Buckinghamshire Council

Health & Adult Social Care Select Committee

Agenda

Date: Thursday 5 November 2020

Time: 10.00 am

Venue: via MS Teams

Membership: K Ahmed, Z Ahmed, A Bacon, P Birchley, M Bradford, M Collins (Vice-Chairman), G Hollis, S Jenkins, J MacBean (Chairman), G Powell, B Roberts, A Turner, L Walsh, J Wassell, L Wood and Zoe McIntosh (Healthwatch Bucks)

Agenda Item		Time	Page No
1	**APOLOGIES FOR ABSENCE/CHANGES IN MEMBERSHIP**	**10:00**	
2	**DECLARATIONS OF INTEREST**		
3	**MINUTES** To confirm the minutes of the meeting held on Thursday 10th September 2020.		**5 - 12**
4	**PUBLIC QUESTIONS** No public questions have been submitted for this meeting.		
5	**CHAIRMAN'S UPDATE** For the Chairman to update Members on health and adult social care scrutiny related activities since the last meeting.	**10:05**	
6	**PROPOSED CLOSURE OF NEW CHAPEL SURGERY, LONG CRENDON** On 20th August 2020, Unity Health launched a public consultation on the proposed closure of New Chapel Surgery in Long Crendon. Members will hear from representatives from Unity Health, the Clinical Commissioning Group and a local action group. The consultation ends on 23rd November 2020. Presenters: Ms L Munro-Faure, Managing Partner, Unity Health Dr S Logan, Clinical Partner, Unity Health	**10:10**	**13 - 26**

Dr A Furlonger, Clinical Partner, Unity Health
Ms J Newman, Head of Primary Care, Clinical Commissioning Group
Ms F Cayley, Chairman of the Local Action Group
Ms F Momen, Member of the Local Action Group

Papers:
Consultation briefing issued by Unity Health on 20th August 2020
Future of Primary Care Services in Long Crendon (Paper prepared by Unity Health)

7 COUNTY-WIDE ENGAGEMENT EXERCISE **11:20** **27 - 38**

Covid-19 has fundamentally changed the way we provide health and social care in Buckinghamshire. The Buckinghamshire ICP agreed to undertake a comprehensive programme of public engagement about the changes we have made and discuss some the changes we are considering in order to reset health and social care services for the future.

The engagement programme has been developed around the following 4 themes – reducing health inequalities, community services, keeping people safe and non face-to-face services.

The programme and survey launched on 24th August 2020 and the survey closed on 19th October 2020. Further engagement work is planned in November. A fuller discussion on the outcomes of this work will be discussed at the January meeting.

Presenters:
Mr D Williams, Director of Strategy, Buckinghamshire Healthcare NHS Trust

Papers:
Cover report
Report which went to the Health & Wellbeing Board, July 2020

8 PHARMACY SERVICES **11:35** **39 - 56**

The Committee will hear from representatives from the Clinical Commissioning Group, the Local Pharmaceutical Committee and a local pharmacist.

Presenters:
Ms J Butterworth,
Mr M Patel, Chief Officer, Local Pharmaceutical Committee
Mr K Patel, Local Pharmacist

Papers:
Medicines Optimisation Governance paper (prepared by the CCG)
Report from the Local Pharmaceutical Committee

9 BUCKINGHAMSHIRE, OXFORDSHIRE AND WEST BERKSHIRE INTEGRATED CARE SYSTEM - JOINT HEALTH SCRUTINY COMMITTEE **12:45** **To Follow**

Details on this item to follow.

10 WORK PROGRAMME **12:55** **57 - 60**

The Committee will discuss the work programme and agree the items for the next meeting.

Presenters:
All Committee Members

Papers:
Work Programme attached

11 DIRECTOR FOR PUBLIC HEALTH ANNUAL REPORT **61 - 144**

Each year the Director of Public Health produces an annual report on the health of their population. In light of the creation of the new Buckinghamshire Council and its 16 Community Boards, this year's report focuses on the overall health and wellbeing of Buckinghamshire's population. It serves as a baseline against which progress in improving the health and wellbeing of our population can be measured. It highlights the many opportunities that the new unitary council and members have to improve the health of our residents through the council's actions on community engagement and leadership, transport, planning, the environment, the economy, education and other services. The aim is to support a strategic approach in the new council and partners to address the health of our population.

Committee Members are asked to note the Director for Public Health's Annual Report.

Papers:

Cover report
Director for Public Health Annual report

12 DATE OF NEXT MEETING **13:00**

The next meeting is due to take place on Thursday 7th January 2021 at 10am.

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

For further information please contact: 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 10 SEPTEMBER 2020 VIA VIDEO CONFERENCE, COMMENCING AT 10.02 AM AND CONCLUDING AT 1.00 PM

MEMBERS PRESENT

K Ahmed, Z Ahmed, A Bacon, P Birchley, M Bradford, M Collins, S Jenkins, J MacBean, A Turner, L Walsh and J Wassell

OTHERS IN ATTENDANCE

Mrs E Wheaton, Ms L Smith, Dr R Sawhney, Dr S Jinah, Dr N Broughton, Ms D Richards, Mr M Etkind and Dr V Khosla

Agenda Item

1 APOLOGIES FOR ABSENCE/CHANGES IN MEMBERSHIP

Apologies were received from Mr B Roberts, Mr G Powell, Mr G Hollis and Mr L Wood.

2 DECLARATIONS OF INTEREST

Julia Wassell declared that she was Chairman of the mental health sub-committee which was part of the Wycombe Community Board. Mr Z Ahmed declared that he was also a member of this sub-committee.

3 MINUTES

The minutes of the meeting held on Thursday 4th June 2020 were confirmed as a correct record.

4 PUBLIC QUESTIONS

There were no public questions submitted for this meeting.

5 CHAIRMAN'S UPDATE

The Chairman updated Committee Members on the following issues:

- **Buckinghamshire Healthcare NHS Trust's Annual Quality Account 2019/20** – the Select Committee had received the draft quality accounts and a small group of Committee Members were working on the response, which would be circulated to the full Committee in due course for their comments before submitting the final version to the Trust.

- **Proposed closure of New Chapel Surgery, Long Crendon** – the Chairman reported that she had been meeting with the key people who were involved in this and information would be shared with the Committee Members over the coming weeks. The consultation process was due to end on 23rd November 2020.

6 MENTAL HEALTH SERVICES

The Chairman welcomed Dr N Broughton, Chief Executive, Oxford Health NHS Trust, Ms D Richards, Managing Director, Mental Health and Dr V Khosla, Clinical Director for Buckinghamshire.

The following main points were made during their presentation:

- Oxford Health NHS Trust was one of the largest providers in the country with over 6,500 staff providing services across Oxfordshire and Buckinghamshire (700 staff were based in Buckinghamshire plus 200 in third party providers across Buckinghamshire).
- The Trust was part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System and had re-organised its services to reflect this.
- The Trust provided all age services in Buckinghamshire.
- There were three main pathways – Adult and Older People, Children and Young People and IAPT (access to psychological services for people suffering with anxiety and depression).
- The Whiteleaf Centre in Aylesbury hosted inpatient services and there were currently four sites in Wycombe with plans to bring three sites together on Easton Street. This project had been delayed due to the current Covid-19 pandemic.
- The CAMHS service had a single point of access and patients were then triaged to the appropriate service. For adults, referrals were mainly via the GP but they could also self-refer. There were plans in progress to make this service a single point of access as well.
- The referral rate had continued to grow over the past two years and last year the CAMHS service saw more patients than it was commissioned to see. During June and July, the referral rate had spiked.
- In Buckinghamshire there were a large number of children diagnosed with autism and ADHD.
- Healthy Minds was one of the best performing services in the country and had been operational for over 10 years.
- The NHS Long-Term Plan, published in 2019, made a commitment to invest in mental health services. Historically, mental health had been relatively underfunded and was struggling to meet demand for services.
- The Trust was rated "Good" by the Care Quality Commission and its ambition was to be outstanding across all services.
- The Trust had created a crisis team with safe havens in Wycombe and Aylesbury which was run by Bucks Mind.
- The current Covid-19 pandemic had impacted on three specific services which had ceased due to the reliance on face-to-face contact but most other services had continued, with limited capacity. Services had been offered digitally as the first port of call and then face-to-face if needed. Young people had been particularly receptive to the digital offer.
- A 24/7 mental health helpline had been established to divert the pressure from 111 and A&E. Whilst this offering had been established quickly, it was deemed unsustainable so the Trust was working with commissioners to find a solution.
- There was a Mental Health Liaison service at Stoke Mandeville which also fed into Wycombe.
- The Trust experienced unique recruitment challenges in South Buckinghamshire due to

the high cost of living and competition with London jobs and salaries. The Trust was looking at ways to make the "offer" more attractive. The Chairman asked if the Committee could see the development and recruitment plans.

ACTION: Ms Richards to send the development and recruitment plans

During the discussion, Members asked the following questions:

- In response to a question about the high referral rate, Dr Khosla explained that the Trust saw a fall in demand in April & May and then a spike in June and July. Historically there were seasonal variations with spikes normally seen in September & October time. It was acknowledged that there would be a further spike in demand due to children returning to school in September, The Trust was commissioned to see 35% of those who were referred into the service.
- Dr Broughton went on to say that the Trust was assessing and treating more patients than it was commissioned for. The Trust was pleased to report that it was exceeding its 25% target but it was not funded to treat all patients. Ongoing discussions were taking place with commissioners to address this shortfall.
- A Member asked about the amalgamation of services in Wycombe and what the feedback from service users had been about the proposed move. Dr Khosla explained that bringing the 3 sites together would bring all age groups together and currently the older people site only had four car parking spaces which created a problem with access.
- A Member went on to ask what work had been undertaken to show that this move would lead to better outcomes for patients. The Member asked to see the evidence to support this amalgamation of sites in Wycombe,

ACTION: Dr Broughton, Dr Khosla and Ms Richards to send the business case

- In response to a question about the challenges around recruitment and retention, Ms Richards explained that the Trust was committed to staff learning and development and had recently taken Nurse Cadets into the Trust as well as offering apprenticeships. The Trust had pro-actively recruited during the Covid pandemic.
- A Member asked whether the Whiteleaf Centre was fully staffed and operating at full capacity. Ms Richards responded by saying that it was a very busy site and at times it had to rely on temporary staff. Dr Broughton added that the inpatient services had to run at less than 100% to ensure it could respond to crisis situations.
- In response to a question about staff understanding of patients with Continuing Healthcare (CHC) at the Churchill and the Whiteleaf Centre, Ms Richards explained that CHC had, historically, been provided by NHS ArdenGen on behalf of the CCG but after concerns over service quality, it was transferred to Oxford Health but it was separate to Mental Health and Learning Disability services. Before the start of the Covid pandemic, the Trust worked closely with the CCG and the Council and worked within the national framework for CHC.
- A Member expressed concern about the impact of Covid-19 on in-patients in the Whiteleaf Centre and asked whether there had been any deaths. Ms Richards explained that the Centre was currently running at around 85% capacity which allowed for patients to self-isolate if they were required to do so. Technology was used to help patients keep in touch with their loved ones and visits to the wards had now started again but in a Covid safe way. There had been two deaths at the Whiteleaf – older adults who had been transferred there for end of life care.
- A Member highlighted their role on the Wycombe Community Board mental health sub-group and the focus on suicide awareness and prevention. Ms Richards said that the

Trust had a nurse consultant who would be willing to come and speak at Community Board meetings.

