Agenda

Health & Wellbeing Board Buckinghamshire

Date: Thursday 6 December 2018

Time: 10.00 am

Venue: Mezzanine Rooms 1 & 2 - County Hall, Aylesbury

9.30 am Pre-meeting Discussion

This session is for members of the Committee only.

10.00 am Formal Meeting Begins

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Agenda Item		Time	Page No
1	**WELCOME & APOLOGIES**		
2	**ANNOUNCEMENTS FROM THE CHAIRMAN**		
3	**DECLARATIONS OF INTEREST**		

4	**MINUTES OF THE MEETING HELD ON 27 SEPTEMBER 2018** To confirm the minutes of the meeting held on 27 September 2018.	**5 - 12**
5	**PUBLIC QUESTIONS**	
6	**BUCKINGHAMSHIRE JOINT HEALTH AND WELLBEING BOARD PERFORMANCE DASHBOARD ANALYSIS REPORT - PRIORITY AREA 4 (PROTECT FROM HARM)** To be presented by Dr T Burch, Public Health Consultant.	**13 - 34**
7	**BUCKINGHAMSHIRE JOINT HEALTH AND WELLBEING BOARD PERFORMANCE DASHBOARD - PROPOSAL FOR FEWER INDICATORS** To be presented by Dr J O'Grady, Director of Public Health.	**35 - 38**
8	**CHILDREN AND YOUNG PEOPLE UPDATE** To be presented by Mr T Vouyioukas, Executive Director, Children's Services.	**39 - 42**
9	**UPDATE ON HEALTH AND CARE SYSTEM PLANNING** • Briefing on whole system winter planning – to be presented by Ms D Richards, Director, Commissioning and Delivery. • Update on cancer alliance work – to be presented by Ms J Ricketts, Divisional Director, Division of Surgery and Critical Care. • Update on the Better Care Fund – to be presented by Ms J Bowie, Service Director, Integrated Commissioning and Ms D Richards, Director, Commissioning and Delivery.	**43 - 152**
10	**TIME TO CHANGE MENTAL HEALTH STIGMA ORGANIC HUB** To be presented by Ms R Hitch, Public Health Principal.	**153 - 158**
11	**CONTRIBUTIONS (BOTH BCC AND PARTNERS) TO THE DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT (DPHAR)** To be presented by Dr J O'Grady, Director of Public Health.	**159 - 186**
12	**QUALITY IN CARE TEAM ANNUAL REPORT** To be presented by Ms J Bowie, Service Director, Integrated Commissioning.	**187 - 202**

13	**BUCKS SAFEGUARDING ADULTS BOARD ANNUAL REPORT** To be presented by Ms M Seaton, Independent Chair, Buckinghamshire Safeguarding Adults Board.	**203 - 206**
14	**HEALTH AND WELLBEING WORK PROGRAMME** To be presented by Mrs S Khan, Business Manager Public Health and Communities, Health & Adult Social Care.	**207 - 208**
15	**DATE OF NEXT MEETING** Thursday 28 March 2019 in Mezzanine Rooms 1 and 2, County Hall, Aylesbury.	

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For further information please contact: Sally Taylor on 01296 531024, email: staylor@buckscc.gov.uk

Members

Dr R Bajwa (Clinical Chair, Buckinghamshire CCG), Ms J Baker OBE (Healthwatch Bucks), Mr S Bell (Chief Executive, Oxford Health NHS), Mrs I Darby (Chiltern District Council), Lin Hazell (Buckinghamshire County Council), Dr G Jackson (Clinical Lead, Buckinghamshire ICS), Mr N Macdonald (Chief Executive, Buckinghamshire Healthcare NHS Trust), Ms A Macpherson (District Council Representative), Mr R Majilton (Deputy Chief Officer, Buckinghamshire CCG), Mr N Naylor (South Bucks District Council), Dr J O'Grady (Director of Public Health), Ms L Patten (Chief Officer, Buckinghamshire CCG), Mr G Peart (Wycombe District Council), Ms G Quinton (Buckinghamshire County Council), Dr S Roberts (Clinical Director for Mental Health, Buckinghamshire CCG), Dr J Sutton (Clinical Director for Children's Services, Buckinghamshire CCG), Mr M Tett (Buckinghamshire County Council) (C), Mr T Vouyioukas (Buckinghamshire County Council), Dr K West (Clinical Director for Integrated Care, Buckinghamshire CCG) (VC), Mr W Whyte (Buckinghamshire County Council) and Ms K Wood (Wycombe District Council)

Minutes

Health & Wellbeing Board Buckinghamshire

MINUTES OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY 27 SEPTEMBER 2018, IN MEZZANINE ROOM 1 - COUNTY HALL, AYLESBURY, COMMENCING AT 10.04 AM AND CONCLUDING AT 12.23 PM.

MEMBERS PRESENT

Dr R Bajwa (Clinical Chair, Buckinghamshire CCG), Ms J Baker OBE (Healthwatch Bucks), Mrs I Darby (Chiltern District Council), Lin Hazell (Buckinghamshire County Council), Dr G Jackson (Clinical Lead, Buckinghamshire ICS), Mr N Macdonald (Chief Executive, Buckinghamshire Healthcare NHS Trust), Mr R Majilton (Deputy Chief Officer, Buckinghamshire CCG), Mr N Naylor (South Bucks District Council), Dr J O'Grady (Director of Public Health), Ms L Patten (Chief Officer, Buckinghamshire CCG), Mr G Peart (Wycombe District Council), Ms G Quinton (Buckinghamshire County Council), Dr S Roberts (Clinical Director for Mental Health, Buckinghamshire CCG), Dr J Sutton (Clinical Director for Children's Services, Buckinghamshire CCG), Mr T Vouyioukas (Buckinghamshire County Council), Dr K West (Clinical Director for Integrated Care, Buckinghamshire CCG) (Vice-Chairman) and Mr W Whyte (Buckinghamshire County Council)

OTHERS PRESENT

Jane Bowie (Service Director, Integrated Commissioning, BCC), Shakiba Habibula (Public Health Consultant), Mrs S Khan (Buckinghamshire County Council) and Ms S Taylor (Secretary)

1 WELCOME & APOLOGIES

Apologies had been received from Mr M Tett, Mrs A Macpherson, Mr M Winn and Ms L Watson.

2 ANNOUNCEMENTS FROM THE CHAIRMAN

There were no announcements from the Chairman.

3 DECLARATIONS OF INTEREST

There were no declarations of interest.

4 MINUTES OF THE MEETING HELD ON 3 MAY 2018

The minutes and actions from the meeting held on 3 May 2018 were reviewed and the following actions had been completed:

- The CCG representatives had been confirmed by Mr R Bajwa.
- Indicator 48 – Excess under 75 mortality rates in adults with serious mental illness was on the work programme for the December 2018 meeting.
- The briefing note on Female Genital Mutilation had been circulated to the Board.

RESOLVED: The minutes of the meeting held on 3 May 2018 were AGREED as an accurate record and were signed by the Chairman.

5 PUBLIC QUESTIONS

A public question had been received since the last meeting which had been responded to by the Chairman, Mr M Tett.

6 BUCKINGHAMSHIRE JOINT HEALTH AND WELLBEING BOARD PERFORMANCE DASHBOARD ANALYSIS REPORT - PRIORITY AREA 5 - SUPPORTING COMMUNITIES TO ENABLE PEOPLE TO ACHIEVE THEIR POTENTIAL AND ENSURE BUCKINGHAMSHIRE IS A GREAT PLACE TO LIVE.

Dr J O'Grady, Director of Public Health, Buckinghamshire County Council stated that the paper on Priority Area 5 had been provided as it fitted well with the Director of Public Health Annual Report (DPHAR) entitled "Healthy Places, Healthy Futures" (agenda item 7). Dr O'Grady gave the following brief update on the report contained in the agenda pack:

- There were some areas where the Buckinghamshire statistics were similar or statistically worse than the national average such as the number of casualties seriously injured or killed on the roads. This figure included anyone, wherever they lived, that were killed on Buckinghamshire roads so a large inflow of traffic could result in a higher number of casualties than the national average. The report contained a fuller explanation.
- When looking at the indicators proposed a year ago there was very little up to date data so the Public Health team was looking at the robustness of the indicators and proposed bringing back an amended list to the Health and Wellbeing Board meeting on 6 December 2018; they would also look at the indicators on the ICS dashboard and harmonise where possible.

In response to questions from members the following key points were made:

- In response to a query on the demographics of the comparator groups; Dr O'Grady confirmed that they were different to the Clinical Commissioning Group (CCG) comparator groups.
- It was noted that the data for Indicator 63 - Utilisation of outdoor space for exercise/health reasons was the most up to date but there was no known reason for Oxfordshire being 50% better than Buckinghamshire. Dr O'Grady stated that Public Health would be comparing the data with at least three national indicators of physical activity.
- After discussion on the level of air pollution it was evident that members of the board supported all plans for reducing the level of air pollution.

RESOLVED: The Board NOTED the Performance Dashboard Analysis Report - Priority Area 5.

7 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT - HEALTHY PLACES, HEALTHY FUTURE

Dr J O'Grady, Director of Public Health, Buckinghamshire County Council provided a brief overview of the DPHAR and stated that it was a statutory obligation and tied in with Priority 5, Performance Dashboard Analysis Report - Supporting communities to enable people to achieve their potential and ensure Buckinghamshire is a great place to live. Dr O'Grady ran through the presentation added to the minutes and requested ideas on what the Board and

individuals could do for the environment and improve the health and wellbeing of the population.

- A member of the board recommended trying to address the issue of young people being excluded from normal activities and resulting in becoming part of a gang as they did not feel they had anywhere else to go. Ms I Darby added that she was involved in a County Council group who were looking into the number of exclusions and said that permanent exclusion was a last resort.
- Ms L Patten, Chief Officer, Buckinghamshire Healthcare Trust (BHT), stated that there was growing evidence to support integrating services to provide greater efficiencies which could be extended to include the voluntary sector; more information was needed in one place.
- It was important to understand the structure of the GP practices and enable communities to come together as a focus point with a shared infrastructure.
- A member of the board commented that many of the priorities linked to planning and questioned how decisions around planning could be influenced Dr O'Grady explained that the County Council, the District Councils and the NHS worked together and that there was a corporate working group which oversaw the planning but she thought there were opportunities to join up even more.

In summary, Dr O'Grady asked each organisation to feed back their suggestions to the next meeting of the Health and Wellbeing Board in December 2018. It was agreed that Ms Patten would respond on behalf of the ICS.

Action: Ms Patten/all

RESOLVED: The Board NOTED the report.

8 CHILDREN AND YOUNG PEOPLE UPDATE

Mr T Vouyioukas, Executive Director, Children's Services, Buckinghamshire County Council provided the following overview of the report contained in the agenda pack:

- The Children's Commissioner had completed his three month review of Children's Services and recommended that Buckinghamshire should retain control of Children's services. It was emphasised that there was still work to do and that there was no "quick fix".
- Mr Coughlan from Hampshire County Council would continue to work with the Children's services as an Improvement Adviser.
- 97% of the actions from the high level action plan produced after the Ofsted inspection had been completed.
- The management team was working hard to improve the quality of the service, in particular, the advice and guidance given to the frontline staff along with the compliance across the service.
- There were some encouraging signs of improvement in the children in need assessments.
- Progress had been made in the performance on the 20 week completion of the Education Health and Care plans.
- An Ofsted inspection was imminent on Special Education Needs and Disabilities (SEND).

In response to questions from members the following key points were made:

- In response to a question on why the caseloads were higher than they should be in specific parts of the service; Mr Vouyioukas stated that it was due in part to the change

in demographics and some of the cases had been re-worked and also the complexity of some of the cases.

RESOLVED: The Board NOTED the report.

9 UPDATE ON HEALTH AND CARE SYSTEM PLANNING

Mr R Majilton, Deputy Chief Officer, Buckinghamshire Clinical Commissioning Groups (CCG) and Ms L Patten, Chief Officer, Buckinghamshire CCGs, ran through the presentation which was circulated to the board members after the meeting.

In response to questions from members the following key points were made:

- A member of the board was impressed by the amount of work that had taken place over the last six months.
- Mr W Whyte and L Hazell stated they were unable to comment on the presentation as they had not been able to read it beforehand as it had not been included in the agenda pack. The Chairman apologised and agreed that the presentation would be circulated to the Board after the meeting. A further update would be provided at the meeting on 6 December 2018.

Action: Mrs Khan

Ms D Richards, Director of Commissioning & Delivery, CCGs and Chair of the System A&E Delivery Board and Ms J Bowie, Service Director, Joint Commissioning, Health and Adult Social Care attended the meeting to present an update on the quarter one data for the Better Care Fund (BCF) and to ask for support to:

- Confirm continued quarterly reporting from the Integrated Commissioning Executive Team (ICET) to the Health and Wellbeing Board.
- Confirm that the ICET would continue to oversee the preparation and submission of the quarterly BCF funds.

Ms Bowie ran through the presentation which was contained in the agenda pack.

Ms Richards summarised that a considerable amount of work had taken place and that there were delays across all providers, not just Bucks Healthcare Trust. When the position deteriorated in May 2017 it was partly due to the renewed focus on delayed transfers of care (DTOC) and trying to ensure consistency of reporting across all the providers. There was a spike in the figures and a new senior escalation process was put in place to resolve barriers. There was also an additional layer of escalation in place for the winter months.

In response to questions from members the following key points were made:

- A member of the board asked whether enough was being done to improve the situation with the Frimley Trust. Ms Richards stated that this was an area of focus and they were working closely with the GP practices in the south of the county and that there was now a South Bucks Interfacing Manager to improve liaison with the practices.
- Ms Richards clarified that patients waiting for a community hospital bed could be declared as a DTOC as well as a patient in a community hospital bed waiting to go home or for a care package to be put in place.

RESOLVED: The Board AGREED to confirm reporting to continue quarterly from the ICET to the Health and Wellbeing Being Board and to confirm that ICET would continue to oversee the preparation and submission of quarterly BCF returns.

10 NHS HEALTH CHECK PRESENTATION

Dr S Habibula, Consultant, Public Health, Buckinghamshire County Council provided a brief summary of the NHS health check programme in Buckinghamshire and ran through the presentation contained in the agenda pack.

In response to questions from members the following key points were made:

- A member of the board stated that the outcome data was strong and powerful and asked if we could apply the national outcome savings data to the local savings and then use the figure in a more compelling way to encourage people to participate.
- The recommendations needed to be more explicit particularly on how they would be delivered. Ms Habibula acknowledged this was a valid point and agreed to look at the data and capacity as it was important to make the programme work. The team was already working closely with the GP practices and other providers.
- Concern was expressed that two thirds of a certain age group were not attending the health checks and there was a public perception that health checks were not applicable to them.
- A member of the board asked how much was spent on administering the programme and could it be carried out by a pharmacy?
- Could health checks be carried out in the work place?
- Should more people be invited to increase the uptake?
- Should the health check programme be part of a broader prevention issue?
- Should there be a health check model within the ICS?

Dr O'Grady, Director of Public Health, explained that the NHS health check programme was a mandatory programme and that consideration had been given to pharmacies carrying out the health checks and for health checks to be held on business premises. It was confirmed that health checks had been carried out at the Buckinghamshire County Council offices but there were not many large employers in Buckinghamshire. Health checks had also been held in local mosques. Public Health wanted to work with primary care to make it a holistic approach as the health check programme was picking up a lot of people with conditions such as high blood pressure or high cholesterol who would benefit from a lifestyle change. Campaigns were targeted to the hard to reach and there was also the Prevention at Scale pilot which focussed on developing insight work on men, particularly Asian groups of men.

A member of the board felt that tackling health inequalities should be a key priority. Dr O'Grady confirmed that Public Health could provide data on health check performance by GP practice. Ms Patten suggested that the information be discussed, at cluster level, in order to see the variability in performance and facilitate peer to peer working.

Action: Public Health and Ms Patten

Communication was thought to be a problem as many people did not understand about NHS health checks. It was noted that Healthwatch England was hosting a conversation on the future of the NHS services; was there any future in looking at what the NHS health checks would look like in 10 years' time due to technological changes?
The Chairman summarised the following key messages from the discussion:

- Inequalities
- The best places for the health checks to be carried out
- How to involve the newly formed GP clusters
- Communications
- Prevention in general.

RESOLVED: The Board NOTED the report.

11 PREVENTION AT SCALE

Mrs S Preston, Principal, Public Health, Buckinghamshire County Council provided an update on the progress of the Prevention at Scale pilot following the paper which had been presented to the Health and Wellbeing Board in January 2018.

Buckinghamshire had been invited to be part of a national LGA pilot and Public Health had chosen to address the challenge of engaging and motivating residents to make lifestyle behaviour change and focussed on three areas:

- Digital innovation – in-depth user testing of the lifestyle website had been carried out.
- Behavioural insight – insight work for priority groups had been completed and work had recently commenced with the Design Council to inform the next steps for using the insight.
- Community and stakeholder engagement using a whole system approach to improve lifestyles.

There would be an event on 31 October 2018 to share the work completed so far and agree next steps. The LGA pilot would finish in November 2018, however for Buckinghamshire this would be the start of the Prevention at Scale work which would continue to be taken forwards. The Chairman agreed to Mrs Preston's request that the member organisations continued to support and participate in the Prevention at Scale pilot and resulting work within their organisations.

L Hazell asked how the pilot would move forward if the support from the LGA was coming to an end. Mrs Preston explained that the Prevention at Scale work so far had been delivered by BCC, with the LGA pilot offering access to expert support, so BCC and local stakeholders would be able to continue to move work forward themselves without needing additional support.

RESOLVED: The Board AGREED to continue to support and participate in the Prevention at Scale pilot and resulting work within their organisations.

12 INTEGRATED LIFESTYLE SERVICES

Mrs S Preston, Principal, Public Health, Buckinghamshire County Council provided the following update on the new Integrated Lifestyle Service (ILS), Live Well Stay Well:-

- The new ILS started on 1 April 2018 and was a one- stop shop for residents and referrers.
- The Service individually tailored support offered via a single point of access.
- Live Well Stay Well delivered a range of lifestyle services and also referral/signposting to other external services such as physical activity opportunities, diabetes management and alcohol reduction.
- There was an easy referral process via the website or telephone.
- Any organisation could make a referral with the consent of the person concerned, not just health and social care professionals.
- Live Well Stay Well was a new and innovative service.
- It was too early in service delivery to provide any outcome information.

- There had been 2,500 referrals in the first quarter; over half had been from GP surgeries, 40% were self-referrals and 7% were from Buckinghamshire Healthcare Trust.
- 24% of the assessments had been carried out digitally.
- A lot of continuing promotional activity was planned.

Mrs Preston asked members of the Health and Wellbeing Board to proactively promote the service.

The Chairman supported the proposal. Mrs Quinton, Executive Director, Communities, Health and Adult Social Care also added her full support and stated that it was an important and significant element of Adult Social Care.

RESOLVED: The Board NOTED the update for the Live Well Stay Well service and AGREED to help support this prevention initiative by proactively promoting and referring residents to Live Well Stay Well.

13 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) TRANSFORMATION PLAN

Dr S Roberts, Clinical Director for Mental Health, Buckinghamshire CCG, reported that the Child and Adolescent Mental Health Services (CAMHS) Transformation Plan was originally written in 2015, outlining the plans to improve access and timely care to mental health services for children in Buckinghamshire . Since 2015 there had been a short annual refresh of the Transformation Plan. This year, Buckinghamshire were preparing a full refresh of the plan, which was due for publication on 31 October 2018.

Dr Roberts highlighted the following points:

- When the new CAMHS service was recommissioned in 2015 it coincided with the transformation plan which enabled some of the actions to be implemented very quickly.
- Buckinghamshire offered a single point of access for children, health professionals, social workers, parents and teachers to access CAMHS services.
- There was a CAMHS link worker allocated to each secondary state school to link mental health and education.
- There was a new perinatal mental health service which had been awarded further funding for expansion in Oxfordshire and Buckinghamshire.
- The aim was to make sure more children were accessing the service in a timely way.
- There had been a 12% increase in access to CAMHS and 90% had been assessed within four weeks.
- Good feedback had been received from young people and families.
- The service still needed to improve access and the aim was, by 2020, a third of children with mental health problems would be seen by the CAMHS service.
- There was a need to develop the skills of parents and professionals to improve awareness of mental health and to sign post to relevant areas.
- The service was working in collaboration with BHT to meet the needs of individuals with more complex neuro-development issues.
- The service was also working with the Integrated Care System (ICS).

Dr Roberts asked the Health and Wellbeing Board review the draft plan and welcomed any feedback on further changes before submission of the plan on 31 October 2018.

In response to questions from members the following key points were made:

- A member of the board acknowledged that the website was very good and that the single point of access had made a huge difference to the young people and the professionals.
- In response to a question on how many other people there were who would benefit from accessing the service, Dr Roberts said she did not have the actual numbers to hand but assured the board that the service was meeting the access targets and stated that those who did access the service had a good outcome. Dr Roberts emphasised that this was where the Health and Wellbeing Board could help by raising awareness of mental health issues in young people, and the services that were available.
- Mr W Whyte raised concern over the waiting times for an assessment and said that he had received feedback from parents and GPs that an average waiting time was more than three months. Mr Whyte asked how the children and young people accessing the service were prioritised. Dr Roberts said 90% of children accessing the CAMHS service received an assessment within 4 weeks, and prioritised according to clinical need. Dr Roberts would ask CAMHS to provide further clarification of the figures to Mr Whyte.

Action: Dr Roberts

- Mrs G Quinton noted that the report said transitions would start at 17.5 years old and asked whether this should start earlier. Dr Roberts agreed to feedback this suggestion for further consideration.

Action: Dr Roberts

- In response to a question on whether the priorities included user related outcomes; Dr Roberts stated that the service had robust outcomes but she would feedback that the board suggests use of user related outcome measures.
- A member of the Board asked how well developed the ability was to assess the impact of the service and the changes that would occur as part of the refresh. Dr Roberts explained that it could be difficult to measure improvements in mental wellbeing and therefore patient feedback was important and was actively collated.

RESOLVED: The Board NOTED the report.

14 HEALTH AND WELLBEING BOARD WORK PROGRAMME

Mrs S Khan, Business Manager, Public Health, Buckinghamshire County Council apologised for the work programme not being included in the agenda pack and advised it would be appended to these minutes. Mrs Khan stated that there was already a very full agenda for the meeting on 6 December 2018 and would therefore circulate the draft agenda to the members of the board to ask which items were time sensitive. Mrs Khan proposed that the ICS item be discussed at the agenda planning meeting along with the frequency of the Board meetings.

15 DATE OF NEXT MEETING

6 December 2018 in Mezzanine Room 1, County Hall, Aylesbury at 10.00 am.

CHAIRMAN

Health & Wellbeing Board
Buckinghamshire

Title	Health and Wellbeing Board Performance Dashboard Analysis Report: Priority Area 4 Indicators
Date	6 December 2018
Report of:	Dr Jane O'Grady, Director of Public Health

Purpose of this report:

Information and commentary on the **Priority Area 4 (Protect residents from harm)** indicators for the Buckinghamshire Health and Wellbeing Board Performance Dashboard are included in this report.

Appendix 1 provides the most recent benchmarked data published on the Public Health England website. Data for Buckinghamshire are presented with trends and comparisons to statistical neighbours, England and the South East region.

For indicators that are now out of date on PHE's Fingertips, additional data were extracted from other relevant bodies. These are unable to be benchmarked and RAG rated.

Summary of the issue:

Health and wellbeing outcomes are closely linked to measures of deprivation. Buckinghamshire is the 2nd least deprived County Council and the 5th least deprived Local Authority in England. As a consequence, health and wellbeing outcomes within Buckinghamshire would be expected to be better than the England average.

To help identify opportunities to further improve Buckinghamshire's health and wellbeing, Appendix 1 also includes commentary for indicators that are similar to or worse than the England average.

For priority area 4, these are:

- 51 Children who are the subject of a child protection plan (per 10,000)
- 56 Adults with learning disability who live in stable and appropriate accommodation
- 58 Total delayed transfers of care
- 59 Proportion of older people (65 and over) still living at home 91 days after discharge from hospital (%)
- 60 Proportion of people who use services who say they've made them feel safe and secure (%)

Recommendations for the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

- Note the analysis for and performance against the indicators for Priority 4.

- Propose any further action(s) required based on the data presented.
- Consider how the Board can contribute to improving system performance.

Health & Wellbeing Board Buckinghamshire

Appendix 1. Benchmarking of Health and Wellbeing Board Performance Dashboard Indicators 50-62

How to interpret the indicators:

For each indicator, local data are compared to England data.

- Where Buckinghamshire (Bucks) data are statistically significantly better than the England average, the indicator is highlighted green.
- Where Bucks data are not statistically different to the England average, the indicator is highlighted amber.
- Where Bucks data are statistically significantly worse than the England average, the indicator is highlighted red.
- Where Bucks data are statistically significantly higher than the England average but there is no judgement as to whether this constitutes being better or worse, the indicator is highlighted light blue. These indicators require interpretation and local context.
- Where Bucks data are statistically significantly lower than the England average but there is no judgement as to whether this constitutes being better or worse, the indicator is highlighted dark blue. These indicators require interpretation and local context.

The time series in Buckinghamshire is provided for each indicator and compared with time series for England and the South East.

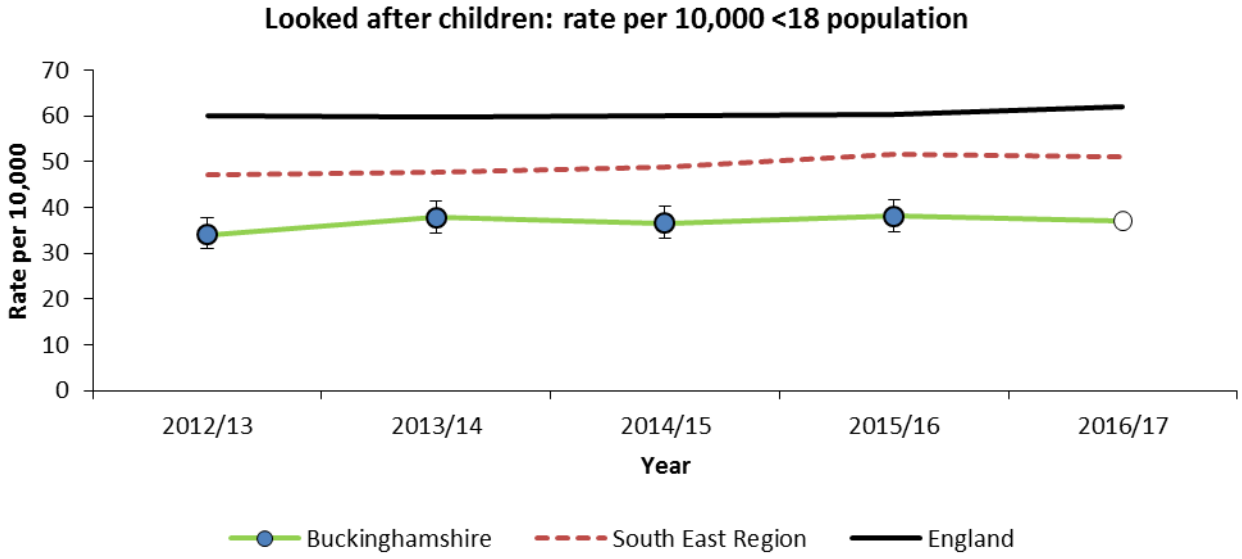
Comparison of the most recent data for Buckinghamshire that can be benchmarked is made with a set of 15 similar local authorities, identified by the Chartered Institute of Public Finance and Accountability (CIPFA). Buckinghamshire's CIPFA peers are:

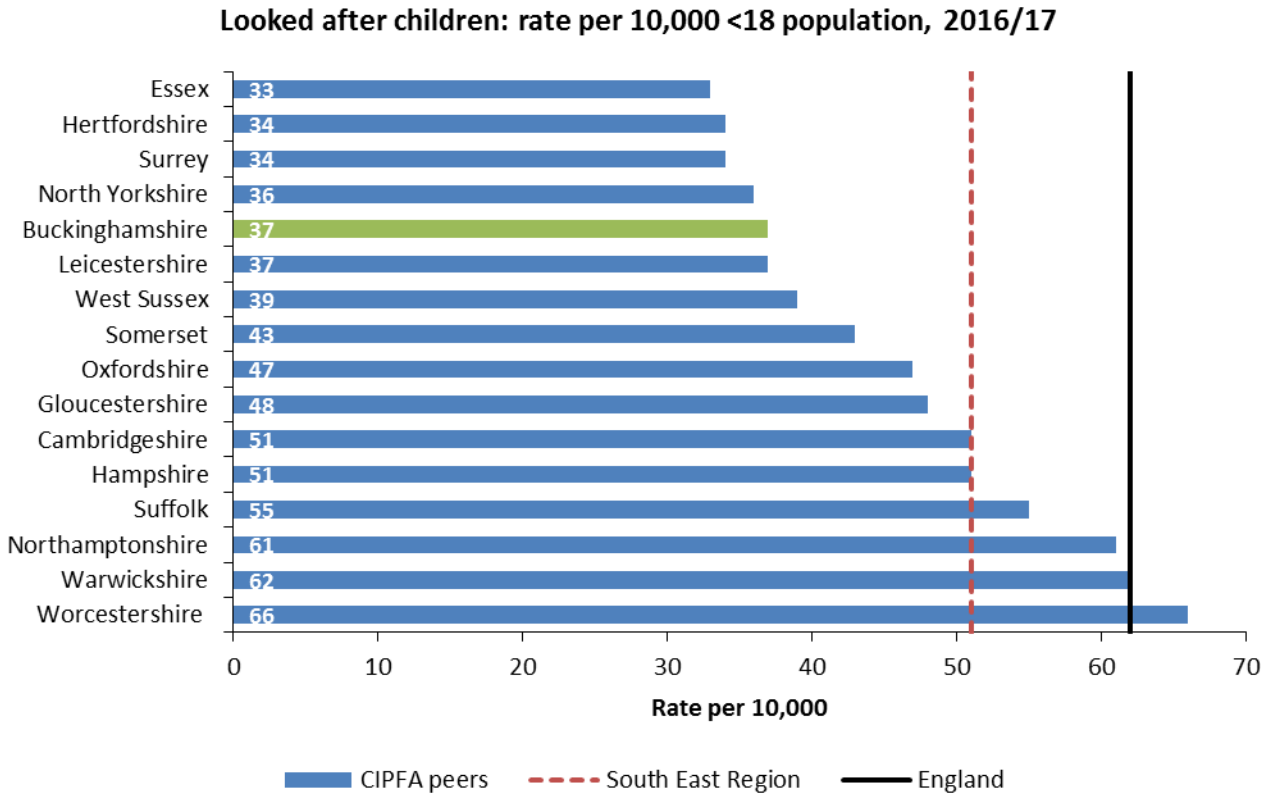
- Cambridgeshire
- Essex
- Gloucestershire
- Hampshire
- Hertfordshire
- Northamptonshire
- North Yorkshire
- Leicestershire
- Oxfordshire
- Somerset
- Suffolk
- Surrey
- Warwickshire
- West Sussex
- Worcestershire

Priority 4. Protect residents from harm

Indicator 50. Looked after children (per 10,000) – NOT RAG RATED
Number of children looked after on 31st March per 10,000 population aged under 18 years.

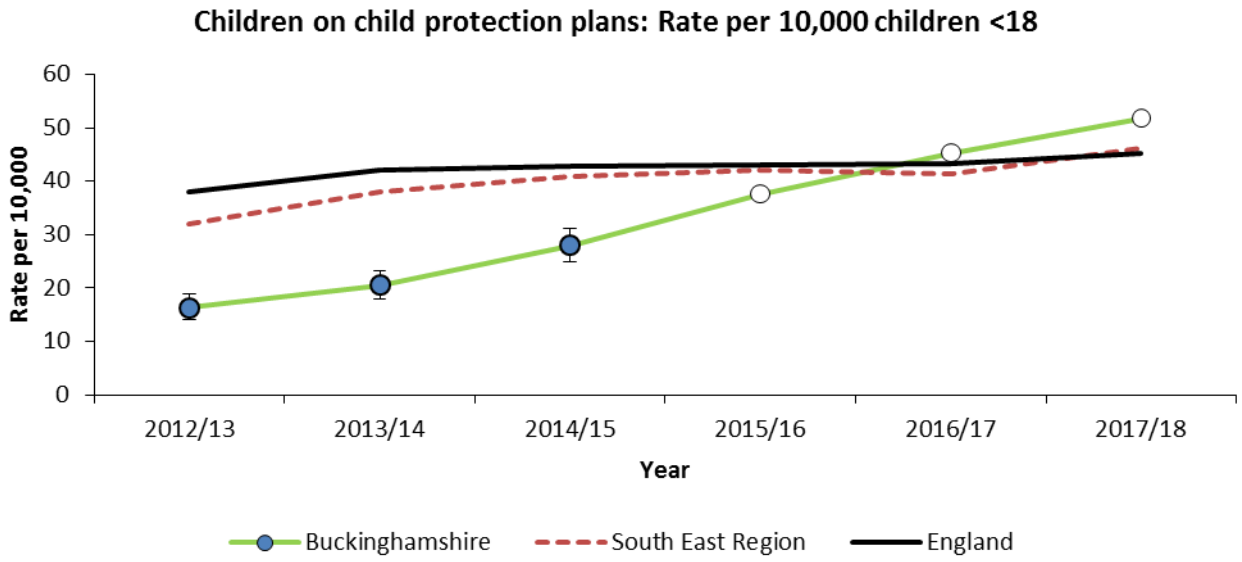
In 2016/17, there were 454 children in care in Bucks. This gave a rate per 10,000 children aged under 18 years of 37, which was better than the rate for England (62). The rate in the South East was 51. Bucks had the 5th lowest rate among its CIPFA peers.

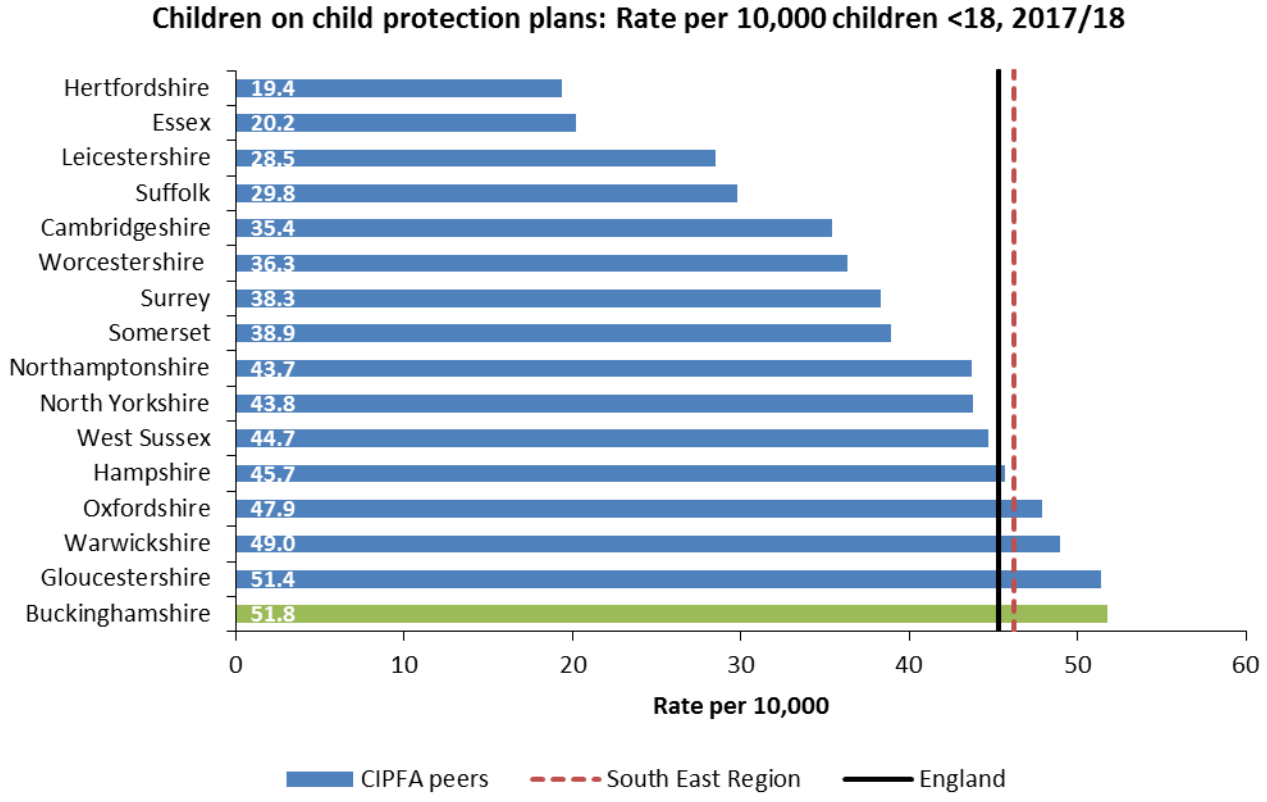




Indicator 51. Children who are the subject of a child protection plan (per 10,000) – NOT RAG RATED
The number of children who are the subject of a child protection plan at the end of the year (31st March), expressed as a rate per 10,000 children aged 0-17 years.

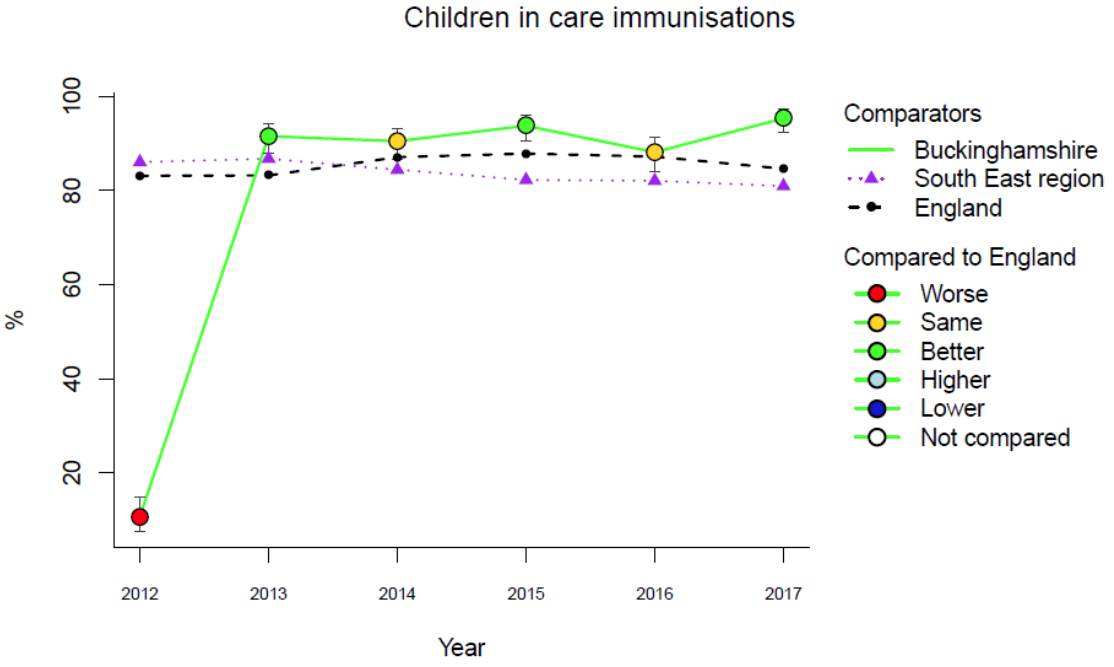
In 2017/18, there were 51.8 children per 10,000 (corresponding to 553 children in Bucks) who were the subject of a child protection plan. The rate in Bucks was higher than England (45.3). The rate in the South East was 46.2. Bucks had the highest rate among its CIPFA peers.



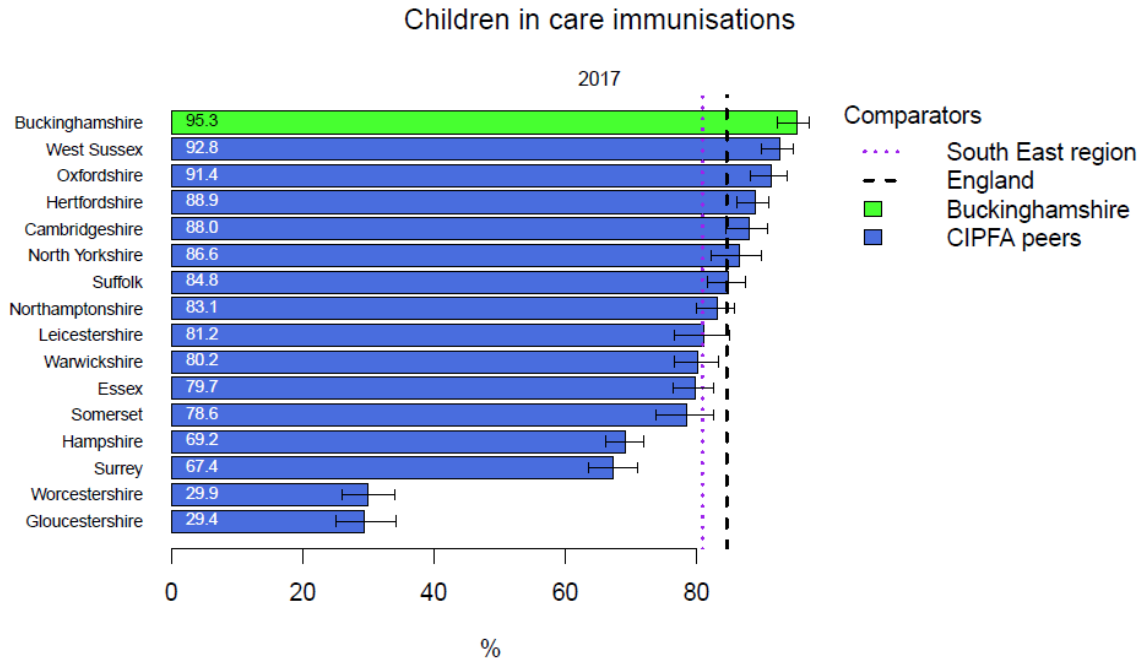


Indicator 52. Children in care immunisations (%) – GREEN (better)
Proportion of children in care for at least 12 months whose immunisations were up to date.

In 2017, 95.3% of children in care for at least 12 months were up to date with immunisations. This corresponds to 285 children. The proportion in Bucks was statistically better than the proportion in England (84.6%). The proportion in the South East was 80.9%. Bucks had the highest proportion of children in care with up to date immunisations among its CIPFA peers.



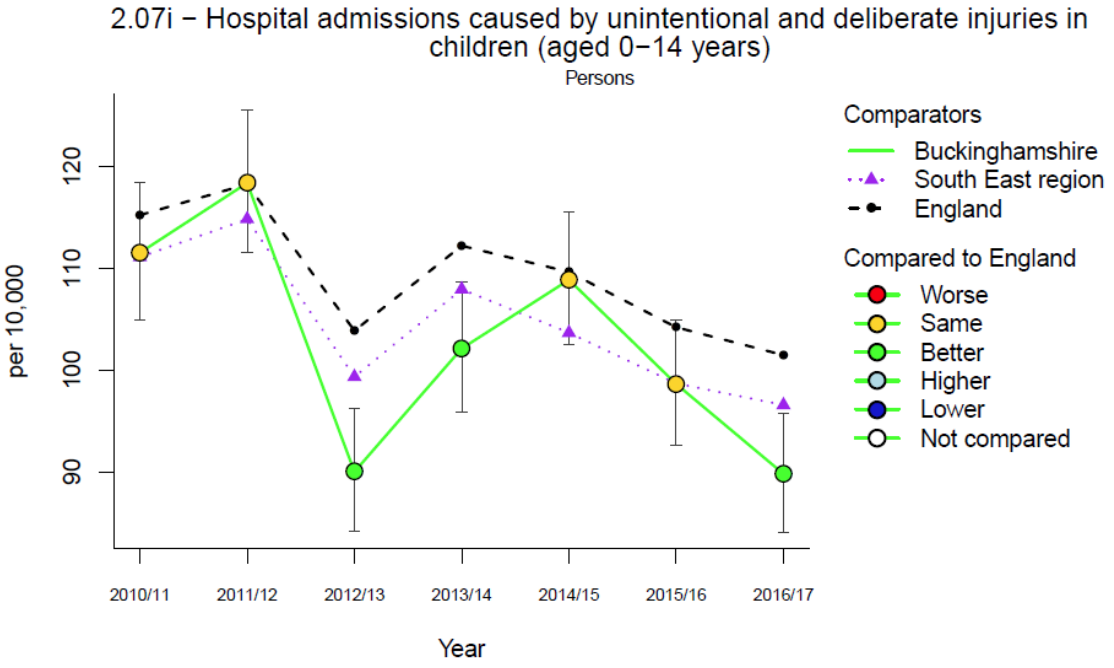
Indicator number: 811

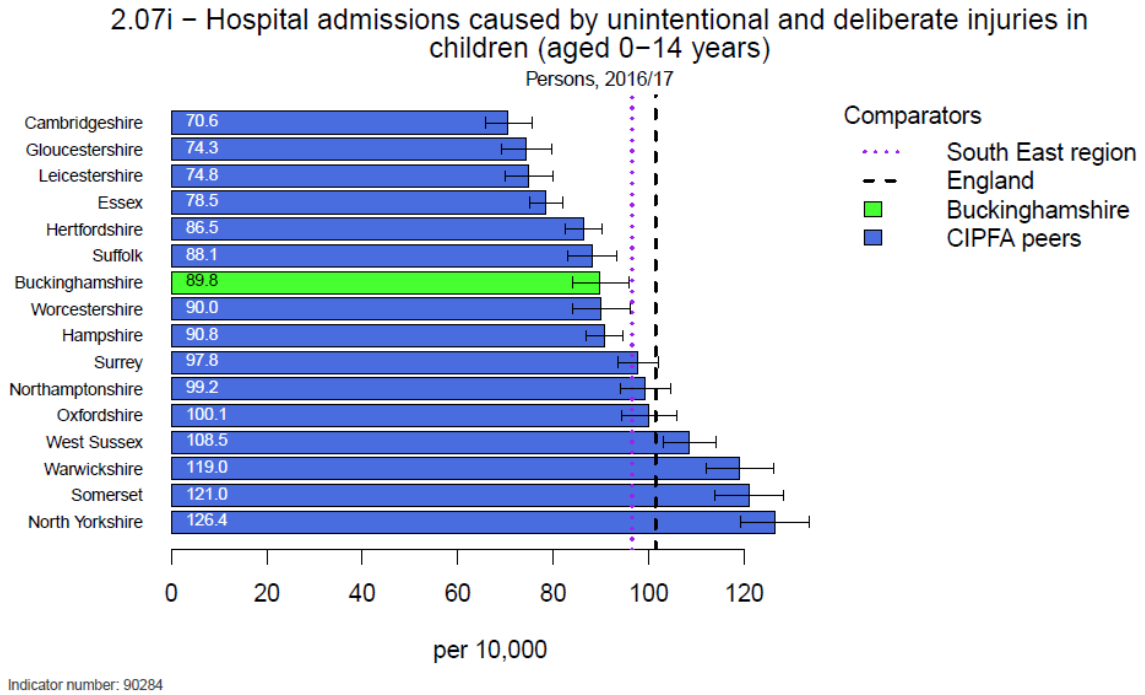


Indicator number: 811

Indicator 53. Hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years (per 10,000) – GREEN (better)
Rate of hospital admissions caused by unintentional and deliberate injuries (crude rate) in children aged under 15 years per 10,000 resident population aged under 15 years.

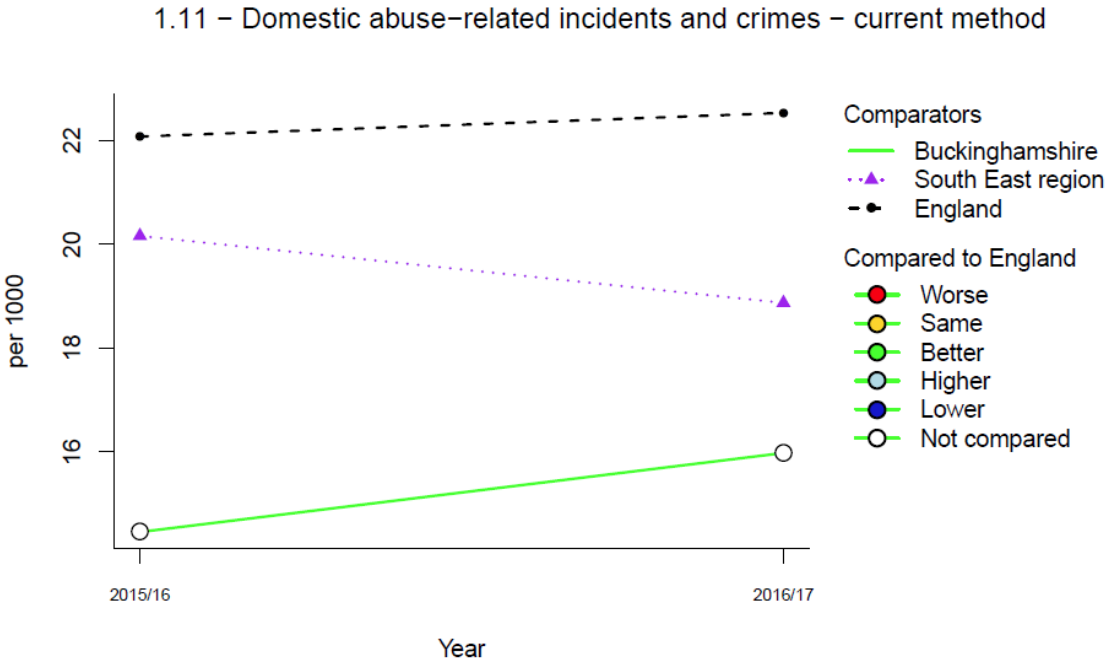
In 2016/17, there were 89.8 hospital admissions caused by unintentional and deliberate injury for every 10,000 children. This is statistically lower than the rate for England (101.5). In the South East the rate was 96.6 per 10,000. Bucks had the 7th lowest rate among its CIPFA peers.

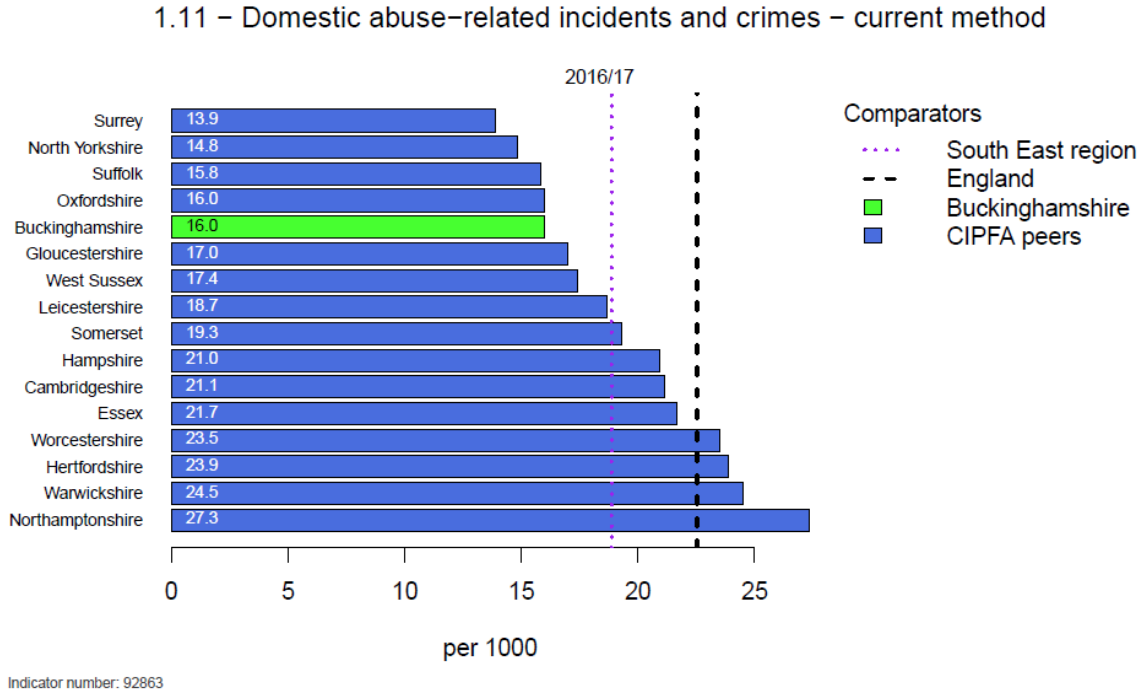




Indicator 54. Domestic abuse-related incidents and crimes (per 1,000) – NOT RAG RATED
Number of domestic abuse-related incidents and crimes recorded by the police, per 1,000 population (crude rate)

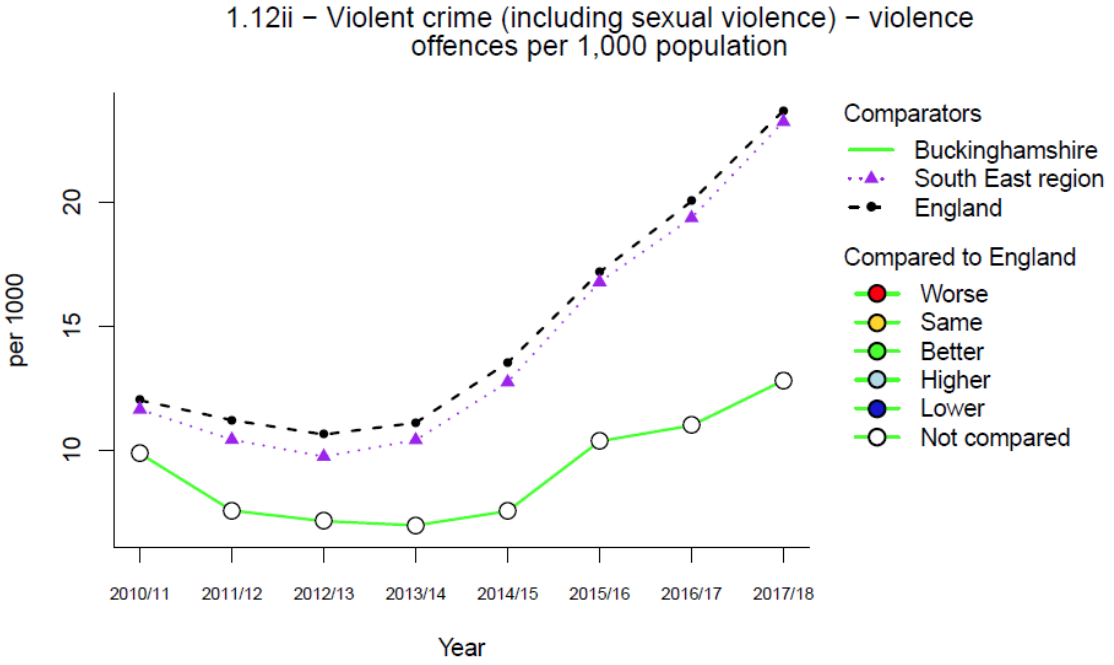
In 2016/17, there were 16.0 domestic abuse related incidents and crimes reported by the police per 1,000 adults in Bucks. This compares to a crude rate of 22.5 for England and 18.9 for the South East. Bucks had the 4th equal lowest rate among is CIPFA peers. This indicator is not RAG rated and there are no confidence intervals.



