Bracknell Forest Council

NOTICE OF MEETING

Health Overview and Scrutiny Panel
Thursday 11 July 2013, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

To: The Health Overview and Scrutiny Panel

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

cc: Substitute Members of the Panel

Councillors Allen, Brossard, Davison, Ms Brown and Heydon

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

ALISON SANDERS
Director of Corporate Services

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Published: 3 July 2013

Health Overview and Scrutiny Panel
Thursday 11 July 2013, 7.30 pm
Council Chamber, Fourth Floor, Easthampstead House, Bracknell

AGENDA

Page No

1. **Election of Chairman**

2. **Appointment of Vice Chairman**

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

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

4. **Minutes and Matters Arising**

   To approve as a correct record the minutes of the meeting of the Health Overview and Scrutiny Panel held on 18 April 2013. 1 - 6

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

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

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

6. **Urgent Items of Business**

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

7. **Public Participation**

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

8. **South Central Ambulance Service**

   To receive updates on the South Central Ambulance Service's performance on 7 - 30

- Out-of-hospital cardiac arrest survival rates; and
- Ambulance response times.

9. **GP Patient Survey Results**

To review the latest General Practitioner Patient Survey results for Bracknell Forest GP Practices. 31 - 38

10. **Health Reforms - Implementation**

To receive a progress briefing on establishing: 39 - 62

- the Public Health function in the Council
- Local Healthwatch

11. **Working Groups Update**

To receive an update on the progress of the Panel's Working Groups. 63 - 64

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

To consider scheduled Executive Key and Non-Key Decisions relating to health. 65 - 68

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

To note the Bi-Annual Progress Report of the Assistant Chief Executive. 69 - 80

14. **Date of Next Meeting**

A special meeting of the Health Overview and Scrutiny Panel has been convened on 19 August 2013.

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HEALTH OVERVIEW AND SCRUTINY PANEL
18 APRIL 2013
7.30 - 9.40 PM

Bracknell Forest Council

Present:
Councillors Virgo (Chairman), Baily, Finch, Kensall, Mrs McCracken, Ms Wilson and Ms Brown (Substitute)

Apologies for Absence were received from:
Councillors Mrs Angell, Mrs Temperton and Thompson

Also in Attendance:
Richard Beaumont, Head of Overview and Scrutiny
Sarah Bellars, CCG Nurse Governor
Zoë Johnstone, Chief Officer: Adult Social Care Health & Housing
Dr Martin Kittel, CCG Clinical Director
Lisa McNally, Public Health Consultant
Angela Snowling, NHS Berkshire East
Mathew Tait, Thames Valley Area Team Director, NHS England
Alan Webb, CCG Accountable Officer

35. **Minutes and Matters Arising**

The minutes of the Panel held on 24 January 2013 were approved as a correct chairman and signed by the Chairman.

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

There were no declarations of interest.

37. **Urgent Items of Business**

There were no items of urgent business.

38. **Public Participation**

There were no submissions from members of the public.

39. **New National Health Service Structures**

The Chairman welcomed Mathew Tait, Alan Webb and Dr Martin Kittel to the meeting.

Mathew Tait, Director Thames Valley Area Team, NHS England made the following points:

- NHS England previously known as the NHS National Commissioning Board, was responsible for effectively overseeing the commissioning of all health

services across England and this included primary care. More specifically, NHS England was responsible for:
  - specialist commissioning
  - supporting, developing and assuring the commissioning system
  - emergency preparedness
  - partnership for quality, this was a key role for NHS England and involved the work of quality surveillance groups. These groups would bring together commissioners and providers to assess services in their area and intervene where necessary. All local authorities would be invited to sit on these groups.
  - clinical and professional leadership across each area
  - strategy, research and innovation for outcomes and growth, an example of work in this area was the Friends and Family Survey.
  - world class customer service: information, transparency and participation.
  - developing Commissioning Support Units
- The Thames Valley Area Team – one of 27 area teams for England - was responsible for Berkshire, Buckinghamshire and Oxfordshire and had a direct budget of £523m for 2013/14. This included ten clinical commissioning groups (CCGs), who were all now fully authorised. There were also four Strategic Clinical Networks who would provide a commissioning overview for every proposed service reconfiguration. In addition there was an Academic Health Science Network, which was important in terms of learning and played a key role in terms of NHS growth.
- NHS England was keen to focus on quality and patients and in terms of measuring progress, the following measures would be used:
  - satisfied patients
  - motivated, positive NHS staff
  - outcome framework progress
  - promoting equality and reducing inequalities
  - NHS Constitution rights, pledges and standards
  - becoming an excellent organisation
  - high quality financial management
- In terms of priorities, the following were given:
  - safe transition, the transition had been complicated and there was still work to do.
  - establishing effective partnership working particularly with health and wellbeing boards would be crucial. Currently good relationships existed across the region with Health and Wellbeing Boards and NHS England was represented on all of them.
  - reconfigurations – Shaping the Future, Frimley/Heatherwood and Wexham Park.

Alan Webb, Chief Officer for the Bracknell and Ascot CCG, described the governance arrangements for the CCG, stressing the value of it being clinically led and reported that there were a number of posts that were shared across CCG's in Berkshire. This included his post as well as the CCG Nurse Governor, Chief Finance Officer and two other support officers.

In terms of current issues, he reported that the proposed merger between Frimley Park and Wexham Park would provide opportunities for the local authority to contribute to CCG discussions on this.

The CCG had held its first Governing Body meeting in public and there had been numerous questions from the public.

The CCG would also have a role to play alongside NHS England to promote quality in primary care.

Dr Martin Kittel, CCG Clinical Director reported that the trajectory of learning for GP's had been immense. The CCG had created a cohesive unit for GPs and was working well.

Lisa McNally, Public Health Consultant reported the positive impression of cohesiveness being generated and said that the priorities for Public Health in Bracknell Forest were:

- health improvement
- tackling risky sexual behaviour
- reducing excessive drinking and smoking

The Public Health team would also be working towards health protection for example, dealing with concerns around a care home and they also had a mandate of responsibility to offer commissioning support to CCGs and inform commissioning decisions. The team would also work towards using levers such as housing and adult social care to improve public health.

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

- The new health structure was much more complex with numerous organisations responsible for numerous roles. In terms of overview, NHS England would be the organisation responsible for this function, where previously primary care trusts had undertaken this role. Quality Surveillance Groups would bring all organisations together to highlight quality risk and how these risks would be addressed. Local Clinical Leadership would also ensure that there was a drive towards improving quality continuously.
- Patients could choose which CCG commissioned services they wished to take up, however there would be some limitations. Dr Kittel acknowledged that the Memorandum of Understanding concerning services at Heatherwood Hospital was one such limitation, which was seen to be necessary so as not to destabilise the Trust. It was noted that it was crucial to include public participation groups at all stages to ensure the patient voice was heard.
- The advantages of localised commissioning would be that the performance of local providers would be well known and referrals would only be made by GPs to good quality providers. If good services were commissioned locally, local people would not choose to take up services elsewhere.
- NHS England would be leading a transparency of information campaign; outcome data on ten surgical processes would be published. It was noted that whilst data was important, so too was soft intelligence. The point was made that data could be interpreted differently as had happened at Leeds Hospital recently, careful evaluation work needed to be completed to avoid this.
- Dr Kittel reported that within 3-5 years there would be an opportunity to change provision offered at Brants Bridge. A number of IT issues needed to be overcome and developed to work towards achieving this.
- The issue of how complaints around commissioning would be dealt with needed to be established by the CCG. In terms of patient complaints, a national number for NHS complaints was due to be launched. In addition, NHS England would support and direct people.
- Dr Kittel advised that if individuals did have concerns around any NHS service, they should inform their GP. GP's used a network called 'Clinical Concerns' where they were able to report concerns raised, if a story began to emerge around a particular service area this would be investigated.

40. **Changes to the Vascular Services Pathway**

Dr Kittel reported that vascular services were for people with disorders of the arteries and veins excluding diseases of the heart and vessels in the chest. Evidence showed that if individuals were treated within an hour (the golden hour) of a vascular problem arising, this was likely to lead to a much better outcome for the patient. The longer the patient waited for treatment, the more likely it would be that the outcome would be less successful for the patient.

This clearly demonstrated that the travel time for patients to receive vascular treatment was critical. Wexham Park Hospital currently provided diagnostic day surgery and outpatient services for vascular conditions. The service did not however have enough clinicians to run a 24/365 emergency service and the use of locums often led to a decline in the quality of a service. Emergency and planned inpatient surgery on complex arterial conditions was currently carried out at the John Radcliffe Hospital in Oxford.

The clinical commissioning groups (CCG) in Windsor, Ascot and Maidenhead, Bracknell and Ascot and Slough had agreed collectively that they would like to review the complex emergency and planned surgery pathway. They had engaged with local providers of services to consider a proposal for future delivery of complex vascular care at Frimley Park as the main arterial centre. Whilst Frimley Park was a closer service than Oxford for the majority of East Berkshire patients, any changes to the pathway was likely to have implications for the sustainability of local vascular services and would need to be considered carefully, it was crucial not to destroy quality services currently provided locally.

CCGs could not commission vascular services as they were specialist services and as a result would be commissioned by NHS England; however the CCG could influence and negotiate decisions around the provision of these services.

In response to members' questions, Dr Kittel reported the rationale behind different clinical screening arrangements for males and females.

The Chairman thanked Dr Kittel for his presentation.

41. **Working Group Update**

The Head of Overview and Scrutiny reported that all three working groups that had been established in the work programme for 2012/13 had now concluded their work. The recommendation in the report proposed that a working group be established to consider the recommendations of the Francis report and specifically those recommendations that related to Overview and Scrutiny.

He reported that Francis had made some very critical comments about health scrutiny at both district and county mid Staffordshire Councils. He had sent members of the Panel a summary of the issues and deficiencies that existed in health scrutiny in mid Staffordshire.

Members felt that the findings were shocking and created a platform for radical change throughout the health service. 492 people had died unnecessarily, appalling failures were either not being reported to health scrutiny or were not being investigated.

The Panel noted that one of the recommendations from the Francis report advocated that health scrutiny should be considering detailed patient complaint information;

members were keen to carry out this recommendation. If this required confidential material to be discussed, this could be done by the Panel with the exclusion of the public and press. It was agreed that the working group consider how complaints could be best tackled by the Panel and make recommendations.

It was agreed that councillors Kensall, Mrs McCracken, Mrs Temperton, Baily, Virgo, Finch and Ms Wilson constitute a working group to consider the Francis report and its recommendations in terms of the role of health scrutiny. It was noted that patient groups should be involved in this work wherever appropriate.

The Head of Overview and Scrutiny agreed to provide GP Patient Survey results for all local practices for the next meeting of the Panel.

42. **'Shaping the Future' Consultation**

Alan Webb, Chief Officer for Bracknell & Ascot CCG reported that the Board of the NHS Berkshire PCT met on 26 March and agreed the following recommendations:

a) Enhance the service model so that the Minor Injuries Unit be integrated with primary care in an Urgent Care Centre (UCC). Subject to certain caveats, the UCC was to be located at the Brants Bridge NHS clinic. The Minor Injuries Unit at Heatherwood Hospital would then close.
b) To close Ward 8 at Heatherwood Hospital and replace it with the following range of services in east Berkshire:
    - Eight additional stroke rehabilitation beds at Wexham Park Hospital
    - An early supported discharge service for recovering stroke patients
    - Community based packages of care for general medical rehabilitation.
c) The Ascot Birth Centre at Heatherwood Hospital be permanently closed.

The Chief Officer reported that the UCC Implementation Group was now established, he would need to confirm that there was appropriate representation from local authorities on the Group.

It was hoped that the UCC would open early in 2014, however if there were any legal challenges to the recommendations agreed above, this could delay the opening of the UCC. There would be regular reports to Overview and Scrutiny as well as other committees and the CCG to inform them of progress on this.

In response to members' queries, it was confirmed that if there was a challenge to the closure of the MIU at Heatherwood Hospital, the development of the UCC would still continue, however there may be a number of issues to work around, as this would impact financial arrangements as it had been envisaged that the service would move from Heatherwood Hospital to Brants Bridge not be duplicated.

The Chief Officer acknowledged concerns about 'cost shunting' on stroke and general rehabilitation and stated that partners would need to work together jointly to ensure that funding of health services locally was maintained.

The Chief Officer recognised that communicating the purpose of the UCC to the public would be a large piece of work. Members reiterated that they strongly felt that there should be a constant GP presence at the UCC.

It was confirmed that physiotherapy services would continue to be delivered at Heatherwood Hospital, only the services that were the subject of consultation were being reviewed.

43. **Quality Accounts**

The Head of Overview and Scrutiny reported that each NHS Trust was required to produce a quality account. The Health Overview and Scrutiny Panel had the opportunity to comment on these accounts and if the Panel did comment, the Trust was obliged to publish comments. There were a number of statistics in the Heatherwood and Wexham Park Trust Quality counts which were of concern. For example:

- 52% of staff said that they would not recommend services provided by the Trust to friends and family, this did not compare favourably to the national average of 24%.
- The Trust also featured very high nationally in terms of their record of risk.
- Medication errors had risen from 121 to 433.

The Chairman stated that it was important that members read the Quality Accounts if they were to undertake appropriate scrutiny of these accounts. It was agreed that the Head of Overview and Scrutiny would resend the Quality Accounts to all members of the Panel as well as the associated draft letters.

Panel members should then forward any comments they wished to make to the Head of Overview and Scrutiny before the Trusts' deadline.

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

The Panel noted the Executive Key and Non-Key Decisions relating to health attached to the agenda papers.

45. **Date of Next Meeting**

11 July 2013

CHAIRMAN

TO: HEALTH OVERVIEW AND SCRUTINY PANEL
11 JULY 2013

SOUTH CENTRAL AMBULANCE SERVICE
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report invites the Health Overview and Scrutiny (O&S) Panel to receive updates on the South Central Ambulance Service NHS Foundation Trust's performance on two issues identified by the Panel as being of interest and concern.

2 RECOMMENDATION

That the Health Overview and Scrutiny Panel:

2.1 Reviews the South Central Ambulance Service's performance on

- **Out-of-hospital cardiac arrest survival rates; and**
- **Ambulance response times.**

3 SUPPORTING INFORMATION

3.1 The Health O&S Panel last reviewed the position on out-of-hospital cardiac arrest survival rates at its meeting on 27 September 2012, and decided to review progress six months later. The relevant extract from the minutes of that meeting are at Appendix 1.

3.2 Following concerns reported in the national press that South Central Ambulance emergency response times had fallen below target, the Panel Chairman decided that this opportunity should also be taken to review the position on response times.

3.3 South Central Ambulance Service's most recently published 'Integrated Performance Report' for the period ending April 2013 covers both these aspects of performance and is attached at Appendix 2. The principal pages are 2, 7 and 9, but the complete report is attached as other pages refer to factors bearing on response times.

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

Contact for further information

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Appendix 1

HEALTH OVERVIEW AND SCRUTINY PANEL
27 SEPTEMBER 2012

Cardiac Arrest Survival Rates

John Black, Medical Director of the South Central Ambulance Service (SCAS), and Steve West, Operations Director North attended the meeting to comment on the Trust's performance on out-of-hospital cardiac arrest survival rates.

Data collection for the SCAS in the South East had been more recent than data collection in London and was expected to improve in the future. One in three patients were taken to hospital with a pulse after a cardiac arrest, which was an improvement on the earlier position. Survival rates in relation to out-of-hospital cardiac arrests were expected to be better in the South East when compared to other regions of the country.

There was a focus on achieving best clinical outcomes and all ambulance crews had received refresher training on new devices and clinical systems. The aim was to despatch ambulances more quickly and community responder teams were being developed. Work was being undertaken with sports teams and there was close working with clinical colleagues. Quality of care in hospitals and direct access to cardiac care was important.

There were challenges regarding information sharing, and there was an indicator for the whole health system in relation to discharges. There was an aim to have an emergency care team at SCAS to assist in improving survival rates for patients.

In response to Members' questions, the following points were made:
• Ambulance services were required by national standards to respond to calls in 8 minutes, and the SCAS responded to 78% of calls in 8 minutes.
• Questions asked from the control room at SCAS did not delay the despatch of an ambulance. The location of a call was confirmed at the same time as questions were asked. Around 95% of calls were answered within 10 seconds and maximum response times were also monitored. SCAS was a national leader in ambulance response times. The control room could advise members of the public or relatives who were with a person who had a cardiac arrest on how to deal with the situation; initial actions by people did help.
• There had been approximately a 6% increase in the number of calls to the call centres which had been amalgamated into one main call centre, and an 8% increase in calls in Berkshire. This had started in February 2012 and was mainly occurring in the evenings and on weekends, and was putting pressure on resources.
• The transfer of staff from Wokingham to Bicester had been seamless and there was now an increased number of staff. Previous call handling had not been as quick but work was being undertaken to improve this and the team of call handlers had been increased to twenty people. Calls were now being answered in approximately 10 seconds. Some staff were redeployed to places other than Bicester. There was a knowledge gap once the merger of call centres had been undertaken and performance had been challenged over the summer months but this had improved now and staff were responding well to the change.
• Capability to progress calls for urgent cases or people requiring community care was being addressed.
• London was a different area to the South East and there was rapid access to defibrillators in many locations in London which made a difference to cardiac arrest survival rates.
• Better quality data was expected in future; just two months of reliable data had been received from hospitals and the way percentages were calculated could make survival rate data look inflated.

• Training was offered to members of the public who wanted to be community responders and ambulance control rooms could instruct people on how to use defibrillators. Signposting to these kits was also important and tracking the location of semi-automatic defibrillators.
• SCAS worked with some 1,400 volunteer Community Responders, and training was refreshed every three months. Anyone interested in becoming a community responder should contact SCAS and they would be put in contact with a local community responder team. Community responder teams were funded by different means including the local community, British Heart Foundation, and public funding. A link would possibly be made with Parish Councils.
• Data was collected using a paper based system which paramedics handed over to hospital staff on arrival to hospital with a patient. Care pathways were well developed and hospital staff used data from electronic systems. The aimwas for there to be electronic links to enable data to be sought directly from hospitals.
• The Department of Health published in May the information from the data collected in relation to cardiac arrest survival rates and this could be shared with members of the Panel.
• There were eleven Ambulance Trusts nationally and clinical indicators were being developed. The aim was to identify good practice and share it.
• There was a national digital system called ‘Airwave’. The next system of digital radio was being jointly procured by the Fire, Police and Ambulance Services.
• Mr Black thanked Bracknell Forest Council for its support towards, for example, the Chiltern Air Ambulance Service.

The Chairman thanked Mr Black and Mr West for appearing before the Panel, and indicated that the Panel may wish to review progress on cardiac arrest survival rates in around six months time.

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Integrated Performance Report
Report Period: April 2013

Overall Scorecard

Red > 30% Red scores, Green > 70% Green and <10% Reds (but no key indicators), Amber - rest
(Key indicators are: national standards, financial risk rating, overall FRR, SIRI's and Never Events).

	RAG	Vs. last month	R	A	G	Lead Director	Assessment of Risk
Monitor - financial rating	G	→	n/a	n/a	n/a	Will Hancock	G
Monitor - governance rating	G	→	n/a	n/a	n/a	Will Hancock	G
Clinical Performance	A	→	20%	30%	50%	John Black	A
National Standards	G	↑	0%	0%	100%	Will Hancock	G
Operational performance	A	↑	15%	15%	69%	Will Hancock	A
Safety and risk management	A	→	21%	0%	79%	Debbie Marrs	A
Patient Experience	R	↓	33%	0%	67%	Debbie Marrs	R
111	A	→	22%	11%	67%	John Nichols	A
Finance	G	→	0%	0%	100%	Charles Porter	G
QIPP's (cost improvements)	R	↓	33%	0%	67%	Charles Porter	R
QIPP's (quality impact)	A	→	4%	77%	19%	Debbie Marrs	A
Human Resources	R	↓	43%	17%	39%	Will Hancock	R

Overall Commentary:

The first month of the year has been challenging in a number of respects: activity remains high (10% up on the same period last year for the 999 service) and hospital delays are 40% higher than last year. In response to this SCAS has increased its operational resources and has exceeded its response time targets for the month for Red 1, Red 2 and Red 19 whilst delivering its financial targets. There have been a number of unfavourable consequences of operating in this high pressure environment - long waits, complaints and sickess are higher than plan and require continued management action to bring back on track.

The 111 service has continued to improve operationally and the Berks area went live on a limited basis in the month.

