Buckinghamshire County Council

Select Committee

Health and Adult Social Care

Date: Tuesday 19 September 2017

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

Venue: Mezzanine Room 1, 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**	**10.00am**	
2	**DECLARATIONS OF INTEREST** To disclose any Personal or Disclosable Pecuniary Interests		
3	**MINUTES** To confirm the minutes of the meeting held on Tuesday 25th July 2017 as a correct record.		**7 - 14**
4	**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/

5	**CHAIRMAN'S UPDATE**	**10.05am**	
6	**COMMITTEE UPDATE** 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 and for District Representatives.	**10.10am**	
7	**SOUTH CENTRAL AMBULANCE SERVICE** The purpose of this item is for Committee Members to explore the challenges facing South Central Ambulance Service (SCAS), the recent contract to provide the 111 non-emergency service for the Thames Valley region and to examine the current performance against targets. **Attendees:** Mark Begley, Head of Operations (Aylesbury Vale and Milton Keynes) Andy Battye, Head of Operations (South Bucks and East Berkshire) **Papers attached:** Report Power point presentation **Outcome:** For Members to have gained a greater understanding of the work of SCAS and its partnership working with other health organisations and to have examined the current performance of the service against its key performance indicators.	**10.15am**	**15 - 46**
8	**CARE CLOSER TO HOME** The purpose of this item is for Committee Members to evaluate the progress of Buckinghamshire Healthcare NHS Trust's (BHT) pilot around developing care in the community, with Marlow and Thame Community Hospitals being developed as community hubs. In February 2017, representatives from BHT attended the HASC Select Committee meeting to brief Members on the proposed 6 month pilot.	**11.00am**	**47 - 80**

Attendees:
Neil Dardis, Chief Executive

Papers attached:
Copy of the proposal (as background)
Report from BHT (to follow)

Outcome:
For Committee Members to evaluate the community hubs pilot based on the key performance indicators, including those included in the original proposal document (as stated below).

Over the next six months, BHT will:

- double the number of outpatient appointments offered at Marlow and Thame
- see 350 patients through the one-stop frailty assessment clinic
- provide intermediate care to over 3000 people
- avoid almost 300 hospital admissions
- manage almost 20,000 referrals through the single point of access.

9 ACCOUNTABLE CARE SYSTEM **11.45am**

The purpose of this item is to provide a short briefing for Committee Members on the progress of the Accountable Care System. In June 2017, Buckinghamshire was announced as being one of the first wave of Accountable Care Systems (ACS). ACSs aim to deliver improvements to local health and care through joining up services in place of what has often been a fragmented system.

Attendees:
Neil Dardis, Chief Executive, Buckinghamshire Healthcare Trust

Papers attached:
None

Outcome:
For Members to better understand the aims of the Accountable Care System and the plans and timeframe for implementation.

10 VASCULAR SERVICES UPDATE ON PROM PROJECT **12 noon** **81 - 88**

The purpose of this item is for Committee Members to

consider a written update on the vascular services and to agree further action.

Papers attached:
Vascular services update

11 ACCESSIBILITY & PROMOTION OF SERVICES FOR ADULTS WITH LEARNING DISABILITIES **12.20pm** **89 - 140**

The purpose of this item is for Committee Members to receive an update on the 12 month progress made on the recommendations in the "Accessibility & Promotion of Services for Adults with Learning Disabilities" inquiry report.

Attendees:
Jane Bowie, Head of Joint Commissioning
David Jones, Head of Community Focus

Papers attached:
Copy of the Inquiry report
Recommendation response table showing 6 month progress and 12 month progress

Outcome:
For the Committee to assign a RAG status to each recommendation (through delegation to the Chairman).

12 COMMITTEE WORK PROGRAMME **12.45pm**

For Committee Members to discuss and agree the items for the next meeting.

- Hospital Discharge Inquiry – 6 month recommendation monitoring;
- Agree Inquiry scoping document (proposed topic is Childhood Obesity);
- Care Homes – to examine CQC results of the Care Homes in Bucks;
- Adult Social Care Transformation – to scrutinise the plans for transforming and modernising Adult Social Care services.

13 DATE AND TIME OF NEXT MEETING **1pm**

The next meeting is due to take place on Tuesday 28 November 2017 at 10am in Mezzanine Room 1, County Hall, Aylesbury.

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.*

Webcasting notice

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Therefore by entering the meeting room, you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If members of the public do not wish to have their image captured they should ask the committee clerk, who will advise where to sit.

If you have any queries regarding this, please contact Member Services on 01296 382343.

If you would like to attend a meeting, but need extra help to do so, for example because of a disability, please contact us as early as possible, so that we can try to put the right support in place.

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

Members

Mr R Bagge
Mr W Bendyshe-Brown
Mrs L Clarke OBE
Mr C Etholen
Mrs B Gibbs (VC)
Mr M Hussain
Mr S Lambert
Mr D Martin
Mr B Roberts (C)
Mr D Shakespeare OBE
Julia Wassell

Co-opted Members

Ms T Jervis, Healthwatch Bucks
Mr A Green, Wycombe District Council
Ms S Jenkins, Aylesbury Vale District Council
Ms J Cook, Chiltern District Council
Dr W Matthews, South Bucks District Council
Mrs M Aston

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 25 July 2017, in Mezzanine Room 1, County Hall, Aylesbury, commencing at 10.00 am and concluding at 12.40 pm.

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 R Bagge, Mr W Bendyshe-Brown, Mrs B Gibbs, Mr M Hussain, Mr S Lambert, Mr D Martin and Julia Wassell

District Councils

Mr A Green	Wycombe District Council
Ms J Cook	Chiltern District Council
Dr W Matthews	South Bucks District Council
Mrs M Aston	
Ms T Jervis	Healthwatch Bucks

Members in Attendance

Lin Hazell, Cabinet Member for Health and Wellbeing
Mr N Brown, Cabinet Member for Community Engagement and Public Health

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies were received from Mr C Etholen and Mrs S Jenkins.

Mrs L Clarke had replaced Mrs A Wight on the Committee. Mrs Clarke had sent her apologies.

Mrs M Aston joined the Committee as a co-optee.

2 DECLARATIONS OF INTEREST

Mrs T Jervis declared an interest relating to item 2 and Commissioning of Services ; Healthwatch Bucks were currently going through their commissioning process

Mrs M Aston declared an interest as Chairman on the Local Abbeyfields Society and as a Trustee of Carers Bucks.

3 MINUTES

The minutes of the meeting held on 13 June 2017 were agreed as a correct record.

4 CHAIRMAN'S UPDATE

Mr B Roberts welcomed Mrs Aston, previous County Councillor to the meeting as a new co-opted member of the Committee. Mrs H Llewelyn-Davies Chair of the Buckinghamshire Heathcare NHS Trust was also welcomed as an observer to the meeting.

Mr Roberts gave an overview of the theme of the meeting; scrutinising whether Adult Social Care in Buckinghamshire was ready for Growth.

5 COMMITTEE UPDATE

Committee Members gave a brief update of progress within their areas.

- Mrs B Gibbs updated the Committee on the Centre for Public Scrutiny conference; a briefing note would be circulated to the Committee
  ACTION: Mrs Gibb
- Julia Wassell highlighted the review of GP provision in East Wycombe that had begun and the commitment to look at GP provision across the County
- Mrs L Wheaton and Mr Roberts had attended the Marlow Community hub open day, an update would be provided at the September HASC meeting
- Launch of Healthwatch Annual report – Mrs Jervis advised that the annual report launch had taken place and the report had been circulated. Any questions were to be directed to Mrs Jervis
- Mrs Wheaton attended the Accountable Care System (ACS) event for officers and circulated an update note. Mrs Wheaton reported that Bucks Healthcare NHS Trust were 1 of 9 ACS in the first wave
- Mr B Bendyshe – Brown and Mr R Bagge would be attending the Bucks Healthcare Trust Board meeting on 26 July 2017 and would provide an update at the September meeting
- The recent Care Quality Commission (CQC) inspection had put the Mandeville Practice into special measure. The report and response from the Clinical Commissioning Group (CCG) had been circulated to Members; progress updates would be provided in due course
- It was updated that Bucks Fire safety checks at Bucks Healthcare Trust sites had

taken place in light of the Grenfell Tower tragedy; no issues had been identified at this stage

6 CABINET MEMBER QUESTION TIME

Lin Hazell, Cabinet Member for Health & Wellbeing and Mr N Brown, Cabinet Member for Community Engagement and Public Health attended the meeting to provide updates on their portfolios.

Dr J O'Grady, Director of Public Health and Ms S Norris, Executive Director of Communities, Health and Adult Social Care were also in attendance.

The Executive Summary of the CHASC Business Unit Plan and the Adult Social Care report that were presented to Cabinet on 26 June 2017 had been circulated to the Committee prior to the meeting.

The following areas were raised and discussed:

- Lin Hazell was questioned on the main priorities in her portfolio. Lin Hazell stated that the service area would be having an in-depth look at whole service delivery with the need to review all care packages. It was confirmed that a Transformation Board had been set up in order to monitor the delivery of this programme.
- The Committee discussed the number of care packages at any one time and how the service user would be consulted in these changes. Lin Hazell responded that there was 6500-7000 care packages at any one time and consultation with service users would be a mix of interviews, focus groups and one to one consultation.
- It was confirmed that due to the ongoing budget pressures a transformation programme was in place, a Programme Manager had been recruited as a secondment for 18 months. The programme was currently at the evidence gathering stage.
- A Member of the Committee raised a concern around a local residents suffering from dementia and the help they had been offered. Lin Hazell confirmed that the case being referred to was being looked into. It was also mentioned that dementia was a growing condition and more work needed to be done around how these services were delivered and the alternatives available. The Committee discussed the plans for Libraries going forward; the improvements planned for the Aylesbury Library were currently out for consultation. The innovative approach to libraries was also discussed referring to other businesses within their premises and creating hubs for the community and the opportunities for more libraries to be run by the community which could include public health service.
- The Committee discussed the Sustainability Transformation Partnerships (STPs), clients were going to be reassessed; it was queried whether this would be done based on their needs and not budget pressures. It was confirmed that while under the Care Act, overall financial resource needs to be considered, service users would still be assessed on their needs.
- The recent Cabinet Member decision reducing the Public Health budget for the Falls Service; it was noted this could have a detrimental effect on individuals feeling safe and wanting to stay in their own homes for longer which would be counterproductive. Dr O'Grady advised that the aim was to have early intervention to take the pressure off these services and work was being done with the NHS to see how best to do this. Dr O'Grady confirmed that the County Council would be working with partners to re-profile the service.

7 IS THE COUNTY COUNCIL READY FOR GROWTH?

Lin Hazell, Cabinet Member for Health & Wellbeing, Mr Brown, Cabinet Member for Community Engagement and Public Health, Ms S Norris, Executive Director, Communities, Health & Adult Social Care, Dr J O'Grady, Director for Public Health and Ms J Bowie attended the meeting for Members of the Committee to seek evidence whether the County Council is ready for growth.

The Committee considered the following key areas for planning for Growth in Adult Social Care and Public Health in Buckinghamshire – Plans and Strategies, Governance, Commissioning of services, Use of data sources and Public Health.

Members received a PowerPoint update from the officers in attendance, followed by an opportunity to ask questions. The key findings and recommendations would then be included in a final report to be presented by the TEC Select Committee to Cabinet in October 2017.

Dr O'Grady and Ms Norris took Members through part 1 of the presentation which outlined the impact of Growth on Health and Wellbeing and Public Health.

The following points were raised and discussed:

- The Committee discussed the new homes being built, with less family living space and outside space for communities and how this was to the detriment to the health and wellbeing of children. Dr O'Grady stated that Public Health were working with developers to ensure community spaces were being considered.
- The Committee discussed the state of the public realm and the need to make these environments safe for all to use. Dr O'Grady stated that this was a shared problem and they were working with communities and other public sector partners to find solutions.
- The Committee asked for examples of where Public Health input had an impact on planning developments, Dr O'Grady reiterated Public Health presence on working groups and in discussions with planners but no examples were given
- The Committee also discussed Active Bucks and the funding only being for a limited time. Dr O'Grady confirmed that although the funding for Active Bucks had stopped, 70% of activities were now self-sufficient and continue to be run
- Provision for the elderly was also discussed and the closure of sheltered housing and the impact that has. Some examples were raised and Ms Bowie agreed to follow them up with colleagues

ACTION: Ms Bowie

Ms Bowie took Members through part 2 of the presentation which outlined the impact of Growth on Adult Social Care

The following points were raised and discussed:

- The Committee discussed the work to support people to remain in their own homes and the work that needed to be done with families and nurses to help them better understand the support available. Ms Bowie confirmed that re-enablement figures were not as strong as they would like them to be therefore this was an area of focus
- The integration of Health and Social Care was also discussed. A roadmap to 2020 had been to the CHASC Board which included integrating commissioning, governance and back office functions

The Committee asked questions set out under the following headings:

Bucks Strategic Infrastructure Plan
The Committee queried what the plan was expecting to achieve, the contribution CHASC made to the final plan and whether the plan was being used to help shape and inform CHASC BU plan. It was confirmed that CHASC officers had been involved in drafting the plan, which looked to enable more community options and conversations had about the type of models that do not work well. The business unit had inputted into the plan and it was acknowledged that the was a really positive approach and supported the ongoing relationships and conversations with District colleagues and developers. They also confirmed they were looking at other authorities to develop best practice around this.

Plans and Strategies
It was queried who had overall responsibility for delivering the CHASC Business Unit Plans, especially the action plans to deal with the predicted growth; as well as how well Public Health information had been used to inform the Council's Business Unit plans. Ms Bowie responded that the responsibility was shared amongst Senior Management colleagues.

The Market Position Statement would be drafted by the end of this year, which would map out how organisations would work together.

The overarching Joint Strategic Needs Assessment (JSNA) was a joint responsibility between Health and Adult Social Care with a lot of core data that informed business unit plans.

Financial Planning and Budget control
The Committee discussed the budget monitoring process being over a 4 year period and whether CHASC colleagues agreed that doing this over a longer term would help achieve greater pace in planning services to meet future demand. Ms Norris confirmed that whilst the overall medium term planning (MTP) process was on a 4 year rolling plan, officers continued to look further ahead; although some areas were harder to plan than others. A longer term capital programme would be beneficial.

S106 money
The Committee asked how well opportunities relating to Section106 money was maximised. Dr O'Grady confirmed that CHASC were sighted on the developments and the use of 106 money.

Other sources of external funding
The Committee asked how well CHASC were at identifying and exploiting external funding streams to help meet future demand and who was responsible for this. Ms Norris stated that CHASC were working on ensuring services were charged at the right rates and that these were affordable. This would also rely on income being collected as efficiently as possible. Ms Norris also confirmed that conversations were ongoing with the NHS.

Income Generation
The Committee asked what plans were in place to look at the possible income generation opportunities across the Business Unit; were there projects being developed which would place the Council in a provider role rather than a commissioning one (for example, Housing for Older People).

Ms Bowie confirmed that reducing the number of placements in care homes would have an adverse effect on the income and work was underway to ensure that the right income streams between BCC and Health were in place. Ms Bowie also highlighted that the County Council were working with local communities to ensure that they were maximising existing resources in the community.

The Committee discussed the value of selling BCC services to other bodies and Assistive Technology was highlighted as an area that could be explored.

It was questioned that with the growing demand on the service and the reassessment of all care packages, whether officers felt there was significant resource to do this. Ms Norris confirmed that there was opportunity to enlist other providers to carry out some of the work as long as this was supervised.

The Committee also discussed the reluctance of some residents in approaching the service for help in fear of being removed from their home. Ms Norris stated that conversations were needed early on and support was to be provided to people in their own homes as early as possible; the County Council worked closely with the voluntary and community sector as well as GPs.

Opportunities
The Committee asked officers to provide more details in relation to opportunities, to build a range of different housing options for older people. Ms Bowie cited the Extra Care facilities that were already available and interest in looking at how these could be further developed. Populations in care homes had shifted nationally and locally and the County Council were looking at the balance between nursing and residential.

Governance
The Committee asked which Officers from CHASC attended the Officer Working Group and how the information was disseminated across the BU to help inform and shape the work of the BU and how they ensured actions were taken forward and managed effectively. Ms Bowie confirmed feedback was provided through the ASC Leadership Group and Members would be briefed directly when necessary. She confirmed that someone from the Commissioning team attended along with Tracey Ironmonger, Assistant Director for Public Health.

Assessment of current arrangements
The Committee queried what was working well with the current governance arrangements and how these could be improved. Ms Norris stated that governance arrangements around Growth needed to continue to be reviewed; although presently these were working effectively to ensure different council functions were linking up. The Committee also discussed the impact of Brexit; issues would be explored by the Brexit Group which had recently been set up.

Senior Management Team
The Committee asked if planning for growth was discussed regularly at Senior Management Team meetings and what informed these discussions. Ms Norris confirmed there were various boards and forums where information and strategic issues were being shared and that Growth was a regular agenda item on agendas at different levels within the organisation.

Commissioning of Services
The Committee questioned if any **Workforce planning** modelling had been done around the impact of Brexit on the market and other external factors, including National Living Wage and the changes in the population profile. It was confirmed that links were in place with discussions taking place nationally with key groups. There were also conversations with local health providers and an event with social care providers taking place w/c 31 July which would include discussions about the impact of Brexit

Dementia
The Committee asked what plans were in place to meet the rising number of people with dementia both in terms of the specialist care homes and also support for carers. Ms Bowie confirmed that there was a joint Dementia Strategy with our health partners and that there were suitable joint arrangements in place to support people from the point of diagnosis and

ongoing. ASC also worked with care home providers and linked into other resources including Assistive Technology.

Self-funders
The Committee discussed if any modelling had been undertaken to highlight whether there would be an increase or a decrease in self-funders in Buckinghamshire and the impact on services. Ms Bowie advised that there were 65% of self-funders in Buckinghamshire, which was high. Work was underway to look at how best to support self-funders to ensure they were not being over exposed and that they had the right information available to them to ensure their decisions were well informed.

Transition from Children to Adult Services
The Committee highlighted the importance of using information held within Children's Services to help inform future demand on Adult Services. Ms Norris confirmed that there was joint working with Ms Bowie having joint commissioning responsibility. It was agreed that more could be done to help aid the parents on how they prepare their children for adulthood.

Learning from other authorities
The Committee asked if there were other local authorities held in high regard in terms of how they were handling the pressure on services and shaping their future delivery of services. Mrs Gibb mentioned Harrogate and Dorset and Ms Norris stated that they also learnt through the regional work they do with ASC colleagues where they share best practice.

Public Health

Planning and Development
The Committee queried the influence and involvement with developers; it was confirmed that there was a Commissioning officer with lead responsibility for housing; with provision and joint arrangements with a number of housing providers in Buckinghamshire. It was confirmed that Public Health were statutory consultees for building care home facilities

Public Health information
The Committee asked how information and data was shared across the County Council from Public health on future population needs. Dr O'Grady confirmed that population projections had been disseminated around the authority; officers were working with the District Council, BCC planners and the NHS.

8 COMMITTEE WORK PROGRAMME

The Committee work programme session took place after the meeting to discuss agenda items for future meetings and possible topics for in-depth inquiries.

9 DATE AND TIME OF NEXT MEETING

Tuesday 19 September 2017 at 10am in Mezzanine Room 1, County Hall, Aylesbury. Please note that Members will have a private pre-meeting at 9.30am.

CHAIRMAN

South Central Ambulance Service NHS
NHS Foundation Trust

SCAS Annual Health Scrutiny Committee Report

Buckinghamshire

Mark Ainsworth (Operations Director)
Mark Begley (Head of Operations, Aylesbury Vale & Milton Keynes)
Andrew Battye (Head of Operations South Buckinghamshire & East Berkshire)

September 2017

The Purpose of this report is to provide an overview of the service provided by South Central Ambulance Service NHS Foundation Trust (SCAS) against our contractual arrangements and, at greater detail, within Buckinghamshire.

Performance

2016/2017 Summary

In 2016/17 SCAS was contracted to perform at 75% against the Red 1 and red 2, 8 minute standards and at 95% for the Red 19 minute standard, This requirement was across the Thames Valley, consisting of Oxfordshire, Berkshire and Buckinghamshire including Milton Keynes. These contractual agreements, measured on an annual basis were not met.

[1]**Red 8** – Performance target for any immediate life threatening call – response to be on scene within 8 minutes.

[1]**Red 19** – Performance target for arrival of conveying resource to Red 8 – response to be on scene within 19 minutes of the original call.

[1]**Red 1 Definition:** Are the most critical types of calls and cover patients who are not breathing or do not have a pulse, and other severe conditions such as airway obstruction. These patients account for less than 5% of all ambulance calls.

[1]**Red 2 Definition:** Are serious but less immediately time critical. And cover conditions such as stroke and fits.

([1]Department of Health, 2012)

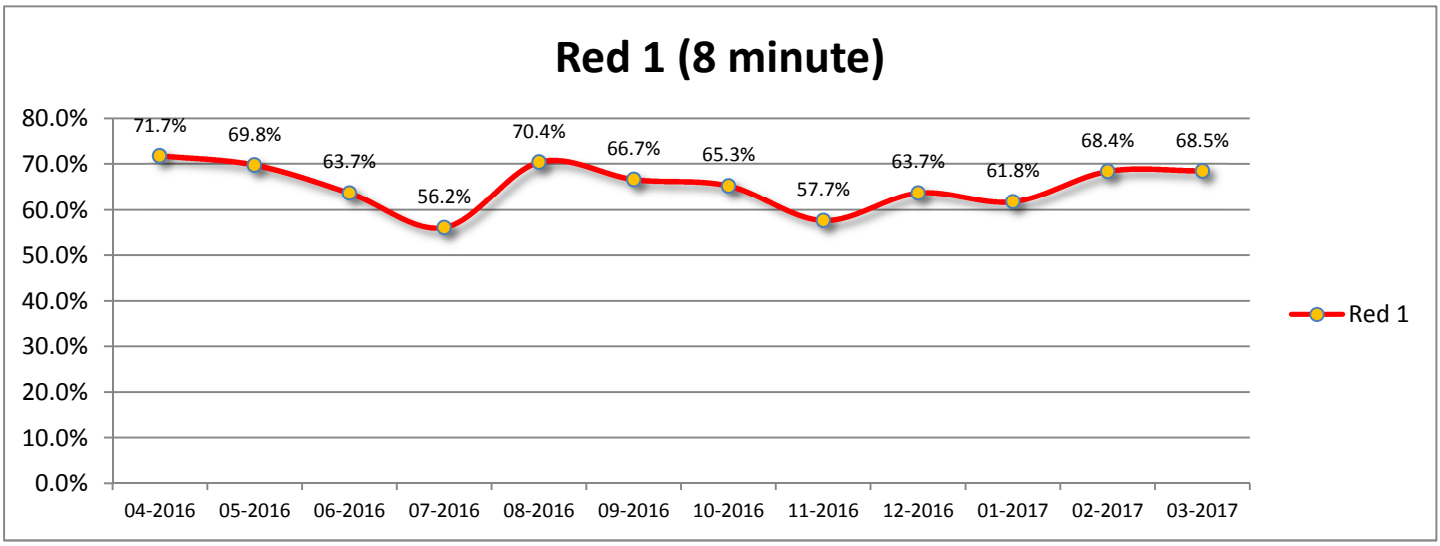
2016/17 Performance Year to date:

The current contract with South Central Ambulance Service NHS Foundation Trust (SCAS) for 2016/17 has been agreed Thames Valley wide (including Oxfordshire, Berkshire, Buckinghamshire and Milton Keynes). This is the area defined for the purposes of performance management and is measured on an annual basis in accordance with the national NHS contract. The Performance measures for 2015/16 as highlighted in this document are from last year's contract which did include Milton Keynes.

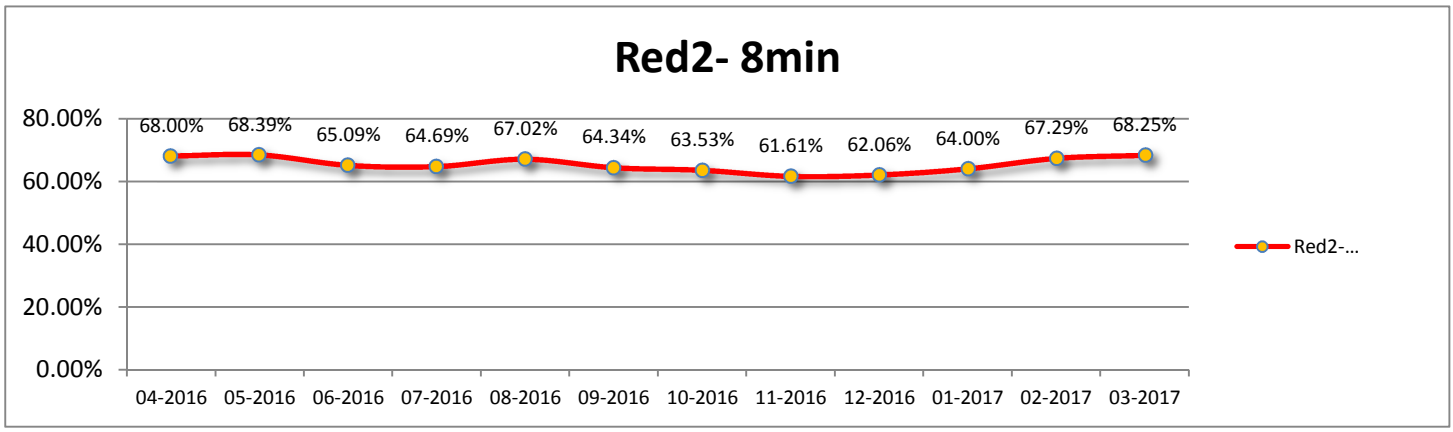
Performance measures are commissioned and reviewed at Thames Valley contract level which we did not achieve, but have seen improvements due to collaborative working with the CCG's and the Acute Trusts.

Performance – Buckinghamshire (*Aylesbury Vale & Chiltern CCG Areas*):

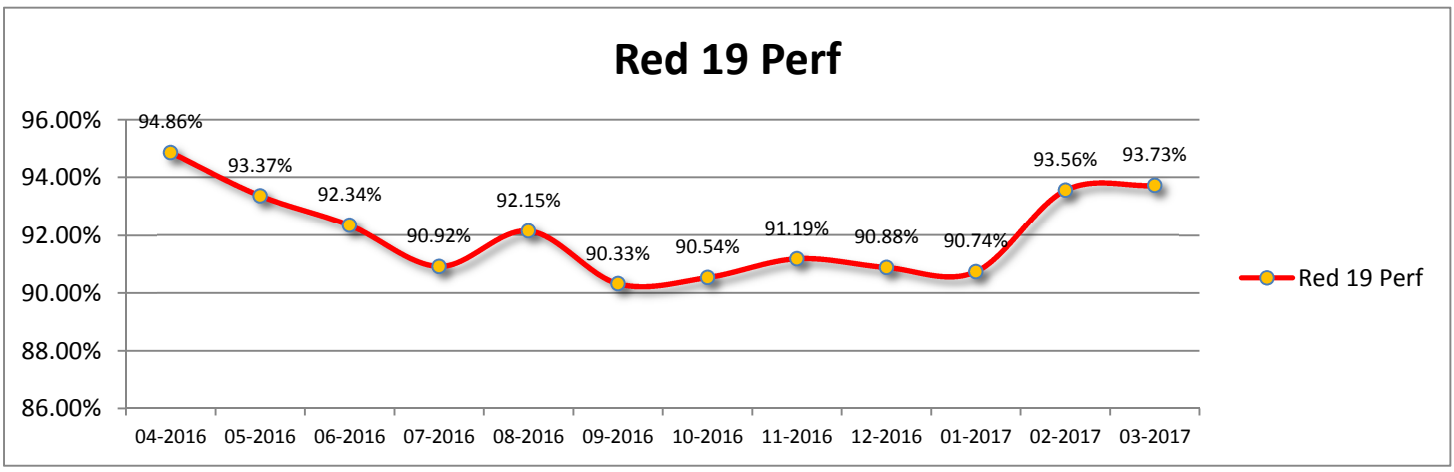
RED1 8 performance



Red 2 8 Performance



Red 19 Performance

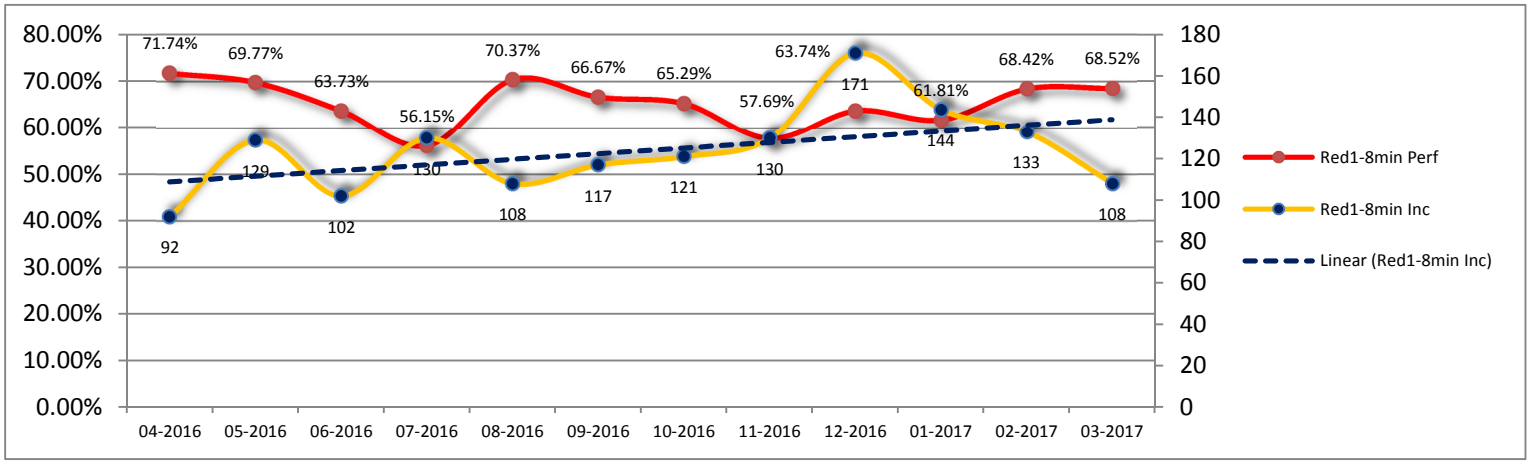


Whilst the performance contract is held at a Thames Valley level, SCAS continues to work in collaboration with the Buckinghamshire Clinical Commissioning Groups (CCG's) to improve

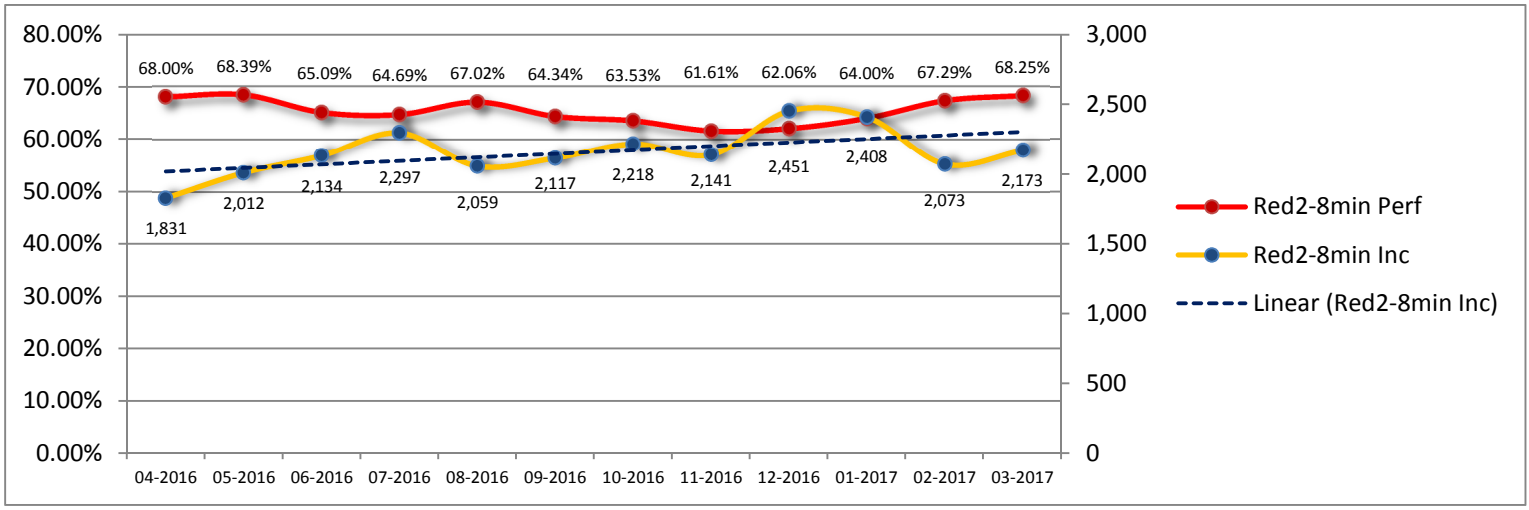
the performance specifically for the Buckinghamshire County area. Since 2014/15 SCAS has been reviewing cases where patients have waited longer than expected with a view to identifying causes, themes, gaining learning and potential for improvement by any mitigating actions in order to prevent repeats. This continues to be a focus for commissioners and SCAS

Performance and Demand

Red 1 (8 minute) – Chiltern & Aylesbury Vale



Red 2 (8 minute) – Chiltern & Aylesbury Vale



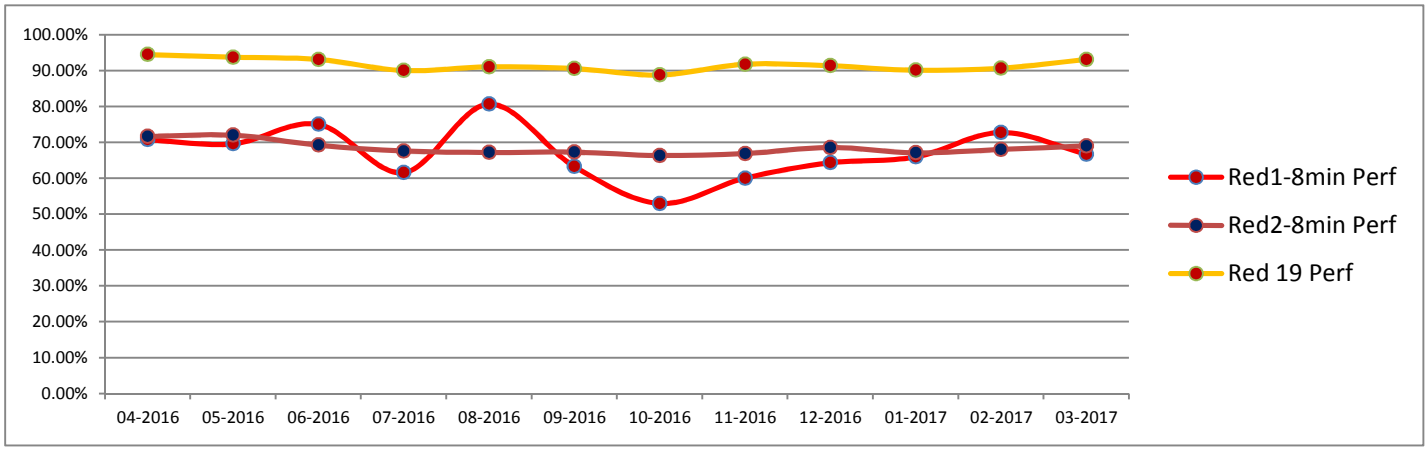
The above charts demonstrate the direct correlation to performance and demand. Both Aylesbury Vale and Chiltern CCG areas have experienced an increase in demand compared to previous years, performance has maintained or improved on previous years, despite a continued increase in demand across the whole of Bucks.

