Health and Wellbeing Board minutes

Minutes of the meeting of the Health and Wellbeing Board held on Thursday 18 November 2021 in The Oculus, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF, commencing at 9.30 am and concluding at 11.48 am.

Members present

Cllr A Macpherson (Chairman), N Macdonald (Vice Chairman) Dr R Bajwa, J Baker OBE, Cllr S Bowles, M Gallagher, K Higginson, Dr J O'Grady, Dr S Roberts and Dr J Sutton

Others in attendance

T Ajmal, M Baragona, J Boosey, D Breen, C Capell, T Ironmonger, S James, H Mee, J Newman, M Patel, C Spalton and S Taylor

Agenda Item

1 Welcome

The Chairman, Cllr Angela Macpherson, Deputy Leader and Cabinet Member for Health and Wellbeing, welcomed everyone to the meeting and explained that some partners had joined the meeting remotely.

2 Apologies

Sally Taylor, Democratic Services Officer, advised that there had been a change in membership; Dr Nick Broughton, Chief Executive, Oxford Health NHS Foundation Trust had re-joined the Health and Wellbeing Board (HWB) as Debbie Richards had left the Trust.

Apologies had been received from Robert Majilton, Deputy Chief Accountable Officer, Buckinghamshire Clinical Commissioning Group (CCG); Richard Nash, Interim Corporate Director, Children's Services, Buckinghamshire Council (Simon James, Service Director, Education attended in place of Richard); Zoe McIntosh, Chief Executive Officer (CEO), Healthwatch Bucks; Dr James Kent - Chief (Accountable) Officer and Integrated Care Systems (ICS) Executive Lead; Dr Nick Broughton, CEO, Oxford Health Trust, (Tehmeena Ajmal, Interim Executive Managing Director, Oxford Health Trust attended in place of Dr Broughton); Cllr Anita Cranmer; David Williams, Director of Strategy and Business Development, Buckinghamshire Healthcare NHS Trust (BHT); Cllr Carl Jackson and Gill Quinton, Corporate Director, Adults and Health.

Note: Martin Gallagher arrived at 9.45 am
Note: Neil Macdonald left at approximately 11.40 am

3 Announcements from the Chairman

The Chairman advised that the aim for future meetings was to accommodate as many partners and members of the public as possible so there would be changes to the location and meeting dates; any changes would be published on the website and members of the Board would receive updated meeting invitations.

The Chairman announced that the Buckinghamshire Integrated Care Partnership (ICP) had nominated Neil Macdonald, CEO, BHT, as Vice-Chairman of the HWB as set out in the Terms of Reference.

The Chairman also welcomed Cllr Steve Bowles, Cabinet Member for Communities to the HWB.

4 Declarations of Interest

Dr Raj Bajwa, Clinical GP Chair, CCG, declared an interest for himself and on behalf of all the board members who worked in primary care, in the primary care components of the meeting.

5 Minutes of the previous meeting

It was noted that the minutes of the meeting held on 22 July 2021 stated that the date of next meeting was 14 October 2021, however, this meeting was cancelled and re-scheduled to 18 November 2021.

Resolved: The minutes of meeting held on 22 July 2021 were **agreed** and signed by the Chairman.

6 Public Questions

The Chairman stated that the HWB encouraged public questions and welcomed public engagement. Questions needed to be submitted by 9.00 am on the Monday before the meeting and ad hoc questions were unable to be taken on the day. Cllr Katrina Wood and Cllr Mark Winn had submitted questions for this meeting which were read by the Chairman; the responses were read out by Jacqueline Boosey, Business Manager, Health and Wellbeing and appended to the minutes.

7 Covid-19 - Cases in Buckinghamshire Update

Dr Jane O'Grady, Director of Public Health, Buckinghamshire Council (BC), provided a presentation appended to the minutes. Dr O'Grady stated that, so far, Buckinghamshire had had over 73,000 cases of Covid-19 and over 1,280 deaths; the cumulative case rate per 100,000 was lower than England but higher than the cumulative case rate in the South East. Death rates had been lower than England and the South East average. A map showed the number of cases per 100,000 in Buckinghamshire which were particularly high in the south of Buckinghamshire, Aylesbury and High Wycombe town centre areas. Over the previous week Dr O'Grady highlighted a hot spot in the Wing/Bierton area which largely reflected the cases in school aged children and the parental age group. Case rate graphs were shown for the different age groups for 0-18 year olds; there had been a peak which

then dropped due to half term; there was a lag in the data and the case rates in school age children were rising again. The adult age range graph showed much lower case rates than children in schools due to the vaccine take up; however, the 19-29 age bracket had started to rise again. At the start of the pandemic, higher rates were seen in those living in deprived areas and front facing roles; however, in the latest week the trend had reversed and was now higher in the least deprived groups as the main place of the epidemic was in school age children who took it home to their parents.

New hospital admissions had decreased slightly and the number of hospital inpatients had plateaued.

A slide provided the number of deaths from Covid-19 during waves one and two; there had been 10 Covid-19 related deaths in Buckinghamshire during the last week which showed that the vaccine was preventing serious consequences and Covid-19 related deaths. The majority of adults had received two doses of the vaccine but there were approximately 60,000 unvaccinated residents who could end up in hospital. Dr O'Grady urged everyone to have their first and second dose and also the booster dose which had shown to be very effective. Inequalities in vaccine uptake were being addressed through outreach clinics to encourage vaccine take up.

Dr O'Grady advised that the Office for National Statistics estimate 1.7% of the population had or had had long Covid-19 with one in five suffering significant limitation in their daily activities.

The Vice-Chairman, Neil Macdonald, added that a specialist hospital base for long Covid-19 had seen approximately 550 referrals between January and October 2021 and there were currently approximately 10-15 referrals per week. It offered a combination of physicians, physios and psychologists. Demographics attending were similar to the national demographic; mainly females in their 50's; there was also a dominant pattern of people with a high body mass index (BMI) and pre-existing significant mental health issues. There was no defined treatment for long Covid-19 apart from rehabilitation. BHT was participating in the ongoing research and it was expected that there would be a large demand for services and an online rehabilitation cohorts had been launched which would be able to treat large numbers of people. The key benefits were to validate their concerns and to reassure and signpost patients to other services. N Macdonald stressed that the understanding of the long term impact of long Covid-19 was still at an early stage.

The following key points were raised in discussion:

- The number of people being referred with long Covid-19 was the 'tip of the iceberg'; there was a large number who were experiencing protracted recovery which impacted the workforce. The impact needed to be considered from a workforce and health service point of view. The Chairman added that signposting was available to BC employees.
- Children and young people were also suffering from long Covid-19. They

generally had a milder illness but a significant proportion had debilitating long covid symptoms.

- Dr O'Grady stressed that being vaccinated significantly reduced the risk of getting long Covid-19; there was also avoidable risk factors such as a high BMI or smoking.

The need for communications regarding references and resources was highlighted. N Macdonald referred to the webpage entitled 'Your Covid Recovery'.

8 Partner Reports - Healthwatch Bucks Update

Jenny Baker, Chair of Healthwatch Bucks, referred to the report dated September 2021 in the agenda pack, which provided information on the remote Mental Health Survey and the Direct Payment project. A summary of the voices data had been included due to the HWB agenda item on Access to GPs/Primary Care Access in Buckinghamshire.

J Baker highlighted the following key projects in progress

- A second report on the vaccination programme covering the period from April to June 2021 had been produced. The first survey (January 2021 to March 2021) had 3338 responses and the second survey had 1205 responses. A total of approximately 4,500 responses had been received with 183 residents indicating they did not want the vaccine, some reasons were provided.
- Before Covid-19 and within its latest contract with BC, Healthwatch Bucks had agreed to discontinue the 'Enter and View' surveys carried out for care homes and replace it with a programme of visits to Community Opportunity Providers (previously called Day Centres) and the first report had been published. Four visits had been completed and a further six would be carried out by the end of March 2022.
- Other live projects included comparisons of cancer services received before and after Covid-19, a year-long project with Oxford Health NHS Foundation Trust looking at access to mental health services; and working with the BHT to understand the experiences of people from South Asian communities accessing secondary care.
- The five local Healthwatch teams in the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) area were obtaining feedback on hospital waiting times via a survey which had closed the previous day and the findings would be brought to the next HWB.

The Chairman advised that the HWB would like to be kept abreast of the development and outcomes of projects planned and jointly undertaken by the five local Healthwatch teams, including Healthwatch Bucks. The Chairman also requested that the HWB publish and promote Healthwatch Bucks' future plans and priorities to help the public to see how they could feed into its work.

