Minutes

HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

MINUTES OF THE HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE HELD ON TUESDAY 24 JANUARY 2017, IN LARGE DINING ROOM, JUDGES LODGINGS, AYLESBURY, COMMENCING AT 10.00 AM AND CONCLUDING AT 12.30 PM.

MEMBERS PRESENT

Brian Roberts (Chairman), Roger Reed (Vice-Chairman), Brian Adams, Chris Adams, Noel Brown, Avril Davies, Wendy Mallen, Thalia Jervis, Tony Green, Sandra Jenkins, Nigel Shepherd and Wendy Matthews

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies were received from Ms J Wassell with Mr S Lambert attending as a substitute
Mrs Avril Davis had been appointed as a Committee member

2 DECLARATIONS OF INTEREST

None

3 MINUTES

The minutes from the 18 October and 29 November meeting were agreed as an accurate record and signed by the Chairman.

4 PUBLIC QUESTIONS

No public questions were received.

5 CHAIRMAN'S UPDATE

Mr Roberts gave the following updates:

Pharmacy Cuts
A meeting had been held with two representatives from the Local Pharmacy Council following the last HASC meeting to better understand the proposed changes to the way local pharmacists receive their funding. .

Ward 5b
A paper had been circulated to Members on the results of the pilot study and the plans going forward (attached to these minutes).

Julia Wassell submitted questions via to the meeting outlined below:

1. How can the pilot be reliable when it has not taken place in the most pressured time of the year in respect of admissions for older people?
2. Why are we being asked to look at this now after the decision has been taken and the ward is closed for its previous patient intake?
3. Can the decision be referred to the Secretary of State for Health?

Mr Roberts confirmed that answers to the questions would be sought and responses circulated to the Committee. **Update: Responses attached**

Action: Mrs Wheaton

Hospital Discharge Inquiry update
The Inquiry Group held a briefing with key stakeholders and a number of visits had taken place to speak to Hospital staff and those working out in the Community. Further evidence was being gathered and a meeting with stakeholders to discuss the key findings would be held at the end of February, to inform the final report going to the Select Committee in March.

Buckinghamshire, Oxfordshire and Berkshire West (BOBW) STP
A special HASC meeting to discuss the BOBW STP was taking place on 21st February. An update on the BOBW STP would be circulated to the Committee members after the meeting.

Action: Mr Roberts

Bucks Care
A meeting with Graeme Betts, Interim Managing Director for Communities, Health and Adult Social Care (CHASC) would be taking place to discuss Bucks Care in more detail. The Committee would be informed of the outcome.

Action: Mrs Wheaton

The Bedfordshire and Milton Keynes Healthcare Review
A meeting was held on 14 December in Bedford to discuss the Bedfordshire and Milton Keynes Health Care Review and the continuation of some of its work as part of the STP process. An update from attendees was awaited.

Notes from the meeting can be viewed here
http://www.councillorsupport.bedford.gov.uk/ieListDocuments.aspx?CId=570&MId=4344&Ver=4]

6 COMMITTEE UPDATE

Mrs W Mallen provided feedback on the Buckinghamshire Dignity Strategy Group and highlighted:

- The Strategy ensured that people were treated with respect
- In Dignity Awards: care providers could be nominated via the BCC website from 1-24 February and shortlisting would take place in March with the awards ceremony in May
- Publicity for the Awards was in hand

Mr Roberts confirmed that regular meetings would be taking place with the CCGs and Bucks Healthcare Trust.

7 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Dr J O'Grady, Director of Public Health and Dr E Youngman, Consultant in Public Health Medicine attended the meeting to present an update on the JSNA (presentation attached).

Dr Youngman made a presentation and highlighted in particular the aims of the JSNA, key findings and key demographics Link to JSNA report: http://www.healthandwellbeingbucks.org/s4s/WhereILive/Council?pageId=2098

The Committee discussed the following points:

- The benefits of early intervention work
- The increase of children and young people at risk of mental health and the need to prioritise work in this area. It was noted that young people's mental health was a national priority with a Government Green Paper on the issue
- The £1.8m grant reduction as part of the medium term plan and the effect on service delivery, in particular the move to integrated, online lifestyle services The targeting of services on areas of higher need

More data was available in the main JSNA documentation.

8 JOINT HEALTH & WELLBEING STRATEGY

Dr O'Grady and Ms K McDonald updated Committee Members on the Joint Health and Wellbeing Strategy.

Ms McDonald highlighted the following points:

- The Strategy was a joint responsibility of the County Council and the Clinical Commissioning Groups (CCGs)
- The Strategy had a strong emphasis on place, mental wellbeing and health equalities.
- Stakeholder engagement meetings would start in the summer, with a following development session with members of the Health and Wellbeing Board.
- The final strategy was planned to be presented at the Health and Wellbeing Board in March
- Themed meetings were being held to provide feedback and members of the HASC invited to attend.

The Committee discussed the following points:

- Alignment of priorities: all the organisations on the H&W Board were required to ensure that their plans and priorities aligned with those agreed in the Strategy. The development of policy would be discussed and driven through the themed meetings. Key performance indicators and outcomes would be monitored by the Health and Wellbeing Board and reported in the annual report
- The link between the Strategy and the Sustainability and Transformation Plan (STP) particularly in relation to governance. The Committee was told that the priorities of the strategy and the STP were aligned, with a Transformation Delivery Group reporting into Healthy Bucks Leaders (Chief Executives of all the health and social care organisations) which in turn reported into the Health and Wellbeing Board
- The decline in smoking, the rise obesity, and the support available to help people lose weight
- The rise in the use of electronic cigarettes and the evidence on their impact

Ms McDonald welcomed any further comments from the Committee.

9 ACTIVE BUCKS

Mrs J O'Grady, Director of Public Health, Mrs S Preston, Public Health Principal and Mr T Burton, Public Health Practitioner attended the meeting to give Committee members an update the Active Bucks initiative.

Mrs Preston gave an Update of progress on the Active Bucks project which is due to complete in September 2017and highlighted the following points:

- 3.5k residents were engaged with Active Bucks community engagement since it started, and 1.7k residents have participated in physical activities in the first 6 months of the project and 79% of those residents were not achieving the recommended activity levels

- 19 Local Area documents were created to understand residents' views and 25 Community Champions had been recruited so far
- The team worked with Local Area Forums (LAFs) and Parish Councils to help engage with residents within their area and support the activities chosen
- The second year activities were chosen at the end of last year by LAFs and the procurement process is now complete, with activities starting between January - March 2017
- The Active Bucks website had been well used with a search by postcode for residents to find local activities. In the first 6 months the website had seen 15k unique users and 800 vouchers had been downloaded (first session free). Partners and providers had undertaken promotional work including stakeholder website, GP patient screens, and Leaflet drops
- The importance of ensuring that activities were accessible by all community groups particularly those with cultural and language barriers.
- Community Champions were being recruited with the aim of ensuring whole county coverage.
- Sustainability of the activities, with 71% of activities currently being sustained, and the possibility of Sport England funding and local support.

10 VASCULAR SERVICES UPDATE

Mrs Aarti Chapman, Associate Director, Strategic Clinical Network and Senate, Mrs Cliodhna Ni Ghuidhir, Thames Valley Vascular Network and Service Manager, Oxford University Hospitals NHS Foundation Trusts, Mrs Annie Tysom, Senior Communications and Engagement Manager and Ms Caroyln Hinton, Quality Improvement Lead, Thames Valley Strategic Clinical Networks attended the meeting to give an update on Vascular Services

Mrs Chapman gave an overview of the developments and highlighted:

- The successful development of the Vascular Services network which was being used as a good example of both patient engagement and clinical involvement
- Good work with the clinical community on a shared vision
- NHS England continues to have involvement
- Funding from NHS funding becoming available

Mrs Ni Ghuidhir gave the Committee an update on patient engagement and feedback and highlighted the following points:

- Patient feedback was gained through interviews and survey
- From 432 patients they had a good (36%) response rate
- Summary of outcomes
    - Meetings to discuss the outcomes from feedback
    - Ward Managers, Sisters and Practice Development Nurses given the feedback to build into their practices and it will also come under the remit of clinical leads
    - Feedback around patient transport and cross county discharges

Clinical outcomes

- Of those asked how they would rate their experience, over 80% said excellent or very good, 5% said ok or poor
- Areas identified for improvement included the discharge process with 25% saying they weren't sure of the next steps after leaving hospital and 25% didn't know who to contact for help once they had left.
- An aid memoir had started to be developed to assist patients on the discharge process. The aid would also be embedded within nursing teams for them to support patients Patient feedback would continue to be discussed at meetings throughout February

Mrs N Ghuidhir agreed to provide more information on threshold for surgery and length of waiting lists, and to circulate the aide memoir

Action: Mrs N Ghuidhir

The Committee requested a further update back in 6 months.

11 INQUIRY RECOMMENDATION MONITORING

Mr Mike Appleyard Deputy Leader and Cabinet Member for Health & Wellbeing and Mr Oliver Stykuc-Dean, Commissioner – Early Intervention and Prevention attended the Committee to give a 6 month update on the recommendations from the Accessibility and promotion of services for Adults with Learning Disabilities inquiry

The Committee requested that the report be updated to reflect changes in personnel.

The following points were discussed:

- Investment in travel training – A joint transition team was looking at this in conjunction with the recommendation to promote 'Fair4All' taxi scheme
- Information - The Committee discussed accessibility to information and concerns were raised about the new County Council website in relation to users with learning disabilities. . Mr Appleyard suggested the need for a project to look at accessibility to and agreed to take this forward
- Mr Appleyard agreed to provide a summary for each of the items on the plan for the Committee and to set up a sub group inviting members of the Committee to take part

Agreed: Members of the Committee agreed to delegate the application of the RAG status to the Chairman of the Health and Adult Social Care Select Committee.

Action: Mr Roberts to meet with Mr M Shaw and Mrs M Aston to discuss developments in their areas.

12 COMMITTEE WORK PROGRAMME

Mr Roberts discussed items to forthcoming meetings. No further items were added.

13 DATE AND TIME OF NEXT MEETING

There will be a special HASC meeting on Tuesday 21st February at 10.00am in the Large Dining Room, Judges Lodgings. This meeting will be an opportunity for the HASC Committee to discuss and question the content of the BOBW Sustainability and Transformation Plan.

CHAIRMAN

Buckinghamshire Healthcare NHS
NHS Trust

Report to the Health Adult and Social Care Committee

Pilot of Moving Care Closer to Home

Ward 5B, Wycombe Hospital

May – October 2016

November 2016

Contents

1. Introduction

Buckinghamshire Healthcare NHS Trust provides a range of services for frail older people of Buckinghamshire and beyond including inpatient, day cases and outpatient care. Following the national direction of providing care closer to people's own homes, the clinical team reviewed the provision of ward services which led to 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.

A pilot transferring care from 5b at High Wycombe into community services was commenced in May 2016. A briefing was provided to the Health and Adult Social Care Select Committee at that time.

The pilot was undertaken to explore the impacts of developing alternative models of care. The purpose of this report is to provide the committee with an update on the outcome of those changes and make conclusions about these results and outline the next steps.

2. Context for change

The national direction is to move care closer to home, where appropriate, and is well supported by evidence that frail older patients recover more effectively at home (BGS. 2010). There is strong evidence that long lengths of in-patient stays can lead to sub-optimal care as older patients decompensate and lose confidence as well as being at risk of hospital acquired infections. British Geriatric Society; RCGPs; Age UK Report: (2014).

Moving care into the community and providing streamlined pathways that integrate health and social care are major components of the National Five Year Forward view, (published in October 2014)

It stresses the importance of "expanding and strengthening primary and out of hospital care" and 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).

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 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 national report into hospital productivity and performance, published in February 2016, it highlights that the number of days lost to patient delays in transferring from an acute bed 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.", such as discharge to assess settings. 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 between 50 and 60 delayed transfers of care per day.

This discharge to assess model offers people who are medically fit and do not require an acute hospital bed an assessment for longer-term care and support needs in the most appropriate setting and at the right time for the person. The benefits of such a model is:

- People's health outcomes improve as more people will be able to live at home for longer if services are designed for discharge to home to be the default.
- People's length of stay in a hospital bed decreases due to longer-term assessments taking place in a more appropriate situation and place. Evidence suggests this should reduce deconditioning and improve outcomes significantly since 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 years.
- Encourages NHS and Adult Social Care leaders to work together for the best outcomes and experiences for people through joint approaches to discharge to assess. This may include joint commissioning or funding.
- Improves system flow by enabling patients to access urgent care at the time they need it.
- Reduces duplication and unnecessary time spent by people in the wrong place.
- Enhances working relationships between the health, social care and housing sectors and increases development opportunities for their staff.

Treating as many patients, especially older people, at home is 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.

3. New Model of Care

At the commencement of this proposal on average there was upwards of 15 frail older patients remaining in Buckinghamshire acute inpatient beds that were 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. These patients were often transferred to ward 5b at Wycombe Hospital, which constituted another process in their journey adding to their length of stay. At the time, 100% of the patients on 5b were deemed medically fit for discharge.

In 2015/16 there were 263 people admitted to the ward. The main sources of referral into 5b were from several key 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 the Short Stay Ward at Stoke Mandeville.

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

The average length of stay on the ward was 24 days; however this was an additional 24 days beyond their initial treatment episode on the referring ward, as most patients (99%) were referred to 5b following an in-patient stay on another ward within Stoke Mandeville Hospital or High Wycombe . Therefore up to 99% of admissions had a projected length of stay within the acute environment as they were waiting for their onward care.

