAS Board. There had been a lot of progress on 'listening and learning' since February 2013.

4.39 DT highlighted the new 111 (non-emergency) telephone service, which she said SCAS had been progressing with well. DT said that the 'conversion rate' of 111 calls – i.e. the percentage passed on to the 999 response teams – was important and the SCAS rate of c.5% was better than the national average. This depended on having highly trained staff. DT described how SCAS had run a massive recruitment campaign, to reduce the usage of temporary staff. No agency staff are used. SCAS make use of nine private providers – being reduced to four - who operate their own ambulances with their own crews. SCAS monitor their performance closely.

4.40 The SCAS Board are involved in the work flowing from Francis, for example in visiting the heliport at Thruxton, and meeting the staff there. Previously, walk-abouts had been very ad-hoc. The board were also being provided with a lot more direct information on patients' experience.

4.41 SCAS had 58 live complaints, currently, and these usually involved other healthcare professional as well as SCAS. Independent complaints investigators are used when necessary. The SCAS response target of 25 days was being achieved in 62% of cases, and improvement to 80% was being aimed for. The 111 service had generated some one million additional phone calls annually, thus resources for complaints handling, including Patient Liaison, had been increased accordingly. The Patient Experience Group, chaired by the Chief Executive, sees summary details of all complaints. DT said that an increase in complaints can be viewed positively, as a sign that an organisation is more open. SCAS recognise the need to do more to spread the learning from complaints, and intended to increase reporting of information on complaints, possibly by theme (such as delays and staff attitude).

4.42 Other matters arising in discussion, and in response to Members' questions were:

a) 'Community First Responders' are volunteers, trained and equipped for first response, who are a very valuable part of the SCAS workforce, and offering a wealth of knowledge and insight.
b) The recent report by Mr Berwick offered a concise and succinct statement of the key actions identified in the Francis report
c) SCAS had recognised that their safeguarding arrangements had been too process-driven, and were deploying two more staff on that to improve quality.
d) Communication skills for call centre staff are all-important, and DT regarded the skills level to be very high at SCAS. The presence of clinical support staff (often experienced A&E nurses) in call centres was also very valuable.
e) SCAS receive a lot of feedback on their service, and enjoy a good standing with its service users, for example in receiving five times as many compliments as

complaints. Also, the SCAS staff survey results are more positive that the average for all Ambulance Trusts.

f) SCAS had engaged with the Urgent Care Boards throughout their area to prepare for the next winter. Provisions included enhanced care for people within their homes instead of taking them to hospital, with more nurses recruited to deliver this enhanced service.
g) Out of hours, doctors do have access to patients' medical records, though the access availability varies between areas.
h) On whether there should have been whistle-blowing at H&WP hospitals, DT said that staff should have raised any concerns with the Hospital Ambulance Liaison Officer. A transfer target of 15 minutes applied to Accident and Emergency (A&E) on receiving patients arriving by Ambulance, but there were widespread delays on this nationally last winter. Fines/penalties applied in the event of delayed admission by hospitals, and there was now double-verification of timings by both hospital and SCAS staff.
i) SCAS experience some hoax and unnecessary calls, though a patient's perspective on need was understandably subjective.
j) A lot of work was done by the NHS on preventing falls, which continued to be a frequent cause of accidents.
k) SCAS operate a range of different vehicles and crewing arrangements to assist efficient and appropriate responses to calls.
l) The Patient Transport Service operated by SCAS is separate from the emergency response function, and is particularly useful for older people who are unable to drive. Some nine formal complaints had been received in 2013-14 to date, and an example of learning was introducing umbrellas to keep patients dry on their journies to and from the vehicles. SCAS regarded an acceptable waiting time to be one hour, but over-runs occasionally arose. We asked DT to look further into the incidence of delays.
m) Call centre dispatchers decide which hospital each ambulance should take a patient to, with reference to the treatment needed, current loading at each hospital, proximity to a person's home address, etc.
n) SCAS might be able to send the Health O&S Panel information on complaints by number and theme, divided into CCG areas.
o) It was noted that information on mortality rates, whilst useful, was complex and subject to various limitations.

<u>Heatherwood and Wexham Park Hospitals NHS Foundation Trust</u>

4.43 On **15 August**, a member of the Group met **Thomas Lafferty, Director of Corporate Affairs of Heatherwood and Wexham Park Hospitals NHS Foundation Trust** (H&WPT), at Wexham Park Hospital to enquire about the detailed arrangements for the trust's handling of complaints by patients. This was used to inform our conclusions and recommendations at paragraph 5.24.

4.44 On **7 October**, the Group met **Philippa Slinger, Chief Executive, and Dr Rob Loveland, Medical Director, HWPT,** to discuss the Trust's progress in applying the lessons from the Francis report; and improving Health Overview and Scrutiny through routine information on complaints, and other matters.

4.45 Philippa Slinger (PS) said that the whole of the NHS had been shocked by the revelations about Mid Staffordshire, and this pointed to widespread corporate and professional malaise. It was very difficult to see why the failures had not surfaced earlier, given the proliferation or organisations involved with the Trust and the complaints from patients and their families (which were largely ignored). The NHS

post-Francis was very different, with a greater willingness by Trusts to look dispassionately and critically at their services.

4.46 Dr Rob Loveland (RL) made the point that everyone needs to be aware that another incident like Mid Staffs could happen; there must be no 'corporate blindness', Trusts cannot afford to cruise, and the price of good patient care is constant attention. Mid Staffs Trust had not taken proper notice of statistical data which pointed to problems, instead their focus was on achieving Foundation Trust status. The CQC report on H&WPT had been the Trust's 'Mid Staffs moment'. PS had been encouraged to see that many people at the Trust were ashamed at CQC's findings, which gave her hope that they would be committed to making improvements. The CQC report had led the Trust to taking a completely different focus by concentrating on patient care. PS added that that this required some bravery, as it put the achievement of traditional targets as secondary. Whilst the experience of the CQC review had been horrible, the outcome was a blessing in disguise.

4.47 PS said that H&WPT was a most challenging organisation to work for, with new 'issues' constantly coming to light some years after they occurred. The improvements being worked on depended on everyone working together with a strong focus on patient care. The previous culture, of a tolerance of poor practices, was taking time to remedy. Particular attention was being given to the 95 front line clinical leaders, supported by coaching and action learning sets. The prospective merger with Frimley Park hospital meant that there would be two years of managerial turmoil at H&WPT. H&WP was organisationally separate from FPH, though efforts were being made to standardise ICT work for example. PS observed that FPH works well for a variety of reasons, some of which could not be replicated in the H&WPT area, for example the differing patient population would require adjustment to their operating model.

4.48 PS said she saw every complaint against H&WPT. The PALS service was active and valued, and tended to deal with lower-level issues. The complaints process can be demanding because of the backdrop of potential liabilities and negligence claims. Historically, complaints had not always been responded to well enough or fast enough. Improvements were being made to the H&WPT process, for example senior staff now usually met complainants face to face when reviewing their complaint, and there is a greater emphasis on remedial actions and learning from complaints. Nevertheless, there continue to be cases where, having listened to patients' views and suggestions, the Trust chooses not to adopt them; and in such cases it is important to explain the reason for that course. There had been instances where the investigation of a complaint had resulted in dismissal of a Trust employee. On the provision of information concerning complaints, PS said that the Patient Safety reports to the Trust Board provided useful summary information, which Members could ask for supplementary information on as they saw fit. However, the Trust would not be able to release information which risked identifying an individual.

4.49 Other matters arising in discussion, and in response to Members' questions were:

a) The Keogh list of hospitals had been compiled from the list of the worst mortality statistics. But the differing measures of mortality showed different hospital 'rankings', illustrating the importance of being aware of different data and interpreting them carefully.
b) The CQC report illustrated that many staff at H&WPT had ceased asking for things they need, as they did not expect requests to be met. Some had also evidently not been seeing things for what they were; people had tended to limit their sense of responsibility to their immediate duties and to 'walk past' matters which needed attention. The 'helpdesk' which all staff could report their equipment

needs to had proved to be very successful (though it now showed a need for more porters), and the building and other works now underway were transforming Wexham Park Hospital.

c) We observed that Trusts could 'hit the target but miss the point'. There was general agreement that if Trusts concentrate on the person and their care, the performance on many of the set targets should be satisfactory. To that end, there needed to be some 'shelter' in terms of Trusts not being criticised for under-performance on targets consequent on priority having been given to patient care.
d) PS suggested that a useful source of information for O&S would be to ask Trusts to notify whenever they receive an 'outlier alert' from the CQC. A recent example was an alert regarding fractured neck and femur cases; H&WP had examined the contributory causes thoroughly and followed this up to good effect. Another suitable source of regular information is the Patient Safety report to the Trust Board.
e) PS encouraged O&S to make use of the work of LHW, as independent , non-clinical people offered a valuable role in continual monitoring and inspection, as did HWP staff unconnected with the service under review.
f) The Trust has a whistleblowing policy, though the whole policy area of the means for raising concerns was currently under re-development.

<u>Executive Member for Adult Services, Health and Housing</u>

4.50 On **7 October**, the Group also met **Councillor Dale Birch, the Council's Executive Member for Adult Services, Health and Housing** to hear about his priorities from the Francis report.

4.51 Councillor Birch (DB) drew attention to the Mid Staffordshire failures having come to light because one person would not accept what was being said by that NHS Trust. He referred to the Health and Wellbeing strategy, which is predominantly concerned with priorities for prevention. There is a need to look at how the appalling patient suffering in Mid Staffs can be prevented in future. DB considered that we should all try and avoid responding from some form of righteous indignation and focus on what matters here locally. Councillors are at a disadvantage in terms of the information available, but the Mid Staffs councillors clearly failed to do their job properly. There is a need to recognise that some other NHS Trusts are close to having similar failures to Mid Staffs, and DB encouraged Members to keep these concerns in mind and put the interests of protecting residents uppermost. In that connection, DB said there was a need to tell residents that that they can raise any concerns about the health issues with the Council, and councillors need to be familiar with the routes open to residents to pursue those concerns.

4.52 DB encouraged Members to build their learning and understanding of the NHS, and to raise their concerns openly if they considered an NHS Trust was failing. DB stressed the importance of effective relationships with NHS partners, and observed that Health O&S Members had occasionally been over-assertive, creating an aggressive environment. A better approach would be for Members to express the source of their concerns, raising them in a supportive manner. DB suggested that O&S would get more value if they fulfilled their 'critical friend' role by adopting a challenging yet supportive stance. DB encouraged O&S to scrutinise compliance with the principals in the NHS Constitution. He said the roles of the Executive, the Health and Wellbeing Board, and O&S were clearly defined. Social Care and Health were being increasingly integrated. He saw Members' priority as being to 'up their game'; this required becoming more knowledgeable and availing themselves of training opportunities. DB illustrated this by reference to making an input to the commissioning process, on which there was to be a Member development event. DB

also suggested that O&S should ask NHS Trusts how they track mortality rates, and how many patients exit the system with an impaired outcome. He regarded the culture within health service providers as being very important.

