Buckinghamshire Council

Health & Adult Social Care Select Committee

Agenda

Date: Thursday 3 February 2022

Time: 10.00 am

Venue: The Oculus, Buckinghamshire Council, Gatehouse Road, HP19 8FF - Aylesbury

Membership: J MacBean (Chairman), S Adoh, P Birchley, M Collins (Vice-Chairman), P Gomm, T Green, C Heap, H Mordue, C Poll, G Sandy, R Stuchbury, A Turner, L Walsh, S Morgan, J Wassell and Z McIntosh (Healthwatch Bucks)

Agenda Item		Time	Page No
1	**APOLOGIES FOR ABSENCE AND CHANGES IN MEMBERSHIP**	**10:00**	
2	**DECLARATIONS OF INTEREST**		
3	**MINUTES** To confirm the minutes of the meeting held on Thursday 25th November 2021.		**5 - 10**
4	**PUBLIC QUESTIONS** Public questions is an opportunity for people who live, work or study in Buckinghamshire to put a question to a Select Committee. The Committee will hear from members of the public who have submitted questions in advance relating to items on the agenda. The Cabinet Member, relevant key partners and responsible officers will be invited to respond. Further information on how to register can be found here: https://www.buckinghamshire.gov.uk/your-council/get-involved-with-council-decisions/select-committees/		
5	**CHAIRMAN'S UPDATE**	**10:10**	
6	**BUCKINGHAMSHIRE HEALTHCARE NHS TRUST'S COMMUNITY HUBS** Committee Members will hear from Buckinghamshire Healthcare	**10:15**	**11 - 84**

Trust's representatives on the Trust's proposal to continue to operate Marlow and Thame as community hubs on a permanent basis, as part of the Trust's strategy to develop care closer to home.

Presenters
Ms K Bonner, Chief Nurse
Mr D Williams, Director of Strategy

Papers
Report attached
Equality Impact Assessment Community Hubs, April 2018
Early Supported Discharge Orthopaedic Service (ESDOS)
Patient leaflet (ESDOS)
Stroke Patient Pathway

7	**ADULT SOCIAL CARE BETTER LIVES STRATEGY**	**11:30**	**85 - 116**

Buckinghamshire Council's Better Lives Strategy 2022-25 reiterates the direction of travel set out in the original Better Lives Strategy 2018-21. Committee Members will examine the progress made through the first strategy and the scope of the second phase of the transformation programme.

Presenters
Cllr A Macpherson, Cabinet Member for Health and Wellbeing
Ms G Quinton, Corporate Director, Adults and Health

Papers
Covering report
Appendix 1 - Better Lives Strategy 2022-25
Appendix 2 – case studies

8	**HEALTHWATCH BUCKS UPDATE**	**12:30**	**117 - 120**

The Committee will receive an update on recent key projects for Healthwatch Bucks.

Presenter
Ms Z McIntosh, Chief Executive, Healthwatch Bucks

Paper
Update attached

9	**WORK PROGRAMME**	**12:40**	**121 - 124**

For Committee Members to discuss the items for the March meeting and to discuss ideas for the work programme for future meetings.

Presenters
Committee Members

Papers
Work programme attached

10	**DATE OF THE NEXT MEETING**	**12:50**

The next meeting is due to take place on Thursday 24th March 2022 at 10am.

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 democracy@buckinghamshire.gov.uk.

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Buckinghamshire Council

Health & Adult Social Care Select Committee

Minutes

MINUTES OF THE MEETING OF THE HEALTH & ADULT SOCIAL CARE SELECT COMMITTEE HELD ON THURSDAY 25 NOVEMBER 2021 IN THE OCULUS, BUCKINGHAMSHIRE COUNCIL, GATEHOUSE ROAD, AYLESBURY HP19 8FF, COMMENCING AT 10.00 AM AND CONCLUDING AT 12.30 PM

MEMBERS PRESENT

J MacBean, S Adoh, P Birchley, M Collins, P Gomm, T Green, C Heap, H Mordue, C Poll, G Sandy, R Stuchbury, A Turner, S Morgan, J Wassell and Z McIntosh

OTHERS IN ATTENDANCE

Mrs E Wheaton, Dr J O'Grady, Mr D Williams and Dr T Kenny

Agenda Item

1 APOLOGIES FOR ABSENCE/CHANGES IN MEMBERSHIP

Apologies were received from Cllr Liz Walsh.

2 DECLARATIONS OF INTEREST

Cllr Chris Poll declared an interest in item 7 as his son was employed by Buckinghamshire Healthcare NHS Trust in the spinal injuries department.

3 MINUTES

The minutes of the meeting held on Thursday 30th September 2021 were agreed as a correct record.

The Chairman updated the Committee on the actions from the last meeting.

- Page 7 - Adult Social Care Winter Plan – the national ASC Winter Plan had just been published so ASC colleagues were currently considering the local plan in relation to this. The plan would be circulated to the Committee once completed.
- Page 7 – GP Access. This was discussed at the recent Health & Wellbeing Board meeting alongside a paper which had been produced by the CCG. The Chairman encouraged Members to view the webcast of this meeting and listen to the discussion.
- Page 8 – Local Directory of Services used by 111 service – Caroline Capell, Director of Winter Planning, had responded to say that BHT had completed a lot of the work as part

of Winter preparation. This would continue to be an ongoing process as all services/providers need to be reviewed every year and a pathway had now been set-up for this.

- Page 8 – involvement of local pharmacists in developing the Winter plan – the chief officer for the local pharmaceutical committee attended the recent Health & Wellbeing Board meeting as part of the winter plan discussions. Colleagues from primary care publicly thanked the support that local pharmacists had provided, and continue to provide, to the local population.

4 PUBLIC QUESTIONS

There were no public questions submitted for this meeting.

5 CHAIRMAN'S UPDATE

The Chairman updated Members on the following:

- Members of the Inquiry Group looking into Primary Care Networks had met to discuss the scoping document. A meeting with the Clinical Commissioning Group's Head of Primary Care Network Development and Delivery was taking place at the beginning of December. Further evidence gathering sessions would take place in January/February.

6 FUTURE GP AND HEALTHCARE SERVICES IN BUCKINGHAM

The Chairman updated Members on the future plans for primary care in Buckingham.

The public consultation closed on 16th November 2021. The Chairman had submitted a formal response on behalf of the HASC Select Committee which highlighted a number of concerns, including the lack of an Equality Impact Assessment (EIA) and a request that the end of consultation report be presented at a future Committee meeting.

7 BUCKINGHAMSHIRE HEALTHCARE NHS TRUST'S CLINICAL STRATEGY

The Chairman welcomed Mr D Williams, Director of Strategy, Buckinghamshire Healthcare NHS Trust and Dr T Kenny, Director of Clinical Partnership, to the meeting.

During their presentation, the following main points were made.

- Surveys with various key stakeholders and focus groups had been undertaken to help inform the strategy.
- The strategy outlines a commitment to quality of care, with the aim of maintaining the CQC's outstanding rating for compassionate care and to move the Trust's overall rating to outstanding.
- The core of strategy was also to improve the health & wellbeing of all Buckinghamshire communities and to help to keep older people at home for longer.
- The Trust was one of the biggest employers across the county and the workforce was a heart of what it does. Staff wellbeing was a priority for the Trust.
- The strategy aligns with the requirements put in place in light of the Covid-19 pandemic.
- A new paediatric department would be opening in April 2022.
- The clinical strategy aimed to provide emergency services on one site and then planned services on another site.
- The Trust was developing a community diagnostic hub at Amersham Hospital which would have extended hours and would move to 12 hours, 7 days a week, as necessitated

by demand in the fullness of time.

- The strategy also focussed on more Integration of community services so people with long-term health conditions could live more independently.
- A new innovation centre would be opening to extend research, especially in terms of spinal injury care. The Trust aimed to be nationally and internationally renowned for rehabilitation services for spinal injury patients.
- Investment in digital care would help to ensure a better patient experience with more co-ordinated patient records and more services available online (as appropriate).
- An Expression of interest had been made to the Government's national hospital infrastructure programme to invest in new facilities to care for Buckinghamshire's existing and growing population. Further details would be available in the New Year once a decision had been made. The public would be engaged on the options as these were developed.

During the discussion, Members asked the following questions.

- A Member asked for clarification around the difference between a Trauma Centre and a Trauma Unit. Dr Kenny explained that a trauma centre would handle the more serious illnesses that need more interventions, for example, cardiothoracic surgery patients. A trauma unit would handle less complicated issues, such as broken limbs.
- In response to questions about health inequalities, Mr Williams explained that waiting lists would be monitored by ethnicity and deprivation quintile to ensure inclusiveness. The Trust had commissioned Healthwatch Bucks to work with individual groups to help improve inclusive care.
- The Healthy Communities strategy was directly linked to health inequalities and each service within the Trust had been asked to outline their contribution to reducing health inequalities.
- Members agreed to consider reviewing health inequalities as part of the Committee's future work programme.
- A Member raised concerns about the planned housing developments in Buckinghamshire and the increased demand for healthcare services. Mr Williams confirmed that the Trust were partners on the Council's Growth Board.
- The Chairman raised concerns about changes in primary care and cited the recent proposed closure of the surgery in Long Crendon and the proposed future primary care services in Lace Hill, Buckingham and emphasised the importance of healthcare planning.
- A Member raised concerns around digital technology and accessibility of services, particularly for the most vulnerable patients. Mr Williams confirmed that face to face appointments were still being offered but he said that a lot of patients, who responded to the survey, said that they prefer virtual appointments, as it fits in better with their lifestyle.
- A Member commented that providing a good workplace for staff is not mentioned in the strategy. Dr Kenny advised that the report focuses primarily on services provided to patients, but a comprehensive work programme for staff ('Thrive') was in place to ensure staff wellbeing.
- A Member expressed concern that the recent surveys were carried out digitally and, therefore, excluded patients who have difficulties with accessing digital services. Dr Kenny explained that voluntary groups helped to distribute surveys and a number of focus groups were held to enable deeper conversations with specific groups.
- Mr Williams acknowledged that more work needed to be done to ensure all patients were well represented and reiterated that gaining feedback was a continual activity. Feedback was gained through the national inpatient surveys, the Friends and Family survey and through compliments and complaints made directly to the Trust. There were

also patient engagement groups who provided invaluable feedback on patient experiences. The Chairman suggested that these sources needed to be referenced and reflected in the strategy document.
- The importance of population health management had been highlighted throughout the pandemic. Dr Kenny went on to say that the development of primary care networks had led to more collaborative working practices between primary and acute services.
- The importance of the care navigator role in working with the Hospital Discharge team was acknowledged.

The Chairman thanked Dr Kenny and Mr Williams for attending and summarised that the development of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) would be key to delivering the clinical strategy, along with the Trust's Estates Strategy, development and delivery of the Primary Care Networks and the strengthening of services within the community. The Chairman confirmed that the Committee would be keeping a close eye on the strategy as it developed.

8 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

The Chairman welcomed Dr Jane O'Grady, Director of Public Health, Buckinghamshire Council and explained that reviewing the Director of Public Health's annual report was part of the Committee's remit.

During the discussion, the following main points were made.

- The annual report focussed on domestic violence and abuse and a wide range of stakeholders were involved in bringing the report together.
- Domestic violence and abuse was often unrecognised and under-reported.
- It was everyone's responsibility to look out for signs of domestic violence and to take appropriate action to safeguard those affected.
- A Member commented that there was a lack of understanding around the services available for children and that the Children and Adolescent Mental Health Service (CAMHS) was struggling to cope with the demand for their services. The Director of Public Health explained that the annual report shines a light on a specific issue and the recommendations were shared with partners for them to develop into action plans.
- A Member asked about the funding available for tackling this issue. The Director of Public Health responded that funding came out of the Community Safety team budget.
- A Member commented that the strategy needed to be embedded in order to make the necessary changes. The Director of Public Health explained that the strategy was owned by all the key partners and an action plan would be developed by the Domestic Abuse Board. She confirmed that it was a priority for the council.
- A Member expressed concern about the data collection methods to which the Director of Public Health explained that one of the recommendations was specifically focussed on improving data collection.
- A Member felt that the fear of children being taken away from them was a major factor in people not reporting domestic abuse and families need to be reassured.
- A local campaign would be developed in line with the national campaigns.

The Chairman thanked the Director of Public Health for her presentation.

9 HEALTHWATCH BUCKS UPDATE

Ms Z McIntosh, Chief Executive, Healthwatch Bucks updated the Committee on the latest activities and made the following main points.

- The Covid-19 vaccine report had now been published and a response had been received from the Clinical Commissioning Group.
- Access to NHS Dentists was still one of the key areas of concern raised by the public. A Member commented on the charges for PPE being added to the patient's bill and it was agreed that this should not be charged for. The Chairman suggested this issue be raised with key partners when dentistry was reviewed again by the Committee.
- A report on remote blood pressure monitoring would be published soon.
- A piece of work around cancer services was currently being undertaken.
- Hospital waiting times were being reviewed across the Healthwatch's covering the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.

10 WORK PROGRAMME

The Committee discussed the items for the next meeting and agreed to add Buckinghamshire Healthcare NHS Trust's proposal on the future of community hubs at Marlow and Thame Community Hospitals. As this was a new item for the February meeting, the Chairman said that she would review the work programme and make any necessary changes. The discussions around future plans for primary care in Buckingham may also need to come to the February meeting, but this had yet to be confirmed.

11 DATE OF NEXT MEETING

The next meeting is due to take place on Thursday 3rd February 2022 at 10am.

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Briefing for Health & Adult Social Care Select Committee

Date: 3rd February 2022

Title: Developing Care Closer to Home – Community Hub Proposal for Thame and Marlow

Author: Karen Bonner, Chief Nurse,
David Williams, Director of Strategy, Buckinghamshire Healthcare NHS Trust

1. Introduction

The purpose of this paper is to outline a proposal to continue to operate Marlow and Thame as community hubs, with no community inpatient facilities, on a permanent basis as part of our strategy to develop care closer to home.

The proposal to pilot community hubs was agreed in 2017. Since 2017 the Trust have been working with system partners to ensure that care is delivered in the right place at the right time enabling residents to remain independent for as long as possible.

The report indicates that the previous inpatient community wards at Thame and Marlow are not suitable for delivering high quality care. The size of the previous wards at 8 and 12 beds respectively do not provide the scale to ensure sustainable staffing and due to the age of the facilities enhanced infection control standards are challenging to meet.

The report provides evidence that the additional services introduced as part of the community hubs as well as to support a 'Home First' model of care have enhanced our ability to provide safe and effective care for patients. The paper outlines plans to develop this model, and the wider development of community health services, further.

The paper provides assurance that the proposals outlined have been developed in conjunction with the Buckinghamshire Health and Social Care Committee (HASC), patients and local stakeholders.

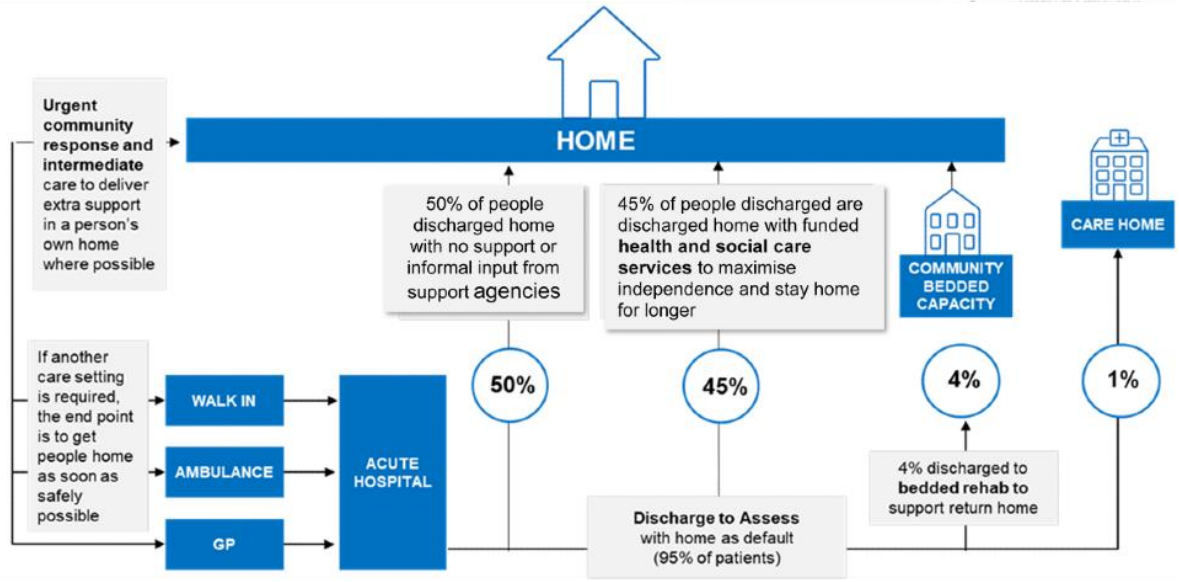
2. Background

Buckinghamshire is seeing a significant increase in the older population. It is estimated that the proportion of over 85s will increase by 38% in the county from 2022 to 2032.

There is strong evidence that for a frail, older person, a hospital admission can have a detrimental impact on their long-term health. Every ten days spent in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80[1]-. Yet each year, nationally nearly 350,000 patients spend more than three weeks in acute hospitals.

Community bedded capacity provides one of four pathways to support discharge for patients from hospital. These are outlined in a national discharge to assess pathways model along with estimated percentage of patients that require different levels of support.

Figure 1 Discharge to Assess Pathways Model [2]



3. Thame and Marlow Community Hub Proposal

In 2016 patients cared for under the '*Community bedded capacity*' pathway were delivered in four community hospitals in Buckinghamshire (Amersham, Buckingham, Thame and Marlow). A total of 80 beds. Evidence suggested that at any one time approximately 24

1

– Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

[2] Hospital and Community Discharge Support, Policy and Operating Model, October 2021, NHSE

patients would have their needs better met through a different pathway outlined here as '*discharge to assess'*.

The community inpatient wards in Thame and Marlow were undersized (8 and 12 beds respectively) which presented challenges with providing the optimum skillmix of staff to maintain high quality care. A high reliance on temporary and agency staff and challenges with flexing staff led the Trust to assess alternative models to support safe and effective rehabilitation for patients.

Following engagement with patients, GPs, staff, other health and social care organisations, voluntary organisations and local communities, a community hubs pilot was launched in Marlow and Thame in April 2017 to develop and test our vision of providing more care closer to home. The aim was to enable more patients to avoid hospital admission or if a hospital admission is unavoidable, helping them to return home. The number of Buckinghamshire community beds were reduced by 20; 8 beds at Thame and 12 beds at Marlow and an alternative model of care established.

The project also improved access to outpatient and diagnostic care at Thame and Marlow providing clinics closer to local communities.

Regular updates on the impact of the community hubs in Thame and Marlow have been provided to Buckinghamshire Health and Social Care Committee (HASC) and community groups since April 2017.

4. Impact of the pandemic

The pandemic, and the disproportionate impact on the older generation, has provided further evidence of the importance of helping to keep people healthy and well and providing support and care in local communities. The average weekly duration of strength and balance activity in adults aged over 65 fell by more than one third from 126 minutes (March-May 2019) to 77 minutes (March-May 2020). The proportion of adults over age 65 performing less than 30 minutes of moderate activity per week also rose to 32% from 27% during those periods. Accordingly, Public Health England has predicted that the total annual number of falls could increase by 124,000 (6.3%) in males and 130,000 (4.4%) in females.

The pandemic has highlighted the importance of infection control. The previous community ward spaces at Thames and Marlow provide significant challenges to meet these enhanced requirements.

During the pandemic, some of our outpatient clinics were delivered virtually for the safety of our patients and our colleagues. Going forward, we will continue to offer our patients a choice of virtual or face to face outpatient appointments based on clinical need and patient preference. The Community Assessment and Treatment Service (CATS) was also suspended during the two pandemic waves so that colleagues could be redeployed to support patients in our acute hospitals. These services were re-established in March 2021.

5. How we have developed the care closer to home model since the pilot was launched

Since the community hubs pilot began, additional services have been implemented to support the aim of helping people avoid hospital admissions and supporting safe discharge. Working with partners across the system, we have been working to ensure that care is delivered in the right place at the right time enabling residents to remain independent for as long as possible.

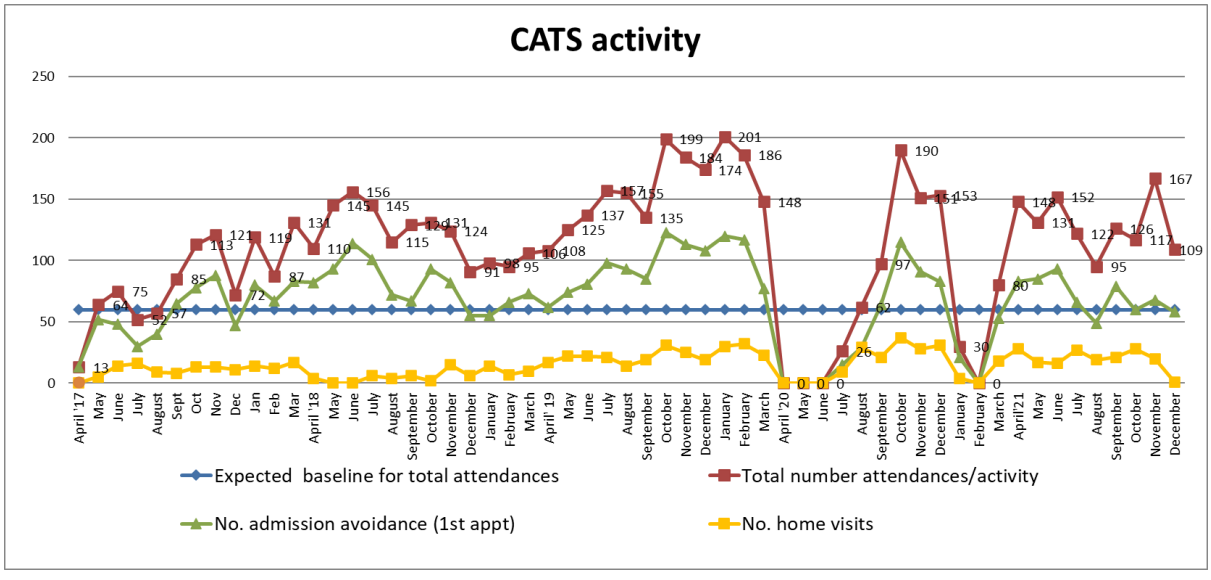
5.1 Urgent Community Response Services

5.1.1 Community Assessment and Treatment Service

The Community Assessment and Treatment service (CATS) is a multi-disciplinary rapid access service with geriatrician, nurse, GP and therapy input, supporting patients stay at home. Over 100 patients a month are seen across the two sites with an estimate of over 80 admissions to hospital avoided per month since March 2021.

The service was suspended at critical points during the covid response to enable re-deployment of specialist staff to support acute colleagues. In between these responses the service recovered quickly and regained its momentum in seeing patients. This is illustrated in the chart below:

Figure 2 CATS Activity April 2017-December 2021



A previous report in October 2018 demonstrated the reduced cost of an attendance at CATs compared to a community inpatient admission. The CATS service was able to see 131 patients in March 2018 compared to 23 community inpatients in the previous March. This demonstrates better value for money for NHS resources in the new model of care.

Following the pilot of the CATS service at Marlow and Thame, a similar service has been established at Amersham Hospital.

5.1.2 Urgent Community Response

Our ability to support patients with urgent needs in the community has been further enhanced by expanding our ability to provide urgent, crisis response care within two-hours and support discharge into the community within two-days.

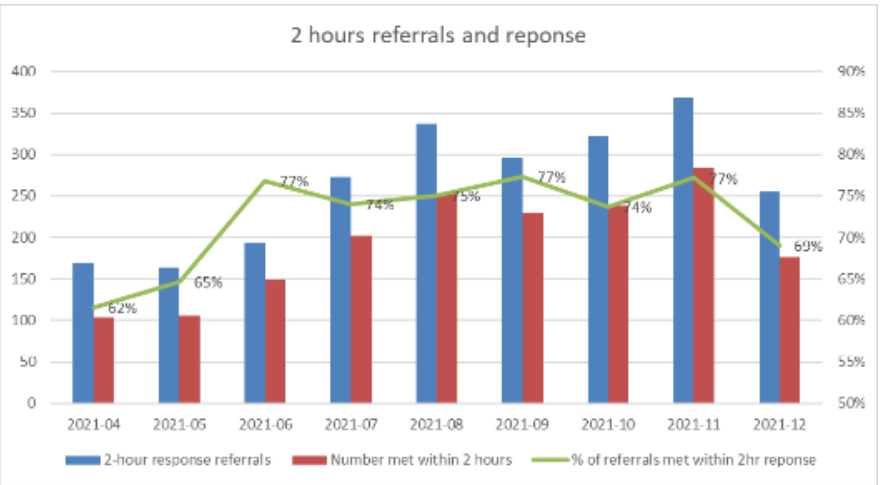
In partnership with social care, a two-hour urgent community pilot between 1 October 2020 and 31 March 2021 across three of the seven Rapid Response Intermediate Care (RRIC) teams in Aylesbury, Thame and Wycombe was introduced. This 'Ageing Well' service was enhanced to reduce preventable hospital admissions by keeping people in crisis in their home environment and facilitate swift discharges from A&E as soon as it was safe to do so, back to a patient's normal place of residence.

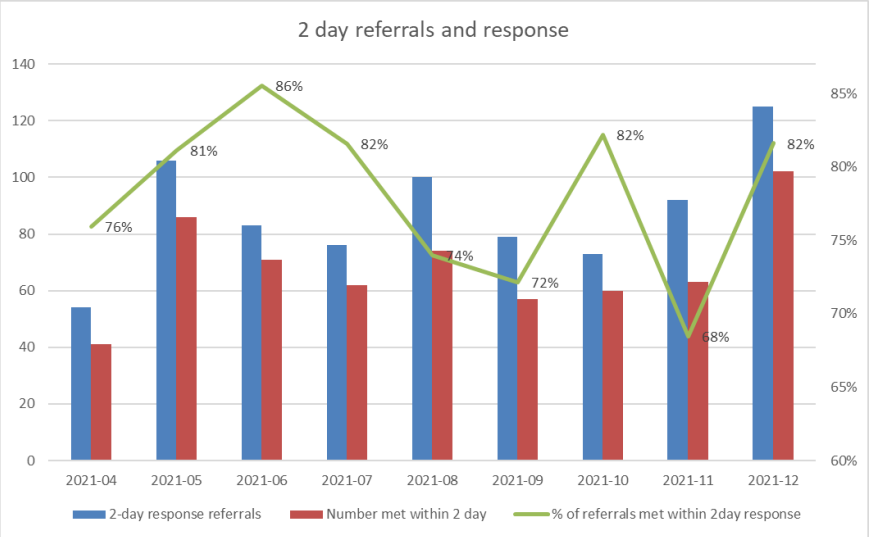
The pilot focused on two care areas:

- an enhanced therapy-led two-hour urgent community response for people at home
- an enhanced multidisciplinary rapid community response in care homes comprising of doctors, nurses and other health and care professionals working together to provide tailored support to help people live well and independently at home for longer.

