Wiltshire Council
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AGENDA

Meeting: Health Select Committee

Place: Committee Rooms B-D, Monkton Park, Chippenham, SN15 1ER

Date: Thursday 17 January 2013

Time: **10.30 am**

Please direct any enquiries on this Agenda to Sharon Smith, of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line (01225) 718378 or email sharonl.smith@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

Membership:

Cllr Desna Allen
Cllr Chuck Berry
Cllr Jane Burton (Vice Chairman)
Cllr Chris Caswill
Cllr Peter Colmer
Cllr Christine Crisp
Cllr Peter Davis
Cllr Peter Hutton (Chairman)
Cllr Tom James MBE
Cllr John Knight
Cllr Nina Phillips
Cllr Pip Ridout
Cllr William Roberts

Substitutes:

Cllr Richard Britton
Cllr Nigel Carter
Cllr Mary Douglas
Cllr Nick Fogg
Cllr Russell Hawker
Cllr George Jeans
Cllr David Jenkins
Cllr Bill Moss
Cllr Jeffrey Ody
Cllr Helen Osborn
Cllr Judy Rooke

Stakeholders:

Phil Matthews	Wiltshire Involvement Network (WIN)
Linda Griffiths/Dorothy Roberts	Wiltshire & Swindon Users Network (WSUN)
Brian Warwick	Advisor on Social Inclusion for Older People

PART I

Items to be considered whilst the meeting is open to the public

1 **Apologies**

2 **Minutes of the Previous Meeting** *(Pages 1 - 10)*

To approve and sign the minutes of the meeting held on 15 November 2012.

3 **Declarations of Interest**

To receive any declarations of pecuniary and non-pecuniary interests or dispensations granted by the Standards Committee.

4 **Chairman's Announcements**

5 **Public Participation**

The Council welcomes contributions from members of the public.

Statements

If you would like to make a statement at this meeting on any item on this agenda, please register to do so at least 10 minutes prior to the meeting. Up to 3 speakers are permitted to speak for up to 3 minutes each on any agenda item. Please contact the officer named above for any further clarification.

Questions

To receive any questions from members of the public or members of the Council received in accordance with the constitution. Those wishing to ask questions are required to give notice of any such questions in writing to the officer named above no later than **5pm** on **Thursday 10 January 2013**. Please contact the officer named on the first page of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

Details of any questions received will be circulated to Committee members prior to the meeting and made available at the meeting and on the Council's website.

6 **Transition of Public Health** *(Pages 11 - 28)*

An update report on the Public Health transition project for the Wiltshire Public Health team is attached for the Committee's consideration and comment.

The transition of Public Health to the Council was identified as theme for investigation by the Committee. At its meeting on 15 November 2012, the Committee agreed to the formation of a Task Group to consider this topic. This was endorsed by the Overview and Scrutiny Management Committee at its meeting on 15 December 2012.

The Committee requested an update on the transition of public health to enable it to consider all aspects of the project and to enable it to provide guidance to the Task Group on possible lines of enquiry.

7 **Update on Help to Live at Home Programme** *(Pages 29 - 34)*

The Committee has a long standing interest in the Help to Live at Home Programme and, following changes to providers in recent times, requested an update on the progress of the programme.

The update report is presented for the Committee's consideration and comment. Nicola Gregson, Head of Commissioning, Older People, will be in attendance, to respond to questions.

8 **Continence Services**

In November 2012, the Wiltshire Carers Action Group indicated its wish to bring a report to the Committee on Continence Services, following changes introduced by the NHS. The Committee agreed to receive the report at its next meeting on 17 January 2013.

At the meeting of the Committee on 15 November 2012, Mr Brian Warwick raised the issue of continence services, having received a letter from a carer concerned about changes to the service. The letter was forwarded to the relevant NHS officer via the Committee and a response has been provided to Mr Warwick.

As a consequence of this issue being raised, the Committee agreed that it should conduct a rapid scrutiny exercise looking into continence services.

The report from the Wiltshire Carers Action Group has been received and, as the Committee has already agreed to look at this issue, the report has been passed to the rapid scrutiny group for consideration. The findings of the rapid scrutiny will be reported to the Committee at its next meeting on 15 March 2013.

9 **Cardiovascular Services** *(Pages 35 - 46)*

The Committee had been made aware that there could be significant changes to the vascular services provided to Wiltshire residents, with the possibility that vascular surgery services would not be available at any of the three hospitals that serve Wiltshire. These potential changes were in response to reports complied by the Vascular Society.

The Committee was aware that a review of vascular services was being undertaken by the Wiltshire Clinical Commissioning Group and requested a report on the progress of the review.

Jill Whittington, Service Improvement & Delivery Manager, Commissioning Support, Wiltshire and B&ANES PCT Cluster and John Goodall, Associate Director Public Health (CVD) will present the report and be available to respond

to questions.

The paper is presented for the Committee's consideration and comment.

10 **Provision of Neuro-Rehabilitation for Rheumatic Diseases** *(Pages 47 - 50)*

A briefing note from the South of England Specialised Commissioning Group is attached providing information on the Royal National Hospital for Rheumatic Diseases (RNHRD) recent announcement expressing a preference to cease providing neuro-rehabilitation services.

The Committee is asked to note the information provided. The NHS is not yet in a position to bring a formal proposal to the Committee but will provide a written service change proposal as soon as it is available.

11 **Abdominal Aortic Aneurysm (AAA) Screening Services** *(Pages 51 - 54)*

The Committee is asked to consider the attached report on AAA Screening Services for men aged 65 and over as introduced in November 2012 and provide comment as appropriate.

12 **Partner Updates** *(Pages 55 - 62)*

It was decided to provide an opportunity for partners to provide updates on topics relevant to the Committee's work. The attached updates have been received from the Royal United Hospital, Bath and the Salisbury Hospital Foundation Trust, which the Committee is asked to note.

Kevin McNamara, Head of Communications & Stakeholder Engagement, will be in attendance to provide an update on the work of the Great Western Hospitals NHS Foundation Trust and respond to questions.

In addition, due to the interest in podiatry services, the Committee asked Age UK Wiltshire to provide an overview of the service it offered which is also attached for the Committee's information.

13 **Urgent Items**

To consider any other items of business that the Chairman agrees to consider as a matter of urgency.

14 **Date of Next Meeting**

The next meeting of the Health Select Committee is on 14 March 2013.

Please note that this will be held at the training college of the Great Western Ambulance Service at Greenways Park, Malmesbury Road, Chippenham, SN15 5LN.

PART II

Items during whose consideration it is recommended that the public should be excluded because of the liklihood that exempt information would be disclosed

NONE

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Wiltshire Council
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HEALTH SELECT COMMITTEE

DRAFT MINUTES OF THE HEALTH SELECT COMMITTEE MEETING HELD ON 15 NOVEMBER 2012 AT COUNCIL CHAMBER, MONKTON PARK, CHIPPENHAM.

Present:

Cllr Desna Allen, Cllr Chuck Berry, Cllr Jane Burton (Vice Chairman), Cllr Chris Caswill, Cllr Peter Colmer, Cllr Christine Crisp, Cllr Peter Davis, Linda Griffiths (WSUN), Cllr Peter Hutton (Chairman), Cllr Tom James MBE, Cllr John Knight, Mr Phil Matthews (WIN), Cllr Nina Phillips, Cllr Pip Ridout, Cllr Bill Roberts and Mr Brian Warwick (Advisor on Social Inclusion for Older People)

Also Present:

Cllr Trevor Carbin, Cllr Jemima Milton and Cllr Bill Moss

14 **Apologies**

There were no apologies.

15 **Minutes of the Previous Meeting**

The minutes of the meeting held on **12 July 2012** were presented. It was,

Resolved:

That subject to the addition of Mr Brian Warwick among the list of attendees, to APPROVE as a true and correct record and sign the minutes.

16 **Declarations of Interest**

There were no declarations.

17 **Chairman's Announcements**

The following announcements were made through the Chair during the meeting.

1) The Chairs of Swindon Borough and Hampshire County Councils had been invited to discuss cross border issues and procedures, which would encourage greater early engagement among partner authorities and organizations and added value to the ongoing development of the Overview and Scrutiny Service.

2) Item 11 on the agenda - *Falls and Bone Health Strategy* - was to be moved forward to Item 8 (Minute 21), with the assent of the Committee. Item 13 - *Appointment to Joint Scrutiny Committee, Great Western Ambulance Service (GWAS)* - was to be moved forward to Item 12 (Minute 25).

18 **Public Participation**

With permission of the Chair, Mr Bryan Warwick read out a question, attached to these minutes, on the issue of continence.

The Chair stated that the question would be appropriately forwarded on and a response provided.

19 **Health Workshop - 3 October 2012**

The Health and Social Care Act 2012 legislates for significant health reforms, the majority of which come into force in April 2013. At a local level, these include the establishment of a Health and Wellbeing Board, a Clinical Commissioning Group (CCG) and Local Healthwatch.

Wiltshire Council agreed that it would continue to exercise its health scrutiny function through the Health Select Committee. To that end, the Committee agreed to organise a workshop to which representatives from the Primary Care Trust (PCT), the three Acute Trusts, Public Health, Community health, Adult Social Care and the Care Quality Commission (CQC) were invited, in order to learn more about the potential impacts of the reforms and to identify potential topics for inclusion on the work programme of the Health Select Committee.

The Health Scrutiny Workshop took place between Members and partner organisations on 03 October 2012, and its conclusions and report were presented to the Committee through the Chair.

The Chair thanked all Members and partners who attended the workshop, and thanked the report author, Maggie McDonald (Senior Scrutiny Officer) for her support of the workshop. It was suggested that the Committee receive updates from partner organisations at future meetings when there are significant updates to communicate.

The Chair also informed the Committee that he had raised with the Overview and Scrutiny Management Committee at its meeting on 18 October 2012 that a Clinical Commissioning Group Task Group should be established, and this had been endorsed by the Management Committee, and therefore required similar endorsement from the Health Select Committee. There were expressions of interest from members of the Committee regarding serving on the proposed Task Group.

A discussion followed, where the major themes identified in the report were raised and debated whether and how these should be investigated further

through the Committee. The need to continue to monitor the integration of Public Health into the Local Authority was noted, along with specific issues, including but not limited to the effective management of patient discharge from hospitals into appropriately located care in the community, and the need for closer co-operation between social liaison and discharge teams.

At the conclusion of discussion, it was,

Resolved:

1. **That the Committee approves the establishment of the CCG Task Group;**

2. **That the Committee receives regular reports on the integration of Public Health into the Local Authority;**

3. **That Task Groups be formed to investigate the key themes identified in the Health Workshop report;**

4. **That a Task Group be formed to investigate the issue of Continence.**

20 **Clinical Commissioning Group (CCG) Presentation**

Dr Steve Rowland (Lead General Practitioner for the CCG) gave a verbal update on the future role and organisation of the Clinical Commissioning Group, and how this would impact the community of Wilshire.

Dr Rowland informed the Committee that the three GP areas for Wiltshire had decided to merge their management under a single body, but would still operate with local group focus on the three existing GP areas. It was stated that the authorisation process for the proposed CCG was currently ongoing, with appropriate papers submitted to the government in October 2012 and a site visit by the National Commissioning Board scheduled for 18 December 2012, and that the CCG was confident authorization would be granted.

Dr Rowland also updated the Committee on some of the work of the CCG, including a pilot scheme on Dementia in the south of the county, which would be rolled out county wide following positive feedback.

A discussion followed, where it was confirmed the administration of the local clusters within the CCG would be merged. In response to queries on how decisions would be taken at a local level within the merged CCG, it was stated a scheme of delegation had been created to establish which decisions could be taken at what level, and that the group would be directly accountable to the appointed Accountable Officer regarding those decisions.

The Committee also raised the issue of geographic variances in services and quality of services that would be provided, and it was stated that the CCG would endeavour to roll out successful services and schemes in specific areas across

the whole area. It was suggested that the CCG Task Group could investigate such concerns further.

The issue of potential conflicts of interest was also raised, where GPs might be both the commissioner of and provider of services, and it was confirmed that conflicts of interests would have to be declared, and if one existed the GP in question would take no part in the decision to commission that service, and that information would be publically available.

It was also noted that invitations would shortly be sent out for a public meeting in February 2013 regarding the transition to the new system, arranged by he Wilshire Involvement Network (WIN).

After discussion, it was,

Resolved:

1. **To thank Dr Rowland for the update to the Committee;**

2. **That the CCG Task Group, once formed, take note of the issues raised as potential areas of interest.**

21 **Falls and Bone Health Strategy**

The last Falls and Bone Health Strategy was published in 2009, and had been updated following consultation with internal services and external organisations to remain valid for a further two years. A public consultation took place over the summer of 2012 to agree the aims of the updated strategy.

Maggie Rae (Corporate Director) and Zoe Clifford (Speciality Registrar in Public Health) presented the Falls and Bone Health Strategy for comment and approval, and drew the Committee's attention to points including the following:

Approximately 40-60% of falls lead to injury, with 5% leading to fractures, and in Wiltshire there was an average of seven emergency admissions every day following a fall. There had been a 34% increase in Wiltshire in hospital admissions as a result of a fall in people aged over 65 between 2003-4 and 2010-11.

As a result, the strategy identified five priority areas for local action, as seen on page 80 of the report pack.

A discussion followed the presentation, where the lack of communication between the Highways and Parking Services and Public Health to address or minimise issues which contribute to falls in Wiltshire was raised. The need for extensive communication to increase awareness of bone health and falling issues among the public was also highlighted, in order to ensure an individual's risk of osteoporosis and other concerns were assessed and treated as soon as possible, and it was noted that it was important to engage with town and parish

councils and care homes to assist in keeping public areas clear to prevent incidents.

The geographic spread of falls admission rates per 100,000 people over 65 was highlighted, and concerns expressed at the higher rate of admissions among southern community areas of Wiltshire, and the reasons for the pattern were sought.

In response to queries on how the implementation plan in the report would be monitored, it was stated there was a strategy group who would review the draft strategy in relation to the comments of the Committee, and monitor its progress in future.

At the conclusion of discussion, it was,

Resolved:

1) **To note the contents of the update;**

2) **To forward the report to the Strategic Planning and Highways Services, to ensure appropriate weight is given to falls and bone health issues;**

3) **To receive an updated report in March 2013, including further details on the geographic spread of falls and injury figures.**

22 **Adults Safeguarding Annual Report 2011/12**

The Annual Report of the Wiltshire Safeguarding Adults Board (WSAB) reviews the work of the Board during 2011-12 and sets out the priorities for the current year, including contributions from all partner agencies. The WSAB was formerly accountable to the Cabinet of the Council, and it is now to be accountable to the Health and Wellbeing Board, to which, in its shadow form, the Annual Report would be presented on 27 November 2012.