Aylesbury Vale	Red 1 = 5.54%+	Red 2 = 16.81%+
Chiltern	Red 1 = 7.14%+	Red 2 = 20.37%+
Bucks	Red 1 = 6.52%+	Red 2 = 20.37%+

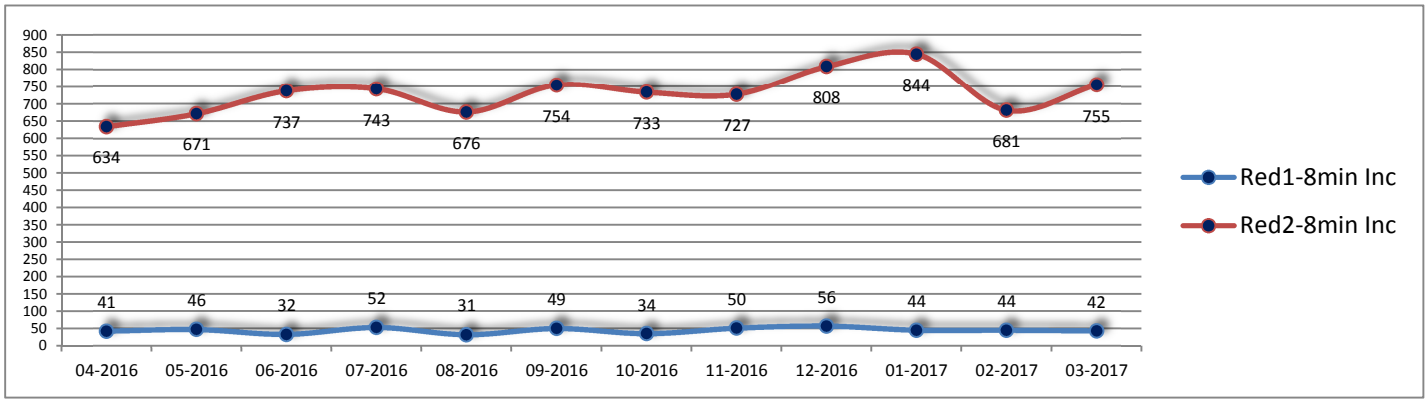
As demand increases, performance can fall, mainly as the increase of demand has surpassed the anticipated level, availability of resource is the reason for reduction in performance, this is multi-factorial in cause.

By Local Authority

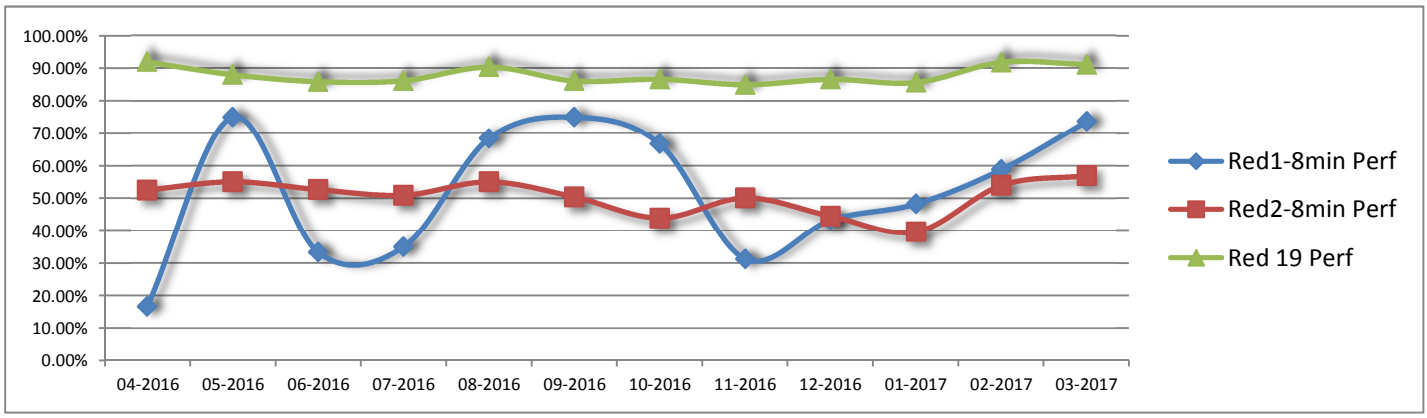
Red 1, Red 2 (8 minutes), Red 19 Performance (Aylesbury Vale LA)



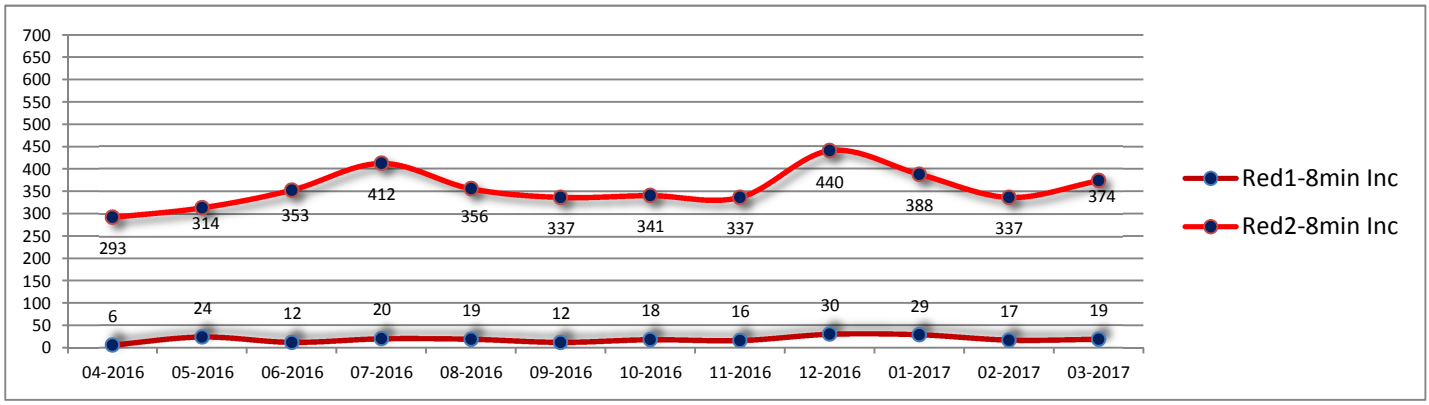
Demand – (Aylesbury LA)



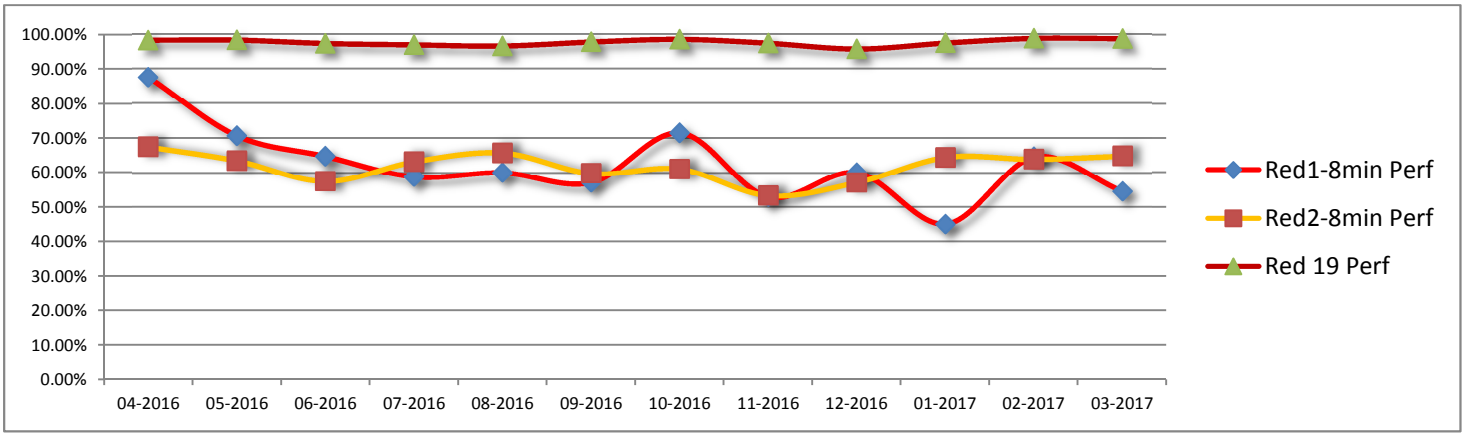
Red 1, Red 2 (8 minutes), Red 19 Performance (Chiltern LA)



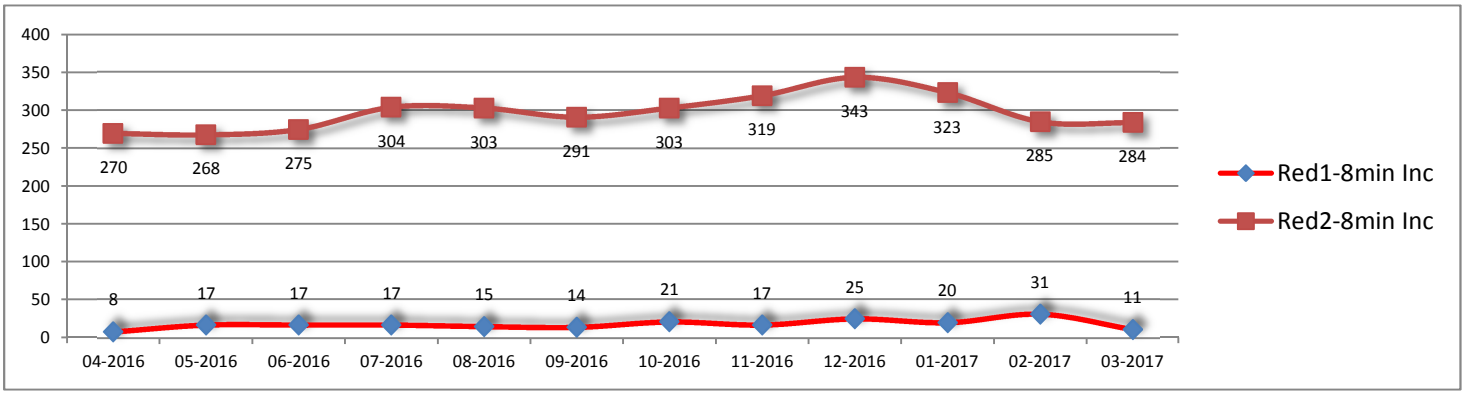
Demand (Chiltern LA)



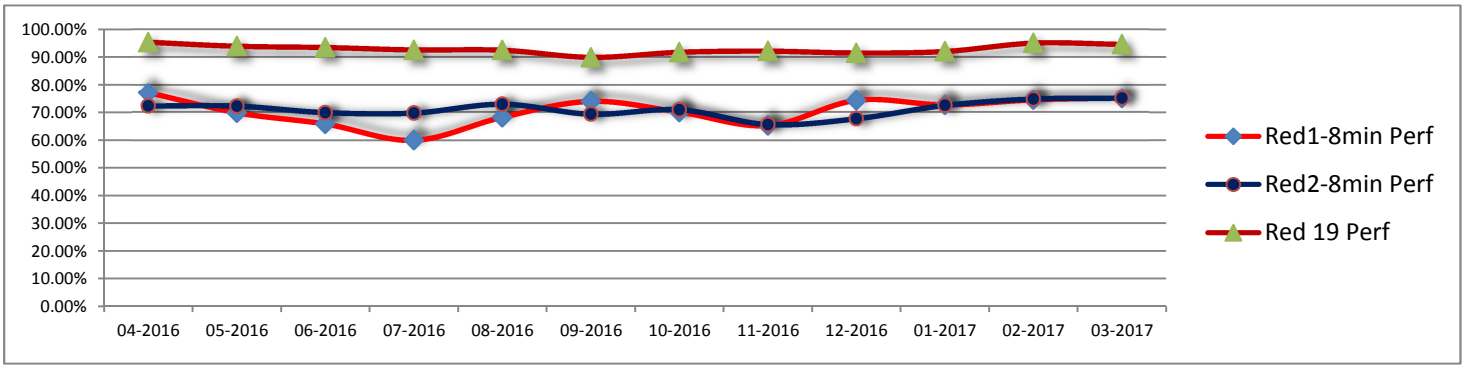
Red 1, Red 2 (8 minutes) Red 19 (19 minutes) Performance (South Bucks LA)



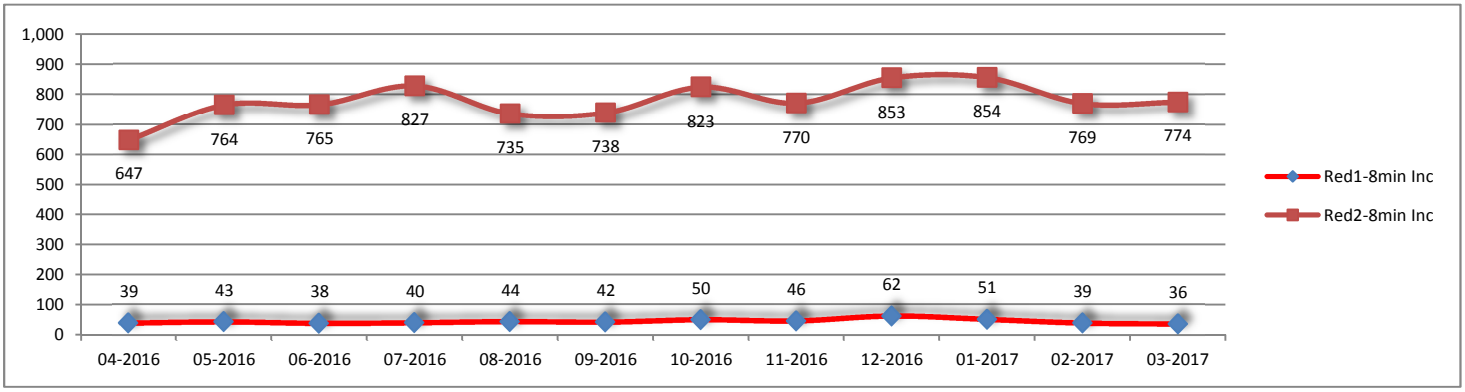
Demand (South Bucks LA)



Red 1, Red 2 (8 minutes) Red 19 (19 minutes) Performance (Wycombe LA)



Demand (Wycombe LA)



SCAS also provides the 111 in Buckinghamshire and through greater integration of the two services is amongst the lowest providers in the country for calls transferred from 111 to 999 now at 7%.

SCAS is very much involved in the implementation and delivery of the Thames Valley Integrated Urgent Care (IUC) working with partner Trusts in various ways including referral of patients to clinicians to avoid a Hospital admissions where possible.

MOBILISATION FOR TV INTEGRATED URGENT CARE:

What is new for Go live 05 September 2017?

New service	Process	Benefit
GP Enhanced triage	Warm transfer by Clinical Navigator to GP to review calls for Complex, Green, Paediatric, Frail patients. (See examples in Appendix 1) GP Liaison with Acute Consultants and Ambulatory Pathways to reduce admission.	• Increase Call closure for patients • Support to 111 Clinicians • Direct liaison with Acute Consultants to support to IUC improves pathways available and reduces hand offs for patients
IUC Clinical Navigator - Call Streaming to additional Clinicians • MHP • Pharmacist • Dental • Single Point of Access (SPA) – Access to Community & Ambulatory pathways Future development to Allied Health Professionals, End Of Life, others	Warm transfer or referral to specialist clinicians within the IUC service. Direct referral to SPA/ Community services Post Event Messages to Buckinghamshire SPA based in Aylesbury (to add Oxfordshire in the future)	Increased access and specialist clinical advice to callers closing more calls in real time within the clinical assessment service. Increased joint working and relationship building across services. Learning and increased senior clinical support to 111 clinicians.

Direct booking to East Berkshire Out of Hours Direct Booking to Westcall (West Berkshire)	Ability to directly book calls to Out of Hours GP services in Berkshire Midweek then extend to Weekends	Direct booking on the first call reduces the need for callbacks from the OOH service. Well received by patients Increased clinical streaming by symptom group to GP out of Hours e.g. Urinary Tract Infections. Westcall. To pilot and extend to other OOOH services (Bucks/Oxfordshire)
Direct booking to MIU/UCCs	Oxfordshire MIIUs Berkshire UCC Berkshire MIU Buckinghamshire MIU (awaiting technical link)	Direct booking is well received by patients. May improve alternative outcome away from A&E This may support future A&E booking. Learn from booked vs walk in model. This is ahead of schedule, included within our SDIP as a year 1 objective.
Extended Health Care Professional lines to support Thames Valley/ Care Homes	Additional lines to support	Direct line for Health Care Professionals and Care Homes

Further key developments (including SDIP year 1)		
On line symptom checker/ Apps pilot with Capita	Joint working with NHSE/Capita to pilot software . Timetable provided to be confirmed • August/Sept - Scoping • October/November- development/testing with Bucks GPs. • December/Jan - 111 Go live • Jan/Feb - Primary Care Go live.	Additional entry point for callers on line. May increase call closure Additional resource away from telephony to support Winter pressures?
Increase access to more clinicians from the Clinical Assessment service	Increasing the referral pathways for IUC clinicians and access to receive direct specialist advice as per the Integrated Urgent Care national vision	Increased access and support to IUC clinicians and callers to the service
Text Messaging for sending of Health Information advice	Callers will receive health information advice over the phone and then supportive text messages	Callers will receive a record of the advice given to support them
Enhanced EOL support	24/7 access to TV Specialist Palliative Care line from IUC	Draft Model agreed with Thames Hospice supported by other providers. Costs/pilot tbc with commissioners
IUC Links into SPAs	Further IUC access to Community services and increased interoperability and working with local authorities via SPA.	Development opportunities • Direct booking • Colocation • Workforce/training

Appendix 1

Examples of GP review from Clinical Streaming pilot

- 26 year old Ongoing headache, cyst on the brain. Complex Call, warm transferred by CN to GP. Patient had an MRI one month prior and due to meet consultant the following week due to previous headaches and discovery of the cyst. Following a fainting episode today, patient was concerned that the cyst was cancerous and/or growing. GP was confident that it wasn't cancerous as the consultant would have seen her quicker than one month and diagnosed a simple fainting episode due to stress. Advised to see consultant and review with GP if any further concerns. Call closed.

- 20 year old called with Abdo pain which was being directed towards Ambulance. Warm transferred to GP to review. Patient gave the birth 12 weeks ago by Caesarean, now pregnant again and diagnosed with Chlamydia on Friday. PV bleeding. Warm transferred to GP who referred as an emergency to Acute Gynae clinic – with suspected ectopic pregnancy.

- 14year old with nervous twitch. Call from father very concerned as she was sent home from school uncontrollably hitting herself in the chest. Also had neck spasm/twitching on Monday. There was a delay in returning the DoS from the sending electronic referral data due to a BHFT Adastra issue. The father was called back. The GP suspected Dystonia which can develop in puberty. She was referred to Acute Paediatrics.

- 26 month Toddler had a high temperature for three days and now a widespread rash. The call handler called the Clinical advice line for support and Mum was warm transferred to the GP. The call was closed with advice.

Lynda Lambourne

Director of Integrated Urgent Care

07 August 2017

Patient Transport Service (PTS):

SCAS PTS continues to not only deliver but is one of the few services that has expanded outside of the SCAS footprint with its proven record of delivering and putting our patients at the forefront of our service. PTS in Bucks has adapted to meet the current demands.

TV/OHFT/MK KPI Spec & crib sheet			
Planned cut off times:	**Thames Valley**	**OHFT**	**MK**
Outpatients	15:00 the day before	Not applicable	12:00 the day before
Discharges & Transfers	17:00 the day before	Not Applicable	12:00 the day before
Book Ready function:	**Thames Valley**	**OHFT**	**MK**
only applies to on the day discharges and transfers and bookings made after the cut off times stated above	Applies	Not Applicable	Not Applicable
Additional Information:			
Thames Valley NEPTS			
2300-0600 discharges and transfers only out of A&E, EAU, AOU (Depts within the Hospital)			
EMU clinics are able to book OTD transport. These clinics include Abingdon EMU, Witney EMU, Wycombe MUDAS, St Marks RAU, Townlands RACU, Thame Hospital and Marlow Hospital Community Assessment and Treatment Units.			
End of Life upstairs/downstairs journeys			
If crews are running late and clinics agree revised times, time is to be changed on Cleric			
No wait and returns in contract			
End of life patients are priority and must travel alone			
The only prison we convey from in Thames Valley is HMP Bullingdon.			
The latest time a Thames Valley same day discharge or transfer out of a ward can be 'booked ready' is 2000 hours to allow for the KPI			
The following exclusions from NEPTS will apply:- • Transport for prisoners • Stretcher outpatient wait and return journeys • Home to Home journeys • Home address to Nursing Home (unless going to an Intermediate Care Bed) • Nursing Home to Nursing Home (unless going to an Intermediate Care Bed) • Paediatric intensive care retrieval • Neonatal intensive care retrieval • Non NHS funded patients • Conveyance of supplies • Patients requiring transport outside of England, Scotland and Wales			

• Transport to Windsor Renal Dialysis Unit for all single crewed patients (SC Inpatient's in Wexham Park can travel on SCAS resources) • Transport to routine GP appointments • We are not to move any Mental Health patient who is under section. (This is as per exclusions under section 3.4 within the specification.)
Milton Keynes NEPTS
The latest time a same day booking in Milton Keynes can be booked is 1900 hours to allow for the KPI. This includes all journey types. On Sunday the latest time booked is to be 1300 unless capacity allows for a later collection
Milton Keynes CCG patients are not to be collected from prisons to be taken to outpatient appointments
Milton Keynes CCG patients travelling to hospitals that fall outside of the MK contract (London/Cambridge hospitals etc) are **NOT** to book this transport via the eligibility line
OHFT NEPTS (Oxfordshire & Buckinghamshire Mental Health)
OHFT journey KPI remains at 15 mins for arrival and collection
OHFT Most frequently used sites include Whiteleaf, Warneford, Fulbrook Centre, Chiltern Day Hosp (Valley Centre), Littlemore Hospital, Elms Centre, Fiennes Unit.
A same day booking for OHFT must be collected within 2 hours from the booked time.
Sectioned patients are in contract within OHFT only however they must not be transported if the patient is under section 135 or section 136 as these are covered by the 999 contract.
Patients can be collected from Police Stations for OHFT providing the patients are not under Section 135 or Section 136
Secure journeys **ARE** in contract for the OHFT contract only.
Transport outside geographical area Quotes may be requested by the Trust for journeys outside the geographical area and acceptance of the quote requires authorisation by a senior person within the Division requesting the transport.

Increased demand continues to present a challenge and we have worked with commissioners and the Acute Trust to minimise delays therefore improve efficiency throughout the local Health economy to gain winter funding to support extra vehicles to assist with Health Care Professional bookings over the winter months. This will free up a proportion of frontline ambulance time to respond to Red category calls.

Journey Times by Local Authority:

The rural aspect of large parts of Buckinghamshire can make journey times a challenge. Following the closure of Wycombe Emergency Medical Centre to the public in October 2012, SCAS saw and increase in journey times to hospital as a result of the additional mileage of Ambulances travelling to Stoke Mandeville and Wexham Park Hospitals from the High Wycombe area. Journey times from this area have remained broadly consistent since the initial increase seen immediately after the High Wycombe EMC Closure.

In Line with a national move towards specialist treatment centres, we also transport patients to a range of hospitals dependent on their particular need, in order to access specialist treatment. This includes Wycombe Hospital (cardiac and stroke); Harefield (cardiac); John Radcliffe and St Mary's, Paddington (trauma centres). This area continues to add to our challenges of achieving performance

Community First Responders:

Community Responders are members of the public, trained by the Ambulance Service, who volunteer to help in their community by responding to medical emergencies before the arrival of an Emergency Ambulance.

There are currently 53 active Community Responders schemes operating in the Buckinghamshire area (excluding Milton Keynes). Work continues with communities across the county.

South Buckinghamshire/Chiltern and Aylesbury areas identified as benefiting responder schemes are

- Amersham
- Aston Clinton
- Beaconsfield
- Buckingham
- Chesham
- Denham
- Gerrards Cross
- Princes Risborough
- Steeple Claydon
- Winslow
- Wing

First Responder schemes work with community volunteers responding within a small radius of their home or work address to immediately life threatening calls, where having someone with training and a defibrillator present a short time scale could make the difference between life and death for the patient. In all instances Community First Responders are backed up and supported by a SCAS clinical response.

We continue to work hard in evaluating new areas and expanding our Community First Responder Schemes in rural areas to continue with our successful campaign placing more defibrillators in villages and training local communities to use them.

Co Responder Schemes

We have been working with the Bucks Fire & Rescue in training their staff in First Person on Scene and emergency driver training. They have already attended many incidents and are proving to be valuable and effective. The response ranges from specific Co-Responding cars to attending in a Fire Truck. The move forward is the use of cars only to attend a range of life threatening calls. This is a similar position as for Community Responders, but with the added bonus of a blue light capable response, some additional training and an agreed number of hours of cover.

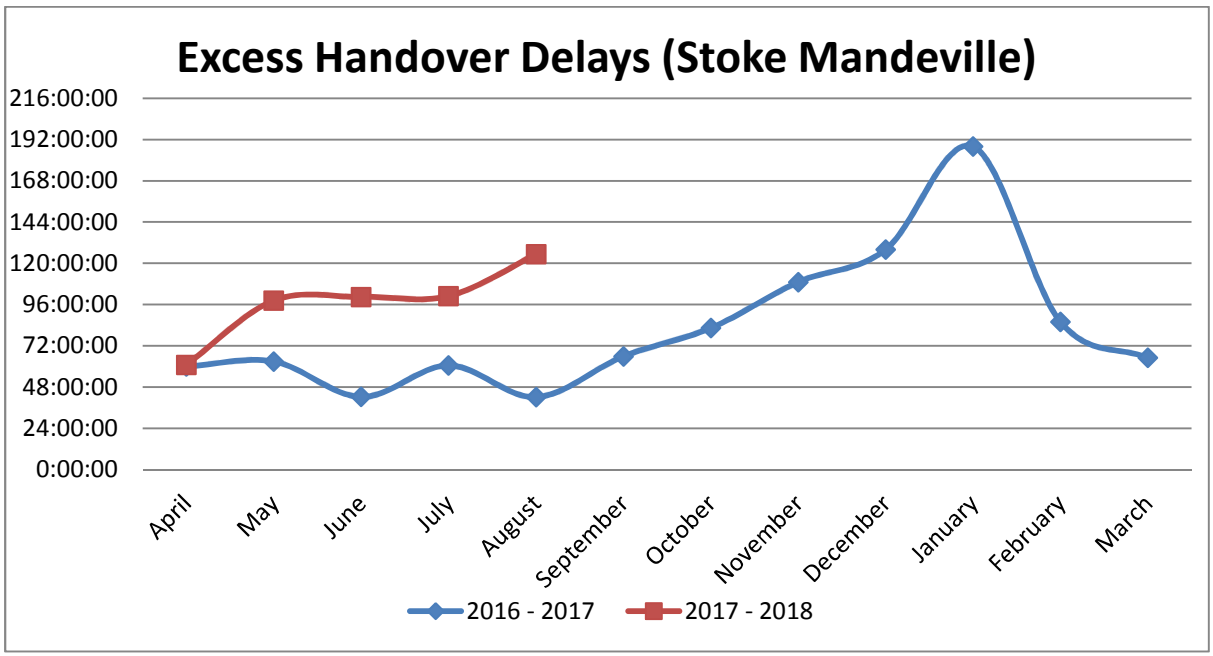
We have also been working with colleagues from Buckinghamshire & Milton Keynes Fire & Rescue Service to provide a similar scheme as the RAF, responding initially from Fire Stations.