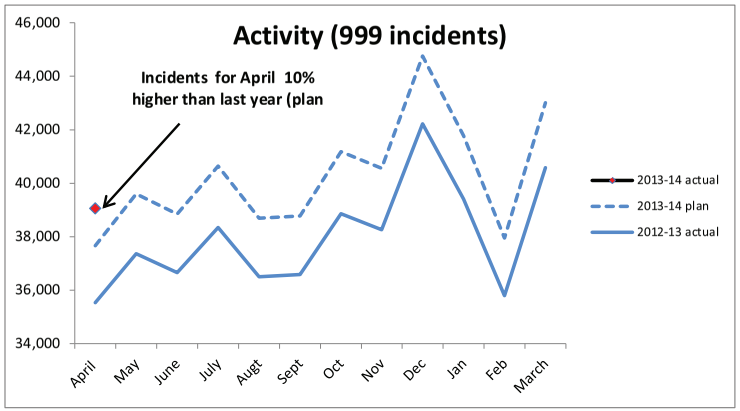
The following areas are rated Red in this month's report and they are commented on as follows:

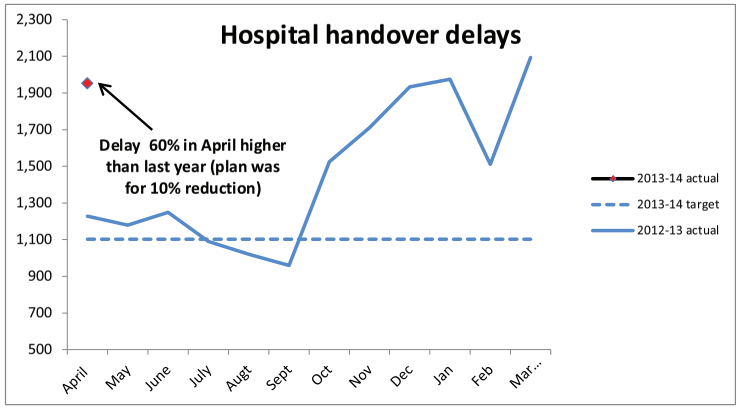
Patient experience – rated red due to the level of complaints. Complaints began to rise in Dec 12 and have remained at a higher level than last year since. Increased incidents/activity may result in increased complaints and thematic analysis shows that patients complain mostly about attitude and delays. Detailed work is being instigated to audit delays and a review of all other complaints to extract real learning and by area. Two further Patient Experience Officers were

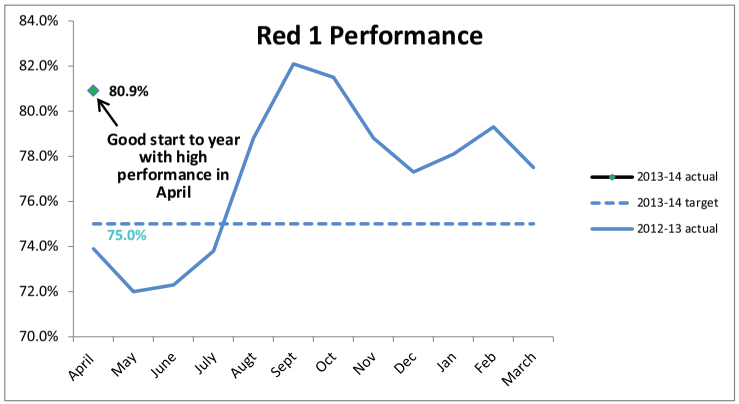
QIPP's - the cost imporvement programme is behind plan due to a number of delays in the A&E and 111 areas (savings are £84k behind the budget of £289k). The principal issues are as follows:

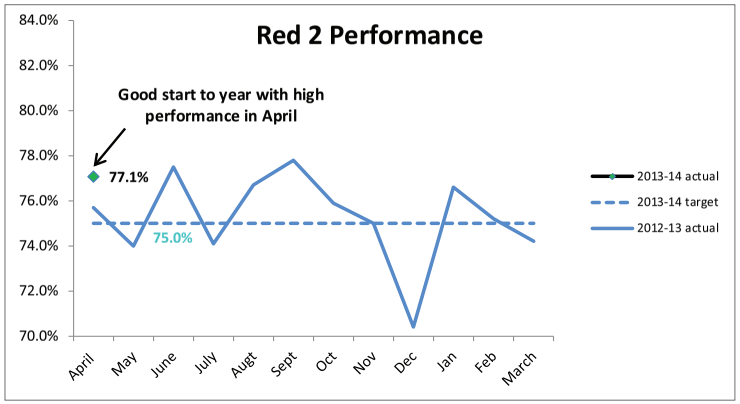
- Nationally, the ambulance unions have challenged the elimination of unsocial payments during periods of sickness. This has caused a delay in the implementation of this policy;
- Sickness remained close to last year's level - although some areas did improve, this was offset by deterioration in other areas;
- The mix of Hear &Treat and See & Treat has not improved as targeted despite using GP's in the EOC.

Human Resources – sickness is higher than plan and appraisals are also behind. A numbers of the plans in this area are still being finalised in order to get this area back on track.


Activity (999 incidents)
Incidents for April 10% higher than last year (plan
46,000
44,000
42,000
40,000
38,000
36,000
34,000
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March
2013-14 actual
2013-14 plan
2012-13 actual


Hospital handover delays
Delay 60% in April higher than last year (plan was for 10% reduction)
2,300
2,100
1,900
1,700
1,500
1,300
1,100
900
700
500
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
Mar...
2013-14 actual
2013-14 target
2012-13 actual


Red 1 Performance
80.9%
Good start to year with high performance in April
75.0%
84.0%
82.0%
80.0%
78.0%
76.0%
74.0%
72.0%
70.0%
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March
2013-14 actual
2013-14 target
2012-13 actual


Red 2 Performance
Good start to year with high performance in April
77.1%
75.0%
84.0%
82.0%
80.0%
78.0%
76.0%
74.0%
72.0%
70.0%
April
May
June
July
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Sept
Oct
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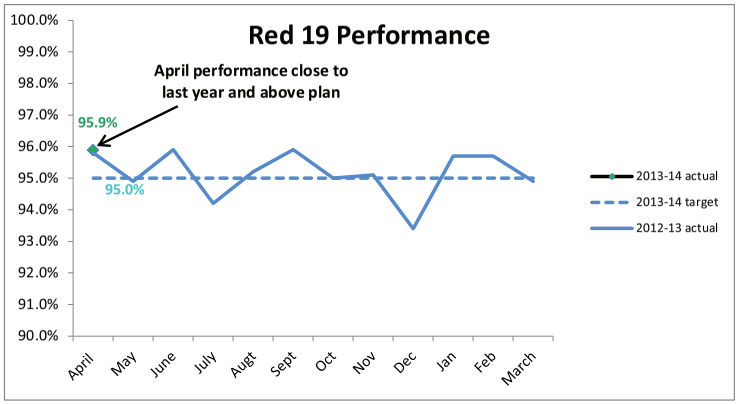
Jan
Feb
March
2013-14 actual
2013-14 target
2012-13 actual


Red 19 Performance
April performance close to last year and above plan
95.9%
95.0%
100.0%
99.0%
98.0%
97.0%
96.0%
95.0%
94.0%
93.0%
92.0%
91.0%
90.0%
April
May
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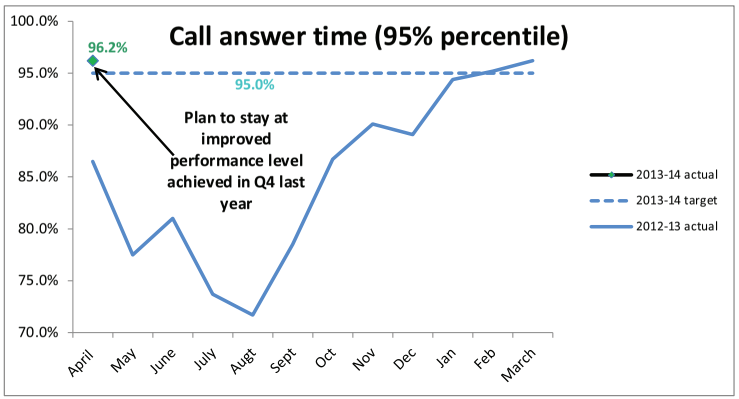
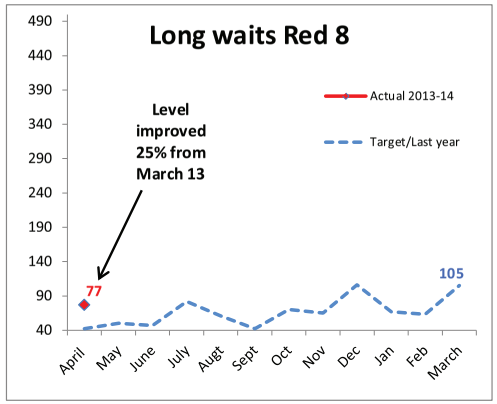
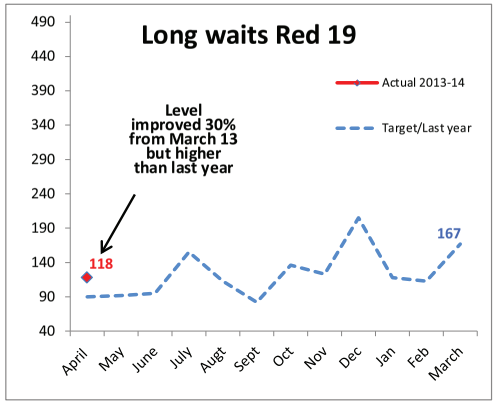
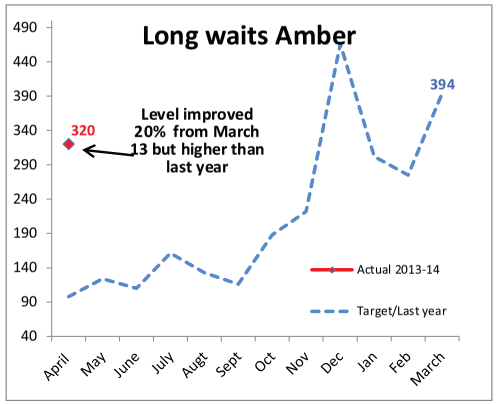
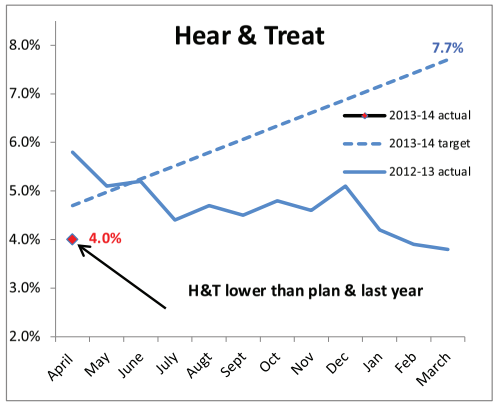
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March
2013-14 actual
2013-14 target
2012-13 actual

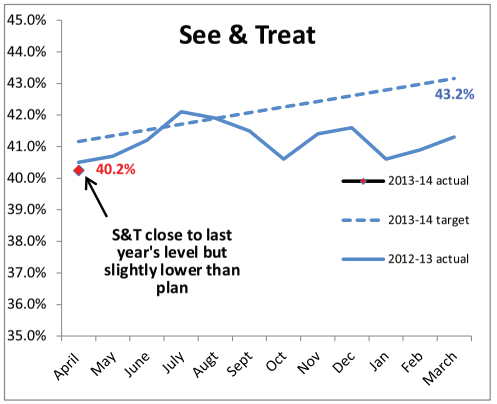

Call answer time (95% percentile)
96.2%
95.0%
Plan to stay at improved performance level achieved in Q4 last year
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March
2013-14 actual
2013-14 target
2012-13 actual

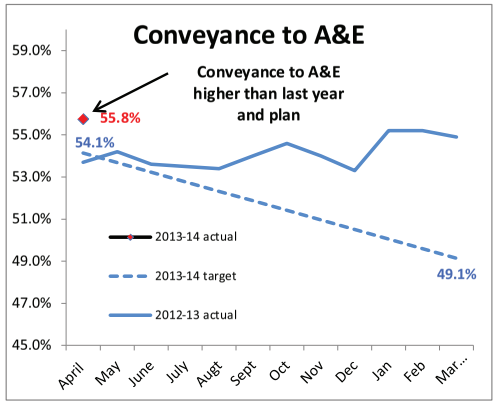

Long waits Red 8
Level improved 25% from March 13
Actual 2013-14
Target/Last year
77
105
490
440
390
340
290
240
190
140
90
40
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March

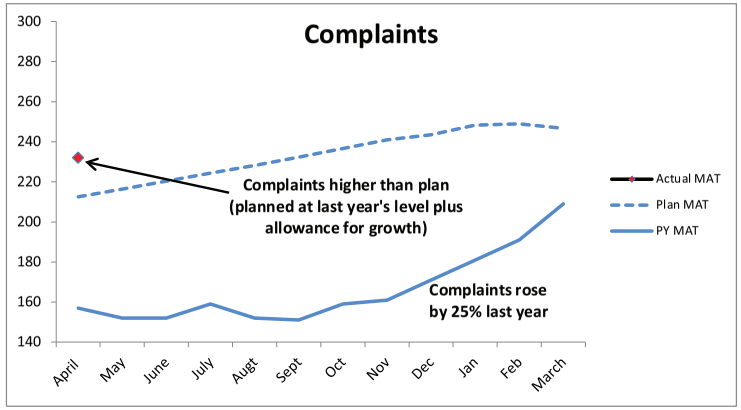

Long waits Red 19
Level improved 30% from March 13 but higher than last year
Actual 2013-14
Target/Last year
118
167
490
440
390
340
290
240
190
140
90
40
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March

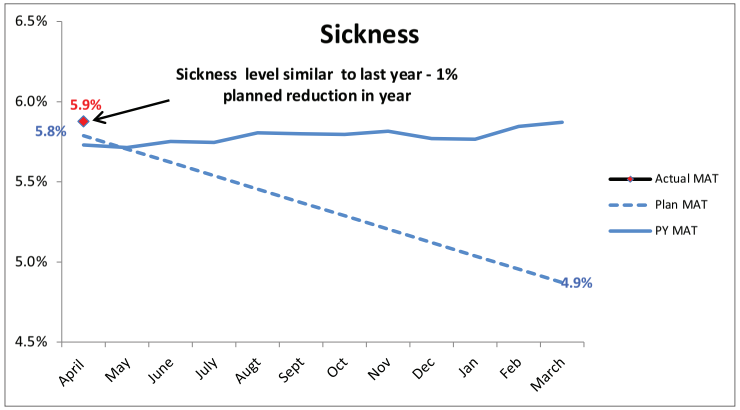

Long waits Amber
Level improved 20% from March 13 but higher than last year
320
394
Actual 2013-14
Target/Last year
490
440
390
340
290
240
190
140
90
40
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March


Hear & Treat
7.7%
4.0%
H&T lower than plan & last year
2013-14 actual
2013-14 target
2012-13 actual
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March


See & Treat
43.2%
40.2%
S&T close to last year's level but slightly lower than plan
2013-14 actual
2013-14 target
2012-13 actual
45.0%
44.0%
43.0%
42.0%
41.0%
40.0%
39.0%
38.0%
37.0%
36.0%
35.0%
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March


Conveyance to A&E
Conveyance to A&E higher than last year and plan
55.8%
54.1%
49.1%
2013-14 actual
2013-14 target
2012-13 actual
59.0%
57.0%
55.0%
53.0%
51.0%
49.0%
47.0%
45.0%
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
Mar...


Complaints
Complaints higher than plan (planned at last year's level plus allowance for growth)
Complaints rose by 25% last year
Actual MAT
Plan MAT
PY MAT
300
280
260
240
220
200
180
160
140
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March


Sickness
Sickness level similar to last year - 1% planned reduction in year
5.9%
5.8%
4.9%
Actual MAT
Plan MAT
PY MAT
6.5%
6.0%
5.5%
5.0%
4.5%
April
May
June
July
Augt
Sept
Oct
Nov
Dec
Jan
Feb
March

Monitor rating

Lead Director: Will Hancock

Financial indicators

Measure	2012-13 - reported				2013-14			
	Actual Q1	Actual Q2	Actual Q3	Actual Q4	Forecast Q1	Forecast Q2	Forecast Q3	Forecast Q4
Financial risk rating	3	3	3	4	4	4	4	4
Forward Financial Risk Indicators (non-compliance out of 10 indicators)	3	1	1	0	0	0	0	0

Commentary:

Financial ratings met target last year with only minimal adverse risk indicators during year (aged debtors higher than target and capital expenditure behind plan). All target should be met in 2013-14.

Governance indicators

Measure	2012-13 - reported				2013-14			
	Actual Q1	Actual Q2	Actual Q3	Actual Q4	Forecast Q1	Forecast Q2	Forecast Q3	Forecast Q4
Red 1	75.6%	78.5%	79.2%	78.3%	75.5%	75.5%	75.0%	75.5%
Red 2	75.6%	76.2%	73.9%	75.3%	75.5%	75.5%	75.0%	75.5%
Red 19	95.2%	95.1%	94.5%	95.5%	95.5%	95.5%	95.0%	95.5%
Failure to comply with requirements regarding access to healthcare for people with a learning disability	Yes	No	No	No	No	No	No	No
Risk of, or actual, failure to deliver mandatory services	No	No	No	No	No	No	No	No
CQC compliance action outstanding (as at 31 Mar 2013)	No	No	Yes	Yes	No	No	No	No
CQC enforcement action within last 12 months (up to 31 Mar 2013)	No	No	No	No	No	No	No	No
CQC enforcement notice currently in effect (as at 31 Mar 2013)	No	No	No	No	No	No	No	No
Minor CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Mar 2013)	No	No	Yes	Yes	No	No	No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Mar 2013)	No	No	No	No	No	No	No	No
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Mar 2013)	No	No	No	No	No	No	No	No
Unable to maintain, or certify, a minimum published CNST level of	No	No	No	No	No	No	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	No	No	No	No	No	No	No	No
Has the Trust has been inspected by CQC	No	No	Yes	No	Yes	No	No	No
If so, did the CQC inspection find non compliance with 1 or more essential standards	Not relevant	Not relevant	Yes	No	No	No	No	No
Overall governance rating	**Green**	**Green**	**Amber-Green**	**Green**	**Green**	**Green**	**Green**	**Green**

Commentary:

Green ratings met thoughout 2012-13 with the exception Q3 (Oct to Dec) due to performance issues arising from high winter demand and items raised in CQC visit. Q4 is expected / provisional. All CQC items are planned to be resolved during 2013-14. We would expect a further CQC visit in this first quarter (although these are unannounced and can not be planned for) which would close any outstanding items.

Clinical performance

Overall rating A

Red > 30% Red scores, Green > 70% Green and <10% Reds (but no key indicators), Amber - rest

Lead Director: John Black

National Clinical Indicators

Measure (nationally submitted data to December 2012, year to date is 9 months to Dec 12)	Apr-13			Year to date			Full year			SCAS ranking	National average	Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	Out of 12 English ambulance services		
STEMI care bundle	67.9%	69.3%	A	68.5%	69.3%	A	77.5%	77.5%	G	11th	77.6%	The administration of analgesia is being reviewed and the new pain ladder is due to be released advising that Entonox and/or Morphine is administered for STEMI patients.
Stroke care bundle	97.9%	95.0%	G	97.0%	95.0%	G	97.0%	95.0%	G	3rd	95.6%	No Comment Required
% STEMI with PPCI to treatment in 150 min	90.5%	88.0%	G	89.9%	88.0%	G	90.0%	88.0%	G	4th	88.1%	No Comment Required
% FAST patients to centre in 60 min	45.4%	49.5%	A	49.0%	49.5%	A	55.0%	55.0%	A	10th	63.6%	A multi team review and root cause analyses is being undertaken involving the Executive team to identify the pinch points to achieving the target.
% patients with return of spont's circul'n by hospital arrive (ROSC)-(nationally submitted data for period Dec 2012)	33.00%	25.0%	G	35.80%	25.0%	G	36.0%	25.0%	G	1st	25.3%	No Comment Required
% patients with return of spont's circul'n by hospital arrive (ROSC) - witnessed cardiac arrest (nationally submitted data for period Dec 2012)	38.5%	47.0%	R	49.5%	47.0%	G	49.5%	47.0%	G	4th	46.9%	No Comment Required
Cardiac Arrest: % discharged alive following ambulance resus'n (nationally submitted data for period Dec 2012)	13.0%	7.5%	G	15.0%	7.5%	G	15%	7.5%	G	1st	7.8%	No Comment Required
Cardiac Arrest: % discharged alive following ambulance resus'n - witnessed cardiac arrest (nationally submitted data for period Dec 2012)	22.2%	22.0%	G	20.7%	22.0%	A	22%	22.0%	G	7th	21.8%	The year to date performance has been affected by November's poor performance (10%). This indicator is quite variable due to small sample size (10-15 each month) so a variation in outcome of one case can move the stats by 50%.

Other clinical indicators

Measure (care bundles are part of National Clinical Performance Indicators data gathering)	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Hypoglycaemia care bundle	94.0%	95.8%	A	94.0%	95.8%	A	95.8%	95.8%	G	The recording of a second blood glucose dropped to 96%
Asthma care bundle	74.0%	76.7%	A	74.0%	76.7%	A	76.7%	76.7%	G	Peak expiratory flow rate has reduced to 86% in April
Limb fractures care bundle	64.0%	40.4%	G	64.0%	40.4%	G	40.4%	40.4%	G	No comment required
Febrile convulsion care bundle	n/a	50.0%	n/a	n/a	50.0%	n/a	50.0%	50.0%	G	No febrile convulsant patient were treated in April
% FAST patients call to leave scene 39 min	48.1%	56.5%	R	48.1%	56.5%	R	48.1%	56.5%	R	A multi team review and root cause analyses is being undertaken involving the Executive team to identify the pinch points to achieving the target.
% STEMI with PPCI to centre in 80 min	91.0%	75.0%	G	91.0%	75.0%	G	75.0%	75.0%	G	No Comment Required

Safeguarding

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Number of adult referrals - this relates to vulnerable adults who may be at risk from abuse or neglect	142	158	G	142	158	G		1,900	n/a	No comment required
Number of child referrals - this relates to children who may be at risk of abuse or neglect	29	35	G	29	35	G		420	n/a	No comment required

Hygiene & infection prevention & control

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Vehicle deep cleans: average frequency per ambulance in weeks	8	6	R	8	6	R	6	6	G	Access to vehicles cntinues to be an issue and the interval between cleans is longer than planned. Work with our suppliers and operational continues to resolve this issue.
Vehicle routine cleans: average frequency per ambulance in days	2	1	R	2	1	R	1	1	G	
Number of cleanliness compliance audits*	51	54	A	51	54	A	648	648	G	Failure to complete required amount of audits reported to interim Director of Ops and Heads of Ops (John Nichols, Mark Ainsworth and Paul Jefferies). Action plan for compliance requested from Area Managers.

