Buckinghamshire County Council
Select Committee
Health and Adult Social Care

Minutes

HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

Minutes from the meeting held on Friday 7 February 2020, in Mezzanine Room 1, County Hall, Aylesbury, commencing at 10.00 am and concluding at 3.00 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 M Appleyard (In the Chair)
Mrs P Birchley, Mrs L Clarke OBE, Mr S Lambert, Mr D Martin and Julia Wassell

District Councils

Mr A Green	Wycombe District Council
Ms S Jenkins	Aylesbury Vale District Council
Dr W Matthews	South Bucks District Council
Mr B Clarke OBE	Healthwatch Bucks
Ms J MacBean	Chiltern District Council

Members in Attendance

Ms L Hazell, Buckinghamshire County Council

Others in Attendance

Mrs E Wheaton, Committee and Governance Adviser
Ms G Quinton, Executive Director (CHASC)
Dr R Sawhney, Clinical Director for Health Inequalities and the Primary Care Networks DES, Buckinghamshire Clinical Commissioning Group
Dr J O'Grady, Director of Public Health
Ms T Ironmonger, Assistant Director of Public Health
Dr T Kenny, Medical Director, Buckinghamshire Healthcare NHS Trust
Ms L Smith, Interim Director Primary Care and Transformation, NHS Buckinghamshire Clinical Commissioning Group
Mr D Williams, Director of Strategy and Business Development, Buckinghamshire Healthcare NHS Trust
Ms J Hoare, Managing Director, Integrated Care System
Ms K Jackson, Service Director (ASC Operations)
Ms F Wise, Executive Lead, BOB Integrated Care System

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies were received from Mr R Bagge, Mr W Bendyshe-Brown, Mr C Etholen and Mr B Roberts.

Ms J MacBean substituted for Mr N Shepherd from Chiltern District Council and Mr B Clarke substituted for Mr M Souto from Healthwatch Bucks.

2 DECLARATIONS OF INTEREST

There were no declarations of interest.

3 MINUTES

The minutes of the meeting held on Thursday 14th November 2019 were agreed as a correct record.

4 CHAIRMAN'S UPDATE

The Chairman reported that an informal meeting had taken place with colleagues from the Health Scrutiny Committee's across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System. At the meeting, it was agreed that further work needed to be done to formalise future scrutiny arrangements for the BOB ICS. Agreement would need to be sought by the new Committee and new Council.

5 BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST - UPDATE ON RECENT ENGAGEMENT EXERCISE ON FUTURE OF NHS COMMISSIONING

The Chairman welcomed Ms F Wise, Executive Lead, Buckinghamshire Oxfordshire and Berkshire West Integrated Care System (BOB ICS).

During her presentation and the ensuing discussion, the following main points were made.

- An engagement exercise ran from 10th October to 1st December 2019 to seek feedback on the future of NHS Commissioning arrangements within the BOB ICS.
- Feedback was sought on the following:
    - Local working in each of the three areas (Integrated Care Partnerships);
    - Wider, at-scale working across the three areas (Integrated Care System).
- Three proposals were included in the document, including the appointment of a single Accountable Officer and Shared Management Team, designing stronger integrated care partnerships using a set of common principles and creating a single commissioning organisation across the BOB geography.

- All CCG Governing Bodies had agreed to a single Accountable Officer (AO) and a shared management team. The appointment of the AO would be made in April and the newly appointed AO would lead on the discussions around the single commissioning organisation.
- The NHS Plan and technical guidance implied that the majority of CCGs would have merged by 2021. There were no plans to merge the three Clinical Commissioning Groups (CCGs) at this stage and would be subject to a fuller discussion if the decision to proceed with this was agreed.
- Digital would be an integral part of the future plans for delivering health and social care.
- A Member asked how much activity would be delivered at scale as past presentations on the BOB ICS had indicated that around 70% of activity would be delivered locally and 30% would be delivered at the wider BOB ICS level. Ms Wise explained that the 999 service, 111 service and some specialist services were already being commissioned at scale and there were plans being developed to look at other acute collaboration of services – for example, Bariatric surgery. She went on to reiterate the importance of activities taking place locally.
- In response to a question about the impact on patient travel times if more services were centralised, Ms Wise acknowledged these concerns but stressed that there were challenges across the system which needed to be addressed.
- Ms Wise acknowledged the need to manage the change process, both with patients and staff.
- Ms Wise explained the benefits of population health management to help understand local needs and provided an example of databases which could identify how many people had diabetes in a particular street.

The Chairman thanked Ms Wise for her presentation.