4.53 DB summarised his priorities from the Francis Report as being:

a) Building the understanding and knowledge of councillors on health issues, including training.
b) Encouraging O&S Panels to work together, in a similar way to Health and Wellbeing Boards. The O&S role in working effectively with LHW might be better defined, and O&S should work in concert between local authorities.
c) Completing the establishment of LHW, and informing residents about how to engage with LHW. DB said that the H&WB Board emphasised the need to concentrate on actions – and that included by LHW - rather than receiving information updates. Members queried whether more value could be added by promoting LHW to residents, rather than simply passing on residents' concerns, also by helping to make it clearer how to raise a complaint.
d) To broaden the network of contacts with health service providers, for example with the Boards of the acute Trusts nearby. Information is passed more easily when good relationships exist. There was a need for the Council to change its culture, in the same way the NHS is having to change its culture.

Healthwatch Bracknell Forest

4.54 On **21 October** the Group met **Clare Turner and Chris Taylor of Healthwatch Bracknell Forest** (HWBF), the Local Healthwatch organisation for the Borough, to discuss O&S collaboration with HWBF in applying the lessons from the Francis report, with particular reference to sharing information on complaints and HWBF's direct knowledge of NHS service providers.

4.55 HWBF said they had recognised a need to communicate more proactively with Members on how HWBF was discharging its role. We were shown a diagram illustrating HWBF's role in relation to complaints handling, with particular reference to ensuring that complaints were dealt with promptly. HWBF would refer people to SEAP as necessary for advocacy assistance, and whilst SEAP would keep HWBF informed of progress generally, they would – correctly – not share personal data. HWBF had embarked on a wide programme of public engagement to learn about people's views of health and care services, and to publicise LHW's role. In that regard, the Clinical Commissioning Group had asked GP Practices to publicise LHW, and HWBF intended to ask the hospital Trusts to publicise LHW too, perhaps in their 'welcome pack' for new patients.

4.56 One Member suggested that Ward Members might raise awareness about HWBF in their ward work, and another Member suggested that Town and Country might be used too. HWBF were keen to know of local events which they could join in on.

4.57 HWBF made the point that complaints tended to be raised at a time of crisis, and HWBF had a valuable role in assisting resolution and preventing unnecessary escalation. Chris Taylor described a recent survey by Healthwatch England (HWE), which had concluded that nationally, the NHS complaints system was not working very well. As a consequence, HWBF was gathering information from service providers on the numbers of complaints and their resolution, and would inform the Health O&S Panel of the outcome of that work. HWBF would be using this to establish trend information. In that regard, they had attended an 'LHW Forum' meeting with the Royal Berkshire Hospital recently, and HWBF was establishing working parties to establish relationships with each of the service providers.

4.58 One Member, referring to an inpatients survey showing low levels of satisfaction with information on how to make a complaint, observed that people may be disinclined to make a complaint, thus the information on complaints received would not give a full picture of patents' concerns. The Group felt that if all NHS providers matched best practice in asking patients for their views about the service – both complaints and compliments – a much fuller picture would be available of the patients' experience overall.

4.59 Other matters arising in discussion, and in response to Members' questions were:

a) If a complainant is dissatisfied with the response to their complaint, HWBF would pursue it and escalate it as necessary. They might also act on a theme, for example if there was a run of complaints about the quality of meals in a particular hospital, they might visit that hospital and directly seek the opinions of patients there.
b) HWBF would be aiming to establish a relationship with the Health Service Ombudsman.
c) The Council produces annual reports about statutory complaints received regarding Children's also Adults' social care, additionally on public health issues, and offered to provide further information to HWBF.
d) HWBF would give regular feedback to the Health O&S Panel on the pattern of complaints themes.
e) The intended specialisation of Health O&S Members would include a focus on the work of HWBF.
f) A Member thanked HWBF for responding quickly to their concern about some GP Practices requiring patients to telephone them using a – higher charged - 0844 rather than an 01344 number.
g) A Member suggested that HWBF might usefully investigate why the act of obtaining a GP's appointment was much harder with some GP Practices than others.

4.60 On **24 October**, two Members of the Group participated in a workshop with the Health and Wellbeing Board and HWBF to forge partnership working and a sense of common purpose in the health arena.

Berkshire Healthcare NHS Foundation Trust

4.61 The Group reviewed the published documents summarising Berkshire Healthcare Trust's (BHT) actions from the Francis report, and noted that that BHT was due to be inspected by the CQC later in November. The Group noted the BHT's positive actions from Francis, though one Member commented that the actions lacked full target dates.

Parliamentary and Health Service Ombudsman

4.62 The role of the Parliamentary and Health Service Ombudsman (PHSO) is to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England. They are statutorily independent of the NHS, and review complaints where people have not received what they regard to be a satisfactory response from the NHS organisation which provided them with a service.

4.63 In an endeavour to gain a fuller understanding of the more serious complaints made against the local NHS service providers, we asked the PHSO whether they could

supply us with regular information about their decisions about our three local hospitals. The PHSO's Deputy Director of Health Investigations responded that they are not currently equipped to service requests for regular information updates, but they were planning to put more information about their casework in the public domain via their website, and from April 2014 an online summary of each investigation, possibly naming the organisations complained about. They also had plans to share information with MPs about decisions made about organisations in their constituencies. The PHSO suggested that the easiest and quickest method of obtaining the information we sought is to contact the complaints departments of the relevant hospitals.

4.64 The Group met for the last time on **20 November**, when it considered its draft conclusions and recommendations for incorporation into a report. We also received a briefing on the Government's detailed response to the Francis report, published the previous day, and we evaluated how our review had been carried out, considering the learning points for future O&S reviews.

5. Analysis, Conclusions And Recommendations

5.1 Anyone who cares about the National Health Service and its treatment of patients must have been truly shaken by the reports by Robert Francis QC about the failings at Mid Staffordshire NHS Trust. The number of excess deaths at Stafford hospital between 2005 and 2008 has been estimated at 492 people, and there were dreadful failures to ensure the safety, dignity and comfort of many other patients. The Francis report describes the failings as a '*disaster*' and '*one of the worst examples of bad quality service delivery imaginable*'.

5.2 Anyone who cares about local authorities standing up for residents' interests in relation to getting good services from the NHS must have been shaken by Mr Francis' comment that '*The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust…. The Overview and Scrutiny Committees in Stafford ….. did not [*take*]… responsibility for identifying and acting on matters of concern; and ……offered ineffective challenge.'*

5.3 Bracknell Forest Council's Health Overview and Scrutiny (O&S) Panel commissioned this review because it cares greatly about the quality of NHS services to residents, and because we want to ensure we scrutinise those services effectively. In short, we are determined that the appalling failures of the Stafford Hospital, and in local authority Overview and Scrutiny there, should not be allowed to happen in Bracknell Forest.

5.4 We have been mindful of the Secretary of State for Health's words: '*This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.'* Our main reason for having the review was therefore two-fold:

- To establish whether the NHS Trusts providing most of the essential health services to Bracknell Forest residents were taking the lessons from the Francis report seriously; and
- To see what improvements were needed to the way the Council carries out its statutory duty to scrutinise local NHS services.

5.5 From its investigations, the Working Group (the Group) has drawn the following conclusions, on which we have based a number of recommendations to some of the NHS Trusts, to the Health Overview and Scrutiny Panel and other parts of the Council.

The NHS Trusts Providing Most Of the Acute Health Services to Bracknell Forest Residents

5.6 The Group reviewed the actions taken by those NHS Trusts which provide most of the hospital, ambulance and other inpatient health services to Bracknell Forest residents:

- Frimley Park Hospital
- Heatherwood & Wexham Park Hospitals
- Royal Berkshire Hospital
- South Central Ambulance Service
- Berkshire Healthcare Trust

As set out in section 4 of this report, our review included appraising published reports on actioning the Francis recommendations, face to face meetings with senior representatives of most of these organisations, discussions with the Clinical Commissioning Group and Local Healthwatch, and visits to two of the hospitals. We are very appreciative of the willing co-operation and candour shown by all the people we met.

5.7 The Group was impressed by the seriousness of purpose by all the Trusts in learning and applying the lessons from Francis. The people we met were all clearly shaken by the appalling failures at Mid Staffordshire. The very real changes and improvements they had embarked upon demonstrated to us their determination not to let similar failures happen in their Trust. Whilst we are greatly encouraged and reassured by this overall response, we do have a few observations and recommendations for further improvement:

a) All the Trusts seemed to us to be striving to ensure that their Boards and staff are fully engaged in understanding the Mid Staffs failures and in making the improvements within their own Trusts. We believe this to be a significant achievement, given the many pressures on NHS staff.
b) The nationally-run Inpatient survey showed very low levels of satisfaction with information being available on how to make a complaint, and we heard similar feedback from patients at a CQC 'Listening Event' which we attended. **Recommendation**: **All Trusts should include in their welcome pack for patients a brief guide to how to make a complaint or compliment.**
c) The Group was encouraged by the Royal Berkshire's development of their 'Patient Safety' reports to include more information on complaints. Also, we were impressed by the level of detail on complaints included in the published 'Patient Experience' reports of the Berkshire Healthcare Trust.
Recommendation: **All Trusts should publish detailed information on complaints, at least equal to the level used by the Royal Berkshire and the Berkshire Healthcare Trust. The published information on complaints should also include the outcome for the complainant, for example – whether the complaints were upheld, lessons learnt and any settlements.** We note that our recommendation is consistent with the new requirements required by the Government in their detailed response to the Francis report, of 19 November 2013.
d) **We recommend that the Trusts display on their website and PALS notice board a postcard summarising the role of O&S and welcoming views (but not individual complaints) from patients to the Health O&S Panel (See paragraph 5.28 (iv) below).**
e) The Working Group wish to thank the people they met for their helpful views on what information they thought the Local Authority Overview and Scrutiny Panel should be receiving routinely from the NHS, and in their willing co-operation to ensure that such information needed is received from them. Full use of their ideas have been made in recommending the improvements the Working Group want to see made to Health O&S at Bracknell Forest.

Improvements Needed to Bracknell Forest's Health Overview and Scrutiny

5.8 There are many learning points arising from the Francis report which could be equally applied to any other O&S Panel and the O&S Commission, but at the heart of the matter is the need for councillors carrying out Health scrutiny to have both researched and be prepared to obtain and scrutinise information on the service users' experience by asking sometimes uncomfortable but pertinent questions. It is equally important that there is an ethos of systematically following matters up through action tracking.

We have grouped our conclusions and recommendations using the themes of the Francis report, as below.

Redefining The Objectives For Health O&S and the Role Of Members

5.9 Francis identified the need for more clarity over what functions/objectives Health O&S intend to follow when scrutinising the NHS. The starting point for this must be the **Health and Social Care Act 2012** and related legislation which gives powers to upper-tier local authorities to: review and scrutinise any matter relating to the planning, provision and operation of health services in their area; to make reports/ recommendations to local NHS bodies, NHS-commissioned providers, and the Secretary of State; to require the attendance of NHS staff and to require information to be provided. The Act also requires NHS bodies to consult the local O&S committee (including joint committees) on matters of substantial development or variation to services. Separately, the CfPS has recommended that council scrutiny is an opportunity to act as the eyes and ears of the community. Also, we must ensure that there is no duplication with or conflict with the Health and Wellbeing Board roles and responsibilities.

The Group recommends to the Health O&S Panel that:

The overall aim of Health scrutiny should be:
'Through constructive challenge and accountability, to work with the Executive, the Health and Wellbeing Board and Health Service Providers to help ensure good health services are provided to residents of Bracknell Forest, reducing health inequalities, and helping everyone to stay fit and lead healthy lives.'

