Wiltshire Council
Where everybody matters

AGENDA SUPPLEMENT (1)

Meeting: **Health Select Committee**

Place: **Kennet Room - County Hall, Trowbridge BA14 8JN**

Date: **Tuesday 10 January 2017**

Time: **10.30 am**

The Agenda for the above meeting was published on 23 December 2016. Additional documents are now available and are attached to this Agenda Supplement.

Please direct any enquiries on this Agenda to Will Oulton, of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line (01225) 713935 or email william.oulton@wiltshire.gov.uk

Press enquiries to Communications on direct lines (01225)713114/713115.

This Agenda and all the documents referred to within it are available on the Council's website at www.wiltshire.gov.uk

8 **Wiltshire Domestic Abuse Support Services Procurement** *(Pages 3 - 4)*

This report provides a brief overview of the domestic abuse reduction agenda in Wiltshire and the current developments.

9 **Final Report of the Better Care Plan Task Group** *(Pages 5 - 16)*

To present the conclusions and recommendations of the Better Care Plan Task Group for endorsement.

10 **Care Home Tender Contract Awards** *(Pages 17 - 20)*

To inform the Committee of the current tender for care home beds for older people.

The Council has recently tendered for contracts for care home beds (both residential care and care with nursing) for older people. Tenders are being

evaluated and the decision to award contracts will be made by Cabinet at its meeting on 13th February 2017.

11 **Dorset and Wiltshire Vascular Network - update** *(Pages 21 - 24)*

For members' information.

In March 2013, the National Service Specification[1] (NSS) for Specialised Vascular Services set out there was strong evidence that death from planned surgery for aneurysm is significantly less in centres with a high caseload than in hospitals that perform a lower number of procedures". This was based on recommendations from the Vascular Society of Great Britain and Ireland (VSGBI) POVS12[1] report in which they set out the need for hospitals to collaborate in a network to provide patients care. As part of this collaboration there is a requirement for the network to decide upon a single hospital which will provide both planned and emergency arterial vascular surgical care. and that all major arterial intervention is performed on the designated arterial site.

14 **Urgent Items** *(Pages 25 - 26)*

Emergent Sustainability and Transformation Plan'

On 14 December an 'Emergent Sustainability and Transformation Plan' was published and can be viewed here. The Plan was also considered by Health and Wellbeing Board on 15 December.

Members are invited to review the document and consider any questions or key topics for discussion when an update on the STP's development is received in March.

DATE OF PUBLICATION: 5 January 2017

[1] VSGBI "The Provision of Services for Patients with Vascular Disease 2012"

Wiltshire Council

Health Select Committee

10 January 2017

Overview of the Domestic Abuse agenda in Wiltshire

Purpose of report

1. This report provides a brief overview of the domestic abuse reduction agenda in Wiltshire and the current developments.

Background

2. Domestic abuse is a complex issue that presents a major public health issue, cross cutting geographic and cultural groups. Rarely an isolated incident, domestic abuse is a pattern of sustained behaviours that violate human rights, significantly impacting on population's health and well-being. The impact on those living with its effects are long lasting and devastating. To effectively tackle this agenda requires a sensitive, multi-disciplinary approach. The current response to domestic abuse in Wiltshire is governed within a multi-agency context (figure 1).

Figure 1

Prevalence of domestic abuse in Wiltshire

3. The levels of domestic abuse continue to increase across Wiltshire, with reports (police) in excess of 3,300 incidences in 2015-16 and increases recorded in all community areas (except Pewsey and Westbury), as well as across all Wiltshire DA support services. Wiltshire recorded a rate of 17.7 incidences of DA per 1000 population, compared against a south west range of 20.9 (high) to 13 (low).

Joint Area Inspection Team (JAIT)

4. Wiltshire undertook a joint area inspection by Ofsted, the Care Quality Commission, HMI Constabulary and HMI Probation between 31 October and 4 November 2016, focusing on the response of children living with domestic abuse. The overall findings were favourable of the multi-agency (MASH) arrangements established in Wiltshire to safeguard children and victims.

Partners remain committed to drive the agenda forward and implement actions identified to ensure continuous learning and improvement is achieved in the safeguarding of Wiltshire's vulnerable populations.

Wiltshire Domestic Abuse Needs Assessment

5. To support Wiltshire's understanding of the current prevalence of domestic abuse, it has commissioned a needs assessment, aiming to enhance knowledge of the volume and demand for local services, as well as identify gaps and emerging best practice. The needs assessment has been developed through a multi-agency task and finish group of the Wiltshire DA sub group and work is now underway to finalise the report.

