Agenda

Health & Wellbeing Board Buckinghamshire

Date: Thursday 9 March 2017

Time: 2.00 pm

Venue: Large Dining Room, Judges Lodgings, Aylesbury

1.30 pm Pre-meeting Discussion

This session is for members of the Committee only.

2.00 pm Formal Meeting Begins

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Agenda Item		Time	Page No
1	**WELCOME & APOLOGIES**	**14:00**	
2	**ANNOUNCEMENTS FROM THE CHAIRMAN**		
3	**DECLARATIONS OF INTEREST**		
4	**MINUTES** To confirm the minutes of the meeting held on Thursday 15 December 2016 and the notes of the themed meeting on Thursday 12 January 2017.		**5 - 18**

To view the full pack of the notes from 12 January, including presentations, please click here.

5 PUBLIC QUESTIONS

6 JOINT HEALTH AND WELLBEING STRATEGY REFRESH 2016 – 2021 **14:10** **19 - 36**

This item will be presented by Katie McDonald, Health and Wellbeing Lead Officer, Public Health.

6A FOLLOW UP FROM HWB MENTAL HEALTH THEMED MEETING ON 12 JANUARY **37 - 48**

The Health and Wellbeing Board held a themed meeting on mental wellbeing on 12 January as part of progressing the 'promoting good mental health and wellbeing for everyone' priority included in the refresh of the Joint Health and Wellbeing Strategy refresh for 2016 – 2021.

7 BUCKINGHAMSHIRE HEALTH AND CARE SYSTEM PLANS **14:30**

7A HEALTH AND SOCIAL CARE INTEGRATION - ROAD MAP TO 2020 **49 - 54**

The 2015 spending review set out an ambitious plan for health and social care to be integrated across the country by 2020. The Health & Wellbeing Board is pivotal to the development of local integration plans.

7B PRESENTATION ON BUCKINGHAMSHIRE HEALTH AND CARE SYSTEM PLANS **55 - 78**

Presenters for this item:

Neil Dardis, Chief Executive, Buckinghamshire Healthcare Trust
Dr Graham Jackson, Clinical Chair, NHS Aylesbury Vale CCG
Lou Patten, Chief Officer, Aylesbury Vale & Chiltern CCGs
Graeme Betts, Interim Managing Director, Adult Social Care

7C	**BETTER CARE FUND 17-19 UPDATE** The Better Care Fund is a local single pooled budget, to incentivise the NHS and local government to work in partnership to integrate health and social care services. **Presenter for this item:** Jane Bowie, Director of Joint Commissioning		**79 - 88**
8	**CYP IMPROVEMENT PLAN UPDATE** Verbal update from David Johnston, Managing Director of Children's Social Care and Learning	**15:45**	
9	**BUCKINGHAMSHIRE PHYSICAL ACTIVITY STRATEGY AND ACTIVE BUCKS** In the refresh of the Joint Health and Wellbeing Strategy 2016-2021, the Health and Wellbeing Board has committed to promote the Active Bucks programme and support the update and implementation of the Buckinghamshire Physical Activity Strategy and action plan. **Presenters for this item:** Dr Jane O'Grady, Director of Public Health Tom Burton, Public Health Practitioner	**16:00**	**89 - 92**
10	**REFRESH OF THE PHARMACEUTICAL NEEDS ASSESSMENT** This report presents the proposal for refreshing the 2018 Pharmaceutical Needs Assessment for approval by the Health & Wellbeing Board. **Presenter for this item:** Dr Emily Youngman, Consultant, Public Health Medicine	**16:20**	**93 - 94**
11	**DATE OF NEXT MEETING** The next meeting is due to take place on Thursday 15 June 2017 at 10.30am.	**16:30**	

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

Members

Mr M Appleyard (Buckinghamshire County Council), Mr R Bagge (District Council Representative), Dr R Bajwa (Clinical Chair), Ms J Baker OBE (Healthwatch Bucks), Mr S Bell (Chief Executive, Oxford Health NHS), Mr G Betts, Ms I Darby (District Council Representative), Mr N Dardis (Buckinghamshire Healthcare Trust), Lin Hazell (Cabinet Member for Children's Services), Dr G Jackson (Clinical Chair), Mr D Johnston (Buckinghamshire County Council), Ms A Macpherson (District Council Representative), Mr R Majilton (Director of Sustainability and Transformation), Mr H Mordue (Aylesbury Vale District Council), Ms S Norris, Dr J O'Grady (Director of Public Health), Ms L Patten (Accountable Officer (Clinical Commissioning Group)), Dr S Roberts (Clinical Director of Mental Health), Dr J Sutton (Clinical Director of Children's Services), Mr M Tett (Buckinghamshire County Council) (C), Dr K West (Clinical Director of Integrated Care) and Ms K Wood (District Council Representative)

Health & Wellbeing Board
Buckinghamshire

Status on Health and Wellbeing Board meeting actions:

9.3.17

Date	Action	Lead officer	Update	Status
15.12.16	Miss K McDonald to add the Healthwatch Bucks Annual Report to the Forward Plan	KM	Healthwatch Bucks Forward Plan added to the HWB Forward Plan for September	Complete
15.12.16	Board Members to submit comments on the refreshed JSNA	KM	No comments received to date	Complete
15.12.16	The HWB to continue to receive regular updates on the progress of the STP, and particularly in relation to how care pathways might change and therefore any impact this could have on patient outcomes	ND, LP, GB	Update on System Planning to be provided at the March 2017 meeting	In progress
12.01.17	**All members** to report back to Katie McDonald on what they are going to do as an organisation to promote mental health and wellbeing and what they can offer both in the work place and in the way of improving communication and access to services	All members KM to co-ordinate	All member organisations have fed back following the meeting.	Complete
	Katie McDonald with public health colleagues and feedback from Health and Wellbeing Board members to take the issues raised at the meeting to draft follow up to set out priorities and actions for agreement by the Health and Wellbeing Board at the next meeting on 9 March 2017.	KM	Table included in 9 March papers	Complete
	For Action: All members to feedback to Katie McDonald on proposals for themed meetings for 2017/2018	KM to co-ordinate	For member discussion at the pre-meet agenda planning session on 9 March	In progress

Minutes

Health & Wellbeing Board Buckinghamshire

MINUTES OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY 15 DECEMBER 2016, IN MEZZANINE ROOM 2, COUNTY HALL, AYLESBURY, COMMENCING AT 12.30 PM AND CONCLUDING AT 3.13 PM.

MEMBERS PRESENT

Mr R Bagge (District Council Representative), Ms J Baker OBE (Healthwatch Bucks), Mr T Boyd (Strategic Director for Adults and Family Wellbeing), Ms I Darby (District Council Representative), Mr N Dardis (Buckinghamshire Healthcare Trust), Lin Hazell (Cabinet Member for Children's Services), Dr G Jackson (Clinical Chair), Mr D Johnston (Buckinghamshire County Council), Dr J O'Grady (Director of Public Health), Ms L Patten (Accountable Officer (Clinical Commissioning Group)), Dr S Roberts (Clinical Director of Mental Health) and Mr M Tett (Buckinghamshire County Council) (Chairman)

OTHERS PRESENT

Ms S Butt, Ms R Cairns, Ms R Carley, Ms K McDonald, Ms G Shurrock, Ms K Taylor and Mrs E Wheaton

1 WELCOME & APOLOGIES

Apologies were received from Mr M Appleyard, Mrs A Macpherson, Dr J Sutton, Dr K West, Mr S Bell and Mrs K Wood.

2 DECLARATIONS OF INTEREST

There were no declarations of interest.

3 UPDATE ON SYSTEM PLANNING

Ms L Patten, Chief Operating Officer, Aylesbury Vale CCG and Chiltern CCG, Mr N Dardis, Chief Executive, Buckinghamshire Healthcare Trust and Dr G Jackson, Clinical Chair, took the Board Members through the presentation and the following main points were made:-

- A detailed presentation had been given to the Health & Adult Social Care Select Committee on system planning.
- Seven locality engagement events had taken place across the county during November and early December.
- Main challenges include an ageing population, a growing population, new demands which cost the NHS at least an extra £10bn a year nationally and evolving healthcare needs, such as the increase in obesity and diabetes.
- If nothing was done to meet these challenges, costs would exceed funding by about £107million over the next four years across the Buckinghamshire health system.
- The CCGs operational plan and Buckinghamshire Healthcare Trust's plans were aligned to the overall BOBW Sustainability and Transformation Plan (Buckinghamshire, Oxfordshire and Berkshire West STP).
- The STPs would provide 'umbrella' plans for change and provide an opportunity to work at scale across a larger population. The STP would also provide the mechanism for

sharing innovation and collectively improving health, care and finance for the wider population. The organisations involved would retain their own accountability whilst also working to a shared, agreed STP plan.

- The majority of the STP work would be delivered locally – 70% of the efficiencies would come from the local health and care plans and 30% from across the larger Buckinghamshire, Oxfordshire and Berkshire West footprint.
- There would be a focus on improving patient outcomes and experience and a shift in spending on bed-based care into prevention and care at home; integrating health and social care service to avoid unnecessary steps in pathways to reduce waste and duplication; deliver cost and productivity improvements; deliver urgent and emergency care services in the right place at the right time and deploy technology to enable rapid access to advice, care and support.
- Community Hubs and Locality Services were currently being developed where each locality would integrate primary care and community based services to meet the health needs of the local population – some services would be in a building whilst others may be virtual.
- The Hubs would bring together health, care and the voluntary sector, to enable more efficient access to Hospital based specialist advice.
- There were no current plans to consult in Buckinghamshire as there were no significant planned changes to services. There would be more public engagement to provide more clarity around the workstreams outlined in the STP and how these workstreams would work locally.
- It was acknowledged that influencing behavioural change was incredibly difficult but the importance of consistent messaging across the BOBW STP footprint would be key to supporting any change.

Ms Patten took Board Members through the CCG Operational Plan, including Commissioning Intentions for 2017-2019 and made the following main points:-

- The intention was to move towards multi-year, placed planning and delivery. For the Buckinghamshire CCGs, it would mean moving from two x one-year plans to one x two-year plan.
- The key themes within the Operational Plan included delivery of transformation and new models of care, develop a Collaborative Provider model of local, primary, mental health and secondary care, commission the iMSK service (integrated Musculoskeletal Service) and explore a new models of care delivery for the Diabetes pathway. There would also be a focus on linking up the existing IT systems so that EMIS Clincial Service system becomes the software of choice for all primary and community services by April 2018.
- Nine national key areas which the CCGs must continue to deliver were outlined – STPs, Finances, Primary Care, Urgent & Emergency Care, Referral to Treatment & Elective, Cancer, Mental Health, Learning Disabilities and Improving Quality in Organisations.

RESOLVED:

Board Members noted the report and commented on the presentation.

4 HEALTH & WELLBEING BOARD MEMBER COMMISSIONING INTENTIONS AND UPDATE ON THE REFRESH OF THE JOINT HEALTH & WELLBEING STRATEGY 2016-21

The Board noted that the Joint Health & Wellbeing Strategy would be discussed at the March 2017 Health & Wellbeing Board meeting.

The Chairman welcomed Ms R Carley (interim Head of Strategic Commissioning, Adults), Ms S Butt (Head of Strategic Commissioning, Children's) and Ms K Taylor (Lead Commissioner) who took Board Members through the commissioning intentions for both Adult Social Care and Children's Social Care and Learning. Dr J O'Grady took Members through the Public Health priorities.

During the presentation, the following main points were made:-

- Key themes across all services were around early help, prevention and intervention and supporting families and communities to be more resilient to avoid additional pressures on the system.
- Health and Social Care Integration – both to meet the formal requirement for integrating services by 2020 but also holistically to provide a better service for our residents.
- Improving the patient experience and services received at the key transition points.
- The Service areas continue to work very closely with health partners.
- Children's commissioning already spanned social care, education and health and the integration with colleagues in adult social care provided more opportunity to take a stronger life-course approach to commissioning.
- In response to a question around mental health services, Ms Butt explained that CAMHS (Children and Adults Mental Health Services) was jointly commissioned in 2015. NHS England had invested significantly into CAMHS for expanding services and had targeted people with eating disorders so that a quicker pathway could be devised. It was acknowledged that more work needed to be done around children's mental health. There was a link CAMHS worker to each school so that issues could be highlighted at an early stage. Parity of esteem was recognised as a huge agenda for CAMHS.
- In Adults, a new operating framework with a focus on prevention and self-care had been developed.
- The investment in prevention was significantly less than in treatment. The challenge was around getting people and communities to take on more responsibility and to do more for themselves.
- Public Health priorities were reflected in the HWB Strategy. A number of services had been recommissioned in 2015, including sexual health services and the healthy living centre. In the next 18 months, the drug and alcohol services for adults, and smoking cessation would be recommissioned. There was a move towards more integrated services and providing services digitally.

RESOLVED:

Board Members noted the commissioning intentions for Adult Social Care and Children's Social Care and Learning and noted the Public Health priorities for 2016-21.

5 UPDATE ON BETTER CARE FUND 2017-19 PLAN AND PERFORMANCE

The Chairman welcomed Ms R Cairns, Programme Manager for Integrated Care (Joint Commissioning). During the presentation, the following main points were made:-

- NHS England was due to release shortly the funding allocations, planning guidance and template.
- The Better Care Fund (BCF) created a local, single pooled budget via a S75 agreement to ensure a transformation in integrated health and social care.
- A first draft plan needed to be submitted to NHS England in mid-January and the final plan in March. The plan needed to align with the STP and would form an essential part of the integration agenda.

- The focus and scope of the plan for 2017-19 would include progress towards full integration of health and social care by 2020, a move towards a pooled budget and to continue to strengthen relationships and partnership working.
- The BCF was aligned to BOBW STP and Buckinghamshire's Health & Wellbeing Strategy.
- The performance dashboard had been updated for Quarter 2 and showed that Buckinghamshire was performing well in terms of non-elective admissions and permanent admissions to care homes. Performance in relation to delayed transfers of care was still over target but was improving. This activity was being overseen by the A&E Delivery Board and delays managed through daily updates.

RESOLVED:

Board Members noted the content of the presentation, timings for the 2017-19 BCF plan and the performance against the metrics.

6 CHILDREN AND YOUNG PEOPLE UPDATE AND SEND STRATEGY

The Chairman welcomed Mr D Johnston, Managing Director for Children's Social Care and Learning and Ms G Shurrock, Head of SEN.

During Mr Johnston's verbal update, the following main points were made:-

- Within Children's Social Care, the Service had received a number of monitoring visits by Ofsted who looked at the Council's services to children needing help and protection. Positive feedback was received. The letter was posted on Ofsted's website
- There was a further visit by Ofsted to review the Council's looked after children and children who had recently come into care – the feedback included comment that children were well known by their social worker and well monitored. The Council is awaiting the final letter which would be published on Ofsted's website on 10th January 2017.
- There were still pressures on the system but the Service was reported to be moving in the right direction.
- In response to a question about whether the Service was where it wanted to be, Mr Johnston explained that a lot of work had been undertaken to integrate services and increase partnership working and there had been a concerted effort to convert some agency staff to Bucks County Council staff. There was more work to be done in terms of recruiting more foster carers.

