



BROMSGROVE DISTRICT COUNCIL

MEETING OF THE OVERVIEW AND SCRUTINY BOARD

MONDAY 16TH JULY 2012
AT 6.00 P.M.

COMMITTEE ROOM, THE COUNCIL HOUSE, BURCOT LANE, BROMSGROVE

MEMBERS: Councillors S. R. Colella (Chairman), P. Lammas (Vice-Chairman), C. J. Bloore, J. S. Brogan, Dr. B. T. Cooper, Mrs. R. L. Dent, K. A. Grant-Pearce, Mrs. J. M. L. A. Griffiths, R. J. Laight, P. M. McDonald, S. P. Shannon, Mrs. C. J. Spencer and L. J. Turner

AGENDA

1. Apologies for Absence
2. Declarations of Interest and Whipping Arrangements
3. To confirm the accuracy of the minutes of the meeting of the Overview and Scrutiny Board held on 18th June 2012 (Pages 1 - 10)
4. Joint Service Review - The Future Configuration of Acute Services in Worcestershire
(Chris Fearn, the JSR Project Director and Director of Strategy for Worcestershire Acute Health Trust will attend with Rose Johnson, Associate Medical Director and A&E Consultant.)
5. A Presentation on the Countywide Homelessness Strategy Report for pre-scrutiny
6. Corporate Performance Monitoring Report Quarter Ending 31st March 2012 (Pages 11 - 22)
7. Sickness Absence Performance and Health Quarter 4 Report (Pages 23 - 32)
8. Forward Plan of Key Decisions 1st July to 31st October 2012 (Pages 33 - 44)

9. Overview and Scrutiny Topic Proposals
10. Overview and Scrutiny Board Work Programme (Pages 45 - 48)
11. WCC Health Overview and Scrutiny Committee Agenda and Minutes (for information) (Pages 49 - 94)
12. To consider any other business, details of which have been notified to the Head of Legal, Equalities and Democratic Services prior to the commencement of the meeting and which the Chairman, by reason of special circumstances, considers to be of so urgent a nature that it cannot wait until the next meeting.

K. DICKS
Chief Executive

The Council House
Burcot Lane
BROMSGROVE
Worcestershire
B60 1AA

6th July 2012



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Agenda Item 3

BROMSGROVE DISTRICT COUNCIL

MEETING OF THE OVERVIEW AND SCRUTINY BOARD

MONDAY, 18TH JUNE 2012 AT 6.00 P.M.

PRESENT: Councillors S. R. Colella (Chairman), P. Lammas (Vice-Chairman), J. S. Brogan, Dr. B. T. Cooper, Mrs. R. L. Dent, K. A. Grant-Pearce, Mrs. J. M. L. A. Griffiths, Mrs. H. J. Jones (Substitute for R. J. Laight, present from Minute No. 1/12 to 14/12)), P. M. McDonald, L. C. R. Mallett (Substitute for C. J. Bloore, present from Minute No. 1/12 to 14/12), S. P. Shannon, Mrs. C. J. Spencer and L. J. Turner

Observers: Councillor Dr. D. W. P. Booth JP, Councillor R. Hollingworth and Councillor C. B. Taylor

Officers: Ms. J. Pickering, Mrs. A. Heighway, Ms. S. Horrobin, Mr. C. Santoriello-Smith, Ms. J. Bayley and Ms. A. Scarce

1/12 ELECTION OF CHAIRMAN

RESOLVED that Councillor S. R. Colella was elected as Chairman for the ensuing municipal year.

(Councillor P. M. McDonald asked that it be noted that he felt that it was not appropriate for the Chief Whip to be Chairman of the Overview and Scrutiny Board.)

2/12 ELECTION OF VICE CHAIRMAN

RESOLVED that Councillor P. Lammas was elected as Vice Chairman for the ensuing municipal year.

3/12 APOLOGIES

Apologies for absence were received from Councillors C. J. Bloore and R. J. Laight.

4/12 DECLARATIONS OF INTEREST AND WHIPPING ARRANGEMENTS

Councillor J. S. Brogan declared a personal interest in respect of Minute No. 14/12 WCC Health Overview and Scrutiny Committee.

5/12 MINUTES

The minutes of the Overview and Scrutiny Board meeting held on 23rd April 2012 were submitted.

A Member requested that at Minute No. 116/11 (second set of bullet points, bullet point 3) the actual estimated figures should be included – therefore should the Council not take any action to address the forthcoming changes, the estimated cost of bed and breakfast accommodation would be £519,000 for the first year and £781,000 for the second.

RESOLVED that subject to the above the minutes be approved as a correct record.

The Board was provided with updates in respect of the following:

Minute No. 116/11 bullet point 9 – the establishment of a credit union in the area.

Minute No. 117/11 Resolved item (b) would be treated as a separate item and the Board would receive a full report on the disposal of stock and any claw back clause at a future meeting.

Minute No. 118/11 - The information requested by a Member in respect of the Environmental Protection Act 1990 legislation had been provided.

Minute No. 119/11 - A response from the Senior Community Safety Officer had been circulated to Members.

6/12 **NEW FLY POSTING POLICY AND PROCEDURES**

The Board received a presentation on the Draft Fly Posting Policy from the Senior Community Safety Project Officer and the Environmental Services Manager. The aim of the presentation was to give the Board an insight into some of the content of the new fly posting policy and to allow the Board's comments to be fed into the report which would be presented to Cabinet in September 2012.

The Senior Community Safety Project Officer explained that the new policy would clarify the Council's approach in tackling fly-posting through its cleansing and enforcement activities and how the Council worked with its partners and other agencies to tackle illegal advertisements and to promote advertising within the parameters of the law. The new policy would provide the Community Safety Team with additional tools, through the Joint Environmental Enforcement Strategy, in particular the use of the fixed penalty notice scheme. Members were informed that, this year the Team had already investigated over 60 separate incidents of fly posting.

Members were provided with a definition of fly posting and its associated problems. Fly posting was an illegal activity which could give the impression of neglect, could attract litter, graffiti and criminal damage to an area, and could potentially obscure important traffic signs and create obstruction and cause injury if dislodged or not fixed appropriately. The Board was also provided with information on how advertisements were controlled; the Local Planning Authority was responsible for the day to day operation of the

advertisement control system and making the decision as to whether a particular advertisement received consent.

The Senior Community Safety Project Officer provided the Board with information on relevant legislation and the Council's powers to take action against those responsible for fly posting. It was highlighted to Members that the Council would always take positive action in line with legislation and its own policies to tackle fly posting where it had a detrimental impact on communities and the environment.

The Board was also provided with details of how the policy would enable preventative action to be taken to deter fly posting. The preventative action encompassed five stages of enforcement, including fixed penalty notices and these were outlined in the Council's Joint Environmental Enforcement Strategy. Members were informed that the policy supported good communications between relevant departments within the Council and partnership working with external agencies in order to ensure the policy was implemented effectively; this included the sharing of intelligence with other districts within the County. The Senior Community Safety Project Officers provided Members with information on how the Council would deal with non-commercial and charitable advertising.

The Board was provided with information on the new procedure for enforcement officers which guided officers through the complexity of fly posting legislation and advertising guidelines. Members were also provided with timescales for implementation of the policy and procedures and it was confirmed that it would be received at the Cabinet meeting scheduled for 5th September 2012.

Following the presentation the Senior Community Safety Project Officer and the Environmental Services Manager responded to questions from Members. Members discussed the following areas in more detail:

- Clarifications in respect of fly posting for such events as church fetes - it was confirmed that there would be a period of time when advice on how to obtain consent would be provided to those that advertised in this way.
- Developers for new housing estates – it was confirmed that these were one of the classes which had deemed consent (each class of deemed consent had its own conditions within that consent).
- The cost to the Council and whether any fines that were levied covered this.
- "A" Boards that were used in the town centre and advertising used by market stall holders. It was confirmed that businesses using this type of advertising came within the Fly Posting Policy and that it would be expected that such businesses ensured that the Boards were placed on land that they had permission for that they owned. Market stall holders would need to apply for permission for any advertising that was required.

- Whether there was a “revocation” clause within the contracts for businesses which hired the Council’s facilities and did not have the appropriate permissions to advertise those events.
- The inclusion within the policy of the stages prior to a fixed penalty being given - it was confirmed that any level of enforcement could be taken for any offence dependent upon its severity and circumstances.
- Clarification in respect of charitable organisations and how such organisations were dealt with within the policy, in particular those larger charities which were run more commercially.

At this stage of the meeting Councillor L. Mallett declared a personal interest as an employee of a charitable organisation and left the meeting for the remainder of the agenda item.

- Confirmation that signage for example for lost pets would be classed as non commercial advertising.
- Advice and written warnings would be provided where necessary.

RECOMMENDED that the policy be amended to ensure the inclusion of a “revocation” clause within the hire contracts for businesses which have hired the Council’s facilities and advertised such events without the appropriate permissions.

RESOLVED that a copy of the Draft Fly Posting Policy be provided to Members when available.

7/12

LONGBRIDGE STATEMENT OF PRINCIPLES AFFORDABLE HOUSING PROVISION - PRESENTATION

The Board received a presentation from the Head of Community Services in respect of the Statement of Principles provision of affordable housing at Longbridge. The Board was provided with background information as to the reasons behind the Statement of Principles and it was stressed that this would not apply to any other development within the district. The presentation covered the following points in detail:

- Where possible the Longbridge site would be treated as a whole, this was in order for the residents of Bromsgrove district to benefit as much as possible from the site.
- The Statement of Principles had been drawn up in order to provide both Planning and Strategic Housing Officers with a set of agreed guidelines to assist them in negotiating affordable housing provision at Longbridge.
- Members were provided with full details of what was included within the guidelines.
- The proportion of new residential development to be affordable housing, the preferred type, size and tenure of affordable housing to be sought together with the targeted standard of construction and the distribution within the development, all of which would be subject to negotiation.

- How nomination rights should be allocated between the authorities – which would allow the flexibility to be able to access the broad range of affordable housing delivered.
- It was stressed that the percentage of affordable housing would vary from site to site and would be dictated through planning applications not through the Statement of Principles.

The Portfolio Holder for Strategic Housing, Business Transformation, Town Centre Regeneration and Special Projects reiterated that the key issue was the 50% nomination rights and the Statement of Principles was a high level agreement to enable the Council to work with Birmingham City Council.

The Chairman invited Councillor R. Hollingworth to add any further comments and the Board was provided with further background information in respect of the working group which had originally been set up and had agreed to the inclusion of the Statement of Principles.

Officers responded to questions from the Board and discussed the following in more details:

- How the nomination rights would be monitored in order to ensure that Bromsgrove district received the agreed 50% - Officers would track every property that became available in order to ensure that this happened.
- As part of the principles of the Area Action Plan (AAP) there was a reduction in affordable housing to 35%, this has not been maintained in respect of the “East Works” area of the Longbridge site. Members were informed that the 35% referred to was across the entire site.
- An independent assessor had provided information on the viability of the site. Reference to this and possible adjustment to the percentage was made within the Statement of Principles.

RESOLVED that the presentation be noted.

8/12

QUARTER 4 CUSTOMER SERVICE UPDATES REPORT

The Board considered the Making Experiences Count – Quarterly Complaints report which was brought before Members following a recommendation from the Planning Policy Task Group final report. The Executive Director, Finance and Corporate Resources informed Members that as this was the first such report received by the Board it gave them an opportunity to feedback on the level of information within the report and whether further information would be helpful.

It was highlighted to Members that the Council was receiving more complaints and compliments; this was due to officers and members of the public appreciating particular issues as being compliments and complaints. There had also been training for officers in respect of identifying the differences between complaints and services issues. Members were informed that the Council was moving away from the use of targets as these tended to drive particular types of behaviour for example by not logging a particular complaint

in order to maintain a target. The decrease in the number of complaints from 2010/11 was due to particular issues in that year which related to garden waste.

From the information available the Council had learnt that the main issue was not keeping the customer informed and not responding in an appropriate manner; the information sent out did not always explain the position and was not written in plain English. An average of 76% of complaints received responses within the target time. Whilst this was a slight increase on the previous year, it was considered unacceptable and Members requested further details on any remedial actions taken to improve this figure.

The Board discussed the following areas in more detail:

- Members queried whether spot checks were undertaken – it was confirmed that “mystery shopper” exercises had taken place over various departments (including members of the public) and the results of these would be provided in the next quarterly report.
- Concerns were raised in respect of the 15 working days response to a customer complaint. It was clarified that an acknowledgement of a complaint would normally be made within 2-3 days. If a complaint required a more detailed complex response, for example in respect of housing benefits, then the response time could be significantly longer.
- The current customer skills training which was being rolled out to employees – both face to face and telephone.
- Concerns were raised in respect of agency waste crews being used without the appropriate training. Members understood that there had been funding allocated for crews to receive specific NVQ training.
- Officers to clarify the point raised by Members in respect of the weight of bins.
- Members noted that a complaint had been received in respect of confidential details being sent in error to the wrong person and suggested that this could be a matter for further investigation by the Audit Board.

Members discussed the overall training needs, which were highlighted within this report.

RESOLVED:

- (a) that the next quarterly report includes information on actions taken to improve the percentage of cases responded to within the target time and where necessary any training needs identified to assist with this improvement;
- (b) that the next quarterly report includes information on the number of complaints responded to quickly and the number which take more time and therefore have a detrimental effect on the average response percentage; and
- (c) that a presentation be included in respect of the training received by staff when the next quarterly report is received by the Board.

9/12 **PLANNING POLICY TASK GROUP - RESPONSE TO CABINET INTERIM REPORT**

The Chairman reminded Members that the revision of recommendations 1, 3 and 6 of the Planning Policy Task Group had been as a result of the Cabinet Interim Response. After a short discussion it was

RESOLVED:

- (a) that the revised recommendations be approved; and
- (b) the revised recommendations be submitted to Cabinet for approval.

10/12 **FORWARD PLAN OF KEY DECISIONS**

The Forward Plan of Key Decisions was considered by the Board.

RESOLVED that the Forward Plan be noted.

11/12 **OVERVIEW AND SCRUTINY BOARD DRAFT ANNUAL REPORT 2011/12**

The Board was advised that the Annual Report for 2011/12 was for consideration and comment. This would be presented to full Council at the meeting to be held on 18th July 2012.

As this had been the first full year of the current Overview and Scrutiny Board, Members considered the Board's workload which had seen the amalgamation of the four previous Boards into one Work Programme and discussed whether there was a need to make any changes to the number of boards which covered the Scrutiny role. Members thanked Officers for producing such a well written, comprehensive and detailed summary of the work the Board had carried out in 2011/12. After further discussion it was

RESOLVED that the report be noted.

12/12 **QUARTERLY RECOMMENDATION TRACKER REPORT**

The Chairman informed Members that the format of the Quarterly Recommendation Tracker had been revised in order to provide Members with a more succinct report. It was noted that some items had been outstanding for a significant length of time. Members discussed the importance of the Tracker and of the need to monitor the progress of recommendations which had not yet been completed. After further discussion it was

RESOLVED that relevant Heads of Services provide a full update on any outstanding items and attend the next available meeting.

13/12 **OVERVIEW AND SCRUTINY BOARD WORK PROGRAMME**

The Board noted that the Work Programme included a number of items carried over from the previous municipal year, together with regular standing items. The Chairman invited Members to consider bringing forward any topics

that would be suitable for the Board to investigate, for discussion at the Board meeting to be held on 16th July 2012.

Members discussed the potential future models of county hospital care, as part of the Joint Services Review, which had recently been announced and in particular the proposed closure of the Accident and Emergency department at the Alexandra Hospital in Redditch, which would have an impact on residents of the District. The Board's representative on the Worcestershire County Council Health Overview and Scrutiny Committee (HOSC), Councillor Dr. B. T. Cooper, provided full details at Minute No. 14/12. The Board considered whether this was an appropriate topic for external scrutiny and whether a presentation on the future model options and a progress report was required, together with an updated report when a decision has been made by the Worcestershire Acute Hospitals NHS Trust on which model it will implement.

RESOLVED:

- (a) that the Democratic Services Officer distribute a blank topic proposal form for completion by Members if required and for such forms to be considered at the Board meeting to be held on 16th July 2012;
- (b) that Officers invite a representative of the Worcestershire Acute Hospitals NHS Trust to attend the Board meeting to be held on 16th July 2012 to give a presentation on the future models of county hospital care; and
- (c) that a report on the disposal of stock and any claw back clause still in existence through BDHT be timetabled into the Board's Work Programme.

14/12 **WCC HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

Councillor Dr. B. T. Cooper, the Council's representative on the Worcestershire County Council Health Overview and Scrutiny Committee (HOSC) informed Members that he had attended its meeting on 22nd May 2012. The main items covered at that meeting had been an update on the Joint Services Review and Acute Stroke Services in Worcestershire. In respect of Acute Stroke Services it was proposed that these would be concentrated at the Worcestershire Royal Hospital and although concerns were raised in respect of travelling time, it had been agreed that this was appropriate for service.

In respect of the Joint Services Review the process for assessing the options had been presented by the Worcestershire Acute Health Trust. On 12th June 2012 a press release was issued on the six options which would be considered, which lead into the period of public engagement, this was a series of community events which had been arranged. The Bromsgrove event would take place on 27th June 2012 between 10.00 a.m. and 2.00 p.m. at the Churchfields Surgery and it was understood that attendees needed to reserve a place. Councillor Dr. Cooper agreed to provide Members with full details of the proposals and timetable via Officers.

The Board discussed the importance of being able to put forward its views as to which of the six options was most suited to the needs of the residents of Bromsgrove and how it could best feed back those views into the engagement exercise as soon as possible. It was understood that individual Councillors would be expected to put forward their preferred option; however the Board as a whole could feed any views through recommendations which would be considered by Cabinet.

The meeting closed at 8.05 p.m.

Chairman

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Overview & Scrutiny Board

16th July 2012

CORPORATE PERFORMANCE REPORT

QUARTER 4, PERIOD ENDING 31 MARCH 2012

Relevant Portfolio Holder	Cllr Mark Bullivant, Portfolio Holder
Portfolio Holder Consulted	Yes at Leaders Group Meeting
Relevant Head of Service	Kevin Dicks, Chief Executive
Wards Affected	All Wards
Non-Key Decision	

1. SUMMARY OF PROPOSALS

- 1.1 This report also provides Members with an opportunity to review the Council's performance for quarter 4 of the 2011/12 financial year and to comment upon it.

