Wiltshire Council
Where everybody matters

# AGENDA

**Meeting**: Health Select Committee

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

**Date**: Tuesday 6 May 2014

**Time:** **10.30 am**

Please direct any enquiries on this Agenda to Kirsty Butcher, of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line (01225) 713948 or email kirsty.butcher@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 Chris Caswill
Cllr Mary Champion
Cllr Christine Crisp (Chair)
Cllr Mary Douglas
Cllr Bob Jones MBE
Cllr Gordon King
Cllr Dr Helena McKeown
Cllr John Noeken (Vice Chairman)
Cllr Jeff Osborn
Cllr Sheila Parker
Cllr Nina Phillips
Cllr Pip Ridout
Cllr Ricky Rogers

**Substitutes:**

Cllr Pat Aves
Cllr Chuck Berry
Cllr Rosemary Brown
Cllr Terry Chivers
Cllr Dennis Drewett
Cllr Sue Evans
Cllr Russell Hawker
Cllr David Jenkins
Cllr Julian Johnson
Cllr John Knight
Cllr Ian McLennan
Cllr Helen Osborn
Cllr Mark Packard

**Stakeholders:**

| | |
|---|---|
| Steve Wheeler | Healthwatch Wiltshire |
| Diane Gooch | 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 11 March 2014.

3 **Declarations of Interest**

To receive any declarations of disclosable interests or dispensations granted by the Standards Committee.

4 **Chairman's Announcements**

To note any announcements through the Chair.

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 **Friday 25 April 2014**. 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.

6a **Performance report on NHS 111**

At its meeting on 11 March the Committee received a report on the NHS 111 performance from the CCG. The Committee was concerned about what it heard and asked the CCG to return to its next meeting with updated

performance figures.

Patrick Mulcahy, Associate Director of Commissioning for Urgent Care, CCG will be in attendance to present the report and answer questions.

6b **Meeting with Harmoni re NHS 111**

Following the meeting on 11 March, the concerns of the Committee were reported in the local media. These reports were picked up by Harmoni, providers of the NHS 111 service in Wiltshire, and as a result they requested a meeting. An invitation was extended to all members of the Committee and on 23 April, 4 members, including the Chair and Vice Chair, met with 3 representatives with Harmoni.

Cllr John Noeken will provide a verbal update.

7 **Development of the Bath, Bristol and Weston Vascular Network - recommended model of care for approval** *(Pages 21 - 46)*

Vascular services are a specialised service and, as such, are commissioned by NHS England. Wiltshire is served by three hospitals, each of which falls within a separate Vascular Network. Salisbury Hospital is in the Dorset Vascular Network, Great Western Hospital in the Gloucestershire and Swindon Vascular Network and the RUH in the Bath, Bristol and Weston Vascular Network.

The report presented relates to the proposed changes to the Bath, Bristol and Weston Vascular Network only, although reference is made to the two other networks.

Members had concerns about proposed changes to the vascular service in January 2013 and wrote to the Director of the local NHS England team in February 2013 to voice their concerns. The report attached addresses those concerns.

The Committee is asked to consider the report and specifically the recommendations under paragraph 10 of the report.

Steve Sylvester, NHS England BNSSSG Area Team Head of Specialised Commissioning in the SW, Lou Farbus, NHS England BNSSSG Area Team Head of Stakeholder Engagement for Specialised Commissioning in the SW, Debbie Hart, NHS England BNSSSG Area Team, Lead Service Specialist for Specialised Commissioning in the SW (i.e. our lead commissioner for vascular services), Marcus Brooks, Consultant Vascular Surgeon, University Hospital, Bristol representing Bath, Bristol, Weston Vascular Network and Johnathon Earnshaw, Consultant Vascular Surgeon Cheltenham General Hospital representing Swindon, Gloucestershire Vascular Network will attend to present the report and answer questions.

8 **Continence Services Task Group - final report** *(Pages 47 - 64)*

The Continence Services Task Group was established in October 2013 following a rapid scrutiny exercise which highlighted concerns about the provision of continence products following the implementation of a new contract.

The chairman of the Task Group, Cllr Jeff Osborn, will attend to present the report (attached).

The Committee is asked to endorse the Task Group's report and refer the recommendations to the relevant executive bodies for response.

9 **Wiltshire figures for delayed transfer to care** *(Pages 65 - 72)*

At its meeting on 11 March the Committee expressed an interest in receiving the figures for delayed transfers to care and requested that reports on the latest figures should be provided at each of the next three Committee meetings.

Cllr Keith Humphries will attend to present the latest figures for delayed transfer to care.

The Committee is asked to note the report and comment as appropriate.

10 **Older People Accommodation Development Strategy - update** *(Pages 73 - 78)*

In January 2011, the Cabinet approved a 10 year development strategy to modernise and improve the way that older people's accommodation is provided, develop and adopt an integrated accommodation system, ensure the best use of increasingly scarce resources and respond to local needs in local communities.

An update report on the Older People Accommodation Development Strategy is provided. The Committee is asked to note its content and comment as appropriate.

11 **Mental Health Strategy - update** *(Pages 79 - 82)*

The Council has been working with the CCG to develop a community centred joint five year Mental Health Strategy.

An update report on the work so far is attached. The draft Strategy will be submitted to the Committee once it has been completed, after which it will go out to formal consultation.

Cllr Keith Humphries will attend to present the report. The Committee is asked

to note the report.

12 **CQC inspection of AWP - 9 June 2014** *(Pages 83 - 84)*

The Committee has received a letter from the CQC (attached) which sets out its inspection programme for April – June 2014. In Wiltshire, the CQC intends to inspect only one organisation, the Avon & Wiltshire Mental Health Partnership NHS Foundation Trust (AWP). The inspection will start on 9 June.

The letter asks the Committee to share any feedback which is relevant about the quality of care provided by AWP and any of the services it provides.

Any member of the Committee who wishes to reply individually can email mhinspections@cqc.org.uk, ensuring that the subject line of the email is:
Avon & Wiltshire Mental Health Partnership NHS Foundation Trust Q1 Mental Health Inspections.

13 **Committee Membership**

It is usual for full Council to review Committee membership in May. In line with this, and following consultation with the Chairman and Vice Chairman, the non-voting stakeholder membership of the Committee has been reviewed. There is a wish to see stakeholders on the Committee who represent registered bodies that reflect the demographics in Wiltshire.

The following non-voting stakeholder membership is proposed:
Wiltshire Healthwatch - Steve Wheeler
Wilshire and Swindon Users' Network (WSUN) – Diane Gooch
Age UK - tbc
Alzheimer's Society - tbc
SWAN Advocacy - Irene Kohler

14 **Task Group Update**

To note verbal updates on Task Group activity.

15 **Forward Work Programme** *(Pages 85 - 86)*

The Committee is asked to consider the work programme.

16 **Urgent Items**

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

17 **Date of Next Meeting**

The Committee is asked to note the date of the next meeting, which is Tuesday 15 July at 10.30am in the Kennet Room, County Hall, Trowbridge.

## PART II

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

None.

Wiltshire Council
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# HEALTH SELECT COMMITTEE

## MINUTES OF THE HEALTH SELECT COMMITTEE MEETING HELD ON 11 MARCH 2014 AT KENNET ROOM - COUNTY HALL, TROWBRIDGE BA14 8JN.

**Present:**

Cllr Mary Champion, Cllr Christine Crisp (Chair), Cllr Bob Jones MBE, Cllr Gordon King, Cllr Helena McKeown, Cllr John Noeken (Vice Chairman), Cllr Jeff Osborn and Cllr Pip Ridout

18 **Apologies**

Apologies were noted from the following:

Cllr Mary Douglas
Cllr Sheila Parker
Cllr Nina Phillips
Cllr Ricky Rogers
Cllr Keith Humphries

Steve Wheeler – Healthwatch Wiltshire
Diane Gooch – Wiltshire and Swindon Users Network
Irene Kohler - SWAN Advocacy
Brian Warwick – Advisor on Social inclusion for Older People
Kevin McNamara – Great Western Hospital
Steve Rowlands – Wiltshire Clinical Commissioning Group
Debbie Fielding - Wiltshire Clinical Commissioning Group

19 **Minutes of the Previous Meeting**

The minutes of the previous meeting held on 14 January 2014 were presented and it was:

**Resolved:**

**To sign and agree the minutes of the previous meeting as a true and accurate record.**

20 **Declarations of Interest**

There were no additional Declarations of Interest made at the meeting. The Committee noted the standing declarations made by members at previous meetings.

21 **Chairman's Announcements**

The Health Select Committee were very sad to hear of the death of Ken Parker, Cllr Sheila Parker's husband, and passed on sincere condolences to Sheila and her family of behalf of the Committee.

The Chair noted that the Health and Wellbeing Strategy was launched at County Hall on 12 February and, at the launch, the Better Care Plan was also signed and was subsequently sent to the Department of Health for approval.

The Chair announced that, following a tendering exercise, the Community Maternity Contract currently held by Great Western Hospital had been awarded to the Royal United Hospital in Bath. The new contract would be effective from June 2014 and run for 3 years.

The Chair discussed the recent workshop held in February, to gain stakeholders views and insights to feed into the national 5 year strategy for NHS England specialised commissioning, which is currently being developed.

The Chair discussed the Cabinet Transformation Committee working groups that had been established to develop a strategic framework for engaging health partners in hubs, campus development and future estates management to ensure that the Council can make the most of the opportunities to work closely with our health partners. The Transformation Committee will be receiving a paper on 'Transformation and Health' at its meeting on 18 March, and members of the Committee were encouraged to attend the sessions.

The Vice Chair, Cllr Noeken, gave a brief update of the Joint Health Overview and Scrutiny Committee for the South Western Ambulance Service (SWAS) that was attended by the Vice Chair and Cllr Ridout. Members were invited to attend the next Joint Scrutiny event to be held at County Hall on 11 April 2014, as the Committee was entitled to 3 members on the Joint Committee, with currently only 2 places occupied.

The Chair also discussed the invitation to attend a stakeholder event in respect of vascular services at Bradford on Avon in the week preceding the Committee, It was noted that at the meeting it was clarified that the service specification for the vascular service cannot be changed, but the local NHS England team was keen to know what local people think about the proposal and to learn from their experiences of vascular services so that their insights and ideas can inform the thinking of commissioners before final decisions were taken about how best to develop the service. Comments on the proposals can be fed back to Tracy Torr at the Wiltshire CCG.

22 **Public Participation**

There were no questions submitted to the Committee and no members of the public expressed a desire to speak.

23 **Royal United Hospital**

James Scott, Chief Executive at RUH Bath, gave a presentation to the Health Select Committee detailing the recent outcome of the CQC Inspection. Mr Scott focussed on the changes in the inspection methodology, and detailed which areas of the Hospital had been examined under the new regime. Mr Scott expressed great pleasure in the findings of the report. As the RUH was a pilot Hospital under the new inspection regime, they were not given an official rating. However, they were informed that they would have received a rating of 'good', so this enables them to apply for Foundation Trust status.

James Scott outlined the inspection teams and the approach adopted by the CQC and the areas that were reviewed during the January inspections. It was stated that more work would be needed regarding the discharge of patients with complex care needs, and that the RUH was working with health partners in the county to address the concerns raised in the report. The Committee were informed of the areas of good practice identified by the CQC. James Scott introduced Dr Tim Craft, Medical Director at RUH who then outlined the areas for improvement highlighted by the CQC.

The Committee offered its congratulations to RUH and welcomed the news of improvements in performance. The Committee questioned the current discharge arrangements in place, and how it was planned they be improved. The primary issues were said to be discharging patients with complex care requirements such as the frail elderly. The RUH was looking to engage all services in the area to ensure that complex care needs could be met.

The Committee questioned the difference in treatment requirements of patients using RUH. It was clarified that the average Wiltshire patient stayed 2 days longer than patients from Bath and North East Somerset. The Committee then discussed the care model developed at RUH and the benefits of 'clinical villages'. Such benefits were said to be advantageous for co-locating staff and services and utilisation of specialist nursing staff. The Committee then discussed wages and salaries paid by RUH, discussing low paid nursing staff and minimum wage staff. It was clarified that all staff are paid in line with the 'Agenda for Change' guidelines. They have also formed a new focus group for cleaning staff.

The Committee discussed the development of the Coombe Ward and praised the way in which the staff on the ward delivered care and the manner in which they conducted their duties. The Committee discussed the £500k cost of the refurbishment of the ward and the number of beds (160) available to elderly patients on the ward. The Committee then discussed mortality rates, and the disparity in findings between Salisbury District Hospital and RUH, focussing in particular on the difference in the recording of patient deaths in hospice care. There was a debate on the Hospital Standardised Mortality Rate, and the difference in categorisation of hospice care arrangements at each hospital.

The Committee then discussed the ethics of recruitment of overseas nursing staff, and the impact on care and patients. It was clarified that RUH felt the training afforded to all its overseas nursing recruits ensured a staff and professional standard of care to its patients, and re-affirmed the difficulty in recruiting and training UK and EU nurses under current financial limitations.

The Committee discussed improvements in the Delayed Transfer of Care figures, and agreed that the figures should be monitored.

**Resolved:**

**To monitor the Delayed Transfer of Care (DToC) figures for the regions acute hospitals on a bi-monthly basis.**

24 **South Western Ambulance Service Foundation Trust Performance**

The Committee welcomed Neil Le Chevalier, Deputy Director of Delivery and Paul Burkett-Wendes, Head of Operations (North) to present a report to the Committee on how the Ambulance Service was performing in Wiltshire and how they were trying to reduce admissions to hospitals.

The presentation highlighted the differences and difficulties in balancing performance and quality. Neil le Chevalier stated that the Ambulance Trust was meeting its contracted performance standards, but were having difficulty meeting the 8min critical response time in such a rural county.

The categories for performance were clarified, and the performance report outlined. The Committee's attention was drawn to the comments made by Sir Bruce Keogh regarding the performance measures being fit for purpose in rural areas. It was clarified that quality outcomes for performance are measured in addition to the response and speed times.

Neil le Chevalier stated that in order to meet the future demand of the service, the Trust had essentially two options. These were to either:

a) Control the demand for the service and the number of hospital admissions.
b) Increase resources to better manage the increase demand.

It was stated that given current financial constraints, it was unlikely that the Trust could sustainably provide an increased service with regard to increasing the number of ambulance on call. Therefore the trust had no option but to control the demand and number of hospital admissions by better managing patients at the scene and providing structured care arrangements away from the hospital. Given that the trust is experiencing a 5% increase in demand year on year, the current arrangements are putting an ever increasing strain on resources. This was further exacerbated by a spike in the number of referrals from NHS 111.

The Committee discussed the role of community first responders and community defibrillators, to further support the front line ambulance staff tasked with reaching critical emergencies in rural parts of the county. Further discussion was also had on the number of ambulance staff and the level of investment required to meet the projected demand, currently estimated at £1.1 million. The Committee also discussed the increase in demand on the ambulance service over the weekend, with up to a 100% increase in calls over the weekend period. It was stated that an estimated 18 additional ambulances would be required to deal with the increased demand as a result of the substantial rise in the number of service users. SWASFT declined to pass comment on the performance of NHS 111, but noted that a large number of ambulance call outs received via NHS 111 were unnecessary, and placed a burden on the resources of the Ambulance Service.

The Committee then asked further questions on the operations of the Ambulance Service, in particular focussing on the control room and staff retention. The Ambulance service currently had 30 vacancies in the north division. As paramedics are university trained, only 1 cohort is available each year in October. The service will over recruit this year to allow for staff turnover throughout the year. The Committee then reaffirmed the importance of quality outcomes as opposed to quantitative measures, and supported the proposals for Community First Responders.

**Resolved:**

**The Committee agreed to note the performance report from the South West Ambulance Service.**

25 **NHS 111 Performance**

The Committee welcomed Patrick Malcahy, Interim Associate Director of Commissioning for Urgent Care at Wiltshire Clinical Commissioning Group (CCG) to give an update on the performance of NHS 111 and the Harmoni contract.

It was stated that the performance of the NHS 111 contract would be scrutinised in closer detail at the Joint Overview and Scrutiny Event where Harmoni had been invited to update the meeting with its performance data. Patrick Malcahy noted that a large volume in calls to NHS 111 were a result of an increase in the number of people needing access to Primary Care over the weekend, and then contacting NHS 111 where they are not able to access the service at Hospital or GP clinics. This in turn has a knock on effect with regard to the number of calls and subsequently the number of referrals made by the service, ultimately leading to additional strain on ambulances and hospitals. Patrick Malcahy outlined the process of ‘warm transfers’, whereby callers are transferred to a clinically trained call handler to better screen the patients care requirements.

Patrick Malcahy stated that as of April 2014, the Wiltshire and BANES CCG's would have the power to issue financial penalties to Harmoni based on performance data. It was suggested that this may yet lead to improved performance and better management of calls. It was stated that the contract was not performing in line with the required standard for the service, but that the CCG were working with partners and colleagues to improve performance.

The Committee then questioned the KPI's used to measure performance and the clinical outcomes of the service, and whether improvements were showing benefits in the treatment of patients and not how long they were waiting for their call to be answered. The Committee agreed that there were aspects of the service which did not meet requirements of the public nor of the CCG or stakeholders. The Committee expressed a formal vote of no confidence in the NHS 111 service following continued lacklustre performance of the Contract provider, stating that NHS 111 was a 'disaster story', and questioned how the service could resolve its problems before the deadline for financial penalties passes. The Committee noted that the service was placing a strain on other services including A&E and the Ambulance Service, and discussed monitoring the performance of NHS 111 at its future meetings.

Patrick Malcahy stated that whilst performance was below the preferred standard, benchmarking data for the winter pressure period stated that Harmoni had actually performed better than the majority of other NHS 111 providers across the country.

**Resolved:**

1) **To note the report from Wiltshire CCG regarding the performance of Harmoni and the NHS 111 contract.**
2) **To receive performance data on the Harmoni Contract and NHS 111 service at its future meetings in May and July 2014.**

26 **Non-Emergency Patient Transport Service**

The Committee welcomed Andy Jennings, Commissioning Manager (Wiltshire CCG) and Ed Potter, Head of Patient Transport Service South West (Arriva) to present a report on the progress of the Patient Transport Service contract.

A summary of the nature of the type of complaints was given under the contract complaints must be investigated and responded to within 25 days. Most complaints fell into the categories of:

a) Waiting times for collection (from hospital);
b) Ability to make bookings via the website;
c) Errors with bookings

Some explanation was given to the types of complaints made under the aforementioned headings, stating that previously the PTS contract had inherited three different methods of booking and tracking as a result of the three different

Acute Hospitals that the PTS contract serves. This had been somewhat resolved since Arriva had implemented a unified booking system for all Acute Hospitals in the county.

Member's attention was drawn to an action plan developed by Arriva in accordance with Acute Hospitals in the County which allows for better management and monitoring of the service. It was noted that the Acute Hospitals had all independently raised concern regarding the previous service, and that performance had subsequently improved with the number of complaints falling dramatically since the unified service was launched.

Members questioned the eligibility of residents across the County with National Eligibility Criteria providing guidance to Arriva on who is able to use the service. Members also drew concern as to the number of agencies who are unaware of the service, with some care homes and residential homes instead opting to use a taxi service at a far higher cost. At the end of the item, the Committee;

**Resolved:**

**To receive a performance update report from Arriva at the September Meeting of the Health Select Committee.**

27 **Sickness/absence figures for Community Maternity Service**

The Committee reviewed the written Sickness Absence figures for Community Midwifery, and noted that the Service is due to transfer from Great Western Hospital to Royal United Hospital Bath in June 2014.

**Resolved:**

**To note the Sickness Absence figures for Community Midwifery as reported.**

28 **National Child Measurement Programme**

The Committee received a report from John Goodall and Lucy James, Public Health into how the Council is addressing child obesity in Wiltshire.

An overview of the report was made, detailing the Council's statutory responsibility to monitor the health and wellbeing of the region's children. Findings of the National Child Measurement Programme detailed over 9000 school children who had been measured, with 20% of reception aged children classified as 'obese'. The report detailed key figures for Community Areas across the county.

The Committee questioned if the data was inclusive of progressive obesity. Unfortunately the data was not recorded from the same child, so previous measurements did not give an indicator of progression data.

The Committee also discussed the impact of the leisure services activity review and the impact that this would likely have on increasing child obesity levels in and around the County. John Goodall was keen to provide a number of examples of positive initiatives designed to combat the problem of obesity including the 'Active Wiltshire' campaign, along with diet and nutritional advice. Members highlighted the problems with take up in initiatives and stressed the importance of increasing participation, not just increasing participative opportunities.

John Goodall stressed the importance of early intervention and education and information initiatives.

**Resolved:**

**To note the figures and update as reported in the 'Results of the National Childhood Measurement Programme for Wiltshire' 2012 School Year.**

29 **Bristol Royal Hospital for Children**

The Committee received the letters that had been circulated by the Bristol Royal Hospital for Children in relation to the inquest into the death of a Wiltshire child, Sean Turner;

**Resolved:**

**To note the findings and information circulated in the letters regarding the death of Sean Turner and to note that an inquiry is to be held into a number of deaths in the cardiac unit at the Hospital, headed by Sir Ian Kennedy.**

30 **Forward Work Programme**

The Committee received a number of updates on the Forward Work Programme from the Chair.

a) The Overview and Scrutiny Management Committee endorsed the disbanding of the CCG Task Group.
b) The Winter Pressures Task Group that was formed to review the success of the plans put in place to deal with the winter pressures did not sit during winter months. However the mild weather, coupled with additional funding made available from central Government, has meant that the pressures on services over the winter period, both nationally and within Wiltshire, have not been excessive and that services have coped well. It was therefore proposed that there would be little value in the Task Group undertaking the proposed review, and instead requested that members of the Task Group remain as a 'rapid response team' ready to address

any urgent issues the Select Committee believes it should investigate in the near future.

c) The Transfer to Care task Group was incorrectly omitted from the Forward Work Programme, and so an updated FWP was circulated at the meeting.

**Resolved:**

**The Committee agreed to note the Forward Work Programme.**

31 **Task Group Update**

Continence Task Group

A final meeting is being planned which will wrap up the findings of the Task Group, where it is hoped that service users will also have a chance to convey their experiences. It is hoped that a report will be made to the next Health Select Committee.

Transfer to Care Task Group

The next meeting of the Transfer to Care Task Group is to be held in March and will focus on reviewing the progress of the actions taken to reduce delays in transfers to care.

Avon Wiltshire Mental Heath Partnership

Good progress had been made and work completed with RUH on the Dementia Ward. The Task Group also visited and spoke with patients and carers in Salisbury. The Task group wished to thank the work of Irene Kohler in progressing the remit of the Task Group.

Help to Live at Home Task Group

The Help to Live at Home Task Group was awaiting further information from the Associate Director of Adult Care and Housing Strategy before it could progress its scrutiny any further.

