Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board agenda

Date: Thursday 21 March 2024

Time: 2.00 pm

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

Membership:

A Macpherson (Buckinghamshire Council) (Chairman), Mr N Macdonald (Buckinghamshire Healthcare NHS Trust) (Vice-Chairman), Dr R Bajwa (Buckinghamshire Clinical Commissioning Group), Ms P Baker, A Cranmer (Buckinghamshire Council), A Hussain (Buckinghamshire Council), Z Mohammed (Buckinghamshire Council), K Higginson (Community Impact Bucks), J Macilwraith (Buckinghamshire Council), C McDonald (Children's Clinical Lead), Dr J O'Grady (Director of Public Health, Buckinghamshire Council), Dr S Roberts (Buckinghamshire Clinical Commissioning Group), Dr R Sawhney (Clinical Commissioning Group), D Walker (Oxford Health NHS Foundation Trust), Dr K West (Buckinghamshire Clinical Commissioning Group), Mr C McArdle and J Meech (Healthwatch Bucks)

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Agenda Item		Time	Page No
1	**Welcome**	**14:00**	

2	**Apologies**		
3	**Announcements from the Chairman**	**14:05**	
4	**Declarations of Interest**		
5	**Minutes of the previous meeting** To agree the minutes of the meeting held on 14 December 2023 and review any outstanding actions from the previous meetings.	**14:10**	**5 - 14**
6	**Public Questions** For a response to be provided at the March Health and Wellbeing Board, questions must be received by 9.00am on Monday 18 March. Any questions received after this deadline will be responded to at the following Health and Wellbeing Board meeting.	**14:15**	

Improving Health & Wellbeing and Tackling Health Inequalities

7	**Healthy Ageing Strategy** Lucie Smith, Public Health Principal.	**14:20**	**15 - 32**
8	**Joint Local Health & Wellbeing Strategy**	**14:45**	
	8a Approval of indicator action plans • Improving places & supporting communities to promote healthy ageing Lucie Smith, Public Health Principal.		**33 - 34**
	8b Indicator 12-month reviews • Reducing prevalence of obesity (Start Well and Live Well) • Reducing rates of cardiovascular disease (Live Well) • Increasing physical activity of older people (Age Well) Jane O'Grady, Service Director Public Health, Early Help & Prevention, Buckinghamshire Council.		**35 - 40**

Promoting Joint Working

9	**Winter Planning** • Review of winter plan, Transfer of Care Hub (ToCH) and discharge performance • Healthwatch care home hubs report	**14:50**	**41 - 52**

	Caroline Capell, Programme Director of Urgent and Emergency Care.		
10	**Healthwatch Update** Zoe McIntosh, Chief Executive, Healthwatch Bucks.	**15:20**	**53 - 58**
11	**Buckinghamshire Executive Partnership** Update from the Buckinghamshire Executive Partnership, including the Health & Care Integration programme. Neil Macdonald, Chief Executive Officer, Buckinghamshire Healthcare NHS Trust.	**15:35**	**59 - 62**
12	**Integrated Care Board Update**	**15:45**	
	12a Buckinghamshire Oxfordshire Berkshire West Integrated Care Board Philippa Baker, Buckinghamshire Place Director, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.		**63 - 68**
	12b Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board Michelle Evans-Riches, Programme Manager, Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board.		**69 - 72**
13	**Health and Wellbeing Board Work Programme**	**15:55**	**73 - 74**
14	**Any Other Business**		
15	**Date of next meeting** PROVISIONAL: 27 June 2024 at 2.00 p.m.	**16:00**	

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Health & Wellbeing Board Buckinghamshire

Health and Wellbeing Board minutes

Minutes of the meeting of the Health and Wellbeing Board held on Thursday 14 December 2023 in The Paralympic Room, Buckinghamshire Council, Gatehouse Road, Aylesbury HP19 8FF, commencing at 2.00 pm and concluding at 4.00 pm.

Members present

A Macpherson (Chairman), Mr N Macdonald (Vice-Chairman), Ms P Baker, Z Mohammed, K Higginson, Dr J O'Grady, Dr S Roberts, D Walker, Dr K West, Mr C McArdle and J Meech

Others in attendance

B Binstead, C Capjon, M Evans-Riches, M Green, S Hone, T McLarty, N Newstone, M Ormerod, N Palmer, G Porter, Dr C Ramsay, J Robinson and S Robinson

Agenda Item

1 Welcome

The Chairman, Councillor Angela Macpherson, welcomed everyone to the meeting.

2 Apologies

Apologies had been received from Councillor Anita Cranmer, Councillor Arif Hussain, John Macilwraith, and Dr Craig McDonald. Mark Green attended in place of John Macilwraith.

3 Announcements from the Chairman

The Chairman highlighted that the Board would receive more detail on the emerging Primary Care Strategy being developed by the Integrated Care Board in a future meeting.

4 Declarations of Interest

There were no declarations of interest.

5 Minutes of the previous meeting

It was noted that all actions had been completed that had been raised at the previous meeting. Following the meeting Dr. Sian Roberts had enquired about Board Member's voting rights. Clare Capjon reported that the Board's Terms of Reference were under review and advised that there was a governance process involved with amending the Terms of Reference. Any proposed changes would be reported back to the Board.

Dr. Roberts highlighted that under item 9 of the previous minutes, Winter Plan, it should read that 25% of unplanned admissions over the age of 65 had dementia,

rather than 25% of patients.

Resolved: The minutes of the meeting held on 21 September 2023 were agreed as an accurate record subject to the above amendment and were signed by the Chairman.

6 Public Questions

No public questions had been received for this meeting.

7 Director of Public Health Annual Report

Jane O'Grady, Director of Public Health, Buckinghamshire Council had a statutory duty to produce an annual report on the health of Buckinghamshire's population. This year's report was on mental health and made recommendations for partners to support children, young people and their families, encourage healthy behaviours and explore how opportunities could be provided for social networking and learning.

Dr O'Grady was joined by Stephen Robinson from Buckinghamshire Mind who had contributed to the report.

During discussion, points raised included:

- The Opportunity Bucks Partnership programme and associated benefits were highlighted, as areas of deprivation were known to suffer from worse mental health. This was often linked to areas such as employment quality and poverty.
- Another area of required focus was maternal mental health, with research showing that during pregnancy, the mother's mental health can have a significant impact on children when born. Good maternity mental health care was linked to fewer early births, reduced depression and improved outcomes for the children.
- Stephen Robinson from Buckinghamshire Mind spoke about the impact of money on mental health and highlighted research undertaken by Buckinghamshire Mind in partnership with Citizens Advice Bucks. Funding was being reviewed with a view to build on this relationship to further support people. The work being done through the Champion the Change programme was also noted, with a focus on destigmatising people talking about their mental health. Mental health and suicide first aid training provided by public health was welcomed and the Board were encouraged to continue to think about who may benefit from this.
- Food insecurity was also identified as a factor impacting mental health and work was being undertaken to look at developing closer links with food banks as well as provide training to foodbank staff given the significant support they provide to communities.
- Young person's counselling services had recently been launched by Buckinghamshire Mind, these linked in with schools and self-referrals were being taken to access the service.
- The Board discussed ways to communicate the report to partners and the

public, including using community boards, social media, the family information service, maternity services and working with schools to promote it. Buckinghamshire Mind would also look to link in with the voluntary sector.
- The Board emphasised the importance of considering digital exclusion when publicising the report.
- Jane O'Grady suggested that the lead organisations, focusing on the respective areas of children's and young people's mental health and adults mental health bring back their action plans in six months' time.

8 Joint Local Health & Wellbeing Strategy

8A Ageing Well

The Board received a report which related to the Health and Wellbeing Strategy ambition of ageing well, part of which was to increase the proportion of people over 65 being formally diagnosed with dementia. In attendance for this item were Nicole Palmer, Alzheimers Society, Dr Sian Roberts, Clinical Director from the ICB, Dr Chris Ramsay, Associate Medical Director for Older Adult Services (Bucks) and Consultant in Old Age Psychiatry, Oxford Health Foundation Trust and Theresa McLarty, Mental Health Nurse, Oxford Health Foundation Trust.

Dr Sian Roberts introduced the report and emphasized the importance of timely diagnosis and support for people with dementia both pre- and post-diagnosis. Dr Chris Ramsey presented the multi-agency action plan developed with various partners, including the Council, voluntary partners, and Integrated Care Board to address the deficit in the dementia diagnosis rate.

During discussion, points raised included:

- Oversight of the action plan was the responsibility of the mental health, learning disability and autism board who would regularly monitor delivery milestones and progress.
- The plan included enhancing the screening program in care home settings, to improve identification of symptoms. In addition to memory clinics, opportunities to expand cognitive assessments into other settings would be explored, including more training for community health and social care professionals as well as the voluntary sector.
- Nicole Palmer from the Alzheimer's Society discussed their efforts to provide memory screening webinars, memory information sessions and pre-diagnostic support. This support helped people on their journey to manage symptoms and access the appropriate support. There was an awareness of health inequalities, particularly in rural communities and amongst BME groups, and work was underway to work closer with other organisations to support these groups.
- There was an ambitious target to work to a 60-day timescale between referral and formal diagnosis. The timescale at present was circa 200 days and work was ongoing to establish baselines within the action plan.

- It was noted that Covid-19 had affected diagnosis rates and there was a significant backlog, which was affecting the length of the waiting list.
- The Chairman raised the need to remain aware of the impact of caring for people with dementia and ensure they were supported.
- John Meech suggested the possibility of new Healthwatch projects to focus on prevention and making these initiatives sustainable.

8B Dashboard

James Robinson, Business Intelligence Business Partner, Buckinghamshire Council demonstrated the Health and Wellbeing dashboard which was a visual tool to help the Board, partners and residents monitor the impact and outcomes of the Health and Wellbeing Strategy. The dashboard, which would be publicly available on the Health and Wellbeing Board website, displayed key indicators such as targets and benchmarking data related to the strategic priorities. Thanks were given to all partners for providing the data.

The dashboard would be updated quarterly and was intended to help inform decision making. The Board discussed the potential for linking targets to strategies and using the dashboard to monitor indicators and inform discussions. It was suggested that in the future it could be beneficial to provide further context behind data such as explanations behind decreases in numbers within a certain indicator.

It was also suggested that to bring the dashboard to life, the relevant indicator(s) could also be linked to discussion at future meetings to understand what was known about each one, what the ambition was and what the current levels were.

The Board thanked James for the significant amount of work that had gone in to producing the dashboard and the Chairman suggested it was a piece of work which could be showcased to the Integrated Care Partnership at an upcoming meeting.

9 Physical Activity Strategy

The Board received the refreshed multiagency Physical Activity Strategy for 2024-2029 which included the key areas for action. Jane O'Grady, Director of Public Health and Sally Hone, Public Health Principal, Buckinghamshire Council presented the Strategy. They were joined by Mark Ormerod, Chief Executive Officer, LEAP.
During discussion, points raised included:

- The achievements of the strategy to date were highlighted. These included the successful Simply Walks programme, which now had over 65 volunteer led walks which had reached over 1000 residents; the active medicine programme in collaboration with LEAP, which had trained 1100 frontline clinical and non-clinical staff to hold healthy conversations around physical activity and signposting opportunities; and the close working with transport colleagues which had seen the installation of new cycling racks in Aylesbury and Wycombe, the Gardenway cycling route and local cycling and walking infrastructure plan.
- It was noted that not all local authorities had a local strategy and that the

strategy supported LEAP in leveraging national investment and helped address inequalities in areas of deprivation.

- Prevention was highlighted as being key, with partners needing to focus on measures to help prevent significant health issues before they arise.
- There was a discussion about the ambition of the strategy and whether the targets could be more ambitious. The targets had been set following a review of data held and recognising what may be realistic. The targets could be more ambitious if partners were able to do more and the Board looked at areas where partners may be able to support further. There was a will to support physical health amongst health practitioners, although capacity was stretched. It was acknowledged that it was not as simple as a GP referral to a social prescriber; physical activity required relationships to be developed to build confidence. Earlier training for GPs on the importance of physical activity in their training paths was also spoken of.
- The Board heard that primary care networks often had health and wellbeing coaches who could support the project, and promote the importance of physical activity in dealing with chronic diseases and illnesses.
- The Board expressed interest in seeing how statistics change over the next twelve months and it was agreed to bring an update on the strategy back to a meeting in a year's time.

Action: Jane O'Grady / Sally Hone

- It was suggested that specific targets could be set for early years providers and schools to increase physical activity. Mark Green offered to hold a discussion on this outside of the meeting.

The Board noted the report and endorsed the strategy.

10 VCS Health and Social Care Workforce

Katie Higginson, Chief Executive Officer, Community Impact Bucks provided an overview of the initial findings of the research undertaken by the BOB VCSE Health Alliance. The research was commissioned to allow the alliance to talk more confidently to the system about the size, shape, and workforce of the VCSE sector within the BOB region. The VCSE sector had an important role as healthcare providers, tackling health inequalities, and undertaking prevention work to help people live independently for longer.

During discussion, points raised included:

- The VCSE sector in Buckinghamshire was made up of 2,400 registered organizations and many more unregistered ones. It deployed an estimated £670 million pounds of value into the economy of the county each year, employing 11,000 paid staff, and engaged around 47,000 regular volunteers per year.
- Two-thirds of the sector was made up of small organisations with a turnover of below £50,000 a year. These small, local, volunteer-led charities promoted

health and wellbeing without always knowing about it, including supporting people to stay fit, reduce loneliness, assist in transporting people to medical appointments and identifying needs not necessarily visible to statutory services. At the other end of the scale, larger organisations with a turnover of £250,000 pounds upwards made up only about 14% of the sector, although accounted for about 87% of the income. These organisations were more likely to be working in formal partnership arrangements with statutory services and often delivered contracts.

- Staffing was the most significant expenditure for the sector, with about 80% of financial expenditure going on staffing costs. This was supported by donated goods, in-kind support, and the proxy value of the hours of activity contributed by regular volunteers.
- Volunteers were critical to the sector; however rates of volunteering were currently at their lowest levels in a decade and falling even more steeply for most ethnic minority groups. This was putting a lot of pressure on VCSE organisations, which were also dealing with reduced public donations, increased demand and increasing costs.
- The final report was due in February 2024 and would contain more detail. The Board looked forward to seeing this as part of the agenda pack for its March meeting.

Action: Katie Higginson

- The Board members discussed the importance of volunteers and the challenge of encouraging more people to volunteer. It was highlighted that there were many strategies upcoming and it would be ensured that the VCSE would be consulted on these with their input very much welcome. The Board also discussed the possibility of including the VCSE workforce in health and care workforce strategies and the opportunities for strengthening the VCSE workforce as part of the wider health and care workforce. This would be strengthened by further data in the final report.

The Board noted the report and looked forward to receiving the full report in March.

11 Healthwatch Update

Zoe McIntosh, Chief Executive, Healthwatch Bucks presented the Healthwatch update. The report focused on a recent project which centred on the hospital discharge support service in Buckinghamshire. The service was commissioned by Buckinghamshire Council and provided by Age UK, with volunteers doing much of the delivery. It consisted of two parts: transport home from hospital and up to six weeks of community support at home, including low-level, light-touch support such as helping with shopping and connecting people to their communities.

The report was based on feedback from 27 people who generally had positive experiences with the service, although through conversations with these individuals several other issues arose that resulted in recommendations for Buckinghamshire

Healthcare Trust, the Integrated Care Board, Buckinghamshire Council, and Age UK. The report also found that 5 out of 27 people who were discharged were then re-admitted to hospital, two of whom were carers for someone living with dementia which indicated how caring responsibilities can impact people and how supported they feel at home.