Within that overall aim, **the objectives for Health Scrutiny should be**:

i. To exercise democratic accountability, representing the interests of Bracknell Forest residents in regard to health services. This entails constructively and transparently holding service providers to account in meetings open to the public, and making recommendations for improvements.
ii. To achieve and maintain knowledge of the patients' experience.
iii. To monitor the performance of the major providers of health services to our residents, with reference to the findings of NHS regulatory bodies, challenging underperformance and encouraging improvement.
iv. To review proposals for substantial service change.
v. To recognise that the vastness of the NHS and the limited time available for O&S means that only those matters deemed to be of greatest significance are scrutinised.
vi. Consequently, to make the best use of the resources available to O&S, by focussing attention on those issues which O&S members judge:
    1. affect a large number of residents, or
    2. are significant service failures or matters of public concern

In delivering these objectives, **the role of Members** is not to be medical experts. Instead, and in line with Mr Francis' reported view, councillors are expected to make themselves aware of, and pursue, the concerns of the public who have elected them.

Which NHS Service Providers Should be Regularly Scrutinised?

5.10 There are a large number of organisations involved in providing NHS services to Bracknell Forest residents. Regrettably, resources available to O&S do not permit them all to be scrutinised, so it is necessary to adopt a tiered approach based on

councillors' views of priority. **The Group recommends to the Health O&S Panel the following approach**:

Organisation	Proposed Approach to O&S	Comment
Health and Wellbeing Board (H&WBBd)	One Member to take lead in monitoring the activities of the H&WBBd, drawing matters to Panel's attention as necessary. Panel to review each year the annual refresh of the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy	H&WBBd Chairman attends Panel meetings routinely
Clinical Commissioning Group (Bracknell Forest and Ascot)	One Member to take lead in monitoring the activities of the CCG. Panel to meet the CCG Chairman and Accountable Officer at least once every two years.	
General Practitioner Practices	GP Patient Survey results to be presented to Panel, which will consider questioning any under-performing GP Practices	
Broadmoor Hospital	No O&S to be carried out, as very low significance for Bracknell Forest health services	Patients drawn from whole south of England
Heatherwood and Wexham Park Hospitals Royal Berkshire Hospital Frimley Park Hospital Berkshire Healthcare Trust	• Review NHS Choices information (includes staff and patient survey results, Friends and Family scores) at each Panel meeting • One Member to take lead in monitoring the complaints made to each hospital, particularly serious and Ombudsman cases, drawing matters to Panel's attention as necessary for follow-up. • Regular follow-up of significant issues, e.g. FPH/H&WP prospective merger, and instances of under-performance • On-going Panel review of any inpatient survey results, CQC and MONITOR reports • Respond to annual Quality Accounts • Formally meet each Trust at least once every two years	Though based outside the Borough, these three hospitals and the Healthcare Trust provide the majority of acute healthcare for Bracknell Forest residents
King Edward VII Hospital Dentists Opticians Pharmacists	O&S Officer to maintain watching brief on any CQC reports/news items and bring anything of concern to nominated Member(s) attention, for them to conduct further enquiries/draw matters to Panel's attention as necessary.	
Other hospitals	No O&S to be carried out, as lower volume of services for Bracknell Forest residents	Reliance to be placed on O&S by those councils in whose areas these hospitals are sited
NHS England & Specialised commissioning	O&S Officer to maintain 'light watching brief' on any news items and bring anything of concern to Panel Chairman for them to conduct further enquiries/draw matters to Panel's attention as	

	necessary.	
South Central Ambulance Service	One Member to take lead in monitoring the activities of/complaints to the SCAS, drawing matters to Panel's attention as necessary. Panel to review SCAS performance at meeting at least once every two years	
Public Health	One Member to take lead in monitoring the activities of/complaints to Public Health, drawing matters to Panel's attention as necessary. Panel to scrutinise annual budget, also to review performance at meeting with Director of Public Health at least once every two years	
Local Healthwatch	Support Healthwatch Bracknell Forest and obtain regular feedback from them on their findings. O&S Officer to maintain 'light watching brief' on any news items and bring anything of concern to specialist member for them to conduct further enquiries/draw matters to Panel's attention as necessary.	Local Healthwatch to be invited to attend all Panel meetings
Private sector providers of NHS commissioned services	No O&S to be carried out, as currently of low significance for Bracknell Forest health services	To be reviewed if 'contracted in' services grow significantly

Note – some of the services referred to in the table above are delivered at the Royal Berkshire Bracknell Clinic.

This frequency of coverage would mean that there is at least one substantive 'visitor item' at each of the Panel's four meetings annually.

Improving Members' Effectiveness (To Include Training, Advice And Support)

5.11 The Francis report said of O&S in Staffordshire: *'It confined itself to the passive receipt of reports…..Difficult though statistics can be to understand, it should have been possible to grasp that they could have meant there was an excess mortality that required at least monitoring by the committee.'*

5.12 The NHS is a vast and multi-faceted operation, such that it is impracticable for any one Councillor to develop an all round knowledge and understanding of the whole organisation, at a sufficient level to achieve effective scrutiny. To attempt to do so - as at present - risks "skating over the surface", the very essence of the Francis report. The Group considers that Member involvement in Health O&S, and the efficiency, quality, depth and effectiveness of scrutiny, could, potentially, be better served by each of the Panel Members concentrating on one defined and major area of NHS services - for example hospital services - and to lead the Panel's scrutiny work on that area. By specialising in an area of choice, and building a relationship with the respective organisation, each Member would develop knowledge of their area, thereby enhancing the O&S approach and greater distribution of the questioning between Members. This approach of having each Member taking the lead on an area of questioning has already been trialled very successfully at the Panel meeting with a hospital Trust on 19 August 2013. Knowledge – building would benefit from continuity of Panel Membership, so Members should be encouraged to view Membership of the Health O&S Panel as a four-year commitment.

The specialist areas for Members would need to be set by the Panel, but a possible grouping of topic areas could be two members each on:

1. Hospitals
2. Mental Health & Ambulance Service
3. Primary Care, to include the CCG, GPs, Dentists, Opticians and Pharmacists
4. Public Health, Health and Wellbeing Board, and Local Healthwatch.

It would be important for each Member to voluntarily take on one of these areas, and collectively they should cover all the areas deemed to be important by Members. Furthermore, each specialist Member should report back to each Panel meeting on scrutiny progress in their designated area, in a standardised report co-ordinated by O&S officers.

The Group recommends to the Health O&S Panel to adopt the focussed, designated Member approach as articulated above and in so doing implement appropriate training for such designated Members.

5.13 The importance, complexity, and continual evolution of the NHS means that Members carrying out Health O&S need regular training if they are to be effective. Use might be made of the training material provided to newly appointed Non-Executive Directors of NHS Trust Boards.

The Group recommends to the Health O&S Panel and to the Director of Adult Social Care, Health and Housing that training should be delivered primarily by officers in the Adult Social Care, Health and Housing Department, and comprise:

a) induction training for all Members new to Health O&S on the NHS structure, functions and local delivery organisations, and on the powers and role of Health O&S;
b) annual refresher training on major developments, to coincide with the annual update of the Joint Strategic Needs Assessment (which sets out the 'health profile' of the borough's population); and
c) targeted training in whichever topic area is selected for a focussed O&S review.

5.14 It is clear to us that expert advice is needed in various fields if Health O&S is to be effective. Members are not equipped with specialist knowledge for the clinical/medical questioning required. We would propose that a pool of experts is established for us to call upon depending on Members deciding what is needed for each aspect of the work. The pool could consist of GP's, be they retired or practicing also Nursing experts in hospital and caring environments. There may be others that Members come forward with. Hopefully these people would give their time to the community free of charge in the knowledge that their time would not be unreasonably used. Depending on the subject before Members, it would be helpful if our specialist expert was present at a scrutiny meeting. We could then take 'time outs' to seek guidance from answers given and, thereby obtain a sensible supplementary examination. The Health Panel will need to exercise care in deciding on the suitability of prospective members of this advisory panel.

The Group recommends to the Health O&S Panel that a Panel of people with clinician experience be recruited in a voluntary 'pro-bono' capacity and used to provide independent expert advice to the Panel on: priority health issues which should be reviewed, the questions which need raising, interpreting the results, and forming value-added recommendations.

Prioritising Issues For O&S Attention, And Getting The Right Information

5.15 There are many different aspects to health services, which are vast, and an O&S Panel which meets four times annually cannot hope to scrutinise more than a small part of those services. This needs to be openly recognised. The slender resources available to O&S means there is a clear need to keep the flow of information to Members of manageable size, to concentrate on exception reporting, flagging of issues of possible concern, and to prioritise quite ruthlessly on where O&S should focus its efforts. The O&S work programme needs to be of manageable proportions for Members, and be more actively shaped and led by Members than has previously been the case. Members might consider prioritising three or four headings to be scrutinised over a two year period, and once finished, then move on to another set of priorities. We think that it would be good practice to redefine the activity after each high level work plan is completed, even if no changes are identified.
The Group recommends to the Health O&S Panel that a process be put in place to facilitate Members identifying and bring forth for scrutiny such matters as they deem appropriate and necessary, for the Panel to agree on one or two issues to focus on, and determine its work programme for each municipal year.

5.16 The CfPS has recommended that council scrutiny should consider establishing a range of 'triggers for action' using data and information to monitor trends. The Panel needs to receive a regular flow of relevant and timely information about the quality of NHS services provided to Bracknell Forest residents. This information should not come just from the NHS organisations themselves (as has usually been the case) but from a variety of relevant sources, in order to arrive at a well-informed and balanced viewpoint. That said, Members must not be buried in mountains of information. Instead, there should be a selective approach, which as mentioned above could be achieved by each Member specialising in one of the principal fields of NHS activity. Each Member, advised by the O&S officer, should decide what matters should be brought to the Panel's attention from their designated area, and they should each lead the Panel's questioning in their respective area. Examples of the information specialist Members would be expected to refer to the Panel would be the in-patient survey results and the GP Patient survey.
The Group recommends to the Health O&S Panel that individual Members work with the O&S Officer to receive and review a regular flow of relevant and timely information about the quality of NHS services provided to Bracknell Forest residents.

5.17 The Group considered the standardised mortality figures* in some detail, and we see some limitations in placing too much emphasis on them. For example, they are a single figure for a whole hospital and could mask a high mortality in some areas, and it is not readily possible to get useful breakdowns of the figures. We considered that the summary mortality information should be regularly reported to the Panel, but other information is needed too. This could include a periodic analysis of the numbers of all types of death in Bracknell Forest, using information from the Coroners Service.

Public Participation

5.18 The Council's published Values include the following statement: 'The Council exists to serve and lead the local community therefore residents are at the heart of everything we do. While serving residents we will be friendly and approachable - we will be open, listening and straightforward.' Furthermore, the Centre for Public Scrutiny (CfPS) has established four core principles to help people understand the most important activities of O&S, including that O&S, 'enables the voice and concerns of the public and its communities'. This forms part of the CfPS 'Good Scrutiny Guide'.

5.19 The Francis report said, *'It [O&S] made no attempt to solicit the views of the public. It had no procedure which would have encouraged Members of the public to come forward with their concerns…..It showed a remarkable lack of concern or even interest in the HSMR [Hospital Standardised Mortality Rate] data…..Scrutiny ought to involve more than the passive and unchallenging receipt of reports from the organisations scrutinised.'*

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* **Summary Hospital-level Mortality Indicator (SHMI)**

The SHMI is used for reporting mortality (i.e. deaths) at hospital trust level across England. It indicates where the mortality of a provider is higher or lower than expected when compared to the England average, given the characteristics of the patients treated. SHMI data is presented in two ways – as a ratio and as a banding.

