Buckinghamshire County Council

Select Committee

Health and Adult Social Care

Date: Tuesday 6 September 2016

Time: 10.00 am (pre-meeting for Committee Members at 9.30am)

Venue: Mezzanine Room 2, County Hall, Aylesbury

AGENDA

9.30 am Pre-meeting Discussion

This session is for members of the Committee only. It is to allow the members time to discuss lines of questioning, areas for discussion and what needs to be achieved during the meeting.

10.00 am Formal Meeting Begins

	Agenda Item	Time	Page No
1	**APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP**	**10.00**	
2	**DECLARATIONS OF INTEREST** To disclose any Personal or Disclosable Pecuniary Interests		
3	**MINUTES** of the meeting held on 26th July 2016 to be confirmed as a correct record.		**7 - 26**
4	**MATERNITY SERVICES** For Committee Members to receive an update on maternity services which will include the following. 1. An overview of maternity services in Buckinghamshire against national and local performance targets; 2. Understanding how choice is managed and met; 3. How services are meeting current demand and modelling to meet future demand for ante-natal & post-natal support services.	**10.10am**	**27 - 40**

AVDC Aylesbury Vale District Council · healthwatch · Chiltern District Council · South Bucks District Council · Wycombe District Council

Attendees:

Carolyn Morrice, Chief Nurse, Bucks Healthcare Trust
Andrea Anderson, Deputy Head of Midwifery, Wexham Park Hospital
Monica Warren, Matron for Intrapartum Maternity Services
Dal Sahota, GP, Clinical Commissioning Group

5 PUBLIC QUESTIONS

This is an opportunity for members of the public to put a question or raise an issue of concern, related to health. Where possible, the relevant organisation to which the question/issue is directed will be present to give a verbal response. Members of the public will be invited to speak for up to four minutes on their issue. A maximum of 30 minutes is set aside for the Public Questions slot in total (including responses and any Committee discussion). This may be extended with the Chairman's discretion.

For full guidance on Public Questions, including how to register a request to speak during this slot, please follow this link:

http://www.buckscc.gov.uk/about-your-council/scrutiny/getting-involved/

6 CHAIRMAN'S UPDATE **11.10am**

To include an update on the Bedfordshire and Milton Keynes Healthcare Review.

7 COMMITTEE UPDATE **11.20am**

An opportunity to update the Committee on relevant information and report on any meetings of external organisations attended since the last meeting of the Committee. This is particularly pertinent to members who act in a liaison capacity with NHS Boards, for District and HealthWatch representatives.

8 VASCULAR SERVICES **11.25am** **41 - 46**

Further to the briefing paper on the re-configuration of the vascular service which was circulated to Members in May and the subsequent meeting between the Chairman and the relevant clinicians, this item will provide further information on the following areas.

1. Communications plan;
2. Patient pathways both pre and post the change;

3. Patient Reported Outcome Measures (PROMs) data update

Attendees:

Aarti Chapman, Associate Director, Strategic Clinical Network and Senate
Andrea Collins, Head of Communications and Engagement, NHS England South (South Central)
Cliodhna Ni Ghuidhir, Thames Valley Vascular Network and Service Manager, Oxford University Hospitals NHS Foundation Trust

9	**15 MIN CARE VISITS REVIEW - 12 MONTH RECOMMENDATION MONITORING** For Members to consider the 12 month progress report on the recommendations made in the 15min Care Visit Review and to delegate authority to the Chairman to complete the status of recommendations on the Committee's behalf. The completed recommendation monitoring report will be published with the Minutes of the meeting.	**12 noon**	**47 - 52**

Attendees:

Mike Appleyard, Deputy Leader and Cabinet Member for Health & Wellbeing;
Steven GoldenSmith, Strategic Commissioner Later Life, Adults, Health & Communities

10	**COMMITTEE WORK PROGRAMME** For Members to discuss and agree the items for the October meeting.	**12.30pm**	**53 - 54**
11	**DATE AND TIME OF NEXT MEETING** The next meeting is due to take place on Tuesday 18 October at 10am in Mezz Room 2, County Hall, Aylesbury.	**12.45pm**	

Purpose of the Committee

The role of the Health and Adult Social Care Select Committee is to hold decision-makers to account for improving outcomes and services for Buckinghamshire.

It shall have the power to scrutinise all issues in relation to Health and Adult Social Care. This will include, but not exclusively, responsibility for scrutinising issues in relation to:

- Public health and wellbeing
- NHS services

- Health and social care commissioning
- GPs and medical centres
- Dental Practices
- Health and social care performance
- Private health services
- Family wellbeing
- Adult social services
- Older people
- Adult safeguarding
- Physical and sensory services
- Learning disabilities
- Drugs and Alcohol Action Team (DAAT services)

* *In accordance with the BCC Constitution, this Committee shall act as the designated Committee responsible for the scrutiny of health matters holding external health partners to account.*

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For further information please contact: Liz Wheaton on 01296 383856 , email: ewheaton@buckscc.gov.uk

Members

Mr B Roberts (C)
Mr R Reed (VC)
Mr B Adams
Mr C Adams
Mrs M Aston
Mrs P Birchley
Mr N Brown
Mr C Etholen
Mrs W Mallen
Ms R Vigor-Hedderly
Julia Wassell

Co-opted Members

Ms T Jervis, Healthwatch Bucks
Mr A Green, Wycombe District Council
Ms S Jenkins, Aylesbury Vale District Council
Mr N Shepherd, Chiltern District Council
Dr W Matthews, South Bucks District Council

Buckinghamshire County Council
Select Committee
Health and Adult Social Care

Minutes

HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

Minutes from the meeting held on Tuesday 26 July 2016, in Mezzanine Room 2, County Hall, Aylesbury, commencing at 10.00 am and concluding at 11.30 am.

This meeting was webcast. To review the detailed discussions that took place, please see the webcast which can be found at http://www.buckscc.public-i.tv/
The webcasts are retained on this website for 6 months. Recordings of any previous meetings beyond this can be requested (contact: democracy@buckscc.gov.uk)

MEMBERS PRESENT

Buckinghamshire County Council

Mr B Roberts (In the Chair)
Mr B Adams, Mr C Adams, Mrs M Aston, Mr N Brown, Mr C Etholen, Mrs W Mallen, Mr R Reed and Julia Wassell

District Councils

Mr A Green	Wycombe District Council
Ms S Jenkins	Aylesbury Vale District Council
Mr N Shepherd	Chiltern District Council

Others in Attendance

Ms J Woodman, Committee and Governance Adviser
Mrs E Wheaton, Committee and Governance Adviser
Ms C Morrice, Chief Nurse and Director of Patient Care Standards, Buckinghamshire Healthcare NHS Trust
Ms L Patten, Chief Officer, Aylesbury Vale Clinical Commissioning Group
Mr P Thiselton, Head of Research, Healthwatch

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies were received from Mrs Wendy Mathews.

Ms Thalia Jervis the new Chief Executive at Healthwatch Bucks was introduced as the new co-opted Healthwatch Member replacing Ms Shade Adoh. Ms Jervis sent apologies for the meeting and Mr Phil Thisleton Head of Research at Healthwatch was substituting.

2 DECLARATIONS OF INTEREST

There were no declarations of interest.

3 MINUTES

The Minutes of the meeting held on 21st June were confirmed as an accurate record with the addition of Mr A Green's apologies and Julia Wassell's comment that she had used social media to highlight the work of the HASC.

Julia Wassell questioned whether a majority view had been established for meetings to remain at County Hall. The Chairman stated that his understanding that a decision was reached at the last meeting and would be reviewed again in a years' time. Julia Wassell motioned for a vote of no confidence in the Chairman on the grounds of failure to listen to the voices of Wycombe representatives. The motion was not seconded.

The Chairman agreed that choice of venues for future HASC meetings could be discussed and agreed by HASC outside of the meeting.

Follow-up on actions

ACTION: Committee and Governance Adviser to investigate how information on public questions could be more prominent on the Bucks County Council web pages.
Currently being investigated

ACTION: Committee and Governance Adviser to invite the Primary Care Commissioner to the 26th July HASC to discuss the Lynton House Surgery decision.
Mrs Lou Patten (Chief Officer Aylesbury Vale CCG) attended the meeting to present the decision briefing paper.

ACTION: Committee and Governance Adviser to write to NHS England to seek response to the formal submission to the Community Pharmacy consultation.
Responses from the Secretary of State for Health the Rt Hon Jeremy Hunt MP to the Rt Hon John Bercow MP and a response from the Rt Hon Cheryl Gillan MP were attached with the agenda. Mrs Aston requested that the issue be kept on the HASC's agenda with an update at the next meeting.

