Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board agenda

Date: Thursday 30 March 2023

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), C McArdle (Adults and Health, Buckinghamshire Council), N Macdonald (Buckinghamshire Healthcare NHS Trust) (Vice-Chairman), 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), J Meech (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**		
3	**Announcements from the Chairman**		
4	**Declarations of Interest**		
5	**Minutes of the previous meeting** To agree the minutes of the meeting held on 15 December 2022 and review any outstanding actions from previous meetings.		**5 - 14**
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 27 March 2023. Any questions received after this deadline will be responded to at the following Health and Wellbeing Board meeting.		
7	**Healthwatch Bucks - The Quarterly Overview** Review of the work undertaken by Healthwatch Bucks over the previous quarter, this will include feedback on surveys with residents/users of local services and an opportunity to look at upcoming surveys. Zoe McIntosh, Chief Executive, Healthwatch Bucks.	**14:10**	**15 - 20**
8	**Integrated Care Partnership** The development of Joint Forward Plan and the Integrated Care Strategy in Buckinghamshire, Oxfordshire and Berkshire West https://yourvoicebob-icb.uk.engagementhq.com/bob-integrated-care-partnership Philippa Baker, Buckinghamshire Place Director, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board Robert Bowen, Deputy Director of Strategy, Buckinghamshire Oxfordshire and Berkshire West	**14:25**	**21 - 34**

Integrated Care Board

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

An update on strategic items in Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) and the BLMK Health and Care Partnership

Michelle Evans-Riches Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board.

9	**Health and Care Integration Programme** Outcomes of integration work over the last year, plans for next year, and what this means for the experience of people using health and care services in Buckinghamshire. Dr Joanna Baschnonga, Programme Director, Adults and Health, Buckinghamshire Council.	**14:50**	**35 - 40**
10	**Joint Local Health and Wellbeing Strategy - Action Plans** A review of the progress on delivery of Joint Local Health and Wellbeing Strategy action plans with a detailed focus on two priorities: • cardiovascular disease prevention and • reducing the prevalence of obesity and increasing physical activity Dr Jane O'Grady, Service Director Public Health and Community Safety, Buckinghamshire Council. Cardiovascular Disease Tiffany Burch, Consultant in Public Health Medicine, Buckinghamshire Council. Reducing the prevalence of obesity and increasing physical activity. Sally Hone, Public Health Principal, Buckinghamshire Council.	**15:05**	**41 - 62**
11	**Suicide Prevention Action Plan** *Trigger warning - these pages contains references to themes of suicide and self-harm which some individuals may find distressing*	**15:35**	**63 - 90**

	Dr Jane O'Grady, Service Director Public Health and Community Safety, Buckinghamshire Council. Louise Hurst, Public Health Consultant, Buckinghamshire Council.		
12	**Joint Local Health and Wellbeing Strategy - Quarterly Performance Review** Performance measures recommended to review the successful delivery of the strategy. Jacqueline Boosey, Business Manager - Health & Wellbeing, Buckinghamshire Council. Dr Jane O'Grady, Service Director Public Health and Community Safety, Buckinghamshire Council.	**15:50**	**91 - 104**
13	**Date of next meeting** To be confirmed.		

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For further information please contact: Shilpa Manek on 01494 475369, 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 15 December 2022 in The Oculus, Buckinghamshire Council, Gatehouse Road, Aylesbury HP19 8FF, commencing at 2.00 pm and concluding at 3.38 pm.

Members present

Cllr A Macpherson, Dr R Bajwa, P Baker, Cllr S Bowles, Cllr A Cranmer, K Higginson, J Meech, Cllr Z Mohammed, Dr J O'Grady, G Quinton, Dr S Roberts and D Walker

Others in attendance

J Boosey, R Bowen, C Capell, R Carley, T Chettle, M Evans-Riches, S Kearey, R Nash, A McLaren, H Mee, Z McIntosh, A Seagar, L Smith, S Taylor and K Vockins

Agenda Item

1 Welcome

The Chairman welcomed everyone to the meeting.

2 Apologies for absence

Apologies were received from Neil Macdonald, Chief Executive Officer (CEO), Buckinghamshire Healthcare NHS Trust (BHT); John Macilwraith, Corporate Director, Children's Services, Buckinghamshire Council (BC); Dr Rashmi Sawhney, Clinical Director for Health Inequalities, Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB); Dr Craig McDonald, Clinical Director, Children's, BHT; Dr Karen West, Member GP and Clinical Director for Quality and Integration, BOB ICB; Jo Baschnonga, Programme Director, Health and Care Integration; Martin Gallagher, Chief Executive Officer, The Clare Foundation.

Andrew McLaren, Chief Medical Officer, BHT, attended in place of Neil Macdonald. Richard Nash, Service Director, Children's Social Care, BC attended in place of John Macilwraith.

Note 1: Michelle Evans-Riches, Programme Manager, Bedfordshire, Luton and Milton Keynes Integrated Care System; Gill Quinton, Corporate Director, Adults and Health BC, and David Walker, Chair, Oxford Health NHS Foundation Trust joined the meeting via MS Teams.
Note 2: The order of the agenda was changed; item 12 was considered after item 10, followed by items 11 and 13.

3 Announcements from the Chairman

Councillor Angela Macpherson, Chairman and Cabinet Member for Health and

Wellbeing and Deputy Leader, BC, thanked Matt Powls, Interim Place Director, for his work on the Board and welcomed Philippa Baker, Buckinghamshire Place Director BOB ICB. The Chairman also thanked Peter Miller for his work on the Board and welcomed John Meech, Chair of Healthwatch Bucks.

The Chairman advised that, due to recent changes in the NHS, a reduced number of clinical leads were in attendance. The clinical leads were valued members of the Health and Wellbeing Board (HWB) and the membership would be reviewed to ensure the right people were round the table. The HWB Terms of Reference would also be reviewed and presented at a future meeting.

4 Declarations of Interest

There were no declarations of interest.

5 Review of Minutes and Actions from the Previous Meeting

Jacqueline Boosey, Business Manager, Health and Wellbeing, provided a review of the action log by exception as follows:

- The Dashboard for the refreshed Strategy had been postponed until March 2023.
- Access to GPs/Primary Care Access in Buckinghamshire – the residual actions would be picked up under item 9 GP Access and the Impact of Growth on GP Services in Buckinghamshire.
- [Partner Reports, Healthwatch Bucks Update] – feedback on hospital waiting times.

Resolved: The minutes of the meeting held on 22 September 2022 were **agreed** as an accurate record and were signed by the Chairman.

6 Public Questions

The Chairman emphasised that public questions were a very important part of the HWB and thanked partner organisations for their responses to the questions which had been received for this meeting. The Chairman was keen to increase public participation and highlighted that there was a new HWB website to help improve communication to the residents. Jacqueline Boosey agreed to circulate the link for partners to cascade/promote. The Chairman asked that a separate section be added to the HWB website for public questions to capture areas of interest for the public.

Action: J Boosey

Mike Etkind, Chair John Hampden Surgery Patient Participation Group, Member of Mid Chiltern Primary Care Network Patients Group and Member Engagement Steering Group of former Bucks Clinical Commissioning Group had submitted three questions which would be responded to under Item 8.

The other six questions were read out along with a summary response. The questions, summary and full response can be found appended to the minutes and will be published on the website. An additional question had been received after

the deadline and would be read out at the next meeting.

7 Partner Reports: Healthwatch Bucks - Quarterly Review

John Meech introduced himself and advised he had been a non-executive director of Healthwatch Bucks for approximately three years and had recently been appointed as Chairman.

Zoe McIntosh, CEO, Healthwatch Bucks highlighted that a positive response had been received from BOB ICB in relation to the 'Awareness of Social Prescribing in Buckinghamshire' report and the recommendations. A report on residents' experiences of social prescribing had also been published and an update would be provided at the next meeting. The current project focussed on young onset dementia – see the report for information on how to take part.

The following key points were raised in discussion:

- Gill Quinton, Corporate Director, Adults and Health advised that work was being undertaken to provide a response to the social prescribing report. There were a number of Dementia groups in Buckinghamshire which Gill recommended Healthwatch Bucks could contact.

Action: G Quinton to contact Z McIntosh

- The Community Boards were another route for cascading/promoting information.

Action: Cllr S Bowles to contact Z McIntosh

8 Integrated Care Partnership - The Development of Buckinghamshire 'Place and the Integrated Care Strategy

Philippa Baker, Buckinghamshire Place Director, BOB ICB, advised that she wanted to raise awareness of the work that partners across Buckinghamshire were doing to move towards the creation of a place-based partnership. A White Paper, published this year, encouraged the creation of place-based partnership arrangements in every area in the country which encouraged local areas to have strong arrangements to bring together health and social care and wider partners, to ensure that they made the best decisions for residents. Work had just commenced and a survey had been sent out to the HWB members. If anyone wanted a copy, contact Philippa. An independent facilitator would work with the partners and Philippa invited everyone to contribute.

Rob Bowen, Deputy Director of Strategy, BOB, ICB explained the three acronyms:

- The Integrated Care System (ICS) was the coming together across BOB of all the different partners interested in keeping populations well and healthy.
- The Integrated Care Partnership (ICP) was a formal statutory committee formed by the local authorities and the ICB and bringing together wider partners to develop an integrated care strategy for the whole system.

- The Integrated Care Board (ICB) was an NHS statutory body and had oversight of the NHS part of the system.

Rob highlighted that the Strategy would set a clear direction for the whole system; the content included as many different parts of the system as possible and there were six thematic areas which lead to some of the 18 proposed priorities which would be measured. The report in the agenda pack contained detail of the emerging strategy and included the 'vision' statement.

Dr Jane O'Grady, Service Director, Public Health and Community Safety, BC, emphasised that the strategy was built from a 'bottom up' approach and it should be possible to recognise parts of the HWB Strategy in the Strategy. The priorities were not designed to encompass everything; it was the working together that would make a real difference.

Rob stated that the aspiration was to ensure that engagement was undertaken with as many voices as possible; the document was available for public engagement until 29 January 2023. Share your views on the BOB ICP Strategic Priorities

In response to a question on any redistribution of resources if needed, Rob explained that the Strategy did not include resource allocation. However, the joint committee, would have representatives from the different local authorities and was where this type of decision would be made. The Chairman confirmed that there were three BC representatives on the ICP; Councillors Angela Macpherson, Zahir Mohammed and Martin Tett.

The Chairman read out Mike Etkind's public questions along with a summary response. The summary and full response could be found appended to the minutes and would be published on the website.

Resolved: The Health and Wellbeing Board:

- **Noted** the progress discussed within the report.
- **Noted** development activity on the Integrated Care Strategy.
- **Agreed** to advise on and support engagement with Buckinghamshire people and communities when this work takes place.

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

The Chairman advised that there were two parts to this item; a follow up on access to GPs which was discussed in November 2021 and the second part would be a focus on longer term plan and the strategy for access to GPs related to the population growth in Buckinghamshire. The Chairman stated that she had received a letter from the Chairman of the Strategic Sites Committee who was concerned about build out of infrastructure alongside essential infrastructure such as primary care (PC) services. Access to GPs was important to our residents and the Chairman was keen to understand how health was working alongside our planning colleagues as the five year plan was developed to ensure the correct provision for residents in the future.

Access to GPs - Philippa Baker, Buckinghamshire Place Director, stated that it was a challenging time nationally as GPs had never been busier and GP retention and recruitment was difficult. Changes had been made to improve access and the direction of travel was to GPs at scale which meant opportunities for groups of GPs to work together, e.g., on the vaccination programme. However, continuity of care would be part of the five year plan. The Primary Care Networks (PCNs) were in place and federated GPs were working in Buckinghamshire. New types of staff were being introduced in primary care involving, for example, pharmacies and social prescribing to improve access. It was recognised that GPs were independent practitioners and that some variation was expected but it was important to challenge unwarranted variation in accessibility or patient experience.

The following key points were raised:

Healthwatch Bucks reported that GP access was one of top issues for residents and a short survey had been carried out to gauge whether the cost of living was impacting GP access. 20% of respondents were worried about being on hold when phoning a surgery and two thirds had been cut off whilst waiting.

Simon Kearey, Head of PCN Delivery and Development, added that there was also currently the challenge of covid, flu and strep A resulting in high demand on GPs. Approximately two thirds of GPs had a new cloud based telephony system, and many people were using online access, video consultation and mobile phone apps. A training programme on digital literacy was being rolled out which should make an improvement.

Gill Quinton, Corporate Director, Adults and Health reported she had seen complaints regarding access to GPs and asked whether any analysis was carried out. Philippa advised that the ICB Place team were reviewing practices in the top and bottom quintiles and asked to be informed of any outliers in terms of complaints.

Dr Sian Roberts, GP and Clinical Director, Mental Health, Learning Disabilities and Dementia, explained the difference between GPs and primary care. Primary care was the first point of contact which could be at a pharmacy, or an appointment with a nurse. Not everyone needed to see a GP; GPs were an aspect of primary care. Philippa added that primary care was changing but there was still an expectation of access to a GP and communications were needed to show the different ways to access primary care.

Michelle Evans-Riches, Programme Manager, Bedfordshire, Luton and Milton Keynes, ICB highlighted that they used a GP bulletin to send to elected members to help inform residents. The Chairman asked for Michelle and Philippa to discuss the possibilities [for Buckinghamshire].

Action: P Baker/M Evans-Riches

The longer term strategy – the Chairman stated that residents needed to

understand that considerable thought was going into where PC provision was required in the future in Buckinghamshire. Philippa added that there were three aspects to explore; the population growth, in particular the new developments and making sure that the PC services and estates were keeping pace with the growth in population; the second area was inequalities and making sure that the services were available to the population in areas of higher social deprivation, and thirdly, the changing types of care that PC was delivering. It was possible that there would be a broader base model, with different kinds of consulting rooms/clinics and different services linking up with community hubs. It was a dynamic, complex picture.

Louise Smith reassured that they recognised the estates as one of the bigger areas of PC and were recruiting a senior manager to oversee the PC estates and to understand the workforce and digital require requirement.

In summary, the NHS were engaged with the five year plan and the Section 106 and Community Infrastructure Levies. Philippa stressed that the ICB was keen to work with the Council, partner organisations and residents, to ensure they understood what was driving and informing the decision making.

The Chairman thanked everyone for their contributions and stated that an item on 'Primary Care' should be brought to the HWB in a year's time.

Action: J Boosey

10 The Director of Public Health Annual Report 2021/22

Dr Jane O'Grady, Director of Public Health and Community Safety, advised that the full version of the Director of Health Annual Report (DPHAR) 2021/22, entitled 'Preventing Heart Disease and Stroke in Buckinghamshire' along with the data and statistics was available on line.

Cardiovascular disease (CVD) was one of the priorities in the Board's Health and Wellbeing Strategy and was one of the biggest causes of ill health and disability in Buckinghamshire but it was preventable in a large proportion of cases. Before the pandemic there had been a decrease in CVD death rates, however, there had since been an increase likely due to a combination of the direct impact of Covid-19 and the indirect impact of Covid-19 on people's living circumstances, stress levels, health behaviours and other factors. CVD was one of the most significant drivers of inequalities, so tackling CVD would help tackle inequalities. The risk factors could be classified into three groups and a holistic approach was required to address what made it harder for people to lead healthier lives. Dr O'Grady stated that the recommendations were listed in paragraph 3.7 of the report and advised that the HWB partners had a role to play in working together with communities and partners across Buckinghamshire to implement the recommendations.

The Chairman asked partners for their contributions and the following key points were raised:

- Work was being undertaken in primary care to increase the number of NHS

health checks and physical health checks for people with severe mental illness.

- Dr Sian Roberts highlighted that 40% of dementia was preventable and what was good for the heart was good for the brain.
- Andrew McLaren, Chief Medical Officer, reported that BHT's Strategy mirrored the recommendations in the DPHAR. BHT employed a large number of staff and had increased the health checks and signposted many staff to Live Well, Stay Well. Approximately half a million out-patient appointments were carried out each year and blood pressure checks would be undertaken on patients during the visit. The Chairman questioned whether other hospitals were also aligned with the DPHAR. Michelle offered to investigate Milton Keynes and the Chairman asked Philippa to check on other acute trusts.

Action: M Evans-Riches/P Baker

- The Oxford Health NHS Foundation trust and BHT were employing smoking cessation advisers.

The Chairman asked that a progress update and CVD action plan be added to the agenda for the next meeting.

Action: J Boosey

Resolved: The Health and Wellbeing Board **noted** the Director of Public Health Annual Report and **endorsed** the recommendations.

11 Health and Care Integration Programme

Gill Quinton, Corporate Director, Adults and Health, stated that a new Health and Care Integration Programme was being developed. A Programme Director, Jo Baschnonga, had been appointed and Jo was forming a team, jointly with BC and BHT, to develop a more integrated programme of care. All but 20 Discharge to Assess (D2A) beds were being decommissioned in the community and other systems were being put in place e.g., assessing people more quickly in hospital, improving care market capacity and creating a new transfer of care hub to bring together an integrated team to get people back to their homes or place of care in the community. A new integrated digital programme would also be implemented to track patients through the system and a business case for the future immediate care offer would be developed.

There were no questions and the Chairman asked that an update be provided at the next meeting.

Action: J Boosey

12 System Winter Plan

Caroline Capell, Director of Urgent and Emergency Care, BHT/BOB ICB, advised that a system-wide Buckinghamshire winter plan had been developed but emphasised that each individual system partner had their own winter plan. The following points were highlighted:

- Additional funding had been secured for the winter period and a number of schemes were in place to increase capacity such as the urgent treatment centre pathway at Stoke Mandeville Hospital, a Same Day Emergency Care unit to enable direct referrals from GPs, virtual ward beds to help keep patients in their own home and the primary care 111 hub which centralised calls to help take pressure off GP practices.
- Adult Social Care were working more flexibly to allow seven day admissions; this included Wexham Park Hospital.
- The uptake of flu and covid vaccines were increasing and communications would encourage patients to use the 111 service.
- The number of beds in the Olympic Lodge and hospitals had been increased.
- A Domiciliary Care Bridge team had been set up to help patients waiting for a care package to go home.

The following key points were raised in discussion:

- Caroline agreed to share the 111 communication for cascade via the Leader's newsletter, town and parish council newsletters and any other avenues.

