Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board agenda

Date: Thursday 15 December 2022

Time: 2.00 pm

Venue: The Oculus, Buckinghamshire Council, Gatehouse Road, Aylesbury HP19 8FF

Membership:

Cllr A Cranmer (Buckinghamshire Council), Cllr A Macpherson (Buckinghamshire Council) (Chairman), Dr R Bajwa (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), Dr J O'Grady (Public Health, Buckinghamshire Council), G Quinton (Adults and Health, Buckinghamshire Council), N Macdonald (Buckinghamshire Healthcare NHS Trust) (Vice-Chairman), R Majilton (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), Dr S Roberts (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), M Gallagher (The Clare Foundation), K Higginson (Community Impact Bucks), Cllr S Bowles (Buckinghamshire Council), Dr K West (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), Cllr Z Mohammed (Buckinghamshire Council), P Baker (Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board), Dr R Sawhney (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), D Walker (Oxford Health NHS Foundation Trust), Dr C McDonald (Buckinghamshire Healthcare NHS Trust), P Miller (Healthwatch Bucks) and J Macilwraith (Children's Services, Buckinghamshire Council)

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Agenda Item		Time	Page No
1	**Welcome**	**14:00**	
2	**Apologies for absence**		
3	**Announcements from the Chairman**		
4	**Declarations of Interest**		
5	**Review of Minutes and Actions from the Previous Meeting** To agree the minutes of the meeting held on 22 September 2022 and review any outstanding actions from previous meetings.		**5 - 12**
6	**Public Questions** In order for a response to be provided at the December Health and Wellbeing Board meeting, questions must be received by 9.00 am on Monday 12 December 2022. Any questions received after this deadline will be responded to at the following Health and Wellbeing Board meeting.		
7	**Partner Reports: Healthwatch Bucks - Quarterly Review** A review of the work undertaken by Healthwatch Bucks over the previous quarter, this will include feedback on surveys with residents/users of local services. Zoe McIntosh, Chief Executive, Healthwatch Bucks.	**14:10**	**13 - 16**
8	**Integrated Care Partnership - The Development of Buckinghamshire 'Place and the Integrated Care Strategy** The importance of Buckinghamshire 'Place' and what this means for our residents. Philippa Baker, Buckinghamshire Place Director, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board. Dr Jane O'Grady, Service Director Public Health and Community Safety, Buckinghamshire Council.	**14:20**	**17 - 30**

	Robert Bowen, Deputy Director of Strategy, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board.		
9	**GP Access and the Impact of Growth on GP Services in Buckinghamshire** Actions and developments since November 2021 report to the Board on 'Access to GPs (primary care)' in Buckinghamshire and plans for development of primary care GP services linked to housing growth in Buckinghamshire. Philippa Baker, Buckinghamshire Place Director, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board.	**14:35**	**31 - 40**
10	**The Director of Public Health Annual Report 2021/21** The Director of Public Health is required to produce an annual report on the health of Buckinghamshire's population. This year's report is on preventing cardiovascular disease which includes heart disease and stroke. Dr Jane O'Grady, Service Director Public Health and Community Safety, Buckinghamshire Council.	**14:55**	**41 - 54**
11	**Health and Care Integration Programme** Dr Joanna Baschnonga, Programme Director, Adults and Health, Buckinghamshire Council.	**15:15**	**To Follow**
12	**System Winter Plan** The Buckinghamshire System Winter Plan is a Health and Social Care plan to help partners manage the anticipated increase in pressures in urgent and emergency care. It covers the whole population of Buckinghamshire, including all ages and all conditions. Caroline Capell, Director of Urgent and Emergency Care, Buckinghamshire Place, Buckinghamshire Healthcare NHS Trust.	**15:25**	**55 - 86**
13	**Addendum to Better Care Fund - Adult Social Care Discharge Fund** Dr Joanna Baschnonga, Programme Director, Adults and Health, Buckinghamshire Council.	**15:40**	**To Follow**

14	**Any Other Business** Paper Only: Developing a One Council approach to delivering housing for people with social care needs. Housing is a key determinant of health and has a key impact on both physical and mental health and wellbeing. This report provides an overview of the development of a One Council Approach to delivering accommodation to meet the needs of children and adults with social care needs.	**15:50**	**87 - 92**
15	**Date of next meeting** Thursday 30 March 2023 at 2.00 pm in the Oculus, The Gateway		

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

Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board minutes

Minutes of the meeting of the Health and Wellbeing Board held on Thursday 22 September 2022 in The Oculus, Buckinghamshire Council, Gatehouse Road, Aylesbury HP19 8FF, commencing at 2.00 pm and concluding at 3.15 pm.

Members present

Cllr A Cranmer, Dr R Bajwa, Dr J O'Grady, Mr N Macdonald (Vice-Chairman), Dr S Roberts, Cllr S Bowles, Dr K West, Cllr Z Mohammed, M Powls, Dr R Sawhney, D Walker and P Miller, Cllr A Macpherson (Chairman), M Gallagher, G Quinton and K Higginson.

Others in attendance

S Taylor, B Binstead, C Kavanagh, T Burch and K Vockins, J Boosey, R Nash, Z McIntosh, G McDonald, P Baker, R Beasley, H Mee, G Elton and M Evans-Riches.

Agenda Item

1 Welcome

The Vice Chairman, Neil Macdonald, Chief Executive Officer for Buckinghamshire Healthcare NHS Trust, acted as Chairman for this meeting due to Councillor Angela Macpherson, Deputy Leader and Cabinet Member for Health and Wellbeing, attending remotely.

N Macdonald welcomed everyone to the meeting and explained that some partners had joined the meeting remotely.

2 Apologies

Rebecca Binstead, Senior Democratic Services Officer, advised that apologies had been received from John Macilwraith, Corporate Director for Children's Services, Buckinghamshire Council; Dr Craig McDonald, Acting Children's Clinical Lead, BHT and Robert Majilton Deputy Chief (Accountable) Officer Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (NHS BOB ICB).

Richard Nash, Service Director for Children's Social Care, attended as substitute for John Macilwraith.

3 Announcements from the Chairman

Councillor Angela Macpherson, Deputy Leader and Cabinet Member for Health and Wellbeing, welcomed Phillipa Baker. From October Philippa will be joining the Board as the Place Director for Buckinghamshire, representing the Integrated Care Board.

Councillor A Macpherson announced that the report on GP access and the impact of

housing growth on GP access in Buckinghamshire, from Dr James Kent the Chief Executive of the Integrated Care System over Buckinghamshire, Oxfordshire and Berkshire, had been postponed to the meeting on 15 December 2022.

4 Declarations of Interest

There were no declarations of interest.

5 Minutes of the previous meeting

Resolved: The minutes of the meeting held on 26 May 2022 were **agreed** as an accurate record.

6 Public Questions

The Vice Chairman stated that no questions had been received before the deadline of 12 noon on the Friday the week prior to the meeting. A question regarding the Pharmaceutical Needs Assessment had been received after the deadline and would be heard under the relevant item, as it had been previously noted during consultation and a response had been included in the corresponding report.

7 Healthwatch Bucks Quarterly Review and Annual Report

Zoe McIntosh, Chief Executive, Healthwatch Bucks, referred to the Quarterly Review and Annual Report in the agenda pack and raised the following:

- The social prescribing survey found that awareness of social prescribing was low, but people who had accessed the service were very positive about the benefits it could offer. The recommendations focused on raising awareness and how this could be achieved, such as targeting specific groups. Healthwatch was awaiting a response from Dr James Kent, Chief Executive, Buckinghamshire Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS), on these recommendations.
- Healthwatch had published 18 reports that had been received by the Health and Wellbeing Board and Commissioners. Recommendations to Commissioners were followed-up with after 6 months to review whether changes had been implemented.
- As a signposting service, Healthwatch had over 200 people come to them for advice and information. Common issues included access to dentistry and General Practitioner (GP) services.
- Priorities for 2023 had been identified as health and inequalities, primary care, and social care, with particular focus on dementia. A project regarding early onset dementia was planned for the next quarter.
- Healthwatch had witnessed an increase in feedback relating to pharmacies, which was likely due to increased footfall. There had been an increase of negative experiences in accessing pharmacies, however it was noted that they were more likely to hear from negative experiences than good ones.

It was noted the resulting recommendations from the social prescribing report included encouraging more GPs and Primary Care Networks (PCNs) to utilise their

own websites to display and promote social prescribing. The Vice Chairman emphasised the importance of raising awareness in professional networks as well as public. It was agreed that Zoe McIntosh would share the details of the report for it to be distributed internally.

Action: Z McIntosh

8 Integrated Care Partnership

Rob Beasley, Interim Director of Communications and Engagement, Integrated Care Board (ICB), advised that the membership of the Integrated Care Partnership (ICP) Committee had been agreed and the first meeting was planned for late October. It was noted that the Intergrated Care strategy must be agreed by the end of 2022.

The Integrated Care Board (ICB) were working on developing communications and an engagement framework, which was due to be received by the ICB on Tuesday 27th September 2022. Pending approval, this aims to make full use of partner's channels to communicate, consult and engage with a wider audience. R Beasley explained that they were also looking to expand the Citizens Panel.

The following key points were raised in discussion:

- That development of Integrated Care strategy would be built upon Health and Wellbeing Board strategies across Buckinghamshire, Oxfordshire and Berkshire West (BOB), to encourage a place-based localised approach.
- Councillor A Macpherson raised concerns over whether key documents and strategies would receive stronger place-based consultation. R Beasley provided reassurance that the ICP would be a partnership comprised of Local Authorities, Healthwatch, local trusts, volunteer and community organisations and its work would reflect this.
- It was queried how residents would be encouraged to contribute and understand the impact of the ICB. Gillian Quinton, Corporate Director Adults and Health, Buckinghamshire Council, emphasised that this was part of the ICB's public facing responsibilities and the ICB need to articulate the benefits of health outcomes for the public as a result of ICB development. R Beasley stated that working as a partnership would allow the ICP to use their channels to reach as wide an audience as possible.
- R Beasley explained that the ICB were planning on developing an improved feedback system through their relationship with the Citizen's Panel, via regular consultation, focus groups and engagement.
- David Walker detailed the challenge of addressing regional inequalities throughout the wider BOB geographical area and the importance of protecting resident's provision.

9 Joint Local Health and Wellbeing Strategy Refresh

Councillor A Macpherson introduced the item by reminding members of the Health and Wellbeing Board meeting on Thursday 26 May 2022, whereby the proposal for the Board to focus on a limited number of key priorities in order to deliver long-term

improvement in health in some of the most challenging areas was agreed. These priorities endorsed the Joint Local Health and Wellbeing Strategy life course approach and over the summer period of 2022, work had been undertaken to refresh the strategy. The Chair gave thanks to everyone involved, in particular the leads for the priority areas:

- Heidi Beddall at Buckinghamshire Healthcare NHS Trust and Dan Flecknoe from Public Health on their work on 'Improving outcomes during maternity and early years'
- Donna Clarke at Oxford Health NHS Foundation Trust and Louise Hurst from Public Health on their work on 'Improving mental health support'
- Sally Hone from Public Health on 'Reducing the prevalence of obesity in children and adults' and 'Increasing the physical activity of older people'
- Tiffany Burch from Public Health on 'Reducing the rates of cardiovascular disease' and
- Dr Sarah Winchester from Public Health on 'Improving places and helping communities to support healthy ageing'

Dr J O'Grady, Director of Public Health, stated that action plans were in development to reduce inequalities and gaps in health across the life course approach. Regarding mental health, the differential access and experience for ethnic minority groups was considered. The Board were informed of the planned work to co-design action plans with local communities and Voluntary, Community and Social Enterprise (VCSE) organisations.

Dr O'Grady referred to the papers in the agenda pack and noted the minor changes to the strategy including the priorities starting on page 33 of the agenda pack. It was explained that performance baseline measures would be presented to the Health and Wellbeing Board in December to help track progress.

Resolved: The Health and Wellbeing Board:

- **Noted** and **agreed** the refreshed Buckinghamshire Joint Local Health and Wellbeing Strategy as set out in Appendix 1.
- **Noted** and **agreed** the Action Plan as set out in Appendix 2.
- **Noted** and **agreed** the Action Plans on a Page as set out in Appendix 3.
- **Noted** and **agreed** that the Strategy is iterative and to contribute to the development of the action plans.

Dr O'Grady spoke about 'Stoptober' to support people to quit smoking. It was agreed the Health and Wellbeing Board alongside its partners issue a shared press release. This would be coordinated through the smoking cessation and tobacco control group.

It was suggested that linking in with existing primary care programmes such as flu clinics, utilising primary care websites, and issuing media for rotating waiting room screens would help reach a wider audience. Recognising that the current cost of

living crisis may be making it more difficult to quit, it was suggested that incorporating financial saving messages may be helpful. Councillor A Macpherson proposed advertising Stoptober to those in the health and local authority workforce.

Action: All – To send any 'Stoptober' ideas to Tiffany Burch

Action: J Boosey – To circulate Tiffany's email address after the meeting

Resolved: The Health and Wellbeing Board **agreed** to support the Stoptober campaign and all partners would promote a shared press release

10 Joint Strategic Needs Assessment

The Vice Chairman welcomed Tiffany Burch, Public Health Consultant. T Burch identified the purpose of the Joint Strategic Needs Assessment (JSNA) as improving health and wellbeing outcomes of the local community and reducing inequalities for all ages. It was noted that the JSNA would help with monitoring progress, identify changing priorities and monitoring emerging trends.

T Burch informed the Board that a new JSNA website would be launched, hosted on the Buckinghamshire Council website. The purpose of this would make it easier for the public to access information in one area and be more accessible.

In the discussion that followed, the Vice Chair enquired into how the development of the ONS Health Index impacted the JSNA. T Burch advised that the JSNA utilised a wider range of social determinate factors to provide more detailed data and fill in gaps of information not covered by the ONS Health Index. It was stated that the aim of the JSNA was to make it easier to access local, national and regional information in one place.

In response to an enquiry into how joint working across BOB would be achieved, it was stated that a longer-term aim was to develop an ICB common set of needs assessment across BOB.

Resolved: The Health and Wellbeing Board:

- **Noted** and **agreed** the proposed focus topics as outlined in the JSNA workplan.
- **Committed** and **agreed** to the delivery by all partners of new and updated JSNA content and priorities.

11 Better Care Fund

This item was presented by Colette Kavanagh, Head of Service Integrated Commissioning, Buckinghamshire Council, as substitute for Tracey Ironmonger, Integrated Commissioning Service Director, Buckinghamshire Council. C Kavanagh referred to the report in the agenda pack and noted the changes to the fourth condition to the Better Care Fund (BCF) Policy Framework. It was noted that the national BCF team had asked for an intermediate care demand and capacity plan for Buckinghamshire to be submitted in order to identify what support systems were needed.

C Kavanagh proposed that the BCF undertook work to look at the impact of the BCF in relation to inequalities and welcomed the Health and Wellbeing Board to help identify and steer priority areas.

The following key points were raised in discussion:

- Councillor A Macpherson suggested that the BCF looked at 9 most deprived wards identified through Opportunity Bucks, to focus funding and deliver health improvements.
- Dr Jane O'Grady enquired into the scope of the project. It was confirmed that the BCF contributed to many core services and the scope had yet to be defined.
- It was suggested that referring to the Health and Wellbeing Strategy would be useful in terms of looking at experiences and opportunities for mental health services for deprived areas and ethnic communities.
- The Vice Chairman stated that it would be interesting to see what the provisions of care and services looked like within BCF mapped wards. It was suggested that the BCF could look at service speed experienced outside of the BOB partnership.
- Dr Raj Bajwa, Clinical GP Chair, confirmed that targeting this resource towards populations of deprivation, regarding inpatient experience, could be achieved.
- Dr Rashmi Sawhney, Clinical Director for Health Inequalities, raised the topic of digital poverty.

Action: **C Kavanagh** – To follow up on scope of inequalities project with Dr Jane O'Grady and bring back to HWB

The Vice Chairman reminded the Board of the Olympic lodge joint programme, which was planned to run additional capacity in October 2022. It was stated that this was above and beyond the scope of the BCF.

Resolved: The Health and Wellbeing Board:

- **Noted** and **approved** the Buckinghamshire Better Care Fund Plan for 2022-2023.
- **Continued** to delegate the authority for the development of Buckinghamshire's BCF plans, allocation of expenditure and proposed metrics trajectories for plans to the Integrated Commissioning Executive Team (ICET) with the provision that the membership of the ICET be reviewed along with the accountability, governance and reporting process due to the transition from the Clinical Commissioning Group to the Integrated Care System.

12 Pharmaceutical Needs Assessment

Note: the running order for this agenda was changed and item 12: Pharmaceutical Needs Assessment was taken after item 10: Joint Strategic Needs Assessment.

Councillor A Macpherson introduced the item by explaining that every Health and Wellbeing Board is required to undertake a Pharmaceutical Needs Assessment

(PNA). In Buckinghamshire, the work is undertaken by a multidisciplinary group. Any decisions on where to locate pharmacies will be taken by the NHS, however one of the pieces of evidence they will consider is the PNA.

Matt Powls, ICB Interim Executive Place Director, referred to the papers in the agenda pack and highlighted the recommendation found in the Buckinghamshire Pharmaceutical Needs Assessment (PNA) 2022-2025 that no improvements or better access were identified in the lifetime of this PNA.

A draft version of this PNA was published online for technical consultation for a 60-day period during 23 May and 24 July 2022 and a general response to feedback had been published within the report. M Powls stated that feedback had been received from members of the public affiliated with the Berryfields geographical area requesting a pharmacy. In response, additional analysis had been undertaken to investigate this, however the recommendation remained the same.

It was noted that a question from managing director of Jardines pharmacy had been received by the Health and Wellbeing Board. Tiffany Burch gave a response which can be found in the agenda pack starting on page 324.

The Vice Chairman welcomed Gary Elton, Treasurer Bucks Local Pharmaceutical Committee. G Elton concurred with the conclusions of the PNA and reported that pharmaceutical colleagues were content that national guidelines and processes had been followed in production of this PNA. It was stated that any applications made to NHS England for a new community pharmacy must pass a series of tests outlined in the Pharmaceutical and Local Pharmaceutical Services Regulations 2013. G Elton stated that a pharmacy contractor could dispute a decision through NHS Resolution and be re-assessed. It was emphasised that a PNA assesses need in a given location, not desirability.

Councillor A Macpherson gave assurance that if planning permission was granted for additional housing developments, the steering group could reconvene and reconsider.

In response to an enquiry on the expanded role of community pharmacies and it's effect on the workforce, it was confirmed that contractors were asked about capacity and it was found to be a concern.

Resolved: The Health and Wellbeing Board:

- **Noted** the Executive Summary, full Pharmaceutical Needs Assessment and the 60-Day Consultation report.
- **Agreed** for the report to be published in line with legal requirements.
- **Delegated** any final responsibility for approval of the PNA following this meeting to the PNA Steering Group.

13 Any Other Business

Jacqueline Boosey, Business Manager, Health and Wellbeing, advised that the

forward plan would be updated to link more closely with the Joint Local Health and Wellbeing Strategy refresh. It was noted that three workshops would be held with partners and relevant organisations in 2023.

J Boosey informed the Health and Wellbeing Board that the website would be launched at the end of October 2022, containing key messages from the Board and its partners.

Action: J Boosey

Councillor Steve Bowles, Cabinet Member for Communities, promoted the Community Safety Consultation which would run until 16 October 2022 and was open to anyone living or working in Buckinghamshire. Residents were encouraged to help the Safer Buckinghamshire Board develop and implement an action plan to reduce crime in Buckinghamshire. A link to the survey is available on the Your Voice Bucks website here.

14 Date of next meeting

Thursday 15 December 2022 at 2.00pm in the Oculus.

Health & Wellbeing Board Buckinghamshire

Healthwatch Bucks Quarterly Review

Date: 15 December 2022

Author/Lead Contacts: Zoe McIntosh, Chief Executive Healthwatch Bucks

Report Sponsor: Zoe McIntosh, Chief Executive Healthwatch Bucks

Consideration: ☒ **Information** ☐ **Discussion**

☐ **Decision** ☐ **Endorsement**

Please indicate to which priority in the Joint Local Health and Wellbeing Strategy, Happier, Healthier Lives Strategy (2022-2025) your report links to.

Start Well	Live Well	Age Well
☐ Improving outcomes during maternity and early years	☐ Reducing the rates of cardiovascular disease	☐ Improving places and helping communities to support healthy ageing
☐ Improving mental health support for children and young people	☐ Improving mental health support for adults particularly for those at greater risk of poor mental health	☐ Improving mental health support for older people and reducing feelings of social isolation
☐ Reducing the prevalence of obesity in children and young people	☐ Reducing the prevalence of obesity in adults	☐ Increasing the physical activity of older people

None of the above? Please clarify below:

Healthwatch Bucks is your local health and social care champion we make sure NHS leaders and other decision makers hear your voice and use your feedback to improve care.

1. Purpose of report

1.1. 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. The report outlines the projects we have been working on over the last quarter. This paper summarises recent project work we have undertaken in relation to health and social care services, as aligned with the priorities of the Joint Health & Wellbeing strategy.

Healthwatch Bucks update

November 2022

This paper summarises recent project work we have undertaken in relation to health and social care services, as aligned with the priorities of the Joint Health & Wellbeing strategy.

Live Well

Social Prescribing Awareness

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) has issued a positive response to our report on awareness of social prescribing in Buckinghamshire.