Proposals from Department of Health were due in July and HASC Members would be circulated with the details.

ACTION: Adult Social Care to provide the current figures for delayed discharges.
These had been sent out to Members and would be re-circulated as new Members had joined the Committee.

ACTION: Buckinghamshire Healthcare Trust to provide HASC with re-admission figures.
The readmission rate for May 16 was 6.9%, an improvement on 8.9% in March 16. The

Chairman stated that HASC would monitor these figures.

4 PUBLIC QUESTIONS

The Chairman stated that responses had been sought on public questions raised outside the time deadlines for the previous meeting. Concern was expressed that the responses had not been distributed at the meeting. The Chairman explained that the responses had been received just prior to the start of the meeting so it was agreed that these would be circulated after the meeting.

The full questions and answers are attached.

5 CHAIRMAN'S UPDATE

The Bedfordshire and Milton Keynes Healthcare Review

The Chairman has been advised that the cancelled 14th June meeting of the Joint Health Care Review Board had not been re-convened as the team wanted to ensure alignment with Sustainability and Transformation Plans. A revised decision making timetable would be presented by the HCR team at the next HASC meeting on 6th September.

Moving Closer to Home Pilot

The Chairman had met with the Chief Executive of Buckinghamshire Healthcare Trust (BHT) to express support for the pilot project.

(See Appendices 2 and 3)

Provision of Communications and Engagement Services to Aylesbury Vale and Chiltern Clinical Commissioning Groups

Buckinghamshire County Council (BCC) and the Aylesbury Vale and Chiltern Clinical Commissioning Groups ('the CCG') had established an agreement for a shared communications and engagement service, hosted by BCC. The decision was ratified by the County Council on 25th July.

Mandeville Practice

Concerns were raised with Mr B Adams regarding Mandeville Practice use of locum GP cover on a Thursday and Friday.

Responses were sought from the Practice Manager who stated that:

'I am sure you are aware of the challenging situation Mandeville has been experiencing and working through over the last 12 months, together with the national problem experienced by GP surgeries nationwide with regard to GP recruitment and retention. Following The Practice U Surgeries Limited taking over the practice on 1st April, 2016 we have steadily been increasing our regular GP clinics. Yes, like all other GP practices, we do need to use the services of locum or self-employed GP's but we work very hard to ensure we have regular self-employed GPs to ensure patient continuity. Our employed GPs work sessions across the week. A new employed GP started with us recently and another will commence at the beginning of August to further support our current team.'

In addition the Head of Primary Care NHS Chiltern and Aylesbury Vale CCGs stated that:

'*Recruitment and retention is a national problem for primary care. Like many other practices, Mandeville Surgery has suffered recruitment issues. Throughout this difficult period the*

practice has remained clinically staffed although it has had to resort to employing locum staff at times.

A successful recruitment campaign has resulted in the employment of 2 new GPs and an Advanced Nurse Practitioner. We are pleased to report that from September 2016 the practice will be able to provide the local population with 50 – 52 GP sessions a week and will no longer be reliant upon locum clinical staff. This should increase the availability of patient appointments and improve the overall patient experience.

On the day appointments with a clinician continue to be available for patients morning and afternoon five days a week. However the surgery does recognise that there has been some irregularity regarding the number of emergency appointments available each day due to clinical capacity. With the addition of the newly appointed clinical staff this imbalance should resolve. From September 2016 a consistent number of on the day appointments will be made available from Monday to Friday. It is worth noting that on days when a high patient demand is expected we would anticipate a larger number of emergency appointments will be made available than on quieter days.
Currently at Mandeville Surgery the average waiting time for a routine GP appointment is 2 days, with emergency appointments being made available sooner. Further, the surgery aims to open for extended hours in the near future which will further help with the availability of appointments.'

See Appendix 4 for a copy of the letter from the Head of Primary Care to Aylesbury Vale Town Council.

Closure of Ridgeway Centre

Concern was expressed that HASC had not been consulted and assurances were sought regarding impact of closure, the number of Buckinghamshire residents affected and details regarding Dove Ward.

Mrs L Patten made the following points:

- Dove Ward, part of the Hertfordshire Partnership Foundation Trust was in Garston and not far from the Ridgeway Centre.
- As a result of ongoing issues with the previous provider Southern Health Foundation Trust, the CCG had sought an alternative provider.
- Hertfordshire Foundation Trust had been selected as it was felt a much better option for patients in the longer term.
- The decision had taken into consideration new models of care which looked to support people in their homes, rather than being in-patient services.
- There was low usage of Ridgeway beds by Buckinghamshire residents and the CCG needed to factor in wrap around care which Dove Ward provide.
- The CGG needed to consider the quality of care for a small and reducing number in-patients from Buckinghamshire (two currently used the service).

HASC discussed how to ensure earlier sight of issues and Mrs Patten suggested the CCG could provide regular information on current issues at the Committee.

(See Appendix 5 attached for further information)

ACTION: Committee and Governance Adviser to liaise with the CCG to arrange a visit for HASC Members to Dove Ward.

6 COMMITTEE UPDATE

There were no Committee updates.

7 COMMITTEE WORK PROGRAMME

The work programme was noted.

8 LYNTON HOUSE SURGERY

Mrs Patten provided background context to the item reporting that she was now the Accountable Officer for the new Federation of Chiltern and Aylesbury Vale CCG. Mrs Patten explained that the change provided clarity regarding staffing and structure and anticipated that communications with Committees such as HASC and the public would improve as a result.

The Committee heard that the CCG was currently working on the current and future population health, social care and infrastructure needs around the seven localities.

With regard to Lynton House, Mrs Patten confirmed that NHS England had been working with Chiltern CGG and that it had been decided to postpone the decision to close Lynton House for 6 months. Mrs Patten explained that this would provide time to review long-term provision for the health and social care needs of residents in East Wycombe which would need to take into consideration public health, housing needs and the desire for patients to be cared for closer to home.

During discussions the following points were made:

- The risk assessment had shown that it was currently safe for patients to be seen at Lynton House.
- It would be necessary to have clear options for consultation based on the needs and future need of the local population.
- Members requested that the review be brought back to HASC

Action: Committee and Governance Adviser to liaise with NHS England and the CCG to ensure the review is considered by HASC at the start of the consultation.

9 TEMPORARY TRANSFER OF CARE OF WOMEN PLANNING TO GIVE BIRTH IN WYCOMBE BIRTH CENTRE

Mrs C Morrice clarified that the decision to temporarily transfer care for women using the Wycombe Birth Centre was temporary until 31st October and that the decision had not been taken lightly and that clinicians had been fully involved. Mrs Morrice explained that the primary concern was the safety of women and their babies and approximately 20 women per month gave birth at the Wycombe Birth Centre and that all affected women were fully consulted.

Mrs Morrice provided the following information:

- 24 maternity services staff had left the Trust over the past year – a mixture of staff retiring and moving to other posts.
- Recruitment was impacted by an ageing workforce and reflected national trends.
- Currently Buckinghamshire Healthcare Trust had 172 midwives in post and was 14 midwives short of its requirement.
- The Trust was currently interviewing 24 Midwives.
- The Wycombe Birthing Centre remained open for ante- and post-natal appointments.

During discussions, the following points were raised:

- The Stoke Mandeville Unit would be clinically more difficult to close as women with more complex birth risks were referred to the Unit (around 50 women per month).
- The Trust was using Birth Rate Plus as a tool for forecasting numbers of midwives needed. The need to future proof services and include the community in discussions was acknowledged.
- Perinatal mortality is 4.6 per 1,000 in Buckinghamshire against a UK rate of 5.9 per 1,000 (source: MBRRACEUK report 2014).
- The Committee requested clarification around the local performance in relation to comparator CCGs in relation to the maternity services pathway at its meeting on 6th September.

ACTION: Commissioning leads for Maternity Services to provide HASC on 6th September with context and detail regarding the areas where the Buckinghamshire CCGs are performing worse than its comparator CCGs against the Commissioning for Value Tool.

10 DATE AND TIME OF NEXT MEETING

The next full webcast committee meeting will be on 6th September 2016 at 10am.

CHAIRMAN

Questions submitted to HASC by Ms Ozma Hafiz

Q Ward 5B closure Wycombe Hospital - Were HASC consulted before the closure of this ward? There was NO mention of this during the 'community hub' meeting. Do HASC agree that given the Home Care Sector is struggling to recruit care staff, and that there is a wait for OT visits, that the closure of this ward is a short-sighted decision? Obviously people wish to return home as soon as possible, and given hospital infections etc this is often good for the patients, but has any consideration been given to potential patients (i.e carers) who may need respite? Some of these tend to be elderly themselves.

