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 24 April 2018, in Mezzanine Room 1, County Hall, Aylesbury, commencing at 10.32 am and concluding at 1.15 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 S Lambert, Mr D Martin and Julia Wassell

District Councils

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

Members in Attendance

Lin Hazell, Buckinghamshire County Council

Others in Attendance

Mr N Macdonald	Buckinghamshire Healthcare Trust
Ms L Patten	Clinical Commissioning Groups
Ms L Watson	Bucks Integrated Care System
Ms C Morrice	Buckinghamshire Healthcare Trust
Dr M Thornton	FedBucks
Ms G Quinton	Executive Director, Communities, Health and Adult Social Care, Buckinghamshire County Council (BCC)
Ms E Wheaton	Committee and Governance Adviser, BCC
Ms S Taylor	Committee Assistant, BCC

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies had been received from:

- Mr C Etholen
- Mrs L Clarke
- Ms C Jones
- Mr N Hussain

Mr Niknam Hussain had replaced Mr Majid Hussain on the Committee.

2 DECLARATIONS OF INTEREST

Ms Aston declared an interest as a Trustee of Carers Bucks and said she knew Thame Community Hospital very well (item 8).

3 MINUTES

The minutes of the meeting held on Tuesday 20 March 2018 were agreed as an accurate record and signed by the Chairman.

4 PUBLIC QUESTIONS

The following public questions had been submitted.

The following question had been received from District Councillor Robin Stuchbury relating to the present consultation on bringing care closer to home by Buckinghamshire Healthcare Trust (BHT). The following question was read out by Mr R Stuchbury.

Q1. I understand that the community hubs pilot resulted in overnight bed closures of 20 beds in Marlow and Thame. Should this pilot be rolled out across the county, will this result in overnight bed closures in our other local hospitals (such as Buckingham, Amersham, Wycombe, Stoke Mandeville)?

This was a concern at the recent public meeting at Buckingham Community Centre where residents felt that the Trust was unable to give their assurance that the beds would not be closed. Please can BHT confirm the timescale for a decision on whether to retain overnight beds at Buckingham hospital and how much money per annum these beds cost the NHS Trust? And how would that decision be taken and by whom?

The following question had been received from Ozma Hafiz and was read out by the Chairman.

Q2. Bed closures in Buckinghamshire were contributing to national patients being affected with operations delayed at NSIC. We have less beds in Buckinghamshire compared to this time last year. Operations at Oxford had again been cancelled this week (http://www.bbc.co.uk/news/uk-england-oxfordshire-43470237) Would the Committee agree that it was time to reopen beds at Marlow, Thame and Wycombe Hospital and restore services to meet population needs.

The Chairman asked BHT to note the question.

The following question had been received from Andrew Clark and was read out by the Chairman.

Q3. What impact would the potential closure of beds at community hospitals have on the health and wellbeing of disabled people living in the relevant localities, and when would the equality impact assessments of these changes be published?

These three questions had been sent to the BHT for a response.

The following question had been received from Linda Derrick and was read out by the Chairman.

Given that:

a) The report on "Developing out of hospital care: Community hubs pilot evaluation and next steps" was dated yesterday (11 April 2018)
b) The Trust refused to provide a copy earlier and referred me to BCC's website; and
c) The deadline for questions from the public was 5pm today ((12 April 2018)

(i) Precisely when did the report go on BCC's website?
(ii) How long does this give members of the public to read the report (which was 51 pages long) and prepare and submit questions; and
(iii) Does BCC or the Trust believe this was a transparent, open or democratic way of making and scrutinising decisions on what is an important healthcare issue for residents in Buckinghamshire?

A written response would be sent after the meeting.

5 CHAIRMAN'S UPDATE

The Chairman reported that the RAG status in the previous minutes for this inquiry had been updated and a copy of the recommendation monitoring report would be attached to the minutes.

6 COMMITTEE UPDATE

There were no updates from members of the Committee.

7 BUCKINGHAMSHIRE, OXFORDSHIRE & BERKSHIRE WEST STP - 12 MONTH PROGRESS

The Chairman welcomed Lin Hazell, Cabinet Member for Health and Wellbeing; Ms L Patten, Accountable Officer, Bucks Clinical Commissioning Groups (CCGs); Ms L Watson, Managing Director, Bucks Integrated Care System; Ms G Quinton, Executive Director, Communities, Health and Adult Social Care, Bucks County Council (BCC) and Mr N Macdonald, Chief Executive, BHT to provide an update on the Buckinghamshire, Oxfordshire and Berkshire West (BOBW) Sustainability and Transformation Plans (STP).