In her letter to Healthwatch Bucks, Dr Rachael De Caux, Acting Chief Executive, BOB ICB, said:

We are very grateful for the findings and recommendations from this piece of work. Your findings confirm to us that there is a lot of work to be done to raise the awareness of social prescribing to our population… Your results present a clear need to ensure that our residents know how to access the support available to them.

Report and response

You can read them **here**.

Social Prescribing Experiences

We have also published a second report looking at people's experiences of social prescribing in Buckinghamshire.

- We developed a short survey and did 14 phone interviews with people who had talked to a social prescriber in 2022.
- We also collected 16 responses in person at three social prescribing 'talking cafes' in July, August and September 2022.
- A further 17 people completed the survey online after receiving a link from a social prescriber or voluntary organisation.
- We also spoke to five social prescribers about the issues they face when trying to get people engaged with new activities or organisations that might be able to help them.

Key findings

- Most people told us they were happy or very happy about being referred to a social prescriber.
- Most people said they had a positive impression following their use of the social prescribing service.
- Respondents said they found speaking with a social prescriber helpful and appreciated their time and support – though there were some issues with getting more support afterwards.
- 86% of the people we spoke to say their health and / or wellbeing has improved because of the new activities or organisations they'd become involved with – and several said the social prescribing service should be better publicised.

Our recommendations

We've made recommendations to Buckinghamshire Council and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB).

These include:

- Improving the provision of accessible, affordable transport
- Extending the support available to people who need help with claiming benefits, and
- Ensuring that social prescribing services are promoted and supported.

The full report can be accessed here.

Young Onset Dementia

We're currently working on a research project focused on young onset dementia. We want to find out about people's experiences of living with this condition in Bucks, and also gather the views of their families and carers.

Our mission is to help improve health and social care services for the people who use them. We'll collect answers to our questions on young onset dementia anonymously, then add them to other peoples' responses to form a report. This will contain a set of recommendations that we hope will improve care.

What we want to know

For this project, we particularly want to know about the support that people with young onset dementia have received. For example:

- What information they were given
- Where or who they first went to for advice on living with young onset dementia

- Whether the information and support on offer was age-appropriate and felt personal to them (and / or their family)
- Whether the right support was made available at the right time.

Overall, we want to know what has worked well for people with this condition, and also what hasn't.

Get in touch

If you showed symptoms of dementia before the age of 65 (even if you are now over that age), or if you know someone who did, please get in touch.

We'd also like to hear about your experiences if you live with (or have lived with) someone with young onset dementia in Buckinghamshire.

You can **register your interest to take part using our online form** or contact Alison on info@healthwatchbucks.co.uk. Alternatively, people can complete the survey here **bit.ly/youngonset**.

Health & Wellbeing Board Buckinghamshire

Integrated Care Partnership (ICP) - The development of Buckinghamshire 'Place' and Integrated Care Strategy

Date: 15 December 2022

Author/Lead Contacts: Philippa Baker, Buckinghamshire Place Director, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board

Dr Jane O'Grady, Service Director Public Health and Community Safety, Buckinghamshire Council

Robert Bowen, Deputy Director of Strategy, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board

Report Sponsor: Philippa Baker, Buckinghamshire Place Director, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board

Consideration: ☐ **Information** ☒ **Discussion**

☐ **Decision** ☐ **Endorsement**

Please indicate to which priority in the Joint Local Health and Wellbeing Strategy, Happier, Healthier Lives Strategy (2022-2025) your report links to.

Start Well	Live Well	Age Well
☒ Improving outcomes during maternity and early years	☒ Reducing the rates of cardiovascular disease	☒ Improving places and helping communities to support healthy ageing
☒ Improving mental health support for children and young people	☒ Improving mental health support for adults particularly for those at greater risk of poor mental health	☒ Improving mental health support for older people and reducing feelings of social isolation
☒ Reducing the prevalence of obesity in children and young people	☒ Reducing the prevalence of obesity in adults	☒ Increasing the physical activity of older people

None of the above? Please clarify below:

N/A

1. Purpose of report

1.1. The Integrated Care Board (ICB) wants effective engagement and partnership at the heart of its thinking, planning and delivery. This report provides an update on the progress on the development of the Board, integration with partners along with development of the more local 'Place' based partnership.

2. Recommendation to the Health and Wellbeing Board

1. The Health and Wellbeing Board are asked to note the progress discussed within the report.
2. The Health and Wellbeing Board are asked to note development activity on the Integrated Care Strategy.
3. The Health and Wellbeing Board are asked to advise on and support engagement with Buckinghamshire people and communities when this work takes place.

3. Content of report

Background

3.1. An Integrated Care System (ICS) is a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

Buckinghamshire is part of an Integrated Care System with Oxfordshire and Berkshire West this is known as BOB.

Developments over the previous quarter

New Chief Executive

3.2. Following the departure of Dr James Kent in September and cover from Rachael de Caux in October, the ICB has appointed Steve McManus as interim Chief Executive for a fixed term to end of March 2023. During this time a recruitment process will be conducted to confirm a substantive Chief Executive.

New Place Director

3.3. To support the development of three strong places across the BOB area, three place directors have been appointed to cover Buckinghamshire, Oxfordshire and Berkshire West. Philippa Baker joined as the Buckinghamshire Executive Place Director in October 2022 from the Department of Health and Social Care.

Place based partnership development

3.4. The ICB – working in equal partnership with the Local Authority, and NHS partners - has begun to make progress towards the establishment of a place-based partnership for Buckinghamshire. We intend to do this in a way that is meaningfully co-produced and builds in perspectives from across the system. The aim of this work is to have an initial Place Based Partnership in Buckinghamshire from April 2023.

3.5. Partners' early thinking is that the partnership should bring together partners across health and social care to make progress on a small number of agreed Buckinghamshire priorities. It a delivery forum at sub Health and Wellbeing Committee level. The partnership needs to be small enough to ensure delivery whilst taking into account the views of all key Buckinghamshire partners. We welcome views on this thinking as we iterate. We are inviting broader views on these proposals via survey work over December and further workshops in the new year. We have commissioned an independent facilitator to lead these workshops to ensure we embed that spirit of co-production into this work.

3.6. Any partnership established in April is also likely to evolve and mature as the partnership approach becomes more established. This is also an opportunity for us to build on and strengthen our place-based relationships, recognising strong, trust based partnerships will enable us to deliver best for the people of Buckinghamshire.

ICP inaugural meeting

3.7. In October 2022 representatives of the local authorities and the ICB met to agree ways of working across the Integrated Care Partnership. This included the election of a chairperson, Jason Brock, Leader of Reading Council and a Deputy Chair, Angela Macpherson, Deputy Leader of Buckinghamshire Council and Chair of Buckinghamshire Health and Wellbeing Board. Also, at this meeting the group discussed the Integrated Care Strategy priorities emerging from the strategy working groups. The initial meeting of the full ICP membership will be in January 2023.

BOB Integrated Care Strategy

3.8. The Integrated Care Partnership is responsible for developing an Integrated Care Strategy to address the needs of the people and communities of Buckinghamshire, Oxfordshire and Berkshire West. This has been developed collaboratively across the local authorities, ICB and other partner organisations in line with guidance published by the Department of Health and Social Care (DHSC).

3.9. Initial priorities have been proposed that align with local Health and Wellbeing Strategies across BOB, including Buckinghamshire's life course based health and wellbeing priorities. Detailed information on emerging priorities can be found in appendix 1.

3.10. A period of public engagement will run to end of January 2023 to understand more from ICS partners, people and communities across the geography.

4. Next steps and review

4.1. The Health and Wellbeing Board will be closely involved in the development of the place development activity and are asked to note development activity.
4.2. Further development of the Integrated Care Strategy with sign off by April 2023.
4.3. Engagement with Buckinghamshire people and communities.

5. Background papers

Appendix 1 – Developing the Integrated Care Strategy

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix 1

Developing the Integrated Care Strategy

Buckinghamshire Health and Wellbeing Board

December 2022

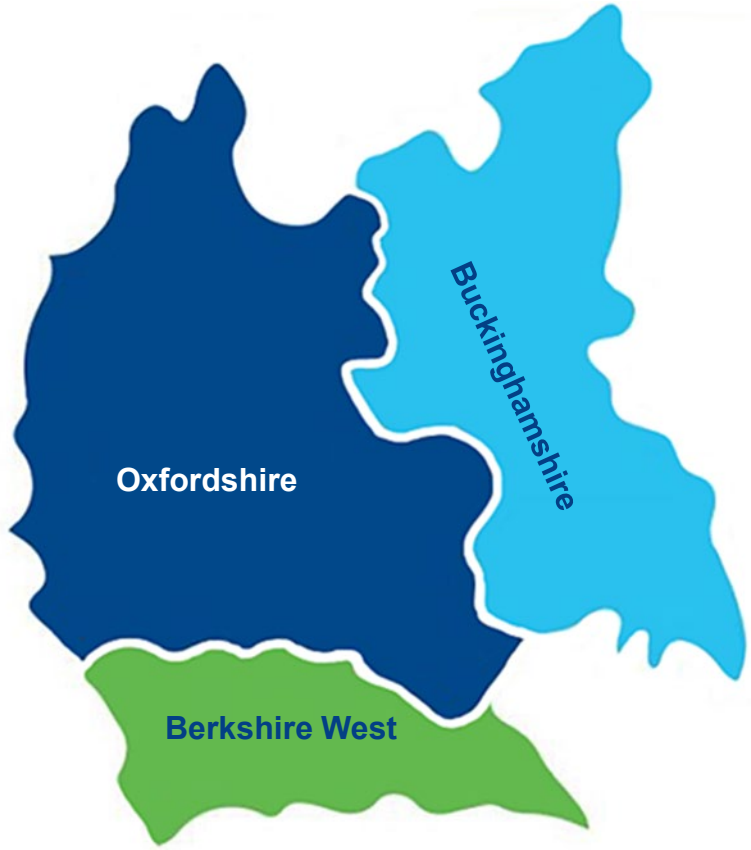
“Integration” – doing more together

Integrated care system (ICS)
A partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area

Integrated care partnership (ICP)
A statutory committee jointly formed between the NHS integrated care board and all local authorities with public health and social care responsibilities in the ICS area

Integrated Care Board (ICB)
A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area

BOB is made up of three places:



Integrated Care Strategy

Purpose of the strategy:

The Integrated Care Partnership are accountable for developing the strategy.

The Strategy will set a clear direction for the system and promote joint working to meet local population health, care and social need.

What?


Improve the public's health and well-being needs


Reducing health inequalities in access, experience and outcomes across our system


Bring learning from across places and the system to drive improvement and innovation


Addresses the problems that would benefit from a system response and multiple partners

How?

- ✓ Complement but not replace/supersede existing priorities
- ✓ Joint working with a wide range of Integrated Care System partners
- ✓ Co-develop evidence-based, system-wide priorities – engaging a broad range of people, communities and organisations

Thematic Working Groups

The working group themes were agreed following analysis of existing strategies and ambitions:

1.Start Well Kevin Gordon, Director of Children's Services Oxfordshire County Council	**4. Promoting Healthy Behaviours** Ingrid Slade, Consultant in Public Health Wokingham Council
2. Live Well Ansaf Azhar, Director of Public Health Oxfordshire County Council	**5. Health Protection** Tracy Daszkiewicz, Director of Public Health Berkshire West Local Authorities
3. Age Well Andy Sharp, Director of Adult Social Care West Berkshire & Dr Raj Thakkar, GP	**6. Improving quality and access to services** Matthew Tait, Chief Delivery Officer Integrated Care Board

Proposed vision and principles

Building on health and wellbeing strategies and discussions in the working groups, the following vision and principles have been agreed to set the direction for the Buckinghamshire, Oxfordshire and Berkshire West health and care system.

Our vision is for everyone who lives in Buckinghamshire, Oxfordshire and the Berkshire West area, to have the best possible start in life, to live happier, healthier lives for longer, and to be able to access the right support when it is needed.

Preventing ill-health	Tackling health inequalities	Providing person centred care	Supporting local delivery	Improving join up between our services
We will help people stay well and independent, enjoying better health for longer. We will help build healthy places and thriving communities to protect and improve people's health and build prevention into all our services.	We will improve physical and mental health for those at risk of the poorest health and social outcomes. This will include addressing differences in access to and experience of our services between different groups and individuals.	We will work together to provide support in a way that meets people's needs and helps them to develop the knowledge and skills to make informed decisions, and to be involved in their own health and care.	We will plan and design support and services with local people and our partners to deliver support close to where people live, learn and work.	We will improve the way our services work together to ensure people get support where and when they need it and residents have a better experience of health and care services.

Our emerging priorities

1. Promote and protect health

Aim: To support people to stay healthy we will:

- Priority 1: We will reduce the proportion of people smoking across Buckinghamshire, Oxfordshire and Berkshire West.
- Priority 2: We will reduce the proportion of people drinking alcohol at levels that are harmful to their health and wellbeing.
- Priority 3: We will reduce the proportion of people who are overweight or obese, especially in our most deprived areas and in younger people.
- Priority 4: We will take action to address the social, economic and environmental factors that influence our health.
- Priority 5: We will protect people from infectious disease by preventing infections in all our health and care settings and delivering national and local immunisation programmes.

2.Start Well

Aim: To help all children achieve the best start in life we will:

- Priority 6: We will improve early years outcomes for all children, particularly working with communities experiencing the poorest outcomes.
- Priority 7: We will improve emotional, mental health & wellbeing for children and young people.
- Priority 8: We will improve the support for children and young people with special educational needs and disabilities, and for their families and carers.
- Priority 9: We will support young adults to move from child centred to adult services.

Our emerging priorities

3. Live Well

Aim: To support people and communities stay healthy for as long as possible we will:

- Priority 10: We will reduce the number of people developing cardiovascular disease (heart disease and stroke) by reducing the risk factors, particularly for groups at higher risk.
- Priority 11: We will improve mental health by improving access to and experience of relevant services, especially for those at higher risk of poor mental health.
- Priority 12: We will increase cancer screening and early diagnosis rates with a particular focus on addressing inequalities in access and outcomes.

4. Age Well

Aim: To help people live healthier, independent lives for longer we will:

- Priority 13: We will support older people to remain healthy, independent, and connected within their communities.
- Priority 14: We will provide joined up care for people as they grow older, and as their long-term conditions advance and care needs become more complex.
- Priority 15: We will look after carers.

5. Improve quality and access to services

Aim: To help people access our services at the right place and right time we will:

- Priority 16: We will develop strong integrated neighbourhood teams so that people's needs can be met in local communities.
- Priority 17: We will reduce and eliminate long waits for our planned services, and address variation in access across the system.
- Priority 18: We will support the consistent development of our urgent care services to reduce demand and support timely access.

Approach to engagement

The engagement will be collaborative, undertaken on behalf of the Integrated Care Partnership not only one organisation

We will:

- Maximise the time for engagement and listening
- Make it easy for people and organisations to provide feedback
- Attend all Health and Wellbeing Boards and other sessions as requested
- Write a report on the feedback received from different people and organisations, reflecting how different perspective will be taken into account

Engagement with public and communities:

- ✓ Online engagement platform
- ✓ Healthwatch / VCSE fora
- ✓ Local Authority and NHS Partners local channels and networks to reach local communities
- ✓ Virtual meetings to outline the vision, principles, strategic themes and priorities and seek feedback

Timescales for engagement:

- Early December – start period of engagement with public and partners.
- December and January – Use meetings and sessions with public and partners to listen to views on proposed priorities for Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.
- End January – Engagement period will close.
- February – Engagement report developed. Strategy material updated. Final document published.

Publication, delivery planning and review

Publication
The Integrated Care Strategy is expected to be published in Buckinghamshire, Oxfordshire and Berkshire West following sign off by the Integrated Care Partnership in February.

Influencing delivery planning
The Integrated Care Strategy will:

- Complement other strategies and plans, not supersede or replace them, notably the local health and wellbeing strategies.
- Be considered as an input to partner organisations' delivery planning activity – The timescales have been designed to specifically influence the NHS planning activity (completed by end of financial year).
- Other partner organisations are also expected to consider the implications of the Integrated Care Strategy as part of their planning activity too.

Review
In time, the integrated care partnership is expected to consider how effectively the strategy is being delivered by the integrated care board, NHS England, and local authorities.

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Health & Wellbeing Board Buckinghamshire

GP Access and the Impact of Growth on GP Services in Buckinghamshire

Date: 15 December 2022

Author/Lead Contacts: Philippa Baker, Buckinghamshire Place Director, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board

Report Sponsor: Philippa Baker, Buckinghamshire Place Director, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board

Consideration: ☐ **Information** ☒ **Discussion**

☐ **Decision** ☐ **Endorsement**

Please indicate to which priority in the Joint Local Health and Wellbeing Strategy, Happier, Healthier Lives Strategy (2022-2025) your report links to.

Start Well	Live Well	Age Well
☐ Improving outcomes during maternity and early years	☐ Reducing the rates of cardiovascular disease	☐ Improving places and helping communities to support healthy ageing
☐ Improving mental health support for children and young people	☐ Improving mental health support for adults particularly for those at greater risk of poor mental health	☐ Improving mental health support for older people and reducing feelings of social isolation
☐ Reducing the prevalence of obesity in children and young people	☐ Reducing the prevalence of obesity in adults	☐ Increasing the physical activity of older people

None of the above? Please clarify below:

GP access affects the whole population of Buckinghamshire and can have an impact on both physical and mental health and wellbeing. The principles discussed in the report below will support the health and wellbeing strategy priorities above, keeping the population of Buckinghamshire healthy.

1. Purpose of report

In November 2021 the Buckinghamshire Health and Wellbeing Board had an extended discussion on Primary Care Access in Buckinghamshire. This included a positively viewed increase in overall activity and face to face appointments but acknowledgement of variation and poor public perception of primary care across Buckinghamshire. Aylesbury town in particular was noted as having poorer access. Items raised at the meeting included:

- Poor actual or perceived access to primary care;
- Failure to understand and address apparent variation in provision in a meaningful way;
- £7.4m funding to support winter access – How was this spent and what was the impact;
- A clear route for complaints / concerns from the public to be addressed;
- Proactive engagement with / and communication for the public to support managing expectations including a move to less face to face.

For this Health and Wellbeing Board we have been asked to report on **GP Access and impact of growth in Buckinghamshire** and to include:

- An update on actions and developments since the November 2021 report
- An analysis of Winter Access Fund spend and impact
- Feedback on residents views from Healthwatch Buckinghamshire (this will be provided verbally)

2. Recommendations to the Health and Wellbeing Board

1. The Health and Wellbeing Board are asked to note the information contained within the report.

3. Content of report

Current Context

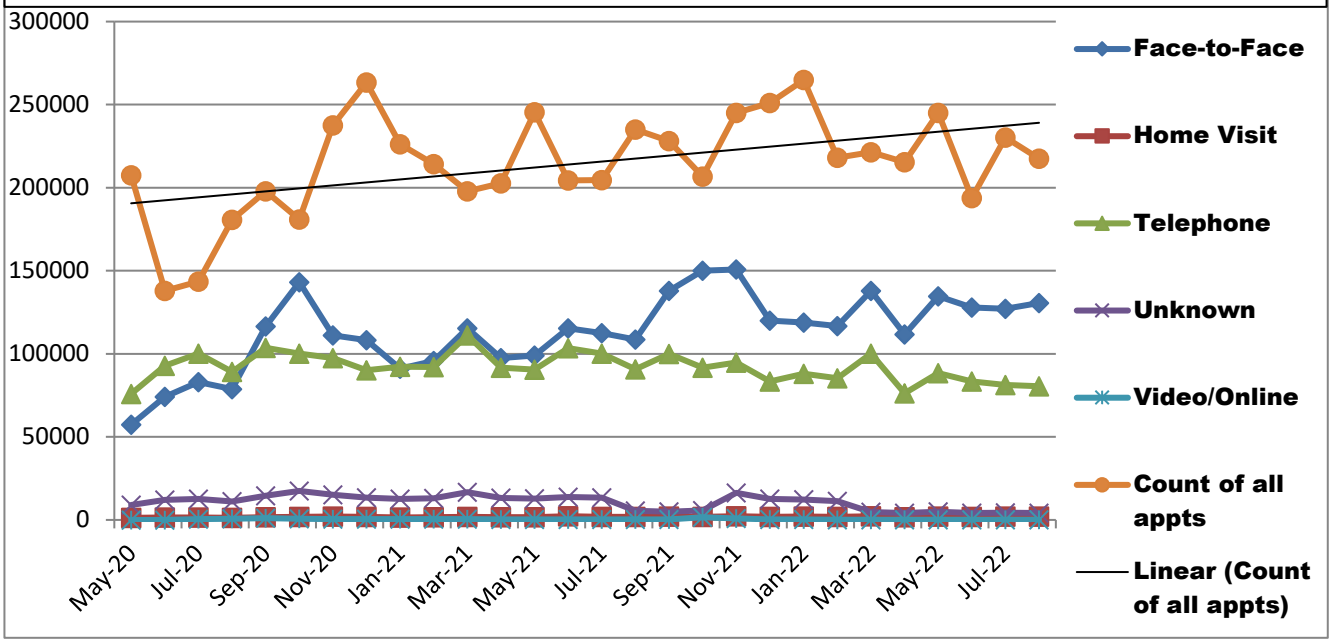
Primary Care has never been busier.