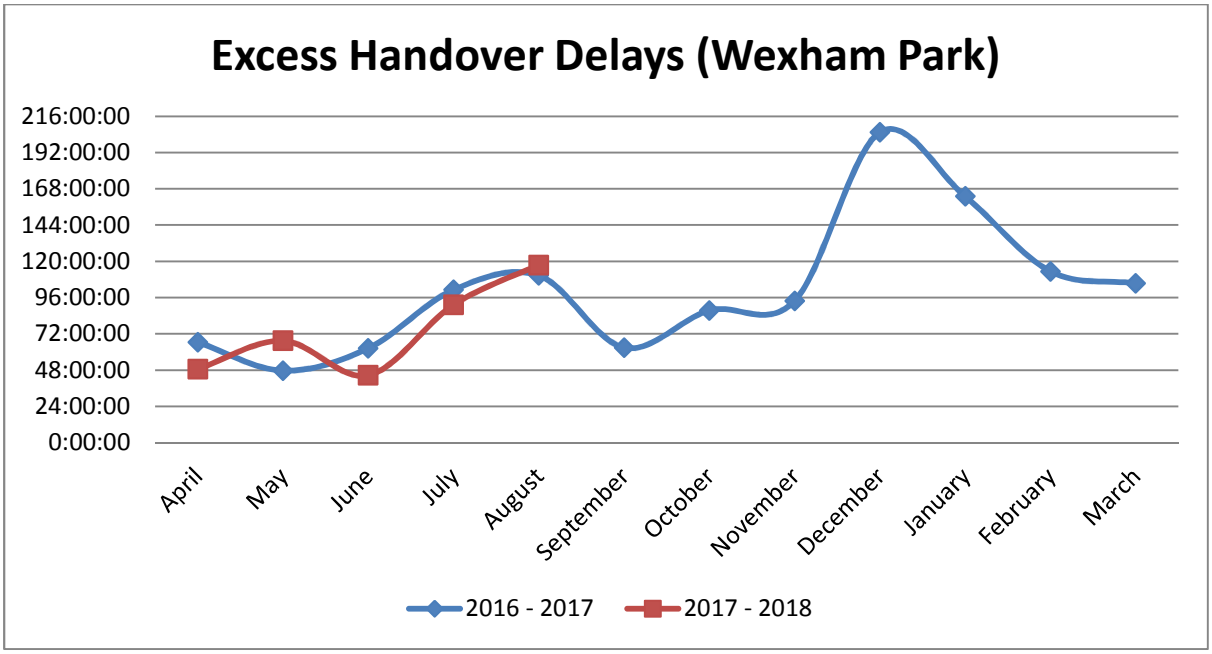
Currently there are 4 Stations running, Buckingham, High Wycombe, Marlow and Chesham. The main difference currently between this and the RAF schemes is the ability to respond on blue lights. Nationally the Fire Services have agreed to attend cardiac arrest patients in Fire tenders if they are the closet available resource.

Hospital Handovers:

Receiving Hospitals are required to facilitate a handover of arriving ambulance patients within 15 minutes of arrival. Local Commissioner fines are no longer applicable to acute hospitals although there is a clear steer that all Acute Trusts **must** focus on minimising delays. Handover is deemed to have occurred when a clinical handover has taken place, the patient is transferred on to the hospital trolley and all ambulance equipment/apparatus is returned (NHS England, 2014).

The chart below details excess handover delays (over 15 minutes) in house by month for the local acute hospitals.





The work started last year with colleagues from the Acute Trusts has continued, however with the increase in demand on both SCAS and the acute Trusts, handover delays have remained a challenge. 2016/17 SCAS lost ***16,182*** hours of which ***992*** hours were lost at Stoke Mandeville Hospital and ***1219*** hours at Wexham Park Hospital due to handover delays. This is the equivalent of losing just over 221 ambulances completing a 10 hour shift. Double verification of handover time between the SCAS crew and receiving hospital clinician is now standard practice across all the major hospitals Emergency Departments (ED's) and Medical Assessment Units within the SCAS area, via a web-based handover screen. As with all processes we are always looking at ways to streamline or improve and this continues in continued dialogue with the Acute Trusts. SCAS has worked with the ED's to provide a more streamlined handover (pit stop style) area whereby SCAS crews can handover their patient to a senior clinician within the area the patient will be transferred to a Hospital bed. This has been successful and provides the patient a much better experience than previously.

During high handover delays, SCAS will provide a Hospital Ambulance Liaison Officer (HALO) as the interface between SCAS and the hospital staff to manage issues and assist with patient flow. HALO's will help by reducing the number of SCAS staff looking after patients (double up) and improve the efficiency of the queue.

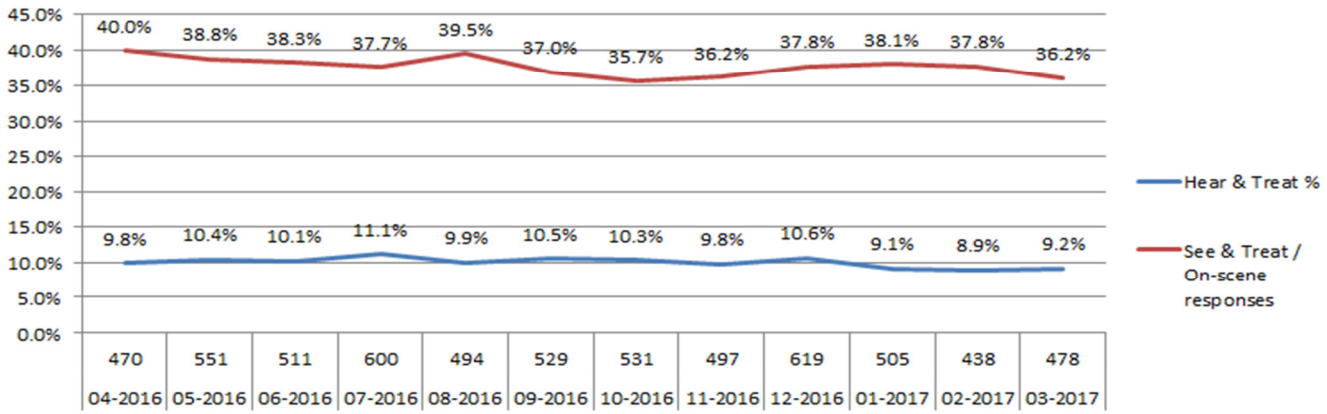
Emergency Journeys and Final Disposition

Hear and Treat:	Emergency calls are dispatched over the telephone without the attendance of an ambulance resource to scene.
See and Treat:	Ambulance resource attends the scene and treats and discharges or refers to another service without transporting the patient to a Type 1/2 (Consultant Led) Hospital Emergency Department.
See, Treat and Convey:	Ambulance resource attends the scene, treats and transports the patient to a type 1/2 (Consultant Led) Hospital Emergency Department.

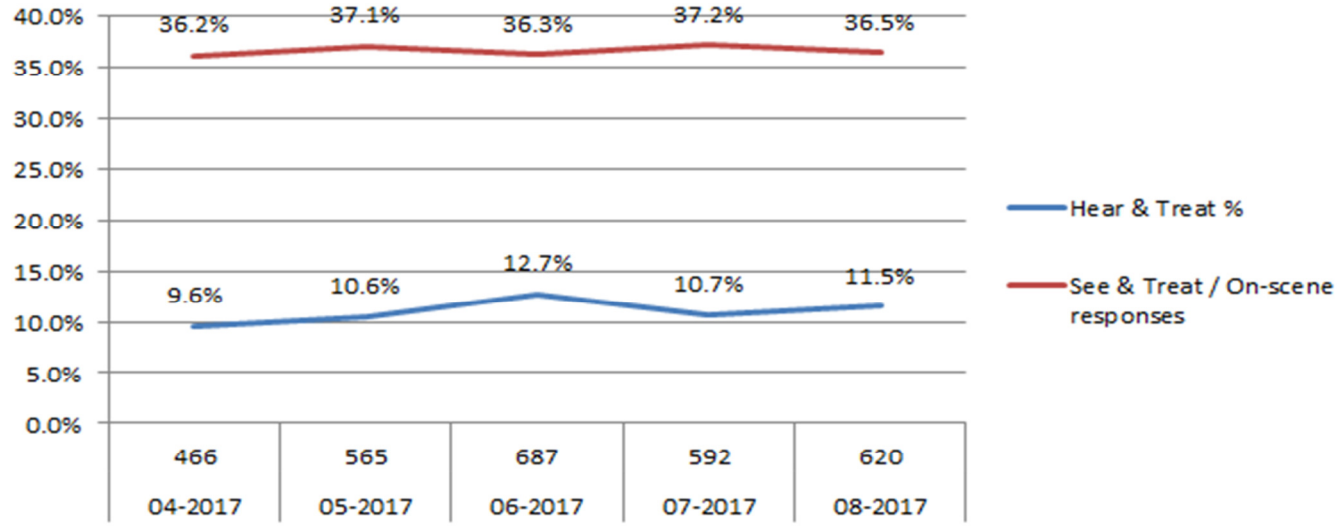
GP Urgent: Urgent Hospital admission booked by a GP or Health Care Professional.

2016/2017

The tables below detail the number of 999 calls in Buckinghamshire and the H & T, S & T %



2017 Cont.



We have virtualised our Emergency Operations Centre to ensure calls are directed to the next available operator and to build further resilience within the operation. In addition we have implemented an electronic patient record and moving away from the current paper based system, which will support improved and more rapid decision making when assessing patients by offering the clinician the ability to review key tools such as Mobile DOS which the staff can access on their ePR, however this is still in its early stages and “work in progress”. These tools will assist the clinician to ensure the patient has the opportunity to follow a more appropriate pathway for their needs rather than direct to the ED.

Private Provider Usage

With the increasing levels of demand, aligned to the challenges faced with staffing levels, has meant that we recognise a continued need to utilise private providers.

Our private providers undergo a strict assessment process before being accepted as a suitable provider. This followed up by regular reviews, undertaken by senior members of SCAS who monitor, review and assess their performance, clinical practice, standards of care and ensure they are maintaining their agreed standards.

As part of the Private Provider cadre, SCAS utilises 5 different providers, including the existing voluntary aid societies, but on a commissioned basis. This varies in use from providing fully equipped Emergency Ambulance or Rapid Response Vehicle to vehicles appropriate to Health Care Professional requests, where an Emergency Ambulance has been deemed not necessary.

Recruitment and Vacancy Rates

Workforce planning continues to be challenging for ambulance trusts nationally. SCAS have had undertaken a partnership with Oxford Brooks University and Northampton University, to fund places for both internal and external candidates to train to become a paramedic. This is now coming to an end with Portsmouth University running the last course.

The trust continues looking at wider options including international recruitment, agency working and collaboration with the armed services.

The trust has redesigned services for response to Health Care Professional calls which has increased the number of non-clinical posts, this is reflected below and these posts are currently being recruited into.

The trust has launched an Associate Ambulance Practitioner (AAP) role. Successful candidates will move into an autonomous clinical role treating patients treating and managing patients across a broad range of emergency, urgent and social care settings. This role will give a good grounding for moving on to a Paramedic.

Current Position – Buckinghamshire

The main staff vacancies are in South Bucks where the cost of living is very high. This is not specific to SCAS but reflects the challenges on the NHS in this area. Work streams are going ahead to include NHS specific low cost housing schemes but unfortunately these do take time to establish.

Ambulance Response Programme:

Content

- Why are we moving to the new national standards
- What are the new national categories 1 – 4
- What are the key benefits?

We are mandated to move to the new standards

18 month Ambulance Response Programme (ARP) trial included over 14 million calls tested using the new operating model and standards.

Key findings / changes:

- Ambulance services dispatch model changed, giving emergency call handlers staff more time to identify patients' needs and allowing quicker identification of urgent conditions.
- New target response times which cover every single patient, not just those in immediate need. For the most urgent patients we will collect mean response time in addition to the 90th percentile.
- "Stop the Clock " rules changed - standards only achieved by ensuring the correct clinical care for the patient dependant on their needs.
- Recognition of life-threatening conditions, particularly cardiac arrest, will improve. London Ambulance Service (LAS) trial estimated that up to 250 additional lives could be saved in England every year.
- Nationally up to 750,000 patients every year would receive an immediate ambulance response, rather than joining a queue.
- The differences in response time between patients living in rural areas and

those in cities should be reduced.

What are the new categories:

CATEGORY 1 - LIFE-THREATENING
Time critical life-threatening event needing immediate intervention and/or resuscitation e.g. cardiac or respiratory arrest; airway obstruction; ineffective breathing; unconscious with abnormal or noisy breathing; hanging.

CATEGORY 2 - EMERGENCY
Potentially serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport.

CATEGORY 3 – URGENT
Urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe.

CATEGORY 4 – NON-URGENT
Problems that are not urgent but need assessment (face to face or telephone) and possibly transport within a clinically appropriate timeframe.

TYPE S – SPECIALIST RESPONSE (HART)
Incidents requiring specialist response i.e. hazardous materials; specialist rescue; mass casualty

EXISTING RESPONSE STANDARDS		
TYPE	% of calls / Demand	National Standard
Red 1	3%	75% within 8 minutes 95% within 19 minutes
Red 2	47%	75% within 8 minutes 95% within 19 minutes
Green	50%	No National Standard – Locally agreed Green 30 mins or Green 60 mins

NEW RESPONSE STANDARDS		
TYPE	% of Calls / Demand	National Standard
Cat 1	8%	7 minutes mean response time 15 minutes; 90th centile response time
Cat 2	48%	18 minutes mean response time 40 minutes; 90th centile response time
Cat 3	34%	120 minutes; 90th centile response time
Cat 4	10%	180 minutes; 90th centile response time

% of activity many vary slightly and is dependent on which call triage assessment tool in use by each Trust (NHS Pathways or AMPDS)

Categories	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 3	120 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 4	180 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

Key Benefits:

- Ensuring a timely response to patients with life-threatening conditions
- The most appropriate clinical resource to meet the needs of patients based on presenting conditions not simply the nearest
- Fewer multiple dispatches = increased efficiency
- Reduction in diversion of resources
- Increasing the ability to support patients through hear and treat, see and treat
- Having a transporting resource available for patients who need to be taken to a definitive place of care
- Improved patient experience
- Provides staff with greater role satisfaction – doing the right thing for patients

Conclusion

Demand has continued to increase throughout SCAS including Bucks. Despite the increase challenges and financial constraints, SCAS has remained focused on delivering a High Standard of pre-hospital care to its patients in the form of both 111 and the 999 service. Our PTS teams have adapted to increase demand but have continued to serve its patients to a high standard making sure wherever possible targets are met.

SCAS has been integral to the future of Integrated Urgent Care in many areas by its professionalism and ability to deliver. Our 111, 999 and PTS services is at the heart of the new IUC by being an important partner and leading on areas of which SCAS is an expert in.

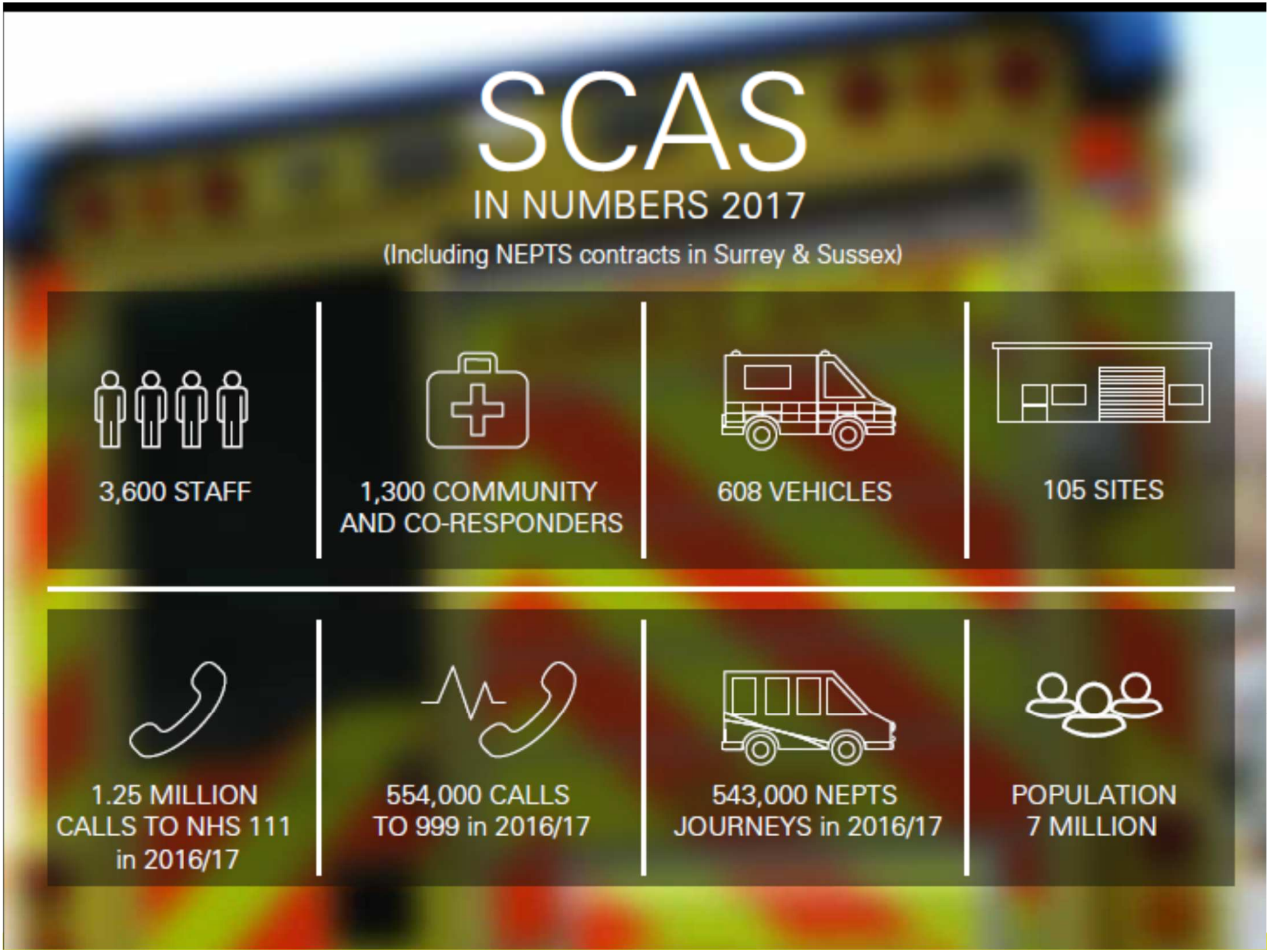
We don’t always get it right, but we learn from our mistakes and welcome all comments which help us to improve.

An overview of SCAS

South Central Ambulance Service NHS
NHS Foundation Trust

What do we do?

- Respond to emergency (999) calls
  - Community/Co-responders
  - Rapid Response Vehicles (RRV)
  - Ambulance
  - Helicopter
- Respond to specialist calls
  - Specialist Paramedics
  - HART
- Respond to non-emergency (111) calls
- Provide non-emergency patient transport services
- Commercial training (HSE First Aid, FPOS, etc.)


SCAS
IN NUMBERS 2017
(Including NEPTS contracts in Surrey & Sussex)
3,600 STAFF
1,300 COMMUNITY AND CO-RESPONDERS
608 VEHICLES
105 SITES
1.25 MILLION CALLS TO NHS 111 in 2016/17
554,000 CALLS TO 999 in 2016/17
543,000 NEPTS JOURNEYS in 2016/17
POPULATION 7 MILLION

South Central Ambulance Service NHS
NHS Foundation Trust

We are a single fully integrated organisation

- 3,600 staff
- 1,300 CFRs and Co-Responders
- 105 sites
- 608 vehicles
- Population 7 million
- 7 RAF bases
- 7 prisons
- Atomic Weapons Establishment
- 1 secure hospital
- VIPs:
  - HM Queen
  - Theresa May – Sonning and Maidenhead

Chequers

Get involved

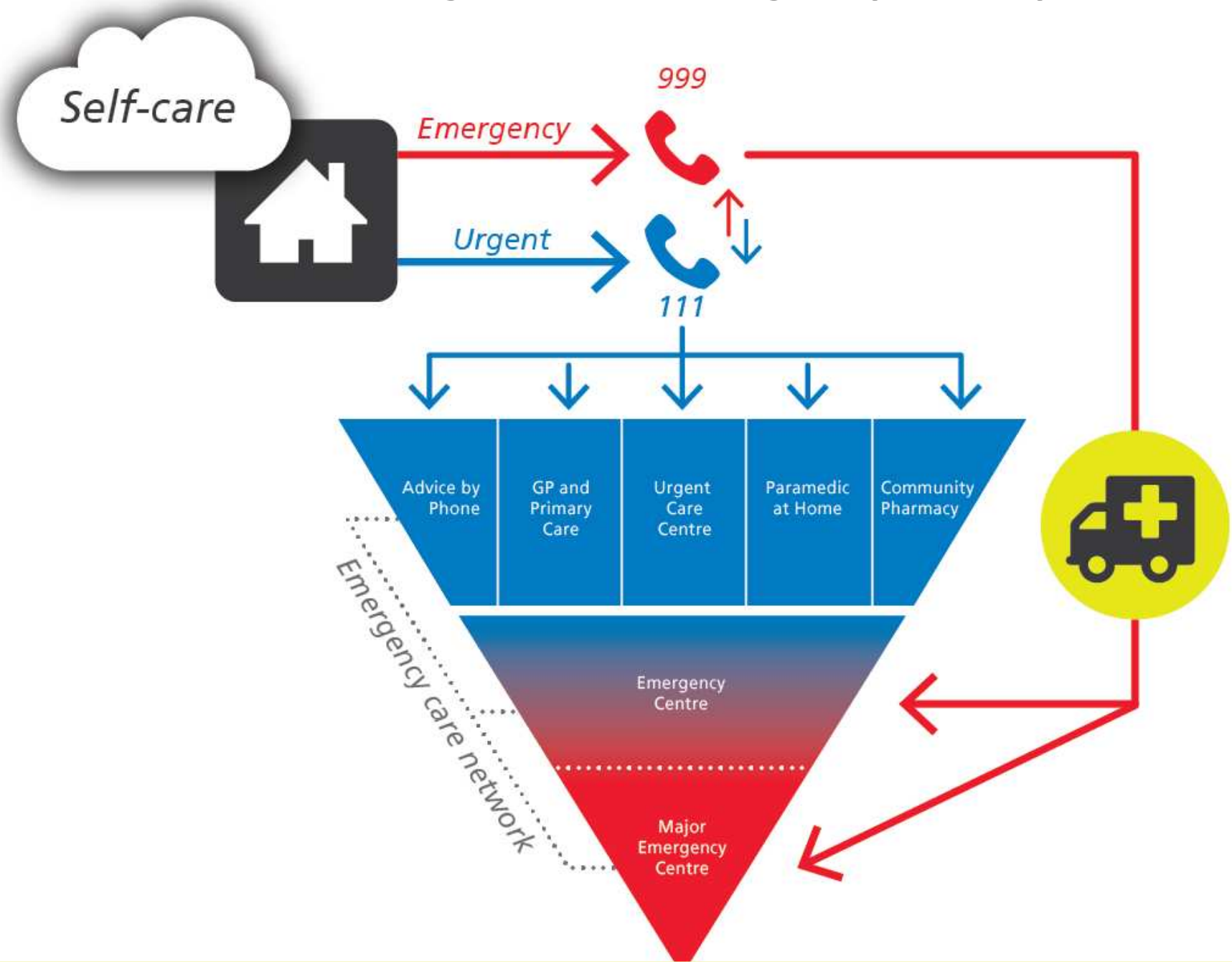
South Central Ambulance Service NHS
NHS Foundation Trust

We operate in a complex setting

- 22 Acute sites
- 2 Major Trauma Centres
- 7 Specialist sites
- 6 Mental health trusts
- 1216 GP surgeries
- 41 Local Authorities
- 568 Dental practices
- 380 Optician branches
- 791 Pharmacies
- 34 CCGs
- 66 MPs
- 13,500 FT public members

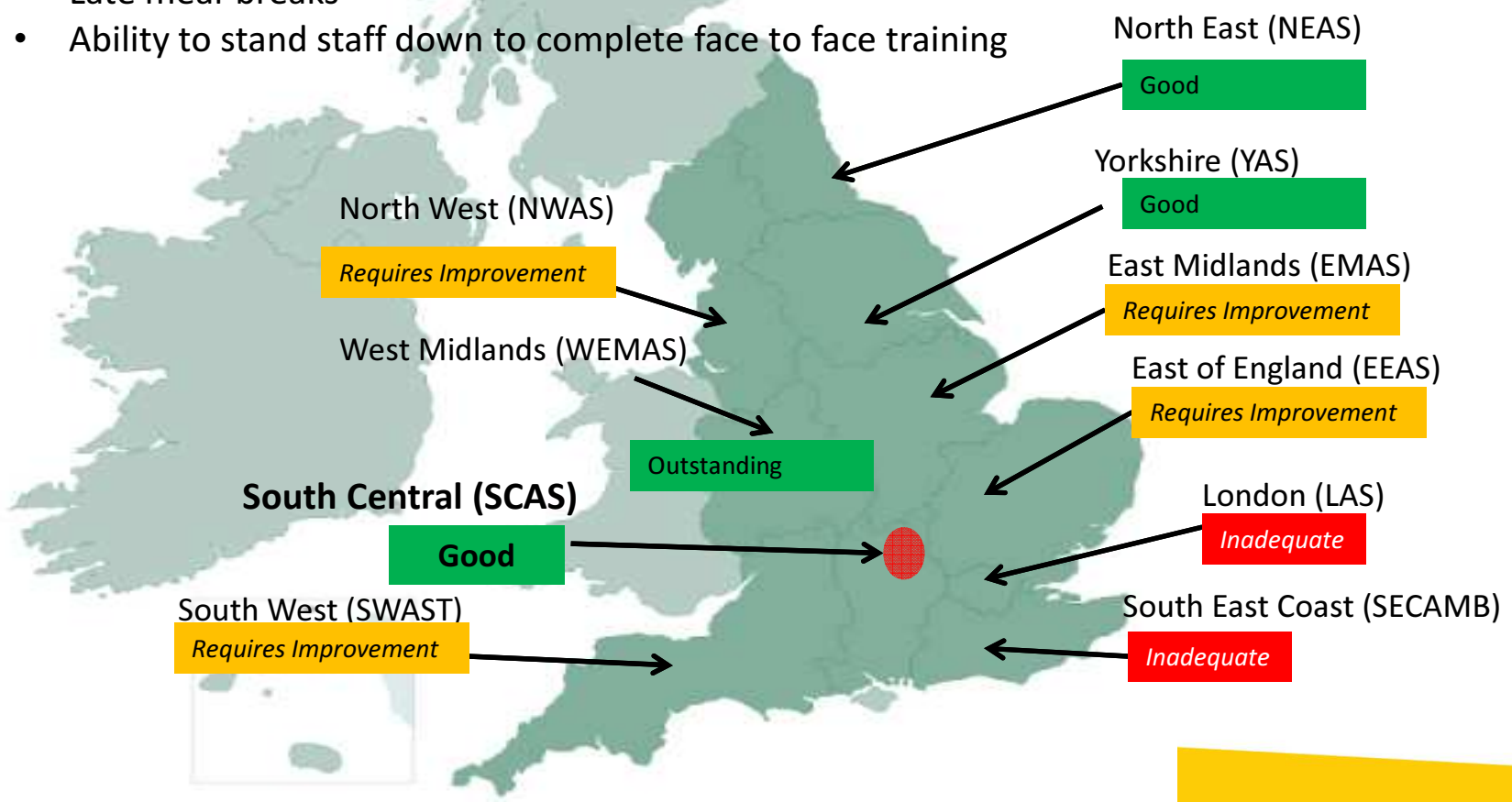
Get involved

Pivotal role in urgent and emergency care systems



CQC Ratings

- All Ambulance Trusts facing increased pressure
- Evidence of challenges faced by UK Ambulance Trusts
- SCAS identified alongside CQC, still areas to improve & focus, including:
  - Shift patterns
  - Shift over-runs
  - Late meal-breaks
  - Ability to stand staff down to complete face to face training



South Central Ambulance Service NHS
NHS Foundation Trust

Strategic themes

- Clinical excellence
- Operational excellence
- Partnership working
- Sound governance
- Commercial viability

Get involved

South Central Ambulance Service NHS
NHS Foundation Trust

Frequent alternative care pathways in Buckinghamshire

- **MuDAS –** ***Frail and elderly are able to be referred to MuDAS including simple falls, cellulitis, conscious confusion, infusions, IV antibiotics, blood transfusion and fluid therapy.***
- Mental Health – *MHPs in the 999/111 operational centre to improve mental health urgent care pathways (in line with National MH Crisis Care Concordat). Able to stop Ambulance attendance and offer alternative care pathway.*
- **GP Surgery –** ***Patients that require further assessment – non-critical and will benefit from staying at home. In previous years, all patients would have been taken to the ED***
- **OOH GP -** ***As above during out of hours and Bank Holidays***
- **Falls team –** ***SCAS attending a frail/elderly fall will complete a "falls referral" sent centrally to our falls team who will alert the local falls prevention team***

Get involved


Proud
to be caring for
you

your community, your care
developing Buckinghamshire together

Developing care in the community: pilot proposal for community hubs

February 2017

Buckinghamshire Healthcare NHS
NHS Trust

Contents

Glossary

Term	Explanation
Locality	Geographical division of the county defined by the registered population of a number of GP practices
Integrated Locality Teams	Teams of staff from a range of health and care organisations working together to support patients living in that locality
Long term conditions	A range of illnesses that cannot, at present be cured; but can be controlled by medication and other therapies. Examples of long term conditions are diabetes, heart disease and chronic obstructive pulmonary disease.

Executive summary

Every year, we care for over 600,000 people outside of hospital. We're working with other parts of the NHS, Buckinghamshire County Council and local organisations to make health and care services safe, sustainable and able to meet the future needs of our local population.

We want to do more to improve the care people receive and how they receive it. We've consistently heard from patients, GPs and community groups that people want their care delivered out of hospital and in local communities, and we have exciting plans to make this a reality. This booklet explains what we're doing and why.

Supporting you to stay well
Through prevention and early-intervention we want to:

- help you to take greater control over your care and treatment
- ensure we meet your long-term needs to help you to stay independent
- make it easier to access the right services by working more closely with your GP and other providers to join-up the care and support, reducing duplication and making better use of new technologies.

Over the next year we'll be investing over £1m to expand our community services, with an emphasis on older people and those with long-term conditions.

What you have told us
Over the past year we've been talking to GPs, staff, patients, other health and social care organisations, voluntary organisations and local communities to understand what you want and develop plans to make this happen. You've told us that you want to avoid unnecessary travel, improve coordination between organisations and be given the support to manage your own health and wellbeing.

