Buckinghamshire County Council

Select Committee

Health and Adult Social Care

Date: Friday 7 February 2020

Time: 9.45 am **(pre-meeting for Committee Members at 9.00am)**

Venue: Mezzanine Room 1, County Hall, Aylesbury

AGENDA

9.00 am Pre-meeting Discussion

This session is for members of the Committee only. It is to allow the members time to discuss lines of questioning, areas for discussion and what needs to be achieved during the meeting.

9.45 am Formal Meeting Begins

Agenda Item		Time	Page No
1	**APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP**	**09:45**	
2	**DECLARATIONS OF INTEREST** To disclose any Personal or Disclosable Pecuniary Interests		
3	**MINUTES** of the meeting held on Thursday 14 November 2019 to be confirmed as a correct record. Also attached is the recommendation monitoring update for the Support for Carers Inquiry – RAG status at 6 months and a summary table showing the activity to date.		**7 - 20**
4	**CHAIRMAN'S UPDATE**		
5	**BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST - UPDATE ON RECENT ENGAGEMENT EXERCISE ON FUTURE OF NHS COMMISSIONING** In October, the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System published an engagement document around the proposals for future arrangements for NHS commissioning. This item will	**10:00**	**21 - 26**

discuss the feedback from the engagement exercise and the next steps.

Attendees:
Ms F Wise, Executive Lead, BOB Integrated Care System

Papers:
Power point presentation on Future of NHS Commissioning Arrangements

Links to additional background papers:

https://bobstp.org.uk/media/1766/future-of-nhs-commissioning-arrangements_-engagement-report-january-2020.pdf

https://bobstp.org.uk/media/1767/2020-01-ccg-management-arrangements-and-engagement-report-vfinal.pdf

https://bobstp.org.uk/media/1768/appendix-1-table-of-stakeholder-mitigations.pdf

https://bobstp.org.uk/media/1769/appendix-2-ccg-engagement-activities.pdf

https://bobstp.org.uk/media/1770/appendix-3-draft-ao-jd-v0-5.pdf

6	**DEVELOPING HEALTH & SOCIAL CARE IN THE COMMUNITY**	**10:30**	**27 - 36**

In July 2019, Primary Care Networks (PCNs) were launched in Buckinghamshire and nationwide which heralded a new kind of collaboration between groups of GP practices and other community based health and care service, with the aim of benefitting both patients and surgeries.

Across the country many GP practices are coping with unprecedented pressures, due to increased workload, increased demand, an aging workforce and a shortage of GPs. At the same time, many patients today have illnesses that are treated in hospital when care provided in the community would have better outcomes. Community services such as general practice, social care, mental health and voluntary community groups will need to work together to achieve these better outcomes. The formation of PCNs seeks to address both these issues.

Buckinghamshire has 12 PCNs, covering the population of the entire county and involving all 50 of its practices.

Attendees:
Ms L Smith, Interim Director Primary Care and Transformation
Dr A Bates, Westongrove Primary Care Network
Lin Hazell, Cabinet Member for Health & Wellbeing
Ms G Quinton, Executive Director, Communities, Health and Adult Social Care, Buckinghamshire County Council
Ms K Jackson, Service Director (Integrated Care), Buckinghamshire County Council
Ms J Hoare, Managing Director, Bucks Integrated Care Partnership

Papers:
Power point presentation

7	**SHARED APPROACH TO PREVENTION** The Committee will hear from Public Health Practitioners and the Clinical Director for Health Inequalities about the system wide project on social isolation and the work being undertaken to reduce health inequalities.	**12:00**	**37 - 46**

Attendees:
Mr G Williams, Cabinet Member for Community Engagement and Public Health
Dr J O'Grady, Director of Public Health
Ms T Ironmonger, Assistant Director of Public Health
Dr R Sawhney, Clinical Director for Health Inequalities and the Primary Care Networks DES

Papers:
Power point presentation

8	**BREAK**	**12:30**	
9	**DELIVERING HEALTH & SOCIAL CARE IN THE HOSPITAL AND COMMUNITY SETTINGS** The Committee will hear from representatives from Buckinghamshire Healthcare NHS Trust (BHT) and the Cabinet Member for Health & Wellbeing and Senior Officers from the Council's Adult Social Care team. This item focuses on the Hospital Trust's improvement journey (2014-2020) and reviews the achievements and challenges still facing the Trust.	**13:00**	**47 - 66**

The Committee will also hear about the continuing progress

with the development of integrated “home first” model and the formal integration of services with the Council, including Discharge and linking with Community Boards and Primary Care Networks.

Attendees:
Mr D Williams, Director of Strategy and Business Development, BHT
Dr T Kenny, Medical Director, BHT
Lin Hazell, Cabinet Member for Health & Wellbeing
Ms G Quinton, Executive Director, Communities, Health & Adult Social Care, Buckinghamshire County Council
Ms K Jackson, Service Director (Integrated Care), Buckinghamshire County Council

Papers:
Power point presentation

10	**UPDATE ON THE TEMPORARY CLOSURE OF CHARTRIDGE WARD, AMERSHAM HOSPITAL**	**14:15**	**67 - 76**

In response to the CQC imposing conditions of registration on Buckinghamshire Healthcare Trust’s (BHT) community wards, Chartridge ward has been closed to admissions since 1 July 2019. A suite of service improvements have been introduced to ensure a high quality service can be provided with our community inpatient capacity reduced by 22 beds.

The Committee will review the impact on the health and social care system following the temporary closure and hear about the future options being looked at by the Integrated Care Partnership.

Attendees:
Mr D Williams, Director of Strategy and Business Development, BHT
Dr T Kenny, Medical Director, BHT
Ms K Jackson, Service Director (Integrated Care), Buckinghamshire County Council

Papers:
Briefing paper

11	**HASC SELECT COMMITTEE - A RETROSPECTIVE**	**14:45**	**77 - 82**

An opportunity for members of the Committee to consider the work the Committee has undertaken since 2017 and how this has contributed to driving improvements. The Committee will also be able to highlight specific issues that the new Unitary Council might want to monitor going

forwards.

Contributors:
All Committee Members

Papers:
A Retrospective report

12 DATE AND TIME OF NEXT MEETING **15:00**
This is the final meeting of the Health & Adult Social Care Select Committee.

Purpose of the committee

The role of the Health and Adult Social Care Select Committee is to hold decision-makers to account for improving outcomes and services for Buckinghamshire.

It shall have the power to scrutinise all issues in relation to Health and Adult Social Care. This will include, but not exclusively, responsibility for scrutinising issues in relation to:

- Public health and wellbeing
- NHS services
- Health and social care commissioning
- GPs and medical centres
- Dental Practices
- Health and social care performance
- Private health services
- Family wellbeing
- Adult social services
- Older people
- Adult safeguarding
- Physical and sensory services
- Learning disabilities
- Drugs and Alcohol Action Team (DAAT services)

* *In accordance with the BCC Constitution, this Committee shall act as the designated Committee responsible for the scrutiny of health matters holding external health partners to account.*

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For further information please contact: Liz Wheaton on 01296 383856 , email: ewheaton@buckscc.gov.uk

Members

Mr M Appleyard (C)
Mr R Bagge
Mr W Bendyshe-Brown
Mrs P Birchley (VC)
Mrs L Clarke OBE
Mr C Etholen
Mr S Lambert
Mr D Martin
Mr I Rashid
Mr B Roberts
Julia Wassell

Co-opted Members

Mr A Green, Wycombe District Council
Ms S Jenkins, Aylesbury Vale District Council
Dr W Matthews, South Bucks District Council
Mr N Shepherd, Chiltern District Council
Mr M Souto, Healthwatch Bucks

Buckinghamshire County Council
Select Committee
Health and Adult Social Care

Minutes

HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

Minutes from the meeting held on Thursday 14 November 2019, in Mezzanine Room 1, County Hall, Aylesbury, commencing at 10.03 am and concluding at 12.45 pm.

This meeting was webcast. To review the detailed discussions that took place, please see the webcast which can be found at http://www.buckscc.public-i.tv/
The webcasts are retained on this website for 6 months. Recordings of any previous meetings beyond this can be requested (contact: democracy@buckscc.gov.uk)

MEMBERS PRESENT

Buckinghamshire County Council

Mr M Appleyard (In the Chair)
Mr R Bagge, Mr W Bendyshe-Brown, Mrs P Birchley, Mrs L Clarke OBE and Mr D Martin

District Councils

Mr A Green	Wycombe District Council
Dr W Matthews	South Bucks District Council
Mr B Clarke OBE	Healthwatch Bucks
Ms J MacBean	Chiltern District Council

Others in Attendance

Mrs E Wheaton, Committee and Governance Adviser
Ms H Cannon, Organisational Development Consultant
Mr J Everson, Senior Commissioning Manager
Ms J O'Neill, Head of HR & OD Consultancy
Ms L Truett, Commissioning Manager
Ms L Patten, Chief Executive, Clinical Commissioning Group

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies were received from Mr C Etholen, Mr S Lambert, Mr B Roberts and Julia Wassell.

Mr B Clarke substituted for Ms T Jervis from Healthwatch Bucks and Ms J MacBean substituted for Mr N Shepherd from Chiltern District Council.

Lin Hazell, Cabinet Member for Health & Wellbeing sent her apologies.

2 DECLARATIONS OF INTEREST

There were no declarations of interest.

3 MINUTES

The minutes of the meeting held on Thursday 19th September 2019 were agreed as a correct record.

4 PUBLIC QUESTIONS

The Chairman reported that a number of public questions had been submitted by Mr T Snaith in advance of the meeting. Mr Snaith's questions related to the future plans for primary care provision in Wycombe. The questions were sent onto the Buckinghamshire Clinical Commissioning Group who provided a written response to the questions. The responses had been sent to Mr Snaith and were also attached to the agenda for the meeting.

5 CHAIRMAN'S UPDATE

The Chairman updated the Committee on the following events and activities since the last meeting.

- A key stakeholder event took place to discuss the future options for Chartridge Ward. The feedback from this meeting would assist Buckinghamshire Healthcare NHS Trust in shaping the future options.
- The Chairman had been invited to attend an Investors in Carers GP Standard award ceremony hosted by Carers Bucks.
- Buckinghamshire Healthcare NHS Trust's open day and AGM took place on 21st September. It was well attended with many local groups taking part in the event.

6 COMMITTEE UPDATE

Committee Members provided the following updates.

- Healthwatch Bucks updated on the following:
    - Live Well, Stay Well (report published)
    - Musculoskeletal (report publilshed)
    - Special Care for Veterans (ongoing project)
    - Dementia (ongoing project)
    - Healthwatch Bucks had hired an interim CEO.
- Mr B Bendyshe-Brown reported that he was the Chairman of the Community Covenant Board. The organisation was working hard to gain recognition of Veterans across the County. Bucks Healthcare Trust would be shortly signing the Community Covenant which was part of the NHS drive to recognise the vulnerability of Veterans. Mr Bendyshe-Brown also reported that those people leaving the services would be issued with a Veterans card and those who had already left the services would be issued one retrospectively.
- Mr D Martin reported that he was working with Mrs A Macpherson on a check and challenge of the Adult Social Care budget, as part of the pre-budget process.
- Mr R Bagge provided an update on his involvement with NICE, which included focussing on Community Pharmacy and improving outcomes for people. He was also Vice-Chairman of Public Health Community Engagement group which was reviewing how to reduce sexually transmitted diseases.

7 SUPPORT FOR CARERS - 6 MONTH RECOMMENDATION IMPLEMENTATION MONITORING

The Chairman welcomed Mr J Everson, Senior Commissioning Manager, Ms L Truett, Commissioning Manager, Ms J O'Neill, Head of HR and OD Consultancy and Ms H Cannon, Organisational Development Consultant.

The purpose of the item was to update Members on the six month progress on implementing the recommendations in the support for carers inquiry report.

During the discussion, the following main points were made.

- The action plan had been co-produced with carers and was aligned to the aims of the Better Lives strategy.
- Emergency planning information was now included as part of the assessment form.
- Carers Bucks had recruited link workers in schools to provide training for teachers around how to identify young carers and provide the relevant interventions and support.
- An independent review was being undertaken of the GP Award for Supporting Carers. Four GP surgeries had been awarded with the Carers Award and a further four surgeries were being evaluated.
- There would be more engagement on the Carers Strategy in early 2020.
- Young carers were able to access three levels of support:
    - Group sessions with other young carers;
    - More targeted interventions;
    - 1:1 counselling.
- The same levels of support were available to adult carers and work was being carried out to ensure a seamless transition between young carers and adults.
- Carers Bucks were also delivering early help mental health intervention in schools.
- The challenges around young carers identifying themselves as carers was acknowledged and work was underway to help address this and to ensure they receive the required support.
- A Member asked whether there was evidence to show that more young carers were being identified. Mr Everson responded by saying that 9 months ago there were 880 young carers registered with Carers Bucks and the latest figure was 1,252 young carers.
- There was also a drive to promote "Time to Talk" within families to highlight the value of discussing issues within the family setting.
- In response to a question about what was being done to address those who were left behind in their education, Mr Everson explained that Carers Bucks were working hard with the young carers aged 16-17 years onwards to ensure they overcome barriers to achieving their educational potential and also assisting them with gaining employment.
- In developing the carers strategy, engagement with partner organisations such as the Local Enterprise Partnership and Bucks Business First would be key. The strategy was due to be finalised and approved in 2020.
- In relation to recommendations 6, 7 and 8, which all related to the support for carers provided by the County Council, Ms O'Neill explained that an E-Learning module had been launched for employees which focussed on what it means to be carer and signpost to various support services.
- A Carers Support Forum had been set-up for employees.
- The Employee Assistance programme had been promoted further across the Council and information on the support for carers was included on the website within the Health & Wellbeing pages.

The Chairman thanked the presenters for their update. Members agreed to delegate the assigning of a RAG status to each recommendation to the Chairman.

8 TEMPORARY CLOSURE OF CHARTRIDGE WARD, AMERSHAM

This item was deferred to the next meeting.

9 THE FUTURE ARRANGEMENTS FOR NHS COMMISSIONING WITHIN THE BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST INTEGRATED CARE SYSTEM

The Chairman welcomed Ms L Patten, Chief Accountable Officer for Buckinghamshire Clinical Commissioning Group and Oxfordshire Clinical Commissioning Group.

During the presentation and discussion, the following main points were made.

- The way in which the NHS Clinical Commissioning Groups (CCG) in the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) would be changing. An engagement document had been produced which sought the views on two new ways of working:
    - Local working in each of the three counties (the integrated care partnerships);
    - Wider, at-scale working across the three areas (the integrated care system).
- The NHS long-term plan set an expectation that each ICS would be covered by a single CCG.
- The engagement document outlined the proposals to:
    - Appoint a single Accountable Officer and Shared Management Team;
    - Design a stronger Integrated Care Partnerships, constituted using a set of common principles;
    - Create a single commissioning organisation across the BOB geography.
- In order to become the delivery vehicles for more local care services, much more would be required of Primary Care Networks (PCNs) than could be delivered within the current commissioning arrangements.
- There was a need for greater oversight and accountability for the ICS which did not currently have permanent leadership or statutory governance.
- Greater collaborative working would provide the best opportunity to support each ICP with its work to improve healthcare, tackle health inequalities and ensure consistency of services in terms of quality and availability across BOB.
- Through the new PCNs and ICPs, GPs and other healthcare providers would focus on developing and delivering services to meet healthcare needs in their local areas, whilst still being involved in strategic commissioning.
- There were 12 PCNs across the County and the PCNs would be working closely with Community Boards as these develop to improve outcomes for each local population.
- Ms Patten stressed that embedding services at the ICP level was important and services, such as 999 and 111 could be provided by the ICS in order to maximise efficiencies and maintain consistency across the 3 areas.
- In response to timings around appointing a single accountable officer, should the proposal be approved, Ms Patten explained that the recruitment process would commence in January 2020 with the aim of appointing the single accountable officer by June and thereafter appoint a shared management team.
- The proposed merger of the CCGs would take effect in April 2021.
- In Bucks, care home admissions were around 9 months earlier than the national average. Ms Patten explained that if effective multi-disciplinary working exists, then admittance would be later. There was a need for closer working between health and social care in order to achieve this. A pilot was being carried out in Aylesbury and Wycombe and progress was already being made.
- The need for a scrutiny function across the ICS was recognised and the Chairman reported that informal meetings between the BOB ICS scrutiny Chairman was taking place.
- A Member asked what was meant by “better outcomes” for local residents. Ms Patten responded that the role of the PCNs was to deliver local GP services and wrap-around services and each PCN would respond to their local challenges.

- A general comment was made about the engagement document and the need for the language to be understood by the public. The use of acronyms was confusing and it was felt that there should be more public engagement about the proposed changes and what that means for local people. Ms Patten agreed to feedback to the ICS communications team.

ACTION: Ms Patten

- A Member commented that the PCNs should be mapped to Community Boards in order to create greater cohesion.
- In response to a question about moving to 7 day working across the whole system, Ms Patten said that there was a move to develop 7 day working and there was already 24/7 access to GP services but there were still some services not operating across 7 days and this would be reviewed over the coming months.

The Chairman thanked Ms Patten for her presentation and Committee Members agreed to send a formal response to the CCGs on their proposals for future commissioning within the specified deadline (1st December 2019).

ACTION: Chairman

10 COMMITTEE WORK PROGRAMME

The last Select Committee meeting of this authority will take place on Friday 7th February 2020. This meeting would be an opportunity to hear from partners across the health and social care system on the key issues discussed at Committee meetings over the last 12-18 months.

There would also be an opportunity to reflect on the work of the Committee and discuss issues that the new authority may want to review.

11 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Friday 7th February 2020 in Mezz Room 1, County Hall, Aylesbury.