Nationally, over 26 million appointments were undertaken in August 2022 which was 3 million more than in August 2019 during pre-pandemic levels https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/august-2022. GP appointment bookings reached record highs over the winter of 2021/22 and Primary Care is bracing for an even busier Winter 2022/23.

The below tables show data for appointments, patient experience and phone access in Buckinghamshire, and our performance against national trends.

Appointments

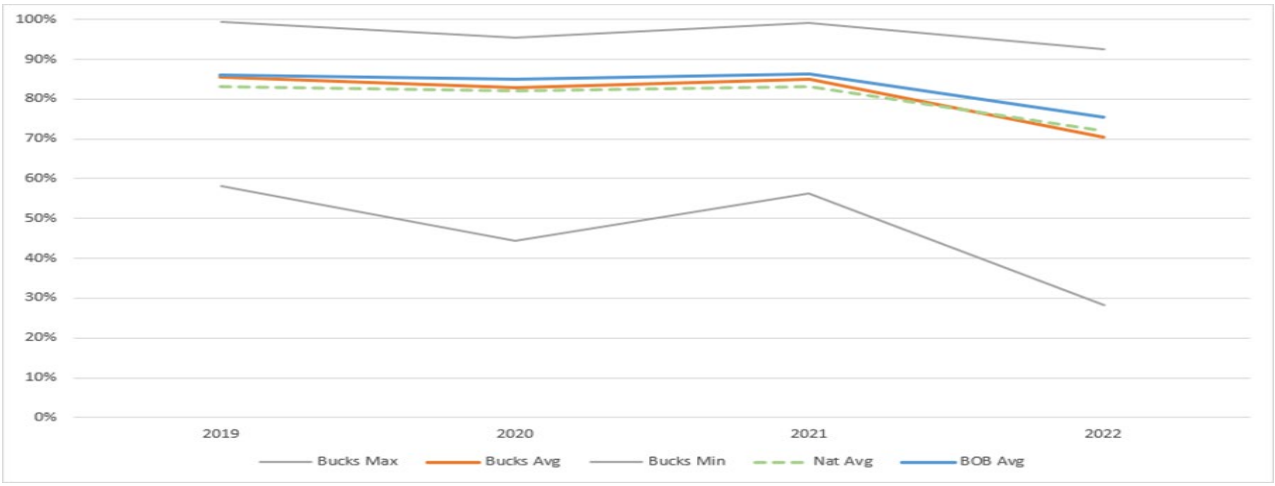
Buckinghamshire GP practice appointment activity April 20 - August 2022 (NHS Digital GPAD data) (*NB we are reviewing the data on video appointments*)



Following the pandemic, video/digital/telephone consultations are now an accepted part of GP access. Aside from face to face appointments, GPs are most likely to offer telephone appointments or triage services followed up by face to face appointments if necessary. We are reviewing the data on video/online appointments.

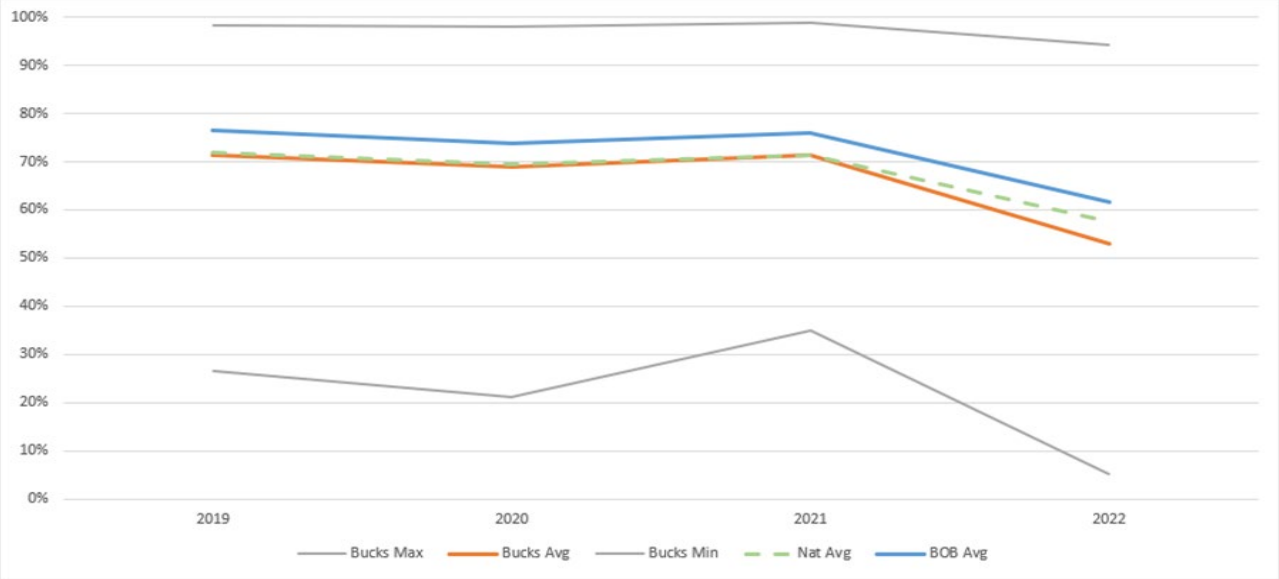
Patient Experience

Reflecting National Trends there has been significant variation between practices in terms of patient experience. 71% of Buckinghamshire patients reported their overall experience of their practice as 'good' or 'fairly good' in the 2022 GP Patient Survey conducted by Ipsos, a reduction from 85% in 2021. Whilst this position is in line with national trends and will in part reflect wider service pressures, it will be important to retain a strong focus on patient experience.



Telephone Access

Percentage of people who said it was 'very easy' or 'fairly easy' to get through to a practice on the phone - *GP Patient Survey*



On telephone access, Buckinghamshire has fallen below national trends – this reflects that the majority of new telephony systems have only been in place since the beginning of 2022 (some are still to be put in place, further detail below). Again, this will be a priority area of focus.

Activity to support GP access and improved patient experience

Buckinghamshire's place based primary care team (within Buckinghamshire, Oxfordshire and Berkshire West [BOB] ICB), are focussed on supporting the following:

- Ensuring that people have a positive experience when accessing their GP;
- Supporting timely access to all to their GP;
- Where appropriate, digitally enabling delivery to support access;
- Recognising that a blend of online/telephone and face to face appointments will be needed;
- Recognising inequalities in access and digital literacy need to be factored into our approach.

We are taking a number of actions to support these aims:

- **Cloud based telephony** – Cloud based telephony supports timely access to GP appointments by enabling GPs to run their telephone systems remotely, allowing for queue management systems and call-backs. It should enable a more positive patient experience when trying to access GPs on the phone. In Buckinghamshire we have supported this by working with GPs to ensure cloud-based telephony is in place in every practice, and aligned with PCN systems. Progress to date has been positive: at the beginning of the year (April 22) approximately 25% of practices had a "cloud-based" telephone system – by the end of the year this is expected to grow to nearly 100%. At the time of writing, 8 practices had newly gone live, 19 are scheduled by March 2023 and 20 had previously implemented cloud-based telephony.

- **Digital appointment bookings** – Digital appointment booking established itself during the covid pandemic, and has now become a recognised tool to enhance and improve GP access. In Buckinghamshire the vast majority of GPs offer a digital booking capability; the NHS App is available to all; and all surgeries should be accessible on the NHS App.
- **Digital/telephone consultations** – again, following the pandemic, video/digital/telephone consultations are now an accepted part of GP access. Aside from in person appointments, GPs are most likely to offer telephone appointments or triage services followed up by in person appointments if necessary. Most GPs offer digital consultations and the main systems used are AskFirst; Klinik; and e-consult, though data on take-up is limited. We are also using online consultation services like Livi to support practice capacity during winter if, for example, there are workforce capacity issues due to illness.
- **Digital literacy** – We recognise that the increasing use of apps and digital approaches to GP access needs to be accompanied by work to support and enhance digital literacy, to ensure those without access to data or smartphones are not disenfranchised, and to ensure that health inequalities are not exacerbated. In partnership with "Barclays Digital Eagles" surgeries are working with patients to increase their digital skills overall which will include access to their patient records and appointments. We also recognise that there will still need to be a telephone and face to face offer in place for individuals who cannot or choose not to adopt digital approaches.
- **Enhanced Access from 1st October** - All Enhanced Access Plans for Primary Care Networks (PCNs) across BOB have been signed off and delivering from 1st October - PCNs will offer extra hours in the morning, in the evening, at weekends and added daytime capacity.

Winter Challenge

2021 Winter Actions - During Winter 2021, the system was supported by the Winter Access Fund (WAF). In summary, of the total BOB WAF allocation of £7.1m, the spend on initiatives for additional appointments to include face-to-face and remote consultations totalled £4.3m (of which Buckinghamshire's allocation was £1.2m), achieving a total of 204,161 additional appointments during the period between November 2021 to March 2022 (51k of which were in Buckinghamshire, and 44k were additional GP appointments).

Additional hours/appointments increased capacity for patients, reduced the provider impact of increased demand and improved morale among reception teams (breakdown for Bucks below):

Table 1: Bucks total number of additional GP sessions versus appointments during the WAF period.

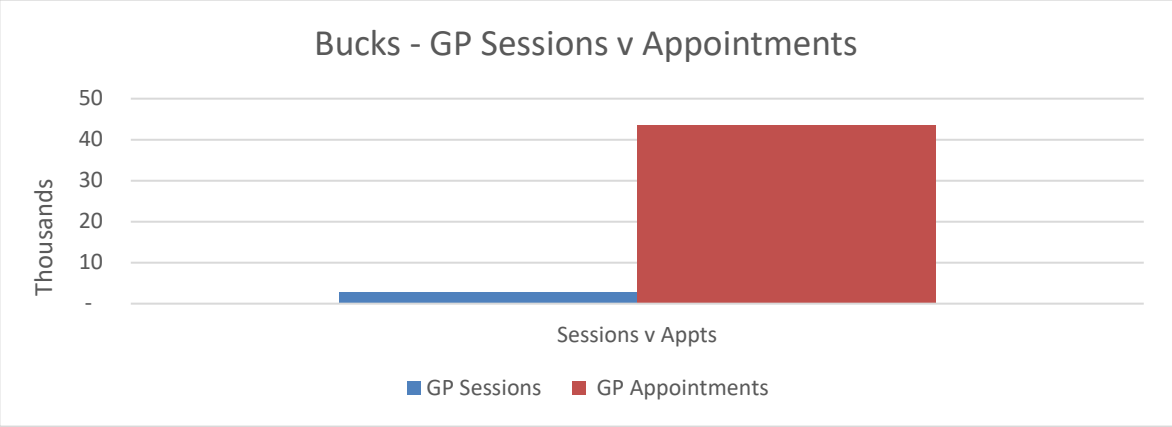
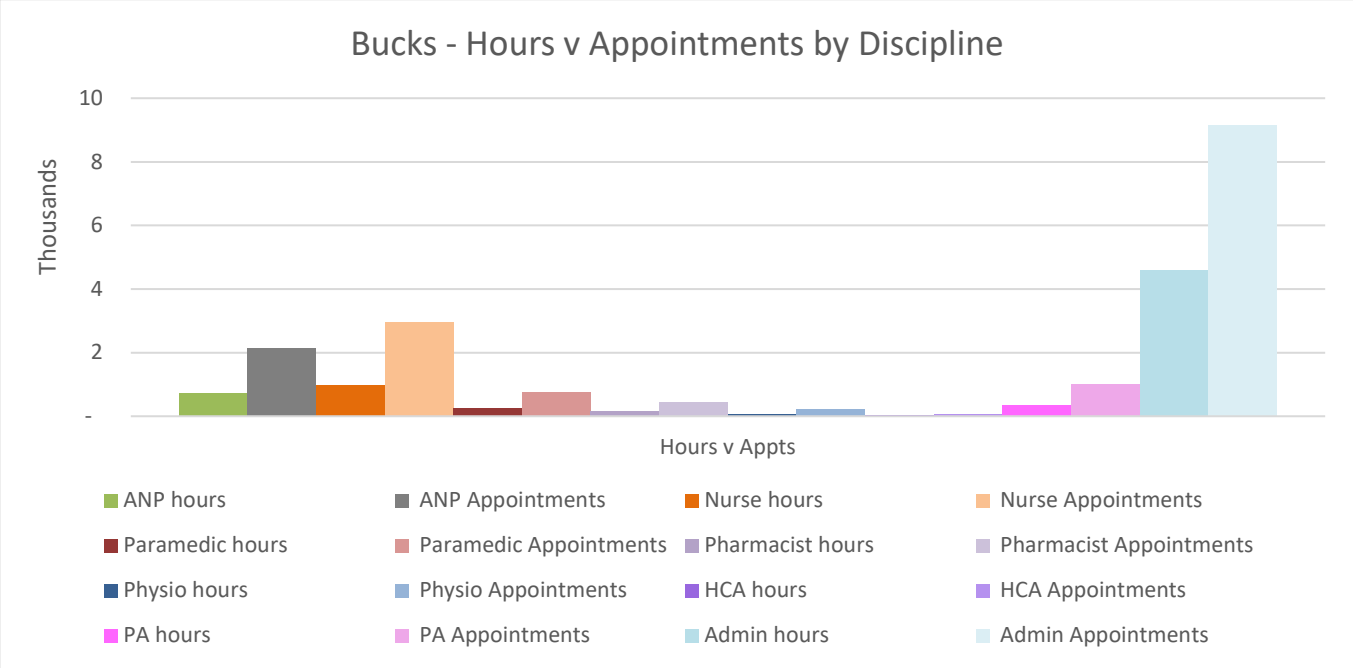


Table 2: Bucks total number of additional hours versus appointments during the WAF period, categorised by disciplines.



Winter funding also enabled implementation of enhanced technology such as advanced telephony roll-out to support flexible, responsive, and integrated services for patients. As a result, practices benefited from improved efficiency and resilience.

Patient satisfaction was maintained despite the challenges faced by our practices, such as staff sickness and the requirement to redirect resources to the accelerated Covid booster vaccination programme.

Despite high levels of staff sickness practices were able to 'keep the doors open' as a result of the additional workforce resources.

2022 Winter Plan

- The ICB is currently working to respond to NHSE's recent letter on winter access in primary care and to secure additional capacity and support providers this winter. Essential interventions to build capacity are being accelerated including:
    - **Roll out of advanced telephony** - as mentioned above, 8 newly live, 19 scheduled by March 2023 and 20 previously implemented in Bucks.
    - Roll out and use of **community pharmacist consultation** service - 33 out of 47 practices are live, we are working with the remainder.
    - **Resilience planning** in response to recent NHSE guidance encouraged practices and PCNs to replicate the innovations undertaken in 2021.
    - **Enhanced Access** arrangements agreed and live from 1st October 22 – all Enhanced Access Plans for Primary Care Networks across BOB signed off and delivering from 1st October - PCNs will offer extra hours in the morning, in the evening, at weekends and added daytime capacity.

- **Same day care** – in addition, to help reduce the demand into primary care, we have implemented a primary care NHS 111 Hub which aims to triage all primary care activity before it reaches GP Practices. This will mean that GP practices will only receive referrals for patients that require a face-to-face appointment. To date we have mobilised 7 practices with the remainder being mobilised before Christmas. Early indications are that up to 80% of activity is being closed down within the hub without onward referral.

Other access workstreams include winter communications; providing additional remote consultation capacity/signposting to national support offers for the most challenged practices; embedding the use of online consultation solutions; and building PCNs' and practices' use of Connected Care/Apex data to manage their capacity and demand. We are also working with practices to review and improve website information and phone messages.

Tackling Variation

All GPs are independent business owners and due to patient needs within the area different systems and requirements are needed to ensure patient outcomes are delivered. This means that there is inevitably some variance in the systems that practices use for patients and delivering services. The ICB has a role to play in working with practices to ensure that any variances remain within an acceptable range, and that patients still have access to services and a positive experience of the care and support they receive.

So for example:

- To support **patient access**, Buckinghamshire's ICB place team is reviewing practices in the top quintile to identify best practice that can be shared and are also reviewing practices in the bottom quintile giving consideration to:
    - Triangulating with other information sources and whether action plans to improve phone access in development with PPG is required;
    - Telephony project status (project supports the upgrade of GP practice telephone systems) and scope to escalate if GPs are having difficulties establishing or delivering new telephony systems.
- To support improvements in **patient experience,** Buckinghamshire's ICB place team are reviewing practices in the top and bottom quintiles for patient satisfaction with making an appointment and overall experience of GP practice. Practices that have been identified as requiring a plan in more than one area will be asked to provide a combined action plan.
- As an example - one practice which identified as having poor waiting times for an appointment (where more than half of responders to the national GP survey stated they had to wait a week or more for an appointment) has been recently reviewed to ensure that appropriate systems and support are in place.

In addition, to ensure we have the best possible data on patient experience, work is underway to increase participation and upload for the newly reinstated Friends and Family Test and to follow-up identified outliers to ensure sufficient patient feedback systems are in place.

We are also providing training as part of the NHSEI funded Health & Wellbeing Primary Care Pilot. This training is being offered to all Primary Care staff (General Practice, Dentistry, Optometry and Pharmacy) who have service user/patient-facing or mental health and wellbeing-related roles. The aim of this training is to re-energise staff working in demanding and challenging environments. It will cover things like effective communication, handling challenging patients and mental health training to enable primary care staff to be able to confidently hold supportive and compassionate wellbeing conversations with their colleagues. It is hoped that by supporting staff in this way we will also see improvements in patient experience.

How are the ICB supporting delivery?

Building on this and taking into account the innovations delivered last year as part of the requirements in the PCN Enhanced Service the following has been implemented

- Weekly situational reports are now requested from general practice to understand their operational challenges, reviewed and followed up where necessary.
- Assurance of primary care services is provided through the following:
    - ICB Primary Care component of the Performance & Assurance report; and
    - ICB's Population Health & Patient Experience Committee
- The primary care team continue to monitor service quality. All Buckinghamshire practices are CQC rated good and above (2 are outstanding).
- PCNs are making good progress towards their contractual requirements including agreeing priorities around personalisation, addressing inequalities and preparing for the roll-out of new anticipatory care arrangements next year.
- From a collaborative working and oversight perspective the BOB teams continue to further develop ways of working including new governance arrangements and building the interface with PCNs and the LMC through a new GP Leadership Group.
- A project to review the approach to workforce planning is reaching a conclusion with the final report expected to be signed off in the next few weeks.

<u>Buckinghamshire GP Estates - Capacity and Assurance</u>

Buckinghamshire is a growing County and it will be important to ensure that GP services can adapt and meet the needs of an increasing population.

The ICB aims to make the best use of capital and estates resources to ensure that:

- Everyone who needs a face-to-face appointment can get one;
- That we have the right facilities to deliver the services and support that people need;
- That we can adapt to the ever-changing populations and health needs of Buckinghamshire.

Major schemes completed in last quarter - Examples of recent developments include Berrycroft Health centre in Aylesbury and Beaconsfield Medical Centre. Both developments saw GPs coming together to redesign their facilities to ensure they are fit for current and future service needs. The developments

recognise that models of care will be increasingly about more than just delivering traditional GP consultations, with a wide range of other therapies, services and support being provided alongside.

Berrycroft Health Centre (2 x merged GP Practices) – improved primary care space as well reception and rooms for community engagement and other services.

Beaconsfield Medical Centre (2 x GP Practices) – revamped space providing a central reception point and increased consultation and other rooms for associated services.

Major schemes in pipeline - There are a number of transformation schemes currently under consideration with the aim being to bring together GP Practices, PCN additional services and hospital services through system working – the most developed of which are included below:

	Scheme	Status	Estimated timescale
Bucks	Lace Hill Buckingham - new Health Centre including Surgery and other additional services Whitehill, Aylesbury – redeveloped GP surgery including additional PCN services	Outline Business Cases submitted for NHSE review and national level approval	2024/25* 2024/25*
	Calcot Medical Centre, Chalfont St Peter – redevelopment of premises to optimise and increase use of GP space and co-locate with some hospital services into vacant neighbouring building and co-locate network team within Chalfont Hospital	Approved project - Tender Procurement & Cost Review in progress	2023/24*

*Subject to relevant planning permissions and agreements being finalised in expected timescales

All local PCNs are currently working on ensuring that their clinical and estates strategies are aligned through the use of the PCN Estates Toolkit. This programme of work is expected to be completed early in the New Year and will enable the baseline position of GP premises provision to be established across

Bucks and through the agreed clinical and associated estates strategies completed to enable an evidence based approach to be applied as and when future capital funding opportunities become available.

Health are working collegiately with Buckinghamshire Council colleagues to link health requirements into the overall Buckinghamshire Plan and how best to access and optimise the use of S106 funding to support the levels of growth predicated.

4. Next steps and review

BOB ICB welcome feedback on this paper and will follow up on any issues arising in discussion.

There are a number of current projects where the support of the HWB would be crucial in ensuring that planning and associated assessments support health development in key areas of the county.

5. Background papers

None

Health & Wellbeing Board Buckinghamshire

Director of Public Health Annual Report

Hearts and Minds - Preventing Heart Disease and Stroke in Buckinghamshire

Date: 15 December 2022

Author/Lead Contacts: Dr Jane O'Grady, Director of Public Health and Community Safety, Buckinghamshire Council

Report Sponsor: Dr Jane O'Grady, Director of Public Health and Community Safety, Buckinghamshire Council

Consideration: ☐ **Information** ☐ **Discussion** ☐ **Decision** ☒ **Endorsement**

Please indicate to which priority in the Joint Local Health and Wellbeing Strategy, Happier, Healthier Lives Strategy (2022-2025) your report links to.

