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 22 May 2018, in Mezzanine Room 1, County Hall, Aylesbury, commencing at 10.08 am and concluding at 12.46 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, Mr N Hussain, Mr S Lambert, Mr D Martin, Julia Wassell, Mrs A Cranmer, Mr G Williams and Lin Hazell

District Councils

Ms T Jervis	Healthwatch Bucks
Mr A Green	Wycombe District Council
Ms S Jenkins	Aylesbury Vale District Council

Members in Attendance

Lin Hazell, Buckinghamshire County Council

Others in Attendance

Mr N Macdonald	Buckinghamshire Healthcare Trust
Ms L Patten	Clinical Commissioning Groups
Ms C Morrice	Buckinghamshire Healthcare Trust
Dr M Thornton	FedBucks
Ms H Delaitre	Clinical Commissioning Group
Ms K Jackson	Buckinghamshire County Council
Ms N Fox	Buckinghamshire Healthcare Trust
Ms E Wheaton	Committee and Governance Adviser, BCC
Ms S Taylor	Committee Assistant, BCC

South Bucks
District Council

1 ELECTION OF CHAIRMAN

RESOLVED

That Mr B Roberts be elected as Chairman of the Health and Adult Social Care Select Committee for the ensuing year.

2 APPOINTMENT OF VICE-CHAIRMAN

RESOLVED

That Ms A Cranmer be appointed as Vice Chairman of the Health and Adult Social Care Select Committee for the ensuing year.

3 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

The Chairman welcomed the following new members to the Committee:

- Ms A Cranmer
- Mrs I Darby
- Mr G Williams
- Mr N Hussain

Apologies had been received from:

- Ms W Matthews
- Ms L Clarke OBE
- Ms C Jones
- Ms M Aston
- Mrs I Darby

4 DECLARATIONS OF INTEREST

There were no declarations of interest.

5 MINUTES

The minutes of the meeting held on Tuesday 24 April 2018 were agreed as a correct record and were signed by the Chairman.

6 PUBLIC QUESTIONS

There were no public questions for this meeting.

7 DEVELOPING CARE CLOSER TO HOME - COMMUNITY HUBS

The Chairman welcomed Mr N Macdonald, Chief Executive, Bucks Healthcare Trust (BHT); Ms C Morrice, Chief Nurse, BHT; Dr M Thornton, GP Partner, Unity Health and Clinical Lead, FedBucks and Ms L Patten, Accountable Officer, Bucks Clinical Commissioning Group.

The Chairman explained that this item had been adjourned at the last meeting and was being re-visited for further questions.

In response to a query regarding the number of patients using the hubs in Thame and Marlow, and the impact on the budget and current staffing levels, if the hubs were run at full capacity; the following points were made:

- If the geographical boundaries were constrained there would be between 30,000 – 40,000 people in the Marlow area.
- The majority of patients came from the locality of the hub.
- Opportunities existed to make better use of the peaks and troughs of demand.
- The next step was to offer a greater breadth of services.
- The referrers needed to be aware of which services were provided and when they were available.
- The “no boundary” approach would continue as it had been found that patients were prepared to travel for the right treatment.

A member of the Committee asked how patients were identified as being members of the community who would benefit by availing themselves of the community hub services and how they could be encouraged to attend the clinics. The following points were noted:

- Data needed to be obtained from the GP surgeries in order to identify those individuals who would benefit from being invited to attend the community hub before the GP made the referral.
- A number of pilots had been studied and it was acknowledged it was an emerging area, making it difficult to know where to invest resources to achieve maximum benefit.
- Individuals at high risk needed to be identified by predictive modelling through integrated work with health and social care colleagues. The individuals would attend the hub to trial some of the services and the outcome would be measured by monitoring population health management data to see if the level of admissions reduced or at least stabilised.
- The challenge would be to know whether the intervention had prevented admission to hospital.
- Ms Morrice had carried out work with the community services to find out the five areas which mattered to the community.
- The KPIs were continually evolving and the service was being shaped to fit the local community and “one size did not fit all”.

A concern was raised over the level of feedback from staff as it was felt they were instrumental to the plans. It was acknowledged that:

- The changes had just as much impact on staff as on patients.
- There may be anxiety amongst some staff and this was being managed by having conversations with staff in order to help shape the future service.
- Staff were being informed and involved in the design of the service.
- The hubs could be an attractive option to encourage talent into Buckinghamshire.
- The community teams had been looking at what could be done differently and the work would be mapped out with colleagues.
- Staff had been placed in their preferred option.
- Staff and patient satisfaction needed to be strengthened.
- The next step was to look how to triangulate outcomes for patients and staff.
- Mr Macdonald and Ms Morrice had met with the teams regularly to discuss and co-design.