Medicines management

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Number of adverse events due to administration errors*	2	1	R	2	1	R	12	12	G	In both cases the patient and or family was aware of the error. In one case the patient was kept in overnight for observation following an overdose of adrenaline for anaphylaxis.
Number of controlled drug incidents*	3	3	G	3	3	G	36	36	G	No comment required

* These items are also reported in the quality accounts

Operational performance

Overall rating (national - Red8 & Red19) G **Overall rating (other)** A

Red > 30% Red scores, Green > 70% Green and <10% Reds (but no key indicators), Amber - rest

Performance Pressures

Lead Director: Will Hancock

Demand Measures	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Incidents	9.6%	6.0%	n/a	9.6%	6.0%	n/a	9.6%	6.0%	n/a	Large increase in first half of month due to 111 (11.5%), moving back close to plan levels in second half (7%).
Calls	7.6%	6.0%	n/a	7.6%	6.0%	n/a	?	6.0%	n/a	As above
Hospital delays										
- Total handover delays over 15 minutes (hours)	1,952	1,103	R	1,952	1,103	R	13,235	13,235	G	Delays 60% higher than Apirl last year. The acute penalties have resulted in greater focus on data quality and actions to reduce waits.
- Total clear-up delays (hours)	453	363	R	453	363	R	4,355	4,355	G	This is subject to further investigation.

National indicators

Performance Measure	Apr-13			Year to date			Full year			SCAS ranking (March - April not yet available for)	National average	Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	Out of 12 English ambulance services	Year to date	
Call connect to call answer (min:sec) - 50th percentile	00:01	00:02	G	00:01	00:02	G	00:02	00:02	G	=2nd	00:01	Ranking based on last month as
Call connect to call answer (min:sec) - 95th percentile	00:05	00:05	G	00:05	00:05	G	00:05	00:05	G	4th	00:19	No Comment Required
Call connect to call answer (min:sec) - 99th percentile	00:39	00:42	G	00:39	00:42	G	00:42	00:42	G	4th	01:02	No Comment Required
% calls abandoned	0.2%	1.5%	G	0.2%	1.5%	G	1.5%	1.5%	G	=2nd	1.45%	No Comment Required
Red 1 A8: % on scene within 8 minutes	80.9%	75.0%	G	80.9%	75.0%	G	75.0%	75.0%	G	4th	74%	No Comment Required
Red 2 A8: % on scene within 8 minutes	77.1%	75.0%	G	77.1%	75.0%	G	75.0%	75.0%	G	6th	75.60%	No Comment Required
Red A19: % conveying response within 19 minutes	95.9%	95.0%	G	95.9%	95.0%	G	95.0%	95.0%	G	6th	96%	No Comment Required
Red 1 A8 on scene within 8 minutes : 95th percentile (mm: ss)	13:06	14:44	G	13:06	14:44	G	14:44	14:44	G	7th	14:14	No Comment Required
Time to Treat - 50th percentile (min:sec)	05:53	06:05	G	05:53	06:05	G	05:53	06:05	G	8th	05:45	No Comment Required
Time to Treat - 95th percentile (min:sec)	17:48	18:48	G	17:48	18:48	G	17:48	18:48	G	7th	17:06	No Comment Required
Time to Treat - 99th percentile (min:sec)	30:38	32:29	G	30:38	32:29	G	30:38	32:29	G	9th	27:53	No Comment Required
% calls from frequent callers	11.66%	n/a	n/a	11.66%	n/a	n/a	n/a	n/a	n/a	12th	1.10%	Ranking looks poor for this indicator which may be use to consistency of definition used between ambulance services
% calls with telephone advice only (Hear & Treat)	4.0%	4.7%	R	4.0%	4.7%	R	7.4%	7.7%	A	=11th	6.00%	Hear & Treat lower than plan - further review to improve this through productivity focus is underway
% resolved without convey to Type 1/2 A&E	41.3%	41.2%	G	41.3%	41.2%	G	43.0%	43.2%	A	5th	35.10%	No Comment Required
% Hear & Treat re-contacts in 24 hours	20.4%	18.2%	A	20.4%	18.2%	A	13.5%	13.0%	A	10th	13.00%	This area is being reviewed to determine the root cause and take action to address
% See & Treat re-contacts in 24 hours	6.9%	6.9%	A	6.9%	6.9%	R	6.3%	6.2%	A	10th	6.20%	

Other indicators	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Amber 20: % response within 20 minutes	83.6%	90.0%	A	83.6%	90.0%	A	83.6%	90.0%	A	Based upon clinical risk, deployment focus has been on Red calls. Delays at hospital impact upon ability to respond to Amber 20 calls.
Green 60: response within 60 minutes	93.3%	n/a	n/a	93.3%	n/a	n/a	93.3%	n/a	n/a	No comment requried
% conveyed to Type 1/2 A&E	56.2%	54.1%	n/a	56.2%	54.1%	n/a	56.2%	49.1%	G	No comment requried
Efficiency indicators										
Frontline resources (rota hours per week)	40,821	38,810	A	40,821	38,810	A	41,466	39,491	A	5% more hours for 10% higher activity
VOR - scheduled maintenance	2.0%	4.0%	G	2.0%	4.0%	G	3.0%	4.0%	G	No Comment Required
VOR - unscheduled	22.0%	20.0%	A	22.0%	20.0%	A	18.0%	18.0%	G	No Comment Required

A&E Performance by CCG Cluster (CCG performance in Appendix 1)

Performance Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Red 1										
Thames Valley Cluster	81.1%	75.0%	G	81.1%	75.0%	G	75.0%	75.0%	G	No Comment Required
Hampshire & MK Cluster	81.7%	75.0%	G	81.7%	75.0%	G	75.0%	75.0%	G	No Comment Required
Red 2										
Thames Valley Cluster	77.8%	75.0%	G	77.8%	75.0%	G	75.0%	75.0%	G	No Comment Required
Hampshire & MK Cluster	77.6%	75.0%	G	77.6%	75.0%	G	75.0%	75.0%	G	No Comment Required
Red A19										
Thames Valley Cluster	96.9%	95.0%	G	96.9%	95.0%	G	95.0%	95.0%	G	No Comment Required
Hampshire & MK Cluster	95.3%	95.0%	G	95.3%	95.0%	G	95.0%	95.0%	G	No Comment Required

Safety and Risk Management

Overall rating A *Red > 30% Red scores, Green > 70% Green and <10% Reds (but no key indicators), Amber - rest*

Patient Safety

Lead director: Debbie Marrs

Patient Safety Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Number of IR1s (this is the internal form to report incidents in SCAS - this covers all types of incident - accidents, injuries, missing equipment etc)	253	220	n/a	253	220	n/a	3036	2644	n/a	Increased reporting viewed as postive feedback from staff. Emerging themes monitored through H&S committee
Number of incidents reported to the NPSA (CQC/NPSA reportable)	20	20	G	20	20	G	240	240	G	No Comment Required
% of incidents reported to the NPSA within 30 days	100%	100%	G	100%	100%	G	100%	100%	G	No Comment Required
Number of Serious Incidents Requiring Investigation (SIRI) reported	2	2	G	2	2	G	20	20	G	No Comment Required
Number of SIRI investigations outstanding after 60 days (excluding events that are officially suspended)	14%	25%	G	14%	25%	G	25%	25%	G	Outstanding information required to close 2 investigations. Monitored through SIRI group
Number of Never Events (CQC/NPSA reportable)	0	0	G	0	0	G	0	0	G	No Comment Required
Clinical negligent claims (CNST)	0	1	G	0	0	G	0	6	G	No Comment Required
Public liability claims	1	1	G	1	1	G	1	12	G	No Comment Required
Long waits (Red 8)* - over 30 minutes	77	42	R	77	42	R	800	800	G	The root cause of this is being investigated to understand why waits are so high despite the good performance. The plan numbers are last year's out-turn which showed rising long waits during the year.
Long waits (Red 19)* - over 30 minutes	118	90	R	118	90	R	1489	1489	G	
Long waits (Amber)* - over one hour	320	98	R	320	98	R	2589	2589	G	

Staff Safety

Staff Safety Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Number of RIDDOR reports (HSE reportable)	2	5	G	2	5	G	56	56	G	No Comment Required
Number of Physical Assaults (NHS Protect reportable)	5	6	G	5	6	G	68	68	G	No Comment Required
Number of Non-Physical Assaults (NHS Protect reportable)	9	14	G	2	14	G	162	162	G	No Comment Required
Number of Security Incidents (NHS Protect reportable)	5	5	G	5	5	G	64	64	G	No Comment Required

* These items are reported in the quality accounts as well

Patient Experience

Overall rating R *Red > 30% Red scores, Green > 70% Green and <10% Reds (but no key indicators), Amber - re*

Complaints

Lead Director: Debbie Marrs

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
- A&E frontline	17	9	R	17	9	R	204	111	R	Complaints have risen on last year's figures. Analysis underway to identify themes/areas.
- A&E EOC and CSD	6	5	R	6	5	R	72	61	R	Complaints have risen on last year's figures. Analysis underway to identify themes/areas.
- PTS	1	3	G	1	3	G	12	31	G	No comment required
- 111 Service	5	3	R	5	3	R	39	39	G	Plan based on last year uplifted for higher volume. Complaints levels for this service still being understood for this new service.
- Other	0	0	G	0	0	G	4	4	G	No comment required
Total	29	21	R	29	21	R	331	247	R	Complaints have risen on last year's figures. Analysis underway to identify themes/areas.

Complaints responded to within 25 days target (Data relates to March 13)	37%	95%	R	37%	95%	R	95%	95%	G	Although March significantly lower than expected; overall position for last year was 73%; delay in return of investigations and shortage of staff in PE Team having a considerable negative impact. 2 new PSOs appointed and in post on 13 May will improve position and work will continue with relevant managers to encourage return of investigations in a timely manner

Compliments

Measure	Apr-13			Year to date			Full year			
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Compliments	No.	No.		No.	No.		No.	No.		
Total	95	61	G	95	61	G	1,140	726	G	No comment required

Surveys

Outcome of surveys	Apr-13 Actual	Apr-13 Plan	Apr-13 RAG	Year to date Actual	Year to date Plan	Year to date RAG	Full Year Forecast	Full Year Plan	Full Year RAG	
A&E frontline - no. of surveys	1	0	G	1	0	G	1	1	G	Survey Plan to be agreed at PERG in June 2013. Front line survey completed.
- satisfaction level	tba	75%	n/a	tba	75%	n/a	tba	75%	n/a	Results still being analysed.
A&E EOC - no. of surveys	0	0	G	0	0	G	1	1	G	No comment required
- satisfaction level	n/a	n/a	n/a	n/a	n/a	n/a	tba	75%	n/a	No comment required
PTS - no. of surveys	0	0	G	0	0	G	5	5	G	No comment required
- satisfaction level	n/a	n/a	n/a	n/a	n/a	n/a	tba	75%	n/a	No comment required
Other - no. of surveys	0	0	G	0	0	G	3	3	G	No comment required
- satisfaction level	n/a	n/a	n/a	n/a	n/a	n/a	tba	75%	n/a	No comment required
Total SCAS - no. of surveys	**1**	**0**	G	**1**	**0**	G	**10**	**10**	G	No comment required
- satisfaction level	n/a	n/a	n/a	n/a	n/a	n/a	**tba**	**75%**	n/a	No comment required

Requests for Information

Measure	Apr-13 Actual	Apr-13 Plan	Apr-13 RAG	Year to date Actual	Year to date Plan	Year to date RAG	Forecast Forecast (last month)	Forecast Plan	Forecast RAG	
Requests responses within timescales										
FOI (Freedom of Information Act)	100%	100%	G	100%	100%	G	100%	100%	G	No comment required
Data protection Act (DPA) - police, solicitor/medical, subject access	100%	100%	G	100%	100%	G	100%	100%	G	No comment required

111 **111 rating** **A**

Red > 30% Red scores, Green > 70% Green and <10% Reds (but no key indicators), Amber - rest

111 Measures

Lead Director: John Nichols

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast (last month)	Plan	RAG	
Oxford :										
Calls (no. answered)	17,417	16,188	G	17,661	16,188	G	175,000	175,000	G	No Comment Required
Call Answering (% within 60 seconds)	90.7%	95%	A	90.8%	95%	A	95.0%	95%	G	Improvement plan in place
999 referrals (%)	6.6%	10%	G	8.7%	10%	G	9.0%	10%	G	No Comment Required
Calls Abandoned (target <5%)	2.5%	5%	G	2.9%	5%	G	3.0%	5%	G	No Comment Required
Warm transfers (clinician %)	19.0%	20%	G	19.0%	20%	G	19.0%	20%	G	No Comment Required
Time taken for call back (% < 10 mins - target 95%)	98.5%	95%	G	98.5%	95%	G	98.5%	95%	G	No Comment Required

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast (last month)	Plan	RAG	
Hampshire :										
Calls (no.)	38,066	39,000	A	38,066	39,000	A	508,000	508,000	G	Slow pick up of 111 across SHP - Call profiles continually under review.
Call Answering (% within 60 seconds)	84.6%	95%	R	84.6%	95%	R	95.0%	95%	G	Improvement plan in place and agreed with commissioners
999 referrals (%)	5.7%	10%	G	5.7%	10%	G	6.0%	10%	G	No Comment Required
Calls Abandoned (target <5%)	4.1%	5%	G	4.1%	5%	G	5.0%	5%	G	No Comment Required
Warm transfers (clinician %)	24.3%	20%	R	24.3%	20%	R	20.0%	20%	G	Action plan in place to reduce - linked with increasing experience of call takers
Time taken for call back (% < 10 mins - target 95%)	98.8%	95%	G	98.8%	95%	G	95.0%	95%	G	No Comment Required

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast (last month)	Plan	RAG	
Berkshire:										
Calls (no.)	1,438	17,776	R	1,438	17,776	R	256,904	256,904	G	Delayed and phased introduction of 111 across Berkshire - Commissioner decision
Call Answering (% within 60 seconds)	95.1%	95%	G	95.1%	95%	G	95.0%	95%	G	No Comment Required
999 referrals (%)	7.2%	10%	G	7.2%	10%	G	10.0%	10%	G	No Comment Required
Calls Abandoned (target <5%)	1.0%	5%	G	1.0%	5%	G	5.0%	5%	G	No Comment Required
Warm transfers (clinician %)	30.8%	20%	R	30.8%	20%	R	20.0%	20%	G	Action plan in place to reduce - linked with increasing experience of call takers
Time taken for call back (% < 10 mins - target 95%)	97.4%	95%	G	97.4%	95%	G	95.0%	95%	G	No Comment Required

Finance

Finance rating: G | QIPP rating: R

Lead Director: Charles Porter

Monitor Financial Risk Rating

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
EBITDA margin rating	3	3	G	3	3	G	3	3	G	No Comment Required
EBITDA % of plan achieved rating	3	3	G	3	3	G	3	3	G	No Comment Required
Financial efficiency rating	3	3	G	3	3	G	3	3	G	No Comment Required
Liquidity rating	4	4	G	4	4	G	4	4	G	No Comment Required
Weighted average rating	**4**	**4**	G	**4**	**4**	G	**4**	**4**	G	No Comment Required

Monitor Continuity of Service Risk Rating (in shadow)

Measure	Apr-13			Year to date			Full year			*Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)*
	Actual	*Plan*	*RAG*	*Actual*	*Plan*	*RAG*	*Forecast*	*Plan*	*RAG*	
Debt service cover rating	*4*	*4*	*G*	*4*	*4*	*G*	*4*	*4*	*G*	No Comment Required
Liquidity Rating	*4*	*4*	*G*	*4*	*4*	*G*	*4*	*4*	*G*	No Comment Required
Continuity of Service Risk Rating	**4**	**4**	G	**4**	**4**	G	**4**	**4**	G	No Comment Required

Monitor Forward Financial Risk Ratings

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Unplanned EBITDA variance for 2 Q's	No	No	G	No	No	G	No	No	G	No Comment Required
FRR forecast variance < 3	No	No	G	No	No	G	No	No	G	No Comment Required
FRR 2 in any quarter	No	No	G	No	No	G	No	No	G	No Comment Required
Overdraft used last quarter	No	No	G	No	No	G	No	No	G	No Comment Required
Debtors > 90 days> 5% total balance	No	No	G	No	No	G	No	No	G	No Comment Required
Creditors > 90 days> 5% total balance	No	No	G	No	No	G	No	No	G	No Comment Required
2 or more change FD in last 12m	No	No	G	No	No	G	No	No	G	No Comment Required
Interim FD > one quarter	No	No	G	No	No	G	No	No	G	No Comment Required
Q end cash<10 days of op expenses or <£4m	No	No	G	No	No	G	No	No	G	No Comment Required
Capex < 85% or >115% of ytd plan	No	No	G	No	No	G	No	No	G	No Comment Required

Cost Improvement Plans (QIPP's)

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast (last month)	Plan	RAG	
	£k	£k		£k	£k		£k	£k		
Total CIP's										
PTS Hampshire	34	31	G	34	31	G	369	371	A	No Comment Required
PTS Berkshire	-39	12	R	(39)	12	R	147	145	G	High use of private provider in the month - being investigated
PTS Ox	24	20	G	24	20	G	169	236	R	No Comment Required
PTS Bucks	12	10	G	12	10	G	273	204	G	No Comment Required
Commercial Training	6	0	G	6	0	G	57	58	A	No Comment Required
Logistic Services	18	5	G	18	5	G	64	64	G	No Comment Required
Management costs	23	0	G	23	0	G	0	0	G	No Comment Required
Subtotal Commercial Division	**78**	**78**	G	**78**	**78**	G	**1,079**	**1,077**	G	No Comment Required
Unsocial Payments	0	44	R	0	44	R	502	591	A	Behind due to union challenge but the national agreement will be implemented once unin issues resolved
Sickness Saving	0	41	R	0	41	R	538	579	A	Behind in month overall although good progress in come areas
Increase Utilisation	45	9	G	45	9	G	380	343	G	No Comment Required
Reduce Private Provider rates	0	0	G	0	0	G	0	0	G	No Comment Required
PP Mix of Vehicles/Suppliers	0	9	R	0	9	R	161	170	A	Negotaiton with suppliers not yet completed
Implementation of agency workers	0	0	G	0	0	G	110	121	A	Not use to start until May
Increase Hear & Treat	(11)	17	R	(11)	17	R	265	360	R	Hear & Treat has reduced despite GP's being used in EOC.
Increase See & Treat	7	20	R	7	20	R	232	245	A	Small iporvement but behind plan - will be driven by increasing GP Triage
Reduce Meal Break payments	0	0	G	0	0	G	152	152	G	Project underway and should give benefit in May
EOC - Reduce Not Ready Time	0	0	G	0	0	G	41	41	G	Project underway and should give benefit in May
EOC - Profile Usage & adjust shift pattern	0	(37)	G	0	(37)	G	45	45	G	Porject commenced - spend has not occrred - will be May - thus giving a benefit
OSD payroll savings	0	10	R	0	10	R	111	121	A	Resources above budget in the month due to high demand
111 savings	0	14	R	0	14	R	1,452	1,426	G	No financial savings achieved due to additional resources used to support improved operational performance
Subtotal A&E	**42**	**127**	R	**42**	**127**	R	**3,989**	**4,193**	A	A&E management are reviewing other projects to make up the shortfall
Education and HR	16	16	G	16	16	G	278	278	G	No Comment Required
Finance, Estates and Information	12	12	G	12	12	G	112	112	G	No Comment Required
ICT savings	0	0	G	0	0	G	149	149	G	No Comment Required
Properties rationalisation	41	41	G	41	41	G	895	895	G	No Comment Required
Other overheads	15	15	G	15	15	G	99	99	G	No Comment Required
Subtotal Corporate	**84**	**84**	G	**84**	**84**	G	**1,533**	**1,533**	G	No Comment Required
Contingency							-401	-604		
Total CIP's	**205**	**289**	R	**205**	**289**	R	**6,200**	**6,200**	G	See individual commentaries on A&E projects