Start Well	Live Well	Age Well
☐ Improving outcomes during maternity and early years	☒ Reducing the rates of cardiovascular disease	☐ Improving places and helping communities to support healthy ageing
☐ Improving mental health support for children and young people	☐ Improving mental health support for adults particularly for those at greater risk of poor mental health	☐ Improving mental health support for older people and reducing feelings of social isolation
☒ Reducing the prevalence of obesity in children and young people	☒ Reducing the prevalence of obesity in adults	☒ Increasing the physical activity of older people

None of the above? Please clarify below:

N/A

1. Purpose of report

1.1. The Director of Public Health is required to produce an annual report on the health of Buckinghamshire's population. This year's themed report is on preventing cardiovascular disease which includes heart disease and stroke. It provides an overview of the impact of cardiovascular disease on the health and wellbeing of Buckinghamshire residents and what needs to be done to address it.

1.2. Cardiovascular disease is one of the largest drivers of poor health and death in the county and the biggest contributor to the gap in life expectancy between residents living in our most and least

deprived areas. It is the second commonest cause of dementia. A large proportion of cardiovascular disease is preventable.

1.3. The report highlights the need for a renewed focus on preventing cardiovascular disease and the risk factors that lead to it. Addressing the key risk factors will improve health in a variety of other ways which include reducing the risk of cancer, diabetes, dementia, musculoskeletal problems and poor mental health and produce many other societal and economic benefits, making Buckinghamshire an even better place to live.

1.4. Implementing the recommendations in the report will help deliver the Health and Wellbeing strategy workstream on cardiovascular disease

2. Recommendation to the Health and Wellbeing Board

1. Note the Director of Public Health Annual Report.

2. Endorse the recommendations for the Board as set out in section 3.7.

3. Content of report

3.1. The report contains information on cardiovascular disease and the differences in its risk factors between different groups and areas in Buckinghamshire and what we can do to prevent it.

3.2. It highlights the risk factors for cardiovascular disease in 3 categories: behavioural risk factors such as smoking, often invisible clinical risk factors such as high blood pressure and diabetes, and social and environmental risk factors. We need to address all these categories of risk factors to tackle cardiovascular disease.

3.3. The social and environmental risk factors include stress at work, poor working conditions and working long hours. Poor air quality and experiencing extreme temperatures such as very cold housing or insufficient protection from heat waves.

3.4. The behaviours of people are heavily influenced by the commercial, social and physical environment around them. A focus on individual change alone will be much less effective than changing the environments in which people live, learn, work and play. For example, the availability, pricing and advertising of alcohol and unhealthy foods influence the food we eat and societal drinking. Children and young people are particularly vulnerable to environmental influences. Many unhealthy behaviours are started during childhood and the teenage years and become entrenched which means they are harder to stop.

3.5. Some risk factors like diabetes, high blood pressure and high cholesterol often cannot be found without clinical tests as many people have no symptoms until later in their illness. It is important to increase the number of people who have been identified as having these conditions so people can be helped to manage them and receive effective treatment. This is especially important for people who are at a higher risk of cardiovascular disease.

3.6. The report identifies that people living in deprived areas and people from South Asian and black ethnic groups are at higher risk of cardiovascular disease. This is due to a combination of interlinked factors that may include poor living and working conditions, exposure to chronic stress,

opportunities to adopt healthy behaviours and biological factors. People living with severe mental illness are also at increased risk of cardiovascular disease. It is important to identify and address risk factors that can be changed to help prevent or delay cardiovascular disease for these groups of people.

3.7. The report highlights some of the work already underway in Buckinghamshire but also identifies where more could be done. Action is asked from all partners on the Health and Wellbeing Board who have an interest in the health and wellbeing of people who live and work in Buckinghamshire. The following recommendations are made to the Board and its members. We need to work together with communities and partners across Buckinghamshire to

1. **Act on the broader determinants of health** such as income, debt, good quality employment, high quality education and healthy environments to level up outcomes across Buckinghamshire. Tackling these issues is an essential component of reducing inequalities in health and cardiovascular disease.

2. **Support a systematic large-scale improvement in behavioural risk factors by**

- ensuring the physical, social, commercial and economic environments in which people live, work and learn support healthy behaviours.
- increasing the understanding and the skills required to design effective behaviour change interventions across Buckinghamshire Council, the NHS and partners. Including rolling out the behaviour change Making Every Contact Count programme. This enables people to have “healthy conversations” to support behaviour change in their day-to-day interactions.
- working with communities to understand what would support them to reduce their risk of cardiovascular disease and co-design and evaluate appropriate approaches.
- supporting NHS trusts to implement the NHS Long Term Plan smoking cessation support requirements as smoking is the single biggest modifiable driver of health inequalities.
- working together with partners and communities to develop a whole system approach to healthy eating and physical activity to combat the rise in unhealthy weight and obesity.
- working together to tackle smoking via the Tobacco Control Action Plan.
- working together to address harmful alcohol misuse through development of our new drug and alcohol strategy.

3. **Increase detection and management of modifiable risk factors in people at higher risk of cardiovascular disease** including those living in more deprived areas, ethnic groups at higher risk of cardiovascular disease and those with mental illness by

- increasing capacity in primary care in more deprived areas to undertake NHS health checks and detect and manage clinical risk factors such as high blood pressure and diabetes, and refer to appropriate interventions such as stopping smoking.

- working with people from ethnic minority groups to design effective, culturally competent approaches to increase detection of risk factors and management of risk factors.
- working with NHS and local authority partners to develop and implement the whole system plan to tackle inequalities in cardiovascular disease.

4. **Improve data collection and monitoring to track progress by**

- improving data collection in primary care (for instance GPs) and secondary care for instance (hospitals) to enable monitoring of outcomes by ethnicity and areas of deprivation and improve the quality, accuracy and completeness of ethnic monitoring data.
- Undertaking surveys known as equity audits to determine access to and uptake of prevention and treatment initiatives of cardiovascular disease by different groups.

4. Next steps and review

4.1. Partners are working together to develop a plan to help prevent cardiovascular disease especially in groups at higher risk of cardiovascular disease. This aligns with the priorities of the Joint Local Health and Wellbeing Strategy recently published by the Board.

4.2. The Opportunity Bucks programme at Buckinghamshire Council aims to promote opportunities to level up health in Buckinghamshire. This provides a way to address the broader determinants of health in the target wards and to work with communities to identify what would work for them to improve their health and quality of life. Health and wellbeing is one of the five themes in the Opportunity Bucks programme and preventing cardiovascular disease is a key component of that theme.

5. Background papers

Appendix 1 – DPHAR 2021/22 Short Read

If you would like to read the report in full please see link below:

https://www.buckinghamshire.gov.uk/documents/18793/Director_of_Public_Health_Annual_Report_2022.pdf

Director of Public Health Annual Report 2022

Hearts and Minds

Preventing heart disease and stroke in Buckinghamshire

SHORT READ VERSION

1. Introduction

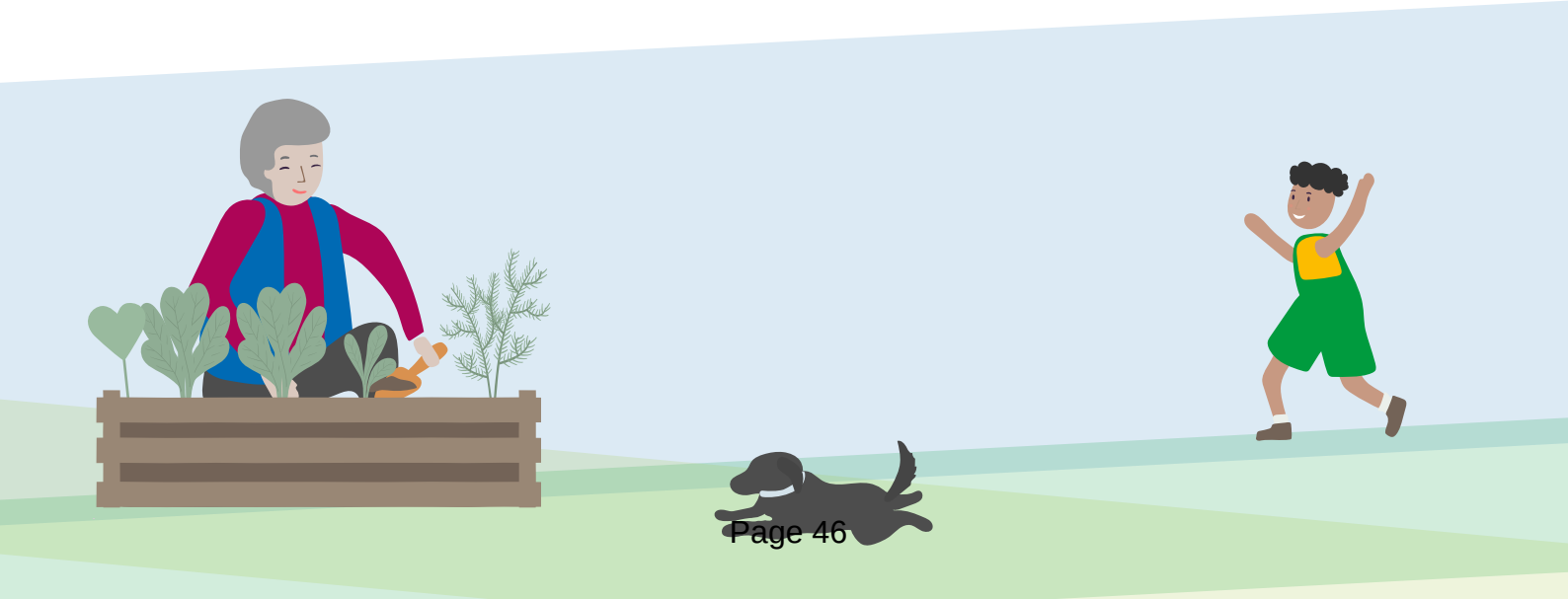
Cardiovascular disease describes diseases of the heart and blood vessels. It includes heart disease, stroke, transient ischaemic attacks (mini-strokes) and vascular dementia, which is the second commonest type of dementia. Cardiovascular disease costs the NHS in England £7.4 billion and the wider economy £15.8 billion every year. It is responsible for one in four premature deaths in the UK and is the biggest contributor to the gap in life expectancy between those living in the most and least deprived areas.

Buckinghamshire is one of least deprived and consequently healthiest counties in England. However, our residents still suffer from a significant burden of preventable diseases, including cardiovascular disease. Although our death rate is lower than the national average, cardiovascular disease is a significant cause of ill health and disability in Buckinghamshire. It causes more than one in five deaths in Buckinghamshire and is the biggest contributor to the gap in life expectancy between people living in our most and least deprived areas.

Death rates from cardiovascular disease had been falling in Buckinghamshire over the last 20 years but progress has been slowing and premature death rates have plateaued recently. Risk factors for cardiovascular disease, such as obesity and diabetes, are rising nationally and locally and could lead to rising rates of cardiovascular disease again.

The COVID pandemic has also had an impact on cardiovascular disease risk by increasing unhealthy behaviours and affecting other cardiovascular disease risk factors. Provisional data covering the pandemic period also revealed a rise in cardiovascular disease death rates between 2020 and 2021. The rise in the cost of living may also have an adverse impact on the development of cardiovascular disease in our residents. We need to act now to reduce the burden of ill health experienced by our communities.

The good news is that the majority of cardiovascular disease can be prevented. Many of the risk factors for cardiovascular disease also cause other diseases, such as cancer, lung and liver disease. Acting on these risk factors will reduce these diseases too and bring many benefits to individuals and communities. It can improve people's health, quality of life and independence as well as the quality of our environment, help mitigate the impact of climate change and increase the economic and social success of Buckinghamshire.



2. Risk factors for cardiovascular disease

We understand a lot about what increases peoples risk of developing cardiovascular disease so we can act effectively to prevent it developing in the first place. It is estimated that up to 80% of cardiovascular disease is preventable.

The risk factors for cardiovascular disease are a mix of personal characteristics, such as age and ethnicity, which cannot be changed and factors that are modifiable, such as the environments and circumstances in which people live, people's opportunities to adopt healthy behaviours and exposure to chronic stress.

The modifiable risk factors can be categorised as behavioural risk factors, clinical risk factors and environmental risk factors and these are discussed below. These factors are often inter-related and therefore we need a multi-agency and multi-level approach to address them. This approach combines actions people can take themselves, actions at a community level and a Buckinghamshire-wide level. National action is also required to help address some of the risk factors.

2.1 Behavioural risk factors

Smoking, being physically inactive, drinking too much alcohol and eating an unhealthy diet increase the risk of cardiovascular disease. The greater the number of risk factors a person has the greater the risk of developing cardiovascular disease. In Buckinghamshire, 13% of adults smoke but this rises to 22% in the most deprived areas of Buckinghamshire according to primary care data.

Changing behaviour is not just a matter of will power. Most health related behaviours are shaped in childhood and adolescence and are influenced by a wide range of factors when we are at an impressionable age. The health behaviours of young people are strongly influenced by the people they see around them, including parents, other adults and their peers. For instance, we know that children who have parents who smoke are more likely to become smokers themselves.

The conditions in which people live also profoundly influences their ability to adopt healthy behaviours. For example, to eat healthily or keep homes warm requires a sufficient level of income. Studies show the poorest 10% of UK households would need to spend 75% of their disposable income on food to meet the recommendations for healthy eating compared to just 8% for the richest 20%. The density of fast food outlets is higher in more deprived areas increasing the availability of unhealthy food. The ability to build physical activity into daily routines is supported by safe cycling or walking routes and safe places to play and be physically active. The pricing, advertising and availability of food and alcohol affect consumption significantly and the food and alcohol industry spend many millions on advertising their products to influence cultural norms and consumption. For all these reasons the prevalence of health promoting or health harming behaviours varies across the population and over time.

Changing behaviour requires much more than a focus on the individual and their behaviour but a whole system approach that supports the individual to make healthy choices and makes healthy choices the easy choices. Interventions that introduce structural changes and require less effort on the part of the individual often have a larger health impact and reduce health inequalities more effectively. The most effective approaches combine population level interventions and individual support. Smoking provides a good example of this combined approach. National action helps produce an environment that discourages smoking through legislation, taxation and advertising and individual support is offered to help people stop smoking.

2.2 'Clinical' risk factors

High blood pressure, being overweight or obese, having high levels of cholesterol in the blood and diabetes increases the risk of cardiovascular disease. The health behaviours described above often contribute to the risk of developing these conditions and addressing health behaviours can help reduce the risk of developing these conditions and help treat them. There are also effective treatments for these clinical conditions that reduce the risk of developing cardiovascular disease.

It is estimated that more than half of cases of type 2 diabetes can be prevented or delayed. The risk factors for type 2 diabetes are an unhealthy diet, being overweight and lower levels of physical activity. In Buckinghamshire, 6% of adults are recorded as having diabetes which is lower than the national average of 7%.

In Buckinghamshire, 16% of adults are recorded as having high blood pressure and the prevalence is higher than the national average, which may reflect better detection or recording. The risk of developing high blood pressure is increased by being overweight, an unhealthy diet ,including eating too much salt, lack of physical activity and higher levels of alcohol consumption.

People often do not know they have high blood pressure, high cholesterol or diabetes as clinical tests are required to detect them. The recorded prevalence of both high blood pressure and diabetes has increased by 8% and 16% respectively in Buckinghamshire since 2012 according to GP data. However, estimates suggest that in Buckinghamshire there may be 10,000 people who have diabetes and 47,000 people who have high blood pressure but it has not yet been recorded or diagnosed. The longer any of these conditions remain undetected and untreated the greater the risk of developing serious complications, such as heart attacks and strokes.

The prevalence of obesity is increasing both in children and adults in Buckinghamshire. More than six in ten adults in Buckinghamshire are overweight or obese and one in three 10-11 year olds are overweight or obese. The prevalence of obesity in 10-11 year olds in Buckinghamshire is highest in the most deprived areas where 26% of children are obese and 14% are overweight.

Some people may not be aware that their weight is putting them at risk. People with a Body Mass Index (BMI) over 30 are classed as obese and have an increased risk of diabetes, high blood pressure, heart disease and dementia. People from South Asian and black ethnic groups have a higher risk of diabetes and cardiovascular disease at lower BMI than people from white groups. Waist circumference is also an indicator of cardiovascular disease risk - a waist measurement of more than 102cm for a man and 88cm for a woman increases the risk of cardiovascular disease.

2.3 Environmental risk factors

Certain types of stress at work have been found to be associated with an increased risk of death from cardiovascular disease. Stressful jobs are particularly damaging to health, and these can be either jobs that make high demands of employees but offer little control, or those that ask for a great deal of effort but provide little reward in the form of pay, recognition or status. These jobs are associated with worse physical and mental health, including higher risks of obesity, heart disease and diabetes. In addition, international evidence has shown that people who work more than 55 hours per week are more likely to die from heart disease and stroke than people working 35-40 hours per week.

Very high and very low temperatures are associated with increased risk of death from cardiovascular disease. Without mitigation climate change will lead to increased summer deaths. Cold homes are also associated with an increased risk of cardiovascular disease and other health problems. Before the COVID pandemic one in five excess winter deaths were due to cardiovascular disease.

Poor outdoor air quality is responsible for up to 36,000 deaths per year in the UK, the majority of which are from heart disease and stroke.

3. Who is more at risk of cardiovascular disease?

While anyone can develop cardiovascular disease, some people are more likely to develop it than others. It is important to understand who is at greater risk of cardiovascular disease to ensure that initiatives to prevent and treat cardiovascular disease are reaching those who need it most and are effective. Increasing people's awareness of their increased risk also enables people to take appropriate steps to reduce their risk by acting on the risk factors that they can change themselves.

Cardiovascular disease increases with age and is more common in men, people living on lower incomes or living in more deprived areas and people from certain ethnic groups, especially black and South Asian ethnic groups. It is also more common in people living with severe mental illnesses, such as schizophrenia or bipolar disease and people with certain inherited conditions, such as familial hypercholesterolaemia. Although cardiovascular disease increases with age it occurs at a younger age in certain groups at risk.

Differences in cardiovascular disease between different groups are a significant driver of health inequalities across Buckinghamshire. Cardiovascular disease is the largest contributor to the gap in life expectancy between people living in our most and least deprived areas.

3.1 People living in deprived areas

People living in the most deprived areas of England are four times more likely to die early from cardiovascular disease compared with people who live in the least deprived areas. This is due to the complex inter-relationship of factors, such as income, employment and environment, their impact on the opportunity to adopt healthy behaviours and the development of conditions such as diabetes. Nationally, people living in deprived areas have higher levels of smoking, physical inactivity and harmful alcohol consumption. They also have higher levels of clinical risk factors such as high blood pressure, diabetes and overweight. They are more likely to live in poorer quality housing and areas with lower environmental quality, have lower incomes and poorer quality jobs, all of which increase the risk of cardiovascular disease.

In Buckinghamshire, data shows that people living in our most deprived areas have a premature death rate from cardiovascular disease which is 2.6 times higher than those living in the least deprived areas. Emergency admission rates to hospital for cardiovascular disease are 60-90% higher from our most deprived areas compared to our least deprived areas but rates of planned admissions are only 20% higher from these areas.

People living in our more deprived areas have higher rates of smoking, overweight and diabetes than in other areas of Buckinghamshire. The frequency of these conditions shows a stepwise increase as area deprivation increases.

3.2 Differences in cardiovascular disease risk between ethnic groups

South Asian ethnic groups

National data shows that people from South Asian groups are more likely to develop and die from cardiovascular disease than white groups and have the highest risk of death from heart disease of any ethnic group. South Asian people also tend to develop cardiovascular disease at a younger age than their white counterparts. South Asian men have been found to develop cardiovascular disease on average at around 60 years of age which is eight years younger

than white men. South Asian women develop cardiovascular disease around 63 years of age which is 11 years earlier than white women. This reflects the complex mix of environmental, social, behavioural and clinical risk factors highlighted above and is not inevitable.

The increased prevalence of diabetes in South Asian groups is a significant driver of increased cardiovascular disease risk. People from South Asian groups are up to six times more likely to develop diabetes than people from white groups and develop diabetes at a younger age at around 62 years compared to 67 years for white European groups. The risk of developing type 2 diabetes increases from age 25 in South Asian groups compared to age 40 in white groups.

By the age of 80 years 40-50% of South Asian people will have diabetes which is twice the prevalence in Europeans.

Being a healthy weight, having a healthy diet and being physically active help prevent or delay the onset of diabetes. Although adults of South Asian ethnicity tend to be a lower weight than white groups, they develop diabetes and cardiovascular disease at a lower weight as measured by Body Mass Index than white groups.

Other risk factors, such as smoking and drinking harmful levels of alcohol, are lower in South Asian groups than white groups which helps protect their health.

In Buckinghamshire, people of Pakistani ethnicity have the highest prevalence of coronary heart disease and diabetes.

Black ethnic groups

People from black ethnic groups appear to have a lower risk of heart disease but are more likely to have high blood pressure and die from stroke than other ethnic groups and more likely to have a stroke at a younger age. Black ethnic groups in the UK may be three to four times more likely to have high blood pressure than white groups and there is some evidence to suggest when blood pressure is detected it is less likely to be well controlled in these groups.

