Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board agenda

Date: Thursday 18 November 2021

Time: 9.30 am

Venue: The Oculus, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF

Membership:

Cllr A Cranmer (Buckinghamshire Council), Cllr C Jackson (Buckinghamshire Council), Cllr A Macpherson (Buckinghamshire Council) (Chairman), Dr R Bajwa (Buckinghamshire Clinical Commissioning Group), Dr J O'Grady (Director of Public Health, Buckinghamshire Council), G Quinton (Corporate Director - Adults and Health, Buckinghamshire Council), J Baker OBE (Healthwatch Bucks), N Macdonald (Buckinghamshire Healthcare NHS Trust) (Vice-Chairman), R Majilton (Buckinghamshire Clinical Commissioning Group), R Nash (Interim Corporate Director, Children's Services, Buckinghamshire Council), Dr S Roberts (Buckinghamshire Clinical Commissioning Group), Dr J Sutton (Buckinghamshire Clinical Commissioning Group), D Williams (Buckinghamshire Healthcare NHS Trust), M Gallagher (Clare Foundation), K Higginson (Community Impact Bucks), Dr J Kent (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS)), Dr N Broughton (Oxford Health NHS Foundation Trust) and Cllr S Bowles (Buckinghamshire Council) and Dr K West (Buckinghamshire Clinical Commissioning Group).

Webcasting notice

Please note: this meeting may be filmed for live or subsequent broadcast via the council's website. At the start of the meeting the chairman will confirm if all or part of the meeting is being filmed.

You should be aware that the council is a data controller under the Data Protection Act. Data collected during this webcast will be retained in accordance with the council's published policy.

Therefore, by entering the meeting room, you are consenting to being filmed and to the possible use of those images and sound recordings for webcasting and/or training purposes. If members of the public do not wish to have their image captured they should ask the committee clerk, who will advise where to sit.

If you have any queries regarding this, please contact the monitoring officer at monitoringofficer@buckinghamshire.gov.uk.

Agenda Item		Time	Page No
1	**Welcome**	**09:30**	
2	**Apologies**		
3	**Announcements from the Chairman**		
4	**Declarations of Interest**		
5	**Minutes of the previous meeting** To agree the minutes of the meeting held on 22 July 2021.		**5 - 14**
6	**Public Questions** In order for a response to be provided at the November Health and Wellbeing Board, questions must be received by 9.00 am on Monday 15th November 2021. Any questions received after this deadline will be responded to at the following Health and Wellbeing Board meeting.		
7	**Covid-19 - Cases in Buckinghamshire Update** To understand the current position and the impact of long Covid-19 in Buckinghamshire Dr Jane O'Grady, Director of Public Health, Buckinghamshire Council. Neil Macdonald, Chief Executive Officer, Buckinghamshire Healthcare NHS Trust.	**09:40**	
8	**Partner Reports - Healthwatch Bucks Update** Jenny Baker OBE, Chair of Healthwatch Bucks.	**10:00**	**15 - 22**
9	**Integrated Care Partnership Update** **Better Care Fund bi-annual update** Tracey Ironmonger, Service Director, Integrated Commissioning, Buckinghamshire Council. **Systems Winter Planning** Caroline Capell, Director of Urgent and Emergency Care, Buckinghamshire Integrated Care Partnership (ICP).	**10:10**	**23 - 76**

10	**Access to GPs/Primary Care Access in Buckinghamshire** Jessica Newman, Head of Primary Care, Buckinghamshire Clinical Commissioning Group.	**10:30**	**77 - 80**
11	**Engagement Strategy** Cat Spalton, Head of Communications and Engagement, Buckinghamshire Council.	**10:50**	**81 - 86**
12	**Director of Public Health Annual Report - Domestic Violence and Abuse** Dr Jane O'Grady, Director of Public Health, Buckinghamshire Council.	**11:00**	**87 - 128**
13	**Any Other Business** **Joint Health and Wellbeing Strategy** **Update on the Start Well action plan** David Williams, Director of Strategy and Business Development, Buckinghamshire Healthcare NHS Trust. **Update on the Age Well action plan** Jacqueline Boosey, Business Manager, Health and Wellbeing, Buckinghamshire Council.	**11:20**	
14	**Date of next meeting** 27 January 2022	**11:30**	
15	**For information** The work programme has been included for information.		**129 - 130**

If you would like to attend a meeting, but need extra help to do so, for example because of a disability, please contact us as early as possible, so that we can try to put the right support in place.

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

This page is intentionally left blank

Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board minutes

Minutes of the meeting of the Health and Wellbeing Board held on Thursday 22 July 2021 in The Oculus, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF, commencing at 10.05 am and concluding at 12.03 pm.

Members present

C Jackson, A Macpherson (Chairman), Dr J O'Grady, G Quinton, J Baker, N Macdonald, M Gallagher, K Higginson and Ms D Richards

Others in attendance

J Boosey, S Taylor, S James, R Stanton, J Pimm, S Robinson, T Jervis, T Ironmonger, E Biggs, M Tait, K Holmes

Agenda Item

1 Welcome and Confirmation of Chairman and Vice-Chairman

Cllr Angela Macpherson introduced herself as the Deputy Leader of Buckinghamshire Council and the Cabinet Member for Health and Wellbeing and stated that, in accordance with the Council's constitution and the Health and Wellbeing Board (HWB) Terms of Reference, she had been appointed Chairman of the Board. The Chairman thanked, the previous Chairman, Cllr Gareth Williams for his excellent delivery.

The Chairman advised that, due to the changes proposed in the Health and Social Care Bill, the Integrated Care Partnership (ICP) was considering its nominee for the position of Vice Charman and it would be confirmed at the next meeting in October.

2 Apologies for Absence

Changes in membership

- Dr Nick Broughton, Chief Executive, Oxford Health NHS Foundation Trust had been replaced by Debbie Richards, Managing Director, Oxford Health NHS Foundation Trust.
- Tolis Vouyioukas, Corporate Director, Children's Services had left BC and Richard Nash was now the Interim Corporate Director for Children's Services and a member of the Health and Wellbeing Board.

Apologies:

Apologies had been received from Dr Karen West, Robert Majilton, Dr Juliet Sutton, Dr James Kent, Richard Nash, Dr Raj Bajwa, David Williams, Cllr Anita Cranmer, Zoe McIntosh, Dr Sian Roberts and Helen Mee.

Substitutions:
Simon James, Service Director for Education attended in place of Richard Nash.
Matthew Tait, Deputy ICS Lead/Director of CCG Transformation attended in place of Dr James Kent.
[It was not announced during the meeting but Kate Holmes, Interim Chief Finance Officer, NHS Buckinghamshire Clinical Commissioning Group attended in place of Robert Majilton and Dr James Kent].

3 Announcements from the Chairman
There were no announcements from the Chairman.

4 Declarations of Interest
There were no declarations of interest.

5 Minutes of the previous meeting
Resolved: The minutes of the meeting held on 1 April 2021 were **agreed** as an accurate record.

6 Public Questions
One public question had been received from Mike Etkind of the John Hampden Patient Participation Group. Jacqueline Boosey, Business Manager, Health and Wellbeing, read out the question:

"Lockdown has shown the valuable contribution the public can make to health and social care. This is one reason why the public should know what is happening at system, place and neighbourhood and be able to have a say.

Could the Health and Wellbeing Board advise what role it will play in ensuring the work and decisions of the ICS involve engagement with the public, including providing accessible and understandable information beyond just having meetings in public with published papers?

For example, will the health and wellbeing action groups of Community Boards be fully engaged and involved? And will there be any public consultation over how the ICS will deliver two commitments in the papers under agenda item 11

- *to "support place and neighbourhood-level engagement to link with communities", and*
- *to "invest in local community organisations"?"*

The Chairman apologised that the question had only come to light just before the meeting and advised that a full response would be provided to Mike Etkind and published before the next meeting.

7 Covid-19 in Buckinghamshire
Dr Jane O'Grady, Director of Public Health, provided a presentation, appended to the minutes. Dr O'Grady gave an update on the cases in Buckinghamshire and

stated that the cumulative total of cases was 38,607 cases and 1,219 deaths. The death rate was similar to the south east rate but lower than the England rate. Maps were shown of the cumulative case rates over last the year for the different areas in Buckinghamshire; the rates varied across the county, with higher rates in deprived areas and areas with a higher ethnic population. The graphs of the age of people with covid-19 in Buckinghamshire showed that the highest rates were currently amongst the 19-24 year olds. The low number of cases in the older age groups was testament to the effectiveness of the vaccine. Hospital admissions were rising before 19 July 2021 and with the impact of the easing of restrictions was expected two to three weeks after that date. Dr O'Grady emphasised the need to take things slowly to avoid a massive peak of hospital admissions. The vaccination programme had been successful with more than 84% of adults in Buckinghamshire having received the first dose and 65% had received two doses. However, one third of the population were not in receipt of their second dose and the more infectious variant required that both doses were needed for protection. The vaccine uptake had been excellent in the older age groups, but younger people needed to come forward, particularly younger men and some key ethnic groups. Dr O'Grady stressed that the vaccine was good, but it was not 100% effective so care was needed to avoid a surge in cases which would put a strain on the health care and other services.

The following key points were raised in discussion:

- The Chairman echoed the message of caution and asked what work was being carried out to increase the uptake. Dr O'Grady explained that vaccine clinics were being held in community venues e.g. mosques; the vaccine bus was going to areas to take the vaccine to people. There was also an NHS training programme called "Vaccine Voices" which trained people to provide the facts and give them the tools to encourage vaccine uptake.
- Following a query from Jenny Baker, Chair of Healthwatch Bucks on whether there was a communications policy on the key messages that could be used by Healthwatch Bucks it was agreed that the BC Comms Team would link in with Healthwatch Bucks.

  ACTION: Kate Holmes/Jacqueline Boosey
- Work was being undertaken with all groups to ensure maximum uptake.
- Neil Macdonald, Chief Executive Officer, Buckinghamshire Healthcare NHS Trust advised that the number of people in hospital with Covid was rising but there was lower ratio who required mechanical ventilation than previously. Approximately a third of the admissions had received one vaccine. There had been an increased demand for paediatric services. Other non-covid service demand was extremely high, and the work force was not immune from isolation pressure and the peak was expected in mid-late August.
- Work was being carried out on the implementation of the flu/Covid vaccine booster programme.
- Debbie Richards, Managing Director, Oxford Health NHS Foundation Trust advised that the mental health team had been working with primary care to ensure those with a serious mental illness or learning disability were prioritised. The team had also been working on vaccine hesitancy. Debbie

acknowledged the efforts of all the NHS staff working under the current heatwave and pressurised conditions.

- Neil Macdonald advised that during the first two waves of the pandemic, paediatric demand was rare; however, recently a few children had been admitted with Covid and, unusually for this time of year, there had been admissions for other respiratory illnesses in children due to the suppression of the usual viruses during the lockdown period.
- Simon James, Service Director for Education stated that secondary schools were experiencing increasing numbers of Covid cases and the Service would continue to raise awareness around the importance of lateral flow testing.
- In response to whether any information was available on the vaccine uptake in pregnant women; Kate Holmes advised that she thought Buckinghamshire was in line with the national average but could track the number. Kate stated that several webinars had taken place and the Vaccine Voices programme was being linked in with the midwives to encourage uptake.

ACTION: Kate Holmes

Resolved: The Health and Wellbeing Board members **noted** and **approved** the Local Outbreak Management Plan.

8 Partner Reports

Healthwatch Annual Report

Jenny Baker, Chair of Healthwatch Bucks, provided a presentation, appended to the minutes. Jenny advised that Healthwatch Bucks was legally obliged to produce an annual report. The report provided a high level summary of what had been carried out during last year, particularly in response to the pandemic. Healthwatch Bucks was a publicly funded independent champion for the residents of Buckinghamshire and received funding from the Council for their core contract. The three year contract from April 2020 also included Independent Complaints Health Advocacy and community engagement. Healthwatch Bucks was supported by Healthwatch England and collaborated with the ICP and the voluntary, community and social enterprise (VCSE) sector. A summary slide provided the results from the work carried out last year, much of which was carried out online due to lockdown. Healthwatch Bucks had been awarded 'highly commended' by Healthwatch England for their work with veterans. Their priorities for 2021-21 were the Covid 19 response and recovery, mental health and primary and community care, with cross-cutting themes across all of these in lesser - heard voices and integrated care.

The Chairman thanked Healthwatch Bucks for their work during the pandemic and emphasised the importance of hearing the voice of service users and residents and asked Jenny to provide an update for every agenda.

Resolved: The Board **noted** the work and achievements of Healthwatch Bucks in 2020/21, **noted** Healthwatch Bucks plans and priorities for 2021/22 and **considered** how Healthwatch Bucks could further help the Health and Wellbeing Board and health and social care providers ensure the residents' voice was well represented in decisions made about health and social care during recovery from Covid-19 and beyond.

Community Impact Bucks – Improving Partnership Working

Rachel Stanton, Programme Manager for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) VCSE Alliance and Health Partnership Programme, provided a presentation, appended to the minutes. Rachel stated that the leadership programme was responsible for developing and maximising the contribution that the VCSE played within the regional BOB wide health structures. It aimed to facilitate better partnership working between Health and Social Care and the VCSE sector and supported the development of a VCSE leadership 'alliance' at a system level, with mechanisms for feeding into all levels of decision making across the ICS. It was expected that by April 2022, the ICPs and the ICS NHS body would develop a formal agreement for engaging and embedding the VCSE sector in the system level governance and decision-making arrangement, ideally working through a VCSE alliance to reflect the diversity of the sector. Since Covid, the NHS and VCSE had been able to reach out to the harder to reach communities that sometimes the statutory organisations did not have the capacity to work towards engaging. A work shop had been held recently, the details would be published, and a formal agreement would be developed. There was a commitment to involving the VCSE in the ICS governance and to formalise the VCSE as a strategic partner supporting the functions in the ICS to deliver integrated care. There was also a commitment to involve the VCSE in shaping the plans to tackle wider determinants of health and to have a role in population health management to capture and share intelligence data from communities into the ICS alongside Healthwatch. A diagram was shown of where the VCSE Leadership Group Alliance sat in the new health structure and what the BOB-wide Alliance would do. The launch of the first VCSE alliance meeting had been held and several organisations/people had signed up and four sub-groups would be established which would then feed into the ICS workstream. The Alliance would continue to map members, develop relationships with the ICS and the ICP, continue to interpret NHS England's development framework and develop the formal agreement between the VCSE Alliance and ICS.

The following key points were raised in discussion:

- Martin Gallagher, CEO, Clare Foundation and Katie Higginson, CEO, Community Impact Bucks, offered to their help to reach out to smaller organisations to ensure an inclusive forum.
- Jenny Baker stressed the importance of aligning national health and social care organisations which had local representation with the Alliance, as they were an important channel for collecting the views of patients. Rachel advised she had already started engaging with some of the organisations but there was still a way to go and would be a priority in the next six months.
- Katie Higginson summarised that there had been some excellent examples of collaborative work between the health partners and voluntary sector over the last year and that Rachel's role was to work across the BOB area to draw the threads together and create a structure at a regional level.

The Chairman thanked Jenny and Rachel for their presentations.

9 Joint Health and Wellbeing Strategy Live Well Action Plan

Jacqueline Boosey, Business Manager, Health and Wellbeing, advised that at the HWB meeting in February 2021, members agreed that future meetings would be themed around the three priorities in the Joint Health and Wellbeing Strategy. The action plans would be provided to the Board to provide assurance that actions had been progressed and to show that better outcomes had been achieved for the residents of Buckinghamshire. The draft Live Well Action Plan, which had been produced in collaboration with all partners had been included in the agenda pack. It was a live document and further engagement would take place over the summer and brought back to the Board in October.

Gill Quinton, Executive Director, Adults and Health, emphasised the importance of how the impact of the action plan was measured and how the Board would oversee and review the outcomes to ensure the plan was impacting residents.

Neil Macdonald, Chief Executive Officer, Buckinghamshire Healthcare NHS Trust, added that focussing on a fewer number of priorities and doing them well was helpful. The Health Index for England from the ONS had a set of comparative data which would be a useful resource for the Board to use as tool to monitor success.

Gill Quinton advised that there were initiatives being worked on across the ICP which had not been included in the action plan and should be fed back to J Boosey. The Chairman requested that all Board members feedback on any missing items.

ACTION: Members of the Board to contact J Boosey with details of any missing initiatives.

ACTION: J Boosey to develop the first draft of the action plans and consider metrics to review outcomes.

Resolved: The Board **considered** and **approved** the Live Well Action Plan, one of the Start Well, Live Well, Age Well priorities in delivering the Happier Healthier Lives Bucks Joint Health and Wellbeing Strategy.

10 Joint Health and Wellbeing Strategy - Live Well Mental Health Deep Dive

The Chairman welcomed John Pimm, Clinical Lead for Oxford Health NHS Foundation Trust's Healthy Minds Service in Buckinghamshire; Samantha Robinson, Head of Buckinghamshire Adult Service for Oxford Health; Thalia Jervis, CEO, Citizens Advice Bucks; Tracey Ironmonger, Service Director, Integrated Commissioning and Liz Biggs, Public Health Principal to the meeting.

A presentation was provided, appended to the minutes. Tracey Ironmonger introduced the item and advised that the presenters would give an overview of the diverse range of mental health services in place to support adults in Buckinghamshire, a number of which were commissioned from and delivered by Oxford Health.

Samantha Robinson stated that the 'Adult and Older Adult Services' included all

community and inpatient services in Buckinghamshire for over 18 year olds and ranged from crisis services, specialist services in the acute trust, specialist community teams for perinatal, early intervention services and generic community health teams. There had been a huge increase in demand during the pandemic, but the Service had continued to develop innovative new services such as the Crisis line. Calls remained steady and referrals to the crisis team, which was established in January 2020 and covered the whole county, continued to rise, and offered alternatives for individuals in crisis. Referral rates had risen by 46% and there was currently a caseload of approximately 3200 across the teams. A mental health community hub had been developed in Easton Street, High Wycombe which bought together a range of mental health teams under one roof to provide improved and integrated high quality services. There had been a decrease in referrals at the start of the pandemic, but the last two months had seen the largest number of referrals since the inception of the service.

John Pimm advised that the Healthy Minds Service worked with people who experienced anxiety and depression; the most common form of mental health difficulty and affected over 45,000 adults in Buckinghamshire at any one time. The Service provided evidence based treatments for anxiety and depression and associated physical health conditions. It was an integrated service and worked with services in BHT and others. There was also an integrated employment service as part of the Healthy Minds service which was provided by the Richmond Fellowship embedded with the Healthy Minds team. Over 8,000 people were seen last year and the number was expected to rise to 14,000 by 2023/24 due to increased population estimates. The workforce needed to be developed/expanded and the service was working with the University of Oxford, Reading and other universities to train new psychological therapists. Oxford Health had also developed the first psychological wellbeing practitioner apprenticeship programme in the country with Bucks New University which had just been accredited by the British Psychological Society. Healthy Minds accepted professional and self referrals and these could be made on-line through the web site, telephone etc. The number of people being seen in the service was expanding rapidly, over 800 per month at present. To improve access, the Service launched an on line Choose and Book system in July 2021 and the majority of people now booked their own appointment on line when they self referred. The service had capacity to see more people and was carrying out a programme to reach out to all communities in Bucks to encourage people experiencing anxiety, depression or stress who could benefit to self-refer.

Liz Biggs explained that she was the suicide prevention lead in the Public Health team. The Suicide Bereavement Support Service had been commissioned in April 2020 to support families bereaved by suicide and was supported by Bucks Mind. Feedback from the one year evaluation had been extremely positive. The Service would be continuing, and work was being carried out as to whether services could be aligned across the BOB area. A bid for national funding for suicidal prevention had been successful and would focus on three key areas; follow up for presentations of repeated self-harm or attempted suicide; a BOB Training and Education lead and enhanced Real Time Suicide Surveillance (RTSS). There was also suicide prevention

grant funding available for the voluntary and community sector focused on prevention of male suicide.

Thalia Jervis explained she was attending in place of Andrea McCubbin, CEO, Bucks Mind, who jointly chaired the Covid-19 Mental Health Voluntary Sector Response Group with Oxford Health. The Group was set up in April 2020 and comprised of over 20 organisations. The Group had made a significant impact; particularly in sharing of resources and peer support which, particularly for smaller organisations during the pandemic, had been critical and had enabled them to respond appropriately. An important aspect had been the enhanced dialogue between the VCSE, Public Health, Primary Care and BHT and the ability to amplify key messages.

The following key points were raised in discussion:

- It was noted that the Community Boards could be a conduit through which to develop activity in the communities as a preventative arm.
- In response to a query on whether there had been any generational research on the digital therapy interventions; J Pimm stated that the digital interventions had been evaluated and recovery rates were as good, or better, as they removed barriers for many people. Older people were doing well with the digital interventions, but it was acknowledged that not all people were able to access digital services and wanted a choice of options.
- A member of the Board asked about the availability of specialist mental health inpatient and residential services and whether any work could be carried out to improve the supply of residential places. S Robinson advised that the Service had partnered with a housing provider to improve pathways out of hospital which had helped patient flow, but the options were not as plentiful as required and placements, as a whole, was an area where partnership working would be beneficial.

The Chairman thanked all the presenters and stated that mental health was as important as physical health and was keen that it was visible and recommended having a follow-up session in six months' time with data on the interventions.

ACTION: J Boosey to add to the forward plan.

11 Integrated Care System (ICS) Design Framework

Matthew Tait, Deputy ICS Lead/Director of CCG Transformation provided a presentation, appended to the minutes, and advised he was attending on behalf of Dr James Kent who was the lead on the development of the Integrated Care System (ICS) Design Framework. M Tait advised that the key purposes of the framework were to improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money and support broader social and economic development. Structural changes would be required, and an ICS Partnership would be set up (a broad partnership that could be based on the principle of how HWBs operated) and a formal ICS NHS body which would discharge the statutory functions. The important element of the ICS Partnership and key change was that it would involve core membership of provider

representation and also local authority representation and would be a different model of governance and leadership that was more inclusive and more integrated. Place based partnership was also an important element of the model and CCG functions would migrate to the ICS. The majority of the delivery happened at place and the place based partnership would be critical to the delivery of outcomes. The clinical leadership would need to change, and work was being undertaken with the staff to create as much stability as possible with a programme board to oversee the whole development piece. Locally, have recently set up a programme board to oversee development. Work had commenced on understanding place based partnerships and engaging at a local level and any thoughts and feedback around how engagement could take place with the HWB would be welcomed. Recruitment for the Chair was imminent, followed by the appointment of the Chief Executive.

The following key points were raised in discussion:

- In response to being asked what the ICS's commitment was for working with the VCSE; M Tait advised that the VCSE was an essential part of the integration and that he was working with Rachel Stanton to develop the right interfaces for the emergent ICS governance.
- M Tait confirmed that the VSCE would have a place on the ICS Board and stressed the importance of not duplicating the really effective, well established links that were happening at place.
- M Tait confirmed that engagement would take place with Healthwatch Bucks on the best way for them to be represented and how they linked into the formal governance structure of the ICS Board. M Tait again stressed the importance of not duplicating or undermining the excellent relationship with residents that was already in place.
- The Chairman asked for M Tait's thoughts on political engagement and at what level it would be and how work could be undertaken together with the HWBs across the BOB footprint. M Tait stated that the political engagement would be part of the partnership board debate on how the ICS Board flexed between political and officer engagement. There needed to be an effective delegation model in place due to the amount of engagement that occurred at place level. The ICS had a role and needed to work on how it engaged on big configurations across multiple boundaries, including the HWBs and Members in order to get the balance right; any ideas would be appreciated.

The Chairman thanked Matthew for attending the meeting and it was agreed that the ICS Design Framework would be bought back to the Board as it evolved.

ACTION: J Boosey to add to the forward plan.

12 Any Other Business

Pharmaceutical Needs Assessment (PNA)

Dr Jane O'Grady, Director of Public Health, stated that the PNA was a statutory responsibility and was used to inform the commissioning of pharmacy services by the NHS and was next due in October 2022. It was a significant piece of work and guidance was expected this summer, after which arrangements would be made to

commission the work.

Health and Wellbeing Terms of Reference Annual Review

Jacqueline Boosey, Business Manager, Health and Wellbeing, had previously noted the changes in membership following the elections in May 2021. The Terms of Reference would be amended to include Cllr Carl Jackson, Deputy Cabinet Member for Public Health. The Chairman also recommended that the Cabinet Member for Communities, due to the involvement of the VCSE sector work on the Board, be a Member of the Board, making a total of four Buckinghamshire Council Members.

Resolved: The HWB Members **agreed** to the Deputy Cabinet Member for Public Health and the Cabinet Member for Communities being Members of the Health and Wellbeing Board.

Debbie Richards, Managing Director, Oxford Health NHS Foundation Trust, declared an interest as having previously worked for the Clinical Commissioning Group.

The Chairman highlighted the papers which had been included in the agenda pack for information/note. No comments were received regarding the papers.

13 Date of next meeting

Thursday 14 October 2021 at 10.00 am.

14 For information

Resolved: The papers were **noted** by the Members of the Health and Wellbeing Board.

Health & Wellbeing Board Buckinghamshire

Date: 18 November 2021

Title: Healthwatch Bucks update (September 2021)

Author and/or contact officer: Zoe McIntosh, Chief Executive Healthwatch Bucks

Report Sponsor: Jenny Baker OBE, Chair of Healthwatch Bucks

Purpose of Report: Feedback from residents on Health and Social Care services in Buckinghamshire

Report for information, discussion, decision or approval: For information

Recommendations:

- Note findings of the report

Executive Summary

We are one of 148 independent Local Healthwatch organisations set up by the government under the Health and Social Care Act 2012. Our role is to ensure that health and social care services put the experiences of people at the heart of their work.

This paper summarises recent project work we have undertaken in relation to health and social care services, as aligned with the priorities of Joint Health & Wellbeing strategy. We have also included a brief summary report looking at feedback about Primary Care services.