Action: J Baker/J Boosey

The Chairman thanked Jenny Baker and acknowledged the importance of the work of Healthwatch Bucks in hearing the voices of the community.

Resolved: The Health and Wellbeing Board members **noted** the findings of the report.

9 Integrated Care Partnership Update

Better Care Fund (BCF)

Tracey Ironmonger, Service Director, Integrated Commissioning, BC, advised that the Better Care Fund (BCF) started in April 2013 to strengthen integration and, more recently, to enable recovery post-Covid-19 and help residents maintain their independence. There was a national requirement to submit the annual BCF plan and this had been carried out on 16 November 2021. The plan had been shared with the Integrated Commissioning Executive Team, lead officers in BC and the CCG. It was recognised that it was not the ideal approach as it did not allow engagement but, due to Covid-19, this financial year and last financial year, national planning guidance was released very late.

The BCF funding totalled just over £42m; a breakdown and information on the initiatives/schemes funded had been provided in the agenda pack. The latest national guidance focussed on hospital discharge and there were a number of new metrics. The BCF plan had been produced by a range of stakeholders across the system and demonstrated that the workplan reflected local priorities including the ICP, Better Lives Strategy and the Joint Health and Wellbeing Strategy. It had been hoped that the planning guidance would look forward for two or three years but this was not the case. A local review of the BCF had started in order to be able to provide an earlier opportunity for the HWB and other relevant forums to look at the focus of the BCF and the priorities being worked on.

The Chairman stated that it was encouraging to see partner input and suggested that it could be broadened further, for example, to include the Housing Team at BC and possibly hospitals that were out of the county.

The following key points were raised in discussion:

- The Vice Chair, Neil Macdonald, stated he understood the issues faced in respect of timing and the BCF and welcomed the planned review.
- In response to whether there was a market or pathway for the setting of the reablement metric which was well below the figure of 87% currently being obtained; T Ironmonger advised that the outcomes were unusual last year due to Covid-19. T Ironmonger had looked at the metrics, historic information and benchmarking performance against the South East and other authorities and advised that the targets were more reflective of 'business as usual'. T Ironmonger stated she would review the metrics for next year. N Macdonald recommended that reablement learning should be captured.
- T Ironmonger confirmed that an evaluation of what had been carried out

would be undertaken as part of the local review. The review would also consider if there was wider opportunity for integration.

Resolved: The HWB:

- Formally **approved** the 2021-22 Better Care Fund (BCF) plan for Buckinghamshire.
- **Noted** the update provided on the BCF including the budget for 2021-22, schemes funded and metric trajectories.
- **Delegated** authority for development of Buckinghamshire's BCF plans to lead officers for Buckinghamshire Council Integrated Commissioning and Buckinghamshire Clinical Commissioning Group. This included allocation of BCF expenditure, trajectories for locally set metrics, completion of supporting narrative, and assurance that all planning requirements and national conditions were met.
- **Agreed** that the Integrated Commissioning Team continued to service all requirements of the BCF, including reporting via the Integrated Commissioning Executive Team on performance and bi-annual updates to the Health and Wellbeing Board.

Systems Winter Planning

Caroline Capell, Director of Urgent and Emergency Care, Buckinghamshire ICP, explained that there was a shared system-wide plan to support a winter and Covid-19 surge across the health and social care system. The plan had been integrated due to the ongoing pandemic and would be delivered across all the system partners. The actions across Buckinghamshire were aligned to the national system requirements which needed to be met. C Capell advised that there was a weekly system-wide incident management structure meeting to manage the action focussed plan. This is also reported to the Buckinghamshire, Oxfordshire and Berkshire West (BOB) ICS team on a weekly basis and support was provided by local partners. Assurance was provided by the Urgent Emergency Care Board.

The Chairman welcomed Mayank Patel, Chief Officer, Buckinghamshire Local Pharmaceutical Committee (LPC). M Patel advised that he looked after the 89 community pharmacies in Buckinghamshire who had carried out a record number of flu vaccines this winter. The pharmacies were also providing the Covid-19 vaccines and booster vaccine at 14 sites in the county and there had been recent discussions to provide further sites to cover the gaps. Some local vaccination sites would be closed over the Christmas and new year period but the pharmacies would be open and consideration was being given to the provision of the Covid-19 vaccine during this period. M Patel stated that a campaign would be launched the following week in order to increase the uptake of the flu vaccine. Lateral flow delivery services were available and a host of new services were being introduced at pharmacies including case finding service for hypertension, discharge medicine service and provision of obesity and weight management. Pharmacies were easily accessible and the majority had a consultation room.

The following key points were raised in discussion:

- In response to a query on whether there was a strong enough link to manage pressures at Place and the escalation into the ICS; C Capell advised there was an ICS Operations Centre which would be fully operational in two weeks' time. The lead director had visited the Trust site last week and relationships were being developed using the principles of mutual aid.
- C Capell stated that it had been recognised that there had been gaps in communication with the pharmacies and that they were now incorporated within the Urgent Emergency Care delivery group.
- A query was raised as to whether residents with dementia had been incorporated into the Plan. C Capell explained that there was a frailty line for care homes to link to an acute consultant to look at alternatives to coming into hospital for patients, primary care GP colleagues could also use the 24/7 frailty line. There was a Frailty Group which met regularly. An urgent care two hour response been set up to manage patients in their home rather than hospital.
- Dr Raj Bajwa thanked the community pharmacies on behalf of primary care for their work throughout the pandemic and the flu vaccination service and stated that the pharmacies were becoming an increasingly important part of the health landscape. The Chair echoed this.
- A comment was made that there had been a spike in the number of children with respiratory viruses recently and primary and secondary care had been overwhelmed. N Macdonald advised that extra provision had been made available in acute care for paediatric beds.

Resolved: The Health and Wellbeing Board **noted** the findings of the report.

10 Access to GPs/Primary Care Access in Buckinghamshire

The Chairman advised that she had requested this agenda item due to the amount of correspondence, which she, and other local members, had received regarding difficulties in accessing not only face to face appointments, but also access over the telephone. The Chairman stated that she wanted to explore the current situation and the actions being taken to address concerns. The Chairman welcomed Jessica Newman, Head of Primary Care, Buckinghamshire CCG and Debbie Breen, Primary Care Director, Berkshire, Buckinghamshire and Oxfordshire Local Medical Council (LMC) to the meeting.

J Newman provided an update on the figures in the agenda pack. The activity figures had continued to improve in terms of total appointments of all types being offered in primary care both nationally and in Buckinghamshire. 56.3% of the appointments in Buckinghamshire in September 2021 were face to face; the total number offered in September 2021 was higher than in September 2019 and was a promising outcome. J Newman stressed that the activity was not equal to face to face appointments and some appointments needed to be remote for many reasons. The 'Improving Access and Supporting General Practice' document had been published recently and was being referred to as the Winter Access Fund. The process, in

conjunction with the Primary Care Network (PCN), the LMC, the urgent care teams at the CCG and BHT, had started the process to decide on how the funding of £7.4m would be distributed to the BOB ICS until March 2022. There were three main areas of work:

- Supporting all practices to increase their capacity and resilience.
- To increase capacity using a primary care hub model, particularly in the evening.
- Acceleration of national initiatives, particularly telephony solutions and the community pharmacy access service.

Dr Raj Bajwa, Clinical GP Chair, CCG, stressed the importance of the topic and that there had been significant discussions in the NHS, media and government in recent months. Dr Bajwa advised that practice activity had returned to pre-pandemic levels; the number of same day appointments had increased. Approximately 350,000 Covid-19 vaccinations had been delivered, mainly off site, and the largest flu vaccination programme, working with the pharmacies, in NHS history. The service had continued to deliver the majority of long-term condition care including mental health conditions which have been especially prevalent. It had also provided the ongoing management of patients waiting for specialist appointments and procedures whilst dealing with the pandemic. Every patient contact took longer due to the need to use personal protective equipment (PPE) and decontaminate equipment and rooms. Staffing pressures had existed due to absence with Covid-19 and the isolation requirements for those who had been in contact with Covid-19. The level and range of activity had only been possible by following NHS England's triage model which ensured every case was clinically assessed and signposted appropriately. There had been a long standing mandate from NHS England to increase the use of technology and recognition that primary care needed to be updated and become more flexible. Before the pandemic, progress was slow as primary care was working to capacity on face to face appointments but, at the start of the pandemic almost overnight, there was the rapid deployment of desktop systems to enable remote video consultations. Before the pandemic, more than 80% of contacts were face to face which did not always meet all GP patients' needs and the request to return to that proportion did not accommodate patients' preferences. It is not known what the correct proportion of face to face appointments should be or how it be determined who would suit a face to face appointment. Work was required with organisations, such as Healthwatch Bucks, in order to balance want with need and supply; the HWB would also have a key role in these discussions. Primary care recognised the challenges and Dr Bajwa pointed out that staff had experienced the same disruption. The issues mentioned by Dr Bajwa were rarely covered in the media and affected the morale of the workforce. Dr Bajwa emphasised that primary care would welcome elected members if they wished to visit a local practice.