Patients from Ward 5B are usually placed there after being moved from other acute wards, will the fact that it no longer will take patients over the next 6 months mean that other 'step down wards' will face more pressure? Will the fact that Ward 5B has closed result in 'bed blocking' on other acute wards?

Chiltern CCG mention that keeping patients on wards for a length of time can result in muscle wastage etc, but will these patients who have been sent home still be in bed anyway and therefore still potentially face bedsores, possible muscle wastage and falls? Could it be argued that some of these patients may well be safer and recover more quickly, with better access to trained staff, on a ward such as 5B?

Response from Buckinghamshire Healthcare Trust (BHT)

Ward 5b cared for patients who were medically ready for discharge or transfer to their next stage of care (be that a nursing home bed or waiting for social services long-term package of care at home). The investment from this ward was transferred into expanded community provision in order to better support this group of patients. A paper on the rationale of the proposal is attached. This is a six month pilot, where the impact and effectiveness will be assessed.

Q What is the real reason behind the emptying of the Tower Block at Wycombe Hospital? What evidence can be given to support this?

Response from BHT

Wycombe Hospital has an exciting and vibrant future and is a key part of our strategy development. We wish to continue to improve facilities at Wycombe Hospital, ensuring that clinical services are provided from our most modern and fit for purpose accommodation on the site. Over recent years we have invested in the development of a new breast care centre, hyperacute stroke unit and cardiac and stroke receiving unit. In the past year the Trust has agreed to expand the endoscopy service and to build a second cardiac cath lab on the site.

Changes to services within the tower block over recent years have been as a response to developments in clinical services. Looking ahead, our clinical strategy will determine the future estates requirements for the Trust including the tower block.

Q What reassurance can be given that the STP footprint 'BOB' won't result in further downgrades in Buckinghamshire's hospitals? What reassurance can be given that Reading's hospital is safe from downgrades?

Buckinghamshire County Council response

Buckinghamshire is part of the wider BOBW STP footprint to collaborate on those areas of common interest including very specialised services, workforce and urgent and emergency care services. There are no current plans to significantly change the range of acute hospital services provided locally.

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20th July 2016

Dear HASC Members,

Statement regarding Buckinghamshire Healthcare Trust 'Closer to home' pilot study

The former Chairman of HASC was informed of this pilot in May and a briefing paper circulated to Members for comment after the 10th May meeting. (a copy of the original briefing paper is attached with this statement)

At the 21st June meeting it was decided the Chairman of HASC would comment on the pilot on behalf of the Committee after a meeting with the Neil Dardis - Chief Executive of the Buckinghamshire Healthcare Trust (BHT). This was due to the fact that Members have not indicated that they would like this to come to Committee to discuss.

I have now had the opportunity of meeting with Neil Dardis along with the Vice Chairman of the Committee. As a result of discussions I fully support the moving close to home pilot BHT are undertaking. My reasons for this are as follows:

- The aim of any acute trust should be to allow medically fit patients to return home as soon as possible ensuring they have a good rehabilitation and support package. For elderly patients this is critical to maintain their independence, mobility and general wellbeing.
- The outcome must always be to maintain or offer better standards of care and not solely a focus on preserving the status quo.
- Evidence shows that people who receive care and support in their own homes enjoy a longer better quality of life.
- A recognition of BHTs work as part of a wider need for health and social care agencies to 'future proof' services particularly for our vulnerable and elderly residents.

The Pilot is still ongoing and the Committee will be kept up to date with any changes.

Kind regards

Brian Roberts

Chairman, Health and Adult Social Care Select Committee

Buckinghamshire Healthcare NHS
NHS Trust

Division of Integrated Elderly & Community Care	
Briefing Paper	Moving Care Closer to Home
Dated	April 2016

1. Introduction

Buckinghamshire Healthcare NHS Trust provides a range of services for frail older people of Buckinghamshire and beyond including community, outpatient, day case and inpatient care. In 2015 a new Integrated Elderly and Community Care Division was created within the Trust to ensure that the organisation maximises the opportunities it has to provide and develop integrated care. The national direction is to move care closer to home, where appropriate. With that in mind the divisional team have looked at the services currently available and developed proposals to further invest in expanding community services in order to support more patients closer to home and to reduce the number of delayed discharges and transfers of care. This could be achieved by shifting resources from acute to community services.

2. Improving the quality of care

Currently, services for frail older people are provided from patients own homes (through the adult community healthcare teams), as well as a variety of outpatient, inpatient and day case services offered from Wycombe, Stoke Mandeville, Amersham, Buckingham, Thame, Marlow, and Chalfont hospitals.

The national Five Year Forward View, published in October 2014, stressed the importance of "expanding and strengthening primary and out of hospital care". It cites various examples of successes in managing elderly complex patients in the community and avoiding admissions. There is good evidence that patient satisfaction is higher when people are treated at home rather than in hospital and there is also some evidence that this may be more cost effective. (Purdy,S, 2010)

Moving care into the community and providing streamlined pathways that integrate health and social care are major components of the five year forward view and is designed to ensure resilience and sustainability in the NHS for the future.

Locally, treating as many patients, especially older people, at home is also a top priority for the Trust and local commissioners. The Chiltern CCG's operational plan for 2014 – 16 states two of their outcome ambitions as:

- Reducing the amount of avoidable time people spend in hospital through better and more integrated care in the community.
- Increasing the number of older people living independently at home following a stay in hospital.

A 2016 report by the independent Commission on Improving Urgent Care for Older People states that there needs to be a greater focus on proactive care. The current system often focuses on providing care reactively. The Commission believed the mind-set of the care system needed to change from reacting in a crisis, to proactively planning to avoid one and to react appropriately if someone deteriorates. They stated this would help support hospital services to meet the needs of those who really needed the unique skills, expertise and environment of the acute sector. It also encouraged greater use of multidisciplinary and multiagency teams. Suggesting the teams could operate in both the hospital and the community, bringing together staff from different backgrounds. Where appropriate, they should encourage and support self-management by working with people and carers, which at Buckinghamshire Healthcare we are uniquely placed to deliver.

In the wide-ranging Lord Carter report into hospital productivity and performance, published in February 2016, it highlights that the number of days lost to bed blocking is higher than previously thought: "Nearly all trusts wrestle with the problem of moving those who are medically fit into settings that are more appropriate for the delivery of their care or rehabilitation, and for the families

and carers." Information provided by trusts reveals that on any given day as many as 8,500 beds in acute trusts (across England) are blocked with patients who are medically fit to be transferred. In Buckinghamshire, we report on between 50 and 60 delayed transfers of care per day.

3. Process for developing new model

On average there can be upwards of 50 – 60 patients remaining in Buckinghamshire acute hospital beds that are medically ready for discharge or transfer to their next stage of care, be that a nursing home bed or waiting for a social services long-term package of care at home. It has been identified that these patients could benefit most from greater investment in community support.

These patients are often transferred to ward 5b at Wycombe Hospital, which can constitute another process in their journey, delaying their discharge and adding to their length of stay. Currently on 5b, 100% of the patients are deemed medically fit for discharge.

Ward 5b is a 20 bedded ward which facilitates both male and female patients. The ward primarily cares for older patients who require additional rehabilitation prior to discharge. 5b also accepts admissions from all parts of the Trust for those patients over the age of 75 who require low level rehabilitation or those who are waiting for social care in the community.

In 2015/16 there were 263 people admitted to the ward. The main sources of referral into 5b were from several main areas:

- 65% were from Medicine for Frail Older People (Wards 8 & 9 at Stoke Mandeville and MUDAS at High Wycombe)
- 34% were from Wycombe Stroke and Cardiology Services.
- 1% direct from Assessment & Observation Unit and Short Stay Ward at Stoke Mandeville.

Of those admitted to the ward, 68% were from the Wycombe and Marlow locality and the remaining from Amersham and Aylesbury, with a few additional out-of-area patients.

The average length of stay on the ward was 24 days. It is important to note that this is 24 days beyond their initial treatment episode on the specialist referring ward, as most patients (99%) are referred to 5b following an inpatient stay on another ward within Stoke Mandeville or Wycombe hospitals. At any given time, 75 - 100% of patients on 5b are medically fit for discharge, waiting to be transferred to the next step in their pathway.

Of those patient admitted in 2015/16:

- 24% were discharged to nursing or residential care.
- 67% were discharged home.
- 9% other discharge destinations.

The division has identified that by increasing investment and capacity in earlier packages of care for people in their own homes would support us to discharge people to the right setting when they are medically fit to leave hospital, reducing their length of stay in the acute hospital. There is strong evidence that a long length of inpatient stay in a hospital setting can lead to sub-optimal care as older patients decompensate and lose confidence as well as increase their risk of hospital acquired infections. (British Geriatric Society; RCGPs; Age UK Report: 2014)

4. Proposed new model of care

Investing in more support in the community will help older people to be cared for in an environment that is most appropriate for their needs and wishes.