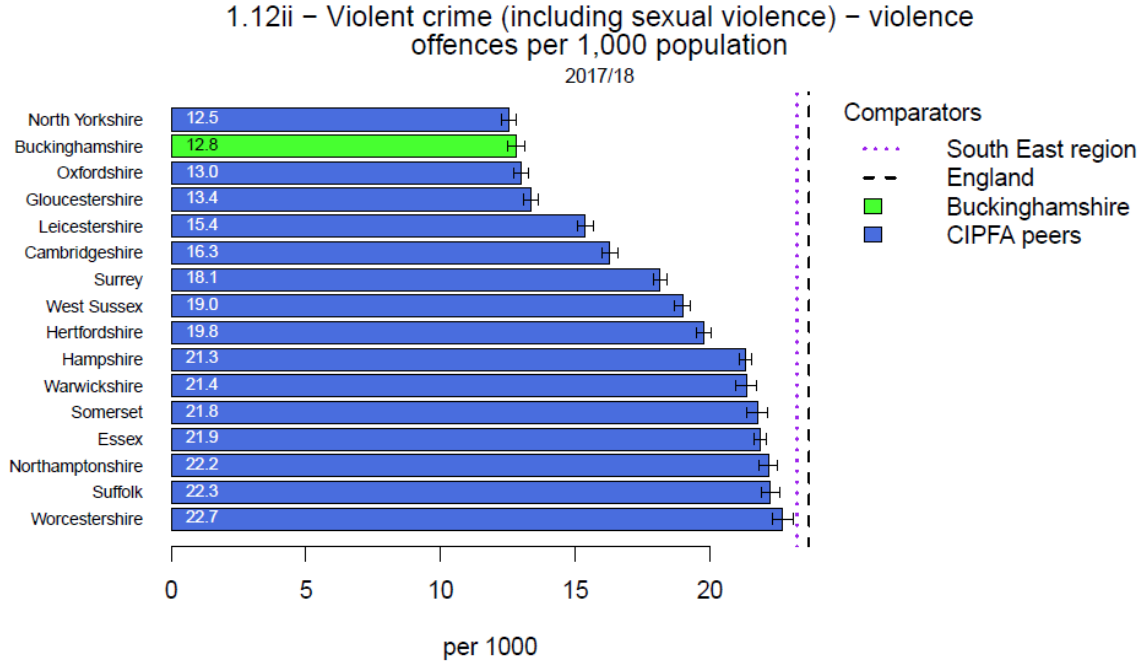


Indicator 55. Violent crime including sexual violence (per 1,000) – NOT RAG RATED
Number of offences of violence against the person recorded by the police per 1,000 population (crude rate).

In 2017/18, there were 12.8 violent crimes (including sexual violence) against the person recorded by the police for every 1,000 people (all ages). This compares to a rate of 23.7 for England and 23.2 for the South East. Bucks had the 2nd lowest rate among its CIPFA peers.



Indicator number: 11202

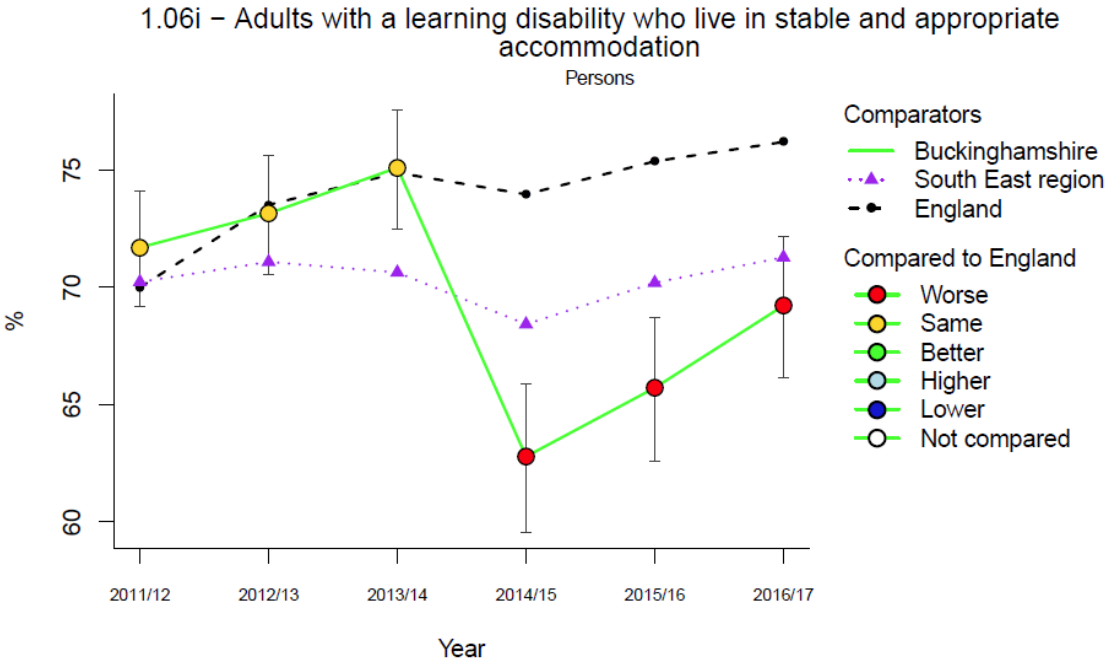


Indicator number: 11202

Indicator 56. Adults with learning disability who live in stable and appropriate accommodation (%) – RED (worse)

Number of working-age learning disability clients who are living in their own home as a percentage of all working-age learning disability clients (aged 18-64 years).

In 2016/17, the proportion of adults in Bucks with learning difficulties who live in stable and appropriate accommodation was 69.2%. This was statistically lower than the proportion in England (76.2%) and corresponds to 623 individuals in Bucks. The proportion in the South East was 71.3%. Bucks had the 5th lowest proportion among its CIPFA peers.



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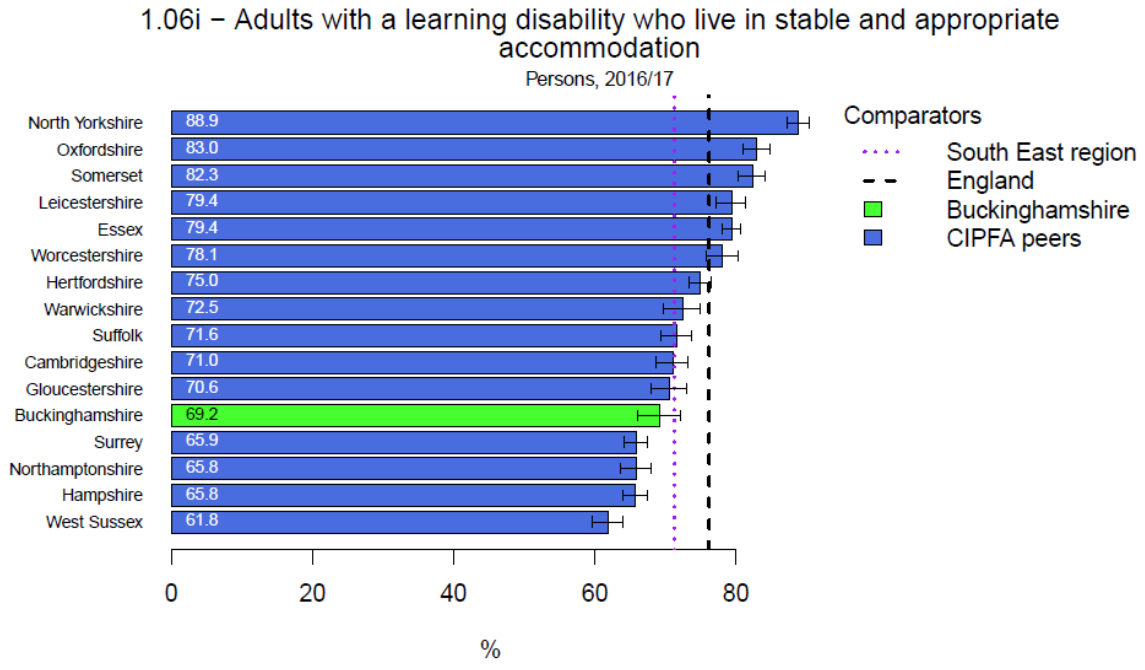
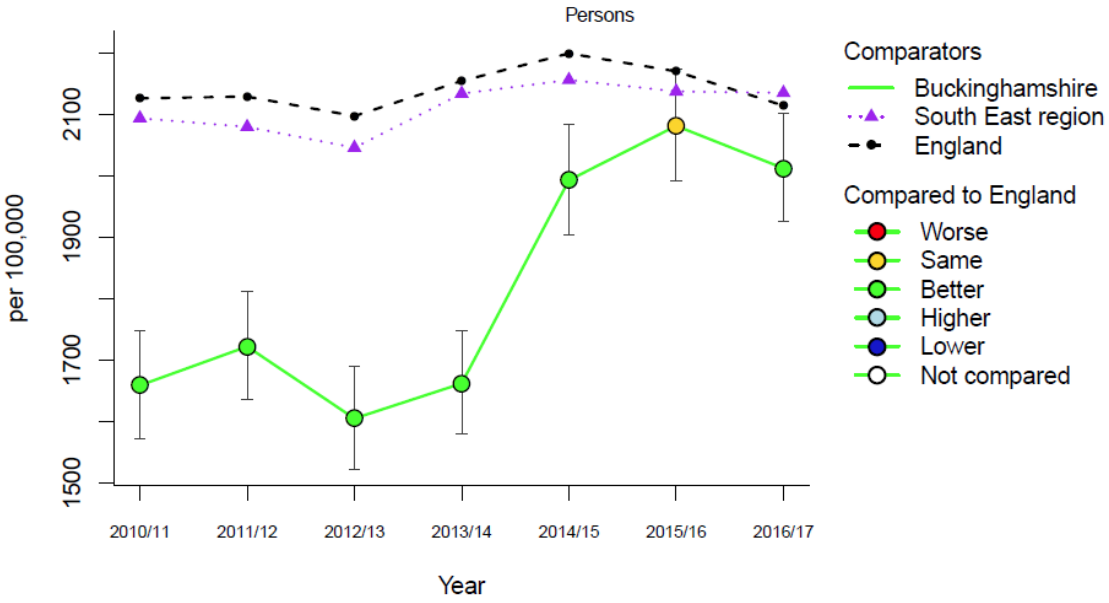


Indicator number: 10601

Indicator 57. Emergency hospital admissions due to falls in people aged 65 years and over (per 100,000) – GREEN (better)
Directly age standardised rate per 100,000 of emergency hospital admissions for falls injuries in persons aged 65 years and over.

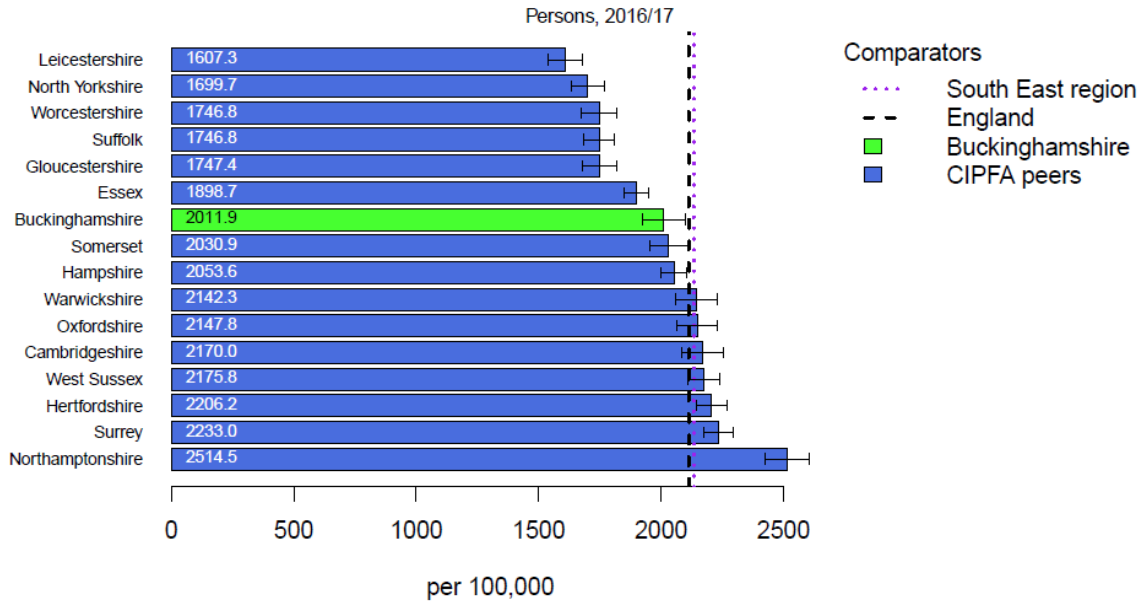
In 2016/17, the rate of emergency hospital admissions in Bucks was 2,011.9 per 100,000 people. This was statistically better than in England (2,113.8). The rate in the South East was 2,134.6 per 100,000. Bucks had the 7th lowest rate among its CIPFA peers.

2.24i − Emergency hospital admissions due to falls in people aged 65 and over



Indicator number: 22401

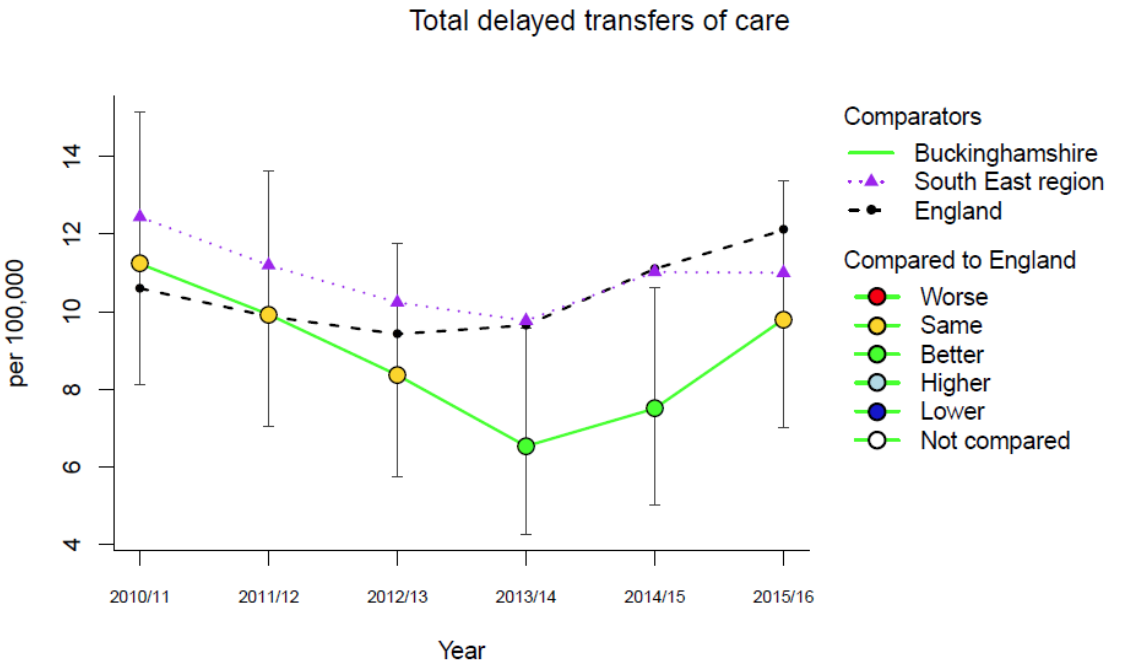
2.24i − Emergency hospital admissions due to falls in people aged 65 and over

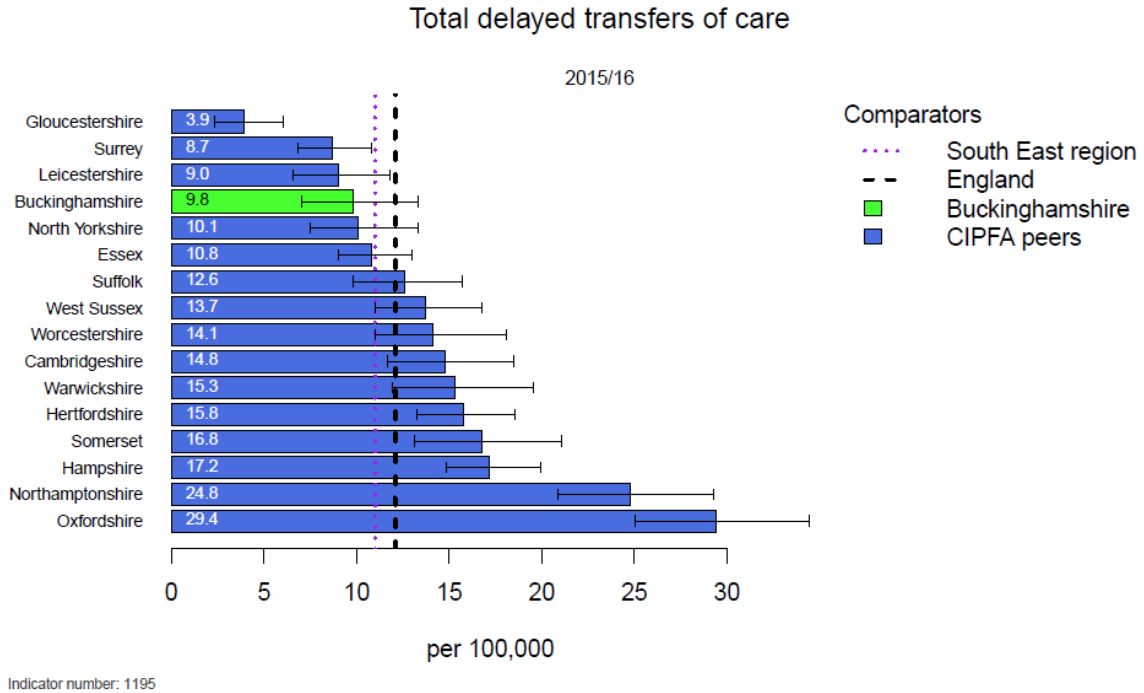


Indicator number: 22401

Indicator 58. Total delayed transfers of care (per 100,000) – AMBER (similar)
The average number of delayed transfers of care. This is the average of the 12 monthly snapshots collected in the monthly Situation Report for acute and non-acute per 100,000 population aged 18+ years.

In 2015/16, the average rate for delayed transferred of care in Bucks was 9.8 per 100,000. This was not statistically different to the England rate of 12.1. The rate in the South East was 11.0. Bucks had the 4th lowest rate among its CIPFA peers.

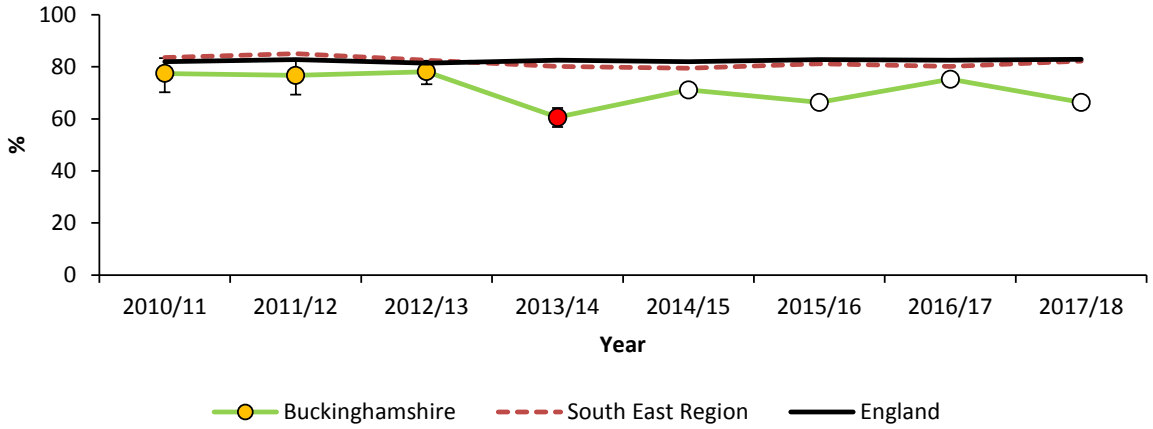




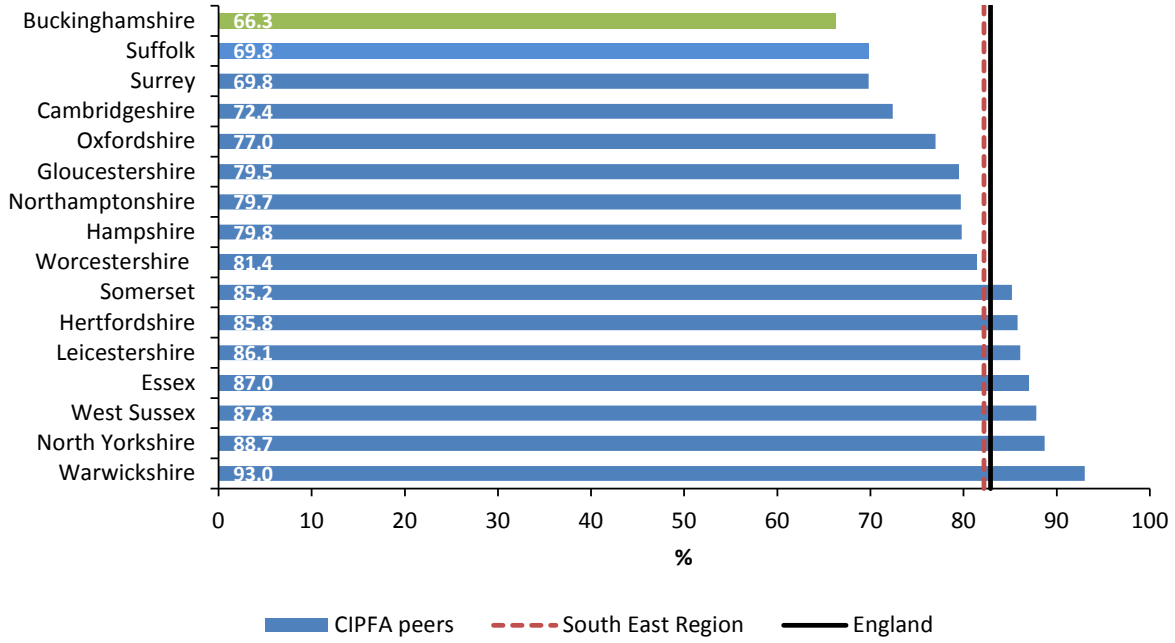
Indicator 59. Proportion of older people (65+ years) who were still at home 91 days after discharge from hospital (%) – NOT RAG RATED
Number of people aged 65 years and over discharged from hospital who are living in their own homes at day 91 post-discharge as a proportion of all discharges from hospital among people aged 65 years and over.

In 2017/18, the proportion (66.3%) of people in Bucks who were still at home 91 days after discharge was lower than in England (82.9%). This corresponds to 266 individuals. Bucks had the lowest proportion among its CIPFA peers.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital



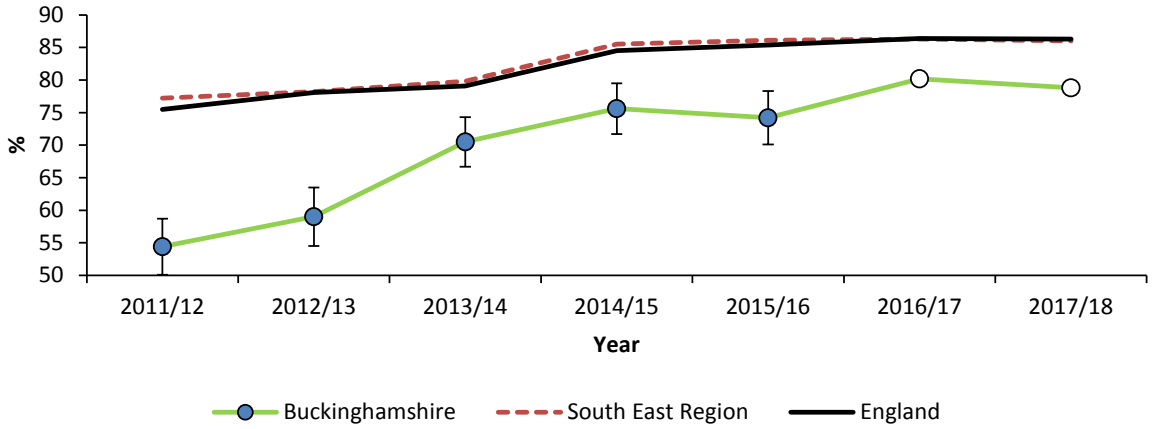
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital, 2017/18



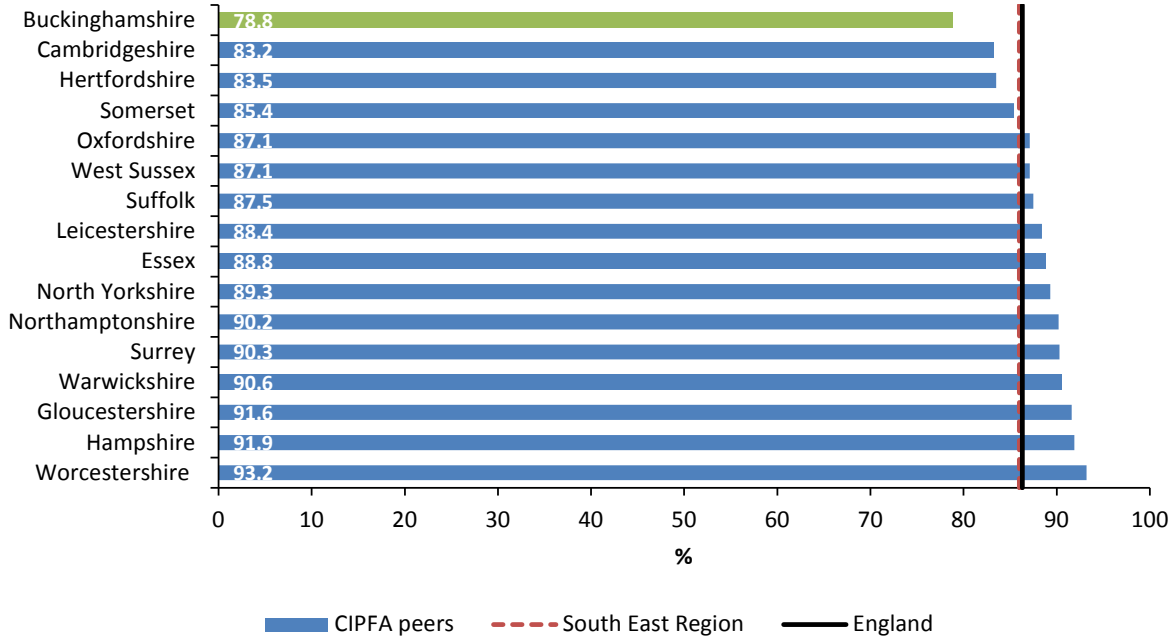
Indicator 60. Proportion of people who use services who say they've made them feel safe and secure (%) – NOT RAG RATED
The number of people responding 'Yes' to the question: "Do care and support services help you in feeling safe?" as a proportion of all respondents.

In 2017/18, the proportion (78.8%) of people in Bucks who reported that they felt safe and secure was lower than in England (86.3%). Bucks had the lowest proportion among its CIPFA peers.

Proportion of people who use services who say that those services have made them feel safe and secure

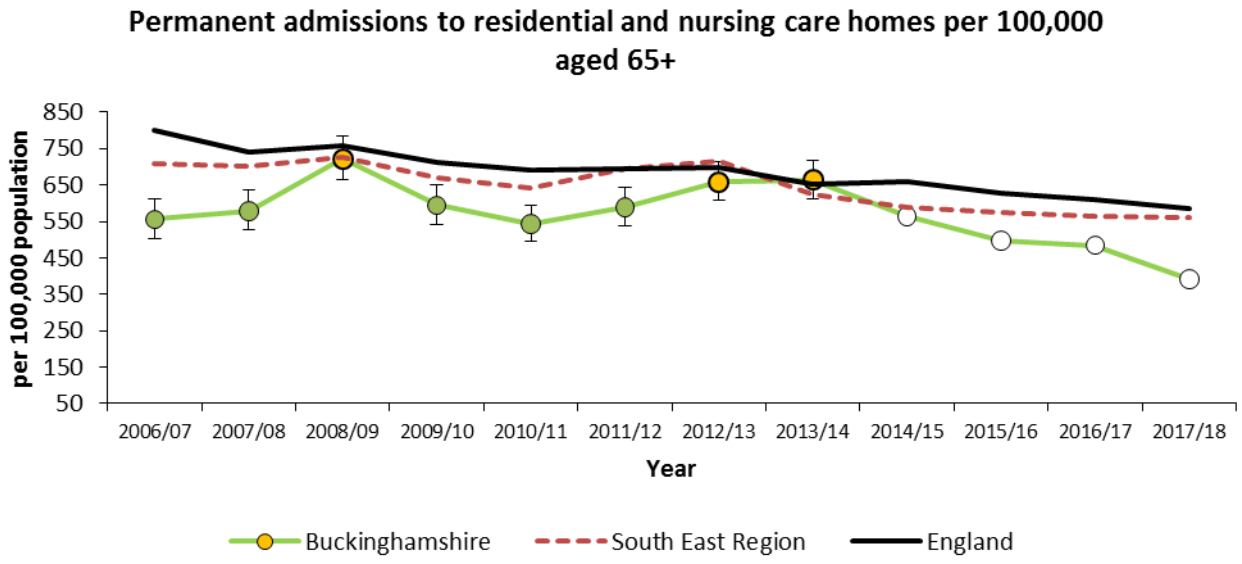


Proportion of people who use services who say that those services have made them feel safe and secure, 2017/18

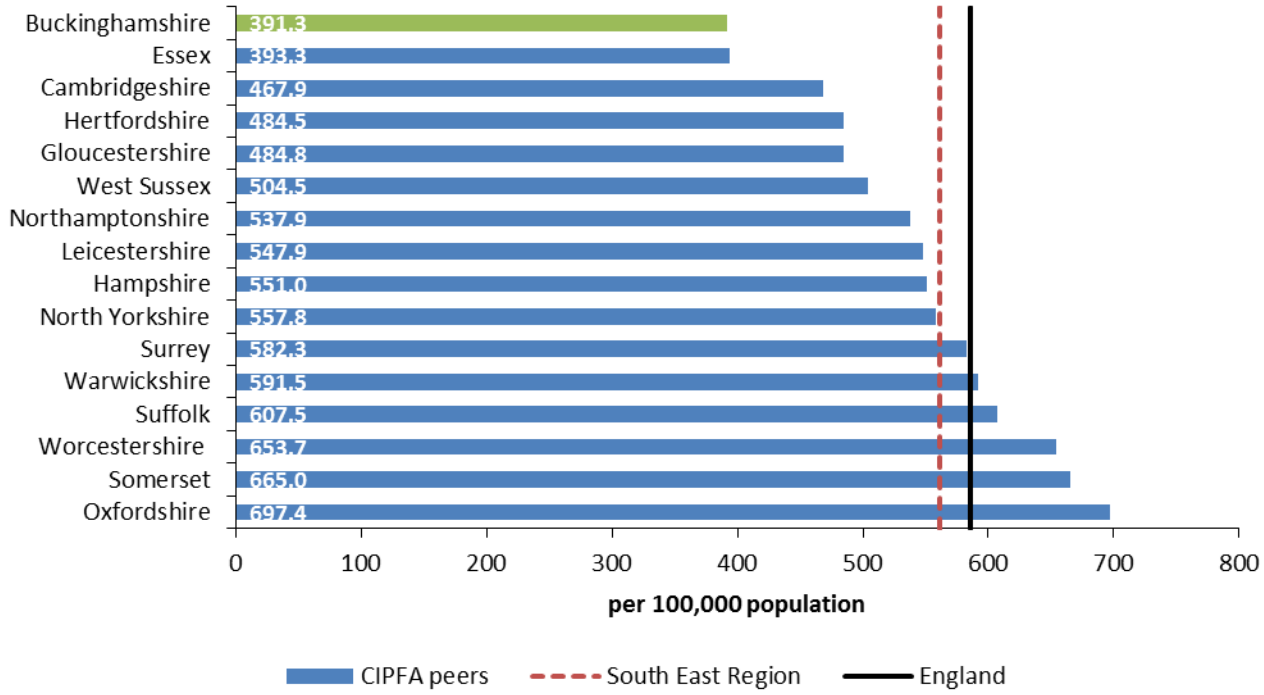


Indicator 61. Permanent admissions to residential and nursing care homes per 100,000 population aged 65 years and over – NOT RAG RATED
Number of council supported admissions of adults aged 65 years and over to residential and nursing care homes relative to the total population aged 65 years and over, expressed as a rate per 100,000.

In 2017/18, the rate (391.3 per 100,000) in Bucks of permanent admissions to residential and nursing care was lower than England (585.6 per 100,000). This corresponds to 389 individuals. Bucks had the lowest proportion among its CIPFA peers.

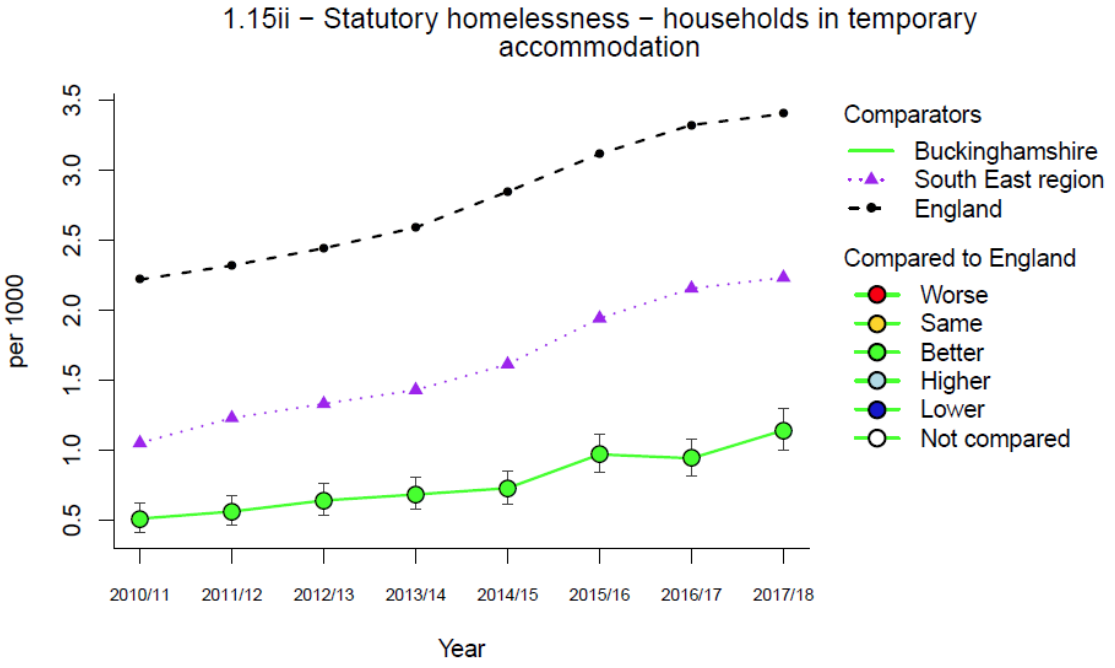


Permanent admissions to residential and nursing care homes per 100,000 aged 65+, 2017/18

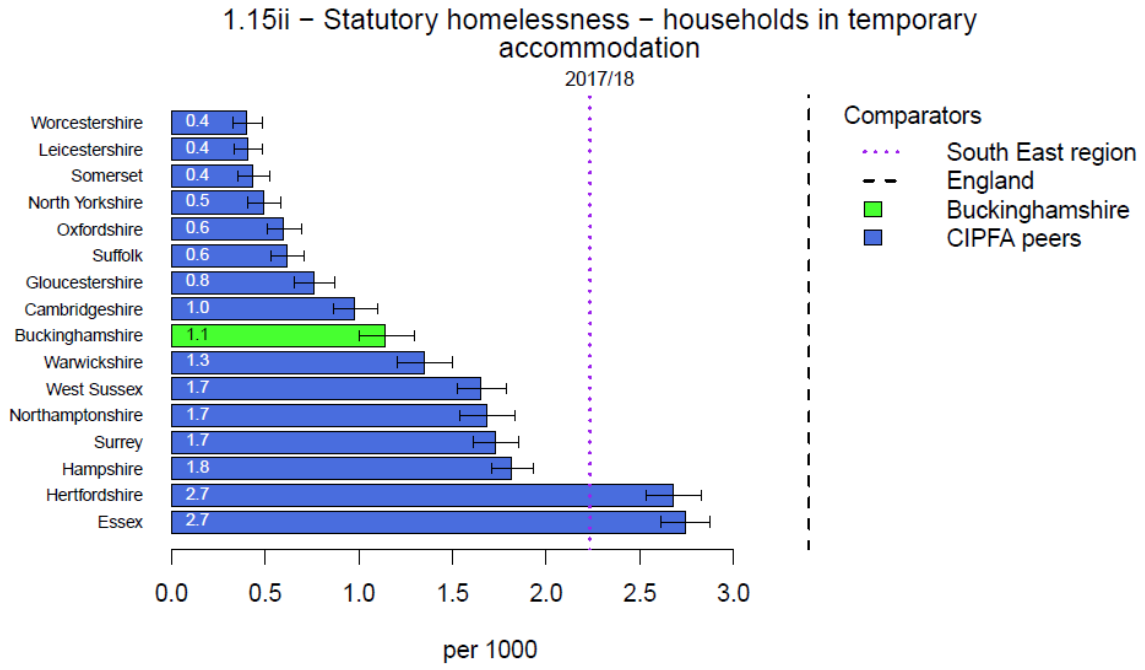


Indicator 62. Statutory homelessness – households in temporary accommodation (per 1,000) – GREEN (better)
Number of households in temporary accommodation as a crude rate per 1,000 estimated total households. This is for all ages and is a snapshot as of 31st March each year.

In 2017/18, the rate (1.1 per 1,000) in Bucks of statutory homelessness was statistically lower than England (3.4 per 1,000). This corresponds to 245 individuals. Bucks had the 9th lowest rate among its CIPFA peers.



Indicator number: 11502



Indicator number: 11502

Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board Dashboard Indicator Commentary – Review of Red and Amber Indicators and Indicators requiring interpretation

Indicator 51. Children who are the subject of a child protection plan (per 10,000)
Explanation
The latest benchmarked data by PHE are from 2014/15. It is unclear why later data for this indicator have not been benchmarked by PHE. The number of children on Child Protection Plans (CPP) has been high for quite some time and therefore the rate per 10,000 remains too high. Based on case file audits, case sampling and Beyond Auditing activities, the service believes that the number on CPP is inflated due to the following factors: • Poor quality assessments and subsequent plans that are unclear about what needs to change. • Inconsistent management oversight that does not drive forward plans and actions. • Variable performance of CP chairs in ensuring plans are SMART and child focused. • Need to improve the understanding and management of risk for children subject to CPP who may require a far more robust intervention to keep them safe.
Are more recent data available? (Please provide)
The data for years after 2014/15 are available nationally from the Department for Education, but these are not benchmarked. This means the data are not able to be RAG rated. At the end of September 2018, BCC's rate per 10,000 is 49.7 which is a slight reduction on the 51.9 reported at the end of Quarter 2. This rate is above the England, South East and statistical neighbour averages.
What work has been done?
Significant work has already started to address poor performance across the service and where new managers have been appointed there are indications of improvement. This is reflected in a slight fall in numbers of CPP, August (645) and September (607).
What work is planned?
The priority for the service is to continue to focus on the performance of first and second line managers and use the quality assurance framework (Beyond Auditing) to determine the quality of the work and the impact it has on outcomes. The main improvement action is to target the auditing of cases on CP Plans for more than 6 months to address risk and delay, and embed learning of good practice.
Can the Health and Wellbeing Board support work targeting this indicator?

Indicator 56. Adults with a learning disability who live in stable and appropriate accommodation (%)
Explanation
The latest benchmarked data from 2016/17 are an improvement from 2015/16. Since 2014/15 this indicator has seen year on year improvements. There were some data quality issues for 2016/17 that impacted on performance.
Are more recent data available? (Please provide)
Data for 2017/18 will be published soon.
What work has been done?
The data quality issues that impacted on performance in 2016/17 have been addressed. There is ongoing monitoring and exception reporting in place to ensure that any future issues are addressed in a timely manner. Work has been done with housing providers to make available suitable tenancies for people with need. 30 units have been released and appropriate referrals are being identified.
What work is planned?
Current actions planned as follows: • Continue to scrutinise placement requests in forum to ensure that the placement is the last resort with consideration of shared lives options and supported living first. • LD Head of Service has worked with commissioning and contracts to develop a specific joint Market Position Statement (MPS) on housing and accommodation to plan and access to housing options for people with needs. It is anticipated this will be signed off soon.
Can the Health and Wellbeing Board support work targeting this indicator?

Indicator 58. Total delayed transfers of care (per 100,000)
Explanation
The latest benchmarked data by PHE are from 2015/16. This definition for this indicator has now changed, so data after that time point are not included in the figures provided.
Are more recent data available? (Please provide)
Data for the new indicator definition are published monthly by NHS England. The latest available data is for April and May 2018 (year to date) which shows the Buckinghamshire rate is 14 days delayed per 100,000 population. This is slightly above the rate for our comparator group (12.8). The rate for ASC-attributable delays is 2.6.
What work has been done?
There has been considerable work completed through the Better Care Fund and High Impact Change model programmes to improve performance on delayed discharges – this work has been routinely reported to the Health and Wellbeing Board
What work is planned?
Current actions planned as follows: • The establishment of a discharge to assess (D2A) programme of support including beds, domiciliary care and 24/7 care at home. • BHT re-launch and roll out of 'get up, get dressed, get moving' at the Trust • 'Fabulous fortnight' due to commence at Stoke Mandeville hospital on 19th November for two weeks – providing the opportunity to embed good practice with system wide support and input. • The system multi-disciplinary team (MDT) action squad is being further developed to help support a reduction in long stay patients and DToCs. • Red Cross team onsite to help support the process of patient re-settlement and repatriation to home. • Daily 09:00 medically fit call with partners to discuss all patients on the medically fit list. Plans to incorporate other providers – particularly out of area. • Local DToC (and stranded and long stay patient) escalation process being rolled out. This will be based on the Oxfordshire model. • NHS Improvement (NHSI) report and recommendations to be shared. This is expected to be geared towards improving processes and improving pathways internally to maximise discharge options. • BHT is also continuing the work to ensure the choice policy is robustly implemented. • Weekly Escalation Call with senior system leaders – a review of the Top 20 longest stay patients across the Trust. • A system deep dive to better understand the delays for September, what the key issues are and actions to support an improved position. • Update the process of how medically fit for discharge (MFFD) and DToC patients are reported through the system to better understand current information and action to support and escalate where appropriate.
Can the Health and Wellbeing Board support work targeting this indicator?

Indicator 59. Proportion of older people (65 and over) still living at home 91 days after discharge from hospital (%)
Explanation
The latest benchmarked data by PHE are from 2013/14. This is due to PHE reviewing which items from the Adult Social Care Outcomes Framework will continue to be analysed and benchmarked by PHE.
Are more recent data available? (Please provide)
The data for years after 2013/14 are available nationally from the Adult Social Care Outcomes Framework, but these are not benchmarked. This means the data are not able to be RAG rated.
What work has been done?
Following confirmation of the 2016/17 outturn, reablement has now revised the admission criteria through a better screening and assessment process ensuring the council targets people with reablement potential. Previously people were supported in reablement who were very ill and/or end of life; this did not achieve the positive benefits reablement is able to offer. By providing the service to the wrong cohort, there was an adverse impact on the performance indicator. A new system has been put in place to report specifically on outcomes from people who received support from the council's reablement service. This will be reported monthly from the internal data system and direct contact with former service users. This process will help to identify any issues affecting the service's performance. The service will be working with BHT colleagues to form a plan for improvement based on these data.
What work is planned?
The current actions planned are as follows: • Strengths Based Approach training has been rolled out across the service area. BCC is now working to embed and monitor learning from good practice as part of a change management process to improve practice. • BCC has a Social Worker and Reablement Assessor partnership working pilot project to further support improvement. • There are several training programmes being rolled out to further support our teams to deliver a high quality service. • A Stakeholder communication action plan is being developed. • Alignment development of the council's and the Trusts's reablement services is also happening.
Can the Health and Wellbeing Board support work targeting this indicator?

Indicator 60. Proportion of people who use services who say they've made them feel safe and secure (%)
Explanation
The latest benchmarked data by PHE are from 2013/14. This is due to PHE reviewing which items from the Adult Social Care Outcomes Framework will continue to be analysed and benchmarked by PHE.
Are more recent data available? (Please provide)
The data for years after 2013/14 are available nationally from the Adult Social Care Outcomes Framework, but these are not benchmarked. This means the data are not able to be RAG rated.
What work has been done?
In 2017/18, the proportion (78.8%) of Buckinghamshire people in receipt of long-term Adult Social Care services reported that the services they receive make them feel safe and secure. The proportion reported for Buckinghamshire is lower than the England outturn (86.3%) and is the lowest outturn reported for our CIPFA comparators. This performance is derived from the statutory annual Adult Social Care Service User Survey. Previous local analysis has indicated that responses to this question may reflect general perceptions of safety rather than those specific to Adult Social Care services.
What work is planned?
Following completion of the 2017/18 service user survey, further analysis is underway to inform BCC on areas and actions for improvement.
Can the Health and Wellbeing Board support work targeting this indicator?

Health & Wellbeing Board
Buckinghamshire

Title:	Health and Wellbeing Board Performance Dashboard Proposal for 2019
Date:	6 December 2018
Report of:	Dr Jane O'Grady, Director of Public Health

Purpose of this report:

The Buckinghamshire Health and Wellbeing Board committed to developing a performance dashboard to monitor the health and wellbeing of Buckinghamshire residents.

The HWB Performance Dashboard and process for reporting were approved by the HWB at its November 2017 meeting, and it was agreed that analysis reports would be produced to help the board in their understanding of the indicators.

Following the use of the current HWB Performance Dashboard for the last year, it has been reviewed with the ambition of streamlining the indicators to enable the Board to review trends in health and wellbeing at a strategic level and free up board time for other agenda items.

The proposed Performance Dashboard for 2019 is included for Health and Wellbeing Board members to consider.

Summary of main issues:

The role of the Health and Wellbeing Board (HWB) is to be the key partnership for securing the best possible health outcomes for all Buckinghamshire residents. It therefore has a key role in monitoring the local health and social care performance as part of its system leadership role.

The current Performance Dashboard has 73 indicators which makes it difficult for Board Members to have a clear overview of the health and wellbeing priorities for Buckinghamshire, and review of the Performance Dashboard is time intensive even when split over several meetings. Most indicators are updated annually by the responsible bodies, and this means more frequent reporting does not add value to the work of the Health and Wellbeing Board.

The proposed new Performance Dashboard has been reduced to 26 key indicators. It is proposed that the indicators will be discussed once a year as a whole.

The proposed indicators are categorised by the Health and Wellbeing Strategy priority areas. Appendix 1 includes the proposed indicators.

The proposed dashboard includes specific performance indicators from national Public Health, Social Care and NHS outcomes frameworks.

It is proposed that:

- The Board will review the dashboard indicators on an annual basis.
- The dashboard can be used by the JSNA Development Group and Health and Wellbeing Board Planning Group to identify potential areas of work for further analysis and discussion by the HWB. Other inputs e.g. from the Population Health Management work stream can also be used to inform areas of work
- Any significant issues or risks will be escalated to the board by exception.

Recommendation for the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

1. Note the proposed Health and Wellbeing Dashboard Indicators included in Appendix 1.
2. Agree the proposed HWB Performance Dashboard Indicators
3. Agree the proposed plan for the review of the Performance Dashboard annually.

Appendix 1: Buckinghamshire Health and Wellbeing Board Performance Dashboard

Proposed indicators for 2019

- Significantly worse than the England average
- Not significantly different to England average
- Significantly better than the England average
- Significantly lower than the England average
- Significantly higher than the England average
- Unable to compare to England
- Lowest Quintile
- 2nd Lowest Quintile
- Middle Quintile
- 2nd Highest Quintile
- Highest Quintile

Overarching indicators		Latest		Previous	
New	Male life expectancy at birth (years)	81.9	2014-16	81.5	2013-15
New	Female life expectancy at birth (years)	84.9	2014-16	84.9	2013-15
1	Male healthy life expectancy at birth (years)	69.4	2014-16	69.6	2013-15
2	Female healthy life expectancy at birth (years)	70.3	2014-16	70.1	2013-15
New	Male inequality in life expectancy at birth (Slope Index of Inequality)	6.5	2014-16	6.5	2013-15
New	Female inequality in life expectancy at birth (Slope Index of Inequality)	5.7	2014-16	4.9	2013-15
Priority 1. Give every child the best start in life					
7	Low birth weight of term babies (%)	2.82	2016	2.77	2015
9	School readiness: children achieving good level of development at the end of reception (%)	73.5	2016/17	70.6	2015/16
10	School readiness: children with free school meal status achieving good level of development at the end of reception (%)	56.9	2016/17	51.6	2015/16
New	Year 6: Prevalence of overweight (including obese)	27.2	2016/17	28.7	2015/16
21	Emergency admissions (0-19 years) (per 1,000)	76.8	2016/17	77.6	2015/16
New	Hospital admissions as a result of self-harm (10 -24 years) (per 100,000)	329.2	2016/17	385.8	2015/16
Priority 2. Keep people healthier for longer and reduce the impact of long term conditions					
27	QOF Recorded diabetes aged 17+ (%)	5.9	2016/17	5.9	2015/16
New	Smoking prevalence in adults – current smokers (APS) (%)	9.6	2017	11.2	2016
35	Proportion of people who feel supported to manage own condition (%)	64.0	2016/17	67.7	2015/16
New	QOF Recorded dementia prevalence (all ages) (%)	0.8	2016/17	0.7	2015/16
Priority 3. Promote good mental health and wellbeing for everyone					
40	School pupils with social, emotional and mental health needs (%)	1.70	2018	1.54	2017
44	Primary school fixed period exclusions (per 100 pupils)	1.37	2016/17	1.34	2015/16
45	Secondary school fixed period exclusions (per 100 pupils)	6.2	2016/17	5.0	2015/16
47	Adults (aged 18-69) in contact with secondary mental health services who live in stable and appropriate accommodation (%)	38.0	2016/17	40.7	2015/16
49	Suicide rate (per 100,000)	7.3	2015-17	7.2	2014-16
Priority 4. Protect residents from harm					
55	Violent crime including sexual violence (violent offences per 1,000)	12.8	2017/18	11.0	2016/17
60	Proportion of people who use services who say they've made them feel safe and secure (%)	74.2	2015/16	75.6	2014/15
Priority 5. Support communities to enable people to achieve their potential and ensure Buckinghamshire is a great place to live					
69	Social Isolation - adult social care users who have as much social contact as they would like (%)	45.5	2017/18	45.1	2016/17
New	Social isolation – adult carers who have as much social contact as they would like – 18+ (%)	30.8	2016/17	38.9	2014/15
73	Excess winter deaths Index (all ages) (%)	22.6	2014-17	18.0	2013-16

Health & Wellbeing Board
Buckinghamshire

Title:	Children's Services Update
Date:	Thursday 6 December 2018
Report of:	Tolis Vouyioukas - Executive Director Children's Services Cllr Warren Whyte - Cabinet Lead for Children's Services Cllr Mike Appleyard – Cabinet Member for Education and Skills
Lead contacts:	Richard Nash – Service Director, Children's Social Care Sarah Callaghan – Service Director, Education

Purpose of this report

1. To provide the Health and Wellbeing Board with an update of the latest developments within Children's Services.

Early Help

2. Following a Cabinet Member decision in October 2018, the Council launched a 10-week consultation to capture the views on proposed ways to deliver early help services to support vulnerable families and children in Buckinghamshire. Currently, existing services are not reaching those families who need help the most. Only 14% of the families who are currently accessing the Council's early help services in 2017/18 had an identified need for support, compared to an estimated 31% of the 0-19 year old population that may benefit from early help services. With this in mind, it is vital that the Council changes its approach to ensure that the service reach those that need it most to prevent future statutory intervention.