2. RECOMMENDATIONS

- 2.1 **The Board is asked to RESOLVE that:**

- i. **the update on key performance indicators for the period ending 31 March 2012 be noted.**

3. KEY ISSUES

Financial Implications

- 3.1 Poor financial performance will be detrimental to any Council assessment and overall performance. Specific financial indicators included in the 2011/12 set are listed below:
- Time taken to process housing benefit / council tax benefit new claims and change events;
 - Percentage of invoices paid by the Council within 30 days of receipt or within the agreed payment terms;

Legal Implications

- 3.2 The Government announced that the former National Indicator set was to be reduced. At present there is no legal requirement for the local authority to produce specific performance data.
- 3.3 As the Council progresses with the transformation programme, Members and Senior Management Team may wish to challenge data

requirements placed upon the Council by external organisations if it is felt that they do not contribute to the purposes of the organisation.

Service/Operational Implications

- 3.4 The current reduced number of indicators allows officers to focus on the areas that are of greatest importance and still require management for the remainder of the financial year.
- 3.5 The corporate performance report was agreed by Cabinet in June 2011 and, due to the change in strategic focus, the transformation programme and associated system thinking, targets were not required for the business plans 2011/12 and as such are no longer contained within the report. The corporate performance report compares the year to date outturn with the same period last year and shows those indicators from the Council Plan which were agreed by CMT for corporate reporting for quarter 3 and quarter 4, 2011/12 and whether they have improved, declined or remained static in performance.
- 3.5.1 In total, data has been provided for 16 indicators for quarter 4, 2011/12. Of these, 10 have improved in performance and 6 have declined when compared to the same period last year.
- 3.5.2 Of those indicators which have declined, there is one which may require further analysis (see section 3.5.4).
- 3.5.3 This report shows that of the 16 indicators reported this quarter, 62.5% have improved when compared to the same period last year (April to March). By way of example:
- The length of time taken to process Housing Benefit / Council Tax Benefit new claims and change events has continued to reduce showing a reduction of 2.2 days when compared to the same period last year (9.7 days in 2010/11 and 7.5 days in 2011/12);
 - The number of people using the BURT and Shopmobility services during April to March continues to rise with 136 and 323 additional users, respectively;
 - Visitors to the Dolphin Centre has increased by 47,940 users when comparing April to March 2010/11 (369,521 users) and the same period 2011/12 (417,461 users);
 - Usage of The Artrix also continues to rise with an additional 8,194 users over the 12 months between April 2011 and March 2012.
- 3.5.4 There is one indicator giving rise to some concern:
- The number of people using town centre car parks continues to fall with a reduction of 62,828 users in the twelve months

Overview & Scrutiny Board

16th July 2012

between April 2011 and March 2012, falling from 1,503,562 users to 1,440,734 users. However work is to be undertaken to develop a marketing campaign with Wychavon District Council; this campaign is expected to be ready for consideration in June 2012.

- 3.6 To maintain data quality, the Council uses an electronic data collection (EDC) spread sheet. This shows our current and historic performance against selected performance indicators.
- 3.7 The Council's current Council Plan makes a clear commitment to improve the way in which priority actions are planned and to improve the way in which performance is managed. Appendix 1 reports on the 2011/12 performance indicators agreed for by CMT for corporate reporting in quarter 4. The performance data contained in the attached report relates directly to the Council's priorities and objectives.
- 3.8 The performance indicator set includes one which reports on the number of working days / shifts lost to the local authority due to sickness absence per full time equivalent staff member. Quarter 4, 2011/12 shows a decrease in the amount of time lost due to sickness absence compared to the same period last year (April – December).
- 3.9 There are a total of 2 performance indicators that relate to air quality and climate change within the list of National Indicators all of which are included in the corporate set.

Customer / Equalities and Diversity Implications

- 3.10 Customer service performance indicators included for 2011/12:
 - Percentage of complaints handled within the agreed time frames.Performance for this indicator can be found in Appendix 1.
- 3.11 Enhanced performance will assist to improve customer satisfaction.
- 3.12 Information contained in the attached appendix will be communicated to both internal and external customers via the intranet/Internet following approval at committee.

4. RISK MANAGEMENT

- 4.1 Assessing the Council's performance forms part of the Council's approach to risk management.

5. APPENDICES

Appendix 1 – Quarter 4, 2011/12 Corporate Performance Report, period ending 31 March 2012.

6. BACKGROUND PAPERS

The details to support the information provided within this report are held by the Policy Team and on the Electronic Data Collection (EDC) system.

AUTHORS OF REPORT

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Bromsgrove District Council Corporate Performance Report
Quarter 4, 2011/12 - Period Ending March 2012

The following pages provide a report for all corporate performance indicators which are contained in the Council Plan, for which data was expected and provided in quarter 4 (January - March) 2011/12 and where there is comparative data available; the data relates to a year to date (April - March) comparison.

	Finance & Corporate Resources (FR)		Leisure, Environmental & Community Services (LEC)		Planning, Regeneration, Regulatory & Housing Svcs (PRRH)		Total	
		%		%		%		%
Total number of corporate performance indicators providing outturn data for quarter 4 where comparative data is available	3		9		4		16	
Total number of indicators showing improvement compared to the same period last year	2	66.7%	7	77.8%	1	25.0%	10	62.5%
Total number of indicators showing a decline compared to the same period last year	1	33.3%	2	22.2%	3	75.0%	6	37.5%
Total number of indicators showing no change compared to the same period last year	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Key Findings for Quarter 4

This report shows that of the 16 indicators reported this quarter, 62.5% have improved when compared to the same period last year. By way of example, the time taken to process Housing Benefit / Council Tax Benefit new claims and change events (days) has continued to improve with the number of days taken falling from 9.7 days to just 7.5 days, and the number of people using BURT (Bromsgrove Urban and Rural Transport) has continued to be well used with the number of users increasing from 2,007 to 2,143. Likewise, the number of people using the Dolphin Centre has shown a good increase in numbers rising by 47,940 when compared to the same period last year. However there are indicators which give rise to some concern; for example, the number of people using the car parks has continued to fall, dropping by 62,828 users over the last 12 month (April 2011-March 2012). There are plans to develop a marketing campaign with a view to increasing these numbers.

The table below shows a key to terms and symbols used throughout this report.

<u>Key to Terms and Symbols</u>	
Improving performance compared to same period last year	☺ +ve
Worsening performance compared to same period last year	☹ -ve
No change in performance compared to same period last year	☺ -ve
No data available for the period	#
Not applicable for this indicator/period	NA
Data is provisional	*
	TBC
	(WVP)
	CSC
	DFG's

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Indicator Description	Current			History - Year End (where available)		Comments
	1 Apr 2010 - 31 March 2011	1 Apr 2011 - 31 March 2012	Direction of Travel (where applicable)	2009/10	2010/11	
Time taken to process Housing Benefit / Council Tax Benefit new claims and change events (days)	9.7	7.5	☺	NA	9.7	Further improvement on processing times as a result of more "1 day decisions" being made. The improvement is as a result of the transformational work; customers present face to face, their claims and changes are being processed there and then and not being passed to the "back office" to process. A new relaxed approach to the evidence requirements has also contributed to quicker processing times.
% of invoices paid by the Council within 30 days of receipt	99.06%	98.34%	☹	98.18%	99.06%	There have been some issues with invoices not being returned within the required time period. The finance team is just commencing their new shared service and further training is going to be offered to staff where required.
Number of working days / shifts lost to the local authority due to sickness absence per FTE staff members (days)	9.85	8.25	☺	TIC	9.85	There has been a decrease in sickness absence in Q4 and when compared to the same period last year; this was expected to have occurred following on from the active sickness management of long term sickness cases. A review of the sickness absence policy is a priority for Human Resources in the coming months. The implementation of shared services has impacted on the comparative data.
% of complaints handled within the agreed time frames	71.51%	76.03%	Contextual	NA	71.51%	There has been a steady increase in the percentage of complaints handled within the time frame over the year and an overall improvement on the same period last year. However, this quarter has seen a fall in recorded complaints and the reason for this cannot be established. Heads of Service and managers are reminded to have mechanisms in place to ensure complaints are properly recorded and further training is available if required. Additionally there will be further training for all managers in respect of complaints handling and escalating issues to the complaints system.

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Indicator Description	Current			History - Year End (where available)		Comments
	1 Apr 2010 - 31 March 2011	1 Apr 2011 - 31 March 2012	Direction of Travel (where applicable)	2009/10	2010/11	
Number of affordable homes delivered	56	161	Contextual	80	56	Good progress in 2011-12 with no unexpected delays affecting performance during quarter 4.
Number of British Crime Survey comparator crimes reported	2,595	2,331	☺	2,808	2,595	Performance in Bromsgrove has been excellent throughout 2011/12. The end of year outturn is 10% lower than that of 2010/11 – a reduction of 264 crimes. There was a slight increase in offending in March 2012, (mainly due to very slight increases in assaults, criminal damage, non-dwelling burglary and theft of motor vehicle offences) but overall performance has been very good.
Number of people using the BURT service	2,007	2,143	☺	NA	2,007	Good progress in 2011-12 with an increase in overall passengers during the year, this was despite vehicle breakdowns. It is anticipated that the figures will increase again in 2012/13 following the hiring of a more reliable vehicle from WCC.
Number of people using the Shopmobility service	2,157	2,480	☺	TBC	2,157	There has been an increase of 323 users during 2012/13 possibly as a result of extending the opening times to include Saturdays and additional word of mouth promotion.
Artrix usage (community use)	69,561	77,755	☺	60,250	69,561	Despite a small drop in the number of people at live events in quarter 4, there has been an increase of 8,194 attendances over the year when compared to the same period in 2010/11.
Visitors to Dolphin Centre	369,521	417,461	☺	415,407	369,521	Good performance showing an improvement on the previous month, comparative quarter last year and at year end.
Household waste collection (kg per head)	88.18	*87.75	☺	NA	88.18	As expected, a seasonal variation in the collection of garden waste reduces the overall amount of household waste collected. A final audited figure from Waste Data Flow is expected within 6 months of the year end.
Residual waste per household (kgs)	539.15	*535.35	☺	581.00	539.15	There has been an decrease of 3.8kg per household in the amount of residual waste collected. This is a provisional outturn. A final audited figure from Waste Data Flow is expected within 6 months of the year end.
% of household waste re-used, recycled or composted	42.54%	*41.3%	☹	37.40%	42.54%	Bring bank tonnages are yet to be confirmed therefore this percentage will increase slightly, resulting in a figure very similar to that achieved in 2010/11. A final audited figure from Waste Data Flow is expected within 6 months of the year end.
Town centre car park usage (avg per month)	1,503,562	1,440,734	☹	TBC	1,503,562	With the price rise and economic climate the reduction in numbers of people using the car park is not unexpected. However work will be undertaken as agreed with Wychavon District Council to develop a marketing campaign. It is expected that the marketing campaign will be ready for consideration in June 2012.

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Bromsgrove District Council Corporate Performance Report
Quarter 4, 2011/12 - Period Ending March 2012

Planning and Regeneration,
 Regulatory and Housing Services

Indicator Description	Current			Direction of Travel (where applicable)	History - Year End (where available)		Comments
	1 Apr 2010 - 31 March 2011	1 Apr 2011 - 31 March 2012	26		2009/10	2010/11	
Number of households living in temporary accommodation (Snapshot)	31	26	☺	NA	31	The number of households in temporary accommodation has remained consistent over the last two quarters and shows a 16% decrease in quarter 4 (Jan-Mar) when compared to the same quarter in 2010/11.	
Processing of major planning applications determined within 13 weeks	68.57%	61.90%	☹	TBC	68.57%	3 applications went over time subject to committee decisions. Performance is down slightly when compared with the same quarter of previous year (57.14% in 2011/12 and 62.50% in 2010/11). The reduction in performance is as a result of a combination of factors including staff involved in transformation and a more relaxed approach to targets with a view to improving customer service in the round. The role of targets in the planning system will be considered as part of the transformation process.	
Processing of minor planning applications determined within 8 weeks	89.69%	79.63%	☹	TBC	89.69%	There has been a significant downturn in performance when compared to the same period last year, however there has been an increase in applications of 11% over the same period of the previous year. The reduction in outturn is due to a combination of factors including staff illness, staff involved in transformation and a more relaxed approach to targets with a view to improving customer service in the round. The role of targets in the planning system will be considered as part of the transformation process.	
Processing of other planning applications determined within 8 weeks	93.61%	82.10%	☹	TBC	93.61%	There has been a significant downturn in performance when compared to the same period last year, however there has been an increase in applications of 25% over same period of the previous year. The reduction in outturn is due to a combination of factors including staff illness, staff involved in transformation and a more relaxed approach to targets with a view to improving customer service in the round. The role of targets in the planning system will be considered as part of the transformation process.	

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BROMSGROVE DISTRICT COUNCIL

Overview & Scrutiny Board

16th July 2012

SICKNESS ABSENCE PERFORMANCE and HEALTH FOR PERIOD ENDING 31st March 2012

Relevant Portfolio Holder	Cllr Mark Bullivant
Relevant Director	Jayne Pickering, Executive Director (Finance and Corporate Resources)
Non-Key Decision	

1 Summary of Proposals

- 1.1 To report to the Overview & Scrutiny Board on Bromsgrove District Council's performance for the last quarter (January – March 2012) and the full year outturn 2011 / 2012 in relation to sickness absence.

2 Recommendations

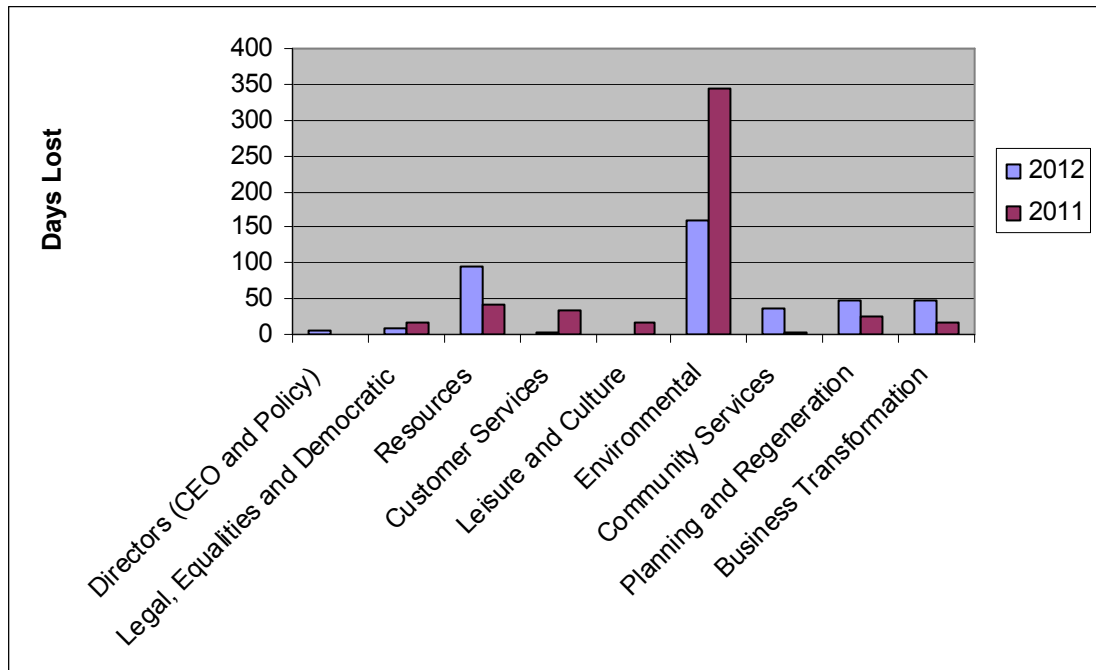
- 2.1 That the data relating to the last quarter / full year end be noted.

3 Key Issues: Analysis of the monthly statistics for the last quarter

- 3.1 Statistics for the Last Quarter (January – March 2012) compared to the same quarter last year

The table and graph below shows performance in the last quarter, compared to the same quarter in the previous year (2010 – 2011). As the staff within Leisure & Cultural Services have transferred to Redditch as part of shared services, these figures are reported in Redditch. Future shared service reporting is referred to in 3.2 below.

	<i>Jan - March 2010/2011</i>	Jan – March 2011/2012	Average days per employee based on FTE for quarter
Directors (CEO and Policy)	0	6.6	0.36
Legal and Democratic	18	9	0.54
Resources	42	95	1.99
Customer Services	34	3.5	0.17
Leisure and Culture	17	0	0.0
Environmental	344	158.4	1.49
Community Services	3	35.2	4.8
Planning and Regeneration	26.5	46.5	1.39
Business Transformation	15.5	48.6	2.29
Total	500	402.8	1.98



This shows a reduction in the total number of days lost for the quarter of almost 100 (20%). This is a positive improvement particularly when considered in light of an increase in the available working days from 16503 to 22439 for the quarter, due to changes to service distribution, and is not therefore a like for like comparison.

The average days lost per person for this quarter is 1.98 days per person.

From April 2012 issues with comparing “like for like” will present inconsistencies within the statistics until the timescale of the introduction of Shared Services across the year has passed, and the services are in the right authority to be compared on a direct basis.