Margaret Sheather (Independent Chair of Wiltshire Safeguarding Adults Board) presented the report alongside a Powerpoint summary of the key points and considerations for the Board, attached to these minutes, raising points including the following:

It was stated the impact of the economic recession was highly significant, and that the national context of savings targets, policy changes and major organisational changes within the NHS had important local impacts. It was further stated that the governmental reports into the Winterbourne View situation was expected by the end of November 2012.

The main achievements of the WSAB in the past year were then detailed, including the re-establishment of the Safeguarding Adults and Mental Capacity Team, strengthened coordination of management of alerts and referrals, and the identification of the need for large scale investigations.

The governance arrangements for the WSAB was then explained in full, as detailed in the attached presentation.

Lastly, the priorities for the WSAB in 2012-13 were identified, including but not limited to assessing appropriate action following the Winterbourne View reports, supporting the smooth transition of safeguarding work from the Primary Care Trusts to the Clinical Commissioning Group, and establishing a quality assurance and performance management system for the Board.

A debate followed, where the difficulties liaising between Child and Adult Safeguarding was raised, in particular with regards to 16-18 year olds, and the need to communicate not just with the Committee, but with school medical officers, parent and teacher groups and others to engage as deeply as possible with the community as a whole. It was suggested the Area Boards could be utilized to identify the most appropriate groups to liaise with further.

Domestic violence within the home being on the rise was discussed, as opposed to violence in the community which occupies much police attention. In response, it was stated that the police recognise the imbalance regarding 'private space' violence and were seeking to address it, **and it was stated further details would be circulated to the Committee.(draft)**

The Committee also continued to approve of the existence of an Independent Chair for the Board, and broadly welcomed the report and its contents, and questions were raised regarding the level of Council representative attendance at the Board. There was discussion as to whether vulnerable adults were receiving appropriate protection, from themselves and others, at the present time.

Resolved:

That the Committee note the Annual Report of the Wiltshire Safeguarding Adults Board 2011-12

23 **Closure of Wiltshire Emergency Operations Centre (EOC), Devizes**

Neil Le Chevalier -Great Western Ambulance Service (GWAS): Executive Officer, Performance and Delivery - presented a report on the closure of the Emergency Operations Centre (EOC) at Devizes. It was stated that the decision had not been made until 28 September, resulting in the short notice for the Committee and others.

It was stated that the new 111 number for county wide ambulance services was to go live in March 2013, with GWAS unsuccessful in its bid to run the service, which impacted upon the assessment of viability of the EOC in Devizes, with savings of 5%, £4.3 millions, required.

The Committee was informed GWAS support local control rooms, and that in Wiltshire there was a lower population covered per centre than many other

counties. It was stated clinical care as well as speed of service was a consideration, and when considering the distance to the GWAS Headquarters, the higher financial cost of running the Devizes Centre and other assessments, it had been decided the closure of the Devizes EOC rather than the EOC in Gloucestershire, was the most appropriate course of action.

Lastly, it was also stated that all 33 staff currently employed at the Devizes EOC would have the opportunity to transfer to the Bristol centre, with efforts to ensure a seamless transfer. It was noted that 999 calls had been handled by the Bristol centre since 2008, and it was stated that it was one of the finest call centres of its type in Europe. It was also stated that there would be no difference in service to the public caused by the closure.

A discussion followed, with a debate on the business case for the closure arising. The amount of rent, between £500-700k, for the Devizes EOC was queried by some members, and it was asked whether the police, who are expected to occupy the building once vacated by the EOC, will be paying a similar rate.

The Committee also discussed the previous emphasis on tri-service centres being reversed as a result of financial pressures. In response to queries, it was confirmed that the building would still hold a Major Incident Room for the area, with all services represented. There was also discussion on retaining local knowledge when services transferred to the Bristol centre, and whether it was possible to maintain that local knowledge as staff turnover would eventually result in few local people employed at the centre in future.

Resolved:

That the comments of the Committee regarding the closure of the Devizes Emergency Operations Centre, be noted.

24 **Care Quality Commission (CQC)**

Karen Taylor (CQC Compliance Manager: South Region) was in attendance to present to the Committee a presentation on the monitoring arrangements for nursing homes.

The Committee was informed that CQC administrative regions did not match Local Authority boundaries, and that therefore not all Wiltshire regions were covered within the same CQC region. The range of services accountable to the CQC was also clarified, including registered dentists and, within months, General Practitioners.

The Committee were further informed of how the CQC regulate services as well as carry out inspections, with information collected from a range of sources besides those inspections.

The relationship between Overview and Scrutiny and the CQC was raised, and it was stated when information could be shared is sometimes restricted due to

legal obligations, with further details on working with Overview and Scrutiny to be provided at the following link:

http://www.cqc.org.uk/sites/default/files/media/documents/a_guide_for_oscs_0.pdf

A discussion followed, where it was mentioned that the CQC website could be frustrating to navigate, and disappointment was expressed that the CQC administrative boundaries were confusing for people, being made to fit CQC convenience, rather than match Local Authority boundaries with which people were familiar.

In response to queries it was also stated that there was an ongoing debate on how often inspectors might be required, and how different services would need to be monitored differently, and that a strategic review was in place to look into such details. The need for clear pathways, communication and Scrutiny involvement were highlighted by the Committee. The possibility of the public being able to track the progression of an inspection process online was also raised as desirable.

Resolved:

To thank the representative from the CQC for attending, and to ask that they take account of the comments of the Committee.

25 **Dementia Task Group - Update to Final Report**

The Dementia and Mental Health Task Group was established by the Health and Adult Social Care Select Committee in July 201a "To consider dementia and the wider area of mental health".

The final report of the Task Group was brought to the Health Select Committee in July 2011, and was reconvened in the autumn of 2011 to receive updates on various projects relating to services for dementia sufferers, and had further meetings in January and September 2012.

The update to the Task Group's final report was presented by the Chair of the Task Group, Cllr Pip Ridout

Resolved:

To endorse the recommendation of the Dementia and Mental Health Task Group, with additions, as follows:

1. **That there is continued promotion of the Dementia Champion project and also wider community engagement regarding dementia in general through local campaigns and Area Boards;**

2. **That efforts to raise awareness of dementia and the support services available are applied in all communities in Wiltshire, including those in rural areas;**

3. **That the Committee encourages the Clinical Commissioning Groups (CCGs) to prioritise, promote and monitor dementia training for GPs across Wiltshire;**

4. **That the Committee continues to conduct regular monitoring and scrutiny of dementia diagnosis rates;**

5. **That the Committee endorses the recommendations of Alzheimer's Support survey report, 'Barriers to Dementia Diagnosis in Wiltshire';**

6. **That the Committee disbands the Dementia & Mental Health Task Group.**

26 **Appointment to Joint Scrutiny Committee - Great Western Ambulance Service (GWAS)**

The Committee at its previous meeting held in July agreed to the appointment of scrutiny representatives to the Great Western Ambulance Service (GWAS) Joint Health Committee, noting that a further substitute representative from the Liberal Democrat Group was required.

As resolved at the meeting, the Group Leader was contacted and the membership is now as follows:

Cllr Desna Allen
Cllr Peter Colmer
Cllr Christine Crisp

Substitute members:
Cllr Peter Hutton
Cllr Pip Ridout
Cllr Chris Caswill

It was noted that not all three members would need to be in attendance at every meeting.

Resolved:

To agree the appointments as detailed above to the GWAS Joint Health Committee.

27 **Task Groups - Expressions of Interest**

Maggie McDonald (Senior Scrutiny Officer) updated the Committee on the formation of approved Task Groups - *Air Quality Task Group* and *Clinical*

Commissioning Group(CCG) Task Group - and sought expressions of interest for membership.

Resolved:

To circulate a list of Task Group opportunities and receive further expressions of interest from non-executive members.

28 **Urgent Items**

There were no urgent items.

29 **Date of Next Meeting**

The date of the next meeting was confirmed as **17 January 2013** at the Committee Rooms in Monkton Park, Chippenham.

The second meeting of the Committee in the New Year was scheduled for **14 March 2013**.

(Duration of meeting: 10.30 am - 1.00 pm)

The Officer who has produced these minutes is Kieran Elliott of Democratic Services, direct line (01225) 718504, e-mail kieran.elliott@wiltshire.gov.uk

Press enquiries to Communications, direct line (01225) 713114/713115

Wiltshire Council

Health Select Committee

17th January 2013

Subject: **Public Health Transition**

Cabinet member: **Councillor Keith Humphries**
Portfolio Holder for Public Health and Public Protection

Key Decision: **No**

Executive Summary
This report provides an update on the Public Health transition project for the Wiltshire Public Health team. It covers an update from the work- streams including HR, finance, communications and IT.

The transfer of Public Health is part of wider NHS reforms and timescales are subject to national milestones. A range of factsheets have been published by the Department of Health -

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131897.pdf

Decisions are being taken in line with national guidance on the Public Health transfer and in conjunction with the Public Health Transition Project Board chaired by Councillor Keith Humphries, Cabinet Member for Public Health and Public Protection. The PCT and Council are represented on this project board and this feeds into the joint PCT cluster programme board. This report provides an update on the progress of the Public Health Transition, the content of which Cabinet members are asked to note.

Proposal(s)
The Health Select Committee is requested to note and approve this progress report

Reason for Proposal
Health Select Committee has set up a task force to look at the transition of public health to the local authority. It was also agreed that the Committee should receive regular reports on the integration of public health into the LA.

Maggie Rae
Corporate Director
Wiltshire Council

Wiltshire Council

Health Select Committee

17th January 2013

Subject: **Public Health Transition**

Cabinet member: **Councillor Keith Humphries**
Portfolio Holder for Public Health and Public Protection

Key Decision: **No**

Purpose of Report

1. The purpose of this report is to provide the Health Select Committee task force with an update on the Public Health transition to the local authority.

Background

2. This transition is part of the Health and Social Care Bill, given Royal Assent on 27 March 2012, which provides the statutory basis for the transfer of a number of Public Health functions currently carried out by the NHS to local government on 1 April 2013.

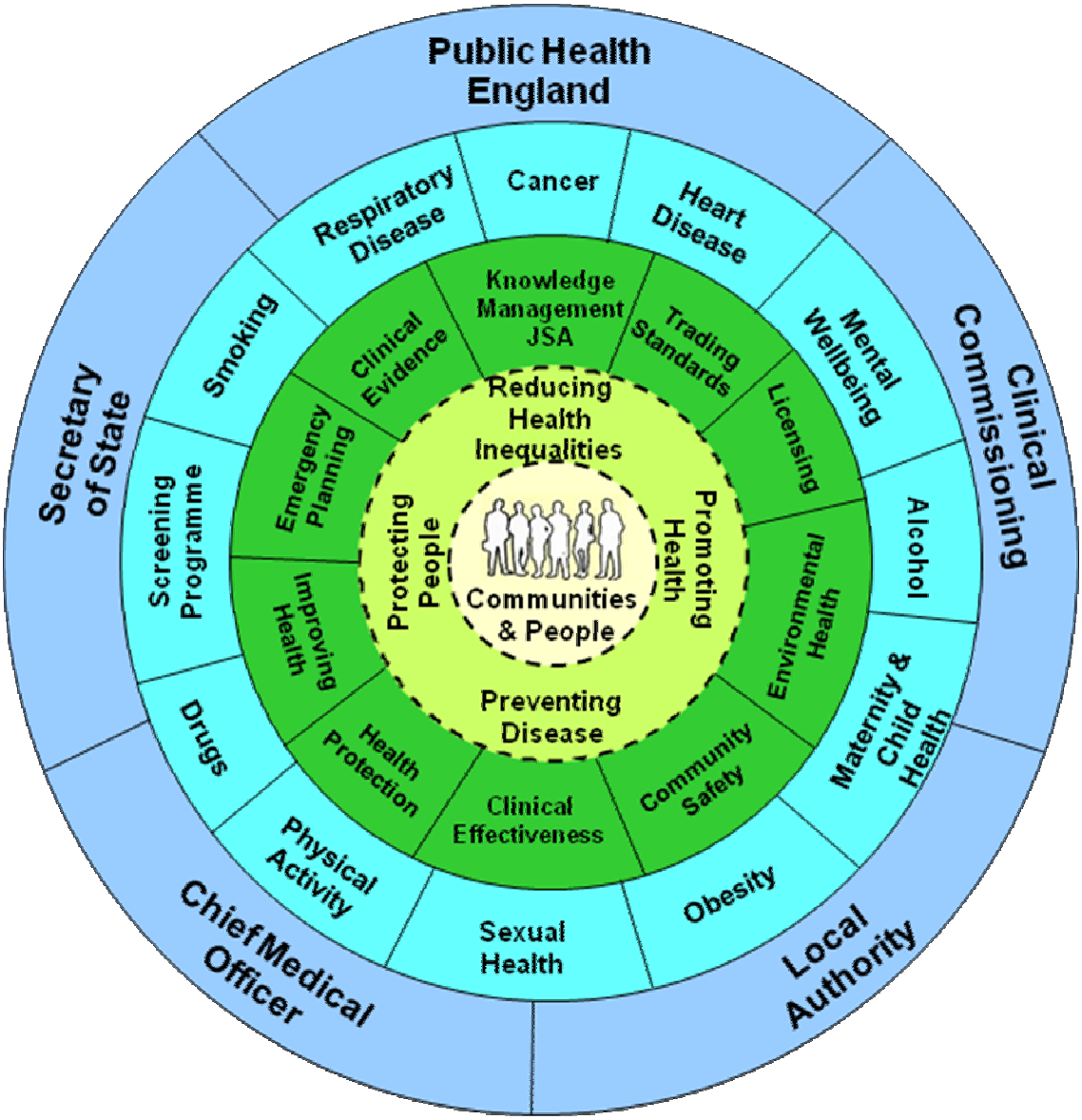
3. The transfer of Public Health to local authorities is part of wider NHS reforms and timescales are subject to national milestones. A range of factsheets have been published by the Department of Health - these are available from http://healthandcare.dh.gov.uk/public-health-system/

   - Public Health in Local Government (summary of all factsheets)
   - Local government leading for public health
   - Local government's new public health functions
   - The role of the Director of Public Health
   - Commissioning responsibilities
   - Public health advice to NHS commissioners
   - Professional appraisal and support, and capacity building

4. The transfer of Public Health to Wiltshire Council builds on the 'One Council', 'One Wiltshire' approach to public health across the public, voluntary and business sectors, with health as part of a county-wide Joint Strategic Assessment which ranges over numerous quality-of-life issues. People and communities, rather than structures or individual services are at the heart of the model for public health. The new model draws on what local government is good at, i.e. engaging with communities. It will try to

capture people's imagination about the life they want to lead and will provide not just health services, but healthy lifestyles.

