Central
Bedfordshire
Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

TO EACH MEMBER OF THE
SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE

23 July 2013

Dear Councillor

SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE - Monday 29 July 2013

Further to the Agenda and papers for the above meeting, previously circulated, please find attached the following additional reports:-

2. Minutes

To approve as a correct record the Minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 10 June 2013 and to note actions taken since that meeting.

10. East of England Ambulance Trust Turnaround Plan

Attached is an additional covering report which provides further guidance relating to the turnaround plan for the East of England Ambulance Trust.

Should you have any queries regarding the above please contact the Overview and Scrutiny Team on Tel: 0300 300 4196.

Yours sincerely

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Scrutiny Policy Adviser
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CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE** held in Council Chamber, Priory House, Monks Walk, Shefford on Monday, 10 June 2013.

PRESENT

Cllr Mrs R J Drinkwater (Chairman)
Cllr N J Sheppard (Vice-Chairman)

Cllrs	R D Berry	Cllrs	Mrs S A Goodchild
	Mrs G Clarke		Mrs D B Gurney
	P A Duckett		M A Smith

Apologies for Absence: Cllrs D Bowater, P Hollick

Substitutes: Cllrs Mrs R B Gammons

Members in Attendance: Cllrs P N Aldis, C C Gomm, A M Turner — Deputy Executive Member for Social Care, Health & Housing

Officers in Attendance:			
	Ms D Clarke	–	Director of Improvement and Corporate Services
	Mrs P Everitt	–	Research and Business Support Officer
	Ms C Harding	–	Corporate Policy Advisor (Equality & Diversity)
	Mrs J Ogley	–	Director of Social Care, Health and Housing
	Mr J Partridge	–	Scrutiny Policy Adviser
	Mr B Queen	–	Interim Head of Operations - Housing Service
	Mr S Rees	–	Assistant Director Adult Social Care
	Ms E Saunders	–	Assistant Director Commissioning
	Mrs G Stanton	–	Chief Communications Officer

Others in Attendance		
	Mr J Boswell	Bedfordshire Rural Communities Charity
	Ms R Featherstone	Chair - Healthwatch Central Bedfordshire
	Dr D Gray	Director of Strategy and System Redesign (Bedfordshire Clinical Commissioning Group)
	Ms B Moran	Arlesey Village Agent

SCHH/13/17 **Minutes**

RESOLVED

That the minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 29 April 2013 be confirmed and signed by the Chairman as a correct record.

SCHH/13/18 **Members' Interests**

- Cllr Mrs Clarke declared an interest as a family member worked for the Clinical Commissioning Group
- Cllr Mrs Goodchild declared an interest as a member of her family was a service user.

SCHH/13/19 **Chairman's Announcements and Communications**

The Chairman announced that no comments had been received from Committee Members on the Annual Quality Accounts and a nil response had been sent.

The Chairman also drew the Committee's attention to a referral from the Audit Committee regarding strategic risks they had been asked to consider. The risks related to insufficient staff resources resulting in the under or mis-direction of investment in the transformation of adult social care services, and insufficient capacity, expertise and competency to deliver the Adult Social Care and Housing agenda. The Director of Social Care Health and Housing explained the process and steps taken to mitigate the risks. In light of the discussion the Committee agreed that they had received adequate assurances and no further action was necessary.

SCHH/13/20 **Petitions**

No petitions were received from members of the public in accordance with the Public Participation Procedure as set out in Part D2 of the Constitution.

SCHH/13/21 **Questions, Statements or Deputations**

The Committee were informed that one speaker had registered to speak. With the agreement of the speaker, the Chairman invited the person to speak at the start of agenda item 10.

SCHH/13/22 **Call-In**

The Panel was advised that no decisions of the Executive had been referred to the Panel under the Call-in Procedures set out in Appendix "A" to Rule No. S18 of the Overview and Scrutiny Procedure Rules.

SCHH/13/23 **Requested Items**

No items were referred to the Committee for consideration at the request of a Member under Procedure Rule 3.1 of Part D2 of the Constitution.

SCHH/13/24 **Executive Member Update**

The Deputy Member for Social Care, Health and Housing updated the Committee on issues pertaining to their portfolio that were not included on the agenda, these included:-

- Attendance at the Developing Health Care meeting arranged by the Clinical Commissioning Group.
- Public Health Bedfordshire had been successfully awarded £400,000 in Government grant through the 'lets get moving' scheme. The Committee would be updated on the development of this scheme at a future meeting.

