Health & Adult Social Care Select Committee Agenda

Date: Thursday 11 May 2023

Time: 10.00 am

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

Membership:

J MacBean (Chairman), S Adoh, P Birchley, P Gomm, T Green, C Heap, H Mordue, S Morgan, C Poll, G Sandy, R Stuchbury, A Turner, N Thomas, M Walsh, J Wassell and Z McIntosh (Healthwatch Bucks)

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Agenda Item		Time	Page No
1	**Apologies for Absence**	**10:00**	
2	**Declarations of Interest**		
3	**Minutes of the Previous Meeting** To confirm the minutes of the meeting held on Thursday 9th February 2023 as a correct record.		**5 - 12**

4 Public Questions

Public Questions is an opportunity for people who live, work or study in Buckinghamshire to put a question to a Select Committee. The Committee will hear from members of the public who have submitted questions in advance relating to items on the agenda. The Cabinet Member, relevant key partners and responsible officers will be invited to respond.

Further information on how to register can be found here: https://www.buckinghamshire.gov.uk/your-council/getinvolved-with-council-decisions/select-committees/

5 Chairman's update

6 Evaluation of System Winter Plan **10:10** **13 - 26**

The Committee reviewed the System Winter Plan at its September meeting so this is an opportunity to hear from system leads about what worked well and what lessons have been learnt to help inform the Winter Plan for this year.

Contributors:

Ms Caroline Capell, Director of Urgent and Emergency Care, Buckinghamshire Healthcare NHS Trust
Dr George Gavriel, Chair, Bucks GP Leadership Group
Mr Raghuv Bhasin, Chief Operating Officer, Buckinghamshire Healthcare NHS Trust
Cllr Angela Macpherson, Cabinet Member for Health & Wellbeing
Mr Craig Mcardle, Corporate Director, Adults & Health
Ms Sara Turnbull, Service Director, Adult Social Care (Operations)
Mr Mayank Patel, Chief Officer, Bucks Local Pharmaceutical Committee

7 Development of Primary Care Networks Inquiry - 6 month recommendation monitoring **11:10** **27 - 34**

The Select Committee undertook an inquiry into the development of primary care networks in Buckinghamshire last year and this item is an opportunity to review the progress being made in implementing the recommendations which were made in the report.

Contributors

Ms Philippa Baker, Place Director
Mr Simon Kearey, Head of Primary Care Development and Delivery
Cllr Angela Macpherson, Cabinet Member for Health & Wellbeing
Mr Craig Mcardle, Corporate Director, Adults & Health
Ms Sara Turnbull, Service Director, Adult Social Care (Operations)

Papers

6 month recommendation monitoring response table

8	**Maternity Services**	**11:40**	**35 - 50**

Committee Members will receive an update on the proposed model for improving maternity services in Buckinghamshire.

Contributors

Nr Neil Macdonald, Chief Executive, Buckinghamshire Healthcare NHS Trust (BHT)
Ms Heidi Beddall, Director of Midwifery, BHT
Mr Ian Currie, Chair of the Women's, Children's and Sexual Health Division (BHT)
Ms Ashleigh Skinner, Co-Chair, Maternity Voices Partnership

Paper

Improving Maternity Services in Buckinghamshire

9	**Dementia Services Rapid Review Report**	**12:30**	**51 - 78**

At its February meeting, the Select Committee agreed the scoping document for a rapid review into the dementia journey and the support services available for people living with dementia and their carers in Buckinghamshire.

The Review Group held a number of evidence gathering meetings during March and the report with the key findings and areas of recommendation is to be discussed and agreed by the Committee Members.

Contributors

Cllr Carol Heap, Chairman of the Review Group
Cllr Shade Adoh
Cllr Phil Gomm
Cllr Robin Stuchbury
Cllr Nathan Thomas

Cllr Alan Turner

Paper
Draft Dementia Review report

10	**Work programme** For Committee Members to discuss and agree the items for the next meeting.	**12:50**	
11	**Healthwatch Bucks** This is an information only item at this meeting.		**79 - 80**
12	**Date of Next Meeting** The dates for future meetings will be confirmed at the full council meeting on 17th May.	**13:00**	

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For further information please contact: Liz Wheaton democracy@buckinghamshire.gov.uk 01296 383856

Health & Adult Social Care Select Committee minutes

Minutes of the meeting of the Health & Adult Social Care Select Committee held on Thursday 9 February 2023 in The Oculus, Buckinghamshire Council, Gatehouse Road, Aylesbury HP19 8FF, commencing at 10.00 am and concluding at 1.00 pm.

Members present

J MacBean, P Birchley, P Gomm, T Green, C Heap, H Mordue, S Morgan, C Poll, G Sandy, R Stuchbury, A Turner, N Thomas, M Walsh, J Wassell and Z McIntosh

Others in attendance

Mrs E Wheaton, Ms J McAteer, Ms E Quesada and Mr W Hancock

Apologies

S Adoh and Cllr A Macpherson

Agenda Item

1 Apologies for Absence

Apologies were received from Councillor S Adoh. Cllr A Macpherson, Cabinet Member for Health and Wellbeing, sent apologies for item 7.

2 Declarations of Interest

- Cllr Chris Poll declared an interest in item 5 as South Central Ambulance Service were a dormant client.
- Cllr Robin Stuchbury declared an interest in item 7 as a retired member of UNITE.

3 Minutes of the Previous Meeting

The minutes of the meeting held on Thursday 17th November 2022 were agreed as a correct record. In response to a Member question about the status of two queries raised in the previous meeting, a response has not yet been received but will be circulated in due course.

4 Public Questions

There were no public questions submitted for this meeting.

5 South Central Ambulance Service

The Chairman welcomed Will Hancock, Chief Executive, South Central Ambulance Service.

During their presentation, the following key points were made:

- In addition to the 999 emergency services and 111 service, South Central Ambulance Service (SCAS) also facilitated non-emergency transport services for vulnerable patients.
- Many of the findings in the CQC inspection report related to concerns around safeguarding. In terms of the wider organisation and governance, there were concerns around managing safety within the organisation. Two factors identified as key risks leading to the inadequate rating were frontline delivery of emergency services and the safety domain for the organisation overall.
- The ratings had considerably declined due to the pandemic. However, an extensive improvement programme had been launched to identify improvements to be made. Immediate concerns had been addressed, with a longer-term plan of quality improvement building on it. A wide range of stakeholders including safeguarding boards were involved in this process.
- No further feedback had been received from the CQC, which was considered positive as any further concerns would have been addressed immediately.

During the discussion, Members raised the following questions:

- In response to a Member question around the timeframe of the improvement plan, it was noted that SCAS were moving to business as usual. Due to the rating, SCAS had dropped from level two to four within the strategic oversight framework. A national oversight and scrutiny process had to be completed, starting with a meeting with NHS England in March to agree the exit criteria. There was an expectation that SCAS would move out of level 4 of the framework by September 2023 and remain on an improvement plan for the next 2-3 years.
- In response to a question about the safeguarding issues raised in the CQC report, Mr Hancock explained that the safeguarding system had been completely overhauled in the past months and the team had been increased from three to nine.
- There had also been issues with the 111 system as it had not being able to pass electronic referrals to local authorities but this had now been resolved.
- A Member asked about workforce training and whether specific training around autism and learning disability was provided to staff. As an emergency service, there were occasions when training had to be cancelled due to extreme pressures. But level three safeguarding training was now protected, with 40 people a week being trained, and training was not cancelled even at the highest level of escalation. A response around specialised training for certain health conditions would be provided outside of the meeting.

ACTION: Will Hancock

- In response to a question about staff appraisals, Mr Hancock confirmed that staff received appraisals and these were reported annually to the Board. The appraisals included a section on health and wellbeing which provided an opportunity to ensure mandatory training had been completed.

- Mr Hancock went on to say that significant interventions to protect the wellbeing for frontline staff had been introduced, such as an end of shift policy outlining which types of patients can be seen by ambulance crews in the last hour of their shift.
- A Member raised concerns about the use of private ambulances. Mr Hancock explained that a strategy was in place to manage private ambulance usage, which included how and why they were being used and monitoring the quality and safety. He went on to say that private providers were regulated and inspected by the CQC.
- In response to a question about workforce challenges, Mr Hancock explained that SCAS had decided to focus more on local recruitment, with paramedics completing training through Buckinghamshire New University in High Wycombe. SCAS also had an apprenticeship programme for paramedics, with many internal employees moving onto the programme. Over 500 students were currently enrolled both internally and externally. There was currently no mechanism in place to ensure that qualified paramedics and clinicians remain with the NHS on completion of their training although there were incentives offered to try and get them to remain with the NHS.
- Mr Hancock went on to say that recruiting and retaining call handlers continued to be challenging as there had been an unusually high turnover following the Covid pandemic. The NHS was due to publish a workforce plan later in the year.
- In response to a question about the quality of the fleet, Mr Hancock said that SCAS had made good progress in terms of modernising its fleet.
- The CQC report found equipment did not always work and medicines were not always being managed safely and effectively. A Member asked how these concerns were being monitored. Mr Hancock responded by saying that an audit of all equipment had been completed and SCAS had invested in an asset tracking tool which monitors the age, location and maintenance record of the equipment. The new system would allow for better identification and reporting of risks. Medicine management was a challenge, but investments were being made in bigger teams and more resilient infrastructure.
- A Member commented that there had been no connection between the improvement plan and the potential impact on SCAS due to current industrial action. Mr Hancock explained that the current industrial action had had very little impact on SCAS in terms of patient care and ability to deliver services. Mr Hancock emphasised the importance of the Board taking responsibility for the CQC overall rating and he reassured Members that the improvement plans were well underway.
- A Member asked for further clarification around the management of safeguarding and the review and governance around it which were identified as areas of concern in the CQC report. Mr Hancock explained that the size of the team had increased in line with additional activities, as had staff training around safeguarding. Members suggested that different pathways could be utilised to decrease pressure on social care. Ms Quesada further emphasised the importance of distinguishing between safeguarding and welfare concerns to ensure that residents are provided with the right care at the right time.
- In response to concerns around staff turnover, particularly at director level, Mr Hancock said that building a permanent team had been difficult, and interims were filling those roles. The Chairman suggested that the recruitment and concerns

around the current safeguarding referral process should be discussed further outside the meeting between adult social care colleagues and SCAS.

- In response to a question about call abandonment rates, Mr Hancock explained that the abandonment rate of 40% was in line with other parts of the country. He went on to say that the demand on the 111 service had led to SCAS seeking support from other areas.
- In response to a Member question about serious incident reports, Mr Hancock explained that the process had was now consistent with the national system. SCAS also had a cascade system to inform staff about risks, improvements and changes made as a result of incidents, both through a route of clinical notices and through the education and training update programmes.
- A Member raised concerns around the level of communication issued by SCAS. It was noted that updates on the improvement programme were issued on a regular basis to stakeholder management groups. Mr Hancock confirmed that he would ensure the Select Committee and Healthwatch received these updates.

ACTION: Will Hancock

- A Member asked about SCAS's strategy for implementing the use of electric vehicles Mr Hancock explained that a range of electric non-emergency vehicles were currently being introduced and tested. A number of national trials were being conducted which also included the use of other fuels.
- A Member raised concerns around the time taken to answer category two calls, which should be answered within 18 minutes. Mr Hancock explained that performance across the country, in December, was the worst on record. However, there had been a significant improvement in January, with the average of category 2 response times decreasing to 19 minutes and 6 seconds.
- Mr Hancock went on to say that 8100 hours were lost in December due to delays in handovers. The average handover time was 36 minutes, but 1700 patients took longer than an hour to transfer.

The Chairman thanked the presenters for their attendance and participation and asked that more data, particularly around the improvement plans be provided to the Committee so that progress could be monitored more closely.

ACTION: Will Hancock

6 Chairman's update

The Chairman updated Members on the following:

The first formal meeting of the Buckinghamshire, Oxfordshire and Berkshire West Joint Health Overview and Scrutiny Committee took place on Wednesday 25th January, 2023. The Chairman reported that she had been elected as the Chairman, and Cllr J Hanna from Oxfordshire County Council had been elected as the Vice-Chairman for the ensuing two years. The draft Integrated Care Partnership strategy had been discussed and a formal response had been submitted to the ICP, outlining the key concerns and suggestions made by JHOSC Members.

Three questions had been submitted to the Cabinet Member for Health and Wellbeing, Cllr Angela Macpherson in advance of the meeting. These questions are

detailed below along with the written responses received.

Funding – What has the impact of the recent Government announcement, in relation to the use of care home beds to support Hospital Discharge, had on ASC and the development of the new model for Hospital Discharge?

With respect to the recent announcement of funding for hospital discharge, this additional government funding is being used to fund additional social work capacity for the social work assessments and working with the person and their family members to support them through the process. Additional discharge beds within care homes are also being sourced alongside provision for patients waiting to be discharged who are unable to return home because they are homeless or their house is in a state of disrepair.

A Health and Care and Integration Programme is already in place which we briefed HASC on at the last committee. This is developing a new discharge model for Buckinghamshire. At the moment, programme capacity has been diverted to manage current winter pressures (drawing on new national funding streams) - this has slowed the development of our new model for hospital discharge. It was agreed in January that the pace on this would be slower across the Winter period and pick up again afterwards with external support.

Capacity – During December and January, how many people have been discharged to Olympic Lodge and other facilities across the county? How does this compare to the same period last year? What has been done differently this time to improve the discharge process at times of significant winter pressure.

By mid-January, Olympic Lodge had been operating for 14 weeks. As at the week ending 15th January, (week 14), Olympic Lodge had admitted 219 patients, compared to 150 in week 14 in 2022.

The key difference to last year is that the focus of the Olympic Lodge facility is patients who are most likely to be able to respond to therapeutic intervention and regain much or all of their former independence. People with highly complex needs such as dementia are being discharged directly into a care setting which is able to support their specialist complex needs – this may be at home with home care or into a care home.

Workforce – At the budget scrutiny session, you mentioned that there are 19 agency staff within the discharge team. Can you give us a sense of how long the agency staff have been working in this area – longest serving staff member to the newest agency staff member. What is the total number of ASC staff working within the integrated team, what is the current vacancy rate and what are the plans to reduce agency staff in this area?

As of 7th Feb, the number of agency staff in the discharge service has risen to 21.

These are funded by the NHS through the winter pressures discharge grant funding. Some of these staff have previously been working in other parts of the ASC service before moving into the discharge area. The longest serving agency worker has been working with us (but not always in the discharge service) since August 2019 and the most recent started in in the last couple of weeks.

There are 19 permanent posts in the ASC discharge service with, (as of 7th Feb) 5 vacancies – a vacancy rate of 26%.

In simple terms, whilst demand continues in hospital discharge and the cost of agency staff is met by external funding, we are not planning to reduce agency use in this area.

7 Adult Social Care Workforce

The Chairman welcomed Jenny McAteer, Director of Quality, Performance and Standards and Elaina Quesada, Service Director, Adult Social Care (Operations), to the meeting.

The Chairman started by explaining that the recent Primary Care Network (PCN) inquiry raised concerns around staff recruitment and retention within the adult social care service One of the recommendations within the inquiry report was in relation to having named social workers to work alongside PCNs The response from adult social care said that it was not possible to have a named social worker due to team capacity and locality mailboxes were currently being used.

During the discussion, Members raised the following questions.

- A Member emphasised the importance of rostering, particularly when dealing with staff shortages. It was noted that staff performance was on track to be the best in the last three years. The team had gone through a restructure in June 2021, which created additional social work and occupational therapy capacity. Despite the challenges in wait times, people contacting the department were offered face-to-face appointments at community cafes, which were joined by other partners for more complex cases. The community cafes were located across the county to ensure residents could visit them locally.
- A Member raised concerns around staff retention once they had obtained their qualifications. . Although some people had left following the service e restructure, there had been significant improvements in the service over the past two years, with some staff returning to the authority. Staff surveys had also had very positive responses. It was further noted that Buckinghamshire Council had a good multimedia presence. Members suggested that contracts could be amended to ensure people who received their qualifications through the Council would remain in the authority for a certain period of time. It was noted that in the past two months, a memorandum of understanding had been signed by local authorities in the Southeast region that social workers leaving a local authority could not be

employed by an agency for 6 months.

- Members raised concerns about the number of agency staff, which made up around 50% of social workers overall. Ms Quesada explained that out of the 50 agency workers, 19 were not paid for by the Council but by the NHS. Compared to the workforce in the department overall, which equated to around 415 staff, 50 agency workers was a relatively small number. It was noted that there would always be a need for agency workers.
- A Member asked about strategies and support that had been put in place to limit burnout in staff members. Ms Quesada explained that staff had regular supervision with their managers, and there were opportunities for teams to get together to reflect on and discuss work situations. A social work task force group was also in placeand the service had also appointed wellbeing champions. Responses to the together survey had been positive, with staff showing high levels of motivation and engagement. In addition, staff members on ASYE had support from the ASYE coordinator, and access to wider wellbeing support offered by the Council.
- A Member raised concerns about remote working for social workers. Ms Quesada explained that social work assessments were carried out all over the country rather than just in Buckinghamshire. Residents who moved outside of the Buckinghamshire area remained in the Council's care. Home working was primarily reserved for administrative duties, such as compiling assessment reports.
- Members raised concerns around whether enough work was carried out with colleges and other educational institutions. Ms McAteer assured the Committee that despite the pandemic, much work had been carried out to increase partnership working with educational bodies, particularly Buckinghamshire New University. For example, an approved mental health programme had been launched in Buckinghamshire, which was the first programme in the country to be quality assured by Social Work England.
- For the past two years, the Council had taken part in the social care cadet scheme, allowing people from any age to get into social work. Ms McAteer noted that feedback on the scheme had been received and collated as part of the annual principal social work report, which could be shared with the Committee.

ACTION: Jenny McAteer

- A Member felt that it would be helpful to hold a Member briefing, following the service restructure, to outline who does what within ASC and where to access useful information on the service.

ACTION: Jenny McAteer

- In response to a Member question, Ms Quesda confirmed that the council had not experienced any issues with the registration of social workers. It was further explained that inspections and registrations were managed nationally.
- As a result of the success of community cafes, the number of referrals taking more than 28 days had dropped significantly in both social care and occupational therapy.

The Chairman thanked the presenters for their attendance and participation.

8 HealthWatch Bucks update

Ms Z McIntosh, Chief Executive, Healthwatch Bucks updated the Committee on the latest
activities and made the following main points:

- A report on social prescribing had been completed to gather information about people's experiences with the service. Feedback was generally positive, but some issues were highlighted around transport and waiting times. The feedback from the report was shared with the ICB, including with Philippa Baker, Place Director for Buckinghamshire.
- A second report had been published concerning young onset dementia, which detailed experiences from people living with the condition in Buckinghamshire. It was established that the support was difficult to access and people living with dementia and their carers felt it was not age appropriate. The feedback had been forwarded to both Buckinghamshire Council and the ICB.