Action: C Capell

- In response to a question on how the public identified 'prescribing pharmacies', Caroline recommended contacting 111 for advice in the first instance.
- A query was raised on whether the 111 service would have the capacity if there was a big comms drive; Caroline advised that they were doing what they could to increase capacity and that another provider could be used if necessary.

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The Chairman thanked Caroline and Tom Chettle for attending.

13 Addendum to Better Care Fund - Adult Social Care Discharge Fund

Gill Quinton, Corporate Director, Adults and Health, advised that the government had recently announced a £500m Discharge Fund with a split of £200m to local authorities (LA) and £300m to health (the ICB). The ICB for BOB had delegated an allocation of £3.8m to Buckinghamshire; £1.4 m via the LA and £2.4m via the ICB. There was a requirement to report regularly to the Health and Care Integration Programme Board to report on capacity improvements across the system. It was a multi-agency task and had been discussed on how best to carry it out in Buckinghamshire – see pages 15 and 16 of the agenda supplement.

The Chairman stressed that it was an important decision and asked if there were any questions.

Dr Sian Roberts commented that she was pleased to see the suggestion of reducing the length of stay for dementia patients and asked if there was an opportunity to improve support to prevent people with dementia being admitted to hospital? Gill apologised that it was not explicit in the report and stated that the transfer of care home would have responsibility for both admission avoidance and facilitating

discharge; the more admissions that could be avoided the better.

Resolved: The Health and Wellbeing Board **approved** the National Discharge Fund Plan for 2022-2023 and **agreed** to delegate authority for the oversight of the Discharge Fund plans and expenditure to the Health and Care Integration Programme Board.

14 Any Other Business

There was no other business.

15 Date of next meeting

30 March 2023

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Health & Wellbeing Board Buckinghamshire

Healthwatch Bucks quarterly update

Date: 30 March 2023

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

Report Sponsor: John Meech, Chair, 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

Purpose of report

Healthwatch Bucks is the Local Healthwatch for Buckinghamshire. We are one of over 150 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.

Health & Wellbeing Board Buckinghamshire

Healthwatch Bucks update

March 2023

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 Experiences

Following the publication of our second report on Social Prescribing, we have received responses to our recommendations from Bucks Council and Bucks ICB. The report and responses can be accessed here.

Young Onset Dementia

We wanted to find out about people's experiences of living with young onset dementia in Buckinghamshire.

The aim of our research project was to learn about the dementia support people had received and how helpful it was for them.

What we did

We developed an online survey that was live from 25 October 2022 until 2 January 2023.

This was publicised through our monthly email newsletter and on our social media channels. We also contacted 27 GP surgeries who have patients with young onset dementia, as well as 42 voluntary and community groups.

The project was also promoted by Buckinghamshire Council's Dementia Strategy Group.

We collected feedback from people living with young onset dementia, as well as their relatives, carers and friends.

Key findings

- Most people we spoke to said that when they received their diagnosis, it was difficult or very difficult to get information about the support that might be available for them.

- Of the people who said they'd been given information, less than half said they'd received anything about young onset dementia or their specific type of dementia. Less than half said they'd been told about making a will or power of attorney.

Most people did not receive information about key issues such as:

- Employment rights, benefits, pension advice, peer or family support groups, how to keep fit and mentally stimulated and where to find age appropriate activities.
- Just over half of the people who were given information said that it was age-appropriate 'to some extent'. Only one told us the information was personal to the individual living with young onset dementia, and only one said the information and support was received quickly enough.
- Many people found it difficult to access the support they wanted later on;
- Half the people who shared their views with us said they would like someone to contact them regularly and see how they were getting on.
- Few of the people we spoke to attended any peer support groups.
- Most didn't know any other individuals or families who were living with young onset dementia.
- A few family members told us they thought that the person living with young onset dementia could benefit from socialising with their peers.

Our recommendations

We recommend that Buckinghamshire Council works with dementia services to provide targeted, local support for people living with young onset dementia.

This could include:

- Providing information in a timely, personal and age-appropriate way, and bearing in mind that such information might be different from that required by older people living with dementia
- Ad-hoc, one-to-one support for issues faced by people with young onset dementia
- A named contact responsible for regularly reaching out to individuals living with young onset dementia, to see where any further information or support might be needed
- Connecting peers (either those with young onset dementia themselves, or their relatives, carers and friends) to create mini support networks.

We recommend that Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB):

- Encourages general practice to consistently code patients with young onset dementia on the EMIS system so that those who may need more support can be identified easily
- Ensures that, when someone is diagnosed with young onset dementia, Memory Clinics offer them and their support networks information about tailored support
- Encourages general practices and primary care networks (PCNs) to work together to connect those with a young onset dementia diagnosis, and their support networks, across localities.

You can read the report here.

Our strategic priorities 2023/24

We've agreed on our strategic priorities for 2023/24. These provide the framework we will use for deciding on the work we do.

Our annual priorities help us determine what research we conduct, as well as where to target our efforts on behalf of local people – particularly individuals and communities whose voices aren't always heard.

We'll use our annual priorities to guide:

- How we engage with other organisations
- Which meetings we go to
- Who we talk to about local health and social care

This year's annual priorities have been informed by our previous work, as well as what we've learned in the past 12 months about people's experiences of health and social care services in Buckinghamshire.

What we'll focus on

Our priorities for 2023/24 are as follows:

- Primary care (with a focus on community pharmacies)
- Social care (with a focus on hospital discharge)
- Children and young people's experiences of health and social care.

Healthwatch Bucks will also take a cross-cutting interest in:

- Health inequalities.

This cross-cutting interest means we will consider health inequalities as part of all the work we do, rather than treat it as a single, standalone issue.

We've put together a report that sets out in detail how and why Healthwatch Bucks has chosen its strategic priorities for this year. We hope this will help our partners and the people of Buckinghamshire to understand the decisions we've made. You can read the report here.

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Joint Forward Plan - Summary Position

Buckinghamshire Health and Wellbeing Board

March 2023

Joint Forward Plan (JFP) requirements

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- JFP is a new **joint statutory responsibility** for ICB and NHS Trusts
- The JFP should describe, as a minimum, how the ICB and its partner trusts intend to arrange and/or provide NHS services… including **delivery of the universal NHS commitments**
- Systems are encouraged to use the JFP to develop a **shared delivery plan for the Integrated Care Strategy**
- A number of statutory requirements that the JFP must address – e.g. duty to improve quality, duty to promote integration etc.

JFP Structure – Aligns to Integrated Care Strategy

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

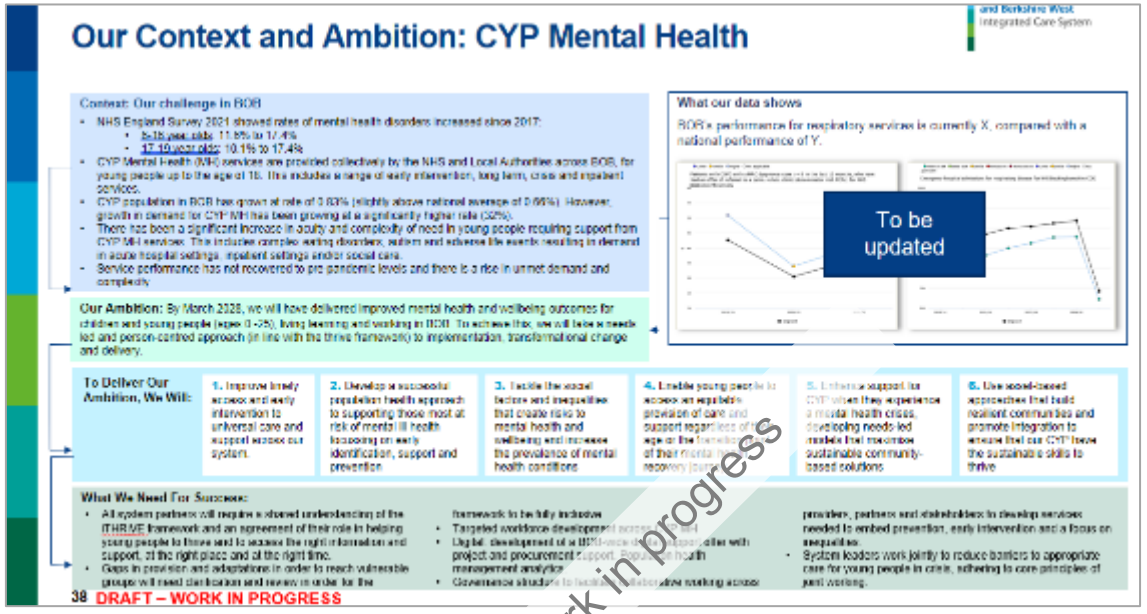
The challenge will be balancing the short term delivery vs long term ambition

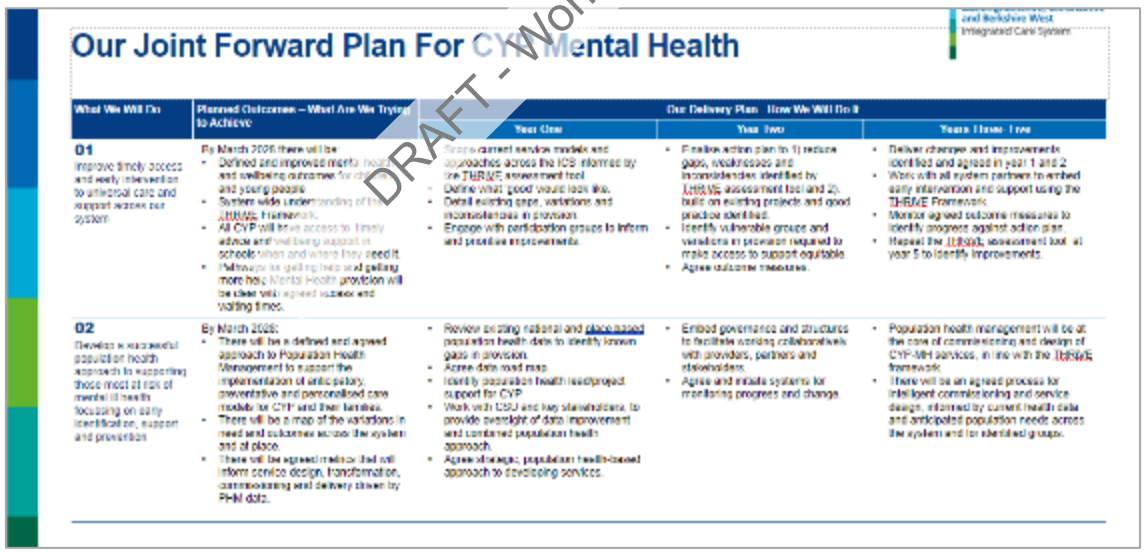
Our Vision 01	Everyone who lives in our area has the best possible start in life, lives happier, healthier lives for longer, and can access the right support when it is needed				
Our System Partnerships 02	Place based partnerships, Neighbourhood teams (PCN led), Clinical Networks, Provider collaboratives				
Addressing Our Biggest System Challenges 03	Priorities to be agreed				
Delivering Our Strategy – Our Five Year Delivery Plans 04	**Promote and protect health:** Keeping people healthy and well	**Start Well:** Help all children achieve the best start in life	**Live Well:** Support people and communities live healthy and happier lives	**Age Well**: Stay healthy, independent lives for longer	**Quality and access:** Accessing the right care in the best place
	1. Prevention 2. Inequalities 3. Vaccination and Immunisations 4. Weight Management	1. Maternity 2. Children and Adult Mental Health Services 3. Learning Disabilities 4. Neurodiversity 5. Children with Long Term Conditions	1. Long Term Conditions (stroke, cardiovascular disease, diabetes, respiratory) 2. Adult Mental Health 3. Cancer	1. Community multi-disciplinary teams (e.g. frailty) 2. Palliative and end of life care	1. Primary care 2. Urgent and Emergency Care 3. Planned care
Supporting and Enabling Delivery 05	Workforce, Finance, Digital, Estates, Research & Innovation, Net Zero, Quality, Personalised Care, Continuing Healthcare				

- Promote prevention
- Address inequalities
- Deliver in partnership

JFP Progress to date

- We have made rapid progress in building a draft end-to-end JFP document
- c. 25 delivery plans developed – services, cross cutting functions, enablers.
  - Context – Outcomes, performance, challenges, national requirements
  - Ambition – 5 Year ambition
  - Workstreams / Projects – Plans: Y1, Y2, Y3-5
  - Enablers / Support required to deliver
- Plans developed and/or tested through system networks – e.g. UEC Programme Board, MH Partnership meeting
- Aligned to strategy structure and priorities
- Year 1 (2023/24) links with priorities and metrics required for the operational plan





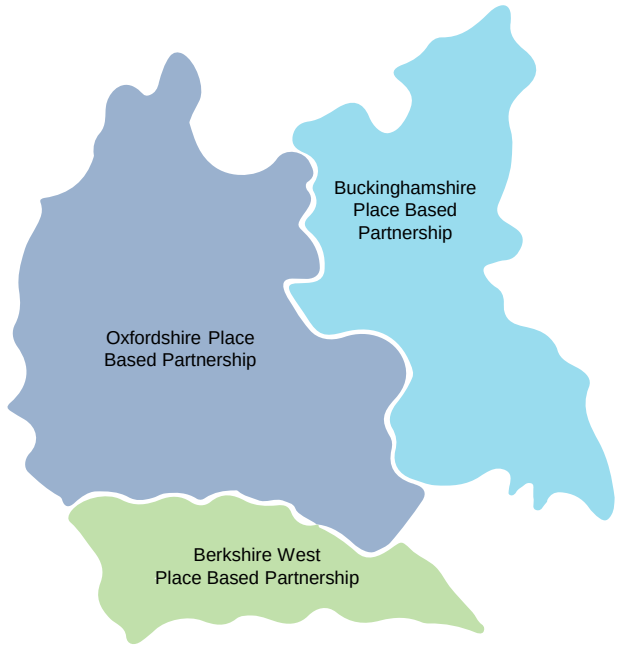
JFP – Emerging JFP Content on Place

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our model for system working has thriving places at its heart. As an ICB we want to empower, support and challenge our places to deliver for the people they serve. Decisions about the delivery of services are best taken close to the people who use those services. If we are to succeed in supporting people to live healthier and more independent lives, we need a nuanced understanding of the issues facing different people and communities in particular places. So this Joint Forward Plan will be delivered in partnership with leaders and staff working closely with our population at every level – be this system-wide, through our Place Based Partnerships, as integrated locality teams, or extending beyond our ICS borders when that is what is needed.

Our Place Based Partnerships (PBPs)

Within BOB we have three strong and distinct Places – Buckinghamshire, Oxfordshire, and Berkshire West – that are broadly co-terminus with local authorities and the catchment for district general hospital services. Each place is establishing a Place-based Partnership which will be leading delivery at a local level, driving transformation and integration, and ensuring the plan delivers improvements in outcomes and experiences for the people living in each place.



The role of PBPs in delivering local priorities

Our PBPs and their wider local arrangements can bring together system partners to deliver the outcomes that really matter to each “Place”, in support of the local Health and Wellbeing strategies, and in conjunction with the Health & Wellbeing Boards

Each place will design its own partnership, which may include local government, primary care and VCSE organisations. In BOB, we see the role of our PBPs as critical to shaping how services are delivered locally, and a maturing partnership approach across BOB will be important in how we best shape services that meet the needs of local populations. We already have a strong history of working at place-level across the BOB system, and will build on this existing strength through our new formal partnerships to ensure local priorities are delivered. We also see our PBPs as vital in driving the integration of services “on the ground”, which make a genuine difference to quality and accessibility for local people.

Developing our PBPs

To support the development of strong places, and based on learning and experiences from other Place-Based Partnerships, we will be reviewing progress against a number of common characteristics we want our places to be have. These will be used as to help set an initial baseline and to support ongoing continuous improvement as Partnerships.

A priority for 2023/24 is to further develop our detailed Target Operating Model which will define how accountability and responsibly is shared between the ICB and our PBPs, supporting the principle of subsidiarity. Over the next five years we anticipate the level of delegated responsibility and budgets to our PCPs will grow as our partnership approach matures.

JFP timescales

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

JFP Timeline

- Formal Publication is required by: **30 June 2023**

  (published and shared with NHS England, the Integrated Care Partnership (ICP) and HWBs)
- First version to be produced by **31 March 2023**

Engagement Requirements

- The plan will be developed with NHS Trusts
- It is a statutory requirement that we engage across the system on the JFP incl.
  - Primary care,
  - Local Authorities and relevant HWBs,
  - VCSE sector,
  - People and communities

Sign Off

- ICB and Trust Boards are expected to formally review and approve the JFP in late April – May 2023
- Each of the five Health and Wellbeing Boards will be given opportunity to review and provide a formal opinion '*on whether the draft takes proper account of local health and wellbeing strategy*' in June 2023 prior to publication – The opinion will be published with the JFP.
- In future years, ICBs and their partner trusts will have a duty to update their JFP before the start of each financial year – i.e. by **1 April**.

Our JFP Engagement Approach

Engagement Level	Purpose and Timing
BOB networks	Engagement through **ICB Planning Leads** to develop and refine service-level content (*Ongoing, supported by weekly calls).* Through the Planning Leads, service level plans continue to be reviewed and iterated through engagement with the relevant **System Networks** as required –e.g. elective care board, UEC Programme Board, integrated cardiac delivery network. Engagement with the **Operational Planning** team to ensure consistency and alignment (*Ongoing, supported by weekly calls*) Updates to the **ICB Executive Team** *(fortnightly)* and **ICB Board** *(21 February)* on progress, emerging content and direction of travel.
NHS Trust	Engagement with **Provider Strategy Directors** to share and test emerging content – particular focus on agreement of System Priorities *(Ongoing)* Updates to the **Provider Executive Teams**, through the Strategy Directors (TBC), to share and test content on priority areas *(March)*
Place	**Place Executive Groups** *(3 March – 30 March) and* **Health and Wellbeing Boards** (16 – 30 March) where possible to update on progress, share emerging content where relevant to the role of Place in JFP, link to JLHWS, link to ICP Strategy Engagement with **Place Directors** *(ongoing)* on ensuring the role of Place is appropriately represented in the JFP
System Partners	Liaison with **VCSE alliance** and **Healthwatch** to agree sharing and input into JFP from VCSE sector and community/patient representatives *(March)* **System Workshop** (*24 March*) – System-wide participation to share progress, test ambition and build opportunities for partnership
Regional	Liaison with **NHS England** to agree how NHSE can support with the development of the plan, visibility of an early draft of the JFP, agreement on development process and how NHSE are involved going forward (*7/8 March*)

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Health & Wellbeing Board Buckinghamshire

Report from Bedfordshire, Luton and Milton Keynes Integrated Care System

Date: 30 March 2023

Author/Lead Contacts: Maria Wogan, Chief of System Assurance and Corporate Services and MK Link Director, Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB)

Report Sponsor: Felicity Cox, Chief Executive, Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB)

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

1. Purpose of report

1.1. The report provides an update on strategic items in Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) and the BLMK Health and Care Partnership, of which Councillor Angela Macpherson is a member.