People from black ethnic groups are also up to three times more likely to develop diabetes and have a higher risk of dying from diabetes than the white population. People from black ethnic groups also tend to develop diabetes at a lower weight than white groups.

People from black ethnic groups are less likely to smoke or consume alcohol to harmful levels than white groups which helps protect their health.

In Buckinghamshire, according to primary care records, black ethnic groups have the second highest prevalence of diagnosed high blood pressure (white British groups have highest prevalence) and the second highest prevalence of diagnosed diabetes. People from black ethnic groups have the lowest prevalence of diagnosed heart disease.

Social and economic factors

Social and economic factors are also likely to play a role in the increased risk of cardiovascular disease in black and South Asian groups. Some ethnic groups are more likely to live in deprived areas and it is likely that this is a marker for other social factors, such as income, experience of work related stress and environmental quality, that are important components of the increased risk of cardiovascular disease in these groups. Experience of racism is also known to affect health by increasing stress levels and may also play a role.

The accuracy and completeness of ethnic recording of hospital health care data for Buckinghamshire residents is incomplete making assessment of access and outcomes by ethnicity more difficult. In addition, death certificates do not currently record ethnicity to allow analysis at local level.

3.3 Differences in cardiovascular disease risk by gender

Men are more likely to have cardiovascular disease and more likely to die from it than women. Before the menopause female hormones have a protective effect on cardiovascular disease in women but after the menopause the prevalence of cardiovascular disease increases in women. In Buckinghamshire, men are 2.3 times more likely to die prematurely from cardiovascular disease than women. Between 2019 and 2021 death rates from cardiovascular disease increased in both men and women but much more markedly in men.

Men are more likely to have diabetes than women at the same age and more likely to smoke and drink to harmful levels.

However, international evidence shows that women are less likely to correctly identify the symptoms of a heart attack, that they are slower to seek treatment, that they are 50% more likely to receive the wrong initial diagnosis and that when a heart attack is diagnosed, they received unequal care. Prompt treatment is critical to reduce complications and damage after a heart attack.

3.4 People with severe mental illness

People with a severe mental illness (such as schizophrenia or bipolar disorder) have a greater risk of developing cardiovascular disease and dying from it than people without a serious illness of a similar age. Some risk factors are more common in people with severe mental illness, such as smoking and alcohol consumption. Diabetes and obesity are also more common in people with severe mental illness and some of this increase may partly be due to the side effects of some medication.

4. Cardiovascular disease and COVID

People with cardiovascular disease or the risk factors for cardiovascular disease, such as high blood pressure, diabetes or obesity ,tended to experience more serious outcomes from infection with COVID.

The COVID pandemic has also increased the risk of cardiovascular disease both directly and indirectly. The pandemic has had an indirect impact on cardiovascular disease by worsening some people's mental health and economic circumstances and increasing the proportion of people with unhealthy behaviours, such as eating unhealthily, being less active, drinking more alcohol and gaining weight.

The pandemic also reduced access to routine health care and preventive interventions, such as NHS health checks and management of blood pressure and diabetes. COVID infection has had a direct impact on cardiovascular disease and led to an increase in cardiovascular disease events after infection, even in those who were not admitted to hospital.

COVID will continue to impact on society and we are still learning about the impact COVID has on long-term health. There is some emerging evidence that COVID itself may increase the risk of cardiovascular disease in people who get infected. COVID will continue to circulate and will impact more severely on those with pre-existing cardiovascular disease or its risk factors, which gives us added incentive to tackle cardiovascular disease now.

5. What are we doing now?

We have a range of programmes in Buckinghamshire designed to address the main behavioural and clinical risk factors for cardiovascular disease. These are highlighted in the main report. We are also developing and implementing a multi-agency plan to address inequalities in cardiovascular disease across Buckinghamshire, overseen by the Buckinghamshire Health and Wellbeing Board.

5.1 Addressing behavioural risk factors

Smoking is addressed through the multi-agency Buckinghamshire Tobacco Control Strategy and implementing the NHS Long Term Plan for smoking cessation. The council provides free smoking cessation support to those who wish to quit smoking through the Live Well Stay Well service.

Physical activity is addressed via the multi-agency Buckinghamshire Physical Activity Strategy 2018-2023 and action plan. Examples of successful programmes include Active Communities, a pilot project taking a whole community approach to reduce sedentary behaviour in two communities, and an Active Movement in Schools programme to reduce sedentary behaviour in children and families. Other programmes support Active Travel and Play Streets.

Healthy eating and a healthy weight are addressed through several programmes, including the Buckinghamshire 'Whole Systems Approach To Healthy Weight'. The approach brings together partners, including housing, planning, transport, leisure and schools and local communities, to develop and agree on a shared action plan that addresses the wider environmental factors that make it easier for people to maintain a healthy weight.

Healthy eating activities include increasing access to healthy affordable food through community growing schemes such as Grow It Cook It Eat It, which supports communities to grow their own food and offers cookery courses, including basic cookery skills and healthy meals on a budget. Grow to Give encourages people to grow more food in their gardens and allotments and donate the surplus to food banks and community fridges. In 2021 the community of growers donated 3.22 tonnes of produce for food parcels that supported over 600 families, that's the same weight as 403 baskets of fruit and vegetables, three giraffes or two family sized cars.

Buckinghamshire Council commissions some weight management services, including through our integrated lifestyle service, Live Well Stay Well. The NHS also offers some weight management support and programmes to prevent the development of diabetes.

5.2 Detecting and managing clinical risk factors

The free NHS health check is offered to eligible adults aged 40-74 and is designed to spot risk factors such as high blood pressure and high cholesterol or early signs of heart disease, type 2 diabetes, stroke, kidney disease or dementia.

It offers opportunities for people to be tested and be given advice about reducing their risk of cardiovascular disease and referred on for treatment if required. The NHS health check was paused during the pandemic but has now restarted and we are working to increase uptake in groups at greatest risk of cardiovascular disease. The NHS is also working to support management of high blood pressure and diabetes as we adapt to living with COVID.

5.3 Addressing environmental risk factors

Buckinghamshire Council and partners have a variety of plans to improve the wider environmental risk factors for cardiovascular disease, including action on climate change, air quality, active travel, employment and housing.

6. Recommendations

We need a renewed focus on preventing cardiovascular disease in Buckinghamshire. This needs to address the key social, economic and environmental risk factors for cardiovascular disease, alongside the behavioural and clinical risk factors to keep our residents healthy and narrow inequalities. Tackling the key risk factors will also improve health in a variety of other ways, including reducing the risk of cancer, diabetes, dementia, musculoskeletal problems and poor mental health, and produce many other societal and economic benefits, making Buckinghamshire an even better place to live.

To tackle cardiovascular disease and reduce inequalities in illness and premature death in Buckinghamshire we need a multilevel approach that addresses risks at the individual, community and Buckinghamshire-wide level that will impact over the short, medium and long term.

We need to work together with partners and communities across Buckinghamshire to:

1. Act on the broader determinants of health, such as income, debt, good quality employment, high quality education and healthy environments to level up outcomes across Buckinghamshire. Tackling these issues is an essential component of reducing inequalities in health.

2. Support a systematic large-scale improvement in behavioural risk factors by:

- Ensuring the physical, social, commercial and economic environments in which people live, work and learn support healthy behaviours.
- Increasing the understanding and the skills required to design effective behaviour change interventions across Buckinghamshire Council, the NHS and partners, including rolling out the behaviour change Making Every Contact Count programme. This enables people to have 'healthy conversations' to support behaviour change in their day-to-day interactions.
- Working with communities to understand what would support them to reduce their risk of cardiovascular disease and co-design and evaluate appropriate approaches.
- Supporting NHS trusts to implement the NHS Long Term Plan smoking cessation support requirements as smoking is the single biggest modifiable driver of health inequalities.
- Working together with partners and communities to develop a whole system approach to healthy eating and physical activity to combat the rise in unhealthy weight and obesity.
- Working together to tackle smoking via the Tobacco Control Action Plan.
- Working together to address harmful alcohol misuse through development of our new drug and alcohol strategy.

3. Increase detection and management of modifiable risk factors in people at higher risk of cardiovascular disease, including those living in more deprived areas, ethnic groups at higher risk of cardiovascular disease and those with mental illness by:

- Increasing capacity in primary care in more deprived areas to undertake NHS health checks and detect and manage clinical risk factors, such as high blood pressure and diabetes, and refer to appropriate interventions, such as smoking cessation.
- Working with people from ethnic minority groups to design effective, culturally competent approaches to increase detection of risk factors and management of risk factors.
- Working with NHS and local authority partners to develop and implement the whole system plan to tackle inequalities in cardiovascular disease.

4. Improve data collection and monitoring to track progress.

- Improve data collection in primary and secondary care to enable monitoring of outcomes by ethnicity and areas of deprivation and improve the quality, accuracy and completeness of ethnic monitoring data.
- Undertake equity audits to determine access to and uptake of prevention and treatment initiatives of cardiovascular disease by different groups.

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Health & Wellbeing Board Buckinghamshire

Buckinghamshire Health and Social Care System Winter Plan

Date: 15 December 2022

Author/Lead Contacts: Caroline Capell, Director of Urgent and Emergency Care, Buckinghamshire Place, Buckinghamshire Healthcare NHS Trust

Report Sponsor: Raghuv Bhasin, Chief Operating Officer, Buckinghamshire Healthcare NHS Trust

Consideration: ☐ **Information** ☒ **Discussion**

☐ **Decision** ☐ **Endorsement**

Please indicate to which priority in the Joint Local Health and Wellbeing Strategy, Happier, Healthier Lives Strategy (2022-2025) your report links to.

Start Well	Live Well	Age Well
☐ Improving outcomes during maternity and early years	☐ Reducing the rates of cardiovascular disease	☐ Improving places and helping communities to support healthy ageing
☐ Improving mental health support for children and young people	☐ Improving mental health support for adults particularly for those at greater risk of poor mental health	☐ Improving mental health support for older people and reducing feelings of social isolation
☐ Reducing the prevalence of obesity in children and young people	☐ Reducing the prevalence of obesity in adults	☐ Increasing the physical activity of older people

None of the above? Please clarify below:

The winter plan covers the whole population of Buckinghamshire, including all ages and all conditions, based on anticipated demands on each Urgent and Emergency Care Service. Ability to access emergency care can have an impact on both physical and mental health and wellbeing. The principles in the plan will support the health and wellbeing strategy priorities above, keeping the population of Buckinghamshire healthy.

1. Purpose of report

The Buckinghamshire System Winter Plan is a Health and Social Care plan to help partners manage the anticipated increase in pressures in urgent and emergency care.

Throughout this plan, the term 'winter' refers to the period Monday 3rd October 2022 to Friday 31st March 2023.

The purpose of this report is to highlight the progress of the Buckinghamshire System Winter Plan and issues relating to its progress.

2. Recommendations to the Health and Wellbeing Board

1. The Health and Wellbeing Board are asked to note the effectiveness of the System Winter Plan, issues identified in this report and to note the positive impact to date.

3. Content of report

Background

The **aims** of the Buckinghamshire System Winter Plan, based on learning from 2021/22, are to ensure our Health and Social Care Providers agree to support and deliver the following:

- The Bucks Health and Social Care System will aim to be **resilient and supportive** throughout the winter period, providing safe, effective, and sustainable care for the local Buckinghamshire population
- The Bucks Health and Social Care System will aim to have sufficient **capacity** available, including flexibility across the workforce where staff may need to help where there is demand, to help meet likely demands over winter and potential surges in Covid-19 or other anticipated challenges
- The Bucks Health and Social Care System will aim to deliver **safe** and high-quality **care** for patients/clients in the most appropriate health and care setting, such as home, hospital or a GP surgery
- The Bucks Health and Social Care System will aim to **achieve** national and local access targets such as ambulance handovers and ED times and planned trajectories across the wider system
- The Bucks Health and Social Care System will continue to learn from previous winters locally and from **other systems** and ensure we adopt **Best Practice** where possible across Buckinghamshire
- The Bucks Health and Social Care System will aim to promote **prevention** and supports self-care for staff and patients / clients, so patients have the support to help look after themselves at home.

The Buckinghamshire System Winter Plan consists of **10** key areas across the Health and Social Care System. These are highlighted in the diagram below.

System partner has contributed to this plan and are committed to delivering and supporting the challenges expected through the winter period.

It should be recognised that our partners may have their own detailed local winter plans in place, such as Buckinghamshire Council and Buckinghamshire NHS Trust will have in place their own winter plans specific to their services.

The 10 areas of focus have their own separate priority plans to help alleviate the pressures across winter.

A selection of the key actions and successes to help alleviate pressures are listed below to ensure we can:

1. Keep patients safe in their own home during winter
2. Keep patients safe when in hospital
3. Getting patients safely home from hospital

Successes

3.1 Additional funding to assist in the increase in additional demand and capacity over the winter period.

Five schemes are in place to help increase capacity bed capacity across Buckinghamshire, see appendix 1 for further details of these schemes.

3.2 Fully operational Urgent Treatment Centre Pathway at Stoke Mandeville Hospital

Urgent Treatment Centre Pathway at Stoke Mandeville Hospital enables patients who self-present to be clinically streamed into a pathway where they will be seen and treated for primary care and minor injury / illness presentations. This service runs from 8am to 8pm 7 days a week. Improvements are being made over the coming weeks with the aim to extend the hours of operation if possible.

3.3 Same Day Emergency Care (SDEC) to take patients direct from GP practices

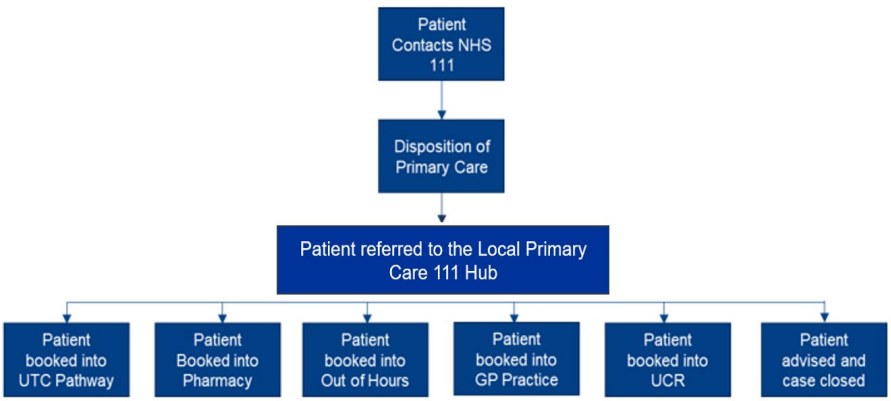
Buckinghamshire NHS Trust have been working closely with our GP practices to enable direct referrals for patients from their GP to the Same Day Emergency Care service. This means patients can present directly to this service and not have to wait in the Emergency Dept or elsewhere in the hospital. The aim is for the patient to be treated and sent home without the need to be admitted. They can be in the SDEC service for up to 23 hours if this is necessary.

3.4 Virtual Wards

Across Buckinghamshire we are establishing 50 virtual ward beds to help manage and maintain patients in their own home. The beds help ensure patients can stay in their own home and be able to have acute physician care without having to be admitted to the hospital. There are currently 50 beds operational.

3.5 Primary Care 111 Hub

Buckinghamshire have been working with GP practices to help reduce demand from 111. We have set up a Clinical Assessment Service Hub where all calls from 111 that have resulted in a Primary Care disposition (as in contact or speak to a GP) will be sent to the hub where a clinical team will triage the patient. The pathway below highlights the potential flow of care for the patient:



As of 30th November, we have 7 practices live with this new pathway with a roll-out plan for other practices. This is optional and we are actively working with practices to encourage moving to this pathway. We will be continuously evaluating this service.

3.6 Adult Social Care

We are working with our Care Homes and Domiciliary Care providers to ensure flexibility to facilitate weekend admission. This is ongoing across the Winter period.

We have 7-day social work staff in place seven days a week and also supporting the hospitals, including Wexham Park to ensure we can match our resources with demand across winter.

3.7 Flu and Covid Vaccinations

The uptake of Covid and Flu vaccinations continues to slowly increase. Comms continues across Buckinghamshire.

3.8 Winter Communications

Buckinghamshire System partners continue to communicate services that are available to our population. There is a growing emphasis on contacting 111 and during winter we will be aligning to the national campaign to use 111 online. The key messaging includes:

Through 111.nhs.uk people can:

- find out how to get the right healthcare in their area, including whether they need to see a GP or seek urgent care
- get advice on self-care
- get a call back from a nurse, doctor, or other trained health professional if they need it.

People should call 111 to speak to someone if they need to:

- Discuss complex medical problems
- Get medical advice for a child under five.

4. Next steps and review

We will continue to monitor progress and challenges throughout the winter months. The system wide overview remains within the Buckinghamshire Urgent and Emergency Care Board, chaired by Raghuv Bhasin, Chief Operating Officer of Buckinghamshire NHS Trust, with senior membership from all Urgent and Emergency Care health and social care providers across Buckinghamshire.

The actions and progress through winter will be a continuous and iterative process. Where required there are daily escalation meetings across the wider system. We also work with our Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB Integrated Care Board) Health colleagues daily for wider support if needed.

The following challenges remain during this winter period:

- Continuing the roll-out of the winter plan
- Resources to cover the whole system UEC services

- Nursing strikes
- GP Practice engagement to move to 111 Hub
- Respiratory Syncytial Virus (RSV in Children) / Covid / Flu
- Vaccination uptake

5. Background papers

For further information in appendix 2 - Buckinghamshire Health and Social Care System Winter Plan, summarises the plan signed off by:

- Buckinghamshire Health and Social Care Select Committee
- Buckinghamshire Urgent and Emergency Care Board
- Buckinghamshire, Oxfordshire and Berkshire West Urgent and Emergency Care Board

The Winter Plan has been developed in partnership with all Urgent and Emergency Care providers across Buckinghamshire.

Appendix 1

Additional funding to assist in the increase in additional demand and capacity over the winter period. schemes are in place to help increase capacity bed capacity across Buckinghamshire:

- **Olympic Lodge** – we have 22 additional beds clinically managed who are discharged from the Acute Trust but not able to go home yet. This has been running since October and will continue until the end of March.
- **Community Beds** – this includes opening and staffing 8 beds in Amersham and Buckingham community hospitals. Provides step-down capacity for medically optimised patients and also patients to receive therapies in a less acute setting closer to home.
- **Dom Care Bridge Team** – This is a dedicated care team to help bridge patients' packages of care so that they can get home quicker when medically optimised for discharge. Provides additional capacity in challenged Dom Care market using employment capacity of the Trust. May be particularly targeted at hot spots where domiciliary care is hardest to obtain. This will support the HomeLink Healthcare Scheme.
- **Wrap Around Care Scheme** –
    - Six-month pilot with provider Sodexo to reduce unnecessary hospital readmissions by providing wrap around care for patients at high risk of readmission. This will improve patient outcomes, patients and professional experience whilst reducing health inequalities and saving hospital bed capacity.
    - Pilot services of HomeLink Healthcare to support the transition from hospital to home-based care by stopping people being admitted to hospital and enabling others to come home more quickly. Providing expert nursing and therapeutic care in the home, to complement and enhance existing hospital-based patient services. HomeLink Healthcare is successfully operating in other systems.
- **Frailty at Front Door** - Develop and strengthen an existing small frailty front door team, by introducing two frailty GPs, as well as a community pharmacist, and four additional therapy/nursing staff with focus on admission avoidance for older people who require a holistic assessment and personalised care plan and maximise the use of the Frailty SDEC pathway. The frailty GPs will link in with the Urgent Care Response team to support the co-ordination of care with interventions and support to promote independence.

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Appendix 2

Buckinghamshire System Winter Plan 2022 / 23

Buckinghamshire Council

NHS Oxford Health NHS Foundation Trust

FedBucks

NHS South Central Ambulance Service NHS Foundation Trust

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

NHS Buckinghamshire Healthcare NHS Trust

Introduction

The Buckinghamshire System Winter Plan 2022/23 presents the intentions of the Buckinghamshire Health and Social Care System to support the six month period of Winter 2022/23. Throughout this plan, the term 'winter' refers to the period **Monday 3rd October 2022 to Friday 31st March 2023**.

This winter plan covers the whole population of Buckinghamshire, including all ages and all conditions so these are not separated throughout the plan that groups priority actions at provider level, based on anticipated demands on each Urgent and Emergency Care Service.

This is a high level iterative plan to support the Buckinghamshire Health and Social Care System across Winter 2022/23 recognising providers will have their own detailed local winter plans in place.

NHSE will be providing a **Board Assurance Framework** to help all systems provide assurance for the anticipated challenges facing us this winter. These areas are embedded throughout this Winter Plan.

National Priorities

The collective core objectives and actions are to:

1. **Prepare for variants of COVID-19 and respiratory challenges**, including an integrated COVID-19 and flu vaccination programme.
2. **Increase capacity outside acute trusts,** including the scaling up of additional roles in primary care and capacity funding to support the system through additional bed capacity during the winter months.
3. **Increase resilience in NHS 111 and 999 services**, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
4. **Target Category 2 response times and ambulance handover delays,** including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
5. **Reduce crowding in A&E departments and target the longest waits in ED,** through improving use of the NHS directory of services and increasing provision of same day emergency care and acute frailty services.
6. **Reduce hospital occupancy,** through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards and improvements elsewhere in the pathway.
7. **Ensure timely discharge,** across acute, mental health and community settings, by working with social care partners and implementing the 10 best practice interventions through 'the 100 day challenge'.
8. **Provide better support for people at home,** including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

Overview of the Buckinghamshire Winter Plan

The Buckinghamshire System Winter Plan consists of **10** key areas across the Health and Social Care System. These are highlighted in the diagram to the left.

