Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board agenda

Date: Thursday 22 June 2023

Time: 2.00 pm

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

Membership:

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

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Agenda Item	Time	Page No

1	**Welcome**	**14:00**	
2	**Apologies for Absence**		
3	**Announcements from the Chairman**		
4	**Declarations of Interest**		
5	**Minutes of the previous meeting**		**5 - 14**
6	**Public Questions** In order for a response to be provided at the June Health and Wellbeing Board, questions must be received by 9.00am on Monday 19th June 2023. Any questions received after this deadline will be responded to at the following Health and Wellbeing Board meeting.		
7	**Joint Strategic Needs Assessment Update** The Joint Strategic Needs Assessment (JSNA) is a joint statutory obligation of Local Authorities and NHS Integrated Care Boards in England. The purpose of the JSNA is to improve the health and wellbeing outcomes of the local community and reduce inequalities for all ages. Tiffany Burch, Consultant in Public Health, Buckinghamshire Council.	**14:10**	**15 - 26**
8	**Joint Local Health and Wellbeing Strategy** Review of delivery of two of Joint Local Health and Wellbeing Strategy action plans with a detailed focus on two priorities: • Improving outcomes during maternity and early years • Improving mental health support for Children & Young People, Adults & Older People Dr Jane O'Grady, Service Director Public Health and Community Safety, Buckinghamshire Council. Donna Clarke, Service Director Buckinghamshire, Oxford Health NHS Foundation Trust. Heidi Beddall, Director of Midwifery, Buckinghamshire Healthcare NHS Trust.	**14:15**	**27 - 54**
9	**Healthwatch Bucks – Quarterly Overview** A review of the work undertaken by Healthwatch Bucks	**14:55**	**55 - 60**

	over the previous quarter, this will include feedback on surveys with residents/users of local services. Zoe McIntosh, Chief Executive, Healthwatch Bucks.		
10	**Buckinghamshire Executive Partnership** Including Health & Care Integration programme and plan for 2023/24 Craig McArdle, Corporate Director Adults and Health, Buckinghamshire Council	**15:10**	**61 - 62**
11	**Better Care Fund** Out-turn for 2022/23 and plan for 2023/25. Craig McArdle, Corporate Director Adults and Health, Buckinghamshire Council	**15:10**	**63 - 104**
12	**Integrated Care Partnership** Buckinghamshire Oxfordshire Berkshire West Joint Forward Plan, Annual Report, Performance Robert Bowen, Deputy Director of Strategy, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board Joint Forward Plan, Annual Report, Performance Michelle Evans-Riches Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board. Draft Response from Health and Wellbeing Board to Joint Forward Plan Rebecca Carley, Head of Business and Governance, Buckinghamshire Council	**15:30**	**105 - 138**
13	**AOB** **For Information Only -** Health & Wellbeing Board Buckinghamshire Forward Plan	**15:55**	**139 - 140**
14	**Date of next meeting** Date of next meeting: Thursday 21st September, The Oculus. The Gateway, Aylesbury		

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

For further information please contact: Shilpa Manek on 01494 475369, email democracy@buckinghamshire.gov.uk.

Health and Wellbeing Board minutes

Minutes of the meeting of the Health and Wellbeing Board held on Thursday 30 March 2023 in The Oculus, Buckinghamshire Council, Gatehouse Road, Aylesbury HP19 8FF, commencing at 2.00 pm and concluding at 3.53 pm.

Members present

Cllr A Macpherson, Mr N Macdonald, Ms P Baker, S Bowles, A Cranmer, K Higginson, J Macilwraith, Z Mohammed, Dr J O'Grady, Dr S Roberts, D Walker, Dr K West and J Meech

Others in attendance

S Taylor, Z McIntosh, J Baschnonga, S Manek, C McArdle, R Bowen, S Preston, G McDonald, T Burch, L Hurst, J Boosey, A Seager, M Evans-Riches and C Spalton

Agenda Item

1 Welcome

The Chairman welcomed all to the meeting.

2 Apologies

Apologies for absence were received from Dr Raj Bajwa and Dr Rashmi Sawhney, Buckinghamshire, Oxfordshire and West Berkshire (BOB) Integrated Care Board (ICB).

Michelle Evans-Riches, Programme Manager, Bedfordshire, Luton and Milton Keynes Integrated Care System and Catherine Spalton, Head of Communications and Engagement, Buckinghamshire Council joined the meeting via MS Teams.

John Macilwraith, Corporate Director-Children's Services joined the meeting at 2. 24pm.

3 Announcements from the Chairman

Councillor Angela Macpherson, Chairman and Cabinet Member for Health and Wellbeing and Deputy Leader, Buckinghamshire Council, thanked Sally Taylor, Democratic Services, for her support to the Board and welcomed Shilpa Manek, Democratic Services. The Chairman also thanked Gill Quinton for all her work on the Board and welcomed Craig McArdle, Corporate Director for Adults and Health at Buckinghamshire Council. The Chairman informed the Board that The Clare Foundation, one of the VCSE partners, that they were stepping down from the Board and thanked them for their contributions over the previous three years and

reassured the Board that she was keen to retain the voluntary and community representation as it was an important part to delivering the Strategy.

ACTION FOR J BOOSEY: The Board membership and Terms of Reference would be updated and brought to a future meeting

4 Declarations of Interest

There were no declarations of interest.

5 Minutes of the previous meeting

Resolved: The minutes of the meeting held on 15 December 2022 were **agreed** as an accurate record and were signed by the Chairman.

6 Public Questions

The Chairman was pleased to inform the Board that the public questions from the December meeting had been shared on the Health and Wellbeing website.

The Chairman informed all that the approach was being modified to focus on high quality responses to questions asked. Going forward, the number of questions would be limited to one per person or organisation, per meeting. A maximum of three questions would be read out at a meeting and those relevant to an agenda item would be prioritised. All questions received from the public would receive a full written response after the meeting.

The Chairman informed the Board that three questions had been received for this meeting and took the opportunity to thank partner organisations around the table who had worked hard to coordinate responses.

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

The question and the summary response was read out for the two remaining questions from Dementia Action Marlow and All Together Community. A full response would be sent to the organisations, published on the website and appended to the minutes.

7 Healthwatch Bucks - The Quarterly Overview

Zoe McIntosh, CEO Healthwatch Bucks, firstly updated the Board on the social prescribing experiences report which had been presented at the last meeting. Responses had now been received from Buckinghamshire Council and the ICB. Both responses had been welcomed and were available in full on the Healthwatch Bucks website.

A report had recently been published on support available for people living with

early onset dementia and their carers. This was also available on the website along with a joint response from Buckinghamshire Council and the ICB. This had been discussed at the Dementia Strategy Group and the Health and Social Care Select Committee. The report showed that the support was not readily available which had formed the basis of the recommendations.

Finally, the Strategic Priorities for the year had also been published. The priorities were set by assessing many factors such as comments from the public in previous years, national and local NHS and social care issues. This year the focus would be on primary care, particularly community pharmacies as there had been an increase in feedback, social care with a focus on hospital discharge, were keen to hear more from children and young people about their experiences of accessing health and social care and focus on health inequalities and hearing more from people who were facing these.

The current project would be reported on at the next meeting. It focussed on talking to people who were deaf and hard of hearing and their access to primary care.

The Chairman welcomed John Meech, Chairman of Healthwatch Bucks, who was in attendance. The Chairman commented that the Council was also looking across the entire pathway of dementia and working closely with all. The Chairman asked if there were any joint areas of work across the Healthwatch and BOB network. It was reported that Healthwatch were very keen on collaborating the joint working but were currently awaiting confirmation on funding from the ICB.

Other Members commented that the recommendations were very practical and could be taken forward and that the discharge item was very timely.

8 Integrated Care Partnership

The Integrated Care Strategy was presented at the beginning of the public engagement, which ran between December 2022 and January 2023. Plenty of feedback was received from individuals and from across the integrated care system. A number of changes were made to the proposed Strategy; the 18 priorities identified in the draft were simplified, now a focusing on only five strategic themes; Start Well, Live Well, Age Well, Promote and Protect Health and Quality and Access. The inclusion of palliative and end of life care and the ambition to work collectively across the partnership.

The amended Strategy was signed off by the ICP as a clear strategy for the next five years, on behalf of all the partners; local authorities, NHS organisations, voluntary sector including Healthwatch.

Thanks was extended to Dr Jane O'Grady for her instrumental amount of work on the Strategy and to Rob Bowen for all the work completed at a considerable pace with minimal resources.

The response for the public question from Mike Etkind was read out by the

Buckinghamshire Place Director, Philippa Baker.

The Chair confirmed that the concerns about the reach into the community and the language used would be addressed in the near future.

The Integrated Care Strategy was noted by the Board.

The Joint Forward Plan (JFP) is the NHS delivery plan for the Integrated Care Strategy, balanced with other mandated operational NHS commitments. This is currently being developed. Work to date has resulted in draft delivery plans for system-wide services. These should all reflect the relevant priorities of the Integrated Care Strategy with continuous themes through the plan to do more with respect to prevention and tackling inequalities. The JFP also included four challenges that need to be addressed through more system wide, collaborative working. These had been the subject of a recent workshop that brought together input from across system partners and would be reflected in the draft of the JFP to be shared imminently. The Health and Wellbeing Board had engaged in the JFP development through specific members.

The Board would be informally consulted on the draft version in April 2023 providing an opportunity to feedback on the JFP. The HWB also has a formal opportunity to provide an opinion on how the Joint Forward Plan takes account of the local Health and Wellbeing Strategy. This input is expected in June 2023.

The Buckinghamshire Place Director, Philippa Baker, informed the Board that the Joint Forward Plan was designed to support place-based partnership working and decision-making. This type of working was already underway, for example partners had come together to take decisions around how to invest national discharge funding. There would be more joint decision making around integrated areas of work going forward.

Partners were also working to establish Place based partnership arrangements across the three parts of BOB ICB: Buckinghamshire, Oxfordshire and Berkshire West. In Buckinghamshire, Terms of Reference had been drafted for the Buckinghamshire Executive Partnership, which would be meeting for the first time formally in May. The Partnership included representatives from the ICB, local authorities, acute, community and mental health providers and primary care. Partners would identify key priorities within the existing ICP Strategy and Joint Local Health and Wellbeing Strategy that would benefit from a more joined up approach to accelerate delivery.

Survey work had been carried out to inform the establishment of the Partnership. There was support for partnership working, greater collaboration, and integration in Buckinghamshire, alongside the need for streamlining and removing duplication. The intention of the Partnership was not to duplicate the work of the Health and Wellbeing Board but to support the partnership to deliver on some priorities. Early discussions focussed around SEND, tackling inequalities, intermediate care, and

focusing on prevention.

ACTION FOR R BOWEN: Circulate draft Joint Forward Plan for comment.

The Board noted the progress.

Bedfordshire Luton and Milton Keynes (BLMK) Integrated Care Board

The Chairman invited Michelle Evans-Riches, Programme Manager, BLMK, to give a brief update to the Board as a number of residents used the health and care services in Milton Keynes, across the border. The Chairman had been invited to all BLMK Health and Care Partnership meetings.

Michelle Evans-Riches commented that the background information had already been provided on the Health and Care Strategy and the Joint Forward Plan and the requirements to produce them. The Health and Care Strategy had been approved by BLMK in December 2022 in which five strategic priorities were reflected of three life cycles; Start Well, Live Well, Age Well. Growth was an additional theme, as there is extensive housing growth planned in BLMK and another theme was Reducing Inequality. BLMK currently developing its one-year operational plan with partners. The draft Joint Forward Plan had been developed and would be circulated to members for comment. The first ICB Annual Report was also being drafted in which the Chairman would have the opportunity to comment. The ICB Board had accepted delegation of responsibility for Pharmacy, Optometry and Dentistry from 1st April 2023 from NHS England.

The Chairman thanked Michelle Evan-Riches for the update.

9 Health and Care Integration Programme

The Programme Director for Health and Care Integration, Joanna Baschnonga, presented the paper, concentrating on the discharge programme. It was reported that this was a turning point for the programme on improving hospital discharge in Buckinghamshire. The papers set out the ambitious plans for the next year. The three key milestones to highlight were: the implementation of an integrated discharge team in June (a patient focussed team that brings together the hospital discharge team and social workers to improve the patient experience); implementation of short-term bedded hubs and an intermediate care centre over Summer, and a new transfer of care hub in October (a new team that would coordinate discharges more effectively and improve the overall experience and in planning of discharge).

These changes are expected to help patients to return home more quickly and avoid readmission.

The Chairman commented that it was a very frank paper with lots to do and it was promising to see progress in some areas. The Chairman asked what the difference was between the June and October actions for the patient and could October be

accelerated. It was explained that June was about the integrated discharge team, working on wards with patients, discussing and planning discharge with the patient and their family to make it a better and clearer experience, reducing anxiety and the stress. October was more about the back-office function around co-ordinating discharge, making decisions about which pathways patients progress along, and oversight on timeliness, safety and quality.

Dr Sian Roberts commented that better support in the community would be really helpful but may lead to more failed discharges. Would this be captured and monitored? The Board were reassured that this would be monitored as part of the performance indicators.

The Vice Chairman commented that it was a tough programme, and it would be beneficial for the Board to see what a multi-year programme looked like and it was confirmed that this would be presented.

The Chairman asked if the patient experience was being improved and was reassured that the process was being mapped, real customer journeys were being looked at, workshops were being run, all to understand the patient perspective.

The focus of Healthwatch for the next year was patient discharge and this would show an improvement in experience.

The Chairman thanked the Director for the paper. The Board noted the paper.

10 Joint Local Health and Wellbeing Strategy - Action Plans

The Chairman welcomed Tiffany Burch, Consultant in Public Health, and promoted the inequalities infographic shared with all Board Members. This is a tool that shows the entire life course and the inequalities across it in Buckinghamshire.

Dr Jane O'Grady commented on the inequalities infographic which is also available on the website, and requested that the Board promoted the better points scheme, a leaflet was also given to all Board members.

The Strategy has been developed. The action plans are being developed by partners with the intention to present a rolling programme of the action plans. The plan is to give regular updates on the action plans. At this meeting, there was an update on cardiovascular disease and Obesity. The next meeting would provide an update on Early Years and Mental Health work.

ACTION FOR J O'GRADY and J BOOSEY: Add to Forward Plan

Tiffany Burch, lead for CVD and smoking cessation (which is a key risk factor for CVD) explained that the work is overseen by the CVD Prevention Working Group which consists of a wide range of partners that meet monthly to discuss the action plans.

The opportunity was taken to focus on three areas of good progress over the last

twelve months and three areas that needed further work.

Great progress had been made with the community initiative to increase residents checking and understanding their blood pressure. Two GPs, Dr Amanda Bartlett in High Wycombe and Dr Tony Gillman in Aylesbury, were instrumental in supporting this action and ensuring that GP colleagues were happy with the blood pressure information and advice shared with residents. Secondly, a pilot programme is ongoing in a faith community that is at higher risk of cardiovascular disease. It is going very well and was created using behaviour science to ensure residents are supported to take healthy actions. This is now being rolled out to other faith groups. From 17 May there will be health kiosks in the Aylesbury and High Wycombe libraries. These tools assess a range of health measures. 17 May is also World Hypertension Day, so partners are encouraged to promote this day. Blood pressure monitors will be available for residents to 'check out' from Aylesbury, High Wycombe and Micklefield libraries. The packs will include simple information on how to look after yourself and what to do if the blood pressure was high. Ongoing work with Parish Councils and Community Boards is working really well. There are now 13 smoke-free parks and playgrounds in the county. The plan is to increase this next year to ensure that there was at least one in every Opportunity Buckinghamshire Ward. Thirdly, a scheme has been produced to increase the capacity in the four priority primary care networks to increase their ability to deliver the NHS Health Check. This is a programme for CVD Prevention in people aged 40 to 74 years. This is going well with the number of health checks increasing.

The three areas that need further momentum are the need for an equity audit and an opportunity to dig deeper into any sort of inequalities in access, experience and outcomes for CVD specifically in primary care. Secondly, to get a plan agreed and delivered around ECGs, which are required as part of the hypertension diagnosis pathway. Finally, a preoperative pilot currently ongoing focussed on long-term conditions such as diabetes, it would be great to expand this to deprived residents who are on surgical waiting lists to support them to stop smoking and get healthier before their surgeries. The Chairman asked for clarification on what an Opportunity Bucks Ward was, and it was explained that it was the Council's programme to ensure that everyone in the county has a healthy and happy start to life through to aging, specifically in ten wards in High Wycombe, Aylesbury and Chesham.

The Place Director, Phillipa Baker was already in discussion about the ECGs and was looking into how the gaps could be addressed. Also, it supported the health inequalities work and ensured it aligned with the Opportunity Bucks Programme.

Councillor Zahir Mohammed was pleased with the momentum building in the work and asked about vaping in children and young people. It was clarified that vaping is a tool to help to stop smoking and it is not something for non-smokers to start. Vaping is not harm free, particularly for our children and young people. Some training is being offered for education colleagues around how to discourage children to vape. It was highlighted that Members could help to lobby The Government around the marketing, promotion and packaging of vaping as it is appealing to children and

young people.

ACTION FOR T BURCH: Share training dates for education colleagues on supporting children not to vape

The Vice Chairman commented that his organisation was happy to help as CVD was also one of their six objectives.

Dr Jane O'Grady commented that the Opportunity Bucks Programme was a vehicle to deliver the health and wellbeing strategy. However, it was important not to overlook other wards such as rural areas.

Sarah Preston, Head of Public Health Strategy, presented the Obesity Action Plan update to the Board. The three key points from the paper were around the whole system approach to healthier weight that the system in Buckinghamshire was taking. Currently there were over sixty stakeholders engaged to put together a comprehensive action plan with lots of collaborative actions across four priority themes that had been identified around food, physical activity, schools and young people and transport. Some of the achievements so far across partners included the new integrated healthy lifestyle service, Better Points, Grow to Give supporting food bank users to access fresh, healthy food, community led cooking programmes, supporting health professionals to have healthy weight conversations with patients, project around active travel and so many more.

Better points was one of the initiatives through collaboration with may partners, helping to promote positive healthy lifestyle changes. Points gained could be redeemed at high street shops or donated to charity. There were currently 775 users in the first few months from launch. Thirty nine percent of users were from the Opportunity Bucks Wards. The programme was still looking for more local businesses to engage with Better Points and accept earned points.

Be Healthy Bucks is the new healthy lifestyle service for Buckinghamshire residents and was due to be launched on 3 April 2023. This would be using a community centred approach with services being delivered in community venues using many delivery methods such as face to face, telephone and digital, concentrating on stopping smoking, child and adult weight management, alcohol reduction and many more areas.

The Members were asked to promote the services and more referrals from health professionals were required.

The Chairman was encouraged to see all the work and the numbers of residents now exercising to gain points. A point to highlight was local businesses and as a county, there were many small and medium businesses. Members were asked to promote and encourage businesses to come forward.

Dr Sian Roberts reminded officers not to forget people with disabilities and mental

health issues and ensured that accessibility was available for all to use. The Board was informed that this had already been recognised and addressed.

Resolved: The papers were noted, recommendations were agreed and the Board were committed.

11 Suicide Prevention Action Plan

Dr Jane O'Grady explained that mental health was a very important theme to this Health and Wellbeing Board and there was a multi-agency suicide prevention plan and the reason for presenting it was because everyone has a role to play in understanding and helping to prevent suicide and mental ill health.

Louise Hurst, Consultant in Public Health, informed the Board that the action plan had been prepared by the multi-agency suicide prevention group which was Chaired by Public Health and attended by many partner organisations.

Every year at least fifty people died in Buckinghamshire by suicide. The effects of which were profound on their families, friends, colleagues and their communities. The rate of suicide had been steadily increasing nationally. There were concerns that the cost-of-living crisis may have an impact on the number of deaths as financial difficulties, debt and unemployment were serious risk factors for suicide, and more middle-aged men were at risk than women. Suicide was preventable and the action plan concentrated on the initiatives. A Suicide Bereavement Service had been launched in July 2022, called Amparo. This was a new confidential service open seven days a week offering support to anyone, of any age, affected by suicide. The website for the service is amparo.org.uk. The council also currently offered assistance through the Helping Hands team offering financial support and the Saving Lives Fund, which delivered projects with voluntary and community sector groups including Talkback and Wycombe Youth Action, targeting men and boys to be able to identify the signs as a high-risk group.

The Board were informed that thirty percent of people who died by suicide saw their GP, two weeks before they died for other issues. It was important for GPs, colleagues in primary care and employers to be alert to the risk factors and signs for suicide and what to do in those instances. However, a large number of people had had no contact at all with health or social care. Employers could play a key role in addressing the stigma around mental health and financial wellbeing in the workplace. Buckinghamshire Council have a Champion the Change programme which is delivered by Bucks Mind. Employers could sign up to the Champion the Change pledge to address stigma in the workplace and through doing that, they received access to a range of resources to help them challenge stereotypes in the workplace. Finally, suicide first aid training was also available. The dates would be launched through Bucks Mind for anyone who was employed by charities, community groups or public sector and for volunteers and people working with those experiencing difficulty around cost-of-living, free of charge.

The question was asked if schools and other educational establishments were being engaged as young children had been impacted by the pandemic and the Board were informed that they were and pre and post-vention guidance was available to schools as a tool to support them, reduce the risk of suicide and consider the support that could be put in place for students. This also included self-harm.

Councillor Bowles commented that the paper and all the work in the action plan was excellent and suggested that the paper should be presented to the Community Safety Board. It was confirmed that it would be.

Dr Sian Roberts commented that the Suicide Prevention training had been very good and recommended and encouraged all to attend. It was important not to be fearful to talk about suicide.

ACTION FOR L HURST: Circulate dates for the Suicide Prevention training

John Macilwraith, Director of Children's Services, commented that communications were already taking place with CAMHs for joint training for schools and social workers to build confidence so the correct conversation could be had with children and young people in the appropriate way.

Grant Macdonald agreed that it was very important to talk about suicide and equally important to learn from each other and share information across primary and secondary care. The Chairman reminded all that the mental health action plan would be presented at the next meeting.

Resolved: The Board noted and endorsed the action plan. This would be presented to the Community Safety Board.

12 Joint Local Health and Wellbeing Strategy - Quarterly Performance Review

A performance dashboard was being developed with partners and public health colleagues. This should enable all to track the progress of the Strategy in terms of a few key indicators. The more detailed outcomes and progress would be measured behind the scenes in the themed action plans. A few high-level indicative indicators had been presented to the Board. All were collectable and had been agreed by partners. Some information on mental health was still being awaited from the Mental Health Trust.

Resolved: The Board noted and endorsed the performance dashboard and it would be presented to the Board annually.

ACTION FOR J BOOSEY: Present to Board annually

13 Date of next meeting

The date of the next meeting was still to be confirmed.

Health & Wellbeing Board Buckinghamshire

Joint Strategic Needs Assessment Update

Date: 22 June 2023

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

Report Sponsor: Jane O'Grady, Director of Public Health, Buckinghamshire Council

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

☐ **Decision** ☐ **Endorsement**

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

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

1. Purpose of report

1.1. The Buckinghamshire Health and Wellbeing Board oversees the statutory requirement for Local Authorities and Integrated Care Boards to prepare a Joint Strategic Needs Assessment (JSNA). The purpose of the JSNA is to improve the health and wellbeing outcomes of the local community and reduce inequalities for all ages.

1.2. The JSNA is a core part of the information will be collected to support the Strategy, and it will allow partners to better understand local needs and ways to address these needs.

1.3. The purpose of this report is to update the Health and Wellbeing Board on the progress made on updating the local Joint Strategic Needs Assessment and the content being delivered over the next few months.