The Chairman thanked Ms McIntosh for her update.

9 The Dementia Journey - a rapid review of support for people living with dementia and their carers - scoping document

The Chairman thanked Cllr Heap and the Principal Scrutiny Officer for their work on the scoping document. It was noted that Cllrs Turner, Thomas and Gomm had volunteered to join the Review Group. Committee Members were asked to email the Principal Scrutiny Officer if they were interested in being part of this Review. Evidence gathering would take place across 3 full days in March.

10 Work Programme

Members discussed the work programme and agreed the following items for the April meeting:

- Maternity Services;
- 6-month recommendation monitoring of the Primary Care Networks Inquiry;
- Evaluation of the System Winter plan.

The Chairman proposed holding a work programming session in advance of the new council year in May.

11 Date of Next Meeting

Thursday 20th April 2023 at 10am.

Buckinghamshire System Winter Review 2022 / 23

Health and Social Care Select Committee

11th May 2023

Buckinghamshire Council

NHS Oxford Health NHS Foundation Trust

FedBucks

NHS South Central Ambulance Service NHS Foundation Trust

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

NHS Buckinghamshire Healthcare NHS Trust

Introduction

The Buckinghamshire System Winter Plan 2022/23 was developed with all Bucks Health and Social Care Partners intended to support the six month period of Winter 2022/23 **Monday 3rd October 2022 to Friday 31st March 2023**.

The winter plan covered the whole population of Buckinghamshire, including all ages and all conditions based on anticipated demands on each Urgent and Emergency Care Service recognising that all partners may have had their own plans in place.

Part of the national assurance to NHSE included providing a monthly update **Board Assurance Framework** to help all systems provide assurance for the anticipated challenges faced this winter and were embedded throughout the Winter Plan.

These slides highlight what went well, not so well and challenges that were not fully anticipated throughout the winter period.

Winter 2022/23 Plan Aims

The original aims of the Buckinghamshire System Winter Plan set at the beginning of the winter were to ensure all key partners were signed up to support and deliver the following:

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

This presentation highlights if these aims were achieved.

What went well

We successfully increased our bed capacity including 30 beds in Olympic Lodge

We managed over 500 calls per week on behalf of practices through the Clinical Assessment Service

We maintained patients in their own home preventing admissions to hospital

We successfully implemented and delivered on all our winter schemes that we set out to do

We were able to keep patients at home under Acute Care through Hospital at Home service throughout Winter

The next set of slides highlights each individual scheme delivered throughout the winter period:

Winter Schemes in Place – Winter Funded Schemes (1 of 6)

A number of schemes were funded and in place across the Winter period including:

- ***Olympic Lodge*** *– we had 30 additional beds clinically managed who were discharged from the Acute Trust but not able to go home yet. This ran October to March with plans to continue until the end of May.*

- ***Community Beds*** *– this included opening and staffing 8 beds in Amersham and Buckingham community hospitals providing step-down capacity for medically optimised patients and also patients to receive therapies in a less acute setting closer to home.*

- ***Dom Care Bridge Team*** *– This was a dedicated care team to help bridge patients' packages of care so that they can get home quicker when medically optimised for discharge. Provided additional capacity in challenged Dom Care market using employment capacity of the Trust.*

- ***Wrap Around Care Scheme*** *– Working with Sodexo to reduce unnecessary hospital readmissions by providing wrap around care for patients at high risk of readmission.*

Winter Schemes in Place – Winter Funded Schemes (2 of 6)

A number of schemes were funded and in place across the Winter period including:

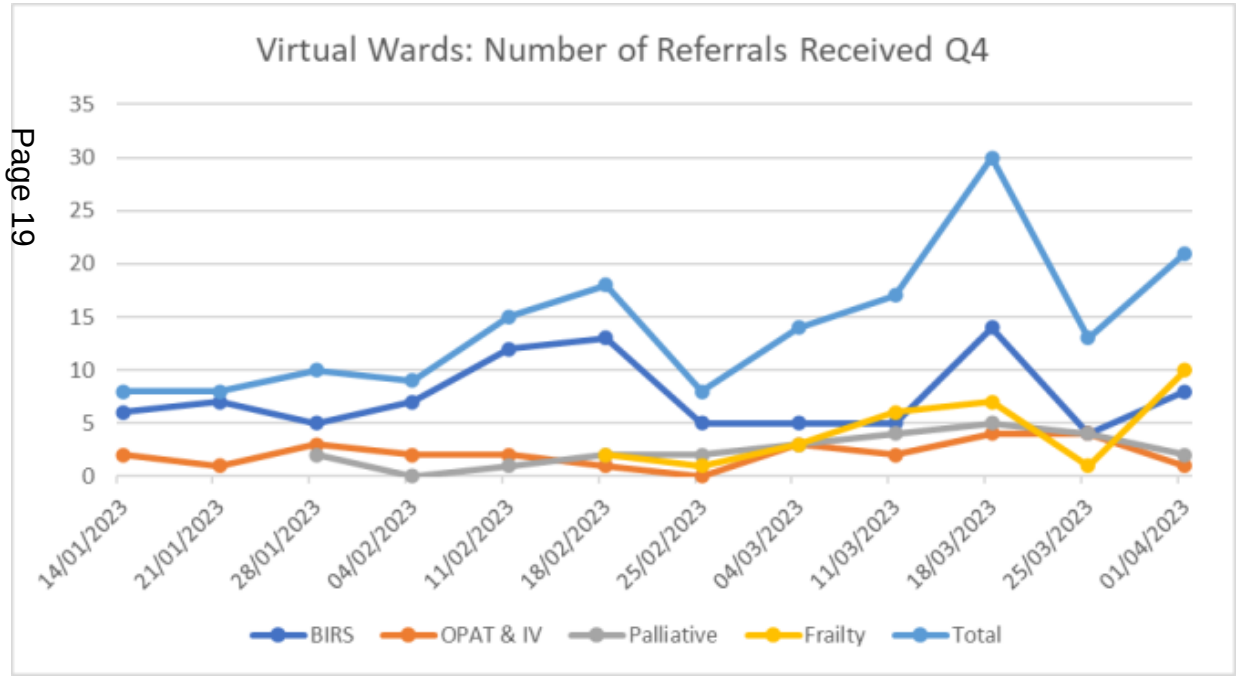
- ***Same Day Emergency Care (SDEC) to take patients direct from GP practices Buckinghamshire NHS Trust*** *- Working closely with GP practices to enable direct referrals for patients from their GP to the Same Day Emergency Care service without having to wait in the Emergency Dept or elsewhere in the hospital, patients are treated and sent home without the need to be admitted.*
- ***Frailty at Front Door*** *- Developing and strengthening an existing small frailty front door team, by introducing two frailty GPs, as well as a community pharmacist, and four additional therapy/nursing staff with focus on admission avoidance for older people who require a holistic assessment and personalised care plan and maximise the use of the Frailty SDEC pathway. The frailty GPs linked in with the Urgent Care Response team to support the co-ordination of care with interventions and support to promote independence.*
- ***HomeLink Healthcare*** *- Pilot services of HomeLink Healthcare to support the transition from hospital to home-based care by stopping people being admitted to hospital and enabling others to come home more quickly. Providing expert nursing and therapeutic care in the home, to complement and enhance existing hospital-based patient services.*

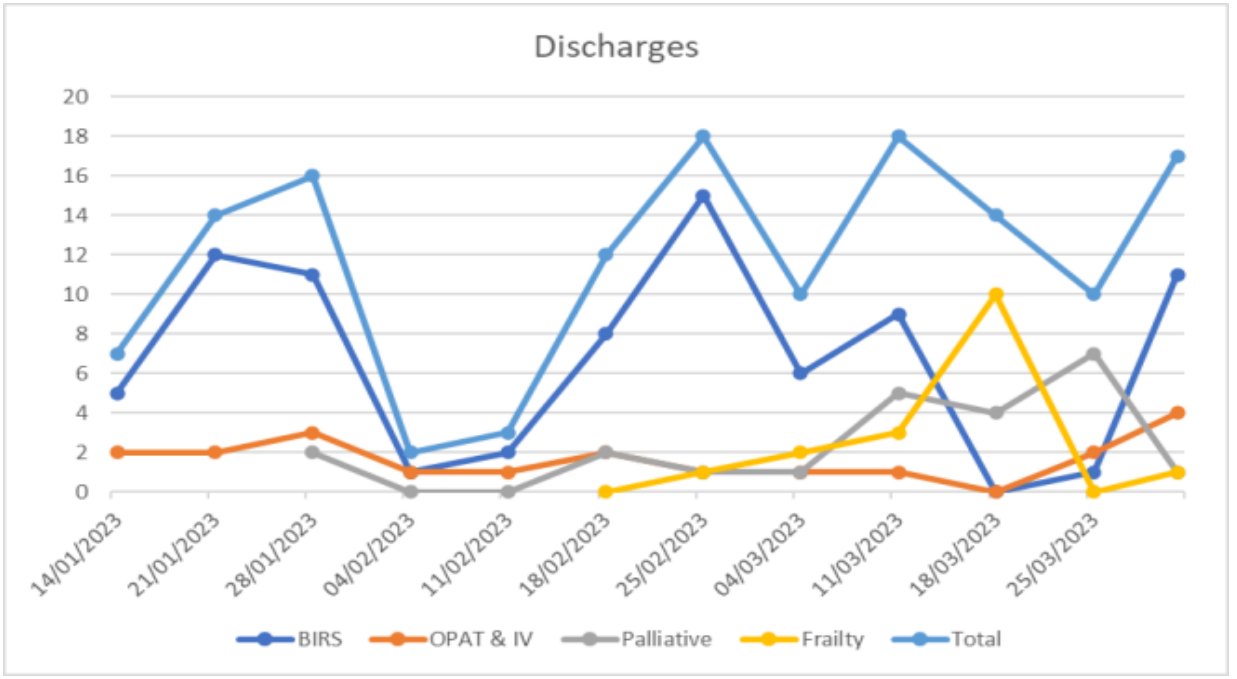
Winter Schemes in Place – Winter Funded Schemes (3 of 6) – Virtual Wards

A number of schemes were funded and in place across the Winter period including:

- ***Virtual Wards (Hospital at Home)*** *- Across Buckinghamshire we have established 50 virtual ward beds to help manage and maintain patients in their own home. The beds help ensure patients can stay in their own home and be able to have acute physician care without having to be admitted to the hospital.*

The charts below highlights the number of referrals and discharges across the Winter period into and discharged from the Buckinghamshire Virtual Ward:

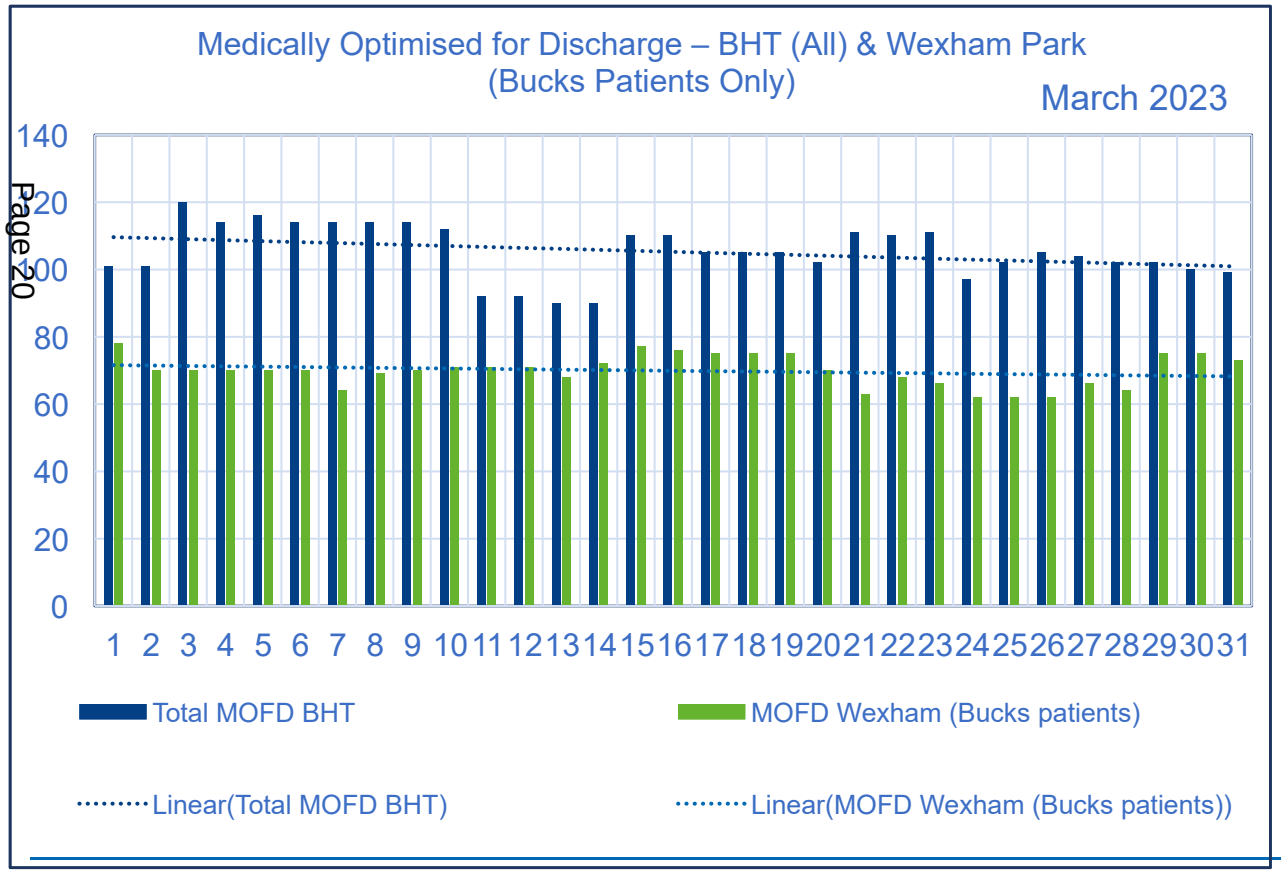


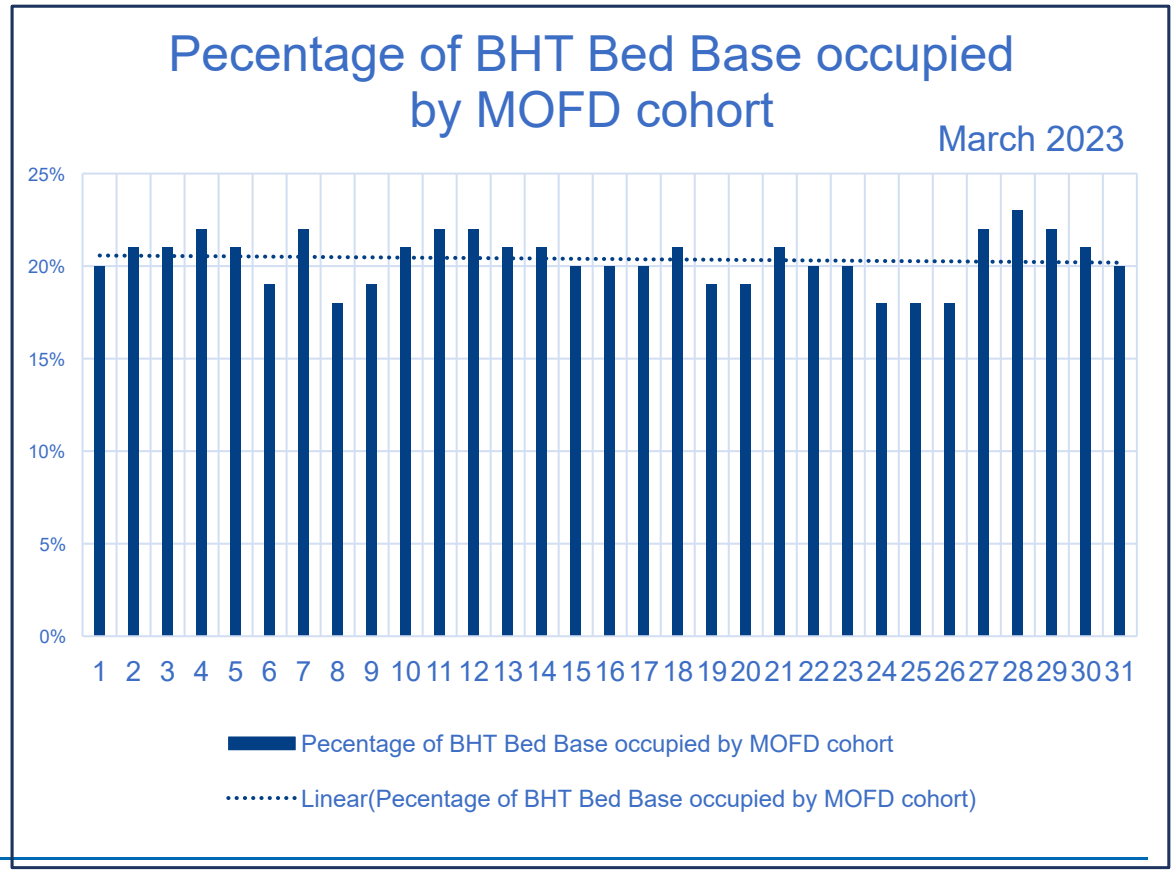


Winter Schemes in Place – Winter Funded Schemes (4 of 6) - MOFD

A number of schemes were aimed to help reduce those patients in hospital who are Medically Fit for Discharge (MOFD) who require onward support in their own home. An integrated approach across Bucks Council, the Integrated Care Board and the Acute Trust this winter helped to manage our medically fit patients.