Of those patients admitted in 2015/16:-

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

As a 100% of the patients were medically fit to leave hospital, it was proposed to pilot a transfer of care from the ward to support people in the right setting, be that in a nursing home bed, or a package of care in their own home.

This new model of community care would help older people live in an environment that was most appropriate for their needs and wishes. However if an older person needed hospital or other healthcare they would and were able to access it still.

This message was echoed by the community who attended the BHT engagement events during April and May 2016.

The plans that were identified at the beginning of the pilot stage were:-

1.	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.
2.	Undertake assessment for social care in a care home setting rather than have to remain in an acute bed in hospital.
3.	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.
4.	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.
5.	Increase capacity to therapy within the Adult Community Health Teams
6.	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.

We believed the benefits of this pilot would include:

a) Older people being cared for in the right environment.
b) Reduction in projected length of stay for older people. Ward 5b had an average length of stay of 24 days in addition to their main ward stay.
c) Better experience for the patient as they receive the right care at the right time, in the right place.
d) 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.

e) Reduction in avoidable admissions for older people.
f) Relocation of permanent skilled ward nurses to the stroke and cardiology services at Wycombe. There were vacancies on these specialist wards which were currently covered by agency and bank staff, which can reduce continuity of care to patients. Staff on 5b have the relevant specialist skills and were offered the opportunity to work on these wards.
g) Staff would have the opportunity of the pilot to explore different working environments that best utilised their skills. After the pilot concludes we will commence a formal consultation process to ascertain whether staff wish to stay where they are.

4. Progress to Date.

The pilot commenced in May 2016 and a review of the effectiveness after the six months concluded:

	The plans that were identified at the beginning of the pilot stage were	What we did
1.	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.	We are providing interim services enabling patient transfer back into the community rather than remain in an acute in-patient bed. This has allowed allow patients to either return home with the right support or be offered an interim bed in a care home providing space to recover and to consider the next stage of care. We have provided 42 packages of care and have provided up to 11 care home beds.
2.	Undertake assessment for social care in a care home setting rather than have to remain in an acute bed in hospital.	
3.	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.	We are working in very close partnership with primary, social care as well as the care home market to develop community teams that highlight our most vulnerable and at risk patients in order to anticipate any crisis and reduce the need of emergency admission. This is in the recruitment phases and will be fully operational from April 2017.
4.	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.	Increased therapy support was offered to the Stroke Ward to ensure that patients continued to have rehabilitation to ensure that their independence was maximised.
5.	Increase capacity to therapy within the Adult Community Health Teams	The development of the Community Rapid Response and Intermediate Care Team is nearing completion and will be fully operational from April 2017.
6.	Enhance the single point of access, making it easier for GPs and other healthcare providers	The development of the community single point of assessment is nearing

	to access health or social care support, supporting admission avoidance and to ensure we have early supported discharge.	completion supported by increases in the capacity of our community teams to deliver a rapid response to meet patient needs. In the community we currently provide up to 50,000 face to face contacts a month.

The workforce from ward 5b were temporarily relocated to alternative clinical areas giving each staff member an opportunity to indicate their preferred clinical speciality, which enabled staff to explore different working environments, which best utilised their skills.

5. Monitoring the Impact - Methodology

It was agreed that the impact of the pilot would be monitored during the duration of the pilot using the following measures:

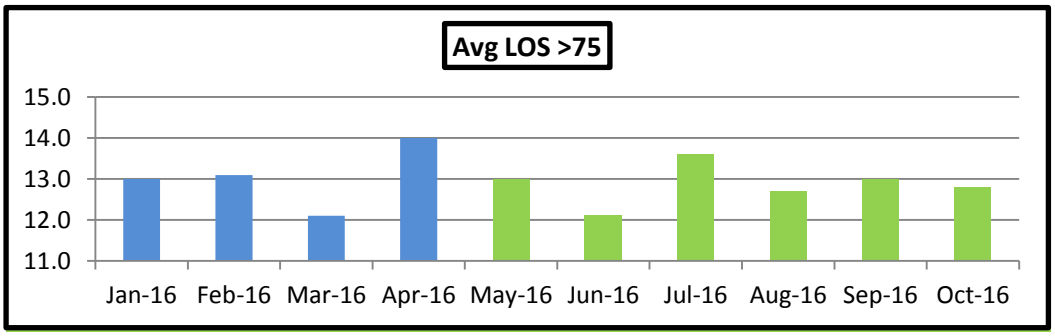
- Average length of stay for older people
- Number of interim packages of care provided
- Discharge destination for older people
- Patient related outcomes measure and patient related experience measures
- Number of admission avoidance delivered by REACT and community healthcare teams
- Focus groups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

6. Analysis of the Impact

a) Review of the length of stay of older people remaining in an acute bed.

The lengths of stay of older people over the age of 75 were reviewed in order to determine if converting to alternative community models of care in the system resulted in an increase in the overall length of stay of older people.

The analysis included those patients who remained in hospital past a 14 day threshold who were often waiting for complex packages of care, rehousing or adaptions. The length of stay in the key wards both at Wycombe and Stoke Mandeville that previously referred to ward 5b were also reviewed. This was to establish if there was an impact on the flow through these wards as a result of the pilot.



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During the pilot phase there was no significant increase in the length of stay of patients over the age of 75 years on acute inpatients which indicated that patients were not being unnecessarily delayed in the system by this change. Across the trust the average length of stay reduced by 1 day for this cohort of patients to 12 days.

b) Number of interim packages of care provided (discharge to assess)

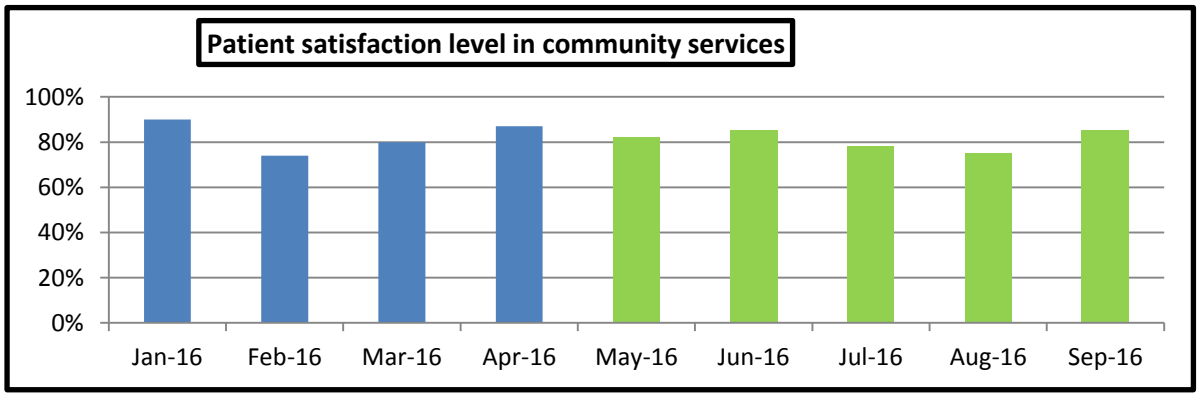
The Trust developed a transitional care model (Discharge to Assess) that allows patients to be transferred to either a care home setting or at home with an interim package of care where they can recover and be assessed as to the level of care they require to meet their needs in the longer term. This provides up to 60 hours of domiciliary care a day and up to 20 care home beds across the county. This is delivered in partnership with domiciliary care providers and care home providers in the county. This is being utilised across the county We are providing on average 60 hours of domiciliary care a day and currently up to 11 care home beds.

c) Patient related outcome measure and patient related experience measures

Patient experience and satisfaction for the community services is currently measured through satisfaction questionnaires.

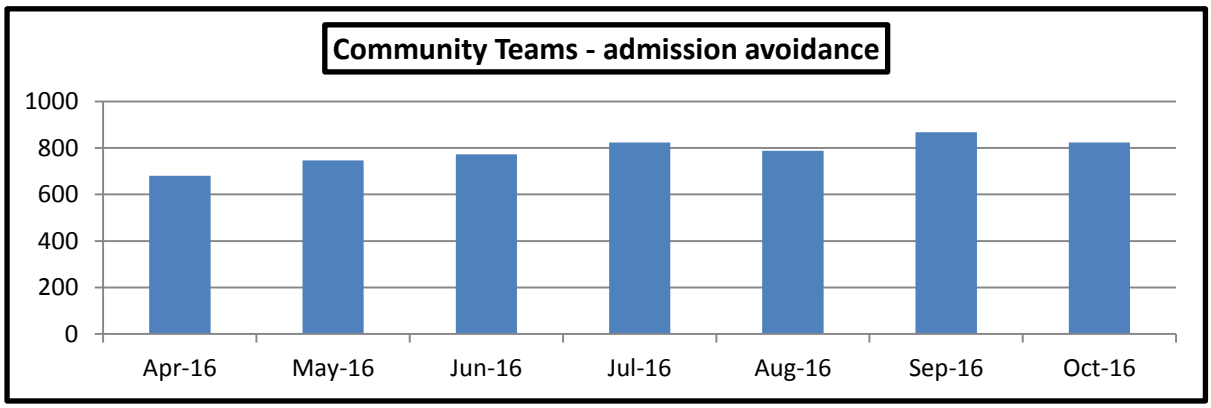
A random sample of patients is selected every month – on average the response rate is 62% of all patients who receive care.

We have measured the levels of satisfaction to determine if there has been any drop in patient experience. Over 80% of patients continue to report that the service they receive as excellent or good.



d) Number of admission avoidance delivered by the community healthcare teams

The Adult Community Healthcare Team (ACHT) collect the number of admissions avoided in order to demonstrate the effectiveness of their urgent response to a patient need. Meeting this need would often avoid an emergency attendance at A&E which could have resulted in an admission. Ongoing monitoring of this would be a key determinant in demonstrating the success of additional investment in the community especially in our single point of access and rapid response services.



Over the last seven months during the pilot stage, there was an increase in the number of admissions avoided by the community services by 150 a month.

e) Staff feedback during deployment phase of the pilot

Forums and informal meetings have been held with all ward 5b staff redeployed to alternative clinical areas for the duration of the pilot.

The feedback indicated that most staff had settled well into their new roles and felt that the redeployment had given them an opportunity to develop further skills.

A staff survey conducted in September, nearing the end of the pilot, determined staff would be happy to remain in the roles to which they had been redeployed. 92% of staff stated they would be happy to stay in their current positions and this can be accommodated. A small number of staff (less than 5) would either like or would need to be redeployed out of their current roles. A staff consultation process is about to be commenced to fully engage staff in understanding the rationale for the changes and how it will affect their current roles. This process provides individual staff with the opportunity to discuss their specific situation and career aspirations for the future.

7. Summary of evaluation

This report provides 6 months of data of the pilot and has provided a data comparison spanning the 4 months prior to temporary transfer of resource from 5b. The data has been analysed and conclusions from the data have been drawn.

The pilot has increased the number of people that have been managed under our admission avoidance pathways and we have reduced the length of stay of over 75s by 1 day.

It can be concluded that from the analysis that there has been no negative impact created in the system as a result of the pilot. This is both across the whole system and from those wards that transferred patients to 5b. Patients that would have ordinarily been transferred to 5b now have alternative care pathway options which are providing better quality and a better experience as well as increases the number of patients cared for in the community.

There has been no drop in the satisfaction experienced by patients accessing community services; this will continue to be monitored closely especially as new services come on line over the forthcoming year.

The impact on the workforce has in fact been generally positive with staff welcoming the opportunity to develop new clinical skills.

We believe that we can confidently move forward to making recommendations for the next stage of plans for ward 5b.

8. Recommendation and Next Steps

In the light of the analysis of the impact of the 5b pilot the following steps should be taken:

- Continue with the new models of care supporting patients in the community that commenced as part of the pilot. Do not transfer care back into ward 5b. Progress staff consultation by January 2017.

- Fully operationalise all our planned community service developments, reporting back to HASC in September 2017 on the impact on care closer to home.

Work stream one	**Single Point of Access**
Developing a single point of access to include all referrals of those patients ready for discharge from Buckinghamshire acute services who require community services. The community services will include: • Rapid response and Intermediate Care • District Nursing services • Community Physiotherapy • Community Hospitals • Transitional care options (beds/ interim packages of care) where available Further work will be undertaken with the development of 111 to ensure this is a point of flow as part of the clinical hub.	
Work stream two	**Rapid Response Intermediate Care (Reablement)**
Rapid response & Intermediate Care The plan is to combine the current REACT team with the reablement capacity within existing services to create a single Rapid Response and Intermediate Care Team that offers: • Continuation of a strong multi-disciplinary assessment and rapid response service from 8am – 8pm 7 days a week at the front door for all emergency admissions. • Multi-disciplinary assessment and treatment in patients' homes for admission prevention and supporting early hospital discharge. • Intermediate care support at home 8am - 9pm 7 days a week. • Daily in-reach and outreach presence at the front door acute services and deep wards. • Rapid assessment and interventions for patients requiring support on hospital discharge or to prevent a hospital admission. • Community physiotherapy for on-going rehabilitation needs to maximise independence • Outreach with the South Central Ambulance Service.	
Work Stream Three	**Buckinghamshire Locality Teams**

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To integrate GPs, ACHTs, MH & social care professionals into multi-disciplinary teams, to work with the person and their carer/wider family to agree and deliver a personalised plan of joined up care and support, designed to meet their holistic needs (physical health, social care and mental health) and remain independent for as long as possible, and be supported by a care coordinator in the team. This is building on the work of the LIT in the South of the County and Over 75s Project in the North.