2. Recommendation to the Health and Wellbeing Board

- To note the progress on the JSNA over the last year.
- To agree the proposed topics for this financial year.
- To commit and agree to the delivery by all partners of new and updated JSNA content and priorities

3. Content of report

3.1. The role of the JSNA is to assess the current and future health, care and wellbeing needs of our local community to inform commissioning decisions with the aim of improving the health and wellbeing of residents and reducing inequalities. JSNAs are a joint responsibility of both Local Authorities and the local NHS (Integrated Care Boards), and they should focus on needs that can be addressed by these partners. This includes considering wider determinants of health, which are the broader social, economic, political and environmental factors that can affect health outcomes and assets, which are things that can enhance health and wellbeing and to help to reduce health inequalities. JSNAs should involve others including Healthwatch and the local community.

3.2. New content is added on an ongoing basis throughout each year. The Buckinghamshire JSNA Directory can be used to identify the range of content by topic. A JSNA is not one report, it includes a range of resources including:

- reports which look at specific topics providing recommendations and considerations for local commissioners
- summary reports on topics providing a snapshot for Buckinghamshire
- data profiles and interactive tools to enable the user to explore the data in more detail

3.3. **The Health and Wellbeing Strategy for Buckinghamshire**

The Joint Local Health and Wellbeing Strategy for 2022-2025 ('Happier, Healthier Lives') has three priority areas – Start Well, Live Well and Age Well.

The Buckinghamshire JSNA aligns with the 3 priorities to support the Strategy's action plan and provide a clear evidence base with the latest data available.

3.4. JSNA content has been delivered over the last twelve months, and more content is to be delivered over the next year. Appendix A sets out the content delivered in the last 12 months and the proposed topic areas for the coming year. The topics for this financial year have been agreed by members of the JSNA Development Group.

4. Next steps and review

4.1. Subject to Health and Wellbeing Board approval of the coming year's topics, the next steps are:

- Scope and deliver the proposed content
- Publish completed chapters on the JSNA webpages as and when these are signed off.

5. Background papers

5.1. Appendix A - Summary of work delivered in 2022/23 and the priority topics for 2023/24.

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Appendix A

Joint Strategic Needs Assessment

Summary of 2022/23 and priorities for 2023/24

Introduction

- The Joint Strategic Needs Assessment (JSNA) is the responsibility of the Health and Wellbeing Board and it supports the health and wellbeing strategy. Its purpose is to support the work to reduce inequalities and improve the health and wellbeing of the whole community.
- It is a continuous process to assess the current and future health, care and wellbeing needs of the local community to inform local decision making, using a variety of data sources.
- New content will be added on an ongoing basis throughout each year. The JSNA Directory can also be used to identify the range of content by topic.
- A JSNA is not one report, it includes a range of resources including:
  - reports which look at specific topics providing recommendations and considerations for local commissioners
  - summary reports on topics providing a snapshot for Buckinghamshire
  - data profiles and interactive tools to enable the user to explore the data in more detail
- More information about the JSNA can be found here - About the Joint Strategic Needs Assessment | Buckinghamshire Council

Key achievements in 2022/23

April to June

- Sexual Health Needs Assessment
- Children and Young People Needs Assessment
- Development of CYP infographic
- NCMP profile developed
- Lifecourse infographic updated

July to September

- New website developed
- Development of interactive JSNA Directory
- Sexual Health Topic Report
- Obesity Topic Report
- Pharmaceutical Needs Assessment

October to December

- Development of the Demography Explorer
- Refresh of Community Board Profiles
- MH JSNA first draft
- Inequalities by deprivation infographic
- Children and Young People topic report

January to March

- MH JSNA - Sign off complete
- Smoking and Tobacco topic report
- Lifecourse Infographic update
- Bucks Summary report
- Protected characteristics

New Website

Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) is a process by which Local Authorities and Integrated Care Boards assess the current and future health, care and wellbeing needs of the local community to inform local decision making.

About the Joint Strategic Needs Assessment

Find out what a JSNA is, what it aims to do and what it includes

Joint Strategic Needs Assessment directory

The JSNA directory provides an interactive tool to help locate the content of the JSNA by themes/topics

Health and wellbeing strategy

Priorities to improve health and wellbeing of Buckinghamshire residents and reduce inequalities

Replaces content on the https://www.healthandwellbeingbucks.org/what-is-the-jsna where archive content and some profiles can still be found

New Website Structure

There are two ways of viewing content - by topic using the JSNA Directory and by report via the links on the main page as shown below.

Joint Strategic Needs Assessment reports

These reports provide a more detailed look at specific topics related to the health and wellbeing strategy priority areas

Health and wellbeing data profiles and tools

Data and tools providing an analysis of health and wellbeing in Buckinghamshire

Bucks Data Exchange

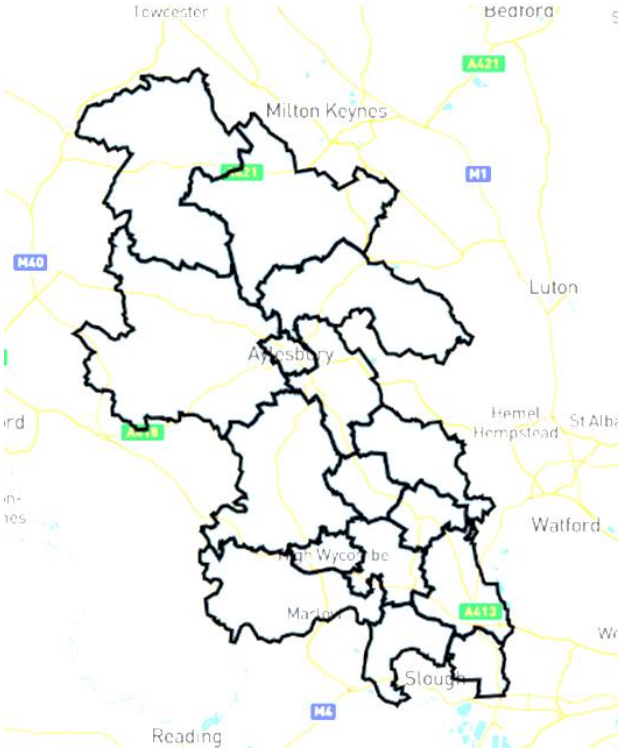
An open-access platform containing the latest insights about Buckinghamshire, aimed at helping people to make informed decisions.

Director of Public Health Annual reports

View previous reports by our Director of Public Health

Pharmaceutical needs assessment

The Pharmaceutical Needs Assessment (PNA) is a comprehensive assessment of the current and future pharmaceutical needs of the local population



Content aligns to the Joint Health and Wellbeing Strategy Priority Areas

Start Well | Live Well | Age Well

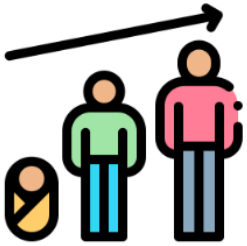
JSNA Directory

Microsoft Power BI

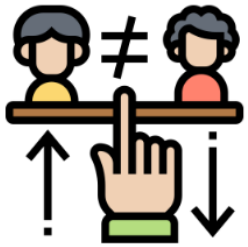
The JSNA Directory is an interactive tool to view content created locally for the Buckinghamshire JSNA. It is also a way of navigating external sources and data via themes/topics.

Overview of Buckinghamshire

Population



The Life Course



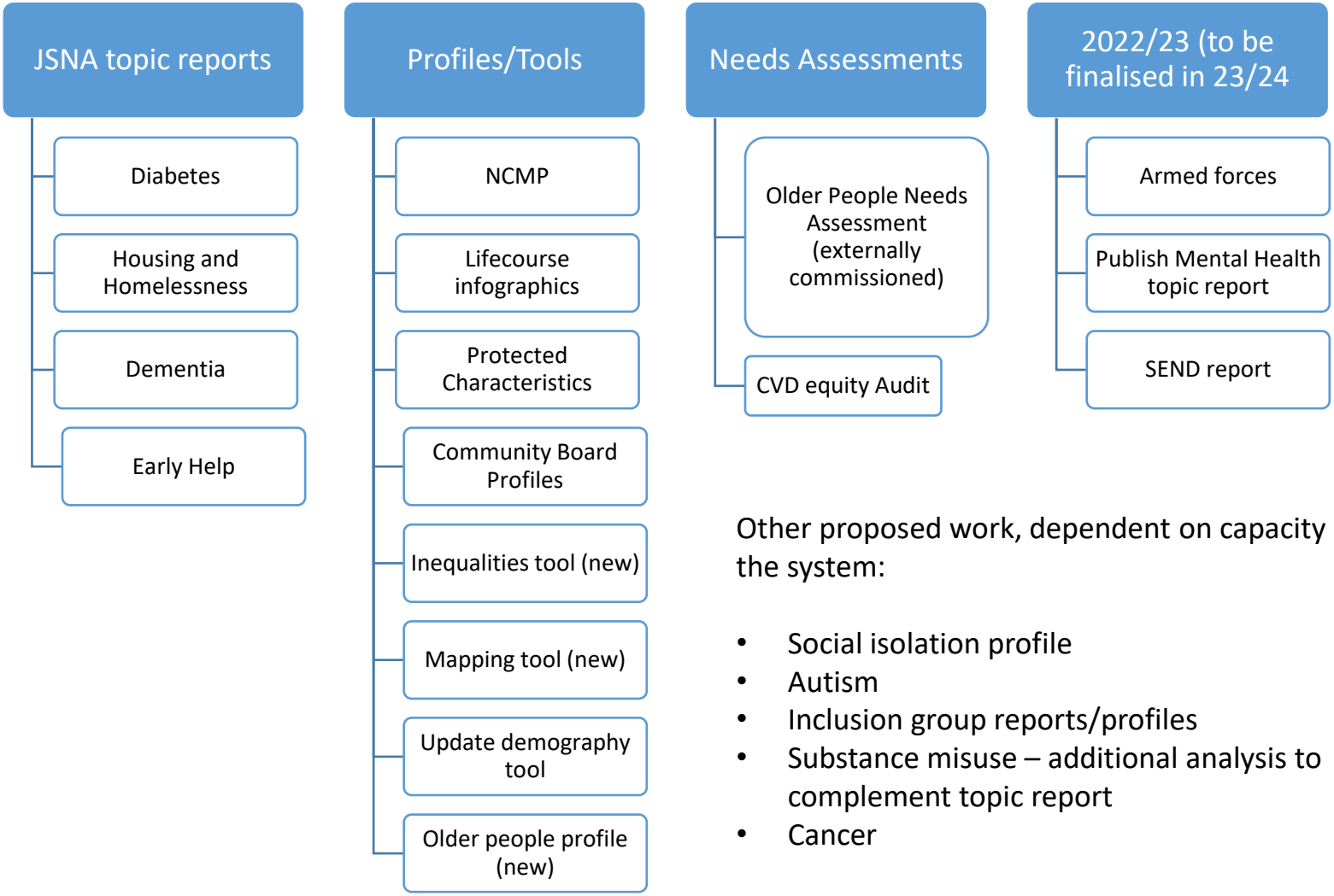
Inequalities

Wider Determinants

Buckinghamshire Council

Health & Wellbeing Board Buckinghamshire

23/24 priorities for the JSNA



Other proposed work, dependent on capacity in the system:

- Social isolation profile
- Autism
- Inclusion group reports/profiles
- Substance misuse – additional analysis to complement topic report
- Cancer

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Health & Wellbeing Board Buckinghamshire

Action Plan to improve maternity and early years outcomes

Date: 22nd June 2023

Author/Lead Contacts: Heidi Beddall, Director of Midwifery, Buckinghamshire Healthcare NHS Trust

Daniel Flecknoe, Public Health Consultant, Buckinghamshire Council

Report Sponsor: Jane O'Grady, Director of Public Health, Buckinghamshire Council

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

☐ **Decision** ☒ **Endorsement**

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

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

1. Purpose of report

1.1. The refreshed Buckinghamshire Health and Wellbeing Strategy includes a priority to improve maternity and early years outcomes for residents. The start of life (from conception to the age of 4 or 5) is the period of our lives which contains the greatest potential for future health and wellbeing outcomes throughout the whole life to be maximised, for health risks to be successfully mitigated and for inequalities to be addressed. The Buckinghamshire Health and Wellbeing Board Strategy 2022-25 Priorities for maternity and early years are:

- To reduce the proportion of women who smoke during (and after) pregnancy in Buckinghamshire

- To improve school readiness in Buckinghamshire children, especially among the most deprived communities, and
- To increase the proportion of babies that are breastfed from birth until at least 6 to 8 weeks old.

1.2. This report provides the action plan for this theme of the Health and Wellbeing Strategy and updates the board on progress towards the above priorities by partners.

2. Recommendation to the Health and Wellbeing Board

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

2.2. The Health and Wellbeing Board are asked to commit their respective organisations to deliver these actions and identify if there are further areas for action.

3. Content of report

3.1. The crucial importance of the first years of life (from conception to the age of 4 or 5) on an individual's future health and wellbeing has been well established. Interventions during this period to reduce exposure to risk factors, improve outcomes and tackle inequalities have the potential to positively affect prospects throughout the whole life course.

3.2. The Buckinghamshire Health and Wellbeing Board Strategy 2022-25 Priorities for maternity and early years are:

- To reduce the proportion of women who smoke during (and after) pregnancy in Buckinghamshire
- To improve school readiness in Buckinghamshire children, especially among the most deprived communities, and
- To increase the proportion of babies that are breastfed from birth until at least 6 to 8 weeks old.

3.3. The "Start Well – Maternity and Early Years Programme Board" is chaired by the Director of Midwifery at Buckinghamshire Healthcare NHS Trust (BHT) and includes representatives from public health, maternity services, education and health visiting. The "Healthier Pregnancies Steering Group" is chaired by a public health consultant at Buckinghamshire Council (BC), and reports to the Programme Board. These two groups are responsible for providing oversight of efforts by the various partner organisations involved in this area of work to improve outcomes and reduce inequalities during pregnancy, birth and the early years of childhood.

3.4. The full current programme of work can be seen in the Action Plan in Appendix A. Two key projects in development are listed below:

3.4.1. Pre-conception health and service access/awareness pilot project.

- This novel pilot project aims to identify and address the health needs and service access challenges experienced by women of child-bearing age in Buckinghamshire who

are either a) of younger age, b) from Black/Asian communities, and c) who live in Opportunity Bucks wards.

- Evidence shows that maternal and early childhood health outcomes vary considerably by deprivation, age and ethnicity.
- For example, the 2021 MBBRACE-UK report (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) identified that the risk of dying during pregnancy was twice the national average for Asian mothers, and four times the national average for Black mothers.
- Deprivation and younger age also show strong associations with a range of risk factors and negative health outcomes for mothers and babies.
- This pilot project has been informed by an engagement and listening exercise, in which the organisers are having open ended conversations with a wide range of potential stakeholders, such as voluntary and community groups (in particular women's groups representing minority communities and/or based in Opportunity Bucks wards). This is designed to inform the planning of a more structured series of focus groups in order to gather views and insights from the groups that the subsequent phase of the project will aim to benefit.

3.4.2. Improving the educational/parenting support available to families in deprived areas.

- Young children from deprived areas of Buckinghamshire are less likely to score at or above expected levels on early development assessments, less likely to achieve school readiness, and consequently less likely to get the most out of their education. This dynamic has the potential to make deprivation a self-reinforcing cycle which traps each generation in the same pattern of poor health and wellbeing.
- However, there is good research evidence that attending high quality early education settings can help to reduce the negative effects of growing up in an economically deprived household, and that parenting programmes can be effective in helping parents and carers to support their children to develop the skills they need to thrive.
- Since the start of the Opportunity Bucks programme, the BC early years education service has been prioritising early years settings in Opportunity Bucks wards with their wide range support offer and increasing efforts to maximise the uptake of funded early education placements (families are only eligible where they are in receipt of universal credit). The percentage of vulnerable 2 year old eligible children in funded early education places increased from 90.3% in Spring Term 2022 to 94.3% in Spring Term 2023.
- The BC public health team and family support service are working together to expand the pre-existing "Family Links" parenting programme in Buckinghamshire, with the aim of expanding capacity in Opportunity Bucks wards for courses such as "Little Talkers", which supports parents with their children's language development.

3.5. The full list of current projects and workstreams can be seen in Appendix A.

4. Next steps and review

4.1. The Start Well: Maternity and Early Years Programme Board, and the Healthier Pregnancies Steering Group will continue to oversee and develop these projects and workstreams and can provide the Board with updates later in 2023 as required.

5. Background papers

5.1. Appendix A - Buckinghamshire Joint Health and Wellbeing Board Strategy: Start Well – Maternity and Early Years Action Plan.

Appendix A

Buckinghamshire Joint Health and Wellbeing Board Strategy: Start Well – Maternity and Early Years Action Plan

Action 1: To reduce the proportion of women who smoke during (and after) pregnancy in Buckinghamshire **Rationale:** Smoking is a key driver of health inequalities and smoking during pregnancy can harm the health of both mother and baby. **Health and Wellbeing Board Performance Hub Metric:** % smoking status at time of delivery					
Ref	**Action**	**Lead**	**Dates**	**Baseline**	**Progress data**
1.1 – reduce the number of women who are smokers when they become pregnant.	Pre-conception health and service access/awareness pilot project targeting women of child-bearing age who are either a) of younger age, or b) from Black/Asian communities, and c) who live in Opportunity Bucks wards.	Buckinghamshire Council (BC) Public Health and Buckinghamshire Healthcare NHS Trust (BHT) Maternity	2023-2025	6% of women smoking at antenatal booking (21/22 fingertips data)	Scoping phase underway including meetings between BC public health and community organisations.
1.2 – increase the proportion of pregnant women who smoke that are identified, referred to smoking cessation services and who are ultimately successful in quitting smoking.	Improve the skills and resources available to midwives to identify and refer eligible women to smoking cessation services. - Ensure the availability and use of carbon monoxide monitors at booking appointments - Provide "Make Every Contact Count" (MECC) training particularly to community midwives located in opportunity Bucks wards; specialist teenage, perinatal mental health and safeguarding midwives who work predominantly with women at risk of health inequality).	BHT Maternity	2023-2025	30% at antenatal booking. 0% at 36 weeks pregnant. 80% of community midwives received MECC training pre pandemic.	Carbon monoxide monitoring was discontinued during the pandemic. It is now routinely taking place at antenatal booking and 36 weeks of pregnancy. Quarter 1 23/24 data demonstrates an improvement in compliance by >60% at pregnancy booking and 65% at 36 weeks pregnant. Community midwives' team has evolved. MECC training rollout is being planned for all non compliant staff, overseen by the Healthier Pregnancies Steering Group.

	Recruit 2 maternity tobacco dependency advisors to support women's quit journeys.	BHT Maternity	2023-2024	No baseline data available. Smoking cessation referral data available from June 2023. Quit rate data available from December 2023.	One tobacco dependency advisor has been appointed; the other post is currently still vacant.

Action 2: To improve school readiness in Buckinghamshire children, especially among the most deprived communities
Rationale: School readiness, allowing to children to make the most of their education, is a key factor allowing young people to escape poverty. **Health and Wellbeing Board Performance Hub Metric:** % of children achieving at least expected levels on their 2-2.5yr developmental assessment in the most deprived areas

Ref	Action	Lead	Dates	Baseline	Progress data
2.1 – improve uptake of the 1 year and 2 year integrated review by families in deprived areas.	Undertake a deep dive into reasons why parents may decline, or just not participate with the universal integrated review offer at one and two years with a focus on Opportunity Bucks wards.	BHT Health Visiting	2023	Year 1 integrated review attendance 76% (21/22) and 72% (22/23). Year 2 integrated review attendance 75% (21/22) and 66% (22/23) Target 85%	Deep dive underway.
2.2 – increase uptake in the Ages and Stages questionnaire with a focus on families in deprived areas.	Maximise the uptake of the Ages and Stages Questionnaire. - Proactive approach to engaging families in the questionnaire process,	BHT Health Visiting	2023	Year 1 ASQ 73.9% Year 2 ASQ 68.6%	Work is ongoing by the children and young people team who are focusing on access to ASQ particularly in the levelling up wards

	particularly families in Opportunity Bucks wards.				
2.3 – improve data collection and sharing on early years development and inequalities.	Pilot a new data collection template. Make improvements to the Rio data system. Work towards granular data sharing on Ages & Stages Questionnaire (AQS3) uptake and outcomes with BC.	BHT Health Visiting	2023-2025	The current data system does not facilitate the kind of data sharing that would allow for targeted catch-up programmes to be put in place.	Work is ongoing at BHT to move towards the collection and sharing of ASQ3 data by deprivation and other demographic factors.
2.4 – improve communication/referral to BC Early Years Education Team.	Improve early years notification referral from health visiting.	BHT Health Visiting/CYP team	2023-2025	No baseline data available.	Work in progress to improve process between health visiting and BC Early Years Education Team.
2.5 – increase and sustain the rate of Education and Health Care Plans (EHCP)	Achieve the target for Education and Health Care Plans (EHCP) assessment. - Co-production of ECHP's - Improved timeliness of the community paediatric input to EHCP's	BHT Health Visiting/CYP team	2023-2025	Current waiting time 27 weeks. Target 8 weeks.	Work is already ongoing as part of the SEND written statement of action
2.6 – improve the support available for families in deprived areas to help their children develop the social, communication and problem-solving skills needed to get the most out of their education.	Maximise the uptake and quality of early years education in the areas of greatest need. - Proactive approach to contacting eligible families who are not currently taking advantage of funded places - Support and further education bursaries targeted to early years	BC Early Years Education team	2023-2025	The percentage of eligible children in funded early education places 90.3% in Spring 2022	Work was already ongoing by the Early Years team to maximise uptake of funded placements. There has been a 4% increase to 94.3% in Spring Term 2023.

	settings in Opportunity Bucks wards.				
	Expansion of the Family Links parenting programme offer to improve access and capacity in Opportunity Bucks wards.	BC Public Health and Family Support Service	2023-2024	The programme includes the "Little Talkers" course which supports parents with their children's language development, but demand is higher than current capacity.	

Action 3: To increase the proportion of babies that are breastfed from birth until at least 6 to 8 weeks old
Rationale: Breastfeeding is a key factor in improving child health and reducing obesity.
Health and Wellbeing Board Performance Hub Metric: Proportion of babies that are breastfed or receive human milk from birth until at least 6 to 8 weeks old.