SCHH/13/25 **Joint Community Bed Review**

A Member of the Public expressed his thanks to the Committee that Biggleswade Hospital would remain open after months of campaigning. Thanks were also extended to the Biggleswade and Sandy Councillors for their support.

The Director of Strategy and System Redesign Bedfordshire Clinical Commissioning Group (BCCG) introduced the Central Bedfordshire Health and Social Care Review – a review of Community Bed Provision in Central Bedfordshire and recommendations for improvement. The report drews out priorities for joint development between NHS Bedfordshire, CCG and CBC through:-

- Development of community bed based services in the north of Central Bedfordshire, by amending the admission criteria for Biggleswade Hospital.
- Development of urgent care pathways
- A single approach to commissioning care home services.

The Bedfordshire CCG had restructured its team and a Deputy Director had been appointed to work with Social Care officers. The recommended future model included:

- Ensuring that services were designed around the customer, so they had choice and access to high quality services.
- Developing a step up, step down facility for the North of Central Bedfordshire. A pilot scheme in Houghton Regis and Dunstable had proved successful, providing intensive support to help residents get back on their feet after a stay in hospital.

- Improving dementia care by establishing a quality accreditation scheme and rewarding high quality care homes.
- An investment programme of extra care and supported living, giving older resident with care needs a greater choice of accommodation locally.

The Committee discussed the contents of the review and a number of points were raised as follows:

- The importance of continuing negotiations with GPs to develop their surgeries following on from the successful of the Step Up, Step down facility in Houghton Regis.
- The importance of providing care at home and training carers so patients can stay in their own homes.
- Concern that a patient, family member or carer would find it difficult to navigate their way through the urgent care pathway and the importance of clear signposting for all. The Director of Strategy and System Redesign (BCCG) reassured the Committee this area was being developed and she would report back on the work undertaken.

In response the Director of Social Care Health and Housing confirmed there was a close working relationship with BCCG to provide a new framework agreement and a single commissioning arrangement. Bearing in mind the complexity of there being no district hospital, the need to ensure Central Bedfordshire residents were not overlooked and had the same options available to them as those in Luton and Bedford was paramount.

The Committee thanked the Director of Strategy and System Redesign (BCCG) for a very welcome report that provided a clear vision for the future.

RECOMMENDED

1. **That the model of care as set out in the paper at Section 4 be endorsed.**
2. **That the three priorities for joint development as set out in the paper at Section 5 be endorsed.**
3. **That the Director of Strategy and System Redesign (BCCG) develop clear guidance for patients, carers and family members to negotiate the urgent care pathway and update the Committee at a future meeting.**

SCHH/13/26 **Arlesey Village Agent**

The Assistant Director Adult Social Care and the Deputy Chief Executive, Bedfordshire Rural Communities Charity (BRCC) delivered a joint presentation which provided Members with an overview of the village agent scheme. The presentation specifically covered:-

- How to building local support networks
- Acting as a facilitator to provide information, advice, guidance and provide access to a wide range of services
- The employment and management of the Arlesey Village Agent

- Referrals handled by the Arlesey Village Agent, which came mainly from vulnerable residents
- Outcomes and key findings and recommendations.

In light of the presentation, the Committee discussed the following issues in detail.

- Whether funding of the pilot scheme could continue until September. The Director of SCH&H confirmed funds were available and future funding would be discussed during the budget setting process.
- Whether the agent's role duplicated the work of ward Members. The Deputy Director of BRCC commented he would not recommend this role to every Town and Parish Council. The village agent complements Councillors work rather than duplicated it.
- Members were supportive of the proactive nature of the Arlesey Village Agent's work. During discussion it was accepted that Members did not have all the necessary skills and knowledge to provide a full village agent service.
- The need for clear pathways to information and services and the building of relationships with the voluntary sector services was key to identify gaps and prevent emergencies.
- The need to share case studies of good practice.

The Committee wished to formally thank Assistant Director of Adult Social Care who was retiring from the Council.

RECOMMENDED

1. **That the Village Agent role in Arlesey be continued until the end of the pilot in September.**
2. **That future funding arrangements for the Village Agent Scheme be discussed during the budget setting process.**

SCHH/13/27 **Homelessness Strategy**

The Interim Head of Operations delivered a presentation on the Homelessness Strategy, which provided members with an update on the current strategy and the need for a mid-term review.