The Chairman asked for an explanation of discharge to assess and how many transitional beds there had been prior to the pilot and how many there were since the closure of the community beds and whether there had been an increase.

Ms N Fox, Chief Operating Officer, BHT, explained as follows:

- The “Discharge to Assess” was a programme put in place to ensure people were assessed in the community at their place of residence and for the care to be in place

in order for a patient to be discharged.

- The programme involved work with a number of independent sectors, care homes, domiciliary care providers and ensured a pathway for self-funders.
- It had also looked at how the discharge to assess process worked with the Reablement teams and the community services.
- The number of transitional beds available under discharge to assess changed through the life of the pilot.
- The amount of domiciliary care provided ranged from 50 hours up to 150 hours to ensure there was a range of services to meet the needs of the individuals.
- The programme did not consist solely of transitional beds but provided a flexible service that reflected availability depending on the needs of the individuals.

In response to a concern raised over a disconnect between the hospital and adult social care and the possibility of a discharge not happening as quickly as it could have done, the following points were made:

- It was acknowledged that there were areas for improvement and close work had been taking place into how the two services could be integrated to provide a seamless discharge from the patient's point of view.

A member of the Committee asked if the service would be reconfigured for staff to have ownership of providing equipment to individuals. The following comments were made:

- More time was allowed for assessments in the hubs and both the individual and carers could be involved to put the plans in place.
- The aim was to assess and put things in place before a person was in crisis.
- A single point of access was a priority.

The cost of the pilot was raised and the following points were noted:

- A full cost evaluation had not been carried out yet.
- It was known that the best practice was to get individuals out of hospital and back to their own homes, but not easy to quantify the amount of money saved as can't accurately predict what 'hospital' costs that might have been prevented.

The challenge of providing transport was raised and the need for a seamless system was emphasised by a member of the Committee. It was acknowledged that there were opportunities to make better use of collective care resources and the transport issue was being addressed with help from the local communities and the voluntary sector; a mixture of transport options were being considered.

The lack of evidence in avoiding up to 300 hospital admissions was raised and it was asked if wards would be closed when the full programme of hubs was rolled out. The following points were made:

- To put it into context, approximately 50 patients were admitted per day at Stoke Mandeville hospital.
- The current hub provision had not lead to a significant impact as the numbers were too small to evidence a reduction in the number of admissions.
- The readmission rate was not relevant to the community hubs.
- It was not healthy for people to stay in bed and it was important to intervene before they became very poorly in order to avoid an acute admission.
- The fear of the potential overall loss of beds was acknowledged but there was no evidence to support this at the moment. In addition the community hubs could provide the facilities for care on a larger scale.
- It was important to work with the District Councils to understand the housing growth

and demographic developments to offer the right level of services.

A member of the Committee asked what would be put in place to encourage the GPs to make more referrals and how many patients had entered the hubs via GP referral during the pilot. The following comments were noted:

- GPs would not be relied upon as the only point of entry into the service.
- The use of technology would be key.
- There needed to be a system in place to automatically identify people who would benefit from the service.
- The building of locality groupings who would work with community teams to build a model of care not entirely led by GPs but by the team would increase the number of referrals.
- As the model expanded, and with the use of technology and teamwork, it would be possible to direct the right people into the service.
- All the current patients had been referred to the community hubs by their GP.
- Social prescribing would play an important part in the community hubs.

The point was raised that the number of patients who had received a CATs appointment was 1,027 which equated to approximately four a day; however, an average GP carried out approximately 40 consultations per day which made the community service sound very expensive; was any of the funding provided by Buckinghamshire County Council (BCC)? The following comments were provided:

- BCC did not provide any funding towards the community hubs.
- A GP would not be able to carry out a full assessment during a ten minute appointment.
- The time invested by the community hub would prevent future use of care.
- Pilots were always expensive initially; if the pilot resulted in reduced dependence it would reduce costs to BCC.
- It would take approximately a year to provide meaningful data.
- It was felt to be the right direction of travel for the NHS.

In response to a question on how the cost of a CATs appointment equated to the cost of a hospital stay the following comments were made:

- The situation was extremely complex as various costs, such as social care, voluntary services and out of hospital care services needed to be taken into consideration.
- It was felt there was a strong clinical case for people not to be in a hospital bed and that the patients wanted to be treated at home where possible.
- The challenge was to keep people healthy for longer by backing long term models of care.
- The funding for the community hubs had come from the government and there had also been some in- year efficiencies which had enabled the review of the areas of greatest need.