Ref	Action	Lead	Dates	Baseline	Progress data
3.1 – improved support for women to initiate and maintain breastfeeding.	Maternity, neonates and paediatrics to work towards stage 2 Baby Friendly Initiative (BFI) Accreditation.	BHT Maternity, Paediatrics and Neonates	2023-2025	BHT maternity and neonates have achieved Level 1 BFI accreditation.	Baby Friendly Initiative Stage 2 assessment in BHT Maternity currently paused due to staff changes, targets continue to be a focus.
3.2 – increase the number of babies admitted to the neonatal unit who are breastfed or receive human milk in the first 24 hours of life	Sustain mat/neo safety improvement project to increase uptake in term babies.	BHT Neonates	2023-2025	55% Target 80%	Mat/neo sip project to increase uptake of breastfeeding/human milk in term infants launched in 22/23. There has been a 7% increase to 62% in term babies receiving human milk on

	Embed pre term optimisation care bundle to increase uptake in babies born before 34 weeks gestation.			69.1 % of babies had all elements of the care bundle (21/22) Target 100%	admission to the neonatal unit but a further 18% increase is required. Care bundle officially launched in practice 22/23 There has been an increase 11.3 % to 80.4% of babies receiving all elements of the care bundle.
3.3 – increase the number of babies who are discharged from the neonatal unit who are breastfeeding or receiving human milk	Implement British Association of Perinatal Medicine (BAPM) maternal breastmilk project to increase the number of babies less than 34 weeks gestation at birth discharged receiving human milk or breastfeeding at discharge.	BHT Neonates	2023-2025	No baseline data. Data will be available from September 2023.	New national initiative. Infant feeding data in neonates is not currently recorded separately for term and pre 34 week gestation babies. Project due to launch July 2023
3.4 – increase the number of babies breastfeeding at 6- 8 weeks old	Health Visiting to work towards achieving sustainability BFI award.	BHT Health Visiting	2023-2025	BHT Health Visitors have achieved Level 3 BFI accreditation.	Previous target of 56% achieved for the last two years. Target to be revised as part of 0-19 healthy child programme contract – provisional Trust target of >60%

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Health & Wellbeing Board Buckinghamshire

Action plan to increase support for mental health and tackle inequalities across communities

Date: 22nd June 2023

Author/Lead Contacts: Donna Clarke, Service Director, Oxford Health NHS Foundation Trust

Report Sponsor: David Walker, Chairman, Oxford Health NHS Foundation Trust

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

☐ **Decision** ☒ **Endorsement**

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

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

1. Purpose of report

1.1. The refreshed Joint Local Health and Wellbeing Strategy (JLHWS) and action plan include a priority to increase support for mental health and tackle inequalities across communities who have poor outcomes and access to mental health services. This requires working in an integrated way across health systems, addressing individuals holistic needs with new and targeted approaches to address inequality including those living in more deprived areas, people from certain ethnic groups and those with serious mental illness.[i]

1.2. Mental and physical health are equally important components of overall health and are often connected. For example, depression increases the risk for many types of physical health problems, particularly long-term conditions like diabetes and heart disease. Mental health is also important in a wide range of social and economic outcomes such as: better

educational achievement, increased skills, healthy lifestyles, employment, productivity at work, reduced anti-social behaviour and reduced criminality.

1.3. Good mental health is particularly important in the first five years of life - these years have a lasting impact and in adolescence, where social and environmental influences may change. Children from deprived areas have increased risks of mental ill health. This report provides the action plan for this theme of the health and wellbeing strategy and updates the board on progress and proposed way forward for the measures, targets, and actions for partners.

2. Recommendation to the Health and Wellbeing Board

- The Health and Wellbeing Board are asked to note the measures, targets and actions set out within the report and in appendix B & C.
- The Health and Wellbeing Board are asked to commit their respective organisations to deliver their actions.

3. Content of report

3.1. Reducing and improving the treatment of mental health conditions is a priority under the Joint Local Health and Wellbeing Strategy's Start Well, Live Well and Age Well themes. Mental illness is a contributor to the gap in life expectancy and healthy life expectancy between people living in our most deprived and least deprived areas. This is the case for all age ranges.

3.2. The reasoning for these aims are as follows:

- In Buckinghamshire it is estimated 1 in 10 children will have a clinically diagnosed mental disorder in childhood, that half of all mental disorders will emerge before the age of 14, and three quarters will emerge before the age of 25. Children from deprived areas have an increased level of risk. Therefore, prevention and early intervention is of key importance for children and young people and a targeted approach is needed for those most at risk.
- Whilst mental illness can affect anyone, residents living in our most deprived areas and people from certain ethnic groups are at a higher risk.
- People living with serious mental illness (SMI) face one of the greatest health inequality gaps in England. This population group is at risk of dying on average up to 15 to 20 years earlier than the general population, mostly due to preventable physical diseases such as cardiovascular disease.

3.3. Dementia is an increasing concern across the county, although there is no cure for dementia at the moment, an early diagnosis means its progress can be slowed down in some cases, so the person may be able to maintain their mental function for longer and get the right support and treatment.

3.4. There are specific multiagency groups that are working together to deliver these themes. Their membership includes representatives from primary care networks, local GPs, Social Care, Education, Integrated Care Board, Public Health, Healthwatch Bucks, Buckinghamshire Healthcare NHS Trust, voluntary sector, Carer and Patient representatives.

- The ICP Mental Health, Learning Disability and Autism Delivery Board
- The Children's and Young People Strategic group
- The Joint Mental Health and Well Being, Community Mental Health Framework Board
- The Buckinghamshire Dementia Strategy Group, (this group is reviewing the recommendations from the Health and Social Care Committee rapid review to further inform the Dementia action plan and will be coming to board in September)

3.5. The Priorities for the themes are as follows.

- Increase access to early mental health support for Children and Young People in response to need. Prevention and early intervention is important for children and young people's outcomes and a targeted approach is needed for those most at risk.
- Address inequalities in access to mental health support for Children and Young People in Opportunity Bucks Wards and ethnic minority Children and Young People.
- Improve access to perinatal mental health services for women from ethnic minority background, for young mothers (age 16-25) and for women living in deprived areas.
- Improve access, experience, and outcomes from services, particularly for people from Opportunity Bucks wards, ethnic minorities, older people and other marginalised groups with mental health problems. This includes activities to reduce the stigma of mental illness, increase local knowledge and access, take actions to prevent suicide. Including focused provision for individuals who do not access mental health services in new and flexible ways i.e. outreach services for people with Personality Disorder and peer support groups.
- NHS Talking Therapies provide evidence-based support for adults with common mental health problems (such as depression, anxiety and stress). However, only a quarter of people who could benefit access therapy and certain groups of people are less likely to be referred, enter treatment and recover. Work to engage with more deprived and ethnic minority communities, provision of services in different languages, tailored communications to specific groups such as young people, older people and ethnic minority groups and the provision of services in primary care and university settings are all a part of the approach to improve access.
- Focused approaches to improve smoking cessation, physical health checks for people with Serious Mental Illness and specific physical activity provision for people with mental health illness will all contribute to improvements in physical health.

3.6. The priority targets for this theme are as follows:

- Increase the Mental Health Support Teams offer to cover all schools in Opportunity Bucks Wards.
- Increase in people accessing NHS Buckinghamshire Talking Therapies.
- Increase in the number of people with mental illness who stop smoking.
- Increase in individuals accessing serious mental illness checks to 60%.
- Increase the number of people with a dementia diagnosis to the national target of 66.7%.

3.7. The action plan for the Working Groups is included as Appendix B & C. These plans set out how the groups are working collectively to deliver the targets.

3.8. Over the last 12 months a variety of actions have been taken by partners on these priorities. Below is a brief summary of key actions;

- Voluntary sector partners have delivered 'saving lives' programme following investment into 5 voluntary sector organisations.
- Some improved linkage to ethnic minority communities by the NHS Buckinghamshire Talking Therapies services resulting in an increase from 22% to 24% of people accessing the service from ethnic minority communities.
- Provision of physical activity for people with mental illness via Sports in Mind.
- Work on developing an outreach model to increase the percentage of people with serious mental illness to receive a physical health check.
- Research into the needs of people suffering inequality completed by Healthwatch.
- A service for people with multiple risk factors for mental illness who do not engage with services commissioned on an outreach basis via Elmore.
- 20 active Champions of Change recruited to reduce mental health stigma.
- Development of an approach to deliver dementia assessment in nursing and care homes.

3.9. Over the next 12 months initiatives will be continuing, and new ones will be starting. Below is a selection of work for these priorities:

- Increase dialogue with Faith leaders and communities to understand the barriers to engagement and develop/deliver projects/pathways together to improve access and engagement as well as reduce stigma.
- Disseminate and action findings from Healthwatch research into inequalities.
- Increase number of people trained in MH first aid and suicide prevention targeting the Opportunity Bucks wards.
- Develop more accessible Talking Therapies services through promotion targeting specific groups and in locations closer to home such as in primary care or in universities.
- Increase the percentage of physical health for people with serious mental illness by increased communications and targeted approaches.

- Increase the number of people accessing dedicated physical health services for those with mental illness with a focus on older adults and perinatal groups.
- Increase the number of people with mental illness who are supported to reduce smoking by proactive approaches by mental health and primary care staff.
- Develop an improved offer for people in the perinatal period with a focus on the young and on women in deprived areas.
- Review the recommendations from the Health and Social Care Committee rapid review to further inform the Dementia action plan.

4. Next steps and review

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

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

5. Background papers

5.1. Appendix B - Buckinghamshire Joint Health and Wellbeing Board Strategy: Start Well - Mental Health Action Plan

5.2. Appendix C - Buckinghamshire Joint Health and Wellbeing Board Strategy: Live Well - Mental Health Action Plan

[i] Buckinghamshire Joint Strategic Needs Assessment refresh on mental health, due to be published July 2023 and available on request

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Buckinghamshire Joint Health and Well-Being Board Strategy: Start Well/Mental Health Action Plan

JH&WBB Action 1: Increase access to mental health support for Children and Young People (CYP) in response to need (including early support to mitigate demand on specialist services).

Rationale: National data show that not all children and young people are able to access mental health support when they need it. We want to make sure that more children and young people that need mental health support in Buckinghamshire can access it.

Health and Wellbeing Board Performance Hub Metric: The number of children and young people (aged under 18) that have accessed support from NHS funded community services and school or college based Mental Health Support Teams in the last 12 months

Ref	Detailed Actions	Lead	Dates	Baseline	Progress data
Prevention and Promotion	Facilitate new project to extend parenting programmes in Opportunity Bucks wards for a range of ages.	BC Public Health / Family Support Service	2023-25	N/A	Increased access in the Opportunity Bucks wards. No of staff trained
	Delivery of Psychological Perspectives in Education & Primary Care (PPEPCare) training to schools and other professionals	OHFT (CAMHS)	2023-25	N/A	PPEPCare participation numbers and feedback
Right help, in the right place when they need it	Facilitate the roll out of further Mental Health Support Teams	OHFT (CAMHS) / BC (Integrated Commissioning) / Buckinghamshire Schools	2023-24	April 22 95 Schools covered.	Number of schools with MHST % Pupil population coverage
	Increase access to digital support	OHFT (CAMHS)	2023-25	KOOTH users 504 April 23 (rolling 12-month total)	Increased use in digital support from KOOTH Setting up of SHaRON Neuro support platform

	Deliver a new Emotional Based School Avoidance (EBSA) project, embed the use of the ESBA toolkit across the relevant services, including CAMHS, and agree joint working practices.	BC (Education)	2023-25	N/A	Number of information sessions delivered Developed and implemented a EBSA counting mechanism
	CYP who are referred for urgent and routine eating disorder intervention starting treatment within national waiting time standards	OHFT (CAMHS)	2023-25	June 22 30 % routine 73% urgent	% Of routine and urgent referrals that meet waiting time standard (urgent – within 5 days/ routine within 20 days)
	Improving the intervention and provision for CYP with high needs and complexity.	OHFT (CAMHS)	2023-25	N/A	Number and range of staff working in this area Link programme evaluation results Number of inpatient admissions
Influence the development of the service through participation and feedback	Strengthen the voice and influence of CYP in current and future development of services	OHFT (CAMHS) / BC (Public Health / Integrated Commissioning)	2023-25	Baseline to be confirmed 07/23	Increase representation of group membership in active CAMHs participation group named Article 12, ensuring it reflects the school population demographic

JH&WBB Action 2: Address inequalities in access to mental health support for Children and Young People in deprived areas and ethnic minority Children and Young People.

Rationale: Children in the poorest households in the UK were 4 times more likely to have serious mental health difficulties by the age of 11 than those in wealthiest. We want to make sure that children and young people living in more deprived areas are as able to access support as those living in the least deprived areas.

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

Ref	Action	Lead	Dates	Baseline	Progress data
Prevention and Promotion	Deliver an ongoing communications programme that promotes positive mental health, addresses stigma and signposts to	BC (Public Health / Comms) / OHFT (CAMHS) /	2023-25	Baseline needs to be established	Online interactions and reach via social media

	services (prevention and treatment) linked to annual mental health campaigns (e.g., Children's Mental Health Week).				
	Deliver a peer support in schools programme, targeting schools in the Opportunity Bucks Wards, to raise awareness of mental health, equipping children and young people with skills to be able to manage their own mental health and support others.	BC (Public Health / Bucks Mind)	2023-25	25 schools at year end 2023	No. schools signed up % Schools signed up in Opportunity Bucks Wards No. of student mentors trained No. of staff coordinators trained
	Programme of funding to deliver voluntary, community and social enterprise (VCSE) sector projects that promote positive emotional mental wellbeing	Heart of Bucks / BC (Public Health) and Buckinghamshire VSCE sector	2023-25	N/A	No of VSCE CYP MH projects funded % VSCE sector organisations awarded funds that met outcomes and were sustained beyond the initial funding % VSCE CYP MH projects funded that were based in Opportunity Bucks wards
	Establish the current baseline then improve the access and use of the Mental Health Support Teams (MHST) for both CYP from an ethnic minority and those living in a deprived area.	OHFT (CAMHS)	2023-25	Baseline to be established	% Increase (and number) of CYP from an ethnic minority using MHST support % Increase (and number) of CYP living in a deprived community using MHST support
Know where to find help and advice that they can Trust	Complete a Gap Analysis of access and outcomes, including by ethnic minority groups. Engage communities with higher levels of deprivation, highest need and poorest access, working with them to understand the barriers to access and their experience. Based on these findings, develop/deliver projects/pathways to improve engagement and access.	OHFT (CAMHS) / BC (Public Health / Integrated Commissioning)	2023-24	N/A	Completed Gap Analysis, with the groups identified Increased access in the groups identified Implementation of a Cultural Competency checklist to define good practice

Right help, in the right place when they need it	Establish the current baseline then improve the access and use of any part of the CAMHs offer for both CYP from an ethnic minority and those living in a deprived area.	OHFT (CAMHS)	2023-25	Baseline to be established	% Increase (and number) of CYP from an ethnic minority using any CAMHs support % Increase (and number) of CYP living in a deprived community using any CAMHs support
	Establish the baseline and demonstrate similar outcomes (using Routine Outcome Measures) of CYP from an ethnic minority and those living in a deprived areas as compared to other users	OHFT (CAMHS)	2023-25	Baseline to be established	Routine Outcome Measures of CYP from an ethnic minority and those living in a deprived area

JH&WBB Action 3: Improve access to perinatal mental health services for women from ethnic minority background, for young mothers (age 16-25) and for women living in deprived areas.

Rationale: Historically, not all women in England that need mental health support in pregnancy and the first year after birth have had good access to support. We want to make sure that women that need support for their mental health at this time can access it.

Health and Wellbeing Board Performance Hub Metric: The number of women that are pregnant, or recently had a baby, that have accessed support from a specialist community mental health service (face to face or video) in the last 12 months

Ref	Action	Lead	Dates	Baseline	Progress data
Improve access to perinatal mental health services	**Women from ethnic minority backgrounds:** • Complete audit of women accessing support within Perinatal Mental Health from an ethnic minority • Identify gaps in access and service provision. • Co-produce new information for women from an ethnic minority. • Targeted engagement with ethnic minority groups	OHFT (Buckinghamshire Specialist Perinatal Team)	2023-25	N/A	Audit completed Gaps identified Co-production planned and complete. Information materials co-produced Information materials distributed

	Young mothers (age 16-25): • **16-18** – Supported by CAMHS with access to specialist advice and consultation with Perinatal Mental Health Team (PHMT) on request • **18-25** – Deliver access to specialist assessment and intervention working across perinatal pathway with maternity, Family Nurse Partnership (or equivalent) and Health Visiting to ensure unified approach	OHFT (Buckinghamshire Specialist Perinatal Team)/BHT	2023-25	N/A	16-18 year age range Number of consultations delivered. 18–25-year age range Number of Assessments and contacts undertaken
	Women living in deprived areas: • Complete audit of women accessing support within PMHT from deprived areas • Identify gaps in access and service provision • Co-produce information for women from deprived backgrounds • Targeted engagement with deprived areas	OHFT (Buckinghamshire Specialist Perinatal Team)	2023-25	N/A	Audit completed Gaps identified Co-production planned and complete Information materials co-produced Information materials distributed

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

H&WBB Action 1: Improve access, experience and outcomes from services, particularly for people from deprived areas and ethnic minorities with mental health problems

Rationale: Mental health problems are common and can affect anyone, but some groups are at higher risk of poor mental health than others.

Health and Wellbeing Board Performance Hub Metric: Reduce gap in % of patients with mental health emergency with no prior contact with services: Ethnic Minority patients vs. white British

Ref	Detailed Actions	Lead	Dates	Baseline	Progress data
	Deliver an ongoing communications programme that promotes positive mental health, addresses stigma and signposts to services (prevention and treatment), linked to specific annual mental health events campaigns	BC Public Health/Comms	2023-25	N/A	Online interactions and reach via social media
	Develop a new programme of work with hairdressers and barbers in Opportunity Bucks wards to facilitate better signposting to services through training and other materials	BC Public Health	2023-25	N/A	Pilot phase to be completed before end 2023
	Deliver a new programme of Community Conversations with people living in our most deprived areas (Opportunity Bucks wards) or from ethnic minority groups. Partners work collaboratively to engage people from ethnic minority and deprived communities to promote positive mental health and understand stigma/barriers to support	BC Public Health	2023-25	N/A	Engage >50 people in community conversations in Year 1 (2023-24)
	Disseminate research findings into barriers to community mental health for identified disadvantaged groups	Healthwatch Bucks/OHFT	2023	Research completed, now to be disseminated	Dissemination of research and actions

					defined to deliver recommendations
	Promote mental health first aid and suicide prevention training offer over the next 3 years to professionals and volunteers working in the Opportunity Bucks wards (including Primary Care Networks (PCNs)) and in services that work with the people most likely to be affected by the cost-of-living crisis for example Helping Hands team, Food banks, Social Prescribers.	BC Public Health/Bucks Mind	2023-25	To date offer has been universal without targeted promotion	10 MHFA and 10 SFA courses delivered (total 160 learners each) % uptake of training by people working or volunteering in Opportunity Bucks wards
	Reinvigorate and promote the Heads-Up campaign (including website), that aims to target men and their mental health.	BC Public Health	Autumn 2023	Establish baseline number of "hits"	Refreshed website launched, number of "hits" on website
	Deliver the Champion the Change programme to address mental health stigma including four social media campaigns a year.	Bucks Mind/BC Public Health	2022-23	20 active champions	Additional 3 active champions recruited per year Deliver promotional events that address stigma and promote MH conversations to 800 people in year 1
	Continuation of Saving Lives Programme (suicide prevention projects targeting men and boys delivered by VCS organisations) to final year (to November 2024) with sustainability focus	Heart of Bucks/BC Public Health	2023-24	5 organisations received funding 2022-23.	To be defined for final year
	Embed new Mental Health Practitioners working with PCNs to deliver timely access to an integrated, patient-centered care within the local	PCNs/OHFT	2022-25	9 MHPs in place with one on boarding. 3 PCNs with no MHP	% PCNs with a Mental Health Practitioner. Patient contacts.

	community that enables people with mental health needs improve their well-being and functionality, with the aim of preventing, reducing or delaying the need for more specialist / secondary services				
	Bucks Health and Social Care Academy work to support faith communities with mental health and delivery of Mental Health First Aid (MHFA)	Bucks Health and Social Care Academy	2023-24	N/A	Number of community leaders trained in MHFA
	A new Community Mental Health Framework programme (bridging primary /secondary mental health care) has been rolled out according to need/deprivation. This new provision will increase access to psychological support, peer support, employment support and support access to voluntary sector services interventions that will support the reduction in the morbidity and mortality of Serious Mental illness (SMI)	OHFT/PCNs/ Voluntary Sector	2022/24	N/A	Number of people supported for each service element Access by ethnicity and Opportunity Bucks wards Selected patient reported outcomes
	Increase % of patients with ethnicity recorded	OHFT/BHT	2023-26	% patients with ethnicity recorded, baseline to defined	Increase % of pts with ethnicity recorded
	Promote availability of mental health services delivered in languages other than English/ interpreter services so that people that do not speak English as their first language can be appropriately referred and have increased confidence to access services.	OHFT Comms/ICP	2023-24	N/A	Report of promotional activity

H&WBB Action 2: Improve access to NHS Talking Therapies for adults especially those from more deprived communities, ethnic minorities, young adults/students, men older people and those living with long term physical health conditions.

NHS Buckinghamshire Talking Therapies (NBTT) provide evidence- based support for adults with common mental health problems (such as depression, anxiety and stress) but some groups are less likely to be referred, enter treatment and recover.

Health and Wellbeing Board Performance Hub Metric: TBC

Ref	Action	Lead	Dates	Baseline	Progress data
	*****Market Mental Health Services and the new NHS Bucks Talking Therapies brand (formerly Healthy Minds - IAPT) to all communities, including more specific communication tools/resources to engage with and promote the service to younger people/ students (18–25-year-olds), older adults (65+), people living with and beyond cancer, ethnic minorities.	OHFT Comms	2023-25	2022-23 Access, completion and recovery rate data/Outcome data for Opportunity Bucks wards to be defined	% Increase in achievement of access, completion and recover data for each priority group and Opportunity Bucks wards
	* Develop links with communities in areas with higher levels of deprivation (Opportunity Bucks Wards), work with them to understand the barriers to engagement, and develop/deliver projects/pathways together to improve access, engagement, and completion of therapy. Groups include Pakistani, black, and African, men, younger people/ students, older adults, people living with and beyond cancer.	OHFT	2023-25	2022-23 Access, completion and recovery rate data/Outcome data for Opportunity Bucks wards to be defined	% Increase in achievement of access, completion and recover data for each priority group and Opportunity Bucks wards
	NBTT Service Improvement Project to evaluate impact of work with Pakistani groups	OHFT	2023-24	Access rate data for Pakistani community in Aylesbury and qualitative data from focus groups	% Increase

	Deliver community-based outreach NBTT clinics to Muslim communities in High Wycombe	OHFT	2023-25	N/A	Monitor activity and outcomes from specific clinics
	Deliver a weekly NBTT clinic at Bucks New Uni for students with reported lower mental wellbeing.	OHFT	2023-25	N/A	Monitor activity and outcomes from specific clinics
	Explore offering NBTT clinics within GP practices/ PCNs	OHFT	2023-24	N/A	Monitor activity and outcomes from specific clinics

Actions Marked with * above will also support delivery of action 1. Improve access, experience and outcomes from services, particularly for people from deprived areas and ethnic minorities with mental health problems

H&WBB Action 3: Address physical health inequalities for people with a serious mental health illness
People with a serious mental illness also have poorer physical health and have a higher chance of dying from cardiovascular disease.
Health and Wellbeing Board Performance Hub Metric: Increase % of patients with a Serious Mental Health Illness (SMI) that have had all components of a physical health check in the last 12 months

Ref	Action	Lead	Dates	Baseline	Progress data
	Increasing the number of people who are admitted to a Mental health inpatient ward who stop smoking (tobacco control alliance) including Smoking champions within mental health services	OHFT	2022-25	Q4 FY 22/23-75%	Increase % of people in mental health inpatient wards that smoke that are offered NHS tobacco treatment services
	Increase the uptake of regular physical health checks, with appropriate advice and treatment including use of Point of Care testing to enhance accessibility, training for professionals and VCSE and an outreach pilot, focused in areas with higher levels of SMI or deprivation	BOB ICPH /PCNs	2022-25	Q4 23 – 59.3%	Increase % of patients with a Serious Mental Illness that have had all components of a physical health check in the last 12 months (all components) The National target for Physical Health

					Checks for SMI patients is 60%
	Increase access to physical activity for people with MH conditions - including older adults and those in the peri- natal period	OHFT/Sports in Mind	2022-25	100 people accessed 2022-23	Number of people accessing service

Health & Wellbeing Board Buckinghamshire

Healthwatch Bucks quarterly update

Date: 22nd June 2023

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

Report Sponsor: John Meech, Chair, Healthwatch Bucks

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

☐ **Decision** ☐ **Endorsement**

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

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

None of the above? Please clarify below:

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

1. Purpose of report

Healthwatch Bucks is the Local Healthwatch for Buckinghamshire. We are one of over 150 independent Local Healthwatch organisations set up by the government under the Health and Social Care Act 2012. Our role is to ensure that health and social care services put the experiences of people at the heart of their work. The report outlines the projects we have been working on over the last quarter.