ACTION: Ms Richards to provide contact details to Committee & Governance Adviser

- In response to a question about whether the funding for Buckinghamshire was ring-fenced, Ms Richards explained that the funding came through the CCG and, therefore services for Buckinghamshire residents were funded by the Bucks CCG. The CCG received its funding allocation based on a formula which, historically had not played out well for Buckinghamshire due to its perceived affluence. The Trust had been successful in bidding for mental health transformation funding (some of this had been awarded at the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System level). The NHS Long-Term Plan made specific reference to investment in mental health – an additional £15m had been allocated to Buckinghamshire over the next 4 years. This would enable expansion of CAMHS, mental health teams in schools and services for looked after children.
- A Member referred to the non-recurrent funding for CAMHS that was mentioned in the report. Ms Richards explained that CAMHS was jointly commissioned by the CCG and Buckinghamshire Council. The Trust was currently in discussions with commissioners about continuing with the funding so that the demand could be met.
- A Member asked how the Trust was going to map future demand on the service due to the Covid pandemic, particularly in terms of return to work (or not) and loss of income. The Member went on to ask for more details around the Trust's plans for tackling staff well-being issues during these difficult times.

ACTION: Ms Richards to provide a response after the meeting

- A Member expressed concern about the increased rates of self-harm and suicide amongst LGBTQ+ and mentioned that work of the High Wycombe Youth Club which had helped to reduce self-harming.

The Chairman explained that the Members who were unable to attend the meeting had submitted some questions which would be sent to the Trust after the meeting for a written response.

7 REFRESHED HEALTH & WELLBEING STRATEGY

The Chairman read the following statement, prepared by the Lead Policy Officer for the Health & Wellbeing Board.

"The Health & Wellbeing Board will be seeking views on the refresh of the Joint Health & Wellbeing Survey, *Happier Healthier Lives – A shared plan for Buckinghamshire* which is due for publication in early 2021. There will be a strong emphasis on three cross cutting priorities – Tackling health inequalities, mental health and community engagement.

The document will be online for 4 weeks and HASC Members are encouraged to respond and share with their partners. It is important to highlight that the action plan that will accompany the strategy will bring in the evidence from recent "listening exercises" and consultation on Health & Social Care services and county wide Covid Recovery Plans. The action plan will predominantly focus on health & wellbeing recovery in its first year. The engagement document will be discussed at the Health & Wellbeing Board on 6th October and then finalised at the Board meeting on 10th December."

The Chairman concluded that the link to the refreshed health and wellbeing strategy would be circulated to Members shortly and Members were encouraged to respond to the consultation and to share the strategy with others.

8 PRIMARY CARE NETWORKS

The Chairman welcomed Ms L Smith, Interim Director Primary Care and Transformation, Clinical Commissioning Group (CCG), Dr R Sawhney, GP at Riverside Surgery and CCG Clinical Director, Dr S Jinah, GP at Hughenden Vale Surgery and Mid Chiltern Primary Care Network (PCN) Clinical Director and Mr M Etkind, representative from John Hampden Surgery Patient Participation Group.

During their presentations, the following main points were made:

- The Covid pandemic had halted the development plans for the Primary Care Networks, although some recruitment had taken place during the last few months (with interviews taking place via Zoom).
- Remote working for GPs had been set-up very quickly, prioritising those that had to shield or look after their families. Hubs were set-up to deal with symptomatic Covid patients, who were filtered through the 111 number.
- The CCG had worked with the Time to Care team and Patient Participation Groups (PPGs) to identify the benefits and challenges through lockdown and this feedback would be used to discuss what would continue in the recovery stage.
- The CCG was working closely with Buckinghamshire Healthcare NHS Trust to see the backlog of patients as part of the recovery plan.
- Phase 2 and 3 of the recovery action plan had been mandated by NHS England.
- There was general consensus by GPs that online consultations had worked well and there were plans to maintain these in the recovery phase as well as face-to-face consultations, where necessary.
- Primary Care Networks had submitted their 20/21 workforce plans which included identifying which additional roles they needed within their networks, including social prescribers, pharmacists, dieticians and podiatrists. A second plan to take them up to 2023/24 needed to be submitted by the end of October.
- A group had been set-up to define clinical harm, quantify and monitor this issue and the learning from this group would be shared across the system.
- Health checks would be promoted to vulnerable groups with the aim of picking up underlying issues.
- There was a pilot study with care home staff to assist with recognising clinical deterioration (RESTORE 2). A Primary Care Network Care Homes page was being developed to bring all the relevant information together in one place.
- It was acknowledged that a co-ordinated approach would be required to improve housing conditions, particularly the impact of poor housing on health conditions such as asthma and COPD.
- The new contract with NHSE included an increase in the use of digital technology to around 50% of patients so the Covid pandemic had accelerated the introduction of this.
- During the lockdown, General Practice and pharmacy was still open – calling patients to reassure them, sending out shielding letters, dealing with prescriptions, emergency blood tests and delivering medications, etc. Appointments were held by phone and/or video-consultation.
- Personal Protective Equipment had been an issue in the early days of the pandemic with poor quality PPE. A number of volunteer groups made visors for those working in primary care.
- It was acknowledged that there would be an unprecedented demand on flu jabs this

year. As yet, there were no real plans on how to resource this and deliver it in a Covid safe way.

- Mr Etkind provided feedback on the work of the Patient Participation Group he is a member of. The surgery had carried out a survey of 400 patients to find out about their experiences of accessing primary care during the lockdown – 49 out of the 114 respondents said that they had received a telephone consultation during lockdown and 80% of those patients said it had been successful/very successful. 58% of all the respondents said they would be happy to have telephone consultations instead of face-to-face in future with 11% not happy and 26% unsure – with comments from all three groups to the effect that it would depend on what they were consulting about..
- Four recommendations had been made to the surgery about remote consultations – flexibility around patient preferences and clinical judgements, maintaining much valued relationships with patients, supporting people who did not have access to digital technology or had privacy issues and providing clear communication about patient expectations.
- The strength of local communities during lockdown was acknowledged and GPs should try to harness this when thinking about how to provide services in the future.
- Whilst the benefits of holding telephone consultations had been recognised (spending more time with patients with complex needs), it was also recognised that this way of working, with GPs seeing more patients in a day, can be very tiring.

During discussion, Members made the following points and asked the following questions:

- Whilst acknowledging that the PPGs were all working differently and were at different stages of development, a Member felt that there needed to be an overall drive to have active PPGs across Buckinghamshire and that good practice needed to be shared. Ms Smith explained that the CCG was responsible for the development of the PPGs and Healthwatch had helped with this in the past. Mr Etkind added that there was no contractual agreement for Primary Care Networks to have a PPG but there could be a role for PPGs to join together to provide a patient perspective to how PCNs chose to develop local services for patients.
- A Member expressed concern about the over-reliance on technology as some patients will not have access to this and mentioned, in particular, patients with dementia. The Member suggested that receptionists need to be trained to assist people who might experience problems.
- In response to a question about flu vaccinations this year, Ms Smith explained that the CCG was working closely with the Hospital Trust and Public Health in terms of developing different models of delivery – for example, possibly using mobile testing units to get people through the vaccine programme. Good communications and signposting for GPs and patients was acknowledged as being critical to its success. Dr Jinah confirmed that there were enough flu vaccines for the patients at her surgery for the time being and there was a balance to be struck between demand and wastage.
- A Member asked whether there was data relating to the number of BAME residents in Buckinghamshire affected by Covid-19 and evidence to show why the numbers were higher in this group. Dr Sawhney clarified that overall deprivation across Buckinghamshire was not just within the BAME community but affected all groups. A national report was currently being produced which recorded ethnicity both nationally and locally. Public Health had provided local data for this report. As soon as this report was available, it would be shared with the Committee.

ACTION: Dr Sawhney to send report to the Committee & Governance Adviser

- A Member asked a specific question around GP provision and how any future plans for expanding a surgery were considered. The Member referred to Wycombe and the proposed plans for a feasibility study in the area. Ms Smith said she would speak to her colleague, Jessica Newman, in the CCG to find out more and to report back to the Committee.

ACTION: Ms Smith to speak to Jessica Newman

- In response to a question about the lack of outpatient appointments, Ms Smith explained that Hospital appointments were starting up again but the majority had been undertaken over the telephone during the past few months.

The Chairman explained that Members who were unable to attend the meeting had sent in a number of questions. These questions would be sent to Ms Smith after the meeting for a written response.

ACTION: Ms Smith to respond to written questions

9 WORK PROGRAMME

Committee Members discussed the draft work programme and agreed the following items for the November meeting:

- Pharmacy services;
- Support for carers and key workers;
- Buckinghamshire Integrated Care Partnership (ICP) Engagement Programme: Working together to improve health and social care in Buckinghamshire;
- Joint health scrutiny committee for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS);
- Director of Public Health Annual Report (item to note).

10 DATE OF NEXT MEETING

Thursday 5th November 2020 at 10am.

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Unity Health is asking patients to share their views on the future of New Chapel Surgery in Long Crendon, Buckinghamshire.

The Long Crendon surgery was temporarily closed at the start of the coronavirus outbreak in March. This was done in the interests of patient and staff safety, as the layout of the building made social distancing and managing the risk of infection virtually impossible.

This situation has highlighted the fact that the Long Crendon surgery is really no longer suitable for the needs of a modern GP practice. The ageing building, which has no car parking facilities and poor disabled access, cannot be expanded or redeveloped to adequate standards. It is no longer possible to safely offer the level of service to patients that we would wish to as a modern, innovative GP Practice.

As a result of these considerations, Unity Health now believes the best course of action is to permanently close the Long Crendon surgery. We hope to apply to NHS Buckinghamshire Clinical Commissioning Group, which is responsible for commissioning all GP services in Bucks, to close the surgery later this year, but it is vital that we first understand the views and needs of our patients to ensure any future proposals take these into account.

Unity Health had already been using telephone consultations to assess patients across its surgeries for a number of years but has developed this and similar remote working systems further during the pandemic. Where appropriate, patients have been invited for face-to-face appointments at alternative surgeries such as Brill or Thame.

If the surgery were to close, we would transfer the Long Crendon clinicians and staff to Brill. We would plan that patients currently registered at Long Crendon would also be transferred to Unity Health, Brill to maintain continuity with their clinical team. They would still be able to see their usual GPs and nurses, and the Brill surgery has a dispensing pharmacy available for its Brill and Long Crendon dispensing patients. Unfortunately, it would not be feasible to secure premises for a new surgery in Long Crendon. We have been informed by NHS Buckinghamshire Clinical Commissioning Group that current NHS guidelines, and its future plans, mean that new-build surgeries need to cater for a significantly larger patient population than could be served in the Long Crendon area.

Dr Anna Furlonger, Partner at Unity Health, said: “We realise many patients will be disappointed at the prospect of our Long Crendon surgery closing but unfortunately this building is simply no longer fit for the purposes of modern general practice. Although some of the coronavirus restrictions may ease to some extent over the coming months, the building’s existing issues make it impossible to maintain a high standard of safe, modern healthcare provision from this site.

“We hope our patients agree that the ways we have assessed and treated them in recent months have been successful and we plan to continue this approach in the future. We are committed to ensuring our patients can access the most modern and effective healthcare possible at Unity Health. We believe that our proposal to shut the Long Crendon site is the most effective way to do that.”