Buckinghamshire Safeguarding Children Board Annual Report

Mr Johnston referred Members to the Annual report. The Safeguarding Board was reported as being in a strong position and had been reinstated with a refreshed membership following the Ofsted inspection.

RESOLVED:

Board Members noted the content of the Buckinghamshire Safeguarding Children Board Annual Report 2015-16 and accepted the priorities for 2016-17.

Update on Children with Special Educational Needs and Disabilities Review and SEND Strategy for 2017-2020

The Chairman welcomed Ms G Shurrock, Head of SEN to the meeting. The following main points were made during the presentation:-

- The Dedicated Schools Grant Schools Block had successively overspent on Higher Needs budget.
- SEN specialist fieldwork staff were prevented from working with schools at an early stage due to formal assessment pressures or conflicting priorities.
- The SEN administration was “at capacity” and, at times, “over capacity”.
- Parents and carers were losing confidence in mainstream education and pressing for special school places. Exclusions and transfers to special school were increasing.
- Higher numbers of EHC (Educational Healthcare) Plans and increasing EHC assessments.
- Ongoing and increasing spend – over budget.
- A number of issues had been identified which need resolving including threshold management, placement trends, operational integration of specialist SEND services and teams, confidence, competence and capacity within mainstream schools and long standing cultures and beliefs in schools and professional staff, parents and carers.
- Seven strategic priorities had been identified to help resolve the issues.
- The SEND Strategy was due to be finalised and published by January 2017.
- A programme manager/co-ordinator had been recruited to start in March 2017.

RESOLVED:

Board Members noted the priorities arising from the SEND review and, in particular, the need to strengthen leadership, reduce dependencies on special school provision and build increased capacity in mainstream schools in Buckinghamshire.

Board Members noted the significant transformation challenges implicit in the action arising from the Review, including achieving a change of direction for some key performance indicators.

7 MINUTES AND ACTIONS

The minutes of the meeting held on Thursday 15 September 2016 were agreed as a correct record.

The Chairman referred Members to the list of actions included in the agenda pack. He expressed his disappointment at not having received a response from David Smith, the local Senior Responsible Officer for the Sustainability and Transformation Plan, to an invitation to attend a Health & Wellbeing meeting.

The Chairman reminded Members that there was still time to submit their comments on the refreshed Joint Health and Wellbeing Strategy (JHWBS).

ACTION:

- **Ms K Mcdonald to add the Healthwatch Bucks Annual report to the Forward Plan.**
- **Board Members to submit comments on the refreshed JHWBS.**

8 PUBLIC QUESTIONS

There were no public questions received within the timeframe.

9 FORWARD PLAN

Board Members were asked to note the Forward Plan.

The Chairman reiterated the importance of receiving regular updates on the progress of the STP, particularly in relation to how care pathways might change and therefore any impact this could have on patient outcomes.

10 DATE OF NEXT MEETING

The next meeting is due to take place on Thursday 12 January at from 10-12.30 (pre-meet at 9.30am). The meeting will take place in Room1, Exhibition Suite, Old County Hall, Aylesbury.

CHAIRMAN

Minutes

Health & Wellbeing Board Buckinghamshire

MINUTES OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY 12 JANUARY 2017, IN ROOM 1, EXHIBITION SUITE, COMMENCING AT 10.00 AM AND CONCLUDING AT 12.40 PM.

MEMBERS PRESENT

Mr M Appleyard (Buckinghamshire County Council), Mr R Bagge (District Council Representative), Dr R Bajwa (Clinical Chair), Ms I Darby (District Council Representative), Lin Hazell (Cabinet Member for Children's Services), Ms A Macpherson (District Council Representative), Mr R Majilton (Director of Sustainability and Transformation), Dr J O'Grady (Director of Public Health), Ms L Patten (Accountable Officer (Clinical Commissioning Group)), Dr S Roberts (Clinical Director of Mental Health), Mr M Tett (Buckinghamshire County Council) (Chairman), Dr K West (Clinical Director of Integrated Care) and Ms K Wood (District Council Representative)

OTHERS PRESENT

Mr D Colchester (Thames Valley Police), Mr D Hardisty (Oxford Health NHS Foundation Trust), Ms C Hart (Bucks County Council), Ms K Hart (Buckinghamshire Healthcare Trust), Ms R Hitch (Public Health Principal), Ms T Jervis (Healthwatch Bucks), Ms A McCubbin (Mind), Ms K McDonald (Bucks County Council), Ms Z Moorhouse (Oxford Health), Mr G Price (Survivors of Bereavement by Suicide), Ms S Robinson (Oxford Health Foundation Trust), Mr R Stringer (Hector's House), Mrs E Wheaton (Bucks County Council) and Mr D Williams (Buckinghamshire Healthcare NHS Trust)

1 REFRESHMENTS AND WELCOME

2 INTRODUCTION FROM THE CHAIR

The Chairman, Martin Tett welcomed everybody to the first themed meeting looking at the priorities of the refreshed Joint Health and Wellbeing Strategy and emphasised the importance of the mental health and wellbeing agenda at both a local and national level.

The Chairman provided context to the meeting by highlighting the Mental Health Five Year Forward View published in 2016 which had put forward a consensus on what needs to change and more recently the Prime Minister, Theresa May, had made her first speech in 2017 outlining plans on how the government was going to tackle mental illness and transform attitudes to mental health problems. It was also announced that the government would be publishing a green paper on children and young people's mental health and wellbeing later in the year. The Chairman confirmed that the Health and Wellbeing Board would focus on Children and Young People's mental health at a future meeting in 2017 to coincide with the publication of the green paper which is why the meeting today was largely focused on adults.

Given the high profile of NHS pressures in the national media, the Chairman invited, David Williams of Buckinghamshire Healthcare Trust (BHT) to provide the board members with a short update on the situation at BHT before the themed meeting started.

David Williams said that the Trust were doing all they could to make sure all patients received care in the right place at the right time but there were clear pressures over the winter months.

On average, throughout the year 95% of patients at BHT are seen within a 4 hour waiting time but during winter months this was around 86%. Nationally the figure is 80% (BHT is operating comparatively at a level of 25 out of 150 Trusts nationally). Work is on-going with partners to speed up delayed transfers of care to free up available beds on wards and this issue was monitored on a daily basis.

3 INTRODUCTION FROM THE DIRECTOR OF PUBLIC HEALTH

Summary:

- Mental health is a Joint health and Wellbeing Strategy priority
- The foundations for good mental health and wellbeing happen in the earliest years
- People from all walks of life are affected but risks are higher for those living in poorer social circumstances, experiencing stressful or traumatic events marginalised groups and those having other illnesses
- Largest single cause of disability in UK costing £105bn and set to rise
- Substance and alcohol misuse – strong determinants of poor mental health
- Best buys for supporting mental health include supporting parents, early years, workplace-based programmes, supporting changes in lifestyle behaviours as well as improvements to the built environment and public spaces

4 PROMOTING GOOD MENTAL HEALTH

Dr Sian Roberts, Clinical Director Mental Health, Learning Disabilities and Dementia (Chiltern and Aylesbury Vale Clinical Commissioning Groups) took Board Members through her presentation.

Summary

- Mental Health is everybody's business and needs a partnership approach
- £40million spend on mental health in Bucks
- 75% of people with mental ill health don't present to a health organisation
- 4000 people in Bucks going through Improving Access to Psychological Therapies Programme (IAPT) with a 50% recovery rate = 15% of the estimated 1 in 4 people in Bucks deemed to have mental health issues. National target is 25% by 2020/21.
- Year on year more adults in Bucks recovering from depression & anxiety with pathways that treats the 'whole person' – body and mind
- The presentation covered the CCG Mental Health Plans, including improving Urgent Mental Health Care, Expanding and increasing access to IAPT services and improving the transitions from CAMHS to Adult Mental Health Services.

Discussion points:

- Support from Health and Wellbeing Board members for a holistic approach and taking forward the NHS five year forward view ambition for parity of esteem
- Recognition that the pathways and number of services are complex and work to be carried out on information provided to the public to increase accessibility and awareness of the services and resources available
- Consensus that the Health and Wellbeing Board should be leading on promoting common messages
- **To note**: launch of Buckinghamshire Recovery College on Friday 27 January .

  A Directory of Services will soon to be available in Buckinghamshire

5 WORK PLACE HEALTH

Karon Hart, Healthier Lifestyles and Staff Wellbeing Services Manager, took Board Members through her presentation. Presentation attached.

Summary:

- Persistently high levels of sickness absence at cost to both individuals and the organisation led to a change of interventions to promote staff health and wellbeing
- Staff are empowered to look after their own health and wellbeing which in turn benefits patient care
- The BHT resilience programme includes lots of group work, increasing the understanding of stress and building resilience, work/life balance and coping strategies. Managers had previously been trained in 'difficult discussions' now trained in 'essential discussions' and wellbeing is a core part of the appraisal process
- Managers are enabled to deal effectively with staff wellbeing and sickness absence through robust case management
- Strong evidence that wellbeing can impact positively on all aspects of business functioning

Discussion points

- Members of the Health and Wellbeing Board were keen to understand what their own organisations were doing to promote mental health and wellbeing in the work place and committed to sharing good practice.
- Board members discussed the role of mental health champions and would like further information on this.
- It was also raised that small/medium sized enterprises and self-employed businesses should be included and suggested that this could be explored through Bucks Business First.

6 SUICIDE PREVENTION

Becky Hitch, Public Health Principal, took Board Members through her presentation. Presentation is attached.

Summary:

- Suicide rates are rising. It is the biggest killer of men under 49 and also the leading cause of death among new mothers.
- There are between 30-38 suicides in Buckinghamshire every year
- Around 1 in 3 people who die by suicide are known to mental health services
- 34% of those who had taken their own life in Buckinghamshire in 2013/14 had consulted a GP for mental health problems in the last 12 months.
- Recognition that more needs to be done to build on partnership working already taking place across Thames Valley.
- Thames Valley Police have a real time suicide surveillance system and a Suicide and Intervention Network led by Oxford Healtcare NHS Foundation Trust.
- The Buckinghamshire Suicide Prevention Group are currently refreshing the county wide suicide prevention strategy and have made a number of recommendations shared in the slide pack which are aimed at specific vulnerable groups as well as calling for a stronger partnership approach to reduce stigma and shared messages, including promotion of the Headsup website http://thisisheadsup.org/.

Discussion points:

- The Health and Wellbeing Board listened to the experiences of Robert Stringer at Hector's House and Geoff Price at Survivors of Bereavement by Suicide who had both personally been affected by suicide and were carrying out important work to improve public awareness and provide support.
- There was a commitment from the Health and Wellbeing Board to do more on suicide prevention and positive support for emerging national guidelines which are yet to be formalised including; Mandatory support to those bereaved by suicide, Training for frontline staff and Funding to cover GPs to attend training.
- Board members commented that there was lots of information but not joined up messaging or clear pathways and this was an area to be strengthened across the partnership.

7 ROUNDTABLE DISCUSSION

Overall summary of the themed meeting:

- A suggestion that as lead commissioners there should be a set of guidelines for mental health and wellbeing in a central repository and this should be carried out in a way that uses existing resources more effectively.
- There was appetite for joined up positive mental health campaigns across the county
- Commitment from members to make sure mental health and wellbeing information is available on their organisation websites (e.g. promotion of the Heads up website)
- Commitment to improve mental health and wellbeing in the work place, share good practice and report back on what each organisation was doing and planning to do
- It was suggested that the Board needed a better understanding of the role of mental health champions and how they could work.
- It was suggested that all members on the Health and Wellbeing Board report back on what they are going to do as an organisation to promote mental health and what they can offer
- To note that Healthwatch are due to publish their report on peer support in mental health in partnership with Mind and will share this with Board members.

1. **For Action: All members** to report back to Katie McDonald on what they are going to do as an organisation to promote mental health and wellbeing and what they can offer both in the work place and in the way of improving communication and access to services

2. **For Action:** Katie McDonald with public health colleagues and feedback from Health and Wellbeing Board members to take the issues raised at the meeting to draft a short report as follow up to set out priorities and actions for agreement by the Health and Wellbeing Board at the next meeting on 9 March 2017.

3. **For Action: All members** to feedback to Katie McDonald on proposals for themed meetings for 2017/2018

A number of websites and resources were mentioned throughout the meeting and these can be found here:

http://www.healthwatchbucks.co.uk/service-guide/mentalhealth/
https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
http://www.bucksmind.org.uk/
http://thisisheadsup.org/
http://www.hectorshouse.org.uk/
http://uk-sobs.org.uk/

CHAIRMAN

Buckinghamshire

Joint Health and Wellbeing Strategy

2016-2021

Our vision: To create the best conditions in Buckinghamshire for people to live healthy, happy and fulfilling lives and achieve their full potential

We are pleased to present a refreshed Joint Health and Wellbeing Strategy for Buckinghamshire.

The Health and Wellbeing Board is renewing the strategy at a time when the health and care system in Buckinghamshire is operating under significant pressures, combined with increased need and demand for local services.

Buckinghamshire residents benefit from good health and access to high quality health and care services relative to the rest of England. Although many people do enjoy good health, this is not the experience of all; the Joint Health and Wellbeing Strategy aims to address this.

We continue to follow the same approach and priorities based around the stages of life as set out in our first strategy, but seek to widen our impact further through a new focus on place and greater emphasis on mental health and reducing health inequalities.

As representatives of Buckinghamshire's health and care services, our Health and Wellbeing Board members have pledged to champion the aims set out in this strategy. We hope that by working closely as a partnership we can make a real difference to improve the health and wellbeing of Buckinghamshire residents. We are also committed to ensuring that residents, patients and key organisations are all involved in helping to achieve the aims of the strategy over the next five years.

Martin Tett

Buckinghamshire County Council Leader

Chair of the Health & Wellbeing Board

Graham Jackson

Clinical Chair of Aylesbury Vale Clinical Commissioning Group

Vice Chair of the Health & Wellbeing Board

What does the strategy do?

This strategy describes our vision, aims and priorities for improving health and wellbeing in Buckinghamshire over the next five years. It supports the ambitions set out by local partners implementing the local plans for the NHS Five Year Forward View and will align with the Buckinghamshire chapter of the Bucks, Oxfordshire and Berkshire West Sustainability and Transformation Plan. It is set to the same timeframe, to coordinate the rebalancing of the health and social care spend and to increase support for prevention and early intervention initiatives, enabling all Buckinghamshire residents to live, age and stay well.

The main evidence base for the strategy is the Joint Strategic Needs Assessment (JSNA), which considers the current and future health, care and wellbeing needs of the local community. The Health and Wellbeing Board started work on refreshing the JSNA in the summer of 2015, starting with a discussion event with key stakeholders. The JSNA has now been set up as a continuous process supported by a multi-agency development group so that it provides an up to date picture to inform commissioners and influence priorities for the use of resources across the county. The Health and Wellbeing Board will continue to draw on the JSNA to prioritise its work programme.