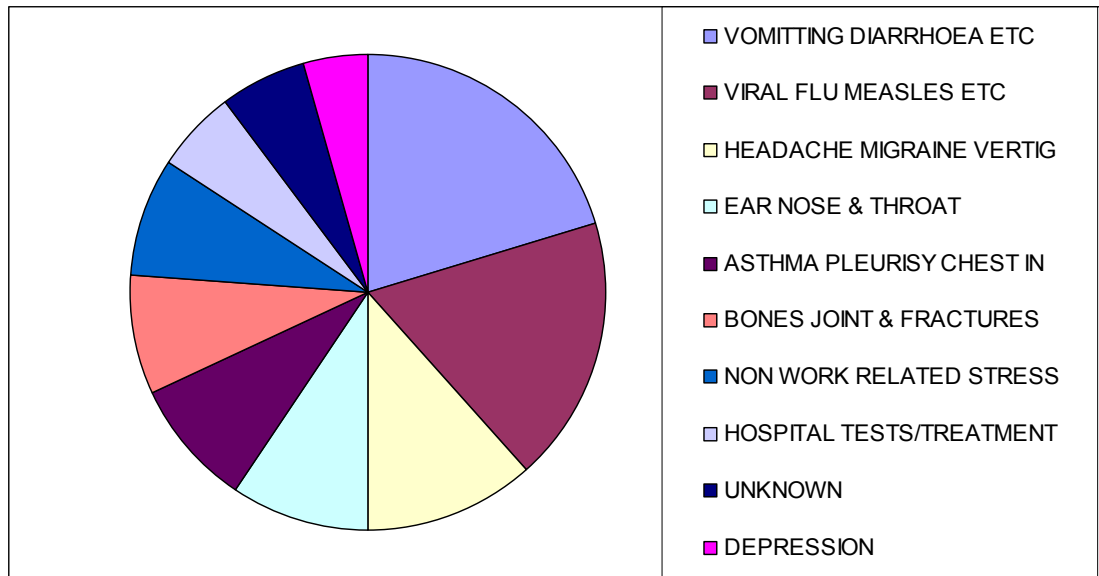
3.2 Implications of Shared Service

Historically data has been collected across service areas and reported accordingly. As part of the Shared Service work statistics for absence will be reported under a “Shared Service” heading where these are across both Councils, and will be reported alongside each Council’s figures. This is to ensure the impact of staff who are absent on one Council’s payroll is measured appropriately within the Shared Service for the other Council.

3.3 Breakdown of absence by sickness type

The graph below shows the top ten causes of absences broken down by sickness type for the last quarter (January to March 2012).

This reflects 138 of 166 days lost for the quarter, which is 83% of the total sickness days.



In this quarter the highest number of absences are attributed to viral infections (flu), ear nose and throat and vomiting and diarrhoea as may be expected during the winter months.

Areas that may be a concern to the organisation from a health and safety / occupational health perspective include 6 instances of work related stress.

For the upcoming year 2012 / 2013 a series of training events has been arranged for managers to help them to understand and deal with mental health issues in the workplace. The aim of this is not primarily to improve sickness absence, but to improve the mental wellbeing of staff in a period of change, with the expectation that there will be a knock on effect both in terms of improved attendance but also in managing “presenteeism” at work from employees who are struggling to cope.

The first of these sessions held in May has been positively received with excellent feedback from those who attended. The HR & OD team are looking to identify further initiatives to support this work.

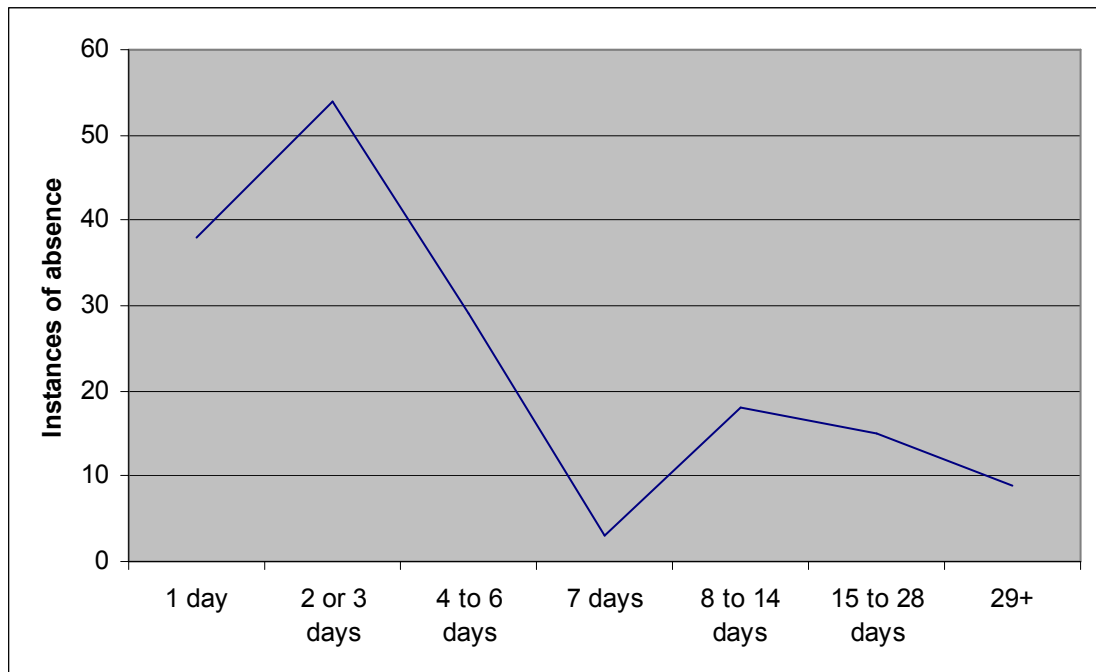
Within the new reporting format it is recommended that the standard Local Government Sickness categories be used, to support consistent collection of information and appropriate action from a health and safety or occupational health perspective when information suggests there may be a problem. These categories are given at appendix 2. The data has not been collected in this format historically so the full year data is not available for 2011 / 2012.

For future reports it is suggested that this information is reported 6 monthly.

3.4 Incidences of absence by duration

An additional piece of information requested for reporting is the number of incidences of absence by duration. This shows there is a significant peak duration of absence time as 2 to 3 days.

Instances of absence	Frequency
1 day	38
2 or 3 days	54
4 to 6 days	29
7 days	3
8 to 14 days	18
15 to 28 days	15
29+	9



Environmental Services have for a period of time been trialling a new approach to absence management, particularly in relation to short-term absence. This has been with full Trade Union involvement and support. Individual absence records are monitored closely with stringent target setting where levels are unacceptable. This has resulted in very positive results as is demonstrated in the data presented at 3.1.

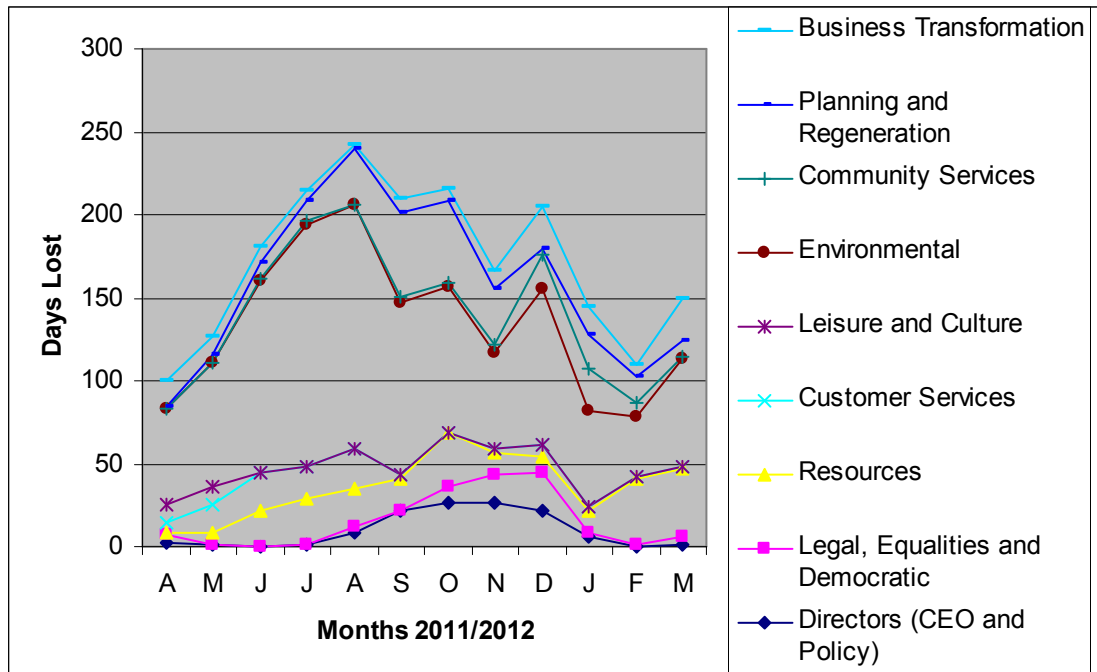
HR Advisors are also working with managers to identify patterns of absence and the causes of sickness in order to address the underlying issues.

4.0 **Statistics for the full year 2011 to 2012**

The full year figure shows an average of 8.25 days lost per employee. This is below the corporate target of 8.75, and is below the most recently available statistics relating to the public sector average of 9.6 days (from the CIPD absence management report 2010).

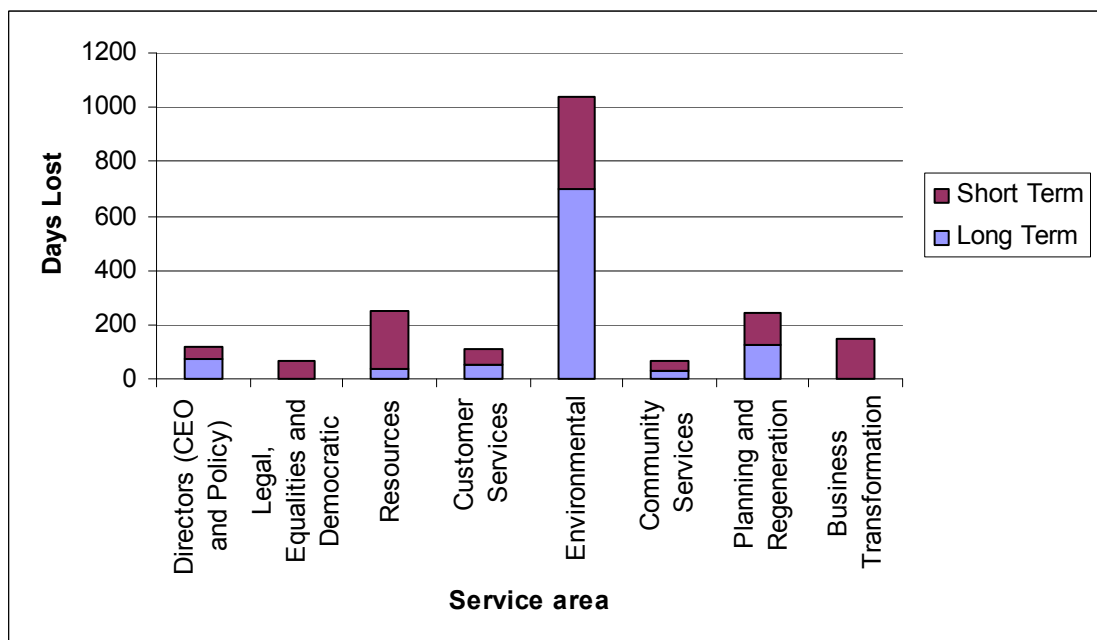
4.1 **Days lost by service for the full year 2011 / 2012**

The background data for this graph is shown at appendix 1.



4.2 The graph above shows peaks across a number of services in June, July and August which follow each other in pattern. There are no identified reasons for these peaks (such as seasonal illnesses as are shown in December). Advice and support may be needed to managers to help in managing sickness where other factors may impact on the amount of time taken off. For example are more sick days taken during school holidays when childcare may be an issue for some staff.

4.3 Long term Absence compared to short term – full year 2011/2012.



Short term absences were only marginally more prevalent across the year as a whole, (1011 days long term compared to 1033 days short term). The distribution of short term to long term days lost however shows two services with no or little long term absence, but a potentially significant number of short term absences compared to the number of employees in the service, i.e. above a benchmark of 1.5% of available days lost. Resources and Business Transformation.

HR Advisors are working closely with managers to identify underlying causes and to provide support and advice in addressing these areas of concern.

Long term absences are slightly higher in Environmental Services, as may be expected from the physical nature of the work and resultant illness types, such as muscular and skeletal problems, within this working environment. There is therefore a higher occurrence of long-term absences due to the roles within this service.

	Long Term absences	Short Term absences	Long term days lost as % of total available days	short term days lost as % of total available days
Directors (CEO and Policy)	71	47	1.89%	1.25%
Legal, Equalities and Democratic	0	65	0.00%	0.76%
Resources	33	217	0.49%	3.21%
Customer Services	55	53	1.53%	1.46%
Environmental	697	345	2.83%	1.40%
Community Services	30	38	0.79%	1.00%
Planning and Regeneration	125	121	1.35%	1.31%
Business Transformation	0	147	0.00%	3.36%
Total for full year	1011	1033		

5 ***Targets for 2012 year (This section is subject to re-wording to reflect the approach of Transformation)***

As part of the process of reviewing sickness reporting, the way in which targets are set has also been reviewed. There is no longer a requirement to report absence in a format specified centrally as part of BVPI reporting, however the benefit of having targets remains, in that Managers and staff have a reference point by which they can measure their performance against a benchmark.

- 5.1 *Historically targets have been set centrally by HR, based on previous years targets, but with some method of distributing the total Council target so that services with particular types of workforce where sickness absence is associated with the type of work being undertaken are recognised (traditionally outdoor, manual work and work involving higher risk environments).*
- 5.2 *For the coming year it has been determined that targets should be set by individual services, in discussion with Human Resources and Senior Management Team. This will ensure ownership of the targets, and specifically ensure they are suited to the workforce they cover.*

6 **Health and Wellbeing**

- 6.1 The format of this report has been passed to the Health and Safety Committee for comment, in order that any work being done within a Health and Safety context can be captured within the report, and to provide additional information

to support and inform the work of the Health and Safety Committee.

7 Financial Implications

None

8 Legal Implications

None

9 Policy Implications

The Sickness Management Policy for Bromsgrove and Redditch are currently part of the work programme for review, and are due to be completed for consultation after the first quarter (July 2012).

10 Council Objectives

Council Objective 2 Improvement

10 APPENDICES

Appendix 1 - Sickness Figures month on month for full year

Appendix 2 - Sickness Reasons Standard format

Appendix 1 – Month on Month Cumulative days lost by Service

Bromsgrove Council	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Directors (CEO and Policy)	3	1	0	1.5	9	22	27	26	22	6	0	0.62	118.12
Legal, Equalities and Democratic	4.00	0.00	0.00	0.00	3.50	0.00	9.00	17.00	22.00	3.00	0.93	5.06	64.49
Resources	1	7.5	22	27	22	18.5	33	14	10	13	40.6	41.36	249.96
Customer Services	6	17	23	20	25	3	0	2	8	2	0.93	0.62	107.55
Leisure and Culture	11	11											
Environmental	58.00	74.00	115.00	146.00	146.00	104.00	88.00	58.00	94.00	58.00	36.00	65.00	1042.00
Community Services	0	0	1	1.5	0	3	2	5	20	25	8.68	1.56	67.74
Planning and Regeneration	1.00	5.00	10.00	12.00	34.50	51.00	49.00	33.00	4.00	21.00	15.11	10.36	245.97
Business Transformation	16	11	10	7	2	8	8	11	25	16	7.16	25.42	146.58

From the Local Government Employers Organisation Guide to Absence Management

A-Z of Causes of Sickness Absence

Instructions

These guidance notes explain how to record the different causes of sickness absence for monitoring purposes

It is recommended that all absences in an authority should be self-categorised or categorised by either HR personnel, or line managers, but not a mixture of these groups, so as to reduce inconsistencies. It is recognised that different authorities will have different procedures for recording absence and so different groups will be responsible for categorising the causes of sickness absence. Where possible, however, it is recommended that self-categorisation be permitted as this will encourage employees to provide meaningful information.

In selecting which types of absence to include, authorities should:

Exclude absences for dental and medical appointments, maternity leave and disability leave
Absence for fertility treatment and cosmetic surgery should only be included when the absence was taken as sickness absence and not some other form of leave (e.g. annual leave, unpaid leave etc.)

All instances of sickness absence to be included as outlined above, should be allocated to one of the following groups:

Back & neck problems

Other musculo-skeletal problems

Stress, depression, anxiety, neurasthenia, mental health & fatigue

Infections; to include colds and flu.

Neurological; to include headaches and migraine.

Genito-urinary; to include menstrual problems.

Pregnancy related

Stomach, liver, kidney & digestion; to include gastroenteritis.

Heart, blood pressure & circulation

Chest & respiratory; to include chest infections.

Eye, ear, nose & mouth/dental; to include sinusitis

Other

- For all absences allocate where possible to the category containing the part of the body affected. For example, absence due to back pain should be allocated to the category "Back & neck problems".
- For infections, allocate where possible to the part of the body that is infected, otherwise allocate to "Infections". For example, an ear infection should be allocated to the category "Eye, Ear, Nose and Mouth/Dental" rather than to the category "Infection", whereas shingles should be allocated to "Infections" as it is not specific to any one part of the body.
- Absences caused by more than one illness should be allocated to the illness that predominates
- If absences are not being self-categorised and the employee has provided a number of causes, use the first item listed.
- Any musculo-skeletal problem that effects the back or neck must be assigned to the "Back & Neck category". If it effects any other part of the body it should be assigned to the "Other musculo-skeletal problems" category. This is why there is a choice of the two categories by some conditions on the A-Z list.

There are 36 following pages which provide an alphabetical list of possible causes of absence and the group to which they should be allocated. There then follows an alphabetical list of possible causes of absence for each of the different absence categories used in this classification.

If there is a situation where a medical note is **illegible** it should be noted that the patient has a right to ring the medical centre or doctor to clarify what is says.

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FORWARD PLAN OF KEY DECISIONS

1 JULY TO 31 OCTOBER 2012

This Forward Plan lists the **Key Decisions** which it is proposed to take during the period 1 July to 31 October 2012. **Key Decisions** are executive decisions which must be taken or delegated by the Council's Cabinet and relate to matters which fall within the Council's agreed Budget and Policy Framework.

Key Decisions are those executive decisions which are likely to:

- (i) result in the Council incurring expenditure, foregoing income or the making of savings in excess of £50,000 or which are otherwise significant having regard to the Council's budget for the service or function to which the decision relates; or
- (ii) be significant in terms of its effect on communities living or working in an area comprising two or more wards in the district;

Key Decisions will include:

1. A decision which would result in any expenditure or saving by way of a reduction in expenditure of £50,000 provided the expenditure or saving is specifically approved in the Medium Term Financial Plan.
2. A virement of any amount exceeding £50,000 provided it is within any virement limits approved by the Council;
3. Any proposal to dispose of any Council asset with a value of £50,000 or more or which is otherwise considered significant by the Corporate Property Officer;
4. Any proposal to cease to provide a Council service (other than a temporary cessation of service of not more than 6 months).
5. Any proposal which would discriminate for or against any minority group.