The proposed model is between 7 – 9 (to be determined) integrated locality teams operating across Buckinghamshire, working to a geographical cluster of GP practices aligned to the Clinical Commissioning Group GP practice localities. The integrated locality teams will liaise closely with a wide range of other services

The team will have access to rapid support close to home in a crisis and intermediate care services such as the expanded rapid response & Intermediate care team and home based step up transitional care bed provision, while available.

Access to the Integrated Locality Teams will be via the single point of access from 8am to 8pm seven days a week, including bank holidays. Subsequent contact can also be direct to the person's care co-ordinator. Early referral by professionals will be encouraged and there will be no 'wrong door for referrals', with onward referral to the appropriate service as required.

- Continue to monitor the impact of the transfer of care closer to home provision on quality of patient care and experience.

- Use the vacant space of ward 5b for additional patient services. From January 2017 ward 8 will temporarily relocate into this space to allow for the refurbishment and expansion of our stroke service in readiness for Wycombe Hospital becoming the stroke centre for patients from east Berkshire. Further details of this expansion is available here http://www.buckshealthcare.nhs.uk/About/cardiac-and-stroke-services-go-from-strength-to-strength.htm.

References

- NHS England October (2014)*: Five Year Forward View*

- Kings Fund Purdy. S December (2010): *Avoiding Hospital Admissions. What does the research evidence say?*

- DOH, Lord Carter Review (2016)

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

Written response from Buckinghamshire Healthcare Trust (BHT) and the Chairman of HASC to questions raised at Heath & Adult Social Care Select Committee meeting held on Tuesday 24 January 2017

Questions submitted in advance of the meeting by County Councillor Julia Wassell, a Member of the HASC, in relation to Ward 5b.

Question 1
How can the pilot be reliable when it has not taken place in the most pressured time of the year in respect of admissions for older people?

Response from BHT - Demand fluctuates across the year and as it was a six month pilot it would have experienced this fluctuation. We continue to monitor and measure the impact of developing care in the community – the purpose of our attending the HASC meeting in September this year is to update on this since the pilot.

Question 2
Why are we being asked to look at this now after the decision has been taken and the ward is closed for its previous patient intake?

Response from BHT - We provided a report to the HASC before the pilot commenced, and details of the Committee's response appears in the July 16 papers. We have also provided details on the evaluation.

Additional point - in terms of beds at the hospital, we haven't closed or lost anything as we are using them for our expanding stroke service instead. The focus is on how we best care for this group of patients who don't need to be in hospital – and were staying 24 days extra because previously the right support wasn't available in the community.

The link below provides further information on the evaluation of the pilot.

http://www.buckshealthcare.nhs.uk/About/patients-benefitting-from-care-in-the-community.htm

Question 3
Can the decision be referred to the Secretary of State for Health?

Response from the Chairman of HASC –This issue has been raised at HASC Select Committee meetings (July and January) and Members of the HASC had the opportunity to raise concerns throughout the pilot stage. If there is sufficient evidence to show that patient safety and quality of care is being put at risk, then the HASC would be looking to raise its concerns through the appropriate channels. To refer it to the Secretary of State at this stage would require the Select Committee to make a recommendation for Council to do so, and sufficient evidence to support the escalation. The HASC Select Committee will continue to monitor this and it will be on the agenda for the September meeting.

Joint Strategic Needs Assessment

HASC Select Committee 24th January 2017

Dr Emily Youngman
Consultant in Public Health Medicine

The Process

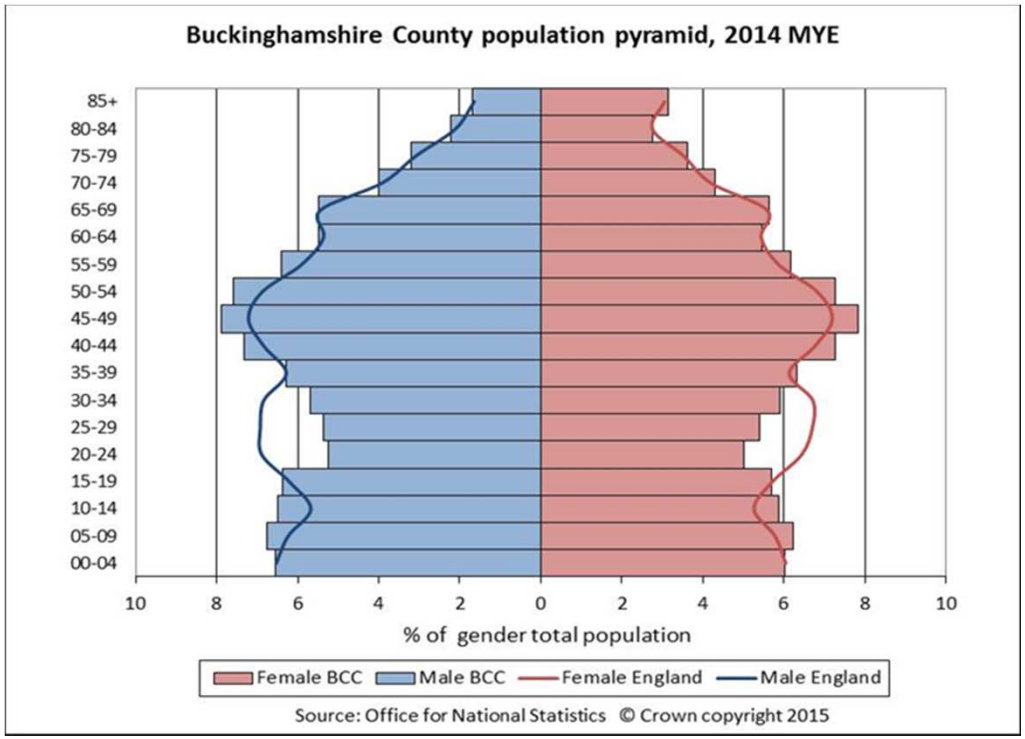
- Joint Strategic Needs Assessment (JSNA) assesses the current and future health, care and wellbeing needs of the local community to inform commissioning decisions with the aim of improving the health and wellbeing of the local community and reducing inequalities
- Local authorities and clinical commissioning groups have equal and joint duties to prepare JSNAs, through the Health and Wellbeing Board
- **Collaborative** - JSNA development comprises representatives from key stakeholders across BCC Business Units, as well as representatives from the Clinical Commissioning Groups, District Councils and Healthwatch
- Structure of the JSNA is
  - Population
  - Wider determinants of health
  - Healthy lifestyles
  - Children, young people and their families
  - Adults
  - Older people

New Developments

- Continuously updated, live resource
- Better data sharing, more complex analysis
  - Identify gaps
  - Data sharing and linkage
- Presented in different ways
  - Summaries
  - Interactive atlas
- Greater public voice

Population

- **528,400** people living in Buckinghamshire in 2015
- ↑ **4.6%** (23,000 people) since 2011
- 2.8% South East
  2.5% England



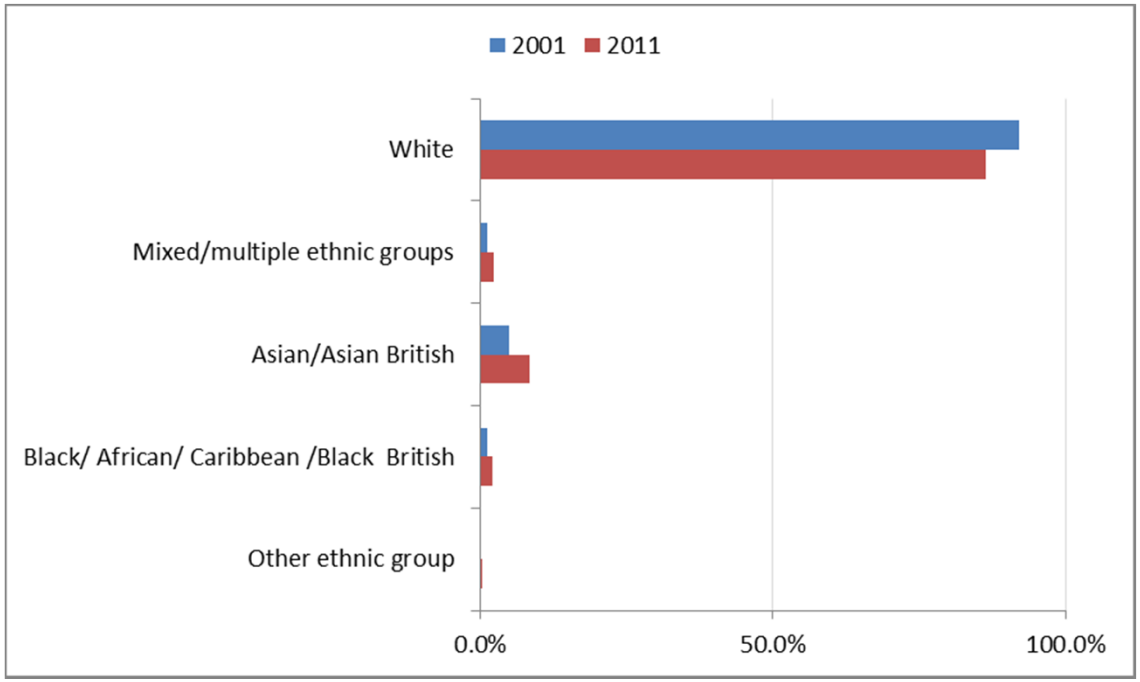
Population Growth

- Buckinghamshire population expected grow by **14% from 2015 to 2033** (extra 73,750 people)
- But,
  - **44% increase** in people aged 80+ years (extra 55,000 people)
  - **140% increase** in people aged 90+ years (extra 6,800 people)

Ethnicity

- **14% population from non-white ethnic groups** (approx. 72,000 people in 2015) (8% in 2001)
- 21% 0 to 19 year olds are from minority ethnic groups
- 26% of births (1,608 births) are to non-UK born mothers, comprising (top 5)
  1. Pakistan
  2. Poland
  3. India
  4. South Africa
  5. Romania

Ethnic Groups, 2001 & 2011, Buckinghamshire



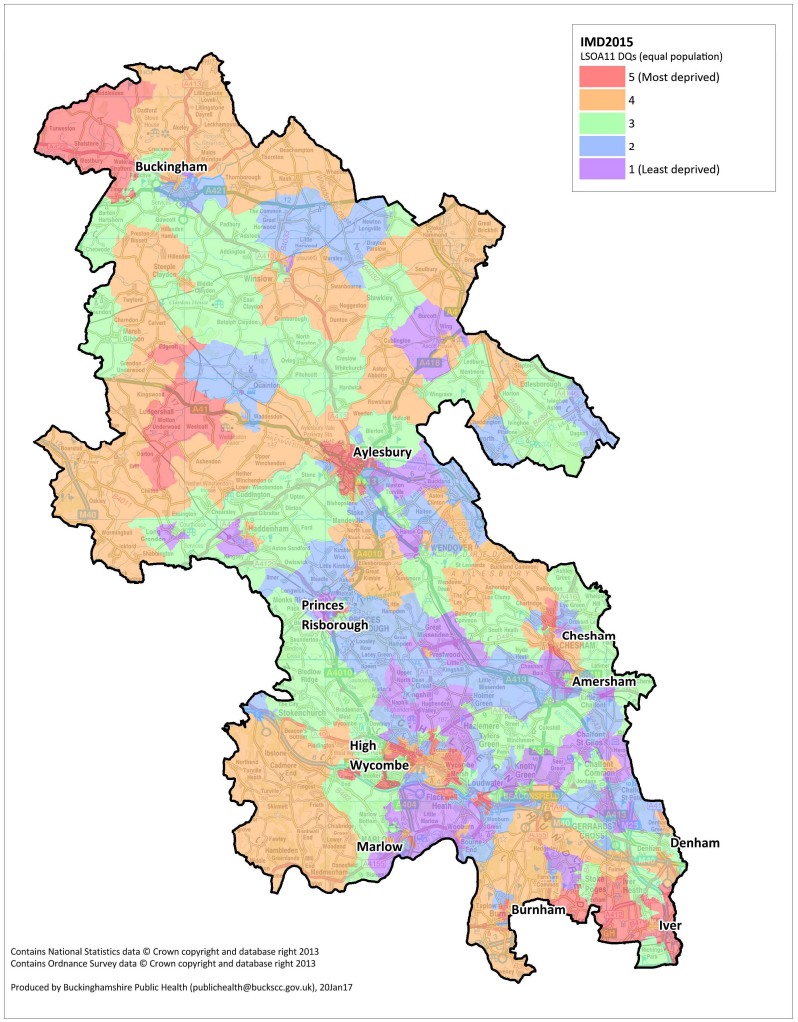
Deprivation

- **5th least deprived local authority** out of 152 in 2015
- 8th out of 149 in 2010
- **3 LSOAs in the 20% most deprived nationally**
  (LSOA is an area containing approx. 1,500 people)
- 0 LSOAs in 2010

Buckinghamshire County Council

Index of Multiple Deprivation Quintiles for Buckinghamshire County Council

Buckinghamshire County, showing LSOA11 IMD2015 quintiles



- Approximately 100,000 people in each quintile
- Red zones are in most deprived quintile
- Purple zones are in least deprived quintile