The recommendations were well received, with a positive response from BHT who were using some of the information to help inform their discharge improvement plan.

The Board noted the report and appreciated the work done by Healthwatch Buckinghamshire.

12 Buckinghamshire Executive Partnership

Neil Macdonald, Chief Executive Officer, Buckinghamshire Healthcare NHS Trust presented an update from the Buckinghamshire Executive Partnership.

- The three priorities of the partnership for this year were SEND, joining up care and health inequalities. SEND was a particularly challenging area, experiencing significant demand and workforce constraints.
- There had been a significant success in reducing the number of bed-days in acute hospital beds by around half compared to the previous year.
- The partnership was also developing a clinical and care plan for the county, which set out priorities for partnership working and changing the way care is delivered.
- A member of the public commented on the need for more specific outcomes and timelines. This would be addressed in future reports.

The Board noted the update and appreciated the work done by the Buckinghamshire Executive partnership.

13 Integrated Care Board Update

13A Buckinghamshire Oxfordshire Berkshire West Integrated Care Board

Philippa Baker, Buckinghamshire Place Director, BOB ICB presented an update on the work of the BOB ICB and its shared system goals. Points raised during discussion included:

- The BOB ICB was looking to create a smaller subset of goals that they wished to prioritize, given the breadth of areas that could be covered within their strategies. Some of the proposed priorities included smoke-free BOB, children's mental health and wellbeing, and a shared estates strategy. Comments on these priorities were encouraged from partner organisations, with the system goals due to be finalised in the last quarter of 2023.
- An update was also provided on the development of the Primary Care Strategy. The emerging model for primary care services was expected to

focus on access, continuity, and prevention. A draft strategy would be published in January 2024. Public engagement sessions were ongoing, and Healthwatch was involved and hosting a webinar to present the draft strategy.

- The Primary Care Strategy was welcomed and the Board hoped to see an estate strategy linked to it to aid understanding of how services and buildings would be delivered, particularly in areas of growth. The increased demand on practices was acknowledged and it was confirmed that the BOB ICB was considering its infrastructure strategy, not just for primary care but also for acute and secondary care. This was linked to Community Infrastructure Levy which was a complex area and at a later stage, plans would be brought to the Board.
- The Chairman emphasized the importance of communication, transparency, and accessibility to everything that BOB is doing. The difficulty in navigating the BOB website for members of the public was raised and it was acknowledged that improvements to the website could be made.

The Board noted the updates and appreciated the work done by the BOB system and its partners.

13B Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board

Michelle Evans-Riches, Programme Manager, Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board provided an update on the ICB emphasising the importance of sharing good practice, as what worked well in one area could often work elsewhere. Points raised during discussion included:

- An update was provided on the Denny review, which was a review by Reverend Lloyd Denny into inequalities in Bedfordshire, Luton, and Milton Keynes. An initial response to the Denny report was considered by the BLMK ICB, and there had been a unanimous commitment from all NHS organisations and local authority partners to work together to address inequalities. A board-level champion had been appointed, and initial programs were being focused on, including a translation service and the development of a health and social care digital record, which would record all information that was important to an individual for all healthcare professionals to be able to access.
- The Board received an independent review report on health and care integration in Milton Keynes Place. It recognised that there had been significant progress made by partners to establish a strong place-based partnership, which had developed the MK deal and had four priorities. Milton Keynes Place had realised the need to develop a fifth priority, which was integrated neighbourhood working. An initial pilot was being undertaken at Bletchley Pathfinder. The Integrated Care Board would produce a framework by June 2024, which will set out how greater responsibility for resources and decision-making could be made available for place-based

partnerships as they matured.

- The Chairman expressed interest in the work being done at Milton Keynes Place and requested contact details be sent to Phillipa Baker for information. She also inquired about data sharing and how associated complications were managed. It was confirmed that data sharing agreements were in place with all providers and primary care, and a digital platform was being developed to share information with local authorities.

Action: Michelle Evans-Riches

The Board noted the updates and appreciated the work done by BLMK ICB and its partners.

14 Forward Plan

The forward plan was noted.

15 Any Other Business

John Meech, Healthwatch Bucks queried the Pharmacy First initiative which was due to start in early 2024 and how this would work in Buckinghamshire. Nicola Newstone would seek to obtain and share information on this.

Action: Nicola Newstone

16 Date of next meeting

21st March 2024

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Health & Wellbeing Board Buckinghamshire

Healthy Ageing Strategy 2024-2029

Date: 21st March 2024

Author/Lead Contacts: Lucie Smith, Public Health Principal, Buckinghamshire Council.

Report Sponsor: Jane O'Grady

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. In response to the Joint Health and Wellbeing Strategy priority to improve places and helping communities to support healthy ageing, a Healthy Ageing Strategy has been developed. This report outlines the approach taken to the develop a Healthy Ageing Strategy and our ambition to become a more 'Age Friendly Buckinghamshire'.

2. Recommendation to the Health and Wellbeing Board

2.1. The Health and Wellbeing Board is asked to note the contents of the Healthy Ageing Strategy and endorse the actions within it.

3. Content of report

3.1. Population projections suggest that over the next 20 years (2022 to 2042) the population aged 65 years and over in Buckinghamshire will increase by one third (34,944 more people) and the population aged 85 years and older will increase by two thirds (10,884 more people). The increase in the older population brings economic and societal opportunities, but these are most likely to be realised if older adults remain well and independent. However, the average number of years of ill health has risen for both men and women in Buckinghamshire and stands at over 15 years.

3.2. The aim of the strategy is for Buckinghamshire to become an 'age friendly community', based on the WHO's evidence-based framework of the 8 interconnected areas that support older people to live healthy, active and independent lives, which are:

- Outdoor space and buildings
- Transport
- Housing
- Participating in society
- Volunteering and employment
- Communication and information
- Community support for health and wellbeing
- Respect and social inclusion (which in Buckinghamshire will run throughout the above areas rather that being a standalone area)

3.3. Basing the strategy on the age friendly community framework means action will take place to improve both the physical and social environments which will realise the Joint Health and Wellbeing Strategy priority to improve places and helping communities to support healthy ageing, including building social connectedness. The strategy aims to do this by:

- Outdoor space and building: we will create high quality, accessible and social public spaces which are safe and help people to move around freely e.g. improving walkability of local areas by repairing pavements.
- Transport: we will promote accessible, affordable and appropriate travel options allowing people to access services they need e.g. enhance flexible transport options such as PickMeUp on demand minibus services.

- Housing: we will support the development of accommodation where people can live safely and comfortably, and which can improve physical and mental health, wellbeing and social connectedness e.g. build an age friendly approach to housing via the Housing Strategy and Local Plan.
- Participating in society: we will reduce and remove barriers to participation to foster engagement with activities and events which build a sense of belonging e.g. support the voluntary and community sector to develop and deliver projects to address social connectedness.
- Volunteering and employment: we will explore how to support older adults to continue in or re-enter employment in the face of falling older adult employment rates, as well as how to facilitate volunteering e.g. adopt age friendly employer pledge to increase age friendly employment practices.
- Communication and information: we will build positive and accessible communications and campaigns, and challenge negative stereotypes and stigma e.g. develop an age friendly communications strategy which tackles stereotypes and stigma.
- Community support for health and wellbeing: we will strengthen the health and wellbeing of communities and support the network of community-based groups e.g. support the Healthy Libraries programme to deliver more health and wellbeing activities which support residents to live and age well.

3.4. Given the breadth of this work and to make progress achievable we will prioritise areas in turn rather than tackle all simultaneously.

3.5. A multi-agency Age Friendly Bucks Partnership has been established to steer the prioritisation of areas and oversee and support a system-wide approach to delivery. The members are senior representatives from partners including the Council, NHS and voluntary sector. The Partnership meets quarterly and is chaired by Cllr Macpherson, Deputy Leader of Buckinghamshire Council and Cabinet Member for Health and Wellbeing.

3.6. The Partnership has oversight of age friendly work, it is informed by several topic-specific strategies and groups, such as the Live Longer Better Alliance and the Physical Activity Strategy which are already working to improve healthy ageing in Buckinghamshire, this ensures emerging issues are not overlooked.

3.7. Prioritisation is informed by our residents and communities. A survey took place between 19th June – 17th July 2023 and 228 responses were received and the results have informed the year 1 priority of outdoor spaces and buildings, as residents raised a number of issues with the walkability of their local areas. Engagement will continue throughout the life of the strategy to ensure our work remains informed by and involves our residents. The second priority area for year 1 has been identified with partners and already agreed as a priority for the

Buckinghamshire Health and Wellbeing Board (participating in society, to tackle social isolation and loneliness).

3.8. The actions taken to progress against these priorities will be recorded, monitored and reviewed via the strategy's action plan and associated metrics. As new priorities are agreed in future additional projects will be added to the action plan.

3.9. To support our age friendly approach, in March 2023 Buckinghamshire successfully joined the UK Network of Age Friendly Communities which is run by the Centre for Ageing Better and affiliated to the WHO's Global Network for Age Friendly Cities and Communities. Being a member of this network provides access to good practice, guidance and advice for our officers to support the successful delivery of a robust and evidence-informed age friendly approach. On reviewing our application, the Centre for Ageing Better complimented us on our draft Healthy Ageing Strategy, our political commitment with our Deputy Leader chairing the Partnership, and the allocation of public health resources to support the work programme.

4. Next steps and review

4.1. Following endorsement by the Joint Health and Wellbeing Board, the strategy will be promoted to partners and the strategy's action plan will be developed more as we work closely with our partners and communities.

4.2. Progress will be reported to the Health and Wellbeing Board on an annual basis.

5. Background papers

Appendix 1: Buckinghamshire Healthy Ageing Strategy 2024-29

World Health Organisation's Age Friendly Community framework

Buckinghamshire

HEALTHY AGEING STRATEGY

2024 - 2029

BUCKINGHAMSHIRE COUNCIL
est. 2020

FOREWORD

This strategy is our commitment to Buckinghamshire becoming more age friendly, which is a priority in the Buckinghamshire Joint Health and Wellbeing Strategy. This means Buckinghamshire will be a place where the natural and built environments plus the approach of our organisations support people to live healthy, fulfilling, and independent lives for as long as possible – to 'age well'.

The good news is Buckinghamshire residents generally live longer than the national average and stay in better health for longer too. But this good health is not spread evenly across the county. People living in our most deprived areas age faster and are diagnosed with a long-term condition on average 10 years earlier than in our least deprived areas. We want everyone to age well but ageing well doesn't only begin over the age of 65. Health in our middle age strongly influences our chances of staying well in our older years. People who have high blood pressure, are overweight or are physically inactive in mid-life have an increased risk of developing dementia or having a stroke later. Conversely adopting healthy behaviours can help people to maintain the capabilities that enable them to get the most out of life and do the things that they value. This strategy will therefore concentrate on those aged 40 and over to help give all our residents the best chance to age well.

This strategy has been produced by the Age Friendly Bucks Partnership – with representatives from across Buckinghamshire Council, the voluntary and community sector, and local NHS organisations. It has been informed by talking to our residents, which we will continue to do throughout the life of the strategy. We would like to thank everyone who helped to develop this strategy and who is keen to play their part in implementing it, most importantly our residents. Everyone has a role to play.

Please help us to implement this strategy and make Buckinghamshire a great place to age well.

Cllr Angela Macpherson
Chair, Age Friendly Bucks Partnership
Deputy Leader, Buckinghamshire Council
Cabinet Member for Health and Wellbeing

Dr Jane O'Grady
Director of Public Health and Community Safety

PURPOSE

Healthy ageing means living a healthy and fulfilling life, being able to participate in activities and contribute to communities, be financially secure and live in suitable homes in safe and thriving communities. With the right policies, environments and support, people can age well and live independent and meaningful lives.

The purpose of this strategy is to create a shared vision for how Buckinghamshire can be a better place for older residents to live healthy and active later lives now and in the future. This strategy and action plan is for everyone who has a role to play in supporting healthy ageing, including residents, communities, the NHS, voluntary sector, and Council.

The actions delivered by this strategy will be created with our residents for our residents. The involvement of older people will be central to the delivery of this strategy's aims and objectives.

For this strategy we are focussing on people who are 40 years of age or older – this includes important years where building healthy behaviours and actions can help residents to enter their older years with greater mental and physical resilience and have better health. Yet some of the actions we take to become more age friendly will also benefit younger people. For example, improving the physical accessibility of our outdoor spaces for those using walking aids will also support people with disabilities of all ages and parents using prams or buggies.

There are three central outcome measures for this strategy which are reported with the overarching Health and Wellbeing Strategy:

1. People over age 65 spending more years of life in good health.
2. More people over age 65 being in work (increasing towards pre-pandemic levels).
3. Fewer adults feeling lonely often or some of the time.

We recognise that these are broad outcome measures that will take time to turn around and also depend on factors outside of local control. Therefore, we will monitor the success of this strategy more closely through progress measures in our action plan.

BACKGROUND

Population projections suggest that over the next 20 years (2022-2042) the total population of Buckinghamshire will increase by 5% (26,132 more people). However, this net result reflects a much larger increase in older age groups, and a slight fall in younger age groups.

The population aged 65 years and over in Buckinghamshire is estimated to increase by 33% (34,944 more people) and the population aged 85 years and older to increase by 66% (10,884 more people) between 2022 and 2042 in Buckinghamshire.[1] This means that the next 20 years, those aged over 65 will increase from being 1 in 5 of our population (2022) to 1 in 4 of our population (2042) (Figure 1).

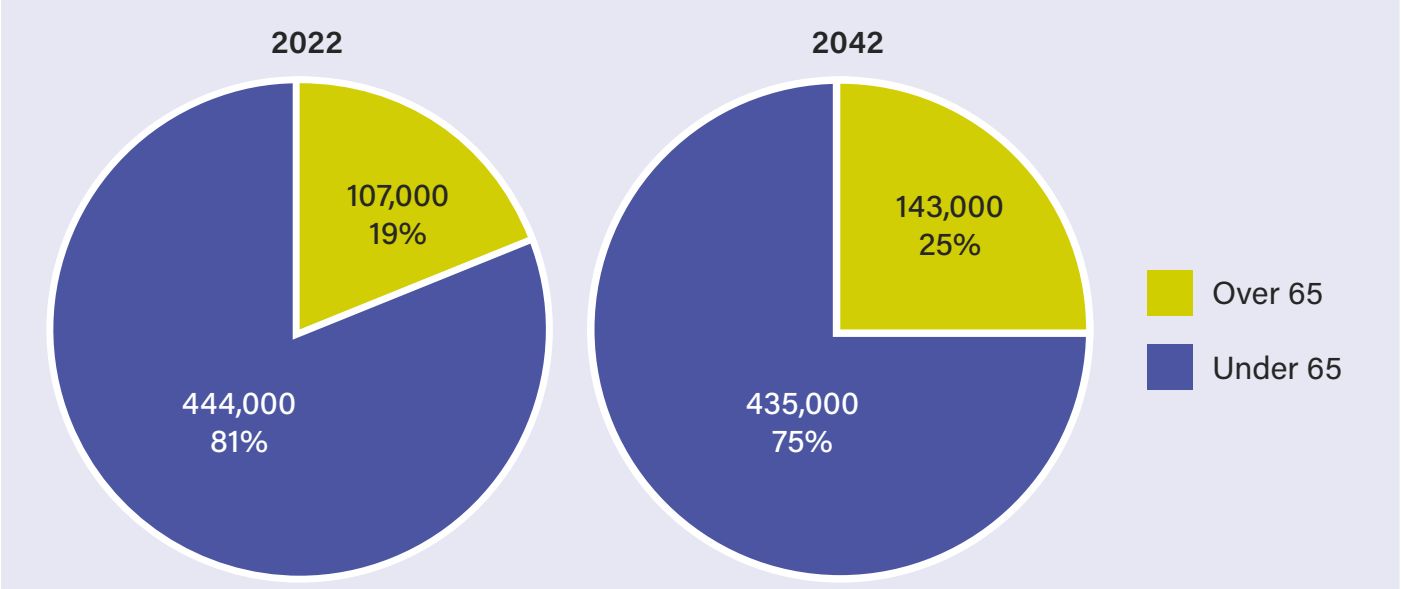


Figure 1: Buckinghamshire population projections, 2022 to 2042

The good news is that people are living longer and the increase in the older population brings economic and societal opportunities. Older workers are vital to public services – 3.4 million key workers are aged over 50.[2] The age group with the most volunteers is the 65-74 year age group.[3]

However, these opportunities are most likely to be realised if older adults remain well and independent. Over the past 10 years of data (from 2009-11 to 2018-20[4]) life expectancy (how long people being born might expect to live if current death rates don't change) has risen in both men and women in Buckinghamshire (Table 1). However, healthy life expectancy (the number of years people might expect to live in good health) has instead fallen over this time in men and remained static in women.[5] Therefore, the number of years of ill health has risen for both men and women in Buckinghamshire, and stands at over 15 years.