The Chairman thanked Dr Bajwa for his considered and sensitive response and stated that no one would dispute the pressures and how agile the service had been. The Chairman agreed that the need to work with patient groups and councillors

would be key. The issue was around perception and the variation from practice to practice needed to be understood.

The following key points were raised in discussion:

- It was emphasised that the meaning of 'access' needed to be explored. Life was returning to normal but face to face consultations might not always be possible and were not always best. Access had increased and improved and it needed to be recognised that pre-pandemic there was a concern. In reality, the length of time in obtaining an appointment to speak to primary care had reduced. Morale had had an impact in primary care; people were burning out and others were leaving the profession.
- One of the GPs stated she had never known it so tough. GPs did their jobs because they cared but the way it had been portrayed in the media had been demoralising. An appeal was made for people to think about the responsibility to their primary care colleagues. Social media attacks on practices and people were damaging and thought should be given before making comments. There were issues with getting through on the telephone, this was being worked on, however once patients had got through good quality care was provided.
- The Chairman stated that the HWB was the forum for the public to hear the facts around the situation. The Chair agreed that not all the reports were bad but there did seem to be differences in access and service across the county and that more needed to be understood around this, particularly how contact could be made easier for people. These were the things which could be worked on together and the Chairman asked how councillors could help and offered to cascade the correct messages to other councillors.
- N Macdonald emphasised the challenges and agreed that primary care access needed to be redefined and articulated in a different way. The data in the paper related to Buckinghamshire and possibly provided limited assurance as there would be variances; a breakdown of the geographical distribution was required.
- J Newman advised that resources from the Winter Access Fund would be distributed according to patient need and priority given to areas where patients were struggling to access primary care; it was not about identifying individual practices and castigating them when they were under pressure.
- Communications were key to share the story and cascade key messages. Suggestions would be considered by the HWB and Communications and Engagement Officer.
- J Newman added that there were some great examples of positive communications on social media on what it was like to work in general practice and offered to share the link with the HWB to enable something similar to be produced for Buckinghamshire.

Action: J Newman

- D Breen advised that the LMC represented the interests of GP practices across the county and heard of the pressures daily and stressed that work needed to be carried out to provide geographical and demographical data.

- J Newman emphasised that the NHS complaints procedure stated that the first point of contact for patient concerns was the practice itself as it gave the practice a chance to respond and make improvements. If the patient then wished to raise it further the next port of call was the NHS England Contact Centre. The CCG needed to understand and know the concerns but were unable to answer questions.

The Chairman requested an update be brought back to the HWB after the winter period.

Action: J Boosey

The Chairman thanked everyone for their contributions and stated that the HWB had heard the reality of the situation; work needed to be undertaken and there were areas where improvements could be made but the intense amount of work carried out during the pandemic should be celebrated.

Resolved: The Health and Wellbeing Board **noted** the content of the report.

11 Engagement Strategy

The Chairman advised the HWB that she had requested this item as she felt the way in which the Board engaged with the public and communicated its priorities could be improved. It was important to ensure that the material contained in the agenda pack was understandable to the general public without the use of too many acronyms.

Cat Spalton, Head of Communications and Engagement, Buckinghamshire Council, acknowledged that the communications items discussed in item 10 were noted and would be reflected back to communications colleagues.

The previous two years had highlighted how significant communication and engagement was in influencing behaviour and the understanding of health and wellbeing issues. C Spalton stated that she was proud of BC and its partners in the role that they had contributed in helping to keep residents safe and support and protect colleagues in the NHS. C Spalton also highlighted how the pandemic had enabled further development of the partnership relationships. The purpose of the report was to build on partnership working, raise the profile of the HWB and make it easier and more accessible for the public to engage with the issues discussed. Looking ahead, work needed to be carried out to co-ordinate and co-produce a communications strategy that aligned with the HWB strategies. There was a requirement to produce a communications strategy at ICS level but it is also recognised that at local level it may also be necessary to re-visit the communications mechanisms to ensure that residents were involved in initiatives and services and C Spalton had suggested reinstating the 'Getting Bucks Involved Steering Group'.

The following key points were raised in discussion:

- A comment was raised that changing behaviour was complicated and that there were many avenues for communication in the county.

- The Chairman thought that the suggestion of a HWB newsletter that could be posted on social media was a good idea. It was highlighted that, before lockdown a one page infographic had been produced and could be a quick fix.

The Chairman recommended that the next step was for the working group to be established. The Chairman emphasised that she did not want communications to be 'dumbed down'. The agenda items were very important but needed to be understandable to the public.

Resolved: The Health and Wellbeing Board:

- **Agreed** to the short-term quick wins for raising the profile of the work of the Board for the next six months and to suggest and agree further quick win suggestions.
- **Agreed** to the creation of a co-produced overarching communications strategy and related communications plans to support the Happier, Healthier Lives strategy by April 2022.
- **Noted** the planned reinstatement of the Getting Bucks Involved steering group in relation to engagement, in addition to the platforms that could be made available across the partnership.

12 Director of Public Health Annual Report - Domestic Violence and Abuse

Dr Jane O'Grady, Director of Public Health, Buckinghamshire Council, provided a presentation appended to the minutes. Dr O'Grady highlighted the size of the problem and emphasised that domestic abuse suffered from huge under-reporting. Abuse could take many forms and it was estimated that 21,000 adults were affected per year; approximately 57 per day and accounted for 15% of all crime in Buckinghamshire. The cost of the consequences of domestic abuse in Buckinghamshire, using national estimates, was £687m. Between 2011 and 2020 there had been 15 domestic homicides.

Highlights:

- Anyone could be at risk of domestic abuse but there was increased risk for those with disabilities, women and those with mental health issues.
- Dr O'Grady stressed the need for improved data collection to understand the use and need of the Services.
- More focus was required on the perpetrators.
- Domestic abuse had a huge impact on victims resulting in, e.g., poor physical and mental health, the ability to work and attempted suicide.
- Covid-19 had resulted in a rise in domestic abuse as people were trapped at home.
- It was estimated that 1 in 5 homeless women was due to domestic abuse.

There was a massive impact on children, in Buckinghamshire:

- There had been approximately 2,400 referrals for a children's social care assessment where domestic abuse was a primary concern in 2021.
- Domestic abuse accounted for almost a quarter of children's social care referrals.
- Domestic abuse was the primary reason for half of the looked after children in 2021.
- There was a higher risk in harmful long term consequences as the children were more likely to abuse alcohol and become victims of perpetrators.

Prevention was key:

- The Domestic Abuse Board was in place.
- Shared training with partners was required.
- Clear and accessible referral pathways were required.
- Intervention for perpetrators.

Dr O'Grady raised the following questions with the HWB members:

- What is your role in prevention, affecting wider social attitudes, bystander training?
- What is your role in awareness raising and identifying instances of domestic abuse?
- What training do your staff have? Is it sufficient, evidence based, comprehensive? Do staff know where to refer?
- How do you support people with domestic abuse and other issues? How do you support your staff experiencing domestic abuse?
- How many domestic abuse champions do you have in your organisation and where are they?
- What data do you have that could help tailor services?
- How can we support the work of the Domestic Abuse Board?

The following key points were raised in discussion:

- The Chairman recommended everyone to read the Director of Public Health Domestic Abuse annual report if they had not already done so.
- Cllr Steve Bowles advised that it was a statutory duty for BC to have a Domestic Abuse Strategy and it was evidence-based and developed using a country-wide needs assessment and co-designed with the new Domestic Abuse Board. The next steps for the Domestic Abuse Board were to draw up an action plan; Cllr Bowles offered to report back on the progress to the HWB.

  Action: J Boosey
- Councillors would be signing a pledge against Domestic Violence.
- A separate strategy was also being considered for violence against women and girls.
- How to pick up issues of domestic abuse would need to be considered when using alternative means of access to GPs when appointments may not be

face to face.

- Women were fearful of their children being taken away.
- How could perpetrators be encouraged to come forward and access the support needed?
- There was real opportunity for a collaborative approach involving the voluntary sector and Dr O'Grady was asked to provide a presentation to the Voluntary, Community and Social Enterprise (VCSE) partnership board.
- In response to Dr O'Grady's request to understand how to implement the training in primary care; Dr Bajwa advised that Bucks Bridges would be arranging training and recommended that Dr O'Grady contact Kathy Hoffman.