**Resolved:**

**To note the updates from Task Groups.**

32 **Urgent Items**

Members were informed of the changes to the NHS England Cystic Fibrosis service. There was relatively little difference in the service, but changes would result in 8 patients in Wiltshire being affected. All patients had been contacted

to explain the changes and, NHS England also welcomed comments from the Committee and patients as to how they think the service could be improved.

33 **Date of Next Meeting**

The Date of the next meeting was confirmed as being Tuesday **6 May 2014**, at 10:30am and would be held in the Kennet Room at County Hall, Trowbridge, Wiltshire BA14 8JN.

(Duration of meeting: 10:30am – 1:30pm)

The Officer who has produced these minutes is Samuel Bath, of Democratic Services, direct line (01225) 718211, e-mail samuel.bath@wiltshire.gov.uk

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

NHS
Wiltshire
Clinical Commissioning Group

# Report on NHS 111 Performance
# 1st November 2013 to 16th February 2014
# for
# Wiltshire Council Health Select Committee
# 11th March 2014

## 1 CONTEXT

The Contract for the delivery of the NHS 111 service was awarded to Harmoni by NHS Wiltshire in July 2012 following a South West procurement process; Harmoni has since been taken over by Care UK Ltd. The NHS 111 service in Wiltshire commenced "soft launch" on 19 February 2013.

As the Health Select Committee are aware, the Performance of the NHS 111 provider in our area was unacceptable during the initial period, and Full Service Commencement was not reached nor a Service Acceptance Certificate issued within the originally anticipated timeframe of March 2013. The CCG Governing Bodies for Wiltshire and Bath and North East Somerset (BaNES) met three times to consider the performance issues and clinical risks; firstly on 24 April 2013, and on 19 June 2013, and then on 17 September 2013 to agree to migrate to Full Services Commencement. The Clinical and Managerial leadership of the CCG were kept fully apprised of developments regarding this service by weekly updates from the Rectification Task Force (which was chaired by Wiltshire CCG and included the other CCGs and established 10 April 2013), and verbal updates in both Governing Body and Executive meetings.

Essentially, given the very poor start of the Service earlier in the year, the Governing Bodies decided to defer the timeline for implementation and the CCGs entered into a Rectification Plan phase with Harmoni in order to remedy the service failures and breaches to date. During this period contingency plans were enacted in order to backstop the service, and at the last meeting of the Joint Governing Body the direction was inter-alia to pursue options to preserve a dedicated Health Care Professional line within the service whilst continuing to work with Harmoni-to bring the Service up to an acceptable standard. This Health Care Professional Line has been in place ever since to provide specified services (such as paramedics, MIU, pathology and Care Homes) and pre agreed patient groups (those on palliative care registers) direct access to the Out of Hours service for clinical advice, and arrange an appointment or visit if required.

The Service reached Full Service Commencement on 28th October

## 2 GOVERNANCE

Wiltshire Clinical Commissioning Group and Bath and North East Somerset Clinical Commissioning Group act as co-commissioners for the contracted provision of NHS 111 services by Harmoni (Care UK Ltd). Similar co-commissioner arrangements exist between Gloucestershire Clinical Commissioning Group and Swindon Clinical Commissioning Group; and the South West Commissioning Support Unit who provide contractual support to Bristol, South Gloucestershire and North Somerset Clinical Commissioning Groups.

Collectively a contract management group has been established that meets with Harmoni to review the monthly performance report.

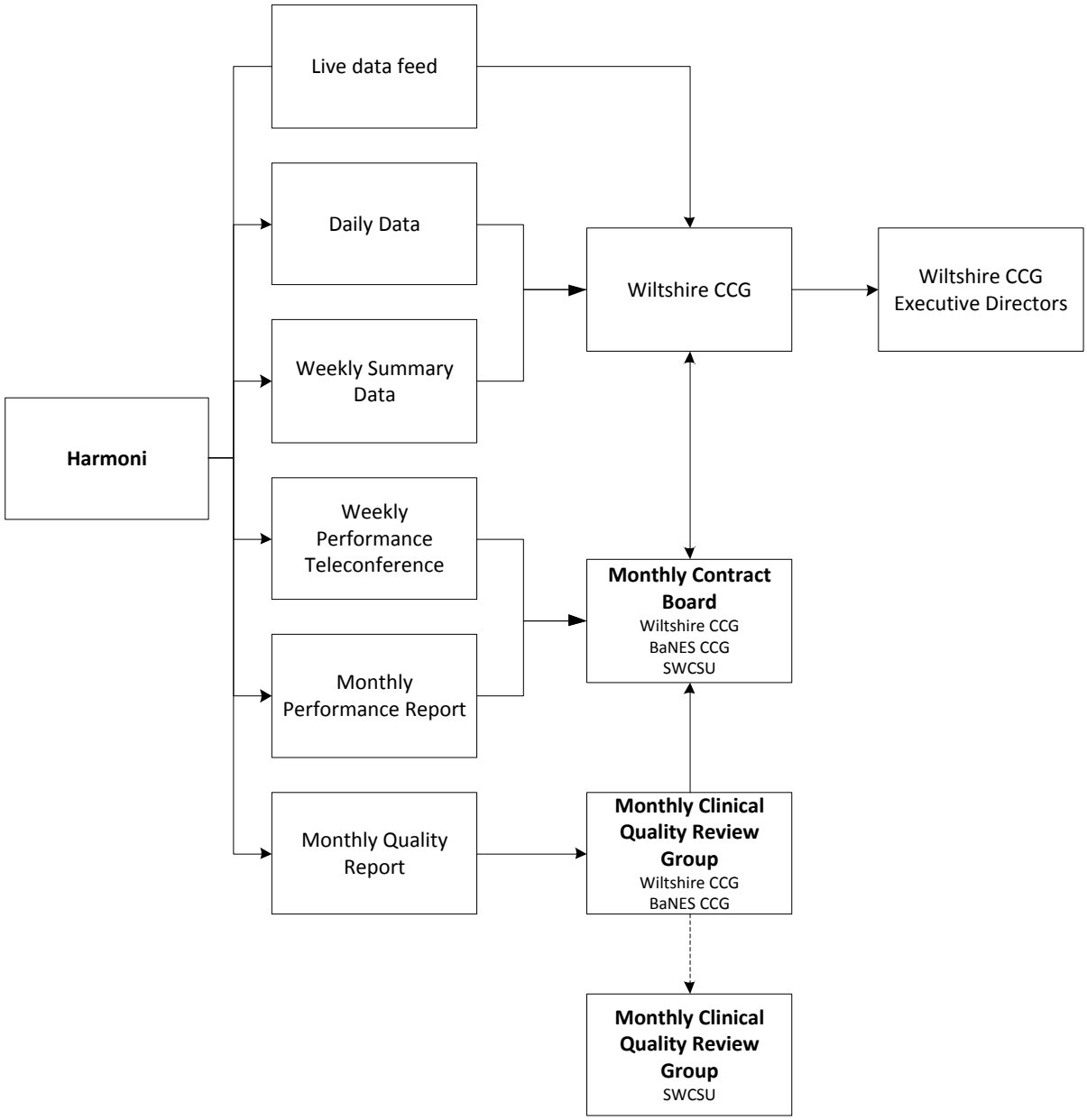
In tandem to this, a Clinical Quality Review group for Wiltshire CCG and BaNES CCG meets with Harmoni to review quality concerns that may have arisen, and also take the lead on any clinical developments. The local GP who chairs this quality group is a co-opted member to the contract board to ensure quality issue are visible to the contract and performance discussions.

In addition to monthly contract board meetings with Harmoni, performance data around a number of matrices is received daily and a weekly performance dashboard is provided prior to a weekly performance conference call.

In addition commissioners are able to access live 'real time' performance data showing the number of calls being received and or abandoned every hour. This is also linked to an automatic email alert, such that commissioners are notified if activity is indicating that performance breaches are likely.

It is expected that as we move through to 2014/15 that the management of the NHS 111 contract will fall into line with regular contract monitoring and revert to quarterly reporting, other than by exception.

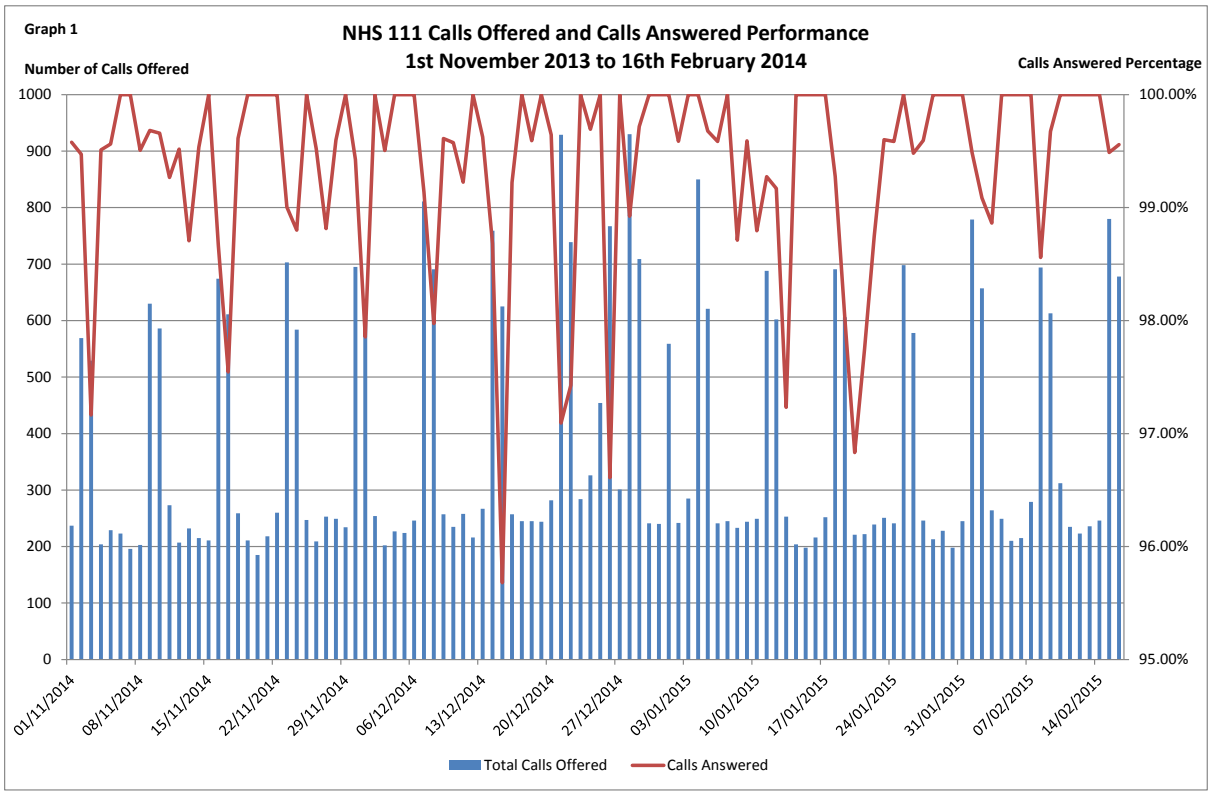
**Reporting and Governance Process**



## 3 PERFORMANCE

Following the period of rectification management and since the contract commencement in November 2013 performance by Harmoni across a number of domains has been variable. Whilst in many areas delivery has been acceptable often exceeding agreed thresholds, the CCG in conjunction with other CCG partners continue to be acutely aware that other areas of performance remain a challenge.

Call volumes for the period show a consistent pattern of around 250 calls on a weekday, increasing to around 650 calls on Saturday and Sunday, (Graph 1). It is also worth noting that calls spiked in excess of 900 for each Saturday preceding the Christmas and New Year public holidays. Whilst this call pattern has a degree of predictability, allowing Harmoni to ensure appropriate staffing volumes are in place to meet the demand, this weekend increase can impact on other NHS providers resulting in increased pressure within the overall health system. Graph 1 also shows that the percentage of calls answered is constantly high, performing often in excess of 99%, although there is a corresponding challenge in performance at times of high call volumes.

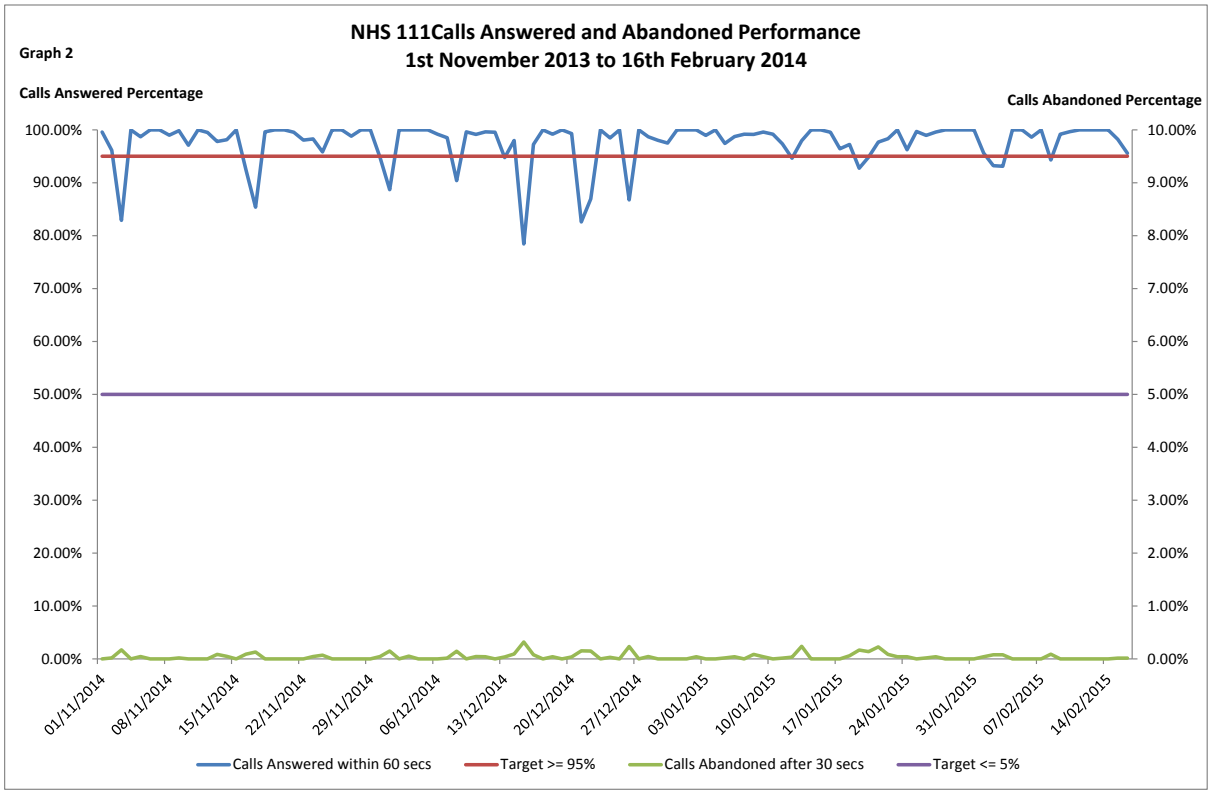


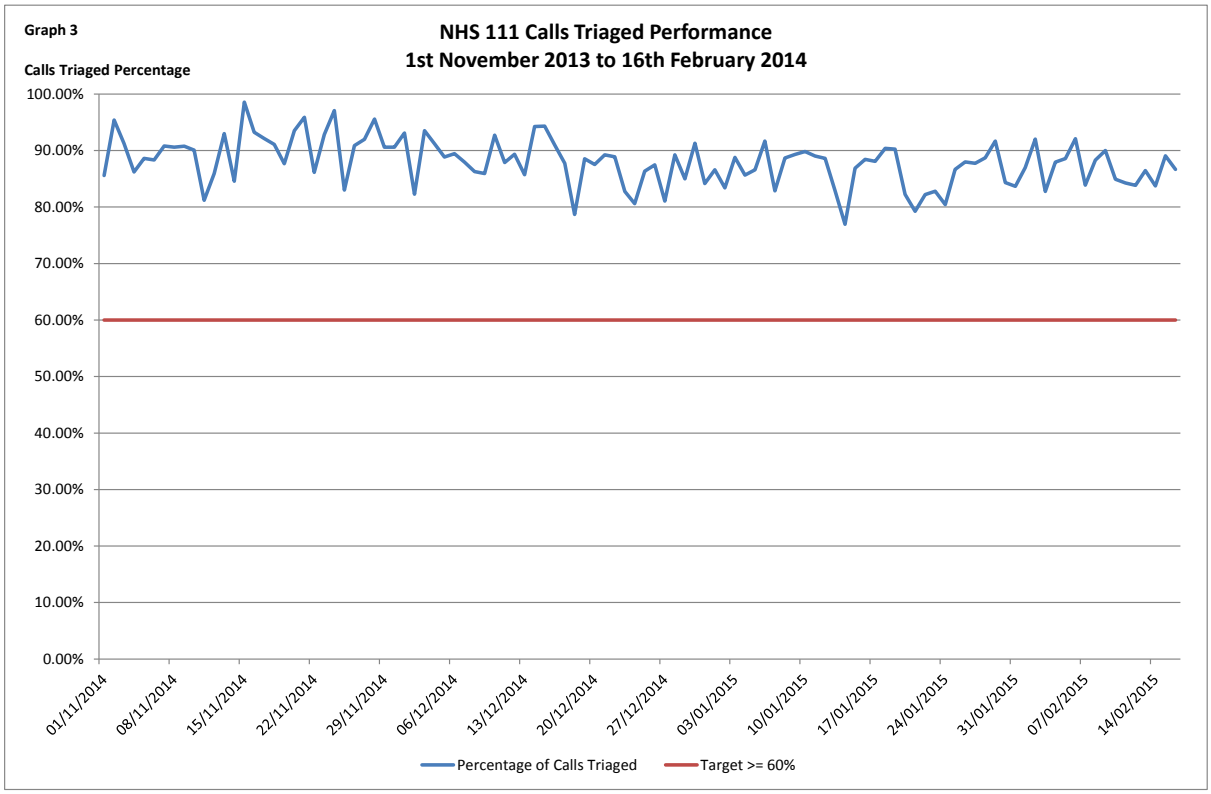

In additional to the call volumes being predictable, the call profile throughout the day follows a clear pattern, with weekday demand increasing in the early evening and weekend calls increasing in the morning to around midday.

It is recognised that performance linked to how quickly a call is answered not only links to how quickly the member of the public can received appropriate treatment or advice, but also links to the quality of the patient experience on the whole service. As such the contract has a KPI where by 95% of calls have to be answered within 60 seconds. In addition to this response measurement, there is also a requirement to ensure that the rate of calls abandoned after 30 seconds does not exceed 5% of the call volume.

Graph 2 shows that for most of the period reviewed, Harmoni have exceeded the performance threshold of 95% for calls answered and also remained below the 5% threshold for calls abandoned

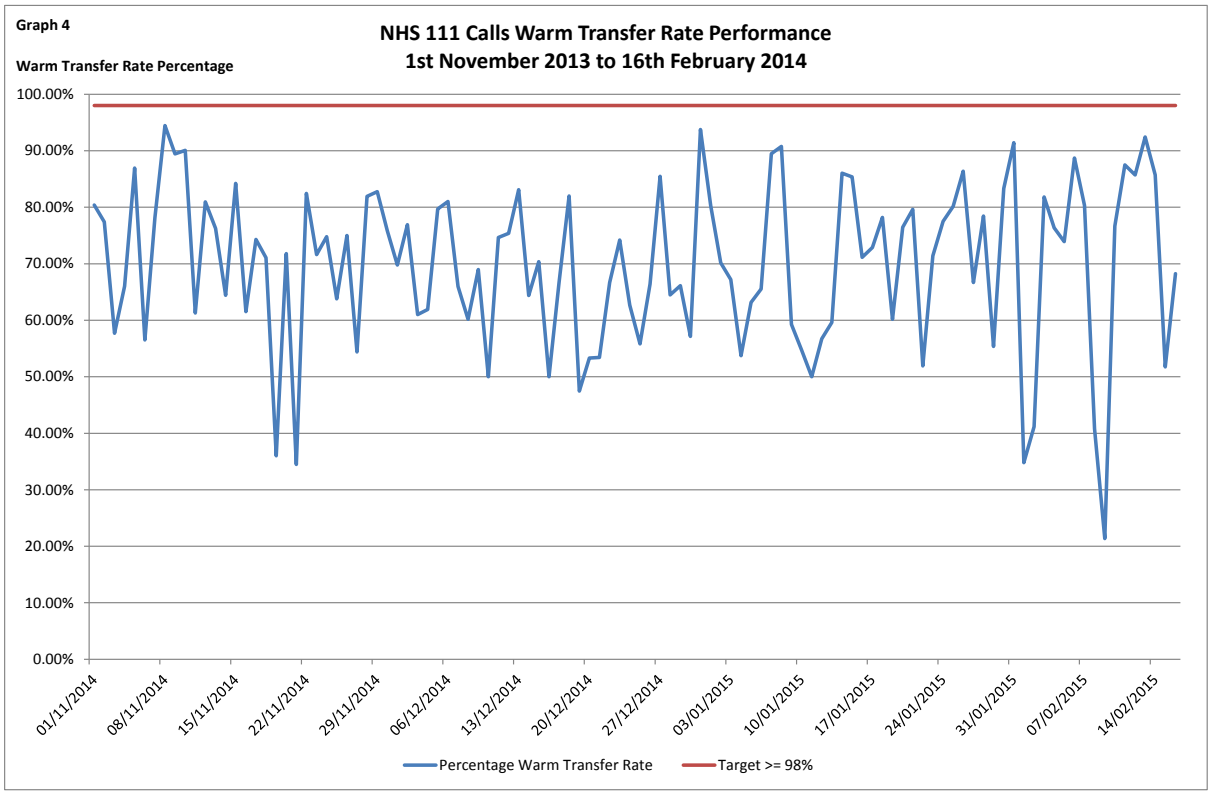
after 30 seconds. The performance breaches for call answering predominately relate to the days over the festive period.



Harmoni have a calls triaged rate[1] performance target of 60%, whereby they have to ensure that over a 24 hour period no less than 60% of calls answered are triaged to another service. To date, and for the period reviewed Harmoni have performed above the threshold required with data showing that the triage rate is consistently between 80 to 90 per cent. (Graph 3).

Although the provider is exceeding performance in this area, the CCG is working with Harmoni to address concerns around sustained performance in the warm transfer rate[2]within 30 seconds (Graph 4). The contractual target is 98%. This is an area being reviewed nationally, as the many of the providers across the country are finding this target challenging, and there may be some changes to the national specification for the NHS 111 service.