Domestic Abuse Strategy 2017-20

6. The current strategy expires March 2017; the domestic abuse needs assessment will inform future local strategic priorities, shaping the next strategy document. This will be governed through the Wiltshire DA Sub group. There will be a consultation period, which will provide opportunity for comment and participation in early spring 2017.

Domestic Abuse Service Procurement

7. The DA contracts for support services expire 30 September 2017; current commissioned provision includes a focus on 'crisis intervention' including outreach and high risk victims (16yrs+), as well as support for children living with the effects of DA (level 3-4 - CiN/CP).

8. There is now a timely opportunity to re-commission services and re-align into a single contract, to go out for competitive tender.

9. The proposed new domestic abuse service model will offer an integrated service approach to tackling domestic abuse, focusing on earlier intervention and prevention, to include targeted support for adults and children living with the effects of domestic abuse and address service user needs for supported accommodation

10. The proposed new procurement model has been shaped and informed by the emerging findings of the DA needs assessment. The work has been developed through a task and finish group of the Wiltshire DA sub group. This work will commence early Spring 2017, with the intention to award the contract by the end of May 2017, to manage the transition stage and ensure continuity of service.

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Wiltshire Council

Health Select Committee

10 January 2017

Final Report of the Better Care Plan (BCP) Task Group

Purpose

1. To present the conclusions and recommendations of the Better Care Plan Task Group for endorsement and referral to the relevant parties.

Background

2. Approximately £800m is spent in Wiltshire on health and social care. The £32m of Better Care funding is a driver for stimulating the integration of health and social care services. The Wiltshire Better Care Plan is built upon the overriding vision of care as close to home as possible, with home always as the first option.

3. The Better Care Fund aims to help deliver on the national conditions and local priority; such as:
    - Protecting social care services – through increased investment in social care services to meet the requirements of demography and of the Care Bill
    - 7-day services to support discharge from hospital – through increased investment across the whole system
    - Data Sharing – through working together on new systems and developing our ability to share information not just between health and social care, but more widely with other public sector services
    - Joint assessments and accountable lead professional – through local joint working and the development of patient/service user-held records
    - Ensuring services support people to remain at home or in their community.

4. The success of the plan is measured against five national performance areas:
    - Admissions to residential and nursing care
    - Success of reablement and rehabilitation
    - Delayed transfers of care
    - Avoidable emergency admissions
    - Patient and service user experience

5. The impact of demography on adult social care has been highlighted by the Local Government Association, who say that on average, Councils are facing a demographic pressure of 3%, with the majority of that relating to services for

people with learning disabilities and services to older people. Overall health and life expectancy in Wiltshire are well above the national average and the number of older people is rising much faster than the overall population of the county.

6. The growing demand for urgent care continues nationally and it is no different in Wiltshire, and, prior to the implementation of the Better Care Plan, resulted in:
    - Increased volume of non-elective admissions;
    - Higher than planned number of “avoidable admissions continuing to admit to acute settings;
    - Increased pressure on care services which result in delays in accessing packages, a longer length of stay and at times readmissions to acute settings;
    - Continued shortage of intermediate care beds;
    - High volumes of delayed transfers of care;
    - Few alternatives to hospital admission in acute setting.

7. Wiltshire was one of only five early implementers of the Better Care Plan nationally.

Membership

8. The task group comprised the following membership:

Cllr John Walsh	Chair of the Task Group, Wiltshire Councillor
Cllr Anna Cuthbert	Wiltshire Councillor (Sep 2015 to May 2016)
Diane Gooch	Chair of Wiltshire & Swindon Users' Network (WSUN)
Cllr Gordon King	Wiltshire Councillor
Cllr Pip Ridout	Wiltshire Councillor

Mr Steve Wheeler, Board Member of Healthwatch Wiltshire and stakeholder on Health Select Committee, was appointed as Special Advisor to the task group.

Terms of Reference

9. Following consideration at the Health Select Committee on 22 September 2015 the following terms of reference were approved:

The Better Care Plan Task Group was set up to support and monitor the implementation of the Better Care Plan (BCP) and to do so will focus on:

i. The learning points identified by the 100 Day Challenge and how these are used to improve and sustain performance.

ii. Key areas of risk as identified below and how they are being managed:
    a. Engagement of the patient (to include choice policy);
    b. Organisation (to include Single View);
    c. Culture;
    d. Quality.

The entire risk register will be monitored regularly new key area of risk may be identified.

iii. The following key priorities of the BCP will be the topics for "deep dive" meetings:
    a. Intermediate Care;
    b. Single View;
    c. Workforce and Organisational Development;
    d. Engagement.

    The other priorities will be monitored and the task group may change the key priorities it focuses on depending on progress.

iv. The effectiveness of integration of the working of all partners, including the integration of information.

v. The task group will also strive to learn from best practice in other areas, including the other four early implementers (Nb. The task group did not address this final term of reference).