Performance measures for Ageing Well are outlined below showing a steady increase in referrals in 2021.

Figure 3 Ageing Well Performance Indicators





5.1.3 Same Day Emergency Care (SDEC)

The Frailty SDEC Service was launched in November 2020. Following a GP referral or triage in A&E this new unit enables patients to be rapidly assessed, diagnosed and treated by a multidisciplinary team of doctors, nurses and therapists without the need for a hospital admission or waiting to be seen in A&E. Frailty SDEC is the provision of same day care for emergency older patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided. The community hubs enable prompt and well-informed referrals to SDEC if a patient requires a higher level of intervention but not admission and facilitates early and supported discharges by way of intermediate care, rapid testing further assessment and health monitoring in the community. The service reviews up to 10 patients a day, reducing the need for admission and facilitating safe and assisted return to home.

Some patients do require a more intensive and supported assessment and the community hubs are also able to refer patients either at triage or directly to our Multi-disciplinary Assessment Service (MuDAS) at Wycombe Hospital, which provides easier geographical access for the south of the county.

5.2 Discharge to Assess (D2A)

The Trust continues to advocate a 'Home First' approach, providing patients with support for safe discharge. Patients are supported to return to their home for on-going assessments on their needs in the community after a hospital stay. As shown in the model above 45% of patients require additional health and care services to support discharge home.

Buckinghamshire has implemented a Discharge to Assess Model (D2A) where discharge to home is the default pathway (with alternative pathways for people who cannot go straight home). This makes sure assessment of ongoing needs can take place in the community rather than in a hospital setting which is national best practice and better for patients in

terms of recovery. It ensures that patients are placed in the most appropriate setting for their care needs.

Since March 2020, Buckinghamshire have commissioned an additional 159[3] beds to support patients where no further clinical intervention is required so that patients can be assessed appropriately for home support.

5.3 Impact of Discharge to Assess Pathways in Buckinghamshire

The table below highlights the positive impact of the introduction of the discharge to assess model. Whilst overall discharges are reduced the total bed days occupied have reduced by 17.9% and 35.3% amongst those patients staying greater than 21 days, offering the hospital 8900 additional bed days from just the 21+ day group, which even allowing for the reduction in overall volume of patients is still more than 900 additional bed days per month (which is more than 30 beds available each day). Overall length of stay for patients has also reduced.

Table 1 Impact on D2A Model in Buckinghamshire

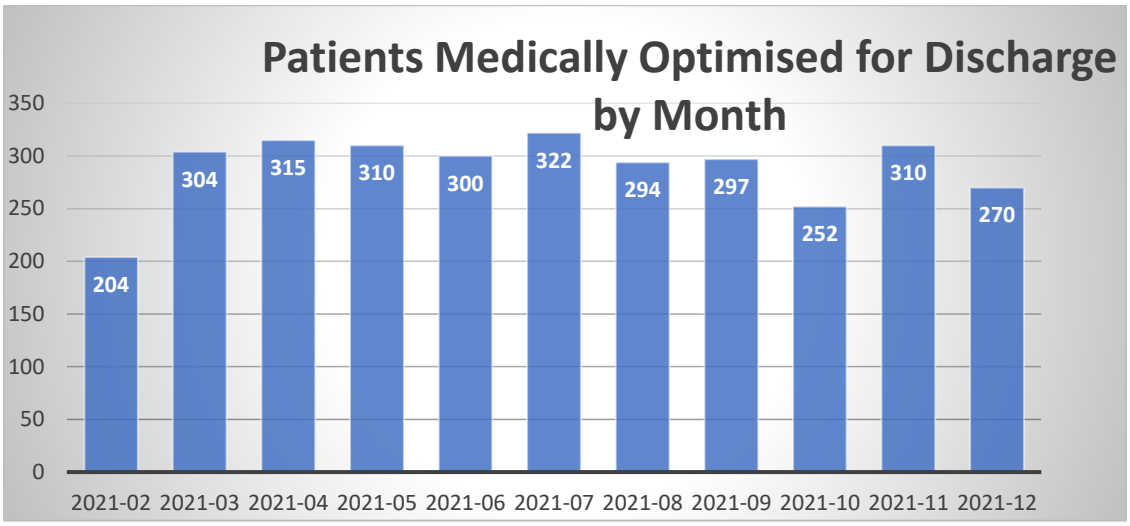
Ref	Description	2019-20 (M1-M4) D2A	2021-22 (M1-M4) D2A	Change	Change (%)
A	Total patients discharged	6251	5564	687	11.0%
B	Number of discharges LOS <21 days	5585	5064	521	9.3%
C	Number of discharges LOS 21< days	666	500	166	24.9%
D	Bed days occupied by patients LOS >21 days	25200	16300	8900	35.3%
E	Total Bed Days - All D2A	53700	44100	9600	17.9%
F	Average Length of Stay - All D2A	8.6	7.9	0.7	7.7%

Table 1 – Key discharge volume and bed day statistics

The number of patients who are medically fit for discharge home is a measure of community support. The monthly figures for the number of patients residing in hospital waiting for domiciliary, social, community, discharge to assess and care home support is highlighted below.

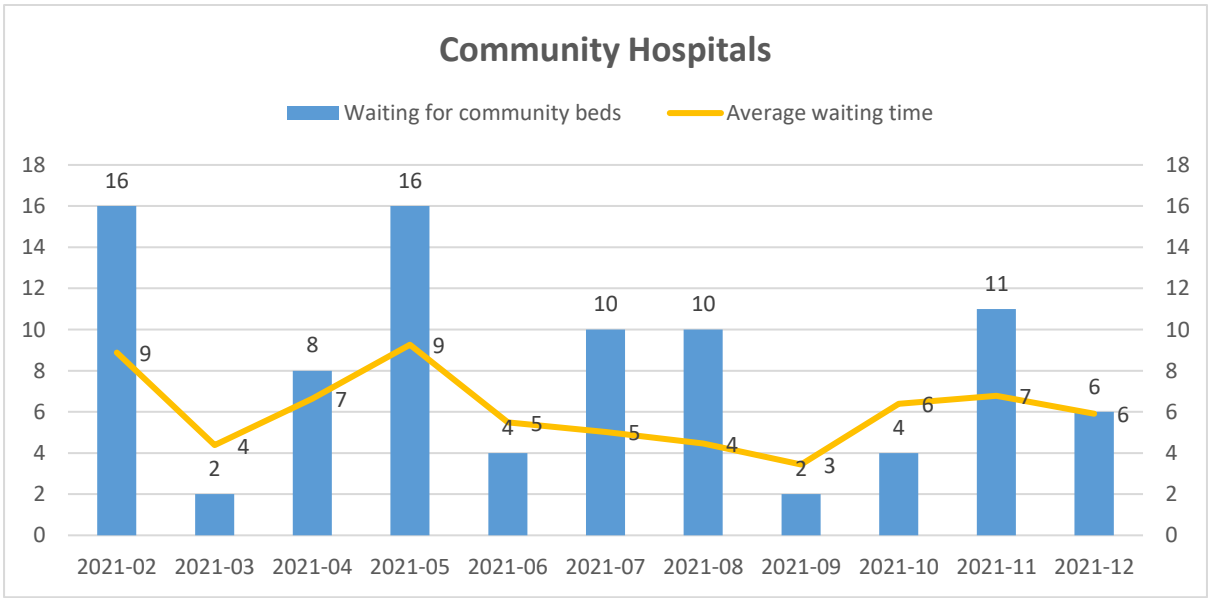
[3] 77 Discharge to Assess beds and 82 'spot purchased beds' in the community

Figure 4 Buckinghamshire - Patients Optimised for Discharge by Month 2021



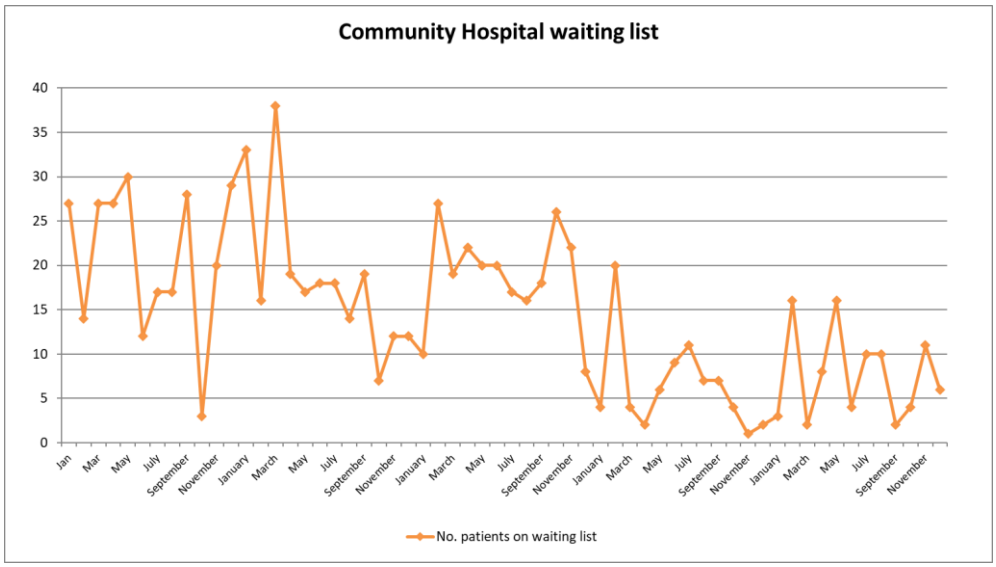
The patients waiting for community beds during this period is highlighted below.

Figure 5 Community Hospital – Number of patients waiting for community beds and average waiting time 2021



The figures above can be compared with previous years which has shown a gradual reduction in the number of patients waiting for community beds since 2017 as other services and support has become available in the Buckinghamshire system.

Figure 6 Community Hospital Waiting List January 2017-December 2021



The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services is a good measure of the support the Buckinghamshire health and care system provide to support patients in their own home after a hospital stay. This measure has improved year on year since 2016/7 against a Buckinghamshire local target of 75%.

Table 2 Rehabilitation Performance Measures

2016/17	2017/18	2018/19	2020/21
66%	72%	77%	87.9%

5.4 Future Plans for Home First, Discharge to Assess and Intermediate Care

There is clear evidence of better patient outcomes and experience as a result of Home First. All healthcare systems are expected to embed home first and discharge to assess as a default process for hospital discharge[4].

Given the introduction of new services a full demand and capacity model has been developed for Buckinghamshire for discharge pathways into community beds, care homes and discharge to assess pathways. The model predicts that community support for the system will increase by 16% over the next five years.

'Real time' scorecards have been developed which will enable services to match and flex their capacity to meet demand and to have visibility across all discharge pathways improving patient outcomes and experience.

[4] NHS Operating Plan Guidance, 2022/23, NHSE, Dec 2021

This model is forming the basis of a business case to develop a single integrated pathway for Buckinghamshire residents delivered across multi-disciplinary teams drawn across health and social care, including a proposal for future provision of bedded capacity across all settings. This will enable:-

- More efficient and cost-effective models of care and ways of working
- Dedicated beds for step up and step down
- Reducing in admissions and speeding up of D2A process
- Reduction on reliance on spot bed purchases

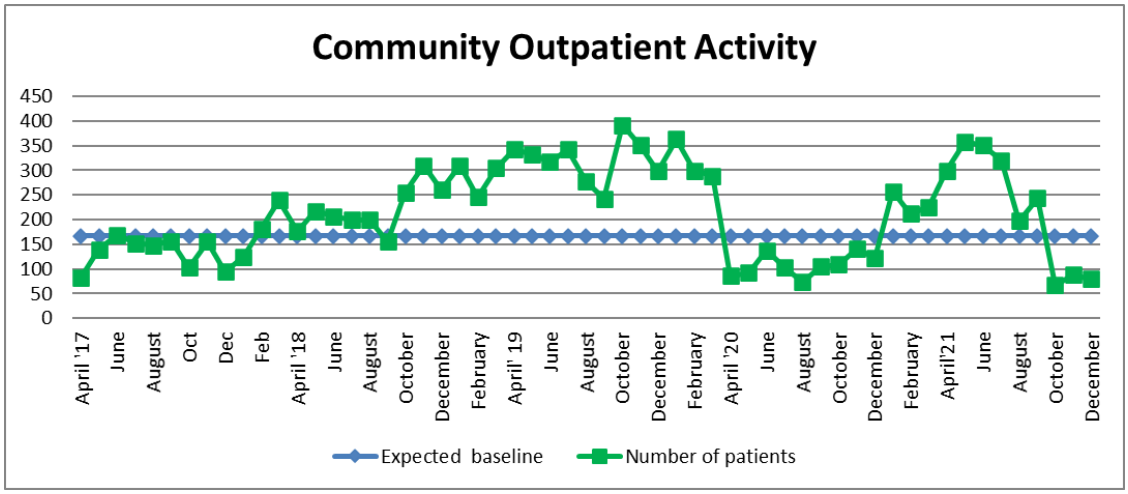
This case will be developed during 2022/23, learning from the changes instigated by the pandemic and will provide further assurance to system partners and the HASC that we are providing effective support to keep our patients safe and supported at home and on discharge from hospital care.

6 Outpatients and Diagnostic Services

6.1 Outpatient clinics

One of the aims of the pilot, was to increase the number of outpatient clinics available in local communities so that patients do not have to travel to one of our main hospitals. The chart below illustrates the increasing use (pre-covid) and the re-establishment of clinics since April 2021.

Figure 5 Community Outpatient Activity April 2017-December 2021



We are currently working closely with clinicians to further expand the range of outpatient clinics we are able to offer at Thame and Marlow.

Table 3 Comparison of outpatient clinics at Thame and Marlow Hospitals

Previous Thame Outpatient Clinics	**Current Thame Outpatient Clinics**
Rheumatology	Health visiting
Physiotherapy	BCG Clinic
Urology	Paediatric audiology
Heart failure	Bereavement counselling
Diabetes	Practice Plus Physiotherapy
Speech and language	Podiatry
X ray	Falls Specialist Clinic
Blood tests	CATS
ENT	Continence clinic
Respiratory	Heart Failure clinic
Dermatology	Plastics
	Pulmonary Rehabilitation
	Thame Day Hospital
	Ultrasound
	Tissue viability
	Hip and Knee team
	AAA screening
	Cancer Support
	Cancer Care
	Warfarin

Previous Marlow Outpatient Clinics	Current Marlow Outpatient Clinics
Rheumatology Physiotherapy Urology Heart failure Diabetes Speech and language X ray Blood tests ENT	Health visiting BCG Clinic Cancer Care Cancer support Oncology Physio Palliative care Physiotherapy Dietetics Podiatry Tissue Viability Vascular Falls Specialist Clinic CATS Continence clinic Heart Failure clinic Diabetes AAA Screening Warfarin Clinic Oral Surgery

6.2 Diagnostics

As well as the X-Ray facility at Marlow (which has not been operational during the pandemic due consolidating staffing in our main hospitals), an ultrasound scanner purchased by the local League of Friends has been installed at Thame since September 2019. Since the ultrasound scanner became operational, over 2,600 scans have been performed and it has remained operational throughout the pandemic. The Trust's diagnostic capacity will be further strengthened through the establishment of an expanded Community Diagnostic Hub (CDH) which will open shortly at Amersham Hospital. Not only will this provide additional capacity, operating 12 hours a day 7 days a week, but it will also improve accessibility and take the current pressure from our acute hospital sites. In 2021/22 we will extend the hours of operation radiology examinations and in the future we plan to offer other diagnostic services including examinations and tests for heart conditions and respiratory diseases at the CDH.

7. Engagement with patients and communities

This section summarises how we have worked with patients and local stakeholders from the inception of the services to ensure that their views shaped the development. We have maintained this engagement throughout with strong support for the current community hubs.

7.1 Community Stakeholder Group

At the start of the pilot, a Community Hubs Stakeholder Group was established to provide feedback and help us to shape services and ensure they were meeting the needs of the local community. The Community Hubs Stakeholder Group comprises of representatives from the Marlow and Thame League of Friends, local GP Patient Participation Groups, Buckinghamshire Older People's Action Group, local councillors as well as members of the general public. The Group has continued to meet on a regular basis and continues to provide valuable feedback to inform our plans and areas of focus. The Group has been supportive of the Community Hubs project and representatives from the Marlow and Thame League of Friends contributed letters of support in a report which went to HASC in April 2018 and are attached as Appendix 1.

In October 2021 a meeting with the Community Hubs Stakeholder Group reconfirmed support for the community hubs model to continue and to permanently close the community beds at Thame and Marlow.

In addition, continued engagement has taken place with the Bucks Older Peoples Action Group (BOPAG). A statement from the Chair of the Group in January 2021 also endorses our approach as Appendix 1.

7.2 General Public

In addition to the initial engagement that took place prior to the start of the community hubs pilot, we have continued to seek the views of the general public and key stakeholders as we have developed our community model of care.

Early in 2018 a series of workshops took place across the county to report back on what had been achieved in the pilot hubs in Thame and Marlow and gather their views on what care closer to home could look like across Buckinghamshire. The community hub model of care, received broad support across all stakeholder groups involved in the review. Whilst highlighting some issues regarding public awareness of the hubs and transportation issues, the consensus was that people wanted to see the current hubs continue and for model to be rolled out across Buckinghamshire, with provision tailored to needs in different areas. An evaluation report was submitted to HASC in April 2018.

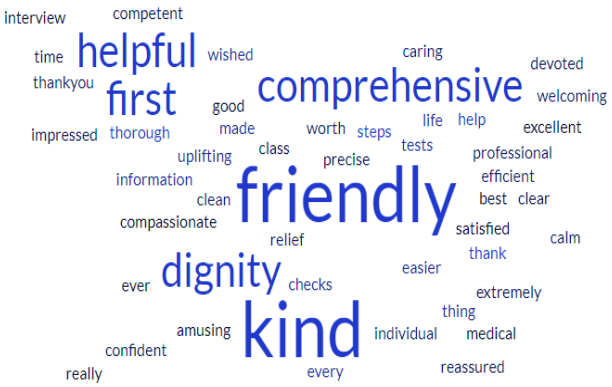
7.3 Buckinghamshire Integrated Care Partnership Survey

In August 2020 we, along with our partners from the Integrated Care Partnership, launched phase 1 of a public engagement programme to ask people what they thought about changes we have made, or are considering, in health and social care. The engagement was designed with support from the Getting Bucks Involved Steering Group which includes members of patient participation groups, representatives from local charities and Healthwatch as well as members of the public. One of the themes was regarding community services, seeking views on organisations working together to promote independence and delivering care in people's home and communities.

Phase 1 was a survey which gathered data from over 2,800 respondents; the majority of whom were white females with an average age of 60. Whilst the concept of community hubs was now well known, the idea was well received with 66% of respondents saying that they would prefer to recover at home than in a hospital if it was safe to do so. Phase 2 was designed to actively seek representation from a diverse range of Buckinghamshire residents, especially groups who are not often reached by such research, such as people living in areas of deprivation. Participants in these focus groups expressed a need for beds to be available to support people who, whilst medically fit, could not be discharged from hospital to their homes.

7.4 Service Users

In the 12 months (2019/2020) pre COVID-19 we had 100% of patients rating the CATS service as good or excellent.



Feedback received since the service has resumed include:

“Everybody was so helpful, and the advice and assistance has changed my life. Nothing was too much trouble and I had as much time as I needed.”

“I went home not quite fixed but having taken the first steps along the road. Thank you”

“You gave me a great uplift with all the checks, tests and information I could have wished for.”

Frailty SDEC, MuDAS and Ageing Well projects have been well received by patients who have articulated the impact of the high quality care received. Friends and family surveys across these services indicate a high level of satisfaction from the patients who have used these services.

7.5 Statutory Bodies

In November 2021 Buckinghamshire Clinical Commissioning Group (CCG) Governing Body supported the recommendation to continue with the community hubs in Thame and Marlow on a permanent basis as did the Buckinghamshire Healthcare NHS Trust Board in January 2022.

7.6 Buckinghamshire Health and Social Care Committee (HASC)

Continued liaison has taken place with the Buckinghamshire Health and Social Care Committee (HASC) and assurances and evidence are attached to this paper following discussions with HASC members. Members were particularly keen to seek reassurance that there were no current plans to reduce the provision of community inpatient beds at Buckingham Community Hospital. The Trust can provide this assurance. The HASC will be communicated with on any significant service change proposed in future ensuring the appropriate engagement with patients and the public takes place.

Additional evidence and assurance attached to this paper is as follows:

- Appendix 1: Letters of Support from Community Stakeholder Groups and Chair and the Bucks Older People Action Group (BOPAG)
- Appendix 2: Orthopaedic and Stoke Community Pathways
- Appendix 3: Initial Equality Impact Assessment from the community hub pilot - April 2018

8. Recommendations

In summary, the previous community inpatient wards at Thame and Marlow are not suitable or sustainable for community inpatient care.

Keeping people healthy and independent in their own homes with the support from community hubs at Thame and Marlow is clinical best practice, delivers better outcomes, improves access and has been developed with patient and local stakeholder input.

We propose continuing with the current model of care in the community, including the community hubs at Marlow and Thame, on a permanent basis and not reintroduce the community inpatient beds on these sites as they are no longer fit for purpose.

We will continue to focus on further developing the closer to home model by

- Developing a business case by September 2022 with partners to support a sustainable Intermediate Care model of care in Buckinghamshire
- Continue to support urgent community response initiatives to prevent unnecessary hospital admissions
- Continued development of virtual outpatient appointments
- supporting primary care to proactively identify patients who may benefit from being

referred to the CATS service and ultimately avoiding a hospital admission
- exploring the feasibility of developing additional community hubs across the county

We will engage with the Community Hubs Stakeholder Group, HASC and the wider community as we continue to develop the community model of care.

Karen Bonner
Chief Nurse

David Williams
Director of Strategy

January 2022

EVIDENCE AND ASSURANCE APPENDICES

Appendix 1

Support statement from Patrick Land on behalf of the Marlow Hospital League of Friends

In relation to the Community Hubs Pilot, on behalf of the Marlow Hospital League of Friends I would like this statement of support to be taken into account when considering the future steps in relationto the Community Hub Pilot Scheme. In the Marlow community there has been great anxiety following the closure of the beds in the Marlow Community Hospital some while ago. This was followed by the appearance of the "closure" of the Hospital, which caused very significant local concern. I, together with fellow representatives of the Marlow Hospital League of Friends, and otherrepresentatives of the Marlow community including the Mayor have attended regularly at the Community Hubs Pilot Stakeholder Group meetings, at which we have been able to be appraised of the latest developments through the course of the Pilot Scheme, and have been able to be involved in discussions in relation to the Community Hubs Pilot. As far as we have been able, we have reported back to the local community.

The view of the Marlow Hospital League of Friends is that the Community Hub Scheme is a positive step which has the potential to be developed considerably, and as such also has the potential to be welcomed widely by the healthcare professionals involved in the delivery of the services, and also bythe community will be able to recognise the constructive use of the much valued Marlow Community Hospital as an integral part of the delivery of a modern healthcare service in the locality.

The Marlow Hospital League of Friends very much hope that it will soon be possible to remove the word "Pilot" from the Community Hub Scheme, and for there to be significant ongoing progress in the rolling out of the various services that can be provided from the Community Hub in Marlow, together with the co-ordination with and mobilisation of additional sectors including the voluntary sector to maximize the potential for the services that can be delivered from the Community Hub, and to support the scheme in ways which are appropriate to the Marlow Hospital League of Friendsas a local charity.

We await news of the outcome of recent discussions with anticipation.

Support statement from Sarah Taylor, Chair of Thame Hospital League of Friends

The establishment of the pilot scheme for the Health Hub in Thame means that, for the first time in years, the League of Friends of Thame Community Hospital is feeling cautiously optimistic about thefuture of their hospital. Indeed, there is growing enthusiasm for the project in the wider Thame community.

The hospital had always been associated with beds, originally used for a mixture of respite and patients needing overnight monitoring. Over the years, the number of beds had

dwindled to a levelthat was not financially viable and the small number of beds meant that, more often than not, theywere occupied by patients from outside Thame: they couldn't be kept free on the off chance that aThame patient might need one. Although there was a lot of activity at the hospital, we lived in constant fear of the place being closed altogether.

The growing consensus that frail elderly patients should be kept out of hospital and at home for aslong as possible has in fact potentially given our hospital a new lease of life.
What we want is a hospital that is there for the people of Thame and surrounding areas and is, in modern parlance, sustainable. That is, it should have a role that is genuinely useful and affordable for the long term. The current pilot scheme offers the vision of just such a role, combining as it does:the excellent CATS (community ambulatory treatment service) which assesses vulnerable patients and provides solutions to keep them at home and prevent admission to A&E; the existing physiotherapy service; the Day Hospital providing rehabilitation and preventative treatments; an increased number of clinics provided by consultants and other healthcare professionals coming fromStoke Mandeville and the John Radcliffe Hospital; input from the voluntary sector such as Carers Buckinghamshire and Oxfordshire; support from the neighboring GP practices; more diagnostic services in the community; facilities for the Day Centre. The Buckinghamshire Healthcare Trust that runs the Hospital is working closely with stakeholder groups to adapt to local needs and break downbarriers between Hospital and the Community.

Of course, these are early days, and all is by no means perfect. We must work hard to ensure that all the GPs in the locality use the services to help make them viable and that patients are aware of whatis on offer and push to be referred to the hospital rather than have to go further afield for assessment and treatment. The hospital needs investment in better IT and better equipment.

Recruiting staff in an area where housing is so expensive remains a perennial problem. The GPs nextdoor are bursting at the seams and need bigger premises. The transition between healthcare and social care is desperately short of the mark. Keeping people at home only works if there is support for them and their carers. We all must work towards finding solutions to these problems.

We have been given a commitment that, should the pilot fail, the beds will be restored, and the hospital returned to what it was. However, we all know that that is not viable in the long run. Therefore, as a League, we are keen for the pilot to be successful and to be confirmed as the policy for the future.