6 DEVELOPING HEALTH & SOCIAL CARE IN THE COMMUNITY

The Chairman welcomed Ms L Smith, Interim Director, Primary Care and Transformation, Dr R Sawhney, Clinical Director for Health Inequalities, Lin Hazell, Cabinet Member for Health & Wellbeing, Ms G Quinton, Executive Director, Communities, Health & Adult Social Care, Ms K Jackson, Service Director (Integrated Care) and Ms J Hoare, Managing Director, Bucks Integrated Care Partnership.

During the presentation and discussion, the following key points were made.

- The health and care needs of the population were increasing and becoming more complex.
- The system was financially challenged and efficiencies had to be made.
- NHSE had clearly articulated its ambitions and implementation expectations in the Long-term Plan.
- Primary Care Networks were mandated and money had been earmarked for community investment.
- The Buckinghamshire Care Model centred around a pro-active community based care model designed around local population health and care needs which through integration would break down the historic barriers between primary, community and secondary care.
- Some of the main features of the model included:
    - Those “at risk” patients would be identified early and pro-actively managed with non-medical interventions and care;
    - Patients with complex comorbidity would be managed by a single community based multi-disciplinary team lead by a complex care manager;
    - Patients would be supported to live independently at home but not isolated;
    - Patients would tell their story once;
    - Patients would be pro-actively pulled out of the Hospital setting back to their

home once medically fit.

- There were three main areas of work – Prevention and Pro-active Care, Responsive Care and Long-term care. A number of enablers, including Digital, Workforce, Capital & Estates and Communications & Engagement ran through all the areas of work.
- There were 12 Primary Care Networks (PCNs) across Buckinghamshire of which 5 had been chosen to be part of a national project around health population management. In time, PCNs would consist of general practices working together with a range of local providers across primary care, community services, social care and the voluntary sector.
- There was a high expectation on PCNs to deliver services and a number of key roles had already been recruited by some PCNs, including social prescribers and pharmacists.
- A Member expressed concern about the ability to recruit to the new roles created by the PCNs. Ms Smith acknowledged that it was a challenge but the investment had been made and a number of roles needed to be filled during 2020/21. A number of hybrid roles had been created and a workforce passport had been developed to enable more flexible working across the system.
- Work was underway to align PCNs with the new Community Boards and there would be a series of workshops to start fostering relationships between the key stakeholders.
- The need to undertake community engagement at "Place" was acknowledged and it was agreed that this would be important over the coming months.
- A number of objectives had been set to strengthen community integration to help tackle inequalities, including identifying and treating those with hypertension who were BME and/or live in quintile 5, mental health activities and reducing the prevalence of smoking, particularly in GP practices in deprivation quintiles 4 & 5.
- In recognition of the importance of integration and collaboration to ensure successful delivery of community change, a Member asked who had overall oversight of this to make sure it happened and that outcomes were monitored and reviewed. Ms Smith explained that Dr Thornton and Ms Quinton were responsible for delivering rapid community change at Place. Ms Quinton explained that it was a partnership approach and progress was being made, although the pace of integration was acknowledged as not being fast enough. The complexity of integrating services was recognised.
- Following a discussion around the use of social prescribing by GPs, Dr Sawhney provided an example of how it works in her GP surgery but acknowledged that social prescribing needed to be embedded across the Primary Care Network.
- A Member commented that the voluntary sector was missing from the slide entitled "The Integration Dynamic" which highlighted the strength of working together to deliver the community model. Ms Smith responded by saying that the voluntary care services and patient engagement ran through the whole model but acknowledged it needed to be represented in the diagram.
- In response to a question about home adaptations and monitoring the quality of this service, Ms Quinton explained that the Disabled Disability Grant, part of the Better Care Fund money, would sit within Ms Quinto's portfolio in the new council. She went on to say that a review of accessibility of this service would be undertaken and value for money and quality of service delivery would also form part of the review.
- Ms Smith agreed to send further information on the primary care training hubs and where this training was taking place as a Member asked whether it was being delivered at Wycombe or Uxbridge.

Action: Ms Smith

- In response to a question about Community Boards and how health and social care would be embedded within communities, Ms Smith explained that the starting point would be to have a local directory of services with a single front door. She went on to say that this approach had been developed in other authorities and mentioned the

Frome model of care. Ms Quinton added that Tier 1 of the Adult Social Care Transformation Programme had delivered the Community Asset Plan which mapped local services and activities. This tool would also help to address social isolation, particularly in rural areas.

