Health & Adult Social Care Select Committee agenda

Date: Thursday 10 September 2020

Time: 10.00 am

Venue: Via Video Conference

Membership:

K Ahmed, Z Ahmed, A Bacon, P Birchley, M Bradford, M Collins, G Hollis, S Jenkins, J MacBean, G Powell, B Roberts, A Turner, L Walsh, J Wassell, L Wood and Mr M Souto (Healthwatch Bucks)

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Agenda Item		Time	Page No
1	**Apologies for absence/changes in membership**	**10:00**	
2	**Declarations of interest**		
3	**Minutes** The minutes of the meeting held on Thursday 4th June 2020 to be confirmed as a correct record.		**5 - 12**

4 Public Questions

No public questions have been submitted for this meeting.

5 Chairman's update **10:05**

For the Chairman to update Members on health and adult social care scrutiny activities since the last meeting.

6 Mental Health services **10:10** **13 - 24**

The Committee will hear from representatives from Oxford Health NHS Trust who provide mental health services for the residents of Buckinghamshire. Members will examine the access and quality of the services provided, particularly in light of the current Covid-19 situation.

Presenters:

Dr Nick Broughton, Chief Executive, Oxford Health NHS Trust
Ms Debbie Richard, Managing Director, Mental Health
Dr Vivek Khosla, Clinical Director for Buckinghamshire

Papers:

Report attached

7 Refreshed Health & Wellbeing Strategy **11:10**

The health & wellbeing strategy has been refreshed and a consultation will be launched shortly asking for feedback on the draft strategy. Members will be asked to review the strategy and submit their feedback as part of the consultation.

This item is for Committee Members to have a general discussion about the refreshed strategy.

Papers:

The draft strategy will be circulated to Members shortly and a link will be made available in the minutes.

8 Primary Care Networks **11:30** **25 - 58**

Primary Care Networks (PCNs) were launched in June 2019 and ambitious plans were put in place to deliver a number of projects across the networks over the coming years, including recruiting to a number of newly created roles.

As part of the Time for Care Programme, NHSE&I is providing support to practices, PCNs and the Clinical

Commissioning Groups to capture the learning and improvements that have arisen through the Covid-19 pandemic.

This item will provide the Committee with the opportunity to hear more about the work of the PCNs, as well as examining how GPs and patients have coped with the changes in how primary care has been delivered in light of Covid-19 and the recovery plans.

Presenters:
Ms Louise Smith, Director of Primary Care
Dr Rashmi Sawhney, representative from the Primary Care Networks in Buckinghamshire
Mr Mike Etkind, representative from a Patient Participation Group

Papers:

- Power point slides - attached
- Scoping report from the work with Primary Care representatives and the Time for Care team, NHS England (June 2020) - attached

9	**Work programme** The Committee will discuss the work programme and agree the items for the next meeting. **Presenters:** All Committee Members **Papers:** Work Programme attached	**12:30**	**59 - 62**
10	**Date of next meeting** The next meeting will take place on Thursday 5th November 2020 at 10am.	**13:00**	

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

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Buckinghamshire Council

Health & Adult Social Care Select Committee

Minutes

MINUTES OF THE MEETING OF THE HEALTH & ADULT SOCIAL CARE SELECT COMMITTEE HELD ON THURSDAY 4 JUNE 2020 IN VIA VIDEO CONFERENCE, COMMENCING AT 10.00 AM AND CONCLUDING AT 12.39 PM

MEMBERS PRESENT

K Ahmed, Z Ahmed, A Bacon, P Birchley, M Bradford, M Collins, G Hollis, S Jenkins, J MacBean, G Powell, B Roberts, A Turner, L Walsh, J Wassell, L Wood and Mr M Souto

OTHERS IN ATTENDANCE

E Wheaton, A Macpherson, G Williams, J O'Grady, G Quinton and N Macdonald

Agenda Item

1 ELECTION OF CHAIRMAN

The meeting was opened by Mrs E Wheaton, Committee and Governance Adviser, Buckinghamshire Council.

RESOLVED: That Mrs J MacBean be elected as Chairman of the Health and Adult Social Care Select Committee for the ensuing year.

2 APPOINTMENT OF VICE-CHAIRMAN

RESOLVED: That Mr M Collins be elected as Vice-Chairman of the Health and Adult Social Care Select Committee for the ensuing year.

3 APOLOGIES FOR ABSENCE/CHANGES IN MEMBERSHIP

There were no apologies for absence.

4 DECLARATIONS OF INTEREST

Members made the following declarations of interest:

- Mr G Hollis declared that he was a first responder for South Ambulance Service;
- Mr A Turner declared that he was a trustee of an independent day care provider, The Princes Centre;
- Mr L Wood declared a non-pecuniary interest as Trustee of a not for profit care agency currently in the start-up phase.

5 COVID-19 UPDATE

Mr N Macdonald, Chief Executive, Buckinghamshire Healthcare NHS Trust, provided the following overview of the work carried out by the Trust since the beginning of the pandemic.

- The Trust normally had 17 critical care beds available. They had been asked to increase this to 75 beds by the Easter bank holiday weekend in line with national data modelling. The cost per bed was in the region of £0.25m.
- Cases had peaked towards the end of April with approximately 30 critical care patients and 150 in-patients at Stoke Mandeville hospital. Locally the peak had not been as high as expected but the plateau had taken longer to decrease.
- All routine work such as screening, elective surgery and face to face out-patient appointments had been suspended.
- Approximately 96% of all out-patient appointments had been completed virtually. This figure was below 6% before the pandemic.
- The Trust had worked with Buckinghamshire Council and local GP's to identify vulnerable people.
- Private hospitals had been utilised as part of the national contract to increase capacity. The Chiltern Hospital had taken cancer surgical patients and The Shelburne Hospital had managed haematology and chemotherapy patients.
- Urgent care, emergency and maternity services had remained. Initially Accident and Emergency departments had seen a decrease in demand of 45% compared with the average for the time of year but this had started to return to normal levels.
- Changes to the estate had included building a new ward, mortuary and testing facilities.
- Intensive work over a two week period had enabled 2000 staff to start working from home.
- At its peak 12% of staff had been away from work either through sickness or the need to self-isolate.
- There had initially been some issues with the supply of PPE. 4,000 members of staff had now been trained in its use.
- As services re-opened additional space, time, staff and PPE would be needed to carry out the same tasks.
- Elective cancer surgery had resumed at Wycombe hospital. Non-emergency cardiac and stroke services were starting to resume.
- All patients brought in for surgery would need to self-isolate at home for 14 days with their whole household.
- It was expected to take several months for all services to resume and would be subject to delay if there were further peaks.

During the discussion, Members asked the following questions.

- In response to a question about how many Buckinghamshire patients were currently in private hospitals and what were the plans for their return, Mr Macdonald made the following key points:
    - At end of March private capacity had been purchased as part of a national package. This was expected to continue until at least the end of July with discussions ongoing at a national level.
    - The Shelburne hospital currently had 8-9 haematology and chemotherapy patients. The Chiltern hospital ran 33 surgery lists per week.
    - The need for additional capacity would still be needed in the longer term as extra space was needed to carry out operations.
- In response to a question about patients needing to self-isolate for 14 days prior to

surgery, Mr Macdonald clarified that the patient's whole household must self-isolate for 14 days.

- A Member asked about the financial impact on the Trust of the Covid-19 crisis. Mr Macdonald explained that there had been additional costs associated with making more space, buying equipment and creating the digital infrastructure for staff to work at home. Central Government had made funding available for this. In response to a question about how non-emergency cases were being prioritised, particularly paediatrics, Mr Macdonald explained that most local paediatric surgical cases would be referred to the Oxford University Hospitals NHS Trust as per existing arrangements.
- A Member asked why patients with covid-19 were not transferred directly to the London Nightingale hospital. Mr Macdonald explained that the Nightingale Hospital had always been intended as a last option for overflow capacity which supported national guidelines.
- A Member commented that there had been national issues around testing and asked what the impact of this had been on the Trust's ability to discharge people to care homes. Mr Macdonald said that testing had been a complicated issue. The Trust had been offering testing to all staff and patients over the last 3-4 weeks. Mobile testing sites were managed outside of the NHS and this had made it difficult to track results. The antigen test was now available across the NHS and the laboratory at Stoke Mandeville hospital had been involved in setting up local access.
- It was acknowledged that the ward environment made it difficult to socially distance and in turn that may make it harder for staff to remain vigilant in non-clinical settings. Steps had been taken to create more space in communal areas.
- A Member asked whether the debts written off by the Government included the Hospital Trust's private finance initiative (PFI) debt. Mr Macdonald confirmed that it did not include this.
- A Member asked about the effects on staffing and service levels and whether agency/bank staff had been used. Mr Macdonald explained that there had been at its peak a 12% staff absence. All leave in April had been cancelled. Where possible staff had been redeployed to support urgent and emergency services. Critical care nursing required specialist training and bank staff had been called in to support this as required.
- In response to a question about whether the new mortuary had been built to meet a critical need or as a precaution, Mr Macdonald confirmed that the mortuary had been used but not to its full capacity.
- A Member asked about the lessons learnt and whether these would be used to shape and inform the Winter resilience planning. Mr Macdonald felt that partnership working during this time had been exceptional. Modelling for the winter would take place and would include planning for possible outbreaks of winter flu, covid-19 and norovirus affecting the hospital at the same time. The Trust would bring further details to the HASC later in the year.
- A Member asked whether the Trust had seen an increase in emergency dentistry during the Covid-19 crisis. Mr Macdonald clarified that local emergency dentistry support was provided by Oxford University Hospitals NHS Trust.
- It was acknowledged that the potential longer term impact of the crisis on NHS staff, care home staff and domiciliary staff was currently unknown but support was in place for people to access when required.

Addendum – a briefing paper from Buckinghamshire Healthcare NHS Trust was submitted after the meeting and is attached.

Mrs A Macpherson, Cabinet Member for Adult Social Care, took Members through the presentation which was contained in the agenda pack. The following main points were made during her presentation.

- Mrs Macpherson thanked all staff for their hard work under difficult circumstances.
- 1,200 social care clients had been identified as vulnerable. This list had been cross referenced with the Government's shielding list Regular calls were being made to support these residents including 300 who received daily calls. There had been positive feedback and social care were considering how this could become part of business as usual.
- Direct care and support service such as day centres had needed to close at the end of March. There would be a recovery plan to look at how to restart these services as lockdown was eased. Plans would be made available to the Committee in due course.
- Mrs Macpherson thanked Stoke Mandeville Stadium and Wheel Power for use of the Olympic Lodge building. The site had been used to support hospital discharges and patients from the community who had needed support. 88 discharge to access (D2A) beds and 33 move on beds had been commissioned to support the discharge process.
- 72 out of 131 care homes in Buckinghamshire had reported cases of covid-19. On 29 May the council had submitted a strategy for supporting care homes in line with government requirements. The enhanced support offer included HR support, staff training, communication, mental health and bereavement support (for staff, families and residents), PPE supplies including a central distribution centre, a central email, webinars and access to clinical support through a central portal.
- The recovery plan would seek opportunities for positive changes including lessons learnt around discharge and supporting providers.

During the discussion, Members asked the following questions.