Ratio
SHMI is calculated as a ratio of A:B , where **A** is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days after the patient left the hospital, and **B** is the expected number of deaths based on the characteristics of the patients treated (for example patient's age, gender, and reason for admission to hospital)

The baseline value is 1 – a Trust would get 1 if the number of patient deaths were exactly the same as the number of patients expected to die (i.e. A = B)

Banding
A range is calculated within which a mortality rate is to be expected. A Trust's mortality rate is considered to be higher/lower than expected if it falls outside of this range. A Trust's mortality rate is judged to be outside of this range if it is 2 standard deviations away from the baseline of 1. Standard deviation measures how much spread there is within the data. A measure of 2 standard deviations will equal to the top and bottom 2.5% of the data and, therefore, represents the extreme ends of the spread of data.

Trusts have been banded into three categories, showing how their mortality compares to the average:
1 – where the trusts mortality rate is higher than expected
2 – where the trusts mortality rate is as expected
3 – where the trusts mortality rate is lower than expected

We noted that RBH and HWPT were currently in Band 2, and FPH was in the top Band 3.

Separately, the CfPS has recommended that Health O&S needs to monitor information about the patient experience, hearing about people's experiences of services, and the public should be given an opportunity to raise issues.

5.20 There is a public participation scheme for O&S at Bracknell Forest, but it has been accessed only rarely, and achieving greater public engagement with O&S is an elusive challenge for the majority of councils. There is an argument that the Public Participation scheme for O&S should be as accessible as that for the Health and Wellbeing Board (which only requires 15 minutes advance notice of questions before Board meetings).
The Group recommends to the O&S Commission and the Health O&S Panel that public engagement mechanisms are kept under review, with the underlying aim of learning about residents' healthcare concerns as directly as possible, and – in concert with Local Healthwatch - by giving the public a voice.

Wider Intelligence Gathering

5.21 Gaining a regular flow of relevant, but not excessive information, would also be assisted by the O&S officer scanning newly released reports by the NHS regulatory bodies, also piloting the use of internet alerts to summarily review media reports containing criticisms, of the NHS organisations selected for regular review. Members should also notify the O&S officer of any adverse media reports they become aware of. Also, the NHS Trusts identified for O&S coverage should be asked to notify the O&S Officer whenever they receive an 'outlier alert' (indicating materially sub-standard performance) from the Care Quality Commission. The O&S officer would then draw any issues of concern from these sources to the relevant 'Specialist Member' and Panel Chairman as appropriate, for them to determine whether, and if so how, to follow the matter up.
The Group recommends to the Health O&S Panel that this information gathering and dissemination process commences.

5.22 **The Group recommends to the Health O&S Panel that it should routinely receive at Panel meetings:**

a) **The summary information from the 'NHS Choices' website on Hospital Standardised Mortality Rate data, Friends and Family ratings, etc**
b) **Regular feedback from Local Healthwatch about any concerns they might have come across**
c) **Regular feedback from the Clinical Commissioning Group about any major concerns they have with the quality of services provided**
d) **Inpatient survey results**
e) **GP survey results**
f) **Any reports issued by the Care Quality Commission and MONITOR about the three hospitals, Ambulance Service and the BHT.**

Information on Patients' Complaints

5.23 Mr Francis recommended that: '*Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.'*

5.24 The Working Group invested some time in research and in visiting two of the Trusts to learn about complaints systems and processes. There is a plethora of information on complaints and so the Panel should be discerning of what information would be useful. Whilst each NHS Trust follows the national regulations for NHS complaints, our research has shown that each Trust deals with complaints in a slightly different

way. We have seen an example of a serious complaint report, and we regard that to be too detailed for O&S purposes. Instead, the quarterly Patient Safety Report, published by each of the NHS Trusts for their Board meetings in public, provides good summary information to gain a good general impression of complaints 'traffic', and does not endanger individual confidentiality. The Specialist Member for this area should request any supplementary information that may be required and brought to the attention of the Health O&S Panel, for example, there may be an upsurge in one type of complaint and so more information may be required beyond the Patient Safety Report. Also a summary of the Ombudsman cases and other more serious complaints may be requested. The Specialist member should relay all relevant information to all Panel members and advise the Panel if it was felt that an issue was big enough and serious enough to warrant action to be taken. It would be beneficial if the specialist member monitoring the complaints, together with all specialist members could present a routine report on their area of speciality at every Overview & Scrutiny Panel meeting. The Panel should seek a regular flow of information from Local Healthwatch, who should relay any concerns that are relevant. Also the Panel should receive the quarterly and Annual report from SEAP (the Complaints Advocacy Service) as this information is at present only available through Local Healthwatch. **The Group recommends to the Health O&S Panel that all specialist members apply the processes above when considering complaints in their specialist areas.**

5.25 It appears that residents do not necessarily associate their ward members with local health issues and so **the Group recommends to the Health O&S Panel that all Members should be encouraged to outreach into their respective wards to relay properly prepared and approved health information and issues to residents living in their wards.**

<u>The Parliamentary and Health Services Ombudsman</u>

5.26 When people who complain are dissatisfied with the response they receive from an NHS Trust, they can take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for them to use their independent statutory powers to investigate. Following the clear direction from Francis to O&S on complaints, we therefore see it as important to establish an information flow from the PHSO to learn of the number of cases received and the outcome, particularly in terms of whether the Ombudsman had asked for further apology, compensation or other action to be taken by a Trust (sometimes termed a 'local settlement'). We approached the Ombudsman to seek such information and were disappointed to have had our request declined. Whilst there may be some confidentiality issues to address and resolve, we do not regard this to accord with the spirit of Francis, nor helping local authorities to fulfil their statutory duty to scrutinise the NHS, and it would be preferable for us to receive information on Ombudsman complaints directly from the PHSO rather than from the NHS Trusts.
The Group recommends that the Health O&S Panel ask the PHSO to reconsider the Council's request for information on complaints.

<u>Working With Partners</u>

5.27 Mr Francis said in his report: '*It [O&S] took no steps to consider the implications of the announcement of an investigation by the HCC [Health Care Commission] or to follow its progress.* And Mr Francis' recommendation no 47 was: '*The Care Quality Commission should expand its work with overview and scrutiny committees…… as a valuable information resource.'*

5.28 For Health O&S to operate well, we need to work with various organisations providing Health Services, and related regulatory and other bodies. The Group regards our relationships to be generally good and productive, but we consider that some improvements could be made:

(i) Local Healthwatch

We had a constructive meeting with 'Healthwatch Bracknell Forest' (HWBF) during the course of our review and the Panel is actively helping HWBF settle into its important, new role to champion patients' interests. We must continue to encourage Local Healthwatch to build and maintain regular contact with patients of the three hospitals, Ambulance Service and the BHT, and feed back any key concerns to the Panel. Local Healthwatch (LHW) was represented (though apparently not as a co-optee) at the Surrey Health O&S Committee meeting we attended. We believe this is entirely appropriate, to emphasise the important role of Local Healthwatch and to build/maintain good working relationships. Our Health O&S Panel has already acted on this by agreeing with HWBF that they should come to all Panel meetings as an Observer (not co-opted onto Panel Membership, as they have a statutory participative role in the Health and Wellbeing Board, which is an Executive function).
Recommendations: a) That the practice of having a Local Healthwatch Observer be formally recognised in the Health Overview & Scrutiny Panel Terms of Reference;
b) That the Panel obtains regular feedback from HWBF on their view of the complaints processes, trends and outcomes.
c) That Panel Members spread awareness of HWBF in their Ward work.

(ii) Councillors On Trust Boards, etc

Some Bracknell Forest councillors have places on NHS Trusts, sometimes as part of their constitutional arrangements. Examples are the Berkshire Healthcare NHS Foundation Trust, and a Governor position at the Heatherwood and Wexham Park NHS Foundation Trust. We are unaware of the full extent of these positions, and there is no regular contact between the Panel and those councillors on Trust Boards/Governing Bodies to collaborate and share information on activities. This is a missed opportunity, and the Council should ensure it takes up its full representation.
The Working Group recommends:

a) **That the Executive Member for Adult Services, Health and Housing carries out a stock take of all the Council's external positions on NHS bodies, and works with Members to ensure that all suitable opportunities are taken up.**
b) **That the Health O&S Panel maintains regular contact with those BFC councillors on Trust Boards/Governing Bodies, with the aim of working in concert with them to best represent the interests of our residents. This should include asking each councillor representative to report to the Panel at least once annually, subject to their trust boards' confidentiality rules.**

(iii) NHS Quality Accounts

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. 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.
The Group recommends that the Health O&S Panel should invite input from all Members including the Executive Member, also the Director, and the Public Health Consultant before commenting on the annual Quality Accounts.

(iv) NHS Trusts

We should be very careful about making hospital visits, as patients might regard this to be an unwelcome intrusion. This is particularly the case where their dignity could be at risk, for example in Accident and Emergency. Instead, reliance should be placed on the hospital visits made by the CQC and Local Healthwatch. If, exceptionally, a hospital visit is made, this should always be by prior arrangement with hospital management, and be accompanied by them or one of their NHS professionals.

As part of the drive to get O&S better known and closer to residents, t**he Group recommends that the Health O&S Panel request each of the three hospitals, the Ambulance Service and the Berkshire Healthcare Trust to display on their website and PALS notice board a postcard summarising the role of O&S and welcoming views (but not individual complaints) from patients to the Health O&S Panel.**

(v) NHS Regulatory Bodies

We set out above how Health O&S should make better use of information from the Care Quality Commission (CQC) and MONITOR. A Member of our Group attended a CQC 'Listening Event' on 7 November to hear at first hand the views of patients about their experience as patients at Frimley Park Hospital, and this helped get us much closer to seeing things from the patients' point of view.
The Group recommends that the Health O&S Panel specialist members concerned should maintain contact with the local CQC Manager, and attend any CQC 'Listening Events' with patients of the three hospitals and Berkshire Healthcare Trust in advance of their inspections. The Panel's specialist member should also actively engage in the CQC 'Quality Summits' for the Trusts we are focussing on.

(vi) Centre for Public Scrutiny

The Group appreciated the advice of the CfPS Health Scrutiny Advisor at the outset of our review, and we think the improvements this report seeks to achieve would be of interest to other councils' Health O&S organisations. **Recommendation: That the Working Group's report be sent, together with our thanks to their representative for her input, to the Centre for Public Scrutiny for sharing widely.**

Improving The Running of Panel Meetings

5.29 The Group consider that some improvements can and should be made to the conduct of meetings, and **our recommendations to the Health O&S Panel are**:

(i) Collectively Planning Ahead and Taking Stock of Progress

The agenda-setting meetings should be held 6 weeks before each panel meeting and be open to all Panel Members, and expanded to:

- provide an opportunity for a de-brief on the previous Panel meeting, and
- be a forum for general discussion on health O&S priorities and progress.

In setting agendas for meetings, there is a clear need for keener prioritisation, including turning down some of the requests by the NHS to address the Panel on issues which the Panel does not see as its priorities.

(ii) Preparation for meetings

Preparation for Panel meetings has benefitted from pre-meetings, which should continue, but there is still a lot more to do, both collectively and by individual Members, if best value is to be obtained from Panel meetings. On our visit to Surrey Council's Health O&S Committee, we observed that the members were evidently well prepared, and they all participated well in the meeting, asking good quality questions. BFC Members need to ensure they are fully briefed and prepared, and be confident to ask challenging questions, seeking advice from the O&S and departmental officers as necessary.