The graphs below highlight the number of patients deemed medically fit for discharge over the winter period broken down by those Buckinghamshire patients in Buckinghamshire Healthcare Trust sites or Wexham Park Hospital:

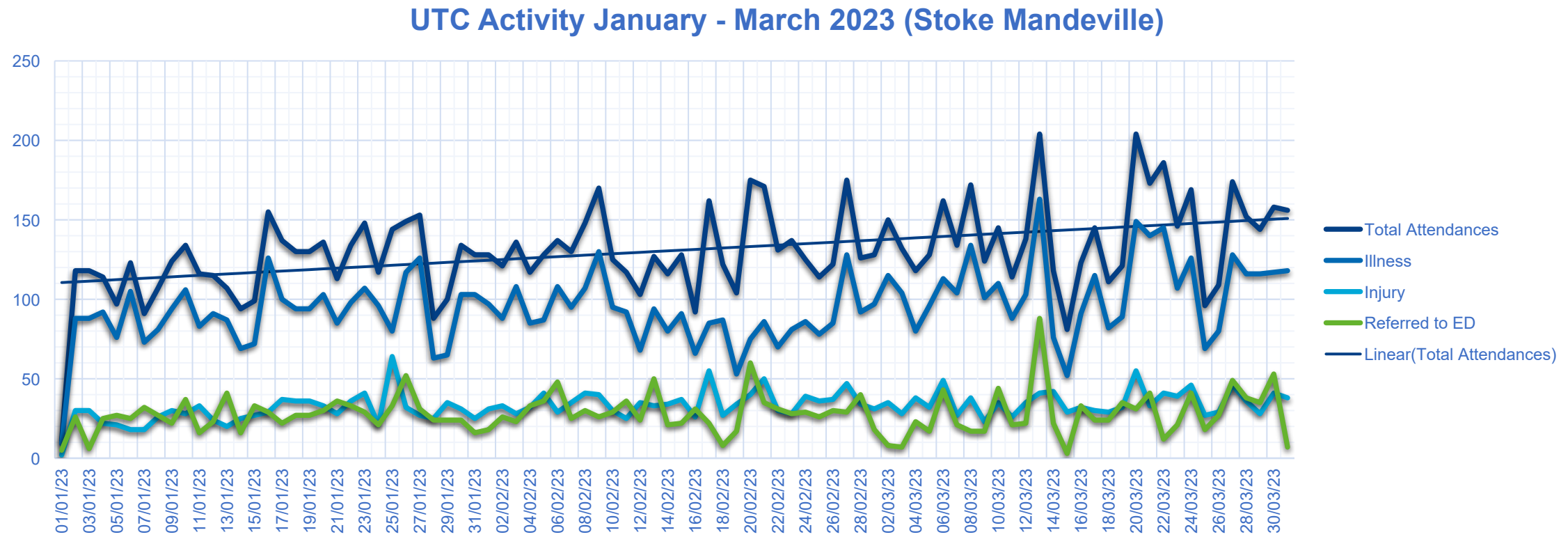




Winter Schemes in Place – Winter Funded Schemes (5 of 6) - UTC

A number of schemes were funded and in place across the Winter period including:

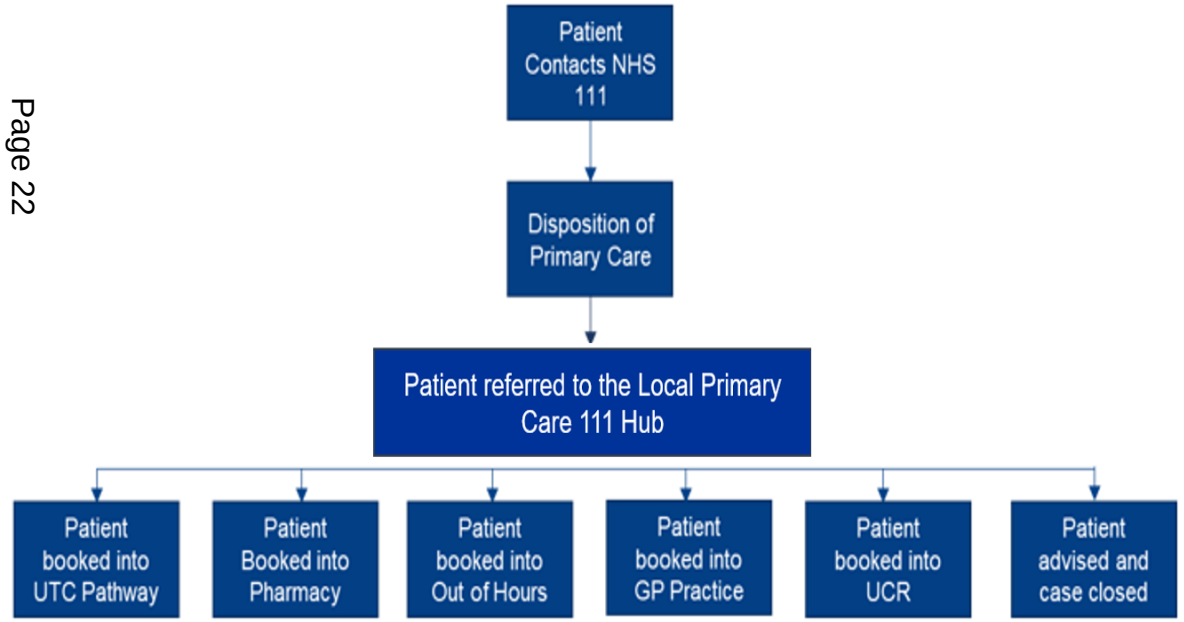
- ***Fully operational Urgent Treatment Centre (UTC) Pathway at Stoke Mandeville Hospital***. - *Urgent Treatment Centre Pathway at Stoke Mandeville Hospital enables patients who self-present to be clinically streamed into a pathway where they will be seen and treated for primary care and minor injury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

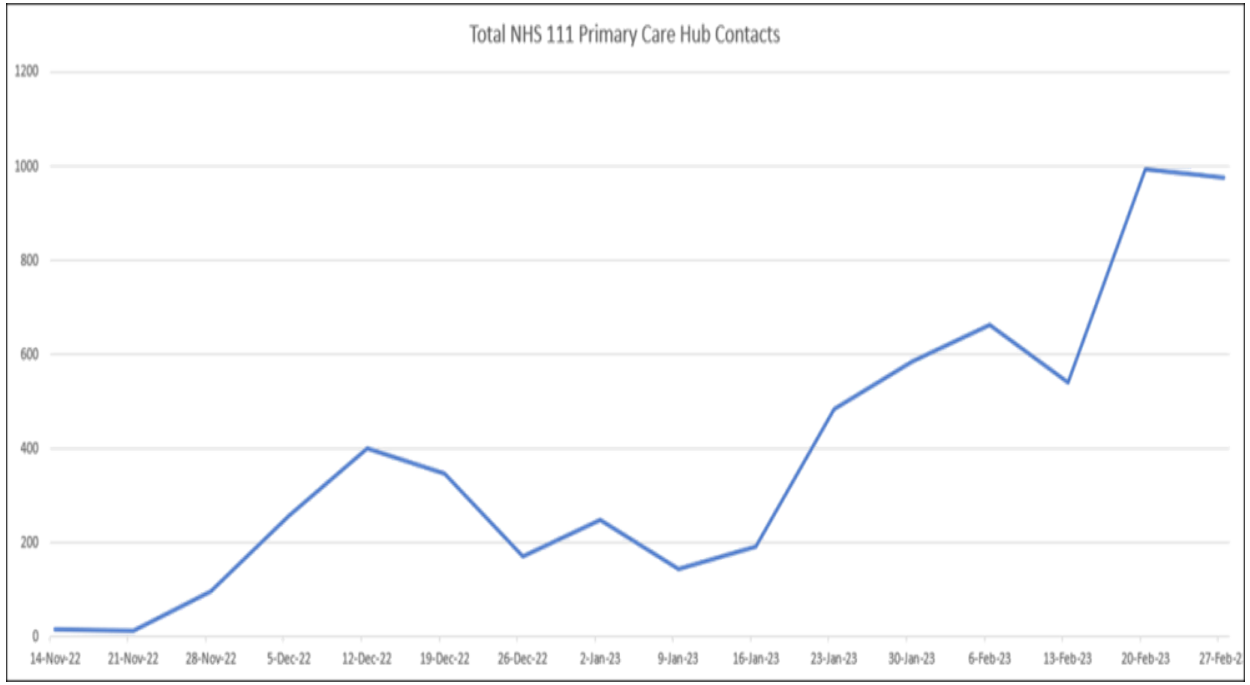


Winter Schemes in Place – Winter Funded Schemes (6 of 6) – 111 CAS

A number of schemes were funded and in place across the Winter period including:

- ***Primary Care 111 Clinical Assessment Service*** *- Buckinghamshire UEC Team worked with GP practices, LMC and PCN Partners to help reduce demand from 111 by setting up a Clinical Assessment Service Hub where all calls from 111 that have resulted in a 'Primary Care disposition' were sent to the Buckinghamshire Clinical Assessment Team ran by FedBucks where a clinical team will triage the patient. The pathway below highlights the flow of care for the patient and the graph highlights the number of contacts sent through to the CAS:*





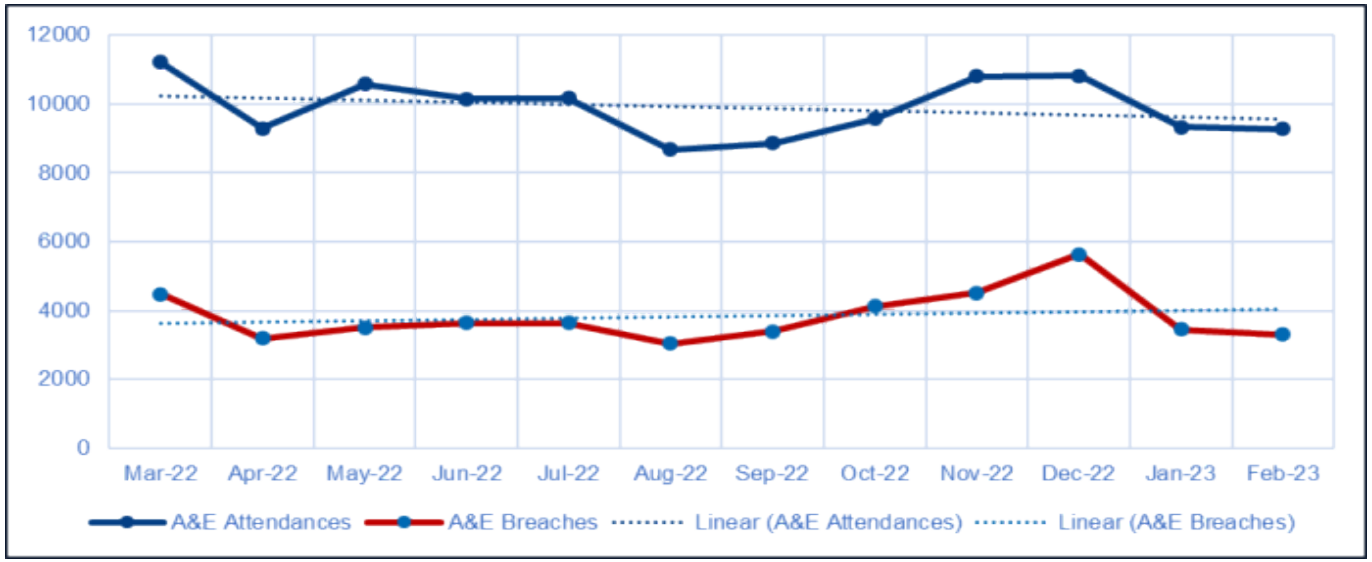
70% of all 111 referrals sent to the Clinical Assessment Service were dealt with outside of the GP Practice.

Social Care Winter Highlights

- Sourced new home care providers to meet demand from hospital discharge
- Provided weekend working for sourcing care to support hospital discharge
- As an ASC system we reduced the number of people placed in temporary care beds post hospital discharge
- Hospital Social Work teams have supported an increase in the number of discharges made directly from hospital to long term care and support.
- *The Home Independence Team have supported 340 new clients between November 2022 and March 2023.*
- *The 7 day hospital social work team have supported timely discharge.*

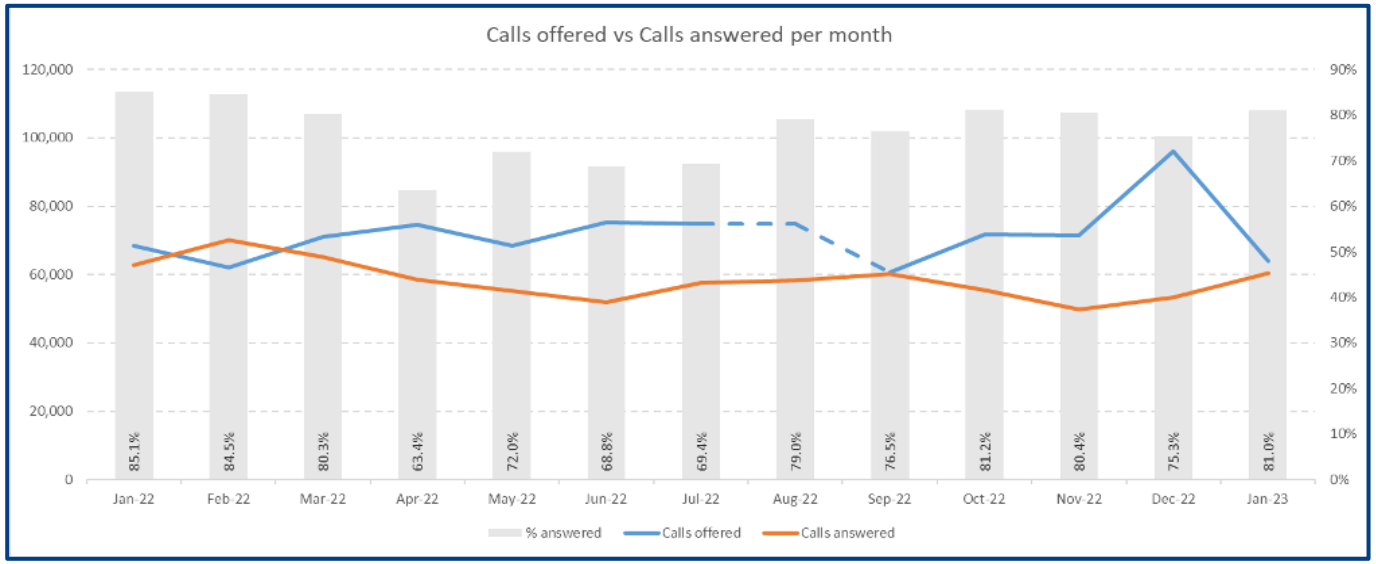
What did not go so well

We saw consistent high demands and higher acuity in ED attendances (the graph to the right highlights the ED attendances at Stoke Mandeville Hospital and ED 4-hour target breaches).



Strep A concerns saw unprecedented demand in all UEC services (the graph to the right highlights the number of calls into 111 highlighting the spike in December).

Industrial Action across multiple health partners impacted on workforce.



Summary of Winter 2022 / 23

The Buckinghamshire System saw a challenging winter across all of our services that was exacerbated by factors that were not considered. The Strep A coverage resulted in unprecedented demands across all health and care partners. The Bucks system stood up an Incident Management Structure and worked closely together to support this including Primary Care, Public Health, Community Pharmacists, Acute and Community and Social Care.

The Industrial Action also added further complexities to managing the surges across the winter period. All partners across Buckinghamshire came together to manage this to mitigate any risks.

Via the Buckinghamshire Urgent and Emergency Care Board we will take learnings from this winter to help improve the next one and to help work in partnership to manage anticipated and unanticipated surges.

Questions?

Development of Primary Care Networks Inquiry – Recommendations from the Health & Adult Social Care Select Committee inquiry group – 6 month recommendation progress table

Inquiry Chairman – Cllr Jane MacBean
Principal Scrutiny Officer – Liz Wheaton
Response from Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) and Buckinghamshire Council's Cabinet

Recommendation	ICB/Cabinet's Response – Y/N & comments	Progress recommendation monitoring in May 2023	Lead Health Partner/ Member/Officer & Timelines
1. A firm commitment from the Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) to invest, both financially and in people, at local Place level to deliver, through strong leadership, regular monitoring and reporting on progress with PCN development, in an open and transparent way with key partners and stakeholders.	Yes BOB ICB confirm that there is an intention to maintain investment in the infrastructure required for PCNs to deliver in line with National direction and available funding including. • Internal overarching BOB wide and place focused support team • Access to PCN Leadership development • Continued commitment and encouragement to utilise the full ARRS workforce funding. • Access to the PCN development funding available • Consideration of 23/24 funding and development PCN performance will continue to be monitored through an evolving dashboard and taken through	Yes The 23/24 PCN DES Contract has reinforced the investment in local leadership as well as removing the caps on a couple of ARRS roles and encouraging further recruitment of ARRS staff during the 23/24 year. There has also been a commitment from NHSE to include ARRS budgets in the ongoing funding for PCNs. ARRS workforce data continues to be regularly monitored to ensure that all PCNs are adding to appropriate capacity which will match their patient needs. The ICB has provided funding and commitment to supporting Primary Care	Louise Smith/ Simon Kearey Ongoing with regular review

	the appropriate governance routes / partnership forums.	Leadership which includes integration of delegates from PCNs within the new Bucks GP Provider Alliance	
2. The undertaking of a mapping exercise to align future primary care provision, based on fully developed PCNs across the county, with future housing growth at "Place and neighbourhood". Ensure senior people are involved in conversations between Buckinghamshire Council and health in relation to future planning of primary care. Attendance at the planned joint Select Committee meeting.	Yes BOB ICB commit to the direction of travel in line with National guidance and emerging contractual requirements of PCNs with regards development and delivery. PCNs will be encouraged to work in neighbourhood groups with Community Boards. BOB ICB will continue to work with planning partners with regards to housing growth and subsequent service and estates requirements in the appropriate forums.	Yes The focus for PCN development work in 23/24 will mainly be around delivery of integrated teams. These will support the Place Based Partnership plans of the ICB.	Louise Smith/ Simon Kearey Ongoing
3. The preparation of an annual report to the Health & Adult Social Care Select Committee on the performance of PCNs, including resourcing, staffing and outcomes.	Yes PCN assurance will be developed in the coming months, expected to include resourcing, staffing and outcomes.	Yes This data will be included in the Annual Report t to the HWB.	Louise Smith/ Simon Kearey March 2023
4. PCN workforce plans to be published on the websites at Place level, as well as being shared with the Patient Participation Group Chairs on an annual basis to coincide with submission of them to the ICB.	Agreed in part The ICB will be able to provide a summary of all place workforce finances allocated and roles recruited to on a yearly basis. There would however need to be further discussion as to which websites these could be posted on most appropriately.	Buckinghamshire Primary Care Team continue to hold patient engagement steering groups which include PPG chairs. Future guidance around this area will be agreed as part of the Patient Engagement Strategy being presented at the BOB ICB board in May.	Louise Smith/ Simon Kearey/ Julie Dandridge / Helen Clarke March 2023
5. Ensure all PCNs have a dedicated network manager in post. Lobby NHS England for this to be a funded position as part of the additional roles reimbursement scheme to ensure fairness across the PCNs and to review the current yearly funding arrangements.	Agreed in part It is currently up to individual PCNs to decide how they utilise their funding. A network manager is recognised by the ICB as a valuable role but cannot be prescribed. As an ICB we are currently reviewing the current commitment to a band 7 network manager working with our GP Leadership Group to understand different options available.	This is still the case with some PCNs being covered by a collaboration of Practice Managers – there is currently still no dedicated funding for Network Managers provided under the ARRS scheme.. With the advent of the Transformation and Innovation role there is a far greater emphasis on a Network Manager being in place for a PCN and we understand recruitment plans are in place for those who do not have one currently.	Louise Smith/ Simon Kearey March 2023