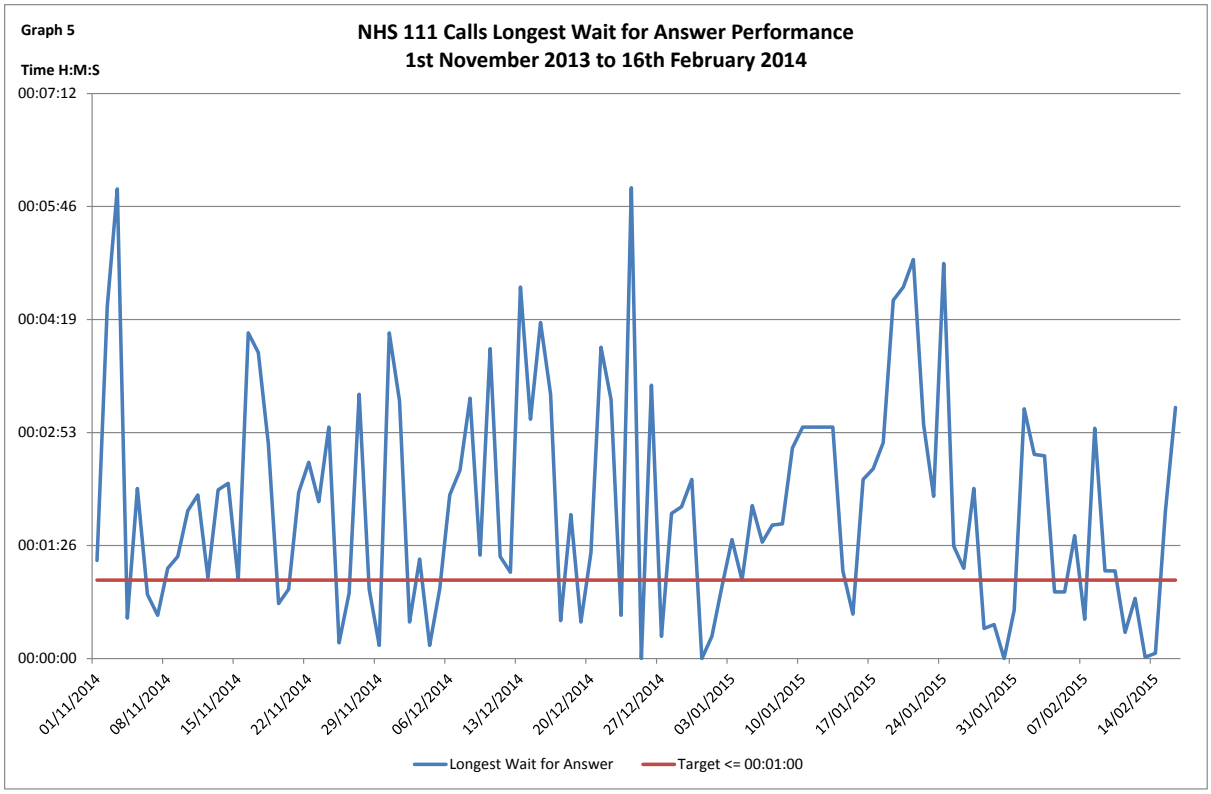

The CCG monitors the performance relating to specific transaction times. Specifically these relate to the time for a call to be answered by NHS 111, after any advisory message, and the time taken for Harmoni to return a call whereby a call advisor has requested that a clinical advisor speak to the caller.

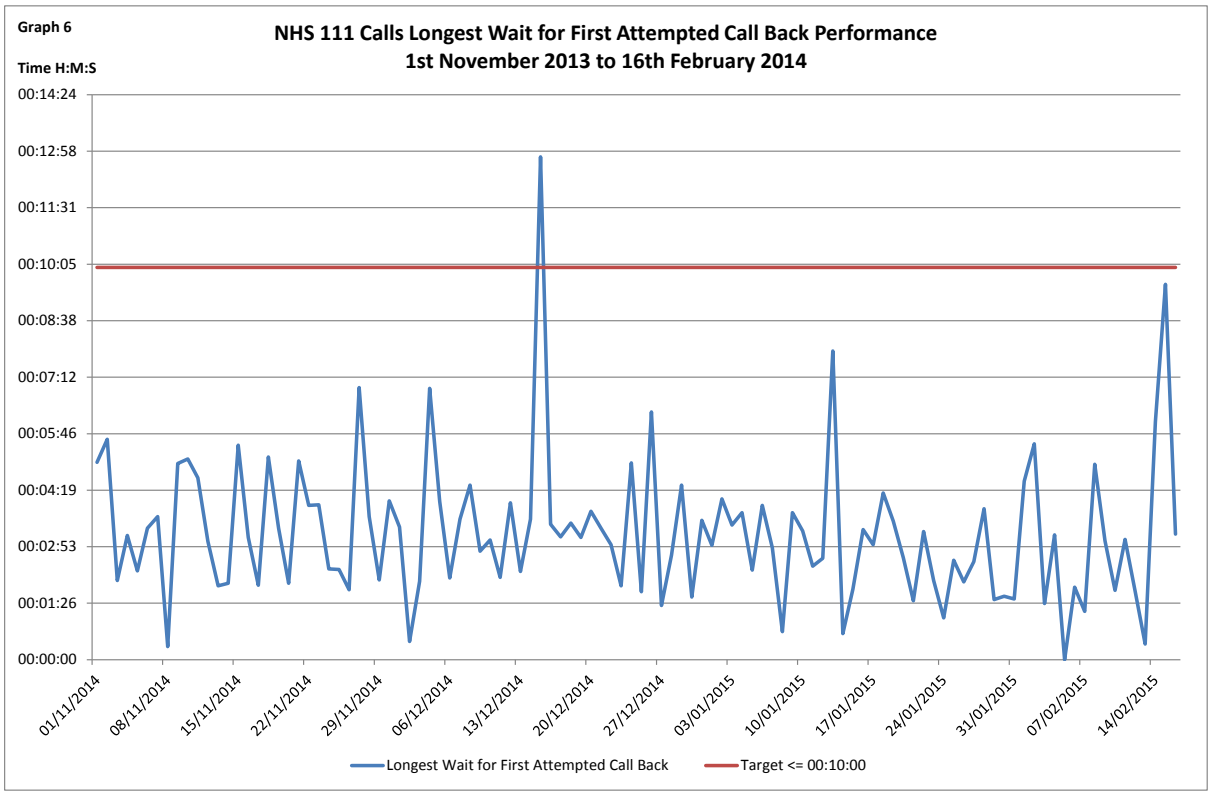
It is expected that Harmoni should answer all calls within 1 minute; the CCG has undertaken a review of these performance matrices and have noted that the inability to meet this target relates to minimal calls within 24 hour period and the majority of calls are answered within limits very close to the 1 minute target (Graph 5).

The time taken to telephone back the caller is set at 10 minutes. With one exception, this target has been delivered throughout the period reviewed (Graph 6) it is likely that the breach was due to a last minute reduction in clinical advisor resources being available on that day.

[1] Triage is the process of prioritisation. When a caller contacts the NHS 111 service and is triaged as needing to receive services from another provider

[2] A telephone call that is transferred from one individual to another (usually a call advisor to a clinical advisor) while the caller is still on the line



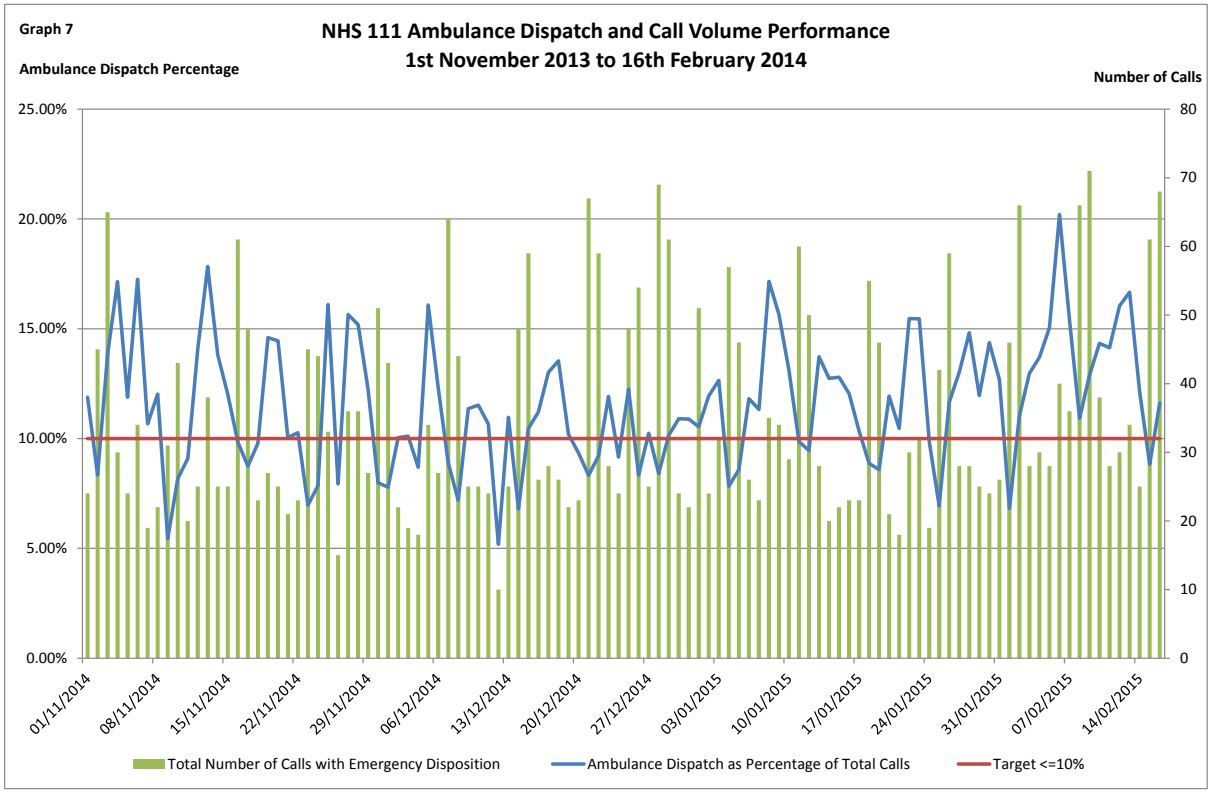

Healthcare today is very much focused on the ability of the health and social care system to respond appropriately to capacity and demand challenges, with an emphasis on collective responsibility across the whole system, rather than the historic model of a provider only being concerned around their own areas of performance. Locally, there have been commissioner and provider discussions

around the NHS 111 ambulance dispatch rate, where a call is put directly into the ambulance dispatch queue without re-triage.

The contract requires that the disposition rate of calls to the ambulance service for an emergency response is no more than 10%. The fact that this target is based on a percentage value in itself can cause the ambulance service capacity problems as the volume of calls will spike in line with calls received by the Harmoni call profile.

(Graph 7) shows the ambulance dispatch performance over the last 3 months. Whilst not being a contractual performance measure, graph 7 also shows the corresponding call volumes for the same period. Whilst the obvious correlation between under performance and increased call volume is evident, there are also periods when Harmoni are achieving performance below the 10% requirement, but call volume is still spiking. It is this scenario that can present the ambulance service with challenges in managing the high emergency disposition volumes.

The Commissioners acknowledge that Harmoni is taking steps to address its performance on the numbers of calls transferred to ambulance services and they are being supported in this by the CCGs. In order to ensure on-going patient safety and quality of service, commissioners have asked Harmoni to demonstrate that their actions will contribute to the improvement of the ambulance dispatch rate.

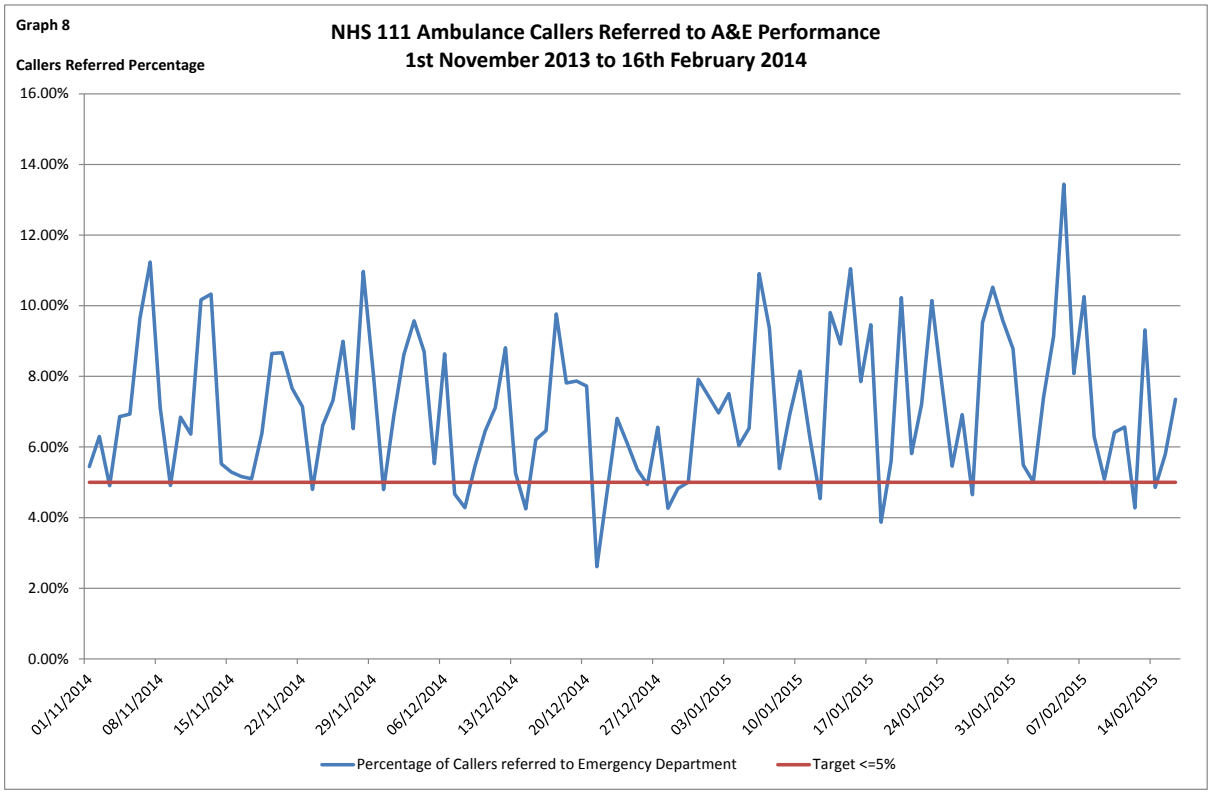



NHS 111 directs patients through algorithmic decision making software. Inherently it is risk adverse by design to ensure patient safety. There is a degree of local tailoring through a Directory of Service[3] to signpost patients to the most suitable NHS service to meet their needs.

The underperformance (over referral rate) is clearly visible and it is likely to be either as a result of an increase in patient acuity, which is a position often reiterated by acute trusts when discussing

[3] The Directory of Service is a data set within the software that details the availability of local services depending upon patient specific conditions.

their own A&E performance, or it may well be a symptom of a lack of alternative services being available.




The local Clinical Quality Review Group has undertaken a number of end to end audits, by listening to recorded NHS 111 calls to ensure that appropriate signposting is taking place and that patients are not referred to Accident and Emergency unnecessarily. The CCG in collaboration with neighbouring CCG's have invested in improved reporting so that we will be able to interrogate the Directory of Service, highlighting when a patient could have accessed an alternative service had it been available. Understanding this data will allow the CCG to be aware of levels of demand and may influence where services could be either redesigned or developed.

## 4 CONCLUSION

The performance of the NHS 111 service for Wiltshire has made significant progress since the launch a year ago; albeit there are a number of areas which are still challenging. Nationally the service specification is under review, and we are mindful that there may be changes which would have to be implemented. When NHS 111 services were benchmarked nationally over the Christmas and New Year period, the local service deliver stood up very well in comparison to other NHS 111 providers.

We are working closely with Harmoni in supporting a number of pilot programmes to explore ways in which performance can be improved. These include the ability for them to network calls across their other call centres during times of increased activity, as well as reviewing the number of clinical advisors / call advisors on shift. Harmoni are also looking at the possibility of developing specialist clinical advisors in areas such as mental health, who would be able to make a much more informed decision around onward care.

We believe that there is a robust performance management and clinically led quality regime in place that is sighted on ensuring that a clinically safe and effective service is delivered in Wiltshire.

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# Wiltshire Health Select Committee Briefing on the development of Vascular Services: Recommended Model of Care for Approval

# Wiltshire Health Select Committee Briefing on Recommended Developments to Vascular Services in the Bath, Bristol, Weston Vascular Network

*For Information and Endorsement*

First published: April 2014

## Executive summary

This report outlines the review of Vascular services that has been conducted locally by NHS England's South West Specialised Commissioning Team, Clinical Commissioning Groups and the NHS Trusts as part of a wider review of vascular care across England as part of NHS England's national Specialised Service Specification Compliance Project that aims to ensure people receive the same high quality of care no matter where they live. The design of this network is supported by the Wiltshire CCG on condition that local GPs are involved in the design of the local clinical pathways for all the networks that serve the population of Wiltshire.

The population of Wiltshire are currently supported by hospitals that form three separate vascular networks: *the Dorset Vascular Network; the Gloucestershire and Swindon Vascular Network; and the Bath, Bristol and Weston Vascular Network.* The Dorset network is currently progressing towards service specification compliance, with Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHT) selected as the 'hub' arterial centre and the Salisbury Foundation Trust and Dorset County Hospital as the 'spokes'. The emergency surgical work is currently delivered at Royal Bournemouth and Christchurch NHS Hospital Trust (RBCHT) with elective work due to follow across during this financial year.

The Gloucestershire and Swindon Vascular network is already operating to the standards set out on the service specification, with the arterial centre based in Cheltenham. The network continues to provide outpatient and daycase work at local hospitals, whilst all vascular surgery is undertaken at Cheltenham. Previous to the implementation of the network, neither Trust was able to fulfil the requirements of the service specification, nor provide consistent specialised out of hours care. In this case, patients were stabilised at their local hospital and then transferred to the 'on-take' Bristol Trust to receive specialised vascular care. Early feedback from patients concerning this network has been positive. Indeed, the model of care in Swindon and Gloucestershire that has increased patients' access to 24/7 arterial in-patient surgery and interventional radiology has influenced discussions in developing the proposals for the Bath, Bristol, Weston Network that is the subject of this report.

This report summarises the patient and public engagement work that has been carried out nationally *and* locally to develop the national service specification and shape the local model of care being proposed. However, **this briefing only relates to proposed changes to the Bath, Bristol, Weston Vascular network.** The research evidence presented here and national and local clinical and public opinion supports the recommended model (to concentrate inpatient vascular surgery in a specialised arterial centre at the new hospital being built at Southmead as opposed to Southmead, Bristol Royal Infirmary and Royal United Hospital, Bath as currently) that is expected to improve patient outcomes (in particular risk of mortality) and increase access to centre level care and outpatient clinics

for many vascular patients in a way that is safe and sustainable and able to meet expected increases in future demand. Therefore, Wiltshire Health Select Committee is asked to:

- Consider the evidence based improvements in patient outcomes the new model of care being offered by the Bath, Bristol, Weston Vascular Network is able to deliver;
- Consider the likely impact of the proposed model (to concentrate in-patient surgery at the new Southmead hospital as opposed to Royal United Hospital in Bath, the old Southmead and Bristol Royal Infirmary hospitals as currently) upon (some) Wiltshire residents has been kept to a minimum as only some (in-patient) surgery is being concentrated in Bristol to provide Wiltshire patients with a full 24/7 service whilst all other vascular support (outpatient, day case surgery etc.) will remain at Royal United Hospital, Bath (RUH) as currently. Moreover, a proportion of people from Wiltshire already need to go to Bristol for their vascular surgery as the service at RUH is only available during working hours, Monday to Friday. In addition, people from Wiltshire can access two further vascular networks: The Gloucestershire, Swindon Vascular Network and the Dorset Vascular Network which are summarised in this document for information. This briefing only relates to proposed changes to the Bath, Bristol, Weston Vascular network.
- Consider the increased access to centre level in-patient vascular surgery for Wiltshire patients from 5pm provision, Monday to Friday as currently to 24/7, 365 days in the future;
- Consider the support and involvement of local clinical leaders, patients, carers and members of the public in developing the recommended model of care;
- Consider that arrangements for outpatient and day case surgery will remain as currently, or access increased, to enable as much care as is safe and appropriate to be provided in ‘spoke’ vascular services at various sites closer to people’s homes;
- Consider the dedicated vascular hybrid vascular theatre and 42 bed dedicated vascular ward that the new Southmead hospital will provide;
- Note the consideration that has been given to protecting the financial stability of Trusts and future development of vascular services;
- Endorse the implementation of the proposal to move elective and emergency vascular surgery to the new arterial centre in Bristol starting in the Autumn of 2014.

A brief video summarising the local case for change and what is being proposed can be found on the NHS England website: http://www.england.nhs.uk/south/south/bnsssg-at/vascular-services/

## 1 Purpose of the Report

The purpose of this report is to seek scrutiny support for the proposal to improve outcomes for vascular patients by commissioning a 'hub and spoke' model of care that concentrates in-patient vascular surgery in an arterial centre. Information on the three Vascular networks providing care to Wiltshire patients are given here although the focus of this report is on the Bath, Bristol and Weston Vascular Network which will provide vascular inpatient care in a new state of the art arterial surgical 'hub' being built at Southmead, Bristol whilst keeping all other vascular diagnostic, day case surgery and outpatient care in local 'spoke' services as currently. This will also enable the vascular services currently providing support for people from Bristol, North Somerset, (parts of) Somerset, South Gloucestershire, (parts of) Wiltshire and Bath and North East Somerset (BaNES) to work together as a network to jointly meet the criteria outlined in the national service specification that is to be implemented across England in a way that is safe, sustainable and increases access to centre level care for some people.

## 2 Recommendations

In relation to the model of care being proposed by NHS England and the hospital Trusts that comprise the Bath, Bristol, Weston Vascular Network, Wiltshire Health Select Committee is asked to:

- Consider the evidence based improvements in patient outcomes the new model of care being offered by the Bath, Bristol, Weston Vascular Network is able to deliver;
- Consider the likely impact of the proposed model (to concentrate in-patient surgery at the new Southmead hospital as opposed to Royal United Hospital in Bath, the old Southmead and Bristol Royal Infirmary hospitals as currently) upon (some) Wiltshire residents has been kept to a minimum as only some (in-patient) surgery is being concentrated in Bristol to provide Wiltshire patients with a full 24/7 service whilst all other vascular support (outpatient, day case surgery etc.) will remain at Royal United Hospital, Bath (RUH) as currently. Moreover, a proportion of people from Wiltshire already need to go to Bristol for their vascular surgery as the service at RUH is only available during working hours, Monday to Friday. In addition, people from Wiltshire can access two further vascular networks: The Gloucestershire, Swindon Vascular Network and the Dorset Vascular Network.
- Consider the increased access to centre level in-patient vascular surgery for Wiltshire patients from 5pm provision, Monday to Friday as currently to 24/7, 365 days in the future;
- Consider the support and involvement of local clinical leaders, patients, carers and members of the public in developing the recommended model of care;
- Consider that arrangements for outpatient and day case surgery will remain as currently, or access increased, to enable as much care as is safe and appropriate to be provided in 'spoke' vascular services at various sites closer to people's homes;

- Consider the dedicated vascular hybrid vascular theatre and 42 bed dedicated vascular ward that the new Southmead hospital will provide;
- Note the consideration that has been given to protecting the financial stability of Trusts and future development of vascular services;
- Endorse the implementation of the proposal to move elective and emergency vascular surgery to the new arterial centre in Bristol starting in the Autumn of 2014.