2. Recommendation to the Health and Wellbeing Board

2.1 Note that the BLMK Health and Care Strategy has been agreed and published.

2.2 Note that the Chair of the Buckinghamshire Health and Wellbeing Board reported on the Buckinghamshire priorities as described at the meeting of the BLMK Health and Care Partnership on 7 March and provided an update on the discussions at the Buckinghamshire Health and Wellbeing Board discussions on 15 December 2023.

2.3 **Note** that the BLMK ICB will be writing to the Chair of the Health and Wellbeing Board to seek feedback on its annual report.

2.4 Note the updates provided on the key items of business considered by the BLMK Health and Care Partnership and Integrated Care Board meetings between November 2022 and March 2023 as listed at Appendix A

3. Content of report

A. BLMK Health and Care Strategy (found here) & Next Steps in Planning

3.1. The Health and Care Act 2022 requires each of the 42 Health and Care Partnerships to produce a strategy and for the ICB and local authorities who are members of the Partnership to have 'regard to' the strategy in discharging their functions.

3.2. The BLMK Health and Care Strategy was agreed by the BLMK Health and Care Partnership in December 2022. It highlighted the difference in life expectancy and healthy outcomes in deprived areas compared to more affluent areas and how health and wellbeing can be affected by more than one inequality. The Partnership was particularly concerned about how the cost-of-living crisis would widen health inequalities and have a significant impact on the health of local people.

3.3. The strategy:

- reflects the 5 strategic priorities (Start Well, Live Well, Age Well, Growth and Tackling Inequalities)
- is committed to subsidiarity (to Place), with a focus on planning, decision-making and delivery as close to the resident as possible
- emphasises the need to further use our partnerships to support residents to live longer, healthier lives, and the central role of VCSE in achieving this; and,
- speaks to real examples that make a difference to local people

B. BLMK (NHS) Operational Plan 2023-2024 and BLMK Five Year Joint Forward Plan 2023-2028

3.4. The Health and Care Act requires the BLMK ICB to produce an Operational Plan (due end March 23) and a Five Year Joint Forward Plan (due end June 23).

3.5. The Operational Plan is for 2023/24 and requires ICBs to describe how the local NHS will deliver against mandated NHSE operating plan requirements, including agreement of the BLMK NHS system budget. This plan takes account of local priorities and will be reported to the Board of the ICB on 24 March 2023.

3.6. ICBs and their partner trusts must involve relevant Health and Wellbeing Boards in preparing or revising the Joint Forward Plans (JFP). This includes sharing a draft with each relevant Health and Wellbeing Board (HWB) consulting as to whether the JFP takes proper account of each relevant local health and wellbeing strategy.

3.7. As JFPs will build on existing Joint Strategic Needs Assessments, Health and Wellbeing Strategies and NHS delivery plans, we do not currently anticipate their development will require full formal public consultation.

3.8. The Chair of the Buckinghamshire Health and Wellbeing Board, Councillor Angela Macpherson, was invited to present Buckinghamshire priorities to the BLMK Health and Care Partnership meeting on 7 March and this will contribute to the development of the JFP for BLMK. BLMK ICB will co-ordinate public engagement on the JFP prior to its anticipated sign off by the Board of the ICB on 30th June 2023.

Recommendation to:

Note that the BLMK Health and Care Strategy has been agreed and published.

Note that the Chair of the Buckinghamshire Council reported on the Buckinghamshire priorities as described at the meeting of the BLMK Health and Care Partnership on 7 March and provided an update on the discussions at the Buckinghamshire Health and Wellbeing Board discussions on 15 December 2023.

C. ICB Annual Report

3.9. ICBs are statutorily required to produce an Annual Report at the end of each year. (In this case the reporting period is July 2022 to end March 2023). As part of the production of that report an ICB must reflect on its contribution to the delivery of relevant local Health and Wellbeing Strategies. In doing so, the ICB must engage with each local Health and Wellbeing Board to seek feedback. The Health and Wellbeing Board is asked to note that the ICB will soon be writing to the Chair for comment. The Annual Report will be published later in 2023.

Recommendation:
Note the arrangements for the Health and Wellbeing Board to comment on the ICB's first annual report.

4. Next steps and review

4.1. An update report from BLMK ICB and Health and Care Partnership will be provided to each Health and Wellbeing Board.

5. Background papers

The papers to the meetings referred to in the report are enclosed at Appendix A.

Appendix A – Summary of BLMK Health and Care Partnership and BLMK Integrated Care Board Business November 2022 - January 2023

1. **Health and Care Partnership – 14 December** 2022

   Health-and-Care-Partnership-7-March-2023-combined.pdf (blmkhealthandcarepartnership.org)

   Agenda items:

- **Health and Care Strategy** – JSNA noted, and strategy agreed
- **Fuller Neighbourhoods** – briefing provided on the findings of a review undertaken by Dr Claire Fuller of integrated primary care, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care across systems.

2. **Health and Care Partnership 7 March 2023, 5-8pm in Milton Keynes,**

- **Joint forward plan** - The plan for the development of the joint forward plan was agreed.
- **Workforce** pressures has been highlighted in a number of reports and an update will be provided at the next meeting on what the system is doing to retain and recruit staff.
- **Place plans, Health and Wellbeing Board updates and Health and Wellbeing Board guidance** –Place plans and the local priorities were presented and key areas of discussion from the Health and Wellbeing Board meetings.
  Health and Wellbeing Board guidance that was published in November 2022 and the requirements it on the Health and Wellbeing Boards, ICBs and ICPs was noted. Health and wellbeing boards – guidance - GOV.UK (www.gov.uk)
- **Delegation of Dentistry, Optometry & Community Pharmacy** – an update on the delegation of responsibility from 1 April 2023 to the ICB of dentistry, optometry and community pharmacy was provided. It was noted that 2023/24 would be a transitional year and provides an opportunity to build relationships with contractors. It was reported that there are significant challenges with the national contracts and partners supported the lobbying for change in contracts to enable more local flexibility. Access to NHS dentists was a real concern for residents and coupled with community pharmacy closures, increases the workload for GPs.
- **Mental Health, Learning Disability and Autism collaboration –** information was shared on the progress that had been made in provision of mental health services since the Mental Health Five Year Forward view was published in 2016 and the investment through the Mental Health Investment Standard. There was an opportunity to have greater collaboration for people with mental health, learning disabilities and autism and the ICB Board had agreed the development of this collaborative. The report contained an update on feedback from engagement that has taken place and what areas of focus service users are identifying.
- **Community Engagement** – a presentation was given on the new approach of pooling partner resources to avoid engagement duplication, agreeing co-production principles and highlighted areas of work e.g., the Denny review.

3. **Board of the BLMK ICB – 25 November 2022 and 27 January 2023 –** 25.11.22-Board-of-the-ICB-in-PUBLIC-Meeting-Pack.pdf **https://bedfordshirelutonandmiltonkeynes.icb.nhs.uk/our-publications/board/board-in-public-27-1-2023/?layout=default**

   Agenda Items:

- **Working with People & Communities Strategy -** approved
- **Memorandum of Understanding (MOU) with the Voluntary, Community & Social Enterprise (VCSE) Sector -** approved
- **Developing a BLMK Mental Health, Learning Disability & Autism Collaborative -** A proposal to develop a BLMK Mental Health, Learning Disability and Autism Provider Collaborative was supported. The vision, which we will seek to further develop with input from service users, patients and system partners, puts patient and service user voice and a focus on place at its heart, refocusing our efforts on addressing inequalities and unwarranted variation, and working at scale where it makes sense to do so.
- **Resident's story** – about the challenges and barriers faced by a transgender resident accessing health services. The story emphasised the importance of raising awareness and sensitivity training which is being supported by the ICB.
- **Luton Airport – Development Consent Order** – supported the proposed development of Luton Airport on the basis on the mitigating actions being taken and the economic benefits of the scheme and the positive impact this would have on BLMK residents.
- **People Strategy** - agreed
- **Inequalities** - update on delivery of the inequalities including how £3.5M had been invested in BLMK.
- **Green Plan Health Impact Assessment** – as described in the main report
- **Delegation of Pharmacy, Optometry, Dental (POD) Commissioning and Specialised Commissioning to the ICB** – progress report with the risks and opportunities associated with the transfer of commissioning responsibility to the ICB. POD is expected to be delegated from April 2023 and Specialised Commissioning from April 2024. A decision on the delegation of POD will be taken at the next Board meeting.
- An update on the **Community Diagnostics Centres** was given. Positive progress for the MK and Bedford sites with more work to do on the proposal for Luton.

Health & Wellbeing Board Buckinghamshire

Buckinghamshire Health and Care Integration Programme: progress, future plans, and what this means for residents

Date: 30th March 2023

Author/Lead Contacts: Jo Baschnonga, Integration Programme Director (Buckinghamshire NHS Trust & Buckinghamshire Council)

Report Sponsor: Craig McArdle (DASS, Buckinghamshire Council); Philippa Baker (Executive Director for Place, ICB), Raghuv Bhasin (COO, Buckinghamshire 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 Health and Care Integration programme has been focusing on hospital discharge. For this reason, it does not directly support any of the specific Joint Local Health and Wellbeing Strategy priorities but does significantly contribute to the health and wellbeing of Buckinghamshire residents.

1. Purpose of report

The report summarises the main outcomes of integration programme of work over the last year, plans for next year, and what this means for the experience of people using health and care services in Buckinghamshire.

2. Recommendation to the Health and Wellbeing Board

Report for information, no recommendation.

3. Content of report

3.1. The key statistics around patient experience and hospital admission and discharge referenced in the national media show that Buckinghamshire is roughly in line with national averages - for ambulance queues (19%), long waits in A&E (26%), and the proportion of patients admitted, treated or discharged within 4 hours (70%).

3.2. However, we know that these markers of patient experience have worsened nationally compared to pre-pandemic levels, and they reflect the ongoing recovery from the impact of Covid. The crisis across NHS and social care services has been well documented this winter - significant demand, capacity and workforce issues have affected all systems, and inevitably this can impact on the experience and safety of patients.

3.3. In Buckinghamshire, the recovery from Covid (in relation to hospital discharge) is being driven by the 'integration programme', seeking to ensure safe and timely discharge from hospital for the residents of Buckinghamshire – wherever possible back to their home. The objectives of the programme are to:

- Reduce delays experienced by Buckinghamshire residents at all points during their discharge journey, both in and out of hospital. The rolling back of the current 'discharge to assess' model (whereby patients who no longer need to be in hospital are discharged pending an assessment of their long-term care needs), is one element of supporting this, alongside others detailed in Sections 3.17- 3.19.
- Stabilise performance and patient experience – so that Buckinghamshire residents have their hospital discharge planned as soon as they are admitted, if they require an assessment for longer term care it happens in the best location for them and does not take longer than 28 days.
- Implement a new model for discharge and intermediate care in the County that drives even better outcomes for patients and staff. (Intermediate care are services such as occupational and physical therapy to help people become more independent after a hospital stay)

3.4. Sections 3.7 to 3.15 summarise the improvements to the Buckinghamshire system over the last year, and what this means for the experience of Buckinghamshire residents.

3.5. There is substantial work left to do to achieve the level of improvement needed. Sections 3.16 to 3.20 describe the plans in place for delivery next year (in part resourced by the national discharge fund, Buckinghamshire is expected to receive £2.4m via the NHS and £0.7m via the Local Authority, with partners coming together to decide how best to spend this).

3.6. The design of new and improved services next year will be based on an understanding of the current patient journey and experience. Workshops with Buckinghamshire residents in April and May will help to develop a better understanding of this, and all service designs will include

'personas' which describe (through the eyes of a patient) how the new design will improve on the current patient experience.

Improvements this year

3.7. Residents who need long-term care at home after they leave hospital are able to go home while they are assessed for their long-term needs, in line with our vision to get people home as soon as possible. This has been achieved through a new service called 'Home First' (launched in November 2020). Performance of this Service has steadily improved over the last year, meaning that Buckinghamshire residents on this pathway now can expect to be assessed at home within 28 days (in line with our target).

3.8. 94 care home beds in Buckinghamshire have been freed up since June 22, meaning they can be used differently (e.g. for long-term care addressing a gap in the market). This boost in long-term care capacity should mean that long-term care is easier to source for some Buckinghamshire residents, meaning they can be discharged from hospital more quickly.

3.9. The 94 care home beds referenced above were previously 'discharge to assess' beds. At the peak of winter, the average length of time a Buckinghamshire resident could expect to stay in one of these beds while waiting to be assessed was over 100 days. Although the intention of the national 'discharge to assess' model was to reduce the time patients waited in beds, it has not worked in Buckinghamshire. The impact on (generally frail and elderly) patients in these beds is significant - for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs (in people over 80 years old). We also know that frail elderly patients are more likely to need long-term bedded care after a period of deconditioning. The transition of 'discharge-to-assess' beds into long-term care capacity in the County is designed to address this issue – by the end of this year there will be approximately 30 discharge to assess beds in the County (compared to 140 in May 22), and next year we plan to phase them out as far as possible.

3.10. Barriers to assessing patients in hospital are being removed, and the system has started delivering more assessments in this setting. In the future this will mean that where a patient requires a relatively simple assessment, this can be done quickly in hospital, meaning they can be discharged directly to their long-term care placement, minimising the potentially disruptive effect of multiple moves for people. We are still at the early stages of this journey (new financial principles and processes have been implemented in March to support this new way of working, but there is more work to do next year to maximise the opportunity).

3.11. We have started to reduce the length of time Buckinghamshire residents spend waiting in 'discharge to assess' beds and on the County's medically optimised for discharge ward at Stoke Mandeville (Chartridge), although there is significant work left to do on this. Patients in these settings are being reviewed weekly for opportunities to accelerate their discharges. The average length of time a patient spent in a 'discharge to assess' bed in the month of January was 75 days, an improvement on December (over 100 days). It is too early to say if this is an improvement trend, and we know there is still substantial work to do to achieve sustained improvement – including around performance and culture (which can take time to embed).

3.12. Buckinghamshire residents may be treated and discharged from many hospitals including Stoke Mandeville, Wexham Park or Milton Keynes Hospitals (usually dependent on where they live in the County). There is now stronger partnership working with neighbouring systems – Frimley system (Wexham Park Hospital - which treats the largest proportion of Buckinghamshire residents after Stoke Mandeville Hospital), have representatives on the key groups that govern the County's integration programme (including the Buckinghamshire Executive Board), and are key participants in the design of our future model for discharge and intermediate care.

3.13. A new hub of twelve beds was opened in January to support discharge of patients through the most intense period of winter (funded by the additional £200m national fund announced on 9th January). This additional provision has supported more Buckinghamshire residents to be discharged from Wexham Park hospital (8 of 12 patients currently being cared for).

3.14. Six new short-term housing units (ground floor one bed units in High Wycombe) are now available to facilitate discharges where residents are waiting for longer term housing. These units act as a 'bridge' between hospital care and returning home for Buckinghamshire residents who are waiting to be housed. The initiative launched in February.

3.15. Similarly, a small number of residents needing to access homelessness services after a spell in hospital over winter have been temporarily housed in hotel accommodation during January – enabling them to be discharged from hospital and into more appropriate accommodation.

Improvements next (financial) year

3.16. Improvement activity has accelerated during January and February, supported by additional NHS funding (£500m national discharge fund – spending plans were agreed through the Health and Wellbeing Board on 15th December, and a £200m fund announced in January). These funding streams were announced very late in the year, meaning it has been challenging to plan and spend the money to impact on flow and patient outcomes this winter.

3.17. There are a number of improvement initiatives in progress, however, which we expect to have an impact in Spring/ Summer and improve the experience of Buckinghamshire residents through the coming year:

- Trusted Assessors – two new posts within the Hospital Discharge Team focused on improving the transfer of patients from discharge to assess beds into long-term care, working with our biggest care provider the Freemantle Trust. There is evidence of significant delays at this point of the discharge process. Our Trusted Assessors will drive improvements and build trust with care providers over a 6 month period, estimated to reduce the length of time residents wait in beds by 286 days. Going live later in March.
- Integrated discharge team – hospital staff and social workers becoming one team and working together with patients on the ward to plan their discharge from the point of admission. Discharge plans will be simplified, based on the strengths of the patient, and developed with residents and their families – this should reduce anxiety and help patients

feel in control. Better planning of discharge will reduce the likelihood of readmission, enabling people to remain at home. Going live from April.

- Better performance data – to drive better performance of our discharge services, we need high quality performance information that is easy to access. Work us underway to develop better performance information on patients delayed in hospital – this is particularly pertinent as more patients are assessed on hospital wards (mentioned in Section 3.9). Expected to go live in April, this information will identify where the longest patient delays are, enabling rapid action to be taken.

3.18. Our most substantial deliverables next year will be a 'transfer of care hub' (going live in October), and a new intermediate care bedded offer. The transfer of care hub will co-ordinate the patient's journey through the system - with hospital and social work staff working together in an integrated team to achieve this. There will be dedicated resource overseeing the patient journey, identifying delays quickly and driving accountability for resolving them. This will make Buckinghamshire residents' experiences of moving through the health and care system smoother and quicker.

3.19. Our new bedded offer will be better aligned to patients' needs (than the current 'discharge to assess' bedded offer), and will include:

- A 22 bedded intermediate care hub within Buckinghamshire Community Hospitals. This will support Buckinghamshire residents get home as quickly as possible after a stay in hospital by providing the right type of therapy and approach to reable them quickly. These beds will complement the intensive rehabilitation beds (35) that are currently provided in Buckinghamshire's Community Hospitals.
- Complex case bedded hubs providing 20 beds for people who need a longer stay (due to complex health needs, for example non-weight bearing) in order to be assessed for their long-term care.
- Two short-term interim bedded hubs providing a total of 20 beds which can be used flexibly to support discharge from acute hospitals. For example, if an assessment is particularly complex or there is a delay in sourcing a patient's long-term placement. Our ultimate aim is to operate without this type of short-term bed, however while we are still improving our processes and performance these beds will help to keep system flow moving and reduce the likelihood of Buckinghamshire residents facing long delays in bedded care.
- Up to 32 additional surge beds to support periods of increased pressure, anticipated to be open from October 2023 – March 2024.