Who are we? The Buckinghamshire Health & Wellbeing Board

Buckinghamshire's Health and Wellbeing Board brings together local councillors, local GPs, senior managers in the local authority and NHS, and a representative of local people through Healthwatch Buckinghamshire. It was established in 2013 to promote integrated working between commissioners of health services, public health and social care services, for the purpose of advancing the health and wellbeing of the people in its area.

Delivering the Joint Health and Wellbeing Strategy

The 2016 – 2021 strategy aims to create the best conditions in Buckinghamshire for people to live healthy, happy and fulfilling lives and achieve their full potential. Our vision is to improve outcomes for the whole population as well as having a greater impact on improving the health and wellbeing of those people in Buckinghamshire who have poorer health and wellbeing.

The strategy aims to make an impact on the five key priority areas set out on this page.

The following pages show each of the priority aims and areas of work partners are committed to over the five years. These are also reflected in local authority and NHS plans. The Health and Wellbeing Board has selected the areas that it agrees will make the biggest difference for residents.

OUR KEY PRIORITIES

1. Give every child the best start in life
2. Keep people healthier for longer and reduce the impact of long term conditions
3. Promote good mental health and wellbeing for everyone
4. Protect residents from harm
5. Support communities to enable people to achieve their potential and ensure Buckinghamshire is a great place to live

1: Give every child the best start in life

Why is this a priority?

To get the best start in life we know that a baby's mother needs to be healthy before and during pregnancy and childbirth. What happens during the early years, starting in the womb, has lifelong effects on many aspects of a child's future health and wellbeing – from obesity, heart disease and mental health, to educational achievement and economic success.

As children enter school, the school environment and their peers become an increasingly important influence. Adolescence is also an important time of development; the brain develops rapidly during early adolescence, particularly those areas that deal with social relationships, taking risks and controlling feelings and emotions. At this time adolescents are susceptible to peer influence and risk taking which may have immediate and harmful consequences.

The focus for 2016 – 2021

During maternity, we will improve the health and wellbeing of mothers and their babies by:

- Supporting the adoption of healthy lifestyles for the whole family.
- Ensuring good support for maternal and paternal mental health.
- Early detection and support for people experiencing domestic violence.
- Ensuring access to high quality parenting advice and support.
- Delivering targeted campaigns to raise awareness about the importance of antenatal care to all women and offer culturally sensitive information, advice and support to women from specific ethnic groups according to need.

During the early years, we will support good health and development for all children in the early years by:

- Offering high quality early years parenting programmes and advice.
- Commissioning a high quality healthy child programme.
- Commissioning sufficient high quality accessible early years and childcare places.
- Ensuring all parents have the advice they need to keep their children healthy and safe from harm.

Through the school years, we will support the physical, emotional and social wellbeing of children and young people by:

- Promoting a whole school approach to health and wellbeing.
- Ensuring emotional resilience of young people is supported and developed.
- Increasing the number of children and young people with a healthy weight by ensuring delivery of the national child weight measurement programme and actions to promote healthy eating.

- Increasing the number of young people who are physically active through implementation of Active Bucks and the Bucks physical activity strategy and action plan.
- Helping to reduce alcohol and substance misuse in younger people through the provision of good quality information and guidance to schools and wider action as part of the Buckinghamshire substance misuse strategy.

We will improve the experience of services for all residents including key transitions through the life course by:

- Working closely with Children's Social Care and Learning and engaging early with services users, carers, families and providers to inform planning and commissioning, and to ensure the timely sharing of data and intelligence.
- Supporting the delivery of the Special Educational Needs and Disabilities Strategy so that the transition from childhood to adolescence and through to adulthood is a good experience for every child and young person.
- Supporting the delivery of the new joint Carers Strategy by identifying and supporting carers, especially those under the age of 16 and those over 75, and jointly reviewing the carers' pathway to ensure the provision of timely, accurate and good quality information to carers and professionals.

2: Keep people healthier for longer and reduce the impact of long term conditions

Why is this a priority?

On average people in Buckinghamshire are healthier than the national average but too many are still suffering from avoidable diseases such as heart disease, cancer and diabetes. The risk of developing these conditions can be reduced by adopting a healthy lifestyle. For the many people who already have a long term condition we want to make it easier for them to look after their health and stay as well as possible. Smoking remains one of the biggest preventable causes of ill-health and early death with an estimated 560 smoking related deaths per year in Buckinghamshire.

Not everyone in Buckinghamshire enjoys the same good health; people living in more deprived areas tend to have poorer health at all stages of life- from birth to old age. Health also

differs between different ethnic groups, and people with mental health problems often also experience poorer physical health.

The focus for 2016 – 2021

We will help people stay healthier for longer, and prevent the development of long term conditions by increasing levels of physical activity and healthy eating, reducing smoking and substance misuse and making it easier to make healthier choices. We will provide advice and support to people with long term conditions to help them live well.

We will do this by:

- Continuing to implement and promote the Active Bucks programme and updating the Buckinghamshire Physical Activity Strategy and action plan.
- Implementing the Buckinghamshire Healthy Eating Strategy.
- Continuing multi-agency action to prevent the uptake of smoking and to support smokers who want to quit.
- Implementing the Buckinghamshire Substance Misuse Strategy.
- Delivering NHS Health Checks to identify people at increased risk of long term conditions and offering support to reduce that risk.
- Integrating the promotion of healthy lifestyles as part of care for people with long term conditions.
- Creating health, care and wellbeing pathways and facilities that actively promote healthy choices and behaviours.
- Ensuring seamless care through further integration of health and social care services centred around the person in need with learning disability, and by regularly reviewing our services.
- Improving outcomes for everyone, particularly those with poorer health such as those living in deprived areas and those from certain ethnic groups, through a range of measures including prevention

and management of cardiovascular disease and by understanding what drives high hospitalisation rates for conditions which are usually managed in the community and through self-care.

- Carrying out targeted interventions to tackle inequalities in the uptake of lifestyle services in the most deprived parts of Buckinghamshire.

We will seek to delay or prevent the development of long term conditions in older people, including dementia by helping people to live healthily by:

- Supporting the care of frail older people by developing multi-speciality provider teams based in community hubs and by redesigning community hospital care and reducing the need for acute hospitalisation.
- Increasing independence, mobility and years of active life for those aged 75+ using digital aids, equipment and adaptations and making tools for self-management available and easily accessible.
- Seeking to identify and diagnose dementia at an early stage and supporting people, their families, carers and communities to help them manage their condition.
- Delivering preventative services in the community, including floating support, and helping older people to stay in touch with family and friends through the use of new technologies such as Face Time and Skype and other appropriate social media.

3: Promote good mental health and wellbeing for everyone

Why is this a priority?

Having good mental health is fundamental to our physical health and overall wellbeing and pivotal to relationships, successful employment and realising our full potential. Poor mental health is common; one in four people in the UK will experience poor mental health in the course of a year.

Half of all mental health problems start by the age of 14, rising to 75 per cent by age 24. Mental health and wellbeing support for children and families is key, including early support for women during pregnancy and the first few months after birth, improved links with schools and better experiences for people as they move between children's and adult services.

The focus for 2016 – 2021

We will seek to promote good mental health and wellbeing by:

- Improving maternal mental health by building effective screening for mental health issues in pregnancy and maternity pathways and ensuring rapid access to effective intervention for all women who require it.
- Improving infant, children and young people's mental health and emotional wellbeing through targeted support and by ensuring access to Child and Adolescent Mental Health Services (CAMHS) and early intervention services.
- Promoting adult wellbeing and resilience in all partner workplaces as part of wider workplace health initiatives
- Promoting good mental health and emotional wellbeing by working with partners to identify and work with groups who are vulnerable to poor mental health.
- Working with partners to improve the physical health of people with mental illness and/or learning disability.
- Reviewing existing services for people with mental health and substance misuse problems to improve their outcomes.
- Implementing plans to reduce the risk of suicide and minimise self-harm.

4: Protect residents from harm

Why is this a priority?

Protecting our residents from harm and ensuring all residents are safe is everybody's business. The Buckinghamshire Safeguarding Adults Board and the Buckinghamshire Safeguarding Children Board are committed to ensuring adults, children and young people feel safe and are protected from harm. It is a priority for the Health and Wellbeing Board to ensure consideration is given to safeguarding for both children and adults in everything we do.

The focus for 2016-2012

The Health and Wellbeing Board's focus on protecting residents from harm will be informed by the joint protocol with the Adults and Children's Safeguarding Boards and the Safer and Stronger Bucks Partnership Board, including joint work on common areas of interest. Based on this, we will seek to protect residents from harm by:

- Reducing child maltreatment by offering both universal and targeted services to address the underlying factors associated with child maltreatment and responding rapidly to address problems early.
- Supporting the implementation of the Buckinghamshire's Children's Strategy and Child Safeguarding Board priorities
- Preventing Child Sexual Exploitation (CSE) by protecting those at risk and ensuring an appropriate multi-agency response through the delivery of the CSE Strategy and action plan.
- Keeping strategic oversight of the Buckinghamshire Female Genital Mutilation Strategy.
- Ensuring the robust safeguarding of adults through effective joint working with the Buckinghamshire Safeguarding Adult Board.
- Improving joint working between agencies supporting people experiencing domestic violence and those experiencing mental health and substance misuse.

5: Support communities to enable people to achieve their potential and ensure Buckinghamshire is a great place to live

Why is this a priority?

We know that having good friends and living in friendly communities is good for our physical and mental health whatever our age. We want to enable communities to support their members in times of need.

We also know that the physical environment, where we live, our communities and social networks have a strong influence on our overall health and wellbeing. As our population ages we want to ensure that homes and neighbourhoods are designed to support people to lead fulfilling lives and stay independent for longer.

We seek to support communities in helping to

The focus for 2016 – 2021

improve people's health and wellbeing by:

- Supporting good design and quality homes with the provision of infrastructure to support healthy lifestyles and environments such as safe green spaces, play areas, cycle and walking routes and flexible community facilities to improve health and wellbeing.
- Working with communities to support thriving community life, including targeted work with the voluntary sector.
- Supporting people who need assistance with their health and care needs and connect them with local organisations and activities in their communities.
- Ensuring more people are living independently for longer by creating the best environments possible by encouraging the development of high quality accommodation and premises for people with care and support needs and the provision of lifetime homes and appropriate housing for older people in Buckinghamshire.
- Working in partnership to deliver effective infrastructure for health and social care which is flexible enough to meet changing needs and support new and innovative models of care.

How will we measure success?

The Health and Wellbeing Board meets six times a year and will focus its meetings on delivering the aims of the strategy. A summary of actions and the next steps will be produced following every meeting and an annual report produced to show the impact that the Board and its partners have made over the year to improving the county's health and wellbeing.

The Health and Wellbeing Board will also develop a set of performance indicators to monitor progress throughout each year to see if the strategy is making a difference in Buckinghamshire.

More information on the Health and Wellbeing Board, its membership, terms of reference and meeting agendas can be found on the Buckinghamshire County Council website.

Health & Wellbeing Board Buckinghamshire

Title	Follow up on Health and Wellbeing Board Themed Meeting on Mental Health on 12 January
Date	9 March 2017
Lead contacts:	Katie McDonald, Health and Wellbeing Lead Officer

Purpose of this report:

The Health and Wellbeing Board held a themed meeting on mental wellbeing on 12 January as part of progressing the 'promoting good mental health and wellbeing for everyone' priority included in the refresh of the Joint Health and Wellbeing Strategy refresh for 2016 – 2021.

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This was the first HWB themed meeting for members to consider one of the Joint Health and Wellbeing Strategy priorities in detail with the aim of identifying potential gaps where a partnership response from the Health and Wellbeing Board could add value.

A summary of this meeting is included in this agenda pack and presentations from the meeting can be found on the HWB webpages https://democracy.buckscc.gov.uk/ieListDocuments.aspx?CId=710&MId=9328&Ver=4

Following discussion of the main themes at the meeting; there were two main actions for each board member organisation:

1. **Workplace Mental Health and Wellbeing**
    - How will the Health and Wellbeing Board organisations lead by example?
2. **Joint Communications**
    - How will the Health and Wellbeing Board improve people's understanding of where to go when they need help or to access services?
    - How will the Health and Wellbeing Board reduce stigma within communities (planning for joint campaigns/common messages)

Responses from HWB members can be found in the table included in this report.

There were also three areas raised as 'quick wins' for the Health and Wellbeing Board to take forward. HWB members are invited to comment and update on these at the 9 March meeting:

1) A suggestion that as lead commissioners there should be a set of guidelines for mental health and wellbeing in a central repository and this should be carried out in a way that uses existing resources more effectively.

2) Appetite for joined up positive mental health campaigns across the county
3) Commitment from members to make sure mental health and wellbeing information is available on their organisation websites (e.g. promotion of the Heads up website)

The following websites and resources were mentioned at the meeting and are useful as reference for taking forward commitments to the mental health and wellbeing priority:

- Does your organisation have a mental health champion? http://www.mentalhealthchallenge.org.uk/
- **The Workplace Well-Being Charter** can provide advice and support for any size of organisation. More information can be found at http://www.wellbeingcharter.org.uk/index.php
- **Mental Health First Aid training for staff** – provided by Bucks Mind - Andrea McCubbin <andrea.mccubbin@bucksmind.org.uk)
- **Suicide prevention training for staff** (STORM or ASSIST) http://www.stormskillstraining.co.uk/ http://www.prevent-suicide.org.uk/asist_suicide_intervention_skills_training_course.html
- Link with IAPT and ensure organisation websites have links to it including a mention that people can self-refer http**://www.healthymindsbucks.nhs.uk/**

Recommendation for the Health and Wellbeing Board:

1) To review the information provided
2) To put forward suggestions on future commitments and actions
3) To agree to review progress on the mental wellbeing priority in autumn 2017.