3. The consultation is specifically seeking the views on:

    a. A draft new Early Help Strategy, which is a partnership document.
    b. The Council's preferred option for service change, as well as other options.
    c. The proposed set-up of a network of 14 family centres (the Council's preferred option).
    d. Possible alternative uses for those children's centre buildings no longer proposed for use for council-run early help services.

4. The proposed family centre model will continue to provide partner services e.g. health visiting and open access sessions for families with 0-5 year olds e.g. stay and play. The area family teams will have staff with the right skills to make sure families get the right support at the right time.

5. Several public meetings have taken place across the County during the consultation period to engage stakeholders and support them in understanding the options and filling out responses. Key partner organisations, particularly health are supporting the distribution of information about the consultation through, for example, GP surgeries. The consultation is due to close on Wednesday 13 December 2018.

6. At the end of the consultation, a report will be prepared by the independent research

company BMG Research on the findings. This consultation results report will be published to inform a Cabinet decision in March 2019.

Special Educational Needs and Disability

7. The Special Education Needs and Disability (SEND) improvement action plan has been updated and signed off by the Integrated Services Board in their October meeting. The action plan includes the following key priorities:

    a. Compliance with the statutory Education Health and Care Planning 20 week timescale, annual review process and effective use of panels.
    b. Improving the quality of Education, Health and Care Plans and the family experience.
    c. Ensuring children have their needs met locally in mainstream schools were possible and appropriate through the work of the inclusion hub.
    d. Developing early identification and early intervention support as part of the Early Help programme that ensures children registered with SEN Support are effectively supported to achieve their potential.
    e. Developing a shared understanding of co-production, owned across the local area and underpinning all SEND delivery and ongoing improvement.
    f. Improving the communication with and experience of families leading to a reduction in the number of complaints and tribunals.
    g. Improving the experience of children and their families preparing for adulthood from year 9 and transitioning to adult services.
    h. Upskilling the workforce across the local area to ensure children and their families benefit from skilled and knowledgeable professionals.

8. Preparation for a potential SEND Ofsted/CQC inspection is also continuing and the Self Evaluation Framework has been shared with partners and parent/carer representatives in a range of forums. A challenge event has been held to ensure all key stakeholders understand the local context, are able to articulate their strengths and have robust evidence to support improved outcomes. In addition, this event will support professionals to describe the areas for development and ensure they have plans in place to address any areas of concern.

9. On 22 October 2018, Cabinet agreed to start a 10-week consultation on revisions to our home to school transport arrangements. There will be no change to the arrangements for more than 5,000 pupils who are eligible for free travel. There are a number of proposed revisions, which would apply to children and young people who we currently support with transport, but who are not eligible for free statutory home to school transport.

10. The proposed changes include:

    a. Improving the mix of council provided and commercial transport to provide more flexible options.
    b. Applying statutory requirements to all Buckinghamshire school children, which would include phasing out of historically agreed local free transport arrangements. Parents choosing a place that is not their nearest eligible school would be required to pay for their transport in future.
    c. Requiring parents of post-16 students with Special Educational Needs to contribute towards their travel costs. This would bring the application of the transport policy for this cohort more in line with their peers attending mainstream education.

11. The public consultation launched on Wednesday 31 October, and seeks feedback on the options for modernising the service to make it more sustainable. The closing date for responses is 4 January 2019.

Ofsted Action Plan Update

12. The Senior Management Team has now been together since April 2018 and although it continues to identify some examples of poor practice, it is also working hard to influence the way our staff engage with children and young people to improve their outcomes. A phase 2 improvement plan has been produced to incorporate these findings and will be presented to Cabinet next week. The plan concentrates heavily on the impact that first line managers need to have in order to improve front line practice. The plan is a live document and will be under regular review to ensure that actions are further expanded where it is necessary.

13. The service is currently working with partner agencies to secure their contribution to the plan and specifically the actions that they can take to assist our improvement journey.

14. Progress will continue to be monitored and reviewed by the Children's Improvement Board, which now includes representatives from partner agencies.

Ofsted monitoring visit

15. Ofsted is due to complete its second monitoring visit on 11 and 12 December 2018. The focus of the visit will be evaluating the experiences of children and young people who:

    a. have become the subject to a multi-agency child protection plan that sets out the help they and their families will receive to keep them safe and promote their welfare, and
    b. have been assessed as no longer needing a child protection plan, but who many need continuing help and support.

16. We anticipate that the findings will be published early in the new calendar year.

Your community
Your care
Developing Buckinghamshire together

Buckinghamshire Integrated Care System

Winter Plan

06/11/2018 (Final)

NHS Buckinghamshire Clinical Commissioning Group

NHS Buckinghamshire Healthcare NHS Trust

FedBucks

Buckinghamshire County Council

NHS Oxford Health NHS Foundation Trust

NHS South Central Ambulance Service NHS Foundation Trust

Contents

Key Objectives

To ensure that the Buckinghamshire integrated health and care system:

- Is **Resilient** throughout the winter period - providing safe, effective and sustainable care for the local population
- Has sufficient **Capacity** available to meet likely demands over winter
- Is able to deliver quality **Care** for Patients/clients in the most appropriate setting
- Is able to **Achieve** national and local access targets and trajectories across the system
- Is compliant with winter planning, national guidance and also includes the **pillars of urgent and emergency care**
- Has learnt from previous winters locally and from **other systems** and **applied best practice** to service delivery to ensure safe and effective patient flow
- Promotes **prevention** and supports self-care

Our Integrated System approach

System plan

- Developed by system partners & overseen by Buckinghamshire A&E Delivery Board
- Partner organisations' **detailed** winter resilience and adverse weather plans inform our overall system plan – planning is a continuous process so these continue to be tested and revised
- Comprehensive plan linked to:
  - 7 pillars in Urgent and Emergency Care (UEC) delivery Plan
  - Buckinghamshire Integrated Care System (BICS) Non Elective (NEL) demand management analysis
  - BICS Population Health Management review of Urgent & Emergency Care
- Informed by lessons learnt from last winter & multi-agency events to test system resilience
- Informed by national guidance & national planning events
- 1st cut plan submitted to NHS England 24/09; currently awaiting feedback

Winter Operating Model

Buckinghamshire Winter Team

- Winter Director interviews held 12/10/18.
- Named responsible directors from each partner agency and named operational leads (virtual team) from each partner agency
- Daily operational system leads call & weekly system director & CEO escalation

Local Escalation Plans & close liaison with regional/national NHSE/NHSI Winter Rooms

- Buckinghamshire system escalation framework with OPEL action cards to support Surge & Escalation – and a rolling system demand and capacity forecast

Bucks Winter Plan – on a page

Challenges

- Rising demand for health and care services
- System performance: A&E, Ambulances & delayed discharges
- Effective demand & capacity modelling across the system
- Finite estate capacity
- Finite staffing resources
- Staff welfare & morale

The Risks

Demand

- Significant increase in flu
- Significant adverse weather event
- Significant variation in demand

Capacity

- Unable to deliver Length of Stay (LoS) reductions
- Independent sector capacity unable to flex & meet demand
- Major staff shortages

Financial

- Risk to individual system partners if joint funding not agreed for initiatives such as Discharge to Assess (D2A)

Improved system planning and co-ordination

- We have been planning all year
- An integrated system Winter Plan
- Organisational winter plans
- Winter Operating Model: shared system winter team approach to manage demand & capacity
- Escalation triggers & protocols to manage surge pressures
- "Fabulous Fortnight" system reset
- Winter projects funded by additional investment
- Communications strategy

Improved resilience

- Adverse weather plans including 4x4 vehicles plan
- Preparedness for Flu: comprehensive targeted all-age flu vaccination programme & outbreak response
- Promotion of alternatives to A&E (where clinically appropriate)
- Enhanced support to care homes
- Support for self-funders

Improved capacity

- More sensitive forecasting of demand & capacity requirements
- Additional space & medical beds
- Additional & more flexible workforce for peak times
- Extended access to primary care
- Support from voluntary sector
- Increased independent sector capacity & Discharge to Assess

Key Messages

Prolonged stays in hospital lead to loss of independence & de-conditioning in older people - HOME FIRST ETHOS

Remember to save A&E for serious and life-threatening conditions
and use services like 111
or www.healthhelpnow.nhs.uk for health information and advice

Lesson learnt from last winter

National: NHS England Delivering resilient services for winter (and beyond) September 6th 2018.

- **NHS 111** – well used and able to direct patients to range of appropriate services – **additional clinical resource secured**
- Focus on frequent users of **A&E**: **high intensity user project live aimed at supporting/reducing attendances**
- **Focus on better use of hospital beds**: improve flow, tackle delays & improve discharge – **NHSI support plan**
- Increase **Flu** vaccination programme – **Robust programme in place** (see slide 23)

Regional: NHS England winter planning exercise 'Bruma' event September 25th 2018.

- **Workforce challenges** – ensure effective system resilience is in place particularly over the weekends and bank holidays
- **Ensure pro-active comms messages**: NHS111, GPs and all other key partners about clinical alternatives to A&E
- Encourage "**safe at home"** and **"home first"** messages
- Ensure **effective cross-system working** & support (STP & beyond)

Local: Bucks system "winter wash up" event May 14th 2018
Local: BHT led Urgent care workshop 28th June 2018 & system winter exercise Sept 2018.

- Need to use system intelligence more to forecast building pressure and ensure response interventions are activated:
  Bucks winter operating model will be in place Nov 2018
- System under greatest pressure when hospital flow slows and patients wait for beds:
  Multidisciplinary action team to improve discharge process – in place October 2018
- Discharge to assess to be based more on 'home first' principles and transition to a sustainable offer not a winter project
  New model for roll-out in November 2018
- Hospital and Ambulance provider to work closely to help reduce ambulance handover delays:
  New assessment area & new ways of working in place and improvements sustained
- More effective support to Bucks patients who interface with Frimley healthcare economy:
  South Bucks project in place and includes enhanced recovery support at home initiative

Draft Bucks Winter Operating model

Team and Location

Operations Team

Daily

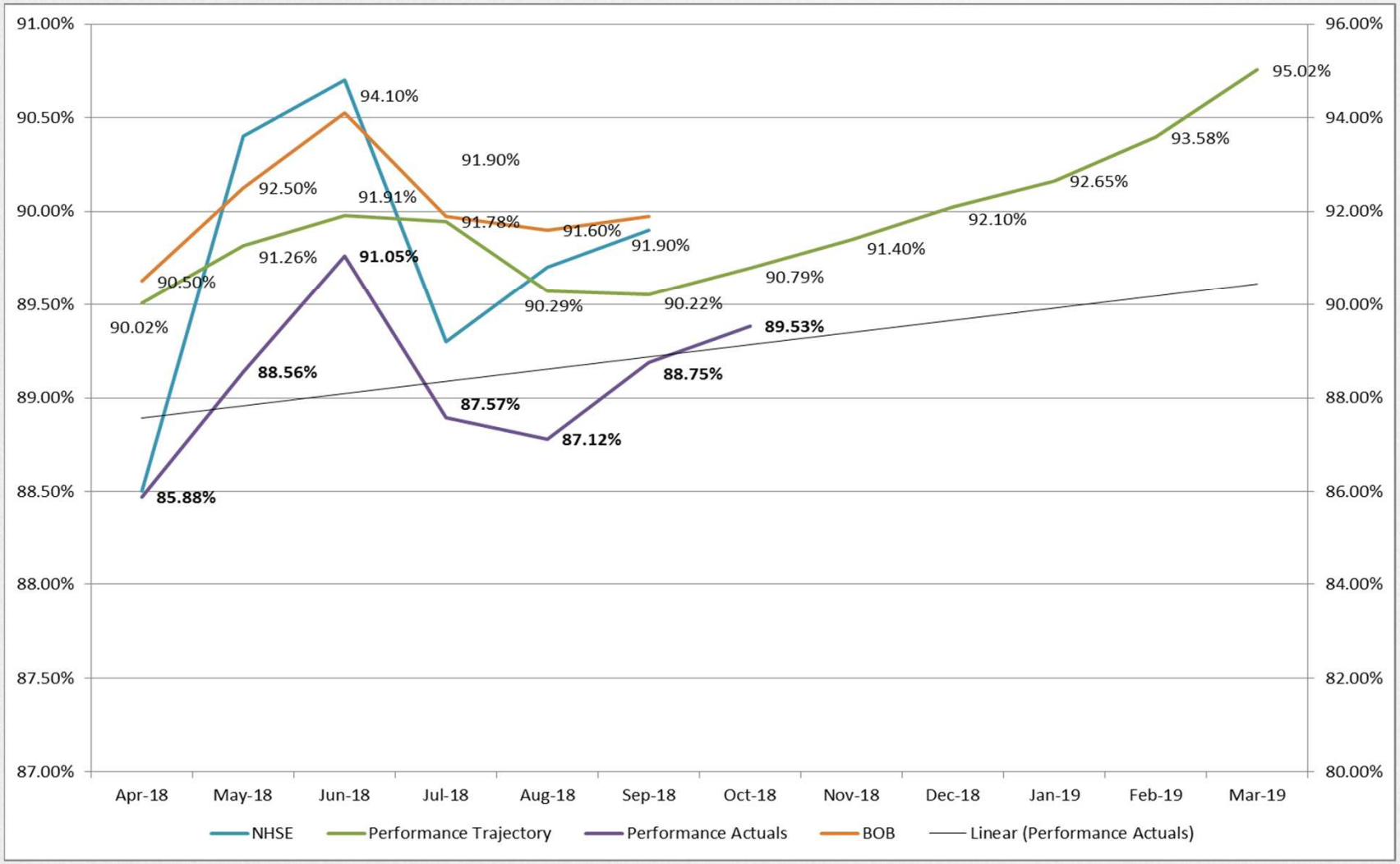
Organisation	Bronze		Silver	
	Role	Name	Role	Name
CCG	System Resilience Manager	Matthew Lynock	Head of Urgent Care	Gary Passaway
BHT	Site team	Rotational	Head of clinical site management	Chris Smith
ASC	Business Support Manager	Cynthia Tapping	Head of Service	Tom Chettle
SCAS	Operations Lead		Head of Operations	Mark Begley
OxH	TBC	Natalie Cleveland	Service Manager (NC)	
RRIC ACHT	Service Manager	Helen Hallett	General Manager	Laura Isard
Fedbucks	Service Manager	Calls-in by exception	General Manager	

Weekly

Organisation	Gold - Directors
	Name
Bucks Winter Director	TBC
ASC	Karen Jackson
BHT	Natalie Fox
BHT	Jane Dickinson
SCAS	Mark Ainsworth
OxH	Pauline Scully
FedBucks	Dr Asma Ali
CCG	Debbie Richards

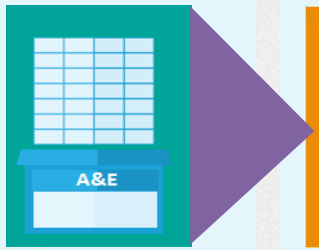
- Under the direction of the Winter Director, we are planning a multi-agency winter team onsite presence at Stoke Mandeville with support as required to other health & care services with cross system/border support
- The model will also operate within a command and control methodology during times of significant system challenge
- The winter director will liaise with NHSE/I winter rooms and when required the WOLF (Winter Operating Look Forward) calls

Operational performance: BHT 4 hour standard

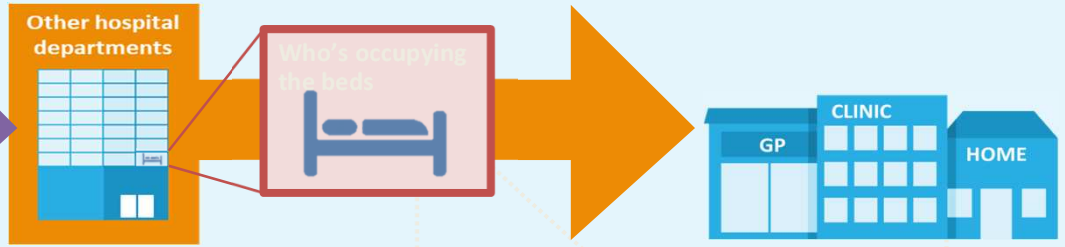


Summary of factors impacting performance:

The A&E department



Patient flow



Key factors

Workforce

- 50% vacancy rate for A&E consultants.
- GP streaming reliant on locums
- 18% registered nurse vacancy

Resilience

- Implement capacity modelling
- Create capacity to flex for surge
- Flexible use of staff
- Standard Operating procedures

Admissions

- Increase in emergency admissions (NEL) relates to implementation in appropriate clinical pathways i.e. Ambulatory Care, Observation Unit

Bed occupancy

Rising occupancy reduces performance, with accelerating effects above 92%. Quarter 3 2017/18 bed occupancy peaked at 96% and A&E performance dropped to 82%

Flu

National picture highlighted that **1/3rd** of the growth in emergency admissions came from flu in winter 17/18

Long stay patients

Long stay patients can decrease performance by reducing bed flexibility.
Over 4% of patients have an average length of stay (ALOS) of > 21 days

Discharges

Average Length Of Stay (ALOS) for NEL 7.4 days which is above national average

System analysis and forecasting

Forecasting: Key focus on being able to forecast the number of discharges required and admissions expected. The **admission/discharge trigger** which can help in planning how capacity can be met. E.G. on average in August the trigger value was -10 per day (i.e. on average each day there were 10 more admissions than discharges). -4 or less is regarded as the target to aim for, otherwise the adverse position can lead to use of escalation beds and paralysis of flow.

NHS Buckinghamshire System

alamac

Daily Forecasting Report: 10Sep18

Forecasting Requirements

	Forecast																
	Tue 11-09-18	Wed 12-09-18	Thu 13-09-18	Fri 14-09-18	Sat 15-09-18	Sun 16-09-18	Mon 17-09-18	Tue 18-09-18	Wed 19-09-18	Thu 20-09-18	Fri 21-09-18	Sat 22-09-18	Sun 23-09-18	Mon 24-09-18	Tue 25-09-18	Wed 26-09-18	Thu 27-09-18
Predicted Attendances	208	226	215	221	216	213	255	220	239	227	233	228	225	260	225	244	232
Predicted Admissions	39	47	47	44	38	33	49	42	50	50	48	40	36	52	45	53	53
Predicted Discharges	32	33	34	33	26	24	35	35	36	37	36	29	26	34	34	35	36
Extra Discharges Required - Total	3	10	9	7	7	6	10	3	10	9	7	8	6	14	7	14	13
Extra Discharges Required - Medicine	1	6	6	4	4	3	5	1	7	7	4	4	3	6	5	9	10
Extra Discharges Required - Surgery	1	2	1	1	1	1	2	1	2	1	1	1	1	3	1	3	2
Discharge Pathway - ASC	4	4	4	4	3	3	4	4	4	4	4	3	3	4	4	4	4
Discharge Pathway - Community	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2	2	2

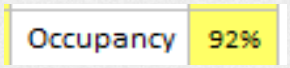
	Forecast																
	Fri 28-09-18	Sat 29-09-18	Sun 30-09-18	Mon 01-10-18	Tue 02-10-18	Wed 03-10-18	Thu 04-10-18	Fri 05-10-18	Sat 06-10-18	Sun 07-10-18	Mon 08-10-18	Tue 09-10-18	Wed 10-10-18	Thu 11-10-18	Fri 12-10-18	Sat 13-10-18	Sun 14-10-18
Predicted Attendances	238	233	230	266	230	250	237	244	238	235	268	232	252	239	246	240	237
Predicted Admissions	51	43	38	36	48	57	57	54	46	40	57	48	58	58	55	46	41
Predicted Discharges	35	28	25	32	32	33	34	33	26	24	35	35	36	37	36	29	26
Extra Discharges Required - Total	11	11	9	19	11	20	19	17	15	13	18	9	18	17	15	14	11
Extra Discharges Required - Medicine	6	6	4	9	6	13	13	8	8	6	8	5	12	12	7	7	6
Extra Discharges Required - Surgery	2	2	2	4	2	4	2	3	3	2	4	2	3	2	3	3	2
Discharge Pathway - ASC	4	3	3	4	4	4	4	4	3	3	4	4	4	4	4	3	3
Discharge Pathway - Community	2	2	2	2	2	2	2	2	2	1	2	2	2	2	2	2	2

Bed Capacity: Model variables – A Tool for Winter

A high level bed model has been developed with BHT to support scenario planning in relation to bed capacity. The model contains many variables that can be adjusted to test impacts of changes on bed capacity.
Bed stock: Emergency Care Beds, elective beds and community hospitals.

Length of Stay can be specified in the model.
Custom and entering the anticipated length of stay (LOS) and the anticipated change to LOS from the ICS wide schemes can be modelled here.

Bed Occupancy. The baseline for Buckinghamshire Hospitals NHS Trust (as an example) has been set at 92% to reflect previous levels.



Volume of Activity within the model reflects expected 2018/19 activity. It is possible to change this for both elective and non-elective increasing or decreasing activity for all specialties. Anticipated changes to demand profile can be made to better predict demand and further impact of the ICS wide schemes.

KEY MESSAGE IS THAT WE DO HAVE ENOUGH BEDS FOR WINTER PROVIDED WE USE THEM WISELY AND TACKLE DELAYS

Analysis of non-elective demand – Summary

A&E activity in Buckinghamshire is 10% less than national average per population (2016/17)

Conversion of attendance to admission was 2% less than the national average in 2017/18 at 26%

Since last winter we have been working to better understand and manage our demand as a system. The latest available data (April – September 2018) compared with last year indicates that:

- Overall A&E attendances have increased by 7% - **but** more people are being seen in GP streaming (up 10%) and in our UTC in Wycombe (up 6%). In the A&E, Type 1 attendances have decreased by 7.1%

- Overall Emergency admissions (NEL) have increased by 8.1% - **but** 0 Day Length of Stay (LOS) admissions at 18.1% have increased due to successful implementation of Ambulatory Emergency Care (AEC) 7/7 and Observation/Assessment Units

- 56% of all emergency admissions had a short length of stay of 0-1day. 40% have a 0 day length of stay; nationally this is 32%

- The Average Length of Stay for NEL admissions is 4.5 days; this includes admissions to AEC and assessment units, **excluding these the Average Length of Stay is 7.4 days – this is an area for ongoing priority action for the system**.

Non Elective Demand Management Programme

We have initiated a comprehensive non-elective (NEL) demand management programme which focuses on:

1. **Avoidable attendances to A&E** - ambulance conveyances, maximisation of ambulatory emergency care (AEC) & community based services, improved support to care homes, GP streaming

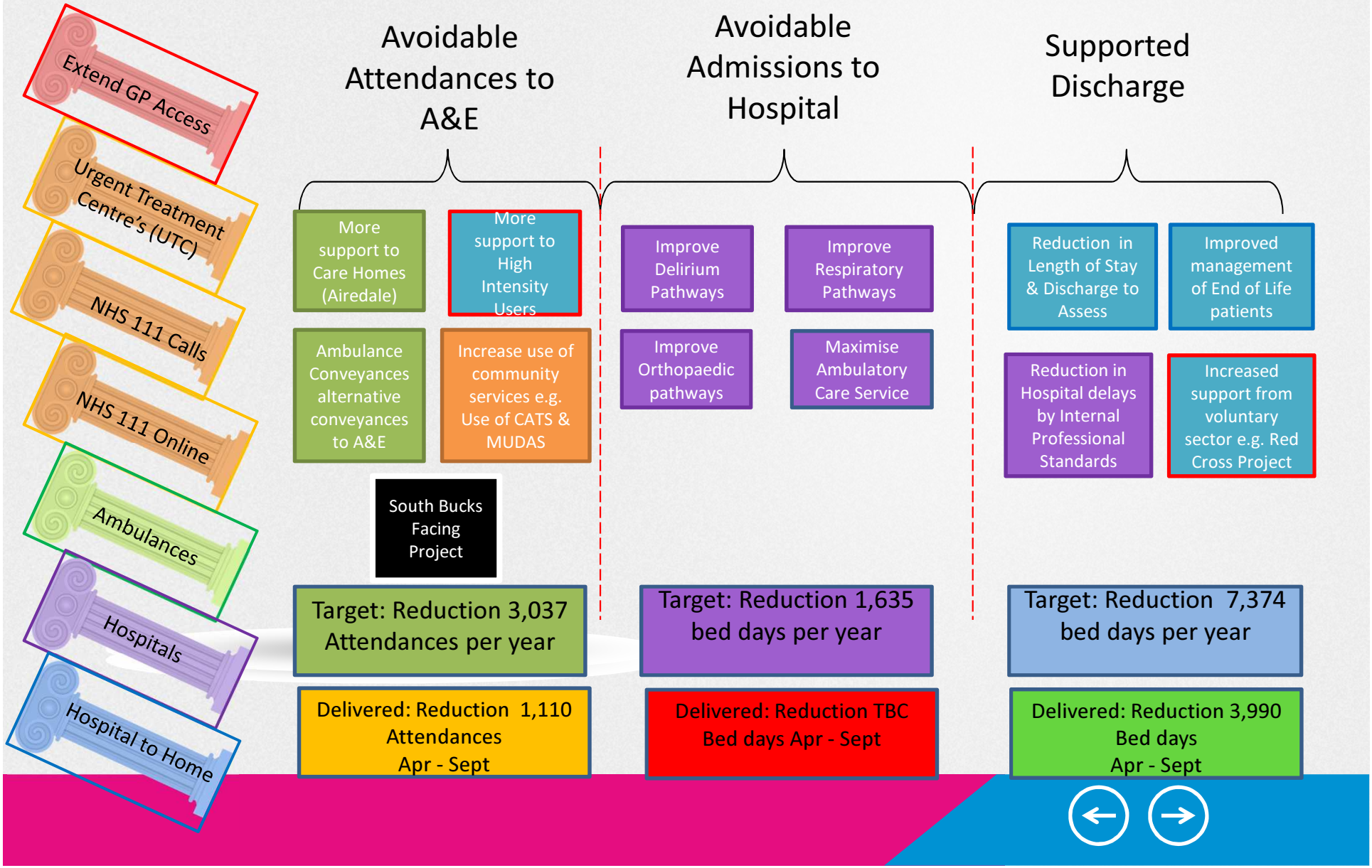
2. **Avoidable non-elective admissions** - improved management of End of Life (EOL), delirium pathway, respiratory pathways, orthopaedic (MSK) pathways

3. **Supported discharge** - discharge to assess, reduction in excess bed days, CAREfully programme

Outcomes are addressed through resolving four key lines of enquiry:

- What can be done in the primary care or community settings to manage non elective demand?
- What can be done to decrease the numbers of admissions and requirement to remain in hospital for diagnostic and ongoing treatment?
- How can non-bed based services be utilised to support delivery?
- How can efficiency be improved by reducing variation and overall demand and what are the resultant effects on savings and cost to the system.

NEL Demand Management – System Priority Areas for action & progress to date



Avoidable Attendances to A&E

NHS 111 – in place
Encourage public to "Talk before you walk" (for non-medical emergencies).
Directory of Service (DoS) refreshed and updated to ensure callers are directed to the most appropriate local clinical setting.
Integrated Urgent Care (IUC): Capability to adjust 'live' capacity when services are under pressure
Direct booking into UTC and Out of Hours GPs
Increased clinicians working in 111 service for winter

NHS 111 Online – New offer recently launched
Reducing pressure on 111 and OOHs as 111 Online directs patients to appropriate service

Ambulance
Ambulance Response Programme (ARP) is now fully established- **Improved Bucks performance**
Telephone advice – Implementation of a Hear and Treat and See and Treat models
Improved support for calls referred by paramedics to GPs - **GP Triage sustained increase in uptake**
CAT 3 & 4 shift of activity to A&E alternatives – **Audit & plan worked through by system clinical group**
Continued focus on Hospital Handover delays – **Improved BHT performance sustained**

Winter project: Urgent & Emergency Care (UEC) Transformation Funds – in place
Schemes to support South Central Ambulance Service (SCAS) improve non-conveyance of ambulances with expansion of the Berkshire West **pilot falls service** across Oxfordshire and Buckinghamshire, where a paramedic and Senior Occupational Therapist are available in a car to visit patients who have fallen, assess them and then make links with rapid response community services to support the patient at home.

Avoidable Attendances to A&E

Extending GP Access (Improved Access to General Practice) – October 2018

- A new and improved service to access GP appointments launched in Buckinghamshire on 1st of October (providing 270 extra hours per week)
- Available to all patients registered with a Bucks GP. This service involves local GP practices working together to offer patients better access to appointments in a **local** practice:
    - Up until 8pm from Monday to Friday. Selected hours on a Saturday
    - 9am until 1pm on Sunday (at one of the three Improved Access Hubs located across the county)

Urgent Treatment Centre – Wycombe General Hospital – new local provider in place

- Designated Wave one site and Open 24/7, 365 days a year.
- Direct booking from NHS 111 in place
- **Activity increase (6.3% compared to previous year) and consistent achievement of 4 hour standard in first six months of new service**

Community Assessment and Treatment Service (CATS) Thame & Marlow

Focus on greater utilisation to enable more patients to receive local assessment, diagnostics & treatments enabling more people to remain cared for at home; to support, Consultant Connect project will be in place in November.

Multidisciplinary Day Assessment Service (MuDAS) Wycombe

- CATs works in tandem with; and enhances the service currently provided by MuDAS.
- **Activity up by 58% comparing April – Aug 2017 to same period in 2018**

Enhanced Health & Care Services in Care Homes

- Airedale project rolled out to more than 30 care homes providing remote access clinical support 24/7
- Red Bag scheme – enables smoother transfers between care homes and hospitals – **Launch in November, 2018.**
- Quality in Care Team (QICT) & Medicines optimisation support in care homes – **Bucks pilot extended for winter**
- Promotion of advanced Care plans
- **NEL admissions from care homes have reduced by 6.8% April –Aug 2018 compared to April-Aug 2017**

Avoidable admissions to Hospital

In Hospital – BHT priority actions

- Implementation of whole Trust ownership approach to management of urgent and emergency care pathways and delivery of Safe patient flow with support from partners
- Implementation of capacity and demand modelling to ensure sufficient beds at predicted peaks
- Support discharge planning
- Effective utilisation of available staffing resources – realignment of job plans and rotas; re-focus role of physicians as part of the Emergency care team aligning acute and emergency care
- Frailty at the Front Door
- Effective utilisation of available estate and workforce to maximise GP streaming and ambulatory care (increasing ambulatory care activity from 23% to 35%)
- **Year to date NEL admissions up 8.1% BUT admissions >24 hours = 1%**

Psychiatric Liaison support 24/7 – in place

- The Psychiatric in Reach Liaison Service (PIRLS) is delivered by Oxford Health & provides psychiatric liaison 24/7. Team provide on-site assessment service to Stoke Mandeville Hospital between the hours of 08.00-20.00hours and an out of hours service. The **- 1 hour response time standard consistently achieves >95%; decision < 4 hours is 53%**
- Challenges are waits for Approved Mental Health Professionals & waits for beds, although 83% are discharged home from A&E
- PIRLS also provide support to wards and staff training
- This winter we have added the Bucks Safe Haven which is an out-of-hours crisis support space run by Bucks Mind in partnership with Oxford Health.

Supported Discharge

Urgent & Emergency Care (UEC) Transformation Funds: winter project

- Long stay patient reduction project to support the earlier discharge of patients, including a Multi Disciplinary Team (MDT) focus on stranded patients.

Community Care Coordination Team (CCCT)

- Health & social care single point of referral for re-ablement – work progressing to integrate Rapid Response Intermediate Care (RRIC) team and BCC led re-ablement team

Implement earlier discharge support for Bucks residents:

- Buckinghamshire County Council leading a system Discharge to Assess (D2A) service model for roll-out in November. This model will be provide a more sustainable approach, ensuring best use of system resources & that opportunities within the Better Care Fund (BCF) are maximised.

Reduce Delayed Transfers of Care (DToCs):

- Reduce delays by focusing on medically fit & long stay patients **across all providers**, acute & community hospitals and mental health
- Escalation process for Long stay patients and a weekly Clinical and operational Directors led call focusing on top 20 long stay patients
- Improved support to Wexham Park, Oxford & Milton Keynes
- **Not yet achieving national ambition but month on month reduction in Q2 2018**

Supported Discharge

Adult social care – additional winter funding announced to enable further reductions in the number of patients in hospital that are medically fit

- Plan being drafted by BCC – not yet agreed with system partners so not in the ICS plan

Independent family support & brokerage and Self Funders

- Brokerage team in place to support families in arranging either a placement or a Package of Care outside of the acute hospital.

Continuing Healthcare (CHC):

- Work to improve responsiveness & patient experience; new provider in place & **additional clinical support on site at BHT**
- Plan to increase the number of assessments in the community (and out of hospital)

Secure Voluntary Sector support

- Home from Hospital – the Red Cross led service.
- Additional Red Cross support with national & local funding for winter to support long stay patients being returned home
- Support for Carers – Carers Bucks & the Carers Hub

South Bucks Project

- Improved system support & responsiveness to Wexham Park Hospital
- Winter project: Enhanced Recovery & Support at Home
- South Bucks locality GP lead to improve community support to focus on avoidable attendances & admissions

Children & Young People (CYP)

Most of our system work is focussed on adults & children.

Additionally, we have a system clinical group working across all providers that looks at CYP demand and informs more targeted work, for example:

- Common illness leaflets have been refreshed/reviewed and distributed to BHT, Frimley, CCG (for GP, pharmacies use), and partner CCGs
- Raise awareness of prevention/self management with parents: Group having representation at Children and babies nearly new clothes sale event on 3rd November; objective to discuss common illness interventions, promote flu vaccine
- Comprehensive flu vaccine programme through schools (detail under flu slide)
- Flu vaccine being offered to children attending asthma and diabetes clinics in children's outpatients this winter – part of the **"make every contact count"** campaign. This also provides another option if a child has missed at school or unable to get to GP

An example of innovative practice:
Asthma Bus: Promotion bus visiting schools across Bucks with an aim to pro-actively target asthma management and reduce the costs associated with non-elective admissions at this time of year. This was led by a paediatric respiratory specialist nurse, a school nurse and a volunteer from Asthma UK

Cross border support

South Bucks Project – specific actions to support Wexham Park Hospital (WPH)

- Enhanced Recovery at Home service – pilot service for this winter, building on South Frimley learning, to ensure patients are discharged home earlier from WPH
- GP discharge lead (funded by CCG) on site at Wexham Park Hospital, supporting patient flow and effective repatriation home/closer to home
- Additional Occupational therapy (OT) support to WPH during the winter period – timely therapy input and liaison to support earlier discharge
- Sustain improved access to Bucks Community Hospital beds (minimum target of 10)
- D2A (domiciliary care & beds) – to provide a step down option
- Dedicated clinical lead and commissioning manager for South Bucks/Frimley facing
- More coordinated community health, social care & CCG support to improve discharge with key staff now using the shared 'IRIS' office at Wexham Park Hospital

Milton Keynes Hospital

Bucks ICS now have a named discharge co-ordinator onsite at **Milton Keynes** hospital to support flow back to Bucks.

Oxford University Hospital

Good links also exist with the **Oxfordshire** system and escalation processes to reduce delayed transfers of care & repatriations have been shared and adopted in Bucks.

Prevention messages

People with pre-existing medical conditions such as Asthma, and Chronic Obstructive Pulmonary Disease are at greater risk of harm from cold weather and can see exacerbation in their conditions leading to increase demand for health services in primary care, A&E attendances, hospital admission and community services and residential/Nursing care placement.
Targeting those with known risk factors to engage in prevention services such winter warmth, self-care, and improved lifestyle choices such as smoking cessation can help reduced demand for Health Care services during winter. Evidence shows that:

- A quarter of all patients occupying beds in acute hospitals smoke
- Nationally in 2016/17 there were estimated to be 484,700 hospital admissions attributable to smoking. This is up from 474,300 in 2015/16 (an increase of 2%), and from 444,700 in 2006/07 (an increase of 9%).
- 22% of all admissions for respiratory diseases, 15% of all admissions for circulatory diseases, and 9% of all admissions for cancers, were estimated to be attributable to smoking
- In 2016 there were estimated to be 77,900 deaths attributable to smoking.
- 37% of all deaths for respiratory diseases, and 26% of all deaths for cancers, were estimated to be attributable to smoking

Recommended Actions

Health and care service providers should be supported to reduce winter-related harm by, for example:

- supporting front line staff to remain fit and well during winter, for example staff flu immunisation programmes
- Promote smoking cessation among all at risk groups who smoke by referring people to local smoking cessation services.
- promote our shared winter related health messages widely
- supporting GPs, district nurses and social workers to identify vulnerable patients and clients on their practice lists, by providing them with toolkits and sharing examples of good practice
- exploring how other services that may have contact with vulnerable groups (eg fire services undertaking home safety checks) should refer people to winter warmth initiatives
- ensuring midwives, health visitors, community health practitioners and school nurses provide advice to parents with young or disabled children about the risk of exposure to low indoor temperatures and heating homes appropriately and affordably.

Flu

Flu awareness is part of the wider **"Stay Well This Winter"** campaign. Key messages include

- Promote vaccination amongst key target groups
- Improve awareness of the nasal spray among parents of 2–3 year olds and those in school years Reception to Year 5 (Bucks reported above the national average in 2017/18)

Staff facing campaign **"Protect yourself**, **Protect your patients. Have a flu vaccination**":

- **Flu Vaccination** of Healthcare Workers in Primary Care, Trusts & CCGs (Target of 75% uptake this year)
- Bucks County Council offer vaccination for all their internal staff and those working in its commissioned services (e.g. Carers in Nursing Homes)
- Activity is overseen by a Multi-agency flu group & fortnightly teleconferences

Outbreak response for care homes

CCGs have an agreed pro-active process for when a localised outbreak of influenza has been identified and which meets national guidance and criteria. This involves working collaboratively with Public Health England and primary care teams.

Flu Vac uptake among school children in Bucks 2017/18

- The school based immunisation programme was extended to include children in year 4 for the 2017/18 season and uptake in all age groups is above national averages
- For 2018/19 the vaccination programme is being extended to include Year 5 children too (i.e. those aged 8 by 31st August 2018). 17/18 uptake below.

Year group	Total pupils	Bucks % uptake	England % uptake
Reception year (4-5 year olds)	6,742	68.1%	62.6%
School Year 1	6,988	65.5%	60.9%
School Year 2	7,154	65.9%	60.3%
School Year 3	7,081	60.8%	57.5%
School Year 4	6,933	58.7%	55.7%

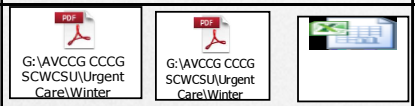
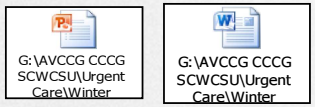
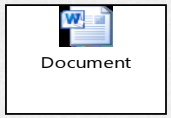
Flu vac staff uptake across partners

Provider	2017-18	2018-19 75% target uptake to date
Buckinghamshire Healthcare NHS Trust	60%	40%
Oxford Health Foundation Trust	51%	No data as yet
Hertfordshire Partnership Trust	57.9%	No data as yet
Frimley Health NHS Trust	71%	No data as yet
Milton Keynes University Hospital	78.1%	No data as yet
Primary Care	Data is uploaded onto ImmForm and monitored by NHSE and the CCG – currently a problem with data upload from EMIS, this is being worked on nationally. Population and primary care staff uptake is monitored through this route.	

Infection control

- Stoke Mandeville Hospital has recently been seriously affected by Norovirus. SMH is being fully supported by partners in their outbreak control processes.
- The system response has been positive and once the incident has been concluded there will be a review so that learning can be shared & further inform this winter plan
- Norovirus is circulating in the community a little but not large numbers.
- Winter guidance including advice on norovirus and flu has been prepared by Public Health England (PHE) and has been circulated to care homes and schools

Provider Plans that underpin our system plan

Service	Organisation	Plan - Inserted	LAE DB Organisational lead	Agreed and signed off by organisation
Acute and community Trust	Buckinghamshire Healthcare Trust		Jane Dickinson	Yes
Ambulance	SCAS 999		Mark Begley	Yes
111 and patient transport	SCAS 111/IUC & PTS		Lynda Lambourne	Yes
Mental Health	Oxford Health		Pauline Scully	Yes
Contuining healthcare	Oxford Health		Pauline Scully	Yes
Adult Social Care	Buckinghamshire County Council		Karen Jackson	Yes
Out of Hours and urgent treatment centre	Fed- Bucks		Dr Penny MacDonald	Yes

Provider highlights:

Buckinghamshire Healthcare NHS Trust

Buckinghamshire Healthcare Trust (Acute and Community)

- Extending the Emergency Observation Unit (EOU) to facilitate extra capacity
- Frailty at front-door
- Consultant Connect – reduced conveyances & admissions - maximising the Silverphone
- Greater use of the Discharge Lounge
- Improved GP Streaming
- Executive ward sponsors throughout winter
- Maximising capacity at the Wycombe hospital site for elective pathways.
- Demand and capacity and forecast bed modelling
- Planning discharge with patients and families on admission to support patients leaving the hospital in a timely and dignified fashion.
- Ensuring a robust community response (MuDAS, CATS, RICC, ACHT, CH, CCCT)
- Support and well being initiatives for our staff
- Robust 24/7 on call process with Gold presence on site at the weekends
- Cold weather plan for the acute and community services
- Recruitment of key members of clinical and support staff
- Flu Plan

Provider highlights:

Buckinghamshire County Council

- Emergency Plan in place – joint with Children's services
- Winter Plan and Business Continuity Plan in place and updated September 18
- The Emergency Social Work team is operational out of usual working hours and over bank holidays and weekends, hosted by Children's Services.
- ASC have a duty manager rota in place 24/7/365, managed and maintained by ASC resilience
- 7 day working at Stoke Mandeville Hospital has been in place for almost 2 years and continues to support BHT
- The co-ordination of the Flu vaccination of care homes staff and community based services across Buckinghamshire has been launched
- Cold weather plan: ASC resilience will communicate all changes in weather alerts and reaffirm the expectations
- In place is an agreed escalation process (Operating Escalation Level, OPEL) across the system to facilitate appropriate actions for any given incident or business continuity position. The OPEL framework; partner actions cards were reviewed in September 2018 by all stakeholders involved.

Provider highlights:

South Central Ambulance Service – 999, 111 and Patient Transport

Reviewed and amended the winter resilience plans in preparation for the pressures and challenges we can expect (999, 111 and Patient Transport)

Continue to review plans and have work streams ongoing to minimise any shortfalls, along with a bi-weekly conference call to review work streams, actions and any other valuable intelligence including:

Incident Control Rooms (ICRs): Activation, Staffing and membership and telephony

Fleet including 4x4 Vehicles: Volunteer and staff database updated: Staff Owners, location and access

Review of existing plans / procedures

- Incident Response Plan
- Demand Management Plan
- REAP (Resource escalation Action Plan)

Workforce planning for winter in all Directorates is well on the way and nears completion to include 111, PTS and 999 services

Contracts with Private providers have already been issued to provide shortfalls to include Christmas and New Year's Day

SCAS will provide a business as usual approach throughout the winter and specifically during the Bank Holidays

Provider highlights

FedBucks

- Increased staffing model for winter months
- On call team supporting Opel framework available 24/7 providing clear escalation processes and links to join all systems calls – compliant with policy and guidelines
- Attendance to all relevant winter planning calls with system partners – ensuring a system-wide response
- Recruitment campaign both clinical and operational – looking to recruit additional contracted and bank operational staff by end of December 2018, clinical recruitment remains ongoing.
- Improved Access is delivering 270 extra hours appointments per week
- Promote and run regular Flu clinics to all staff
- Challenge staffing models to utilise ANP's and UCP's onto our Out of hours rota – Multi skilled workforce model
- Assist where possible with admission avoidance by home visiting rather than 999 response
- Introduction of EPS to assist with peak pressure and avoid unnecessary base appointments
- Weekly FedBucks winter planning calls from October covering : Rota fill including weekend either side of holiday period, winter equipment needed in all cars and bases, ensure business continuity plans are up to date, resilient and all staff compliant, including adverse weather plans, staffing resilience model

Provider highlights

Oxford Health (Mental health and Continuing Healthcare)

- Cold/Adverse weather plan agreed and updated
- Major incident plan in place
- Director on call response manual in place
- Business continuity plans updated
- System pressure response updated and based on OPEL framework
- Escalation processes in place
- Planning in place to ensure packages of care are in place for continuing health care over the festive period

Communications Plan

PREVENTION

Aim:
Change public behaviour to help PREVENT pressures on our health and social care system during the winter period.

COMMUNICATIONS OBJECTIVES

- Promote use of NHS 111, 111 online and Health Help Now app to encourage people to use them when they have an urgent, but non-life-threatening medical need so that they can be directed to the most appropriate service
- Increase uptake of flu vaccines amongst target groups
- Encourage people to visit their community pharmacist when they begin to feel unwell and before it becomes serious

PREPARE

Aim:
Build awareness of the work that the system is implementing to be PREPARED for the winter period.

COMMUNICATIONS OBJECTIVES

- To better inform and educate the media and general public on what the local health and social care organisations plan to do to prepare for winter
- Promote Help us Help You to build understanding on how to stay well and access the most appropriate health and care services

PERFORMANCE

Aim:
Ensure the health and care system responds to all reputational issues associated with PERFORMANCE during the winter period in a co-ordinated and credible way

COMMUNICATIONS OBJECTIVES

- All partners to use owned channels to share consistent messaging.
- Ensure people know how and where to access support.
- Provide important and immediate messaging to support safety and infection control
- Help to reduce unnecessary pressure on services.

Joined-up communication reduces duplication, increases clarity and amplifies our messages

Communication strategy

Comms resources

Printed materials

Leaflets promoting flu vaccination to be place in council buildings and libraries and distributed to nurseries, children centres etc.

GP pack and pharmacy pack sent to all GPs and pharmacies including posters, leaflets

Social media

All partner organisations will use their social media channels to produce their own messages as well as share national and partner posts

Digital screens

Screens in council offices, BHT, libraries and **GP practices** to include messages around staying well this winter

Media

A media briefing will be held at the earliest opportunity which will include representatives from partner organisations and frontline staff

Advertising

Advertising will be restricted to paid adverts on social media to promote extended GP access. This campaign will run throughout the winter period.

Let's Talk Health Bucks

Around 900 people registered including many PPG members who can spread messages

Newsletters/bulletins

Via BCC to promote flu vaccination

Staff newsletters to promote staff vaccines and infection control measures

Promote extended GP access and winter plans in the ICS newsletter

Key Messages

The NHS and social care are well-versed in planning for inevitable winter pressures.

We are working even more closely with our health and social care partners to ensure we are even stronger this year; however demand for services is increasing.

To ensure we treat people in greatest need as a priority **we all can help:**

- Please get a flu vaccination - we have offered more flu vaccinations than ever
- Seek immediate advice from a pharmacist as soon as you feel unwell and before it gets serious
- Stay healthy and know which health service is best for you. Use NHS 111 to find the right service for you.
- Keep your home heated to at least 18 degrees C
- Stock up on medications ahead of Christmas break

Remember to save A&E for serious and life-threatening conditions - but if it is a genuine emergency, don't delay – dial 999

QUESTIONS?

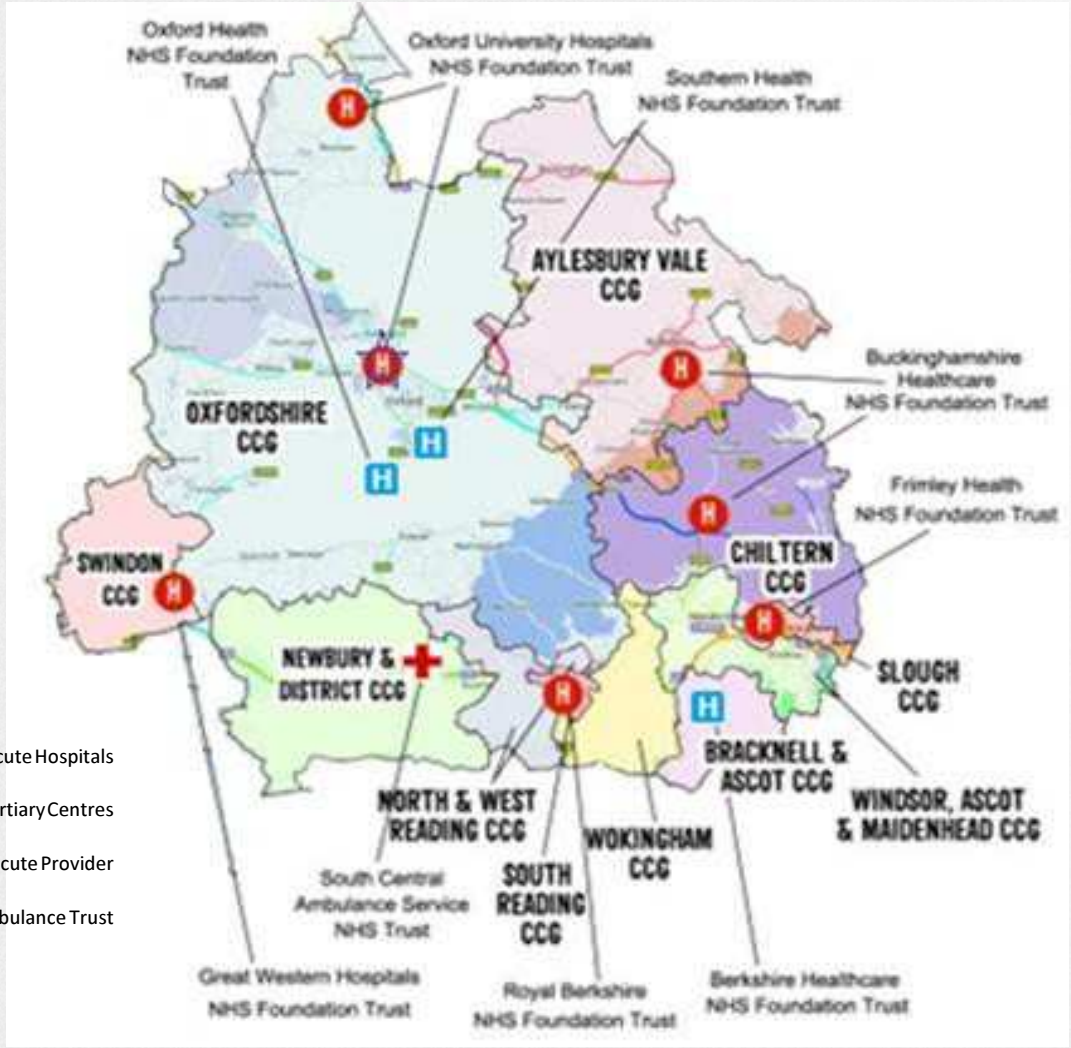
Your community
Your care
Developing Buckinghamshire together

Buckinghamshire Integrated Care System

Cancer Update
Health & Wellbeing Board, December 2018

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

Thames Valley Cancer Alliance footprint



- 2.3 million population
- 3 STPs (whole /partial)
- 4 CCGs
- 1 Tertiary Provider
- 5 Provider Trusts

- Of Note, CCGs have reduced from 11 to 4

Our Vision

To create a region that secures and delivers the best possible outcomes for every patient *affected by cancer by working together to maximise resources, to deliver the best possible, clinically-led and patient driven health and social care so that every person affected by cancer in Thames Valley receives the best possible outcomes*

Key Ambitions

By March 2021:

- **Reduce** adult smoking prevalence to **10.8%** from 15.4% (30% reduction based on projected 2021 population)
- **Increase** the proportion of patients with a recorded cancer stage to **80%**
- **Deliver the 28 day standard - 95% of patients** referred for testing by a GP are definitively diagnosed with cancer, or cancer is excluded, within four weeks
- **Every person with cancer** has access to all four elements of the **Recovery Package**
- **Increase** one-year survival for all cancers to **75%** from 72.5%
- **Increase** the numbers of patients surviving ten years or more **by 1400 (57%)**
- **Increase** the proportion of cancers diagnosed at **stage 1&2 to 75%**

Strategic Development of Cancer Care

The “Five Year Forward View” led to the development of Cancer Alliances nationally to strategically lead and facilitate the improvement of cancer care for the whole population – engaging with populations and health systems to improve access and care. Improving cancer survival beyond 5 years.