This page is intentionally left blank

Healthwatch Bucks update (September 2021)

This paper summarises recent project work we have undertaken in relation to health and social care services, as aligned with the priorities of Joint Health & Wellbeing strategy. We have also included a brief summary report looking at feedback about Primary Care services.

Live Well

Remote Mental Health Survey

Due to the COVID-19 pandemic, many people had their face-to-face mental health support stopped. To make sure people could still access support, remote support was offered.

Healthwatch Bucks have attended the Buckinghamshire Mental Health COVID-19 strategic response group since April 2020. From this, we became aware that remote appointments were an area lacking in service user feedback.

We wanted to find out about the patient experience of remote support for mental health treatment from adult mental health services since April 2020.

We designed a survey, working closely with Oxford Health NHS Foundation Trust who run mental health services in Buckinghamshire. Our survey ran online during May and June 2021.

We wanted to find out:

- About the treatment people had received
- Any previous treatment they had
- Changes made to their treatment since the COVID-19 pandemic
- Access to their support
- Their experiences of appointments.

In total, we received 54 valid responses. Our report – including our recommendations -can be accessed here Remote Mental Health Survey Report — Healthwatch Bucks

Direct Payment project

This work sat outside our core Healthwatch role and was a piece of work that Buckinghamshire Council asked us to undertake to find out about people's experience of Direct Payments.

We heard from 127 people through a survey, focus groups and telephone interviews between June – July '21. Our report made a number of recommendations to the Council including making the wording on the Direct Payment policy clear and concise, using a variety of formats to make the policy accessible to all and providing more support and training to those in receipt of direct payments.

Voices report

Part of our role at Healthwatch Bucks is to collect feedback on local Health and Social Care services. We do this in a number of ways including our signposting service and the 'rate and review' facility on our website.

Voices September 2019 to September 2021

Introduction

This is short summary of the voices data we have gathered from September 1st 2019 to September 14th 2021. We have mainly focused on Primary Care services.

We have tried to exclude questions and comments we collected about vaccine availability.

All Voices

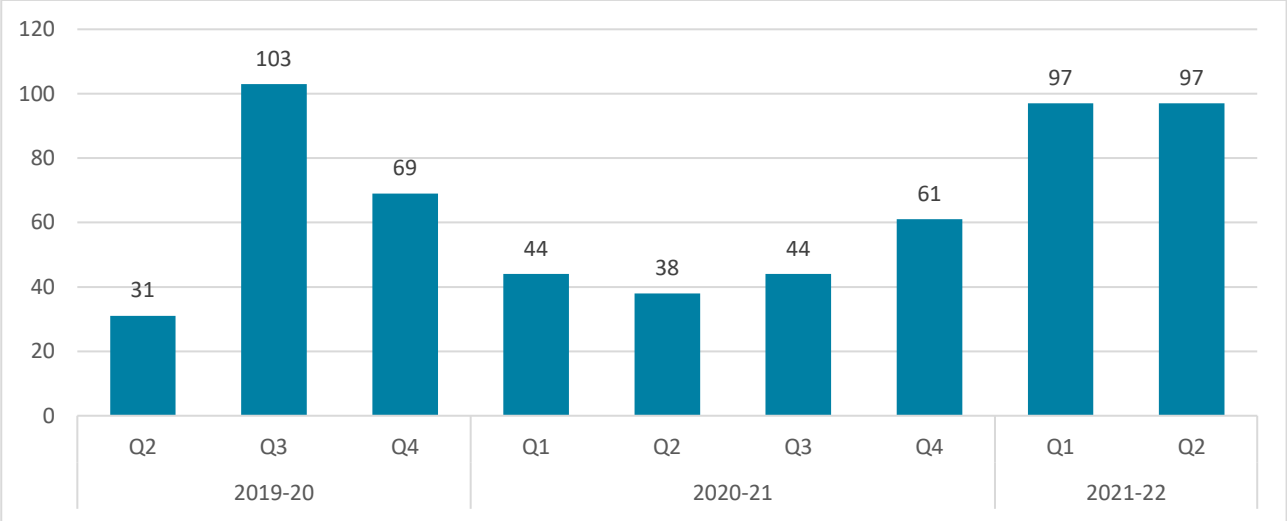


Figure 1 - Voices collected by Year and Quarter

In Figure 1 there is a clear dip in Q1 to Q3 of 2020-21 which coincides with national lockdowns and restrictions. We assume less people used health services and so we received less feedback.

The rate of feedback picks up again as we enter 2021.

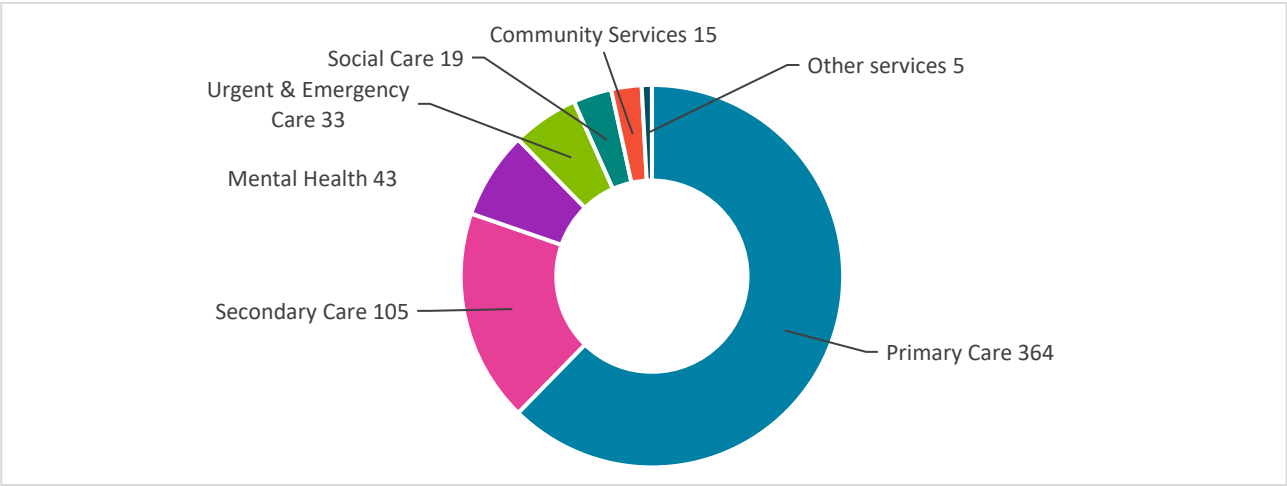


Figure 2 - Voices by Service Type

Figure 2 shows that the majority of comments we have collected are about Primary Care (66%). Following this, Secondary Care makes up just 14% of the feedback.

Primary Care

Figure 3 below shows when these Primary Care Voices were collected. Feedback about Dentistry has featured more often since April 2021. Our feedback about General Practice has doubled in this time.

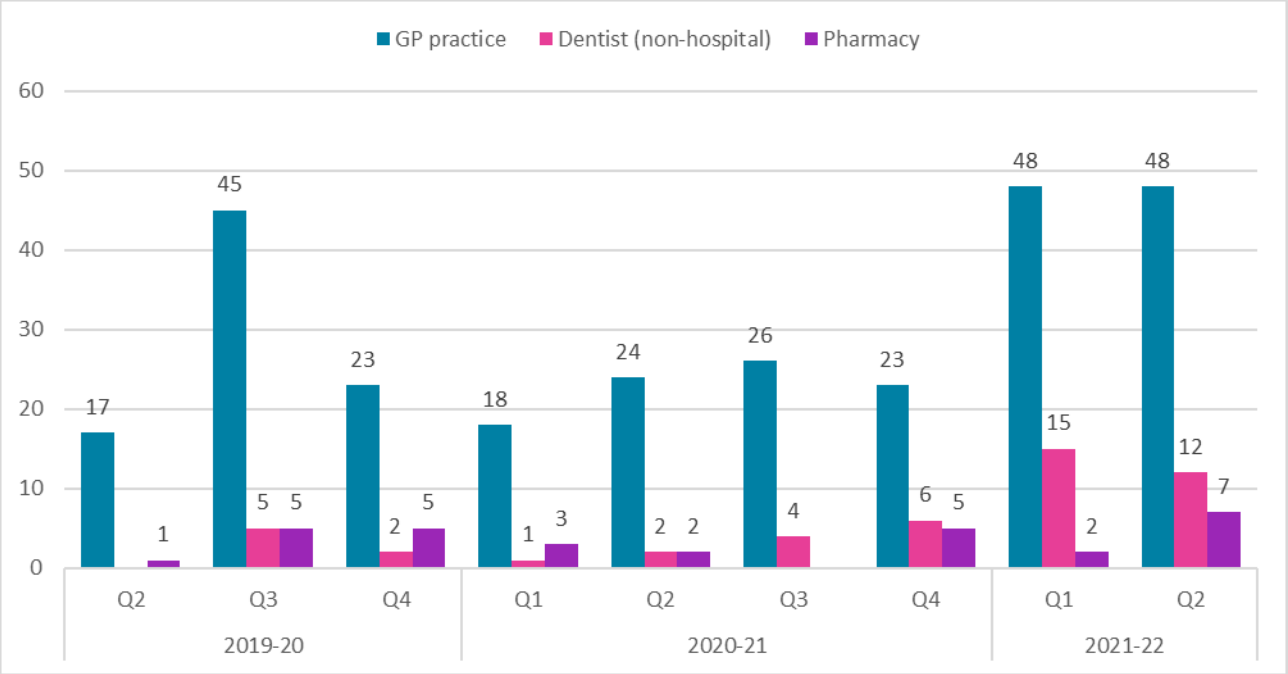


Figure 3 - Primary Care Voices by Type, Year and Quarter

We can look at the sentiment of the comments for Primary Care, as shown in Figure 4. We can see a clear increase in the number of negative comments.

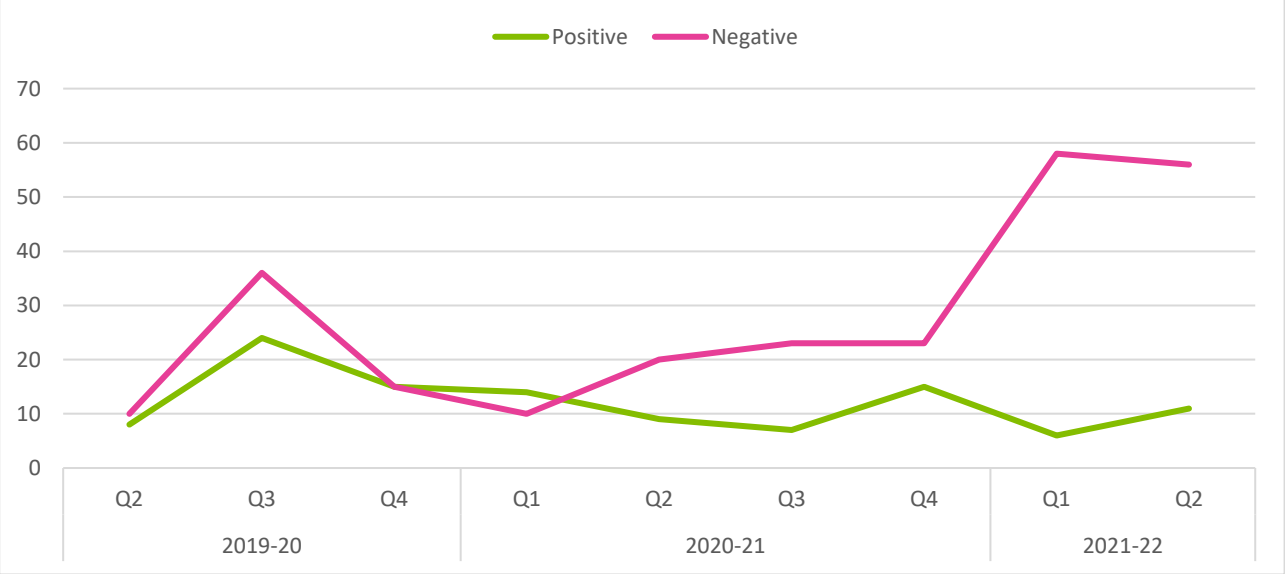


Figure 4 - Sentiment of Primary Care Voices by Year and Quarter

Themes in Primary Care

All of the feedback we collate is categorised according to what aspects of the service the comment was about. This is the most important aspect of the data we collect. With this information we can see where things are good and where improvements might be made.

Figure 5 shows the top 10 negative themes across Primary Care for the whole period (Sept 2019 – Sept 2021)

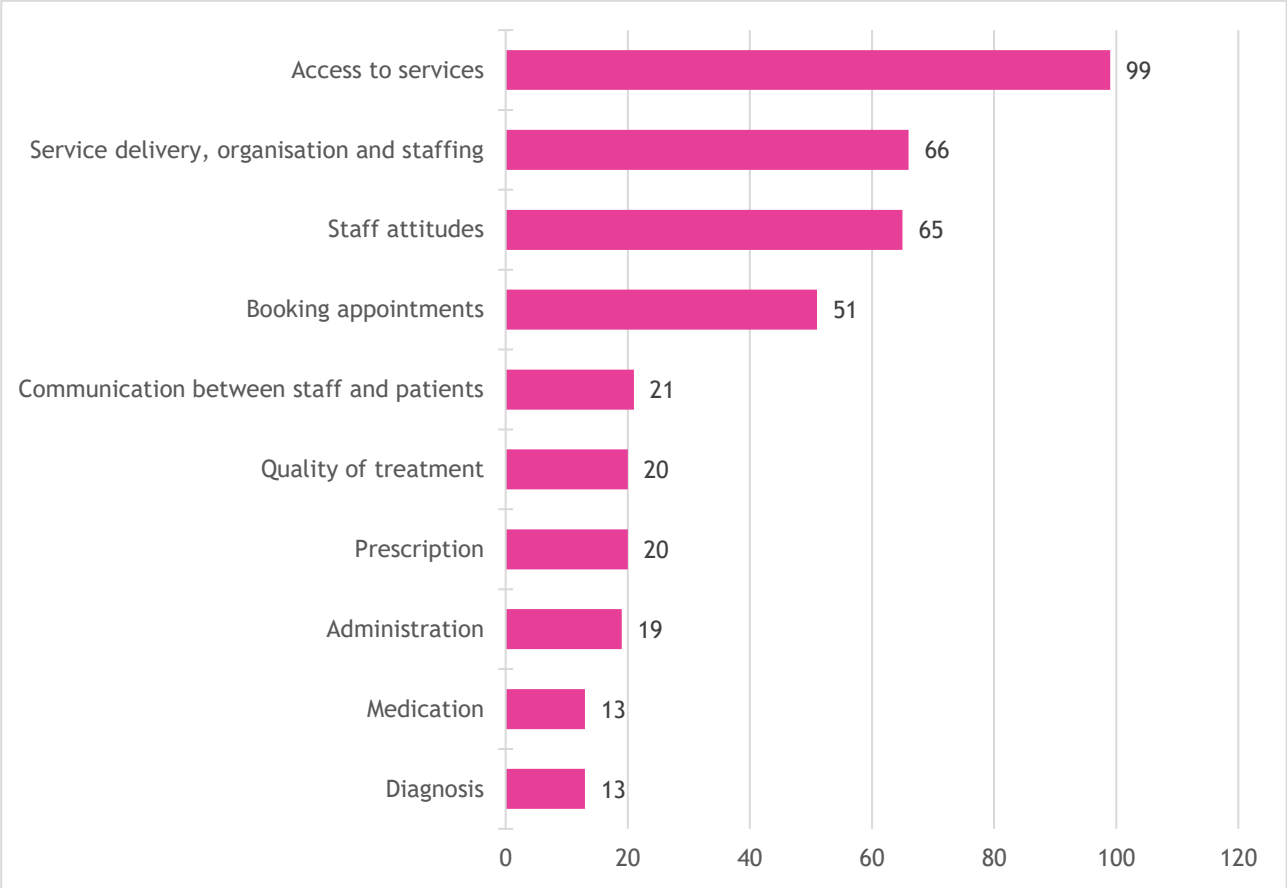


Figure 5 - Top 10 Negative Themes in Primary Care

We can look at positive themes in the same period, as shown below in Figure 6.

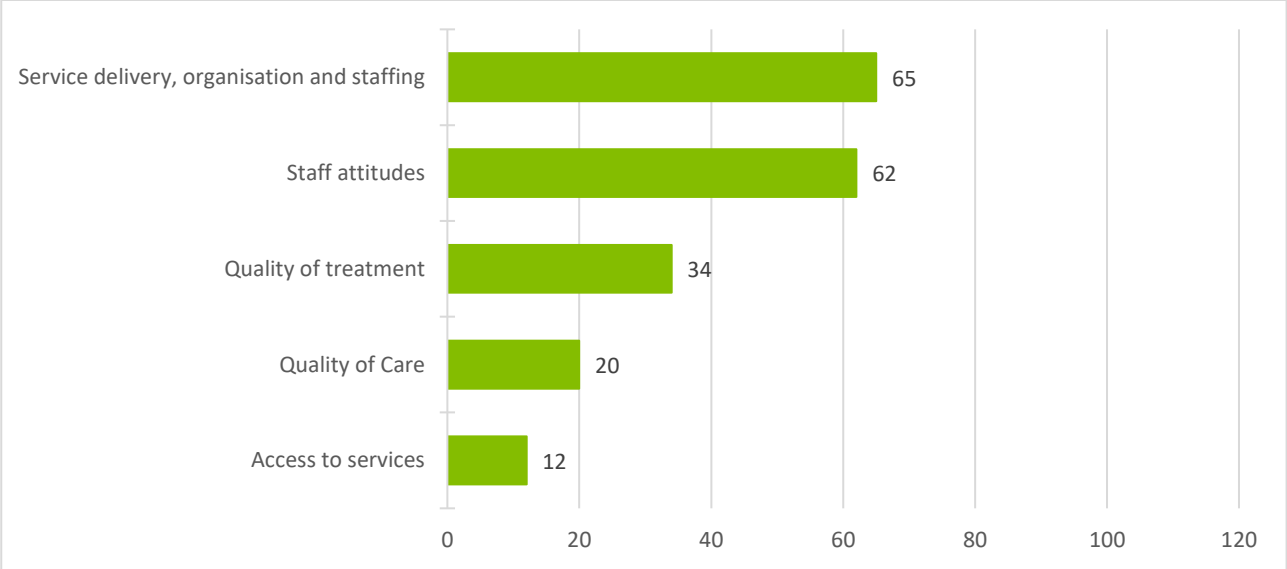


Figure 6 - Top 5 Positive Themes in Primary Care

Access to Services

If we look more closely at this theme by date, we can see that this has become much more of an issue since April 2021.

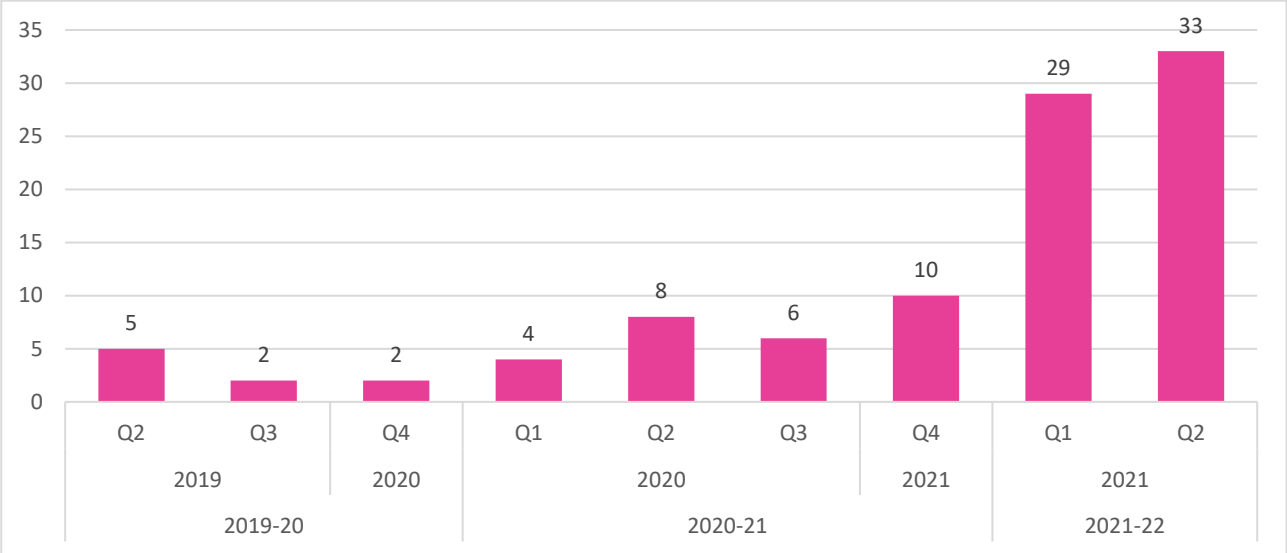


Figure 7 - Negative comments on Access to Service in Primary Care by Year and Quarter

Service Delivery, Organisation and Staffing

We used this theme as a catch-all for generally positive or negative comments. Figure 8 shows that these sorts of comments have tended to be more negative recently.

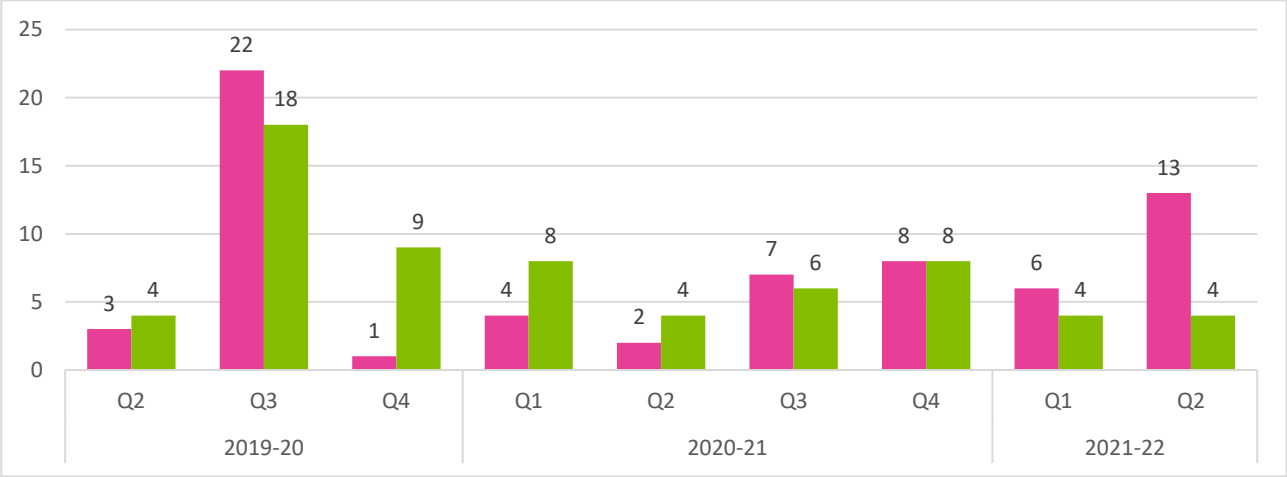


Figure 8 - Comments on Service Delivery, Organisation and Staffing in Primary Care by Year and Quarter

Staff Attitudes

We can also see from Figure 9 (below) that comments in this area have also tended to be negative.

Figure 9- Comments on Staff Attitudes in Primary Care by Year and Quarter

Health & Wellbeing Board Buckinghamshire

Date: 18 November 2021

Title: BCF 2021-22 HWB Update

Author and/or contact officer: Erica Boylett – Commissioning Manger, Adults and Health, Buckinghamshire Council

Report Sponsor: Gill Quinton, Corporate Director, Adults and Health, Buckinghamshire Council

Purpose of Report: To provide the Health and Wellbeing Board with an overview of the Better Care Fund (BCF) for 2021-22 and Buckinghamshire's BCF plan

Report for information, discussion, decision or approval: For approval

Related Joint Health and Wellbeing Strategy Priority: This paper relates to priority 2 – Keep people healthier for longer and reduce the impact of long-term conditions.

Recommendations:

1. **To formally approve the 2021-22 Better Care Fund (BCF) plan for Buckinghamshire**
2. **To note** the update provided on the BCF including the budget for 2021-22, schemes funded and metric trajectories
3. **To delegate** authority for development of Buckinghamshire's BCF plans to lead officers for Buckinghamshire Council Integrated Commissioning and Buckinghamshire Clinical Commissioning Group. This includes allocation of BCF expenditure, trajectories for locally set metrics, completion of supporting narrative, and assurance that all planning requirements and national conditions are met.
4. **To agree** that the Integrated Commissioning Team continue 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.

Executive summary

1.1 To provide the Health and Wellbeing Board (HWB) with an overview of the Better Care Fund (BCF) for 2021-22. This includes Buckinghamshire's confirmed funding allocations, schemes to be funded through the BCF, national and local changes since 2020-21 and an update on the new and existing requirements for metrics with planned trajectories.

1.2 The paper asks for the HWB to formally approve the 2021-22 BCF plan for Buckinghamshire. Due to the HWB meeting taking place after the national BCF

submission deadline of 16th November, the BCF plan has been submitted to the national team, as permitted, with delegated authority pending the full HWB meeting.

1.3 The plan has been shared with and agreed by the Integrated Commissioning Executive Team and lead officers from both Buckinghamshire Council Adult Social Care and Buckinghamshire Clinical Commissioning Group (CCG) before being shared with and signed off by Rachael Shimmin and Dr James Kent.

Content of report

1.4 The Better Care Fund (BCF) Policy was published on 19th August 2021. The subsequent planning guidance and budget allocations were published on 30th September 2021.

1.5 Each HWB area is required to submit, for national assurance, a BCF plan. This includes detail on proposed expenditure, metric trajectories, how the fund will be utilised to enhance and improve integrated working and agreement of the four national conditions.