System partner has contributed to this plan and are committed to delivering and supporting the challenges expected through the winter period.

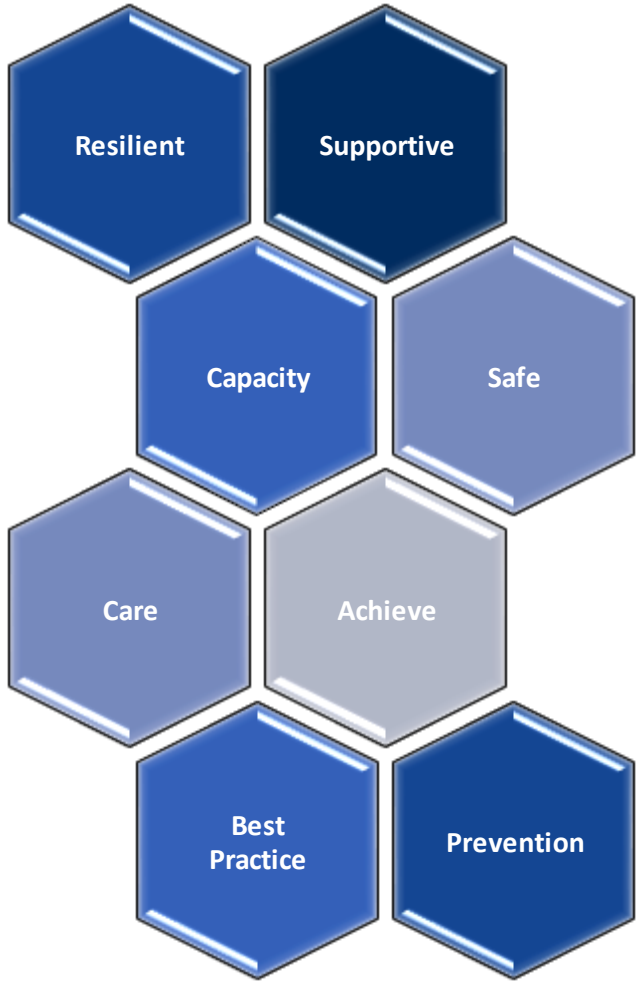
It should be recognised that all providers will have their own detailed local winter plans in place.

A **Winter Plan Tracker and Dashboard** will be developed to help track the delivery and impact across the winter period. This will be overseen via the Buckinghamshire UEC Board.

Aims

The **aims** of the Buckinghamshire System Winter Plan, based on learning from 2021/22, are to ensure all key partners are signed up to support and deliver the following:

- ✓ The Bucks System will aim to be **resilient and supportive** throughout the winter period, providing safe, effective and sustainable care for the local population
- ✓ The Bucks System will aim to have sufficient **capacity** available, including flexibility across the workforce, to meet likely demands over winter and potential surges in Covid-19 or other anticipated challenges
- ✓ The Bucks System will aim to deliver **safe** and high-quality **care** for patients/clients in the most appropriate setting
- ✓ The Bucks System will aim to **achieve** national and local access targets and trajectories across the wider system
- ✓ The Bucks System will continue to learn from previous winters locally and from **other systems** and ensure we adopt **Best Practice** where possible across Buckinghamshire
- ✓ The Bucks System will aim to promote **prevention** and supports self-care for staff and patients / clients.

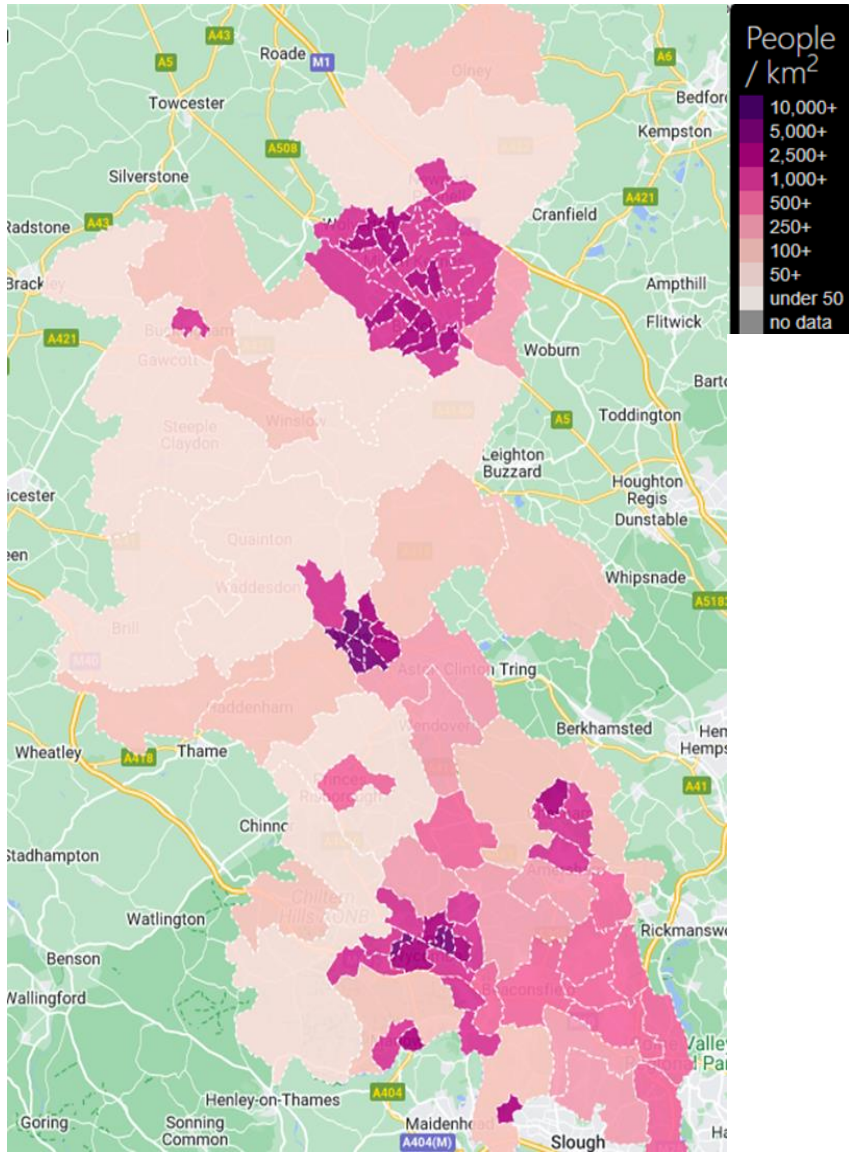


Overview of Buckinghamshire

Buckinghamshire has a resident population of approximately **553,100**. The authority is the 4th (out of 19) least densely populated upper tier local authority in the South East, with a population density of 353 residents per square kilometre as highlighted in the map to the right. The demands on our services continues throughout the year with the approximate volume highlighted below:

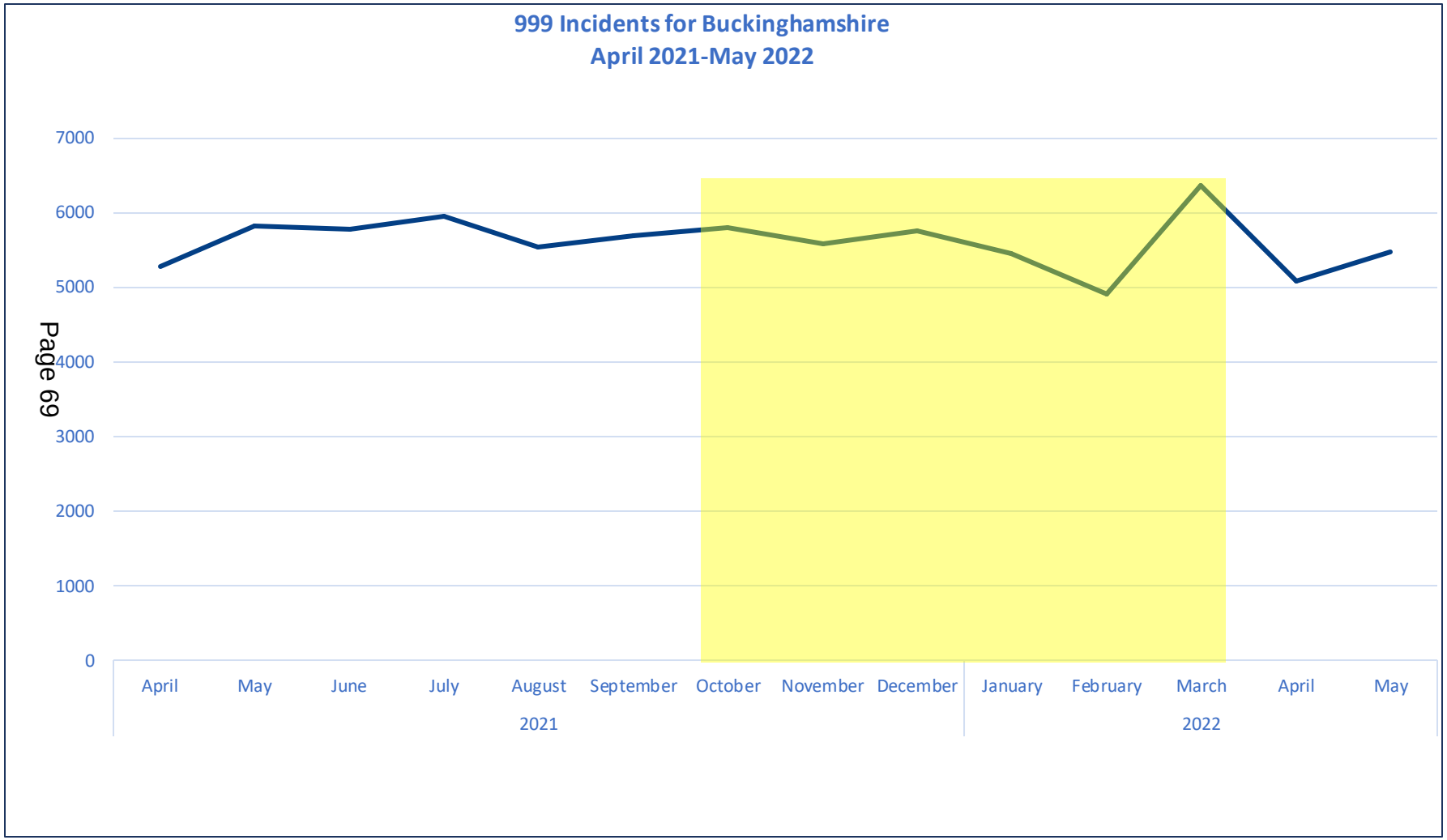
- **246,330** calls to 111 per annum from Bucks residents
- **66,543** calls to 999 per annum from Bucks residents
- **104,213** ED attendances per annum into Stoke Mandeville Hospital
- **37, 665** patients admitted into hospital in Bucks per annum
- **34,000** attendances at the Urgent Treatment Centre at Wycombe Hospital per annum
- **2.7m** GP contacts across Buckinghamshire
- **48,265** contacts with Out of Hours Primary Care

Throughout the following slides, the activity that took place across the previous winter will be highlighted.



Ambulance – 999

Access to urgent and emergency care is frequently sought through the 999 process. The management of high demand represents an ongoing challenge for any ambulance trust. The activity for winter 2021-22 is highlighted in yellow on the chart.

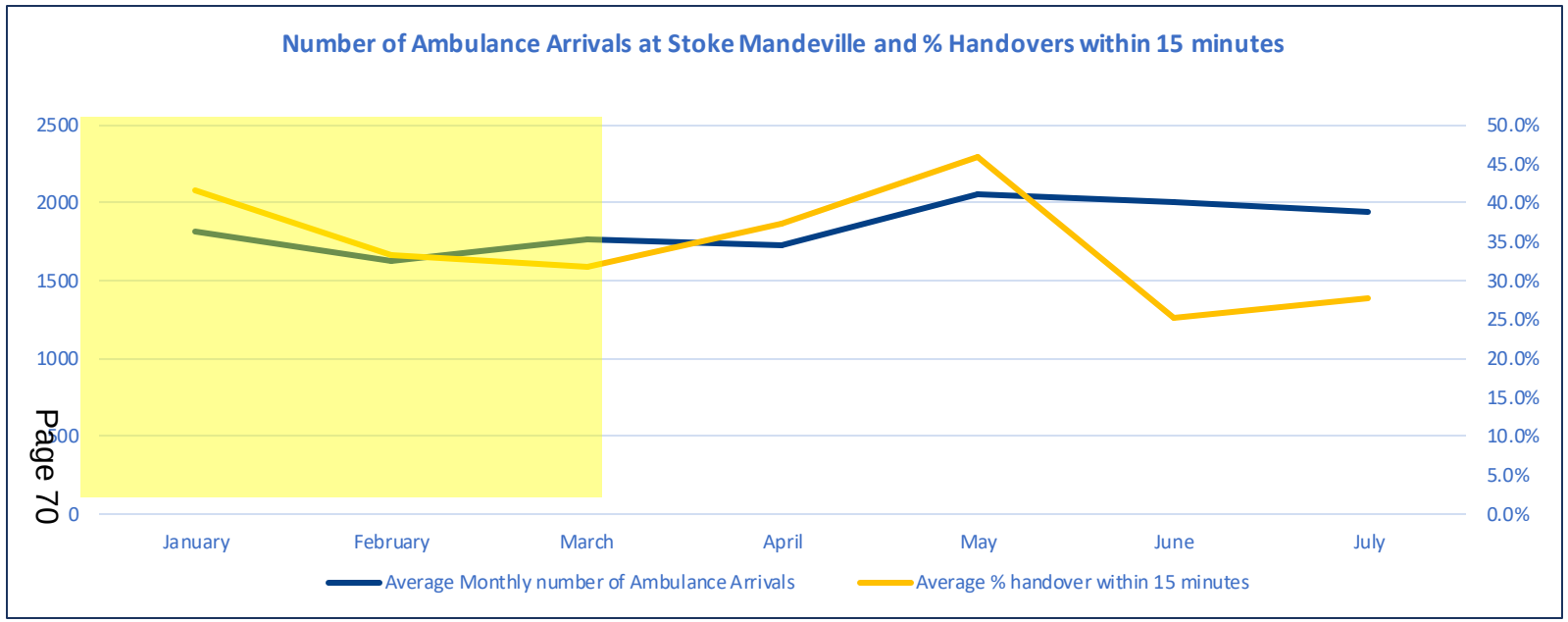


It is important to note that not every 999 incident results in an ambulance being dispatched and not every ambulance dispatch results in a conveyance to a hospital.

Approximately **53%** of 999 calls result in an ambulance being conveyed to a hospital and **35%** being managed by a paramedic on scene (see and treat) and **12%** being managed from within the call centre with clinical support.

Ambulance - handovers

The volume of ambulances arriving at hospital and the speed at which they can handover a patient are vital in understanding patient flow into the hospital. Most of the calls and care from ambulances within Buckinghamshire are via South Central Ambulance Service (SCAS).



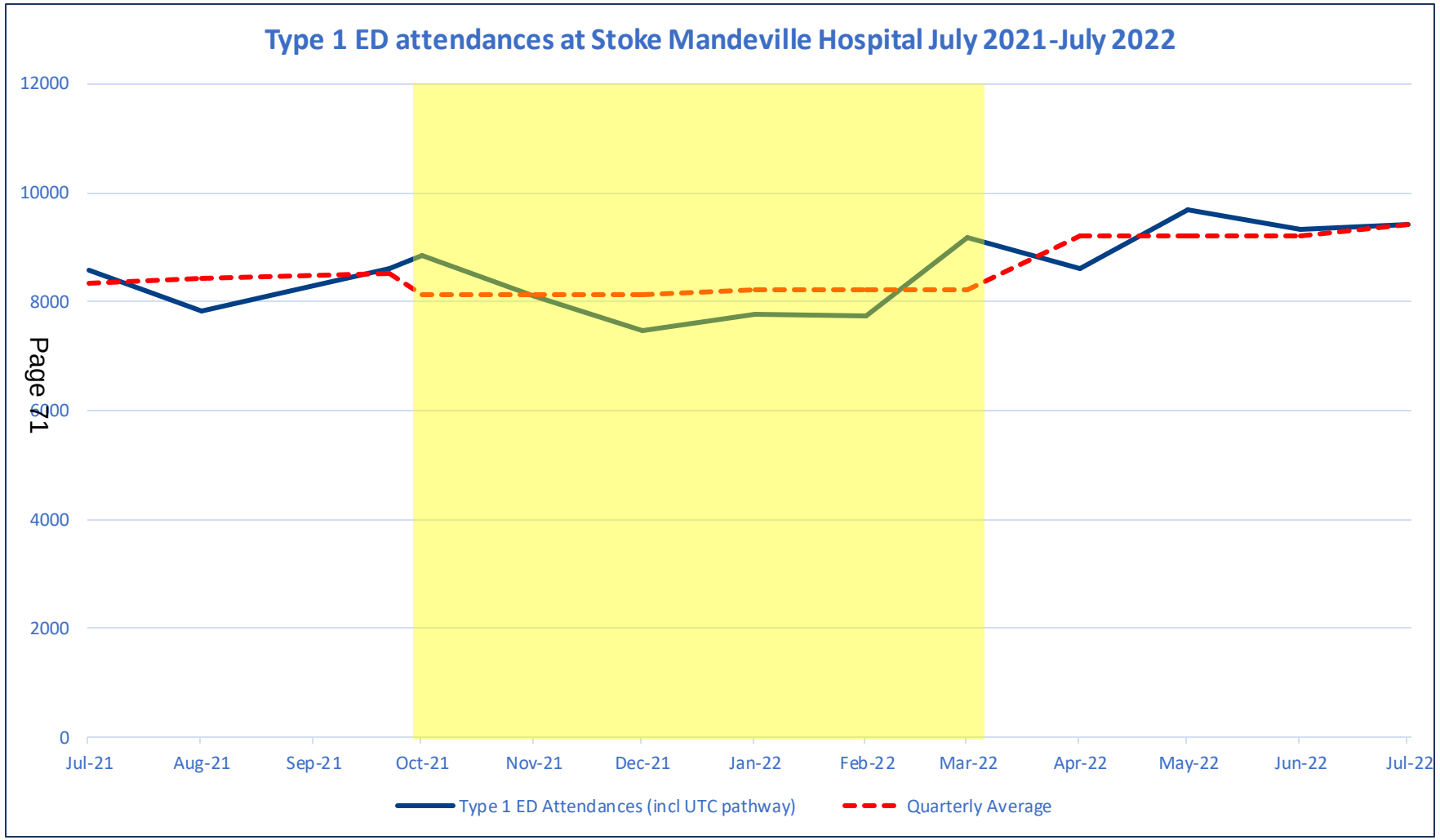
Ambulance arrivals continued to increase beyond the winter period 2021/22 with continued challenges to the speed at which handovers were completed. Significant focus has been placed upon improving the overall handover process within the hospital as well ensuring specific winter actions are in place. SCAS have an organisational winter plan that also has this as a high priority item.

We will be working closely with SCAS, who have a comprehensive Winter Plan, to help support the Buckinghamshire population. The table below highlight the actions intended through the Winter period:

Winter Challenge	Action
Alternatives to an Emergency Dept for patients	Ensuring the SDEC pathway is in place for winter
	Ensuring SCAS utilise Consultant Connect for the Frailty Line and SDEC line
Workforce to help manage increased demands	SCAS recruiting additional call handlers and where able, Paramedics to help with the anticipated increase in demand

Acute (Stoke Mandeville Hospital)

The Emergency Department at Stoke Mandeville Hospital, like most acute sites, has been experiencing sustained pressure and demand for some time. The graph below shows the total type 1 attendances at Stoke Mandeville since July 2021. The yellow highlighted section shows the winter period for 2021-22.

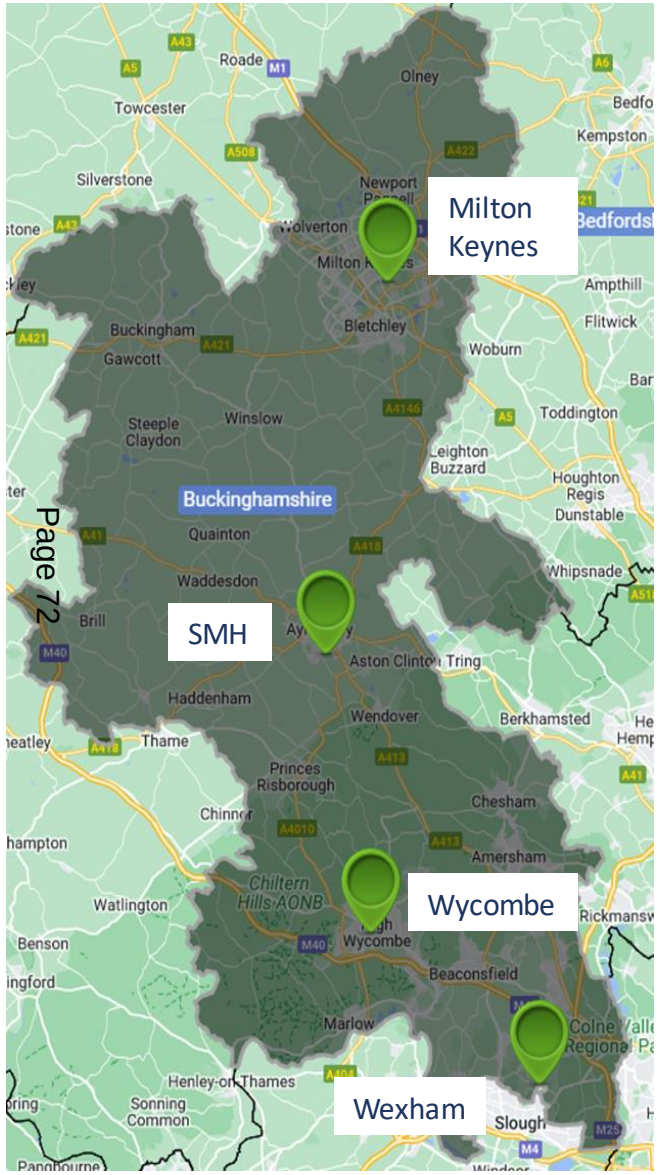


The trend shows that the 4-month period after "winter" last year saw a 13% increase which has sustained across the summer period.