South Central Ambulance Service NHS
NHS Foundation Trust

Quality Impact Assessment of the Cost Improvement Programmes 2013-14

Action to Mitigate Downside Scenario	Potential Impact to Quality/Delivery	Risk Rating	Mitigating Actions	Mitigated Risk Level
Unsocial - Reduction in payments (Incl. EOC)	Potential issues with staff morale if not communicated and consulted / attendance when not well/ spread of infection.	9	Consultation with staff side / local management by team leaders of staff returning from sick leave to ensure well enough and no infection risk	6
Sickness reduction of 1%	Potential issues with staff morale sickness not managed appropriately / attendance when not well/ spread of infection. Resource levels have been planned on the basis of the reduced level of sickness - if this is not achieved then there is a risk around not having sufficent resources to deliver quality and safety to appropriate standards.	12	Consultation with staff side / local management by team leaders of staff returning from sick leave to ensure well enough and no infection risk. Sickness to be monitored weekly and resource levels adjusted through other variable resource if sick levels are higher than plan.	9
Matching supply & demand (UHU)	Possible risks to care if resources are too low	12	Weekly review of the effect of UHU model implementation on performance and quality to ensure that this does not result in an adverse effect on response times and all misses are reviewed in detail.	8
Private Provider cost reduction	Lower cost suppliers may have lower quality of staff, vehicesl and reliability.	15	Incident reporting system for adverse events relating to reduced privates or availability to attend. Quality assessment of private providers suppliers by SCAS - surprise visits, review of systems etc. Qlikview monitoring of performance of private providers.	12
Implemetation of agency workers	Utilisation of agency may result in inconsistent standards of care to patients.	15	Training programme. Work alongside SCAS staff. Quality assurance processes with agency supplying the staff.	12
Increase Hear &Treat	Potential patient safety issue if CSD undertake high levels of hear and treat / Incorrect balance of front line vehicles for see and treat and transporting patients / Potential rise in complaints due to increased hear and treat and patient perceptions of wanting an ambulance / Potential negative media coverage from poor patient experiences	20	Monitoring of complaints, feedback and concerns through PERG and IPR. Monitoring of CSD activity and performance through level 2 meetings and through IPR. CSD patient satisfaction survey. Peer review audit in CSD. Refresher training CSD from May 13. GP's in EOC should enhance the level of clinical decision-making.	12
Increase non-conveyance through more see and treat	Potential patient safety issue with leaving patients at home that need urgent care and treatment. Failure to align to health community QUIP. Patients not going to most appropriate place for their needs. Staff not confident and not had training applicable to assessment and leaving at home or onward referral to another care pathway. No care pathways available for onward referral. Potential increase in complaints and poor media coverage if patient left at home then deteriorates.	20	GP triage schemes – working with GP commissioners - tracked through meeting minutes and stakeholder calls • Locality care plans • Non conveyance work streams outlined in programme – monitored through Executive team • Locality unscheduled care boards – monitored through meeting minutes • Matching of QUIP plans through BPB programme and Re-contact rates measured through IPR • Use of the Clinical Support Desk to undertake complex clinical assessment / increase ECP use	15
Meal breaks	Planned savings from 1 May 2013. Inability to reach patients as per need and target affecting outcome and/or experience if staff unavailable. Timing of meal breaks must not impact on availability of staff to respond; potential to increase delays and long waits.	12	This has been modelled on the Optima software and there is no estimated impact on performance (any misses as a result only move to a different time - no overall impact). Monitor long waits and incident reports.	6
EOC Savings - Reduce not ready time	May reduce wrap up time risking poor documentation and communication	6	Shift mangers monitoring	6
EOC Savings - shifts	Potential to not have sufficient staff across shifts.	8	Modelling against demand rather than flat shift pattern.	6
OSD Payroll savings	Staff may not be able to access OSD for vehicle repair/maintenance/ moving vehicles as readily resulting in vehicle availibility reduction and ability to respond.	12	If there is a quality impact more resources will be taken on which would jeopardise the financial savings in the interest of maintaining quality.	8
	Risk to delivery if budgeted resources are not sufficient to meet demand for vehicle movements/management.		Recruit staff as soon as possible to replace agency staff. Archipelago review of fleet/OSD should recommende efficiencies.	
111 savings	Risk to delivering performance in 111 services if staff not in post/trained. Patients may not receive timely response resulting in adverse outcome/poor experience.	15	Demand profile rostering using ErlangC model. Monitored daily. Performance monitored - call abandonment/call answering. Incident calls and Datix. Clinical Governance group and reporting SIRI's.	12
Total Commercial CIPs	Potential risk to care from reduction of deiver training and reduced level of resource for private providers.	12	PTS patient satisfaction survey results. Monitor any incidents. Monitor complaints and performance. Reduced length driver course has been comprehensively piloted and is subject to onging review.	8
Education direct savings	Potential for students not attending in a timely way if having to travel long distances to course venue or being too tired to engage optimally in the training.	6	Monitoring uptake of training: DNA figures and actions. Instructors can authorise accomodation if travelling time deemed excessive - budget reduced not eliminated entirely.	4
Reduce induction to 1 day	Potential for staff not to meet essential training requirements through local induction or Elearning. Impact could adversely affect patients through poor staff understanding of procedures.	12	Strengthen Elearning for staff and access. Monitor uptake through WFDB. Local induction in workplace. Monitor incidents relating to lack of training/info.	8
Reduce length of training for paramedics (post University)	Reducing local induction time may result in poor undertsanding of local procedures. Impact on Team Leader and Clinical Mentor time	15	Measure quality of student feedback. Monitor patient safety incidents. Monitored through WFDB. Clinical Supervision policy.	12
Reduce length of training for ECA's	Reducing training time may increase demands on TL's and CM's	15	Measure quality of student feedback. Monitor patient safety incidents. Monitored through WFDB. ECA supervision plans.	12
Income from TV series	Reputational risk if SCAS portrayed in unfavourable light.	3	Oversee all TV programmes before release.	2
Payroll negotiation	Risk minimal (ensure staff paid correctly - otherwise could adversely affect morale)	1	New payroll provider - monitoring of performance.	2
Stop paying removal expenses	Ability to attract right senior managers to the organisation.	2	Monitor any requests and negotiate individually if required.	2

Reduce CRB costs	Should be no risk as budget should be sufficient to cover all new joiners requiring DBS checks	6	New staff DBS checked as per recruitment process. Action if positive DBS check.	4
Agency savings in PIT	Ability to extract timely, accurate clinical data. Adversely affecting audit and analysis for contract and service improvements.	12	Recruitment plan for employing substantive staff to replace more expensive agancy staff.	9
Wokingham Closure	No Quality risk identified as Wokingham EOC already closed.	1	No further mitigation required	1
MIS contract (IT)	Request for operational information not able to be accessed. Inability to meet FOI requests.	6	Ad hoc requests still possible . PRFs accessible.	4
ICT agency cost reduction	IT reduction in staff may adversely affect resilience in IT systems affecting dispatch, 111.	8	Recruitment plan in place and most staff are transferring from agency to permanent rather than being new to SCAS .	6
Domestic cleaning costs	Reduced cleaning may result in CQC non compliance. Affect working environments in NH and SH.	15	Leadership walkarounds. Station cleanliness audits. CQC action plan. Use of facilities. Consultant/adviser used to nesuer quality not compromised..	12
Reduce mileage to Northern House	Minimal risk to staff retention if staff can no longer afford to pay travel costs once the reimbursement for this ceases.	3	Low risk so no further mitigation required.	2
Average		10		8
	Overall rating - Red 1-3, Amber (3-12), Red 13+	A		

Reds	1	4%
Amber	20	77%
Greens	5	19%
Total	26	100%
Overall		A

Human Resources

Overall rating R *Red > 30% Red scores, Green > 70% Green and <10% Reds (but no key indicators), Amber - rest*

Sickness absence

Lead Director: Will Hancock

Measure - Data refers to previous month (March 2013)	Apr-13 Actual %	Apr-13 Plan %	Apr-13 RAG	Year to date Actual %	Year to date Plan %	Year to date RAG	Full year Forecast %	Full year Plan	Full year RAG	Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
Trust	5.6%	5.0%	R	5.6%	5.0%	R	4.9%	4.9%	G	We continue to actively manage sickness but this remains high as a result of operational pressures
- A&E Operations	6.1%	5.2%	R	6.1%	5.2%	R	5.5%	5.5%	G	
- A&E EOC	5.0%	5.3%	G	5.0%	5.3%	G	5.9%	5.9%	G	
- PTS	6.9%	4.4%	R	6.9%	4.4%	R	4.5%	4.5%	G	
- Other Commercial Division	3.0%	3.7%	G	3.0%	3.7%	G	4.4%	4.4%	G	
- 111 service	6.0%	5.0%	R	6.0%	5.0%	R	5.0%	5.0%	G	
- Other	2.6%	2.3%	R	2.6%	2.3%	R	2.5%	2.5%	G	

Appraisals (% completed of those due)

Measure	Apr-13 Actual %	Apr-13 Plan %	Apr-13 RAG	Year to date Actual %	Year to date Plan %	Year to date RAG	Full year Forecast (last month) %	Full year Plan	Full year RAG	Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
Trust	85.5%	95.0%	A	85.5%	95.0%	A	85.5%	95.0%	A	On April 1st 2013, 142 appraisals became overdue, joining the year-end overdue total of 160. This left a total of 304 not yet completed, In April 2013 only 28 appriasals were reported as complete.
- A&E Operations	94.7%	95.0%	A	94.7%	95.0%	A	94.7%	95.0%	A	
- A&E EOC	89.0%	95.0%	A	89.0%	95.0%	A	89.0%	95.0%	A	
- PTS	89.9%	95.0%	A	89.9%	95.0%	A	89.9%	95.0%	A	
- Other Commercial Division	14.5%	95.0%	R	14.5%	95.0%	R	14.5%	95.0%	R	The majority of CLS was made overdue in April 2013. Awaiting confirmation of appraisal completions from management team
- 111 Service	33.3%	95.0%	R	33.3%	95.0%	R	33.3%	95.0%	R	Action plan in place to improve
- Other	60.0%	95.0%	R	60.0%	95.0%	R	60.0%	95.0%	R	In RED mainly due to Operational Support Services who have 54/104 appraisals overdue.

Attrition (12 MONTH ROLLING STAFF TURNOVER)

Measure	Apr-13 Actual %	Apr-13 Plan %	Apr-13 RAG	Year to date Actual %	Year to date Plan %	Year to date RAG	Full year Forecast %	Full year Plan	Full year RAG	Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
Trust	0.8%	TBA	n/a	9.8%	TBA	n/a	TBA	TBA	n/a	Based on a 12 Month rolling period, with 20 leavers in April 2013
- A&E Operations	TBA	TBA	n/a	TBA	TBA	n/a	TBA	TBA	n/a	ESR does not currently break down the turnover results using the categories in the IPR. The Workforce Team are currently building reports that will meet the categories shown in the IPR.
- A&E EOC	TBA	TBA	n/a	TBA	TBA	n/a	TBA	TBA	n/a	
- PTS	TBA	TBA	n/a	TBA	TBA	n/a	TBA	TBA	n/a	
- Other Commercial Division	TBA	TBA	n/a	TBA	TBA	n/a	TBA	TBA	n/a	
- 111 Service	TBA	TBA	n/a	TBA	TBA	n/a	TBA	TBA	n/a	
- Other	TBA	TBA	n/a	TBA	TBA	n/a	TBA	TBA	n/a	

Workforce

Measure	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Trust	2,530	2,530	G	2,530	2,530	G	2,769	2,769	G	The April 2013 Workforce figures are all green, as this reflects the start of the year and a baseline figure. The May IPR will have the Plan included and will measure the actual vs plan for April and May 2013.
New Starters	35			35			240			
Vacancy Factor	0.0%	5%		0.0%	5%		0.0%	5%		
A&E Ops	1,367	1,367	G	1,367	1,367	G	1,521	1,521	G	
New Starters	7			7			155			
Vacancy Factor	0.0%	25%		0.0%	25%		0.0%	25%		
EOC	239	239	G	239	239	G	281	281	G	
New Starters	4			4			42			
Vacancy Factor	0.0%	25%		0.0%	25%		0.0%	25%		
111 Service	232	232	G	232	232	G	236	236	G	
New Starters	19			19			4			
Vacancy Factor	0.0%	0.25		0.0%	25%		0.0%	25%		
PTS	310	310	G	310	310	G	335	335	G	
New Starters	5			5			24			
Vacancy Factor	0.0%	25%		0.0%	25%		0.0%	25%		
Other Commercial	74	74	G	74	74	G	78	78	G	
New Starters	0			0			5			
Vacancy Factor	0.0%	25%		0.0%	25%		0.0%	25%		
Other	308	308	G	308	308	G	318	318	G	
New Starters	0			0			10			
Vacancy Factor	0.0%	25%		0.0%	25%		0.0%	25%		

Measure (% completed of staff requiring the training)	Apr-13			Year to date			Full year			Commentary on exceptions (Red - action to correct, Amber - action to reduce risk, Green - nil)
	Actual	Plan	RAG	Actual	Plan	RAG	Forecast	Plan	RAG	
Fire Awareness	61.0%	95.0%	R	61.0%	95.0%	R	95.0%	95.0%	G	Fire Awareness has been low. Commercial Services is the lowest return with 31% whilst A&E is currently at 77% compliance.
Information Governance	37.0%	95.0%	R	37.0%	95.0%	R	95.0%	95.0%	G	After initial push in 2012/13 the renewal rate for Information Governance has been low. Commercial Services is 18% and Corporate Services are on 21%. A&E is at 46% and EOC and 111 have reached 40%
Corporate Induction	23.0%	TBA	n/a	23.0%	TBA	n/a	23.0%	TBA	n/a	11 Corporate Inductions recorded in ESR against 48 Starters. Education Team are updating the records, so this result is expected to improve significantly.
Resuscitation	n/a	TBA	n/a	n/a	TBA	n/a	n/a	TBA	n/a	The Resuscitation face-to-face and e-learning training has started (May 2013). We are now waiting for the data to be loaded into OLM to report. Expected to start reporting results in next months IPR

National Ambulance Clinical Quality Indicators (CQI's)	
Cat Red 8	The percentage of Category Red (immediately life-threatening) calls reached within 8 minutes – the target is 75%.
Cat Red 19	The percentage of Category Red (immediately life-threatening) calls where a vehicle able to transport the patient has arrived within 19 minutes – the target is 95%.
Cat Red 1	Red 1 call are the most time critial of Red call and cover cardiac arrest patients who are not breathing and do not have a pulse and other severe conditions such as airways obstruction.
Cat Red 2	Red 2 calls are serious but less immediately time critical and cover conditiona such as stroke and fits.
Abandoned calls	The percentage of 999 callers who have hung up before their call was answered in an emergency control room.
Recontact 24hrs Telephone	The number of patients who have re-contacted the ambulance trust within 24 hours of them having called 999 and been offered clinical advice over the phone.
Recontact 24hrs On Scene	The number of patients who have re-contacted the ambulance trust within 24 hours of them having called 999 and then were discharged on scene following face to face ambulance assessment.
Frequent caller	The number of patients who have re-contacted the ambulance trust within 24 hours for whom a locally agreed frequent caller procedure is in place. These patients are referred to as "patients at risk" in SCAS.
Resolved by telephone	The proportion of 999 calls that have been resolved by providing telephone advice and no ambulance response.
Non A&E	The number of patients who have been cared for and treated at the scene of the 999 call or taken to somewhere other than an A&E department for treatment (for example, an NHS Walk-in Centre).
ROSC	The total number of patients who having had suffered a cardiac arrest and stopped breathing have then been recorded as having had a return of spontaneous circulation (a pulse/heartbeat) at the time of their arrival at hospital.
ROSC - Utstein	The number of patients who have been witnessed suffering a cardiac arrest and stopped breathing, whose heart was then in a rhythm which allowed it to be shocked with a defibrillator and have then been recorded as having had a return of spontaneous circulation (ROSC) at the time of their arrival at hospital.
STEMI - 60	The percentage of patients who have suffered an ST-elevation myocardial infarction (STEMI) – a type of heart attack – and who have received thrombolysis (treatment with a clot-busting drug) within 60 minutes of the original 999 call to attend them.
STEMI - 150	The percentage of patients who have suffered an ST-elevation myocardial infarction (STEMI) - a type of heart attack - and who then been directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and received angioplasty treatment within 150 minutes of the original 999 call to attend them.
STEMI - Care	The percentage of patients who have suffered an ST-elevation myocardial infarction (STEMI) - a type of heart attack - and who have received the correct treatment (appropriate care bundle) in line with ambulance guidelines.
Stroke - 60	The percentage of patients who have suffered a stroke, as confirmed by the face to face carrying out of a Face Arm Speech Test (FAST) and who were potentially eligible for stroke thrombolysis (treatment with a clot-busting drug) and who arrived at a hyperacute stroke centre within 60 minutes of the original 999 call to treat them.

Stroke - Care	The percentage of suspected stroke patients who were assessed face to face and who received the correct treatment (appropriate care bundle) in line with ambulance guidelines.
Cardiac - STD	The overall percentage of patients who having suffered a cardiac arrest and stopped breathing were successfully resuscitated and survived to be discharged from hospital.
Cardiac - STD Utstein	The percentage of patients who have been witnessed suffering a cardiac arrest and stopped breathing, whose heart was then in a rhythm which allowed it to be shocked with a defibrillator and were successfully resuscitated and survived to be discharged from hospital.
Time to Answer - 50%	The time taken to answer 999 calls in an emergency control room measured by the time below which 50% of calls were answered.
Time to Answer - 95%	The time taken to answer 999 calls in an emergency control room measured by the time below which 95% of calls were answered.
Time to Answer - 99%	The time taken to answer 999 calls in an emergency control room measured by the time below which 99% of calls were answered.
Time to Treat - 50%	The time taken for a health professional working for the ambulance trust to arrive at the scene of a Category A (immediately life-threatening) call, measured by the time below which 50% of patients were reached.
Time to Treat - 95%	The time taken for a health professional working for the ambulance trust to arrive at the scene of a Category A (immediately life-threatening) call, measured by the time below which 95% of patients were reached.
Time to Treat - 99%	The time taken for a health professional working for the ambulance trust to arrive at the scene of a Category A (immediately life-threatening) call, measured by the time below which 99% of patients were reached.

Other terms and abbreviations

Handover improvement	Hospital handover time is the time from hospital arrival by ambulance personnel to clinical handover to hospital clinical staff. This had a target of 15 minutes. Handover improvement is where the total handover time for all hospital arrivals has improved compared to the same period last year.
Clear-up improvement	Clear-up time is the time from clinical handover above to the time that the ambulance vehicle departs hospital. This had a target of 15 minutes. Clear-up improvement is where the total clear-up time for all hospital visits has improved compared to the same period last year.
Turnaround improvement	Turnaround time is the total of handover and clear-up time. This had a target of 30 minutes. Turnaround improvement is where the total turnaround time for all hospital visits has improved compared to the same period last year.
CQC	Care Quality Commission
NPSA	National Patient Safety Agency
SHA	Strategic Health Authority
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
HSE	The Health and Safety Executive
NHS Protect	NHS Protect leads on work to identify and tackle crime across the health service.

TO: HEALTH OVERVIEW AND SCRUTINY PANEL
11 JULY 2013

GENERAL PRACTITIONER PATIENT SURVEY RESULTS
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report invites the Health Overview and Scrutiny (O&S) Panel to review the latest survey responses given by patients of Bracknell Forest General Practitioner (GP) practices.

2 RECOMMENDATION

That the Health Overview and Scrutiny Panel:

2.1 Reviews the GP Patient Survey results for Bracknell Forest.

2.2 Considers further scrutiny of survey themes or individual GP practices where the survey results are markedly different to the England average.

3 SUPPORTING INFORMATION

3.1 The Health O&S Panel has shown a growing interest in gaining direct knowledge of the service user's perspective of public services, and the recent report by Robert Francis QC recommends fostering a culture where the patient is put first.

3.2 The GP Patient Survey is run every six months by NHS England. It is designed to give patients the opportunity to comment on their experience of their GP practice. Every 6 months, around 1.36 million questionnaires are sent out to adult patients, randomly selected from all patients registered with a GP in England. This means that each year around 2.7 million different patients in England are sent the questionnaire.

3.3 The survey asks patients about a range of issues related to their local GP surgery and other local NHS services. This includes questions about how easy or difficult it is for patients to make an appointment at their surgery, satisfaction with opening hours, and the quality of care received from their GP and practice nurses, amongst other things. Ipsos MORI, an independent survey agency, administers the survey on behalf of NHS England. The core of this questionnaire was developed by Ipsos MORI in conjunction with the University of Exeter Medical School and the General Practice and Primary Care Research Unit at the University of Cambridge.

3.4 The full results of the July 2012 - March 2013 GP Patient survey are accessible on the NHS England website at http://www.gp-patient.co.uk/. The survey results for 'core questions' for patients of the Bracknell Forest GP Practices (2,238 responses) are attached in graphical form, also showing the averages for England (937,247 responses) and the average for all GP practices in the Bracknell and Ascot Clinical Commissioning Group area. The survey includes additional questions, for example on people's preferences for the mode of contact with their surgery, also the frequency of their contact with their surgery.