1.6 The paper provides an overview of the 2021-22 BCF plan. It provides an overview of the BCF financial allocations for 2021-22 and the schemes and services that the BCF supports the delivery of and asks the Board to note these.

1.7 The paper focuses specifically on changes within the BCF both nationally but also locally a part of system work to review the BCF within Buckinghamshire.

1.8 An update on the requirements around metrics and proposed targets for all metrics are detailed and asks the board to note these. These have been set based on a number of factors including historical and current data, forecasts, joint discussions and feedback from the regional Better Care Fund team, whilst ensuring they are sufficiently stretching in line with the planning guidance.

1.9 The paper asks for formal approval of the 2021-22 BCF plan and for the HWB to delegate authority for the development of BCF plans to lead officers for BC Integrated Commissioning and Buckinghamshire CCG as well as the Integrated Commissioning Executive Team for servicing requirements related to BCF.

Consultation and communication

1.10 Previous iterations of this update prior to the cancelled October HWB meeting, were shared and approved by the Integrated Commissioning Executive Team (ICET), BC Adults and Health Board (AH Board) and BC Corporate Management Team (CMT). Amendments have been made to the recommendations and additional information

related to the metrics added since to reflect the development of Buckinghamshire's plan between the original and rescheduled dates.

1.11 In determining expenditure allocations for 2021-22, these were discussed and agreed with the BCF Working Group between April and October 2021, consisting of the following key attendees: BC Service Director for Integrated Commissioning; BC Service Director – Adult Social Care Operations; BC Head of Finance; Buckinghamshire CCG Interim Chief Finance Officer; Buckinghamshire CCG Deputy Chief Officer; Buckinghamshire Healthcare Trust (BHT) Director of Finance and Integrated Care Partnership (ICP) Finance Lead.

1.12 Trust related metric trajectories and narrative for National Condition 4 were discussed with BHT via individual conversations and shared with the Buckinghamshire ICP Discharge Cell. Discussions were held with Frimley Health Foundation Trust (FHFT) via a joint meeting between the Trust and BCF leads across the Trust's patch (Surrey, Buckinghamshire, Berkshire East, Hampshire).

1.13 Buckinghamshire's full BCF plan was shared with and agreed by ICET, BC Service Director for Integrated Commissioning; BC Service Director – Adult Social Care Operations, BC Corporate Director – Adults and Health and BC Chief Executive on behalf of the Council; and Buckinghamshire CCG Governing Body (virtual) and Buckinghamshire CCG Accountable Officer on behalf of the CCG. Finance leads for both organisations agreed the plan via ICET.

Next steps and review

1.14 The 2021-22 BCF plan will now undergo regional assurance before being formally approved by 11 January 2022.

1.15 The BCF Section 75 agreement will also be updated.

Background papers

None

This page is intentionally left blank

Health & Wellbeing Board Buckinghamshire

Better Care Fund (BCF) 2021-22 Plan

Tracey Ironmonger – Service Director, Integrated Commissioning

November 2021

Introduction

- The Better Care Fund (BCF) is a national vehicle for driving health and social care integration
- It requires a jointly agreed plan to be set and owned by each Health and Wellbeing Board (HWB), using a pooled budget
- Now want to build on progress made during the pandemic
- Aim to strengthen integration, delivery of person-centred services and enable system recovery
- There will be continued focus on improving how and when people are discharged from hospital

2021-22 Overview

BCF 2021-22
(£42,494,480)

- Policy guidance published 19th August
- Allocations published 30th September
- The total allocation for 2021-22 is **£42,494,480**. This includes:
  1. Minimum Clinical Commissioning Group (CCG) contribution
  2. Improved Better Care Fund (iBCF)
  3. Disabled Facilities Grant (DFG)
- Due to ongoing system pressures this will be a 1-year plan with minimal changes

Funding overview

1. Minimum CCG Contribution

- Total allocation is £33,535,839
- At least £11,236,611 is mandated for Adult Social Care and allocated against a variety of schemes
- This is a **5.52% increase** on the 2020-21 allocation
- At least £9,536,590 is mandated for NHS Commissioned out of hospital spend
- Continues to include funding to support:
  - Implementation of the Care Act 2014
  - Reablement
  - Provision of carers breaks
- Can pool additional funding if desired

CCG Minimum Contribution
(£33,535,839)

Funding overview

2. Improved Better Care Fund (iBCF)

- Confirmed as £4,892,680 for 2021-22
- This is **the same as** 2020-21

3. Disabled Facilities Grant (DFG)

- Confirmed as £4,065,961 for 2021-22
- This is **the same as** 2020-21
- Due to the move to unitary council status, this is no longer passported to District Councils

Schemes funded through the BCF

- **CCG Minimum – Fully Funded**
  - BC Hospital Discharge Teams supporting delivery of D2A
  - BC Home Independence Team
  - BC Short Term Intervention Team
  - British Red Cross Home from Hospital Service
  - Assistive Technology Service
  - Alzheimer's Society Memory Support Service
  - BHT Falls pathway
  - Advocacy and Deprivation of Liberty Safeguards (DoLS) services
- **CCG Minimum – Part Funded/Contribution**
  - Integrated Commissioning functions for delivery of quality care
  - Carers Bucks Integrated Carers Service (Not children's element)
  - BHT Integrated Community Health Services
  - Local Authority additional placement pressures from D2A (non-HDP funded)

BC = Buckinghamshire Council
BHT = Buckinghamshire Healthcare Trust
D2A = Discharge to Assess
HDP = Hospital Discharge Pathway

Schemes funded through the BCF

- **iBCF**
  - Brokerage to support self-funders
  - Healthwatch community engagement contract
  - Contribution to 65+ placements for residential and nursing care, respite, step up/step down and supported living to support pressures
  - Contribution to Direct Payments
- **DFG**
  - Mandatory capital funding of home adaptations
  - Schemes linked to enabling discharge/admission avoidance including:
    - Deep cleans supporting homeowners that self-neglect
    - Healthy Homes on Prescription Grant – essential works to address health and safety hazards in the home

Locally – What's changed for 2021-22?

- System BCF working group set up as part of local BCF review
- BCF Action plan put in place to support BCF review
- Reviewed and re-mapped BCF expenditure
  - Realigned to reflect changes following the Adult Social Care Operations restructure
  - New schemes added which contribute to BCF outcomes
  - Split out expenditure related to Care Act Pressures to enable clearer and more measurable reporting
  - Identified services/schemes for review for 2022

Nationally – What's changed for 2021-22?

- National condition 4 amended to reflect changes to hospital discharge pathways:
  - Now: ***"Plan for improving outcomes for people being discharged from hospital"***
  - Changed from: *"a clear plan on managing transfers of care including implementation of the High Impact Change Model for Managing Transfers of Care….adopt the centrally-set expectation for reducing or maintaining rates of delayed transfers of care…"*
- Metrics revised (see slide 11)
- Reviewing further support for the COVID-19 response and recovery, including funding for the hospital discharge policy
- BCF spending plans for Quarter 3 & Quarter 4 to take into account future funding decisions relating to this

Meeting National Condition 4

- Demand and capacity modelling taking place to facilitate more effective and strategic commissioning
- Home First pathway being reviewed to create a more simplified and streamlined pathway
- Setting up of an Integrated Hub to facilitate greater MDT working
- Understanding the impact of Continuing Healthcare (CHC) and complex case delays on length of stay (LOS)
- Developing clarity around pathways to ensure appropriate people go through Discharge to Assess (D2A)
- High Impact Change Model – continue to use this tool to enable successful delivery and implementation of the discharge policy

MDT = Multidisciplinary Team

Metrics and Reporting

- Delayed transfers of care (DToC) suspended March 2020 – metric replaced with **discharge indicators.**
- For 2021-22, as an interim measure, this data will be collected from hospital systems through NHS Secondary Uses Service (SUS)
- Focuses on improvements in
  - Length of stay (% of inpatients longer than 14 and 21 days)
  - Proportion of people discharged home to their usual place of residence
- Non-elective admissions replaced with **avoidable admissions**
  - Better reflects joint health and social care work to support independent living and prevent avoidable stays in hospital
- Trajectories required from Quarter 3 of 2021-22

Metrics and Reporting

- **NEW: Avoidable Admissions**
- Defined as: “Unplanned hospitalisation for chronic ambulatory care sensitive conditions” (NHS Outcome Framework indicator 2.3i)
- Proposed trajectory:

	19-20 actual	20-21 actual	21-22 plan
Rate per 100k population	525.8	401.2	512

- Target to be set as 512 admissions per 100k population based on analysis of performance since 2018-19
- Represents an improvement on 2019-20 performance but not 2020-21. Data suggests the decrease in 2020-21 is due to fewer admissions during the pandemic

Metrics and Reporting

- **NEW: Length of Stay**
- Defined as: “Percentage of inpatients, resident in the HWB, who have been an inpatient in an acute hospital for:
  - 14 days or more as a percentage of all inpatients
  - 21 days or more as a percentage of all inpatients”
- Proposed trajectory:

	21-22 Q3 plan	21-22 Q4 plan
14+ days	12%	12%
21+ days	6.7%	6.6%

- Targets set based on data and forecasts provided, discussion with Buckinghamshire Healthcare Trust and Frimley Health Foundation Trust, on guidance from colleagues and the regional BCF team

Metrics and Reporting

- **NEW: Discharge to usual place of residence**
- Defined as: “Percentage of people, resident in the HWB, who are discharge from acute hospital to their normal place of residence”
- Proposed trajectory:

	19-20 actual	20-21 actual	21-22 plan
% discharged to usual place of residence	94.1	92.8	93.5

- Target to be set as 93.5%, which is average performance from April 2019 to date and slightly above forecasted values
- Represents an improvement on 2020-21 performance and, if achieved, would be reviewed again for 2022-23

Metrics and Reporting

- **Effectiveness of reablement** metric remains
  - 2020-21's outturn for the 91-day reablement measure was 87.9% against a target of 75%.
  - This is a significant increase on the 2019-20 performance of 77%.

Data Summary - 20-21

	Yes	No	Unknown	Total	% at home
At home at 91 days - RRIC	75	6	6	87	86.2%
At home at 91 days - ASC	187	22	2	211	88.6%
	262	28	8	298	87.9%

- Target set as 77% in line with BC corporate target for this indicator as impact of covid on last year's performance unclear at this point. This is in line with SE regional performance of 76.9% (ASCOF 2020)

RRIC = Rapid Response Intermediate Care
ASC = Adult Social Care
ASCOF = Adult Social Care Outcomes Framework

Metrics and Reporting

- **Long term admissions to care homes** remains
  - Due to the transfer of data from AIS to LAS, reporting on this metric for 2021-22 will be available from October/November
- The 2020-21 care home admission metric **was met**, with a rate of 329 against a pro-ratered target of 350 for admissions to 16th February 2021
- The target for 2021-22 is set as 526.5 admissions per 100,000 population per year in line with the Buckinghamshire Council corporate indicator. This is equal to South East Regional performance in 2019-20 and remains lower than the England average of 584 (ASCOF 2020).

AIS = Adult Social Care IT System
LAS = Liquidlogic Adult Social Care System

Assurance

- Planning template completed
- Sign off through Buckinghamshire Council and Buckinghamshire CCG governance including the HWB
  - *Due to the challenging timeframes for submission of the plan, it has been submitted with delegated authority pending formal approval by the HWB*
- Draft plan submitted and reviewed
- Final plan submitted
- Regional assurance and moderation
- Formal approval of plan received

Future of BCF - Nationally

- The BCF review, committed as part of the NHS long term plan, concluded:
  - A fund should continue, dismantling it would be a backward step
  - The NHS contribution to Social Care should be maintained
  - More clarity around BCF policy and aims is required
- Positive changes resulting from Covid-19 need to be built upon
- Areas are in different stages towards better joint working
- Proposals set out in the Health and Care Bill will impact longer term system thinking and planning – future BCF arrangements will support these proposals
- Government will explore options to introduce incentives linked to improved discharge outcomes

Future of BCF - Locally

- Continue to deliver against the BCF action plan including:
  - Further review of expenditure for 2022 onwards
  - Strategic planning in response to upcoming changes to enable greater integration
  - Review and develop internal reporting on performance and outcomes
  - Review and update the Section 75 pooled budget agreement
  - Share best practice across the Integrated Care System (ICS) and other HWB areas
  - Align to other national initiatives such as the Ageing Well Programme
- When there is clarity around future hospital discharge funding, ensuring future plans support delivery of improving outcomes for those discharged from hospital
- Incorporate changes to CCGs and ICS's ensuring a place-based commissioning model remains to support integration within Buckinghamshire
- Utilise opportunities for support from the national BCF team to embed this

Recommendations for the Board

- **To formally approve the 2021-22 BCF plan for Buckinghamshire**
- **To note** the update provided on the BCF including the budget for 2021-22, schemes funded and metric trajectories
- **To delegate** authority for development of Buckinghamshire's BCF plans to lead officers for BC Integrated Commissioning and Buckinghamshire CCG. This includes allocation of BCF expenditure, trajectories for locally set metrics, completion of supporting narrative, and assurance that all planning requirements and national conditions are met.
- **To agree** that the Integrated Commissioning Team continue to service all requirements of the BCF, including reporting via the Integrated Commissioning Executive Team on performance and bi-annual updates to Health and Wellbeing Board.

Health & Wellbeing Board
Buckinghamshire

Date: 18 November 2021

Title: Buckinghamshire Winter and Surge Plan 2021 / 22

Author and/or contact officer: Caroline Capell, Director of Urgent and Emergency Care, Buckinghamshire Integrated Care Partnership (ICP)

Report Sponsor: Buckinghamshire Integrated Care Partnership

Purpose of Report: Incorporating the key actions each of our key system partners will deliver during the forthcoming winter period and the challenges being faced as part of managing the COVID-19 Pandemic

Report for information, discussion, decision or approval: For information

Recommendations:

- Note findings of the report

Executive Summary

The term 'winter' refers to the period Monday 4th October 2021 to Monday 18th April 2022. Actions would be expected to commence as soon as possible to support the winter period. This also recognises that we remain in the Covid surge (third wave) with anticipated periods of surge throughout the winter.

This plan is an iterative plan to support the Buckinghamshire System across Winter 2021/22 and incorporates the key actions each of our key system partners will deliver during the forthcoming winter period.

Background documents

Definitions for acronyms used in the report are included below for your reference.

Acronym	Definition
AMHP	Approved Mental Health Professional
BOB	Buckinghamshire, Oxfordshire and Berkshire West
CAMHS	Child and Adolescent Mental Health Services
CATS	Children's Acute Transport Service
CMHT	Community Mental Health Team
D2A	Discharge to Assess
DoS	Directory of Services
ED	Emergency Department
EHCH	Enhanced Health in Care Homes
HBPOS	Health Based Place of Safety
IAPT	Improving Access to Psychological Therapy
ICP	Buckinghamshire Integrated Care Partnership
LTC	Long Term Condition
MDT	Multi-Disciplinary Team meeting
MUDAS	Multi-Disciplinary Day Assessment Unit
PCNs	Primary Care Networks
SCAS	South Central Ambulance Service NHS Foundation Trust
SDEC	Same Day Emergency Care
UEC	Urgent and Emergency Care
UTC	Urgent Treatment Centres

Your community
Your care
Developing Buckinghamshire together

Buckinghamshire Winter and Surge Plan 2021 / 22

Health and Wellbeing Board

NHS Buckinghamshire Clinical Commissioning Group
NHS Buckinghamshire Healthcare NHS Trust
FedBucks
Buckinghamshire Council est. 2020
NHS Oxford Health NHS Foundation Trust
NHS South Central Ambulance Service NHS Foundation Trust

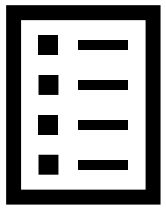
Context

Throughout this plan, the term 'winter' refers to the period Monday 4th October 2021 to Monday 18th April 2022. Actions would be expected to commence as soon as possible to support the winter period. This also recognises that we remain in the Covid surge (third wave) with anticipated periods of surge throughout the winter.

This plan is an iterative plan to support the Buckinghamshire System across Winter 2021/22.

This plan aims to incorporate the key actions each of our key system partners will deliver during the forthcoming winter period and incorporating the challenges being faced as part of managing the COVID-19 Pandemic. This plan is complimented by:

- COVID-19 Third Wave Surge Plan
- Buckinghamshire Paediatric Surge Plan
- Buckinghamshire Primary Care Surge Plan
- Buckinghamshire Discharge Surge Plan
- Buckinghamshire Local Outbreak Management Plan (Covid-19)
- Buckinghamshire Urgent and Emergency Care (UEC) Transformation Programme
- Buckinghamshire Flu Plan
- System Partners Winter Plans including at ICP and ICS level



Aims and Principles

Aims:

The key partners across Buckinghamshire will ensure their services and workforce:

- Are **resilient and supported** throughout the winter period and Covid-19 pandemic, providing safe, effective and sustainable care for the local population
- Have sufficient **capacity and support** available to meet likely demands over winter and potential surges in Covid-19
- Are able to deliver safe and high-quality **care** for patients/clients in the most appropriate setting, maximising the opportunities provided by PCNs and Primary Care Services
- Are able to **achieve** national and local access targets and trajectories across the system
- Are compliant with winter and COVID-19 planning and national guidance
- Have learnt from previous winters locally and from **other systems** and **applied best practice** to service delivery to ensure safe and effective patient flow
- Promote **prevention** and supports self-care for staff and patients / clients.

Principles:

The Buckinghamshire system's approach will be governed by the following principles.

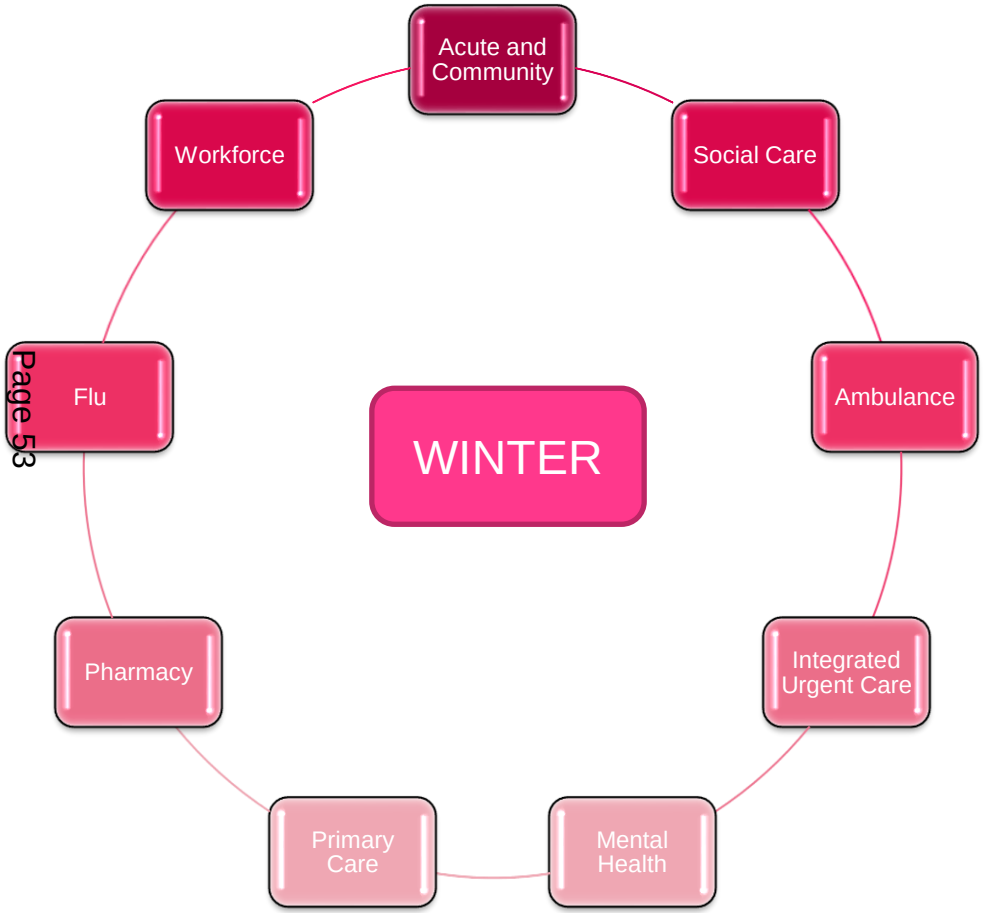
- **Outcomes** – Delivering safe and effective care for all patients/clients receiving care from the Buckinghamshire system.
- **Prevention** - Build on Covid-19 lessons regarding infection control (PPE / Handwashing etc, Flu Planning etc.) and better ways of working together
- **Avoiding Attendances** - Attendances at Emergency Department should be avoided where possible and clinically justified. The provision of suitable and safe alternatives to hospital attendance must be utilised or enhanced.
- **Avoiding Admissions** - The use of various streaming, Same Day Emergency Care (SDEC) and pathway initiatives to both alleviate Emergency Department use and avoid unnecessary admissions will be vital to patient flow.
- **Rapid Discharge** - Delays to discharges from hospital must be minimised.
- **Supporting Care Providers -** Care providers must be supported to ensure high quality placements are available for hospital discharge

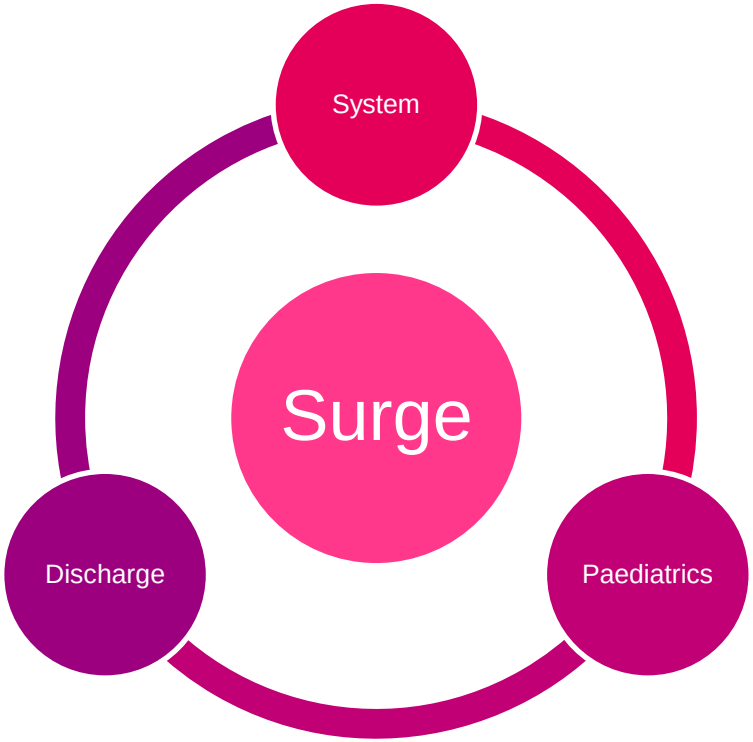
All parts of the system will adhere to these principles and defaults and to the actions set out in the remainder of this paper. All providers should have their own winter and surge planning processes to which they should adhere.