Life Expectancy

- Men and women in Buckinghamshire live **on average two years longer than the national average**
- But, varies across county
- 104,440 people living in the most deprived areas of the county who will die on average up to **6 years earlier for men** and **four years earlier for women**, than those living in the least deprived areas in Buckinghamshire

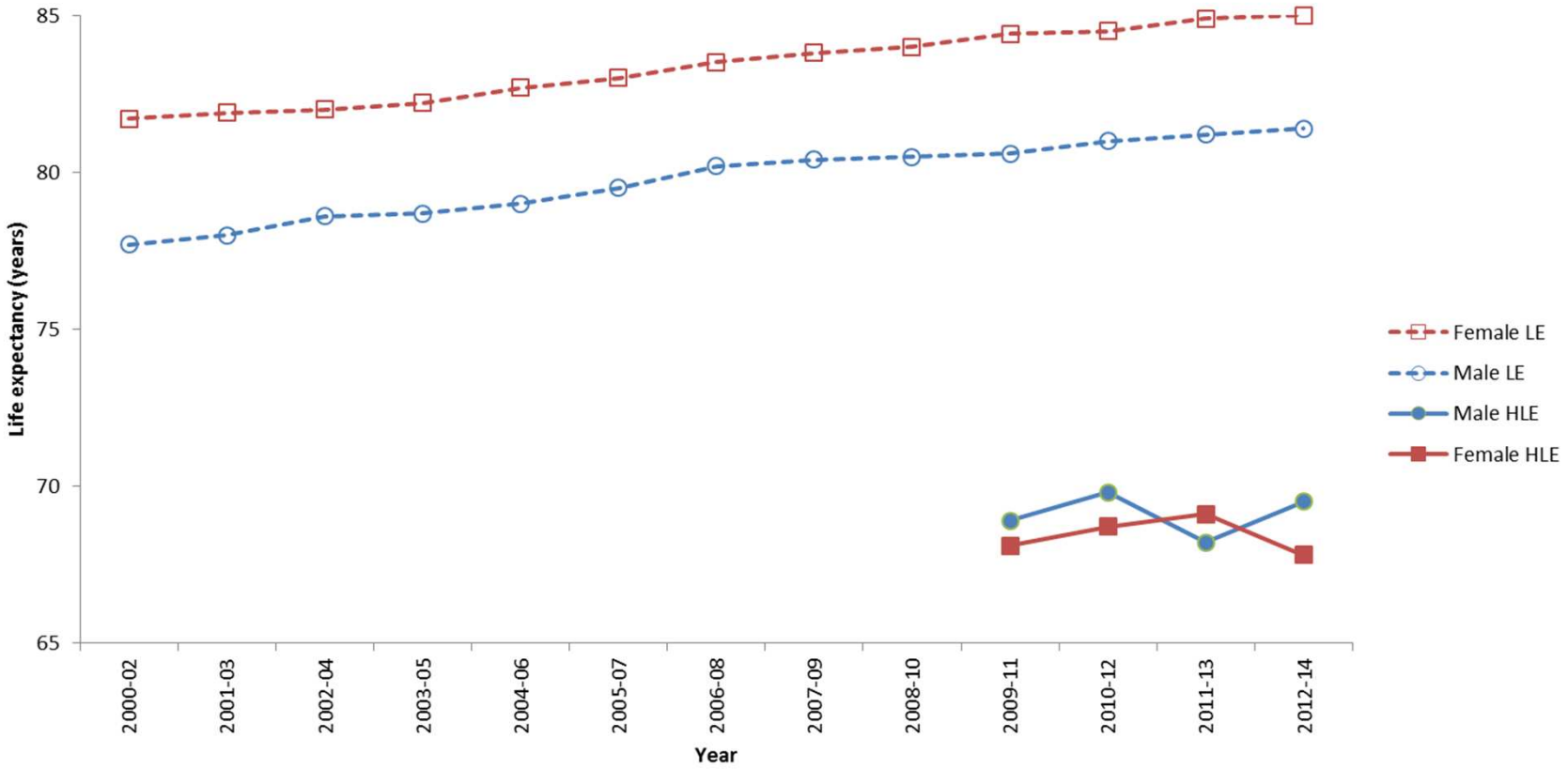
Healthy Life Expectancy

- Every year, the life expectancy at birth of men and women in Buckinghamshire increases by about 4 months
- However, there have not been similar increases in healthy life expectancy, suggesting that the extra years of life are not free of ill-health

For example…

- For females, 80% of life spent in ‘good’ health, with on average 17 years spent in ill-health
- For males, 85% of life spent in ‘good’ health, with on average 12 years spent in ill-health

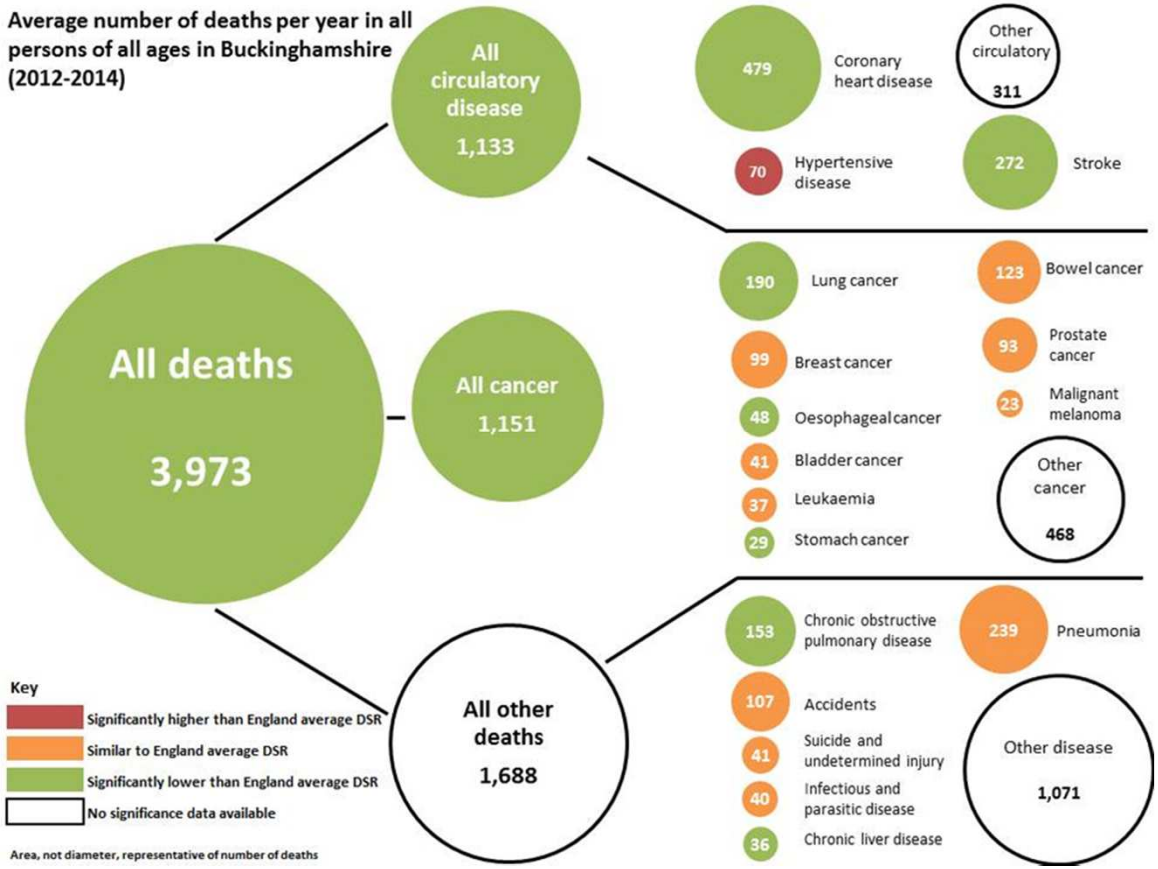
Trend in life expectancy at birth and healthy life expectancy in men and women in Buckinghamshire



Self-Reported Health in Buckinghamshire

- 14% increase in people self-reporting good or very good health from 2001 to 2011 and 2% drop in those reporting bad or very bad health
- 85.8% population (433,800) self-reporting good or very good health in 2011, compared with 74.9% (27,800) in 2001
- 3.5% population (17,500) self-reporting good or very good health in 2011, compared with 5.8% (358,616) in 2001
- 13.4% population (67,900 people) with limiting long term illness in 2011, compared with 12.8 % (61,300 people) in 2001