3.20. Our final area of focus next year will be around culture and performance across the health and care system. For health and care services to operate effectively, hospital discharge must be a priority for all members of staff, and woven through the fabric of our partnership. In April we will be working on reaffirming a clear vision and compelling narrative for staff, helping all

colleagues to understand their role in improving the outcomes and experience of Buckinghamshire residents.

4. Next steps and review

4.1. The integration programme will continue to be governed through the Integrated Care System Executive Board, which meets monthly.

Health & Wellbeing Board Buckinghamshire

Action Plan to Reduce the Rates of Cardiovascular Disease

Date: 30 March 2023

Author/Lead Contacts: Tiffany Burch, Consultant in Public Health, Buckinghamshire Council

Report Sponsor: 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:

Not applicable.

1. Purpose of report

1.1. The refreshed Joint Local Health and Wellbeing Strategy (JLHWS) and action plan include a priority to reduce the rates of cardiovascular disease and tackle inequalities in cardiovascular disease. This requires addressing the risk factors for cardiovascular disease particularly in people at higher risk including those living in more deprived areas, people from certain ethnic groups and those with serious mental illness (see Director of Public Health Annual Report). Cardiovascular disease has serious consequences and causes heart attacks, stroke and dementia. This report provides the action plan for this theme of the health and wellbeing strategy and updates the board on progress and proposed way forward for the measures, targets and actions by partners.

2. Recommendation to the Health and Wellbeing Board

2.1. The Health and Wellbeing Board are asked to note the measures, targets and actions set out within the report and in appendix A.

2.2. The Health and Wellbeing Board are asked to commit their respective organisations to deliver their actions.

3. Content of report

3.1 Reducing the rates of cardiovascular disease is a priority under the Joint Local Health and Wellbeing Strategy's Live Well theme. Cardiovascular disease causes 1 in 5 of all deaths in Buckinghamshire and is the major contributor to the gap in life expectancy between people living in our most deprived and least deprived areas. Whilst cardiovascular disease can affect anyone, residents living in our most deprived areas and people from certain ethnic groups are at a higher risk of cardiovascular disease than the Buckinghamshire average.

3.2 The aims and the reasoning for these aims are as follows:

- Over the last 5 years, residents in more deprived areas have received fewer NHS Health Checks compared to residents in less deprived areas. NHS health checks screen for risk factors for cardiovascular disease and give patients advice and treatment where necessary to help reduce their risk. To improve the outcomes of residents at increased risk of cardiovascular disease, there should be an increase in their access and experience of preventative services like the NHS Health Check and referrals to services such as smoking cessation, alcohol misuse services diabetes prevention and weight management services.
- NHS inpatients (acute and mental health) and maternity patients who smoke should be offered the opportunity to quit smoking while under the care of the NHS. This approach has been shown to be successful is increasing the number of residents who stop smoking. Smoking is a major contributor to the gap in life expectancy between those living in the least and most deprived areas and the lower life expectancy of people with a serious mental illness. Smoking during pregnancy results in worse outcomes for babies.

- Residents in the more deprived areas of the county are more like to develop high blood pressure earlier than residents in other areas. However, they are less likely to be identified early and have their blood pressure adequately controlled at an early stage. Therefore, increasing the numbers of higher risk residents who check their blood pressure regularly will increase the numbers receiving support. Increasing the number of patients with hypertension whose blood pressure is controlled will also result in better long-term cardiovascular health for these patients.

3.3 The CVD Prevention and Inequalities Working Group for Buckinghamshire is working together to deliver on this theme. Members include representatives from primary care networks, local GPs, Integrated Care Board, Public Health, Healthwatch Bucks, Buckinghamshire Healthcare NHS Trust and Oxford Health NHS Foundation Trust.

3.4 The four priority targets for this theme are as follows:

- The number of eligible people in priority risk groups (in the 40% most deprived areas in Bucks) who have an NHS Health Check each year.
- The proportion (%) of eligible of patients who were referred to NHS tobacco dependency services (acute inpatients, maternity and mental health inpatients) who later successfully quit smoking (four week quit).
- Proportion of patients (15+) who have had their blood pressure checked in the last year in the four most deprived Primary Care Networks
- Proportion of patients who have their blood pressure treated to target in the 4 most deprived Primary Care Networks Proportion of patients under 80 years old with hypertension whose last blood pressure reading (in the last 12 months) was <= 140/90 mmHg for the four most deprived Primary Care Networks.

3.5 The action plan for the Working Group is included as Appendix A. This plan sets out how the group is working to achieve the collectively agreed targets outlined above.

3.6 Over the last 12 months a variety of actions have been delivered by partners on this priority. Below is a brief summary of some of the key actions:

- Buckinghamshire Healthcare NHS Trust and Oxford Health NHS Foundation Trust have made progress on developing their ‘In-house’ tobacco dependency teams and services. These are for acute inpatients, mental health inpatients and maternity patients as set out in the Long Term Plan.
- The Public Health team alongside Community Boards and Parish Councils have delivered 13 SmokeFree Parks and Playgrounds in priority areas of the county. This project aims to reduce smoking around children and young people.
- A successful pilot looking at whether faith communities can become ‘health promoting’ communities was led by Public Health. This pilot used behavioural science to co-create a

community-based blood pressure initiative with a faith community located in an area with increased cardiovascular disease risks.

- A scheme to increase capacity for the NHS Health Check in primary care was designed by Public Health and resourced by the Clinical Commissioning Group (now the Integrated Care Board). This scheme has launched in two of the four priority Primary Care Networks.
- NHS Health Checks were successfully delivered to employee groups who are unable to access preventative services due to the nature and hours of their jobs. For example, the Council's waste operatives were able to access these at their depot over a number of days. This received exceedingly positive feedback and identified a number of individuals with increased CVD risks.

3.7 Over the next 12 months a large number of initiatives will be continuing and new ones will be starting. Below is a selection of work for this priority:

- Additional faith communities will be trained in how to be health promoting communities. Several of these communities will co-create bespoke projects for their members.
- Two health kiosks will be installed in targeted libraries in Opportunity Bucks areas to allow residents to keep an eye on their overall health status.
- The current pre-operative pilot (for patients on surgical waiting lists) will be expanded to include smoking cessation and healthy behaviours advice and referrals to get residents to 'stop before the op'.
- A plan to increase access to Electrocardiograms (ECGs) to check for signs of heart disease for patients moving through the hypertension diagnosis pathway will be agreed and delivered.
- Seven additional SmokeFree Parks and Playgrounds will be launched in Opportunity Bucks areas.
- An equity audit for the access, experience and outcomes of cardiovascular disease in Buckinghamshire should be conducted to better understand the impacts of a wide range of factors on cardiovascular disease inequalities.

4. Next steps and review

4.1. Partners will continue to work together to deliver the action plan for this priority, and updates will be provided to the Health and Wellbeing Board as appropriate.

4.2. This priority is also a priority for the Opportunity Bucks programme at Buckinghamshire Council which aims to promote opportunities to level up health in Buckinghamshire. This provides a way to work with communities to identify what would work for them to improve their health and quality of life. These relationships are important for delivering the action plan in a sustainable way.

5. Background papers

5.1. Director of Public Health Annual Report on Cardiovascular Disease

5.2. Appendix A – Buckinghamshire Joint Health and Wellbeing Board Strategy: Live Well/Cardiovascular Disease Action Plan

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Appendix A

Buckinghamshire Joint Health and Wellbeing Board Strategy: Live Well/Cardiovascular Disease Action Plan

Action 1: Increase access to NHS Health Checks in priority risk groups
Rationale: More people will be advised about their cardiovascular disease risk earlier and supported to get the help they need, in particular groups of residents who are at higher risk of poor outcomes.
Health and Wellbeing Board Performance Hub Metric: The number of all NHS Health Checks delivered that were for residents in DQ4 and 5

Ref	Action	Lead	Dates	Baseline	Progress data
	Increase capacity in primary care in priority areas to undertake more NHS Health Checks to detect and manage clinical risk factors in 4 priority primary care networks.	ICB	2023/24 The programme will also run through 2024/25.	1,072 NHS Health Checks Delivered in the 4 priority primary care networks during 2021/22	Number of NHS Health Checks delivered in the 4 priority Primary Care Networks. Target of 2700 checks completed.
	Increase the number of NHS Health Checks delivered by primary care in deprivation quintiles 4 and 5	ICB General Practice	2023 to 2025	1,393 NHS Health Checks delivered in deprived areas of the county in 2021/22	Number of NHS Health Checks delivered by primary care in DQ 4 and 5 practices
	Deliver outreach NHS Health Checks in a variety of community settings.	Public Health Healthy lifestyle service	2023-2025	691 NHS Health Checks conducted in community venues in 2022/23 Venues for 2022/23 included Waste Depots, leisure centres, libraries, and community health settings.	Wider breadth of community venues utilized.

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Action 2: Increase access to tobacco dependency services Rationale: More people will be supported to stop smoking, and this will reduce their risk of cardiovascular disease. Smoking is one of the biggest causes of the gap in life expectancy between residents living in our most and least deprived wards. **Health and Wellbeing Board Performance Hub Metric:** The % of eligible of patients who were referred to NHS inhouse tobacco dependency services who later successfully quit smoking (4 week quit)					
Ref	**Action**	**Lead**	**Dates**	**Baseline**	**Progress data**
	Deliver a fully-functioning in-house tobacco dependency service for acute inpatients with a robust discharge path to community stop smoking support. **(NHS Long Term Plan)**	BHT Acute Inpatients	April 2023	For January 2023 48 Smokers were referred to the in-house Tobacco Dependency advisors 29 smokers were seen by the Tobacco Dependency Advisors 23 referred to community stop smoking support	Increased number of inpatients are referred to the in house service. Increased number of these patients are successfully referred to the community stop smoking service.
	Deliver a fully-functioning in-house tobacco dependency service for mental health inpatients with a robust discharge path to community stop smoking support. **(NHS Long Term Plan)**	OHFT	April 2023	For January 2023 4 Smokers were referred to the in-house Tobacco Dependency advisors 4 smokers were seen by the Tobacco Dependency Advisors 0 referred to community stop smoking support (2 remain as inpatients)	Increased number of inpatients are referred to the in house service. Increased number of these patients are successfully referred to the community stop smoking service.
	Deliver a fully-functioning in-house tobacco dependency service for maternity patients with a robust discharge path to community stop smoking support. **(NHS Long Term Plan)**	BHT Maternity	April 2023	The service has not yet launched due to recruitment challenges.	Increased number of inpatients are referred to the in house service. Increased number of these patients are

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					successfully referred to the community stop smoking service.
	Agree a plan and resources to support patients on surgical waiting lists to 'stop before the op' by stopping smoking and other unhealthy behaviours that increase the patients' risks of poor outcomes following surgery. Start implementation of this plan.	BHT ICB	2023-2024	Currently all patients on waiting lists have their smoking status checked, but not all are actively referred to Stop Smoking Services during the pre-operative process. There are no data for these referrals.	Plan agreed for inclusion of smoking and 'stop before the op' in the pre-operative process/pathway. Number of surgical waiting list patients referred for smoking cessation support in the community. Number of surgical waiting list patients who successfully stop smoking.
	Increase the understanding and skills of the health and social care work force to 'Make Every Contact Count' by having supportive conversations with residents to make healthy behaviour changes.	BHT OHFT ICB Buckinghamshire Council	2022-2025	Health and social care colleagues trained in 2022/23 167 Buckinghamshire Council & voluntary sector colleagues trained. Data for NHS colleagues were not available at the time of submission.	Increase number of health and social care staff trained in MECC by their respective employers and/or other MECC training provision.
	Joint communications campaigns to promote smoking cessation (including regional and national campaigns)	Public Health/ Buckinghamshire Council All NHS partners	2023-2025	1 campaign jointly promoted for Stoptober in October 2022	Number of campaigns delivered each year and the stats that show their 'engagement and

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		Healthy Lifestyle Service		Stats of reach and engagement from joint Stoptober campaign* Facebook: 11 posts that reached 10,404 people Twitter: 7 tweets that reached 5,532 people Instagram: 8 posts that reached 1,856people Nextdoor: 6 posts that reached 15,393 impressions LinkedIn: 8 posts that reached 1,733 people **Some of the people may be duplicates. We are unable to say how many times a single person interacted with the various posts.*	reach' via social media to our residents.
	SmokeFree Parks and Playgrounds to promote smokefree areas for children to play	BC Public Health Community Boards Ward Partnerships	2023-2024	13 smoke free parks and playgrounds	Install at least 1 SmokeFree Park and Playground in every Opportunity Bucks ward.

Action 3: Increase numbers of residents aged 15 years and older who have their blood pressure checked at least once a year in the 4 most deprived Primary Care Networks
Health and Wellbeing Board Performance Hub Metric: Proportion of patients (15+) who have had their blood pressure checked in the last year in the 4 most deprived Primary Care Networks

Ref	Action	Lead	Dates	Baseline	Progress data
	Equity audit of cardiovascular disease access, experience and outcomes to be conducted	ICB	By the end of 2023/24	No equity audit in place	Completion of the equity audit.
	Collaborate with faith communities at risk of cardiovascular disease to create community based blood pressure	BC Public Health Ward Partnerships Community Boards	2023-2025	1 faith community participating	Number of communities increases

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	initiatives across Aylesbury, High Wycombe and Chesham.	Primary Care Networks			
	Co-design a blood pressure prevention initiative with taxi drivers across the county.	BC Public Health and Taxi Licensing	2023-2025	No initiative in place.	Initiative co-designed with taxi driver representatives and firms. Number of taxi drivers checking their blood pressure increases
	General practice to increase the proportion of hypertensive patients who are treated to target in the priority areas. *Quality and Outcomes Framework metric HYP003 - Hypertension aged 79 or under BP 140/90 mmHg or less*	ICB Primary Care Networks	2023/24	2021/22 data* • 52.1% Central Maple PCN (range 45-63%) • 61.5% Central Aylesbury (range 47-66%) • 61.2% Cygnet (range 43-68%) • 57.5% Dashwood (range 44-75%) **These averages mask some of the practices who are poorly performing on this metric.*	Increase the proportion treated to target in 4 priority PCNs increases
	Health Kiosks installed in libraries in key levelling up areas to allow residents to keep an eye on various health assessments, including blood pressure.	BC Public Health and Libraries	2023-2025	No health kiosks currently in place	2 kiosks installed Number of residents accessing these machines and checking their blood pressure
	Blood pressure loan kits will be available for residents to 'check out' from local libraries in Aylesbury, High Wycombe and Chesham.	BC Public Health and Libraries	2023-2025	No loan kits currently in place	Loan kits installed Number of residents accessing these kits

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	ICB to deliver a plan to increase access to ECGs for patients moving through the high blood pressure diagnosis pathway.	ICB	2023/24	Currently not enough ECG appointments available.	Increase the number of ECG appointments available, in particular for patients in the 4 most deprived PCNs.
	Pharmacies to deliver more blood pressure checks to residents who fit set criteria as part of the NHS agenda to increase blood pressure checks.	Local Pharmaceutical Committee NHSE/DHSC	2023-2025	Data for November 2021 to December 2022 43 pharmacies provided the service 3,411 blood pressures were checked 109 patients with high blood pressure were given a 24-hour blood pressure monitor by a pharmacy	Increase in the number of pharmacies participating Number of residents who have checked their BP at their local pharmacy

Health & Wellbeing Board Buckinghamshire

Action Plan to reduce the rates of obesity and increase physical activity

Date: 30 March 2023

Author/Lead Contacts: Sally Hone, Public Health Principal, Buckinghamshire Council

Report Sponsor: 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:

Not applicable.

1. Purpose of report

1.1. The refreshed Joint Local Health and Wellbeing Strategy (JLHWS) and action plan include a priority to reduce the prevalence of obesity across all age groups in Buckinghamshire. This will require a focus on increasing the proportion of people eating healthily and being physically active to prevent people becoming overweight and obese and increasing the number of people accessing weight loss services. This report provides the action plan for the obesity and physical activity themes of the health and wellbeing strategy and updates the board on progress and proposed way forward for the measures, targets and actions by partners. The action plan is attached at appendix A.

2. Recommendation to the Health and Wellbeing Board

2.1. The Health and Wellbeing Board are asked to note the progress, measures, targets and actions set out within the report and appendix A.

2.2. The Health and Wellbeing Board partners are asked to commit their respective organisations to deliver their actions and consider what more they might be able to do.

3. Content of report

3.1 In Buckinghamshire 18.2% of Reception age children and 31.5% of Year 6 children are overweight or obese and 61% of adults classified as overweight or obese. Obesity is an important risk factor for cardiovascular disease and dementia and some cancers. Tackling the risk factors for obesity such as diet and physical activity reduces the risk of more than 20 long term conditions, increases economic productivity and reduces demand on health and social care services. Whilst overweight and obesity occurs across all social groups, people living in our most deprived areas and people from certain ethnic groups are at a higher risk than the Buckinghamshire average. COVID and the cost of living crisis have increased the prevalence of unhealthy behaviours and increased the need for access to affordable healthy food.

3.2 The aims of the healthy weight plan are as follows:

- To stop the year on year rise of childhood obesity, aiming for a long-term downward turn
- To stop the upward trend in the number of adults who are overweight and obese
- To ensure those identified as overweight and obese are accessing the support they need to lose weight
- Increase the percentage of adults meeting the recommended physical activity levels
- Increase the number of 65+ year olds utilising local leisure centres
- Educate health professionals to be able to provide physical activity advice to older age clients
- Increase the number of older adults achieving 2 or more sessions of muscle strength exercises per week

3.3 The Whole Systems Approach to Healthy Weight for Buckinghamshire is a collaborative approach, working with a over 60 partners from a variety of sectors to develop and deliver the joint action plan. This includes partners from:

- Buckinghamshire Healthcare Trust and BOB Integrated Care Board
- Voluntary, Community and Social Enterprises such as Khepera, Wycombe Wanderers Foundation, Leap, Active in the Community
- Charities such as TalkBack, Rothschild Foundation, Community Transform, Community Impact Bucks
- Local Providers such as Everyone Active, Places for People, Greenwich Leisure

3.4 There are targets and measures across all childhood and adult obesity and physical activity in older people themes as follows:

- Halting the rise in the proportion of children who are overweight or obese in reception and year 6
- Increasing the proportion (%) of eligible families who are accessing Healthy Start scheme
- Increasing the number of children accessing weight management services
- Halting the rise in the percentage of adults who are obese
- Increasing the numbers of adults accessing weight management services
- Increasing the percentage of adults attaining the recommended physical activity levels
- Increasing the numbers of physically active older adults by increasing numbers of people over 65 accessing leisure centres, increasing the number of professionals trained in advising older people about the benefits of physical activity.