Winter and Surge Plan

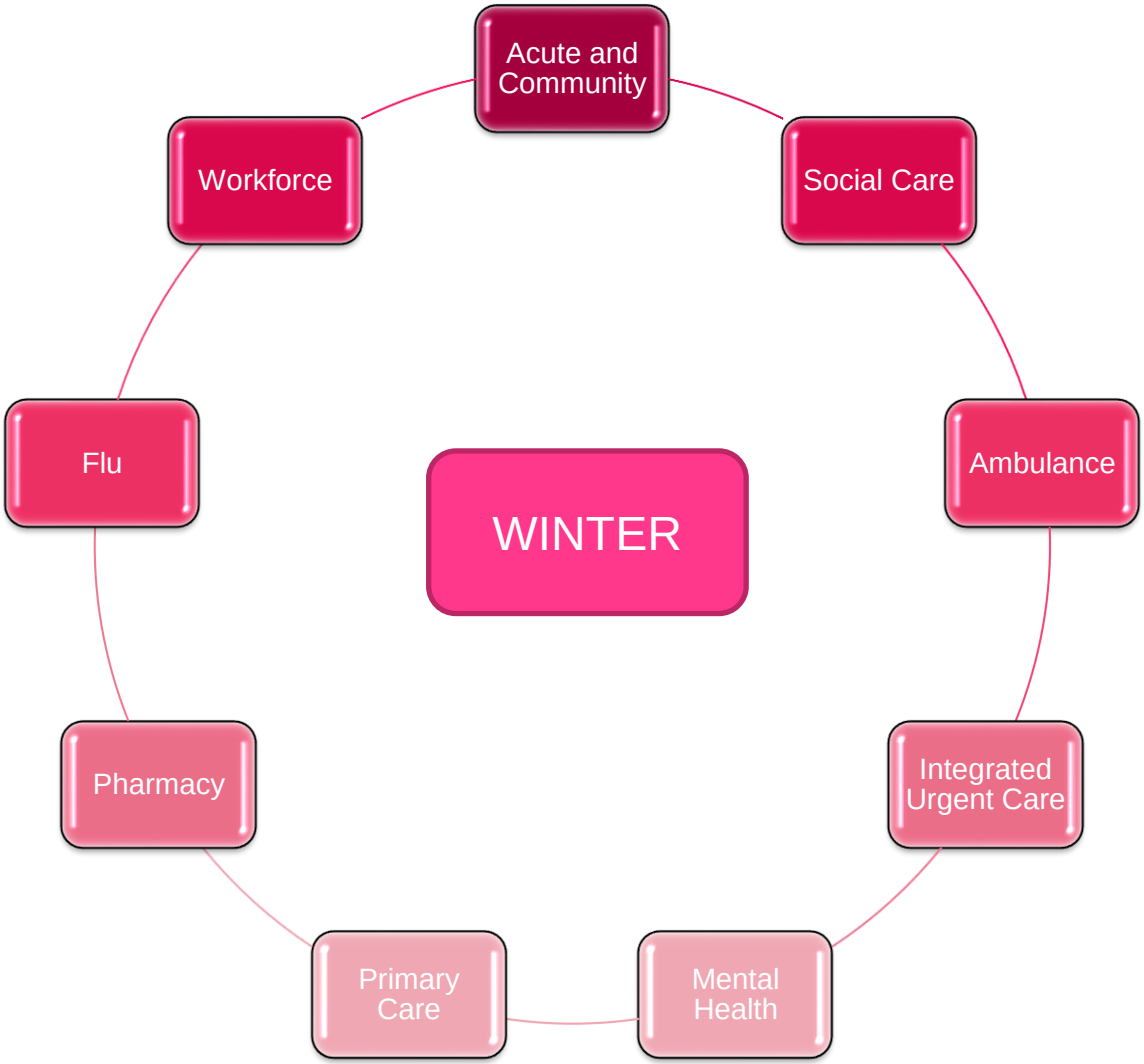
Key Workstream Areas:

The two diagrams below highlight the NHSE expected areas of focus for both Winter and for Surge, each of which have expected deliverables. The next set of slides break down the Winter areas of focus interwoven with surge:





Winter Plan


Acute and Community
Social Care
Ambulance
Integrated Urgent Care
Mental Health
Primary Care
Pharmacy
Flu
Workforce
WINTER

Acute and Community – Front Door

The table below highlights actions the Buckinghamshire Healthcare NHS Trust will deliver in order to support the winter period and Covid-19 pandemic:

The aims of these actions are to help support the workforce, patients and the pathways in order to:

- Eliminate necessity to manage patients in ED corridors
- Improve performance to ensure patients are seen and treated in a timely manner and no patients spend more than 12 hours in ED from the time of arrival
- Help with the ambulance handovers to ensure ambulances can get back on the road in a timely manner
- Help maintain a resilient workforce through support and management
- Help reduce the number of breaches on a daily basis
- Reduce bottlenecks in ED through new pathways
- Work with system to improve pathways to support direct bookings
- Support provision of various streaming, SDEC and pathway initiatives

Action	By When	Principle
Buckinghamshire to increase and support workforce levels sufficient to cover winter demands and build in contingency plans at periods of surge	1st November and ongoing through winter	All principles
Ensure proactive and robust discharge planning to ensure patients are discharged when medically optimised	Ongoing	Rapid Discharge
Ensure communications and processes in place with partners regarding referrals, admissions and discharges are clear and unequivocal	1st October	All principles
UTC Pathway at the Front Door of the Emergency Dept to help manage increasing primary care demand at the front door, improve performance and support capacity	October 2021	Outcomes
Work with SCAS to manage handover pathways to reduce handover delays	Ongoing	Outcomes
Supporting Think 111 First including development of ED pathways and direct bookings from 111	Ongoing	Avoiding Attendances
Ensuring staff are vaccinated to support staff welfare and patient care	1st November	Outcomes/ Avoiding Attendances
Enhanced engagement with system to improve flow of patients	Ongoing	Rapid Discharge
Hospital Ambulance Liaison Administrator (HALA) to support front end ED with smooth handover of ambulances and streaming of patients to appropriate services	1st October	Outcomes

Acute and Community – Bucks 24/7

The table below highlights actions Bucks 24/7 (FedBucks) will consider in supporting the winter period and Covid-19 pandemic:

The aims of these actions are to help support the workforce, patients and the pathways in order to:

- See patients in a timely and safe manner
- Increase number of direct bookings via 111 to support Think 111 First and ensure patients are seen in the right place first time
- Provide overall support for the wider urgent and emergency care system

Action	By when	Principle
Increase workforce levels sufficient to cover winter demands building in contingency plans for the management of Covid-19 and periods of surge	1st November and ongoing through winter	All principles
Reopening all UTC pathways including direct bookings and aligning to the Think 111 First pathway	Ongoing	Avoiding Attendances
Management of patients in the community via high level triage/base appointments/home visiting during the out of hours setting	Ongoing	Avoiding Attendances/ Outcomes
Covid-19 support through in hours triage, home visiting services and hot hub clinics	Ongoing	Avoiding Attendances/ Outcomes
Continuing to support roll out of Think 111 First by aligning the UTC model with the ED pathway and supporting capacity and demand where possible	Ongoing	Avoiding Attendances
Delivery of flu vaccinations to support staff and system as required, also supporting prophylaxis	1st January 2022	Avoiding Attendances/ Outcomes
Supporting ED with Front Door resources and supporting Primary Care with locally commissioned services	Ongoing	Avoiding Attendance/ Outcomes

Acute and Community – Community

BHT provides community services provision for adults and children across Buckinghamshire which includes Rapid Response & Intermediate Care (RRIC), the Adult Community Health Team (ACHT), the Falls pathway, specialist nursing, therapies and day assessment units

The table below highlights the key actions that will be taken to support the winter period and any future Covid-19 surges. These actions aim to support the workforce, patients and the pathways by helping reduce demand on the acute sites. This will be achieved by:

- Focussing on the prevention of admission as a key priority to keeping people at home and preventing unnecessary hospital admissions. This includes patients who need a two-hour crisis response, i.e. Urgent Community Response (UCR)
- Supporting the step down from hospital for people who need appropriate intervention to enable them to return to their home environment

Action	By When	Principle
Community Services to proactively support and prioritise the workforce for patients that are deemed at risk of admission and provide a 2-hour crisis response for those at high risk, which includes patients in ED / SDEC	Ongoing	Avoiding Admissions/ Outcomes
Community Services to support timely discharge for patients medically optimised for discharge utilising the Home First pathway	Ongoing	Rapid Discharge/ Outcomes
Close working between RRIC and Home Independence Team to maximise available capacity and best utilisation of staff	Ongoing	Rapid Discharge/ Outcomes
Promotion and reminder about use of CATS and MUDAS to GPs, community teams and acute	Ongoing	Avoiding Admissions/ Outcomes
Promotion of pathways with SCAS to increase the utilisation of community services such as RRIC, CATS and MUDAS	Ongoing	Avoiding Admissions/ Outcomes
Regular review with DoS Manager for utilisation of UCR pathways by NHS 111	Ongoing	Avoiding Admissions/ Outcomes
Review of Consultant Connect Pathway to support PCN referrals as alternative pathways to ED	Ongoing	Avoiding Admissions/ Outcomes

Social Care (1 of 2)

Adult Social Care and Stoke Mandeville Hospital discharge coordinators collectively form the Integrated Discharge Team to provide a holistic, admission avoidance and discharge service for patients who are referred or admitted to Stoke Mandeville Hospital. BC also oversee the Home Independence Team across Buckinghamshire.

The table below highlights actions Buckinghamshire Council will consider in supporting the winter period. BC has its own separate winter plan as which these actions align to.

The aims of these actions are to help support the workforce, patients and the pathways in order to:

- Help reduce demands on acute sites by facilitating discharge
- Providing timely assessments and providing support
- Helping maintain a resilient and supported workforce

Action	By when	Principle
Discharge to Assess under home first principles - Enabling more people who need care and support to be discharged from hospital as soon as they are medically fit	Ongoing	Rapid Discharge
Ensure 7 Day Working to support rapid discharge. Enabling clients to remain at home and effective discharge at weekends	Ongoing	Rapid Discharge
Implementing Holiday Cover to support rapid discharge. Enabling clients to remain at home and effective discharge over the winter period	1st October and ongoing through the winter period	Rapid Discharge

Social Care (2 of 2)

The table below highlights the remaining actions for Bucks Council in Buckinghamshire during the winter period.

Action	By when	Principle
Provider resilience for care and support providers. Supporting providers to deliver safe and effective services throughout the winter period	Ongoing	Avoiding Attendances/ Avoiding Admissions/ Supporting Care Providers
Supporting the safety and continuity of care for vulnerable residents	Ongoing	Avoiding Attendances/ Avoiding Admissions
Supporting wider providers (such as Apetito, Red Cross Home from Hospital, NRS) who can deliver safe and effective services over the winter	1st October and ongoing over the winter period	Avoiding Attendances/ Avoiding Admissions
Promoting and enabling the uptake of flu vaccination for all BC staff but prioritising front line staff and those at risk. Promoting to care providers	1st January 2022	Avoiding Attendances/ Avoiding Admissions
Promoting and enabling the uptake of Covid-19 vaccination for all BC staff but prioritising front line staff and those at risk and promoting to care providers	Ongoing	Avoiding Attendances/ Avoiding Admissions/ Supporting Care Providers
Provide the public with information on staying well and appropriate routes to access reports	Ongoing	Avoiding Attendances/ Avoiding Admissions
The availability of Emergency Response to support rapid discharge. Ensure the delivery of safe and effective adult social care services	1st October and ongoing through the winter period	Rapid Discharge
Support the Community 2 hour and 2-day rapid response plan	Subject to successful ICP proposal and funding, potential start 1st December	Avoiding Admissions

Care Homes (1 of 2)

With pressure on bed capacity within the acute sector and the need for rapid discharge to alleviate this pressure, care homes represent a pivotal element of the system as many patients will be transferred to and from hospital during the winter period. There are 129 care homes in Buckinghamshire that have a registered Buckinghamshire GP.

The table below highlights actions the system will consider in supporting care homes to cope during the winter period. It is based on the premise that patients will remain in a care home to receive their care where possible especially if this is their usual place of resident but that also care homes may be used to step down patient care and the system must facilitate this in order for it to work effectively:

The aims of these actions are to help support the workforce, patients and the pathways in order to:

- Ensure care homes are safe and supported by the wider system
- Ensure residents are only conveyed when all other options have been appropriately sought
- Ensure all staff and residents receive flu and Covid-19 vaccination

Action	By when	Principle
RESTORE2 (Nursing Homes) and RESTORE2 Mini (Residential Care Homes) Training to enable care homes to proactively identify deteriorating care home patients and treat quickly and effectively	1st November	Outcome/ Avoiding Admissions
Implementation of effective treatment escalation plans in Care Homes (RESTORE2)	1st November	Outcomes
PCN support for care homes in place through ward rounds, MDTs, personal care plans and EHCH	Ongoing	Outcomes

Care Homes (2 of 2)

The table below highlights the remaining actions for Care Homes in Buckinghamshire during the winter period.

Action	By when	Principle
Care Home understanding and involvement in the SDEC approach so that they understand the need and importance of accepting patients back following an intervention	Ongoing	Rapid Discharge
Telehealth - Consistent use of Immedicare across Bucks to ensure 24/7 reactive medical support for care homes as required. Known to reduce the need for further support. Links directly to the local geriatrician team for support as necessary via Consultant Connect	1st October and ongoing through winter	Avoiding Admissions
Ensuring all staff and residents are vaccinated as part of the flu and Covid-19 vaccination programme	Covid-19 vaccinations ongoing 1st January 2022 for flu vaccination	Avoiding Admissions

Ambulance

The table below highlights actions SCAS will consider in supporting the winter period and Covid-19 pandemic. SCAS have an operational plan in place: 'Demand Management Plan' to help manage winter demand across the whole SCAS region.

The aims of these actions are to help support the workforce, patients and the pathways in order to:

- Support system in keeping patients at home where safe and clinically appropriate
- Maximize use of SCAS Connect to support urgent care pathways and convey only when necessary and clinically appropriate
- Reduce handover delays to free up ambulance capacity
- Continue to ensure there is adequate ambulances throughout the winter to manage demand
- Help increase the 'hear and treat' and 'see and treat' so patients can be dealt with appropriately in a timely manner
- Help deliver on the Category 1 target for the most urgent cases

Buckinghamshire Actions	By when	Principle
SCAS to increase usage of See/Treat and Hear/Treat pathways where clinically appropriate whilst reviewing and improving existing urgent care pathways to maximize usage and reduce conveyances. SCAS will encourage staff to utilise SCAS Connect (MiDOS) in accessing pathways other than the ED	Ongoing and will continue through winter, monitored through the UEC Transformation Programme	Avoiding Attendances/ Outcomes
Assistant Senior Operations Manager to support urgent care pathways	In post since July 2021 and will be supporting on a permanent basis	Avoiding Attendances/ Outcomes
SCAS to monitor workforce levels and proactively plan to cover winter demands and build in contingency plans ahead of predicted surge by utilising short-term and long-term forecasts. Ensuring workforce remains supported and resilient.	Started and ongoing through winter, monitored through UEC Transformation Programme	Avoiding Attendances
Home Visiting Service	In place until September. Extension to support winter to be confirmed	Avoiding Attendances/ Outcomes
SCAS Car - Urgent Care Service, predominantly aiming to cover respiratory type illnesses	TBC	Avoiding Attendances/ Outcomes
SCAS to adopt the extreme weather guidelines as part of the Adverse Weather Condition Policy in ensuring service delivery for the population is maintained where possible.	As required dependent on weather	Outcomes
Ensuring staff are vaccinated to support staff welfare and patient care (covering Covid-19 and flu)	Band 7 Vaccination Coordinator appointed in August 2021 - 12 month secondment	Outcomes/ Avoiding Attendances

Integrated Urgent Care

The table below highlights actions 111 will consider supporting the winter period and surge.

The aims of these actions are to help support the workforce, patients and the pathways in order to:

- Continue to support Think 111 First to ensure adequate capacity in 111 call centres and clinical assessment service
- Improve performance for call answering
- Help maintain a resilient workforce through ongoing support and management

Action	By when	Principle
Fully promote / communicate campaign for NHS 111 and choices of services across the system	Ongoing	Avoiding Attendances
NHS 111 service to commit to achievement of revalidation targets of ED and Ambulance dispositions to maintain the low levels of patients being redirected to ED. As part of the 111 First this is being reviewed and additional resources are being looked at as each area roll out the programme	Ongoing	Avoiding Attendances
111 to increase workforce levels sufficient to cover winter demands and build in contingency plans at periods of surge	Ongoing	Avoiding Attendances
Supporting the roll out of Think 111 First by increasing resourcing within the 111 service managed by SCAS. To deliver 111 establishment are to be increase and SCAS are recruiting HA and CA to the new establishment figures	Ongoing	Avoiding Attendances

Mental Health (1 of 2)

Mental Health and Wellbeing Service provide mental health services across Buckinghamshire and Oxfordshire and the table below highlights actions OHFT will consider supporting the winter period.

The aims of these actions are to help support the workforce, patients and the pathways in order to:

- Help provide 24/7 support to patients
- Ensure pilots to support the winter period are up and running
- Help support the wider system providing direct support in the Acute Trust and where else possible
- Helping maintain staff resilience through ongoing support and management

Action	By When	Principle
Strengthen pathways with SCAS to increase the utilisation of the facility to assess individuals at the White leaf if they do not need physical health intervention	1st November	Avoiding Attendances
CAMHS will continue to provide planned interventions and 24hr crisis service over this period responding to urgent and emergency demands	1st September and ongoing through winter	Avoiding Attendances
CAMHS will provide a member of staff into A&E to support CYP who present through mental health distress/self-harm to expedite assessment and rapid discharge	1st November	Rapid Discharge
Maximum use of Crisis Service as an alternative to hospital admission and reduce out of area placements by responding proactively to urgent and emergency demand. Safe Haven + operational in High Wycombe to support alternatives to ED	1st September and ongoing through winter	Avoiding Admissions
Community Services (crisis and CMHTs) to support timely discharge through proactive working across services and system	1st September and ongoing through winter	Rapid Discharges
Develop system wide process to expedite discharges/reduce stranded patients/improve flow	1st November	Rapid Discharges

Mental Health (2 of 2)

The table below highlights the remaining actions for Mental Health services in Buckinghamshire during the winter period.

Action	By When	Principle
AMHP service staffed to ensure assessments are undertaken in timely manner for all urgent care pathways	1st September and ongoing through winter	Rapid discharges
Single point of referral for OHFT HBPOS established to improve operational oversight and communication with system partners	9th August and ongoing through Winter	Rapid Discharges
IAPT will ensure there is sufficient capacity to provide urgent psychological assessments (within 24 hours) for people with common mental health disorders including those re-directed from 111 and ED	1st September and ongoing through winter	Avoiding Attendances/ Avoiding Admissions
IAPT to provide Long Covid clinics and psychological therapies for people with LTCs (COPD, diabetes, cardiac conditions etc). Linked to hospital, community and primary care physical health services to prevent deterioration leading to admission and facilitate recovery from physical or psychological crisis	1st September and ongoing through winter	Avoiding Attendances/ Avoiding Admissions
Robust encouragement for all staff to be up to date on Covid and Flu vaccinations in the run up to the winter period	1st September and ongoing through winter	Avoiding Attendances/ Avoiding Admissions

Primary Care (GP Practices)

Buckinghamshire currently has 48 GP practices covering core general practice services, including extended primary care access for their own registered population and across the Buckinghamshire Practices with the national Extended Access Programme.

The table below highlights actions primary care can consider supporting the winter period and Covid-19 pandemic.

The aims of these actions are to help support the workforce, patients and the pathways in order to:

- Improve access over the winter period
- Continue to support the 111 pathway by providing directly bookable slots for 111
- Promote and deliver on the wider flu and Covid-19 programme
- Continue to support remote consultations to manage demand

Action	By when	Principle
CCG to review NHS 111 Directory of Services ensuring ranking and profiles of key services are correct	Ongoing	Outcomes/ Avoiding Attendances
GP practices will ensure the appropriate numbers of directly booked appointments are made available for direct booking from 111 and they are fully utilized	On-going	Outcomes/ Avoiding Attendances
Delivery of vaccinations including the Covid-19 and flu vaccines to the eligible patient cohorts	Covid- 19 vaccinations ongoing, flu and Covid-19 Phase 3 starting 1st September	Outcomes/ Avoiding Admissions
Maximise patient & GP practice use of online consultation and triage systems to ensure patients are guided to the most appropriate service or to self-care	Ongoing	Avoiding Attendances
Review triage protocols within the Ask First online consultation tool to reflect Winter requirements including flu	1st November	Outcomes/ Avoiding Attendances
Twice weekly operational performance monitoring of covid services and D2A beds with SCAS and FedBucks for escalation and support of service delivery	Ongoing	Outcomes
Workforce planning support offer to practices and PCNs to maintain resilience	Ongoing	Outcomes
Primary Care situation reporting for early escalation and mitigation of issues with demand management and service delivery	Ongoing	Outcomes/ Avoiding Admissions

Pharmacy

The table below highlights actions our local Medicine Management team will consider supporting the winter period and Covid-19 pandemic:

The aims of these actions are to help support the workforce, patients and the pathways in order to:

- Help take pressure off other services, including GPs, by streamlining pathways for patients
- Help facilitate flu and Covid-19 vaccinations throughout Bucks
- Use public facing forums to promote 111 and self-care

Action	By when	Principle
Supporting the communications campaign providing a focus on putting out messages about self-care to all patients	1st October and ongoing through the winter period	Outcomes/ Avoiding Attendances
To support in the delivery of the Covid-19 and flu vaccines for care homes as required, including staff	1st October and ongoing through the winter period	Outcomes/ Avoiding Attendances
Increasing use of electronic repeat dispensing service through comms and engagement	1st October and ongoing through the winter period	Outcomes
FedBucks support for supply of antiviral for flu prophylaxis/treatment in care homes	1st October and ongoing through the winter period	Outcomes/ Avoiding Admissions

Flu Vaccinations

All systems are awaiting national guidance relating to the likely combining of flu and covid-19 booster vaccinations.

This started in October 2021 focusing on the at risk groups which include:

- Clinically at risk Group (6 months to 65 years)
- Over 65 years
- Children aged 2 – 10 years
- Pregnant women
- Long stay residents in care homes
- Carers
- Close contacts with immunocompromised individuals
- Health and Social Care staff

All key system partners will support the roll out of the vaccinations subject to national guidance.

The Buckinghamshire Flu Plan is embedded below:

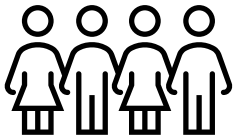
Microsoft Excel Worksheet

Workforce

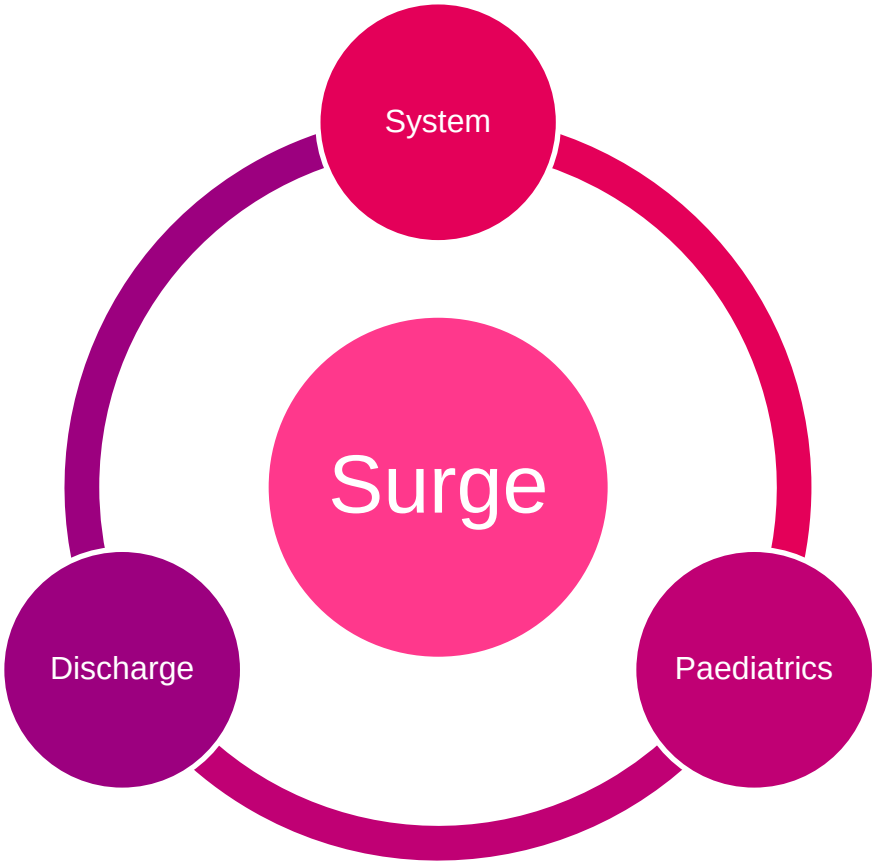
Across the Buckinghamshire Health and Social Care system all providers have their own Surge and Winter plans in place. The plans include the management of workforce.

The Buckinghamshire system is not yet mature enough to enable cross organisational working, however there are steps being taken to improve this including:

- UTC Pathway at Front Door in SMH as a partnership model with BHT and FedBucks
- 111 Clinical Assessment where Fedbucks validate UTC dispositions prior to bookings in partnership with SCAS



Surge



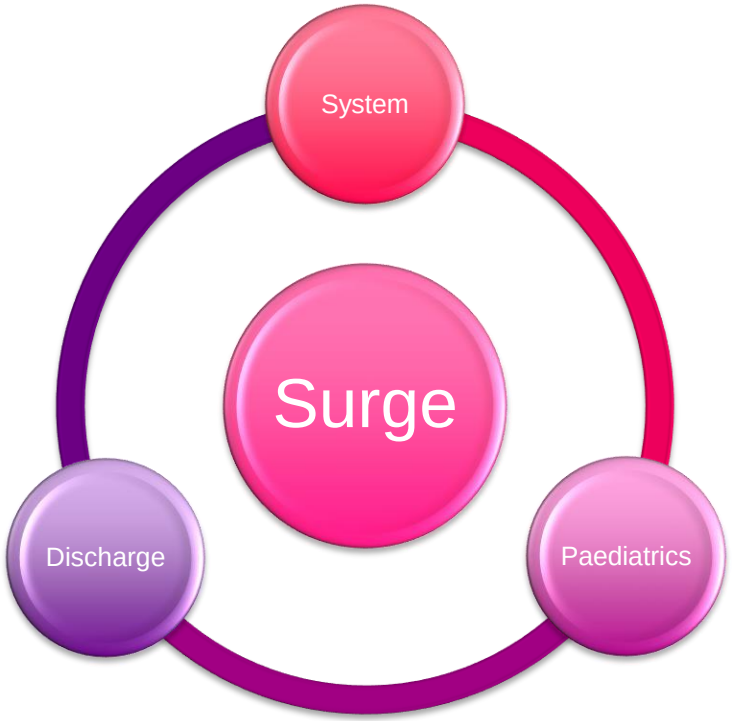
Surge

Across Buckinghamshire a Surge Plan has been developed and agreed.

This focuses on three key areas:

- ❑ System
- ❑ Paediatrics
- ❑ Discharge

As part of the requirement for assurance to NHSE the embedded document also includes an assurance checklist that will be implemented in preparation for surge and winter.



Paediatrics Surge

The general principles outlined in this plan relate to both paediatrics and adult populations. The section below highlights various points of focus for children's urgent care. The aims of these actions are to help support the workforce, patients and the pathways in order to:

- Ensure children receive safe and timely treatment and care through this winter
- Communication supporting Covid-19 and other paediatric conditions is in place
- Ensure residents are only conveyed when all other options have been appropriately sought
- Ensure all children in the appropriate age range receive a flu vaccination

Actions	By When	Principle
To ensure full consultant and senior nurse cover available in the Trust 24/7 to manage children and treat in a timely manner	1st October and ongoing through winter	Outcomes
To ensure a dedicated space for paediatric minor injury is operational	In place	Rapid Discharge
Handing of ward 9 to paediatrics to increase paediatric bed capacity, providing initially an extra 12 beds but potentially up to 22 from 13th September 2021 (ward 9 at SMH)	13th September 2021	Rapid Discharge
Use of remote consultations to support outpatient services	In place	Avoiding Attendances/ Avoiding Admissions
Maximise use of GP telephone advice line	1st October and ongoing through winter	Avoiding Attendances
Ensuring availability of Hot Hubs for management of symptomatic children	In place until September, winter plan to be put in place by 1st October	Avoiding Attendances
Communications strategy jointly with the Council and Public Health on common winter childhood illness and self-care	Already in place and will be ongoing with targeted messaging through winter	Avoiding Attendances
Establishment of green pathways for shielded and elective children	Already in place through the Children's Day Unit at Wycombe	Avoiding Attendances
Paediatrics / Paediatric Ambulatory Care to work with community nursing teams to develop early discharge pathways and home monitoring SOP	Process and SOP already in place. The majority of admitted children are discharged without the need for oxygen. Those specific children who require oxygen at home will have individualised plans for monitoring and will be supported at home by the paediatric community team.	Outcomes

Managing Winter and Surge 2021 / 2022

Winter and Surge Management

Across the Buckinghamshire Health and Social Care system all providers have ICP policies in place and adhered to.