Support statement from Alan Barnard, Chair of Bucks Older people Action Group (BOPAG)

Alan Barnard has provided the following statement of assurance from a BOPAG and Valley Plus perspective:

> As the Chairman of Valley Plus, (the Marlow Bottom Older Persons Action Group) and BOPAG (Buckinghamshire Older Peoples Action Group) I have represented them at Stakeholder meetings since the early days of the pilot. initially, there were strong local feelings against the closure of the hospital beds and the change of use. Since seeing the evidence presented of the progress being made and personal involvement, I have become a firm advocate of the Hub service, in particular the CATS. The sooner this can become more widely used by the local GP's to refer patients the better this will be, likewise greater use by the Ambulance Service in preference to taking patients to distant A & E services (both Stoke Mandeville and Wexham Park being difficult to reach by public transport from Marlow). I am sure there is room for further services such as blood testing, X-ray (although only basic equipment), ENT, Urology and in particular Dementia would be greatly appreciated locally.
>
> Both Valley plus and BOPAG have given the BHS a number of opportunities to present the purpose and progress of the project at our meetings, which has been very well received. BOPAG's monthly magazine which is widely distributed to older people throughout the area, online and hard copy, has given wide coverage to the projects progress and is readily available to assist in the future.
>
> It is unfortunate that the Covid 19 pandemic has overshadowed and hindered much of the progress of the project, with closures and a slowdown of HNS services. However, now that the scheme is planned to become a permanent one enabling progress on alterations and signage can be made.
>
> The closure of the inpatient beds, so far, seems to passed with little negative impact, a number of people I have consulted were not even aware of any closure, so perhaps once Covid infections become much less of a problem greater attention could turn to more publicising the Hub and getting greater public awareness, in the meantime we look forward to working with BHT in the future for the success of the project.

Buckinghamshire Healthcare NHS
NHS Trust

Equality Impact Assessment:
Developing Community Hubs

1.0 Introduction

In line with the Five Year Forward View, our vision was to provide more care closer to home with care delivered out of hospital and in local communities, which is what our patients and clinicians have told us is important to them.

Through prevention and early-invention we want to:

- Help people to take greater control over their care and treatment.
- Ensure we meet long-term needs to help people to stay independent.
- Make it easier for people to access the right services by working more closely with GPs and other providers to join-up care and support, reducing duplication and making better use of new technologies.
- Provide a model which results in better outcomes for our patients and communities.

The idea for community hubs was formed following engagement with patients and the public in 2016. To best understand what will work for our communities, our clinicians wanted to test some of their ideas before we finalise our plans or propose permanent changes. In April 2017 we launched two community hub pilots in Marlow and Thame, towns where we already have strong community bases.

Since April 2017, and taking on board feedback from patients and other key stakeholders, we have been working on a range of service improvements in the hubs and to other out of hospital services offered across the county. £1m has been invested in expanding our community services, with an emphasis on older people.

2.0 Community Hubs Proposals

The development of Community Hubs in Buckinghamshire is to provide out of hospital services. Two hubs were established at Thame and Marlow community hospitals. They are providing a local base for community staff and help patients to access multidisciplinary rapid assessments and treatment including domiciliary visits, prevention services, primary care services (as appropriate) more local hospital services (such as outpatient appointments, diagnostics) and supporting district nursing teams in providing wound care and routine catheter changes for those who are not house bound .

During the pilot the community hubs have offered the following services:

- **Community assessment and treatment services** including a multidisciplinary assessment service where geriatricians, nurses, therapists and GPs provide expert assessment, undertake tests and agree a treatment plan to help frail older people to stay at home and avoid an A&E visit or hospital admission.
- Additional **diagnostic facilities** such as one-stop blood tests and x-rays.

- An extended range of **outpatient clinics.**
- Support from **voluntary organisations** such as Carers Bucks and Prevention Matters ranging from clinics, drop-in sessions and information stands.

To support this work across the whole of Buckinghamshire there are:

- **Locality teams** comprising of nurses working 24/7 to provide cover to those needing the greatest health and support, linking in with GPs and social care as required.
- **Rapid response intermediate care** working 7 days a week providing short-term packages of support helping people back to independence to avoid hospital admission and supportive early discharges.
- **Community care coordination team** who provide a dedicated phone and email 'single point of access' for referrals from health and social care staff to access district nursing, rapid response, intermediate care, community physiotherapy community hospitals and social care reablement joining up care between organisations.

3.0 Impact Assessment Methodology

The objective of the impact assessments was to identify the impacts (positive and negative) of the proposed development of out of hospital & community hubs across Marlow & Thame in Buckinghamshire, considering the service areas and the changes overall, regarding the likely effects on:

- health outcomes
- access to services
- equality groups

The output of the integrated HIA and EqIA is the production of a set of evidence-based findings and recommendations that can be used by decision-makers to maximise the positive impacts and minimise any negative impacts of the proposals.

These aspects are considered with particular emphasis placed upon impacts on health inequalities and equalities groups. Focus will also be placed on the impacts for those patients who would be disproportionately affected (i.e. vulnerable groups) compared to effects on the whole of the Buckinghamshire population.

The scope of this assessment covers:

- The service changes proposed within the BHiB Programme
- The geographical boundary of Marlow & Thame in Buckinghamshire
- The likely impacts related to health outcomes and access

The report 'Developing care in the community hubs September 2016' which gave the rationale for the programme, this EQIA has been developed in conjunction with the evaluation of the pilot and considers the service areas, examines the health, equality and wider impacts that are likely to be experienced because of the new service model. The

specific equality groups and geographical areas that are likely to experience most impacts are also highlighted. It makes recommendations for actions that could be taken to mitigate any potential adverse impacts arising from proposed changes to services identified by the impact assessment. Finally, the report also makes a number of suggestions as to how potential benefits of the changes can be maximised and equality of outcomes improved and enhanced.

(Buckinghamshire Risk Stratification Analysis) 

4.0 Health Impacts

Since BHT embarked setting up the Community Hubs

Top-line results

- The community assessment and treatment service at Thame and Marlow has seen **1027** people from April 2017 to March 2018 which is in line with the proposal estimate.
- **Less than 1%** of patients seen by the community assessment and treatment service were subsequently referred to A&E.
- **2,439** patients seen in the multidisciplinary day service assessment (MUDAS) at Wycombe Hospital in 2017/18 - **an increase of 25%** on the previous year.
- There have been no overnight packages of care required so far during the pilot, other than transitional beds already commissioned as part of the 'discharge to assess' project.
- There has been a **60%** increase in outpatient appointments offered at the two sites.
- We have worked with a range of stakeholders to develop and refine the pilot; they are supportive of the work achieved to date and the continued development of the hubs model as part of the wider community transformation programme.

5.0 Equality Impacts

The EqIA process aims to prevent discrimination against people who are categorised as being disadvantaged or vulnerable within society. These categories are called equality target groups (ETGs) and are currently designated by the standards set Greater London Authority (GLA):

- women;
- black, Asian and ethnic-minority people;
- young people and children;
- older people;
- disabled people;
- Lesbian people, gay people, bisexual people and transsexual people; and
- People from different faith groups.

<u>The role of the stakeholder engagement group</u>

Central to the development of the hubs has been the co-design with local people through the stakeholder engagement group. The stakeholder engagement group is chaired by our system wide chief nurse and director of communications. It comprises of representatives from Healthwatch, Marlow and Thame Community Hospitals' Leagues of Friends, Thame and District Day Centre, Marlow and Thame town councils and patient participation groups of local practices. The group acts as a critical friend to the pilot, helping us to review how the new services are working and performing against key indicators, as well as helping us to shape how we can engage and involve people in the on-going development. The group has been meeting every six weeks since the pilot began, reviewing the activities of the hubs, the feedback we have had from people that have used the services and they have made suggestions to refine and improve the model. All information, KPIs and minutes from the meetings are published on the Trust's website.

6.0 Conclusions and Recommendations

The community hub model of holistic care, closer to home, received broad support across all stakeholder groups involved in the review. The majority of patients and the public wish to see the current hubs continue and the model rolled out across Buckinghamshire, with provision tailored to different needs in different areas.

All stakeholders felt the hubs had made a good start, however they felt the hubs were yet to achieve their full potential. Levels of awareness of the hubs was low amongst both patients and GPs. Transport was highlighted as an issue, with concern expressed that the lack of community transport to the hubs could potentially be a barrier to access for many patients.

Key recommendations

- Raise awareness of the current hubs with public and GPs, in part through clearer branding
- Increase the service to at least five days per week at both sites.
- Review the current referral process with GPs, and consider expanding the process to self- referral.
- Ensure better co-ordination of the different services operating within the hubs.
- Work towards changing the environment within the community hospital settings of the hubs to become more clinic-like, to provide better facilities for partner organisations to provide their services, and to be dementia, mental health and learning disability friendly.
- Mobilise a wider range of outpatient clinics.

Roll out of hubs model

- Roll out model across Buckinghamshire, including utilising the Trust's existing bases in Buckingham, Chalfont and Amersham, and considering a range of options tailored to need in different areas, such as mobile units and other public sector estate.
- Ensure effective joint working across health and social care and with voluntary sector.
- Consider how pubic and community transport to hubs could be improved.

- Provide signposting to other public and voluntary sector support services.

Transport infrastructure is a key part of the delivery of any local service – Amersham, Buckinghamshire, Chalfont, Thame and Marlow are served by regular buses and train routes. The hubs are accessible from a well-established & comprehensive public transport network. There are also a range of community transport schemes available, which the Trust could utilise more, and patient transport is available for those who are eligible.

It is recommended that to reduce the inpatient activity & presentations at our emergency department at Stoke Mandeville, the models of care must meet the needs of the patient demographic this aligns to the 5 year forward plan for NHS England. It is recommended that we continue open face to face dialogue with of local community.

Proposed next steps

Continue with the current community hubs at Thame & Marlow for another two years so that the other complementary elements of community services transformation have time to be developed, rolled out across the county and evaluated for impact. This includes developing the community hubs model across the county.

- Phase 1, April 2018: confirm the continuation of the community hubs in Thame and Marlow for a further two years
- Phase 2, April - June 2018: Review out of hospital care model to understand scalability of services between the Hubs and Integrated teams.
- Phase 3, June 2018 – March 2019: Increase the scale of delivery of the hubs and integrated teams across the county.
- Phase 4, April 2019 - March 2020: Integrate the out of hospital elements into the full care model.

Appendices

Appendix 1 (Buckinghamshire Risk Stratification Analysis)

Buckinghamshire
Risk Stratification

Appendix 2 (Developing out of Hospital Care – HASC paper April 2018)

Screening - Initial Assessment
Stage – 1

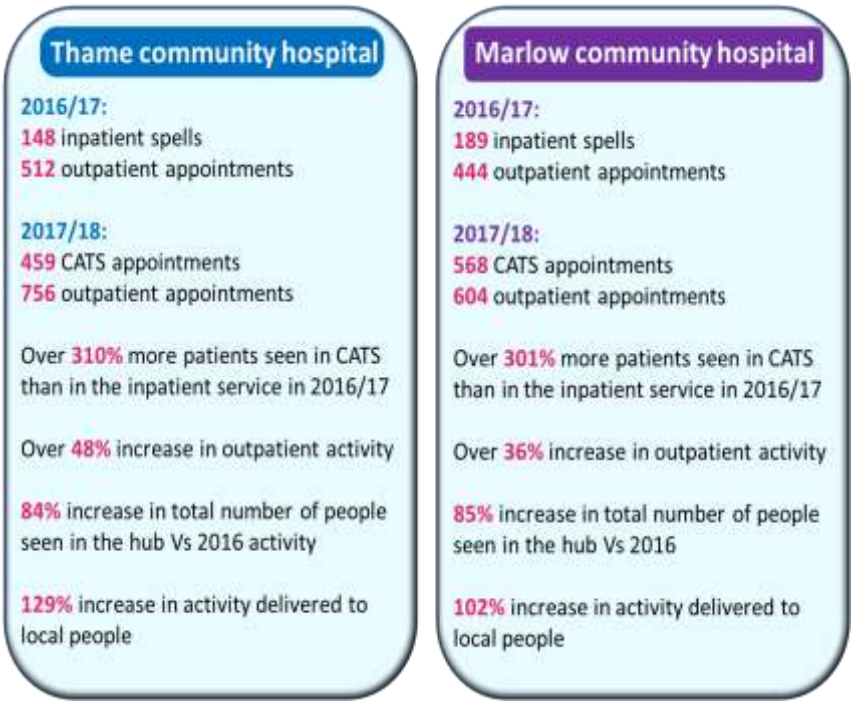
The screening process must be used on all new policies, projects, service reviews and staff restructuring. If you are not able to determine why your proposal has a positive/ negative / neutral effect on patients, services users or staff you will require a more detailed analysis and need to conduct a full equality impact assessment.

Questions	Answers
1. Brief summary of the project/ policy including the main aims and proposed outcomes.	The proposal is to expand the support available in the community which will help to maintain people's health and independence which would otherwise deteriorate if admitted to hospital for a length of time. By introducing Hubs in with a rapid response service and specialist frailty multidisciplinary assessment clinics in the community, reducing the need for bedded care in hospital. A pilot of this new model of care has been running at Marlow and Thame Hospitals for 12 months and during that time our clinicians have not admitted patients to the inpatient wards there but instead have used the space to run the new rapid assessment multidisciplinary community assessment and treatment service. The pilot has increased the access to diagnostics locally, outpatients and also involved services being located on site from the voluntary sector. The pilots have broadly, according to patients, the public and clinicians, been a success and it is now proposed to continue these services in Thame and Marlow for a further two years, whilst co-designing hubs with localities across the rest of the county as part of the wider community transformation programme is implemented.
2. Does the project/ policy need to reference or consider any other policy or strategy?	The community hubs project is inextricably linked with the wider vision for community health and care services in Buckinghamshire. To support we have invested £1m into the community services. A total of nearly 36 new posts were created in the community in the Community Care Coordination Team and Rapid Response Intermediate Care. We have also redeployed staff from the Community Hospitals in both Thame and Marlow to work within the community assessment and treatment service (CATS) team. The 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.
3. Could the proposed strategy, policy, service change, or function have a direct or indirect affect on patients, service users, staff or local community? Please explain your answer.	The development of community hubs will affect patients, service users, staff and the wider community directly. It is anticipated that the service offered has had a positive direct impact on patients based on the positive feedback received. The patients liked having all their care co-located and have made suggestion how the services could be further developed and improved. To support this, the Trust set up a range of workshops and stakeholder engagement sessions made up of local representatives, staff and voluntary sector organisations and GPs. BHT Human Resources policies have been deployed with staff from the initial dialogue with staff to consultation on changes and now it is envisaged that little or no impact will be experienced by staff the majority of whom have already be redeployed into new positions elsewhere or are working within the HUBs. A key part of the model has been the development and pilot of community hubs in Marlow and Thame community hospitals. Over the past year they have offered: • Community assessment and treatment service (CATS) including a frailty assessment service where geriatricians, nurses, therapists and GPs provide expert assessment, undertake tests and agree a treatment plan to help frail older people to stay at home and avoid an A&E visit or hospital admission • Additional diagnostic facilities such as one-stop blood tests and x-rays • An extended range of outpatient clinics, including chemotherapy clinics at Marlow, community occupational therapy clinics at Marlow (and in Thame in the near future), tissue viability clinics, Parkinson's disease and falls clinics • Support from voluntary organisations, such as Carers Bucks and Prevention Matters, ranging from clinics, drop-in sessions and information stands. There are monthly stands from Age UK in Thame and Carers Bucks are running a 'clinic' in Marlow on a fortnightly basis. VictimSupport has also begun a weekly session in Thame • Links with other public services have also been made – for example library services are now available in Marlow, providing books to support self-care and the management of mental health and long term conditions. This is in line with what patients and clinicians told us they wanted - rapid access to testing anddiagnostics and a place where they could access a full range of therapy services. Having these services based in the local community makes it easier for GPs to become full

members of the multidisciplinary team that delivers the care. We have put in place a single point of access to make it easier for clinicians to refer to the multi professional, multiagency frailty assessment clinics.

Outcomes

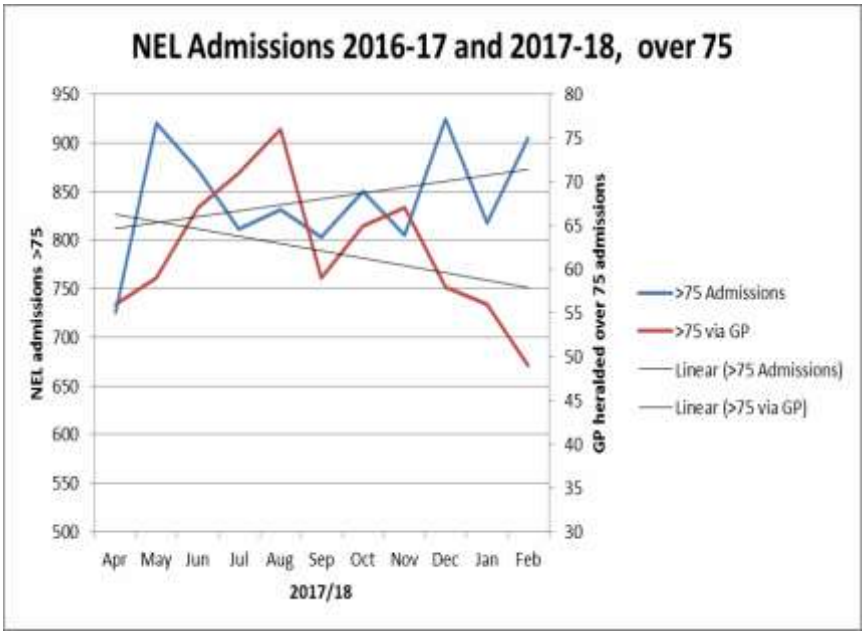


How else are patients benefitting?

- **980** patients seen in the community and **92** followed up in their own homes
- **Less than 1%** of patients seen by the community assessment and treatment service were subsequently referred to A&E.
- **2,439** patients seen in the multidisciplinary day service assessment (MUDAS) at Wycombe Hospital in 2017/18 - an increase of 25% on the previous year. This service is similar to the community assessment and treatment service at Marlow and Thame, and is referred to through the same route via the geriatricians.
- Since April 2017 **128,006** patient visits have been undertaken by the rapid response and intermediate care service.
- Since April 2017, the community care coordinator team has received **6,063** referrals.

We have seen a reduction in non-elective admissions via GP referral for people over 75 years of age when we compare 2016/17 with 2017/18. In addition, although the numbers of people over 75 attending A&E have risen throughout 2017, the trend in referrals from GPs to A&E has reduced over the last 4 months. This may be indicative of GPs referring more patients to MUDAS and CATs services. We believe that the increase in referrals to the MUDAS

service is due to an increased awareness of and commitment to a more community-based model of care by general practice.

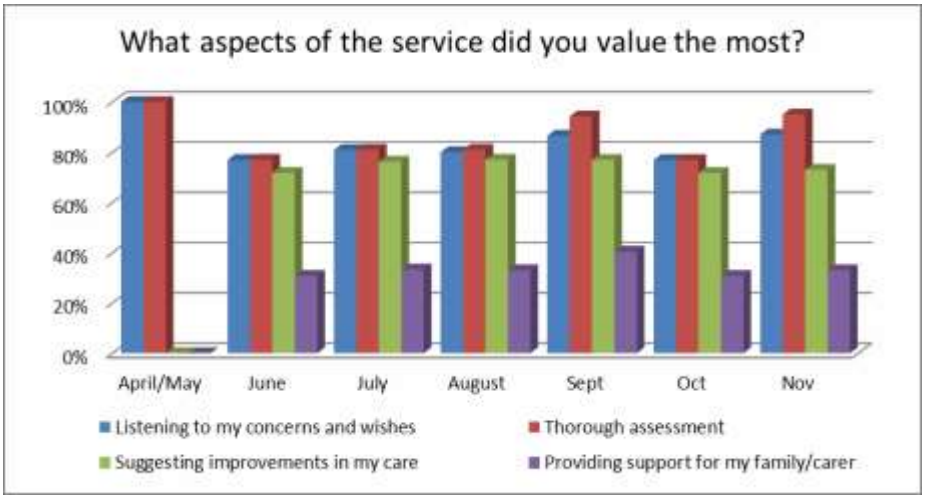


Who is being seen in the hubs?

The vast majority of patients using the community assessment and treatment service are referred from home by their GP. Only three patients were referred as part of their discharge from hospital care. 77% of patients were seen only once, the majority of whom were discharged with no further care required or back into the care of their GP.

There were 60% more outpatient appointments available in Thame and Marlow than in the previous year. A range of additional clinics have been offered at these sites, although we believe there is opportunity for this to be expanded further. The addition of systemic anti-cancer therapies (including chemotherapy and psychological assessments) at Marlow has been a particular benefit for those who would have previously travelled to Aylesbury and Wycombe. Following the success of these therapies we are working in partnership with Macmillan to look at how we can roll this model out across the county and Macmillan are providing funding for additional staff to support the project.

Every patient attending the community assessment and treatment service for the first time have been asked to complete a feedback form at the end of their appointment. In this feedback people have been consistent in feeling listened to and having a thorough assessment and there are a growing number of people who report that they received improvements to their care and support for their family or carer was given as part of the package. Care has been almost unanimously rated as excellent.



Both clinical and support staff have been integral to the development of the model. Staff who attended our engagement events felt positive about the changes. They felt that having the time and support to offer a truly holistic and thorough assessment and work out how best to help the patients was fantastic and had really added value. They want to see the service develop further, opening for more days of the week, broadening the range of services on offer and working hard with key partners, particularly GPs to enable the service to see a larger number of patients and be more proactive.

Voluntary sector organisations have been engaged in the process of community hub development both in the stakeholder group and by providing services in the hubs themselves. These services have not yet been as well used as everyone had hoped. Their views were sought as part of this review to inform the development of the hubs programme.

Key findings:

- All interviewees found the Hubs staff friendly and helpful
- All had expected to receive referrals to their service through CATS, but this has not happened to the extent they had hoped.
- Interviewees felt that the different organisations operating in hub could work together in a more co-ordinated way.
- The VCS organisations felt that the environment within the hub was too clinical and could be redesigned to be more patient friendly.

GPs are integral to the new model of care, which was co designed with some local GPs. As part of the CATS service two GPs work as members of the multidisciplinary team undertaking assessments, developing care plans and arranging on-going care. The wider community of GPs, who refer into the service, also participate as part of the stakeholder group. To ensure a wide range of views are taken into account as the service develops, meetings with locality

	leaders have taken place, and some sessions with GPs in the localities. The GPs have been relatively consistent in describing how they would like to see the service develop. They want it to become more proactive and hold responsibility for the patients for longer. In addition, care co-ordination has been identified by GPs as one of the areas on which we could improve as well as access to a single IT system to increase ease of communication. To this end EMIS, the preferred GP computer system, has gone live in both Thame and Marlow allowing CATS staff to both see and enter information directly into the GP record. We are working with clinicians to understand what other benefits we could get from the system e.g. taking away the need for the GP to make a separate referral.
4. Could the proposal have a positive or negative effect on patients, service users, staff or local community by the protected characteristics (age, disability, gender, gender re-assignment, marriage & civil partnership, pregnancy & maternity, race religion or belief, sexual orientation? Briefly explain your answer by consider each characteristic and state what is the impact on each group.	The proposal is seen as a positive step forward by the patients and BHT from the evidence Buckinghamshire Risk Stratification Analysis appendix 1 this highlighted that the community hubs met the needs of the populace for the conditions that can be seen and treated in the community setting and therefore is regarded as a positive step to treatment of all protected characteristics. BHT is working towards changing the environment within the community hospital settings of the hubs to become more clinic like, to provide better facilities for partner organisations to provide their services, and to be dementia and learning disability friendly. We have received feedback from some patients that parking and transport can be an issue. We are working to provide parking which can accommodate up to 10 patients attending CATS as well as patients attending other services in the community hub. We will improve turnover of parking spaces by staggering patient's arrival time and will better accommodate the parking needs of our patients by adding an extra disabled parking space at both locations with easier access to the entrance.
5. Is there any indication or evidence (including from engagement/ consultation with relevant groups) that	Given the nature of the proposed service change it is likely that there will be a differential impact on users of services, particularly based on age. There has been widespread engagement with the public on the development of community hubs. There were seven public events in Spring 2016; a further series of BHT led events in Autumn 2017 and

different groups have or will have different needs, experiences, issues, and priorities in relation to the proposals? Or do you need more information?	through January and February 2018 • To engage with and involve the local community to ensure their views and experience inform future decision making around the pilots both in Marlow and Thame and more widely across the county • To review the criteria for community hubs that the public had developed in 2016 to see what progress had been made and to test their continued relevance • To get feedback from staff and patients, and partner organisations involved in the pilots to inform on going service development • Opportunity to talk about wider transformation strategy , population health management and co-design with local communities to develop services that meet local need for example, League of Friends is funding an ultrasounds machine for Thame Community Hub At all of these attendees have been asked to consider the needs of a wide range of individuals and needs. Every effort is made to ensure that the public, who attend the events, appropriately represent the local community (Figures are available at appendix A). The engagement report appended to the final evaluation report, outlines the range of methods and people involved to inform the hubs pilot and next steps. The focus of Community Assessment and Treatment service is for pre-frail and frail people, avoiding needing to attend A&E and holistic assessment. It is known that the frail and elderly have transport issues that are different as well as a desire and need for coordinated, joined up care. The needs of families and small children are different again.
6. What measures are you proposing to take to mitigate /reduce the impact of your proposal for any of the protected characteristics, within patients, service users or staff?	The community hubs model has been developed in line with all the best practice guidance available to ensure that there the impact for any of the protected characteristics is mitigated / reduced. There are examples & opportunities to learn from other Clinical Commissioning Group (CCG) who have developed and rolled out best practice models of care in the community setting already. There has been widespread engagement with the public on the development of community hubs with seven public events in Spring 2016 and a further series of BHT led events in Autumn 2017 and through January and February 2018
7. Are there any measures that you can take to produce a	The new service model itself is based on the principle of providing care closer to home, in a community setting so this will produce a positive impact for some of the protected characteristics particularly in relation to age and disability.

positive impact for any of the protected characteristics, within patients, service users or staff?	The pilot has tested the model for 12 months and found that it is broadly supported by both users of the services and clinicians. Outcomes demonstrate that we are moving in the right direction in terms of reducing the need, particularly for people over 75 years of age, to make unplanned visits to A&E. Engagement with local people in communities across the county show that there is support for replication of the model across the county, but taking into consideration local needs which may differ in each locality. Key Performance Indicators which have been developed with the stakeholder engagement group and used to monitor and challenge performance during the pilot. Unfortunately the uptake of the voluntary sector was not as large as we had hoped. Having listened to the local voluntary organisations we realise that for many it would require new investment and this made it difficult for some 3rd sector organisations to work within the Hub, as they had already established bases elsewhere or had restricted funding. Feedback from service users is that someone based in the hub to signpost people to the service they need and to encourage those reluctant to accept help, for example the lonely, to contact services would be more helpful than co-location. Work more closely with acute clinicians to facilitate earlier patient discharge with support provided by the community hubs. Work closely with GPs to proactively identify patients who may benefit from being referred to the community assessment and treatment service. Explore the option of greater direct access for patients complementary elements of the community transformation programme to be implemented and integrated. Patients can be offered patient transport from the ambulance service with same day or next day availability. Recently the contract has confirmed a patient can be accompanied by a carer if the need arises. Patients have to be ready 2 hours in advance of the appointment time. Pick up and drop off times can vary and be unpredictable. On occasions this has led to delays in patients being picked up from the hub. This has led to reluctance in booking later afternoon appointment times. As an alternative, a number of community voluntary transport options have been sourced. Many of these require notice to book and therefore are unable to respond to the rapid response appointment system of the CATS service. However for those appointments that can be planned in advance these transport options have been of benefit and offer a cheaper and reliable alternative to taxis. Community Impact Bucks offers signposting to transport services across the county and their number is offered to patients at the time of appointment booking
8. As a result of the screening is a full EQIA	The nature and scale of the proposed change means that a full EQIA is appropriate.

necessary?	