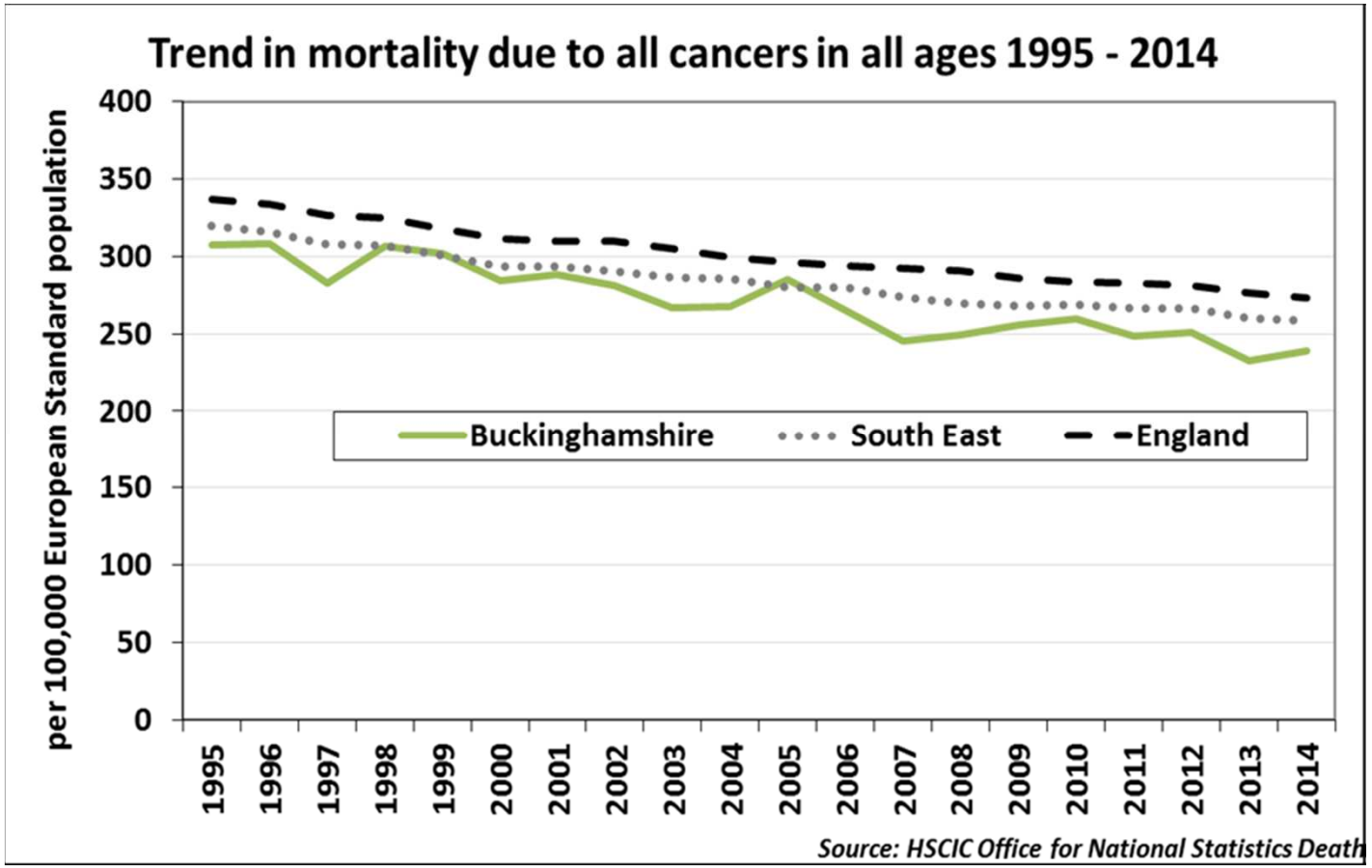
Causes of death



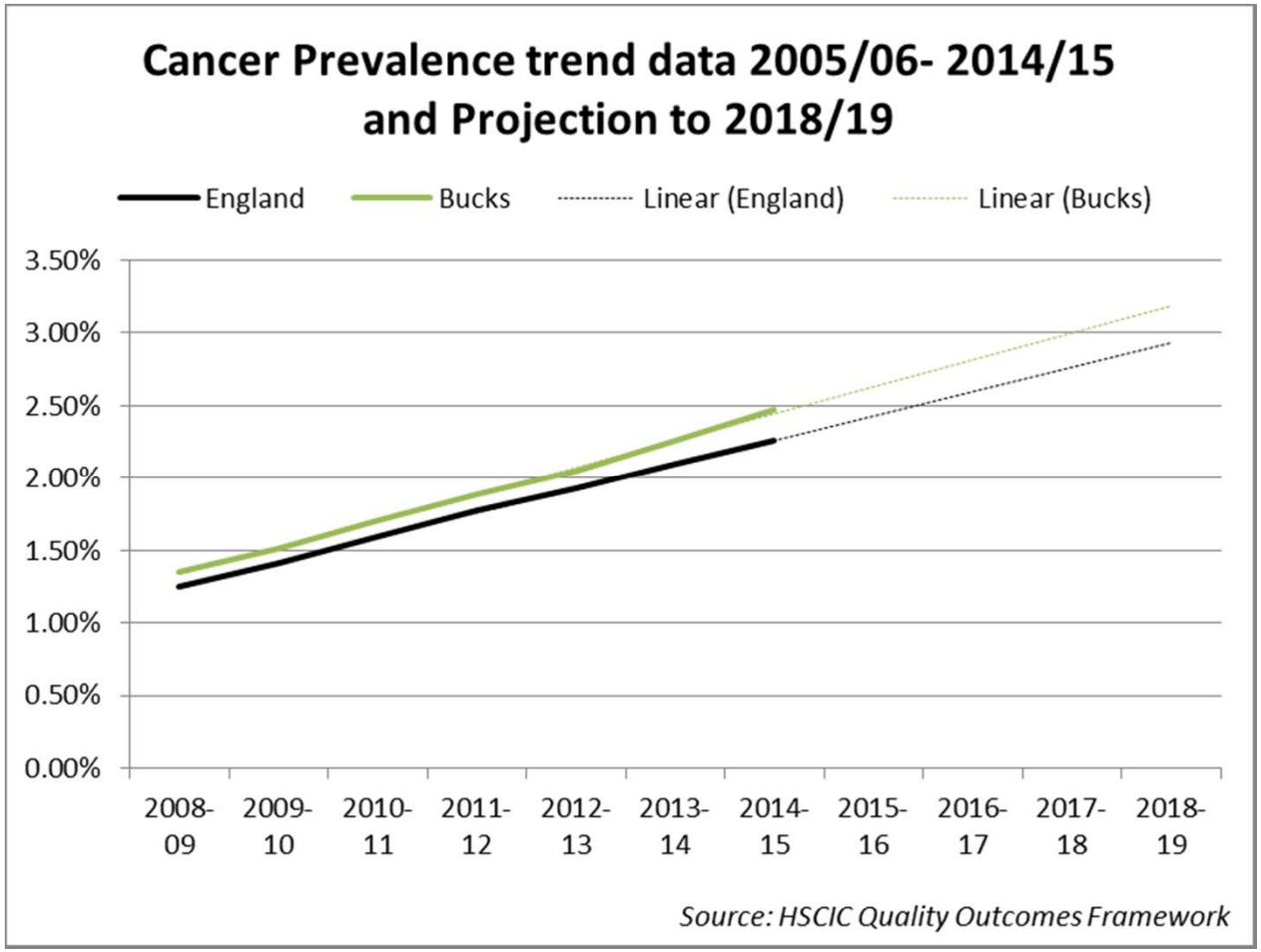
Premature Death

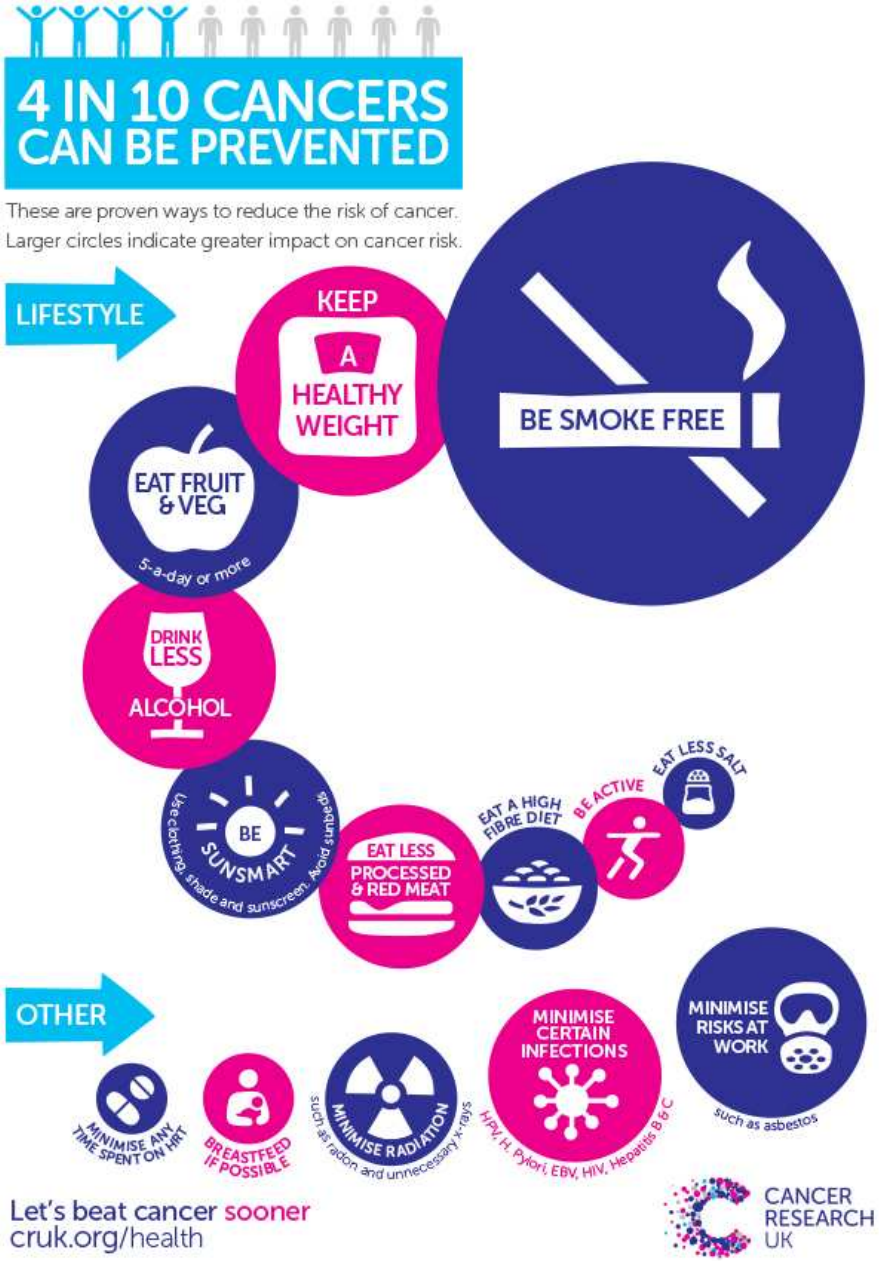
- Overall premature death rate is declining and 4th lowest out of 150 LAs in England
  - Rate decline is slowing
  - Can do even better
- Premature death rate from cardiovascular disease is decreasing and 3rd lowest, but
  - 59% of premature cardiovascular deaths are preventable
    = **422 preventable deaths in 2012-14**
- Overall premature death rate from cancer is decreasing and 7th lowest, but
  - **Premature death rate for breast cancer 102nd lowest**
  - **Premature death rate for colorectal cancer 22nd lowest**

Deaths due to all cancers are decreasing



Prevalence of cancer is increasing





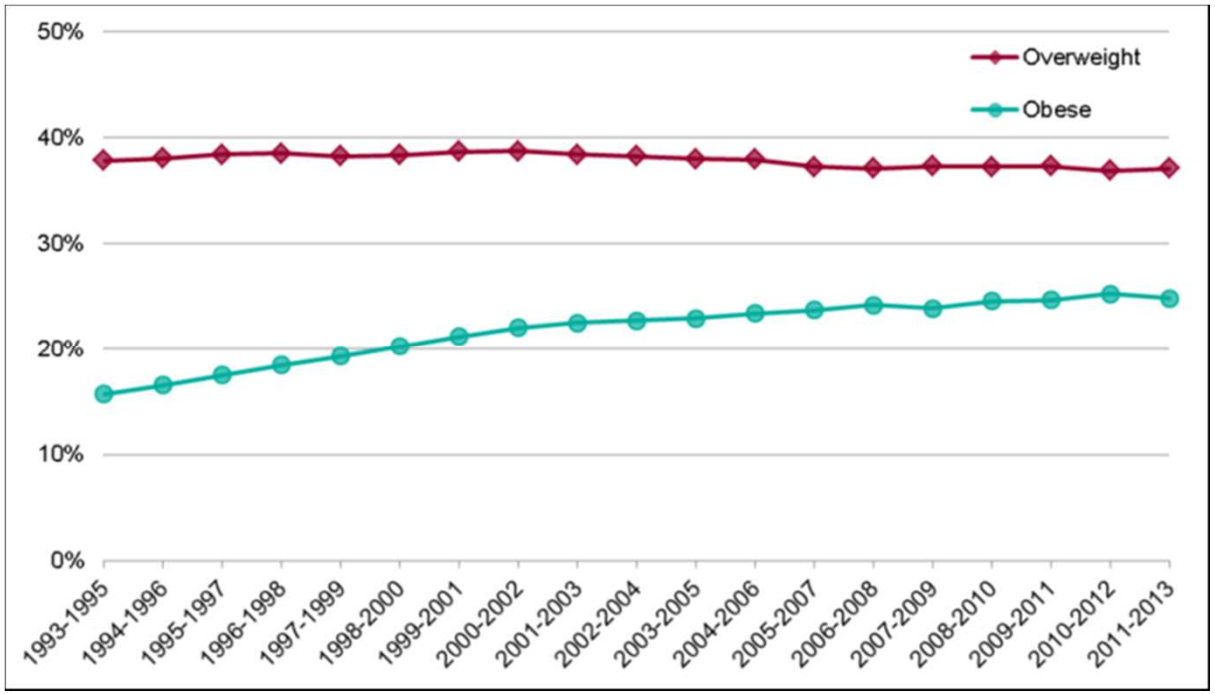
- 55% of premature cancer deaths are preventable
- = 816 preventable deaths in 2012-14

Healthy lifestyles in adults

Buckinghamshire

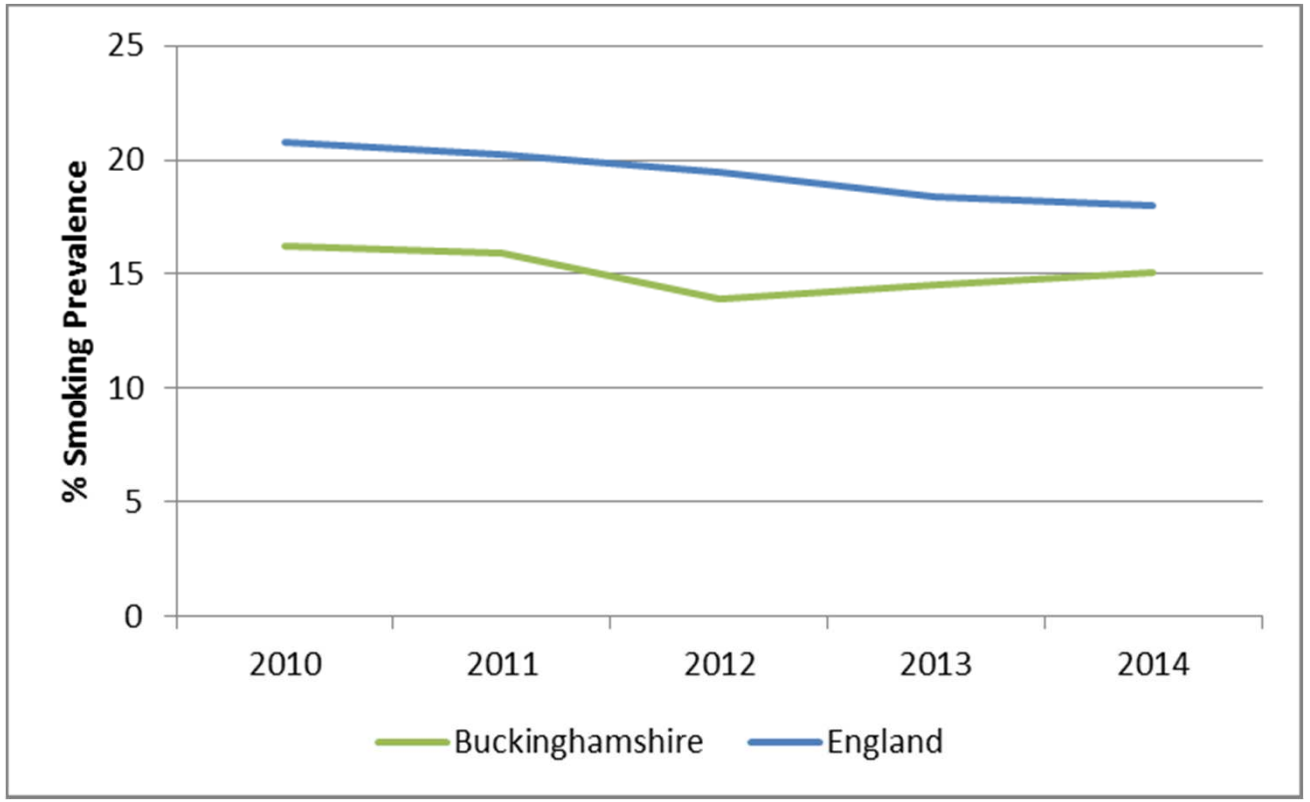
- 2 in 3 adults (261,700 people) are overweight or obese
- 1 in 5 adults (78,500 people) are physically inactive
- 1 in 8 adults (49,000 people) are at risk of developing diabetes