- A Member expressed concern about the breadth of issues that the Community Boards were being asked to review, from local infrastructure to transport issues.
- A Member commented that there needed to be more grass-roots projects and cited mental health as an example, where more out-reach work needed to be done.
- A Member commented that the increased demand in A&E patients was partly due to people not understanding when to visit A&E rather than accessing other services, such as the pharmacist or the MIIU.
- The inconsistency in the quality of Patient Participation Groups was acknowledged and a Member felt more investment should be given to ensuring these groups all provided the same level of service.
- A Member felt that, from a voluntary organisation point of view, the Council's current commissioning system was very complicated and a more proportional approach to commissioning would be beneficial.

The Chairman thanked the presenters and concluded that training and education of health and social care professionals and addressing health inequalities might want to be reviewed by the Committee in the new council.

7 SHARED APPROACH TO PREVENTION

The Chairman welcomed Dr O'Grady, Director of Public Health, Dr R Sawhney, Clinical Director for Health Inequalities and the Primary Care Network and Ms T Ironmonger, Assistant Director of Public Health.

During their presentation, the following main points were made and questions asked.

- People who lived in the most deprived areas (DQ5) become multi-morbid approximately 10 years earlier than the least deprived areas (DQ1).
- There were 4 pillars to improve population health – Communities, Lifestyles, Broader determinants of health (such as income, education, employment and housing conditions) and Access and Quality of integrated health and social care.
- The Better Lives strategy builds on existing multi-agency strategies and action plans, including NHS, Fire & Rescue, Thames Valley Police and Community Impact Bucks.
- A Shared Approach to Prevention had been developed with an agreed set of principles.
- Social isolation had been agreed as a priority for the system and a design process had been adopted. A pathway for those "at risk" of social isolation would be implemented alongside pilot work in small geographical areas to get greater insight into social isolation and co-design solutions with local communities.
- The Healthy Communities Partnership had developed action plans for healthy eating and tobacco control.
- A co-ordinated approach to social prescribing with the Clinical Commissioning Groups had been developed.
- The Bucks Online Directory (BOD) had been launched to help people find activities and support in Buckinghamshire. Further work was currently being undertaken to identify and quality assure Community Assets for the database and to expand the number of Street Associations and Dementia Friendly Communities.
- Public Health was helping to fund the work of the new Community Boards.
- The Clinical Commissioning Group's priorities over the next 5 years included reducing smoking overall, with a focus on the most deprived populations, mental health for young people, care and support planning and improving the detection of hypertension and its management in the County's most deprived and BAME communities.

- All state schools had a Children and Adult Mental Health Service (CAMHS) link worker.
- In response to a question about the effects of vaping, Dr O'Grady explained that vaping was safer for people who were trying to give up smoking.

The Chairman thanked the presenters.

8 BREAK

9 DELIVERING HEALTH & SOCIAL CARE IN THE HOSPITAL AND COMMUNITY SETTINGS

The Chairman welcomed Dr T Kenny, Medical Director, Buckinghamshire Healthcare NHS Trust, Mr D Williams, Director of Strategy and Business Development, Buckinghamshire Healthcare NHS Trust (BHT), Ms G Quinton, Executive Director, Communities Health & Adult Social Care and Ms K Jackson, Service Director (Integrated Care).

During the presentation, the following main points were made.

- Every year, BHT cares for:
  - 600,000 members of the community;
  - 460,000 outpatients;
  - 100,000 inpatients.
- The latest CQC inspection resulted in BHT being rated as "Good". A number of specific areas of improvement had been identified to help BHT move forward on its journey to being "Outstanding". These areas included safer staffing levels within community inpatients wards and reducing the waiting times for children, young people and families within the community health teams.
- BHT had recently signed the Armed Forces Covenant which highlighted its commitment to local people and staff within Buckinghamshire.
- BHT's A&E 4-hour performance mirrored the national trend. The Trust had seen a 7% increase in A&E demand over the last few months and was working hard with partners to alleviate pressure on A&E.
- BHT had received funding from NHS Improvement during December to support identified areas of improvement, including additional out of hospital capacity, escalation beds for patients who were medically fit for discharge at Wycombe Hospital and other smaller projects.
- Waiting lists had increased – cancellation of routine activity due to emergency demand had had a negative impact on waiting times. There had been a particular increased demand for ophthalmology.
- BHT was performing above the national average in terms of patients receiving first cancer treatment within 62 days of referral but it remained a challenge due to a number of factors, including higher numbers of patients requiring more complex diagnostics and patients being on multiple tumour pathways. A number of actions had been introduced to help improve the service, including a one-stop clinic for patients, electronic requesting for endoscopy and a new MRI scanner at Wycombe Hospital.
- Six reablement beds had been procured by the County Council to help reduce reablement waiting times.
- Four beds had been procured in a local nursing home to support reducing length of Hospital stay (these were procured until the end of January).
- The County Council's Adult Social Care team had co-located with teams at Stoke Mandeville, Wycombe, Wexham Park, Amersham, Milton Keynes (2-3 days a week) and Whiteleaf Oxford Health Foundation Trust.
- More patients were being referred to the Community Assessment and Treatment Service (CATS) and there had been an increase in outpatient activity in Thame and Marlow. Amersham was now providing similar services following the temporary