As a matter of routine, any presentations to be delivered should be circulated to members at least a few days in advance, to allow them to prepare for meetings well.

(iii) Summing Up Discussions

The Panel Chairman has recognised the need to arrive at a clear conclusion at the end of each agenda item, ideally ending with a voted motion, possibly containing a recommendation. Inconclusive meetings are of limited value, and this discipline should continue.

(iv) Official Record of Health O&S Panel Meetings

Mr Francis said, '*It has been far from easy to determine [what scrutiny activity was carried out]… as the minutes… are brief to the point of being uninformative: they register that a topic was discussed and summarise presentations made …… but there is no summary of the debate….. In many cases, the decision was often merely to "note" a presentation. It was widely accepted by witnesses that this style of minute taking was inadequate'.*
Officers have revised the format of our Health O&S Panel minutes in line with the Francis criticism, to more comprehensively record the questions raised and the answers received. No objections have been raised to the improved format, which should continue.

(v) Proper Follow-up to Panel meetings

Health O&S Panel Members should be reminded that follow-up questions can be sent in writing as necessary, after Panel meetings.
In our visit to Surrey, we observed that there is a regular agenda item on 'action tracking' (systematically following matters up, including previous recommendations). Subject to resources being available, this would be a good addition to the Health O&S Panel's procedures.

Resourcing the Recommended changes to Health O&S

5.30 Mr Francis recommended in his report that, '*Scrutiny Committees should be provided with appropriate support to enable them to carry out their scrutiny role*' (recommendation 149).

Member Resources

5.31 Implementing the Group's recommendations would add noticeably to the time demands on Members. **The Panel should not agree to the recommendations in this report unless all its Members are personally committed to putting in the time to deliver what is recommended as new responsibilities.**

Officer Resources

5.32 Implementing the Group's recommendations would also add noticeably to the time demands on officers. The Panel currently has around 0.3 full-time equivalent of an O&S Officer to support its work. By contrast, we observed that Surrey Council had two officers supporting Health O&S, however the two are not directly comparable: it is possible they have other duties; besides the Health O&S responsibilities for Surrey are more numerous than for Bracknell Forest. We must also recognise that the recommendation regarding member training would be a significant new demand on officers in the Adult Social Care, Health and Housing Department too. Pending experience of the actual resource implications, it is vital that we grasp this nettle either we may need to increase/divert resources, or openly acknowledge that we will not be able to implement all the learning points from Francis.

Our priority is - through scrutiny – to ensure that good health services are delivered to our residents. **The Group recommends that the Health O&S Panel, in consultation with the O&S Commission decides how to meet these new demands on officer time. One possible solution could be to not implement the more resource-intensive of our recommendations (e.g. recruiting and maintaining a panel of expert advisors; information gathering for the specialist member; and action tracking).**

If no option is taken up, it would be unfair and unrealistic to ask our existing officer resource - which is already hard-pressed - to just accommodate these extensive new demands, so there could be no expectation that our recommended improvements could be implemented.

Applying the lessons of this review to other O&S Panels

5.33 The Group is confident that adopting the recommended improvements in this report will make Health scrutiny more robust and effective when monitoring the actions of the NHS Trusts that serve the residents of Bracknell Forest. By gathering and scrutinising information from a number of different sources the Panel will be in a strong position to act and advise if action is deemed necessary. We also believe that many of the improvements envisaged for Health O&S could be applicable to the conduct of O&S by the O&S Commission and other O&S Panels. For example, other Panels could benefit by considering whether they should obtain corresponding information on complaints to obtain a better understanding of the service user's perspective.

The Group recommends that the O&S Commission and Panels consider reviewing the scope for replicating the improvements to Health O&S throughout the Council's O&S function.

Glossary

A&E	Accident and Emergency
BHT	Berkshire Healthcare Foundation Trust
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CfPS	Centre for Public Scrutiny
DoH	Department of Health
FPH	Frimley Park Hospital NHS Foundation Trust
GP	General Practitioner
H&WBBd	Health and Wellbeing Board
H&WPT	Heatherwood & Wexham Park Hospitals NHS Foundation Trust
HOSC/P	Health O&S Committee/Panel
HWBF	Healthwatch Bracknell Forest
HWE	Healthwatch England
LHW	Local Healthwatch
LINk	Local Involvement Network
O&S	Overview and Scrutiny
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
RBH	The Royal Berkshire (Hospital) NHS Foundation Trust
SCAS	South Central Ambulance Service NHS Foundation Trust
SEAP	Support Empower Advocate Promote
SMHI	Summary Hospital-level Mortality Indicator
'The Group'	The Working Group of the Health Overview and Scrutiny Panel

APPENDIX 1

BRACKNELL FOREST COUNCIL

HEALTH OVERVIEW AND SCRUTINY PANEL
MAY 2013

WORK PROGRAMME 2013 – 2014

Terms of Reference for

FRANCIS REPORT - OVERVIEW AND SCRUTINY WORKING GROUP

Purpose of this Working Group / anticipated value of its work:

1.	Review the comments regarding Health O&S practices in the report by Mr Francis on the failings surrounding the Mid Staffordshire NHS Hospital
2.	Recommend to the Panel what improvements are needed to the Health O&S practices at Bracknell Forest in the light of Mr Francis' report
3.	Participate in the workshop for key partner organisations run by the Health and Wellbeing Board, regarding Francis
4.	Review the steps being taken to implement the lessons of the Francis report by those principal NHS organisations serving Bracknell Forest residents.

Key Objectives:

1.	To thoroughly review the weaknesses in O&S highlighted by Francis, showing that Bracknell Forest Council has responded properly to the lessons it offers
2.	To determine the type and frequency of information (particularly on complaints) needed from which NHS organisations serving Bracknell Forest residents
3.	To re-appraise Members' health O&S role, and identify how to improve their effectiveness (to Include training, advice and support)
4.	To identify improvements to Health O&S practices, including prioritisation and the summing up and minuting of Health O&S Panel meetings

Scope of the work:

1.	The implications for Health O&S arising from the report by Mr Francis of the failings at Mid Staffordshire hospital

Not included in the scope:

1.	Care must be taken not to over-step the role of O&S into – for example - Local Healthwatch's role
2.	Anything outside the Francis report and its immediate implications

Terms of Reference prepared by: R M Beaumont

Terms of Reference agreed by: The Working Group

Working Group structure: Councillors Baily, Finch, Heydon, Kensall, Mrs McCracken, Mrs Temperton, and Virgo.

Working Group Lead Member: Councillor Mrs McCracken

Portfolio Holder: Councillor Birch, Executive Member for Adult Services, Health and Housing

BACKGROUND:

1. The Francis Inquiry followed a series of investigations and reports, including an investigation by the Healthcare Commission in 2009 and an independent inquiry also conducted by Robert Francis QC. The failings at Stafford Hospital have been well reported in the media. The number of excess deaths between 2005 and 2008 is estimated at 492 people. Examples of poor care include patients being left in soiled bedclothes for lengthy periods, lack of assistance with eating and drinking, filthy wards and toilets, lack of privacy and dignity such as people left naked in a public ward, and triage in A&E undertaken by untrained staff. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'.

2. In the Government's initial response to the Francis report, the Secretary of State for Health said in March 2013: *'The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry makes horrifying reading. At every level, individuals and organisations let down the patients and families that they were there to care for and protect. A toxic culture was allowed to develop unchecked which fostered the normalisation of cruelty and the victimisation of those brave enough to speak up. For far too long, warning signs were not seen, ignored or dismissed. Regulators, commissioners, the Strategic Health Authority, the professional bodies and the Department of Health did not identify problems early enough, or, when they were clear, take swift action to tackle poor care. They failed to act together in the interests of patients. This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.'*

3. The Francis Inquiry report attributes accountability for the appalling care at Stafford Hospital to the Trust Board, but also points to a systemic failure by a range of national and local organisations – including the Health Overview and Scrutiny Committees of both the County and District councils concerned - to respond to concerns. The report indicated that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS.

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

5. At its meeting on 18 April 2013, the Health O&S Panel decided to commence a Working Group with the broad purposes to:

    - recommend to the Panel what changes are needed to the Health O&S practices at Bracknell Forest;

- participate in the workshop envisaged by the Health and Wellbeing Board;
- review the steps being taken to implement the lessons of the Francis report by those NHS organisations serving Bracknell Forest residents.

SPECIFIC QUESTIONS FOR THE PANEL TO ADDRESS:

1.	Which NHS Trusts are to be scrutinised*, and what information is needed from them?
2.	What follow-up action on Francis is being taken by the Health scrutiny committees of the local authorities where the trusts are based?
3.	What should the scope and objectives of Health scrutiny in Bracknell Forest be, and what is the role and contribution of councillors to that?
4.	Are there wider lessons for O&S beyond Health O&S, particularly on gaining a better understanding of residents' experience of using council services?

INFORMATION GATHERING:

Witnesses to be invited

Name	Organisation/Position	Reason for Inviting
Representative	Centre for Public Scrutiny	To learn about best practice in O&S follow-up to Francis
Representatives	NHS Trusts principally serving Bracknell Forest residents	To review how they are applying the lessons from Francis
Cllr Dale Birch	Executive Member	To discuss his priorities from Francis, and the conclusions of the review
Glyn Jones	Director, Adult Social Care, Health and Housing	To discuss officer support. Link Officer for review.
Representative	Local Healthwatch	To ensure O&S and LHW roles are complementary

Site Visits

Location	Purpose of visit
Surrey County Council	Lead Member and Panel Chairman to join in discussion with Surrey CC O&S Members to see if a partnership approach is feasible to the O&S approach to Frimley Park Hospital
Possibly 3-4 Hospital sites	To possibly meet PALS complaints teams to understand their role and the flow of information?

Key Documents / Background Data / Research

1.	Report by Mr Francis QC on the failings of the Mid Staffordshire Hospital

TIMESCALE

* Now determined by the Working Group to be: Heatherwood & Wexham Park, Frimley Park, the Royal Berkshire, and South Central Ambulance Service. Views will also be sought from the Clinical Commissioning Group.

Starting: May 2013 Ending: November 2013 (this might extend to January 2014)

OUTPUTS TO BE PRODUCED

1. A report to the Health O&S Panel with the Working Group's recommendations for improvements
2. A clear commitment by the principal NHS Trusts to future information flows.
3. Relationship building with Local Healthwatch

REPORTING ARRANGEMENTS

Body	Date
Health Overview and Scrutiny Panel	12 December 2013

MONITORING / FEEDBACK ARRANGEMENTS

Body	Details	Date
Health Overview and Scrutiny Panel	Progress reports to each Panel meeting	11 July 2013 and subsequently
Health and Wellbeing Board	To advise the Board of the review's commencement, and – in due course – its conclusions	TBC

For further information on the work of Overview and Scrutiny in Bracknell Forest, please visit our website on http://www.bracknell-forest.gov.uk/scrutiny or contact us at:

Overview and Scrutiny, Chief Executive's Office, Bracknell Forest Council, Easthampstead House, Town Square, Bracknell, Berkshire, RG12 1AQ,
or email us at overview.scrutiny@bracknell-forest.gov.uk
or telephone the O&S Officer team on 01344 352283

This document can be made available in large print, in Braille or on audio cassette. Copies in other languages may also be obtained. Please contact the Chief Executive's Office, Easthampstead House, Bracknell, RG12 1AQ, or telephone 01344 352122.