CHAIRMAN

Health & Adult Social Care Select Committee Support for Carers Inquiry
6 month recommendation monitoring

Select Committee Inquiry Title: Support for Carers
Committee Chairman: Brian Roberts
Date report submitted for response at Cabinet: 25th March 2019
Lead BCC Cabinet Members and Lead Officers: Lin Hazell, Cabinet Member for Health & Wellbeing, John Chilver, Cabinet Member for Resources and Anita Cranmer, Cabinet Member for Education and Skills, Gill Quinton, Executive Director (CHASC), John Everson, Specialist Commissioning Manager (CHASC) and Lisa Truett, Commissioning Manager (CHASC)
Select Committee Support Officer / Advisor (Extension): Liz Wheaton (ext. 3856)
Suggested frequency of future updates on progress to the HASC Select Committee: 6 & 12 months

Recommendation	BCC Cabinet / Partner Agency Response including proposed action	Cabinet Member	Officer	RAG status (6 months)
Recommendation 1 (Communities): **a)That an action plan is created with key partners which brings together the working practices of the operational and commissioning teams to ensure better sharing of information on carers and early detection of issues.** **That the action plan:** • **b) creates a single point of access for all carers (see slide 26) and includes signposting for financial assistance, care planning, assessment and review guidance, health and social care needs (including specific information for self-funders);** • **c) develops a *single assessment form which can be accessed by all key organisations; includes timescales and measurable outcomes** •	**Response: Agreed** **<u>6 month update</u>** The action plan has been drafted and circulated to all key partners for consultation around key processes and recommended information sharing protocols. The Carers provision delivers an all age integrated service to all carers within Buckinghamshire. The council's vision is for the service provider to work with other community and voluntary community sector (VCS) partners to promote a strengths based whole family approach to service delivery. The transformation of integrated care within Buckinghamshire, whilst in its infancy, brings better sharing of information across commissioning teams, social work teams, hospital and community teams to include carers and their needs within provisions alongside those of the 'cared for'. Dialogue between Carers and commissioners has led to the development of a new Carers Assessment. This approach will improve over time as systems become imbedded. The service provider are the main point of access for all carers to receive support and advice including information on accessing respite provisions, benefits, entitlements and help with completing forms, providing signposting and regular Carer Support Groups to address their wellbeing and social needs. Members of the Brokerage Team have met with service provider staff to inform and share information about the brokerage service which can support carers looking for packages of care for the person they care for. The brokerage service is free of charge for respite care. <u>Better Lives: My Carers Assessment process</u>[1] has been completed, which maps journey of carers. A new <u>My Caring Role</u>[2] form has been developed with Carers who provided feedback on their experience of completing the existing Carers Assessment form. The new form focuses on enabling Carers who opt to complete the form to write about what matters to them and what will make a difference in their caring role. **My Carers Assessment forms** – '<u>Supporting you'</u> [3] & '<u>Improving Wellbeing'</u>[4] being launched in September 2019, this new strengths based carers assessment has been developed in conjunction with Carers and Carers Bucks who provided feedback about their experiences during a co-production session which explored the Better Lives strength based approach. The new form will enable, through the use of strengths based conversation, both the Carer and Social Care Worker to explore positive outcomes for the Carer with a focus on improving wellbeing as well as supporting the Carer in their caring role.	Lin Hazell	John Everson to lead and co-ordinate	★

[1] <u>Better Lives: My Carers Assessment process</u>
[2] <u>My Caring Role</u>
[3] '<u>Supporting you'</u>
[4] '<u>Improving Wellbeing'</u>

• • • **to help demonstrate improved support for carers of all ages year on year;** • **d) includes specific actions for young carers to help increase identification and introduces a measure to track their educational attainment;** • **e) Ensures contingency care plans are in place for all carers - reviewed regularly as part of the carer assessment reviews.**	A new My Carers Wellbeing Plan[5] (contingency is included in this plan) will enable both the Carer and Social Care Worker to work collaboratively on care and support planning with Wellbeing Outcomes at the centre of the planning process. Further co-production meetings will be held with Carers and Carers Bucks to review and gather further feedback. A **young carer** is defined as a child under 18 years of age, whose life is significantly affected because of the need to care for a family member who is ill, has a disability or mental illness or is affected by substance abuse (including alcohol) or other debilitating illness. For information there are 1875 young carers aged 0-19yrs in Bucks. Buckinghamshire Children's Services Procedures Manual [6] provides guidance to social Workers and Children's Services on identifying and supporting young carers. Children's Services use the procedures manual for children requiring a young carer assessment and follow BCC' local assessment protocol[7] and will then also complete a Child and Family assessment form[8] to assess their needs. When a young carer reaches 18 they will undergo a transition assessment, this may have already been collected as part of the young carers needs assessment. Another identification opportunity is via Early Help Pathways Team, the family referral form will identify if there is a Young Carer within that family. The development of the new BCC website is about to go live. This contains explanatory information to support Carers of all ages including signposting and links to other agencies, information and advice in relation to benefits, allowances, assessments and respite care. Link to BCC Carers webpage; https://careadvicebucks-preprod.pcgprojects.co.uk/your-care-and-support-options/caring-for-someone/ [9] The provider is participating in a Pilot Project with the CCG and CAMHS within schools to help practitioners identify and support young carers suffering from mental health issues because of their caring responsibilities. This will start in Jan 2020 within a selected number of schools.			
Recommendation 2 (Health): **That good practice with GPs is developed further and experience of undertaking the GP Award is shared with all practices through the Practice Manager Forum.**	**Response: Agreed** **6 month update** An independent review is being undertaken of the GP Award highlighting best practise and areas for improvement. This will be shared with GP Practices through the Practice Manager Forum. The key recommendation will be communicated to Carers Bucks who coordinate the award; implementation will be overseen by the lead commissioning manager. There are 4 GP surgeries who have completed the process and been awarded and another 4 about to be evaluated for the award	Health lead	Louise Smith (CCG) and John Everson to lead and co-ordinate	

[5] My Carers Wellbeing Plan
[6] Buckinghamshire Children's Services Procedures Manual
[7] BCC' local assessment protocol[7]
[8] Child and Family assessment form
[9] BCC Carers webpage; https://careadvicebucks-preprod.pcgprojects.co.uk/your-care-and-support-options/caring-for-someone/

Recommendation 3 (Health): **That an independent review be undertaken of the GP Standard award to seek views from GP practices and use the feedback to make changes to the existing framework with the aim of increasing the take-up of the award.**	**Response: Agreed** **<u>6 month update</u>** An independent review has commenced with engagement and feedback visits arranged with: - GP surgeries who have completed the award - GP surgeries who have started but have yet to complete the award - GP surgeries who have not signed up to complete the award. The review will identify the benefits that GP practises feel are attained through completion of the award and also any areas in which they have struggled to complete. Views will be gathered from the surgeries completing to identify how long they have been completing the award and the barriers to completion. The overall report will make recommendations with regards to improvements to the programme and ways that the scheme can be positively promoted across Buckinghamshire. The implementation of the recommendations will be overseen by the commissioning manager; commissioners will also be responsible for promoting the award to colleagues in health and social care. Initial findings by commissioners and the CCG has revealed that the current process required is too time consuming for most GP's and whilst the work is necessary this is not enough impetus for GP's to sign-up. We therefore plan to work with the CCG, to review the case loads at those practices that have signed up to the scheme in order to verify whether the scheme has resulted in a reduction of the number of appointments carers and their cared for now have with their GP. Should this indicate a reduction in work for GP's we anticipate that this will encourage a larger take up by GP's.	Health lead	Louise Smith (CCG) and John Everson to lead and co-ordinate	
Recommendation 4 (Public Health): **a)That the costs for providing annual health checks for carers be explored and possible funding streams investigated.**	**Response: Agreed** **<u>6 month update</u>** This does not fit within the existing public health responsibilities. However, colleagues across CCG, Adult Social Care and Children's Social Care are investigating the cost associated with providing annual health checks for carers and how existing health checks might be utilised. There are a range of health checks and assessments currently provided for a number of different groups across Buckinghamshire. These include GP NHS Health Checks, SMI Health Checks. NHS health check cost is £22-£28 (DQ dependent), (current age restriction, 40-74yrs). Carers Bucks have 11,539 carers registered aged 17-104 yrs. The highest proportion of carers in Buckinghamshire is in the 50-64 range, which aligns with the NHS health check. GP Register Data for 2018/19 says 450 carers (aged 40-74yrs) received a NHS Health Check. 2402 carers have had a health check in the past five years[10]. Cost for health check for registered carers outside 40-74yrs would be approx. £139,524.00 *(age brackets from Carers Bucks stats do not give breakdown by individual ages so cannot be accurate figure).* NHS EMIS Data [11]12,230 Carers tracked via EMIS register. 375 identified as having a CMI (Common Mental Health Issue). 200 are on the SMI Register (Serious Mental Health Issue) and 65 have had a SMI Health Check. SMI Health Check - GP receives £45 for each assessment given. <u>Healthy Child Programme</u>[12] also covers some health checks during 0-19 years.	Health lead	Louise Smith (CCG) and John Everson to lead and co-ordinate Marie Mickiewicz – Community (SCM Prevention Services) Public Health	 Due to cost implications
Recommendation 5 (Education):	**Response: Agreed** **<u>6 month update</u>**	Anita Cranmer	Gareth Drawmer	

[10] Please note this figure represents 49 of the 50 Bucks practices (one practice uses a separate clinical system

[11] **EMIS Enterprise extracts is for patients registered with a member GP practice of Bucks CCG. As with all EMIS data searches, the information extracted is reliant on consistent, accurate and up-to-date coding by the practices.** *(EMIS Health, formerly known as Egton Medical Information Systems, supplies electronic patient record systems and software used in primary care, acute care and community pharmacy in the UK.)*

[12] <u>Healthy Child Programme</u>

That the Council lobby Government to include a question about the number of young carers identified at school as part of the annual school census return.	Following further consideration, the service is in the process of drafting a letter to Government, encouraging them to include a question about young carers as part of the annual school census return. Historically, young carer data was considered as a proposal by the DfE in their 2016-17 review of the census; however, the proposal was withdrawn before it went through their star chamber scrutiny board.			
Recommendation 6 (Employment): **That a corporate training programme be developed for BCC Managers and other partners within the ICS to help identify and support carers, to coincide with the launch of the employee health & wellbeing strategy.**	**Response: Agreed** **6 month update** An e-learning module, 'carers awareness' has been introduced on BCC's online learning platform, in the 'Wellbeing in the Workplace' section. The module looks at the characteristics that define a carer, including the roles of both young and adult carers, and demonstrates how to identify somebody who might be a carer, and how to help them find support. Carers awareness training will become part of the manager development programme for Buckinghamshire Council, which is currently being developed as part of the Unitary OD Work Programme. HR colleagues are working with ICP partners across healthcare to develop a unified People Plan and are meeting regularly to share best practice ideas. Carers support will be developed as part of the 'Supporting our Staff' work stream. As an additional point, becoming a new organisation presents the need to create a new careers website. As part of this project HR will be reviewing the candidate journey and relevant to this, whether we should ask candidates if they currently have caring responsibilities. We need to be clear why we're asking this question and what we're doing with this information (i.e. that we're asking so a supportive conversation can be had and be a prompt to tell candidates how we as an organisation support employee carers).	John Chilver	Helen Cannon – Organisational Development Consultant - BCC	Due to no measured outcomes
Recommendation 7 (Employment): **That an employee carers support group be established and an annual survey be undertaken to find out the views of carers and help shape future support for carers services.**	**Response: Agreed** **6 month update** Bucks Carers have launched a support group called the BCC Employee Carers Group and they have now met twice in September & October 2019 with 6 'carers' attending the first and an increase to 8 on the second. The first of the events was featured in Internal Comms and CHASC newsletter[13]. Attendees reported that they wanted to meet peers who were also carers. They felt it would be beneficial in providing information, signposting and importantly emotional support. These groups will now be held monthly and not fixed to specific days of the week to ensure people can access around meetings and working days etc. Carers Support Group Poster [14] and we intend to extend them to District colleagues and to the ICP Terms of reference[15] for the group Once we have grown the network, we'll seek to create a targeted survey, to supplement discussion at the support group meetings and to feed into how we shape future support for carers. A group (including commissioning, communications, digital and HR) is meeting in October to develop a creative internal communications campaign to improve carer awareness and promote the support group.	John Chilver	Helen Cannon	

[13] CHASC newsletter
[14] Poster
[15] Terms of reference

	Health and Wellbeing at work guide[16] has been produced to support employees. This guide features a page (page 11) specifically around carers' support; include carers' leave, flexible working arrangements, the carers' support group and signposting to Carers Bucks.			
Recommendation 8 (Employment): **That the Employee Assistance Programme is more widely promoted amongst employees and feedback from users is obtained to ensure service quality.**	**Response: Agreed** **6 month update** PAM Assist, the employee assistance programme (EAP), has been recommissioned as part of a wider Occupational Health contract with the PAM Group, which is joint with the District Councils. PAM Assist is an independent service to help employees, and their families, through life's ups and down. A free phone line is available 24/7, as well as online support and resources, including online CBT. Counselling is available. PAM Assist is being promoted as part of wider health and wellbeing communications, for example at Unitary Roadshows and at pops up. The EAP is currently underutilised and part of the strategy is to increase the number of employees benefitting from the advice and resources available to them. We plan to run a promotion specifically on how EAP can support carers/people who have recently become a carer, towards the end of this year.	John Chilver	Helen Cannon	

RAG Status Guidance (For the Select Committee's Assessment)

	Recommendation implemented to the satisfaction of the committee.		*Committee have concerns the recommendation may not be fully delivered to its satisfaction*
	Recommendation on track to be completed to the satisfaction of the committee.		*Committee consider the recommendation to have not been delivered/implemented*

[16] Health and Wellbeing at work guide

Cabinet Response – Condensed Version – Support for Carers

You Said	We Did
Create Carers action plan with key partners	Consulted with all key partners around key processes and sharing protocols.
You want a single point of access for carers	The service provider is the main point of access for all carers to receive support.
Want a single assessment form	New strengths based carers assessment form launched September 2019.
Increase identification of young carers	From Jan 2020, Pilot Project starts with the CCG and CAMHS within schools to help identify and support young carers.
Contingency care plans in place for all carers	New My Carers Wellbeing Plan is in place.
GP Award - good practice developed further/shared and undertake independent review	4 GP surgeries completed the process & 4 being evaluated. Independent review under taken and will be shared. Initial findings revealed the current process is too time consuming, so will be changed.
Explore costs for providing annual health checks for carers	Cost for health check for registered carers outside 40-74yrs would be approx. £139,524.00
Lobby Government about the number of young carers identified at school	Education said this would put additional burden on local schools, as alternative 'Young Carers Groups' within school settings will help identify carers. 28 schools already completed Gold & Silver training/support.
Develop corporate training programme for BCC Managers and other partners within the ICS	Carers Awareness e-learning module has been introduced on BCC's online learning platform. HR colleagues are working with ICP partners across healthcare to develop a unified People Plan and are meeting regularly to share best practice.
Establish employee carers support group and an annual survey	BCC Employee Carers Group support group launched will be extended to District colleagues and the ICP. Health and Wellbeing at work guide produced to support employees.
Promote Employee Assistance Programme amongst employees and obtain feedback	Employee assistance programme has been recommissioned; this is being promoted as part of wider health and wellbeing communications. We are promoting specifically on how EAP can support carers/people.

Facts		
1875 young carers aged 0-19yrs in Bucks.	450 carers (aged 40-74yrs) received NHS Health Check (2018/19)	2402 carers had a health check in the past five years
12,230 Carers tracked via NHS EMIS Data:-		
375 have Common Mental Health Issue	200 are on the Serious Mental Health Issue Register	65 have had SMI Health Check. (GP receives £45 for each assessment)

Future arrangements for NHS commissioning

January 2020

1

Introduction

An engagement exercise was run from 10th October 2019 to 1st December 2019 to seek feedback on the future of NHS commissioning arrangements within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS).

The exercise was not a formal public consultation but rather an opportunity to gather the views of a broad range of stakeholders at the early stages of developing proposals.

Views were invited on proposals related to two ways of working:

1) Local working in each of the three areas (Integrated Care Partnerships)
2) Wider, at-scale working across the three areas (the Integrated Care System)

These proposals were set out in an engagement document called "*The future arrangements for NHS commissioning in your area*".

Summary of Proposals

1) Appointment of a single Accountable Officer and Shared Management Team

Proposal for a single Accountable Officer role to provide a focal point for leadership and accountability within the Integrated Care System. It is proposed that the post holder would also assume the role of the Executive Lead for the BOB ICS.

2) Design stronger Integrated Care Partnerships using a set of common principles

Our three Integrated Care Partnerships (ICPs) will be the focal point to deliver our shared ambition to transform services

2) Creation of a single commissioning organisation across the BOB geography

In line with the Long Term Plan, there is an expectation that each ICS will 'typically' be covered by a single CCG by April 2021.

Delivery of Engagement

Feedback was invited through:

- an online survey, available on the CCG and BOB ICS websites
- written submissions to either the ICS Office or a respondent's local CCG.

Communication and engagement activities were delivered by the three CCGs, using their local channels, while working to an overarching BOB ICS communication and engagement plan.

Channels used to promote the survey included: public newsletters, staff newsletters , digital display screens and correspondence with key stakeholders.

The proposals were discussed at a wide range of meetings, including Health and Wellbeing Boards, meetings with Healthwatch organisations, and Patient Participation Groups. These activities were determined by each CCG.

Responses

By the end of the engagement period, 224 responses had been received

These ranged from brief answers to multiple pages of feedback on the emerging principles of the proposals.

Of these 224 responses, 209 were "countable" – 15 responses were either blank or contained information which could not be categorised consistently.

Although the engagement survey was designed to gather qualitative data, every response submitted has been reviewed and categorised by place, type of respondent and level of support for the proposals (quantitative analysis).

This showed neither strong support nor outright rejection of the proposal. Many qualified their responses with views which they believed were important to be addressed in the design or implementation of proposals

A copy of the full engagement report is available with this presentation and on the BOB ICS website.

Key Themes

Proposal One: A single Accountable Officer/ICS Lead and Shared Management Team for the three CCGs

- Process for design, decision making and implementation
- Link to local populations and their democratic oversight
- Deliverability of the shared Accountable Officer role at a larger scale
- Operation and effectiveness of a shared management team

Proposal Two: The design principles for the creation of stronger Integrated Care Partnerships

- A voice for local people in the design and decision-making processes
- Ensuring that ICPs are subject to accountability and transparency
- Enabling ICPs to meet their objectives and deliver more integrated, joined up care provision

Proposal Three: The creation of a single commissioning organisation across the BOB geography

- Ensuring that existing Places are not financially disadvantaged by the creation of a single CCG with its own allocation
- Protecting the interface between Local Authorities and their counterpart NHS organisations
- Loss of the 'local voice' within a larger commissioning organisation
- The BOB boundary being an 'un-natural' grouping of three very different geographies

Responding to Feedback

In response to engagement feedback, the following are examples of changes put forward for consideration by CCG Governing Bodies.

Transparent decision making process and partner involvement
The recruitment process would be transparently designed and agreed with CCG Governing Bodies, Chairs and Lay Members. Regular updates would be provided to CCG Governing Bodies and the BOB ICS System Leaders Group which is comprised of senior executives from each of the BOB ICS member organisations.

Combining of the AO role with the ICS Lead role is undeliverable due to size and complexity of job / geography
This is an emerging national model which is already successfully in operation in other STP / ICS parts of the country. NHS England hold the authority for the selection and appointment of the ICS Lead role.

Financial implications
Recurrent savings are anticipated from any change to management arrangements, contributing to the required reduction in CCG running costs. At this juncture, there is no proposal to merge the CCGs thus ensuring no implications for annual financial allocations.

Responding to Feedback (cont.)

Loss of local influence, control and oversight of the CCGs and their leadership
It is proposed that place-based Managing Directors, each with a seat on a single Management Team would ensure a continuity of local control and oversight. These roles would co-ordinate and lead a significant proportion of the day-to-day operational delivery and planning requirements for the CCGs, ensuring the Accountable Officer role can operate in a strategic manner.

Loss of scrutiny by and accountability to democratically elected politicians
The Accountable Officer and Place Based Managing Directors would continue to attend important meetings with democratic leaders such as Health & Wellbeing Boards, Oversight & Scrutiny Committees and joint working forums with Local Authority elected members and their appointed leaders.

Maintain links with local groups and ensure senior appointments at Place level
It is proposed that place-based Managing Directors, each with a seat on a single Management Team would ensure links with local groups are maintained.

Next Steps Following the Engagement Exercise

All feedback received has been fully considered by CCG and ICS leaders and has informed recommendations to CCG Governing Bodies about a single Accountable Officer/ICS Lead and associated supporting management structure (proposal 1)

CCG Governing Bodies are meeting in January to receive the engagement report and discuss recommendations regarding proposal 1.