The Chairman recommended the questions for the HWB and should be circulated to the board.

Action: J Boosey

Resolved: The Health and Wellbeing Board:

- **Noted** the Director of Public Health Annual Report and **endorsed** the recommendations.
- Members of the Health and wellbeing Board **agreed** to identify how their organisation could tackle domestic violence and contribute to the delivery of the Director of Public Health Annual Report recommendations and the actions in the developing Buckinghamshire Domestic Abuse Strategy.
- The Health and Wellbeing Board **agreed** to ensure active engagement of the relevant organisations in the Buckinghamshire Domestic Abuse Board.

13 Any Other Business

Age Well Action Plan

Jacqueline Boosey, Business Manager, Health and Wellbeing, advised that a workshop had been held in October 2021 with partners in attendance from across the Voluntary and Community Sector, the NHS and adult social care colleagues to identify key strategies and priorities. The draft action plan would be shared at the next HWB meeting in January 2022 for sign off.

Start Well Action Plan

Simon James, Service Director, Education, also advised that a workshop had been held and there would be a substantive item at the next meeting. There would be four key goals; school readiness, mental health in children, vulnerable children and supporting the community.

14 Date of next meeting

27 January 2022. The meeting was expected to be face to face in line with current legislation.

15 For information

The work programme had been included in the agenda pack for information.

Item 6 Public Question for Health and Wellbeing Board 18th November 2021

Question from Councillor Wood 11th October 2021:
I would like to ask a question regarding children who are potentially high functioning autistic but who are not being diagnosed by the NHS within the published timescales of 18 months.

The reason appears to be because they are home schooled. Many of these children are being pulled out of school by their parents because forcing them into mainstream schools is resulting in severe physical and mental health issues.

It is nothing to do with their learning abilities as many are extremely clever, but my question today is not about schooling.

I am aware of one 6-year-old who has been waiting 4 years for a diagnosis having been referred by a paediatric consultant neurologist at the John Radcliffe, and who has recently been told that there is still a 6 year waiting list, and other children who have had an initial consultation but once it is known they are home schooled, no follow up appointments are conducted by the NHS.

From a very quick 10 minute count up in only one group of home educated neurodivergent children in Bucks, there are 6 who have been waiting for an appointment since 2017, 7 since 2018, 1 has just been diagnosed after waiting 4 years, 1 after 6 years and one an appalling 11 years. This is just the tip of the iceberg. I emphasise that this was a very quick count up and this is a really widespread issue not an exception.

- Berkshire offer a portage service where children under 3 and their parents have a team to help the parents cope and offer advice and 2 weekly meetings.
- In Hillingdon, there are health visitors specially trained in autism, who are there to support parents and children.
- In Hertfordshire, they are diagnosing home educated children within 6 months and they have access to all the support they need.
- In Bucks, children are not even able to get a diagnosis unless they are in a school. The Bucks NHS will not accept private diagnosis even when the consultant doing the assessment is the same one the NHS use. The families get no help or support. There is no access to specialist services such as occupational therapy, educational psychologists and eating disorder clinics unless the child is in a school.

These children's basic human rights are being denied, as they are being wiped off the system and slipping through the cracks. Basically, they are being told that because they are home schooled, they are not entitled to the medical help they need. I would like to know why this is happening to our Buckinghamshire children and if something is going to be done about it.

Responses have been received from the Buckinghamshire Healthcare NHS Trust (BHT) and Buckinghamshire Council (BC) Children's Service.

The assessment service for an autism diagnosis sits within the Neuro Development Collaborative (NDC) across NHS Buckinghamshire Healthcare Trust and NHS Oxford Health

Foundation Trust. In order to reduce waiting times, £750,000 has been invested into the pathway over the last 18 months. The current average wait from referral to assessment is 572 days – these figures include both Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).

The NDC will assess children and young people who are home schooled and this is not a prohibitive factor to accessing the service. Gathering information as a secondary source (as indicated by National Institute of Clinical Excellence) can be more challenging, but it is not a restrictive factor in referring for assessment or receiving diagnosis via the NDC. Parents can self- refer for assessment and do not require a school referral.

Children and young people diagnosed in the private sector with ASD can be referred to the NHS pathway for post–diagnostic support without requiring a further diagnostic assessment on the NHS. Children and young people diagnosed with ADHD in the private sector can be referred to the NHS pathway for medication follow up without needing another formal diagnosis via NHS. There is a wait list for medication follow-up but work has been completed to reduce this.

For those children who need to see a community paediatrician outside of the NDC, the maximum waiting time as of last month for a child into community children's services delivered by NHS Buckinghamshire Healthcare Trust is 63 weeks; there are 12 children waiting over a year. Access to this service is not predicated on school setting.

The integrated therapies service (covering speech and language, occupational therapy and physiotherapy) is delivered by NHS Buckinghamshire Healthcare Trust. Referrals for home-educated children who require therapies are accepted should they meet current service criteria. The therapies will be delivered to home educated children either face-to-face in a clinic setting or remotely into the home depending upon clinical requirements. There are more challenges for delivery of provision for those home educated as if supporting for education need or statutory provision then therapies will be supporting outcomes within the home environment, whereas outcomes on an Education and Healthcare Plan (EHCP) will have been set for the education setting. Additionally, a large cohort of these children and young people are likely to have social communication difficulties and outcomes around this need are best supported within the education setting. This is because there is opportunity for carryover of therapy skills with peers in naturalistic social situations (as well as group therapy interventions where appropriate).

Buckinghamshire has a portage service and children do not need a formal diagnosis to access this service.

Children and young people in Buckinghamshire are able to access eating disorder services; elective home education has no bearing on access to this service.

Buckinghamshire has a strong co-production ethos and works closely with Families and Carers Together (FACT) Bucks on commissioning and delivery of services. Families with children with special educational needs should be encouraged to contact FACT Bucks for support.

Additionally, if families have complaints or issues to resolve, they can access support via Special Educational Needs and Disability Information, Advice and Support Service (SENDIASS), which is independent from the Council and health services. Should families want support raising issues specifically with health services they can also contact the Patient Advice and Liaison Service (PALS) for support.

Pupils who are electively home educated with additional needs are monitored particularly closely and are reviewed regularly.

Question from Councillor Winn 8th November 2021:

The question I would like to ask is how does the Patient to GP ratio in Aylesbury compare to the rest of Buckinghamshire? And to the UK? And how we will address any gaps in provision both in the short term and longer term as the population increases as a result of the Vale of Aylesbury Vale Local Plan?

Responses have been received from the Buckinghamshire Clinical Commissioning Group (CCG) and Buckinghamshire Council (BC) Planning and Environment Service.

In relation to GP coverage:

The data available from NHS Digital shows that on 29 September 2021:

- The combined total coverage for Aylesbury practices is 47 full time equivalent (FTE) GPs per 100,000 patients.
- This compares with coverage for the combined practices in the rest of Buckinghamshire (excluding the Aylesbury practices) of 59 FTE GPs per 100,000 patients.
- The national data available suggests that the average coverage is 43 FTE GPs per 100,000 patients.
- However, primary medical services are provided by a wide range of healthcare professionals such as nurses, pharmacists and paramedics, not just GPs. The use of a GP to patient ratio does not fully represent the primary workforce that is available to the population.

In respect of how gaps in provision will be addressed in the shorter term:

There is a national shortage of GPs and other primary care professionals. The CCG recognises that PCNs and practices are working hard to recruit to vacant positions.

The Winter Access Fund has provided the opportunity to increase capacity and improve access to GP services this coming winter, but this will be dependent on sourcing additional workforce.

In relation to how gaps in provision will be addressed in the longer term:

The CCG has been working with practices and Primary Care Networks (PCNs) in Aylesbury to ensure there is capacity to meet population growth.

Finally, The Council's Planning Policy Team has provided the following information in relation to Vale of Aylesbury Vale Local Plan:

The Aylesbury CCG and its replacement body, the Buckinghamshire CCG were involved over several years in the preparation of the Adopted Vale of Aylesbury Local Plan (VALP) (2021).

The CCGs are key stakeholders for Local Plans and Councils seek their input as the Local Plan policies and site allocations are prepared, for example asking for their views and advice at key consultation stages. As a result of the engagement with the CCG, a number of the VALP policies include requirements for primary healthcare. These are linked to the level of planned new development and the associated population increases arising from that level of development.