Evidence gathering

10. Since its commencement the task group has met regularly and received written and/or verbal evidence from the following witnesses:

James Roach, Joint Director of Integration	Wiltshire Council / Wiltshire CCG
Sharon Bensi, Better Care Plan Business Manager	Wiltshire Council
Jenny Hair, Workforce and Organisational Development Lead	Wiltshire CCG
Andrew Osborn, Specialist Lead – Care Act & Personalisation and Carers Support	Wiltshire Council
Jeremy Hooper, Public Health Scientist	Wiltshire Council
Ian Baker, Head of Programme Office	Wiltshire Council
Paul Mills, Programme Manager – Single View	Wiltshire Council
David Ashdown, Project Officer	Wiltshire Council
Olly Spence, Community Commissioner for Adult Social Care	Wiltshire Council
Emma Cooper, Chief Executive	Healthwatch Wiltshire
Lucie Woodruff, Volunteer and Engagement Manager	Healthwatch Wiltshire
Dr Celia Grummit	Camelot Care Homes
Violet Gwaze	Camelot Care Homes
Katie Bastick	Camelot Care Homes
Amanda Brookes,	Manager of Bradford on Avon Health Centre
Dr James Heffer, Locality Lead	Bradford on Avon GP

Kate Payne	
Saskia Barowsky	Melksham Care Centre
Ruth Randall, Project Support Officer	Bradford on Avon and Melksham Health Partnership
Janet Evans	Mears Care Ltd
Kelly Keane	Mears Care Ltd
Andy Hyett , Chief Operating Officer	Salisbury Foundation Trust

11. The task group is very grateful for all those who contributed to this scrutiny review.

Findings

Integrated working

12. Underpinning the Better Care Plan is a commitment to delivering integrated care at the point of need at as a local a level as possible. The task group received good examples of effective integrated working between different teams across the health care system, such as:

- Improved networks through hub-based working
- Different teams spending a day "in each other's shoes" to understand the challenges, pressures, priorities and culture of the different organisations
- Regular multi-disciplinary meetings that enable an "all angle" approach to cases and, when working well, a much quicker response time
- Nurses supporting staff in residential homes by providing a few sessions a week advising on education, training, assessment, empowering care staff and reducing the increased number of calls to GPs at weekends
- Meetings between GPs and care home managers to understand each other's expectations
- Integrated Discharge, including integrated care assessments.

13. The ultimate aim of integrated discharge is to produce a single pathway for people discharged from hospital and for people in the community who may need social care or therapy input to avoid a hospital admission. The pathway includes the following principles:
    - Home is the first option
    - Services are based on cluster working
    - Discharge to assess from hospital once medically stable (rather than medically fit)
    - The pathway supports health 'rehab' and social care 'reablement' needs.

14. The task group are pleased to report that integrated discharge is now embedded in the three acute hospitals (Salisbury District Hospital, Great Western Hospital and Bath Royal United Hospital).

15. As well as successes, task group also received evidence that there are barriers to integrated working, such as,

    - Workforce issues
    - Clashes between different working cultures
    - Limited ICT interconnectivity between different teams and organisations
    - Differing data recording and sharing protocols
    - A lack of shared approach to risk
    - Short term financial planning and a lack of long-term financial security

16. These challenges are addressed throughout the report below.

Workforce

17. The challenges faced nationally in attracting workers to the care sector are well publicised and, due to its low unemployment, Wiltshire faces particular difficulties. Especially lacking are staff to provide:
    - Domiciliary care, where annual staff turnover is around 40%
    - Intermediate care (see paragraph 23)
    - Physiotherapy
    - Occupational therapy
    - Significant nursing vacancies also exist across the system with a 25% vacancy rate for Registered Nurses in A&E.

18. Consequently a lack of appropriate care or therapeutic provision can delay patient discharge, causing blockages in the system, even when other areas such as integrated care assessments are working well.

19. Workforce is a long-term challenge is in respect of a shortage of carers and a lack of an established career structure. The task group received some good examples of work to address these challenges. The Wiltshire Workforce Action Group (Wilts WAG) leads on this area, taking forward initiatives such as:
    - Leadership Development – collaboration across providers on a common topic
    - Shared coaching register
    - Pan-Wiltshire 'passport' for common learning and development
    - Care staff taking on health tasks such as wound dressings and blood glucose monitoring
    - Recruitment literature to be used at careers fairs identifying all health and care providers, roles they offer and career pathways for support staff across the system

20. The task group welcomes the introduction of some alternative role profiles in order to help address the gaps, such as Rehab Support Assistants who support people in the first few days after discharge.