Healthwatch Bucks update

Start Well | Live Well | Age Well

Health & Wellbeing Board
Buckinghamshire

June 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

Following the publication of our report on Young Onset Dementia, we have received a joint response to our recommendations from Bucks Council and Bucks ICB. The report and response can be accessed here..

The recommendations in our report have been incorporated into the recommendations from the Bucks Council Health and Social Care Select Committee report 'a Rapid Review of support for people living with dementia and their carers' in Buckinghamshire'.

Early intervention for Eating Disorders: youth engagement in Buckinghamshire

Oxford Health asked to gather views from diverse and lesser heard groups of young people on FREED -First Episode Rapid Early Intervention for Eating Disorders.

FREED is a targeted service for 16 to 25-year-olds who have had an eating disorder for three years or less. There are support services for eating disorders available to people of all ages in Buckinghamshire. However, young people getting help for eating disorders through FREED get rapid access to professional support.

What we did

The views that we heard were not from FREED service users. The people we spoke to had never heard of FREED.

We ran a series of five focus groups during December 2022 and January 2023. We worked in partnership with:

- **SV2G (St Vincent and the 2nd Generation)** – an African and Caribbean Arts and Heritage organisation based in High Wycombe. SV2G offers a range of creative arts and heritage programmes that empower and develop young people of various diverse backgrounds.

- **Khepera CIC** – a health and wellbeing organisation supporting young people and their families.

Focus group facilitators explained the FREED service model to young people before asking questions.

In total, thirty-three young people took part in these sessions.

Key findings

- Overall, young people would recommend the FREED service to others.
- There was a concern that FREED service delivery times were too long and that a triage approach could work better i.e., call within 48 hours and simultaneous assessment.
- Young people were more likely to speak to a friend rather than go to a doctor if they thought that they had an eating disorder.
- A fear of being labelled would stop people from seeking professional help.
- There was stigma around prescribed medication.
- Gender-neutral communication for promoting the FREED service was preferred.

Our recommendations

We recommended that Oxford Health NHS Foundation Trust, Community Mental Health Teams, enhance awareness by:

- Developing referral partnerships with youth organisations in Buckinghamshire
- Linking with local educational and training providers
- Distributing FREED leaflets in General Practices across Buckinghamshire. First point of contact in the health care system is likely to be in General Practices
- Targeting FREED promotion in community settings such as youth clubs, leisure centres, further education colleges
- Using digital platforms to inform young people, educators and local organisations about the service.

Communicating with young people about FREED

We recommended that the FREED service should use:

- **Gender-neutral** images and language. The younger generation is more open and accepting of gender fluidity. This also breaks down stereotypes that only females experience issues with eating
- **Positive words** to inform young people about the FREED service with choices and alternative paths to seek help

- Increased emphasis on **talking treatments**. There are no specific drugs to treat eating disorders. However, focus groups highlighted a fear of being put on medication as part of the treatment process
- Clear messaging about **confidentiality** and handling of personal information.

You can read the report and the response from OHFT here .

GP surgery care when you're deaf, Deaf or hard of hearing

We wanted to find out about the experiences of people who are deaf, Deaf or hard of hearing when they try to access care from GP surgeries.

The aim of our research was to identify health inequalities that might affect deaf, Deaf and hard of hearing people so we could make recommendations on tackling them.

What we did

We asked people about their experiences of booking and attending appointments at their GP surgery in Buckinghamshire. In line with SignHealth guidance, we used the terms 'Deaf', 'deaf' and 'hard of hearing as follows when we designed our research questions and reported our findings.

- deaf – used to describe or identify anyone who has a severe hearing problem
- Deaf – used to refer to people who have been deaf all their lives, or since before they started to learn to talk
- hard of hearing – used to describe people with less severe hearing problems.

We developed a survey which was online from 7 February to 30 April 2023. This was publicised via social media, as well as via community and service providers' newsletters. We also held three focus groups.

Altogether, 90 people who were deaf, Deaf or hard of hearing told us about their experiences of accessing GP surgery care in Bucks.

Key findings

We received feedback about a range of issues. People highlighted challenges they had faced with basic communication, making appointments and attending appointments.

- Few people knew they could ask for their GP records to be 'flagged' with their communication needs
- Many were frustrated by having to remind people inside the surgery (and then in secondary care if they were referred) that they had a degree of hearing loss
- Few Deaf people had experience of British Sign Language (BSL) interpreters in a GP surgery. They said it took too long to book, and/or that Sign Live or similar apps were not generally used
- Many people who are hard of hearing, deaf or Deaf find making appointment by phone or receiving speech calls from GP surgeries difficult
- While several people asked family members, friends and/or social workers to help them book appointments and/or communicate with medical staff, some felt this did not allow them to keep aspects of their medical history private
- Some people told us that not being able to communicate in a way that suited them left them confused, frustrated, ill-informed or they felt the experience affected their self-esteem in a negative way.

Our recommendations

We recommended that BOB ICB should encourage Buckinghamshire GP surgeries to sign up to the Healthwatch Bucks Deaf and Hearing Loss GP Practice Charter. This sets out a commitment to reducing inequalities in access to GP surgery care that may affect people who are deaf, Deaf or hard of hearing.

The Charter should be displayed in GP practices and on their websites. By signing up to the Charter, practices would help demonstrate that they are committed to meeting the requirements of the Accessible Information Standard.

You can read the report here.

Local awareness of Community Pharmacies

Our current 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 service. We are doing this both face to face and online. To complete the online version please click here.

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Report to Health and Wellbeing Board 22nd June 2023
Buckinghamshire Executive Partnership (BEP) Meeting, 9th May 2023

Author: Craig McArdle, BEP Vice-Chair

Please find below a summary report of the inaugural Buckinghamshire Executive Partnership meeting on 9th May 2023. A further update on the Health and Care Integration Programme is also included as an appendix.

Item	Summary	Impact
Ways of Working	Discussed and finalised TOR and communications materials. Agreed priorities for BEP and 'Plan on a Page'.	BEP have agreed to focus on three priorities for Buckinghamshire: Transforming SEND, Joining Up Care; and Tackling Health Inequalities. The BEP will ensure its work is transparent and will share 'Plan on a Page' with partners.
SEND	Discussed plans for investing £4.6m SEND transformation funding across three areas of Integrated Therapies, Neurodevelopmental Pathway and Community Paediatrics.	Partners will focus on immediate investment to stabilise waiting lists this year, and will work together across the ICB, Local Authority and providers to develop transformation plans, through existing SEND governance and mechanisms for engaging the voices of families and children.
Joining up Care	Progress update on the Health and Care Integration Programme, which focusses on hospital discharge arrangements for residents, and the work of the Buckinghamshire Urgent and Emergency Care Board.	Agreed that we need to ensure alignment across UEC, discharge and primary care strategies to join up care. Deep dives on UEC and Primary care planned for subsequent meetings.
Health Inequalities	Discussions around £1.1m NHS investment in Health Inequalities, linking to NHS's 'Core20plus5' agenda, Opportunity Bucks and Joint Local Health and Wellbeing Strategy.	Opportunity to align programmes of work on Health Inequalities to turn the dial on health outcomes in the ten most deprived Wards of Buckinghamshire.

Appendix – update on 'health and care integration programme'

At the last meeting of the Health and Wellbeing Board in March we updated on our plans for the year ahead which focus on improving the hospital discharge model in Buckinghamshire. These plans hinge off the delivery of four key changes, as below. The programme is on-track to deliver its key milestones.

New Bed-base

Including 5 new bedded discharge hubs and an intermediate care centre. The first 3 bedded hubs were launched in May, they support patients who require more complex assessments which cannot be done within an acute setting. Each hub has it's own multidisciplinary team who will support patients during their stay, and clear performance targets tracking patient experience.

An intermediate care centre will be launched at Amersham hospital in October, providing 22 beds for patients with therapy input, clear goal setting and a focus on reablement to enable as many people to return home following a time limited stay.

Integrated Discharge Team

Hospital staff and social workers becoming one team and working together with patients on the ward to plan their discharge from the point of admission. Discharge plans will be simplified, based on the strengths of the patient, and developed with residents and their families – this should reduce anxiety and help patients feel in control. Better planning of discharge will reduce the likelihood of readmission, enabling people to remain at home. Pilot phase started in April – social workers and hospital staff are now co-located, and social workers have joined ward-based multi-disciplinary teams. A new process for quality assuring referrals for discharge services was launched in May. Full launch at Stoke Mandeville Hospital is planned for June.

Transfer of Care Hub

An integrated team (hospital, social work, service finding, Housing and VCS) working together to co-ordinate the patient's discharge effectively, with case managers working with more complex patients to ensure their discharge progresses smoothly. There will be strong oversight of length of stay, and blockages/ delays will be escalated and dealt with quickly. Design phase is in progress – including engagement with patients, carers, staff and VCS. Launch is planned for October.

Trusted Assessor Model

Two new Trusted Assessor roles working with patients who are usually resident at one of our Fremantle Care Homes (largest care provider in Buckinghamshire). The Trusted Assessors will manage communication and information flow between the Patient, the Care Home and the Ward to ensure patients move through the system quickly and effectively. Over time, relationships and trust will develop between these partners.

Agenda Item 11

Health & Wellbeing Board Buckinghamshire

Better Care Fund Plan 2023-2025

Date: **22 June 2023**

Author/Lead Contacts: Colette Kavanagh, Head of Service – Integrated Commissioning, Buckinghamshire Council

Report Sponsor: Craig McArdle, Corporate Director – Adults and Health, Buckinghamshire Council

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

☐ **Decision** ☒ **Endorsement**

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

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

1. Purpose of report

1.1. The Better Care Fund (BCF) is a national vehicle for driving health and social care integration using pooled budgets. The BCF policy framework requires a jointly agreed plan to be set between local health and social care commissioners and signed off and owned by the Health and Wellbeing Board. The planning guidance for 23-25 was published on 5th April 2023 and each HWB area is required to submit a BCF plan to NHS England for assurance on 28th June 2023.

2. Recommendation to the Health and Wellbeing Board

2.1. To approve the Buckinghamshire Better Care Fund Plan for 2023-2025

Start Well | Live Well | Age Well

2.2. To continue to delegate the authority for the development of Buckinghamshire's BCF plans, allocation of expenditure and proposed metrics trajectories for plans to the Integrated Commissioning Executive Team.

3. Content of report

3.1. Background

The Better Care Fund (BCF) is a national vehicle for driving health and social care integration, using pooled budgets. The BCF has 2 core objectives:

- to enable people to stay well, safe and independent at home for longer
- to provide people with the right care, at the right place, at the right time

It requires a jointly agreed plan to be set and owned by each Health and Wellbeing Board. In Buckinghamshire, the Integrated Commissioning Executive Team (ICET) provides oversight of the strategic direction, budget, and performance of the BCF.

3.2. BCF Planning Requirements

Each HWB area is required to submit, for national assurance, a BCF plan to NHS England on 28th June 2023. This must include narrative on how the fund will be utilised to enhance and improve integrated working (appendix 1) and a completed template detailing proposed expenditure, metric trajectories and supporting narrative (appendix 2). The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved. The planning guidance was published on 5th April 2023 and for 23-25 the conditions are:

The national conditions for the BCF in 2023 to 2025 are:

- a jointly agreed plan between local health and social care commissioners, signed off by the HWB
- implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer
- implementing BCF policy objective 2: providing the right care, at the right place, at the right time
- maintaining the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services

To support delivery of the BCF plan, HWB areas must work towards meeting several indicators related to improving health and social care outcomes. The metrics are:

Provide people with the right care, at the right place, at the right time
In 2023 to 2024:

- discharge to usual places of residence
- new: discharge metric ahead of winter 2023

In 2024 to 2025:

- discharge to usual places of residence
- new: discharge metric ahead of winter 2023
- new: proportion of people discharged who are still at home after 91 days

Enabling people to stay well, safe and independent for longer
In 2023 to 2024:

- admissions to residential and care homes
- unplanned admissions for ambulatory sensitive chronic conditions
- the proportion of older people who were still at home 91 days after discharge from hospital into reablement or rehabilitation services
- new: emergency hospital admissions due to falls in people over 65

In 2024 to 2025:

- admissions to residential and care homes
- unplanned admissions for ambulatory sensitive chronic conditions
- emergency hospital admissions due to falls in people over 65
- new: outcomes following short-term support to maximise independence

3.3. Buckinghamshire's BCF Plan Priorities 2023-25

The BCF is now a 2-year plan. The local priorities for the BCF for 23-25 are:

1. Hospital discharge
2. Admission avoidance
3. Inequalities

There are well established programmes and workstreams to deliver on the first two priorities. A new piece of work will be undertaken during 23-25 to review and shape how the BCF schemes address inequalities.

3.4. BCF Funding

	2022-23	2023-24	2024-25
Minimum ICB contribution	£35,443,967 • £11,872,603 minimum mandated for Adult Social Care • £10,076,361 mandated for NHS Commissioned out of hospital spend	£37,439,530 • £12,544,593 minimum mandated for Adult Social Care • £10,646,683 mandated for NHS Commissioned out of hospital spend	£39,558,608 • £13,254,617 minimum mandated for Adult Social Care • £11,249,285 mandated for NHS Commissioned out of hospital spend
Improved Better Care Fund (iBCF)	£5,040,826	£5,040,826	£5,040,826
Disabled Facilities Grant (DFG)	£4,065,961	£4,065,961	Figure has not yet been released by NHSE.
Adult Social Care Discharge Fund	£3,790,765	£706,716	£1,173,148
Total	**£48,331,519**	**£47,253,033**	**£45,772,582**

The BCF pooled budget is allocated against schemes which are central to the delivery of the BCF priorities and fully fund specific contracts such as:

- Home from Hospital
- Dementia Support Service
- Carers Bucks (Adult and Young Adult service)

The budget also contributes to core Adult Social Care and NHS schemes which enable the delivery of the BCF priorities. The BCF now formally incorporates the Adult Social Care Discharge Fund. The plan is to allocate the uplift for 23-24 and the Adult Social Care Discharge Funds to the Health and Social Care Integration Programme which is focused on improving hospital discharge and admission avoidance.

3.5. Consultation and Communication

- Draft BCF plan to NHS England for feedback 19th May 2023
- Feedback received form NHSE 31st May 2023
- Cabinet Member for Health and Wellbeing and DASS 5th June 2023
- Health and Care Integration Programme Board 8th June 2023
- Buckinghamshire Executive Partnership Board 13th June 2023
- Integrated Commissioning Executive Team 15th June 2023
- Health and Wellbeing Board 22nd June 2023
- Final plan submission to NHS England 28th June 2023

4. Next steps and review

4.1. Regional and National Assurance

NHS England will approve BCF plans in consultation with the Department for Health and Social Care and the Department for Levelling Up, Housing and Communities. Assurance processes will confirm that national conditions are met, ambitions are agreed for all national metrics and that all funding is pooled, with relevant spend agreed.

- HWB area BCF final plan for 23-25 submitted to national BCF Team at NHS England 28th June 2023
- Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation 28th July
- Cross regional collaboration 3rd August 2023
- NHSE issue approval letters giving formal permission to spend (NHS minimum) 8th September 2023
- BCF section 75 agreements to be signed and in place 31st October 2023

4.2. Buckinghamshire next steps

If delegated responsibility is approved, the ICET will continue to monitor and oversee the BCF plan, expenditure, and reporting through monthly meetings.

The work to assess how each of the schemes is addressing inequalities, particularly for individuals with a protected characteristic will commence in 23-24.

5. Background papers

Appendix 1 Buckinghamshire BCF Narrative Plan 23-25
Appendix 2 Buckinghamshire BCF Plan 23-25

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Better Care Fund Narrative Plan
2023-2025
Buckinghamshire Health & Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils). How have you gone about involving these stakeholders?

Buckinghamshire has a joint (NHS Integrated Care Board and Council) Integrated Commissioning Executive Team (ICET). ICET is made up of Health, Social Care and Housing senior leaders. ICET also has representation from clinical leads in Mental Health and LD, CYP, Integration and Primary Care as well as representation from Public Health, Business Intelligence, and the lead commissioner for the Disabled Facilities Grant.
ICET holds the delegated responsibility for overseeing the BCF plan and through monthly meetings, leads the BCF development and planning. In addition to this, the BCF planning is taken to establish integrated boards and meetings as both executive level and at operational levels to get input from a wider group of stakeholders including the Trusts.
In addition to this, Buckinghamshire uses the established mechanisms to gather input. Some examples include:

- Within hospital discharge, commissioners, Home First representatives and hospital discharge representatives meet with Home First home care providers (monthly) and care home providers (weekly). The feedback and discussions contribute to the BCF planning.
- The Carers Board has representatives from all key stakeholders including health and social care leaders, carers and the VCS. This reports into the Buckinghamshire Council Transformation Board which contributes to BCF planning.

Information collected through routine contract and quality monitoring of BCF scheme providers and feedback from service users is shared via ICET and informs the BCF planning process.

Governance Please briefly outline the governance for the BCF plan and its implementation in your area.

Buckinghamshire has joint governance arrangements in place for the BCF. The Health and Wellbeing Board (HWB) hold overall responsibility for the BCF plan but has delegated the responsibility for the development and oversight of the plan and expenditure to the Integrated Commissioning Executive Team (ICET).

ICET is made up of Health and Social Care senior leaders and is co-chaired by the ICB Executive Place Director and the Council's Service Director for Integrated Commissioning. Membership includes the ICB Finance Place Lead and the Council's Head of Finance, representation from the Council's Social Care Housing lead, clinical leads in Mental Health and Learning Disabilities, Children Young People, Integration and Primary Care as well as Public Health, Business Intelligence, and the lead commissioner for the Disabled Facilities Grant.

ICET has representation from all areas of Joint Commissioning. The joint commissioners routinely engage with care providers and the Voluntary and Care Sector organisations through a variety of mechanisms including routine visits and monitoring, the care association network meetings, care providers registered managers network, home care provider forums, hospital discharge provider forums and there is a dedicated integrated commissioning email address for provider queries and feedback. Information collated via these routes is brought to ICET via the commissioners reporting and this enables care providers and the VCS to influence the plan.

The BCF Plan is endorsed by the ICB Accountable Officer who has delegated authority from the ICB and by the Local Authority Corporate Director and DASS and the Cabinet Member for Health and Wellbeing prior to going to the HWB for final agreement.
Following approval and submission of the BCF 2023-25 Plan, the BCF Section 75 agreement will be updated.

Executive summary
This should include:

- Priorities for 2023-25
- • Key changes since previous BCF plan.

The Priorities for 23-25 are:

1. Hospital discharge
2. Admission avoidance
3. Inequalities

The key changes are increased investment in the Health and Care Integrated Programme which is a joint Council, ICB and NHS Trust programme. The programme has an initial focus on hospital discharge but will also incorporate admission avoidance during 23-25. The additional BCF funding and discharge fund for 23-25, alongside the existing funded schemes, will enable Buckinghamshire to implement new models of working for hospital discharge and admission avoidance. The first phase of the programme in 23-24 will focus on hospital discharge and admission avoidance will be the second phase.

The previously funded schemes continue to be funded but some will be reviewed during the 23-25 period as contracts end or as outcomes and impact are reviewed.

National Condition 1: Overall BCF plan and approach to integration
Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25

- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care.

Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

The BCF priorities broadly align to those of the Buckinghamshire Executive Partnership which draws upon the Health and Wellbeing strategy to shape its priorities. For 23-25 the BCF priorities are:

1. Hospital discharge
2. Admission avoidance
3. Inequalities

Buckinghamshire has an Integrated Commissioning model. There are Integrated Commissioning Teams which are hosted by the council, but health and social care funded to jointly commission services. There are s75 agreements to formalise the integrated commissioning arrangements including for Integrated Therapies, s117, Integrated Community Equipment, Continuing Health Care, Hospital Discharge and BCF. Through ICET, there is shared oversight of commissioning plans to steer and monitor joint priorities.

There are integrated approaches to broader commissioning functions such as the management of care sector quality with a formal integrated Quality Surveillance Group and an integrated Care Home Outbreak Risk Group. There are integrated workstreams for key areas including the integrated hospital discharge programme, Mental Health, Learning Disability and Autism.

An integrated approach is now embedded at every level of the system. From the Buckinghamshire Executive Partnership, which is the place-based partnership of the Chief Executive Officers and their senior colleagues within the Council, the NHS Trust and the ICB through to daily integrated operational meetings. There are an increasing number of joint funded integrated posts, many of which are funded via the BCF, and any new initiatives and workstreams are used as an opportunity to further embed integration.

For 23-25, there is significant additional investment into the Health and Care Integrated Programme which has a number of joint funded workstreams and schemes and joint funded integrated programme team and joint funded schemes which will drive forward the new models of working for hospital discharge and admission avoidance. The programme will deliver a range of initiatives within a new model, including Trusted Assessors, an Integrated Discharge Team, A transfer of care hub, a community hospital intermediate bedded care hub, a care home hub bed model for complex cases and a short-term care home interim bedded care hub. Together, this will ensure people get out of hospital as soon as they are medically ready and will, wherever possible, return home. Anybody requiring ongoing care will be able to access the right care, in the right place, at the right time.

National Condition 2:
Use this section to describe how your area will meet BCF **objective 1: Enabling people to stay well, safe and independent at home for longer.**
Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home.
Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65

the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population

Adult Social Care is supported with BCF funding to deliver the Buckinghamshire Council Better Lives Programme which is a strengths-based model of care. The programme seeks to enable more people to live longer, independent lives in their communities and ensure more high cost, high dependency care in residential and nursing homes is only used when absolutely needed.
The programme has delivered a shared model of prevention, agreed by partners across Buckinghamshire. The Better Lives Programme aims to keep people healthy and in their own homes and communities for longer.
BCF funded schemes which support this include:

- Advocacy – ensuring the voice of the individual is heard and the rights of individuals are protected.

- Integrated Carers Service – provides support to carers and helps to identify carers
- Supported Living – provision of housing which enables people to live at independently whilst within a supported environment and helps them to sustain their tenancies
- Direct Payments – supporting service users to make choices over the care and support they receive
- 'Home from Hospital' service which also includes a community service which provides low level support to enable people to remain at home and prevent admission to hospital.

The BCF also funds a Memory Support Service which supports early diagnosis and delivers intervention for people with mild to moderate dementia. It provides individuals with a person-centred service, which empowers people with dementia or memory concerns and their carers to make informed decisions about care and which helps maximise quality of life. The service aims to reduce the risk of crises later in the illness and enable the person to be cared for at home for as long as possible while this is the preferred place of care.

In Buckinghamshire, the BCF is used to fund integrated community health services. This is being used to support Primary Care Networks (PCNs) as part of a culture of shared ownership for improving the health and wellbeing of the population. In 23-25, these integrated neighbourhood teams, through collaboration and joint working will seek to streamline access to care and advice and provide more proactive, personalised care with support from a multidisciplinary team of professionals ensuring healthy communities are created and the incidence of ill health is reduced.

The Rapid Response and Intermediate Care (RRIC) service is also funded via the BCF contribution to the Buckinghamshire Health Trust Community Services contract. RRIC provides Urgent Community Response (2 hour and 2 day response, rehabilitation and intermediate care, improving function, clinical outcomes, maximising independence and preventing deterioration to remain at home, community physiotherapy, hospital discharge support through community physiotherapy or intermediate care on discharge.

The BCF is also used to fund the Home Independence Team via social care which provides a hospital discharge and community reablement service which also supports individual to return home or to remain independent in the community for longer.

If step-up care is required, the current model is admission to a community hospital if there is an identified health need and admission to a spot purchased care home bed if there is a social care need. Although capacity is currently meeting demand, the additional BCF funding and discharge funding is contributing to the Health and Care Integration Programme which is a joint Council, ICB and NHS Trust programme. The programme has an initial focus on hospital discharge but will also incorporate admission avoidance during 23-25 as the second phase of the programme. The additional BCF funding and discharge fund for 23-25, alongside the existing funded schemes, will enable Buckinghamshire to implement new models of working for admission avoidance which aim to make a more efficient use of resources and improve the individual's journey.