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

Contact for further information

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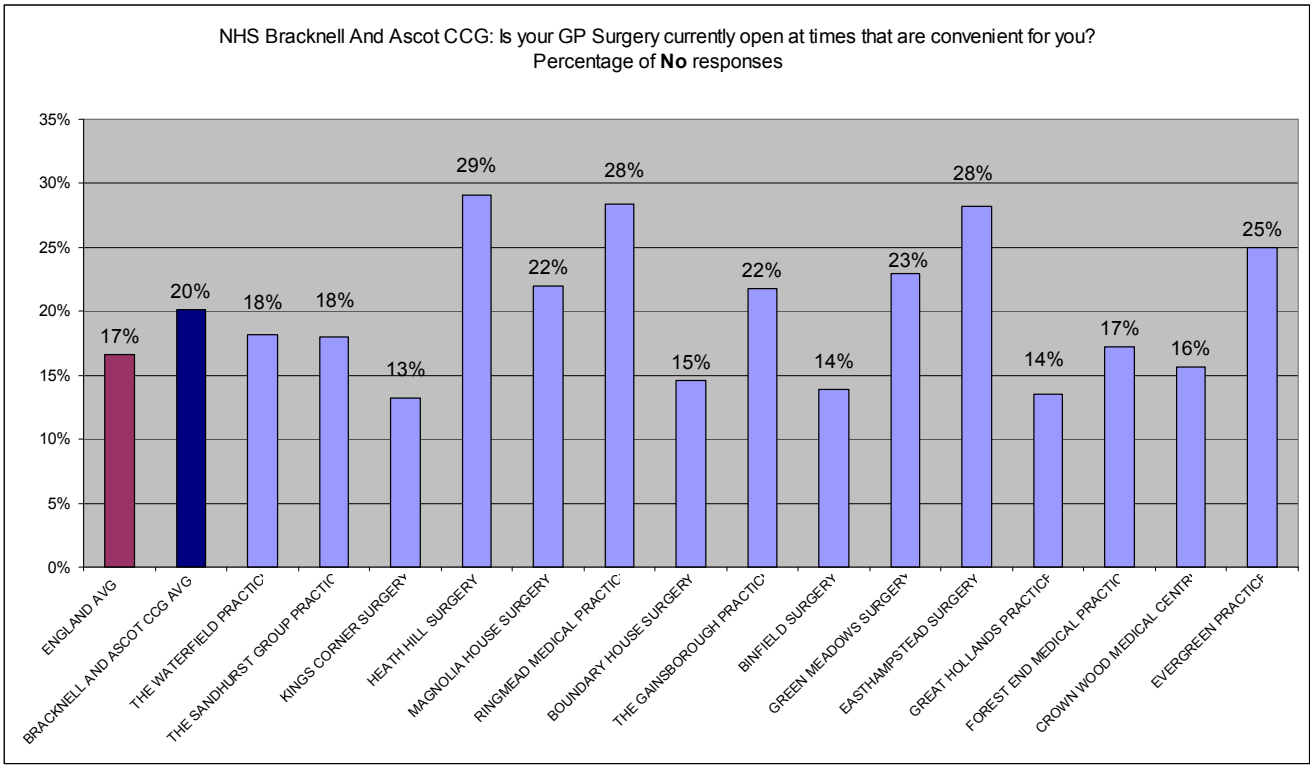
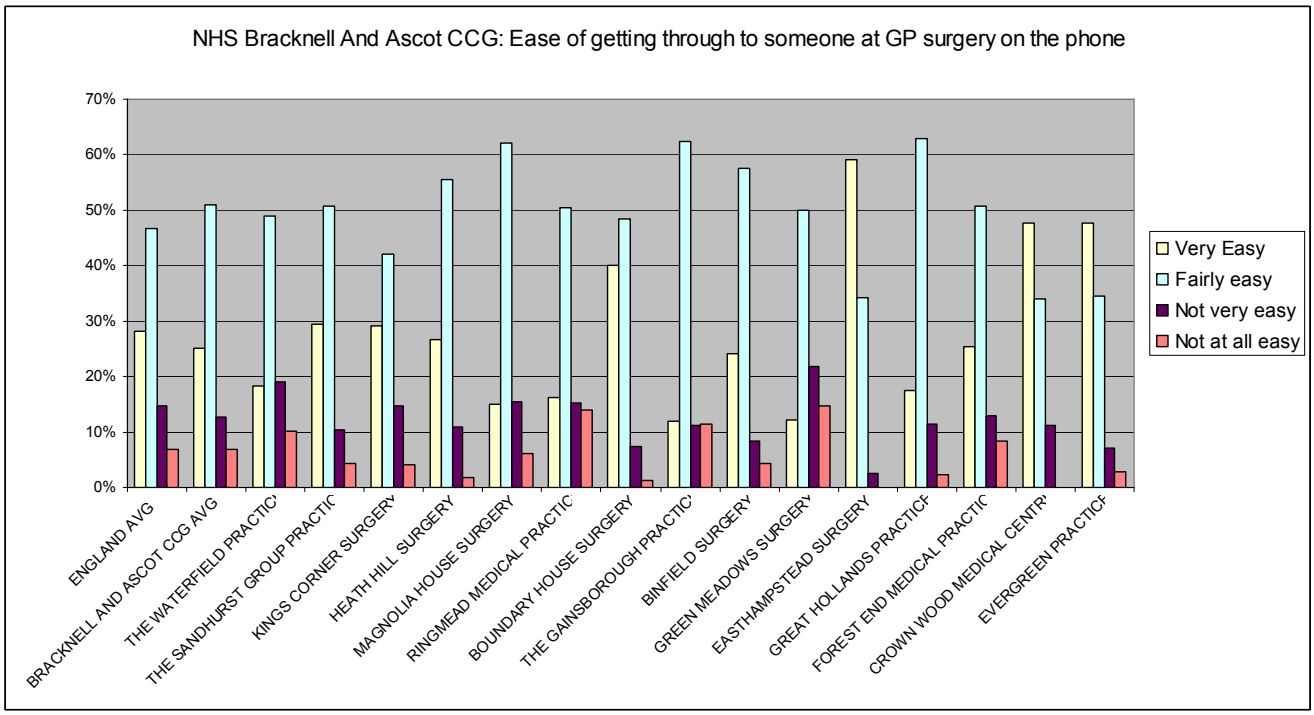
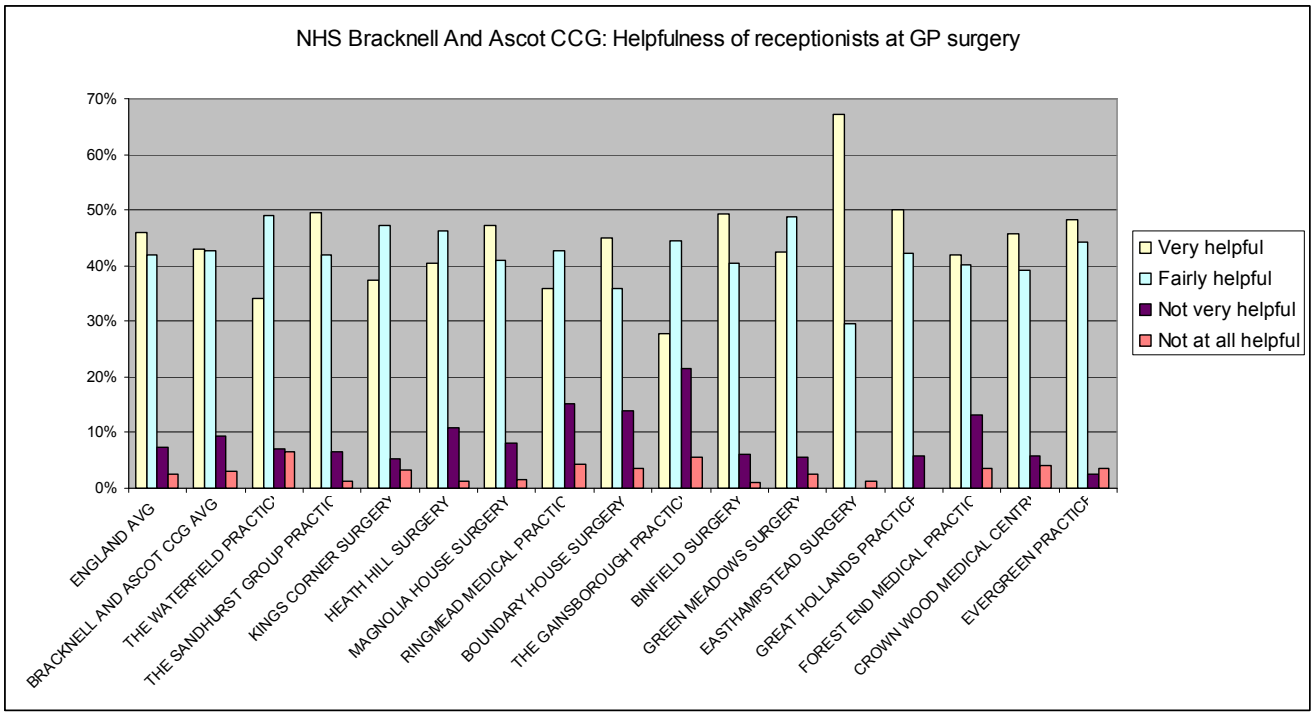
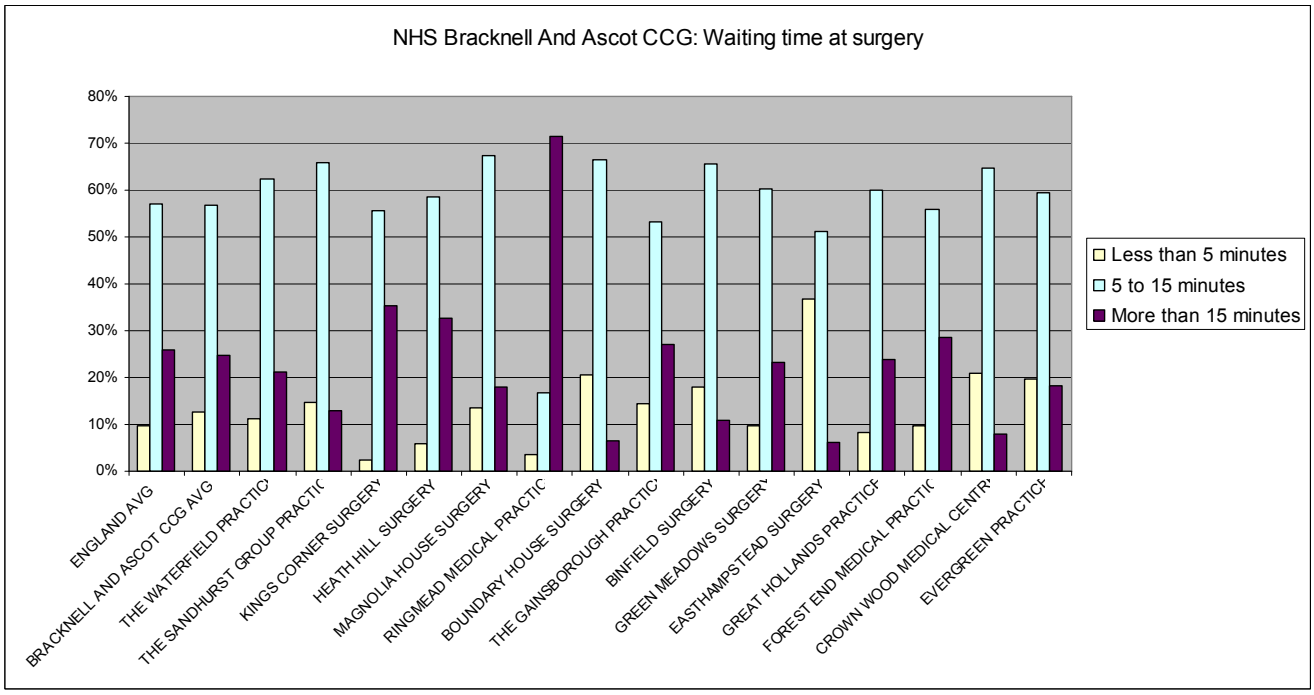
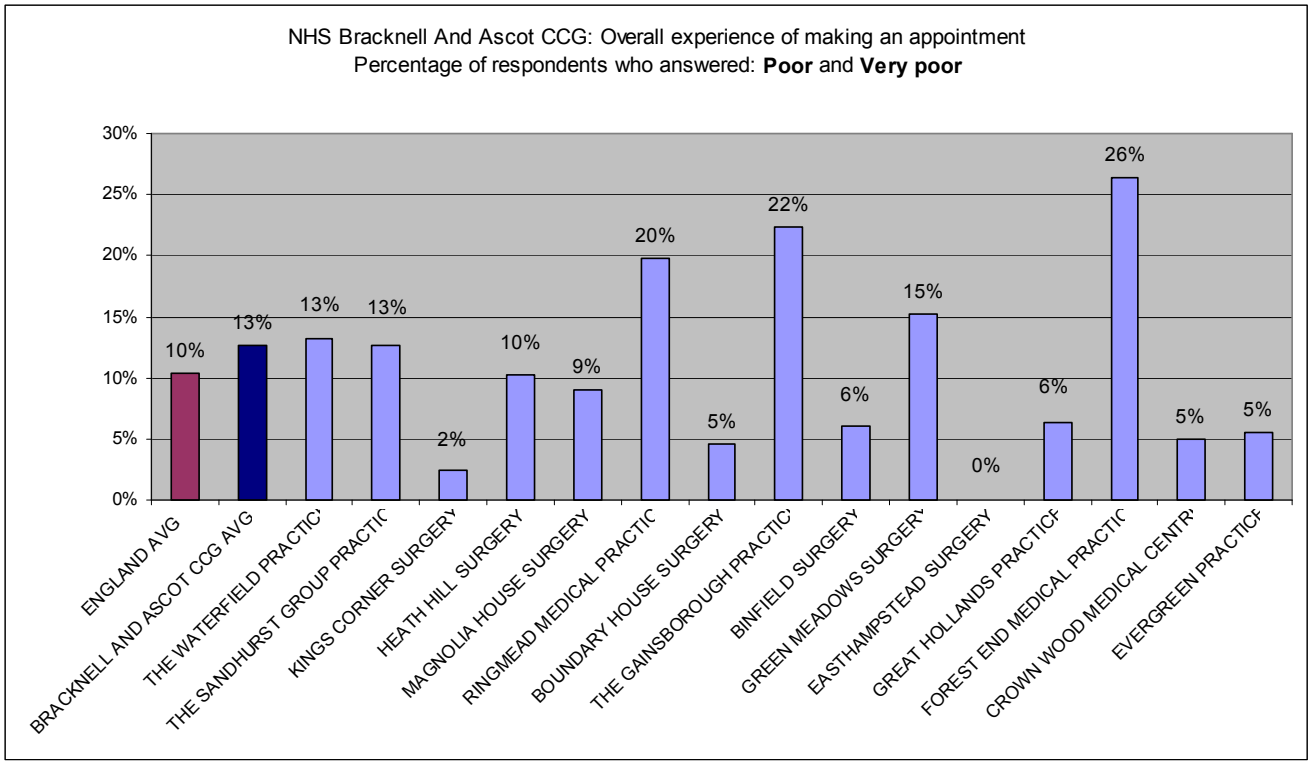
GP Patient Survey Results for Bracknell Forest Practices July 2012 - March 2013: Core Questions

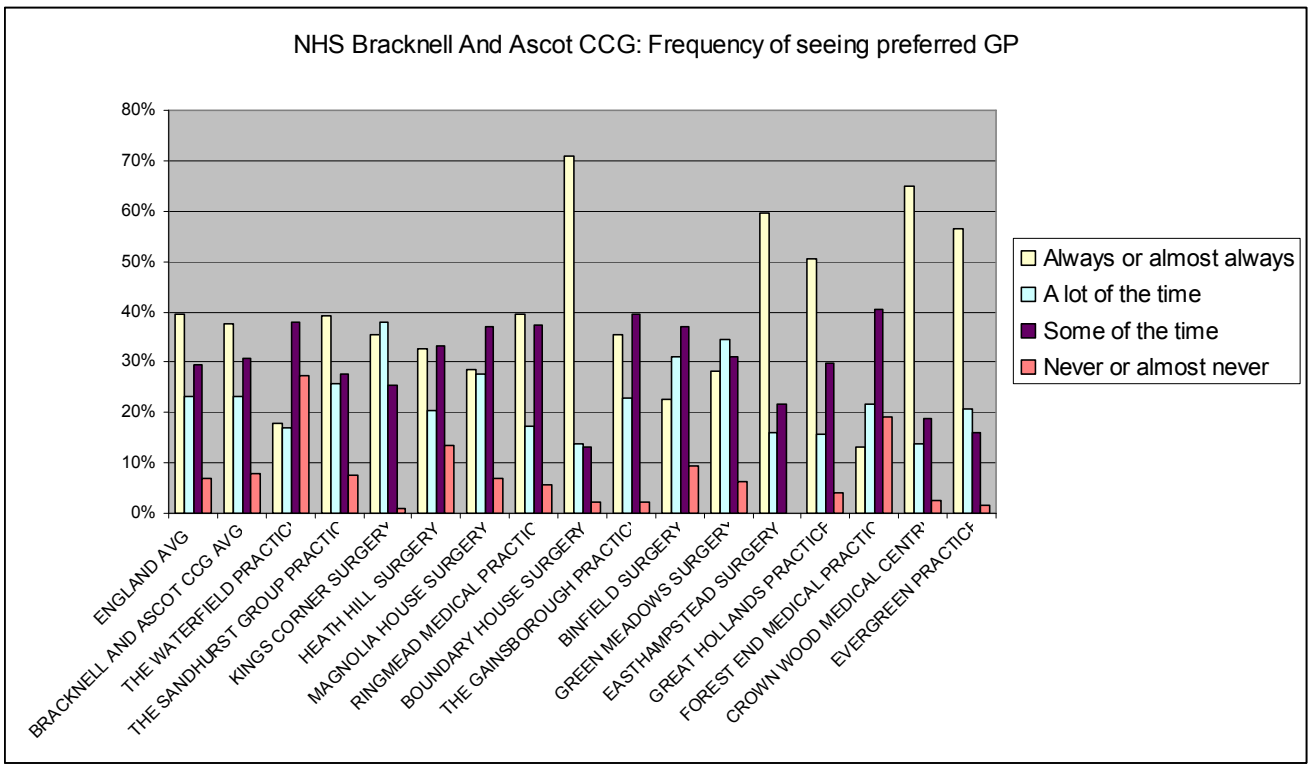


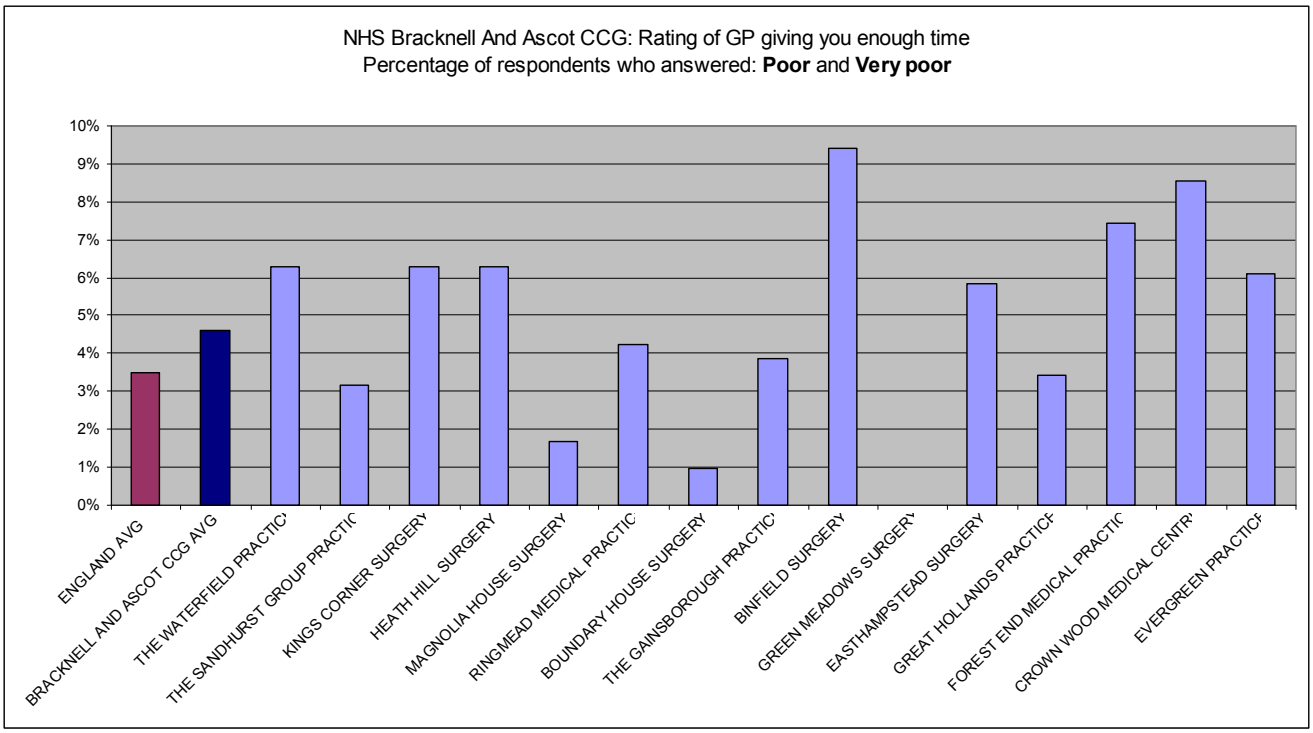


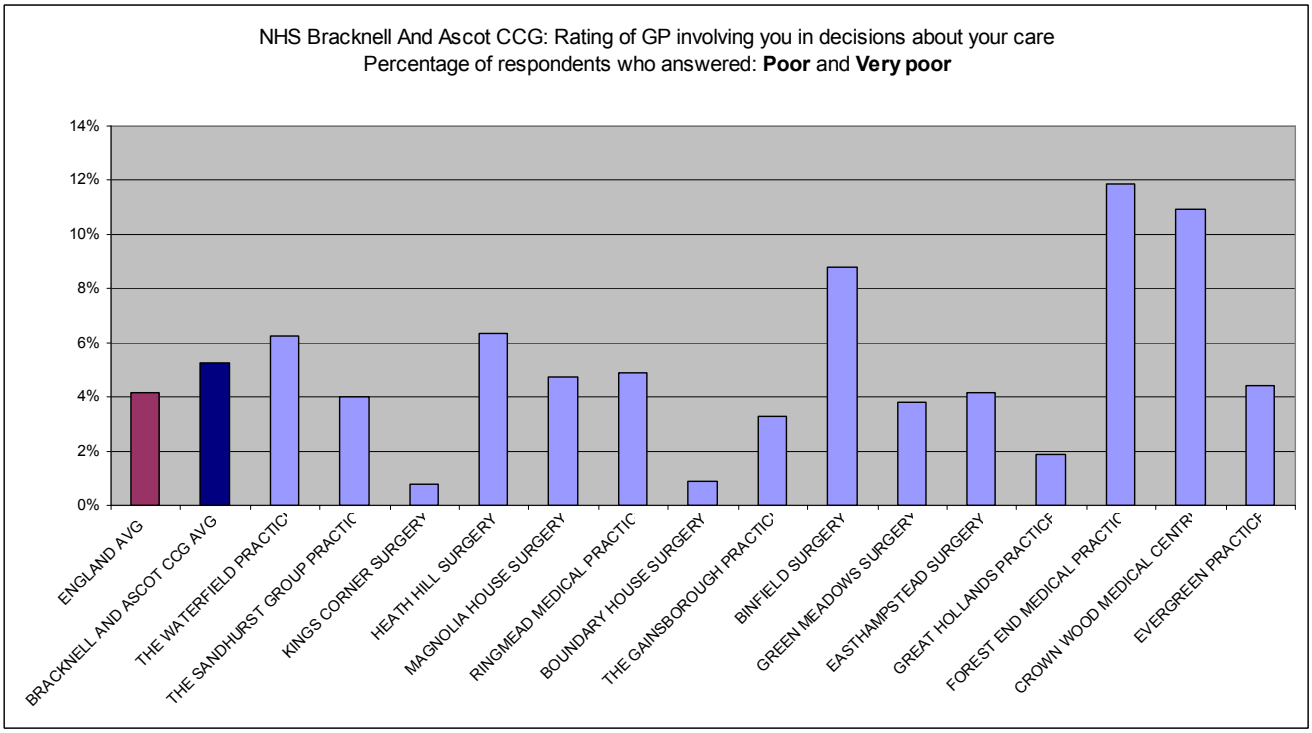

NHS Bracknell And Ascot CCG: Helpfulness of receptionists at GP surgery
70%
60%
50%
40%
30%
20%
10%
0%
ENGLAND AVG
BRACKNELL AND ASCOT CCG AVG
THE WATERFIELD PRACTIC
THE SANDHURST GROUP PRACTIC
KINGS CORNER SURGERY
HEATH HILL SURGERY
MAGNOLIA HOUSE SURGERY
RINGMEAD MEDICAL PRACTIC
BOUNDARY HOUSE SURGERY
THE GAINSBOROUGH PRACTIC
BINFIELD SURGERY
GREEN MEADOWS SURGERY
EASTHAMPSTEAD SURGERY
GREAT HOLLANDS PRACTICE
FOREST END MEDICAL PRACTIC
CROWN WOOD MEDICAL CENTR
EVERGREEN PRACTICE
Very helpful
Fairly helpful
Not very helpful
Not at all helpful