21. The task group also supports the upskilling of care staff to undertake tasks, such as blood glucose checks, urine dipping and replacing like-for-like dressings. The partners of patients who require regular, minor medical support

are often shown how to do this and the same approach can be taken across different professions.

22. Although it has seen evidence of good work, the task group is not assured that the skills of the health and care workforce are being utilised and developed to their fullest extent. Making progress in this area will be essential to address the significant and growing pressure on primary and acute health care services, and needs to include:
    - Implementing a clear and attractive career structure for the care sector where staff who are willing and able are supported to grow their skillset beyond caring duties, adding to the vibrancy of the role
    - Expanding and utilising the skills of staff across the health care system so that duties are delegated to the lowest appropriate level of seniority, with appropriate training and support measures in place
    - Making the principles of integrated working prominent within all partners' recruitment and induction strategies so new staff are aware of this expectation
    - Communicating the move away from traditional roles effectively to the public so they retain confidence in their treatment.

Intermediate care

23. Intermediate care means short-term care for people who either no longer need to be in hospital, but need extra support to help them recover ("step down"), or who need support in order to avoid a hospital admission ("step up"). There is a strong focus on enablement and reablement to support patients back to independence as quickly as possible.

24. There are currently 73 intermediate care beds in Wiltshire. This was reduced from 100 with the rationale that fewer beds encourages managers to maintain patient flow by supporting their reablement. Having the beds in a smaller number of care homes also gives the specialised teams supporting intermediate care fewer locations to attend.

25. The task group supports the ongoing work in this area to improve the process and systemise the assessment of people ready to go home to be more effective. During the task group work it observed a significant improvement in the quality of the recording, collating and analysing of data with regards to intermediate care and further improvements were planned.

26. The task group conclude that intermediate care,
    - Is a good option to help an overloaded system and to prevent hospital admissions, enable "smoother" discharge and support patients' recovery to maximum independence
    - Increase staff's ability to innovate by enabling multi-agency discussions regarding care and assessments
    - Create opportunities for teams to learn about each other's work and establish stronger working relationships

27. However, there are also the following challenges:

- A lack of domiciliary care provision means that patients cannot always move on from intermediate care even when successfully ‘re-abled’
- Recruiting appropriate staff can be difficult because the skills required for intermediate care are different to those needed in a ‘normal’ care home
- Any shortage of intermediate care staff affects the wider system.

ICT interconnectivity

28. The task group received several briefings on the council-led Single View project to integrate information across health and social care. Information Governance is a complex area involving the issue of consent from the service user as well as different partner approaches to sharing information and their respective duty to comply with the Data Protection Act. The task group supports the goals of the Single View project and, given the scale of the task, believes that the digital integration of health and care partners may benefit from further scrutiny input to in the future.

Choice Policy

29. The Choice Policy was adopted in Wiltshire in 2015 and defines how acute, community hospitals and intermediate care settings should manage choice throughout a patient's stay with regards to discharge planning. Its aim is to enable choice in the context of reducing delays in the appropriate transfer of care or discharge of patients through early engagement and support, and the implementation of a fair and transparent escalation process that all parties understand and can contribute to.

30. The task group recognise the quality of the work undertaken to make the Choice Policy and supporting documents user-friendly. It was pleased to note that training on the Choice Policy was undertaken in all three community hospitals (Chippenham, Savernake and Warminster) and that some in-house mediation training had taken place within the acute hospitals, which have all adopted the Choice Policy.

31. There was some initial concern that the addition of a ‘choice’ could create an extra bureaucratic step and confusion for some patients, such as those with dementia, delaying their discharge. This particularly applied to those funding their own care (‘self-funders’) for two main reasons: a) Potential unwillingness to accept their status as self-funder, and b) Their desire to wait until their preferred care setting could accommodate them before being discharged.

32. Overall, however, the task group concludes that the Choice Policy has created greater simplicity and clarity for staff and improved the discharge process for most patients when followed properly. Delays to discharge do not hinge primarily on management of the Choice Policy, but on a) discharging hospitals giving realistic indications of the care provision available, and b) the availability of the appropriate care provision.

Information, Guidance and Advice

33. The “Your Care, Your Support Wiltshire” portal is the outcome of partnership work between Wiltshire Council and Healthwatch Wiltshire to create a single web portal to make available all the information required for both the council and Healthwatch to deliver their statutory duties.

34. The task group considered the portal and made a number of suggestions to ensure that the portal was as “user-friendly” as possible, which were positively received by the officers involved with the re-design.