## 3 Current Service - What Happens Now?

The scope of specialist vascular services can be briefly summarised as preventing death from aortic aneurysm, preventing stroke from carotid artery disease and preventing lower limb amputation from peripheral arterial disease and diabetes. In 2007 over 65,000 people in the UK had surgery for a problem relating to vascular disease (Vascular Society of Great Britain and Ireland - VSGBI, 2009). The prevalence of vascular disease increases with age meaning that demand for vascular services is likely to increase over time. In addition, there are currently an estimated 3 million people with diabetes in England and this prevalence is increasing; patients with diabetes and vascular disease have a worse outcome, as evidenced by the increasing rate of lower limb amputation in this patient group.

The outcomes from vascular surgery in the United Kingdom have not compared well internationally, with the UK until recently having the highest mortality rates in Western Europe for abdominal aortic aneurysm repair (VASCUNET, 2008). It is widely recognised that some models of vascular care in England are not sustainable in the long term in the face of growing demand and the need to adopt and develop new innovations that lead to better patient outcomes. Hence, it is a national priority for the NHS to ensure vascular services are configured in ways that reflect best practice to ensure their safety and quality both now and for years to come.

In 2012 VSGBI published a series of recommendations describing how vascular services should be organised to deliver the best outcomes for patients (Provision of Vascular Services, 2012). VSGBI also developed quality improvement frameworks (QIFs) for both abdominal aortic aneurysm (AAA) repair and lower limb amputation. The recently introduced NHS AAA Screening Programme has made adopting the AAA QIF mandatory for providers treating men referred from the programme.

In light of these recommendations NHS England, as the commissioners of specialist vascular services since April 2013, published a national specification for the provision of vascular services in July 2013. This specification sets out both the essential components of a specialist vascular service and the clinical outcomes that the service should achieve. A clinical reference group, comprised of patients and vascular and commissioning experts from all the regions of England and chaired by Prof. Matt Thompson, Professor of Vascular Surgery, has developed the service specifications and reporting outcomes of all vascular surgical procedures to the new National Vascular Registry will be mandatory. A copy of the service specification for vascular services can be found at:

http://www.england.nhs.uk/wp-content/uploads/2013/06/a04-spec-vascu-adult.pdf

Since the publication of the service specification we have been reviewing vascular services across the South West to determine the work needed to ensure local vascular provision complies with the best practices outlined in the service specification. The key elements of which are that providers of vascular services should:

- Serve a minimum population of at least 800,000 people to ensure an appropriate volume of procedures;
- Ensure that highly experienced staff are treating sufficient numbers of patients to maintain competency;
- Have 24/7 on site vascular surgery and interventional radiology on-call rotas that are staffed by a minimum of 6 vascular surgeons and 6 interventional radiologists;
- Provide access to cutting edge technology including a hybrid operating theatre for endovascular (minimally invasive) aortic procedures;
- Provide a dedicated vascular ward and nursing staff;
- Have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine as part of a comprehensive multi-disciplinary service.

Central to national recommendations is the requirement for arterial surgery to be delivered out of fewer, higher volume specialist arterial surgical centres to improve clinical outcomes (in particular mortality rate) and deliver a range of other benefits to patients. Due to the way services are currently delivered at the majority of hospitals and the limited number of specialist doctors that are available it is currently not possible for patients to always be treated by a vascular specialist, especially out of normal working hours.

Patients from Wiltshire are currently supported by hospitals that form three separate vascular networks: the Dorset Vascular Network; the Gloucestershire and Swindon Vascular Network; and the Bath, Bristol and Weston Vascular Network. The tables below show the numbers of Wiltshire patients who were cared for by these networks.

**Dorset Network**

| | | Procedure Type | | | | | |
|---|---|---|---|---|---|---|---|
| **Trust** | **Year** | **Elective AAA (incl. EVAR)** | **Carotid Endarterectomy** | **Emergency AAA** | **Major Amputation** | **Leg Bypass** | **Total** |
| **Salisbury NHS Foundation Trust** | 2010 – 11 | 9 | 18 | 5 | 22 | 30 | 84 |
| | 2011 - 12 | 16 | 20 | 3 | 6 | 33 | 78 |
| | 2012 - 13 | 20 | 22 | 9 | 11 | 13 | 75 |
| | 2013 - to Nov 2013 | 7 | 14 | 2 | 5 | 10 | 38 |
| | **Trust Total** | **52** | **74** | **19** | **44** | **86** | **275** |
| **Oxford University Hospitals NHS Trust** | 2010 - 11 | 4 | 2 | 3 | 0 | 1 | 10 |
| | 2011 - 12 | 4 | 1 | 1 | 0 | 0 | 6 |
| | 2012 - 13 | 1 | 3 | 1 | 0 | 1 | 6 |
| | 2013 - to Nov 2013 | 4 | 2 | 0 | 0 | 0 | 6 |
| | **Trust Total** | **13** | **8** | **5** | **0** | **2** | **28** |

N.B the numbers of Wiltshire residents seen at Dorchester & Royal Bournemouth are <10 in total for the timeframe 2010-2014 so cannot be included here to protect patient confidentiality.

## Swindon, Gloucestershire Network

| Procedure Type | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Trust** | **Year** | **Elective AAA (incl. EVAR)** | **Carotid Endarterectomy** | **Emergency AAA** | **Major Amputation** | **Leg Bypass** | **Total** |
| **Great Western Hospitals NHS Foundation Trust** | 2010 – 11 | 0 | 5 | 0 | 5 | 8 | 18 |
| | 2011 - 12 | 1 | 7 | 0 | 2 | 6 | 16 |
| | 2012 - 13 | 0 | 3 | 0 | 7 | 3 | 13 |
| | 2013 - to Nov 2013 | 0 | 0 | 0 | 1 | 4 | 5 |
| | **Trust Total** | **1** | **15** | **0** | **15** | **21** | **52** |

N.B. the table does not include information for Gloucestershire Hospital because Wiltshire patients have only recently started to go there for aspects of their care and so it is too early to provide this.

Source: Dr Foster, provided by South West Commissioning Support Unit 25.2.14

Both the Dorset Vascular Network and the Gloucestershire and Swindon Vascular Network were formed before NHS England took over responsibility for commissioning vascular services in April 2013. When we reviewed vascular services in Swindon and Gloucestershire they met the national specification. Consequently, in the absence of any quality or safety concerns, we will not be suggesting any developments to this network in the near future.

The Dorset network is currently progressing towards service specification compliance, with Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHT) selected as the 'hub' arterial centre and the Salisbury Foundation Trust and Dorset County Hospital as the 'spokes' (these terms are explained more fully below). The emergency surgical work is currently delivered at Royal Bournemouth and Christchurch NHS Hospital Trust (RBCHT) with elective work due to follow across during this financial year. Outpatients and daycase work will continue to be undertaken at both Dorset County Hospital NHS Foundation Trust (DCH) and Salisbury NHS Foundation Trust (SFT). The above table does not include activity data for DCH and RBCHT because there were less than 10 patients from Wiltshire that attended in total over the entire recording period. We are unable to report this to ensure patient confidentiality.

The Gloucestershire and Swindon Vascular network is already operating to the standards set out on the service specification, with the arterial centre based in Cheltenham. The network continues to provide outpatient and daycase work at local hospitals, whilst all vascular surgery is undertaken at Cheltenham. Previous to the implementation of the network, neither Trust was able to fulfil the requirements of the service specification, nor provide consistent specialised out of hours care. In this case, patients were stabilised at their local hospital and then transferred to the 'on-take' Bristol Trust to receive specialised vascular care. Early feedback from patients concerning this network has been positive. Indeed, the model of care in Swindon and Gloucestershire that has increased patients' access to 24/7 arterial in-patient surgery and interventional radiology has influenced discussions in developing the proposals below for the Bath, Bristol, Weston Network that is the subject of this report.

### Bath, Bristol, Weston Network

The table below shows the number of Wiltshire patients being cared for by the trusts within the Bath, Bristol and Weston Vascular network.

| Procedure Type | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Trust** | **Year** | **Elective AAA (incl. EVAR)** | **Carotid Endarterectomy** | **Emergency AAA** | **Major Amputation** | **Leg Bypass** | **Total** |
| **Royal United Hospital Bath NHS Trust** | 2010 - 11 | 21 | 25 | 2 | 21 | 41 | 110 |
| | 2011 - 12 | 18 | 21 | 6 | 11 | 18 | 74 |
| | 2012 - 13 | 20 | 29 | 2 | 16 | 21 | 88 |
| | 2013 to Nov 2013 | 13 | 36 | 1 | 4 | 23 | 77 |
| | Trust Total | 72 | 111 | 11 | 52 | 103 | 349 |
| **North Bristol NHS Trust** | 2010 - 11 | 0 | 0 | 0 | 3 | 1 | 4 |
| | 2011 - 12 | 0 | 0 | 0 | 1 | 2 | 3 |
| | 2012 - 13 | 0 | 0 | 0 | 0 | 1 | 1 |
| | 2013 - to Nov 2013 | 1 | 1 | 0 | 0 | 0 | 2 |
| | **Trust Total** | **1** | **1** | **0** | **4** | **4** | **10** |
| **University Hospitals Bristol NHS Foundation Trust** | 2010 - 11 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2011 - 12 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2012 - 13 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2013 - to Nov 2013 | 0 | 0 | 0 | 2 | 1 | 3 |
| | **Trust Total** | **0** | **0** | **0** | **2** | **1** | **3** |

Source: Dr Foster, provided by South West Commissioning Support Unit 25.2.14

Current vascular services provide two care pathways for vascular patients: elective and emergency.

### Elective pathway

Patients may enter an elective pathway via a GP referral, a referral from the emergency department, a referral from another secondary care specialty (e.g. diabetes or stroke) or through the AAA screening programme. If the referral is generated by secondary care the patient will tend to be seen in the same hospital from which the referral is generated. If the referral is made by a GP or from the screening programme the patient should be given a choice regarding which hospital they would like to attend.

For elective patients, the initial referral will normally be for an outpatient appointment. These currently take place at Frenchay Hospital, Southmead Hospital (NBT), the Bristol Royal Infirmary (UHB), the Royal United Hospital (RUH), Weston General Hospital (WAHT) as well as community clinics in Cossham, Yate and Clevedon.

Following an outpatient appointment people will normally be sent for diagnostics at their local hospital including vascular studies (through vascular laboratories) and radiology.

Following discussion at a multidisciplinary team (MDT) meeting, if the decision is made to operate, the patient will be listed either for surgery or an interventional radiological procedure (as either a day case or inpatient procedure). The patient will then be required to attend the hospital where they will be having surgery for a pre-operative assessment. At this stage it may also be determined that a high care bed is required and this will be requested. Currently surgery is provided by the RUH, NBT at Southmead and at University Hospitals Bristol (UHB at the Bristol Royal Infirmary - BRI). Patients from Weston Area Health Trust (WAHT) currently have their surgery at the BRI. Non-arterial surgery commissioned by local CCGs (e.g. varicose vein surgery) is also provided at each of these sites.

Following elective surgery patients recover in the hospital in which they had their surgery. They will then be discharged home or to a community provider (if further rehabilitation is required or if there are further co-morbidities or social issues).

**Emergency Pathway**

Patients may present as an emergency either via ambulance or through self-presentation to the emergency department. In hours (Monday-Friday 08:00-17:00) there is currently a vascular consultant presence at RUH Bath, UH Bristol and NBT. Any emergencies (either blue light or self-presenters) will be treated at each of these hospitals. There are occasional exceptions to this however (e.g. during consultant leave periods and at weekends) because there are currently insufficient numbers of consultants in each hospital to guarantee year round cover. In general, ambulances will take patients to the closest appropriate hospital.

Historically a vascular on call rota has existed between the two Bristol Trusts. However since February 2013 a vascular emergency on call rota was established involving surgeons from the RUH. However, the geographical distance between hospitals currently means the on call surgeon is only able to attend to the Bristol hospitals. Consequently, out of hours emergencies in Bath need to be transferred to the on take Bristol hospital. Currently the on call take hospital alternates weekly between the UH Bristol and North Bristol Trust hospitals.

Currently, ambulances will still take the patient to the closest hospital meaning that if this is not the on call hospital (either the RUH, WAHT or the non-on call Bristol Trust) the patient is stabilised and transferred to the on call hospital if surgery is required.

Following emergency surgery patients recover in the hospital in which they had their surgery. They will then be discharged home or to a community provider (if further rehabilitation is required or if there are further co-morbidities or social issues). Following discharge they may be referred for ongoing care/monitoring at either the same hospital or locally.

The current provision of care to meet the national standards is presented in the table below showing that the trusts within the Bath, Bristol and Weston Vascular Network do not currently meet the national service specification in full.

| Provider | 24/7 MDT | 6 vascular surgeons | 24/7 IR on call | Elective and emergency arterial surgery | In-patient non-arterial vascular services | AAA Screening | Outpatient Assessment | Diagnostic imaging (duplex, MRA and CTA) | Day case surgery |
|---|---|---|---|---|---|---|---|---|---|
| RUH | No | No | No | Yes | Yes | No | Yes | Yes | Yes |
| UHB | No | No | No | Yes | Yes | Yes | Yes | Yes | Yes |
| WAHT | No | No | No | No | Yes | No | Yes | Yes | Yes |
| NBT | No | No | Yes | Yes | Yes | No | Yes | Yes | Yes |

Royal United Hospital Bath NHS Trust (RUH)
University Hospitals Bristol NHS Foundation Trust (UHB)
Weston Area Health NHS Trust (WAHT)
North Bristol NHS Trust (NBT)

## 4 What is being proposed?

In line with the results of the local and national public and patient engagement that has been conducted and after 2 years of local clinical discussions, the table below summarises what local clinical leaders of vascular services are proposing to enable them to provide a 24/7 service that meets the criteria in the national service specification by working together in a network. This means that instead of approximately 80 Wiltshire patients per year going to RUH for their in-patient arterial surgery and a very few going to UHB in Bristol, all specialised in-patient arterial surgery and immediate recovery will be provided at the new arterial centre in the new NBT hospital at Southmead in Bristol. All other aspects of vascular care (outpatient clinics, day case surgery, non-arterial vascular surgery, diagnostic imaging etc) will remain where it is currently provided. In addition, the network are currently considering possible locations for additional community outpatient clinics so that as much care as is safe and appropriate can be delivered within the 90 minute maximum that people from Wiltshire told us they are willing to travel for an outpatient appointment.

As approximately 50% of the vascular workload is urgent or emergent, timely access to vascular outpatient clinics is essential. GP referrals will have access to a ‘hot’ vascular clinic Monday to Friday via a single point of contact (Network Coordinator or Vascular Nurse Specialist) at NBT and access to urgent review at NBT via the Emergency Department hot clinic as currently. In addition a consultant of the week (free from elective and operating commitments) will be available to offer telephone advice. Access to these ‘hot’ clinics will be aligned to diabetic foot services (i.e. access for the foot protection team) and stroke services (access from TIA/Stroke clinics). A hot clinic allows quick access to a specialist opinion and is designed to avoid unnecessary admission to hospital.

NBT will become the site of the new major arterial centre for the Bath, Bristol, and Weston Vascular Network as soon as is safe and appropriate after the new 42 bedded dedicated vascular ward and hybrid vascular theatre staffed by an expert vascular MDT opens.

NBT will provide 24/7 vascular surgery and 24/7 interventional radiology cover for vascular surgery patients, a dedicated vascular ward and state of the art ‘hybrid’ operating theatre.

The new arterial centre will deliver a sustainable consultant led vascular service with daily review of all inpatients by a consultant vascular surgeon and 24/7 vascular surgery and interventional radiology on call rotas.

All elective and emergency arterial surgery, including major lower limb amputation, for UHB, WAHT and RUH to transfer to the arterial centre to ensure care is delivered in line with national standards of best practice, both for arterial surgery and rehabilitation following major amputation, delivered by a specialist team managing a sufficient volume of cases.

This service will be delivered by specialists from NBT, UH Bristol, WAHT, and the RUH working together as in a modern vascular network to deliver arterial surgery, lower limb amputations and emergency vascular care from the single arterial centre. Thus retaining the expertise we have in the region.

Pre-operative assessment must be carried out where the patient will be having their surgery (i.e. at the arterial centre for inpatient elective and emergency arterial surgery). This is the only way to ensure patient safety by standardising workup for surgery and ensuring all local Trust requirements are met before admission (i.e. thromboprophylaxis and infection control screening). Where possible additional investigations will be arranged in the patients local hospital so that only a single pre-operative visit is needed to the arterial centre.

Day case vascular interventional radiology (i.e. peripheral angioplasty for patients with intermittent leg pain) will not transfer to NBT and local arrangements will be put in place for emergency vascular intervention and clinical governance.

The RUH would in addition provide inpatient non-arterial vascular services, for example varicose vein surgery and diabetic foot surgery.

Patients from Weston General Hospital will be transferred to Southmead hospital for surgery (as opposed to the BRI as currently occurs).

A triage policy will be required for all conditions and consideration given to which staff group has the appropriate competencies for triage. This policy will also need to define those conditions that trigger automatic transfer directly to the arterial centre (i.e. ruptured abdominal aortic aneurysm or acute limb ischaemia), bypassing the local hospital. These policies are being jointly developed with the ambulance service to minimise delay.

Robust pathways are being agreed (Network Repatriation Policy) to enable effective repatriation (return) of patients to a hospital closer to home following surgery (either for continued acute care or for rehabilitation) once specialist vascular care is no longer required. This is similar to other specialised services, such as major trauma care. Links with the tissue viability services will be maintained and rehabilitation for major amputees is being developed at both RUH Bath and WAHT.

Clinical protocols will be agreed for the management of patients presenting via TIA/stroke services or to diabetic foot teams at NBT, UH Bristol, RUH and WAHT to ensure timely access to vascular surgery or interventional radiology.

The network also aims to reduce current inequalities in access to these services and improve the timeliness with which they are delivered, with dedicated operating lists scheduled though the week at the major arterial centre to accommodate this activity.

The Bristol Heart Institute (BHI) currently delivers a regional service for patients presenting with thoracic aortic disease (thoracic aortic aneurysm and Type B aortic dissection). Increasingly these patients require endovascular stent grafting in place of open surgery as this has been shown to be safer. The vascular network will be expected to work with the BHI to deliver this service. The new arterial centre is also the preferred provider for regional complex endovascular services.

Effective pathways have already been agreed for the transfer of emergency patients from emergency departments to the on call vascular hospital. These do not need to change.

Daily access to a vascular surgical opinion for inpatients at the RUH, UHB and WAHT to be achieved by either network cover or a daily presence. How specialist cover is provided to 'spoke' (non-centre) hospitals and the location of additional community clinics were just two of the things that NHS England, CCGs and providers sought patient, carer and public views on during the progra0mme of public and patient engagement outlined in Section 5 below.

This proposed model will meet the evidence based requirements in the national service specification across the Bath, Bristol and Weston Vascular Network is outlined here. The 24/7 network provision will also meet the requirement for MTD and appropriate numbers of vascular and IR consultants for the on-call rota.

| | Inpatient Vascular arterial procedures | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Provider | Emergency AAA | Elective AAA | Carotid endarterectomy | Lower limb arterial bypass | Major amputation | AAA Screening | Outpatient Assessment | Diagnostic imaging (duplex, MRA and CTA) | Daycase Surgery |
| RUH | No | No | No | No | No | No | Yes | Yes | Yes |
| UHB | No | No | No | No | No | No | Yes | Yes | Yes |
| WAHT | No | No | No | No | No | No | Yes | Yes | No |
| NBT | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

## 5 Local Impact Assessment

The table below shows the average impact on public and private travel times for residents of Wiltshire that were calculated using the Government's transportdirect website:

http://www.transportdirect.info/Web2/Home.aspx?&repeatingloop=Y

The journey start time was set at 8am on a Monday morning following advice from scrutiny colleagues and the table presents the mean average of the times and mileage from 10 randomly sampled postcodes of current Wiltshire patients. Please note, the postcode of the current Southmead hospital and the proposed arterial centre are identical.

| Patient<br><br>Postcodes from | Receiving hospital | Receiving hospital postcode | Public transport (mins) | Car (minutes) | Distance (miles) |
|---|---|---|---|---|---|
| Wiltshire | Southmead Hospitals (NBT) | BS10 5NB | 143.4 | 51.1 | 31.17 |
| Wltshire | Bristol Royal Infirmary (UHB) | BS1 3NU | 127 | 47.6 | 31.51 |
| Wiltshire | Royal United Hosp., Bath | BA1 3NG | 102 | 41 | 18.88 |

This means that the few Wiltshire patients that would currently go to UHB for in-patient vascular surgery will have to travel approximately 5 minutes longer by car to attend the new Southmead hospital on average. However, (approximately) 80 patients that currently travel to RUH would have approximately 10 further minutes to travel.

Nevertheless, while the travel time to the arterial centre by car is well within the 90 minute limit set by local people, the public transport time exceeds it. Consequently, the network have been asked to ensure vascular in-patients are informed about the new free non-emergency patient transport service in Wiltshire to ensure patients travel times do not exceed the maximum local people have set and that patients with low incomes have equality of access.

It is also worth noting that 100% of survey respondents said they currently use their own car to travel to vascular services. Although the sample size was small so are overall patient numbers, therefore we do not expect patient transport services to see much increase in demand as a result of this request. How we will work with transport services to monitor demand and capacity. Information about the new transport service can be found below:

http://www.wiltshireccg.nhs.uk/news/new-patient-transport-service-for-wiltshire

In terms of the impact of the proposal on the NHS Trusts that currently provide vascular surgery, we considered:

- The estimated annual cost of each service now;
- The impact on those figures change as a result of concentrating in-patient surgery at NBT;
- The different between the cost of each service before and after the service development as a proportion of the Trust net annual income.

The publically reported income of each Trust in the network is presented below. Due to ongoing contract negotiations we are unable to provide exact figures regarding the flow of income related to vascular services at this time. However, we know enough at this time to confidently assert that in

each instance we expect the value of surgery moving to NBT would be less than 1% of a Trust's total net income.