We believe that community hubs - a focal point for health and wellbeing in local communities – could be part the solution. There is no one-size-fits-all solution but some of the services you've told us you'd like to see include:

- Rapid access to testing
- Easier signposting to health and care services – a single point of access
- Joined up teams across the system
- Full range of therapy services
- Health and wellbeing function, enhancing self-management and providing education
- A sociable space with a café
- A base from which skilled staff can work in the community
- More outpatient clinics locally
- Virtual networks providing information for patients supported by excellent technology
- More information shared between organisations to improve patient care

What's happening now?
We've joined up some services already so that it is easier for you to get the right care when you need it. For example:

- Our community nurses and therapists are available round the clock to help you stay at home or get home again quickly if you are admitted to hospital. They can provide intravenous antibiotics (via a drip) or wound care at home and, when they visit, they have the technology to monitor your improvements, access the right support for you (such as ordering equipment) and review your clinical notes.
- If you have a long term condition (such as COPD or diabetes) our specialist nurses can support you to manage your own condition. They work closely with hospital consultants to keep you independent and at home should your condition worsen.
- If you need specialist stroke care our early supported discharge team will work to provide your therapy and nursing care at home so that you don't need to stay in hospital for a long time.

What is the national position?

There are three main influences that challenge the way health and care services are provided across the country. These have been outlined in local NHS plans and are supported in the Buckinghamshire, Oxfordshire and West Berkshire Sustainability and Transformation Plan published in late 2016:

1. **Clinical evidence**: according to a report by Monitor[1] as many as 50% of patients in an acute hospital could be better treated elsewhere. Evidence shows that a healthy older person's mobility could age by up to 10 years if they are bed bound for just 10 days[2]
1. **Patient feedback**: work by National Voices in 2012 highlighted that patients want to stay in their own homes, remain independent and part of the community, not be a burden to others, and continue with activities that give them meaning. Our local communities have told us the same.
2. **National direction**: the NHS Five Year Forward View outlines the long term future of the NHS. It seeks to close the:
    - *health and wellbeing gap*, focusing on prevention
    - *care and quality gap*, shifting the way care is delivered, reducing variation and making better use of technology
    - *finance and efficiency*, closing the first two gaps should have a positive impact on this, but the NHS is also looking at investing in new ways of working to join-up care and help it become more productive.

Making this a reality: Our plans for expanding out of hospital care

To best understand what will work for our communities, our clinicians want to test some of the ideas that we heard before we finalise our plans or make permanent changes. Some can be implemented now but others will take longer to develop.

From April 2017, we will start to introduce the following:

- **Locality integrated teams**: We will bring together community and specialist nurses, therapists, social workers, GPs and relevant voluntary organisations. They will provide 24/7 cover to manage those patients identified as needing the greatest health and care support, typically those who have long term conditions. As a result patients will receive better, more coordinated care in their homes.
- **Rapid response intermediate care**: Therapists, care staff and community nurses, working as part of the locality integrated team, will provide short-term (up to six weeks) packages of support to those who would benefit from a 'jump start' back to independence. Available 8am – 9pm, seven days a week, these teams will support people to stay at home and avoid a hospital admission, and get people home more quickly from hospital to avoid transfer to a community hospital bed. The team will visit as often as required and provide a range of support including rehabilitation or help with tasks such as washing, cooking or visiting the shops.
- **Community care coordinator:** This will provide GPs, hospital clinicians and other health and social care staff with 24/7 phone and email 'single point of access' to organise specialist community services for their patients (including the rapid response intermediate care service). Making it easier to access community services will help to prevent admissions to hospital and avoid the delays to discharge that keep people in hospital for longer than they need to be.
- **Community hubs:** The hubs will provide a local base for community staff and will help patients to access prevention services (Live Well, Stay Well), primary care services (as appropriate) and hospital services (such as outpatient appointments, wound care or diagnostic testing) that people may have previously had to travel to.

  Commencing first in Marlow and Thame, where we already have strong community health bases, we'll be working closely with staff and local GPs to test these ideas for six months. We're planning to provide the following services in these hubs:
    - **Frailty assessment clinics**: GPs can refer patients to specialist clinics in the community to help frail older people to stay at home and avoid an A&E visit or hospital admission. The new one-stop same-day or next-day clinic, will be available 9am – 5pm, five days a week

[1] Monitor: Care Closer to Home, DH, Sept 2015

[2] Kortebein et al, 2008

across Marlow and Thame. A multi-professional team of geriatrician consultants, nurses, therapists, paramedics and GPs will provide expert assessments, undertake tests and agree a treatment plan with patients. If required they can refer patients to the right community or hospital team to provide on-going support or treatment. These clinics are already available at Stoke Mandeville and Wycombe hospitals, their introduction in Thame and Marlow will reduce the need for patients to travel for support.

- **Outpatient clinics**: Five more clinical specialties – palliative care, orthopaedics, care of the elderly, falls and oral surgery - will for the first time offer outpatient clinics in the community. We aim to further increase the number of outpatient clinics and specialities over the pilot period, with a focus on supporting people with long term conditions.
- **Voluntary sector and signposting:** We are working with Prevention Matters, Carers Bucks and the Citizen Advice Bureau to offer a range of advice, support and signposting services in the first step of creating a single point of access to health and care services for the public. Carers Bucks will help carers access additional support such as benefits advice, practical and emotional learning, and emergency planning. Prevention Matters will support people to regain confidence and independence by finding suitable social activities and community services in their area.

Our clinicians believe that significantly expanding the support available to people in the community will help to maintain a person's health and independence, which would otherwise deteriorate if admitted to hospital for a length of time. In particular, by introducing a rapid response service and specialist frailty assessment clinics in the community, we will reduce the need for bedded care in hospital. During the pilot therefore our clinicians will not admit patients overnight to the inpatient wards at Marlow and Thame hospitals, as these are our smallest inpatient units (12 and 8 beds respectively). Instead the space will be used to run the new frailty assessment clinics. On the rare occasion that a patient may need additional overnight support, which cannot be provided by the locality integrated teams, local transitional care home beds and overnight packages of care (night-sitting support for people in their own homes) will be available to our clinicians.

Over the next six months we will:

- double the number of outpatient appointments offered at Marlow and Thame
- see 350 patients through the one-stop frailty assessment clinic
- provide intermediate care to over 3000 people
- avoid almost 300 hospital admissions
- manage almost 20,000 referrals through the single point of access.

<u>How will we monitor the pilot?</u>

We're piloting these ideas to give us a better understanding of what works for these two communities. We will monitor how well things work - responding and adapting quickly if we are not demonstrating improvements for our patients and communities – and use our learning to inform our final plans.

We'll look at how well things are working on a daily basis including how many people we have helped to stay independent and not admitted to hospital, and the patient experience of the new services. Our medical director and chief nurse will oversee this pilot to make sure the quality and safety of our care to patients and staff is maintained.

During the six month pilot we will also continue discussions with our staff, GPs, social care, other health and care providers, patients and the public in order to learn from their experiences of these new services and to further develop care in the community.

We will take this learning and have similar discussions in other communities across the county so that by the end of the pilot we have a clear proposal about how we wish to provide more care in the community in the future.

1. Why do we want to change?

Our health and social care services face some big challenges. The population of Buckinghamshire is growing; we can expect another 40,400 residents by 2025, which means there are more people to care for. More importantly, the type of care that people need is continuing to change. Advances in healthcare mean that people are generally living longer, some with complex and multiple long-term conditions that previously we did not have the drugs or technology to treat.

Our system does not always deliver the joined-up care that people want or need to help them with the daily challenges they face living with multiple long-term conditions. People have told us they would like the health and care system to act as one organisation, and where they interact with multiple public services, they would like to be able to tell their story just the once.

Our services are also faced with responding to illnesses associated with the more sedentary lifestyles people now have (for example 1 in 5 adults in the county are physically inactive and 2 in 3 adults are overweight or obese). It is the long-term impact of the increase in disease related to obesity, such as diabetes, which is most concerning.

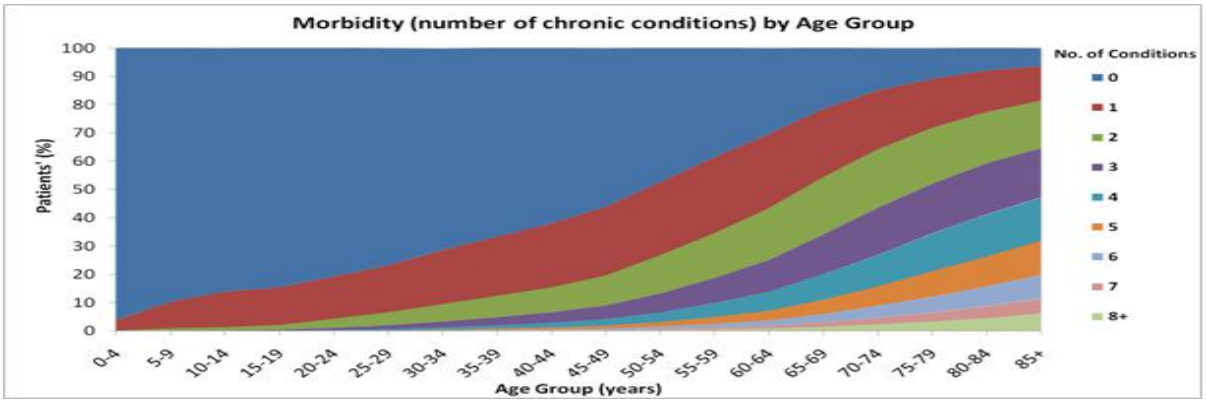
Older people generally require more health and social care. The impact of an ageing population therefore manifests as: increasing demand on GPs; pressure on hospital beds and social services; and delayed transfers of care. It is imperative therefore that we provide more care in and close to people's own homes, reducing our reliance on institutions that are expensive to run, do not always provide the right kind of support and do not allow us the flexibility to meet the needs of this growing number of older people.

The increase in the number of people aged 80 and over is very significant. They currently make up 4.9% of the population but account for 22.2% of all emergency admissions to hospital in Bucks (as of July 2016).

Numbers of people 80 and over in Bucks over the next 20 years:

2015	2020	2025	2030
26,800	32,200	38,700	48,200

The graph below shows the number of long term conditions by age group based on national data (Scottish School of Primary Care, Barnett et all, Lancet, May 2012):



So as our population ages, and the number of people living with long term conditions increases, delivering care closer to home (including access to outpatient clinics and voluntary organisations) will be critical.

Many people would prefer to be cared for in their own homes rather than in hospital or residential care and the national agenda has for some time now been encouraging more care to be provided in, or as close as possible to, people's own homes. This is in alignment with the NHS Five Year Forward View and the National Voices 'I statements':

'My care is planned with people who work together to understand me and my carers, put me in control, coordinate and deliver services to achieve my best outcomes.'

A recent report by Monitor (Monitor: Care Closer to Home, DH, Sept 2015) stated that as many as 50% of patients in an acute hospital could be better treated elsewhere. This is supported by compelling evidence that if a healthy older person is cared for unnecessarily in a hospital environment it can actually be harmful – 10 days bed rest can lead to a 14% reduction in hip and leg muscle strength and a 12% reduction in aerobic capacity. This is the equivalent of ageing them by 10 years (Kortebain, 2008).

There is also evidence that support provided from a range of professionals and a variety of organisations results in less people being readmitted to hospital both within 30 days and 18 months – by providing care at home that is holistic and promotes independence, the chances of that individual being readmitted to acute care is reduced (Caplan et al. 2004). We also know that quality of life measures improve and depression decreases for people cared for at home (Tibaldi, 2009).

Put simply, if people do not get the right care and support, their illness will get worse and they could then need emergency care in a hospital. When long-term conditions are managed well in the community – with people actively involved in choices around their own care – hospital admission should be the exception.

There is evidence that providing support and access to high quality advice enables people to take action to live healthier lives as well as provide self-care if they have a long term condition. The Self Care Forum (established in 2011 with members from a range of professional organisations) has estimated that approximately 80% of all care is self-care. Empowering and supporting this increased personal responsibility helps, they believe, to improve people's health and wellbeing, to better manage the long term condition and ultimately to ensure the long term sustainability of the NHS.

2.0 Our vision for integrated care in the community

All NHS organisations, Buckinghamshire County Council and other local organisations are working closely together to make sure that health and social care services continue to be safe, sustainable and delivered close to home in the face of these challenges. This is outlined in the Sustainability and Transformation Plan published in late 2016. Healthy Bucks Leaders (made up of health, care and council leaders in Bucks) has ensured that individual organisational plans are informed by and consistent with this wider, long term vision.

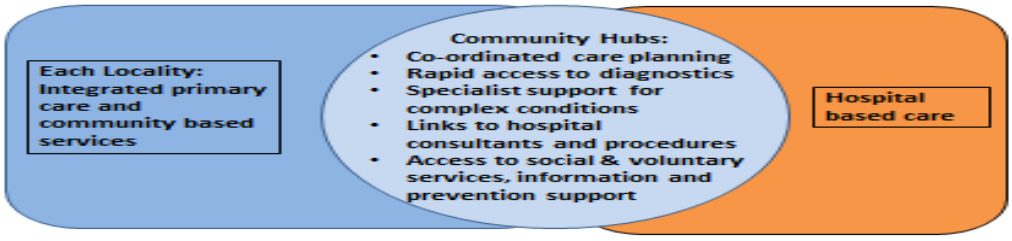
Our vision is to have everyone working together so that the people of Buckinghamshire have happy and healthier lives. We want to rebalance the health and social care spend to increase support for more people to live independently at home, especially older people and those with long-term conditions, by providing high quality prevention and early intervention services. The development of community services will be concerned with adults and children, physical and mental health needs and virtual and real service provision models.

Through prevention and early intervention we want to:

- Support people to keep themselves healthy and live, age and stay well
- Enable more people to live independently for longer
- Create the right health and support in the community in order to reduce pressure on our hospitals and GPs

The Clinical Commissioning Groups model shows the relationship between community and hospital based care which will be reflective of local circumstances and population need:

Community Hubs and Locality Services



The principles of the vision that have and continue to shape changes are:

- People are cared for at home wherever possible and that services are focussed on this.
- People will be encouraged to manage their own mental and physical health and wellbeing (and those they care for) so they stay healthy, make informed choices about care and treatment to manage their long term conditions and avoid complications.
- We combine resources and expertise across the health and care system so that people receive joined-up care.
- People can access good quality advice and care in the most suitable and convenient way possible, as early as possible to prevent problems becoming more serious.
- People have access to specialist support in their community, working with a named responsible clinician.
- We will work together on prevention, not just as professionals but as communities and individuals

Our next step, having considered what we could do to tackle the challenges we face in these three areas, is to test our proposals in a range of ways, of which this proposed pilot is one. We want patients, carers and local people to be involved in the key decisions we will need to take. We want to work more closely with local councils and the voluntary sector who are also key to helping us to make the necessary changes.
Starting in April 2017 we will begin to introduce the following:

- **Locality integrated teams**: We will bring together community and specialist nurses, therapists, social workers, GPs and relevant voluntary organisations. They will provide 24/7 cover to manage those patients identified as needing the greatest health and care support, typically those who have long term conditions. As a result patients will receive better, more coordinated care in their homes.
- **Rapid response intermediate care**: Therapists, care staff and community nurses, working as part of the locality integrated team, will provide short-term (up to six weeks) packages of support to those who would benefit from a 'jump start' back to independence. Available 8am – 9pm, seven days a week, these teams will support people to stay at home and avoid a hospital admission, and get people home more quickly from hospital to avoid transfer to a community hospital bed. The team will visit as often as required and provide a range of support including rehabilitation or help with tasks such as washing, cooking or visiting the shops.
- **Community care coordinator:** This will provide GPs, hospital clinicians and other health and social care staff with 24/7 phone and email 'single point of access' to organise specialist community services for their patients (including the rapid response intermediate care service). Making it easier to access community services will help to prevent admissions to hospital and avoid the delays to discharge that keep people in hospital for longer than they need to be.
- **Community hubs:** The hubs will provide a local base for community staff and will help patients to access prevention services (Live Well, Stay Well), primary care services (as appropriate) and hospital services (such as outpatient appointments, wound care or diagnostic testing) that people may have previously had to travel to.

  Commencing first in Marlow and Thame, where we already have strong community health bases, we'll be working closely with staff and local GPs to test these ideas for six months. We're planning to provide the following services in these hubs:

- **Frailty assessment clinics**: GPs can refer patients to specialist clinics in the community to help frail older people to stay at home and avoid an A&E visit or hospital admission. The new one-stop same-day or next-day clinic, will be available 9am – 5pm, five days a week across Marlow and Thame. A multi-professional team of geriatrician consultants, nurses, therapists, paramedics and GPs will provide expert assessments, undertake tests and agree a treatment plan with patients. If required they can refer patients to the right community or hospital team to provide on-going support or treatment. These clinics are already available at Stoke Mandeville and Wycombe hospitals, their introduction in Thame and Marlow will reduce the need for patients to travel for support.
- **Outpatient clinics**: Five more clinical specialties – palliative care, orthopaedics, care of the elderly, falls and oral surgery - will for the first time offer outpatient clinics in the community. We aim to further increase the number of outpatient clinics and specialities over the pilot period, with a focus on supporting people with long term conditions.
- **Voluntary sector and signposting:** We are working with Prevention Matters, Carers Bucks and the Citizen Advice Bureau to offer a range of advice, support and signposting services in the first step of creating a single point of access to health and care services for the public. Carers Bucks will help carers access additional support such as benefits advice, practical and emotional learning, and emergency planning. Prevention Matters will support people to regain confidence and independence by finding suitable social activities and community services in their area.

In addition to these transformational changes to the services provided, there is also work ongoing by providers (particularly Buckinghamshire Healthcare, Oxford Health and FedBucks) to consider other ways of aligning our organisations to ensure that we create an environment within which integrated teams and new ways of providing care and support can flourish.

3.0 Pilot proposal

The development of community hubs and this proposed pilot sits within this context of wider system integration – developing integrated teams, increasing self-care support - that will support a shift in the emphasis of our services so that more self-care and prevention support is available and that people are able to be independent for as long as possible.

The community hubs pilots will be the first step towards providing a facility within which services and support can be provided that will achieve our goals but the journey will continue beyond this pilot and be informed by it and other service improvements.

3.1 Engagement to inform the development of community hubs

This compelling case for change and vision for community hubs was developed through engagement that has explored how we could provide more care and support closer to home.

3.1.1 Public events

Events were held in April – May 2016 across the Buckinghamshire localities. The aim of the events was to create an early opportunity for patients, carers, relatives, members of the public, partners and key stakeholders including voluntary and charitable organisations to inform the development of our plans for future models of care and devise a vision for community hubs. The involvement and input from a broad range of participants, perspectives and views was comprehensive and informative.

At each event, there were presentations to set the context and then facilitated group work with participants to identify what services could be delivered closer to home, how a hub might work and priorities for development.

Across all 6 sessions 183 participants attended and feedback was also provided online. There was good representation from key stakeholders, partners, voluntary and charitable groups.

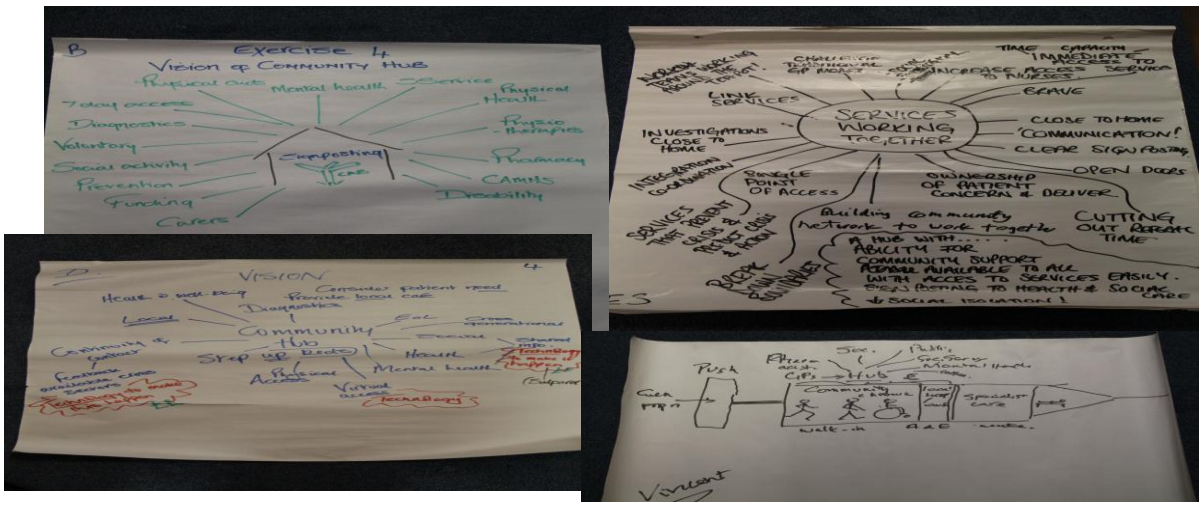
There were 9 subjects that were suggested in every location:

- Rapid access/local diagnostics/near home testing
- Signposting/navigation to health and care services – a single point of access?
- Integrated teams across the system
- Full range of therapy services
- Health and wellbeing function, enhancing self-management and providing education
- A sociable space with a café
- A base from which skilled staff could outreach in to the community
- More outpatient clinics locally
- Virtual networks providing information for patients supported by excellent technology
- More information shared between organisations to improve patient care

The general vision was a physical multifunctional space, with a multidisciplinary integrated model providing key services in the local community with a drop-in capacity. People described a one-stop-shop and a base for clinical staff to work within and to outreach from.

Key services suggested included rapid access to assessment, intervention and diagnostics. The provision of outpatient services, therapies and rehabilitation, health and wellbeing services with prevention, health education and information also featured strongly. Services to improve support for dementia and dementia cafes were also seen as important. (Full summary Appendix C).

A selection of 'vision' drawings from the public events:



In addition to the events held in spring 2016, the Buckinghamshire Clinical Commissioning Groups have held public events in all seven localities in late 2016 as part of their ongoing public dialogue about the development of services. They described the concept of locality teams and a community hub which was well received by the public present and provided additional input to the design of the pilot.

Meetings have also been held with representatives of the League of Friends organisations that support Marlow and Thame community hospitals. They have been supportive of the need to change service models and pleased that the vision sees a crucial role for these community facilities.

3.1.2 GP engagement and clinical engagement

Several GPs and staff attended the public events and engaged with patients in robust debate about access and support. In addition, specific and ongoing conversations have been held with GPs both directly related to the provision of services in the community hospital but also more widely in relation to the longer term vision and model of integrated community services. Discussions with the GP localities (starting with Wooburn Green and Aylesbury South within which Marlow and Thame Community hospitals are located) have considered the wider vision to ensure that the model for community hubs evolves appropriately in each locality.

The GP practices co-located with the community hospitals in Marlow and Thame are supportive of the proposed pilot and keen to work together to see how services could develop collaboratively to provide the best care and support to local patients.

The GP discussions have played a key part in developing the assessment and diagnostic services element of the pilots. The discussions are ongoing to ensure that we bring together GPs and consultants to provide a high quality frailty assessment service, supported by a range of expertise. It is planned to have GPs working as part of the service which will support the provision of seamless care for the patient.

Staff engagement sessions were also held in Spring 2016 and January 2017. A wide range of staff both from acute and community settings shared their visions for community hubs which resonated very closely with the views of patients.

GPs and staff remain critical to the development of plans for this pilot and wider developments and the dialogue will be continued throughout the pilot period.

3.2 Vision for community hubs

We have ambitions for community hubs and would like to see them become a genuine focal point in communities to support people to lead happier and healthier lives with a range of organisations and professionals working together to achieve that objective.

The views of the public, staff and other key stakeholders have helped us to define an early vision for community hubs. They would be real and virtual service offerings, multifunctional spaces (ideally in light and airy buildings) where a broad range of services would be provided by a wide range of organisations. The focus would be on prevention and self-help as well as offering services that traditionally people would have had to travel to a large hospital for.

The services would be coordinated and offered seamlessly to patients and include the following:

- prevention and self-help services (smoking cessation, pre-diabetes education, pulmonary rehabilitation)
- services that are currently provided in some GP surgeries (ECGs, minor surgery, travel immunisations)
- traditional hospital based services such as outpatient appointments for long term conditions, DVT care, IV antibiotics, other infusions, tests (with immediate results where necessary and appropriate),
- multidisciplinary assessment for frail people
- services provided by the voluntary sector such as Carers Bucks and Prevention Matters.

The hubs would provide a base for staff who mostly support people in their own homes to work together as integrated teams to enable them to provide a seamless, holistic and patient-centred service.

The range and scope of services that can be operated from a hub will be limited by the space available (so alternative sites may need to be considered in the long term), the viability of offering a service on that scale and the availability of interdependent services.

3.3 Community hubs pilots in Marlow and Thame

It is proposed to run pilots of the emerging community hubs model in the Marlow and Thame localities. We want to run a pilot so that we can learn from it – hear the experiences of patients, GPs and staff and inform how the model could iterate and grow to determine the right mix of services for their locality in the future. We will carefully monitor the impact of these changes during the pilot – from a clinical, operational and patient perspective and will make changes during the course of the pilot if that is

necessary. Our ambition is to create hubs across all localities, shaped to meet the needs of that local area and the pilot will help to inform these developments.

As a result of what we heard from the public and our research from elsewhere in the country we are proposing to trial changes in six areas:

- Outpatient services
- Voluntary sector and community services
- Assessment and diagnostic services
- Signposting
- Integrated teams
- Inpatient services

The table overleaf provides an indication of the services currently provided at Marlow and Thame community hospitals, our proposals during the pilot and other services that are currently being worked up to go in to the hub environment. It is anticipated that the model for community hubs will evolve through the life of this pilot and beyond as we work with local people, patients and clinicians on what works best for their locality. Some of the services we would like to put in might not work and others that we have not yet started to scope may.
Further detail on the model and current activity information can be found at Appendix A and B.

3.3.1 Marlow pilot

Service area	Now	Pilot	Additions being planned
Outpatient clinics	• Rheumatology • Physiotherapy • Urology • Heart failure • Diabetes • Speech therapy	In addition to current clinics: • Palliative care • Orthopaedics • Care of the elderly • Falls assessment clinic	• Chemotherapy • Respiratory • Oral surgery • Other clinics supporting long term conditions management
Voluntary sector	• None	• Carers Bucks staff offering support and linking with staff • Prevention Matters	• Wide range of organisations using space regularly to provide services and support
Inpatient care	• 12 beds • 85% step down from acute hospitals (see Appendix B)	• Care in people's own homes through investment (rapid response and intermediate care) • Transitional care beds and overnight packages of care (night-sitting) if required • Community hospital beds in Amersham/Buckingham (if required)	• Integrated locality teams supporting care at home. • Virtual support via technology particularly for those with long term conditions
Assessment/ Diagnostic services	• Plain film X ray 2 days a week • Blood tests	In addition to current services: • Frailty assessment service accessed via telephone and provided by geriatrician, nurse, GP and therapist to assess and arrange care to keep patients at home • Point of care blood testing to enable immediate results to	• Ultrasound service • Increased range of point of care testing

		support decision making.	
Base for staff who work across the locality	• Adult Community Healthcare Teams (nurses, therapists) • Health visitors	In addition to current staff: • Prevention Matters	• New base for staff from across health and social care working as part of integrated locality teams
Signposting	• None	• Prevention Matters • Citizens Advice Bureau	• Integrated signposting to support people to access the right service at the right time.

3.3.2 Thame pilot

Service area	Now	Pilot	Additions being planned
Outpatient clinics	• Rheumatology • Respiratory • Physiotherapy • Heart failure • Diabetics • Urology • Dermatology • ENT • Speech therapy	In addition to current clinics: • Palliative care • Orthopaedics • Care of the elderly	• Chemotherapy • Respiratory • Other clinics supporting long term conditions management
Voluntary sector	• None	• Carers Bucks offering support and linking with staff • Prevention Matters	• Wide range of organisations using space regularly to provide services and support
Inpatient care	• 8 beds • 85% step down from acute hospitals (see Appendix A)	• Care in people's own homes through investment (rapid response and intermediate care) • Transitional care beds and overnight packages of care (night-sitting) if required • Community hospital beds in Amersham/Buckingham (if required)	• Integrated locality teams supporting care at home. • Virtual support via technology particularly for those with long term conditions
Assessment/ Diagnostic services	• Plain film X ray 2 days a week • Blood tests	In addition to current services: • Frailty assessment service accessed via telephone and provided by geriatrician, nurse, GP and therapist to assess and arrange care to keep patients at home • Point of care blood testing to enable immediate results to support decision making.	• Ultrasound service • Increased range of point of care testing
Base for staff who work across the locality	• Adult Community Healthcare Teams (nurses, therapists) • Health visitors	In addition to current staff: • Prevention Matters	• New base for staff from across health and social care working as part of integrated locality teams
Signposting	• None	• Prevention Matters • Citizens Advice Bureau	• Integrated signposting to support people to access the right service at the right time.

3.3.3 Outpatient clinics

What we have heard
We provide a range of outpatient services from across our hospital and community sites but at the public engagement sessions we heard that people believed they would benefit from not having to attend acute hospitals as often for routine appointments where it may be possible to provide them closer to home.

What we are planning to do
There is considerable work ongoing to modernise how outpatient services operate across the county – ensuring we make best use of technology in particular to minimise travelling and patients having to spend time in clinics for interactions that could have been managed differently. The community hubs will however see an expanded number of clinics available with a particular focus on support for those with long term conditions. It is expected that double the number of appointments will be available in the community over the course of the pilot. This will be aligned with work already ongoing to transform care for patients with diabetes, which will also reduce the number of visits required at acute sites with more care and support available in the community.

We are also exploring with other specialities the possibility of their providing outpatient clinics within these hubs. It is likely that we will be able to provide more respiratory services in community settings and are working up the feasibility of providing some chemotherapy at community sites for cancer patients.

3.2.4 Assessment and diagnostic services

What we have heard
We know from public events and from feedback every day to individual staff from individual patients that people would like to be cared for at home as much as possible and avoid coming in to hospital if at all possible. This is no less true for our frail, elderly patients.

GPs and hospital clinicians have said that keeping people out of hospital is a priority as it helps them to maintain their independence.

At the moment people often have to travel to Wycombe, Stoke Mandeville and Amersham hospitals for various diagnostic tests and investigations. We heard from attendees at the public events that it would be beneficial to travel only as far as a community setting for a test or investigation if that were possible.

What we are planning to do
To support more care to be provided at home and to facilitate more frail older people avoiding admission to hospital it is proposed during the pilot to provide an assessment service for frail patients. This will be a community based service that enables patients to be seen as a day patient (ie not admitted to an inpatient facility) and have access to assessment and a wide range of services from preventative and primary care through to specialist care.

This model will involve a geriatrician, nurse, paramedic and therapist working with GP colleagues to identify and support patients who, without a quick intervention, might soon require a hospital admission. This service will operate 5 days a week between Marlow and Thame as required and allow same-day access. It will work in tandem with, and enhance the service currently provided by, the MuDAS (multidisciplinary assessment service) at Wycombe Hospital which already supports approximately 1000 patients per year. We expect an additional 350 patients a year would be seen, assessed and supported through this model. The model has been co-developed with local GPs to ensure it can support them to meet the needs of their patients. In some cases home visits will be facilitated too.

Technological advances mean it is now possible in some cases to use equipment that provides test results immediately (point of care testing). We will use this technology to support the clinicians providing the frailty assessment service so that their ability to make quick decisions on the best course of action for a particular patient is enhanced and will increase the likelihood of them being able to remain at home.

The assessment service will get blood results immediately, be able to undertake ECG tests and give intravenous medicines such as antibiotics and other drips. They will also have access to the full range of community services that a patient might need so for example if they have had a fall, they will seamlessly ensure they have access to the experts in that service or if they have a wound that needs dressing that care will be arranged too.

X-ray is currently offered at Marlow hospital and we are investigating the possibility of providing other radiology services in hubs such as ultrasound.