The BCF is used to fund Immedicare to support care homes. Immedicare is a clinical healthcare provider that operates on a 24/7/365 basis and enables clinicians and others involved in healthcare provision to respond and assist patients remotely in real-time, via the use of video-based technologies. Our data is showing us that in 22-23, if Immedicare was not in place, more than 70% of calls would have resulted in a GP call and 6% of callers would have called for an ambulance. There is evidence that immedicare is helping to keep people in the community for longer and prevent admission to hospital.

The BCF is used to fund a falls prevention service which aims to prevent repeat falls through education and therapy input, enabling people to remain independent and living in the community for longer. It also supports preventable hospital admissions. There was a reduction in falls related admissions to hospital in 2022-23 compared to the previous year.

The number of people entering long term care in residential and nursing homes has increased and exceeded our estimate for 2022-23. Although the data does not explain why, we know that approximately two thirds of the new admissions came through hospital discharges. The new models for hospital discharge are aiming to reduce any possibility the system has contributed to this figure. This will be done through robust mechanisms to ensure bed-based care is used when it is the only suitable option to safely meet an individual's need but also to reduce length of stay in bed-based care to prevent any deterioration that might lead to the need for a permanent admission to a care home.

In 2021/22 Buckinghamshire Council established a specialist accommodation steering group to maximise the benefit of becoming a unitary authority by co-ordinating activity across Adult Social Care, Children's Social Care, Housing, Planning and Property. As part of the 2022/23 action plan this group worked together to support the completion of an Adult Social Care Market Analysis to estimate the demand for accommodation-based care over the next 20 years. This analysis is being used to inform the local plan and to explore opportunities to work with planning and property within the Council to bring new developments to market. The market analysis has identified that Buckinghamshire needs to particularly focus on increasing capacity in nursing care beds, supported living and extra care (including private as well as Council funded). The work is also promoting the need for general housing to support people with care needs. To support this work the group has also developed design principles for supported living accommodation (which are also adaptable for other settings) to help develop design briefs for specific cohorts of clients. This will assist the Council in working with developers. Children's accommodation priorities are also being explored within the specialist accommodation steering group, which will also support activity around transition to adult services.

National Condition 3
Use this section to describe how your area will meet BCF **objective 2: Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- how additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified - planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

Discharge to usual place of residence

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

During 22-23 Buckinghamshire set up 'The Health and Care Integration Programme' which is a joint Council, ICB and NHS Trust programme. The programme has an initial focus on hospital discharge but will also incorporate admission avoidance during 23-25. The additional BCF funding and discharge fund for 23-25, alongside the existing funded schemes, will enable Buckinghamshire to implement new models of working for hospital discharge and admission avoidance. The first phase of the programme in 23-24 will focus on hospital discharge and admission avoidance will be the second phase. Management of the programme has dedicated

integrated posts funded through the BCF and is jointly funded but the BCF will also contribute to schemes that align to the domains in the High Impact Change Model. Buckinghamshire was previously assessed as established or planning in most areas. The new models and schemes for 23-25 aims to move all areas to mature or exemplary.

Change 1: Early discharge planning – the new model will have an integrated discharge team which will include hospital based social workers. There will be early discussions about discharge with both patients and family members within 48 hours of admission. There are carers support workers based within the hospital which are BCF funded. An early screening process to identify any potential complexities or circumstances which might present a barrier or delay to discharge will be implemented so issues can be addressed prior to individuals being ready for discharge.
Change 2: Monitoring and responding to system demand and capacity – the demand and capacity planning in previous years, alongside the additional discharge funding has enabled the trial and evaluation of different approaches including the flexing of the workforce. Based on the learning, the 23-25 plan includes a planned increase in the number of beds over the winter period through the temporary opening of a bed based intermediate care facility on the hospital site for the winter surge from October to March, as required. The change of the operational model to include the co-located multi-agency integrated discharge team and a new transfer of care hub will enable live monitoring of capacity across the system so that available capacity can be used effectively.
Change 3: Multi-disciplinary working – the creation of an integrated discharge team with hospital staff and social workers becoming one team and working together with patients on the ward to plan their discharge from the point of admission. Discharge plans will be simplified, based on the strengths of the patient, and developed with residents and their families. Better planning of discharge will reduce the likelihood of readmission, enabling people to remain at home. The integrated discharge team will work alongside a new co-located multi-agency transfer of care hub which will co-ordinate the patient's journey through the system with hospital, social work, therapy, and commissioning staff co-located and working together in an integrated team to achieve this. The ToCH will also track and manage capacity within the discharge pathways and will include input from housing and the VCS as well as the statutory partners.
Change 4: Home first – the Home First model of assessing people at home has been successful in Buckinghamshire and this will continue for 23-25. However, the bed based D2A model had long lengths of stay and was not achieving the ambition to get people home in a timely way, which was resulting in many temporary beds becoming permanent. The bed-based model is changing in 23-25. There will be the re-introduction of more hospital based assessments to enable more people to go straight home from hospital. There will also be the introduction of a new bedded hub model which will each have multi-disciplinary teams attached to them ad include:

- A 22 bedded intermediate care hub within Buckinghamshire Community Hospitals. These beds will complement the intensive rehabilitation beds (35) that are currently provided in Buckinghamshire's Community Hospitals.
- A complex case bedded care home bed hub providing 20 beds for people who need a longer period in a bed to support complex health needs such a being non-weight bearing or with delirium

- Two short term interim care home bed hubs providing a total of 20 beds which can be used to flexibly support discharge from acute hospitals. This will include people who will be assessed in line with a D2A but can be flexible to be used for people who could be delayed in hospital for other reasons.

Change 5: Flexible working patterns – the new multi-agency transfer of care hub will operate across seven days and for extended hours not the evening. The care home hub beds will have seven-day assessment and admissions within their contracts.

Change 6: Trusted assessment – the discharge fund enabled the development of a Trusted Assessor model. In 23-24, two new full time trusted assessors have been appointed and will work within the hospitals to undertake assessments on behalf of care providers. This will be piloted and expanded if successful.

Change 7: Engagement and choice – the establishment of a multi-agency integrated discharge team within the hospitals will enable earlier conversations with individual and their families. The BCF also funds a brokerage offer within the hospitals to support self-funders and funds carers support to be present within the hospitals. Communication and associated information materials are being reviewed as part of the programme of work for 23-25.
Change 8: Improved discharge to care homes – as part of the new care home hub model, care homes will have in-reach MDTs to support the hospital discharge beds which includes dedicated GP support.
Change 9: Housing and related services – Council housing representatives have been involved in the development of the transfer of care hub model. Housing will form part of the ToCH support to ensure timely discharge from hospital. The integrated discharge team will also identify any housing issues, including the need for small adaptions or equipment, prior to the person being medically optimised for discharge. The ToCH will facilitate any equipment, technology or housing adaptions required for discharge.

The model has been driven from previous learning. Up until the end of 22-23, Buckinghamshire had a Discharge to Assess model. We know that elements such as the Home First model have been successful in getting people home. Home First was improved through 22-23 and people are now discharged to this pathway very quickly and consistently assessed within 28 days.

However, the D2A bedded model was not as successful. This was due to there being a large number of beds distributed across a high number of care homes over a wide geographical area. The therapy and social care resource could not be used efficiently due to this, and it contributed to long lengths of stay in these beds. In addition to this, the beds had a very wide eligibility criteria which meant that some people who needed a further non-acute period in bedded care for health reasons would go into the D2A beds but were not able to be fully assessed within a 4-6 week period. The combination of these factors resulted in the average length of stay in the service being over 100 days. This may have resulted in deconditioning which could be one of the factors in the number of new permanent admissions to care homes increasing beyond our estimate.

During 22-23, the number of general D2A beds has been reduced with a focus on improving length of stay and ensuring only people requiring bedded care will go to a care home. The reduction in the number of D2A beds has also increased the market capacity for longer-term placements.

Barriers to assessing patients in hospital are being removed, and the system has started delivering more assessments in this setting. The discharge fund has supported the social work resource to enable this. This will mean that where a patient requires a relatively simple assessment, this can be done quickly in hospital, meaning they can be discharged directly to their long-term care arrangement, minimising the potentially disruptive effect of multiple moves for people.

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

Housing partners are involved in the integrated programme and are involved in the new discharge models. During the winter of 22-23, six new short-term housing units were available to facilitate discharges where residents were waiting for longer term housing. The units acted as a 'bridge' between hospital care and returning home for Buckinghamshire residents who were waiting to be housed. The learning from the initiative will inform the future model.

The BCF also funds a VCS provider to deliver a 'Home from Hospital' service which provides transport and low-level support to settle individuals in at home on discharge from hospital on Pathway 0.

The HICM will be used as regularly one of the evaluation tools during 23-25 to assess the impact of the new model and ways of working.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Buckinghamshire commissions a VCS organisation, Carers Bucks, to provide an All Age Integrated Carers Support Service and the adult element of this service is fully funded by the BCF. In line with Care Act duties, Adult Social Care have a tiered system to identify support needs for carers

with a focus on improving wellbeing, as well as supporting the Carer in their role. The conversations range from signposting or providing information and advice through to a full assessment leading to an agreed outcome-based care plan.

The Care Act 2014 sets out that Local Authorities must protect carers. The Act identifies a range of wellbeing principles and recognises that a carer's wellbeing is to be protected equally to the person/s that they care for. The Carers Bucks contract enables the council to meet their duty to:

- Provide carers with support to meet their needs, according to national eligibility criteria
- Provide information and advice, to promote wellbeing and to prevent the carer developing their own care needs because of being a carer.

Carers Bucks have worked with the Council and partner organisations to develop innovative and creative solutions to meet carers needs. Over the course of the contract the number of carers known to the service has increased significantly. At present, 28.4% of the 41,773 unpaid carers (identified in the 2021 census) in Buckinghamshire are registered with Carers Bucks. This is significantly higher than neighbouring authorities but there is a plan to build upon this. Over 70% of carers registered with Carers Bucks are caring for more than 50 hours per week in contrast to 25% of carers overall in Buckinghamshire. This would indicate that Carers Bucks is effective at reaching carers providing high numbers of hours of care. Carers Bucks offer a range of support to carers at different levels ranging from advice and information through to an intensive crisis support service. They also support carers via primary health environments by developing their investors in GP award, working with surgeries across the County. The award requires that all staff within GP primary care settings are trained in recognising the needs of carers and that flexibility is offered where possible to promote carer wellbeing. Carers Bucks also have support staff located in the acute hospitals to support carers, with a particular focus on hospital discharge.

Buckinghamshire has a Carers Transformation programme (2022 – 2024). During 22-23, an integrated Carers Board was established which has senior leadership representation from Adult Social Care, Cabinet Members, ICB, Buckinghamshire Healthcare Trust, the voluntary and community sector (VCS) and Carers. The Board will use a co-production approach to oversee the carers transformation workstream to deliver improved outcomes for carers in Buckinghamshire. During23-25, the joint Carers Strategy will be refreshed, and the Carers Support service will be recommissioned.

Buckinghamshire Council has well established Direct Payment options and carers breaks are funded through Direct Payments. In addition to this, work is being undertaken in 23-24 to review the planned overnight respite offer within Buckinghamshire which forms part of the Community Opportunities transformation workstream.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

In 2021/22 Buckinghamshire Council established a specialist accommodation steering group to maximise the benefit of becoming a unitary authority by co-ordinating activity across Adult Social Care, Children's Social Care, Housing, Planning and Property. The aim of this group and work is to maximise the potential to develop accommodation solutions that will meet the future needs of people with adult social care needs, aligning the strategic objectives of both housing and adult social care. Included in this is accommodation that can support delivery models that focus on maintaining independence and maintaining wellbeing. As part of the 2022/23 action plan this group worked together to support the completion of an Adult Social Care Market Analysis to estimate the demand for accommodation-based care over the next 20 years. This analysis is being used to provide evidence to incorporate adult social care accommodation needs into the Local Plan and will inform future commissioning activity. The workstream is also promoting the need for general housing to support people with care needs and work has been undertaken to develop design principles for different types of adult social care need to support independence at home.

Through collaboration between Council departments (Adult Social Care, Children's Social Care, Housing and Planning), and in consultation with recipients of DFG, the Council intends to enhance the delivery of DFG to better meet the needs of its residents whilst aligning with the various strategies in place (and in development). This will include ensuring adults are supported to remain independent in their own homes for longer, ensuring children are given the best start in life and ensuring that people are living in homes that support them to have positive health and social care outcomes.

In Buckinghamshire, access to DFG is administered by a single, dedicated Grants and Adaptations Team within Housing while the assessment of need is undertaken by Occupational Therapists within Adult Social Care. The funding is now retained by the single unitary council and a policy review began in 2022 and is currently going though governance processes for adoption.

To enhance the delivery of DFG the council is working across all departments and in consultation with recipients of DFG, to better meet the needs of its residents. This will include ensuring residents are supported to remain independent in their own homes for longer, ensuring children are given the best start in life and ensuring that people are living in homes that support them to have positive health and social care outcomes.

Opportunities for 23-25 include:

- Reducing 'handoffs' between social care and housing to improve client experience and speed up delivery by creation of a single grants and adaptions team.
- Aligning operational practices to abolish the nuances between the former district councils' approaches, where possible, in some cases, this is outside of the Council's control e.g., different housing organisations have different approaches to adaptations
- Reviewing the referral criterion to determine how we can make improvements to access
- Reviewing and extending the support available to applicants in making a DFG application
- Reviewing procurement processes for DFG works, to streamline application timelines

- Bringing DFG closer to the Integrated Community Equipment service to allow greater access
- Closer working with registered provider landlords and the housing options team to enable mutual exchanges/swaps to take place where suitable properties for adaptations can be identified
- Evolving discretionary use of the grant to further support hospital discharge and preventative measures

As well as capital funding to support permanent adaptations to homes, the DFG is also currently used for some minor discretionary approaches that serve a preventative purpose. These are outlined below:

Healthy Homes on Prescription – Seeks to prevent hospital admissions and assist with managing timely discharge from hospital by funding essential works to address health and safety hazards in homes. This could range from installing and repairing heating and other minor repairs, to installing electrical points for medical equipment and widening doorways to accommodate wheelchairs.

Better Housing, Better Health – seeks to prevent or reduce cold related illness by providing grants for heating and insulation measures for those residents with a health condition impacted by the cold.

DFG currently runs in parallel to the Integrated Community Equipment Service (ICES). The ICES service within Buckinghamshire is delivered by NRS through a joint funding arrangement between health and social care and encompasses several service elements including provision of simple and complex aids to daily living, minor adaptations, technology enabled care, continence products, long term wheelchair provision, sensory equipment, and domestic lift maintenance. The service plays a key role in supporting discharge of people into their own homes, preventing avoidable admissions to hospital and maximising service user independence.

Additional information (not assured)
Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)
If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Yes, 8% of the budget is for discretionary services. Buckinghamshire is a Unitary Authority.

Equality and health inequalities
How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Local Authorities and NHS organisations have a duty to consider the impact of decisions on people with protected characteristics. In Buckinghamshire any new services or any changes to services, including commissioned and directly delivered services, must have an Equalities Impact Assessment carried out and this includes the BCF schemes. For 23-25, there is a plan to take this further and review schemes funded via the BCF to not just ensure that they are not having a negative impact on equalities but to identify what positive impact they are having on addressing inequality. This work has started with a multi-agency workshop, facilitated by the BCF leads, in April 2023 to review the impact individual schemes are having on addressing inequalities. There will be further discovery work and then ICET will review and determine any improvements that can be made.

Buckinghamshire JSNA has identified that the number of people being admitted to hospital due to a fall, is more prevalent in deprived areas, with a particular focus on the south of the county, as it has a higher figure than the overall average in England. The BCF funds a Falls Prevention service in Buckinghamshire via the NHS community contract and primarily works with older adults. However, the service focuses on people who have already had a fall in order to prevent further falls. The falls prevention service is being reviewed during 23-25 to ascertain if it is the most effective way to get outcomes for older people.

Cardiovascular disease and smoking are current HWB priorities. There is a focus on smoking cessation as this is the number one cause of health inequalities in Buckinghamshire and has been identified within the CORE20PLS5 approach as having a positive impact on all five identified key clinical areas. THE BCF funds the NHS Integrated Community Services which delivers some of the workstreams addressing health inequalities. The workstream includes:

- Improving referrals and access to smoking cessation services
- Prioritising long term conditions reviews for cohorts of patients who smoke and are an ethnic minority
- Developing smoking cessation support for acute inpatients, maternity services, and mental health services
- Ensuring pathways and services are culturally appropriate
- Improving the cultural competence of the workforce

- Focusing on the most deprived practice areas including Aylesbury and High Wycombe

It is evidenced that people with SMI are more likely to die prematurely and individuals with SMI are 3 x more likely to smoke. BCF funding is used for Annual Health Checks for people with SMI to reduce the inequalities this cohort faces, in line with the CORE20PLUS5 approach. The work has increased the proportion of patients receiving all six elements of the physical health check.

The JSNA shows rates for people with dementia in Buckinghamshire are estimated at 7,000 people aged 65+ having been diagnosed. A Dementia Needs Analysis has been carried out in 22-23 and this has identified that Buckinghamshire's low dementia diagnostic rate (56.9%, or 4,061 people diagnosed out of estimated prevalence of 7,142, as per NHS Digital report from March 2022) illustrates the underdiagnosis of people living with dementia in the area, which results in people not accessing the appropriate dementia support. 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. In Buckinghamshire, the BCF funds a Memory Support Service which as well as providing diagnosis and intervention, it seeks to raise awareness and reduce stigma relating to dementia which disproportionately impacts older people.

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts an

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions.pdf/2.3.i-unplanned-hospitalisation-for-chronic

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details. The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF P

2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Complete:
Health and Wellbeing Board:	Buckinghamshire	Yes
Completed by:	Colette Kavanagh	Yes
E-mail:	Colette.kavanagh@buckinghamshire.gov.uk	Yes
Contact number:	01296 387428	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	<Please Select>	No
If no please indicate when the HWB is expected to sign off the plan:	Thu 22/06/2023	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Angela	Macpherson	angela.macpherson@buckinghamshire.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Matthew	Tait	matthew.tait@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Philippa	Baker	philippa.baker@nhs.net	Yes
	Local Authority Chief Executive		Rachael	Shimmin	rachael.shimmin@buckinghamshire.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Craig	McArdle	craig.mcardle@buckinghamshire.gov.uk	Yes
	Better Care Fund Lead Official		Colette	Kavanagh	colette.kavanagh@buckinghamshire.gov.uk	Yes
	LA Section 151 Officer		David	Skinner	david.skinner@buckinghamshire.gov.uk	Yes
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	Buckingamshire Council- Integrated Commissioning Service Director		Tracey	Ironmonger	tracey.ironmonger@buckinghamshire.gov.uk	
	Buckinghamshire ICB- Chief Finance Officer		Kate	Holmes	kate.holmes@buckinghamshire.gov.uk	
	Buckinghamshire Council - Adults and Health Finance Director		Elspeth	O'Neil	elspeth.oneill@buckinghamshire.gov.uk	

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Buckinghamshire

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£4,065,961	£4,065,961	£4,065,961	£4,065,961	£0
Minimum NHS Contribution	£37,439,530	£39,558,608	£37,439,530	£39,558,608	£0
iBCF	£5,040,826	£5,010,826	£5,040,826	£5,010,826	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£706,716	£1,173,148	£706,716	£1,173,148	£0
ICB Discharge Funding	£2,442,000	£4,315,000	£2,442,000	£4,315,000	£0
Total	**£49,695,033**	**£54,123,543**	**£49,695,033**	**£54,123,543**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£10,646,683	£11,249,285
Planned spend	£23,561,364	£23,561,364

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£12,544,593	£13,254,617
Planned spend	£12,544,593	£13,254,617

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	120.3	98.4	112.8	104.9

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,205.1	2,159.8
	Count	2287	2240
	Population	103712	103712

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.0%	95.3%	95.7%	93.5%

Residential Admissions

2021-22 Actual	2023-24 Plan

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	523	490

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Buckinghamshire

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Historic data has been used to estimate the figures shown below. DEMAND HOSPITAL DISCHARGE - Pathw

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	Social support (including VCS) (pathway 0)	80	90	121	76	100	86	119	109	137	113	97	102
FRIMLEY HEALTH NHS FOUNDATION TRUST		40	68	49	60	80	61	66	59	47	56	54	72
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	Reablement at home (pathway 1)	27	27	29	29	32	32	36	37	40	42	43	43
FRIMLEY HEALTH NHS FOUNDATION TRUST		12	12	12	12	14	14	15	16	16	17	19	19
OTHER		5	5	5	5	8	8	9	10	10	10	10	10
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	Rehabilitation at home (pathway 1)	126	119	109	111	104	131	128	109	92	121	129	135
FRIMLEY HEALTH NHS FOUNDATION TRUST		63	59	55	56	52	66	64	55	46	61	65	68
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	Short term domiciliary care (pathway 1)	67	80	86	71	95	58	78	90	89	94	76	94
FRIMLEY HEALTH NHS FOUNDATION TRUST		25	47	43	36	46	29	29	49	48	37	39	25
OTHER		9	18	13	11	14	10	15	21	22	12	11	19
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	Reablement in a bedded setting (pathway 2)	28	32	12	21	15	6	62	60	89	56	57	71
FRIMLEY HEALTH NHS FOUNDATION TRUST		11	7	7	5	5	6	3	8	10	4	8	7
OTHER		7	4	3	2	4	1	1	0	1	1	4	3
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	86	86	87	61	61	61	47	47	48	56	56	56
FRIMLEY HEALTH NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	0	0	0
FRIMLEY HEALTH NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	33	34	28	37	29	26	29	49	35	41	27	34
Urgent Community Response	581	581	581	581	581	581	581	581	581	581	581	581
Reablement at home	25	25	28	28	36	36	40	42	44	49	51	51
Rehabilitation at home	120	120	120	120	120	120	120	120	120	120	120	120
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	126	159	171	154	198	165	204	187	203	191	173	196		100%	
Reablement at Home	Monthly capacity. Number of new clients.	60	60	60	60	60	60	60	60	60	60	60	60		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	181	171	157	160	150	189	184	157	133	175	186	195	100%		
Short term domiciliary care	Monthly capacity. Number of new clients.	220	220	220	220	220	220	220	220	220	220	220	220	100%		
Reablement in a bedded setting	Monthly capacity. Number of new clients.	28	13	14	20	20	20	36	36	36	36	36	36			100%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	11	22	22	22	22	22	38	38	38	38	38	38			100%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	7	13	14	20	20	20	20	20	20	20	20	20			100%

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	131	132	126	122	114	111	103	123	109	133	119	126		100%	
Urgent Community Response	Monthly capacity. Number of new clients.	581	581	581	581	581	581	581	581	581	581	581	581	100%		
Reablement at Home	Monthly capacity. Number of new clients.	40	40	40	40	40	40	40	60	60	60	60	60		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	100	100	100	100	100	100	100	100	100	100	100	100	100%		
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			100%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			100%
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			100%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Buckinghamshire

Local Authority Contribution Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	Complete:
Buckinghamshire	£4,065,961	£4,065,961	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£4,065,961**	**£4,065,961**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Buckinghamshire	£706,716	£1,173,148	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS Bedfordshire, Luton and Milton Keynes ICB	not applicable	not applicable	Yes
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£2,442,000	£4,315,000	
Total ICB Discharge Fund Contribution	£2,442,000	£4,315,000	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Buckinghamshire	£5,040,826	£5,010,826	Yes
Total iBCF Contribution	**£5,040,826**	**£5,010,826**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
				Yes
Total Additional Local Authority Contribution	**£0**	**£0**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Bedfordshire, Luton and Milton Keynes ICB	£450,594	£476,097
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£36,988,937	£39,082,510
Total NHS Minimum Contribution	**£37,439,530**	**£39,558,608**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding	
				Yes
Total Additional NHS Contribution	**£0**	**£0**		
Total NHS Contribution	**£37,439,530**	**£39,558,608**		