The Buckinghamshire system continues with an Incident Management Process with the following in place which will remain throughout the winter period:

- ✓ BHT Incident Management Meeting (meets weekly (Wednesday))
- ✓ System Incident Management Meeting (meets weekly (Wednesday))
- ✓ BHT Bronze Daily meetings (Divisional escalation)
- ✓ Provider Incident Management meetings in place

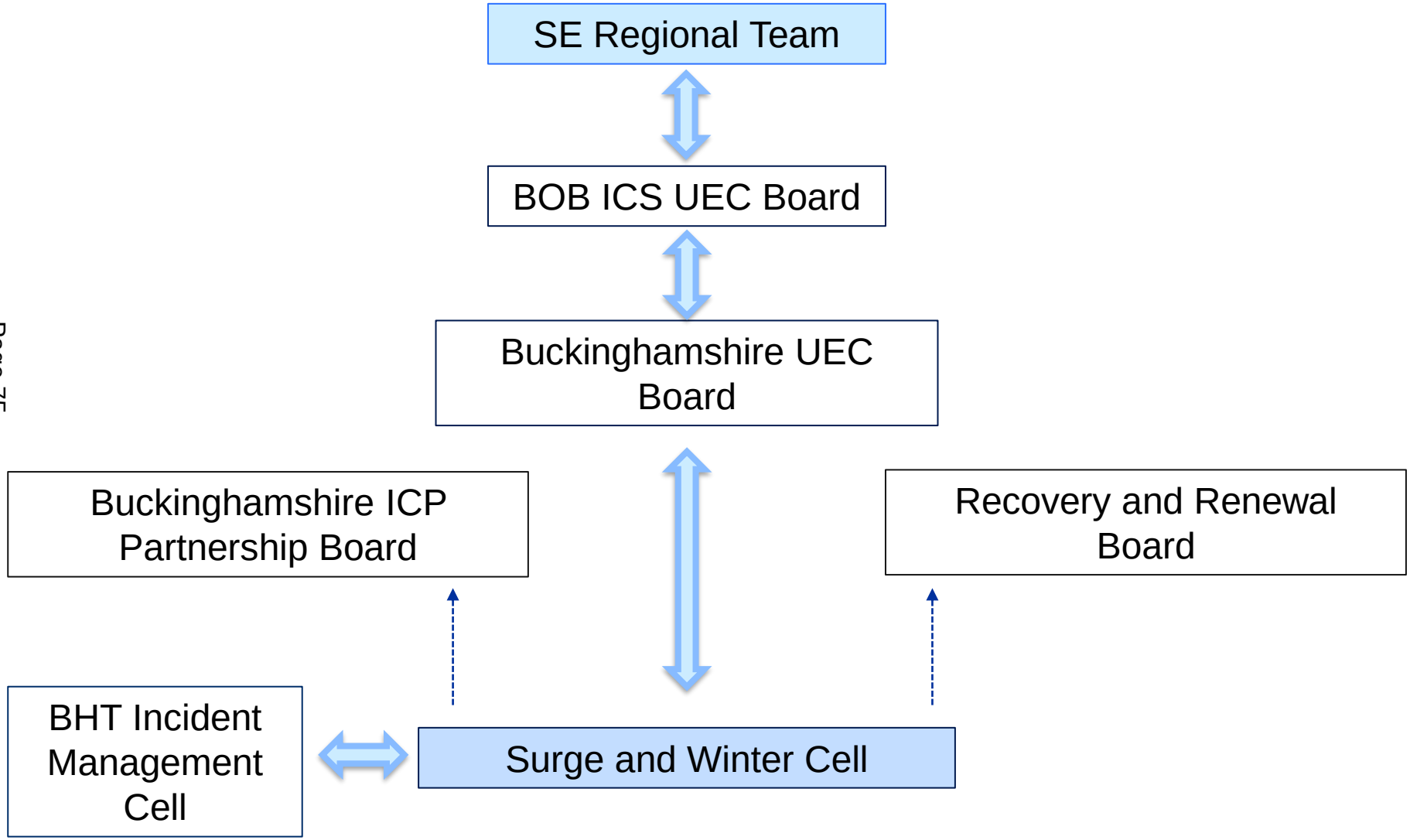
There is a single action tracker to help manage winter and surge across winter and this is embedded below:

Microsoft Excel Worksheet

System Winter and Surge Governance

All Surge plans and the Winter Plan are reviewed weekly and updated via an Action Tracker managed within the CCG UEC Team.

The Governance and Escalation Structure is highlighted below:



Risks

The table below highlights a selection of the current risks associated with surge and winter alongside the mitigations:

	Risk	Mitigation
1	There is a risk that patients will default to attending ED regardless of symptoms	System-wide communications plan to advise public of alternative services and support for self-care where appropriate
2	Increased ED conveyance	Implementation of updated urgent care pathways across Buckinghamshire and enhanced communications to healthcare professionals on the use of alternative conveyance pathways where clinically appropriate and
2	Fragility of the care home capacity due to Covid-19, leading to to challenges with capacity to discharge and flow across system	Look at alternative provision and monitor gaps in provision as proactively as possible, supporting flow within D2A
3	Delays to discharges from hospital leading to challenges to bed capacity and risks to patient safety in hospital	Agreements to • system wide escalation processes • implementation of actions outlined within the Discharge Surge Plan • daily check-in with care providers to expedite discharges
4	Availability of packages of care and access to reablement/ home independence/ home first pathways leading to issues in discharge from hospital	Facilitate quicker decision making along with enhanced joint working within teams and implementation of actions outlined within the Discharge Surge Plan
5	Further surges of Covid-19 ahead of the winter period could have a direct negative impact on all services in Buckinghamshire and exhaust available capacity	System-wide Surge Plans in place including: • Covid-19 Third Wave System Surge Plan • Discharge Surge Plan • Paediatric Surge Plan • Primary Care Surge Plan • Buckinghamshire response to South East UEC Surge Planning Above plans are supported by individual provider plans and will help facilitate flow within system. Reporting and management of activity in community and acute settings.
6	Workforce across the system	Plans in place for this across the system
7	Ambulance handover delays at hospital, impacting on demand management and potentially leading to increase in hospital conveyance	Implementation of HALA model at front end in ED to support timely handover of patients

Health & Wellbeing Board Buckinghamshire

Date: 18 November 2021

Title: Primary Care Access in Buckinghamshire

Author and/or contact officer: Jessica Newman, Head of Primary Care Buckinghamshire CCG

Report Sponsor: Robert Majilton, Deputy Chief Officer, Buckinghamshire CCG; Dr Raj Bajwa, Clinical Chair, Buckinghamshire CCG

Purpose of Report: To provide an update to the Health and Wellbeing Board on Primary Care Access in Buckinghamshire presenting the national activity data collected from GP practices. In addition, clinical members of the Health and Wellbeing Board will be able to provide an update from their perspective.

Report for information, discussion, decision or approval: For discussion

Recommendations:

- Note content of the report

Executive Summary

The report provides information on primary care (GP Practice) appointments and summary of the recent GP survey in Buckinghamshire.

Next steps and review

Primary Care resilience and support is included in the system winter surge plan. As part of Buckinghamshire, Oxfordshire and Berkshire West (BOB), the CCG in Buckinghamshire is working on a response to recent publication by NHS England of the 'Improving Access and Supporting General Practice' document.

Background Documents

Links to relevant information are included in the paper.

Primary Care in Buckinghamshire – Access

This report provides an update to the Health and Wellbeing Board on access to Primary Care in Buckinghamshire. The report uses national data at Buckinghamshire level to give an overview.

Background

Primary Care has continued to be operational during the pandemic and practices have needed to adapt both to delivering national operational model with services to the populations they serve.

Primary Care across Buckinghamshire have continued to offer face to face consultations. The proportion of appointments delivered face to face reduced during the pandemic with more offered, largely by telephone with the addition of on-line and video consultations.

Referrals have continued into other services such as for planned operations and suspected cancers. Practices have offered and increased the percentage uptake in the flu vaccination and increased the percentage of people with Learning Disabilities who have had a health check during 2020/21. Since December 2020 Practices, working through Primary Care Networks (PCNs) have also delivered over 350,000 COVID vaccinations.

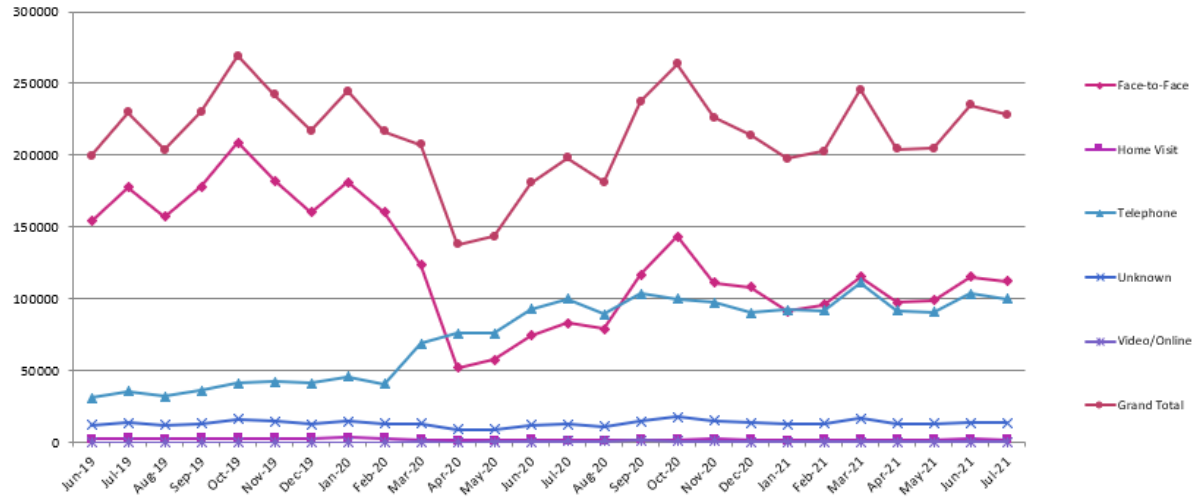
Activity - appointments

Primary Care appointments information is collected and published nationally[1] with aggregate activity data at a CCG level. Currently practice level data is not available but NHS Digital has been required to remedy that as part of 'Improving Access and Supporting General Practice'. In addition, until recently there has been no uniform way of recording appointments in primary care but work has started to provide systematic recording of appointment data. By 30 September, all practices were required to allocate appointments into nationally defined appointment types. This will improve the accuracy of appointment data and facilitate comparison at a practice, PCN and Integrated care systems (ICS) level.

The data available does however provide comparable data on pre-pandemic and current activity. **Activity broadly returned to pre-pandemic (i.e. 2019) levels since September 2020** (i.e. within 6 months of the first lockdown) and average circa 98% since then. Significantly, the data does not include the work undertaken by primary care to deliver COVID vaccinations, which started at the end of 2020 and continues today.

There are an average of 217,000 appointments per month with practices. Between April and July 2021 there were 872,000 appointments plus 183,000 COVID vaccinations undertaken by Practices in Buckinghamshire. There were 19,000 extra appointments (2%) than in April – July 2019 (where there were 853,000 appointments).

[1] Appointments in General Practice - NHS Digital



In July 2021 114,000 (50%) of all appointments were on the same day – in July 2019 this was 106,000 (an increase of 7.5%) – this compares with circa 45% nationally. 40% of these same day appointments were face to face (69% in July 2019).

Face to Face appointments

There have been national concerns on the ability to access face-to-face appointments with practices and Buckinghamshire is not unique in that regard. Practices in Buckinghamshire have continued to offer face to face appointments through the pandemic. **Between April 2020 – July 2021 there were circa 1.6m face to face appointments in Buckinghamshire**. The proportion of total appointments that are face to face has reduced nationally and locally since April 2020. Pre-pandemic about three quarters of appointments were face to face, now about half are (compared to circa 57% nationally).

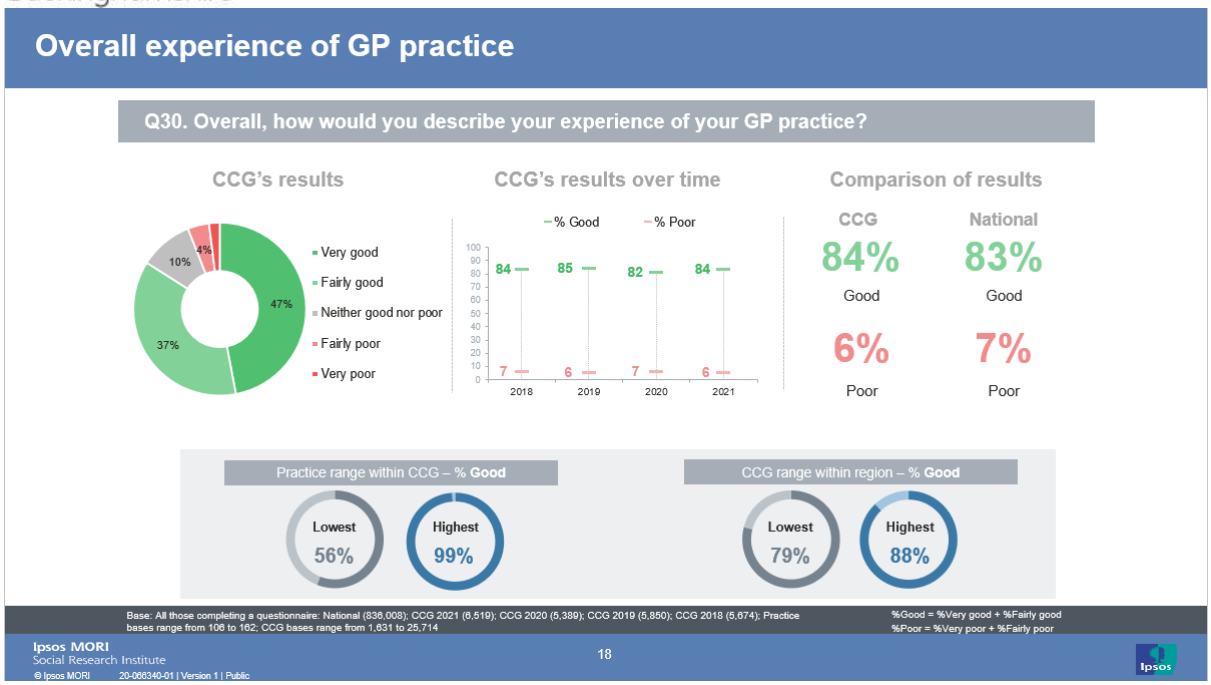
A new "Single Operating Procedure" was produced by NHS England in March 2020 as part of the primary care element of the pandemic response and moving to a "Level 4" incident (i.e. under national direction). This included total triage which increased the proportion of appointments that were undertaken on telephone with an assessment on the requirement for a face-to-face appointment.

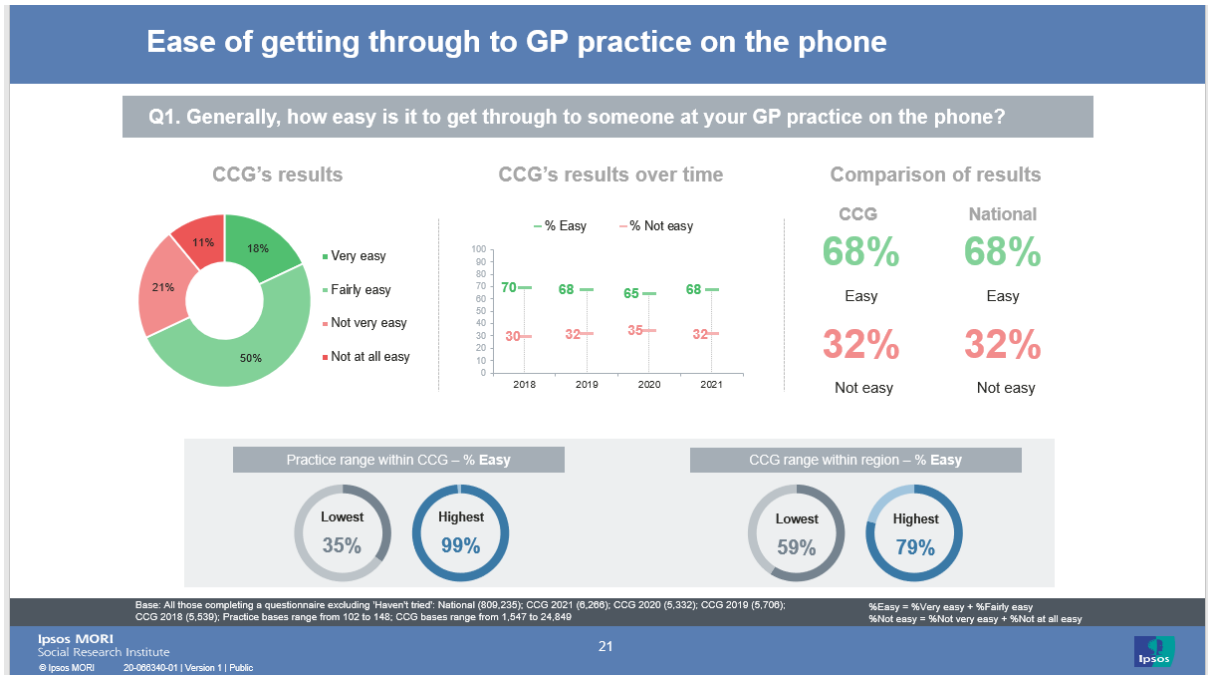
GP Patient Survey

The annual GP survey was published in July 2021[2] (based on surveys of circa 6,500 residents). 84% rated their practice as good (in line with the national average), with a range of between 56% - 99%.

Largely the Buckinghamshire results are in line with previous years and in line with the national average with variability across practices. 9 out of 10 patients tried to book appointments by the telephone with 7 out of 10 finding it easy to do so.

[2] GP Patient Survey (gp-patient.co.uk)





Improving Access and Supporting General Practice[3]

Whilst practice level appointment data is not currently available, through its commissioning and support activity the CCG is aware of the areas in the county where patients are having difficulty accessing primary medical services. The reasons for this are complex and the programme of work set out in the 'Improving Access and Supporting General Practice' document is proving helpful in defining the problems and facilitating solutions. This work, which is required to be managed at an ICS level, is at a very early stage but an update will be available at the Board meeting on 18 November.

[3] BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf (england.nhs.uk)

Health & Wellbeing Board
Buckinghamshire

Date: 18 November 2021

Title: Raising the profile of the Health and Wellbeing Board, communicating the priorities of the Health and Wellbeing Board and engaging with our audiences.

Author and/or contact officer: Cat Spalton - Head of Communications, Buckinghamshire Council

Report Sponsor: Cllr Angela Macpherson

Purpose of Report: To start a discussion about how we can raise the profile of the work of the Health and Wellbeing Board and set a strategic direction for communications that support the objectives and desired outcomes of the Happier, Healthier Lives strategy.

Report for information, discussion, decision or approval: For decision

Recommendations:

The Health and Wellbeing Board is asked to:

1. Agree 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.

2. Agree to the creation of a co-produced overarching communications strategy and related communications plans to support the Happier, Healthier Lives strategy by April 2022.

3. Note the planned reinstatement of the Getting Bucks Involved steering group in relation to engagement, in addition to the platforms that can be made available across the partnership.

Executive Summary
There is a consensus view that the work of the Board is not as visible as it could be.

This paper sets out a timeline and actions that can be taken to improve visibility and promote engagement with partners.

Background documents
Terms of reference for Getting Bucks Involved group

Introduction

1. The Health and Wellbeing Board is a statutory forum in the form of a partnership between local government, the NHS, voluntary sector and the communities of Buckinghamshire. It includes local GPs, councillors, senior local government and NHS officers, Healthwatch Bucks and voluntary sector representatives. The Buckinghamshire Health and Wellbeing Board was formed in 2013.

The Health and Wellbeing Board aims:

- To make a visible difference to health outcomes and reduce health inequalities across the county
- To support and enable strong, motivated and empowered communities in Buckinghamshire
- Deliver its statutory responsibilities and drive whole system leadership for health and wellbeing across Buckinghamshire

2. Earlier this year, the Board agreed the Joint Health and Wellbeing Strategy "Happier, Healthier Lives – A Plan for Buckinghamshire". This includes the three key strategic themes of start well, live well and age well, in addition to the cross-cutting theme of better mental health. The plan also incorporates Covid-19 recovery.

3. The Board continues to review and agree action plans related to its strategy.

4. In general, people do not always make the connection between what is discussed at Board meetings like this and the availability and/or changes to health and social care that impacts on them personally.

5. There is a desire from Board members to raise the profile of its work and encourage wider participation as part of the public questions. In addition, Board members would like to see a better alignment of strategic communication priorities related to health and social care with the Happier, Healthier Lives strategy.

Short to medium-term: October 2021 to March 2022

6. It is important to recognise the constraints that all partners are currently working in, both as a result of the Covid-19 pandemic and as we move into what is anticipated to be a very challenging winter. This is all in addition to the changes that are happening within the wider system as a result of the Health and Care Bill.

7. For these reasons the recommendation is to focus the strategic alignment of communications activities from April 2022, rather than progressing activity during the autumn and winter months.

8. However, there are some simple things that can be done in the meantime to help to raise the profile of the work of the Board.

9. The first is to provide a very basic introduction to all of the reports for the Board. Naturally some of the topics and issues discussed are very technical, which can make the content less than accessible for anyone who is not a clinician or immersed within the health and social care environment.

10. Secondly, the Board could make greater use of partner members' collective social media channels, highlighting how people can ask questions of the Board, decisions that have been made, what is being discussed and why it is important. This could be done right across the partner members of the Board using #HappierHealthier.

11. Board members are welcome to suggest other communication quick wins that have limited resource implications and will raise the profile of the work of the Board, including working with the Community Boards. Suggestions will be agreed in consultation with the Chair of the Board.

Longer-term: April 2022 onwards

12. It is proposed that in the longer-term, the Board could expand use of social content, for example report authors giving a short video update on reports to make them more accessible and easier to digest for wider audiences. This content could be published on their own organisation's social media channels and shared by partners.

13. There is also a real opportunity to build on the strong communications and engagement partnerships that were further developed in response to the Covid-19 pandemic.

14. The Board may also wish to consider encouraging greater participation in the Board on health and wellbeing matters, including those areas affecting wider determinants of health such as housing or transportation.

15. As a system across Buckinghamshire, Oxfordshire and Berkshire West, we are taking the opportunity to develop and deliver a shared communications plan for Winter 2021/22, which is then localised to specific concerns where appropriate, with plans to seek further opportunities for joint working.

16. Never has it been more obvious than during the Covid-19 pandemic that clear and timely information and compelling behaviour change communication plays an important and active role in creating healthier communities. It has also further highlighted how much our messages and resources are amplified when we work together on common causes.

17. In order for communications to support the work of the Health and Wellbeing Board - as individual organisations and as a partnership – it must be guided by and aligned to the Boards strategic priorities for the year. This will ensure that the service focuses on delivering what matters and we direct our effort and resources to what is going to make the biggest difference.

18. While we have identified key areas to work together on, it is recommended that this is taken a step further by developing a communications strategy for the Board that is co-produced by all partners. A related plan will set out the communication activity that will be undertaken by each organisation over the coming year, aligning core campaigns to Health and Wellbeing priorities, both as individual organisations and opportunities for the partnership.

19. By co-producing the strategy and related plan, we will:

    - identify opportunities to share resources and ideas
    - establish where we need to focus our collective efforts
    - highlight the work of each of the partners – together and individually
    - amplify and not duplicate campaigns and the work of each member organisation
    - ensure that our communications activity is aligned to the core priorities of the Health and Wellbeing Board
    - have a clear Buckinghamshire wide communications plan on promoting responsibility for health and wellbeing
    - incorporate Covid-19 recovery.

20. It is recommended that a timescale of April 2022 is set to develop a Buckinghamshire-wide communications strategy which promotes the work of the Board and encourages and supports people to take up responsibility for their own health and wellbeing. It is proposed to establish a working group to develop the strategy.

Engagement

21. Engagement – however formal or informal – is essential to shaping health and social care policy, priorities and delivery.

22. The Getting Bucks Involved Steering Group was a helpful mechanism in which to shape plans for engagement activity. For many of the reasons outlined above, this group has not met in a meaningful way since December 2020.

23. While the terms of reference for this group may need to be updated, partners have recognised the value of this group. As a result, the group – and the communications sub-group – will be reinstated with the first meeting anticipated to be by January 2022.

24. Engagement is a core principle of the Integrated Care System proposed in the Health and Care Bill. It will therefore be integral to co-ordinate with the approach being taken across Buckinghamshire, Oxfordshire and Berkshire.

25. The Council has further renewed its subscriptions to the consultation platform 'Your Voice Bucks', in addition to a further platform which has recruited 1500 people to participate in health and social care surveys. Partners are once again invited to share in using these resources (and the cost).

26. The Council's Community Engagement Team's work in supporting Public Health, NHS and comms colleagues in areas such as Covid vaccination outreach, tackling health inequalities and targeting health/ prevention messages, will continue to be extremely valuable as we progress the "Happier, Healthier Lives" strategy.