HEALTH OVERVIEW AND SCRUTINY PANEL
7 JANUARY 2014

THE PATIENTS' EXPERIENCE
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This routine report invites the Health Overview and Scrutiny Panel to consider the current information from the NHS Choices website, for the NHS Foundation Trusts providing most secondary NHS services to Bracknell Forest residents.

2 RECOMMENDATIONS

That the Health Overview and Scrutiny Panel:

2.1 Considers the NHS Choices information concerning the nearby NHS Trusts
2.2 Determines whether to make any further enquiries based on that information.

3 SUPPORTING INFORMATION

3.1 The Panel's Working Group on the Francis report has identified a need to regularly present the Panel with information on the patients' experience of NHS services, along with other high level information on the performance of the NHS trusts principally providing NHS services to Bracknell Forest residents. At item 9 on the agenda, the Panel is being asked to consider the Working Group's recommendations on the full extent of that information but in the interim, the Panel Chairman has agreed that it would be sensible to have regular reports using the information from the 'NHS Choices' website.

3.2 NHS Choices (www.nhs.uk) is the UK's biggest health website. It provides a comprehensive health information service, including more than 20,000 regularly updated articles. There are also hundreds of thousands of entries in more than 50 directories that can be used to find, choose and compare health services in England.

The site draws together the knowledge and expertise of:

- NHS Evidence, formerly the National Library for Health
- the Health and Social Care Information Centre (HSCIC)
- the Care Quality Commission (CQC)
- many other health and social care organisations

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

Contact for further information

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

	NHS Choices users rating	Recommended by staff	Responding to patient safety alerts	Mortality rate	Care Quality Commission national standards
	i	i	i	i	i
Heatherwood Hospital					Remove
Tel: 01344 623 333 London Road Ascot Berkshire SL5 8AA 2.58 miles away | Get directions	21 ratings Rate it yourself	51 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	As expected in hospital and up to 30 days after discharge (1.0278)	Some standards not met Visit CQC profile
Frimley Park Hospital					Remove
Tel: 01276604604 Portsmouth Road Frimley Surrey GU16 7UJ 6.78 miles away | Get directions	158 ratings Rate it yourself	84 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	As expected in hospital and up to 30 days after discharge (0.904)	All standards met Visit CQC profile

	NHS Choices users rating	Recommended by staff	Responding to patient safety alerts	Mortality rate	Care Quality Commission national standards
	i	i	i	i	i

King Edward Vii Hospital Remove

Tel: 01753 860 441 St Leonards Road Windsor Berkshire SL4 3DP 6.92 miles away | Get directions P	☆☆☆☆☆ No ratings yet Rate it yourself	73 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	OK As expected in hospital and up to 30 days after discharge (1.0686)	All standards met Visit CQC profile

Upton Hospital Remove

Albert Street Slough Berkshire SL1 2BJ 8.97 miles away | Get directions	★★★☆☆ 7 ratings Rate it yourself	64 % of staff who would recommend this organisation	Good - All alerts signed off where deadline has passed	n/a Data not available	All standards met Visit CQC profile

	NHS Choices users rating	Recommended by staff	Responding to patient safety alerts	Mortality rate	Care Quality Commission national standards
	i	i	i	i	i
St Marks Hospital					☐ Add to shortlist
Tel: 01628 632012 St. Marks Road Maidenhead Berkshire Berkshire SL6 6DU 7.40 miles away | Get directions	★★★½☆ 11 ratings Rate it yourself	64 % of staff who would recommend this organisation	✓ Good - All alerts signed off where deadline has passed	n/a Data not available	✓ All standards met Visit CQC profile
Royal Berkshire Hospital					☑ Add to shortlist - View
Tel: 0118 322 5111 London Road Reading Berkshire RG1 5AN 9.47 miles away | Get directions P ♿	★★★★☆ 157 ratings Rate it yourself	73 % of staff who would recommend this organisation	✓ Good - All alerts signed off where deadline has passed	OK As expected in hospital and up to 30 days after discharge (1.0686)	✓ All standards met Visit CQC profile

	NHS Choices users rating	Recommended by staff	Responding to patient safety alerts	Mortality rate	Care Quality Commission national standards
	i	i	i	i	i
Wexham Park Hospital					Add to shortlist
Tel: 01753 633000 Wexham Park Hospital Wexham Slough Berkshire SL2 4HL **10.92 miles away** | Get directions 	 100 ratings Rate it yourself	51 % of staff who would recommend this organisation	 Good - All alerts signed off where deadline has passed	 As expected in hospital and up to 30 days after discharge (1.0278)	☐  Enforcement action in progress Visit CQC profile
Prospect Park Hospital					☐ Add to shortlist
Tel: 0118 960 5000 Honey End Lane Tilehurst Reading Berkshire RG30 4EJ **11.79 miles away** | Get directions 	 18 ratings Rate it yourself	64 % of staff who would recommend this organisation	 Good - All alerts signed off where deadline has passed	n/a Data not available	 Some standards not met Visit CQC profile

Explanatory Notes

NHS Choices User Ratings

The proportion of the people who rated this hospital on NHS Choices who would recommend the organisation's services to a friend.

Recommended by Staff

This measure shows whether staff agreed that if a friend or relative needed treatment they would be happy with the standard of care provided by the trust. The results are taken from the 2010 national NHS staff survey.

Responding to Patient Safety Alerts

Whether an NHS organisation is signing off its response to patient safety alerts that are issued by the National Patient Safety Agency. The 'Poor' category shows that the organisations has not signed off as complete **one or more** safety alerts for which the deadline has passed, the 'Good' category shows that the organisation has signed off **all** alerts for which the deadline has passed.

Mortality Rate

Whether the rate of deaths for an NHS Trust is better or worse than expected for the Trust based on the type of cases treated. The adjusted mortality ratio reflects deaths in hospital and within 30 days of discharge.

Care Quality Commission National Standards

As the independent regulator for health and adult social care in England, CQC check whether services are meeting their national standards of quality and safety.

Agenda Item 11

HEALTH OVERVIEW AND SCRUTINY PANEL
7 JANUARY 2014

WORKING GROUPS UPDATE AND 2014/15 WORK PROGRAMME
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, and invites members to propose items for inclusion in the Panel's work programme for 2014/15.

2 RECOMMENDATIONS

That the Health Overview and Scrutiny Panel:

2.1 Notes the progress achieved to date by the Panel's Working Groups
2.2 Determines the membership and commencement date for the review of the Brants Bridge health facility
2.3 Proposes items for inclusion in the Panel's work programme for 2014/15.

3 SUPPORTING INFORMATION

Francis Report

3.1 The review of the implications for Health O&S of the report of Francis Inquiry has been completed and the report is at item 9 of the Agenda for the Panel's consideration. The Working Group comprised Councillors Mrs McCracken (Lead Member), Mrs Angell, Angell, Baily, Kensall, Mrs Temperton, and Virgo.

The Brants Bridge Health Facility

3.2 The Panel's Work Programme for 2013/14 includes forming a Working Group to review the operation of the cancer and renal facilities, also the creation of the Urgent Care Centre at Brants Bridge, Bracknell. It was planned to commence this review once the Working Group on the Francis Report had concluded its work, but it was delayed further on account of the referral to the Secretary of State by RB Windsor & Maidenhead concerning the Urgent Care Centre. As that referral was unsuccessful, the way is now clear to commence the review.

Work Programme

3.3 To assist members' consideration of possible items for inclusion in the Panel's work programme for 2014/15, the previously completed reviews are listed on the following page, also the work programme for the current year.

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

Contact for further information

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

Previously Completed Health Overview and Scrutiny Reviews

Date Completed	Title
November 2005	The Management of Coronary Heart Disease
July 2007	Review of Healthcare Funding
November 2007	Review of the Council's Health and Wellbeing Strategy
Annually since 2009	Annual Health Check Response to the Healthcare Commission / NHS Trusts
April 2009	Children's Centres and Extended Services in and Around Schools in Bracknell Forest
December 2009	NHS Core Standards
January 2010 (Addendum in 2011)	Review of the Bracknell Healthspace
July 2010	Preparedness for Public Health Emergencies
December 2010	Hospital Car Parking Charges (Joint East Berks Health O&S Committee)
October 2012	Major Health Reforms
November 2012	Health and Wellbeing Strategy
February 2013	'Shaping the Future' of Health Services in East Berkshire – consultation response
April 2013	NHS Trusts Quality Accounts 2011/12 (letters submitted to three Trusts)

2013-14 Health Overview and Scrutiny Work Programme

Policy development and monitoring the implementation of the major changes from the 2012 Health and Social Care Act

To contribute to and monitor the Council's and NHS policy development, in particular:

- Completing the transfer of the Public Health responsibilities from the PCT to the Council;
- The work of the Health and Wellbeing Board;
- The Joint Strategic Needs Assessment and the Health and Wellbeing Strategy;
- Further integration of health and social care functions (with particular focus on hospital discharge and managing long-term health conditions);
- Relationship building with Local Healthwatch, MONITOR and the Care Quality Commission.

[Panel updates]

The Brants Bridge Health Facility

Forming a Working Group to review the operation of the cancer and renal facilities, also the creation of the Urgent Care Centre.

2014/15 Budget Scrutiny

To review the Council's budget proposals for public health in 2014/15, and plans for future years.

Monitoring the performance of the NHS trusts and Clinical Commissioning Group serving Bracknell Forest This will include: the work of the Bracknell Forest and Ascot CCG; reviewing the application of any lessons learnt from the Francis Report on the failings of the NHS and Health Overview and Scrutiny in Mid Staffordshire; the implementation of the actions from the 'Shaping The Future' consultation; delivery of the national NHS priorities set by the Department of Health; the progress of health service providers; the results of the GP Patient Survey; and the financial position of Heatherwood and Wexham Park Hospitals Trust.
Responding to NHS Consultations The Health O&S Panel is a statutory consultee for any substantial variation in NHS services affecting the Borough.

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TO: HEALTH OVERVIEW AND SCRUTINY PANEL
7 JANUARY 2014

EXECUTIVE KEY AND NON-KEY DECISIONS RELATING TO HEALTH
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report presents scheduled Executive Key and Non-Key Decisions relating to Health for the Panel's consideration.

2 RECOMMENDATION(S)

2.1 That the Health Overview and Scrutiny Panel considers the scheduled Executive Key and Non-Key Decisions relating to Health appended to this report.

3 REASONS FOR RECOMMENDATION(S)

3.1 To invite the Panel to consider scheduled Executive Key and Non-Key Decisions.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

5.1 Consideration of Executive Key and Non-Key Decisions alerts the Panel to forthcoming Executive decisions and facilitates pre-decision scrutiny.

5.2 To achieve accountability and transparency of the decision making process, effective Overview and Scrutiny is essential. Overview and Scrutiny bodies are a key element of Executive arrangements and their roles include both developing and reviewing policy; and holding the Executive to account.