Governing Body decisions and next steps will be considered by CCG and ICS leaders in early February.

Work will continue to establish the Specialised Commissioning Planning and CCG Commissioning Boards.

Next steps regarding any proposals about a single commissioning organisation will be considered by Governing Bodies in early 2020.

Any proposals for future CCG configuration would be subject to consultation with CCG members later in 2020.

Your community Your care
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Developing Health & Social Care in the Community

Why Community Integration at Place

Patients and the Population

- Health and care needs increasing and changing
  - Ageing Population
  - Increased complexity/co-morbidity
- Access challenges
- Fragmented Care
- What patients want – maximising independence

Local organisations

- Financially challenged – efficiencies to be made
- BCC Better Lives Strategy
- Services built around historic care and spend and not health and care needs
- Recruitment and retention issues
- Build on what we know works – e.g. success of telehealth solutions

National context

- NHSE clearly articulated Long term Plan (LTP) ambition and implementation expectations
  - https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained
  - https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/the-nhs-long-term-plan-summary.pdf
- Nationally mandated community and PCN contractual changes
- Earmarked community investment

Fragmented Care - Patient Example

Elderly woman with dementia, who lives alone, supported by daughter found locked out of her house in the street.

Police called and daughter contacted.

Daughter contacts social care who assess a mental health need.

Mental health contacted and assess is a social care need.

GP practice contacted by daughter in distress.

Conversations between practice, social care and mental health could not resolve issue.

Patient taken to A&E as a "place of safety" overnight.

Next day psychiatric assessment agreed and respite bed required.

What Patients Want

*Commissioned by NHS England on behalf of the national collaboration for integrated care and support & co-developed with the health and care system by national voices

Buckinghamshire Care Model

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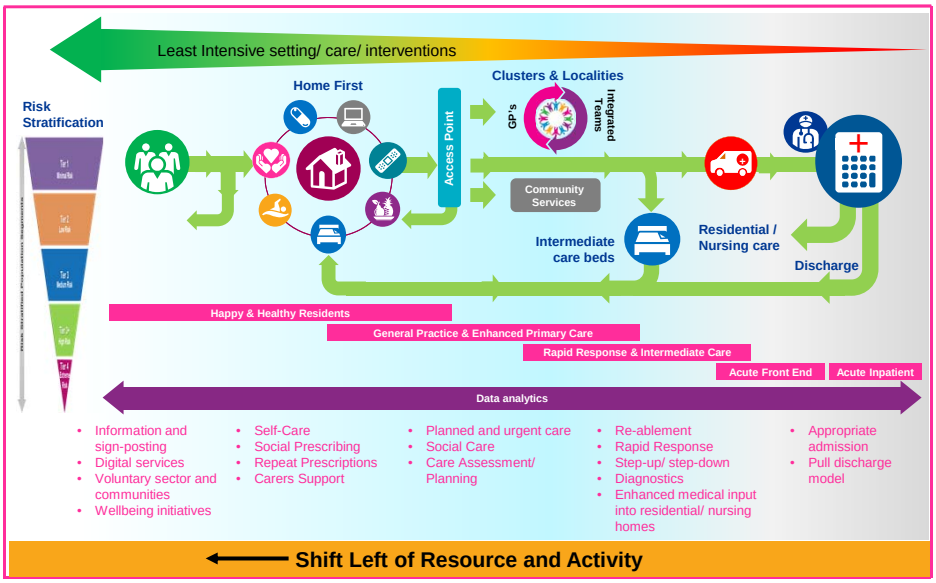


Community Integration - Ambition

"A proactive community based care model designed around local population health and care needs which through integration breaks down the historic barriers between primary, community and secondary care."

1. Scope and understand the total community services and spend for physical health, mental health, social care and community voluntary and not for profit sector by PCN.
2. Build on existing work in defining the community model by describing its future structure in collaboration with staff and local communities and developing an implementation plan for delivery over the next 2 years
3. Identify dedicated leadership for the community programme of work including clinicians who will own and drive the programme of change
4. Accelerate the national work programmes in order to achieve the expected benefits of integration and the quadruple aim of improved population health outcomes, patient and staff experience and financial balance
5. Optimise capacity to meet existing and growing demand
6. Enable PCNs to develop to lead in the system as part of a collaborative leadership model to drive service change in the system for the benefit of patients and populations
7. Strengthen the integration between physical health, mental health and wellbeing through jointly commissioned and provided services with aligned outcomes and incentives which may include risk share
8. Provide PCNs with shadow community budgets so that they can understand the service delivery components and how they can flex the model in order to optimise delivery and value for money.
9. Provide an integrated data set that establishes a baseline from which to set goals and monitor impact so that we can be assured that we are providing an effective model of care and improving health and social care outcomes.
10. Drive a model that is consistent whilst also being capable of tackling inequalities.

What will this mean to patients

- Those 'at risk' patients will be identified early and proactively managed with non medical interventions and care where appropriate
- Those with Complex comorbidity will be managed by a single community based multidisciplinary team lead by a complex care manager
- Care services will be developed that are tailored to local need based around PCNs or groups of PCNs – form will follow function.
- Patients will be supported to live independently at home but not isolated
- Patients will tell their story once
- Patients will be proactively pulled out of the hospital setting back to their homes once medically fit
- Health inequalities will be reduced so that patients should expect to have the same health outcomes as the top 10% of the country
- Medicines optimisation in at risk groups

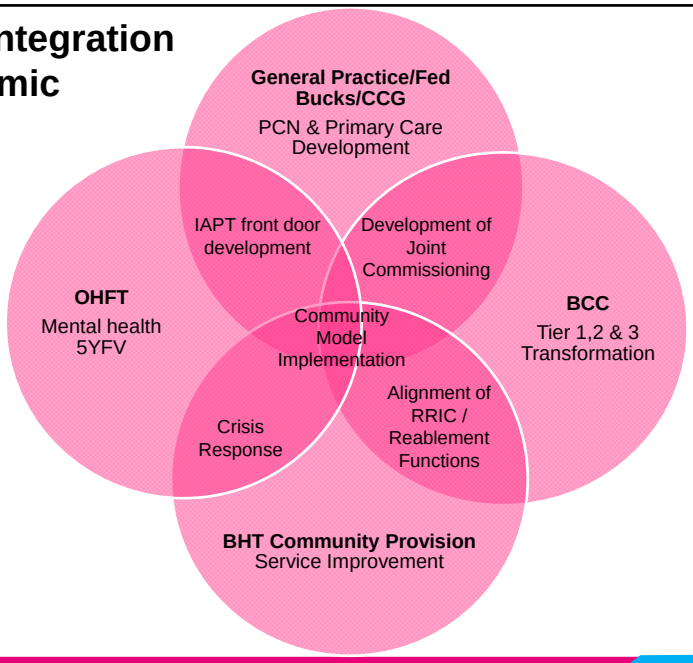
What will this mean to staff

- Practice and community nurses will work collectively with a single caseload where appropriate
- There will be read / write access to care records by multiple professionals
- Single templates will be used across the system agreed by the health and care e.g. advanced care plans
- There will be single operating processes
- Pathways of care will be standardised
- Staff will act as if they are in one organisation with shared values, learning and culture (including third sector)
- New workforce roles will be created supporting community based services
- Information to be easily available to staff and readily shared when appropriate

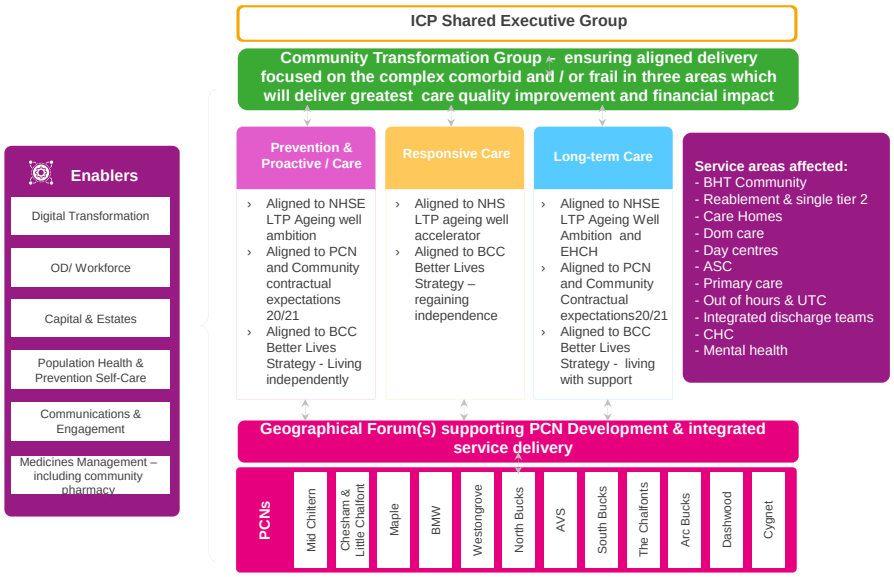
What will this mean to the Organisations

- System costs will be reduced by identifying and removing nursing and care duplication and identifying opportunities to use resources better
- Services will be Improved value by enhancing the cost effectiveness and quality of interventions
- Improved coding and data management
- Realisation of systematic telehealth solutions

The Integration Dynamic



Delivering Rapid Community Change at Place



Prevention and Proactive Care

Achievements 19/20

- Introduction of complex care managers – Senior health care professionals who specialise in helping patients with multiple long-term conditions to stay in their own homes. In addition to current district nursing staff, these roles will support patients who need a high level of care in the community.
- Extension of the Community Assessment and Treatment Service to Amersham. This service assesses frail elderly patients in the community and puts in place additional support to enable them to remain independent and at home, avoiding a hospital admission.
- Extension of specialist geriatrician to enable health care professionals to receive immediate advice and support in order to help patients receive appropriate care in the community.
- MDTs for comorbid complex patients, diabetes and children

Expectation 20/21

- Focus on comorbidity
- Full roll out and embedding of complex care nurses
- Full roll out of integrated teams and further MDT meetings appropriate to the population
- Sites to receive population health management support to enable identification of at risk patients and proactive care
- Medicines optimisation
- Embed social prescribing
- Introduce patient activation measures
- Introduce proactive patient assessment – mental health, falls etc

Outcome Measures

- % of people signposted to early help and prevention services
- % reduction in non elective attendances and admissions (ACS Conditions)
- % reduction in DTOC

Responsive Care

Achievements 19/20

- Award of Ageing Well Crisis Response Accelerator site – National pilot with £800k investment to deliver crisis response locally
- Provision of comprehensive rehabilitation and delivery of therapy at weekends - increasing capacity through the recruitment of therapists, rehabilitation support workers and physiotherapists.
- Increased therapy available to patients in their homes
- Maximising patients' independence at home through the Community Physiotherapy Service and RRIC Teams
- Elderly care consultant in A&E to identify those patients who do not need to be admitted and to ensure the relevant support is put in place to enable them to go home.

Expectation 20/21

As part of the Crisis Response Accelerator

- Develop delivery plan
- Ensure community health data set collected – form baseline
- Work with 111 to develop single point of access to community services

Outcome Measures

- % of people accessing 2 hour urgent community response services
- % of people able to access intermediate care/reablement within 2 days.
- % increase in people successfully re-abled

Long-term Care

Achievements 19/20

- Roll out of Red Bag scheme - Initial Pilot showed that it reduced length of stay in hospital by up to 10 days per care home resident
- NHS Mail for social care providers – To date 21 care homes using NHS Mail enabling closer digital links with health and social care and reducing an average of 10 hours a week of nurses admin time per home
- Immedicare - 37 Care Homes (2000 beds) shown to reduce hospital admissions and demands on primary care (full analysis in progress).

Expectation 20/21

- Delivering on enhanced health in care home agenda
- Every care home to be aligned to a single PCN
- Identification of those at the end of life and their proactive management
- Introduce multidisciplinary support to care homes
- Strengthen mental health support in care homes
- Evaluate and potentially roll out immedicare to wider number of care homes
- Continue NHS mail roll out – care homes and hospices

Outcome Measures

- % of emergency admissions to hospitals from care homes
- % reduction in DTOC
- % reduction in residential and nursing care placements
- % reduction in length of stay in residential and nursing care
- % increase in people successfully re-abled

Role of Primary Care Networks

What are PCNs

- PCNs are still very new, but in time networks will consist of **groups of general practices working together with a range of local providers**, including across primary care, community services, social care and the voluntary sector, to offer more personalised, joined up care to their local populations.
- Relationships will be key and PCN Accountable Clinical Directors (ACD) have a key leadership role
- One of these relationships will be with the Unitary Community Boards

19/20 Achievement - See next slide

20/21 Expectation

- Additional roles reimbursement
  - first contact physiotherapist & physician associates
  - paramedics (21/22)
- Recurrent organisational development funding to support PCNs to progress and mature
- New nationally mandated services proposed but there remains uncertainty over provision of these
  - Anticipatory Care
  - Personalisation
  - Structured medication reviews
  - Early Cancer Diagnosis
  - Enhanced Health in Care Homes
- Review what local services could be provided by a PCN
- Improved Access review

PCN 19/20 Progress

PCN	Social Prescriber	Pharmacist	PPG Engagement	OD Events	Other PCN Project
North Bucks PCN	√	√	√	√	DMARD research project
Westongrove PCN	√	√		√	NA
Central BMW PCN	Recruiting in New Year	√	√	√	Respiratory project, Acute Pathways project and the Paediatric Hub project.
Central Maple PCN	√	√	√	√	Care Homes Patient Online project, High Intensity User project and the Paediatric project
AVS PCN	Staring 02/01/2020	√	√	√	NA
Chesham & Little Chalfont PCN	Not recruiting in 2019/20	Not recruiting in 2019/2020		Date tbc	NA
Mid Chiltern PCN	√	√	√	√	Development of a Social Prescribing Community Network / Pathway
Cygnet PCN	√	Starting 06/01/2020		21/01/2020 & 11/02/2020)	NA
Dashwood PCN	√	√	√	Awaiting proposal	Thames Valley Cancer Quality Award Scheme [CQAS] project
South Bucks PCN	√	√	√	04/02/2020 & 05/02/2020)	Mapping of local services
Chalfonts PCN	√	√		√	NA
Arc Bucks PCN	√	Starting 06/01/2020	√	√	PCN Community Social Activation Model (based on Frome) intended to improve outcomes for patients related to the wider determinants of health.

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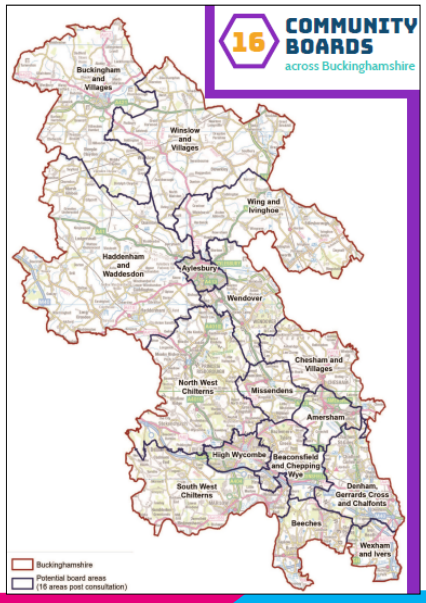
PCN & Community Board Alignment

Community Board	PCN
Buckingham and Villages	North Bucks
Winslow and Villages	North Bucks
Wing and Ivinghoe	North Bucks
Haddenham and Waddesdon	North Bucks/AV South
North West Chilterns	AV South
Aylesbury	BMW/Maple
Wendover	Westongrove
Chesham and Villages	Chesham and Little Chalfont
Amersham	Mid Chilterns
Missendens	Mid Chilterns
High Wycombe	Dashwood/Cygnet
Beaconsfield and Chepping Wye	Arc Bucks
South West Chilterns	Arc Bucks
Denham, Gerrards Cross and Chalfonts	Chalfonts/South Bucks
Beeches	South Bucks
Wexham and Ivers	South Bucks



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Challenges and support required to deliver

Challenges

PCN Specific Are the expectations too high?

- Pace of delivery versus strengthening of relationships & collaboration
- New services specs – considerable challenge

- How prepared are they
- Are they sufficiently resourced
  - Management support

Integrated Working

- Varied progress by groups of practices and community partners in integrating
- Lack of capacity to develop above BAU
- Persistent 'tricky' issues that are never resolved such as single system wide templates and process e.g. access to records/ACPs, trusted assessor

Community Engagement

- How do we meaningfully engage with our communities

Support

Support for PCNs and Community Providers

- Time
- Management support to PCNs
- Specialist expertise
- Transparent funding arrangements and fair funding allocation in line with local need
- Focused implementation plan
- Targeted support to deliver
- Reliable data and BI support
- Commitment to meeting community investment allocations
- Community engagement in codesign of services - unitary council / community boards

Commissioning Support

- The ICS, aligned to national guidance, to set out direction of travel – high level deliverables/outcomes
- Aligned service outcomes across community providers
- The Health and Social Care Joint Commissioning function to be strengthened at place through ICET
- At Place providers to become self regulating informed by reliable data and BI support
- Utilisation of any alternative funding arrangements to maximise collaboration and integrated delivery

The Future of Core Primary Care Provision

The BOB primary care strategy (now part of the Long Term Plan) sets out the actions that will be taken across the three Integrated Care Partnerships to invest the new resource identified to deliver a transformed model of primary care. The outcomes for our patients will be:

- Improved access to care;
- a stronger focus on population health and prevention;
- access to a wider range of practice staff, appropriate to clinical need;
- services delivered from modern buildings, co-located with community and preventative services, hospital specialists and mental health care;
- more services delivered in the community, including in people's usual place of residence, that are currently delivered in hospital;
- primary care delivering key components of broader clinical pathways e.g. cancer, urgent care, and mental health.

Community Integration to Tackle Inequality

Objectives (2019 to 2023)

1. Hypertension - Target support to identify and treat those with hypertension who are BME and/or live in quintile 5. Demonstrated by improvements in prevalence rates and % of hypertensive patients treated to target by 2022 from the 2018 baseline.
2. Mental Health – Promote good mental health and improve access to mental health services for those that need it, with an additional focus on children and young people who are more vulnerable to poor mental health. Current activity to be baselined across schools, colleges and health in order to identify which catchment areas should be targeted with support in the areas that have the highest levels of deprivation.
   - **Measure 1:** Increased number of Mental Health Support Teams (MHSTs) against targeted schools and colleges in catchment areas that have the highest levels of deprivation (DQ5)
   - **Measure 2:** Increased numbers of children and young people from schools within DQ5 accessing mental health services in 19/20 (compared to 18/19 baseline)
3. Long Term Conditions (LTC) (including mental health) - Reduce the gap between the experience of BME and White British patients to manage their LTC. Evidenced by improved experience of Care and Support Planning for these cohorts from the 2018 baseline and by improved recording of ethnicity in the Primary Care Record from 2018 baseline.
4. To reduce the prevalence of smoking generally and to see the greatest reduction in smoking prevalence in GP Practices in DQ 4&5.

Achievements 19/20

- TB outreach Screening
- Children's Hubs
- Trailblazer - Mental Health Support Team
- Breast Screening for patients with Learning Disability

Expectation 20/21

- Each CCG portfolio to identify a health inequality project - economic studies have shown that addressing health inequalities not only brings better outcomes for patients but also reduces pressure on the health and social care budget)
- Agree one key objective to deliver on at place as a collective - this can be taken from the equality objectives i.e. tackle smoking so all system partners can work together towards meeting that objects.
- Each PCN Clinical director to focus health inequalities – that could be just getting better recording on EMIS – but using this system intelligence to target populations that need better health interventions – see below PCN project that is being worked on now - the aim of this exercise is to increase the recording of carers & ethnicity coding so that identification of needs of the said group.