We want people to receive the right care at the right time in the right place. Therefore the division wants to transfer some of its resources from acute care to invest in better community provision. This will help to prevent avoidable admissions where possible and ensure that older people are supported with their discharge home to remain as independent as possible for as long as possible. As ward 5b currently cares for patients who are medically ready for discharge or transfer to their next stage of care (be that a nursing home bed or waiting for social services long-term package of care at home) it is proposed to transfer the investment from this ward into expanded community provision. It is proposed that this is piloted for a six month period in order to assess impact and effectiveness.

What we will do
Put packages of care (domiciliary care) in place for older people within their own homes without the need to wait in an acute hospital bed until this can be organised.
Increase access to rapid support in a crisis; to enable people to get back to their own homes from hospital and regain their independence quickly.
Offer enhanced physiotherapy and occupational therapy for stroke patients to aid rehabilitation in the treatment wards at Wycombe. Thus not requiring the need to transfer to another ward to receive this rehabilitation.
Increase capacity to therapy within the Adult Community Health Teams
Enhance the single point of access, making it easier for GPs and other healthcare providers to access health or social care support, supporting admission avoidance and to ensure we have early supported discharge.

Total shift in investment that is being proposed is: £1,000,000
We estimate that up to 90% of those patients admitted to 5b last year could have benefited with access to this community provision and as a consequence could have had a reduced length of stay in the acute environment. However for those patients still requiring inpatient treatment then their care and treatment will not be affected by this change – they would remain on their specialist ward, but with the benefit of easier access/support to be directly discharged from that ward when medically fit, instead of being transferred to 5b whilst awaiting final packages.

5. Benefits

We believe the benefits of this shift of investment would include:

- Older people being cared for in the right environment.
- Reduction in projected length of stay for older people, as we have an average length of stay of 24 days on 5b.
- Better experience for the patient as they receive the right care at the right time, in the right place.
- Seamless pathways of care for older people, with patients not being transferred between wards and sites whilst waiting discharge home or packages of care in the community.
- Reduction in avoidable admissions for older people.
- Relocation of permanent skilled ward nurses to the stroke and cardiology services at Wycombe. There are vacancies on these specialist wards which are currently covered by agency and bank staff, which can reduce continuity of care to patients. Staff on 5b have the relevant specialist skills and will therefore be offered the opportunity to work on these wards.
- As this is a pilot, staff will have the opportunity to explore different working environments, which best utilises their skills. After the pilot concludes we will commence a formal consultation process to ascertain whether staff wish to stay where they are or whether they wish to look for different opportunities, which we will support them with.

6. Proposed next steps

Phased investment has already commenced in expanding community care, which has enabled the team to reduce bed capacity on the ward. The intention is not to transfer new patients onto 5b once all current inpatients are discharged or transferred to the right community setting (there are currently five patients on the ward). Community care – as outlined above – will be directly accessible to the relevant medicine for older people services and specialist wards. Patients requiring specialist care will continue to receive this across the medically frail older people wards, stroke wards and cardiology wards – this remains unchanged from the current provision.

We are commencing a consultation with staff on changes to their working patterns during this pilot.

We will review again in six months' time, alongside overall Trust capacity planning, to establish that there is no longer a requirement to re-provide this inpatient setting.

We will monitor the following:

- Average length of stay for older people
- Number of pre-paid packages of care provided
- Discharge destination for older people
- Patient related outcome measures & patient related experience measures.
- Number of admission avoidance delivered by REACT & the community healthcare teams.
- Focus group with the redeployed staff to see if they feel they have been well supported, what went well and what we could improve on.

References

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British Geriatric Society; RCGPs; Age UK Report: Fit for Frailty- consensus best practice guide for the care of older people living with frailty in the community and outpatient settings (2014)

NHS
Aylesbury Vale
Clinical Commissioning Group

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E-mail: feedback.aylesburyvaleccg@nhs.uk

25th July 2016

Aylesbury Town Council
Town Hall
5 Church Street
Aylesbury
Bucks
HP20 2QP

Attn: Mark Broughton

Dear Dr Broughton

Re: Mandeville Surgery

We understand that concerns regarding the service levels provided by Mandeville Surgery were raised at the Aylesbury Town Council Meeting held on 13 July 2016.

We have been notified that following a visit to The Healthy Living Centre, a councillor was left with the impression that only two GPs were working at Mandeville Surgery with patient appointments only available from Monday to Wednesday. We understand that the Councillor has raised this matter with the Buckinghamshire Health Overview and Scrutiny Committee.

A service review meeting took place on Thursday 21 July at Mandeville Surgery and we would like to take this opportunity to inform you of some of the positive developments that have occurred within the practice. We would further like to reassure you that the concerns relayed to the Councillor were erroneous.

As you may be aware, Mandeville Surgery has experienced a challenging year resulting in a change in contractor. From 1 April 2016, the Practice U Services Ltd has been responsible for the provision of primary medical services at Mandeville Surgery and we meet regularly with senior staff at the practice as well as NHS England South to monitor their performance and to ensure that they fulfil their contractual obligations.

Recruitment and retention is a national problem for primary care. Like many other practices, Mandeville Surgery has suffered recruitment issues. Throughout this difficult period the practice has remained clinically staffed although it has had to resort to employing locum staff at times.

A successful recruitment campaign has resulted in the employment of 2 new GPs and an Advanced Nurse Practitioner. We are pleased to report that from September 2016 the practice will be able to provide the local population with 50 – 52 GP sessions a week and will no longer be reliant upon locum clinical staff. This should increase the availability of patient appointments and improve the overall patient experience.

On the day appointments with a clinician continue to be available for patients morning and afternoon five days a week. However the surgery does recognise that there has been some irregularity regarding the number of emergency appointments available each day due to clinical capacity. With the addition of the newly appointed clinical staff this imbalance should resolve. From September 2016 a consistent number of on the day appointments will be made available from Monday to Friday. It is worth noting that on days when a high patient demand is expected we would anticipate a larger number of emergency appointments will be made available than on quieter days.

Currently at Mandeville Surgery the average waiting time for a routine GP appointment is 2 days, with emergency appointments being made available sooner. Further, the surgery aims to open for extended hours in the near future which will further help with the availability of appointments.

The Quarter 1 Performance report demonstrated that patient experience with the practice is improving month on month. The level of and severity of complaints and significant events are well within normal tolerance with no requirement for escalation.

Despite the success so far, the practice acknowledges that further work and development is required. We are satisfied that the new contractor is continuously refining processes and working patterns whilst building a robust team in order to provide a high level of patient care for its patients.

When speaking to the practice about these concerns, the practice was keen to extend an invitation to any representative of the council who wished to visit the practice, if this would be helpful. Similarly, please do not hesitate to contact the CCG should you have any further concerns or queries regarding this or another practice in our area.

Yours sincerely

Helen Delaitre
Head of Primary Care
NHS Chiltern and Aylesbury Vale CCGs

Southern Health NHS
NHS Foundation Trust

21 July 2016

Dear Julia

CLOSURE OF THE RIDGEWAY CENTRE, HIGH WYCOMBE

I am writing to follow up on your email of 29 June 2016 – which advised that Cllr Brian Roberts, HASC chair, had no objections to our plans to close The Ridgeway Centre in High Wycombe.

Following consultation with yourselves and also with Oxfordshire HOSC, I wanted to inform you that the Trust has now made the decision to proceed with the closure of The Ridgeway Centre on 1 September 2016.

This decision was reached after communications with the people who use our services, their carers, our staff and local patient groups. This included letters, information leaflets, easy read documents and the offer of a meeting for those Oxfordshire people (and their families) who had had an inpatient stay at The Ridgeway Centre in the past year.

As detailed in my briefing paper, the decision has been made in light of the wider planned changes to learning disability services across Buckinghamshire and Oxfordshire. Specifically to protect the safety of our patients and to ensure the highest quality care for the people we care for in the long term.

Importantly, the number of learning disability inpatient beds being commissioned and provided for Buckinghamshire and Oxfordshire patients will remain unchanged. The change is simply *where* these beds will be provided in the future, to ensure the safest and best possible care for people when they need a specialist inpatient stay.

If you'd like to further discuss any aspect of The Ridgeway Centre closure, please do call me on 01865 228090.