5. The new role for Public Health and Wiltshire Council means that public health and protection services will be joined up for the residents of Wiltshire and enabling the delivery of these services more efficiently and effectively. This integrated model will bring together existing plans to improve the health of the local population through the integration of Public Health with relevant Council services, including Public Protection, as shown in the diagram below.



6. The Corporate Director provides strategic leadership (together with the support of the senior staff) to deliver additional Council responsibilities in addition to the traditional Director of Public Health duties. These include community safety, environmental health, knowledge management, emergency planning and resilience, licensing, trading standards – over 150 frontline services. These services are all focused on improving the

quality of life and effective delivery systems that can improve and protect population health, particularly for the most vulnerable.

7. Recently Wiltshire Councillors took the decision to restructure the senior management team, and to merge the responsibility for public health with the corporate director role that has statutory responsibility for adult social services. This resulted in a new corporate director role with statutory responsibility for services delivering adult social care and public health. This innovative moves presents further opportunities for integration and synergies to be realised.

8. The Public Health transition aims to avoid interruption to the provision of robust public health services which will continue to operate 24 hours a day, seven days a week. The public health team is dedicated to serving the local population and is prepared and available to deal with public health emergencies and incidents.

9. This report considers the Public Health transfer of responsibilities to Wiltshire Council. The Health and Social Care Bill is far reaching and mean there are other changes for the Council, for example the new Health and Wellbeing Board (of which the Corporate Director with statutory responsibility for public health and adult social care, will be a statutory member) , requirement to produce a joint Health and Wellbeing Strategy, and Healthwatch. These changes are not part of the Public Health transition project, and are being implemented elsewhere in the Council. Therefore this report does not provide an update on these changes. However, the Public Health team are involved in this changes as required.

Main Considerations

Transition Plan

10. The Wiltshire Public Health transition plan was developed jointly between the PCT and the Council and submitted to the South of England Strategic Health Authority (SHA) cluster in March 2012. As part of the SHA assurance process, the leader of the Council, along with the Cabinet Member for Public Health and Public Protection and the Corporate Director, met with representatives from NHS South of England in (19th April 2012) and in the written feedback, the plan was commended for its comprehensiveness and was held up as an example of good practice within the region.

11. Wiltshire's model of integrated Public Health and Public Protection, led by the Corporate Director has been published as a case study on the Local Government Association resource "From transition to transformation in public health". This is available from http://www.local.gov.uk/web/guest/media-centre/-/journal_content/56/10171/3374673/NEWS-TEMPLATE

12. To ensure continued resilience in health emergency planning, every local resilience forum area has been asked to establish a local health resilience partnership (LHRP). This new group which is co-chaired by the local

Director of Public Health and NHS Commissioning Board Area team, will contain representation from all local NHS trusts, CCGs and Wiltshire Council. The position is well advanced and the group has already sat in shadow form. Both the LGA and SHA have set robust assurance targets to fulfil this new requirement which we are confident in meeting these.

13. Following on from positive feedback around the Wiltshire model for Emergency Planning, Response and Recovery, the leader of the council wrote to the Department of Health to invite a representative to come and see the arrangements in the county. As a result of this invitation, Duncan Selbie, Chief Executive Public Health England is due to visit Wiltshire on 1 February 2013 to observe the model in operation.

14. The Public Health transition plan builds on the development and implementation of a joint working arrangement (JWA) setting out key elements of the locally agreed joint working initiatives which was approved by the Public Health Transition Project Board on 19 January 2012 and which covers the interim period until the formal transfer.

15. As part of the transition assurance returns have been completed for both the Strategic Health Authority (SHA) and Local Government Association (LGA), these include HR and financial returns, transition plans, and legacy and handover plans.

16. Cabinet, the PCT Board and the HWB receive regular updates on the Public Health transition, the last being in November 2012.

Project Structure

17. The project board continues to meet on a monthly basis and leadership of each of the sub-groups has now been passed from the PCT to the Council to reflect the changing dynamic and the desire for the Council to drive more of the activity as the receiving organisation. The structure of the project board is shown in Appendix A.

18. There are Public Health senior management team and specialist representatives for all of the sub-groups of the Project Board (see Appendix B). The risk register is reviewed prior to each project board, and any relevant risks are added as they are identified.

HR

19. It has been agreed by the PCT and Council that the Transfer of Undertakings (Protection of Employment) Regulations 2006 ('TUPE') will apply to the transfer of all staff fully assigned to the public health functions transferring to Wiltshire Council on 1 April 2013 under the Health and Social Care Act 2012.

20. A letter from the Department of Health and Local Government Association dated 17 May 2012 confirms the Local Government Association's view that staff who have access to the NHS Pension Scheme on 31 March 2013 should retain access to the NHS Pension Scheme on transfer. A

further letter on the treatment of pensions after 1 April 2013 in relation to the transfer of public health staff to local authorities was received in December 2012, from Public Health England and the Local Government Association. This is available from http://healthandcare.dh.gov.uk/pensions-letter/

21. There is a formal consultation for Public Health staff on the transfer of employment to the Council and the physical relocation to County Hall in Trowbridge. This took place in August 2012. A separate statutory consultation regarding the TUPE transfer commenced in December 2012.

22. There are two staff representatives on the Public Health transition project board. Relevant unions have been involved in the transition and staff consultations through the PCT staff forum board.

23. The Department of Health has published a range of guidance for the Public Health transition, this is available from http://www.dh.gov.uk/health/2012/06/public-health-functions/

Physical Relocation

24. The Transition Project Board agreed that the Public Health team would relocate to County Hall in advance of the formal transfer in April 2013. The relocation took place in the first week of December 2012. This early relocation of the Public Health team, complements the best practice guidance, Gateway reference 17711, Transitional Working Arrangements (12 June 2012).

25. Public Health will be incorporated into the Workplace transformation programme that is underway at the Council, preparing staff for the new ways of working in the flexible office environment. Public Health staff are located on the first floor of County Hall.

26. Care has been taken to ensure that any transitional arrangements made by the Council before that date are within the statutory powers of the Council. The proposal to co-locate Public Health staff within the Council offices prior to statutory transfer is within the Council's general power of competence under the Localism Act 2011.

Finance – Public Health grant

27. For the financial year 2013/14, a direct ring fenced budget will be allocated to the Council to correspond with the statutory transfer of Public Health functions. For the current financial year 2012/13, expenditure and budgets remain within the NHS. A number of financial returns have been being completed to help inform future budgets.

28. Current estimates for national Public Health spend in 2012-13 total £5.2bn, including £2.2bn on services that will be the responsibility of local authorities. The grant will be made under Section 31 of the LGA 2003 and will carry conditions about how it may be used. The intention is for the grant to be spent on activities whose main or primary purpose is to impact

positively on the health and wellbeing of local populations, with the aim of reducing health inequalities in local communities. The Director of Public Health will retain control and responsibility for the Public Health grant.

29. The financial guidance sets out standard governance, financial management and reporting requirements (Revenue Account Budget Estimates – RA return, Revenue Outturn – RO return, and Quarterly Revenue Outturn - QRO return) on the use of public funds by LAs which will apply equally to the PH grant. Reporting is likely to be against 15-20 categories.

30. The amount allocated to local authorities for 2013-14 will not fall below the estimates published in February 2012 (other than in exceptional circumstances); for Wiltshire this is £11.868m.

31. The Department for Communities and Local Government (DCLG) released and then withdrew a press release indicating that public health funding to local authorities would increase from £2.2 billion to £2.64 billion. The DH has indicated that is now working on a two year settlement which will not be made known until early January 2013.

32. Health premiums are an incentive scheme and responses to the first consultation raised concerns there could be perverse incentives. This with the significant data lag for many outcomes means the first payments will be delayed until 2015-16, the third year of LA responsibility for public health.

33. The Department of Health provide national guidance on Public Health funding, the latest guidance can be found here, http://www.dh.gov.uk/health/2012/06/ph-funding-la/

Core Offer to CCGs

34. From April 2013 Clinical Commissioning Groups (CCGs) will have a duty to seek public health advice, and local authorities will have a duty to provide this advice to CCGs. This will be in the form of a "core offer" of specialist public health advice.

35. Although the provision of public health advice will be mandatory, the detail of the arrangement needs to be planned locally. The Department of Health (DH) published guidance encouraging CCGs and public health teams to explore and develop plans for how the CCG will make best use of public health expertise from local authorities in the new system. CCGs also need to demonstrate the ability to obtain advice from a broad range of professionals, including public health expertise, in order to become authorised.

36. The CCG Assurance Visit took place on the 18th December 2012. A team of 6 panel members assessed the CCG authorisation application. As a result of the panel sessions and provision of additional evidence the number of red key lines of enquiries reduced from 57 to 11. This places the CCG in a good position.

37. The Department of Health has set out the following 3 key areas of specialist public health advice that should be provided to CCGs:

1. Strategic planning:
    a. Assessing needs
    b. Reviewing service provision
    c. Deciding priorities
2. Procuring services
    a. Designing shape and structure of supply
    b. Planning capacity and managing demand
3. Monitoring and evaluation
    a. Supporting patient choice, managing performance and seeking public and patient views

38. A memorandum of understanding has been developed in conjunction with the Wiltshire CCG, Wiltshire Council and Public Health. This has been presented to the shadow Health and Wellbeing Board.

Assurance testing

39. As part of the assurance process for Transition, there is a requirement to demonstrate that continuity of service and resilient arrangements are in place for the following areas during transition:

- Emergency preparedness
- Screening
- Information management

40. Wiltshire has a strong track record in all of these areas and is confident that the transition process will not affect the delivery of these services. Wiltshire Public Health is operating a business as usual approach to the transition including factors such as commissioning and contracts.

Communications and Engagement

41. The communications and engagement activity has been reviewed. Two Councillor seminars on Public Health were held in September (a further seminar will take place in January 2013) and an ELT session held in November. These sessions were designed to help Councillors and Officers understand the Public Health function and statutory responsibilities and included a presentation and question and answer session. The Public Health team have also presented to a number of departmental and team meetings to raise awareness of the transfer throughout the Council. A further catch up session for councillors who missed the original presentation is planned for the end of January.

42. There have been broader engagement activities with articles in the Residents' magazine (October 2012 and January 2013) and a short film for area boards and stakeholders. A DVD is being developed.

43. All public health staff moving across to Wiltshire Council have received a tailored induction and receive regular transition updates.

44. The existing Wiltshire Council induction for all new staff has been updated to include a section on Public Health and its integration within the Council. Briefing sessions for staff and managers will include information on the transition and role and functions of Public Health.

45. Public Health will be part of the Councillor Induction and Service Fair following the elections in May 2013.

Information Technology

46. The IT component is crucial to the business continuity of the Public Health transition. The arrangements are complex, in part due to the patient level information used by Public Health but also with the need for continued interfaces with the wider health economy (acute hospitals and GP practices).

47. A mapping exercise has been completed to identify systems used by Public Health staff and this has been shared by with the Council.

48. IT related risks are noted on the Public Health transition risk register and are reviewed on a monthly basis. The relocation of the Public Health team in early December was successful and staff are able to retain access to all necessary NHS systems.

Public Health Outcomes Framework (PHOF)

49. From April 2013, the Public Health Outcome Framework concentrates on two high-level outcomes to be achieved across the public health system. These are:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities

50. The outcomes reflect a focus not only on how long people live but on how well they live at all stages of life. The second outcome focuses attention on reducing health inequalities between people, communities and areas. Using a measure of both life expectancy and healthy life expectancy will enable the use of the most reliable information available to understand the nature of health inequalities both within areas and between areas. A set of supporting public health indicators will help focus understanding of progress year by year nationally and locally on those things that matter most to public health. The indicators, which cover the full spectrum of public health and what can be currently realistically measured, are grouped into four ‘domains’:

- improving the wider determinants of health
- health improvement

- health protection
- healthcare public health and preventing premature mortality

51. Baseline data for the PHOF was recently published, and will be updated on a quarterly basis. This can be viewed at http://transparency.dh.gov.uk/2012/11/20/phof-data-autumn-2012/

Joint Strategic Assessment programme

52. Although not part of the Public Health transition project, the Health and Social Care Bill includes the responsibility to produce an annual assessment of health and wellbeing needs of the local population. In Wiltshire this is led by the Corporate Director, Maggie Rae in conjunction with other Council officers and partners.

53. The JSA programme in Wiltshire comprises of a strategic assessment of Wiltshire, known as the JSA for Wiltshire. This considers the issues facing Wiltshire for not only health and wellbeing, but also other parts of the Council's business including housing, community safety, environmental, children and young people and the economy.

54. Supporting the JSA for Wiltshire, are more detailed assessments of need, including the JSA for Health and wellbeing. This has recently been subject to a full refresh and is now published on the Wiltshire Intelligence Network website and will be presented to the Cabinet, Health and Wellbeing Board and Clinical Commissioning group later in January 2013.

55. The transition will not affect the production of the JSA programme.

Environmental and climate change considerations

56. There are no known environmental and climate change considerations.

Equalities Impact of the Proposal

57. An EIA has been completed to cover the physical relocation of the Public Health team in December 2012 and transfer of employment in April 2013 (August 2012)

Risk Assessment

58. The Public Health transition risk register is reviewed on a monthly basis by the project board and submitted to the PCT cluster transition programme.

59. The Public Health transition is included in the Council's Risk Register and updated on a quarterly basis, see Appendix C.

60. There are Public Health risks currently on the PCTs risk register which will transfer to the Council on the 1 April 2013, an example being pandemic flu. These risks have been shared with the Council's Corporate Risk team and are being managed within current PCT risk processes.

61. The Public Health transition has been included on the Council's Annual Assurance Statement 2011-12.

62. The Public Health transition is part of the Council's internal audit plan, and a report will be published in late February 2013.

63. Nationally, there is a proposal to strengthen the NHS Constitution so it is more responsive to the needs of patients and the public and can be better used to hold the NHS to account. The consultation is particularly pertinent in light of recent reports about poor care and complaint handling in some NHS services. There are several issues of relevance to local authorities in these proposals. In particular, one of the new measures involves extending the application of the NHS Constitution to local authorities in their new public health functions. The consultation is available at http://www.lgiu.org.uk/briefing/consultation-on-strengthening-the-nhs-constitution-implications-for-local-authorities/

Financial Implications

64. In April 2013, the Public Health budget will transfer to Wiltshire Council. The grant will be ring fenced for Public Health. This exact amount will be determined nationally and will be based on financial returns submitted to the SHA.

65. Public Health financial information will be included in the Council's Financial Plan 2013.

Legal Implications

66. A representative from Council Legal Team attends the Public Health transition project board and has been involved in all relevant aspects of the project including staff transfer decisions.