This page is intentionally left blank

Health & Wellbeing Board
Buckinghamshire

Date: 18 November 2021

Title: Director of Public Health Annual Report: Domestic Violence and Abuse

Author and/or contact officer: Dr Jane O'Grady, Director of Public Health, Buckinghamshire Council

Report Sponsor: Cllr Angela Macpherson / Cllr Carl Jackson

Purpose of Report: It is a statutory duty for the Director of Public Health to produce an annual report on the health of their population. This year's report focuses on domestic violence and abuse and makes recommendations for all partners in Buckinghamshire.

The report is particularly relevant to members of the health and wellbeing board as domestic abuse has a significant impact on mental and physical health. Many people presenting to partner services will be experiencing domestic abuse and services have an opportunity to identify, support and refer victims of domestic abuse to key services. Domestic abuse will affect many people working in our organisations which makes tackling domestic abuse a key part of any organisational wellbeing strategy. Ending domestic abuse is everyone's business and requires a co-ordinated response from national government, local partners and the public.

Background

The report was based on the findings of a needs' assessment conducted pre-pandemic by the Public Health team and a recent literature review. It takes into account the views of a range of partners from Buckinghamshire Council, the NHS, Thames Valley Police, Women's Aid and the views of survivors of domestic abuse and service users.

This report covers key areas including how to recognise signs of domestic abuse and signposts where to get help, who may be at greater risk of experiencing domestic abuse and when, including research on warning signs leading up to domestic homicides. It also covers what is known about interventions that contribute to reducing the risk and harms of domestic abuse and the need for more work to focus on preventing perpetrators from committing domestic abuse.

The Domestic Abuse Bill 2021 was passed by Parliament in April 2021. The Bill and its statutory requirements, such as the formation of a Domestic Abuse Board, will inform local actions.

This report has been shared with members of the new Buckinghamshire Domestic Abuse Board to help inform the developing strategy. It makes recommendations based on our local situation for the Board and a range of partners in Buckinghamshire to implement. The Buckinghamshire Domestic Abuse Board will be responsible for strategy development and

development and oversight of an action plan which should include the responses to these recommendations.

Report for information, discussion, decision or approval: This report is for discussion and endorsement by the Health and Wellbeing Board.

Recommendations:

- The Health and Wellbeing Board is requested to note the Director of Public Health Annual Report and endorse the recommendations.
- Members of the Health and wellbeing Board are requested to identify how their organisation can 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 is requested to ensure active engagement of the relevant organisations in the Buckinghamshire Domestic Abuse Board.

Recommendations within the Director of Public Health Annual Report: Domestic Violence and Abuse

The following recommendations should, in addition to statutory duties for support for people living in safe accommodation, inform the work of partners and the Domestic Abuse Local Partnership Board strategy and delivery plan:

1. The Domestic Abuse Board should support awareness raising of domestic abuse through coordinated, county-wide participation in a selected national campaign.
2. The Domestic Abuse Board should consider how bystander training could be utilised locally and promoted, as an evidence-based intervention to challenge harmful attitudes, language and behaviour relating to domestic abuse for people of all ages.
3. Buckinghamshire Council Community Safety team should consider how to increase the diversity within the domestic violence and abuse champions scheme by actively recruiting network members that reflect the diversity of people that may experience domestic abuse.
4. The Domestic Abuse Board should develop and roll-out high-quality, shared, scenario-based training across Buckinghamshire for key stakeholders and front-line staff. Primary care should also consider implementing the IRIS training package as an effective evidence-based training programme across Buckinghamshire.
5. The Domestic Abuse Board should oversee the development of a Buckinghamshire domestic abuse referral pathway for all staff to follow, to ensure timely and responsive delivery of services, fully understood by frontline staff and accessible to victims seeking help

6. All Board member agencies to support the development of an evidence base for what works for perpetrators, to inform commissioning of promising interventions, and evaluation of their effectiveness

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT: DOMESTIC VIOLENCE AND ABUSE. EXECUTIVE SUMMARY.

What is domestic abuse and who is at risk?

1.1 The Domestic Abuse Bill 2021 defines domestic abuse behaviour to consist of any of the following; physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; psychological, emotional or other abuse.

1.2 Domestic abuse if often poorly recognised by victims and others and under-reported when recognised. Less than 1 in 5 women experiencing domestic abuse report it to the police.

1.3 One in 20 adults are estimated to experience domestic violence every year equating to almost 21,000 people a year in Buckinghamshire or 57 people every day.

1.4 Domestic violence crimes accounted for 15% of all recorded crime in Buckinghamshire from 2019 to 2020.

1.5 Domestic abuse can happen to anyone, at any age, across all gender identities, ethnic groups and walks of life. It can take place in different types of relationships such as between family members, ex-partners and people not living together.

1.6 Women are more commonly victims of domestic abuse than men and twice as many women as men experience domestic abuse. Police data for Buckinghamshire reveals 71% of victims of domestic violence were female

1.7 Women experience more of certain types of abuse including; more repeated physical violence, more severe violence, more sexual violence, more coercive control, more injuries and more fear of their partner than men. 91% of domestic violence crimes causing injuries are against women.

1.8 Domestic abuse can happen to anyone however it appears that some people are more likely to be victims of domestic abuse. A lack of complete data on victims limits our understanding of the full picture e.g. data on ethnicity is often not recorded. Much of our data comes from surveys or services. A lack of data may reflect reluctance to provide information, poor data collection, or barriers to accessing services, either because they are not inclusive or are perceived not to be.

1.9 From the data that exists it appears that being younger, having poorer mental health, having a physical or learning disability, being unemployed, from a single-parent household, of mixed ethnicity or identifying as lesbian, gay, bisexual, transgender, or

another definition of gender and sexuality identity increased the risk of experiencing domestic abuse.

1.10 This risk of domestic abuse is increased at certain times; when separating or fleeing from abuse, during or after pregnancy, when drugs or alcohol are used and around the time of football matches.

1.11 We know even less about perpetrators but the evidence that exists shows that the majority are men. Male perpetrators are more likely to seriously injure or kill their victim. Police data for Buckinghamshire show that 72% of perpetrators in Buckinghamshire were male (10 months to January 2021).

1.12 Having low self-esteem or depression, being hostile towards women, experiencing economic or marital stress, and communities with low social cohesion and social capital, and low bystander intervention increase the risk of people becoming perpetrators. Normalising abusive behaviour also increases the risk of becoming a perpetrator.

1.13 Perpetrators of domestic homicides are more likely to be men and are more often a partner or ex-partner. 86% domestic homicides between 2017 and 2019 in England and Wales were committed by men.

Trends in domestic abuse

1.14 In England and Wales, domestic abuse rates had been gradually decreasing between 2005 and 2020. However, since the Covid-19 pandemic, this trend has reversed. During the first lockdown (March-June 2020), Police data showed a 7% increase in domestic abuse related offences. Contacts to the National Domestic Abuse charity Refuge rose by 61% and contacts to the charity Respect which supports male victims of domestic abuse rose by 70%.

1.15 Local data for Buckinghamshire showed an increase in both reported domestic abuse crimes and use of services by victims. Data up to January 2021 showed a 15% increase in domestic abuse crimes reported to police in Buckinghamshire.

Impact of Domestic Abuse

1.16 Experiencing and witnessing domestic abuse can have devastating impacts on victims, and their children, friends and wider family. Harm as a result of domestic abuse can have lifelong impacts on physical, mental and sexual health. The more severe the abuse, the greater the impact. In the worst cases, domestic abuse can result in homicide, including suicide as a result of domestic abuse.

1.17 The harms from domestic abuse include 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.

1.18 Domestic abuse also increases the risk of homelessness, poverty and impacts 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.

1.19 It is estimated 1 in 5 children are exposed to domestic abuse in UK. This causes emotional, psychological, social, educational and developmental problems. This can be due to being directly harmed by a perpetrator but also by witnessing the abuse. The impact of moving home and school to escape a perpetrator and the wider social and economic impact on the family can affect children profoundly. There is also a danger that children may in some cases begin to see abuse as normal behaviour.

1.20 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). As a result 700 children were given children in need, child protection plans or became looked after. This accounted for half of all children who became looked after that year.

1.21 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 a predictable pattern of behaviour characterised by eight stages leading up to homicide in many cases examined. In almost all cases the perpetrator had a history of coercive control, stalking or domestic abuse. Leaving the relationship is a particularly dangerous time for women and 40% of women killed by a male partner in 2018 were separating/just separated from partner.

1.22 Between 2017 and 2019 there were 357 domestic homicides in England and Wales. Men committed 86% of all domestic homicides. The victim was female in 77% of domestic homicides. The perpetrator was male in 96% of female homicides and 53% of male homicides.

1.23 Between 2011 and 2020, there were 39 domestic homicides in the Thames Valley area, of which 15 were in Buckinghamshire.

1.24 Using national estimates, the potential annual cost of the consequences of domestic abuse in Buckinghamshire is £687 million. We estimate that the cost of responding to the domestic abuse cases *that we know about* in Buckinghamshire is about £3.5 million.

What works to tackle domestic violence?

1.25 There are many potentially effective domestic abuse interventions for victims, including school-based awareness raising, bystander interventions, improving public

awareness and advocacy, training of frontline staff, and support such as independent domestic violence advisors and multiagency risk assessment conferences.

1.26 Historically, many interventions addressing domestic abuse have not been thoroughly evaluated so it is vital that new and existing programmes should be monitored and reviewed to improve the robustness of the evidence base.

1.27 Interventions for perpetrators are even less well understood, however these interventions are an extremely important part of tackling domestic violence and abuse services and should be developed and thoroughly evaluated. There needs to be much more focus on preventing people becoming abusers in the first place and preventing perpetrators from continuing their abuse.

Next steps for Buckinghamshire

1.28 Domestic abuse is a complex societal issue and prevention of domestic abuse and the response to domestic abuse must be multifaceted and multi-agency. The need to embed early intervention and prevention into a multiagency response to domestic abuse is highlighted in the government's Violence Against Women and Girls Strategy. The response includes government-led initiatives as well as local authority multi-agency working, safeguarding, and commissioning. It highlights the multi-layered and co-ordinated health, social and criminal justice approaches required to tackle this issue and can be applied to all victims.

1.29 Preventing domestic abuse from occurring must be a priority and we are supporting our schools to implement recent RSHE (relationships, sex and health education) that includes recognising domestic abuse and abusive relationships, coercive control, consent, and mutual respect in friendships and relationships.

1.30 The new multi-agency Domestic Abuse Local Partnership Board will be championing good practice in awareness raising, education and training and the provision of high-quality support and advocacy services.

1.31 Services for victims (including children) and perpetrators will need to be further developed to meet the needs of diverse groups and people with protected characteristics, recognising that anyone can be a victim.

1.32 Starting with partners on the Board, all organisations should adopt measures to keep employees and service users safe from domestic abuse especially during this period of home working, remote digital working and digital consultations.

1.33 The Domestic Abuse Board will also need to explore how we can share and learn from past and current domestic homicide reviews to understand how such tragedies can be prevented in the future.

1.34 The following recommendations should, in addition to statutory duties for support for people living in safe accommodation, inform the work of partners and the Domestic Abuse Local Partnership Board strategy and delivery plan:

1. The Domestic Abuse Board should support awareness raising of domestic abuse through coordinated, county-wide participation in a selected national campaign.
2. The Domestic Abuse Board should consider how bystander training could be utilised locally and promoted, as an evidence-based intervention to challenge harmful attitudes, language and behaviour relating to domestic abuse for people of all ages.
3. Buckinghamshire Council Community Safety team should consider how to increase the diversity within the domestic violence and abuse champions scheme by actively recruiting network members that reflect the diversity of people that may experience domestic abuse.
4. The Domestic Abuse Board should develop and roll-out high-quality, shared, scenario-based training across Buckinghamshire for key stakeholders and front-line staff. Primary care should also consider implementing the IRIS training package as an effective evidence-based training programme across Buckinghamshire.
5. The Domestic Abuse Board should oversee the development of a Buckinghamshire domestic abuse referral pathway for all staff to follow, to ensure timely and responsive delivery of services, fully understood by frontline staff and accessible to victims seeking help.
6. All Board member agencies to support the development of an evidence base for what works for perpetrators, to inform commissioning of promising interventions, and evaluation of their effectiveness.

This page is intentionally left blank

DIRECTOR OF PUBLIC HEALTH
ANNUAL REPORT 2021

Domestic Violence and Abuse

Contents

Acknowledgements

Thanks to all who participated in the domestic violence and abuse needs assessment and in compiling this report, especially those who allowed us to reflect their views and personal stories. Also particular thanks to Lucy Cunningham who led on pulling together all the information for this report.

Contributing stakeholders:

Adam Johnson
Amanda Andrews
April Benson
Brian Daly
Carol Stottor
Caroline Thickens
Claire Hawkes
Elaina Quesada
Elaine Jewell
Elkie Dolling
Faye Blunstone
Francis Habgood
Jenny Chapman
Karen Ross
Lisa Latchford
Louise Hurst
Lucy Cunningham
Mollie Raine
Sanita Kalyan
Sue Hinks
Teresa Martin
Tiffany Burch

Thank you to the survivors and service users who shared their experiences.

If you think you or someone you know may be experiencing domestic abuse, go to reducingtherisk.org.uk/Buckinghamshire for support and advice.

1. INTRODUCTION

This year my Director of Public Health Annual Report focuses on domestic violence and abuse.

One in 20 adults are estimated to experience domestic abuse every year equating to almost 21,000 people a year in Buckinghamshire or 57 people every day. Women are more commonly victims of domestic abuse than men but it can happen to anyone, at any age, across all gender identities, ethnic groups and walks of life.

Domestic abuse is a crime often hidden from view, at home and out of sight. It often goes unreported, as victims and witnesses such as children in the family may not report abuse for many different reasons. Surveys suggest fewer than one in five women experiencing domestic abuse report it to police. On average it takes three years for victims of domestic abuse to access support services.

Domestic abuse has a profound impact on victims and survivors, their family and wider society. Domestic abuse causes poor physical and mental health both in the short and long term, and in some extreme cases death. There are also serious consequences for children in the household witnessing domestic abuse with impacts on their mental and physical health, safety and educational attainment. Domestic abuse also contributes significantly to homelessness and increases the risk of poverty for victims and their children. The Home Office estimates that the economic and social costs of domestic abuse are over £66 billion in England and Wales.

The prevalence of domestic abuse was vividly highlighted during the Covid-19 pandemic. During and following the first lockdown, data up to January 2021 showed a 15% increase in domestic abuse crimes reported to police for Buckinghamshire with a 13% increase in known victims and perpetrators. Service data showed an increase in demand for domestic abuse support services.

Ending domestic abuse is everyone's business and requires a co-ordinated response from national government, local partners and the public.

This report is informed by a needs assessment undertaken by Buckinghamshire Council, views from victims and service users, frontline professionals and organisations in Buckinghamshire. It covers key areas including how to recognise signs of domestic abuse and where to get help, who may be at greater risk of experiencing abuse and when, including research on the warning signs leading up to domestic homicides. It also covers what is known about interventions that contribute to reducing the risk and harms of domestic abuse and the need for more work to focus on preventing perpetrators from committing domestic abuse. The Domestic Abuse Bill 2021 was recently passed in April and will also inform local actions. My report makes recommendations based on our local situation for a range of partners in Buckinghamshire to implement.

Finally I would like to thank all those who participated in the needs assessment and in compiling this report, especially those who allowed us to reflect their views and personal stories. I hope that the coming years will see us make very significant progress in reducing domestic abuse in Buckinghamshire and offering effective support to all those affected.

Dr Jane O'Grady
June 2021

2. WHAT IS DOMESTIC ABUSE AND HOW CAN WE RECOGNISE IT?

What is Domestic Abuse?

The Domestic Abuse Bill (2021) sets out a new statutory definition of domestic abuse that covers both the nature of the relationship and the range of behaviours that are considered abusive.[1]

It says that **behaviour is abusive** if it consists of any of the following:

1. Physical or sexual abuse.
2. Violent or threatening behaviour.
3. Controlling or coercive behaviour.
4. Economic abuse.
5. Psychological, emotional or other abuse.

The behaviour can consist of a single incident or ongoing behaviour.

Domestic abuse can take place in different types of relationships, it can be between family members, ex-partners and people not living together. The definition refers to people aged 16 or over, but the Bill says that children can still be victims. If the abuser directs his/her behaviour at a child in order to be abusive to another adult, this is domestic abuse (see appendix for full definition).

For women, coercive control has been shown to be the most common, and the most dangerous context of abuse.

There were 24,856 offences of coercive control recorded by the police in the year ending March 2020 in England and Wales.[2] It is defined as "*...assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*". This can also include stalking, which is a pattern of persistent and unwanted attention. For women, coercive control has been shown to be the most dangerous context of abuse.[3]

> In middle class suburbia, there's a culture of things being hidden. It's humiliating to admit you're going through something like this.
>
> - Victim of domestic abuse, Buckinghamshire

How can we recognise signs of domestic abuse?

Recognising domestic abuse is the first step to taking action.

Recognising domestic abuse is the first step to taking action. Some victims as well as their friends, family and colleagues may not recognise or acknowledge the abuse. There are resources available to help us all recognise domestic abuse,[4] and to respond effectively as a positive bystander so that we can assist victims safely.[5]

Signs that someone may be a victim of domestic abuse include:

- Being withdrawn.
- Becoming isolated from family and friends.
- Having bruises, burns or bite marks.
- Having finances controlled.
- Not being allowed to leave the house, or stopped from going to college or work.
- Having internet, social media or other communications monitored.
- Being repeatedly belittled, put down or told they are worthless.
- Being told that abuse is their fault, or that they are overreacting.

Children may respond to experiencing and/or witnessing abuse in different ways. Signs in children include:

- Being anxious, depressed or withdrawn, easily startled.
- Having difficulty sleeping, having nightmares or flashbacks.
- Complaining of physical symptoms such as tummy aches.
- Bed wetting.
- Developing behavioural problems e.g. temper tantrums and problems in school, behaving as though they are much younger than they are, becoming aggressive.
- Having a lowered sense of self-worth.
- Older children playing truant, using alcohol or drugs, or self-harming.
- Developing an eating disorder.
- Feeling angry, guilty, insecure, alone, frightened, powerless or confused.
- Having ambivalent feelings towards both the abuser and the non-abusing parent.

> It took me a long time to realise there was a problem and therefore to seek help. I felt that it wasn't bad enough to be abuse because he wasn't hitting me.
>
> - Victim of domestic abuse, Buckinghamshire

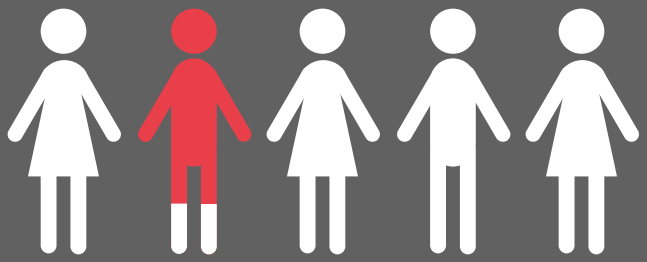
3. HOW COMMON IS DOMESTIC ABUSE?

Victims

Data on domestic abuse comes from several sources. The Crime Survey for England and Wales and national police data on recorded crime are analysed and published by the Office for National Statistics. Local data from Thames Valley Police is available to inform what is happening in Buckinghamshire.

We can also use national and local data on use of domestic abuse services to determine who is using services.

The current data have limitations. Domestic abuse often goes unreported and, when it is reported, there can be a lack of detail about the type of abuse suffered and the characteristics of people involved e.g. ethnicity. For example, fewer than one in five women (17%) who had experienced partner abuse in the year to March 2018 reported the abuse to the police.[6]



Fewer than one in five women (17%) who had experienced partner abuse in the year to March 2018 reported the abuse to the police.

For the year to March 2020 in England and Wales[7] we know that:

- One in 20 adults aged 16 to 74 years reported experiencing domestic abuse in the year to March 2020 (ONS).
- There were approximately 1.28 million recorded domestic abuse-related incidents and crimes.
- Twice as many women experienced some form of domestic abuse as men.
- Women aged 16 to 19 years were more likely to report being a victim of domestic abuse than women in all other age groups. 14% of women in this age group said that they had experienced any domestic abuse.
- For men, the age group most likely to report being a victim of domestic abuse was also 16 to 19 years old. 5% of men of this age said that they had experienced any domestic abuse.
- People with a disability were more likely to experience domestic abuse than people without a disability.

- Unemployed people were more likely to have experienced domestic abuse than those who were employed or economically inactive.
- People living in a single-parent household were more likely to experience domestic abuse.
- People in the Mixed ethnic group were more likely to experience domestic abuse compared to other ethnicity categories (Asian/Asian British, Black/Black British, White and Other).
- Women in the lowest household income bracket are four times more likely to report being victims of domestic abuse.[8]
- There were 357 domestic homicides between 2017 and 2019.[9] Men committed 86% of all domestic homicides. The victim was female in 77% of domestic homicides cases. The suspect was male in 96% of female homicides and 53% of male homicides.

We also know from research in England and Wales that:

- Women experience more of certain types of abuse: more repeated physical violence, more severe violence, more sexual violence, more coercive control, more injuries and more fear of their partner compared to men.[10]
- 91% of domestic violent crimes causing injuries are against women.[11]
- 83% of victims experiencing more than ten violent crimes are women.[11]

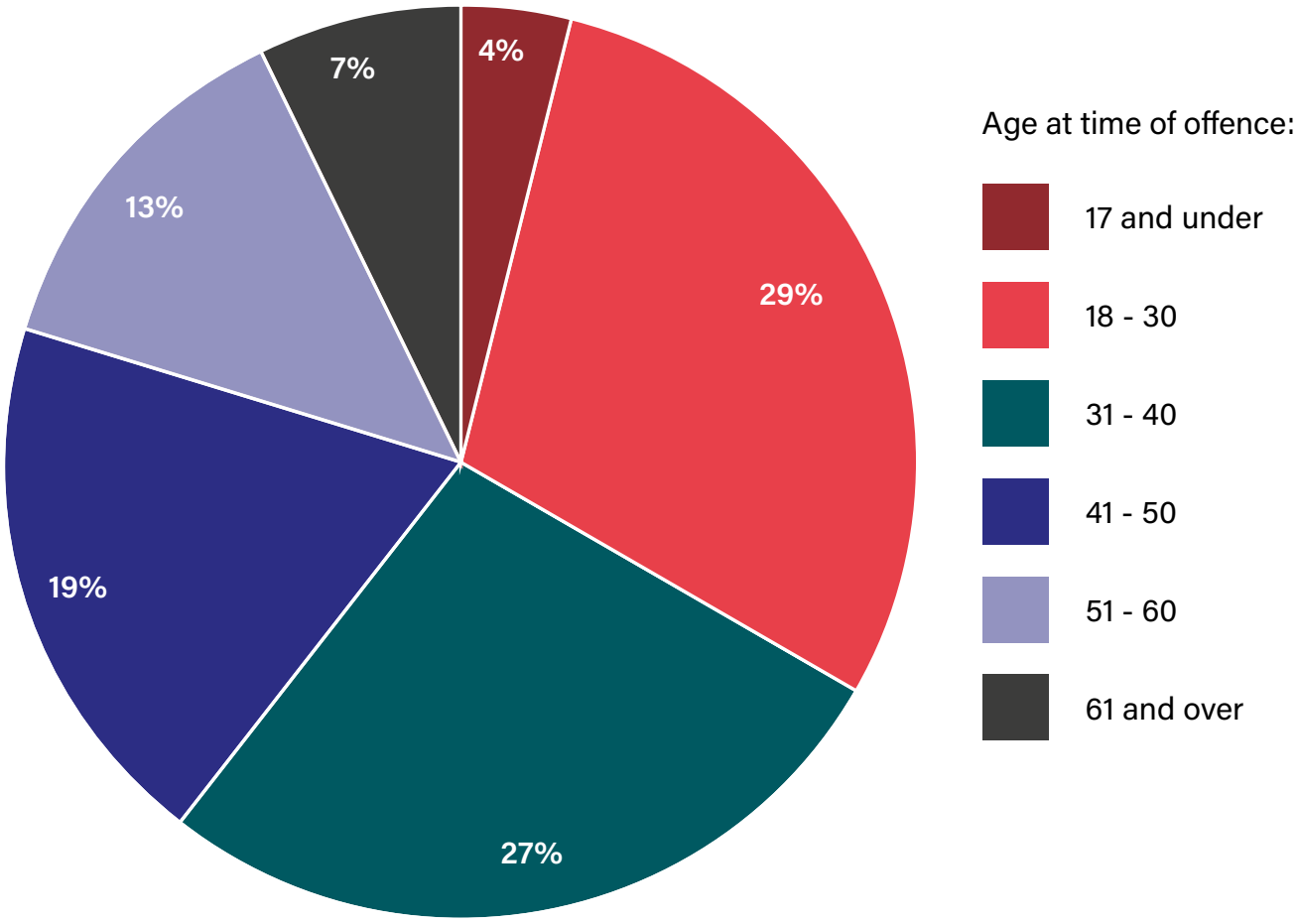
Domestic abuse affects an estimated 21,000 adults in Buckinghamshire each year, or 57 people every day.

Domestic abuse data for Buckinghamshire tell us the following:

- Domestic abuse affects an estimated 21,000 adults in Buckinghamshire each year, or 57 people every day.
- Police data for Buckinghamshire from 2020 to 2021 showed that:
  - Only around 4,000 victims of abuse were recorded. This reflects a known pattern of under-reporting of domestic abuse for all victims.
  - More victims are female (71%) than male.
  - Over half of victims (56%) are aged between 18 and 40 years of age.
- Between 2011 and 2020, there were 15 domestic homicides in Buckinghamshire and 39 across the Thames Valley area.