Thames Valley Cancer Alliance (TVCA) was developed as our regional alliance working with systems in Buckinghamshire, Oxfordshire, Berkshire and Swindon.

In 2017 Thames Valley Cancer Alliance successfully secured £9.07million from the National Cancer Modernisation Fund to support the delivery of priority areas identified by the Independent Cancer Report: ***Earlier Diagnosis, the Recovery Package, stratified follow up pathways***

Priorities include:

- Sustainable achievement of the 62 day referral to treatment standard through pathway redesign
- earlier diagnosis of cancer and improving outcomes for cancer patients through screening, diagnostic and capacity improvement.
- Implementation of stratified follow up pathways and the living with and beyond cancer model of care

Buckinghamshire ICS and TVCA

The Buckinghamshire Integrated Care System has facilitated collaborative working to support TVCA and the national strategy for improving cancer care and access. To date, a local strategy board has been assembled and includes representation from patients, CCG, BHT, PHE, NHSE, TVCA, Cancer Research UK and Macmillan. The group has developed a Buckinghamshire strategy that complements the national one and provides local context and focus. This has paved the way for delivery of TVCA's priorities.

Working with TVCA, the Bucks ICS has initiated a programme of work, utilising funds made available by TVCA. The programme focuses on key areas:

- Development of Diagnostics Services (using a Vague Symptoms Clinic consistent with the Oxford model and planning for a Rapid Diagnostic Centre)
- Development of pathways (UGI, LGI, Prostate and Lung)
- Supporting primary care and communities to improve screening and early detection (using QIS)
- LWBC – Supporting primary and secondary care to discharge and support patients using risk stratified pathways.
- LWBC – working with Macmillan to improve patient experience and care following diagnosis and treatment through better communication and coordination.

Progress in Buckinghamshire

The Buckinghamshire Integrated Care System has already made significant progress in delivering its programme of work, supported by TVCA. To date we have:

- Employed resource to allow focus on delivering work streams.
- Developed new pathways through urology and lung.
- Engaged with practices and populations of greater need to improve screening.
- Created additional diagnostic capacity.
- Implemented recovery packages for patients with breast cancer.
- Facilitated public and patient engagement events to support the development of LWBC work streams.
- Recovery and achievement of the 62 day standard for August and September.

Next steps

The TVCA programme of work will continue over the next 2-3 years to achieve sustained improvement in access, care and quality. Further engagement with communities and primary care are planned to improve screening and early detection of cancer. Further pathway redesign will be undertaken to improve care and outcomes – focusing on breast and prostate. Our LWBC work stream will continue to take steps to improve support for patients with cancer and those living beyond cancer.

How are we performing? (August 2018 data)

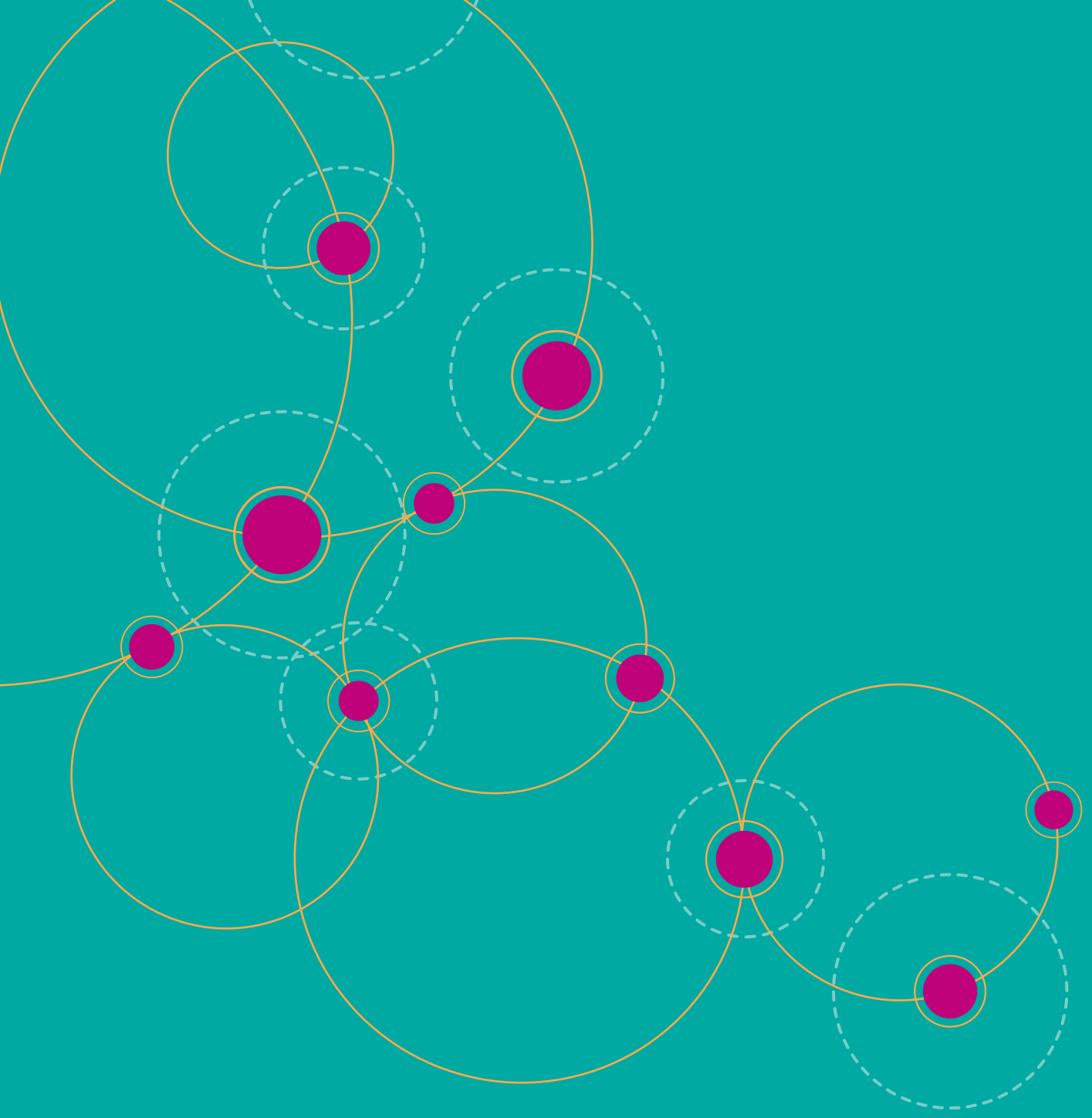
BUCKINGHAMSHIRE CCG						
2018-19 INDICATOR	National Standard	*NHS E agreed Bucks CCG trajectory	Report Month	Report Period Actual	Year to Date	Commentary
Cancer patients						
Cancer - 2 week wait	93%		Aug	94.9%	94.6%	
Cancer - Breast symptoms 2 week wait	93%			100.0%	91.1%	
Cancer - 31 day first definitive treatment	96%			97.3%	96.2%	
Cancer - 31 day subsequent treatment - surgery	94%			93.8%	89.5%	30 out of 32 patients seen within standard.
Cancer - 31 day subsequent treatment - drug	98%			100.0%	99.7%	
Cancer - 31 day subsequent treatment - radiotherapy	94%			96.0%	96.1%	
Cancer - 62 day - Urgent GP Referral to 1st Definitive Treatment	85%			86.7%	80.6%	
Cancer - 62 day - Screening	90%			80.0%	85.9%	20 out of 25 patients seen within standard.
Please note: RAG rating for all Monthly standards will be against NHS E agreed local trajectory if included/YTD RAG rating is against National Standard.						

Performance is improving month by month and is a positive picture

NHS

Thames Valley
Strategic Clinical Network
and Clinical Senate

Road to 2020:
The journey so far



Contents

Working with STPs and ICSs: **Highlights**

Stroke

Hosting a stakeholder forum to make the case for a thrombectomy service in Oxfordshire to benefit stroke patients across the patch

Maternity

Local Maternity Systems created for the BOB and Frimley STP footprints to improve maternity care for all women and their families

Diabetes

Oxfordshire CCG Diabetes Case for Change has influenced the development of cases for BOB and Frimley STPs

Cancer Alliance

Cancer Alliance will develop optimum pathways across the BOB and Frimley STP patches

Clinical Senate

Smoking prevention recommendations that will benefit the whole population

End of Life

ReSPECT workshops held to promote adoption of this new tool to improve end of life care for patients

Prevention

Large scale training programmes for all staff in BOB and Frimley STPs to benefit from Making Every Contact Count (MECC)

Mental health, dementia, neurology

Headache pathway developed and used to manage neurology referrals across BOB. This is now being used nationally

Musculoskeletal

Organising and hosting a best practice event to establish what could be done at an STP level. Data packs shared, including benchmarking by STP, catalogue of best practice example, and RightCare and Public Health England information

Long term conditions

Successful care and support planning training to upskill staff across both patches and enabling people to manage their conditions

Introduction: What is the Thames Valley Strategic Clinical Network and Clinical Senate?

Acute Trusts: **4**

GP Practices: **274**

Thames Valley Population: **2.4 million**

Mental Health Trusts: **2**

Community Hospitals: **18**

The Road to 2020

Cancer

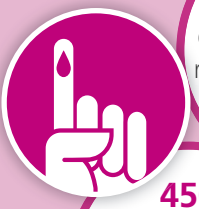
Reduce smoking prevalence to **10.8%** (a **30%** reduction)

80% of cancers staged

Additional **1,400** people surviving cancer for 10 years or more

Diabetes

4,400 more newly diagnosed patients receiving structured patient education



450 fewer lower limb amputations across Thames Valley

Every GP practice in Thames Valley meeting **40%** achieving the three treatment targets

Mental Health, Dementia & Neurology

5,000 more people with Serious Mental Illness (SMI) receiving physical health checks

90% of individuals with dementia to have patient-centred care & support plans

100% of all acute hospitals in Thames Valley have all-age Mental Health Liaison services in A&E and inpatient wards

Long Term Conditions and End of Life

(LTC) - **80%** of patients having care & support planning consultations

(EoLC) - **10%** increase across Thames Valley of death in place of usual residence

Stroke

200 fewer strokes in TV

850 additional patients in TV experiencing stroke symptoms will be taken to a HASU for the first 72 hours of their stay in hospital

Maternity

1,300 more women to be seen by Perinatal Mental Health services in TV

Reduce stillbirths by **20%** (4.1 per 1000 in TV)

Children

3,000 more children seen in MH services in Thames Valley

Children with Eating Disorders **seen within 4 weeks/ 1 week for urgent cases**

Cancer Alliance

In 2016, the SCN established the Thames Valley Cancer Alliance and published its ambitious five year cancer delivery plan, which is the Alliance's blueprint for locally delivering the national strategy Achieving World-Class Cancer Outcomes.[1]

Established Thames Valley Cancer Alliance and dashboard

£9.07m of cancer transformation funding secured

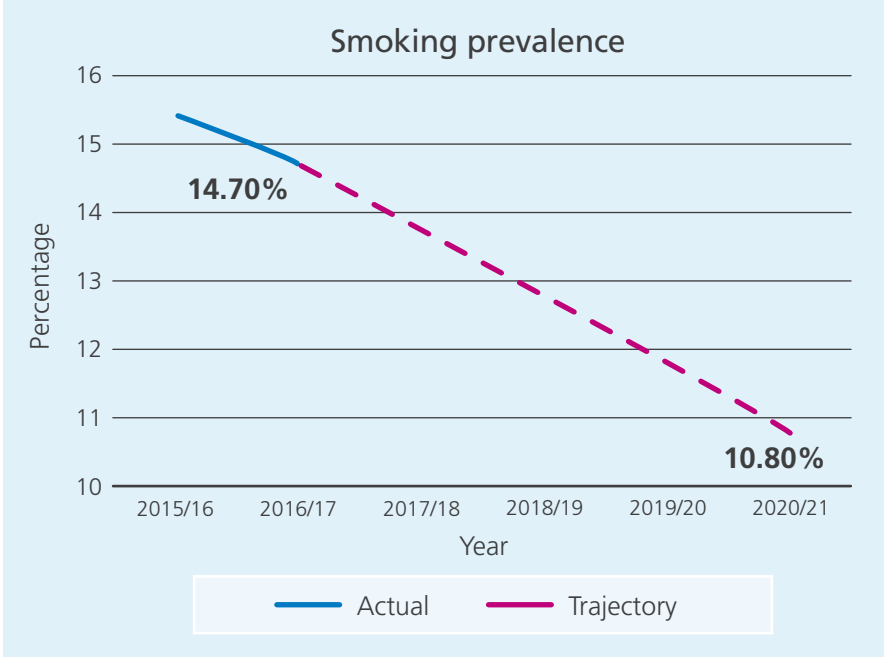
Significant increase in patients with a recorded cancer stage, now over **78%**

3% increase in numbers of cancer diagnosed at stage 1 & 2

Thames Valley Cancer Alliance vision

To create a region that secures and delivers the best possible outcomes for every patient affected by cancer by working together to maximise resources, to deliver the best possible, clinically-led and patient driven health and social care so that every person affected by cancer in Thames Valley receives the best possible outcomes.

Our journey so far



Reducing smoking prevalence

Reduce smoking prevalence to **10.8%** (a **30%** reduction)

- Completed the review of community smoking cessation services across Thames Valley
- Developed and circulated annual calendar of prevention and awareness events to support systems with prevention initiatives
- Supported systems with collation of toolkits and supporting resources for national, regional and local campaigns.

The journey ahead

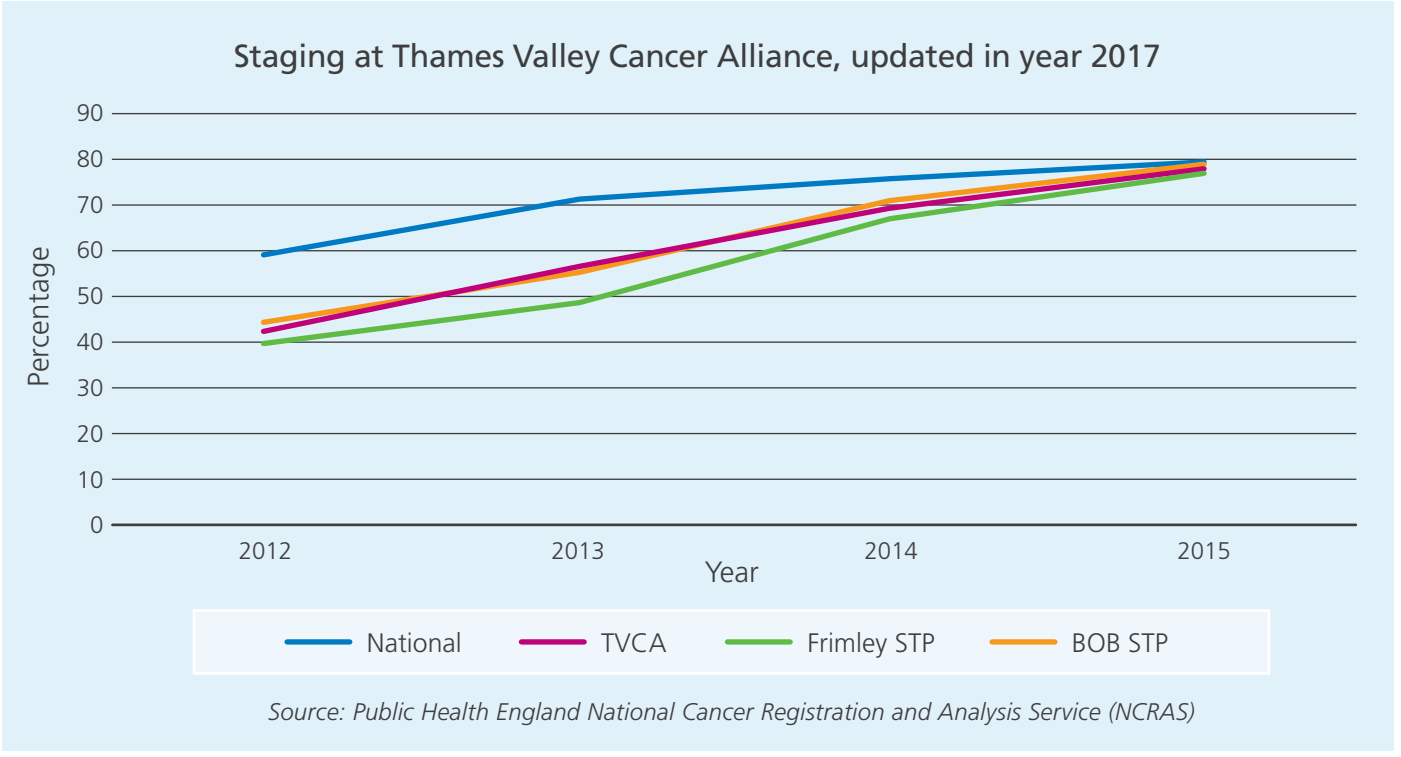
Planned activities include:

- Developing an Alliance-wide education strategy to support front-end staff (Making Every Contact Count - see page 43)
- Development of resource pack around lifestyle services to support secondary care to signpost benign two week wait patients accordingly.

Accurate staging/ increasing cancer staging

Our focus continues to be on the benefits of diagnosing cancer at an early stage. Early diagnosis can increase chances of survival. Over the last three years, we strongly recommended within the SCN commissioning guidance that all CCGs include in their contracts with providers a local ambition to stage 80% of cancer diagnoses. The latest available data shows that following this effort, the Thames Valley Cancer Alliance has rapidly caught up with England, as charted below.

80%
of cancers staged



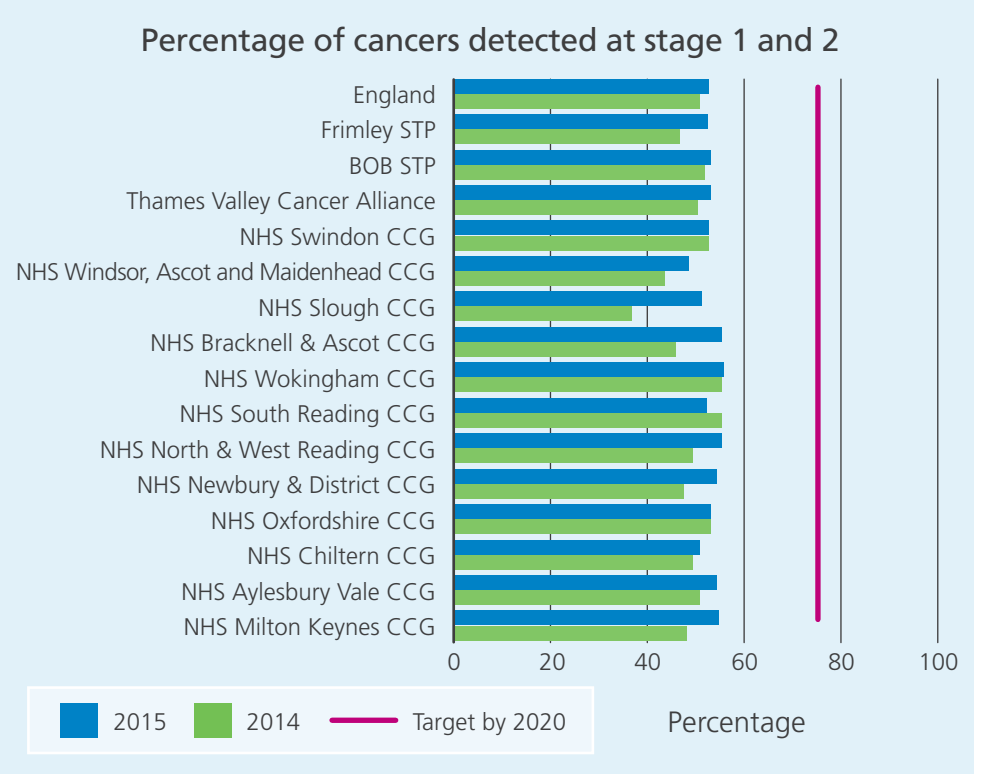
Source: Public Health England National Cancer Registration and Analysis Service (NCRAS)

To achieve 80% patients with recorded stage

*Additional patients required per CCG

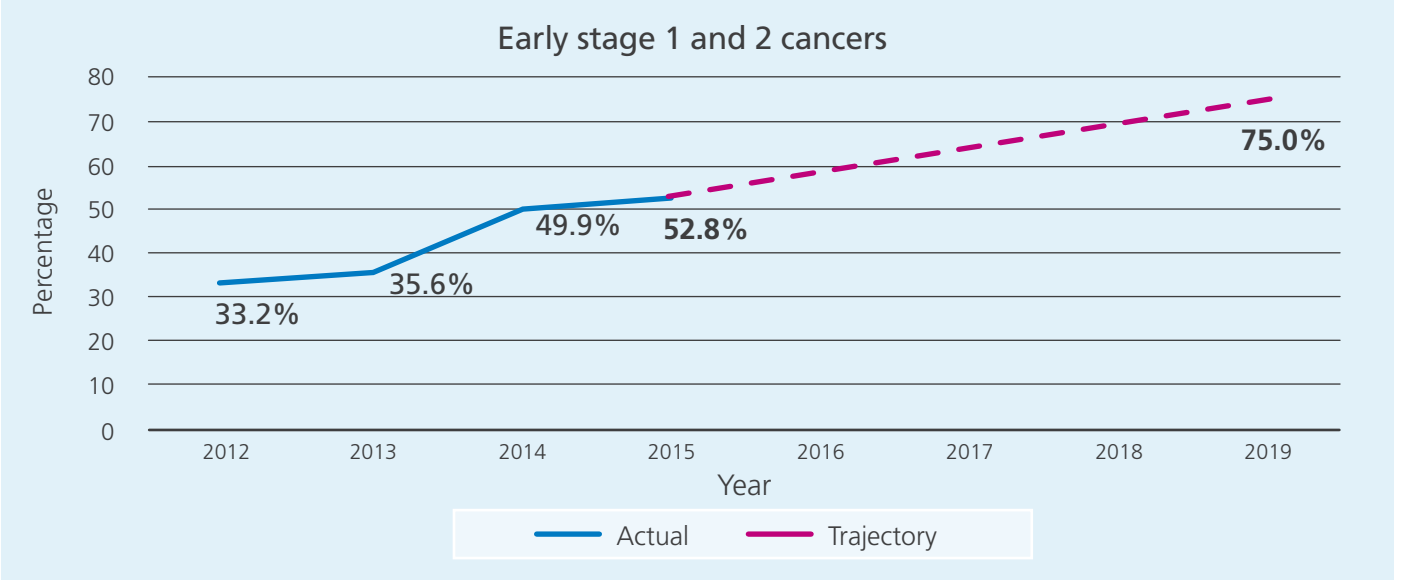
	Previous	Now
Bucks CCGs	380	51
Oxfordshire CCGs	95	0
West Berks CCGs	289	56
East Berks CCGs	311	86
MK CCGs	167	13
Swindon CCGs	44	0

The proportion of patients with cancer diagnosed at stage 1 or 2 disease can vary because of a number of factors, including the presence and uptake of national screening programmes. There are two major components of early detection of cancer: education to promote early diagnosis, and screening. The proportion of patients being diagnosed at stage 1 and 2 has also increased in Thames Valley and at a rate faster than the rest of the country. This is good evidence of system-wide working having a positive impact on patients, their families and the sustainability of the system.



Percentage of cancers diagnosed at stage 1 and 2

	2014	2015	Increase
Thames Valley Cancer Alliance	49.9	52.8	2.90%
England	50.7	52.4	1.70%
BOB STP	51.6	53.0	1.30%
Frimley STP	46.4	52.3	6.00%



The journey ahead

Planned activities include:

- Continued collaboration with partners to improve public awareness of different cancer symptoms and encouraging people to seek care when these arise
- Providing training and education to primary care health workers so they can undertake accurate and timely referrals
- Ensuring people living with cancer can access rapid, safe and the most appropriate and effective treatment.

Improving patient experience

Enabling Swindon and Wiltshire head & neck cancer patients to receive care closer to home

Current head and neck cancer (HNC) patient experience for those in Swindon and Wiltshire

New pathway of care for those with head and neck cancers due to commence in September 2018 ensuring that 65-70 patients a year will receive:

- Care closer to home
- The benefit of co-located specialist staff at hospital site closer to home

Proposed pathway diagram:

Group 1: Stages 1-2	Group 2: Stages 2-3	Group 3: Stages 3-4
Minimal input needed, single type of treatment, good support	Limited surgery/unilateral radiotherapy, moderate needs, higher risk of recurrence	High complexity case and treatment. May have tracheostomy or treated with curative intent or other complications
Discharged to Great Western Hospital 4-6 months post treatment	Shared care for 6-12 months, and then discharged to Great Western Hospital	May be shared care months 6-12, or may keep at Oxford University Hospitals for 12 months before discharge to Great Western Hospital

Acting on the recommendations	The benefits to patients
Offering patients stratified follow up pathways	Sustainable, resilient pathway
Developing local specialist HNC teams	Reduction in long journeys to OUH
Increasing rehab staff and restorative dentistry services	Development of local specialised team which can be built on in future
Introducing a programme of learning opportunities	Increased patient education and focus on prevention of recurrence

Delivering the cancer strategy

The Alliance successfully secured £9.07m cancer transformation funding across three priority areas over two years:

Area	Revenue		Capital investment
	2017/18	2018/19	2017/18
Early diagnosis	£1,630,308	£2,855,408	
Recovery package	£1,044,626	£968,201	£55,000
Risk stratified pathway	£173,850	£300,355	
Health Information Exchange (HIE)	£740,000	£740,000	£570,000
Subtotal	£3,588,784	£4,863,964	£625,000
Total per annum inc capital	£4,213,784	£4,863,964	
Total funding awards	£9,077,749		

Early diagnosis workstream incorporates three projects focused on:

- Diagnosing a high proportion of patients whilst their cancer is in the early stages
- Supporting achievement of cancer waiting time standards and improving patient experience by streamlining cancer patient pathways and by increasing diagnostic capacity.

Recovery package workstream (includes risk stratified pathways) focused on:

- Consistent Alliance-wide delivery of the four elements
- Reduction in cancer recurrence amongst cancer survivors
- Providing a unique multifactorial package of care, integrating existing elements
- Identification of clear steps and support to help patients to 'truly' self-manage where able to.

Health information exchange workstream focused on:

- Developing a single cancer database across the Alliance (integrating cancer systems, eg Infoflex and Somerset across the Alliance and with local trust-based electronic patient records to stop duplicate data entry and improve clinical safety)
- Developing tools to support self-care and improve patient experience
- Risk stratification and population health analysis
- Improving data capture and quality in trust-based systems.

Our journey ahead

- Provision of additional triage, outpatient and diagnostic capacity to support the estimated additional patients across the Alliance area 2018/19
- Developing robust benefits tracking to ensure that expected vision is achieved from the funding provided, encompassing best practice and value for money to achieve a sustainable health system
- Provision of significant additional CT and MRI capacity and implementation of straight to test pathways
- Implementing recovery package across Thames Valley
- Implementation of Vague Symptoms Multidisciplinary Clinics across the Alliance in 2018/19.

[1] Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020 https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf (last accessed 2nd February 2018)

Clinical Senate

Smoking: Stop before the Op

The cost burden of smoking attributable deaths and chronic illness is increasing to **£320m**

8,000 smoking attributable admissions

Three to six-fold risk of pulmonary complications

Complications during and after surgery

With both the BOB and Frimley STP plans looking at the potential to 'stop before the op', the Thames Valley Clinical Senate undertook a review of the work carried out by the London Clinical Senate in 2014, Helping Smokers Quit, to identify learning and best practice. It also carried out a review of the local results of the British Thoracic Society (BTS) national audit (2016) into smoking cessation services in secondary care.

The Senate has identified opportunities to increase the smoking cessation interventions prior to a surgical procedure and has produced a set of recommendations.

They include:

- Ensuring that a consistent message is delivered across health and social care in the key time leading up to surgery when patients will be reflecting on their health
- Ensuring that all opportunities to discuss smoking with the patient are maximised including appointment correspondence
- Improving the recording of smoking status in patient notes
- Increasing the delivery of Very Brief Advice training to frontline staff
- Making pharmacotherapy available in the formulary.

Conversations with Trusts to take this forward will commence in May.

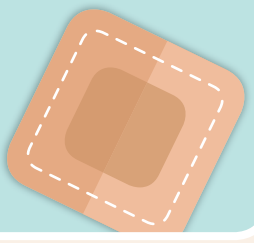
British Thoracic Society

Thames Valley Clinical Senate undertook a review of BTS Clinical Audits in acute Trusts and found:

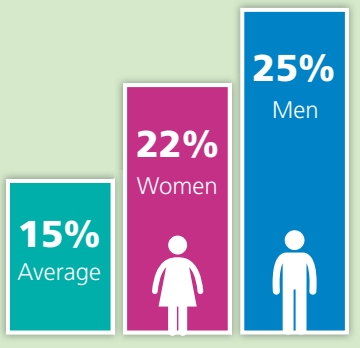
33% of inpatients were not asked their smoking status

Only **25%** of identified smokers were asked if they wanted to quit

Only **2%** of current smokers were offered nicotine replacement



And... smoking prevalence in acute Trusts is **higher** than general prevalence



NHS Bed Test

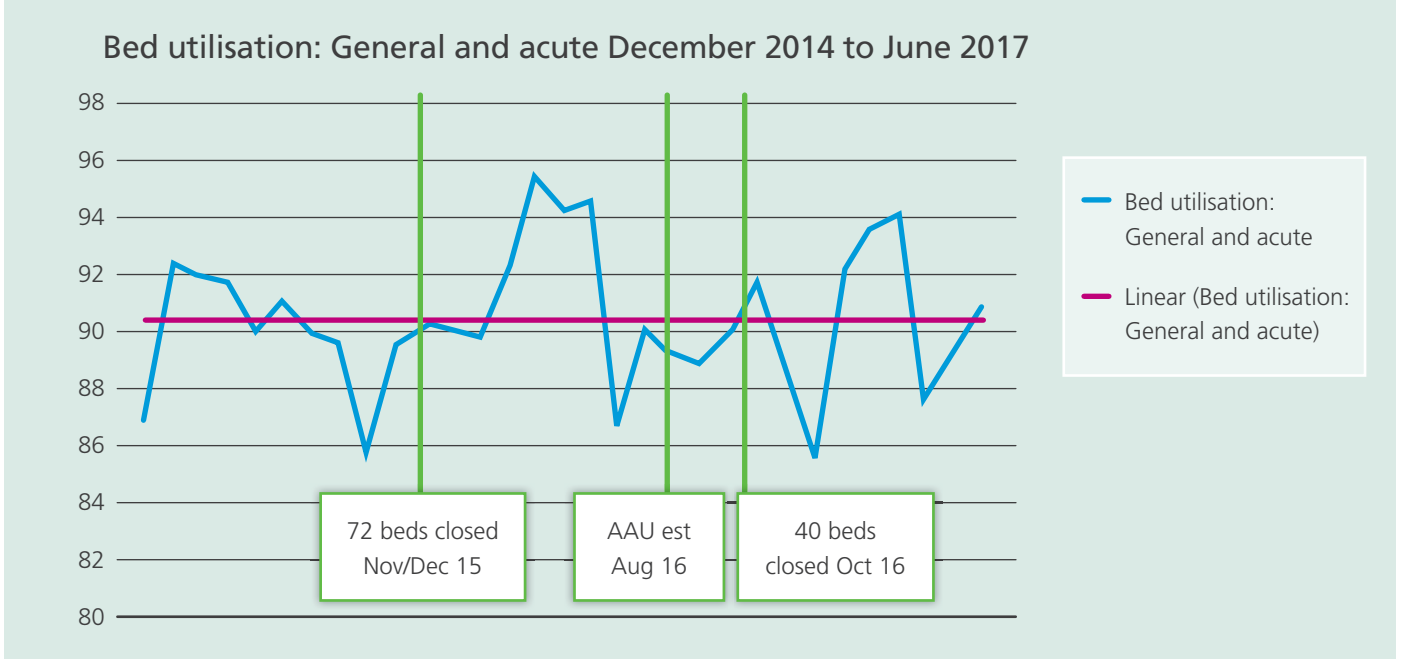
In 2017, the Senate was asked to apply the NHS bed test to the 110 beds that had been temporarily closed at the Oxford University Hospitals Foundation Trust (OUH FT) during the Phase 1 Oxfordshire Transformation. The NHS bed test came into force in 2017 and is an addition to the Government's four tests for reconfiguration proposals. It states that bed closures will only be supported if the organisation can demonstrate that it can meet one of the three new conditions as below:

1. Show that enough alternative provision is being put in place alongside or ahead of bed closures, and that a workforce would be there to deliver it and/or
2. Show that specific new treatments or therapies would reduce specific categories of admissions or
3. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance with affecting patient care.

The Senate review focused on condition one as the applicable test in this case. The alternative services which were put in place included an ambulatory unit (AAU) which increased the number of patients that could be treated in hospital on a day basis, returning home overnight; and a new approach clinically led by a Liaison Hub which focused on transferring patients who no longer needed acute medical care from the hospital setting to into a nursing home bed while they awaited the next stage of their care.

To consider the case, the Senate undertook a review of literature, data and serious incidents and conducted a number of interviews and Q&A sessions with clinicians working within the new services. There was ample national and international evidence to support the provision and effectiveness of both the AAU and the Liaison Hub and the move towards the ambulatory care model was both clinically supported and well received by patients and GPs. A review of activity data showed that the Trust, despite continued growth in emergency activity, had been able to reduce the amount of time patients needed to spend in hospital and length of stay has been reduced for the over 65s.

The trend of bed use at the Trust, measured from December 2014 to June 2017, remained stable despite the growth in activity and whilst beds in the Trust were reduced by 110, this was matched by the purchase of a similar number of beds in the nursing homes.



There were concerns about the delays in the system around domiciliary care and the impact these delays were having on the Trust bed capacity, but the Senate found that a significant amount of work was being undertaken in the system to understand the reasons for the delays and to put solutions in place.

The Senate agreed that the principle of what the Trust was aiming to achieve with the new services should be supported and there was evidence that they were delivering benefits to patients in reducing admissions and length of stay.

Vascular

In 2015-16, the vascular network underwent a reconfiguration to provide compliant Specialised Vascular Services across the Thames Valley. This work was led by the Thames Valley vascular network and its proposals were considered by the Clinical Senate to ensure that wider implications and co-dependencies were fully considered. The Senate supported the option for Buckinghamshire Healthcare NHS Trust to become a non-arterial vascular centre, as with the Royal Berkshire NHS with OUH FT as the arterial centre, and for all hospitals in the area to provide outpatient care. The Senate highlighted certain issues to be resolved within a six month timeframe, which included the provision of additional vascular beds at the OUH.

The Senate carries out reviews of its recommendations to ascertain the impact and benefit of its work and as part of this, undertook a review with the vascular network. Through this work, the Senate established that not all of the additional beds had been provided and that this was impacting on elective admissions. The Trust was invited to attend the June Senate meeting to update on the progress made in delivering the new pathway and to discuss the shortfall in beds. As a result of the discussion with the Senate, the Trust provided assurance that the additional beds would be supplied following the resolution of the current nursing shortfall. This requirement was considered to be part of the NHS Bed Test review.

Thrombectomy

In May 2017, NHS England launched a public consultation on a proposition for introducing thrombectomy services across the country. Mechanical thrombectomy dramatically reduces the significant burden of disability caused by certain types of stroke by providing a more effective clot removal procedure, reducing the level and severity of damage caused to the brain. It also improves access to specialists for patients experiencing other types of stroke.[1] The cost savings to CCGs with the introduction of a thrombectomy service are £6.2m in year one, rising to £28.9m in year five, with additional savings arising outside the healthcare system, by reducing rates of disability and dependence in stroke survivors.[2]

The stroke network held a stakeholder forum earlier in the year to discuss the potential of a thrombectomy service in Thames Valley, and came to the conclusion that the best option for patients in TV and neighbouring areas is the establishment, as soon as possible, of a full service at the John Radcliffe Hospital. This has been commissioned by Specialised Commissioning.

The Senate will use its relationships and whole system view to focus on the development of the pathways including hospital transfers and post procedural care and consider unintended consequences. The work will involve stakeholder involvement within Thames Valley, Swindon and Milton Keynes and will be undertaken in early summer.

Learning from reconfigurations

A formal role of the Clinical Senate is to carry out clinical reviews to inform the NHS England assurance process. The NHSE assurance is based on the Government's four tests for service reconfiguration and the Senate provides advice to NHSE on the clinical elements highlighted below:

Four tests list

The four tests from the Government's mandate to NHS England

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners

Best practice checks list

In addition to these four tests a range of best practice checks for service change proposals, these include:

- Clear articulation of patient and quality benefits
- The clinical case fits with national best practice
- An options appraisal includes consideration of a network approach, cooperation and collaboration with other sites and/or organisations.

You cannot avoid a referral for judicial review but the way in which you go about your plans and consultation can help put you in a better position if this should happen. We have shared some learning from reviews to help those working in reconfiguration this year.

Make sure you know and understand your statutory requirements as they relate to reconfiguration at the outset.

Engage with your stakeholders and the Local Authority scrutiny process early – a Local Authority can refer to the Secretary of State for an independent review if they do not believe that they have been consulted adequately or if they consider the proposal is not in the interests of health services in the area.

Make sure your consultation is lawful; it should be undertaken at a formative stage of the proposals and you need to show how you have considered the feedback and applied it to the proposals.

Consultation: You need to be able to share a vision that provides a context for the service change that clearly communicates benefits for patients. It should address funding, transport and emergency care explicitly and openly and your implementation plans should be transparent and credible.

Make sure you have credible clinical endorsement for your proposals.

Take advice early from your lawyers, NHSE, Independent Review Panel and the Clinical Senate – you can work with the Senate from an early stage for independent clinical advice or to test your proposals.

[1] Consultation on Specialised Services clinical commissioning policies and service specifications, https://www.engage.england.nhs.uk/consultation/clinical-commissioning-consultation-may-2017/ (last accessed 4th December 2017)

[2] Thrombectomy in Thames Valley, presentation by Dr Matthew Burn to the Thames Valley Clinical Senate, November 2017.

Diabetes network

At present, 9%, or £8.8 billion of the annual NHS budget is spent on diabetes care. 80% of this money is spent on preventable complications. Across Thames Valley, the cost burden of diabetes is £369m, and is expected to increase to £487m by 2035. The per patient cost for treating diabetes is £3,000, and the number of diagnosed patients in Thames Valley is set to increase by 44,723.[1] The impact of this is illustrated below:

	Berkshire West CCG	Oxfordshire CCG	Buckinghamshire CCG	Bracknell And Ascot CCG	Slough CCG	Windsor, Ascot and Maidenhead CCG	North East Hampshire and Farnham CCG	Surrey Health CCG
Cost burden in 2016	92	126	105	23	35	29	39	17
Cost burden by 2035	118	163	136	32	49	37	50	22
No of diagnosed patients 2016/17	21,177	29,469	26,087	6,152	10,491	6,529	10,745	4,344
No of diagnosed patients by 2035	27,240	38,117	33,910	8,399	4,386	8,413	13,727	5,487

Prevalance

	Berkshire West	Oxfordshire CCG	Buckinghamshire CCG	Bracknell and Ascot	Slough	WAM	North East Hampshrie	Surrey Health
in 2016	30,513	42,063	34,978	7,771	11,792	9,550	12,943	5,755
in 2035	39,249	54,407	45,467	10,610	16,171	12,306	16,535	7,269

Assessing the current picture and understanding the scale of the future challenge has been a vital part of the SCN's work this year, leading to the creation a number of cases for change. The first being for Oxfordshire, whose feedback and review confirmed the approach. Further cases for the Buckinghamshire and Frimley geographies have been produced, with Berkshire West due in April. The case for change for diabetes has been shared widely with networks and CCGs across the South region to support local examples being developed. It has been used by CCG clinical leads to raise the profile of diabetes across their organisations and executive teams. It has informed the local model of diabetes care and shaped future priorities of work.

As well as identifying the current and future burden of diabetes, the case for change documents identify areas, and the scale of opportunity for potential and substantial cost savings.

Case for change	Possible saving	Method
Thames Valley wide	£2.5m in three years	Reducing amputation rates to match the best performing CCG
Thames Valley wide	£1.6m in five years	50% of patients achieving the three treatment targets
Buckinghamshire	£1m in three years	Reducing amputation rates to match the best performing CCG
Oxfordshire CCG	£1.7m in ten years	50% of patients achieving the three treatment targets
Frimley STP	£1.3m in ten years	50% of patients attending structured patient education

Network ambition

The Thames Valley diabetes network set itself three key ambitions to be achieved by 2020, centred on treatment targets, patient education and amputation rates. By 2020:

- At least 40% of patients with diabetes in every GP practice in Thames Valley will receive the three treatment targets on a regular basis.
- At least 50% of all newly diagnosed patients with diabetes will receive structured patient education.
- The amputation rate across Thames Valley will match that of the best CCG in England.

Treatment targets

Data on treatment target achievement is gathered in the National Diabetes Audit. Practice participation for the latest 2016/17 audit was 100%. There remains wide variation across practices in achievement of the treatment targets. This remains an area of focus, as well-controlled diabetes plays a key role in improving outcomes and reducing complications.

3 Treatment Target achievement for type 1 and 2 diabetes, by STP

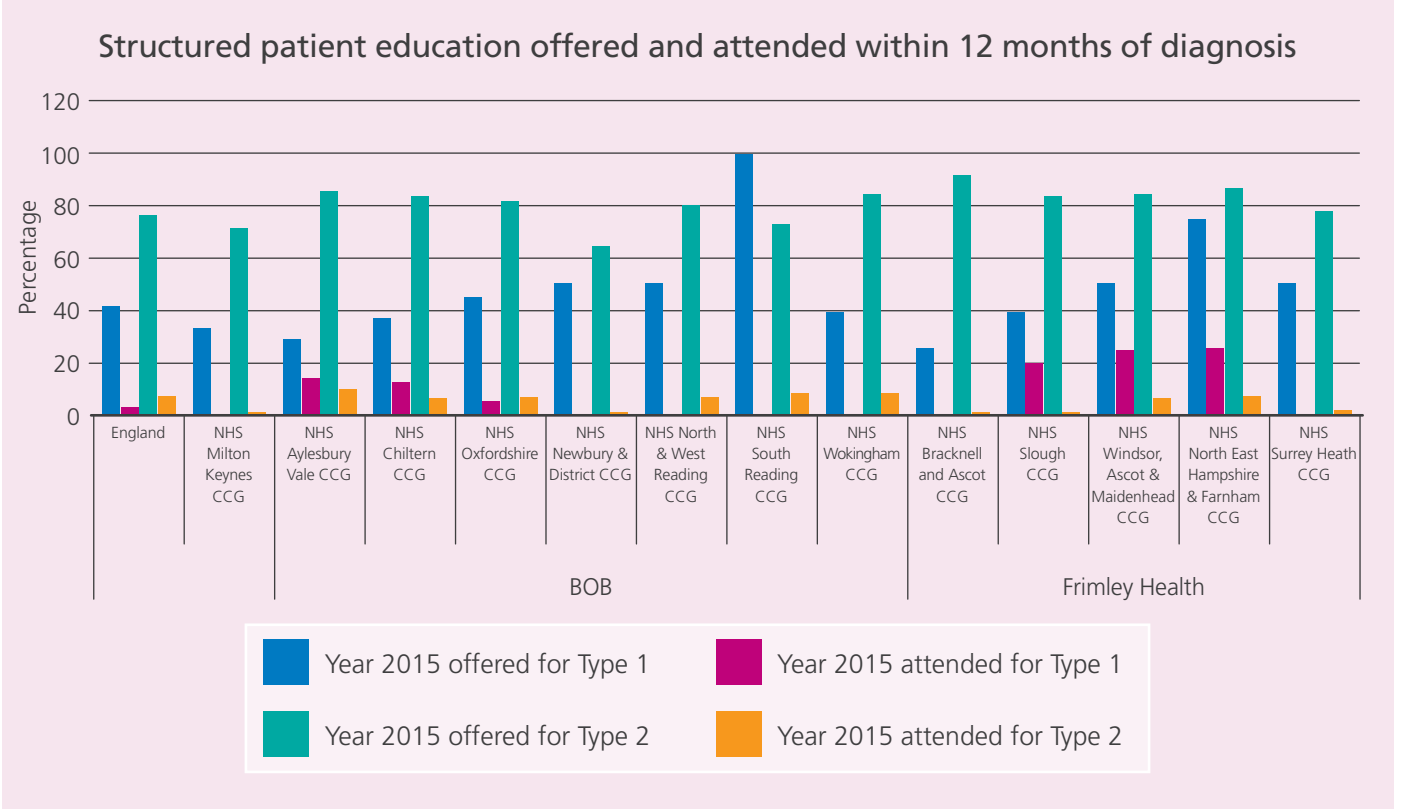
Type	STP	CCG	% of patients achieving 3TT	Compare to last year 15/16	Percentage of practices achieving less than 40%	No of people not achieved 3TT
Type 1		England	19.0	↑		131,585
		Thames Valley SCN	21.8	↑	82.5	5,700
		NHS Milton Keynes CCG	22.9	↓	85.2	640
	BOB	NHS Aylesbury Vale CCG	19.0	↓	100.0	555
		NHS Chiltern CCG	20.5	↓	88.2	755
		NHS Oxfordshire CCG	22.3	↑	84.3	1,635
		NHS Newbury & District CCG	21.7	↑	100.0	270
		NHS North & West Reading CCG	25.8	↑	70.0	245
		NHS South Reading CCG	25.4	↑	50.0	235
		NHS Wokingham CCG	22.1	↑	84.6	370
	Frimley Health	NHS Bracknell & Ascot CCG	21.8	↑	80.0	340
		NHS Slough CCG	18.7	↑	68.8	305
		NHS Windsor, Ascot & Maidenhead CCG	21.3	↑	82.4	350
		NHS North East Hampshire & Farnham CCG	21.0	↑	100.0	545
		NHS Surrey Heath CCG	17.6	↓	100.0	210

Type	STP	CCG	% of patients achieving 3TT	Compare to last year 15/16	Percentage of practices achieving less than 40%	No of people not achieved 3TT
Type 2		England	41.1	↑		1,435,080
		Thames Valley SCN	41.5	↓	100.0	53,810
		NHS Milton Keynes CCG	38.3	↓	59.3	6,435
	BOB	NHS Aylesbury Vale CCG	42.8	↓	33.3	4,670
		NHS Chiltern CCG	44.3	↓	20.6	7,370
		NHS Oxfordshire CCG	40.4	↑	42.9	14,140
		NHS Newbury & District CCG	37.7	↑	60.0	2,375
		NHS North & West Reading CCG	40.3	↑	60.0	2,225
		NHS South Reading CCG	40.4	↑	43.8	2,760
		NHS Wokingham CCG	41.6	↑	38.5	2,945
	Frimley Health	NHS Bracknell & Ascot CCG	44.2	↓	40.0	2,730
		NHS Slough CCG	42.6	↓	37.5	5,200
		NHS Windsor, Ascot & Maidenhead CCG	43.9	↑	29.4	2,960
		NHS North East Hampshire & Farnham CCG	43.6	↓	34.8	4,830
		NHS Surrey Heath CCG	41.2	↑	62.5	2,035

Diabetic structured patient education

Diabetic structured patient education is a NICE-recommended intervention which enables those with diabetes to better manage their condition. Currently, only 7.1% of newly diagnosed patients attend these sessions nationally. It is recognised that data recording is an issue, however access to good quality education and information directly contributes to improved confidence, knowledge and self management.

The ambition is that by 2020, at least 50% of all newly diagnosed patients with diabetes will receive structured patient education. This will require significant focus.



Footcare

Minor and major amputations are a significant complication of poorly controlled diabetes, and are costly procedures for the NHS. By 2020, the network plans for the amputation rate across Thames Valley to match that of the best CCG in England. This requires a reduction of 492 amputations across Thames Valley and Milton Keynes. The method of data collection has changed significantly from last year so direct comparison is difficult.

Amputations per 1,000 people aged 17+ with diabetes

		Apr 2013 - Mar 2016 (3 years data)				Achieving the best CCG within TV (11.1 per 10,000 people)			Achieving the best CCG in England (9.5 per 10,000 people)		
		Major amputation (adjusted*)	Minor amputation (adjusted*)	Crude rate per 10,000 people	No of cases	No of cases to be reduced	No of cases	% reduced	No of cases to be reduced	No of cases	% reduced
	Lowest CCG in England	**3.0**	**7.2**	**9.5**	**50**						
	Highest CCG in England	**21.3**	**45.4**	**57.0**	**161**						
	England average	**8.1**	**21.0**	**29.1**	**25,527**						
	NHS Milton Keynes CCG	6.8	28.8	34.3	124	84	40	67.8%	90	34	72.3%
BOB STP	NHS Aylesbury Vale CCG	6.3	22.2	30.7	88	56	32	64.0%	61	27	69.1%
BOB STP	NHS Chiltern CCG	8.4	19.5	26.2	120	69	51	57.8%	76	44	63.7%
BOB STP	NHS Oxfordshire CCG	8.1	12.9	22.2	186	93	93	50.3%	106	80	57.3%
BOB STP	NHS South Reading CCG	9.1	15.3	24.1	37	20	17	54.1%	22	15	60.5%
BOB STP	NHS Newbury & District CCG		18.7	25.2	33	19	14	56.1%	21	12	62.3%
BOB STP	NHS North & West Reading CCG	12.1	18.4	32.1	40	26	14	65.5%	28	12	70.4%
BOB STP	NHS Wokingham CCG	9.1	15.3	24.8	43	24	19	55.5%	27	16	61.8%
Frimley Health STP	NHS Bracknell & Ascot CCG		9.6	11.1	19	0	19	0.0%	3	16	14.1%
Frimley Health STP	NHS Slough CCG	8.2	28.4	25.3	72	41	31	56.3%	45	27	62.5%
Frimley Health STP	NHS Windsor, Ascot & Maidenhead CCG	5.8	10.4	16.3	31	10	21	32.1%	13	18	41.7%
Frimley Health STP	NHS North East Hampshire & Farnham CCG	5.6	24.9	31.9	92	60	32	65.4%	65	27	70.2%
Frimley Health STP	NHS Surrey Heath CCG	11.7	18.6	30.4	37	24	13	63.7%	25	12	68.8%
	Thames Valley SCN				**793**	**442**	**351**	**55.8%**	**492**	**301**	**62.0%**
	TOTAL				**922**	**526**	**396**	**57.1%**	**582**	**340**	**63.1%**

*Note: *Directly (age & ethnicity) standardised rate of major amputations per 10,000 patients with diabetes*

To achieve the target amputation rate, the Thames Valley footcare pathway has been updated, and a suite of documents previously provided to each locality will be available on the SCN website by the end of April.

The documents that have been produced for each locality will assist in improving footcare across the pathway, and ultimately to reduce amputations. This includes a revised pathway, gap analysis, commissioner guide and latest data. Task and finish groups have been established in each locality to utilise these resources in driving improvements in footcare.

The Thames Valley clinical leadership group for footcare will be re-established in the Spring, and the SCN will be offering input to each task and finish locality group that was established following production of the materials.

Transformation bids

2017 has seen the CCGs focusing on delivery of the transformation programme. The network provided and funded bid writing support, and Thames Valley secured a disproportionately high allocation of the money available. The bids focused on four areas: improving achievement of the key treatment targets, increasing the uptake of structured patient education, reducing the number of amputations by improving access to multidisciplinary footcare teams and reducing the length of hospital stays by improving access to inpatient support via specialist nursing teams. £1.5 million of this money will be used across the BOB STP. The network is now providing ongoing support and guidance to CCGs, individually and collectively, in delivering this programme of work.

Patient structured education

Education features in all locality bids with addressing the hard to reach groups being a common theme. The network will be working with a number of CCGs providing resources and expertise to enable this work to reach a timely conclusion. Areas covered include increased BME community-specific education, increased staff training in order to deliver structured courses, and marketing the courses to the population.

All CCGs have signed up to the Diabetes UK pledge to increase patient education uptake. Data is now being tracked for uptake, with CCGs self-reporting via the national and regional dashboards.

Treatment targets

All CCGs secured funding to support improved achievement of the treatment targets. Enabling people to improve their knowledge and confidence to self-manage their conditions reduces the risk of complications. All Thames Valley CCGs have adopted Care and Support Planning as the approach of choice in achieving self-management (see page 27).