Kind regards,

Donna Schell
Oxfordshire and Buckinghamshire Learning Disability Services
Southern Health NHS Foundation Trust

Buckinghamshire Healthcare NHS Trust

Maternity services in Buckinghamshire

Audrey Warren

Divisional Chief Nurse and Head of Midwifery

Buckinghamshire Healthcare NHS Trust

August 2016

Overview of maternity services provided by Buckinghamshire Healthcare NHS Trust (BHT)

Overview

In order to be among the best maternity care providers, BHT strives to put women, babies and their families at the centre of their care.

In BHT, as with the national picture, the birth-rate continues to increase. Women are giving birth later in life and with increasingly complex medical conditions. Professionals working together across boundaries to ensure the right care in the right place has never been more important.

Maternity sits within the Division of Women and Children at BHT. The service structure in Maternity is:

- Based at Wycombe
  Freestanding Birth Centre (WBC) – on average 25 births per month
  Community Midwifery Teams (Wycombe, Chiltern and South Bucks areas)
  Antenatal Clinic
  Postnatal drop in clinic
  Antenatal anaesthetic appointments
  BCG vaccination clinic
  Newborn examination clinics
  Home birth service
- Based at Stoke Mandeville
  Alongside Birth Centre (ABC) – on average 60 births per month
  Obstetric-led Labour Ward – on average 350 deliveries per month
  Obstetric Theatres
  Neonatal Unit
  Inpatient Antenatal and Postnatal Wards
  Antenatal Clinic including specialist fetal medicine and pre-term birth clinic
  Postnatal drop in clinic (weekends only)
  Maternity Day Assessment Unit
  Community Midwifery Teams (Aylesbury Vale)
  Home Birth Service

During April 2015 - March 2016, BHT provided labour care to women who delivered 5541 babies throughout the service including 43 home births. In addition the community midwifery service provided a comprehensive antenatal and postnatal service to a similar number.

Clinical outcomes for the year 2015/16 are outlined below:

Clinical outcome	BHT figures	National benchmark/best practice
Perinatal mortality	5.3 per 1000 births	5.9 per 100 births
Vaginal birth rate	55.3%	63%
Caesarean section rate	27.2%	26.5%
Midwife to birth ratio	1:32	1:28 to1:32
Breastfeeding initiation rate	79.9%	80%
Complaints	13	(There were 30 the year before)
Friends and Family Test approval rating	97.8%	82%

The national picture shows that the UK is short of 2300 midwives. Buckinghamshire is not immune to this pressure and in order to improve our recruitment and retention the maternity service has established a 'Great Place to Work Group' engaging the midwives and support staff in strategies to make BHT an attractive place to work. This group has already identified more flexible and effective midwifery shift patterns. In addition BHT has offered jobs to all of our local midwifery students and additional 15 midwives will join us in October 2016.

Quality improvements

BHT is a learning organisation and encourages external scrutiny. We have recently commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to undertake a peer review to offer independent scrutiny of our care and processes. Recommendations from this review will be incorporated into our ongoing quality improvement programme.

Strong multi-professional links are essential to promote a safety culture. BHT has just been accepted to participate in a pilot labour ward leadership programme run by the RCOG which promotes team working.

Last year, together with our Commissioners, we commenced a pre-term birth clinic in order to reduce the number of low birth weight babies. We are measuring the outcomes from this first cohort which will be reported later this year.

This year the focus is on women for whom English is not a first language and improving communication through the whole of the maternity pathway.

In partnership with Oxford Health NHS Foundation Trust, BHT is making perinatal mental health a priority. To this end we have employed a specialist mental health midwife.

Choice agenda

The Maternity Matters Department of Health report underlines the importance of providing high quality safe care and also its commitment to four national choice guarantees:

1. How to access maternity care
   At BHT, women access their community midwives usually via their GP surgery
2. Choice of type of antenatal care
   All women have a named community midwife who provides continuity throughout their antenatal care.
3. Choice of place of birth
   As outlined above all Buckinghamshire women have a choice of home delivery, birth centre care, or consultant led care.
4. Choice of place of postnatal care
   BHT works from children's centres across the county. All women get their first visit at home and subsequent visits are arranged in partnership with the woman and her family

Modelling current and future antenatal and postnatal care

We provide continuity of midwifery care antenatally and 1:1 care in labour.

There are opportunities for further improvement in continuity throughout the whole pathway. To this end we have applied to be part of the first tranche of early adopters to implement the recommendations of the national maternity services review. This will enable us to review all our pathways and provide the right professional in the right place as well as ensuring the woman's voice is central to our service planning. We are working with our commissioners and other partners to ensure we are responsive to future demands of the service and sustaining high quality care and maintain choice for women in Buckinghamshire.

Frimley Health NHS
NHS Foundation Trust

Maternity Service

Wexham Park Hospital Site

Andrea Anderson
Deputy Head of Midwifery
August 2016

Merged with Frimley Health October 2014, since then there has been much work to join the 2 units as one:

- Cross site peer review work – midwifery matrons undertake the peer review on a monthly basis, greater level of staff engagement noted. Cleanliness of clinical areas and levels of care greatly improved. Women have reported an improved patient experience within the unit.
- Cross site clinical governance meets quarterly.
- New hand held notes in place across both sites
- A total of 35 guidelines have been ratified and adopted across both sites. This process will take approximately 3yrs to complete all 92 guidelines.
- Currently working on Better Births, Saving lives bundle and spotlight on maternity services

CQC inspection in October 2015.
Overall The Trust results were GOOD.
Woman and Children services – GOOD
Some outstanding practice identified
Leadership and culture shift
Female Genital Mutilation - comprehensive approach
Preceptorship for newly qualified midwives
Management of complex mums in labour – great care plans

Birth rate – this has increased since 2014 from 4100 to 4400. The maternity activity on the Wexham Park Hospital site in quarter 1 has increased by 8.12% compared with the same quarter last year. If the first quarter activity is replicated over the year an expected out turn of maternities would be 4564, which would be an overall increase in activity of 3.35%. This positive increase in activity is thought to be due to the changing reputation and a positive CQC outcome.

Lower Segment Caesarean Section (LSCS) rates – The LSCS rate continues to decline with a year of 27.6% compared to a 30% rate in April 2015. There is continued monitoring of the rate and this continues to fall. There is much work being done to reduce the Caesarean Section rates further.

The birth after caesarean section guideline has recently been reviewed in line with the revised Royal College of Obstetricians and Gynaecologists guidelines. This includes a new pathway where some women will stay under the care of the consultant midwife throughout their pregnancy with the support of an obstetrician if needed for a post-dates care plan or if any medical or obstetric concerns arise during pregnancy.

Women who are undecided if they want a vaginal birth after caesarean (VBAC) are referred to the birth choices class which is held monthly and run by the consultant midwife. Evidence based information is given at the class to help women decide on the mode of birth for their current pregnancy. Women are referred from their community midwife, obstetrician or can self-refer.

Women who request a primary caesarean section without a medical or obstetric reason or have had a previous traumatic birth and requesting a caesarean section are referred to the birth choices clinic which is run by the consultant midwives. Approximately 50% of the women with support strategies put in place will then choose to have a vaginal birth following the birth choices clinic and those still requesting a caesarean section are referred to a committee which includes the labour ward lead obstetrician, consultant midwife, 1 other consultant obstetrician and a midwife with experience of perinatal mental health. Each individual case will be discussed within the multidisciplinary team and the labour ward lead obstetrician will then meet with the woman's named consultant to discuss recommendations from the committee meeting.

A midwifery led breech clinic is held weekly, if a community midwife thinks a woman may be presenting with a baby in the breech position she can be referred to the breech clinic from 34 weeks pregnant. Presentation scans are carried out in the morning. During the afternoon first pregnancy (prim parous) women who are 36 weeks and above and women with previous pregnancies (multiparous) who are 37 weeks and above will be offered procedures to turn the foetus (ECV), which are undertaken by either a Consultant Midwife or Consultant Obstetrician. The same people run the clinic every week to ensure continuity and there is evidence that this also helps with the success rate of ECV's. Women are given a breech information leaflet and a full discussion takes places of the risks and benefits.

Women who are below this gestation will be offered moxibustion, which is a Chinese herbal remedy that consists of burning a herb compacted in a roll in form of a moxa stick at an acupuncture point located at the outer aspect of the tip of the fifth toe. 30 women chose to have moxibustion during 2015 which resulted in a success rate of 17%. The women who did not have successful moxibustion would have been offered an ECV. The success rate of ECV's during 2015 was 56%, which is above the national recommendation of 50%.