Value of NBT service (2013/14 Business Plan): ~ £533million

Value of UHB service (Annual Report and Accounts, 2012/13): ~ £520million

Value of RUH service (Annual Accounts 2012/13): ~ £215million

Value of WAHT service (Annual Accounts 2012/13): ~ £82million

## 6 Public and Patient Involvement & Experience

The national clinical reference group that developed the service specification that is driving the proposed developments was comprised of patient and carer representatives as well as clinical and commissioning experts from across England and representative of the Vascular Society of Great Britain throughout its development. Following this a national programme of public and patient engagement informed the production of the final service specification that specialised commissioning teams have now been asked to implement across England. NHS England's response to the public consultation can be located at:

http://www.england.nhs.uk/wp-content/uploads/2013/07/consult-ssscp-13-14-sum.pdf

However, to help us determine the impact of the proposed model of care on *Wiltshire* patients and hear local people's views all patients who had vascular surgery at the RUH (where the majority of people from Wiltshire affected by the proposal attend) in the last 12 months were invited to attend a public event on the 6th of March 2014 and/or to complete a survey that ran alongside the event, which was also published on various NHS England, CCG and Healthwatch websites. People from outside Wiltshire and BaNES were not prohibited from attending the event, although the location (Bradford on Avon) was selected to target them as the populations most affected by the proposed service development in line with the government's Consultation Principles. The event and the survey were advertised on a number of CCG, NHS England and Healthwatch websites and Healthwatch and scrutiny colleagues were invited to submit questions they would like us to ask local people. Wiltshire members raised the following concerns that we discussed with people who attended the events:

- Many parts of Wiltshire already have long travel times to hospitals, don't want them to get any longer, especially in urgent/emergency situations for elderly patients;
- Concern over viability of local hospitals and the 'salami slicing' of services away from them (particularly, Salisbury);
- Lack of evidence to support suggested improvement in outcomes.

Approximately 50 people attended (exact figures cannot be given as we had to bring in additional seating to accommodate several people who arrived after attendance had been recorded), with one person from Somerset and the remainder from Wiltshire (~60%) and BaNES (~40%). All but five members of the audience were there as patients, carers or

members of the public, including some who were also members of their local Healthwatch. The following summary provides the themes of what people said at the public event and survey responses received to date mirror these. A copy of the questions and the answers we gave at the public event immediately following presentation from NHS England, and consultant vascular surgeons from RUH and UHB and full preliminary results and notes from both the event and survey are available at the following website.

http://www.england.nhs.uk/south/south/bnsssg-at/vascular-services/

*Local views*

Once people learned that no vascular service was being closed and had listened to the two Consultant Vascular Surgeons (from the two Trusts that have most to lose in financial terms) explain the reasons why they support in-patient arterial surgery they currently provide being moved to the arterial centre in Bristol and provided the evidence that leads them to suggest this is better for patients (by reducing risk of mortality and improved prognoses), there was support for the clinical model and people said they understood the reasoning behind it and the benefits to them as patients of the service.

There were understandable concerns around travelling distance and the need for clearer directions to Southmead hospital and sufficient available parking. However, once someone in the audience told everyone about the free community transport service that operates in Wiltshire concerns about distance moved to concerns about the ability of ambulance and community transport services to cope with additional demand. Consequently, commissioners are asking vascular providers to include information about available community support, such as transport, in patient information packs as standard, and are working transport services to monitor capacity and demand.

In relation to concerns about ambulance capacity to cope with the transport and repatriation of in-patients between the arterial centre and outlying spoke hospitals NHS England is in discussions with the ambulance team and the network to ensure robust and sustainable transport protocols are agreed before the arterial centre opens.

In addition people at the event were asked how far they would be willing to travel for in-patient arterial surgery and how far they would be willing to travel to an outpatient clinic. We asked this to help the network and commissioners decide the location of additional outpatient services that are needed to ensure equality of access. People were unanimously agreed that they are willing to travel up to 90 minutes for surgery at an arterial centre and 1 hour to an outpatient clinic. This is currently being used to inform planning discussions regarding where to develop additional outpatient provision.

People also wanted GPs to be given information packs for new patients regarding the service and any practical support they can access to facilitate as much of their care being delivered close to or at home as possible and help them to manage their own health to maintain their independence. They also suggested GPs should be made aware of any changes to vascular services and referral pathways before any changes are implemented to ensure new patients are correctly referred.

Current vascular patients also wanted to know ‘what do we need to do?’ ‘Do we need to register somewhere or do anything different?’ The consultant vascular surgeons from RUH

and UHB explained that most aspects of pre and post operative care would remain where they are, with the front door of the service being their local hospital or GP who would explain what they would need to do in relation to any elective procedures. They were told that patients needing emergency procedures would most likely be transported by a blue lit ambulance straight to the nearest arterial centre and would be too unwell to choose a different hospital.

Some patients from Wiltshire were surprised to learn they could access three vascular networks and .asked our advice on which of the three networks they should choose for their elective and outpatient care. People at the event were told NHS England plans to publish this information online some time this year so patients can compare services more easily. However, currently clinical outcomes are collected through the National Vascular Registry (NVR) which replaced the National Vascular Database (NVD) in December 2014. We have yet to have an NVR report released so the latest data is from the NVD and the associated Royal College of Physicians Carotid Audit. Surgeon level data for AAA repair and CEA was released by HQIP last summer. Vascular Society QIP Reports are located at:

http://www.vsqip.org.uk/reports/

Two people who were initially concerned that the proposal was to move all vascular care from RUH to Bristol later asked us why it takes so long to make improvements to services when we know it will lead to improved clinical outcomes and save lives. We are now working hard to secure the support of the local health overview and scrutiny committees in Bristol, Bath and North East Somerset, Somerset, North Somerset, South Gloucestershire and Wiltshire before June 2014, with a view to implementing the model of care that is supported by local clinicians and the majority of local people by the Autumn.

All information related to the public and patient engagement, including a video explaining the reason for the proposed development, presentation slides from the event, a link to an electronic version of the questionnaire and a summary of the event and analysis of the survey conducted by Wiltshire CCG can be found at:

http://www.england.nhs.uk/south/south/bnsssg-at/vascular-services/

## 7 Expected Benefits: The evidence

There is a large body of evidence to support the model of care being proposed. For example,

***Volume-outcome relationship: The case for concentrating in-patient surgery***
As a rule, and not surprisingly, the risk of dying decreases when patients receive their surgery from teams that operate on higher numbers of patients. The relationship between the volume of cases undertaken and the outcomes achieved has been demonstrated most clearly for elective abdominal aortic aneurysm repair. A meta-analysis[1] based on over

[1] In statistics, a **meta-analysis** refers to methods focused on contrasting and combining results from different studies, in the hope of identifying patterns among study results, sources of disagreement among those results, or other interesting relationships that may come to light in the context of multiple studies.

400,000 elective AAA repairs world-wide concluded in favour of higher volume centres (Holt, Poloniecki, et al., 2007). More recent research by Holt et al. also found an 8.5 per cent mortality rate in lower volume centres compared to 5.9 per cent in higher ones (Holt, Poloniecki, & al., 2010). Holt et al have also found mortality differences between hospitals in the lowest and highest volume quintiles of providing ruptured abdominal aortic aneurysm repair of up to 24% (Holt, Karthikesalingam et al., 2010). There is evidence that similar relationships affect the performance of other vascular procedures including lower limb arterial reconstruction and carotid endarterectomy (Karthikesalingham, et al., 2010; Moxey, et al., 2012).

***New technology:***

A major driver for the proposed model of care has been the introduction of minimally invasive endovascular techniques (i.e. the use of interventional radiology to treat arterial disease thereby avoiding open surgery and reducing recovery time). Such techniques have reduced mortality, morbidity and hospital length of stay (EVAR1 Trial, 2005), but they require specific infra-structure, such as hybrid operating theatres that are equipped with advanced medical imaging (CT, MRI) devices, and are dependent on an adequate case volume (higher number of patients) to ensure their safe introduction. Evidence suggests that high volume centres are more likely to adopt new technologies (Dimick & Upchurch, 2008) and a hybrid vascular theatre that enables this is being built at the proposed centre at Southmead.

In other words the new arterial centre would provide complex aortic endovascular procedures from a dedicated vascular hybrid theatre supported by 24/7 vascular surgery and 24/7 interventional radiology. This would bring together the expertise and experience of key clinicians in these techniques and would offer both elective endovascular procedures but in addition emergency ones, such as endovascular repair for ruptured abdominal aortic aneurysm which has the potential to significantly improve length of recovery and reduce risk of mortality as compared to conventional open repairs.

***The impact of travel distance and times:***

Irrespective of what local people say about how far they will travel, there may be understandable concerns that having to travel further for surgery will put their lives at risk. However, numerous studies have been published reporting no [statistically] significant impact of distance on mortality for vascular surgery. For example, Cassar et al. studied nearly a decade of records from Raignor hospital in the Scottish highlands and reported no significant difference in the community mortality rate after ruptured aortic aneurysm between patients living within or further than 50 miles from the hospital (Cassar et al., 2001). Interestingly, a significantly **lower** hospital mortality rate was in fact reported in the study for those patients living greater than 50 miles from the hospital than those living within 50 miles (26 percent compared with 60 percent) although this was likely due to factors including likelihood to refer patients with a poor prognosis and differential diagnosis quality by general practitioners as opposed to distance travelled (Cassar et al., 2001).

Several further studies attempting to determine the impact of distance on mortality have showed similar results. Butler et al. (1978) studied the impact of regional hubs delivering vascular surgery on mortality outcomes and found no significant difference in operative mortality following ruptured abdominal aortic aneurysm (RAAA) between patients admitted from the local catchment area (58%) and those transferred from other centres for surgery (54%). Similar results were reported in studies by Fielding et al. (1984), D'Sa Barros (Barros, 1990), van Heeckeren (1970), Amundsen et al (1989), Farooq et al. (1996) amongst others, all reporting that centralisation does not prejudice the community mortality outcome for RAAA.

In terms of patients attitudes towards travel for specialist services, an extensive study by Holt et. al (2009) reported that 237 of the 258 patients questioned (92 percent) stated a willingness to travel for at least one hour beyond their nearest hospital. Patients also had a stronger willingness to travel to access services with lower peri-operative mortality, stroke and amputation rates, routine availability of EVAR and an experienced surgical team as opposed to other considerations such as length of stay, seeing the same doctor every time, waiting lists and car parking. The authors of this paper strongly endorse the idea of concentrating vascular surgery in regional centres to achieve the desired mortality outcomes.

Despite the evidence on outcomes and preferences, the Bath, Bristol, Weston Vascular Network is working to mitigate concerns with distance as far as possible and a key principle of the planning process has been to ensure that any care that can safely be provided locally will be. This includes outpatient clinics, access to diagnostics, minor day case procedures and follow up care. Repatriation and rehabilitation pathways will also be developed to enable patients to recover close to home following their surgery. Vascular consultants, specialist nurses and other specialist vascular professionals will continue to maintain a daily presence at those hospitals that are not the designated arterial centre to ensure equity of access to specialist input remains across the region and to support other acute services (e.g. stroke, diabetes). The development of clearly defined pathways and ensuring continued specialist presence at the non- arterial centres will also address concerns such as those raised by Adam et al. amongst others that fewer patients may be considered for surgical intervention outside of the central hub (Adam et al. , 1999). The network is also working with local patients to determine the location of additional outpatient clinics to minimize the travel for patients that live some distance from their nearest spoke service.

**Expected Measurable Outcomes:**

The over-riding aim of this proposal is to improve the outcomes for patients requiring vascular surgery with patient safety at the centre of what drives this proposal. The primary benefits and measures of success therefore are to achieve measurable improvements in each of the following areas. Progress against these targets will be monitored regularly by NHS England to ensure the expected benefits to patients are realised:

- Deliver an elective mortality for abdominal aortic aneurysm surgery of less than 3.5%, in line with the Vascular Society abdominal aortic aneurysm quality improvement programme;
- Reduced rate of amputation in patients with diabetes and a mortality rate for major amputation surgery of less than 5%, in line with Vascular Society Amputation quality improvement programme;
- Increase the percentage of patients with symptomatic carotid stenosis assessed as high risk of stroke treated within 48 hours and of low risk patients by 2 weeks by 2014, in line with National Stroke Strategy.

**On call rota:**

Providing a 24/7 vascular surgery and interventional radiology rotas is vital to ensure patients have emergency access to vascular specialists. Due to the consultant numbers at each site this is only achievable by having a single rota across the four organisations. Patient safety will be increased by having a single arterial site since any emergencies (either post operatively following elective work or via blue light admissions) can be managed in one place.

**In summary, the expected benefits for patients are:**

- Improved clinical outcomes, in particular patient mortality;
- Development of skills and expertise so that patients are better able to manage their condition and recovery;
- Shorter length of stay;
- Improved resources at arterial centre at NBT (hybrid theatre, dedicated ward etc.);
- Increased access to outpatient clinics;
- Increased access to arterial surgery (from 9-5 Monday to Friday to 24/7 provision);
- Clear lines of accountability and clinical governance that puts clinicians and patients at the heart of performance monitoring and service development.

**Other benefits include:**

- Standardised methods and promotion of best practice across the clinical teams;
- A more productive and efficient service (minimisation of duplication and waste);
- Improved opportunities for training, research and innovation;
- Recued length of stay for patients and more effective pathway links with community providers to support timely repatriation of patients following surgery;
- Surgery undertaken in a modern, innovative new hospital;
- The co-location of the arterial centre with the major trauma unit;
- Compliance with the quality assurance standards of the Bristol, Bath and Weston Abdominal Aortic Aneurysm Screening Programme to have a single arterial centre providing aortic aneurysm repair for the programme.

## 8 Risks and/or disbenefits of not implementing the proposed service improvement

The current vascular services delivered by North Bristol Trust, University Hospital Bristol and the Royal United Hospital Bath do not meet the national service specification for vascular surgery. In the near future such providers are unlikely to be commissioned to provide this work - leading to a contractually necessary service development of services to centres that do meet the required specification and costly procurement processes.

In addition, the new specialty status for vascular surgery changes to junior doctor working patterns and increasing recognition of the need for seven day working weeks make delivery of arterial surgery unsustainable without a minimum of six vascular surgeons and six interventional radiologist based on a single site.

Failure to deliver would be a missed opportunity to bring together and retain expertise developed at the local hospitals, to improve patient outcomes and build a regional complex endovascular aortic service (including fenestrated and branched aortic stent grafts) for the South West and may put current vascular services that do not meet the service specification at risk if commissioners had to put the service out to tender.

There would also be a negative impact on NBT's ability to move other services to the new hospital, which could significantly delay the new hospital's ability to become fully operational. The cost impact of this to NBT would also be substantial.

NHS England would be unable to assure the safety and sustainability of current arrangements as services struggle to cope with expected increases in demand.

## 9 Timescales and Next Steps

The Hospital Trusts working together on this change in service in line with the national service specification are continuing to finalise pathway details to ensure that the stepped transfer of services will be implemented in a safe manner by the Autumn 2014.

## 10 Recommendations

Wiltshire Health Select Committee is asked to:

- Consider the evidence based improvements in patient outcomes the new model of care being offered by the Bath, Bristol, Weston Vascular Network is able to deliver;
- Consider the likely impact of the proposed model (to concentrate in-patient surgery at the new Southmead hospital as opposed to Royal United Hospital in Bath, the old Southmead and Bristol Royal Infirmary hospitals as currently) upon (some) Wiltshire residents has been kept to a minimum as only some (in-patient) surgery is being concentrated in Bristol to provide Wiltshire patients with a full 24/7 service whilst all other vascular support (outpatient, day case surgery etc.) will remain at Royal United Hospital, Bath (RUH) as currently. Moreover, a proportion of people from Wiltshire already need to go to Bristol for their vascular surgery as the service at RUH is only

available during working hours, Monday to Friday. In addition, people from Wiltshire can access two further vascular networks: The Gloucestershire, Swindon Vascular Network and the Dorset Vascular Network. This briefing only relates to proposed changes to the bath, Bristol, Weston Vascular network.

- Consider the increased access to centre level in-patient vascular surgery for Wiltshire patients from 5pm provision, Monday to Friday as currently to 24/7, 365 days in the future;
- Consider the support and involvement of local clinical leaders, patients, carers and members of the public in developing the recommended model of care;
- Consider that arrangements for outpatient and day case surgery will remain as currently, or access increased, to enable as much care as is safe and appropriate to be provided in 'spoke' vascular services at various sites closer to people's homes;
- Consider the dedicated vascular hybrid vascular theatre and 42 bed dedicated vascular ward that the new Southmead hospital will provide;
- Note the consideration that has been given to protecting the financial stability of Trusts and future development of vascular services;
- Endorse the implementation of the proposal to move elective and emergency vascular surgery to the new arterial centre in Bristol starting in the Autumn of 2014.

## Glossary

| | |
|---|---|
| Abdominal aortic aneurysm repair | Abdominal aortic aneurysm (AAA) repair is a procedure used to treat an aneurysm (abnormal enlargement) of the abdominal aorta. Repair of an abdominal aortic aneurysm may be performed surgically through an open incision or in a minimally-invasive procedure called endovascular aneurysm repair (EVAR). |
| Angioplasty | *Angioplasty* is the technique of mechanically widening narrowed or obstructed arteries. |
| Arterial surgery | This includes a range of procedures to prevent death from aortic aneurysm, prevent stroke from carotid artery disease, and prevent lower limb amputation from peripheral arterial disease and diabetes. |
| Carotid endarterectomy | A *carotid endarterectomy* is a surgical procedure to unblock a carotid artery (blood vessels that supply the head and neck). |
| Clinical Reference Groups | The specialised commissioning function of NHS England is supported by a devolved clinical leadership model. Seventy-five Clinical Reference Groups (CRGs) covering all prescribed specialised services draw membership from each of the 12 geographical areas in England. CRGs bring together clinicians, commissioners, and Public Health experts with the patients and carers who use specialised services. Members are volunteers who have a particular interest, knowledge or experience of a specific area of specialised healthcare and wish to contribute to its development. They are responsible for preparing national specialised service level strategy and developing specialised service contract products such as service specifications and commissioning policies. |
| Comorbidities | Comorbidity is the presence of one or more additional disorders (or diseases) co-occurring with a primary disease or disorder; or the effect of such additional disorders or diseases. The additional disorder may also be a behavioral or mental disorder. |
| CT | A CT scan is a specialised X-ray test. It can give quite clear pictures of the inside of your body. In particular, it can give good pictures of arteries, which do not show on ordinary X-ray pictures. |
| Endovascular stent grafting | An endovascular stent graft is a tube composed of fabric supported by a metal mesh called a stent. It can be used for a variety of conditions involving the blood vessels, but most commonly is used to reinforce a weak spot in an artery called an aneurysm. Over time, blood pressure and other factors can cause this weak area to bulge like a balloon and it can eventually enlarge and rupture. The stent graft is designed to seal tightly with your artery above and below the aneurysm. The graft is stronger than the weakened artery and it allows your blood to pass through it without pushing on the bulge. |

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| EVAR | See Abdominal aortic aneurysm repair. |
| Hot clinics | A ‘hot clinic’ is a clinic available for review of urgent patients to avoid unnecessary admissions to hospital while ensuring a more senior review within 24 hours. Orthopaedics (‘fracture clinic’) and Emergency Department (‘review clinic’) have used this model for some time whereby junior doctors can direct patients into clinics in which they will be seen by a senior. The vascular team will offer such reviews at NBT (5 days a week) and RUH (exact days TBC). |
| Interventional radiology | Interventional Radiology is a medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases in nearly every organ system. The concept behind interventional radiology is to diagnose and treat patients using the least invasive techniques currently available in order to minimize risk to the patient and improve health outcomes. These procedures have less risk, less pain and less recovery time compared to open surgery. |
| MRI | *Magnetic resonance imaging* (*MRI*) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. |
| Peri-operative | The *peri-operative* period is the time period describing the duration of a patient's surgical procedure. |
| Peripheral arterial disease | *Peripheral arterial disease* (PAD) is a common condition in which a build-up of fatty deposits in the arteries restricts the blood supply to leg muscles. |
| Public and patient engagement | ‘Engagement’, ‘involvement’, ‘consultation’, ‘co-production’ and ‘participation’ are all words that can be used to describe communicating with and listening to patients, carers and members of the public. This ranges from providing information to people about NHS services and commissioning decisions to working with patients and carers at a strategic level so their experiences and insight can be used to shape NHS policy and commissioning decisions. |
| Service specification | A service specification is a description of what a service should include. For example the number and skills of the staff that provide the service, registration with professional bodies or the environment in which certain procedures and care are carried out (like special thermo-regulated rooms for people being treated for severe burns). |
| Specialised services | Specialised services generally involve complex procedures that only a few people may have the skills and experience to perform or because they use very specialised, expensive equipment that the NHS simply could not afford to put into every local hospital and/or because the people who need these services are relatively few in numbers, such as very premature babies or people with rare cancers or genetic conditions. |
| Thoracic aortic disease | Thoracic aortic aneurysms — bulges in the wall of the aorta – are more common than doctors originally thought. If it tears the aorta, the main pipeline for blood from the heart to the body, suddenly bursts, cutting off the supply of life-sustaining blood and flooding |

| | |
|---|---|
| | the chest or abdomen with blood. |
| Thromboprophylaxis | Thromboprophylaxis prevents death from thrombosis (blood clots in the veins). |
| TIA | *A transient ischaemic attack* (*TIA*) or 'mini stroke' is caused by a temporary disruption in the blood supply to part of the brain. |
| Triage | Triage is the process of determining the priority of patients' treatments based on the severity of their condition. |
| Vascular studies | Vascular studies are a non-invasive (the skin is not pierced) procedure used to assess the blood flow in arteries and veins. A transducer (like a microphone) sends out ultrasonic sound waves at a frequency too high to be heard. When the transducer is placed on the skin at certain locations and angles, the ultrasonic sound waves move through the skin and other body tissues to the blood vessels, where the waves echo off of the blood cells. The transducer picks up the reflected waves and sends them to an amplifier, which makes the ultrasonic sound waves audible. |
| Vascular surgery | Vascular surgery is a specialty of surgery in which diseases of the arteries and veins are managed by medical therapy, minimally-invasive catheter procedures, and surgical reconstruction. Vascular operations are no longer performed by general surgeons but by specialist vascular multi-disciplinary teams. |
| Abdominal aortic aneurysm repair | Abdominal aortic aneurysm (AAA) repair is a procedure used to treat an aneurysm (abnormal enlargement) of the abdominal aorta. Repair of an abdominal aortic aneurysm may be performed surgically through an open incision or in a minimally-invasive procedure called endovascular aneurysm repair (EVAR). |
| Angioplasty | *Angioplasty* is the technique of mechanically widening narrowed or obstructed arteries. |
| Arterial surgery | This includes a range of procedures to prevent death from aortic aneurysm, prevent stroke from carotid artery disease, and prevent lower limb amputation from peripheral arterial disease and diabetes. |
| Carotid endarterectomy | A *carotid endarterectomy* is a surgical procedure to unblock a carotid artery (blood vessels that supply the head and neck). |
| CT | A CT scan is a specialised X-ray test. It can give quite clear pictures of the inside of your body. In particular, it can give good pictures of arteries, which do not show on ordinary X-ray pictures. |
| Interventional radiology | Interventional Radiology is a medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases in nearly every organ system. The concept behind interventional radiology is to diagnose and treat patients using the least invasive techniques currently available in order to minimize risk to the patient and improve health outcomes. These procedures have less risk, less pain and less recovery time compared to open surgery. |

| | |
|---|---|
| MRI | *Magnetic resonance imaging* (*MRI*) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. |
| Peripheral arterial disease | *Peripheral arterial disease* (PAD) is a common condition in which a build-up of fatty deposits in the arteries restricts the blood supply to leg muscles. |
| Public and patient engagement | 'Engagement', 'involvement', 'consultation', 'co-production' and 'participation' are all words that can be used to describe communicating with and listening to patients, carers and members of the public. This ranges from providing information to people about NHS services and commissioning decisions to working with patients and carers at a strategic level so their experiences and insight can be used to shape NHS policy and commissioning decisions. |
| Service specification | A service specification is a description of what a service should include. For example the number and skills of the staff that provide the service, registration with professional bodies or the environment in which certain procedures and care are carried out (like special thermo-regulated rooms for people being treated for severe burns). |
| Specialised services | Specialised services generally involve complex procedures that only a few people may have the skills and experience to perform or because they use very specialised, expensive equipment that the NHS simply could not afford to put into every local hospital and/or because the people who need these services are relatively few in numbers, such as very premature babies or people with rare cancers or genetic conditions. |
| Triage | Triage is the process of determining the priority of patients' treatments based on the severity of their condition. |
| Vascular studies | Vascular studies are a non-invasive (the skin is not pierced) procedure used to assess the blood flow in arteries and veins. A transducer (like a microphone) sends out ultrasonic sound waves at a frequency too high to be heard. When the transducer is placed on the skin at certain locations and angles, the ultrasonic sound waves move through the skin and other body tissues to the blood vessels, where the waves echo off of the blood cells. The transducer picks up the reflected waves and sends them to an amplifier, which makes the ultrasonic sound waves audible. |
| Vascular surgery | Vascular surgery is a specialty of surgery in which diseases of the arteries and veins are managed by medical therapy, minimally-invasive catheter procedures, and surgical reconstruction. Vascular operations are no longer performed by general surgeons but by specialist vascular multi-disciplinary teams. |

**Wiltshire Council**

**Health Select Committee**

**6 May 2014**

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**Report of the Continence Services Task Group**

## Purpose of report

1 To present the findings of the Continence Services Task Group and seek endorsement for them.

## Background

2 The Continence Services Task Group was established in October 2013 following a rapid scrutiny exercise which highlighted concerns about the provision of continence products following the implementation of a new contract.