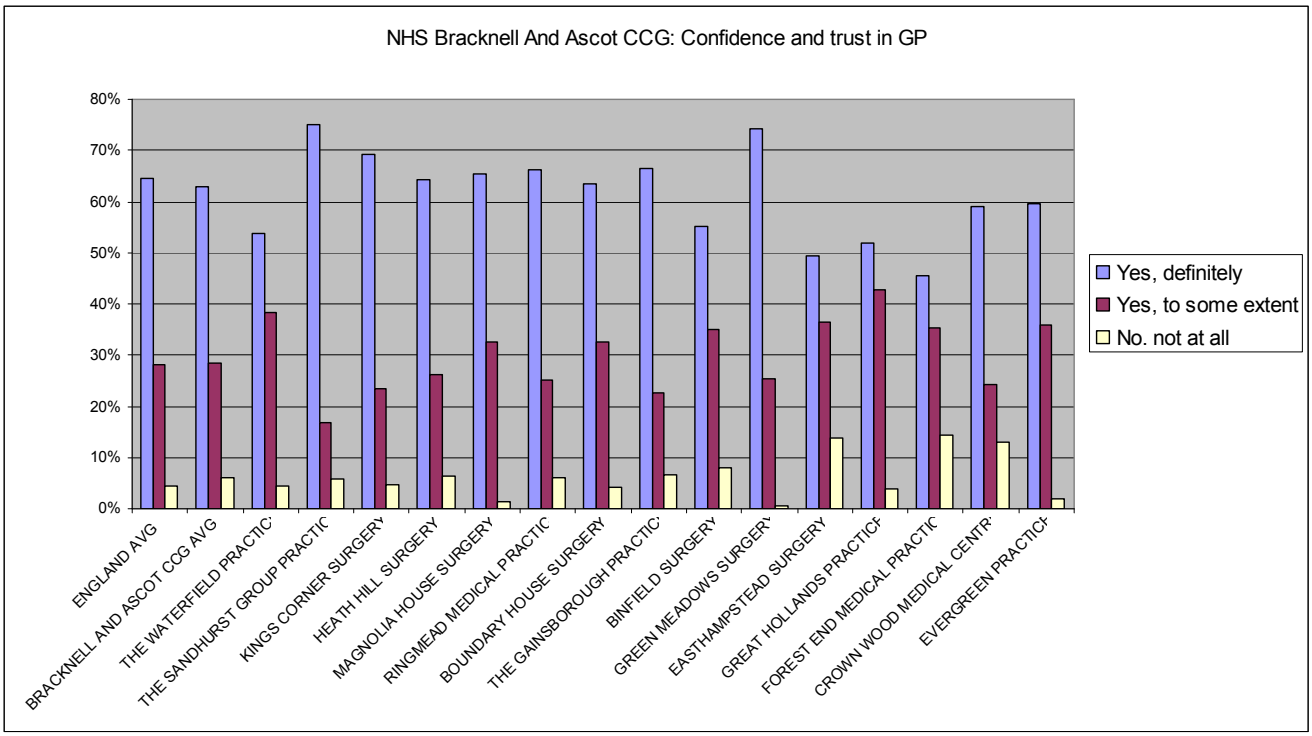

NHS Bracknell And Ascot CCG: Waiting time at surgery
80%
70%
60%
50%
40%
30%
20%
10%
0%
ENGLAND AVG
BRACKNELL AND ASCOT CCG AVG
THE WATERFIELD PRACTIC
THE SANDHURST GROUP PRACTIC
KINGS CORNER SURGERY
HEATH HILL SURGERY
MAGNOLIA HOUSE SURGERY
RINGMEAD MEDICAL PRACTIC
BOUNDARY HOUSE SURGERY
THE GAINSBOROUGH PRACTIC
BINFIELD SURGERY
GREEN MEADOWS SURGERY
EASTHAMPSTEAD SURGERY
GREAT HOLLANDS PRACTICE
FOREST END MEDICAL PRACTIC
CROWN WOOD MEDICAL CENTR
EVERGREEN PRACTICE
Less than 5 minutes
5 to 15 minutes
More than 15 minutes

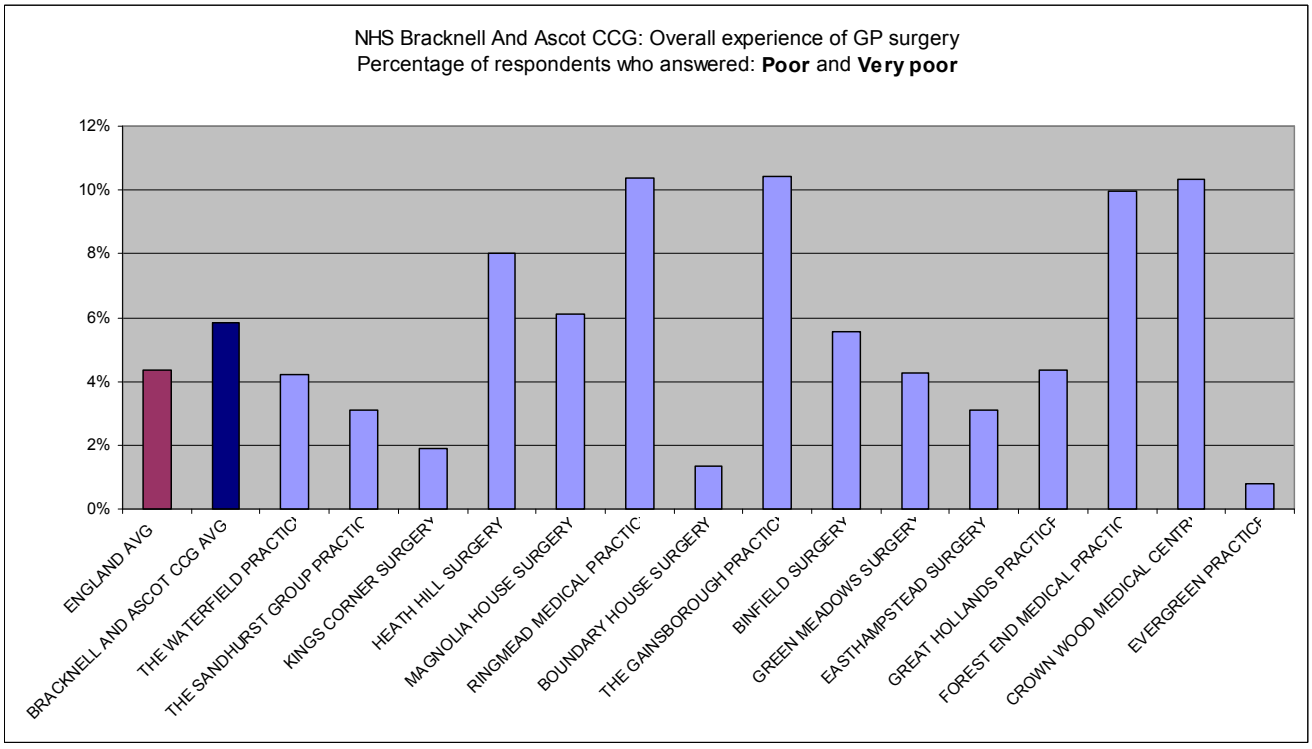

NHS Bracknell And Ascot CCG: Overall experience of making an appointment
Percentage of respondents who answered: **Poor** and **Very poor**
30%
25%
20%
15%
10%
5%
0%
10%
13%
13%
13%
2%
10%
9%
20%
5%
22%
6%
15%
0%
6%
26%
5%
5%
ENGLAND AVG
BRACKNELL AND ASCOT CCG AVG
THE WATERFIELD PRACTIC
THE SANDHURST GROUP PRACTIC
KINGS CORNER SURGERY
HEATH HILL SURGERY
MAGNOLIA HOUSE SURGERY
RINGMEAD MEDICAL PRACTIC
BOUNDARY HOUSE SURGERY
THE GAINSBOROUGH PRACTIC
BINFIELD SURGERY
GREEN MEADOWS SURGERY
EASTHAMPSTEAD SURGERY
GREAT HOLLANDS PRACTICE
FOREST END MEDICAL PRACTIC
CROWN WOOD MEDICAL CENTR
EVERGREEN PRACTICE

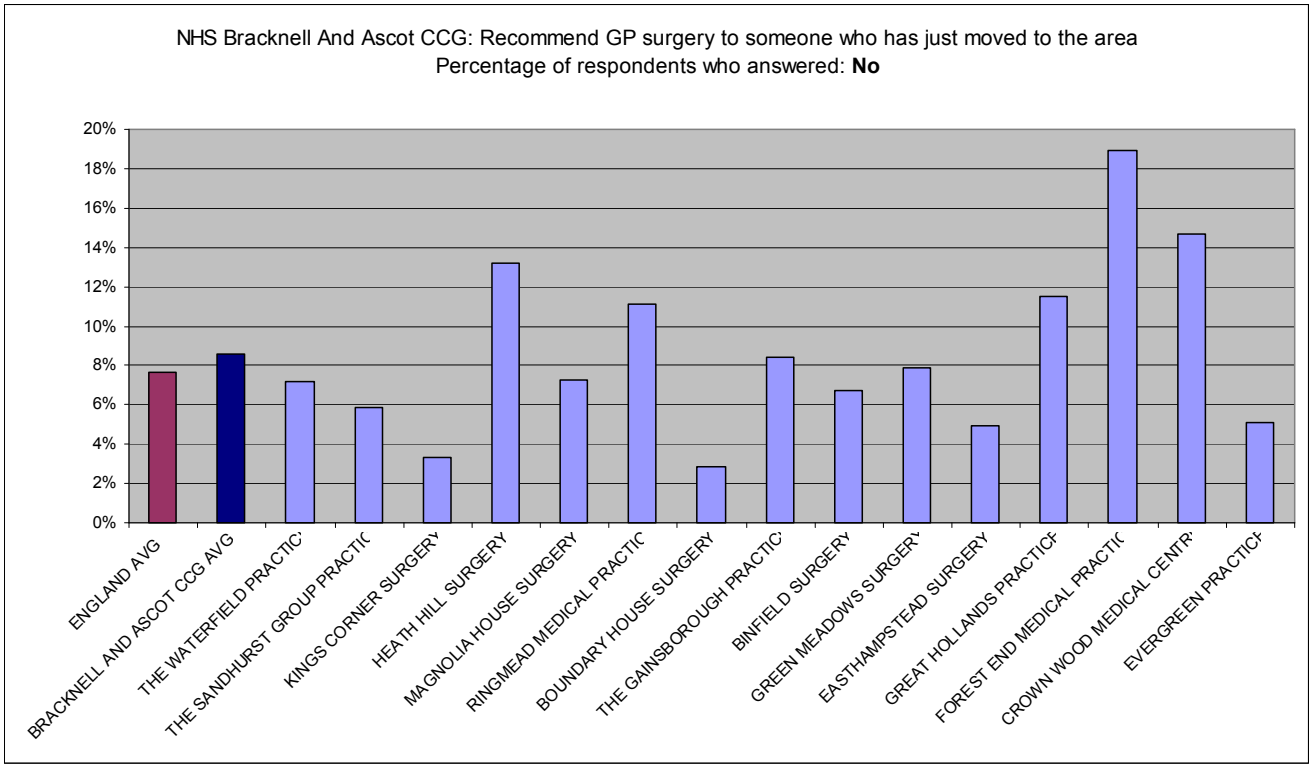

NHS Bracknell And Ascot CCG: Frequency of seeing preferred GP
80%
70%
60%
50%
40%
30%
20%
10%
0%
Always or almost always
A lot of the time
Some of the time
Never or almost never
ENGLAND AVG
BRACKNELL AND ASCOT CCG AVG
THE WATERFIELD PRACTIC
THE SANDHURST GROUP PRACTIC
KINGS CORNER SURGERY
HEATH HILL SURGERY
MAGNOLIA HOUSE SURGERY
RINGMEAD MEDICAL PRACTIC
BOUNDARY HOUSE SURGERY
THE GAINSBOROUGH PRACTIC
BINFIELD SURGERY
GREEN MEADOWS SURGERY
EASTHAMPSTEAD SURGERY
GREAT HOLLANDS PRACTICE
FOREST END MEDICAL PRACTIC
CROWN WOOD MEDICAL CENTR
EVERGREEN PRACTICE


NHS Bracknell And Ascot CCG: Rating of GP giving you enough time
Percentage of respondents who answered: **Poor** and **Very poor**
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
ENGLAND AVG
BRACKNELL AND ASCOT CCG AVG
THE WATERFIELD PRACTIC
THE SANDHURST GROUP PRACTIC
KINGS CORNER SURGERY
HEATH HILL SURGERY
MAGNOLIA HOUSE SURGERY
RINGMEAD MEDICAL PRACTIC
BOUNDARY HOUSE SURGERY
THE GAINSBOROUGH PRACTIC
BINFIELD SURGERY
GREEN MEADOWS SURGERY
EASTHAMPSTEAD SURGERY
GREAT HOLLANDS PRACTICE
FOREST END MEDICAL PRACTIC
CROWN WOOD MEDICAL CENTR
EVERGREEN PRACTICE


NHS Bracknell And Ascot CCG: Rating of GP involving you in decisions about your care
Percentage of respondents who answered: **Poor** and **Very poor**
14%
12%
10%
8%
6%
4%
2%
0%
ENGLAND AVG
BRACKNELL AND ASCOT CCG AVG
THE WATERFIELD PRACTIC
THE SANDHURST GROUP PRACTIC
KINGS CORNER SURGERY
HEATH HILL SURGERY
MAGNOLIA HOUSE SURGERY
RINGMEAD MEDICAL PRACTIC
BOUNDARY HOUSE SURGERY
THE GAINSBOROUGH PRACTIC
BINFIELD SURGERY
GREEN MEADOWS SURGERY
EASTHAMPSTEAD SURGERY
GREAT HOLLANDS PRACTICE
FOREST END MEDICAL PRACTIC
CROWN WOOD MEDICAL CENTR
EVERGREEN PRACTICE


NHS Bracknell And Ascot CCG: Confidence and trust in GP
80%
70%
60%
50%
40%
30%
20%
10%
0%
ENGLAND AVG
BRACKNELL AND ASCOT CCG AVG
THE WATERFIELD PRACTIC
THE SANDHURST GROUP PRACTIC
KINGS CORNER SURGERY
HEATH HILL SURGERY
MAGNOLIA HOUSE SURGERY
RINGMEAD MEDICAL PRACTIC
BOUNDARY HOUSE SURGERY
THE GAINSBOROUGH PRACTIC
BINFIELD SURGERY
GREEN MEADOWS SURGERY
EASTHAMPSTEAD SURGERY
GREAT HOLLANDS PRACTICE
FOREST END MEDICAL PRACTIC
CROWN WOOD MEDICAL CENTR
EVERGREEN PRACTICE
Yes, definitely
Yes, to some extent
No. not at all


NHS Bracknell And Ascot CCG: Overall experience of GP surgery
Percentage of respondents who answered: Poor and Very poor
12%
10%
8%
6%
4%
2%
0%
ENGLAND AVG
BRACKNELL AND ASCOT CCG AVG
THE WATERFIELD PRACTIC
THE SANDHURST GROUP PRACTIC
KINGS CORNER SURGERY
HEATH HILL SURGERY
MAGNOLIA HOUSE SURGERY
RINGMEAD MEDICAL PRACTIC
BOUNDARY HOUSE SURGERY
THE GAINSBOROUGH PRACTIC
BINFIELD SURGERY
GREEN MEADOWS SURGERY
EASTHAMPSTEAD SURGERY
GREAT HOLLANDS PRACTICE
FOREST END MEDICAL PRACTIC
CROWN WOOD MEDICAL CENTR
EVERGREEN PRACTICE


NHS Bracknell And Ascot CCG: Recommend GP surgery to someone who has just moved to the area
Percentage of respondents who answered: **No**
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
ENGLAND AVG
BRACKNELL AND ASCOT CCG AVG
THE WATERFIELD PRACTIC
THE SANDHURST GROUP PRACTIC
KINGS CORNER SURGERY
HEATH HILL SURGERY
MAGNOLIA HOUSE SURGERY
RINGMEAD MEDICAL PRACTIC
BOUNDARY HOUSE SURGERY
THE GAINSBOROUGH PRACTIC
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EASTHAMPSTEAD SURGERY
GREAT HOLLANDS PRACTICE
FOREST END MEDICAL PRACTIC
CROWN WOOD MEDICAL CENTR
EVERGREEN PRACTICE

HEALTH OVERVIEW AND SCRUTINY PANEL
11 JULY 2013

HEALTH REFORMS - IMPLEMENTATION
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 To provide the Health Overview and Scrutiny (O&S) Panel with a progress briefing on establishing:

- the Public Health function in the Council
- Local Healthwatch.

2 RECOMMENDATIONS

That the Health Overview and Scrutiny Panel:

2.1 Notes the attached reports to the Health and Wellbeing Board providing an update on Public Health and on progress in establishing Local Healthwatch.

3 SUPPORTING INFORMATION

3.1 The Work Programme for the Health O&S Panel for 2013/14 includes monitoring the implementation of the major changes from the 2012 Health and Social Care Act. The most significant changes include the transfer of the Public Health responsibilities from the NHS to the Council, also the creation of Local Healthwatch from April 2013.

3.2 The attached reports are due to be considered by the Health and Wellbeing Board at its meeting on 4 July.

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

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TO: HEALTH AND WELL BEING BOARD
4 JULY 2013

PUBLIC HEALTH UPDATE
Director of Adult Social Care, Health and Housing
Strategic Director of Public Health

1 PURPOSE OF REPORT

1.1 The purpose of this report is to set out the priorities for Bracknell Forest Public Health work in 2013/14, as well to map these against Public Health priorities at a county and national level.

1.2 The report goes on to discuss the launch of the "longer lives" project and the impact for Bracknell Forest Council and its partners.

1.3 Additionally, there has been a further investment in Public Health of £100k for 2013/14. An internal process was established to invite bids for projects which could be undertaken during the year. The successful bids are set out in para 5.11, progress will be monitored by the Health and Well Being Board.

2 RECOMMENDATIONS

That the Health and Well Being Board:

2.1 Note the publication and key messages of the 'Longer Lives' mortality data.

2.2 Note the successful Public Health Grant project proposals.

2.3 Agree that the proposed priorities for local Public Health work in 2013/14.

3 REASONS FOR RECOMMENDATIONS

3.1 The data recently published as part of the Longer Lives project has highlighted high levels of premature mortality in Bracknell Forest relative to areas deemed to be socioeconomically comparable.

3.2 The publicity this data has attracted provides a salient opportunity to outline Public Health priorities for the coming year. In this context it is important that local Public Health priorities in Bracknell Forest are understood and supported.