3.5 The action plan for the Working Group is included as Appendix A. This plan sets out how the group is working to achieve the collectively agreed targets outlined above.

3.6 Over the last 12 months a variety of actions have been delivered by partners on this priority. Below is a brief summary of some of the key actions:

- **Be Healthy Bucks** – a new lifestyle service for Bucks, Be Healthy Bucks, launches on the 1st April (formerly LiveWellStayWell). The new service will offer choice in line with need, with higher intensity services targeted in priority areas. The service will include stop smoking, adult and child weight management, outreach NHS Health Checks and enhanced alcohol brief intervention. This new contract will be able to support a larger number of 7-13 years to reach a healthy weight and the adult weight management provision will offer greater service choice.
- **BetterPoints -** a behaviour change programme that incentivises and rewards people with points for making positive changes to their lives, such as being active and getting support to lose weight. The points can then be redeemed with high street shops and local businesses or donated to a choice of charities and local food banks.
- **Simply Walks -** Simply Walk provides a variety of led walks for all abilities across Buckinghamshire which are run by local volunteer walk leaders. There are over 60 weekly walks available countywide offering grades of walks to suit most abilities from 45 mins to 2 hours.
- **Healthy Start Social Marketing -** Healthy Start is a government food assistance programme for low-income families. It provides financial support to low-income families and pregnant women for fruit, vegetables, pulses, milk or infant formula. Healthy Start is available to all women under the age of 18 (regardless of their income) and is means-tested for women aged 18 and over who are 10+ weeks pregnant, and for families with a child or children under the age of 4, who qualify for certain benefits. Through the use of localised social marketing, based on community insight work, the project aims to increase the uptake of the

scheme across eligible populations as well as increasing the number of retailers aware of the scheme and accepting the vouchers.

- **Healthy Schools Award –** an online tool to help schools self-validate against four core health themes; personal, social and health education, healthy eating, physical activity and social emotional and mental health. With each element schools can access support and guidance to achieve the required levels to achieve the award,
- **Volunteer Led Cooking (Grow It, Cook It, Eat It) –** The project aims to empower and encourage communities to make the best use of the food they have access to. The cooking course focuses on educating and strengthening the community's knowledge, skills and confidence of basic cooking skills while encouraging innovation using minimum ingredients and equipment to make nutritious meals.

3.7 Over the next 12 months further projects are planned including:

- **Love Exploring** – An app to encourage communities to explore their local areas, parks and green spaces more through walking. Creates bespoke activities to bring audio guides and augmented reality games to the local area. Free to all, the games and guided trails include quizzes that get the user hunting for clues as they explore the place they are visiting.
- **Playstreets -** Play Streets sessions involve low-key, temporary road closures, on a quiet residential street outside of rush hour and organised by neighbours, creating safe spaces for children to play out together and for people to connect informally on their doorstep.
- **Early Years (family centres and nurseries) and Primary School Support Package** – Development of a comprehensive support package for early years providers and primary schools so they have the knowledge, skills and resources to support healthy eating and physical activity. Provision of bite-sized workshops for families to develop their knowledge and ability to improve the health and well-being of their own family
- **Older Adults Physical Activity -** Create more opportunities for older people to be more active and increase awareness about the activities that are available across the county. Increasing awareness among people working with older residents about the benefits of physical activity in older age
- **Schools Growing Project** – Provision of guided growing sessions to encourage families to grow their own fruit and vegetables. With teacher training to show how to use the available resources and maintain growing within their school long-term.

4. Next steps and review

4.1. Partners will continue to work together to deliver the action plan for this priority, and updates will be provided to the Health and Wellbeing Board as appropriate.

4.2. Access to healthy affordable food is also a priority for the Opportunity Bucks programme at Buckinghamshire Council which aims to promote opportunities to level up health in Buckinghamshire. This provides a way to work with communities to identify what would work for

them to improve their health and quality of life. These relationships are important for delivering the action plan in a sustainable way.

5. Background papers

5.1. Appendix A - Health and Wellbeing Strategy Obesity and Physical Activity Theme Plan

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Appendix A Health and Wellbeing Strategy Obesity and Physical Activity Theme Plan

1. **Healthy Weight and Physical Activity**

BC – Buckinghamshire Council
BHT – Buckinghamshire Healthcare Trust
BOB ICB – Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board

Ref	Action	Lead	Dates	Baseline	Progress data
Start Well – Reducing the prevalence of obesity in children and young people	Development of a multi-agency action plan to address unhealthy weight in children in Buckinghamshire	BC Public Health	2023/24	18.2% Reception age children and 31.5% Year 6 age children overweight (including obesity) (21/22)	2022/23 plan delivered – refresh workshop taking place 18/04/23
	Develop a comprehensive support package for early years providers (family centres and nurseries) and primary schools so that they have the knowledge, skills, and resources to support healthy eating and physical activity	BC Public Health / Early Years	2023/24	New project – baseline to be established	Provider appointed for Early Years project – starts 06/23
	Delivery of MECC training to frontline staff working with children and adults to increase skills and confidence in talking to people about healthy lifestyles.	BC Public Health	Ongoing	228 frontline staff trained through collaboration with partners and including 70 trained by Public Health	To date 22/23 228 people have been trained in MECC
	Increase in the number of schools across Buckinghamshire achieving Healthy Schools Award	BC Public Health	2023/24	New project – baseline to be established	
	Delivery of social marketing campaign to increase the number of eligible families accessing the Healthy Start Scheme	BC Public Health	Jan 23 – Sept 24	Jan 23 56% eligible households accessed healthy start scheme	Contract awarded. Insight work commenced
	Increase referrals into child weight management services delivered through the Integrated Lifestyle Service for 7–13-year-olds identified	BC Public Health / Healthy Lifestyle Service Provider	Ongoing	112 completing (21/22 – last full year)	New Healthy Lifestyle Service commencing 1st April 2023. From 1st April KPI for new provider is 200

	as overweight or obese and increase numbers completing the programme (75% sessions)				children per annum accessing the programme
	Increasing the prevalence of mothers breastfeeding at 6 to 8 weeks following birth	BHT 0-19 service / Integrated Commissioning Team	Ongoing	58% of mothers breastfeeding at 6-8 weeks following birth	2022/23 Q1 and Q2 data is indicating 58.4% breastfeeding at 6-8 weeks (HV reporting)
Live Well – Reducing the prevalence of obesity in adults	Development of a multi-agency action plan to address unhealthy weight in adults in Buckinghamshire	BC Public Health	2023/24	62.4% adults classified as overweight or obese (20/21)	2022/23 plan delivered – refresh workshop taking place 18/04/23
	Referral of adults identified as overweight or obese to appropriate weight management services (includes services commissioned by ICB and PH)	BC Public Health / BOB ICB	Ongoing	2660 accessing services (20/21)	New Healthy Lifestyle Service commencing 1st April 2023
	Increase healthy food consumption and access to healthy foods for those who need it most through community growing and cooking initiatives	BC Public Health	2023/24	3 Tonnes of fresh fruit and vegetables donated to food banks and community fridges across Bucks (22/23)	Contract renewed for 23/24 growing season
	Delivery of a behaviour change rewards-based intervention (Better Points) to motivate and encourage communities to make healthier lifestyle choices	BC Public Health	2023/25	New project – baseline to be established	BetterPoints went live 10/01/23 - KPI for Yr. 1 is for 1000 downloads of the app with additional target of another 1000 in Yr. 2
	Encouraging communities and local business to make active travel (walking, cycling and wheeling) the norm	BC Transport Team	Ongoing	82.7% cycle or walk once a month 77.2% cycle or walk once a week 47% cycle or walk at least 3 x a week 33% cycle or walk at least 5 x a week (2021)	N.B – walking is over 10 mins and cycling any length)
Age Well – Increasing the physical activity of older people	Refresh of Physical Activity strategy for Bucks alongside development of associated action plan	BC Public Health	2023/24	69.2% adults physically active in Bucks (20/21)	New strategy and action plan in development for 2023-2028

	Maintain the Bucks Live Longer Better Alliance to support, guide and coordinate the offer to support adults in later life to recondition and build back physical and emotional wellbeing.	Leap	2021 - October 2023	N/A 35 partners engaged in LLB alliance 15 Instructors on the Health Network	7 Oomph on Demand Licences provided including 2 care homes (expired 12/22) Developed health instructor network with 15 attending 10 Licences provided to partners for Live Longer Better training
	The provision of volunteer and self-led community wellbeing walks accessible to the whole community regardless of fitness level	BC Public Health	Ongoing	65 volunteer led walks 700 residents regularly engaging with simply walks	
	Increase physical activity provision in social care, day centres and sheltered housing to increase the everyday movement and activity.	BC Public Health	Ongoing	New projects to be developed	Current projects are coming to an end in March ’23 and currently scoping out new projects.

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Health & Wellbeing Board Buckinghamshire

Buckinghamshire Suicide Prevention Action Plan 2022/23 and 2023/24

Date: 30 March 2023

Author/Lead Contacts: Becky Hitch, Public Health Principal and Louise Hurst, Consultant in Public Health, 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

1. Purpose of report

1.1. The Buckinghamshire Suicide Action Plan 2022/23 and 2023/24 is shared with the Buckinghamshire Health and Wellbeing Board to update the Board and for endorsement.

2. Recommendation to the Health and Wellbeing Board

1. The Board is asked to note and endorse the Buckinghamshire Suicide Action Plan 2022/23 and 2023/24.

3. Content of report

Background

3.1. Suicide is a major issue for society. It is a leading cause of years of life lost. When someone dies by suicide there is a huge impact on people that are close to them, people that know them and the community they live in. Suicide can be prevented and there are many ways that services, communities, individuals, and society can help prevent suicides.

3.2. Around 50 people take their own lives each year in Buckinghamshire. The Buckinghamshire suicide rate is similar to South-East and England rates. Over the last ten years, in both Buckinghamshire and England there has been an increase in deaths by suicide.

3.3. The Covid-19 pandemic and restrictions like lockdown have affected mental well-being for many people. The NHS has seen more people coming forward needing mental health support. In many cases these mental health problems are more complicated and need urgent care. The cost of living crisis is also likely to impact people's mental wellbeing, so it is more important than ever that we take action to prevent suicides.

3.4. Buckinghamshire has an active Suicide Prevention Partnership Group which has been running since 2015. Led by the Buckinghamshire Council Public Health Team, it includes people from the NHS, ambulance service, charities as well as people who have experienced suicidal thoughts or have lost family members to suicide. The group members use local data and national guidance to develop projects to prevent suicides.

Buckinghamshire Suicide Prevention Partnership Priorities

3.5. Each local authority area is required to have a Suicide Prevention Action plan which is to be developed and put into action together with by partners. The Plan has been developed by a wide range of partners using national and local evidence and data. The plan highlights five priority areas. For each priority area it sets out the actions to that will be taken to address it, expected outcomes, timescales, and lead partners.

3.6. The priority areas are:

1.	Reduce the risk of suicide in key high-risk groups
2.	Tailor approaches to improve mental health in specific groups
3.	Reduce access to the means of suicide
4.	Provide better information and support to those bereaved or affected by suicide
5.	Support research, data collection and monitoring

3.7. The plan will be delivered using existing funding from Buckinghamshire Council and its partners. Some specific projects are funded by other organisations, such as by NHS England, and funding for these has already been received.

3.8. Progress and impact of the plan will be monitored by the multi-agency Suicide Prevention Partnership Group using local data and reports from group members.

4. Next steps and review

4.1. A suicide audit will be completed for 2020-2022 to inform the refresh of the action plan from 2024/25 onwards.

5. Background papers

Appendix A: Buckinghamshire Suicide Prevention Action Plan 2022/23 and 2023/24

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Appendix A

Buckinghamshire Suicide Prevention Action Plan 2022/23 and 2023/24

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SUICIDE PREVENTION ACTION PLAN **12**

Background

Death by suicide is preventable. Each life lost is a tragedy. One suicide will always be one too many. When someone dies by suicide, the effect on people that are close to them – family, friends, colleagues – can be profound. But the impact can extend much wider, to those that have known them and the people in the community around them. Over the last decade, the trend in Buckinghamshire has mirrored the England picture and there has been an increase in deaths by suicide. We know that over the Covid-19 pandemic, as more people have experienced bereavement, loss of employment and financial difficulty and other negative impacts of restrictions used to control the virus, mental well-being has been negatively affected across our communities. The risk of deaths by suicide increases in times of economic downturn, therefore, action to prevent death by suicide is more important than ever. Alongside the actions set out in this plan, national and local programmes, such as "Levelling Up", will play a key role in addressing inequalities in known risk factors for death by suicide.

This action plan has been developed by Buckinghamshire's multi-agency Suicide Prevention Partnership Group. This Group has been delivering the Buckinghamshire Suicide Action Plan since it was first created in 2015, and monitoring suicides locally in real time since 2017. It includes representatives from the local authority, voluntary sector, community and acute health providers, emergency services, and other partners including people with experience of suicide ideation and people bereaved by suicide.

Aim

This plan aims to reduce the number of people that die by suicide in Buckinghamshire and provide support for those bereaved or affected by suicide. The impact of this plan will be monitored by assessing local trends and by comparing suicide rates in Buckinghamshire against national data and neighbouring counties.

By combining national and local evidence, five key areas for action have been identified to support delivery of this aim:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support research, data collection and monitoring

Context

- Suicide is used in this Plan to mean a deliberate act that intentionally ends one's life.
- Suicide is often the end point of a complex history of risk factors and distressing events.
- Suicide is a major issue for society and a leading cause of years of life lost. Suicides are not inevitable. There are many ways in which services, communities, individuals, and society as a whole can help to prevent suicides.
- Around 50 people take their own lives by suicide each year in Buckinghamshire. The Buckinghamshire suicide rate (10.8 suicides per 100,000 population for deaths registered in 2018-2020), is roughly the same as the South East and England rates. The suicide rates nationally, in Buckinghamshire and the South East have been rising steadily over the last ten years.
- Suicide affects children, young people, and adults – whether by taking their own life or as a person bereaved by suicide. Death by suicide (both nationally and locally) is highest in middle-aged men (peaking between 45 and 64). Nationally, suicide is a leading cause of death for young people aged 15–24 years.

Suicide and inequalities

Suicide is a major inequality issue. National research tells us:

- Men in their middle years, living in the most deprived areas, have more than double the risk of suicide compared with those living in the least deprived areas. The greater the level of deprivation experienced by an individual, the higher their risk of suicidal behaviour. People who are unemployed are two to three times more likely to die by suicide than those in employment.
- Increases in suicide rates have been linked to economic recessions.
- People working in less skilled occupations (e.g., construction workers) have higher rates of suicide.
- A low level of educational attainment and no home ownership increase an individual's risk of suicide.

Approach

Partnership: As a large percentage of suicidal individuals are not in contact with health or social care services, action is also required beyond the health and social care system. Real partnership is required with community groups, local business and the third sector to help identify and support people at risk of suicide and those bereaved by suicide. Key messages learned from practice and research are that suicide is preventable, that it is everyone's business, and that collaborative working is key to successful suicide prevention. This Plan has been developed by a wide range of partners to ensure that it is a collaborative effort, and that action to prevent suicide is a shared responsibility across Buckinghamshire.

Prevention and early intervention: The Plan supports early action to prevent individuals from reaching the point of personal crisis where they feel suicidal. This requires action much earlier and across a range of settings from General Practice to schools, the workplace and community groups.

Life-course: This Plan takes a "life course" approach aligned with the national suicide prevention strategy.

Evidence based: This Plan is informed by evidence. It uses national and local evidence to both identify areas of focus and specific need, and to inform the actions that will be taken to address need.

Inclusive of self-harm: The relationship between suicide and self-harm is complex. We know that many people who die by suicide have a history of self-harm, and we know that self-harm is a significant concern in its own right. This strategy will consider self-harm in relation to suicide risk.

How we will measure success: We want to see a reduction in Buckinghamshire's suicide rate, but we are mindful that the recent and anticipated global events will pose a significant challenge to this goal. Therefore, we will not only monitor local trends but compare them against national and neighbouring areas to assess our success. Because of the small numbers of deaths by suicide, it can be difficult to demonstrate statistically significant changes over time, we will therefore also use additional (proxy) measures to monitor our progress., this includes for example, levels of self-harm in the population.

National policy

In 2012 the government published Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives [1]. The strategy identifies six key areas for action:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

In March 2021 a fifth progress report of the cross-government suicide prevention strategy[2] was published by HM Government. The report highlighted:

- The importance of intelligence to monitor self-harm and suicide risk
- Pre-pandemic risk factors in vulnerable groups, particularly children and young people, men, and people with mental illness
- The exacerbation of risk factors during the pandemic whilst showing no escalation on suicide figures
- The impact of the pandemic on people bereaved by suicide; the increased risk posed by harmful online content; the need to improve population mental wellbeing; and the importance of ensuring everybody can recognise possible signs of suicidality and gain the skills to save a life

A new national Plan for Mental Health is being developed, and HM Government has announced that a separate national Suicide Prevention Plan will follow, to refresh the national strategy of 2012.

These national documents, as well as learning from other local authorities in suicide prevention combined with local intelligence have been taken into account in the development of our Buckinghamshire Plan. The plan will be refreshed when the new national Suicide Prevention Plan is launched.