Prevention

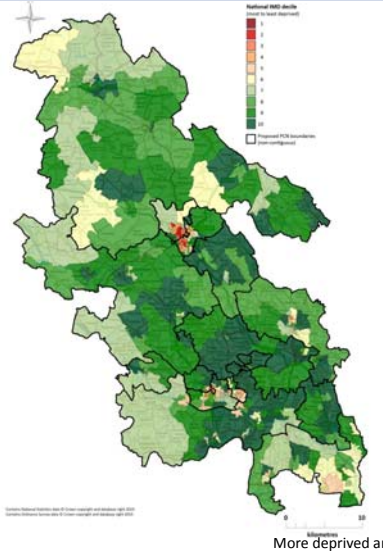
Jane O'Grady
Director of Public Health
Tracey Ironmonger
Assistant Director of Public Health

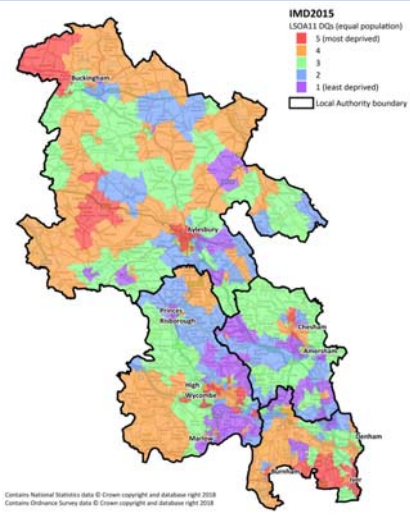
Buckinghamshire Context

- Population growing - 635K by 2039
- Those over 65 years will increase by 60,000, working age population by only 16,000
- People are living longer but not all those years in good health and there is variation in outcomes
- Men living to 82 years but only healthy to 69.6 yrs
- Women living to 85 years but only healthy to 70 yrs
- Much preventable ill health
- Unhealthy lifestyles
- 58% of people over 60yrs have long term condition
- Multi-morbidity is the new norm more common and develops 10-15 years earlier in deprived groups

Deprivation in Buckinghamshire

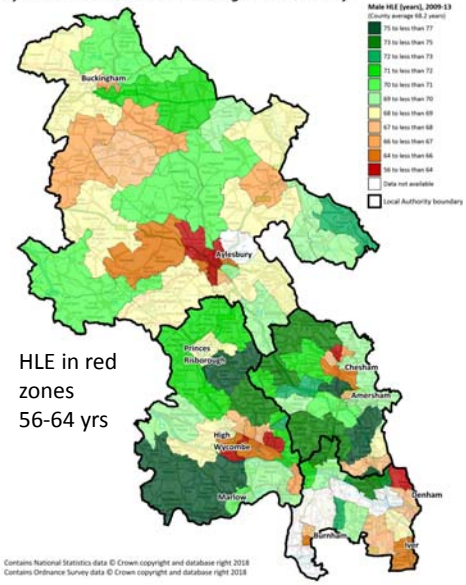
England Deprivation Deciles	Buckinghamshire Deprivation Quintiles



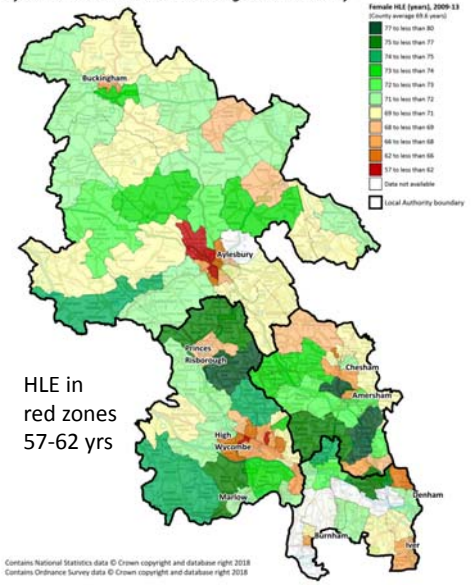


More deprived areas are shown in red.

3



HLE in red zones 56-64 yrs



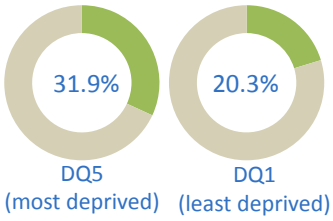
HLE in red zones 57-62 yrs

PLACE BASED APPROACH is VITAL TO IMPROVE HEALTH & WELLBEING

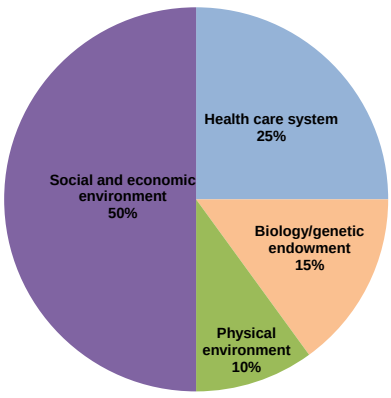
Multi-Morbidity

- = having multiple long term conditions
- 1 in 2 people in Buckinghamshire has a long term condition (LTC). 3 in 10 have two or more conditions.
- People who live in the most deprived areas (DQ5) become multi-morbid approximately 10 years earlier than in the least deprived areas (DQ1).

Proportion of 45 to 49 year olds with Multi-Morbidity by Deprivation Quintile



What determines our health ?



Source: Canadian Institute for Advanced Research, Health Canada, Population and Public Health Branch AB/NWT 2002

"Lifestyles" - 30% - but choices not made in a vacuum

4 pillars to improve population health

- Communities – social cohesion, community resilience and empowerment, community safety
- Lifestyles
- Broader determinants – income, education, employment, housing conditions, neighbourhood environment
- Access and quality of integrated health and social care

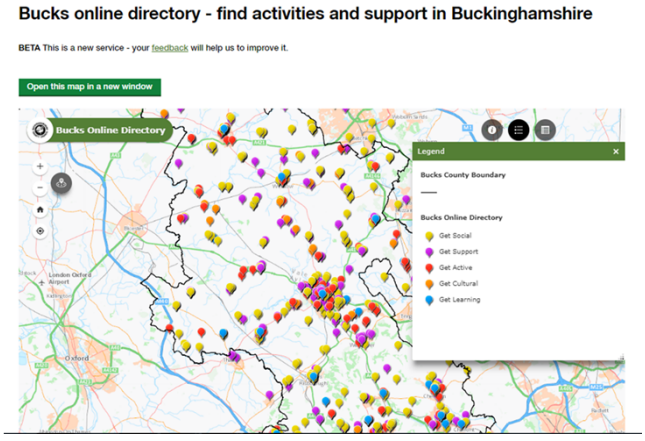
Better Lives – The Partnership Journey

- Building on existing multi-agency strategies and action plans
- Looking to ‘Add Value’ to existing work
- Diverse group of partners including NHS, Local Authorities, Fire and Rescue, Thames Valley Police, Department of Work and Pensions, Community Impact Bucks
- Iterative process building on areas of joint interest
- Building commitment

Better Lives – Shared Approach to Prevention – Working with Partners

- Developed a Shared Approach to Prevention set of principles with 13 partners
- Partners agreed social isolation as a system wide priority
- Developed a work programme for the Healthy Communities Partnership including supporting the development of new action plans for healthy eating and tobacco control
- Population Health Management
- Developing a co-ordinated approach to social prescribing with CCG
- Strength Based Discussions and Making Every Contact Count – 45 minute training session and animation
- Bucks Online Directory
- Supporting development of organisations prevention plans

Bucks Online Directory (BOD)



- https://www.buckscc.gov.uk/services/community/bucks-online-directory

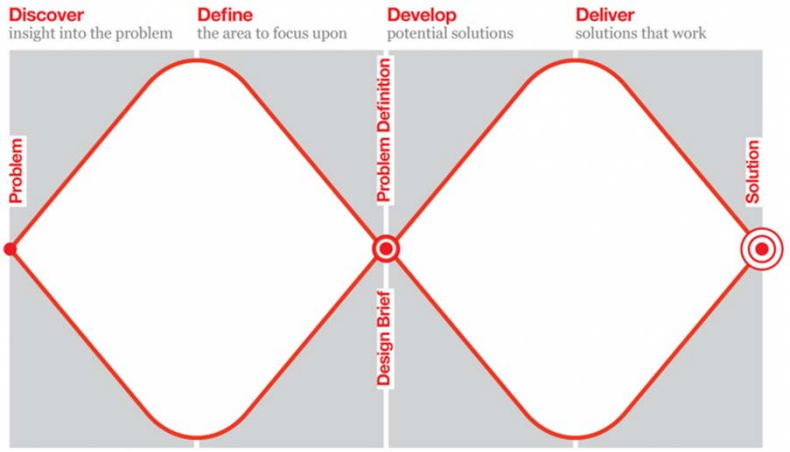
Better Lives - Strengthening Communities

- A planned programme of community appraisals
- Identify and quality assure Community Assets for the database
- Expand the number of Street Associations
- Expand the number of Dementia Friendly Communities and support the Dementia Friendly Alliances

Better Lives – System Wide Project on Social Isolation

- Agreed as a system wide priority that all partners could contribute to and an issue that has significant impact on health and wellbeing
- Social isolation vs loneliness
- Adopting a design process, including co-design with communities
- Launched with a 2 day workshop attended by 30 organisations
- Workshop considered two challenge statements:
  - How might we support and develop the assets and strengths of individuals and communities:
    - To prevent social isolation at key life events?
    - To prevent social isolation in those with limiting health conditions and disabilities?

Social Isolation – The Design Process



Social Isolation – The Projects

- 'Quick Wins'
- Developing or sourcing a screening tool and then developing and implementing across partners a pathway for those 'at risk' of social isolation (prototyping)
- Pilot work in small geographical areas to get greater local insight into social isolation and then to co-design solutions with local communities (co-design)

Supporting Action to Reduce Health Inequalities

- Shared Approach to Prevention
- Needs assessments
- DPH Annual Reports
- Health Profiles for NHS and Community Boards
- Focus and monitoring of Public Health commissioned services – smoking cessation, substance misuse, early years and young mothers
- Public Health funding for Community Boards
- Supporting partners to develop inequalities approach

Working with NHS partners

- **Smoking - accounts for half of life expectancy gap between rich and poor**
- **Maternity** physical, mental & social health & smoking cessation
- **Alcohol**
- **Mental wellbeing**
- **Severe mental illness, learning disability & autism**
- **Rough Sleepers**
- **Partnerships -** Encourage innovation and new ways of working to address inequalities

Bucks CCG's Priorities - the next 5 years

Your community Your care
Developing Buckinghamshire together

- Smoking: reduction overall, with a focus on the most deprived populations
- Mental health for young people: increasing mental health support teams in schools in deprived areas
- Care & support planning: improving the gap in patient experience between the Black and minority ethnic (BAME) & white communities
- Improving the detection of hypertension and it's management in our deprived and BAME communities

THANK YOU

BUCKINGHAMSHIRE COUNTY COUNCIL

Your community Your care
Developing Buckinghamshire together

Delivering Health & Social Care in our Hospitals & Communities

07 February 2020

Buckinghamshire

Buckinghamshire, Oxfordshire & Berkshire West Integrated Care System (BOB ICS)

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Buckinghamshire Integrated Care Partnership (ICP)

Your community Your care
Developing Buckinghamshire together

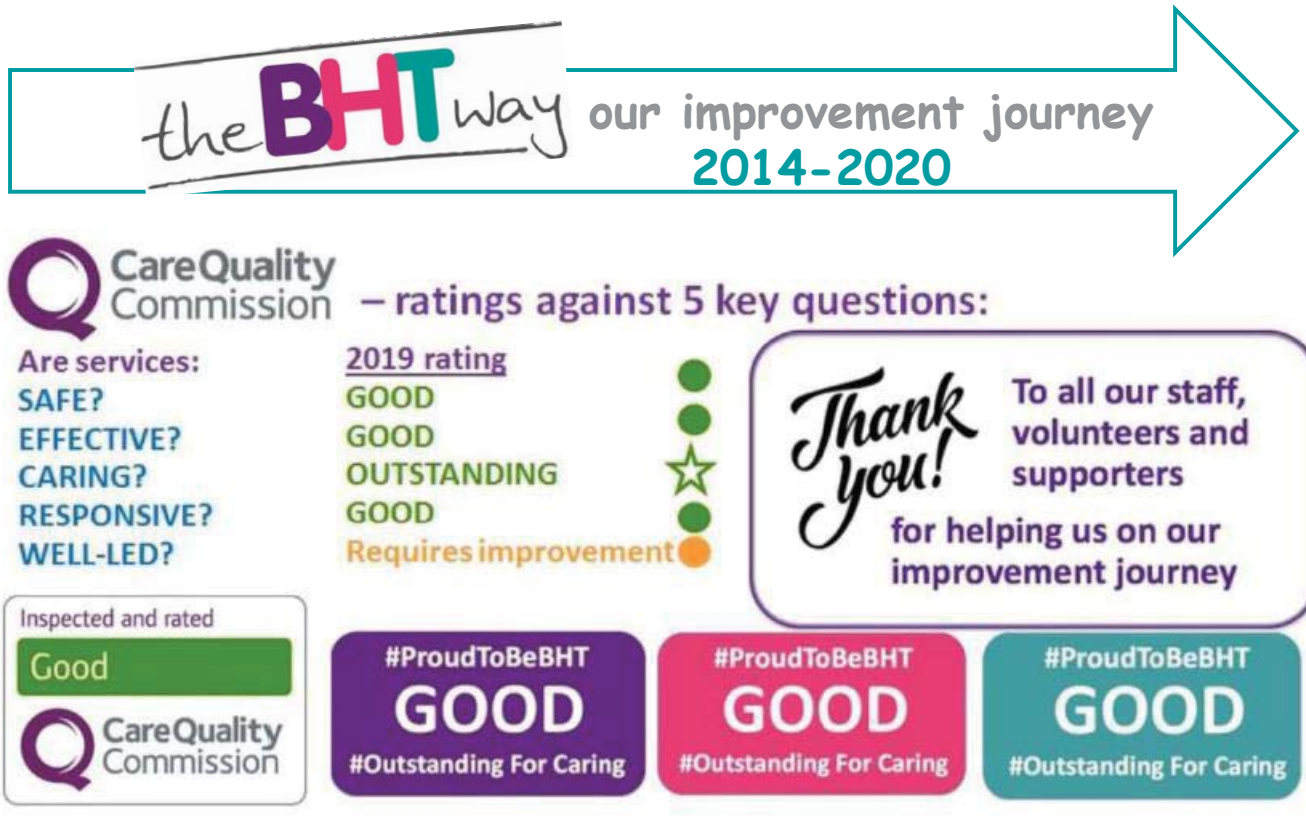
NHS Buckinghamshire Clinical Commissioning Group
NHS Buckinghamshire Healthcare NHS Trust
FedBucks
Buckinghamshire County Council
NHS Oxford Health NHS Foundation Trust
NHS South Central Ambulance Service NHS Foundation Trust

Buckinghamshire Healthcare NHS Trust

NHS Buckinghamshire Healthcare NHS Trust

Every year we care for:

- 600,000 members of our community
- 460,000 in our outpatient units
- 100,000 in our inpatient units



Care Quality Commission Inspection 2019

Outstanding practice

- Emergency care
  - Consultant admission
  - Patient flow coordinators
  - Staff intranet
- End of Life Care
  - Purple Rose model
  - Medical Examiner
  - Culture of talking about death and dying and providing support to staff
  - Evolving, inclusive model of chaplaincy, available 7 days/week
- Outpatients
- Community adult services
  - 'Better Balance' classes
  - 'Feeding for comfort' guidelines
  - Community nutrition nurse
  - Consultant competency training
  - Community Head Injury Service 'Working Out' specialist brain injury programme

Work to do

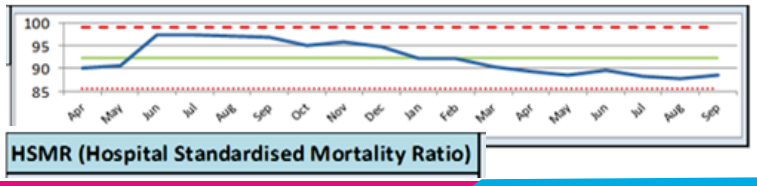
- Well-led
  - Proactive approach to governance
  - More effective risk identification
  - Information used more robustly to monitor performance and drive change
- Surgery
  - Medicines management
  - Storage of emergency medicines
  - Surgery checks
  - Risk assessments for patients
  - Equipment properly maintained
- Emergency care
  - Suitable environment for vulnerable patients including those with mental health needs
  - Fully completed patient records
- Community inpatients
  - Safer staffing levels are appropriate
  - Processes in place for describing impact of safer staffing levels on patients' rehabilitation journeys
- Community health for children, young people and families
  - Reduce waiting times

Quality – achievements

- Cardiac arrests reduced from 40 last year to 21 this year
- BHT audiologist nominated as National Paediatric Audiologist of the Year 2019 (awarded by the British Academy of Audiology)
- BHT Children and Young Peoples' services rated 8th out of 66 Trusts surveyed by Picker; six of the seven above BHT in ranking for overall positive score are specialist children's hospitals
- New diagnostic pathway for patients presenting with vague symptoms that could indicate cancer (low risk, but not no risk)

	Cardiac arrests	Peri/met calls	False alarms
2019	21	200	82
2018	40	138	73

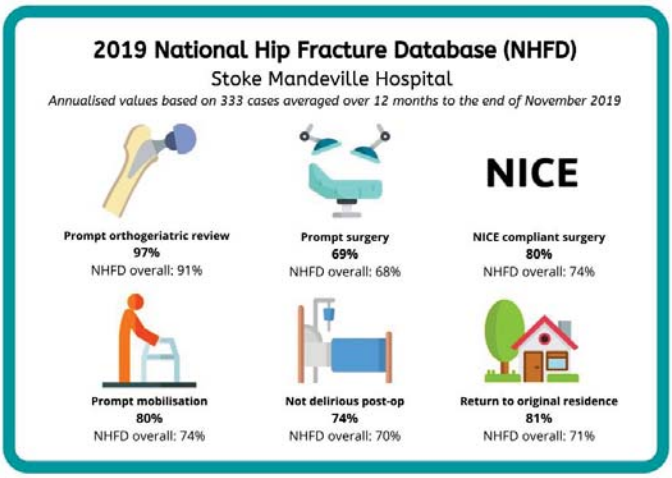
- Single Sign On – access to multiple systems using one password
- Medical Examiners contact over 95% of bereaved families
- Signed Armed Forces Covenant, our commitment to local people and staff from this community
- Hospital Standardised Mortality Ratio: steady improvement over last 12 months



HSMR (Hospital Standardised Mortality Ratio)

Quality – achievements

- Listening event held on the neonatal unit to hear and act on views of parents
- 41 patients took part in three workshops to review pathways for minor eye conditions, cataracts and glaucoma
- 18 staff trained in 'Listening to the Patient Voice'; staff reported an average of three point increase in confidence on 10 point scale
- Launch of our first two continuity of carer teams on 27 Jan (teams of midwives providing continuity for women on the midwifery-led care pathways)
- Better than the national average in all six measures of the National Hip Fracture Database
- Envoy Friends and Family Test digital platform; pilot in Emergency Department: increased response rate from 8% to average of 32% (national average is 12%)