“We are keen to hear any feedback from our patients on this proposal so that their views can help to shape any future plans.”

Unity Health will work closely with our Patient Participation Group and we would like to hear from our patients about how the proposed branch closure may change things for them and how to ensure patients continue to receive the best services in the future. You can give your feedback up until the 23rd November.

As we hope you will appreciate, face-to-face feedback sessions are not practical in light of the current pandemic, but patients will be able to feedback in a number of ways

- By email to: unityhealthbucks.patientfeedback@nhs.net (please enter LC Feedback as the subject on your email)
- By post to: Unity Health, Wades Field, Stratton Road, Princes Risborough, HP27 9AX
- Online, via the Your Voice Bucks platform yourvoicebucks.citizenspace.com/clinical-commissioning-group/new-chapel-surgery. There is a survey you can complete here on the services you currently use and the impact possible closure would have for you.
- You can post comments through the letterboxes of the Long Crendon, Brill and Thame surgeries.
- If you would be interested in taking part in any future virtual feedback sessions on this matter, with Partners at Unity Health, please let us know and provide your contact details - including an email address. Please provide this by the end of September so we have time to make arrangements.

Princes Risborough Surgery
(Main Site)
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Stratton Road
Princes Risborough
Bucks HP27 9AX
Tel: 01844 344281
Fax: 01844 274719
Web: www.unity-health.co.uk

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Dr Thomas Broughton Dr Anna Furlonger Dr Stuart Logan
Dr Swagatika Mohapatra Dr Michael Mulholland
Dr Stephen Stamp Dr Mike Thomas Dr Martin Thornton
Dr James Weir

Managing Partner
Lesley Munro-Faure

The Future of primary care services in Long Crendon

Purpose of this document

This document is intended to inform the discussion and decision-making about the future of primary care for people living in Long Crendon and surrounding areas.

We have set out the main issues including the background to these together with a summary of patient concerns and some information about the direction that primary care is likely to take nationally and in this part of the country over the next few years. All of the information provided in this paper is our own interpretation and references to the documents we have used are included at the end of this report.

The document goes on to set out the position of Unity Health on each of four options which are:

1. Continue providing services at New Chapel Surgery
2. Provide services from new GP premises to be built in Long Crendon
3. Close Long Crendon surgery and provide all services from Brill Surgery
4. Register all patients with Brill surgery but continue to provide some services from another facility in Long Crendon to address some of the patient concerns identified through the consultation process and the difficulties in accessing services in rural communities.

We have given a number to each of these four options for ease of reference but it is important to note that **this is not a formal options appraisal**, but rather sets out the position of Unity Health on each one.

Unity Health is committed to continuing to meet the needs of our patients currently registered with the Long Crendon surgery and this document sets out our views on how this might be achieved.

Definitions

Long Crendon or **the surgery** or **the premises**- meaning New Chapel Surgery, 38 High St, Long Crendon, Aylesbury HP18 9AF

Primary care – meaning services conventionally delivered by the staff of GP surgeries or in GP premises for which patients do not need a referral. These include GP consultations; nurse

treatments; dispensing of prescribed medicines; clinics for people with long term conditions; mother and baby clinics; vaccinations; travel vaccinations; and so on.

Background and current situation

Unity Health

Unity Health primary care provides services to over 22,000 patients from five practice premises. We are a training practice, taking GP registrars through the final stages of their GP training.

In 2017 Thame Health Centre and Long Crendon and Brill Surgeries (originally operating as Trinity Health) merged with Wellington House Practice, based in Princes Risborough and Chinnor to form Unity Health. Unity Health is now one of the larger practices in Buckinghamshire and is unusual in providing services to this number of patients across five premises covering approximately 200 square miles.

Long Crendon Surgery is one of two dispensing premises within Unity Health serving approximately 7,000 patients who live more than one mile from a community pharmacy.

Population growth

Long Crendon Parish Neighbourhood Plan 2013-2023[1] makes provision for at least 82 new dwellings in the parish. This plan is also included in the Vale of Aylesbury Local Plan 2013-2033[2] (VALP) as a proposal for 100 homes. Within the Neighbourhood Plan period the council has secured provision for a mix of housing on two village sites that have been granted outline planning permission. The Chearsley Road site has permission for 41 new houses, including 30% classed as affordable, a doctor's surgery and a children's play area. There is a Memorandum of Understanding for this site which outlines the type of housing and amenities that will be provided. Permission has also been approved at a second site in the village for 19 new houses, including 30% classed as affordable. In the plan period these two sites will contribute to the amount of affordable housing and the housing mix for the village. The effect of approximately 82 to 100 new dwellings would mean an additional 220 patients for the Unity Health surgery. This is broadly in line with the increase in list size for Long Crendon that we have seen since merger of 228 patients; a growth of around 6%.

National Strategy for primary care

General practice at scale - the General Practice Forward View[3] (5YFV) sets out a plan for primary care over the next 5 years (2016-2021), encouraging practices to work together in larger groups to offer better access and extended services. General Practice at Scale[4] is a project supported by NHS England that encourages collaboration between individual GP practices in order to deliver new care models set out in the 5YFV[5]. The update on the Forward View[6] includes a focus on investing in space that has increased flexibility to accommodate multi-disciplinary teams and to develop primary care 'at scale'. The merger that created Unity Health (see above) is in line with this ambition.

Primary care networks – GP surgeries will increasingly work together in primary care networks or hubs with a patient population of at least 30,000- 50,000 which will allow practices to share community nursing, mental health, and clinical pharmacy teams, expand diagnostic facilities, and pool responsibility for urgent care and extended access; as well as providing funding for additional roles shared across the PCN, such as social prescribers, paramedics, pharmacists, care co-ordinators and physiotherapist. GP premises need to have the physical capacity to support this. Unity Health is a member of the AVS Primary Care Network (AVS PCN). Many of the new roles, services and staff are available to the practice through the PCN. These new services and the staff that deliver them

are not attached to specific premises but work across a number of sites. Changes to premises such as Long Crendon will not affect patients' access to these new services.

Local plans for GP premises

The emerging strategy for NHS buildings in Buckinghamshire highlights a number of issues that are relevant to the situation in Long Crendon.

1. Much of the current estate is more than 55 years old and not fit for purpose
2. The backlog maintenance costs for hospital and community hospital/health centre properties are high and need to be reduced
3. Rationalising the estate - delivering care from fewer buildings - is a necessary part of delivering high-quality, integrated care
4. Larger, multi-purpose buildings are essential to achieve the NHS Five Year Forward View aim to move more care out of hospital and closer to people's homes

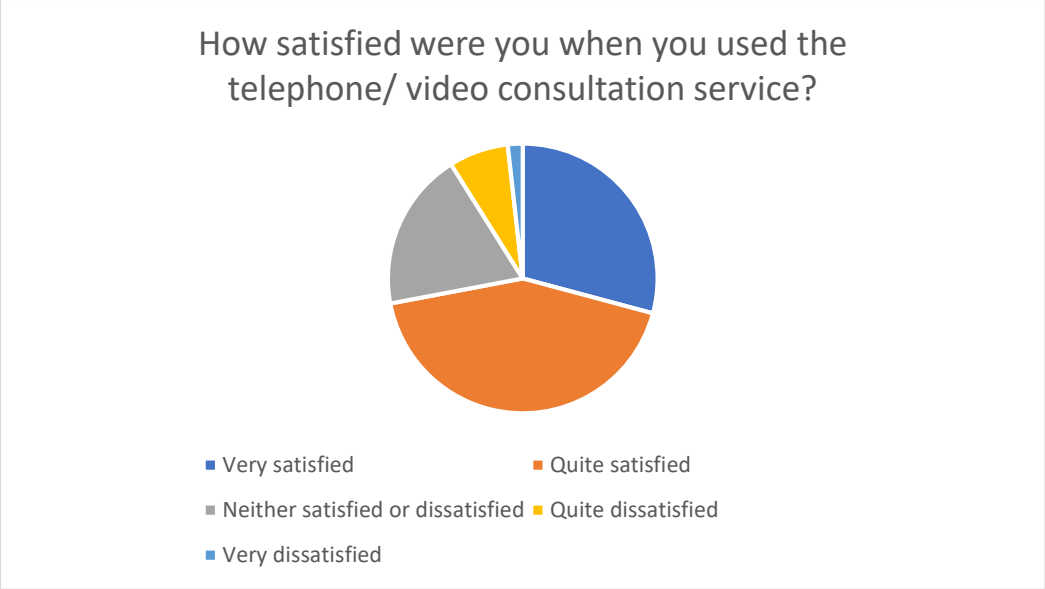
COVID-19

The COVID-19 pandemic has forced the NHS to find new ways of delivering services in hospitals, in the community and in GP practice. When we compare GP appointments in England in July 2019 to those in July 2020[7] we can see dramatic changes in the proportions of face-to-face and telephone appointments:

	Jul-19	Jul-20
Face-to-Face	79.7%	49.9%
Home Visit	0.9%	0.6%
Telephone	13.5%	45.1%
Unknown	5.3%	4.1%
Video Conference/Online	0.6%	0.4%
All appointments	100.0%	100.0%

In addition, a recent report from AISMA (Association of Independent Medical Accountants) in their Autumn newsletter reported that prior to the covid pandemic 7 in 10 GP appointments were face to face; by the end of April these figures were reversed with 3 in 10 being face to face. Some of these may be short term measures and we are working with the local health and social care system to return to 'business as usual' with the minimum delay. However, the pandemic continues to evolve and there is no clear date for a return to completely normal working. It is likely that the measures put in place to care for our patients in Long Crendon and at our other surgeries will continue for some months in many cases and may be permanent in others.

It should also be recognised that some of the innovations that have been put in place have been well received by patients and have helped to make our service more responsive and efficient. For example, of the 168 people who responded on the issue of the telephone/video consultation in the patient consultation[8], 72% were either 'very satisfied' or 'quite satisfied'.



Patient concerns

A consultation was carried out asking the residents of Long Crendon a number of questions about the future of New Chapel Surgery, Long Crendon[9]. The consultation remains open until 23 November 2020 and an interim report is available summarising the responses for each question.

At the time of writing (23 October) Unity Health has reviewed all of the comments to identify important concerns. This information is summarised in the table below:

Concern	Number	% of total
Attending Brill Surgery	164	60.3%
Pharmacy and prescription issues	91	33.5%
Attending Thame Surgery	75	27.6%
Elderly patients	65	23.9%
Parking issues	44	16.2%
Public transport	44	16.2%
Population growth in Long Crendon	24	8.8%
Children and childcare issues	16	5.9%
Total responses registering 1 or more concerns	272	

We also have additional responses via patient letters and emails. An initial review highlighted similar concerns to the ones above and we will include these in the final report once the consultation has closed.

Long Crendon does have a limited bus service to Brill; services 111, 112 and 113 provide a number of buses in the morning and the afternoon, although some services only operate during the school term and the service seems to be intermittent and un-coordinated. There are three community bus/car services locally which may cover Long Crendon or from which we could learn to look to set up something similar locally; these include Aylesbury Vale Dial-A-Ride; Winslow & District

Community Bus; and Chearsley Car Service.[10] Census data from 2011 shows that 91.6% of households in Long Crendon owned at least one vehicle.