Ms Patten referred to the presentation in the agenda pack and made the following main points:

- Anything that made sense to do at scale in terms of commissioning would be undertaken at scale and the following facts and figures were provided as an example of how it was working:

- ❖ Total population of 1.8 million
- ❖ £2.5 billion place-based allocation
- ❖ Three Clinical Commissioning Groups
- ❖ Six Foundation Trust and NHS Trust providers
- ❖ 14 Local Authorities

- Ms Patten was now Interim Chief Executive Officer of Oxfordshire CCG as well as leading the Buckinghamshire CCGs.
- Fiona Wise was the STP Executive Lead from 5 March 18.
- The programmes led by the STP included cancer alliance, prevention, population health management, estates and workforce.
- Best practice was being shared in urgent and emergency care, mental health, primary care and maternity.

Ms Watson said she had been in post for 3 months to support the Buckinghamshire Integrated Care System and emphasised that she was not aligned to any particular organisation; her post was to support and challenge the system to ensure the best outcomes for the population of Buckinghamshire.

Ms Watson then highlighted the following points with regard to the Buckinghamshire Integrated Care System:

- The vision and objectives of the Integrated Care System.
- The transformation journey so far.
- The work with BCC on the emerging care model to target services for those most at need and make the best use of resources.
- The significant amount of engagement with the public and stakeholders over the last year and highlighted that engagement would continue during 2018.

Ms Quinton mentioned the following points concerning the integration and transformation of social care:

- Adult Social Care had recently launched its new strategy called The Better Lives Strategy and within this was the context of the transformation programme.
- The aims – to help people live independently; to help people regain control of their independence; help for people to live with support but as independently as possible.
- The Strategy was underpinned by a new social work approach model which focussed on what people could do rather than what they could not do.
- £161m was spent on adult social care; it was a very complex system supporting over 8,000 clients with a myriad of providers.
- There were approximately 10,000 new contacts into adult social care each year, of which 2281 resulted in an ongoing care package i.e. 22%, a ratio of 5:1; best practice was 22:1.
- At the moment, 59% of people were helped to live independently but this should be much higher at approximately 80%.
- The average length of stay in residential care was approximately 2.6 years; best practice was 1.8 years.
- Different types of provision of care and support were needed to allow people to live independently.
- There would be better commissioning of services, reduced duplication, focus on evidence and prevention, early health and tele-health.
- There were three tiers – living independently, regaining independence, living with support.

In response to a question on whether the STP would be able to support the huge growing older population in Buckinghamshire and reduce the ratio of people needing a care package to 22:1, the following points were made:

- Ms L Patten said the majority of the care will happen locally in Buckinghamshire but it meant that, where possible, it made sense to commission at scale with linkage between Buckinghamshire and Oxfordshire.
- Ms Quinton said the ratio would involve building more community capacity and would need investment. It could be achieved by redistributing resources already in the system e.g. if the average length of stay in residential care was reduced by six months there would be a nett saving of £2 m.
- The following demographic figures were provided: 33% of ASC clients were less than 65 years old, 54% were between 65-85, 13% were over 85. It was acknowledged that the number of people aged over 85 would increase and that Adult Social Care needed to be prepared.
- Ms L Watson clarified that they were looking at what made sense in the whole of Buckinghamshire and said that the providers in Buckinghamshire had signed a provider collaborative agreement. It would mean looking at developing integrated teams and involving social care professionals to integrate the resource into a multi-disciplinary team. It would need to be planned very carefully with a realistic timescale.
- In response to a question regarding the difficulty in getting a primary care appointment; the pressure moving to a different place and taking people out of the GP service; Mr Macdonald said providers could not work in isolation and that there was a shortage of GPs and nurses. GP surgeries could offer more services if district nurses, reablement services and other support services were provided which would prevent people from going to hospital. Mr Macdonald added that BHT was one of eight pilot sites and was learning from best practice and co-designing collectively to provide more services via GP clusters than individually.

The following points were made with regard to how the move would be made from “aspiration” to “delivery” and how the objectives would be measured.

- Ms Quinton provided the example that in December 2017 there was a significant waiting list for occupational services. There was now a triage service which prioritised calls and adopted a process called “trusted assessor models” which meant the health professionals were trusted to make those decisions on Adult Social Care’s behalf for relatively low cost equipment that could transform people's lives resulting in people obtaining equipment much faster than they would have done otherwise. There was no need for expensive assessments and as a consequence the waiting list, which was approximately 900 clients, was now down to about 90 and would be zero by May 2018.