Further details of each Key Decision are appended to the Forward Plan. To assist with internal forward planning, this Plan also lists other non-key decisions which the Cabinet is expected to make during the specified four month period. It also includes decisions to be taken over a longer period where these are known. The Forward Plan is updated and published on the Council's website on a monthly basis.

CABINET MEMBERSHIP

Councillor R. Hollingworth	Leader of the Council and Portfolio Holder for Finance, Partnerships and Economic Development
Councillor Mrs. M. A. Sherrey	Deputy Leader of the Council and Portfolio Holder for Health and Well-being
Councillor M. J. A. Webb	Portfolio Holder for Leisure, Cultural Services, Environmental Services and Emergency Planning
Councillor Dr. D. W. P. Booth	Portfolio Holder for Strategic Housing, Business Transformation (including ICT) with special responsibility for the Town Centre Regeneration and Special Projects
Councillor C. B. Taylor	Portfolio Holder for Planning, Core Strategy and Regulatory Services
Councillor M. A. Bullivant	Portfolio Holder for Policy, Performance, Communications, Customer Services, Legal, Equalities, Democratic Services and Human Resources

CONSULTATION AND REPRESENTATIONS

For **Key Decisions** the summary document appended to the Forward Plan sets out details of any proposed consultation process. Any person/organisation not listed who would like to be consulted or who wishes to make representations on the proposed decision are encouraged to get in touch with the relevant report author as soon as possible before the proposed date of the decision. Contact details are provided.

Alternatively you may write to The Head of Legal, Equalities and Democratic Services, The Council House, Burcot Lane, Bromsgrove B60 1AA or email: committee@bromsgrove.gov.uk

Item No.	Decision Taker & Expected Date of Decision	Original Expected Date of Decision	Proposed Decision	Type of Decision (Key or Non-Key)	Lead Councillor/ Portfolio Holder	Comments
1	Cabinet 4 July 2012		Income Management and Payment Card Industry Compliance (request for capital resources)	Non-Key*	Councillor R. Hollingworth	*Cabinet will make recommendations to the full Council on 18 July 2012
2	Cabinet 4 July 2012		Corporate Performance Monitoring Quarter 4 2011/12	Non-Key	Councillor M. A. Bullivant	
3	Cabinet 4 July 2012		Financial Monitoring Quarter 4 2011/12	Non-Key	Councillor R. Hollingworth	
4	Cabinet 4 July 2012		Refurbishment Scheme - Bromsgrove High Street	Non-Key	Councillor Dr. D. W. P. Booth	
5	Cabinet 4 July 2012	Cabinet 6 June 2012	Review of RIPA Policy (annual operational review)	Non-Key	Councillor M. A. Bullivant	Deferred by officers for further consideration
6	Cabinet 4 July 2012		Town Centre Project - Development Site (Birmingham Road) Update	Non-Key*	Councillor Dr. D. W. P. Booth	*If any decisions require Council approval these will be referred to the next possible meeting of the full Council

7	Cabinet 5 September 2012	Cabinet 4 July 2012	Parking Review (including Blue Badge Holders)	Non-Key*	Councillor M. J. A. Webb	*If any decisions require Council approval these will be referred to the next possible meeting of the full Council
8	Cabinet 5 September	Cabinet 7 March 2012	Countywide Homelessness Strategy	Key	Councillor Dr. D. W. P. Booth	Deferred by officers for further consideration
9	Cabinet 5 September 2012		Budget Preparation Guidelines 2013/14 and Initial Estimates / Budget Projections for 2014/15 to 2015/16	Non-Key*	Councillor R. Hollingworth	*Cabinet will make any recommendations to the full Council on 26 September 2012
10	Cabinet 5 September 2012	Cabinet 6 June 2012	Tenancy Strategy	Key	Councillor Dr. D. W. P. Booth	Deferred by officers for further consultation
11 Page 36	Cabinet 5 September 2012	Cabinet 6 June 2012	Fly Posting Policy	Non-Key	Councillor Mrs. M. A. Sherrey	Delayed by officers for further consideration
12	Cabinet 5 September	Cabinet 6 June 2012	Land Disposal Policy	Non-Key	Councillor R. Hollingworth	
13	Cabinet 5 September 2012		QEII – Dedication of Sites in Bromsgrove	Non-Key	Councillor M. J. A. Webb	
14	Cabinet 26 September 2012		Statement of Accounts 2011/12	Non-Key*	Councillor R. Hollingworth	*Cabinet will make recommendations to the full Council on 26 September 2012

15	Cabinet 3 October 2012		Core Strategy / Local Plan – Approval to Publish	Key	Councillor C. B. Taylor	*If any decisions require Council approval these will be referred to the next possible meeting of the full Council
16	Cabinet 3 October 2012		Belbroughton Conservation Area Appraisal	Non-Key	Councillor C. B. Taylor	
17	Cabinet 3 October 2012		Landscape Character Appraisal	Non-Key	Councillor C. B. Taylor	
15	Cabinet 7 November 2012		LSP Annual Report 2011/12	Non-Key	Councillor R. Hollingworth	

Note: There is no Cabinet meeting scheduled for August 2012

KEY DECISION

Proposed to be made by
the Cabinet on
5th September

<p>LEAD MEMBER/ PORTFOLIO HOLDER Councillor Dr. D. W. P. Booth</p>	<p>ITEM COUNTY HOMELESSNESS STRATEGY</p>	<p>WARDS AFFECTED All</p>
<p>DOCUMENTS TO BE CONSIDERED BY THE DECISION TAKER The County Homelessness Strategy REPORT AUTHOR Andy Coel Strategic Housing Manager</p>	<p>SUMMARY The report introduces a revised and updated County Homelessness Strategy for approval. The Strategy sits under the County Homelessness Strategy and sets out the County’s goals and aspirations for preventing homelessness or meeting the needs of those who become homeless. The Strategy will be in two parts – the Countywide element and then a series of local Action Plans for each partner local authority.</p>	<p>REASONS FOR BEING ON THE FORWARD PLAN The Strategy is relevant for anyone who is facing homelessness or actually homeless across this District.</p>

CONSULTATION DETAILS	Method of Consultation	Consultation period or dates
<p>Stakeholders Service users, partners and other stakeholders</p>	<p>Paper and telephone survey of those who have accessed housing options services across the County. Interviews of homeless households. Countywide Home Truths event for stakeholders.</p> <p>Draft report circulated to partners and stakeholders</p>	<p>July – Sept 2011</p> <p>Oct – Nov 2011</p>

DECISION TO BE MADE IN PARTNERSHIP WITH

Other local authorities across the County.

Item No. 10

KEY DECISION

Proposed to be made by
the Cabinet on **5th September 2012**

LEAD MEMBER/ PORTFOLIO HOLDER Councillor Dr. D. W. P. Booth	ITEM	WARDS AFFECTED
<p>DOCUMENTS TO BE CONSIDERED BY THE DECISION TAKER 'Report of the Head of Community Services'</p> <p>REPORT AUTHOR Head of Strategic Housing</p>	<p>SUMMARY</p> <p>The Localism Act 2011 introduces a number of housing reforms including the ability for local authorities and social landlords to grant fixed term tenancies with limited security of tenure and changes to the allocation of housing and the law relating to homelessness.</p> <p>The Localism Act places a duty on the Local Authority to prepare and publish a Tenancy Strategy by November 2012.</p> <p>A Tenancy Strategy has been developed by working in close consultation with our Registered Providers, stakeholders and the Housing Management Department of Redditch Borough Council.</p> <p>The strategy will come forward, following the close of the consultation period, for approval by Members.</p> <p>The report will update members on new guidance for the allocation of accommodation that it is anticipated will be issued by mid summer. The guidance is expected to</p>	<p>ALL</p> <p>REASONS FOR BEING ON THE FORWARD PLAN</p> <p>Affects two or more wards within the District</p>

	addresses issues including the ability to discharge the homelessness duty through the use of private sector rented housing, greater priority for members of the armed forces and additional ability for LAs to formulate local allocation and lettings policy.	
<p>CONSULTATION DETAILS</p> <p>Stakeholders District Councils County Council Supporting People RSLs Homes and Communities Agency GOWM OT Service PCT</p>	<p>Method of Consultation</p> <p>A multi agency consultation event was hosted by Bromsgrove on the 18th November 2011 for authorities across Worcestershire that enabled all parties to contribute through a workshop approach.</p> <p>A draft Tenancy Strategy is being circulated to stakeholders for comments to be returned by the 27th April 2012.</p> <p>In addition, Localism introduces an opportunity for local authorities to discharge the homelessness duty into the private rented sector, subject to suitability guidelines and the granting of a minimum 12 month tenancy. A Homeless Policy dealing with homelessness generally and discharging the Homeless Duty into the Private Rented Sector has been developed collaboratively with bdht.</p> <p>Localism has also introduced a requirement to ensure that members of the Armed Forces get additional priority for social housing, where they have a reasonable preference and urgent housing need. Where they have been discharged from the forces within the last 5 years they should not be discounted from the local authorities waiting list due to residency criteria.</p>	<p>Consultation period or dates</p> <p>Last week of January - 29th February 2012</p>

DECISION TO BE MADE IN PARTNERSHIP WITH

All six districts are adopting individual Tenancy Strategies. However an approach is being undertaken whereby there is a Countywide framework developed to achieve a degree of uniformity across the County but still allowing for individual authority strategies to reflect the more localised detail necessary. The Bromsgrove strategy is being developed in collaboration with Redditch BC to achieve maximum uniformity. The Homeless Policy has been developed in partnership with bdht who deliver the homeless service on behalf of the Council. The Allocations policy change is supported by the sub regional Home Choice Plus Steering Group

Item No. 15

KEY DECISION

Proposed to be made by the Cabinet
on **3rd October**

<p>LEAD MEMBER / PORTFOLIO HOLDER</p> <p>Councillor Kit Taylor</p>	<p>ITEM</p> <p>Landscape Character Assessment Supplementary Guidance</p>	<p>WARDS AFFECTED</p> <p>All</p>
<p>DOCUMENTS TO BE CONSIDERED BY THE DECISION TAKER</p> <p>Landscape Character Assessment Supplementary Guidance</p> <p>REPORT AUTHOR -</p> <p>Sumi Lai</p>	<p>SUMMARY</p> <p>The Landscape Character Assessment Supplementary Guidance (LCA SG) is a non-statutory document that will provide guidance on the application of landscape character principles to development.</p>	<p>REASONS FOR BEING ON THE FORWARD PLAN</p> <p>It is intended that the final document will carry weight as a 'material consideration' and so can form part of the reasoning for planning decisions.</p>
<p>CONSULTATION DETAILS</p> <p>The draft Guidance and its Sustainability Appraisals had been circulated to Worcestershire County Council (WCC) Cabinet members and were also available for inspection in the WCC Member Support Unit, at County Hall Reception, and WCC's website.</p>	<p>Method of Consultation</p> <p>Website Deposit of documents at the Council House, Dolphin Centre and all libraries in the District.</p>	<p>Consultation Period or Dates</p> <p>13 June 2011 to 22 July 2011</p>

<p>In Bromsgrove, the consultation was advertised on the Council's website and copies were available for inspection at the Council House, Dolphin Centre and all the libraries in the District.</p>		
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<p>DECISIONS TO BE MADE IN PARTNERSHIP WITH N/A</p>
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OVERVIEW & SCRUTINY BOARD

WORK PROGRAMME

2012-13

This Work Programme consists of two sections: Items for future meetings (including updates) and Task Group Reviews.

RECOMMENDATION:

(a) To consider and agree the work programme and update it accordingly.

ITEMS FOR FUTURE MEETINGS

Date of Meeting	Subject	Other Information
16th July 2012	Countywide Homelessness Strategy – pre-scrutiny Report	Picked up from Forward Plan at meeting 26th March 2012.
	Sickness Absence Performance and Health for Period ended 31st March 2012	
	Quarter 4 Performance Monitoring Report	
	Forward Plan of Key Decisions	
	Overview and Scrutiny Topic Proposals for consideration	
	Overview & Scrutiny Work Programme 2012-13	
	WCC Health Overview & Scrutiny Committee	
10th September 2012	Quarter 1 Finance Monitoring Report	
	Scrutiny of Crime & Disorder Partnerships – Introduction to the Work of the North Worcestershire Community Safety Partnership	Deferred from July meeting – pending first meeting of the new partnership.
	Council Annual Report	
	Disposal of Stock and any Claw back Clause - BDHT	Requested following meeting of 23rd April 2012
	Homelessness Grants 2012/13 – Update Report	Update requested following meeting 27th February 2012
	Progress report on the impact of the Government Welfare Reforms	Update requested following meeting 23rd April 2012
	Sickness Absence Performance and Health for Period ended 30th June 2012	

Date of Meeting	Subject	Other Information
	Overview and Scrutiny Board Quarterly Recommendation Tracker	
	Forward Plan	
	Overview & Scrutiny Work Programme 2012-13	
	WCC Health Overview & Scrutiny Committee	
22nd October 2012	Quarter 1 Performance Monitoring Report	
	Quarter 1 Customer Services Updates Report	
	Quarterly Summary of Environmental Enforcement Action Taken	
	Forward Plan	
	Overview & Scrutiny Work Programme 2012-13	
	WCC Health Overview & Scrutiny Committee	
19th November 2012	Quarter 2 Finance Monitoring Report	
	Sickness Absence Performance and Health for Period ended 30th September 2012	
	Forward Plan	
	Overview & Scrutiny Work Programme 2012-13	
	WCC Health Overview & Scrutiny Committee	
4th December 2012 (Tuesday 5.00 p.m.) <i>TBC</i>	Budget Scrutiny (Informal meeting)	
17th December 2012	Quarter 2 Customer Service Updates Report	
	Quarter 2 Performance Monitoring Report	
	Overview and Scrutiny Board Quarterly Recommendation Tracker	
	Forward Plan	
	Overview & Scrutiny Work Programme 2012-13	
	WCC Health Overview & Scrutiny Committee	
8th January 2013 (Tuesday 5.00 p.m.) <i>TBC</i>	Budget Scrutiny	

Date of Meeting	Subject	Other Information
21st January 2013	Quarterly Summary of Environmental Enforcement Action Taken	
	Forward Plan	
	Overview & Scrutiny Work Programme 2012-13	
	WCC Health Overview & Scrutiny Committee	
25th February 2013	Quarter 3 Finance Monitoring Report	
	Sickness Absence Performance and Health for Period ended 31st December 2012	
	Forward Plan	
	Overview & Scrutiny Work Programme 2012-13	
	WCC Health Overview & Scrutiny Committee	
26th March 2013 (Tuesday)	Council Plan	
	Quarter 3 Customer Services Updates Report	
	Quarter 3 Performance Monitoring Report	
	Overview and Scrutiny Board Quarterly Recommendation Tracker	
	Forward Plan	
	Overview & Scrutiny Work Programme 2012-13	
	WCC Health Overview & Scrutiny Committee	
22nd April 2013	Planning Policy Task Group 12 Month Review	
	Quarterly Summary of Environmental Enforcement Action Taken	
	Forward Plan	
	WCC Health Overview & Scrutiny Committee	

Budget Meeting Dates (Provisional)

4th December 2012 – 5.00 p.m. (Informal and all Councillors invited to attend)
8th January 2013 – 5.00 p.m.

Scrutiny of Crime & Disorder Partnership Meeting Dates

TBC

Reports not allocated

Annual Review of Call In
Write Off of Debts – Quarterly Report
Countywide Sustainable Community Strategy – this is a ten year strategy and not due to be reviewed until 2014

OVERVIEW & SCRUTINY TASK GROUP/INQUIRY REVIEWS 2012-13

Task Group	Date of Review
Recreation Road South Car Park Task Group	September 2012
Reduction In Bus Services Task Group	October 2012
Planning Policy Task Group	September 2013



Health Overview and Scrutiny Committee Tuesday, 19 June 2012 (2.00pm), County Hall, Worcester

Membership

Worcestershire County Council Mr A C Roberts (Chairman), Mr M H Broomfield, Mrs M Bunker, Mr B F Clayton, Mr A P Miller, Mrs P J M Morgan, Mr J W Parish, Mr T Spencer.

Bromsgrove District Council Dr B T Cooper
Malvern Hills District Council Mrs J Marriott
Redditch Borough Council Mrs P Witherspoon
Worcester City Council Mr R Berry
Wychavon District Council Mr G O'Donnell
Wyre Forest District Council Mrs F M Oborski

Agenda

Item No	Subject	Page Nos
1	Apologies	-
2	Declarations of Interest and of any Party Whip	-
3	Public Participation <i>Members of the public wishing to take part should notify the Director of Resources in writing or by e-mail indicating the nature and content of their proposed participation no later than 9.00am on the working day before the meeting (in this case 18 June 2012). Enquiries can be made through the telephone number/e-mail address below.</i>	-
4	Confirmation of Minutes – 22 May 2012	Previously circulated
5	Constitutional Matters	1
6	Update on the Health and Well-being Board and Consultation on the Joint Health and Well-being Strategy Supporting Information:	2

Agenda produced and published by the Director of Resources, County Hall, Spetchley Road, Worcester WR5 2NP

To obtain further information or copies of this agenda, please contact Sandra Connolly:
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 or minicom: Worcester (01905) 766399 email: sconnolly@worcestershire.gov.uk

The above reports and supporting information can be accessed via the Council's website at
<http://www.worcestershire.gov.uk/cms/democratic-services/minutes-and-agenda.aspx>

Date of Issue: 8 June 2012

	<ul style="list-style-type: none"> • Appendix 1 – Health and Well-being Board terms of reference • Appendix 2 – Health and Well-being Board's work programme • Appendix 3 – Draft Joint Health and Well-being Strategy 2012-15 	
7	Worcestershire Health and Care NHS Trust's Draft Integrated Business Plan Supporting Information: <ul style="list-style-type: none"> • Appendix 1 – Summary Integrated Business Plan Draft 2 	31
8	Update From West Midlands Ambulance Service NHS Trust on Make Ready, Performance and Worcestershire's Joint Services Review	48
9	Health Overview and Scrutiny Committee Round-up	51

Health Overview and Scrutiny Committee
22 May 2012, County Hall, Worcester – 2.00pm**Minutes****Present:**

Worcestershire County Council:
Mr A C Roberts (Chairman), Mrs M Bunker, Mr A P Miller,
Mrs P J M Morgan, Mr J W Parish, Mr T Spencer.