Signed off by	
Name of lead officer:	
Signature & date:	
Name of Divisional Director:	**Natalie Fox**
Signature & date:	***April 2018***

Full Equality Impact Assessment
Stage – 2

Step 1: Identify the aims of the proposal for the strategy, policy, or service.

In your response please consider;

- What is the purpose and out comes that you are trying to achieve?
- Who does it intend to benefit (i.e. which groups) and how?
- Who are the main stakeholders?
- What outcomes do the main stakeholders want from your proposal?

The care model we have been co-designing with a wide range of stakeholders, including staff, GPs, patients, general public and other health and social care providers, will deliver care closer to home in the least intensive setting and has four elements:

1. *Prevention and self-care*
   – supporting people to live healthier lives and manage their own health

2. *Integrated urgent care services*
   – including rapid community response to reduce the number of people attending A&E and admitted to hospital

3. *Enhanced primary care*
   – where access to general practice is extended and where the range of professions which can be accessed in a local hub setting including for example; community services, therapies, mental health and social care

4. *Integrated care for those with complex needs*
   – where patients are systematically identified and clinicians and patients work together to develop proactive care plans

The model provides care closer to home & provides easy access to a wide range of health and social care services that specifically support those who don't necessary need to attend an acute hospital. It also means working together with the patient in partnership to ensure the best possible results for them.

It helps older adults to remain independent, living in their own homes for as long as possible to help them avoid unnecessary hospital stays and plans for any changes. Its provides a single point of access for the patient enabling health and social care teams to coordinate their responses to changes in patient's needs and to proactively plan in anticipation of any potential changes.

The stakeholders have said that the way in which care for has been offered in the past has been, “too fragmented” and added that patients, “do not want to have to tell their story to lots of different care professionals every time they access care.

In July 2017 Buckinghamshire was announced as one of the 8 shadow Integrated Care System (ICS) nationally, in recognition of the strength of the relationships between commissioners and providers across the system and the innovative new care models it was piloting.

NHS England, through the Integrated Care System programme, has committed to support Buckinghamshire with both capital and transformation funding in 2018/19. This will help us develop general practice at scale to increase resilience, extend access by driving collaboration between practices and develop the estate which would allow this to happen.

The development of community hubs is only one part of our wider transformation strategy to deliver more care closer to home and out of hospital across Buckinghamshire.

Whilst the evidence shows that community hubs are already making a significant contribution to achieving our vision, they can’t be viewed in isolation. The real impact will only be seen once the other elements are fully operational.

Step 2: Consideration of available data, research and information

You should gather all relevant quantitative and qualitative data that will help you to assess whether at present there are different outcomes for the different protected groups by; age, disability, gender, gender re-assignment, marriage & civil partnership, pregnancy & maternity, race religion or belief, sexual orientation.
In your response please consider;

- Data from, surveys, national statistics, census, local research, Public Health Observatory, or Public Health - Joint Strategic Needs Assessments.

  These links may be of some help or you can also talk to the Buckinghamshire County Council Public Health Team on 01296 387728

  Office of National Statistics;
  www.ons.gov.uk/ons/guide-method/census/2011/census-data/index.html

  Department of Health:
  https://www.gov.uk/government/organisations/department-of-health

  Public health Authority:
  www.ukpha.org.uk

  Buckinghamshire Joint Strategic Needs Assessment 2010:
  www.buckscc.gov.uk/media/883284/jsna_20101.pdf

- What does the data tell you in relation to any significant under / over representation in the use of or access to services, when compared to their population / employment profile size?
- What factors /barriers may account for the under / over representation?
- Are there any gaps in the data and what actions would you need to take fill the gaps?
- What over evidence/ data would you need to support your conclusions?

The 2011 Census identified 505,283 Buckinghamshire residents in 200,727 households The most recent population estimates available are for mid-2014 and it is estimated that Buckinghamshire then had a resident population of 521,9221.

In 2011, 25% (126,491 persons) of residents of Buckinghamshire were aged 0 to 19 years, 16.7% of the population (84,150 persons) were aged 65 years and over, of whom 39,460 (7.8% of the total) were 75 years and over and 11,210 (2.2% of the total) were 85 and over (Table 1). The proportion of the population falling into these older age groups is slightly higher in Buckinghamshire than in England as a whole. The largest non-White ethnic minority group were Asian or Asian British, comprising 8.6% of the Buckinghamshire population compared to 7.8% in England

Table 1 Selected population characteristics in the 65 and over age group as reported in the 2011 Census, Buckinghamshire and England Age bands and Ethnic groups	Buckinghamshire % (numbers)	England %
Aged 65 and over	16.7% (84,150)	16.3%
Aged 75 and over	7.8% (39,460)	7.7%
Aged 85 and over	2.2% (11,210)	2.2%
% from non-White ethnic background	13.6%	14.6%
% lone parent households with dependent children	5.3%	7.1%
% households classed as pensioners living alone	11.8%	12.4%
% households classed as pensioners not living alone	9.6%	8.4%

Source: 2011 Census

The proportion of households which were classed as pensioners living alone was slightly lower in Buckinghamshire (11.8%) compared to England (12.4%), while the proportion classed as pensioners not living alone was slightly higher (9.6% in Buckinghamshire compared to 8.4% in England).

BUCKINGHAMSHIRE - 2011 Census Summary Profile	2011 BCC Population	2011 BCC % Population	2001 BCC Population	% Change in BCC 2011 vs 2001	% South East	% England
Population						
Total population	505,283	100.0%	479,024	5.5%	100.0%	100.0%
Males	248,346	49.1%	234,738	5.8%	49.1%	49.2%
Females	256,937	50.9%	244,286	5.2%	50.9%	50.8%
0 to 4 yrs	31,832	6.3%	30,456	4.5%	6.2%	6.3%
5 to 10 yrs	37,192	7.4%	38,257	-2.8%	6.8%	6.7%
11 to 19 yrs	57,467	11.4%	54,260	5.9%	11.1%	11.0%
20 to 39 yrs	117,413	23.2%	127,311	-7.8%	25.2%	27.0%
40 to 59 yrs	145,986	28.9%	135,576	7.7%	27.4%	26.7%
60 to 74 yrs	75,932	15.0%	61,219	24.0%	15.0%	14.6%
75 to 84 yrs	28,249	5.6%	23,067	22.5%	5.8%	5.5%
85 to 94 yrs	10,279	2.0%	8,167	25.9%	2.3%	2.1%
95 yrs +	933	0.2%	711	31.2%	0.2%	0.2%

BUCKINGHAMSHIRE - 2011 Census Summary Profile	2011 BCC Population	2011 BCC % Population	2001 BCC Population	% Change in BCC 2011 vs 2001	% South East	% England
Religion						
Total population (religion)	505,283	100.0%	479,026	5.5%	100.0%	100.0%
Christian	305,804	60.5%	347,727	-12.1%	59.8%	59.4%
Buddhist	2,207	0.4%	1,120	97.1%	0.5%	0.5%
Hindu	6,244	1.2%	2,967	110.4%	1.1%	1.5%
Jewish	1,511	0.3%	1,571	-3.8%	0.2%	0.5%
Muslim	25,781	5.1%	17,333	48.7%	2.3%	5.0%
Sikh	4,657	0.9%	1,657	181.1%	0.6%	0.8%
Other religion	1,803	0.4%	1,226	47.1%	0.5%	0.4%
No religion	121,190	24.0%	72,411	67.4%	27.7%	24.7%
Religion not stated	36,086	7.1%	33,014	9.3%	7.4%	7.2%
Health and Care (perceived health categories changed since 2011)						
Total population (general health)	505,283	100.0%	479,026	5.5%	100.0%	100.0%
People with a limiting long-term illness 1.	67,928	13.4%	61,328	10.8%	15.7%	17.6%
People without a limiting long-term illness	437,355	86.6%	417,698	4.7%	84.3%	82.4%
People who don't provide unpaid care	455,769	90.2%	435,205	4.7%	90.2%	89.8%
People providing unpaid care: 1 to 19 hours a week	35,820	7.1%	33,913	5.6%	6.7%	6.5%
People providing unpaid care: 20 to 49 hours a week	5,268	1.0%	3,617	45.6%	1.1%	1.4%
People providing unpaid care: 50 or more hours a week	8,426	1.7%	6,291	33.9%	2.0%	2.4%

Life expectancy

http://www.healthandwellbeingbucks.org/Resources/Councils/Buckinghamshire/Documents/JSNA/3.3%20Life%20Expectancy.pdf

The proportion and number of the population in Buckinghamshire aged 65 and over is expected to increase; in 2015 this was estimated to be 96,800 people, 18.5% of the population[3], and by 2025 there are projected to be 120,800 people aged 65 and over, 21.5% of the population.

Table 1 Buckinghamshire resident population estimates by age group at District Council level, number (% of total), 2014

Age bands	Aylesbury Vale	Chiltern	South Bucks	Wycombe	Buckinghamshire
19 and under	46,642 (25.3%)	23,605 (25.1%)	16,032 (23.4%)	44,127 (25.2%)	130,046 (25%)
20 to 64	107,739 (58.4%)	50,558 (53.8%)	38,212 (55.8%)	100,709 (57.6%)	297,218 (57.0%)
65 and over	30,179 (16.4%)	19,809 (21.1%)	14,268 (20.8%)	30,042 (17.2%)	94,298 (18.1%)

Source: ONS Mid-Year Estimates 2014

Table 4 Number (% of population) of people in Buckinghamshire Districts, Buckinghamshire and England in main ethnic groups, 2011 Census

	Aylesbury Vale	Chiltern	South Bucks	Wycombe	Bucks	England
White	156,079 (89.6%)	84,749 (91.5%)	56,365 (84.3%)	139,477 (81.3%)	436,670 (86.4%)	45,281,142 (85.4%)
Mixed/ multiple	3,864 (2.2%)	2,040 (2.2%)	1,607 (2.4%)	4,849 (2.8%)	12,360 (2.4%)	1,192,142 (2.3%)
Asian/ Asian British	10,105 (5.8%)	5,046 (5.4%)	7,533 (11.3%)	20,585 (12.0%)	43,269 (8.6%)	4,143,403 (7.8%)
Black/ Black British	3,323 (1.9%)	524 (0.6%)	709 (1.1%)	5,934 (3.5%)	10,490 (2.1%)	1,846,614 (3.5%)
Other ethnic group	766 (0.4%)	276 (0.3%)	653 (1.0%)	799 (0.5%)	2,494 (0.5%)	548,418 (1.0%)
Total	174,137	92,635	66,867	171,644	505,283	53,012,456

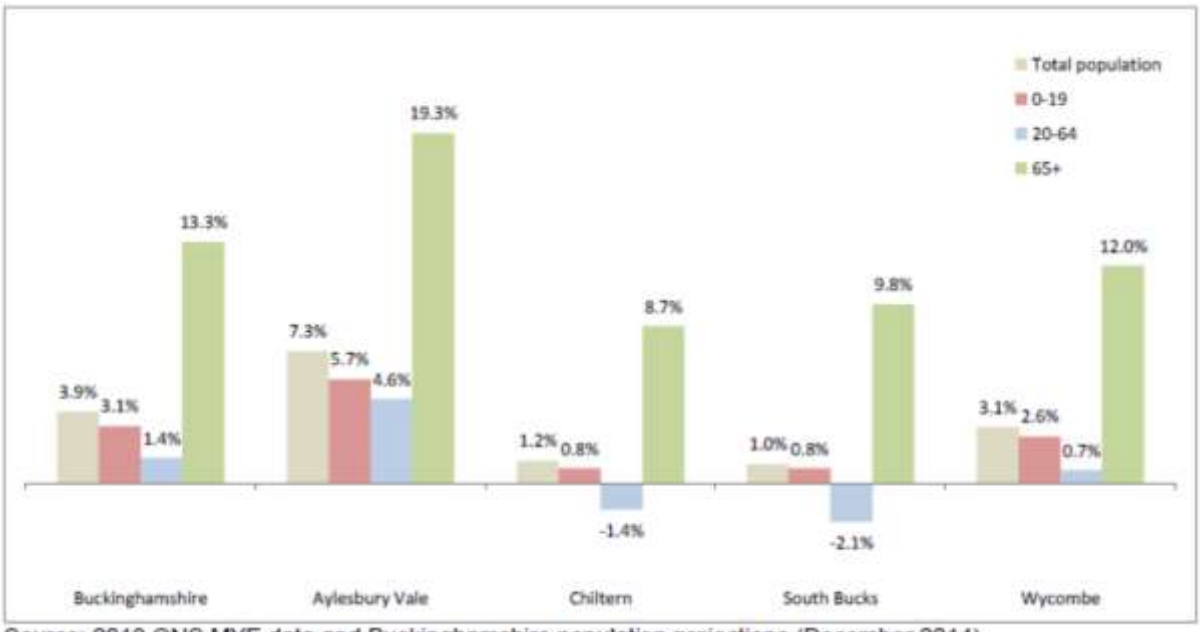
Source: Census 2011

Protected characteristics

http://www.healthandwellbeingbucks.org/Resources/Councils/Buckinghamshire/Documents/JSNA/3.4%20Protected%20characteristics.pdf

The out of hospital & community hubs provide a full Geriatrician and multidisciplinary frailty service. The data shows below Figure A1/A2 (dark green) we are serving and meeting the needs of local residents in at the appropriate locations as those of 65+ increase.

Projected Percentage Change in Age Groups in Buckinghamshire between 2013 and 2018



Source: 2013 ONS MYE data and Buckinghamshire population projections (December 2014)

Figure A1 Ward level life expectancy at birth for males, 2010-2014

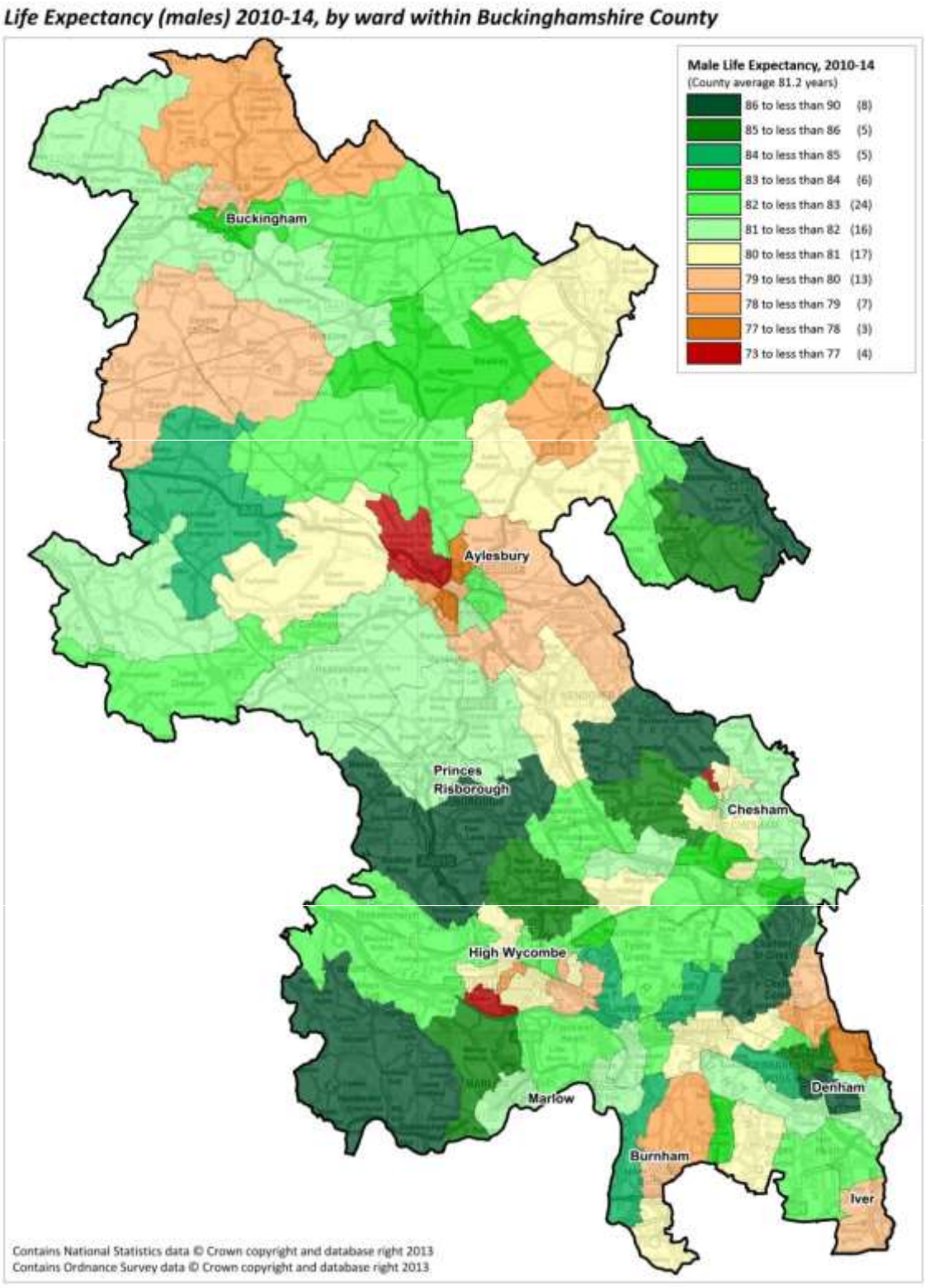
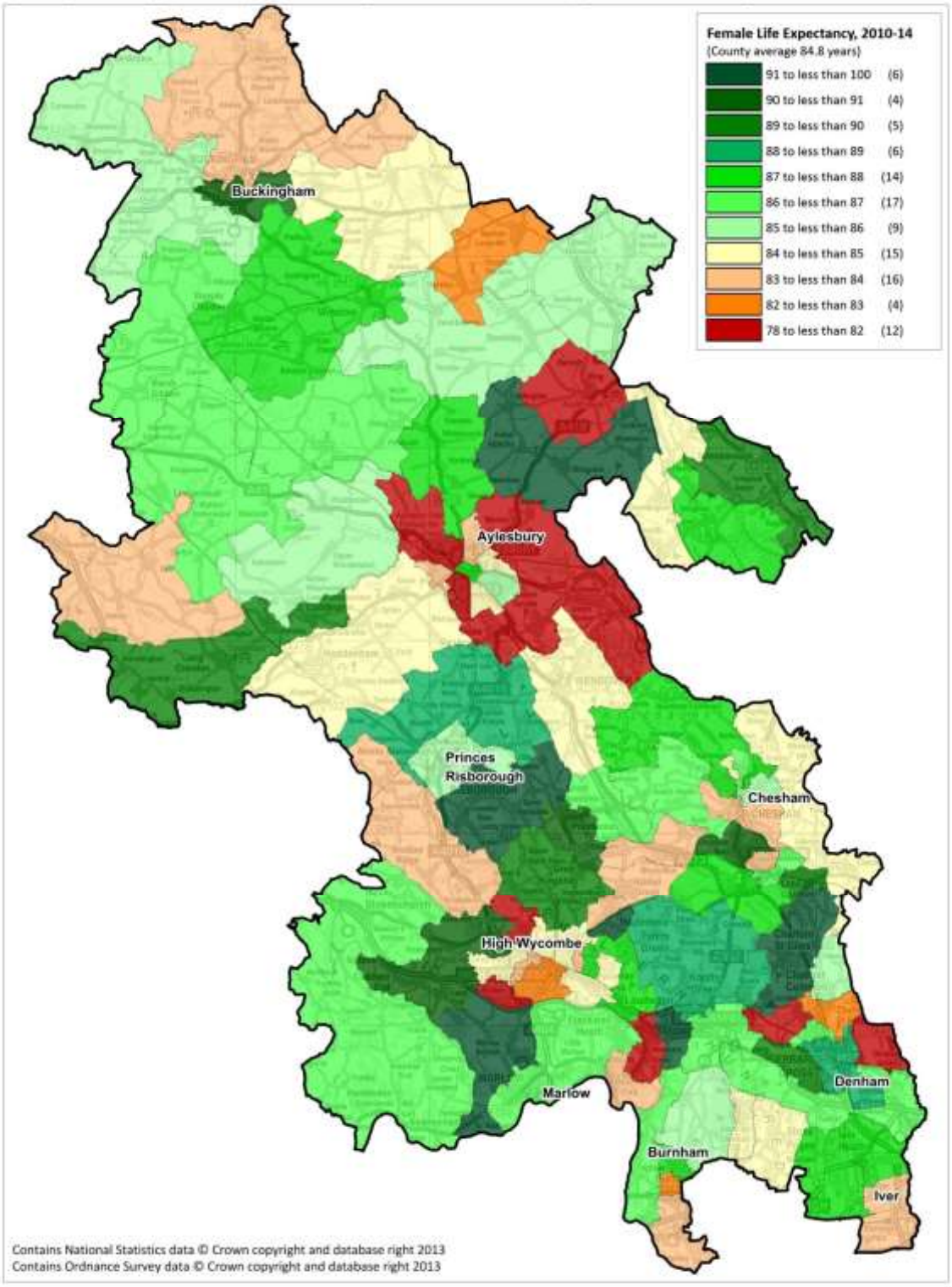


Figure A2 Ward level life expectancy at birth for females, 2010-14

Life Expectancy (females) 2010-14, by ward within Buckinghamshire County



Community Hub Developments

A key part of the model has been the development and pilot of community hubs in Marlow and Thame community hospitals. Over the past year they have offered:

- Community assessment and treatment service (CATS) including a frailty

assessment service where geriatricians, nurses, therapists and GPs provide expert assessment, undertake tests and agree a treatment plan to help frail older people to stay at home and avoid an A&E visit or hospital admission

- Additional diagnostic facilities such as one-stop blood tests and x-rays
- An extended range of outpatient clinics, including chemotherapy clinics at Marlow, community occupational therapy clinics at Marlow (and in Thame in the near future), tissue viability clinics, Parkinson's disease and falls clinics
- Support from voluntary organisations, such as Carers Bucks and Prevention Matters, ranging from clinics, drop-in sessions and information stands. There are monthly stands from Age UK in Thame and Carers Bucks are running a 'clinic' in Marlow on a fortnightly basis. VictimSupport has also begun a weekly session in Thame
- Links with other public services have also been made – for example library services are now available in Marlow, providing books to support self-care and the management of mental health and long term conditions.

Overall the number of varied consultant and nurse led outpatient clinics in the community hubs at Thame and Marlow continue to show significant growth. From March 2018 additional consultant clinics will be provided at Marlow and Thame and there will be further activity in the hubs from system partners such as Buck County Council.

	Outpatient clinics	Voluntary sector services	Assessment and diagnostics
Marlow	• orthopaedics • general surgery • surgery – plastics • chemotherapy and Macmillan • IAPT (psychological therapies) • Parkinson's disease • routine catheter changes	• Carers Bucks staff offering support and linking with NHS staff • Prevention Matters • Healthy Minds (IAPT)	• community assessment and treatment service (CATS). Patient's care is provided by geriatrician, nurse, GP, occupational therapist and physiotherapist. Domiciliary visits are also arranged to keep patients at home • comprehensive geriatric assessment (details in Appendix B) • additional day of plain film x-ray (3 days a week) • point of care blood testing to enable immediate results to support decision making (details in Appendix B).
	In Development		
	• *women and children* • *long term conditions management support* • *wound management*	• *Citizens Advice Bureau* • *Alzheimer's Society*	• *ultrasound service*
Thame	• general surgery • orthopaedics • care of the elderly • IAPT (psychological therapies) • plastic surgery • long term condition management support • falls assessment clinic & care of the elderly	• Carers Oxford staff offering support and linking with NHS staff • Prevention Matters • Health Minds (IAPT)	• community assessment and treatment service (CATS). Patient's care is provided by geriatrician, nurse, GP, occupational therapist and physiotherapist. Domiciliary visits are also arranged to assess and arrange care to keep patients at home • comprehensive geriatric assessment (details in Appendix B) • Point of care blood testing to enable immediate results to support decision making (details in Appendix B).
	In Development		
	• *chemotherapy* • *routine catheter changes* • *wound management* • *oral and maxillofacial outpatient clinics*	• *Alzheimer's society* • *Citizens Advice Bureau*	• *ultrasound service /x-ray*

- General Surgery is increasing their clinics at Thame and Marlow from March 18
- GI have schedule weekly clinics both at Marlow and Thame starting March 18 2018
- OMSF Dental services have confirmed start dates in March both at Marlow and Thame. They are waiting for confirmation of space at Buckingham and Amersham
- Macmillan Outreach anti-cancer treatment project in progress – to be set up at Amersham, Buckingham, Thame and Marlow. This is in addition to the chemotherapy clinic currently running at Marlow.
- COT BCC – community OT – started clinics at Marlow on 5th March. Space is being worked up at Amersham and Thame to facilitate this service further.
- Plastic Surgery

Transport

Transport infrastructure is a key part of the delivery of any local service – Amersham, Buckinghamshire, Chalfont, Thame and Marlow are served by regular buses and train routes.