1. Continue providing services at New Chapel Surgery

Long Crendon Surgery provides services to approximately 3,490 patients; of these approx. 2,350 live in Long Crendon and the remainder in surrounding villages so are already travelling to receive services from Long Crendon surgery. The current premises in Long Crendon are inadequate. Although well maintained, the premises are essentially 'unfit' for purpose in a number of ways including:

1. The practice team has grown to meet demand and the present space is very constrained, leading to a poor working environment and increased inefficiency
2. Teaching activities at this site have been curtailed since the premises are not suitable for GP training - with only 2 consulting rooms there are no spare clinical rooms to enable students to see patients separately. The practice has ceased its teaching programme for medical students and future GPs from this site and is unable to expand GP and nurse training facilities
3. The Practice provides a crucial and valued dispensing service to approximately 6,500 patients from Long Crendon and Brill; split roughly equally across the two sites. The current dispensary in Long Crendon is too small for the number of prescriptions dispensed
4. The premises cannot be modified to comply with the Disability Discrimination Act – for example the absence of a lift means that patient areas are limited to the ground floor where consulting rooms are small and access is challenging for some patients
5. Drainage problems are significant due to the shared nature of the drainage facilities
6. Access to the site has no safe off-road drop off area or disabled parking
7. The single, small treatment room restricts nursing provision and does not allow for minor operations to be carried out
8. Due to the size of the waiting room it is difficult to maintain patient confidentiality at the point of reception
9. Clinical room sizes, including both consulting rooms and the treatment room, are below the primary care design guidance range (the guidance is for 16m2 for consulting/treatment rooms)
10. The nature of the premises means that there is no opportunity for expansion.

Unity Health position on this option

The issues described above make it clear that it is not possible to continue delivering services from New Chapel Surgery in the longer term.

2. Provide services from new GP premises to be built in Long Crendon

Unity Health GP Partners have, over the years, engaged with the local community including the Parish Council which has proposed that a new surgery could be built on land on Chearsley Road, made available as a condition of planning permission for new houses. The Council has kindly offered to support Unity Health in building a new surgery to replace the current building.

The Chearsley Road site has a space allocated for a new doctor's surgery, although no agreement was reached with the CCG that this would be supported prior to this allocation. We understand that

the land would belong to the Parish Council for healthcare purposes only but reverts to the developer if development has not started by December 2021.

The build costs for a new surgery for the growing population of the village would be in the region of £1.4m (2016 estimate), with an additional non-recurring cost of £80,000 to furnish the surgery to current required standards. Prior to merger, Trinity Health pursued the building of a new surgery on this site a number of times (see timeline in Annex 1); these were repeatedly refused by the CCG/PCT since they were not aligned to the NHS Estates Strategy

Buckinghamshire Clinical Commissioning Group (CCG) has made clear its position on funding new GP premises (see Annex 2). There are two important points to note:

1. The CCG has no capital budget to fund new premises
2. The CCG will only support the development of new practices or premises which cater for populations of at least 10,000

A new practice premises in Long Crendon of a similar size would require us to continue working in ways that are not sustainable in the longer term. Issues include:

1. GPs, nurses and other health professionals would be required to work in isolation from the wider primary care team.
2. An impact on recruitment and retention of staff
3. Insufficient space and appropriate facilities to provide the expanded range of services available to patients using other Unity Health premises
4. The premises are not suitable for training of practice staff

Unity Health position on this option

Without support from Buckinghamshire CCG, building and sustaining new premises in the village is not financially viable.

Even if the necessary financial support were to be available, new separate premises in Long Crendon would not fit with the local or national strategy for NHS services and would not address the other issue around professional isolation/recruitment.

3. Close Long Crendon and provide all services from Brill Surgery

Patients would either transfer to neighbouring Unity Health premises in Brill or Thame or choose to register with another GP practice. Patient appointments would be held at either of these sites according to patient preference.

Patients registered at Brill Surgery would continue to access dispensing services in the same way as presently although we would also look at the possibility of establishing a delivery service for Long Crendon patients.

Visits to patients in their own homes by GPs and other staff would continue as now.

The road distance between the Long Crendon and Thame is 3 miles and 4.2 miles between Long Crendon and Brill. More than 91% of households in the Long Crendon have access to a car and off-road parking is available at both premises.

This option is in accord with national and local strategy to concentrate care in larger premises that can support the expanding range of services provided in primary care settings. In the long term, the

provision of a planned new facility in Thame would potentially allow us to deliver services that patients currently have to attend hospital for.

This option would remove the issues of our staff working in isolation and we anticipate that it will make the practice a more attractive place to work, ensuring that we continue to recruit and retain high-quality staff.

Unity Health position on this option

Closure of Long Crendon would resolve issues and avoid some of the problems highlighted in options 1 and 2, allowing us to continue to deliver a high-quality and equitable service to all Unity Health patients now and into the future.

There are a number of concerns identified by patients with this option (see section Patient concerns, above). Continuing a dispensing service and home visits would address some of these concerns but it is recognised that further work with the parish Council, patient organisations and local Healthwatch is needed to devise a suitable model that addresses these issues.

The practice recognises that this option will lead to an increase in car journeys and the accompanying environmental impact. However, the reduction in sites and the consequent efficiencies in staff travel, energy and waste disposal would need to be taken into account in any impact assessment.

4. Provide services from another facility in Long Crendon

Under this option patients would be registered with Brill as their surgery as with Option 3 above. The difference is that we would continue to provide some essential services in Long Crendon from shared, multi-use premises as detailed below. Clinical services and staff would be based primarily in Brill but would continue to run some services in Long Crendon to address issues raised in the patient consultation.

This solution relies on securing a facility that Unity Health can lease and that is suitable for delivery of the range of services identified. We believe that this should comprise:

1. Consulting rooms for GP and nurse appointments, suitable for minor procedures such as phlebotomy, injections and dressing change
2. A facility for storage and dispensing of medicines that have been prescribed to patients registered with the practice
3. A facility for patients to use for video consultations where they do not have the facility to do this at home
4. We would also like to have access to a multi-use room that would allow us to bring together the entire Unity Health team (around 70 people) for training and for practice events. We anticipate this would also be used for group patient consultations and health promotion as well as use by the wider community.
5. We would like a ‘future-proofed’ facility that could, potentially be expanded to adapt to future changes in NHS provision, including possible hosting of PCN staff.

Under this arrangement we would expect to provide the services listed below for patients who are unable to travel to the Brill surgery:

1. GP appointments

2. Nurse appointments
3. Other health professional appointments
4. Phlebotomy (taking blood for tests)
5. Clinics for people with long term conditions such as diabetes
6. Dispensing pharmacy service

Unity Health position on this option

We believe that this option has the potential to deliver a high-quality service to patients who currently use New Chapel Surgery as well as reducing professional isolation and recruitment difficulties. It would allow patients to benefit from all of the innovations and new services that will follow in the foreseeable future. This option also has the advantage of meeting many of the concerns expressed by patients regarding access, convenience and environmental impact.

It relies on finding a suitable site that could be configured for delivering the services described and that can be made available through a financial arrangement that is affordable for the practice. This requires the agreement of Buckinghamshire CCG to support the on-going running costs of the service.

Document information

Prepared by Tim Jones for Unity Health

25 October 2020

Annex 1 – Indicative timeline of key events during property negotiations relating to surgery in Long Crendon (LC)

Date	Event
2005	Completion Brill surgery / Ashley House Build – rental agreement in place
Oct 2010	Outline Business Case for New LC Surgery premises- GVA Grimley Heads of Terms agreed for 2 year option on land off Chearsley Road, LC Proposal fails approval for onward progression by PCT
Oct 2016	Update Announcement Re Primary Care Transformation Fund – Approach to funding 2016- 2019 Dame Barbara Hakin – Later referred to as ETTF below
April 2015	Letter of approach from Trinity Land on behalf of Land promoter Paul Fincken offering possible site for new surgery in LC. CCG had already been approached by them and they were informed that any proposal for a new surgery would not be supported.
Jan 2016	Outline Project Initiation Document (PID) submitted for approval from NHS England to move to a business case stage for procurement and development of primary medical care premises / Estates and Technology Transformation Fund (ETTF) bid. Bids submitted by the practice for both LC and Thame sites.
2nd Nov 2016	Emails confirming NHS England not approved onward progress of Thame project. Reserve placed on LC scheme to carry out pre-project planning.- – Helen Delaitre Head of Primary Care CCG
4th Nov 2016	Letter confirming successful application for pre-project planning costs from ETTF for LC project £50 K – Helen Delaitre Head of Primary Care CCG
20th Mar 2017	Letter of clarification of approval of funding -£25 K and reallocation to Thame Hub -Ginny Hope/ Head of Primary Care NHS England
Oct 2017	Formation of Unity Health by merger of Trinity Health and Wellington House Practices

Annex 2 - Buckinghamshire CCG position on funding new premises

Questions from the public 10/09/2020 at Bucks CCG AGM

Question stated from Diana Bowerman, on the committee for the newly formed action group to keep open Long Crendon surgery (Aylesbury Vale).

Why, when the Government wants 6000 more GPs and 50 million more appointments, is the CCG considering the proposed closure of the only GP surgery in Long Crendon, yet unsupportive of a surgery in a building in the village, fit for purpose, when the site has already been given.

NHS Buckinghamshire Clinical Commissioning Group is responsible for the commissioning of primary medical services to meet the needs of its entire county wide population. Where seeking to invest in additional service provision it must take into consideration the differing health needs of the populations it serves, existing service provision and the requirement to reduce inequalities across the county.

Each General Practice has a contract to deliver services to their registered list of patients. As part of this contract they are responsible for arranging suitable premises from which it can deliver these services. A decision to close or relocate a surgery will therefore originate from the practice. When a practice takes such a decision, it must apply to the CCG's Primary Care Commissioning Committee (PCCC) for approval.

Part of the application process requires that patients, public and local stakeholders are consulted on the proposed change (which is currently in progress with regards to Long Crendon). The PCCC then decides whether or not to approve the application, taking into account feedback from the consultation and a range of wider considerations, such as the health and social care needs of the affected area in the context of wider county requirements and service provision.

In terms of investment, although the ***CCG is responsible for reimbursing practice rent in accordance with the Premises Costs Directions, it is not responsible for developing them and indeed, does not hold any capital funding to do so***. That said, the CCG does have a role to play in setting estate strategy and ensuring value for money and upholds the following principles in line with the local and national transformation agenda:

The CCG supports the development of modern, fit for purpose premises that are accessible to local populations.

The CCG will work with practices to make sure they remain resilient and sustainable for the future. This means it would only wish to support the development of new practices or premises which cater for populations of at least 10,000, for example. If a proposal for the development of smaller premises were to be made by a practice, it would be considered. But cost and long-term sustainability would be key factors in any decision.

Where possible, the CCG will promote the consolidation of services onto fewer sites. This maximises the use of existing infrastructure and promotes joint working between healthcare services and professionals.

Response from Louise Smith, Interim Director of Primary Care and Transformation

References

[1] Long Crendon Parish Neighbourhood Plan 2013-2023

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[2]Vale of Aylesbury Local Plan 2013- 2033 https://www.aylesburyvaledc.gov.uk/section/vale-aylesbury-local-plan-valp-2013-2033

[3] NHS England (2016) General Practice Forward View. London: NHS England. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf (accessed February 2018).