5.3 The power to hold the Executive to account is granted under Section 21 of the Local Government Act 2000 which states that Executive arrangements of a local authority must ensure that its Overview and Scrutiny bodies have power to review or scrutinise decisions made, or other action taken, in connection with the discharge of any functions which are the responsibility of the Executive. This includes the 'call in' power to review or scrutinise a decision made but not implemented and to recommend that the decision be reconsidered by the body / person that made it. This power does not relate solely to scrutiny of decisions and should therefore also be utilised to undertake pre-decision scrutiny.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

No advice was sought from the Borough Solicitor, the Borough Treasurer or Other Officers or sought in terms of Equalities Impact Assessment or Strategic Risk Management Issues. Such advice will be sought in respect of each Executive Forward Plan item prior to its consideration by the Executive.

7 CONSULTATION

None.

Background Papers

Local Government Act 2000

Contact for further information

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OVERVIEW & SCRUTINY COMMISSION

EXECUTIVE WORK PROGRAMME

REFERENCE	I042554
TITLE: Tender for Bridgewell Clinical Support	
PURPOSE OF DECISION: For approval of the Procurement Plan regarding Community Response and Reablement Staffing.	
FINANCIAL IMPACT: Within existing budget	
WHO WILL TAKE DECISION: Executive Member for Adult Services, Health and Housing	
PRINCIPAL GROUPS TO BE CONSULTED: Internal teams within Adult Social Care who are part of the project team and local stakeholders	
METHOD OF CONSULTATION: Meetings with interested parties	
DATE OF DECISION: Monday, 3 Feb 2014	

REFERENCE	I041994
TITLE: Joint Commissioning Strategy for People with Dementia 2014-2019	
PURPOSE OF DECISION: To seek approval to the Joint Commissioning Strategy for people with Dementia which has been developed by Bracknell Forest Council and Bracknell and Ascot Clinical Commissioning Group. The Strategy has been developed following a full 12-week public consultation held prior to the development of the strategy to ensure that people with dementia, their carers and families and the voluntary sector were involved in informing the commissioning priorities for the next five years.	
FINANCIAL IMPACT: Within existing budget	
WHO WILL TAKE DECISION: Executive	
PRINCIPAL GROUPS TO BE CONSULTED: People with dementia Carers of people with dementia People working in Health and Social Care Voluntary sector colleagues Members of Bracknell and Ascot CCG Other individuals with an interest in dementia support	
METHOD OF CONSULTATION: Public consultation event Online consultation form Hard copy consultation form posted out Presentations at local voluntary groups	
DATE OF DECISION: Tuesday, 7 Jan 2014	

REFERENCE	I041920
TITLE: Learning Disabilities Commissioning Strategy 2014-2019	
PURPOSE OF DECISION: To agree the Learning Disabilities Strategy for 2014-2019. This is a joint commissioning strategy between Bracknell Forest Council and Bracknell and Ascot Clinical Commissioning Group. It identifies objectives for service development for the next five years. A 12 week consultation is held prior to the development of the strategy to help inform the priorities within the strategy.	
FINANCIAL IMPACT: None at this time	
WHO WILL TAKE DECISION: Executive	
PRINCIPAL GROUPS TO BE CONSULTED: People with Learning Disabilities Carers People working in Health and Social Care Voluntary sector colleagues Members of Bracknell and Ascot CCG Other individuals with an interest Learning Disabilities support	
METHOD OF CONSULTATION: Letter Meetings with interested parties Presentations Presentation Online questionnaires Group and individual interviews	
DATE OF DECISION: Tuesday, 11 Mar 2014	

REFERENCE	I042645
TITLE: Community Response and Reablement Staffing	
PURPOSE OF DECISION: Following a competitive tender process, to approve the award of a contract for the staffing services to the Community Response and Reablement Team.	
FINANCIAL IMPACT: To be incorporated into the report.	
WHO WILL TAKE DECISION: Executive	
PRINCIPAL GROUPS TO BE CONSULTED: Internal teams within Adult Social Care who are part of the project team and local stakeholders.	
METHOD OF CONSULTATION: Meetings with interested parties	
DATE OF DECISION: Tuesday, 11 Mar 2014	

REFERENCE	I044516
TITLE: Modernisation and Transforming Older People's Services	
PURPOSE OF DECISION: To consider the outcome of the consultation on the future of the in-house Dementia Home Care Service.	
FINANCIAL IMPACT: Revenue savings anticipated	
WHO WILL TAKE DECISION: Executive	
PRINCIPAL GROUPS TO BE CONSULTED: Staff People who receive service and their families	
METHOD OF CONSULTATION: Letter Meetings with interested parties	
DATE OF DECISION: Tuesday, 11 Feb 2014	

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TO: HEALTH OVERVIEW AND SCRUTINY PANEL
7 JANUARY 2014

OVERVIEW AND SCRUTINY PROGRESS REPORT
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report highlights:

(i) Overview and Scrutiny (O&S) activity during the period May to November 2013.
(ii) Significant national and local developments in O&S.

2 RECOMMENDATIONS

2.1 To note Overview and Scrutiny activity and developments over the period May to November 2013, set out in section 5 to 6, and Appendices 1 and 2.

3 REASONS FOR RECOMMENDATIONS

3.1 The Chief Executive has asked for a six monthly report to be produced on O&S activity.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

Overview and Scrutiny Structure and Membership

5.1 Council appointed Rev Cannon Nick Parish, Church of England representative, also Councillor Sargeant, to the O&S Commission, and the Commission appointed Rev Parish to the Children, Young People & Learning Overview and Scrutiny Panel. A councillor vacancy on the Commission remains to be filled. Mrs Carol Murray (Parent Governor representative) and Mrs Catriona Mitchell (Co-optee) resigned during the period. Action is in hand to fill both vacancies, also the long-running vacancy for a representative of the Catholic Diocese.

Overview and Scrutiny Work Programme and Working Groups

5.2 The programme for 2013-14 was approved as part of the Annual Report of O&S for 2012-13, including formal consultation with the Corporate Management Team and the Executive. The programme is broadly on course for completion as planned, and a routine report has been submitted to each O&S Commission meeting, monitoring progress against the O&S Work Programme using traffic light indicators.

5.3 The table at Appendix 1 sets out the current status of the O&S Working Groups, along with the list of completed reviews.

Overview and Scrutiny Commission

5.4 The O&S Commission met on 2 and 15 May (Annual meeting), 1 July, 5 September and 21 November. The main items included: reviewing the quarterly performance reports for the Corporate Services Department, the Chief Executive's Office and the Council as a whole; meeting the Police and Crime Commissioner also representatives of Thames Valley Police and the Community Safety Partnership to review their performance and the refreshed Community Safety Plan; receiving briefings on the Commercial Property Portfolio and the Residents' Survey; considering progress reports on the Community Infrastructure Levy, and the implementation of the strategies for Customer Contact and Channel, Information and Communications Technology, and Office Accommodation; a discussion with the Borough Treasurer on the evolving budgetary position; adopting the report of the Commission's Working Group which reviewed Delegated Authorities, and considering the Executive's response to that report's recommendations. The Deputy Leader said about that report: *'I find the document detailed and comprehensive and an excellent piece of scrutiny work'*.

5.5 At each of its meetings, the Commission also reviewed corporate items on the Executive Forward Plan, and monitored the delivery of the O&S work programme, with particular reference to the Commission's own Working Groups. Separately, the O&S Commission made an input to the consultation on the new Community Engagement strategy in May.

5.6 The O&S Commission's next meeting is on 30 January 2014. The Commission intends commencing its Working Group on the impact of re-localisation of Business Rates in early 2014.

Environment, Culture and Communities O&S Panel

5.7 Meetings of the Panel were held on 25 June and 24 September. During the meetings the Panel considered and commented on: Quarterly Service Reports for the relevant quarters; the Schools Annual Environmental Management Report 2011/12; outcomes of the Residents' Survey; the Residents' Parking Scheme consultation; Local Development Framework updates; the Revised Statement of Community Involvement; the evolving departmental budgetary position; Sustainable Modes of Transport; the O&S Work Programme 2013-14; the six monthly O&S progress report; and scheduled Executive key and non-key decisions. The Panel also received presentations from the Council's Emergency Planning Manager and representatives of the Environment Agency and Thames Water explaining how the Council managed flood risk in partnership with these external agencies. The Panel has monitored the progress of its working group which has guided the Borough's emerging Bus Strategy for implementation in April 2014 and plans to establish a new working group to review the Council's cultural services offering (see Appendix 1).

5.8 Actions arising from Panel meetings have resulted in the circulation to Panel Members of a school's energy consumption figures following the installation of a photovoltaic system and information concerning blue wheeled bin registration and the recycling incentive scheme. The next meeting of the Panel is taking place on 21 January 2014.

Health O&S Panel

5.9 The Panel met on 11 July, 18 August and 3 October. The main items considered at those meetings included: considering the South Central Ambulance Service's performance on cardiac arrest survival rates and Ambulance response times; reviewing the GP Patient Survey results for the Borough; monitoring the progress on delivering the reforms to health arising from the Health and Social Care Act, specifically the transfer of Public Health responsibilities to the Council, and establishing Local Healthwatch, with whom we had a

meeting to review their progress in fulfilling their role; and having a meeting dedicated to reviewing the response of Heatherwood and Wexham Park Hospitals Trust to very critical reports issued by the Care Quality Commission. At each of its meetings, the Panel also considered scheduled Executive Key and Non-Key Decisions relating to Health, and monitored the progress of its Working Groups. A new standing item has included regularly reviewing the information from the 'NHS Choices' website concerning summary information on mortality and other key information for the NHS Trusts providing most of the acute care services for Bracknell Forest residents.

5.10 Between formal meetings, the Panel's activities have included, for example: monitoring the delivery of 'Shaping the Future' programme for health services in East Berkshire, monitoring the prospective merger of two hospital Trusts nearby, visiting the South Central Ambulance Service Call Centre in Bicester in July, also their Annual General Meeting in September. A major activity has been progressing a Working Group to review what has been and can be learnt locally from the Francis report on the appalling failures concerning the Mid Staffordshire NHS Trust. The Panel's next meeting is on 7 January 2014.

Joint East Berkshire with Buckinghamshire Health O&S Committee

5.11 This Committee, formed jointly with Slough Borough Council, the Royal Borough of Windsor & Maidenhead, and Buckinghamshire County Council has remained suspended, the last meeting having been held in March 2013. The O&S Commission had previously decided to end the Council's involvement in the Joint Committee, unless there is a need to respond to a statutory consultation affecting health services in East Berkshire. The Council declined RB Windsor and Maidenhead's suggestion in November that the Committee might meet to consider an issue at a local hospital.

Children, Young People and Learning O&S Panel

5.12 Meetings of the Panel took place on 3 July and 11 September, 2013. The Panel received a presentation from the Bracknell Forest Youth Council regarding its recent activities and considered and commented on: Quarterly Service Reports for the relevant quarters; youth provision; the 2013/14 Service Plan and Revised Key Actions and Indicators; Adoption and Foster Care Services Annual Reports 2013; Children and Young People's Plan; implementation of the Common Assessment Framework; Children's Social Care Complaints and Compliments Annual Report 2012/13; Life Chances Team update; Annual report on the Work of the Virtual School; Residents' Survey; Positive Approaches to the Engagement of Young People; the evolving departmental budgetary position; O&S Work Programme 2013-14; the six monthly O&S progress report; and scheduled Executive key and non-key decisions. The Panel also agreed the report of its Working Group which reviewed School Governance and received the resulting favourable Executive response (see Appendix 1).

5.13 Activities between Panel meetings included referring the School Governance Working Group report to the Governor Appointments Committee and the receipt of information concerning work to improve engagement with young people, a school leaflet explaining the Common Assessment Framework assessment process, data on A*-C grades in different GCSE subjects and performance of pupil premium students. The Panel's next meeting is being held on 15 January 2014.