3 The Task Group focussed its work on the delivery and provision of continence products in the home setting.

## Main considerations

4 The Task Group believes that the number of continence products, their quality and the range currently provided do not meet the needs of all clients using the continence service. There is a lack of accurate figures on the delivery and product costs of the service. There is also a lack of information about incontinence and the continence service for the public. The Council and the NHS need to invest adequately in the continence service to support service users and their carers, to uphold the joint vision of ensuring that people can live longer in their homes and also to reduce wider costs.

## Proposal

5 To endorse the Task Group's report and refer the recommendations to the relevant executive bodies.

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**Wiltshire Council**

**Health Select Committee**

**6 May 2014**

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## Report of the Continence Services Task Group

### Background

1 In January 2012 the Council and the NHS issued a new contract which brought together a number of services that had previously been fulfilled by a number of providers; this included the continence service. The contract was awarded to Medequip Assistive Technology Ltd (Medequip) and the specification included the introduction of the iDExpert range of continence products across the county (previously named Euron).

2 In November 2012, the Wiltshire Carers' Action Group (WCAG) indicated its wish to bring a report to the Health Select Committee on continence services, following changes introduced under the new contract. The Committee agreed to receive a report at its meeting in January 2013.

3 The WCAG report raised issues including the adequacy, range and number of continence products being offered under the contract and the failure of these to meet patients' needs, and also raised delivery and storage concerns.

4 As a consequence of the issues being raised, the Committee agreed that it should conduct a rapid scrutiny exercise looking into continence services and this was duly carried out in February 2013.

5 The rapid scrutiny exercise reported to the Committee in March 2013 and raised a number of issues of concern which it believed required further investigation. Consequently one of its recommendations was that the Committee establish a Task Group to look into the issues identified.

6 There was a delay in the establishment of the Task Group due to Council elections and the need for the new Health Select Committee to agree its forward work programme, which included the Continence Services Task Group as a legacy item.

### The Task Group

7 The Task Group had its first meeting in October 2013 with the following membership:

| | |
|---|---|
| Cllr Jeff Osborn (Chairman) | Cllr Mary Champion |
| Cllr Christine Crisp | Mr Brian Warwick |

8 The Task Group agreed to adopt recommendations b) to f) below, made by the rapid scrutiny exercise, as its terms of reference with the addition to recommendation c) of looking at 'value for money'. It agreed that it would not look at the whole continence service, only those aspects that applied to the supply of continence products in the home setting.

*b) The Task Group considers the assessment/re-assessment process, in particular the nature of it, the criteria involved and timescales around it.*

*c) The Task Group investigates the logistics of the service, with reference to Medequip and the options offered, in relation to the requirement for greater flexibility and client choice, and considers the monitoring of performance issues.*

*d) The Task Group looks at patient outcomes and requirements, including availability of appropriate continence products, frequency of supply, buffer stocks and flexibility.*

*e) The Task Group reviews Council's role, responsibilities and authority in continence care under its Health and Wellbeing remit.*

*f) The Task Group examines the terms and conditions of the Disability Living Allowance (DLA) and its applications.*

9 The Task Group took evidence from:

Angela Billington, Lead for Continence Services (6 month contract), Clinical Commissioning Group (CCG);
Nicola Gregson, Head of Commissioning Care, Support and Accommodation;
Chris Bull, Regional Area Manager, Medequip;
Tabitha Dawson, Customer Services (continence), Medequip;
Louise Rendle, Head of Network Services, Wiltshire and Swindon Users' Network (WSUN);
Sue Barnes, School Nurse, St Nicholas School, Chippenham (a school for children and young people, aged 3 – 19, with special needs, 40 – 50% of whom wear continence products);
Mr Tim Mason, carer and representative of the Carers' Support Group.

**The Contract**

10 The provision and delivery of continence products (CP) is undertaken by Medequip. This is one element of a larger contract which provides an integrated community equipment and support service (ICESS). It was

estimated that the continence element of the contract represents 20% of the contract costs. The contract began in January 2012 and was awarded for 5 years with the possibility of an extension of a further 2 years.

11 The contract is jointly commissioned by the Council and the Clinical Commissioning Group (CCG). The CCG developed the service specification for the continence service, with the Council hosting the budget provided by the CCG. As the Council does not pay VAT, unlike the CCG, it allows maximum use of the budget. Joint commissioning also allows a more strategic approach to be adopted. It was suggested that the delivery costs for the continence service were high compared to other local authorities, but was acceptable across the whole contract.

12 Medequip meet with the Council and CCG regularly and meet with the contract monitoring group every 6 weeks. The contract is built on volumes, whereby payment increases with the number using the service.

13 The CCG appointed a lead for the continence service redesign (for 6 months) and also appointed a paediatric continence nurse in September 2013.

14 It is estimated that 3000 – 4000 patients in Wiltshire have continence products delivered.

**The Service**

Delivery

15 The delivery cycle of continence products to client's homes is 8 weeks. The delivery can be extended but not brought forward. After the initial delivery, the client is required to contact Medequip to re-order by either email or free phone. Clients can arrange for deliveries to be left if they are not likely to at home to receive them.

Assessment/re-assessment

16 A copy of the assessment process is contained in Appendix 1. People can self-refer or may be referred by their GP. If a client encounters problems with the products they are using, this should trigger a reassessment which, it was suggested, should be carried out within 2 weeks, or sooner if it is an emergency. A district nurse is not authorised to change the products provided and would need to refer to a specialist nurse if a change is required.

17 Currently health and social care plans are separate. A social care plan can trigger a referral to the continence service, which would then undertake an

investigation to see if there are any underlying causes for the continence that may need to be treated. Continence products may or may not be provided.

18 The national target for 'referral to treatment' from an assessment service, which may result in an onward referral to a consultant-led service, is 18 weeks. It is for the NHS locally to decide how the waiting time rules are applied to individual patients, pathways and specialities, based on clinical judgements. The local target in Wiltshire is for 95% of cases to be treated within 18 weeks.

19 In Wiltshire in 2013-14 there were 231 referrals to the continence service for children. The average waiting time was 14.8 days; 100% were seen in less than 18 weeks. In the same year, 2018 adults were referred. The average waiting time was 35 days; 99.9% were seen in less than 18 weeks. Figures for reassessments were not available at the time of production of this report.

20 A copy of the eligibility criteria for the supply of continence pads is contained in Appendix 2.

Products

21 A range of products is provided from the iDExpert range (previously named Euron). Some clients have up to 3 types of product to address their needs. Clients are allowed a maximum of 4 products per 24 hours. The eligibility criteria state that 'exceptions will arise in certain clinical situations such as terminal illness, or where the individual's output exceeds the functional capacity of 4 pads. The Continence Nurse Specialist may approve exceptions determined by specialist clinical knowledge'. Pull-up pants (pull-ups) are not provided under the service. Clients can purchase additional and/or alternative products from Medequip. Medequip report that sales of continence products are rising month on month (including people not covered by the service).

**Evidence from carers and service users**

Delivery

22 There were significant problems with delivery when the new contract was introduced, with some people not being aware that the service had changed. Medequip reported that most problems were resolved within the first two cycles of deliveries (16 weeks) and currently there were few complaints about deliveries. This was confirmed by carers/users.

23 However, some issues remain. A report was received of deliveries being left outside the home of a wheelchair user. This person was physically not able to

bring these into the house and had to ask a neighbour to assist, causing embarrassment. In addition, some delivery drivers were reported to have made inappropriate/insensitive comments.

Products

24 The majority of the issues raised by carers/users related to the products provided under the contract introduced in January 2012, in particular the number supplied and their style, quality and size.

25 It was stated that 4 products per 24 hours were insufficient for many people. An example was given of a child with a condition that results in him having constant diarrhoea who was not granted additional products.

26 The quality of the products offered in terms of absorbency was also an issue which impacted on people in several serious ways. The absorbency was so poor that some people were reluctant to go out. Other people reduced their fluid intake to try to cope. Many people, although they had been assessed as being entitled to receive products, chose to buy their own, more absorbent products, which in some cases resulted in significant financial hardship.

27 The absorbency of one 'nappy-style' product provided was designed to hold 1600 mls of fluid. The weight of 1600 mls of water is 3.5lbs; it was suggested that the weight of this would be very unpleasant for the wearer.

28 In addition to absorbency, it was reported that the odour control of the products provided was poor, resulting in embarrassment for the wearer.

29 The quality of the products was such that St Nicholas School implemented toileting clinics, which aim to 'time train' some pupils, to manage the products. The support of the paediatric continence nurse in this, and other work, was praised by the school.

30 Sizes of the products offered were a particular issue at the school. The children's sizes were too small and the adults' sizes too large for some of the young people. Also the products were not elasticated around the leg and as a result were prone to leaking. There had been issues with incorrect sizes being provided as the service had used out-of-date records of measurements for the children.

31 A significant issue was the style of product offered; only pads and nappy-style products were provided, pull-ups were not provided. The care workers at many day centres are not required to offer support with personal care, which includes help with continence products. Therefore such day centres will only

accept elderly people who wear pull-ups. People have to buy their own pull-ups if they wish to attend.

32 An example was given of a family with 2 young people with Down's Syndrome who had previously been provided with pull-ups. When the contract changed the young people had to use a nappy-style product, the result of which was that they had regressed in their toileting behaviour and were no longer independent.

33 Pull-ups were considered especially desirable for people with dementia, some of whom had difficulty identifying the nappy-style product as underwear. In addition those with arthritis had great difficulty peeling the protective layer off the sticky tabs that secured the product (2 on each side).

Storage

34 An 8 week supply of products can be extremely bulky and require a large space for storage. This is a particular problem for many elderly people and especially those in sheltered accommodation. Many people have to distribute the products around their homes including in the living room, causing embarrassment and loss of dignity. There are also health and safety issues as the boxes are large with sharp corners. People can easily trip or knock their legs, possibly resulting in ulcers.

35 Medequip indicated that they could look at the possibility of people collecting products from various locations if requested to do so by the commissioners.

Additional issues

36 It was reported that there was a real lack of awareness of the continence service and a lack of literature on the service. People were not aware that they could self refer. Many people were not aware of the help available and delayed asking for help. This could mean that opportunities for using conservative measures for treatment were missed. The approach of some GPs to patients with continence problems was that patients would 'just have to live with it'.

37 One witness who attended the Task Group undertook inspection with the Care Quality Commission (CQC) as an 'expert by experience'. The witness commented that 'with the products and numbers available, domiciliary carers had to function at a lower standard than the CQC would allow in a care home'.

38 The eligibility criteria state that 'Children's product request forms have to be submitted by the Health Visitor or School Nursing Team. Subsequent

changes to requirements will be following updates from the child's parent/carer, who should contact the Salisbury Team'. The school nurse explained that some parents she worked with had needs of their own, including literacy issues, but she had been discouraged from helping such parents as the service maintains that it is the role of the parent to request changes.

39 The most common response to people when trying to obtain alternative products was that 'they are too expensive'.

**Task Group findings/views**

40 The Task Group was focussed on the provision of continence products in the home setting. It did not interview staff from care providers who provide domiciliary care and acknowledges that this would have been another source of information.

41 There was concern about the way the contract had been implemented. Although some staff had attended carers focus meetings to discuss the pending changes, many people were not aware of the changes and the new product range supplied did not meet the full range of needs of those requiring products.

42 The Task Group had included in its remit, looking at 'value for money' in the contract, but was not able to do so. The software in use does not allow accurate figures to be provided and the breakdown between costs for delivery and products cannot be provided. The service itself is unsure of the numbers of people receiving continence products. This issue needs to be resolved if the service is to be able to make informed decisions and to monitor the performance of the contract for continuous improvement as required by the contract.

43 People are assessed each year if no problems arise during the year. It was felt that a year between assessments could be too long for some people, such as those with learning difficulties. The waiting times for assessment were provided and they fall within the national guidelines, but the Task Group would be interested to know what the waiting times are for reassessment.

44 Storage of 8 weeks' supply of products was clearly very difficult for some people, both physically and emotionally. Although the contract allows for deliveries on a 4 – 12 weekly cyclical basis, it is acknowledged that more frequent deliveries may be prohibitively expensive, but the option of collecting supplies could be investigated with the provider. This could be through the use of the existing network of peripheral stores currently in use for urgent provision or through the designated retail outlets referred to in the contract.

There should also be discussions with the housing associations and housing providers to establish what they can do to help resolve the problem.

45 The maximum number of products available was insufficient for some people. Although the eligibility criteria state exceptions can be approved 'determined by specialist clinical knowledge', the Task Group found no example of when this had happened.

46 The size range on offer for children and young people does not accommodate them all. A wider range of sizes needs to be sourced to ensure that the products fit correctly and ideally with elasticated legs to aid a good fit. Where necessary children should be measured to ensure they receive the correct size of product.

47 The quality of product in terms of odour control and absorbency was insufficient for some people. The Task Group was concerned that some people reduced their fluid intake; this is contrary to the advice given to maintain good bladder health and could lead to infections and greater costs to the system. They also felt that if people were reluctant to go out because of the poor absorbency of the products, this would increase their social isolation, with its attendant problems.

48 The Task Group was particularly concerned that the eligibility criteria stated 'pull-up pants would not be supplied', having heard about the impact of that decision on both adults and children. Although the draft Service Review for Continence Services indicates that pull-ups can be approved, again, the Task Group found no cases of this. The ability of children and young people to be able to use pull-ups represented a significant stage in their progress towards independence. Elderly people denied pull-ups risked not being able to attend day centres, and dementia sufferers in particular need a product they can cope with without support.

49 Incontinence is a problem that affects a large number of people but it remains a taboo subject, causing great embarrassment to those afflicted, and the loss of dignity often suffered by people with incontinence should not be underestimated. There is a role for public health to raise the profile of incontinence to help break down this stigma. It is suggested that it could investigate linking to the national publicity campaign that sites posters in motorway services, highlighting potential bladder problems.

50 The continence service itself also needs to increase awareness of the service and what it can provide. Some people do not wish to contact a third party so this information also needs to be made available in such a form that an individual can access it without the need to visit a clinician. Earlier

engagement with the service may mean that people can be helped through various therapies and treatments, so avoiding the need for expensive continence products.

51 The Task Group was impressed by the support and commitment provided by carers, many of whom were family members, and were concerned to hear how long it took some families to obtain what they needed for their relative. Carers described how they were 'worn down' by the system and how many of them gave up trying and resorted to buying the products required. Some people were using their DLA to buy products, a benefit which is intended to provide care.

52 The Task Group acknowledge that there were a number of problems when the contract was introduced and that some of those issues have now been resolved satisfactorily, but it is clear that there are significant problems for some people that have still not been addressed. Account should be taken of the distressing psychological and social effects of incontinence as well as the physical aspects. In addition, the physical and emotional impact this condition can have on carers needs to be recognised.

53 The Task Group believes that the aspects of the continence service it has considered do not accord with the vision the Council is trying to achieve through the Health and Wellbeing Strategy and the Better Care Plan. It believes that a much more holistic approach needs to be adopted and that treatment should take account of individual needs and preferences (as required by the NHS Constitution for England).

54 The Council is committed to ensuring that people can live independently for longer. Incontinence is second only to dementia as the main reason for entering a care home. For carers, incontinence can be the 'last straw' and is often the main reason for the breakdown of the caring relationship, leading to admission to residential care.[1] Providing the most suitable continence products, including pull-ups, must be a priority in maintaining people in their own homes.

55 As the elderly population grows in Wiltshire, so will the number of people requiring the continence service. The draft Review for Continence Services suggests that the total population who are likely to have urinary continence problems could be between 92,974 and 149,651. The budget for the home delivery service of products is currently significantly overspent. When carers' requests for alternative products are declined, expense is the reason usually given.

[1] *Good Practice in Incontinence Services*, Department of Health, 2000

56 The Task Group is mindful of the difficult economic climate and acknowledges that some products may appear to be expensive, but believes very strongly that the provision of poor quality products is a false economy. It believes also that, in considering the cost of the continence service, account needs to be taken of the potential wider costs to the Council and the NHS of not investing in it adequately.

57 Lack of investment could result in more infections and the likelihood of people being admitted or re-admitted to hospital, increased numbers of people entering care/nursing homes, social isolation impacting further on physical and mental health and, importantly, loss of dignity for the people affected.

58 By investing in the service and required products satisfactory outcomes for people will be achieved, complications such as infections are likely to be reduced, carers will be supported and the likelihood of those people needing to enter a care home early reduced. Using a product they can depend on with allow those people currently reluctant to go out, to do so, thereby increasing their activity, social interaction and engagement and quality of life.

**Conclusion**

59 The Task Group considers that the number of products, quality and range currently provided under the contract do not meet the needs of everyone using the continence service. The contract allows alternative products to be sourced if those provided fall below acceptable performance levels.

60 Awareness of continence as an issue and the continence service itself need to be promoted to the general public.

61 The service needs to ensure that it has the necessary data, currently unavailable, to be able to make informed decisions.

62 To support the aim of the Council of people living independently for longer, the continence service needs to take a more holistic view when assessing people for products to support people, and their carers, in the home. It needs to invest at this early stage in suitable products to reduce the number of people potentially going into care homes earlier than they might otherwise. In doing so, it needs to consider the wider costs to the Council and the NHS in not investing adequately in the continence service.

**Recommendations**

63 The Task Group makes the following recommendations:

a) **That the joint commissioners re-evaluate the home delivery service of incontinence products currently being offered, taking into consideration the issues raised above;**

b) **That the Task Group meets with the Wiltshire Clinical Commissioning Group to discuss their findings;**

c) **That the home delivery service of incontinence products is reviewed after 6 months to assess progress made.**

**Next steps**

64 To seek endorsement from the Health Select Committee of the report and its recommendations.

65 To forward the report to the Cabinet member for Public Health, Protection Services, Adult Care and Housing and the Wiltshire Clinical Commissioning Group for written response.