	Yearly funding arrangements will be reviewed as a matter of course.		
6. Create through the Place-based Partnership support for PCNs to be creative when recruiting to the additional roles and to lobby NHS England to allow more flexibility around the roles matched to local need.	Yes The ICB will work to ensure that PCNs maximise the ARRS funding within the boundaries available and by working with partners so as not to destabilise the workforce and ensure patients are seen by the most appropriate professional and outcomes are maximised. Integrated ways of working will support this.	Yes We continue to support the recruitment for ARRS staff across the ICB by working closely with key partners such as Oxford Health and the Local Authority to ensure that opportunities are widely circulated and taken up.	Louise Smith/ Simon Kearey Ongoing
7. Investment by the ICB to ensure a more consistent approach to GP websites leading to updated, accessible and user-friendly information for all patients. Websites to be used to promote the additional services available across the PCN, promote PPGs and to publicise current vacancies.	Yes Currently most practices are using similar templates to provide their websites. The ICB will work with providers to ensure that certain minimum information levels are provided in line with the most recent guidance NHS England » Creating a highly usable and accessible GP website for patients	Yes Practices are regularly provided with key information to put on their websites and the primary care team monitor that this is happening.	Louise Smith/ Simon Kearey/ Julie Dandridge / Helen Clarke March 2023
8. Greater consideration should be given to the working environment. Access to IT and other equipment for PCN teams needs to be made easier and the funding available needs to be more clearly publicised to the Network. The benefits of working within a PCN need to be promoted through the recruitment campaigns and to the wider community.	Yes The ICB is currently ensuring that all new and existing roles have appropriate IT to support them and that communities of practices are created to ensure peer support. As part of the new working arrangements the ICB will work with PCN directors to ensure ongoing transparency and involvement.	Yes A great deal of work has been carried out in this area and all ARRS staff should now have access to the appropriate equipment - with data sharing arrangements still being finalized.	Louise Smith/ Simon Kearey/ Andy Ferrari March 2023
9. A "Back to Basics" approach should be adopted for developing Patient Participation Groups. The Place-based Partnership should work with Healthwatch Bucks and PPG Chairs to refresh and re-affirm the statutory need to establish a PPG, including a clear steer on the role of the Chair. A directory of PPG Chairs needs to be developed as a	Yes The ICB intends to develop its patient and public engagement strategy including that linked to place and community hubs. This may include PPG development as appropriate and will be reviewed in a wider context with support from Healthwatch and Nursing/Communications Directorates. The ICB have noted that the Place-based partnership when set up	Yes The ICB has committed to support Healthwatch to support the continued development of PPGs – the Engagement Strategy paper being presented to the board in May expected to outline the way forward in this aspect.	Louise Smith/ Simon Kearey December 2022 and September 2023

matter of urgency and circulated to all PPGs and Network Managers to encourage closer collaboration and the sharing of knowledge and best practice.	will consider this.		
10. Develop a fair, comparable and consistent approach in supporting the development of Patient Participation Groups across the BOB ICS with clear, measurable outcomes. These outcomes to be co-produced with PPG representatives.	Yes As above (point 9) The ICB will continue to work with PPGs on the best way to develop patient and public engagement for Primary Care	Yes See above (point 9)	Louise Smith/ Simon Kearey/ Julie Dandridge / Helen Clarke April 2023
11. Provision of regular communications to all PPGs, including topical webinars with guest speakers and regular newsletters for PPGs to help increase their membership. Development of basic mandatory practices, including automatic sign-up prompts for new patients and greater collaboration between PPGs and GP practices to recruit PPG members.	Yes As above (point 9)	Yes See above (point 9)	Louise Smith/ Simon Kearey/ Julie Dandridge / Helen Clarke March 2023
12. Linked to recommendation 7, clearer and more comprehensive information on GP surgery websites relating to the work of the PPG, including upcoming meetings and minutes. It needs to be regularly refreshed and updated to include more emphasis on the benefits/improved outcomes that PPGs can provide for patients and a working mechanism for patients to contact their PPG.	Yes As above (point 7 & 9) Healthwatch and the ICB may continue to provide updates which can be publicised on Practice Websites which can be used to support and show the value of the work of PPGs	Yes above (in point 7 and 9)	Louise Smith/ Simon Kearey March 2023
13. Develop a formalized approach/framework with clear pathways to ensure named social workers are known to GPs, Practice Managers, Network Managers and Community Healthcare Teams.	Agreed in part **<u>Council response</u>** The Council understands that the Inquiry's recommendation in relation to having a named social worker is about creating a single point of contact (SPOC) for PCNs into adult social care. Named social workers are being established for adult social care residents who live at home in the community.	**<u>Council response</u>** Actions are now complete. A Head of Service within ASC Operations has been allocated as the thematic lead for ensuring strong relationships between PCNs, GPs and social care. Closer working has been achieved from this approach to integrate into BAU with the following actions taken:	Cabinet Member: Cllr Angela Macpherson, Cabinet Member for Health & Wellbeing Lead Officer: Service Director for ASC Operations, Buckinghamshire Council (Sara Turnbull))

The service understands the vital importance of a SPOC to facilitate effective working and the restructure of adult social care operations in June 2021 was designed to align the service more closely to PCNs in 4 geographical areas of Buckinghamshire - North, East, South and Central:

ASC Area (North, East, South & Central)	**PCNs in the ASC areas** In order of size of the area covered by the PCN (brackets: overlap is minimal)
North	Aylesbury North PCN AVS PCN BMW PCN Maple PCN
East	Aylesbury North PCN Chesham & Little Chalfont PCN Westongrove PCN Mid Chiltern PCN Maple PCN (BMW PCN) (Dashwood PCN) (Cygnet PCN)
South	Arc PCN South Bucks PCN The Chalfonts PCN Mid Chiltern PCN (Chesham & Little Chalfont PCN) (Cygnet PCN)
Central	AVS PCN Mid Chiltern PCN Dashwood PCN Cygnet PCN (Arc PCN)

To ensure that any enquiries or requests for support are picked up in a timely manner, adult social care has provided each PCN with a specific telephone number and generic email address for the assigned social work team:

a) Contact details have been communicated with all PCNs for adult social care for locality teams. Information provided on appointment of SPOC (named worker) for cases where this is required.

b) This has been completed – these links have been established and staff are attending monthly online meeting with The Swan & Aylesbury North PCN, GP surgeries at Hughenden Valley and Poplar. The plan is to expand this approach with other localities and PCNs countywide.

c) ASC provided a presentation to all the PCN Network coordinators meeting in January 2023, sharing Buckinghamshire Council's vision and the scope of work covered by ASC.

		Integrated Care Board response This work is very much the focus of establishing integrated neighbourhood teams. We have now aligned teams across the varies areas and partners and are working on establishing a key single point of contact for each team	Louise Smith/ Simon Kearey March 2023
14. Re-introduce regular Multi-Agency Group meetings to include mental health practitioners, social prescribers, social workers, district nursing teams and reablement & rehabilitation teams.	Agreed in part **Integrated Care Board response** Multi-discipline team working is a key aspect of the Integrated Care Partnership strategy linked to primary care.	Agreed **Integrated Care Board response** All teams are very much currently working closely as part of a Multi-disciplinary team approach. We are following up on some work undertaken in MK to support integrated teams. Social Care: in MK they are about to give Social workers access to the HIE (Health Information Exchange) so that Social Workers can see the full Primary Care and hospital medical record as long as they have recorded	Louise Smith/ Simon Kearey/ Jenny Ricketts March 2023

North	Unit 1 Midshires Business Park, Smeaton Close, Aylesbury, HP19 8HL	01296 38
East	King George V House, King George V Road, Amersham, HP6 5AW	01296 38
South	Seeleys House, Campbell Drive, Knotty Green, Beaconsfield, HP9 1TF	01494 58
Central	Buckinghamshire Council, Queen Victoria Road, High Wycombe, HP11 1BB	01296 38

A manager within social care will be contacting all PCNs within the next 3 months to ensure PCNs are clear on the process, which will be monitored and reviewed as necessary to ensure joint working is as effective as possible for the benefit of residents. Adult social care would also benefit from as SPOC within the PCNs and this is something that will be asked for when making contact.

Integrated Care Board response

As part of the wider development of integrated care teams it is expected that relevant individuals in PCNs, Practices and community teams are linked into local social workers and vice versa.

	Council response Adult social care regularly works with the partners referenced in the Inquiry's recommendation as part of our business as usual approach of multi-disciplinary meetings linked to individual clients. There is a well established process for discussing complex cases, partners are able to refer and take part in complex case panels, if business as usual approaches are not achieving the outcomes needed for our residents. The Council agrees the need for a wider discussion with health and the VCS in developing the approach for more integrated neighbourhood working in Buckinghamshire. As yet, there is no blueprint on the approach but a new joint programme team has been established to take forward the delivery of integrated health and care. Proposals will be discussed at the new Place-based Board, once it is established for Buckinghamshire.	the NHS number on their IT system. This is an enormous achievement and they expect 70% coverage of Social Services clients. **Council response** Multi-agency group meetings are part of the BAU within adult social care. Ongoing liaison with partners happens operationally and strategically.	Cabinet Member: Cllr Angela Macpherson, Cabinet Member for Health & Wellbeing Lead Officer: Service Director for ASC Operations, Buckinghamshire Council (Sara Turnbull)
15. Community Board Managers to reach out to PPG Chairs and PCN Inequality Champions to build relationships and work together to realise both the NHS LTP in bringing PCNs, PPGs and local communities together as well as supporting the delivery of the "Opportunity Bucks" theme around health and wellbeing.	Agreed **Council response** The Opportunity Bucks programme aims to ensure that all residents in the county have the opportunity to succeed, that nobody gets left behind and we reduce inequality within our communities. Through this programme, we are targeting 10 wards where there are longstanding challenges and residents are facing significant hardships. This programme is overseen by a board with multi-agency membership including the Council, NHS, BBF, LEP, Registered Social Landlords and VCSE.	Agreed **Council response** The Opportunity Bucks programme is progressing and priority initiatives for the next 12 months have been identified within the Health & Wellbeing theme. These priorities include establishing play streets, smoke free parks and playgrounds and ensuring there is sufficient mental health support within schools in target areas. In addition to the theme priorities, ward partnerships have been established in the 10	Cabinet Member: Cllr Steve Bowles, Cabinet Member, Communities Lead Officers: Wendy Morgan-Brown, Head of Community Boards and Matt Everitt, Service Director, Service Improvement

	Community engagement and involvement is a key principle of the programme. We are establishing Ward Partnerships within each of the 10 target areas to provide local insight, identify issues and best practice, and codesign solutions. The Ward Partnerships are supported by Community Board Managers who help to identify activity being delivered across partners within the ward areas and coordinate involvement in the partnership. **<u>Integrated Care Board response</u>** Each Community Board will be linked in to their local PCN leads.	target wards, with input from local Councillors, community organisations and local representatives to identify local issues and challenges to address through the programme. Community Board Managers have contact details for PCNs (and vice versa). Involvement in the Boards varies depending on each Board and their priorities/meeting subject, or when there is a need or value to them for the Board to be involved. **<u>Integrated Care Board response</u>** There has been some work on this but work still to do to ensure a comprehensive and across the county link between the Community Boards and the work being undertaken by neighbourhood and PCN teams.	Louise Smith/ Simon Kearey March 2023
16. Investment by the ICB to prioritise the delivery of consistent digital and data solutions. Develop a clear strategy for delivering population health management across the county for PCNs, informed by updated census information.	Yes Population Health data will be provided on a regular basis to all PCNs who will use this to drive a population health management (PHM) approach to key patient cohorts as well as monitor outcomes. All PCNs will have a good level of PHM knowledge and access to support if needed.	This is an outstanding piece of work – resources have been provided to ensure that PHM information can be provided and PCNs have taken advantage recent updates to the JSNA. Advanced Care Finder tools are being worked on to deliver to all practices and PCNs in the next couple of months to support PHM work locally.	Louise Smith/ Simon Kearey/ Andy Ferrari / Jane O'Grady June 2023
17. The Place-based partnership to develop a co-ordinated communications and engagement plan for key partners involved in PCN development to enhance joint working, deliver key public messages, written in Plain English and share best practice and information. Plans to be published on all GP surgery websites and PCN websites.	Yes When set up, we would expect the Place-based partnership to develop a comprehensive communication and engagement plan aimed at delivering key public messages, encompassing best practice and developments elsewhere.	Yes We are working closely with Place Based Partnerships to ensure consistent and comprehensive communications are provided.	Louise Smith/ Simon Kearey/ Philippa Baker June 2023

Report to Health & Adult Social Care Select Committee

Date: **May 11th 2023**

Title: **Improving Maternity Services in Buckinghamshire**

Author: **Heidi Beddall, Director of Midwifery for Buckinghamshire Healthcare NHS Trust (BHT)**

Officer support:

Recommendations/Outcomes:

Executive Summary

- The purpose of this paper is to update HASC on the proposed model for improving maternity services in Buckinghamshire, which is based on clinical evidence as well as engagement with service users. These proposals, which include developing Wycombe as a centre of excellence for ante and postnatal care rather than a birthing centre, have the support of key stakeholders including the co-chairs of the Bucks Maternity Voices Partnership, BOB Local Maternity and Neonatal System (LMNS), South-East Regional Chief Midwife, BOB ICB Chief Nurse and BOB ICB Deputy Director for Quality and Safeguarding and do not require any additional funding or resources.

- Women currently have the choice to have their baby either at home in a midwifery led birthing unit at the Aylesbury Birth Centre (which is within Stoke Mandeville Hospital) and obstetric led labour ward births at Stoke Mandeville. Midwifery led ante and postnatal outpatient care is offered at both Wycombe and Stoke Mandeville Hospitals. Our community midwives provide home visits, including going to see mum and baby on the first day after birth.

- During the last few years, and also driven by the removal of midwives from GP surgeries, we have taken the opportunity to strengthen the midwifery ante and postnatal care at Wycombe based on best practice and want to continue to do so by building on the following:

    - Continuity of carer in the antenatal and postnatal period i.e. being looked after by the same midwife or midwives throughout
    - mental health care
    - smoking cessation support
    - infant feeding support

- The benefits of continuing with the current choice of birthing options, and remodelling Wycombe Birth Centre (WBC) as a centre of excellence for ante and postnatal care, will be that we can provide continuity of carer during **and after pregnancy to over 1,000 women - SEVEN times more women than were previously giving birth at WBC**, with no additional resource required. At least **50%** of these women will be some of the most vulnerable in our community, enabling us to reduce health inequalities.

  It will deliver better outcomes for women and their babies as evidence shows that continuity of carer:

  - **Reduces pregnancy loss before 24 weeks by 19%**
  - **Reduces pregnancy loss at any gestation by 16%**
  - **Reduces preterm birth by 24%**

  It will also ensure that those who choose to have their baby in a midwifery led unit do so more safely. By having their baby at the Aylesbury Birth Centre, which is part of Stoke Mandeville Hospital, they have easy access to additional obstetric care if they choose to do so or the need arises, ensuring the safety of women and their babies.

Background in Brief

- Births have been suspended at Wycombe Birth Centre (WBC) since June 2020. This was originally driven by the COVID-19 pandemic and the need to temporarily reorganise midwifery services and more recently by the shortage of midwives. This means that due to not always being able to guarantee safe staffing midwifery numbers in the WBC, we cannot safely deliver babies there. At a freestanding birth unit such as WBC, a second midwife is required to attend due to the lack of access to immediate medical aid for mother and baby.

- Although the WBC was originally established in 2009 and provided intrapartum care, the numbers of births there has significantly reduced over the ten years it has been operational. It has never reached the expected level of 350-400 births a year.

- In 2019/20 (the last year births took place at WBC) only 169 women, out of 4,737 deliveries at Buckinghamshire Healthcare NHS Trust, chose to give birth at WBC with 130 actually giving birth there (2.74% of all births). Of the 169, 39 were transferred to Stoke Mandeville Hospital at the onset of, or in labour, due to a change in clinical risk or maternal preference, with a further 33 being transferred to Stoke Mandeville Hospital after birth. This transfer rate of 42.6% is higher than the national average of 21%.

- The childbearing population in Buckinghamshire has changed over this time; the health inequalities gap has widened, particularly for women from ethnic minority heritage or living in the most socially deprived areas. MBRRACE (2022) highlights that there are distinct inequalities in stillbirth and neonatal deaths for Black, Asian and mixed ethnicity women and women living in the most deprived areas. It is a national and local priority to reduce health inequalities for women and babies, particularly those from Black, Asian or

minority ethnic heritage and/or those living in the most deprived areas (CQC 2020, Ockenden 2022, NHSE 2019 and 2022).

- Stillbirths are highest in Black African women living in deprived areas. Neonatal deaths are highest in Pakistani women living in deprived areas. Because of the increased risks, it is not safe for many of these women to give birth in a freestanding midwifery unit. Of those that were eligible to do so, only 10 women from an ethnic minority and socially deprived background chose to give birth at WBC in 2019/20 compared with 56 at the Aylesbury Birth Centre and 864 in the labour ward at Stoke Mandeville Hospital.

Next steps and review

We are seeking support from HASC to continue with the current model of care on a permanent basis, which consists of:

- A choice of birthing options – home birth, midwifery led birthing unit at the Aylesbury Birth Centre (which is within Stoke Mandeville Hospital) and obstetric led labour ward births at Stoke Mandeville
- Midwifery led ante and postnatal outpatient care at Wycombe and Stoke Mandeville
- Community - home visits, including visiting mum and baby on the first day after birth.

without the requirement for formal consultation given that this does not represent a substantive change.

If HASC agrees next steps would include:

- further engagement with key stakeholders to socialise future enhancements to the agreed model
- co design of additional ante and postnatal services at Wycombe with service users.

Improving Maternity Services in Buckinghamshire

National Context and future direction for maternity services

Since the publication of Better Births (2016), a five-year forward view for maternity services, the NHS Long Term Plan, the launch of the national maternity transformation programme, maternity incentive scheme and maternity and neonatal safety improvement programme, the key focus across maternity services in England has been improving outcomes for women and babies.

The vision is for maternity services to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.