Background documents:

Organisation	Workplace 1. How will the Health and Wellbeing Board members lead by example as employers?	**Communication** (planning for joint campaigns/common messages) 1. How will HWB members improve people's understanding of where to go when they need help or to access services? **2.** How will the Health and Wellbeing Board reduce stigma around mental illness within communities?	**Future commitments /actions raised at 9 March meeting**
Buckinghamshire Healthcare Trust	Karon Hart, Healthier lifestyles and Staff wellbeing services manager gave a full presentation on BHT work on improving mental health and well-being of staff at the 12 January Health and Wellbeing Board meeting. A number of people approached Karon after the meeting. There was an enquiry at the meeting about BHT availability to provide support/interventions to other organisations and David Williams and Karon Hart confirmed that BHT would be available to offer support and answer any queries going forward. Karon Hart is the Senior Responsible Officer for the Buckinghamshire, Oxfordshire Berkshire West Sustainability and Transformation Plan workforce wellbeing and prevention and chairs a bi- monthly meeting of NHS wellbeing services, which also links to Oxford Academic Health Science Network and other large organisations e.g. Johnson and Johnson, Vodaphone and BMW, therefore raising awareness and circulation of best practice examples.	BHT continue to use the Healthier Lifestyles Service as a portal for staff, patients and visitors to the Trust to be signposted/ referred to appropriate internal/external specialist services as appropriate. This is available via self-referral and clinician referral, while we offer specialist psychological interventions to staff, our remit does not extend beyond that for treatment services. BHT will continue to use the Healthier Lifestyle Service communications methods (Information stands that are on site at all hospitals to advertise and raise awareness of joint campaigns in line with BCC Public health calendar of events. BHT continue to use 5 ways to wellbeing as our 'entry point' awareness raising around mental wellbeing	STP work place Project Initiation Document to be circulated to HWB members once ready

Organisation	Workplace 1. How will the Health and Wellbeing Board members lead by example as employers?	Communication (planning for joint campaigns/common messages) 1. How will HWB members improve people's understanding of where to go when they need help or to access services? **2.** How will the Health and Wellbeing Board reduce stigma around mental illness within communities?	Future commitments /actions raised at 9 March meeting
	Karon is currently updating the PID for this stream of STP and attends the monthly BOB STP prevention work stream meetings in Newbury that this feeds into. The PID will ensure the raising of work place wellbeing standards across the BOB STP region. It is of note that at the meeting of NHS providers mental health in the workplace and its management by both the individual and the manager of the individual, as well as organisation wide initiatives was certainly the most pressing topic.		
Oxford Health NHS Foundation Trust	OHFT has an established Health & Wellbeing Action Group chaired by a Trust Executive who works with a network of Champions, from across the workforce focused on staff health & wellbeing. OHFT has a co-ordinated Wellbeing Action Plan: *The plan aims to support an inclusive workplace, where staff feel safe to raise concerns and are provided with the tools to look after their own emotional and psychological-wellbeing.*	OHFT is committed to raising awareness of joint campaigns and continues to use 5 ways to wellbeing as our 'entry point' awareness raising around mental wellbeing	

Organisation	Workplace 1. How will the Health and Wellbeing Board members lead by example as employers?	**Communication** (planning for joint campaigns/common messages) 1. How will HWB members improve people's understanding of where to go when they need help or to access services? **2.** How will the Health and Wellbeing Board reduce stigma around mental illness within communities?	**Future commitments /actions raised at 9 March meeting**
	OHFT will Continue their work to support the reduction of Workplace Stress through a number of initiatives, including: • Further develop opportunities for staff recognition • Apply for and attain; Wellbeing Charter, Healthy Workplace award • Promote and enable 'activity' groups via Workplace Champions, share good practice with external organisations, support a calendar of Wellbeing events. • Increase Organisational wide awareness for Wellbeing		
Aylesbury Vale and Chiltern Clinical Commissioning Groups	Robust wellbeing programme in place at the CCG (tasters with sports, regular pilates, walks, choir etc.) The Partner Forum to discuss signing up to the	Mental Health Partnership Board to discuss improving awareness in communities. Use of Prevention matters, Community Development Workers, Recovery College,	

Organisation	Workplace 1. How will the Health and Wellbeing Board members lead by example as employers?	**Communication** (planning for joint campaigns/common messages) 1. How will HWB members improve people's understanding of where to go when they need help or to access services? **2.** How will the Health and Wellbeing Board reduce stigma around mental illness within communities?	**Future commitments /actions raised at 9 March meeting**
	Mindful Employer Charter The Partner Forum will review the HR Health and Wellbeing Policy There is a Mental Health First Aider on the CCG staff Details of the National GP Mental Health service has been circulated to primary care- for GPs suffering with Mental health issues.	Schools, aligning with national campaigns Mental Health services information on CCG website (public facing) regarding services available locally with links to relevant services.	
Buckinghamshire County Council	BCC Organisational Development currently leading on 'Health and Wellbeing Ambition' to create a healthy, positive and engaged workforce. Current offer to staff includes - E-learning, online courses to assist with personal resilience and stress awareness - Mindtools: offers 70 free online courses around managing stress including coping strategies, happiness, wellbeing and relaxation and sleep. - PAM Assist EAP (Employee Assistance Programme) BCC currently in liaison with Karon Hart at BHT to	Public Health lead the multi-agency Suicide prevention group who are currently updating a comprehensive action plan which included priorities for improving communication and will be presented to the Health and Wellbeing Board later in the year. Public Health also leads a multi-agency adult mental wellbeing group who are also updating an action plan which will be aligned to the Joint Health and Wellbeing Strategy.	

Organisation	Workplace 1. How will the Health and Wellbeing Board members lead by example as employers?	**Communication** (planning for joint campaigns/common messages) 1. How will HWB members improve people's understanding of where to go when they need help or to access services? **2.** How will the Health and Wellbeing Board reduce stigma around mental illness within communities?	**Future commitments /actions raised at 9 March meeting**
	co-ordinate running a team resilience session for People and Organisational Development team.		
Wycombe District Council	Wycombe DC has a Health and Wellbeing Working group who provide direction and co-ordinated action to improve the health and wellbeing of staff via our Health and Wellbeing Strategy. The Health and Wellbeing Group are supported by the Health and Wellbeing Champions who promote health and wellbeing in their work areas and encourage colleagues to get involved. This includes a specialist Health and Wellbeing Champion for Mental Health who leads mid-week staff meditation sessions and signposts to additional advice and support resources. Information can be found in staff newsletters and within the leisure room. We also have Activity Representatives who organise activities and encourage colleagues to participate in physical activities such as football, badminton and keep fit classes. Regular activity is recognised as an important aspect of mental health and wellbeing.	Wycombe DC recognise regular exercise and access to green open spaces as being important to resident's health and wellbeing. Continue to consider and understand the important of green open spaces within new housing developments, particularly within the local plan on mental wellbeing Continue to support and fund county wide physical activity programmes and projects including Active In and Active Bucks. Continue to promote the district's attractions including walking and cycling routes via social media platforms and tourist information points. Lead officer for health to continue to represent WDC at county wide strategic health meetings, providing resources, assisting with partnerships and carrying out communication strategies with	

Organisation	Workplace 1. How will the Health and Wellbeing Board members lead by example as employers?	Communication (planning for joint campaigns/common messages) 1. How will HWB members improve people's understanding of where to go when they need help or to access services? **2.** How will the Health and Wellbeing Board reduce stigma around mental illness within communities?	Future commitments /actions raised at 9 March meeting
	The Mental Health Awareness Week was piloted in 2016 and included a lunchtime brief bites session open to all employees, a literature stand and a quiz amongst other activities. Event to be held in 2017. The Occupational Health service delivered by PAM Assist. The Occupational Health nurse visits the council offices once a week for appointments at the request of line managers or officers. A telephone advice service is also available for all employees. Stress risk assessments carried out twice a year by line managers. Regular one to ones between line managers and officers.	local residents when required. Introduce council's health strategy and action plan for 2017/18 to ensure a more co-ordinated approach within departments. Develop a Dementia Awareness training programme for employees and members and support the High Wycombe Dementia Friendly Communities steering group. Desired outcomes to better support residents living in the District who have Dementia and to ensure they live well.	
Chiltern and South Bucks	Both councils already have Stress Policies, Absence policies, Occupational Health and provide additional therapy for staff as required through the occupational health process.	In relation to customers the services assist persons with complex needs to enable access to; benefits, housing, homelessness assistance, address housing standards, deal with neighbourhood issues including antisocial	Training for the Housing Team on suicide prevention. Improve

	The Councils developing a Joint Health and Wellbeing Strategy for employees. In terms of prevention the Councils have a Wellbeing offer including; massage, thoughtfulness therapies, physical exercise initiatives, including leisure discounts, healthy eating advice, employment counselling and mediation and a telephone advice line and an Employee assistance programme.	behaviour and nuisance. Due to the complex issues the team liaise with mental health services, early help, adult and children's services, police etc. An identified gap during the housing service review was to train staff to deal with people at risk of suicide such as the suicide first aid training. In relation to community asset building and resilience the work we undertake follows the principles around 5 Ways to Wellbeing supporting people to; connect, take notice, keep learning, give, and be active, supporting increasing volunteering, community asset building and building community empowerment. Some examples include supporting the setup of; dementia friendly communities, community and street associations, good neighbour schemes, community transport initiatives, intergenerational projects, and community outreach activities supporting learning and physical activities.	signposting for mental health and wellbeing services
Aylesbury Vale DC	AVDC has policies on Stress, Absence and Drug and Alcohol testing. AVDC employs the services of PAM Occupational Health and Aylesbury Counselling services on a pay as you go basis. As well as conducting individual stress assessment with staff as required. We ensure staff involvement in wellbeing through the Health, Safety & Wellbeing committee. In 2016, we developed a Health, Safety & Wellbeing strategy with an action plan. To monitor our staff wellbeing and identify stressors within AVDC we	AVHT links	

	have conducted a HSE Management standards survey and Staff engagement survey which we use to identify any issues which need addressing through training or other means. Wellbeing is managed internally with various offerings delivered by face to face training, eLearning and awareness programmes including resilience, mental health awareness, healthy lifestyles and drug and alcohol awareness. We are currently running a variety of workshops on financial wellbeing, mindfulness and are in the process of designing a new eLearning module called "Email Efficiency" which includes email stress. We have a series of articles on our intranet to address subjects such as stress, sleep and active lifestyles and are currently developing this further. We have recently delivered resilience training to specifically support the Union and staff reps as we embarked on a major restructure. AVDC support staff with issues that may be affecting them outside of work by sign posting organisation. Our previous learning at work week included an exhibition "support and opportunities for you", exhibitors included Age UK, Carers Bucks, Community Impact Bucks, Healthy Minds and Active Bucks. We also run regular sessions with Alzheimer's UK on dementia awareness.		
Healthwatch	Healthwatch Bucks: Provide a highly flexible and mutually supportive working environment that allows our staff to achieve work life balance	Healthwatch Bucks will be: - Using our signposting and engagement activities to direct to relevant services - Merging our mental health directory with	

	Holding events for volunteers and staff to increase engagement, mutual support and well being Transparent and collaborative approach to activities Promoting access to and engagement in CIB Monday Mile	the directory being produced by Bucks MIND Healthwatch needs: - A central point to be identified to carry a mental health directory of services which we can signpost to Healthwatch Bucks is unlikely to be delivering projects and services designed specifically to reduce stigma. However it can play a part in a number of different ways: - Support communications from other Health and Wellbeing Board participants aimed at doing this; - Support communications around key calendar events (e.g. World Mental Health Day); - Ensure that mental health is given parity with other areas in terms of prioritisation of our work. - Partnering with related voluntary sector organisations (e.g. Bucks MIND); and - Ensure that Healthwatch Bucks work in this area is aligned with this outcome (reduction in stigma) in terms of how we deliver our work reaching out to seldom heard groups to capture their experiences of local health and care services	
SOBS (NB. SOBS not	**N/A**	• Raising awareness of the vulnerability of Suicide Survivors [those who have lost someone dear to them through suicide]	

member of HWB but voluntary sector organisation who attended the Mental Health themed meeting and committed to raising awareness in Bucks)		as a group, especially in the early weeks of bereavement up to and including the inquest. • Early intervention, from the Thames Valley Police initiative onwards, sympathetic support from the Coroner's Office, positive intervention by their GP, signposting to organisations such as ourselves. They will often be part of the Sickness and Absence data, as well as drawing on benefits • SOBS is able to talk to any group, professional body or volunteers, to give them an insight into the feelings and reactions of the bereaved	

Health & Wellbeing Board
Buckinghamshire

Title	Health and Social Care Integration: Road Map to 2020
Date	9 March 2017
Report of:	Healthy Bucks Leaders Group Rachel Shimmin, *Chief Executive Buckinghamshire County Council* Lou Patten, *Chief Officer, Aylesbury Vale and Chiltern Clinical Commissioning Group* Neil Dardis, *Chief Executive, Buckinghamshire Healthcare Trust*
Lead contacts:	Sheila Norris/Graeme Betts, *Managing Director Of Communities, Health and Adult Social Care, BCC*

Purpose of this report:
The 2015 spending review set out an ambitious plan for health and social care to be integrated across the country by 2020. This report acts as a statement of intent for more integrated working between health and social care organisations in Buckinghamshire. It sets out the opportunities for local integration to deliver joint outcomes for the health and wellbeing of Buckinghamshire residents and better manage demand on services.

As the system-wide forum with democratic accountability for local communities, the Health and Wellbeing Board is pivotal to the development of local integration plans. The Sustainability and Transformation Plan guidance also stipulates that STPs are to be aligned with local integration programmes and its success requires the engagement of all partners across the local system. The Health and Wellbeing Board has a key role to play in oversight of progress to drive forward transformation of services in Buckinghamshire.

.**Recommendation for the Health and Wellbeing Board:**

The Health and Wellbeing Board is asked to:

1. Note the report and discuss its contents at the meeting on 9 March
2. Discuss the presentation submitted with the report on Buckinghamshire Health and Care System Plans
3. Agree an approach for the HWBs role in the on-going oversight of achieving integration by 2020

Background documents:

Health & Wellbeing Board
Buckinghamshire

Health and Social Care Integration Roadmap to 2020

1. Purpose of report

This report sets out the opportunities for Buckinghamshire County Council and the NHS to have more integrated working (between commissioners and providers of health services, public health and social care services and other council services) for the purposes of advancing the health and wellbeing of our residents and better managing demand.

2. National position

2.1 Sustainability and Transformation Plans

STP's articulate at a high level how local services will evolve and become sustainable over the next five years, contributing to the national 'Five Year Forward View' vision of better health, better patient care and improved NHS efficiency. STPs were announced in December 2015 as part of NHS planning guidance. There are 44 'footprint' areas for England each with a STP, a 'place based' plan. These draft plans were published in 2016 and are going through a process of assessment, engagement and further development.

2.2 Demand

Business intelligence reveals a growing and ageing population. Notably, a significant increase in the 85+ population which leads to rising pressures on health services, social care, informal care, supported housing and other services. Life expectancy is increasing, and time spent in ill health is rising as people are living longer in poor health, resulting in a growing number of people with high levels of complex need: most older people have more than one long term condition. Our current health and social care system, whilst it has made improvements, has failed to keep pace with the population's needs and expectations and is unsustainable. We face unprecedented constraints on funding and growing demand and therefore fundamental innovative changes in the design and delivery of care are needed. Integration offers an opportunity to redesign services around the needs of individuals, not organisations, and to make the best use of collective resources to manage demand more effectively.

2.3 Prevention, early intervention and care co-ordination

There is a longstanding ambition to shift more health care from hospitals to settings closer to people's homes and from reactive care to prevention and proactive models based on early intervention. By identifying risk factors to poor health and wellbeing early on, we can help people to help themselves by drawing on support in the community and by joining up local services to meet the needs of our diverse local population. However, to achieve these aims, health and social care services will need to be better co-ordinated around the individual, ensuring the right care is offered at the right time and in the right place. To support this, we will identify people with existing conditions to manage these safely with support in the community, and to co-ordinate care for those most at risk of hospital admission to keep them at home for longer. We also will create health and social care hubs that can provide a wealth of information, support and advice to support this aim to keep individuals and families healthy and well in their communities.

2.4 Collaboration and innovation

Given the rising demand on services and financial pressures all agencies are facing, there is a growing need to work together to improve performance and transform care. Whilst health and care professionals are committed to better integration, there can often be a perceived level of complexity and lack of clarity on what this means in practice which in turn reduces the pace of change. The Buckinghamshire system is developing, taking a strategic view with a set of agreed and shared outcomes and clear action plans to drive forward to reach a fully integrated care and health system by 2020/21.