3.3 The priorities should also be shown to reflect key strategic drivers such as the Bracknell Forest Health & Well-Being Strategy, the priorities of Public Health England and the national Public Health Outcomes Framework.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None

5 SUPPORTING INFORMATION

5.1 In June 2013, the 'Longer Lives' Project was launched by Public Health England (PHE) in order to examine premature mortality across the country. This initiative compares (age standardised) data on mortality before the age of 75 across local authority areas.

5.2 As part of the Longer Lives project, local authorities were allocated to groups according to their index of multiple deprivation, allowing their premature mortality rates to be compared with 14 others that have similar socioeconomic status.

5.3 Bracknell Forest was estimated to have the 37th best rate of overall premature mortality from among 150 local authority areas.

5.4 However, when considered in comparison to its socioeconomic grouping (defined by PHE as 'least deprived') it is ranked as having the worst rate of mortality among the15 comparable areas. In relation to disease specific rankings, Bracknell Forest is estimated to have the worst cancer mortality in the 'Least Deprived' group. A summary of the rankings is in **Appendix A**).

5.5 A salient comparison highlighted by the Longer Lives data is that between Bracknell Forest and Wokingham. While Bracknell Forest has a overall mortality rate of 240.6 per 100,000 population, the corresponding rate for Wokingham is only 200.03, meaning it ranks as having the best premature mortality levels in the 'least deprived' grouping.

5.6 Some of the assumptions behind the 'Longer Lives' initiatives have been criticised:

5.6.1 A key criticism has come from the Local Government Association which has taken the view that the project "dangerously oversimplifies matters and ignores the very complex and socio-economic and cultural factors that affect the premature mortality rate" (The Municipal Journal, June 2013).

5.6.2 One such factor that may be relevant to Bracknell is its status as a New Town and the arrival of many people from East London a few decades ago.

5.6.3 The method used for grouping 'similar' socioeconomic areas has also been criticised. The Longer Lives project grouped areas according to the Index of Multiple Deprivation. However, other methods produce a different set of comparable areas (such as the 'Nearest Neighbours' groupings used by the Chartered Institute of Public Finance & Accountancy).

5.7 Despite these criticisms the publicity that the Longer Lives project has attracted draws attention to the need for action in relation to the health of the public in Bracknell Forest, and as such, provides a salient opportunity to clarify and justify priorities.

5.8 As an example, analysis suggests that reducing smoking in Bracknell Forest should be a key Public Health priority. According to the Longer Lives data, Bracknell Forest has a premature mortality rate that is 20% higher than that in Wokingham. Data from the Local Tobacco Profiles indicate that it also has a 20% higher rate of smoking-attributable mortality (173 per 100,000 population versus 144 in Wokingham) and a 40% higher rate of smoking (19.4% versus 13.8% in Wokingham).

5.9 An outline of the proposed Bracknell Forest Public Health priorities for 2013/14 is set out in **Appendix B** along with an indication of how they map on to key drivers such as the Health & Well-Being Strategy, Public Health England Priorities and the Public

Health Outcomes Framework. A brief overview of these documents is included in **Appendix C** for reference.

5.10 In summary, the proposed Public Health priorities cover three key domains: Health Intelligence & Insight, Health Improvement and Health Protection.

5.11 The Public Health priorities listed in Appendix B reflect the recent funding awards made under the Public Health Project Grants scheme. A total of 18 bids were received, collectively bidding for £214k. Funding was agreed in the case of 9 projects with a total amount of £93,200 awarded. The successful bids came from all four council directorates and are aimed at improving the health and well-being of a range of groups, including older people, children, people with learning disabilities and the Nepali community. Key themes include increasing children's physical activity, reducing social isolation, improving self-care and the prevention of cardiovascular disease:

1. Holistic Health and Social Inclusion in Vulnerable Older People £15000

Aimed at encouraging more effective self-care among older people. Methods include an action research approach to identifying socially excluded older people, in addition to the production of self-help resources and delivery of workshops aimed at these vulnerable older residents. Supported by BA CCG.

Project Leads: Dave Rossiter & Phillip Ellis Martin (ASC)

2. Work Based NHS Health Checks £8200

Aimed at making comprehensive NHS Health Checks available free of charge to employees aged 40 to 74 years old, this project brings a service only previously available in General Practice into a setting more convenient and accessible for many people. The health checks can provide feedback on cardiovascular and other risk factors, as well as incorporate expert advice on health improvement. .The funding will enable a pilot with BF Council Staff, from which lessons can be learned for future roll out with other employers.

Project Leads: Kim Stevens & Tony Madden (Corp Services with ECC)

3. Beat the Streets' Schools Challenge £15000

An active travel school competition motivating children to walk, cycle or scoot to school or on other regular journeys. The project utilises e+ smartcards along with 'Beat Box' sensors installed across the local area that measures and log active journeys. Schools compete with others both locally and across the world.

Project Lead: Phillip Burke (ECC)

4. Family Health & Learning Project £15000

Focussing on children with low levels of physical activity - this project aims to engage whole families in a more active lifestyle and healthy eating. Regular sessions will aim to improve knowledge and confidence, as well as deliver measureable increases in activity levels.

Project Lead: Sue Pike (CYP&L)

5. Healthy Voices £10000

A programme aimed at improving health and well-being among the local Nepali community. Building on previous work the project will utilise NHS Health Checks, Health Trainers and work aimed at Language Skills development to provide a comprehensive vehicle for sustainable improvement in the health inequalities often experienced by local Nepali people.

Project Lead: Abby Thomas (Corp Services)

6. NHS Health Checks in Leisure Centres £8000

This project brings an NHS Service only previously available in General Practice settings into a setting that is more accessible and in immediate proximity to facilities that can facilitate health improvement. Evaluations will explore the extent to which the work can become financially cost neutral for leisure services by encouraging new membership.

Project Lead: Chris Vaal & Mark Rose (ECC)

7. Healthy Lifestyles in People with Learning Disabilities £3000

Aimed at improving healthy lifestyle awareness among people with LD. The project will deliver a series of targeted sessions delivered by qualified health and nutrition specialists. Tailored (easy read) resources will be developed.

Project Lead: Mark Sanders (ASCHH)

8. Raising Food Hygiene in Poor Performing Premises £4000

This project will go beyond usual enforcement work to actively engage and educate premises rated lowest against Food Hygiene Rating Scheme. Intensive work will result in agreed action plans from which measureable and sustained improvement will be achieved.

Project Lead: Maria Griffin (ECC)

9. Supported Discharge & Falls Assistance via Forestcare £15000

Aimed at preventing hospital readmission or unnecessary ambulance attendances via the provision of a remote 'life line' and key holding service By providing a free trial of these services this project will encourage more people to actively evaluate them and consider long-term use - thereby increasing the overall number of local users. The positive impact of this increase will be significant on both individual well-being and health services resources.

Project Lead: Claire Bennett (ASCHH)

Total funding initially agreed £93200

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 None

Borough Treasurer

6.2 The funding for the successful project proposals will be met from existing budgets earmarked for this purpose.

Equalities Impact Assessment

6.3 Following agreement of the proposed priorities, each work stream will be subject to a equality impact assessment.

Strategic Risk Management Issues

6.4 None

7 CONSULTATION

Principal Groups Consulted

7.1 The priorities proposed within this paper are based upon key strategic drivers such as the Health & Well-Being Strategy. These in turn were based on extensive consultation with relevant agencies and community groups. This paper is written for the purposes of consulting colleagues and key partners.

Method of Consultation

7.2 Meetings

Representations Received

7.3 None

Background Papers
Longer Lives: Summary of Bracknell Forest rankings (Annex A)
Summary of proposed Bracknell Forest Public Health priorities for 2013/14 (Annex B)
Summary of themes and priorities in key strategic drivers (Annex C)

Contact for further information

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Public Health England

Bracknell Forest

Similar local authorities
Worst | 15th out of 15

National
Best | 37th out of 150

Population
113,696

Total premature deaths
785 2009–2011

Compare:

Similar local authorities

All local authorities

Bracknell Forestis in
Socioeconomic decile 10

Socioeconomic deprivation
Least deprived

Local authorities in this socioeconomic deprivation bracket

Bath and North East Somerset
Bracknell Forest
Buckinghamshire CC
Central Bedfordshire
Hampshire CC
Hertfordshire CC
Kingston upon Thames
Leicestershire CC
Richmond upon Thames
Rutland
South Gloucestershire
Surrey CC
West Berkshire
Windsor and Maidenhead
Wokingham

View full rankings

Similar local authorities

Similar view: Bracknell Forest's rank within the 15 local authorities in the same socioeconomic deprivation bracket.

Premature mortality outcomes worst worse than average better than average best

Overall premature deaths per 100,000 for 2009–2011

15th OUT OF 15 SIMILAR LOCAL AUTHORITIES

200
LOWEST: WOKINGHAM

241
HIGHEST: BRACKNELL FOREST

HIGHEST DEATH RATE

Rank	Deaths per 100,000 for 2009–2011	Common causes
15th OUT OF 15 SIMILAR LOCAL AUTHORITIES	**Cancer** 89 LOWEST: RICHMOND UPON THAMES 107 HIGHEST: BRACKNELL FOREST HIGHEST DEATH RATE	Smoking Alcohol Poor diet How to reduce cancer rates Reduce your risk of cancer
8th OUT OF 15 SIMILAR LOCAL AUTHORITIES	**Heart disease and stroke** 40 LOWEST: WOKINGHAM 47 BRACKNELL FOREST 55 HIGHEST: RUTLAND	High blood pressure Smoking Poor diet How to reduce heart disease rates Reduce your risk of heart disease
11th OUT OF 14 SIMILAR LOCAL AUTHORITIES	**Lung disease** 14 LOWEST: SOUTH GLOUCESTERSHIRE 18 BRACKNELL FOREST 20 HIGHEST: CENTRAL BEDFORDSHIRE	Smoking Air pollution How to reduce lung disease rates Reduce your risk of lung disease

12th
OUT OF 14
SIMILAR LOCAL
AUTHORITIES

Liver disease

9
LOWEST: WEST BERKSHIRE

13
BRACKNELL FOREST

15
HIGHEST: KINGSTON UPON THAMES

Alcohol

Hepatitis

Obesity

How to reduce liver disease rates

Reduce your risk of liver disease

Bracknell Public Health Priorities (DRAFT)

Mapping of Bracknell Forest Public Health priorities against the priorities of Public Health England, the Joint Health & Well-Being Strategy and the Public Health Outcomes Framework

Ref	Project Title	Primary Outcomes & Methods	Cross References to Other Plans / Drivers
1. Insight & Intelligence			
PH 1.1	JSNA Development	**Outcomes** - Improved accessibility and quality of Bracknell Forest section of JSNA - Greater engagement and utilisation of JSNA by local stakeholders **Methods** - Development of work plan with Shared Berks Public Health Team - Stakeholder engagement (CCG, local services, community groups) - Collation of secondary data (health service, national surveys) - Primary data collection (see 1.2) - Dissemination and feedback (eg: stakeholder events) **Responsible Officer: Lisa McNally** **Completion/ Review: End of Q3 2013**	**H&WB Strategy** JSNA informs H&WB Strategy **PH England Priorities** Priorities: 1, 6, 7 **Public Health Outcomes Framework** JSNA and other data related projects informs performance monitoring against PHOF
PH 1.2	Bracknell Forest Health Survey	**Outcomes** - New or enhanced quantitative data on health status, health behaviour and satisfaction with health services. - Mapping of mental well-being and pre-clinical mental health indicators - New qualitative data (local narratives) on aspects of health and healthcare **Methods** - Survey design (random sampling within demographic quotas) - Initial drafting and short listing of survey questions - Commissioning of survey provider - Monitoring of survey data collection	**H&WB Strategy** New data on health will inform H&WB Strategy **PH England Priorities** Priorities: 1, 6, 7 **Public Health Outcomes Framework** JSNA and other data related projects informs performance monitoring against PHOF

		- Data analysis and reporting - Dissemination via web, stakeholder events, JSNA (see 1.1) **Responsible Officer: Lisa McNally** **Completion/ Review: End of Q3 2013**	
PH 1.3	Public Health Promotion and Feedback	**Outcomes** - Increased awareness and uptake of Health Improvement services. - Enhanced service quality arising from changes made on basis of feedback. **Methods** - Web-Based Pubic Health Promotion & Service Guide **Responsible Officer: Lisa McNally** **Completion/ Review: End of Q1 2013**	**H&WB Strategy** Priorities: 7, 9, 11, 12, 13, 15, 16 **PH England Priorities** Priorities: 1, 7 **Public Health Outcomes Framework** Domain 2
2. Health Protection			
PH 2.1	MMR Uptake	**Outcomes** - Increased MMR immunisation coverage within target school-age groups on 2012 levels (ie: greater than 71% uptake). **Methods** - Liaison work with schools, General Practice and community organisations - Dissemination of information and promotional work in collaboration with PHE - Project Monitoring and Evaluation **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**H&WB Strategy** Health Protection is mandatory responsibility of BF Council and H&WB Board **PH England Priorities** Priorities: 3 **Public Health Outcomes Framework** Domain 3
PH 2.2	Influenza Vaccination	**Outcomes** - Increased Flu Vaccination uptake among priority groups such as pregnant women, adults over 65 and adults with chronic illness, those with lowered immune systems. **Methods** - Liaison work with General Practice and community organisations	**H&WB Strategy** Health Protection is mandatory responsibility of BF Council and H&WB Board **PH England Priorities** Priorities: 3, 4

		- Dissemination of information and promotional work in collaboration with PHE - Project Monitoring and Evaluation **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**Public Health Outcomes Framework** Domain 3, 4
PH 2.3	Cancer Screening Uptake	**Outcomes** - Increased uptake of key cancer screening programmes such as breast, bowel and cervical screening. **Methods** - Liaison work with General Practice and community organisations - Dissemination of information and promotional work in collaboration with NHS Eng / PHE - Targeted work within other projects aimed at specific groups (eg: see priority 2.5 work on with older people on bowel screening) - Project Monitoring and Evaluation **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**H&WB Strategy** Priorities: 17 **PH England Priorities** Priorities: 1 **Public Health Outcomes Framework** Domain 4
3. Health Improvement			
PH 3.1	Activity and Obesity in Children	**Outcomes** - Increased physical activity among children - Reduced obesity among children **Methods** - Continued provision of child measurement programme via school nurses - 'Beat the Streets' Physical Activity scheme - Family-focused activity and weight management project. - Project Monitoring and Evaluation **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**H&WB Strategy** Priorities:8, 16 **PH England Priorities** Priorities: 4 **Public Health Outcomes Framework** Domain 2, 4

PH 3.2	Delivery of NHS Health Checks in General Practice Settings	**Outcomes** - Increased delivery and uptake of NHS Health Check Programme - Target = 3418 checks (divided between General Practice and Community Settings – see PH 2.2) **Methods** -Establish systems for administration, payment and data transfer. -Liaison work to increase and maintain participation in programme across General Practices. - Promotion and dissemination of service promotional resources to General Practices (see 1.2) - Service Monitoring and Evaluation **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**H&WB Strategy** Priorities: 7, 15, 16 **PH England Priorities** Priorities: 1, 2 **Public Health Outcomes Framework** Domain 2, 4
PH 3.3	Delivery of Health Checks in Work & Community Settings	**Outcomes** - Increased delivery and uptake of NHS Health Check Programme. - Target = 3418 checks (divided between Community Settings and General Practice– see PH 2.1) **Methods** - Settings TBC but may include workplaces (BF Council), Leisure Centres, Community Support Settings (eg: Learning Disability, Nepalese Community) - Establish systems for administration, payment and data transfer. - Recruit / Train staff to deliver Heath Checks - Promotion and dissemination of service promotional resources to delivery settings (see 1.2) - Project Monitoring and Evaluation **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**H&WB Strategy** Priorities: 7, 15, 16 **PH England Priorities** Priorities: 1, 2, 5 **Public Health Outcomes Framework** Domain 2, 4

PH 3.4	NHS Stop Smoking Service Development	**Outcomes** - Achievement of successful 4-week quits in excess of 2012/13 target (ie: n > 725) **Methods** - Continuation of contract from 2012/13 - Campaigns x3 (Stoptober, New Year, No Smoking Day) - New strategies for smoking in young people & pregnant women - Project Monitoring and Evaluation **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**H&WB Strategy** Priorities: 15, 17 **PH England Priorities** Priorities: 1 **Public Health Outcomes Framework** Domain 2, 4
PH 3.5	Development of 'Mental Health Competency' in Workforce	**Outcomes** - Increased ability of staff to identify and support mental health problems within workforce and client group - Evidence of mental health support 'action plans' from service providers / managers **Methods** - Mapping of mental well-being and pre-clinical mental health indicators (see PH 2) to identify target areas & groups for intervention - Mental Health 'First Aid' Training for staff in BF Council and other agencies (eg: General Practice, Community Services) - Action Plan collation and analysis - Project Monitoring and Evaluation **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**H&WB Strategy** Priorities: 12, 13 **PH England Priorities** Priorities: 2, 5 **Public Health Outcomes Framework** Domains 1, 2, 4
PH 3.6	Physical and Mental Well-Being among Older People	**Outcomes** - Increased levels of perceived well-being within areas or target groups - Increased social activity within target areas or groups - Improved mental health within target areas or groups - Increased levels of bowel cancer screening	**H&WB Strategy** Priorities: 3, 6, 12, 13, 14 **PH England Priorities** Priorities: 2, 6

		Methods - Mapping of mental well-being and pre-clinical mental health indicators (see PH 1.2) to identify target areas & groups for intervention - Delivery of evidence based well-being and social inclusion project with 'at risk' older people - Delivery of enhanced care project with Forest Care. - Project Monitoring and Evaluation - Collaborative work to promote increase bowel cancer screening **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**Public Health Outcomes Framework** Domains 1, 2, 4
PH 3.7	Activity and Obesity in Children	**Outcomes** - Increased physical activity among children - Reduced obesity among children **Methods** - Continued provision of child measurement programme via school nurses - 'Beat the Streets' Physical Activity scheme - Family-focused activity and weight management project. - Project Monitoring and Evaluation **Responsible Officer: Lisa McNally** **Completion/ Review: Ongoing - Quarterly**	**H&WB Strategy** Priorities:8, 16 **PH England Priorities** Priorities: 4 **Public Health Outcomes Framework** Domain 2, 4
PH 3.8	Initiatives aimed at reducing harmful levels of alcohol consumption.	**Outcomes** - Improved intelligence and insight on patterns and attitudes relating to alcohol consumption. - Greater awareness of impact of harmful levels of drinking among target groups. **Methods** - Data collection (qualitative and quantitative) in collaboration with Drink Aware - Targeted promotional and brief intervention work in collaboration with Drink Aware. - Work with local Licensing Group to reduce drink related problems in target areas	**H&WB Strategy** Priorities: 9 **PH England Priorities** Priorities: 7 **Public Health Outcomes Framework** Domains 1, 2, 4

		Responsible Officer: Lisa McNally **Completion/ Review: Ongoing - Quarterly**	

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Appendix C: Priorities from Public Health Plans and Key Drivers

- Public Health England Priorities 2013/14

1. Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol

2. Reducing the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact, including dementia, anxiety, depression and drug dependency

3. Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics

4. Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme

5. Improving health in the workplace by encouraging employers to support their staff, and those moving into and out of the workforce, to lead healthier lives

6. Promote the development of place-based public health systems

7. Develop our own capacity and capability to provide professional, scientific and delivery expertise to our partners

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192676/Our_priorities_final.pdf

- Health & Well-Being Strategy Priority Areas

1. Appropriate/adapted Housing
2. Respiratory Illness
3. Dementia - Early diagnosis, treatment and support
4. Diabetes and diabetic retinopathy
5. Education, skills and employment
6. Falls
7. NHS Healthchecks
8. Vulnerable children and young people
9. Prevention of alcohol & substance misuse
10. Prevention of Domestic abuse
11. Sexual health
12. Prevention of Social and Emotional Isolation
13. Reduction of high rates of depression
14. Support for people who have had stroke
15. Tobacco and smoking cessation
16. Weight management, diet and nutrition and physical activity
17. Cancers

http://www.bracknell-forest.gov.uk/BF-JHWS-Final.pdf

Public Health Outcomes Framework 2013–2016

At a glance (Autumn 2012)

VISION
To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest
Outcome measures
Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System

* Indicator shared with the NHS Outcomes Framework.