The Chairman asked the Committee to support the future plans put forward by BHT and for BHT to provide an update to the Committee every six months; with the first update due in November 2018. The following areas of concern were noted:

1. Strengthening of staff feedback
2. To ensure that transport was central to the future development
3. Continued increase of GP buy-in
4. Use of technology
5. Community involvement
6. Economic evaluation

7. Evidence of integration of the whole system of health and social care

RESOLVED: The Committee unanimously AGREED to support the future plans for the community hubs pilot.

A letter to be sent to BHT detailing the concerns raised by the Committee.

Action: Committee & Governance Adviser

8 GP PROVISION

The Chairman welcomed Ms L Patten, Accountable Officer, Bucks Clinical Commissioning Group and Ms H Delaitre, Associate Director of Primary Care to the meeting.

The Chairman advised that the item would be coming back to the Committee in September for a fuller discussion. Ms Delaitre ran through the presentation and highlighted the following points:

- Primary care consisted of GPs, dentists, opticians and community pharmacies.
- There were 3 types of GP contract; the General Medical Services (GMS); Personal Services Medical (PMS); Alternative Provider Medical Services (APMS).
- The contract holders were small independent businesses and were monitored on their service delivery of the contract.
- There were 51 general practices serving 528,000 patients from 72 buildings.
- Primary Care Commissioning Committee meetings were held in public.
- GPs received a core services payment and could opt in or out of providing certain services.
- There would be a growing pressure of housing growth in the next 15-20 years and the CCG was liaising with the District Councils with reference to the impact on primary care
- Population demographics – there was an ageing population and an increase in the prevalence of long term conditions.
- Fewer GPs were choosing primary care as a profession.
- Work was being carried out to encourage GPs to work in Buckinghamshire.
- Most GP surgeries were full; support was needed for the GP practices.
- Primary Care was part of the Buckinghamshire One Public Estate initiative and the Integrated Care System (ICS).

In response to questions the following points were discussed.

- The GPs would be encouraged to work together to share opportunities and best practice and support the emerging community model.
- The problem of persuading some GPs to move out of their existing accommodation and into new rented accommodation in order to create modern facility was acknowledged but it was the GP’s decision as an independent business.
- People needed to be directed to the right place via 111 to avoid unnecessary visits to the A&E departments.
- It was confirmed that GPs did not gain financially for referring fewer patients but evidence suggested that GPs should refer a patient to see a specialist only when all other options had been explored first.
- The GPs funding allocation was weighted for deprived populations and areas with an older population.
- The community hubs would take into consideration the forthcoming demographic changes.
- The future strategy would be to co-locate GP practices with other services wherever possible.
- The commissioners were responsible for making sure the correct level of services

was available to the patients.

- It was likely there would be a move to appointments being available from 8.00 am to 8.00 pm.
- Bookable appointments between 8am and 8pm weekdays would be available for all patients in Buckinghamshire by the end of 2018.
- It was acknowledged that there was a challenge with GP appointment availability.
- The definition of a GP cluster was more than one GP practice working together.
- It had been an incentive for GPs to work together in clusters with 30,000-50,000 registered patients as there was value in close working with nurses, physio therapists and other healthcare professionals.
- The planning for the new housing developments taking place now happened a few years ago and the Section 106 discussions in many cases did not include health provision so there was no funding coming from the developers; therefore the NHS was bidding for capital funding, against their peers within the STP, from NHS England.

RESOLVED: The Committee gained a greater understanding of the current GP provision across the County.

9 HOSPITAL DISCHARGE INQUIRY - 12 MONTH RECOMMENDATION MONITORING

The Chairman welcomed Lin Hazell, Cabinet Member for Health & Wellbeing, BCC; Ms K Jackson, Director of Operations, BCC; Ms N Fox, Chief Operating Officer, BHT and Ms C Morrice, Chief Nurse, BHT

The Committee heard about the progress with the recommendations made in the Inquiry report and the following main points were made.

- Community nurses had now been linked to the Hospital wards.
- Pharmacists were now part of the Discharge team.
- Paramedics were working in A&E which was proving to be successful.
- There was a drive to build on the reablement services which the CQC had recently rated as “Good”.
- Healthwatch Bucks were thanked for their hospital pharmacy project and commended for their work around improving the processes and patient experience which followed on as part of the Inquiry.

RESOLVED: The Committee agreed to delegate the assigning of the RAG status to the Chairman.

10 CHAIRMAN'S UPDATE

The Chairman did not have any updates to report.

11 COMMITTEE UPDATE

None to report.

12 COMMITTEE WORK PROGRAMME

The Committee noted the work programme.

13 DATE AND TIME OF NEXT MEETING

Tuesday 24 July 2018 at 10.00 a.m.

CHAIRMAN