Given the winter period is normally associated with increased activity, it is reasonably to assume that the activity will be very challenging this winter.

Therefore, a strong focus on alternative options to attending ED will be vital.

Acute Hospitals



BHT will also have their own more detailed Winter Plan in place. Buckinghamshire Healthcare Trust (BHT) has two main Acute Hospital sites: Stoke Mandeville Hospital (SMH) and Wycombe Hospital. Buckinghamshire patients also attend neighbouring Milton Keynes and Wexham as highlighted on the map.
In Buckinghamshire, the winter period additional actions will take place to help manage the anticipated increased demands. The high level actions are included in the table below.

Winter Challenge	Action
Insufficient Bed Capacity to meet the demand of the activity	Additional funding to assist in the increase in additional demand and capacity over the winter period. Plans are being developed to mobilise this as soon as funding approved
Lower acuity patients self-presenting at ED	Fully operational UTC Pathway at SMH to take approximately 40% of all ED demand through winter
Treating patients who do not need admission but require longer support.	Same Day Emergency Care (SDEC) to take patients direct from GP practices, 999 and 111 through the winter period
Volume of ambulances attending ED	SDEC to take direct referrals from the Ambulance Service to be operational during winter
Ensuring actions support demand	BHT will run a 'Perfect Week' in October to fully test proposed pathways and to enable tweaks in preparation for winter.
Reducing Ambulance handover delays	Ensuring clinical care is available for patients to be handed over appropriately

Community

Buckinghamshire Healthcare Trust (BHT) has five Community Hospitals:

- Amersham Hospital, which has two inpatient wards (36 beds) and the Bucks Neuro Rehab Unit (17 beds)
- Buckingham Community Hospital, which has 12 inpatient beds
- Chalfonts and Gerrards Cross Hospital, which provides community health services only with no inpatient beds
- Marlow Community Hospital, which provides community health services only with no inpatient beds
- Thame Community Hospital, which provides community health services only with no inpatient beds

The actions below highlight the support for the winter period. alongside multiple community based services supporting the population of Buckinghamshire. The high level actions are included in the table below. BHT will also have their own more detailed Winter Plan in place.

Winter challenge	Action
Insufficient bed capacity to meet demand	Additional funding to assist in the increase in additional demand and capacity over the winter period. Plans are being developed to mobilise this as soon as funding approved which include the re-opening of the Olympic Lodge reablement facility (22 beds) on 3rd October 22
	Increase existing Community Hospital capacity by another eight beds, facilitating discharges from Wexham Park Hospital
	50 virtual ward beds will be established across Buckinghamshire by December 22, enabling early supported discharge and admission avoidance across the county
Helping managing patients in their own home instead of coming to hospital	Improve function of Single Point of Access and increase UCR referrals from Primary Care, ED, Care Homes, 999 and 111. Communications to all key referrers as a reminder of the UCR offer. Strengthen collaboration with SCAS (pulling off stack and Perfect Days) and increase specialist practitioners in RRIC. Exploring potential to extend UCR offer later into evening to support discharges home from ED
	Three 'Big Conversations' planned with BHT, Age UK and local residents about how to prepare and plan for winter and how to access additional support to help keep well and active

Social Care (Adults)

Buckinghamshire Council provides both adults and children's social care support for all Buckinghamshire residents. This includes Care Act Assessments and organising long term support for people.

The actions below highlight the support for the winter period. Buckinghamshire Council will also have their own Winter Plan for wider council services.

Winter Challenge	Action
Social Care Provider Resilience	• Ensure all providers have updated business continuity plans • Maintain regular communications with providers for early identification of issues in the care market and for rapid distribution on key messages and guidance • Monitor market capacity through the national capacity tracker so commissioners understand placement and care package availability • Promoting Covid and Flu vaccination to care providers for clients and staff
Delivering an effective discharge pathway	• Local Outbreak Management Plan in place to ensure appropriate admissions to care homes impacted by Covid • ASC Surge Plan in place • Working with Care Homes and Domiciliary Care providers to ensure flexibility to facilitate, as far as possible, admissions during the weekend
ASC Workforce	• 7 day social work in place to match resource with demand • Promoting and enabling the uptake of flu vaccination for all frontline ASC staff and BC staff but prioritising front line staff and those at risk.
Supporting the safety and continuity of care for vulnerable residents	• Supporting wider providers (such as Apetito, Red Cross Home from • Hospital, NRS) who can deliver safe and effective services over the winter • Work closely with Social Prescribing Link Workers (SPLWs) and VCSE to maximise the support for vulnerable residents • Contingency plans in place to support vulnerable adults during emergencies • Provide communications to carers so they know what support is available to them and who to contact if they need help

Social Care (Children's)

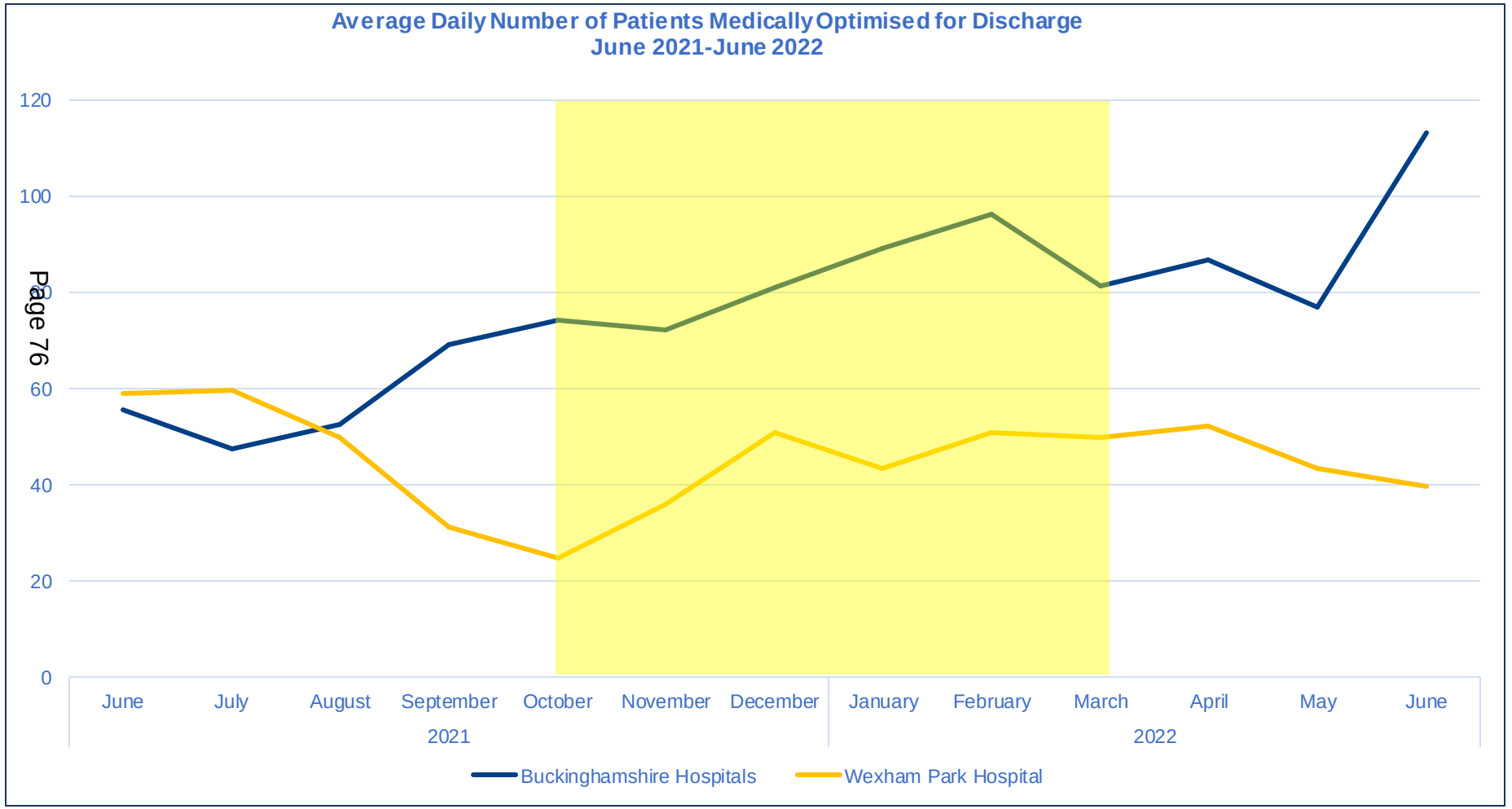
Buckinghamshire Council provides Both adult and children's social care support for all Buckinghamshire residents. This includes Care Act Assessments and organising long term support for people.

The actions below highlight the support for the winter period. Buckinghamshire Council will also have their own Winter Plan for wider council services.

Winter Challenge	Action
CSC: Staff absence due to sickness / inability to travel due to adverse weather	• Staff encouraged to take up offered vaccinations • Workers may be temporarily deployed to locations closer to home to lessen travel obligations • Team managers to prioritise risk and ensure that most vulnerable children are visited in accordance with our practice standards, where this cannot be achieved escalate concerns to Service Director
CSC: School closures due to adverse weather	• Met office warnings shared with education providers when at earliest opportunity • Remind schools to keep Schools Web up to date of closures / alternative learning plans and • Ensure maintenance of grounds is up to date for preventative action i.e. frozen pipes
CSC: Availability of placements for looked after children	• Continue with the implementation of our Recruitment and Retention Strategy • Commissioned services to ensure that all contracts include adequate business continuity planning to ensure services offered are not compromised • Ensure that our placements team have an accurate understanding of placement availability • Financial sustainability concerns as a result of ongoing cost of living and energy price pressures identified at the earliest opportunity through contract monitoring discussions in order to determine continuity plan/additional support required
CSC: Transport for children and young people to school and activities	• Commissioned services to ensure that all contracts include adequate business continuity planning to ensure services offered are not compromised.

Discharge from Hospitals

A key metric to understand the challenges with discharge and hospital flow is the Medically Optimised for Discharge (MOFD) list. This is patients who no longer require an acute hospital bed and are now waiting to be moved to the next appropriate care setting.
The graph below shows the daily average number of patients on the MOFD over a 12 month period. The highlighted yellow area shows the winter period 2021-2022.



As with ED attendances, challenges with MOFD numbers have sustained beyond the last winter period.

Significant focus is being placed upon improvements to the discharge process across winter and beyond both with additional investments and process improvement work.

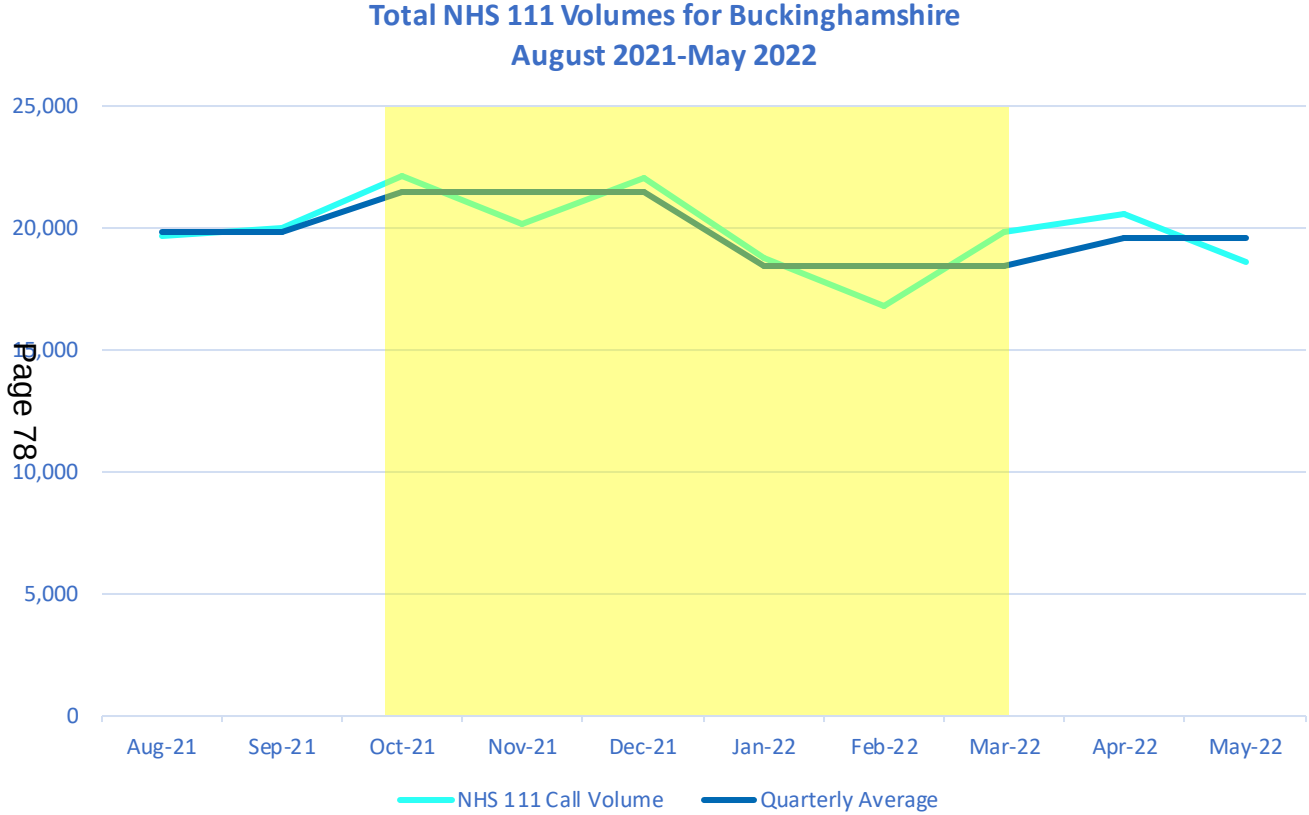
Discharge

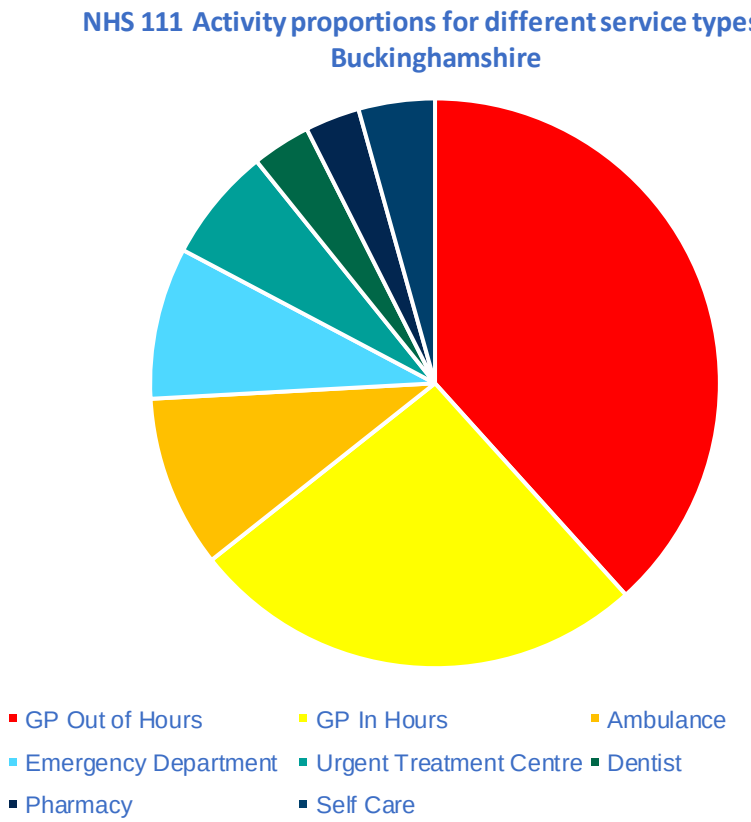
During winter we will ensure patients are discharged from hospital in a safe and appropriate manner. All system partners will work together to deliver on key actions to help ensure patients are in the best setting for their health care needs. The actions below highlight the support for the winter period:

Winter Challenge	Action
Discharging patients from hospital beds in a timely way when they no longer meet the Criteria to Reside	Ensure patients who will require complex discharges are identified early in their admission and MDT planning takes place to support a timely discharge. This will be supported by the recruitment of the additional ward based discharge co-ordinators at BHT
	Ensure all patients have Expected Dates of Discharge (EDD) and system focus on progressing towards discharging patients within 48 hours of not meeting the Criteria to Reside. Agree trajectory and performance management via the discharge dashboard
	Ensure 7-day working across all wards and support this with consistent processes and documentation across the MDT. This is a key focus area of BHT flow transformation
	Utilising demand and capacity plans to help manage patients who are fit to go home. A detailed analysis of demand and capacity for discharge has been completed and is informing capacity planning being led by the Care Integration Programme Board
	Increased surge capacity to be operationalised to support flow via the demand and capacity funding. This will include additional community beds in multiple settings and care capacity

Integrated Urgent Care

Integrated Urgent Care comprises a number of services: NHS 111, Out of Hours, Urgent Treatment Centres and Clinical Advisory Services. NHS 111 represents the entrance point for the majority of urgent care activity into the other urgent care services. The charts below show the NHS 111 activity for NHS 111 (yellow highlighted area shows winter 2021-22) as well as the proportions of where the 111 activity is directed.





NHS 111 activity remained relatively stable across the last winter period and into the months following. In addition, an average of 250 people a day access NHS 111 via the online platform.

Most of the activity from NHS 111 is directed into primary care (in and out of hours). Less than 10% of patients are directed to ED.

Integrated Urgent Care

To help urgent care demand across Buckinghamshire there are a number of 'Integrated Urgent Care' services that are managed locally including:

- Urgent Treatment Centres,
- Out of Hours

At the BOB Integrated Care Board (ICB) level, focus will continue to be support 111 and 999 call handling performance and the continued integration with other urgent care services. The table below also highlights the potential actions to support the Winter period:

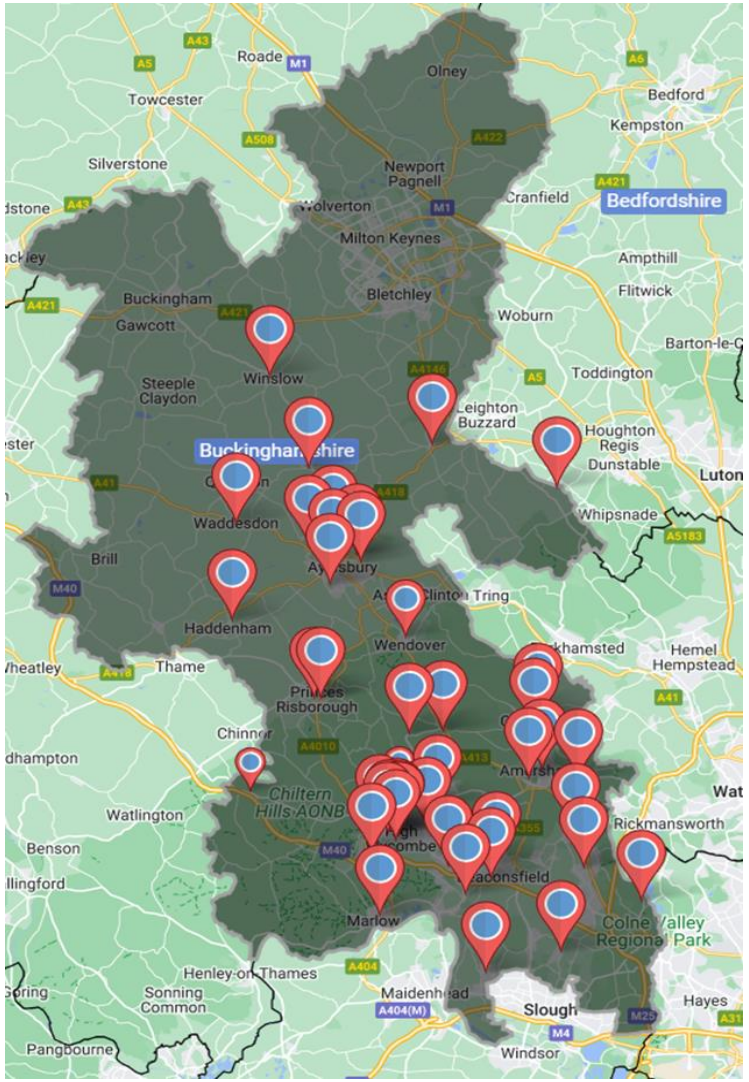
Winter Challenge	Action
Low acuity dispositions sent to Primary Care taking higher priority slots	Potential CAS proposal to revalidate all primary care dispositions over winter being developed to help reduce demand on GP practices and out of hours to free up capacity
Ensuring patients are sent to the right place first time	Review of Directory of Service before winter to ensure pathways fully utilise the services and bookings across the system, including increasing referrals to Pharmacy
Supporting minor injuries across Buckinghamshire	Explore and implement direct booking pathways for injuries into the UTC pathways at both Stoke and Wycombe. Also considering an extension of opening hours in Wycombe to be equitable across the County and demand management
Ensuring patients ring 111 first before self-presenting at services	Communications for 111 and the opportunities across Buckinghamshire going via this pathway

Primary Care

Buckinghamshire has **47** GP practices and **13** Primary Care Networks (PCN) across the county. PCNs are groups of GPs working together with a range of local providers to offer more personalised and coordinated health and social care to their local populations.