3. Local position

Every health and care system across England has been asked to come together and create its own ambitious local blueprint for accelerating implementation of the NHS Five Year Forward View. As one of the 44 footprint areas, NHS organisations and local authorities across Buckinghamshire, Oxfordshire and Berkshire West (BOB) have come together and developed an STP to reduce the gaps in health and wellbeing, care and quality and finance. The STP umbrella provides transformational planning across all three areas. It is an opportunity to build on good practice, maximise opportunities, generate at scale efficiencies and avoid future costs.

The Health and Adult Social Care Select Committee and the Health and Wellbeing Board have had several discussions on STP progress in September and October. On 21 October the draft STP (2017 – 2020) was submitted to NHS England and throughout November and December public stakeholder engagement events were held. On 15 December the Health and Wellbeing Board discussed the STP and local delivery plans in detail, recognising some of the challenges and the need for better integration to advance the health and wellbeing of everyone within the footprint area.

Whilst we have made progress, we now need to move from planning to delivering our aspirations. Our current model of health and social care is in the main reactive, based upon provision of support when problems arise, creating a degree of dependency. Whilst there will always be a need to provide some level of reactive services, it is essential we shift our focus towards supporting our communities to stay healthy and well for longer, working at scale to generate new types of services and support that meet our community's needs.

4. Roadmap to 2020

In order for health and social care to become fully integrated, we must work collaboratively, with pace, to shift investment from reactive services to early intervention and preventative services, looking at the whole life cycle with particular focus on transition points. To support the next phase of development we have identified four closely interlinked areas of work (each underpinned by an action plan which is currently being reviewed by the Transformation Delivery Group).

1. Joint Commissioning
2. Integrated Provision
3. Back office (One Public Estate, Communications and Business intelligence)
4. Governance

4. 1 Key Area 1: Joint Commissioning

Joint commissioning must ensure that as a health and care system we invest in keeping people well and independent, creating the right incentives for providers to achieve these outcomes and stripping out duplication. It means working closely with communities, individuals and carers as partners in supporting people to stay healthy and independent. We need to optimise opportunities by having better alignment between health and social care; ensuring services are funded and commissioned with a whole life course approach. Commissioning has a key role to play including reshaping the way voluntary sector are funded to ensure a coordinated approach to developing and providing services. Jane Bowie, Director of Joint Commissioning, joined Buckinghamshire County Council in January and has a wealth of experience integrating health and care across both children's and adults services Work has already begun in aligning commissioning teams therefore it is anticipated further work will progress quickly. Outputs include developing a co-commissioning (health and social care) integration team and developing a commissioning vision (aligned with the STP and health and wellbeing strategy) which will use the best of all approaches from health and social care to deliver integrated provision.

4.2 Key area 2: Integrated Provision

Locality working and intermediate care are two critical aspects to focus on which will provide maximum outcomes for residents.

A simpler pathway through the health and social care system is needed so professionals and residents can navigate and access the right support at the right time. Transformation into place based planning (a locality model) where a multi-disciplinary team (primary care, social care, mental health, community health services, acute expertise, public health and the voluntary sector) deliver a seamless pathway of health and social care to a designated General Practice cluster population enables a more coordinated model of care with a common vision and purpose. With a thorough understanding of a community's health and care needs, resources can be pooled and services aligned to deliver improved quality care closer to people's homes, reducing reliance on the acute sector. The locality model takes a local assets based approach, ensuring access to local voluntary and community services in multi-functional community 'hubs', as well as considering the wider infrastructure implications. By streamlining and simplifying care pathways, providing better information, advice and signposting we will reduce dependence, promote self-management and increase resilience. Each locality team will be expected to identify those most in need, and those whose needs are rising, within its population and to work together to support them.

An important part of the new integrated locality model of care and ensuring there are appropriate care solutions in the community, is the transformation of our care home and domiciliary care sectors. Approximately 15% to 18% of emergency admissions into the hospital are from care homes and the length of stay for these people tends to be higher than for average admissions. In addition, people often enter care homes following a hospital admission, with individuals and their families losing confidence in their ability to regain their independence. Yet most people want to be cared for in their own homes and we know this is best for their wellbeing. This will require good partnerships with the care home sector and the domiciliary care market – with a presumption not to assess people's long-term care needs while they are in hospital. Intermediate care is the short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care. An intermediate care strategy with a

strong re-ablement ethos will be the foundation of the integrated provider programme. At the centre of the locality model approach is care that is person-centred, focused on rehabilitation and delivered by a combination of professional groups.

Local NHS providers in Buckinghamshire have agreed to form a Primary and Acute Care System (PACS) as a vehicle to transform services to this new model of care firmly based around the patient in localities. Oxford Health NHS Foundation Trust (our NHS mental health provider), Buckinghamshire Healthcare NHS Trust (our NHS acute and community provider) and FedBucks (an organisation supporting 85% of GP practices in Buckinghamshire) are the partners in this provider alliance. The alliance has prioritised four areas of service transformation to break down barriers between professionals, organisations and care pathways; urgent care, frail elderly, diabetes and mental health. The PACS will be learning from similar PACS and Multi-specialty Community Providers across the country as it develops the locality model.

4.3 Key area 3: Back office

Developing coordinated back office systems could not only lead to enhanced service development but also enable significant efficiencies. This is widely becoming acknowledged and NHS Improvement has highlighted that back office bills can result in savings of £350m over the next four years. Greater Manchester, Kent, Essex and North West London have been chosen to become back office merger pathfinders. NHS providers in the wider Thames Valley region are working on areas such as procurement, human resources and joint financial systems to generate synergies and efficiency savings for the NHS.

Building on the development of a shared service for communications and engagement, work must now mature to ensure commonly agreed narratives, consistent messages, enhancing all digital opportunities and links to national campaigns.

One public estate (OPE) partnerships across the country have shown the value of working together across the public sector. Buckinghamshire has six projects as part of a current OPE application for the county. These projects demonstrate the benefit of a strategic and collaborative approach to asset management to maximise public buildings and resources enabling service transformation and savings on running costs.

Business Intelligence will help drive integrated care across health and social care both within and between organisations. Working together and sharing information will bring together the evidence base and intelligence to inform strategic planning. It will enable integrate systems allowing better data management where health and care professionals fully understand the needs of the population they serve. It will provide a platform for better analysis prompting early intervention campaigns and encourage everyone to use technology to manage their own wellbeing. Additionally, developing integrated IT systems across health and social care organisations will support patient centred care and enhance decision making. A first step along this journey has been linking GP practice systems so that the summary care records can be viewed across organisations. This has improved the visibility of the summary patient record to both health and social care staff.

Buckinghamshire will focus on supporting the development of the workforce to ensure we can continue to recruit and retain the highest quality staff to care for our patients and communities. A workforce group across the STP is developing a plan for support workers,

focussing on leadership development and using the apprenticeship levy to its full extent to train and develop new skills in our workforce for the future.

4.4 Key area 4: Governance

Strong leadership, transparency, measurable outcomes and continued scrutiny are needed to drive through improvements to this shared agenda. In Buckinghamshire, the Health and Wellbeing Board will have oversight of progress, monitor key deliverables and system wide projects.

It is essential that all local (and border) plans align to the STP and joint health and well-being strategy. Clear accountability will be required to ensure there are no duplications and a streamlined governance framework is in place. It is important that there is full visibility in relation to the decision making process. Developing a streamlined and coherent governance framework will speed up decision making and create a positive environment within which commissioners collaborate and transformation is driven forward.

March 2017

Rachael Shimmin
Chief Executive
Buckinghamshire County Council

Louise Patten
Chief Officer
Aylesbury Vale and Chiltern Clinical Commissioning Group

Neil Dardis
Chief Executive
Buckinghamshire Healthcare NHS Trust

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Buckinghamshire Health and Care System Plans

Neil Dardis Chief Executive, Buckinghamshire Healthcare Trust
Dr. Graham Jackson Clinical Chair, NHS Aylesbury Vale CCG
Louise Patten Chief Officer, Aylesbury Vale & Chiltern CCGs
Graeme Betts Interim Managing Director, Communities, Health and Adult Social Care, Buckinghamshire County Council

Agenda

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1. BOB STP update

2. Buckinghamshire priorities for 2017/18

3. Examples of what this will mean for residents

Background

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- **44 STP footprints across England of a scale which should enable transformative change and the implementation of the *Five Year Forward View* vision of:**
  - **better health and wellbeing;**
  - **improved quality of care; and**
  - **stronger NHS finance and efficiency**
- **STPs vary in size and complexity – from 0.3m population,1 CCG, West, North & East Cumbria (success regime) to 2.8m population, 12 CCGs, Greater Manchester (DevoManc)**
- **Buckinghamshire, Oxfordshire, Berkshire West 'footprint' 1.8m population, £2.5bn place based allocation, 7 Clinical Commissioning Groups, 6 Foundation Trust & NHS Trust providers, 14 local authorities**

THE NHS IN BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST

£2.5 BILLION
BUDGET

175
GP SURGERIES

182
DENTAL PRACTICES

MAJOR HOSPITAL TRUSTS

Buckinghamshire Healthcare NHS Trust, Oxford University Hospitals NHS Foundation Trust and Royal Berkshire NHS Foundation Trust, providing acute medicine, surgery, maternity and paediatric services for local people, as well as more specialist services for a larger geographic area, including areas outside of BOB

37,000 STAFF

from district nurses to surgeons, porters to managers, pharmacists to physiotherapists

18,000 PATIENTS
SEEN DAILY BY GPs

400 PATIENTS A DAY
have emergency admissions to hospital

1,200
VISITS TO A&E A DAY

MENTAL HEALTH SERVICES

Provided by Oxford Health NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust

COMMUNITY HEALTH SERVICES

Provided by Buckinghamshire Healthcare NHS Trust, Oxford Health NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust

LEARNING DISABILITY SERVICES

Provided by Southern Health NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust and Hertfordshire Partnership NHS Foundation Trust

AMBULANCE SERVICES

Provided by South Central Ambulance NHS Foundation Trust

BOB STP finances

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- **Resources allocated to BOB CCG commissioners for purchasing health services total £2.55bn in 2016/17 and will increase to £2.87bn by 2020/21, an increase of 12%**

- **This increase is to pay for population growth, inflation and technological advances, together with funding for new national initiatives, such as implementing 7 day working across the NHS, implementing the GP and Mental Health *Five Year Forward View* objectives**

- **Some funding for these initiatives has been retained centrally which BOB will have to compete for (transformation bids)**

- **Expenditure is growing at a faster rate than the increase in funding and there is a growing financial gap under the 'do nothing scenario' by 2020/21 of £479m**

- **Local authority partners' care budgets are under relentless pressure as a result of allocation reductions, demography, need and deprivation**

BOB STP approach

The overall approach is based on **developing STP plans in local systems where it makes sense with key partners** e.g. for integrated health and care and the Buckinghamshire transformation programme, and **collaborating across the STP footprint as necessary on cross system issues** e.g. workforce

- STP has been developed 'bottom up' and builds on plans already developed locally across the three health and care systems
- Shift the focus of care from treatment to prevention
- Access to the highest quality primary, community and urgent care
- Collaboration of the three acute trusts to deliver equality and efficiency
- Maximise value and patient outcomes from specialised commissioning
- Mental Health development to improve the overall value of care provided
- Establish a flexible and collaborative approach to workforce
- Digital interoperability to improve information flow and efficiency

Programme delivery

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- Programme management structure and process reviewed in January 2017 and will continue to be refined
- *STP Executive Board* (Chief Executive health and care system leaders) continues to drive this work
- *STP Operational Group (*lead Directors/Senior Responsible Officers) to oversee and align delivery of the three health and care system plans and BOB-wide programmes
- Aligns resources, reduces duplication and gives clear programme leadership and programme management
- Individual organisations remain accountable but approach supports planning and state of readiness to position the footprint for transformation resources

Levels of commissioning across the STP

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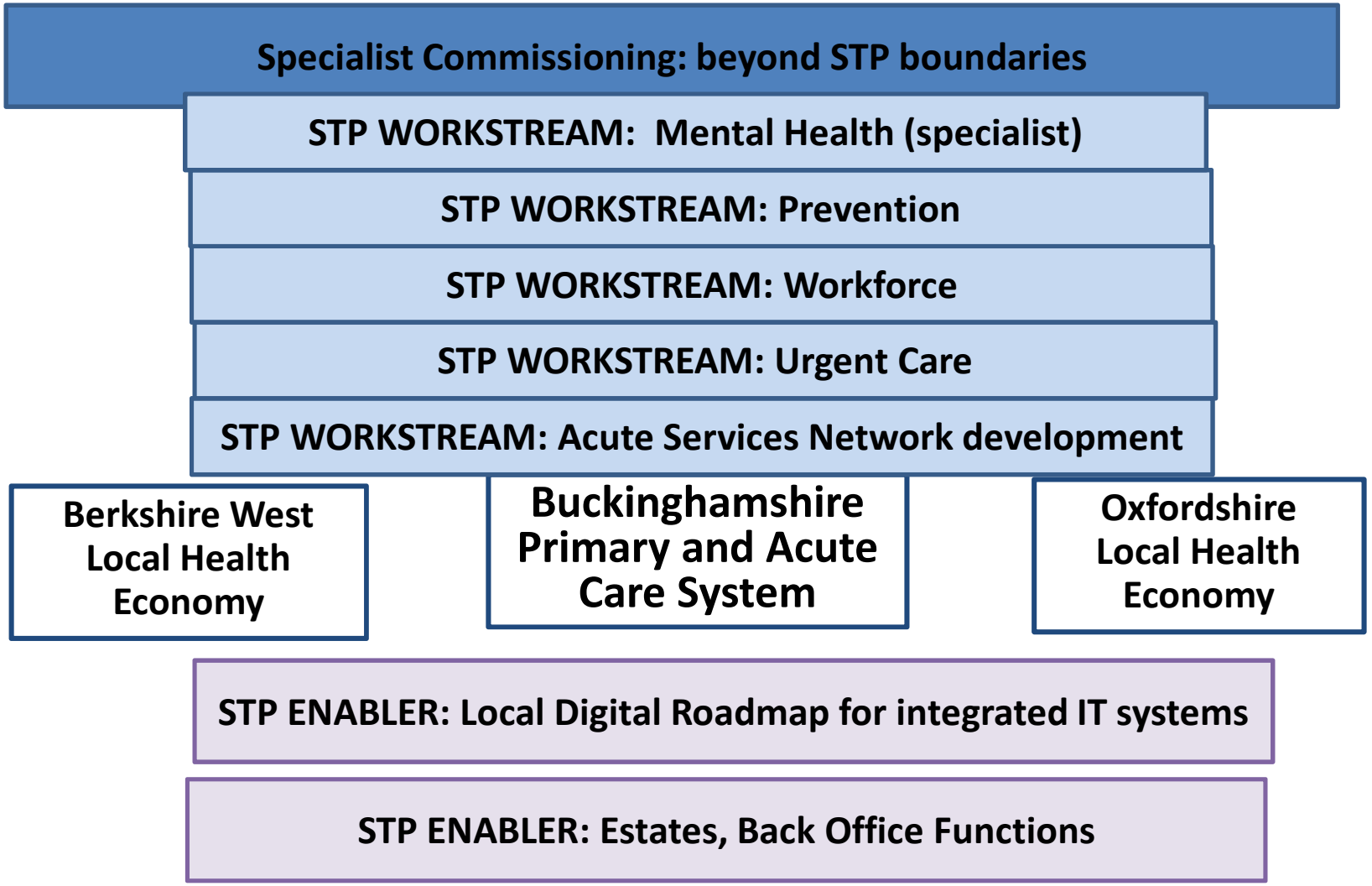