Despite the increasing numbers of women with complex pregnancy and births due to physical emotional or social factors, and a national shortage of midwives, there has been progress towards improving outcomes nationally and locally, such as reducing stillbirths, neonatal deaths, brain injuries and maternal deaths. However, the learning from enquiries into maternity services at Morecambe Bay, Shrewsbury & Telford, and East Kent highlights the need to do more. In addition, MBRRACE reports (national maternal and perinatal mortality data) as well as patient experience reports show that there are stark inequalities for women and babies from Black, Asian and minority ethnic backgrounds as well as those from socially deprived areas.

Key priorities and enablers have been identified in the various national reports and a single delivery plan is awaited from NHS England to provide clear expectations and guidance for maternity services across England.

Current maternity services in Buckinghamshire

Buckinghamshire Healthcare NHS Trust provides maternity services including antenatal, intrapartum and postnatal care to women and their families from Buckinghamshire and the surrounding border areas including Bedfordshire, Oxfordshire and Hertfordshire.

Maternity care is provided through either a:

- consultant-led obstetric clinical pathway
- midwifery-led clinical pathway

The pathway of care is determined through risk assessment at the initial booking appointment with a community midwife. Risk assessment is undertaken at every antenatal contact; therefore, the pathway of care may change according to the clinical need of the woman. Additional specialist services may be required to support the woman's individual needs such as multiple pregnancy or perinatal mental health.

Routine antenatal care is no longer provided by GPs in line with national guidance. This ceased in Buckinghamshire in 2014. However, the GP has a fundamental role in:

- pre-pregnancy counselling of women with pre-existing medical or mental health conditions that may be aggravated by pregnancy
- addressing with women preconception lifestyle issues, smoking cessation, weight management prior to pregnancy
- supporting medical concerns during pregnancy

Location of maternity services

Maternity services are provided across the Trust sites and in the community.

Stoke Mandeville Hospital

Claydon Wing:

- Consultant-led Labour Ward (11 birth rooms)
- Aylesbury Birth Centre (4 birth rooms)
- Maternity triage (3 beds)
- Obstetric theatres and recovery
- Observation bay (4 beds)
- Antenatal/Postnatal ward (46 beds)
- Neonatal Unit (Level 2 unit with 16 cots)

Waddesdon Wing:

- Obstetric antenatal clinics including fetal medicine, pre-term birth clinic, multiple pregnancy, mental health, diabetes
- Early Pregnancy Unit
- Day Assessment Unit
- Sonography
- Community midwife postnatal clinics

Wycombe Hospital

- Obstetric antenatal clinics
- Sonography
- Midwifery antenatal and postnatal clinics

Community Midwifery

- Antenatal and postnatal home visits
- Community hospital clinics
- Antenatal clinics at GP surgeries (where facilities available)

- Home births

Year to date statistics 2022/23

Number of deliveries	4529
Number of babies born	4577
Spontaneous vaginal births	44.7%
Instrumental births	13.4%
Caesarean section	40.3%
Planned caesarean section	17.4%
Emergency caesarean section	22.9%
Pre-term births	6.13%
Term admissions to neonatal unit	4.76%

The Trust has set out a clear strategy and interventions underpinned by the Ockenden and East Kent reports, maternity transformation programme, maternity and neonatal safety improvement programme, NHS People Plan, Local Maternity and Neonatal Systems equity plan and NHS operational guidance for 2023/24.

Improving outcomes for women and babies in Buckinghamshire requires a multi-faceted approach that supports and enables both service users and maternity staff. As stated in the Better Births report, “no one action alone will deliver the change we need to see”.

Our priorities include:

- Continuity of carer in the antenatal and postnatal period (having a named midwife and seeing only one or two midwives during community midwifery care)
- Better perinatal mental health care
- Reducing smoking in pregnancy to 5% or less
- Reducing avoidable moderate or severe harm by 50%
- Personalised care plans for 100% of women
- Implementing all recommendations from the Ockenden report, and the ten safety actions of the national maternity incentive scheme (and the single delivery plan once published)
- Improved access to services and information
- Reducing staff vacancies
- Robust multidisciplinary training
- Focusing on staff wellbeing and positive safety culture

Wycombe Birth Centre (WBC)

Following the Shaping Health Services reconfiguration of Women & Children's Services in Buckinghamshire, the Wycombe Birth Centre, a freestanding midwifery unit, was opened in 2009. Care in labour at WBC was provided solely by midwives and maternity support workers with no immediate access to medical aid, operating theatres or a neonatal unit. In the event of complicated birth, women and babies are transferred by ambulance to the labour ward at Stoke Mandeville Hospital.

Declining numbers

When WBC was established, the expectation was that 350–400 women a year would birth there in order to ensure a safe, sustainable, effective service. The birth rate at WBC has never reached the expected levels and has decreased over a ten-year period.

Year	Number of births at WBC	Percentage of birth rate
10/11	313	5.5%
11/12	334	5.7%
12/13	323	5.6%
13/14	257	4.8%
14/15	261	4.9%
15/16	264	4.9%
16/17	132	2.4% *
17/18	207	4%
18/19	174	3.55%
19/20	130	2.7 %

Of the 4,737 births at the Trust in 2019/20 over 87% were born in our obstetric-led labour ward. Furthermore, on average c.200 women a year who live in South Buckinghamshire choose to have their baby in the obstetric-led labour ward or alongside midwifery unit at Wexham Park Hospital.

Patient/Public Involvement and Engagement

There has been extensive patient involvement and public engagement since 2017 to increase the number of women choosing to birth at WBC. This has included:

- open evenings and relaunch events that have taken place at WBC
- promotional campaigns in the Eden centre in High Wycombe
- promotional videos and website updates

but there has been low attendance and little public interest.

Prior to the pandemic, the Trust, supported by the Maternity Voice Partnership, held two Better Births public engagement events combined with a service user survey "Delivering

Better Births in Buckinghamshire" (with 835 responses) in order to hear the views and preferences from women about the maternity services they wished to receive.

Feedback from the women we engaged with showed that the majority would like to give birth in a midwife led unit attached to a hospital (such as the Aylesbury Birth Centre which has direct access to medical aid as it is part of Stoke Mandeville Hospital). Women also expressed a preference for seeing the same midwife throughout their pregnancy.

Health inequalities

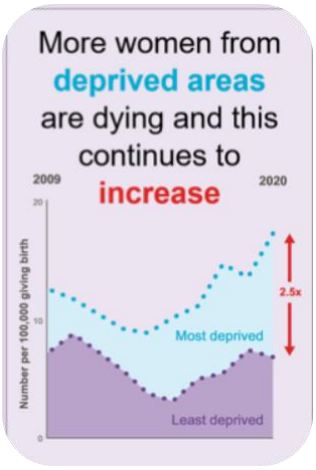
The eligibility criteria for a freestanding midwifery unit is restricted to ensure birth is as safe as possible in an out of hospital setting, due to the lack of access to medical aid, operating theatres or a neonatal unit if complications arise. This means that the majority of local pregnant women do not safely meet the eligibility criteria to birth in a freestanding midwifery led unit as most women require obstetric led care.

The population in Buckinghamshire is changing, with greater ethnic diversity and areas of social deprivation. WBC is located in central Wycombe (postcode HP11). This location is in one of the five postcode areas in South Buckinghamshire that women at the most risk in pregnancy due to their ethnicity or social background reside **and it particularly excludes:**

- Black, Asian and minority ethnic women due to their increased incidence of pregnancy related illness such as hypertension, diabetes
- Women from areas of social deprivation due to risk factors that may lead to complications in pregnancy such as a low birth weight baby

It is a national priority to reduce health inequalities for women and babies, particularly those from Black, Asian or minority ethnic heritage and/or those living in the most deprived areas (CQC 2020, Ockenden 2022, NHSE 2019 and 2022).

MBRRACE (2022) highlights that there are distinct inequalities in stillbirth and neonatal deaths for Black, Asian and mixed ethnicity women and women living in the most deprived areas. Stillbirths are highest in Black African women living in deprived areas. Neonatal deaths are highest in Pakistani women living in deprived areas. Because of the increased risks, it is not safe for many of these women to give birth in a freestanding midwifery unit. Of those that were eligible to do so, only 10 women from a BAME and socially deprived background chose to give birth at WBC in 2019/20 compared to 56 at the Aylesbury Birth Centre (which is part of Stoke Mandeville Hospital) and 864 in the labour ward at Stoke Mandeville Hospital.



The tables below demonstrate how many women from Black, Asian or minority ethnic heritage and the most socially deprived postcodes across the whole of Buckinghamshire gave birth at WBC compared to ABC and Stoke Mandeville labour ward in 2019/20.

Place of birth	Number of births	Percentage of births	Number of women from BAME heritage	Number of women of BAME heritage and from most socially deprived postcodes
WBC	130	2.74%	22	10
ABC	431	9.09%	97	56
Labour ward	4140	87.39%	1053	864

The data clearly demonstrates that:

- In the previous operating model WBC was not serving local women for whom the greatest health inequalities exist when compared to Aylesbury Birth Centre (ABC)
- The majority of women for whom the greatest health inequalities exist already give birth on the labour ward at Stoke Mandeville

In contrast, the proposed model will provide enhanced ante and postnatal care for at least 450 women from Black, Asian or minority ethnic backgrounds and/or the most socially deprived areas.

Safety

In 2019/20 169 women planned to give birth at WBC. Of these 72 women required ambulance transfer to Stoke Mandeville Labour Ward:

- 39 women were transferred at the onset of, or in labour
- 33 were transferred after birth

This transfer rate of 42.6% is higher than the national average of 21% (Birthplace study 2011). This is because, despite women being clinically assessed as low risk in pregnancy and choosing to birth at WBC, there was either:

- a change in clinical risk during labour or after birth, meaning that it was no longer safe to stay in a freestanding midwifery unit, or

- the woman chose to transfer because she wanted an epidural which is not available at WBC. This was the most frequent reason for transfer.

Current situation

Births have been suspended at WBC since June 2020. This was originally driven by the COVID-19 pandemic and the need to temporarily reorganise midwifery services and more recently by the national shortage of midwives which means that we cannot safely deliver babies there.

Safe Staffing

Safe staffing and the provision of one-to-one care is essential for all women in labour, regardless of location. At a freestanding birth unit such as WBC, a second midwife is required to attend due to the lack of access to immediate medical aid for mother and baby. At the time of suspending intrapartum care at WBC, there was a 50% vacancy factor in the WBC team.

Since June 2020, multiple attempts to recruit midwives to the WBC team have been made with no success. This is not just an issue in Buckinghamshire but nationally there is a shortage of c. 2000 midwives.

Extensive staff engagement has been undertaken over the last two years and a survey of midwives and maternity support worker staff undertaken by the Head of Midwifery in 2022 revealed that only five members of part time staff would be willing to work at WBC if we reintroduced births, which is insufficient to provide safe care. The reasons given by staff were:

- they feel it is an isolated birth environment
- there is a lack of wider multidisciplinary team support available should things not go according to plan
- they are concerned that they will not be able to maintain their professional competency in a unit with such a low birth rate

Patient choice

We have continued to provide women with a choice of birth settings – home birth, midwifery led unit (situated within Stoke Mandeville Hospital) and obstetric led labour ward as we have sufficient capacity and safe staffing to be able to do so.

Patient/Public Involvement and Engagement

Throughout the pandemic, extensive service user engagement has been undertaken in conjunction with the Maternity Voices Partnership, including online surveys between April 2021 and the end of September 2022, asking women if they have been impacted by the suspension of births at WBC from June 2020 onwards.

Of the 128 women who responded over 100 said that they had not been impacted with 5 stating that they had been slightly impacted, 9 moderately and 12 severely. All women were provided with alternative place of birth, either at home or in the Aylesbury Birth Centre.

The Maternity Voices Partnership is integral to providing responsive maternity services and there has been a continuous transparent dialogue with the lay co-chairs and vice chair about the WBC since births were suspended in June 2020. There has been collaboration throughout the last three years, ranging from consideration of potential options to restore births, discussion about staffing levels, to transforming the service provision at WBC to better serve the wider population and reduce health inequalities.

Co-design is central to maternity services development and transformation. The Maternity Voices Partnership will be working as a collegiate group of service user and NHS provider colleagues to ensure that the enhanced model of antenatal and postnatal care at WBC meets the needs and preferences of pregnant women in Wycombe.

Enhanced ante and postnatal care

We have taken the opportunity to adapt the facility at Wycombe to strengthen ante and postnatal care based on best practice. This has been particularly important given the loss of GP facilities out of which our community midwives can deliver their services.

This operating model sets strong foundations for enhancing maternity services in line with national priorities, without making a significant change or requiring additional resources. Over the last two and a half years, WBC has provided an environment for midwifery led ante and postnatal outpatient care due to the loss of facilities in local GP surgeries that has simultaneously occurred during the COVID-19 pandemic.

The Future

Delivering safe, effective care that improves maternal and neonatal outcomes for all women and babies using maternity services is paramount. We would like to build on the current operating model at WBC, enhancing ante and postnatal services, by providing a 'one-stop' centre of excellence. Key areas of focus are:

- Continuity of carer in the ante and postnatal period i.e. women being looked after by the same person/or people during and after their pregnancy
- mental health care
- smoking cessation support
- infant feeding support

Continuity of carer

The provision of midwifery continuity of carer in the ante and postnatal period is clinically proven to improve outcomes for mothers and their babies.

Evidence demonstrates that continuity of carer:

- Reduces pregnancy loss before 24 weeks by 19%
- Reduces pregnancy loss at any gestation by 16%
- Reduces preterm birth by 24%

Extensive engagement with service users demonstrates that continuity of ante and postnatal midwifery care is something that women would welcome. In the "Delivering

Better Births in Buckinghamshire" survey undertaken by the Trust, nearly half of the 835 women who responded said that they would like to see the same midwife they saw in pregnancy after birth with the majority saying that they would like to see the a maximum of two different midwives during antenatal care.

Mental Health

One in four women have mental health issues during pregnancy or after birth (Howard et al 2018). Mental health related deaths account for 40% of maternal deaths in the UK and death by suicide is the leading direct cause (MBRRACE 2022). Cultural stigma may prevent women from disclosing mental illness. Providing continuity of midwifery care enhances relationships between women and their midwife which increases the likelihood that women will speak up about their mental health. Building on the current model at WBC through immediate access to perinatal mental health specialist midwives /support workers ensures women get the right care at the right time in the right place.

Infant feeding

Including infant feeding support workers in the team at WBC will improve breastfeeding rates. Breastfeeding is proven (UNICEF Baby Friend Initiative) to improve outcomes for babies with:

- fewer gastrointestinal infection-related hospital admissions and fewer GP consultations
- lower respiratory tract infection-related hospital admissions and fewer GP consultations
- fewer acute otitis media (middle ear infections) related GP consultations

In our "Delivering Better Births in Buckinghamshire" survey, women have told us that they would like more support and advice with infant feeding in the first few days. This is also a consistent theme in our regular service user feedback. The most recent annual Picker survey of women's experiences of maternity services in Bucks (2022) demonstrated that women wanted:

- more information about feeding their baby
- more support with feeding their baby
- more help and advice about feeding their baby in the first six weeks

Smoking

Core20PLUS5 (NHSE 2022) identifies smoking as a key clinical area of health inequality. Smoking in pregnancy is the single most modifiable factor that can reduce preterm births and stillbirths (NHSE 2019) and is a key priority in the Bucks health and wellbeing strategy. Building on the current model at WBC by providing immediate access to a smoking cessation advisor at midwife appointments, will improve engagement and uptake of smoking cessation services for those communities most likely to smoke, as opposed to the current referral process to an external provider. Women from deprived backgrounds are more likely to be smokers when they become pregnant. They are less likely to stop smoking during their pregnancy or after the birth of their baby (RCPCH 2020). Smoking in pregnancy increases the risk of:

- miscarriage
- stillbirth
- premature birth
- a baby born smaller than it should be
- sudden infant death syndrome (cot death)

Financial Impact

There is no financial impact associated with continuing the current model of care alongside developing and enhancing the ante and postnatal care at Wycombe:

- there is no reduction in workforce due to the consolidation of births and ongoing requirement for the correct midwife to birth ratios (NICE 2015)
- there is no increase in workforce as perinatal mental health midwives and support workers, infant feeding support workers are in the existing workforce. Tobacco dependency advisors are externally funded by NHS England
- there are no resources required to further equip the WBC facility for ante and postnatal services

External Validation

The maternity service has engaged extensively with key stakeholders including the Maternity Voices Partnership co-chairs, BOB Local Maternity and Neonatal System (LMNS), South East Regional Chief Midwife, BOB ICB Chief Nurse, BOB ICB deputy director for quality and safeguarding.

External validation is being provided by the BOB LMNS Board. Minutes of February's board meeting will evidence this.

In Summary

In summary, delivering safe, effective care that improves maternal and neonatal outcomes for all women and babies, particularly those for whom the greatest health inequalities exist, is paramount.

The transformation of services at WBC is a key enabler to addressing these priorities, the needs of local maternity service users and providing safer, more personalised care through provision of a 'one-stop' community-based service.

This innovative community midwifery model enables WBC to become a hub of excellence, providing the midwifery continuity of carer in the ante and postnatal period that service users want and for which there is strong evidence that it improves outcomes for women and their babies.

Providing multidisciplinary care in a centre of excellence, based in the heart of the community provides ease of access and offers greater inclusion to the local community.

By continuing with the current choice of birthing options, and remodelling WBC as a centre of excellence for ante and postnatal care, we will be able to provide continuity of carer to SEVEN times more women than were previously giving birth at WBC, with no additional resource required. At least **50%** of these will be some of the most vulnerable in our community, enabling us to reduce health inequalities.

It will be the vanguard for transforming community midwifery services in Buckinghamshire; providing safer maternity care, supporting healthier communities, improving perinatal mental health care, and reducing the gap where health inequalities exist for women, their babies and families.

Next steps and review

We are seeking support from HASC to continue with the current model of care on a permanent basis, which consists of:

- A choice of birthing options – home birth, midwifery led birthing unit at the Aylesbury Birth Centre (which is within Stoke Mandeville Hospital) and obstetric led labour ward births at Stoke Mandeville
- Midwifery led ante and postnatal outpatient care at Wycombe and Stoke Mandeville
- Community - home visits, including visiting mum and baby on the first day after birth.

without the requirement for formal consultation given that this does not represent a substantive change.

If HASC agrees next steps would include:

- further engagement with key stakeholders to socialise future enhancements to the agreed model
- co design of additional ante and postnatal services at Wycombe with service users.