In light of the presentation, the Committee discussed the following issues in detail:-

- The current Lets Rent scheme and how it was working. It was confirmed that the scheme would be reviewed with the possibility of inviting all estate agents to take part.
- The issue of homelessness at home with the additional pressure on the Council emanating from the Government's Welfare Reforms and the need to find housing for 18-20 year olds. It was confirmed this would be a key factor of the review
- The threat of mortgage repossessions and the importance of evidence to support a claim. The Interim Head of Operations confirmed the Council worked hard with its partners to avoid repossessions where possible.

- The need to match homelessness facilities in the north of the district to that available in the south.

Members of the Committee were reminded that a Seminar on Housing Allocations was due to take place on Friday 14 June in the Chamber at Priory House and all Members are invited to attend.

RECOMMENDATION

- **That the information contained in the presentation be noted.**
- **A progress report be received in January 2014 on the areas highlighted in the presentation.**

SCHH/13/28 **Equality and Diversity Strategy**

The Director of Improvement and Corporate Services introduced the Equality and Diversity Strategy to the Committee. In response to the Strategy and the further clarification provided by the Director of Improvement and Corporate Services Members of the Committee discussed the following:-

- The Strategy should include references to the Big Society.
- The need for the Disability Guide for Councillors to be updated and reference made to the Equality and Diversity Strategy. Members also commented on the high levels of abuse on disabled people highlighted in the presentation. The Corporate Policy Adviser (Equality and Diversity) confirmed the Community Safety Partnership Executive had picked up on these findings and an improved approach was being discussed.
- Whether complaints received by the public and staff had informed the strategy. The Corporate Policy Adviser explained that although complaints were not referred to specifically in the Strategy, they had informed it and case studies were used in equality training.

RECOMMENDED

That the Strategy be supported and the comments of the Committee be considered by the Director of Improvement and Corporate Services. In addition to incorporating a reference to the Big Society.

SCHH/13/29 **Work Programme 2013/14 and Executive Forward Plan**

The Committee considered its current work programme and the latest Executive Forward Plan and were informed that the following items had been added to the work programme.

1. Sheltered Housing (29 July 2013)
2. Winterbourne View (9 September 2013)

RESOLVED that the Committee's Work Programme be approved subject to the amendments as detailed in the Minute above.

(Note: The meeting commenced at 10.00 a.m. and concluded at 12.40 p.m.)

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East of England Ambulance Service NHS Trust

Background
The Trust was created in 2006 and covers the six counties which make up the east of England - Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. The Trust provides a range of services, but is best known for the 999 emergency services.

The Trust employs around 4,000 staff and 1,500 volunteers to deal with over 900,000 999 calls every year. In addition the Trust handles more than one million non-emergency patient journeys to and from routine hospital appointments (patient transport services).
The Trust's control rooms (located in Bedford, Chelmsford and Norwich) are handling more 999 calls every year, as demand on the ambulance service continues to increase. Around 30% of these calls are classified as potentially life threatening.

Over the past few years the Trust has been pursuing a strategy of delivering a more tailored service to patients – the right care, in the right place at the right time. As a result, the Trust has the lowest conveyance rates of patients to hospitals in the country.

It has also introduced more in depth telephone assessment for those patients with less serious conditions to get them the help they really need (which could be advice over the phone or referral to a more appropriate health service such as their GP or minor injuries unit) rather than sending an ambulance.

This is being carried out by Clinical Support Desks who are now saving over 800 ambulance journeys a weeks. This is better for the patients as they get the help they need without needing to go to hospital, better for the NHS and hospitals and it frees up ambulances to respond to patients who really need an emergency response.

The Trust also provides other services such as running the 111 number in Norfolk, first aid training, driver training and resilience plus patient transport services.

How 999 calls are prioritised
All 999 calls received into our control rooms (Health & Emergency Operations Centres) are triaged by call handlers using software called the Advanced Medical Priority System. The purpose of the triage is to identify the seriousness of the patient's condition by asking a series of focussed questions around the chief complaint to determine the priority of the call.

The call priority then determines the level and type of response sent in line with Trust policies and national and government targets, so that those in most need get the fastest response. The call priorities and level of response are broken down into red and green categories nationally:

- Red 1 and Red 2
  These are calls that are classified as immediately life threatening and require an emergency response (with blue lights). The target is to arrive at these patients within 8 minutes irrespective of location in 75% of cases. For example, Cardiac Arrest for Red 1 or Stroke for Red 2

- Green 1
  These are serious calls but not life threatening which require an emergency response to arrive within 20 minutes. For example a road traffic collision.