Our Local Plan Delivery

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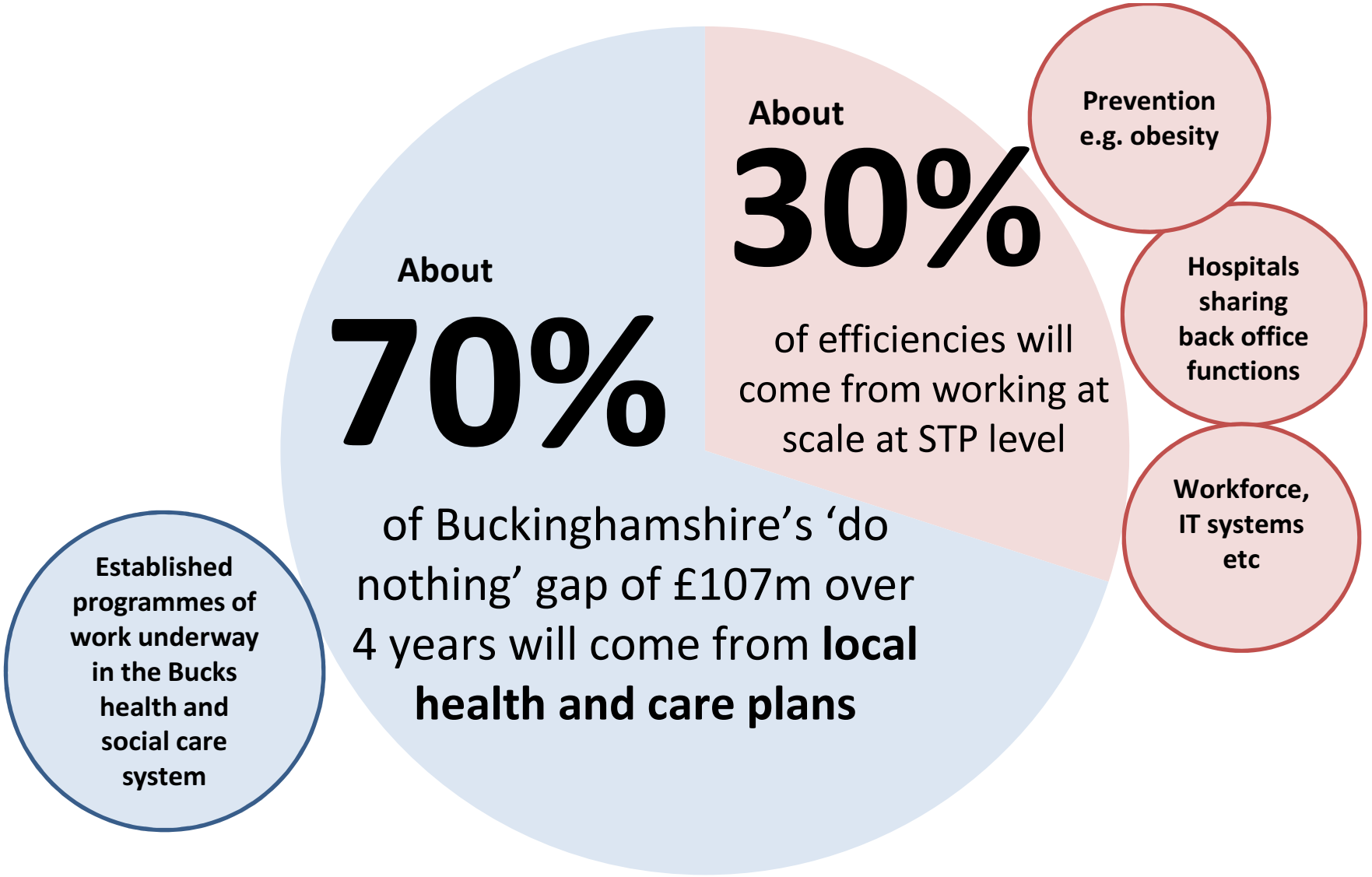

Strong record of achievement:

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- **Better Healthcare in Bucks** – transformation programme to centralise A&E and emergency services
- **Stroke and Cardiac** - innovative model of care introduced at Wycombe Hospital
- **Redesigned emergency and urgent care** including seven day medical ambulatory care facility
- **Quality and Outcomes framework** – nationally recognised innovation to increase use of Care and Support planning in Primary care
- **System wide quality improvement** – aligned monitoring and governance, e.g. Looked After Children
- **Over 75s community nursing** – delivering 'upstream' care to prevent admission and shorten length of stay for our older population

Bucks priorities 2017/18

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- **Prevention and self-care:** healthy lifestyles and Active Bucks
- **One Bucks Commissioning Team:** further developing joint health and care commissioning across NHS and the Council (adult and children's services, public health, mental health etc)
- **Key providers** are planning a formal alliance to deliver joined up care (FedBucks [GPs] + Oxford Health NHS Trust + Buckinghamshire Healthcare NHS Trust)
- **Continue investing** in rehabilitation and community services, so fewer people need hospital care
- Introducing better, simpler models of care for people with **diabetes and musculoskeletal problems** (back/neck/limb)
- **Stroke and cardiac treatment:** widen catchment, so Bucks patients don't have to travel to London; expanding services to Berkshire
- **Community Hubs:** piloting new ways of joining up health and care closer to home, tailored to the needs of local communities
- **One Public Estate:** six shared projects, using our property assets to provide better services and value to residents
- **Workforce:** increase apprenticeships for support workers, continue reducing agency spend, collaboration on temporary staffing contracts, investment in leadership
- **IT:** development of local digital roadmaps e.g. to share records across organisations

Our Roadmap….

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2016/2017

System Leadership:

Healthy Bucks Leaders establishes a system-wide Transformation Delivery Group

Building trust and transparency across the system

Commissioners:

- Working towards leaner commissioning with Bucks CC and Oxfordshire CCG
- Working through what STP means for local and at scale commissioning

Providers:

- FedBucks, a single organisation across 80% of Bucks GPs is established
- BHT, OHFT and FedBucks agree to principles of PACS

2017/2018

System Leadership: Preparing for PACS

Leaders establish a year of transition to place based services with outcomes based contracts

All transformation projects prioritised for system delivery through a common PMO

Further work to scope and share management functions

Commissioners:

Clarity on what is commissioned:

- As a single team with Bucks County & District Councils
- Across Bucks & Oxon & STP
- At larger scale (Specialist and Alliance)
- Clarity on contracting with PACS for 18/19 including social care provision

Providers:

- Strategic & Business case for provider PACS model finalised
- Clusters of GPs (30-50k populations) supported by the FedBucks 'umbrella' working with integrated multidisciplinary teams including MH

2018/2019

System Leadership: PACS to ACO

The Provider PACS becomes accountable for the primary, community and general physical & mental health needs of the Bucks registered lists of patients.

Leaders will use this year to establish what areas of commissioning may come into the PACS (as an ACO) and what needs to remain at larger scale

ACO established for 2019/2020

A Primary & Acute Care System (PACS) in 2018

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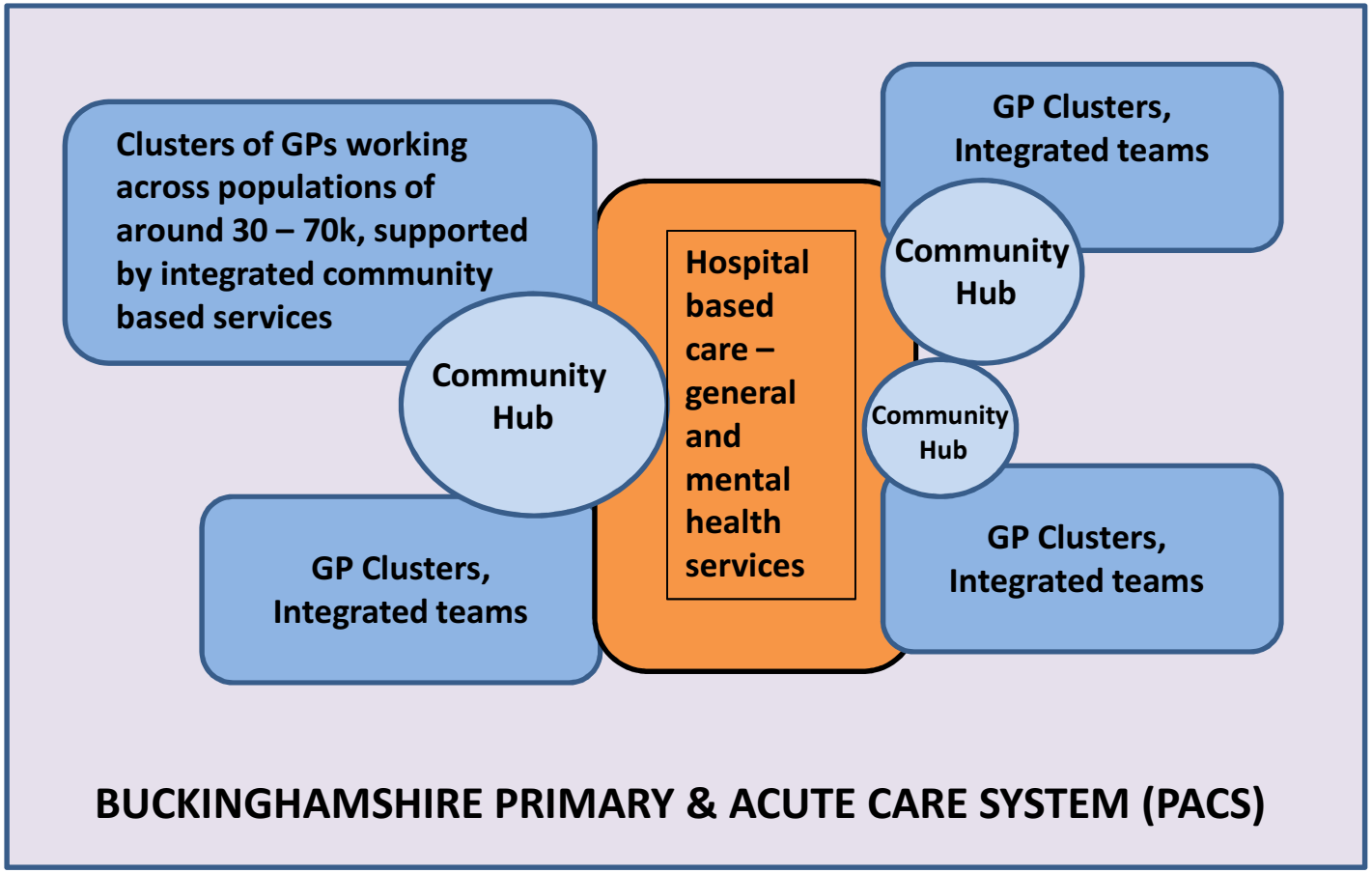
STP: commissioning at scale



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What does this mean for Patients, Clients, Carers and the Public?

What's happening now?

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- Community nurses and therapists available round the clock
- Specialist nurses supporting patients with long term conditions
- Early supported discharge for stroke patients providing therapy and nursing care at home reducing hospital stays

What the public told us

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- GPs, staff, patients, other health and social care organisations, voluntary organisations and local communities have informed plans

Themes

- avoid unnecessary travel
- improve coordination between organisations
- support to manage own health & wellbeing

- Consistent feedback from our hubs engagement…

- Rapid access to testing
- Easier signposting
- Joined up teams
- Full range of therapy services
- Health and wellbeing - enhancing self-management, providing education
- sociable space with a café
- base for skilled staff working in the community
- More local outpatient clinics
- Virtual information networks
- Information shared between organisations to improve care

Patient experience:
GP Consultations

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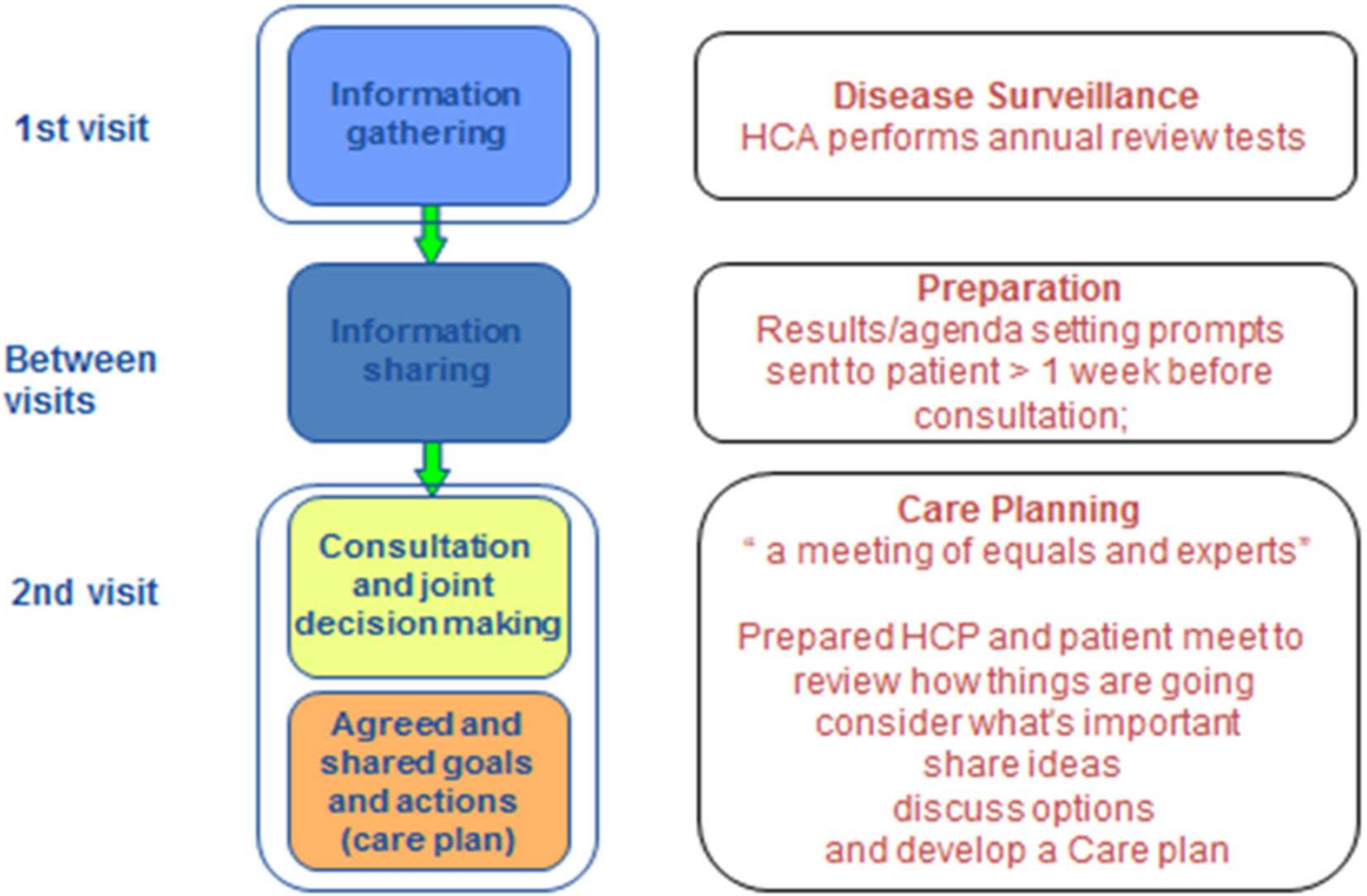

YEAR OF CARE PARTNERSHIPS

Encouraging self management

House of Care model

The House of Care emphasises that effective care and support planning (CSP) consultations rely on four elements working together in the local healthcare system

CASE STUDY:
The Airedale approach

- Airedale, in Yorkshire, has **reduced A&E attendances from care homes by 45%** and **emergency admissions to hospital from care homes by 37%**.