- A Member asked whether the reporting lines for those working with care homes could be reviewed and made clearer. Mrs Quinton explained that there was currently one point of contact for care homes via a web portal but communication of this was important.
- A Member expressed concerns around the safeguarding of patients, particularly those brought to Olympic Lodge. Mrs Macpherson confirmed that Safeguarding policies had been strictly adhered to. The Olympic Lodge site was large enough to restrict movement and isolate different categories. The Buckinghamshire Health Trust (BHT) had been carrying out testing before transfer and maintained a good relationship with providers to aid this.
- A Member raised concerns in relation to deprivation of liberty safeguards following amendments to the Care Act. Mrs Quinton confirmed that all statutory duties, including those related to deprivation of liberty, had continued as normal in Buckinghamshire as the council had not applied for a Care Act Easement as provided for in national legislation.
- In response to a question about residents who receive domiciliary care, Mrs Quinton acknowledged that there were a wide number of ways residents may be supported in their homes not just residential care arrangements. Monitoring and contingency plans were in place for all health care providers who were aware of how to raise issues. For residents who relied on a single carer and who were vulnerable, they received a regular call to make sure they had access to medication and food. All had continued to receive support in their own homes without significant issue.
- It was acknowledged that access to PPE had initially been difficult but all care homes in Buckinghamshire now had good access through the national supply line and locally held supplies.
- A Member asked for clarification over who was responsible for food parcels and raised concerns that some had been cancelled with no notice. Mrs Quinton confirmed that those on the government shielded list received food parcels from a service administered

centrally and issues should be reported to central government. The local Community Hubs had provided some support i.e. collecting unwanted parcels to deliver to food banks. This was separate from the local list of vulnerable social care clients.

- In response to a question about current levels of sickness and vacancy rates within the care sector, Mrs Quinton said that the sickness rates had been complicated to report as there was a difference between illness and being unavailable to work due to self-isolation. The council only had figures for BC staff with outside organisations managing their own figures. Across BC 90-95% were available to work with a decrease in sickness levels. This may be due to the greater flexibility arising from working from home and lessons learnt would be reviewed. It was hoped health care recruitment would become easier in the long term due to positive media coverage of the sector.
- It was acknowledged that the number of volunteers was expected to drop as people returned to work. It was hoped that some volunteers would be retained to support the phone calls to the most vulnerable. It was confirmed that this would not be instead of visits from qualified social workers.

Mr G Williams, Cabinet Member for Communities & Public Health, and Dr J O'Grady, Service Director for Public Health, provided the following update.

- There had been much joint working between communities, social care, public health and the voluntary community sector (VCS).
- Mr Williams thanked BC staff for their hard work coming together in the spirt of the unitary council.
- The new website had been built in record time and gave a single number for referrals. It included information on how to access support and volunteer time.
- There were now 1,800 volunteers identified through BC with many managed through the Clare Foundation. Mental health support had been made available for volunteers.
- £250k of Community Board funding had been released early to allow BC members to support efforts in their local wards.
- 3,522 Buckinghamshire residents appeared on the central government shielded list. Community hubs had assisted with the delivery of around 500 food parcels.
- National and regional charities had given positive feedback around BC approach to partnership working.
- Additional mental health support had been made available for workers including no longer needing line manager approval for counselling and raising awareness of mental health and domestic abuse.

During discussion, Members asked the following questions:

- A Member asked for clarification around the death rates for Buckinghamshire. Dr O'Grady confirmed the following:
    - Early in the pandemic, testing had only been available to a limited number of people; infection and covid-19 death rates would be expected to rise as testing became more widely available.
    - In Buckinghamshire, 51% of deaths had been in woman, this was not in line with national figures.
    - It was important to consider inclusion criteria when comparing figures. For example Belgium had much wider inclusion criteria than most countries.
    - Local authority level reporting did not begin until 17 April 2020. Areas such as London had experienced outbreaks before that date making it difficult to draw comparisons until after the pandemic was over.
    - There had been 292 deaths in Buckinghamshire as of 1 June 2020, the latest available date.
    - Comparing death rates including all causes of death worked well. For example

comparing all deaths in care homes:
    - Buckinghamshire - 91.3 deaths per 1000 care home residents.
    - Nationwide - 91.6/1000.
    - South East England - 91/1000.
- It was hoped that reporting at a local level would improve as track and trace was rolled out.
- The Public Health team were aware of efforts in Sheffield and Tower Hamlets. The newly formed Health Protection Board (HPB) would meet for the first time on 5 July 2020 and would review ways to keep infection levels as low as possible as Buckinghamshire came out of lockdown..
- The Public Health team was working closely with local education services and schools as they started to re-open.
- Dr O'Grady stressed that only medical grade PPE offered full protection and should be used by health care professionals. Wearing a mask out in the community may reduce the risk of spreading and catching the virus but masks must be removed and disposed of correctly. Masks may give people a false sense of security and should not be seen as an alternative to social distancing and hand washing.

The Chairman thanked all presenters for their updates.

6 KEY PRIORITIES FOR 2020/21

Mrs A Macpherson, Cabinet Member for Adult Social Care, highlighted the following priority:

- The Better Lives service started in 2018. Its aim was to support residents to live independently for longer. This was in line with resident's wishes but also delivered savings against care home costs. The service supported re-enablement and worked with Childrens Services to support young people as they transitioned into the adulthood.

Mr G William, Cabinet Member for Communities, highlighted the following priorities a:

- To provide an effective response to the pandemic with a joint approach including:
    - The immediate response including contact tracing and local outbreak control.
    - Working with the HASC, including inviting voluntary and community sector (VCS) partners to join.
    - Creating community board profiles to with the support of local people to understand local needs.

7 WORK PROGRAMME

Members of the committee discussed ideas for the work programme and made the following comments:

- A Member felt that the "Support for carers" item should also include support for medical staff and other key workers in the health care sector.
- The request for a definitive update on the Chartridge Ward should be changed from "could" to "will".
- A Member asked for an update on social prescribing as part of the Primary Care Network item.
- A Member suggested that the new test, tracing and tracking service should be reviewed by the Committee.
- It was agreed that an n update on the delivery of the Better Lives strategy should be an item early in 2021..
- A Member commented that an update on integration of Health and Social Care would be useful at a future meeting.

ACTION:

- **Mrs Wheaton to amend the work programme in light of the above comments and circulate to Members.**
- **A briefing would be organised for Committee Members in advance of the next Select Committee.**

8 DATE OF NEXT MEETING

10 September 2020, 10am

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Report to Health & Adult Social Care Select Committee

Date:	Thursday 10th September 2020
Title:	**Mental Health in Buckinghamshire**
Author and/or contact officer:	Dr Nick Broughton, Chief Executive, Oxford Health NHS Trust Ms Debbie Richards, Managing Director, Mental Health Dr Vivek Khosla, Clinical Director for Buckinghamshire

PURPOSE OF THE PAPER

This paper gives an overview of the mental health services provided by Oxford Health Foundation Trust in Buckinghamshire and addresses a number of areas requested by the Committee:

- **An Introduction to the Trust and our services**
- **Access to services**
- **Transformation of Mental Health Services**
- **Quality & service user feedback**
- **Our COVID response**
- **Workforce Challenges in Buckinghamshire**

1 INTRODUCTION

Oxford Health NHS Foundation Trust (OHFT) provides a range of physical health, mental health, specialist mental health, social care and learning disability services for people of all ages across Oxfordshire, Buckinghamshire, Bath and North East Somerset, Swindon & Wiltshire. We are rated 'Good' by the Care Quality Commission (CQC and are actively involved in research and collaborations with Oxford University. Our Oxford Health Biomedical Research Centre (BRC) is only the second mental health BRC in the country.

Our services are delivered at community bases, hospitals, schools, GP surgeries, clinics and in people's homes. We focus on delivering care as close to home as possible. We employ more than 6000 staff and operating across more than 150 sites. Although we provide mostly community focused services, we have a capacity of nearly 400 inpatient mental health beds across our regional footprint and 130 community hospital beds in Oxfordshire

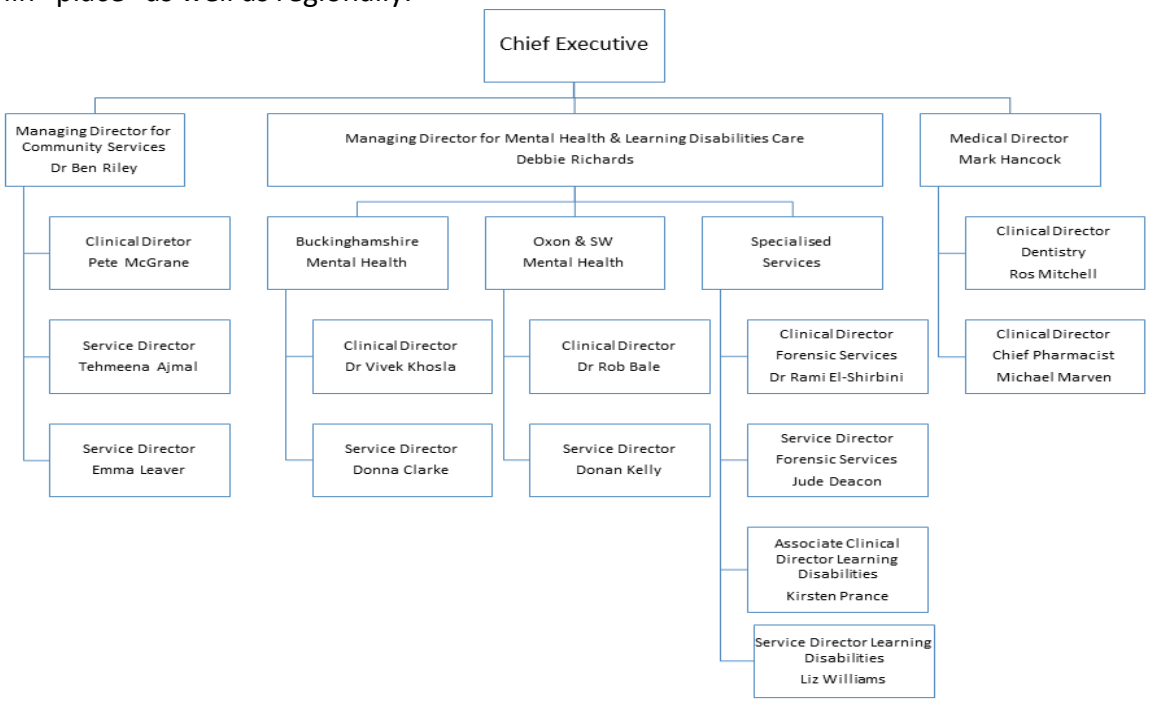
We provide the following services in each county:

Buckinghamshire	Mental health & eating disorder services for children, young people, adults and older people and Continuing Healthcare
Bath and North East Somerset, Swindon and Wiltshire	Mental health services for children and young people and eating disorder services.
Oxfordshire	Physical health – primary care & community services including community hospitals; mental health, eating disorder and learning disability services for children, young people, adults and older people.
Nationally Commissioned inpatient services	Tier 4 CAMHS, Eating Disorders and Forensic Services

System working and organisational structures

Buckinghamshire is part of the Integrated Care System (ICS) alongside Oxfordshire and West Berkshire (collectively BOB ICS). Within BOB, Oxford Health provides Mental Health services in Buckinghamshire and Oxfordshire, Berkshire Healthcare provide mental health services in West Berkshire, as well as other areas of Berkshire which fall into the Frimley ICS.