		Healthy life expectancy (years)	Total life expectancy (years)	Ill health (years)
Males	2009-11	67.6	80.4	12.8
	2018-20	66.8	81.5	14.7
Females	2009-11	68.6	84.2	15.6
	2018-20	68.6	85.1	16.5

Table 1: Life expectancy at birth in Buckinghamshire, 2009-11 to 2018-20[6]

Unfortunately, the data shows significant inequalities. Those living in more deprived areas have a lower life expectancy and experience more years spent in ill health (Figure 2). For women, life expectancy ranges from 80.1 in Aylesbury North West ward to 89.5 in Bernwood ward (covering Haddenham, Long Crendon and nearby villages) – a gap of 9.4 years. For men, life expectancy ranges from 77.3 in the Wycombe ward of Booker, Cressex and Castlefield to 84.4 in Gerrards Cross – a gap of 7.1 years.

Most of the data presented above does not include the Covid pandemic, or only includes its initial period. However, the pandemic has had a variety of negative effects which are likely to impact on older people in particular:

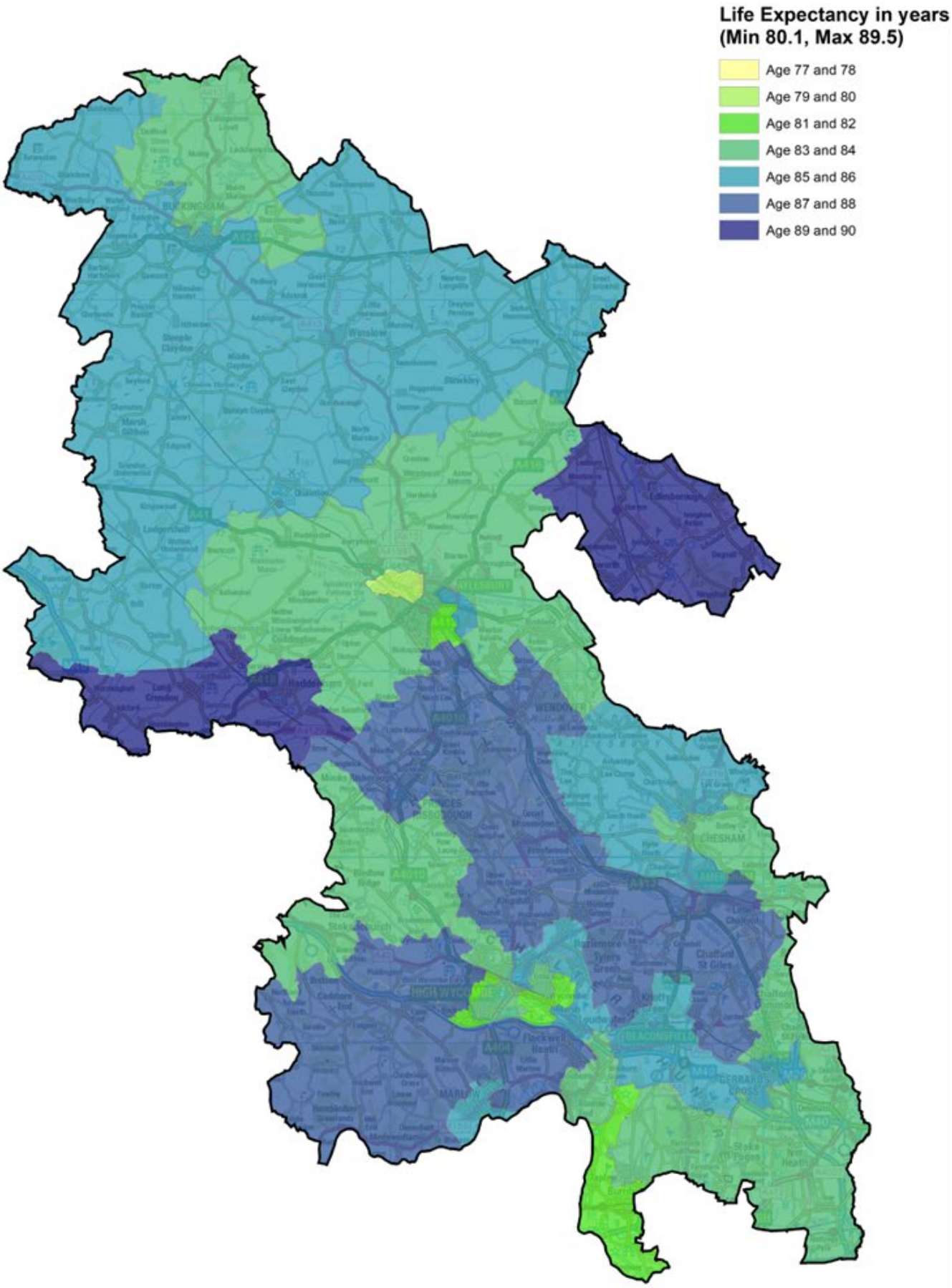
1. **Physical activity rates reduced**, with the average duration of strength and balance activity in England falling from 126 (2019) to 77 (2020) minutes per week. This type of activity is essential to reduce the risk of falls, support mobility, and retain independence. The proportion of people being inactive worsened with more people doing no activity or less than 30 minutes of moderate intensity physical activity per week (32% inactive in 2020 compared to 27% inactive in the previous year).[7]

2. **Loneliness has increased**, from 18% reporting feeling lonely sometimes or often in Buckinghamshire in 2019/20 to 24% in 2020/21.[8] This is on a background of rising one-person households across the South East – projected to rise from 46% to 55% of over 65s living alone over the next 20 years.[9]

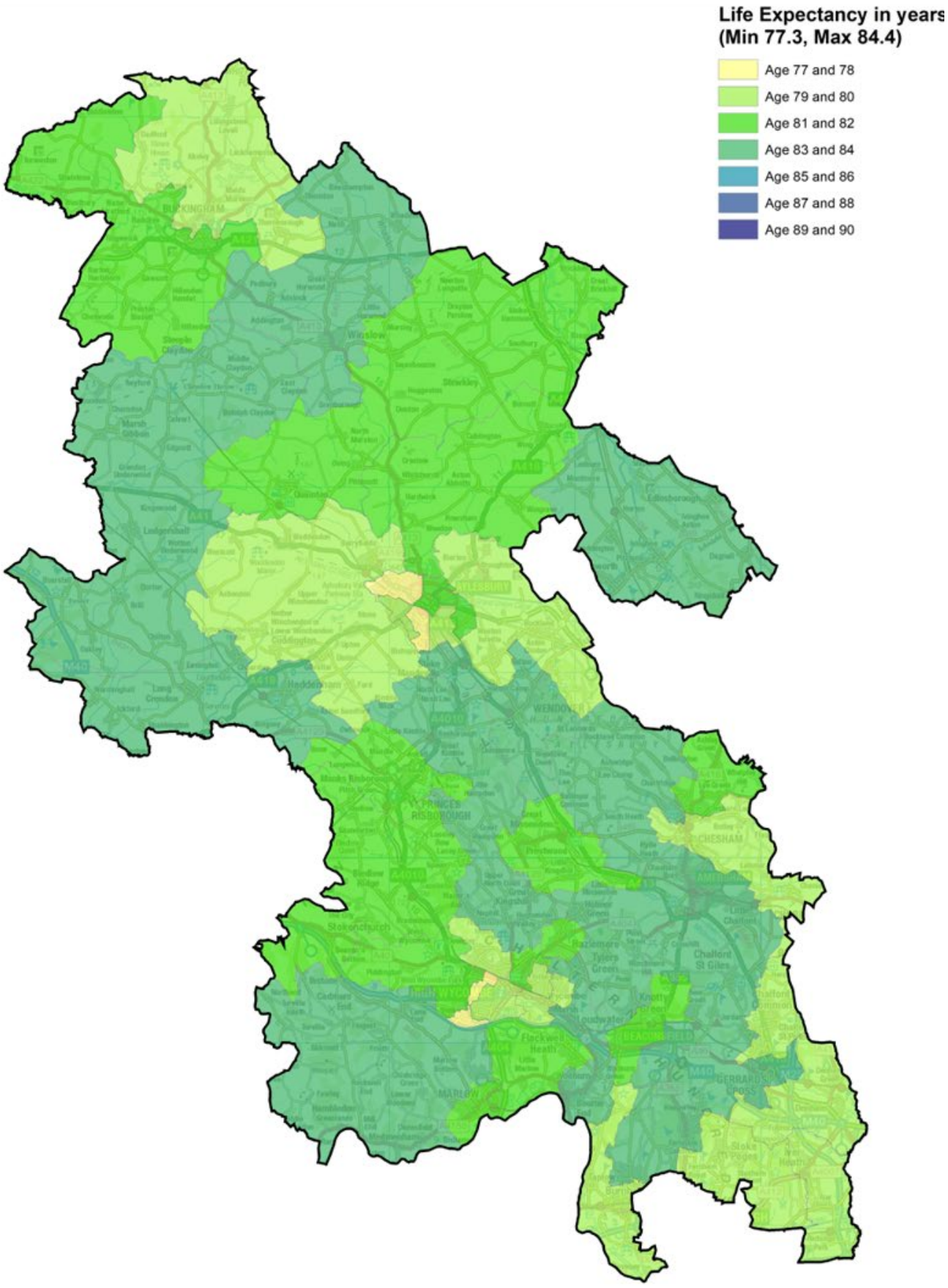
3. **Employment of older adults has fallen**. The proportion of people aged 65 and over who were in employment has fallen from an average of 16% in the two years pre-Covid to 13% in 2021/22.[10]

Figure 2: Life expectancy at birth across Buckinghamshire by gender, 2016-20[11]

Female life expectancy (at birth), 2016-20, by wards in Buckinghamshire



Male life expectancy (at birth), 2016-20, by wards in Buckinghamshire



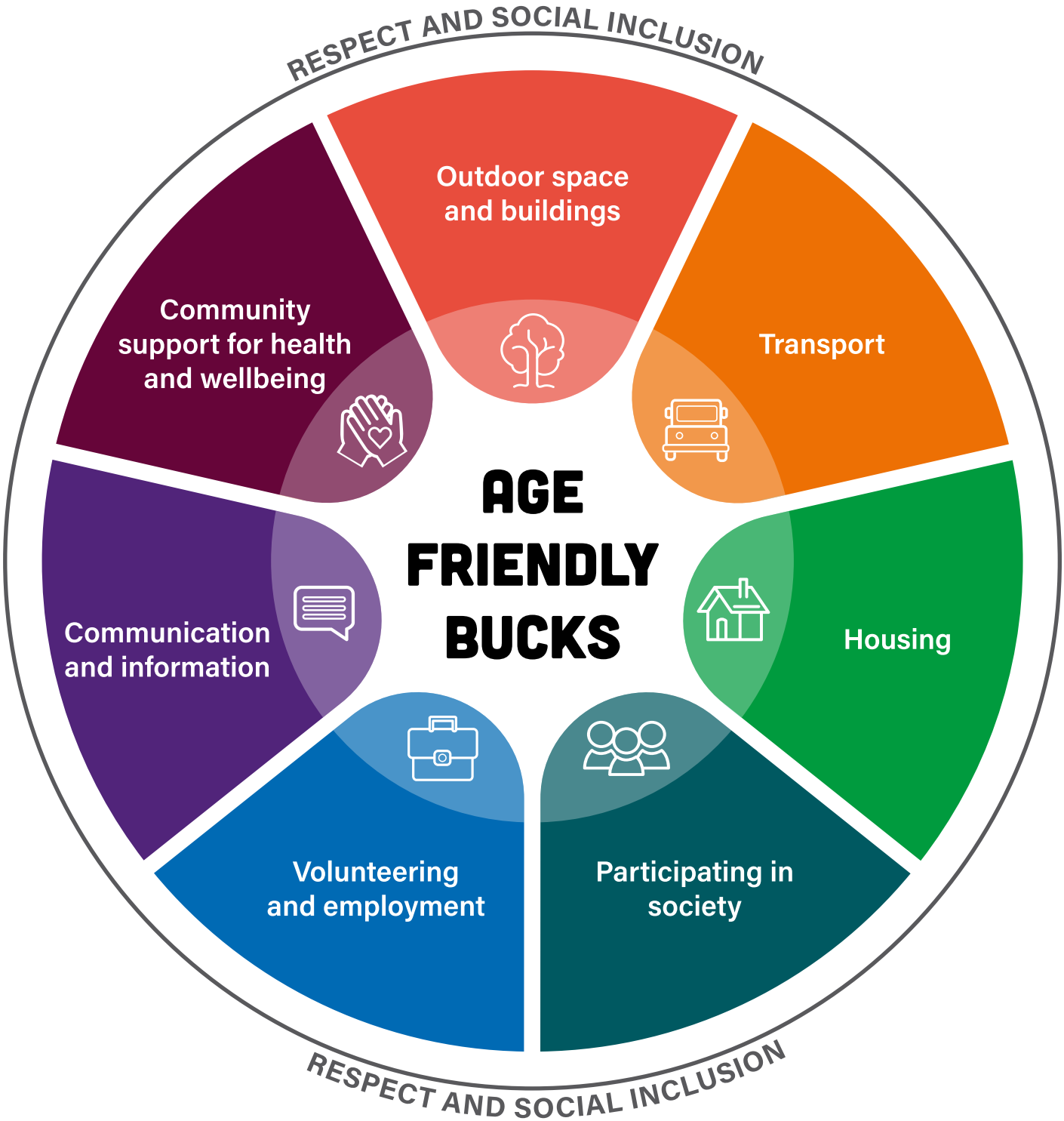
BECOMING MORE AGE FRIENDLY

Age friendly Buckinghamshire is based on the World Health Organization's evidence-based framework of the eight domains that support older people to live healthy and active lives.[12]

The eight domains are interconnected. For example, if people can travel, they can participate in social activities and connect more with friends and family, reducing isolation.