closure of Chartridge Ward at Amersham Hospital.

- Continued development of integrated 'home first' model to do everything practicable to ensure residents return to or remain in their preferred place of residence.
- BHT's vision for 2025 and beyond, included the following activities:
    - Redesign Urgent and Emergency Care;
    - Consolidate Rehabilitation Services;
    - Partner in Diagnostics Services;
    - Transform Outpatients.
- 61% of practice nurses and 36% of all non-medical staff were over 50.
- The Health & Social Care Academy was working with Universities to attract and train the next generation of health and social care professionals.
- There were a number of ambitions outlined for mental health services, including increasing timely access to mental health services to ensure that people could get the most appropriate help and support at the most appropriate time and the roll-out of a new community mental health framework to help bridge the gap between primary and secondary care services.
- In response to a question about key worker housing, Mr Williams explained that at a recent AVDC Cabinet meeting, it was agreed to use section 106 money to build more affordable housing in the Vale.
- A Member asked whether it would be possible to receive BHT performance data in a dashboard format on a regular basis. It was agreed that BHT would supply this on a quarterly basis.

Action: Buckinghamshire Healthcare NHS Trust

- In response to a question about the extended "silver phone" service, Dr Kenny explained that it was a well-used service where consultants provide support to GPs and paramedics as part of their patient decision-making.

The Chairman thanked the presenters.

10 UPDATE ON THE TEMPORARY CLOSURE OF CHARTRIDGE WARD, AMERSHAM HOSPITAL

Dr T Kenny, Medical Director, Buckinghamshire Healthcare NHS Trust and Mr D Williams, Director of Strategy and Business Development, Buckinghamshire Healthcare NHS Trust (BHT) presented the item.

During their presentation, the following main points were made.

- In response to the CQC imposing conditions of registration on BHT's community wards, Chartridge Ward had been closed to admissions since 1 July 2019. The CQC identified the challenges of providing sustainable safe, effective care in the Trust's community inpatient wards in its 2019 report.
- The two community wards in Amersham – Waterside and Chartridge – had a combined capacity of 46 beds.
- The Trust had introduced a number of improvements to ensure a high quality service could be provided with a reduced inpatient capacity of 22 beds.
- The current service model proposed no inpatient beds in Chartridge ward and improved care in the community with enhanced therapy and geriatric consultant support to the acute site.
- Two more therapists and three rehabilitation support workers had been recruited. Further recruitment was in progress for five further physiotherapy posts in both community and acute settings.
- Seven complex care managers had been introduced to community nursing and an additional elderly care consultant had been recruited to spend time in A &E identifying patients who did not need to be admitted and to ensure the relevant support had

been put in place to enable them to go home.

- A Community Assessment and Treatment Service had been established at Amersham, two days a week. This service assesses frail, elderly patients in the community and puts in place additional support to enable them to remain independent and at home, avoiding a hospital admission.
- To enhance support for patients over the winter months, BHT had:
    - Provided 6 beds for non-weight-bearing patients in Lakeside care home;
    - Supported Adult Social Care to provide rehabilitation beds in Fremantle care home; and
    - Opened 10 temporary rehabilitation beds in Wycombe Hospital for patients stepping down from acute care.
- In response to a question about the impact of the changes on patient care, Mr Williams explained that the priority of the Trust was to keep patients and communities safe and to provide the right care in the right place. Since the temporary closure, re-admission rates had remained the same but the falls rate had decreased.

The Chairman concluded by suggesting the new council should continue to evaluate the impact of the service changes alongside the ongoing provision of community services at Marlow and Thame. Representatives from BHT would be invited to a future meeting.

Action: Committee & Governance Adviser

11 HASC SELECT COMMITTEE - A RETROSPECTIVE

Members noted the Retrospective document.

12 DATE AND TIME OF NEXT MEETING

This was the final meeting of Buckinghamshire County Council's Health & Adult Social Care Select Committee.

CHAIRMAN