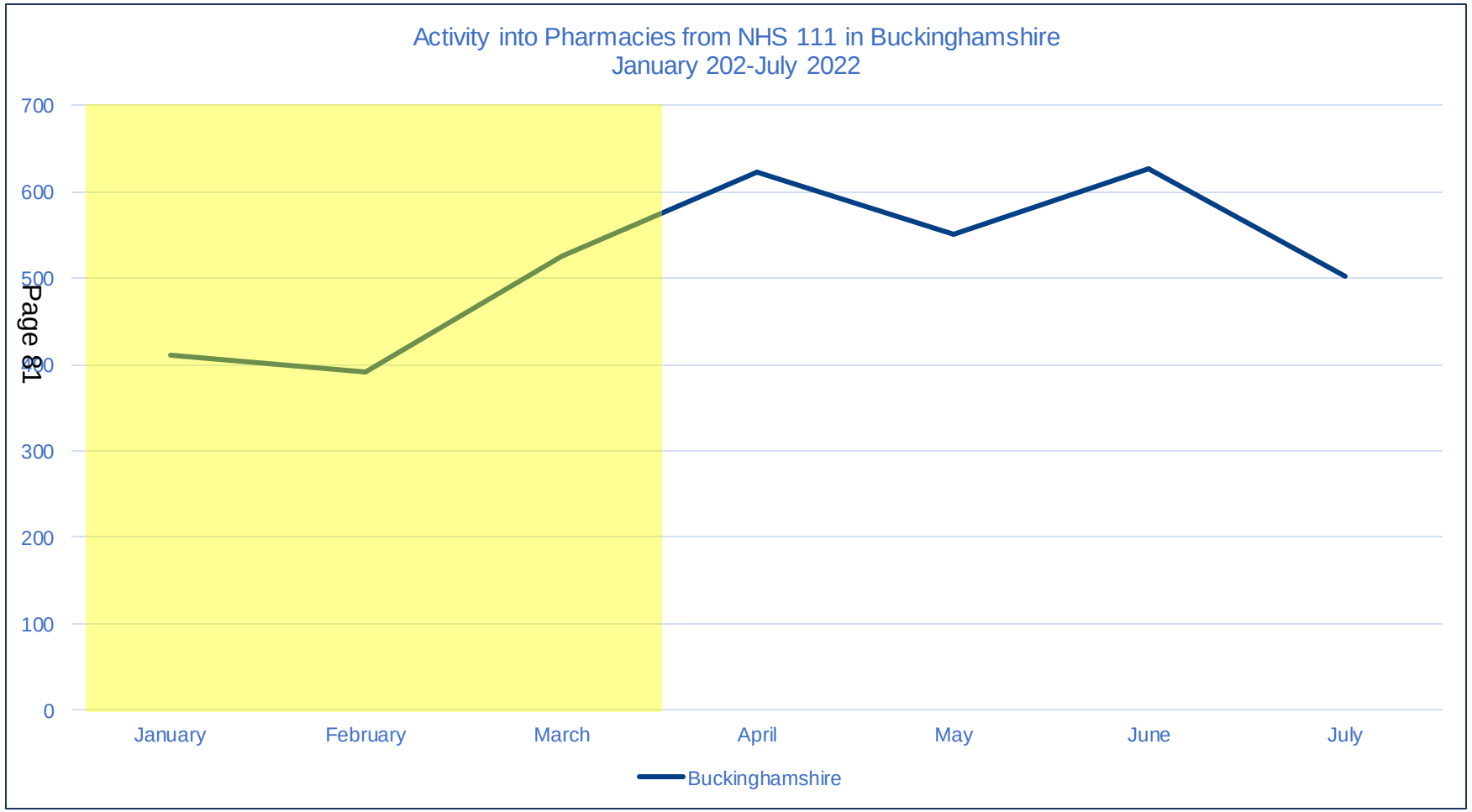
The map highlights where the 47 GP Practices are located across Buckinghamshire. The table below highlights the actions practices intend to deliver during the winter period.

Winter Challenge	Action
High volume calls from 111	Potential CAS proposal to revalidate all primary care dispositions over winter being developed to help reduce demand on GP practices and out of hours to free up capacity
Key winter cohorts	Frail Elderly provision and support for isolated patients – ensuring that community support available
Practice Capacity	System agreed protocol in place for dealing with GP capacity and service interruption – weekly sitrep
Vaccination	Practices will help support the wider vaccination programme across Buckinghamshire



Community Pharmacists

There are **87** Community Pharmacies in Buckinghamshire. Pharmacists play a key role in providing quality healthcare. They are expert in medicines, and use their clinical expertise, together with their practical knowledge to advise on common problems, such as coughs, colds, aches and pains, as well as healthy eating and stopping smoking.



We have been working with our local pharmacies to increase direct bookings into the service from 111 and our GP practices. The graph shows the activity via NHS 111 into pharmacies since January 2022.

We intend to increase this during winter as a crucial clinical support to our patients. Pharmacies can see patients with minor ailments and illnesses as well as manage repeat prescriptions.

Communications to the public and to pharmacies will also be stepped up to ensure clarity on process and expectations.

Mental Health

Mental Health services in Buckinghamshire are delivered on behalf of Oxford Health NHS Foundation Trust. The services are integrated into most areas across Buckinghamshire including Emergency Dept, GP Practices, 111 and 999. The continuous pressures following the pandemic have been growing and therefore anticipated as a challenging winter for all Mental Health services.

The table below highlight the actions intended through the Winter period. Mental Health services also have a detailed internal winter plan.

Winter Challenge	Action
Pressures on CAMHS emergency care services.	• Seek additional capacity to recruit additional staff specifically to support Childrens' emergency care services. • Review/commission community placements for CYP ED to divert from Pediatric acute where appropriate
Community Mental Health: increased referrals, more acute presentations, increased pressure on inpatient beds and demand for housing, due to social and financial issues.	• Further coms regarding 111 service for MH • Optimise flu and COVID vaccinations for patients and staff • Strengthening partnerships though the CMHF programme to increase capacity to meet additional Winter demands for support (including Safe Havens) • Planning to purchase short-term supported housing for temporary stays to increase flow of inpatient wards over Winter • Implementation of a Patient Flow Team to manage bed capacity and facilitate delayed discharges to reduce LOS
IAPT (Healthy Minds) service expects increased demand during winter, as in previous years.	Seek additional capacity for: • outreach workers or peer support workers to help prevent acute admissions through early identification of older adults with comorbid mental health and physical health conditions and signposting to suitable services. • therapists to increase capacity for rapid assessment and provision of interventions for older adults with comorbid mental health and physical health conditions to reduce risk of admission or demand on A&E.

Frimley

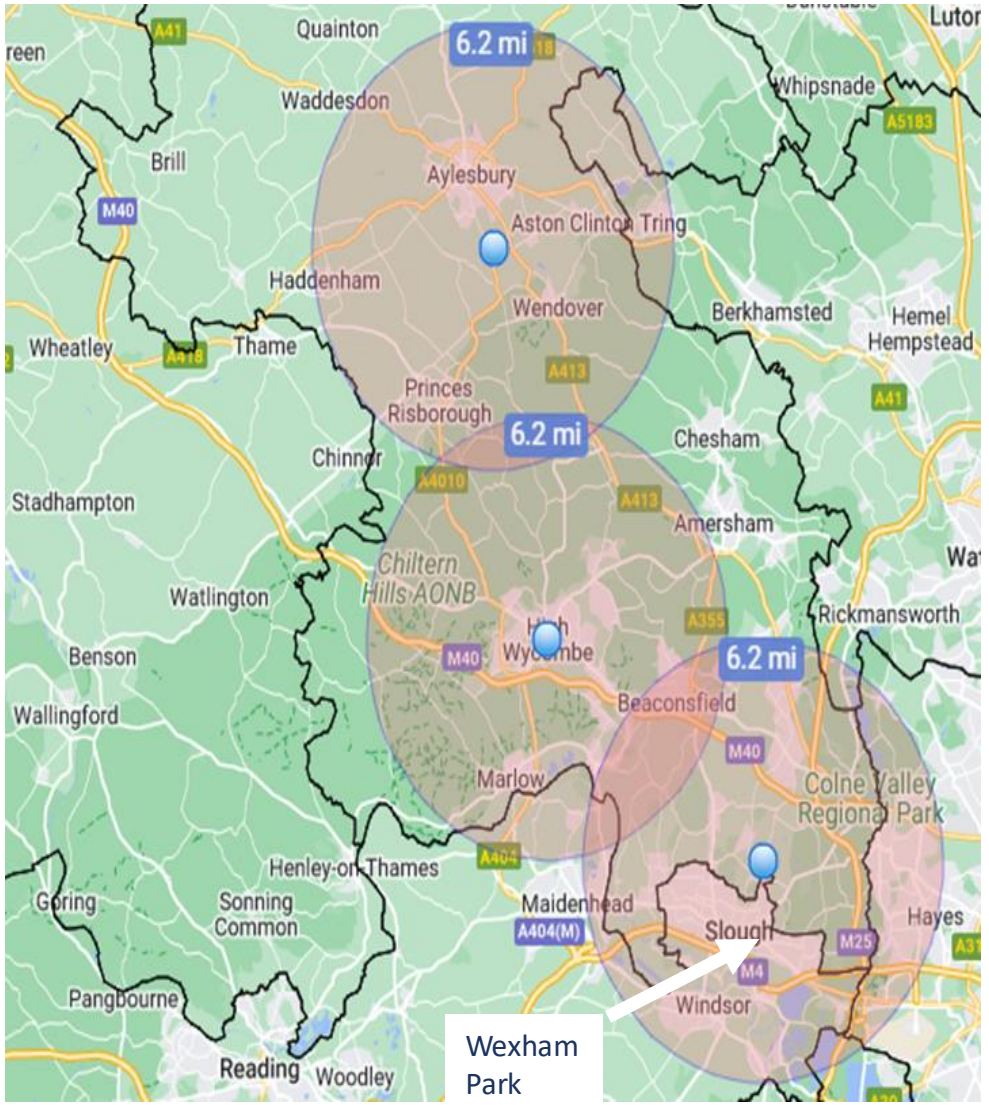
Key services such 999, NHS 111, Out of Hours and Urgent Treatment Centres are commissioned to cover the whole population of Buckinghamshire. However, there is a dense population area in the south of the county that are within a six mile radius of Wexham Park Hospital (within the Frimley ICB). This is therefore the closest Emergency department for approximately 30% of the population.

We will continue to work closely with Frimley to ensure our actions directly support the Buckinghamshire patients who receive care from the Trust.

There a number of actions and processes which are a permanent feature of the relationship between the two areas which will be vital during the winter period:

- Daily contact facilitating discharges from hospitals with social care presence
- Three times weekly MOFD meetings with Wexham Park discussing discharge challenges
- Ensuring Urgent Community Response teams can align into the Wexham Park hospital process.
- Input into Frimley ICB Gold system calls

We will also ensure we are supporting Frimley ICB in managing the potential impact on their winter demand. Communications teams from Frimley ICB and BOB ICB have co-ordinated communications efforts so the population in South of Buckinghamshire can receive consistent messages as those within the Frimley border.



Infection, Prevention and Control (IPC) and COVID

Infection, Prevention and Control

Infection, Prevention and Control is ever present aspect of healthcare services and as such all providers continue to adhere to national IPC measures. We will continue to work closely with partners to ensure the safety of the population.

COVID Variants

National agencies and all local services remain vigilant for any surges in COVID numbers and new variants. It is anticipated that this winter, high numbers of beds may be needed for respiratory patients. As such, IPC requirements will make bed management complex, especially if bed occupancy remains high. Providers continue to stress test their processes and plans taking all the learning gained from the previous surges in cases.

Vaccinations

Vaccinations:
There will be a full Vaccination Programme across Buckinghamshire for:

- Covid Booster Vaccines
- Flu Vaccines

This will be led and overseen by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

As in previous years there will be priority groups for the vaccinations and we will aim to deliver through our tried and tested approaches across Primary, Community and Acute Care as well as with Pharmacy and Oxford Health Partners.

Communication

Throughout the winter period there will be the expectation for our system partners to support preventative care and supporting the public around the right healthcare choices, through our social media and other comms outlets. We are awaiting the BOB ICB Winter Comms Plan.

The list below highlights some of the areas of communication focus across the winter period:

- Think 111 First
- What Pharmacies can offer
- Choose Well Campaign
- Reminder of Repeat Prescriptions – Use of NHS 111 online
- Agreed System Escalation Comms
- Get Vaccinated Comms
- Align communications with messages with Frimley ICB

Health & Wellbeing Board Buckinghamshire

Developing a One Council approach to delivering housing for people with social care needs

Date: 15 December 2022

Author/Lead Contacts: Tracey Ironmonger, Service Director Integrated Commissioning, Buckinghamshire Council

Report Sponsor: Tracey Ironmonger, Service Director Integrated Commissioning, Buckinghamshire Council

Consideration: ☒ **Information** ☐ **Discussion** ☐ **Decision** ☐ **Endorsement**

Please indicate to which priority in the Joint Local Health and Wellbeing Strategy, Happier, Healthier Lives Strategy (2022-2025) your report links to.

Start Well	Live Well	Age Well
☐ Improving outcomes during maternity and early years	☐ Reducing the rates of cardiovascular disease	☐ Improving places and helping communities to support healthy ageing
☐ Improving mental health support for children and young people	☐ Improving mental health support for adults particularly for those at greater risk of poor mental health	☐ Improving mental health support for older people and reducing feelings of social isolation
☐ Reducing the prevalence of obesity in children and young people	☐ Reducing the prevalence of obesity in adults	☐ Increasing the physical activity of older people

None of the above? Please clarify below:

Housing is a key determinant of health and has a key impact on both physical and mental health and wellbeing. The delivery of appropriate and quality accommodation for children and adults with social care needs is also key in helping individuals maximise their potential and stay independent longer. Some design principles will support the specific health and wellbeing strategy priorities above.

1. Purpose of report

1.1 This report provides an overview of the development of a One Council Approach to delivering accommodation to meet the needs of children and adults with social care needs. The development of the Unitary Authority has provided a new opportunity for social care, housing, planning and property teams with the Council to work in a co-ordinated way to achieve this. Housing is a key wider determinant of health.

2. Recommendation to the Health and Wellbeing Board

1. The Health and Wellbeing Board are asked to note the proposals contained within the report.

3. Content of report

Background

3.1 The Unitary Authority offers new opportunities to take a co-ordinated and Council wide approach to the planning and delivery to meet the housing needs of children and adults with social care needs. To progress this the Council has established an Adult Social Care Accommodation Steering Group, which has been developing an action plan to maximise the potential of a Unitary Authority to support this agenda. Appropriate housing is a key determinant in the health and wellbeing of social care clients. In addition, access to appropriate housing also has a financial impact, with the availability of the right types of housing enabling people to stay independent for longer, supporting more effective care provision and enabling clients to continue to reside in Buckinghamshire. The creation of a One Council Action Plan will deliver benefits for both residents and the Council.

Housing and health & wellbeing

3.2 There is existing evidence that a safe, warm and secure home underpins people's ability to lead a happy and healthy life and prevents physical and mental ill health. The Covid pandemic has illustrated the importance of having the right home, as we have been asked to stay in our homes for long periods, often without social contact. It is also widely recognized that different types of housing can play a significant role in effective care and support to enable people with substantial social care and health needs to live as independently as possible within their community, including people with dementia.

3.3 In 2018, Buckinghamshire's Director of Public Health wrote her report with a focus on housing, 'Healthy places, healthy futures, growing great communities'. The report recognised that poor housing is a driver of poor health and increasing health inequalities and has significant impact on our mental health and wellbeing. Living where you can afford, knowing that you have certainty of a safe and stable home helps us to put down roots and create a sense of belonging and greater involvement within community life. The report recognised that improving the health of Buckinghamshire residents reduces the demand on health, social care and other public services.

3.4 The right home environment is crucial to health and wellbeing, so housing is considered to be one of the wider determinants of health. Unhealthy, unsuitable or unstable housing presents a risk to a person's physical and mental health. Investing in housing, particularly for vulnerable people, can also affect and avoid costs for other public services, for example reducing costs of health services and residential care.

3.5 However, not everyone has the same opportunities for securing a good quality and affordable home in the right place. People who are elderly or young without a support network or family, adults with disabilities or mental health needs are all more likely to need help to get the right housing.

3.6 Within Buckinghamshire Council, Housing, Planning and Property are working together with Adults and Health and Children's Services to plan strategically to deliver the right housing for people with social care needs and to help those people access appropriate housing, as the Council has statutory duties towards its residents in respect of both housing and care. Being flexible with resources and collaborating across departments to meet those statutory duties will ensure that we can respond holistically to need, but also focus on prevention, allowing people to live as independently as possible in their own community.

Social care reform

3.7 The need for improved collaboration between health, housing and social care has long been recognised and indeed was set out within the Care Act 2014. This need for effective collaboration has never been more important, with significant changes for social care underway through social care reform and funding for local government. In December 2021 the Government issued its plans for the future of social care in England – People at the Heart of Care: Adult Social Care Reform. The paper recognised that too many people with care and support needs still live in inappropriate housing and three housing priorities were identified: embed housing into the local health and care system, make it easier for people to adapt their home so they can live independently and increase the supply of specialist housing.

One Council approach to accommodation for people with social care needs

3.8 The creation of the Unitary Council in Buckinghamshire from April 2020 onwards brought together in one place the key responsibilities for housing, including homelessness, housing allocations, the wider housing strategy and planning. Whilst recognising the wider public health and housing agenda, it should also be acknowledged that all of these responsibilities have the potential for significant impact on people with social care needs, both positive and negative.

3.9 A partnership approach therefore needs to be developed both within the Council and with its external partners for housing and care, as well as generating new partnerships with external developers and providers to increase housing capacity and deliver innovative models of care.

3.10 Action and progress has already been made:

- The Adult Social Care Accommodation Steering Group has been established. It is attended by representatives from a range of council departments and is chaired by the Director of Integrated Commissioning, Adults and Health. The overlap with accommodation for children with care needs has been recognised and the membership and terms of reference for the group are currently being reviewed and will include representation from Children's Services.
- A Market Analysis has been commissioned and is close to completion. This analysis will use local data to forecast the accessible housing requirements for people with social care needs.
- Children's Services are mapping both the potential housing needs of young people who will transition into Adult Social Care (to inform the Market Analysis above) and the numbers of young people leaving care which will inform the accommodation need for this group into the future.
- Work has been completed to develop a set of design principles for people with social care needs / accommodation requirements to inform how these needs can be supported through local planning.

3.11 The creation of the Adult Social Care Accommodation Steering group is a positive step to bring together people from within the Council with the right skills and knowledge. The meetings to date have generated much discussion and wider engagement from different departments. The group includes representation from Children's Services who have accommodation needs in respect of young people leaving care and jointly with Adult Social Care in respect of transitions. The group is in the process of transitioning to a Specialist Housing Group, to act as a sub group to key plans and strategies for planning and housing. The Specialist Housing Group will report into and have membership from three Directorates within the Council, these are; Adults and Health, Children's Services and Planning, Growth and Sustainability.

3.12 The work of the group has identified a range of strategies and plans that need to align to deliver maximum benefit. These include:

- Housing allocation policy
- Local Plan
- Business cases to consider children's or adults social care accommodation for any Council land or property that becomes available for development

Future work needs to ensure that these plans enable responses to social care housing needs.

3.13 Key to informing these strategies and plans is the availability of good evidence on the housing needs of social care clients in terms of type of housing, location, numbers and key design features. The Market Analysis, commissioned by Adults and Health, in respect of specific housing requirements for adult social care, has been undertaken in many other parts of the country and should provide the evidence base in respect of accommodation currently used by

service users. It will also forecast forward future requirements of housing units needed across the county and will form the basis for development of the housing elements of the adult social care Market Position Statement for accommodation, which is due to be updated in 2023. The Market Position Statement is a key document to inform developers, housing providers and care providers of the future needs in Buckinghamshire to facilitate the development of local provision.

4. Next steps and review

4.1 It is recognised that it will take time to further develop and truly embed a One Council approach. The ongoing work will have 4 areas of focus:

- Identifying and mobilising key responsibilities and joint working across teams within the Council
- Ensuring full co-ordination across key strategies and plans and where appropriate the development of businesses cases for specific developments
- Ongoing market analysis and effective use of data and intelligence
- Engagement with wider stakeholders such as Registered Housing Providers and Developers
- Return to Health and Wellbeing Board in 12 months to discuss progress and successes

5. Background papers

None

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