- Green 2
  These are serious calls, but not life threatening, which require an emergency response to arrive within 30 minutes. For example a fall with a fracture to the leg.

- Green 3
  These are low acuity calls which require a response within 60 minutes or a telephone assessment within 20 minutes (a clinician calling back for a secondary telephone triage to establish the best pathway of care) or an ambulance response at normal road speed within one hour. For example a headache but fully alert.

- Green 4
  These are the lowest acuity calls which require a response within 60 minutes or a telephone assessment within 60 minutes. For example, a fall but no injury or diarrhoea and vomiting.

The Trust's Turnaround plan and Governance review

In mid-December the Board appointed a new interim Chief Executive – Andrew Morgan. Subsequently a new interim Chair, Dr Geoff Harris, has also been appointed to the Trust. Following the publication of an independent Governance review that was commissioned by the NHS Trust Development Authority, five of the Trust's Non-Executive Directors resigned. Recruitment for these posts is underway with adverts on the NHS Trust Development Authority website. Two interim non executive directors have been appointed whilst this recruitment is underway.

The Trust has developed a single action plan that incorporates actions from the published Turnaround Plan and the recommendations from the Governance Review. This plan recognises that the organisation needs to improve its services to patients and build better staff engagement and empowerment. This has been submitted to the NHS Trust Development Authority for review.

Some of the turnaround plan's highlights include:

- **recruit** 82 specialist paramedics, 149 paramedics, 24 emergency medical technicians and 96 emergency care assistants
- this front line recruitment in addition to reducing staff sickness and reducing spend on private ambulances will enable the Trust to **provide the equivalent of at least an extra 25** of its own 24/7 double staffed ambulances
- **meet tough sickness absence targets**, aiming for a 1% point decrease in frontline sickness every month for six months from June
- **investing in people** by re-launching the emergency medical technician career pathway and developing clear career pathways for front line staff
- **devolve management and accountability** away from a centralised management system through an operational management restructure
- **implement an organisational development strategy** which will better empower, involve and engage with staff

These proactive measures will better support staff already working in the service and help the Trust work towards excellent, sustainable clinical care for patients.

Some examples of early progress (as of 30 Jun) with the Action Plan are:

- **Recruiting**: over 60 paramedics and 60 Emergency Care Assistants recruited or offered posts.

- **Sickness absence**: sickness in May stood at 6.25%. Whilst this is still a concern, this is the fifth consecutive month that it has reduced.
- **Sector approach** – three sector leaders have been appointed and are being held to account via quarterly reviews to discuss performance and local accountability
- **Improved internal and external engagement** – an internal 'Listening into Action' scheme is underway with strong staff participation alongside a comprehensive external engagement plan with MPs, HOSCs, Healthwatch and other stakeholders
- **What work is taking place to respond to these challenges?**
    - Patient safety remains our first concern and we are working very hard to ensure all our patients get the service they need.
    - Over the past few years the Trust has been pursuing a strategy of delivering a more tailored service to patients – the right care, in the right place at the right time. As a result, the Trust has the lowest conveyance rates of patients to hospitals in the country.
    - The Trust is continually looking to improve the quality of the services it delivers. The public, rightly, demand better services year on year and it is the Trust's job to drive forward improvements. There is significant work being undertaken at all levels to improve the level of service that the Ambulance service supplies to Bedfordshire.
    - The Trust has already invested an extra £5 million from its own resources into front line services. It has now launched a programme to invest a further £20 million into front line services by finding savings out of all not patient contact areas.

Currently in Bedfordshire the Trust is trialling a pilot to improve the stroke response and outcome for patients. Wherever possible the Trust will send a double staffed ambulance to all calls triaged as a possible stoke as the first response. This may cause a small decline in local Red performance but is the right thing to do for the patients of Bedfordshire to ensure they get a transportable resource, as quickly as possible, to take them to the nearest stroke centre.

The Trust has started to work with PEPS (Partnership in Excellence Palliative care) based at Sue Ryder in Moggerhanger, who specialise in offering support to palliative care patients and their families. The Trust is educating ambulance crews to contact this centre direct for advise on any palliative care issues and where appropriate take referrals to St. Johns rather than admission to hospital.