Inpatient care

People with diabetes have longer lengths of hospital stay, often associated with poor management of their diabetes. This funding focuses on increasing the input of specialist nurses to see patients and provide training and education of ward staff. Improved quality of care combined with reduced length of stay is anticipated from these bids.

These complications increase the amount of time people with diabetes spend in inpatients beds; their average excess length of stay is 0.8 days, costing the NHS £573 million per year.[2] A number of CCGs in Thames Valley have secured transformation bid money for diabetes specialist inpatient staff; diabetes specialist inpatient teams improve the quality of patient care and reduce costs by lowering the number of adverse events, the average length of stay, admission and readmission rates, and by increasing the number of day rate cases.

Multidisciplinary footcare team (MDFT)

Complementing the Thames Valley work on footcare, two CCGs secured additional funds to enhance MDFT provision, including expansion of the service and increasing speed of assessment and treatment.

Currently, 80% of the current spend on diabetes is on the complications associated with it; achieving all three NICE treatment targets is key to avoiding complications.[3]

Local progress

Through the transformation programme, CCGs are starting to see tangible improvements in patient care, such as the number of patients seen within 24 hours by the multidisciplinary footcare team, the number of inpatients seen by a diabetic nurse specialist and improvements in the 3 treatment targets and 8 care processes.

Bucks HSJ spotlight

The HSJ has put together a guide on how to cut the cost of diabetes by increasing patient compliance with treatment, and upskilling primary care staff to reduce the diabetes burden on secondary care.

The guide highlights the work done in Buckinghamshire for the diabetes transformation programme. Aylesbury Vale and Chiltern CCGs have worked to provide care and support planning (see page 27 for more information on care and support planning) for each person with diabetes, improved access to psychological services, and are upskilling staff. They are targeting 50% of patients receiving structured patient education, up from a current rate of around 10%.

View the online guide, and Buckinghamshire's excellent work here: https://guides.hsj.co.uk/5687.guide

Network leadership

Recognising the importance of strong clinical leadership, the network has established a CCG clinical leads group to set out and deliver a strategic ambition for diabetes care across the Thames Valley.

This complements the diabetes reference group which is the forum for the sharing of good practice, discussion of challenging issues, and setting out the Thames Valley position on key areas, and the network contribution to locality meetings and monthly transformation calls to support and assist with transformation programme delivery. The network has provided a position statement for the adoption of FreeStyle Libre, will be hosting a conference on how to achieve personalised, value-based outcomes for people with type 1 diabetes, to support CCGs in their thinking on the optimum model of care for people with type 1 diabetes. There will be a half day meeting on dietary challenges, to explore the contentious and complex issue of personal choice and dietary advice, aiming to reach a consensus across Thames Valley by all partners. The issue and opportunity of 'diabetes in remission' is recognised and the network is exploring the opportunity this could afford CCGs in offering a different model of care to free up primary care resources. A Thames Valley-wide definition and local audits to determine potential gain are work in progress.

[1] Diabetes - Case for Change Oxfordshire CCG: Thames Valley Strategic Clinical Network, June 2017

[2] Inpatient Care for People with Diabetes: The Economic Case for Change https://www.diabetes.org.uk/resources-s3/2017-10/Inpatient%20Care%20for%20People%20with%20Diabetes%20%20The%20Economic%20Nov%202011_1.pdf (last accessed 26 March 2018)

[3] Diabetes Case for Change – Oxfordshire CCG

End of Life network

The end of life (EOL) network works with commissioners and providers to support them in the delivery of their strategic plans and ongoing work around improving end of life care for their population.

The network has been focused on a small number of key areas to support the ambition of increasing the number of deaths in the usual place of residence. This ambition sits alongside the drive to reduce unwarranted hospital admission in the last 90 days of life, and increasing the number of patients supported in their care by a robust electronic palliative care record.

The Choice Commitment (DH 2016) is the Government's response to the report by Choice Review (NCPC 2015) 'what is important to me' outlining six key declarations to improve quality of care, choice and control for patients and those important to them at the end of life. The Choice Review provided evidence of what was important to people at the end of life from hearing what the public wanted.

EPaCCS effectiveness: *"Data from the South West on 3,012 EPaCCS patients and over 67,000 total deaths demonstrated differences in hospital death of 9.8% vs 33.9% for patients with cancer and 8.3% vs 49.9% for patients without cancer, respectively, on and off EPaCCS."*[1]

EPaCCS, a key tool within end of life care to support communication and coordination with all professionals involved in a patient pathway.

The focus has been on reviewing the robustness of their localised EPaCCs. Using a self-assessment tool (adapted from the South West EOL region) has highlighted the complexities and difficulties in ensuring patients care plans and reviews can be both viewed and updated.

It covers:

1. Who (health and social care professionals) on the patient's pathway has access to the system (read only or read edit permissions).
2. What information has been input to identify key EOL care priority needs, to support proactive planning and communicate what care has been put in place. (This supports 11 of the 60 Minimum Data EoL Set Information standard.)
3. Review: How many records have been updated in the last four weeks?

Key areas of work

Electronic Palliative Care Coordination Systems (EPaCCS)

The network is supporting the implementation and review of EPaCCS to improve communication, care planning and coordination at the end of life.

Area	Initial scoping complete and in progress	Key gap identified	Level of functionality established	Phase 2 action for development
Buckinghamshire	Awaiting results	To be determined	Yes	Yes: 2018-19
NHS Oxfordshire CCG	Scoping completed	Yes	Yes	Yes: 2018-19
Berkshire West	Scoping completed	Yes	Yes	Yes: 2019-20
Berkshire East	Awaiting results	To be determined	Yes	Yes: 2019-20

Robust EPaCCs improve communication, care planning and coordination at the end of life

CCG SELF-ASSESSMENT

- Who has access to the system?
- What information has been input to identify key EOLC priority needs
- How many records have been updated?

DASHBOARD CREATED

- Avoiding in-hospital deaths
- Provides support and improvements for all professionals across the pathway

Urgent and emergency care work

STP	CCG	Proportion of all people admitted into hospital during the last 90 days of their life (2015)	Proportion of people who have three or more emergency hospital admissions during the last 90 days of life (2015)	Proportion of all people who died in hospital (2015)
	England	67.7	6.9	46.7
BOB	**STP - Buckinghamshire, Oxfordshire & Berkshire West**	65.2	6.8	44.5
	NHS Aylesbury Vale CCG	64.3	5.8	43.2
	NHS Chiltern CCG	66.1	6.6	47.2
	NHS Newbury & District CCG	61.3	5.4	51.6
	NHS North & West Reading CCG	66	5.7	43.3
	NHS Oxfordshire CCG	65	7.2	42
	NHS South Reading CCG	69.2	7.4	48.4
	NHS Wokingham CCG	65.2	8.1	45.4
Frimley Helth	**STP - Frimley Health**	65.5	6.9	47.2
	NHS Bracknell & Ascot CCG	64.5	7.5	48.3
	NHS North East Hampshire & Farnham CCG	67.1	6.7	42.5
	NHS Slough CCG	66.5	7.8	57.2
	NHS Surrey Heath CCG	63.6	7.3	41.1
	NHS Windsor, Ascot & Maidenhead CCG	64.7	5.9	49.8

Source: NEoLCIN-End of Life Care Sustainability and Transformation (STP) Tool (PHE (NEoLCIN) from NHS Digital HES linked to ONS Mortality Data)

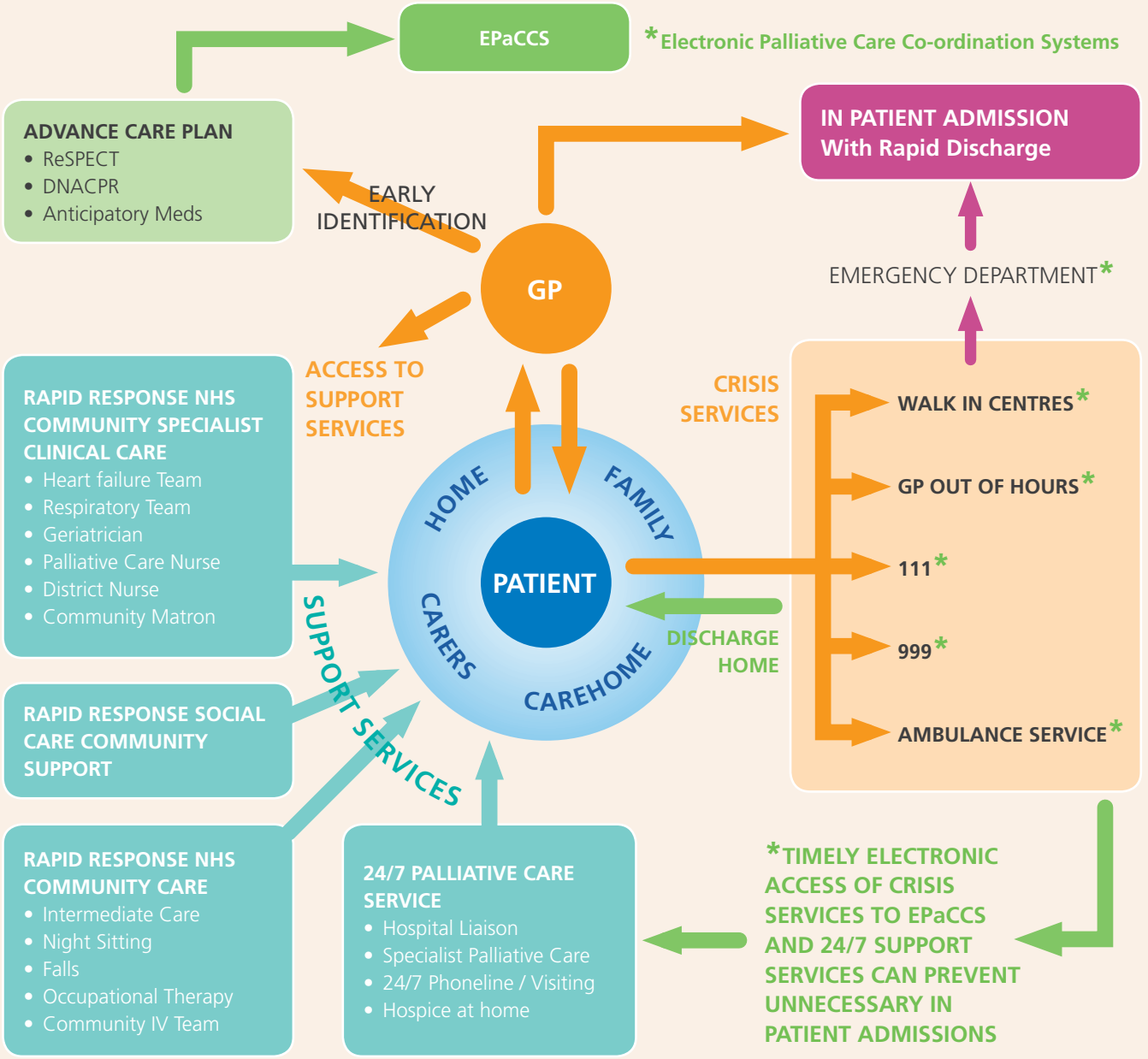
Key: Compare to England

- Higher than England value
- Similar to England value
- Lower than England value

Supporting STP priority programmes

Setting out the contribution of end of life care to the priority programmes of cancer, mental health, primary care and urgent & emergency care (U&EC) is an ambition of the EOL team. The network has focused on U&EC, and developing an optimum pathway. This pathway illustrates the complexity and range of services, but shows where they work together: wrapped around the patient as well as supported by a robust EPaCC system. This will have a positive impact on the U&EC system and unwarranted emergency admissions.

Optimum pathway for end of life care in urgent and emergency care



Recognised by the National EOL care NHS England programme as a model of good practice and used by the National Urgent and Emergency Care Team, the work was subsequently presented at NHS Expo 2017. It has been shared widely across Thames Valley with end of life and urgent & emergency care colleagues.

Leading end of life

The network team continue to provide impartial, expert advice and support to CCG colleagues directly, and through contribution at locality meetings. The Thames Valley commissioner forum provides opportunities for the sharing of good practice locally and nationally, as well as exploring key topics in depth. In conjunction with Health Education England Thames Valley, a series of clinical workshops are offered to colleagues across the health and social care system, updating and challenging thinking in areas such as meaningful conversations at the end of life, ethical dilemmas around treatment options, human rights and considerations with capacity and decision-making.

ReSPECT

The ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process supports patients to have open and honest conversations with healthcare professionals, and to provide a summary of recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

Such emergencies may include death or cardiac arrest. The process is intended to respect both patient preferences and clinical judgement. The ReSPECT tool is used to capture the conversation and joint decision making.

The network hosted a half day workshop for commissioners and key stakeholders to hear more from key speakers about implementing ReSPECT. Learning and sharing of best practice from the event is now being rolled out by the Thames Valley end of life team, with the majority of localities signed up to this initiative.

The team is now supporting organisations and facilitating ways to enable the process to become an approach offered to all people in Thames Valley.

Locality	Adoption of ReSPECT	Progress	Timescales
Berkshire West	Royal Berkshire Hospital Berks West CCG Berks West Community Provider	Full project plan with endorsement by governance and quality boards CCG: actively going through executive boards to support rollout from Royal Berkshire Hospital (RBH). Community- business case submitted	To go 'live' September 2018 as an electronic record: RBH CCG and provider to aim to be in line with RBH launch date
Buckinghamshire	No		
Berkshire East	In agreement and to go to CCG EOL Board for decision	Awaiting approval	Aim to be in line with RBH launch date
Oxfordshire	Awaiting for the digital/electronic solution to be available		

Supporting the Choice Commitment

This work, by the network, supports the delivery of the six commitments outlined in the government document *Our Commitment to You for End of Life Care*:[2]

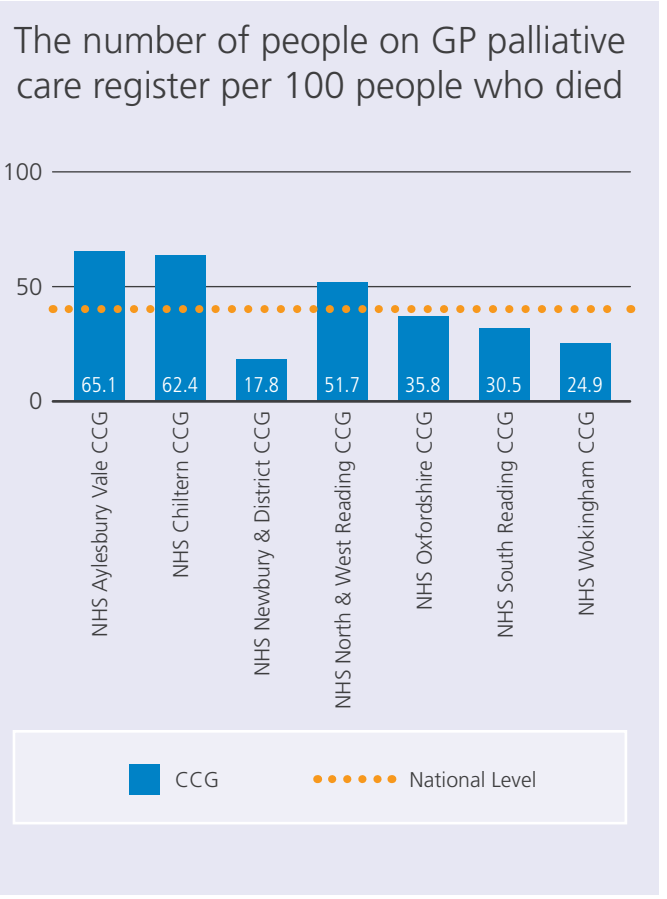
1. Have honest discussions about needs and preferences
2. Make informed choices about care, supported by clear and accessible information
3. Develop and document a personalised care plan
4. Share the personalised care plan with care professionals
5. Involve, to the extent that you wish, family, carers, and those important to you
6. Know who to contact if you need help and advice at any time.

These commitments provide a benchmark for the network to support locality work on personalised care planning and the implementation of personal health budgets (PHB) at the end of life. The EOL network works with the PHB national team to ensure commissioners are well informed about the opportunity of providing the population with more choice and control.

Case for Change

The network is developing a locally based, bespoke case for change for each STP. Population changes in the next 5-10 years are expected to put significant pressure on resources. This will bring challenges to CCGs in the commissioning and provision of good quality end of life care. Population projections suggest a sharp increase in the over 75 years age group, and whilst the number of deaths in Thames Valley is currently rising slowly and is expected to rise more sharply over the coming years to 2035, and a review of ONS data (England and Wales) tell us approximately 75% of deaths can be predicted.[3]

The recently published NHS England end of life care Sustainability and Transformation Partnership support tool demonstrates not only are more people expected to die at an older age in Thames Valley and will be likely to have more complex needs and comorbidities that could increase the level and intensity of secondary care use at the end of life.[4] The table below, taken from the STP support tool, demonstrates the percentage of deaths in different settings per CCG, highlighting that hospitals are the main care setting for where patients currently die.



Drawing on the EOL STP data packs and analytics commissioning tool, the case for change will set out the future challenges and recommended initiatives that will provide a quality of care gain, as well as releasing capacity in other parts of the system. For example, Coordinate my Care (CMC) (the EPaCCS system used in London) demonstrated that from 2012-16, 32,000 care plans were created, and figures in 2015 showed that 79% achieved their preferred place of death. Among patients who created a CMC urgent care plan, just 18% died in hospital, with more spending their final days in their preferred place.[5]

Looking forward

During 2018/19 the network will work with CCGs to complete the work on EPaCCS and continue to support local systems in the adoption of ReSPECT. We will publish the case for change for BOB and Frimley STPs, and set out the contribution of EOL care to the other STP priority programmes and actively share and promote to the STP programme leads.

The network will also lead the piloting of a 111 specialist palliative care service, in conjunction with South Central Ambulance Service and Thames Hospice. This nine month pilot will gather evidence to determine the impact of the provision of a 24/7 telephone advice line for clinicians and patients/carers. This work has the support and mandate of the BOB STP U&EC group and the evaluation will inform future commissioning decisions.

[1] Petrova M, Riley J, Abel J, et al Crash Course in EPaCCS (Electronic Palliative Care Coordination Systems): 8 years of successes and failures in patient data sharing to learn from. BMJ Supportive and Palliative Care. Published Online First: 16 September 2016. Doi: 10.1136/bmjspcare-2015-001059, http://spcare.bmj.com/content/early/2016/09/16/bmjspcare-2015-001059 (last accessed 20th November 2017).

[2] Our Commitment to You for End of Life Care: The Government response to the review of choice in end of life care, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/536326/choice-response.pdf (last accessed 24th November 2017)

[3] Predicting Death: Estimating the proportion of deaths that are 'unexpected' http://www.endoflifecare-intelligence.org.uk/resources/publications/predicting_death (last accessed 26 March 2018)

[4] End of life care in Thames Valley; Public Health report

[5] Coordinate My Care: a clinical solution to address NHS urgent care crisis? http://coordinatemycare.co.uk/cmc/wp-content/uploads/2014/06/cmc-opinion-article.pdf (last accessed 12th December 2017)

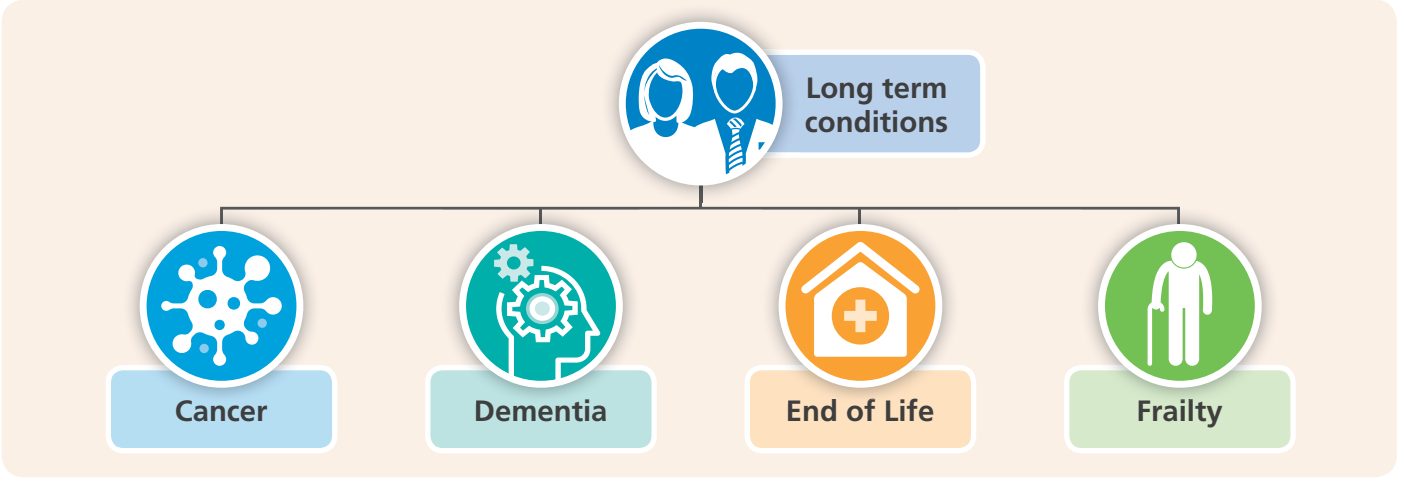
Long term conditions

The long term conditions programme continues in its support of a person-centred approach to care. The common psychological approach across Making Every Contact Count (MECC), Shared Decision Making (SDM) and care and support planning is providing opportunities for wider collaboration.

Care and Support Planning (CSP) recognises that people who live with long term conditions (LTC) make the majority of the decisions that affect their lives themselves, spending relatively little time with a health and/or care practitioner.[1] Making the most of this time is therefore key, and the CSP approach supports this.

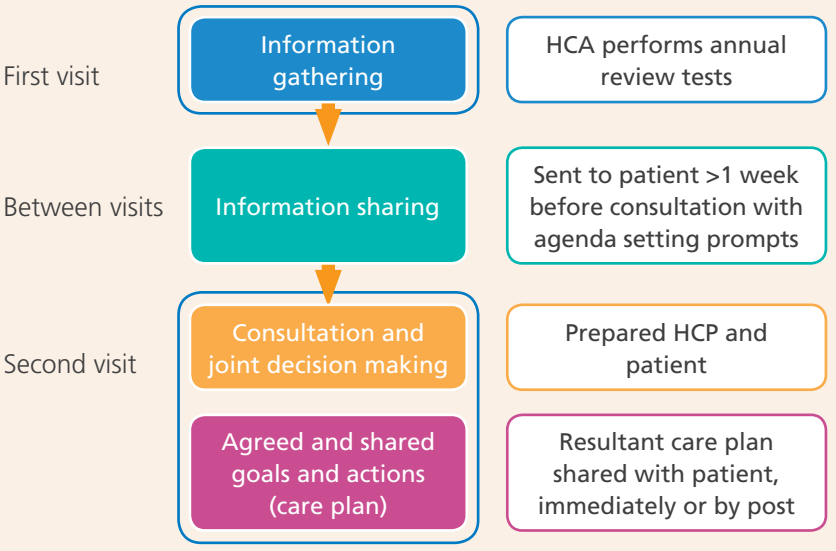
The initial focus of CSP for people with diabetes is being expanded for people with long term conditions, recognising that comorbidity is the norm for many people.

"Personalised care planning is a collaborative process used in chronic condition management in which patients and clinicians identify and discuss problems caused by or related to the patient's condition, and develop a plan for tackling these. In essence it is a conversation, or series of conversations, in which they jointly agree goals and actions for managing the patient's condition."[2]



A Cochrane Review has demonstrated that patients with long term conditions benefit from a person-centred approach to care; involvement in CSP shows indications of better physical health (better blood glucose level and lower blood pressure measurements among people with diabetes), reduced symptoms of depression, and improvements in people's confidence and skills to manage their health.[3]

The four steps of CSP:[4]



System benefits

- Reducing general practice running costs
- Reducing pressures on general practice staff
- Improving healthcare professional job satisfaction
- For people at the end of life, enabling the capturing of their preferences for treatment and place of care.
- Reduction in appointments due to a single patient review rather than multiple disease focused appointments.

Adoption of CSP across Thames Valley

Oxfordshire

Previously an area with very low CSP implementation, this approach is now being adopted as a core element to Oxfordshire's diabetes model of care. Interest from practices in adopting this approach has been positive with significant uptake of the training, which has been very well evaluated. The CCG has invested in post-training support to assist implementation.

Oxfordshire CCG has long term sustainability plans. There is an aspiration for CSP to be adopted across LTC, and the generic training provides practices with the resources to implement wider if they so wish.

Buckinghamshire

Aylesbury Vale and Chiltern CCGs have actively progressed adoption of CSP as the norm for working with people with long term conditions, and so is a core component of the diabetes model of care within Buckinghamshire. Fifty percent of Aylesbury Vale practices have implemented this approach for LTCs, including dementia where the learning is being used as part of the Dementia Friendly Practices initiative led by the dementia network. The change, which also includes improved access to psychological services and an advice line for staff, has been featured in an HSJ article on How to Cut the Cost of Diabetes. See page 20 for more details on the HSJ article.

Berkshire West

Care and Support Planning has replaced the annual review process for most people with diabetes with a care planning review. Eighty nine percent of practices are offering CSP for people with diabetes, and 28% of practices for people with COPD.

Percentage of practices delivering CSP for diabetes:

	Practices trained in CSP	Practices delivering CSP	CCG sustainability in place	Evaluation in place
Bucks				
Aylesbury Vale CCG	18	100%	Yes	Yes
Chiltern CCG	31	88%	Yes	Yes
Berkshire West				
Newbury & District CCG	10	100%	Yes	Yes
South Reading CCG	20	70%	Yes	Yes
North & West Reading CCG	10	80%	Yes	Yes
Wokingham CCG	12	92%	Yes	Yes
Berkshire East				
Slough CCG	10	62%	Yes	No
Bracknell & Ascot CCG	15	100%	Yes	Yes
WAM CCG	18	90%	Yes	No
Oxford				
Oxford CCG	55	78%	Yes	In Progress

Berkshire West has undertaken an evaluation of CSP using the Year of Care Quality Mark tool. Practices are evaluated against ten benchmarks for quality CSP.

This work has identified a number of 'beacon' practices that are the best performing for care and support planning. These 13 beacon practices, spread across Berkshire West, are also high achievers for diabetes care, with the majority in the top decile of achievement for the eight care processes.

Working with the beacon practices, Berkshire West is progressing the expansion of CSP to other LTCs during 2018-19.

Berkshire East

In common with the rest of Thames Valley, Berkshire East have embraced care and support planning as a core component of their diabetes model of care, and the majority of practices have engaged in CSP training. The CCG has recently invested in post-training support and evaluation.

The LTC programme, in conjunction with Health Education England Thames Valley, continues to fund training for practices and train the trainer, providing advice and guidance to CCGs and to support trainers and facilitators across Thames Valley.

[1] Interpersonal Education in Person-Centred Care for Long Term Conditions

[2] Coulter A, Entwhistle VA, Eccles A, Ryan S, Shepperd S, Perera R. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database of Systematic Reviews 2015, Issue 3. Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2 http://www.cochrane.org/CD010523/COMMUN_effects-of-personalised-care-planning-for-people-with-long-term-conditions (Last accessed 11th December 2017)

[3] Coulter A, Entwhistle VA, Eccles A, Ryan S, Shepperd S, Perera R. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database of Systematic Reviews 2015, Issue 3. Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2 http://www.cochrane.org/CD010523/COMMUN_effects-of-personalised-care-planning-for-people-with-long-term-conditions (Last accessed 11th December 2017)

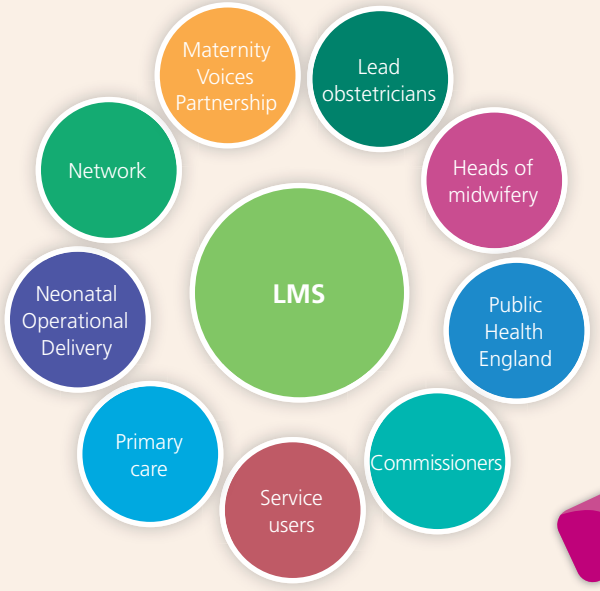
[4] Delivering Person Centred Care Through CSP in Berkshire West, February 2016 http://tvscn.nhs.uk/wp-content/uploads/2017/06/41-Claire-Scott.pdf (last accessed 9th April 2018)

Maternity network

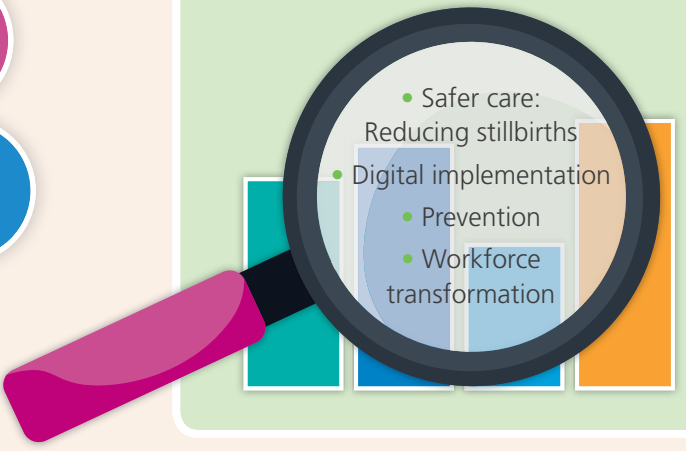
Local Maternity Systems

The Better Births report set out the maternity transformation programme, and required that providers and commissioners of maternity services come together to form Local Maternity Systems, which will plan the design and delivery of services of populations from 500,000 to 1.5 million people.[1]

TVSCN has established two Local Maternity Systems each comprising:



LMS Action Plans are in place to transform maternity services up to 2021, and aligning to STP goals to include:



Better access to perinatal mental health services

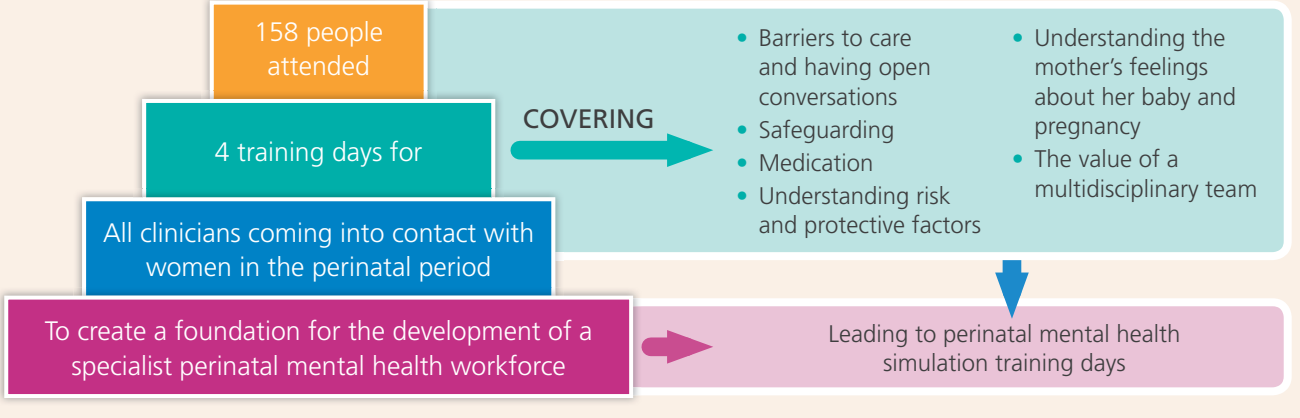
The national drive is for 30,000 additional women in England to be seen by perinatal mental health services, which equates to 1,338 women in Thames Valley (including 529 for Berkshire).

Following the successful wave 1 perinatal Community Service Development Funding (CSDF) for Berkshire, from 1 January 2017 a further 433 women across Berkshire have received additional interventions as a direct result of the National Perinatal Funding.

Women now have access to a perinatal psychiatrist, perinatal pharmacist and nursery nurses, and perinatal CBT therapy delivered in the woman's home alongside the clinicians who have provided a limited assessment and follow up service, prior to the national funding and who continue to provide interventions at home.

In order to enhance the provision of, and reduce variation in, perinatal mental health care for all women in the Thames Valley, the SCN perinatal mental health network has delivered training days, as described below:

Perinatal mental health training days



Attendees came from all areas of the Thames Valley geography, and represented primary care, secondary care, health visitors, educational institutions, and public and third sector groups. The feedback from the attendees was excellent.

Following on from these sessions, the network is hosting simulation training days in early 2018, comprising of six clinical scenarios over the whole day, structured to develop a broad range of clinical and communication skills for working with women with complex health needs during the perinatal period.

Perinatal mental health matrix

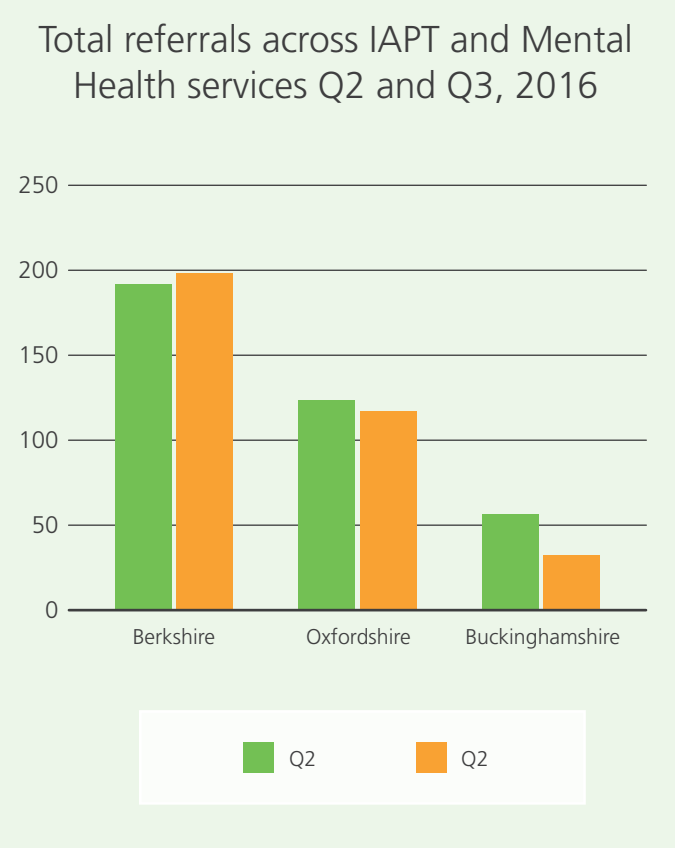
The SCN was delighted to launch the perinatal mental health matrix (PNMH matrix) in September 2017, modelled on the early interventions in psychosis (EIP) matrix, developed by the Oxford AHSN. It has been designed to evaluate the quality of perinatal mental health care provided by maternity, health visiting, secondary care mental health and primary care psychology (IAPT) services in the Thames Valley.

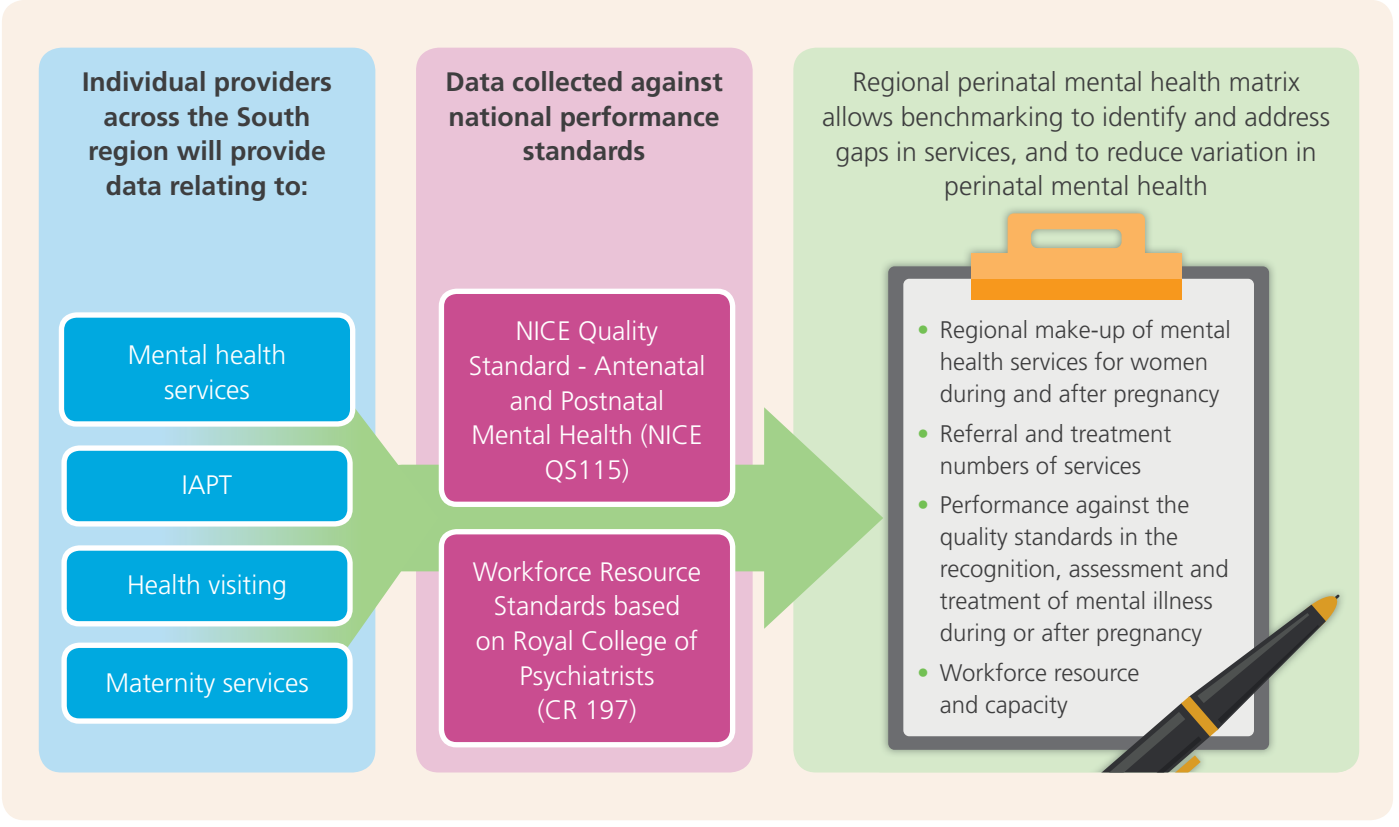
Perinatal Mental Health Matrix NICE Quality Standard QS115

In 2016, the Thames Valley Strategic Clinical Network identified variation in the audit and data collection of services in contact with women in the perinatal period.

An online data collection matrix tool was developed. The matrix collects data measuring services against the NICE Quality Standard for antenatal and postnatal mental health (QS115) and the Royal College of Psychiatrists workforce standards (CR197).

Data is entered by maternity, health visiting, IAPT, specialist perinatal mental health and adult community health teams, and is collected on a quarterly basis. This enables comparison of data between teams and across the region, benchmarking against NICE standards. The roll-out across Thames Valley is nearing completion, and the next step is to roll out the matrix across the rest of the South region, starting in the South West.





Improving stillbirth rates

The stillbirth rate in the Thames Valley SCN area has gone down from 5.2 per 1,000 live births to 4.6 per 1,000 live births. Our 2020 target is to reduce this further to 4.1 per 1,000 live births.

Saving Babies' Lives is a care bundle designed to support providers, commissioners and professionals to take action to reduce stillbirths.

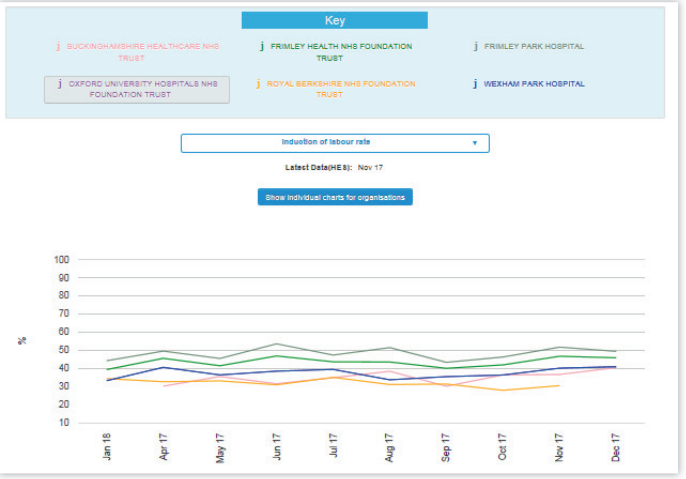
Buckinghamshire NHS Trust		Frimley Health Foundation Trust		Oxfordshire Foundation Trust		Royal Berkshire Foundation Trust	
2016	2017	2016	2017	2016	2017	2016	2017
Element 1: Reducing smoking in pregnancy							
Element 2: Risk assessment and surveillance for fetal growth restriction							
Element 3: Raising awareness of reduced fetal movement							
Element 4: Effective fetal monitoring during labour							

Progress of Trusts in implementing the four elements of the care bundle

Key: Completed and ongoing; Partially completed and action plan

Regional maternity dashboard

In June 2016, the Heads of Midwifery and Lead Obstetricians agreed to establish a regional maternity dashboard. The dashboard uses Trust local data and also extracts the Hospital Episode Statistics (HES) data to compare national submissions to local data, for accuracy. The dashboard went live for data submission in April 2017, and to allow for data inaccuracies it will be piloted for a year, and will run concurrently with local maternity dashboards. The aim ultimately is for one dashboard to be used as it allows for services to benchmark against each other, and understand good practice and areas for improvement. It will be used from April 2018 as the data source for the BOB and Frimley LMS.



[1] https://www.england.nhs.uk/mat-transformation/ (last accessed 20th November 2017)

Mental health, dementia and neurology network

All age mental health

Crisis care

Mental health liaison and psychological medicine services

In line with the Mental Health Five Year Forward View ambition to ensure that no acute hospital should be without all age mental health liaison services in both A&E and inpatient wards, the SCN produced a benchmarking report[1] on service provision in BOB and Frimley which highlighted:

All Thames Valley acute hospitals are:

- ☑ Providing on-site mental health teams in hospital 24/7
- ☑ Offering close day-to-day working with medical teams
- ☑ Focused on education, training and supervision of all staff
- ☑ Fostering a culture of holistic, integrated care for the patient

N.B. while some local service models differ, plans are in place for ALL acute Thames Valley sites to comply with Core 24 standards by 2020

The Thames Valley SCN mental health network will continue to support STP developments in crisis care by working with commissioners and providers to further identify good practice in areas such as:

- Enhanced workforce and skill mixes to match specific local needs, such as drug & alcohol services and self-harm clinics
- Improved response times after referral
- Extended services for all ages
- Further integration with acute hospital teams
- Future plans for service development and service measuring.

Out of Area Placements: a partnership solution

The Thames Valley mental health network is supporting their Operations and Delivery colleagues to achieve the Mental Health Five Year Forward View goal of eliminating the practice of sending people out of area for acute inpatient care by 2020/21. By providing its networking capability, the SCN has worked with its key mental health providers to participate in learning events through NHS England's national team. A stocktake was developed which highlighted that whilst there is a mismatch between anticipated and current levels of Out of Area Placements (OAP), or what constitutes an appropriate or inappropriate OAP, the report also described the positive work in local providers to support reduction and the initiatives in place to drive the improvement.

By harnessing best practice from across the country, providers are engaging in learning from Cheshire and Wirral NHS Partnership NHS Foundation Trust[2] who have addressed this through:

- Streamlining the inpatient care pathway
- Developing specialist rehabilitation skills and staff to facilitate discharge planning
- Harnessing teams and partnerships across the health economy to enable discharge and support to ensure bed availability and throughput of those that are inpatient > 40 days

This work has seen a reduction in the average length of stay for:

- Inpatient rehabilitation by 35 days
- Secure services by 18 days

Addressing the physical health needs of those with serious mental illness

NHS England state that by 2021, those on the SMI Register should be receiving an additional 280,000 physical health checks across England. While national benchmarking is provided to support delivery in 2018-19, in Thames Valley this could require our local system to increase physical health checks to the scale of:

			Percentage of people receiving a full annual physical health assessment on the GP SMI register		Delivering physical health assessment	
		SMI prevalence (QOF) 2016/17	30%	60%	Primary care 50%	Secondary care 10%
	England	**534,431**	**160,329**	**320,659**	**267,216**	**53,443**
	BOB STP	14,092	4,228	8,455	7,046	1,409
	Frimley Health STP	5,791	1,737	3,475	2,896	579
BOB	NHS Aylesbury Vale CCG	1,611	483	967	806	161
BOB	NHS Chiltern CCG	2,519	756	1,511	1,260	252
BOB	NHS Oxfordshire CCG	6,093	1,828	3,656	3,047	609
BOB	NHS Newbury & District CCG	836	251	502	418	84
BOB	NHS North & West Reading CCG	907	272	544	454	91
BOB	NHS South Reading CCG	1,234	370	740	617	123
BOB	NHS Wokingham CCG	892	268	535	446	89
Frimley Health	NHS Bracknell & Ascot CCG	912	274	547	456	91
Frimley Health	NHS Slough CCG	1,487	446	892	744	149
Frimley Health	NHS Windsor, Ascot & Maidenhead CCG	1,137	341	682	569	114
Frimley Health	NHS Surrey Heath CCG	571	171	343	286	57
Frimley Health	NHS North East Hampshire & Farnham CCG	1,684	505	1,010	842	168
	NHS Milton Keynes CCG	1,952	586	1,171	976	195

In "Implementing the Five Year Forward View for Mental Health" [2] and the "NHS Operational Planning and Contracting Guidance 2017-19" [3], NHS England stated that "CCGs should offer NICE-recommended screening and access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year".

In line with refreshing NHS Plans for 2018/19, CCGs will be provided figures on the numbers of people on GP practices' SMI Registers. This will enable development of a robust quarterly trajectory for each CCG throughout 2018/19 and beyond. (Due April 2018)

Improving joint working across primary and secondary care

Joint working between primary care and secondary mental health providers is essential to improve physical healthcare for people living with SMI.

NHS England's proposed approach to trajectory setting for the delivery of physical health checks will be based upon:

50% of people with SMI register in *primary care* + **10%** of people with SMI register in *secondary care* = Achieving **60%** in total from 2018/19 *Min 280,000 people nationally

Evidence suggests that the benefits of systematic approaches to offering physical health checks are:

- Communication of the strategic aim of the physical health check ambition and hardwiring the 'why' to frontline staff
- Creating stronger communication and connection between primary and secondary care to ensure recording of completed physical health checks are captured by NHS Digital
- The view of service users on what constitutes a physical health check, so as to address concerns or preconceptions
- A revised approach to education and training on approach, needs of user and access to training to support the conversation.

A comprehensive cardio-metabolic risk assessment in line with the NHS health check

BMI, blood pressure and pulse, blood lipids including cholesterol, blood glucose, lifestyle including diet and exercise, smoking status (enquiry about presence of cough, wheeze or breathlessness), and alcohol use. Approved risk assessment tools such as the QRISK Tool can be used to assess cardio-metabolic risk. Further details on the comprehensive checks can be found in the relevant NICE guidelines.

Where indicated, relevant national screening programmes to be delivered or followed up

Cervical and breast cancer screening for women and bowel cancer screening for men and women.

Medicine reconciliation and monitoring

Ensuring medication remains up to date and accurately recorded and is cross checked with all electronic records. Conduct any additional medication monitoring according to the particular Summaries of Product Characteristics (SPC) e.g. Lithium level, U&Es, LFTs, prolactin, ECG if indicated during this review.

General physical health enquiry

Medical and family history, sexual health including use of contraception, substance misuse assessment (illicit or non-prescribed drug use), oral health assessment and any indicated physical examination.

Proactive engagement and psycho-social support may be required to ensure people with SMI access checks/ interventions and follow-up care including personalised care planning.

Follow-up interventions may include implementation of NICE guidelines for: Smoking cessation, Obesity, Hypertension, Lifestyle intervention, Diabetes, Lipid modification, Drug misuse, Signpost to cancer pathway.

While data for the region suggests positive work is being undertaken, the ambition to achieve the large increase in numbers of physical health checks requires a shift in discussion and partnership.

Physical Health in SMI: A networked approach

Increasing Access to Psychological Therapies

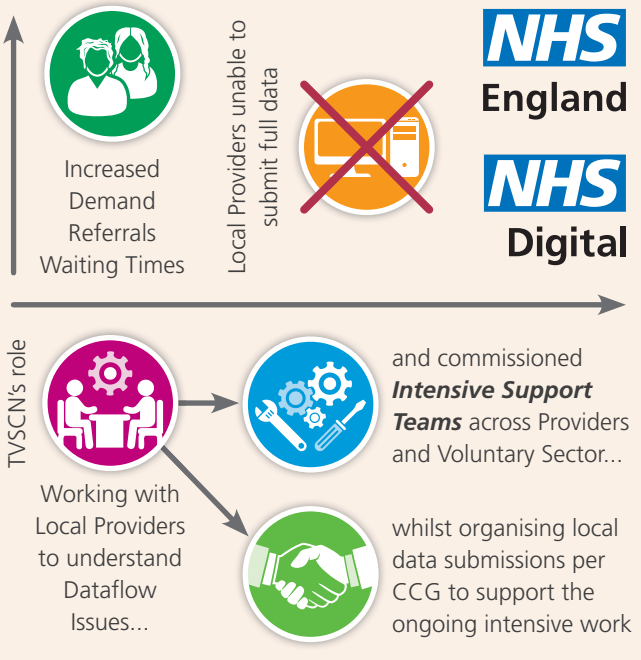
Increasing Access to Psychological Therapies (IAPT) is a key component of the Mental Health Five Year Forward View, and local STP plans. 20% (1 in 5) of over 65s living in the community is affected by depression, however, despite IAPT services being open to all adults, older people are underrepresented amongst those accessing services.

Regional transformation funding has been in place for the past year to support the implementation of the integrated IAPT programme, the new service set up last year for patients suffering with long term conditions and depression. Current activity levels of the IAPT service for the long term conditions cohort of between 6.8-8% suggests that there is scope to address an improvement in quality for those patient groups that would benefit from the therapy.

Children's mental health

Good mental health is vital to give children and young people the opportunity to grow up happy, safe and healthy. The vision for the Thames Valley is to empower children and young people to be resilient, have good mental health, and if they need help, the knowledge that they can access high quality, timely services.

To enable this vision, accurate data is crucial to ensuring access to services.

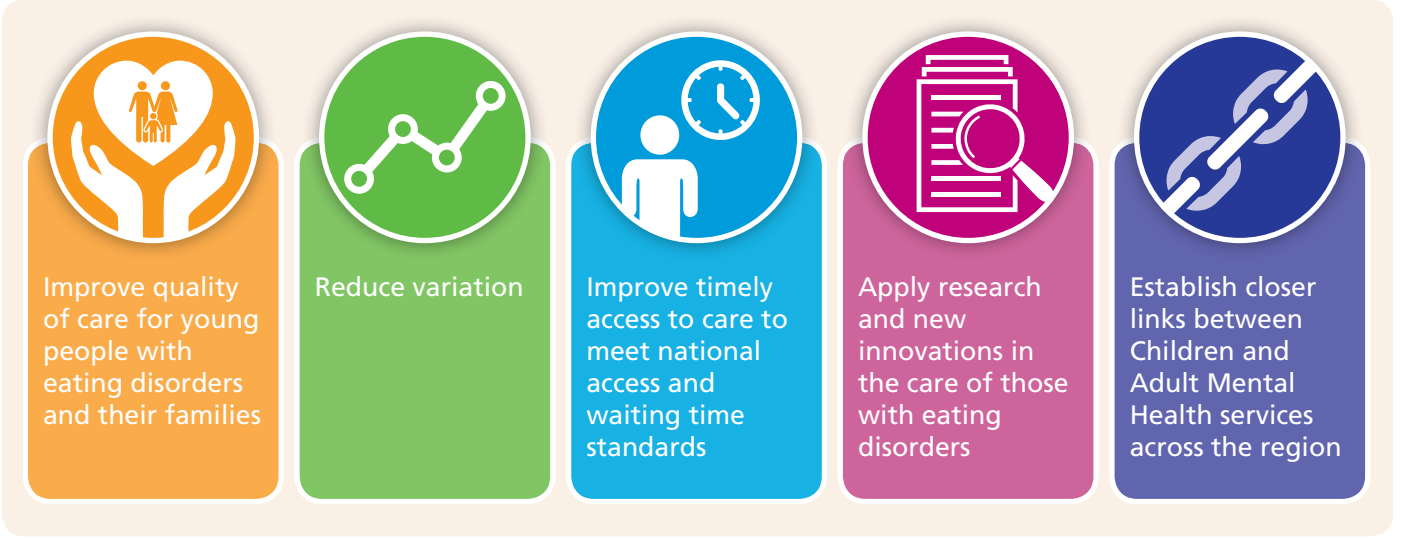


Intensive support is being offered in four key areas:

- Data completeness
- Capacity and demand: how to manage waiting time
- Pathway design (eg lean pathways, what does good look like)
- Value for money: investment/productivity.