The Council will continue to engage with health providers as part of the preparation of the new Local Plan for the whole of Buckinghamshire. Early contact has already been made with key stakeholder organisations such as the Buckinghamshire CCG. This has been about how the Council will engage with them in drawing up the Local Plan and the strategic issues of interest to them.

This engagement will continue, for example at each key consultation stage and, importantly, as part of the infrastructure evidence needed to underpin the new Local Plan. The future needs of the health sector will be an essential part of this work. Infrastructure requirements will be tested and set out as the Local Plan proceeds towards adoption. When planning applications related to Local Plan site allocations are considered the Council will work with developers as they bring sites forward to ensure infrastructure requirements are met.

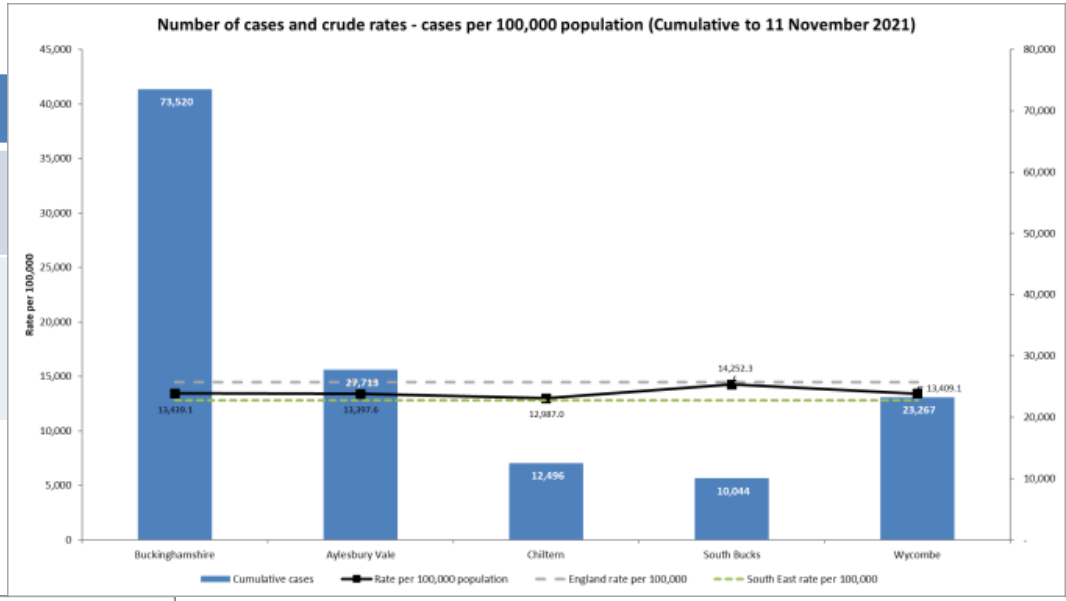
More information about the Local Plan for Buckinghamshire, and the current timetable can be seen on the website https://www.buckinghamshire.gov.uk/planning-and-building-control/local-development-plans/buckinghamshire-local-plan/

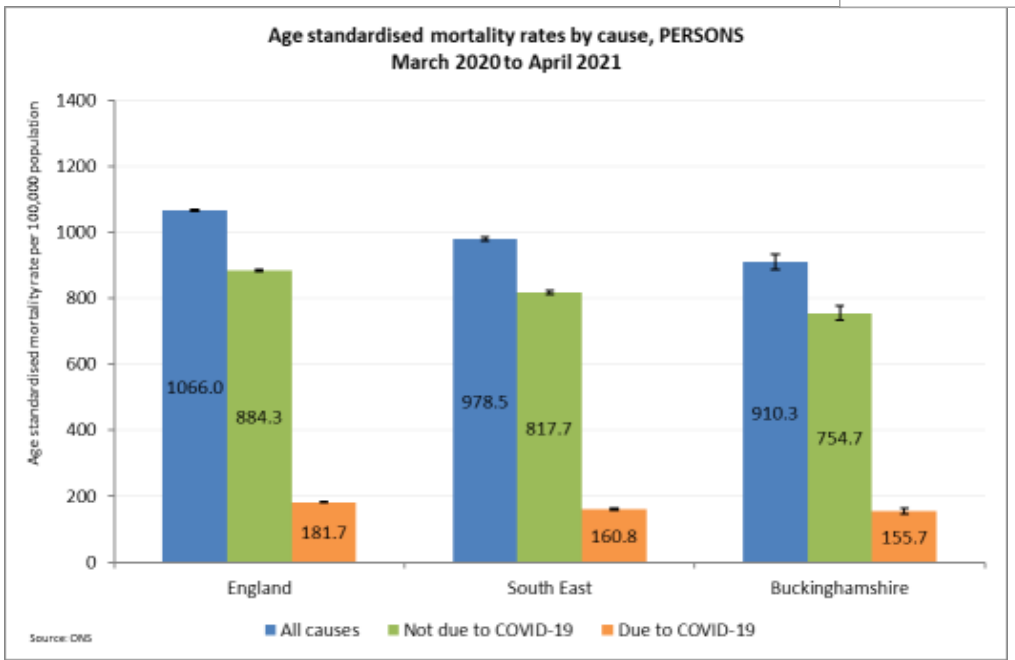
Health & Wellbeing Board Buckinghamshire

COVID - cumulative cases and deaths

	Buckinghamshire
Cumulative no. of cases to 11th November 2021	73,520
Cumulative no. of deaths* to 5th November 2021	1,286

* The number of deaths involving coronavirus (COVID-19), based on any mention of COVID-19 on the death certificate.



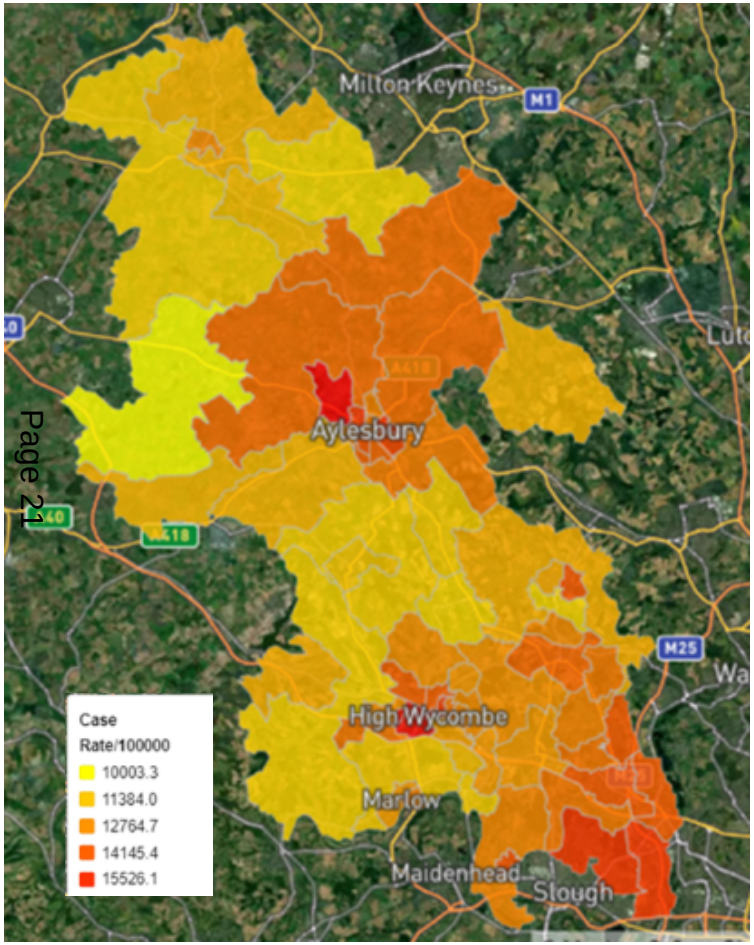


Cumulative case rate per 100,000 population up to 11 November 2021:

- Buckinghamshire = 13,439 per 100,000
- South East = 12,781 per 100,000
- England = 14,457 per 100,000