[4] https://www.rcgp.org.uk/clinical-and-research/our-programmes/general-practice-at-scale.aspx

[5] Nuffield Trust (2016) A look at the facts: can large-scale general practice deliver? https://www.nuffieldtrust.org.uk/news-item/a-look-at-the-facts-can-large-scale-general-practice-deliver

[6] NHS, Next Steps on the Five Year Forward View, March 2017 https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

[7] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

[8] The future of New Chapel Surgery, Long Crendon: Interim report - consultation responses. 23 September 2020

[9] The future of New Chapel Surgery, Long Crendon: Interim report - consultation responses. 23 September 2020

[10] The Vale of Aylesbury Plan Long Crendon Fact Pack December 2011 https://www.aylesburyvaledc.gov.uk/premisess/default/files/page_downloads/LONG-CRENDON03-05-2013.pdf

Report to Health & Adult Social Care Select Committee

Date: **5th November 2020**

Title: **Buckinghamshire Integrated Care Partnership (ICP) Engagement Programme: Working together to improve health and social care in Buckinghamshire**

Author: **David Williams, Director of Strategy, Buckinghamshire Healthcare NHS Trust**

Officer support:

Recommendations/Outcomes:

The Committee is asked to note the contents of a report to the Health and Well-Being Board and to receive a verbal update on how the community engagement exercise is progressing.

1. Background

Covid-19 has fundamentally changed the way we provide health and social care in Buckinghamshire. The Buckinghamshire ICP agreed to undertake a comprehensive programme of public engagement about the changes we have made and discuss some the changes we are considering in order to reset health and social care services for the future.

The engagement programme has been developed around the following 4 themes:

- **Reducing health inequalities**: improving health for vulnerable groups and people living in deprived areas.
- **Community services**: organisations working together to promote independence and deliver care in people's homes and communities.
- **Keeping People Safe**: delivering services differently to prevent the spread of infections.
- **Non face-to-face services**: accessing care using technology such as video, telephone, apps and emails.

The paper enclosed was approved by the Buckinghamshire Health and Well-Being Board in July 2020 and provides the background and details of the programme.

2. Next steps and review

The programme and survey was launched on 24th August 2020. Detailed information can be found at the following link:-

https://yourvoicebucks.citizenspace.com/icp/health-social-care-survey-2020-1/

The survey closed on 19th October 2020 and over 2,500 responses were received. Results will be analysed and a verbal update will be provided at the Committee.

Separately, 12 focus groups and 20 1:1 interviews will take place in November 2020 to provide further detailed qualitative information for the Buckinghamshire ICP to review.

The timelines for reporting have been extended from the report to the HWW Board in July and a report will now be available by 16th December and for discussion at the HASC in January 2021.

Date: Tuesday 7 July 2020

Title: Buckinghamshire Integrated Care Partnership (ICP) Engagement Programme: *Working together to improve health and social care in Buckinghamshire*

Author and/or contact officer: Daniel Leveson, Deputy Director of Strategy, Buckinghamshire Healthcare Trust

Report Sponsor: David Williams, Director of Strategy, Buckinghamshire Healthcare Trust

Report for information/decision or approval: We are seeking the support of the Health and Wellbeing Board for our ICP approach to engaging communities in changes to health and social care.

Related Joint Health and Wellbeing Strategy Priority: Changes in Buckinghamshire ICP (ICP) aim to meet the health and social care needs of the Buckinghamshire population addressing the challenges of demographic change and population growth, health inequalities and financial sustainability.

Recommendations: The Health and Wellbeing Board is asked to support the Buckinghamshire ICP approach to engaging communities about changes related to health and social care.

1.0 Executive Summary

1.1 Covid-19 has fundamentally changed the way we provide health and social care in Buckinghamshire. We need to use this as a lens to reset services and undertake a comprehensive programme of public engagement about the changes we have already made and discuss some the changes we are considering.

We are proposing to develop a public engagement programme around the following 4 themes:

- **Reducing health inequalities**: improving health for vulnerable groups and people living in deprived areas.
- **Community services**: organisations working together to promote independence and deliver care in people's homes and communities.
- **Keeping People Safe**: delivering services differently to prevent the spread of infections.
- **Non face-to-face services**: accessing care using technology such as video, telephone, apps and emails.

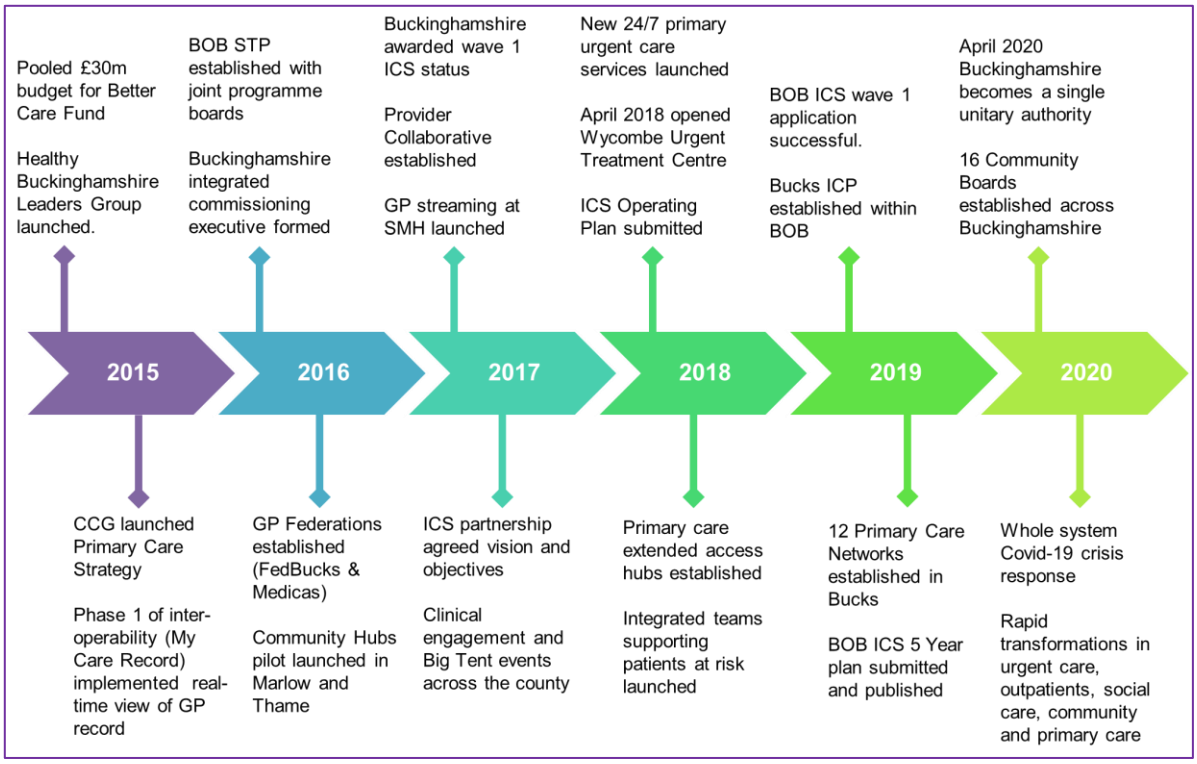
2.0 Introduction

2.1 The Buckinghamshire Integrated Care Partnership (ICP) aims to meet the health and social care needs of the Buckinghamshire population addressing the challenges of demographic change and population growth, health inequalities and financial sustainability.

2.2 On 9 June 2020, the Buckinghamshire ICP Partnership Board approved a paper that summarised the impact of Covid-19 and proposed a programme of public engagement about the changes we have made or are considering making.

2.3 This paper summarises the proposed approach of the Buckinghamshire ICP to public engagement and is seeking support from the Health and Wellbeing Board.

3.0 Bucks ICP: Our Journey So Far



4.0 Responding to Covid-19

4.1 In response to Covid-19 health and social care organisations have made rapid changes to how services are accessed and delivered. Covid-19 will continue to have profound impacts as we begin to reset the system. Some of the key things to consider include:

- The impact Covid-19 has had on the morbidity and mortality of our population, particularly in vulnerable groups and those receiving care in care homes and the community.
- Changes in the behaviour of people accessing health and care services including A&E, social care, primary care, mental health and routine and urgent referrals.
- The impact on our care processes and the rapid roll-out of non-face to face (digital or telephone) appointments including rapid changes in outpatient services and general practice consultations.
- The impact on the health and wellbeing of health and care staff and the additional support they need as well as safety measures such as personal protective equipment (PPE).
- The changes to our buildings and facilities and the impact of social distancing and segregation to reduce the risks of infection.
- Growth in waiting lists for planned care and diagnostics (including cancer pathways) and the impact on people's health.
- Rapid technology adoption to enable remote work in communities and home-working for many support services staff.

- Changes in risk thresholds and collaboration to enable rapid discharges from hospitals and to support people in their homes to avoid unnecessary admissions.
- Changes in how people access urgent care services implementing talk before you walk and appointment-based services via a single point of access.
- The likely impact of recession on financial pressures and the impact on health inequalities as the wider determinants of health adversely affect people living in deprived areas.

5.0 Previous Engagement

5.1 Over the last few years we have undertaken engagement activities that relate to developing an integrated way of working:

Integrated Care System – Staff Events

Two events held in July 2017 reaching 300 staff across six organisations: Buckinghamshire County Council, Buckinghamshire Healthcare NHS Trust, NHS Aylesbury Vale and Chiltern Clinical Commissioning Groups, Oxford Health NHS Foundation Trust, South Central Ambulance Service NHS Foundation Trust and FedBucks.
From this event, a staff advisory group was created.

Integrated Care System Health and Social Care Summit

In November 2017, we organised Buckinghamshire's health and social care summit to shape the future of health and social care integration. There was a wide spectrum of contributors at this event from across:

- Voluntary and community sector
- County Council
- District councils
- Town and parish councils
- Wider public services
- Health and social care professionals
- Patient representatives

Duncan Selbie, Chief Executive for Public Health England gave the national perspective on integration with local leaders providing the Buckinghamshire context. These helped inform debate amongst the 200 attendees on the priorities and challenges for:

- Community working
- Prevention
- Mental Health
- Carers
- Housing and growth

A video capturing attendees' reflections from the day can be seen here - https://www.youtube.com/watch?v=FXNCsqWsha4&feature=youtu.be

Overview of other related engagement activities

Engagement	Outcome
Sustainable Transformation Partnership Engagement - 2017	Public roadshow involving seven public meetings to gather the views from the localities on what was working well in their area and where there was room for improvement.
Your Community, your	The roadshows allowed us to engage with local groups, talking

care Roadshow programme Engagement - 2018	with residents about proposed changes to community services in their area and to find out what improvements they wanted to see. These roadshows reached over 600 people in 30 different groups gathering significant local views on the issues that concern people in their areas and have contributed to the formation of the community care model for the ICS.
Co-production Group – Patient Outcomes for the ICS	An initial workshop of over 30 people, who responded to an invite through the press and social media, looked at the outcomes we wanted to achieve for residents in Buckinghamshire. From this a small working group of patients worked on these and presented them to the CCG's Executive. Once these were drafted and had been presented to wider audience, they were then promoted to people through the Lets Talk Health portal. The feedback was taken into account including redrafting using the Flesch-Kincaid readability tool. These patient outcomes and how they will be measured are the result of co-production from start to finish.
Equalities, Diversity and Inequalities Steering Group	An Independent Advisory Group aims to take an independent role in facilitating engagement and to provide advice and expertise to Buckinghamshire CCG to help prevent ill health and reduce health inequalities. At its inaugural meeting Dr Ravi Balakrishnan and Dr Raj Thakkar were key speakers at the meeting. The group has received a lot of interest. As a result of this group we have: • Carried out blood pressure checks at a school on a range of staff, parents and grandparents from differing ethnic backgrounds. 50 people were engaged, 23 had blood pressure checked with 6 advised to see GP • Helped promote survey for a GP surgery through community forums, mosques and schools • Arranging more health checks in areas of most deprivation to help reduce health inequalities • working with Public Health to increase support available to schools including health and wellbeing teaching within their curriculum
Improved Access	In June 2018, we undertook a survey through social media aimed at understanding what was important to our residents. It was promoted using a range of static posts as well as gifs and videos through Facebook and Twitter with the specific aim of reaching working adults. Materials were also created in easy read to reach those with a learning disability. Over a fieldwork period of 3 weeks, 1018 responses were reached with over 60% being from those who work – our target audience. Results of the survey can be viewed here. These results were fed back to Fedbucks for creating the additional appointment times as well as the clinics and types of appointments residents wanted to see in these extended hours.