Children and young people's eating disorder services in Thames Valley

This year has seen newly established eating disorder services going live across the Thames Valley. As with any new service, it is essential to provide support and networking opportunities:



Eating disorder service performance

	12 months (July 2016 - Jun 2017)		12 months (Oct 2016 - Sept 2017)			12 months (July 2016 - Jun 2017)		12 months (Oct 2016 - Sept 2017)		
	Urgent					Routine				
Providers	Total number of completed pathways	% within 1 week	Total number of completed pathways	% within 1 week	Changes from the previous	Total number of completed pathways	% within 4 weeks	Total number of completed pathways	% within 4 weeks	Changes from the previous
Berkshire Healthcare NHS Foundation Trust	27	62.96%	29	65.52%	↑	39	84.62%	54	85.19%	↑
Oxford Health NHS Foundation Trust	49	79.59%	50	82.00%	↑	314	77.39%	329	82.07%	↑

Source: NHS England/statistical-work-areas

[1] Mental Health Liaison Services – Berkshire, Oxfordshire, Buckinghamshire STP, Frimley STP and Milton Keynes, No health without mental health. TV SCN report, October 2017

[2] Complex recovery assessment and consultation - Cheshire and Wirral Partnership NHS Foundation Trust - NCCMH http://positivepracticemhdirectory.org/nccmh/complex-recovery-assessment-consultation-cheshire-wirral-partnership-nhs-foundation-trust/ (last accessed 29th January 2018)

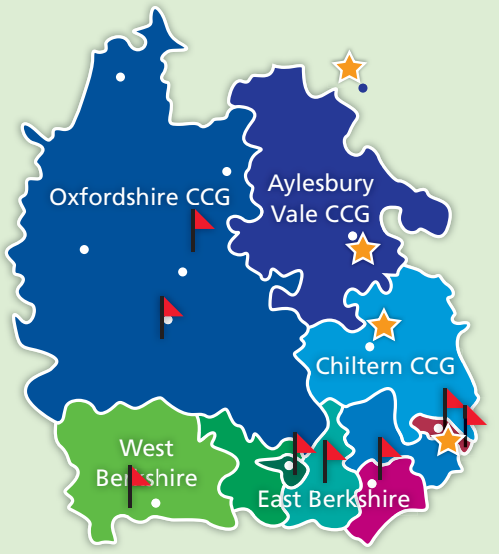
Dementia: Building capacity and capability through clinical leadership

Supporting the SCN's ambition to create distributed leadership across the Thames Valley, the mental health network have taken the successes of the initial Dementia Friendly Practices pilot scheme, and expanded it out to the remaining Thames Valley CCGs.

This year (2017/18) has seen eight new GP practices working towards becoming exemplar dementia friendly surgeries to create pockets of learning and leadership within each CCG region.

The crucial role of clinical leaders

Creating a supportive environment and investing in our clinical leaders has allowed us to focus not only on the process changes of the programme, but also on improving the skills of our leaders. We convened quarterly action learning sets for colleagues to share successes, challenges and learning to take back to their practices. This support has contributed to increased ownership of 'on the ground' issues and created greater visibility of dementia as a subject at CCG level.



Phase 2 (2017-18): Developing 8 Exemplar Dementia Friendly GP Practices to develop clinical leadership

Phase 1 (2015-16): Developed 4 Dementia Friendly GP Practices to implement SPACE principles

All clinical leads supported by the SCN and Health Education England programme have been trained to tier 2 with dementia skills. 80% of their practice staff have tier 1 dementia skills.

2017

- Eight clinical leaders trained in tier 2
- 80% of practice staff trained in tier 1

- Clinical lead appointed dementia lead for CCG
- Clinical lead nominated for National GP Innovation Award for work in dementia

- Improved diagnosis rates observed and improvements supported

2018

Development of a holistic toolkit to support post-diagnosis across clinical requirements and practical living

Use simulation training for senior leaders to experience dementia and build the case for focus across all CCGs

Clinical leadership forum to promote evaluation and positive developments region-wide

Extended tier 1 training rolled out to localities

Toward 2020/21

Increased training opportunities in both classroom and simulation

Ensure national target is exceeded across CCGs — DDR rates

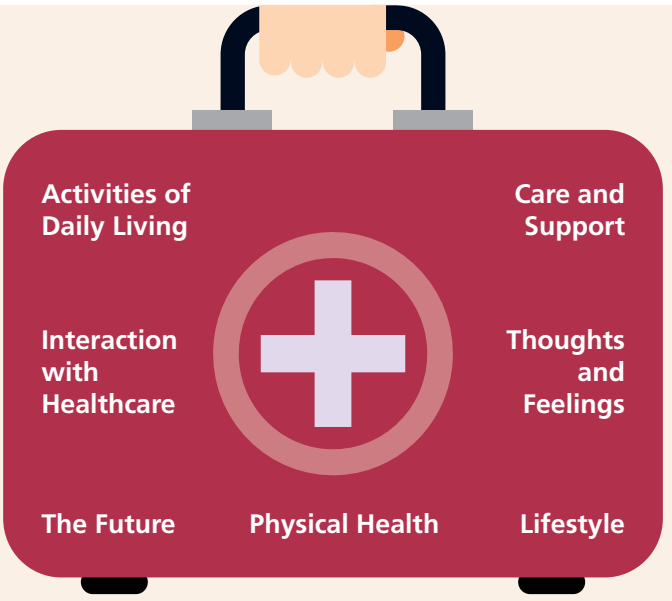
Clinical leaders supported by TVSCN and embedded as CCG clinical leads

Care planning approach to be embedded across region, utilising toolkit and clinical leadership

Postdiagnostic support and care plans

This calendar year will see the SCN develop a toolkit to support a systematic approach to care planning.

This work will aim to provide those undertaking care plans with the right prompts to ensure support post-diagnosis. This will aim to support the national requirement of 90% of all patients having a care plan to support them, and will include:



Leadership delivers results: Dementia diagnosis rates

CCG	Sept 2016 (%)	Sept 2017 (%)	Overall change	DFP Practice	Apr 2017 (%)	Nov 2017 (%)	Change
NHS North & West Reading CCG	69.8	64.2	↓	K1	52.8	55.63	↑
NHS South Reading CCG	72.8	65.5	↓				
NHS Bracknell & Ascot CCG	67.1	68.1	↑	K2	51.93	66.47	↑
NHS Aylesbury Vale CCG	70.5	70.8	↑				
NHS WAM CCG	68.9	71.6	↑	K3	77.94	108.61	↑
NHS Oxfordshire CCG	67.8	67.8	↔	K4	53.76	62.86	↑
NHS Milton Keynes CCG	64.5	67.6	↑	K5	63.1	71.61	↑
NHS Wokingham CCG	64.2	65.5	↑	K6	94.32	89.62	↓
NHS Newbury & District CCG	60.9	62	↑	K7	59.91	65.92	↑
NHS Slough CCG	60.2	66.4	↑	K8	70.9	64.21	↓
NHS Chiltern CCG	66.4	63.9	↑				

Upskilling the workforce through training and education

Workforce shortages, and new ways of shaping the future workforce continue to be an issue for the health system nationally. While this debate continues, the SCN has positioned itself, in partnership with HEE, as a regional convenor of specialist and generic training to build confidence in the existing workforce. This is highlighted by the work ongoing in mental health:

Primary care

- GP psychiatry study days
- PPEPCare/PPIPCare mental health training
- Dementia: Tier 1 training
- Perinatal mental health training: Generic
- Making Every Contact Count training (STP wide)

Specialist training

- Dementia: Tier 2 training
- Perinatal mental health training: specialist
- Making Every Contact Count training (Provider wide)

Simulation training - innovative approach

- Creating different training models outside of traditional classroom-based
- Simulation training in dementia and perinatal mental health

Case Study: PPEPCare - Partnerships ensuring positive mental health in children and young people

It is widely accepted that mental health problems in early life can have enduring long term issues across the life course. To ensure a focus on early support and empowering all parts of the system to acknowledge and better support young people in their mental health at as early a stage as possible is crucial.

PPEPCare is a partnership approach across Berkshire, Buckinghamshire and Oxfordshire to train staff in education and primary care to recognise and better understand common mental health issues using psychoeducation and psychological techniques, such as cognitive behavioural frameworks.

Strategic Context

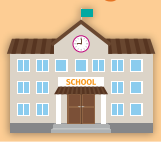
Future in mind
Promoting, protecting and improving our children and young people's mental health and wellbeing

Transforming Children and Young People's Mental Health Provision: a Green Paper

PPEPCare training modules delivered in 2016/17

- Low mood and depression
- Anxiety
- Self-harm
- Behavioural difficulties
- Eating disorders
- Mental health difficulties

Staff in educational settings



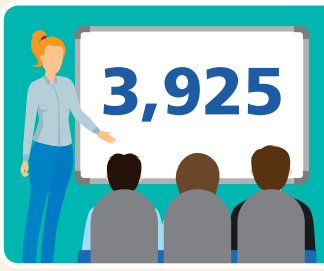
School nurses

Primary care staff

Local Authority staff

Success of the programme:

Between 2016 and 2017



3,925 people have been trained in **153** sessions across Berkshire, Bucks and Oxon

Each component of the training was evaluated and shown to increase skills and confidence for attendees by a minimum of two points on a ten point scale

TVSCN continue to support the training in 2018/2019 - the programme is also adapting delivery to include promoting resilience in children and young people and autism spectrum disorder

Neurology

Headache pathway

In Oxfordshire CCG, 1 in 3 referrals to neurology outpatients is for headache, and 66% of all headache referrals could be managed in the community. Following on from work to support the CCG to produce the Oxford Headache Pathway, the network has created a generic Neurology Case for Change, summary document, and slide set which advises CCGs on developing a revised headache pathway. This will mean appropriate care closer to home, reduced costs and faster access to specialised help for patients. The materials produced by the network have been used in the national NHS RightCare framework for migraine and other headache disorders, which lay out a gold standard to guide commissioning decisions across the country. This work has also featured in the forthcoming report Society's Headache: The socioeconomic impact of migraine produced by the Work Foundation.

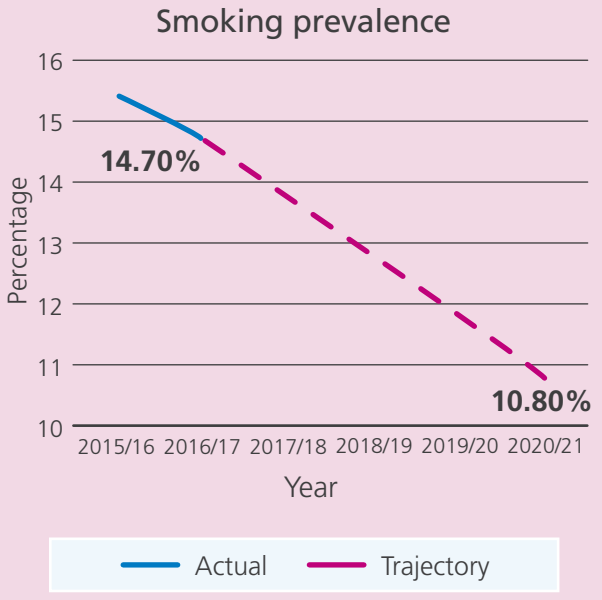
Prevention

Prevention and population health

For practitioners and the people we work with, health promotion, the importance of better self-care and a focus on prevention of ill health are core foundations for a healthier, happier population. The TVSCN and Clinical Senate have spent the past year supporting our CCGs, STPs and the emergent Integrated Care Systems in bringing these areas to the fore.

A Senate and networked approach to smoking prevention

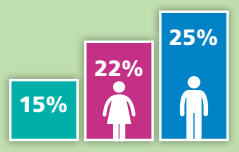
While smoking prevalence is reducing...



We know that, in acute trusts for example

TV Clinical Senate undertook a review of BTS Clinical Audits in acute trusts and found:

- **33%** of inpatients were not asked their smoking status
- Only **25%** of identified smokers were asked if they wanted to quit
- Only **2%** of current smokers were offered nicotine replacement
- Smoking prevalence in acute trusts is higher than general prevalence

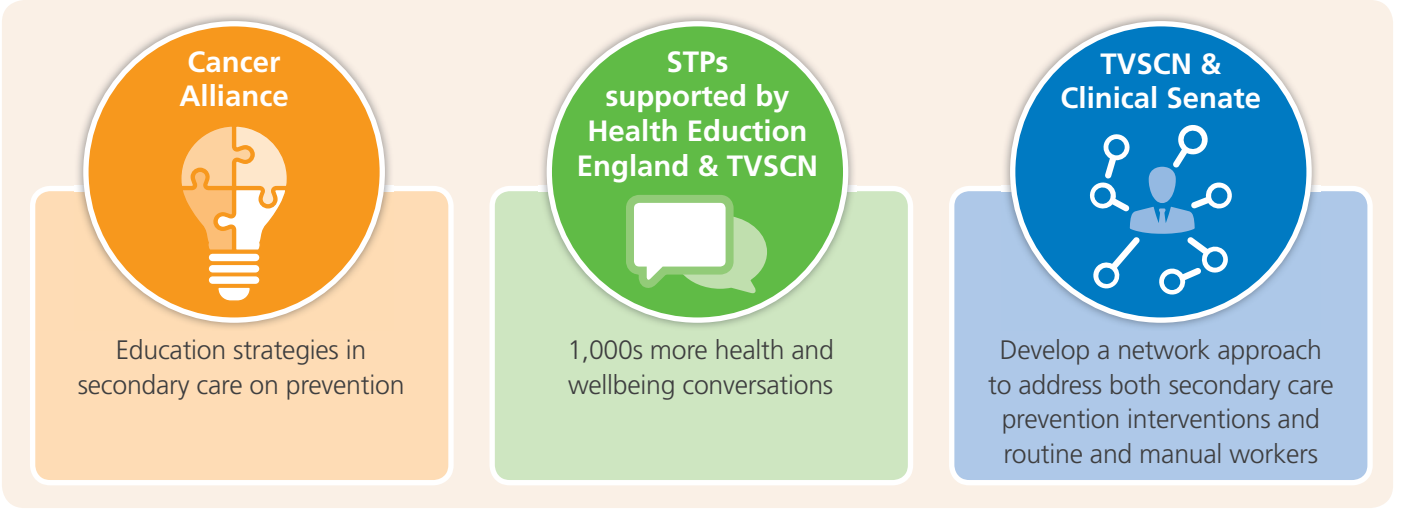


And in the BOB STP area, just over 50% of smokers come from routine and manual workers categories, yet the percentage of those groups accessing services are low, especially in Oxfordshire

Smoking for routine and manual (R&M) workers

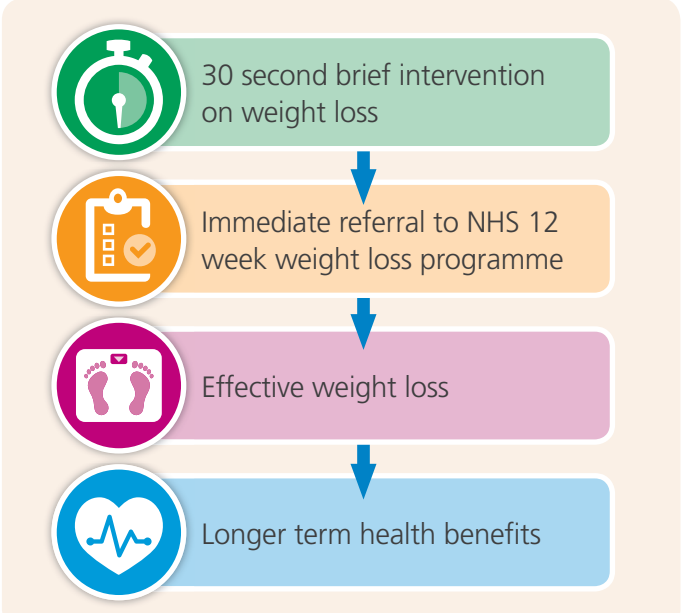
Local Authority	Number of R&M workers July 16/ June 17	Prevalence of those R&M workers who smoke March 16/April 17	Approximate number of smokers	Percentage of smokers from routine and manual workers
Buckinghamshire	67,300	26.8%	18,036	57%
Oxfordshire	87,600	24.6%	21,550	51%
West Berkshire	21,800	21.9%	4,774	46%
Reading	24,000	30.4%	7,296	53%
Wokingham	15,700	8.8%	1,382	19%
BOB STP	216,400		53,038	50%

The journey ahead



Obesity

In April 2017, Thames Valley SCN was delighted to host Professor Susan Jebb OBE from University of Oxford Nuffield Department of Primary Care to deliver a webinar on brief interventions for weight loss in primary care settings. Key to her department's recent findings were:



The webinar and Q&A can be accessed here: http://bit.ly/2yCi4KL and the transcript here: http://bit.ly/2hi6Nrz

Making Every Contact Count

Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their health and wellbeing.

Through support from Health Education England and the TVSCN, BOB and Frimley STPs are upskilling over 110 multidisciplinary staff across provider trusts to take on a MECC champion role so as to be at the forefront of offering:

These champions will contract with their organisations to undertake onward training and upskilling events (Frimley Health) as well as build communities of action around MECC (BOB).

Wider determinants and population health

The building blocks of population health

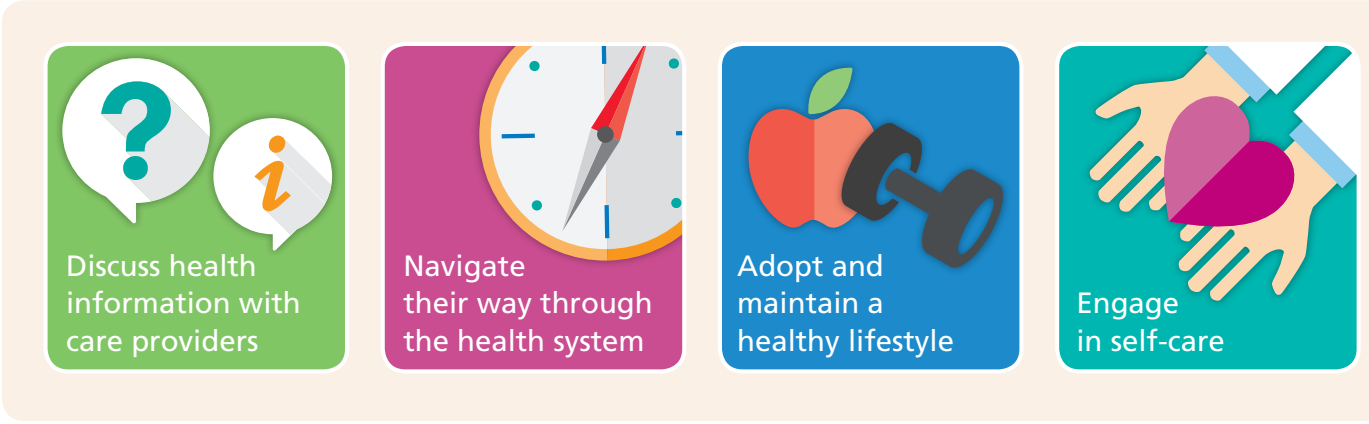
Places as systems: it is in the interaction between these elements of the system that change can be delivered

Population health

Through late 2017 and early 2018, Thames Valley SCN and Clinical Senate have been supporting local systems by helping to bring out the many differing definitions that currently exist around population health. An event was held in February 2018, attended by senior CCG and ICS leads, to hear from regional and national leaders on the exciting work being undertaken not only in the world of data and informatics, but also opportunities for towns to build health and wellbeing into their communities, as well as embracing the power of social networking for health and opportunities for the health app sector. All presentations and our latest Population Health publication can be accessed at the TVSCN website: http://bit.ly/2huYB7b

Health literacy

A person whose levels of health literacy are low or average may have less ability to:



In October 2017 we invited Professor Jo Protheroe (GP and Chair of Health Literacy UK), Jonathan Berry (NHS England) and Mandy Wardle-McLeish (Community Health and Learning Foundation) to discuss health literacy as an essential element of the prevention and self-care agenda. Key to this is the message:

Health information is too complex for...

43% of people

61% of people when the information requires maths skills

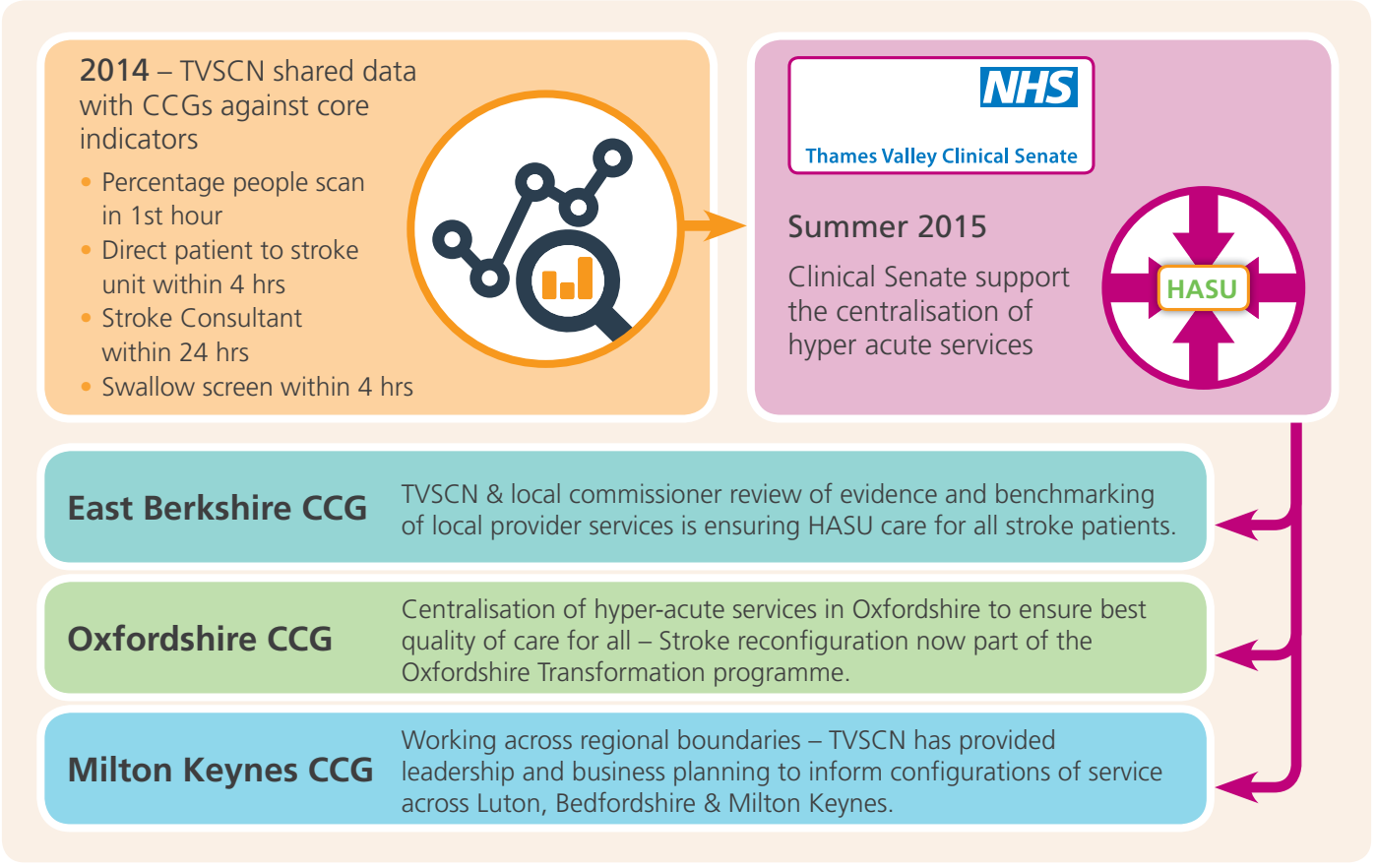
STPs and the emergent Integrated Care System (ICS) architecture are learning from webinars such as this, alongside the national work undertaken since 2015 which saw evidence and best practice being developed leading to, in 2017:

- An STP level learning programme on health literacy being tested and developed in Greater Nottinghamshire STP, to develop a health literate decision support framework which can be transferred and implemented in other emergent integrated care systems.
- Health Education England have designed a toolkit which makes available a range of strategic and practical interventions towards improving health literacy: http://bit.ly/2H25F3n

Stroke network

Hyper acute stroke services

In line with the ambition in Thames Valley to improve hyper acute stroke services and to centralise them, all HASUs in Thames Valley now have an A or B team-centred score. In addition, approximately 500 additional patients experiencing stroke symptoms are taken to a HASU for the first 72 hours of their stay in hospital.



SNNAP Scoring summary (Team-centred Total KI level)

Period (Quarter)	Jan-Mar 2014	Jan-Mar 2015	Jan - Mar 2016	Dec - Mar 2017
Wycombe General Hospital	D	A	A	A
Milton Keynes General Hospital*	D	E	D	C
John Radcliffe Hospital	C	B	B	A
Royal Berkshire Hospital	A	B	A	A
Frimley Park Hospital	C	B	A	A

Note: A SSNAP scoring system has been derived to provide a summary of performance based upon results for 44 key indicators which are grouped into 10 domains covering key aspects of stroke care. For Domains 1 – 10, the scores have been calculated and given a performance level (A-E). A is the best level and E is the worst.

** Note: Hospital does not have hyper acute stroke unit*

Hypertension and atrial fibrillation

The network has developed a cardiovascular disease (CVD) prevention programme in conjunction with Oxford Academic Health Science Network (AHSN), and using an evidence base provided by Public Health England (PHE).

Hypertension interventions

Nationally, hypertension costs the NHS £2bn a year, and accounts for 13% of visits to GPs. As a high risk factor for stroke, preventing and treating hypertension effectively is essential. There are currently 228,816 undiagnosed cases of hypertension in Thames Valley:

Hypertension: Diagnosed and undiagnosed and QOF prevalance

STP	CCG	% of people with hypertension have been diagnosed	GP range from	GP range to	No of adults (age 16 and older) with undiagnosed hypertension	Diagnosed hypertension prevelance 2016/17	Compared to previous year
	England	59%				13.83	↑
	Thames Valley SCN (including NHS Milton Keynes CCG)	57%			228,816	12.41	↑
	Thames Valley SCN	57%			203,511	12.43	↑
	BOB STP	57%			164,064	12.60	↑
	Frimley Health STP	57%			68,474	12.49	↑
BOB	NHS Aylesbury Vale CCG	59%	47%	77%	19,494	13.60	↑
BOB	NHS Chiltern CCG	58%	43%	72%	32,238	13.36	↑
BOB	NHS Oxfordshire CCG	57%	24%	79%	65,430	12.31	↑
BOB	NHS Newbury & District CCG	57%	46%	62%	11,229	12.83	↑
BOB	NHS North & West Reading CCG	59%	45%	75%	10,135	13.41	↔
BOB	NHS South Reading CCG	54%	25%	69%	11,383	10.15	↔
BOB	NHS Wokingham CCG	58%	39%	63%	14,155	12.43	↑
Frimley Health	NHS Bracknell & Ascot CCG	56%	39%	72%	12,742	11.89	↑
Frimley Health	NHS Slough CCG	56%	39%	69%	12,658	12.01	↑
Frimley Health	NHS Windsor, Ascot & Maidenhead CCG	55%	36%	73%	14,047	11.41	↑
Frimley Health	NHS North East Hampshire & Farnham CCG	59%	45%	77%	20,102	13.45	↑
Frimley Health	NHS Surrey Heath CCG	58%	52%	64%	8,925	13.66	↑
	NHS Milton Keynes CCG	57%	43%	73%	25,305	12.21	↑

Source: 1) CVD primary care intelligence pack, published in July 2017 for diagnosed and undiagnosed hypertension
Note: This table shows hypertension prevalence estimates created using data from QOF hypertension registers 2014/15 and undiagnosed hypertension estimates for adults 16 years and older. 2014. Department of Primary Care & Public Health, Imperial College London
2) QOF 2016/17 for prevalance

The SCN and Senate are investing in interventions in both the prevention and detection of hypertension:

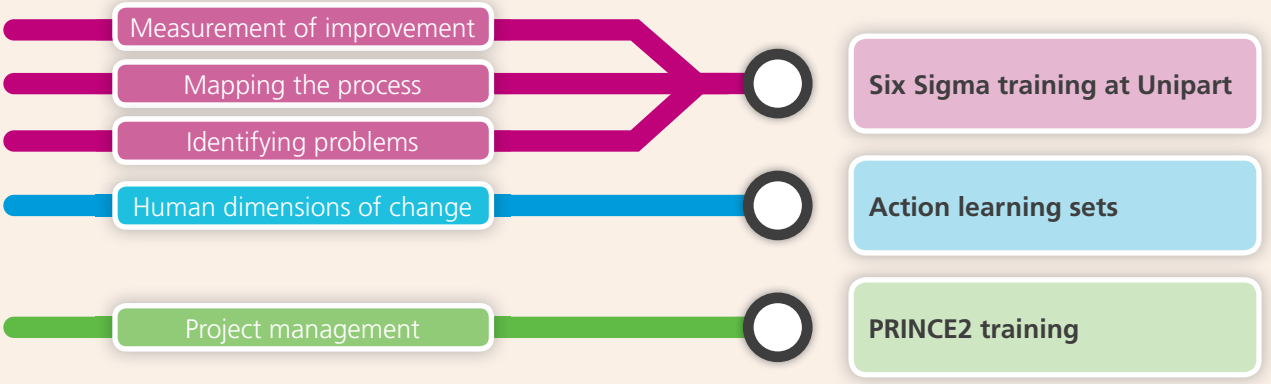
- Increasing clinical leadership around the detection of high blood pressure
- Supporting healthy lifestyle choices through the adoption and spread of care and support planning
- Education around brief interventions in obesity (see page 43 for more information on our brief interventions webinar)
- Reducing smoking (see page 42 for the Senate and Cancer Alliance's work on smoking reduction)
- GP education on physical health for people with serious mental illness.

The SCN and Senate team

How we work together and with others

We learn together

We mapped what we wanted to learn about service improvement tools, and then arranged training



We also set up Lunch & Learns to capitalise on expertise already held within the team

Minute taking

Email management

Demystifying healthcare databases

Behaviour change

We take wellbeing seriously

Weekly team lunches

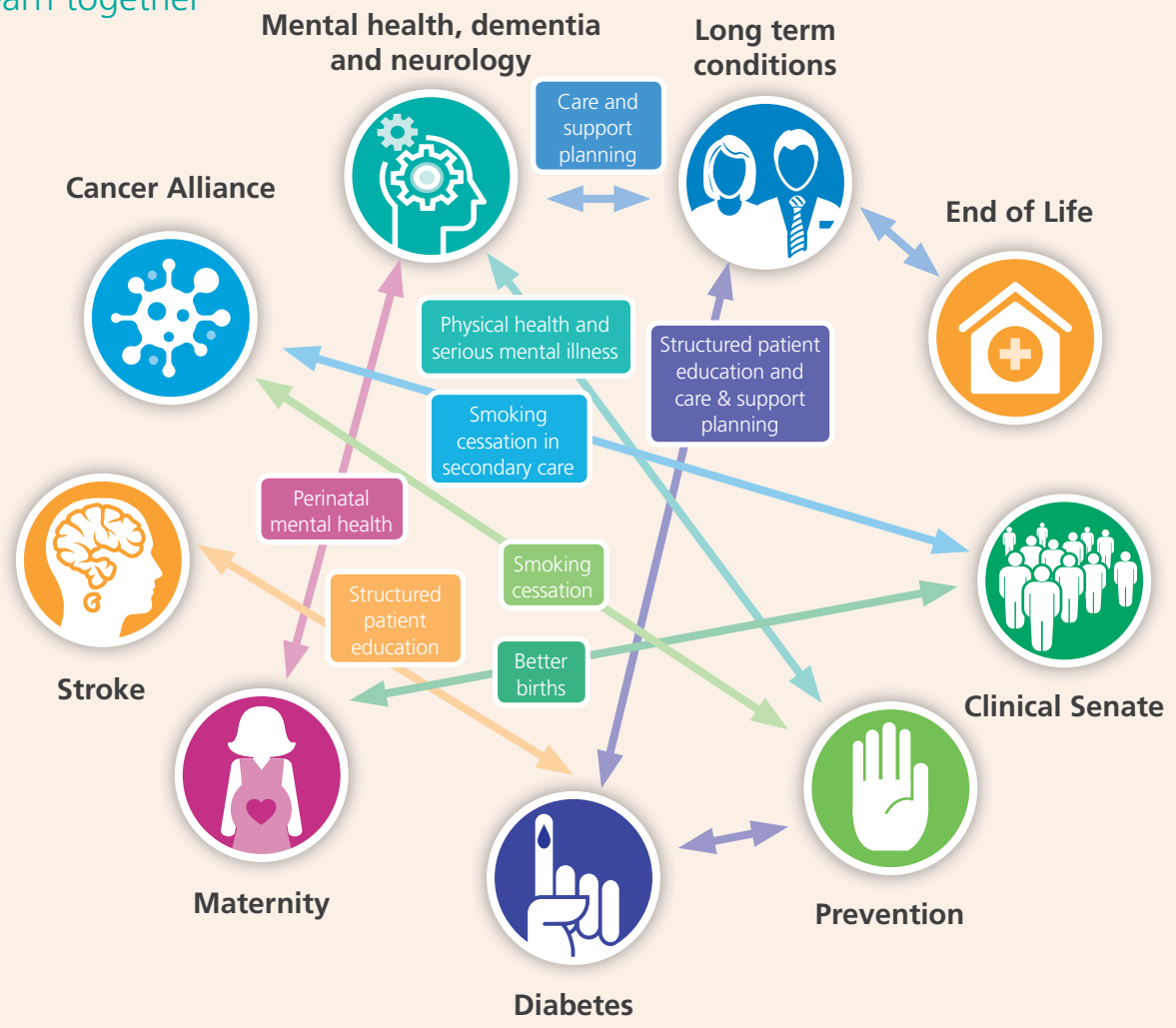
Lunch and team building games

mhfa mental health first aid england

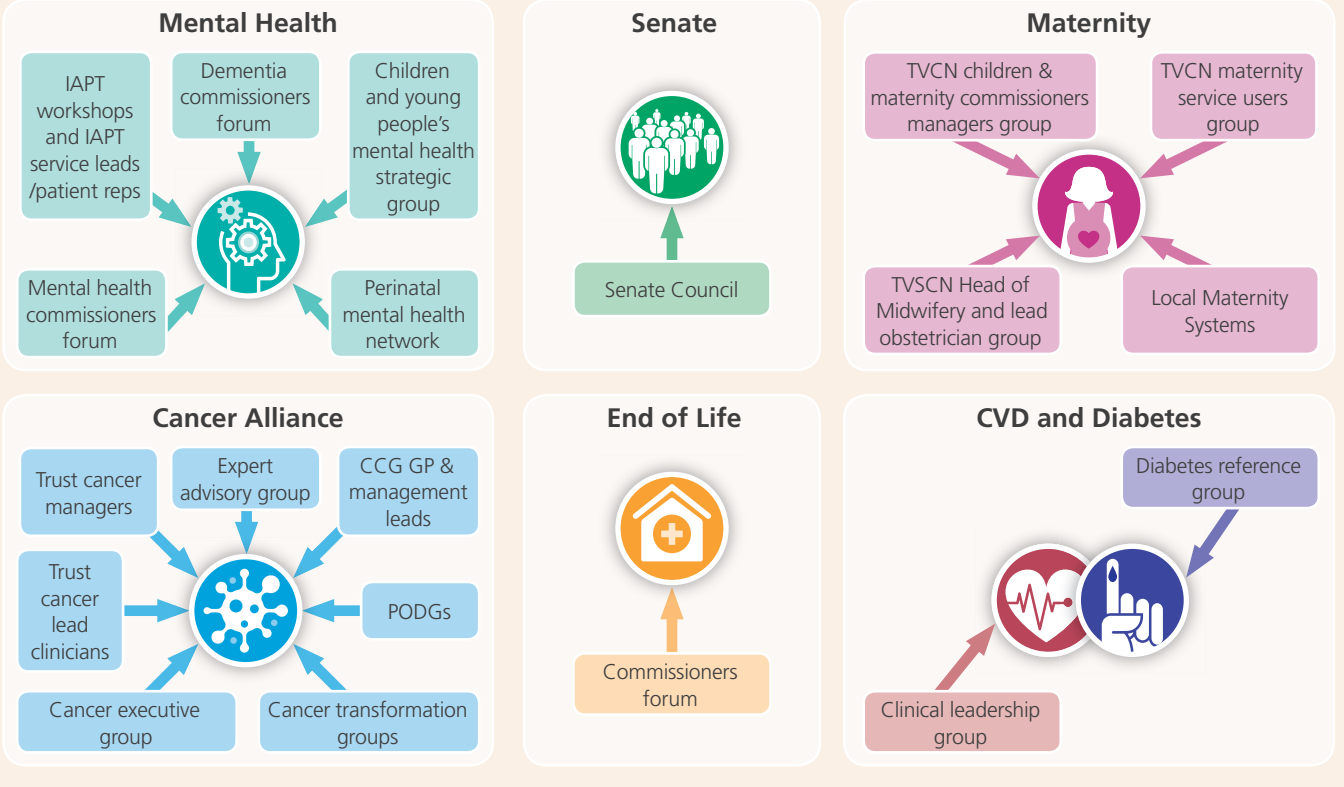
Mental health training and resources

Volunteering in the community

We learn together



Stakeholders define our work programme



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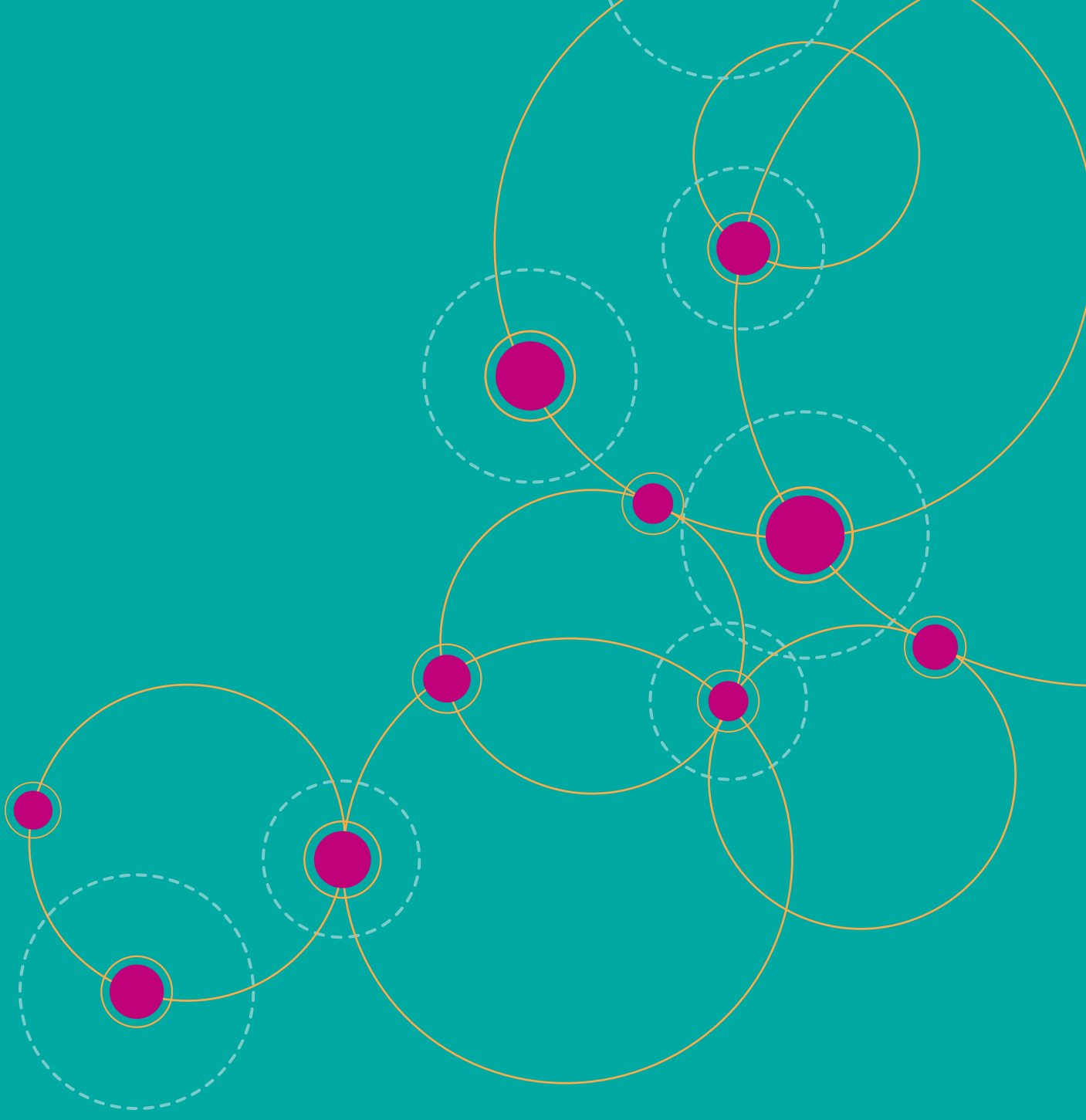
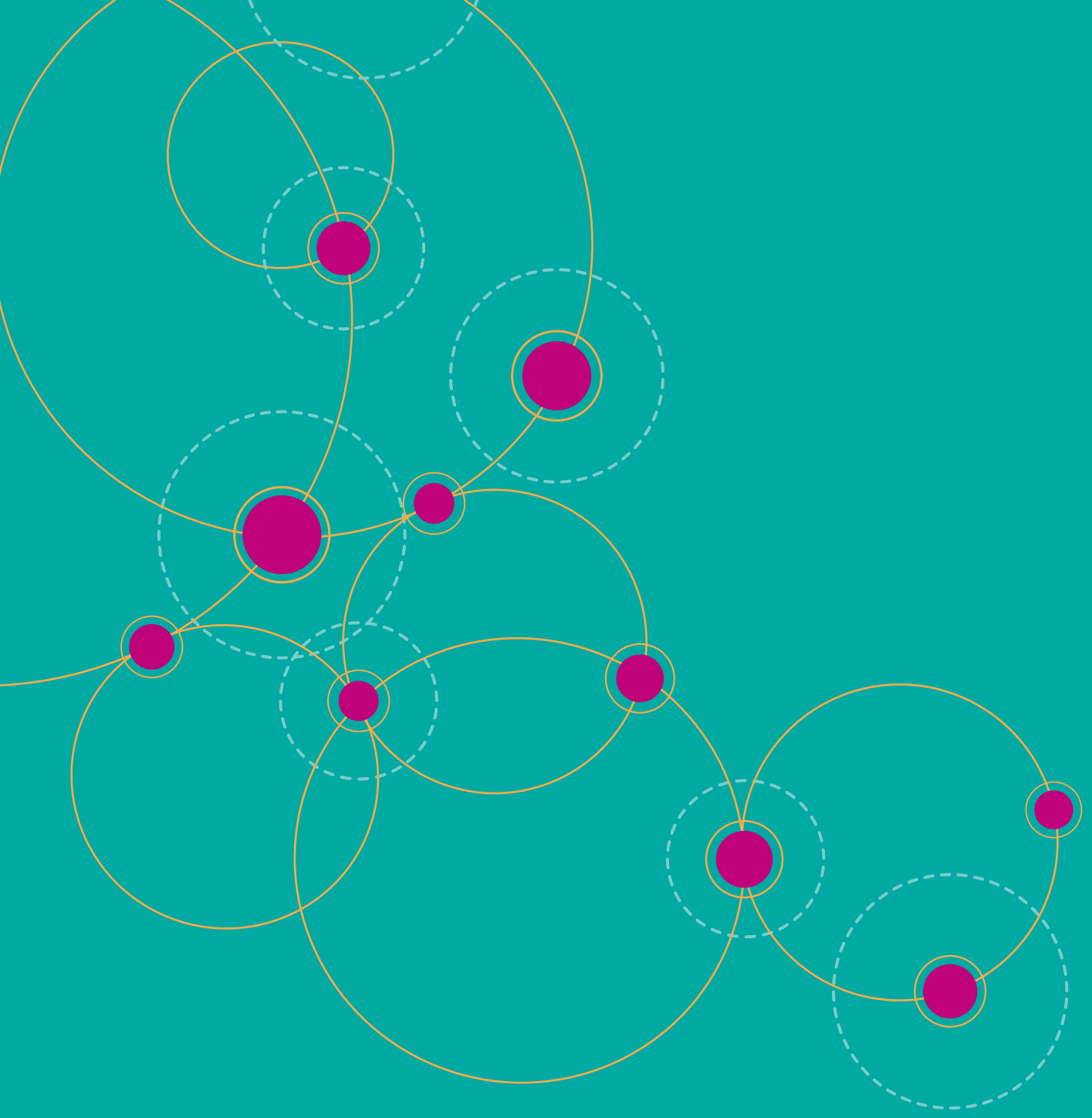
01338 251755





http://tvscn.nhs.uk/
http://tvsenate.nhs.uk/

Purpose

To update the Health and Wellbeing Board on Better Care Fund (BCF) and Improved Better Care Fund (iBCF) planning, performance and activity.

The refreshed BCF Plan was submitted to the BCF national team in line with requirements and an update was taken to the Health and Wellbeing Board on September 27th 2018 and informed the Board of the revisions to the plan.

The system received confirmation on October 1st 2018 from the Better Care Support Team, that 'the revised plan you provided has been reviewed against the BCF requirements. As it remains compliant, the revised plan has been noted and will form part of the BCF 2018-19 aggregation of plans'. We have also received a follow up email from our BCF manager lead for Bucks at NHS England (NHSE) indicating that no further clarification regarding the refresh of our plan is required.

The Quarter 2 return was submitted in line with the requirements by 19th October 2018. There has not been any feedback received.

The BCF allocation for 2019 / 2020 has still not been confirmed. This is anticipated in December.

Performance

Performance continues to be monitored through the Integrated Commissioning Executive Team ICET). Figures for September 2018 were published on Thursday 8th November.

1. Delayed Transfers of Care performance

The total number of bed days delayed for Buckinghamshire (social care, NHS and joint) in September was 1806 compared with 1245 days in August; and 1554 days in July. In June the total number of days delayed was 1593. Whilst for previous three months we have seen a month on month reduction of 309 days delayed per month between July and August, we have seen a significant increase in September of 561 days.

Month	No of days delayed per month	Direction of travel from previous month
April	1567	↑ + 73
May	1969	↑ + 402
June	1593	↓ - 376
July	1554	↓ - 39
August	1245	↓ - 309
September	1806	↑ + 561

The number of bed days delayed attributable to adult social care (ASC) decreased from June to July, but increased in August and September (328 in June, 247 in July, 282 in August and 345 in September). The number of NHS attributable delays has increased from June to July, decreased July to August but then increased significantly in September (1246 in June; 1307 in July; 957 in August; and 1459 in September).

The top five reasons recorded as reason for delay and delayed transfers of care (DToC) for September were:

- Care package in own home
- Further non - acute NHS care
- Patient choice – (this figure doubled from August to September)
- Nursing care home bed
- Residential care home bed

The system wide position for August was much improved against the July position but the number continued to be above the target level to achieve the Buckinghamshire contribution to the national ambition. In order to deliver in line with the national metrics adult social care should have no more than 6.8 delayed per day.

However the August level was 9.1 and September level was 11.5. If NHS DToC reductions are to be in line with national ambition, which is set to be delivered from September 2018 onwards, the number should be no more than 24.9 and the August performance was 30.9 and September 48.6 delayed per day.

	Target	**July 2018**	**August 2018**	**September 2018**
Health	24.9	42.16	30.9	48.6
Social Care	6.8	7.97	9.1	11.5
Joint	0.1	0	0.2	0.1
Total	31.8	50.1	40.2	60.2

Both NHS and adult social care performance need to improve to achieve the national ambition.

CIPFA comparator data shows:

- Buckinghamshire has just above the average number of DToC all bed days delayed year to date per 100,000 population (Buckinghamshire 12.9, group average 12.7, with performance of comparators ranging from 5.8 to 21.2).

- Buckinghamshire has below the average number of DToC adult social care and joint days delayed year to date per 100,000 population (Buckinghamshire

2.5, group average 5.2, with performance of comparators ranging from 0.6 to 11.9).

The High Impact Change work continues and we are planning to review the current activities and consider strengthening specific elements of work. The High Impact Change priorities form part of the Urgent and Emergency Care Transformation Programme which is monitored by the system through the A&E Delivery Board (A&EDB).

Actions in place to recover the position include:

- The establishment of a discharge to assess (D2A) programme of support including beds, domiciliary care and 24/7 care at home. This is supporting discharges from BHT and Wexham Park Hospital (WPH).
- BHT re-launch and roll out of 'get up, get dressed, get moving' at the Trust
- 'Fabulous fortnight' due to commence at Stoke Mandeville hospital on 19th November for two weeks – providing the opportunity to embed good practice with system wide support and input.
- The system multi-disciplinary team (MDT) action squad is being further developed to help support a reduction in long stay patients and DToCs.
- Red Cross team onsite to help support the process of patient re-settlement and repatriation to home.
- Additional on-site CHC clinical support.
- Daily 09:00 medically fit call with partners to discuss all patients on the medically fit list. Plans to incorporate other providers – particularly out of area.
- Local DToC (and stranded and long stay patient) escalation process being rolled out. This will be based on the Oxfordshire model.
- NHS Improvement (NHSI) report and recommendations to be shared. This is expected to be geared towards improving processes and improving pathways internally to maximise discharge options.
- BHT and social care are working together closely to continue the work to ensure the choice policy is robustly implemented.
- Weekly Escalation Call with senior system leaders – a review of the Top 20 longest stay patients across the Trust (acute and community beds).
- A system deep dive to better understand the delays for September across all providers, looking at what the key issues are and actions to support an improved position.
- Update the process of how medically fit for discharge (MFFD) and DToC patients are reported through the system to better understand current information and action to support and escalate where appropriate.
- Additional support to WPH through commissioning specific capacity for south Bucks.
- Further support to WPH includes additional therapy for Buckinghamshire discharges, a dedicated GP on-site to support discharges, some additional community GP support and project resource.

- Improved escalation processes to drive down delays in mental health beds within Oxford Health Foundation Trust (OHFT).

The Red Cross long lengths of stay project has been developed during September with input from BHT (Lead Nurse for Patient Flow) and Adult Social Care Commissioning and Operations (Specialist Commissioning Manager and Business Manager for Hospital Social Work Team). The first patient has been seen and is being worked with by the care navigator with a view to discharge, and work continues to finalise the criteria for selection onto the project. The approach will be to respond rapidly and will prototype the criteria and the activities to enable that. A provisional set of performance measurements have been agreed but will be subject to further refinement. The project team will continue to meet frequently for the time being to ensure that the maximum value is being derived from the project.

Target Areas

September data shows there were more year to date acute days delayed from Frimley Health NHS foundation (3294) than there were at Buckinghamshire Healthcare Trust (2840). This continues to need to be an area of focus.

The wait for a care package at home remains the most usual recorded reason for delays, accounting for 905 days delayed to date attributable to adult social care and 955 days delayed to date attributable to health. The most usual recorded reason for delays for health are attributed to waits for non-acute NHS (community hospitals): 2660 NHS delayed days to date and patient and family choice attributable for 1018 delayed days to date.

Figures for September 2018 for the remaining measures are not available for this report.

2. Reducing non-elective admissions (NEL)

Quarter 2 data is not yet available. However NEL continue to grow across several localities although a comprehensive programme of work is ongoing to address this. The programme amalgamates the following key elements:

1. Avoidable attendances to Emergency Department (ED) - ambulance conveyances, 0-4 hour NEL admissions, maximisation of ambulatory care sensitive conditions including children and attendances from care homes
2. Avoidable non-elective admissions - improved management of End of Life patients, delirium pathway, and respiratory pathways
3. Supported discharge - discharge to assess, reduction in excess bed days, CAREfully programme

As positive impact has been evidenced and the Airedale care home project for patients in care homes has been extended to more care homes in the county. There

is promotional activity to support increased access to alternatives to presentation in Accident and Emergency such as the Medical Day Service, Clinical Assessment and Treatment Service, minor injury and illness unit and out of hours service. Implementation of High Intensity User or Personalised Care Service (PCS) scheme is rolling out across several localities.

Quality Innovation Productivity and Prevention (QIPP) targets have been identified to try and drive improvements. Work also continues to establish the Buckinghamshire Integrated teams to support NEL reduction (admission avoidance) and also earlier discharge.