Quality – challenges

- Operational pressures, including rising numbers of children
- Staffing – doctors/physios/nurses/community nurses
- Influenza and norovirus
- Environment
- Pressure ulcers:

PRESSURE ULCERS (deep tissue damage)		
Dec-19		Compared to last period
2		Deterioration
		0

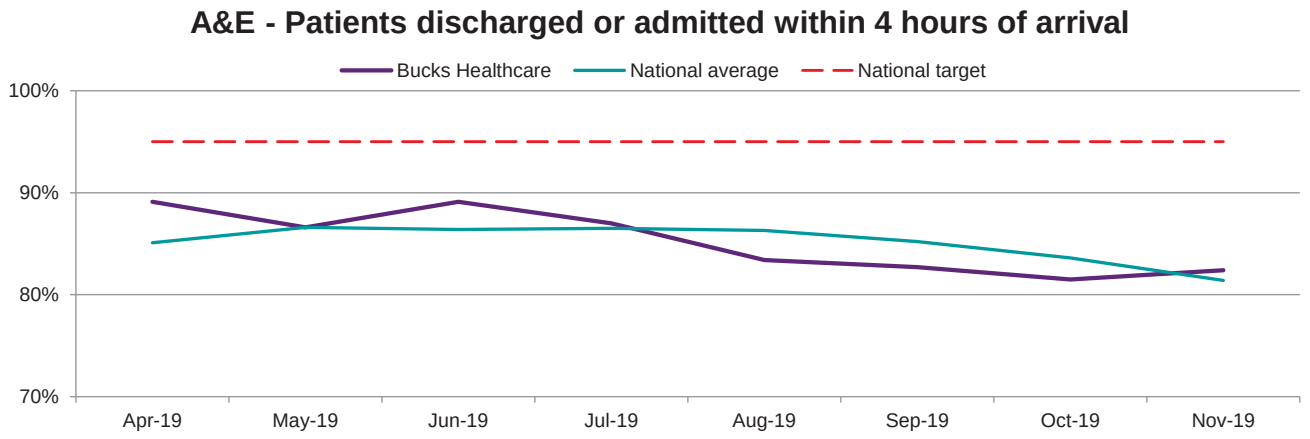
Quality – new approaches

- Use of digital technology:
  - electronic observations
  - electronic prescribing
  - using Perfect Ward (app) for quality rounds with patient assessors
- Innovation:
  - cancer transformation funding for urology one stop clinics
  - point of care testing in Emergency Department (ED) for influenza
  - paediatric GP streaming and waiting room guardians in ED
- New staffing models:
  - community case managers
  - increased physiotherapy on Stoke Mandeville site at weekend
  - seven consultant nurses, including one in ED
  - psychologists in Intensive Care Unit
- Phase 1 building works in ED: entrance and signage improved
- Preventing pressure ulcers:
  - Review of pressure ulcer documentation and introduction of revised gold standard national care bundle for assessment, prevention and management of pressure injuries
  - Design and roll out of an improved mechanism for flagging vulnerable patients
  - Further preventative initiatives such as possibility of purchasing evidence-based devices

iCARE digital @ BHT

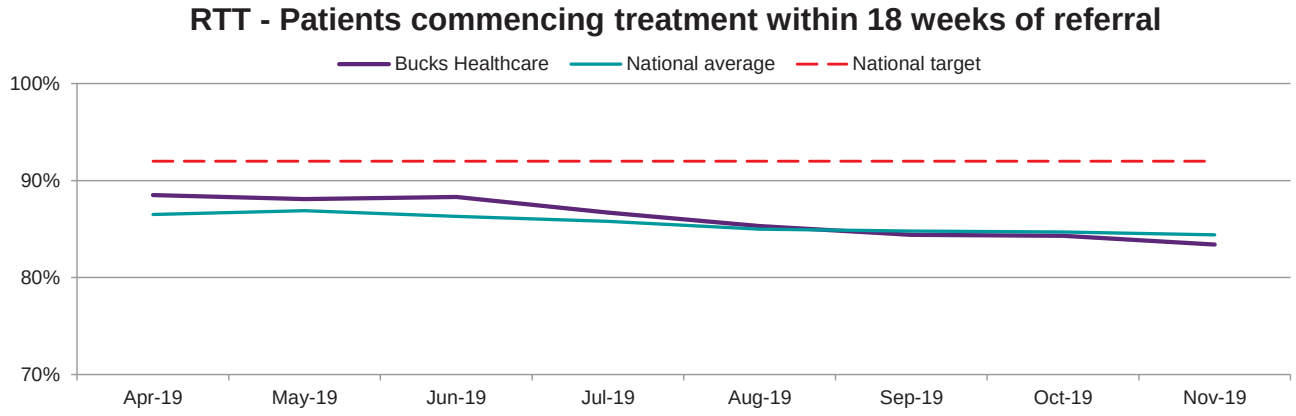
Quality improvement Qi@BHT

Accident & Emergency (A&E) 4-hour performance



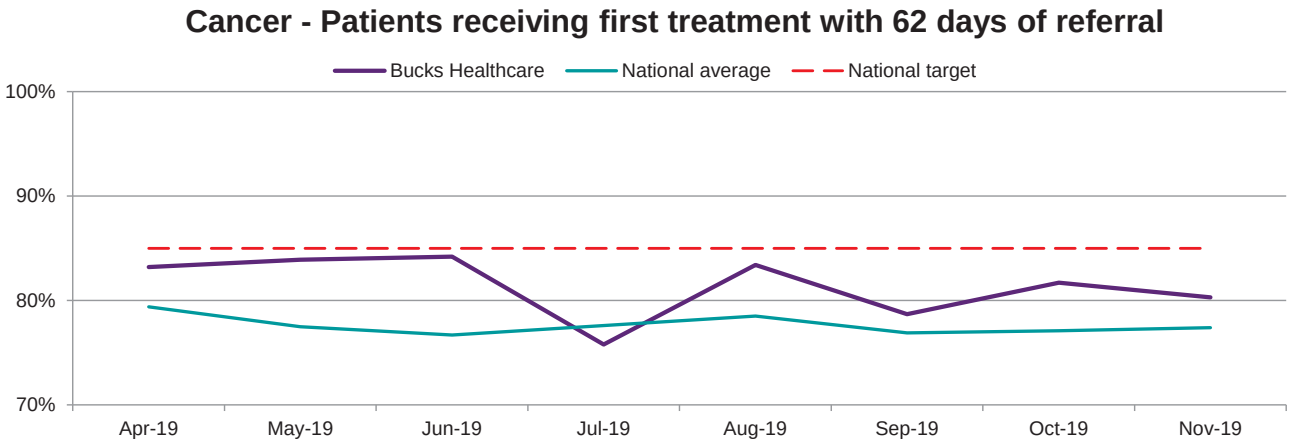
- Higher than anticipated attendances at A&E during the last two quarters
- Performance against 4-hour standard trend similar to the national average
- Received support from NHS Improvement during December to support identified areas of improvement, including additional out of hospital capacity, escalation beds for patients who are medically fit for discharge at Wycombe Hospital and other smaller projects

Referral To Treatment (RTT) waiting times



- Waiting lists have increased; cancellation of routine activity due to emergency demand has had a negative impact on waiting times; particularly pertinent to the winter season; specialities are working to reduce the impact
- Demand for ophthalmology remains high; discussing potential options for resolution with partners
- Receiving support from NHS England & Improvement for waiting list validation review
- Performance following the national trend

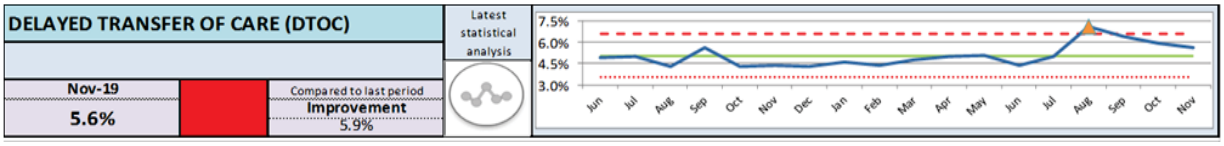
Cancer 62-day target



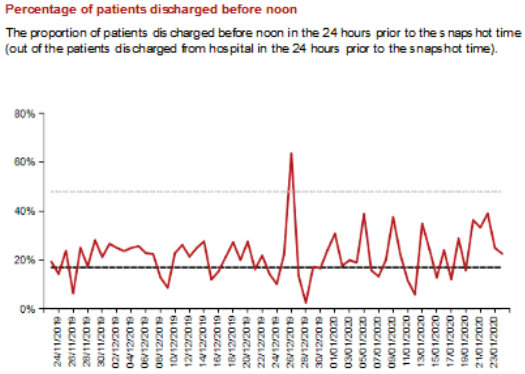
Although we are performing above the national average, achieving the cancer 62-day target has been challenging; the reasons behind this are complex and include: diagnostic capacity (both within BHT and externally; particularly endoscopy and radiology); patients needing more complex diagnostics or requiring a change in treatment plan; and patients who were unfit, were on multiple tumour pathways, or chose when to have their diagnostics.

We have a range of actions to help improve this during the last quarter of the year, including a one-stop clinic for patients, and electronic requesting for endoscopy. There is also a new MRI scanner due to be available at Wycombe Hospital in quarter 4.

Delayed Transfer of Care (DTOC) and discharge performance



- Six 'non-weight-bearing' beds procured by BHT in a nearby care home to increase capacity
- Six reablement beds procured by Bucks County Council to help reduce reablement waiting times
- Daily reviews of medically fit patients by BHT acute and community teams, adult social care and reablement teams, and Clinical Commissioning Group (CCG)
- *Ad hoc* placements via CCG to support delirium pathway; now supported by dedicated nurse
- 4 beds procured in local nursing home to support reducing length of stay until end of January
- Training for Rapid Response and Intermediate Care staff to enable them to support with medications

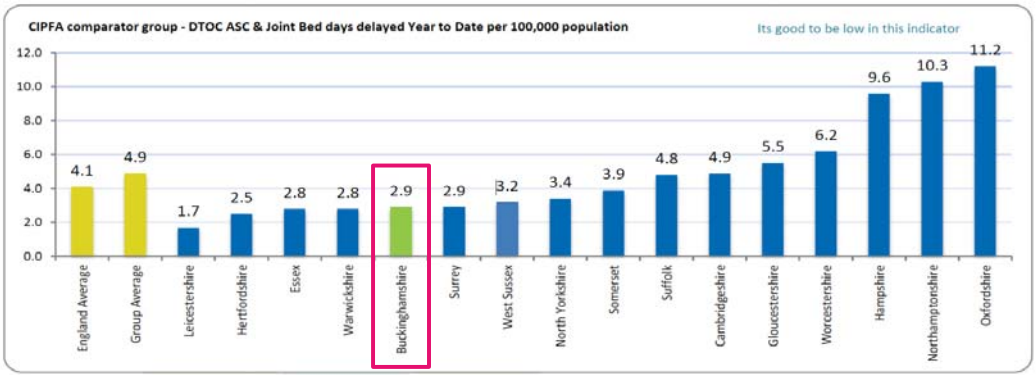


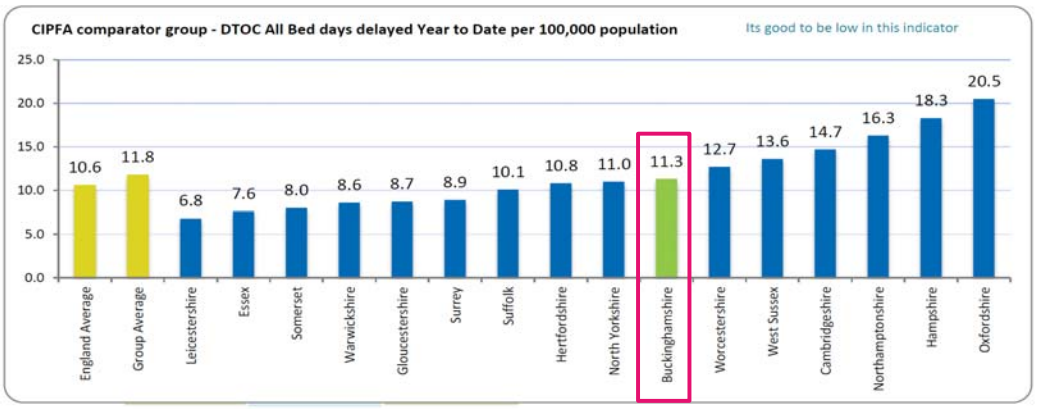
- Discharge workshop for all staff
- "Golden Discharge" challenge – identifying morning discharges before 10:00 and celebrating them
- Welcome & discharge pack
- Weekend Discharge doctor, weekend discharge tracker
- Patient Choice policy
- Seated discharge lounge
- Introduction of Red2Green on two ward areas – making each day count
- SAFER – patient flow bundle developed by NHSI

Adult social care

- Bucks County Council Adult Social Care has co-location alongside health teams at: Stoke Mandeville, High Wycombe, Wexham, Amersham, Milton Keynes (2/3 days a week), Whiteleaf (Oxford Health Foundation Trust)
- We also receive referrals from the community hospitals, Oxford and many of the London acute sites
- Working together:
  - All partners attend daily discharge meetings at the relevant hospital
  - Social Care and nurses work collaboratively in A&E towards hospital avoidance
  - Joint Assessment forms are currently being used on wards in Stoke Mandeville Hospital and will be rolled out across all sites
  - Weekly meetings with all partners across Buckinghamshire to review patients with a long length of stay
  - Multi Agency Discharge Events (MADE)
  - Intermediate care beds x 4 step down from hospital (independent sector)
  - 7-day working
  - Red cross home from hospital (third sector)
  - Trusted assessor for continuing healthcare with the CCG
  - Joint Integrated Care Partnership medication policy in progress
  - Discharge to assess in the south of the county

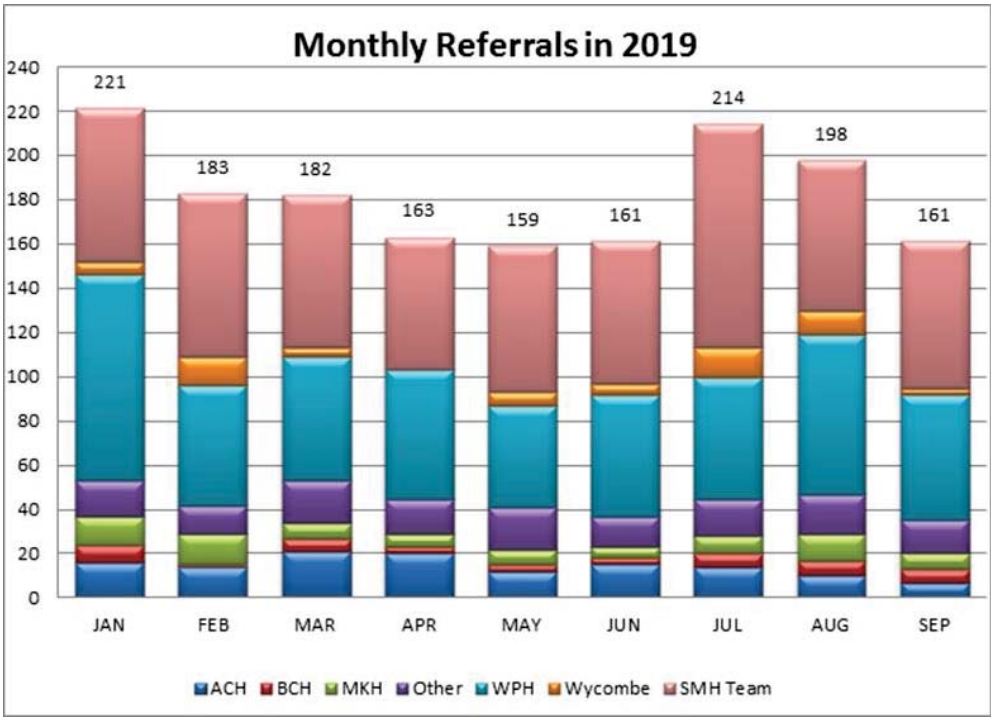
DTOC performance





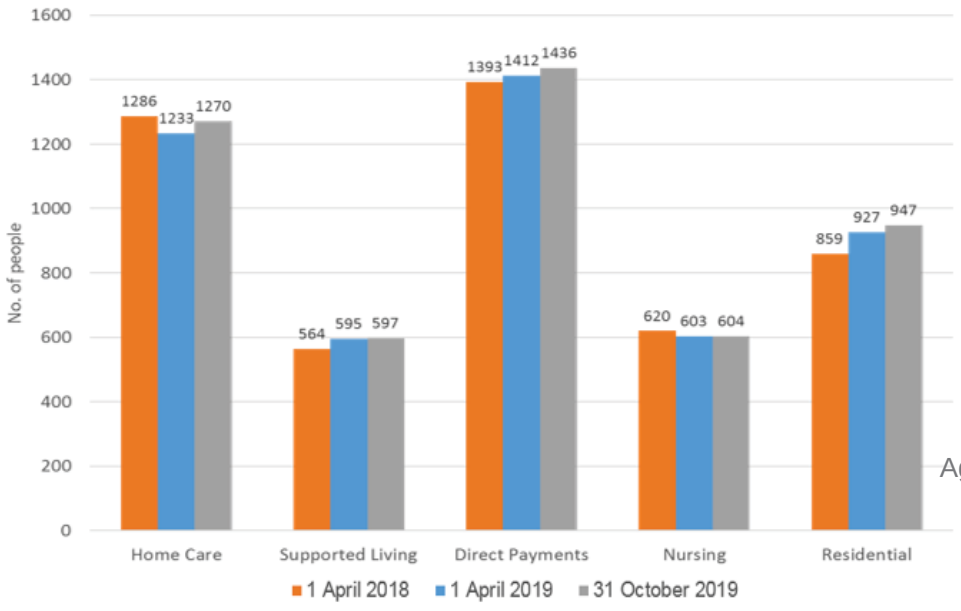
Data are from April to November 2019 from the Chartered Institute of Public Finance and Accountancy (CIPFA)

Hospital referral to Adult Social Care

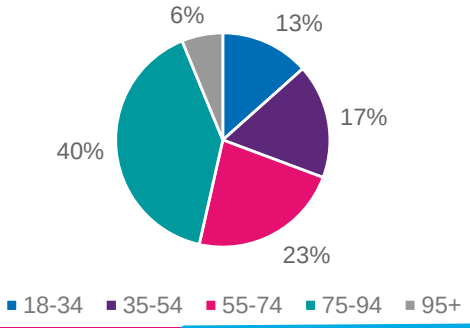


ACH: Amersham Community Hospital; BCH: Buckingham Community Hospital; MKH: Milton Keynes Hospital; WPH: Wexham Park Hospital; SMH: Stoke Mandeville Hospital