[1] Preventing suicide in England - A cross-government outcomes strategy to save lives (publishing.service.gov.uk)
[2] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)

Data and intelligence on suicide in Buckinghamshire

Key data sources which inform this section are:

- Office of National Statistics
- Thames Valley Real Time Suicide Surveillance System[3]
- Preliminary data from the Buckinghamshire Suicide Audit[4] of deaths registered between 2017 and 2019

Suicide rates

On average around 50 people die by suicide in Buckinghamshire each year. Buckinghamshire's suicide rate (10.8 suicides per 100,000 population for deaths registered in 2018-2020) is statistically similar to the England and South East rates. Suicides in Buckinghamshire and England have in general increased since 2017. In 2020 (the latest available data) there were 57 deaths by suicide in Buckinghamshire recorded by the Office of National Statistics, compared to 33 in 2017. This is Buckinghamshire suicide rate increased from 7.3 deaths per 100,000 population in 2015-17 to 10.8 in 2018-20. In 2017 the Buckinghamshire rate was statistically lower than the South East and England rates. The Buckinghamshire rate in 2018-20 is statistically similar to the South East and England rates (see Appendix 1 for more information).

Gender and age

Men are more likely to take their own lives than women, both in Buckinghamshire and nationally. Preliminary data from the latest Buckinghamshire Suicide Audit shows that between 2017 and 2019 64% of suicides in Buckinghamshire were among men and 33% among women.

The majority of deaths by suicide in Buckinghamshire and England occur in middle age, particularly for men and this has been the case since around 2010. There were 49 deaths among people aged 45-64 in Buckinghamshire between 2017-19, of which around three quarters were men. The highest number of deaths of any age group occurred among those aged 50 to 54, for both men and women.

Nationally, suicide is a leading cause of death for young people aged 15–24 years. In Buckinghamshire 20 people aged 15-24 died by suicide between 2017 and 2019 with eight deaths among those aged 19 and under. This is an increase since the last audit of deaths registered in 2014-16. However great care must be taken when interpreting trends from some such small numbers.

[3] Buckinghamshire Real Time Suicide Surveillance System was established in 2017. Thames Valley Police Officers make a real time assessment of suicide at the scene they attend which is later cross referenced with the Buckinghamshire Coroner.

[4] The Buckinghamshire Suicide Audit is an audit of Coroner verdicts, which include 'suicide' and 'undetermined injury'. Data from the Office of National Statistics only includes deaths with a verdict of 'suicide'.

Contact with health services

30% of those who died by suicide in Buckinghamshire had been in touch with their GP two weeks before death, and 73% within the last three months. Of the cases who had been seen by their GP within the last two weeks 47% were in contact about their mental health.

28% of those who died by suicide in Buckinghamshire were known to mental health services (not necessarily services in Buckinghamshire) at time of death. Of these cases under the care of mental health services, the majority were under the care of the Community Mental Health Team, and the majority had a depressive or anxiety related illness.

Hotspots

There are no defined suicide hotspots in Buckinghamshire.

Impact of the pandemic and the economic crisis

It is still too early to know what effect the coronavirus pandemic has had on suicide rates so far. This is because it takes a long time to register, analyse and report on suicide data at a national level, and this has been further delayed due to the pandemic. Provisional suicide registrations for 2020 in England do not suggest an increase in rates, and early data from 'real-time surveillance' systems in several parts of England found no change in suicide trends following the first national lockdown (between April-October 2020). There were more suspected suicides in this period compared to the same period in 2019, but this was considered in line with the longer-term trend of rising suicide rates, rather than the impact of the pandemic. [5]

It is, however, likely that the pandemic will have enduring effects on the general population and vulnerable groups, compounded by the subsequent global economic crisis. Data from the national voluntary sector showed an increase in people seeking support for mental health issues comparing before with after lockdown. In 2020, PAPYRUS (the national charity for the Prevention of Young Suicide) saw a 20% increase in contacts from young people aged between 11 and 25 nationally during this period.

[5] One year on: how the coronavirus pandemic has affected wellbeing and suicidality. Samaritans. June 2021. Samaritans Covid 1 Year On Report 2021.pdf

Groups at higher risk of suicide

The following groups are at highest risk of suicide in Buckinghamshire. These groups have been identified through analysis of preliminary data from the Buckinghamshire 2017-19 Suicide Audit, and national data/evidence including the national strategy report Preventing Suicide in England: Fifth Progress Report

- Middle aged people, particularly men
- Children and young people aged 10-24
- Individuals who have previously self-harmed
- Individuals with mental illness, especially untreated depression
- People experiencing family and relationship problems; financial difficulties and debt (particularly for middle aged men); physical health conditions

Other groups at higher risk of suicide include:

- People who misuse alcohol and drugs, including those with coexisting mental health and drug/alcohol misuse problems
- People in contact with the criminal justice system
- People experiencing housing problems and homelessness; bereavement; loneliness; domestic abuse
- Lesbian Gay Bisexual Transgender (LGBT) groups; black and ethnic minority groups; asylum seekers (including from Ukraine); veterans
- Pregnant women and those who have given birth in the last year – nationally suicide is the leading cause of death occurring within a year after pregnancy[6]

[7]During the COVID 19 pandemic two categories of vulnerable individuals emerged:

- Those for whom the pandemic exacerbated existing problems (as above)
- Those for whom the pandemic resulted in significant and specific new issues, that we know are potential drivers of suicide. For example, job loss, unmanageable or mounting debts as a result of reduced income, bereavement and loneliness or social isolation.

As the current economic crisis unfolds it is likely that for many their existing problems will be further exacerbated. [8]Men in mid-life may be particularly vulnerable to the effect of economic adversity, with an increase in self-harm and suicide in this group particularly apparent after the 2008 recession.

[6] MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf (ox.ac.uk)
[7] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)
[8] Suicide and the 2008 economic recession: Who is most at risk? Trends in suicide rates in England and Wales 2001–2011 - ScienceDirect

Protective factors

When attempting to understand which factors promote resilience or vulnerability to suicide, it is important to consider a wide range of protective and risk factors. Suicide is complex, risk can change with circumstance, and what is a risk or protective factor for one person may not be the same for another in similar circumstances.

The below highlights some of the known protective factors that help mediate against suicidal behaviour in those at risk:

Society:

- Health system (effective and accessible services)
- Reduction of poverty

Individual:

- Hopefulness
- Problem-solving skills
- Being in control of behaviour, thoughts, emotions
- In positive employment
- Full and active life

Community:

- Social support
- Connectedness
- Supportive school and work environments

Relationships:

- Personal relationships
- Children
- Relationships at work

Self-harm

Self-harm is a concern in its own right, as well as being a risk factor for suicide. Not everyone that self-harms will have suicidal thoughts, whilst not everyone that dies by suicide will have self-harmed. However, we know that previous self-harm is an important predictor for suicide with the risk of suicide raised up to 49-fold in the year after self-harm, especially in the first month[9]. The risk of suicide after self-harm increases by 3% for every one year increase in age at hospital presentation; men are three times more likely to die by suicide after self-harm than women; and people who live in the least deprived areas have a greater risk of dying by suicide after self-harm compared to those living in the most deprived areas.[10]

Between 2017 and 2019 23% of people (all ages) who died by suicide in Buckinghamshire were known to have previously self-harmed, and 27% were known to have previously attempted to take their own life[11]. These figures may be an underestimate as evidence suggests around 50% of people who die by suicide have previously self-harmed[12].

The latest available data show that Buckinghamshire's rate of emergency admissions as a result of self-harm, all ages, (144.7 admissions per 100,000 population in 2018/19, 750 admissions) is below the national and South East averages. The South East rate is 199.7 admissions per 100,000 population and the England rate 196 admissions per 100,000)[13]. In addition, Buckinghamshire's rate for people aged 10-24 (370 admissions per 100,000 population in 2018/19, 325 admissions) is also similar to the national and South East averages (the South East rate is 470 admissions per 100,000 population and the England rate is 444[14]). There also has been no significant change since 2014/15.

It is important to note that this data is only the 'tip of the iceberg'. The majority of self-harm occurs in the community and does not lead to hospital attendance. Academic research also shows that data on hospital episodes underestimates the rate of hospital presentations for self-harm by around 60%, possibly due to data collection and reporting[15].

[9] Department of Health - Mental Health, Disability and Equality Division, Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives, (Feb 2015) accessed March 2015 at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf

[10] Geulayov, G, Casey, D, Bale, L, Bard, F, Clements, C, Farooq, B, Kapur, N, Ness, J, Waters, K, Tsiachristas, A & Hawton, K, (2019), Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: long-term follow-up study. Accessed from The Lancet Psychiatry.

[11] Preliminary data from the Buckinghamshire Suicide Audit of deaths registered between 2017 and 2019

[12] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)

[13] Please note the South East and England figures should be taken with caution due to data quality issues

[14] [14] Please note the South East and England figures should be taken with caution due to data quality issues

[15] Clements, C., Turnbull, P., Hawton, K, Geulayov, G., Waters, K., Ness, J., Townsend, E., Khundakar, K., Kapur, N. (2016). **Rates of self-harm presenting to general hospitals: a comparison of data from the Multicentre Study of Self-harm in England and Hospital Episode Statistics.** *BMJ Open*; **6**:e009749.

Suicide Prevention Action Plan

For each action a lead partner is named, though it is the expectation of the Buckinghamshire Suicide Prevention Partnership Group that all members will support the delivery of actions as relevant and required. A detailed performance dashboard developed by the Group is in Appendix 2. Some actions in the plan do not yet have an indicator on this dashboard as the projects are still being finalised. These will be finalised in the coming months, and relevant indicators identified. These projects are:

- The Children and Young People's Mental Health Strategic Group Action Plan
- Oxford Health Trust-wide Suicide Prevention Action Plan
- Three-year Public Mental Health and Well-being Action Plan to address inequalities in mental well-being

Priority 1: Reduce the risk of suicide in key high risk groups

The following groups are at higher risk of suicide in Buckinghamshire. These locally defined groups are in line with at risk groups identified by national guidance such as the national strategy report Preventing Suicide in England: A Fifth Progress Report.

- People who misuse alcohol and drugs, including those with coexisting mental health and drug/alcohol misuse problems
- People in contact with the criminal justice system
- People experiencing housing problems and homelessness; bereavement; loneliness; domestic abuse
- Lesbian Gay Bisexual Transgender (LGBT) groups; black and ethnic minority groups; asylum seekers; veterans
- Pregnant women and those who have given birth in the last year – nationally suicide is the leading cause of death occurring within a year after pregnancy

Ref.	Target Group	Action	Lead partner	Timescale	Anticipated outcome
1.1	Groups at higher risk (all ages)	Map the different services, organisations, and support groups (e.g., Helping Hands, Citizens Advice, Foodbanks, Gyms, Libraries, Men's Sheds, Housing services as well as Health Services) that each of the at risk groups are likely to have frequent contact with, i.e., their "touch points" in order to identify gaps and where pathways can be improved, and training delivered.	Bucks Council Public Health	March 2023	People with suicidal ideation or with mental health needs are identified, supported, and referred for support at an earlier stage.

1.2	Groups at higher risk (all ages)	Commission a programme of mental health and suicide prevention training to include groups identified by the mapping exercise (action 1.1)	Bucks Council Public Health	November 2022	People with suicidal ideation are identified, supported, and referred for support at an earlier stage.
		Develop and promote a website-based guide on mental health and suicide prevention for frontline workers to help them support clients with suicide ideation, self-harm, or in mental health crisis. - Website live (adults' information) - Promotion to partners - CYP info on website	South Central Ambulance Service	Autumn 2022 Winter 2022 March 2023	
		Partners to implement their own suicide prevention training for staff and students/pupils	All Partners	March 2024	
1.3	Children and Young People	The Children and Young (CYP) People's Mental Health Strategic Group to develop and deliver a three year action plan. Priorities are: 1. All organisations and services working with CYP, parents and/or carers will encourage and enable physical and mental wellbeing. 2. CYP who need support for their emotional wellbeing will be identified early, offered appropriate support and/or referred to services. 3. All CYP, their parents and/or carers and professionals working with children, know how to access mental health support/services if they need them, and receive the right help, in the right place when they need it. 4. All young people who are transitioning between services are supported throughout the process to ensure transfers are managed safely, appropriately and in a timely manner. 5. Adults living or working with children (inc. parents) receive the support they need to improve mental health for children. 6. CYP, parents, carers and other stakeholders will influence the development of prevention programmes and services through participation and feedback. Action plan developed	Children and Young People's Mental Health Strategic Group	April 2023	CYP receive emotional support early; CYP and their parents/carers know how to access mental health support/services and receive the help they need; CYP transitioning between services are supported to ensure transfers are managed safely, appropriately and in a timely manner.

1.4	University students	In academic year 22-23: • Implement suicide & MH first aid training, mental health advisors, student mentoring programme. • Increase awareness of MH support by improving the student induction process and relaunching the student services department. • Introduce Single Session Therapy for students delivered by wellbeing staff[16]	Bucks New University	Sept 2023	Students know what support is available; are identified early; and receive the support they need.
		Deliver a weekly Heathy Minds clinic at Bucks New Uni and support with MH promotion for all students and students attending courses with reported lower mental wellbeing.	Healthy Minds	Autumn 2022	
		Identify the specific needs of other universities and higher education institutions and scope actions to address these needs.	Bucks Council Public Health	March 2023	
1.5	Men	Deliver Wave 2 of Savings Lives male suicide grants programme and support currently funded projects to become self-sustaining.	Bucks Council Public Health	Nov 2022	Men at risk of suicide have the opportunity to take part in tailored community-based support which builds resilience, reduces the impact of stigma, and promotes positive mental health.
		Deliver the new one year 'Mind the Gap' men's wellbeing support group project launched in March 2022. Assess options for continuing for an additional year(s)	Buckinghamshire Mind	March 2023 March 2024	
		Reinvigorate and promote the Heads Up male suicide website launched in Men's Health Week (June).	Bucks Council Communications/BC PH	June 2023	
1.6	People with mental health disorders	Develop and deliver a new Trust wide suicide prevention strategy. Priority areas: gender, access and inclusion, substance misuse and research/monitoring/comms.	Oxford Health	2022-2025	Equal access to services when in suicidal crises; Evidence based interventions tailored to vulnerable groups; Services compliant with NICE guidance.

[16] Single Session Therapy is a single counselling session which focuses on cognitive restructuring and skills training. For some clients this is sufficient and for others this is a swift bridge to longer term support.

					Effective dissemination of research findings and development of plans for translation into practice; Effectively trained workforce.
1.7	People who self-harm	Deliver a trial of improved self-harm follow up. Service Users who present following self-harm or expressing suicidal thoughts who do not meet the referral criteria for secondary mental health care will have a safety plan and recommendations for support and will receive a follow up call within 48 hours to see if they need support to access the next stage of care.	Oxford Health	January 2023	Service Users will have improved safety planning, follow up and access to the next stage of care.
		Develop a new process using SCAS business intelligence to identify patients at clinical high risk of suicide and self-harm. Work with partners to develop and implement a red flag escalation process to inform partnership in practice and multi-agency frequent caller meetings. The relevant agencies at these meetings will then develop enhanced multi-agency support for these high risk patients. • Project scoping completed including development of dashboard • Detailed project plan developed	South Central Ambulance Service	 Nov 2022 Dec 2022	Clinically high-risk patients will be identified quickly and provided with associated wrap around support when, where and how they need it.
1.8	People in financial difficulty and debt	Develop the letters sent to residents regarding Council Tax debt to encourage repayments and support mental health using behavioural science techniques. Investigate the feasibility of developing different styles of letters depending on the recovery stage of the debt and characteristics of the debtor.	Bucks Council Revenues and Benefits Team; Bucks Council Public Health	Nov 2022 June 2023	Recover more council tax debt, recover it sooner and with lower impact on the mental health of our residents.
		Expand the financial insecurity pilot activity delivered in Wycombe to all of Bucks, with focused activity in Aylesbury and Chesham. Includes support, info and signposting on food insecurity, debt, benefits, gaining employment and returning to work.	Bucks Council, Community Support	Summer 2023	Support for people experiencing debt and financial insecurity is improved.
		Commission a new countywide model of support for people experiencing debt and financial insecurity.	Bucks Council, Community Support		Support for people experiencing debt and

		• Scope the model and infrastructure required to meet increasing demand • New model in place		Summer 2022 Sept 2023	financial insecurity is improved.
		Map the mental health training needs of 'front door' agencies involved in financial insecurity/debt, deliver training and signposting information.	Bucks Council Public Health and Community Support	November 2022	People with suicide ideation are identified, supported, and referred for support at an earlier stage.

Priority 2: Tailor approaches to support improvements in mental health in specific groups

As advised by the national guidance, the following groups may need tailored approaches to support improvements in their resilience and contribute to (with other actions) improved mental health.

- People who misuse alcohol and drugs, including those with coexisting mental health and drug/alcohol misuse problems
- People in contact with the criminal justice system
- People experiencing housing problems and homelessness; bereavement; loneliness; domestic abuse
- Lesbian Gay Bisexual Transgender (LGBT) groups; black and ethnic minority groups; asylum seekers; veterans
- Pregnant women and those who have given birth in the last year – nationally suicide is the leading cause of death occurring within a year after pregnancy
- Plus, some of the "at risk" groups identified through Priority 1.

Ref.	Target Group	Action	Lead partner	Timescale	Anticipated outcome
2.1	People with mental health struggles	Deliver the Champion the Change programme to address mental health stigma including four social media campaigns a year.	Bucks Mind	March 2024	People experiencing mental health struggles will live free of stigma which will encourage earlier access to informal and formal support.