Bromsgrove District Council: Dr B Cooper
Redditch Borough Council: Mrs P Witherspoon
Worcester City Council: Mr R Berry
Wyre Forest District Council: Mrs F M Oborski

Officer Support:
Siân Clark – Democratic Governance Manager
Sandra Connolly – Overview and Scrutiny Officer

Available papers:

- A. The Agenda papers and appendices referred to therein (previously circulated);
- B. Presentation on Worcestershire NHS Joint Services Review, Update to the Health Overview and Scrutiny Committee (circulated at the meeting);
- C. Presentation on Worcestershire Acute Hospitals NHS Trust's Finances (circulated at the meeting);
- D. Quality Accounts, Trips and Falls, A View From Public Health (circulated at the meeting);
- E. The minutes of the meeting held on 17 April 2012 (previously circulated).

A copy of documents A-D will be attached to the signed Minutes.

**Chairman's
Announcements**

The Chairman welcomed guests and members of the public in attendance and Pat Witherspoon who was the new representative on the Health Overview and Scrutiny Committee (HOSC) of Redditch Borough Council. The Chairman also congratulated Roger Berry on his recent appointment as Mayor of Worcester City.

**557. (Agenda item 1)
Apologies**

Apologies were received from Maurice Broomfield, Jan Marriott and Gerry O'Donnell.

**558. (Agenda item 2)
Declarations of**

Andy Roberts declared a personal interest in relation to agenda item 6 as his daughter was due to start a job within the stroke service in Bromsgrove.

**Interest and of
any Party Whip**

Terry Spencer declared a personal interest in relation to agenda item 5 that Dr Anthony Kelly, one of the meeting's attendees was his family's GP.

Roger Berry declared a personal interest in relation to agenda item 5 as his daughter-in-law was employed by Worcestershire Acute Hospitals NHS Trust.

Fran Oborski declared a personal interest in relation to agenda item 5 as a member of the Joint Services Review Stakeholder Reference Board.

**559. (Agenda item 3)
Public
Participation**

Mr Brendan Young thanked the HOSC for allowing him to address them regarding acute stroke services in Worcestershire. Since his last attendance at the HOSC in January 2012, Mr Young had participated in the stroke service options review as one of 5 patient representatives. Mr Young considered that the review had been robust and comprehensive and all participants had had the opportunity to voice their preferences regarding the future of acute stroke services. The outcome of the review was unambiguous and would provide a safe, high quality, 24/7 service which had the potential to save up to 44 deaths a year and reduce stroke related disability. Mr Young urged the HOSC to accept the recommendations of the review, highlighting that time was of the essence for stroke victims and a commitment to a timescale for implementation was needed.

**560. (Agenda item 4)
Confirmation of
Minutes**

The Minutes of the meeting held on 17 April 2012 were confirmed as a correct record and signed by the Chairman subject to the amendment on page 12 that Alan McMichael, Consultant in Dental Public Health was from NHS Worcestershire, not Worcestershire Health and Care NHS Trust.

**561. (Agenda item 5)
Joint Services
Review – The
Future
Configuration of
Acute Services
in
Worcestershire –
Emerging
Options,
Evaluation
Criteria and
Financial Issues**

Attending for this item were Penny Venables, Chief Executive, Worcestershire Acute Hospitals NHS Trust, Eamonn Kelly, Chief Executive, West Mercia Cluster, Christine Fearn, Director of Strategic Development, Worcestershire Acute Hospitals NHS Trust and Project Director for the Joint Services Review (JSR), Dr Bryan Smith, Chairman, JSR Project Steering Group, Dr Anthony Kelly, Chairman, Worcestershire Clinical Senate and Dr Richard Harling, Joint Director of Public Health. Also attending from Worcestershire Acute Hospitals NHS Trust to discuss the Trust's finances were Harry Turner, Chairman and Chris Tidman, Director of Finance.

Members of the Health Overview and Scrutiny Committee received a presentation outlining the case for change and

the joint services review, developing the outline clinical models and short list of options and next steps.

Members were advised that it was not surprising that a review needed to be undertaken in Worcestershire as there were national challenges facing all acute trusts such as demographic pressures, increasingly specific guidance from Royal Colleges, scrutiny of quality, increasing financial pressures and a national quality drive to achieve £20 billion savings. Locally there were significant demographic pressures and a £50 million funding gap was predicted in the County by 2014/15 if there was no change. Worcestershire Acute Hospitals NHS Trust needed to achieve foundation trust status by 2014 and so needed an affordable configuration by then. It was also noted that the Clinical Commissioning Groups (CCGs) would hold the budgets by 2013/14.

Worcestershire's elderly population was growing at over 3% more than the national average every year. Additionally, year-on-year demand for urgent and emergency care amongst the over 65 population was rising as a proportion of the Trust's attendances. In terms of workforce, the Trust would need to comply with emerging evidence and guidance for 24/7 acute care. The review needed to plan services designed to tackle this gap. A key element of the pressures facing the Trust was the need to take into account recommendations from key Colleges to enable better 24/7 services. The review needed to take account of such recommendations.

From a financial perspective, locally a £40-£50 million funding gap was predicted which needed to be closed through productivity measures, reducing unwarranted variation and lowering the cost base through the JSR and reconfiguration efficiencies.

The vision for the JSR was to ensure high quality, safe and sustainable services, producing a business case setting out a programme of strategic change for the County's acute services. Since the initial timetable of the review was drafted there had been a 1 month delay to allow more time for clinical discussion development and to bring in experts from outside to support the process. Public engagement had been undertaken throughout and would continue on an ongoing basis up to and including public consultation on final options.

It was possible to demonstrate how the Acute Trust had achieved 'easy' efficiency gains, changed operating models and was sharing and integrating services and it was acknowledged that reconfiguration across sites would be important in delivering ongoing sustainability. Scale was also a critical factor as expert guidance suggested that

quality of care was often improved by consolidating and increasing the scale of services. Reconfigurations were happening in many parts of the country and it was anticipated that they would also become even more widespread than at present.

Members were advised how the JSR had gone about reviewing clinical activity to design models of care and options for future delivery. Emergency and A&E standards which draw on Royal College guidance were shared with Members, covering access to senior and specialist skills, access to multi-professional teams and processes. The JSR had not wanted to overload the HOSC, but this provided an example of the sort of evidence being used in the JSR.

An important issue was the inter-dependencies between services which would drive clinical models of care. It had been necessary to work through the alignment of services to ensure 24/7 access to the right standards and the right people. Inter-dependencies had been driving all of the clinical debate.

Nationally, there was a range of delivery models. These models ranged from local hospitals, to 'warm sites' where A&E was provided but not with a full range of adjacencies, to 24/7 major acute hospitals and elective centres, also known as 'cold sites', where patients were generally 'well'. The JSR had looked at the different types of hospitals and how services were designed nationally.

The review had been clinically-led, with approximately 120 clinicians involved in the 4 Clinical Working Groups (CWGs). The CWGs reported into a Clinical Reference Group which comprised 30 clinicians and synthesised the views of the CWGs to feed into the Clinical Senate which made recommendations to the JSR Steering Group.

Each CWG had had 4, 3 hour sessions, each being co-chaired by an acute and a community service representative. The first meetings had considered the case for change, the second had considered aspirations and evidence, the third had looked at pathway configuration options and the fourth had been to agree emerging clinical models. Co-chairs had met Focus Groups to explain how the CWGs were moving through the process and sought their input.

Themes emerging from the CWGs were outlined. In Emergency Care a variety of options were being considered having reviewed how services were delivered now and options for moving services forward. The Elderly Care CWG discussions had been themed around

admissions prevention and reducing length of stay. Planned Care CWG had looked at co-dependent services and how services could be delivered in the acute setting. The Women and Children CWG looked at staffing requirements and their implications for reconfiguration or redesign of services.

The CWGs reported their outcomes to the Clinical Reference Group which included clinicians from the Acute Trust and from the CCGs. Taking the outcomes from the CWGs, the Reference Group would be modelling how services could be redesigned. In building the clinical models, the Reference Group looked at the current 3 site model. The Group then mapped services, recognising that where an A&E service operated, it needed an enormous panoply of services to back-up A&E. Modelling was a long and ongoing process. Outcomes from the mapping process would be assessed for their clinical feasibility and viability.

It was noted that whilst the status quo model but with gaps in rotas addressed would have the benefit of resolving staffing issues and meeting professional guidance, a number of challenges would still remain. These included concerns about safety and quality, that even with additional funding and goodwill, rotas may still possibly not be filled and care may not be delivered to best practice quality standards. There had been consensus that major concerns would remain about clinical viability given concerns about the ability to recruit and meet training standards.

It was highlighted that the review was clinically-led and focussed on what was clinically feasible rather than being muddled with the financial picture. It was not being suggested that services were not safe today, but if the Trust was to go forward as it currently operated, it would not be able to achieve the necessary recruitment and provide the required quality of care.

In addition to the ongoing work looking at clinical models and how services could be organised, work was also being done on how they could be delivered once options were agreed. Additionally, a working group of 20-30 people, including clinicians and patient representatives, had been working on evaluation criteria. Five categories of non-financial criteria had been identified including:

- clinical quality to ensure the best outcomes
- access, including travel, car parking, opportunities for co-location of services with partners
- training, teaching and HR needs
- resources and the best possible use of people and buildings

- deliverability, including speed of implementation.

The proposed weighting of these criteria was shared, with clinical quality being at the forefront. As these were shared with the public there would be the opportunity to comment on the weighting and suggest how they should be adjusted.

There were 2 important factors when looking at the financial aspect. The overall affordability of options needed to be considered, including looking at the options' contribution to closing the funding gap, capital spending needs and enabling costs, such as staffing exit costs. Value for money also needed to be considered to ensure the best value for the public purse and that options made sense for the taxpayer, for example, not transferring costs to other parties. Options would be looked at over their medium term affordability. Some options may be unaffordable.

In looking at the financial modelling, a number of assumptions had been used. The Acute Trust was unable to wait for changes and had to drive efficiencies and to address the forecasted 2014/15 £17 million recurrent deficit, this assumed the delivery of £30 million of efficiencies, approximately 10% of the Trust's income. Whilst this was a big challenge, it was no different to many other trusts. The base line assumption was that the status quo was not tenable.

Modelling assumptions, such as patient flow, were quite complex. A lot of time had been spent with external consultants building models to test the sensitivities and the impact of changes on patient flow, both inside and outside Worcestershire. It was highlighted that as more services moved into a single site and patient flows followed, there was not necessarily a financial increase for the receiving site as there was an increasing cost to the organisation receiving the work and real costs were released when work was transferred out. Such issues were being worked through and were highly sensitive. Members were advised that the review team was not attending the HOSC with analysis of travel times, etc. but important information on scale was really complex and was a work in progress. Members were advised that they should have confidence that work was being done to a high standard to show review details both diagrammatically and in numbers.

In terms of next steps, the JSR Steering Group would consider evaluation criteria and a communications plan for the phase 4 wider review of the decision criteria and clinical models. Clinically feasible models would be finalised at the end of May with input from external experts. Public engagement on the long-list of clinical models and

weighted decision criteria would start in June. In early July the decision criteria would be applied to the long-list of options to create a short-list for detailed modelling to understand the options better. As the clinical work was resolved, in July-August external formal review would be undertaken on the clinical feasibility of those options.

During the ensuing discussion, the following main points were raised:

- Members asked about the membership of the Clinical Working Groups, particularly for Elderly Care and whether it included representatives of the Health and Care Trust and County Council given the potential for demand to be pushed onto those organisations, highlighting that the Council was also stretched. Members were advised that all of the CWGs included representatives from the Acute Trust, Health and Care Trust, primary care and social services;
- the JSR team was congratulated on the amount of work undertaken to-date and Members recognised that the problems were not easy to crack;
- whilst it was considered that ultimately clinical criteria were the most important, Members flagged up that the anticipated outcomes of the review would make it necessary for people to travel and something therefore needed to be done about hospital parking and charges as they were always flagged up by the public as concerns. When patients were called to a hospital appointment they often had no way of knowing how long they might be there and concern was expressed about those on a tight budget who could find themselves needing to top-up their car parking payment during an appointment. Some Members were appalled by some of the charges patients had experienced and the review needed to look into this as a serious consideration. Whilst Members recognised the review needed to be clinically-led and address financial issues, the HOSC was also bothered by social and political factors. Members had previously heard of a patient needing to attend Kidderminster from Worcester and being charged £22 for community transport. Whilst this might be a reasonable rate for that journey, it would be a significant proportion of a pension and concerned HOSC Members. Members were advised that the JSR Steering Committee included Trish Haines as a member and there were representatives of lay views rather than just clinicians. Whilst it was recognised that there would be no easy answers, social and political factors were taken very seriously;
- County Council representation on the Clinical Working

Groups was questioned. Members were advised that Jonathan Monks was on the Elderly Care CWG;

- it was requested that the County's older people's fora needed to be included in forthcoming consultations;
- it was highlighted that if services such as women's and children's services were moved to a single site this could cause problems, for example in Redditch where it was considered that transport was dire. An example was provided of a Redditch woman without transport who had been offered a 7.30am appointment at Kidderminster Hospital. She had approached a community transport provider who quoted £40 for the journey which was unaffordable for the woman. Councillors had intervened, spoken to the hospital and transport had been arranged but concern was expressed that people would not generally know what support they could access. It was highlighted that a lot of people did not have cars and used public transport and an appeal was made to pay particular attention to such issues especially if there was a risk of services moving out of Redditch. Members were assured that transport and access were included in the evaluation criteria and when they were consulted on, people would be able to indicate if they considered that they should have a greater weighting, but there would need to be a trade-off with another criteria, such as clinical quality;
- Members reiterated that the County could have the best services but if patients could not get to them, they would not be used. There were examples of patients spending £60 on a taxi to attend an ophthalmology appointment which was a significant amount from the patient's £400 monthly income. Transport was a vital issue if the review was talking about moving women and children's services for example, highlighting that if a pregnant woman needed to spend 2 hours travelling to an appointment, possibly with other young children, she may not attend her appointment and a greater reliance on community midwives could develop. It was suggested that the review needed to get a grip on transport issues before other issues and it should not be a question of deciding on a service model and then thinking about transport;
- in response to a question about clinical involvement in the Clinical Working Groups and particularly the Women and Children's group, Members were advised that there was a panoply of healthcare professionals and the importance of midwives was recognised. One of the external experts working with the review was a midwife. A recent radio programme was highlighted

which noted that women laboured better when closer to home, that the caesarean section rate had increased over recent years and that 85% of babies were now delivered by a midwife. It was urged that childbirth should be thought of as a normal process and not medicalised;

- it was noted that transport and access to hospitals was not just an issue for patients. When Kidderminster Hospital was downgraded, staff were made promises about buses but some of the services no longer existed. It was highlighted that it was not possible to get to Kidderminster Hospital by 7.30am from Kidderminster itself by public transport or after 6pm;
- an example was highlighted of a bus being stuck in traffic within the Worcestershire Royal Hospital site for an hour and it was noted that it could be easier for a patient from Malvern Link to attend a hospital appointment by train in Birmingham than by bus in Worcester;
- Members were advised that the review was doing sophisticated work on the clinical models. Broader implications were a core part of the work and there would be travel time analysis. The review would not deal with transport itself, but rather what it could mean for patients;
- it was noted that the CWGs had been established just for the JSR process and once outcomes were implemented the CWGs would end. The future of the Clinical Senate would be a matter for the CCGs and providers to decide what mechanism they wanted in Worcestershire to bring clinicians together. It was hoped that it would continue and would be used by the Health and Wellbeing Board;
- the JSR was mindful that patients used services outside Worcestershire and that Worcestershire's services were also used by patients from outside the County. Members were advised that discussions were needed with external providers and that patient choice also needed to be recognised. It was highlighted that radiotherapy services were being brought into the County and a key reason behind this was to give better access and improve uptake demonstrating that the local NHS did recognise the importance of access. Bringing such services in-County, including cardiac and renal services, not only benefited patients but also the local organisations and their reputations and helped recruiting staff. Members were advised that there had to be a lot of ambition too and there would be difficult trade-offs;

- the time-consuming nature of the work under the JSR was noted and the local NHS organisations were congratulated on the amount of work done;
- it was questioned whether the Acute Trust's application for foundation trust status was helpful in the review or a complication. Members were advised that the review and application were linked as the Trust had to have viable clinical and financial strategies. All trusts needed to be a foundation trust or become part of a foundation trust by 2014 and the Trust's view was that secondary care in Worcestershire would be better if managed within Worcestershire. Commissioners were supportive of both the review of acute services and the Acute Trust's application for foundation trust status. The Strategic Health Authority (SHA) was very happy with the progress of the JSR and all would work to ensure the review was not compromised by the foundation trust application process;
- in response to a question about whether the review was reinventing the wheel and could lessons be learnt from other areas, Members were advised that similar reviews were already taking place around the country or soon would be as all were expected to deal with financial challenges and the need for 24/7 consultants. The JSR was looking to learn from others and drawing on their experiences and models, such as 'warm hospitals'. The SHA had pointed out other operating models and it was suggested that the HOSC might wish to visit other examples;
- concern was expressed about the relationship with reviews taking place outside the JSR, such as acute stroke services and a recent options appraisal undertaken by the Health and Care Trust regarding acute psychiatric beds when some of those patients may also require services from the Acute Trust. At the options appraisal event, it was confirmed that it was not part of the JSR and needed to be completed by October. Members were advised that whilst the detail of the Health and Care Trust's option appraisal was not known, all needed to be clear about interdependencies. Within the last 2 weeks it had been decided that in order to be able to deliver against core assumptions, 30% less beds would be provided in the County. To do this, local NHS organisations would need to explain it in detail and convince all that services would still be available. A piece of work was to be undertaken with colleagues from social care to work up a detailed business case specifically regarding out of hospital elderly care. A critical part of elderly care was that it

had to deal with multiple morbidity issues including cognitive impairment and psychiatric needs. Eamonn Kelly undertook to pick this up with the Health and Care Trust to ensure the direction of travel was not compromised.

The Chairman noted that a lot of complex work had been undertaken and the overarching concern of HOSC Members was that reassurances were needed that factors such as travel would be addressed in the JSR's solutions.

Members received a presentation on Worcestershire Acute Hospitals NHS Trust's finances, outlining the history, borrowing powers, today's position, nursing spend, emergency admission trends and the future.