3. Reducing the rate of permanent admissions to residential care per 100,000 population

Performance remains strong and continues below maximum number of permanent admissions we were aiming to achieve. The target for the rate of permanent admissions to residential care per 100,000 population is no more than 260 and admissions in Q2 was 200.9. The national Adult Social Care Outcomes Framework (ASCOF) target has been revised and this strong performance remains within the revised ASCOF target.

4. Proportion of older people (age 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

This return is only available annually at year end.

Improved Better Care Fund (iBCF) update

The iBCF allocation is a three year allocation and for the third year, 2019/2020 the value is £2.3m which is £1.3m less than 18/19.

We submitted the iBCF update as part of the quarter one return for the BCF and established the anticipated level of activity in respect of the following:

- Number of home care packages 2100
- Hours of home care provided 683,793 Hours
- Number of care home placements 1,930

The areas of focus for the iBCF investment are:

- **Maintaining a stable care market** – the stabilisation which was achieved by uplifting payments to domiciliary care providers has been sustained into 18/19 and no provider exits to date from the market have been seen since the start of the financial year.

- **Support to self-funders –** at the moment our brokerage service is focussing on supporting people with direct payments to make the right care choices. We are now starting to work more closely with self-funders who with appropriate brokerage support would make appropriate care decisions, which could expedite their discharge from hospital and ensure that the care they purchase is appropriate and proportionate to their needs, preserving their assets for longer and enabling them to maintain their independence as long as possible.

  Broker coordinators will be based in hospital to ensure patients can access brokers in a timely way. There is an opportunity to look at how we might work with Frimley Park Hospitals Trust to provide brokerage support to Buckinghamshire residents being treated as inpatients in their hospitals, expediting discharge and contributing to reducing delayed transfers of care.

- **Protecting preventative services** – the level of grant funding into preventative services has remained consistent. Work is in progress to refocus the outcomes deliverable from our grants to support maximising and maintaining independence

Your community Your care
Developing Buckinghamshire together

Discharge to Assess in Buckinghamshire

The discharge to assess service (D2A) helps patients be discharged earlier from hospital by co-ordinating and providing care from other providers, in non acute settings. It is for those people whose care can safely be continued elsewhere but may still require some interventions from our services. They are provided with short-term, funded support in their own home or another community setting. Assessment for any longer term care and support is carried out in the most appropriate setting and at the right time for the person.

It incorporates various health and care activities allowing effective management of demand across Buckinghamshire's integrated care system (ICS).

Reablement and rehabiliatation to support patients to regain their independence is an important feature of D2A. A multi-disciplinary team, including discharge co-ordinators will support patients and their families throughout the discharge process.

The service gets its name from its focus on assessing patients for their ongoing care needs outside the hospital rather than waiting in a acute hospital bed to be assessed. The ICS vision is that no decisions about long-term care should be made in an acute setting.

Our Aims

Patients on a D2A pathway are discharged from hospital into nursing or residential homes or into their own home, sometimes with live in care. This care and support is for a defined period of time and has a rehabilitation and reablement focus.

Our objectives are:

- Promote the independence of adults on D2A by placing them at the centre of any decisions that impact their lives
- Allow people, with their carers and families, to take a full and active part in planning their long-term care and support
- Reduce the need for long-term packages of care by assessing people's long term care needs outside of the acute hospital, in settings which can maximise their ongoing independence
- Review plans regularly to make sure they are appropriate and effective
- Work together across the ICS to improve patient flow, reduce delayed transfers of care and increase health outcomes

Characteristics

- Assessment for care needs take place at home or in residential care, not hospital
- Three pathways for three groups of patients – no patient is excluded
- Multidisciplinary team assesses and provides patient care
- Independent brokerage available in hospital

- Deliver quality care to vulnerable adults in safe environments
- Use telecare solutions where appropriate to promote and improve independence

Our Values

Privacy	Your rights to expect sensitivity and confidentiality in dealing with your personal information.
Dignity	Respecting your uniqueness, your personal needs and your right to be treated with respect.
Independence	Your right to choose and control the way care is delivered to you and supporting your right to independence.
Competence	D2A services will be delivered by appropriately qualified managers, nurses and care and support workers who are competent to do their job.
Reliability	We will deliver what has been specified, providing information about the services. We will keep you and your carers informed of any changes in services.
Equality	We will be responsive and sensitive to ethnicity, gender, disability, sexual identity, age, religion, sexual orientation, marital/civil partnership status, culture, lifestyle, values and social circumstance. We will ensure we do not disciminate against you on any of these grounds.
Courtesy	We will ensure you and your carers are treated with respect.

Our Structure

In the Buckinghamshire integrated care system and through the Better Care Fund, we already have initiatives underway to reduce length of stay in acute inpatients wards, reduce delayed transfers of care (DToC) and manage bed occupancy.

We also want to improve business as usual through effective multi agency team planning and communication across the health and social care system and to always reinforce the “home first” philosophy.

Home care

Providing time limited home care and live in care focussing on reablement. This allows safe and timely discharge from hospital to peoples own home, then allowing assessment of longer term care and support in their home

Bed-based intermediate care (including step up, step down capacity)

Providing a residential or nusing care home bed to provide time limited care and support with a reablement focus. The aim is to either:

- Allow safe and timely discharge to allow an assessment of longer term care and support; or
- Prevent admission to hospital through timely intervention

ENABLER – Multidisciplinary team (MDT)

The MDT is made up of nurses, OT's physios and social workers from BCC and BHT. They are involved in planning for patient discharge when medically fit and identify suitable patients for the D2A pathway.

They refer patients to providers identified as being able to provide short term discharge to assess packages. This could be home care, live-in care or a care home.

Key personnel act as a trusted assessor completing referrals. The trusted assessor refers to D2A beds without the care home needing to carry out an assessment.

Brokerage in hospitals

Buckinghamshire County Council independent broker service is located in hospital, alongside discharge co-ordinators. They will support self-funders with options for when they are discharged to ensure they are taking up care and support options proportionate to their needs.

Red Cross Care Navigators

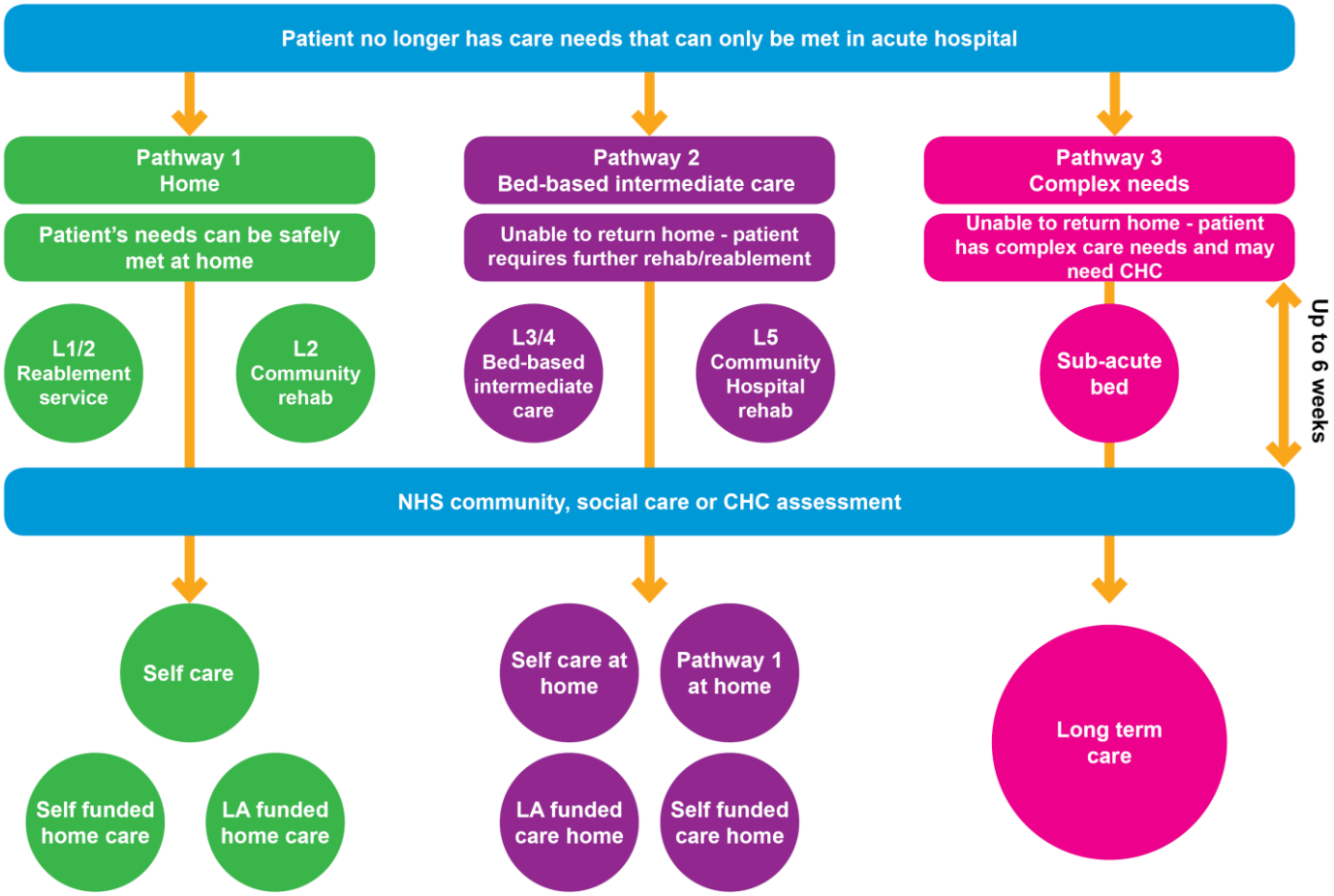
This has been aligned to Buckinghamshire's Home from Hospital support, where the Red Cross provides transport and a settling in service for people discharged to their home. The Care Navigator will work with long length of stay patients on the ward to motivate and encourage them to make plans to go home. They will then provide at home support to help with the discharge.

Also available as part of discharge to assess:

- Home from Hospital service
- Support for carers
- Seven day service from BCC social care
- Reablement
- Community Health care teams
- Assistive technology
- Airedale Video consultation for Care Homes

How patients benefit

The three pathways allow patients to be discharged from hospital in a timely way and support patients to rehabilitate fully in their own home or the community.



Pathway 1 for patients on a hospital ward who can return home with additional support from the reablement team or with community rehabilitation. They will remain on this pathway for up to six weeks.

Pathway 2 for patients who cannot be discharged home directly but could return there with additional rehabilitation

Patients are discharged to residential care or community hospitals for up to two weeks.

Pathway 3 for patients likely to need ongoing, long-term care and may be eligible for continuing healthcare funding.

Working together, Buckinghamshire's integrated care system has:

- **Access to short term care home beds**. These beds have been commissioned from providers the County Council has recognised as capable of high quality care for this model.
- **Access to additional domiciliary care support**. Extra hours have been commissioned from providers to enable people to be assessed in their own homes.
- **Built in links with primary care**. GP practices have been commissioned to provide clinical input to these beds. GP cover of a high quality is essential to allow the patient to move along the pathway within six weeks.

Enabler: Working with Buckinghamshire Reablement Service

Joint working across the Buckinghamshire integrated care system has been essential. Collaboration allows for a rapid and smooth transition between different services avoiding delays as patients wait for social care packages or a care home place.

The reablement service is crucial for Pathway 1. Staff have been retrained using a strengths-based approach focussing on what the patient can do for themselves rather than what they cannot, working with the patient for six weeks. The aim is to reduce the cost of expensive long-term care packages and help patients live independently in their own home.

Intensive support during the six week period of the reablement package means that at the end patients require significantly less home care.

What this means?

The service aims to offer patients the ability to return home more rapidly and improve their recovery from periods of illness or after an accident. All discharges should be appropriate and safe and it should demonstrate that it has not led to an increase in readmissions despite an earlier discharge home. The ICS is also working to establish a sustainable long-term D2A service.

Challenges

To understand the effectiveness of the D2A service we will examine key performance areas and any gaps in data. This will include evaluation of the impact of interventions in reducing unnecessary hospital admissions, delayed transfers of care and long length of stay for patients to support patient flow.

Challenges and lessons learned will need to be recorded to support planning for the following year.

Evaluation

An evaluation report will be produced and shared in May 2019

Health & Wellbeing Board
Buckinghamshire

Title:	Time to Change Mental Health Anti-stigma Project
Date:	6 December 2018
Report of:	Jane O'Grady, Director of Public Health
Lead contacts:	Ruth Page, BCC Communities Team

1. Purpose of this report

This report provides an update on the local Time to Change Buckinghamshire Hub which was launched in July 2018. It reports on progress to date, challenges experienced, and actions which the Health and Wellbeing Board can support.

2. What is Time to Change?

Time to Change is a national movement changing how we think and act about mental health. It is led by Mind and Rethink Mental Illness and started in 2007. Thousands of organisations now support it. The goals are to:

- Improve public attitudes and behaviour towards people with mental health problems.
- Reduce the amount of discrimination that people with mental health problems report in their personal relationships, their social lives and at work.
- Make sure even more people with mental health problems can take action to challenge stigma and discrimination in their communities, in workplaces, in schools and online.

3. Background

In November 2017 the Health and Wellbeing Board agreed to support an application for Buckinghamshire to become a Time to Change Organic Hub. An application was submitted and in March 2018 we had confirmation that the bid had been successful.

The Buckinghamshire Hub was officially launched in July 2018. It is a partnership of local organisations and individuals committed to challenging mental health stigma and discrimination. The key partners in the Hub are: people with personal experience of mental health problems; Buckinghamshire County Council; Buckinghamshire Mind; the District Councils; Oxford Health; Buckinghamshire Clinical Commissioning Group; Wycombe Mind; The Recovery College; Bucks Business First; and Leap (the County Sports Partnership).

Time to Change Hubs are asked to encourage conversations about mental health between people with and without personal experience of mental health problems. Time to Change call this 'social contact methodology'. Hubs are therefore asked to recruit volunteer 'Time to Change Champions', people with lived experience who are happy to talk openly about their experiences.

The application identified specific population groups to explore targeted work with. These are men, children and young people, employers and pregnant women/women who have recently given birth. An action plan to reach these groups is in development. This plan involves local people with lived experience as core to planning and delivery, therefore ensuring Time to Change's social contact methodology is followed. The main sections of the action plan are:

- Recruitment and support of Champions
- Activities on key days in the year such as World Mental Health Day (October) and Time to Talk Day (February)
- Communications and social media activity
- Attendance at events organised by others called 'piggy back events' such as the Buckinghamshire County Show
- Large scale events/activities to reach the identified target groups
- Influencing Buckinghamshire's employers to take the Time to Change Employer Pledge which is a demonstration of commitment to how we think and act about mental health in the workplace and make sure that employees who are facing these problems feel supported.

4. Progress to date

This update on progress covers: the initial set up of the project; wider partnership working; recruiting Time to Change Champions; piggy back event; larger scale events; and the Employer Pledge.

4.1 Set up

The set up phase of the project took place from April to July 2018. Achievements in this phase were:

- Formation of the Time to Change Partnership Group, co-chaired by a Champion.
- Recruitment of a Hub Coordinator by Buckinghamshire Mind.
- A formal launch of the Hub at the 'Busk for Bucks Mind' event in July. This was a live music event held in Aylesbury attended by over 100 people.
- Development of Communications Plan including print material, website, press and social media
- Establishment of the 'Champions Fund'. This is funding available for Champions to claim up to £500 to run their own anti-stigma events and activities. Buckinghamshire Mind manages this for the Buckinghamshire Hub.

4.2 Wider partnership working

The Buckinghamshire Time to Change Hub Partnership Group, has worked with a wide range of partners to bring the Time to Change movement to Buckinghamshire. The following has taken place since the Hub launch in July:

- Close working relationships have been developed with the national Time to Change team
- A number of partnership Groups have been engaged in the work of the Hub including the: Children and Young People's Emotional Wellbeing Group; Mental Health Partnership Board; Five Year Forward View Partnership Group; Suicide Prevention Group; Perinatal Mental Health Network.
- Community groups and charities are being engaged with as well as all Buckinghamshire libraries.

4.3 Recruiting Time to Change Champions

Recruiting volunteer Time to Change Champions is core to the success of the Hub. Champions sign up via the national Time to Change website www.time-to-change.org.uk. In May 2018 the national Time to Change website had nearly 80 Time to Change Champions registered from Buckinghamshire. However after the introduction of the General Data Protection Regulations, explicit consent was required for Time to Change to hold their data. A lack of response on the consent has resulted in a significant drop in the number which dropped to single figures. As a result since the launch, significant effort has been focused on recruiting local Time to Change Champions, and this needs a continued partnership effort. The following has been completed since the launch.

- Two information drop-in sessions for interested people to learn more about the Champion role. 25 people attended.
- Social media advertising including general advertising on Facebook and twitter and targeted (paid for) advertising on Facebook
- Production of a comprehensive toolkit for partner organisations to use to help raise awareness of Time to Change and specifically to recruit Champions. This includes a template press release, posters for internal and external use, and social media resources. This can be accessed from www.timetochangebucks.org

The number of Time to Change Champions is steadily increasing and currently there are 37 registered in Buckinghamshire.

4.4 Piggy back events

The ability to have an effective presence at piggy back events relies on having a high number of people in the pool of local Champions. This is because Champions are needed at these events to informally talk about their experiences. As more Champions are recruited, more events can be attended. Events attended so far are:

- Buckinghamshire County Show, Wycombe Festival of Wellbeing, and the Bucks New University Welcome and Freshers' events
- Buckinghamshire Mind stall in the Market Place in Aylesbury for World Mental Health Day
- High Wycombe library's 'Libraries Week' event on mental health and Time to Change for World Mental Health Day

4.5 Larger events

Work has started to explore delivering larger scale events for each of the four identified target groups

- Men: Discussions are taking place with Wycombe Wanderers Football Club about a programme of anti-stigma activity including a match day event and shared opportunities with LEAP the county sports partnership
- Children and young people: Discussions have taken place with CAMHS, and the Youth Service; and Time to Change Young Leader and Professionals training is being explored for schools and other settings.
- Employers: Discussions have taken place with Bucks Business First about how to encourage local employers to take the Employer Pledge
- Pregnant women/women who have recently given birth: possible links are being explored to perinatal wellbeing groups to work with women with lived experience of mental health problems to develop activities to address stigma.

4.6 Employer pledge

For World Mental Health Day 2018, Buckinghamshire County Council signed the Time to Change Employer Pledge at an event open to all staff, encouraging them to have conversations about mental health. The event was very successful with good attendance and opportunities to talk about how the employer pledge can really make a difference in an organisation.

5. Next steps

A meeting is taking place in Aylesbury on 26th October to bring together local individuals, groups and organisations who have an interest in tackling stigma in our communities. This will involve a wider group than the Partnership Group and the hope is to recruit more Champions and plan future activity across Bucks. The Hub intends to establish better connections with local Champions and provide support to groups and individuals to increase engagement and activity.

Work continues on planning larger events to address the target audiences together with increased promotion of the Champions Fund.

The Hub is working proactively with the National Time To Change Team to overcome barriers in relation to sharing information on Champions who sign up on the national website and better publicity for the local champions fund through the national website. Baseline research from funded Hub's has been made available from the national team and is being utilised locally and further support is awaited on evaluation tools, resources and methodologies.

This 18 month project provides the opportunity to stimulate a longer term change in attitudes towards mental health. Actions to support the ongoing sustainability of the work includes: embedding the activity undertaken by Champions into their local communities and local organisations adopting the employer pledge. Time to Change

has opened applications for the third tranche of funding (from March 2019 to August 2020) and the Buckinghamshire Hub will be submitting a bid.

6. Support requested from the Health and Wellbeing Board

The Buckinghamshire Time to Change Hub requests that the constituent members of the Health and Wellbeing Board:

- Commit to signing the Time to Change Employer Pledge, if they have not already. Support for this is provided by Time to Change national.
- Influence wider partner organisations and local businesses to consider signing the Time to Change Employer Pledge.
- Actively promote Time to Change and the recruitment of Champions using the Communications toolkit.
- Make suggestions for additional events across Buckinghamshire that the Hub could have a ‘piggy back’ presence at.

Health & Wellbeing Board
Buckinghamshire

Title:	Buckinghamshire County Council Contribution to the Director of Public Health Annual Report
Date:	6 December 2018
Report of:	Dr Jane O'Grady, Director of Public Health

Purpose of this report:

At the September 2018 Health and Wellbeing Board, the 2018 Director of Public Health Annual Report 'Healthy Places, Healthy Futures – Growing Great Communities' was presented.

As all partners on the board have a key role to play in shaping the places we live, it was requested that partners bring back an update on what they were doing in relation to the 6 key areas identified in the report to the December meeting.

This paper presents the responses received so far from Health and Wellbeing Board partners.

Summary of main issues:

The 2018 DPH Annual Report focuses on six areas of the physical and social environment that play an important role in health and wellbeing. These are:

- Community Life
- Healthy Homes
- Healthy Travel
- Air and Noise Pollution
- Green Spaces and Natural Environment
- Healthy Food Environment

Appendices 1-6 provide summaries of Health and Wellbeing Board partners' work and activities that are contributing to the delivery of the recommendations for the six areas.

Recommendation for the Health and Wellbeing Board: The Health and Wellbeing Board is asked to:

Note the contributions of partners to achieving the recommendations of the 2018 DPH Annual Report, as outlined in Appendices 1-6.

Appendices

1. Contribution from Buckinghamshire County Council
2. Contribution from Aylesbury Vale District Council
3. Contribution from Chiltern District Council
4. Contribution from South Bucks District Council
5. Contribution from Wycombe District Council
6. Contribution from NHS organisations

Appendix 1: Contributions by Buckinghamshire County Council for 'Healthy Places, Healthy Futures, Growing Great Communities'

Community Life
The communities we live and work in profoundly affect our wellbeing. Actions to strengthen communities, increase social connections and social cohesion, give local people more say in services, increase volunteering, reduce social isolation and protect vulnerable people all of which improve health and wellbeing.

Portfolio	Actions

Planning and Environment/ Transportation	• Volunteering opportunities are available across Transport, Economy and Environment to support community links in Bucks. These include :
	  ○ Assisting the Rights of Way team with management and maintenance of the Rights of Way network, with advice provided by the Buckinghamshire Local Access Forum.
	  ○ Gathering information and reports to ensure the Environment team have up to date records regarding local wildlife and heritage
	  ○ The Simply Walks programme, which provides volunteer led walks to over 700 walkers every week on more than 80 walks across the County.
	  ○ Working as part of the Natural Environment Partnership (NEP), we have also pulled together a volunteering directory for those looking to get involved in conservation in their area.
	  ○ Conservation volunteering at the Country Parks e.g. Heathland management, coppice management
	• BCC works in partnership with the District Council and Local Enterprise Partnerships on the Aylesbury Garden Town initiative. This aims to deliver a well-planned and sustainable environment for communities in Aylesbury while providing for future growth. The masterplan for AGT is due in June 2019.

Children's Services/ Education and Skills	• The Bucks School Linking Network facilitates twinning locally between schools in different contexts. This encourages conversations and connections between young people of different backgrounds. It supports young people and adults to understand each other better, strengthens community cohesion and promotes British Values. • Bucks Model United Nations events engage students in debating world affairs and deepen understanding of diversity, equality and community. • Links with a range of community organisations across Bucks who engage with the Council on education issues regarding achievement and attainment of vulnerable • The Community Consultative Group has worked to increase the number of School Governors from under-represented groups in the community. • 15 youth centres have been leased on a nominal rent to community run management committees. • Youth Service programmes that focus on building on young people's strengths and promote factors to help young people cope with adversity and challenge, particularly social isolation. • Youth Service approaches to co-designing services with children and young people including children and young people in care and with special educational needs and disability. These include We Do Care council for children and young people, SEND Youth Forum for young people with varying levels of SEND and Young People's Interview Panels. • The Council's Gypsy and Traveller Liaison works to build community cohesion. • The Council is currently revising its Integrated Carers Strategy which

	will include information for young and adult carers to reduce their isolation and support their health and wellbeing.
Adult Social Care, Health and Wellbeing, Community Engagement and Public Health	• Implementing the Adult Social Care 'strength based approach' to social care practice which utilises the support that families and the local community can offer. This includes support for carers and support is provided through Carers Bucks. • ASC is expanding its Shared Lives offer through which local people provide respite support for people with social care needs. • Working with partners, including the Charitable & Communities Sector, to create a shared approach to prevention and strengthening communities. • Street Associations focus on building community resilience by supporting residents to keep their neighbours safe and well. • Developing a Community Assets Digital Tool to make information on over 2,000 local community resources available to the public and professionals • Community appraisal workshops to identify their community's strengths and assets. • Developing a cultural strategy that addresses health and wellbeing and social isolation • The East Wycombe Community Organising programme works involves local communities identifying priorities and actions that they can take to promote health and wellbeing in their area. • Walton Court and Southcourt Healthy Living Centre community engagement work ensures programmes reflect the needs of the community • Local Area Forums have developed a wide range of projects which are community based and both engage and strengthen communities. These include mental health outreach, Buckingham Activities Group, Men in Sheds, Marsh Gibbon Mobile Skate Park amongst many others.
Resources	• Customer Service Centre supports all the key areas by dealing with community queries by assisting and signposting to the relevant areas. • Using research with users to understand how people with different needs or abilities interact with services to inform decisions about how we design all aspects of our services (face to face, post, telephone and online) • Undertaking communication campaigns to ensure local communities are well informed about issues which can impact on their health and wellbeing including topics such as Time to Change, working with Trading Standards on scams, preparation for flooding, promoting green spaces and improving health for people with learning difficulties and autism

Healthy Homes
Living in an affordable and good quality home is fundamental to people's physical and mental health and wellbeing and can reduce demand on services

Portfolio	Actions
Adult Social Care, Health and Wellbeing, Community Engagement and Public Health	• Adult Social Care are working with partners to develop and utilise a range of options to maintain independence such as extra care, shared live and assistive technology • Adult Social Care Market Position Statement for Housing and Accommodation Solutions is under development • BCC has a new duty to refer those at risk of homelessness which came in through the Homelessness Reduction Act 2017. ASC is working to ensure all staff are aware of the duty and is working with the Districts on implementing this duty.

Healthy Travel Active travel, such as walking and cycling improves our health by promoting physical activity. It also delivers other benefits such as reducing air and noise pollution and increasing social connections	
Portfolio	**Actions**
Planning and Environment / Transportation	• Rights of Way Team manage, maintain and promote the 3324km of Rights of Way Network across Buckinghamshire. An interactive 'Buckinghamshire Walks and Rides' map is available • BCC are one of 10 local authorities working in partnership with Modeshift and Cycling UK on the Living Streets project to encourage active travel to schools and workplaces as well as route audits and travel planning. Fifty-one schools in Bucks have been awarded Modeshift Stars for their school travel plans (37 bronze, 8 silver, 6 gold) • Walking Zone Maps are available to schools to create 5/10/15 minute walking zones around their schools. The maps, showing walking and cycling routes, will help to encourage more families to actively travel to school *(This is cross portfolio with Education and Skills and Community Engagement and Public Health)* • The Transport Strategy team works with developers to develop travel plans for new developments • 10km of cycleway has been delivered between Winslow and Buckingham to promote healthy and active travel. The next (current) stage is to extend this cycleway into Buckingham Town Centre. • Construction of a cycleway in Taplow is expected to start in early 2019 and there are HS2 assurances on a Stoke Mandeville Cycleway and extending the network in Wendover by 2022. • Transport Strategy colleagues are working with HS2 to adapt their schemes and plans to incorporate more cycling opportunities to align with the county's cycling aspirations. • Continuing to look for more opportunities active and sustainable travel through footpaths and cycleways around the county. Aspirations include: Thame - Haddenham Station – Aylesbury, High Wycombe – Bourne End, National Cycleway Scheme following the HS2 corridor north to south. These are currently being progressed to the feasibility stage with a view to seek funding for their implementation. The feasibility studies of new cycle facilities will be due in mid-2019. • The canal improvement delivered, in partnership with the Canal and River Trust, between the Arla site and Aylesbury town centre; there is an aspiration for upgrade of the canal between Aylesbury, Tring and Wendover which would provide further active travel opportunities. • Investigating the causes of road traffic collisions on Buckinghamshire County Council's roads and taking measures to prevent them. • There are a number of schemes to instil road safety and active travel principles in children from a young age with a number of schemes such as the Junior Road Safety Officer scheme. • Travel Assistance guidance has been drafted and being incorporated into Council-wide policy development *(This is cross portfolio with Children's Services, Health and Wellbeing)*
Children's Services / Education and Skills	• Footsteps is a practical pedestrian training scheme for young children which develops awareness of roads and road safety. (*Cross portfolio with TEE)* • Bikeability is a cycle training scheme. These modules will be delivered via schools until 2020. (*Cross portfolio with TEE)* • 55 School crossing Patroller sites helping children and their

	parents/carers to cross busy roads on their journeys to and from school. The Patrollers actively engage with schools and pupils to encourage walking to school. (*Cross portfolio with TEE)* • 'Healthy Movers' programme. Healthy Movers is a holistic approach to building the knowledge, skills and understanding of families and early years practitioners to promote physical activity and the benefits associated with this. E.g. walking instead of using a buggy and making use of green spaces in their community
Adult Social Care, Health and Wellbeing, Community Engagement and Public Health	• The ASC Transformation programme includes a work stream to review transport options and support maximum independent travel. This includes maximising local community assets. • ASC has Travel Assistance guidance that is being incorporated into council-wide policy development.

Air and Noise Pollution (Healthy Travel will also contribute to this key area)
Air and noise pollution have a range of harmful effects on health the very young, very old and those with poor health are most likely to be negatively affected by pollution.

Portfolio	Actions
Planning and Environment / Transportation	• An Office for Low Emission Vehicles funded project to deploy 27 car charging points in Buckinghamshire for residents who don't have access to charging points at home • Local Transport Plan 4 encourages active and sustainable travel for appropriate journeys e.g. Bucks Commute Smart, expansion of the cycle network. • BCC is currently preparing an Low Emission Strategy to set out its approach to air quality. • One of the key objectives of the recently adopted Freight Strategy is to protect the environment and minimise pollution. • The Integrated Transport team has started a campaign to get bus drivers to turn off their engines in Aylesbury bus station. This is supported by improved signage and information to support drivers. • Major new infrastructure proposals such as the Oxford-Cambridge Expressway are expected to increase car use. BCC will aim to secure funding to mitigate any adverse impacts of these schemes, where possible. • Monitoring environmental measures in relation to all Local Growth Fund schemes. This includes noise and vibration, traffic counts and speed surveys, as well as air quality monitoring and lighting. The surveys are undertaken pre and post scheme implementation to evaluate the effectiveness of the schemes. These schemes include: o Eastern Link Road and South East Aylesbury Link Road to be delivered by end of 2021. o Wycombe Town Centre Masterplan is currently ongoing and is taking into consideration the historic street patterns and buildings to develop usable active travel routes. • The HS2 Road Safety Fund will soon be launched to provide communities and parishes the opportunity to apply to fund road safety related schemes such as cycleways and footpaths. • The 'Getting to School Strategy' fulfils the council's duty to produce a Sustainable Modes of Travel Strategy (SMoTS) as outlined in the Education and Inspections Act 2006. This was adopted in August 2018. It sets out the benefits to air quality of fewer people driving their children to school and the benefits of active travel such as walking and cycling. • Work will consider how digital connectivity that may reduce some travel and the potential of increased teleworking
Adult Social Care,	• Public Health led on and co-ordinated a countywide multi-agency

Health and Wellbeing, Community Engagement and Public Health	workshop on air quality. The workshop identified a number of key actions and these will now be progressed by the Air Quality Management Group.

Green Spaces and Natural Environment

Contact with the natural environment is vital for physical and mental health and wellbeing at all ages. Exposure to green spaces reduces stress and depression, and every 10% increase in green space is associated with a reduction in disease equivalent to 5 years of life gained.

Portfolio	Actions
Planning and Environment /Transportation	• Within Buckinghamshire there are four Country Parks (Black Park, Langley Park, Denham and Thorney). These provide 800 acres of green space for the public and manage activities such as Park Run, children's play areas and bike hire. There were 1 million visitors in 2017/18. • The Country Parks team are looking into a proposal for indoor play facilities. This would mean that active play opportunities would be available year round at Black Park. • Pursuing a net environmental gain principle in local plans i.e. all developments need to demonstrate a net environmental gain. • A countywide biodiversity accounting system is being developed and will involve improvements to local green infrastructure as part of new developments. Developers are now recognising the benefit of this in proactively designing green infrastructure into developments from the start. • Three panels (Calvert Area, Colne Valley and Chilterns AONB) have been set up, in relation to HS2, which have funding for environmental mitigation projects (£1m, £3m and £3m). • New Green Infrastructure standards are being developed under the DEFRA 25 Year Environment Plan which focuses on connecting people with the environment to improve health and wellbeing.
Children's Services / Education and Skills	• ALF - through the various activities that are provided by the 3 centres in the Charity develop an appreciation of the natural environment is promoted and skills are developed through activities to enable young people to be aware of green spaces and the beneficial impact these can have on their lives.

Healthy Food Environment

The quality and quantity of the food and drink that we consume are important contributors to our health. A poor diet increases the risk of becoming overweight, developing diabetes, heart disease, stroke, some types of cancer and dementia.

Portfolio	Actions
Planning and Environment / Transportation	• The Fighting Food Waste Project is run by the Buckinghamshire Waste Partnership. It aims to reduce food waste across Bucks and recycle what is left. It has delivered a 12% increase in food collected for recycling since October 2017. • Let's Cook project to train local community groups to deliver healthy eating workshops in Buckinghamshire. • The San Remo Café at Black Park offers healthy food options and is accredited with a Gold Award as part of the 'Eat Out, Eat Well' scheme.
Children's Services / Education and Skills	• During 2017-18 training has been delivered to early years practitioners to support them with promoting healthy eating within their setting and to encourage children and their families to eat healthily *(cross portfolio with Community Engagement and Public Health)*.

Wider planning and environmental issues	
Portfolio	**Actions**
Planning and Environment / Transportation	• Working in partnership with the District Council and Local Enterprise Partnerships on the Aylesbury Garden Town initiative. • Working in partnership with Chilterns Conservation Board as part of their management plan to enhance access to recreational purposes • The BCC HS2 team are providing support to a number of projects who are looking to submit bids to the HS2 Ltd Community & Environment Fund. These include: Wendover Community Library to part fund their aspiration to extend the library, and a Blue Light services project to construct a community hub near the North Portal.
Adult Social Care, Health and Wellbeing, Community Engagement and Public Health	• The Public Health Team contributes to work on the health impacts of new growth areas and national infrastructure. This includes commenting on scoping documents for and completed Environmental Impact Assessments and contributing to responses to national consultation documents
Resources	• The Property Team give due care and consideration of matters pertaining to Community Life, Travel, Pollution, Landscaping and Environment by including these aspects within their briefing of consultants and contractors for building construction projects, particularly the larger ones.

Appendix 2: Contributions by Aylesbury Vale District Council for 'Healthy Places, Healthy Futures, Growing Great Communities'

Community Life

The communities we live and work in profoundly affect our wellbeing. Actions to strengthen communities, increase social connections and social cohesion, give local people more say in services, increase volunteering, reduce social isolation and protect vulnerable people all of which improve health and wellbeing.

Portfolio	Actions
	• The Paralympic Flame Lighting event took place in 2018. AVDC is the lead funder and organiser and we also part fund the National Paralympic Heritage Trust.
	• The AVDC Grants Panel has met to recommend 2018/19 community grants to be awarded. These grants support AVDC priorities around mental health, older people and people with disabilities.
	• AVDC continues to deliver regular physical activity sessions for target groups including people with disabilities (Disability Arts Sports and Health and Doorways Dance Group) and ladies only swimming, which encourages women who might not otherwise take up this activity.
	• AVDC supported BCC's planning of the World War 1 commemoration event with entertainment, stands and refreshments at the Gateway.
	• To strengthen community cohesion, AVDC delivered the following events in the summer of 2018 around the vale: Play around the Parishes, National Playday and WhizzFizz Fest. There were high levels of attendance at all events. Planning is now underway for 2019.
	• AVDC organised hoarder support training for partner organisations in December 2017 leading to the setting up of Buckinghamshire's first support group, hosted by Buckinghamshire Fire and Rescue Service, for those affected by this WHO classified medical disorder.
	• AVDC's Dementia Friends Champion runs Information Sessions for staff as well as joins other partners to provide sessions in the Vale. In 2017 AVDC and a BCC Champion from the Library Service ran sessions for children at Buckingham School.

Healthy Homes

Living in an affordable and good quality home is fundamental to people's physical and mental health and wellbeing and can reduce demand on services

Portfolio	Actions
	• AVDC's 2018-2021 Housing and Homelessness Strategy has been approved by Council.
	• AVDC bid for and was awarded Rough Sleeper Initiative funding to help those with complex needs into housing. As part of this, we have appointed an Accommodations Officer and Mental Health Nurse as well as additional drug and alcohol outreach to support people with mental health and substance misuse issues to help them sustain tenancies in the longer term.
	• A consortium led by AVDC was awarded £625,000 in government funding to help prevent homelessness across Buckinghamshire. The Building Resilience Service identifies those at risk of homelessness early on and gives them the support they need before reaching crisis point.
	• Vale of Aylesbury Local Plan, including Affordable Housing Policies, has been submitted to the Planning Inspectorate for public examination. The Plan will help to accommodate national housing growth demand and bring more investment, employment and opportunity, thus helping the district to thrive.

	• AVDC organised hoarder support training for partner organisations in December 2017 leading to the setting up of Buckinghamshire's first support group, hosted by Buckinghamshire Fire and Rescue Service, for those affected by this WHO classified medical disorder.
	• AVDC part funded Youth Concern's Nightstop service which provides emergency host-accommodation for young people aged 16-25 years who are facing a homelessness crisis.
	• AVDC works with partners to ensure there is a sufficient supply of disabled, adapted and accessible properties.
	• In December 2017 AVDC hosted a series of workshops by the Domestic Abuse Housing Alliance for housing providers to understand more about their role in identifying and supporting tenants who are victims of domestic abuse.

Healthy Travel

Active travel, such as walking and cycling improves our health by promoting physical activity. It also delivers other benefits such as reducing air and noise pollution and increasing social connections

Portfolio	Actions
	• Aylesbury Garden Town recently hosted a Netherlands delegation of cyclists who visited the Garden Town to evaluate the cycling network – we are currently awaiting their recommendations.

Air and Noise Pollution (Healthy Travel will also contribute to this key area)

Air and noise pollution have a range of harmful effects on health the very young, very old and those with poor health are most likely to be negatively affected by pollution.

Portfolio	Actions
	• AVDC's ongoing work as identified in the creation of 3 Air quality management areas (Tring Road, Friarage Road and Stoke Road) in order to tackle vehicle emissions of nitrogen dioxide.
	• AVDC promoted Clean Air Day on 21 June 2018 through their social media channels and encouraged the public to reduce and avoid air pollution to make the air cleaner and healthier for everyone.
	• Following AVDC attendance at the first Bucks Air Quality conference in May, the Buckinghamshire Air Quality Action Group, which has representatives from the four district councils, Milton Keynes Council, Bucks County Council, Public Health from Bucks CC and Public Health England, will develop a Buckinghamshire Wide Low Emission Strategy to tackle poor air quality across the County.
	• AVDC has published a number of self help factsheets on noise pollution and how to tackle it including letter templates, to support those experiencing noise pollution. Officers will investigate complaints where there is evidence of a statutory nuisance.

Green Spaces and Natural Environment

Contact with the natural environment is vital for physical and mental health and wellbeing at all ages. Exposure to green spaces reduces stress and depression, and every 10% increase in green space is associated with a reduction in disease equivalent to 5 years of life gained.

Portfolio	Actions
	• Work has begun on the Aylesbury Garden Town masterplan. A draft will go out to public consultation next spring with the final version expected by summer 2019.
	• AVDC conducts ongoing improvements to parks and green spaces which includes accessibility and play equipment for children and young people. 3 Sites have Green Flag status (2 in Aylesbury, 1 in Buckingham). AVDC negotiate with S106 contributors to improve public open spaces. An

	example of innovative play equipment can be seen at Riverside Walk Park on Meadowcroft.
	• AVDC Officers work closely with local environmental and conservation volunteer groups who are essential to conservation management in the vale and have established a number of community conservation groups such as the Friends of Bourton and Heartlands Park.

Healthy Food Environment

The quality and quantity of the food and drink that we consume are important contributors to our health. A poor diet increases the risk of becoming overweight, developing diabetes, heart disease, stroke, some types of cancer and dementia.

Portfolio	Actions
	• AVDC regularly promotes Public Health messages and campaigns throughout the year including promotion of the Public Health England One You campaign in raising awareness to help adults across the country to avoid future diseases caused by modern day life.
	• AVDC encourages those registering new food and drink businesses to consider healthy menu options by providing a link to the Public Health webpage on sugar and calorie reduction on the associated registration page.

Wider planning and environmental issues

Portfolio	Actions
	• AVDC Heritage and Ecology Officers continue to work to improve landscapes and improve biodiversity on council owned land as well as offer advice to other landowners. To celebrate National Tree Week in December 2017, AVDC planted four trees (including Oaks) in Heartlands open space to support local biodiversity and improve the landscape for future generations.
	• AVDC Officers advise and comment on planning applications to help protect the local environment.

Appendix 3: Contributions by Chiltern District Council for 'Healthy Places, Healthy Futures, Growing Great Communities'

Community Life
The communities we live and work in profoundly affect our wellbeing. Actions to strengthen communities, increase social connections and social cohesion, give local people more say in services, increase volunteering, reduce social isolation and protect vulnerable people all of which improve health and wellbeing.

Portfolio	Actions
	Established the Chiltern Community and Wellbeing plan to deliver opportunities to strengthen communities, increase social connections and social cohesion, give local people more say in services, increase volunteering, reduce social isolation and protect vulnerable people all of which improve health and wellbeing. http://www.chiltern.gov.uk/ChilternCommunityandWellbeingPlan
Creating community capacity through	
Healthy Communities	Build community infrastructure and resilience through working with the towns and parishes, community associations and community groups e.g. supporting the continued delivery of priorities identified through community led planning.
	Work with faith, youth, older person and voluntary and community organisations to support community development.
	Support the CCG community engagement strategy and Buckinghamshire County Council's Local Area Forum (LAFs) priority themes joining up projects and initiatives to improve local services
	Promote opportunities for communities to become more involved in the prevention of crime, and or support environmental, heritage and wellbeing community events
	Work in partnership with Community Impact Bucks to improve volunteer recruitment and voluntary organisations' access to information, advice, support and training in fundraising, creating social enterprises and good governance
	Supporting volunteering through • Identify ways to recruit volunteers from the newly-retired marketplace and support young people to access volunteering opportunities. • Increase opportunities for young people to volunteer and learn new skills by supporting schemes such as the National Citizen Service. • Run an annual community awards event to celebrate the contribution of local volunteers across Chiltern. • Deliver the council's community grants and lottery scheme that support community organisations to deliver local initiatives that improve the quality of life for residents across the district.
Enabling healthier lifestyles through	
	• Work in partnership with GLL BETTER or leisure provider, Buckinghamshire and Milton Keynes Sports Partnership (LEAP), and other voluntary sector organisations to increase levels of physical activity of young people
	• Support voluntary run sports, leisure & culture groups including community associations and their activity programmes, libraries, youth clubs, older persons clubs.
	• Assist older people to access local community based activities through the BETTER outreach programme, including the 60+ Club Hubs at Chesham and Chalfont Leisure Centres and Club Games for the Over 50s. Activities such as tai chi, gentle exercise, stretch and flex, knit and natter.
	• Support GLL BETTER to deliver the "Healthwise" programme which is the GP referral scheme offering exercise, weight management and falls prevention programmes • In 2017/18, a total of 203 referrals from the Chiltern District area to the

	programme. The programme can demonstrate high long term retention rates over a three year period and demonstrate high levels of conversion of clients to regular exercise.
	• Manage the provision of a workplace health and wellbeing programme including physical activity and alternative therapies such as lunchtime walks, yoga, Pilates, acupressure massage and reflexology.
	• Support the implementation of Public Health's Active Bucks programme and encourage 1,000 adults become more active from 2016 to 2018.
	• Chiltern's leisure facilities enable more than 1 million visits per annum.
	• Enable communities to become active by the provision of community-based activities such as Gentle Exercise, Tai Chi, Stretch and Flex, netball, volleyball, yoga and Pilates.
	• Promote activities taking place for older people at the BETTER Leisure Centres e.g. swimming, badminton, short tennis, table tennis and aerobics.
	• Facilitating the planning and business case for the re-development of Chiltern Pools into the new Chiltern Lifestyle Centre. As well incorporating a library, nursery and community centre, facilities will include a new 8 lane swimming pool, spa, sports hall, soft play, climbing, fitness and dance studios and diving facilities.
	• Support Community and Workplace health activities e.g. health and wellbeing fairs, dementia awareness events, promoting healthy lifestyles.
Supporting Older People through	
	Help to provide opportunities for older people to socialise, access relevant information, advice and access appropriate services, enabling Prevention Matters which identifies those at risk of isolation direct them to voluntary sector and statutory support through;
	• Enabling communities to get involved in volunteering, intergenerational activities, Street Associations and Good Neighbour Schemes in order to reduce social isolation.
	• Developing and support activities that encourage greater interaction between older and younger people, including events related to commemorating the Word Wars, local history projects, environmental initiatives, using Information Technology or addresses social isolation
	• Supporting the development of Dementia-friendly communities and promote the Safe Place scheme.
	• Updated the older people's service guides for Amersham, Chalfont, Prestwood/Great Missenden and Chesham.
	• Support Dial-a-Ride and the development/continuation of community based transport schemes.
	• Address the loneliness experienced by some care home residents by encouraging local neighbourhood residents, schools, youth clubs and voluntary groups to engage with care homes
Reducing crime and the fear of crime through	
	Working in partnership with Thames Valley Police and other key partners to reduce crime and disorder and raise awareness of the risk of abuse in all its forms through.
	• Co-ordinate local community activity to help reduce crime and the fear of crime and address environmental issues with appropriate solutions.
	• Raising awareness to help prevent child sexual exploitation, drug and alcohol abuse, bike theft and all forms of abuse via mobile phones, social media and the internet.
	• Support the setting up of Neighbourhood Watch Schemes, Street Associations and Good Neighbour Schemes to help build resilient communities

	• Raise community awareness of the need to safeguard vulnerable adults and to report concerns as they arise, signposting the voluntary sector to suitable safeguarding training.
	• Promote the existence of local safeguarding training including Prevent to adults working with and for young people
	• Deliver the Community Card Scheme in primary schools encouraging health and wellbeing, community integration, cyber safety and money management
	• Adopted appropriate licencing requirements to protect the travelling public and raise awareness of taxi drivers as to the current safeguarding issues
	• Maintain the Safe Place Scheme in Amersham, Chalfont St Peter, Chesham, Great Missenden, Little Chalfont, and Prestwood.
Supporting heritage and inclusion through	
	• Support the Armed Services Community Covenant so that Service families are more integrated into the wider community.
	• Support community groups across Chiltern commemorate the Word War I Centenary
	• Assisting communities celebrate their heritage e.g. Eid and national day events as well as supporting countywide activities such as Bucks Art of Islam Festival

Healthy Homes

Living in an affordable and good quality home is fundamental to people's physical and mental health and wellbeing and can reduce demand on services

Portfolio	Actions
Resources	Provide welfare advice and assistance through the delivery of Housing Benefit and Council Tax services
Healthy Communities	Support the local Citizen Advice Bureau service enabling access to independent housing, welfare advice
	Provide housing advice and financial assistance to prevent poor housing conditions and maintain decent housing standards through the provision of refundable home loans, disabled facility grants and assistance to tackle cold homes.
	Provide the Flexible Loan scheme to householders and local traders helping support older people access low interest loans to undertake home repairs, adaptations and improve security.
	Promote and support schemes to enable homeless and key workers secure housing they can afford (including the private rented sector).
	Provide housing advice and assistance to prevent homelessness and provide emergency housing accommodation as necessary
	Support through the planning process the delivery of new sustainable dwellings 40% of which are to be affordable homes
	Reviewing and developing opportunities to develop affordable housing on Council owned land
	Work with housing associations to maximise the delivery of new affordable homes
	Enable the development of affordable housing. A total of 58 new build affordable homes (for rent or shared ownership) were delivered in Chiltern by housing associations during 2017/18.
	Work to return empty homes to use, revitalise the areas of poorer housing
	Providing advice and assistance to reduce debt and manage finances through the operation of the CAB and the promotion of the South Buckinghamshire Community Bank (part of the M for Money Credit Union).
	Ensuring national space standards, lifetime homes / adaptable homes are delivered

	through the planning process
	Adopting a 20% renewable energy standard for new homes which together with high insulation standards will enable new homes to address the fuel poverty issues

Healthy Travel

Active travel, such as walking and cycling improves our health by promoting physical activity. It also delivers other benefits such as reducing air and noise pollution and increasing social connections

Portfolio	Actions
Healthy Communities	Work in partnership to improve energy efficiency, identify and implement greener travel initiatives and identify ways in which we can live more sustainably within the District.
	Support the Simply Walks initiative to attract 1000 additional walk participants from 2016 to 2018 as well as supporting other community walk initiatives.
	Build an effective Local Air Quality partnership to review and enhance the Air Quality Action plans arising from the impact of road transport enabling improving air quality and reducing NOx and CO2 emissions within the district.
	Implemented the Air Quality Action Plan in Chesham resulting in sustained reductions in NOx which includes the introduction of clean buses, green wall, tree planning, cycling storage, enhanced anti-idling campaign

Air and Noise Pollution (Healthy Travel will also contribute to this key area)

Air and noise pollution have a range of harmful effects on health the very young, very old and those with poor health are most likely to be negatively affected by pollution.

Portfolio	Actions
Healthy Communities	Build an effective Local Air Quality partnership to review and enhance the air quality action plan improving air quality and reducing NOx and CO2 emissions within the district.
	Monitor air and noise emissions across the district to enable preventative action to be undertaken
	Implemented the Air Quality Action Plan in Chesham resulting in sustained reductions in NOx
	Reduced carbon emissions from Chiltern District Council's operations by 30%. The 2017 report can be viewed at http://www.chiltern.gov.uk/article/6713/Corporate-performance-reporting-
	Provide advice, information and challenge to enable that all new strategic transport and infrastructure developments consider the impact of air, noise on the local community
	Provide advice and assistance to enforce statutory provisions in relation to air and noise pollution
Environment Portfolio	Established electric vehicle charging points in all CDC car parks
	The new waste contract considering the use of all electric vehicles
	Utilising renewable sources of energy to reduce the council carbon emissions
	Chiltern Lifestyle Centre designs incorporate sustainable materials and energy reduction technology to deliver an A rated energy performance facility.

Green Spaces and Natural Environment

Contact with the natural environment is vital for physical and mental health and wellbeing at all ages. Exposure to green spaces reduces stress and depression, and every 10% increase in green space is associated with a reduction in disease equivalent to 5 years of life gained.

Portfolio	Actions
Healthy Communities	Assisting communities local community groups and parish councils to deliver against the Open Space strategy - improve the quality of green spaces, green landscapes, to encourage greater use of these valuable spaces

	Creating a new community park in Chiltern to enable walking, cycling, and running in a safe environment
	Enable communities to take ownership of their environment e.g. community managed foot paths and woodland, promoting "Walkers are welcome" routes.
	Help to preserve the character of our landscapes and conservation areas by working in partnership with local conservation groups.
	Supporting the regular delivery of 'Park Runs' in the district
	Supporting communities to improve play provision playing pitches, nature parks & outdoor education

Healthy Food Environment

The quality and quantity of the food and drink that we consume are important contributors to our health. A poor diet increases the risk of becoming overweight, developing diabetes, heart disease, stroke, some types of cancer and dementia.