35. The task group recognises the importance and value of the portal in providing relevant and easily accessible information to members of the public. However, there is also a need for professionals across the health care system to use it so everyone is looking at one resource and advising clients accordingly. A re-launch of the Portal may be beneficial in increasing its profile. Given its potential audience of everyone involved in the care system (whether professional, volunteer, carer or patient), the task group would welcome seeing links to the Portal being clearly displayed on all appropriate websites, including all of the council’s health and wellbeing partners, town and parish councils and voluntary and community sector (VCS) organisations.

36. Wiltshire Council’s website would also benefit from improving its use of clear language, “searchability” and its linkage to the Portal.

37. Self-funders are not entitled to council-provided care, but they are entitled to support, guidance and information. At present the council’s communications on where self-funders can find these could be improved. Easily accessible support is particularly important because carers tend to be busy meeting the day-to-day challenges of caring.

Overall delivery

38. Since the implementation of the Better Care Plan positive changes have been achieved, though in some cases outside factors have reduced or cancelled out their positive impact. In 2016-17 the system achieved:
    - Reduction in social care Delayed Transfers of Care (DToCs)
    - Reduction in non-elective admissions for patients over the age of 65
    - 86% of residents remaining independent post-discharge – the highest ever achieved in Wiltshire
    - Targeted reduction in long term residential care placements achieved
    - High volume of complex patients being managed in alternative schemes
    - Intermediate Care Length of Stay reduced from 62 days to 32.5 days

39. In 2016-17,
    - DToCs have increased back to 2014-15 levels, in part due to CQC restrictions on one of the Better Care Fund schemes limiting the workforce to support admission avoidance and discharge. Prior to this Urgent Care at Home was helping to avoid around 50 admissions per month.

- Non-elective admissions have grown by around 5.7%, but this represents around 1,000 fewer than might have been expected when considered against demographic growth.
- Avoidable emergency admissions are down by 4.8% in the Age 65+ population. The Wiltshire rate of emergency admissions is lower than the average for England.
- Help to Live at Home providers are delivering more hours of care, supporting the same number of clients
- Reablement remains around the 86% target and Permanent Placements are again on track to be below the 550 target.

40. Given the positive impacts demonstrated, the task group supports the Better Care Plan principle of delivering integrated care at the point of need at as local a level as possible and the approach of integrated working as the right direction in order to achieve this. It also recognises that innovations driven by the Better Care Plan have made Wiltshire's health and care system more resilient than those in many other areas, despite the considerable demographic and financial challenges being faced. This is in itself a significant achievement.

41. However, the task group remains concerned that the health care system can quickly come under significant pressure when blockages occur in one area, for example, limited resource in a certain type of care provision. This precariousness must be addressed.

42. Although the task group is aware of good examples of integrated working, there needs to be a demonstrable commitment to integration at the strategic level. The financial and demographic pressures on health and care are such that a genuinely integrated approach to commissioning and delivering services cannot be taken forward piecemeal. This now includes integration across the Sustainability and Transformation Plan (STP) footprint area.

43. Integrated working includes taking a shared approach to risk. The task group received evidence that in some cases acute hospital clinicians continue to discharge patients when medically fit, rather than medically stable, causing unnecessary delays in the system. Patients' care is then sometimes overprescribed, also due to risk averseness, causing further delays and an inefficient use of resources.

44. At an operational level, good examples of integrated working are evident, but the task group also heard instances of staff in different organisations not taking a joint approach to care and retaining traditionally delineated responsibilities. Strong leadership will be required to engender the integrated approach across services and address clashes between different working cultures.

45. Despite the challenges, there was a general consensus amongst the organisations interviewed that integrated working was the right direction in order to meet the needs of the community. The task group supports this and Scrutiny may have an important role to play in driving this integration further forward in the coming years.

Recommendations

The Task Group recommend that the Health Select Committee:

1) **Supports the Better Care Plan's commitment to delivering integrated care at the point of need at as local a level as possible and the approach of integrated working as the right direction in order to achieve this.**

2) **Recognises that the integration and innovation driven by the Better Care Plan has made Wiltshire's health and care system more resilient than those in many other areas despite the considerable demographic and financial challenges being faced.**

3) **Notes that, despite Better Care Plan successes, problems occurring in non-Better Care funded services can quickly cause 'blockages' across the health and care system.**

4) **Supports the principles of Integrated Discharge as improving the patient experience and reducing delays in discharge, but acknowledges that a lack of domiciliary care can create a "bottleneck" in the system, making delayed discharges unavoidable.**

5) **Notes that overall the Choice Policy has created greater simplicity and clarity for staff and improved the discharge process for most patients when followed properly.**

6) **Supports the principles of intermediate care in supporting patients' journey to reablement.**

7) **Recommends monitoring of the Better Care Plan against its five national performance areas (below) as a topic for scrutiny under the 2017-21 Council:**
    a) **Admissions to residential and nursing care**
    b) **Success of reablement and rehabilitation**
    c) **Delayed transfers of care (DTOC)**
    d) **Avoidable emergency admissions**
    e) **Patient and service user experience**