Community Impact Bucks - community tra

FINAL low res Travel Leaflet.pdf

https://www.buckscc.gov.uk/services/transport-and-roads/buses-and-trains/bus-timetables/

Getting to Amersham Hospital

Whielden Street, Amersham, Buckinghamshire HP7 0JD.Telephone: 01494 434411

Amersham Hospital is served by the following buses:		
Service	Operator	Route
Route 1	Arriva/Carousel:	High Wycombe – Hazlemere – Holmer Green - Amersham – Chesham
Route 55	Redline Buses:	Aylesbury – Stoke Mandeville Hospital – Wendover – Great Missenden –Amersham – Chesham
Route 73	Red Rose Travel:	Whelpley Hill – Chesham – Amersham – Winchmore Hill - Coleshill
Route 353	Redline Buses:	Slough – Stoke Poges – Gerrards Cross – The Chalfonts – Amersham

Getting to Buckingham Hospital

Buckingham Hospital, High Street, Buckingham, MK18 1NU, T: 01280 813243

The Buckingham Community Hospital is located close to the main bus stand on the High Street.

Buckingham Hospital is served by the following buses:		
Service	Operator	Route
Route 18	Langston & Tasker:	Bicester – Marsh Gibbon – Twyford – Steeple Claydon – Padbury – Buckingham
Route 60/X60	Arriva: Aylesbury	Winslow – Buckingham – Maids Moreton/Milton Keynes
Route 131/132	Redline Buses:	Brackley – Tingewick – Buckingham local estates – Buckingham
Route 133	Redline Buses:	Water Stratford – Tingewick – Buckingham (Tuesdays only)
Route 134	Redline Buses:	Westbury –Dadford – Buckingham (Tuesdays only)
Route 151	Redline Buses:	Akeley/Thornborough – Buckingham
Route X5	Stagecoach:	Cambridge – Bedford – Milton Keynes – Buckingham – Bicester – Oxford

Getting to Chalfonts and Gerrards Cross Hospital

Chalfont and Gerrards Cross Community Hospital, Hampden Road, Chalfont St Peter, SL9 9DR Tel: 01753 883 821

The hospital is located in Chalfont St Peter opposite the local GP practice and health clinic.

Chalfont and Gerrards Cross Community Hospital		
Service	Operator	Route
Route 335	Redline Buses:	Slough – Stoke Poges – Gerrards Cross – Chalfont St Peter – Chalfont Common

Route 353	Redline Buses:	Slough – Stoke Poges – Gerrards Cross – The Chalfonts – Amersham
Route 580	Carousel:	High Wycombe/Beaconsfield – Seer Green – The Chalfonts – Gerrards Cross - Uxbridge
Route 730	Carousel:	Hemel Hempstead – Chesham – Amersham – The Chalfonts – Gerrards Cross - Uxbridge

Getting to Marlow Community Hospital

Marlow Community Hospital, Victoria Road, Marlow, SL7 1DJ T: 01628 482292

Marlow Community Hospital		
Service	Operator	Route
Route 155	Red Eagle Buses:	Little Marlow – Marlow Bottom – Marlow town – Maidenhead
Route 158	Red Eagle Buses:	Marlow town –Marlow Bottom – High Wycombe
Route 160	Red Eagle Buses:	Marlow town – Little Marlow – Marlow Bottom
Route 800	Arriva:	High Wycombe – Marlow – Henley-on-Thames – Shiplake – Reading
Route 850	Arriva:	High Wycombe – Marlow – Henley-on-Thames – Twyford – Reading
Route X80	Carousel:	High Wycombe – Marlow – Henley-on-Thames – Caversham – Reading

Getting to Stoke Mandeville Hospital

Mandeville Road, Aylesbury, Buckinghamshire HP21 8AL.Telephone: 01296 315000

Stoke Mandeville Hospital has Aylesbury station. Details of trains to Aylesbury station can be accessed via the Chiltern

Stoke Mandeville Hospital		
Service	Operator	Route
Route 9	Arriva:	Aylesbury – Walton Court – Stoke Mandeville Hospital
Route 55	Redline Buses	Aylesbury – Stoke Mandeville Hospital – Wendover – Great Missenden – Amersham – Chesham
Route 112	Z&S Transport:	Waddesdon – Brill – Thame – Bishopstone – Aylesbury (Wednesday and Friday only)
Route 165	Z & S Transport:	Leighton Buzzard – Aston Abbotts – Wingrave – Aylesbury – Stoke Mandeville Hospital
Route 300/X30	Arriva	Aylesbury – Stoke Mandeville - Princes Risborough – (Naphill 300 only) – (Saunderton X30 only) - High Wycombe
Route 321	Redline:	Aylesbury – Stoke Mandeville – Butlers Cross – Princes Risborough – Saunderton – High Wycombe

Getting to Thame Community Hospital

Thame Community Hospital, East Street, Thame, Oxfordshire, OX9 3JT Tel. 01844 212727

Service	Operator	Route
40	Carousel:	High Wycombe – Stokenchurch – Thame
110	Redline Buses:	Aylesbury – Chearsley – Long Crendon – Thame – Worminghall
111	Z&S Transport:	Oakley – Brill – Thame – Aylesbury
Route 112	Z&S Transport	Waddesdon – Brill – Thame – Bishopstone – Aylesbury (Wednesday and Friday only)
Route 113	Z&S Transport:	Oakley – Thame – Longwick – Princes Risborough (Tuesday and Thursday only)
Route 280	Arriva:	Aylesbury – Haddenham – Thame – Wheatley – Oxford
Route X8	Arriva:	Oxford – Headington – Tiddington – Thame/Aylesbury

Getting to Wycombe Hospital

Queen Alexandra Road, High Wycombe, Buckinghamshire HP11 2TT - Telephone: 01494 526161

Wycombe Hospital
Wycombe Hospital is located just 10 minutes' walk away from the town centre bus station. The bus station is served by all bus routes in the area; please use the Traveline Journey Planner to plan a journey to the bus station. Alternatively the following buses call just outside the hospital grounds.
34 Arriva: Cressex – Wycombe Hospital – Railway Station – Bus Station
High Wycombe Park & Ride PR1/X80 Carousel Buses: High Wycombe Coachway (Handy Cross) – Wycombe Hospital – Bus Station – Railway Station – Hicks Farm Rise (this is the order of the PR1 journeys, the X80 journeys serve the bus station before the Hospital). Please see the timetable for details.

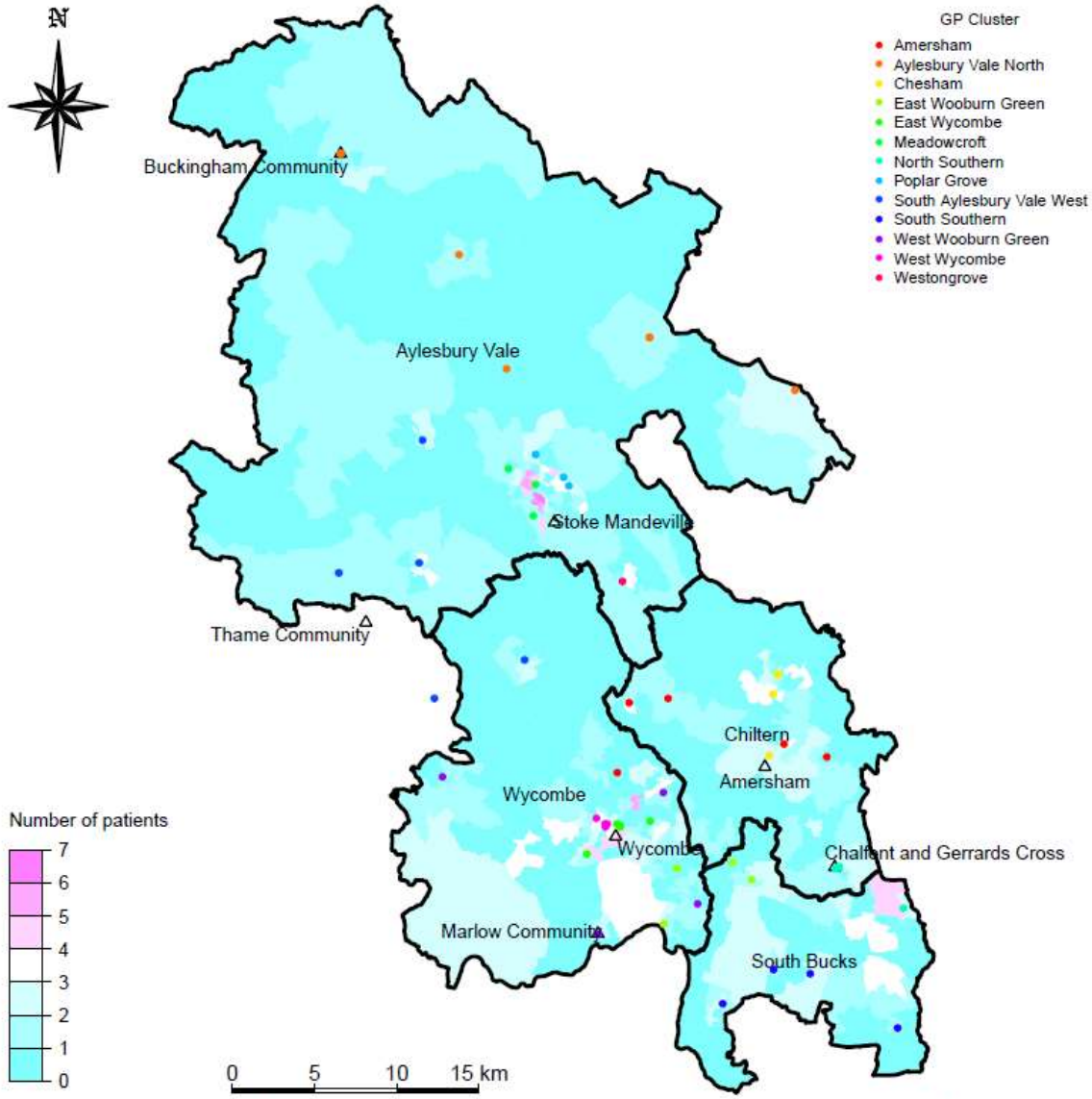
Services that have commenced in the Community Hubs

Mental Health

https://www.westsussexconnecttosupport.org/s4s/api/FileManagement/GetFileContent?id=/69/

Improving Access Psychiatric Services (IAPT) is now an integrated service provided out of clinic at Thame & Marlow.

Probability of inpatient admission during 6 months
309 patients with Schizophrenia among 5.5% high risk



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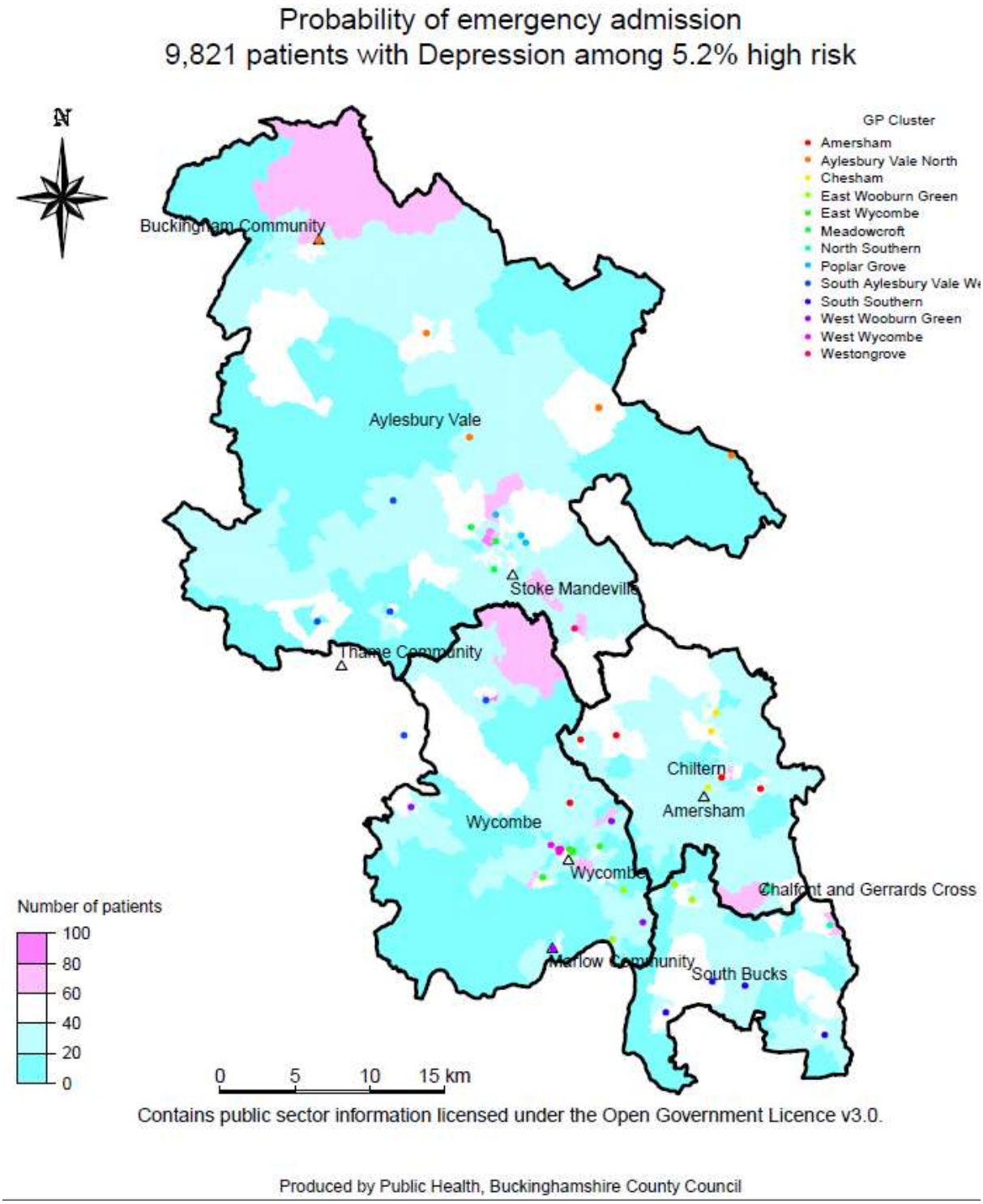


The potential to avoid at least mostly 9,821 attendances at Stoke Mandeville emergency department for the patients in & around Buckingham Community Hospital is a great example of offering services out of hospital closer to home.

https://www.oxfordhealth.nhs.uk/healthyminds/wp-content/uploads/sites/8/2011/12/Healthy-Minds-Information-Leaflet-A4.pdf

Oxford Health NHS Foundation Trust: - Provides specialist mental health services to people in Oxfordshire, Buckinghamshire and the surrounding counties and work from with the hubs at Thames & Marlow and provide support closer to home
www.oxfordhealth.nhs.uk

Buckinghamshire Mind provides support for a range of mental health disorders. Their web directory has further links to local services in Buckinghamshire and has direct access from the hubs for all patients. Website: www.bucksmind.org.uk

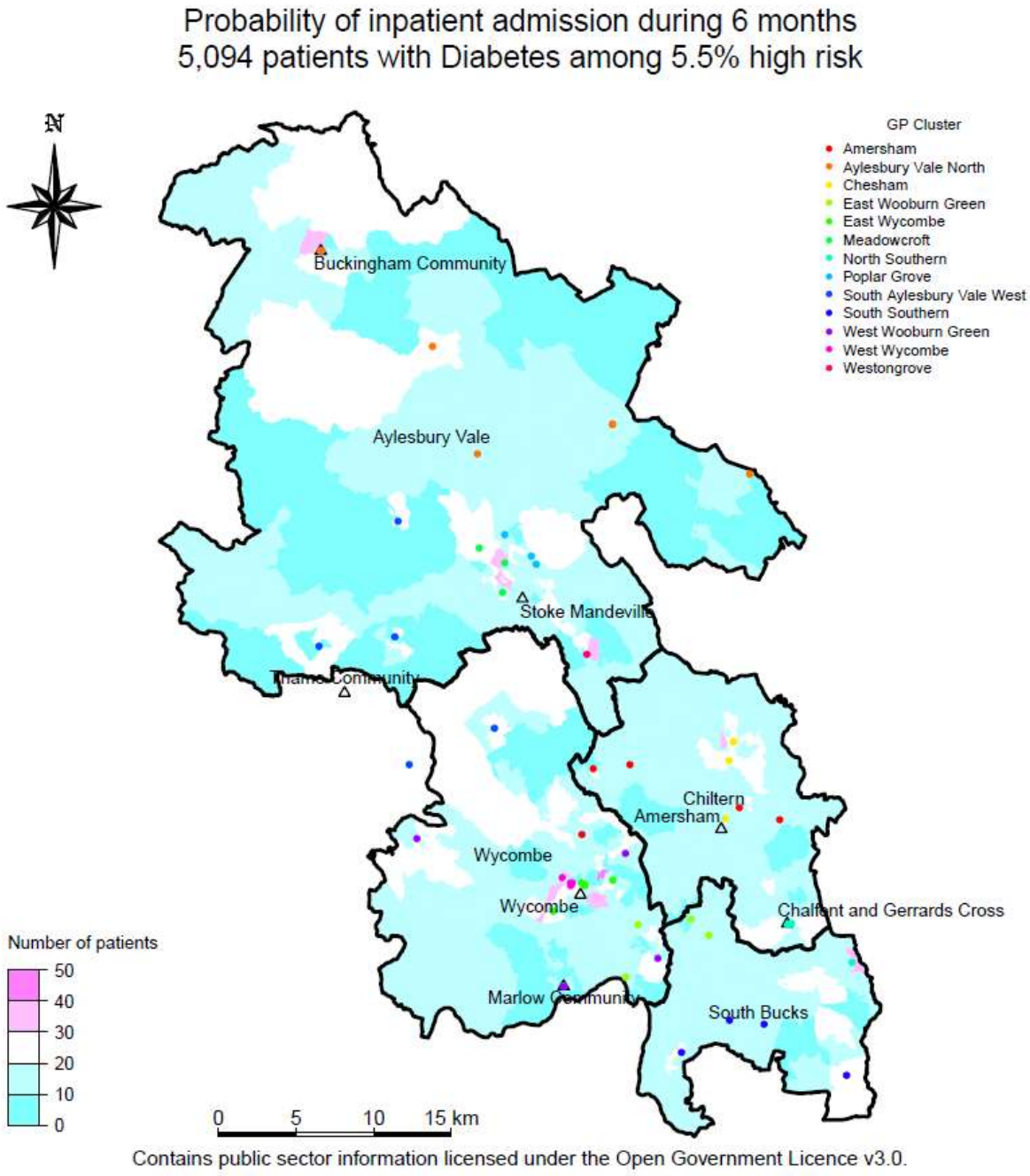
For each of the services the teams at Marlow & Thames provide sign posting & leaflets allowing patients to make self-referrals or stream into the clinics when they are on site.

Health and well-being services stop smoking
Rates of adults smoking in Buckinghamshire declined from 16.2% in 2010 to 13.9% in 2012. Smoking prevalence in Buckinghamshire has remained significantly below the England rate throughout 2010 to 2014. National rates have fallen from 26% in 2002 to 19% in 2015.

Accessing NHS Stop Smoking Services increases an individual's chance of quitting by four times compared to attempting to quit with no support. It is under discussion for the hubs to offer this.

Victim support
Victim support at Thame operates out of the hub on a Monday – so meeting needs of other population as well as outpatients.

Diabetic Patients
Type 2 diabetics' patients have benefited from delivery of care closer to home with clinic support, advice and guidance helpline. We have provided the backdrop for success is the education in primary care with 915 patients been identified of all equality diversity backgrounds. The service is 75% on a journey of linked up working practices across community & secondary care



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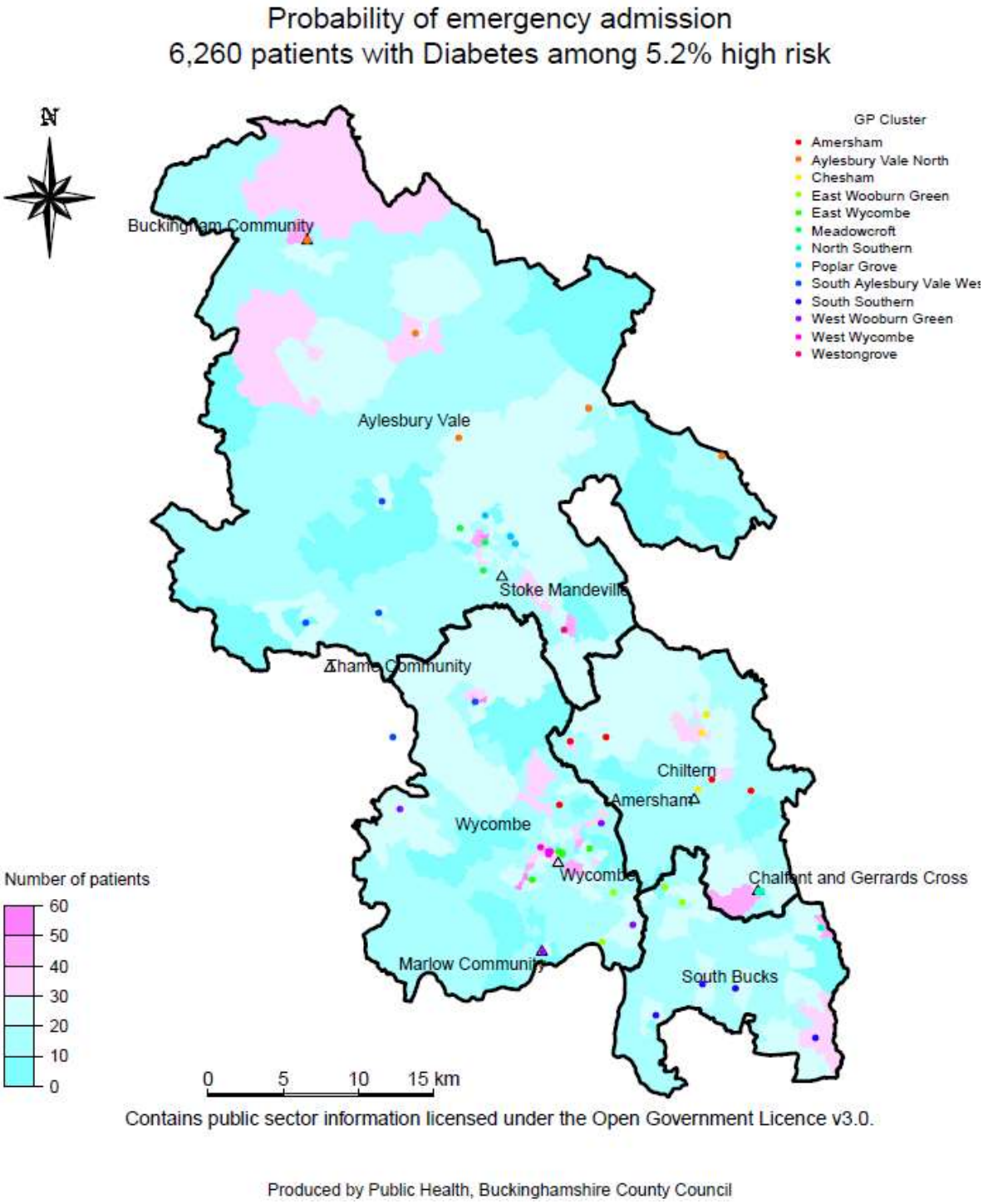
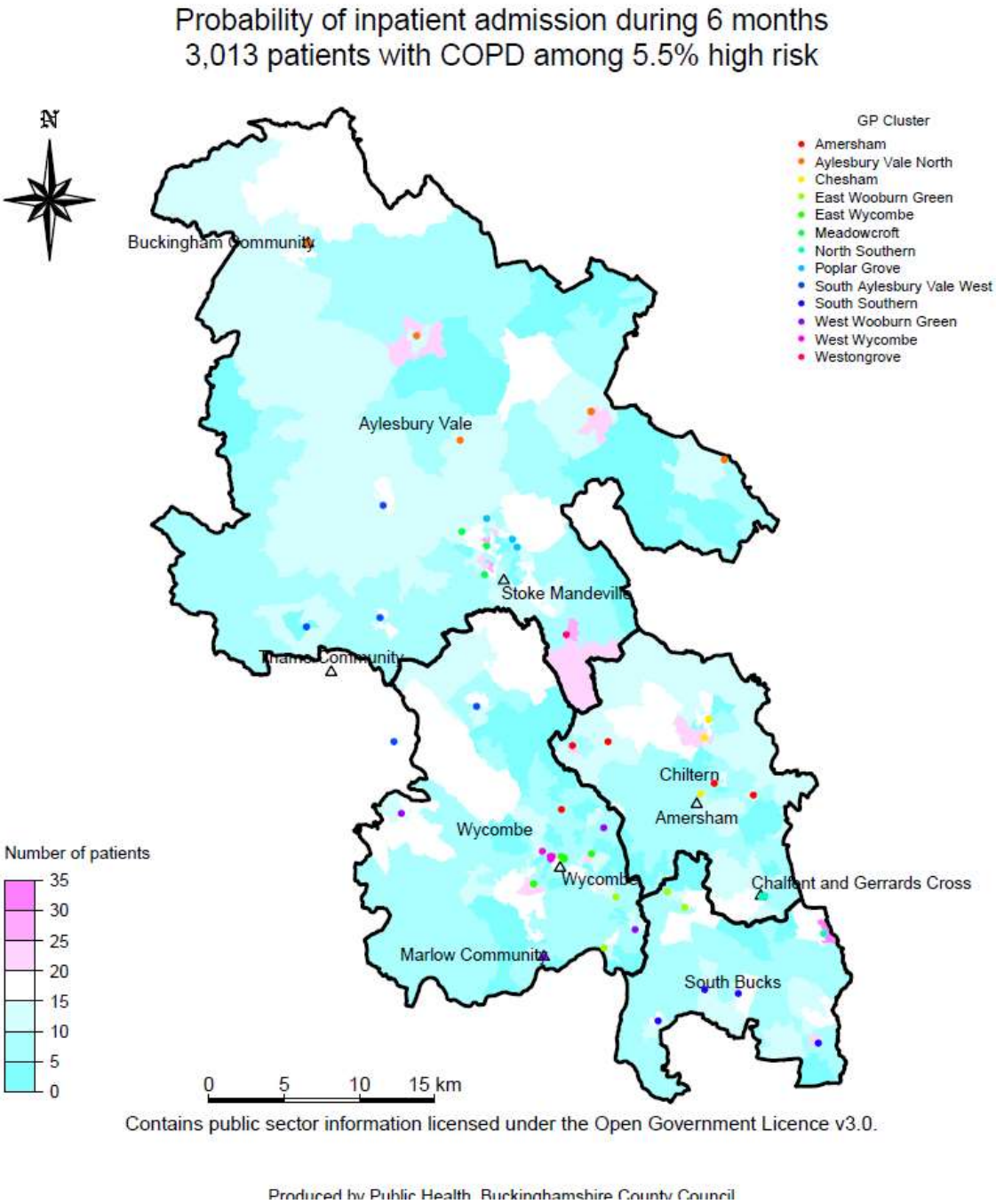