Staffing

- Medical staffing has been monitored via the maternity dashboard on a monthly basis and the consultant cover to Labour Ward is now a prospective 132 hours per week. There are no issues of staffing with consultant cover to the unit.
- There is now a new Lead Obstetrician for the labour ward who is also the departmental chair.
- Midwifery recruitment has been challenging. Incentives have been to raise the pay of new starters though it is acknowledge that it is difficult to compete with London Weighting, staff often lost to other areas due to this. Current Midwife to mother ratio funded at 1:30 with a 90/10% split to include support staff. Current month birth ratio is 1:32
- Sickness rates of maternity staff have reduced from a high of 6.65% to 4.57% at the end of the year.
- New starters offered a preceptorship package to enable them to meet their competencies in a supportive environment and attain their band 6.

- Recent appointment of a Perinatal Mental Health specialist Midwife, a Diabetic Midwife specialist and a Clinical Skills facilitator.

Safety - improved level of safety continues. There have been 4 serious incidents requiring investigation to date for 16/17 reported. There has been no rise in the number of major incidents reported, and the number of infants admitted to the neonatal unit from the labour ward has reduced. Quarterly reporting to the Trust quality committee continues.

Sign up to safety Campaign

The sign up to safety project for reduction in third and fourth degree tears has now been introduced on the Wexham site. To date the changes in practice are:-

- Additional training to all staff for indications requiring episiotomy and performing an episiotomy

Patient experience

We have introduced "you said we did" boards in clinical areas. Some concerns that women had and told us about have led to some changes, such as:

- Concerns raised that women had to take their babies to the neonatal unit for intravenous (IV) antibiotics. To reduce the necessity of this midwives were trained to give neonatal IV antibiotics on the postnatal ward.
- Women experiencing high risk pregnancies wanted the opportunity and facilities to have fewer interventions on the labour ward. Telemetry was purchased to ensure women could mobilise and still have the foetal heartbeat recorded (CTG monitoring), whilst labouring in the birthing pool.
- Noise levels high at night due to noise from bins; soft close bins purchased.
- Bereavement room created on the labour ward to ensure early access to pain relief and care by midwifery staff.

Complaints have decreased; 2 formal complaints to date from April 2016

Maternity Voices due to be introduced - To facilitate a voice for women and their families that use the maternity services at Wexham Park, we are commencing a quarterly group which all our women, and their families, will be invited to attend. Attendees will be able to discuss any aspects of their maternity care and any issues raised will be addressed. This will ensure that our services remain focussed on what women want.

The first meeting is at 10am until 12pm on Tuesday 27th September 2016 at Orchard Childrens Centre, Slough, SL1 6HE.

Family and friends Test – all areas have improved and average scores are now 98% across the service who would recommend the service to others.

Maternity Assessment Centre – the Maternity Foetal Assessment Unit and Triage has now merged together to create MAC. Aim to offer a streamlined service for outpatient assessment of maternal and foetal wellbeing and to ensure parity within collaborative working. There is a lead consultant for this clinical area.

Rebuild – Plans have been passed for new build of the maternity department, including the outpatients' gynaecological services. Build to start Early October in 3 phases and to last 50 weeks. Rebuild will take place on the same footprint, capacity target for the rebuild 5500.

We have listened to what our users have told us and 2 reception and waiting entrances will be created for both antenatal and gynaecology patients to sit separately. During this time Early Pregnancy Unit will run from our Gynae Assessment Unit which operates 24/7

Community Midwifery - The community midwives are divided up into 7 teams, each with a team leader and each with responsibility for certain GP surgeries. Most teams offer a traditional model of community midwifery undertaking antenatal appointments in the GP surgery and either home visits or drop-in clinics postnatally. The teams are supported by a small team of Maternity Healthcare Assistants who assist with newborn bloodspots, newborn hearing screening and infant feeding.

The Crystal Team takes care of the most vulnerable women and families on our caseload, for example those women with mental health problems, social or domestic problems or alcohol and substance misuse. They liaise closely with other agencies such as Social Care, Mental Health networks, domestic abuse agencies and others.

The Windsor Team have been offering home assessments in early labour to low-risk women and have seen a reduction in admission to hospital in the latent phase of labour and an increased homebirth rate. There is also promising evidence of good outcomes for these women in terms of a lower rate of assisted deliveries. As this service has been evaluated so well by women and families, it was felt that it should be extended to an area which is less socially privileged. Hence, the Eftokia team adopted the home-assessment model earlier this year in central Slough, where they are slowly building up their caseloads. Eftokia hold monthly drop-in parent education sessions in the local Tesco store and this has been warmly received in the community. Similarly the Windsor team have a monthly Positive Birth group where women come with their birth stories regardless of mode of delivery, thereby dispelling fear and emphasizing that birth can be a positive experience for everyone.

Bubble – This is a relaxation space on the antenatal ward used to provide massage and quiet area for women experiencing early labour or induction of labour. Sky tiles ceiling awaiting installation to provide a relaxing environment.

Hypnobirthing - We run complimentary hypnobirthing classes for women who would like to achieve a calm natural birth, enhanced by relaxation and breathing techniques taught to them

Aromatherapy - We run post-dates clinic offered on the birth centre where aromatherapy is used to encourage labour and decrease the rates of induction of labour

Baby friendly accreditation commitment - we are committed to achieve UNICEF Baby friendly status and aim to have achieved stage 1 by end of 2016.

Post-dates clinics - The aim of the clinic is to reduce the number of induction carried out on low risk women, this serves to reduce the workload for the antenatal ward staff, reduce costs to the trust and increase deliveries in the birth centre environment.

We use a combination of what is perceived as routine care (antenatal check blood pressure, palpation urinalysis etc.) including stretch and sweep in combination with aromatherapy (3% blend of clary sage, lavender and Jasmine) foot massage, reflex zone therapy (reflexology) and acupressure. These are done prior to the induction date as the research suggests if these methods will work they will do so within a 48hr period, all attendees to the clinic are sent home with some of the aromatherapy oil to continue treatment at home.

66.4% (127) of women did spontaneously labour following the treatment and prior to the induction date they had been given.

Challenges – Capacity for Ultrasound scanning to meet the requirements of the GAP and grow protocol has also been added as a new risk this quarter, and the two departments are working collectively to identify a solution. This issue is becoming more noticeable as bookings rise. There is not sufficient capacity of rooms of ultrasonographers to achieve all scans in the current way the departments work. There has been no change from the previous quarter in the level of this risk.

Type	Section	Metric Name	Apr-16	May-16	Jun-16	Jul-16	Aug-16
	Normal Deliveries		114	126	115	118	
	Normal Deliveries	Maintain Normal delivery rate as per stated criteria	30.2%	32.8%	30.3%	30.1%	
	C- Section	Total rate (planned & unscheduled)	26.7%	25.5%	31.6%	26.7%	
		Elective caesarean section	14.2%	10.6%	13.4%	12.5%	
		Emergency caesarean section	12.4%	14.8%	18.2%	14.2%	
	VBAC	Successful VBAC (opting women)	92.3%	46.7%	58.3%	68.8%	
Work force	Staffing Levels	Woman/Midwife ratio	1.35	1.35	1.32	1.32	
Clinical Indicators	Neonatal morbidity	All neonatal deaths under 28 days	0	0	2	1	
	Breast feeding	Breastfeeding at Initiation	79.3%	80.7%	78.3%	77%	
	Breast Feeding at Discharge	Breastfeeding at Discharge from hospital	75.7%	80.2%	77.8%	76%	
Patient Experience	Complaints	Formal Complaints	0	1	1	0	
		% against maternities	0%	0.26%	0.26%	0.00%	
		Number of Duty of Candours for the month	0%	0.00%	0.00%		
		Number of Debriefs per month undertaken by midwives					

Briefing

Move of carotid endarterectomy surgery from Wycombe Hospital to the John Radcliffe Hospital

25 August 2016

Background

In May 2016, NHS England submitted a brief to Buckinghamshire HASC on the Thames Valley Vascular Network. This brief set out the changes to date in relation to the centralisation of vascular services in the Thames Valley and highlighted the requirement for Buckinghamshire Healthcare NHS Trust to take the final step to become fully part of the Vascular Network, completing the last phase of its development across the region. This last phase requires the move of carotid endarterectomy surgery from Wycombe Hospital to the John Radcliffe Hospital on 1 September 2016. A carotid endarterectomy is a surgical procedure to unblock a carotid artery, which, if left untreated, can lead to a stroke.

The previous and current HASC chairs have also been separately briefed by the recently retired medical director of NHS England South (South Central). No objections were raised at any of these meetings.

This change means that patients requiring carotid endarterectomy surgery will now be treated at the John Radcliffe Hospital rather than Wycombe Hospital, where they will have access to a specialist vascular team 24 hours a day, 7 days a week.