A Member asked to see performance metrics to demonstrate direction of travel at a future Committee meeting.

Action: Ms Quinton

In response to a query asking for clarification on the statistic of 22:1 receiving a care package and the strength based approach to social care, Ms Quinton made the following points:

- The strength based approach to social care was not new; it was part of the principles

and values of social work practice but had not been adopted in Buckinghamshire before.

- The new model involved healthcare professionals having a different type of conversation with people on how they could regain their independence rather than saving money.
- The ratio was indicative of the dependency model created, which is not what people want.
- More telecare and digital assistance could be provided in people's homes so they could stay at home for longer and by providing different types of environments such as supported living and extra care rather than residential care.
- Fewer people would get high end care packages, resulting in dependency and worse outcomes. More people would receive other types of care, which focused on enabling independence.
- It was confirmed that there was eligibility criteria for care.
- BCC was sharing best practice with colleagues from other local authorities via the Association of Directors of Adult Social Care and Social Services (ADASS).
- Best practice nationally was confirmed as 22:1; regional data was not yet available but Ms Quinton agreed to provide the figures to the Committee.

Action: Ms Quinton

- Part of the care model being developed was heavily reliant on local pharmacists in towns and villages to provide diagnoses of minor illnesses and ailments and the immunisation programme.
- Ms Patten said the work of pharmacists in care homes was incredible and would provide more detail to the Committee at a later date.

Action: Ms Patten

- In response to a query over whether Ms Patten had the capacity to cover both CCGs; Ms Patten said she had been covering the two roles since January 2018 and that the funds that would have funded the other Accountable Officer in Oxfordshire had gone into the team to help provide the backfill. It was not to save money; the most important thing was her personal experience and it made it much easier to see what could be done across the two CCG areas as there were masses of similarities across Buckinghamshire and Oxfordshire and opportunities existed to reduce overlap.
- Ms Patten clarified that the whole of the Thames Valley area was looking at their diagnostic capacity in cancer so it could be mapped across the demographic growth in the next ten years.
- The GPs were independently contracted to the NHS but were encouraged to work together in clusters across the County in order to expand opening hours and reduce costs and provide a comprehensive service for patients; however, this was still in development.
- Ms Quinton confirmed that the figure of 33% of under 65 year olds requiring adult social care was in line with the demographic profile of other areas.
- A green paper on the future funding of health and social care was expected to be published in the summer of 2018.
- In response to a question on where public health education would play a part; Ms Watson explained the following:

    - There was a key strand on population health management.
    - The ICS networked across the country with the other seven sites to learn from each other.
    - There was a significant, sophisticated modelling tool in the NHS to compare with other geographical areas.

- In Buckinghamshire there were likeminded localities which could be shared with the Committee.
- The ICS was working closely with the BCC Public Health team on self-care and how to ensure local communities were equipped to deal with local people which would be good to share with the committee as it was one of their "four pillars".

- A Committee Member asked when people would see a change as it was hard to understand in detail what progress had been made so far and the level of public and stakeholder engagement. Ms Patten offered to respond to Ms Jervis' points outside of the meeting and thought it best if Ms Wise attended the next meeting.

Action: Ms Patten and Ms Wheaton

- Not all the provider contracts were managed by BCC and Ms Quinton confirmed that there was a large team of commissioners monitoring the contracts.
- Ms Watson clarified that she had set objectives for 2018 and that the first one was the creation of the delivery plan with measurable outcomes. There would also be a gateway review process at the end of September 2018 which would look at the indicators set alongside the financial reporting elements. Ms Watson would be looking at a shared system reporting mechanism and operating model for the ICS.
- Mr Macdonald reported that since December 2017 patients could access a GP at Stoke Mandeville hospital via a triage system. On 3 April 2018 the MIIU service in High Wycombe was brought back in to the ICS under BHT so it would now be possible to link up 111, A & E, the out of hours service and the district nursing team to make it easier to navigate for people. There would be more changes in the future and Ms Watson confirmed the situation would be monitored.

The Committee NOTED the progress made in delivering the plans set out in the BOBW STP as well as the progress of the ICS in delivering the local plans.

8 DEVELOPING CARE IN THE COMMUNITY - END OF 12 MONTH COMMUNITY HUBS PILOT

The Chairman welcomed Ms C Morrice, BHT; Dr M Thornton, GP Partner Unity Health and Clinical Lead, FedBucks; Mr N Macdonald, Chief Executive, BHT and Ms L Patten, Accountable Officer, Bucks CCGs.