The Trust had run up large debts in the last part of the decade, to almost £35 million at one stage. Improvements had been made and the legacy debt was now £18.4 million.

The Trust was applying for a £21 million capital cash loan to address the legacy debt and the loan would be repaid in 7 years from surpluses. The Trust would also be borrowing money to invest in new services, for example the planned radiotherapy development and increased cardiac services. Members were assured that it was appropriate for the Trust to borrow money.

Whilst there had been a deficit at the start of 2011/12, the Trust had balanced its books. The Trust had reduced its costs, been paid for the work done and received the right level of transitional support from commissioners all of which had helped the Trust achieve financial balance.

Members were advised that it was noted in the March Trust Board financial papers that nursing spend had risen and this had been the case in the winter. The Trust had deliberately put additional bed capacity in to address expected seasonal pressures but the pressures were not expected to have been as challenging as they were and the Trust saw demand increase and pressures increase with Norovirus outbreaks. The Board had been disappointed that the Trust had needed to rely on agency staff rather than using its own bank of nurses but it had been necessary to do this, using accredited agencies. Members were advised however that nursing spend remained in-budget. It was also highlighted that emergency admissions appeared to be showing a 6% increase year on year. Other than an increase in February due to Norovirus, nursing spend per bed day had been broadly constant over the year.

The past was an issue for the Trust and it was in

discussions with the SHA and Department of Health about how to deal with the legacy debt in the transition to foundation trust status. It was recognised that the Trust could be both clinically and financially viable but the debt could remain a constraint. Finances would be squeezed in the public sector over the next 3-5 years and whilst the Trust's overall budget remained flat, demand continued to grow by about 5% every year. It was also noted that NHS tariffs were being reduced by 4% and CCGs were also under pressure too. Acute trusts would therefore all be looking to make annual savings of 5%. Whilst the Trust needed to become more efficient, this could only achieve so much and the Trust needed services to be redesigned.

- it was queried how the Trust planned to pay off the £21 million loan when the Trust also needed to make 5% savings and it was suggested that the Trust was facing an incredible challenge. If the historical debt could be wiped out the position would be clearer but Members questioned the planned surpluses. Members were advised that within the planned 5% savings, 1% of this was surplus and equated to £3 million annually, amounting to £21 million over 7 years. Members were also advised that the JSR needed to leave the Trust with a modest surplus or it would leave the Trust with no contingency and reinvestment funds;
- it was noted that the Trust's plans were based on current budgets yet national decisions could impact on NHS budgets. Members were advised that it was not possible to predict what the Treasury might do in future years. The Trust was planning as best it could and would respond to any challenges as necessary and it was highlighted that it was difficult for all of the public sector. The Trust's Chairman advised that there was hope that something might happen regarding the historical debt following indications from the Secretary of State that if the future picture looked good for trusts with historical debts, there might be an option to deal with the debt;
- there was a suggestion that taxes should be increased to fund a decent NHS;
- in response to a question about provision to retrain the staff no longer needed in the acute setting to deliver community-based care given the movement of patient care to community settings, Members were advised that this was being considered under the JSR. The JSR recognised that if different models of care were implemented, the review needed to look at what was needed in other settings, as there was no sense in losing clinical skills. Members were assured that work

was being done on what out of hospital care would look like and the Acute Trust was working with the Health and Care Trust on pathways, staffing and skills;

- it was noted that the Government had stated that the NHS was one area where money would not be reduced and there would be increases in spending. It was questioned where this could be seen. Members were advised that whilst overall there was real terms growth in spend, it was miniscule, at 0.1 or 0.2 of a percent. It was highlighted that acute trusts would not necessarily see this money. As demand continued to increase, funding was not keeping pace so better models of service delivery were needed. Government funding protected the NHS against inflation but not against increasing demand;
- it was queried whether it was known yet whether CCGs would require the same levels of hospital activity as at present or if this remained unknown. Members were advised that planning assumptions were taking into account the CCGs' 3 year assumptions and work was being done to align planning assumptions as much as possible;
- Members were assured that work was being done across health and social care on the nature of the out of hospital care needed in Worcestershire. It was recognised that the 2 key aspects of reducing numbers and length of stay would impact on both community care and social care and work was being done to look at what was needed and the resources needed, with a focus on the elderly care pathway;

The Chairman thanked all guests for their attendance.

**562. (Agenda item 6)
Acute Stroke
Services in
Worcestershire**

Attending for this item were Eamonn Kelly, Chief Executive, West Mercia Cluster, Chris Emerson, Deputy Director – Delivery, NHS Worcestershire, Menna Wyn-Wright, Service Improvement Manager, Herefordshire & Worcestershire Cardiac and Stroke Network/NHS Worcestershire and from Worcestershire Acute Hospitals NHS Trust were Harry Turner, Chairman, Penny Venables, Chief Executive, Jonathan Lofthouse, Interim Director of Emergency Care and Simon Hellier, Clinical Director of Medicine.

Members of the Health Overview and Scrutiny Committee received an oral presentation outlining the background to acute stroke services and developments since the last update to the HOSC.

Members were advised that previously acute stroke service commissioners and providers had been concerned about the ability to deliver key quality indicators and there had

been a debate about whether service provision should be from a single site or 2 sites. Since then, it had been agreed that in order to comply with national stroke strategy and NICE guidance, a centre of excellence was needed and the development of a single site service at the Worcestershire Royal Hospital (WRH). Previously there had been concerns about capacity at WRH. However, there had been changes since then, including the development of an 8-bed unit at the Timberdine Unit in Worcester which released capacity at WRH. There would be no change of services provided at WRH.

There had been improvements in the current service since January, including access to screening, scans, thrombolysis and the time patients spent on a dedicated stroke unit. However, concerns remained about the current service provision, including access to stroke beds and the sustainability of the service. There was also increasing evidence of centralised stroke services increasing the quality of care, reducing mortality, long-term disability and length of stay.

In April, an options appraisal was undertaken. This involved a wide representation, including Worcestershire Local Involvement Network (LINK), the stroke tsar and other key stakeholders. The outcome of the appraisal was that there was now even stronger evidence to support a centralised service for Worcestershire. Consideration had also been given to some flow out of county, for example to Dudley, the Queen Elizabeth Hospital (QE) in Birmingham and to Warwickshire. In looking at a site for a centralised service, WRH would offer the best option for the greatest number of patients reaching hospital within 45 minutes. WRH also offered the benefit of being able to link with vascular services based there. It was hoped that today the HOSC would support the development of an implementation plan without the need to conduct formal public consultation given the support received during the optional appraisal process.

The option appraisal had involved patient representatives, the Ambulance Trust, service providers and commissioners and built on the review work previously undertaken. In 2011, options considered had been to continue the service at both WRH and the Alexandra Hospital or just on one of those sites. In 2012, an additional model was considered, providing thrombolysis on both sites with 1 acute stroke unit, either in Redditch or Worcester. In assessing the options, for consistency, the same evaluation criteria as had been used previously were used again. These criteria included clinical quality, access, development of existing or provision of new services, strategic fit, training and teaching needs, more effective use of resources and ease of

delivery.

The team reviewed the options and agreed that a centralised service should be developed at WRH as soon as possible as this option offered good access for all of Worcestershire and would serve the larger critical mass, leading to improvements in mortality. A detailed plan needed to be developed by the Acute Trust and discussions were needed with partner organisations as soon as possible.

From a clinical perspective, stroke was a very complex event to respond to and there were very stringent standards nationally to be achieved. It was clear that where organisations centralised services into centres of excellence, services improved exponentially and this applied in both urban and rural areas as well as in larger conurbations. Stroke treatment had changed in the last 5-10 years and where care had previously been managed by generalists, stroke care was now an area for specialists, providing CT scans and interpretation and thrombolysis, all within short timescales. It was suggested that it would soon be unusual not to have a full-time, dedicated stroke unit. It was recognised that the acute care was not the entirety of stroke care and provision of rehabilitation services more locally was also key. Putting acute care onto a single site would give patients a higher level of care.

Members were advised by the LINK that this country currently had the worst survival rates for stroke in the developed world and were 3 times worse than Denmark, for example. It was essential therefore to concentrate acute stroke services on a single site. In the absence of a 24/7 service, care at weekends was often lost and length of stays subsequently increased, survival rates were worse and quality of life afterwards was worse too. To do the best for Worcestershire, a robust stroke pathway was needed and it would be possible to reduce overall bed numbers if there were 24/7 therapy services rather than just Monday-Friday access.

During the ensuing discussion, the following main points were raised:

- concern was expressed that the proposed service would principally benefit the south of the County, being based at WRH, yet over 50% of the County's residents lived in north Worcestershire, with the nearest hospital for some of them being Russells Hall Hospital, Dudley or the QE. Whilst it might be easier for ambulances to take patients from Wyre Forest to Dudley, travel for visitors to WRH would be a breeze in comparison to travelling to Dudley and it was highlighted that as most stroke victims were elderly, many of their visitors would

be elderly too. There was concern about the over-development of patients from the north of the County being sent where was convenient for the Ambulance Trust, but inconvenient for visitors. Members were advised that of the approximate 800 stroke patients treated by the Trust each year, about 500 were at WRH and 300 at the Alexandra Hospital;

- the travel times stated in the paperwork were questioned, with Members suggesting it took 20 minutes to travel from Kidderminster to WRH rather than the 30-40 minutes in the documentation. It was also suggested that the A449 should be made back into a dual carriageway. Members were advised that the mapping of journeys had been provided by Public Health;
- it was highlighted that targets for scans were currently not being hit a lot of time and it was questioned whether there was confidence this would improve if the service was provided on a single site. Members were advised that a single site service would ensure clinical leadership and extended therapies such as occupational therapy and physiotherapy 7 days a week and greater access to CT and Doppler scans, etc. Clinicians were confident that a single site option would better maintain a centre of excellence, meeting national stroke strategy and NICE standards;
- it was noted that in the Joint Services Review, it had been clearly stated that for the Acute Trust to remain viable, it needed in-County service provision but this proposed model for acute stroke services would see some patients currently treated in-County, in future being treated outside Worcestershire. Members were advised that not all of the 300 stroke patients currently treated at the Alexandra Hospital would be treated outside the County under the proposed model and approximately 150 of them would be treated at WRH. Members were also assured that repatriation was not a key or a sole factor in determining the financial sustainability of the Acute Trust. Members were also advised that a key issue was the repatriation of services not currently provided in-County, for example radiotherapy and some cardiac services. Emergency flows were a different group and patients needed to get to their nearest hospital;
- it was also highlighted that the service had experienced difficulty attracting consultants and therapy staff and if the service was located on a single site, it would be more attractive;

- Members were assured that the aim of such reviews was to achieve the best clinical outcomes. The recent review of trauma services now meant all major trauma being sent to the QE. Key factors were saving lives and reducing injury and disability. Where clinically appropriate, services would be provided in Worcestershire, but if more appropriate, they would be provided elsewhere. For stroke services, the benefits of the proposed model in terms of reduced deaths and long-term disability were highlighted, recognising that there would be a short-term cost to families if they needed to travel to the QE or Dudley;
- whilst it was noted that London's stroke services now produced outcomes which were amongst the best in the world, Members noted that London also had a good transport system. However Members were advised that stroke patients tended to arrive at hospital via the ambulance service;
- it was suggested that for the best outcomes to be achieved, provision must also include services in the community. It was noted that there was a resource in south Worcestershire to treat those with an acquired brain injury, but not in the north and it was not known why this was;
- it was highlighted that the people of Redditch did not feel that they would get a better service under the proposed model. When the news broke in the previous week of the proposed change, there was a storm locally and a lot of anger. Concern was expressed that accessing WRH might be OK if you owned a car, but not everyone did. Most patients would be elderly and their relatives would not be able to get in to visit them and service commissioners and providers were doing nothing about this. Members were advised that a key benefit of the proposed model would be the reduced length of stay patients would need before being able to transfer to a community setting, closer to their relatives;
- concern was also expressed about the planned changes to ambulance provision which would see cars sent initially with an ambulance arriving possibly 30 minutes later. Residents of Redditch would prefer to continue to use the Alexandra Hospital. Members were advised that the days of ambulances being sat in ambulance stations had long-gone and were instead stationed around the County so they were able to respond more promptly. It was proposed to close Redditch ambulance station and open 3 alternative sites and whilst people were being told such changes were not about money, people did not feel that these changes were about improving patient care;

- it was noted that how everyone told the story was critically important. There were 2 major objectives for Worcestershire's health services, i.e. ensuring clinically sustainable services and facing the productivity challenges. Whilst the feelings of the people of Redditch about their local hospital could be understood, it was questioned how honest the local NHS had been about outcomes of the current stroke care and the number of unnecessary deaths and levels of disability. If the NHS was honest, people may better understand why changes were being proposed. It was necessary for the local NHS organisations to use their skills and resources to communicate messages clearly. Where national stroke standards were implemented, there were significant reductions in deaths and this needed to be brought into Worcestershire. What was critical was how to get patients back into their community quickly. What people were being told was key and this was the local NHS's responsibility;
- it was questioned whether, once patients moved from a centralised acute stroke service to their locality, they would have access to the essential tools needed to maintain progress, such as speech therapy, occupational therapy and physiotherapy. It was also questioned that whilst the additional 150 patients to be treated in WRH could be accommodated as a result of the additional 8 beds at the Timberdine Unit, whether there would be a similar in-County provision for those 150 patients who were treated outside the County for their acute stroke care. Members were assured that significant work had been done to develop services across the County to ensure robust early discharge with rehabilitation services in a patient's locality. Members were further assured that Worcestershire's out of hospital care was amongst the best nationally and whilst it could perhaps be better, it was starting from a good strong base;
- concern was expressed that there had been huge concerns historically about the provision of speech and language therapy for children and it was also important for stroke victims. Members were advised that a single site service would allow all therapies to be provided 7 days a week;
- it was suggested that the case had been overwhelmingly made and was difficult to ignore and additionally the cost envelope meant there was a dilemma with the resources not available to provide 2 centres of excellence in Worcestershire. However there was concern that this was the thin edge of the wedge

**563. (Agenda item 7)
Quality
Accounts –
Health Overview
and Scrutiny
Committee
Comments**

and the Joint Services Review would see the continued centralisation of services and ignore the needs of local people and it was questioned what WRH would lose to accommodate a centralised stroke service. Members were advised that bringing the service together on a single site would enable more efficient use of the bed stock. At present, clinicians and therapists did not operate 7 days a week so current resources were not maximised. The proposed service had been modelled and it was planned that 26-28 beds at WRH would meet the service's demands and was also economically sensible compared with the 42 beds currently in place in Worcester and Redditch;

The Chairman considered that the HOSC recognised the case had been made and the proposed model would result in better outcomes. HOSC Members would not always agree on site decisions and in reality would represent their locality. The HOSC was not comfortable that the case for change had been made to the public and highlighted concerns raised in the local media, for example by MPs and encouraged the local NHS to do more to get the message across. Concerns remained amongst Members about post-acute care and Members would wish to keep an eye on this.

The Chairman thanked all guests for their attendance.

Members considered the draft Quality Accounts of the 3 local healthcare organisations which were required to produce Quality Accounts. Health Overview and Scrutiny Committees were invited to submit up to 1000 words on each organisation to be included verbatim in the NHS organisations' Quality Accounts which were to be submitted to the Secretary of State for Health by 30 June 2012.

Each draft Quality Account (QA) was considered in turn by the HOSC.

West Midlands Ambulance Service NHS Trust

The Chairman welcomed Adele Pearson, Regional Head of Professional Standards and Quality and Tony Gill, Clinical Performance and Governance Manager from the Trust. Members were advised of the Trust's priorities for improvement for 2011/12, performance against those priorities and the Trust's priorities for 2012/13.

In discussing the Trust's Quality Account, the following comments were made:

- Members suggested that the Trust would be increasingly busy in Worcestershire with the anticipated structural changes to acute services, including acute stroke services and it was hoped the Trust would have

the necessary provision in place. Surprise was expressed that the Trust was not more involved in the County's ongoing Joint Services Review;

- it was noted that Members had already done some work outside the meeting to consider the draft quality accounts and some words had been drafted. It was considered that the draft QA provided a fair reflection of the Trust's services and the Trust was to be congratulated on the clarity of the QA which was a document to be aimed at the public;
- Members were interested that within its falls pathway priority for 2012/13, the Trust intended to focus on prevention and education;
- given the HOSC's interest in the quality of stroke care, Members welcomed the Trust's priority regarding the management of onset of stroke;
- it was suggested that there should be discussions between NHS Trusts about their priorities to enable more integration in target setting;
- the Trust was congratulated on its achievements over the last 12 months as detailed in the draft QA;
- the Trust's use of GPS and local knowledge in transporting patients to acute hospitals was questioned, with an example given of a patient from Fernhill Heath in Worcester transported through the city centre rather than around the outskirts which had proved a quicker journey. Members were advised that in the absence of local knowledge, ambulance crews did work off GPS. Members highlighted that concerns had been expressed about the loss of local knowledge when Worcestershire lost its dedicated ambulance trust and had predicted that this would be a major problem;
- the reality of patient choice was questioned in relation to patients being transported to an acute hospital by the ambulance service. Members were advised that in an emergency, patients were transported to the nearest acute hospital. However, if a patient was receiving ongoing care, they were not in a life-threatening situation and their preferred hospital was not unreasonable, there could be patient choice;
- the Chairman advised that the Trust's Chief Executive had requested that he attend a future HOSC and it was suggested that questions such as these would be best discussed with him at that meeting.

Worcestershire Acute Hospitals NHS Trust

The Chairman welcomed Helen Blanchard, Director of Nursing and Chris Rawlings, Head of Clinical Governance and Risk Management from the Trust. In discussing the Trust's Quality Account, the following comments were made:

- surprise was expressed that although in the Chief Executive's statement in the draft QA it was stated that the emergency access target in A&E had been disappointing all year and this was a key priority of the Board, it was not identified as one of the Trust's 2012/13 priorities for improvement in the QA. Members were advised that this related to the structure of draft QAs and that there would be a focus on emergency access;
- Members noted that the draft QA picked up the Care Quality Commission's inspection and the lessons learned. However Members expressed concern that there needed to be a clear structure for safeguarding. The definition of a vulnerable adult could apply to all patients and it was suggested that the Trust needed to be clearer about safeguarding. Members were advised that the Trust had received a very favourable assessment following the West Midlands Quality Review Service assessment of vulnerable adults in acute services but the point was taken about safeguarding work.