References

CQC (2020) Getting Safer Faster: key areas for improvement in maternity services

Howard et al (2018), British Journal of Psychiatry, The accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy

MBRRACE (2022) Saving Lives, Improving Mothers Care

MBRRACE (2022) National Perinatal Mortality Surveillance for Births in 2020

NHSE (2022) NHS Long term plan

NHSE (2022) 2023/24 Priorities and Operational Planning Guidance

NHSE (2022) Core20plus5

NHSE (2019) Saving babies lives care bundle 2

NICE (2015) Safe Staffing in Maternity Settings

NPEU (2015) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study

Ockenden (2022) Findings, Conclusions and Essential Actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust

RCPCH (2020) State of Child Health

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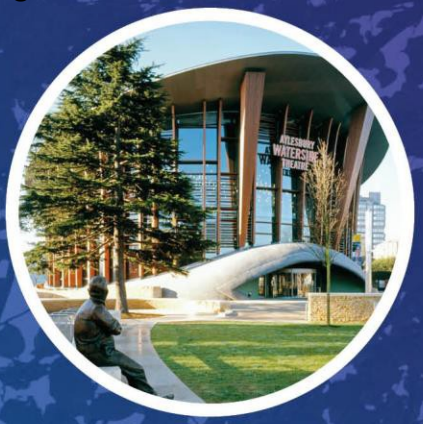


Health & Adult Social Care Select Committee – The Dementia Journey: a rapid review of support for people living with dementia and their carers in Buckinghamshire

Contents

Introduction

Cllr Carol Heap
Chairman of Review Group

"Through the work of the Health & Adult Social Care Select Committee, the review group were aware of the council's Adult Social Care transformation programme which included work around improving services for people living with dementia and their carers. As a review group, we wanted to undertake this review within a short time frame so the findings and recommendations could be used to support ongoing discussions between health and social care colleagues. We had four weeks from agreeing the scope to the first evidence gathering meeting and we really appreciated people giving up their time to talk to us at such short notice. We held three full days of evidence gathering meetings, all of which were incredibly valuable in widening our understanding of the existing pathways and support provided for people living with dementia and their carers.

I would like to take this opportunity to pay tribute to all those people who help support people living with dementia and their carers. Throughout the evidence gathering meetings, it became apparent just how much work is needed to provide the right level of support and how many people were directly affected by dementia in their own lives.

We support the NHS, in recognising dementia as a key priority in its Long-Term Plan and hope the findings and recommendations in this report will help to raise awareness of dementia and lead to an integrated health and social care dementia support service to meet the individual needs of all those living with dementia and their carers on their dementia journey."

Cllr Shade Adoh
(Day 1 only)

Cllr Phil Gomm

Cllr Robin Stuchbury

Cllr Nathan Thomas

Cllr Alan Turner

"There are currently around 900,000 people with dementia in the UK. This is projected to rise to 1.6 million people by 2040. There are over 42,000 people under 65 with dementia in the UK, known as young-onset dementia."

Alzheimer's Society website

Aim of the Rapid Review

As part of its remit, the Health & Adult Social Care Select Committee reviewed the refreshed Better Lives Strategy which is the council's strategy for providing support for adult social care clients. The strategy focusses on three levels of support – living independently, regaining independence and living with support. As part of the Better Lives Strategy and vision to ensure that people can remain as independent as possible, dementia support has been included as part of Adult Social Care's Transformation programme which includes a number of workstreams.

The Select Committee was keen to undertake a cross party rapid review to examine the existing dementia pathways, from diagnosis to end of life care, including a review of the prevention programme.

In addition, the Review Group wanted to identify examples of what is currently working well and discuss areas of improvement with key health partners and stakeholders leading to enhanced partnership working and a better integrated service.

Rapid Review scope

The review was set-up to achieve the following:

- A greater understanding of the prevalence of dementia, including the current diagnosis rates against the national target by Primary Care Network in Buckinghamshire;
- An understanding of current service provision and how these services are funded in Buckinghamshire. A comparison of funding with other authorities (ideally Oxfordshire and Berkshire West, part of our Integrated Care System);
- Clarity around who is responsible for delivering services in each pathway from diagnosis to accessing services, ongoing support to end of life care;
- Examine the quality of the signposting services and advice provided to dementia patients following diagnosis, including support and information for carers;
- Review the waiting times from referral to assessment for the memory clinic services;
- Review the current waiting times for carer assessments;
- Explore the involvement, co-production and engagement in developing dementia care journeys to help empower all people affected by dementia, including the partnership working with local communities and the voluntary sector;
- Overall aim – to identify potential gaps in the current pathways and develop a series of recommendations that could lead to improved working practices and provision of services.

Methodology

Evidence gathering sessions were held on Thursday 9th March, Tuesday 14th March and Thursday 16th March 2023 with the following groups of key stakeholders and individuals.

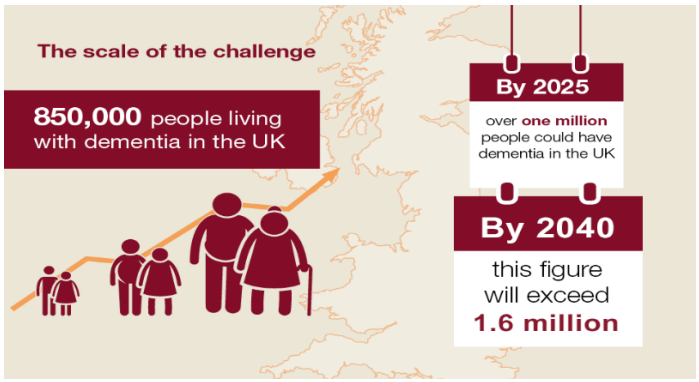
- Specialist Commissioning Manager (All Age Mental Health)
- Chair of the Dementia Strategy Group
- Lead GP for Dementia, Integrated Care Board
- Director of Public Health;
- Consultant in Public Health;
- Head of PCN Delivery and Development, Integrated Care Board;
- Consultant Psychiatrist and Associate Medical Director for Older People Mental Health (Oxford Health);

- Dementia Specialist Nurse (Oxford Health);
- Head of Service (Oxford Health);
- Head of Service, Localities, Adult Social Care;
- Dementia Connect Local Services Manager, Alzheimer's Society;
- Dementia Connect Adviser, Alzheimer's Society;
- Head of Service, Integrated Commissioning;
- Assistant Director, Adult Social Care;
- Communities Officer and Dementia Friends Ambassador, Aylesbury Town Council;
- Wendover Dementia Support;
- Princes Centre and Bourne End Centre;
- Dementia Action Marlow;
- Carers Bucks;
- Healthwatch Bucks;
- Primary Care Network Manager and Social Prescribers;
- Voices of people living with dementia and their carers;
- Care Home Managers;
- Nurse Consultant Older People, Buckinghamshire Healthcare NHS Trust;
- Clinical Lead – Mental Health & Learning Disability, South Central Ambulance Trust;
- Lead Nurse, Palliative and End of Life Care, Buckinghamshire Healthcare NHS Trust.

National Context

According to the Alzheimer's Society website, there are currently around 900,000 people living with dementia in the UK and there are projected to be over 1 million people with dementia in the UK by 2025. This is projected to rise to nearly 1.6 million in 2040. These numbers demonstrate the increasing scale and impact of dementia and the urgent need for action to be taken to meet current and future care needs. The NHS Long-Term Plan identifies dementia as a key priority and it is noted as one of the top causes of early deaths for people in England. There is a clear emphasis in the NHS Long-Term Plan on improving the care and support for people living with dementia, whether in hospital or at home and a commitment to continue working closely with voluntary organisations.

According to updated guidance published by the Office for Health Improvement and Disparities in February 2022, dementia costs society £34.77 billion a year in the UK and this cost is set to rise as the population ages. An estimated 540,000 people in England act as primary carers for people with dementia; half of these are employed, 112,540 have needed to leave employment to meet their caring roles and 66,000 carers have cut their working hours. The Alzheimer's Society shows that the contribution of unpaid carers of people with dementia in the UK totals £13.9 billion a year, costs which would otherwise have to be picked up by the government.



Source: Office for Health Improvement & Disparities website

Local Context

As of September 2022, 4,164 people were diagnosed with dementia (aged 65+) in Buckinghamshire. The current rate of diagnosis is 57.3% against a national target of 66.7%. The estimated prevalence is 7,266 meaning 3,102 people live with dementia but remain undiagnosed (as per NHS Digital report) which means they are not accessing appropriate support. It is estimated that there may be at least 240 people with young onset dementia in Buckinghamshire.

According to a recent needs analysis report produced by Buckinghamshire Council's Service Improvement team, which looked at Dementia in Buckinghamshire, it has been suggested that the gap is not within the current diagnostic pathways, but instead around increasing awareness, reducing stigma and encouraging people to come forward to be diagnosed. However, by employing proactive behaviour in identifying dementia signs and supporting access to a diagnosis, not only would the dementia diagnostic rate (DDR) increase but more people would access the appropriate dementia support sooner.

The Covid-19 pandemic impacted on national performance and the national diagnosis target rate is currently 62.2%. Buckinghamshire currently represents the 19th lowest diagnosis rate amongst 105 clinical commissioning groups (before they were abolished in 2022 and became part of an Integrated Care Board).

Dementia support is provided by a myriad of organisations across the health, social care and voluntary and community sector. Therefore, clear and coherent pathways are an essential part of ensuring the person living with dementia can readily access the right service at the right time. Supporting people to live independently for longer has a positive impact on the health and social care system, so ensuring the appropriate levels of care and support is a key part in achieving this.

Summary of Recommendations

The Health & Adult Social Care Select Committee Review group make the following recommendations, grouped together under the NHS England Dementia Well Pathway which has been adopted by Buckinghamshire.

PREVENTING WELL	DIAGNOSING WELL	SUPPORTING WELL	LIVING WELL	DYING WELL
The risk of people developing dementia is minimised.	Timely accurate diagnosis, care plan, and review within the first year.	Access to safe, high-quality health and social care for people with dementia and carers.	People with dementia can live in safe and accepting communities.	People living with dementia die with dignity and in the place of their choosing.

The NHS Dementia Well Pathway

Overview

<u>Recommendation 1</u> – Develop a multi-agency Buckinghamshire Dementia strategy with specific action plans aligned to the Dementia Well pathway which brings together activities from across the health and social care system and local communities.

<u>Recommendation 2</u> – Review the membership of the Dementia Strategy Group to include a broad representation within each pathway to ensure a strong, collaboration of key people responsible for delivering the dementia strategy.

Preventing Well

<u>Recommendation 3</u> - Commitment by Public Health and Primary Care to provide a renewed focus on increasing the take-up of the NHS Health check for eligible 40-74 year olds. A memory question should be part of all health checks and a more consistent approach to the information provided to patients as part of the health check should be agreed.

<u>Recommendation 4</u> – Public Health to include risks associated with dementia as part of all relevant public health campaigns, particularly on cardiovascular disease, so people make the connection that lifestyle choices affect both the heart and the brain.

<u>Recommendation 5</u> - School Liaison Officers to explore whether a dementia awareness programme for all school age children could be developed and promoted to all schools in Buckinghamshire to help reduce stigma, address cultural differences and create a better understanding of dementia and what support is available.

<u>Recommendation 6</u> – The BetterPoints initiative to be more widely promoted across Buckinghamshire to include all Members, council staff, BHT staff, South Central Ambulance Service staff, Oxford Health staff, Community Boards, voluntary and community groups and all PCNs.

Diagnosing Well

Recommendation 7 – Oxford Health to provide clarity about medication reviews to those people who are receiving dementia medication and to include contact details of who to speak to about dementia medication.

Recommendation 8 – Social care commissioners to review the memory service provided in Oxfordshire and consider introducing dementia support workers at the memory clinics to provide a joined-up service to those who have just been diagnosed.

Recommendation 9 – Primary care, social care commissioners and the Dementia Support Service to work together to develop a consistent approach to memory screening and reduce waiting times across the county. To clarify and promote the pre-diagnostic support available.

Recommendation 10 - Each Primary Care Network to introduce a named dementia specialist to co-ordinate the screening and pre-diagnostic support within primary care and to work closely with the Alzheimer's Society Local Dementia Advisers to deliver screening training to those nominated across the PCNs.

Supporting Well

Recommendation 11 – Adult Social Care (ASC) to ensure they refer people with memory concerns to the appropriate person – GP or social prescriber/named dementia specialist for a memory screening assessment and for those people with a dementia diagnosis, ASC need to refer to the Dementia Support Service.

Recommendation 12 – Agreement by the Integrated Care Board to additional investment in dementia support services for Buckinghamshire to address the current under investment in services. Additional investment to be used to provide a better integrated service across all pathways, with clear lines of responsibility.

Recommendation 13 - The recommendations in Healthwatch Bucks report on young onset dementia should be progressed alongside these recommendations in this report and therefore progress will be reported to the HASC Select Committee.

Recommendation 14 – Care homes to be part of the development of the Buckinghamshire Dementia Strategy and develop closer working between primary care network social prescribers, including the named dementia specialist, voluntary groups and local care homes to develop dementia specific activities to meet the needs of the local community.

Recommendation 15 – Care homes, primary care, hospital care and social care partners to encourage the use of "This is me" to help capture information on the person with dementia. Reassurance from BHT that the John's principles around the right to stay with people with dementia is part of the care offered during Hospital stays.

Living Well

Recommendation 16 – The Dementia Strategy Group to undertake an exercise to map current provision and highlight the gaps in support services with input from social prescribers, social care commissioners for day opportunities and community board managers with their local community groups. If the recommendation above to have a dementia specialist within each PCN is implemented, then we would encourage them to be part of this exercise.

<u>Recommendation 17</u> – Consideration to be given to using existing space at the council-owned day centres at Buckingham, Aylesbury, Beaconsfield, Chesham, Wycombe and Burnham to accommodate dementia cafes, dementia support groups and other activities (both voluntary and commissioned) to increase access to these services across the county.

Dying Well

<u>Recommendation 18</u> – Buckinghamshire Healthcare NHS Trust educators work with the council's library services, voluntary groups and community board managers to re-introduce and develop a series of "Big Conversation" events across the county on a rolling basis.

Please read on to understand more fully the reasoning and evidence behind the recommendations.

Key Findings & Recommendations

After carefully considering the evidence collected at meetings with key stakeholders and bringing together the background research, undertaken at the outset, the Review group wish to report on our key findings, observations and recommendations.

Buckinghamshire follows the NHS England Transformation Framework – the Dementia Well pathway so our findings and recommendations have been grouped under the headings of Preventing Well, Diagnosing Well, Supporting Well, Living Well and Dying Well.

Overview

We started our evidence gathering by talking to the council's adult social care commissioners to understand, in more detail, the work which is currently being undertaken as part of the Better Lives Strategy and the transformation workstreams which focus on dementia services. The workstreams are as follows:

- Pre and post diagnostic support;
- Intensive support (for those at risk of short-term crisis);
- Information advice and guidance (developing a single platform for dementia specific advice);
- Other broader workstreams relating to carers support and community opportunities.

We heard about the following activities which are supporting the workstreams.

- DiADeM pilot – a pilot focussing on increasing diagnosis of dementia within care homes;
- Dementia information resources focus group – launch of landing page on website;
- Dementia Connect Model – business case to expand the current support service to include named case workers;
- Dementia Diagnostic pathway – remodelling of the memory clinic service;
- Dementia intensive support – development of a business case for a multi-disciplinary support team.

As part of our background research, we read the "Dementia in Buckinghamshire needs analysis and recommendations" report which was produced in March 2022. The needs analysis report highlighted 6 key gap areas (listed below) which then led to 9 areas of recommendation to address these gaps.

- Named case worker;
- Specialist dementia nursing support;
- Timely diagnosis and assessment;
- Community opportunities/short breaks;
- Communications;
- Crisis support.

Whilst recognising that carers support and community opportunities both have a broader reach than just those people living with dementia and their carers, we would like to see these areas feature more prominently in the ongoing development of dementia support. Currently, the workstreams for carers support and community opportunities are led by different teams within adult social care and the deliverables from these workstreams are not clear.

The review group would like to see the areas of recommendation outlined in the gap analysis align more clearly with the existing workstreams and be used to develop a whole system, multi-agency action plan for delivering high quality dementia care throughout the entire pathway. We found it difficult to piece together how the council's work around dementia linked with the wider system work around dementia. Using consistent language and headings will provide some of the clarity needed to ensure a more joined-up, integrated approach as well as clear lines of responsibility for each area.

The needs analysis report states that Buckinghamshire follows the NHS England Transformation Framework – the Dementia Well Pathway so we feel that this pathway should be used to help develop the multi-agency action plan, with each pathway having a lead organisation(s) responsible for reporting progress to the Dementia Strategy Group.

Dementia Strategy Group (DSG)

Members noted that an All-Age Mental Health and Wellbeing Strategy Bucks 2020-23 has been developed. This strategy is supported by the Dementia Strategy Group (DSG) which brings together commissioners and local partners. The DSG meets bi-monthly and supports delivery of some of the actions that underpin the council's dementia transformation programme.

Throughout the evidence gathering meetings, we heard that some people regularly attend the DSG meetings whilst others did not always attend and some people did not know about the group. We received feedback that the meetings had a clinical focus and voluntary groups reported having to wait until the end of the meeting to be heard by which time some members had left.

We heard that dementia is not a mental health condition. It is primarily a set of progressive physical symptoms and whilst mental health issues may occur in some patients, for example, depression or delirium, this is not inevitable.

The review group heard that Buckinghamshire Healthcare NHS Trust has developed a dementia strategy and as mentioned above, the DSG supports specific actions, as part of the Adult Social Care's transformation work. However, we found no evidence of an overarching dementia strategy for Buckinghamshire involving all the key partners.

The review group feels that a multi-agency strategy, which is owned by the members of the DSG, would lead to a more joined-up, collaborative approach to supporting people living with dementia and their carers. Formulating a separate multi-agency dementia strategy, where specific action plans for each pathway are developed and owned by key partners, would separate it from the mental health strategy and give dementia its own platform. Progress on delivering the action plans should be monitored by the DSG and reported to the Health & Wellbeing Board.

As part of the background research, we reviewed examples of how other local authorities provided dementia support and we found some good examples of collaborative, multi-agency strategies. We particularly liked Birmingham and Solihull's dementia strategy and the joint health and social care dementia strategy for Surrey.

Examples of multi-agency dementia strategies

Birmingham and Solihull – Birmingham and Solihull Dementia Strategy 2022-2027 (icb.nhs.uk) (Draft strategy)

Surrey County Council – Joint Health and Social Care Dementia Strategy (surreycc.gov.uk)

<u>Recommendation 1</u> – Develop a multi-agency Buckinghamshire Dementia strategy with specific action plans aligned to the Dementia Well pathway which brings together activities from across the health and social care system and local communities.