What will this mean for patients?

Mrs S is not feeling at all well and has become more forgetful than normal
Previously - Mrs S attends A&E and is admitted to hospital where she has a raft of tests and gets progressively more forgetful and weak.

Now – her GP sends her to the **community hub** for a **frailty assessment**. The geriatrician, nurse and therapist do a full assessment as well as taking bloods (and use their point of care testing machine to get the result immediately). They diagnose a urine infection and so give Mrs S some antibiotics into a vein over six hours.

Outcome: Mrs S does not go to A&E. She is treated at the community hub and is able to go home later. She has follow-up visits at her house for a couple of days.

3.3.5 Base for staff working across the locality

What we have heard
GPs and the public have been very clear that the wide range of organisations delivering health and care services in the community are hard to understand and navigate. There appear to be gaps and duplication between services and people do not believe that they are receiving seamless, or indeed joined-up care.

What we are planning to do
There is significant work ongoing across Buckinghamshire to develop integrated community services. This will involve aligning teams from all organisations across health and social care, supported and facilitated to work together, reducing gaps and duplication. Building on the pilots already established in Wycombe and Aylesbury Vale, it is proposed to develop multi-disciplinary teams that 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 and enable them to remain independent longer.

The teams will access rapid response intermediate care if required as well as work closely with all organisations and teams supporting an individual even if they are not formally part of the team. Referral processes will be streamlined and care coordinators will be identified for each patient. There will be no 'wrong door' for referrals – the team will pass referrals on as appropriate. The team's key functions will be:

- Identifying patients at risk of increased frailty
- Working with patients to develop individual care plans
- Coordinating care for individuals to minimise confusion, gaps and duplication
- Providing treatment, care, support and review

The work that is ongoing triailing different ways of supporting care homes will be incorporated into this workstream as the response should be the same regardless of where you live (although tailored if you have nursing care already).

These teams will probably be based in community hubs and by sharing a base will be better placed to join up the care and support offered to patients. Staff currently being aligned more closely, include district nurses and social workers, as well as therapists (council and health occupational therapists in particular) and GPs. These staff spend much of their time visiting people in their own homes but our

pilot will enable us to use some space in the existing community hospital buildings to create flexible bases where staff can begin to meet and work together.

What will this mean for patients?

GP is concerned that Mr Y is getting frailer and seems a bit less able to cope
Previously – the GP is concerned but can't pinpoint anything specific that needs treating. He's worried that Mr Y might need longer term care, possibly in a home and so sends him to hospital where he stays several weeks before transferring to a care home.

Now – the GP calls the **community care coordinator** and talks to the community matron, part of the **integrated locality team.** The nurse will go and visit, assess Mr Y and talk to him about his life. She will then be able to talk to other members of the team, including social care, frailty assessment, intermediate care etc to put in place a variety of support that enables him to maintain his independence maybe some help with meals, someone to help with cleaning and some company.

Outcome: Mr Y's health does not deteriorate. His care is organised and structured around his needs and he remains at home.

3.3.6 Inpatient services

What we have heard
We know that, particularly for older people, hospital-based care does not deliver the benefits we would like to see in terms of returning people to independence after a period of ill health. We heard from the public that more care is required to support people to remain as independent as possible, for as long as possible, in their own homes. Inpatient beds in community hospitals are not always used effectively and can impact on a patients' ability to remain independent as their stay can be extended inappropriately.

The patients currently cared for across the four community hospitals in Buckinghamshire (80 beds) have a range of needs but audits show that at any one time approximately 24 patients' would have their needs better met in an alternative setting.

What we are planning to do
Given these factors it is proposed to trial caring for patients previously who may have been traditionally admitted to Marlow and Thame community hospitals in alternative environments. The frailty assessment service (described in section 4.4) will enable admission avoidance – by supporting GPs with the assessment and care planning for frail older people. This pilot will also help enable the cultural shift that is required to ensure that hospital staff are supported (through a single point of access and increased investment) to facilitate discharge to the most appropriate place with the most appropriate care.

During the pilot therefore our clinicians will not admit patients overnight to the inpatient wards at Marlow and Thame hospitals, as these are our smallest inpatient units (12 and 8 beds respectively). Instead the space will be used to run the new frailty assessment clinics. On the rare occasion that a patient may need additional overnight support, which cannot be provided by the locality integrated teams, local transitional care home beds and overnight packages of care (night-sitting support for people in their own homes) will be available to our clinicians.

In addition, there is significant investment in and development of the rapid response intermediate care services that are required to support patients in their own home either to avoid a hospital admission or facilitate discharge from hospital. At present there are several services offering reablement services and the plan is to combine the current REACT team (at the front door of A&E) with the reablement capacity in the ACHT locality teams and Bucks Care to create a single **Rapid Response Intermediate Care Team** that offers:

- Short-term packages of support (for up to six weeks)
- Multi-disciplinary assessment and rapid response from 8am-8pm, 7 days a week at Stoke Mandeville Hospital
- Multi-disciplinary assessment and treatment in patients own homes for admission prevention and supporting hospital discharge
- Intermediate care support at home 8am-9pm 7 days a week
- Daily in-reach and outreach presence on hospital wards and at the front door
- Community physiotherapy for ongoing rehabilitation needs to maximise independence
- Integrated with other services, both existing and being developed, as part of wider service alignment

It is expected that this investment and alignment of services will create an additional 50% contacts for intermediate care with the number of contacts rising from 12764 to 19145 per annum to enable an additional 300 admissions to be avoided.

To support and enable appropriate and efficient access to these services, a full single point of access will be established to include all referrals of those patients ready for discharge from acute services but who require some additional support as well as those at home who require some additional support to avoid a hospital admission.

In time this referral point will be expanded in line with referrer needs and it likely to become the access point for all specialist community services (eg falls/bone health services), elements of continuing health care services and perhaps some social care services.

What will this mean for patients?

Mrs J has a fall and is taken by ambulance to A&E
Previously – Mrs J is admitted to hospital, spends several days as in inpatient and loses her confidence to be at home by herself. Social care is involved and it takes several weeks to arrange suitable alternative care accommodation.

Now – the **rapid response intermediate care** team have staff in A&E so Mrs J can go home. They arrange for a member of the team to visit her at home later that day to organise her care whilst she gets over the fall and gets her confidence back.

Outcome: Mrs J is able to return home and recover much more quickly. With a short-term package of support in place she maintains her confidence and independence.

3.3.7 Voluntary sector and community services

What we have heard
We know that the needs of the population are rarely met by one individual or organisation and increasingly, as we heard at the public events, the voluntary sector are providing invaluable services that support people to maintain their independence.

What we are planning to do
We will work with voluntary sector partners to offer opportunities to run services from the community hub buildings. We plan to trial this with Carers Bucks and Prevention Matters during the pilot. It is proposed that they will have a presence at both sites most days of the week and be available to offer guidance and support and signpost to other services as appropriate. The service could be 'drop in' or by appointment but exact details are still being finalised.

3.3.8 Signposting

What we have heard
A key message from the engagement events was that the public felt they could be more self-sufficient if they had access to better signposting advice to help them navigate complex and complicated health

and care systems. We also heard of the important work that many voluntary organisations and charities already provide in localities to support local communities in this way. Many felt it would be beneficial for these organisations to work more closely with health and care to improve the advice and guidance offered.

What we are planning to do
We are keen therefore to develop in these community hubs the right support to people to ensure they receive the right care from the right person at the right time. Developing a full signposting service will take time but we are proposing to trial some new models in the first phase of the community hubs development including working with Patient Participation Groups from GP practices (Healthmakers project) and the Citizen's Advice Bureau.

4. Learning from the pilot

By piloting these developments we will have a better understanding of what works for these two communities. This approach will allow us to both closely monitor how well things work – responding and adapting quickly if we are not demonstrating improvements for our patients and communities – and use our learning to inform our final plans.

We will be monitoring, using a range of measures, how well things are working on a daily basis – this will range from how many people we have helped to stay independent and not be admitted to hospital, to the patient experience of the new services. Our medical director and chief nurse will be overseeing this pilot to make sure the quality and safety of our care to patients and staff is maintained. By doing this we will be able to quickly make any changes or adaptations as or when we need to.

During the six month pilot we will also be continuing discussions with our staff, GPs, social care, other health and care providers, patients and the public in order to learn from their experiences of these new services and to further develop care in the community. We will want to know the impact on the care and experience of users of the hub. We will therefore ask a range of patient representative organisations, including Healthwatch, Practice Participation Groups, League of Friends, to share with us feedback that they receive about the services at the hubs and/or in their own homes. We will want to know specifically about the range of services offered, ease of access to services, impact on travel time and the quality of the service received.

We will take this learning and have similar discussions in other communities across the county so that by the end of the pilot we have a clear proposal about how we wish to provide more care in the community in the future.

We will know that this change has worked if frail, usually older people are staying in their homes for longer. This is not easily quantified or measured but is the expectation based on what national and international evidence there is.

In addition to these qualitative measures, we believe that there will be specific things we can measure to help us assess the impact. We believe the benefits of this shift in care model would include:

Measure	Baseline	Expected improvement
Increased numbers accessing outpatients at community sites	1000 outpatients/annum	2000 appointments/annum
Admissions avoided (all sites)	800/month	850/month
Rapid response intermediate care contacts	12764 per annum	19145 per annum
Patient related experience measures		Demonstrate improvements across a range of measures
Number of people discharged from acute care to normal place of residence	92% (all patients)	94%
Numbers seen in frailty	N/A	15 per week across both

assessment service		locations
Referrals managed through community care coordinator	N/A	765 per week
Readmissions of over 75s	TBC	To see a reduction in overall admissions
Numbers of patients requiring additional overnight support	N/A	To monitor as part of pilot to inform future

As part of our quality assurance processes, the chief nurse and medical director have reviewed these proposals and the measures described above and will monitor the impact on patients throughout the pilot. As well as daily monitoring, a group has been established that will meet bi-weekly and has operational and clinical staff attending.

5. Summary and timeline

This pilot proposal has been built up over time with considerable engagement with the public, GPs and other key stakeholders. It is part of the ongoing, system wide development of integrated community care that will ensure our health and care system is high quality and sustainable to cope with the pressures it currently and will continue to face.

The service will iterate and grow during and hopefully after the pilot, informed by our learning and ongoing dialogue with the public and GPs to determine the right mix of services for their locality. Depending on the shape and scope of the future service model, it may well be that further engagement or consultation is required before permanent changes are made.

The proposed timeline is outlined below and demonstrates the ongoing commitment to learning from the pilots to inform development of the model for community hubs within the context of wider system change.

Date	Activity
End January – 14th February	• Stakeholder communications • Further iteration of pilot proposal • Ensure baseline data collated
21st February	• HASC meeting
Feb - March	• Staff consultation to support pilot
1st April	• New clinics established • Frailty assessment service commences • Investment in rapid response intermediate care and additional staff recruited • No new admissions to community inpatient beds at Marlow and Thame
June – September	• Ongoing discussions with patients and GPs in localities • Fortnightly meetings to evaluate ongoing impact and iterate if required • Development of plans for future model across the county
September / October	• Measure expected benefits
October / November	• Share proposals to determine next steps for countywide hubs

Appendix A

MARLOW COMMUNITY HUB

Outpatients

Currently:
Speech and language therapy (weekly)
Heart failure (weekly)
Diabetes (weekly)
Rheumatology (weekly)
Urology (monthly)
AAA screening (weekly)
Physiotherapy
Dental
Speech and language therapy (weekly)

In addition:
Palliative care (weekly)
Care of the elderly (weekly)
Trauma and Orthopaedics (monthly)

Inpatient services

Currently:
12 inpatient beds

In future:
Frailty assessment service –
Geriatrician, nurse and therapist 3 days a week (flexible) focussing on assessments to avoid hospital admissions

Transitional care beds and overnight packages of care available if required

Investment in rapid response intermediate care and other community services

Staff bases

Currently:
Adult Community Healthcare Teams (district nurses, therapists, health care assistants)
Health Visitors
Macmillan Nurses

In future:
Bucks County Council occupational therapists
Base for integrated locality teams

Voluntary organisations services

Currently:
None

In future:
Carers Bucks clinics
Alzheimers Society advice point
PPG Expert patients advice point
Prevention Matters Community Development Worker
Library link
Citizens Advice Bureau

Ambulatory/diagnostic services

Currently:
Xray (Tues & Thurs am)
Blood tests

In addition:
Ultrasound (3 x week)
Point of care testing

NB: Descriptions in *italics* are those that are not yet completely in place but discussions are ongoing.

BACKGROUND INFORMATION: Marlow

NB: Some figures are different as different time frames used for the 12 month analysis

The hospital provides the following services:

- 12 inpatient beds (in 3 and 4 bed bays)
- Outpatient clinics
- Musculoskeletal physiotherapy
- Staff base for ACHT, Health visitors

On the inpatient ward the current staffing issue is 6.52 band 5 vacancies against a wte budget of 10.53 ie a 60% vacancy rate.

Average age of inpatients	
CH	**Age**
Marlow	83

Admissions

ADMISSIONS TO MARLOW - 1ST APRIL 2016 TO 31ST OCTOBER 2016												
Community Hospital	Total Admissions	Step-up source					Step Down Source					
		GP	other provider	Elective booked	A&E /Bed bereau	Totals Step UP	Other/CH	Other Comm hosp	Wycombe	AGH	SMH	Total Step down
Marlow	127	5	8	2	6	21	2	2	17	0	85	106

Vast majority of admissions are step down from acute hospitals (Wycombe, Stoke Mandeville and Wexham Park).

Medical cover is provided by GPs from Marlow practice as commissioned by BHT.

Number of admissions per CCG locality (Oct 15 – Oct 16)

Total number of admissions	**182**
High Wycombe	78
Marlow	45
Amersham & Chesham and Southern Chiltern localities	35
Aylesbury CCG Localities	15
Out of county	9

Discharges

The average length of stay was 22.0 days.

A spot audit of all community hospital beds in 2015 showed that 30% of patients were fit for discharge (38% of those awaiting a package of care, 25% awaiting reablement at home). These are all patients who are discharged home but with this additional support.

The discharge destinations of the patients were as follows:

Discharge Destination	Marlow
Local authority residential accommodation	3
N/A- patient deceased	3
NHS other General Hospital	4
NHS run care home	3
Private Care Home	0
Temporary place of residence	6
Usual place of residence	78
Care Home (probable)	13
Grand Total	**110**

Outpatients

Shows total number of outpatients Oct 15 – Oct 16 with idea of where patients came from.

Total number of appointments	488
Number patients referred by GP practices in local vicinity	323

Diagnostics

Plain film Xray is provided two mornings a week and there are approximately 650 undertaken in 6 months.

Appendix B

THAME COMMUNITY HUB

Outpatients
Currently: Speech and language therapy (weekly) Heart failure (weekly) Diabetes (fortnightly) Rheumatology (monthly) Urology (monthly) Audiology (monthly) ENT (monthly) Dermatology (monthly) Respiratory (fortnightly) Physiotherapy
In addition: Palliative care (weekly) Care of the elderly (weekly) Trauma and Orthopaedics (monthly) *Respiratory*

Inpatient services
Currently: 8 inpatient beds
In future: Frailty assessment service – Geriatrician, nurse and therapist 2 days a week (flexible) focussing on assessments to avoid hospital admissions Transitional care beds and overnight packages of care available if required Investment in rapid response intermediate care and other community services

Staff bases
Currently: Adult Community Healthcare Teams (district nurses, therapists, health care assistants) Health Visitors
In addition: *Bucks County Council occupational therapists*

Voluntary organisations services
Currently: Smoking cessation
In future: *Carers Bucks clinics* *Alzheimers Society advice point* *PPG Expert patients advice point* *Prevention Matters Community Development Worker* *Library link* *Citizens Advice Bureau*

Ambulatory/diagnostic services
Currently: *Blood tests*
In addition: *Ultrasound (3 x week)* *Point of care testing*

NB: Descriptions in *italics* are those that are not yet completely in place but discussions are ongoing.

BACKGROUND INFORMATION: Thame

NB: Some figures are different as different time frames used for the 12 month analysis

The hospital provides the following services:

- 8 inpatient beds
- Day hospital
- Outpatient clinics
- Staff base (ACHT, health visitors)

On the inpatient ward there are currently no vacancies at band 5.

Average age of inpatients	
CH	**Age**
Thame	84

Admissions

ADMISSIONS TO THAME - 1ST APRIL 2016 TO 31ST OCTOBER 2016												
Community Hospital	Total Admissions	Step-up source					Step Down Source					
		GP	other provider	Elective booked	A&E /Bed bereau	Totals Step UP	Other/CH	Other Comm hosp	Wycombe	AGH	SMH	Total Step down
Thame	95	2	11	0	3	16	0	0	1	1	77	79

Vast majority of admissions are step down from acute hospitals (SMH).

Medical cover is provided by GPs from CV Health as commissioned by BHT.

Number of admissions per CCG locality (Oct 15 – Oct 16)

Total number of admissions	172
Thame (Haddenham, Long Crendon, other villages)	87
Aylesbury (and surrounding villages)	52
Chiltern CCG localities	33
Out of county	3

Discharges

The average length of stay was 22.2 days.

A spot audit of all community hospital beds in 2015 showed that 30% of patients were fit for discharge (38% of those awaiting a package of care, 25% awaiting reablement at home). These are all patients who are discharged home but with this additional support.

The discharge destinations of the patients were as follows:

Discharge Destination	Thame
Local authority residential accommodation	1
N/A- patient deceased	3
NHS other General Hospital	10
NHS run care home	1
Private Care Home	3
Temporary place of residence	2
Usual place of residence	51
Care Home (probable)	12
Grand Total	**83**

Outpatients

Shows total number of outpatients Oct 15 – Oct 16 with idea of where patients came from.

Total number of appointments	608
Number patients referred by GP practices in local vicinity	345

Appendix C

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

PUBLIC BOARD MEETING
Wednesday 27 July 2016

Details of the Paper

Title	Your care, your community – Feedback from community hub engagement
Responsible Director	David Williams – Director of Strategy and Business Development
Purpose of the paper	• To provide a summary and overview of 'Your community, your care', our recent public engagement programme on developing community hubs. • To provide an outline of overall key feedback • The Trust Board is asked to note and accept this paper as a summary record of the engagement process
Action / decision required (e.g., approve, support, endorse)	The Board is asked to note and accept this paper as the report on the Your community, your care public engagement exercise.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	***Strategy***	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	***Public Engagement /Reputation***	***Equality & Diversity***	***Partnership Working***	*Information Technology / Property Services*

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
Quality and patient safety
Integrated Care

Please summarise the potential benefit or value arising from this paper:
Patient centred change resulting in more effective use of resources avoiding errors in change that later need correcting, better patient experiences, improved joint management of care and sustainability.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	*If you need advice on completing this box please contact the Director for Governance)*

Author of paper: Tracey Underhill, Head of Membership, Engagement, Equality and Diversity-*(operational)*

Presenter of Paper: David Williams Director of Strategy and Business Development

Other committees / groups where this paper / item has been considered:

Date of Paper: 15 July 2016

Buckinghamshire Healthcare NHS
NHS Trust

Your community, your care
Feedback from community hub engagement
July 2016

1.0 Purpose

- To provide a summary and overview of 'Your community, your care', our recent public engagement programme on developing community hubs.
- To provide an outline of overall key feedback
- The Trust Board is asked to note and accept this paper as a summary record of the engagement process.

2.0 Executive Summary

The subject of this paper is our recent programme of public engagement, Your community, your care (YCYC). This was a series of 6 public and 2 staff engagement sessions that took place across April and May of this year led by Buckinghamshire Healthcare NHS Trust (BHT). The six engagement sessions took place starting on the 7th April 2016 at Thame and concluded on the 12th May in Buckingham. Other locations included, Marlow, Chalfont, Aylesbury and Wycombe.

Each session worked to a set programme and sessions were 2.5 hours and were designed to have three stages e.g. information giving, group work and a plenary.

The aims of this programme are listed below and this paper seeks to provide assurance to the Trust Board and the public that early conversations have taken place about the potential of developing community hubs and delivering more care closer to home. In addition, this paper offers assurance to the board that the aims of the, Your community, your care engagement programme have been met.

In total, 26 different groups of people across the 6 sessions have provided feedback. The information we have as a result of analysis is represented below summarising with a vision of a community hub that seems to be the most commonly supported from the feedback we have received.

This is a summary report of the process and feedback from patients and stakeholders; it does not seek to report on potential plans, options or changes. In thinking about the potential of moving more care closer to home, the Trust felt it was very important to have an early dialogue, without pre-defined models or ideas. We wanted to first listen to the views of local people, in the current climate, to see if the concept of care closer to home is supported. Having the dialogue early means that feedback can genuinely help to inform the shape of future services as we try to develop the ideas and suggestions received along with our partner organisations who will need to be involved. Much of the feedback spanned more than the remit of just health.

3.0 Introduction

As a result of a shift to delivering care closer to home, BHT committed swiftly to a programme of early engagement with the local community. In February 2016 the BHT Board with the support of partners agreed to run a series of public engagement events with a focus on the development of community hubs in line with national direction. BHT wanted to create an early opportunity for patients, carers, relatives, members of the

public, partners and key stakeholders including voluntary and charitable organisations to inform the development of our plans for future models of care. The feedback received will be used to help inform decisions around health and social care changes within local communities. Feedback will also help to inform projects as they emerge from the future Sustainability and Transformation Plan. This will be a regional plan that involves key partners such as social care, local authorities and mental health across the Buckinghamshire, Oxfordshire and West Berkshire footprint.

Aims of the engagement programme included:

- An early opportunity to explore with local communities how we might develop community care hubs and what that might look like locally
- To better understand what patients and carers identify as the services that could be provided closer to home and the benefits to local people and the quality of their care
- To identify those services that people feel they don't need to travel to an acute hospital site for
- To understand how we might be able to support different people's needs in different areas via a community hub
- To establish a list of priorities from each session
- To provide an opportunity to gather feedback from individuals on their vision of what a hub might look like as well as the collective view from group work
- To deliver meaningful engagement sessions for patients, carers, partners and stakeholders to attend.

The participation and input from a broad range of participants, perspectives and views has been very comprehensive and informative. More detail is provided below.

4.0 Process

At each event, opening presentations were delivered by our Chief Executive, Neil Dardis and our Chief Nurse, Carolyn Morrice, with the exception of Thame when our Director of Strategy and Business Development presented on behalf of the CEO. The presentations focussed on setting the context, explaining the national drivers for care closer to home, with a few examples from elsewhere. They included some of our achievements and challenges to date and highlighted our wish to seek people's views early.

Facilitated group work followed with participants responding to specific questions via a range of exercises using a set format and method to maintain consistency across the sessions. Following the group work individuals were offered the opportunity to record their own personal vision. Group work included identifying what services would people like delivered closer to home, how a hub might work, priorities and creating a vision of what a community hub might look like.

Sessions concluded with a plenary and closing comments. Participants were informed of how their feedback would contribute to informing developments. All participants were asked to complete evaluation forms and equality monitoring sheets.

Each participant was informed that they would receive a report of the session they attended and they would be able to verify the accuracy of the report ahead of any analysis.

All 6 reports have been completed, circulated for comment and verified by participants and are available on request. All reports are consistent in format and approach and carry the branding that we have developed for this programme. Responses have been positive and the reports have been welcomed with some minor amendments.

Finally, following acceptance of this paper and it's content by Trust Board, our promise to participants is to develop an overall report drawing on all 6 reports and this will then be circulated to all participants and staff.

5.0 Summary of key outputs
Following collation of all the feedback there is a significant amount of information to analyse. From the 6 sessions, we had feedback from 26 groups across several exercises. Our analysis has looked at comments provided by frequency, by location, the priorities groups decided at each session and we have developed key themes. Still to analyse are the individual personal visions of what a community hub looks like. We received 113 of these which is very positive and these will further add to the richness of information collected.

5.1 Attendance
Across all 6 sessions

- 183 participants attended
- 281 people actually booked which demonstrates the level of interest
- 66 people did not arrive
- 32 people cancelled

There has been good representation from key stakeholders, partners, voluntary and charitable groups.

Evaluations have been collected from each session along with equality monitoring forms. Of the 183 attendees 117 completed evaluation forms some examples of responses include:

- 112 of a 117 responses said they valued the opportunity to discuss with others, ideas about community hubs
- 111 of 117 responses valued the facilitation of the group work positively
- 107 of the 117 responses said they valued clinical staff being present.

5.2 Analysis of top ten points of feedback resulting from collation of:-
- priorities identified by groups across all 6 sessions – exercise 3
- analysis of feedback by frequency – exercise 2
- analysis of feedback by site – exercise 2

It is important to note that where ** is shown this indicates a skew of data due to one location identifying the topic as significant for them so this needs to be interpreted with great care and does not reflect the overall list which is listed further below. However, it is important to note that there are some differences about local needs between different locations and some variation between what people feel is important. The data below is shown for all 6 locations.

Top ten priorities identified by the groups in all 6 locations via exercise 3	Top ten services people identified as wanting to see delivered closer to home by frequency via exercise 2	Top ten services people would like to see delivered closer to home by site. Cross analysis exercise 2
Integration of services i.e health, social care, voluntary and charitable sectors	Rapid access to assessment, diagnostics (lab in the bag example strongly supported)	Rapid access local diagnostics near home testing (LAB in a bag example strongly supported)

Hub seen for health wellbeing and prevention including training and education opportunities for patients Providing a range of services	Therapies, rehabilitation, and physiotherapy mentioned frequently as a service would like to access closer to home. Could see in a hub	Signposting / navigation to services – would like a single point of access to contact for information and signposting. to health and social care services Citizens advice bureau mentioned frequently for model and ? could they help to deliver?
Rapid Access to diagnostics/ assessment	Step up / step / down / transition bed provision locally **Skewed listing position Thame heavily weighted barely mentioned elsewhere. See left hand column.	Integrated teams/Integrated skills and integrated working with health and social care.
Navigation and signposting to services across health and social care. Central single point of access wanted eg. Telephone line / online. Which services provided where and how to access.	Better communication, 24 hour access to records / record sharing/ sharing of information between care providers more joined up	Dementia services Dementia Café Other services for those in need of mental health support
Diagnostics	Technology – Telemedicine, Skype, remote access to care, telephone for remote advice for follow up. Etc	Local access to rapid advanced level first aid – The message is – would help with demand on A&E “help us to help ourselves” Key message – want face to face – most just need reassurance anxiety and uncertainty drives people to A&E unnecessarily can’t access GP quickly enough.
Technology – care skype/telemedicine /virtual information & sharing of information and 24 hour access to records and for general information.	More personalised care **Skewed listing position Chalfont Cited strongly in Chalfont see also below - continuity	Rehabilitation services Therapies Physiotherapy mentioned frequently
Information	Radiology /Imaging /Ultrasound **Skewed listing position Thame heavily weighted	Prevent social isolation need services/action to help
Communication across services and care providers.	Outpatients A broad range of out patient clinics cited. Most strongly desired in Buckingham but not skewed and eyes and ear care came up most	Step up/down/transitional beds **Skewed listing position Thame heavily weighted barely mentioned elsewhere. Beds not necessarily in hub or even the hospital but

	frequently along with podiatry	provision needs to be kept local. Access matters.
Transport to hub make hubs accessible. Good public transport access. Transport issues generally	Continuity of care **Skewed listing position Chalfont. See above personalised care.	24 Hour access to patient notes/information/record sharing
Joint 10th Reduce social isolation – health deteriorates.	*Joint 10th* Carers support	Community Hub with health, wellbeing and prevention centre / function Integrated services with social care Drop in facility Voluntary groups and charitable groups either present, input, or signposted to from hub Most mentioned, Citizen's advice bureau Carers Bucks, Age Uk / Age concern
Joint 10th Step up / step / down / transition beds **Skewed listing position Thame heavily weighted barely mentioned elsewhere. Beds not necessarily in hub or even the hospital but provision needs to be kept local. Access matters.	*Joint 10th* Childrens and Family Services	Telemedicine/Skype/Remote advice

5.3 Analysis of the feedback by showing which themes were brought up at every one of the 6 locations

i.e these are the only 9 subjects that were mentioned by every location:

- Rapid access / local diagnostics near home testing (LAB in a bag example type approach)
- Signposting / navigation to health and social care services /a single point of access
- Integrated health teams/Integrated health and social care teams/skills
- Therapies / Rehabilitation services and in particular physiotherapy
- All locations saw the hub as also having a health and wellbeing function a wellness centre promoting exercise and weight loss, enhancing self management providing health education and helping with prevention of ill health as well as having a social space most also saw a café as being part of the space.
- Skilled staff needed and idea to use hub as base to outreach into the community from.
- Outpatients – opportunities to run outpatient clinics more locally
- Virtual networks providing information for patients, sharing records, technology for improving better communications between teams and organisations
- Information sharing – includes records to improve care for patients moving from one care provider to another.

5.4 Common themes from the visions groups produced

There were some common key themes to the visions of participants in their groups. A few of these are listed below:

- People generally saw the concept of a hub as a physical space but there were discussions about whether it could be a virtual rather than a physical framework so virtual networks, remote telecare, telephone advice, electronic signposting, others suggested a hub which they saw as a mobile similar to the screening vehicle that could outreach to rural areas. Some liked the idea of a combination of a physical hub combined with some potential for a mobile as outreach from the hub
- Interestingly, there were several visions drawn of physical spaces but in round buildings.
- Majority of feedback for the vision showed a hub as a physical multifunctional space for health and social needs. There is strength in the feedback regarding the need to have a social space, drop in function and skilled clinical members of staff on site.
- It should offer co-location of services and there should be a multidisciplinary approach. Some saw it with GP present but more saw it without and many wanted any plans to develop a hub to avoid duplication.
- Voluntary and charitable groups are included in the vision either within the hub to provide input and support or, to signpost from the hub
- It is seen as a one stop shop
- It houses and delivers integrated services from health but also with social care services (joined up care)
- Signposting and navigation is seen as very important
- It needs to provide services that meet the needs across all ages including children and young families as well as older people.
- The hub is seen to offer a health, wellbeing and prevention function helping to keep people well, keep fit classes, falls prevention, cardiac and stroke rehabilitation classes rather than just treat illness, empower people to better manage long term conditions.
- People see it as providing a social space to help reduce social isolation nearly all visions created had a café in this space.
- Dementia services and a dementia café and making any facility dementia friendly as well as accessible for those with physical or sensory impairments.
- Phone access or drop in for advice people want to see someone quickly for advice and reassurance some said they don't always find NHS 111 helpful or appropriate for their needs and get directed inappropriately to care they don't need people want to see a trained professional – have confidence in the advice.
- We also heard of good experience of 111. People advised avoid making things any more complex
- It is seen as being in either a central location or an area with good footfall potential, must have good access via public transport, utilising an area already established that needs to be better used some community hospitals were suggested for this or other community established buildings that could be shared or developed. One comment suggested co locating fire, health and police together as a community hub.

To provide a flavour of the services that participants saw the hub providing spans a range of outpatient clinics with ophthalmology and audiology services being mentioned quite frequently. Telemedicine remote service provision, diabetes, therapies, podiatry, rehabilitation, rapid assessment and diagnostics, advanced first aid, dementia care,

children and young people and young family services are also clearly identified as are others.

5.5 Summary and Conclusions.
To complete our process, our plan is to draw together a wider overall report, mentioned earlier, along with the analysis of the personal visions received, the staff feedback (which is very similar) and views collected from our digital online feedback facility.