67. Transfer schemes will be signed by the Council in February 2013.

Options Considered

68. Decisions are being taken in line with national guidance on the Public Health transfer and in conjunction with the Public Health Transition Project Board chaired by Councillor Keith Humphries, Cabinet Member for Public Health and Public Protection. The PCT and Council are represented on this project board and this feeds into the joint PCT cluster transition programme board.

Conclusions

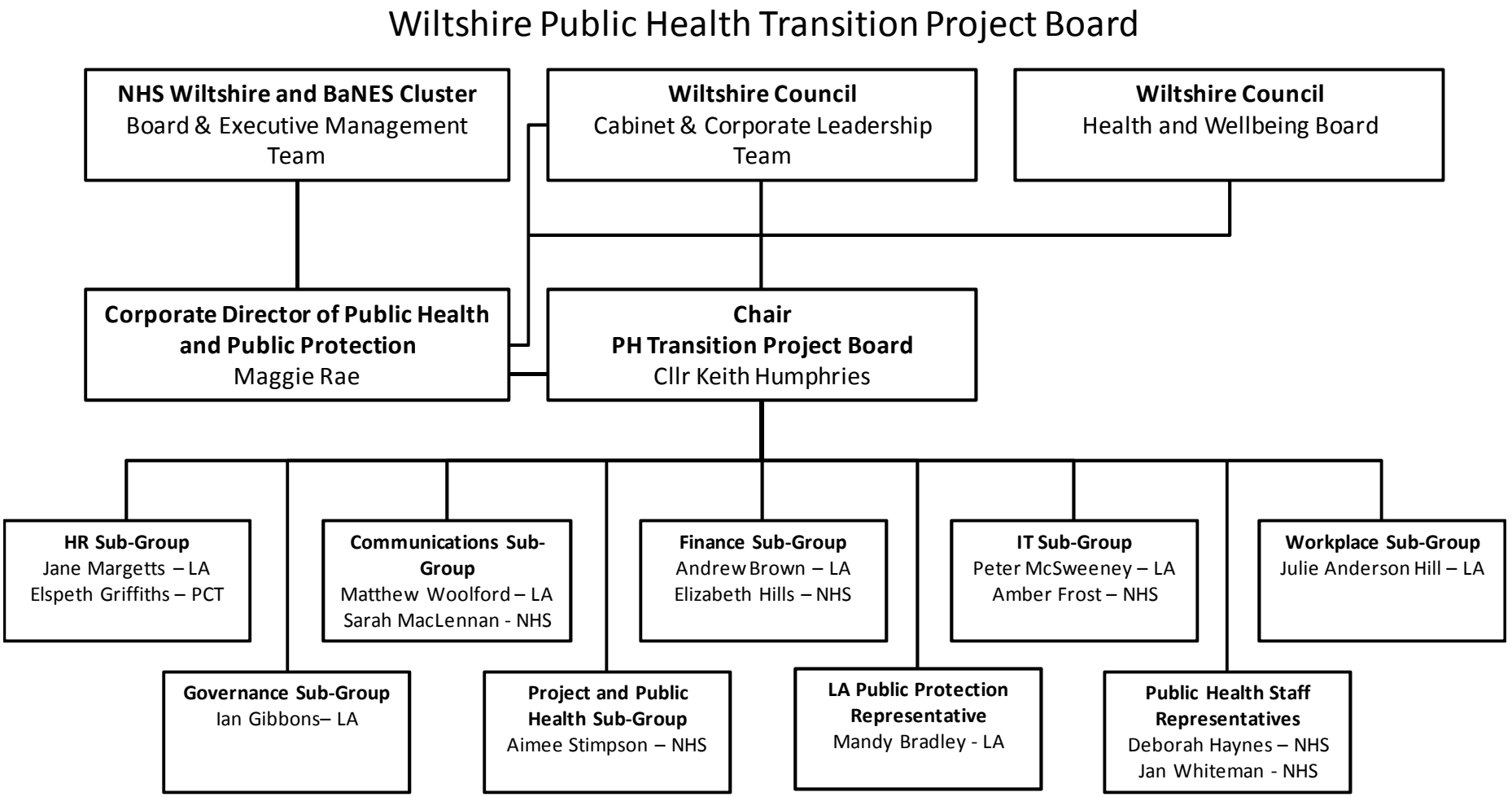
69. The Public Health transition project is well advanced in Wiltshire and considered on track.

Maggie Rae
Corporate Director
Wiltshire Council

Report Author:
Aimee Stimpson
Associate Director of Public Health – Evidence and Intelligence
January 2013

Appendices
Appendix A – Transition Project Board Structure and Responsibilities
Appendix B – Transition sub-group responsibilities
Appendix C – Public Health risk from Council's Risk register

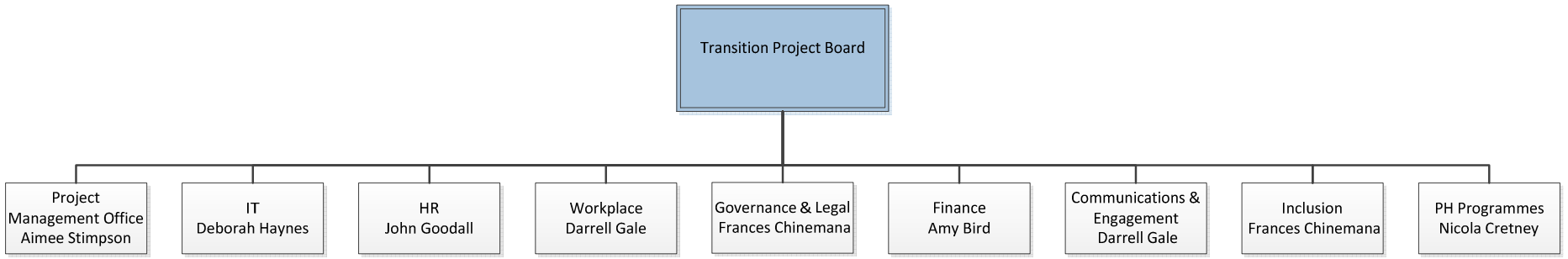
Appendix A – Transition Project Board Structure and Responsibilities



Appendix B – Transition sub-group responsibilities

Public Health - Transition Project Leads

Project Sub-Group	SMT Lead	Specialist Representative	Sub-Group Lead	PCT Lead
Project Management Office	Aimee Stimpson	n/a	n/a	n/a
IT	Deborah Haynes	Tom Frost (Vicky Storey)	Peter McSweeney	Amber Frost
HR	John Goodall	Issie Tucker	Jane Margetts	Elspeth Griffiths
Workplace	Darrell Gale	Margaret Winskill	Julie-Anderson-Hill	n/a
Governance and Legal	Frances Chinemana	Tbc	Ian Gibbons	Tbc
Finance	Amy Bird	Sally Johnson	Andrew Brown	Tbc
Communications & Engagement	Darrell Gale	Giles de Burgh/Mike Jones	Matthew Woolford	Sarah MacLennan
Inclusion	Frances Chinemana	Katie Currie	Dot Kronda/Sue Geary	n/a
PH Programmes	Nicola Cretney	Tracy Daszkiewicz/Kay Selman	n/a	n/a



Appendix C - WILTSHIRE COUNCIL RISK ACTION PLAN

Risk Ref: 1180	Risk: Transfer of Public Health function to Wiltshire Council			Date of Action Plan Update: October 2012
Current Risk Rating: I = 2 L = 2 Current Score = 4	**(High, Med, Low)** Low	**Target Risk Rating:** I = 1 L = 1 Target Score = 1	**(High, Med, Low)** Low	**Progress on Risk Action Plan:** RAG = Green

Comment on Current Status of Risk (for use in risk management update reports)

There is a PH transition risk register in place which is reviewed on a monthly basis by the PH transition project board. The risk register is also submitted to the Cluster Transition Programme Board (Wiltshire and BANES) each month and high risks are incorporated into the cluster risk register. Current high risks include finalizing the PH budget which will transfer to the LA and the ICT solution. These are being addressed locally and nationally. Wiltshire Council have confirmed that staff will transfer under TUPE conditions, and the Department of Health have confirmed that staff will retain NHS pensions.

Action Plan

Risk Owner	Maggie Rae	**Key Officers**	Maggie Rae, Aimee Stimpson

Scope / Background to Risk
(Insert information about the risk that explains it further including any history, cause of risk and potential impact and likelihood evaluation information)

Cause: The new role for Public Health in Wiltshire Council, as part of the Health and Social Care Bill, enhance the existing integrated PH model with Public Protection and Knowledge Management and across the Council

Impact:
Reputational risk to the Council
Business continuity
Service delivery

Controls in place to manage risk

Robust PH transition project board, chaired by Cllr Keith Humphries. There are a number of subgroups within this project which are now lead by the Council as the receiver organization. There is a joint PH transition project plan which was agreed by both the PCT and Council in March 2012. There are separate plans for the Public Health transition including a Communications and Engagement Plan, IT plan, HR plan.
Monthly review of the PH transition risk register.
The Public Health Transition is included within the Council's Annual Governance Statement 11-12

The Health and Social Care Act is radical and far reaching. Two Councillor briefings have been held in October 2012 and were well attended. These covered an overview of the changes and implications of PH transferring to the Council.
The Council held a seminar of the HASC Act and this included a presentation regarding the Public Health transfer. Health Select Committee held a workshop in early October 2012, where there were group discussions regarding CCGs, acute trusts, Public Health. The output of this will determine the Health Select Committee work plan.
For the public, information on the transfer has been included in the Wiltshire Residents Magazine.
The PH budget will be ring fenced; information regarding the PH budget will be included in the Council's Financial Plan 13-14.
N3 upgrade has been ordered, to ensure the transfer of sensitive information between the LA and NHS will continue.
IT set up for Public Health staff who are transferring has made good progress.
Staff continue to be supported throughout this period of change – through regular staff briefings, team meetings, presentation from the Council transformation team, Council induction session (15th November), FAQs, staff reps and a staff support program (e.g. staff workshops)
Public liability for staff transferring has been confirmed from April 2013

Actions to take to improve the management of this risk OR Contingency Arrangements	**Responsibility for action**	**Date for completion**	**Progress / Status Report for Improvement Actions**
ICT solution – identity solution and test this to ensure appropriate IT systems are in place for PH staff when in the Council and to ensure retention to current NHS systems	Peter McSweeny in conjunction with PCT	November 2012	Options paper has been discussed by PH transition project board and this confirmed the risk is reducing.
Public Health budget	Andy Brown/ Leanne Sykes	December 2012	Further work is being completed by the Department of Health to identify the ring fenced public health budget. The final allocation for 2013-14 is expected to be confirmed by December 2012 but will not fall below the shadow estimated budget figure of £11.866 million. The grant will be made under Section 31 of the LGA 2003 and will carry conditions about how it may be used. The intention is for the grant to be spent on activities whose main or primary purpose is to impact positively on the health and wellbeing of local populations, with the aim of reducing health inequalities in local communities. Information regarding the Public Health

			budget will be included in the Council's financial plan.
Assurance testing	Maggie Rae	December 2012	National milestones for assurance testing have been revised. The requirement to assure future arrangements for screening have been removed. The milestone for testing emergency preparedness and resilience remains in place and will be tested in early November, and the SHA are visiting the PCT as part of this process. The assurance required for intelligence has been moved from September to December; factsheets regarding this have recently been published by the Department of Health and is being reviewed by the ICT subgroup for implications.
To ensure the implications of the transfer to PH to the Council is fully understood within the Council	Maggie Rae	January 2013	There is a session planned for ELT for the 17th November and further information will be included in the Residents Magazine in January 2013.
SHA PH transition returns	Maggie Rae/ Aimee Stimpson	December 2012	Completion of various SHA PH transition returns for example HR, finance.

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Wiltshire Council

Health Select Committee

17 January 2013

Help to Live at Home Programme

1. The purpose of this report is to provide an update to Health Scrutiny on progress related to the implementation of the Help to Live at Home programme that includes a number of different services – care and support, telecare and response, integrated equipment, independent support planning and brokerage and independent financial advice.

2. Particular interest has been shown in the care and support service to which this report relates. Further details about other elements of the programme can be provided if required.

THE HELP TO LIVE AT HOME PROGRAMME

Help to Live at Home service – care and support: Reablement, domiciliary (personal) care, housing support to people living in sheltered housing and preventive services, provided by Leonard Cheshire, Aster Living, Somerset Care and Enara.

Telecare and response service: A variety of electronic alarm devices provided by Medequip in partnership with Aster Living, linked to a call centre and a physical response service able to visit people at home 24 hours a day, provided by Wiltshire Medical Services.

Integrated equipment: Aids and adaptations and equipment, home improvement and handypersons service, continence products, telecare and pressure care supplied and delivered by Medequip.

Independent support planning and brokerage service: For people who want a direct payment and would like to be supported by others who have a direct payment. This service is provided by Wiltshire Centre for Independent Living, a user led organisation.

Independent Financial Advice: Two specialist financial firms accredited by the Society of Later Life Advisors able to provide financial advice and products to people likely to fund their own care.

By September 2012, the HTLAH programme was providing support to:

- 1,824 council customers with telecare,
- 1184 private customers
- 1278 carers with an Emergency Card;
- 978 customers had reablement or care at home;
- 1316 customers supported jointly with the NHS neighbourhood teams
- 2012 people living in sheltered accommodation

3. This represents a small proportion of older people in Wiltshire where there are 42,000 people over 75 years of age, the majority of whom have no contact with the Council. This is for one of two reasons either they have no social care needs or they believe they are not eligible to receive support from the Council so do not approach us. Our strategy to address this going forward is twofold, firstly to ensure people have access to the information, advice and support they need to enable them to access services they require and secondly, to encourage more people to seek an assessment from the Council to help identify what their needs how and what services are available to meet those needs. This will reduce the number of people accessing services they do not require. (It is estimated that significant numbers of people in care homes do not require that level of care).

Background to the Help to Live at Home Service (HTLAH) – care and support

4. In July 2010 the Council awarded contracts to 4 providers to deliver the Help to Live at Home (HTLAH) service across Wiltshire. This service is different from previous domiciliary care services because instead of the Council paying providers for the number of hours of care they deliver, the Council pays for the outcomes the providers deliver for customers.

5. In September 2010 the HTLAH providers began supporting new and existing customers and from April 2011 these providers started to deliver services based on the outcomes that customers wanted to achieve rather than the time they spent with the customer.

Current Position:

6. HTLAH is expected to improve the quality of support people receive, by supporting them to achieve the outcomes agreed with them during their assessment.