2.2	People with coexisting substance misuse and mental health problems	Deliver the new joint working protocol between Oxford Health and One Recovery Bucks to improve referrals and communication between services. New post holder in post in One Recovery Bucks and regular clinician meetings between Oxford Health and ORB in place.	One Recovery Bucks / Oxford Health	March 2024	People with coexisting problems receive support for their mental health problems and drug or alcohol problems concurrently.
2.3	People in contact with the criminal justice system	Identify suicide risk for those individuals who have entered the Criminal Justice system into Police Custody, having been arrested or voluntarily interviewed about a criminal matter for which they are a suspect. Ensure appropriate care provision within custody and signposting to appropriate support services, ensuring risk management information is shared with relevant partners on transfer.	Thames Valley Police; Courts and Probation; Prisons	October 2023	People with suicide ideation are identified and referred for support throughout their criminal justice journey.
2.4	Employees with mental health struggles	Sign the Champion the Change Employer pledge to tackle mental health stigma in the workplace.	Bucks Council Organisational Development Team	October 2022	Staff will have good mental health and wellbeing, sickness absence from stress and mental health related issues will be low, and there will be a culture where people look out for each other, are safe and supported.
		Deliver the mental wellbeing actions in the new Health and Wellbeing Framework • Set up Employee Financial Hardship Task and Finish Group; Review how the organisation is utilising Mental Health First Aiders; Launch PAM Wellbeing App	Bucks Council Organisational Development Team	May 2022 July 2022 Dec 2022	

		• Train new and existing Mental Health First Aiders • Communications campaigns			
2.5	Ethnic minority groups, older people, children, and young people	Deliver a three-year Public Mental Health and Well-being Action Plan to address inequalities in mental well-being in Buckinghamshire communities (including projects to address inequalities for ethnic minority groups; older people; and children and young people)	Bucks Council Public Health	Winter 2022	Inequalities in public mental health will be reduced evidenced by appropriate indicators for each project (see plan).
2.6	Older adults, ethnic minorities physical health problems, LGBT groups.	Develop a set of marketing and communication tools/resources to engage with and promote the service to older adults, ethnic minorities, and LGBT groups.	Oxford Health - Healthy Minds	May 2022	Uptake of Healthy Minds services by underrepresented groups will be at the same level as the general population.
		Assess the service against the ethnic minority positive practice audit tool and deliver actions based on resulting recommendations.	Oxford Health - Healthy Minds	Dec 2022	
		Develop links with underrepresented communities, work with them to understand the barriers to engagement, and develop/deliver projects/pathways improve engagement. Groups include Pakistani, black, and African, men, LGBT, older adults, people living with and beyond cancer.	Oxford Health - Healthy Minds	March 2023	

2.7	Pregnant women and women who have given birth in the last year	Explore ways to support women who have lost a child due to perinatal/neonatal death, or whose child has been taken into care.	Perinatal Mental Health Network	April 2023	Women who have lost a child receive the mental health and family planning support they need, when they need it.
		Recruit an additional specialist Health Visitor for perinatal mental health.	Bucks Healthcare Trust Healthy Child Programme	Aug 2022	New mothers experiencing mental health struggles will be offered early support and where needed faster referrals to perinatal mental health services
2.8	Residents experiencing mental health struggles	As part of The Community Mental Health Framework, develop a team of Mental Health Practitioners to deliver brief mental health interventions within Primary Care Networks, support primary care with demand, and deliver a more integrated approach to mental health. Staff are employed jointly by Oxford Health and Primary Care Networks to deliver a more integrated approach to mental health interventions.	Oxford Health	Sept 2022	Service Users will receive mental health support within primary care to enable a holistic community-based approach to healthcare within their community, where appropriate and safe to do so.

Priority 3: Reduce access to the means of suicide and reduce imitational suicidal behaviour

Reducing or restricting access to the lethal means individuals use to attempt suicide is an important part of a comprehensive approach to suicide prevention.

Research evidence shows that certain types of media depictions, such as explicitly describing a method, sensational and excessive reporting, can lead to imitational suicidal behaviour among vulnerable people. In contrast, coverage describing a person or character coming through a suicidal crisis can serve as a powerful testimony to others that this is possible and can encourage vulnerable people to seek help. This objective aims to promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media and reduce the risk of additional suicides.

Ref.	Target Group	Action	Lead partner	Timescale	Anticipated outcome
3.1	All age groups	Monitor local media coverage to ensure reporting is line with Samaritans guidance and take appropriate action if instances of incorrect reporting take place, such as asking media to remove damaging or inappropriate reports.	Bucks Council Comms	Ongoing	Reporting of suspected suicides is sensitive, respectful, and follows Samaritans guidance.
3.2	All age groups	Use real time surveillance and other suicide data to monitor emerging hotspots and new suicide methods for prevention.	Thames Valley Police	Ongoing	Emerging hotspots and new suicide methods are identified early and where necessary postvention and prevention activity is put in place.

Priority 4: Provide better information and support to those bereaved or affected by suicide					
The provision of timely information and support to those bereaved or affected by suicide such as families, friends, colleagues, and peers, is important in supporting people through the different stages of bereavement and in preventing future mental ill health. We know that death of a family member or friend by suicide is a risk factor for suicide in the bereaved.					
Ref.	**Target Group**	**Action**	**Lead partner**	**Timescale**	**Anticipated outcome**
4.1	People bereaved by suspected suicide	Launch a new enhanced Suicide Bereavement Support Service across Buckinghamshire, Oxfordshire and Berkshire with initial support and signposting/referral being provided by Thames Valley Police, and ongoing support by Listening Ear.	Thames Valley Police, Listening Ear	August 2022	People bereaved by suicide receive practical/emotional support when, how and where they need it.
		Develop and implement a local Suicide Clusters Process • Develop • Implement	Bucks Council Public Health	Jan 2023 Ongoing	Emerging suicide clusters are identified quickly, and appropriate partnership based postvention work is implemented.
		Work with Bucks Bereavement Group to ensure staff/volunteers working for their services know the basics in supporting people bereaved by suicide, can spot the signs of suicide, and know where to refer.	Bucks Council Public Health	March 2023	Counsellors know how to spot the signs of suicide, and where to refer; counsellors understand the basics of supporting people bereaved by suicide.
4.2	Children and Young People	Following a light refresh in autumn 2022, fully reassess and re-promote the school's suicide postvention guide as part of the review cycle.	Bucks Council Public Health	Nov 2023	Schools are better prepared to support their staff and students in the event of a suicide.
4.3	Council Staff	Explore developing a suicide postvention process in the event a staff member takes their own life, or a staff member is bereaved by suicide of a loved one.	Bucks Council HR Policies Team	April 2023	Appropriate and timely support and signposting provided to affected staff.

Priority 5: Support research, data collection and monitoring					
It is important to build on the existing research evidence and other relevant sources of data on suicide and suicide prevention, and to use these regularly to inform local action.					
Ref.	**Target Group**	**Action**	**Lead partner**	**Timescale**	**Anticipated outcome**
5.1	All groups	Scope a method of comparing Buckinghamshire suicides with other local authority areas into the suicide audit and/or real time surveillance data which provides current information and accounts for population size and makeup.	Bucks Council Public Health	March 2023	Method for comparison established to better monitor local suicides.
		Finalise the local Suicide Audit and share learning to improve action planning.	Bucks Council Public Health	Autumn 2022	Audit to inform suicide action plan refresh.
		Review current and potential options to monitor trends and emerging clusters in partnership with colleagues across the Thames Valley.	Bucks Council Public Health / Thames Valley Police	March 2024	Improved identification of suicide clusters, including more robust data to inform response action; and to support system wide learning.

Appendix 1 – Suicide Data

Table 1. Number of suicides in Buckinghamshire 2017 to 2020. Source: Office of National Statistics

Year	No. suicides in Bucks
2020	57
2019	51
2018	45
2017	33

Table 2. Number of deaths and age-standardised suicide rates per 100,000 population for local authorities, rolling three year aggregates, deaths registered 2001 to 2020. Source: Office of National Statistics[17]

Year	No. suicides in Bucks	Bucks suicide rate	South East suicide rate	England suicide rate
2018-2020	153	10.8 (9.1-12.5)	10.1 (9.7-10.5)	10.4 (10.3-10.7)
2017-2019	129	9.2 (7.6-10.8)	9.6 (9.2-10.0)	10.1 (9.9-10.3)
2016- 2018	111	8.0 (6.5-9.5)	9.2 (8.8-9.6)	9.6 (9.5-9.8)
2015-2017	100	7.3 (5.9-8.7)	9.4 (9.0-9.8)	9.8 (9.6-10.0)

[17]

- Figures are for persons aged 10 years and over.
- The lower (LCI) and upper (UCI) 95% confidence limits have been provided as denoted by "10.8 (LCI 9.1 – UCI 12.5)" . These form a confidence interval, which is a measure of the statistical precision of an estimate and shows the range of uncertainty around the estimated figure. Calculations based on small numbers of events are often subject to random fluctuations. As a general rule, if the confidence interval around one figure overlaps with the interval around another, we cannot say with certainty that there is more than a chance difference between the two figures.
- The area is based on the persons usual residence
- Figures are based on the date of registration, as opposed to the date the death occurred, in each calendar year. Due to the length of time it takes to hold an inquest, it can take months or even years for a suicide to be registered

Appendix 2 – Performance Dashboard

The Performance Dashboard below in the embedded document has been developed by the Buckinghamshire Suicide Prevention Partnership to measure delivery of the action plan. Some actions in the plan do not yet have an indicator on this dashboard as the projects are still being finalised. These will be finalised in the coming months, and relevant indicators identified. These projects are:

- The Children and Young People's Mental Health Strategic Group Action Plan
- Oxford Health Trust-wide Suicide Prevention Action Plan
- Three-year Public Mental Health and Well-being Action Plan to address inequalities in mental well-being

Other actions will be measured by regular updates at the Suicide Prevention Group meetings with progress recorded in the measuring sheet on tab 2 in the embedded document below.

Please note this performance dashboard can be made available to members of the Health and Well-being Board on request.

Health & Wellbeing Board Buckinghamshire

How the Board Will Monitor the Success of the Joint Local Health and Wellbeing Strategy - Performance Data

Date: 30 March 2023

Author/Lead Contacts: Jacqueline Boosey, Business Manager Health and Wellbeing, 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

1. Purpose of report

1.1. The refreshed Joint Local Health and Wellbeing Strategy (JLHWS) and action plan were approved at the September 2022 Health and Wellbeing Board (HWB).

1.2. The action owners have proposed measures and targets which will measure the success of the JLHWS.

1.3. This report is to agree the baseline data and approach to monitoring progress.

2. Recommendation to the Health and Wellbeing Board

2.1. To note and agree the performance measures and targets in the attached table (appendix A).

2.2. To note and agree the frequency of monitoring at the Health and Wellbeing Board as set out in paragraph 3.6.

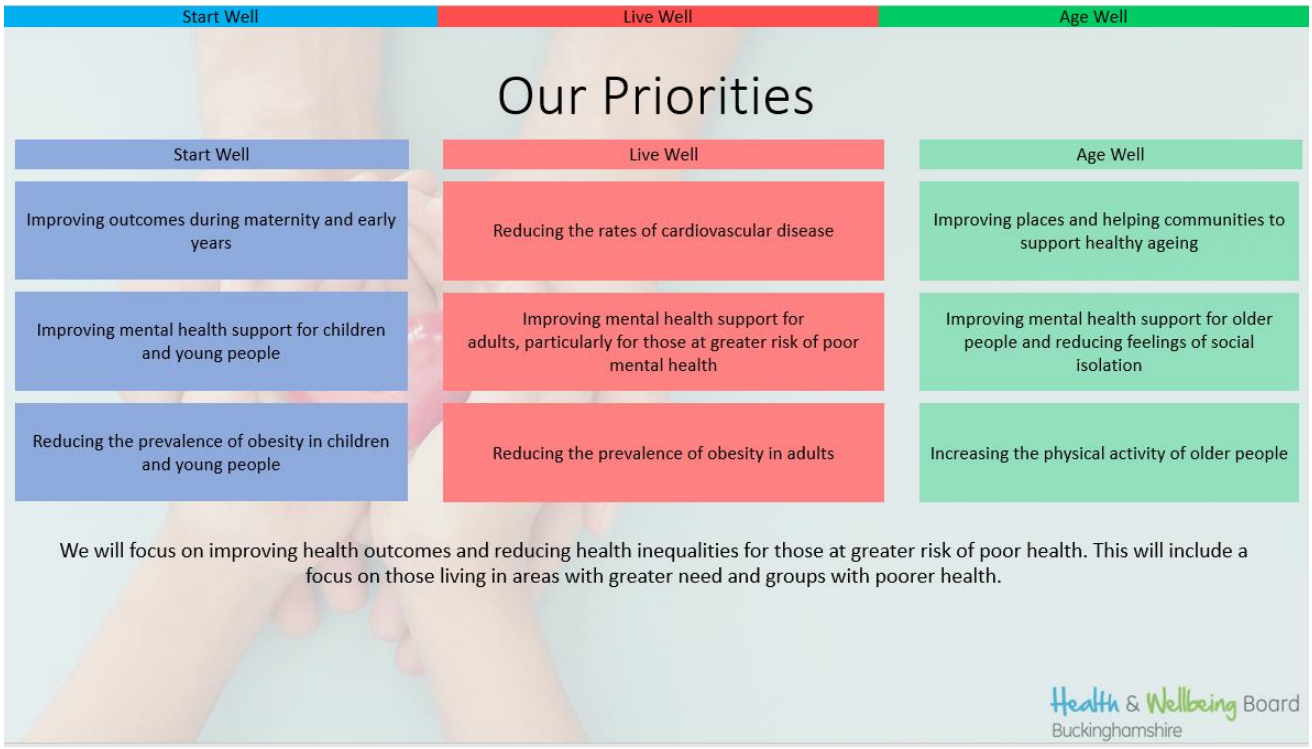
2.3. To note that the performance dashboard is under development.

3. Content of report

Background

3.1. The refreshed Joint Local Health and Wellbeing Strategy (JLHWS) and action plan are in place for three years until September 2025.

3.2. There are three strategic themes, Start Well, Live Well and Age Well with three priorities identified for each strategic theme:



3.3. Leads have been agreed for each of the nine priorities across Health and Wellbeing Board partners. The action plans for each of the nine priorities will be used to hold Board members to account for delivery of the actions.

3.4. Each lead has been asked to provide performance measures for the Board to monitor the delivery of the action plans. The aim for each plan is to improve the health and wellbeing of Buckinghamshire residents and reduce health inequalities.

3.5. This report summarises the proposed performance measures which can be found in appendix A.

3.6. A number of measures are dependent on release of data from national bodies, which can often be received up to six months after the period of monitoring. A majority of these performance measures are captured annually. It is proposed that the performance measures are presented to the Board annually.

3.7. In order to ensure that progress is monitored regularly, it is proposed that after discussion of initial action plans short regular updates on progress and help required are brought to the Board on a six monthly basis.

Start Well

Improving outcomes during maternity and early years

3.8. What are the measures?

- Percentage of women who are smokers when they give birth
- Percentage of children achieving at least expected development levels on their two to two and a half year old health visitor assessment in our most deprived areas
- Percentage of babies who are breastfed from birth until they are at least six to eight weeks old

3.9. Why have these measures been chosen?

- Smoking during pregnancy is the most preventable risk factor for low birth weight, premature birth and miscarriage. Those who smoke in pregnancy are more often living in deprived areas where people already have poorer health outcomes.
- A young child's early development of skills such as communication and problem-solving is essential to ensure that they can get the most out of their education when they start school. Currently children from more deprived areas are less likely to achieve the key development milestones which are so important for school readiness.
- Babies that are breastfed have a lower risk of asthma, obesity, diabetes, and sudden infant death syndrome (SIDS), but breastfeeding is less likely to be initiated and sustained by women living in more deprived communities.

Improving mental health support for children and young people

3.10. What are the measures?

- The number of children and young people (aged under 18) that have accessed support from NHS funded community services and school or college based Mental Health Support Teams in the last 12 months
- The gap in the proportion of children and young people (aged under 18) that have accessed support from NHS funded community services and school or college based Mental Health Support Teams in the last 12 months, between the most and the least deprived fifths of the population

- The number of women that are pregnant, or recently had a baby, that have accessed support from a specialist community mental health service (face to face or video) in the last 12 months

3.11. Why have these measures been chosen?

- National data show that not all children and young people are able to access mental health support when they need it. We want to make sure that more children and young people that need mental health support in Buckinghamshire can access it
- Children in the poorest households in the UK were 4 times more likely to have serious mental health difficulties by the age of 11 then those in wealthiest. We want to make sure that children and young people living in more deprived areas are as able to access support as those living in the least deprived areas
- Historically, not all women in England that need mental health support in pregnancy and the first year after birth have had good access to support. We want to make sure that women that need support for their mental health at this time can access it.

Reducing the prevalence of obesity in children and young people

3.12. What are the measures?

- Percentage of children in Reception year at school who are overweight and obese
- Percentage of children in Year 6 at school who are overweight and obese
- Percentage of eligible families accessing the Healthy Start scheme
- Number of children accessing weight management services in Buckinghamshire

3.13. Why have these measures been chosen?

- The National Child Measurement programme (NCMP) is a mandatory screening programme delivered by the Local Authority which measures the height and weight of children in Reception and Year six at state-funded schools on an annual basis giving an accurate picture of current prevalence
- Healthy Start is a government food assistance programme for low-income families. It provides financial support to low-income families and pregnant women for fruit, vegetables, pulses, milk or infant formula.

Live Well

Reducing the rates of cardiovascular disease

3.14. What are the measures?

- The number of eligible people in priority risk groups (in the 40% most deprived areas in Buckinghamshire) who have an NHS Health Check each year
- The percentage of eligible of patients who were referred to NHS tobacco dependency services (acute inpatients, maternity and mental health inpatients) who later successfully quit smoking (four week quit)

- Proportion of patients (15+) who have had their blood pressure checked in the last year in the four most deprived Primary Care Networks
- Proportion of patients under 80 years old with hypertension whose last blood pressure reading (in the last 12 months) was less than or equal to 140/90 mmHg for the four most deprived Primary Care Networks.

3.15. Why have these measures been chosen?

- Residents living in our most deprived areas and people from certain ethnic groups are at a higher risk of cardiovascular disease than the Buckinghamshire average. The NHS Health Check aims to reduce the risk of a person's cardiovascular disease by identifying people's risk factors and what they can do about it. Over the last five years, residents in more deprived areas have received fewer NHS Health Checks compared to residents in less deprived areas. To improve the outcomes of residents at increased risk of cardiovascular disease, there should be an increase in their access and experience of preventative services like the NHS Health Check and smoking cessation services.
- NHS inpatients (acute and mental health) and maternity patients who smoke should be offered the opportunity to quit smoking while under the care of the NHS. This approach has been shown to be successful at increasing the number of residents who stop smoking thus reducing a wide range of health problems including cardiovascular disease and cancer.
- Residents in the more deprived areas of the county are more like to develop high blood pressure earlier than residents in other areas. However, they are less likely to be identified early and have their blood pressure managed appropriately. Therefore, increasing the numbers of higher risk residents who check their blood pressure regularly will increase the numbers seeking support sooner.