In Buckinghamshire, we will use seven of the domains as our key themes, with the eighth domain of respect and social inclusion running as a golden thread throughout our work (Figure 3)

Figure 3: Age friendly Buckinghamshire



Our aims across the age friendly Buckinghamshire themes:

Outdoor spaces and buildings

We will create high quality, accessible and social public spaces which are safe and help people to move around independently.
e.g. access to local and welcoming warm spaces.

Transport

We will promote accessible, affordable and appropriate travel options allowing people to access services they need.
e.g. age friendly active travel schemes.

Housing

We will support the improvement and development of accommodation for people to live safely and comfortably, and which can improve physical and mental health, wellbeing, and social connections.
e.g. age well design codes used in new build properties.

Participating in society

We will reduce and remove barriers to participation to foster engagement with activities and events which build a sense of belonging.
e.g. access to toilets so people feel confident and able to leave home and engage in activities.

Volunteering and employment

We will explore how to support older adults to continue in or re-enter employment in the face of falling older adult employment rates, as well as how to facilitate volunteering.
e.g. healthy retirement planning.[13]

Communication and information

We will build positive and accessible communications and campaigns, and challenge negative stereotypes and stigma.
e.g. local inclusive communications plan.

Community support for health and wellbeing

We will strengthen the health and wellbeing of communities and support the network of community-based groups.
e.g. libraries acting as a health and wellbeing hub in local communities.

Respect and social inclusion

All age friendly activities across our seven themes must support people from all backgrounds to age well, with respect and dignity.

AREAS FOR ACTION

Given the breadth of this work, to make progress achievable we will prioritise domains in turn rather than tackle all simultaneously.

To inform our prioritisation, and better understand the types of action that might best enable people to age well, we will be talking with residents and communities to hear their views throughout the life of the strategy.

This will concentrate on four key questions which all ask for free text responses to enable an unfiltered insight into residents' views:

1. What would make where you live a great place to age well?
2. What do you think your area does well to support people to age well?
3. What are the challenges to ageing well where you live?
4. What do you think would meet these challenges/better support people to age well?

An initial survey in summer 2023 received 228 responses. Responses were received from adults aged 40 to over 85, with 61-65 year olds the average age group.[14] Four in ten respondents reported that they had a disability, impairment and/or long term health condition. Based on participants' postcodes, six in ten respondents were from rural areas and four in ten were from urban areas (predominantly Aylesbury, High Wycombe and Chesham and therefore closely overlapping with our Opportunity Bucks areas).

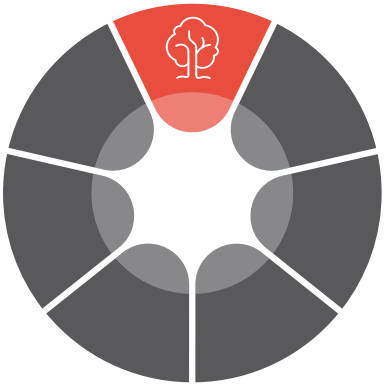
Urban and rural participants raised different themes when responding to their local challenges to ageing well. Urban residents concentrated on outdoor spaces and buildings – with accessibility for walking and wheeling being the most important challenge at over 40% of the responses in this theme. Rural residents were concerned with transportation – chiefly bus availability.

These findings mirror age friendly engagement across the country – in both small and large settings. Banbury, Oxfordshire, reported their most commonly raised themes to be community outdoor spaces, particularly pavement condition, followed by transportation.[15] Age friendly Wales has made ensuring the natural and built environment is safe and age friendly their top priority, with a focus on reducing pavement parking.[16] Research has found that people over the age of 60 represent 20% of the UK population, but only 8% of pedestrian activity, while accounting for 42% of pedestrian fatalities – with the maintenance of pavements, appropriateness of crossing facilities and state of road lighting cited as contributors.[17]

In the first year (2024) we will concentrate on two themes:

Participating in society

To tackle social isolation and loneliness which have been raised by local organisations working with older people and follows national recognition of an increase in the risk factors for loneliness among older people since the COVID-19 pandemic.[18] Social isolation has therefore already been agreed as a priority for the Buckinghamshire Health and Wellbeing Board.[19]



Outdoor spaces and buildings

Raised as the top concern for urban residents where we know life expectancy and healthy life expectancy is lower in our county. This theme is fundamental in enabling people to participate in society through the access to local amenities and community venues and the use of green spaces.[20]

In later years the focus will shift to remaining themes, starting with transportation in year two (2025) as the top current concern for rural residents. Throughout the course of the strategy all areas will be addressed, but their order will be influenced by emerging issues and the changing priorities of our residents and partners.

We know that there is lots of good work already underway by a wide variety of stakeholders. This strategy will seek to build on and enhance this work, rather than duplicate it, when co-creating new actions with residents and partners. During our initial consultation survey there were reports of positive work across all themes, and it is important that we recognise these achievements.

IMPLEMENTATION AND MONITORING

An action plan will underpin the strategy – capturing work and monitoring progress across all themes. The action plan will be reviewed quarterly and amended annually to reflect new priorities and opportunities. As new themes are tackled and projects are agreed extra progress measures will be added to our action plan.

An Age Friendly Bucks Partnership has been established to oversee the development and delivery of the strategy and support a system wide approach to delivery. It will form an umbrella for age friendly work – informed by several topic-specific strategies and groups (such as the Live Longer Better Alliance and the Physical Activity Strategy) already working to improve healthy ageing in Buckinghamshire. The Partnership will ensure emerging issues do not fall between the cracks. Membership includes senior representatives from partners including the Council, NHS, and voluntary sector, and it is chaired by the Cabinet Member for Health and Wellbeing who is also Deputy Leader of Buckinghamshire Council. This Partnership will report progress into the Buckinghamshire Health and Wellbeing Board annually.

A wider network of stakeholders, including residents, will also be established. This network will inform the priorities with insight and experience and will work together to create activities across our priority themes.

REFERENCES

[1] These projections use 2018-based estimations – the latest produced at a local authority level by the Office for National Statistics. They therefore do not include the direct impacts of the COVID pandemic, nor any changes to demographic behaviour since the pandemic.

[2] Office for National Statistics, 2020

[3] Department for Culture, Media and Sport, 2020

[4] This data includes 2020 so covers the early COVID-19 pandemic. Given the high number of excess deaths due to COVID-19, life expectancy fell in 2020 across the county.

[5] Productive Healthy Ageing Profile - Data - OHID (phe.org.uk)

[6] Buckinghamshire Health and Wellbeing Profile

[7] Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults

[8] Sport England - Active Lives

[9] Local authority ageing statistics, household projections for older people - Office for National Statistics

[10] Nomis

[11] Local Health - Office for Health Improvement and Disparities - Indicators: maps, data and charts

[12] The WHO Age-friendly Cities Framework

[13] Retirement planning can include helping people to reduce their hours and change careers which may enable them to stay working for longer, as well as facilitating a smoother and healthier transition into retirement.

[14] Six responses were received by adults aged 30-40, however the comments they submitted were in alignment with the other 222 responses received and so were included in the analysis.

[15] Age Friendly Banbury Consultation

[16] Age friendly Wales: our strategy for an ageing society

[17] Musselwhite, C & Haddad, H: Older people's travel and mobility needs. A reflection of a hierarchical model 10 years on. Quality in Ageing and Older Adults, 19(2), 87-105.

[18] Age UK, 2021 - Loneliness and Covid-19

[19] The Health and Wellbeing Board brings together partners from across a range of local organisations to understand and improve the health and wellbeing needs of the Buckinghamshire population, and encourage services to work in a more joined up way.

[20] Inclusive Design for Getting Outdoors: Research Findings

Priority 1 – Age Well

Improving places and supporting communities to promote healthy ageing

What are we going to do in Buckinghamshire?

- The new Healthy Ageing Strategy and action plan set out how we will make Buckinghamshire more age friendly. This includes:
  - creating high quality safe public spaces which everyone can use and which help people to move around independently.
  - reducing and removing barriers which prevent people from getting involved in activities and events that build a sense of belonging.
  - using positive communications and campaigns that everyone can understand and which challenge negative stereotypes and stigma.

How will we know it's working?

Older people spend more years of life in good health

More older people are in work (increasing towards pre-pandemic levels)

Fewer older people feel lonely

Buckinghamshire is a place where the environment and local organisations help people to live healthy and independent lives

Some examples of how we will do this:

- Improve accessibility for walking and wheeling, through the pavement maintenance programme and reporting defects using Fix My Street
- Develop a 'Welcome In' scheme to increase public seating and toilet facilities
- Adopt the Age Friendly Employer Pledge so more employers have age friendly employment practices

SPOTLIGHT – Some examples of what we are already doing in Buckinghamshire

- ❖ We have joined the UK network of Age Friendly Communities, to improve our age friendly work
- ❖ We are working with Age UK Bucks to make Buckinghamshire more age friendly
- ❖ We are talking with our residents to understand what will help people to age well in Buckinghamshire

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Health & Wellbeing Board Buckinghamshire

Review of Healthy Lifestyle Indicators

Date: 21st March 2024

Author/Lead Contacts: Tiffany Burch, Consultant in Public Health / Sally Hone, Principal in Public Health

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

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

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

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

1. Purpose of report

1.1. This report provides a review of the healthy lifestyle indicators within the Joint Local Health and Wellbeing Strategy. The report provides an update against indicators linked to:

- Reducing the prevalence of obesity in children and young people
- Reducing the prevalence of obesity in adults
- Reducing the rate of cardiovascular disease
- Increasing the physical activity of older adults

2. Recommendation to the Health and Wellbeing Board

2.1. The Health and Wellbeing Board is asked to note progress against the defined indicators.

3. Content of report

3.1. Reducing the prevalence of obesity in children and young people

3.1.1. The prevalence of obesity in children and young people is monitored through the National Child Measurement Programme (NCMP) whereby children in Reception and Year 6 are routinely measured.

3.1.2. The 2022/23 academic year data for Reception has shown a slight increase in the number of children classified as overweight or obese from 18.2% to 18.5%. However, looking further into the data it shows a reduction from 8.3% to 7.1% for those classified as obese.

3.1.3. Year 6 2022/23 academic year data indicates a reduction in the percentage of children classified as overweight or obese in line with the targets. As has been shown in the Reception age data, the percentage of Year 6 children classified as obese has also reduced from 18% to 17.1%.

3.1.4. Children measured as part of the NCMP receive parental feedback letters, those identified as overweight or obese are signposted to the child weight management service delivered as part of the Buckinghamshire's healthy lifestyle service. During 2022/23 110 children accessed the programme against a service target of 100 children, with 92% completing the 12-week programme. 87% of children completing the programme either maintained or reduced their BMI Z score against a service target of 80%. The target of 150 relates to the new lifestyle service which commenced the 1st April 2023, full year data for 2023/24 is not available yet.

3.1.5. Healthy Start is a food assistance programme for low-income families, providing financial support to eligible parents and pregnant women for healthy food and milk. Since January 2023 the uptake by eligible residents across Buckinghamshire has increased. As of February 2024, 70% of the eligible population in Buckinghamshire were accessing the scheme.

Indicator	Baseline	Target	Actual
Percentage of children in Reception who are overweight and obese	18.2%	18%	18.5%
Percentage of children in Year 6 who are overweight and obese	31.5%	31%	31%
Percentage of eligible families accessing the Healthy Start scheme	56%	65%	70%
Number of children accessing weight management services	100	150	110

NB: Target for number of children accessing weight management services relates to 23/24 service provision – data not available until April 2024.

3.2. Reducing the prevalence of obesity in adults

3.2.1. The percentage of adults classified as overweight or obese in Buckinghamshire has reduced from 61% (2020/21) to 60% (2021/22). Likewise the percentage of adults classified as obese in Buckinghamshire has also reduced from 21.4% (2020/21) to 20.5% (2021/22).

3.2.2. Adult weight management services within Buckinghamshire are commissioned by Buckinghamshire Council, the Integrated Care Board and Buckinghamshire Healthcare Trust and delivered by a number of different providers. During 2022/23, 2974 people accessed weight management programmes across Buckinghamshire.

3.2.3. The Chief Medical Officer recommendation that adults undertake a minimum of 150 minutes (2.5 hours) of moderate physical activity per week, or 75 minutes of vigorous physical activity per week or an equivalent combination of the two, in bouts of 10 minutes or more. The percentage of adults (19 years+) meeting these levels has increased in Buckinghamshire. In 2020/21 71.9% of adults met the recommendations, that percentage has increased to 73.2%, 2021/22.

Indicator	Baseline	Target	Actual
Percentage of adults classified as overweight or obese	61%	61%	60%
Number of adults accessing weight management services per year	2660	3500	2974
Percentage of adults meeting recommended physical activity levels	71.9%	73%	73.2%

3.3. Increasing the physical activity levels of older people

3.3.1. This indicator reflects unique leisure centre users 65+ and over, focusing on those that have a membership of some description at one of our leisure centres. The previous figures on the Moving Communities database in Dec 2023 showed a figure for this category of 5,843 for the period April 2021- March 2022. As we have moved through 2023 into far more positive public re-engagement with leisure and physical activity from older residents, we are seeing the numbers increasing. We are also working with our Leisure Operators to consider how we could include the regular participants that have returned to the Indoor Bowls Centre at Wycombe – which are not currently included in any returns as this is run by the Club itself.

3.3.2. Educating health professionals to be able to provide physical activity advice to older age clients is required to increase the number of older adults regularly active and meeting the recommended activity levels. Being active is important for both our physical and mental wellbeing, reducing the risk of heart disease, type 2 diabetes, depression, anxiety and many other conditions. Over 2022/23, 104 health professionals attended Active Medicine training aimed at enhancing the skills of health professionals to enable them to keep fit and live healthier for longer.

3.3.3. Poor muscle strength in older adults increases the risk of falls and those who have already had a fall are three times more likely to fall again. Strengthening and balance activities help to improve this alongside improved mood, sleep patterns, increased energy levels and reduced risk of an early death. Data for 2021/22 is not available for Buckinghamshire, although previous figures indicated that 47.2% of adults are achieving the recommended twice a week of muscle strengthening exercises. Looking at data specifically related to older adults (65 years +), 38.1% achieved the recommended levels in 2020/21 (2021/22 data not available).

Indicator	Baseline	Target	Actual
Return usage numbers of local leisure centres by people aged 65+ to pre-pandemic levels	13,975	14,000	10,040
Number of health professionals trained to provide physical activity advice to older age residents	88	100	104
Percentage of adults (16 years +) achieving 2 or more sessions of muscle strength exercises per week	47.2%	50%	No update available

3.4. Reduce the rates of cardiovascular disease

3.4.1. The proportion of all NHS Health Checks delivered in the two most deprived quintiles allows us to monitor inequalities in access to the CVD prevention checks for residents aged 40-74 (certain exclusions apply). Additional clinical support is being provided to the 4 more deprived primary care networks to enable more NHS Health Checks to be conducted as well as more smoking cessation referrals for higher risk residents.

3.4.2. In addition to practices taking more blood pressures 'in house', there are a variety of programmes in Buckinghamshire to support residents to check their blood pressure. Local pharmacies provide blood pressure checks for adults aged 40+ and those referred from their GPs. There are health kiosks that can check blood pressure (amongst other health metrics) in Aylesbury, High Wycombe and Burnham libraries and in Health on the High Street in Friars Square Shopping Centre. Libraries across the county also provide blood pressure monitors for residents to 'check out' and use in the comfort of their homes. A range of faith and community groups are part of the Pump It Up initiative to get residents age 18+ checking their blood pressure more regularly. All the community kiosks and venues ask people to share their blood pressure readings with their GP surgery for recording on their clinical record. The acute trust is also exploring ways to share blood pressure readings taken within their clinics with general practice.