> It's more difficult to tell people that you're a victim of abuse if you're male – it's too shameful and embarrassing.
>
> - Victim of domestic abuse, Buckinghamshire

Age of victim at time of abuse. Buckinghamshire data as recorded by Thames Valley Police, April 2020 to Jan 2021



A local needs assessment (2019) found that domestic abuse services in Buckinghamshire compare well to gold standard guidance from the National Institute for Health and Social Care Excellence (NICE).[12] For example, the county has the recommended number of independent domestic violence advisers (IDVAs) for its population size. Local domestic abuse service data add to our knowledge of domestic abuse.[a] Understanding who is (and who isn't) using services can inform service planning, commissioning, and delivery.

Data collection in these services can be challenging and sensitive, and therefore service data are often incomplete. However, comparing the data we have with national estimates suggests that some groups may be under-represented in service users. These groups include, but may not be limited to: men, older people, ethnic minorities, disabled people and people who are lesbian, gay, bisexual, transgender, or have another definition of their gender and sexuality (LGBT+). This under-representation may reflect the fact that not all victims want to seek help, and/or that services are not meeting the needs of these groups.

[a] *Women's Aid Bucks provides domestic abuse services in Buckinghamshire, including independent domestic violence advice (IDVA), outreach services and refuge space.*

Perpetrators

Less is known about the people who carry out domestic abuse than their victims.

Less is known about the people who carry out domestic abuse than their victims. It is vital that we understand more about perpetrators if we are to understand how to prevent abuse and change their behaviour.

Whilst data are limited,[13] one report suggested that there are around 400,000 perpetrators in England and Wales causing high and medium levels of harm.[14] Perpetrators are more often a partner or ex-partner rather than a family member.[15] They are more likely to be male. Male perpetrators are more likely to seriously injure or kill their victim; of the 357 domestic homicides committed in England and Wales between 2017 and 2019, 86% were committed by men.[16]

3,212 perpetrators committed 4,431 domestic abuse crimes.

From Thames Valley Police data for Buckinghamshire (10 months to January 2021), we know that:

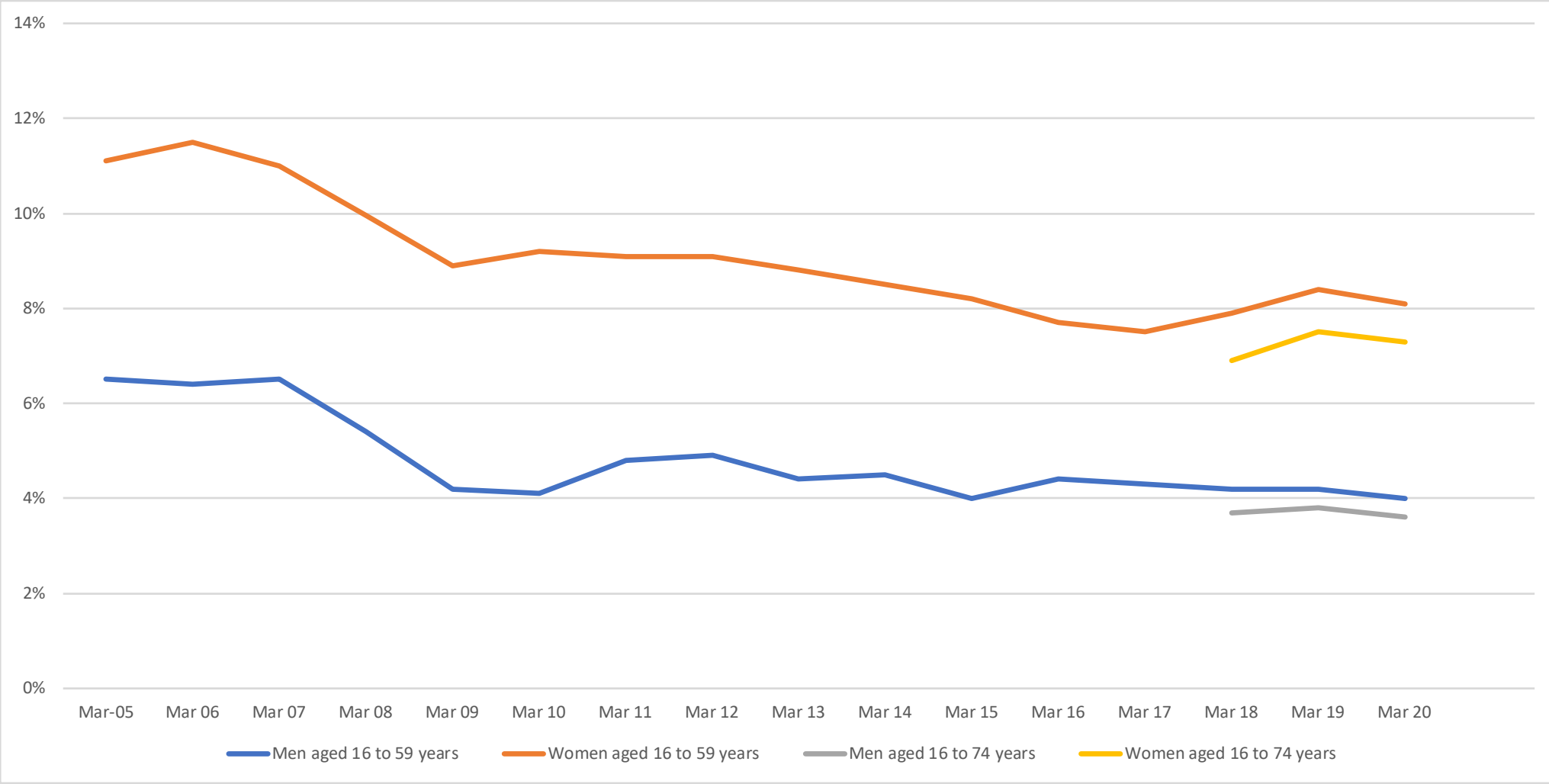
- There were 3,212 perpetrators who committed 4,431 domestic abuse crimes (Thames Valley Police data for Buckinghamshire, April 2020 - January 2021).
- 72% of perpetrators of known gender were male.
- 64% of perpetrators of known age were 40 years old or under.

Perpetrators can be children as well as adults. Research and local professionals tell us that teen-to-parent and teen-to-teen domestic abuse occurs locally.

Trends over time

Crime Survey for England and Wales data show fewer people experiencing domestic abuse over time, from 2005 to 2020.

Percentage of adults reporting domestic abuse in the annual Crime Survey, England and Wales, 2005 to 2020.[17]



Despite the gradually decreasing rates of domestic abuse reported in surveys, there was a 9% increase in domestic abuse-related incidents and crimes reported to police from 2019 to 2020 in England and Wales. This may relate to changes in police recording or may reflect a true increase in reporting to the police.

Domestic abuse-related incidents and crimes accounted for 15% of all crime in Buckinghamshire from 2019 to 2020.

In Buckinghamshire, these crimes accounted for 15% of all recorded crime from 2019 to 2020, 14% of all crime from 2018 to 2019, and 11% of all crime from 2017 to 2018.

The Covid-19 pandemic saw a significant increase in reported domestic abuse. During the first lockdown (March to June 2020), police data showed a 7% increase[b] in domestic abuse related offences.[18] In the 10 months from April 2020, contacts to the National Domestic Abuse charity Refuge[19] rose by 61% and contacts to the charity Respect which supports male victims of domestic abuse rose by 70%.[20] Calls to the National Stalking Helpline in the year from March 2020 increased by almost 10%.[21] The lockdown resulted in victims being confined at home with perpetrators. School closures may have increased exposure of children to household violence. In-person contact with health and social services reduced. And home visits which may have identified and intervened in risky situations were reduced. Victims reported that the abuse worsened during the pandemic, especially if they lived with their abuser.[22]

[b] *As the number of offences flagged as domestic abuse-related has been increasing in recent years, it is not possible to determine what impact the coronavirus pandemic may have had on the increases in 2020.*

The Covid-19 pandemic saw a significant increase in reported domestic abuse.

Victims reported that the abuse worsened during the pandemic, especially if they lived with their abuser.

In Buckinghamshire, reports of domestic abuse and use of domestic abuse services have increased since the start of the pandemic. The table shows increases in police and service use data.

POLICE DATA	Before Covid-19 April 2019 to Jan 2020	After Covid-19 April 2020 to Jan 2021	Percentage change
Reported domestic abuse crimes	3849	4431	15% ↑
Numbers of victims	2924	3291	13% ↑
Numbers of perpetrators	2839	3212	13% ↑
Domestic-related stalking crimes*	54*	415*	669% ↑*
**Large increase is due to changes in recording practises by the Home Office in April 2020.*			
SERVICE DATA	**Before Covid-19 April to Sept 2019**	**After Covid-19 April to Sept 2020**	**Percentage change**
Victims supported by IDVAs[c]	601	1062	77% ↑

[c] *This includes victims supported within a police station and/or within Women's Aid IDVA services in Buckinghamshire.*

I never expected domestic abuse would happen to me

"I always thought that domestic violence and abuse was something that happened to other people. But it happened to me. This is my story from ten years ago.

"He will be nameless. We met online, but we had mutual acquaintances in common, so I felt okay about meeting him. We first met in a quiet local pub - he wasn't really my type, and I only agreed to a second date to not hurt his feelings. However after meeting more, I felt that we had a connection. We ended up moving in together quite quickly and that's when my life began to change.

"From the start he was 'love bombing' me, a tactic that abusers sometimes use to get you on side – sending texts saying that he really liked me, and thought I was amazing. He was also controlling and overbearing – my phone would ring and he would be hovering, wanting to hear what I was saying. He would question me – what did they want, why had or hadn't I spoken about him? Then there were questions about why people weren't ringing or texting me. I felt that I couldn't do anything right.

"Things reached a head when I stayed away overnight for a work trip. He accused me of making it up – I was going away because I was having an affair (I wasn't). He cornered me in our bedroom, pushing me against the wall, yelling and screaming at me. In his mind, he was right – I couldn't say anything to stop him. I'm not proud of it, but I slapped him. Silence. Nothing happened. I got my bags and I left. For the next 36 hours I had text after text saying things like the police would arrest me, he was sorry, please come back, I love you, I need you, why aren't you telling me the truth, don't you dare come back, your stuff is in bin bags at the front door.

"You might wonder, why I didn't ring someone and tell them? What do you say? Who do you tell? Abusers pull you away from your friends and family. Contact becomes limited, and often you can't see people without the abuser being present. Unless you've been in this position, you can't imagine how lost and alone you feel. Reaching out to talk to someone, becomes the most impossible thing you can do.

"Christmas came. I was trapped in a flat, with a man I was petrified of. We rowed, and by 4am, he had ripped out clumps of my hair, tried to strangle me, kicked me in the ribs, given me a black eye, and ripped an earring out my ear. He proposed at some point that night. I said yes because I didn't know what else to say. It was terrifying. I couldn't even cry. I just felt numb.

"It was another three weeks before I left, and I can't tell you what happened. I don't let myself think about it. But I did leave. And I didn't go back."

- Anonymous resident, Buckinghamshire

4. WHO IS AT GREATER RISK OF SUFFERING DOMESTIC ABUSE?

Some people are more likely to be victims of domestic abuse. Tools such as the DASH risk checklist (Domestic Abuse, Stalking and Harassment and Honour Based Violence) help trained health and social care professionals and the police to assess the risk level (standard, medium or high) of domestic abuse victims.[23] The checklist identifies vulnerabilities such as mental ill health, financial dependency and disability. High and medium risk victims receive support from independent domestic violence advisors (IDVA), and may be referred to a multi-agency risk assessment conference (MARAC).

However, a lack of complete data on victims limits our understanding of the full picture of who is at greater risk of domestic abuse. Much of our data come from surveys or services. A lack of data may reflect reluctance to provide information, poor data collection, or barriers to accessing services, either because services are not inclusive or are not perceived to be.

Disability

Around 14% of disabled adults experienced domestic abuse, compared with 5% of adults without disabilities from 2018 to 2019 (in England and Wales).

Around 14% of disabled[d] adults experienced domestic abuse, compared with 5%of adults without disabilities from 2018 to 2019 (in England and Wales).[24] Disabled men are twice as likely to experience domestic abuse compared to non-disabled men (8% and 4% respectively);[25] disabled women are more than twice as likely compared to non-disabled women (17% and 7%). National and local data suggest that either disability is not recorded by services, or that disabled victims are not accessing them.

> Having a physical disability meant that it was difficult for me to get advice or support outside home.
>
> - Victim of domestic abuse, Buckinghamshire

Learning disability

National data suggest that one in five (19%) people with a learning disability experienced any domestic abuse in the last year (2019 to 2020).[26]

[d] *Being disabled refers to a person self-reporting a long-standing illness, condition or impairment, which causes difficulty with day-to-day activities.*

Mental ill health

Domestic abuse and mental ill-health are commonly associated. Recent research suggests that women with mental health problems are three times more likely to experience domestic abuse, and women experiencing domestic abuse are three times more likely to develop mental health problems.[27]

Older people

Older people are affected by domestic abuse. Police data for Buckinghamshire from 2019 to 2020 showed that 9% of victims of known age were 61 years or older. However this age group only made up 4.5% of IDVA service users in the same year. Older people may be more vulnerable to coercive control (including economic abuse) given their dependence on family and carers as they age.[28] They may be unwilling or unable to disclose, recognise or leave abusive relationships due to age-related conditions such as dementia. Such situations are both a safeguarding and a domestic abuse concern.

Ethnicity

Ethnicity is not well recorded in relation to domestic abuse. Recent police data show that in Buckinghamshire, in 70% of cases the victim's ethnicity was not recorded. Domestic abuse is also commonly under-reported in ethnic minorities. Although domestic abuse is experienced by people from all ethnic origins, cultural values and norms will affect people's perceptions of and responses to domestic abuse. For people from some ethnic minority backgrounds, these may include fear (of not being believed, of being exposed, of the criminal justice system), victim-blaming culture, and failure to recognise abuse. Honour and shame are highly important concepts in certain cultures, and the consequences of dishonouring family or community by disclosing abuse are significant.

> I will live with the abuse rather than get divorced. Divorce in my culture means my life is over.
>
> - Quote from Thames Valley BAMER Project Report

Honour and shame are highly important concepts in certain cultures, and the consequences of dishonouring family or community by disclosing abuse are significant.

The Thames Valley Black, Asian, minority ethnic and refugee (BAMER) Project Report identified barriers faced by women from ethnic minorities who experience abuse. For example a victim needing a family member to interpret at appointments is denied privacy to discuss abuse with the health or social care professional.[29]

> English isn't my first language so I use language translation apps when I meet with different workers – it's not perfect but it works.
>
> - Victim of domestic abuse, Buckinghamshire

Gypsy, Roma and Traveller communities

There are limited data around domestic abuse in the Gypsy, Roma and Traveller communities. However, as in other communities, community members and workers have noted domestic abuse as a serious and long-standing problem.[30] The domestic abuse charity One Voice 4 Travellers estimated as many as three in four women from these communities experience domestic abuse at some point in their lives.[31]

Sexual orientation and gender identity

National statistics do not report domestic abuse by sexual orientation or gender identity. However, studies suggest that between 25 and 40% of lesbian, gay and bisexual people report one or more domestic abuse incidents in their lifetime. This rises to between 28% and 80% for trans people.[32] An NSPCC survey in UK schools suggested that 44% of teenagers with same-sex partners had experienced some form of physical partner violence, increased from 20% for those in heterosexual relationships.[33]

Domestic abuse victims with lesbian, gay, bisexual, transgender, or another definition of their gender and sexuality identity (LGBT+) are known to present with higher levels of risk and complex needs compared to non-LGBT+ people, such as mental health problems, self-harm and drug and alcohol misuse.[34]

LGBT+ victims may face threats of 'outing' about sexual orientation and gender identity.

They also face unique issues such as being victim to threats of 'outing' about sexual orientation and gender identity, and 'identity abuse' which may include withholding of medication or clothing relating to their identity.[35]

> Most of my friends and family didn't know I was gay so I didn't want to drop a double bomb-shell on them by telling them I was also being abused by my partner.
>
> - Victim of domestic abuse, Buckinghamshire

5. WHAT ARE THE RISK FACTORS FOR BECOMING A PERPETRATOR?

Certain factors are associated with increased risk of perpetrating domestic abuse. They may not cause the abuse to happen, but they contribute. Risk factors can be cumulative, and combine to increase the risk of committing domestic abuse.[36]

Greater risk is associated with low self-esteem, hostility towards women, and/or the need for dominance and control. A history of depression and suicide attempts have also been linked to increased risk of becoming a perpetrator. Where economic stress, marital conflict and/or jealousy occurs, domestic abuse is more likely. Additionally, evidence suggests that communities with lower social cohesion, lower bystander intervention, and lower social capital have higher rates of intimate partner violence.

In contrast, protective factors can reduce the influence of risk factors. Good physical and mental health and a sense of wellbeing are protective against perpetrating abuse.

Good physical and mental health and a sense of wellbeing are protective against perpetrating abuse.

Having a stable home and family life are also protective. Communities with greater social cohesion, good access to healthcare and knowledge and training of bystander interventions have reduced risk of domestic abuse. Social norms that discourage violence and support gender equality, and public policy that aims to level up health inequalities are also protective.[37]

To illustrate the interplay between risk and protective factors, a recent study with domestic abuse practitioners showed common risk and protective factors associated with becoming a perpetrator.[38] For example, normalising abusive behaviour was a risk factor. Protective factors included having meaningful support networks. Understanding these multilevel factors can help identify various opportunities for prevention. For example, improving access to stable housing, and promoting bystander interventions to reduce the risk of domestic abuse.

> It was useful - I learnt how to put myself in my partner's shoes and to see things from her perspective.
>
> I wouldn't have done this unless I'd been forced to. There should be more help and advice like this to help men before they get into a criminal situation like I did.
>
> - Perpetrators of domestic abuse in Buckinghamshire reflecting on their attendance at a positive relationships programme

6. WHEN IS SOMEONE MORE AT RISK OF DOMESTIC ABUSE?

There are certain times when abuse may be more severe or more frequent.

Pregnancy and postnatal period

International estimates suggest that between four and nine of every 100 pregnant women are abused during pregnancy or soon after birth.[39]

Pregnancy is associated with an increased risk of domestic abuse.

Pregnancy is associated with an increased risk of domestic abuse and also changes to the pattern of abuse.[40] The time of greatest risk is thought to be the postnatal period. Estimates suggest that between 290 and 650 Buckinghamshire women may be affected by domestic abuse each year when pregnant or in the postnatal period. Midwives and Health Visitors are aware of the potential for domestic abuse and screen patients carefully, seeking specialist help as appropriate. Local domestic abuse services support pregnant and postnatal women.

Drug and alcohol use

Drug and alcohol use can decrease inhibitions, act as a catalyst, and may lead to violence to solve conflicts in intimate partner relationships.[41] In the Crime Survey for England and Wales (2018) victims reported that the perpetrator was under the influence of alcohol in 17% of cases and drugs in 11% of cases. Victims were under the influence of alcohol (8%) and drugs (2%) less often at the time of abuse.[42] Recent police data for Buckinghamshire show that nine in ten perpetrators were not using alcohol at the time of the offence.

Separating or fleeing from perpetrator

> Leaving - and shortly after leaving - an abuser is a dangerous time for the victim.

Leaving an abuser is a dangerous time. The risk of further abuse can increase as and after the victim leaves. One study explored post-separation violence, and found three in four women suffered further abuse, and one in three women suffered continued post-separation violence.[43] Furthermore, 37 of the 91 women killed by a male partner in the UK in 2018, had either separated or were taking steps to separate from their partner. Eleven of the 37 women were killed in the first month of separation.[44]

Football matches

Studies in England have shown significant increases in the number of domestic abuse cases recorded by the police when the men's national team are involved in significant football matches, both when they win, and even more so when they lose.[45] A recent study showed that England football success in international tournaments also increased the likelihood of alcohol-related violent behaviours in the home.[46] A London hospital reported a 200% referral increase to its domestic abuse support service during the 2014 men's football World Cup.[47] The Women's Aid campaign 'Football United Against Domestic Violence' aims to raise awareness of domestic abuse, and battle sexist attitudes that underpin abuse against women. Wycombe Wanderers are one of the football clubs that supports this campaign.[48]

7. WHAT ARE THE IMPACTS OF DOMESTIC ABUSE?

Experiencing and witnessing domestic abuse can have devastating impacts on victims, and their children, friends and wider family. There are also wider societal impacts. Tools such as the DASH risk checklist help trained health and social care professionals to identify the risk of harm victims may be facing.

Victim's health

Harm as a result of domestic abuse can have lifelong impacts on physical, mental and sexual health.

Harm as a result of domestic abuse can have lifelong impacts on physical, mental and sexual health. The more severe the abuse, the greater the impact. In the worst cases, domestic abuse can result in homicide, including suicide as a result of domestic abuse.

One in five domestic abuse victims at high risk of serious harm or murder reported attending an accident and emergency department because of their injuries in the year before getting help. Abuse can also result on long term health problems.

A study interviewing women and girls over 15 years old found that those who had experienced physical or sexual violence by a partner were more likely to report overall poor health, chronic pain, memory loss, and problems walking and carrying out daily activities.[49]

Sexual violence can lead to infections, chronic pelvic pain, sexually transmitted infections, unintended and unwanted pregnancies, and abortions.[50]

Alcohol and drugs can be used by the victim as a way of coping or self-medicating, putting victims at risk of further ill health.[51] Their effects may also leave victims less capable of negotiating resolution and at risk of further violence.

Domestic abuse and mental ill health are commonly associated. A recent study found that half of women presenting to their GP with domestic abuse had already had some form of diagnosed mental illness.[52] Victims experience anxiety, depression, low self-esteem, inability to trust others, flashbacks, eating and sleeping disorders, and emotional detachment.[53] Considering or attempting suicide has been reported in 16% of victims, and self-harming in 13% of victims.[54] An estimated one in three women who attempt suicide in the UK have experienced domestic abuse.[55]

Domestic abuse affects all areas of life, as well as poor health.

Housing and homelessness

Domestic abuse is a leading driver of homelessness. Latest national figures from 2020 show that domestic abuse was the second most common reason given for losing a home.

Domestic abuse is a leading driver of homelessness. Latest national figures from 2020 show that domestic abuse was the second most common reason given for losing a home (14.5% of cases).[56] The homeless charity Crisis estimates that almost one in five of homeless women (18%) are homeless due to domestic abuse.[57] Domestic abuse accounts for at least one in ten people who require local authority support for homelessness in England, Wales and Scotland.[58] Actual need may be higher; the survey showed that one in three respondents left their home because of the abuse or leaving a relationship.

Finances

A recent survey of female survivors of domestic abuse found that one in three respondents said their access to money during the relationship was controlled by the perpetrator.[59] One in four respondents said that their partner did not let them have money for essentials during the relationship. A similar number reported that they used savings or children's money for essentials. Many (43.1%) reported being in debt because of the abuse, and over a quarter regularly lost sleep through worrying about debt.

The consequences of domestic abuse can increase the risk of poverty. One study found that women in poverty were more likely to have faced extensive violence and abuse (14%), compared to women not in poverty (6%).[60]

Employment

Over half (56.1%) of respondents on the same survey who had left an abusive relationship felt that the abuse had impacted their ability to work. Just under half of all respondents felt the abuse had negatively impacted their long-term employment prospects/earnings.

Children and young people

In the words of UNICEF, some of the biggest victims of domestic abuse are the smallest.

In the words of UNICEF, some of the biggest victims of domestic abuse are the smallest.[61] Domestic abuse has a negative impact on the mental, emotional and psychological health of children. Children can suffer social and educational developmental problems, and in some cases grow to accept abuse as normal behaviour. An estimated one in five children are exposed to domestic abuse in the UK,[62] with 130,000 children living in homes where there is a high risk of serious harm or murder due to domestic abuse.[63]

In Buckinghamshire, for the financial year 2020 to 2021, there were over 2,400 referrals for a social care assessment to children's social care where domestic violence was the primary concern. This represents a 31% increase on the previous year. This accounts for 23% of all children's social care referrals. Almost 700 children and young people where domestic violence was a concern were given children in need plans, child protection plans or became looked- after. Children starting a social care service from 2020 to 2021 – where domestic violence was the primary concern – accounted for 23% of all children's social care services received. 105 children who had domestic abuse mentioned as a factor in their assessment became looked after by the local authority from 2020 to 2021. This represents half of all children who became looked after in that year. These figures will underestimate domestic abuse suffered and witnessed by children in Buckinghamshire as not all cases will be referred to social care. Of the 116 children accommodated in Women's Aid Buckinghamshire refuges from 2019 to 2020, over half (66%) had directly witnessed domestic abuse, and 17 of the families were subject to a Child Protection Plan.

The full extent of harm will differ for each child depending on their circumstances and age. Around two in three (62%) children living with domestic abuse are thought to be directly harmed by the perpetrator; harm is also caused by witnessing abuse.[64] Wider effects such as having to move home and school to escape abuse can further harm children by increasing instability in their lives. A survey of women in English refuges showed that about two in three residents had children with them.[65]

Growing up with domestic abuse is likely to be a traumatic and stressful negative experience.

Growing up with domestic abuse is likely to be a traumatic and stressful negative experience, and the impacts will vary between children. Children may demonstrate outward behaviours such as aggression, anti-social behaviour and risk taking;[66] others may have difficulty expressing their emotions. Children may also feel depressed, anxious, angry, guilty, confused, and helpless.[67]

The impacts can be long term. Studies suggest that exposure to domestic abuse in early life may increase the risk of:

- Alcohol use. Children witnessing violence are more likely to misuse alcohol later in life.[68]
- Becoming a victim or perpetrator of domestic abuse, although this association is complex.[69,70] For example, normalising experiences of abuse will make it difficult for children to establish and maintain healthy relationships, and may increase their risk of domestic abuse in the future.
- Antisocial and risk-taking behaviour, early pregnancy and homelessness. Experiencing any or a combination of these in adolescence increases vulnerability to sexual exploitation and criminal behaviour.[71]

> Feeling safe is even more important when you have your children to think about.
>
> - Victim of domestic abuse, Buckinghamshire

Wider society

A Home Office report estimated the annual economic and social costs of domestic abuse, including domestic homicides, to be over £66 billion in England and Wales (year ending March 2017).[72] The largest costs as a consequence of domestic abuse were the physical and emotional harms (£47,287 million). The largest costs in response to domestic abuse were police costs (£1,257 million). The average total cost per victim was an estimated £34,010, made up of lower-costing crimes such as indecent exposure, to the highest-cost crime of domestic homicide.