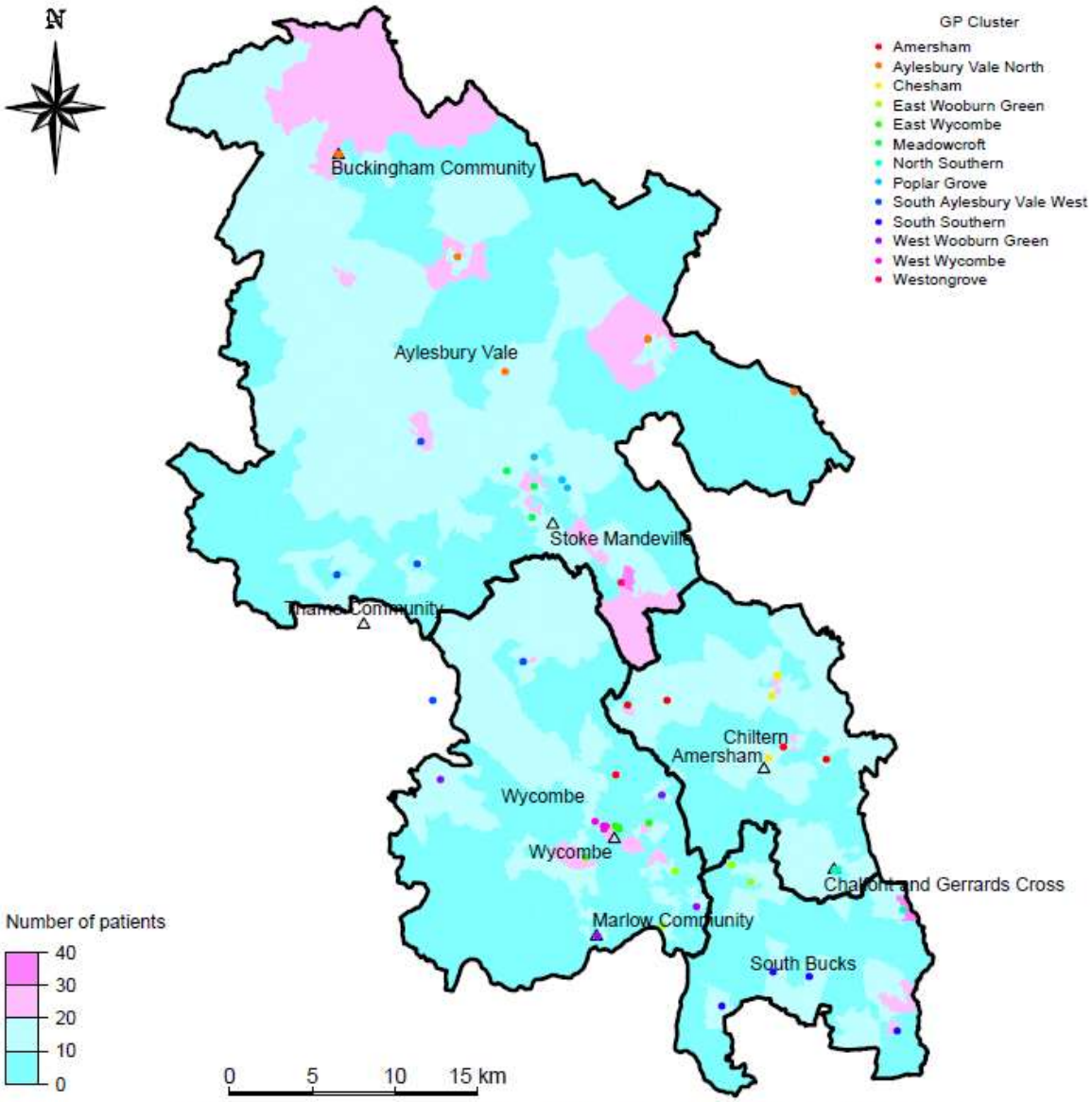
COPD

COPD respiratory related airways diseases pathways are being reviewed with a vision to offer a similar offering as detailed above. The service will review how and where to best locate these clinics.



Providing a clinic that meets the needs of those with a condition of COPD could save a potential of 3,434 patients attending the emergency department from a catchment area predominantly around area around Buckingham Community.

Probability of emergency admission
3,434 patients with COPD among 5.2% high risk



Produced by Public Health, Buckinghamshire County Council

We have enhanced continuity of care by sharing patient's electronic records across an integrated system.

Buckinghamshire have carried out a number of analyses on patient conditions & the risk stratification for each service is available in the attached PDF

Bucks_risk_stratification_maps_2_of_4.pdf

Step 3: Assessment of impact

Using the information you have gathered and analysed in step 2, what do you think are the main issues relating to equality of opportunity / eliminating discrimination/ and any disproportionate impact that has been identified in relation to the protected groups.
In your response please consider;

- How do the current practices and measures affect different protected groups?
- What specific actions are you are proposing?
- Does the EQIA reveal that the proposal unlawfully discriminates or impacts on human rights?
- Any other information that you may have that is not from step 2 which may help you to assess impact.

In line with the Five Year Forward View, our patients and clinicians have told us that it is important to them that we provide more care closer to home, with care delivered out of hospital and in local communities.

Evidence from the national New Care Models programme found that by implementing a whole population care model, including hub-based care, health and care systems:

- reduced the rate of growth in non-elective admissions by approximately 4%, when compared to non-new care model systems
- emergency bed days showed a 1% reduction in comparison to a non-new care model systems which grew by 1%.

We are seeing a significant increase in the older population and increasing numbers of people with multiple long-term conditions and frailty. Long-term conditions and frailty are not an inevitable consequence of ageing, much of this is driven by unhealthy lifestyles coupled by a historic lack of investment in prevention so we must find ways to improve this too.

We also know that a frail, older person has muscle deterioration equivalent to 10 years

for every 10 days in hospital. Inpatient beds are not always used effectively and can impact on a patient's ability to remain independent as their stay can be extended inappropriately. In summary, keeping people healthy and independent in their own homes is what our patients have asked for, is better for them and for the provision of services.

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.

In summary, through prevention and early intervention we want to:

- Support people to keep themselves healthy and live well, 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 principles of the vision that have and continue to shape our transformation 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 are 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.

The stakeholder group has been an important part of the pilot, they have provided scrutiny and challenge to the developments, have represented views of their communities, and helped to develop links between the services and local organisations

Based on your analysis what is the impact of your proposal on the protected groups?				
Protected characteristic group	**Positive impact**	**Negative/Adverse impact**	**Neutral impact**	**Explanation**
Race	The services model has been developed to meet the needs of all race characteristics and populace. Facilities are available to allow patients to communicate using their own dialect via language line services	Given where ethnic minority populations live this model (both the pilot sites and possible roll out other locations) are not where the ethnic minority population live.	The pilot provides little or no impact change for any groups	Both pilot sites have the ability to facilitate patients of all race creed & colour. The catchment sites of the pilot have ethnic demographic
Sex	As a day assessment service (rather than inpatient) it reduces any dignity issues.	Need to ensure dignity when getting changed for diagnostics etc. and adequate space to allow segregation	Sex neutral service	Providing services to all genders across the community including those within a specific medical group
Age	Less far to travel for treatment. Smaller, easier to get around, more familiar. Not an age specific service i.e. all OPD is for everyone, assessment for frailty not old age.	Not yet well developed for children (but they have children's centre) Doesn't have everything so still might have to go elsewhere for higher level diagnostics however more local to people. Environment is better and more time with clinical staff.		The delivery of this model is in keeping & in combination of work of the five year forward view to reduce the activity for non-urgent care away from the Main Hospital and move the service to the community closer to home.
Sexual orientation			Sex neutral service	Providing services to all population who require these services across the community
Gender reassignment	Side rooms available should they be required for privacy and dignity	Mixed sex environment – curtains, toilets, changing.	As a day assessment service (rather than inpatient) it reduces any dignity issues.	This is the optimal service provided at all our pilot areas
Religion & belief		Don't have differentiated toilets	Food provided and available as snacks Prayer room at MuDAS	Patients are not in long enough to require separate catering. If did, might need to go to Wycombe – Other service areas offer toast; soup and biscuits so would be the minimal

				requirement.
Disability	Smaller, more familiar, easier to get around Services/people come to you not the other way around Higher staff ratio and a more holistic approach to time and space to reduce anxiety Disabled bays right outside because a smaller place. Thame on the flat, Marlow ramp.	Not modern buildings and when it was an in-patient area the same challenges were present.	These will be looked into : Doors narrow, wheelchairs hard to manoeuvre ; not many patients attending require a wheelchair No induction loops No colour signage or pictures etc for those with a learning disability which is being looked into	When looking to roll out we may need to consider this ensuring suitable for frail, elderly patients. Local charities have indicated support to develop environment.
Maternity & pregnancy	Could develop to meet their needs. E.g. see GP at CATS for bloods. If surgeries struggling to have the space could do midwifery clinics here			
Marriage & Civil Partnerships	No impact			

If there are any barriers that cannot be removed, you need to identify what groups will be affected and what positive actions are you proposing in order to reduce the adverse impact on those groups.
Consider what practical changes or measures would help reduce the adverse impact on particular protected groups.
If the impact is;

- **High** – needs very detailed and thorough process with significant external or risk of legal challenge.
- **Medium** – needs reasonably robust process with some degree of external challenge
- **Low** – needs some a degree of rigor to confirm that it is in line with statutory duties but external challenge not needed

Protected characteristic group	**Actions to mitigate any negative/adverse impacts**
Race	None
Sex	None
Age	Children's services - LOW
Sexual orientation	None

Gender reassignment	None
Religion & belief	None
Disability	**Low** - Will need to review and assess facilities available and requirements to ensure buildings provide equitable service for people with a disability .
Maternity & pregnancy	None
Marriage & Civil Partnerships	None

Step 4: Engagement or Formal Consultation

Make sure that you reach as many of the protected groups as possible in particular those who are likely to be affected by the proposal. Please click on link to the **Corporate Equality Monitoring Form** **http://swanlive/corporate-information/equality-diversity**

In your response please consider;

- Who you intend to engage / consult with: patients, service users, carers, staff, and stakeholders.
- Are there any concerns that relate to the assessment in steps 2 and 3 that you need to address during the engagement or formal consultation?
- What are the main issues and concerns from the engagement or formal consultation?
- How in your engagement /consultation have you responded to the groups that you have engaged or consulted with, in relation to the issues and concerns raised during the process?
- What changes are you going to make as a result of the engagement or formal consultation?

Staffs were consulted with at the start of the pilot period, and have been asked to provide feedback over the past 12 months. For those currently working within the hubs, group and individual meetings will continue to be offered however as they will remain in the roles they are currently doing, the impact of the change at this point is minimal so no formal consultation will be necessary. A full 'Equalities Impact Assessment' -Workforce Profile has been completed (see Appendix A)

Public & Stakeholder To ensure we could respond quickly to patient and stakeholder feedback about the pilot we established number of mechanisms to make certain the pilot is robust, new models of care are being properly tested and any issues or ideas for improvement could be implemented quickly. This includes quantative and qualitative research with patients, staff and GPs – both on an informal and formal basis. In addition we have been raising awareness of the pilot through traditional and social media, attendance at community events such as the Thame community market, presentations to interested groups such as the Buckinghamshire Older People Action Group along with successful open days at Marlow and Thame.

A key initiative has been to establish a stakeholder engagement group, which is chaired by

our chief nurse and director of communications. Comprising of representatives from Health watch, Marlow and Thame League of Friends, Thame and District Day Centre, Marlow and Thame town councils and patient participation groups of local practices, the stakeholder engagement group acts as critical friend to the pilot, helping us to review how the new services are working and performing against key indicators, as well as helping us to shape how we can engage and involve people in the on-going development (membership and terms of reference can be found in Appendix A).

This group has been key in helping us to raise awareness of the pilot at a very local level. They have made important recommendations to the governance group and the Trust's executive management committee which are shaping the pilot, including increasing outpatient clinics, more in-depth patient surveys and follow-up calls from clinicians to GPs to seek feedback and improve the coordination of care. This group has added significant value to the pilot, providing a range of perspectives as the pilot has progressed.

Most significantly the stakeholder engagement group recommended to extend the original pilot by six months to enable us to mobilise a greater range of services, increase the number of referrals and assess the impact on patients during the winter months. Support statements have been provided by League of Friends and can be found on Appendix 4 in the 'Developing Out of Hospital Care report and copied below'


Appendix 4.docx

Clinical staff from the community teams have also been working with GP colleagues at individual practices to help them identify patients who might benefit from the new services (particularly the community assessment and treatment services element) to increase referrals and ensure that the services are being fully used.

This wide involvement has enabled the model of care to change during the pilot. For example we are bringing more outpatient services on stream with chemotherapy introduced at Marlow in August and we are looking at the possibility of being able to offer ultrasound facilities at Thame.

For full Engagement report, please see 'Developing our of Hospital Care' report – Appendix 2.

Step 5: Monitoring & Training
It is essential that all Public Authorities understand the effects of their policies and practices, to assist them to comply with the general duty. As noted in the Equality Delivery System (EDS) for the NHS monitoring should cover all of the protected characteristics. The purpose of equality monitoring is to see how the proposal is working in practice and to identify if and where it is producing disproportionate adverse effects and to take steps to address those effects.

Unlike the EDS monitoring does not have to be done across all the groups in every instance. You need to assess which groups are more relevant to your proposal and groups where concerns have been raised. You should use the Trusts Corporate **Equality Monitoring Form**.

If the proposal is introducing a new system or ways of working or changes to current practices you need to consider the training implications. You may also need to raise awareness of equality issues.

In your response please consider;

- What arrangements do you have or will you put in place to monitor?
- Who will be responsible for monitoring?
- What indicators and measures will be used to monitor and evaluate the effectiveness of the strategy/ policy/ service/function and its equality impact?
- Where will this information be reported and how often?
- What training requirements are needed as a result of the proposal?

No changes are anticipated in the roles staff members are undertaking within the Community Hubs so no additional training requirements are anticipated. Staff working within community assessment and treatment service have been provided with, and will continue to be provided with, additional training to develop skills and competencies for interventions that are new to them or have not practised for some time. Line managers will continue to monitor and assess staff training requirements through the annual appraisal process, and by ensuring compliance with statutory and mandatory training. Full Diversity & Equality training is part of the core modules that all staffs complete annually.

Step 6: Commissioning / Procurement and Partnerships

If the proposal involves the commissioning or procurement of services you need to ensure that the contract includes equality and human rights considerations. Specifically you should set out how you will make sure that any partner you work with complies with equality and human rights legislation, and how you will monitor this.

You will need to think about:

- Tendering and specifications
- Awards process
- Contract clauses
- Performance measures
- Monitoring

This is generally managed through the Procurement department you are advised to seek advice by contacting the internal team.

Existing facilities have been re-developed with no commissioning change or procurement impact currently on the development of the Community Hubs during this pilot stage

Step 7: Summary of Impact
In the table below, summarise for each protected group the impacts that you have identified in your assessment. Please remember to summarise the positive as well as negative impacts. **This information should be used for publication or if a summary is required for reports.**

Protected characteristic / group	**Summary of Impact**
Race	Both pilot sites have the ability to facilitate patients of all race creed & colour. The catchment sites have a small ethnic demographic and therefore has little or no impact on the service offering
Sex	Assessment clinics facilitated at Hubs and therefore as long as facilities are maintained for privacy & dignity to allow patients to change there should be no problem
Age	As an OPD direct access and availability for all patients ages – however at this time limited setup of children's services. Separate children's centre already in place to meet their needs – however in the future development locally.
Sexual orientation	Both pilot sites have the ability to facilitate patients of all sexual orientations
Gender reassignment	Both pilot sites have the ability to facilitate access for all patients
Religion & belief	Patient availability to food and drink in line with their religion of belief.
Disability	As programme continues will need to continue to review and assess facilities available and requirements to ensure buildings provide equitable service for people with a disability.
Maternity & pregnancy	No impact
Marriage & Civil Partnerships	No Impact

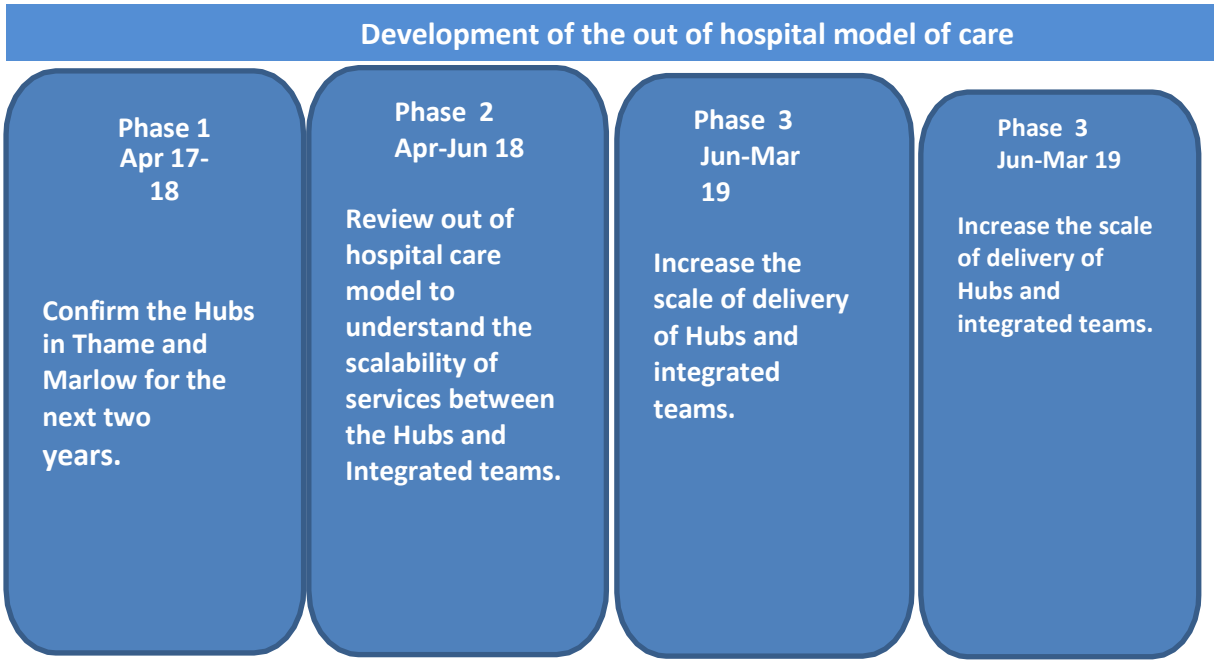
http://www.healthandwellbeingbucks.org/Resources/Councils/Buckinghamshire/Documents/JSNA/3.4%20Protected%20characteristics.pdf

Step 8: Action Plan (Implementation and review)
At this stage an Action Plan / Improvement Plan should be developed to address any concerns or issues related to equalities in the proposal. This plan should be integrated into the appropriate Service or Business Plan.

Responsibility for implementation of Action Plan:	
Name of Committee monitoring the progress:	

Next Steps

- Continue with the current community hubs at Thame & Marlow for another two years so that the other complementary elements of community services transformation have time to be developed, rolled out across the county and be properly evaluated. This includes developing the community hubs model across the county.
- Work with general practice localities to further integrate services and to support the proactive identification of patients who are likely to benefit from the CATS service e.g. through risk stratification.
- Work with care homes to ensure that residents in a care home, who would benefit from the CATS service, have access to it.
- Explore further development of the referral model potentially widening the range of people who can refer directly to the services within the hub including self-referral.
- Review the discharge from A&E and acute inpatient care pathway to ensure that CATS is recognised as a viable alternative to a 'bedded 'option, developing a local concept of the virtual ward.
- Work with local GPs to increase the capacity of the CATS by increasing the number of days of operation in line with demand.
- The Integrated Care System will set up local stakeholder engagement groups aligned to the integrated team localities – building on those in place for Marlow and Thame - to co-design the local detail of the out-of-hospital care model, including the hubs, ensuring that they meet the needs of the local community.
- Identify the target population cohorts and care professionals that the new model of care will apply to
- Define the service combinations that will comprise the future model and the level at which services will be delivered across Buckinghamshire.
- Drawing on the base lining of all existing projects, identify the financial contribution of the services and change projects in scope to meet the system's 2018/19 financial requirements.
- Provide suggested timeline for implementation and outline workforce projections.
- Review the care model to strengthen prevention and self-care and ensure that it maximises the care delivered locally and focusses on health and wellbeing in line with the design principles in Appendix 5.
- Development of a robust communication plan with the public and professionals to raise the awareness of the hubs and increase the productivity and value of the services for the local community.
- Review outpatient services to ensure that the shift to local provision is transformational, meets the local health population needs and not just utilising space.
- Local services for local people to minimise travel and have a home first approach where possible.
- Put in place signposting, education and care navigation in hubs.



Step 9 – Sign off & Publication	
Please sign, date and submit to your Diversity Champions for quality checking and then your Associate Chief Operating Officer for sign off. The Lead Officer must publish the Summary of Impact (step 7) with the relevant policy, guideline, strategy It is important that a copy of this EQIA is kept as you could be asked to produce this at a later date. Please also send final copy to the Equality & Diversity Manager at equality@buckshealthcare.nhs.uk for publication.	
Name of lead officer:	***Natalie Fox***
Signature & date:	***April 2018***
Name of Diversity Champion:	
Entered on Divisional Risk Register (Y/N)	***Yes***
Diversity Champion Signature & date:	
Name of Assistant Chief Operating Officer:	***Natalie Fox***
Signed off and date:	***April 2018***
Publication Officer & date:	

Early Supported Discharge Orthopaedic Service (ESDOS)

Buckinghamshire Healthcare Trust

1

Purpose of ESDOS

- To provide intensive, multi-disciplinary rehabilitation in the home environment, for up to 4 weeks
- This intervention follows seamlessly and immediately from the rehabilitation received in the acute ward
- To facilitate early discharge from hospital for T&O patients who are medically stable but have ongoing rehab needs

2

Acceptance Criteria

- Patient is registered with a GP
- Patient is medically fit
- Rehabilitation potential has been identified by the MDT with specific functional / rehab goals (achievable within 4 weeks)
- Patient, family or carer are agreeable to intensive rehabilitation at home and transfers can be managed

3

Referral Process

- A member of ESDOS team attends DFM on wards 1& 2 regularly where potential new patients are highlighted.
- New patients are also referred straight from inpatient therapy team. Referral forms are completed.
- New patients are assessed by ESDOS team whilst on the ward and medical information is collected. Patient information folders are issued to the patient on their consent to the service. Relatives or care homes are contacted as necessary
- Patients are contacted within 24 hours of discharge

4

Who To Refer – Change of Culture

We support EARLY discharge for patients of **all ages** and **all degrees of severity**

We provide rehab at home with the same **intensity as the ward**

Discharge goals to get the patient home start pre discharge so we can take patients out **as soon as** they are medically stable with the appropriate support at home. Supporting a micro living environment initially.

5

ESDOS – What we provide

- Assessment and provision of equipment as necessary
- Opportunity to practice ADL at home – this assists in regaining independence and meaningful quality of life
- Advice and support for patients and family regarding their recovery pathway
- Continuous assessment and review of client centred goals
- Onward referral

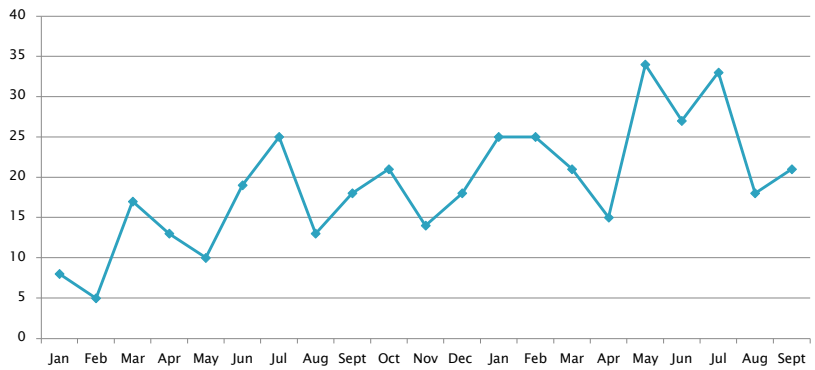
6

Audit Collection

- Data is collected for every patient.
- Data details include patient condition, discharge date from ward, first visit by ESDOS, discharge date from ESDOS, number of visits per patient

7

Number of NP to ESDOS per month 2014 – 15



8

Advantages of ESDOS

- Specialists Therapists in Orthopaedics
- Can treat patients daily if required for period of 4 weeks (intensive service)
- Often first health professional to visit post discharge
- Work closely with the inpatient team
- Close relationships with nursing staff on wards to discuss any nursing issues
- Attend trauma meetings and can ask consultants directly any issues with patients

9

Advantages of ESDOS cont

- Can facilitate bringing fracture clinic appts forward if required
- Integrated Working
- All Assessments are done with a Qualified OT and PT on the first visit.
- Establishing good working relationships with Nursing and Residential Homes. They take patients much earlier with ESDOS.
- Therapy CSW are highly specialised in both OT and PT skills.

10

Advantages of ESDOS

- Responsive team ethos ie Step down beds(winter 2014)
- Saving Bed Days (even one can make an impact), often prevent pts transferring to community hospitals
- Able to address any outstanding equipment needs
- Evolving service

11

Contact Details for ESDOS

Monday to Friday 8.30am to 4.30pm
Office number: 01296 315099
Please contact us with any physiotherapy/occupational therapy concerns/questions.

All medical concerns please contact:
1. Your GP
2. 111
3. Medical emergency 999

How can I help reduce healthcare associated infections?

Infection control is important to the well-being of our patients and for that reason we have infection control procedures in place. Keeping your hands clean is an effective way of preventing the spread of infections. We ask that you, and anyone visiting you, use the hand sanitiser available at the main entrance of the hospital and at the entrance to every ward before coming in to and after leaving the ward or hospital. In some situations hands may need to be washed at the sink using soap and water rather than using the hand sanitiser. Staff will let you know if this is the case.

www.buckshealthcare.nhs.uk

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Author: ESDOS physio team
Issue date: March 2019
Review date: March 2020
Leaflet code:
Version: 3.0

Buckinghamshire Healthcare NHS
NHS Trust

Early Supported Discharge after Orthopaedic Surgery

Information for Trauma & Orthopaedic patients ready for earlier discharge home from hospital

Appendix

Where your needs always come first

What is Early Supported Discharge (ESDOS)?