Worcestershire Health and Care NHS Trust

The Chairman welcomed Sandra Brennan, Director of Quality (Executive Nurse) and Della Lewis, Quality Governance Manager from the Trust. In discussing the Trust's Quality Account, the following comments were made:

- the draft QA did not include any targets or measures for the 2012/13 priorities. Members were advised the Trust considered that quality was central to the organisation and had decided that it would include its QA within the Trust's Annual Report and together, the documents provided a full picture. Members were also advised that consultation had led to the addition of 2 of the Trust's 5 priorities, i.e. dementia and no incidents of avoidable pressure sores;
- Members suggested that it was depressing that the Trust needed to prioritise improving pressure care when there had been systems in place even in 1965 to ensure their prevention and cure and it was questioned what had changed that now required the Trust needing to make this a priority. Members were advised that over the years, priorities in nursing had changed but the

Trust was now going back and reflecting on the role and was, for example, reintroducing care rounds. The Trust was aiming to get 'back to essential care'. It was highlighted that one particular challenge for the Trust was that it provided a lot of care in people's homes and therefore had less ability to control things. For example, even though the Trust could provide the necessary pressure mattresses, etc. there was less the Trust could do if patients did not use them, although questions could be asked about whether this might be a safeguarding issue, recognising that this would need to be balanced with people's freedoms and liberties;

- it was noted that at the recent Royal College of Nurses' AGM, there had been some very disturbing comments about the ratio of qualified nurses to patients. Members were advised that the Trust did not have just 1 trained nurse covering any of its areas. A recent RCN document had been published making recommendations about elderly care and the Trust considered it was very applicable to the Trust and was just starting the work to look at the recommendations;
- assurances were sought that mental health matters had not taken a backseat at the Trust following the merger of mental health services and community services under the formation of the new Trust. Members were assured this was not the case and an example was shared that demonstrated the benefit of shared practice and knowledge which saw patients with cognitive impairment in the community hospitals benefiting from improved care due to access to specialist nurses when they would not have received mental health care previously. Staff coming together from separate organisations into one had seen the pooling of skills and resources. Members welcomed the improving care for patients with dementia and were advised that different types of training was provided for different staff groups.

564. (Agenda item 8) Health Overview and Scrutiny Committee Round-up

Ongoing issues around the County were discussed:

- Cllr Bunker had attended a meeting organised by Worcestershire Health and Care NHS Trust regarding planned bed reductions. The Chairman would follow this up with the Trust;
- Hereford and Worcester Fire Service had scheduled a meeting which clashed with a meeting of the HOSC. The HOSC meetings were detailed on the Council's calendar of meetings and it was asked that the Fire Service be advised where to access the up-to-date calendar to avoid future clashes;

- concern was raised that the Worcestershire carers of people with mental health issues were feeling in limbo and in need of help and that they no longer had access to the Community Psychiatric Nurses they used to. It was suggested that this needed to be addressed with Worcestershire Health and Care NHS Trust. Cllr Bunker advised that the Trust had indicated that its proposed bed reductions were planned as a result of improvements to community based services;
- concern was expressed that there appeared to be a void between what the HOSC was being told and what GPs were doing. Examples included that GPs had only just come on board the Children's and the Adults' Safeguarding boards and it was considered GPs had also not had a focus on Child and Adolescent Mental Health Services and children's speech and language therapy. Members considered that they needed to meet the lead GPs from the County's 3 Clinical Commissioning Groups. The Chairman undertook to follow this up;
- an update was requested on out of hours GP services.

The meeting ended at 5.10pm.

Chairman

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Health Overview and Scrutiny Committee

Wednesday, 4 July 2012 (2.00pm), County Hall, Worcester

Membership

Worcestershire County Council Mr A C Roberts (Chairman), Mr M H Broomfield, Mrs M Bunker, Mr B F Clayton, Mr A P Miller, Mrs P J M Morgan, Mr J W Parish, Mr T Spencer.

Bromsgrove District Council Dr B T Cooper
Malvern Hills District Council Mrs J Marriott
Redditch Borough Council Mrs P Witherspoon
Worcester City Council Mr R Berry
Wychavon District Council Mr G O'Donnell
Wyre Forest District Council Mrs F M Oborski

Agenda

Item No	Subject	Page Nos
1	Apologies	-
2	Declarations of Interest and of any Party Whip	-
3	Public Participation <i>Members of the public wishing to take part should notify the Director of Resources in writing or by e-mail indicating the nature and content of their proposed participation no later than 9.00am on the working day before the meeting (in this case 3 July 2012). Enquiries can be made through the telephone number/e-mail address below.</i>	-
4	Confirmation of Minutes – 19 June 2012	To follow
5	Joint Services Review – The Future Configuration of Acute Services in Worcestershire – Emerging Models and Evaluation Criteria Supporting Information: <ul style="list-style-type: none"> • Appendix 1 – Why We Need to Change Our Hospital Services in Worcestershire. Worcestershire Hospitals – Fit For Tomorrow – Engagement Phase 	1

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<http://www.worcestershire.gov.uk/cms/democratic-services/minutes-and-agenda.aspx>

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Health Overview and Scrutiny Committee
19 June 2012, County Hall, Worcester – 2.00pm**Minutes****Present:**

Worcestershire County Council:
Mr B F Clayton (Chairman), Mrs M Bunker,
Mr M H Broomfield, Mr A P Miller, Mr J W Parish.

Bromsgrove District Council: Mr B Cooper
Worcester City Council: Mr R Berry
Wyre Forest District Council: Mrs F M Oborski

Also in attendance:

Mr C A Chorley, Children and Young People Overview
and Scrutiny Panel for agenda item 6
Mrs A T Hingley, Adult Care and Well Being Overview
and Scrutiny Panel for agenda items 6 and 7
Mrs Y Smith, Redditch Borough Council

Officer Support:

Suzanne O'Leary – Overview and Scrutiny Manager
Sandra Connolly – Overview and Scrutiny Officer

Available papers:

- A. The Agenda papers and appendices referred to therein (previously circulated);
- B. Presentation on Draft Joint Health and Well-being Strategy (circulated at the meeting);
- C. Presentation on Worcestershire Health and Care NHS Trust's Draft Integrated Business Plan (circulated at the meeting);
- D. Presentation on West Midlands Ambulance Service NHS Trust (circulated at the meeting);
- E. The minutes of the meeting held on 22 May 2012 (previously circulated).

A copy of documents A-D will be attached to the signed Minutes.

In the absence of the Chairman and Vice Chairman, Health Overview and Scrutiny Committee (HOSC) Members agreed that Councillor Brandon Clayton be appointed Chairman for this meeting.

565. (Agenda item 1)
Apologies

Apologies were received from Jan Marriott, Penelope Morgan, Gerry O'Donnell, Andy Roberts, Terry Spencer

**566. (Agenda item 2)
Declarations of
Interest and of
any Party Whip**

and Pat Witherspoon.

Dr Brian Cooper advised that he had been appointed to the governing body of the Redditch and Bromsgrove Clinical Commissioning Group. The Overview and Scrutiny Manager would review this to determine if there would be a conflict.

**567. (Agenda item 3)
Public
Participation**

None.

**568. (Agenda item 4)
Confirmation of
Minutes**

The Minutes of the meeting held on 22 May 2012 were confirmed as a correct record and signed by the Chairman.

**569. (Agenda item 5)
Constitutional
Matters**

Mrs J Marriott, the representative of Malvern Hills District Council was nominated by the District Council representatives as the Vice Chairman of the Health Overview and Scrutiny Committee. Mrs Marriott would be formally appointed at Worcestershire County Council on 5 July 2012.

**570. (Agenda item 6)
Update on the
Health and Well-
being Board and
Consultation on
the Joint Health
and Well-being
Strategy**

Attending for this item were Marcus Hart, Chairman of the Health and Well-being Board (HWB) and Cabinet Member with responsibility for Health and Well-being and Dr Richard Harling, Joint Director of Public Health.

Members of the Health Overview and Scrutiny Committee received a presentation outlining the Joint Health and Well-being Strategy, how it was developed, the vision, priorities, key findings from the Joint Strategic Needs Assessment, outcomes and indicators, implementation and next steps.

Members were advised that the Joint Health and Well-being Strategy (JHWS) was now out for consultation. Under the new Health and Social Care Act 2012, production of a JHWS was a statutory duty for Councils and Clinical Commissioning Groups (CCGs) from 2013. The Strategy set out Worcestershire's Health and Well-being Board's priorities and goals for the next 3 years. The timescale for the Strategy had been debated and a 3 year period agreed in the first instance. The Strategy would set the context for all other plans of the NHS, public health and related services. Within the NHS, for example, CCGs would need to demonstrate that their individual commissioning plans were consistent with the Strategy and would be held to account for the delivery of outcomes.

The shadow Health and Well-being Board (HWB) had developed the Strategy over a period of time. The Strategy

was informed by the key findings from the Joint Strategic Needs Assessment (JSNA) and was released for consultation on 30 May. The vision within the Strategy was to create a health and well-being system with shared responsibility, reducing dependence on health and social care services, which would offer high quality services, protect the public and be transparent and accountable.

The HWB's proposed priorities had been debated at length with 5 being agreed:

- older people and management of long-term conditions
- mental health
- obesity
- alcohol
- acute hospital services, included mainly due to the ongoing work on the reconfiguration of acute services in Worcestershire

The priorities selected offered a balance of long and short term issues, were relevant for different age groups, affected large numbers of people, related to major causes of ill health and death, required substantial spend, were of a high importance to the public, had potential to improve outcomes and required major transformational change, strong leadership and co-ordinated action.

Key findings from the JSNA were set out in the Strategy. There was an ageing population in Worcestershire with those aged over 65 years to increase annually by 3%, meaning the population needing care would increase. Overall, health was improving but there were pockets of disproportionate ill-health. The whole of the public sector was having to make savings and this would impact on a range of services. There were 56,000 adults and 9,000 children in Worcestershire with mental health problems. Both obesity related ill-health and alcohol related issues had significant costs not just for health services but for the wider society too.

Each priority identified had outcomes and indicators, drawn from National Frameworks where possible and focussed on what could be achieved rather than how. It was highlighted that it was not easy to find indicators. Additionally, for each priority there was an implementation plan and possible expected actions were included in the Strategy but were illustrative rather than exclusive. The HWB would work to ensure closer integration of service commissioning and the Joint Commissioning Unit was growing to accommodate this and better enable joined-up action.

The HWB was seeking views on the draft Strategy and a final version would be agreed by the HWB at its 26

September meeting.

During the ensuing discussion, the following main points were raised:

- concern was expressed that it was not possible to see in the Strategy where the priorities had come from and it was questioned whether as the Strategy was based on the JSNA, this too would be available. Members were advised that the HWB had looked at the needs assessment and other things in determining priorities. A suite of documents had been used, including those relating to specific services such as Child and Adolescent Mental Health Services and speech and language services. In mid-July an interactive tool would be launched which would provide an overview of health and well-being with much more detail available for individual areas and this could be shown to the HOSC in the future;
- it was further questioned whether there was a requirement to consult on the JSNA as there appeared to be no clear final guidance on this and in addition to seeing the detailed data for individual areas, Members were interested to see how the priorities for Worcestershire had been reached from the JSNA. Members were advised that whilst it was not clear if consultation on the JSNA was a statutory requirement, there was an expectation of involvement. Although the JSNA was not a single document, but was part of the process by which services were commissioned and would be shown in the interactive tool and a series of documents, a summary document could be produced;
- it was highlighted that there was little mention in the Strategy of housing yet this was a major component affecting people's lives. Members were advised that in identifying the 5 priorities there had been lots of discussion and it had been recognised that some things needed to be made a priority or there would be no priorities. Suggestions were welcome and would be given further consideration by the HWB;
- it was noted that district councils in south Worcestershire had only 1 representative on the HWB due to the representation being linked to the structures of the CCGs. It was considered that this was not very representative, particularly as district councils carried a responsibility for preventative health services through environmental health. Members were advised that such concerns had already been articulated and were being looked at. However, the HWB needed to remain strategic and could not be too big so it would not be

proposed to increase the numbers on the HWB. Instead, consideration would be given to mechanisms for district councils to feed into the HWB as well as looking at links between the district councils and CCGs;

- a function of the HWB would be to support the development of joint commissioning and pooled budgets and it was questioned whether local authorities and CCGs already had these in place. Members were advised that the Strategy had not been produced in a vacuum and commissioners, both PCTs and CCGs, had plans. In moving forward, those plans would be reviewed by the HWB to check that they were consistent with the Strategy. In response to a further question about whether commissioning plans were developed first or in tandem with provider plans, Members were advised that there were ongoing commissioner / provider plans. The JHWS was a vehicle for service commissioning and provision and would influence these over time rather than starting a new clock from the Strategy's finalisation;
- concern was expressed that it was critical that every child be given the best possible start in life, yet women and children were not identified as one of the HWB's priorities. Whilst it was accepted that older people should be a priority, their health issues had been brought upon themselves by their lifestyles. If improvements to outcomes were to be achieved, it would be important to focus on children to ensure a healthy young generation otherwise issues created by alcohol and obesity would be repeated interminably. Members were advised that views on the priorities were welcome and would be taken into account by the HWB and whilst women and children would be covered within the existing 5 priorities, under the consultation process, the priorities or the phrasing of them could be looked at again;
- it was noted that there was a huge amount of work within the priorities and it was questioned whether there might be too many and would more progress be achieved with fewer priorities. It was also questioned who would monitor progress and how. Members were advised that whilst everyone wanted their priorities to be included, it had been necessary to review the competing interests and reduce the number of priorities to a manageable number. In terms of monitoring, this would be undertaken by the HWB but the HOSC might also possibly wish to review progress and there would be metrics against which plans would be monitored. It was recognised that there would be less, not more, money in the system in the future and a key challenge would be using that money to its greatest effect. It was

important to recognise that there would be input not just from the public sector, but also from industry and communities too and strong leadership would be key in mobilising the resources of society;

- it was questioned what the set-up should be for an older person contacting an emergency telephone number in the absence of their named social worker. Whilst the detail of this was outside the Strategy under discussion, an expectation underpinned the Strategy that all services would be high quality. The HWB needed to consider quality and set clear expectations around response times, integration, etc.;
- it was suggested that health organisations should be part of the planning process with planners and planning committees taking note of health issues and potentially using greater leniency in some applications. It was highlighted that such a principle was behind the national drive for the formation of HWBs which would see the greater involvement of local councillors in health as well as them being able to bring their influence to bear in planning matters. Whilst there might be issues with national planning legislation, through the HWBs there was likely to be an increasing collective willingness to work together;
- concern was expressed that there was only 1 representative on the HWB from the voluntary sector. Members were advised that whilst there was only 1 person, they represented a plethora of community and voluntary organisations. Concern remained however that the representative did not represent Bromsgrove or Redditch but Members were assured that they would do so and there would be reporting mechanisms to feed in comments as it was not possible to have inordinate numbers on the HWB. Members were further assured that following the HWB stakeholder event held on 30 May, there had been a discussion about wider community involvement which had been very helpful at identifying methods of involvement with the HWB other than having a seat on the Board, for example, through membership of virtual networks;
- it was suggested that it was disappointing that prevention did not feature in the Strategy as a priority as there were issues which could be addressed such as poor quality housing, excess winter deaths, homeless figures and deprivation. It was considered that there needed to be improvements and tackling issues such as housing, employment and school performance would be better priorities for the HWB. Members were advised that if the prevention agenda did not come

across sufficiently strongly the HWB could review this. It was agreed that in any other year, acute hospital services would probably not have featured in the list of priorities but given the ongoing major review of acute services in Worcestershire, they should be a priority;

- it was questioned whether members of the HWB would be able to put in the necessary time given the vital and huge agenda of the Board. Members were advised that the members of the HWB recognised the importance of the Board, its key leadership role and their ability to influence strategically and within their own organisations;
- in response to a question about the relationship between the HWB and the HOSC, Members were advised that the HOSC would be able to hold the Board to account for both the Strategy and its delivery and the relationship between the Board and the HOSC would continue to evolve over time;
- it was questioned how the public would know about what the HWB was doing and how they could get involved. Members were advised that all meetings of the HWB were now being held in public and members of the public and the HOSC had attended the first public meeting in May. Papers for the HWB were published in the normal and proper way and were available on the internet. Meetings included 30 minutes for public questions and would be held at different locations around the County, for example, in Wychavon in July and in Wyre Forest in September. Meetings would be advertised and it was hoped that they would get local engagement; and
- concern was expressed about how the public would be helped to understand ongoing changes to health services and structures and the implications of proposed cuts. Members were advised that across the whole public sector, services and structures, e.g. PCTs / CCGs, were being transformed and there were cuts in some areas. It was recognised that it was difficult for the public to understand how this all fitted together and it was everyone's responsibility to try and help the public understand, including the HOSC. It was also hoped that the HWB's communications plan would allow people to engage and the HOSC had a role in publicly holding systems to account.

Members agreed that the Overview and Scrutiny Manager should bring together the views expressed by the HOSC, Adult Care and Well Being and Children and Young People Overview and Scrutiny Panels for submission in response to the consultation on the draft

**571. (Agenda item 7)
Worcestershire
Health and Care
NHS Trust's
Draft Integrated
Business Plan**

Joint Health and Well-being Strategy.

Attending for this item from Worcestershire Health and Care NHS Trust (the Trust) were Chris Burdon, Chairman, Sarah Dugan, Chief Executive, Susan Harris, Director of Business Development and Andrew Ferguson, Deputy Director of Strategy.

Members of the HOSC were advised that the Trust was now almost a year old and had had a very busy year, including developing a range of strategic documents. The Trust was to present a top level view to the HOSC and clearly any specific developments would be brought to the HOSC as necessary in the future. The Trust was en route to foundation trust (FT) status and had agreed a timeline with the Strategic Health Authority (SHA) and Department of Health which should see the Trust submitting its application to Monitor in early 2013. The Trust was seen as progressing well on the timeline, meeting all the necessary targets and the Trust was confident it would achieve FT status. Those trusts which did not become FTs by the Government's deadline would be acquired by another trust and the potential in Worcestershire if this happened was for services to come under an out-of-County trust with the potential for a reduction in emphasis on Worcestershire's needs.