3.4.3. In addition to getting people to check their blood pressure, it is important that residents who have been identified as having hypertension (high blood pressure) are clinically managed and 'treated to target'. This means patients who have hypertension and are younger than 80 maintain their blood pressure reading at 140/90 mmHg or lower. Primary care networks across

the county have been working on quality improvement projects for cardiovascular disease; many of these were focused on improving hypertension management. These 'CVD Champions' will be doing another round of quality improvement projects on blood pressure and lipid management in the next financial year.

3.4.4. For 2023 of those patients who accepted treatment at 28 day follow up 36.8% had quit. 9.9% had deceased, 22.8% remained smoking and 30.4% were unable to be contacted. In order to try and reduced the number of people who are unable to be contacted Buckinghamshire Healthcare NHS Foundation Trust now has an agreement with Be Healthy Bucks (the stop smoking service) to receive quit data and BHT are also exploring other methods to quickly obtain quit data from patients e.g. text messaging. For maternity patients, patients remain under the care of a midwife throughout their pregnancy. The tobacco dependency advisors for maternity stay with the patient the entire pregnancy. For this group, we know the quit rate is 40%.

Indicator	Baseline	Target	Actual
% of all NHS Health Checks delivered that were for residents in DQ4 and 5	27.6% (2021/22)	40% (proportion these 2 quintiles constitute of Bucks population)	38.8% (23/24 up to Q3)
Proportion of patients (15+) who have had their blood pressure checked in the last year in the 4 most deprived Primary Care Networks	30.4% (2021/22)	39% (Bucks %)	38.5% (23/24 up to Q3)
Proportion of patients aged <80 years with hypertension whose last blood pressure reading (in the last 12 months) was <= 140/90 mmHg for the 4 most deprived Primary Care Networks (PCN)	53.2% (2021/22)	65.7% (England %)	67.5% (23/24 up to Q3)
% of eligible patients who were referred to NHS inhouse tobacco dependency services who later successfully quit smoking (4 week quit)	NA	35% (based on NICE standard smoking cessation services)	40% for maternity. 36.8% for acute inpatients

4. Next steps and review

4.1. Following review and feedback from the Health and Wellbeing Board, monitoring of the above indicators will continue. Services will be continuously reviewed and monitored to ensure meeting the needs of the residents of Buckinghamshire.

5. Background papers

5.1. None

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Health & Wellbeing Board Buckinghamshire

Buckinghamshire Urgent and Emergency Care Winter Evaluation 2023/24

Date: 21st March 2024

Author/Lead Contacts: Caroline Capell, Director of Urgent and Emergency Care, NHS BOB ICB

Report Sponsor: Philippa Baker, Buckinghamshire Place Director

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 In September 2023 the Health and Wellbeing Board was presented with the Buckinghamshire Urgent and Emergency Care (UEC) Winter Plan, developed across partners to provide a comprehensive response to health and care pressures in the system and ensure the best quality care for our patients and residents during this period. It was built on work that had been done through the year on Urgent and Emergency Care Improvement, national guidance and learning from last year.

2. Recommendation to the Health and Wellbeing Board

2.1. The Health and Wellbeing Board is asked to note the content of this report and acknowledge the system collaboration to support this winter period.

3. Content of report

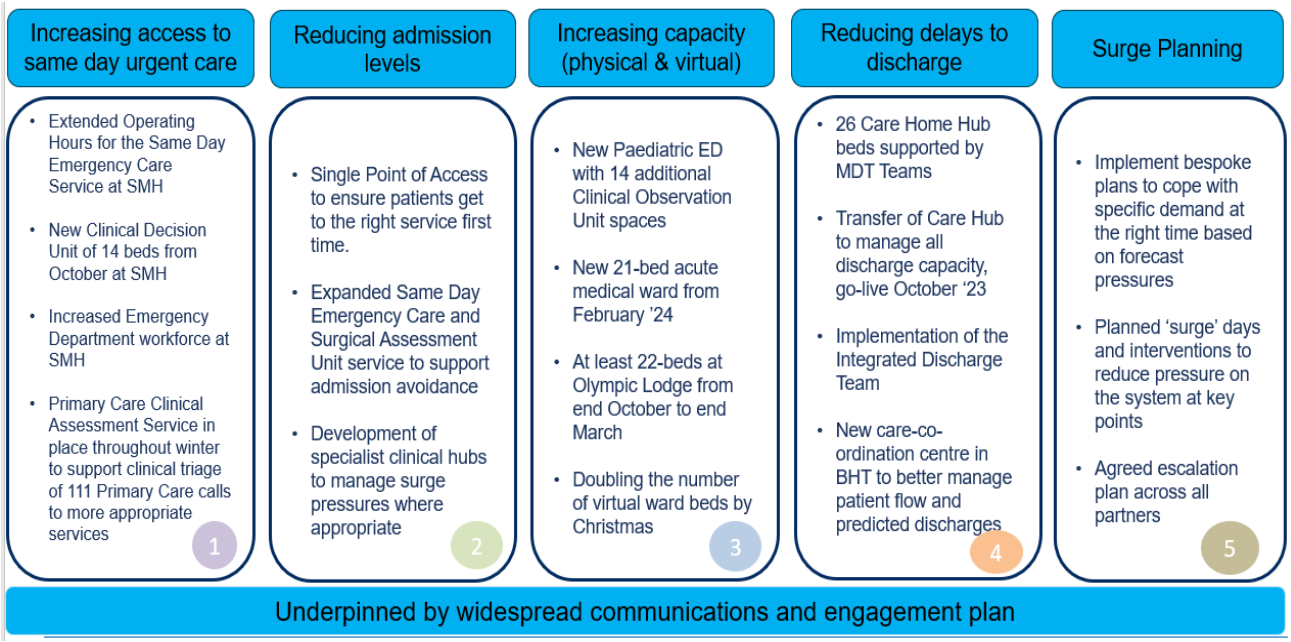
3.1 Winter Planning

The Buckinghamshire UEC System Winter Plan for 2023 / 24 was developed and approved with all system partners across Buckinghamshire. Key Buckinghamshire partners also contributed to a separate Frimley Winter Plan. For 2023 / 24 the winter period was defined as Monday 30th October 2023 to Sunday 7th April 2024, recognising the higher demand periods were historically between the months of December to February.

The Buckinghamshire UEC System Winter Plan aimed to define how the Buckinghamshire System would manage demands through the winter period, and covered the whole population of Buckinghamshire, including all ages and all conditions, who would have a direct impact on the Buckinghamshire System.

The Buckinghamshire Winter Plan was treated as a high-level, iterative plan to support the Buckinghamshire Health and Social Care System across Winter 2023/24 recognising that there were also detailed local winter plans in place at provider level.

The Buckinghamshire Winter Plan was broken down into five key challenges and how we wanted to address them as a system:



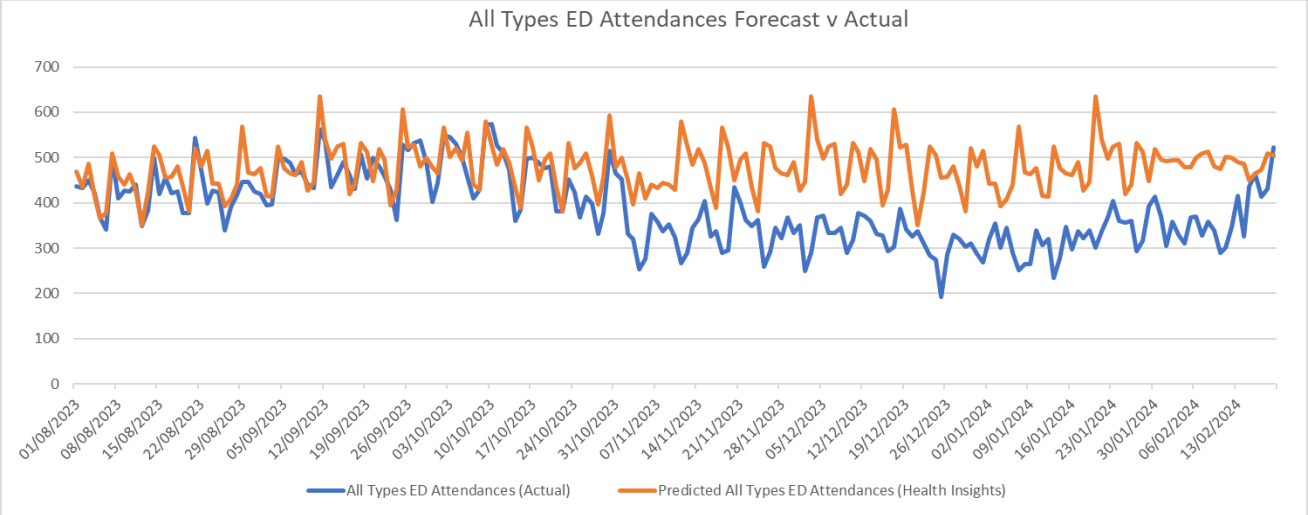
To help provide assurance to partners and the wider system throughout the winter period, a weekly tracker was circulated with a 'Key Message of the Week' highlighting any specific likely impact such as Industrial Action or anticipated surges.

The next sections highlight the winter plan impact in further detail.

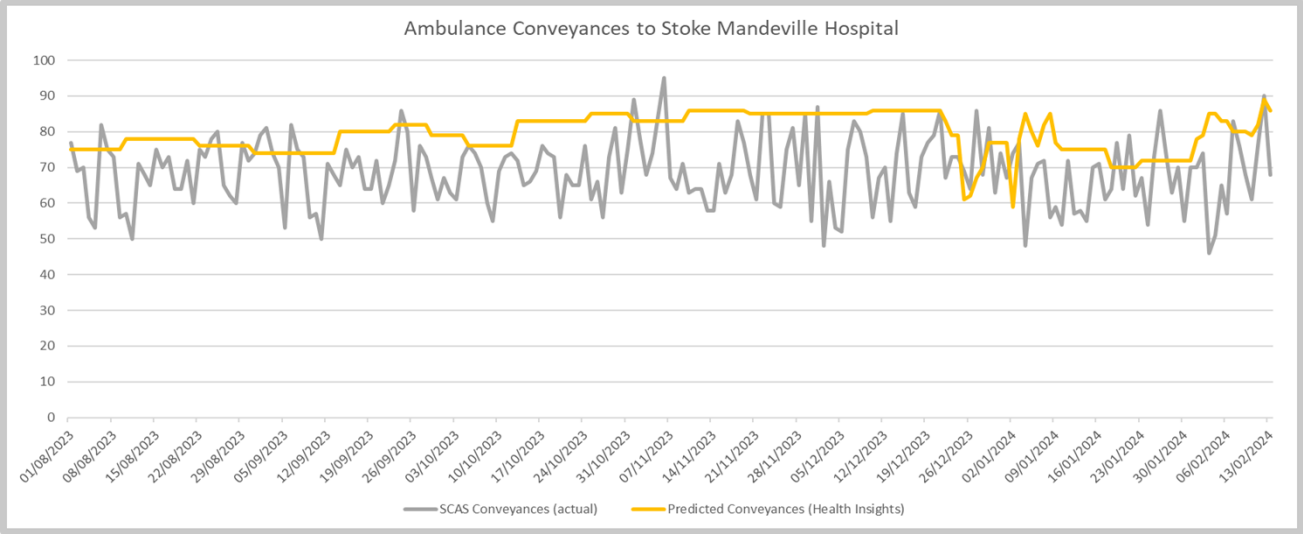
3.2 Winter Activity – Emergency Care and Ambulance Conveyances

During the winter period this year, Buckinghamshire has been able to forecast the likely winter demand in our Emergency Departments and for ambulance conveyances into Stoke Mandeville Hospital. We mapped this and monitored it against actuals. The graphs below highlight the actual and predicted for the Emergency Dept and for the Ambulance conveyances into Stoke Mandeville Hospital:

Graph 1: All Types ED attendances at Stoke Mandeville Hospital, this includes Type 1 attendances (Emergency Dept) and Type 3 attendances (Urgent Treatment Centre) combined



Graph 2: Predicted SCAS ambulance conveyances to Stoke Mandeville Hospital compared to actual numbers.

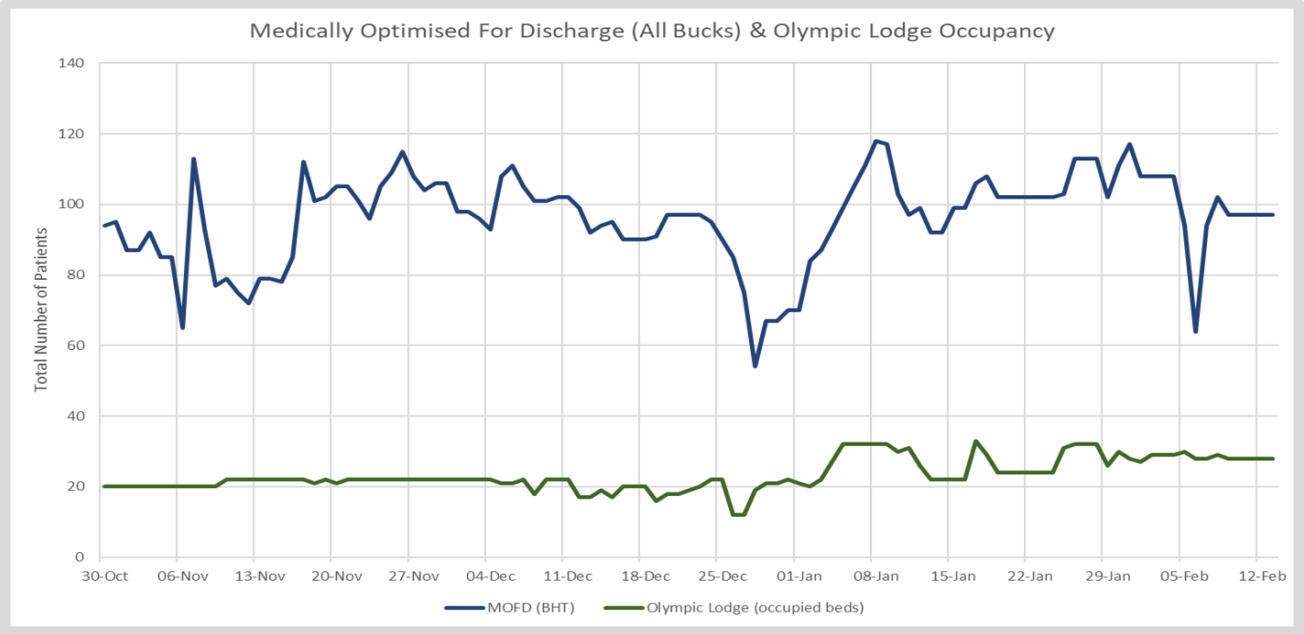


3.3 Winter Activity – Discharges

During the winter period, the Buckinghamshire system monitors the number of patients in an acute bed at Stoke Mandeville Hospital and who are 'medically optimised for discharge' (those who can go home, but require further support to enable this to happen). This includes patients who may need to go to a nursing home, need domiciliary care, or further care interventions.