Patients will only be asked to travel for these procedures where there is clear evidence of benefit in doing so – namely for complex procedures. All other services will continue to be delivered locally, with patients receiving their pre-operative care and follow-ups at Wycombe Hospital to reduce the need to travel.

Vascular surgeons will continue to offer day surgery at Wycombe Hospital (such as for varicose veins) and run outpatient clinics, including diabetic foot clinics, from Wycombe, Stoke, Amersham and Chalfont Hospitals. Abdominal aortic aneurysm (AAA) screening will continue to be provided as before with no change to this service.

These changes are based on national clinical guidance and best practice and are important to ensure the safety of patients and ongoing provision of these services. Research shows that there is evidence of improved outcomes for patients when treated in large centres by a highly trained specialist team caring for a high volume of

patients. This means that staff are able to carry out enough complex procedures to maintain and improve their skills and consistently provide safe, quality care.

Local surgeons and clinicians have been working together to prepare for this migration and plans are in place to ensure the John Radcliffe Hospital has the capacity and flexibility to cope with the additional volume of patients, which is expected to be 60 to 100 patients per year.

Arrangements have also been made to monitor the move to providing complex vascular surgery at the John Radcliffe Hospital, including gathering and analysing patient experience.

The Buckinghamshire Healthcare NHS Trust (BHT) stroke unit is a high performing unit and has good working relationships with the vascular surgeons at the John Radcliffe Hospital, Oxford.

The new arrangements will not impact stroke services at Wycombe Hospital as the quality of this interaction and referral pathway will be unchanged.

The move of carotid endarterectomy surgery will not impact on interventional radiology either. Surgery to prevent stroke caused by carotid artery disease (carotid endarterectomy) is provided by vascular surgeons, not interventional radiologists. Interventional radiologists provide a wide range of elective and emergency interventional procedures and only a proportion of these are vascular.

Communications activity

In preparation for the move of carotid endarterectomy surgery from Wycombe Hospital to the John Radcliffe Hospital, a suite of communications materials has been developed. These have been informed and reviewed by a patient representative who has been involved with this programme of work since 2010, as well as clinicians and communications leads from Buckinghamshire Healthcare NHS Trust, Oxford University Hospitals NHS Foundation Trust and NHS England, together with representatives from Thames Valley Vascular Network.

These materials include:

- Press release
- Patient poster
- Copy for local trusts and clinical commissioning groups (CCGs) to include on their websites / intranets and in their patient and staff newsletters
- Stakeholder brief
- Frequently asked questions
- Twitter messages.

The appropriate materials have been shared with the following stakeholder groups:

- Buckinghamshire MPs
- Healthwatch Buckinghamshire

- Buckinghamshire media
- South Central Ambulance Service NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Oxford University Hospitals NHS Foundation Trust
- West Berkshire, Buckinghamshire and Oxfordshire CCGs
- Age UK Bucks
- Aylesbury Vale Stroke Club
- British Heart Foundation
- Bucks Stroke Support (Stroke Association)
- Diabetes UK, Aylesbury Vale

Feedback and queries relating to these changes are being monitored and where possible, meetings are being offered with any individuals who have additional questions. Communications activity will continue in the lead up to and in the initial stages of go live, with the intention of developing case studies of those patients who have carotid endarterectomy surgery under these new arrangements.

Patient pathways pre and post change

Principles of proposed changes

- Treat all symptomatic patients within 14 days where clinically appropriate
- Keep as local as possible
- Streamlined communication pathway between clinicians at Bucks and OUH
- As little disruption to current practice as possible and practical

Current Bucks pathways

1. Outpatient pathway

Patient referred to Bucks for outpatient clinic

➔ Bucks outpatient clinic + clinical investigations (eg. Duplex scan)

➔ If clinically appropriate, date for surgery arranged at Bucks

2. Inpatient pathway

Patient has stroke/TIA

➔ Hyperacute Stroke Unit (HASU) at Wycombe Hospital

➔ Vascular specialist (consultant, nurse, specialty doctor) review patient +/- clinical investigations

- If clinically appropriate, date for surgery arranged at Buckinghamshire Healthcare NHS Trust

3. Follow up care arrangements

Bucks patient have outpatient appointments with both a vascular surgeon and stroke physician after their treatment.

Proposed new pathways

1. Outpatient pathway

Patient referred to Bucks for outpatient clinic

- ➔ Bucks outpatient clinic + clinical investigations (eg. Duplex scan)
  - ➔ If clinically appropriate, date for surgery arranged on next available theatre list for either Bucks consultant at the John Radcliffe Hospital
    - If Bucks consultants' theatre lists are full, Bucks Vascular team to liaise with on-call Consultant of the Week at John Radcliffe Hospital to arrange surgery on next available theatre list
      - ➔ Patient comes in to John Radcliffe Hospital through Theatre Direct Admissions (meaning they are admitted on the day of their surgery) or inpatient stay night before

2. Inpatient pathway

Patient on Hyperacute Stroke Unit (HASU) at Wycombe Hospital

- ➔ Vascular specialist (consultant, nurse, specialty doctor) review patient +/- clinical investigations
  - ➔ If clinically appropriate, date for surgery arranged on next available theatre list for either Bucks consultant at the John Radcliffe Hospital with transfer to the John Radcliffe Hospital the night before
    - If Bucks consultants' theatre lists are full, Bucks Vascular team to liaise with on-call Consultant of the Week at John Radcliffe Hospital to arrange surgery on next available theatre list and transfer the night before

3. Repatriation pathway

- ➔ Where appropriate, discharge directly back home from John Radcliffe Hospital.
  - ➔ If patient needs ongoing inpatient care, on-call Consultant of the Week refers patient back to Stroke Physicians or Stroke Nurse of the Day (SNOD) at Wycombe Hospital to find out whether to discharge back to;
    - HASU at Wycombe Hospital
    - Rehabilitation Ward (Ward 9) at Wycombe Hospital

4. Follow up care arrangements

The Vascular Ward 6a team will email the patient's discharge summary back to the Bucks Vascular team to make follow-up appointment (as is currently in place for all Buckinghamshire patients having surgery at the John Radcliffe Hospital).

The Vascular Ward 6a team will email the discharge coordinator/ward clerk/shift coordinator at John Radcliffe Hospital to ring SNOD at Wycombe Hospital to let them

know where patient is going (eg. HASU, Rehab ward, home) and ask them to make follow-up appointment with Stroke Physician.

PROMS update

Approach

A mixed-methods approach to investigating patient experiences in the network was chosen, entailing a questionnaire sent to all patients in the network and qualitative interviews with a specific patient cohort. By doing this, all patients in the network are given a chance to provide feedback and the network team can also probe more deeply into particular areas of interest.

Patient feedback questionnaire

The questionnaire is posted to each inpatient treated in the Thames Valley Vascular Network whose primary cause for admission was a vascular condition, starting with those discharged in May. Patients are posted this questionnaire in a monthly mail-out with an addressed envelope to return it.

Items on the questionnaire are mostly modified versions of items taken from validated questionnaires with some novel items created to inquire into networked care across organisations. The questionnaire had significant input from the Vascular Network Group Patient Representative. A number of different teams reviewed the questionnaire for content, phrasing and format, such as the Communications Team and Patient Experience Team of Oxford University Hospitals NHS FT and the Clinical Audit Team and Patient Experience Manager of Buckinghamshire Healthcare Trust.

The response rate of patients is approximately 30% to date. Analysis of the data is ongoing.

Qualitative patient interviews

The network team decided to focus on patients treated for urgent conditions such as critical limb ischaemia and diabetic foot ulcers, including those who undergo amputations for these conditions. This was for a number of reasons:

- Some of these patients could be managed locally in their local hospital, such as Royal Berkshire Hospital or Stoke Mandeville Hospital. By focusing on this group, any impact that the centralisation of services might have on patient experience could be investigated.

- These patients are often transferred and repatriated between different sites; therefore, focusing on these patients should examine how this particular aspect of networked care affects patients.
- These patients often have prolonged inpatient stays in hospitals, and so would conceivably have thoughtful and considered insights on how the inpatient experience might be improved.
- As these patients are urgent cases but not emergencies, these patients may have less positive experiences of care when there are bed capacity issues.

The Network Manager undertook to interview a minimum of three patients from each trust on different pathways in order to compare experiences across the network. By August 25th seven interviews were carried out with patients, and in some cases with their partners too.

Advice and support has been provided by several qualitative researchers from the Nuffield Department of Primary Healthcare, University of Oxford and also qualitative researchers in the health and social care field from Manchester Business School, University of Manchester.

Clinical involvement

The Vascular Network Group has been involved in this project since it was initiated in 2015. Clinicians across all of the trusts in the network and the Vascular Network Group Patient Representative have been instrumental in identifying aspects of patient experience and outcomes to be investigated in the questionnaire (eg. distance for family to travel, issues with repatriations) and also focusing the qualitative interviews on patients with urgent lower limb conditions.