8) **Recommends the integration of services across Wiltshire's health care sector as a priority topic for scrutiny under the 2017-21 Council.**

9) **Supports the Single View project to integrate information across the health and care system and recommends this as a topic for scrutiny under the 2017-21 Council.**

The Task Group recommends that Wiltshire's Health and Wellbeing Board partners:

10) **In light of the significant workforce challenges faced in Wiltshire, commit to**

- **Implementing a clear and attractive career structure for the care sector**
- **Expanding and utilising the skills of staff across the health care system**
- **Promoting the principles of integrated working within all partners' recruitment and induction strategies**
- **Protecting public confidence in the workforce's skills.**

11) **Demonstrate the ambitious commitment to integration required to address the demographic and financial challenges faced by:**
    - **Taking a genuinely integrated approach to commissioning health care services**
    - **Ensuring that the principles of integrated working are in place at an operational level across the system**
    - **Adopting a shared approach to risk across health and care partners.**

The Task Group recommends that Wiltshire Council and Wiltshire Healthwatch:

12) **Consider re-launching the "Your Care, Your Support" online portal to raise its profile as a resource amongst professionals, volunteers, patients and carers in the health and care system in Wiltshire. The re-launch to include more links to the portal from local websites and more prominent guidance for self-funders.**

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Wiltshire Council

Health Select Committee

10 January 2017

Adult Care Tender – Care home placements for older people

Executive summary

This paper is to inform the Committee of the current tender for care home beds for older people.

The Council has recently tendered for contracts for care home beds (both residential care and care with nursing) for older people. Tenders are being evaluated and the decision to award contracts will be made by Cabinet at its meeting on 13th February 2017.

Proposal

That the Committee notes the information contained in this report and that a further update will be provided once contracts have been let.

Reason for proposal

To inform the Committee of the tender process

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Wiltshire Council

Health Select Committee

10th January 2017

Adult Care Tender – Care home placements for older people

Purpose of report

1. The purpose of this report is to inform the Committee of the current tender for care home beds for older people.

Background

2. The Council currently uses three methods to purchase nursing and care home beds for older people:
   - Block contracts – a fixed number of pre-purchased beds which ensure a more competitive rate and guaranteed supply.
   - Framework contracts – pre-agreed rates, terms and conditions, but with no commitment to purchase beds. Frameworks do not guarantee supply, but support more competitive rates and reduce administration costs around individual placements
   - Spot contracts – beds purchased as required, at rates which are not pre-agreed, so will be at the discretion of the provider.

3. In addition to the above, the Council has long-standing contracts with the Order of St John Care Trust (OSJ) for residential beds. These contracts are not affected by the current tender.

Main considerations for the committee

4. Block and framework contracts maximise the opportunity for the Council to manage the supply of beds and spend on placements. The contracts place obligations on the provider to achieve specified quality of care outcomes and also to facilitate prompt admissions, which supports hospital discharge arrangements.

5. The Council is renewing arrangements for block and framework contracts and has recently tendered inviting bids for the following:

   - Nursing home block beds (up to 200 beds)
   - Nursing home framework beds (approximately 200 beds)
   - Residential home framework beds (approximately 200)
   - Intermediate care block beds (up to 75).

6. Tenders are currently being evaluated and the decision to award contracts will be made by Cabinet at its meeting on 13th February 2017.

Environmental impact of the proposal

7. A level of choice of residential and nursing bed provision across Wiltshire will reduce the level of travel and associated costs for families and will help to ensure that Wiltshire residents can remain living in Wiltshire.

Equality and diversity impact of the proposal

8. The specification for the service states that providers will be expected to demonstrate use of local resources and provision of service which take account of customers' religious and cultural needs and recognises the right of diversity.

Risk assessment

9. If contracts are not awarded, this will create additional pressure for the Council because care home beds would need to be purchased under spot-purchase arrangements. The costs of spot placements are individually negotiated and are likely to be higher than placements made at pre-agreed rates. In addition, block and framework contracts make it easier to be specific about the Council's expectations for delivering to agreed quality standards.

10. There is a risk that there will be insufficient bidders of a suitable quality to meet the number of block-contract and framework beds required, or that there will not be an adequate spread of care homes across the County. It may be necessary to re-tender and/or target specific parts of the county, with support for care homes to enter into the tender process.