Long-term Client Numbers



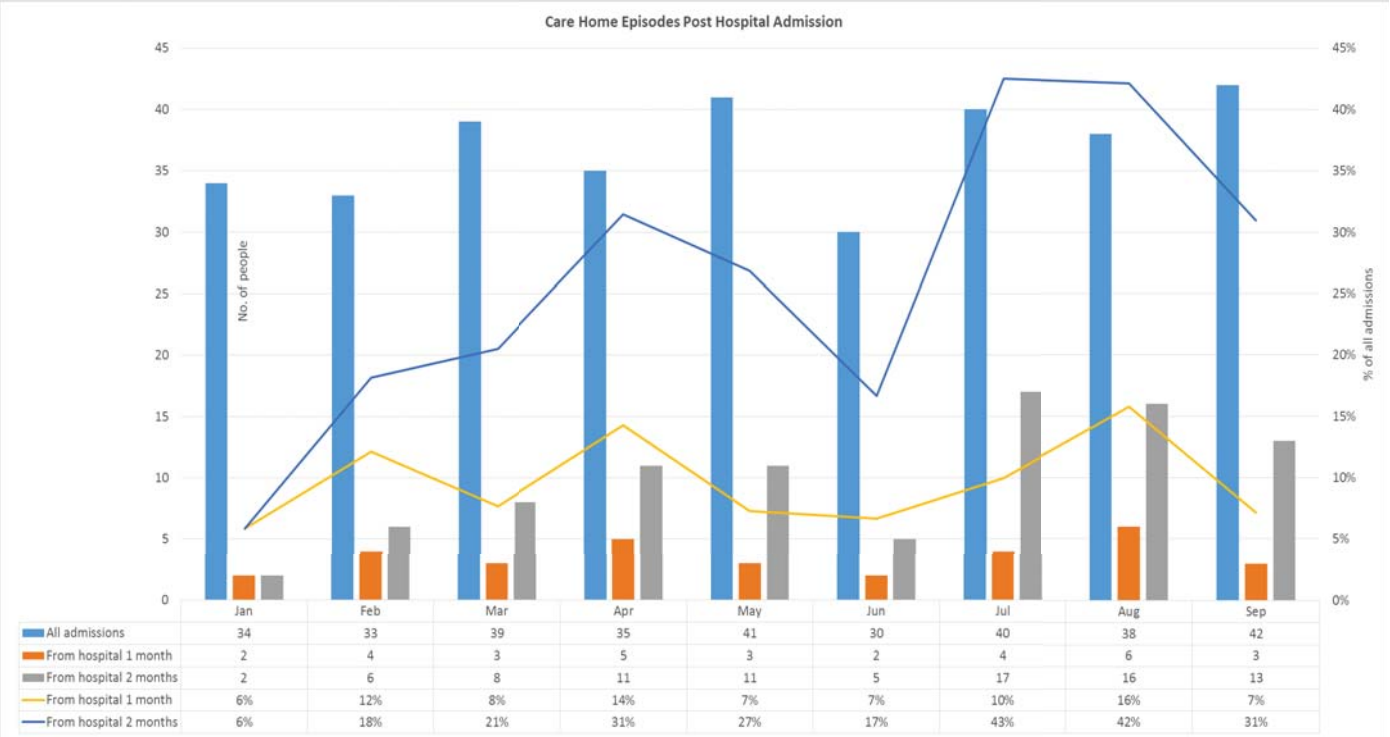
Age Profile of Adult Social Care Clients (December 2019)



Number of clients:

	18-64	65+
Learning disability support	982	106
Mental health support	451	220
Physical support	504	2183
Sensory support	13	8
Social support	95	31
Support with memory cognition	29	220

Care home episodes after hospital admission



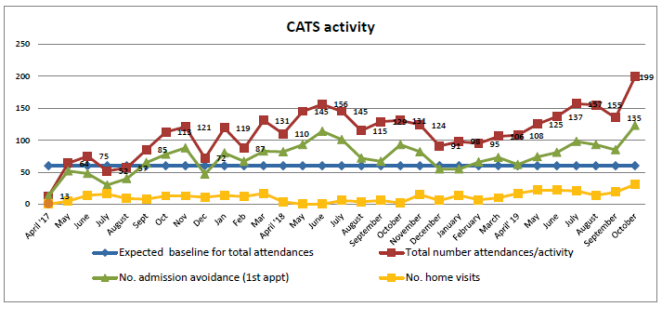
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
All admissions	34	33	39	35	41	30	40	38	42
From hospital 1 month	2	4	3	5	3	2	4	6	3
From hospital 2 months	2	6	8	11	11	5	17	16	13
From hospital 1 month	6%	12%	8%	14%	7%	7%	10%	16%	7%
From hospital 2 months	6%	18%	21%	31%	27%	17%	43%	42%	31%

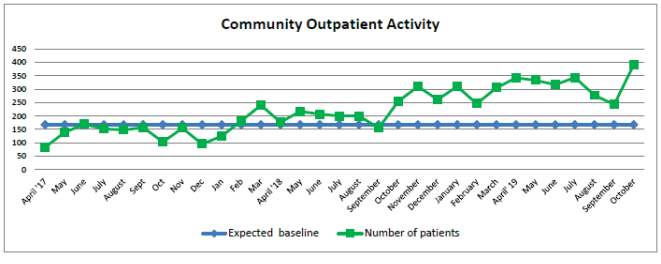
Integration / Community

- Multidisciplinary Day Assessment Service (MuDAS) activity:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
MUDAS - First appointments	137	162	131	141	153	157	180	144	136
MUDAS - Follow Up appointments	70	84	64	66	73	65	84	79	86

- Community Assessment and Treatment Service (CATS) activity and total outpatient activity in Thame and Marlow
  - Additional site at Amersham





- Expansion of clinics and services provided in the community hubs
- Dedicated support for elderly or frail patients:
  - Elderly Care Physician of the Day (ECPoD) in ED
  - Consultant geriatrician supporting general surgery
  - Extended 'silver phone' – consultant support for GP decision-making
- Community nutrition specialist nurse to help manage malnutrition
- Complex care managers: senior district nurse dedicated to patients with complex needs
- Close working with council to provide rehab beds in care home
- 7-day therapy service in community inpatient
- Therapy and nursing led unit in Stoke Mandeville

Mental Health – performance

Standard	Service area	Threshold	This month	Year to date performance
Children & Young People (CYP) access indicator: number of CYP receiving their second contact within the 3 months of referral	Child and Adolescent Mental Health Services (CAMHS)	242	279	322 (mean)
% of routine referrals to CYP eating disorder service that are seen within 4 weeks	CAMHS	90%	100%	76.7%
Referral to treatment target of 6 weeks for psychological interventions	Perinatal	95%	100%	80%
Improving Access to Psychological Therapies (IAPT) access: the proportion of people with depression/anxiety (as per national public health data) that have entered psychological therapies	IAPT	Local target 19% National target 22%	18%	20%
% of referrals where the patient is deemed fit for interview by A&E staff will be seen for assessment within 1 hour of referral	Psychiatric In Reach Liaison Service (PIRLS)	95%	98%	98%
Out of Area Treatments: number of new patients placed in an out of area mental health bed per month	Adults and Older Adults	0 inappropriate	4 (vast improvement vs 2018/19)	25 (cumulative)
Early Intervention in Psychosis (EIP): >50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral	EIP	50%	100%	95%

Mental Health – achievements from 2020-21

Children & Young People

Buckinghamshire identified as Trailblazer for CYP Transformation

2 multi agency Mental Health Support Teams now live covering 30 schools and colleges

Tier 4 CAMHS provider collaborative established, greater access to more local beds

Perinatal Mental Health

Uptake of specialist perinatal mental health service in line with anticipated demand

Launched peer support online forum across Buckinghamshire, Oxfordshire and Berkshire

Enables current and previous service users to connect online

Improving Access to Psychological Therapies

Some of the best IAPT recovery rates in the country

Delivery model incorporates Relate, Richmond Fellowship and Ieso

Further development of wider system working across long term conditions pathways and primary care

Acute & Crisis

Urgent care pathway transformation underway

Night Response Team in place to offer alternative to A&E for those experiencing Mental Health Crisis

Safe Haven in Aylesbury delivered alongside Buckinghamshire Mind

Adult and Older Adult Serious Mental Illness

Individual Placement & Support in place to help patients get back into employment

Positive engagement with Primary Care Networks to align current services and plan implementation of community mental health framework

Dementia & Frailty

Greater system working in relation to dementia diagnosis and memory clinics

Improved delirium identification in collaboration with acute hospital

Dementia Strategic group formed to coordinate delivery plans for coming financial year

Mental Health – future ambitions

Deliver priorities and objectives outlined in the NHS Long Term Plan for mental health:

- Increase timely access to mental health services to ensure that people can get the most appropriate help and support at the most appropriate time
- Eliminate inappropriate out of area placements by providing inpatient care locally or alternatives to admission
- Working alongside system partners to roll out new community mental health framework to help bridge the gap between primary care and secondary care services
- Further develop partnerships with third sector, local authority, schools, emergency services and other NHS and non-NHS care providers (primary care, care homes etc.)

Our current workforce

HEALTH AND SOCIAL CARE STAFF IN Buckinghamshire Healthcare

5,354 FTE 19/20 health staff in provider Trusts

Source – ESR as at Oct 19

4,140 of these patient-facing, 1,214 non-patient facing

7,900 FTE 18/19 adult social care staff

Source: Adult SC analysis by SE STP, HEE National Data Library

218.2 children's services

Source: Dept for Ed, Children & family social workforce in England Sep 2018 (N.B. Experimental Statistics)

1,163 FTE Sep 2019

15.1 FTE pharmacists

Source: National Workforce Reporting System

360 vacancies are **nursing** posts

NB – Based on variance between Establishment and Staff in post

Source – HEE Strategic Plan (eWorkforce) Nov 19 (Bucks HC only)

32% turnover in social care, with

37% turnover in direct care

Source: SfC Workforce Intelligence LA Comparison

Roles (Bucks HC only)

12% of the trust based health workforce is medical

32% of the non-medical trust based health staff are registered nurses; **8%** are allied health professionals; **6%** are scientific, therapeutic and technical (including healthcare scientists)

Nearly 72% of the social care workforce is employed in roles providing direct care

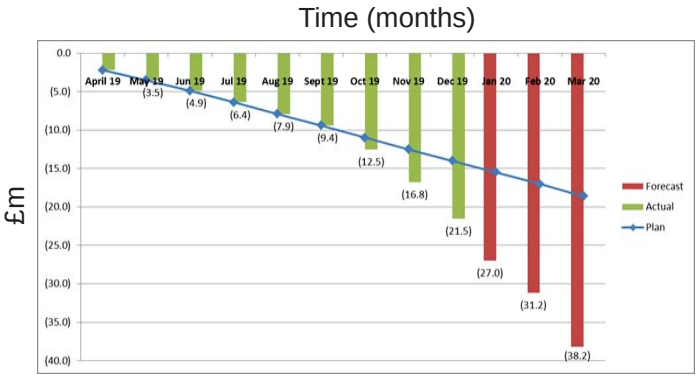
61% of practice nurses and 36% of all non-medical staff are over 50

Workforce – achievements

- Comprehensive programme for staff wellbeing
- Partnership working:
  - University of Bedfordshire Stoke Mandeville teaching and learning facility
  - Bucks New University site in Aylesbury; placements for 29 Nurse Degree students and 9 Nursing Associate apprentices
  - 16 nurse cadets joined in November; additional cohort in quarter 4
- Internship programme for 7 students with learning disabilities from Stoney Dean School
- International recruitment supported by Erasmus programme
- Freedom To Speak Up Guardian, Tracey Underhill
  - Operational Support Worker of the Year (south east region) at Our Health Heroes awards
  - Monthly 'concerning conversations' workshops
- National Inclusion Week, November 2019
  - Plenary from Yvonne Coghill, director of the NHS Workforce Race Equality Standard (WRES), at BHT Inclusion Conference
  - Launch of NHS rainbow badges
- Apprenticeships: 16 different programmes, incl. nursing
- Trainee Leadership Board Quality Improvement outpatient programme

Money

- 2018-19 outturn: £33m
- 2019-20 forecast: £29m
  - Critical IT infrastructure upgrades
  - Winter operational pressures
  - Backlog maintenance & PFI
  - Medical pay award shortfall
  - Drug prescribing changes
- Small Change, Big Difference campaign
  - Efficiencies of £74.5k



- Capital challenges to fund essential digital and estates upgrades – exploring options with NHSE/I and partners in Bucks
- Use of resources
  - BOB ICS procurement:
    - early pilot projects have so far yielded annualised savings of around £510k across all participating Trusts, with more than £150k in BHT
    - starting to identify opportunities in a number of more clinically complex product areas, including orthopaedics, cardiology, wound care, cardiothoracic, energy devices and sutures
  - Use of estates: cost per m^2 now rated green on Model Hospital

Drivers of deficit

£60m system* underlying, recurrent deficit

- 30 ‘drivers’ defined across four themes
- Not expected to review every driver
- Senior team reviewed and identified 13/30 key drivers for further analysis
- Performed analysis and benchmarking
- Fed into System Recovery Plan

*BHT & Bucks CCG only

Theme	Low	High
Structural Outside the control of the system, e.g. geographical isolation or stakeholder service requirements	£22.7m	
Strategic Outside the control of a single organisation but within the control of the system, e.g. capacity and/or quality of community care	£2.8m	£6.6m
Operational Within the control of a single organisation, e.g. poor historical CIP achievement	£21.8m	£44.5m
Total	£47.3m	£73.8m

Other achievements

- Anaesthesia Clinical Services Accreditation for anaesthetic team
- Launched pilot Children’s Community Hubs in Aylesbury
- Investments in paediatricians and plastics consultants
- Improving waiting times for paediatrics
- First BHT Organ and Tissue Donation Conference
- First BHT Burns Symposium; Consultants from the Plastics and Burns unit at the Trust have been involved in research with Oxford University
- National Optometry Conference held at Stoke Mandeville Hospital site
- Open Day and joint Annual General Meeting with Bucks CCG (September 2019)
- Charlotte Windsor, one of our health visitors, was awarded the Dora Roylance Memorial Prize 2018
- A&E buddy, Trevor Hudson, was shortlisted for HelpForce Volunteer of the Year
- CATS team was highly commended at HSJ Awards; BHT was also shortlisted for Freedom To Speak Up Organisation of the Year

Your community Your care
Developing Buckinghamshire together

Discussion

Future challenges

Population growth

- Population 635k by 2039
- Large amount of housing and infrastructure growth
- People >65y increasing by 60,000
- Working age increasing by 16,000
- People living longer but not all years in good health
- Social and climate impacts of these changes

Public Health, Buckinghamshire County Council

Demand

- More A&E attendances and emergency admissions, especially for people who are frail or living with more than one long term condition
- More elective admissions and day cases for age-related conditions, and ophthalmology
- Increasing demand on diagnostics, especially for early detection of major conditions such as cancer, stroke and cardiovascular disease; mental health services; maternity; and children's services

Inequalities

- Some wards have the worst health outcomes across BOB ICS for emergency admissions for certain conditions
- Poorest have 60% higher prevalence of long term conditions than richest and greater severity
- In our more deprived areas:
  - Higher prevalence of low birthweight and infant mortality
  - Lower levels of children developing well
  - Higher levels of Children in Need and Children Looked After
  - Higher prevalence of long term conditions & multimorbidity
  - Lower update of screening
  - Higher emergency admissions for all causes
  - Higher premature mortality

Public Health, Buckinghamshire County Council

Workforce

- GPs – particularly out of hours
- Band 5 nurses – acute, mental health, learning disability community, practice
- Occupational therapists, diagnostic radiographers, allied health professionals, medical physicists, infection sciences, endoscopists
- Direct Patient Care Workers

Vision for community

- Continued development of integrated 'home first' model to do everything practicable to ensure residents return to or remain in their preferred place of residence
- Formal integration of services with Bucks County Council, including discharge, linking with Community Boards and Primary Care Networks
- Rapid response community model – national pilot site from 2020
    - Community response time of two hours (alternative to A&E)
    - 48-hour rehabilitation support – to enable more rapid discharge after a hospital stay
- Use population health data to anticipate and provide support for patients earlier in care pathway
- Single support offer to care homes

Integrated discharge service

The Integrated Discharge Service will bring together all staff in the system who are integral to achieving a streamlined and effective transfer of care planning process for patients and carers, supporting wards and multidisciplinary teams when there are factors that could lead to delay

- Discharge planning process needs to strengthen the capability to handle simple discharge in a streamlined and timely way
- Teams and services focus on patients returning home, ensuring patients have the correct follow up assessment and care planned after an admission
- Strong links with Primary Care, community services and locality teams, to ensure services reflect patients' needs and are informed by a picture of their baseline needs at home prior to admission

- Improve patient and carer experience
- Provide clinical leadership and direction around discharge and transfer of care for staff working across a range of provider organisations
- Provide the integrated health and social care support required to discharge patients with social and/or complex medical needs
- Minimise delays arising from problems with inter-agency liaison
- Decision-making with the patients and carers at the centre of processes
- Work with system partners to analyse trends e.g. frequent attenders, locality trends, reduction in bed use, increase in community care support packages
- Identify end of life patients who wish to be looked after at home and ensure that they receive expedited discharge with the right health and care support
- Ensure effective use of community services capacity and capability to manage patient need and risk at home
- Reduce the need for on-going packages of health and care through better use of reablement services and assessment of long term needs in the right place at the right time i.e. at home or in the community

The Buckinghamshire Integrated Care Partnership will develop a model of acute services that ensures:

- High quality, safe and compassionate care every time for every patient
- Delivery of the aspirations of the NHS Long Term Plan
- Our people can work in an environment where they have the skills and values to deliver excellent care
- Best use of resources and is financial sustainable

Our vision for 2025 and beyond

What new models of care can we implement to deliver the best outcomes at sustainable costs with a satisfied workforce.