7. The programme is also expected to achieve financial savings from lower contractual rates but more significantly, transformational savings by changing the way in which these services are now delivered. HTLAH providers work in their local communities, helping customers to access support from those communities thereby enabling people to continue to be part of the community in which they live. In addition, all the support that is provided through HTLAH is time limited and reviewed regularly to be sure that the customer is continuing to benefit from the service. This approach together with the telecare and 24 hour response service has resulted in less placements in care homes being made which is expected to continue as the programme develops. (For example, this week 21 people in Wiltshire were attended to during the night in response to an alarm raised with the 24 hour response service).

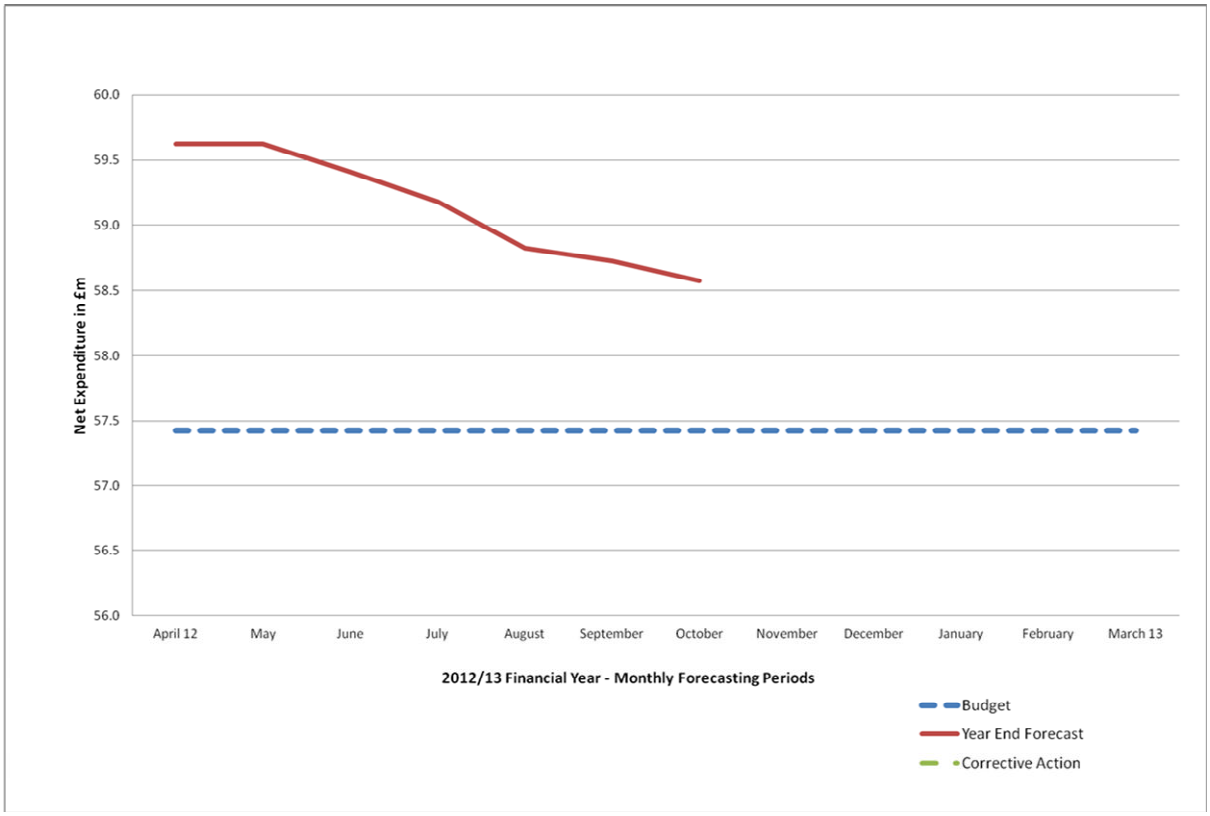
Financial Benefits:

8. The HTLAH care and support service is delivered in 8 geographical areas, with each of the four providers being responsible for all the care and support

requirements in one area. This has resulted in reduced travel time and enabled these companies to recruit local people to deliver care to others within the same community. Further economies of scale have been achieved by trading with fewer providers, reducing contracts from 90 to eight. This has resulted in lower unit costs, reduced travel costs and lower back office costs.

HTLAH has delivered £2.8 million of procurement savings as a result of the changes.

9. The 2012/13 Adult Services older peoples budget of £52.8 million includes a further £4.8 million of savings from HTLAH. The Council will achieve this by avoiding long term residential placements, supporting more people in the community with outcome based support. We are currently on target to deliver this.



Service Benefits:

10. As well as financial benefits, HTLAH has:

- Enabled more people to live in their own homes and live active, interesting and stimulating lives regardless of disability, age or infirmity.
- Have facilitated more people to regain, recover or learn skills to enable people to remain in their own homes – see table overleaf.

Reablement/Initial Support
April to November 2012

396 customers have completed a short period of intensive service called Initial Support to help them recover some independence.

1) 236 people (59.6%) regained their independence and do not need ongoing care. (The national benchmark is 50%.)
2) 78 people (19.7%) needed ongoing support but it cost less per week than Initial Support.
3) 82 (20.7%) needed ongoing support that cost more per week than Initial Support.
4) 12 customers left the H2LAH service and moved to a care home.
5) The average price for six-week Initial Support delivered in Wiltshire was £1200. The London School of Economics estimates that the average cost of a six week "reablement" service (the generic name for Initial Support) is about £2000.

Sustaining improvement in Services:

11. A key feature of HTLAH is payment by results which provides a permanent incentive. If quality deteriorates, providers' revenues will fall.

12. As well as improvements to front line services there have also been improvements to back office processes. HTLAH providers access the Council's care management system and there is a shared performance management system in place that enables the Council and providers to monitor performance on a daily basis.

Performance and Contract Management

13. Since the start of the contract the Council has carefully monitored the performance of Providers. One of the benefits of moving to 4 providers, rather than the large number agencies under previous contracts is the ability to have regular discussions with providers about performance issues.

14. Issues in one contract area led to a need to re-tender that contract area. This resulted from active conversations about the quality the Council required in the contract with the provider and mutual agreement about the best way to resolve those issues. The Operations team worked closely with the out-going provider and the new provider to ensure customers support was not affected and customers were successfully transferred.

Customer Engagement and Choice:

15. From the outset older people, their carers and others have been involved in HTLAH. This group, supported by Wiltshire and Swindon Users Network, has been involved in the design of services, in the award of the contracts and in

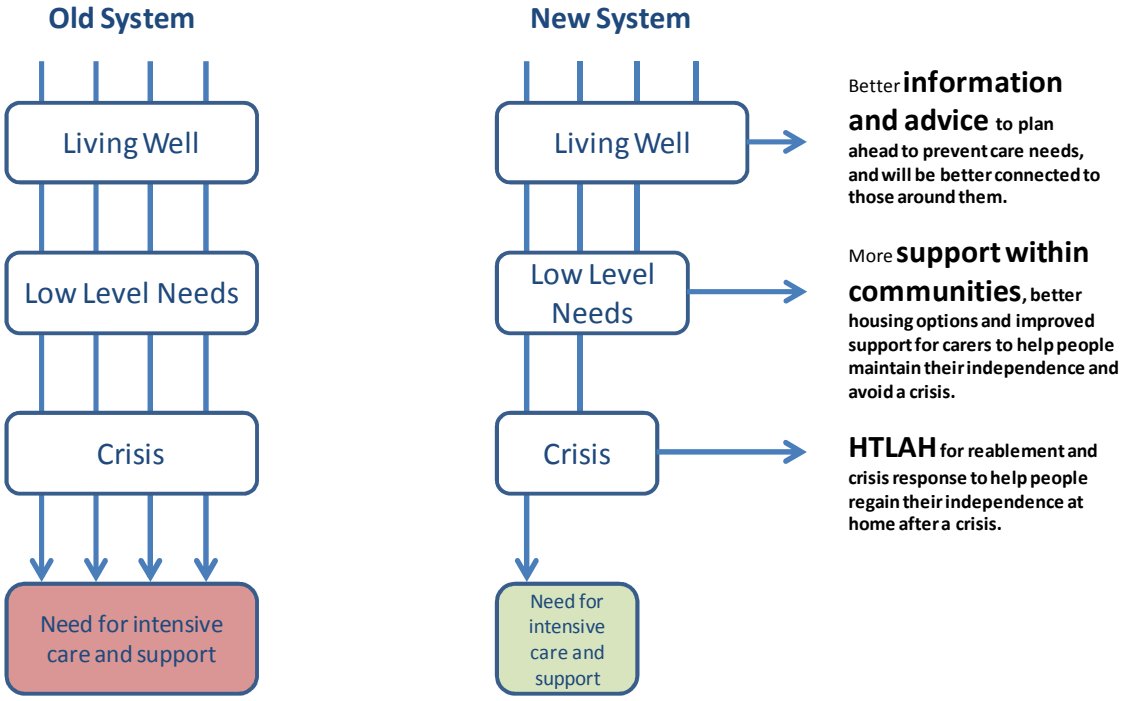
monitoring the services that are delivered. Members of the group have received training and are actively engaged in monitoring the services provided. They hold meetings with HTLAH customers to ascertain their views about the services they received.

16. For those customers who do not wish to receive a service from HTLAH providers and prefer to make their own care arrangements, there is a choice. These individuals are offered a direct payment and independent support to make these arrangements. The value of the direct payment is equal to the cost of their support plan if they had chosen to have services provided by the HTLAH providers. A 'self-directed support service' to help customers who choose Direct Payments has been commissioned from Wiltshire Centre for Independent Living – a user led organisation.

Working with Communities:

17. A key principle of HTLAH is to ensure people get the help they need as soon as possible and to put in place services that prevent peoples' needs escalating. By working with HTLAH providers, the Voluntary and Community Sector and others we ensure that people get help as early as possible. In the next phase of the programme we will be developing new information and advice services and commissioning a range of different services from existing voluntary and community organisations. The diagram overleaf illustrates the approach:

Doing things differently: Shifting the focus from crisis to wellbeing



The Next Steps - Developing the Help to Live at Home programme

18. The first year of the service has seen Providers get to grips with running the new service. They have had challenges around:

- adapting their current operational systems
- recruiting staff to address issue around speed of response, particularly hospital discharges
- changing the culture of their staff to deliver a “doing with” not doing for” ethos across the service
- Supporting the delivery of the sheltered accommodation service

19. The service is intended to be a strategic partnership approach and over the next year the Council will be working with providers on:

- Workforce development and joint approaches to learning and development
- Service improvement to ensure people’s outcomes are met
- Community engagement, so that people in the wider community who are not eligible for support can benefit and improve their chances of being independent for longer
- Greater use of telecare services in the way people are supported.

Summary and Conclusion:

20. The HTLAH programme involved the complete redesign of how we assess and commission services for older people who approach the Council for support. This was central to helping to change the ways we worked. One of the principles of HTLAH is to provide support quickly and address the crisis that has led to the person needing support. A key target for us is to reduce the length of time people have to wait before they receive a service. Completion times for assessments have fallen from 20 to 13 days. This will be further reduced.

21. The change of approach has enabled people, who would have gone into residential care, the opportunity to live at home, often with less support.

22. Customers have been able to tell us what is important to them about their support, not what the council thinks they need.

Nicola Gregson
Andrew Osborn

December 2012

Wiltshire Council

Health Select Committee

17th January 2013

The National Vascular Services Review – Its progress and implications for Wiltshire

1.0 Purpose and Executive summary

1.1 Purpose of the Paper

The purpose of this paper to

- Inform the Health Select Committee of the implications for Wiltshire of the national Vascular Surgical Services Review
- Seek the Committee's support for the way forward.

1.2 Executive Summary

1.2.1 This paper seeks to appraise the Health Select Committee of the progress and the emerging implications of the national vascular services review for the residents of Wiltshire.

1.2.2 The review is in response to two reports from the Vascular Society: The Provision of Services for Patients with Vascular Disease (January 2012), and Outcomes after Elective Repair of Infra-renal Abdominal Aortic Aneurysm (March 2012).

1.2.3 The target is for plans for the implementation of changes to meet the recommendations to be in place by April 2013 including a clear schedule for meeting any outstanding requirements. Each network is reviewed individually by Specialist Commissioning but they expect recommendations to be implemented in full as soon as possible. This recognised that those networks reliant on major building work or reconfiguration may not be able to be fully operational until 2014.

1.2.4 The NHS Wiltshire Primary Care Trust is presently responsible for commissioning health services in Wiltshire. This role will transfer from April 2013 to the Wiltshire Commissioning Group (CCG) In the interim the CCG is taking operational responsibility for commissioning. In April 2013, Specialist Commissioning will be taking the lead for a number of services and this will include vascular services.

1.2.5 Wiltshire Clinical Commissioning Group (CCG) believes that the potential implications of service reconfigurations presently being considered require further analysis. Clarification of the balance of benefits for patients is also required before we are able to either clearly present options or recommend a future service configuration to our population.

2.0 Proposal

2.1 Wiltshire CCG request that the Health Select Committee:

1. Notes the progress of the local work to review vascular services in line with the Vascular Society recommendations
2. Supports Wiltshire Commissioning Group's intention to work with providers and commissioners to undertake further analysis of the service and outcome factors in order to have a clear understanding of the vascular and wider service implications and to develop options to best meet the needs of Wiltshire's population
3. Supports Wiltshire Clinical Commissioning Group in clarifying the issues and options prior to developing any engagement plan.
4. Supports Wiltshire Clinical Commissioning Group in its position of obtaining and sharing this information with stakeholders prior to agreeing to any solutions proposed by the vascular networks.
5. Agrees to receive a further report from Wiltshire CCG in March 2013, prior to the transfer of responsibility for the commissioning of vascular surgery to Specialist Commissioning.

Author:

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With input from:
Beatrix Maynard, Head of Commissioning and Service Improvement for Sarum, Wiltshire CCG

John Goodall, Associate Director Public Health (CVD),Public Health, NHS Wiltshire

Dr Elizabeth Stanger, Sarum Executive Director, GP Lead for Vascular Review, Three Swans Surgery, Rollestone Street, Salisbury

3.0 Background

3.1 A national review of vascular services is underway following the release of the Vascular Society of Great Britain & Northern Ireland's (VSGBI) recommendations. A draft specification was issued for comment on 12th December 2012 following feedback on earlier versions.

3.2 The review is in response to two reports from the Vascular Society: The Provision of Services for Patients with Vascular Disease (January 2012), and Outcomes after Elective Repair of Infra-renal Abdominal Aortic Aneurysm (March 2012).