The Trust is an active partner in the Buckinghamshire Integrated Care Partnership (ICP) and has realigned its Operational Directorate Structures support the delivery of all-age services within "place" as well as regionally.



Services provided by OHFT in Buckinghamshire

Oxford Health deliver a wide variety of mental health services in Buckinghamshire. Many of these services involve strong partnership working alongside many other NHS and non-NHS providers to best meet the needs of residents. Our services include:

- Children and adolescent mental health community service (CAMHS) in partnership with Barnardo's
- Mental Health Support Teams in schools, delivered alongside education, local authority and 3rd sector partners.
- A small autism/ADHD diagnostic service
- Perinatal service working closely with maternity services, and in conjunction with health visitors, social workers, nursery nurses and peer support workers from Buckinghamshire Mind
- Adult mental health, community and inpatient services
- Urgent care (Crisis and Home treatment team, Safe Havens delivered by Buckinghamshire Mind, Street Triage team alongside ambulance and police partners, 24/7 Helpline)
- Emergency psychiatric liaison service at Stoke Mandeville hospital
- Healthy Minds: Improving access to psychological therapies or IAPT (for mild or moderate conditions), delivered alongside Richmond Fellowship and Relate.
- Support service to access and maintain employment (IPS)
- Complex needs community service for people with personality disorders
- Early intervention in psychosis service
- Eating Disorder community service
- Older people mental health, memory clinics, community and inpatient service
- Forensic mental health, community and inpatient service

Our community services in Buckinghamshire are delivered from centres in Aylesbury, High Wycombe and Amersham. In Aylesbury we have the Whiteleaf Centre, a purpose-built modern building from which our inpatient and several adult community services operate. In High Wycombe, at present we have 4 main sites, but we will be bringing 3 of these sites together into a new site on Easton Street in the new year; this development has been possible with the support of the One Public Estate work in Buckinghamshire and will bring a number of benefits for residents and our staff.

2 ACCESS TO SERVICES

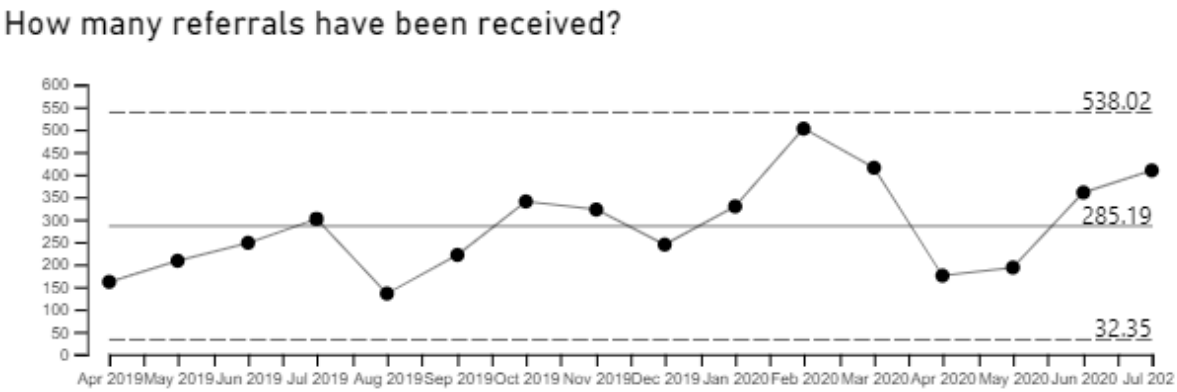
In order to be responsive, mental health services in Buckinghamshire can be accessed in a number of ways but most commonly self-referral or through the GP.

Our Child and Adolescent services (CAMHS) receive referrals from young people themselves, parents, carers, GPs, Schools, Health Visitors, Social care through a dedicated SPA (Single Point of Access). Referrals can be made directly using on the online referral form.

Buckinghamshire CAMHS access rates for treatment are greater than the national expectation – this means we see more young people than would be expected of us. This also means, however, that waiting times for non-urgent pathways and specialties are longer than children and their families may expect. Buckinghamshire CAMHS are one of a select group of services that are piloting new waiting time standards across England. We see all emergency referrals within 24 hours and urgent referrals within a week.

For all other referrals, from April 2020, the median wait time for all children seen by CAMHS in Buckinghamshire is is 22 days. These waits include children wating for neuro-developmental assessments. This service has the longest waiting list and faces the greatest challenge in terms of mismatch between the significant increase in demand and the funding provided to the team to meet this demand. WE are pleased to report that commissioners have recently made available some non-recurrent funding to help reduce the waits during the remainder of this year.

The chart below shows the number of referrals received by the CAMHS single point of access April 2019 – July 2020:



Adult and Older Adult Community Mental Health Teams receive referrals mainly from GPs and each team has a single point of access.

For individuals in Buckinghamshire with common mental health problems such as anxiety and depression, the IAPT (Improving Access to Psychological Therapies) service, Healthy Minds, is accessible via self-referral, further details can be found on their website.

IAPT services are expected to expand year on year and it is anticipated that by 2023 / 2024, over 14,000 individuals per annum will enter treatment. This year we are expecting 10,000 individuals to enter treatment in Buckinghamshire. Waiting times for IAPT services are better than national standards, over 96% of patients start treatment within 6 weeks (national target is 75%) and over 99% of patients start treatment within 18 weeks (national target is 95%). Within IAPT, we offer a number of different tailored to the needs of different populations, such as our BAME communities, those who are deaf and older adults.

For individuals that require an urgent response to their mental health need, the mental health helpline will offer immediate support and signposting to the most appropriate service. Our community and crisis teams also respond to urgent and emergency referrals as

well as more routine referrals. In an emergency, patients who present at the emergency department at Stoke Mandeville Hospital will be assessed by our Psychiatric Liaison Service. If required, a patient may be admitted to an acute hospital bed or be transferred to the Whiteleaf centre for a mental health admission.

In addition to these routes, and as part of our response to COVID we established a 24/7 Mental Health Support line (see below).

3 TRANSFORMING MENTAL HEALTH SERVICES

In the UK demands on mental health services are increasing as they are worldwide. NHS England reports that one in four adults and one in 10 children experience mental illness, and many more of us know and care for people who require support with their mental health and wellbeing.

January 2019 saw the publication of the NHS Long Term Plan (LTP). Building on the Five Year Forward View for Mental Health, the Long Term Plan made a renewed commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years and set some ambitious improvement expectations.

Under the Plan, there was a commitment that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending. This means that children and young people's mental health services will for the first time grow as a proportion of all mental health services, which will themselves also be growing faster than the NHS overall.

NHS funding is complex, but we do expect to have received over £17 million additional investment into Buckinghamshire mental health services by 2023/24.

We are working with our system partners on our Mental Health Transformation Programme and in the last 18 months we have progressed a number of key developments in Buckinghamshire mental health services including:

- New Crisis and Home treatment team
- Opening of Safe Havens with MIND in Aylesbury and High Wycombe
- Mental Health Support Teams in schools pilot sites
- Significant expansion of the Perinatal team
- IAPT expansion so that almost 10,000 individuals will enter treatment this year.

4 QUALITY OF SERVICES and SERVICE USER AND CARER FEEDBACK

We take a continuous quality improvement approach to monitoring and improving the quality of care informed by:

- Feedback from patients and service users.

- Key Performance indicators
- Learning from incidents and complaints.
- Learning from deaths to identify learning from unexpected and inpatient deaths.
- Local and national clinical audits.

I Want Great Care is the standardised system the Trust uses to offer/ collect regular electronic and paper survey feedback from patients and carers for our services and for individual teams. In addition to this method we use a range of other approaches i.e. focus groups, regular patient/carer groups, telephone interviews, complaints, compliments, patient stories, national surveys.

In the 12 months from July 2019 to 2020, we received 701 reviews for Buckinghamshire Adult and Older Adult Mental Health services with an average rating of 4.73 out of 5 and 93% were likely to recommend the service.

We also receive patient feedback from other sources for example national surveys, surveys carried out by Healthwatch and of course from complaints/concerns/accolades received by the Trust.

5 SERVICE DELIVERY DURING THE COVID-19 PANDEMIC

Oxford Health maintained the vast majority of its services throughout the COVID-19 Pandemic but did change some of the ways in which services were delivered. Along with most healthcare providers, the number of residents seeking access to services in March, April and May was lower compared with previous years. We have however seen demand return to previous levels and are now experiencing a significant surge in activity and acute presentations to our community and crisis teams.

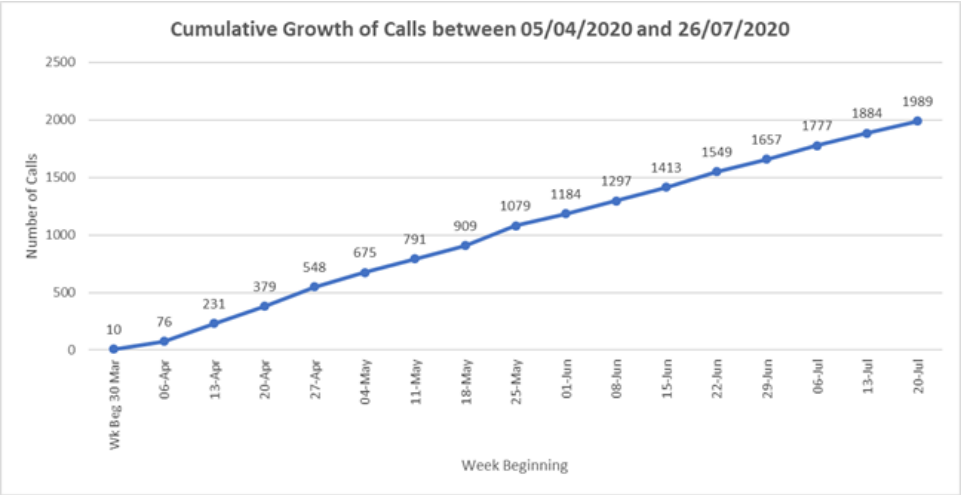
24/7 Mental Health crisis line

Trusts were requested to establish 24/7 open access telephone lines for urgent NHS mental health support, advice and triage, for people of all ages to access the NHS urgent mental health pathway / further support if needed. The main drivers were to redirect demand from NHS111 and accident and emergency departments, and to respond to an anticipated increase in mental health demand triggered by COVID-19..

Access to the helpline is via freephone telephone numbers or via NHS111 and the OHFT line covering Buckinghamshire and Oxfordshire directs callers to either the CAMHS or Adults/older adult or Learning disability service professionals. Further details can be found at the following link.

The new helpline teams were setup at pace and were initially resourced by a combination of redeployed mental health staff from the Trust and our third sector partners. We have now moved to an interim model hosted for both counties in Buckinghamshire and we are working to secure funding from commissioners to sustain the service.

The service received almost 2,000 calls between April 2020 and end July 2020. These calls were either received directly to the freephone number or diverted from 111.



Where identified as coming from either of the two counties, calls were received on a 60/40 split between Oxfordshire and Buckinghamshire.

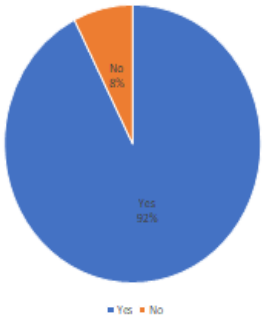
User feedback has been systematically collected and the service has received broadly positive feedback.