Despite the breadth of feedback, there are some common broad themes that can be established to help inform an overall view:-

The general vision appears to be a physical multifunctional space, with a multidisciplinary integrated model providing key services in the local community with a drop in capacity. It is seen as a one stop shop facility. Additionally, it is seen as a base for clinical staff to work within and to outreach from. A key element of feedback has been the need for better integration across health but also with social care. A hub is seen as needing to be accessible and on good routes for public transport.

Key services include rapid access to assessment, intervention and diagnostics, the lab in the bag example shown in the presentation appears to be well received and supported. The provision of outpatient services, therapies and rehabilitation, health and wellbeing services with prevention, health education and information also feature strongly. This includes services such as falls prevention, cardiac and stroke rehabilitation, and dietry advice. A form of advanced first aid for face to face reassurance is seen to potentially helpful to prevent people attending A&E unnecessarily and could be accessed via the hub. Services to improve support for dementia and dementia cafes were also seen as important.

Other elements strongly supported is improved use of technology e.g. Skype, telemedicine for remote access to clinical advice and information and some follow up appointments whilst remembering those that may not be able to access or use technology.

It was also felt that a hub would provide an additional function of helping to reduce social isolation which can lead to ill health thus preventing further need of care.

6.0 Recommendations

- The Board is asked to note and accept this paper as the report on the Your community, your care public engagement exercise
- Note that this engagement exercise will inform future discussions and care model development within Buckinghamshire
- Support continued engagement and communication with our communities on the development of health and social care services
- Feedback has demonstrated many similarities but also differences between locations and any future models may need to take account of local needs.

Tracey Underhill
Head of Membership, Engagement, Equality and Diversity *(operational)*
On behalf of
David Williams
Director of Strategy and Business Development.

Thames Valley Vascular Network Update September 2017

Appointment of Clinical Lead

Mr Jeremy Perkins, Consultant Vascular Surgeon at Oxford University Hospitals NHS FT was appointed as Clinical Director for the Thames Valley Vascular network in February 2017 following an interview process. The panel comprised Dr Shahed Ahmad, Medical Director, NHS England South Central, Dr Matthew Gibson, Interventional Radiologist from Royal Berkshire Hospital NHS FT and Dr Matthew Burn, Consultant Stroke Physician and SDU Lead for Stroke and Neurology from Buckinghamshire Healthcare NHS Trust.

The network is developing its work programme for the next couple of years and this is the focus of a Thames Valley Vascular network meeting on 15 September 2017.

Update on Service requirements for Phase III move from Buckinghamshire Hospitals NHS Trust to Oxford University Hospitals NHS FT which took place September 2016

The following additional requirements were included in the plan to move patients to Oxford.

• Consultant of the week on-call system	Completed
• Additional theatre access (10 hours)	Completed
• Additional angiogram facility	Completed
• Additional Critical Care bed days (5)	Absorbed (2)
• Additional ward beds (4)	Part Completed (2)
• Hybrid Theatre	Await new build

The additional 5 bed days for critical care, had been shown through experience not to be necessary, but 2 bed days had been added as a failsafe.The development of the hybrid theatre is likely to be at least another 24 months. The new theatre is needed for more complex procedures and is included in the future estates plans for the Oxford University Hospitals NHS FT.

There was an initial delay in providing the 4 additional beds meaning that, on occasion, beds had to be utilised in other parts of the hospital. The impact of this was monitored by the Trust and the network is assured that numbers of patients affected were small (a total of 5 between September and December 2016). As at June 2017, the Trust confirmed that two of the additional beds had been made available and the remaining two were added at the end of that month. However the serious shortfall in nursing establishment in Oxford University Hospitals NHS FT at the moment means that the Trust are currently unable to recruit sufficiently to safely support all four of these additional beds and therefore two have been temporarily closed. The Trust has instigated a number of measures to increase nursing establishment over the preceding months and has given assurance that as soon as they are able to staff the beds in line with NICE guidance, the designated additional beds will be re-opened.

The network is ensuring focus is maintained on the opening of these beds which are part of the original project commitment.

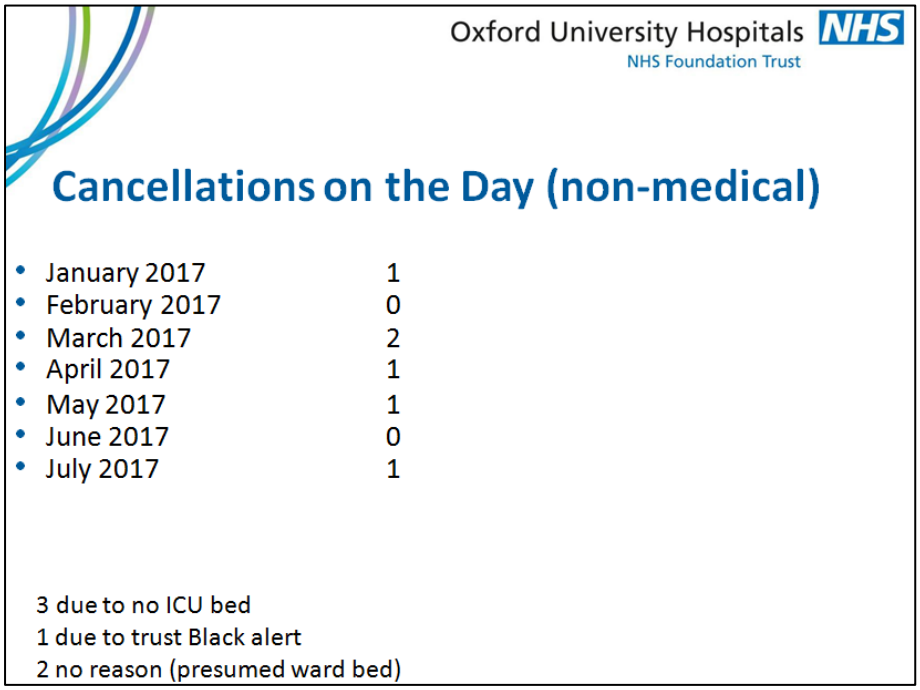
Patient Outcomes

Thames Valley network patient outcomes have been benchmarked with the South West network and have proved to be more favourable. The network also reviews the results from the Annual Vascular registry report to compare current performance to the previous year and other Trusts. The Registry report is usually published in the Autumn and can be accessed at the following link.
https://www.vsqip.org.uk/reports/2016-annual-report/ - Published in Nov 2016

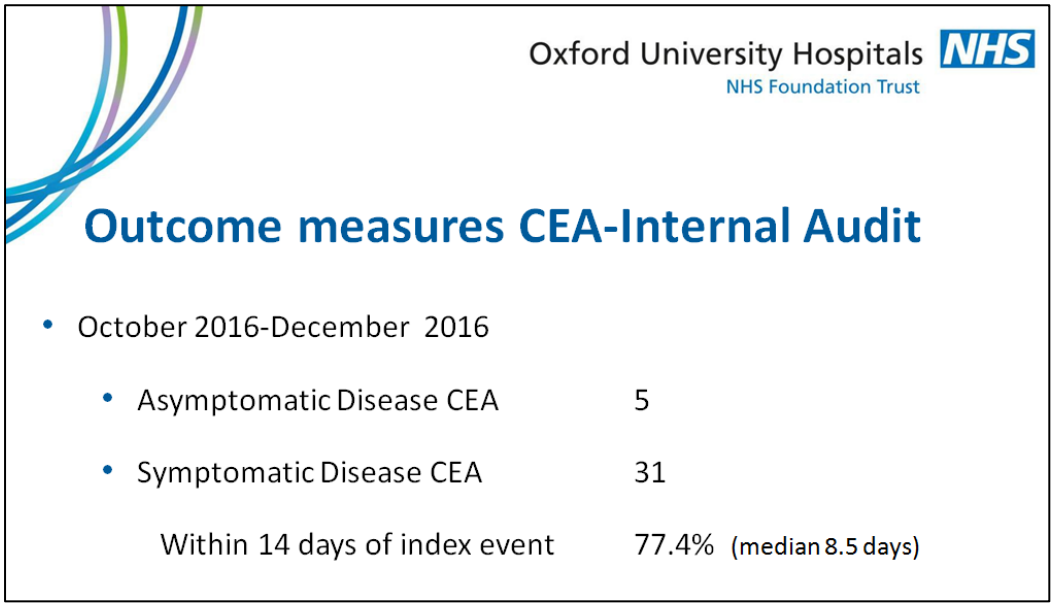
The Vascular registry report also includes detail on individual surgeon performance.
https://www.vsqip.org.uk/surgeon-outcomes/

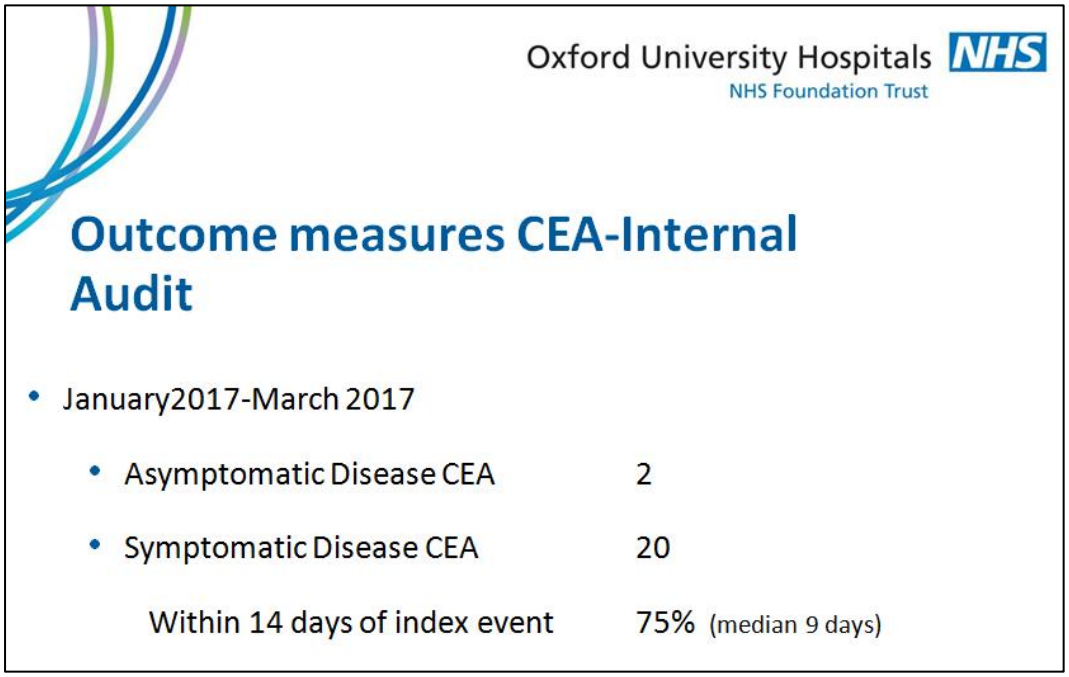
The following slides provide assurance on current performance.

They following slide outlines the number of cancellations on the day during the period of January – July 2017. The majority of these are out of the control of the Vascular network.

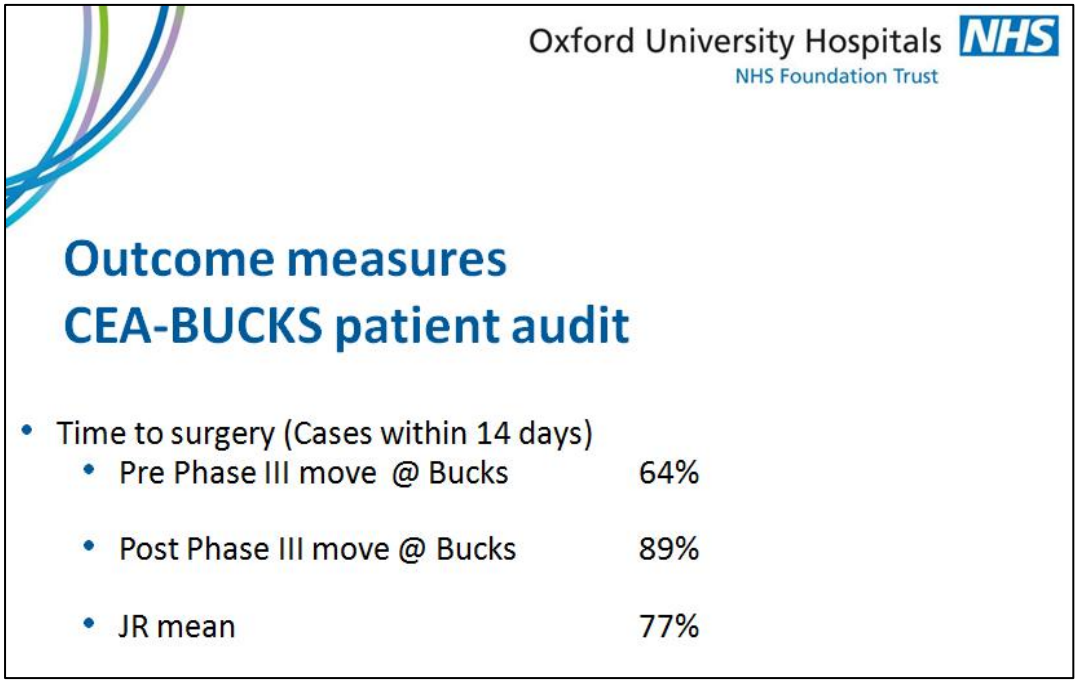


The following two slides show the number of carotid endarterectomies undertaken at Oxford during October 2016 – March 2017 and how many patients received their treatment within 14 days. This is a standard outcome measure.

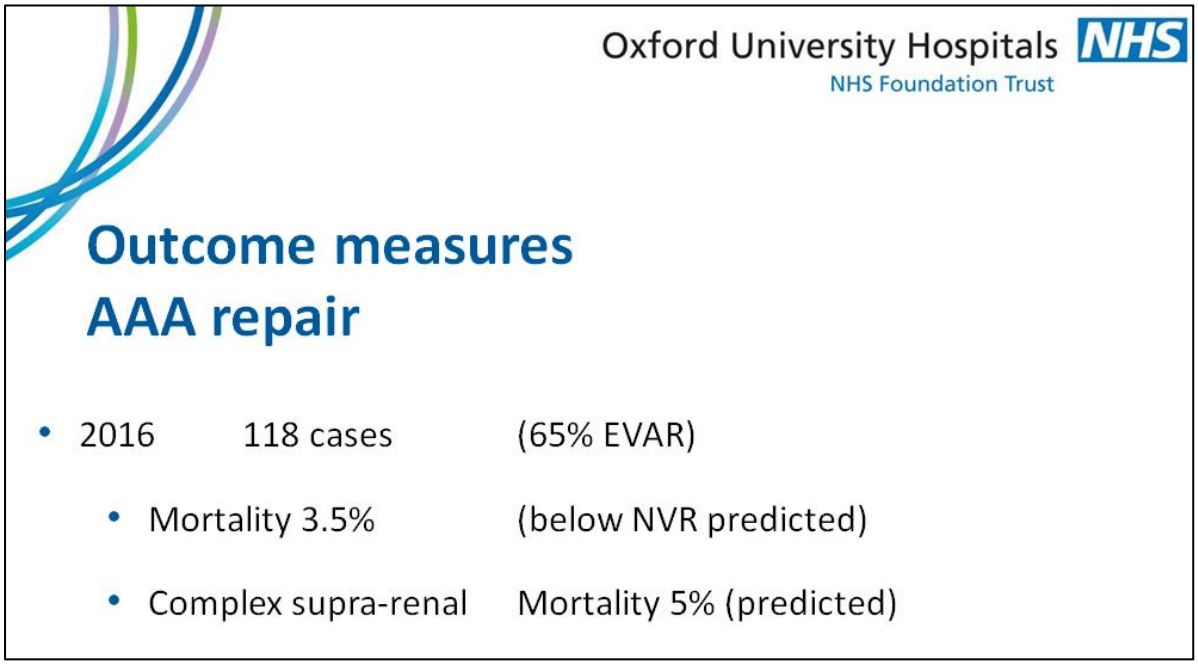




The following slide shows how many Buckinghamshire patients have had their surgery for carotid endarterectomies within 14 days. This is higher than before the move to Oxford and higher than the mean for the John Radcliffe as a whole.

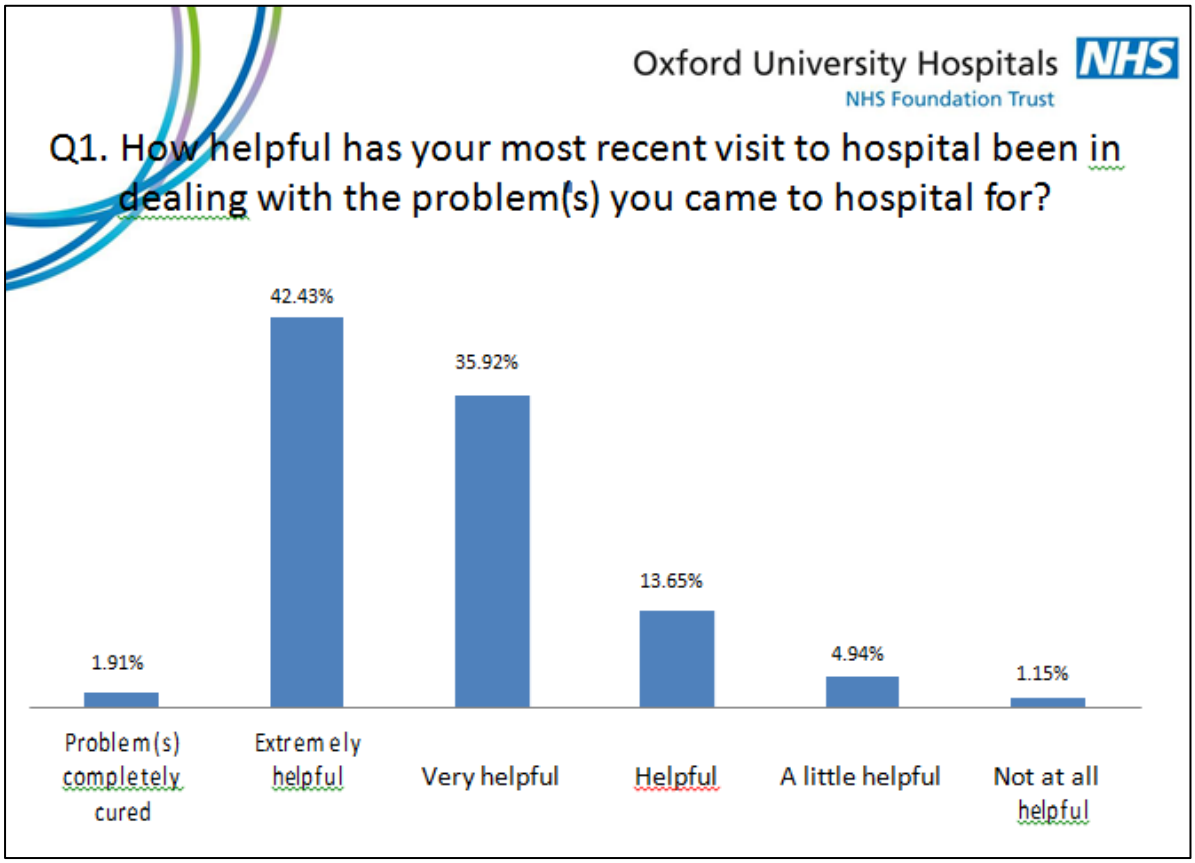


The slide below shows the number of Abdominal Aortic Aneurysm repairs completed at Oxford during 2016 and how many were performed by Endovascular aneurysm repair procedure. It also provides assurance that the mortality rate is within the expected predicted figures from the National Vascular Registry.



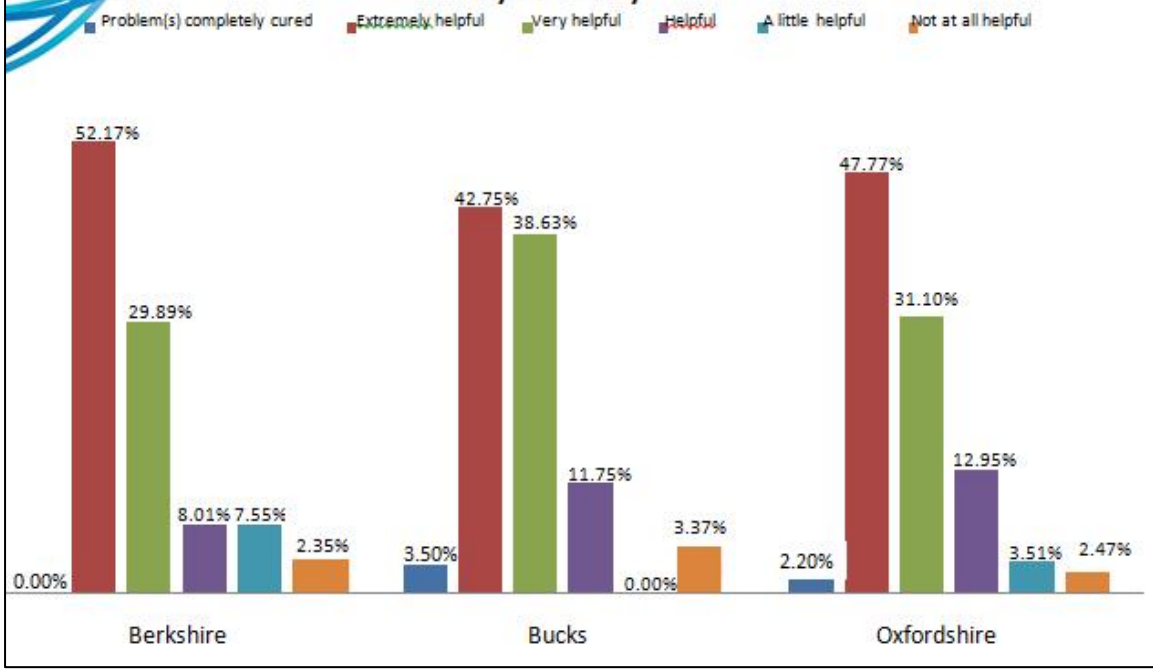
Patient Reported Outcome Measure results – December 2016 – June 2017

The patient survey work which has previously been presented to the Committee is based on the whole pathway and is a robust baseline for comparison. The results of the Patient Satisfaction survey between December 2016 to June 2017 are described below. Slides 2,3 and 4 show the experience by county to evidence that patients from Buckinghamshire have a similar experience to patients from other parts of the Thames Valley.



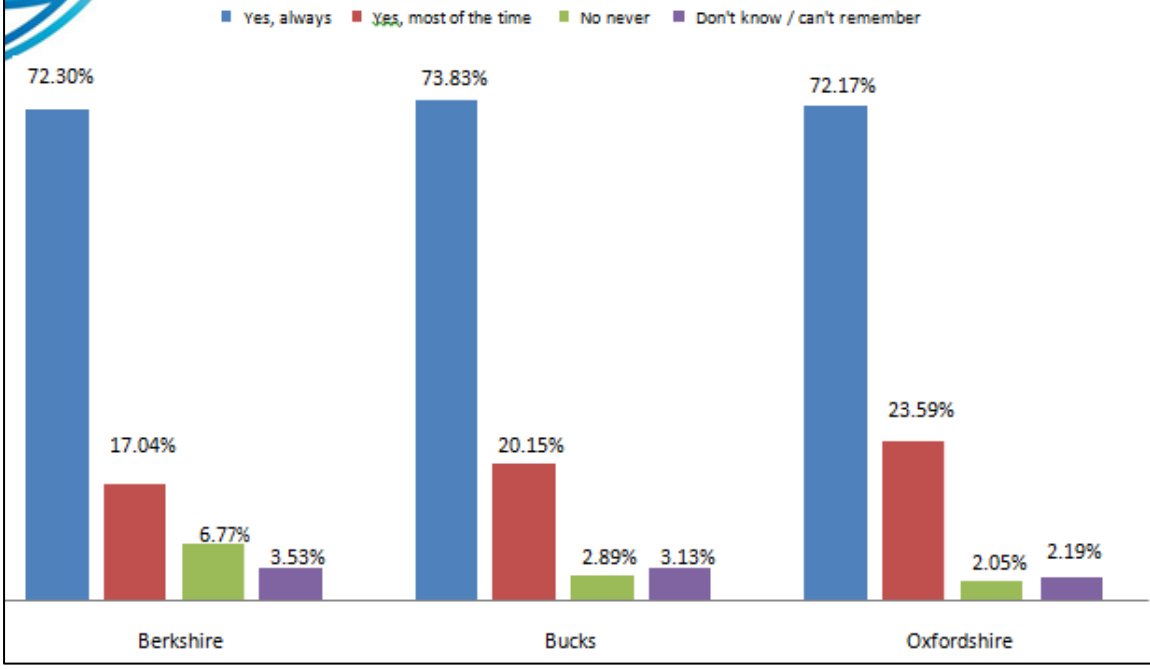
Oxford University Hospitals NHS
NHS Foundation Trust

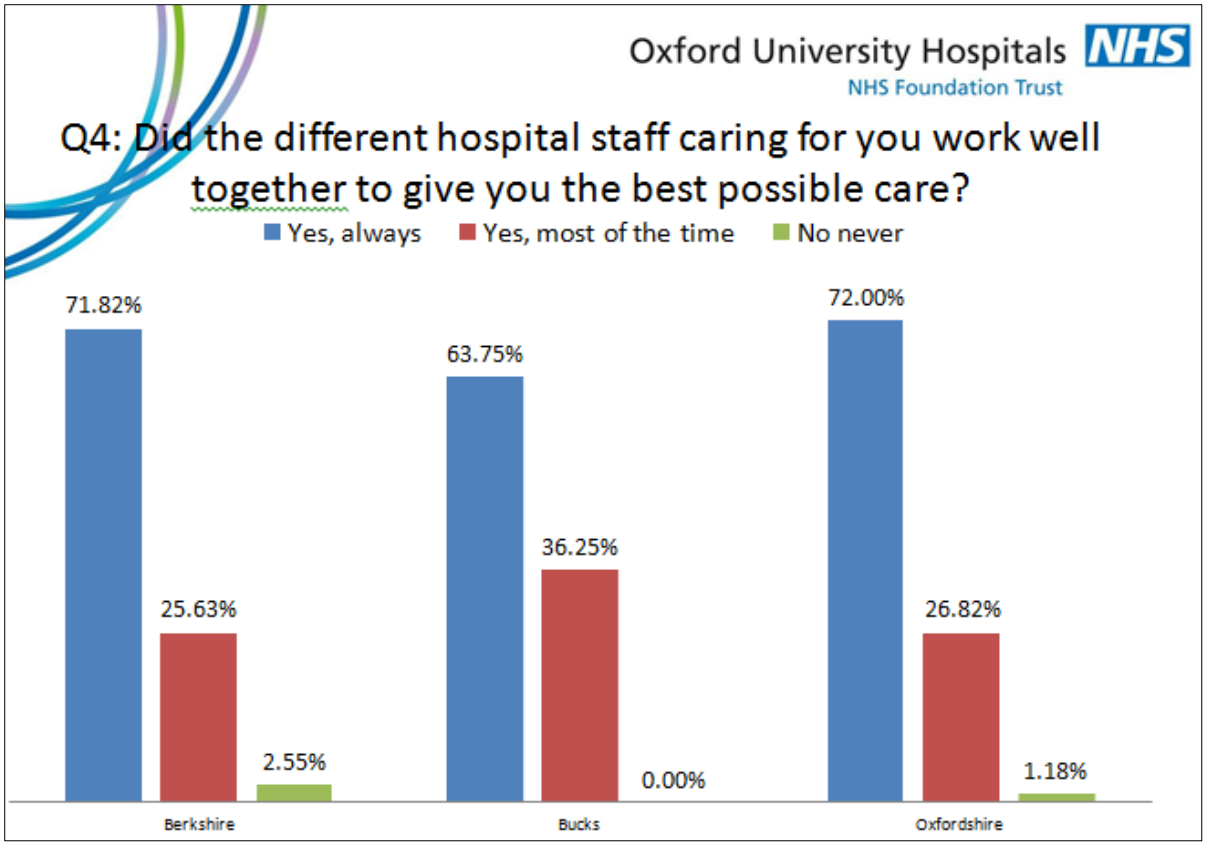
Q2. How helpful was your treatment? By county



Oxford University Hospitals NHS
NHS Foundation Trust

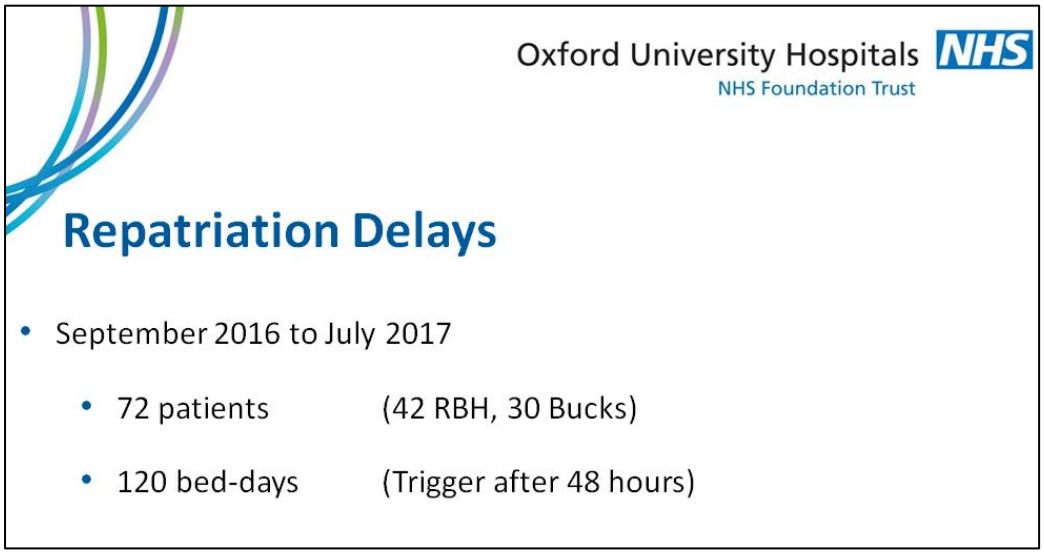
Q3. Clarity about appointments before your inpatient stay?





Repatriation

There continue to be problems with delays in repatriation of patients from Oxford to Buckinghamshire and Berkshire. A co-ordinator has been employed by the Trust and the situation is improving. This is a system wide problem and needs to be addressed by the whole system collectively.



Progress on Diabetic Foot care

Questions had previously been raised at HASC about diabetic foot care in Buckinghamshire. The following is an update from the Diabetes Network Manager.

Excellent diabetic footcare is a current priority for the Thames Valley Strategic Clinical Network (SCN) with the aim of ensuring all Thames Valley localities deliver services at least as good as the best performing CCGs in England.

The emerging development of an Accountable Care System in Buckinghamshire offers opportunity for all parties to work collaboratively and focus on reinvesting the current cost of reactive care (estimated at c.£1m over three years) earlier in the pathway, preventing limb loss and supporting patient mobility and independence.

Issues being addressed include;

- full engagement with all key partners in the delivery pathway
- ensuring full registration and submission of all cases to the National Diabetic Foot Audit
- review of current data to include the identification of demand and capacity constraints
- the provision of a forum for sharing and learning from root cause analysis when a limb amputation has been necessary.

Seven day services

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. The purpose of the standards is to deliver safer patient care; to improve patient flow through the acute system; to enhance patients' experience of acute care; to reduce the variation in appropriate clinical supervision at weekends and, potentially, to mitigate the excess mortality that has been shown in large studies to be associated with weekend admission to hospital.

Four of the 10 clinical standards for seven day services were highlighted as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

All trusts need to meet the four standards identified as being 'must do' by 2020 but all urgent network specialist services including vascular surgery, need to implement the four priority standards by Autumn 2017.