Adult Social Care and Housing O&S Panel

5.14 The Panel met on 18 June and 17 September, 2013. The main items considered at the meetings included: Quarterly Service Reports for the relevant quarters; Annual Complaints Report for Adult Social Care and for Housing 2012/13; Adult Social Care and Health Local Account 2012/13; Community Based Support Services for People with a Learning Disability; Commissioning Strategy for Adults with Long Term Conditions; Benefits Service Update;

Bracknell Forest Safeguarding Adults Partnership Board Annual Report 2012/13; Joint Commissioning Strategy for People with Learning Disabilities Consultation; Outcomes of the 2012/13 Carers' Survey; Caring for Our Future Consultation; the evolving budgetary position for Adult Social Care and Housing; the six monthly O&S progress report; and scheduled Executive key and non-key decisions. The Panel also considered a monitoring update report in respect of the implementation of the programme of Modernising Older People's Services, following the related review previously undertaken by one of its working groups.

5.15 A new working group has been established to undertake a review of the Council's Role in Regulated Adult Social Care Services (see Appendix 1). The next meeting of the Panel is taking place on 14 January 2014.

Other Overview and Scrutiny Issues

5.16 Responses to the feedback questionnaires on the quality of O&S reviews are summarised in Appendix 2, showing a consistently high score across the various questions posed.

5.17 Quarterly review and agenda setting meetings between O&S Chairmen, Vice-Chairmen, Executive Members and Directors are taking place regularly for the Panels (every two months for the O&S Commission).

5.18 External networking on O&S in the last six months has included both O&S officers attending the annual conference of the Centre for Public Scrutiny in June. The Head of O&S attended a meeting of the South East Employers Local Democracy and Accountability network event in November, and he has continued to represent South East councils' O&S interests at meetings of the National O&S Forum, run by the Centre for Public Scrutiny.

6 Developments in Overview and Scrutiny

6.1 The Local Government Association Peer Challenge report of May 2013 said in relation to O&S: '*There is a strong and effective overview and scrutiny function. There is a role that stretches beyond routine monitoring and holding to account, with an increased emphasis on pre-decision involvement and contribution to policy development. Work programmes are determined by scrutiny members in conjunction with lead officers and members, and taking account of the Executive's Forward Plan. This helps Overview and Scrutiny Panels make a relevant and timely contribution to policy development. There are several examples of this, such as the work on localisation of council tax benefits, early intervention, and the Community Infrastructure Levy'.*

7 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Statutory Scrutiny Officer

7.1 The monitoring of this function is carried out by the Statutory Scrutiny Officer on a quarterly basis. Good progress has been made on the agreed programme of work by Overview and Scrutiny for 2013/14. Scrutiny Panels have continued to focus on areas of importance to local residents, and the quality of the work done continues to be high.

Borough Solicitor

7.2 Nothing to add to the report.

Borough Treasurer

7.3 There are no additional financial implications arising from the recommendations in this report.

Equalities Impact Assessment

7.4 Not applicable. The report does not contain any recommendations impacting on equalities issues.

Strategic Risk Management Issues

7.5 Not applicable. The report does not contain any recommendations impacting on strategic risk management issues.

Workforce Implications

7.6 Not applicable. The report does not contain any new recommendations impacting on workforce implications.

Other Officers

7.7 Directors and lead officers are consulted on the scope of each O&S review before its commencement, and on draft O&S reports before publication.

8 CONSULTATION

Principal Groups Consulted

8.1 None.

Method of Consultation

8.2 Not applicable.

Representations Received

8.3 None.

Background Papers

Minutes and papers of meetings of the Overview and Scrutiny Commission and Panels.

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Doc. Ref

CXO\Overview and Scrutiny\2013-14\progress reports

Appendix 1

OVERVIEW AND SCRUTINY CURRENT WORKING GROUPS – 2013/14
Position at 18 November 2013

Overview and Scrutiny Commission								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Delegated Authorities	Angell (Lead), Mrs Birch, Gbadebo, Finnie and Leake	Alison Sanders	Richard Beaumont	√	Completed	Completed	√	Executive response due to be considered by O&S Commission on 21 November

Health Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Francis Report on NHS Mid Staffordshire Hospital	Mrs McCracken (Lead), Mrs Angell, Angell, Baily, Kensall, Mrs Temperton, and Virgo	Glyn Jones	Richard Beaumont	√	Information gathering complete	In draft		Draft report being considered by Working Group on 20 November

Environment, Culture and Communities Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Bus Strategy Working Group	Finnie (Lead), Brossard, Ms Brown, Gbadebo and Leake	Bev Hindle / Sue Cuthbert	Andrea Carr	√	Four meetings have taken place and the review is virtually completed	N/A	N/A	The Bus Strategy will be shared with the Working Group for any final comments once prepared for approval by the Executive in January 2014
Cultural Services Offering	Brossard, Ms Brown, Finnie and Thompson	TBC	Richard Beaumont		At planning stage			The first meeting of the Working Group is yet to be arranged

Children, Young People and Learning Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
School Governance	Mrs Temperton (Lead) Mrs Birch, Ms Hayes, Mrs McCracken, Mrs Cauchi	Martin Surrell	Andrea Carr	√	Completed	√	√	The review report was completed in July and a favourable Executive

	(former PGR) & Mr Jackson (Kerith Centre)							response was received in September, 2013
School Places	Mr Briscoe (PGR) (Lead) Mrs Birch, Gbadebo, Kensall, Mrs McCracken, and Mrs Temperton	Chris Taylor	Andrea Carr	√	Review commenced in September 2013 and two meetings have taken place to date			A third meeting is being arranged to consider the capital programme and impact of new housing etc.

Adult Social Care and Housing Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
The Council's Role in Regulated Adult Social Care Services	Harrison (Lead), Mrs McCracken, Mrs Temperton and Thompson	Zoë Johnstone	Andrea Carr	√	The first meeting of the Working Group has taken place			The second meeting is being arranged to consider CQC inspection criteria and reports, and examples of contracts

Completed Reviews

Date Completed	Title
December 2003	South Bracknell Schools Review
January 2004	Review of Adult Day Care Services in Bracknell Forest (Johnstone Court Day Centre & Downside Resource Centre)
May 2004	Review of Community & Voluntary Sector Grants
July 2004	Review of Community Transport Provision
April 2005	Review of Members' Information Needs
November 2005	The Management of Coronary Heart Disease
February 2006	Review of School Transfers and Performance
March 2006	Review of School Exclusions and Pupil Behaviour Policy
August 2006	Report of Tree Policy Review Group
November 2006	Anti-Social Behaviour (ASB) – Review of the ASB Strategy Implementation
January 2007	Review of Youth Provision
February 2007	Overview and Scrutiny Annual Report 2006
February 2007	Review of Library Provision
July 2007	Review of Healthcare Funding
November 2007	Review of the Council's Health and Wellbeing Strategy
December 2007	Review of the Council's Medium Term Objectives
March 2008	2007 Annual Health Check Response to the Healthcare Commission
April 2008	Overview and Scrutiny Annual Report 2007/08
May 2008	Road Traffic Casualties
August 2008	Caring for Carers
September 2008	Scrutiny of Local Area Agreement
October 2008	Street Cleaning
October 2008	English as an Additional Language in Bracknell Forest Schools
April 2009	Overview and Scrutiny Annual Report 2008/09

Date Completed	Title
April 2009	Healthcare Commission's Annual Health Check 2008/09 (letters submitted)
April 2009	Children's Centres and Extended Services in and Around Schools in Bracknell Forest
April 2009	Older People's Strategy
April 2009	Services for People with Learning Disabilities
May 2009	Housing Strategy
July 2009	Review of Waste and Recycling
July 2009	Review of Housing and Council Tax Benefits Improvement Plan
December 2009	NHS Core Standards
January 2010	Medium Term Objectives 2010/11
January 2010	Review of the Bracknell Healthspace (publication withheld to 2011)
January 2010	14-19 Years Education Provision
April 2010	Overview and Scrutiny Annual Report 2009/10
July 2010	Review of Housing and Council Tax Benefits Improvement Plan (Update)
July 2010	The Council's Response to the Severe Winter Weather
July 2010	Preparedness for Public Health Emergencies
October 2010	Safeguarding Vulnerable Adults in the context of Personalisation
October 2010	Review of Partnership Scrutiny
December 2010	Hospital Car Parking Charges
January 2011	Safeguarding Children and Young People
March 2011	Review of the Bracknell Healthspace (Addendum)
April 2011	Overview and Scrutiny Annual Report 2010/11
June 2011	Office Accommodation Strategy
June 2011	Plans for Sustaining Economic Prosperity
July 2011	Review of Highway Maintenance (Interim report)
September 2011	Performance Management Framework

Date Completed	Title
September 2011	Review of the Council's Medium Term Objectives
October 2011	Plans for Neighbourhood Engagement
October 2011	Regulation of Investigatory Powers
October 2011	Site Allocations Development Plan Document
January 2012	Common Assessment Framework
February 2012	Information and Communications Technology Strategy
April 2012	NHS Trusts Quality Accounts 2011/12 (letters submitted to five Trusts)
April 2012	Overview and Scrutiny Annual Report 2011/12
June 2012	Commercial Sponsorship
July 2012	Communications Strategy
November 2012	Proposed Reductions to Concessionary Fares Support and Public Transport Subsidies
November 2012	Modernisation of Older People's Services
January 2013	Preparations for the Community Infrastructure Levy
February 2013	Substance Misuse
February 2013	'Shaping the Future' of Health Services in East Berkshire
April 2013	Overview and Scrutiny Annual Report 2012/13
April 2013	NHS Trusts Quality Accounts 2011/12 (letters submitted to three Trusts)
July 2013	School Governance
September 2013	Delegated Authorities
October 2013	Bracknell Forest Bus Strategy

Appendix 2

Results of Feedback Questionnaires on Overview and Scrutiny Reports

Note – Departmental Link officers on each major Overview and Scrutiny review are asked to score the key aspects of each substantive review on a scale of 0 (Unsatisfactory) to 3 (Excellent)

	Average score for previous 19 Reviews[1]
PLANNING Were you given sufficient notice of the review?	**2.8**
Were your comments invited on the scope of the review, and was the purpose of the review explained to you?	**2.9**
CONDUCT OF REVIEW Was the review carried out in a professional and objective manner with minimum disruption?	**2.7**
Was there adequate communication between O&S and the department throughout?	**2.8**
Did the review get to the heart of the issue?	**2.6**
REPORTING Did you have an opportunity to comment on the draft report?	**2.8**
Did the report give a clear and fair presentation of the facts?	**2.5**
Were the recommendations relevant and practical?	**2.5**
How useful was this review in terms of improving the Council's performance?	**2.6**
Overall average score	**2.7**

[1] Road Traffic Casualties, Review of the Local Area Agreement, Support for Carers, Street Cleaning, Services for Adults with Learning Disabilities, English as an Additional Language in Schools, Children's Centres and Extended Services, Waste and Recycling, Older People's Strategy, Review of Housing and Council Tax Benefits Improvement Plan, 14-19 Education, Preparedness for Public Health Emergencies, Safeguarding Children, Safeguarding Adults, the Common Assessment Framework, Modernisation of Older People's Services, Community Infrastructure Levy, School Governance, and Delegated Authorities.