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**Cllr Jeff Osborn, Chairman, Continence Services Task Group**

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**Appendices**

1 Continence assessment and reassessment process

2 Eligibility criteria for supply of continence pads (NHS)

**Background documents**

- Wiltshire Council and Medequip Assistive Technology Ltd Service Agreement
- Service User Consultation Report – Continence Service, 23 May 2012 (Wiltshire Parent Carer Council)
- Draft Service Review for Continence Services 2013 – 2014 (CCG)

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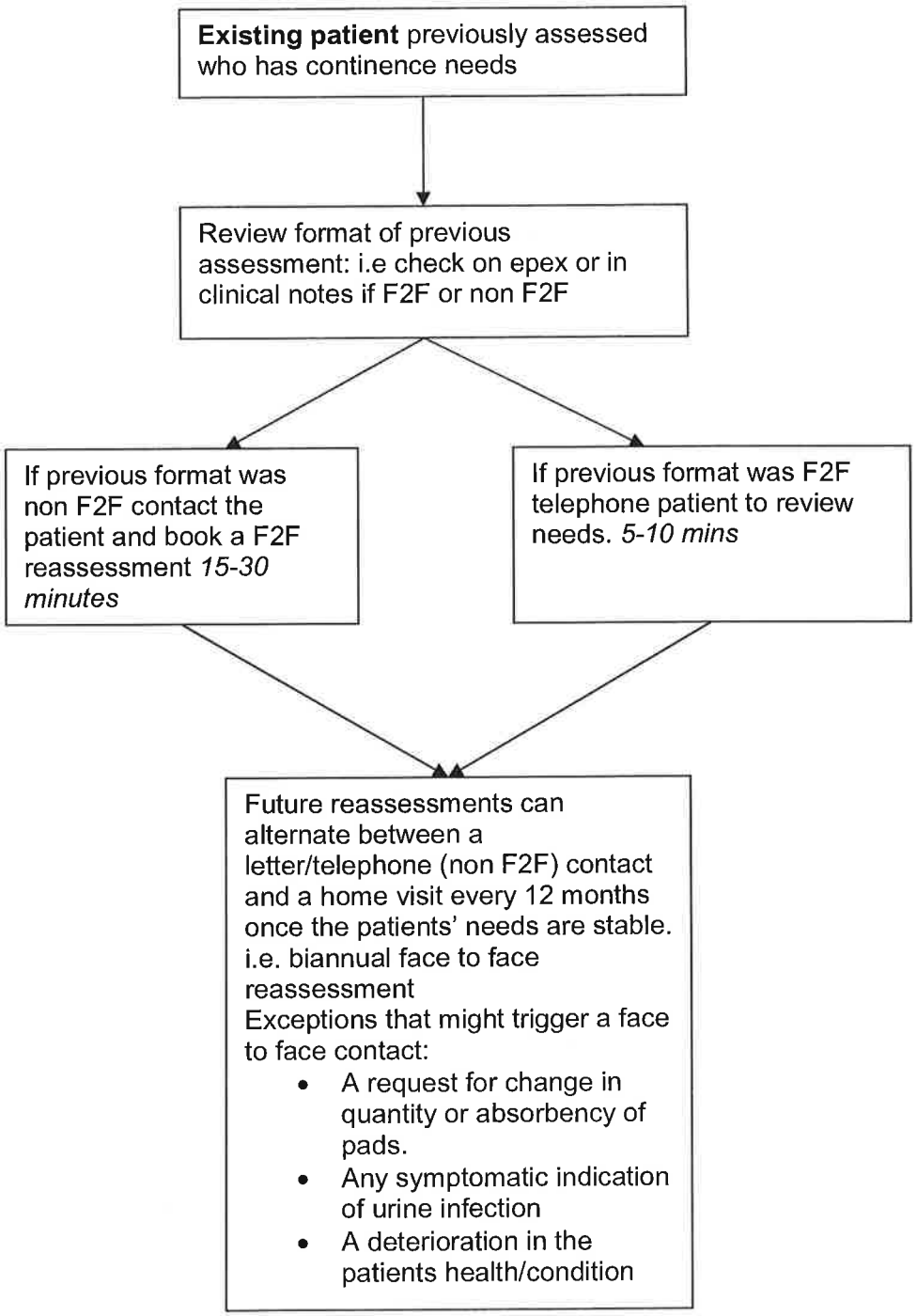
# CONTINENCE ASSESSMENT AND REASSESSMENT PROCESS



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WILTSHIRE CONTINENCE SERVICE

## Eligibility Criteria for Supply of Continence Pads

- Children registered with Wiltshire GP's, from their 4th birthday, with a medically diagnosed condition or disability, in receipt of Disability Living Allowance, following completion of a request form from a healthcare professional. Children's product request forms are to be completed by HV/School Nursing Team and sent to the Salisbury continence office. Subsequent changes to requirements will be following updates from the child's parent/carer and they should be advised to contact the Salisbury continence team on 01722 323196.
- Adults registered with Wiltshire GP's
- Adult continence assessments are to be carried out by a Health Care Professional using the Wiltshire Integrated care pathway.
- The individual experiences incontinence throughout the 24 hour period i.e. not solely nocturnal enuresis.
- The individual experiences a level of incontinence greater than light stress incontinence. (Generally considered to be small leaks that can be managed with a panty liner or light "tena lady" style pad.)
- The individual experiences ongoing faecal incontinence more than twice a day, despite investigation and treatment.
- The individual requires a body worn pad with a level of absorbency above Rothwell band **I8** (small light absorbency pad). (System of banding continence products developed by former PaSA in conjunction with Dr Alan Cottenden and members of the national consultation group for continence and urology. It is based on ISO 11984-1 and total absorbency levels.)
- To require 2 - 4 incontinence body worn pads of **I8** or above per 24 hours.
- If an individual chooses to supplement their supply of pads by purchasing their own, they will still be eligible to receive products from the continence service.
- Where an individual is at high risk of falls at night or are unable to be toileted, they may be supplied a single high absorbency pad to negate the need for toileting, providing they have had a pressure ulcer risk assessment.

**Limitations of the Eligibility Criteria**

- A maximum of 4 pads per 24 hours are supplied. Exceptions to this will arise in certain clinical situations such as terminal illness, or where the individuals output exceeds the functional capacity of 4 pads. The Continence Nurse Specialist may approve exceptions determined by specialist clinical knowledge.
- Incontinence pads with an absorbency below **I8** will not be supplied
- "Pull up pants" will not be supplied. Individuals whom have previously been in receipt of these products will be reassessed by the clinician for alignment to the range of products supplied through the ICESS contract.
- Bed and chair protection will not be supplied
- Individuals with nocturnal enuresis will not be supplied.
- Individuals with indwelling catheters will not be supplied unless for faecal incontinence.
- Individuals, whom experience urinary leakage post urological surgery such as Radical prostatectomy, will be required to purchase their own supplies until their assessment in the continence clinic. Appointments are usually 2-4 weeks post-op. Following assessment NHS supply may be commenced if they are eligible.

Individuals are responsible for sourcing and purchasing products in these situations but the service may be able to signpost where to get them.

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**Wiltshire Council**

**Health Select Committee**

**06 May 2014**

## Report: Delayed Transfers of Care Data

### Purpose of report

1. To present the latest data with respect to Delayed Transfers of Care.

### Definition

2. A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

   a – A clinical decision has been made that patient is ready for transfer AND
   b – A multi-disciplinary team decision has been made that patient is ready for transfer AND
   c – The patient is safe to discharge/transfer.

3. A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.

4. For patients of no fixed abode, the council responsible for the patient is the council whose area they reside. This is irrespective of whether the patient lives on the street or in a hostel.

5. Asylum seekers and others from overseas should be listed under the council in which they currently reside. It is the responsibility of this council to decide whether they are eligible for social services.

### Background

6. Delayed Transfers of Care are seen by the Department of Health as, one of a number of markers of the effective joint working of local partners, and of the effectiveness of the interface between health and social care services.

7. There are 2 measures of Delayed Transfers:

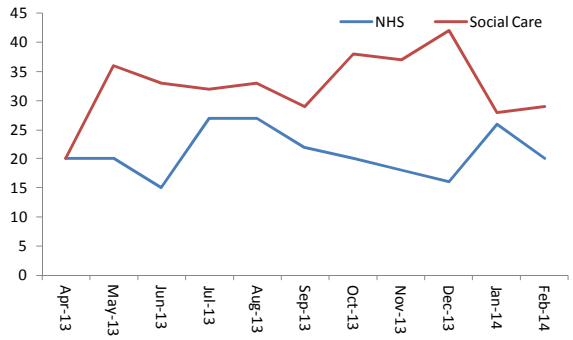
   a. The Adult Social Care Outcomes Framework uses the number of people whose discharge has been delayed occupying a bed at midnight on the last Thursday of a month.
   b. The Better Care Fund Indicator uses the total number of delayed days.

8. The official statistics are collected by NHS England from all acute trusts in England and reported monthly with around a month's delay to allow for collation.

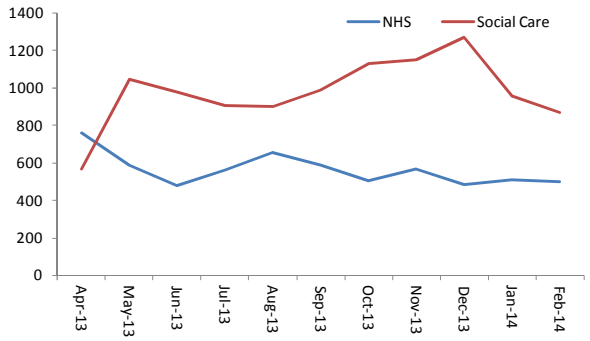
9. NHS Wiltshire CCG collects the data weekly, there is some inconsistency between the weekly data and the official statistics but this is within expected limits.

## Analysis of NHS England Statistics

10. The data from NHS England provides allows for a comprehensive analysis of delayed transfers of care. The charts below show the trends for Wiltshire.




Graph 1 – Delays by responsible organisation




Graph 2 – Delayed days by responsible organisation

| | 2012-13 | 2013-14 (YTD) |
|---|---|---|
| NHS | 20 | 21 |
| Social Care | 30 | 33 |
| Both | 1 | 0 |
| Total | 51 | 54 |

Table 1 – Avg. Monthly Delays by responsible organisation

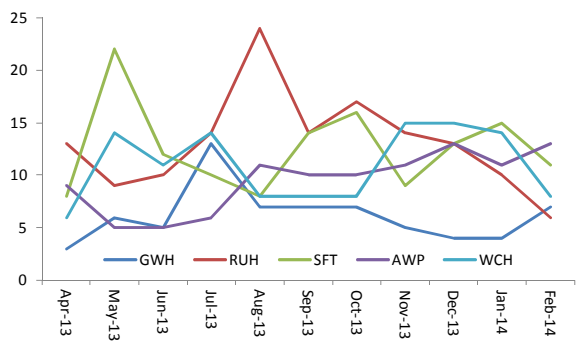
| | 2012-13 | 2013-14 (YTD) |
|---|---|---|
| NHS | 465 | 564 |
| Social Care | 929 | 979 |
| Both | 28 | 10 |
| Total | 1,423 | 1,553 |

Table 2 – Avg. monthly delayed days by responsible org.

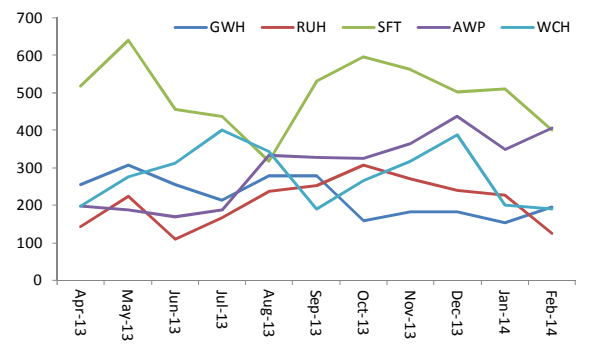
11. The number of people delayed in 2013-14 as measured on the last Thursday of the month has increased slightly (5.6%) when compared to 2012-13. The number of delayed days has increased more substantially (9.1%) when similarly compared.

12. Delayed Days for health reasons (21.3%) have increased more rapidly than Social Care Delays (5.4%).

13. The charts below show the trends for the main providers for all delayed transfers. These 5 providers account for around 98% of the delayed transfers of care for Wiltshire patients.




Graph 3 – Delays by Provider Organisation




Graph 4 – Delayed days by Provider organisation

| | 2012-13 | 2013-14 (YTD) |
|---|---|---|
| GWH | 8 | 6 |
| RUH | 13 | 13 |
| SFT | 12 | 13 |
| AWP | 8 | 9 |
| WCH | 10 | 11 |
| Total | 51 | 54 |

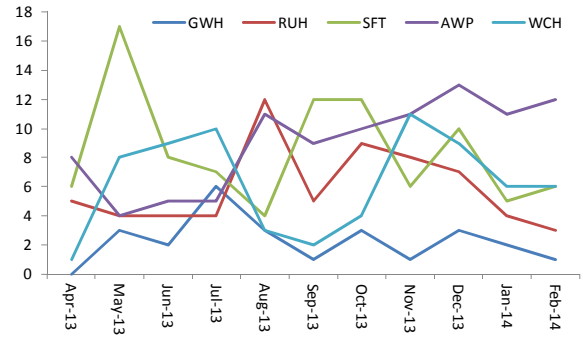
Table 3 – Avg. Monthly Delays by provider organisation

| | 2012-13 | 2013-14 (YTD) |
|---|---|---|
| GWH | 203 | 223 |
| RUH | 192 | 209 |
| SFT | 406 | 498 |
| AWP | 274 | 299 |
| WCH | 325 | 280 |
| Total | 1,423 | 1,553 |

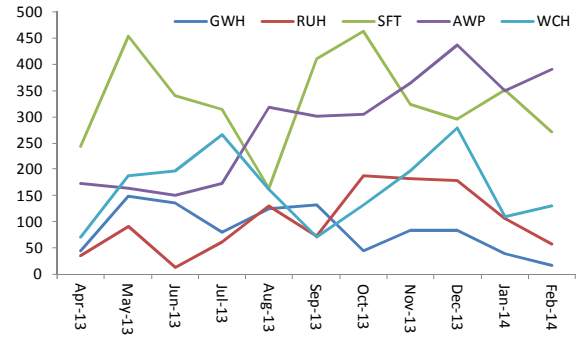
Table 4 – Avg. monthly delayed days by provider

14. Most of the providers show a marginal increase in the number of people delayed on the last Thursday of the month. With the exception of Wiltshire Community Hospitals all providers are showing an increase in the number of delayed days. By far the biggest increase is at Salisbury Foundation Trust (22.6%).

15. Social Care Delays account for around three fifths of all delayed transfers of care. The charts below show the trends for delays where social care is the responsible organisation for the main providers.




Graph 5 – Social Care delays by Provider organisation




Graph 6 – Social Care delayed days by Provider organisation

| | 2012-13 | 2013-14 (YTD) |
|---|---|---|
| GWH | 2 | 2 |
| RUH | 6 | 6 |
| SFT | 8 | 9 |
| AWP | 7 | 9 |
| WCH | 6 | 6 |
| Total | 30 | 33 |

Table 5 – Avg. Monthly Delays by responsible organisation

| | 2012-13 | 2013-14 (YTD) |
|---|---|---|
| GWH | 85 | 85 |
| RUH | 111 | 102 |
| SFT | 270 | 330 |
| AWP | 234 | 284 |
| WCH | 216 | 164 |
| Total | 929 | 979 |

Table 6 – Avg. monthly delayed days by responsible org.

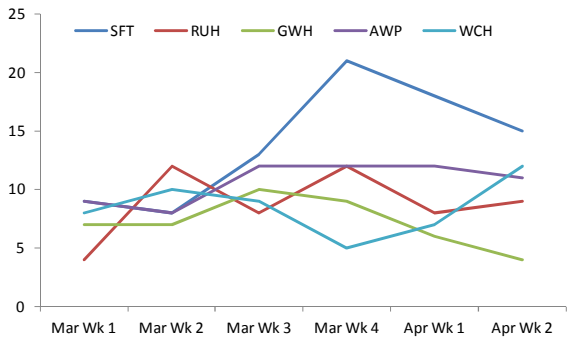
16. Most of the providers show a marginal increase in the number of people delayed on the last Thursday of the month. RUH and Wiltshire Community Hospitals have seen a reduction in the number of social care delayed days while Great Western has seen no change. There are large increases at both Salisbury Foundation Trust (22.2%) and Avon and Wiltshire Partnership (21.4%).

17. The underlying data for each of the charts is showing in Appendix 1.

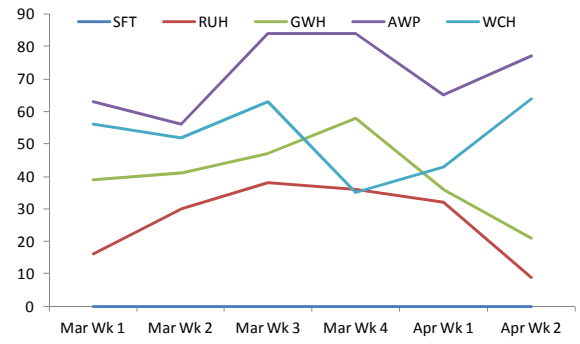
## Analysis of CCG Weekly Data

18. The weekly data is collated by NHS Wiltshire CCG to inform their weekly performance report which is published with around a week's delay. The weekly data is only provisional as there are a number of potential areas of discrepancy between the weekly data and the monthly official statistics:
    a. There may be ongoing discussions between the CCG or ASC and the Providers about the classification of a particular patient/s.
    b. Weeks do not naturally fit into whole months so in some months there will be duplication of a couple of days.
    c. Salisbury Foundation Trust stopped reporting delayed days weekly during 2013-14, despite repeated requests by the CCG have not restarted.

19. The charts show the weekly position for March and April for all delayed transfers of care:




Graph 7 – Delays by provider organisation

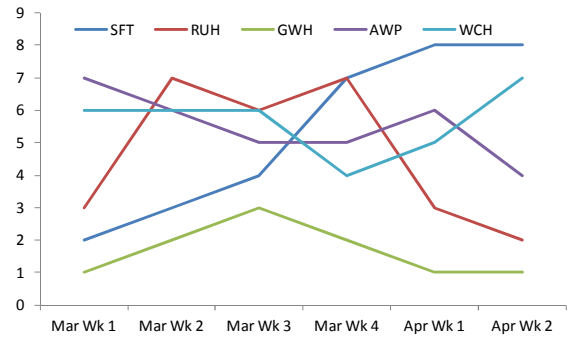



Graph 8 – Delayed days by provider organisation

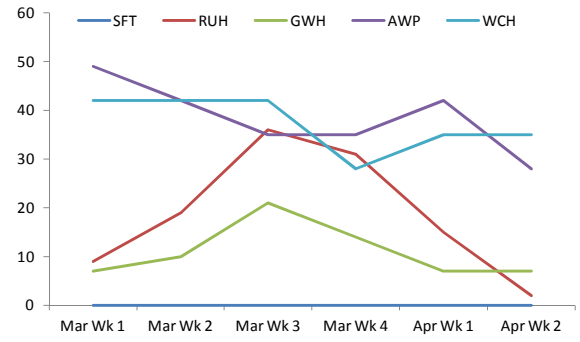
20. For the last week the RUH data for delayed patients and days are the same which is likely to change.

21. With the exception of SFT the number of delays seems to fairly consistent, however SFT has seen a big increase. The delayed days for the trusts which report show a general downward trend with the exception of WCH and AWP.

22. The charts show the weekly position for March and April for social care delayed transfers of care:



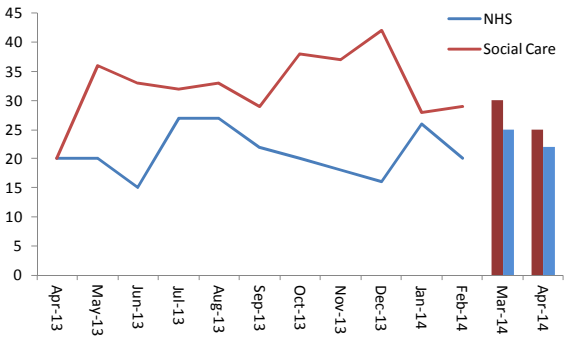

Graph 9 – Social Care delays by provider organisation



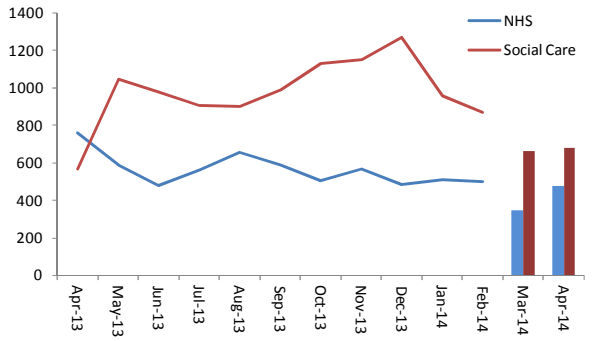

Graph 10 – Social Care delayed days by provider

23. This shows a more stable picture than the overall delayed transfers of care with the number of delays broadly flat. The number of delayed days seems to show a slight decreasing trend.

24. The weekly data provides a good indication of the likely final monthly official figures. Using simple projection techniques the charts below show an update of those seen earlier with the Wiltshire monthly position.




Graph 9 – Delays by responsible organisation



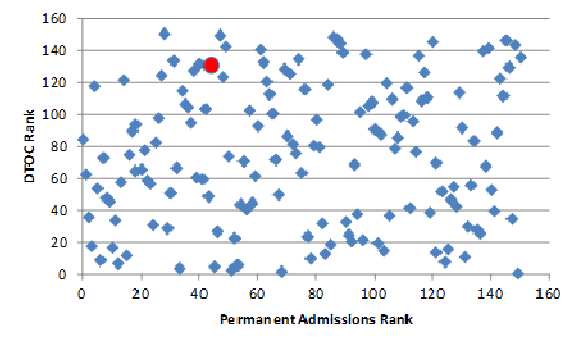

Graph 10 – Delayed days by responsible organisation

25. The number of delays seems to increase slightly in March but may fall again in April. The delayed days seem to show a continued reduction. This is likely to be caused by the lack of delayed days from SFT and the projection methods used.

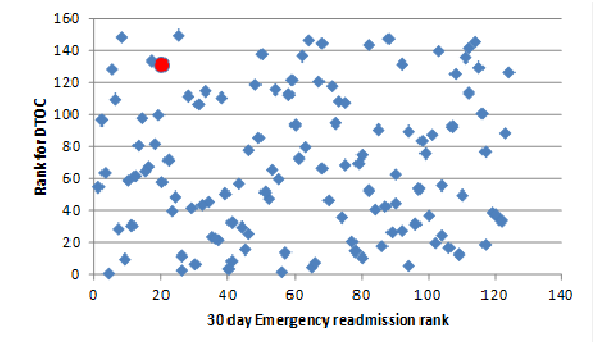
26. The underlying data for each of the charts is showing in Appendix 1.

## Analysis of relationship with other indicators

Indicators such as Permanent admissions to care homes and 30 day emergency readmissions are other indicators of the effective joint working between health and social care. Analysis of the rank of Wiltshire Council for DTOC and other indicators is shown in the following graphs.




Graph 11 – Permanent Admissions to Care Homes & DTOC




Graph 12 – 30 day Emg Readmissions & DTOC

The performance of Wiltshire Council is within the Top quartile nationally for both these indicators while our DTOC position is in the bottom quartile. The initiatives being undertaken to reduce delayed transfers are designed to ensure this good performance is not adversely impacted.