<u>Recommendation 2</u> – Review the membership of the Dementia Strategy Group to include a broad representation within each pathway to ensure a strong, collaboration of key people responsible for delivering the dementia strategy.

Preventing Well

The NHS Dementia Well pathway describes "Preventing Well" as minimising the risk of people developing dementia.

- Although there are medicines available that can slow the progression of some of the early symptoms of dementia, these are not suitable for everyone. There is no cure for Alzheimer's disease or any other type of dementia. However, appropriate early diagnosis of dementia can extend independent living for up to 2 years and improve quality of life beyond that.
- We heard that 40 % of dementia is avoidable and lifestyle changes can significantly reduce the risk of developing dementia. Cardiovascular health is linked to dementia and promoting a healthy lifestyle is therefore crucial to help reduce the risk of developing dementia. ***"What's good for the heart is good for the brain."***

NHS Health Checks

- The NHS Health check is a preventative healthcare programme and invites adults aged between 40 and 74 for a health check-up every 5 years to spot early signs of stroke, kidney disease, diabetes or dementia. The check is for people who do not have a pre-existing condition as they will already be receiving regular check-ups. Local authorities are responsible for the commissioning of the programme which is normally provided by GP practices and carried out by healthcare professionals, pharmacists or the GP. The funding is provided through the Public Health budget.
- Data shows that less than 50% of eligible patients in Buckinghamshire between 2012 and 2018 had their health check – in Buckinghamshire, 73,855 NHS Health checks were recorded between April 2012 and March 2018 compared to 109,286 non-attendance (source: Microsoft Power BI).
- We understand that most of the GP practices in Buckinghamshire have signed up to carry out the health checks and practices are paid according to the number of checks carried out.
- We heard that patients are invited via letter and text to attend their health check. The Gov.uk website states that "health and care professionals should provide support and advice on dementia risk reduction as part of their daily contact with individuals. Every contact counts as a chance to educate and empower people to make positive choices about their own health". In Buckinghamshire, health and care professionals support the Making Every Contact Count approach.
- We heard one example of someone attending their regular diabetic check-up who mentioned to the healthcare professional that they had memory concerns. They then received a memory test but this was not a routine part of this check-up.
- We understand that there are programmes underway to promote the health checks within specific communities, as part of Opportunity Bucks, focussing on specific wards within Buckinghamshire. We heard that there are cultural differences surrounding dementia, with some cultures not recognising the condition within their own language.

- With the known pressures on GP practices, members are concerned about capacity within the surgeries to undertake the health checks and believe that there needs to be a renewed focus on promoting the benefits of the health check and for a memory question to be part of the discussion for all patient's receiving health checks.
- As health checks are carried out by different healthcare professionals in primary care, we are also concerned about potential inconsistencies in how the checks are carried out and would like to see a guidance note issued by Public Health to all GP surgeries.
- According to the NHS website and the detailed information about what to expect as part of the health check, it states that "if you're over 65, you'll also be told the signs and symptoms of dementia to look out for". The review group's view is that this should be part of every health check and not age specific as early onset dementia starts well before the age of 65.
- We would like to see a more concerted effort to encourage better take-up of these health checks by those patients who are eligible for them. We would also like to see a question around memory concerns as part of regular check-ups for people who have a pre-existing condition.

<u>Recommendation 3</u> - Commitment by Public Health and Primary Care to provide a renewed focus on increasing the take-up of the NHS Health check for eligible 40-74 year olds. A memory question should be part of all health checks and a more consistent approach to the information provided to patients as part of the health check should be agreed.

Cardio-vascular disease and public health campaigns

- The Health & Adult Social Care Select Committee discussed the Director for Public Health Annual Report at its November meeting. The annual report focused on reducing the risks associated with cardio-vascular disease. We would like to see dementia risks included in all relevant public health campaigns which promote reducing cardio-vascular disease.
- We are aware that cardio-vascular disease is a strategic priority for the Integrated Care Board but there was little reference to dementia in the ICB strategy. As dementia is a key priority in the NHS Long-Term Plan, we feel that it should be more prominent in the ICB strategy and there should be joint activities to help reduce the risk of heart disease, stroke and dementia.

<u>Recommendation 4</u> – Public Health to include risks associated with dementia as part of all relevant public health campaigns, particularly on cardiovascular disease, so people make the connection that lifestyle choices affect both the heart and the brain.

Raise awareness and reduce stigma within schools

- We heard about an initiative within schools to help increase the awareness of dementia, encourage more discussion and to help reduce the stigma. Young children recognised and related to dementia as seen in their own family or acquaintances and this could be built on to raise awareness in the community.
- This finding is slightly out of scope as we were not expecting to speak to colleagues from the Education service but speaking to school age children was acknowledged by health professionals as an important part of raising awareness and providing dementia information for different cultures would help to reduce the stigma and increase understanding. We appreciate that more work would be required before speaking to schools - we suggest that a piece of work be undertaken to see what has been done in other areas and whether there is a relatively easy way to get key messages about dementia to young people.

<u>Recommendation 5</u> - School Liaison Officers to explore whether a dementia awareness programme for all school age children could be developed and promoted to all schools in Buckinghamshire to help reduce stigma, address cultural differences and create a better understanding of dementia and what support is available.

"Bucks BetterPoints" initiative

- Public Health colleagues shared information on a new App, BetterPoints, which has just been launched (January 2023). People can earn points for undertaking healthy activities across Buckinghamshire which can then be redeemed as vouchers to spend at high street stores or donate to charities. This new initiative has been promoted on social media and the Bucks website and the target is to have 1,000 users this year and a further 1,000 the year after.

<u>Recommendation 6</u> – The BetterPoints initiative to be more widely promoted across Buckinghamshire to include all Members, council staff, BHT staff, South Central Ambulance Service staff, Oxford Health staff, Community Boards, voluntary and community groups and all PCNs.

Diagnosing Well

The NHS Dementia Well pathway describes "Diagnosing Well" as timely, accurate diagnosis, providing a care plan and review within the first year.

Memory Diagnosis Service (provided by Oxford Health Foundation Trust)

- We understand that most people with memory concerns contact their GP in the first instance. The GP will assess the patient and may decide to refer them to the memory clinic for a further assessment which could lead to a formal diagnosis. Following a formal diagnosis, a letter is sent back to the GP so the diagnosis can be recorded on the patient's record.
- The memory clinic is funded through the mental health block contract which is provided by Oxford Health Foundation Trust. The waiting times for the memory clinic are currently between 4-6 months. We understand the service is in the process of being redesigned to have a single point of access but it was not clear about how the proposed redesigned service would lead to reduced waiting times.
- There are currently 2 memory assessment clinics – Whiteleaf Centre and Saffron House. A number of GP practices used to offer consulting room space for memory clinics but due to challenges with surgery space, these have now been rescinded.
- We heard about the ambition to undertake memory assessments closer to home but this relies on appropriate space within communities, availability of staff to undertake assessments and the financial costs associated with this model.
- Recruitment remains one of the biggest challenges and we heard that it took 12 months to recruit a dementia specialist nurse. Recruiting in the south of the county continues to be a challenge as roles are competing with others nearby which offer London salary weighting.
- Oxfordshire has adopted a different model of delivery for people over 65 and those under 65 follow a neurology pathway rather than being mental health led.
- We heard that at the time of diagnosis, Oxford Health provide an information pack for the patient which contains details on the Dementia Support Service, provided by the Alzheimer's Society (Buckinghamshire Council is the lead contract holder and the service is funded by the Better Care Fund).
- Speaking to people who had been diagnosed with dementia and their carers as part of this Review, we heard that not everyone received an information pack and once diagnosed, there was no follow-up by Oxford Health. Oxford Health used to undertake this but they are no longer commissioned to provide the follow-up service to all those who attend the memory clinic. Oxford Health only provides follow-up to those who are prescribed medication for their dementia.
- We understand that the Dementia Connect Service is only available to those people who contacted them after being diagnosed – their details could not automatically be sent to the Dementia Connect Service due to data protection issues. People explained that they were often left to find their own information and support groups. We understand that in North Bucks, contact details from consenting patients are given to the Dementia Support Service to enable them to make contact to offer post-diagnostic support. However, there appears to be a gap in current service provision in South Bucks.
- The review group heard that in Oxfordshire, the memory clinics work closely with the Alzheimer's Society to ensure support can begin at the time of diagnosis by having a dementia support worker based in the memory clinic.
- We learned that the numbers of referrals to the memory clinic had increased markedly and that many of these cases could be dealt with in the GP/community setting, via screening and signposting to the appropriate support. This would serve to reduce waiting times and allow the clinic to concentrate on the more complex cases.
- We heard from a carer who had experienced problems with medication reviews and had been passed between the GP and Oxford Health. We understand that GPs cannot prescribe medication for dementia as this has to be done by the psychiatrist. To ensure this is clear, we would like to ensure that Oxford

Health provides this information when speaking to the person with the dementia and their carer and includes contact details for medication reviews.

<u>Recommendation 7</u> – Oxford Health to provide clarity about medication reviews to those people who are receiving dementia medication and to include contact details of who to speak to about dementia medication.

Dementia Support Service (provided by the Alzheimer's Society)

- In 2022, the Dementia Support Service was recommissioned and was based upon delivery of a "dementia connect model" providing pre and post diagnostic support both on a face-to-face basis and virtually depending on the needs of the person. Tier 1 support is a national telephone service and is the first point of contact for someone with memory concerns. Tier 2 is the next level of support under the Dementia Connect model and includes support calls, home visits and follow-ups. The Dementia Adviser provides a named contact to the person with memory loss and their carer throughout their journey with dementia.
- In Buckinghamshire, the above service is delivered by 5 dementia advisers. Based on the estimated dementia prevalence and the capacity of the advisers, the current service reach is around 10%.
- The latest performance report on the Dementia Connect service shows that 110 referrals were made to Tier 1 between 1 October 2022 and 31 December 2022. 46 referrals were made to Tier 2 (33 were self-referrals and 4 were referrals from the memory clinic).
- Very few GPs are referring patients to the Dementia Support Service (11 referrals came via the GP during the same 3 month timeframe) which suggests GPs are not aware of the Dementia Support Service.
- Prior to the recommissioned service, we heard that the contract for dementia support services included a much broader range of services, including a memory screening test which was undertaken by a local dementia adviser, at the pre-referral stage to the memory clinic. The screenings took place in the community using the GP COG assessment tool.
- The Health & Adult Social Care Select Committee carried out an in-depth inquiry last year into the development of Primary Care Networks (PCNs). To support PCNs, the Additional Roles Reimbursement Scheme provides funding to recruit to additional posts to create bespoke multi-disciplinary teams, including mental health practitioners, social prescribers, health and wellbeing coaches and pharmacists.
- As part of the evidence gathering, we spoke to social prescribers from across the Primary Care Networks. Two of these social prescribers explained that they have undertaken training to use the GP COG assessment tool to screen people who have memory concerns. One social prescriber said that she took this responsibility on herself as she could see there was a gap in the screening process. She has screened over 90 people during the last few months.
- A gap in service provision seems to have occurred at the time of re-commissioning the service in 2022 which has meant that memory screening is no longer provided as part of the commissioned service.
- With waiting times at the memory clinic around 4-6 months, people do not seem to be receiving pre-diagnosis support in the same way that they did before the service was recommissioned. We are unclear about what pre-diagnosis support looks like in the current pathway. People told us that this long wait for a diagnosis was particularly stressful and that they and their carers felt unsupported during this time.
- We also feel that there should be named dementia specialists within each Primary Care Network who are responsible for co-ordinating the GP COG screening programme and training people within the PCN to undertake the screening. This will ensure a consistent approach and a forum for sharing learning and areas of improvement.

<u>Recommendation 8</u> – Social care commissioners to review the memory service provided in Oxfordshire and consider introducing dementia support workers at the memory clinics to provide a joined-up service to those who have just been diagnosed.

<u>Recommendation 9</u> – Primary care, social care commissioners and the Dementia Support Service to work together to develop a consistent approach to memory screening and reduce waiting times across the county. To clarify and promote the pre-diagnostic support available.

<u>Recommendation 10</u> - Each Primary Care Network to introduce a named dementia specialist to co-ordinate the screening and pre-diagnostic support within primary care and to work closely with the Alzheimer's Society Local Dementia Advisers to deliver screening training to those nominated across the PCNs.

Supporting Well

The NHS Dementia Well pathway describes the "Supporting Well" pathway as providing access to safe, high-quality health and social care for people with dementia and carers. This pathway includes care at home, in care homes, hospital care and crisis support.

Social Care support and signposting services

- We heard from Adult Social Care (ASC) officers about their work in supporting approximately 307 people living with dementia who are eligible for council funding. With over 4,000 people living with a dementia diagnosis in Buckinghamshire, this represents a small number who are currently being supported by ASC.
- The role of Adult Social Care is to support people, who are identified as in need of statutory support for personal and social care, to live independently and well. Everyone is entitled to an assessment under the Care Act 2014 and we understand that the current waiting time is more than 30 days. If a person is eligible for council funding to help with their care needs, this funding can be used to provide support at home including sitting-in service or Day Centre opportunities (places are booked by the council at privately funded day centres). There are no council run day opportunities specifically arranged for people living with dementia.
- Adult Social Care also provide a Carer's assessment to support carers in their caring role. Support for carers is generally provided through the council's commissioned service with Carers Bucks.
- If a person is not eligible for council support, they are signposted to a number of different places, including Prevention Matters. We also heard about a paid for brokerage service which helps to match a person's needs to local services - this service costs around £300.
- In terms of dementia related support, we understand that the council commissions the Dementia Support Service (provided by the Alzheimer's Society) and Carers Bucks, as well as purchasing individual sessions at privately funded day centres based on assessed need.
- ASC also refer people to the NRS team to help maximise independence, security and support, for example, via the provision of pendant alarms, memo minders, GPS trackers and door sensors.

Prevention Matters (commissioned by Buckinghamshire Council)

- The review group understands that the council commissions another service called Prevention Matters. This service does not provide specific dementia support. Whilst reviewing this website, we found that some of the links do not work. For example, "finding activities and services near you" defaults to the Buckinghamshire Council landing page.
- We heard that ASC refer people to Prevention Matters which, according to their website, is a free and friendly advice service linking eligible adults in Buckinghamshire to social activities, voluntary and community services. In this instance, eligible means not eligible for funded social care services. It was not clear where people living with dementia (funded or otherwise) would be referred to by Adult Social Care for dementia support.
- From our limited discussions about this service during the review meetings, it appears that part of this service is very similar to that which is now provided by social prescribers through the 13 Primary Care Networks in Buckinghamshire.
- The Health & Adult Social Care Select Committee recently undertook an inquiry into the development of Primary Care Networks and one of the recommendations was to have a named social worker for each PCN. We feel that these links should help to ensure social workers refer people with memory concerns to the right place, ie. the GP or social prescribers/dementia specialist or the Dementia Connect Service if the person has received a dementia diagnosis.

Dementia Support Service (commissioned by Buckinghamshire Council)

- As mentioned in the earlier section, the council commissions the Alzheimer's Society to deliver the Dementia Support Service (DSS) in Buckinghamshire.
- The latest service specification (2022) states that the DSS should provide the Dementia Connect model, memory information sessions, post diagnosis information sessions, keeping in touch calls and memory screening assessment support.
- We heard that the Dementia Connect Service is currently delivered by 3.8 full-time equivalent advisers (1 full-time and 4 part-time) who look after between 12-20 cases, with 2-3 new referrals each week per adviser.
- We understand that some of the services described above are not currently being delivered due to the disruption caused by the Covid-19 pandemic. We saw evidence of very limited events taking place in the south of the county – Amersham Carer support group, run by a facilitator (face-to-face), Carers support group (held virtually and supported by a Dementia Adviser), Memory information sessions for members of the public in Amersham Lifestyle Centre and "Singing for the Brain" in Beaconsfield.
- The review group understand that the current reach of the Dementia Connect Service is only 10% of the prevalent population. We are aware of the business case to expand the Service to increase the reach to around 25% of the prevalent population of Buckinghamshire by providing named case workers for people living with dementia throughout their journey.
- We heard that Oxfordshire reaches around 39% of its prevalent population through greater investment in providing dementia support services. It appears that their offer includes a wider breadth of services, which includes the Dementia Connect model but also provides additional support via Admiral Nurses for the later stages of the dementia journey, when more intensive support is required. Dementia Advisers work closely with Oxford Health in the memory clinics.
- Through our evidence gathering meetings, we heard that access to the right information at the right time is not always happening. One carer mentioned that they were not given any information at the point of diagnosis and did not know where to go for support.
- We did hear from a carer who had accessed the Dementia Connect Service and spoke very highly about the support she had received from a Dementia Adviser. Some of the voluntary groups which we spoke to were not aware of the Dementia Connect service, but they were all aware of the support offered by Carers Bucks.
- We understand that the service specification for dementia support services prior to 2022 included the provision of community activities (including singing for the brain and community cafes to provide support for people with dementia and their carers) and advice and support for communities to help them become dementia friendly. Some of these activities continue to be provided by Alzheimer's Society but with reduced capacity.
- We support the business case to provide additional investment in the Dementia Connect Service. However, there are other gaps along the dementia journey which need to be reviewed and strengthened with additional investment in support services needed to ensure all needs are met.
- We would like to see a more blended approach to providing more dementia support services in local communities to ensure the needs, at all stages of the dementia journey, are met. The needs of people living with dementia change, but we did not feel that the current service is able to effectively meet the needs of the person throughout their dementia journey

<u>Recommendation 11</u> – Adult Social Care (ASC) to ensure they refer people with memory concerns to the appropriate person – GP or social prescriber/named dementia specialist for a memory screening assessment and for those people with a dementia diagnosis, ASC need to refer to the Dementia Support Service.

<u>Recommendation 12</u> – The Integrated Care Board to agree to additional investment in dementia support services for Buckinghamshire to address the current under investment in services. Additional investment to be used to provide a better integrated service across all pathways, with clear lines of responsibility.

Carers Bucks (commissioned by Buckinghamshire Council)

- In terms of support for carers who are caring for people with dementia, we understand that the council commissions Carers Bucks to provide information, advice, guidance and emotional support to unpaid carers in Buckinghamshire.
- They currently support 2,040 carers who are caring for someone with a type of dementia. Of those, 2,035 are adults aged 18 and above, with 3 being in the 18-24 age bracket, and 2,032 in the 25+ age bracket. They also support 5 young carers aged between 12-16 who are helping to care for someone with dementia.
    - Carers Bucks will make up to 6 home visits, where appropriate, to carers aged 75 and above who may struggle to access support through "usual" means – for example, if they cannot leave the person they care for, if they have their own mobility problems meaning it's hard to come to an in-person support group, if they have hearing problems rendering telephone support unsuitable
    - Their hospital support team cover the four Bucks hospitals – SMH/Wexham/Wycombe/Amersham – and are able to support carers on site, both practically and emotionally
    - They have limited funding pots which can be used to support carers with their own health and wellbeing, whether that's via access to talking therapies or complementary therapies.
- The feedback on the services provided by Carers Bucks, which we heard during the evidence gathering meetings, was very positive from both groups and individuals.