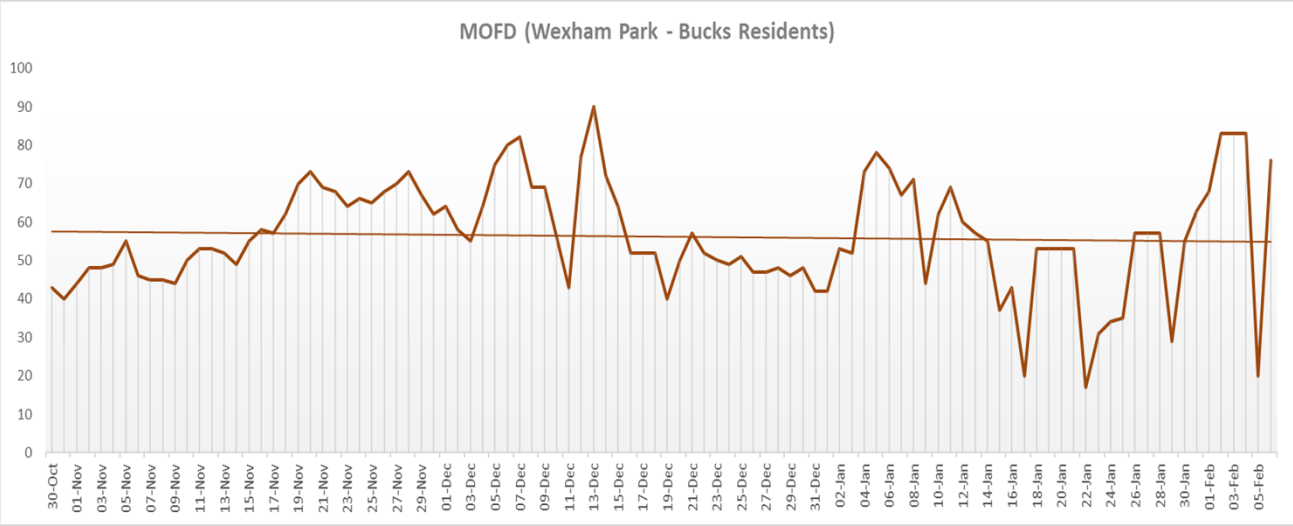
Graph 3 below highlights the number of patients who were medically optimised for discharge. The Bucks system also funded additional beds in Olympic Lodge to help reduce this pressure and to provide additional capacity. This occupancy is also highlighted in the graph below:

Graph 3: Stoke Mandeville Hospital medically optimised for discharge and Olympic Lodge occupied beds.



Graph 4 below highlights the numbers of Buckinghamshire patients medically optimised for discharge who were occupying beds in Wexham Park Hospital.

Graph 4: Buckinghamshire patients occupying beds in Wexham Park who are Medically Optimised for discharge



3.4 Winter Planning

The table below highlights the actions agreed as the Buckinghamshire UEC system to support the winter period:

Action	Description	Progress
Extend Same Day Emergency Care (SDEC) Operating hours at Stoke Mandeville Hospital	To extend the operating hours of Adult SDEC from 0800 to 2000 at Stoke Mandeville Hospital. The operating hours increased with effect from July 2023 with the new hours of 0800 to midnight.	Complete
Clinical Decision Unit (CDU) at Stoke Mandeville Hospital to be opened	To open an additional 14 beds in a CDU. These beds enable flow in ED and provide a bedded area for patients SDEC patients that require an overnight stay. This service opened in October 2023.	Complete
Emergency Dept Workforce Increase	To increase the workforce in the Emergency Dept at Stoke Mandeville Hospital and take steps to reduce vacancy rate.	Complete
Clinical Assessment Service operational	hours primary care dispositions and will take the calls and triage them prior to being booked into a GP practice. This service continued from 2023 as an ongoing service to support practice capacity and demand from 111.	Complete
Single Point of Access (SPA) live	Single Point of Access has gone live in November 2023 to support healthcare professionals to enable redirection and signposting of referrals to the most appropriate BHT services via the Community Care Co-ordination Team (CCCT).	Complete
Development of Clinical Hubs	Launch of specialty hubs to cope with seasonal demand. Now likely to be delayed until Spring 2024.	
Olympic Lodge Opening	Opened 23rd October. 22 beds to support delayed transfer of care cases and help increase escalation capacity. Extra capacity increased to 30 beds 12.02.24	Complete
Health on the High Street Hub	Opened in October, providing walk-in Health & Wellbeing advice as well as signposting for members of the public - Unit 33 located in the Friar's Square Shopping Centre, Aylesbury.	Complete
Frailty Line link to Immedicare	Work ongoing to connect services via Consultant Connect, allowing the Immedicare service helping care homes to access Frailty consultants in the hospital to support attendance avoidance from care homes.	Complete
Paediatric Clinical Observation Unit	Additional 14 beds in Paediatric Emergency Dept at Stoke Mandeville Hospital.	Complete
Acute Medical Ward	Additional 20-bedded ward at Stoke Mandeville Hospital due Spring 2024	
Increase Virtual Ward Capacity	Total of 150 beds by March 2024.	
Care Home Hubs	We have 21 care home hub beds to support system flow in Buckinghamshire spread across 3 homes to provide county-wide access.	Complete
Transfer of Care Hub	Launched on the 23rd October, supporting a system integrated approach to discharges across Bucks.	Complete
Integrated Discharge Team	Launched in June 2023, providing a joined up approach to discharge planning between Bucks Adult Social Care and BHT Discharge Team. Co-located in the Hartwell Building at Stoke Mandeville. Completed 12.02.24	Complete
Care Co-ordination Centre in BHT	Control room setup off corridor J at Stoke Mandeville Hospital, with IT infrastructure now in place to support the integrated working.	Complete
Bucks Directory Service Webpage	Specific website for Bucks providers focusing on services that are available across Bucks. Delayed to March 2024.	
UEC Winter Message of the week	Set up and distribute message of the week to Bucks System.	Complete

3.5 Winter System Survey

As part of our system winter evaluation, we conducted a partner survey based on our original plan and aims. The following questions were asked with the results of the survey highlighted below:

1. How have you found the pressures of this winter compared to last winter?
2. What areas do you think were the most challenging across this winter?
3. What do you think will need to happen to improve next winter?
4. Do you think the additional care home hub intervention helped manage demands across Buckinghamshire this winter?
5. Do you think the Olympic Lodge intervention helped manage demands across Buckinghamshire this winter?
6. Do you think the Clinical Assessment Service intervention helped manage demands across Buckinghamshire this winter?
7. Do you think the Consultant Connect lines (Frailty / SDEC etc) helped manage demands across Buckinghamshire this winter?
8. Do you think receiving the Winter tracker weekly helped keep track of winter?

The following highlights the results of the above questions received from our System partners:

1. How have you found the pressures this winter compared to last winter?

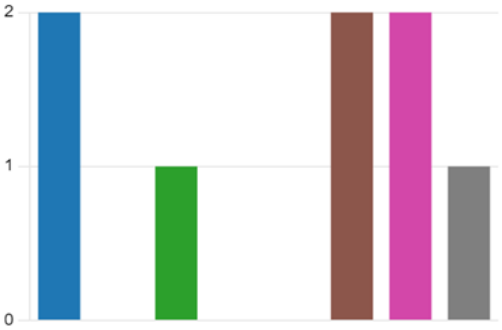
More Details

Worse	2
Better	6
Same	0

2. Which areas do you believe were the most challenging across this winter?

More Details

Acute	2
Social Care	0
Discharges	1
Community	0
Mental Health	0
Primary Care	2
Ambulance	2
111	1

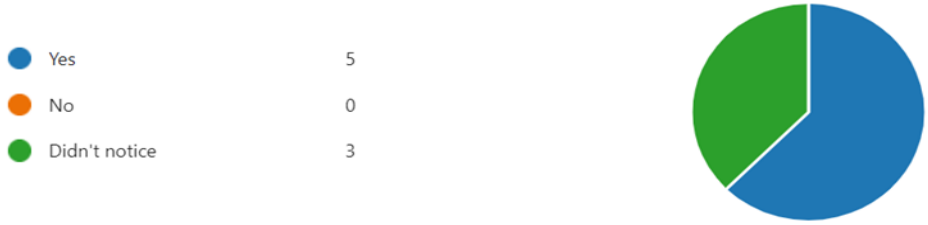


3. What do you think will need to happen to improve next winter?

1	Additional hot-clinics/ambulatory care pathways for seasonal illnesses/conditions
2	Identification of resource requirements earlier - prewinter and ensuring the resources are in place
3	Better system awareness, escalation management and response to prevent silo working and missing the impact of other services on the system as a whole.
4	Strengthen Admission Avoidance pathways. More mental health support for CAMHS and adults
5	Improve links between UCR and Emergency Floor - Link with SCAS re: HALO - Earlier opening of areas such as Olympic Lodge - Space for mental health patients awaiting assessment and more robust response times and escalation processes - Transport for 4-man crews - Sharing what worked well in the system this Winter - Preventing care home residents attending ED (working with Frailty) - Links with GPs re: high intensity users
6	Provide better communication that is clear and timely to the public about available services, resources and preventative measures. Streamline processes and procedures to reduce wait times and improve overall efficiency during peak periods. Develop further strategies to address staffing shortages, such as recruitment drives, training programs, and flexible working arrangements as well invest in additional beds, equipment to handle demand.
7	Direct pathways into secondary care for 111 for Buckinghamshire resident patients.

4. Do you think the additional Care Home Hubs Beds intervention helped manage demands across Bucks this winter?

More Details



5. Do you think the Olympic Lodge intervention helped manage demands across Bucks this winter?

More Details

Yes	6
No	0
Didn't notice	2

6. Do you think the Clinical Assessment Service intervention helped manage demands across Bucks this winter?

More Details

Yes	6
No	0
Didn't notice	2

7. Do you think Consultant Connect Lines (Frailty/SDEC etc) intervention helped manage demands across Bucks this winter?

More Details

Yes	5
No	0
Didn't notice	3

8. Did you think receiving the weekly winter tracker helped keep track of winter?

More Details

Yes	4
No	1
Don't know	3

3.6 Winter Pressures (OPEL Framework)

Across the winter period the Buckinghamshire system measures, on a daily basis, the pressures across our partners. This is done through a national Operational Pressures Escalation Levels (OPEL) Framework. The table below shows the pressures across our partners this winter broken down by the worst-case status for each week to date through winter:

Date	Bucks System OPEL Status	Bucks NHS Trust (Acute)	FedBucks (Urgent Care)	Bucks NHS Trust (Community)	Bucks Council (Adult Social Care)	Oxford Health (Mental Health)	SCAS (Ambulance)	Frimley NHS Trust (Wexham Park)
W/C 30-Oct-23	3	3	2	2	3	3	2	4
W/C 6-Nov-23	3	4	2	3	3	4	2	4
W/C 13-Nov-23	3	3	2	2	3	4	2	4
W/C 20-Nov-23	3	3	2	2	3	3	2	Business Critical Incident
W/C 27-Nov-23	2	3	2	2	3	3	2	Business Critical Incident
W/C 4-Dec-23	3	4	2	2	3	3	2	4
W/C 11-Dec-23	2	3	2	2	3	3	2	Business Critical Incident
W/C 18-Dec-23	2	3	2	2	3	4	2	4
W/C 27-Dec-23	2	3	2	2	3	3	2	3
W/C 2-Jan-24	2	4	2	2	3	3	2	4
W/C 8-Jan-24	3	3	2	2	3	3	3	4
W/C 15-Jan-24	3	3	2	2	3	3	2	Business Critical Incident
W/C 22-Jan-24	3	4	2	2	3	3	2	Business Critical Incident
W/C 29-Jan-24	3	3	2	3	3	3	2	4
W/C 5-Feb-24	3	4	2	2	3	3	2	4
W/C 12-Feb-24	3	4	2	3	3	3	2	4

Status	Description
Business Critical Incident	When a system / service reaches Business Critical Incident, they have concerns for the safety of their patients and require further intervention to reduce risks.
4	Pressure in the local health and social care system continues and there is increased potential for patient care and safety to be compromised. Decisive action must be taken to recover capacity and ensure patient safety.
3	The local Health and Social Care System are experiencing major pressures compromising patient flow, and these continue to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required and increased external support may be required.
2	The local Health and Social Care System is starting to show signs of pressure and to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible.
1	The local Health and Social Care System capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. Additional support is not anticipated.

3.7 Social Care

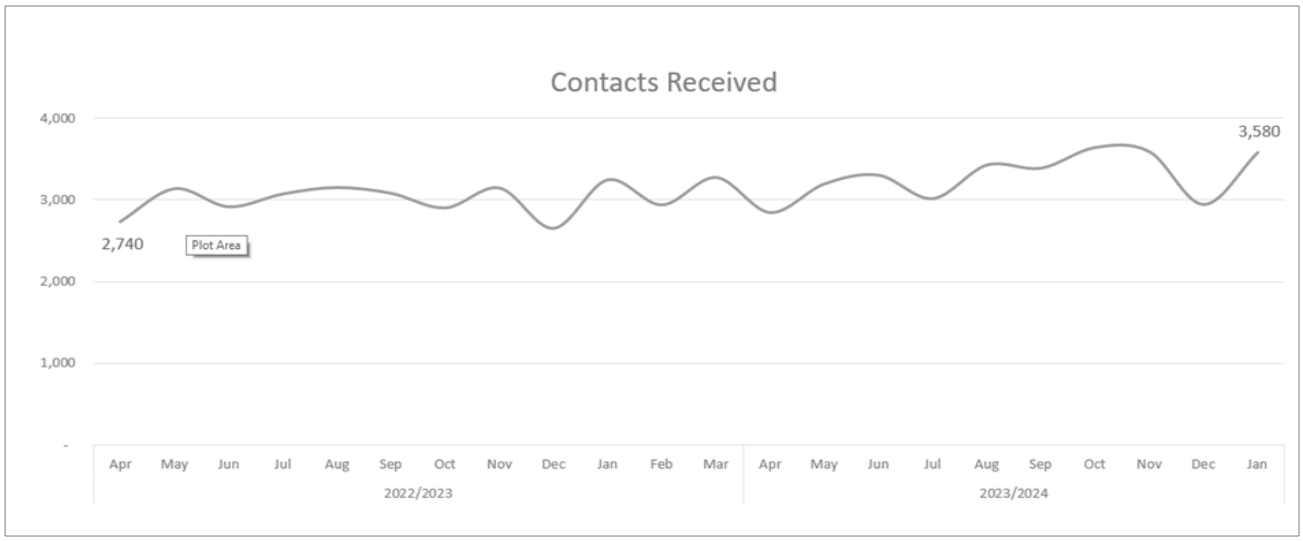
Overview

There are approximately 3,200 contacts that are made to the Adult Social Care service each month. 3,580 were made during January 2024 relating to either new or existing clients. The number of contacts received in the last year has steadily increased from an average of 3,025 at the start of the year. October was the latest peak in contacts (3,641).

From the contacts received over the winter period (October 2023 to January 2024), a total of 4,009 care related provisions were made on behalf of a total of 2,040 clients.

	October	November	December	January	Total
Provisions	1001	1018	935	1055	4009
Clients	770	761	691	767	2040*

*please note total clients will sum to more than there are individual months as clients could have had different provisions in the months. We have used the total number of provisions and taken unique clients from this.