Patient involvement

The Vascular Network Group Patient Representative set the direction of this project from the outset, and continued to contribute after the Network Manager took responsibility for implementing the project. Numerous iterations of the patient feedback questionnaire were trialled with inpatients on Ward 6a, the vascular ward at the John Radcliffe Hospital, which significantly influenced the final content and format of the questionnaire.

Authorisation across all trusts

This project and was authorised as a Clinical Audit/Service Evaluation by Oxford University Hospitals NHS Trust. The Royal Berkshire Hospital Research and Development department and Buckinghamshire Healthcare NHS Trust Clinical Audit department both signed this work off as a Clinical Audit. Both the RBH and BHT Caldicott Guardians have approved sharing patient information for this research.

HASC 15 mins Care Visits Inquiry – 12 month progress on recommendations

Select Committee Inquiry Report Completion Date: 11th August 2015
Date of this update: 6th September 2016
Lead Officer responsible for this response: Ali Bulman (Rec 1), Marcia Smith (Recs 2a, 2c, 3.) Adam Payne (Recs 2b) Rachael Rothero (Rec 4) Trevor Boyd (Rec 5)

Accepted Recommendations	Original Response and Actions	Progress update at 6 months	Committee Assessment of Progress (RAG status) at 6 months	Progress update at 12 months	Committee Assessment of Progress (RAG status) at 12 months
1: The Cabinet Member agrees the "Delivering Dignified Care Policy (15 min calls)" as a key decision, as required by the Council's Constitution and Operating Framework to formally validate it as Council policy.	The service will submit this as a policy but the HASC work has identified to the service that we need to be clear about what is a policy and what should be issued as guidance to our staff and partners. It is the officer's view that in hindsight this document is more appropriate as guidance. The use of 15 minute calls has been in place for many years and the essence of this 'policy' was to provide guidance and clarity for officers and partners about the appropriateness of 15 minute calls. A reviewed policy document is being submitted for key decision in September 15.	The policy has been submitted for a key cabinet member decision which will be due in March 2016. See link: https://democracy.buckscc.gov.uk/mgIssueHistoryHome.aspx?IId=43087&Opt=0	30th September 2015 deadline	Completed	

2: We recommend that there are clear monitoring and implementation arrangements in place to ensure that policy compliance is regularly reviewed. Improvement arrangements should include: a) Stronger communications of the Council's policy to staff, providers and stakeholders.	a)Once the revised policy/guidance has been approved the Service will recirculate the policy to staff and instruct that this is to be reviewed at team meetings, with confirmation required including minutes of the meeting at which it is discussed. We will re-circulate to our providers and ask them to confirm that this has been cascaded to their front line staff. We will also, promote the policy at the next Provider Forum on the 20th October 2015. A leaflet on the dignified care policy will be devised and providers will be asked to ensure it is shown to all clients and that it is kept in the client handbook for all users and their families to be reminded of, for future use if needed.	a) This is being done on an ongoing basis as we get new clients.	a) 31st Oct 2015	a) Policy approved & issued to all Care Management teams and contracted providers. Internal staff were offered training sessions & service users to receive a newsletter within the next 6 weeks. Policy embedded into domiciliary care contracts discussed monthly at contract review. Providers are expected to challenge any cases where a 15 minute call has been implemented when not appropriate e.g. medication check call	
b) Improvements to the quality and detail of care plans to ensure consistency across the service	b) A piece of work has been commissioned from our business and systems team to review the current care plan arrangement to improve on the system fines or recording and the outcomes identified for individuals. The guidance has been re-written and will be launched as part of the new ways of working.	b)Every individual care plan is now signed off and authorised by a care supervisor and care plans are being completely rewritten and made simpler and clearer, this action is still ongoing.	b) 31st Dec 2015	b) ASC Business & Systems Team has updated guidance & processes for recording in care plans. There is specific guidance for managers approving care plans is approved and budget allocations in respect of new packages of care. All ASC Business Managers briefed via dashboard updates.	
c) Greater proactive utilisation of data to monitor scheduled visits	c) Monthly reports are run which identify where the total time allocated/commissioned to a visit is	c) This is being done on an ongoing basis	c) with immediate effect	c) We are able to identify when this occurs through our payment process, highlighting	

which regularly exceed allocated time to ensure compliance with the policy.	either exceeding or under-utilised. In the first instance, care providers will be questioned to identify why this has occurred i.e. whether this is a one off or likely to be ongoing and change requests made as appropriate			where there are significant over/under utilisation. The 'overs' are questioned directly with suppliers. How we deal with 'unders' is more difficult. We are trying to be more pro-active on managing these. Both 'unders' and 'overs' are discussions for variations in care packages with the appropriate Business Manager.	
3: A monthly change request analysis report is produced as part of the Service Area Performance Scorecard, to review and monitor the impact of the process as part of the contract monitoring process. The analysis should include: a) The number of requests received for the period and whether they are for increases or decreases in time. b) Whether the requests were accepted or not (if not reason) c) Date that change request was received and date change d) Identification of delays in the process (para 40-48).	All these points will be included.	a) In place b) In place but manual audit of case files is required c) In place d) In place	With immediate effect	a) This process and recording mechanism is in place with the Care Resource Team, which is now part of Joint Supply Management function in ASC. It was also reissued in April 2016 when the new Dom Care contracts were awarded. The process is currently under review via Lee Fermandel and Sarah Burke for effectiveness and timeliness.	

4: To help drive quality of care, and staff recruitment and retention, new contracts for Domiciliary Care from March 2016 should include a contract clause that requires staff to be paid for their hours of work, which should include travel time between care visits.	Providers, in line with their national policies, utilise a range of contract terms and conditions to pay Bucks based carers. These may include travel time as part of an enhanced hourly rate or they may pay time travel time and mileage in addition to a basic hourly rate. Buckinghamshire County Council commissions hours of care which we pay for using a composite rate, currently averaging £17.85 per hour. We expect the composite rate to cover all costs incurred by suppliers, including travelling time incurred by carers between each care visit. For the new contracts being awarded from April 2016, providers will need to demonstrate how they calculate the composite rate they submit and how travel time is costed as part of this rate. We accept the recommendation in part, because we will achieve the required outcome, although not through contract stipulation, but through our contract monitoring. We will gain evidence and assurance that, however staff are paid, they receive at least the national minimum wage when calculating the total time that they have spent on duty including both care time and travel time.	The evaluation process for the Council retender of dom care services included an assessment of each bidder's position on appropriate remuneration over travel time for care workers. The winning bidders have confirmed that travel time is accounted for within their payment rates to their care workers. As this will be within the contracted price, the contract clause would not be necessary, other than contract monitoring to be applied.	April 2016	Completed	

5: The Cabinet Member for Health and Wellbeing should, in future, take key decisions on how services are commissioned prior to going out to tender where those contracts and services are deemed to be significant, as defined in the Council's Constitution.	The service will be fully compliant with the Council's Constitution.	This has been agreed and in in place as part of policy guidance issued to staff	With immediate effect	Completed	

RAG Status Guidance

	*Recommendation implemented to the satisfaction of the committee.*		*Committee have concerns the recommendation may not be fully delivered to its satisfaction*
	*Recommendation on track to be completed to the satisfaction of the committee.*		*Committee consider the recommendation to have not been delivered/implemented*

Date	Topic	Description and purpose	Lead Service Officer	Attendees
Health & Adult Social Care Select Committee				
18 Oct 2016	Better Care Fund	The Better Care Fund – update and impact of national funding locally, report back on the BCF risk register and the inclusion of action against red and amber residual risk.	Liz Wheaton, Committee and Governance Adviser	Mike Appleyard, Cabinet Member for Health & Wellbeing; Louise Patten, CCG
18 Oct 2016	Locality working and new models of primary care	Areas of focus • The Locality working model in Bucks – what will it look like and how will it be shaped by local population needs? • Consider new models of primary care that are under development e.g. the Mandeville Practice • Further responses to HASC's GP Inquiry • What can we learn from the integrated primary and acute care systems vanguard sites? • Understanding programmes to increase self-management building on the Stay Well-Live Well model (this model brings Public Health programmes and Psychological Wellbeing services together) – what is happening, impact and areas for further development?	Liz Wheaton, Committee and Governance Adviser	Louise Patten, CCG; GP leads and representatives; GP Patient groups; Public Health
18 Oct 2016	Transformation Plans	An update on the Strategic Transformation Plan and funding	Liz Wheaton, Committee and Governance Adviser	Louise Patten, CCG