Covid-19 Related Engagement

Any planned changes are subject to appropriate patient and resident engagement and involvement

Engagement has been taking place or is due to take place during the current pandemic to understand the impact on our residents.

Data from these surveys should feed into our understanding of the appetite for change and the impact. This includes:

Organisation	Survey	Audience	Covers
Buckinghamshire Council	Public Health Coronavirus Listening Exercise	• All residents (including Residents Panel) • BAME community • Deprived groups • Men • Taxi drivers • Caring staff	• Challenges people have had • Exercise • Alcohol • Smoking • Cooking/Food poverty • Worries/concerns
Buckinghamshire Healthcare Trust	Family and Friends Survey	• Outpatients	• Use of technology for appointments
Healthwatch Bucks	Your experience of health and social care services during Covid-19	• All residents. More general in its scope, looking at patients across the board.	
	Assessing the impact on routine treatment	• Second project - look at a specific cohort of patients, such as Cancer patients or people with mental health issues, to whom delays or cancelled appointments are more critical	• Explore people's experience of delays to routine healthcare services, or services/treatments not being available • Experience of services adapting to provide digital consultation
Community Impact Bucks (VCS)	Covid-19 State of the Sector survey		• To understand how Covid-19 has impacted the VCSE sector and the key challenges they are facing. • To inform VCSE recovery plans • To inform the support we and others such as the Council provide • Help to make the case for funders and others about the support the sector needs
	Engagement with the VCSE sector around the NHS England-funded project with BOB ICS		• The project works to improve partnership working and communication at three levels: system (BOB ICS), place (e.g. Buckinghamshire Council

Any planned changes are subject to appropriate patient and resident engagement and involvement

			area) and neighbourhood (e.g. Primary Care Networks and Community Boards). • It will do this through: • Embedding partnership working with the VCSE sector at all levels of decision-making within those structures • Supporting better communication and co-ordination between the VCSE sector by creating or strengthening VCSE leadership forums or alliances

5.0 Buckinghamshire ICP Programme of Engagement

5.1 During the Covid-19 emergency we made changes without public engagement in the interests of protecting the health of the population. If there are changes we have made, or changes we are considering, that we would like to make permanently we need to engage the public.

Good communication and feedback from a diverse range of people alongside clinical perspectives will improve our understanding of the impacts of Covid-19 and the changes we have made. Each interaction is an opportunity for co-production, to identify things we may not have considered and to work with people to make changes sustainable

We are proposing to develop content and engage communities during the summer about the following 4 themes:

#	Theme	Changes / Ideas for Changes
1	**Reducing Health Inequalities** *Improving health for vulnerable groups and people living in deprived areas*	-Understanding wider determinants of health and inequalities - Implementing joint prevention plan (smoking, obesity, alcohol & social isolation) - Enhanced services for vulnerable / deprived populations
2	**Community Services** *Organisations working together to promote independence and deliver care in people's homes and communities*	- Integrated community home-first service (enabling people to stay at home or return home quickly) - Home based crisis response for over-65's & vulnerable people; enhanced intermediate care. - Introduced Clinical Assessment and Treatment service (CATs) for frail people and piloted closure of beds in community hospitals. - Community based multi-disciplinary teams (health and social care) - Enhanced services and support for care homes - Community / home based diagnostics

Any planned changes are subject to appropriate patient and resident engagement and involvement

3	**Keeping People Safe** *Delivering services differently to prevent the spread of infections*	- Appointment only services (e.g. urgent care talk b4 you walk) to reduce people waiting in rooms for appointments. - Testing, tracking, PPE etc. in health and social care. - Changes to buildings e.g. red/green zone facilities, limited visiting, changes to communal areas, smaller inpatient bays etc. - Changes to how/where planned care is delivered to meet backlog and demand
4	**Non-face to face Services** *Accessing care using technology such as video, telephone, applications or emails*	- Hospital outpatient appointments - GP appointments - Social care appointments - Therapies and community services - Mental health appointments

5.2 The engagement activity we wish to undertake will:

- Support the ICP in understanding the views of residents (especially those living in deprived areas and members of BAME population) and other stakeholders on their views of health and social care services in the future.
- Enable the ICP to co-design options for our approach to healthcare including physical location of services in dialogue with patients and stakeholders (including staff)
- Ensure the ICP in Buckinghamshire is adhering to a process for redesigning services that is in line with best practice and legal requirements

5.3 We recognise that our approach to how we undertake this process needs to take into account the impact of Covid-19 on how we can engage with our population and stakeholders. However, this does not mean we cannot undertake meaningful engagement.

We will take a phased approach to the engagement:

Phase 1: Getting health support during lockdown – how was it for you?

To help us start to explore the impact of changes in health and social care and develop options for new models of care that to deliver the aims of the ICP:

- Online engagement survey to help us understand **resident's** views on changes we have made or are considering making.
- Online engagement survey to help us understand our **staff's** (across all organisations within the ICP and VCS) views on changes we have made or are considering.
- Engagement toolkit – to allow groups, families, town and parish councils, Patient Participation Groups etc. to hold their own discussions and then feedback to us.

Phase 2: Workshops and Focus Groups (*this phase will require outsourcing).*

This Phase will overlap with Phase 1. Its purpose is to ensure we target specific groups to understand their challenges and concerns. Where possible we will also undertake after the engagement survey to use the data gathered to understand the issues and co-design our approach to meet the aims of the ICP.

Whilst, this will be for the selected agency to decide on exact methodology, we suggest it will be feasible to undertake some groups online (e.g. Zoom which allows for breakout rooms in workshops) or Face-to-face (when this becomes possible).

Any planned changes are subject to appropriate patient and resident engagement and involvement

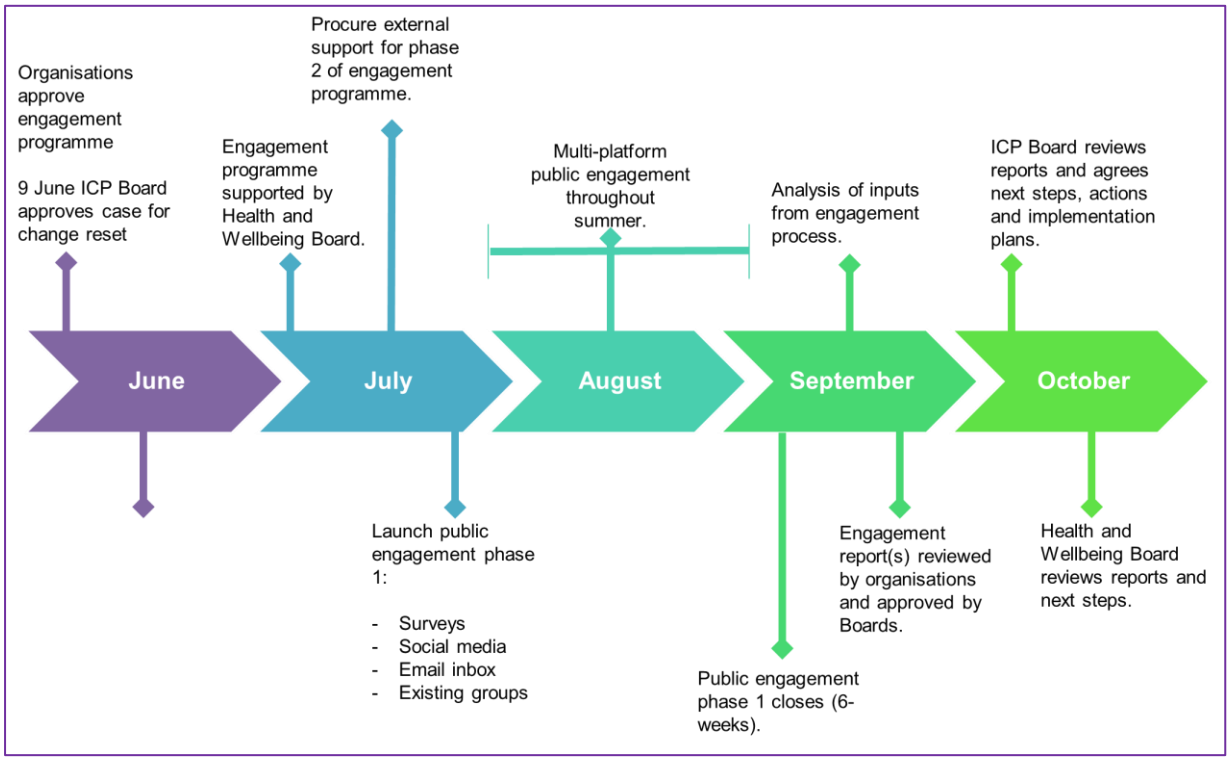
- **Co-design workshop** of an appropriate length, with approximately 30-40 participants from all stakeholder engagement groups and 'umbrella' organisations, and those impacted by Covid.
- **5 to 7 x Focus Groups** of at least 70 participants, specifically considering service users and patients and ensuring we address health inequalities and those impacted by Covid
- **20 x one-to-one** interviews to reach different demographics or directors in organisations
- Engaging with Buckinghamshire Councils newly developed **Community Boards** to understand the needs of these communities and other vulnerable groups such as people living in deprived areas and BAME populations.

Phase 3: Findings Report and Options Appraisal

- Review the feedback and who we have heard from and prepare key findings report to make next decisions on options appraisals.
- Identify what has been said.
- Identify any gaps in who we have heard from.

Please note: Buckinghamshire has a **Getting Buckinghamshire Involved** **Steering group** whose role it is to co-design and/or review all engagement and consultation activities for the health and care partnership

6.0 Timeline and Governance



6.1 The first phase of engagement will begin at the end of July and run through August into September. The final dates are subject to confirmation by the Buckinghamshire Integrated partnership Board. We are undertaking a thorough stakeholder analysis to understand if there are particular groups that may not be able to participate fully during August.

Any planned changes are subject to appropriate patient and resident engagement and involvement

6.2 We will aim to resource the programme with existing capacity from the system but where it is not available we will need to procure external support.

6.3 We will work with subject matter experts in the system develop the public narratives and to undertake credible engagement with the public.

6.4 Public Health is leading the Health Impact Assessment (HIA) and Joint Strategic Needs Assessment (JSNA) in Buckinghamshire and will provide vital insight about the impacts of Covid-19 on population health and wellbeing. The ICP engagement process will work alongside the HIA and JSNA and community boards will play a pivotal role.

6.5 The ICP Executive will oversee the process and allocate leadership responsibilities and resources.

5.0 Action required by the Health and Wellbeing Board

5.1 The Health and Wellbeing Board is asked to support the approach to engaging communities in changes to health and social care in Buckinghamshire.