	2023-24	2024-25
Total BCF Pooled Budget	**£49,695,033**	**£54,123,543**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Buckinghamshire

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£4,065,961	£4,065,961	£0	£4,065,961	£4,065,961	£0
Minimum NHS Contribution	£37,439,530	£37,439,530	£0	£39,558,608	£39,558,608	£0
iBCF	£5,040,826	£5,040,826	£0	£5,010,826	£5,010,826	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£706,716	£706,716	£0	£1,173,148	£1,173,148	£0
ICB Discharge Funding	£2,442,000	£2,442,000		£4,315,000	£4,315,000	£0
Total	**£49,695,033**	**£49,695,033**	**£0**	**£54,123,543**	**£54,123,543**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above)

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£10,646,683	£23,561,364	£0	£11,249,285	£23,561,364	£0
Adult Social Care services spend from the minimum ICB allocations	£12,544,593	£12,544,593	£0	£13,254,617	£13,254,617	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
									Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Hospital Discharge Service	Voluntary care sector contract delivered by Age UK to support individuals to	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£279,658	£279,658	90%
2	Asisstive Technology	Provision of 'end to end' Technology Enabled Care service (including	Assistive Technologies and Equipment	Assistive technologies including telecare		7980	7980	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£875,660	£875,660	74%
3	Dementia	Memory Support Service delievered by the Alzheimer's Sociey - works	Prevention / Early Intervention	Other	Dementia support service				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£156,000	£156,000	100%
4	Integrated Carers Service	Statutory information, advice and guidance service operated by Carers Bucks.	Care Act Implementation Related Duties	Other	Carer advice and support				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£543,219	£543,219	66%
5	Falls	The falls pathway delivered by Buckinghamshire Healthcare Trust aims to	Prevention / Early Intervention	Other	Falls pathway				Social Care		LA			NHS Acute Provider	Minimum NHS Contribution	Existing	£250,000	£250,000	100%
6	BC Home Indepdence Team	Supports the delivery of reablement services - This is the Buckinghamshire Council	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)		652	652	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,118,666	£2,118,666	100%
7	Hospital Social Work Teams	Funds the ASC hopsital team staff supporting the D2A pathway seven days a week	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,342,909	£1,342,909	78%
8	Integrated Commissioning Team	Takes the functions of the disbanded quality in care team now distributed across	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£601,051	£601,051	12%
9	LA Additional Placement Pressures	To fund additional placements pressures	Home Care or Domiciliary Care	Domiciliary care packages		17093	16380	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£393,139	£393,139	1%
10	LA Additional Placement Pressures	To fund additional placements pressures	Residential Placements	Nursing home		17	16	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£970,592	£970,592	1%
11	NRS - Bucks Integrated Sensory Service	An integrated service to children young people and adults with hearing, sight or	Assistive Technologies and Equipment	Community based equipment		154	154	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,000	£52,000	23%
12	Advocacy Contract (POWHER)	Supports delivery of the Care Act requirements	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£240,000	£240,000	89%
13	DOLS (including legal costs)	Supports delivery of the Care Act requirements	Care Act Implementation Related Duties	Other	DOLS				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£686,103	£686,103	100%

14	Early Resolution and Safeguarding and Short Term	Newly restructured Adult Social Care Team incorporating safeguarding	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,768,343	£1,768,343	69%
15	Occupational Therapy Team	Buckinghamshire Council Occupational Therapy team delivering therapy within the	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,628,081	£1,628,081	100%
16	Integrated Community Services	The ICBs commission a range of integrated community services from	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£22,626,364	£22,626,364	94%
17	Annual Health Checks for people with severe	Offering annual health checks to clients diagnosd with serious mental illness in	Prevention / Early Intervention	Risk Stratification					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£96,000	£96,000	100%
18	DOLS (ICB)	Supports delivery of the Care Act requirements	Care Act Implementation Related Duties	Other	DOLS				Primary Care		NHS			NHS	Minimum NHS Contribution	Existing	£88,000	£88,000	100%
19	Immedicare (contribution)	24/7 NHS Clinical and Technical Support via video link to support care homes	Assistive Technologies and Equipment	Assistive technologies including telecare		5589	5589	Number of beneficiaries	Primary Care		NHS			Private Sector	Minimum NHS Contribution	Existing	£751,000	£751,000	98%
20	Disabled Facilities Grant	Mandatory capital grant for home adapations to support older and vulnerable people	DFG Related Schemes	Adaptations, including statutory DFG grants		221	221	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£3,895,961	£3,895,961	100%
21	Healthy Homes on Prescription	Funds essential works to address health and safety hazards in homes, to enable	DFG Related Schemes	Discretionary use of DFG		15	15	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£170,000	£170,000	100%
22	Brokerage support in hospitals	Supporting self funders being discharged from hospital with sourcing long term care	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	iBCF	Existing	£83,000	£83,000	43%
23	Residential Placements	Additional capacity to support ASC pressures	Residential Placements	Care home		7	7	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£336,589	£336,589	0%
24	Home or domiciliary care and live in care	Additional capacity to support ASC pressures	Home Care or Domiciliary Care	Domiciliary care packages		6581	6581	Hours of care	Social Care		LA			Local Authority	iBCF	Existing	£1,251,730	£1,251,730	5%
25	Direct Payments	Supports person-centred delivery of care through direct payments to service	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	iBCF	Existing	£768,870	£768,870	3%
26	Respite	Short breaks to support people with disabilities and their families and carers	Carers Services	Respite services		160	160	Beneficiaries	Social Care		LA			Local Authority	iBCF	Existing	£659,464	£659,464	23%
27	Admission Avoidance Beds	Spot purchased care home beds for social care admission avoidance	Bed based intermediate Care Services (Reablement,	Other		120	120	Number of Placements	Social Care		LA			Local Authority	iBCF	Existing	£650,000	£650,000	100%
28	Nursing Placements	Additional capacity to support ASC pressures	Residential Placements	Nursing home		16	15	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£932,796	£932,796	2%
29	Supported Living	Additonal capacity to support ASC pressures	Residential Placements	Supported housing		5	5	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£328,377	£328,377	1%
30	Care Home Discharge Hub Intermediate Care Beds	Intermediate bedded care to support timely dsicharge from hospital	Bed based intermediate Care Services (Reablement, rehabilitation, wider	Bed-based intermediate care with reablement (to support discharge)		131	0	Number of Placements	Social Care		LA			Local Authority	Local Authority Discharge Funding	New	£706,716	£0	42%
31	Hospital Discharge Social Workers	Hospital Discharge social workers	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	New	£420,000	£0	50%
32	Health and Care Integration Programme	Hopsital Discharge Schemes	High Impact Change Model for Managing Transfer of Care	Other	Integrated models of provision				Acute		NHS			NHS	Minimum NHS Contribution	New	£1,333,573	£0	50%
33	Additional contribution to home from	Additional conribution to home from hospital service	Community Based Schemes	Other	Home from hospital				Social Care		LA			Local Authority	iBCF	New	£30,000	£0	10%
34	Wider integration projects	Wider integration projects	High Impact Change Model for Managing Transfer of Care	Other	Integrated models of provision				Social Care		LA			Local Authority	Local Authority Discharge	New	£0	£1,173,148	100%
35	Wider integration projects	Wider integration projects	High Impact Change Model for Managing Transfer of Care	Other	Integrated models of provision				Social Care		LA			Local Authority	Minimum NHS Contribution	New	£0	£1,349,196	100%
36	Wider integration projects	Wider integration projects	High Impact Change Model for Managing Transfer of Care	Other	Integrated models of provision				Acute		NHS			NHS	Minimum NHS Contribution	New	£0	£2,742,627	100%
37	Care Home Discharge Hub Intermediate Care	Intermediate bedded care to support timely dsicharge from hospital	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		151	268	Number of Placements	Acute		NHS			NHS	ICB Discharge Funding	New	£984,350	£1,739,340	58%
38	Home First Therapists	Workfoce to support with intermediate home based care to support timely	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Acute		NHS			NHS	ICB Discharge Funding	New	£934,987	£1,652,117	58%

39	Home first home care	Intermediate home care to support timely dsicharge from hospital	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		22724	40154	Hours of care	Acute		NHS			NHS	ICB Discharge Funding	New	£522,663	£923,543	58%
40	Integrated Commissioning	Workfoce to support with intermediate home based care to support timely	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	New	£108,000	£0	50%
41	Bed based intermediate care services	A programme dedicated to improving the experience of people using health and care services in	Bed based intermediate Care Services (Reablement, rehabilitation, wider	Bed-based intermediate care with reablement (to support discharge)		21	0	Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	New	£111,172	£0	7%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.

11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Buckinghamshire

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	122.7	100.3	115.1	107.0	The actual ISR rate of 436.4 per 100k has been set as the target for 2023-24. Which is an increase of 2% of the 2022-23 target. As Q1 23/24 data is not yet available to compare to previous years, 2% improvement has been chosen as a realistic and stretching target. This is also a lower than our average performance since 2019-20- which is 438.1	Plan for reducing rates for this metric and how schemes and enabling activity for Health and Social Care Integration are expected to impact: Schemes (BCF and non-BCF funded) which impact on this metric include: •Adult Community Healthcare Teams (ACHT) – funded through the BCF as part of the BHT Integrated Community Services	Yes
	Number of Admissions	758	620	711	-			
	Population	555,257	555,257	555,257	555,257			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	120.3	98.4	112.8	104.9			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,195.8	2,205.1	2,159.8	As with other metrics, falls data has fluctuated in recent years. •Data projections for 22/23 show a reduction in emergency hospital admissions due to falls in people aged over 65. •We have set a target to reduce this by a further 2% in 23/24. •As per the guidance, the indicator values	Plan for reducing rates for this metric – •The BCF is used to fund the Buckinghamshire Falls prevention service, which aims to prevent repeat falls through education and therapy input, enabling people to remain independent and living in the community for longer. It also supports preventable hospital admissions, by providing advice via	Yes
	Count	2,425	2287	2240			Yes
	Population	104,469	103712	103712			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
	Quarter (%)	93.1%	94.4%	94.7%	92.6%	1% improvement on 22/23 performance. In 22-23 the overall figure was 93.7%	The transfer of Care Hub - will co-ordinate the patient's journey through the system	Yes
	Numerator	8,879	7,142	7,120	8,570			

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Denominator	9,541	7,568	7,517	9,253	therefore an increase of 1% has been set for 23-24 to 94.6%. Data from the BCF pack and the CSU, has been utilised to set and agree trajectories: •Average performance since Q1 2019-20 to Q3 2022-23 is 93.6% •Average performance in 2019-20 was 94%	with hospital, social work, therapy and commissioning staff working co-located and working together in an integrated team to achieve this. Continutation of the successful Home First model. •A 22 bedded intermediate care hub within Buckinghamshire Community Hospitals. This will support Buckinghamshire residents get home as	Yes
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	94.0%	95.3%	95.7%	93.5%			
	Numerator	8,968	7,213	7,192	8,656			Yes
	Denominator	9,541	7,568	7,517	9,253			

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	522.5	489.0	500.2	489.5	The target for 2023-24 is 489. The reasonings for this being: •Our corporate target for 22-23 is 524 per 100,000 •The target is below the 524.3 average across South East region for 2022-21	The number of people entering long term care in residential and nursing homes has increased and exceeded our estimate for 2022-23. Although the data does not explain why, we know that approximately two thirds of the new admissions came	Yes
	Numerator	544	525	537	534			Yes
	Denominator	104,114	107,356	107,356	109,081			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.1%	86.4%	86.4%	87.0%	22/23 measure is unavailable at present as it measures 91 days after the final discharge, therefore to consider those discharged at the end of March this report needs to be run at the end of June with the figure being avaialble in early July	Buckinghamshire Council's Home Independence Team (HIT) and the NHS Rapid Response and Intermediate Care (RRIC) service provide reablement and rehabilitation services.	Yes
	Numerator	180	216	216	214			Yes
	Denominator	209	250	250	246			Yes

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Buckinghamshire

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes	Please refer to the detail within the attached narrative			Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes	Please refer to the detail within the attached narrative			Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes	Please refer to the detail within the attached narrative			Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	Please refer to the detail within the attached narrative			Yes
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes	Please refer to the detail within the attached narrative			Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes	Please see the detail on the expenditure tab			Yes
Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	Please see the detail on the expenditure tab			Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes	Please refer to the detail within the attached narrative			Yes

Health & Wellbeing Board Buckinghamshire

Buckinghamshire, Oxfordshire and Berkshire West Joint Forward Plan

Date: 22 June 2023

Author/Lead Contacts: Robert Bowen, Acting Director Strategy and Partnerships Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB)

Report Sponsor: Robert Bowen

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

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

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

None of the above? Please clarify below:

Not Applicable.

1. Purpose of report

1.1. To describe the process for finalising the Joint Forward Plan and providing links to the plan documents to enable the Health and Wellbeing Board to provide a formal opinion on whether the Joint Forward Plan takes 'proper account of the joint local health and wellbeing strategy'.

2. Recommendations to the Health and Wellbeing Board

2.1. Review the BOB joint forward plan documentation and consider its alignment to the priorities of the Buckinghamshire Health and Wellbeing Strategy

2.2. Provide a formal opinion on whether the Joint Forward Plan takes 'proper account of the joint local health and wellbeing strategy' as per the national guidance.

3. Executive summary

3.1. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Joint Forward Plan (JFP) describes how the Integrated Care Board (ICB) and partner NHS trusts are required to develop an annual, five year Joint forward Plan. This plan intends to balance delivery of the BOB Integrated Care Strategy ambitions with delivery of the other NHS commitments.

3.2. The plans have been developed jointly with BOB Integrated Care System (ICS) partners with input and feedback from wider system and public engagement, including input from local authority partners.

3.3. All the BOB Health and Wellbeing Boards are asked to provide comment on the JFP's alignment to current health and wellbeing strategies through June 2023 – specifically whether the draft Joint Forward Plan takes proper account of each joint health and wellbeing strategy.

3.4. The JFP will be formally published by the end of June 2023.

4. Introducing the Joint Forward Plan

4.1. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB) and its partner trusts are required to publish the first Joint Forward Plan (JFP) by 30 June 2023.

4.2. National Guidance sets out that at a minimum the JFP needs to describe how the ICB and partner NHS trusts "*intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments*". Additionally, systems are encouraged to use the JFP to develop a shared delivery plan for the Integrated Care Strategy and the Joint Local Health and Wellbeing Strategies (JLHWS).

4.3. The Buckinghamshire, Oxfordshire and Berkshire West JFP addresses these ambitions across our organisations and also recognises the value and importance of our partnerships with local authorities in the ongoing development and delivery of services for the benefit of the people and communities who live and work in our areas.

4.4. The JFP sets a rolling five-year ambition and will be updated annually before the beginning of each subsequent financial year.

4.5. There are two supporting documents with this paper:

- Appendix A: Joint Forward Plan Summary
- Joint Forward Plan – All documents and appendices

5. Aligning to joint health and wellbeing strategies

5.1. As described in previous meetings with the Health and Wellbeing Board, the Joint Forward Plan has been developed specifically in response to the ambitions of the Integrated Care Strategy, signed off by the ICP in March 2023. The strategy was developed jointly by system partners, including local authority representatives, to reflect the needs of local populations as described in the local health and wellbeing strategies.

5.2. The Joint Forward Plan has subsequently been developed with further input from system partners to ensure these ambitions are reflected and local needs are taken into account.

5.3. The ICB and partner NHS trusts are asked to consult with Health and Wellbeing Boards on "*whether the draft takes proper account of each JLHWS [Joint health and wellbeing strategy] published by the health and wellbeing board that relates to any part of the period to which the JFP relates*". The Health and Wellbeing Board must respond with its opinion and may also send that opinion to NHS England, telling the ICB and its partner trusts it has done so - see page 7 of national guidance (paragraph 4.2) on developing the Joint Forward Plan.

5.4. Our JFP, guided by the ambition set out in the Integrated Care Strategy, aligns with and builds on the local strategies, approaches and targets set out by our three local health and wellbeing strategies developed by the five Health and Wellbeing Boards across BOB.

We recognise that Buckinghamshire have set out key priorities in the joint local health and wellbeing strategy:

Start well

1. Improving outcomes during maternity and early years
2. Improving mental health support for children and young people
3. Reducing the prevalence of obesity in children and young people

Live well

1. Reducing the rates of cardiovascular disease
2. Improving mental health support for adults, particularly for those at greater risk of poor mental health
3. Reducing the prevalence of obesity in adults

Age well

1. Improving places and helping communities to support healthy ageing
2. Improving mental health support for older people and reducing feelings of social isolation
3. Increasing the physical activity of older people

5.5. We are confident that the BOB Joint Forward Plan takes into account these strategic priorities and are picked up in the service delivery plans aligned to the five themes of the Integrated Care Strategy – Promoting and Protecting Health, Start Well, Live Well, Age Well and Improving Quality and Access to services.

5.6. The table below sets out the alignment.

Buckinghamshire Health and Wellbeing Priorities	Mapping to the BOB Joint Forward Plan
Start Well: 1. Reduce the differences in health between Improving outcomes during maternity and early years 2. Improving mental health support for children and young people 3. Reducing the prevalence of obesity in children and young people	Priorities 1 and 2 are addressed in the 'Start Well' strategic theme. This theme describes plans to deliver easily accessible services that support healthy children and families across diverse communities. The service delivery plans in the Joint Forward Plan have extensive detail regarding our ambition to continuously improve our maternity and neonatal services and outcomes and to improve children and young people's mental health. Additionally, the JFP describes our ambition to work collaboratively to support children reach their early development milestones and to implement to recommendations of the 'The Best Start for Life – a vision for the 1001 critical days' report – particularly for those families living in the most deprived areas in each place. The Start Well theme also addresses our ambition to support and promote good mental health and wellbeing for children and young people across the BOB population. This includes plans to develop a population health approach to identify and support children and young

Buckinghamshire Health and Wellbeing Priorities	Mapping to the BOB Joint Forward Plan
	people most at risk of mental ill health focusing on early intervention, early support and prevention. Reducing levels of obesity is addressed in our first strategic theme 'Protecting and Promoting Health' specifically in the prevention service delivery plan there are targeted actions and ambition for supporting people reduce excess weight. We plan to work with partners to achieve a reduction in the proportion of people who are overweight or obese including children and young People'.
<u>Live well</u> 1. Reducing the rates of cardiovascular disease 2. Improving mental health support for adults, particularly for those at greater risk of poor mental health 3. Reducing the prevalence of obesity in adults	Reducing the rates of cardiovascular disease is addressed in our strategic theme 'Live Well', notably in the Integrated Cardiac Delivery Network plan. Actions described in the Promote and Protect health theme will also have a material impact on CVD. Through the development of the JFP, we recognise the fundamental change in focus required, from a system based on treating illness to one that prioritises prevention and keeping people healthy in their communities. This includes plans for a strong focus on CVD prevention and early detection. Building on the priority described in the Start Well section, the JFP includes details on our collective ambition to support and promote good mental health and wellbeing across our populations. This is also addressed in the Live Well theme and specific service delivery plans. These plans aim to identify and support those at greatest risk of poor mental health, providing timely support for people in times of mental health crisis, building more resilient communities, and promoting more join up across the different support opportunities available. To reduce the prevalence of obesity in adults the service delivery plan focussed on prevention outlines specific actions and ambitions aimed at supporting healthy weight management, reducing excess weight and increasing physical activity rates. The JFP describe a commitment to working collaboratively with partners, particularly at Place level to support people and communities where obesity prevalence is high.

Buckinghamshire Health and Wellbeing Priorities	Mapping to the BOB Joint Forward Plan
Age well 1. Improving places and helping communities to support healthy ageing 2. Improving mental health support for older people and reducing feelings of social isolation 3. Increasing the physical activity of older people	These priorities will be address in our 'Age Well' strategic theme. The JFP includes detail on our collective ambition to support more people to remain healthy, independent, and connected in their communities with a particular focus on identifying and supporting people who feel lonely or isolated and also helping people remain physically active for as long as possible – recognising the value this has on people's physical and mental health and wellbeing. The JFP also commits to providing proactive and targeted support to those whose health, care and support needs are becoming more complex, and requiring more intensive support. The plans recognise the importance of working across the ICS partnerships to provide this support, particularly linking with local authorities and providers from the voluntary, community and social enterprise sectors.

5.7. Additional information on how the Joint Forward Plan aligns to the ambition of the Integrated Care Strategy can be found in the JFP supporting documents. These provide details of how the service delivery plans correspond to the ambitions of the Strategy.

6. Recommendation:

The Health and Wellbeing Board is asked to:

6.1. Review the BOB Joint Forward Plan documentation and consider its alignment to the priorities of the Buckinghamshire Health and Wellbeing Strategy

6.2. Provide a formal opinion on whether the Joint Forward Plan takes 'proper account of the joint local health and wellbeing strategy' as per the national guidance.

7. Next steps and review

7.1. The Joint Forward Plan will be finalised for publication by 30th June 2023.

8. Background papers

8.1. There are two supporting documents with this paper:

- Appendix A: Joint Forward Plan Summary
- Joint Forward Plan – All documents and appendices

AppendixA

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Joint Forward Plan Summary

May 2023

DRAFT – WORK IN PROGRESS

Welcome and Foreword

We are delighted to introduce our first five-year Joint Forward Plan which details how the NHS collaboratively aims to deliver and improve our services to meet the health and wellbeing needs of people in our area.

Together, our organisations exist to improve the health and wellbeing of the people they serve. We fund, plan and deliver NHS services for the people of BOB. We want everyone who lives in our area to have the best possible start in life, live happier, healthier lives for longer, and to be able to access the right support when it is needed

Our ambition and hopes for Buckinghamshire, Oxfordshire and Berkshire West (BOB) communities were first set out in our Integrated Care Strategy, published in March 2023, based on what local organisations and communities told us was important to them.

In this Joint Forward Plan we set out our aim to further develop and improve our services to better meet the needs of our people and communities. We know that we can only do this successfully by working together, listening to our people and communities, to deliver change. However, this is not a plan just about the NHS, it is about how the NHS working with councils, charities, education, science and the voluntary sectors will combine the skills and resources to jointly improve the lives and communities of the people we serve.

This integrated approach is about recognising that all our organisations deploy different skills, expertise and resources which if used collaboratively, in a jointly planned and delivered way, will have a much greater impact on improving people's lives and community wellbeing.

In developing our Joint Forward Plan we have identified a small number of key challenges that, if addressed, we believe will have the greatest impact on ensuring our services more effectively meet the needs of people in BOB. Meeting these challenges will require long term change, working in new ways – with greater collaboration across system partners and with our communities - and will require a fundamental change in focus, from a system based on treating illness to one that prioritises prevention and keeping people healthy in their communities.

Alongside our focus on key challenge areas, we have also developed detailed service plans, setting out our ambition and plans for how we intend to develop and deliver our NHS services in BOB over the next five years, in line with our Integrated Care Strategy.

As a collective of NHS providers in BOB we will work in together and in partnership with other organisations to listen and respond to our communities. We want to know what people think of the services they experience, what their ambitions and hopes are and how we can support them. We want to understand and reflect the diversity of our populations and ensure our services are responsive to changing lifestyles and different communities' needs.

We will update our Joint Forward Plan on an annual basis, continuously reflecting on feedback from our partners and communities and developing our plans in line with the resources available to us, as we make progress in improving our services and delivering in a sustainable way for the population we serve.