Health & Wellbeing Board Buckinghamshire

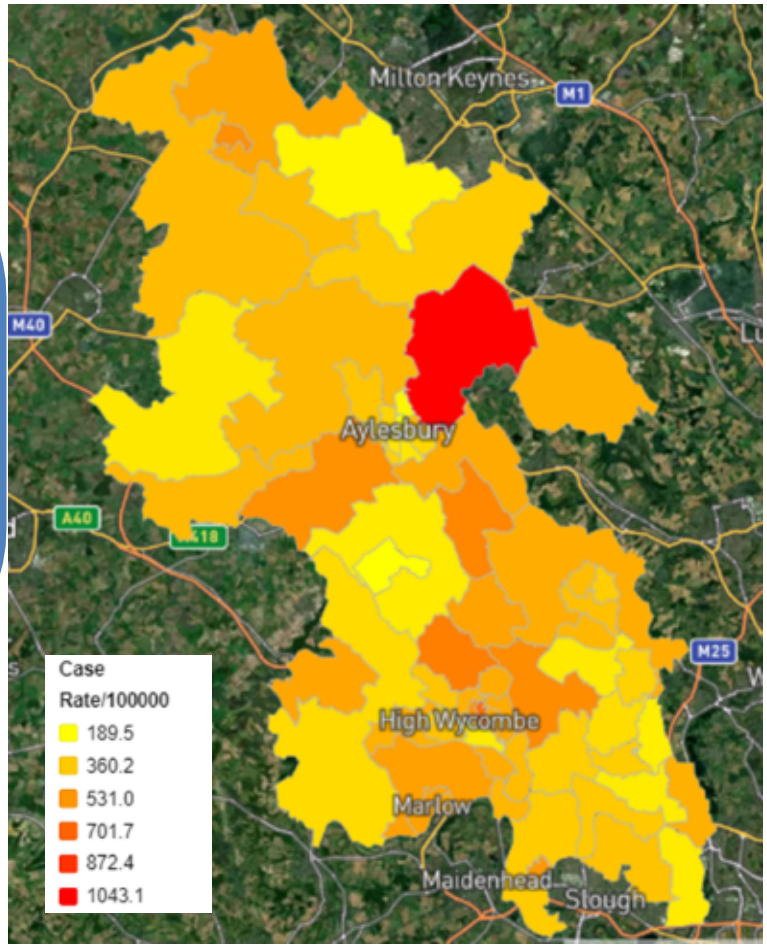
COVID Cumulative and latest week cases in Buckinghamshire



COVID-19 Rates by MSOA

<Cumulative since 1 March 2020

latest week>



Produced by Public Health Intelligence Buckinghamshire Council
October 2021

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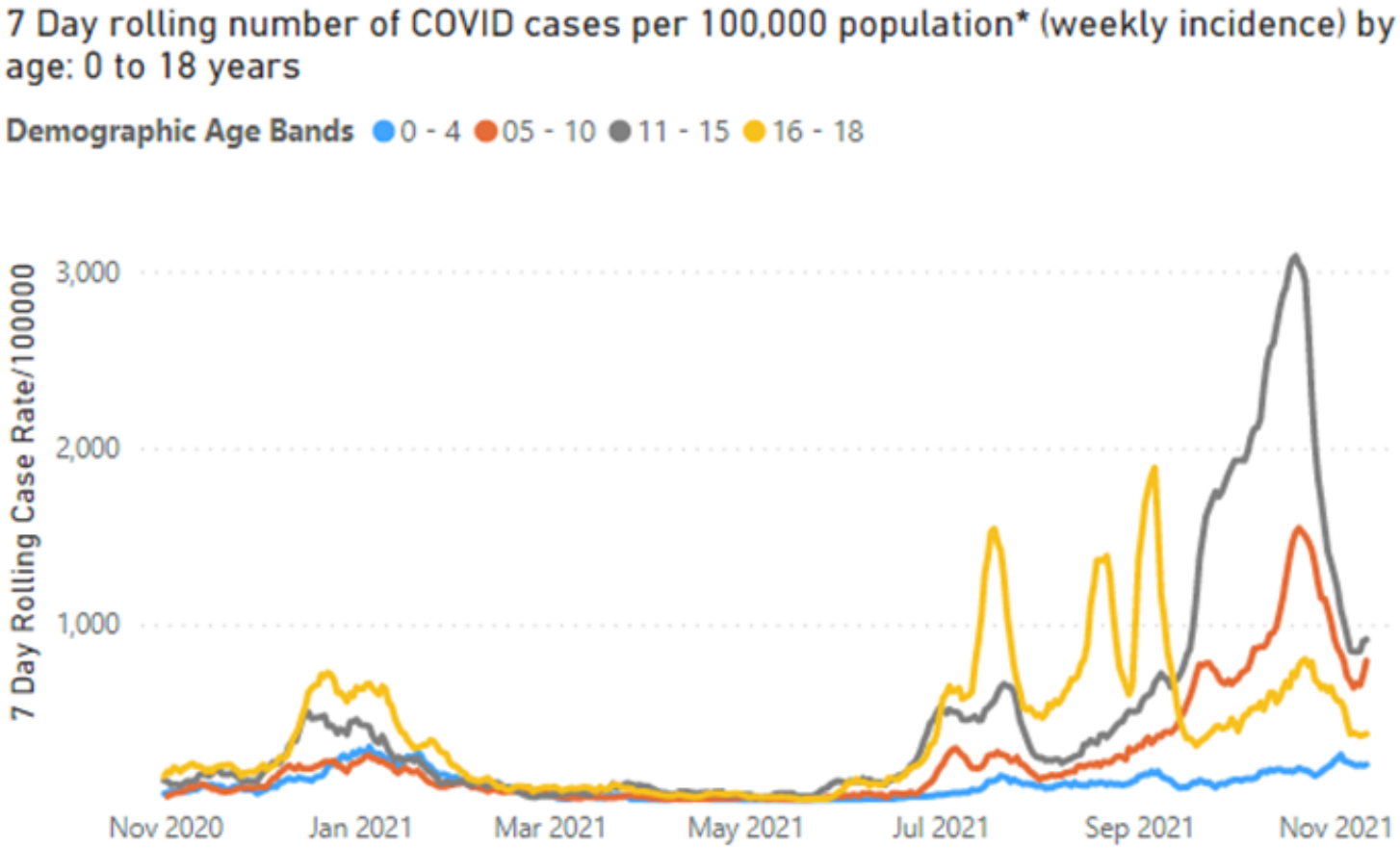
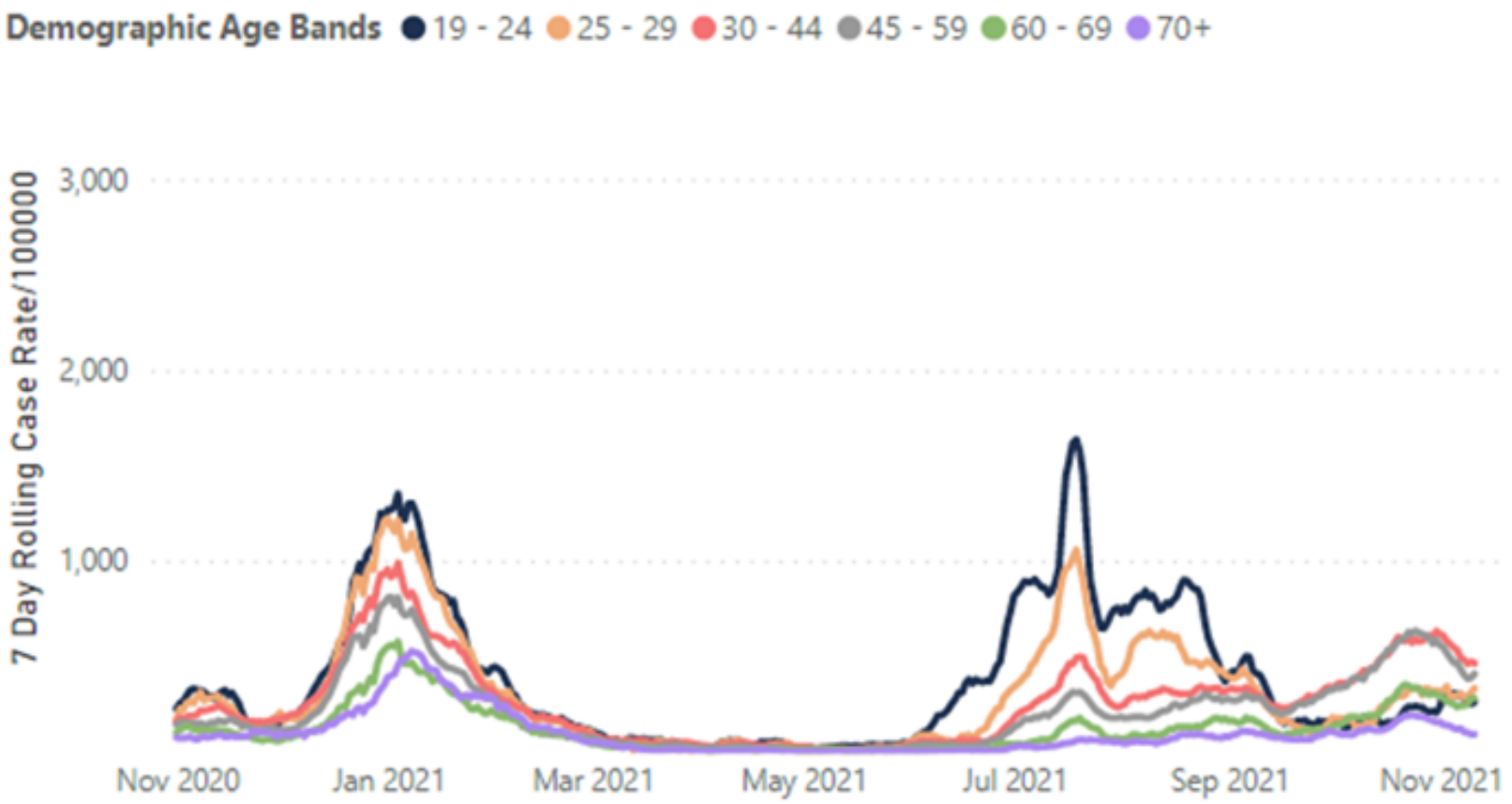
Age of Buckinghamshire COVID-19 Cases

Current case rate for 5 to 11 November is **401.6** per 100,000 in Buckinghamshire, compared with 383.1 in the South East and 364.2 in England as a whole.