Young Onset Dementia

- Healthwatch Bucks recently carried out a project looking at young onset dementia. The aim was to find out about peoples' experiences of living with young onset dementia (where symptoms first occur before the age of 65). Their report detailed a number of recommendations including providing information in a timely, personal and age appropriate way, a named contact regularly reaching out to the person with young onset dementia and their carers and the creation of mini support networks. The full report can be found here Young Onset Dementia Report.docx (sharepoint.com).
- We heard through the evidence gathering meetings that there is no clear pathway for people diagnosed with young onset dementia. This type of dementia requires a different approach. For example, people affected are of working age so need different support and the disease can also progress rapidly. The estimated number of people with young onset dementia in Buckinghamshire is 240.
- Without wishing to duplicate the work of Healthwatch Bucks, we would like to use their report to highlight that there needs to be provision for young onset dementia as part of the overall dementia offer and to ask that their recommendations are considered alongside the Review Group's recommendations.

Recommendation 13 – The recommendations in Healthwatch Bucks report on young onset dementia should be progressed as part of the recommendations in this report and therefore progress will be reported to the HASC Select Committee.

Care Homes

We heard from care home managers that some of them were hosting dementia cafes/drop-in sessions before the Covid-19 pandemic and were now starting to re-introduce them as part of their programme of activities, as they were well received by those who attended. We felt that this idea could be developed further and we would encourage social prescribers from across the PCNs to link with the care homes in their areas to discuss how these activities could reach those within their PCN. It would also enable social prescribers to discuss local community activities with the care homes to ensure these are known to them and available to their clients. If the recommendation to have a nominated dementia specialist across the PCNs is implemented, that person should also be involved in these discussions.

From those we spoke to during the evidence gathering, care home managers are interested in the DiaDem pilot which aims to increase dementia diagnosis within care homes. We heard that there are currently significant numbers of people in care homes without a dementia diagnosis, including some who have been discharged to assess but are awaiting permanent placements.

We would like to see the inclusion of care homes in the development of a Buckinghamshire Dementia Strategy with specific actions around closer partnership working between PCNs, voluntary groups and care homes.

Recommendation 14 – Care homes to be part of the development of the Buckinghamshire Dementia Strategy and develop closer working between primary care network social prescribers, including the named dementia specialist, voluntary groups and local care homes to develop dementia specific activities to meet the needs of the local community.

Hospital Care

- Through speaking to Buckinghamshire Healthcare NHS Trust colleagues (BHT) and South Central Ambulance Service colleagues (SCAS), we heard about the way both organisations currently support people living with dementia and their carers.
- We heard about the personalised care passport specifically used by people with dementia called "This is Me". The document contains individual information, for example, likes and dislikes of the person, their routines and cultural background. It is intended to go with the person to health settings and to enable person-centred care. Oxfordshire Health Trust have developed a similar passport and this document is called "Knowing Me". Care homes have their own paperwork on their clients. Whilst this is not a mandatory document, the usefulness in helping to meet the needs of the person with dementia was acknowledged. This is me | Alzheimer's Society (alzheimers.org.uk)
- Whilst recognising the difficulties associated with discharge summaries, we heard from key stakeholders about the poor quality of discharge summaries, with information missing or being inaccurate - in some instances this had resulted in a patient being re-admitted to hospital.
- We were made aware of a national campaign "John's Campaign" which is about the right of people who care for someone living with dementia to be able to stay with them – and the right of people with dementia to be able to have a family carer stay with them. Whilst acknowledging the difficulties with adhering to this during the pandemic, we seek reassurance from BHT that they adhere to these principles and have processes in place to ensure this happens. John's Campaign | Dementia Partnerships
- We heard that BHT have developed a Dementia Strategy and would ask that this is shared with all health care partners and the Health & Adult Social Care Select Committee.

Recommendation 15 – Care homes, primary care and social care partners to encourage the use of "This is Me" to help capture information on the person with dementia. Reassurance from BHT that the John's principles around the right to stay with people with dementia is part of the care offered during Hospital stays.

South Central Ambulance Service (SCAS)

- Whilst SCAS remains on an improvement journey, following the latest Care Quality Commission (CQC) inspection, its plan to become a dementia-friendly organisation is not a key priority at the moment. Dementia awareness is included in induction training but due to operational pressures, dementia specific training ceased at the beginning of the year.
- The review group heard about a recent initiative to make their ambulances dementia friendly (and child friendly) by using reassuring stickers to help create a talking point and to reassure the patient. It was good to hear during the meeting that the BHT representative felt that it would be good to use the same

themed stickers on the Older People Hospital wards to create the same reassuring environment and continuity for the person with dementia.

Dementia Intensive Support Team

The review group heard about the plans for an intensive support team as part of the Dementia Transformation workstream. Plans are in place to develop a model based on a multi-disciplinary team, offering both clinical and social care support to people living with dementia (and their carers/supporters) who are at risk of short-term crisis leading to unplanned hospital admission or transfer into residential care.

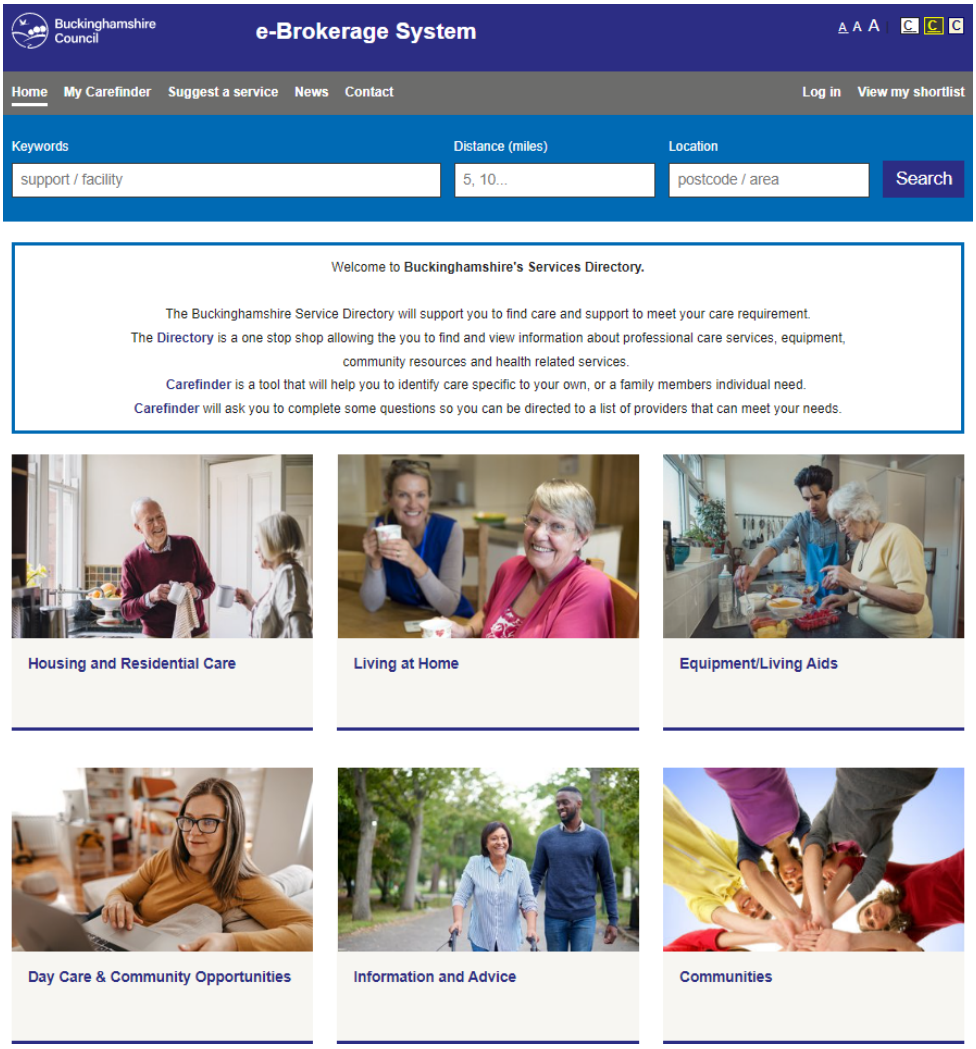
Whilst we appreciate the plans are in their early stages, we support the need for a crisis team who are able to support people living with dementia and their carers within their local community and look forward to hearing about the progress being made in delivering a crisis team in Buckinghamshire.

Living Well

According to the NHS Dementia Well pathway, “Living Well” represents people with dementia living in safe and accepting communities.

Access to information

- The review group is aware of the Bucks Online Directory and as part of the background research for this Review, we reviewed the website to see what dementia specific activities were available in certain parts of the county. Whilst we commend the website for bringing together community-run organisations, we felt there were gaps, some out of date entries and it did not represent all organisations, as it relies on self-registration. We found the search facility was not robust enough to ensure a meaningful result for someone who was looking for local dementia support groups.
- Throughout the evidence gathering meetings and as part of the background research, we reviewed various websites, including the council’s website. There were a number of examples within the dementia support pages where the links did not work, for example to the carer assessment page.
- We heard about projects to improve the content of websites and we understand that the Dementia Strategy Group will be launching a “toolkit” for people to access information about dementia support through one front page on the website.



- The screenshot above is taken from the council's website and was found whilst researching the brokerage service which was mentioned during the evidence gathering meetings. This website has not been developed and we are not clear who is responsible for developing the content for it.
- We have not seen the new launch page, which the DSG are working on, but we hope it will include links to the information above as we felt this brought all the important aspects of support together in one place.
- Whilst we support the need for an updated, co-ordinated and user-friendly website, we also heard that people with dementia and their carers do not necessarily access online information and preferred written materials which they could refer to as and when required.

Planning for the future

- Advance Care Plans, Attendance allowance, Power of Attorney and other financial discussions are best had whilst the person still has capacity and should be encouraged at the time of diagnosis. We heard that people can feel overwhelmed at the time of diagnosis and giving lots of information can add to this so this needs to be handled in a way that ensures people have the information as and when they are ready. We would like to see future planning be a key part of the "Big conversation", more detail on this is in the next section.

Community activities

- Whilst the provision of meaningful and timely information is important, we heard that face-to-face meetings were crucial for people living with dementia and carers. The recent Covid-19 pandemic had created many challenges but we heard how some local community groups carried on throughout the pandemic, offering face to face meetings (adhering to social distancing), which were much appreciated.
- Having listened to local voluntary and community groups as part of the evidence gathering, we feel that there is not enough of this type of provision across the county to support people living with dementia and carers. That said, all those who we heard from are providing fantastic support, including regular cafés and singing activities but these rely heavily on the goodwill and availability of volunteers to successfully make these available in local communities.
- We understand that finding suitable local premises for dementia cafes and other support can be an issue but the need for regular, locally run activities which provide face-to-face contact for both the person with dementia and their carer is a crucial part of the dementia journey yet access to services across the county is not consistent. There is a current over-reliance on the voluntary sector to provide these services with minimal financial input. Some voluntary groups are having to restrict numbers due to capacity constraints.
- The council runs a number of Day Opportunity Centres across the county but these are primarily aimed at adults with learning disabilities and autism. Clients who have dementia are supported with some specific activities, according to their needs. We heard that the council books places at the Princes Centre and Bourne End for clients who are eligible for funded activities. These are excellent, volunteer-led Day

Centres set up to look after people living with dementia. Many more attendees are self-referred and pay for places at these centres. We heard that many of these do not have a formal dementia diagnosis or have not accessed other dementia support on their journey.

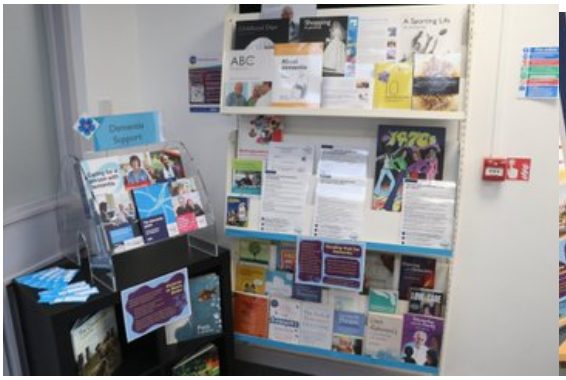
- Through the evidence gathering meetings, we did not receive clarity around the future plans for day opportunity centres and whether more provision could be provided for people with dementia at the existing centres. As mentioned earlier, we would like to see more evidence of a joined-up approach towards the provision of services within the community. At present, it feels as though there is a disconnect between council-run facilities and those run by voluntary and community groups. An exercise to bring the activities together and discuss the gaps in provision would help to plan the future services.

<u>Recommendation 16</u> – The Dementia Strategy Group to undertake an exercise to map current provision and highlight the gaps in support services with input from social prescribers, social care commissioners for day opportunities and community board managers with their local community groups. If the recommendation above to have a dementia specialist within each PCN is implemented, then we would encourage them to be part of this exercise.

<u>Recommendation 17</u> – Consideration to be given to using existing space at the council-owned day centres at Buckingham, Aylesbury, Beaconsfield, Chesham, Wycombe and Burnham to accommodate dementia cafes, dementia support groups and other activities (both voluntary and commissioned) to increase access to these services across the county.

Dementia Awareness events

- We were pleased to hear about a recent awareness event in Buckingham Library, where the Alzheimer's Society Local Service worked in partnership with the library to produce a new set of resources to support people living with dementia, including various games, activities and books from their era.



- There is an opportunity to replicate this initiative across other Libraries and we would encourage the Library service to work with the Alzheimer's Society to do this as part of the Big Conversation events which we refer to in the next section.
- We are aware of the Dementia Awareness Week (May 15-21, 2023) and would like to see more local engagement events following this national event.
- We heard that Aylesbury Waterside theatre offers dementia-friendly showings which were well received by those who we spoke to. There was a suggestion that it would be good to be able to offer the same at the Wycombe Swan, as Aylesbury is quite a distance for some people to travel to. Could theatres be used as a venue for the Big Conversation?

Dying Well

- Whilst this is the hardest and most emotionally charged pathway, we saw first-hand the compassion and enthusiasm from colleagues working within the Palliative Care and End of Life pathway.
- The over-riding key message which we heard through talking to colleagues was the importance of planning for this part of the journey as early as possible. Planning in the early stages is important whilst the person with dementia still has mental capacity to make decisions about their own care.
- We heard about the role of Buckinghamshire Healthcare NHS Trust (BHT) educators who help to promote the benefits of planning and what needs to be covered as part of the planning process. Examples might include, an Advance Healthcare Directive (Living Will), Power of Attorney, wishes for your funeral and having an up-to-date Will.
- Before the Covid pandemic, we heard that BHT educators ran a number of "Big Conversation" events across the county. There were very well received by those who attended and we heard that BHT educators would be willing to talk to dementia support groups.
- "Everyone's Business" – we heard that End of Life (EoL) talks had been delivered to BHT podiatrists as they have regular contact with people, some of whom may have memory concerns and would be in a position to discuss the benefits of planning within the context of wider health conversations. This is just one example of how every part of the health and care system has a role to play in reaching out to those living with dementia and their carers and can be part of the "Big Conversation".
- We would like to encourage more opportunities for planning conversations to take place to help support the Dying Well pathway. This pathway states that people living with dementia should die with dignity and in the place of their choosing and by working in partnership, this can be achieved.

<u>Recommendation 18</u> – Buckinghamshire Healthcare NHS Trust educators to work with the council's library services, voluntary groups and community board managers to develop a series of "Big Conversation" events across the county on a rolling basis.

Conclusion

In bringing this report to its conclusion, the review group would like to reiterate the overriding take-home message which we heard throughout the evidence gathering meetings - people living with dementia and their carers need a joined-up, easy to navigate and easy to access, integrated dementia support service, which brings together all parts of the health, social care and voluntary sector. Face-to-face opportunities, whether that be 1:1 meetings with a dementia adviser or with a peer group at a dementia café or support group, were particularly valued by those we spoke to.

People living with dementia and their carers often struggle or do not have time to spend searching online resources (however good these may be) for information. There was a clear need for well written hard copies of information that could be kept and referred to at a later stage. The carers we spoke to as part of this review mentioned that having someone to contact when a crisis occurs was important.

The evidence shows that Buckinghamshire is currently under-funded in its dementia support service and there is significant unmet need across the existing dementia pathways which needs to be addressed.

There needs to be a renewed focus on raising awareness of dementia, reducing the stigma, increasing diagnosis rates in care homes and the community, as well as providing an integrated dementia support service.

The report highlights the importance of partnership working to support the person with dementia, their families and carers within local communities. There are many examples of outstanding services in Buckinghamshire but we need to do more, particularly in supporting the voluntary sector to deliver the necessary support services within local communities.

As outlined in the report, a Buckinghamshire Dementia Strategy needs to be developed for the entire dementia journey, clearly showing who the key partners are within each pathway and demonstrating an integrated and holistic approach with the person living with dementia at the centre. Regular reviews of how the strategy is progressing are needed with all key partners involved in those discussions.

Whilst acknowledging the pressures on budgets, the review group felt that there needs to be some creative solutions developed to maximise all available resources that are currently underutilised. Examples have been given in this report.

We would urge commissioners to review this report and its recommendations and to be ambitious in future commissioning. There are a number of different models for dementia support that could be considered but partnership working between the commissioned services should be a key component. We support the need for more dementia case workers but this is just one part of the dementia support needed and we would like to see more opportunities available within local communities to meet the needs of people living with dementia and their carers (including access to quality day opportunities for people living with dementia to allow their carers some respite).

We found that the uptake of the current Dementia Connect Service is low, so we feel that there needs to be a concerted effort to improve the communication of the Dementia Connect Service amongst GPs, Primary Care Network staff, hospitals, social care and other healthcare providers. There are examples from other authorities who provide support in different ways, such as specialist Dementia nurses. We would like to see more dementia support services being introduced in Buckinghamshire to ensure those living with dementia and their carers receive the support they need at the right time in their dementia journey.

Healthwatch Bucks update

April 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

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. We made a number of recommendations to Buckinghamshire Council and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board. Their joint response to these recommendations can be accessed 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.

Community Pharmacies

Our new research project will focus on community pharmacies. We want to find out how much local people know about the services they offer, as well as learn about Bucks residents' experiences with using those services. Please share the survey with your residents; About us: Community Pharmacy Services (smartsurvey.co.uk)