Hospital Discharge & Transfer of Care Hub (ToCH)

The pressures on the Hospital Discharge Team have been steady throughout the winter period consistent with usual winter pressures. Approximately 1,105 discharges have been facilitated via the Transfer of Care Hub which opened in October 2023. The majority of discharges going via the HomeFirst and HIT (Home Independence Team) pathways. The HIT pathway focuses on providing rapid and intensive rehabilitation at home, while the HomeFirst pathway provides tailored rehabilitation and care for a longer period to support people recover and regain their independence at home.

Referrals that go to Social Work for assessment have tended to be cases with high complexity, requiring additional time and resources to safely discharge, such as safeguarding involvement or where a long-term need for care has been established, avoiding the need for rehabilitation.

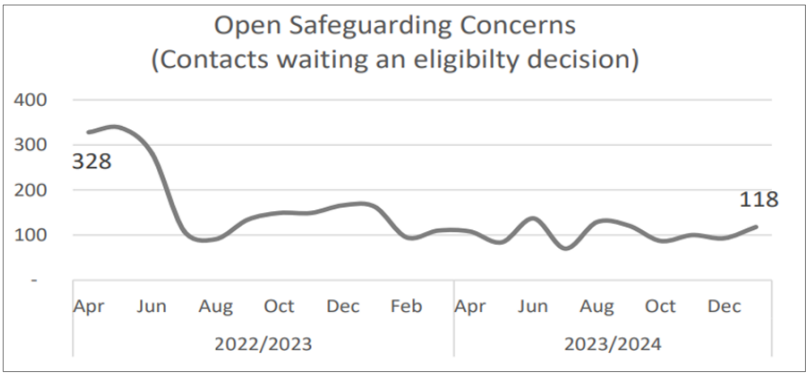
The Home Independence Team (HIT) pathway is a service that provides short-term support to people who are discharged from hospital and need some assistance to regain their independence at home.

Pathway	Total No Discharges (Approx)
Community Hospital	115
HomeFirst	343
HIT	234
HUB Bed	40
RRIC	191
Interim Health Funding	11
ASC N&E	95
ASC S&C	69
Alternative Pathway	7
	1105 Total Discharges

**Please note that figures for this table have been counted manually from several data sources*

Early Resolution and Safeguarding

The number of open Safeguarding Concerns has increased at the end of January 2024 to 118 compared to December 2023 (93). This remains low compared to the level reported at the beginning of last year. There were 1,137 safeguarding concerns received in January 2024, with a monthly average of 1,139 concerns per month so far this year. That is a 13% increase on the number of Safeguarding Concerns received between April and March last year at 1,008 concerns a month, which compared to 953 a month during 2021/22.



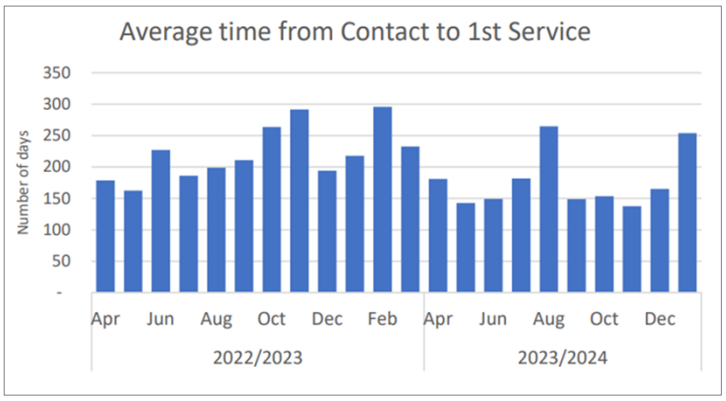
Month	Average New Safeguarding Concerns Per Week	Open Safeguarding Concerns (snapshot at the end of each month)	% of Eligibility Decisions triaged within 2 working day
October	259	87	72%
November	296	100	78%
December	259	93	83%
January	272	118	85%

Social Care Contact Outcomes – A Snapshot

Of the 3,580 contacts received during January 2024 alone, 3,387 contact outcomes had been triaged at the time of writing, of which:

- 2,181 (60.9%) of contact outcomes were related to care and support needs (1,128 new referrals, 1,053 existing).
- 590 (16.4%) contact outcomes were for information, advice and guidance.
- 202 (5.6%) Contacts for Safeguarding progressed to a concern.
- 224 (6.25%) contact outcomes received were for a request for a Deprivation of Liberty Safeguards (DoLS) assessment.
- 144 (4%) contacts were signposted to another agency.
- 46 (1.2%) required no further action.
- 193 (5.3%) are being progressed.

The time it took for a new contact to progress to service provision averaged 171 days between October 2023 and January 2024**.** The time taken is measured from the first point of contact to the start date of the first provisioned service.



4. Next steps and review

As winter continues until the beginning of April, we will undertake a full evaluation and data analysis exercise to ensure we can take learning into 2024/25 winter. We will continue to distribute the Winter tracker weekly, moving to business-as-usual tracker for our Urgent and Emergency Care services, making improvements via feedback from our partners.

We will continue to plan for the next Winter, with funding agreements for the whole year currently being discussed and agreed, based on the impact from this winter actions.

Health & Wellbeing Board Buckinghamshire

Healthwatch Bucks quarterly update

Date: 05 March 2024

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

Report Sponsor: John Meech, Chair, Healthwatch Bucks

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

☐ **Decision** ☐ **Endorsement**

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

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

None of the above? Please clarify below:

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

Purpose of report

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

1. Recommendation to the Health and Wellbeing Board

1.1. The Health and Wellbeing Board is asked to note the content of the report.

Healthwatch Bucks update

March 2024

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/Age Well

Discharge Hub report

What we did

The Discharge Hub has been operating, as a pilot, in Bucks since May 2023. Through the Hub, patients are discharged from hospital to a hub bed in a Buckinghamshire care home. When they are ready, they then move back 'home.' 'Home' may be where people lived before going into hospital or may be new e.g. moving into a care home. In a hub bed, a multidisciplinary team (MDT) provide patients with support. The hub beds provide care for:

1. Patients with complex health needs that prevent discharge assessment within 4 weeks, and it is inappropriate to wait in acute hospital (e.g. delirium, fractures affecting mobility)
2. Flexible support for discharge from acute hospitals (e.g. a delay in placement to a care home following hospital assessment).

The aim is for patients' length of stay, in these hub beds, to be up to 28 days (up to 70 days for more complex cases).

We wanted to know about the experiences of people who have used these beds managed by the Discharge Hub. We wanted to understand what worked for them and what they would want to change.

We developed a set of questions with the team responsible for the pilot. We started the conversation with the patient and/or nominated representative (usually a relative) once they moved from hospital to a hub bed. We went to the location where the patient was living to talk with them. We also talked with family members, usually by phone. The subsequent conversations took place after approximately another 2 and 4 weeks. All of our conversations took place between 21 November 2023 to 6 February 2024.

We talked with 16 patients occupying discharge hub beds in three care homes. We also talked, by phone, with 18 relatives.

Key findings

- Many of the relatives told us about issues during their loved ones stay in hospital, prior to their transfer to a hub bed.
- Looking back, after their loved one had moved out of a discharge hub bed, three quarters of the relatives we spoke to said they were satisfied with the hub bed stay.

Hospital discharge

- Half of the relatives we spoke to were dissatisfied with the information and communication from the hospital around discharge, to a hub bed. Two relatives were unaware that their loved ones had moved until after the event.

Integration of services and communication between professionals

- The concept behind the discharge hub was broadly welcomed by patients and families.
- Two people told us they felt a discharge hub bed should have been the first option on discharge from hospital.
- Most relatives and patients preferred to move to a hub bed than occupying a hospital bed any longer than necessary.
- Two families were unhappy about patients being discharged home, after their hub stay, because handrails or sensors had not yet been installed.

Communication with patients /families

- None of the people we spoke to had received a letter/leaflet outlining the purpose of a discharge hub, and what patients/families should expect. For some, this caused distress.
- There was a range of understanding about the aim of a discharge bed is and how long a patient might stay in one.
- In the first few weeks of their stay in a hub bed, half the relatives were satisfied with the communication and information they received about the hub stay and what happened next. However, others felt they should have been told more about what the process would be during their loved ones stay so they could prepare for, or decide on, the next steps with more insight.
- Many relatives found it difficult to plan to be available for conversations, make changes at the patient's home or to be there when they were discharged, if they had little, or no, notice.
- While people were positive about communication with the physiotherapists, (who they often saw face to face), a quarter of the relatives found it difficult to get hold of the social workers (which was often by phone).
- In our final conversation, three quarters of the relatives were satisfied with the information they were given about moving on from the hub and what happened next.

Choice, user involvement and being listened to

- Two thirds of the relatives, and two patients said they did not feel involved in the decision to move to a hub bed. However, the majority of the relatives agreed that moving to a hub bed was the best decision at that point in time.

- Three patients did not like being in a hub bed. They wanted to go home. Two of these, still in a hub bed, said they should have been moved on to a more permanent place quicker.
- Two thirds of relatives were satisfied with their interactions with the MDT team, a few weeks after the move to the hub bed.
- Most relatives were invited to a discharge meeting. However, a few did not feel listened to in this meeting.
- Two thirds of relatives felt supported to make informed choices about the future long term care of their loved ones. However, a few told us they were surprised by some of the information given in the discharge meeting which they felt should have been passed onto the relatives beforehand.
- Once the patient had returned home, only one out of six relatives thought this was the incorrect place for them.

Caring, kindness, and respect

- People told us that staff were kind and the care was good.
- Relatives were pleased that patients were putting on weight and getting physically and mentally stronger in the hub.
- Three relatives said their loved ones were isolated in a hub bed on the top floor.
- Two relatives told us their loved one's clothing went missing during their stay in the hub bed.

Quality of treatment

- In our first conversation, half of the relatives felt their expectations of a hub bed (providing care, physiotherapy and assessing patient's needs) were met. This increased to two thirds of relatives by the end of our conversations.
- Most relatives, of those discharged by the end of our conversations, told us their loved ones were ready to move on when they did.
- Many people praised the work of the physiotherapists. Many patients received more physiotherapy in the hub bed than they had received in hospital.
- Two people told us that they thought the checks to see what a loved one with dementia could, or could not independently, do were not robust enough.
- Several relatives told us they believed that, in the absence of a hub bed, their loved ones would have been readmitted to hospital.

Follow on **treatment** and continuity of care

- A few relatives had specific concerns around the coordination of existing appointments, paperwork not returning home resulting in delayed treatment, carers without a keycode, paid carers being unaware of a dementia diagnosis, a patient not getting transport home when expected and carers late on the first day.

Read the full report (including our recommendations) here.

BOB ICB Primary Care Strategy

We have supported the development of the BOB ICB Primary Care strategy in the following ways:

- Attending the Primary Care Strategy Away day in November hosted by BOB ICB on the draft strategy. We have advocated throughout for greater patient and public engagement and involvement in its development.
- Promoting the strategy consultation on social media, website and news bulletins to our networks and public.
- Holding a webinar with BOB ICB on 30 January 2024 aimed at representatives from Buckinghamshire Patient Participation Groups to hear from the ICB about the draft strategy and give feedback. 21 members of Bucks PPGs and Practice Managers attended. The session can be seen here.
- Shared feedback from the public on primary care with BOB ICB, notably difficulties in accessing general practice and NHS dentistry; numerous reports which look into patient and public experience of primary care including GP care when you're deaf, Deaf or hard of hearing.
- Our response to the draft strategy can be read here.

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Health & Wellbeing Board Buckinghamshire

Buckinghamshire Executive Partnership Report

Date: 21st March 2024

Author/Lead Contacts: Nicola Newstone, Assistant Director for Partnership Development – Bucks, BOB ICB

Report Sponsor: Neil Macdonald, Chief Executive, BHT

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 purpose of this report is to provide an update to the Health and Wellbeing Board from the Buckinghamshire Executive Partnership on the Executive's key areas of focus which directly align with the priorities of the Joint Local Health and Wellbeing Strategy.

2. Content of report

2.1. Please find below a summary report from the Buckinghamshire Executive Partnership (BEP) meeting held on 13th February 2024.

Item	Summary	Impact
BEP has 3 agreed priorities in 23/24. A monthly update is given for each of the following: **1. Special Educational Needs and Disabilities (SEND);** **2. Joining Up Care;** **3. Health Inequalities.**	**SEND:** Partners continue to work together to reduce waiting times for assessment and to develop transformed ways of working	Funding has been agreed to support 4 projects which will enhance the provision of additional, early support to children and their families.
	Joining Up Care: There have been operational winter pressures during January and February which has increased demand to discharge services. The positive position compared to a year earlier was recognised.	The performance of the Home First service continues to improve. This service supports people to return home from hospital with therapy and care. The service focusses on enabling people to maximise their level of independence once home. The Length of Stay in all of our pathways is a key focus of all partners.
	Health Inequalities: Progress continues to be made in the projects in place and additional projects will start in 24/25.	Within current projects recruitment has been successful and implementation has started. An additional project in 24/25 is supporting the establishment of a 'Deep End Network'. This will support GP Practices in the most deprived areas to collaborate to address Health Inequalities with a strategic approach.
The Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) Operating Model and System Goals	The BOB ICB is taking forward a review of its operating model and as part of this the ICB is considering how it will best work with partners in each of the three places. Discussion took place between partners on thoughts for this in Buckinghamshire.	The BOB ICB will continue to evolve the proposal for its future operating model. This will be done in partnership with organisations in Buckinghamshire so the final proposal is one which best supports Buckinghamshire and its population.

24/25 Financial Planning	The challenging financial context for all organisations going into 24/25 was recognised. Partners discussed the financial planning approach for 24/25. All were committed to build on the progress made in 23/24 in key priority areas such as discharge.	Partners acknowledge that the development of the partnership has enabled good progress to be made towards agreeing a financial plan for 24/25. All partners were confident of achieving an agreed plan for 24/25 which continues to support ongoing transformation.
24/25 Bucks Place Priorities and Governance Proposal	Buckinghamshire partners are working together to consider what areas the Buckinghamshire Executive Partnership should focus on in 24/25. Recognising that these will be priorities where it is felt progress will be best achieved through partnership and are not duplicative of existing areas of focus.	Partners share an ambition to build on the progress made in 23/24 on the current priority areas of: Joining Up Care, SEND and Health Inequalities. It was agreed that these priorities will be developed further with partners with a clear delivery plan for 24/25.
Draft Primary Care Strategy	An update was given on the Draft Primary Care Strategy, the feedback received to date and the next steps to progress the Strategy.	The Primary Care strategy is accessible via this link: https://yourvoicebob-icb.uk.engagementhq.com/primary-care-strategy There will be an agenda item dedicated to discuss this at the Health and Well Being Board in July 2024.

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Health & Wellbeing Board Buckinghamshire

Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board (BOB ICB) Report

Date: 21st March 2024

Author/Lead Contacts: Sue Boyce, Deputy Head of Communications and Engagement (acting) and Nicola Newstone, Assistant Director for Partnership Development – Bucks, BOB ICB

Report Sponsor: Philippa Baker, Place Director – Bucks, BOB 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.

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☒ 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

Purpose of report

The purpose of this report is to provide an update to the Health and Wellbeing Board from the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB). The report provides an update on priority areas for BOB ICB and areas of particular focus in Buckinghamshire.

Content of report

Included within this report:

1. ICB Board Meeting

BOB ICB Board meeting 19 March 2024; Board papers and reports are on the BOB ICB website

2. BOB ICB Primary Care Strategy

The BOB ICB published its draft Primary Care Strategy which highlights ambitions for the future of general practice, community pharmacy, optometry (eye care) and dentistry across BOB.