Age of Buckinghamshire COVID-19 Cases

7 Day rolling number of COVID cases per 100,000* population (weekly incidence) by age: 19 years and over

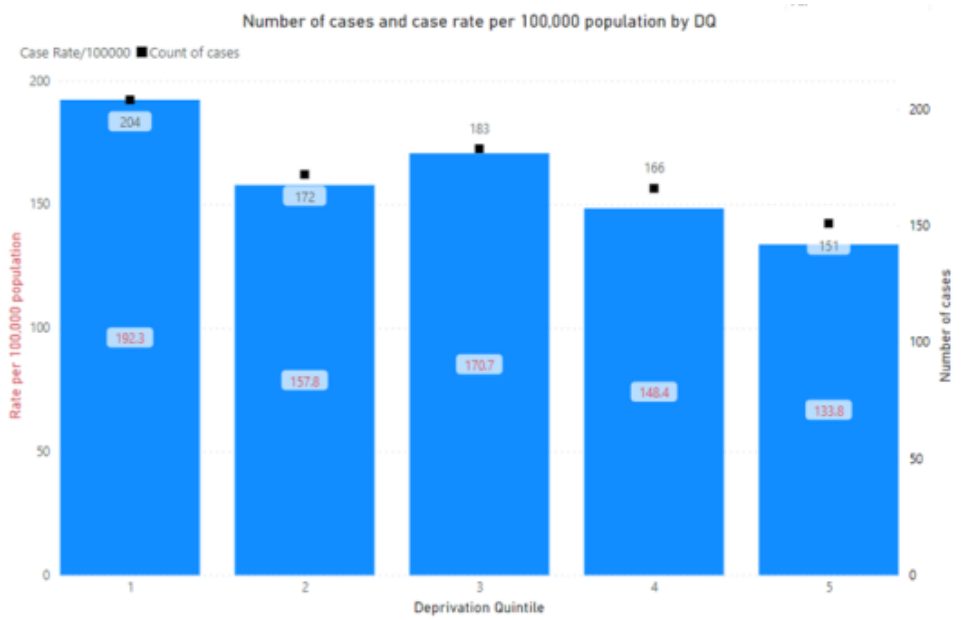


Deprivation

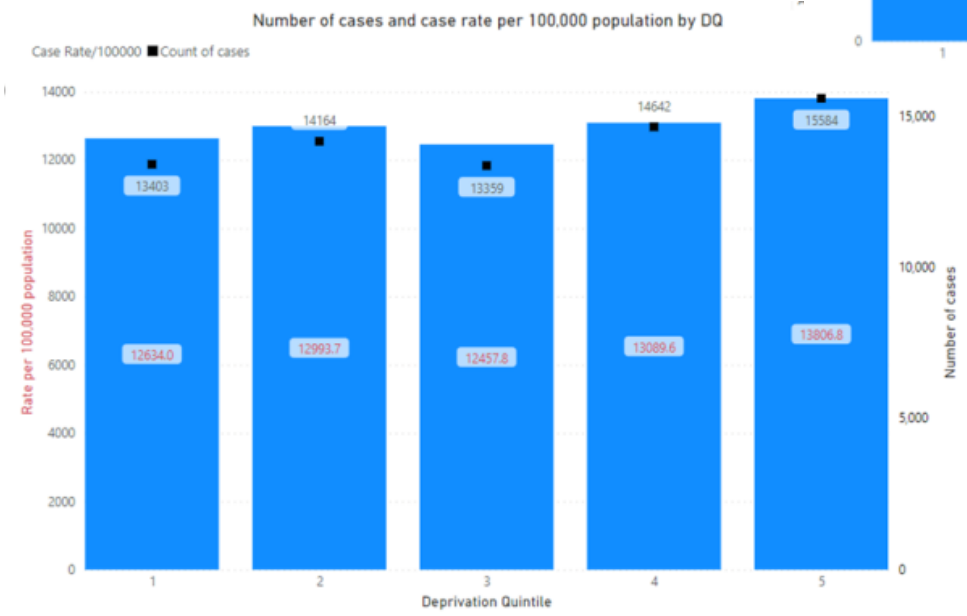
Cumulative case rate by deprivation shows higher rates in the more deprived areas.

The recent case rate shows a different trend with higher rates in the least deprived areas, although differences are not significant.

Latest week



Cumulative



Deprivation quintile 1 = least deprived within Buckinghamshire
Deprivation quintile 5 = most deprived within Buckinghamshire

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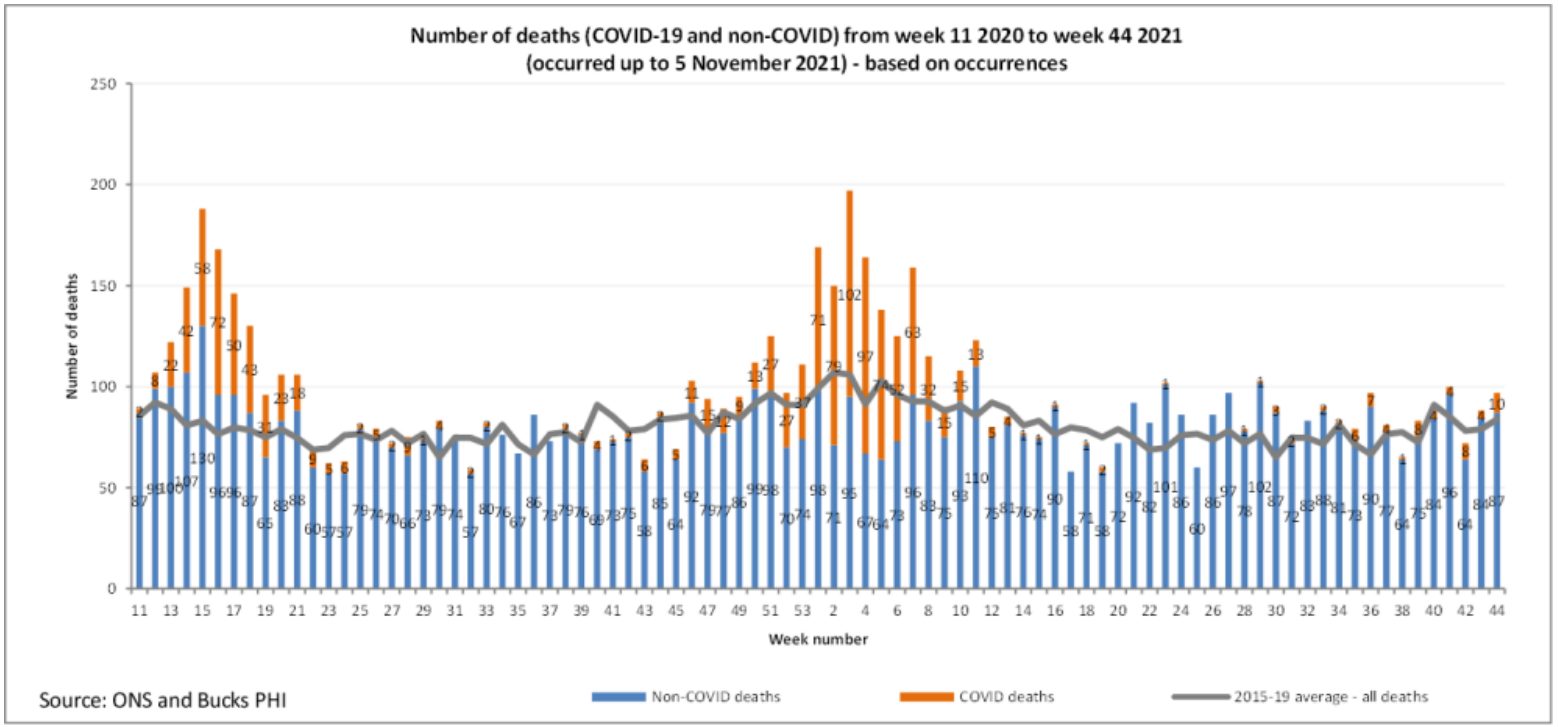
COVID-19 Hospital admissions-