- They've done this by offering people in care homes the opportunity to talk to a doctor and other clinicians over the phone 24 hours a day. This has helped to make sure that people are directed to the most appropriate health service, be that a pharmacist, their GP or a hospital.

- We have been piloting this service in two test sites in Aylesbury; the early indications are positive, so **we are planning to roll it out to cover 30 care homes.**

Community services

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From April 2017, we will have further developed services in the community that will support frail older people …

Locality integrated teams
Integrated teams, which will include nurses, therapists and social workers, will provide 24/7 cover to manage those patients identified as needing the greatest health and care support, typically those who have long term conditions

Rapid response intermediate care
Therapists, care staff and community nurses will provide short-term packages of support to those who would benefit from a 'jump start' back to independence

Community care coordinator
This will provide GPs, hospital clinicians and other health and social care staff with 24/7 phone and email 'single point of access' to organise specialist community services for their patients

Community hubs

- Will provide the following:
  - **NEW** frailty assessment clinics
  - **MORE** outpatient clinics
  - **NEW** voluntary sector and signposting
- Expanding the support available to people in the community will help to maintain a person's health and independence, reduce need for bedded care
- Pilot to launch at Marlow and Thame hospitals for six months
- During the pilot patients will not be admitted overnight to the inpatient wards at Marlow (12beds) and Thame (8beds) hospitals.

Patient story…

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GP is concerned that Mr Smith is getting frailer and seems a bit less able to cope

Previously – GP concerned but can't pinpoint anything specific that needs treating. The only option is to admit to hospital.

Now – GP calls the community care coordinator and talks to the community matron, part of the integrated locality team. The team visit and provide Mr Smith with appropriate treatment and support.

Outcome – Mr Smith's health is stabilised. His care is organised and structured around his needs and he remains at home.

Monitoring the pilots

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- Piloting to give us a better understanding of what works for these two communities
- Medical director and chief nurse will oversee
- Range of measures
- **Responsive and able to quickly adapt**
- Discussions will continue with patients, staff, GPs, other health and social care professionals, and communities
- Will finish pilot with a clear proposal – based on what we've tested and what we've heard

Over the next six months we will…

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- Manage almost **20,000 referrals** through the community care coordinator
- **Double** the number of outpatient appointments offered at Marlow and Thame
- See **350 patients** through the one-stop frailty assessment clinic
- Provide rapid response intermediate care to over **3000 people**
- **Avoid** almost **300** hospital **admissions,** reduce delayed discharges
- Improve **patient experience**

Health & Wellbeing Board Buckinghamshire

Title	Better Care Fund Update
Date	9 March 2017
Report of:	Jane Bowie, Director of Joint Commissioning
Lead contacts:	Rajni Cairns, Programme Manager for Integrated Care

Purpose of the Report

The BCF is a local single pooled budget, to incentivise the NHS and local government to work in partnership to integrate health and social care services. The BCF is governed through a S75 agreement and is an opportunity for local areas to reduce duplication, innovate and enhance services improving outcomes for local residents.

The BCF is an identified element of the Government's vision for integration of health and social care by 2020. Local areas are being asked to demonstrate their process for integration through the 2017-19 BCF plans and their sustainability and transformation plans (STP).

The Health and Wellbeing Board has a duty to promote integration and is the body with overall accountability for Buckinghamshire's Better Care Fund. This report provides the Health and Wellbeing Board with an update on the Better Care Fund 2017-19 submission and gives a summary of the BCF expenditure in 2016/17. It also includes the current BCF performance dashboard as an appendix.

Recommendations

- To agree the approach outlined in the report
- To note that the final submission will not be taken to the Health and Wellbeing Board as there is not a planned meeting prior to the national submission deadline. Health and Wellbeing Board members will be invited to an engagement event and look at the BCF Plan retrospectively in June.
- The HWB is asked to agree that the Integrated Commissioning Executive Team (which includes members of the Health of Wellbeing Board) seek approval of the submission through their governance channels and keep the Chair and Vice Chair of the Health and Wellbeing Board informed throughout this process.

Health & Wellbeing Board
Buckinghamshire

Aylesbury Vale Clinical Commissioning Group
Chiltern Clinical Commissioning Group

BETTER CARE FUND UPDATE

BACKGROUND

Integration of health and social care is about improving service user experience and outcomes – to streamline access points, stop duplicating assessments and reduce multiple visits and interventions by different professional teams; bringing together all the elements of care that a person needs.

The recently published National Audit Office report on Health and Social Care Integration [1] came to the conclusion that the BCF has not achieved the expected value for money; in terms of savings, outcomes for patients or hospital activity over its first year (2015-16). However, the report highlights that the BCF has been successful in incentivising local areas to work in partnership and has achieved improvements in reducing permanent admissions of people aged 65 and over to residential and nursing care homes, and in increasing the proportion of older people still at home 91 days after discharge from hospital in reablement or rehabilitation services.

BCF IN BUCKINGHAMSHIRE

To date, the BCF in Buckinghamshire has followed the nationally-set financial contributions, made up of:

i. CCG minimum contributions
ii. Disabled Facilities Grant
iii. Care Act 2014 Monies
iv. Former Carers' Breaks funding

Buckinghamshire County Council (BCC) and the Buckinghamshire Clinical Commissioning Group (CCG) have agreed not to contribute any extra funding to the pooled budget other than the nationally required CCGs' uplift – the assumption had

[1] https://www.nao.org.uk/report/health-and-social-care-integration/

been for a 1.7% increase but this has not been confirmed by NHSE and systems have now been advised to plan on the assumption of no uplift.

BCF EXPENDITURE 2016-17

Source of funds	**Value**	**Purpose**
NHS	£18,243,650	NHS priorities
LA	£11,970,280	Protection of social care LA Care Act DFG
Total	£30.21m	Combined funding streams – Mandatory minimum

Scheme Name	Funds	2016/17 Expenditure (£)	Origins of funding
7 Day Service	social care	640000	Via the CCG transferred to the LA
Falls Service	social care	275000	Via the CCG transferred to the LA
Hospital Discharge Teams	social care	791000	Via the CCG transferred to the LA
Carers Bucks Contract	social care	550000	Via the CCG transferred to the LA
MAGs	social care	50000	Via the CCG transferred to the LA
Reablement	social care	2172000	Via the CCG transferred to the LA
Home from Hospital	social care	222000	Via the CCG transferred to the LA
Assistive Technology	social care	306000	Via the CCG transferred to the LA
Dementia Advisors	social care	156000	Via the CCG transferred to the LA
Stroke Advisors	social care	70000	Via the CCG transferred to the LA
Quality in Care Team	social care	310000	Via the CCG transferred to the LA
Care Act	social care	1400000	Via the CCG transferred to the LA
Existing Social Care Pressures	social care	2151000	Via the CCG transferred to the LA
BCF Administration	social care	100000	Via the CCG transferred to the LA
Adult Community Healthcare Teams	Health	13979650	CCG funding
Community In Patient	Health	4205000	CCG funding

Services			
IV Therapy & OPAT services	Health	59000	CCG funding
DFG	social care	2777280	Via the LA

POSITIVE IMPACT FROM BCF TO DATE

Establishment of the Integrated Commissioning Executive Team (ICET) - Joint group established to extend integrated commissioning across health and social care demonstrating qualitative, and efficiency improvements for both health and social care

Bucks Integrated Teams - bringing together existing reablement services, routine services and a new team with a senior nurse and a dedicated GP to ensure that the most frail are identified, treated holistically and have care coordinated in a person centred way

Reablement - Reablement services (health and social care) came together during 2015/16 to create a joint referral point ***Bravo (Single point of access)*** with services aligning more closely behind that. They are now using the same assessments throughout someone's journey with the teams.

Delayed Transfers of Care (DToC) - Collaborative working and pathway management has meant that Buckinghamshire benchmarks well as having significantly lower levels of Delayed Transfers of Care (DToC) especially for those clients requiring a social care response**.**

7 day service – Hospital social work team operating 7 days a week to facilitate weekend discharge where appropriate

Assistive Technology – We are using assistive technology across the health and social care economy to drive efficiencies and promote system wide cultural change. By enhancing or supplementing face to face contact time, people can maintain their independence and self-care. We have now developed a performance reporting framework to evidence intervention-reliant efficiency and benefits.

> The Telecare Medication Prompt service is working really well for me. So far I have not required any further hospital admissions (which were very frequent before). They call me through my Pendant Alarm unit to make sure I take my time-critical medication on time and if I am in the process of taking it they stay on the line until I have finished. Although I still have some domiciliary care, it was impossible to align my care visits with the strict timings that my Parkinson's medication needed to be taken. This service has really helped me to feel more in control of my condition and enable me to continue to live independently, as well as support my wife who has her own care needs. *AT Client*

Dementia - Support for delivery of Buckinghamshire's Dementia Strategy by the procurement of a contract to provide Memory Support Services across the county. The service is designed to support individuals and their families, promoting independence and access to community assets and strengthening communities.

Quality in Care Team (QiCT) Support for care homes across the county via the QiCT has supported the contract monitoring of both social care and health contracts, improved quality of care and is also designed to contain the rate of A&E attendances and non-elective admissions from care homes.

Joint working - By building stronger and more collaborative relationships, the CCGs have now been able to commission some "back office" functions previously provided by the CSU from BCC, e.g. Communications and engagement.
Development work is underway to move towards an Integrated Joint Commissioning Team from q2 2017/18

INTEGRATION BY 2020

Operational vision for integration

To integrate health and social care; delivering high quality, best value services that will improve outcomes for Buckinghamshire residents

Buckinghamshire plan for 17-19

- Build on achievements to date and continue to strengthen partnership working across Buckinghamshire
- Focus on improving performance against nationally measured BCF metrics and move towards graduation from the BCF[2]
- Move towards a Pooled budget with associated risk share agreement
- Additional services in the pooled budget
- Workshop with stakeholders to design innovative ways of working towards integration
- Extend to include children and young people's services

How will the BCF link to STP?

The 2016/17 BCF outlined our system integration milestones and in large part these have informed the Buckinghamshire priorities for the Sustainability and Transformation Plan (STP)

How will the BCF move Buckinghamshire towards integration?

The BCF is part of the wider agenda for integration and will facilitate joint working solutions that will address:

- The demographic and funding challenges experienced by both organisations and the need to think differently about how resources are used
- The outcomes and priorities set out in the Health and Wellbeing Board strategy
- The outcomes and priorities set out in the Bucks Chapter of the BOBW STP

[2] *It is the government's policy intention that all areas move beyond minimum requirements for BCF and move towards fuller integration of health and social care by the end of this parliament. The timescales over which all areas will graduate are yet to be decided and will depend on when areas are ready, the time it takes for earlier waves to graduate and the levels of support needed for areas.*

There is a joint recognition that there is more we could do with the BCF to further our system integration aims. On this basis, once we have the published guidance, we are proposing to submit a compliant BCF to NHSE which consolidates many of the initiatives that were in the 2016/17 BCF. A number of these come to the end of their contracts in 17/18. Other areas have been subject to public engagement discussion. We can then take the engagement feedback and commissioning reviews to inform our integration and transformation priorities for the BCF. It is our intention to hold a BCF workshop, involving a wider range of stakeholders than we have previously been able to do.
NHSE have offered some facilitation and we propose to maximise this resource.

NEXT STEPS AND TIMING

- Update for endorsement/approval to:

Integrated Commissioning Executive Team	23rd February
CCGs Executive Team	23rd February
CCGs Governing Body in public	9th March
H&WBB	9th March

- Planning template and guidance from NHSE — Mid-March
- HASC update on BCF — 28th March
- Final plan to:

OCB	19th April
Cabinet	24th April
ICET	27th April
CCG Execs	27th April

- Final plan submitted to NHSE — Mid May - TBC
- Stakeholder workshop — June
- Final Plan presented to HWB — June
- Updated BCF plan/strategy following workshop — August
- Plan re-presented to H&WBB — September

Buckinghamshire County Council

Better Care Fund Metric Dashboard

Date Published	14/02/2017

Current Year data period	Qtr3

1. Emergency Admissions
Source: NHS South, Central And West Commissioning Support Unit

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr3 2016/17	Qtr3 2016/17	
Total non elective admissions to hospital (specific acute) all ages			51003	52906	12545	12423	11924	Good to be low
Definition: A non-elective admission is one that hasn't been arranged in advance. Specific acute non-elective admission may be an emergency admission or a trnasfer from a hospital bed in another healthcare provider other than in an emergency. There should be a reduction in growth of the number of non-elective activity								
Commentary: **Q3 update: October and November activity is 12,545 which is above the plan of 11,924. The year to date position is on plan with activity at 35,629 aginst a plan of 35,598. The BCF plan is based on a proportion of the CCG's national activity, taken from SUS, with baseline data supplied and monitored by NHSE. When these activity plans were produced NHSE directed the CCG's to include IHAM growth, which was 3.8%, however, this growth was not mirrored in the CCG's contracts with provider trusts bringing a discord between the contacted activity and the activity data which is monitored as part of the BCF process. The BCF CCG plans only include Specific Acute activity, so don't include emergency maternity or excess bed days, therefore CCG pressures in these areas (which will be shown in finance and contract reports) are not reflected in the BCF dataset.**								

2. Care Home Admissions
Source: BCC Adult Social Care AIS System

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr3 2016/17	Qtr3 2016/17	
Permanent admissions of Older People aged 65+ to residential & nursing care homes, per 100,000 population		687	581	486	697	287.5	412.5	Good to be low
Definition: This indicator reflects the number of admissions of older adults, aged 65 or over, to residential and nursing care homes relative to the population size of people in this age group. Numerator: Number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers Denominator: Size of the older people population in area from the latest ONS mid-year estimate. Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency. The inclusion of this measure in the dashboard supports local health and social care services to work together to reduce avoidable admissions.								
Commentary: This is currently exceeding the target for 2016/17. Feb Update: this continues to outperform the target set for the year. The number of admissions is expected to increase in Quarter 4, as it does every year during this period, but this is not expected to change the RAG performance for the year								