Using Home Office costs with our local estimate of 21,000 victims, we estimate that the potential annual cost of the consequences of domestic abuse in Buckinghamshire is £687 million.

Using Home Office costs with our local estimate of 21,000 victims, we estimate that the potential annual cost of the consequences of domestic abuse in Buckinghamshire is £687 million. This is physical and emotional harm costs of £510 million, lost output costs of £152 million (time off work and reduced productivity), and health service costs of £25 million.

Using Home Office costs with our local estimate of about 4,000 victims known to the police in 2020 to 2021, we estimate that the potential annual cost of responding to domestic abuse in Buckinghamshire only for those we know about is £3.5 million, of which police costs account for £2.5 million. However, the health impact and costs would still accrue whether the victim reported the crime or not, so the local health costs will be an underestimate.

Deaths from domestic abuse: domestic homicide reviews

A domestic homicide review must be carried out by local authorities in England and Wales following the death of an individual aged 16 or over, which has, or appears to have resulted from violence, abuse or neglect, and inflicted by someone personally connected to the victim.[e]

Each review provides a detailed account of events leading up to the homicide, the context, and what we can learn from the event. The most recent data from the Home Office (December 2016) show that over 400 reviews have been completed since domestic homicide reviews started in 2011.[73] As of July 2020, 39 domestic homicides have taken place in the Thames Valley region, and 15 in Buckinghamshire.

As of July 2020, 39 domestic homicides have taken place in the Thames Valley region, and 15 in Buckinghamshire.

What can we learn from these deaths?

Published homicide data for England and Wales (from the Home Office report and another recent report), show that no two cases are the same.[74] However, there are certain key themes which have been identified. Data for England and Wales are used given the limited data available for local cases.

- Women are more likely to be victims than men. About eight in ten victims are female.
- Men are more likely to be perpetrators than women. About nine in ten perpetrators are male.
- Data on ethnicity of victims is often missing.
- Substance misuse can be a prominent feature in the lives of both victims and perpetrators.

[e] *Perpetrator and victim related, or are/were in intimate partner relationship, or member of the same household.*

- Victims and perpetrators are commonly known to services prior to the homicide. For example, just under half of cases were known to the police to be in an abusive relationship.
- Perpetrators of homicides follow a pattern of behaviour, including having previous controlling behaviour, and reacting violently to loss of control of the victim or relationship.[75]

Given that domestic homicide reviews aim to identify learning, service improvements and better prevention of domestic abuse and homicide, an anonymised and accessible national database of reports would help local authorities learn from other areas to help prevent these tragedies from happening.[76]

Warning signs for intimate partner homicides

Between 2009 and 2018, a woman was killed every four days by her partner or ex-partner in the UK.[77]

Most victims of intimate partner homicides are women. A review of 372 intimate partner homicides of female victims, and patterns of behaviour in national domestic homicide review information identified **eight stages** that may predict homicide.[78] Controlling behaviour by the perpetrator was the best predictor of homicide, rather than a history of violence. This review has led to learning about how these homicides can be predicted, and therefore prevented.

All perpetrators who reached the last stage and committed homicide moved through each of the eight stages. However, many cases saw progression to stage five or six, followed by either regaining control and returning to stage three, or moving to another relationship.

1. **Pre-relationship history.** In almost all cases the perpetrator has a history of coercive control, stalking or domestic abuse.
2. **Early relationship.** The relationship moves at speed, such as moving in together and declaring love early on.
3. **Relationship.** There are controlling patterns in every case study, such as limiting the victim's movements, what she wears, or who she sees. The relationship may be dominated by coercive control, stalking, or domestic abuse. This stage ranged from 3 weeks to 50 years in the case studies.
4. **Trigger/s.** Risk rises due to possible loss of control by the perpetrator over the victim or the relationship. Usually this loss of control comes from separation initiated by the victim.
5. **Escalation.** The perpetrator tries to gain back control back. More frequent and severe controlling behaviours are seen, such as crying, violence, stalking, or suicide/murder threats.
6. **Change in thinking.** With the loss of control comes a decision by the perpetrator about how they deal with this loss. This may be to form a new relationship, to mend the current relationship, or to decide to kill someone.
7. **Planning.** The perpetrator plans the homicide. This could include buying weapons, digging a grave, researching methods online, planning and organising finances, or stalking to gather intelligence.
8. **Homicide.** Case studies included violent homicides where the level of violence used appears to have no direct relation to that within the relationship.

Over 125 domestic abuse organisations and professionals have been calling for a national response to perpetrators for some time, including a national perpetrator strategy. A positive step towards this came in the HM Treasury Budget 2021, which included funding across England and Wales for perpetrator behaviour change programmes that work with offenders to reduce the risk of abuse occurring.[79]

To start with it was the occasional push or slap, but it got worse

"I met my ex-husband when I was 17. I moved in with his family six months later when I was pregnant. Everything went well for a while. However, one evening at the pub he suddenly told me we were going home – I thought it was a bit strange but agreed. On the way home he told me that he was angry with me as I was flirting with another man. I told him that I hadn't and he slapped me around the face. This was a bit of a shock but he apologised straight away and told me that he was sorry.

"Things went okay, we got married and my child was born. I quickly became pregnant again and although things did become a bit tense, I put this down to the pressures of suddenly having a family. My ex-husband would drink a bit. It seemed that if he had too much we would argue, he would say that I was lazy, and that I could not look after my children properly. The drinking was happening most evenings and so were the insults. Then it started to get physical.

"To start with it was the occasional push or slap, but it got worse. One particular evening, when the children were six and five, he came home from work early and shouted at me because the dinner was not ready when he had arrived. He told me that I was useless, slapped me across the face and then told me to get on with his dinner. When I took it through to him he started shouting at me – 'What the hell are you giving me, I don't like this...' He grabbed the back of my neck, and pushed my face towards the food, shouting at me all the time, saying I was trying to poison him. Then he shoved his hand full of food in into my mouth and told me to eat it. He pushed me to the floor and started to punch and kick me.

"The children were screaming. He told me to shut them up or he would sort them out too. I managed to quieten them down by taking them upstairs. When I returned I apologised to him about the food and he told me to clear it up. He said that I was not fulfilling my duty as his wife properly. He then made me have sex with him and all the time he was telling me how useless I was and that I deserved everything I got.

"The next morning I decided that I could not do this anymore. I contacted my friend and she took me to her house. We spoke to housing and they gave me the number for Women's Aid, where there was space in a refuge for me and my children. I did not have much with me, just a few clothes and things for the children. When I got to the refuge I was shown to a room and was given some spare clothes and food. I did not have any money. My worker helped me to claim a crisis loan and sorted out getting my benefits. I did report what had happened to the police and my worker came with me to make a statement. The police were very helpful but unfortunately although they arrested him he denied everything. They were unable to proceed with any charges.

"When I was in the refuge I was helped with things like housing, and support for the children getting them in to school. I stayed in the refuge for six months and I was then offered a house from the Council. The staff at the refuge helped me to get things for the house and helped me move in. I contacted Women's Aid later as my ex-husband had applied for custody of the children. He was awarded contact only. I could not have coped without the help of Women's Aid and I am so grateful to them for helping me and the children. My ex-husband no longer sees the children as he moved out of the country."

- Anonymous resident, Buckinghamshire

8. WHAT WORKS TO PREVENT DOMESTIC ABUSE?

Domestic abuse is a complex societal issue spanning many areas of life. Prevention and the response must be multifaceted.

Domestic abuse is a complex soccietal issue spanning many areas of life. Prevention and the response must be multifaceted. The National Institute for Health and Care Excellence (NICE) has published guidance on multi-agency working for domestic violence and abuse (2014) which includes 17 recommendations.[80] These include a local strategic partnership to prevent domestic abuse; the scope, shape and variety of local services; the quality of partnership working; and staff knowledge and skills in identifying and supporting victims of domestic abuse.

Embedding early intervention and prevention into a multiagency response to domestic abuse is highlighted in the government's Violence Against Women and Girls Strategy (2016 to 2020).[81] The response includes government-led initiatives as well as local authority multi-agency working, safeguarding, and commissioning. It highlights the multi-layered and co-ordinated health, social and criminal justice approaches required to tackle this issue and can be applied to all victims rather than only women and girls.

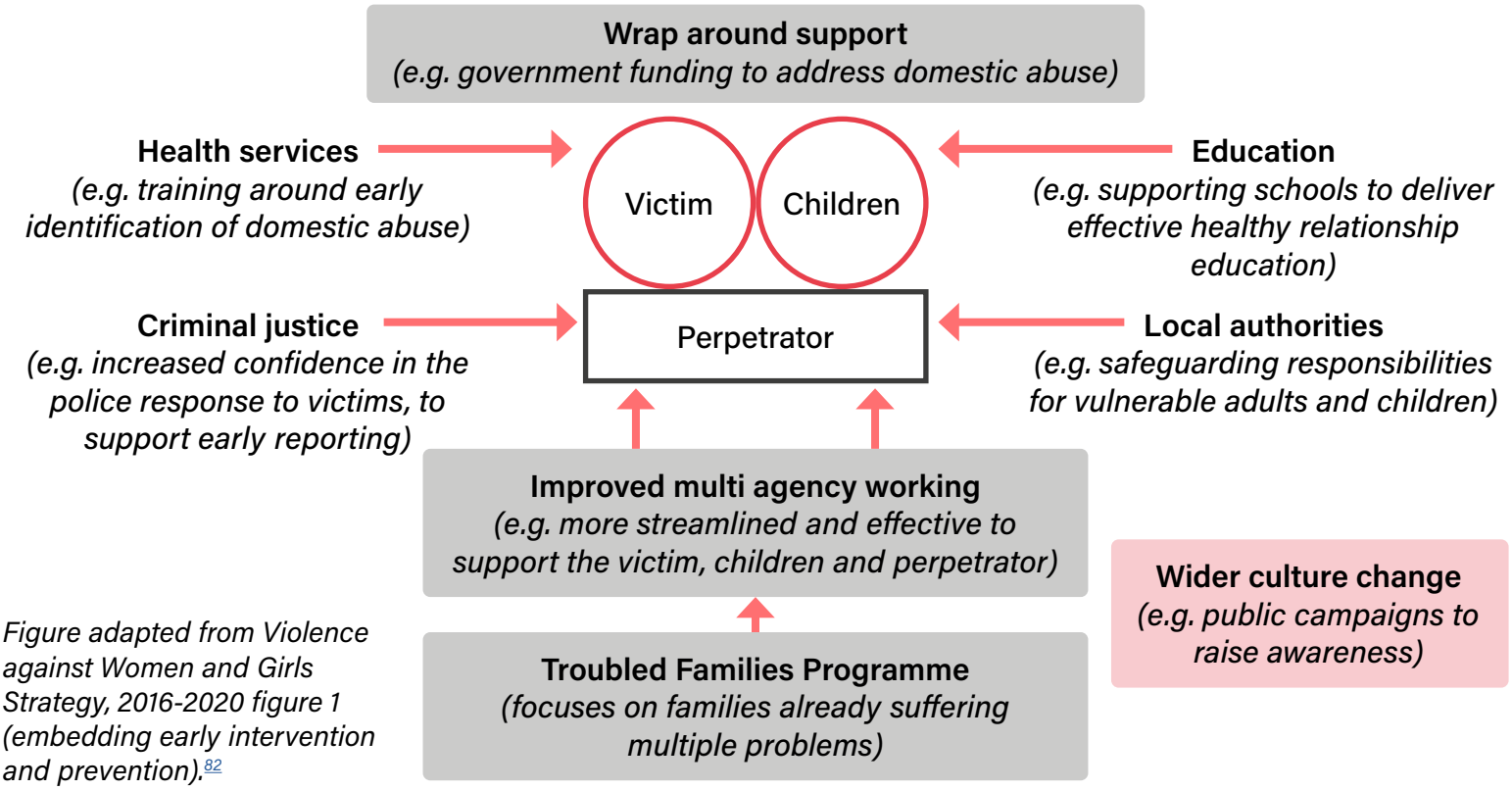


Figure adapted from Violence against Women and Girls Strategy, 2016-2020 figure 1 (embedding early intervention and prevention).[82]

New and existing programmes should be monitored and reviewed to improve the robustness of evidence.

Historically, many interventions addressing domestic abuse have not been thoroughly evaluated so it is vital that new and existing programmes should be monitored and reviewed to improve the robustness of the evidence. Some evidence based or potentially effective domestic abuse interventions are highlighted below.

- **School-based awareness raising of domestic abuse** is known to achieve positive changes in knowledge and attitudes towards domestic abuse and prevent dating violence.
- **Campaigns to raise awareness of domestic abuse** is a fundamental step in victims and bystanders recognising domestic abuse. This should be combined with signposting the public and professionals to services.

'Bystander interventions' challenge harmful attitudes, language and behaviour relating to domestic abuse.

- **'Bystander interventions'** challenge harmful attitudes, language and behaviour relating to domestic abuse.[83] These interventions – from challenging a disrespectful statement to noticing signs of domestic abuse and offering support – can be undertaken by anyone. Solace Women's Aid provides training and materials via their website for everyone,[84] as well as information specifically for men.[85]
- **Offering safe opportunities to seek help** such as campaigns using code words that victims can use in specific circumstances to alert someone to abuse. As services have moved online, and in-person interactions are replaced with a digital offer, a hand signal or gesture may be preferred to a code word. Examples include the recent 'Ask for ANI', 'Ask for Angela', and the Zoom signal campaigns.[86]

- **Advocacy** interventions with victims are based on empowerment, discussing solutions, and settings goals to respond to their situation. These interventions usually link survivors with legal, police, housing and financial services, and many also include psychological or psycho-educational support. NICE recommends that all domestic abuse victims should be provided with advocacy and advice services tailored to their level of risk and specific need.[87] Evidence suggests that intensive advocacy may improve quality of life and reduce physical abuse for one to two years.[88]

- **Training of health care professionals** in domestic abuse education and advocacy may lead to an increase in awareness, and greater disclosure, identification and referral to domestic abuse services.[89] For example, data from domestic homicide reviews show us that a victim's contact with services may be limited to their GP so it is vital that GPs are skilled and proactive in recognising signs of domestic abuse and referring patients for urgent help.

  The 'Identification and Referral to Improve Safety' (IRIS) training and support programme is an example of an effective health care training intervention, designed for GP surgeries.[90] Evaluation of IRIS showed improved identification of women experiencing domestic abuse and improved referral rates to specialist services (compared to surgeries not trained in IRIS).[91] A recent evaluation across GP surgeries in London showed that of the 144 surgeries trained in IRIS, a 30-fold increase in domestic abuse referrals was seen compared to the those surgeries without IRIS training.[92] These outcomes show that clinician behaviour can be changed in relation to domestic abuse enquiry and referral, for the benefit of the victim. A cost-effectiveness study showed the IRIS programme to have lower costs and greater effectiveness for GP surgeries, compared to surgeries offering usual care (not using IRIS).[93]

- **Independent Domestic Violence Advisors (IDVA)** are trained to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members. There is evidence suggesting that IDVAs have a positive impact on the safety and well-being of victims experiencing extremely serious levels of domestic abuse.[94] This reduced risk of harm has some effect on reducing the risk of domestic abuse to children.

- **Multi-Agency Risk Assessment Conferences (MARACs)** are regular multiagency meetings to discuss high risk domestic abuse cases. A coordinated safety plan is enacted to support the victim. The victim is ideally represented by an IDVA. Research indicates that MARACs (and IDVAs) can improve victim safety and reduce revictimization, and therefore may be a highly cost-effective measure.[95]

Perpetrator interventions

Interventions aimed at perpetrators can be either criminal sanctions, or perpetrator interventions and programmes. Only 1% of perpetrators receive any specialist intervention to challenge or change their behaviour.

NICE guidance states that *'There is lack of consistent evidence of the effectiveness of programmes for people who perpetrate domestic violence and abuse.'* However, *'such interventions are an important part of domestic violence and abuse services, and provided they are supported by robust evaluation to inform future commissioning decisions, should be recommended.'*[96]

NICE has also published quality standards for domestic violence and abuse (2016).[97] The standards are (1) asking about domestic abuse, (2) responding to domestic abuse, (3) referring to specialist services for victims, and (4) referring to specialist services for perpetrators.

9. SUMMARY AND RECOMMENDATIONS

This report shows that domestic violence and abuse is common, but often hidden and underreported. The impacts for victims, survivors, their families, and society are serious and wide-reaching. In preparing this report, we have reviewed the latest data, evidence and looked at current service provision.

Preventing domestic abuse from occurring must be a priority and we are supporting our schools to implement recent RSHE (relationships, sex and health education) that includes recognising domestic abuse and abusive relationships, coercive control, consent, and mutual respect in friendships and relationships. Looking ahead, the new multi-agency Domestic Abuse Local Partnership Board will be championing good practice in awareness raising, education and training and the provision of high-quality support and advocacy services. Services for victims (including children) and perpetrators will be further developed to meet the needs of diverse groups and people with protected characteristics, recognising that anyone can be a victim. Starting with partners on the Board, all organisations will be encouraged to adopt measures to keep employees and service users safe from domestic abuse including during home working, remote digital working, and consultations. The Board will also explore how we can share and learn from past and current domestic homicide reviews to understand how such tragedies can be prevented in the future.

The following recommendations should, in addition to statutory duties for support for people living in safe accommodation, inform the Domestic Abuse Local Partnership Board strategy and delivery plan:

1. The Domestic Abuse Board should support awareness raising of domestic abuse through coordinated, county-wide participation in a selected national campaign.
2. The Domestic Abuse Board should consider how bystander training could be utilised locally and promoted, as an evidence-based intervention to challenge harmful attitudes, language and behaviour relating to domestic abuse for people of all ages.
3. Buckinghamshire Council Community Safety team should consider how to increase the diversity within the domestic violence and abuse champions scheme by actively recruiting network members that reflect the diversity of people that may experience domestic abuse.
4. The Domestic Abuse Board should develop and roll-out high-quality, shared, scenario-based training across Buckinghamshire for key stakeholders and front-line staff. Primary care should also consider implementing the IRIS training package as an effective evidence-based training programme across Buckinghamshire.
5. The Domestic Abuse Board should oversee the development of a Buckinghamshire domestic abuse referral pathway for all staff to follow, to ensure timely and responsive delivery of services, fully understood by frontline staff and accessible to victims seeking help.
6. All Board member agencies to support the development of an evidence base for what works for perpetrators, to inform commissioning of promising interventions, and evaluation of their effectiveness.

10. GLOSSARY

Adverse Childhood experience (ACE): ACEs are stressful events occurring during childhood that directly affect a child or affect the environment in which they live (e.g. growing up in a house where there is domestic violence). ACEs can have long-term negative impacts on health and well-being.

Child protection plan: A plan drawn up by the local authority to set out how a child can be kept safe, how things can be made better for the family and what support they will need.

Honour based violence: A crime or incident which has or may have been committed to protect or defend the honour of the family and/or community.

Independent domestic violence advisor (IDVA): IDVAs support victims to reduce immediate risk and increase self-esteem and resilience. The aim of the service is for victims to effect change and keep themselves safe in the longer term.

LGBT+: People who are lesbian, gay, bisexual, transgender, or have another definition of their gender and sexuality.

Multi-agency risk assessment conference (MARAC): A multiagency panel producing a coordinated action plan to increase the victim/s safety and manage the perpetrator/s behaviour.

Protected characteristics: It is against the law to discriminate against someone because of the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, or sexual orientation. The Equality Act of 2010 protects citizens against discrimination.

Stalking: This can be a form of domestic abuse. It is a pattern of persistent and unwanted attention, and is often committed by ex-partners but can be committed by anyone.

11. APPENDICES

I. Domestic abuse full definition

Full government definition of domestic violence and abuse:

- Behaviour of a person towards another person is domestic abuse if (a) the people are each aged 16 or over and are personally connected to each other, and (b) the behaviour is abusive.
- Behaviour is abusive if it consists of any of the following:
    a. physical or sexual abuse
    b. violent or threatening behaviour
    c. controlling or coercive behaviour
    d. economic abuse
    e. psychological, emotional or other abuse

The definition covers different types of relationships including family members, ex-partners and those who are not cohabiting. Although the definition refers to people aged 16 or over, children can still be victims. If the abuser directs his/her behaviour at a child to be abusive to another adult, this is domestic abuse.

Controlling behaviour is defined as *"a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour"*. Coercive behaviour is defined as *"an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim".* This can also include stalking, which is a pattern of persistent and unwanted attention.[103]

Economic abuse is wider than financial abuse, as described by the charity Surviving Economic Abuse: *"Economic abuse is designed to reinforce or create economic instability. In this way it limits women's choices and ability to access safety. Lack of access to economic resources can result in women staying with abusive men for longer and experiencing more harm as a result."*[104]

Psychological, emotional or other abuse can include controlling another person using emotional or manipulative methods such as shaming, criticizing and embarrassing. A consistent pattern of emotional abuse will have a negative effect on a victim's self-esteem and mental health.

II. Domestic Abuse Bill

The Domestic Abuse Bill 2021 was passed in April 2021.[105] It will:

- Widen the definition of domestic abuse to include other abusive behaviour as well as violent or sexual offences
- Improve the justice system to provide protection for victims, for example limiting or prohibiting cross-examination of victims

- Strengthen the support for victims of abuse by statutory agencies
- Appoint Domestic Abuse Commissioner (Nicole Jacobs was appointed in September 2019)

The Domestic Abuse Bill 2021 includes a number of statutory and non-statutory intentions that affect local authorities, some of which are summarised here:

Local authorities in England to provide support* to victims of domestic abuse and their children in refuges and other safe accommodation.

- Local authorities in England to establish a multi-agency Domestic Abuse Local Partnership Board. The Board will:
    - Assess the need for accommodation-based domestic abuse services for all victims
    - Develop and publish a strategy for this provision, and use for commissioning decisions
    - Monitor and evaluate the effectiveness of the strategy, and report back to central government
    - Include wide representation (local authority, voices of victims and their children, domestic abuse charities, health care providers and police and other criminal justice agencies)

* Support includes advocacy support, domestic abuse prevention advice, specialist support for victims with protected characteristics and/or complex needs, children's support, housing-related support, and counselling and therapy for adults and children.

All eligible homeless victims of domestic abuse automatically have 'priority need' for homelessness assistance.

- Currently, domestic abuse victims without a priority need (such as being pregnant) must show that they are vulnerable as a result of fleeing domestic abuse in order to access homelessness assistance. The Bill removes the need to prove this vulnerability.

When rehousing an existing lifetime secure tenant, local authorities must honour this by granting a new lifetime secure tenancy in the case that the tenant or household member has been a victim of domestic abuse and is being rehoused as a result.

Introduce regulations and statutory guidance on Relationship Education, Relationship and Sex Education, and Health Education.

Invest in domestic abuse training for responding agencies and professionals.

This page is intentionally left blank

Health and Wellbeing Board 2021/22 Work Programme

Meeting Date	Report	Lead and Organisation	Notes
27 January 2022 Paper deadline Thursday 13 January 2022	COVID-19 – Cases in Buckinghamshire update	Jane O'Grady - Public Health	
	Healthwatch Bucks update paper	Zoe McIntosh - Healthwatch	
	Integrated Care Partnership update	Neil Macdonald - Buckinghamshire Healthcare NHS Trust Gill Quinton - Buckinghamshire Council David Williams - Buckinghamshire Healthcare NHS Trust Robert Majilton- Clinical Commissioning Group	
	Public Engagement paper	Jenny Baker - Healthwatch	
	Mental Health CYP Transformation	Tracey Ironmonger/Jack Workman - Buckinghamshire Council	
	Joint Health and Wellbeing Strategy Start Well Action Plan Live Well Action Plan Age Well Action Plan Annual Plan	David Williams - Buckinghamshire Healthcare NHS Trust Jacqueline Boosey - Buckinghamshire Council Martin Gallagher - The Clare Foundation Jacqueline Boosey - Buckinghamshire Council Gill Quinton/Jacqueline Boosey - Buckinghamshire Council Jacqueline Boosey - Buckinghamshire Council	
	Children's priority update	Richard Nash - Buckinghamshire Council	
	Adults Safeguarding Annual Report	Gill Quinton - Buckinghamshire Council	
	Children's Safeguarding Annual Report	Richard Nash - Buckinghamshire Council	
	Female Genital Mutilation (FGM) Strategy	Joanne Stephenson - Buckinghamshire Council	

Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board 2021/22 Work Programme

Meeting Date	Report	Lead and Organisation	Notes
3 March 2022 Paper deadline Thursday 17 February 2022	COVID-19 – Cases in Buckinghamshire update	Jane O'Grady - Public Health	
	Healthwatch Bucks update paper	Zoe McIntosh - Healthwatch	
	Integrated Care Partnership update	Neil Macdonald - Buckinghamshire Healthcare NHS Trust Gill Quinton - Buckinghamshire Council David Williams - Buckinghamshire Healthcare NHS Trust Robert Majilton- Clinical Commissioning Group	
	Community Boards update – Workshops and health priorities identified (how embracing the role of improving HWB)	Katie McDonald - Buckinghamshire Council	
	Mental Health	Tracey Ironmonger - Buckinghamshire Council	
	Joint Health and Wellbeing Strategy Annual Report	Jacqueline Boosey - Buckinghamshire Council	

Health & Wellbeing Board Buckinghamshire