Financial implications

11. Spend on block and framework care home beds depends upon contract prices and the volume of placements made. In the last financial year (excluding OSJ block contract) was as follows:

Nursing beds block contract	£7.53m
Nursing beds framework contract	£7.37m
Nursing beds spot contract	£5.18m
Residential beds framework contract	£3.87m
Residential beds spot contract	£15.48m
Intermediate care block (Better Care Fund)	£2.9m

12. Awarding block and framework contracts supports market management and gives greater control of spend, because rates, terms and conditions have been agreed within the contract.

Legal implications

13. None

Conclusion

14. The Committee is requested to note the information contained in this report and that a further update will be provided once contracts have been let

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Background papers

None

Working together with the Dorset and Wiltshire Vascular Network

Briefing for Health Overview and Scrutiny

Background

1) In March 2013, the National Service Specification[1] (NSS) for Specialised Vascular Services set out there was strong evidence that death from planned surgery for aneurysm is significantly less in centres with a high caseload than in hospitals that perform a lower number of procedures".

2) This was based on recommendations from the Vascular Society of Great Britain and Ireland (VSGBI) POVS12[1] report in which they set out the need for hospitals to collaborate in a network to provide patients care. As part of this collaboration there is a requirement for the network to decide upon a single hospital which will provide both planned and emergency arterial vascular surgical care. and that all major arterial intervention is performed on the designated arterial site.

Dorset and Wiltshire Vascular Network

Establishment of the network

A Dorset and Wiltshire Vascular Network (DWVN) was established in 2010; as agreed by the then South West Strategic Health Authority and in 2012 the following arrangement for services was proposed:

	Hospital	Designation
RBH	Royal Bournemouth Hospital	Major Arterial Centre (MAC)
JGH	Jersey General Hospital	Non-Arterial Centre (NAC)
PHFT	Poole Hospital	NAC
DCH	Dorset County Hospital NHS Trust (Dorchester)	NAC
SDH	Salisbury District Hospital NHS Foundation Trust	NAC

[1] VSGBI "The Provision of Services for Patients with Vascular Disease 2012"

Following the VSGBI POVS12 report, the requirement for and need for formalisation of the DWVN was recognised, and was supported by all three Trust Management teams with the establishment of a Steering Group to oversee implementation. Sarah Hulin, vascular surgeon from SDH, was appointed Network Clinical Lead. As the emerging network model allowed for only one hub, it was agreed in December 2012 that RBH would become the arterial centre and DCH and SDH would become spoke hospitals

In June 2012 a draft of the NSS , based upon POVS12, was issued. A presentation was made by Sarah Hulin, Vascular Clinical Lead, on 18th December 2012 to the South of England Specialised Commissioning Group, South West Team, which proposed a Dorset & Wiltshire Vascular Network.

This proposed RBH as the single arterial network hub undertaking all elective arterial surgery and complex vascular interventional radiology. SDH and DCH would be spokes with weekday 0900-1700 vascular presence (including DCH renal access surgery), and elective vascular interventional radiology. This would include centralisation of the emergency rota which was then operated as a 1:7 flipping between RBH and SDH. The proposal was approved.

Wiltshire CCG presented a summary of vascular services reconfiguration proposals affecting Wiltshire patients to the Wiltshire Health Select Committee on 17th Jan 2013 and concerns were expressed about the impact of proposals on emergency travel times for 15.4% of Wiltshire patients who would fall within the 60-75 minute 'blue light' average drive time. It was noted that 24.3% of Dorset patients also fall within this range, with a further 5.1% of Dorset patients in even lengthier drive time averages.

Whilst these concerns were acknowledged, the Vascular Society of Great Britain and Ireland (VS) identified that the improved outcomes of larger specialist centres outweighed any risk of a slightly longer travel time. It was also recognised that an emergency on call rota of less than 1:6 was not sustainable.

The first step in creating the network, was to centralise emergency on call at RBH in December 2013. A 1:7 rota was established consisting of 4 RBH, 1 SDH and 2 DCH vascular surgeons. RBH also provides out of hours Interventional Radiology (IR) which is not provided at SDH or DCH and EVARs were also centralised at RBH.

Activity to complete the programme of reconfiguration

The DWVN Vascular Implementation Board (VIB) was established in October 15 to oversee completion of the transfer of major arterial services to RBCH.

It was clearly recognised by the VIB that a sustainable vascular service requires a minimum of 6 vascular surgeons and 6 vascular interventional radiologists to provide 24/7 emergency vascular on call. This was the rationale for centralisation of emergency services to one site. It was also clearly recognised that to provide elective vascular services without 24/7 on site emergency vascular services was an unacceptable risk.

None of the sites on its own has a population size which would make a 1:6 rota financially viable. Equally, there would be insufficient procedures for three sites to ensure surgeons maintained their current skill base by undertaking the recommended minimum number of procedures.