DRAFT

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Joint Forward Plan on a Page

Our System Vision and Partnerships 01

Everyone who lives in our area has the best possible start in life, lives happier, healthier lives for longer, and can access the right support when it is needed

Place based partnerships, Provider Collaboratives, Clinical Networks, VCSE, Communities

Addressing Our Biggest System Challenges 02

1. An **inequalities** challenge
2. A **model of care** challenge
3. An **experience** challenge
4. A **sustainability** challenge

A reduction in inequalities in outcomes and experience
People are better supported in their communities to live healthier lives
Improved accessibility of our services and elimination of long waits
A sustainable model of delivery across the BOB system

Delivering Our Strategy – Our Service Delivery Plans 03

Promote and protect health: Keeping people healthy and well	**Start Well:** Help all children achieve the best start in life	**Live Well:** Support people and communities live healthy and happier lives	**Age Well**: Stay healthy, independent lives for longer	**Quality and access:** Accessing the right care in the best place
1. Inequalities 2. Prevention 3. Vaccination and Immunisations	1. Women's, maternity and neonatal services 2. Children and Adolescent Mental Health Services 3. Learning Disabilities 4. Children's Neurodiversity	1. Long Term Conditions (stroke, cardiovascular disease, diabetes, respiratory) 2. Adult Mental Health 3. Adult Neurodiversity 4. Cancer	1. Ageing well services (e.g., frailty – community multidisciplinary teams)	1. Primary care 2. Urgent and Emergency Care 3. Planned care 4. Palliative and End of Life Care

Supporting and Enabling Delivery 04

Workforce, Finance, Digital, Estates, Research & Innovation, Net Zero, Quality, Safeguarding, Infection Prevention and Control, Personalised Care, Continuing Healthcare, Delegated Commissioning

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Purpose of the Joint Forward Plan

What is our Joint Forward Plan and what is it for?

The **Buckinghamshire, Oxfordshire and Berkshire West (BOB)** Joint Forward Plan (JFP) describes how we intend to balance delivery of the BOB Integrated Care Strategy ambition with the national NHS commitments and recommendations, including the requirements of the 2023/24 operational plans.

This is our first JFP since the BOB Integrated Care Board (ICB) was formally established on 1 July 2022. It is an opportunity for the ICB and its partner trusts to set out how we will arrange and/or provide NHS services to meet our population's physical and mental health needs. This JFP therefore sets out our five-year comprehensive plan to improve and transform our services, whilst also recognising our most immediate priorities for the year ahead.

This plan will be updated annually before the start of each financial year. Assuring delivery of the Joint forward plan will be picked up formally through the ICB Board and relevant Board assurance committees.

This plan focuses on actions that will be delivered by the NHS in BOB (ICB, NHS Trusts, primary care, etc). As we develop as a system it is expected that future joint forward plans may reflect more fully our wider partnership activities including the role of social care, public health, voluntary and community groups.

We have worked with our partners to develop this plan, including a consultation with our five Health and Wellbeing Boards, whose opinion can be found in Appendix C.

Delivering our Integrated Care Strategy

Our vision is that ***everyone who lives in our area has the best possible start in life, lives happier, healthier lives for longer, and can access the right support when it is needed***. We are focusing on five Strategic Themes to help us achieve that vision.

In the JFP, we have considered how our services align to these themes and developed detailed plans for how we should jointly improve and transform these services over the next five years in order to deliver on our strategy.

2023/24 Operational Planning Requirements

In common with health and care services across the country, our system continues to experience a period of sustained pressure. In line with the priorities and requirements of the Operational Planning Guidance issued by NHS England, a detailed operational and financial plan has been submitted for BOB that demonstrates how we will deliver on specific priorities. It also indicates the financial pressure we continue to operate within.

Our plans for the first year of our JFP are aligned to our 23/24 Operational Plan, whilst also identifying our longer term transformation ambitions.

Delivering the JFP within our 2023/24 financial allocation

Our JFP sets a five year ambition across multiple service areas Although our annual financial envelope across this period will be significant, we do not have clarity on our financial allocations beyond 2023/24.

The commitments included in this plan for 2023/24 are to be delivered within the constraints of the 2023/24 financial envelope. The 2023/24 JFP delivery plans and BOB operational plan ambitions have been developed together to maximise alignment.

The JFP commitments for subsequent years remain subject to our allocation being confirmed. It is recognised that these ambitions will need to be balanced with operational planning requirements yet to be specified. However, this plan is clear on the ambition to move towards a model more focused on prevention and keeping people well in their communities. We anticipate our long term financial planning to support this shift.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Biggest System Challenges

As a system, we have a comprehensive understanding of:

- Our population demographics
- Our population health trends
- People's experience of our services, and
- How our services are currently performing

Through analysis of these areas, it is clear we have a number of key challenges that have a significant impact on people in BOB's access, experience and outcomes. In particular, we have identified

1. An **inequalities** challenge
2. A **model of care** challenge
3. An **experience** challenge
4. A **sustainability** challenge

These challenges will require us to work in new and different ways to address them effectively. They will require greater collaboration across the system, we can harness the knowledge and expertise of all our system partners and the academic research conducted in each partner organisation. The challenges will require a long-term focus and will need us to be innovative and ambitious in how we respond.

	Our Biggest System Challenges	The Outcomes We Want To Achieve	Aligning to the BOB Integrated Care Strategy
An inequalities challenge	1. People in certain communities and demographic groups in BOB have **much worse health outcomes and experience**	**Reduction in inequality of access, experience and outcomes** across our population and communities	**Promote and Protect health**
A **model of care** challenge	2. We have an **ageing population in BOB and more people living with long term conditions**, who will be increasingly poorly served by an acute-focused model of care	People are supported to **live healthier lives for longer in their communities**	**Start, Live and Age well**
An **experience** challenge	3. People in BOB tell us their **experience of using our services has deteriorated** – driven primarily by long waits and difficulty accessing services	**Improve accessibility of our services and eliminate long waits** to improve citizen experience.	**Improving quality and access to services**
A **sustainability** challenge	4. We have **a large forecast financial deficit** across our system with **significant workforce gaps**, which is likely to get worse without change	A sustainable model of care in BOB – achieving **financial balance** with a **stable, resilient workforce**	

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Addressing our Inequalities Challenge

Outcome goal: Reduction in inequality of access, experience and outcomes across our population and communities

Where are we now and what action are we already taking?

Across our BOB partnerships, there are already numerous examples of collaborations focussed on reducing inequalities in access, experience and outcomes. Reducing these inequalities is a central ambition of our partnership as set out in the BOB Integrated Care Strategy. In 2023/24 we have activity planned that will accelerate and grow our support to people and communities with greatest needs. These activities include:

- ***Increased investment for place based initiatives*** – A £4 million new annual investment for 23/24 & 24/25 will be directed towards populations who face the largest health inequalities in access, experience, and outcomes. The funding, devolved to Place, will focus on key ill health prevention reflecting local needs and includes:
  - ✓ Reducing premature mortality though **community outreach programmes** in Berkshire West with local, targeted actions including increasing health checks, BP monitoring and promoting 'active medicine'
  - ✓ Supporting Buckinghamshire's **Opportunity Bucks** programme targeting the 10 most deprived areas in Bucks – actions including health checks for people with severe mental illness, preconception and maternity support for highest risk ethnic communities,
  - ✓ In Oxfordshire supporting specific communities including people who are **homeless**, building partnerships and **increasing community capacity** with VCSE and local partners to deliver local core20plus5 initiatives.
- ***Core20Plus5*** – an ongoing focus on the priorities identified through our core20plus5 analysis. For example: smoking cessation – Further investment of £835,000 in Tobacco Advisory Services in acute in-patient, maternity and mental health inpatient

We have places where Population Health Management is working successfully already on a small scale (for example, in the Reading West PCN and Banbury Cross Health Centre). We are improving our understanding and outcomes in relation to people with diabetes in our Nepalese community and our most deprived housebound patients. Further detail on these plans are available in the relevant service delivery plans.

Service Plans Reference:

Tackling inequalities is a theme running through all delivery plans. Most actions included in:

- Inequalities & Prevention
- CYP and Adult Mental Health
- Maternity and Neonatal
- Long Term Conditions
- Personalised care

Our longer term transformation approach – Unlocking population health management

We recognise that a more consistent approach to identifying and addressing inequality challenges will be significantly strengthened through the development of a robust approach to **population health management**. Although we have examples across BOB where PHM is used to make decisions, this could be strengthened and spread across the system. We commit to progressing this in 23/24 through the following actions: :

- Create an **integrated data set** across our providers, with data available for analysis to identify opportunities for targeting support to communities and people in BOB
- Establish the right **analytical capability and decision making infrastructure** to clearly understand where the areas of greatest inequalities exist and analyse the causes
- Utilise the Population Health data and analysis to **target activity** in the areas which have the greatest need and where the most impact will be made, with initial rollout in targeted clinical areas.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Form an ICS Data Leadership and Governance Group with clinician and patient input. • Completed stock-take of data sets, collection and reporting	• Define and establish Centre of Excellence for Data including learning and community of practise. • ICS Data Charter established.	• Build a team that can work with local teams and produce proof of value analysis. • Agree shared responsibility between ICS and local system functions	• Finalise development of a common ICS data architecture. • Embed culture of data driven transformation is embedded as part of PHM approach.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Addressing our Model of Care Challenge

Outcome goal: People are supported to live healthier lives for longer in their communities

Where are we now and what action are we already taking?

As a system, we recognise that we need to shift to a more preventative and community-based approach for health and care services, that better meets the needs of the different populations we serve. We have a range of initiatives already in place to change the way we deliver our care and services in BOB. In 2023/24 we will build on these programmes, setting the foundation for longer term transition. Our activity includes:

- ***Earlier identification for those with Long Term Conditions*** – we will empower individuals to manage their own health and wellbeing, in particular where they have Long Term Conditions (LTCs). For example – cardiovascular disease is one of the most common causes of deaths in BOB and a major contributor to the gap in life expectancy between people living in our most and least deprived areas. Our plans include some important actions for 2023/24, including:
  - ✓ Better identification and control of Blood Pressure and Cholesterol in primary care
  - ✓ CVD Champions in Primary Care Networks to help deliver CVD prevention and improve community links
  - ✓ Extend delivery of NHS health checks in settings outside of primary care such as places of work and non-health care settings
  - ✓ Deliver consistent messaging around lifestyle changes by increasing the number of staff confidently utilising "Making Every Contact Count
- ***Increase the ARRS roles*** across the whole of the BOB system – promoting multi-professional partnership working to support our people in our communities, building resilience to pressures and helping people navigate to the right care in the best place (incl. pharmacy, social prescribing, etc.)

People who live in BOB are critical partners in shaping the model of care that we need as a system and we will involve our communities in co-designing our strategies and services, ensuring no individual or group is left out.

Service Plans Reference:

- Live Well and Age Well Service Plans
- Inequalities & Prevention
- Primary Care
- Planned Care
- Urgent and Emergency Care

Our longer term transformation approach – An integrated approach to primary care

To support people better in their communities we need to materially change the way our primary and community care services operate across the system. In 2023/24 we are therefore committed to developing a Primary Care Strategy to confirm how we can develop our primary care services in particular to support a more community-focussed model of care that better meets the needs of our population, balancing continuity of care with same day access where needed. Through the Primary Care Strategy, and in response to the Fuller review, we anticipate the focus of our delivery in 2023/24 to be:

- **Prevention** – in target areas identified through PHM approach (based on Core20PLUS5), focus on growing and fully utilising new roles like social prescribing link workers
- **Access** – begin to implement a new approach to delivering same-day primary care appointments, both virtual and face to face
- **Continuity –** pilot integrated neighbourhood teams, with a first priority focus on target areas identified through Core20PLUS5 PHM approach.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Current state analysis, highlighting underlying gaps in data, technology and service provision for Primary Care. • Identify & accelerate opportunities for integrated neighbourhood team rollout (incl. piloting models for different communities)	• Stakeholder engagement to agree Primary Care vision • Co-design ways of working for Primary Care in BOB – looking at challenges of workforce, digital, and opportunities for strengthening partnerships.	• Commence detailed planning and implementation of new ways of working – focusing on the core areas of focus from the Fuller Stocktake – Access, Continuity and Prevention.	• Publish a Primary Care Strategy with a 5-year roadmap, incl costs and implementation plan • Confirm timetable for change and start to implement the action plan

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Addressing our Experience Challenge

Outcome goal: Ensuring people can access high quality care and support at the right time and in a place they can get to

Where are we now and what action are we already taking?

As a system we continue to experience significant issues with long waits and accessibility of services that negatively impacts the experience of people and communities in BOB. This is the case across many of our services including elective care, primary care and mental health. We do, however, already have a range of key initiatives in place aimed at delivering material improvements for the population we serve, and indeed in several areas have already started to see significant progress. Key interventions that will further develop over 2023/24, that are built into our service plans, include:

- **Achieving a maximum 65 week waits** – Although a very long wait this evidences an ongoing improvement in the BOB position. The system wide Elective Care Board will oversee the delivery of collaborative system working to improve patient experience, reduce waits and to deliver more sustainable for those specialties with the longest waits and highest volumes
- **Increase diagnostic capacity –** Further capacity will be developed in our **Community Diagnostics Centres**. In line with national guidance, we will increase activity levels by a minimum of 120% of pre-pandemic levels across 2023/24 and 2024/25 to support the recovery of performance to 95% of patients being treated within 6 weeks by March 2025
- Within Primary Care, we will introduce a new **demand and capacity tool in every practice** helping to understand appointment capacity and flexibility across the region and for each practice to make decision about required capacity.

Service Plans Reference:

- Urgent and Emergency Care
- Planned Care
- Primary Care
- CYP Mental Health
- Adult Mental Health
- Cancer
- Prevention and Inequalities

Our longer term transformation approach

Whilst we are already making some progress in improving the experience of people in BOB – for example by reducing the size of our waiting lists and eliminating some of our very long waits – we know we need a more transformational approach in the longer term to improve how people experience our services in BOB. To achieve our longer term ambitions, in 2023/24 we will focus on:

- Developing a better and more complete **understanding of demand and capacity** across the system – facilitated through development of the right tools and data
- Using this understanding to make targeted **pathway-specific improvements through the Elective Care Board and Acute Provider Collaborative**, where we know they will have the greatest impact on improving waiting times and accessibility (e.g. ENT, Urology, Outpatients, Theatres), to improve patient experience and outcomes, requiring collaborative work between providers.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Define demand and capacity problem statement • Agree with clinical and pathway leads priority areas for analysis and focus • Understand existing data landscape across system partners	• Baselining current capacity levels across BOB • Assessment of available resources and how to deploy • Evaluation and decision on tools, methodology.	• Refinement of model to ensure comprehensive capture of system level capacity	• Analysis of system interventions to determine likely impact • Utilisation of strategic planning tool to inform flexible use of system capacity, plan development and prioritisation

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Addressing our Sustainability Challenge – Workforce

Outcome goal: A sustainable model of delivery in BOB – achieving financial balance with a stable and resilient workforce

Where are we now and what action are we already taking?

In response to the workforce challenges we face in BOB, we have a number of key activities already underway that will continue over 2023/24, including:

- Scoping of the potential benefits that may be delivered through a system-wide **recruitment and retention hub**
- Commissioning research on the **cost-of-living crisis**, how this is impacting our workforce, and the effect on recruitment and retention of our staff to confirm most effective support interventions for our staff
- Rollout of **Kindness, Civility and Respect** training for all staff across NHS partners to improve staff experience and wellbeing
- Established a **Temporary Staffing Programme Board** responsible for overseeing use of agency and bank staff and optimise use of temporary staffing across system partners
- **System Inclusion Group** set up to identify and share best practice and support across system partners on Equality, Diversity and Inclusion.

Service Plans Reference:

- Workforce

Our longer term transformation approach – Co-creating a BOB 5-year People Plan

We will develop a five-year People Plan for the Integrated Care System setting out our ambitions for our 'one workforce' which includes those working health, social care, the voluntary, community and social enterprise (VCSE) sector, and unpaid carers.

The plan development will be overseen by BOB ICB's People Committee.

The People Plan will define our system's transformational approach to addressing our workforce challenges – including key areas such as staff experience and wellbeing, use of voluntary and community workers, sharing best practice, career pathways, role design, and staff retention.

As part of our People Plan, in 2023/24 we anticipate the focus of delivery to be:

- Targeted work on the **cost-of-living crisis** – influenced by the research currently underway- and what we can do differently to attract, support and retain our workforce despite these challenges.
- Working with system partners to agree way forward on building workforce stability and mobility across the system through collaborative models of resourcing including establishing a **system-wide recruitment & retention hub**
- Strengthening **staff engagement, experience and wellbeing** (e.g. through flexible working project task and finish group, strengthening of staff networks) to build workforce resilience across the system and optimise collaborative delivery arrangements of occupational health and psychological support services between providers in the ICS.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Build comprehensive understanding across system partners to understand key workforce issues- e.g. through hosting a Q1 Education Summit • Develop comprehensive workforce intelligence to support appropriate targeting of interventions.	• Undertake a deep dive into the barriers for successful recruitment campaigns • Build volunteer and reserve capacity. • Develop and expand apprenticeships. • Focus on our flexible working offer with the aim of increasing availability	• Develop our full People Plan collaboratively with leaders and people across BOB's health and care system. • Deep dive into the differences of terms and conditions across the BOB health and care sector, developing alignment proposals	• Finalise our People Plan for publication on 1st April 2024. • Undertake a full review of all recruitment and retention programmes, developing targeted action plans.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Addressing our Sustainability Challenge – Financial

Outcome goal: A sustainable model of delivery in BOB – achieving financial balance with a stable and resilient workforce

Where are we now and what action are we already taking?

Over the five-year period of this plan, the BOB system will spend approximately £15bn on the provision of NHS care and services. How this money is spent will be critical to the delivery of our ambitions for change across the system. We will need to make bold choices about how money can be used to support and facilitate the changes required. Our long-term financial planning must encourage the shift to a more preventive model that supports people to be healthy for as long as possible in the community.

However, as a NHS system at the end of the 2022/23 financial year we had an out turn deficit of £30.6m (subject to audit) and through our operational and financial planning for the 2023/24 year, we continue to forecast significant financial pressure across our system. Our ambition is to achieve financial balance in 2024/25.

In 2023/24 the ***ICS Efficiency Collaboration Group (IECG),*** established to bring together collective opportunities for change and transformation, will contribute to this goal as it seeks to develop a medium to longer term delivery programme improving patient services whilst generating financial savings. To this end the IECG is focussed on productivity gains, underpinned by improvements in areas such as theatre utilisation, reduced follow-ups, delayed transfers of care and length of stay and continued medicines optimisation. This will be supported by robust and efficient support functions which continue to evolve as the ICS develops, within which efficiency initiatives are also being developed to maximise the value for money delivered by those services.

Service Plans Reference:

- Finance

Our longer term transformation approach – Co-developing a 5 Year Finance Strategy

We will develop a five-year Finance Strategy for the Integrated Care System setting out our ambitions for a sustainable future across the ICS. The plan development will be overseen by BOB ICS's Chief Finance Officers through the Senior Finance Group.

The Finance Strategy will define our system's financial approach to supporting changes that address our sustainability challenges – including in key areas such as optimisation of estates, effective use of workforce, sharing best practice, maximising productivity.

As part of our Finance Strategy, in 2023/24 we anticipate the focus of delivery to be:

- Targeted work on ensuring a **comprehensive understanding of the core cost base and drivers of deficit** position
- Working with system partners committed to a **system wide efficiency plan** that supports the route to a system breakeven position in 24/25 with the programme led by a Chief Finance Officer alongside a clinical executive partner
- To develop a **long-term approach our financial plans** that support system wide delivery of our wider strategic ambition through production of long term financial model that encompasses the whole system position supported by individual organisation detail.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Finalise Operating Plan for 2023/24 • Review actions required in year to achieve position. • Launch IECG and improvement targets • Commence build of long term financial model to include system and individual organisation level detail	• Build on our understanding across our system partners of the key long term pressures within our current financial position. • Develop comprehensive intelligence to support appropriate targeting of interventions	• Develop our full Finance Strategy collaboratively with leaders and people across BOB's health and care system. • Deliver initial quick wins and opportunities from the efficiency group that can support the 24/25 system plan and beyond	• Finalise our Finance Strategy for publication on 1st April 2024. • Undertake the Operating Plan process for financial year 24/25 and a full review of associated impact on the Long Term Finance Model.

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2023/24 Delivery Architecture

Oversight of delivery

For the identified challenge areas, the following groups will be used to ensure progress is made with respect to the planned activities.

Challenge Area	Inequalities challenge	Model of Care challenge	Patient experience challenge	Sustainability challenge	
Action proposed to address challenges	Deliver a **population health management** at scale in BOB	Develop a sustainable **primary care strategy**	Target Improvements to **waiting times and access**	Develop a **Finance Strategy** to support change	Develop a 5 year **People Plan**
Governance Group to oversee progress	**BOB ICB Prevention, Pop. Health & Reducing Health Inequalities Group**	**TBC** **(multi-stakeholder group to co-design model)**	**Elective Care Board**	**CFOs in Senior Finance Group**	**ICB People Committee**

The governance for all the detailed delivery plans (appendix B), oversight of progress will be through existing governance channels. Each plan will have a named accountable ICB executive.

Progress on all delivery plans will be reported through to the ICB on a twice yearly basis (see governance details in appendix B).

2023/24 Building the foundations for change

- The actions proposed in previous pages are to address the challenge areas are explicitly and deliberately focused on 2023/24.
- These actions aim to balance activity that will impact people, communities and staff in BOB and the short term with setting a foundation for future change.
- However, longer term action plans are required for each of these areas. These need to be developed jointly between BOB ICB, NHS Partner Trusts, and wider system partners. It is proposed these action plans will be co-developed over the course of 2023/24.
- A **System Transformation Group** will be established to lead this planning.
- The System Transformation Group will:
  - ✓ Receive updates on the 2023/24 challenge areas actions, both short and long term (see pages X-Y) – providing support and challenge as necessary
  - ✓ Meet at least quarterly
  - ✓ Ensure wider engagement in development of longer term plans –both from their representative organisations and from wider stakeholders
  - ✓ Agree, define and scope system priorities that will support the transition to a sustainable BOB Integrated Care System, with a model more focused on prevention and supporting people to be healthy in their communities for as long as possible
  - ✓ Consider future governance arrangements to support long term transformation in BOB.

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Promoting and Protecting Health – Our Ambition

Promoting and Protecting Health – People living in Buckinghamshire, Oxfordshire and Berkshire West are generally healthier and live longer lives in good health than the national average. However, this can mask variation in access, experience and outcomes of services for certain populations and communities. We need to support people to live healthier lives by improving the circumstances which people live by taking action to tackle the social, economic and environmental factors that affect health.

The Importance of Prevention – It is estimated that between 20-25% of people's health is determined by the access to and quality of formal health or care services. The circumstances in which people live (e.g., housing, environment, employment, education) have a far greater impact on people's health and the choices they make. We want to therefore move from a model of care that is based predominantly around treating illness, to one that prioritises prevention and supporting people to live healthier lives in their communities.

Therefore, our Joint Forward Plan identifies our key areas of focus and ambition in improving prevention and addressing inequalities in BOB.