Redesign Urgent and Emergency Care	Consolidate Rehabilitation Services	Partner in Diagnostics Services	Transform Outpatients

Workforce

Health & Social Care Academy

Mission: to be the de facto provider of training, education and career development for all health and social care workforce in Buckinghamshire

Started July 2019

Support recruitment and retention in the health and social care sector and give Bucks a unique selling point for workforce destination

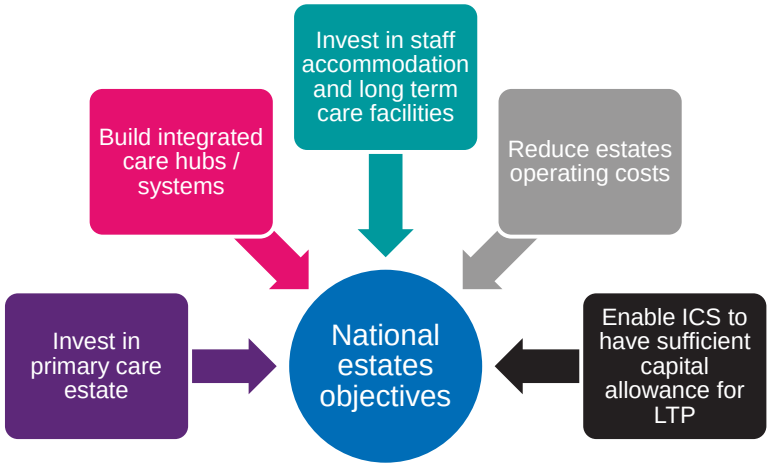
Faculties:

Nursing
Allied Health Professionals
Primary care
Population health & prevention
Social care
Medical
Leadership and management
Research, development and innovation

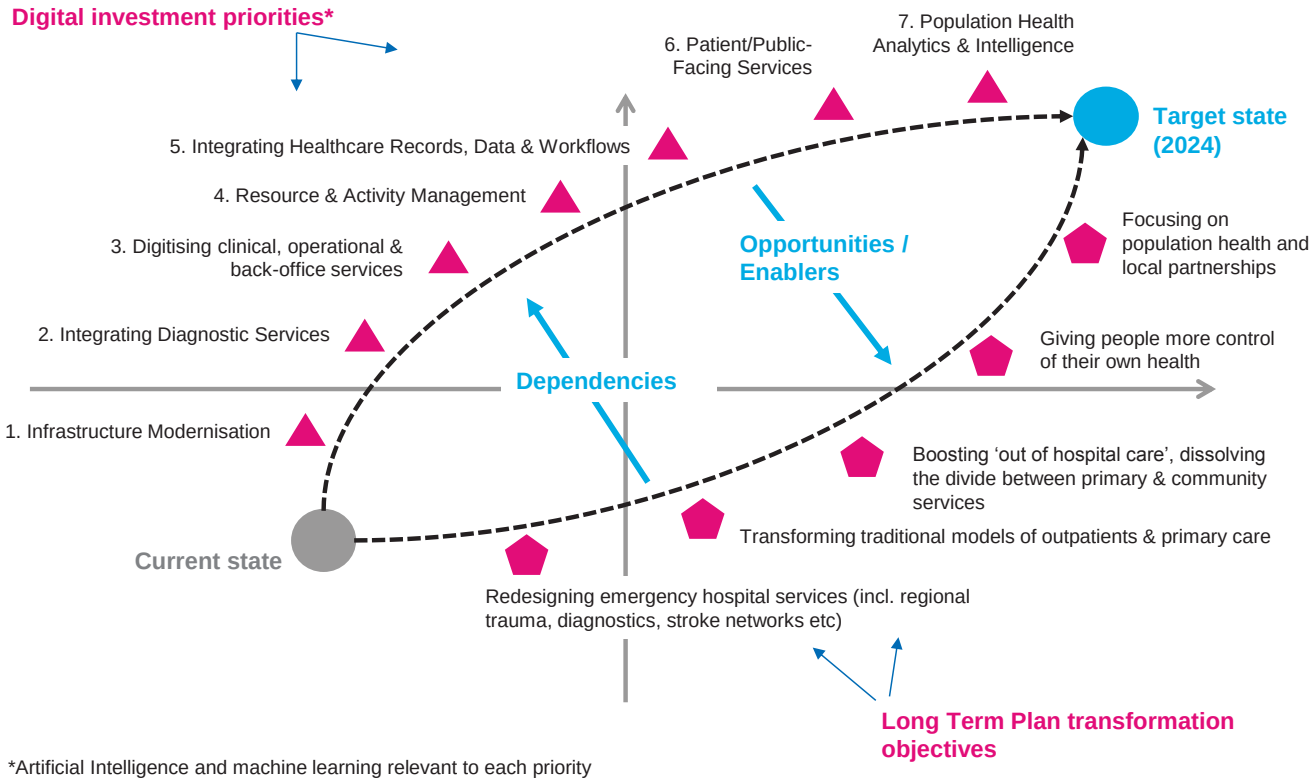
Estates strategy

Aims:
- Meet national estates objectives
- Good quality safe environments
- Estates and workforce operating as efficiently and ergonomically as possible
- Clinical buildings are in most appropriate locations to meet clinical need
- Opportunities for key worker housing
- Release capital for reinvestment
- Agile working

Bucks ICP needs 15x the level of capital spending to deal with the long term impact of under investment in estates and digital



Digital opportunity



*Artificial Intelligence and machine learning relevant to each priority

One Buckinghamshire

With funding we will deliver …

2 UK firsts

Single integrated voice and data network across ICP

Single digital front door – one point of access for all public and voluntary services

A mobile workforce accessing information from any location, enabling operational efficiency and improving the patient experience

Consultation & engagement

- The Buckinghamshire Integrated Care Partnership will engage in a conversation about the future of healthcare in the county with patients and communities in quarter one 2020/21. This is based on principles of engagement in service change agreed through the Buckinghamshire Health and Wellbeing Board. This will:
  - Share the health and population opportunities and challenges over the next five years linked to the NHS Long Term Plan
  - Seek contributions on how we can improve the health and wellbeing of our communities by redesigning community and hospital services
  - Explore how we are moving to a digital environment, using our buildings and developing our workforce to improve care
- This will be the start of a process to transform care in Buckinghamshire by shaping future services with the involvement, engagement and consultation of staff and local residents.

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Discussion

UPDATE ON THE TEMPORARY CLOSURE OF CHARTRIDGE WARD AT AMERSHAM HOSPITAL

FEBRUARY 2020

Ben Collins, Deputy Director of Integrated Elderly and Community Care

1. Summary

In response to the CQC imposing conditions of registration on BHT's community wards, Chartridge ward has been closed to admissions since 1 July 2019. A suite of service improvements have been introduced to ensure a high quality service can be provided with our community inpatient capacity reduced by 22 beds.

Stakeholders including primary care, Bucks Clinical Commissioning Group, Frimley Health Foundation Trust and Buckinghamshire County Council have been engaged throughout the process. Public workshops were held in October 2019 and January 2020.

This paper proposes that the current service model - with no inpatient beds in Chartridge ward and improved care in the community and enhanced therapy and geriatric consultant support to the acute site - continues. In addition, a rehabilitation service will be considered as part of an engagement process from which will take place during Quarter 1 of 2020 around plans for delivering community health and social care services across Buckinghamshire.

2. Background

Buckinghamshire Healthcare NHS Trust is on a journey to achieving an 'Outstanding' overall rating from the Care Quality Commission (CQC), and we are particularly proud that the CQC has rated us as 'Outstanding' for being caring.

However, the CQC identified the challenges of providing sustainable safe, effective care in the Trust's community inpatient wards in its 2019 report.

In response to this, on 1 July 2019 the Trust temporarily closed Chartridge ward in Amersham Hospital to concentrate staff across two community inpatient wards, rather than three, to deliver a safer and more effective model of care.

The aim is to help people avoid a hospital stay, or, if they do need to be admitted, to help them to return home as quickly as it is safe to do so, to continue their recovery in the comfort of their own homes.

Whilst we have continued to try to recruit staff to enable us to reopen Chartridge Ward, we have also been working with members of the public and other health and social care providers to develop a safe, effective and sustainable alternative model of care, should we be unsuccessful in our recruitment drive to reopen the ward. This paper describes the outcome of this work, and our current thinking about the future based on:

- What is best for patients from a clinical and patient experience point of view;
- What is best for staff;
- What is best for the system as a whole;
- What we have heard from our stakeholders; and
- How we make the best use of the resources we have available.

This has been developed within the context the NHS Long Term Plan[1] which outlines improvements to urgent community services over the next five years in the following areas:-

- Expansion of Urgent Community Response services to operate seven days a week 24/7;
- Delivery of the new national standards for Urgent Community Response (within 2 hours for urgent care and 2 days for accessing intermediate care/reablement services); and
- Partnership working with Primary Care Networks to develop new service models of Anticipatory Care to help people stay well and fully implement the clinical domains of the ageing well guidance[2] (as provided in the NHS Long Term Plan).

3. Service Improvements

The following actions have been taken since the temporary closure of Chartridge Ward to improve patient outcomes and help them to either return home as quickly as possible or to avoid a hospital admission in the first place:

- We have recruited two more therapists and three rehabilitation support workers. This is helping us to provide more comprehensive rehabilitation, including delivery of therapy at weekends. Further recruitment is in progress and shortlisting has been completed for five further physiotherapy posts in community and acute settings.
- We have increased therapy available to patients in their homes:
    - Our Rapid Response Intermediate Care (RRIC) service provides physiotherapy, occupational therapy and care within 2 hours, for up to six weeks. Patients can receive therapy up to three times daily, seven days/week. The RRIC service has had an average caseload of 196 patients at any one point in time during 2019/20.
    - Our Community Physiotherapy Service maximises patients' independence at home, for longer term patients. The RRIC service has had an average caseload of 564 patients at any one point in time during 2019/20.

  Both of these services work in close partnership with Buckinghamshire County Council's Reablement and Adult Social Care teams.
- We have an additional elderly care consultant in A&E for two hours every day to identify those patients who do not need to be admitted and to ensure the relevant support is put in place to enable them to go home.
- We are introducing seven complex care managers to community nursing. These complex care managers specialise in helping patients with multiple long-term conditions to stay in their own homes. In addition to current district nursing staff, these roles will enable us to support and look after patients who need a high level of care in the community. We have appointed to six out of the seven roles planned and these managers are currently developing their caseloads.
- We have provided an additional six hours of specialist elderly care consultant support for our elderly patients on our general surgery wards at Stoke Mandeville Hospital. As well as providing specialist geriatric support to emergency laparoscopy patients, these consultants are also part of a multi-disciplinary ward round, which has been

[1] NHS England Long Term Plan: https://www.longtermplan.nhs.uk/
[2] NHS England Long Term Plan Ageing Well: https://www.longtermplan.nhs.uk/areas-of-work/ageing-well/

shown to improve outcomes and reduce mortality. This contribution has been described as 'vital' by the surgical leads. As a direct result of this, BHT has some of the highest levels of postoperative elderly care support in the Thames Valley Region, and is a positive outlier according to the National Emergency Laparotomy Audit (NELA).

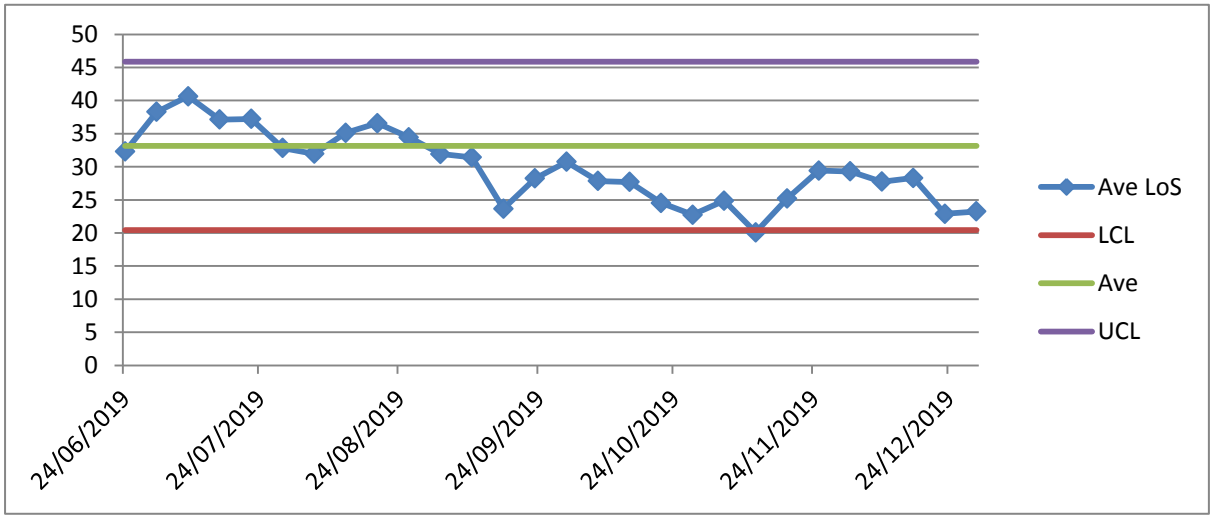
- We have established a Community Assessment and Treatment Service at Amersham two days a week. This service assesses frail, elderly patients in the community and puts in place additional support to enable them to remain independent and at home, avoiding a hospital admission.
- We have extended the hours that GPs and other health care professionals can contact a specialist geriatrician and receive immediate advice and support to help patients receive appropriate care in the community.
- We have recruited to one of the two additional physiotherapist posts to enhance the Early Supported Discharge Orthopaedic Service and are actively recruiting into the second post.
- To enhance our support for patients over the winter, we have:
    - Provided 6 beds for non-weight-bearing patients in Lakeside care home;
    - Supported Adult Social Care to provide rehabilitation beds in Fremantle care home; and
    - Opened 10 temporary rehabilitation beds in Wycombe Hospital for patients who are stepping down from acute care.

4. What The Benefits Have Been For Patients

4.1. Length of Stay

Length of stay on Waterside Ward has dropped significantly, with 8 data points[3] since 23 September being below the average. The increased number of permanent staff, including therapy provision at weekends, has supported patients to be discharged and return home sooner compared to the previous model. The average length of stay for our patients in July 2019 was 37.2 days and in December 2019 it was 26.3 days.

Chart 1. Average Length of Stay of patients on Waterside Ward, measured weekly.



[3] No data was available for the week beginning 18 November 2019.

4.2. Community Beds Waiting Lists

Charts 2 and 3 show the number of patients waiting for community beds in Buckinghamshire. Chart 2 shows the number of BHT patients waiting and Chart 3 shows the number of patients in Wexham Park Hospital waiting for community beds in Buckinghamshire.

Chart 2. Number of patients in BHT waiting for Bucks community beds.

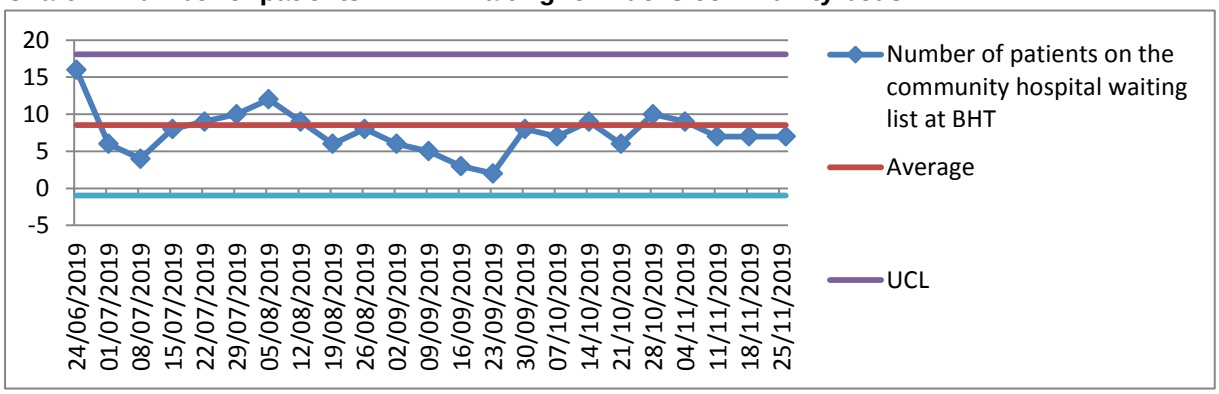
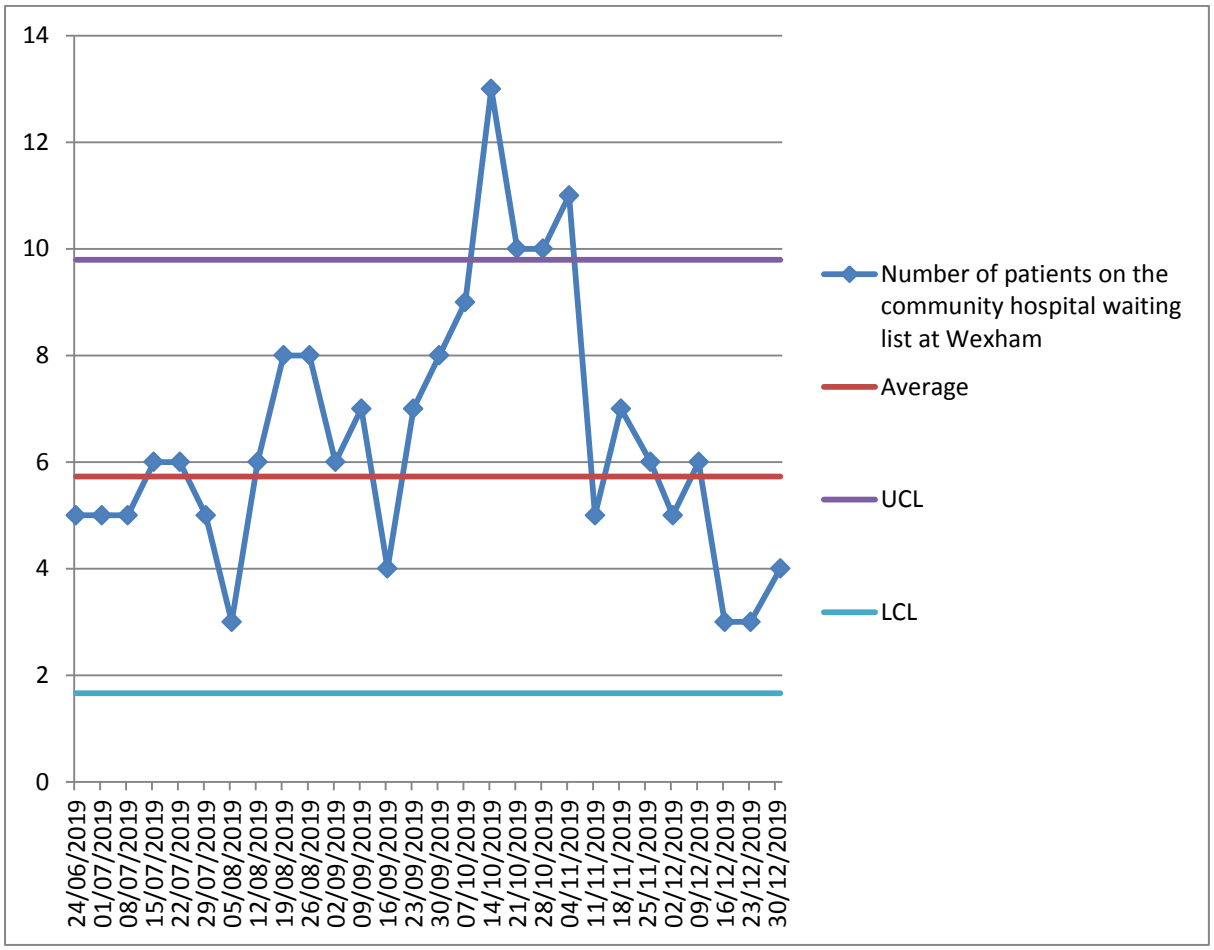


Chart 3. Number of patients in Wexham Park hospital waiting for Bucks community beds.