This will ensure that patients:

- Standard 2 - do not wait longer than 14 hours from admission to initial consultant review
- Standard 5 - get access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour
- Standard 6 - get access to specialist, consultant-directed interventions
- Standard 8 - those with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

The Thames Valley vascular network has previously audited patient records to check that timings are recorded and during August undertook a further audit to review compliance with the 14 hour window for consultant review. The results of this recent audit are not yet known but the network is confident of compliance with the required standards.

Buckinghamshire County Council

Health and Adult Social Care Select Committee

Inquiry Report

Accessibility and promotion of Services for Adults with Learning Disabilities

The Health and Adult Social Care Select 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 has the power to scrutinise all issues in relation to Health and Adult Social Care.

Membership of the Select Committee
Mrs Angela Macpherson (Chairman)
Mr Roger Reed (Vice-Chairman)
Mr Brian Adams
Mr Chris Adams
Mrs Margaret Aston
Mrs Patricia Birchley
Mrs Janet Blake
Mr Noel Brown
Mr Brian Roberts
Mrs Julia Wassell
Ms Shade Adoh, Local HealthWatch
Mr Tony Green, Wycombe District Council
Mrs Sandra Jenkin, Aylesbury Vale District Council
Mr Nigel Shepherd, Chiltern District Council
Mrs Wendy Matthews, South Bucks District Council

Membership of the Accessibility and promotion of Services for Adults with Learning Disabilities Review Group
Mrs Margaret Aston
Mrs Avril Davies (co-opted)
Mr Steven Lambert (co-opted)
Mrs Angela Macpherson
Mr Brian Adams

Contact:
Julia Woodman, Committee & Governance Adviser, HQ Member Services
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Further information on the Health and Adult Social Care Select Committee can be found at:
https://democracy.buckscc.gov.uk/mgCommitteeDetails.aspx?ID=137

Contents

Acknowledgments

The County Council has a critical role under the Care Act in ensuring the market place for Adult Social Care meets the needs of all users in Buckinghamshire who need care and support. The ambition is to continuously improve quality, choice and the cost-effectiveness of services.

We wanted to hear first-hand from service users, carers and providers to understand the current marketplace of activities and services for adults with learning disabilities.

We would therefore like to express our thanks and gratitude to those who participated in this Inquiry, in particular:

- Service users and Talkback who helped us understand a range of issues linked to accessibility of services such as choice and availability.
- Carers and Carers Bucks, who helped us to particularly understand aspects of safeguarding risk, provision of transport and the costs implications of the current marketplace.
- We would also like to thank the Learning Disability Partnership, The Learning Disability Providers forum and all the Council officers involved for supporting the Committee, providing information and support.

Executive Summary

Learning Disability and support services are high up the national agenda as a result of the Winterbourne Review in 2011 and the more recent 2014 Independent Review by Sir Stephen Bubb which has highlighted the need to accelerate the progress of reform. Locally Buckinghamshire County Council commits a significant proportion of its Adult Social Care budget to Learning Disability Services with a forecasted growth of residents with severe and complex needs.

The Inquiry group gathered evidence in different ways—speaking directly to frontline carers and service users through holding focus groups; research into best practice elsewhere; interviews with service providers, officers and through dedicated discussion sessions with the Learning Disability Partnership Forum and the Learning Disability Providers Forum.

Key findings included the importance of:

- Good public transport and travel training to enable adults with learning disabilities to have better access to a broader range of universal services independently.
- Providing information on services and activities available in a range of formats than can be easily accessed and understood by adults with learning disabilities and their carers.
- Offering a breadth of services and activities to meet a range of needs and abilities.

Adults with less complex Learning Disabilities in semi-independent living situations want to be supported to participate in universal activities, in universal and community settings. The cost of paying for support to access these activities individually is prohibitive and therefore greater availability of group activities is needed. User feedback also indicates the lack of evening activities and the success of local providers such as Gateway and Social Link highlights a real demand for this.

User, carer and provider feedback highlighted a lack of awareness of activities that are available locally. Currently there is no website or ‘whats on’ guide to easily assess what is available and accessible to adults with a learning disability. The adult social care brokerage service has a list of providers, but this is across the adult social care spectrum and not in the public domain. It is therefore difficult to establish how much of the issue of service provision is down to poor communication.

We found evidence that the market place of activities for adults with learning disabilities is very volatile and sustainability of provision is an issue. Opportunities for making links with other council services should be more extensively explored.

Although outside the scope of this Inquiry, a common thread from our carer and provider evidence was significant concerns regarding the provision of safeguarding support and awareness training for Users, Carers, and Care Support Staff. This could not be ignored and merited an extra chapter on safeguarding

Recommendations

Transport

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. (para 22-26)**

2. **Buckinghamshire County Council should coordinate learning disability awareness training for drivers within managed transport services, ensuring this training is annually refreshed and monitored. (para 27-29)**

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. (para 27-29)**

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. (para 30-31)**

5. **Buckinghamshire County Council should continue to invest in travel training – ensuring all appropriate Adults with Learning Disabilities can access this as part of the transition to independent living. (para 32- 36)**

Accessibility of Information on Community Services

6. **Buckinghamshire County Council should ensure its web pages are accessible for all users, with Adults with Learning Disabilities seen as a priority group. (para 37 -42)**

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 (para 37 -42)**

8. **Buckinghamshire County Council to evaluate and consider investing in a dedicated Buckinghamshire venue guide for users with disabilities, working collaboratively with District Councils (para 43-47)**

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 (para 43-47)**

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 Social Care Services) (para 48-52)**

Ensuring Universal Community Services and facilities are in place to meet needs

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. (para 53-64)**

Encouraging mainstream services to be more accessible

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 (para 65-70)**

Safeguarding

13. **Buckinghamshire Council to work with Local Safeguarding Boards to ensure safeguarding training and support by providers to service users with learning disabilities is provided with a particular focus on the following: avoiding exploitation, money management, relationship management and use of social media (para 71-72)**

Chapter 1: Inquiry Context

1. We agreed in early 2015 to have an Inquiry into Adult Learning Disabilities Services. The key drivers for having this Inquiry were linked to the national commitment to transform care and support for people with learning disabilities post Winterbourne Review. A review of Buckinghamshire evidence did not highlight significant issues to warrant a Select Committee inquiry in relation to preventing admission and the discharge process, due to a low and stable number of inpatients. In addition, a significant programme of work is in place to deliver the requirements of the Transforming Care Agenda. The Select Committee felt it was important to focus on issues linked to social inclusion and accessibility of services for adults with learning disability as this was highlighted in consultation evidence from CHASC as an issue.

2. We decided to use consultation evidence from users and carers to determine the focus recognising this covered a broad range of services. We identified service users' and their carers' experiences of accessing services and amenities through existing feedback and engagement groups. From this we then agreed on our focus (The full scope is attached at Appendix 1.)

3. The Committee appointed us (as an Inquiry Group).. The Inquiry Group comprised: Mrs Margaret Aston (Chairman), Mr Brian Adams, Mrs Angela Macpherson, Mr Steven Lambert and Mrs Avril Davies. Julia Woodman, Committee and Governance Adviser from the Council's Member Services team provided the officer support for the Inquiry**.**

4. The Inquiry Group gathered evidence through the following stages:

   - A 'scene setting' meeting with the Lead Commissioner for Learning Disabilities and Talkback in October 2015: This focused on current performance and consultation findings.

   - A meeting with the Service Manager of Learning Disabilities, Transitions and Continuing Health Care in November 2015 to consider, the care management process, care and support planning. The Review group considered the type of activity and choice available to users.

   - A meeting in December 2015 to consider best practice modes both nationally and locally.

   - A User focus group in January 2016 facilitated by Talkback which looked at:
     - Barriers to accessing services,
     - How people find out what is going on in the community
     - What was working well and what could be improved

   - A Carer focus group facilitated by Carers Bucks was held in February 2016, which focused on:
     - How carers access information about services (how many use the computer and use the internet),
     - Awareness of the Care Advice Buckinghamshire web site,
     - To gain a view on the accessibility of facilities and activities in the local community.

   - Attending the Buckinghamshire Learning Disability Providers Forum in February 2016 to consider areas that are working well, gaps in services and barriers faced by users, carers and care support staff.

- A series of one to one interviews the service providers conducted by the Committee and Governance Advisor and the Chair of the Review.

The National Context

Social inclusion and opportunities

5. Highlighted below are some of the key facts about adults with learning disabilities which impact on their life opportunities:

   - Education and training - just 1 in 3 people with a learning disability take part in some form of education or training.[1]

   - Independence – people with learning disabilities do not get the same chances as other people to gain independence, learn key skills and make choices about their own lives.[2]

   - Carers support - 7 out of 10 families caring for someone with profound and multiple learning disabilities have reached or come close to 'breaking point' because of a lack of short break service[3]

   - In addition, people with learning disabilities, especially those with less severe disabilities who do not use learning disability services, are more likely to be exposed to common "social determinants" of health such as poverty, poor housing conditions, unemployment and social disconnectedness.[4]

The Local Context

6. At the last census (2011) Buckinghamshire had a population of 505,280 of which an estimated 5890 (18-65) and 1370 (over 65yrs) were adults with a learning disability[5]. 1600 adults are known to the council and of these approximately 1000 are currently in receipt of services.

7. In line with the general population figures for Buckinghamshire, of the people with learning disabilities:
   - 37% live in Aylesbury Vale
   - 33% live in Wycombe
   - 17% in Chiltern
   - 13% in South Bucks

8. The adult learning disability social care service for Buckinghamshire is made up of two area based care management teams, responsible for the assessment of needs of individuals and their carers. They work with people from the age of 18 and may work with people into their 80's. They provide assessments, support plans, review plans and packages of support to ensure they meet the person's eligible care and support needs.

9. Currently there are a number of teams in Children Social Care (CSC). Some young people with a learning disability will be known to the Children with Disabilities team (CWD) and the Health Complex Care team and most young people with a learning disability will be known to the Special Educational Needs (SEN) team. A proportion of those known to these children's teams will transition to Adult Social Care (ASC) at the age of 18, (although if they stay in

[1] https://www.mencap.org.uk/get-involved/campaigns/what-we-campaign-about/employment-and-training
[2] https://www.mencap.org.uk/about-learning-disability/about-learning-disability/facts-about-learning-disability
[3] https://www.mencap.org.uk/sites/default/files/documents/2008-04/campaigns_breaking_point_0408.pdf
[4] https://www.improvinghealthandlives.org.uk/uploads/doc/vid_7479_IHaL2010-3HealthInequality2010.pdf
[5] Population statistics for Buckinghamshire – ONS 2011 (BCC, 2013)

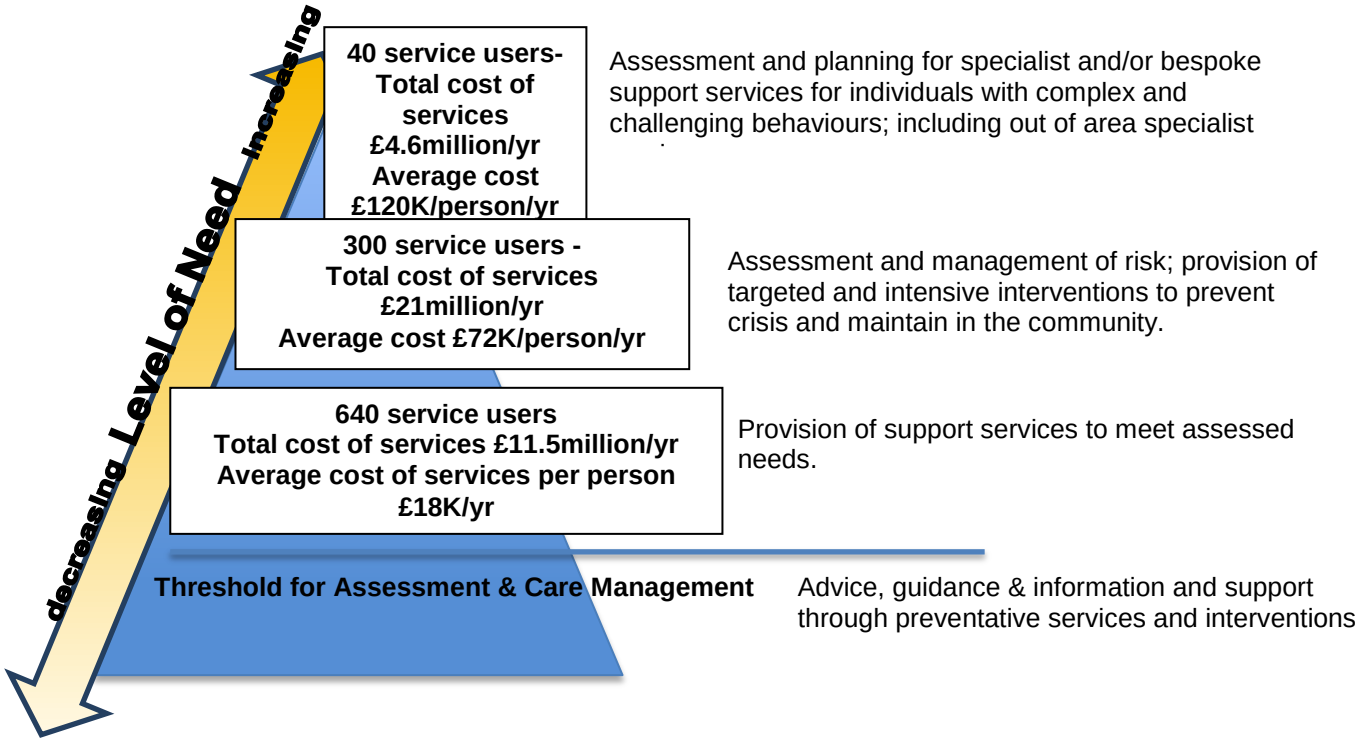
education they can be supported by the SEN team up to the age of 25 years); this usually numbers about 50-60 additional young people each year.

10. The Learning Disability Social Care service (LDSC) for Buckinghamshire is made up of two area based care management teams, responsible for the assessment of needs of individuals and their carers. In addition a small team is responsible for the assessment and support planning for those transitioning into adulthood.

11. Currently the number of adults aged 18yrs+ with learning disabilities, assessed as eligible and in receipt of services from the local authority in Buckinghamshire is around 1000. This number has remained relatively consistent over the last 5 years.

12. Individuals are in receipt of a range of care/support packages including supported accommodation, day services, supported employment, and domiciliary care.

Costs for services for people with learning disabilities increase in relation to assessed needs, and for some, the packages of care may be high due to very complex support needs. The diagram below gives an approximation of numbers of adults with a learning disability and costs in relation to assessed needs.



13. Where there are health needs, these will be met through health funding streams. For a small number of individuals who may have behaviours that challenge, support will be intensive and specialist at times and may require either short periods of time in specialist hospital settings or long term placements with specialist providers, either in county or out of area. Currently this funding is in excess of £8million per year (including Continuing Health Care).

14. Specialist learning disability health services in Buckinghamshire are currently provided by Southern Health Foundation Trust. This service is commissioned and funded by the Chiltern Clinical Commissioning Group; the total budget for this service is £3.4 million and provides specialist community assessments and interventions as well as inpatient beds at an assessment and treatment unit in Wycombe.

Future demand

15. Estimated projections regarding the population of adults with learning disabilities in Buckinghamshire have been sourced through Planning4Care.[6]The overall number of people with learning disabilities aged 18-64yrs is projected to decrease, whilst the number of people with profound and multiple learning disabilities is projected to increase (table 1).

	2011	2021	2031	% Change 2011-2031	
				Buckinghamshire	England
PMLD[7]	150	169	199	30%	44%
SLD[8]	1130	1101	1077	4.5%	7%
MLD[9]	4610	4498	4356	5%	5.5%
Total	5890	5768	5631	4%	6.5%

Table 1: Estimated projections for number of adults with learning disabilities (by severity) aged 18-64yrs, in Buckinghamshire. Source Planning4Care 2010

16. The population of older people (65yrs+) with learning disabilities in Buckinghamshire, is projected to increase over the next 20years (table 2).

	2011	2021	2031	%change 2011-2031	
				Buckinghamshire	England
PMLD	20	30	40	100%	102%
SLD	160	190	240	50%	50%
MLD	1190	1500	1840	55%	49 %
Total	1370	1720	2120	55%	50 %

Table2: Estimated projections for number of adults with learning disabilities (by severity) aged 65yrs and over, in Buckinghamshire. Source Planning4Care 2010

17. Both older people with learning disabilities and those with profound and multiple difficulties will require complex long term case management support.

Current performance

18. The Annual Joint Health and Social Care Self-Assessment Framework enable authorities to assess and compare services for users with learning disabilities against the following themes:

Staying Healthy – making sure people with learning disabilities can access health services, including GPs, chemist, dentists and at the hospital.

Keeping Safe – being safe at home, whilst in hospital or out and about in the community.

Living Well - making sure people with learning disabilities get the same life chances as other people, are part of what happens in their area, and can access universal services.

[6] Source Planning4Care estimates 2010
[7] Profound and multiple learning difficulties
[8] Severe learning difficulties
[9] Moderate learning difficulties

19. The table below highlights the areas where Buckinghamshire is doing well and areas for improvement. [10] (table 3)

	Areas of good performance	Areas for improvement
Staying Healthy	• We have a Staying Healthy working group, representing healthcare providers, including GPs and hospitals • GP registers include all those with learning disabilities known to social care • Annual Health Checks have increased • There are two new Learning Disability Liaison nurses in Buckinghamshire hospitals • There is a new flagging system at the hospital so people know if an individual has a learning disability and may need additional support • We have developed a Health Passport for people to keep all their health information in one place	• Information recording and sharing amongst health care professionals • Make sure people with learning disabilities and their families know about the support available • Improve health awareness of people with learning disabilities and those that support them • Improve the skills of mainstream healthcare to better support people with learning disabilities
	Areas of good performance	**Areas for improvement**
Keeping Safe	• Contract managers meet regularly with our big service providers and have close links with Care Quality Commission (CQC) • Commissioners liaise with NHS England and Monitor • There is a well-established safeguarding board in Buckinghamshire • People with learning disabilities are included in the safeguarding forum • There are positive initiatives for keeping people safe e.g. Safe Place Scheme • Commissioners closely monitor all those in specialist hospitals • People are regularly asked their views on services and involved in developing and tendering new services • Talkback make sure the voices of people with learning disabilities are heard.	• Making sure the views of the Learning Disability Partnership Board are heard by those making decisions • Involving people with learning disabilities in checking the quality of services
Living Well	• We have some joint funded and services • Front line staff work well together to deliver the right support to people • We have a well-established supported employment service and many work related opportunities for people with learning disabilities • There are examples of how people with learning disabilities can access some ordinary places and services • Accessibility has improved in most places	• Ensuring people can access universal services and don't have to rely on special services all the time if they don't want to • Not all our information about services is accessible • People still cannot access ordinary sports and leisure services when they want to • People with learning disabilities still experience discrimination in their own communities

[10] Current performance as at 30th Oct 2015[11] https://www.amey.co.uk/amey-in-your-area/london-south-east/buckinghamshire-transport-services/

Barriers to social inclusion

20. National evidence and local evidence gained by Talkback (a user led engagement and self-advocacy charity) from users has highlighted the following barriers:

    - Prejudice and stereotypes
    - Inflexible organisational practices
    - Inaccessible information and a lack of some information
    - Inaccessible buildings
    - Unsuitable transport
    - Exclusion from decision making

    "More needs to be done to strengthen the support framework that enables people with learning disabilities to achieve social inclusion…. we need to think about how well people are supported to access the life they want, whether or not public services are really accessible for all' Talkback.

21. From the perspective of users, carers and providers, the key issues we heard were around transport, finding out about services, how accessible they are and provision of support and training to access services. In addition we have also looked at the safeguarding implications of current provision. The following chapters set out the details of our findings and recommendations in relation to these issues.

Chapter 2: Accessibility of Transport

Key findings

- Transport is a vital part of accessing services and living an independent life for adults with learning disabilities.
- Bus timetables are not accessible to adults with learning disabilities in Buckinghamshire, and real time display boards are vital to enable access to the right bus service.
- Significant issues around transport were highlighted in numerous historic consultation exercises with adults with learning disabilities and yet currently the perceptions of poor accessibility remain
- An inconsistency in the level of disability awareness of drivers employed by Buckinghamshire County Council supported transport services is leading to a lack of confidence in the service by users and carers.

Ensuring User and Carers experiences effectively inform service improvements

22. Our key findings on the experiences of users and carers were as follows:
    - The taxi and transport service provided by Amey [11] was used by significant numbers of the focus group to transport them from home to college. User experiences of this service were mixed. The majority of 10 users in our focus group felt that multi-user taxis were daunting. In addition, journeys were made more stressful if drivers tried to engage in inappropriate conversations. Two incidents of users being dropped-off in the wrong location were reported.
    - The majority of users in the focus group reported experiencing long journey times due the volume of people each taxi took home. Examples were given of a normal 20 minute journey taking around 1.5 hours. The Carers focus group said that they would like a direct line to call in the event of a serious delay, to find out what, if any issues there are. Presently a Carer has to call a Social worker, who calls Amey, who then calls the taxi company, making communications difficult

23. The evidence we received from the Head of Client and Public Transport highlighted that there had been significant change during 2015, as a significant amount of transport provision was transferred from the Communities, Health and Adult Social Care Services Business Unit to the Amey Client Transport Team. Difficulties were experienced during the handover, leading to the service reporting a high volume of complaints. Whilst the services were now working better, we were told that improved procedures are being put in place to support better engagement with colleges and services to prevent the issues arising again.

24. We note that services managed by the Amey Client Transport team will from 1 April 2016 come back in-house, forming part of the Client and Public Transport team forming up under the Transport, Economy and Environment (TEE) Business Unit. The integrated in-house team

[11] https://www.amey.co.uk/amey-in-your-area/london-south-east/buckinghamshire-transport-services/

will continue to work with Talkback and the Learning Disability Partnership in understanding user issues with public transport, subsidised public bus and client transport services.

25. As part of this Inquiry we have not looked in-depth at the contract management arrangements in transportation as this was outside of the scope of our work. We can report that the User and Carer evidence of the home to college transport gained by the Inquiry group is post the 2015 changes and indicates that more effective mechanisms need to be in place to ensure user issues lead to review and change.

26. We are therefore seeking assurances going forward that the KPIs include indicators of complaints and customer feedback so that we have confidence that the contract management process will identify and enable systematic capturing of the experiences of adults with learning disabilities as part of this process.

Recommendation

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.**

Disability Awareness Training for Drivers

27. Our key findings on the experiences of users and carers were as follows:

- Bus and taxi drivers' lack of learning disability awareness – users gave examples of brusque and unhelpful staff which acted as a disincentive to access transport independently.

- A perceived lack training of drivers and escorts reported by Carers due to the way their son / daughter is spoken to and physically lifted / manoeuvred.

28. We were provided with assurances from the Head of Client and Public Transport is that providers under contract to the Council to deliver transport services undergo stringent checks that go beyond formal DBS checks and are required to undertake training and pass assessments covering communication and technical skills, including physical handling and use of wheelchair accessible transport. The public transport team (currently under TfB but from 1st April part of the TEE Client and Public Transport team) also works with bus operators to improve disabled access on buses, at bus stations, bus stops and for public transport information training and assessment processes.

29. Despite the current steps in place by the Council to support bus providers and taxi companies to ensure their staff are aware and considerate of the needs of adults with disabilities, we concluded that more work was needed as the experiences of users & carers we spoke to (as well as supporting evidence from the TalkBack Survey) showed that lack of awareness by drivers was still a barrier. We therefore ask for more targeted training in learning Disability

Awareness to drivers, to improve communication and that should be reinforced via annual training and assessment.

Recommendations

2. **Buckinghamshire County Council should coordinate learning disability awareness training for drivers within managed transport services, ensuring this training is annually refreshed and monitored.**

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.**

Fair4All

30. We found that users and carers reported a perceived high cost of taxis to enable participation in any evening activities. Users also reported paying high charges for journeys and a feeling that they were being exploited.
31. We are aware of the Fair4All taxi licencing project in Buckinghamshire and part of the code of practice includes to 'agree a fair price for the journey before it starts. A fair price means the normal price for the taxi will be charged and there will not be an extra change just because the customer is disabled.' Evidence gained from the Learning Disability Partnership indicates that although the scheme was launched in 2014 adults with learning disabilities or carers had limited awareness of the scheme. The scheme should be more widely promoted, using Easy Read formats and this would help to allay fears and anxieties users have about exploitation and poor disability awareness amongst taxi and mini cab operators.

Recommendations

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.**

Travel Training

32. Travel training is designed to help people with learning disabilities become confident to travel independently. Travel training can help overcome barriers to:
    - Employment
    - Social inclusion
    - Independent journeys to school/ college

33. Trainers will accompany trainees on their journeys, providing encouragement and guidance until trainers feel confident that trainees have developed the appropriate skills to travel independently. Trainers are there to develop skills such as:
    - Coping with traffic on major roads, with and without pedestrian crossings
    - Learning the highway code
    - Confidence in using buses and trains

- How to plan a journey
- Familiarisation of travel routes and timetables
- Identification of landmarks
- Where to get help
- Personal safety

34. The user focus group highlighted that a number of users were waiting for travel training which they had not yet received. The training is delivered by Talkback but the company is reliant on resources for this. The evidence gained from the Talkback facilitator at the User Focus Group is that current provision is piecemeal and reliant on supported funding from charities such as local Mencap.

35. There is no statutory responsibility to provide travel training and responsibilities for travel support do not sit clearly within one service area within the Council and currently it sits across, as the CHASC BU, Children's Social Care and Learning (CSL) or TEE BUs.

36. We believe that it is in the Council's financial best interests to provide sufficient travel training to meet demand; as this will reduce the high cost of paying for taxis. Our evidence indicated that there was a need for more investment to be made in travel training, in particular for young adults with learning disabilities who are accessing the home to college taxi and bus services.

Recommendations

5. **Buckinghamshire County Council should continue to invest in travel training – ensuring all appropriate Adults with Learning Disabilities can access this as part of the transition to independent living.**

Chapter 3: Accessibility of Information on Community Services

Key findings

- Currently there is no easily accessible information available for adults with learning disabilities, carers or providers on 'what's on' in Buckinghamshire.
- Our consultees strongly supported the need for 'what's on' in the community information housed in one place.
- There is a need and demand for an online solution to help provide better information on 'what's on'.
- Information should be made available to those who are not IT literate.

Access to Community Information

37. The way in which adults with learning disabilities access communications may be different to non-disabled people; and people with different impairments have different needs or experience different 'barriers' to accessing information. There is no one-size fits all approach. Accessibility is about ensuring that adults with learning disabilities can access communications through media such as a website, leaflets, email or, telephone and that there are no barriers that prevent this. A barrier to access might be only providing materials in hardcopy, font size 10, or only offering one type of communication route e.g. telephone contact details but no email or postal address. Making *something* accessible means providing alternative means (formats or options) to access what's on offer if the 'standard' offer is not accessible. An inclusive communication is designed to reach as broad and diverse an audience as possible with accessibility for different groups built in and part of the core communication.

38. We held a dedicated user focus group from which a key feedback was that users are finding out about services through the BCC Contact centre and leaflets but are not accessing information online via the Council's website.

39. A providers' forum for adults with learning disabilities and the Carers focus group also stated there were difficulties in finding out about activities and clubs as they are not well advertised.

40. The Carers focus group expressed difficulty in finding out about services and finding the appropriate level of support and help. Not all carers accessed the web and therefore were not aware of the Carers Advice Bucks web pages. Older carers used the telephone, word of mouth and Carers Bucks to find out what services are available.

41. We investigated what was available for users and carers and found that the main source of information is currently through a new web site Carers Advice Bucks, an organisation commissioned by CHASC BU. The Carers Advice Bucks website provides important advice and support features and ensures that the Council is compliant with the Care Act 2014. Its challenge is providing a breadth of accessible information in a dynamic format and its .org web address means it does not feature in standard searches for support or advice. The User IT focus group also found the web site difficult to navigate.

42. In response to the user evidence, the Head of Digital HQ thought that a more dynamic 'what's on' activity guide should be explored on a community-wide basis. We conclude from our evidence that work is needed to improve the accessibility of the Council and community information available to adults with learning disabilities, as well as ensuring that online information is promoted to this audience.

Recommendations

6. **Buckinghamshire County Council should ensure its web pages are accessible for all users, with Adults with Learning Disabilities seen as a priority group.**

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**

The Accessible Information Standard

43. We also received evidence from the Customer and Communication Team, HQ, regarding a new Accessible Information Standard for Health and Social Care Services. The Council will need to be compliant with the 'Accessible Information Standard for Health and Social Care Services', by 31st July 2016. Work is underway and it is understood that a more realistic timeframe for the Council to achieve this will be the end of 2016. The Council will need to need to establish a clear, local policy and processes for following the Accessible Information Standard.

44. The Head of Digital HQ stated that the Council will also need to develop guidance to ensure that BCC's customer-facing digital tools comply with the Accessible Information Standard.

45. We see the Accessible Information Standard, coupled with user and provider evidence as providing a strong business case for more dynamic 'what's on' digital information and providing users with an easy mechanism to find out about the accessibility of local services. In order to ensure the new accessibility information standard is followed, there will need to be staff training across the Council.

46. In regards to the Carers Bucks website, we were concerned about the lack of any awareness that the users and carers focus groups had of this as an information source, specifically in relation to Adults with Learning Disabilities. We recognise the importance of this website for general information and advice for carers overall, but question whether the website is working effectively as an information portal specifically for Adults with Learning Disabilities.

47. An evaluation should be made as to whether this information source is effective in meeting the needs of Adults with Learning Disabilities, and to fully consider other options. For example, to develop accessible information for Adults with Learning Disabilities either 'in-house' on the BCC website or via other third party solutions. A clearer link needs to be made through the Council's .gov.uk address as users and carers consulted were unaware of the resource.

Recommendations

8. **Buckinghamshire County Council to evaluate and consider investing in a dedicated Buckinghamshire venue guide for users, working collaboratively with District Councils**

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

DisabledGo – A web-based information guide on accessible local and national services

We researched how other local authorities were promoting the accessibility of a range of universal services in their areas.

48. One national service that stood out and is used by over 250 public and private organisations is DisabledGo. www.disabledgo.com/. DisabledGo works with local authorities to integrate their accessibility information into area specific websites, directories and access guides that covers shops, leisure, and culture and community services. The information collected by DisabledGo surveyors is developed in consultation with disability organisations to ensure that it meets the needs of people with a wide variety of impairments.

49. We see the advantages of DisabledGo as follows:
    - It allows an up to date guide of services that could be used by carers and community organisations.
    - It would help to further promote disability awareness and encourage businesses to become more accessible.
    - It is developing all the time and will include an autism friendly assessment (this is currently being piloted).
    - It would be complementary to the development of community 'what's on' digital guide.

50. Central Bedfordshire Council has used DisabledGo since 2011 and stated that:

    'Whilst we knew that the information would be helpful for people with physical disabilities, we have also found that it's really helpful for people with mental health and learning disabilities who may be anxious about accessing a new venue and who have been able to use the website to prepare themselves before a visit… Many council venues are featured on DisabledGo and we have added numerous link pages on our own Council website to help people access information and also to promote the issue of disability access….. We have seen over the years that as access information is updated, that some venues have carried out improvements. We also have venues who approach us and ask to be featured, so I think that some organisations are starting to see the value of providing disabled people with this type of information.'