MH Helpline Urgent Care Feedback

NHS Oxford Health NHS Foundation Trust

Of the 8% of those respondents not recommending the helpline, we have been able to see and look to improve the way we manage frequent callers. Other learning have included how we validate callers concerns and give feedback about length of wait for services and hospital admissions in a way that callers hear without feeling like we do not care about their concerns.

Question 4 - would you recommend using the MH helpline?



"I felt I was really listened too and that she actually cared even though I was really embarrassed"

"No change - they did everything i could have asked for, maybe a text prior to calling otherwise all was perfect"

"Felt the service was good but didn't help what he needed help with which was housing and this aspect was frustrating for him "

"I spoke to so many people that where rubbish, but the mental health helpline woman was good "

"Understand the persons circumstances because some of the suggestions could not be achieved in my current environment"

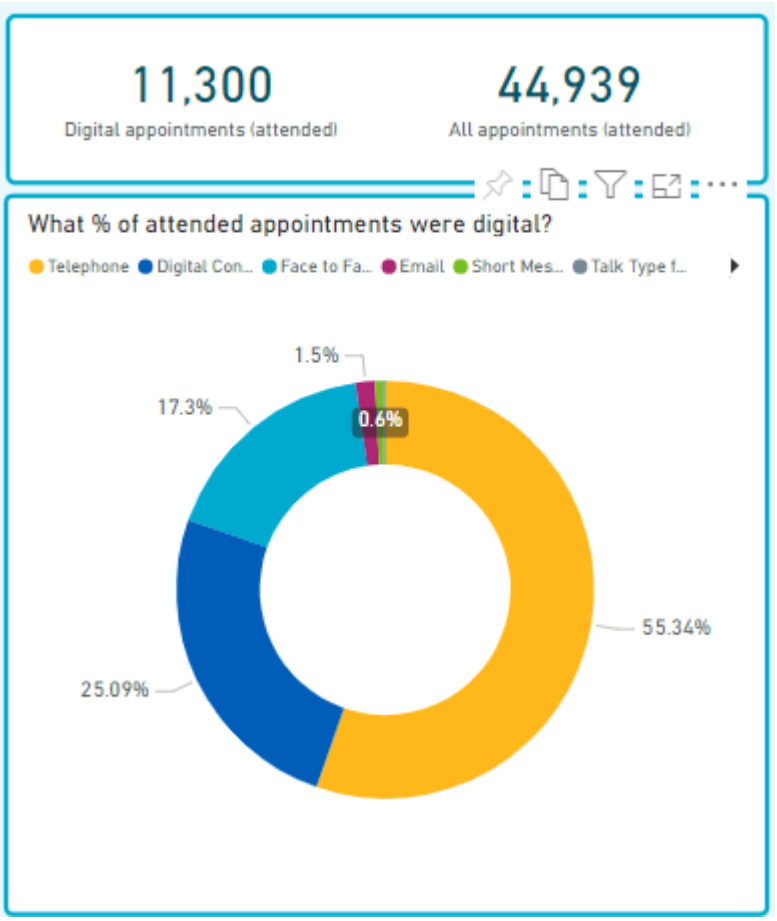
"No changes - very easy, very worth while conversation, person knew what they where talking about "

Clinical Care during the COVID Pandemic

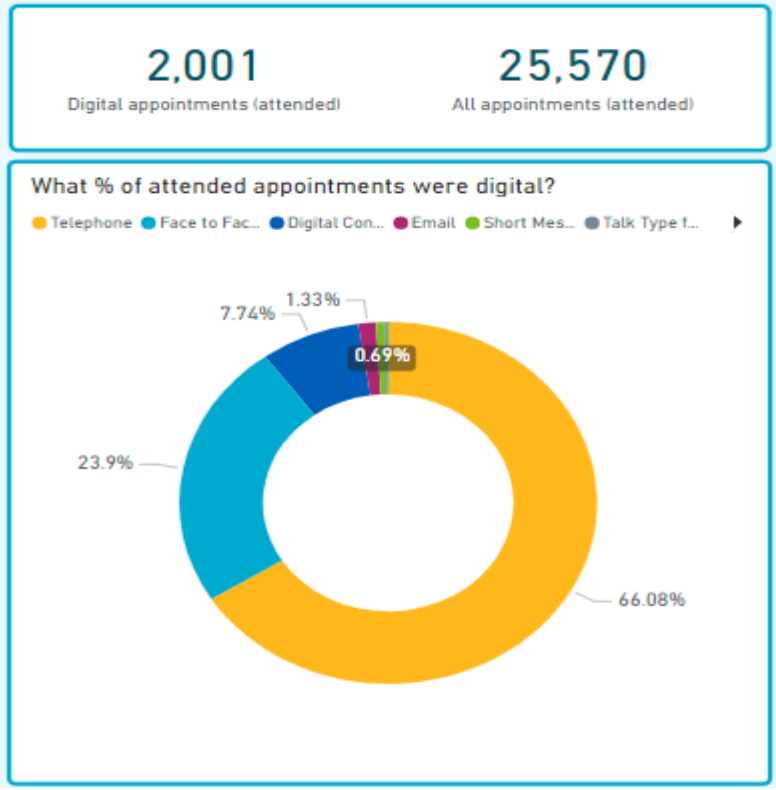
Since the beginning of the pandemic, many mental health services moved to a digital/telephone offer as the first option although face to face appointments have continued where clinically essential. Such appointments have taken place with appropriate use of personal protection equipment (PPE). Many services (such as IAPT, community teams, Day Hospital) have continued to provide high levels of contacts digitally or via telephone.

Some specific services (Memory Service, Neurodevelopmental assessments for children and adults, psychological therapies) ceased face to face contact but these services have resumed face to face contact, albeit limited in reduced numbers due to ongoing social distancing requirements, and with appropriate precautions.

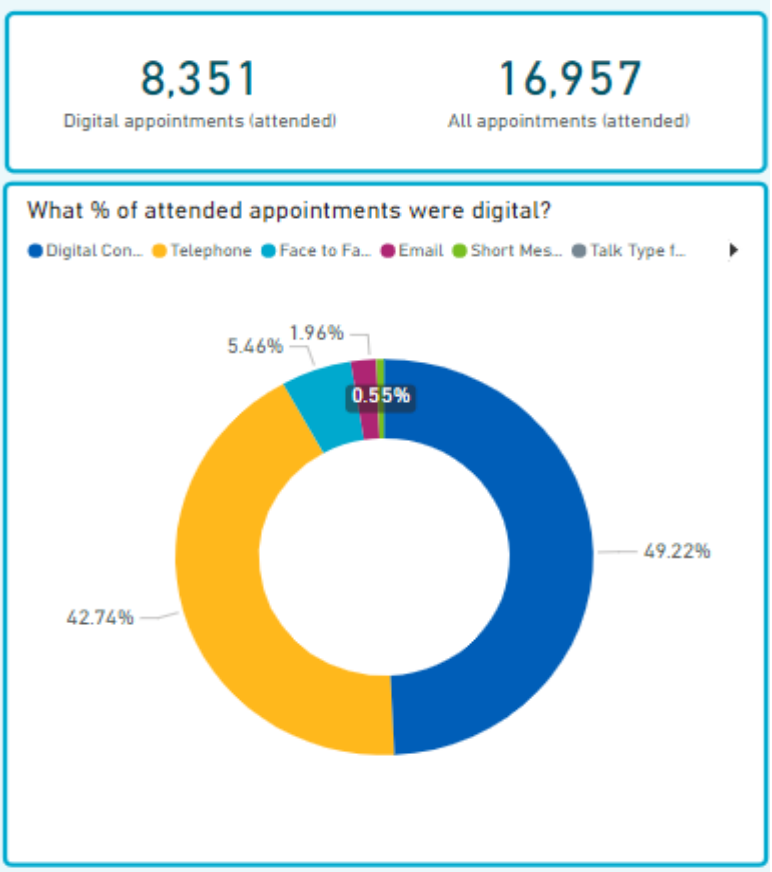
Consultations in Buckinghamshire Directorate (16th March 14th August 2020)



Consultations in Buckinghamshire Adults/Older Adults (16th March 14th August 2020)



Consultations in CAMHS (16th March 14th August 2020)



Since further easing of lockdown, we have embarked on a significant piece of work with clinical staff and estates colleagues to enable services to safely increase face to face work with patients, families and carers.

Restrictions from the lockdown had a significant impact on some aspects of care delivery and we have had to work innovatively to address these impacts. For instance, all visits to our inpatient wards had to be temporarily stopped and wards used technology to ensure patients and their loved ones were able to maintain contact with each other.

For patients in residential facilities, we have continued to provide care as required, digitally wherever possible but also face to face with suitable PPE where necessary. We have been working closely with partners in wider system to support care homes.

Quality of digital consultations

Whilst efforts continue to maximise the number of consultations undertaken digitally (and by phone) rather than face to face, our colleagues are aware of the need to focus on the quality of these consultations, both from a clinician and a patient perspective.

For clinicians, work with Oxford University Department of Psychiatry is progressing well on evaluation of digital consultations on uptake, acceptability, clinical utility and overall service impact, and also on developing a practical training programme on digital consultation to be used in routine clinical care.

We are also collecting feedback from patients and clinicians systematically. Interestingly, for some service users from BAME communities especially the younger populations, we are receiving reports that digital offers have been found to enhance access.

Urgent care pathway and interface with other emergency services

Our mental health services interface with other emergency service several levels. we have mental health workers in the NHS 111 service. Our health-based place of safety suites are located at the Whiteleaf centre for people detained under Section 136.

Due to the demands on the wider healthcare system caused by the Covid 19 pandemic, and to divert people for A & E, 111 and other emergency services, we set up an Urgent Care Centre at the Whiteleaf Centre. At this centre, individuals can be assessed, receive short term intervention, and be signposted to suitable treatment settings.

Psychiatric Liaison services (PIRLS), provide service to people who have both mental and physical health problems in a general hospital setting. They play a role in supporting people in crisis and help to reduce emergency acute admissions, attendances at A&E and extended lengths of stay which can be distressing and debilitating for patients. It is for all adults over the age of 16 presenting at A & E at Stoke Mandeville Hospital, patients over the age of 18 years admitted to wards at SMH, over the age of 65 years at Wycombe General Hospital. Berkshire Health Foundation Trust provides this service in Wexham Park.

The PIRLS operates 24 hours a day 7 days a week providing a 1-hour response time to those patients attending A&E with mental health difficulties. Extended services to the remainder of the hospital is provided 7 days a week 08:00 until 20:00. Out of hours the team is

supported by an on-call Consultant and head on call to support staff in managing any complex situations as necessary.

We also work very closely with the police. Our Street Triage team works in partnership with TVP to provide mental health advice and guidance to assist the police in their decision-making process around managing risk. The Street Triage seeks to provide an inclusive service to ensure that people who come into contact with police and are considered having a mental disorder receive a high quality, competent and effective range of interventions. The service delivery includes liaison, prevention and ultimately if needed, equitable access to mental health services across the trust. They will, where appropriate, make referrals/re-direct into other mental health services.