Service Area	Five-year Ambition	Governance & Reporting
Inequalities	**Reduce health inequalities (access and experience of services & health outcomes) for our population** so that everyone has equal access to appropriate services and support. To enable this, we will provide tailored support to defined populations or groups, particularly those living in deprived areas, certain ethnic groups, LGBTQ+ communities, people with special educational needs and disabilities, people with long-term mental health problems, carers and groups who often are or feel socially excluded.	• Inequalities & Prevention will be reporting into *Prevention, Population health and Reducing health inequalities* • ICB Exec Lead –Chief Medical Officer
Prevention	**Increase primary and secondary prevention work year-on-year**, keeping people healthy for as long as possible and delaying a deterioration into poor health.	
Immunisation and Vaccinations	**Protect our population from vaccine preventable diseases** through the implementation of the national immunisation strategy. We will maximise uptake across all vaccination programs, reduce the occurrence of outbreaks while focusing on addressing local vaccine inequalities.	• Immunisation and Vaccinations will be reporting into the *Vaccine Oversight Board* • ICB Exec Lead – Chief Nursing Officer

** More detail on the service delivery plans can be referenced in the full JFP document*

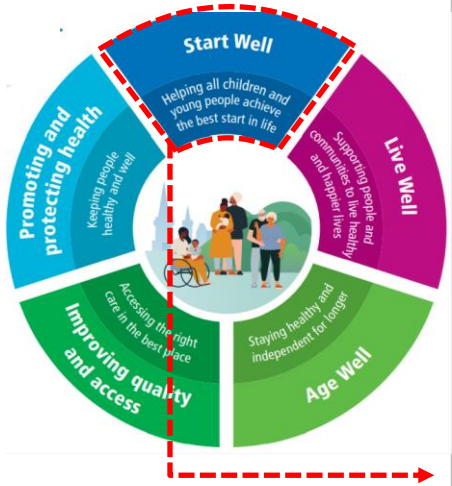
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Start Well – Summary of Our Ambition

Start Well- In BOB, we want to ensure that every child and young person gets the best possible start in life. The foundations for a person's future health and wellbeing are set in the early years of life. This begins with supporting mothers during and after their pregnancy and then working together to ensure children achieve their early development milestones so they are ready to get the most out of life, their education and future opportunities. We recognise the recommendations of 'The Best Start for Life – a vision for the 1001 critical days' report and are committed to working collaboratively across the system to support implementation. We want to promote communities and environments that support all children and young people to make healthier choices, and which will allow them to thrive and achieve.

This can only be achieved through cross-organisation working and our focus is to continue to develop partnerships across BOB that will support the delivery of the right care, support and services that will promote the healthy development of our children and young people.

Therefore, our Joint Forward Plan sets out our five-year ambition for supporting early years development and children and young people. It also highlights the key actions we will take, working with Local Authorities, VCSE and other partners, to improve and transform maternity and neonatal, children and young people's mental health and learning disability services across BOB.



Service Area	Five-year Ambition	Governance & Reporting
Maternity and Neonatal	Ensure our maternity and neonatal services in BOB prioritise and provide care which is **safer, equitable, personalised, kinder and sustainable** and ensuring positive work cultures and behaviours.	• Maternity & Neonatal reporting into *LMNS Stakeholder & Assurance Group* • ICB Exec Lead – Chief Nursing Officer
CYP Mental Health	**Improved mental health and wellbeing outcomes for children and young people** (ages 0 – 25), living learning and working in BOB. To achieve this, we will take a needs-led and person-centred approach (in line with the thrive framework) to implementation, transformational change and delivery.	• CYP MH reporting into the *ICB MH Partnership Board* • ICB Exec Lead – Chief Nursing Officer
Learning Disabilities	By March 2028, we will have delivered **improved physical, mental health and wellbeing outcomes for children, young people and adults with a learning disability and their families/carers**.	• Governance route in development. • ICB Exec Lead – Chief Nursing Officer
CYP Neurodiversity	By March 2028, we will ensure **that all neuro-divergent children and young people will receive the right support, at the right time and in the right place** dependant on their needs and not dependant on a diagnosis.	• Governance route in development. • ICB Exec Lead – Chief Nursing Officer

** More detail on the service delivery plans can be referenced in the full JFP document*

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Live Well – Summary of Our Ambition

Live Well – We want to support all people and communities in BOB to live a healthier and happier life. There are key factors that can have an impact on people's health and wellbeing, which we need to tackle as a system. To support individuals to make healthy life choices, we will focus on targeted preventative work around health conditions that affect large numbers of people in BOB. We want to support people to manage long term conditions (LTCs) such as heart disease or diabetes, and work with system partners to deliver more integrated care.

Therefore, our Joint Forward Plan sets out our five-year ambition and the key actions we will take to improve and transform support and services for people living with long term conditions and those at risk of developing these conditions.

Service Area	Five-year Ambition	Governance & Reporting
Adults Mental Health	**Improved mental health and wellbeing outcomes for all adults and older people** living, learning and working in BOB.	• Adults MH reporting into the *ICB MH Partnership Board* • ICB Exec Lead – Chief Nursing Officer
Adults Neurodiversity	BOB will be an area where Neurodivergent people thrive, and their strengths are embraced.	• Governance route in development. • ICB Exec Lead – Chief Nursing Officer
Cancer	**Reduction of the cancer backlog and consistent delivery of the Faster Diagnosis Standard** by March 2024. Sustainably meet all Cancer Waiting Times by March 2028, and achieve the National Cancer Ambition of diagnosing 75% of cancers at Stage I & II.	• ICB Exec Lead – Chief Medical Officer
Long term Conditions – Introduction	• Improve outcomes in population health and healthcare. • Act sooner to help those with preventable long-term conditions. • Support people with LTCs to stay well & independent. • Provide quality care for those with multiple needs as population ages. • Co-produce consistent pathways across ICS to reduce unwarranted variation. • Integrate service models to delivered joined up care wrapped around patients' needs.	• All LTC service areas reporting into the *ICB Clinical Programme Board* • ICB Exec Lead – Chief Medical Officer
Integrated Cardiac Delivery Network	Reduce the number of CVD events by having a strong focus on prevention and reduce the health inequality gap by using PHM approach. We aim to **co-design consistent and integrated pathways and empower patients to live well with CVD** and other co-morbidities.	

** More detail on the service delivery plans can be referenced in the full JFP document*

Live Well – Summary of Our Ambition (cont.)

Live Well – We want to support all people and communities in BOB to live a healthier and happier life. There are key factors that can have an impact on people's health and wellbeing, which we need to tackle as a system. To support individuals to make healthy life choices, we will focus on targeted preventative work around health conditions that affect large numbers of people in BOB. We want to support people to manage long term conditions (LTCs) such as heart disease or diabetes, and work with system partners to deliver more integrated care.

Therefore, our Joint Forward Plan sets out our five-year ambition and the key actions we will take to improve and transform support and services for people living with long term conditions and those at risk of developing these conditions.

Service Area	Five-year Ambition	Governance & Reporting
Integrated Respiratory Delivery Network	**Patient-centred, integrated clinical pathways delivering high quality respiratory care that is accessible** to all across BOB ICS Supporting people with respiratory disease to live longer.	• All LTC service areas reporting into the *ICB Clinical Programme Board* • ICB Exec Lead – Chief Medical Officer
Integrated Stroke Delivery Network	A **collaborative approach to service improvement of the whole stroke pathway**, including prevention, ensuring a patient centred, evidence-based approach to delivering transformational change.	
Integrated Diabetes Delivery Network	We will support the education and training of our workforce we will reduce clinical variation and health inequalities. We will adopt new diabetes care technologies and improve access to services, as well as Improved primary and secondary prevention interventions and supported personalised self-care will enable people with diabetes to manage their health so they can live the life they want to live.	

** More detail on the service delivery plans can be referenced in the full JFP document*

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Age Well – Summary of Our Ambition

Age Well – There is a growing aging population in BOB. We recognise the increased support and care that individuals require as they get older and therefore, the importance of working with system partners to deliver more joined up and personalized care plans. Approximately a quarter of people in the local area are aged over 60 and this number will grow by around 11% in the next five years.

We are committed to support older people stay healthy and independent for longer and will ensure our communities are co-designing services with us, to meet their needs. Working in partnership with the individual, their family and carers, we can ensure plans are personalized and maximise the person's independence.

Therefore, our Joint Forward Plan sets out our five-year ambition and the key actions we will take to support older people.

Service Area	Five-year Ambition	Governance & Reporting
Age Well Services	By March 2028, we will be: • Supporting more people to remain healthy and independent for longer. • Providing **proactive, personalised and coordinated care for more people who are becoming frail** and their health conditions more complex. • Supporting more unpaid carers.	• Governance route in development. • ICB Exec Lead – Chief Nursing Officer/Chief Medical Officer

** More detail on the service delivery plans can be referenced in the full JFP document*

 DRAFT

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Improving Quality and Access – Summary of Our Ambition

Improving Quality and Access – In BOB, we will continue to move towards a preventative model of care to prevent-ill health and keep people healthy. As a system, we continue to experience significant issues with elective waits and accessibility of services that is negatively impacting the experience of people and communities in BOB. During our public engagement, we have heard how unfortunately, accessing support or services can sometimes be difficult or slow and through our Joint Forward Plan we are determined to make this better. We want to do more to improve the support we offer to people at all stages of life and support those groups within our communities whose access to, and experience of, services and outcomes is worse than others e.g. minority ethnic groups.
Therefore, our Joint Forward Plan therefore sets out our five-year ambition and focuses on services for people at every stage in life, both improving these services and ensuring everyone, irrespective of their personal characteristics/circumstances can access the support they need at the right time.

Service Area	Five-year Ambition	Governance & Reporting
Urgent and Emergency Care	By 2028, our ambition is to ensure we get patients **the right access to the right care when it's needed, improving the outcomes and the experience of patients, their families and friends** and consistently delivery against the operational standards determined by NHSE.	• Reporting into *BOB UEC Programme Board* • ICB Exec Lead – Chief Delivery Officer
Planned Care	By March 2028 we will aim to **sustainably reduce and eliminate long waits for our elective services and address variation in access across the system,** recovering to at least pre-pandemic planned care performance levels against NHS Constitutional Standards by March 2028. We aim to improve access to services by enhancing pathways and coordinating approaches across the system, reducing variation and non value-added interventions.	• *Reporting into the BOB Elective Care Board* • ICB Exec Lead – Chief Delivery Officer
Primary Care	To transform how primary care is delivered in each community/neighbourhood, enabling integrated primary care provision which **improves the access, experience and outcomes for communities aligned to their needs**. Through the mobilisation of integrated neighbourhood health and care teams, primary care services will become more sustainable, and patients will get the support they need when they need it.	• Reporting into *Primary Care Operational Meeting* • ICB Exec Lead – Chief Medical Officer
Palliative and End of Life Care	We will **deliver high quality, personalised, integrated 24/7 services shaped by those with lived experience for Palliative and End of Life Care** (PEoLC) for all ages, across the BOB ICS.	• Reporting into the *ICB Palliative and End of Life Care Board* • ICB Exec Lead – Chief Nursing Officer

** More detail on the service delivery plans can be referenced in the full JFP document*

 DRAFT

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Key Enablers for Delivery – Summary of Our Ambition

Key Enablers for Delivery – Meeting the ambitions of our Joint Forward Plan relies on the us having the right supporting and enabling plans in place as a system to ensure we can deliver effectively. Our enabling plans set out how we will develop the most important elements we rely on in delivering our services, such as having the right number of skilled staff and IT that effectively supports front-line care and a sustainable financial environment where we can invest in the right things. In BOB, we start from a position of strength in some of these areas, for example we have recently completed our system Digital Strategy that will provide the basis for improving our services through better use of digital and data over the next five years, while on others we know we have a lot to do. As well as our enabling plans, we have a number of supporting plans that provide the foundation of delivery of our core services.

We have developed five-year plans across our enabling and supporting plans. Some examples are outlined below:

Service Area	Five-year Ambition	Governance & Reporting
Workforce	By March 2028 we will have an **integrated workforce that is looked after, feels valued and respected, is reflective of our communities** and made up of the right people in the right roles at the right time delivering health and care services for our communities.	Reporting into the *ICB People Committee* • ICB Exec Lead –Chief People Officer
Digital and Data	Improve the lives and experiences of those accessing and working in our Integrated Care System, through building collective digital and data maturity across our partners and providers. By 2025, we will have: • **Enabled safe and informed care** by aligning our providers behind a single shared care record. • **Improved maturity of electronic patient records** by converging providers onto platforms which meet national data standards. • **Equipped our workforce** in exploiting the use of digital and data and develop DDaT professions across the ICS.	• Reporting into the *CIO Forum* • ICB Exec Lead – Chief Information Officer
Quality	It is our ambition that **"Each patient will receive timely, safe, effective care with a positive experience."** We will demonstrate this by delivering on our Quality Strategy and improving against comprehensive system metrics and our CQC and SOF ratings.	• Reporting into the *System Quality Group* • ICB Exec Lead – Chief Nursing officer

** More detail on the service delivery plans can be referenced in the full JFP document*

Health & Wellbeing Board Buckinghamshire

Report from Bedfordshire, Luton and Milton Keynes Integrated Care System

Date: 22nd June 2023

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

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

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

☐ **Decision** ☐ **Endorsement**

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

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

1. Purpose of report

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

2. Recommendation to the Health and Wellbeing Board

2.1 Note that the BLMK NHS Operational plan 2023/24 was submitted to NHS England at the end of March 2023 and finalised in May 2023.

2.2 Review the draft BLMK Joint Forward Plan and confirm that Buckinghamshire Council Health and Wellbeing Strategy has been taken proper account of in the BLMK Joint Forward Plan.

2.3 Note the updates provided on the key items of business considered by the BLMK Integrated Care Board meeting on 24 March 2023 as listed at Appendix A. (The report from the Health and Care Partnership on 7 March was presented to the last meeting)

3. Content of report

3.1 BLMK (NHS) Operational Plan 2023-2024

The Health and Care Act requires the BLMK ICB to produce an Operational Plan (draft submitted to NHS England at the end March 2023, final version submitted in May 2023).

The Operational Plan for 2023/24 describes how the local NHS will deliver against mandated NHSE operating plan requirements, including agreement of the BLMK NHS system budget. This plan takes account of local priorities which were reported to the Board of the ICB on 24 March 2023. A financially balanced plan has been submitted to NHS England, delivery of this plan is dependent on the delivery of efficiency and effectiveness schemes across the system during the current year.

3.2 BLMK Joint Forward Plan

The Health and Care Act 2022 requires the BLMK ICB and its partner NHS Trusts and Foundation Trusts to produce a Joint Forward Plan covering a minimum of five years (final version due to be agreed by the Board of the ICB on 30 June 2023).

The Joint Forward Plan (JFP) is required to set out a framework for how the ICB and partners intend to arrange and/or provide services to meet our population's physical and mental health needs. This will include narrative on the universal NHS commitments and address the four core purposes and statutory duties of an ICS to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social economic development

The Board of the ICB agreed that the BLMK JFP, which at this stage is a 'plan for a plan' will extend from 2023 to 2040 to address:

1. the expected and sustained expansion of our population to 2040 and beyond.
2. multi-agency very complex issues which are best resolved through partnership delivery to improve health outcomes, tackle inequalities in local communities whilst ensuring optimal use of public money to deliver services.
3. wider determinants of health and well-being to maximise prevention and supporting communities to thrive.

The extended timeframe of the BLMK JFP will enable all partners of the BLMK ICS to develop longer-term plans in collaboration to best deliver the ICS' statutory duties in the local context of sustained population growth over this period. The first iteration of the detailed Joint Forward Plan is expected to be signed-off by March 2024, and local residents and Health and Wellbeing Boards will have an opportunity to shape this more detailed plan and the place-specific elements within it from the summer onwards.

The Plan has been developed based on prior engagement with the public and partners will be agreed and published in June 2023 following further engagement with Health and Wellbeing Boards, NHS Trust Boards and VCSE groups. As the JFP focuses on longer-term delivery of existing plans, the plan will not require full formal public consultation.

The current working draft JFP is available on the ICB Website here. The Health and Wellbeing Board is asked to discuss and comment on the draft Joint Forward Plan. Any comments will be reported to the Board of the ICB for consideration prior to approval of the plan and submission to NHSE by 30 June 2023.

The Council's health and wellbeing strategy is reflected within the BLMK Health and Care Strategy which the Joint Forward Plan has been developed in response to. Therefore the Health and Wellbeing Board can confirm, as required by the guidance Health and wellbeing boards – guidance - GOV.UK (www.gov.uk) that the Joint Forward Plan 'takes proper account' of the Council's Health and Wellbeing Strategy.

4. Background papers

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

Appendix A – Summary of BLMK Integrated Care Board Business March 2023

1. Board of the BLMK ICB – 24 March 2023

- **Resident's Story** – the Board heard from a Milton Keynes resident about their journey to address back pain and the difficulties she faced in gaining appropriate diagnosis and support. There were numerous opportunities cited where the patient was not listened to and where their care was compartmentalised and not joined-up.
- **Integrated musculoskeletal (MSK) and pain service** – the approach to tendering for MSK services across BLMK was supported including the development of place-based services. Reference was made to the resident's story and how the proposed approach will aim to address the issues raised.
  ***Note**: since this meeting it has been decided to extend the contract with current providers for one year to allow further market engagement, a robust competitive procurement and additional time to continue to engage with patients and residents.*
- **Fuller programme** – the Board reflected on the useful Board seminar session held on 24 February 2023 with Claire Fuller and committed to support the development of integrated neighbourhood teams.
- **Core20PLUS5 - for Children and Young People** – the Board agreed to adopt a targeted approach to adapting the Core20Plus5 approach to tackling health inequalities in relation to children and young people. The focus of Core20PLUS5 is on five key areas: asthma, diabetes, epilepsy, oral health and mental health.
- **Delegation of Community Pharmacy, Optometry and Dentistry (POD)** – the Board formally approved the transition of the management of these contracts from NHS England to the ICB from 1 April 2023.
- **BLMK Joint Forward Plan (JFP)** – NHS England has asked for draft Joint Forward Plans for each integrated care system (ICS) to be submitted by 31 March 2023 with final plans published by 30 June 2023. The JFP will cover at least a 5-year time horizon explaining how the four core requirements of ICSs and NHS priorities are to be delivered. The Board agreed the approach including how targeted public engagement work about the JFP will be carried out.
- **Financial and Operating Plan 2023/24** – the Board agreed for the final plan to be signed off by the Chief Executive following a meeting of system chief executives on 29 March 2023. The Board discussed bridging the financial gap, addressing capacity issues to achieve the target for elective activity of 109% of pre-Covid levels and plans to manage hospital flow.

- **Board Assurance Framework (BAF)** – the latest iteration of the BAF was presented. The BAF sets out the key system risks which the Board monitors at each of its formal meetings. Currently, the highest three risks (all scoring 20 out of 25) are as follows.
    - Developing suitable workforce
    - System pressure and resilience
    - Population growth

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Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board Formal response to ICB Joint Forward Plans

Date: 22nd June 2023

Author/Lead Contacts: Rebecca Carley, Head of Business & Governance, Buckinghamshire Council

Report Sponsor: Craig McArdle, Corporate Director, Adults & Health, Buckinghamshire Council

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

☒ **Decision** ☐ **Endorsement**

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

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

1. Purpose of report

1.1. This report sets out the proposed response from the Buckinghamshire Health & Wellbeing Board to the 5 Year Joint Forward Plans (JFP) for the Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board (BOB ICB); and the Bedfordshire, Luton and Milton Keynes Integrated Care Bord (BLMK ICB).

2. Recommendation

2.1. The Health and Wellbeing Board is recommended to:

- confirm that the draft Joint Forward Plans of the BOB ICB and BLMK ICB take "proper account" of the Buckinghamshire Health and Wellbeing Joint Local Strategy (JLHWS)

- agree that this confirmation is provided to both ICBs, including any additional comments required by the Board

3. Background

3.1. Buckinghamshire is part of the geographical area covered by the BOB ICB. However as some of our residents receive services from the BLMK area, we also engage with the BLMK ICS. And for this reason, the Council's Cabinet Member for Health and Wellbeing and Chair of the Buckinghamshire Health and Wellbeing Board sits on the BLMK Health and Care Partnership.

4. Five Year Joint Forward Plan (JFP)

4.1. All ICBs are required to create and maintain a rolling 5 year forward plan, known as the Joint Forward Plan (JFP). The JFP sets out how the ICB will deliver the Integrated Care Strategy and national NHS commitments.

4.2. This is the first year that ICBs have produced JFPs and the JFPs must be submitted to NHS England at the end of June.

4.3. All ICBs are required to consult with Health & Wellbeing Boards on the proposed JFP, specifically with respect to the Joint Local Health & Wellbeing Strategy – Buckinghamshire's Joint Local Health & Wellbeing Strategy can be viewed here.

4.4. JFPs will be refreshed annually and submitted by the start of the financial year; and each year Health and Wellbeing Boards will be consulted and asked to provide the statement about whether the JFP takes "proper account" of the Buckinghamshire JLHWS.

4.5. The two ICBs have taken very different approaches to their JFPs:

- The BOB ICB has developed a detailed 5 year JFP which will be reviewed and updated annually
- In contrast, BLMK ICB has developed a "Plan for a Plan" and will continue to engage on the development of its JFP with a view to submitting a detailed version in March 2024 spanning the period up to 2040, subject to annual review and updating

4.6. Since this Board's last meeting in March, both BOB and BLMK ICBs consulted with the Buckinghamshire Health and Wellbeing Board on their draft JFPs.

5. Have the draft JFPs taken account of the Buckinghamshire Joint Local Health & Wellbeing Strategy?

5.1. Both ICBs have submitted detailed reports to this meeting agenda regarding their Joint Forward Plans. Board members are able to review both draft JFPs, which are summarised in the ICB reports which also contain links to the detailed JFPs.

5.2. I have reviewed both JFPs and can provide assurance to the Board that:

- the BOB ICB JFP directly takes account of the Buckinghamshire JLHWS
- whilst the BLMK JFP is still in development, its emerging themes and proposed development approach indicate proper account of the Buckinghamshire JLHWS

6. Next steps and review

6.1. The decision of the Board will be communicated to the ICBs with respect to whether their JFPs take proper account of the Buckinghamshire JLHWS with any additional comments requested by the Board.

6.2. Members will be kept informed of opportunities to engage in the development of the detailed BLMK JFP.

6.3. Annually, starting March 2024, the Health and Wellbeing Board will be able to review the updated JFPs and provide its opinion.

7. Background papers

- BOB ICP draft 5 year Joint Forward Plan
- BLMK ICP draft Joint Forward Plan

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Buckinghamshire Health and Wellbeing Board Forward Plan

Standing items:

- Welcome, minutes and actions, declarations of interest, Chair's announcements
- Public questions
- Healthwatch update
- Buckinghamshire Executive Partnership update
- ICB/ICS update
- JSNA update
- Forward plan

Meeting date	Item
21st Sept 2023	BCF – discussion on opportunities to use the BCF to address inequalities
	JLHWS • Dementia action plan (following conclusion of HASC rapid review into dementia) • Proposed performance dashboard
	Physical Activity Strategy
	Housing Needs (One Council Approach) quarterly update
	Review of Board's Terms of Reference
14th Dec 2023	System winter plan including primary care
	Director of Public Health Annual Report
	JLHWS • Age Well detailed action plan (excluding MH and dementia elements as reviewed by Board in June and Sept) • 1st full performance dashboard
	Healthy Ageing Strategy

21st March 2024	JLHWS:
	• Action plan reviews:
	  ○ Start Well:
	  ▪ Reducing prevalence of obesity in children and young people
	  ○ Live Well:
	  ▪ Reducing prevalence of obesity in adults
	  ▪ Reducing rates of cardiovascular disease
	  ○ Age Well:
	  ▪ Increasing physical activity of older people
	• Performance dashboard

	BOB and BLMK ICB – Joint Forward Plans

June 2024 Date TBC	JLHWS action plan update:
	• Start Well:
	  ○ Improving outcomes during maternity and early years
	  ○ Improving mental health support for children and young people
	• Live Well:
	  ○ Improving mental health support for adults particularly for those at greater risks of poor mental health
	• Age Well:
	  ○ Improving mental health support for older people, reducing feelings of social isolation

	Better Care Fund 2023/24 out-turn and 2024/25 plan

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