3.3 In March 2012 vascular surgery became a speciality in its own right. In line with many specialist services the direction of travel for vascular surgery is towards more specialist services, concentrated through a smaller number of high volume arterial centres. The VSGBI recommendations state that a minimum population of 800,000 is considered necessary for an AAA screening programme and therefore considered the minimum population required for a centralised vascular service. It is considered each vascular centre would perform at least 60 Abdominal Aortic Aneurysm procedures per year (based upon a 1 in 6 rota with each surgeon performing 10 procedures per annum.) A minimum of 50 carotid endarterectomy procedures is also indicated with an overall resultant improvement in mortality outcomes for patients. Each of these units would have improved networks into adjacent hospitals and community facilities.

3.4 Wiltshire has a population of 471,000 and has the added complication of three distinct patient flows: in the south to Salisbury NHS Trust, in the west to the Royal United Hospital in Bath (RUH), and in the north to Great Western Hospital in Swindon. Each of these flows is effectively delivered by separate clinical networks to support these services, with the hospitals linking to neighbouring units rather than with each other across Wiltshire. The impact is that none of the units are presently in a position in terms of patient numbers and clinical cover to sustainably meet the new specialist service recommendations.

3.5 The NHS Commissioning Board required that clinical networks developed proposals for the future configuration of services in their area to be presented to them in December 2012 in preparation for transfer of responsibility to the Specialist Commissioning service in 2013.

4.0 Progress to Date

4.1 Within Wiltshire a clinical lead, Dr Elizabeth Stanger and a Project Manager, Jill Whittington, have been linking to this work with public health support from John Goodall. A significant focus of this work has been in the south around services provided by Salisbury Foundation Trust, who presently deliver vascular services and the AAA screening contract, and where there may be significant implications not only for Wiltshire patients but also for wider service provision at Salisbury Hospital.

4.2 To the West of Wiltshire North Bristol Trust (NBT) United Hospital Bristol (UHB) and RUH Bath have agreed to implement an interim emergency vascular service to commence February 2013. This will mean that, where

appropriate, some emergency treatment of Wiltshire patients has the potential to take place in Bristol where a specialist on-call surgeon will always be based. When patients have recovered from their procedure, care will be transferred back to Bath or the community as appropriate.

4.3 A vascular review panel has been established for NBT and RUH together with Weston Area Health Trust (WAHT) and United Hospital Bristol to establish the most appropriate model for future delivery. This work will take place over the following 3-6 months. It will be working with CCGs and seeking the views of Wiltshire stakeholders across the review period to ensure that the highest quality of services and experience for patients is maintained into the future.

4.4 The Healthy Futures Programme Board in Bristol has designated the new Southmead Hospital to be tested as potential preferred provider for the regional vascular service. RUH Bath is currently reviewing the impact of different models of provision as part of the review supported by Bath and North East Somerset CCG, which leads the commissioning of the RUH Bath hospital services.

4.5 If the future service is delivered at Southmead, patient flows to the west would be to Bristol.

4.6 To the North of Wiltshire we understood that Vascular Services would be developing a fully centralised service based at Gloucester Royal Hospital. The travel time analysis in this paper reflects that understanding. We have now been informed that the current plan is for a hub and spoke model to be developed with the hub at Cheltenham General Hospital and spoke services to be delivered at Great Western Hospital Swindon and Gloucester Royal Hospital. (See Appendix A for outline of a typical hub and spoke model) We understand that a full scoping and impact analysis is being undertaken.

4.7 In the South of Wiltshire, a clinical network encompassing Salisbury Hospital NHS FT (SFT), Royal Bournemouth and Christchurch Hospitals NHS FT (RBCHFT) and Dorset County Hospital NHS FT (DCHFT) has proposed a networked ‘hub and spoke’ model with all vascular surgery delivered at Bournemouth (See Appendix A for initial outline of ‘hub’ services based upon a typical hub and spoke model).

4.8 This proposal would meet the vascular society guidelines and is intended to increase the ‘hub’s’ clinical team’s surgical volume, which would then exceed the Vascular Society’s minimum guidelines, with the intention of improving outcomes and ensuring full vascular emergency cover at a single site.

4.9 Within this model the proposal is that Salisbury Hospital should act as a ‘spoke’ and maintain a weekday 0900-1700 vascular presence to support outpatient services and other linked services. A full understanding of the feasibility and range of this service has yet to be reached.

4.10 Wiltshire CCG understands that a vascular service is important in the provision of a range of linked services currently provided at Salisbury including:

- Diabetic foot service
- Stroke / Transient Ischaemic Attack services

- Interventional cardiology
- Inpatient vascular emergencies
- Interventional vascular radiology
- Trauma
- General Surgery
- Plastic Surgery (N.B SFT is presently a regional plastic centre)
- Maternity Services

4.11 A Bournemouth-based vascular surgery hub was proposed by the South's clinical network to the Specialist Commissioning Vascular Surgery Review Panel at a meeting on 18th December 2012. An alternative 'twin hub' proposal, whereby SFT & Bournemouth would alternate as the hub on a rota basis, had been previously discussed as an option. The panel was unable to support this option because it did not fully meet the Vascular Society of Great Britain and Ireland (March 2012) (VSGBI) recommendations.

4.12 The purpose of the Specialist Commissioning Review Panel was to assess the robustness of plans to achieve the recommendations as detailed within the VSGBI recommendations, including the measures that will be taken locally to address the implications for non-surgical centres.

4.13 The hub and spoke model with the hub at Bournemouth, was recognised as meeting the requirements of the guidelines but with concerns on the capacity to deliver the increased services at Bournemouth, increased travel times for patients (with associated risks), the loss of interventional radiology and the impact on linked services at Salisbury.

5.0 The Wiltshire Clinical Commissioning Group Position

5.1 Wiltshire CCG clearly supports the aim of improving outcomes for patients. We recognise the value of increased volumes of activity in this specialist surgery area for this high risk group of patients.

5.2 Outcomes in Salisbury however are already good and consistently meet or exceed required threshold targets. Unfortunately clinical team rotas do not meet the new guidelines and the current service is therefore not sustainable in the long term.

5.3 Taking a Wiltshire wide view we have a number of concerns about the implications of the service reconfigurations presently under consideration:

5.3.1 The potential absence of vascular surgery services at any of our three main hospitals would result in travel time in excess of the 60 minutes recommended by the Vascular Society. Initial analysis showed that over 15% of people in Wiltshire would not be able to access a surgical centre within 60 minutes (blue light emergency travel). This % may further increase if vascular services are based in Cheltenham rather than Gloucester Royal Hospital. This time would be still further extended if patients first travelled to their local hospital and does not include ambulance response times. Should a vascular service be provided at Salisbury this figure would drop to less than 1%. See the isochrone maps and table provided at Appendix B.

5.3.2 The ambulance service has yet to provide an impact analysis of the proposed change but more Wiltshire patients would clearly need to travel greater distances to reach hospital which is likely to create additional demand on ambulance services.

5.3.3 Current services in the south have good mortality outcomes. We are awaiting data for the north and west. Patients who wait longer for surgery may suffer increased long term morbidity as a result of organ damage and this must be balanced against any potential mortality benefits. Earlier versions of the VSGBI guidelines, upon which the options of a single site or twin site hub were appraised, had stated a minimum of 33 elective AAA repairs as being the minimum acceptable per vascular centre. In the South, where the number of operations was originally close to the recommended 33 per annum, a purely theoretical assessment of the numbers suggested that lives saved for elective surgery could increase by a maximum of 1 or 2 patients per year. This does not factor in the potential negative impact of increased travel times for emergencies.

5.3.4 There is also negative impact of loss of vascular support to other specialities at the hospital. Vascular surgery related services, affect a significant number of patients (for example the diabetic foot service, cardiac, stroke) and is yet to be fully understood and balanced with the relative benefit for complex vascular patients.

5.3.5 The longer term impact on the sustainability and services that our local hospitals will be able to provide is not yet understood.

5.3.6 It is anticipated that the proposed changes to services would increase costs to the NHS. The extent and impact are not yet fully understood.

5.3.7 As a Clinical Commissioning Group it is our responsibility to commission the best possible services for the population we serve. We are therefore continuing to work with our providers, neighbouring commissioners and specialist service commissioners to achieve a better understanding of the full range of implications of any options for future service provision. It is anticipated that this work will be completed by the end of February 2013. This will then allow us to share a clearer picture of any options with the Committee, our patients, carers and the public.

6.0 Engagement Plan

6.1 Wiltshire Clinical Commissioning Group is unable to confirm its public engagement plan until the options and implications are clearer

7.0 Environmental Impact

7.1 The environmental impact of any reconfiguration options will be assessed. Current proposals would be likely to increase travel by the ambulance service and by carers and may have wider travel implications for patients

8.0 Equality and Diversity Impact

8.1 A full Equality and Diversity Impact analysis will be carried out to include the results of a full stakeholder engagement as appropriate. Current proposals, if implemented, would be likely to reduce patient choice

9.0 Risk Assessment

9.1 A full risk assessment will be carried out when the options and implications are clear. Current options may have risks for patients to include access to local services.

10.0 Financial Implications

10.1 These are not yet confirmed but it anticipated that there will be additional costs to the NHS

11.0 Legal Implications

11.1 These have not yet been reviewed.

12.0 Conclusion

12.1 Wiltshire CCG recognises that the proposed models linked to our three key hospitals works towards meeting the vascular society guidelines.

12.2 Although the drivers for change in terms of improved outcomes are understood, there appears to be limited evidence that this would improve morbidity outcomes or significantly improve mortality outcomes for vascular patients in Wiltshire. Furthermore there presently appears to be a potential risk to local provision of other services important to a large number of our patients.

12.3 Wiltshire CCG believes that there is a need for further work to understand the wider service and financial consequences of the proposed reconfiguration in this geographical area and how these could be managed.

12.4 Wiltshire CCG cannot therefore presently support the proposed model of a single site model based at Bournemouth to service the southern area until detailed risk, financial and impact analysis on other services has been carried out. We also need a greater understanding of the plans for vascular surgery in Bath and Swindon and the associated implications for the population of Wiltshire in terms of travel times and availability of vascular and vascular related services

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13.0 Background papers

13.1 Vascular Society of Great Britain & Northern Ireland's (VSGBI) recommendations. A draft specification was issued for comment on 12th December 2012 following feedback on earlier versions.

13.2 Two reports from the Vascular Society: The Provision of Services for Patients with Vascular Disease (January 2012), and Outcomes after Elective Repair of Infra-renal Abdominal Aortic Aneurysm (March 2012).

14.0 Appendices

14.1 Appendix A Proposed Services at Bournemouth Hub & Salisbury & Dorchester ‘spoke’ sites based upon a typical ‘hub and ‘spoke’ model

14.2 Appendix B Travel Times and Isochrone Maps

Appendix A

Proposed Services at Bournemouth Hub & Salisbury & Dorchester 'spoke' sites based upon a typical 'hub and 'spoke' model

Elective work at Hub

- All arterial surgery
- Complex vascular interventional radiology, including thrombolysis
- Continuation of RBH vein, outpatient, and diabetic foot services.

Elective work at the spokes will be limited to

- Vein procedures (day case)
- Outpatient clinics
- 'non-complex' vascular interventional radiology

Ward/inpatient urgent referrals will be accommodated as far as possible by the presence of a vascular surgeon at the spoke 9-5, during the working week.

Facilities at the hub

- 24/7 vascular surgery and vascular interventional radiology on-call. Supported by on-call vascular theatre teams and on-call radiographers/nursing team;
- Junior team support, including a 'Middle-grade' surgeon on-call, particularly at night (surgical assistant for emergency cases)
- Sufficient Critical care capacity;
- Vascular 'High-care' ward area;
- 'Ring-fenced' vascular unit beds;
- One-stop vascular outpatient clinics;
- Secretarial support for all surgeons;
- Vascular MDT coordinator.

Facilities at spokes

Spoke sites will become one-stop outpatient clinics for vascular patients. The aim would be to run clinics alongside diabetic foot and TIA clinics as far as possible.

There will be a small amount of vascular equipment for trauma cases, or any emergency iatrogenic vascular trauma cases.

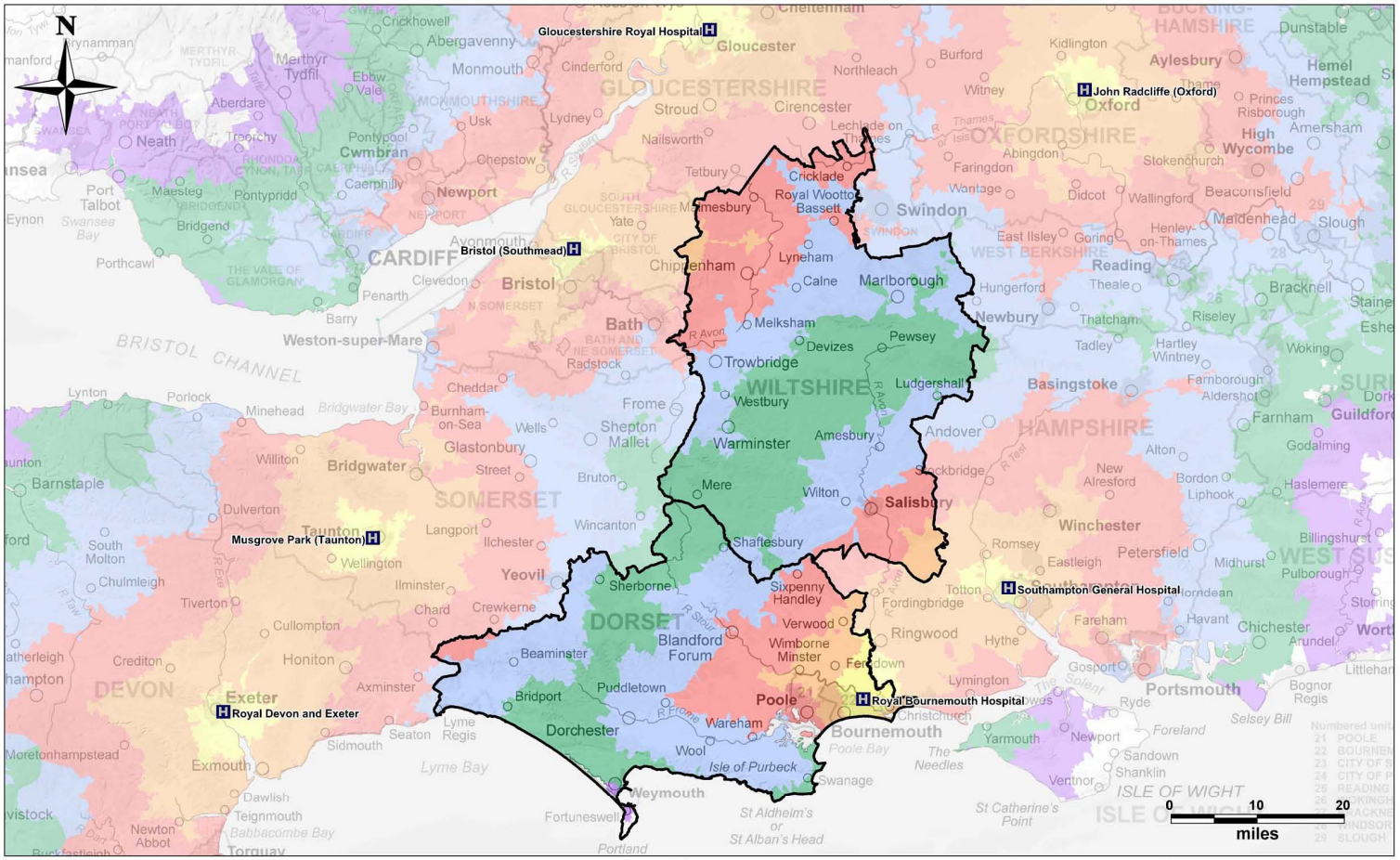
Appendix B – Travel Times

Table to show % population in each travel time band.