Stakeholders, patients and the wider public were invited to share their views via an online survey at: https://yourvoicebob-icb.uk.engagementhq.com/primary-care-strategy – to help further inform and shape these plans. The survey closed on 29 February 2024. Focus groups, webinars and face-to-face meetings with a wide variety of stakeholders have also taken place over the last four months

A report on the public involvement will be developed and made available in April 2024.

Alongside this, engagement has been going on with primary care providers and NHS partner Trusts.

The final strategy will go to the ICB Board for agreement in May 2024.

The draft strategy outlines three priorities to help deliver the ICB ambitions:

1. to improve access so patients get the right support first time to manage their health and wellbeing;
2. to develop proactive and personalised community care for patients with complex health needs;
3. to prevent ill health by using and sharing data with our partners about the health needs of local communities.

To help deliver these priorities we are proposing to further develop the following services:

- Non-complex same day care
- Integrated Neighbourhood Teams
- Cardiovascular Disease Prevention

Non-complex same day care

Primary care will better manage patients who require same day support; but whose conditions are not complex. The aim is to improve the patient experience as they get the support they need promptly. This will be achieved by triaging patients more efficiently with an initial contact made with the right health service or professional. This way of working will allow GPs to focus on patients with more complex needs (having more than one health condition).

Integrated Neighbourhood Teams

GPs will work with multi-disciplinary teams in the community made up of hospital consultants, district and

community nurses supported by care navigators, physiotherapists and the voluntary sector to provide personalised, proactive care to patients with more than one health condition (complex) such as frail elderly people.

Cardiovascular Disease (CVD) Prevention

Primary care will work with health and care partners to reduce the risk of patients developing CVD by tackling smoking, obesity and high blood pressure. CVD is one of the most common causes of ongoing ill-health and deaths across the ICB leading to heart attack and strokes. This approach will rely on using and sharing data (Population Health Management) between partners to understand better the health needs of our local communities.

3. NHS industrial action

Junior doctors undertook their 10th period of industrial action from 24 - 29 February. All local trusts across Buckinghamshire, Oxfordshire and Berkshire West were affected.

The ICB worked closely with partners across the NHS and care sector during the strikes to ensure services remained safe.

We prioritised resources to protect emergency treatment, critical care, neonatal care, maternity, and trauma, and ensured priority for patients who had waited the longest for elective care and cancer surgery.

Unfortunately, some appointments and procedures were re-scheduled and patients were informed. During the period of industrial action from 24 – 29 February 2024 inclusive, a total of 2,641 outpatients, 341 inpatients and day cases, and five community appointments were rescheduled across the system. The NHS trusts are working to see patients and service users as quickly as possible.

4. Vaccination programme – measles and Covid-19

With the rise in measles cases across the country, data shows that one in five children who catch the virus will need to visit hospital. BOB ICB is working to encourage anyone unsure of their MMR vaccine status or that of their child to check with their GP surgery.

For children, one dose is usually given at one year old, and the second dose given at three years, four months. Two doses are needed for maximum protection.

Anyone older who may have missed out for any reason is also being encouraged to catch up with routine vaccines as soon as possible, including those people:

- planning a pregnancy
- travelling abroad
- starting college or university
- frontline health and care staff
- anyone born between 1970 and 1979, as they may have only been vaccinated against measles
- born between 1980 and 1990, as they may not be protected against mumps

The BOB ICB Stay Well page has information on flu and other routine vaccines: Immunisation and vaccination - Stay Well (staywell-bob.nhs.uk)

In addition, the Covid-19 Spring Booster campaign is expected to start in mid-April for the following cohorts:

- adults aged 75 years and over
- residents in care homes for older adults
- individuals aged 6 months and over who are immunosuppressed

5. Buckinghamshire Focussed Update:

The Buckinghamshire Executive Partnership has identified three priority areas for 2023/24. These are SEND (Special Educational Needs and Disabilities), Joining Up Care and Health Inequalities. The Buckinghamshire Executive Partnership (BEP) report to the Health and Well Being Board provides an update for each of these priorities, reflecting the commitment of partners to making progress in these areas.

5.1 Health Inequalities

There has been a particular focus from the ICB in Buckinghamshire to support Health Inequalities through the allocation of NHSE Health Inequalities funding to agreed projects. An update for each of these projects is given below.

5.1.1 Preconception Pilot

This pilot will support research to better understand the factors that impact pre-conception health in specific population groups and so help to shape services for better outcomes

The initial research and scoping phase of this project has been completed, this included an online survey and qualitative interviews. A group is now using the insights from this initial phase and innovative best practice to develop a new model, supported by an action plan for delivery.

5.1.2 Pre-habilitation Pilot

This pilot focusses on proactive outreach to people on a Buckinghamshire Healthcare Trust waiting list, who are smokers, have poorly managed diabetes, poorly managed hypertension or with Body Mass Index of over 35. The pilot aims to support people to have better outcomes following surgery and continue with a healthier lifestyle and where relevant better management of their long term condition. This pilot is working in partnership with Dashwood and Aylesbury Central Primary Care Networks.

A multi-agency stakeholder engagement session took place on 22nd January 2024, from this session pathways have been developed and key metrics agreed. Health Coach roles are being recruited to and 1,318 members of staff have completed 'Very Brief Advice' smoking cessation training. An evaluation framework is being developed.

5.1.3 Physical Health Checks for people with Severe Mental Illness (SMI)

This pilot is focussed on increasing the number of eligible people with a severe mental illness having a physical health check and on understanding why people do not attend health checks in this population group. All of the posts for this project are recruited to and the recruited outreach team has now started work in Dashwood Primary Care Network (PCN). Their focus is for patients with no or a partial SMI Health Check in over three years.

There will be support for patients accessing wider services to promote physical and mental health for these patients who have a high level of need including signposting to Be Healthy Bucks.

A BOB wide working group will share best practice on SMI physical health checks and agree evaluation parameters.

5.2 Additional Projects supported and plans for 24/25

5.2.1 VCSE grant programme to support the communities access Mental Health services

Specific NHSE funding has been identified to support communities access to Mental Health Services. Examples of the projects being supported are given below.

- A dedicated worker has been recruited by Elmore to focus on developing relationships with the South Asian community and increasing referrals to Mental Health Services.
- Gypsy, Roma, Traveller awareness training has been co-produced with community members and Margaret Clitherow Trust for Oxford Health and wider partners. A one hour training video will be produced for wider sharing with partners. The aim is to support improved access and outcomes for people from this community with mental health needs.
- The Aylesbury jamming groups being delivered by Chiltern Music Therapy for people with Serious Mental Illness have started. This aim is to support people with serious mental health conditions through using music as a therapeutic tool.

5.2.2 Projects in 24/25

The projects detailed above will continue through 24/25. Funding for the following projects has also been agreed:

- **Making Every Adult Matter (MEAM) Team Year 2**
  The MEAM team launched in April 2023 to provide intensive support for people facing multiple disadvantage within the areas targeted through Opportunity Bucks. This funding will support the project to continue from April 2024 until April 2025.
- **Communities of Practice**
  The project will support the set up of 3 Communities of Practice for frontline workers in the Opportunity Bucks areas. The aim is to improve knowledge sharing, problem solving, integrated working and expedite delivery of key priorities.
- **Community Researchers**
  The project will develop the infrastructure within Healthwatch and a sustainable model for community research to be undertaken in Buckinghamshire to support community driven and partner requested research.
- **Deep End Network**
  This project will support the set up of a network of General Practice providers tackling health inequalities in the most deprived areas, aligning to the Opportunity Bucks geographies. The Networks will enable a preventative approach to health inequalities, providing dedicated forums for knowledge-sharing.

- **Health Coaches**
  The project will support Bucks Health and Social Care Academy to deliver an accredited course to train people working in health, social care and the voluntary sector in health coaching so they can support people in managing their physical and mental health.

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Health & Wellbeing Board Buckinghamshire

Report from Bedfordshire, Luton and Milton Keynes Integrated Care System

Date: 21st March 2024

Author/Lead Contacts: Maria Wogan, Chief of Strategy and Assurance 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

Purpose of the Report

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. Councillor Angela MacPherson is a member of the BLMK Health and Care Partnership (the ICP in BLMK).

Recommendation to the Health and Wellbeing Board

The Health and Wellbeing Board is asked to **note** the report.

The Health and Wellbeing Board is asked to **authorise** the Chair of the HWBB to offer an opinion on any significant amendments to the Joint Forward Plan if it is not possible to bring any amendments to a formal meeting for consideration due to timing issues.

Content of report

The following summarises items of interest that have been considered by the Board of the ICB which met on 8 December 2023.

Bedfordshire, Luton and Milton Keynes Integrated Care Board

The Board of the ICB met on 8 December 2023 and a summary from the meeting is given below.

Resident's Story – Importance of a Personalised Approach

Members watched a video from Roxy, a resident from Milton Keynes who attended the Board meeting in March to share how back pain has affected her life. She returned to the Board to provide an update on her condition and how her insight is shaping service delivery. The ICB's Chief Nurse, Sarah Stanley, explained how the ICB has worked with Roxy to inform how personalised care and treating the person, rather than the symptom, provides a more positive outcome and experience. These lessons are being factored into the procurement process for musculoskeletal (MSK) services across BLMK.

Joint Forward Plan (JFP)

The ICB is required to publish a revised JFP by 31 March 2024. The ICB does not anticipate any significant changes will be needed as the Plan was only agreed with partners in June 2023. As part of the annual NHS planning process for 2024/25, work is also underway with colleagues from local NHS trusts to prepare NHS financial, workforce and activity plans for next year. A two year financial settlement was made in the 2023/24 planning year and the financial position is challenged. Our commissioning plans, and plans to invest in or transform services, may need to change to respond to the challenged financial environment.

We will reflect the outcome of our 2024/25 planning as appropriate in an updated Joint Forward Plan (JFP); Should the ICB consider that any significant changes to the Joint Forward Plan are necessary, we will seek the Health and Wellbeing Board's opinion on whether the Plan continues to take proper account of the local Joint Health and Wellbeing Strategy. Depending on timing, this may need to be outside formal HWBB meetings.

The Board is asked to note the proposed approach to the annual review of the Joint Forward Plan (JFP) as described above and authorise the Chair of the HWBB to offer an opinion on any significant amendments to the JFP if it is not possible to bring any amendments to a formal meeting for consideration due to timing issues.

System response to the Denny Review of Health Inequalities

Following publication of the Denny Review in September, the Board was asked to agree a system wide response to the Denny Review, which included nine key recommendations. Members welcomed the report, agreed to formally thank Reverend Lloyd Denny for the review, and confirmed their commitment to supporting a generational change in BLMK.

They approved all nine recommendations, including the appointment of Lorraine Sunduza, Chief Executive of East London Foundation Trust (ELFT), as the Board level Champion for this work. It was noted that all partners have agreed to consider the application of the Review's recommendations to their own organisations and to participate in system-wide improvement activity accordingly.

The Board supported the decision to explore the development of a system wide translation service, commit to an annual update for three years and to hold a board seminar event in spring 2024.

Delivering integrated Primary Care in BLMK (including NHSE Delivery Plan for Recovering Access to Primary Care)

The Board received a progress report on the development of integrated neighbourhood working in BLMK, based on the principles in the Fuller Report and provided assurance on the ICB's response to the NHS England primary care access recovery plan. Board members commented that further consideration needed to be given to communications with the public about how primary care was changing. Feedback from the Board suggested that a faster pace for some elements of the programme would be beneficial as well as clarification on how the outcomes will be measured and clarity on how partners can be involved in this important work.

Carnall Farrar Review of the Development of Health and Care Integration in Milton Keynes (MK)

Michael Bracey, Chief Executive, Milton Keynes City Council, introduced the report in which there was positive recognition for the partnership working in MK and some suggestions for improvement to the MK Deal, such as more extensive use of population health data, needing longer-term security around funding, the need to consider the long-term vision for MK health and care integration and to build resilience into the team.

The Board approved the next steps to develop a framework by June 2024 which sets out how greater responsibility for resources and decision making will be made available to place based partnerships as they mature.

The Provider Selection Regime (PSR)

The Board received an update on a new statutory responsibility that is expected to come into force on 1 January 2024. The PSR will be a set of new rules for procuring health care services in England by health organisations and local authorities. The introduction of the PSR requires the ICB and all partner organisations within scope to review procurement, contracting, commissioning and governance processes, both current and future, to ensure these are in line with the requirements of the Regime. The ICB and its partners also need to ensure that where joint commissioning or collaborative

arrangements are in place, all partners are clear on responsibilities and accountabilities, and decision-making is transparent and consistent.

Financial and operational updates and system assurance

Members received formal updates from quality and performance and finance and investment committees as well as reviewing system risks and the Board Assurance Framework. They also discussed the reports from the place-based partnerships in all four boroughs.

The Board approved the request to extend the contract for the ICB business intelligence support services with Arden GEM for a further one year (and possible additional year). The Board also noted the update on the work undertaken by the HR team on the Workforce Race Equality Standard and the Corporate Governance Update and reports from other Committees.

Early Years Seminar

The Integrated Care Board (ICB) and Health and Care Partnership (HCP) held its second strategic seminar on Early Years on 24 November 2023 in Milton Keynes. Nearly 70 delegates attended the event including representatives from Parent Carer Fora, Council elected members and officers, early years schools and SEND professionals, public health, NHS organisations and the ICB.

Michael Bracey, Chief Executive of Milton Keynes City Council, and Matthew Winn, Chief Executive of Cambridgeshire Community services were the executive sponsors for the seminar and were keynote speakers at the event. Michael reflected that it had been 20 years since the publication of Every Child Matters which set out a clear and ambitious policy framework for putting children and families at the centre of our work, but he challenged on what has really changed in that time, except demand for services have increased Matthew stressed the importance developing a holistic view of the child in the context of their family, community and wider support network, emphasizing the need to move from a service-led to a needs-led approach. At present many children wait for specialist services when earlier assessment of needs and bespoke support from multi-disciplinary teams could meet needs quicker and more locally.

At the seminar, there were two interactive sessions based in the four places of Bedford Borough, Central Bedfordshire, Luton and Milton Keynes. The groups were chaired and facilitated with the aim of agreeing a high-level action plan for each place to be agreed at Place Board level. The two questions the workshop groups focused on were:

- In identifying gaps in existing pathways and when considering the needs of our local children and families – what do we need to change?
- How do we achieve our ambition, agree the right strategic outcomes and what actions should we take in the short, medium and long term.

The summary of the Place based group discussions will be reported to the Milton Keynes Health and Care Partnership to consider what actions will be taken to address the local challenges.

Buckinghamshire Health and Wellbeing Board Forward Plan

Standing/recurrent items:

- Welcome, minutes and actions, declarations of interest, announcements from the Chair
- Public questions
- Healthwatch update
- Buckinghamshire Executive Partnership update
- ICB/ICS update

Meeting date	Item
June 2024 **Date TBC**	JLHWS Dashboard Review
	Better Care Fund 2023/24 out-turn and 2024/25 plan
	BOB ICB Primary Care Strategy (including estates strategy)
	BOB Joint Forward Plan
	Tobacco Control Strategy
Sept 2024 **Date TBC**	System Winter Plan
	Suicide Prevention Strategy
	Children's and young people's mental health and adults mental action (action from January 24 meeting)
	JSNA Terms of Reference
Dec 2024 **Date TBC**	Physical Activity Strategy update - statistics change over the last twelve months (action from January 24 meeting)

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