Mr Macdonald advised it was important to review the pilot as part of the jigsaw of the STP and ICS in trying to pull together to solve the growing issue of effectively managing emergency demand and dealing with some of the issues of an increasingly frail and elderly population Mr Macdonald also thanked the members of the Thame and Marlow stakeholder groups.

Ms Morrice said the purpose of the presentation was to provide an overview of the full paper contained in the agenda pack. The aim of the presentation was to share the results, explain how the pilot fitted into the wider communications strategy and outline the next steps. The following points were highlighted:

- 600,000 contacts cared for outside of hospital annually.
- Working with partners to ensure safe services were provided.
- Invested over £1m to expand community services.
- Delivering what patients and clinicians had asked for.
- Creating a health and social care environment to reduce pressure on the GPs and

hospitals.

- Developing locality teams, rapid response intermediate care teams and community care co-ordinators.
- There had been a 12 month pilot at Marlow and Thame hospitals which had provided a new community assessment and treatment service (CATS), more outpatient clinics and more diagnostic services.
- The pilot was run with a strong governance structure by an operational group.
- Dr Thornton advised that The Clinical Innovation Group had been looking at how to develop the service further. Frailty was an emerging area and clinicians had been looking at the next steps of development to try to predict who may need to use the service.
- Ms Morrice said she worked with the Stakeholder Engagement Group and had received a lot of challenge on the key performance indicators. Stakeholders had provided a wealth of information on the population.
- Over **300%** more patients had been seen in CATS than in the inpatient service in 2016/17 at Marlow and Thame.
- 92 people were followed up on in their own homes.
- Less than 1% of patients seen by CATS were subsequently referred to A&E.
- The number of Community Care Co-ordinator referrals of 6,063 included families.
- Patients felt the clinicians had the time to listen and understand care needs.
- Patients thought the new model should have been better communicated.
- Transport was a consistent issue; there had been some progress with looking at using transport hubs and having staggered appointment times.
- Stakeholder views on the hubs were obtained by a variety of means.
- Recommendations from the stakeholders were to raise awareness, increase the service to five days a week, consider expanding the process to self-referral, more outpatients and voluntary sector involvement.
- Dr Thornton showed an example of what the model of care might look like which showed input onto self-management with more support. GPs had started to work together and were empowering people to look after themselves.
- The proposed next steps over the next two years were as follows: Phase 1; to continue with the community hubs in Marlow and Thame. Phase 2; April-June 2018 – to review the out of hospital care model. Phase 3; June 2018-2019 - to increase the scale of delivery of the hubs and integrated teams across the county. Phase 4; to roll out the full care model by March 2020.

A short video was shown.

In response to questions from Members, the following key points were made:

- There were no negative comments in the report as no formal complaints had been received. The staff tried to resolve issues at the time but acknowledged there had been issues around transport. However, nothing had been hidden and Ms Morrice reiterated that there had not been any specific complaints about the hubs themselves.
- Feedback had been received to say that more could be done and Ms Morrice agreed that the service needed to be taken up a notch to get to the harder to reach communities. Ms L Jones, Director of Communications, BHT, said the stakeholder engagement had been focussed on Thame and Marlow. In Buckingham there was a group looking at how to develop a joined up approach to bring different work streams together.
- Ms Patten said a key area was to provide information and work on prevention at the national STP level in order to educate people and change their behaviour. Dr Thornton acknowledged that behaviour change was a major challenge and advised

that a programme called care and support planning had been implemented to try and achieve behaviour change in those people that were ready for it. The challenge was to find out the barriers that prevented people living independently

- Mr Macdonald said there had been eight beds in Thame and 12 in Marlow and the starting theory was that resources could be invested in different models of care to reach out and treat more patients and prevent people coming into hospital. Mr Macdonald thought if beds were built at the rate that the population changes in traditional healthcare required it would not be affordable; another limiting factor was the shortage of nurses.
- The stakeholder groups did not want the beds to be re-opened; they wanted a better use of resources. Rather than waiting for a GP to send a patient to the community hub; the hub should be getting the data out of the GP system and targeting those individuals who were at risk and likely to be healthcare users and proactively bringing them into the hubs to develop bespoke care plans that were beyond what a GP could provide.
- The Buckingham situation would be decided jointly with the residents of Buckingham. Mr Macdonald offered to find out the cost of a bed outside of the meeting.