Portfolio	Actions
Healthy Communities	Support businesses improvement and growth through advice, coaching and publication of food hygiene ratings. Support businesses to provide nutritional menus through the "Eat Out Eat Well" scheme.
	Provide opportunities for local businesses to access food safety, licensing, and health and safety courses targeted to their needs.
	Enforcing legislative requirements to protect public health

Wider planning and environmental issues

Portfolio	Actions
Healthy Communities	Improve safeguarding of the general public by enforcing regulatory controls and the use of health impact assessment tools to better protect the environment and human health.
Healthy Communities	Work wherever possible to return vacant employment sites or contaminated land sites to use.
Healthy Communities	Work with partners and the community to reduce CO2 emissions and the impact of climate change.
Planning	Design including ensuring policies to ensure health and wellbeing are designed in to the layout and urban design. This builds on the learning of the NHS Healthy New Town project and the TCPA learning project
	The requirements for a Health Impact Assessment (HIA) which also includes sections on mental health
	Ensure that national infrastructure projects e.g. HS2, are managed sustainably and enhance local economies.
Economic Development	In terms of the economic dev - the emerging Local Plan also has the policy about community employment plans, local procurement and similar social clauses
	Supporting the delivery of the Chiltern and South Bucks Economic Development Strategy which has the vision of creating a District with "prosperous and diverse economies that encourage local employers and small businesses.
	Working with the Chesham wellbeing project BCC/Department of Work and Pensions/Jobcentre Plus to help us support workless back in to employment Be Your Own Boss programme is providing a range of support for anyone looking to start their own business. The programme, delivered by Bucks Business First, is funded by Chiltern and South Bucks District Councils, Wycombe District Council and a number of local housing associations, and offers an enterprise day, training and events, help and guidance and networking opportunities.
	Working with Bucks Skills Hub, and a number of local training, education and apprenticeship providers to enable Enterprise Advice in local schools. Ensuring

	individuals are aware of the employment opportunities available and have the skills they need to take advantage of these is extremely important to them as individuals and to supporting the future growth of businesses.
	Promote local events and high street diversification that will encourage greater footfall in the district's high streets e.g. Small Business Saturday / Chinese New Year / St George's Day/ pre-Christmas activities.
	Work with Parish Councils, business associations and community groups to convert tourist day visits to overnight stays.
	Support the development of broadband and mobile technologies as they are introduced into the District.
	Using social media to promote various business support initiatives, including on World Mental Health Day, tweets around the resources available to support improved workplace wellbeing.

Appendix 4: Contributions by South Bucks District Council for 'Healthy Places, Healthy Futures, Growing Great Communities'

Community Life
The communities we live and work in profoundly affect our wellbeing. Actions to strengthen communities, increase social connections and social cohesion, give local people more say in services, increase volunteering, reduce social isolation and protect vulnerable people all of which improve health and wellbeing.

Portfolio	Actions
	Established the South Bucks Community and Wellbeing plan to deliver opportunities to strengthen communities, increase social connections and social cohesion, give local people more say in services, increase volunteering, reduce social isolation and protect vulnerable people all of which improve health and wellbeing. http://www.southbucks.gov.uk/CommunityWellbeingPlan
Creating community capacity through	
Healthy Communities	Build community infrastructure and resilience through working with the towns and parishes, community associations and community groups e.g. supporting the continued delivery of priorities identified through community led planning.
	Work with faith, youth, older person and voluntary and community organisations to support community development.
	Support the CCG community engagement strategy and Buckinghamshire County Council's Local Area Forum (LAFs) priority themes joining up projects and initiatives to improve local services
	Promote opportunities for communities to become more involved in the prevention of crime, and or support environmental, heritage and wellbeing community events
	Work in partnership with Community Impact Bucks to improve volunteer recruitment and voluntary organisations' access to information, advice, support and training in fundraising, creating social enterprises and good governance
	Supporting volunteering through • Identify ways to recruit volunteers from the newly-retired marketplace and support young people to access volunteering opportunities. • Increase opportunities for young people to volunteer and learn new skills by supporting schemes such as the National Citizen Service. • Run an annual community awards event to celebrate the contribution of local volunteers across South Bucks. • Deliver the council's community grants and lottery scheme that support community organisations to deliver local initiatives that improve the quality of life for residents across the district.
Enabling healthier lifestyles through	
	• Work in partnership with GLL BETTER or leisure provider, Buckinghamshire and Milton Keynes Sports Partnership (LEAP), and other voluntary sector organisations to increase levels of physical activity of young people
	• Support voluntary run sports, leisure & culture groups including community associations and their activity programmes, libraries, youth clubs, older persons clubs.
	• Assist older people to access local community based activities through the GLL BETTER outreach programme e.g. Tai Chi in Burnham Library, Walking Football in Burnham and Stoke Poges, promotion of their 50+ programme at the Beacon Leisure Centre (Short mat bowls, Badminton, Walking Football and Pickleball) as well as the annual Club Games for the Over 50s.
	• Support GLL BETTER to deliver the "Healthwise" programme which is the GP referral scheme offering exercise, weight management and falls prevention programmes • In 2017/18, 90 residents who have suffered a coronary or stroke medical condition were enabled to complete the GLL BETTER Healthwise exercise

	referral programme.
	• Manage the provision of a workplace health and wellbeing programme including physical activity and alternative therapies such as lunchtime walks, yoga, Pilates, acupressure massage and reflexology.
	• Support the implementation of Public Health's Active Bucks programme and encourage 1,000 adults become more active from 2016 to 2018.
	• Attracting 220,000 annual visits in South Buck's leisure centre facilities.
	• Enable communities to become active and reduce the risk of social isolation by the provision of community events at Beacon and Evreham Leisure Centres and the Curzon Centre Beaconsfield.
	• Provision of the South Buckinghamshire Golf course and redevelopment of the original Golf Academy site into an open space leisure facility.
	• Provision of Farnham Park Playing Field – Softball UK headquarters and provision of football and rugby pitches. Currently undertaking feasibility study to consider future opportunities for increasing access to sport and leisure
	• Support Community and Workplace health activities e.g. health and wellbeing fairs, dementia awareness events, promoting healthy lifestyles.
Supporting Older People through	
	Help to provide opportunities for older people to socialise, access relevant information, advice and access appropriate services, enabling Prevention Matters which identifies those at risk of isolation direct them to voluntary sector and statutory support through;
	• Enabling communities to get involved in volunteering, intergenerational activities, Street Associations and Good Neighbour Schemes in order to reduce social isolation.
	• Developing and support activities that encourage greater interaction between older and younger people, including events related to commemorating the Word Wars, local history projects, environmental initiatives, using Information Technology or addresses social isolation
	• Supporting the development of Dementia-friendly communities and promote the Safe Place scheme.
	• Developing older people's service guides for the Beeches area, Beaconsfield, Gerrards Cross and Denham, Wexham and Iver.
	• Support the development/continuation of community based transport schemes.
	• Address the loneliness experienced by some care home residents by encouraging local neighbourhood residents, schools, youth clubs and voluntary groups to engage with care homes
Reducing crime and the fear of crime through	
	Working in partnership with Thames Valley Police and other key partners to reduce crime and disorder and raise awareness of the risk of abuse in all its forms through.
	• Co-ordinate local community activity to help reduce crime and the fear of crime and address environmental issues with appropriate solutions.
	• Raising awareness to help prevent child sexual exploitation, drug and alcohol abuse, bike theft and all forms of abuse via mobile phones, social media and the internet.
	• Support the setting up of Neighbourhood Watch Schemes, Street Associations and Good Neighbour Schemes to help build resilient communities
	• Raise community awareness of the need to safeguard vulnerable adults and to report concerns as they arise, signposting the voluntary sector to suitable safeguarding training.
	• Promote the existence of local safeguarding training including Prevent to adults working with and for young people

	• Deliver the Community Card Scheme in primary schools encouraging health and wellbeing, community integration, cyber safety and money management
	• Adopted appropriate licencing requirements to protect the travelling public and raise awareness of taxi drivers as to the current safeguarding issues
	• Maintain the 'Safe Place Scheme' in Beaconsfield, Holtspur, Burnham, Farnham Common, Gerrards Cross, Iver, Iver Heath and Richings Park.
Supporting heritage and inclusion through	
	• Support the Armed Services Community Covenant so that Service families are more integrated into the wider community.
	• Support community groups across South Bucks commemorate the Word War I Centenary
	• Assisting communities celebrate their heritage e.g. Eid and national day events as well as supporting countywide activities such as Bucks Art of Islam Festival

Healthy Homes

Living in an affordable and good quality home is fundamental to people's physical and mental health and wellbeing and can reduce demand on services

Portfolio	Actions
Resources	Provide welfare advice and assistance through the delivery of Housing Benefit and Council Tax services
Healthy Communities	Support the local Citizen Advice Bureau service enabling access to independent housing, welfare advice
	Provide housing advice and financial assistance to prevent poor housing conditions and maintain decent housing standards through the provision of refundable home loans, disabled facility grants and assistance to tackle cold homes.
	Provide the Flexible Loan scheme to householders and local traders helping support older people access low interest loans to undertake home repairs, adaptations and improve security.
	Promote and support schemes to enable homeless and key workers secure housing they can afford (including the private rented sector).
	Provide housing advice and assistance to prevent homelessness and provide emergency housing accommodation as necessary
	Support through the planning process the delivery of new sustainable dwellings 40% of which are to be affordable homes
	Reviewing and developing opportunities to develop affordable housing on Council owned land
	Work with housing associations to maximise the delivery of new affordable homes
	Enable the development of affordable housing. A total of 58 new build affordable homes (for rent or shared ownership) were delivered in Chiltern by housing associations during 2017/18.
	Work to return empty homes to use, revitalise the areas of poorer housing
	Providing advice and assistance to reduce debt and manage finances through the operation of the CAB and the promotion of the South Buckinghamshire Community Bank (part of the M for Money Credit Union).
	Ensuring national space standards, lifetime homes / adaptable homes are delivered through the planning process
	Adopting a 20% renewable energy standard for new homes which together with high insulation standards will enable new homes to address the fuel poverty issues

Healthy Travel

Active travel, such as walking and cycling improves our health by promoting physical activity. It also

delivers other benefits such as reducing air and noise pollution and increasing social connections	
Portfolio	**Actions**
Healthy Communities	Work in partnership to improve energy efficiency, identify and implement greener travel initiatives and identify ways in which we can live more sustainably within the District.
	Support the Simply Walks initiative to attract 1000 additional walk participants from 2016 to 2018 as well as supporting other community walk initiatives.
	Build an effective Local Air Quality partnership to review and enhance the Air Quality Action plans arising from the impact of road transport enabling improving air quality and reducing NOx and CO2 emissions within the district.

Air and Noise Pollution (Healthy Travel will also contribute to this key area) Air and noise pollution have a range of harmful effects on health the very young, very old and those with poor health are most likely to be negatively affected by pollution.	
Portfolio	**Actions**
Healthy Communities	Build an effective Local Air Quality partnership to review and enhance the air quality action plan improving air quality and reducing NOx and CO2 emissions within the district.
	Monitor air and noise emissions across the district to enable preventative action to be undertaken
	Introduced the newly designated Iver Air Quality Action Zone established to mitigate air quality issues arising from existing and new development and traffic routes
	Worked to highlight air quality actions local schools in Iver can adopt to reduce the impact of poorer air quality on children
	Reduced carbon emissions from South Bucks District Council's operations by 42%. The 2017 report can be viewed at http://www.southbucks.gov.uk/article/8308/Corporate-performance-reporting-
	Provide advice, information and challenge to enable that all new strategic transport and infrastructure developments consider the impact of air, noise on the local community
	Provide advice and assistance to enforce statutory provisions in relation to air and noise pollution
Environment Portfolio	Establishing electric vehicle charging points in SBDC car parks
	The new waste contract considering the use of all electric vehicles
	Utilising renewable sources of energy to reduce the council carbon emissions

Green Spaces and Natural Environment Contact with the natural environment is vital for physical and mental health and wellbeing at all ages. Exposure to green spaces reduces stress and depression, and every 10% increase in green space is associated with a reduction in disease equivalent to 5 years of life gained.	
Portfolio	**Actions**
Healthy Communities	Assisting communities local community groups and parish councils to deliver against the Open Space strategy - improve the quality of green spaces, green landscapes, to encourage greater use of these valuable spaces
	Creating a new community park in South Bucks to enable walking, cycling, and running in a safe environment
	Enable communities to take ownership of their environment e.g. community managed foot paths and woodland, promoting "Walkers are welcome" routes.
	Help to preserve the character of our landscapes and conservation areas by working in partnership with local conservation groups.
	Supporting the regular delivery of 'Park Runs' in the district
	Supporting communities to improve play provision playing pitches, nature parks & outdoor education
	Supporting HS2 to re-provide Hillingdon Outdoor Activity Centre in South Bucks

Healthy Food Environment The quality and quantity of the food and drink that we consume are important contributors to our health. A poor diet increases the risk of becoming overweight, developing diabetes, heart disease, stroke, some types of cancer and dementia.	
Portfolio	**Actions**
Healthy Communities	Support businesses improvement and growth through advice, coaching and publication of food hygiene ratings. Support businesses to provide nutritional menus through the "Eat Out Eat Well" scheme.
	Provide opportunities for local businesses to access food safety, licensing, and health and safety courses targeted to their needs.
	Enforcing legislative requirements to protect public health

Wider planning and environmental issues	
Portfolio	**Actions**
Healthy Communities	Improve safeguarding of the general public by enforcing regulatory controls and the use of health impact assessment tools to better protect the environment and human health.
Healthy Communities	Work wherever possible to return vacant employment sites or contaminated land sites to use.
Healthy Communities	Work with partners and the community to reduce CO2 emissions and the impact of climate change.
Planning	Design including ensuring policies to ensure health and wellbeing are designed in to the layout and urban design. This builds on the learning of the NHS Healthy New Town project and the TCPA learning project
	The requirements for a Health Impact Assessment (HIA) which also includes sections on mental health
	Ensure that national infrastructure projects e.g. HS2, are managed sustainably and enhance local economies.
Economic Development	In terms of the economic dev - the emerging Local Plan also has the policy about community employment plans, local procurement and similar social clauses
	Supporting the delivery of the Chiltern and South Bucks Economic Development Strategy which has the vision of creating a District with "prosperous and diverse economies that encourage local employers and small businesses.
	Working with the Chesham wellbeing project BCC/Department of Work and Pensions/Jobcentre Plus to help us support workless back in to employment Be Your Own Boss programme is providing a range of support for anyone looking to start their own business. The programme, delivered by Bucks Business First, is funded by Chiltern and South Bucks District Councils, Wycombe District Council and a number of local housing associations, and offers an enterprise day, training and events, help and guidance and networking opportunities.
	Working with Bucks Skills Hub, and a number of local training, education and apprenticeship providers to enable Enterprise Advice in local schools. Ensuring individuals are aware of the employment opportunities available and have the skills they need to take advantage of these is extremely important to them as individuals and to supporting the future growth of businesses.
	Promote local events and high street diversification that will encourage greater footfall in the district's high streets e.g. Small Business Saturday / Chinese New Year / St George's Day/ pre-Christmas activities.
	Work with Parish Councils, business associations and community groups to convert tourist day visits to overnight stays.
	Support the development of broadband and mobile technologies as they are introduced into the District.
	Using social media to promote various business support initiatives, including on World Mental Health Day, tweets around the resources available to support improved

	workplace wellbeing.

Appendix 5: Contributions by Wycombe District Council for 'Healthy Places, Healthy Futures, Growing Great Communities'

Community Life
The communities we live and work in profoundly affect our wellbeing. Actions to strengthen communities, increase social connections and social cohesion, give local people more say in services, increase volunteering, reduce social isolation and protect vulnerable people all of which improve health and wellbeing.

Portfolio	Actions
Planning	Through Local Plan policy, planning guidance and planning decisions, ensure new large developments relate well to existing communities and where appropriate and justified include new community facilities (eg new schools, community facilities, shops etc).
	Through Local Plan policy and planning decisions (including the application of Green Belt policy) ensure wherever possible that different communities remain physically distinct.
	Through Local Plan policy, planning guidance and planning decisions, seek wherever possible the retention of land used for community facilities in a future community use.
	Secure ongoing improvements to our town centres and in particular their public realm to ensure they remain attractive and vibrant centres of our communities, including funding through Community Infrastructure Levy and other external funding sources. Eg High Wycombe town centre masterplan, Local Plan policies and proposals for Princes Risborough Town Centre
Community Services	Youth Council- providing young people living in Wycombe district which an opportunity to have a say on council services and the issues that affect them and their local community.
	Dementia- WDC's Dementia Friendly project reviews ways in which the council can better support local residents living with Dementia through training and most recently an environmental audit. It also plays an important role in the High Wycombe Dementia Action Alliance, which meets monthly.
	Annual Revenue Grant supports One Can Trust foodbank for local residents in times of crisis.
	Community Grants Programme-Assists with the funding of various local community events and initiatives including East Side Youth Club, Hazlemere Fete and Singing Across the Ages.
	Wycombe Lotto- Fundraising platform for charities and good causes who support the community in various ways including High Wycombe Shopmobility, Wycombe Mind and Social Link.
	Continue to promote and expand the Safe Play Scheme which provides suitable venues e.g. local shops, restaurants where vulnerable people can go to seek help and support.
	Continue to work in partnership with Places Leisure to deliver Health and Wellbeing Programmes which include GP Referrals Scheme, Weight management, Cardiac rehab and Cancer rehab.
	Continue to support partnership working with Active-In to deliver community based sports development programmes and projects to increase levels of physical activity across the district. Includes targeted programmes coordinated with LEAP (Bucks County Sports Partnership).
	Continuing to invest in WDCs Leisure facilities. Expansion of Risborough Springs Swim and Fitness Centre gym and new fitness studio from 2019 and refurbishment of Court Garden Leisure Complex Marlow from 2020.

Healthy Homes
Living in an affordable and good quality home is fundamental to people's physical and mental health and wellbeing and can reduce demand on services

Portfolio	Actions
Planning	Using planning policy in the Local Plan and section 106 planning agreements to secure 30-40% of homes in new developments as affordable homes
	Through planning policy in the Local Plan, planning guidance and development management to secure high quality homes in well-designed housing developments, achieving high standards of amenity commensurate with healthy living
	To review with stakeholders on an annual basis the quality of new developments ("Quality Conts") to continue to learn lessons to apply to improve the quality of future developments.
Housing	Diligent enforcement of housing standards and new HMO legislation by properly resourced teams to help ensure the health, safety and welfare of residents occupying homes in the private rented sector.
	Encouragement of the provision of affordable homes through regeneration work and through planning policies.
	Working with and supporting housing providers to deliver properties with affordable rents, and securing nomination rights to these homes using S106 funding.
	Operation of a 'healthy homes on prescription' service in partnership with GP's and social care. This provides practical home improvements for owner occupiers who are unable to afford necessary work which would improve health outcomes.
	Statutory Disabled facility grants are administered by the housing service to ensure disabled applicants can have life improving adaptations carried out in their homes- following referrals from occupational therapists.
	Funding of a county wide (in partnership with the other DC's) rough sleeper outreach service to assist rough sleepers off the streets and into accommodation- thereby improving dramatically their health and well-being.
	Statutory housing advice and homelessness provision- if a household or an individual are living in substandard accommodation, or in accommodation that it detrimental to their health they will obtain priority on the housing register and/or receive assistance via the homelessness route into alternate, suitable accommodation.
	Funding of Wycombe Rent Deposit guarantee scheme and Wycombe Homelessness Connection. WRDGS provide assistance to mainly single people without stable accommodation into private rented homes- again improving health and well-being.

Healthy Travel
Active travel, such as walking and cycling improves our health by promoting physical activity. It also delivers other benefits such as reducing air and noise pollution and increasing social connections

Portfolio	Actions
Planning	Through Local Plan policy and planning decisions, to locate new development in locations accessible to jobs and main services to maximise the opportunity for people to walk and cycle.
	Through Local Plan planning policy, planning guidance (eg development briefs and masterplans) and planning decisions to secure appropriate footpath and cycleway provision in new developments
	Delivering enhancements to footpaths and cyclepath network through the use of projects funded by the Community Infrastructure Levy and other external funding. Eg Footpath/cycleway along former High Wycombe to Bourne End railway line, new footpath from former RAF Daws Hill to the valley bottom.

Air and Noise Pollution (Healthy Travel will also contribute to this key area)
Air and noise pollution have a range of harmful effects on health the very young, very old and those

with poor health are most likely to be negatively affected by pollution.	
Portfolio	**Actions**
Environment	Air quality within the Wycombe district is monitored on a continuous basis. Where air quality has failed to meet national standards the council has responded by declaring three Air Quality Management Areas. In order to improve air quality in these areas the council, together with its partners on the steering group has produced a twenty five point action plan which seeks to improve air quality.
Planning	Through Local Plan policy and planning decisions, to locate new development in locations accessible to jobs, main services and public transport routes to maximise travel choice by non-car modes
	Through Local Plan policy, planning guidance and planning agreements, secure improvements to public transport provision through new development (eg provision of new bus routes, re-routing or financial contributions from development to improve bus services), and ensure new developments are designed to maximise opportunities for bus penetration
	To increase urban tree planting, including through the new Local Plan Canopy Cover policy to help mitigate pollution and urban heat island effects.
	Implement schemes to improve public transport through Community Infrastructure Levy and other external funding.
	Secure ongoing improvements to our town centres and in particular their public realm to ensure they remain attractive and vibrant centres for businesses and services in what are the most accessible locations in the District by a range of sustainable travel modes. Eg High Wycombe town centre masterplan, Local Plan policies and proposals for Princes Risborough Town Centre

Green Spaces and Natural Environment

Contact with the natural environment is vital for physical and mental health and wellbeing at all ages. Exposure to green spaces reduces stress and depression, and every 10% increase in green space is associated with a reduction in disease equivalent to 5 years of life gained.

Portfolio	**Actions**
Planning	Provide protection from development of important green spaces within towns and villages, and the valued open countryside including the Chilterns Area of Outstanding Natural Beauty through Local Plan policy and day to day planning decisions
	Securing provision of new open space, landscaping and biodiversity enhancements in the design of new developments through planning policy, design guidance and planning agreements.
	Delivering enhancement schemes (eg to open spaces and biodiversity etc) through projects funded by the Community Infrastructure Levy and other external funding – eg tree planting, enhancing/opening up the River Wye, improving access to the countryside/Area of Outstanding Natural Beauty etc
Community	Continue to support the Chiltern Rangers Service with their volunteer programmes which include working with special needs groups, undertaking woodland, river, and countryside management and conservation work.
	Continuing to improve active recreation and play provision across Wycombe's parks & open spaces. New Parkrun established in Higginson Park Marlow Summer 2018, New adult fitness trail being installed in Totteridge opening January 2019, Installing new skate park facilities for young people at Holmer Green (2019). Promoting the use of our parks and open spaces for active recreation use including Nordic Walking Groups, Nature walks, and exercise classes.

Healthy Food Environment The quality and quantity of the food and drink that we consume are important contributors to our health. A poor diet increases the risk of becoming overweight, developing diabetes, heart disease, stroke, some types of cancer and dementia.	
Portfolio	**Actions**

Wider planning and environmental issues	
Portfolio	**Actions**
Planning	Through Local Plan policy, planning guidance and planning decisions, to secure new sports and play facilities, including playing pitches and other play facilities, in new development, and to prevent the loss of existing facilities from development

Dignity and respect at the heart of care

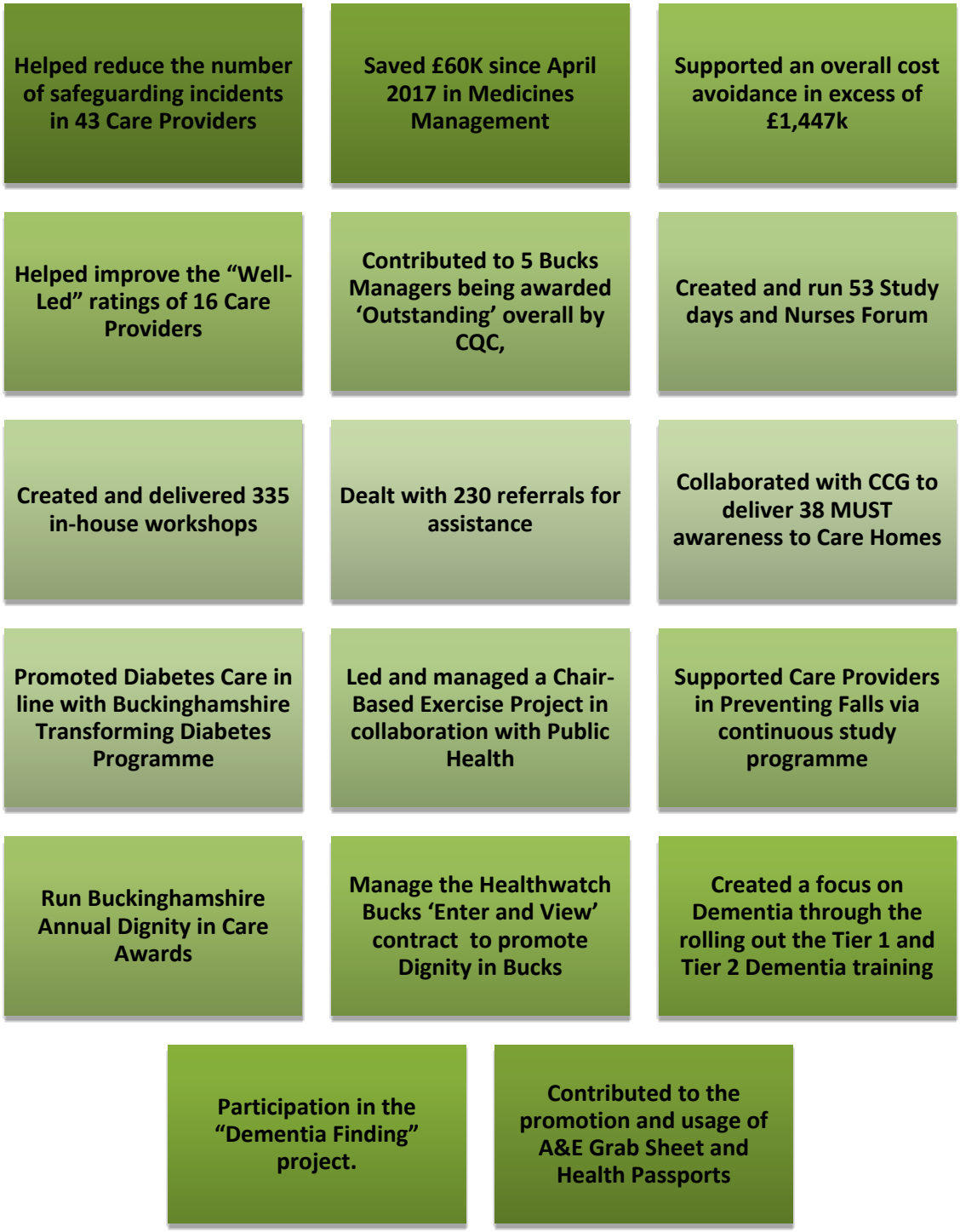
Buckinghamshire QiCT Quality in Care Team

Buckinghamshire Healthcare NHS Trust

Buckinghamshire County Council

Contents

1 Quality in Care team achievements 2017-2018



2 Background

The Quality in Care Team (QiCT) is a small multi-disciplinary team whose aim is to support domiciliary care, care home (residential or nursing), day services, respite centres and Supported Living providers to deliver high quality care in today's challenging environment. QiCT is funded through the Better Care Fund (BCF), which seeks to joining-up health and social care services. Therefore, its governance is structured through a multi-agency steering group which meets on a quarterly basis and sets the overall direction of the team's work, ensuring that all partners' priorities are delivered effectively. This is reflected by the team's work plan which is monitored by the steering group. The 2017/18 structure of the QiCT, reflects the multi-disciplinary expertise required to deliver the team's functions – see Appendix A.

The Quality in Care team has successfully operated within its budget and has supported cost avoidance in excess of £1,447k alone through focused work on two key areas of work (namely medicines optimisation and reduction in A&E admissions), with other additional beneficial impact on reduction in safeguarding incidents, enhanced quality of care and skilling up the workforce.

3 Market Oversight and Business Intelligence

Data is collected by the QICT from the Care Quality Commission (CQC), Bucks Healthcare Trust (BHT), Buckinghamshire Commissioning Group (CCG), Bucks Safeguarding Adult Board, Bucks County Council's contracts team and providers on a regular basis, informing work priorities and data referrals. The results of our analysis of this information are routinely shared with all of these services and organisations to support sound partnership working.

The Quality in Care team participates in relevant meetings aimed at supporting services most in need, such as the bi-monthly Quality Surveillance Group and the provider concerns response group. This assists effective market oversight and joint working between partners.

4 Service Offer

Most QiCT interventions are multifaceted and include management support and up-skilling of care staff. The team work in partnership with health and social care colleagues and signpost providers back into these services if and when appropriate.

Referrals are accepted from providers and health and social care professionals who have concerns about the standards of care being delivered by an organisation. Referrals are prioritised by the level of risk and severity of the impact on individuals in care and service delivery, based on data analysis.

QiCT has dealt with 230 referrals for assistance since April 2017, 82 of these were self-referrals by organisations to access preventative support. All other referrals were in response to concerns identified by multi-disciplinary professionals

In carrying out work the team has worked with:

- 58 residential care homes
- 35 nursing homes
- 17 domiciliary care services
- 8 Supported Living services
- 2 regional organisations
- 7 day care services

The QiCT does prioritise working with providers that are rated inadequate or requires improvement by the regulator, the Care Quality Commission, to help rapidly improve care delivered.

The service offer recording successes are as follows:

- Reduction in the number of safeguarding incidents reported in 43[1] providers over a twelve-month period following intervention (estimated at 175 safeguarding incidents avoided)
- 45% of services who were referred into QICT for support subsequently showed reduced non-elective A&E attendance, by an average 40%[2].
- Reduction in the number of A&E admissions by 22% with a subsequent estimated overall saving of £1,387k in hospital admissions and ambulance call-outs (during a 9 month period)[3]
- Has improved the "well-led" ratings of 16 providers (those that have been re-inspected after QiCT intervention)
- Made 53 referrals to partner's organisations, including 19 to the pharmacist teams since April 2017.

QiCT is demonstrating continuous improvement of quality of care in Buckinghamshire, as demonstrating by the Annual Survey's findings – see table below:

Q5) Do you feel that we have helped you to improve the quality of care?	2014	2015	2016	2017
Significant improvement	13%	31%	29%	43%
Noticeable improvement	60%	45%	38%	40%
Moderate improvement	20%	21%	22%	12%
Some improvement	3%	2%	7%	5%
No improvement	3%	0%	4%	0%

End of Intervention Survey

An anonymous survey is sent to providers following the closure of a referral. The table below reflect levels of satisfaction and impact on care following service offer by respondents from April 2017 to March 2018:

[1] As of 15/03/2018
[2] Estimated on data collected 3 months pre & post QiCT intervention
[3] Estimated on data collected 3 months pre & post QiCT intervention for non-elective Ambulance call outs reduction, (51.8% of admissions with an average of 7.8 days stays in hospital – Health Data)

Rating the following:	Strongly Disagree	Disagree	Neither Disagree nor agree	Agree	Strongly Agree
The QiCT offers an accommodating service				25%	75%
The QiCT offers valuable support/advice				30.5%	69.5%
The QiCT has helped improved quality in care				36%	64%
The QiCT has helped improve staff's knowledge, skills and confidence			3%	25%	72%
There has been a significant change in culture and/or workplace practice as a result of the QiCT's input			16.5%	44.5%	39%
In terms of an overall experience, the QiCT are professional in their conduct				25%	75%
I would engage with the QiCT again				19.5%	80.5%

5 Pharmacists Reviews

QiCT contributes to CCG objectives by providing support to providers in medicines management and medicines optimisation services in care homes. In total, QiCT saved £60K since 1st April 2017 in medicines management (reducing waste, stopping or optimising medication of residents) in residential and nursing homes.

The table below covers all medicines optimisation carried out by the QiCT care homes pharmacist during 2017/18.

Clinical Effectiveness	Total
Number of residents for whom medication is stopped (as no longer indicated)	198
Number of medicines stopped (total for care home)	247

Medicines optimisation (actual)	Total
Number of residents reviewed	202
Cost saving for medicines stopped or optimized	£ 26,052

Waste reduction	Total
Annualised Saving	£ 34,291

Total Cost Saving	Total
Total cost saving (waste, medicines optimized)	£ 60,343

6 Supporting the Development of a Skilled Workforce

Training

The Quality in Care team is continuing to improve knowledge, skills and confidence amongst the care workforce in Buckinghamshire as demonstrated by the Annual Survey – see table below:

Q6) Do you feel we have helped improve staff knowledge, skills and confidence?	2014	2015	2016	2017
Significant improvement	25%	22%	23%	42%
Noticeable improvement	50%	56%	43%	47%
Moderate improvement	21%	17%	25%	7%
Some improvement	0%	5%	9%	5%
No improvement	4%	0%	0%	0%

Study Days

Study days have been organised by QiCT to provide high quality full or half days clinical and non-clinical training to care workers in partnership with Buckinghamshire Healthcare Trust specialist nursing and medical teams, Oxford Mental Health Trust, CCG medicines management, service users and provider partners.

The study days generated an overall income of £11,318 in 2017/18 which covered venue and speaker costs.

The QiCT created and run 53 study days and nurses fora since April 2017, up by 61% from the previous year, providing training to 559 Bucks care home staff, up by 11% from the previous year.

The attendance at these study days represented 86.6% of all beds from nursing homes and 50.6% of all beds from residential care homes in Buckinghamshire.

Workshops

Clinical and non-clinical workshops are provided at the providers base by the QiCT to form an interactive session with staff that aims to embed best practice into the day to day running of care provision. Our goal is to provide increased knowledge, skills and confidence to at least 50% of the workforce in order to ensure theory is translated into positive practice improvements.

In 2017-18, QiCT has delivered 335 in-house workshops, involving 2,307 care home staff, covering over 52% of all residential and 40% nursing home beds.

Workshop Attendance	Total	County Bed Nos	% Beds Covered
Care Home Nursing	911	2238	40.7%
Care Home Residential	1082	2057	52.6%
Day Care	75		
Domiciliary Care	136		
H/O	39		
Other	7		
Supported Living	56		
Total	2306	4295	

Furthermore, providers who have responded to the Annual Survey felt that in-house workshops are the most useful source of support – see table below:

Q8) Which support provided by us do you find useful?	Total
Assistive Technology Support	10% (5)
Management / Staff Support	26% (13)
Medicines Management	19% (10)
Other	2% (1)
QICT Webpage	33 % (17)
Signposting	19% (10)
Study Days	43% (22)
Workshops	83% (42)

7 Project programmes

- The key priorities for 2017/18 have been identified from collaborative working with our health and social care partners, along with data intelligence collated. This, together with national quality improvement initiatives, have steered the various work streams undertaken. It has included:
- Chair-based exercise sessions – the QiCT successfully led and managed the Chair-Based Exercise Project in 8 care homes, with a core group of 63 residents, showing improvement in stability and promoting independence at the end of the project – See full report. Following the success in 2016/17, the project has received further funding from public health for continuation. The new cohort started in September 2017, involves the participation of 79 residents (core group) across 12 different homes.

Clinical

- Sepsis and Acute Kidney Injury – the QiCT is offering workshops on Sepsis Awareness and Acute Kidney Injury Awareness, developed in collaboration with NHS Think Kidneys Campaign, BHT Sepsis Lead Nurse and CCG Infection Control Nurse. A total of 15 Awareness sessions have been delivered in 2017-18.
- Diabetes Care - QiCT continues its integrated working with the district nurse service and CCG medicines management team to implement the Good Practice Guideline for residents with diabetes in care homes, diabetic hypos and dysphagia, and insulin safety. Additionally, QiCT has coordinated 9 sessions on blood glucose monitoring and 15 study days on diabetes awareness, for nurses and carers.

Continence

- Continence pathway - the QiCT is supporting the countywide review of the Continence pathway, aiming to deliver a more efficient and patient centred approach.
- Catheter Care - the QiCT has started a review of data to establish whether a reduction in A and E attendances for primary diagnosis catheter problems, and a reduction in symptomatic urinary tract infections (UTIs) in the community has been achieved. The audit intend to present recommendation for best practice in Buckinghamshire on catheter care.
- Continence and catheter care awareness – the QiCT is offering awareness sessions on continence and catheter care to care homes and a total of 14 such sessions have been delivered across care homes in 2017-18.

Dementia

- Dementia Findings - the QiCT has continued working with the Dementia Partnership Board and the Memory Service to support the use of the DiADeM tool in care homes through the Dementia Finding Project. A total of 76 additional Dementia Assessments were carried out as a direct result of this project in 2017-18.
- Dementia Awareness - 27 Dementia themed workshops were offered to various providers to enhance awareness of Dementia, improving care for people living with

Dementia in care homes. QiCT is now delivering both Tier 1 and Tier 2 Dementia training.

- Depression and delirium – a new service offer has been made available in 2017-18 to include depression, delirium and sleep hygiene to enhance better care for people receiving care.

Dignity in Care

- Healthwatch Bucks Enter & View: - 24 Enter and View' visits and reports produced within agreed timescale (following contract from 2016/17 with similar criteria). Additionally, generating referrals to QiCT should Healthwatch Bucks identify concerns or issues during their visit but that are outside their role under the Dignity in Care agenda. QiCT now works more closely with the providers where recommendations made by Healthwatch Bucks have not been implemented. A new process has been applied in March 2018 whereby a data referral is generated to offer further support.
- Dignity Award 2017: - QiCT coordinated, promoted and delivered successfully the Annual Countywide Dignity Awards Ceremony in 2017, with over 100 people gathering at the Oculus in Aylesbury on 19th May to celebrate examples of best practice where dignity and respect was demonstrated across our care services in Buckinghamshire.
- Dignity in Care training - QiCT has developed a new "Dignity in Care" workshop which is now available to all care providers, to enhance knowledge, skills and Confidence for Care Staff to provide dignified assistance for people living in care settings.

Falls Prevention

QiCT has continued to support providers to reduce falls for care home residents. 19 workshops and 1 study day were provided, targeting a total of 156 care staff. QiCT has built relationship with South & Central Ambulance Services (SCAS) and have agreed to share data in order to identify homes with the highest incidences of falls thus targeting resources efficiently in 2018/19.

Hospital Transfer Pathway

QiCT is supporting the CCG in implementing a pilot project to improve the hospital transfer pathway in Buckinghamshire – also known as the Red Bag Scheme. The scheme is modelled on the Sutton Vanguard project, to ensure that residents living care homes receive safe, coordinated and efficient care should they need to go into hospital in an emergency.

Learning Disabilities and Domiciliary Care

QiCT has strong relationships with providers supporting people living in the community. QiCT works very closely with the Learning Disability Managers Forum and the Community Learning Disability Team. This has resulted in an increase of support offered to Supported Living and domiciliary care providers at times when this market is experiencing multiple pressures.

QiCT has continued to support use of Health Passports and A&E grab sheets to all providers and are encouraging services to request health checks and the yearly medicine reviews in line with CCG key priorities.

My Home Life

- My Home Life Leadership Programme - QiCT manages this national programme here locally in Buckinghamshire. So far, this has contributed to 5 Bucks provider managers being rated 'Outstanding' overall by CQC. Additionally, a further care provider received an "Outstanding" rating in the "Caring" domain, following participation in the programme. QiCT is currently supporting a further 22 care home managers to participate in My Home Life Leadership programme in 2017/2018.
- FaNs Community Engagement - QiCT supported the development of the South Bucks FaNs (Friends and Neighbours) in partnership with South Bucks District Council. FaNs is the first "not for profit" community organisation supporting greater continued inclusion of care home residents within their neighbourhoods.

Nutrition & Hydration

- Malnutrition Universal Screening Tool (MUST) - QiCT is working in close partnership with the CCG prescribing support dietician team to support care homes in preventing and treating malnutrition, implementing the MUST tool and Food First Programme. QiCT offers MUST Awareness session to carers and catering assistants across the county. A total of 38 such sessions have been delivered in 2017-18. Additionally, 2 study days have been coordinated on Enteral Feeding, 4 study days on Dysphagia and 4 study days on Nutrition for Caterers.
- Hydration - 2 study days have been delivered on Managing Hydration and QiCT is working in partnership with the CCG to minimise risks of dehydration for people most at threat.

8 Communication

The QiCT Webpage offers multi-disciplinary resources, tools and information from all relevant partners in Buckinghamshire to support all providers. The website has been accessed by 42,296 individual users, with a total of 374,722 pages viewed from April 2017 to March 2017.

The QiCT produces quarterly newsletters which are disseminated to all relevant partners and providers in Buckinghamshire for effective communication and promotion of good practice. Safety Alerts and any other relevant information are also disseminated as and when relevant to all providers

The 2017 Annual Survey showed that communication with providers is effective – see table below:

Q9) Do you feel the amount of comunication we send is?	2014	2015	2016	2017
Too much information	0%	0%	2%	0%
Just about right	90%	100%	92%	98% (49)
Not enough	10%	0%	6%	2% (1)

9 Key Priorities for the Coming Year

The key priorities for 2018/19 will be identified from collaborative working with health and provider partners and understanding the needs of their staff and service users along with data intelligence received from a variety of sources including CSU data, CQC and professionals. This together with national quality improvement initiatives will steer future work streams. Priorities already identified include:

- Increasing resources and capacity to support providers in Buckinghamshire with inadequate and requires improvement CQC ratings or those with data indicating quality issues, and making better use of the one dashboard (inter-agencies data gathering) to inform priorities.
- Working in partnership with BHT, CCG, OHFT partners to create standardisation of clinical education (Care Homes Pilot Project).
- Coordinating a pilot project on management of hydration in care homes in partnership with CCG and Health Education Thames Valley (HETV).
- Supporting the CCG in its key priority to achieve medicines optimisation in care homes.
- Influencing policies in Buckinghamshire to embed dignity in all aspects of health and social care delivery, improving engagement with the Dignity in Care (DiC) agenda by updating and improving communications to include webpage, newsletter, strategy group and events.
- Supporting the Red Bag Scheme pilot project in Buckinghamshire in partnership with all relevant partners.
- Auditing standards of catheter care across Buckinghamshire to support best practice in Buckinghamshire.
- Delivering and evaluating the Chair-Based exercise across 12 homes.
- Evidencing falls reduction, working in partnership with SCAS.
- Organising and coordinating the 2018 Buckinghamshire Annual Dignity in Care Awards.
- Continue to support providers through the delivery of high quality study days, with a target to achieve full cost recovery on venues and guest speakers.
- Managing the 2018/19 Healthwatch Bucks ‘Enter and View’ contract (24 visits).
- Managing the 2018/19 My Home Life Programme and further supporting the Leadership Programme for registered care home managers.
- Supporting the development of a FaNs organisation in the north of the county.
- Participating in the Enhanced Health Care Homes community of practice.

10 Key Challenges for the coming year

- Resources as referrals could exceed levels of capacity, especially in clinical areas.
- Risk to meeting target on medicines optimisation reliant on successful recruitment of a full-time QiCT pharmacist.

11 Feedback from providers

"Trainer gave clear information to staff. Also was able to give hand outs on where to find more information. Staff have all said they felt more confident with certain matters regarding the health and well being of our residents".

"Quality in care team were flexible and accommodating. They were friendly".

"Understood, listened and acted accordingly to needs of management concerns and to those of staff and seniors".

"Met objectives, very accommodating, always professional".

"Support the whole team by offering advice, guidance and training. Always respond quickly to requests and not judgemental".

"Training delivered in house, group workshops worked well and all staff feel it has benefitted them".

"Providing a tailored service for the home".

12 Case studies

Case study 1: Chair-Based Exercise

A resident of a nursing home, previously bed-ridden and unable to leave his bedroom, is now able to come down to the lounge following his active and consistent participation in the Chair-based exercise programme.

Case study 2: FaNs

Residents participating in the FaNs visited their local leisure centre and were offered the opportunity to part-take in sport such as table tennis, badminton, volley ball and even football. All of the residents felt exhilarated to be doing some form of indoor sport which can be quite restrictive when living in a care home environment as they can have no space to cater for such activities. As a result, one resident came out of his shell and thoroughly enjoyed himself playing badminton and passing the football. This gentleman rarely takes part in any of the activities held inside the care home on a general day to day basis however, on this particular occasion, he really loved his game of badminton. He suffers from Parkinson's disease and this can deter him from actively concentrating on any particular activity for a long period of time. On the day he came to the leisure centre, his concentration level was particularly high and the different environment rejuvenated his memories of what he used to love doing. Visits to the Leisure Centre are on-going on a regular basis and the gentleman is especially enjoying Table Tennis.

Case Study 3: Diabetes Care

Improving Diabetes Care has been identified as a priority following an audit in Diabetes Management in care homes. For example, one resident had been waking up with an episode of hypoglycaemia every other morning. She had been into hospital following a fall (and her blood glucose was noted to be just 1.8mmol/l) yet she was still receiving a high dose of insulin several times a day. She was at risk of harm from repeated episodes of hypoglycaemia and urgent action was needed. The QiCT Pharmacist worked in close partnership with the Diabetes Specialist nurse and the Prescribing Support Dietician (CCG) to deliver 10 Study Days across Buckinghamshire to improve Diabetes Care for residents. It was hoped that at least one staff member from each care home attend. These individuals were to become the 'Diabetes Champions' who would disseminate information and generally drive the required improvement to support residents to live well with diabetes in all of Buckinghamshire's care homes. As a result of this intervention, this particular resident has had all her diabetes medication reviewed and reduced by the Medicines Management team. She no longer had any hypos and felt so much better as a

result. As urgent diabetes training was arranged for this care home, and also trained the carers to safely check blood glucose levels, her risk of future hypoglycaemia events was reduced. Staff also noticed a visible improvement in her wellbeing, as she was now able to join in home activities.

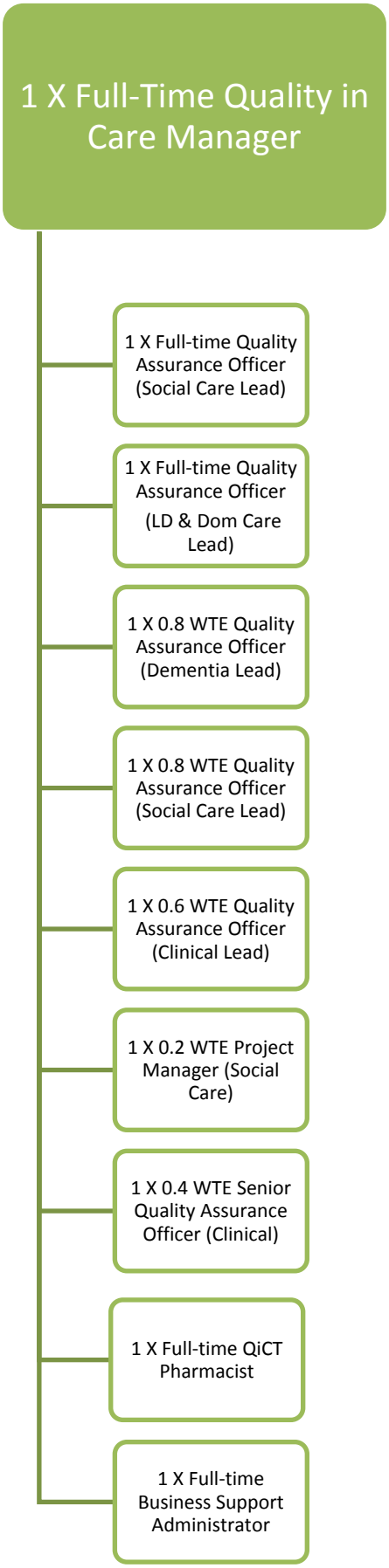
Case Study 4

Following the delivery of a sepsis workshop in a care home, information was cascaded to all staff to ensure that all were aware of the sepsis pathway.

The following day, a carer, (who had attended the workshop) became concerned about a resident. She informed the nurses who took action. As a result, the resident went into hospital, was diagnosed with early stages of sepsis, and treated accordingly before returning to the nursing home. The resident remains frail but otherwise has recovered.

The team at this particular care home felt that, without this workshop, the outcome for this resident would have been very different.

13 Appendix A: Team Structure



Health & Wellbeing Board
Buckinghamshire

Title:	Buckinghamshire Safeguarding Adults Board Annual Report 2017/18
Date:	6 December 2018
Report of:	Buckinghamshire Safeguarding Adults Board
Lead contacts:	Marie Seaton Independent Chair/ Julie Murray Head of Adult Safeguarding

Purpose of this report: The purpose of this report is to provide a brief summary of the work of Bucks Safeguarding Adults Board over the period April 2017 to March 2018, with a particular focus on those issues relevant to the Health and Wellbeing Board.

Summary of main issues:

Under the Care Act 2014 each Safeguarding Adults Board has a duty to produce an Annual Report and to share this with partner agencies. The Annual Report must contain information in relation to the activities carried out by the Board during the financial year, April 2017 to March 2018.

In the year 2016/17 the Board had gone back to basics to build strong and effective governance arrangements for keeping people safe, so in 2017/18 the Board moved onto look at updating its Strategic and Business plans in order to meet its statutory responsibilities as a Safeguarding Adults Board. These documents are available on the Board's website http://www.buckinghamshirepartnership.co.uk/safeguarding-adults-board/about-the-bsab/bsab-board-documents-and-policies/.

As well as updating the strategic and business plan to deliver its objectives, the Board has focused this year, on three priorities included as new categories of abuse, introduced under the Care Act, which included:

- Domestic Abuse
- Self-Neglect
- Modern Slavery

The Board decided to have themed Board meeting on each of these events in order to understand the nature and extent of these issues both nationally and locally within Buckinghamshire and provide assurance that appropriate actions were being taken. These themed meetings therefore led to work being undertaken within the Board's subgroups and their individual work plans can again be found on the website.

There were several crucial pieces of work that the Board carried out during this financial year. The main one of which was carrying out its statutory responsibilities in relation to Safeguarding Adults Reviews and two reviews where completed in the 2017/18 period. The main learning from these was around Self Neglect and as a

result the Board's self-neglect tool kit was revised and reissued across agencies to support staff in identifying individual circumstances when this is an issue that requires professional intervention. The self-neglect tool kit is available on the BSAB website.

The second piece of priority work for the Board was the development of its own Performance and Assurance Dashboard which enabled Board members to understand the overall picture relating to Safeguarding adults within Buckinghamshire. The aim is to include information from other Board's in particular from the Safer Stronger Bucks Board in relation to shared subjects such as Domestic Abuse.

Finally, the Board developed its own suite of E Learning packages which are open to Board members and other agencies to undertake free of charge and cover subjects including:-

- Basic Safeguarding
- Scams and Mental Capacity
- Modern Slavery and Adult Safeguarding
- Fire Safety

One of the main challenges that the Board had to manage in 2017/18 was in the budget setting process. In the past there had been limited ownership, control and oversight of the budget by Board members and following a series of reports from the Board manager it became clear that a significant uplift in the budget was going to be needed to meet the increase expenditure of the Board. This came at a time when agencies were facing budget constraints and seeking further cost saving efficiencies. Therefore discussions had to take place in a challenging financial context. It reflects the commitment of all partners that by the end of the year a realistic budget was agreed through an approved formulae and budget principles which will be used going forward into future financial years.

Recommendations for the Health and Wellbeing Board:

This year the Board has focused on ensuring that board members were aware of the nature of safeguarding issues within Buckinghamshire and then providing strategic leadership to identify ways of proactively addressing these to prevent abuse or provide appropriate support to vulnerable adults. There has been more collaboration between the Boards, particularly in the newer safeguarding priority areas of Modern Slavery and Domestic Abuse which have required the Board's to work closely together to deliver objectives in joint work plans. This has been reflected in the development of an agreed Joint Board Protocol, and joint priorities across the whole partnership system.

Board members has become aware that there are other topics which are hosted by other Boards which will become the focus of greater collaboration and joint work such as Forced Marriage, Female Genital Mutilation, and suicide prevention. All of which are important safeguarding issues for adults with care and support needs.

Bucks Safeguarding Adults Board would like to therefore make the following recommendations to the Health and Wellbeing Board:-

- To endorse the continuation of closer working between the Local Safeguarding Children's Board; Safer, Stronger Communities Board and the Health and Well Being Board on areas of joint concern such as Domestic Abuse,
- That the Health and Wellbeing Board shares its work plan and priorities with the BSAB so that joint areas of work can be highlighted.
- That there is a link member on each of the Board's to enable feedback from each Board meeting to other Boards.

Background documents:

- Buckinghamshire Safeguarding Annual Report 2017/18
- Buckinghamshire Strategic Plan
- Buckinghamshire's Business Plan
- Safeguarding Adult Review – Mr Q and Miss T.

Health & Wellbeing Board
Buckinghamshire

. Buckinghamshire Health and Wellbeing Board Work Programme 2018-19

Date	Item	Lead officer	Report Deadline	Further Information
Thursday 28 March 2019	Update on Health and Care System Planning/ Sustainability and Transformation Partnership and Integrated Care System To include update on Better Care Fund	Louise Patten Louise Watson/ Neil Macdonald/ Gill Quinton Jane Bowie	**Monday 18 March**	
	Children and Young People update	Tolis Vouyioukas, Executive Director Children's Services		
	Health and Wellbeing Board Annual Report	Katie McDonald		
	BSCB Annual Report (tbc)	Fran Gosling Thomas		
	BSAB Annual Report (tbc)	Marie Seaton		
	HWB Work plan	Katie McDonald		
	FGM Action Plan - update	Joanne Stephenson		
	Serious Mental Illness – presentation on how the board and partners can support	Dr Sian Roberts		
	Healthwatch Achievements and Priorities Presentation	Jenny Baker		
	JSNA progress and prioritisation presentation	Dr Tiffany Burch		
	Voluntary Sector	Lead contact: Claire		

	contribution to the health and wellbeing agenda	Hawkes		
	Health Protection Annual Report	David Munday		
	Childhood Obesity – HASC Report and Action Plan	Lucie Smith		
	Physical Activity Strategy – Action Plan progress update	Lucie Smith		