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**Cllr Keith Humphries (lead)**

Report Author: Jeremy Hooper, Interim Public Health Scientist
01225 716699 jeremy.hooper@wiltshire.gov.uk

**APPENDIX 1 – Data Tables**

27. The following tables show the data for the charts presented above:

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS | 20 | 20 | 15 | 27 | 27 | 22 | 20 | 18 | 16 | 26 | 20 |
| SC | 20 | 36 | 33 | 32 | 33 | 29 | 38 | 37 | 42 | 28 | 29 |
| Both | 2 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 |
| All | 42 | 56 | 48 | 59 | 60 | 53 | 58 | 55 | 58 | 54 | 49 |

Number of delays on last Thursday of the month by responsible organisation

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NHS | 760 | 590 | 481 | 561 | 655 | 591 | 505 | 565 | 486 | 508 | 501 |
| SC | 568 | 1,045 | 979 | 908 | 902 | 988 | 1,131 | 1,152 | 1,272 | 958 | 867 |
| Both | 41 | 0 | 0 | 5 | 8 | 28 | 21 | 2 | 0 | 0 | 0 |
| All | 1,369 | 1,635 | 1,460 | 1,474 | 1,565 | 1,607 | 1,657 | 1,719 | 1,758 | 1,466 | 1,368 |

Number of delayed days for the Month by responsible organisation

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|
| GWH | 3 | 6 | 5 | 13 | 7 | 7 | 7 | 5 | 4 | 4 | 7 |
| RUH | 13 | 9 | 10 | 14 | 24 | 14 | 17 | 14 | 13 | 10 | 6 |
| SFT | 8 | 22 | 12 | 10 | 8 | 14 | 16 | 9 | 13 | 15 | 11 |
| AWP | 9 | 5 | 5 | 6 | 11 | 10 | 10 | 11 | 13 | 11 | 13 |
| WCH | 6 | 14 | 11 | 14 | 8 | 8 | 8 | 15 | 15 | 14 | 8 |
| Others | 3 | 0 | 5 | 2 | 2 | 0 | 0 | 1 | 0 | 0 | 4 |

Number of delays on last Thursday of the month by provider

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|
| GWH | 254 | 306 | 256 | 213 | 278 | 278 | 159 | 182 | 182 | 153 | 196 |
| RUH | 144 | 224 | 109 | 168 | 236 | 252 | 306 | 272 | 240 | 227 | 126 |
| SFT | 518 | 641 | 456 | 437 | 317 | 531 | 597 | 563 | 503 | 510 | 400 |
| AWP | 199 | 187 | 169 | 188 | 334 | 327 | 326 | 365 | 437 | 350 | 406 |
| WCH | 198 | 277 | 312 | 400 | 343 | 189 | 266 | 317 | 388 | 200 | 191 |
| Others | 56 | 0 | 158 | 68 | 57 | 30 | 3 | 20 | 8 | 26 | 49 |

Number of delayed days for the Month by provider

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|
| GWH | 0 | 3 | 2 | 6 | 3 | 1 | 3 | 1 | 3 | 2 | 1 |
| RUH | 5 | 4 | 4 | 4 | 12 | 5 | 9 | 8 | 7 | 4 | 3 |
| SFT | 6 | 17 | 8 | 7 | 4 | 12 | 12 | 6 | 10 | 5 | 6 |
| AWP | 8 | 4 | 5 | 5 | 11 | 9 | 10 | 11 | 13 | 11 | 12 |
| WCH | 1 | 8 | 9 | 10 | 3 | 2 | 4 | 11 | 9 | 6 | 6 |
| Others | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |

Number of social care delays on last Thursday of the month by provider

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|
| GWH | 45 | 149 | 135 | 81 | 124 | 132 | 44 | 84 | 83 | 40 | 16 |
| RUH | 36 | 91 | 13 | 61 | 130 | 73 | 188 | 183 | 178 | 107 | 57 |
| SFT | 243 | 454 | 340 | 314 | 163 | 411 | 462 | 323 | 296 | 352 | 271 |
| AWP | 173 | 163 | 151 | 173 | 317 | 302 | 304 | 365 | 437 | 350 | 391 |
| WCH | 71 | 188 | 198 | 265 | 161 | 70 | 133 | 197 | 278 | 109 | 130 |
| Others | 0 | 0 | 142 | 14 | 7 | 0 | 0 | 0 | 0 | 0 | 2 |

Number of social care delayed days for the Month by provider

| | 06/03/2014 | 13/03/2014 | 20/03/2014 | 27/03/2014 | 03/04/2014 | 10/04/2014 |
|---|---|---|---|---|---|---|
| GWH | 7 | 7 | 10 | 9 | 6 | 4 |
| RUH | 4 | 12 | 8 | 12 | 8 | 9 |
| SFT | 9 | 8 | 12 | 21 | 18 | 15 |
| AWP | 9 | 8 | 12 | 12 | 12 | 11 |
| WCH | 8 | 10 | 9 | 5 | 7 | 12 |

Number of delays for the week by provider

| | 06/03/2014 | 13/03/2014 | 20/03/2014 | 27/03/2014 | 03/04/2014 | 10/04/2014 |
|---|---|---|---|---|---|---|
| GWH | 39 | 41 | 47 | 58 | 36 | 21 |
| RUH | 16 | 30 | 38 | 36 | 32 | 32 |
| SFT | | | | | | |
| AWP | 63 | 56 | 84 | 84 | 65 | 77 |
| WCH | 56 | 52 | 63 | 35 | 43 | 64 |

Number of delayed days for the week by provider

| | 06/03/2014 | 13/03/2014 | 20/03/2014 | 27/03/2014 | 03/04/2014 | 10/04/2014 |
|---|---|---|---|---|---|---|
| GWH | 1 | 2 | 3 | 2 | 1 | 1 |
| RUH | 3 | 7 | 6 | 7 | 3 | 2 |
| SFT | 2 | 3 | 4 | 7 | 8 | 8 |
| AWP | 7 | 6 | 5 | 5 | 6 | 4 |
| WCH | 6 | 6 | 6 | 4 | 5 | 7 |

Number of social care delays for the week by provider

| | 06/03/2014 | 13/03/2014 | 20/03/2014 | 27/03/2014 | 03/04/2014 | 10/04/2014 |
|---|---|---|---|---|---|---|
| GWH | 7 | 10 | 21 | 14 | 7 | 7 |
| RUH | 9 | 19 | 36 | 31 | 15 | 2 |
| SFT | | | | | | |
| AWP | 49 | 42 | 35 | 35 | 42 | 28 |
| WCH | 42 | 42 | 42 | 28 | 35 | 35 |

Number of social care delayed days for the week by provider

| | Mar – Based on Weekly | April – Projection based on 2 weeks |
|---|---|---|
| NHS | 30 | 25 |
| SC | 25 | 22 |
| Both | 4 | 4 |
| All | 59 | 51 |

Estimated number of delays on last Thursday of the month by responsible organisation

| | Mar – Based on Weekly | April – Projection based on 2 weeks |
|---|---|---|
| NHS | 347 | 477 |
| SC | 666 | 680 |
| Both | 49 | 60 |
| All | 1062 | 1217 |

Number of delayed days for the Month by responsible organisation

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**Wiltshire Council**

**Health Select Committee**

**6th May 2014**

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**Subject:** **OLDER PEOPLE'S ACCOMMODATION DEVELOPMENT STRATEGY – ANNUAL UPDATE REPORT**

**Cabinet member:** **Councillor Toby Sturgis / Cllr Keith Humphries**

**Key Decision:** **No**

---

## Purpose of report

1. To update Members of the Health Select Committee on the progress of the implementation of the Older People Accommodation Development Strategy.

## Background

2. In order to address the shortage of appropriate facilities for older people, an Older People's Accommodation Development Strategy was produced and approved by Members in January 2011. The 10 year development strategy aims to:

    - modernise and improve the way that older people's accommodation is provided;
    - develop and adopt an integrated accommodation system;
    - ensure the best use of increasingly scarce resources; and
    - to respond to local needs in local communities.

3. The Strategy identified that there was a significant under-provision of extra care housing across all tenures within Wiltshire and set out the need for an additional 1,100 units of extra care accommodation across all community areas by 2026.

4. There was also an under supply of nursing care homes and specialist care homes for people with dementia with a large number of residential care homes that are not sustainable in the longer term.

5. The various accommodation is being developed utilising a variety of partnerships, contractual arrangements and funding opportunities including the Council's long-term partnering agreement with the Orders of St John Care Trust (OSJCT); a preferred development partner framework agreement for extra care; the review of existing sheltered housing provision [to ensure best use is made of existing assets] and working with independent sector providers and housing associations.

Main considerations for Members

6. The Strategy will ensure that there will be fit for purpose accommodation available across the county to support a wide range of need, thus enabling people to live within their community area for as long as they can with access to specialist accommodation and care and support when they need it. Development or redevelopment of different types of housing provision will enable communities to become more sustainable giving people more choice and control over their housing options and assist the council in managing future budgetary pressures.

7. The projected timescales of some developments have been brought forward whereas others have taken longer to come to fruition than was originally anticipated. In certain instances, the requirements for a community area have changed due to the need to respond to proposed changes in demographics and / or service provision. Registered Housing Providers have also been less willing to commit resources to extra care given the additional costs over traditional general needs housing, at a time when their budgets and grant funding has been reduced. As a result greater subsidies are being sought from Wiltshire Council to facilitate delivery.

8. The Strategy is constantly being reviewed to ensure that we remain on course to deliver the new accommodation that is needed across Wiltshire and reflect the changing environment. As part of that process, the following activities are being undertaken:

- A Review of the Extra Care Framework through which we manage our procurement of new schemes, looking at improving its effectiveness and alternative delivery routes.

- Working with the Orders of St John Care Trust to ensure demand for specialist care is met through reprovision, homes that are not fit for purpose are closed and that surplus land is sold to fund the wider development programme.

- Bidding for additional funding to subsidise the development of new extra care, including a bid in April 2014 to the Homes and Communities Agency's (HCA) Affordable Homes Programme 2015-18. We have been successful in earlier rounds and this has enabled up to support the delivery of two extra care schemes.

- Continuing to make best use of existing assets, such as sheltered housing, to ensure that it meets the needs of older people into the future and working with housing partners to identify some schemes that may be suitable for remodelling to extra care.

- Forging greater links with the CCG and local health care providers to ensure that older people's accommodation is developed in partnership and that there is joint commissioning of health, housing and social care outcomes.

- Looking to identify synergies with the development of a Campus in each community area, including how services for older people can be better delivered and the joint use of facilities where there are opportunities to do so.

Development Update

9. The current status of the developments in each of the community areas is set out below.

10. **Amesbury:** The Council has secured a 60 unit extra care scheme on the new King's Gate development through a Section 106 agreement. This will eventually see the site being transferred to Wiltshire Council and the development of a scheme tendered. We anticipate a start on site in 2016 with the scheme operational by 2017.

11. **Bradford on Avon:** A new private 60 bed care home and 18 units assisted living [open market] have been developed on the former hospital site. There is still a need for additional affordable extra care units in the town and a site needs to be identified.

12. **Calne:** We are working with GreenSquare Housing to identify how we can deliver 50 units of extra care in the town. A number of options are being explored and we anticipate that there will be firm proposals before the end of the year.

13. **Chippenham:** Work continues to identify a site for extra care and a care home. The Middlefields site on Hungerdown Lane was under consideration but Members have asked for other options to be considered to deliver up to 60 units of extra care. We are also working with the Orders of St John Care Trust to identify a site in the town for a new 80 bed specialist care home.

14. **Corsham:** The strategy identified the need for an 80 bed care home and a 50 unit extra care housing scheme. Outline planning permission has been obtained to provide extra care as part of a section 106 agreement on the Copenacre site. We are also working with the Orders of St John Care Trust to identify a site in the town for a new 60 bed specialist care home.

15. **Devizes:** Construction has started on the development of an 80 bed nursing and dementia care home in Horton Road. The development is being managed by the Orders of St John Care Trust and is due to be completed in November 2014. Residents at both Anzac House and Southfields care homes will move to the new care home and both existing facilities will be closed.

16. Approval also has been given by Cabinet in November 2013 to use the Southfields site for a 40 to 50 unit extra care scheme. Work will begin shortly

to start designing a new scheme and commence to start a procurement process to appoint a developer. Construction is likely to be completed by summer 2016. Crammer Court in the town already provides 50 units of extra care.

17. **Malmesbury:** Heads of Terms have been agreed with Abbeyfield [Housing Partner] and Leadbitter plc for the development of a mixed tenure 48-53 unit extra care scheme on the site of the former Burnham House care home. A planning application should be submitted by the developer this summer with a start on site towards the end of 2014. We anticipate that the scheme will be operation by summer 2016.

18. **Marlborough:** OSJ have bought the freehold of Coombe End Court care home but no extension is now planned – this home will meet care needs in Marlborough. 50 units of extra care are also needed in the town but no site has yet been identified.

19. **Melksham:** 60 units of extra care are required but no site has yet been identified.

20. **Mere:** 45 units of extra care are required but no site has yet been identified.

21. **Pewsey:** There are already 32 units of extra care at Meadow Court in the town. A further 23 units will be required in the long term and a site has not yet been identified.

22. **Wootton Bassett:** Housing 21 has been given planning permission for the construction of a 48 unit extra care scheme in the town – this will be a mixture of units for affordable rent and shared ownership. Construction should start this summer and this will see us nominating tenants into the scheme from about March 2015.

23. **Purton:** Wiltshire Council has negotiated a 50 unit extra care scheme on the Ridgeway Farm development as part of a section 106 agreement. We anticipate that this scheme will start to proceed within the next two years.

24. **Cricklade:** A Working Group has been established in Cricklade to progress the development of 50 unit of extra care. Options are currently being investigated with GreenSquare Housing and we expect to have some detailed proposals later this summer.

25. **Southern:** The Orders of St John Care Trust [OSJ] has planning permission for a 120 bed dementia and nursing home at Old Sarum and construction is likely to start in the coming weeks. There is also a need for 52 units of extra care in this Community Area and a site needs to be identified.

26. **Salisbury:** Wiltshire Council has negotiated a 50 unit extra care scheme on the Fugglestone Red development through as part of a section 106 agreement. We anticipate that this scheme will start to proceed within the next two years.

27. **Tidworth:** 40 units of extra care are required but no site has yet been identified.

28. **Tisbury:** there is a requirement for extra care units in Tisbury and we anticipate that there will be some firm proposals by the summer.

29. **Trowbridge:** The Orders of St John Care Trust [OSJ have purchased The Paddocks site and submitted a planning application for a new 64 bed dementia care home at the end of February with a decision expected in mid May. There are currently 40 units of extra care at Florence Court and a further 70 units will be required, although a site[s] has not yet been identified.

30. **Warminster:** The construction of a new 82 bed nursing and dementia OSJCT care home is expected to be completed this August. As a result, Woodmead care home will close and residents will move across to the new home by the end of the year. 50 units of extra care are also being negotiated through a section 106 agreement as part of the West Warminster Urban Extension.

31. **Westbury:** Discussions continue with partners, including Selwood Housing, to identify a site for the development of 50 units of extra care. We anticipate that there will be firm proposals before the summer.

32. **Wilton:** 33 units of extra care are required but no site has yet been identified.

Conclusion

33. Significant progress has been made in the implementation the Older People's Accommodation Development Strategy since its adoption in January 2011. Over the last year, construction has started on two new care homes and we expect start on site on two new extra care schemes in 2014.

34. Whilst development has been slower than expected in some areas, as set out above, progress is being made and we fully anticipate that the required number of extra units and new specialist care homes will be delivered over the next 10 years.

35. The development of these facilities will ensure appropriate provision to meet the needs and expectations of the growing older population across Wiltshire, whilst providing choice and maximising independence in a cost effective manner.

36. Members are asked to note the progress of the Older People's Accommodation Development Strategy.

**Maggie Rae**
**Corporate Director**

Report Author: James Cawley
Associate Director
Adult Care Commissioning, Safeguarding and Housing

Date of report: 24th April 2014

**Background Papers**

The following documents have been relied on in the preparation of this report:

i. Older People Accommodation Development Strategy – Cabinet Report, 25th January 2011

ii. Preferred Development Framework / Burnham House, Malmesbury – Cabinet Capital Assets Committee Report, 14th September 2011

iii. Devizes Extra Care scheme – Cabinet Capital Assets Committee Report, 21st November 2011

**Appendices**

None.

**Wiltshire Council**

**Health Select Committee**

**6 May 2014**

## Report on Wiltshire's Mental Health Strategy

### Purpose of report

1. To present an update to the Committee on the work of Public Health to produce a joint Mental Health Strategy for the County with the Clinical Commissioning Group (CCG).

### Background

2. Wiltshire Council's vision is to create stronger and more resilient communities which are inclusive and in which everyone is able to achieve their potential, lead a high-quality life and is protected from harm.

3. To achieve this vision it is necessary to narrow the achievement and aspiration 'gap' between people from vulnerable groups and to ensure those who require support have control over their daily lives and can shape services around their needs and aspirations. We aim to deliver Public Services to support people of all ages to take responsibility for not only their own physical wellbeing, but their mental wellbeing.

4. Without action, the demand for health, social care and mental health services is predicted to increase substantially, putting strain on carers and public services. Wiltshire's retirement-age population is predicted to increase from 21.5% of the population in 2011 to 29.8% in 2026. By 2020 the number of older people with dementia will double and the number with long-term health conditions will triple.

5. Population data shows that 25% of us will experience poor mental health at some point in our lives, with 15% of us experiencing this at any one time, giving an indication of the chronic nature of poor mental health for those affected. We aspire for a sense of mental wellbeing for everyone in our communities, young or old, with or without a previous period of poor mental health, and whatever their economic and social situation.

6. Measures to improve mental health will not only make our communities more resilient but, through early intervention work, we have the opportunity to reduce the incidence of and cost of mental health. The Department of Health currently estimates that for every £1 invested in early diagnosis and treatment of depression at work, total economic returns of £5.03 and for every £1 invested in early intervention in psychosis, total economic returns of £17.97.

7. To realise its vision of stronger communities in which everyone is able to achieve their potential Wiltshire Council is working with the Clinical Commissioning Group to produce a five year joint mental health strategy to

support all those who live and work in Wiltshire to achieve and sustain good mental health and wellbeing.

8. The Council and CCG are committed to joint commissioning for mental health. This will be a new way of working, enabling a more co-ordinated, efficient and therefore responsive and cost-effective service that allows for enhancing quality of life for all.

9. In line with our Business Plan, our Joint Health and Wellbeing Strategy 2014-2015, and Wiltshire CCG's Five Year Plan 2014-2019, we seek to design and deliver a mental health and wellbeing strategy to ensure that people in the county are supported to live healthily and independently, are listened to, involved and kept safe from harm.

**Position, April 2014**

10. The model being proposed through this five year strategy, in line with all health and wellbeing in Wiltshire, is community centred and will be delivered through:

    a) strengthening social capital via the community area boards, education and local partners;

    b) enhanced seven day primary care and community based solutions with improved multidisciplinary services wrapped around general practice rather than being acute care or hospital centric;

    c) a single point of access for health and social care and for these multidisciplinary teams to share data and information with increasing use of shared technology to avoid duplication in assessments;

    d) encouraging personal responsibility; and

    e) addressing the wider determinants of poor mental health and wellbeing especially in vulnerable individuals, groups and communities.

11. Work has been undertaken to include key messages from international and national organisations such as the World Health Organisation, Department of Health, Royal Colleges, national reports including those from national mental health charities and our own strategic direction over the next five years.

12. Stakeholder meetings have taken place with the wide variety of local professionals and partners who work within the field mental health, and with our service users via the Wiltshire Service User Network (WSUN).

13. We enter this next five year period in a strong position there are aspects of care in Wiltshire that have recently seen significant enhancement:

    a) We now have three places of safety, available 24/7, for all ages, spread across the county for those needing urgent assessment under section 136 of the mental health act.
    b) We have significantly increased investment in liaison psychiatry in all three of our acute hospitals. Our self referral community psychology service 'LIFT'

is consistently in the top ten Improving Access to Psychological Therapies (IAPT) services in the country.

c) Where possible, individuals with mental health problems are treated in the community as this supports long term recovery, is more cost effective, preferred by patients and allows for building of community resilience and reduction of stigma and discrimination.
d) In a national well-being annual population survey 81.2% of respondents said they were satisfied with life.

14. The strategy will focus on improving partnership working, continuing to build robust safeguarding mechanisms for those that are particularly vulnerable, providing support and education to build life skills, and recognising and responding to the factors that contribute to poor mental health. A new approach will also allow ensure better signposting to resources and education, that our services are accessible, an assessment of our current accommodation needs and provision, and whether transport is a barrier to people getting jobs and thus sustaining their mental wellbeing.

**Next stages**

15. The draft Wiltshire Mental Health Strategy is due to be discussed with the CCG team and will be submitted to Cabinet for approval.

16. The Strategy will then be submitted to the Health Select Committee for comment.

17. A period of public consultation will then be undertaken before the final Strategy is published and a new model of working instituted.

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**For the attention of the local health/social care overview and scrutiny committee chair**

**April-June 2014 CQC Inspection Programme**

Dear health/social care overview and scrutiny committee chair,

I'm pleased to inform you of our inspection plans for April-June 2014/15, where we will be carrying out inspections in the following sectors:

- Acute Hospitals
- Mental Health
- Community Health
- NHS GP Practices and GP out of hours services (we are inspecting a sample of GPs and out of hours services in 12 clinical commissioning group areas to test our new approach)

A list of the trusts and CCG areas is shown at the end of this letter. We will be making contact with your committee/s before an inspection if you are based in any of the areas covered by these services and trusts. This will give you a chance to advise us how we can best gather peoples' experiences of care, and give you the opportunity to share information you have about these services.

You can also send us information now. The table below gives you the email boxes you can use. If you have information that cuts across different services, please send it to whichever mailbox you feel is most relevant and we will make sure the information gets to the right inspection team.

There are some differences in our approach to inspecting different services, but they all aim to answer five key questions about an organisation:

- Is it **safe**?
- Is it **effective**?
- Is it **caring**?
- Is it **responsive** to people's needs?
- Is it **well-led**?

All NHS acute hospitals will now be rated as outstanding; good; require improvement; or inadequate. We are developing our approach to ratings in other sectors.

We would like you to share any feedback which is relevant about the quality of care provided by these organisations and any of the services they provide. This includes evidence of high-quality care as well as concerns you have identified. We will use your information to help the inspection team plan the inspection and what to look for on the inspection.

We may summarise the information you send us in the data pack we produce for each organisation, unless you specifically ask us not to. The evidence will not contain personal or confidential information and we understand that any references to examples you share will be anonymised.

During April-June we will also be carrying out inspections of Adult Social Care services. Some of these will test our new approach to inspecting these services and some will use our current approach. These are all unannounced and therefore we will not be publishing the details. However we would be interested in any information you may have about adult social care services in your area. You can contact us via ascinspections@cqc.org.uk or by phoning 03000 616161. You can also discuss these inspections with your local CQC contact.

After the NHS inspections, CQC will hold Quality Summits to discuss the inspection findings and any improvement action needed. The local health overview and scrutiny committees will be invited to take part in the Quality Summit.

**Please note:** We will continue to make sure you have a local CQC contact and be able to discuss our inspections with them. We would also encourage you to sign up for our new e-mail alerts about inspections of your local care services.

Yours sincerely

Professor Sir Mike Richards, Chief Inspector of Hospitals
Professor Steve Fields, Chief Inspector of General Practice
Andrea Sutcliffe, Chief Inspector of Adult Social Care

# Overview and Scrutiny Work Plan

| Committee | Review / Task Group | Mar-14 | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Scrutiny Officer | STATUS (incl. date) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Cabinet 18th Mar | Cabinet 22nd April | Cabinet 20th May | Cabinet 17th Jun | Cabinet 22nd Jul | | Cabinet 16nd Sep | Cabinet 7th Oct | Cabinet 11th Nov | | |
| | | | | Council 13th May | | Council 29th Jul | | | Council 21st Oct | | | |
| HEALTH | Tranfers to Care Task Group | Review in progress | | | | | | | | | ED | Task Group to meet in May to review impact of DtoC measures |
| | Continence Services Task Group | Review in progress | | Health May 2014 | | | | | | | MM | Task Group reviewing provision of continence products. Report to HSC May 2014 |
| | Review of AWP/Dementia Services | Review in progress | | | | | | | | | MM | Task Group reviewing provision of revised dementia services. Awaiting completion on consultation on Dementia Strategy. |
| | Help to Live at Home | | | | Review in progress | | | | | | MM | Task Group to commence June 2014 to consider Peer Review on HTLAH. |
| | Local Safeguarding Adults Board Annual Report | | | | | | | Health Sept 2014 | | | MM | Annual Report Next due Sept 2014 |
| | Public Health Annual Report | | | | | | | Health Sept 2014 | | | MM | Annual Report Next due Sept 2014 |

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