Action: Mr Macdonald

- £0.5m worth of community care in terms of care packages and domiciliary care were put in place over the winter period to support people coming out of hospital sooner which had worked well considering the extraordinary levels of demand this winter. It would be an ongoing challenge and the key would be to reduce the number of people turning up in the A&E department. Mr Macdonald said he supported the GP cluster scheme and the building of community hubs that could spend more time, particularly with the frail elderly, or providing more outpatient care and then connecting to the hospital only when required.
- Dr Thornton said the project was massive; and agreed that mental health patients need the right services in place; the pilot was one small cog in a much bigger wheel. As a GP he could see much more clearly how the system could connect together.
- Dr Thornton explained that the big agenda was to identify patients who were housebound. If transport was provided; housebound patients could often get to appointments but were put off psychologically. It was more time consuming for various clinicians to go out to people's houses and it would be a better use of resources for transport to be provided to get people to the hubs.
- The ideal would be to expand opening times at Thame.
- Access to be hubs had been through GPs but it could become a self-referral process.
- Volunteers could make the hubs more sustainable e.g. by running exercise programmes. It was felt there were a lot of retired people in Buckinghamshire who could contribute.
- Ms Jervis, from Healthwatch Bucks, asked for reassurance that BHT would work with BCC to consider building plans and the existing transport infrastructure. Ms Jervis felt transport needed to be a priority and that there were opportunities for strategic working to support community transport and the flow of patients to and from appointments.
- It was suggested that a lot of people in Buckinghamshire were keen to be involved in the clinical intervention group.
- Transitional beds had been in place since the autumn 2017. Patients were assessed as to whether they needed a transitional bed rather than an acute bed. The aim was to move people out of hospital more quickly. The outcome had remained the same in that the patients were no more or less likely to be re-admitted to hospital. Mr Macdonald said there had not been enough volume to ascertain if it cost less to run.
- In response to a query on the funding situation if the community hubs were to open

five days a week; Ms Morrice said the early evidence showed that reduced duplication would release funding to be re-invested into care outside of a hospital setting.

- Ms Morrice added that the community hubs provided the opportunity to do something different; often an occupational therapist could give a better outcome than a nurse; releasing nurses to deal with those with more complex needs.
- The data on page 43 was queried and the Committee asked for defining terms, baselines and clinical outcomes to be provided. Mr Macdonald offered to produce a data fact sheet.

Action: Mr Macdonald

- Mr Macdonald clarified that intermediate care was the reablement and community based services. MUDAS was the original service based in Wycombe and similar to the CATS service. A single point of access had been introduced for GPs to refer to.
- A committee member raised concern that early discharge would have an impact on carers particularly as carers' respite was not as readily available. Ms Morrice agreed it was necessary to monitor the impact on carers and to look at the health support network for the person.

It was agreed that more time was needed to be dedicated to this important subject and that the Committee would ask more questions at the next meeting on 22 May 2018. The Chairman thanked the presenters for attending.

9 COMMITTEE WORK PROGRAMME

The Chairman thanked everyone for attending the meeting. Mr Martin thanked Ms Wheaton for the preparation documents.

10 DATE AND TIME OF NEXT MEETING

Tuesday 22 May 2018 at 10.00 am in Mezz room 1, County Hall.

CHAIRMAN

Dear Linda,

Please see below responses to the questions you submitted for the Health & Adult Social Care Select Committee meeting held on Tuesday 24th April.

1. **When did the report go on BCC's website?**

Response - The report was published as part of the agenda pack for the meeting. It was first published on Thursday 12th April and then re-published on Monday 16th April within the statutory deadline. The agenda pack was republished in order to incorporate further public questions which were submitted.

2. **How long does this give members of the public to read the report (which is 51 pages long) and prepare and submit questions?**

Response – Public questions can be submitted at any time but the deadline for receiving questions for a specific meeting is 7 working days before the meeting. The public questions were handled in accordance with the guidelines published on the Council's website and Constitutional requirements.
Bucks Healthcare Trust published the engagement report as part of their public Board papers and the key performance indicators are published regularly on the Trust's website.

3. **Does Bucks County Council or the Trust believe this is a transparent, open or democratic way of making and scrutinising decisions on what is an important healthcare issue for residents in Bucks?**

Response – The purpose of the Health & Adult Social Care Select Committee is to hold decision-makers to account through its scrutiny process to help improve outcomes for the public. The Committee welcomes public involvement and invites the public to attend meetings or to watch them live on webcast to promote transparency. Whilst the Committee is not a decision-maker on health issues, the Committee is keen to ensure that the public are able to have their say and, as such, the Committee provides a public question procedure so that the Committee can pass questions onto the appropriate health organisation for a response. This is in addition to public engagement activities undertaken by the health sector.

Regards,
Liz

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