It should be noted that the Wiltshire population is supported by three different vascular networks. The northwest patients flow to Bristol as part of the Bath, Bristol and Weston Vascular Network, the northeast patients to Cheltenham as part of the Gloucestershire and Swindon Vascular Network and from the south to the Dorset and Wiltshire Vascular Network.

The population of Dorset for 2015 is estimated at 762,400 and the Community Areas (CA) surrounding Salisbury, including Salisbury itself, have a population of around 106,000 making a total of 868,400. The population of Jersey is just over 100,000 making the total population served nearly 1m. Approximately 23% of the Dorset population, however, is >65years compared to 17% nationally. The comparable figure for the 4 Wiltshire CAs is 20%. When combined this makes the comparable equivalent population of around 1.2m.

JGH and PHFT do not have an on-site vascular surgical service. DCH and SDH have their own vascular surgeons. RBH have 4 vascular surgeons, DCH have 2 and SDH has 1, plus 2 general surgeons who continue to undertake some elective vascular procedures.

The current status of DWVN is that Bournemouth acts as a MAC for emergency vascular services (centralised in 2013) for all hospitals. The two DCH vascular surgeons and one from SDH make up a 1:7 emergency on call rota with those from RBH (although one from the latter has been on long term sick leave).

DCH surgeons undertake elective AAA EVAR and AAA open procedures at RBCH but all other elective vascular surgery is undertaken at DCH. The local surgeons provide informal emergency on call when elective surgery is undertaken.

THE SDH surgeon has acted as lead for the network and undertakes elective AAA EVAR and AAA open procedures at RBH but all other elective vascular surgery is undertaken at SDH. The local surgeons provide informal emergency on call when elective surgery is undertaken.

SDH undertake AAA screening on behalf of the network.

All AAA procedures have now been transferred and it is planned that the small number of remaining major elective arterial procedures will transfer to RBCH by a date to be confirmed. Work is also progressing to ensure that vascular services are available at all the NAC sites (including SDH) to support dependent services as needed and to allow for patients to have vascular outpatient appointments and investigations carried out at the spoke sites. For elective (planned) surgery, in line with national policy on patient choice, patients in the geography can choose to access care at other hub sites.

Work is also progressing to ensure that vascular services are available at all the NAC sites (including SDH) to support dependent services as needed and to allow for patients to have vascular outpatient appointments and investigations carried out at the spoke sites. Thus, for Wiltshire patients, there will be a need to travel to Bournemouth only for their surgical procedure. This is in line with the way in which networks are operating for Wiltshire residents who use arterial services centred at Cheltenham or Bristol. For elective (planned) surgery, in line with national policy on patient choice, Wiltshire residents can choose to access care at other hub sites.

Agreement has not yet been reached with SDH for a date to transfer remaining major arterial services to the MAC, nor for NAC service level requirements to be provided on site at SDH. SDH have

two general surgeons who undertake vascular services but who have not elected to become vascular specialists and who are not part of the DWVN emergency on call rota. SDH have indicated that these surgeons (who are members of the VS but whose job plans comprise both general and vascular surgical duties) could undertake NAC vascular services at the SDH site without undertaking major arterial procedures or participating in the on-call rota.

Next Steps

1) NHS Wessex has commissioned an independent expert panel to review the current vascular services configuration and proposals of the DWVN, and to make recommendations for finalisation of reconfiguration. One objective is an assessment of the existing workforces and long term sustainability.
2) A communications and engagement workstream has been established to ensure strong public, patient, staff and clinical engagement. This group includes Dorset and Wiltshire Healthwatch. As a first step we are planning to engage with patients around what is important to them and recruit a patient reference group to support implementation of any proposals recommended by the review. Survey attached.
3) The numbers of patients affected by the services changes are small and we feel it is better to engage directly with patients and representative groups (diabetes UK; stroke association) about what matters to them before service changes are implemented..

Procedure:		**RBH**	**SDH**	**DCH**
Abdominal Aortic Aneurysm (AAA)	EL	21	3	6
	NEL	33		
Endovascular Aneurysm Repair (EVAR)	EL	42		
	NEL	6		
Carotid Endarterectomy (CEA)	EL	12	15	15
	NEL	15		
Bypass Procedures	EL	72	18	57
	NEL	42		3
Varicose Vein Procedures	EL	73	105	96
	NEL			
Major Amputations	EL	6		3
	NEL	48		3
Minor Amputations	EL	3	6	6
	NEL	12		21
Renal Procedures	EL	96		126

Health Select Committee

10 January 2017

Urgent item:

On 14 December an ‘Emergent Sustainability and Transformation Plan’ was published and can be viewed here. The Plan was also considered by Health and Wellbeing Board on 15 December.

Members are invited to review the document and consider any questions or key topics for discussion when an update on the STP’s development is received in March.

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