3. Reablement

Source: BCC Adult Social Care AIS System & Buckinghamshire Healthcare NHS Trust

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr3 2016/17	Qtr3 2016/17	
Proportion of people over 65 still at home 91 days after discharge from hospital into reablement services		61%	71%	66%	75%	~	75%	Good to be high

Definition: This indicator measures the effectiveness of Reablement services. The figure reported represents the proportion of people discharged from hospital to reablement or rehabilitation services who are still at home 91 days after discharge.
Denominator: The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital.
Numerator: The number of older people identified in the denominator and who are at home or in extra care housing or an adult placement scheme setting three months after discharge from hospital. This excludes those who are in hospital or in a registered care home those who have died within the three months.
Improving the effectiveness of these services is a good measure of delaying dependency and will reduce avoidable admissions

Commentary: Data collected between January and March and reported at year end only

4a. Delayed Transfers of Care

Source: NHS England, https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr3 2016/17	Qtr3 2016/17	
Total delayed transfers of care from hospital (NHS, ASC, Joint)		6.7	7.6	9.8	10	12.3	10	Good to be low

Definition: This measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. A delayed transfer of care occurs when a patient is ready for ransfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:
(a) a clinical decision has been made that the patient is ready for transfer AND
(b) a multi- disciplinary team decision has been made that the patient is ready for transfer AND
(c) the patient is safe to discharge/transfer.
This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services.
Denominator: Size of adult population in area (aged 18 and over)
Numerator: The average number of delayed transfers of care (for those aged 18 and over) on a particular day taken over the year. This is the average of the 12 monthly snapshots collected in the monthly Situation Report

Commentary: Performance is below target for Quarter One - however as the target is calculated as the average of a snapshot this does not imply that we will not meet the year end target. In 2015/16 our performance for Quarter One was slightly lower at 8.9 and within target at year end. **Q3 Update. Performance for Q3 is a rate of 12.3 which is higher than the target of 10. Of the delays recorded to date, 33 are due to delays in Social Care provision, 1 was a joint delay and 285 were due to delays in Health**

4b. Delayed Transfers of Care

Source: NHS England, https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr3 2016/17	Qtr3 2016/17	
Delayed transfers of care (delayed days) from hospital			1872	1076.8	468	902	741.8348889	Good to be low
Definition: As per 4a but measuring the number of days delayed rather than delay events Numerator: The total number of delayed transfers of care (for those aged 18 and over) for each month Denominator: ONS mid-year population estimate. The subsequent rate is divided by the number of months in the period and is per 100,000 population								
Commentary: This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.The DTOC target was not met in Q1 with a rate of 862.3 next to a plan of 562.6. However, the DTOC has an increase of rates though 2016/16, and from April to June the number of delayed delays bed days decreased. In order for the yearly target to be met the monthly days delayed would need to drop to an average of 930 days of delayed discharge a month. **Q2: The number of delayed days has hugely increased from 3536 to 5607. However the figures for Oxford Univeristy Health Trust for July are exceptionally high. Figures have been queried and the Q2 figures have been reworked to estimate Oxford University Health Trust in July. Q2 improved on Q1 however figures are still over target.** **Q3 data for October and November shows an increase in the number of days delayed in the quarter, with an average rate of 886 .3 next to a plan of 741.8.**								

5. Patient Experience (Social Care)

Source: BCC Adult Social Care Service-User Survey

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr3 2016/17	Qtr3 2016/17	
Overall satisfaction of people who use care and support with services		56%	58%	61%	60%	~	65%	Good to be high
Definition: This indicator is derived from the annual Adult Social Care Survey, Question 1: "Overall, how satisfied or dissatisfied are you with the care and support services you receive." This indicator is aligned to Domain Three of the Adult Social Care Outcomes Framework: Ensuring that people have a positive experience of care and support The survey is run annually between January and March with performance metrics available from April								
Commentary: Data collected between January and March and reported at year end only								

6. Patients aged 65+ discharged to the same address

Source: NHS South, Central And West Commissioning Support Unit

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr3 2016/17	Qtr3 2016/17	
Patients (65 and over) discharged to the same place from which they were admitted				92.0%	92.2%	92.9%	93.0%	Good to be high
Definition: This is a local metric and the rate is expressed as a % of those admitted to hospital who are discharged to the same address from where they were admitted.								
Commentary: **Q3 Update. Q3 has seen an increase of patients discharged to the same address, with 92.9% discharged to the same address. The YTD is still slightly under plan.**								

Health & Wellbeing Board
Buckinghamshire

Title	Active Bucks and the Physical Activity Strategy
Date	Thursday 9 March 2017
Report of:	Dr Jane O'Grady, Director of Public Health
Lead contacts:	Tom Burton, Public Health Practitioner

Purpose of this report:
In the refresh of the Joint Health and Wellbeing Strategy 2016 -2021, the Health and Wellbeing Board has committed to promote the Active Bucks programme and support the update and implementation of the Buckinghamshire Physical Activity Strategy and action plan.

This report provides members of the Health and Wellbeing Board with an update on progress of Active Bucks, as well as progress of the current Buckinghamshire Physical Activity Strategy and plans to develop a new Strategy from 2018

Active Bucks – Summary of progress:
The Active Bucks programme has been designed to provide Bucks residents with the opportunity to increase their levels of regular physical activity, with a focus on engaging residents that don't achieve recommended activity guidelines – particularly those that are inactive. Active Bucks will also help achieve the all 4 strategic objectives of the Bucks Physical Activity Strategy (outlined below).

Between May 2016-September 2017, a minimum 142 activity programmes (lasting 6 months each) will be commissioned, with a large proportion taking place in areas of green space due to its positive effect on mental wellbeing.

Key highlights of the Active Bucks programme to date (end Jan 17):

- **3500** residents have provided feedback to help shape activities
- **2202** unique participants have taken part so far
- There have been over **10,300** attendances
- **74.9%** of all unique participants didn't meet CMO activity guidelines at the point they registered with **35%** classifying themselves as inactive
- Over **70%** of activities sustained beyond the 6 month funding period
- **26** active Community Champions have been recruited to promote and support activity
- There have been over **29,000** visits to www.activebucks.co.uk with over **1850** 'first session free' activity vouchers downloaded

- Early indications from the independent evaluation suggests that, at 3 months, **56%** of participants have increased their activity levels from baseline - meaning they have moved up an activity category, and **39%** of participants have maintained their activity levels from baseline - meaning they may, in real terms, have increased their activity levels but not enough to move them up an activity category. There has also been a general improvement in mental wellbeing and social cohesion

The Active Bucks programme has been requested to be showcased at a regional PHE physical activity roadshow in May 2017 to highlight best practice examples of engaging people in regular physical activity.

Physical Activity Strategy - Summary of progress:
The current Buckinghamshire Physical Activity Strategy was developed in 2013/14 to last a period of 3 years to finish on 31st March 2017. However, the Bucks Physical Activity Strategy Group – a multi-agency group comprising of various partners including district councils and the CCG, agreed that the existing Strategy should be extended for an additional year to ensure the new Strategy can fully understand the implications of the new national Sport England Strategy 'Towards an Active Nation (2016-2021)'. Therefore, the current Strategy now finishes on 31st March 2018.

Since 2013, the proportion of Bucks adults (16+) meeting recommended activity levels (>150 mins a week) has increased by 2.2%; and the proportion of inactive adults (<30 mins a week) has reduced by 2.4%. However 22% of adults remain inactive (APS, 2015).
For young people in Buckinghamshire, only 14.1% achieve recommended guidelines of 60 minutes physical activity each day – with boys more likely to achieve this than girls.

Buckinghamshire County Council has also been shortlisted for an LGC award (Public Health category) for our whole system approach to physical activity.

The four strategic objectives of the Strategy are:

1. An active start to life
2. Building activity into everyday life
3. Adding years to life and active life to years
4. Building activity into health and social care

Key highlights of the Strategy to date:

- Improving children's' physical literacy can positively affect their confidence/competence to be physically active into later childhood/adolescence. The **Physical Literacy** project has trained 87 staff members from 53 early years and primary school settings to deliver a physical literacy curriculum. Our independent evaluation highlighted that there was a statistically significant improvement in the physical literacy of pupils undertaking the intervention (baseline and 6 months) against a control group. Settings are now offered the opportunity to purchase the training for their staff

to attend. In addition, a digital parental resource will be developed to support parents to get their children more active, more often

- The National Childhood Obesity Strategy (2016) stated that building more activity into and around the school day by is a key approach to helping children meet recommended guidelines. We are currently working with 20 Bucks primary schools to introduce the **Daily Mile** initiative – with schools looking to compete against each other. In addition, active travel is being encouraged through getting schools to adopt **School Travel Plans** and improving cycle skills of pupils through the **Bikeability** programme. In partnership with the BCC Transport Strategy Team, we are working with 10 primary schools **School Travel Zone** to introduce 5 and 10 minute walking zone maps to encourage parents to park further away from the school site, thereby increasing active travel and reducing localised congestion. Leap is also supporting schools to spend their annual Primary Sport Premium in an effective, sustainable way

- Adolescent girls remain more inactive than their male counterparts. Alongside extra-curricular physical activity opportunities through the 'Satellite Club' programme operated by Leap, the **Girls Active** project is working with 11 Bucks secondary schools and to engage 'non-sporty' girls aged 13-15 to help improve the PE and extra-curricular activity experience. These girls will also get to try new activities to see what would interest them back on their school site

- Working age adults continue to be encouraged to travel actively to and from their places of work through initiatives such as cycle racks at train stations and forthcoming **Work Travel Plans** through our partnership with Living Streets. Businesses in Bucks engage with the **Workplace Challenge** programme, enabling staff to track their activity levels and take part in sporting competitions against other companies

- Physical activity has been embedded into the **Live Well, Stay Well** single point of access for lifestyles and long term conditions – ensuring patients who require increased activity levels are signposted to various opportunities to be regularly active. In addition, physical activity plays a key role in various clinical pathways such as Diabetes, Heart Disease, COPD and Cancer. Physical activity is also highlighted in the **Sustainability and Transformation Plan (STP)** as a key means to prevent and treat various long-term conditions, and STP work at BOB (Bucks, Berks and Oxon) level will explore opportunities to work together to increase activity levels

- Health walks through **Simply Walk** continue to expand with 80 individual weekly walks taking place across Bucks – including a range of new, short walks developed as part of the Active Bucks programme. The project has received accreditation through the national Walking for Health initiative

- An Expression of Interest has been submitted to Sport England as part of their Active Ageing Fund. If successful, a 3-year project will be developed that enables testing of approaches to engage residents at point of retirement, or

have retired within last 5 years. Tiered support (digital/phone/face to face) will be offered to those who are inactive to support them into a sustained active lifestyle

- Supported by the BCC Quality in Care Team, staff from 19 residential care homes have received training to deliver regular **Chair-Based Exercise** to their residents. Early indicators show improvements in functional ability as a result of taking part

Next Steps:

- New Active Bucks commissioned activities will be delivered up until September 2017, including traditional activities such as Beginners Jogging, Children and Young People's Team Sports/Dance and Adult Gentle Exercise; as well as 'stealth' activities such as Bush Craft, Dog Agility, Quidditch and NERF Games
- Ensure take up of Physical Literacy training with local early years and primary schools
- Continue to deliver and evaluate the Primary School Daily Mile and School Travel Zone projects with local secondary schools
- Continue to deliver and evaluate the Girls Active project with local secondary schools
- Continue to deliver and evaluate Chair-Based Exercise project with residential care homes
- If successful, fully develop inactive older adult project utilising Sport England Active Ageing funding
- Support delivery of BOB-level STP workshop for physical activity
- Working closely with the Physical Activity Strategy Group, work will take place this calendar year to develop a new Strategy that highlights need within Bucks, as well as identifies priorities and recommendations for action. A final draft will be ready to share with members of the Health and Wellbeing Board in early 2018

Recommendation for the Health and Wellbeing Board:

1. Continue to support promotion of the Active Bucks website using all available communication channels to staff and residents
2. Continue to share any physical activity good practice, or project ideas, with Tom Burton to ensure sharing across wider networks and local support provided
3. Support development and provide approval for the new Physical Activity Strategy ready for April 2018

Tom Burton
Public Health Practitioner (Advanced)
tburton@buckscc.gov.uk

Health & Wellbeing Board
Buckinghamshire

Title	Proposal for refresh of 2018 Pharmaceutical Needs Assessment
Date	9th March 2017
Report of:	Dr Jane O'Grady
Lead contacts:	Dr Emily Youngman

Purpose of this report:

This report presents the proposal for refreshing the 2018 Pharmaceutical Needs Assessment for approval by the Health and Wellbeing Board.

Summary of main issues:

The Health and Social Care Act 2012 gave Health and Wellbeing Boards the statutory duty to develop and publish Pharmaceutical Needs Assessments (PNAs) for their areas by 1st April 2015. Buckinghamshire Health and Wellbeing Board published their PNA in March 2015. Health and Wellbeing Boards are required to publish a revised assessment within three years of publication of their first assessment; **by end March 2018**.

Requirements for PNAs are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013[1]. These cover the minimum information to be included, the matters which must be considered, and the process to be followed. This process includes formal consultation with specific stakeholders for a minimum of 60 days.

The PNA is a key commissioning tool to ensure that local areas have high quality pharmaceutical services that meet local needs. The PNA sets out the community pharmaceutical services that are currently provided and gives recommendations to address any identified gaps, taking into account future needs. It supports the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers. The PNA will inform commissioning decisions by local authorities, NHS England and clinical commissioning groups[2]. The PNA is also a key document used in decisions around applications to open new and close pharmacy premises.

Buckinghamshire needs a thorough and robust PNA that complies with the regulations and follows due process. This will ensure that community pharmacy services are provided in the right place and that commissioned services meet the needs of local communities. This PNA update needs to be presented to the Health and Wellbeing Board by March 2018.

[1] http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf
[2] https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

It is proposed that a steering group is established to complete the 2018 PNA. The proposed membership of the steering group is:

- Jane Butterworth - Associate Director Medicines Management and Long Term Conditions, CCG
- Emily Youngman – Consultant in Public Health Medicine, Buckinghamshire County Council
- Clinical Director Medicines Management, CCG
- Buckinghamshire Local Medicines Committee representative
- Buckinghamshire Local Pharmaceutical Committee representative
- Buckinghamshire Local Pharmaceutical Committee representative
- NHS England Thames Valley Area Team representative
- Local Pharmaceutical Network representative
- Healthwatch Bucks representative

Recommendation for the Health and Wellbeing Board:

1. Note and approve the process for carrying out a fit for purpose pharmaceutical needs assessment for Buckinghamshire as set out in this paper.
2. Consider a progress report on this work in September 2017.

Background documents:

The 2015 PNA is available to view here:
https://www.buckscc.gov.uk/services/health-and-wellbeing/pharmaceutical-needs-assessment/