51. For Suffolk County Council, the annual access survey demonstrates improvements services have had to make to ensure a DisabledGo entry. Access improvements have included:

    - The installation of a hearing assistance system
    - Information being available in different formats – large print or Braille
    - Staff at a venue receiving formal disability equality or awareness training
    - Being able to contact the venue by fax or email
    - The installation or refurbishment of an accessible toilet
    - The addition of accessible parking bays
    - A lowered section fitted to a reception desk
    - Hoists being fitted in changing rooms or in leisure facilities

- Installation of automatic doors

52. We view the DisabledGo webpages as a powerful mechanism for promoting good accessibility practice amongst local businesses in addition to providing users and carers with a clear guide before they visit any site or service. We also think it would be impossible for the Council to provide such information in-house as all venues would have to be inspected on an annual basis. We see having an accessibility guide to local shops and businesses as complementary to a more bespoke community activity portal. We also think investment could be considered as a joint project with district councils as it has the potential to increase tourism in Buckinghamshire.

Recommendations

10. Buckinghamshire County Council to evaluate and consider investing in a dedicated Buckinghamshire venue guide for users with disabilities, working collaboratively with District Councils

Chapter 4: Ensuring universal community services and facilities are in place to meet needs

Key Findings

- Post 16 provision and apprenticeships is highlighted as an example of good practice, recognised recently in the national press.
- The ambition for many users is to live independently and to have phased support to enable this.
- Adults with learning disabilities, particularly those who are semi-independent, do not want to use Day Opportunity Centres (DOC's) and are looking for support to access mainstream services, in mainstream settings,. Affordability is a key factor. Carers of adults with complex needs who are using DOCs stated they have curtailed usage due to high costs and this has respite implications.
- A lack of breadth of group activities across Buckinghamshire has implications for the high costs of social activities for users. It means that users who want to go to activities such as the cinema and need support will have to pay for themselves and an escort. It means a cinema trip with a £15per hour escort could cost over £50.
- Smaller providers find it difficult to sustain provision and cannot weather dips in use or the time it takes for usage to grow.
- 'Taster' sessions were highlighted as a mechanism to find out about what they liked to do and to stimulate interests and hobbies.
- Carers underlined the importance of bespoke activities to fit a wide range of needs.
- Ngage (run by Talkback,) The Gateway Clubs (facilitated by local Mencap), Get Active and Social Links (a Social Enterprise) were given as examples of success stories.

53. Promoting a diverse and sustainable market arises from Section 5 of the Care Act 2014. This sets out new duties for Councils' with regard to shaping and managing their local care markets. There are duties placed on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways. The ambition as set out in the Care Act is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

54. We interviewed the manager from Social Link as this organisation featured prominently in the focus group and consultation evidence as a success story in terms of providing more choice based services and a sustainable business model. Social Link evolved from a youth club in Gerrards Cross for people with a learning disability. The charity has been running for five years and at the time there were limited services for users aged 25 years and over with less complex needs. It is a charity that is self-funded via clients' Direct Payments and benefits. The service has established a base of volunteers, some of who are former users of services and have gone on to take paid positions in the charity.

55. The Charity has a focus on developing and maintaining independence and social skills. The emphasis is on a less structured approach to create a more 'real world' feel. Activities provided

will be based on the needs and wishes of the individuals attending the service. Social Links offer courses in areas where there is a need: relationship training, drug and alcohol awareness, first aid, safeguarding: using a mobile phone and surfing the internet safely, 'stranger danger'. It encourages healthy lifestyles approaches through promoting variety of physical activities for all abilities, cooking classes and healthy eating making users aware of the sugar content of foods and drinks.

56. The service cannot meet all the demand and success is down to regular consultation and shaping of services and activities around user choice. The manager commented that user's expectations can be low when they arrive at Social Link, but horizons are expanded through offering broad choice which puts users at the heart of the development of activities.

57. In addition the service offers a weekly session in Wycombe as a mechanism for users to discuss a range of issues, which is arranged in the afternoon to enable those who work to attend. The manager commented that there was a demand for users in independent and semi-independent living situations to discuss a range of issues such as money management. A number of users were getting into debt with mobile phones and taxi services with no-one to discuss the issues with.

58. We understand that Prevention Matters works with clients such as those seen by Social Link. Prevention Matters also employ Community Link workers to identify gaps and help to support organisations. However funding is limited and is for the whole of adult social care services. Funding is currently in place until August 2016.

59. We interviewed the Senior Joint Commissioner for Adults with Learning Disabilities who stated these types of services meet the needs of those users with Direct Payments or those accessing prevention services as they sit just under the eligibility criteria for a set package of council funded support. The Commissioner added that this type of evidence informs the Joint Strategic Needs Assessment (JSNA) updated by the Public Health Service.

60. We interviewed the Brokerage manager within CHASC BU. The manager stated that an extensive list of providers was put together across the Direct Payments market place and she did not feel the issue was lack of breadth of activities but more a reluctance in some users to try new activities. The manager added that the Brokers role is also to provide market gap intelligence to the Commissioning Team, where more strategic market place issues could be identified.

61. We tried to establish through our Inquiry if there was a need for more provision community activities for adults with learning disabilities (feedback from the users & carers) or whether it was more the case that users did not wish to try new activities. We did not have any specific evidence of 'new' activities where that had been a low take up. We requested a list of providers specifically for adults with learning disabilities to consider the types of provision offered. However, there is no segmented list specifically showing provision for adults with learning disabilities as there is only one list of providers for Adult Social Care overall.

62. We think the consultation evidence from the focus groups is clear that users, particularly those who are semi-independent, do not want to use Day Opportunity Centres (DOC's) but want support to access mainstream services, in mainstream settings.

63. We note that a key part of the sustainability of services like Social Link is to proactively stimulate choice, regularly consult and encourage the shaping of services by users. The users accessing these services are using their Direct Payments to pay for activities. Social Link has created a success story from a new choice based market place

64. We concluded that our evidence is that users and carers perceive that there is a gap in provision, particularly in regard to community services for those with less complex needs and we were not provided with any specific evidence by the commissioning team to demonstrate that this is incorrect. We therefore can only conclude that either that there is a real gap in provision for activities for adults with learning disabilities or that there is a gap in communications. Either way, there is an issue to addressed. We do not think that the information contained within a JSNA chapter is sufficiently detailed to provide information on the current provider market and user needs for adults with learning disabilities. We therefore are asking for the commission team to undertake work to map current provision and either demonstrate that there is sufficient activities in the marketplace and communicate this provision to potential users; or to identify and fill gaps in service provision.

Recommendation

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.

Chapter 5: Encouraging mainstream services to be more accessible

Key findings

- The Safe Places Scheme is seen by adults with learning disabilities as a good idea and provides reassurance in accessing mainstream services independently
- Kent's 'charter' of accomplishments is linked to helping people to navigate and connect to community resources. Kent Libraries aimed to welcome adults with learning disabilities into libraries as part of this initiative. Work undertaken won the 2011 Libraries Change Lives Award from the Chartered Institute of Library and Information.

65. We considered a range of evidence looking at making mainstream services more accessible to users with a range of disabilities. We have highlighted one local scheme Safe Place, which is a good example of a low cost solution that has high user awareness and buy-in. We also reviewed schemes from other local authorities and considered Kent's Accomplished Community worth highlighting due to its award winning work with adults with learning disabilities. In looking at the Kent initiative, we considered what elements could be replicated within a local setting.

The Safe Places Scheme

66. The Scheme provides reassurance to vulnerable people, and to their families and carers, so that they have a means to alert someone of any potential risk or emergency if they are out alone. The programme is co-ordinated by district councils in Buckinghamshire with support from Thames Valley Police and local voluntary organisations. Over 80 shops and services across Buckinghamshire have signed up so far.

    Martha Edwards, Community Safety Coordinator, County Council, is currently working with the Council's Communications Team to more broadly advertise the Scheme to increase business sign-up. The service is currently developing an online training package for businesses and a short leaflet on disability awareness which will be handed out as businesses sign up to the scheme. A publicity campaign will be launched for the summer. The team have already produced the following video:https://www.youtube.com/watch?v=GAxK2ntkIV4

67. All members of the User focus group were aware of the Safe Place Scheme and how they could use it. Although none of the users had yet needed to use it, there was a majority view that the Scheme provides reassurance and is a good idea.

Kent County Council – The Accomplished Community

68. Kent's 'charter' of accomplishments is linked to helping people to navigate and connect to community resources
    - Local people have access to independent facilitation, in-depth knowledge of local community resources and the offer of support to make new connections if needed.
    - Self-funders receive good advice and support to maximise the use of their income and get the most for the funds they have available.
    - Local people have good access to, or can purchase, high quality information, advice and guidance.
69. Kent Libraries aimed to welcome adults with learning disabilities into libraries. The work undertaken won 2011 Libraries Change Lives Award from the Chartered Institute of Library and Information

The work has included:

- Increased provision of easy read books, promotion of Assistive Technology, delivery of inclusive events (including arts exhibitions and events), and use of new volunteers.
- Development of mystery shopping to check access and report on findings as one important way of gaining customer feedback.
- Visual choice cards and menus. These have been developed by libraries to assist librarians in serving customers who may not use spoken language, and who may need visual images to help them make choices.

Kent's 'charter' of accomplishments linked to information and communication

- Provide information in different formats like easy read, including person-to-person contact
- Community groups, associations and public services are skilled in the production of easy information, have clear standards for how public information is produced and get feedback on how well they are doing.
- Those producing written information for the public have clear easy-access standards to guide their work.
- Those responsible for producing information for the public are skilled in producing material for different audiences and know what the issues are for different sections of the community.
- Information is available in a variety of formats,
- Visual images are selected to represent people from the whole community and challenge negative stereotypes.

70. We interviewed Fay Ewing, Adult Reading Development Coordinator to look at how the Kent model could be used in libraries in Bucks. We understand that BCC Library Service has met with Kent Library Service and local providers. The results of this work will now inform a business case for activities for adults with learning disabilities that could be provided in libraries in Aylesbury and High Wycombe.

Recommendation

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

Safeguarding

Key findings

- Providers stated that safeguarding for adults with learning disabilities needs to include minimising the risk of exploitation.
- Providers are reporting significant safeguarding and awareness training gaps for both professionals and adults with learning disabilities and provision that is in place is not coordinated.
- Providers thought that Adults with learning disabilities need to have support and awareness sessions reinforced throughout their adult life around key risk areas such as relationships and managing money. Dedicated awareness raising sessions could be reinforced through drop-in sessions.
- Users stated that Facebook and Facetime was an important part of keeping in contact with families and some users were aware of potential dangers with unwanted contact. Users did highlight a need to be able to use social media safely and to have a person they could talk to if they did encounter any difficulties. Outside of the college environment, users stated minimal awareness training or support is available for using the internet and social media safely.

71. In terms of communication and information the following was highlighted at the Learning Disability Providers Forum:

    - Training and awareness information needed to be available for carers and staff to provide appropriate advice and information to those in their care around relationship management, sexual health. Examples were given where this advice falls to care assistants with no support materials or training.

    - Money management and prevention of exploitation were identified as real risks. A carer provided the review group with an example of her son in semi-independent living who had given sums of money to an individual whilst she was away on holiday.

72. Providers felt there needed to be leadership and advice from the CHASC Business Unit and the Adult Safeguarding Board to run training sessions and produce easy read literature (or links to freely available resources) that care staff can use with their clients.

Recommendations

13. Buckinghamshire Council to work with Local Safeguarding Boards to ensure safeguarding training and support by providers to service users with learning disabilities is provided with a particular focus on the following: avoiding exploitation, money management, relationship management and use of social media

Appendix 1

HASC Inquiry into Services for Adults with Learning Disabilities Scope

Title	**Accessibility and promotion of Services for Adults with Learning Disabilities**
Signed-off by	
Author	Julia Woodman, HASC Committee Advisor
Date	
Inquiry Group Membership	Mrs Margaret Aston (Chair) Mr Brian Adams, Mrs Avril Davies, Mr Steve Lambert, Mrs Angela Macpherson
Member Services Resource	Sara Turnbull, Head of Member Services, Policy Advice and Report Quality Assurance Julia Woodman, Committee Adviser, Policy Lead & Project Management
Lead Cabinet Member	Mike Appleyard, Cabinet Member for Health and Wellbeing
Lead HQ/BU Officers	Rachel Rothero, Service Director Commissioning & Service Improvement, BCC Adults & Family Wellbeing Zita Calkin – Lead Commissioner for Learning Disability & Autism
What is the problem that is trying to be solved?	People with learning disabilities do not have equity of access and provision to a range of universal services, Issues: • A lack of reasonable adjustments made in universal services and amenities in the community • Access to ordinary activities increase social exclusion including: - Work; support to enter and maintain employment - Leisure activities; cinema, theatre, music venues etc. - Sports facilities - Being involved in local decision making - Changing facilities in toilets - Public transport i.e. bus pass timings; improved links Poorer health outcomes 'People with learning disabilities have poorer health than the general population, much of which is avoidable. These health inequalities often start early in life and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. The impact of these health inequalities is serious. As well as having a poorer quality of life, people with learning disabilities die at a younger age than their non-disabled peers' - Public Health England The Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) found that men with learning disabilities died on average 13 years younger than men in the general population and women 20 years younger.

Is the issue of significance to Buckinghamshire as a whole?	• The area was identified as a top priority from extensive learning disability engagement reports in May 2015; the Learning Disability Partnership Board (LDPB) focus groups feedback, engagement and action plans.
Is the topic of relevance to the work of BCC?	Yes - The service has identified users experiencing a number of transport issues and a lack of challenge to wider universal services and issues that fall outside services control and influence
Is this topic within the remit of the Select Committee?	Yes - Services for Adults with Learning Disabilities cuts across both Health and Adult Social Care.
What work is underway already on this issue?	The Learning Disability Partnership Board is a forum for hearing the views of people with learning disabilities; some mapping and assessment of universal services has been carried out by the community links workers and other voluntary sector organisations.
Are there any key changes that might impact on this issue?	
What are the key timing considerations	
Who are the key stakeholders & decision-makers?	Other stakeholders: • Adult and Family Wellbeing Service commissioners • Service users and their families/carers • Service providers • Buckinghamshire Learning Disabilities Partnership Board • Healthwatch Bucks • Carers Bucks • Talkback
What might the Inquiry Achieve?	A key outcome would be to identify service users' and their carers 'experiences of the accessing ordinary and universal services and amenities through existing feedback and engagement groups. From this the review group could highlight areas that they would like to focus on This could also achieve: • Improvements to advocacy mechanisms for resolving issues around community inclusion particularly those which sit outside Health and Social Care remit i.e. transport, local leisure amenities • Championing the rights of people with learning disabilities • Championing good practice in universal/community services across Buckinghamshire

Appendix 2

Schedule of evidence gathering

30th October 2015	Zita Calkin – Senior Joint Commissioner – Adults with Learning Disabilities Alex Britton - Project Coordinator, Talkback Considering contextual, performance and consultation evidence.
5th December	Adam Payne - Service Manager Learning Disabilities, Transitions and Continuing Health Care Considering Care Management process and Care Plans
7th December	Dan Hussey -Business Change Support Manager, Adults & Family Well-being Considering models of best practice and the development of the Care Advice Bucks web site
14th January 2016	Learning Disability Partnership Consultation with users regarding use of IT and accessibility of the Care Advice Bucks web site
18th January	Wendy Dunn, Social Link Manager
19th January	Martha Edwards – Community Safety Coordinator To discuss Safe Places Scheme
20th January	Dean Eales - Head of Business Development (Local Authorities) – DisabledGO
26th January	Bev Frost – Customer and Communications Team
29th January	User Focus Group facilitated by Talkback
1st February	Fay Ewing – Adult reading Development Coordinator To discuss Kent CC Libraries work with adults with learning disabilities and applicability in a local setting
4th February	Carers Focus group facilitated by Carers Bucks
10th February	Learning Disability Provider Forum
24th February	Natalie Flemming – Brokerage Service Manger

Appendix 3

Summary of User, Carer and Provider Feedback

Transport

The User experience

- The high cost of taxis to enable participation in any evening activities. Users also reported paying high charges for journeys and a feeling that they were being exploited.
- Bus and Taxi Drivers having a lack of disability awareness. Users gave examples of brusque and unhelpful staff which acted as a disincentive to access transport independently.
- The taxi and transport service provided by Amey was used by significant numbers of the focus group to transport them from home to college. Experiences of this service were mixed. The multi-user taxis were daunting and made more stressful by incidents of users being dropped off in the wrong location.
- Schools using community buses were highlighted as a problem – bags were left on empty seats and seats were not available for users or the elderly. Wheelchair access was also compromised during these times.
- Bus timetables are not accessible to the majority of users and display boards are vital to enable users to access the right bus service.
- National bus companies (Arriva) are not accepting bus passes before 9.30am. On local buses (Carousel) it is 9.00am, which causes confusion and difficulties getting to appointments, work placements and college.
- Travel training was an important part of accessing transport independently and users would like the provision to be more extensive.

The Carer experience:

- Significant concerns were expressed regarding taxi and bus services supplied through Amey [12] used to take users to college and activities at Day Opportunity Centres. In particular the following was highlighted:

    - Users are experiencing long journey times due the volume of people each taxi is taking home. Examples were given of a normal 20 minute journey taking around 1.5 hours. This is exacerbated by delays. Carers would like a direct line to call in the event of a serious delay, to find out what if any issues there are. Presently a Carer has to call a Social worker, who calls Amey, who then calls the taxi company.
    - Instances of single female users collected by male driver and male escort raising safeguarding concerns amongst carers.
    - The poor condition of transport used by one company leaving scrape marks on the leg of one user.
    - An apparent lack training of drivers and escorts noted by Carers due to the way their son / daughter is spoken to and physically lifted / manoeuvred.
    - A general lack of consistency of drivers and taxi firms which leads to greater anxiety in users. Carers felt in the past their son / daughter could build a rapport with drivers from one firm.

[12] https://www.amey.co.uk/amey-in-your-area/london-south-east/buckinghamshire-transport-services/

- There is a lack of clarity around the types of bus passes that can be used and clarity around restrictions of use. There was a perception that bus passes' could not be used on national bus services within Buckinghamshire from 9am. This is not the case as the local policy allows for bus passes to be used in Buckinghamshire from 9am. There have been issues with Arriva bus swipe machines accepting Smart Cards between 9-9.30am but bus drivers should be aware of the local policy of use. The review group understands that the issue with the smart card bus pass is resolved.

At the Learning Disability Partnership Executive Board in November 2015 it was noted that transport is a significant issue that is constantly raised in during consultations but no changes are made. The College to home transport service is highlighted as a particular concern.

Communication and information

The User experience

- Users are finding out about services through the BCC Contact Centre, leaflets and are not using the Bucks CC website. To have a 'what's going on' dedicated space on the web would encourage users to look at the Bucks CC site.
- A lack of Easy Read leaflets to enable users to find out what is going on – the cinema was given as an example where users find it difficult to find out what is on – 'there is a lack of leaflets and can't telephone to find out' . Odeon cinemas however were given as examples of services having helpful staff.
- Aylesbury Waterside Theatre was cited as a local good practice example. The theatre sends out a readable what's on guide in the post and credit (free theatre tickets) is given in exchange for voluntary work.
- Facebook and Facetime was an important part of keeping in contact with families and some users were aware of potential dangers with unwanted contact. Users did highlight a need to be able to use social media safely and to have a person they could talk to if they did encounter any difficulties. Outside of the college environment minimal awareness training or support is available for using the internet and social media safely.

The Carer experience

- Carers expressed difficulty in finding out about services and finding the appropriate level of support / help. Not all carers accessed the web and therefore were not aware Carers Advice Bucks web pages. Older carers used the telephone, word of mouth and Carers Bucks to find out what services are available.
- There are difficulties in finding out about activities and clubs as they are not well advertised. The problem is exacerbated by a lack of sustainability in the provider market and availability is limited.

Provision of services and activities

The User experience

- Users would like more support and training to access mainstream services independently, with their friends and partners.
- 'Taster' sessions were highlighted as a mechanism to find out about what they liked to do and to stimulate interests / hobbies.
- Schools and colleges were providing a vital role in instilling confidence and transition to adult life and all Users provided very positive feedback of the transition from school college life. Talkback stated that Buckinghamshire is leading the way in post 16 provision and Buckinghamshire County Council funding enables 5 days a week college and community provision instead of the normal 3 days a week. The tapering of college days is also supported through links to work placement provision and community activity provided by Talkback.

Buckinghamshire's apprenticeship programme has also recently featured in the Guardian as an example of good practice.
http://www.theguardian.com/social-care-network/2016/feb/16/apprenticeships-young-disabled-people-social-care-employment?CMP=ema-1696&CMP=

The Carer experience

- Carers underlined the importance of bespoke activities to fit a wide range of needs. One carer gave the example of her daughter's willingness to only participate in smaller group activities which made it difficult, when the provider market was so small.
- A lack of breadth of group activities across Buckinghamshire has implications for the expensiveness of social activities for users. It means that users who want to go to activities such as the cinema and need support will have to pay for themselves and an escort. It means a cinema trip with a £15 per hour escort could cost over £50.
- Carers said that limited use was made by their sons / daughters of the Day Opportunity Centres. One of the constraints is the expense of frequent use. More use was made of 'Gateway Clubs' facilitated through local Mencap and were extremely popular due to price and provision of mainstream activities.
- There was confusion amongst carers regarding the scope of the use of Direct Payments. This is not always clearly evidenced in the support plans. There appeared to be anomalies in what carers could access.

Views gained from the Learning Disability Provider Forum

- Users with less complex needs do not want to use Day Opportunity Centres; they are looking to access mainstream services.
- Smaller providers find it difficult to sustain provision and cannot weather dips in use or the time it takes for usage to grow.
- A number of carer organisations commented that they will find an activity for the person they care for and then the organisation folds. In addition comments were made that the time they spend looking for activities impacts on the time left for actually participating in the activity for those they care for.

- The Changes in the Disability Living Allowance for those in semi-independent and supported living has led to reductions in the amount available to spend on transport costs and social activities. A contraction in what users can afford further impacts on the stability of provision.
- Ngage (run by Talkback,) The Gateway Clubs (facilitated by local Mencap), Get Active and Social Links (a Social Enterprise) were given as examples of success stories. It was felt that users need to be offered a variety of taster sessions to stimulate choice and interest in activities.

Safeguarding

Feedback from the User, Carer and Provider Forums has raised significant concerns regarding the provision of support and awareness training for Users, Carers, and Care Support Staff

Unanimous feedback from providers is that no one service is offering safeguarding and awareness training across the county.

In terms of communication and information the following was highlighted:

- Training and awareness information needed to be available for carers and staff to provide appropriate advice and information to those in their care around relationship management, sexual health. Examples were given where this advice falls to care assistants with no support materials or training.

- Money management and prevention of exploitation were identified as real risks. A carer provided the review group with an example of her son in semi-independent living who had given sums of money to an individual whilst she was away on holiday.

Providers felt there needed to be leadership and advice from the CHASC Directorate and the Adult Safeguarding Board to run training sessions and produce easy read literature (or links to freely available resources) that care staff can use with their clients.

In addition users need to have support and awareness sessions reinforced throughout their adult life around key risk areas such as relationships and managing money. Dedicated awareness raising sessions could be reinforced through drop-in sessions

A consultation with 14 users who are using social media regularly indicated that half would like more support on how to use social media sites safely. Users did indicate they have encountered problems using Facebook and Facetime.

Scrutiny Inquiry Progress Update on Recommendations for Accessibility and Promotion of Services for Adults with Learning Disabilities Interim Progress Report (12 months on)

Select Committee Inquiry Report Completion Date: Signed off by Select Committee April 2016 (went to Cabinet in May 2016)
Date of this update: September 2017 (12 month update)
Lead Officers responsible for this response: Oliver Styukc-Dean/Kelly Taylor/ Leah Smith
Cabinet Member that has signed-off this update: Lin Hazell (Cabinet Member for Health & Wellbeing), Noel Brown (Cabinet Member for Communities), Mark Shaw (Cabinet Member for Transportation), Mike Appleyard (Cabinet Member for Education & Skills)

Accepted Recommendations	Original Response and Actions	Progress Update (6 & 12 months)	Committee Assessment of Progress (RAG status) at 6 months	Committee Assessment of Progress (RAG status) at 12 months
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	Responsible Cabinet Member & Officers – Mark Shaw/Phil Dyson **6 month update** • 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 **12 month update** • Already a core part of the contract monitoring process, we have also increased the number of monitors taking place at Day Centres and improved the engagement with Day Centre Managers/staff. • Business audits being undertaken. Business process/management improvement plans being developed with each supplier. • Dynamic Purchasing System in place for new transport arrangements/contracts. Each supplier assessed and required to meet minimum quality standards. **COMPLETED**		
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.	Responsible Cabinet Member & Officers – Mark Shaw/ Phil Dyson **6 month update** • In hand and ongoing; the updated training element covering learning difficulties has recently been shared with CHASC colleagues for review.		

		12 month update • In hand and ongoing, all transport provider staff have had the safeguarding and awareness training, English language competency assessment. Training material is reviewed periodically and updated as required. • Existing activity that provides individual needs assessments for each client in place and on-going. • New activity planned to provide training material of more detailed needs and actions through risk assessments of specific needs on transport. **COMPLETED**		
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	Responsible Cabinet Member & Officers – Mark Shaw/ Phil Dyson **6 month update** This is an ongoing engagement with local bus operators. **12 month update** • Engagement with the main bus operators continues. Bus company managers will be attending a future LD Partnership meeting to outline their		

	Competence which requires all bus drivers to complete 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.	awareness training and discuss specific concerns. **COMPLETED**		
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.	Responsible Cabinet Member & Officers – Mark Shaw/ Phil Dyson **6 month update** Support to this initiative is ongoing. **12 month update** • Funding has been provided to BuDS for the Fare4All website. The BCC Public Transport team will promote this when it is finished. **COMPLETED**		
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 CSCL to establish	Responsible Cabinet Member & Officers – Mike Appleyard/ Phil Dyson/ Mark Kemp		

access this as part of the transition to independent living.	a strategic, effective and cost effective approach • Establishing suitable ownership of this workstrand a priority.	**6 month update** A work-strand to be established under the Integrated Transport Programme, enabling CSCL and CHASC to develop and implement a strategic, effective and VFM plan. **12 month update** • An Independent travel training scheme pilot (1-2 years) is being developed. The lead area is Children's targeting years 10 and 11 SEN pupils however CHASC are also involved in the schemes development. **COMPLETED**		
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	Responsible Cabinet Member & Officers – Noel Brown/ Mark Adams-Wright **6 month update** 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.		

		12 month update The new BCC site launched on January with much improved accessibility for mobile and tablet device users, reduced site speed times and clear, Plain English written pages based on guidelines used by the Government Digital Service (GDS). The website is designed for up to W3C AA standards of accessibility and is regularly reviewed and updated in line with best practice. **COMPLETED**		
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.	• Two assessors (including an external expert) will lead the work	Responsible Cabinet Member & Officers – Lin Hazell/ Mark Adams-Wright **6 month update** 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. **12 month update** BCC has reviewed the County Council web site and Care Advice		

		Buckinghamshire in order to make sure it meets needs of all users. The updated county council site launched in January 2017 has taken on key recommendations to make the site is accessible and reduced content to make it simpler and quicker to find the necessary information. Care Advice Buckinghamshire has been updated in line with best practice for social care users and is regularly reviewed by the digital team and service user groups to help identify areas for improvement and change. **COMPLETED**		
8. Buckinghamshire County Council to evaluate and consider investing in a dedicated Buckinghamshire venue guide for users with disabilities, working collaboratively with District Councils	• 6 week 'discovery' activity to be undertaken in order to understand user needs and develop prototypes • Findings will be reviewed by CID board to enable prioritisation	Responsible Cabinet Member & Officers – Noel Brown/ Mark Adams-Wright **6 month update** 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. 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. **12 month update** BCC has evaluated a dedicated venue guide for users with disabilities but due to the enhancement of the new County Council website, this has not been taken further at this stage. **COMPLETED**		
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	• To discuss ownership of role with CHASC information officer as an annexe/addition to care advice bucks website	Responsible Cabinet Member & Officers – Noel Brown/ Mark Adams-Wright **6 month update** We are taking this forward as part of the work to address point 8. **12 month update** BCC has worked in collaboration with its technology partner, PCG, to explore alternative ways for presenting community activities. Together they have also taken part in a national		

		initiative to allow community data to be managed in a standardised format to allow easy sharing across the council, health and community partners. This work has been led by iStand UK and is hoping to publish a national standard later this year. This paves a way to sharing community activities via a number of 3rd party portals and other useful sites that users come into contact with. BCC involvement completed, awaiting publication of standard **COMPLETED**		
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)	• Note - compliance with the standard goes beyond digital platform. To review whether this sits within digital or with Customer and Comms.	Responsible Cabinet Member & Officers – Lin Hazell/ Mark Adams-Wright **6 month update** 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. **12 month update** A BCC style guide has been set up for editors to use to ensure content meets customers' expectations and reduces the need for secondary contact. With the number of online forms and services on the website, a style and user guide is currently being developed for a consistent approach across the site. Training has also been given and a scheduled roll-out of any new forms will be tested and approved before going live. Full rollout as business as usual expected by Q3. **COMPLETED**		
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.	• LD accommodation review paper to leadership May • LD Strategy handover from CCG partners to determine gaps in provision • Review the LD commissioning strategy	Responsible Cabinet Member & Officers – Lin Hazell/ Susie Yapp/ Graeme Finch **6 month update** 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 month update We have revisited the framework to the LD strategy review and have decided we need to have a smarter commissioning approach – we will be agreeing how we will progress service strategies in the future. There are 7 LD commissioned services with contracts currently under review. This will involve some recommissioning activity and will inform the LD commissioning strategy. We are working to develop access to general needs housing (through RSL's and Bucks Home Choice) to facilitate move on for people who have gained independent living skills which will free up supported living accommodation. **COMPLETED**		
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	Responsible Cabinet Member & Officers – Noel Brown/ David Jones/ Fay Ewing **6 month update** 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 **12 month update**		

		Discovery Tours in planning. Volunteering roles and application process now online and accessible to all Autism awareness training scheduled for September **COMPLETED**		
13.Buckinghamshire Council to work with Local Safeguarding Boards to ensure safeguarding training and support by providers to service users with learning disabilities is provided with a particular focus on the following: avoiding exploitation, money management, relationship management and use of social media	• Work with the Safeguarding Adults Board to raise awareness and deliver training in relation to all aspects of exploitation of people with learning disabilities • 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	Responsible Cabinet Member & Officers – Lin Hazell/ Julie Puddephatt **6 month update** BSAB & Talk back to progress this action by March 2017 via SAFE sub-committee. 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. **12 month update** L1 Safeguarding Training will be rolled out to partners from Sep 17 and will include aspects of exploitation for		

	life/independent living skills and reduce the risk of harm and exploitation	people with learning disabilities. The SAFE group is no longer a sub-group of BSAB but continues as a forum with representatives in all subgroups. Talkback continue to engage with SAFE and will support in the development of a prevention strategy if agreed by BSAB. Our contracts and residential care and supported living specifications set expected standards, indicators and outcomes related to developing and maintaining independent living skills and reducing risk of harm and exploitation through appropriate support planning, appropriate recruitment and staff training and ensure appropriate safeguarding policies are in place. This is monitored through the contract management framework. The specialist learning disability community health team (Herts partnership Foundation Trust since 1st September 2016) has now a fully functioning Intensive Support Service (as of 1st April 2017) which supports people (and their carers) in crisis 24/7. The community team is also available to support those who have been subject to exploitation/abuse in the community.		

		COMPLETED		

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*