This service has received positive feedback from the TVP. Earlier this year, colleagues from team collected an LPA Commanders Commendation Award for their "invaluable service and commitment" to the people of Wycombe and officers of Thames Valley Police. During lockdown, the model of care changed to non-face to face support. However, our clinicians were able to return to the station from Monday 22nd June.

Support to residential and supported living

During the pandemic visits to care home settings were only carried out where absolutely necessary to minimise risk of transmitting infection within these vulnerable groups. Remote assessments were the mainstay, largely in the form of telephone contact with a small minority of contacts being carried out via digital means where facilities within the care homes allowed. In order to ensure adequate monitoring and support continued, each of the care homes were allocated a link worked who contacted the homes weekly to offer both pastoral support in addition to clinical monitoring, on a weekly basis.

The duty teams continued to offer advice in relation to patients in care home settings and also started to accept direct referrals from care home staff in order to negate delays in accessing care due to GP availability etc.

We are currently working with the CCG to contribute to the Immedicare telemedicine solution as well as working with system partners to deliver a multi-agency approach to Enhanced Health in Care Homes.

Measures taken to support staff

We are very proud of and grateful to all our staff who have worked tirelessly and innovatively during the pandemic.

We have taken significant measures to protect our workforce during this crisis. We have rolled out COVID specific risk assessments for all staff and are offering regular testing. Like in other areas, some of our staff have had to shield due to the high risk to them from Covid. The Trust has issued clear guidance to staff regarding the use of PPE at work. With the roll

out of digital consultations, we have ensured that staff are able to work remotely as much as possible. We have recently developed a 5-point Risk Reduction Plan for staff to reduce the risk of catching or transmitting COVID, alongside rolling out initiatives to promote well-being of staff.

Our IAPT service is also providing specific support for those recovering from COVID and for NHS and care staff experiencing anxiety or depression related to the pandemic.

6 WORKFORCE - BUCKINGHAMSHIRE SPECIFIC CHALLENGES

Recruitment remains a challenge across the Trust although we have continued to proactively recruit throughout the pandemic. Recruitment and Retention of qualified staff particularly in South Buckinghamshire continues to be very challenging and we have plans to try and address this.

Feedback indicates that South Buckinghamshire is impacted by the prices of properties and the proximity to neighboring Trusts who are able to offer higher financial incentives (London allowances).We are currently looking at whether a recruitment and retention premium could be offered to staff in this area but we have also taken other measures to attract staff.

The teams currently offer flexible working opportunities and good career development and training “earn while you learn” schemes.

CONCLUSION

This paper has provided an overview of mental health service provision in Buckinghamshire. More detail and resources are available through our website and the specific links contained in this paper.

Buckinghamshire Primary Care Networks

Your community Your care
Developing Buckinghamshire together

1. COVID Challenges & Recovery
2. Patient participation groups
3. PCN Overview & PCN Progress

HASC meeting 10 September 2020

Louise Smith, Dr Rashmi Sawhney & Mike Etkind

NHS Buckinghamshire Clinical Commissioning Group
NHS Buckinghamshire Healthcare NHS Trust
FedBucks
Buckinghamshire County Council
NHS Oxford Health NHS Foundation Trust
NHS South Central Ambulance Service NHS Foundation Trust

Primary Care Recovery & Restoration

- Primary Care responded rapidly during COVID-19 including moving to remote working, digital consultations, hot hubs and additional support for care homes. The response advanced quickly and effectively as a result of joined up partnership working across health and care providers and commissioners. As plans are developed in Buckinghamshire for Recovery and Restoration in Primary Care we are looking to 'lock in' new ways of working and review previous Long Term Plan and financial recovery goals.

- In Buckinghamshire we conducted a survey of general practice and worked with Time For Care, part of NHSE/I, to understand the challenges faced from COVID, suggestions for support and what changes and benefits to 'lock in'. (See full report attached)

- Primary care continues to manage the delivery of both COVID-19 and non COVID-19 services. Like other providers there is a backlog of patient care that needs to be managed and met and this will be managed through the recovery and restoration groups and clinical harm forum.

- A Primary Care Restoration and Recovery Group is advancing the primary care recovery plan. The plan will address COVID-19 recovery including content of the Phase 2 and 3 letter, feedback from the survey and learning events and the requirements of the Long Term Plan. These actions will need to be set in the context of the financial regime we expect to see announced as a part of Phase 3 announcements.

- The CCG is advancing work with the respect to restoration and recovery of all health and care services including primary care. This is being driven by the ICP and the supporting Executive Group.

General Practice Recovery & Restoration

What Has Worked Well ?

* Digital Transformation Solutions – remote consultation and patient contact
* Home working / flexible working
* Building willing, flexible strong teams working together to achieve common goals
* Total triage - reduced patient footfall and ability to ensure appropriate patient access
* Good communications across practices and with partner organisations – a sense of working together as a health system
* Less bureaucracy and administrative burdens

What was paused that needs to re-start?

* Heath checks and LTC reviews
* Cervical Screening
* B12 Injections
* Blood Pressure monitoring
* F2F consultations for vulnerable and complex patients
* Medication reviews
* QOF Work
* Internal HR functions

What have practices done during the pandemic which they can now stop doing?

* Nothing the pandemic has not stopped – we still need to continue to be cautious to protect our patients and our staff
* Screening patients at the door
* Welfare calls
* Discouraging some patients from accessing general medical services in the normal way

What support do practices and practices and primary care staff want?

* Continue to enable flexible working / working from home
* Continue to provide / provide more PPE
* Patient education campaign to encourage patients to continue accessing services appropriately as we come through / out of the pandemic
* Further digital solutions / improved digital solutions
* Good communication across the system

Phase 2 Actions Progress

Quote	Status	Proposed Ops lead	Area of work	Next steps	Notes
"Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns."	Done and assured	Louise Smith	6) Primary Care	Ensure that surgeries continue to provide clear guidance for patients - provision of sufficient PPE in line with guidelines	MJOG text messages funded for practices and Website check for key messaging
"proactively contact all those in the 'shielding' cohort of patients who are clinically extremely vulnerable to Covid19, ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary."	Done and assured	Louise Smith	6) Primary Care	Practices provided with communication for Shielded patient and a range of services they can access.	Communication to practices regarding list of "shielded" patients self registration process publicised out by the Council. Medicines drop off for shielded patients organised
"Bring forward a package of support to care homes drawing on key components of the Enhanced Care in Care Homes service and delivered as a collaboration between community and general practice teams. This should include a weekly virtual 'care home round' of residents needing clinical support."	Done and assured	Louise Smith	6) Primary Care	Work with practices re : implementation of Care Home PCN DES Monitor and act to address any gaps/ queries that emerge, supplementary network service being coproduced - all patients to receive recorded ward round - identify clinical leads for care homes at PCN level	CCG Monitoring Report underdevelopment to show practice performance against requirements Care Home Tracker in use provides daily updates from Care Home re their risk status ICP care home group established to ensure coordination of activities Clinical Lead for Care Homes appointed Care Home Intelligence group established to review coordinate Outbreak Response Care Home Visiting Covid Response Service established Funding identified to support enhanced care in care homes provision and communicated to PCNs.
"Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using 'advice and guidance' options where appropriate."	Done and assured	Louise Smith	6) Primary Care	Ongoing monitoring of advice and guidance usage - regular conversations and updates with secondary care colleagues as to usage	Regular report received on referrals made by GPs and communications out to Primary Care regarding referral mechanisms and areas of coverage of Advice and Guidance
"Deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening."	Done and assured	Louise Smith	6) Primary Care	Monitor waiting lists and ensure that administration tasks for practices are kept to the minimum - support from the new Ardens suite of forms and services and manage ensure functionality of DXS is transitioned accordingly Work with NHSE SE Region on the screening expectations	Admin tasks have been reduced for Primary Care and pro-active support for elective care referrals and management maintained
"GP Practices should continue to triage patient contacts and to use online consultation so that patients can be directed to the most	Done and	Louise	6) Primary Care	Extend and develop use of secondary	Intermediate care services prioritised. Continue with

Phase 2 Actions Progress

Quote	Status	Proposed Ops lead	Area of work	Next steps	Notes	Assurance chased
"Complete work on implementing digital and video consultations, so that all patients and practices can benefit."	Complete - assurance required	Balvinder Heran	6) Primary Care	Ensure that there is a standard offering across all practices	Primary Care usage of ACCURX across the board	
"Given the reduction of face-to-face visits, stratify and proactively contact their high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams." and "In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered."	Up to date and ongoing	Louise Smith	6) Primary Care	5 PCNs of 12 working with optum and national team on population segmentation and risk stratification related to COVID. It is a 20 week programme with accelerated learning for other PCNs. Data will be from acute, primary and council systems.	In the initial operational context of COVID this has been addressed and is complete. Further work will continue to ensure that any continued risk is managed in an appropriate and adaptive way.	Clinical Harms group focussed on where the greatest risk sits and how these patients are being managed by providers. Various reporting from general practice including vulnerable patient coding, frailty assessments, care planning etc. Care home (including LD/MH) support available The next steps on risk stratification in relation to COVID will be monitored through the primary care recovery group.

Phase 3 Actions Progress

Requirement	Quote	Status	Notes
Restore cancer presentation levels	To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.	In progress	Coms exercise underway across bucks to encourage patients to attend screening, report on suspected cancer (and other) presentations and access to general practice - 2ww and screening attendance to be use as proxy measure Support from Macmillan sponsored lead GP
GP activity to usual levels	General practice, community pharmacy and optometry services should restore activity to usual levels where clinically appropriate	In progress	As part of recovery and restoration, the CCG has supported practices to implement good practice guidelines on how to open up safely and financially supported practices in improving infection control standards where needed. Activity tracked as appts and compared with baseline
Community Pharmacy activity to usual levels	General practice, community pharmacy and optometry services should restore activity to usual levels where clinically appropriate	In progress	It is assumed that this should read 'community pharmacy'. Community pharmacy and optometry services are commissioned by NHSE.
Optometry activity to usual levels	General practice, community pharmacy and optometry services should restore activity to usual levels where clinically appropriate	In progress	Community pharmacy and optometry services are commissioned by NHSE.
Proactive approach to vulnerable	Reach out proactively to clinically vulnerable patients and those whose care may have been delayed.	In progress	Practices asked to ensure that they had a support plan for all those identified through the extremely vulnerable list (shielded list). Contact also made via PCN and CCG Social Prescribing Link Workers working with Buckinghamshire Council. The CCG is supporting practices with risk stratification toolkits in order to identify those most vulnerable (diabetes and respiratory complete) Text Messages have been developed that target patients with differng LTCs to signpost and encourage them towards self help support and services. inc weight/ smoking, exercise Risk Stratification work has been started to identify & prioritise those most at risk of Diabetic/ Respiratory and CVD disease and to re-engage them back into General Practice. Virtual Clincal Training has been developed in the areas of Diabets & Respiratory to ensure clinicans are kept up to date as well as guidelines/ protcols for best practice remote monitoring and enagegement of patients.
Dental practice back to F2F	Dental practices should have now mobilised for face to face interventions.	n/a	Dental services are commissioned by NHSE
Childhood immunisations and cervical screening backlog initiatives	GP practices need to make rapid progress in addressing the backlog of childhood immunisations and cervical screening through specific catch-up initiatives	n/a	Childhood immunisations and cervical screening is commissioned by NHSE. The CCG will support the NHSE Public Health plans to address the backlog of childhood immunisations and cervical screening as required, especially with reference to supporting those practices with previously low uptake, once the data is available.