The aim of the ESDOS team is to enable orthopaedic patients to return home from hospital as soon as possible, whilst continuing to receive specialist physiotherapy and occupational therapy in their home.

Patients will only be discharged home from the ward once they have been seen by the Doctor who will declare them medically fit and the therapy team are happy that you are safe for discharge.

You have been referred to this service as the trauma and orthopaedic team feel it is the best way forwards for your recovery following your injury.

The ESDOS Team:

Physiotherapist: Will focus on improving your physical function, movement and strength.

Occupational Therapist: Will teach you techniques and supply equipment to enable you to perform daily living tasks.

Clinical Support Workers: Support the Physiotherapist and Occupational Therapist, helping you to carry out exercises and activities as prescribed by the qualified staff member.

Please note we are a therapy only service

How does it work?

The ESDOS therapists will contact you via telephone call once they have received your referral from the ward team.

Together, we will arrange a time for a home visit as soon as convenient after your discharge home from hospital.

During your initial assessment, we will jointly agree an appropriate treatment plan and set goals together to achieve during your time with our team. The number of times you are seen will be tailored to meet your specific needs.

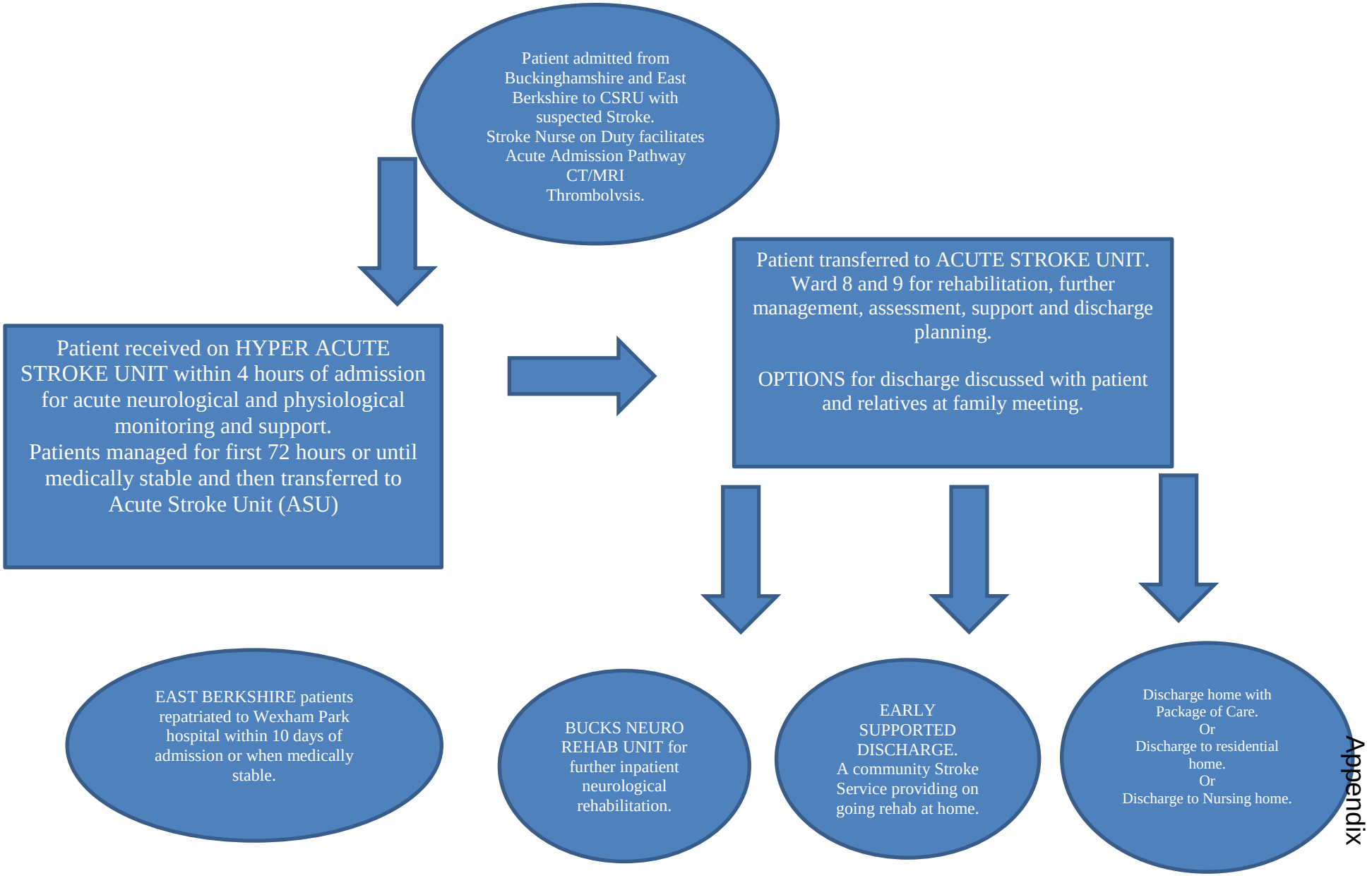
Due to the nature of our service, visits are allocated on a daily basis at our morning team meeting therefore you will be contacted on the day of your visit rather than a pre-planned appointment arranged. You may be seen by a combination of staff members who will be familiar with your tailored goals & treatment plan.

If appropriate, our service lasts a maximum of 4-6weeks and if you require further physiotherapy after this, we will refer you on to the appropriate team.

At the end of your treatment, we will send a discharge letter detailing our ESDOS input to your GP.

Buckinghamshire Healthcare NHS
NHS Trust

STROKE PATIENT PATHWAY



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Report to Health and Social Care Select Committee

Date: 3rd February 2022

Title: Better Lives Transformation Programme

Relevant councillor(s): Angela Macpherson, Cabinet Member Health and Wellbeing

Author and/or contact officer: Gillian Quinton, Corporate Director, Buckinghamshire Council

Ward(s) affected: none specific

Recommendations: That the Health and Social Care Select Committee notes and provides feedback on the contents of the report.

Executive summary

1.1 Buckinghamshire Council's Better Lives Strategy 2022-25 was published on 19th January 2022. The strategy reiterates the direction of travel set out in the original Better Lives strategy 2018-21. This report provides a summary of the progress made through the first strategy and explains the scope of the second phase of the transformation programme to deliver Better Lives in Buckinghamshire.

Content of report

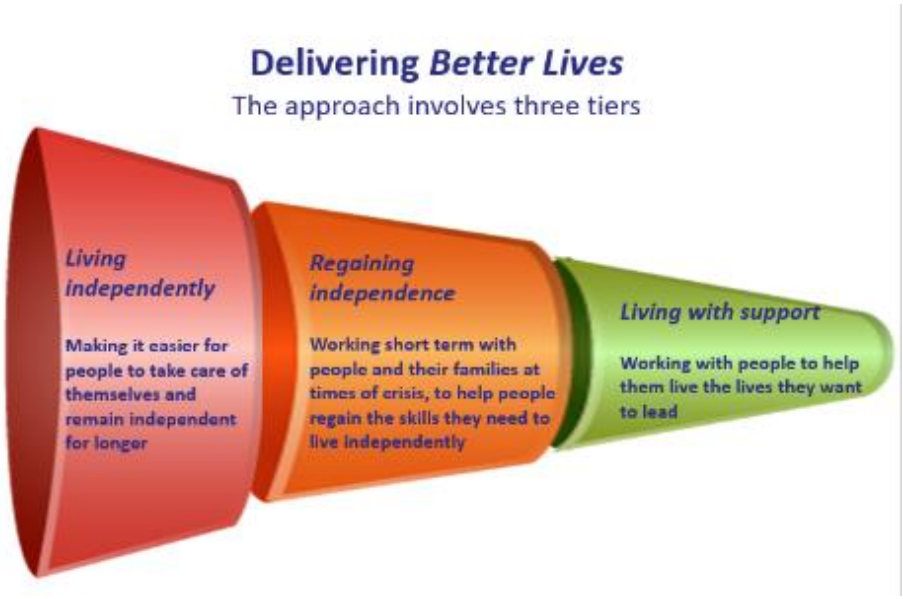
1.2 In 2018 Buckinghamshire County Council published its first overarching strategy for adult social care, *Better Lives*. The strategy set out the intention to transform social care services from a traditional, paternalistic approach to one that promotes independence, where the outcomes and goals of each individual shaped the support they can draw on.

1.3 Buckinghamshire Council has recently published a refreshed document (Appendix 1). Given the scale of the ambition set out in the original strategy, the refresh reinforces the Council's vision and builds on the successes to date. It demonstrates how the approach is making a difference to people's lives and Appendix 2 provides some example case studies. The refreshed strategy also identifies areas of focus for the

next three years, to embed the changes made to date and continue on the programme of transformation.

The Better Lives Strategy

1.4 The Better Lives Strategy sets out the Council's ambition to reduce the number of people in long-term residential and nursing care, ensuring that these services are only used when absolutely necessary. Instead, more people will be supported to regain independence through short term interventions and remain living independently for longer, in their own homes particularly through better signposting and advice. The approach not only provides better outcomes for people, but also focusses activity into the lowest cost provision, resulting in a financial benefit for the council. For example, the average weekly cost of a home care package is £285 compared with the average cost of a nursing home placement at £1,000. The diagram below explains the model, which is based on three tiers of support: Living Independently; Regaining Independence; and Living with Support.



1.5 The strategy describes the Council's determination to transform services to improve outcomes for people and focusses on:

- Independence without the need for long-term care wherever possible
- People having greater choice and control over their care
- With each person, looking at what they can and want to achieve, building on networks of support that they already have in place
- Safeguarding adults when it is necessary
- Delaying/reducing the need for traditional care services

- Working with providers in the care market to develop solutions which will meet current and future needs
- Working as part of the health and social care system to provide high quality care and support to residents
- Best value for money

Better Lives Transformation Phase 1 (2018-21)

1.6 During the lifetime of the initial Better Lives strategy, the service made some fundamental changes to the way in which adult social care worked, which are providing a strong foundation for Phase 2 of the programme.

1.7 The first of these was the introduction of strengths-based practise. The approach moves the focus of our interaction with people away from traditional service provision, which assessed people's needs, informed them of what they needed and which wrapped services around people to keep them safe. The strengths-based approach means that staff work with people, their families and community assets to understand the outcomes they want to achieve, providing advice and support to help them realise their goals and remain independent. Some of the examples in Appendix 1 demonstrate the difference this approach has made to the lives of those who have been in contact with adult social care in Buckinghamshire.

1.8 To modernise the service to support this strengths-based approach, two major change projects were also implemented during Phase 1 of Better Lives. A new social work case management recording system was launched in March 2021 and an operations service restructure which placed long-term teams on a locality footprint with a new 'front door' to social care. A new multi-agency hub means that enquirers can be helped in a more holistic way. Workers from different services and organisations are co-located to provide appropriate advice and support on issues such as drugs, alcohol and housing as well as social care. A new advice website, Care Advice Bucks, co-designed with Buckinghamshire residents was launched, providing a wealth of information and support as well as a new online directory to link people with activities in their area.

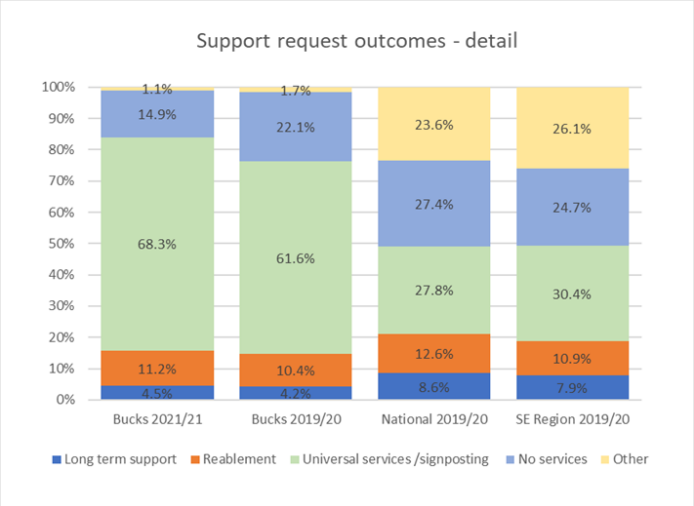


Fig 1: comparison of support request outcomes, National SALT return 2020-21

The latest national statistics return on short and long-term services demonstrates how this approach is helping many more people in Buckinghamshire with

the advice and support they need at first contact, compared regionally and nationally (Fig 1)

1.9 Through our Tier 1 transformation, Buckinghamshire is now one of the best performing authorities for proportion of new requests for support managed through universal services and signposting (Fig 2).

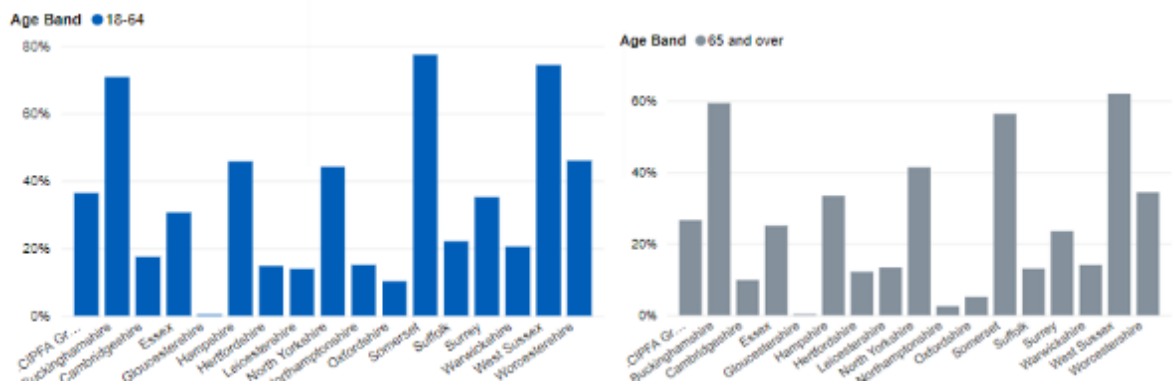


Fig 2: Proportion of requests for support that result in Universal Services and Signposting, by age group

1.10 Work to align internal services and with health colleagues in relation to hospital discharge, alignment of processes and reablement during Phase 1 of the Better Lives Transformation programme has resulted in more efficient and responsive services. There have been significant reductions in inappropriate referrals for short term interventions and waiting lists were improving, even during the pandemic (Table 1 below). However, Buckinghamshire still provides lower levels of short-term intervention than comparator authorities and this area remains a focus for improvement.

Table 1: Comparison of short-term intervention metrics, June 2021

	Feb 2019	Feb 2020	Feb 2021
Number of inappropriate referrals	64	91	24
% of referrals inappropriate	32.32%	41.55%	23.08%
Average waiting time from referral to assessment (days)	8.01	8.06	2.84

1.11 Prior to Covid our Better Lives approach was delivering on the Tier 3 ambition to reduce the numbers of people in residential and nursing care. Fig 4 below shows

how the trend in residential and nursing home admissions in Buckinghamshire was significantly different to that being seen regionally and nationally.

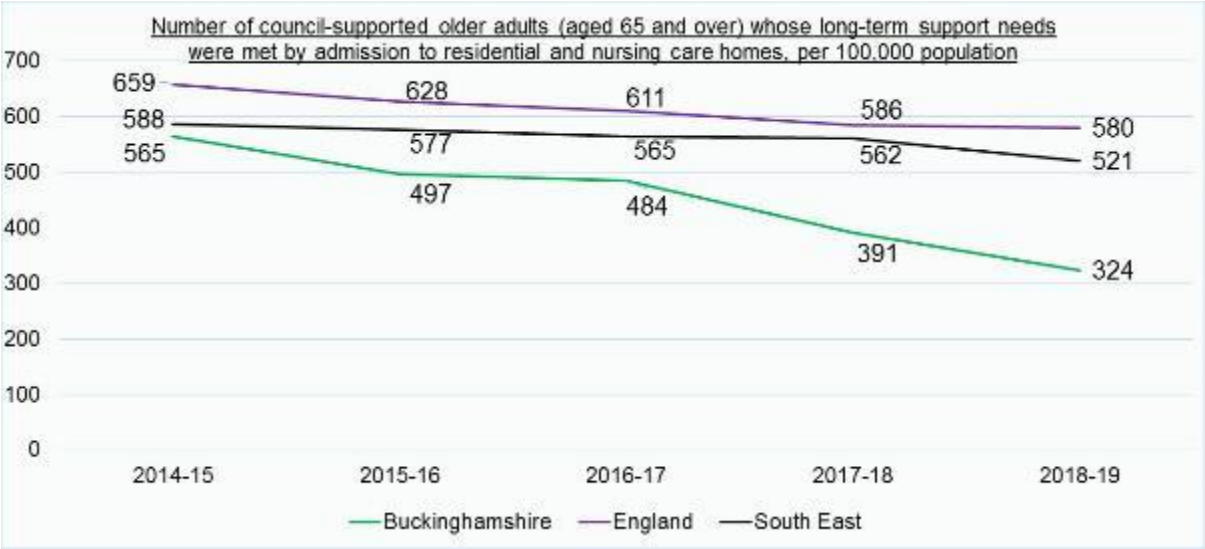


Fig 4: Trends in residential and nursing care admissions 2014-2019

1.12 The impact of Better Lives is also being reflected in the views of those who draw on social care services. The latest national user survey (2020-21) showed improvements in satisfaction with the Council's adult social care services despite the pandemic. Satisfaction with the care and support that people received has improved (68%) and is now higher than both the CIPFA comparators (65%) and the England average (64%). Only 3% of people were dissatisfied with the service they received.

1.13 The number of people reporting that they have control over their daily lives has also risen from 75% in 2019-20 to 83% (78% CIPFA, 77% England), and those who say that they feel safe has increased to 77% from 68% (71% CIPFA, 70% England).

1.14 Finally, the Better Lives transformation programme underpinning the strategy has been primarily responsible for delivering savings of over £10m, which have mitigated pressures on services from increases in demand and complexity of need.

Better Lives Transformation Phase 2 (2022-25)

1.15 A small number of projects are continuing into the next phase of our change programme, underpinning the refreshed Better Lives strategy, alongside a number of new areas of focus. The projects and the desired outcomes are:

Mental Health: reviewing the arrangement with Oxford Health Foundation Trust to ensure social work practise is aligned with the Better Lives approach

Community Opportunities: building on the successful transfer of Thrift Farm to an appropriate provider, this project will continue the programme to develop a broad community opportunities offer with voluntary and community sector partners, a county-wide short breaks offer, improved access to training and supported employment for working age adults and to volunteering opportunities

Autism: Understanding the support needs of people with autism and making it easier for people with autism to get the help they need at the earliest opportunity

Technology-enabled Care: The use of technology is mainstreamed so that it is used where it is appropriate to do so to enable people to live as independently as possible

Specialist Housing: Revising the prospectus to attract investment in specialist housing development in Buckinghamshire and making sure there is enough specialist housing provision to meet demand within the county

First Response: Bringing multi-agency partners into the adult social care 'front door' means that people can be supported more swiftly and effectively. One Recovery Bucks and Connexions Support have already joined and more are due, to prevent, reduce or delay the need for statutory assessments

Carers Support: Carers in Buckinghamshire have a broader offer of support available to them and have a better experience of the assessment process. As a result, there will be fewer care breakdowns in families

Self-directed Support: People with social care needs have greater choice and control over how their personal goals are achieved

Dementia Specialist Services: The route through to services is made easier to navigate and there are more services on offer for people with dementia and their families. More people are able to live at home for longer and fewer people with dementia have end of life care in hospital

In addition, initiatives to continue improving quality will continue with a strong focus on resident engagement and on supporting staff through greater learning and development opportunities, including career pathways.

The integrated commissioning service is introducing a new way of procuring packages of care for people which will allow the Council to set out new terms relating to price and quality. Providers who have met these terms will then be able to bid for packages of care through an online portal, making the process of procurement much more efficient, improve quality and deliver value for money.

Each project will have identified metrics by which their success can be measured and the overall programme metrics, some of which are shown above, are monitored at the service's monthly Transformation Board. The Cabinet Member for Health and Wellbeing is a member of the Board.

Challenges

In terms of challenges, the ambition of the programme and the projects is extensive. Over the past two years much of the capacity of services has been focussed on continuity of service provision for those who use social care services, as well as support to our local NHS in their response to the pandemic. The rapid transmission of the Omicron variant has meant that services are working to maximise hospital discharges and support care providers. To add to this pressure, towards the end of 2021 the council experienced a significant demand for adult social care services and safeguarding. Capacity to deliver transformational change is currently and understandably therefore limited.

In addition, the Government has issued its social care reforms and the council needs to ensure it plans appropriately for implementation. In October 2023 a new cap on personal care, new capital limits and changes for self-funders of care will be introduced. Work is taking place to assess the potential impact, and initial indications are that this will be significant. Over the next two years, adult social care and colleagues in affiliated Directorates will be needed to prepare the council for the reforms.

Finally, at the current time, there will be a legislative change to the Deprivation of Liberty Safeguards in April 2023. This will impact social work practise and will require a substantial implementation project.

Despite the challenges, the transformation programme, alongside other priorities, are kept constantly under review to ensure that where possible, capacity is available to deliver the Better Lives ambition.

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Better Lives 2022-2025

A strategy for the future of adult social care in Buckinghamshire

Appendix

Contents

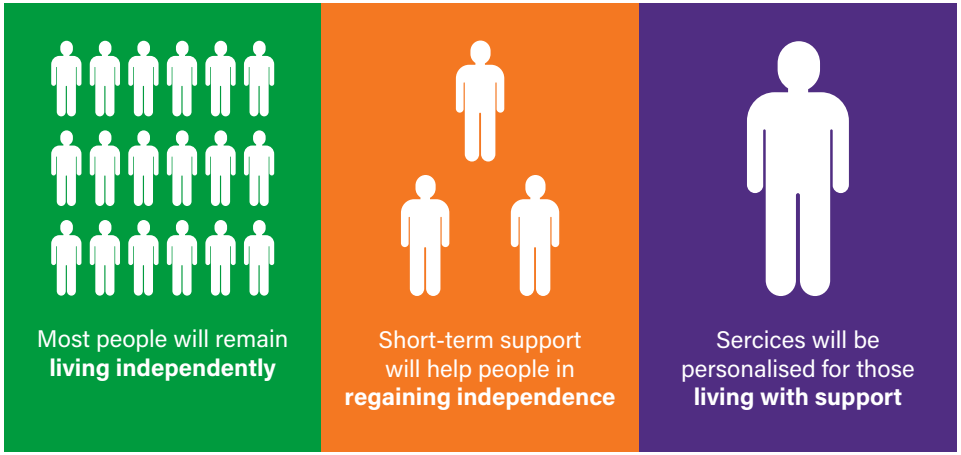
Introduction

Our residents consistently tell us that they want to live as independently as possible for as long as possible, and that they should be able to rely on the council for support and guidance to help this happen. In response to this, we launched our Better Lives Strategy in 2018. The strategy sets out how we aim to help people to live healthier lives and to regain their independence, whilst offering a little extra support when needed.

We want to improve adult social care and create sustainable services for residents of Buckinghamshire. By placing a much greater emphasis on prevention, delaying the need for formal services, and enabling people to live independently for longer, this strategy is helping us change the way we support residents.

There are three key parts to our Better Lives strategy: living independently, regaining independence and living with support. These are explained further in this document. This updated strategy builds on the learning and achievements of the last 3 years and sets out our priorities for the next 3 years.

Financial pressures are growing year on year, and adult social care will need to support more people due the ever-growing population and the long-term impacts of Covid. With all our partners, including the voluntary and community sector, we have a role to play in helping individuals, their carers and communities to recover from the impact of the pandemic. This will be a challenge for the council and our partners, and means that we will need to do things differently to make sure people get the support they need at the right time.



Angela Macpherson
Deputy Leader & Cabinet Member
Health & Wellbeing

Gill Quinton
Corporate Director
Adults and Health Directorate

Better Lives outcomes

Both now and in the future:

- more residents will live independently without the need for long-term care
- fewer residents will require support in a residential or nursing setting
- more residents will return to living independently after leaving hospital
- younger people moving on from children's services with care and support needs will be better prepared for adulthood
- people will have more choice and control over their own care, drawing upon community resources as widely as possible
- people will experience more seamless care and support across social care and the NHS

The Better Lives approach - three key parts

Helping people to live independently

Firstly, we will:

- work closely with communities, local groups and the voluntary sector to improve the support available in local areas
- make it easier for people to build strong local networks of support
- make sure that a wide range of information and advice is easily accessible so that people can quickly find the support that they need

Helping people to regain independence

If additional support is needed, we will:

- work with individuals and their families to come up with plans to help prevent problems from getting worse
- provide short-term support to help people recovering from an illness or injury or living with long-term social care or health conditions to gain or regain the skills they need to live independently

Helping people to live with support

Finally, if longer-term support is needed, we will:

- offer people more choice and control over their support
- work closely with the individual, their family and their community to achieve the best outcomes
- consider the individual's desired outcomes when deciding how best to support them within the resources available
- support the development of a wide range of services to help people live more independently

At all times, we will work with people to help them find solutions to daily risks and challenges – allowing them to remain living as independently as possible whilst keeping them safe from significant harm.

Better Lives principles

Following these principles will help to ensure that residents of Buckinghamshire are able to lead fulfilled, satisfied lives.

- decisions are taken with people rather than for them
- support is proportionate to the person's needs and focuses on what they can do and not what they can't
- people are supported to live independently for longer
- a focus on prevention and short-term intervention helps people regain the skills they need to continue living independently
- services are sustainable for the future
- decisions are evidenced, reasoned and recorded
- our workforce is supported and skilled to deliver the changes
- we robustly monitor, manage and evaluate our performance

How does our approach work?

Living independently

What this means

To help people to live independently for longer, we will ensure more support is available locally, from the voluntary and community sector and from the community itself. Information and advice will also be easily available and accessible which will in turn help people to lead independent and fulfilled lives.

To make this work we will:

- make sure people can easily access information and advice
- make it easier for people to build strong local support networks
- work with communities, local groups and organisations to build upon the support and opportunities available in local areas

What has changed as a result of the 2018-21 strategy?

We have significantly improved our information service. The number of people aged 18-64 we provided with advice and guidance has increased by 73% and more than tripled for people aged 65 plus. This means that many more people are accessing the information they need as quickly as possible.

