

**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

	and Pat Witherspoon.
<b>566. (Agenda item 2) Declarations of Interest and of any Party Whip</b>	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.
<b>567. (Agenda item 3) Public Participation</b>	None.
<b>568. (Agenda item 4) Confirmation of Minutes</b>	The Minutes of the meeting held on 22 May 2012 were confirmed as a correct record and signed by the Chairman.
<b>569. (Agenda item 5) Constitutional Matters</b>	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.
<b>570. (Agenda item 6) Update on the Health and Well-being Board and Consultation on the Joint Health and Well-being Strategy</b>	<p>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.</p> <p>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.</p> <p>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.</p> <p>The shadow Health and Well-being Board (HWB) had developed the Strategy over a period of time. The Strategy</p>

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 2<sup>nd</sup> 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

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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 .....