Phase 3 Actions Progress

Requirement	Quote	Status	Notes
Care home medication reviews	GPs, primary care networks and community health services should build on the enhanced support they are providing to care homes, and begin a programme of structured medication reviews.	In progress	SMR referral pathway and support page set up on Bucks TeamNet webpage SMR process defined and reporting template developed– Arden's SMR template SMR Pilot in progress with expected full roll out date: September 2020. SMR trajectory should be back to pre-covid level by Xmas if PCN DES is implemented. Risks/Mitigations Understaffing and lack of capacity of senior PCN pharmacists and pharmacy teams in MOCH and local hospital trust to delivery SMR Define IT systems support for remote consultation required for SMR and linking SMR process in locals hospitals to primary care/ community.
F2F GP appointments	All GP practices must offer face to face appointments at their surgeries	In progress	In Buckinghamshire, the aim is to deliver 230,000 appointments a month by September 2020 (750,000 appointments across BOB) across all modes (face to face, home visits, telephones video/online. NHS Digital data will be monitored monthly.
Identify all LD patients	GP practices should ensure that everybody with a Learning Disability is identified on their register	In progress	Place based support offer for GP practices to deliver the LD QOF to be finalised and mobilised in 20-21 Q2 as described in LDA Recovery and Restoration plan.
LD annual health checks	GP practices should ensure that everybody with a Learning Disability has their annual health check completed;	In progress	Annual health checks completed is monitored quarterly as part of claims made against the Learning Disability DES. Check sign up to DES and follow up with practices who are not signed up. RAG based on risk to health check target not in status of workplan progress, which would RAG as green. Primary care to continue to deliver AHCs with reasonable adjustments made as appropriate. Bucks Actions 1. Trajectories reviewed- end of year target 75% 2. Practice and PCN dashboards in place to support monitoring and uptake. 3. Comms has gone to each practice in Bucks and each PCN re importance of resuming LD AHC. 4. Education, Webinar to LD leads (July) . session with PCN CDs in Sep , PLT in October . 5. Primary care LD TeamNet page – with resources, data and tools to support AHC uptake 6. Staying Healthy Workgroup resumed and supporting uptake of AHC . 7. Optimising all available levers to support uptake- LD AHC DES, QOF QI domain , PCN IIF , PCN Des Care Home.
Proactive LD screening and flu vaccinations	GP practices should ensure that everybody with a Learning Disability has access to screening and flu vaccinations proactively arranged.	Further work to be done	LD will be captured within the cohorts for screening and flu vaccinations. Patients not attending are followed up. Bucks Actions 1. Comms to practices and PCNs to improve Flu Uptake in LD population (including reasonable adjustments) 2. Working with Ardens to develop a local prompt for LD flu vaccination on clinical systems (EMIS) 3. Staying Healt hy Group supporting uptake via networks . 4. Linking comms with wider Flu Campaign in Bucks

Primary Care Recovery & Restoration

As we move into a recovery phase for Covid, a Primary Care plan, including public and patient engagement, is being developed to feed into Buckinghamshire and BOB ICS plans. The results of an initial survey of general practice are shown below.

Key Changes to Lock In:

- Remote consultations
- Home working
- Total Triage

Key Challenges:

- Managing patient expectations
- Opening up general practices in a way which is safe for staff and patients

The CCG will establish a task and finish group to look at the outcomes from our general practice survey and the Time for Care workshops. From this we will develop a comprehensive recovery and restoration plan.

The CCG Can Help By:

- Maintaining Covid hubs and visiting service
- Securing sufficient availability of PPE
- Ensuring general practice is actively involved in recovery plans
- Support and continually improve the new way of working and encourage sustainable use of technology
- Engage patient representatives in the process of embedding new sustainable and safe ways of working
- Reinforce a consistent message that general practice will not go back to how it was – to protect patients and staff coming into the surgery is no longer the default position
- Support self – help communications for the general public
- Reducing unnecessary reporting and bureaucracy

Primary Care Recovery & Restoration - What Next

- **Communication with, expectation management of and advice for patients** – explore opportunities to share expertise and consistent messaging. This could be an ask of the communications group.

- **Planned approaches to winter including capacity, surges and flu** – many practices raised this as a concern in the surveys. COVID-19 will require novel approaches to flu immunisation and management and plans for winter capacity. There is scope to plan this collaboratively.

- **Further development of multidisciplinary integrated care teams** – this is a proven mechanism for maximising workforce for delivery of patient care. There a number of services where MDT working will yield benefits. Specifically by 30 September 2020 Community Services providers are required to become party to the PCN Network agreement. The Enhanced Health in Care Homes service requires an integrated MDT to be operating from 1 October 2020.

- **Advanced advice and guidance** – building on direct contact with Consultants, looking for new ways of working in out of hospital settings. Primary Care involvement in work to recover Planned Care services. This will enable full pathway discussion and shared management of patients (waiting lists, risk of harm).

Primary Care update

August 2020

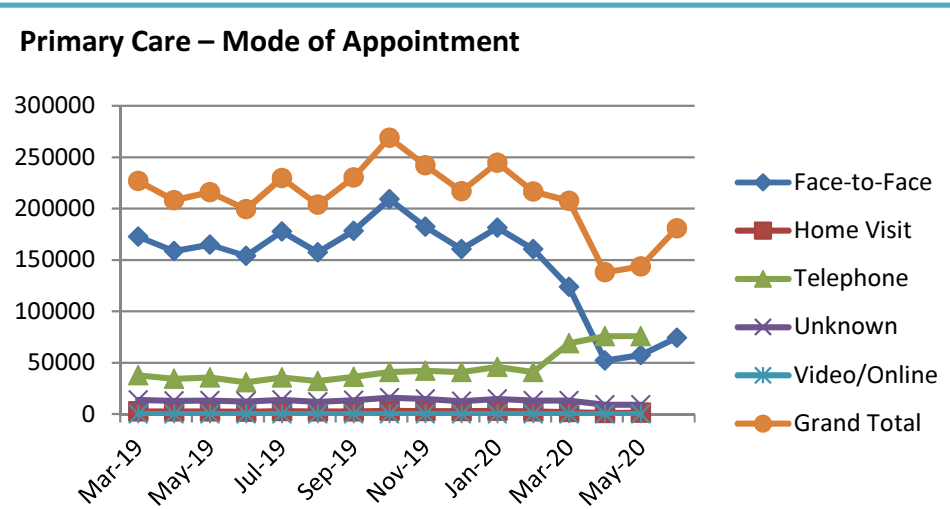
Lead: Louise Smith **PM:**

Comments & escalation

Primary Care Recovery Group has met 3 times since July and created 5 workstreams:

- Workforce
- Digital
- General Practice Recovery (Phase 3 response)
- Primary Care Network Development
- Population Health Management programme

Each group, working on a task and finish basis, will develop a workplan and report into the Primary Care Recovery Group.



Top 3 actions in last period

- Development of metrics for measuring primary care activity as part of Phase 3 recovery.
- PCNs drawing up workforce plans.
- Agreement of a Care Homes Supplementary Network Service to support PCNs to meet the care homes element of the PCN DES.

Top 3 actions in next period

- Population Health Management programme starts 20.08.20 until 28.01.21.
- Recruitment of additional roles as per PCN workforce plans.
- Delivery of flu vaccinations as part of Winter Plan.

Workstream	Status
Workforce	Green
Digital	Green
General Practice Recovery	Amber
PCN development	Amber
Population Health Management	Green

Risk	Score	Next action/ date
General Practice Recovery; resilience of general practice	20	To November, review of practice resilience and impact of covid. December, allocation of General Practice Resilience Funding as indicated.
General Practice Recovery; access to primary care	16	Monitoring of access is part of metrics, agreement of right mix of digital v face to face. On-going. Second wave of covid could de-rail restoration.
PCN development; delivery of PCN DES	16	Creating robust PCNs to enable delivery of the PCN DES. Confirmation of OD funding needed, due August.

Role of Primary Care Networks

What are PCNs

- PCNs are still relatively new, but in time networks will consist of **groups of general practices working together with a range of local providers**, including across primary care, community services, social care and the voluntary sector, to offer more personalised, joined up care to their local populations.
- Relationships will be key and PCN Accountable Clinical Directors (ACD) have a key leadership role
- One of these relationships will be with the Unitary Community Boards

Achievement to date - See next slide

20/21 Post Covid-19 Expectation

- Recurrent organisational development funding to support PCNs to progress and mature
- Additional roles reimbursement Scheme (ARRS) – 11 new roles to support care delivery
- New nationally mandated services
  - Enhanced Health in Care Homes
  - Structured Medication Review and Medicines Optimisation
  - Early Cancer Diagnosis
- Review what local services could be provided by a PCN
- Delays to
  - Improved access review
  - Personalised care
  - Investment and Impact Fund (Oct 20)

PCN Progress Update

PCN	Social Prescriber	Pharmacist	PPG Engagement	OD Events
North Bucks PCN	1	1	√	√
Westongrove PCN	1	2		√
Central BMW PCN	1	1	√	√
Central Maple PCN	1	2	√	√
AVS PCN	2	1	√	√
Chesham & Little Chalfont PCN	0	0		TBC
Mid Chiltern PCN	3 (starting 05/10/20)	0	√	√
Cygnet PCN	1	2		√
Dashwood PCN	1	Recruitment planned / underway	√	√
South Bucks PCN	1.5	1	√	√
Chalfonts PCN	1 (will cease Oct 20 with no plans to continue)	1		√
Arc Bucks PCN	1	Recruitment planned / underway	√	√

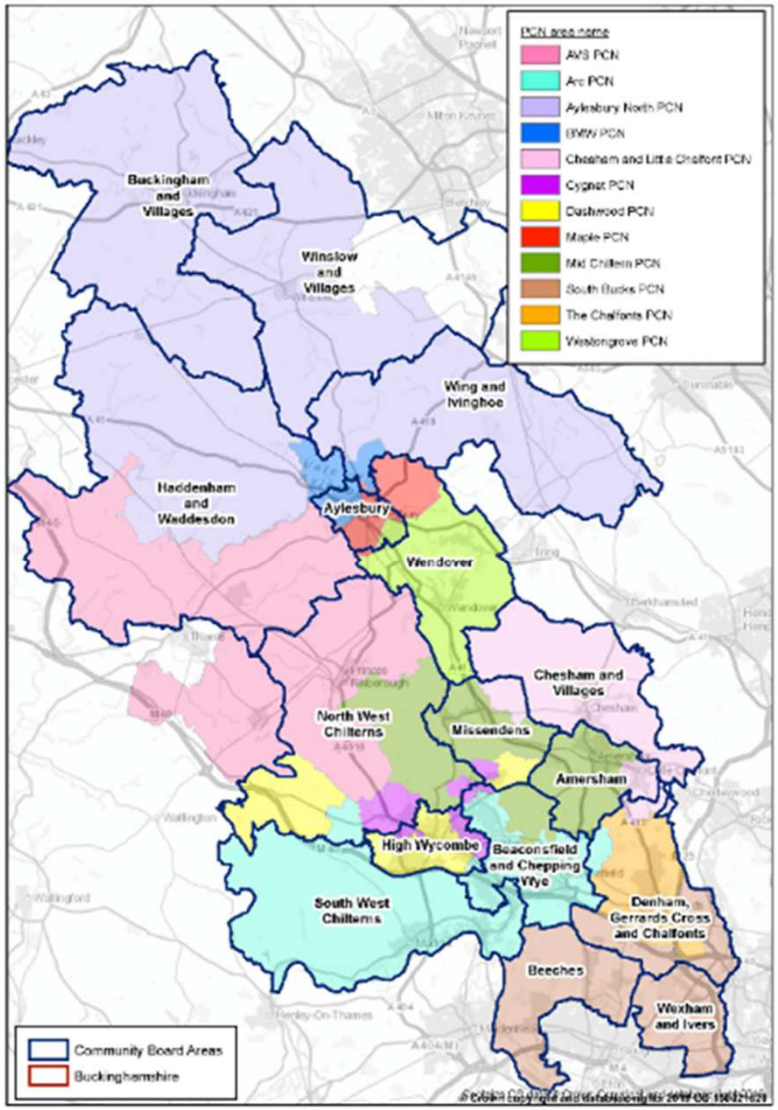
Additional Roles Reimbursement: In 2020/21 PCNs have the opportunity to recruit to 10 eligible roles:

- Clinical Pharmacists
- Pharmacy Technicians
- Social Prescribing Link Workers
- Health & Wellbeing Coaches
- Care Co-ordinators
- Physician Associates
- First Contact Physiotherapists
- Dieticians
- Podiatrists
- Occupational Therapists

PCNs have submitted workforce plans on 31 August 2020 outlining their recruitment intentions for the above eligible roles for 2020/21.