Our focus for the Better Lives strategy 2022-25

Over the next 3 years we will:

- continuously improve the information and advice available by working with the voluntary and community sector and other professionals
- build better connections to improve support for people experiencing mental health issues and victims of domestic abuse
- work with carers to improve the support available to them
- develop more opportunities for people to be supported by their communities, both in the short and longer term

Living independently case study - Peter

Peter had a varied career in security services. He was forced into retirement through redundancy and ill health a few years ago. Despite his poor health, Peter continued to live independently.

Lockdown and self-isolation changed everything for Peter. The effect of this was that Peter stopped caring properly for his home or himself.

In the summer, the police were called out by neighbours who were worried about Peter. The police alerted the council's adult safeguarding service as they were concerned about how he was looking after himself, hoarding and the condition of his home.

Peter was shocked by the police and council being called in. He described it as a wake-up call and was keen for support to get back on top of things before they got any worse. The council was able to arrange for a swift deep clean of Peter's house, help Peter organise a regular cleaner and keep in light touch contact with him. Life has now improved for Peter who is also thinking about moving back to Devon where he has stronger social connections.

Living independently case study - Phil

Phil lives alone and keeps his home immaculate and always makes sure that he is personally well presented.

Phil is blind, caused by diabetes. A recent stroke severely affected his mobility and he has become very unsteady. After falling several times getting in and out of the bath and over-bath shower, Phil took the difficult decision to rely on strip-washing at the kitchen sink. Over-grown ivy stopped him from opening windows and had started to grow through and around the window panels and Phil was embarrassed by the condition of the property.

Phil suffers from depression and anxiety. Being unable to shower and feel properly clean has affected his mental health further and Phil's GP referred him to the council for support.

With Phil's agreement, an application was made for grant funding for a walk-in shower. The occupational therapist working with Phil also came up with an interim solution which would allow Phil to safely get in and out of the bath whilst waiting for the walk-in shower to be installed. At the same time, she alerted his landlord to the problem with the ivy.

The occupation therapist visited Phil the day after the walk-in shower was installed. Phil had made use of the shower as soon as the workmen left and the landlord had been out to clear the garden and removed the ivy. The changes made a big difference for Phil, who described them as giving him back his life, pride and independence.

How does our approach work?

Regaining independence

What this means

Some people are likely to need more support in the future. However, helping people to plan for the future can often prevent problems from getting worse and help people to stay independent, reducing the need for long-term care.

Where people are recovering from an illness or injury, we will help them to get back to their best health and fitness as soon as possible through short-term care, with support from their families, communities and other organisations.

To make this work we will:

- support people to live well with long-term conditions, recover from illness or injury and regain their independence quickly and safely
- provide short-term health and social care support when needed, to help people remain as independent as possible
- support people to return home from hospital as soon as possible when they are well enough by helping them to regain the skills they need to live healthy and independent lives.

What has changed as a result of the 2018-21 strategy?

Working closely with our NHS colleagues, we have significantly reduced the waiting time for short-term support services (from 8 days in 2019 to less than 3 days in 2021). Meanwhile, the proportion of people helped to recover, enabling them to remain living independently at home, has increased by 77%.

Our focus for the Better Lives strategy 2022-25

Over the next 3 years we will:

- build on our improvements and significantly increase the number of referrals for short-term support so that more people can regain their independence
- improve the use of technology to help people live as independently as possible

Regaining independence case study - Lorraine

Lorraine is 78 and living with her daughter. She was referred to the council by her GP who felt that Lorraine needed more support. Lorraine had become increasingly frail and had been living upstairs, as she was very anxious about using the stairs. Lorraine also loved to have a long, hot bath but was now unable to get in and out of the bathtub.

When the council's occupational therapist visited, she saw that Lorraine was also struggling to get in and out of bed, although once up she could move around well with a walking frame.

Although Lorraine was not complaining about her living situation, she knew that she would struggle to get downstairs in an emergency. Most importantly, living upstairs separated her from the family social life and increased her dependency on her daughter who had to bring Lorraine's meals to her upstairs.

The occupational therapist was able to arrange for a special handrail so that Lorraine get downstairs. Equipment was also provided so that Lorraine could use the bath and get in and out of the bed more easily.

Lorraine hadn't known that she would be entitled to help from the council. The changes have meant that Lorraine can now join in with family life and meals, play with her grandchildren in the garden and enjoy trips outside her home.

Regaining independence case study - Mark

This story is a tribute to Mark's determination, but it also shows how the council is able to support people back to independence.

Four years ago, Mark was a fit and healthy dad with a busy job. Unexpectedly he contracted a traumatic illness which left him paralysed from the waist down. After much work, a year on Mark was able to leave hospital but still needed intensive social care visits each day to help him with everyday tasks such as washing and dressing.

Despite his disability, Mark was determined to continue working and to regain as much independence as possible. The NHS provided physiotherapy, and with the daily support from the carers, Mark was able to return to work. During 2020, his employer provided him with an adapted car so he could drive himself to and from the office. He also got a motorised scooter which meant he could start an independent social life. As Mark continued to build up his strength and capability, he found he needed less and less social care support.

It's been a long, tough journey for Mark, but by September 2021 he was living independently once more and no longer needed any help from the council.

How does our approach work?

Living with support

What this means

People will have more choice and control over the support they receive, whether it is funded by themselves or the council. We also understand the vitally important role of carers and know that they may also need support.

We will support the development of a wide range of services within local communities to allow people to live as independently as possible.

To make this work we will:

- ensure we assess people's needs at the right time
- fully involve individuals and their carers in decisions
- offer all carers an assessment to ensure we identify any support they need to help them in their caring role
- work with partners to improve the service offered to residents and help to ensure they only have to 'tell their story' once

What has changed as a result of the 2018-21 strategy?

We have helped more older people to live at home for longer rather than in a nursing or residential home. There has also been a steady increase in the number of people with mental health issues supported within the community and the number of adults in contact with secondary mental health services who are living independently has increased by 80%.

Our focus for the Better Lives strategy 2022-25

Over the next 3 years we will:

- work with carers to improve the support we offer to them
- improve the range of housing options for people in need of support
- make it easier for people to have a choice in how their care needs are met
- ensure that people can be supported in their home for as long as possible by working with care providers to review how people receive support at home
- improve the support for residents in supported living accommodation

Living with support case study - Adrian

Adrian is a young man who was living on his own after his family moved away. Adrian has Asperger's Syndrome, Attention Deficit Disorder and also suffers from depression. During the 2020 lockdown, his mental health deteriorated badly. He started hoarding and his neighbours, realising that he was also deeply unhappy, contacted the council. Adrian was very suspicious of the social worker and it took some weeks to build a good relationship with him - first by talking on the telephone, then meeting on his doorstep - and finally Adrian found the confidence to allow us into his flat.

Each room of the flat was piled from floor to ceiling with rubbish, with a narrow path so he could reach the fridge, sink, toilet, bed and sofa. Adrian acknowledged that he was overwhelmed and he didn't know how he had reached this position.

Adrian allowed us to work with him and the first big change was clearing his flat out and a deep clean. He worked with the council and followed the plan that had been agreed with him to take care of his flat and look after his physical and mental health. Unfortunately, despite his best efforts and additional support, Adrian's mental health became worse and he struggled with each day. It was agreed with Adrian that he needed a more supportive living environment to help him manage his daily life better.

Adrian is now living in Supported Living. He has his own flat with people on hand to encourage him to look after himself and support him to socialise. Adrian says his mental health is much better and he has started developing some new interests.

Living with support case study - Dave

Dave was discharged from hospital into a care home. A multi-agency meeting was being held with Dave and his family to review his treatment and what support he needed so he could return home. The particular concern was Dave's physical frailty - it was a fall which had triggered the stay in hospital.

Council staff met with Dave and his family before the multi-agency meeting to understand Dave's views before the "stress" of a formal meeting. Whilst much of the multi-agency meeting focused on Dave's medical and care needs, Dave made it clear a priority for him was to reduce his social isolation and reduce reliance on his family. Due to Dave's lack of mobility, he was unable to visit groups, so a volunteer from a local befriending charity began regularly visiting Dave to help him to develop more of a social life.

Dave is now back home and continues to receive visits via the befriending charity, and his wellbeing has significantly improved. Plans are in place to support Dave to start venturing outside which he's been really enjoying. Although Dave will continue to receive support from the council, he is so pleased to be able to get out and about and is feeling much more positive about his situation.

Living with support case study - Susie

Susie was struggling to cope with her grief following the suicide of her brother and death of her husband. Susie found herself unable to keep up with housework and everyday tasks. Hoarding became an issue and Susie became very depressed. She also had a serious chronic health condition which she was struggling to manage; she was frequently running out of medication and missing appointments. Susie struggled to read and write and didn't use a computer which meant she wasn't able to make use of services that were available to her.

Helped by her landlord, Susie moved to a smaller and more manageable home. Sadly, this took her away from a close friend and the familiar neighbourhood that held happy memories.

A lot of professionals had been working with Susie but she was struggling to attend appointments or follow through on plans. Susie's situation worsened and she was referred to the council by both her GP and suicide bereavement support worker. It was clear that Susie needed long-term support to manage daily life.

Isabel is a Personal Assistant who now works with Susie 3 hours a week to help her organise and attend appointments, manage her home, exercise and re-build a social life. They've built a strong relationship and often go out shopping and to gardens and events, which Susie really enjoys. Recently, with Isabel's support, Susie felt able to visit her parents' graves, which she found a great comfort.

Working together

It is essential that we involve the people who use the service in discussions about how future services are developed. For this strategy, we sought advice from service users, their families and carers, as well as councillors and social care staff, in line with the Care Act 2014.

We will continue to support you and listen to you so that we can consistently improve and deliver services to our community.

We will:

- co-produce and design services with people receiving support from adult social care
- consult with services users and be open and transparent about what we are doing and why
- ensure our staff have the skills and experience they need to deliver the Better Lives strategy through a comprehensive training and development programme and develop systems that will support staff to focus more on the people using services
- embed Better Lives outcomes in partner organisations to support with the integration of health and social care

Community engagement and co-production

Our vision for co-production is that people who use services and carers are involved from the start. They will actively help define and design local services to inform adult social care decision-making in areas that impact on their lives.

We have established a service user and carer forum to provide additional opportunities for residents to share their experiences and agree a programme of actions and activities to improve the delivery of services.

What our staff say

I'm Sue Lightbown - I'm a qualified social worker and have worked with Buckinghamshire Council for 15 years.

During this time, I've seen many changes in the approach to working with clients. Out of all of these approaches, the Better Lives approach supports the social worker to focus on being really person-centred and creative to achieve the best outcomes for the individual. It focuses more on the strengths and aspirations of the clients rather than just their needs, and helps them to think about their goals and what help they would like, and this makes it so much more rewarding for me.

Sue Lightbown
Social Worker

After 30-odd years in banking, I really wanted to work in a frontline caring role. Following a couple of years in the NHS, I came to work in social services – initially specialising in care and support for people with learning disabilities.

The Better Lives ethos really supports me to take a person-centred approach, supporting our clients to be as independeant as possible and get as much of what they can out of life. And I can also see how the unavoidable but necessary paperwork and record-keeping is being continuously improved to support the outcome-based approach. Five years on, I still love the job.

Sandie Kemp
Social Work Assistant

For more information

Contact us:

buckinghamshire.gov.uk/care-adults

01296 383204

Buckinghamshire Council
The Gateway
Gateshouse Road
Aylesbury
HP19 8FF

Key documents and links:

Joint Strategic Needs Assessment (JSNA)

Our Market Position Statements

The Care Act 2014

Buckinghamshire Council

Appendix 2 – Better Lives Strategy Case Studies

Living independently

"A gentleman came to the Coffee Club at the Library for the first time having seen the advertisement in the local paper. He was divorced with two grown-up daughters who live quite a way away. They were concerned that he was not coping very well. He said he was feeling very lonely and that he had come to the library to 'break the silence'. We gave him details about the Simply Walk group and our Learn My Way basic computer sessions. He stayed for the session and enjoyed chatting to other customers and to our volunteers. He now regularly attends many of our events in the library and has made new friends."

<u>Peter</u>

Peter had a varied career in security services. He was forced into retirement through redundancy and ill health a few years ago. Despite his poor health, Peter continued to live independently. Lockdown and self-isolation changed everything for Peter. The effect of this was that Peter stopped caring properly for his home or himself.

In the summer, the police were called out by neighbours who were worried about Peter. The police alerted the council's adult safeguarding service as they were concerned about how he was looking after himself, hoarding and the condition of his home. Peter was shocked by the police and council being called in. He described it as a wake-up call and was keen for support to get back on top of things before they got any worse.

The council was able to arrange for a swift deep clean of Peter's house, help Peter organise a regular cleaner and keep in light touch contact with him. Life has now improved for Peter who is also thinking about moving back to Devon where he has stronger social connections

<u>Phil</u>

Phil lives alone and keeps his home immaculate and always makes sure that he is personally well presented. Phil is blind, caused by diabetes. A recent stroke severely affected his mobility and he has become very unsteady. After falling several times getting in and out of the bath and over-bath shower, Phil took the difficult decision to rely on strip-washing at the kitchen sink. Over-grown ivy stopped him from opening windows and had started to grow through and around the window panels and Phil was embarrassed by the condition of the property.

Phil suffers from depression and anxiety. Being unable to shower and feel properly clean has affected his mental health further and Phil's GP

referred him to the council for support. With Phil's agreement, an application was made for grant funding for a walk-in shower. The occupational therapist working with Phil also came up with an interim solution which would allow Phil to safely get in and out of the bath whilst waiting for the walk-in shower to be installed. At the same time, she alerted his landlord to the problem with the ivy.

The occupation therapist visited Phil the day after the walk-in shower was installed. Phil had made use of the shower as soon as the workmen left and the landlord had been out to clear the garden and removed the ivy. The changes made a big difference for Phil, who described them as giving him back his life, pride and independence.

Regaining independence

Vicky

Vicky has a learning disability. She lives in a shared flat in a supported housing scheme in Buckinghamshire run and staffed by an independent provider where she is supported by 24-hour support workers. Another provider delivered a further 11 hours of homecare support to enable Vicky to safely access leisure activities.

During an annual review, it was clear that Vicky was well supported in her current living environment. Throughout the review, she gave the clear message that she would appreciate fewer staff interruptions, as she felt confident in her own ability to manage her daily life and found these intrusive and annoying. Vicky's support plan showed staff were making frequent calls to the flat to support her throughout the day.

The worker conducting the review spoke with the provider, who agreed to reorganise the support hours to reflect Vicky's request of less direct intervention.

As a result, the support workers were able to provide more support to Vicky out in the community, reducing the need for the second provider without reducing her social activities which were extremely important to her. Vicky's overall care package was reduced as she didn't need it.

Lorraine

Lorraine is 78 and living with her daughter. She was referred to the council by her GP who felt that Lorraine needed more support. Lorraine had become increasingly frail and had been living upstairs, as she was very anxious about using the stairs. Lorraine also loved to have a long, hot bath but was now unable to get in and out of the bathtub .

When the council's occupational therapist visited, she saw that Lorraine was also struggling to get in and out of bed, although once up she could move around well with a walking frame. Although Lorraine was not complaining about her living situation,

she knew that she would struggle to get downstairs in an emergency. Most importantly, living upstairs separated her from the family social life and increased her dependency on her daughter who had to bring Lorraine's meals to her upstairs.

The occupational therapist was able to arrange for a special handrail so that Lorraine get downstairs. Equipment was also provided so that Lorraine could use the bath and get in and out of the bed more easily. Lorraine hadn't known that she would be entitled to help from the council. The changes have meant that Lorraine can now join in with family life and meals, play with her grandchildren in the garden and enjoy trips outside her home.

Mark

Four years ago, Mark was a fit and healthy dad with a busy job. Unexpectedly he contracted a traumatic illness which left him paralysed from the waist down. After much work, a year on Mark was able to leave hospital but still needed intensive social care visits each day to help him with everyday tasks such as washing and dressing. Despite his disability, Mark was determined to continue working and to regain as much independence as possible. The NHS provided physiotherapy, and with the daily support from the carers, Mark was able to return to work.

During 2020, his employer provided him with an adapted car so he could drive himself to and from the office. He also got a motorised scooter which meant he could start an independent social life. As Mark continued to build up his strength and capability, he found he needed less and less social care support.

It's been a long, tough journey for Mark, but by September 2021 he was living independently once more and no longer needed any help from the council.

Living with support

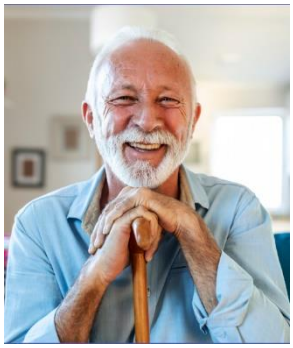
Janice

Janice is 91 years old. She has a keen sense of humour and worked with her husband as a publican. She has a very supportive family who are good advocates for her.

Janice lives in a nursing care placement and has done since she was discharged from hospital in 2014. Her brother contacted the council to ask whether Janice could move nearer to the family. A review was done using the Better Lives principles and identified that as her health has stabilised over this time, she didn't need nursing care.

Janice now lives in a residential home nearer to family and which provides more social interaction and activities. By reducing the intensity of support, Janice's quality of life has increased and savings have been made.

Dave



Dave was discharged from hospital into a care home. A multi-agency meeting was being held with Dave and his family to review his treatment and what support he needed so he could return home. The particular concern was Dave's physical frailty - it was a fall which had triggered the stay in hospital.

Council staff met with Dave and his family before the multi-agency meeting to understand Dave's views before the 'stress' of a formal meeting. Whilst much of the multiagency meeting focused on Dave's medical and care needs, Dave made it clear a priority for him was to reduce his social isolation and reduce reliance on his family. Due to Dave's lack of mobility, he was unable to visit groups, so a volunteer from a local befriending charity began regularly visiting Dave to help him to develop more of a social life.

Dave is now back home and continues to receive visits via the befriending charity, and his wellbeing has significantly improved. Plans are in place to support Dave to start venturing outside which he's been really enjoying. Although Dave will continue to receive support from the council, he is so pleased to be able to get out and about and is feeling much more positive about his situation.

Susie

Susie was struggling to cope with her grief following the suicide of her brother and death of her husband. Susie found herself unable to keep up with housework and everyday tasks. Hoarding became an issue and Susie became very depressed. She also had a serious chronic health condition which she was struggling to manage; she was frequently running out of medication and missing appointments. Susie struggled to read and write and didn't use a computer which meant she wasn't able to make use of services that were available to her. Helped by her landlord, Susie moved to a smaller and more manageable home. Sadly, this took her away from a close friend and the familiar neighbourhood that held happy memories.

A lot of professionals had been working with Susie but she was struggling to attend appointments or follow through on plans. Susie's situation worsened and she was referred to the council by both her GP and suicide bereavement support worker. It was clear that Susie needed long-term support to manage daily life.

Isabel is a Personal Assistant who now works with Susie 3 hours a week to help her organise and attend appointments, manage her home, exercise and re-build a social life. They've built a strong relationship and often go out shopping and to gardens and events, which Susie really enjoys. Recently, with Isabel's support, Susie felt able to visit her parents' graves, which she found a great comfort.

Healthwatch Bucks update (January 2022)

This paper summarises recent project work we have undertaken in relation to health and social care services, as aligned with the priorities of Joint Health & Wellbeing strategy.

Live Well

Enter and View visits to Community Opportunity providers

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement.

The Health and Social Care Act allows these representatives to watch how services are delivered and to talk to service users their families and carers on premises such as hospitals, care homes, GP & dental surgeries and others. Enter and View visits can happen if people tell us there is a problem with a service but equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first-hand.

In 2021/22 we are looking at Covid19 response and recovery in Health and Social Care. Together with our cross-cutting interest in lesser heard voices, we decided to visit locations where community opportunity services are provided. These had to close in 2020 at the height of the pandemic and then adapt to changing circumstances as they opened through 2020 and 2021.

We wanted to hear from those who attended this provision in Buckinghamshire; what they gained from the experience and how it promotes wellbeing and self-reliance, one of the aims of Our Ambition | Buckinghamshire Council (buckscc.gov.uk). In this strategy, Bucks, Council are looking to develop 'meaningful and appropriate day and employment opportunities in the community to enable people to live fulfilling lives. We want to support a culture of choices for individuals rather than the current culture of dependency and having to fit into services.' We also wanted to identify good practice and ways to improve service delivery.

Reports for visits in November and December 2021 can be accessed here;

- Enter & View visit to Missenden Walled Garden – Healthwatch Bucks
- Enter & View visit to The Princes Centre – Healthwatch Bucks
- Enter & View visit to Thrift Farm – Healthwatch Bucks

Patient Participation Groups in Bucks

The CCG asked us to conduct a survey to find out what support Patient Participation Groups (PPGs) need. The aim of the survey was to identify:

- examples of what PPGs are doing that can be shared with other practices and PPGs in Bucks

What did we do?

In June 2021 we invited PPGs and practices to complete our online survey. The survey closed on 9th July. We asked about:

- PPGs want further support.

- the recovery of PPG work in a COVID-secure way
- the development of PPGs
- PPGs networking within a Primary Care Network (PCN).

We were pleased to hear about PPGs in 19 practices (out of 48 in Bucks). You can read what we found out here Healthwatch Bucks - report of 2021 PPG survey

What are we doing next?

We have shared these results with the CCG and will also be sending every Practice in Bucks a link to the report through the CCG. Based on the feedback we have suggested some ways that the CCG and/or Healthwatch Bucks could help PPGs. These ideas will be discussed at a PPG networking event planned for later in January.

This work was funded by Buckinghamshire Clinical Commissioning Group.

Voices report

Part of our role at Healthwatch Bucks is to collect feedback on local Health and Social Care services. We do this in a number of ways including our signposting service and the 'rate and review' facility on our website;

https://www.healthwatchbucks.co.uk/your-voices-interactive-report/

Below are some of the main observations from October through December 2021 (Q3).

Signposting

The main concern raised through our signposting service is still **access to services**. This means people either unable to find a suitable provider or get an appointment with a provider. This accounts for around a third of the total contacts we received.

Around 70% of the concerns about access to services were, again, related to **NHS dentistry**.

General Practice

On the positive side, we heard about services were **well-run** and where the **quality of treatment** was good.

On the negative side, we again heard about **access to services**, **staff attitudes** (mostly in relation to receptionists) and the **appointment booking process** (not being able to reach the surgery to book).

Secondary Care

We heard from less than 20 people about Secondary Care, so we should not infer too strongly. There was next to **no positive feedback** in this period. The main issues were around **Quality of Care and Treatment**. There was one case of very poor care at Wexham Park (Frimley Health) but unfortunately, we couldn't gather any more information from the contact.

Urgent Care

We heard from less than 10 people about Urgent Care services but that was **mostly positive**. There was good feedback about Stoke Mandeville A&E. There were also positive comments about the UTC at Wycombe but also one very poor experience.

Mental Health

We continue to hear of poor experiences under Chiltern Adult Mental Team and the Chiltern Crisis Team. The public tend to view these as a single service. While these experiences are few in number (around one a month) they all have very similar themes in common:

- Promised calls never come
- Patients find staff rude, condescending and dismissive of their perceived needs

Over the past 3 years, 90% of the feedback we have had for this service has been negative. Half of all feedback relates to poor staff attitudes.

Health and Adult Social Care Select Committee (Chairman: Jane MacBean, Scrutiny officer: Liz Wheaton)

Date	Topic	Description & Purpose	Lead Presenters	Contributors
3rd February (Agenda published 26th Jan)	Buckinghamshire Healthcare NHS Trust - Community hubs	To discuss BHT's proposal around Thame and Marlow community hubs, as part of its strategy to develop care closer to home	David Williams, Director of Strategy	Karen Bonner, Chief Nurse
	Better Lives Strategy	This strategy was launched in 2018 and was a 3-year strategy so due to be refreshed in 2021. Opportunity for the Committee to evaluate the effectiveness of the strategy and review the plans for the refreshed strategy.	Angela Macpherson, Cabinet Member for Health & Wellbeing	Gill Quinton, Corporate Director
24th March (Agenda published 16th March)	ICS	ICS Strategy due to be finalised by April 2022 (now delayed to July 2022) so an opportunity to review and feedback on the plans (from a local, place perspective).	Presenters to be confirmed but to include: Chair, ICS Accountable Officer for the ICS Managing Director, ICP	

To be scheduled	Support for Carers/Staff Wellbeing	The HASC undertook a one-day inquiry into support for carers in October 2018. A previous Committee reviewed the progress in implementing the recommendations after 9 months so this item could look at the latest situation. In light of Covid-19, the Committee could also hear from Buckinghamshire Council and Buckinghamshire Healthcare NHS Trust about staff wellbeing and the support services available for key workers.	Angela Macpherson, Cabinet Member for Health & Wellbeing Neil Macdonald, Chief Executive, Buckinghamshire Healthcare NHS Trust	Gill Quinton, Corporate Director Lisa Truett and John Everson, Commissioning Managers (ASC) TBC – representative from BHT's health & wellbeing team
To be scheduled - depending on timeframes, this item may require a special meeting	Buckingham Primary Care provision	To review the results from the consultation on proposed changes to primary care provision in Buckingham. Consultation launched on 23rd August and closes on 16th November.	Representatives from Swan Hill Practice and the CCG	
To be scheduled	Buckinghamshire Healthcare NHS Trust	Review progress in the areas of concern raised in the HASC's statement in relation to the Trust's Quality Account 2020/21.	Representatives from BHT (tbc)	

Potential pieces of work in other Select Committee's which HASC Members could link in with and report back to the Committee on:

- Children's SC – Young people with eating disorders

- Growth, Infrastructure and Housing – Infrastructure considerations when planning housing developments (including S106/CIL). Also links with education provision as well as health provision. Another issue - Key worker housing.

Possible Inquiry/Rapid Review items:

- Development of Primary Care Networks;
- Mental Health.

Issues to keep under review and to update Members on but not necessarily items for the Committee meetings:

- Progress with developing the community-led health centre in Long Crendon;
- Dentist provision – follow-up on comments/questions made after the March 2020 HASC meeting;

Issues to keep an eye on via Health & Wellbeing Board and through the issues coming before the Committee and review work:

- Community engagement exercise and the 4 themes identified – digital services, keeping people safe, community services and reducing health inequalities. Challenge how the results of this engagement work have been used to shape, inform and make improvements in the key areas. Engagement is ongoing with further engagement supposed to have been undertaken in the Summer 2021;
- Pharmaceutical Needs Assessment – due October 2022.

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