Total Wiltshire Population	459,835		(ONS 2010 mid-year population estimates)			
	Wiltshire population with access to Vascular Surgery hospitals					
Hospital	Average drive-time to Hub sites		Average 'blue-light' drive-time to Hub sites		Average drive-time to Hub and Spoke sites	
	Number	%	Number	%	Number	%
0-15 minutes	0	0.0%	0	0.0%	23,248	5.1%
15-30 minutes	1,832	0.4%	6,185	1.3%	51,961	11.3%
30-45 minutes	50,425	11.0%	155,382	33.8%	86,952	18.9%
45-60 minutes	191,923	41.7%	227,503	49.5%	203,996	44.4%
60-75 minutes	172,085	37.4%	70,765	15.4%	93,678	20.4%
75-90 minutes	43,570	9.5%	0	0.0%	0	0.0%
>90 minutes	0	0.0%	0	0.0%	0	0.0%
Total Dorset Population	715,042		(ONS 2010 mid-year population estimates)			
	Dorset population with access to Vascular Surgery hospitals					
Hospital	Average drive-time to Hub sites		Average 'blue-light' drive-time to Hub sites		Average drive-time to Hub and Spoke sites	
	Number	%	Number	%	Number	%
0-15 minutes	90,229	19.6%	135,589	29.5%	115,812	25.2%
15-30 minutes	181,470	39.5%	211,202	45.9%	266,369	57.9%
30-45 minutes	165,483	36.0%	129,776	28.2%	263,334	57.3%
45-60 minutes	66,688	14.5%	103,500	22.5%	63,253	13.8%
60-75 minutes	99,913	21.7%	111,891	24.3%	6,274	1.4%
75-90 minutes	86,672	18.8%	15,956	3.5%	0	0.0%
>90 minutes	24,587	5.3%	7,128	1.6%	0	0.0%
	* 1,579 added to 30-45 minutes where LSOA centroid falls outside travel isochrones					

Isochchrone Maps

Isochrone map showing average **blue light** drive times for patients and carers accessing emergency services at our network and neighbouring proposed. Hubs are shown in map below.



Dorset and Wiltshire Vascular Surgery Services
Average Blue-light drive times to all Vascular Surgery Hub Sites (Dorset and Wiltshire)

Drive Times

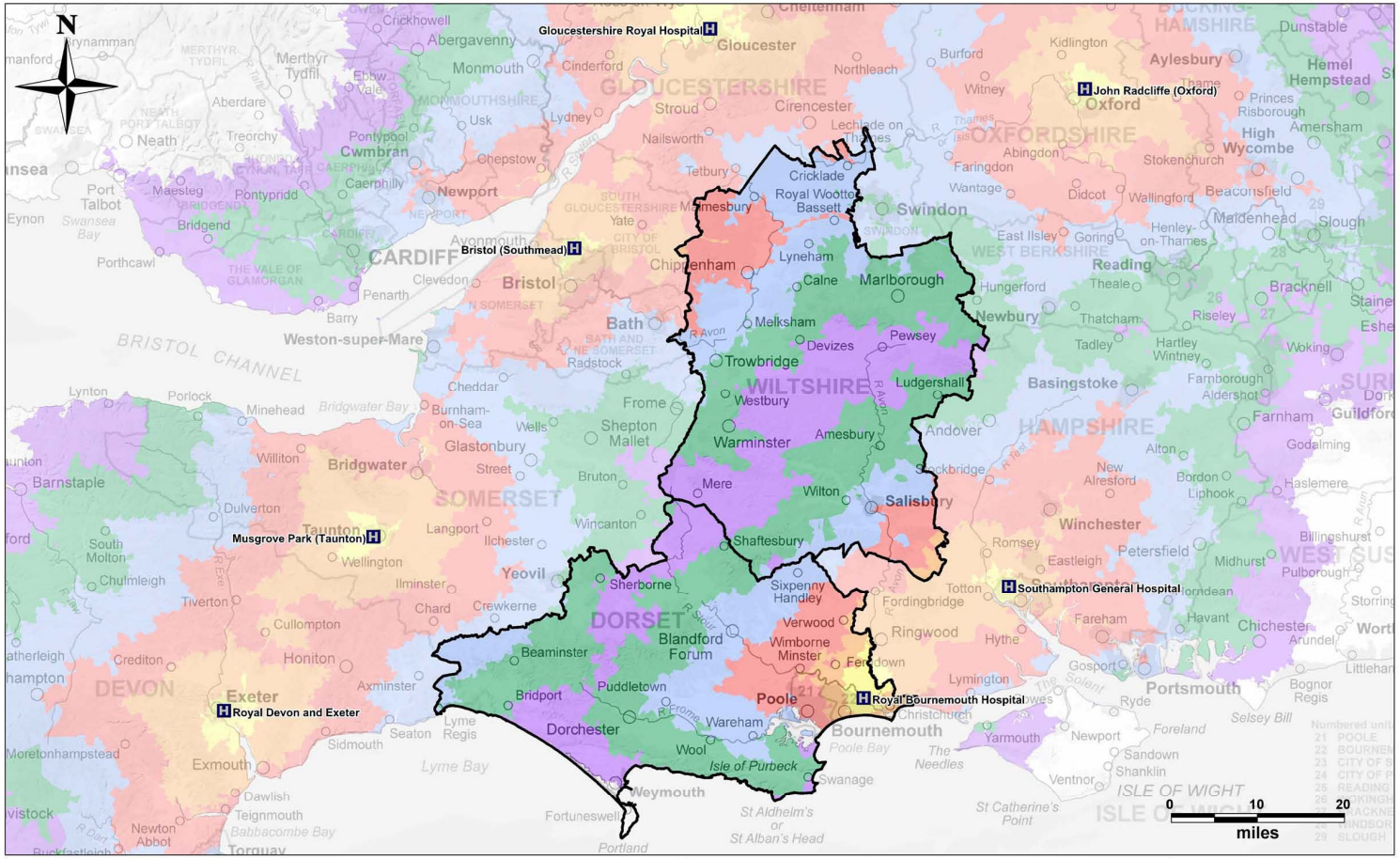
- 75 to 90 Mins
- 60 to 75 Mins
- 45 to 60 Mins
- 30 to 45 Mins
- 15 to 30 Mins
- 0 to 15 Mins
- Vascular Surgery Site
- Dorset and Wiltshire

Avon IM&T Consortium NHS

Trevor Foster - 10 December 2012

X:\Wiltshire\Public Health\Vascular Surgery Access v3 (SV)\

Average drive times for patients and carers accessing network and neighbouring proposed hubs are shown in map below.



Dorset and Wiltshire Vascular Surgery Services

Average drive times to all Vascular Surgery Hub Sites (Dorset and Wiltshire)

Drive Times

- 75 to 90 Mins
- 60 to 75 Mins
- 45 to 60 Mins
- 30 to 45 Mins
- 15 to 30 Mins
- 0 to 15 Mins
- Vascular Surgery Site
- Dorset and Wiltshire

Avon IM&T Consortium NHS

Trevor Foster - 10 December 2012

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Wiltshire Health Overview & Scrutiny Committee
Briefing FOR INFORMATION
Potential Re-provision of RNHRD Neuro-Rehabilitation Service

NHS
South of England
Specialised Commissioning Group

NHS
Bath and
North East Somerset

Re: Provision of Neuro-Rehabilitation at the Royal National Hospital for Rheumatic Diseases
OSC Briefing: For Information & Comment

PCT Sponsoring Director/s:	Jennifer Howell, Interim CEO, NHS Bath and North East Somerset (B&NES) & NHS Wiltshire Cluster Dominic Tkaczyk, Interim Director of Finance, NHS B&NES & NHS Wiltshire Cluster Sarah McLennan, Head of Communications, NHS Wiltshire Susan Lambert, Patient Engagement Manager, NHS Wiltshire
Specialised Commissioning Team:	Sue Davies, Acting Director of Commissioning, South of England Specialised Commissioning Group, South West Team Angela Hibbard, Acting Director of Finance, South of England Specialised Commissioning Group, South West Team Arthur Ling, Lead Commissioner for Specialised Neuro-Rehabilitation Services, South of England Specialised Commissioning Group, South West Team Lou Farbus, Head of Public & Patient Engagement, South of England Specialised Commissioning Group, South West Team

1 Purpose of the Report

1.1 To report to Wiltshire Health Overview & Scrutiny Committee:

- the response of the South of England Specialised Commissioning Group (South West Team) to the Royal National Hospital for Rheumatic Diseases (RNHRD's) recent announcement that it is expressing a preference to cease providing its neuro-rehabilitation service; an issue on which it will engage with patients, the public and all relevant stakeholders.

2 Decisions / Actions Requested

2.1 Wiltshire Health Overview & Scrutiny Committee is asked to note:

- patients needing this service will continue to be treated. The NHS will continue to provide high quality neuro-rehabilitation services for those who need them;
- patients from outside the area who need less complex neuro-rehabilitation are increasingly being treated near to where they live;
- as a result, referrals, particularly from outside the region, have consistently reduced;
- there have been no issues regarding quality or safety;

- all options for re-provision of the neuro-rehabilitation service will be explored and a decision made following a full programme of engagement;
- commissioners' intention to work with key stakeholders, including patients and the public as well as potential providers to identify the best way for patients from the south west to continue to receive high quality, specialised neuro-rehabilitation services in future.

3 Background

3.1 The RNHRD in Bath specialises in Rheumatology, Neurological Rehabilitation, Fatigue Management and Chronic Pain. As the smallest Foundation Trust in the country it is currently addressing significant financial challenges. It therefore needs to consider carefully the future of any service where patient referrals are reducing.

3.2 The neuro-rehabilitation service provides care for patients requiring either specialised or non–specialised (less complex) care. RNHRD has experienced a steady decline in patient numbers over the last few years, with patients from outside the area particularly, being treated closer to where they live. There have also been new pathways for some of the non–specialised patients. These are appropriate and reflect ongoing changes in the way care is delivered.

3.3 The table below shows that the trend of reduced patient numbers is not the case for specialised patients, but that the numbers of these patients in any year across the South West and for individual PCTs is low. The table shows the number of patients requiring specialised care over the last 3.5 years (**N.B. the figures for 2012/13 are for 6 months only**). The overall change in demand however has meant that the income for the service has reduced by almost 50% over this period. The service went from a peak in August 2010 when the unit provided 578 occupied bed days to August 2012 when activity had reduced to 192 occupied bed days. This has led to the service becoming unsustainable and the Trust's proposal to cease providing it, which is recognised by commissioners.

Primary Care Trust Population / Year	**09-10**	**10-11**	**11-12**	**12-13**	**Grand Total**
BATH AND NORTH EAST SOMERSET	13	20	20	12	65
BOURNEMOUTH & POOLE	0	1	0	0	1
NORTH SOMERSET	2	0	1	0	3
SOUTH GLOUCESTERSHIRE	3	1	2	2	8
SWINDON	3	0	0	0	3
BRISTOL	2	1	1	1	5
CORNWALL & ISLES OF SCILLY	0	0	1	0	1
DEVON	1	0	0	3	4
DORSET	0	1	0	0	1
GLOUCESTERSHIRE	0	0	3	1	4
SOMERSET	1	2	4	3	10
WILTSHIRE	6	4	2	7	19
HAMPSHIRE	16	13	9	1	39
All OTHER PCT's	8	5	6	0	19
Grand Total	**55**	**48**	**49**	**30**	**182**

4 Next Steps

4.1 As the services provided at the RNHRD include specialised and non-specialised aspects of care the commissioners at the South of England Specialised Commissioning Group (South West Team) and NHS B&NES will work together to identify and evaluate all possible options for how (respectively) the specialised and non-specialised aspects of the Neurological Rehabilitation service can be re-provided.

4.2 We are aware of other providers that may be able to provide the service and will explore all options with them to ensure continuity of a high quality, specialist service. The team will endeavour to ensure that other providers have sufficient capacity and expertise to cope with any increase in complex referrals.

4.3 Following these discussions the specialised commissioning team will be in a position to outline the options to the public, patients and carers so their views can inform the preferred option for re-provision that will be brought to overview and scrutiny colleagues for their consideration. Hence, a programme of public and patient engagement will be designed around the options for re-provision and targeted at the populations most affected by any potential change in the location of the service.

4.3 Meanwhile, RNHRD will continue to provide the service until a decision is taken, and will lead on meeting its duties to involve the public and scrutiny colleagues concerning the proposal to cease providing the service, while the SWSCT and NHS Wiltshire will meet these responsibilities in relation to re-provision of the service.

5 Recommendations

5.1 Wiltshire Health Overview & Scrutiny Committee is asked to note:

- patients needing this service will continue to be treated. The NHS will continue to provide high quality neuro-rehabilitation services for those who need them;
- patients from outside the area who need less complex neuro-rehabilitation are increasingly being treated near to where they live;
- as a result, referrals, particularly from outside the region, have consistently reduced;
- there have been no issues regarding quality or safety;
- all options for re-provision of the neuro-rehabilitation service will be explored and a decision made following a full programme of engagement;
- commissioners' intention to work with key stakeholders, including patients and the public as well as potential providers to identify the best way for patients from the south west to continue to receive high quality, specialised neuro-rehabilitation services in future.

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Wiltshire Council

Health Select Committee

17 January 2013

Abdominal Aortic Aneurysm (AAA) Screening Programme

Executive summary

This paper is to inform the Health Select Committee about the AAA screening service for Wiltshire.

Proposal

That the committee:

Notes the creation of an AAA screening service for Wiltshire males aged 65.

Reason for proposal

The offer of screening scans for AAA to Wiltshire males aged 65 began in November 2012.