It is a legal requirement to make available background papers relied on to prepare a report and these should be listed at the end of the report (copies of background papers for executive decisions must be provided). ***Hyperlinks to papers published online should be used where possible. Where there are no background papers, insert none.***

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Report to Health & Adult Social Care Select Committee

Date: 5th November 2020

Title: **Pharmacy and Medicines Optimisation in Bucks**

Author: **Jane Butterworth, Clinical Commissioning Group**

Recommendations/Outcomes:

- **For information: Governance of decision making**

1. Background

Buckinghamshire has a strong history of good medicines optimisation and joint working across the primary and secondary care interface. With the introduction of Bucks Integrated Care System, Pharmacy and Medicines Optimisation teams were in a strong position to move to a single governance structure and even closer working.

Our vision is to provide the right medicine at the right time in the right place in order to deliver the best outcomes for patients and the best value for the system. There is an agreed Bucks strategy which aims to make an impact on three key priority areas; value, safety and integration.

The Pharmacy workforce delivering NHS services sit in a number of organisations:

Acute and community trusts: statutory responsibly related to the legal and safe storage, supply and use of medicines within the trust and community settings.

CCGs: Responsible for ensuring commissioned services deliver high quality medicines optimisation and pharmacy services. Responsible for the statutory funding of NICE TAs. Supporting primary care in the clinically and cost effective safe use of medicines;

PCNs: New GP contract supports PCNs with funding for additional clinical pharmacist and pharmacy technician roles to deliver the DES;

Practice pharmacist: Some GP practices employ pharmacists as part of their team to ensure safe use of medicines;

Community pharmacy: Hold standard NHS contract managed by NHSE. They may also be commissioned to deliver local services eg health checks, antiviral stocks;

Increasingly the barriers between these different working environments are being broken down through joint posts and cross sector working. Bucks now has a single Medicines resource centre to manage all clinical queries from secondary and primary care and patients. it also manages the joint formulary and clinical guidelines.

With the introduction of the role of clinical pharmacists and pharmacy technicians in PCNs the CCG, BHT and GP federation provided a system offer to PCNs to support the recruitment, hosting arrangements, clinical supervision and networking. Pharmacy technicians are funded from 2020/21 and PCNs have been ambitious in their plans this year. Recruitment is underway but has not been without its challenges as demand is high and Covid has delayed the process.

PCN	**Clinical Pharmacists**					**Pharmacy Technicians**			
	19/20	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
North Bucks PCN	1			2.5				1	1
Westongrove PCN	1					1		0.9	
Central BMW PCN	1								
Central Maple PCN	1							1	
AVS PCN	1		2				1	1	
Chesham & Little Chalfont PCN	0			4					
Mid-Chiltern PCN	1			2					
Cygnet PCN	2			1	1			4	
Dashwood PCN	0				3				2
South Bucks PCN	1			3				1	
The Chalfonts PCN	0.6			2	5			1	
Arc Bucks PCN	1		4				1		
Totals	**10.6**	**29.5WTE**				**15.9WTE**			

Two PCNs have also been successful in securing additional funding for Pharmacy technician apprenticeships. These are supported by HEE and require partnerships between GP practices and community pharmacies.

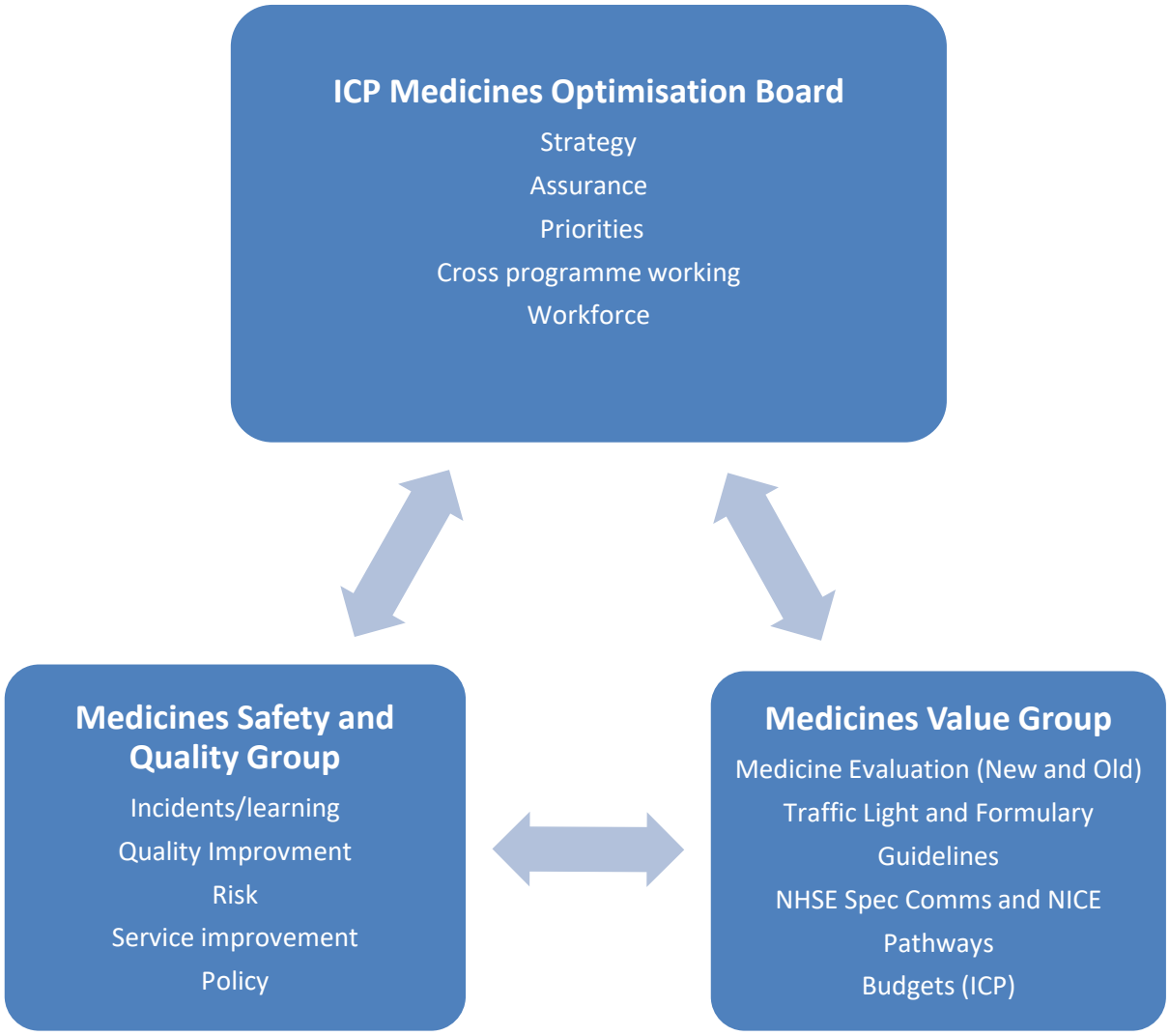
2. Bucks Pharmacy and Medicines Optimisation Governance Structure

The Bucks Medicines Optimisation system partners include:

BCCG	Medicines optimisation team
BHT	Acute Pharmacy department
OMHFT	Acute Pharmacy department

GP Federation	PCN and practice pharmacists
LPC	Representing community pharmacy contractors

These partners have agreed the single governance process below and have representatives on the Medicines Optimisation board and its subgroups:



Members of the Medicines Optimisation Board (MOB) hold individual delegated authority from their own organisations to make decisions.

include a little more detail around the recruitment of additional clinical pharmacists and pharmacy technician roles within the PCNs. Baseline details at start of recruitment process, i.e. how many in post and where, details of recruitment campaign and specific increases achieved and timelines for recruiting to the posts across the PCNs. As you may be aware, the Committee received a presentation about the PCNs at its last meeting so Members are keen to review the progress being made in recruiting to the additional roles.

3. Covid

MOB meet monthly but during Covid this was stood down and a weekly governance meeting took its place to ensure rapid decision making and mutual support. There was almost daily contact between the different organisational partners within Bucks and across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) system to ensure a consistent approach, avoiding duplication of work and sharing of workload. It was quickly recognised that it was community pharmacy rather than the acute trust that was at the point of falling over when Covid-19 first hit Bucks.

All communication to primary care was directed through a single Covid Bulletin including those related to medicines. A single FAQ document for both primary care and community pharmacy was developed across BOB and approved through a virtual governance meeting.

Mutual aid was explored. Unfortunately due to insurance constraints and no specific requests the CCG team could not mobilise staff to work within community pharmacies when the need was highest. The barriers were escalated up through regional Covid meetings to a national level and later resolved. But support in terms of communication to practices and public, information on managing stock shortages and cascade of information from national/regional meetings was given by the CCG team.

The need for rapid access to end of life drugs including delivery to care homes was identified by the system. Close working with the LPC helped identify key pharmacies to provide the service. Decision making was timely through the pharmacy governance process and the CCG financial process.

A pharmacist support whatsapp group was utilised and continues to be actively used by community, practice and PCN pharmacists to support the management of stock shortages.

Community pharmacy access to PPE and then testing was raised as an issue and the CCG team facilitated a solution through the Primary care hub.

The use of paper prescriptions was recognised as a risk in managing the spread of Covid-19. The CCG have promoted the use of Electronic prescriptions by practices and provided staff to support practices move patients onto electronic repeat dispensing, . This project is continuing to support the restoration and recovery programme and to provide additional resilience for Wave 2.

The Pharmaceutical Needs Assessments was due to be renewed and published by Local Authority Health and Wellbeing Boards in April 2021. Department of Health and Social Care announced on 22 May that due to current pressures across all sectors in response to the Covid-19 pandemic, the requirement to publish renewed Pharmaceutical Needs Assessments will be suspended until April 2022. The PNA only looks at services within the national community pharmacy contract.

The members of MOB are monitoring the impact of wave 2 of Covid-19 and will stand up more frequent governance meetings as required to support all members of the workforce where needed.

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"Community Pharmacy – the public's first choice for health care in the community"

OVERVIEW OF PHARMACY SERVICES IN BUCKINGHAMSHIRE

About the LPC

The Local Pharmaceutical Committee is an elected body recognised and specifically referred to in NHS legislation, set up to represent the interest of all local NHS Pharmacy Contractors which has to be consulted by the NHS England Area Team on all matters relating to the terms of service and contracts for Community Pharmacy. We work with the NHSE&I South East team.

The LPC is funded by a levy paid by all contractors in Buckinghamshire. The committee meets formally six times a year sometimes with other meetings in between.

The LPC is here to help and advice pharmacy contractors on all NHS matters and to improve pharmaceutical services to the local populations. Their primary aim is to accurately reflect and put forward the professional views and aspirations of all pharmacists engaged in community pharmacy that provide NHS pharmaceutical services in this area.

Buckinghamshire LPC is made up of 9 voting members and 1 chief officer. The committee has a Chair, Vice Chair and a Treasurer. The committee is a fair representation of interests of Company Chemists Association (CCA), Association of Independent Multiples (AIM) and Independent (IND) contractors.

We have 5 CCA members on the committee who represent multiples, namely Boots, Lloyds, Rowlands, Superdrug and Superstore pharmacies (Tesco, Morrisons, Asda). We have 1 AIM member on the committee who represent the mid-sized multiples, namely H A McParland, Jardines, Well, Butts & Hobbs. We have 3 IND members on the committee who represent the smaller independent pharmacies.