Trend in Prevalence of overweight and obesity England

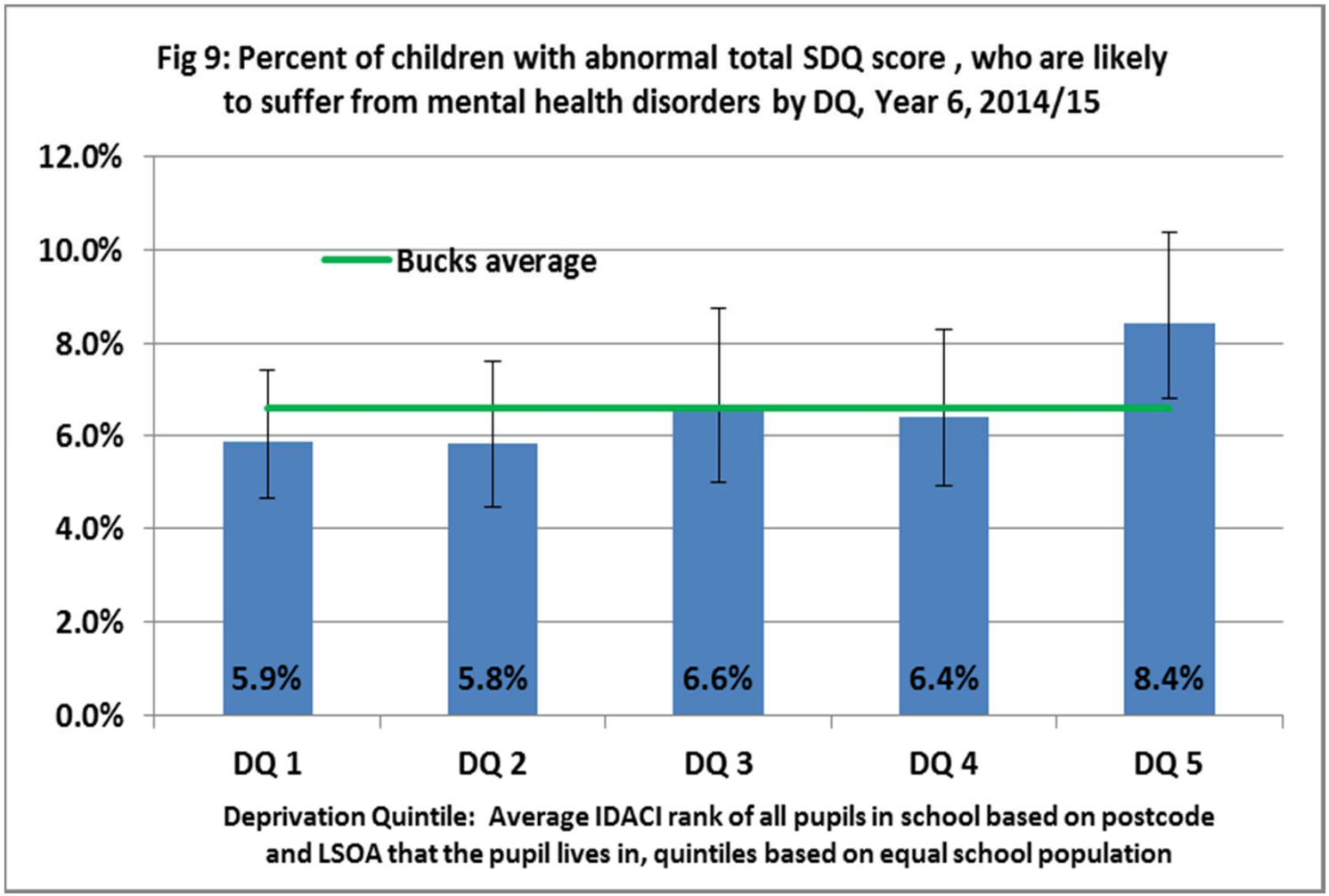


Trends in smoking prevalence in Buckinghamshire

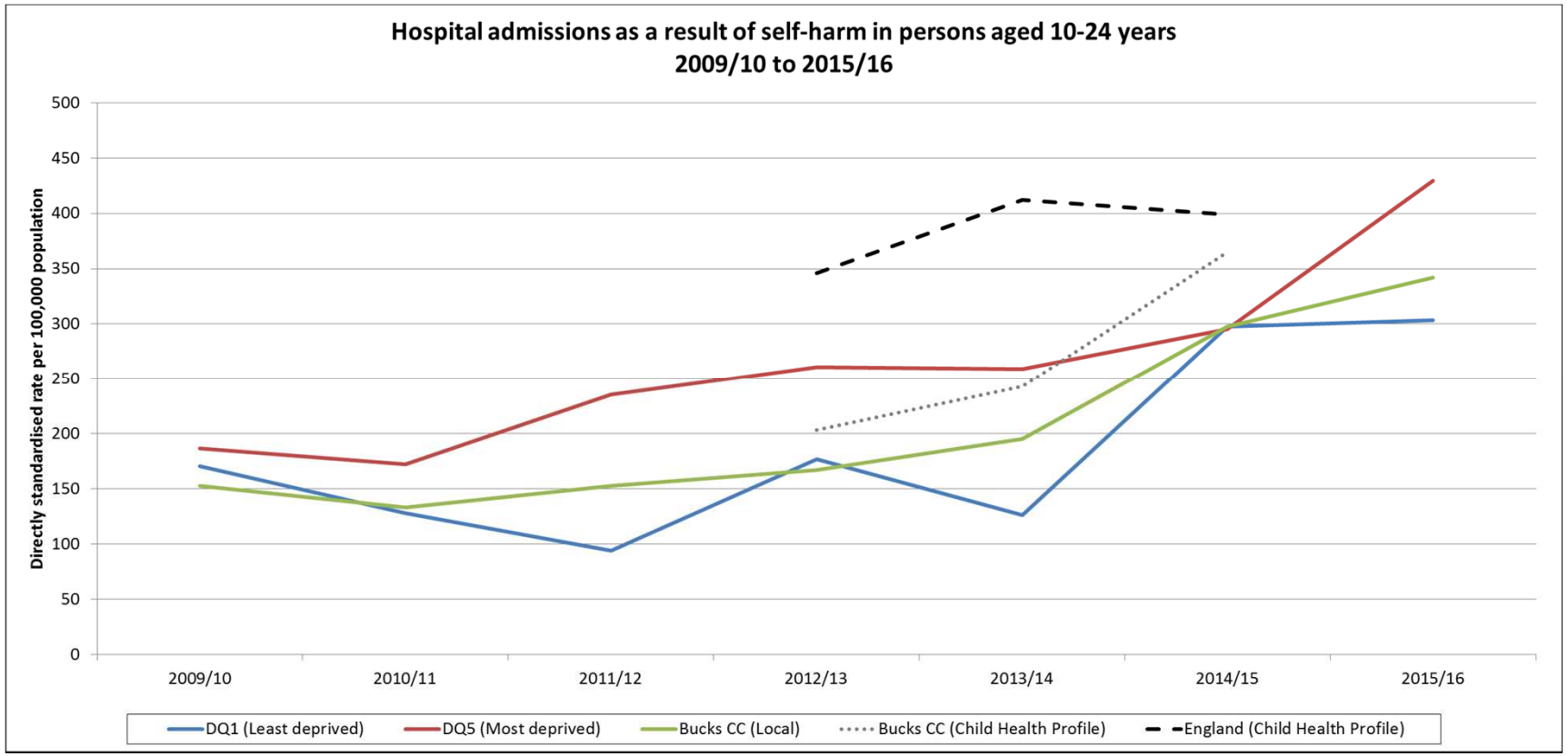
- 1 in 9 adults smoke (43,600 people)
- 1 in 5 adults in manual workers (78,500 people)
- 1 in 14 pregnant women are smokers at the time of delivery (433 women)



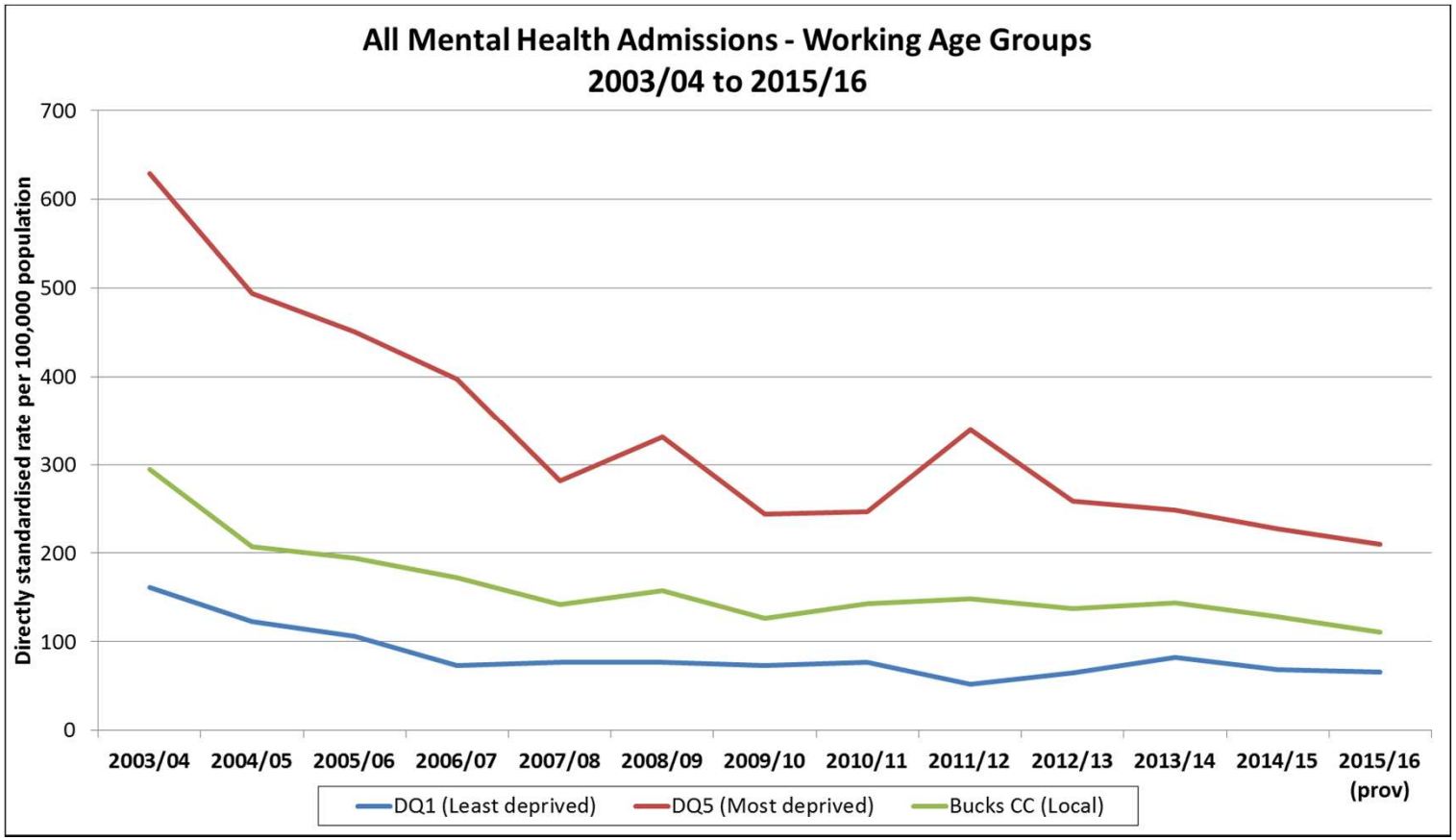
Risk of mental health problems by school deprivation quintile Year 6 (10 to 11 years old) in Buckinghamshire



Hospital admissions for self harm aged 10-24 years



Mental health admissions – working age group

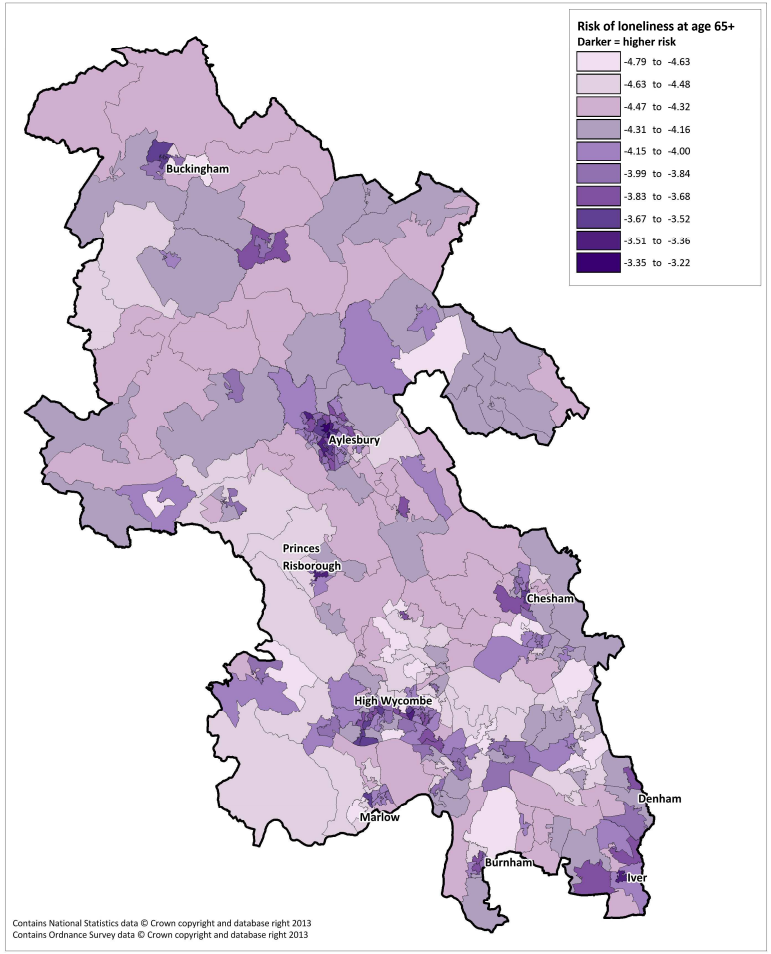


Older people

- Around **1 in 10 people** aged 65 and over are frail, rising to between 25% and 50% of those aged 85 and over.
- In 2015, this would equate to **9,700 frail older people** aged 65+, rising to **12,000 in 2025**.
- In Buckinghamshire, an estimated **7,000 people** aged 65+ have dementia and this number is expected to rise to more than **8,000 in the next 5 years**
- **23% more** people aged 85 and over die in the winter months in Buckinghamshire, which is higher, but not statistically different, than England and South East averages
- Frailty and disease not an inevitable part of ageing as intervening in mid-life can prevent dementia and frailty in later life