	3 weeks before	2 weeks before	1 week before	Most Recent
New COVID Admissions	**11 to 17 Oct**	**18 to 24 Oct**	**25 to 31 Oct**	**1 to 7 Nov**
Buckinghamshire HT	26	26	27	27
Frimley Health	59	64	87	64
Milton Keynes	28	27	44	35
Total	**113**	**117**	**158**	**126**
Inpatients with COVID-19 (# of these in ICU)	**On 19 Oct**	**On 26 Oct**	**On 2 Nov**	**On 9 Nov**
Buckinghamshire HT	27 (4)	37 (3)	25 (2)	33 (3)
Frimley Health	56 (8)	90 (10)	96 (6)	83 (9)
Milton Keynes	33 (1)	33 (1)	45 (2)	47 (3)
Total	**116 (13)**	**160 (14)**	**166 (10)**	**163 (15)**

NB: Not all cases who are included above reside in Buckinghamshire. These data are publicly available data.

COVID-19 Related Deaths - Buckinghamshire residents



In the last reported week **(up to 5 November)**,
there were 1**0 deaths** related to COVID-19* for a Buckinghamshire resident.

1,286 COVID deaths overall, twice as many in the second wave compared to the first.

Data from the Office for National Statistics.

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COVID-19 Vaccinations - Buckinghamshire residents

- More than 86% of adults in Buckinghamshire have had one dose of Covid-19 vaccine and **more than 83% have had both doses.**
- However, this leaves just under **60,000 people** (aged 18+) **unvaccinated** and an additional **15,000 people** who have **only had one dose** within Buckinghamshire.
- Uptake has been highest in older age groups, 92% of people aged 40 and over have had one dose of Covid-19 vaccine and 90% have had both doses
- A booster programme for all adults aged 40 and over, people in flu/Covid-19 risk groups and household contacts of immunosuppressed people is being delivered.

Variation in vaccine uptake

- Younger adults, men, people living in more deprived areas and people from ethnic minorities (most markedly people from White Other and Black ethnic categories) are less likely to have been vaccinated
- Uptake has tended to be lower in areas that have persistently had the highest infection rates in Buckinghamshire (parts of High Wycombe, Aylesbury and South Bucks)
- Inequalities in uptake are being addressed through community outreach clinics, the Health on the Move bus and new NHS Bucks Vaccine Voices training

Health & Wellbeing Board Buckinghamshire

More information

For more information please see the Buckinghamshire COVID dashboard

https://covid-dashboard.buckinghamshire.gov.uk/

Domestic Violence and Abuse
Director of Public Health Annual report

Dr. Jane O'Grady

Director of Public Health

The size of the problem in Buckinghamshire

- Estimated 21,000 adults per year, or 57 people everyday.
- Significant under-reporting
- 4,000 victims of abuse crime recorded by police -71% women (20/21)
- 3,212 perpetrators - 72% men (10 months data)
- 15% of all recorded crime in Buckinghamshire.
- 15 domestic homicides 2011 – 2020.
- Using *estimated* numbers of victims in Buckinghamshire, cost of consequences ~ **£687m**.

Who is at risk of domestic abuse?

- Anyone
- Women 2x as likely to experience domestic abuse as men. 91% of domestic violence crimes causing injuries are against women.
- Increased risk in disabled adults , people with a learning disability , women with mental health problems
- unemployed, single parent households, mixed ethnic group, women from lowest household income bracket, LGBT and transgender people.
- Under-reporting by older people and poor ethnic coding.

Times of increased risk

- 4 - 9% pregnant women abused during pregnancy or soon after birth. Potentially 300-600 Buckinghamshire women affected annually.
- Leaving/preparing to leave partner
- Drug or alcohol use
- Football matches.

Perpetrators

- More likely to be male (72% in Buckinghamshire).
- 64% 40 years and under.
- Often a partner or ex-partner.
- Male perpetrators are more likely to seriously injure or kill their victim.
- Men committed 86% of the 357 domestic homicides in England and Wales 2017 – 2019.

Impact

- poor physical & mental health, chronic pain, memory loss, problems with daily activities, the consequences of sexual violence and “self-medicating” with drugs or alcohol.
- 16% of people experiencing domestic abuse consider or attempt suicide and 13% self harm.
- 1 in 5 high risk victims attended A&E with injuries in the year before getting help offering opportunities to detect and prevent further abuse.
- Increase risk of homelessness, poverty and impact on employment. Domestic abuse is 2nd most common reason for losing a home and it is estimated that 1 in 5 homeless women are homeless due to domestic abuse

Impact on children

- estimated 1 in 5 children are exposed to domestic abuse in UK.
- emotional, psychological, social, educational and developmental problems.
- moving home and school to escape a perpetrator
- a danger that children may in some cases begin to see abuse as normal behaviour.
- In 2020/21 in Buckinghamshire there were 2,400 referrals for social care assessment where domestic abuse was the primary concern (23% all children's social care referrals).
- 700 children were given children in need, child protection plans or became looked after. Accounted for half of all children who became looked after that year.
- **Long term consequences** - alcohol misuse, becoming a victim or perpetrator of domestic abuse, anti-social & risk taking behaviour, early pregnancy, homelessness, increased vulnerability to sexual exploitation & criminal behaviour.

Intimate partner homicides

- From 2009 to 2018 a woman was killed every four days by her partner or ex partner in the UK.
- Controlling behaviour by the perpetrator was the best predictor of homicide rather than a history of violence.
- Research has indicated predictable eight stages leading up to homicide . https://www.youtube.com/watch?v=lPF_p3ZwLh8

- Almost all cases perpetrator has history of coercive control, stalking or domestic abuse.
- Relationship moves at speed and is controlling.
- Triggers – loss of control over relationship/separation & escalation of control.

What works to prevent domestic abuse?

- School based awareness raising of domestic abuse.
- Campaigns to raise awareness of domestic abuse.
- Bystander interventions.
- Offering safe opportunities to seek help.
- Advocacy interventions with victims.
- Training healthcare professionals (including IRIS for GP surgeries).
- Independent domestic violence advisors.
- Multi agency risk assessment conferences.
- NICE quality standards.
- Need more research on perpetrator interventions.
- Need evaluation of all programmes to build evidence base

Reflections

- Prevention is key – wider societal attitudes, schools RSHE, bystander training, awareness raising and recognition of domestic violence, links with Violence Against Women and Girls Strategy
- Need better monitoring data to tell us who is affected, who is using services and what outcomes are in order to tailor services and ensure they are effective
- Develop services to meet the needs of all potential victims of DV and address gaps including housing and refuges
- Much more focus on perpetrators – primary & secondary prevention
- Learn from domestic homicide reviews

Recommendations in DPH report

1. Domestic Abuse Board should support awareness raising of domestic abuse via coordinated promotion of a national campaign.
2. DA Board should consider how to use and promote bystander training locally, to challenge domestic abuse as an evidence-based intervention.
3. Council Community Safety team should consider how to increase diversity within their domestic abuse champions scheme.
4. DA Board should develop and roll-out high-quality, shared, scenario-based training for stakeholders and front-line staff. Primary care should consider implementing IRIS training.
5. DA Board should oversee development of a referral pathway to ensure responsive services – fully understood by staff and accessible to victims seeking help.
6. DA Board agencies should support the development of an evidence base for perpetrator interventions, to inform commissioning of interventions and evaluation of effectiveness.

Questions for Health and Wellbeing board & partners - How can we make a difference ?

- What is your role in prevention, affecting wider social attitudes, bystander training ?
- What is your role in awareness raising and identifying instances of domestic abuse?
- What training do your staff have ? Is it sufficient , evidence based, comprehensive ? Do staff know where to refer ?
- How do you support people with domestic abuse and other issues ? How do you support your staff experiencing domestic abuse?
- How many domestic abuse champions do you have in your organisation and where are they ?
- What data do you have that could help tailor services ?
- How can we support the work of the Domestic Abuse Board ?