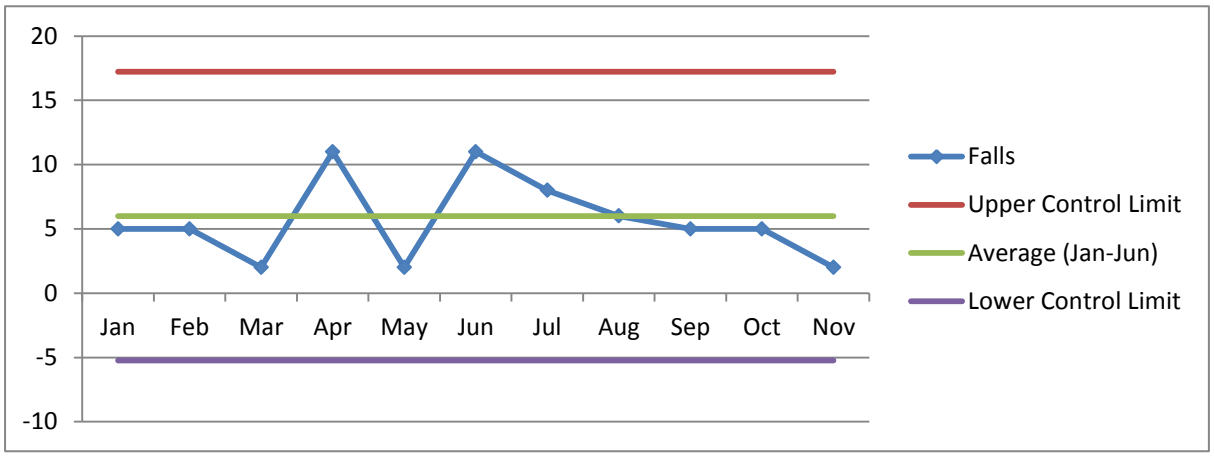


4.3. Safety

- **Pressure Ulcers.** No Grade 3 or 4 pressure Ulcers have been deemed Serious Incidents since March 2019.

- **Falls.** Chart 4 shows a downward trend in falls on Waterside ward since staff from Chartridge were redeployed there:

Chart 4. Falls on Waterside Ward.



4.4. Flow

The two community wards in Amersham – Waterside and Chartridge – had a combined capacity of 46 beds, of which 10 were allocated to Wexham Park hospital for the step down of south Bucks patients, and typically 6 beds were occupied by amputee and non-weight bearing (NWB) patients. These patients typically have a very long length of stay.

Closing Chartridge to admissions reduced the capacity by 22 beds to 24. The amputee and non-weight bearing admissions were redirected to Ward 8 (Therapy and Nursing Led Unit) in Stoke Mandeville, effectively freeing up 8 beds in Amersham.

The impact this has had on patient flow in BHT, is a reduction in step down capacity of c.11 patients/month, when comparing Sept-Dec 2019 to the same period in 2018 (Table 2).

Table 2. Patient Flow through Amersham Hospital Community Wards.

	Waterside and Chartridge, Sept-Dec 2018	Waterside, Sept-Dec 2019
Average monthly inpatient admissions	30.75	20

Furthermore, readmission rates among the group of patients who would most likely be referred to a community inpatient ward as part of their care have shown a downward trend from 17.7% in the three months prior to the temporary closure of Chartridge Ward, to 15.7% in the three months since the closure.

5. Stakeholder Engagement.

5.1. Work with Health and Social Care Partners

Our aim is to help patients to return home as quickly as it is safe to do so following an inpatient stay. A Discharge Coordinator and Social Worker attend the Daily Facilitated Meetings (DFMs) on the ward – a forum where doctors, nurses, therapists and social care staff meet to plan each patient's care and discharge arrangements. Actions are reviewed in weekly meetings along with the next steps required to move the discharge plan forward. Social workers are present at Buckingham Community Hospital ward twice a week, with one of these being the weekly discharge meeting.

Waterside is covered medically by a consultant geriatrician and GP trainees and Buckingham Community Hospital ward by GPs provided by the Swan Practice. There are good working relationships between the medical and non-medical staff. Out of hours, GP cover is provided by the 24/7 primary care services across Buckinghamshire.

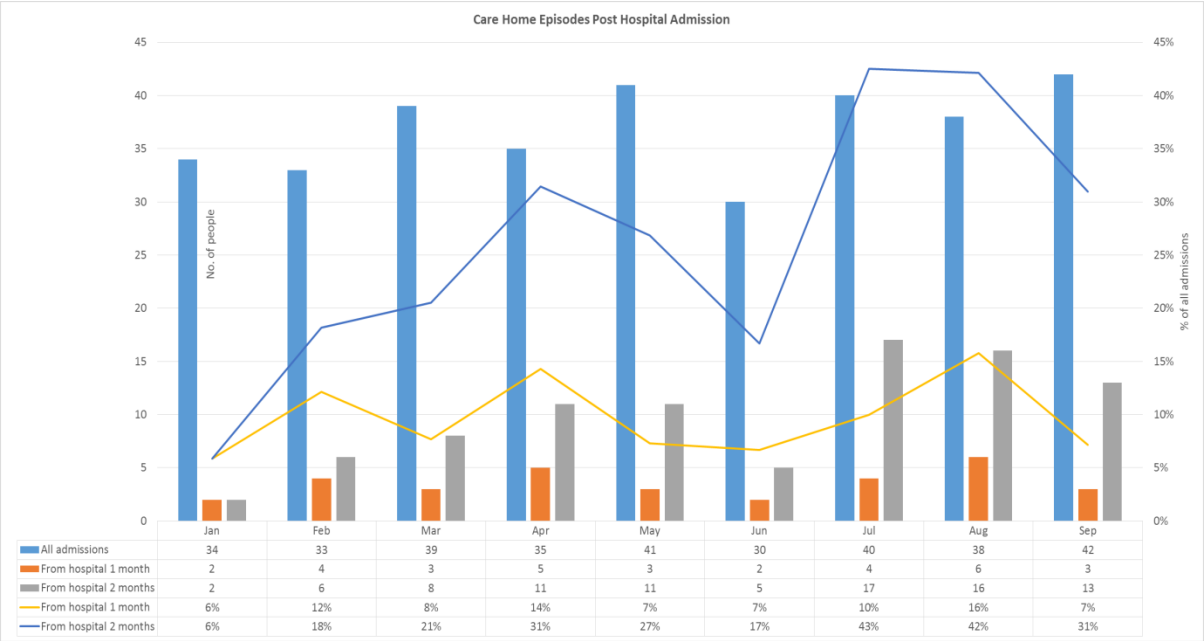
In addition to this work, Buckinghamshire Healthcare NHS Trust and Buckinghamshire County Council (BCC) are working closely together on a number of areas to improve services for our patients. These include:

- An Integrated Discharge Team, based at Stoke Mandeville Hospital, where the hospital social workers and BHT discharge team are working as one team to support patient discharges and flow through the hospital;
- An Integrated Single Point of Access (SPA) to make it easier for community health and social care services to work together. The team within the Integrated SPA will be staffed by Buckinghamshire Healthcare NHS Trust and Buckinghamshire County Council;
- Social workers are permanently based at Amersham hospital and at Buckingham community hospital ward twice a week. This is a strength-based approach with a 'home first' philosophy.

Chart 5 shows that there is no particular trend for people being admitted into long term residential or nursing placement on discharge from a hospital setting or within 30 days of their hospital episode.

However, it does show that since January 2019, there has been an increase in the number of people being admitted to long term residential or nursing care post a hospital episode; up from 5% in January to 30% in September and in some months in excess of 40%.

Chart 5. Post Hospital-Admission Care Home Episodes



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
All admissions	34	33	39	35	41	30	40	38	42
From hospital 1 month	2	4	3	5	3	2	4	6	3
From hospital 2 months	2	6	8	11	11	5	17	16	13
From hospital 1 month	6%	12%	8%	14%	7%	7%	10%	16%	7%
From hospital 2 months	6%	18%	21%	31%	27%	17%	43%	42%	31%

5.2 Public Engagement

First Public Workshop, 9 October 2019

We held a workshop attended by 33 people and a wide range of participants. Participants were asked to consider the challenges and opportunities of the following scenarios:

> **Scenario 1.** Continue to try to recruit staff to enable us to re-open Chartridge Ward, returning to the previous model of care.
> **Scenario 2.** Continue to develop the model of care, which has been put in place since the temporary closure.
> **Scenario 3.** Open some beds on Chartridge Ward for patients who are well enough to go home but are awaiting onward care or improvements to their home.

The consensus was that people should be supported at home and in the community. There was recognition that staffing challenges mean that reopening the ward at Chartridge is not an option at present, and therefore Scenario 2 - enhancing the services already under way - was the preferred option.

Additional concerns were expressed regarding the availability of acute beds for seriously ill patients at Stoke Mandeville and, with the onset of winter, how additional acute beds could be freed up/created to relieve the pressure on A&E and mitigate the perceived impact of the closure of the ward in Amersham.

Second Public Workshop, 8 January 2020

The 13 participants were presented with data and outcomes of the work to date. They felt that the Community Assessment and Treatment (CATS) service, along with the enhanced therapy being provided at Amersham hospital, and the care being given to patients at home

was helping patients get out of hospital and back to an environment they were familiar with and more comfortable in: their homes.

Amersham Hospital will continue to offer the CATS service and additional therapy services. Suggestions from this workshop, and further discussions about additional services, will continue internally and with external stakeholders.

Concerns were expressed with regards to transport within the community and ensuring patients had to ability to get to Amersham should they need to. It was suggested more work should be done with Buckinghamshire County Council and the local CCG to address this issue.

It was also suggested that the Trust continues to monitor the impact closing Chartridge ward has on the system in general. Whilst at the moment the data shows positive results in terms of reducing length of stay and maintaining waiting list for community beds, attendees wanted to ensure this continued to be monitored for a longer period of time.

5.3 What do our patients say?

A total of 23 recent or current Amersham community ward patients were interviewed in two surveys, in September and December 2019, giving a snapshot of patient experience:

September Survey

Prior to the closure

- Most patients felt that they would have benefitted from more physiotherapy.
- Patients felt that short staffing led to delays in staff responding to patients.

Since the closure

- Patients felt that the physio they were receiving was in line with their needs; some felt that a 7 day-a-week service would be better.

Generally

- Patients wanted to be at home, but felt that they needed to be in hospital due to the nature of their condition.
- Eleven out of thirteen patients either had a domestic care package in place, or had one scheduled for their discharge.

December survey

- Patients are receiving consistent physiotherapy, which is an improvement from the feedback from our September report where a number of patients who had been discharged had not felt they had received the amount of physiotherapy they needed.
- Most patients felt that Waterside was the right place for them due to the level of injury or illness they had experienced.
- The addition of an activity co-ordinator has been much appreciated by patients, and all patients are encouraged to take part in activities.

- The two areas patients felt could improve the service further were having consistent, prompt response to call bells, and more staff at night.
- Nearly all of the patients we spoke to were, or had been, able to return home with carers coming in to assist.

6. Next Steps for Chartridge Ward

Whilst we are continuing our recruitment drive for our community hospitals, there are still challenges in terms of being able to safely and sustainably staff inpatient care in Chartridge ward. However, there are still options for using the clinical space to give patients a better experience and outcomes, whilst supporting acute services. A new CATS service in the Chartridge space is currently operating for two days/week, and is seeing a steady increase in activity, helping people to avoid a hospital admission.

In addition to the CATS service, the following options are being considered to develop Amersham as a specialist rehabilitation centre:

- **A joint Community Neuro Rehab Service (CNRS)/Community Head Injury Service (CHIS) clinic:** This could also offer efficiencies by being co-located with Bucks Neuro Rehab Centre. CHIS needs a South Bucks base to improve access for patients and work more jointly with CNRS as part of overall service development.

- **Out Patient Antibiotic Treatment (OPAT) clinic:** A clinical setting where patients can receive IV antibiotics could benefit our community OPAT team by cohorting patients in Amersham, and also provide an environment to which SMH inpatients awaiting IV antibiotics could be safely discharged more quickly.

- **Explore community rehabilitation services:** We will continue to explore whether some bedded facilities can be provided at Amersham subject to the ability to recruit staff.

7. Conclusion & Recommendations

Since closing 22 beds in Amersham hospital, care closer to home has developed and the number of therapists has increased. The overall quality of care continues to improve: services are safer than before the closure and length of stay has decreased on Waterside Ward. In terms of flow, step-down admissions have decreased by only 11 admissions/month, but we are providing a better patient experience, reduced length of stay, and no increase in community bed waiting times.

The changes described here have provided a platform for wider and sustainable changes in the model of care across Buckinghamshire. The Integrated Care Partnership will be engaging partners and the population on the future shape of primary and community services during Quarter 1 of 2020.

HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

RETROSPECTIVE

FOREWORD

Cllr Mike Appleyard

"I was elected Chairman of the Health & Adult Social Care Select Committee (HASC) in June 2019 but I held the same position from 2002-2011, when health scrutiny was first established.

The Committee holds decision-makers to account for improving outcomes and services for the residents of Buckinghamshire. The Committee works cross party and for the good of all Buckinghamshire residents. It has the power to scrutinise all issues in relation to Health & Adult Social Care.

The Committee comprises of 11 County Councillors, 4 co-opted Members from the District Councils and a representative from Healthwatch Bucks. It holds around 6 formal Committee meetings a year and undertakes in-depth reviews which run alongside the meetings on topics which are agreed by the Committee. The Committee also undertakes pre-decision scrutiny on proposals for service change within the health & social care sector and responds to consultations.

Committee Members attend various stakeholder meetings and events throughout the year, including AGMs, annual report launches, open days and I was recently invited by Carers Bucks to attend the GP Carers Award ceremony."

KEY ISSUES CONSIDERED BY THE COMMITTEE OVER THE LAST 2 YEARS

- Developing Care Closer to Home
- NHS Long-Term plan
- Vascular services
- Musculoskeletal services
- Services for Adults with Learning Disabilities
- Adult Social Care transformation of services
- Temporary closure of Chartridge Ward, Amersham Hospital
- Director of Public Health annual report
- Local medicine supplies (in light of planning for Brexit)
- Mental health services
- The development of Primary Care Networks
- Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System
- Winter resilience across health and social care
- Bucks Healthcare NHS Trust performance (including responding to BHT's annual quality accounts)
- Hospital Discharge (inquiry)
- Child Obesity (inquiry)
- Support for Carers (inquiry)
- Adult residential short breaks (pre-decision scrutiny)

HOSPITAL DISCHARGE INQUIRY

This Inquiry was set-up to review the Hospital Discharge process to include performance around delayed transfers of care across the whole system. The move towards more integrated health and social care services provided an opportunity to review the current discharge process to see which areas required more focus and resource in order to create a seamless patient pathway in the future. Evidence was gathered through speaking directly to frontline health and social care professionals through focus groups and individual meetings.

Recommendations were made to:

- Co-locate the health and social care hospital discharge teams
- Standardise and computerise patient paperwork across the system.
- Improve the Patient, Carer and Family Voice in the decision-making process.
- Develop a Trusted Assessor role to speed-up the assessment process.
- Speed up the introduction of seven-day working to reduce pressure across the system.

A joint response to the recommendations was developed by the County Council, Buckinghamshire Healthcare Trust and Buckinghamshire's Clinical Commissioning Groups. It was presented to Cabinet on 24th April 2017 and all the recommendations were agreed (one was partially agreed). The progress on the recommendations was monitored by the HASC after 6 months and at 12 months. The Committee were particularly pleased to hear that the co-location of the teams had led to significant improvements.

CHILD OBESITY INQUIRY

The Government's Childhood Obesity Plan, which was published in 2016, aims to reduce England's rate of childhood obesity within the next 10 years so this inquiry was built around testing how well Buckinghamshire was tackling this issue.

During the evidence gathering it became clear that there is no simple solution to this complex issue. The recommendations focussed around enabling the Council to play an even greater role in facilitating change through strengthening partnership working leading to measurable reductions in child obesity across Bucks in the coming years. The Committee monitored the progress in implementing the recommendations made in the report at its June 2019 meeting.

Members were pleased to hear that the Health and Wellbeing Board have agreed a specific action plan to address childhood obesity issues.

SUPPORT FOR CARERS INQUIRY

This inquiry was set-up to gain a greater understanding about the current level of support for carers (from children to adults) across the system – health, social care, local communities and schools. A full day of evidence gathering took place on Tuesday 30th October 2018 and a report with recommendations was presented to Cabinet in May 2019. 7 of the 8 proposed recommendations were approved by Cabinet.

Recommendations included:
· Creating a single point of access for all carers with signposting to all relevant services;
· Developing a single assessment form to be accessed by all key organisations to reduce duplication;
· Ensuring all carers have contingency plans in place and that these are reviewed regularly as part of the carer assessment reviews;
· Further development of the GP Carers Award with the aim of increasing the number of accredited GP practices in Buckinghamshire;
· Development of a training programme for the Integrated Care System to help identify and support carers who are employees within the system.

PRE-DECISION SCRUTINY

A Task & Finish Group was set-up in January 2019 to undertake pre-decision scrutiny around the proposal for residential short breaks (respite) for older people and adults with a learning, mental, sensory or physical disability. A letter outlining the key findings of the Group was sent to the Cabinet Member for Health & Wellbeing for her consideration as part of the final decision-making process.

OTHER KEY AREAS OF WORK

- Prepared an annual statement for inclusion in the Buckinghamshire Healthcare NHS Trust's quality account
- Prepared a response to South Central Ambulance Service NHS Foundation Trust's annual accounts 2018/19 (June 2018)
- Responded to Adult Social Cares Short breaks strategy consultation (July 2018)
- Provided feedback to the Cabinet Member for Health & Wellbeing on the transformation plans for adult social care services.

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Green light for plans to tackle childhood obesity in Bucks

Published by Local Democracy Reporter Jasmine Rapson at 5:40am 30th October 2018.

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Plans to tackle childhood obesity in Buckinghamshire were given the green light this week, after it was revealed hundreds of children under the age of five in the county are overweight.

NHS plans to reduce elderly patient visits to hospital

NHS plans to reduce elderly patient visits to hospital

By
JASMINE RAPSON
Email

Published: 09:25
Wednesday 30 January 2019

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NEWS

30th January

Bucks pharmacies 'prepared' for medicine shortages amid Brexit uncertainty

By Jasmine Rapson | @Jasmine_BFP
Local Democracy Reporter

12 comments

Bucks pharmacists have assured residents there are plans in place to deal with potential medicine shortages if Britain leaves the European Union without a deal.

According to national reports, shortages in medicine supplies could be made worse by uncertainties over Brexit, causing some panicked patients to stockpile their medication.

However, at a meeting of Bucks County Council's (BCC) health and adult

PUBLIC ENGAGEMENT

Members of the public are actively encouraged to get involved in the work of the HASC and this can be done via submitting questions for the Committee meetings, responding to calls for evidence during an inquiry, undertaking a petition or by raising a specific issue with their local Member.

As an example, the HASC received a petition from a member of the public in relation to community hospitals. Below is a response to the petition which was sent to the petitioner:

The role of the HASC is to hold health organisations to public account for their decisions and help to improve health outcomes for Buckinghamshire residents. The HASC speaks up for patients needs and robustly challenges health organisations on an ongoing basis through its regular public meetings, as well as through its detailed Inquiries where a report and recommendations for improvements are made.

To this end the HASC invited representatives from Buckinghamshire Healthcare Trust to its special meeting on Tuesday 21st February 2017 where BHT's pilot proposal for developing care in the community was discussed.

The HASC has sought reassurance from Buckinghamshire Healthcare Trust that it will be kept fully briefed throughout the pilot stage and the item will be discussed at a future HASC meeting to evaluate the pilot and to be part of any engagement or consultation process should the proposal be developed further across the County. The measures around patient outcome will form part of the HASC's questioning around the evaluation of the pilot.

In terms of funding, this issue is being monitored at a higher level by the HASC through its ongoing work of scrutinising the Sustainability and Transformation Plan and the HASC will continue to ask questions around funding at its future meetings on this subject

- March 2017

ONE COUNCIL, NEW OPPORTUNITIES

The launch of Buckinghamshire Council in April 2020 provides opportunities for the Select Committee to reflect on the achievements of the Committee over the last few years and to make suggestions for future areas of work for the new authority.