** Complementary to indicators in the NHS Outcomes Framework

† Indicator shared with the Adult Social Care Outcomes Framework

†† Complementary to indicators in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.1 Children in poverty

1.2 School readiness (Placeholder)

1.3 Pupil absence

1.4 First time entrants to the youth justice system

1.5 16-18 year olds not in education, employment or training

1.6 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H)*

1.7 People in prison who have a mental illness or a significant mental illness (Placeholder)

1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services *(i-NHSOF 2.2) ††(ii-ASCOF 1E) **(iii-NHSOF 2.5) †† (iii-ASCOF 1F)

1.9 Sickness absence rate

1.10 Killed and seriously injured casualties on England's roads

1.11 Domestic abuse (Placeholder)

1.12 Violent crime (including sexual violence)

1.13 Re-offending levels

1.14 The percentage of the population affected by noise

1.15 Statutory homelessness

1.16 Utilisation of outdoor space for exercise/health reasons

1.17 Fuel poverty (Placeholder)

1.18 Social isolation (Placeholder) † (ASCOF 1I)

1.19 Older people's perception of community safety (Placeholder) †† (ASCOF 4A)

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.1 Low birth weight of term babies

2.2 Breastfeeding

2.3 Smoking status at time of delivery

2.4 Under 18 conceptions

2.5 Child development at 2-2½ years (Placeholder)

2.6 Excess weight in 4-5 and 10-11 year olds

2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18s

2.8 Emotional well-being of looked after children

2.9 Smoking prevalence – 15 year olds (Placeholder)

2.10 Self-harm (Placeholder)

2.11 Diet

2.12 Excess weight in adults

2.13 Proportion of physically active and inactive adults

2.14 Smoking prevalence – adults (over 18s)

2.15 Successful completion of drug treatment

2.16 People entering prison with substance dependence issues who are previously not known to community treatment

2.17 Recorded diabetes

2.18 Alcohol-related admissions to hospital (Placeholder)

2.19 Cancer diagnosed at stage 1 and 2

2.20 Cancer screening coverage

2.21 Access to non-cancer screening programmes

2.22 Take up of the NHS Health Check programme – by those eligible

2.23 Self-reported well-being

2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

3.1 Fraction of mortality attributable to particulate air pollution

3.2 Chlamydia diagnoses (15-24 year olds)

3.3 Population vaccination coverage

3.4 People presenting with HIV at a late stage of infection

3.5 Treatment completion for Tuberculosis (TB)

3.6 Public sector organisations with a board approved sustainable development management plan

3.7 Comprehensive, agreed inter-agency plans for responding to public health incidents and emergencies (Placeholder)

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.1 Infant mortality* *(NHSOF 1.6i)*

4.2 Tooth decay in children aged 5

4.3 Mortality rate from causes considered preventable** *(NHSOF 1a)*

4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*

4.5 Under 75 mortality rate from cancer* *(NHSOF 1.4i)*

4.6 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*

4.7 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*

4.8 Mortality rate from infectious and parasitic diseases

4.9 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5)*

4.10 Suicide rate

4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*

4.12 Preventable sight loss

4.13 Health-related quality of life for older people (Placeholder)

4.14 Hip fractures in people aged 65 and over

4.15 Excess winter deaths

4.16 Estimated diagnosis rate for people with dementia* *(NHSOF 2.6i)*

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Report for Health and Wellbeing Board 4th July 2013

Healthwatch Bracknell Forest – Forward Plan (25/06/13)

Healthwatch Bracknell Forest (HWBF) is currently in the implementation phase of the contract and therefore is not yet delivering its long-term operational objectives. The implementation plan is being monitored by the Local Authority (LA) commissioner and is ahead of schedule. At the recent Healthwatch England conference it became clear that this is the situation for many local Healthwatch organisations; with some areas not yet having a contracted organisation.

Progress to date:

- Contracts signed, monthly monitoring meeting schedule and monitoring measures agreed between LA and HWBF.
- First monitoring meeting held.
- Website and social media sites published.
- First meeting of the partner organisations forming the consortium held and forward schedule agreed.
- SEAP (NHS Advocacy and Healthwatch partner) have arranged bi-monthly drop ins at The Space – where HWBF is based.
- Development of governance documents and Memorandum of Understandings (MoU) with partners is underway; majority agreed.
- Initial meeting with CCG held to discuss expectations from both parties.
- Information meeting attended with other Berkshire Healthwatch organisations with Berkshire Healthcare Foundation Trust to discuss engagement.
- Meeting held with LA about future involvement in the local account.
- Information events for LA social care staff planned. So far delivered to Children, Young People & Learning Departmental Management Team and Community Team for People with Learning Disabilities.
- Engagement with other patient representatives (individuals and groups) underway.
- Regional Healthwatch networking events attended and agreed with other Berkshire Healthwatches that regular meetings needed to share information, best practice and discuss issues needed. Bracknell will be hosting the first event; West Berkshire are organising.
- Inaugural Healthwatch England conference attended in Birmingham on 20th June.

Andrea McCombie-Parker

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HEALTH OVERVIEW AND SCRUTINY PANEL
11 JULY 2013

WORKING GROUPS UPDATE
Assistant Chief Executive

1 PURPOSE OF REPORT

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

2 RECOMMENDATIONS

That the Health Overview and Scrutiny Panel:

2.1 Notes the progress achieved to date by the Panel's Working Groups.

3 SUPPORTING INFORMATION

Francis Report

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

3.2 The Working Group comprises Councillors Mrs McCracken (Lead Member), Heydon, Kensall, Mrs Temperton, and Virgo. The Working Group has decided its objectives are to:

- Thoroughly review the weaknesses in O&S highlighted by the report by Mr Francis concerning the failings in Mid Staffordshire, showing that Bracknell Forest Council has responded properly to the lessons it offers.
- Determine the type and frequency of information (particularly on complaints) needed from principal NHS organisations serving Bracknell Forest residents.
- Re-appraise Members' health O&S role, and identify how to improve their effectiveness (to Include training, advice and support)
- Identify improvements to Health O&S practices, including prioritisation and the summing up and minuting of Health O&S Panel meetings.

3.3 The Working Group held its first meeting on 7 May. Matters covered to date have included: a background briefing by officers; discussing the review's approach with a representative of the Centre for Public Scrutiny; agreeing the main issues to be addressed, the scope and approach to the review; analysing the specific issues to be

addressed from the Francis report; and agreeing an allocation of responsibilities for work streams.

3.4 The Lead Member and Panel Chairman are to meet Surrey County Council O&S Members regarding the O&S approach to Frimley Park Hospital, on 4 July. The next meeting of the Working Group will be on 5 July, principally to commence a series of meetings with the main acute NHS Trusts serving Bracknell Forest residents, to learn about their progress in applying the lessons from the Francis report, and explore the information requirements for O&S. Further meetings are in the course of being arranged, with the Working Group aiming to present its report to the Health O&S Panel in December 2013.

The Brants Bridge Health Facility

3.5 The Panel's Work Programme for 2013/14 includes forming a Working Group to review the operation of the cancer and renal facilities, also the creation of the Urgent Care Centre at Brants Bridge, Bracknell. It is currently planned to commence this review once the Working Group on the Francis Report has concluded its work.

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

Contact for further information

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TO: HEALTH OVERVIEW AND SCRUTINY PANEL
11 JULY 2013

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

1 PURPOSE OF REPORT

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

2 RECOMMENDATION(S)

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

3 REASONS FOR RECOMMENDATION(S)

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

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

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

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

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

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

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

7 CONSULTATION

None.

Background Papers

Local Government Act 2000

Contact for further information

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HEALTH OVERVIEW & SCRUTINY PANEL

EXECUTIVE WORK PROGRAMME

REFERENCE	I041141

TITLE: Intermediate Care Services - Staffing

PURPOSE OF DECISION: To approve a waiver of the Contract Standing Orders for staffing provision for Intermediate Care Services.

FINANCIAL IMPACT: None

WHO WILL TAKE DECISION: Executive

PRINCIPAL GROUPS TO BE CONSULTED: None

METHOD OF CONSULTATION: None

DATE OF DECISION: Tuesday, 9 Jul 2013

REFERENCE	I040863

TITLE: Section 75 Agreement

PURPOSE OF DECISION: To approve a Section 75 partnership agreement with the Bracknell and Ascot Clinical Commissioning Group for the purposes of delivering joint health and social care services in Bracknell Forest.

FINANCIAL IMPACT: Within existing budget

WHO WILL TAKE DECISION: Executive

PRINCIPAL GROUPS TO BE CONSULTED: Intermediate Care Partnership Board
Bracknell and Ascot Clinical Commissioning Group

METHOD OF CONSULTATION: Meetings with interested parties

DATE OF DECISION: Tuesday, 9 Jul 2013

REFERENCE	I041994

TITLE: Joint Commissioning Strategy for People with Dementia 2014-2019

PURPOSE OF DECISION: To seek approval to the Joint Commissioning Strategy for people with Dementia which has been developed by Bracknell Forest Council and Bracknell and Ascot Clinical Commissioning Group. The Strategy has been developed following a full 12-week public consultation held prior to the development of the strategy to ensure that people with dementia, their carers and families and the voluntary sector were involved in informing the commissioning priorities for the next five years.

FINANCIAL IMPACT: Within existing budget

WHO WILL TAKE DECISION: Executive

PRINCIPAL GROUPS TO BE CONSULTED: People with dementia
Carers of people with dementia
People working in Health and Social Care
Voluntary sector colleagues
Members of Bracknell and Ascot CCG
Other individuals with an interest in dementia support

METHOD OF CONSULTATION: Public consultation event
Online consultation form
Hard copy consultation form posted out
Presentations at local voluntary groups

DATE OF DECISION: Tuesday, 10 Dec 2013

TO: HEALTH OVERVIEW AND SCRUTINY PANEL
11 JULY 2013

OVERVIEW AND SCRUTINY PROGRESS REPORT
Assistant Chief Executive

1 PURPOSE OF REPORT

1.1 This report highlights:

(i) Overview and Scrutiny (O&S) activity during the period September 2012 to April 2013.
(ii) Significant national and local developments in O&S.

2 RECOMMENDATIONS

2.1 To note Overview and Scrutiny activity and developments over the period September 2012 to April 2013, set out in section 5 to 6, and Appendices 1 and 2.

3 REASONS FOR RECOMMENDATIONS

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

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 None.

5 SUPPORTING INFORMATION

Overview and Scrutiny Structure and Membership

5.1 Council appointed Mr Robin Briscoe, Primary Parent Governor Representative, to the O&S Commission, and the Commission appointed Mr Briscoe to the Children, Young People & Learning Overview and Scrutiny Panel. The membership of the O&S Commission and Panels was set again by Council and the Commission respectively at their annual meetings on 15 May 2013. The vacancies of the representatives of both the Church of England also the Catholic Diocese remain to be filled, and officers are in contact with the church authorities on that.

Overview and Scrutiny Work Programme and Working Groups

5.2 The programme for 2012-13 was approved as part of the Annual Report of O&S for 2011-12, including formal consultation with the Corporate Management Team and the Executive. The programme continues the increased focus on contributing to policy development and pre-decision scrutiny, through short reviews; with fewer major reviews reviewing important topics in depth, over several months.

5.3 A routine report was submitted to O&S Commission meetings, monitoring progress against the O&S Work Programme using traffic light indicators.

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

Overview and Scrutiny Commission

5.5 The O&S Commission met on 22 November 2012, and in 2013 on: 30 January, 28 March, 2 May and 15 May (Annual Meeting). The main items included: agreeing the Annual Report of O&S for 2012-13; determining with the O&S Panels the work programme for 2013-14; reviewing the service plans and quarterly performance reports for the Corporate Services Department, the Chief Executive's Office and the Council as a whole; meeting the Police and Crime Commissioner also representatives of Thames Valley Police and the Community Safety Partnership to review their performance and the refreshed Community Safety Plan; consideration of the 2013-14 budget proposals; proposals for Council Tax support and technical changes; receiving briefings on work of the Economic and Skills Development Partnership, the Customer Contact Channel Strategy, and the response to the 'Community Right to Challenge'; considering the results of the survey of residents' views; adopting the report of the Commission's Working Group which reviewed the preparations for the Community Infrastructure Levy, and considering the Executive's response to that report. At each of its meetings, the Commission also reviewed corporate items on the Executive Forward Plan, and monitored the delivery of the O&S work programme, with particular reference to the Commission's own Working Groups.

5.6 The O&S Commission's next meeting is on 1 July. Meanwhile, the Commission is running a Working Group on Delegated Authorities.

Environment, Culture and Communities O&S Panel

5.7 Meetings of the Panel were held on 23 October 2012, and 22 January and 30 April 2013. During the meetings the Panel considered and commented on: Quarterly Service Reports for the relevant quarters; the Thames Valley Vision for carbon reduction; car club schemes; service delivery options for public realm services in 2014; O&S Work Programme 2013-14; the Local Flood Risk Strategy; 2013-14 budget proposals; departmental Service Plan 2013-14 and Revised Key Actions; the annual report of the Activate GP Referral Health Scheme; Climate Change Action Plan; Air Quality Management Areas; and scheduled Executive key and non-key decisions. The Panel received progress updates in respect of the Local Development Framework, the Recycling Incentive Scheme and the transfer of Public Health services. A Working Group of the Panel has been reviewing the emerging Bus Strategy for the Borough and the Panel has monitored its progress (see Appendix 1). The next meeting of the Panel is taking place on 25 June.

Health O&S Panel

5.8 The Panel met on 27 September 2012, and in 2013 on 24 January and 18 April. The main items considered at those meetings included: considering how the architecture of the new NHS structures will help to deliver better health services in Bracknell Forest, in discussion with representatives of NHS England (Thames Valley Area Team) and the Bracknell Forest & Ascot Clinical Commissioning Group (CCG) ; monitoring the progress on delivering the reforms to health arising from the Health and Social Care Act, specifically reviewing the Primary Care Trust's (PCT) draft 'Quality Handover Document' as part of the national transfer of healthcare responsibilities, the transfer of Public Health responsibilities to the Council, setting up the Health and Wellbeing Board, and establishing Local Healthwatch; considering the South Central Ambulance Service's performance on cardiac arrest survival rates; and receiving a briefing concerning possible changes to the pathway for surgical services dealing with disorders of arteries and veins. At each of its meetings, the Panel also

considered scheduled Executive Key and Non-Key Decisions relating to Health, and monitored the progress of its Working Groups.

5.9 Between formal meetings, the Panel's activities have included: producing letters in April 2013 commenting on the performance of three NHS Trusts in relation to their 'Quality Accounts'; producing jointly with the Executive the Council's response to a consultation by the PCT on the 'Shaping the Future' programme for health services in East Berkshire (endorsed by Council). The Panel recently commenced a Working Group to review what has been and can be learnt locally from the Francis report on the appalling failures concerning the Mid Staffordshire NHS Trust. The Panel's next meeting is on 11 July.

Joint East Berkshire with Buckinghamshire Health O&S Committee

5.10 This Committee, formed jointly with Slough Borough Council, the Royal Borough of Windsor & Maidenhead, and Buckinghamshire County Council had previously suspended its meetings from February 2011, owing to resource constraints and the absence of formal consultations on NHS service changes affecting the whole of East Berkshire. However, in view of the proposals by the PCT and Heatherwood and Wexham Park Hospitals Trust on the 'Shaping the Future' (STF) programme for health services in East Berkshire, since January 2012 the Committee resumed meeting regularly. The Committee agreed a joint response to the consultation document, which was consistent with the Bracknell Forest response; it supported two of the proposals but said no consensus could be reached on the third (the removal of the Minor Injuries Unit).

5.11 The O&S Commission decided in 2011 to end the Council's involvement in the Joint Committee, unless there was a need to respond to a statutory consultation affecting health services in East Berkshire. Accordingly, on 16 May the Chairman of the O&S Commission informed the three other councils that whilst members might choose to meet informally, Bracknell Forest did not agree to re-commencing formal committee meetings and could not provide any Officer support for this Joint Committee unless the need to respond to a statutory consultation arises.

Children, Young People and Learning O&S Panel

5.12 The Panel met on 3 October 2012, and 16 January and 17 April 2013 when it received the minutes of the Corporate Parenting Advisory Panel and considered and commented on: Quarterly Service Reports for the relevant quarters; the annual report of School and Children's Centre inspections 2011-12; 2013-14 budget proposals; study programmes for 16-19 year olds; pupil places and admission appeals; the Bracknell Forest Local Safeguarding Children Annual Report 2011-12; Annual Admission Arrangements 2014-15; 2013-14 O&S Work Programme; 2011-12 Annual Report of the Independent Reviewing Officer for Children's Social Care; changes affecting special educational needs; scheduled Executive key and non-key decisions; and the Education Transport Policy 2014-15. A working group of the Panel is currently reviewing school governance and the Panel has been monitoring its progress (see Appendix 1). The Panel's next meeting is being held on 3 July.

Adult Social Care and Housing O&S Panel

5.13 Meetings of the Panel took place on 9 October 2012, and 15 January and 23 April 2013. The main items considered at the meetings included: Quarterly Service Reports for the relevant quarters; Approaching Adulthood Strategy for Children and Young People Moving into Adulthood; Long Term Conditions Strategy; Sensory Needs Service; 2013-14 budget proposals; 2013-14 O&S Work Programme; departmental Service Plan and Revised Key Actions; redesign of Housing and Benefit Services; benefit changes; Fixed Civil Penalty – Overpayment of Housing or Council Tax Benefit; the Local Council Tax Support Scheme; the Strategy for Older People in Bracknell Forest 2013-16; and scheduled Executive key

and non-key decisions. The Panel received updates in respect of the transfer of Public Heath functions and new legislation. It also monitored the progress of its working groups (see Appendix 1) reviewing the Modernisation of Older People Services and substance misuse, agreed the reports of the reviews and considered the Executive responses. The next meeting of the Panel is taking place on 18 June when it will consider its next piece of review work.

Other Overview and Scrutiny Issues

5.14 The O&S Annual Report for 2012-13 was adopted by Council on 24 April.

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

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

5.17 The O&S Chairmen and Vice Chairmen are meeting on a regular basis to consider cross-cutting O&S issues. They last met on 10 April, and their next meeting is planned for 4 September.

5.18 External networking on O&S in the last six months has included the Head of O&S attending a South East Employers Local Democracy and Accountability network event in March and representing South East councils at meetings of the National O&S Forum, run by the Centre for Public Scrutiny.

6 Developments in O&S

6.1 The *Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations* 2013 continue the core health scrutiny provisions for local authorities to review and scrutinise matters relating to the planning, provision and operation of the health service in their area. They replace the previous 2002 and 2004 regulations on health scrutiny. Under the new system of health scrutiny, local authorities have greater flexibilities in how they discharge their health scrutiny functions. Certain elements of the previous regulations have been preserved but there are new obligations on NHS bodies, relevant health service providers and local authorities around consultations on substantial developments or variations to services to aid transparency and local agreement on proposals.

7 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Statutory Scrutiny Officer

7.1 The monitoring of this function is carried out by the Statutory Scrutiny Officer on a quarterly basis. Good progress has been made on the agreed programme of work by Overview and Scrutiny for 2012/13. Scrutiny Panels have continued to focus on areas of importance to local residents, and the quality of the work done continues to be high.

Borough Solicitor

7.2 Nothing to add to the report.

Borough Treasurer

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

Equalities Impact Assessment

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

Strategic Risk Management Issues

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

Workforce Implications

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

Other Officers

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

8 CONSULTATION

Principal Groups Consulted

8.1 None.

Method of Consultation

8.2 Not applicable.

Representations Received

8.3 None.

Background Papers

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

Contact for further information

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Doc. Ref CXO\Overview and Scrutiny\2012-13\progress reports

Appendix 1

OVERVIEW AND SCRUTINY CURRENT WORKING GROUPS
Position at 30 April 2013

Overview and Scrutiny Commission								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Community Infrastructure Levy	Leake (Lead), Angell, Mrs Birch, Heydon, Virgo and Worrall	Bev Hindle	Richard Beaumont	√	Completed	Completed	√	Review completed, though letter sent to Leader on 26.4.2013 concerning the Executive Response
Delegated Authorities	Angell (Lead), Mrs Birch, Gbadebo, Finnie and Leake	Alison Sanders	Richard Beaumont	√	Around 75% complete			Information gathering almost complete

Health Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Francis Report on NHS Mid Staffordshire Hospital	Mrs McCracken (Lead), Baily, Finch, Heydon, Kensall, Ms Wilson, Mrs Temperton,	Glyn Jones	Richard Beaumont					First meeting held on 9 May

	and Virgo							

Environment, Culture and Communities Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Bus Strategy Working Group	Finnie (Lead), Brossard, Ms Brown, Gbadebo and Leake	Bev Hindle / Sue Cuthbert	Andrea Carr	√	Review underway and three meetings have taken place			One further meeting is anticipated

Children, Young People and Learning Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
School Governance	Mrs Temperton (Lead) Mrs Birch, Ms Hayes, Mrs McCracken, Mrs Cauchi (former PGR) & Mr Jackson (Kerith Centre)	Martin Surrell	Andrea Carr	√	Review commenced on 13 September 2012			Review should be completed in June 2013
School Places	Mrs Birch, Kensall, Mrs McCracken, Mrs Temperton and Mr Briscoe (PGR)	Bob Welch	Andrea Carr		Review expected to commence in late June 2013.			Not yet commenced.

Adult Social Care Overview and Scrutiny Panel								
WORKING GROUP	MEMBERS	DEPT. LINK OFFICER	O&S LEAD OFFICER	SCOPING	PROGRESS OF REVIEW	REPORT / SUBMISSION	EXECUTIVE RESPONSE	CURRENT STATUS
Substance Misuse	Virgo (Lead), Blatchford and Brossard	Jillian Hunt / Mira Haynes	Andrea Carr	√	Completed.	√	√	Executive response was considered by the Panel on 23 April 2013.
Modernisation of Older People's Services	Allen (Lead), Brossard, and Mrs Temperton	Mira Haynes	Andrea Carr	√	Completed.	√	√	Executive response was considered by the Panel on 15 January 2013.

Completed Reviews

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

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

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

Appendix 2

Results of Feedback Questionnaires on Overview and Scrutiny Reports

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

	Average score for previous 16 Reviews[1]
PLANNING Were you given sufficient notice of the review?	**2.8**
Were your comments invited on the scope of the review, and was the purpose of the review explained to you?	**2.9**
CONDUCT OF REVIEW Was the review carried out in a professional and objective manner with minimum disruption?	**2.8**
Was there adequate communication between O&S and the department throughout?	**2.7**
Did the review get to the heart of the issue?	**2.7**
REPORTING Did you have an opportunity to comment on the draft report?	**2.9**
Did the report give a clear and fair presentation of the facts?	**2.6**
Were the recommendations relevant and practical?	**2.5**
How useful was this review in terms of improving the Council's performance?	**2.7**

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