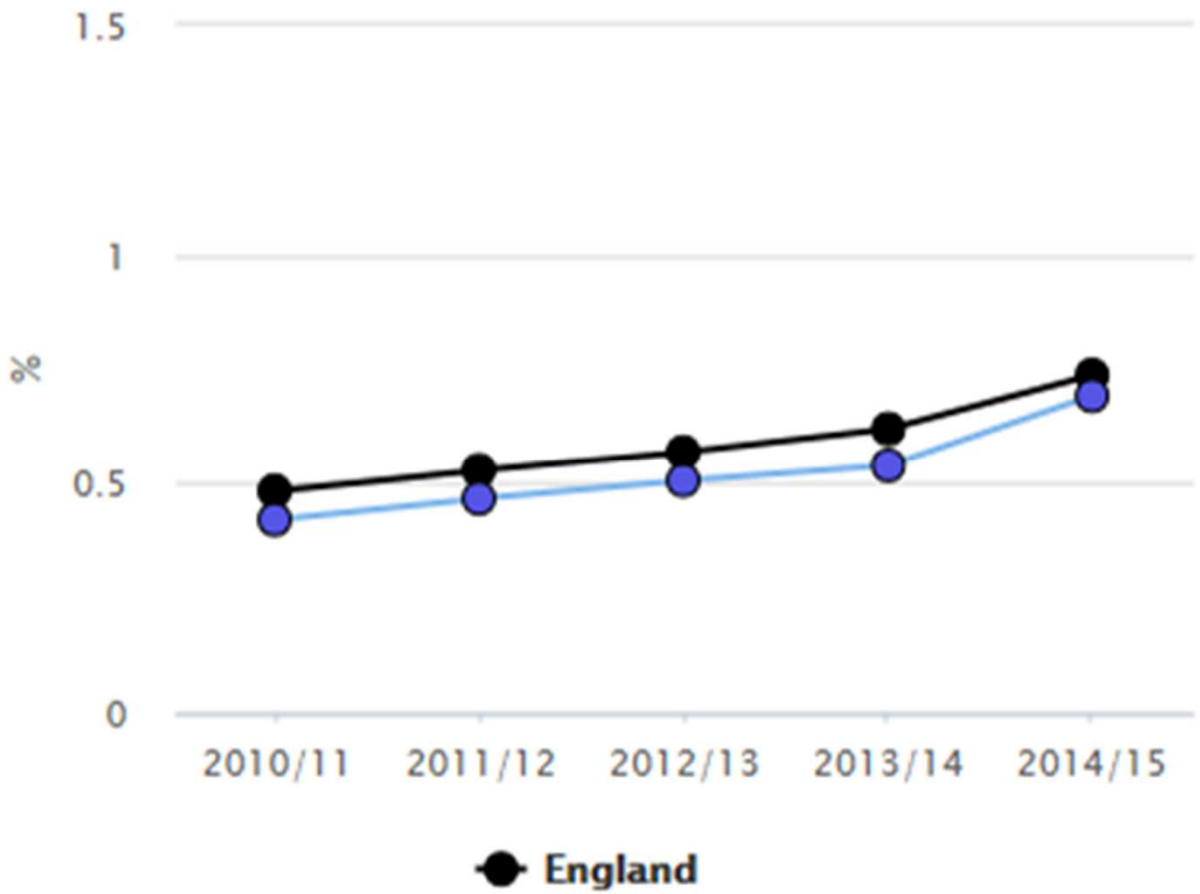
Loneliness

Risk of loneliness at age 65+, Buckinghamshire LSOA



- Darker areas = higher risk of loneliness

Recorded prevalence of dementia in Buckinghamshire



Thank you

- Any questions?

- JSNA
  - http://www.healthandwellbeingbucks.org/s4s/WhereILive/Council?pageId=2098

Active Bucks

move more, feel great!

BUCKINGHAMSHIRE · COUNTY COUNCIL

Why promote physical activity?

- Wide ranging health and social benefits
- Directly contributes to 1 in 6 deaths in the UK
- Half of women and a third of men are not active enough for good health
- 22% of adults in Bucks are inactive
- 32% boys and 48% girls are inactive
- A priority for the Health & Wellbeing Strategy

Active Bucks

- Increase physical activity levels of Bucks residents
- Engaging communities to identify what physical activity communities want to participate in
- Utilising the role of members as community leaders
- Providing evidence based and best practice physical activity interventions which deliver the Bucks Physical Activity Strategy
- Develop activities that are sustained past the end of the project

Community engagement

- May – September 2015
- To understand what residents wanted to participate in
- Over 3500 residents have been engaged
- 70% of those were not achieving recommended activity levels
- Countywide recommendations
- LAF level recommendations
- 25 Community Champions recruited so far…

Local decision making

- Local Area Forums (LAFs) have played an active role:
  - Engaging residents
  - Reviewing recommendations
  - Deciding which activities to commission for their area
- The second year of activities chosen by LAFs are starting between January and March 2017.
- Activities are also being delivered that have been commissioned countywide

Some of the activities….

Dance

Junior Park Run

Social Ballroom

Walking

Fire fit

Bushcraft

Dog Agility

Quidditch

Walk/Jog/Run

Live Action Role Play

Handball

Cage Cricket

Buggy Fit

Gardening

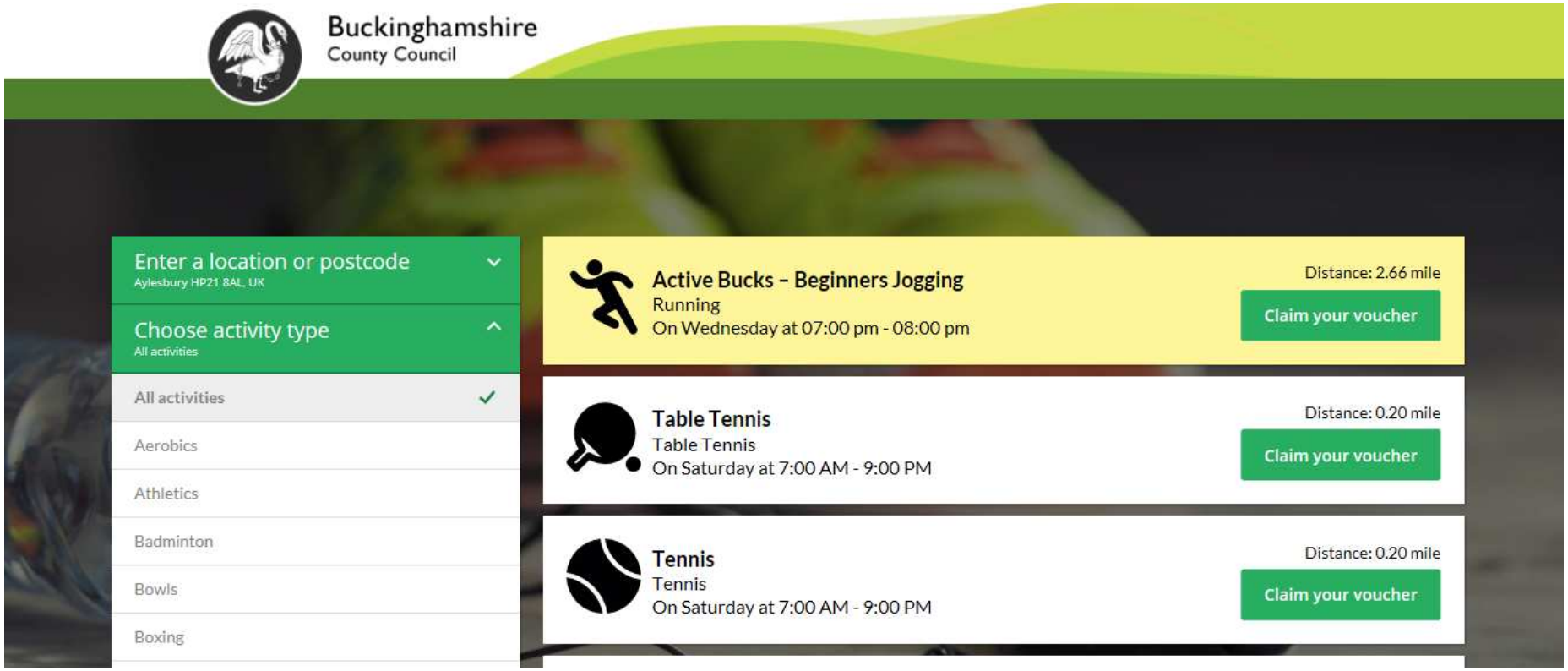
NERF Games

Flag Football

Dads and Toddlers

Photography

www.activebucks.co.uk



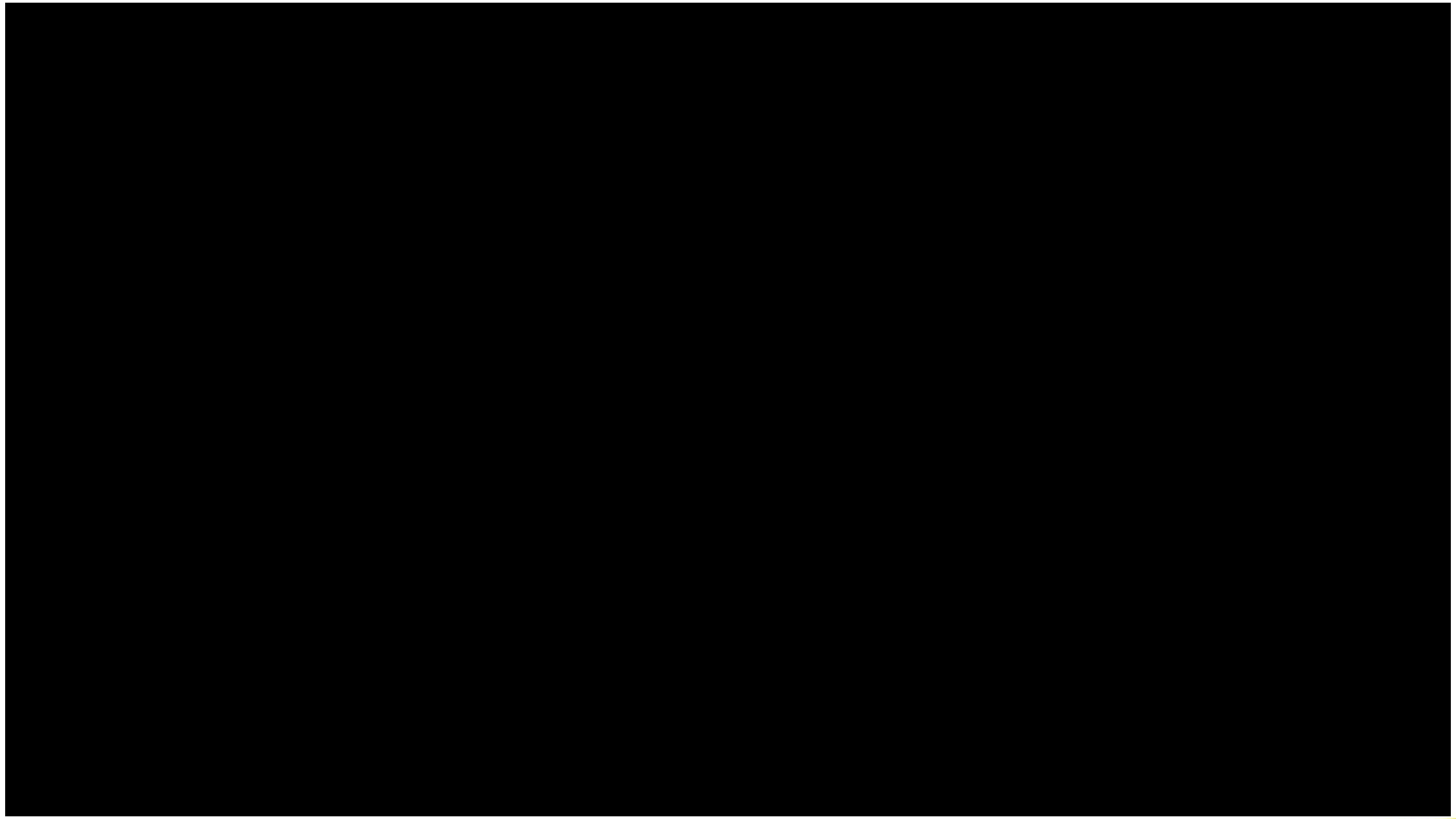
www.activebucks.co.uk

- Launched in June 2016
- Activity Search
- Over 2500 activities across the county offering a first session free, including Active Bucks activities.
- Search for an activity you enjoy within 20 minutes of home/work on a day/time that suits
- 15,000 unique users
- Over 800 vouchers downloaded

Results so far…..