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Abdominal Aortic Aneurysm (AAA) Screening Programme

Purpose of report

1. This paper is to inform the Health Select Committee about the AAA screening service for Wiltshire.

Background

2. The aorta is the largest artery in the body, extending from the left side of the heart down into the abdomen. The abdominal aorta (the part of the aorta that runs through the abdomen) can sometimes develop an aneurysm. This is a localised weak spot that causes part of the artery to swell like a balloon. Aneurysms are more common in men, in people with high blood pressure and in those over the age of 65.

3. Most aortic aneurysms are asymptomatic until they are on the point of rupturing. Some patients have their condition detected during imaging processes for an unrelated cause, but most present as a rupture. The only treatment currently for this condition is surgery which requires a vascular surgeon, as well as the skilled attention from medical and nursing staff in the operating theatre, in intensive care and on the surgical ward.

4. Deaths from a ruptured AAA account for an estimated 2.1% of all deaths in men aged 65 and over. This compares with approximately 0.8% in women of the same age. Mortality from rupture is high, with nearly a third dying in the community before reaching hospital. Of those who undergo AAA emergency surgery, the post-operative mortality rate is around 50%, making the case fatality after rupture 82%. This compares with a post-operative mortality rate in high quality vascular services of 3-8% following planned surgery.

5. Over the 5 years from 2007 to 2011, on average, 23 Wiltshire men died each year from a ruptured AAA.

6. In 2008, the Department of Health announced the introduction of a National Abdominal Aortic Aneurysm Screening Programme (NAAASP) for men aged 65. Phased implementation nationally commenced in March 2009.

Wiltshire's AAA Screening Programme

7. As part of the National AAA Screening Programme, and in accordance with the wishes of Wiltshire GPs, Public Health Wiltshire has worked with NHS Dorset to provide an AAA screening service for Wiltshire and Dorset males aged 65.

8. NHS Wiltshire, NHS Dorset and NHS Bournemouth and Poole agreed to jointly commission a provider for the AAA screening service. A competitive tender process was undertaken, with Salisbury NHS Foundation Trust (SFT) awarded the contract in April 2012. Subsequently, SFT procured appropriate specialist imaging equipment, recruited and trained screening staff, and began to invite patients for screening in November.

9. The screening programme is run from an administrative hub at SFT and screening scans are performed locally, in community settings around the counties of

Dorset and Wiltshire. Separate clinics will be held at HMP Erlestoke for Wiltshire prisoners who meet the eligibility requirements for screening.

10. Depending on the results of their screening scan, men will follow one of these pathways:

a. Normal result (Aorta < 3cm) = no further scans required.
b. Small AAA (Aorta 3 – 4.4cm) = repeat scan in one year.
c. Medium AAA (Aorta 4.5 – 5.4cm) = repeat scan in 3 months.
d. Large AAA (Aorta ≥ 5.5cm) = refer to surgeon in vascular network to consider elective repair of AAA.

11. Where possible, natural patient flows in Wiltshire will be maintained, with patients being referred to their nearest appropriate hospital for elective surgery, if required.

Equality and diversity impact

12. Following recommendations by the National Screening Committee, on the 4th January 2008, the Secretary of State for Health announced the introduction of a national screening programme for men aged 65. Not implementing an AAA screening programme would have led to inequity for the Wiltshire population.

Risk assessment

13. Not implementing the AAA Screening Programme would result in undetected AAAs rupturing, with the consequent risk of death for patients.

14. Not implementing the AAA Screening Programme would have placed Wiltshire as an outlier in not providing this service and thus at risk of public and other challenges.

Financial implications

15. There are no financial implications for Wiltshire Council as full funding for the first 18 months of screening is provided by the Department of Health, with subsequent funding from the NHS National Commissioning Board.

16. There are not expected to be overall financial savings for the NHS associated with the NAAASP. The Department of Health decision to implement the NAAASP was based on the reduction in AAA-related deaths from trials and the expectation was not that it would be a cost saving exercise.

Conclusion

17. There is an AAA screening service for Wiltshire males aged 65.

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RUH

Royal United Hospital Bath NHS

NHS Trust

Partner Update – RUH Bath

Best in class hyper-acute stroke services now available for Wiltshire residents

There has been much in the press recently relating to the need for 7 day health services and the National Audit office conducted an analysis which found that 350 people unnecessarily die within seven days of their stroke simply because they were admitted at the weekend. The RUH's stroke service has been recognised as amongst the best in the country according to the Dr Foster report 2011 and the National Stroke Audit 2012. Its stroke research team also won a highly commended award from the National Institute for Health Research in 2012. It is now delighted to report that it received a grant from the local stroke network in 2012 for a pilot of 7 day stroke therapy. This commenced in September 2012 and is proving very successful. In April 2013, a 7 day TIA (ministroke) clinic will also be starting which will help prevent local people going on to suffer the consequences of a full stroke.

Significant investment in dementia care

The Royal United Hospital Bath, together with partners in Wiltshire and BaNES, has been successful in its £450,000 application to the NHS South Dementia Challenge fund. The CQUIN PLUS: Integrating hospital and community care pathways project is led by Dr Chris Dyer, consultant Geriatrician. The aim is to implement and evaluate an innovative pathway of care for patients with dementia based on best practice. This includes; access to the right staff and skills 7 days per week including a much increased mental health liaison service, improved timeframes for assessment and intervention, and puts carers at the heart of the service. In addition the project will ensure an optimal environment using care bundles and technological solutions, alongside follow up pathways which support carers and avoid readmission. The RUH is working closely with, among others, Wiltshire Council, Alzheimer's Support and the Alzheimer's Society and the intention is to ensure the RUH is recognised as the best hospital in the UK for the quality of its dementia care.

Specialist vascular services review

Changes in the NHS landscape from 1st April 2013 will bring vascular services under the remit of commissioning by the NHS Commissioning Board through their Bristol, North Somerset, Somerset & South Gloucestershire Area Team. To ensure consistent standards of care are achieved, the Commissioning Board have recently published national service specifications. These standards encourage networking of hospitals to achieve the scale of activity which will support dedicated specialist vascular expertise and best-

practice 24/7 provision. These changes will impact on all providers of vascular services. RUH Bath has now commenced its review of vascular provision in a network with Bristol Hospitals. Over the following 3-6 months it will be seeking to establish the most appropriate model for future delivery - which complies with national specifications whilst maintaining sufficient capacity, quality of associated services eg stroke and accessibility for the populations it serves. RUH has traditionally been a leader in key fields of vascular surgery and interventional radiology. It will be working with CCGs and seeking the views of Wiltshire stakeholders across the review period to ensure that the highest quality of services and experience for patients is maintained into the future.

From February 2013, an interim 24/7 on-call rota, specific to emergency vascular surgery, has been arranged with Bristol in order to maintain compliance with national guidelines pending completion of the review. This will mean that, where appropriate, some emergency treatment of Wiltshire patients has the potential to take place in Bristol where a specialist on-call surgeon will always be based. When patients have recovered from their procedure, care will be transferred back to Bath or the community as appropriate.

UPDATE FROM THE SALISBURY HOSPITAL FOUNDATION TRUST

PATIENT EXPERIENCE

Patients' experience of hospital care is important to us as it enables us to identify where we do well and where we need to make changes. It is also increasingly being seen as a way of assessing standards of care in individual hospitals. People needing emergency treatment have rated the Accident and Emergency (A&E) Department at Salisbury District Hospital as one of the best in the country, with confidence in staff, privacy, and patient's experience rated highly in an independent Care Quality Commission (CQC) survey *(please see local results attached)*. This follows good survey results relating to inpatient and outpatient care last year.

PIONEERING CARE AND TREATMENT FOR MILITARY PERSONNEL

Surgeons at Salisbury District Hospital carry out pioneering reconstructive surgery on soldiers who have been injured in Afghanistan and Iraq and, together with nurses, therapists and support staff in plastic surgery and on Laverstock ward, provide a wide of range of care to military personnel. Recognition for this work was reflected in consultant surgeon Rod Dunn being named Healthcare Civilian of the Year by UK health departments and the Ministry of Defence in the Military and Civilian Health Partnership Awards and staff on Laverstock Ward receiving a Hero award from national charity Help for Heroes.

VASCULAR SERVICES AT SALISBURY DISTRICT HOSPITAL

As mentioned before, the Vascular Society of Great Britain and Ireland is recommending that vascular treatment should take place in specialist centres and, in line with other parts of the country, our commissioners are considering a 'hub and spoke' model. This would mean that services currently provided by the Trust at Salisbury District Hospital would move to Bournemouth. Further to the initial briefing, having raised concerns within the clinical network, other options are now being considered alongside the initial recommendation, which includes one which has Salisbury as the centre. Discussions are ongoing and any final decision has now been delayed, together with an implementation date which is likely to be put back to 2014.

NEONATAL INTENSIVE CARE UNIT AT SALISBURY DISTRICT HOSPITAL

Specialist commissioners have been considering a proposal to downgrade the Trust's Neonatal Intensive Care Unit (NICU) to a Special Care Baby Unit which means that we would see less pre-term high risk babies. This proposal is based on British Association of Perinatal Medicine guidelines and nursing and healthcare professional staffing models used at Salisbury. While the commissioners are satisfied with the Trust response to these issues, they have since raised an issue about the Trust's medical staffing model. The Trust believes that it is not only compliant, but provides more extensive cover than is required. If unsuccessful, Wiltshire families will have to travel further to other hospitals to access services we currently provide to a very high standard from a newly refurbished, modern facility in Salisbury.

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PEOPLE'S EXPERIENCES OF ACCIDENT AND EMERGENCY SERVICES

During 2012, the Care Quality Commission sent a questionnaire to 850 people who had attended an NHS accident and emergency department (A&E). Based on patients' responses to this survey, each Trust that took part was given a rating of 'Better', 'About the same' or 'Worse' **compared to other trusts**. Local results are detailed below.

	DORSET COUNTY HOSPITAL NHS FT	GLOUCESTERSHIRE HOSPITALS NHS FT	HAMPSHIRE HOSPITALS NHS FT	POOLE HOSPITAL NHS FT	ROYAL UNITED HOSPITAL BATH	SALISBURY NHS FT	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS	UNIVERSITY HOSPITAL SOUTHAMPTON	YEOVIL DISTRICT HOSPITAL
Travel by ambulance	9.6/10 BETTER	9.2/10 ABOUT THE SAME	9.3/10 ABOUT THE SAME	9.3/10 ABOUT THE SAME	9.6/10 BETTER	9.6/10 BETTER	9.2/10 ABOUT THE SAME	8.9/10 ABOUT THE SAME	9.2/10 ABOUT THE SAME
Reception and Waiting	6.9/10 BETTER	6/10 ABOUT THE SAME	6.3/10 ABOUT THE SAME	6/10 ABOUT THE SAME	6.7/10 BETTER	6.6/10 BETTER	5.9/10 ABOUT THE SAME	6/10 ABOUT THE SAME	6/10 ABOUT THE SAME
Doctors and Nurses	8.4/10 BETTER	7.9/10 ABOUT THE SAME	8.3/10 ABOUT THE SAME	8.4/10 ABOUT THE SAME	8.2/10 ABOUT THE SAME	8.6/10 BETTER	8/10 ABOUT THE SAME	7.9/10 ABOUT THE SAME	8/10 ABOUT THE SAME
Care and Treatment	8.3/10 ABOUT THE SAME	8.1/10 ABOUT THE SAME	8.5/10 ABOUT THE SAME	8.5/10 BETTER	8.4/10 ABOUT THE SAME	8.8/10 BETTER	8.1/10 ABOUT THE SAME	8/10 ABOUT THE SAME	8.2/10 ABOUT THE SAME
Tests	8.6/10 ABOUT THE SAME	7.9/10 ABOUT THE SAME	8.5/10 BETTER	8.3/10 ABOUT THE SAME	8.3/10 ABOUT THE SAME	8.8/10 BETTER	8.3/10 ABOUT THE SAME	8.5/10 ABOUT THE SAME	8.3/10 ABOUT THE SAME
Hospital Environment and Facilities	8.5/10 ABOUT THE SAME	8.1/10 ABOUT THE SAME	8.3/10 ABOUT THE SAME	8.3/10 ABOUT THE SAME	8.3/10 ABOUT THE SAME	8.7/10 BETTER	8/10 ABOUT THE SAME	8.1/10 ABOUT THE SAME	8/10 ABOUT THE SAME
Leaving the A&E Department	6.6/10 ABOUT THE SAME	5.8/10 ABOUT THE SAME	6.6/10 ABOUT THE SAME	6.6/10 ABOUT THE SAME	6.8/10 ABOUT THE SAME	7.2/10 BETTER	6/10 ABOUT THE SAME	6.2/10 ABOUT THE SAME	6.4/10 ABOUT THE SAME
Overall views on experience	7.1/10 ABOUT THE SAME	7.1/10 ABOUT THE SAME	7.3/10 ABOUT THE SAME	6.8/10 ABOUT THE SAME	6.9/10 ABOUT THE SAME	7.5/10 BETTER	7/10 ABOUT THE SAME	6.5/10 ABOUT THE SAME	6.5/10 ABOUT THE SAME

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Update from Age Concern in relation to services which complement local NHS podiatry services.

Age UK Wiltshire has run a basic nail cutting service for the last seven years. This is not a podiatry service but aims to offer the kind of support that a caring relative or friend might offer an older person who is experiencing difficulty with this task. Toe nails that are too long can mean that a person may end up wearing poorly-fitting footwear which in turn can contribute to falls. The risks of falling to older people are well known and any service that can contribute to reducing that risk is valuable.

Older People themselves campaigned for an affordable nail cutting service through their older people's forums, as the eligibility criteria for the NHS Podiatry Service became tighter and the cost of using private podiatry services for simple nail cutting were considered excessive. Age UK Wiltshire has worked in partnership with Housing Associations and the Order of St John Care Trust who have provided premises for the running of the nail cutting clinics. The service was supported in the start-up phase by the NHS Podiatry Service who provided training in nail cutting techniques for staff and volunteers, but with the additional pressures they now experience Age UK Wiltshire now have to source this training from a private podiatry practice.

Age UK Wiltshire run clinics in 14 different locations, either fortnightly, three-weekly or monthly. The cost is £10 per attendance, in addition there is a one-off cost of £7 when people start to use the service for the clippers and file which each service user will bring with them to their appointments. The service is supported through Wiltshire Council and NHS Wiltshire. Age UK Wiltshire currently has approximately 350 people using the service attending on average every 8 weeks. They are not able to cut the toe nails of anyone who is diabetic or for people who are taking warfarin or certain other anti-coagulant drugs.

The feedback from service users show that they appreciate being able to access the service and how much difference it can make to an individual when their feet are comfortable. Further information about the service can be obtained from the main office in Devizes 01380 727767.

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