What is being done to ensure people know what to expect when they contact the emergency services?

- The Trust's main challenges is around managing people's expectations – unless you've been fortunate to learn more at school, no-one is ever really told what to expect from any emergency service so expectations are built up based on other people's experiences, the picture 20 or 30 years ago when you called 999, and/or what people *think* should happen
- When someone calls 999 they are given as best an estimation as possible of what the ambulance service's response will be (a crew, a car, 'hear and treat', etc.). Clearly if a patient is in cardiac arrest or in another life-threatened situation, the patient should expect a very quick face to face response (for these patients, we

should be there in eight minutes at least 75% of the time) but otherwise we try to estimate with those less seriously ill what to realistically expect in the time immediately following their call

- The Trust has an online information package to educate people on how 999 calls are handled and prioritised. *Right Call* includes a frequently asked questions sheet which gives details about the service, how calls are handled, and a myth buster. It also includes a flowchart that shows how types of call are triaged. This campaign is regularly shared with, and highlighted to, all stakeholders including the media.
- Additionally, the Trust's website also carries information about how to use the service, and when other NHS services or indeed self-help would be more appropriate
- The Trust is basing a new campaign on challenging public perception about how the ambulance service responds to patients – it's unlikely that we can change behaviours in the short term or in isolation, so the additional challenge is to say 'if you use us this way, this is what is likely to happen'. In other words people respond less well to 'don't call us' campaigning, but instead to 'actions and consequence'-type messaging
- Ambulance services nationally are also working on an awareness campaign to help build a national 'identity' and address head-on some of the common challenges all services have. This will have, hopefully, the same impact as successful national campaigns such as the British Heart Foundation 'hard and fast', and the stroke awareness FAST campaigns.

Bedfordshire CCG area performance

	Target	**April – June 2012**	**July – Sept 2012**	**Oct – Dec 2012**	**Jan – Mar 2013**	**Apr – Jun 2013**
Red1	75%	78.7	79.2	77.4	79.5	80.1
Red 2	75%	77.9	78.9	76.9	76.8	79.4
A19	95%	98.6	98.0	97.6	97.7	97.8
Green 1	75%	86.4	88.6	88.0	88.4	87.7
Green 2/3	75%	86.1	86.4	83.1	87.3	88.4
Green 4	75%	77.5	80.5	76.9	82.7	84.9

Performance in terms of the quality of care given to patients in Bedfordshire is shown in the table below.

Indicator	**Trust target**	**2012/13**	**April 2013**
ROSC at time of arrival at hospital	21.5%	27.8%	25%
ROSC at time of arrival at hospital (Ustein Comparator Group)	45.0%	51.2%	100%
Survival to discharge from cardiac arrest – overall survival rate	6%	7.0%	12.5%
Survival to discharge from cardiac arrest – Utstein comparator group	25.0%	20.0%	100%
Percentage of patients suffering a STEMI who receive an appropriate care bundle	80.0%	89.8%	77.3%
Percentage of FAST positive stroke patients who arrive at a hyperacute stroke centre within 60 minutes of call	62.0%	58.1%	44.4%
Percentage of suspected stroke patients who receive an appropriate care bundle	95.0%	95.7%	97.1%

Notes to ambulance clinical quality indicators

Clinical quality indicator	Description
Return of Spontaneous Circulation	Following a cardiac arrest, the Return of Spontaneous Circulation or ROSC (e.g. signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene. By including both out of hospital and in-hospital periods of care, this measure reflects the effectiveness of the whole acute healthcare system in managing out of hospital cardiac arrest, showing the care delivered by both ambulance services and acute trusts. ROSC and survival to discharge are calculated for two patient groups: the overall rate measures the overall effectiveness of care; the rate for the 'Utstein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival (e.g. 999 calls where the arrest was not witnessed and the patient may have gone into arrest several hours before the 999 call are included in the figures for all patients but are excluded from the Utstein comparator group figure).
Outcome from acute ST-elevation myocardial infarction	Heart attack or ST segment elevation myocardial infarction (STEMI) is caused by a prolonged period of blocked blood supply. It is vital that blood flow is quickly restored through clinical interventions such as primary percutaneous coronary intervention. In addition, patients with STEMI need to be managed in the correct way, including the administration of an appropriate care bundle (i.e. a package of clinical interventions that are known to benefit the health outcomes of patients).
Outcome from Stroke	The health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis.

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