PCN & Community Board Alignment

Community Board	PCN
Buckingham and Villages	North Bucks
Winslow and Villages	North Bucks
Wing and Ivinghoe	North Bucks
Haddenham and Waddesdon	North Bucks/AV South
North West Chilterns	AV South
Aylesbury	BMW/Maple
Wendover	Westongrove
Chesham and Villages	Chesham and Little Chalfont
Amersham	Mid Chilterns
Missendens	Mid Chilterns
High Wycombe	Dashwood/Cygnet
Beaconsfield and Chepping Wye	Arc Bucks
South West Chilterns	Arc Bucks
Denham, Gerrards Cross and Chalfonts	Chalfonts/South Bucks
Beeches	South Bucks
Wexham and Ivers	South Bucks



PCN & Community Board Activity

- Original engagement with the PCNs whilst agreeing the Community Board configuration
- Pre Covid-19 expectation that there would be an opportunity for bringing parties together in the July
- Post Covid-19
  - the BC Community Board Team is going out to PCNs Directors to update them on progress and agree how best to get engagement and representation on meetings – who and how
  - Need a two-way communication approach to problems, projects and priorities
  - Shared understanding of population Health needs - original public health needs assessments but moving to a population health management approach including risk stratification and segmentation (project in own right).
  - Investment potential – Not just health directly but recognising the many health needs are influenced by the social determinants of health
  - Supporting the community board level Covid-19 response
- Next Steps
  - Identifying the key areas of focus
  - Wider public engagement – PPG involvement
  - September community board meetings scheduled and need health representation

Pre Covid-19 Challenges & Support Required

Challenges

PCN Specific Are the expectations too high?

- Pace of delivery versus strengthening of relationships & collaboration
- New services specs – considerable challenge

- How prepared are they
- Are they sufficiently resourced
  - Management support

Integrated Working

- Varied progress by groups of practices and community partners in integrating
- Lack of capacity to develop above BAU
- Persistent 'tricky' issues that are never resolved such as single system wide templates and process e.g. access to records/ACPs, trusted assessor

Community Engagement

- How do we meaningfully engage with our communities

Support

Support for PCNs and Community Providers

- Time
- Management support to PCNs
- Specialist expertise
- Transparent funding arrangements and fair funding allocation in line with local need
- Focused implementation plan
- Targeted support to deliver
- Reliable data and BI support
- Commitment to meeting community investment allocations
- Community engagement in codesign of services - unitary council / community boards

Commissioning Support

- The ICS, aligned to national guidance, to set out direction of travel – high level deliverables/outcomes
- Aligned service outcomes across community providers
- The Health and Social Care Joint Commissioning function to be strengthened at place through ICET
- At Place providers to become self regulating informed by reliable data and BI support
- Utilisation of any alternative funding arrangements to maximise collaboration and integrated delivery

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NHS
Buckinghamshire
Clinical Commissioning Group

MEETING:	Primary Care Commissioning Committee	**AGENDA ITEM:**	E
DATE:	4 June 2020		
TITLE:	Report from Scoping Work with Primary Care Representatives and Time for Care Team, NHS England		
AUTHOR:	Wendy Newton, Primary Care Transformation Manager		
LEAD DIRECTOR:	Louise Smith, Interim Director Primary Care and Transformation		

Reason for presenting this paper:	
For Action	
For Approval	
For Decision	
For Assurance	
For Information	✓

Summary of Purpose and Scope of Report:

As part of the Time for Care Programme, NHSE&I is providing support to practices, PCNs, and CCGs to capture the learning and improvements that have arisen through the Covid-19 pandemic. The goal is to enable primary care to identify and design alternative ways of working as we move through and out of this period. The CCG invited the Time for Care Team to provide some independent support to help design some of the primary care services and hub solutions for Buckinghamshire as part of a primary care recovery programme.

The Time for Care Team facilitated three virtual workshops which were designed to capture a stocktake of the situation, to build on what has worked well, learn from what has worked less well and identify what is needed for the future so that the new “business as usual” is safe, sustainable and effective. We were very grateful to have GP and Practice Manager representation at these workshops, all of whom were able to provide valuable input.

Based on the outputs from these workshops and the priorities identified, the programme offers a series of structured virtual interventions to assist in the design of any pan-Bucks initiatives that can dovetail with localised services.

Feedback from the workshops was very positive. Attendees had the opportunity to consider the conditions that enabled positive changes as a result of the pandemic and the benefits of building upon those changes. It was clear that there was a fundamental shared purpose amongst the group to move forward and to continue to deliver quality care safely for staff and patients, whilst maintaining the system drivers to allow innovation to continue to develop. There have been benefits for practices as a result of the changing way patients have accessed services, which have allowed clinicians the opportunity to prioritise their time to help patients at greatest need. It was apparent that practices teams had become stronger as a result of the challenging situation. Primary Care now has a unique opportunity to capitalise on recent changes and to continue to exploit technology and strong patient messaging to ensure that the future of primary care fully meets the needs of our patients.

As part of the next steps the primary care team will address specific areas of work that have

been highlighted by this series of workshops and endeavour to engage patient representatives to create a sustainable primary care system for the future. We recognise that patients have been tolerant to the different ways of accessing primary care throughout this situation. The primary care team intend to engage with patient representatives to ensure that changes adequately meet the needs for Buckinghamshire patients The work will also be fed into CCG, BOB ICS and integrated care provider recovery plans.

PCCC is asked to **note** the progress to date on formulating a primary care recovery plan which reflects the views of primary care teams.

Conflicts of Interest:

None arising from this paper.

Strategic aims supported by this paper:(please tick)

Better Health in Bucks – to commission high quality services that are safe, accessible to all and achieve good patient outcomes for all	✓
Better Care for Bucks – to commission personalised, high value integrated care in the right place at the right time	✓
Better Care for Bucks – to ensure local people and stakeholders have a greater influence on the services we commission	✓
Sustainability within Bucks – to contribute to the delivery of a financially sustainable health and care economy that achieves value for money and encourages innovation	✓
Leadership across Bucks – to promote equity as an employer and as clinical commissioners	☐

Governance Element	Y	N	N/A	Comments/Summary
Patient & Public Involvement		✓		.
Equality			✓	
Quality	✓			
Financial			✓	
Risks			✓	
Statutory/Legal			✓	
Prior consideration Committees / Forums / Groups			✓	
Membership Involvement			✓	

Supporting Papers:

Time for Care Covid-19 Summary
Change Model for Health and Care

GENERAL PRACTICE FORWARD VIEW

NHS

Buckinghamshire

Time for Care Covid 19 Support - summary

May 2020

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GENERAL PRACTICE
FORWARD VIEW

NHS

What changed that we want to keep / build / start?

1. Patients access to services
   a. Consultations and mix of types
   b. Appointments systems
   c. Care navigation
   d. Patient behaviours & education for the future (national message)
   e. Exploitation and how to avoid
2. Bureaucracy
   a. Hindrances identified and barriers removed
   b. Governance
3. Staff support
   a. Mental health & wellbeing
   b. Teamwork & collaboration at all levels
   c. Upskilling in different areas
4. Collaboration
   a. Within practice
   b. Across practices – network / locality / federation
   c. Across CCG
   d. National
5. Safety

Why was it possible?

During the pandemic we could see the different components of the Change Model at play including:

- Fear as a driver
- Single clear & compelling purpose - not personal agendas
- "Get on and do"
- Minimal bureaucracy / governance / measurement
- Role modelling & stepping up
- Trust

GENERAL PRACTICE
FORWARD VIEW

NHS

To recreate those conditions for our future success, we need to pay attention to:

- Developing a compelling narrative & consistent messaging across the system about what we are here for, our values and what we aspire to, so we generate and maintain the energy for change
- Patient and population ownership of their health and wellbeing, their role in staying healthy and staying safe, how they can work with us for greatest effect – how to capitalize on learning from Covid-19 (as a local system / nationally)
- Keep flatter hierarchies and straightforward decision-making processes for minimal levels of bureaucracy to keep us safe and allowing people to step in and step up
- Own our own agenda, not being driven off course by external forces and agendas – use the wind in our sails to drive us forward, not off course
- All this to keep the headroom we have had that enables us to give quality time to patients in line with clinical need, and keep both our patients and staff safe

GENERAL PRACTICE FORWARD VIEW

The CCG can help by:

NHS

- Ensuring that general practice is actively involved in recovery plans.
- Managing carefully and sensitively the opening of practices, consider feelings and fears locally and involve people in the planning and use consistent messaging.
- Supporting with new way of working and the message that what we do now is as good as (*or better than*) what we did before, including help to continually improve new ways of working
- Patients have accepted the current change but may expect things to revert to how they used to be once the crisis phase passes – how do we involve them in embedding new sustainable and safe ways of working?.
- Reinforcing a consistent message at local and national level – we won't go back to how things were; protecting patients & staff – coming to the surgery is not the default position
- Sustainable use of technology: what is the right thing that enables and supports us to do the right appts, effective delivery of care? *Technology has been rolled out and adopted – now how do we use the new solutions as effectively as possible?*
- Communication to public about self management would be a big help – big campaigns; engaging patients and public in public health and service use / redesign messages
- If we think of ourselves as an ICP rather than primary and secondary, and set priorities together and set the pathway this might help.

GENERAL PRACTICE FORWARD VIEW

Things that will hinder further progress:

NHS

Not distinguishing between want and need.

Excessive bureaucracy E.g. – contradictory messages. Need to support not mandate – and put into context. Enable and motivate – suddenly starting to performance manage on isolated issues. 'How' and 'safety' are important.

Performance management – drives certain behaviours and not necessarily the right process.