<u>Improving mental health support for adults particularly for those at greater risk of poor mental health</u>

3.16. What are the measures?

- Reduce the gap in the percentage of white British and ethnic minority patients with a mental health emergency that have not previously had contact with mental health services
- Reduce the gap in patients that complete NHS Talking Therapies treatment between those living in the most and least deprived areas in Buckinghamshire
- Increase the percentage of patients with a Severe Mental Illness (have a diagnosis of schizophrenia, bipolar affective disorder or psychosis) that have had a full physical health check with their doctor in the last 12 months (all components)

3.17. Why have these measures been chosen?

- People from some groups find it harder to access mental health services when they need them and have a poorer experience of services when they do. This includes people from certain ethnic minority groups. We want to ensure people can access mental health support earlier, and not as an emergency, regardless of their ethnic group.
- Emergency mental health admissions are also higher in our more deprived areas. NHS Talking Therapies are an evidence based early treatment for people that need support with their mental health and we want to ensure that people living in deprived areas are as able to access and complete treatment as those living in the least deprived areas.
- People with a severe mental illness (schizophrenia, bipolar disorder, and major depressive disorder) have an 85% higher chance of dying from cardiovascular disease compared with people that do not. Physical health checks can help to identify and manage risk factors earlier.

<u>Reducing the prevalence of obesity in adults</u>

3.18. What are the measures?

- Percentage of adults classified as overweight or obese
- Number of adults accessing adult weight management services in Buckinghamshire
- Percentage of adults meeting the recommended physical activity levels

3.19. Why have these measures been chosen?

- Tackling obesity is a long-term health challenge with many causes. Obesity prevalence continues to rise in both men and women, and it is a significant health risk, associated with increased risk of diseases including diabetes, heart disease and some cancers, alongside implications for mental health and a reduction in life expectancy. Obesity rates are highest in the most deprived areas and are higher in some ethnic minority groups.

Age Well

<u>Improving places and supporting communities to promote healthy ageing</u>

3.20. What are the measures?

- Healthy life expectancy at age 65 (males and females)
- Proportion of people aged 65+ who are economically active
- Third metric (process-based) to be agreed once healthy ageing strategy produced

3.21. Why have these measures been chosen?

- Increasing healthy life expectancy is an ultimate outcome to strive for in a population and represents real success at a system level and across the full length of people's lives. There is a lag in reporting so it is worth noting that it will get worse before it gets better due to the direct impact of the Covid-19 pandemic, so this will be a long-term sustained ambition. We

know that economic activity in older adults reduced during the pandemic so we expect this measure will be a more responsive marker of recovery for the health of a population, as well as labour shortages being an issue in their own right.

Improving mental health support for older people and reducing feelings of social isolation

3.22. What are the measures?

- The proportion of adults reporting feeling lonely often/always or some of the time
- The proportion of people aged over 65 estimated to have dementia that have been diagnosed
- The number of people aged 65 and over who enter treatment with NHS Talking Therapies

3.23. Why have these measures been chosen?

- Loneliness increased in adults in Buckinghamshire with the start of the Covid pandemic, and this is on a background of a longer term trend of more older adults living alone across the South East. Reduced loneliness is a marker of improved wellbeing itself, but also reduces the risk of developing dementia and is often accompanied by greater physical activity.
- Providing a timely dementia diagnosis enables the provision of treatment and support to people living with dementia and their carers to reduce the impact of the condition and facilitate better health and care outcomes.
- Older people with common mental health problems are six times more likely to be prescribed medication and less likely to receive talking therapies than younger people. We want to make sure people over the age of 65 are as able to access talking therapies as people in younger age groups.

Increasing the physical activity of older people

3.24. What are the measures?

- Increase the number of 65+ year olds utilising local leisure centres
- Educate health professionals to be able to provide physical activity advice to older age clients
- Increase the number of older adults achieving two or more sessions of muscle strength exercises per week

3.25. Why have these measures been chosen?

- Local adult physical activity levels are monitored through national surveys which do not provide age breakdowns. Monitoring the number of older adults accessing services or offered guidance and support via a health professional is the most reliable proxy measure of success.

4. Next steps and review

4.1. Development of supporting data including contributions from VCSE over April to September.

4.2. Development of performance dashboard for the HWB internet site over April to September.

5. Background papers

5.1. Appendix A - Joint Local Health and Wellbeing Strategy 2022 – 2025 Action Plan Performance Measures

Appendix A

Health & Wellbeing Board Buckinghamshire

Joint Local Health and Wellbeing Strategy 2022 – 2025 Action Plan Performance Measures

Start Well Priority Area	Action	How Will we Know it's Working?	Performance Measure	Baseline	Target	To be Delivered by	Frequency at HWB	Lead Officer	Responsible Board Member
Improving outcomes during maternity and early years	Increase the number of pregnant women referred to and accepting support to stop smoking and successfully quitting smoking, leading to a smaller proportion of women still being smokers when they give birth.	There will be a reduction in the number of women smoking during pregnancy The health of mothers and their babies in Buckinghamshire will improve	Percentage of women who are smokers when they give birth	7%	5%	Mar-25	Annual	Heidi Beddall, Director Of Midwifery, Buckinghamshire Healthcare Trust	Neil Macdonald, Chief Executive, Buckinghamshire Healthcare Trust
	Increase the proportion of children in the most deprived communities achieving all milestones at the 2 to 2 ½ year health visitor review, with the aim of narrowing the gap in school readiness (measured by EYFSP scores in reception year).	Reduced inequalities in the proportion of children meeting their expected development goals at 2 to 2 and ½ years Children from deprived areas will be better prepared for school, enabling them to get greater benefit from their education	Percentage of children achieving at least expected development levels on their 2 to 2½ year old health visitor assessment in our most deprived areas	87%	90%	Dec-25	Annual	Heidi Beddall, Director Of Midwifery, Buckinghamshire Healthcare Trust	Neil Macdonald, Chief Executive, Buckinghamshire Healthcare Trust
	Increase the proportion of babies that are breastfed from birth until at least 6 to 8 weeks old	There will be an increase in the number of babies that are exclusively and partially breastfed at birth and 6-8 weeks old	Percentage of babies who are breastfed from birth until they are at least 6 to 8 weeks old	TBD	TBD	TBD	TBD	Heidi Beddall, Director Of Midwifery, Buckinghamshire Healthcare Trust	Neil Macdonald, Chief Executive, Buckinghamshire Healthcare Trust
Start Well Priority Area	**Action**	**How Will we Know it's Working?**	**Performance Measure**	**Baseline**	**Target**	**To be Delivered by**	**Frequency at HWB**	**Lead Officer**	**Responsible Board Member**
Improving mental health support for children and young people	Increase access to mental health support for Children and Young People in response to need (<u>including</u> early support to mitigate demand on specialist services)	Children and Young People receive the Mental Health support they need when they need it	The number of children and young people (aged under 18) that have accessed support from NHS funded community services and school or college based Mental Health Support Teams in the last 12 months	6,830	N/A	Mar-24	Annual	Donna Clarke, Service Director Buckinghamshire, Oxford Health Foundation Trust	David Walker, Chairman, Oxford Health Foundation Trust
	Address inequalities in access to mental health support through work with Children and Young People in deprived areas and ethnic minority Children and Young People to • Increase knowledge about mental health • Increase awareness of support available	Reduced inequalities in mental health outcomes for children and young people living in deprived areas and ethnic minority groups	The gap in the proportion of children and young people (aged under 18) that have accessed support from NHS funded community services and school or college based Mental Health Support Teams in the last 12 months, between the most and the	TBD	Under develop ment	TBD	Annual	Donna Clarke, Service Director Buckinghamshire, Oxford Health Foundation Trust	David Walker, Chairman, Oxford Health Foundation Trust

	• Address stigma • Ensure accessible support with appropriate referral to specialist services Address barriers to access, experience and outcomes in Child and Adolescent Mental Health Services (cultural competency)		least deprived fifths of the population)						
	Improve access to perinatal mental health services for women from ethnic minority background, for young mothers (age 16-25), for women living in deprived areas	Pregnant women and new mothers receive the mental health support they need and there will be improved outcomes in early years Reduced inequalities in mental health outcomes for children and young people living in deprived areas and ethnic minority groups	The number of women that are pregnant, or recently had a baby, that have accessed support from a specialist community mental health service (face to face or video) in the last 12 months	285	548	Mar-25	Annual	Donna Clarke, Service Director, Buckinghamshire Oxford Health Foundation Trust	David Walker, Chairman, Oxford Health Foundation Trust
Start Well Priority Area	**Action**	**How Will we Know it's Working?**	**Performance Measure**	**Baseline**	**Target**	**To be Delivered by**	**Frequency at HWB**	**Lead Officer**	**Responsible Board Member**
Reducing the prevalence of obesity in children and young people	Develop a comprehensive support package for early years providers and primary schools so that they have the knowledge, skills, and resources to support healthy eating and physical activity Increase in the number of schools across Buckinghamshire achieving Healthy Schools Award	Reduction in the percentage of children in Reception who are overweight and obese Reduction in the Percentage of children in Year 6 who are overweight and obese	Percentage of children in Reception who are overweight and obese 31.5%	18.2%	18% 31%	2025 2025	Annually Annually	Sally Hone, Public Health Principal, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Increase healthy food consumption and access to healthy foods for those who need it most Increase in the number of eligible families signed up and accessing the Healthy Start Scheme	More children meeting the minimum 5 fruit and vegetables a day / eating healthier diets	Percentage of eligible families accessing the Healthy Start scheme	56%	65%	2025	Monthly	Sally Hone, Public Health Principal, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Increase access to weight management services for 7–13 year-old's identified as overweight or obese Increase in the number of children accessing weight management services	Children supported to achieve and maintain a healthy weight	Number of children accessing weight management services	100	150	2022/23	Quarterly	Sally Hone, Public Health Principal, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council

Live Well Priority Area	Action	How Will we Know it's Working?	Performance Measure	Baseline	Target	To be Delivered by	Frequency at HWB	Lead Officer	Responsible Board Member
Reducing the rates of cardiovascular disease	Increase access to NHS Health Checks in priority risk groups	More people are advised about their cardiovascular disease risk earlier and supported to get the help they need resulting in fewer in Buckinghamshire having cardiovascular disease	Number of all NHS Health Checks delivered that were for residents in DQ4 and 5	1393 (21/22)	2700	End of 23/24	Annually	Tiffany Burch, Consultant in Public Health, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Increase access to tobacco dependency services, particularly for people from deprived areas and ethnic minorities	More people are supported to quit smoking and maintain this status resulting in fewer in Buckinghamshire having cardiovascular disease The in house tobacco dependency services for acute inpatients, mental health inpatients and maternity patients will be up and running with agreed discharge pathways to community stop smoking services.	The number and percentage of eligible patients who were referred to NHS inhouse tobacco dependency services who later successfully quit smoking (4 week quit).	0%	30%	end of 23/24	Annually	Steve Goldensmith, Senior Responsible Officer for Prevention and Health Inequalities, BOB ICB*	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Increase numbers of residents aged 15 years and older who have their blood pressure checked, and increase the number of residents with hypertension who are well controlled in higher risk areas of the county.	More people take part in regularly checking their blood pressure in the 4 most deprived Primary Care Networks This will ultimately result in more high blood pressure being detected and managed earlier in life to reduce the burden of heart disease and stroke, resulting in fewer residents in Buckinghamshire having cardiovascular disease	Proportion of patients (15+) who have had their blood pressure checked in the last year in the 4 most deprived Primary Care Networks	30.4%	50%	End of 2023/24	Annually	Philippa Baker, Place Director for Buckinghamshire, BOB ICB*	Philippa Baker, Place Director for Buckinghamshire, BOB ICB* Jane O'Grady, Director of Public Health, Buckinghamshire Council
			Proportion of patients aged <80 years with hypertension who last blood pressure reading (in the last 12 months) was <= 140/90 mmHg for the 4 most deprived Primary Care Networks	57%	60%	End of 2023/24	Annually	Philippa Baker, Place Director for Buckinghamshire, BOB ICB*	Philippa Baker, Place Director for Buckinghamshire, BOB ICB* Jane O'Grady, Director of Public Health, Buckinghamshire Council
Live Well Priority Area	**Action**	**How Will we Know it's Working?**	**Performance Measure**	**Baseline**	**Target**	**To be Delivered by**	**Frequency at HWB**	**Lead Officer**	**Responsible Board Member**

Improving mental health support for adults particularly for those at greater risk of poor mental health	Improve access, experience and outcomes from services particularly for people from deprived areas and ethnic minorities with mental health problems	Reduced inequalities in mental health outcomes for people, particularly from deprived areas and for ethnic minority groups	Reduce the gap in the percentage of white British and ethnic minority patients with a mental health emergency that have not previously had contact with mental health services	Under development	TBD	TBD	TBD	Donna Clarke, Service Director Buckinghamshire, Oxford Health Foundation Trust	David Walker, Chairman, Oxford Health Foundation Trust
	Improve access to talking therapies (IAPT) for people from ethnic minorities, students, men and LGBTQ+ communities	Reduced inequalities in mental health outcomes for people from under-served communities	Reduce the gap in patients that complete NHS Talking Therapies treatment between those living in the most and least deprived areas in Buckinghamshire	Under development	TBD	TBD	TBD	John Pimm, Consultant Clinical Psychologist, Oxford Health Foundation Trust	David Walker, Chairman, Oxford Health Foundation Trust
	Address physical health inequalities for people with a mental disorder	Improved healthy life expectancy for people with mental disorders or Serious Mental Illness	Increase the percentage of patients with a Severe Mental Illness (have a diagnosis of schizophrenia, bipolar affective disorder or psychosis) that have had a full physical health check with their doctor in the last 12 months (all components)	48.2%	50%	Mar-25	Quarterly	Donna Clarke, Service Director Buckinghamshire, Oxford Health Foundation Trust	David Walker, Chairman, Oxford Health Foundation Trust
Live Well Priority Area	**Action**	**How Will we Know it's Working?**	**Performance Measure**	**Baseline**	**Target**	**To be Delivered by**	**Frequency at HWB**	**Lead Officer**	**Responsible Board Member**
Reducing the prevalence of obesity in adults	Partners deliver the healthy weight action plan to reduce the proportion of adults who are overweight or obese	People are a healthy weight and there is a reduction in long term conditions and improved mental health	Percentage of adults classified as overweight or obese	61%	61%	2025	Annually	Sally Hone, Public Health Principal, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Increase the number of adults accessing support to lose weight	People are supported to achieve or maintain a healthy weight	Number of adults accessing adult weight management services per year	2,660	3,500	2022/23	Quarterly	Sally Hone, Public Health Principal, Buckinghamshire Council Angela Jessop, Transformation Manager, Integrated Care Board	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Increase physical activity levels	People take part in regular physical activity	Percentage of adults meeting the recommended physical activity levels	71.9%	73%	2025	Annually	Sally Hone, Public Health Principal, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council

Appendix A

Health & Wellbeing Board Buckinghamshire

Age Well Priority Area	Action	How Will we Know it's Working?	Performance Measure	Baseline	Target	To be Delivered by	Frequency at HWB	Lead Officer	Responsible Board Member
Improving places and supporting communities to promote healthy ageing	Develop a system wide approach to healthy ageing through the development of a multi-agency strategy and action plan	People over the age of 65 spend more years of life in good health Buckinghamshire is a place where the natural and built environments and the approach of organisations support people to live healthy and independent lives	Increase in healthy life expectancy at age 65 (males) Increase in healthy life expectancy at age 65 (females)	12.4 13.7	TBD TBD	TBD TBD	Annually Annually	Sarah Winchester, Consultant in Public Health, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Work with partners to promote positive age-inclusive communication and reduce age-related discrimination	The proportion of people aged over 65 who are in work will increase towards pre-pandemic levels More older people are supported and able to participate as fully in society as they wish	Increase in number of people aged 65+ who are economically active	13%	16%	Mar-28	Quarterly	Sarah Winchester, Consultant in Public Health, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Third key action to be agreed during first year of Health and Wellbeing Strategy once Healthy Ageing Strategy in place and priorities have been agreed with partners								

Age Well Priority Area	Action	How Will we Know it's Working?	Performance Measure	Baseline	Target	To be Delivered by	Frequency at HWB	Lead Officer	Responsible Board Member
Improving mental health support for older people and reducing feelings of social isolation	Build social connectedness for older adults through initiatives developed by the Healthy Ageing Collaborative and increased use of social prescribing in primary care	Older adults are able to create social contacts in their communities and become less isolated Fewer older adults will feel lonely	Reduction in the proportion of adults feeling lonely often/always or some of the time	24%	18%	Mar-24	Bi annual	Lucie Smith, Public Health Principal, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Improve the detection and formal diagnosis of dementia	People with dementia receive more timely health and care, improving outcomes	Increase the proportion of people aged over 65 with dementia that have been diagnosed	56.8%	66.7%	Mar-25	Annual	Donna Clarke, Service Director Buckinghamshire, Oxford Health Foundation Trust	Sian Roberts, Clinical Lead for Mental Health, Integrated Care Board
	Improve access to, and uptake of, talking therapies in older people with anxiety disorders and depression	Older adult experience improvements in their mental health	Increase the number of people aged 65 and over who enter treatment with NHS Talking Therapies	215	TBD	Mar-25	Annual	John Pimm, Consultant Clinical Psychologist, Oxford Health Foundation Trust	David Walker, Chairman, Oxford Health Foundation Trust

Age Well Priority Area	Action	How Will we Know it's Working?	Performance Measure	Baseline	Target	To be Delivered by	Frequency at HWB	Lead Officer	Responsible Board Member

Increasing the physical activity of older people	Increase awareness of the benefits of physical activity and what counts as physical activity amongst older people, using the behavioural insights work	More people are physically active in older age	Return usage numbers of local leisure centres by people aged 65+ to pre-pandemic levels	13,975	14,000	2025/26	Quarterly	Sue Drummond, Head of Leisure, Buckinghamshire Council	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Increase awareness among people working with older residents about the benefits of physical activity in older age	More older adults are regularly active and meeting the recommended activity levels	Number of health professionals trained to provide physical activity advice to older age clients	88	100 per annum	Mar-24	Annually	Chris Gregory, Head of Strategic Relationships LEAP	Jane O'Grady, Director of Public Health, Buckinghamshire Council
	Create more opportunities for older people to be more active and increase awareness about the activities that are available across the county	Improved physical function and a reduction in the risk of falls and injury from a fall and subsequent loss of independence	More adults achieving 2 or more sessions of muscle strength exercises per week	47.6%	50%	Mar-27	Annually	Sally Hone, Public Health Principal, Buckinghamshire Council	Councillor Angela Macpherson, Cabinet Member Health & Wellbeing, Buckinghamshire Council