Members received a presentation outlining the Trust's foundation trust programme, the purpose of the Integrated Business Plan (IBP), growth and cost reduction, principles behind the planning, service improvement and development and corporate objectives.

Members were advised that the Trust's aim was to achieve FT authorisation by next summer and could not give a more precise date as this was out of the Trust's control to some extent given the queue of organisations seeking approval. In developing an Integrated Business Plan (IBP), there was a number of submissions to be made, with the IBP being reviewed throughout the process. Future submissions of the IBP would be made on 16 November and 1 February. Consultation was underway on the Trust's application for FT status and its proposed constitution and this would be considered at a future HOSC and would influence the next iteration of the IBP as well as various tests and interviews aimed at checking that the organisation had strong corporate and clinical governance to become a stand-alone organisation.

The IBP was a somewhat technical 5 year document. It clarified how the Trust was planning to organise itself in terms of governance and membership structure, it defined the Trust's strategic goals and their delivery and how the

Trust would improve patient care and develop services. The IBP also demonstrated how the Trust would manage risk and address any changes occurring during the next 5 years. It was recognised that 5 years was a long time in the NHS and 5 years ago no-one could have predicted the current changes. As it was not possible to predict what might happen over a 5 year period, the Trust needed to be able to demonstrate how it would manage risks.

The IBP also needed to demonstrate the Trust's sustainability. The Trust's base case needed to be a prudent plan and could not include any speculation, only including signed commissioner support and secured contracts. However, the Trust did have aspirations, for example, with the formation of community treatment hubs, which if implemented in their entirety would see an impact of about 22% potential growth for the Trust. The downside was also covered within the IBP, looking at specific risks and what could potentially happen, to consider whether, if there were difficulties, was the Trust able to take action to remain sustainable. The Trust also committed in the IBP to deliver cost improvements to address cost pressures at 4% per annum. For example, as a community based organisation, staff travelled and fuel cost was therefore a significant issue for the Trust and would be managed under a cost improvement plan which would look at making the organisation more efficient. Similarly, 70% of the Trust's costs were staffing and whilst at present there were no inflationary rises, incremental rises continued and the Trust needed to ensure it was achieving maximum efficiency from its staff.

The Trust worked to a set of guiding principles in its planning. It aimed to provide quality services to deliver the best outcomes and improve the patient experience and there would be a Worcestershire focus, although the Trust would look outside if wider provision would not have a detrimental impact. The Trust would aim to improve service integration and develop more alternatives to acute hospital care and strengthen the role of community hospitals.

The Trust had a number of areas it planned to develop. The Trust aimed to develop Extended Primary Care Teams to include district nursing, physiotherapy, etc. which would work closely with one or more GP practices to deliver consistent planned care. Wrapped around these would be Community Enhanced Care Teams. Whilst the services provided by such teams might already exist, they were disjointed. The proposed community Enhanced Care Teams would bring together a variety of specialist teams to deliver 24/7 365 day care for complex patients. Wrapped around these would be Community Treatment Hubs which would see an extension of the

services provided in the County's community hospitals. In the longer-term the Trust also planned to look at basing assessment units in the Community Treatment Hubs and build on existing integration between health and social care in mental health and learning disability services. These areas of planned development were not in the summary IBP shared with the HOSC but by the next IBP submission in November, the Trust would produce a more concise version of the IBP and such developments would feature more clearly.

In addition to planned service development, the Trust also had a series of corporate objectives which set the organisation a demanding agenda. For example, the Trust aimed to stimulate a revolution in the way it engaged with patients with examples of this including the Big Recovery project and learning disability service users acting as health check reviewers.

Members were advised that the IBP was not a fixed document and would continue to change, taking on board local and national changes as they happened. Locally, the main ongoing issue was the Joint Services Review (JSR) and the Trust was aware that it could need to change the IBP to reflect the work of the JSR.

During the ensuing discussion, the following main points were raised:

- in response to a request for clarification, it was confirmed that the proposed Community Treatment Hubs would be the existing community hospitals. The Trust intended to change the terminology to reflect their proposed broader role. The proposed expansion was considered to be positive and a way of improving the County's health and well-being;
- it was questioned whether the Trust was engaging with other NHS organisations to develop the community hospitals, particularly given the changes proposed to the provision of surgery at Tenbury Community Hospital. Members were advised that Tenbury was a key resource for the Trust and highlighted that the surgical provision was in the remit of Worcestershire Acute Hospitals NHS Trust. The Trust was in touch with its partners in relation to the future of the community hospitals and this included the Acute Trust which was a key player given the ongoing JSR and the co-location of services. Social care services were also a key partner for the Trust given that mental health, learning disability, CAMHS and other services were increasingly integrated. Tenbury remained key to the Trust given its geographical location when looking at

access and travel issues. Looking at the County strategically, taking the 5 community hospitals and 3 acute hospitals, all patients would be 15 minutes travelling distance from one of those sites. Establishing the proposed Hubs would help further improve patient length of stay, support effective discharge from hospital and release capacity in the community hospitals. Members were also advised that the Trust currently had a significant number of buildings and wanted to co-locate more which would again increase capacity. Members were assured that Tenbury remained critical to the Trust and the Trust was involved with the Acute Trust and the CCG on the future of surgery at the site;

- the Trust's financial position was queried and the financial risks facing the Trust from the ongoing JSR. Members were advised that the Trust was on target financially and last year had achieved its required £1.5 million surplus. The Trust viewed the JSR on the up rather than downside, potentially providing opportunities for the Trust to increase its income. However, the guiding principle of the JSR was what was best for patients rather than the benefits for any organisation. The JSR could see fewer outpatient clinics in the Trust's sites with a loss of rental income, but the Trust considered it was in a very strong position and the efficiencies which could be made should not be underestimated and the Trust was well-placed;
- Members were advised that the Trust was not interested in buying-in services from other neighbouring Trusts but would take opportunities to provide services in other areas. For example, the Trust now provided offender health in Staffordshire, setting up a new team there which was managed from Worcestershire. The Trust considered that there were opportunities for it to grow;
- it was noted that the Trust would attend the July HOSC to discuss progress against its modernisation plans for adult mental health and older adult mental health. From the Trust's perspective, since its formation from the 2 previous organisations, the landscape had essentially not changed and the direction of travel remained a move away from inpatient care to community-based care. The Trust would attend in July to share progress but frame it in today's situation which was a different backdrop to the one which existed when the modernisation programme was previously presented to the HOSC. Today, the Trust had greater capacity to deliver and Members would receive an update in July;
- Members were advised that a key benefit of the formation of the new Trust was around integration and

now, rather than looking only at community services or mental health services for example, the Trust's IBP would apply to all aspects and real benefits were already being seen from integration. GPs were keen to see mental health experts providing in-reach services within primary care;

- concern was expressed about estates changes, that there was a number of empty buildings and it was not fully understood what was happening with them. Members were advised that the question of the Trust's estate was the focus of a strategic review in parallel with the IBP. Where properties were currently vacant, they remained with the PCT. The Trust only owned those where it currently delivered services. The Trust intended to look for opportunities to maximise the use of the public estate;
- it was questioned whether there were fixed targets for actions following a patient's appointment with a consultant as it was considered the waits following appointments were often worse than the patient's problems. Members were advised that within acute services the key measure was the 18 week referral to treatment time. Whilst this measure did not apply to the Trust, it was used as a benchmark. There were no consistent measures within the NHS for the time, for example, for results to be provided to a patient and whilst pathways were mapped out, timescales were not although it was recognised that perhaps they should be. Members were advised that increasingly patients were being seen at early triage for initial assessment and this enabled the NHS to advise patients at an early stage about how long they might need to wait. It was also suggested that the NHS could be a victim of history and locally for example where there would have been a long wait to access CAMHS 10 years ago, now there was only a 4 week wait;
- it was questioned whether the Trust had sought the views of those mental health patients and carers with whom the previous Trust had had a relationship to determine whether they were satisfied with services since the merger. Members were advised that when the new Trust was first established there had been concerns amongst service users that mental health services would not have the same level of priority in the new Trust. The Trust had worked extensively with lead representatives and set up locality forums and all were running well. The Trust had checked the views of patients and carers and feedback had been positive overall. Members were advised that the recovery workstream which had been established prior to the

**572. (Agenda item 8)
Update from
West Midlands
Ambulance
Service NHS
Trust on Make
Ready,
Performance,
and
Worcestershire's
Joint Services
Review**

formation of the new organisation, remained ongoing;
and

- it was questioned how information about outcomes and patient care could be brought to scrutiny. Members were advised that the Trust was having ongoing discussions with its commissioners and there was a national drive around outcomes measures. Members could continue to monitor outcomes through the Trust's performance matrix. The Trust also advised that it would be happy to bring details about its projects to the relevant scrutiny committee or provide briefing papers as necessary.

The Chairman thanked all guests for their attendance.

Attending for this item from West Midlands Ambulance Service NHS Trust (the Trust) were Anthony Marsh, Chief Executive and Barry Thurston, Director of Service Delivery.

Members of the HOSC received a presentation outlining the structure of the Trust, its vision and future developments, foundation trust progress, NHS pathways and the directory of services, Make Ready, performance, the Trust's quality and risk profile, reference costs, training and development, awards, patient handover at hospitals, ambulance service commissioning, NHS 111 and Olympic games preparedness.

Members were advised that the Trust covered the whole of the West Midlands but the Trust recognised the very different population areas it covered. The Trust had a clear vision and strategic objectives and a series of values created in consultation with the Trust's staff. The Trust was also clear on the journey of the organisation towards becoming a broader provider, maintaining what it did well, but recognising the overall direction of the NHS and patients was to have more treatment provided in the home.

There was a golden thread running through the Trust's Integrated Business Plan with 3 key aspects:

- workforce development which would see a paramedic on each vehicle. In Worcestershire, the Trust was nearly at this point but this was not yet fully implemented across the region;
- streamlining; and
- care pathways redesign.

The Trust's foundation trust application had been through the Strategic Health Authority and Department of Health and the Trust was now waiting for the Secretary of State to allow the Trust's application to be submitted to Monitor. The Trust hoped it would be authorised by the end of the

summer. On the shadow council of governors, Worcestershire was represented by Malvern Hills District Council.

New software, NHS Pathways and Directory of Services, had been introduced by the Trust a year ago and the Trust was happy with how staff had embraced this. Its use ensured the most appropriate response was provided and if patients did not need a service provided by the Trust, they were signposted appropriately. Members were advised that they were very welcome to visit the Trust.

Make Ready had been in place in Staffordshire for the last 15 years. Two years ago the Trust had reviewed whether to roll-out the Staffordshire model across the region or reinstate the traditional model in Staffordshire. The Trust's Board had taken the decision to roll-out Make Ready across the region and by the end of March it would be fully implemented across the West Midlands. Plans for Worcestershire were not yet finalised. The original intention had been to have a single hub for the County with 7 community ambulance stations and 8 community response posts. Of the 3000 999 calls the Trust received every day, only 60% of these required patients to be transported to hospital and more patients were now being treated on the scene by advanced community paramedics. In Worcestershire, the Trust was now revising its arrangements on the basis that the Trust had been unable to find a suitable location for a single central hub. The likely outcome was the development of a hub in Worcester on the existing ambulance station site which would be completely refurbished with an additional hub on a site to be determined elsewhere in the County. Under these revised plans, there would be only 6 community ambulance stations.

National response targets, measured on an annual basis had been exceeded by the Trust in the last financial year. Monitor required national targets to be met on a 2-quarterly basis rather than annually and the Trust had experienced a blip in quarter 2 in relation to answering 999 calls within 5 seconds. Performance in Worcestershire in 2011/12 had been good and the Trust congratulated its staff for this.

The Trust was the best performing in the country for some of the clinical performance indicators, set by the Department of Health, but acknowledged that it could improve cardiac and stroke care.

The Care Quality Commission (CQC) produced a profile of each trust based on a wide range of indicators and the Trust improved against these on a monthly basis with

May showing the best results the Trust had ever achieved. Whilst the CQC did not publish these profiles publicly so benchmarking was not possible, the Trust's Chief Executive would challenge any other trust to show a similar level of performance.

All of the Trust's high performance was achieved despite relatively low reference costs and the Chief Executive advised that it was a real testament to the Trust's staff that the Trust achieved what it did given its funding. Under the NHS performance framework data for the local cluster, the West Midlands Ambulance Service NHS Trust out-performed others.

Training and development was very important to the Trust and there was a programme of staff investment. The Trust continued to invest in this despite pressures on funding and had maintained the overall training days.

Nationally, the Trust had won a number of awards, including ambulance service of the year and had also held a number of local awards ceremonies.

Handover of patients at hospitals continued to remain a challenge for the Trust. The situation was an improving one but did need to improve further.

The Trust continued to work with the region's primary care trusts and clinical commissioning groups during the ongoing transition period.

Nationally, NHS 111 was to be implemented in most areas by the end of March 2013. The Trust had submitted a tender in partnership with 2 other organisations for the service provision and hoped to hear the outcome by the end of August. The Trust was confident and hopeful that its bid would be successful.

The Trust would be playing its part in the forthcoming Olympics. Not only was Coventry hosting some of the football, but paramedics from the Trust would also be working in London to support the London Ambulance Service.

The Trust highlighted that it was keen to continue to improve its leadership and clinical care to maintain its excellent levels of high quality services, ensuring excellence was spread across the organisation. The support of the HOSC for the Trust's staff was very much appreciated.

During the ensuing discussion, the following main points were raised:

- it was questioned when the additional hub under the Make Ready strategy would be known and where it was likely to be located. Members were advised that the strategy would be implemented in Worcestershire by the end of March 2013, subject to the Board's approval in the summer of the site for the additional hub. The Trust had been unable to find a single site for a hub in the County and instead would renovate the ambulance station in Worcester and with a 2nd hub to be determined by the Board in the summer. Both Bromsgrove and Redditch had existing ambulance stations;
- the Trust's involvement in the Worcestershire Joint Services Review was queried. Members were advised that the Trust had had some involvement and would be increasingly involved during the consultation. The Trust had already experienced a similar situation with the changes in mid-Staffordshire and the night-time closure of A&E which had seen much concern about the impact on ambulance services. The Trust had received additional funding from commissioners to address the impact on the ambulance service of having to travel further afield to ensure access levels. Whilst there had been concerns that there would be more 999 calls due to patients being unable to make their own way to A&E, that patients would be unhappy and that the ambulance service would not be able to cope, none of these had materialised. Members were assured that the Trust would be able to draw on its experience to support whichever service model was implemented. The Trust was relaxed about the situation as its staff were trained, paramedics would be on most ambulances by Christmas and the Trust's staff were able to respond to changes;
- the Trust advised that the changes under the JSR would not influence the Trust's Make Ready plans. The decision about the location of the hubs was a logistical one;
- it was suggested that having a second hub would address concerns in the north of the County about access issues, particularly in the winter. Members were assured that travelling in the winter was an issue every year but was not causing the Trust any concerns. The Trust had a fleet of 4 x 4 vehicles and volunteers also helped to move staff around as necessary;
- it was questioned whether ambulance paramedics would need to return to the hub at the end of a shift. Members were advised that paramedics had a legal duty to sign their drugs back in to a locked safe. The

paramedics would also need to return their personal protection equipment and their own cars would also be at the hub;

- Members were advised that vehicles returning to the hubs would be prepared for their next use by a reduced number of non-clinical staff. The community paramedics would stay in the community;
- the Trust considered that in its review of service provision, Make Ready was a relatively small part of the changes to make the service more efficient and there were also changes being made to how staff were rostered to ensure staggered cover by changing shift start times;
- it was questioned what the situation was with ambulance turnaround times at the County's hospitals. Members were advised that the Trust continued to work with acute trusts to address this issue. There were Hospital Ambulance Liaison Officers at all major acute hospitals in the region and there were known particular points during the days / weeks when there were pressures. There was a lot of practical on-the-ground work being done. At the end of the month, a summit would be held in Dudley with the Trust, acute providers and commissioners and issues would be discussed from all perspectives. Members were assured that there was close working together on this issue as it was recognised as a major problem. There were examples of success in addressing the issue and a representative from Whipps Cross in London would be attending the summit;
- at the previous meeting of the HOSC, use of satellite navigation systems by the Trust had been discussed. Members were advised that the Trust was currently undertaking a piece of work on such systems but it was highlighted that the Trust used industrial satellite navigation equipment rather than from the cheaper end of the market. Like any technology, equipment could develop faults and the Trust encouraged staff to use local knowledge when it was available. It was highlighted that the quickest route was not necessarily always a good option for an ambulance, for example if there were schools or road calming on the route. All ambulance trusts had similar issues and all were trying to resolve them;
- the application of patient choice by the Trust was questioned. Members were advised that normally patients were taken to their nearest emergency hospital or nearest specialist hospital, for example in the case of trauma, stroke or cardiac care. If a patient was already

**573. (Agenda item 9)
Health Overview
and Scrutiny
Committee
Round-up**

receiving treatment, the Trust did try to be helpful and take a patient to the hospital of their choice if there was no major difference in transport distance. The priority would always remain that patients should access the service which was best for them; and

- the Trust was thanked for reconsidering the number of hubs to be established in Worcestershire under Make Ready. It was questioned whether the Trust would consult on the location of the additional hub in the north of the County. The Trust advised that it had consulted on its Integrated Business Plan last year which referred to the roll-out of Make Ready and therefore did not intend to consult on the location of the hub. The location of the hub would be determined at the Trust's July Board.

The Chairman thanked all guests for their attendance. Mr Marsh advised that the Trust was happy to attend any future meetings as necessary.

Ongoing issues around the County were discussed:

- in Wyre Forest, the key issue was the ongoing Joint Services Review and there were concerns about some of the options. A notice of motion would be presented at the District Council that it was essential that services should be maintained in the County's 3 acute hospitals. It was highlighted that the County's transport difficulties were known and, with the closure of surgery at Tenbury for example, the idea of travelling to Worcester or Redditch would be unacceptable. It was considered that the County's travel situation required the retention of 3 sites;
- in Worcester City there had been an event organised by Diabetes UK which not many people had attended. Organisers had been told by the County Council that they were unable to have their vehicle located in the centre of the city and Cllr Berry had undertaken to follow this up; and
- Members were advised that an additional meeting of the Health OSC had been scheduled on 4 July at 2pm to consider the models under the JSR and the evaluation criteria.

The meeting ended at 4.15pm.

Chairman