- First 6 months of a 17 month programme of activities (May – November 16)
- 49 six month programmes of weekly activity
- 71% of these have been sustained past the end of the funded period
- Over 1750 unique participants
- Over 10,000 attendances
- 79% of participants were not achieving recommended levels of activity at registration
- 39% of participants were inactive

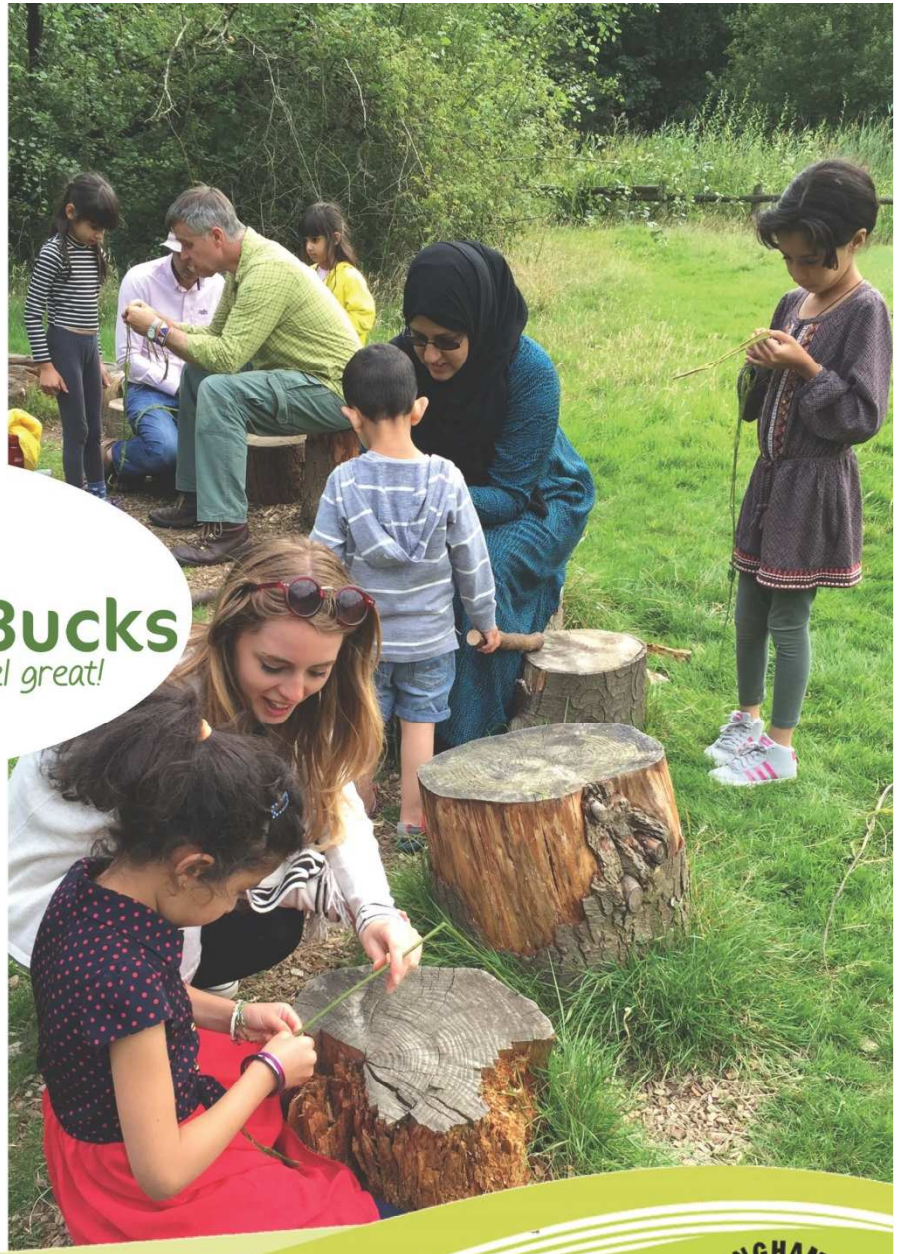
What residents think….



Next Steps

- Next phase of activity starting January – March 2017
- Activity delivery will complete in September 2017
- Full evaluation report expected February 2018

- Continue to support the promotion of Active Bucks to residents



Active Bucks

move more, feel great!

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Scrutiny Inquiry Progress Update on Recommendations from the Accessibility and Promotion of Services for Adults with Learning Disabilities Inquiry Interim Progress (6 months on)

Select Committee Inquiry Report Completion Date: May 2016
Date of this update: January 2017 (due to no meeting in December)
Lead Officer responsible for this response: Oliver Stykuc-Dean/Kelly Taylor
Cabinet Member that has signed-off this update: Mike Appleyard

Accepted Recommendations	Original Response and Actions	Progress Update	Committee Assessment of Progress (RAG status)
1. Buckinghamshire County Council should ensure that the experience of Adults with Learning Disabilities who use the college and day opportunity centre transport service is a core part of the contract monitoring process, and is reflected within the Key Performance Indicators for the Contract.	• Contract terms will be reviewed • Customer satisfaction feedback, via compliments/complaints and through surveys to be incorporated into performance management arrangements for all client transport services	• Contract terms address standards of performance in providing stipulated services; providers are aware that customer satisfaction is material to our assessment of them. • The plan is also to conduct periodic surveys, to complement existing arrangements, from the New Year.	

2. Buckinghamshire County Council should coordinate learning disability awareness training for drivers within managed transport services, ensuring this training is annually refreshed and monitored.	• Safeguarding assurance procedures and the associated training package were revised and relaunched for 2016 and incorporates SEND/LD element • Training package will be further reviewed.	• In hand and ongoing; the updated training element covering learning difficulties has recently been shared with CHASC colleagues for review.	
3. Buckinghamshire County Council should promote the importance of learning disability awareness training with local bus operators as part of the Council's role in improving disabled access on buses.	• LDA training is already including in the new driver induction process for the main bus companies operating in Buckinghamshire. • Existing training will be reviewed • We are working with bus companies to include additional and refresher training via the Driver Certificate of Professional Competence which requires all bus drivers to complete	This is an ongoing engagement with local bus operators.	

	35 hours of additional training per 5 year period of their career. • Public Transport team are engaging with the LD Partnership Board to address individual issues.		
4. Buckinghamshire County Council, in conjunction with Buckinghamshire district councils, should promote the 'Fair4Aall' taxi scheme so that Adults with Learning Disabilities are supported to have trust and confidence in using taxi and mini-cab services safely.	• Funding has been provided allowing BuDS to revamp the Fair4All website due to be completed by June 2016. • The Public Transport Team will work with BuDS and AVDC to promote the current scheme more widely. • Options to enhance the scheme will be considered jointly with AVDC.	Support to this initiative is ongoing	
5. Buckinghamshire County Council should continue to invest in travel training – ensuring all appropriate Adults with Learning Disabilities can	• Further work required with colleagues across both CHASC and	A work-strand to be established under the Supported Transport Programme, enabling CSCL and CHASC to develop and implement a strategic, effective and VFM plan.	

access this as part of the transition to independent living.	CSCL to establish a strategic, effective and cost effective approach • Establishing suitable ownership of this workstrand a priority.		
6. Buckinghamshire County Council should ensure its web pages are accessible for all users, with Adults with Learning Disabilities seen as a priority group.	• We are currently building a new set of webpages, designed to improve the overall experience and make content better for adults with learning disabilities	As a result of the changes already made, we have reduced the number of issues with accessibility by 72%. We expect the corporate website to have no significant accessibility issues by the end of the financial year.	
7. Buckinghamshire County Council undertakes a digital service standards assessment of www.careadvicebuckinghamshire.org and the County Council web site in order to identify immediate, short and medium term priorities for ensuring it meets the needs of all users.		An assessment has been made and reported to CID board in October 2016. It made 5 recommendations for the continued improvement on the website to better meet the needs of users. We have also engaged the provider of the 'browse aloud' function to help improve the usability and performance reporting of the service.	
8. Buckinghamshire County Council to evaluate and consider investing in a dedicated Buckinghamshire venue guide for users with disabilities, working collaboratively with District		Evaluation of DisabledGo proposal to produce dedicated venue guide has been completed. Fees range from £31,150 to £62,541 for 700 to 1500 venues and officer time of 1 week is required for establishment.	

Councils		We have reviewed our approach to promoting venues and events and developed a proposal for a single dataset which can be used across all BCC's web estate, and by the wider community, to promote venues and events relevant for people with disabilities. CID board will review the findings from the prototype and user research and make a decision on whether to proceed.	
9.Buckinghamshire County Council should explore how information on community activities could be presented in a more dynamic format for example via a community portal		We are taking this forward as part of the work to address point 8.	
10.Buckinghamshire County Council should develop an implementation plan that includes staff training and guidance to ensure effective compliance with the Accessible Information Standard (for Health and Adult Social Care Services)		We are raising awareness of the accessible information standard amongst all those who write for the web. We have put prominent posters on the wall so that people are aware of key principles and circulated these to all teams. As part of the internal customer and digital communications campaign, we will be distilling key messages and capturing case studies to show how. The specific requirements of the standard relate to the way data on communication preferences is captured in our line of business	

		applications, which is a matter for the Business Unit working with ICT.	
11.Buckinghamshire County Council should review current community provision (not solely Council services) for adults with learning disabilities identifying needs, gaps in services and actions for how these will be met in the future.		Work is in progress to review Learning Disability care and accommodation provision in Bucks. Commissioning is an ongoing cycle analysing and reviewing needs at the population level and identifying suitable ways in which this can be meet. A Business case and action plan was presented and supported by PMO board outlining next steps and the rational for resource targeting. Development discussions are now to take place with key providers, the first scheduled for 14th Nov 2016, to clarify practical & support partnership needed to deliver objectives. A Strategic Intent document is to be produced in New financial year to demonstrate to market the aims and objectives of the modernisation of specialist accommodation in the county. Currently there are plans being developed and users and carers are being consulted as we look to re-provide respite accommodation to create sustainable and fit for purpose accommodation to meet current and future requirements. Work is also in progress engaging commissioners from adult social care, children social care and learning and the CCG to review the pathway of our service users through the	

		life course and more closely integrate our thinking and planning to improve the experience of service users and their families at key transition points in their lives. This will ensure that strategic commissioning has appropriate data in a timely manner to ensure that the range of services required to meet needs in the most cost effective way, are developed. Review the LD Commissioning Strategy: - There are a number of existing strategies that impact upon services for people with a Learning Disability; e.g. Housing, Children, Carers. In line with National drivers for the Transforming Care Agenda for people with Learning Disabilities and/or Autism, Buckinghamshire have an integrated 3 year plan in place: - http://www.aylesburyvaleccg.nhs.uk/wp-content/uploads/2016/06/Transforming-Care-Planning-Buckinghamshire-v10-final-submission-26072016.pdf By Summer 2017, Health and Social Care Commissioners intend to generate a high level document which pulls together 3 year commissioning intentions and priority areas from each of the aforementioned strands.	

12.Buckinghamshire County Council should make its regular activities and services more accessible to adults with a learning disability e.g. its library services developing services that people with a learning disability could access	• Included in business plan • Prepare business case	Visit Kent Libraries, see activities in action and gather further evidence. Aim to develop 6 month project of activities, utilising existing resources, which will demonstrate impact. Planning meeting with Helen Krauze from Talkback identified the following actions Library staff to visit and meet adults at Talkback and deliver a bag book session – date TBC Kent libraries session plan for Discovery tour to be used as template for tours in Bucks libraries Create a group library ticket for Talkback to borrow library items for use at Talkback / individual membership will also be encouraged Job / volunteer role descriptions plus feedback from staff about current work experience and volunteering placements for adults with autism to develop future placements for adults with learning disabilities Planning BCC Autism Awareness training for frontline library staff with Paulette Hunn – date TBC	
13.Buckinghamshire Council to work with Local Safeguarding Boards to ensure safeguarding training and support by providers to service users	Work with the Safeguarding Adults Board to raise awareness and deliver training in relation to all	BSAB & Talk back to progress this action by March 2017 via SAFE sub-committee.	

with learning disabilities is provided with a particular focus on the following: avoiding exploitation, money management, relationship management and use of social media	aspects of exploitation of people with learning disabilities - Work still in progress, paper to be presented to BSAB in January 2017 Engage Talk Back and the Learning Disability Partnership in developing a prevention strategy Work alongside health and social care commissioners to identify/create roles/services aimed at supporting people with learning disabilities to develop and maintain essential life/independent living skills and reduce the risk of harm and exploitation	Engage Zita Calkin & BSAB BM by March 2017 with Hertfordshire NHS Trust to identify current services in place and future shape of LD ILS services in order to prevent risk of harm and exploitation.	

RAG Status Guidance (For the Select Committee's Assessment)

	*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*