Need patients outcomes at the centre – and flow of money needs to be appropriate to the flow of outcomes. Currently through secondary care, so how does this need to change? Needs to be freer, and support to work together. *A focus on outcomes and money linked to outcomes, not to outputs, activity and transactions*

GENERAL PRACTICE FORWARD VIEW

NHS

Change Model for Health and Care

GENERAL PRACTICE
FORWARD VIEW

Something determines what we do, how we act and can be outside Of our control. We need to make sure the work we are doing is aligned to the drivers in the system otherwise we are fighting against something that is working against us.

Fear was a big driver – need to recognise that.

GENERAL PRACTICE FORWARD VIEW

Shared Purpose – what keeps us together.

Offering the best care we can under the circumstances
Minimise harm to all – staff and patients.

What happens when the message changes – did it become more confusing?

Hippocratic oath – wider than just doctors – doing the right thing in caring for people.
From cleaner to consultant there was a purpose about caring and helpful.

GENERAL PRACTICE FORWARD VIEW

One of the principles is planning ahead from the beginning – how will make it sustainable, what's already out there, what we can put into play and use to suit us. Where people use this we have greater success at making things happen and putting things into practice.

Different modes of consultation was already there – eConsult and tele consult – adopted it and ramped it up. **Used what we had in place**. Some practices had already done some things. Came back to our purpose – came back to what we are here for, helping our patients. Seen the merits.

Pace of change and adoption – for managers and patients, non-clinicians. Blockers in every group, and patients slow to adapt to change, and don't give consent. Speed of this worked in our favour.

Speed has been a great leveller – has got everyone quickly to a similar degree.

There was no other way – this was how we had to do it and **no time to think through.** Things evolved alongside. Sense of urgency and clarity of purpose helped.

Whatsapp – pace of communication. Worked like a herd – wanted to do what others were doing. Digital networking helped us to change quite quickly!

Had to give it a go – didn't quite know how but just did it.

GENERAL PRACTICE FORWARD VIEW

It almost doesn't matter what kind of tool you use, as long as you use something that is an evidence base to drive the improvements.

Is there anything we are conscious of that we used deliberately and systematically.

Evidence that we would normally fall back on wasn't there, guidance came out, some good RCGP / NHS E pages to help us develop our plans.

Early on we were overwhelmed by information – but perseverance of daily groups became really helpful. **Seeing things live and current**, and really helped us get through this, understand the information and make it useful. Teamnet has also helped. But has been overwhelming.

Guidance and advice – conflicting at times and different bodies having different views made it very difficult to navigate. Bewildering, and no risk assessment. Need the right things available to help us to do the work.

Use of PDSA – usually want to get it right first time, but because no-one knows we've had to **just get on and do it**. Seen it in motion a lot. (Permission to fail – do it quickly and make it safe, we learn more from things that fail, and having the ability to try things out.)

Involving the whole practice – whole team briefed at the same time. Team not used to this, and worried a number of the team that there wasn't an answer. And having conversations as a practices was disturbing. Transparency is good – but comes with risk.

GENERAL PRACTICE FORWARD VIEW

What do we have in place to make sure we are staying on track?

'Just do it' attitude – less concern about who does what. Just ringing up and getting on with it. The person who is doing it in the crisis may not be the person who does it once we are

Agile management style rather than the normal 'project management' – more rapid, lighter touch, rather than trying to get everything planned and right. Considering ways in which to embody this agile management style in the future.

What is the tension between governance and agility? Where is the balance between managing the risk and allowing people to test out different things.

With agility has also come some lack of accountability – need a movement towards an accountable system

Flexibility and changes in finance regime has helped, and stepping back and allowing teams to just get on. Need some governance and some flexibility. Previously wasn't the headroom to fail – have had to have rigidity. Evidence around PDSA...

How do we satisfy our governance and risk without sacrificing flexibility and pace.

Trust – what has given us that? Shared purpose helped us to break down the barriers. We knew where the motivation was. Going forward – what do we create as a shared purpose to break down the barriers. Don't build the fiefdoms around it.

GENERAL PRACTICE FORWARD VIEW

Measurement for improvement, for change – proportionate. Is it making things better or worse? Measurement as a means to an end. Is it informing what we are doing and if it's helping?

R-rate and mortality rate have helped to keep us going – are we keeping infection rate down and keeping people safe?

Tend to measure the process rather than the outcome. Most important measure is the outcome. (Acknowledging sometimes we need to measure the process because outcome far in the future).

Links to trust – confident in people's intent, and interest, we are less likely to want lots of measures.

Feedback (as a measure) – tend to overlook sometimes because the process has become so important. Cognitive bias/

GENERAL PRACTICE FORWARD VIEW

Who do we need to take with us? Not just getting them on board, but what do we need to do to let people contribute to the best of their abilities.

Patient journey – need to capitalise on it. No-one should come to the practice unless necessary. But the biggest message is about being healthy – being in charge of our own health and wellness will have a massive impact.

Everyone wanted to do something to support the wider need and wider ask – became a social movement to support the national effort.

Seeing everyone doing their bit has re-enforced the shared purpose – has inspired us all forward. Everyone is on the same side and wanting to do their best. Efforts have been really positive. At some point there will be a 'critique' which could be really de-motivating.

Been able to overcome 'self-interest'. Being able to work more closely with other teams – working differently with teams that we don't normally work with.

Fear can be a catalyst but did something else keep us going... People were quite demotivated before – felt like a job, this has brought this back to a vocation.
How do we harness this as a collective going forward as teams, to change the way we operate.

Trialling some things now in the practice as 'BAU' but how do we do this across wider teams?

GENERAL PRACTICE FORWARD VIEW

Everyone has a part to play and leading change through. Big part of that is 'role modelling'. Do we give people the space, tools, resources to lead. Are we enabling people to make this change happen. All about behaviour… what do we see happening, or what do we do to enable others to lead the change in their own way.

Where there was a void people stepped in and said 'I can do that bit' – naturally stepped outside of their comfort zones and doing things they didn't know they could do. Because people have done it others have also done it – to meet the needs of the team. Small wins (PDSA) made a difference. Re-enforced that they could try again. Positive behaviour – saying thank you! Previously hadn't happened… were being taken for granted. Saw how small things help us to achieve the bigger things. Highlights what we value.

Most junior members of the team – stepping in taking IC, PPE and stock take every day, just doing it and getting on. Reception being really caring and reaching out to vulnerable patients. Really stepping up.

Discussion about patients have changed – collegiate leadership emerging.

Do we create the conditions to allow people to lead?

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Health & Adult Social Care Select Committee				
10 Sept 2020	Mental Health Services	For Members to examine the access and quality of services provided by Oxford Health NHS Trust, particularly in light of Covid-19 crisis. To include an update on the recent launch of the 24/7 mental health crisis line.	Dr Nick Broughton, Chief Executive, Oxford Health NHS Trust	Ms Debbie Richards, Managing Director, Mental Health Dr Vivek Khosla, Clinical Director for Buckinghamshire
10 Sept 2020	Primary Care Networks (PCNs)	With the launch of PCNs in June 2019, ambitious plans were set out which included recruiting to a number of roles within the primary care networks. The Committee will review the progress PCNs are making in delivering their plans. In light of the Covid-19 crisis, the Committee will examine feedback on how GPs and patients have dealt with the changes in the way primary care has been delivered, including online/telephone consultations.	Robert Majilton, Deputy Chief Executive, Clinical Commissioning Group Louise Smith, Director of Primary Care	Representatives from Primary Care Networks – tbc Representatives from Patient Participation Groups – tbc
10 Sept 2020	Refreshed Health & Wellbeing Strategy	Members will receive the draft refreshed health & wellbeing strategy. Members will be asked to provide feedback as part of the consultation process which is taking place throughout September/October.	Gareth Williams, Cabinet Member for Communities and Public Health	Jane O'Grady, Director for Public Health Katie McDonald, Policy Lead, Health & Wellbeing Board

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5 Nov 2020	Pharmacy services	During the Covid-19 crisis, pharmacy services were under enormous pressure so this item will provide an opportunity for Members to hear from those involved in delivering these services to explore how they coped, the lessons learnt and the impact on future provision.	TBC	Jane O'Grady, Director for Public Health
5 Nov 2020	Support for Carers and key workers	The HASC undertook a one day inquiry into support for carers in October 2018. The previous Committee reviewed the progress in implementing the recommendations after 9 months so this item will look at the latest situation. In light of Covid-19, the Committee will also hear from Buckinghamshire Council and Buckinghamshire Healthcare NHS Trust on the ongoing support available for key workers.	Angela Macpherson, Cabinet Member for Adult Social Care Neil Macdonald, Chief Executive, Buckinghamshire Healthcare NHS Trust	Gill Quinton, Corporate Director for Housing and Adult Social Care Lisa Truett, Commissioning Manager (ASC) TBC – representative from BHT's health & wellbeing team
5 Nov 2020	Developing Care Closer to Home	For Members to continue monitoring and evaluating the outcomes of BHT's strategy of developing care closer to home. To include an update on the plans for Chartridge Ward, Amersham Hospital following the temporary closure in July 2019.	Neil Macdonald, Chief Executive, Buckinghamshire Healthcare NHS Trust	TBC

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5 Nov 2020	Joint Buckinghamshire, Oxfordshire and Berkshire West Health Scrutiny Committee	For Members to discuss the proposals for a joint health scrutiny within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.	Nick Graham, Service Director, Legal and Democratic Services	Liz Wheaton, Committee & Governance Adviser (Health & Adult Social Care Select Committee)
5 Nov 2020	Director for Public Health Annual report	For Members to note the annual report.	Gareth Williams, Cabinet Member for Communities and Public Health	Jane O'Grady, Director for Public Health
7 Jan 2021	Hospital Discharge	This item will focus on the recent introduction of the Discharge2Assess model and explore the impact of early discharge on the health and social care system, particularly during the Winter months.	Angela Macpherson, Cabinet Member for Adult Social Care Neil Macdonald, Chief Executive, Buckinghamshire Healthcare NHS Trust	Gill Quinton, Corporate Director for Housing and Adult Social Care Elaina Quesada, Service Director, Adult Social Care (Operations)
7 Jan 2021	Buckinghamshire Integrated Care Partnership	For Members to hear from the Leads within the ICP on key priorities and projects delivered to date.	TBC	TBC
4 March 2021	Healthcare provision	Item to be developed	TBC	TBC

DRAFT

4 March 2021	Obesity/Healthy Lifestyles	Item to be developed but could build on the Child Obesity Inquiry undertaken by the HASC in 2018 (have the child obesity rates been affected by lockdown and the plans to address any negative impact). Could also explore the impact on adult and children's eating habits/lifestyle during the Covid-19 crisis.	Gareth Williams, Cabinet Member for Communities and Public Health	Jane O'Grady, Director for Public Health Sarah Preston, Public Health Principal
29 April 2021	ASC Service Transformation	For Members to review and evaluate the progress made in delivering the projects outlined in the Better Lives Strategy.	Angela Macpherson, Cabinet Member for Adult Social Care	Gill Quinton, Corporate Director for Housing and Adult Social Care Officers from Tier 1, Tier 2 & Tier 3
29 April 2021	ASC – Quality Assurance Framework	For Members to seek assurance around the continued improvements in adult social care services.	Angela Macpherson, Cabinet Member for Adult Social Care	Jenny McAteer, Director of Quality, Performance and Standards (ASC)

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