Please click on the link below to see our Constitution:

https://www.buckslpc.org/about/constitution-governance-annual-reports/constitution/

Please click on the link to see our latest Annual Report and Accounts:

https://www.buckslpc.org/wp-content/uploads/simple-file-list/Annual-Reports/2020/Annual-Report-Buckinghamshire-LPC-31-March-2020-Amended.pdf

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About the PSNC

The Pharmaceutical Services Negotiating Committee (PSNC) promotes and supports the interests of all NHS community pharmacies in England. They are recognised by the Secretary of State for Health and Social Care as the body that represents NHS pharmacy contractors. The PSNC works closely with Local Pharmaceutical Committees (LPCs) to support their role as the local NHS representative organisations.

Their goal is to develop the NHS community pharmacy service, to enable community pharmacies to offer an increased range of high quality and fully funded services that meet the needs of their local communities and provide value and good health outcomes for the NHS and the public.

The PSNC works with NHS England and other NHS bodies, and with the Department of Health and Social Care, to promote opportunities for the development of community pharmacy services, and negotiate the contractual terms for the provision of NHS community pharmacy services.

PSNC also operates the Prescription Audit Centre (PAC) which checks a percentage of all prescriptions sent to **NHS Prescription Services** and identifies any errors in pricing.

Please click on the link below as to PSNC Priorities and Negotiations Action List (August 2020)

https://psnc.org.uk/psncs-work/psnc-briefings-psncs-work/psnc-briefing-025-20-psnc-priorities-and-negotiations-action-list-august-2020/

About the PNA

Since April 2015, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep an up-to-date statement of the needs for pharmaceutical services for the population in its area, referred to as a pharmaceutical needs assessment (PNA). The PNA will be used by NHS England to determine whether to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The relevant local arm of the NHS England team will then review the application and decide if there is a need for a new pharmacy in the proposed location. When making the decision, NHS England is required to refer to the local PNA.

PNAs are also used by the NHS to make decisions on which NHS-funded services need to be provided by local community pharmacies. These services are part of local health care, contribute to public health and

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affect NHS budgets. The PNA may also be used to inform commissioners, such as Clinical Commissioning Groups and Buckinghamshire County Council, of the current provision of pharmaceutical services and where there are any gaps in relation to the local health priorities. Where such gaps are not met by NHS England, these gaps may then be considered by those organisations.

The PNA includes information on:

- Pharmacy contractors in Buckinghamshire on the pharmaceutical list for Buckinghamshire's Health and Wellbeing area and the essential and advanced services they currently provide
- other local pharmaceutical services, such as enhanced and locally commissioned services
- relevant maps relating to Buckinghamshire and providers of pharmaceutical services in the area
- services in neighbouring Health and Wellbeing Board areas that might affect the need for services in Buckinghamshire
- the population and health of Buckinghamshire
- potential gaps in provision that could be met by providing more pharmacy services, or through opening more pharmacies, and likely future needs.

Please click on the link below to see both the Executive and Full PNA.

https://www.buckslpc.org/professional/fmd/pharmaceutical-needs-assessment-pna/

The LPC has a role to engage with the HWB in the development of the PNA and we have a consultative role when informing about any applications made or changes wanted to be made, by contractors ,using the PNA.

Pharmaceutical Needs Assessments are due to be renewed and published by local authority health and wellbeing boards in April 2021. This document is a statutory responsibility which records the need for pharmaceutical services within a specific area. Due to current pressures in response to the COVID-19 pandemic, the Department of Health and Social Care has today announced that the requirement to publish renewed Pharmaceutical Need Assessments will be suspended until April 2022. Your health and wellbeing boards will retain the ability to issue supplementary statements to respond to local changes and pharmaceutical needs during this time. The NHS Pharmaceutical and Local Pharmaceutical Services Regulations 2013 will be updated in due course. You may wish to forward this announcement to your health and wellbeing teams, who I'm sure will welcome this reduced burden

https://content.govdelivery.com/accounts/UKLGA/bulletins/28c92ef

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Community pharmacies in the COVID-19 pandemic

Community pharmacies are continuing to support the UK's COVID-19 response as a frontline provider of pharmacy services as a very important part of the NHS family. Community pharmacies have provided a critical service during the pandemic, ensuring patients had access to the medicines and healthcare advice that they needed. Community pharmacies have been both innovative and adaptable at their own cost to make substantial changes to make them COVID-safe for their staff and everyone visiting them.

KEY PUBLIC MESSAGING

- Pharmacy teams are working hard to maintain the health services that local communities need, despite some staff becoming ill or needing to self-isolate.
- Some pharmacies have had to and may need to make further changes where local outbreaks of COVID-19 occur – the public are asked to please check opening hours before you visit.
- During the pandemic there was very high demand for pharmacy services and advice and we expect the same in the second lockdown therefore we seek from the public to be patient if it takes a bit longer for prescriptions to be dispensed or to speak to a pharmacist.
- The public are asked to please respect pharmacy staff and help keep them and others safe by following any safety measures they have put in place – this includes keeping a safe distance from other people in the pharmacy and wearing a face covering if possible.

Medicine supply (including the Brexit and pandemic related impact)

PRESCRIBING

The CCG and LMC have strongly advocated GP surgeries to follow the 28 day prescribing advice which is understood to be the norm even during the pandemic. Despite the messaging GP surgeries were prescribing 56/84/168 day scripts. The problem was also compounded by patients who were not on regular medications such as inhalers were requesting prescription medicines. This caused tremendous pressure on community pharmacies in sheer volume of prescriptions being received and having to manage stock shortages.

LOCAL SERVICES IMPACTED

We have limited local services for community pharmacy.

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Many local services e.g. Emergency hormonal contraception were effectively discontinued during COVID lock down and subsequent social distancing, as they were face to face with patients. The shutting down of services not only affects patient care but influences income streams into community pharmacies adversely.

The services need to be reviewed in light of pandemic and payments for them need to be reviewed annually to ensure continued CP engagement with them. Public health has the leadership role here to help consider new COVID safe practice e.g. patient zoom access to meetings to ensure service continuation. LPC is not being communicated with by public health about these services.

Other face-to-face services which suffered are the issuance of Champix for smoking cessation service, unable to provide supervised consumption service in the same standard prior to COVID. The limited number of community pharmacy providers of the needle exchange service continued through the pandemic.

During COVID, we engaged and contracted with the CCG, where 14 community pharmacies across Buckinghamshire to hold a set quantity of Palliative Care Drugs and with some pharmacies engaged in 1 hour delivery service to patients.

The underlying concerns for the provision of local services are the lack of training to deliver and monitor the services under very complex contractual arrangements, enabling community pharmacy to make professional referrals to say Live Well Stay Well service of services which community pharmacy had previously provided. We have been contacted by the managing director of Parkwood Healthcare but have not had a follow up.

OPERATIONAL SOLUTIONS

COVID-19 has helped accelerate the use and benefits of some NHS digital solutions which pre-existed and the take up was slow. GP Prescribers are working towards converting from paper green scripts to EPS (Electronic Prescription Service) and eRD (Electronic Repeat Dispensing Service). Both of these solutions help manage the steady supply of medicines and reinforce the 28 day prescribing regime with built in reviews. eRD is very useful where patients are stable with regular use of up to 5 medicines. Both the rollouts continue with eRD requiring staged implementation as the right patients need to be identified for the use of the service.

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EPS is also being looked to be used for hospital use, dental use and from other community settings. Examples of primary and community care settings who can use EPS include:

- GP practices
- hospitals
- dental practices
- child health services
- community physiotherapy, occupational therapy, podiatry, speech and language
- community paediatric clinics, palliative care, mental health services
- district nursing, intermediate care
- specialist nursing services (for example, diabetes, heart failure, incontinence, tissue viability)
- sexual health services
- urgent treatment centres, clinical assessment services
- extended access hubs, GP out of hours

Community Pharmacy has handled lot of green scripts during the pandemic from the community settings especially dental scripts. The time and effort required to process paper scripts is considerable and there was reluctance in the beginning in physical handling of paper due to COVID.

REASSURANCE

- Community pharmacy teams are working hard to make sure that all patients continue to have access to the medicines they need, when they need them.
- In general, medicines supply routes via pharmacies work extremely well, ensuring that millions of patients in the UK receive the prescription medicines they need, safely and efficiently.
- Medicine supply issues are not a new phenomenon and the Department of Health and Social Care (DHSC), along with pharmacies, have well-established procedures to deal with them.
- HM Government is working with medicines manufacturers and suppliers to put contingency plans in place for the end of the transition period – this is a multi-layered approach including creating stockpiles and looking at alternative routes to bring medicines into the country.
- Patients are asked to only order the medicines they need so that everyone can continue get what they need.

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- If there is a delay in getting access to a medicine, patients can be assured that their local community pharmacy will be doing all that they can to help, working to solve problems that are out of their control.
- National pharmacy organisations are in regular contact with DHSC to help monitor the situation and resolve any issues when they occur.

Removal of services for shielding patients

- Medicines deliveries for shielding patients stopped when the Government's shielding support package ended.
- Community pharmacies no longer receive any financial support from Government to help them to continue delivering medicines to patients' homes – there is no NHS-funded medicines delivery service.
- It is reasonable for pharmacies to ask patients to cover the costs of non-NHS services themselves, or to refer them back to their general practice.
- Funding cuts in previous years mean that many pharmacies are struggling financially – to ensure that they can stay open and keep serving their local communities they have had to cut back on free services such as delivery and dosette dispensing aids.
- Pharmacy teams can help patients to make other arrangements – for example, by giving medicines to a patient's relative or helping source a local volunteer to collect medicines.
- However, pharmacy medicines deliveries will be made available in local outbreak areas where clinically vulnerable patients have been advised to shield.
- The NHS also does not routinely pay community pharmacies to offer services such as checking patients' blood pressure, or ordering repeat prescriptions.

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GOOD NEWS STORY

Hedgegrail Pharmacy, Stoke Poges, received the award in recognition of customer service and going above and beyond to care for the community. This was during the Covid period and also for the past few years.

Mr Bahra, Pharmacy Owner and Superintendent said "We look after our customers as local pharmacy have gained a reputation of going the extra mile to help our customers. During the covid period, we partnered with the local parish council and church to form a group of volunteers to help those vulnerable people and those who had to self-isolate. We provided free PPE, toiletries and sundries to this group and this was welcomed by the needy.

We have raised over £10,000 for different charities since I have been at the pharmacy through charity bike rides and Macmillan coffee morning. This year I cycled for a hospice charity and raised over £1,500 and our Macmillan coffee morning in September was £1,100."

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FLU VACCINATION

We have already surpassed last year's seasonal target in the 6/7 weeks into the flu season.

Figures as at 19th October of Community Pharmacy vaccinations already done in Bucks

Bucks	**18008**	
65 years and over	13786	76.55%
Asplenia or splenic dysfunction	19	0.11%
Carer	405	2.25%
Chronic heart disease	278	1.54%
Chronic kidney disease	40	0.22%
Chronic liver disease	20	0.11%
Chronic neurological disease	129	0.72%
Chronic respiratory disease	1428	7.93%
Diabetes	758	4.21%
Health and social care workers employed through Direct Payment of Personal Health Budget	38	0.21%
Hospice worker	16	0.09%
Household contact of immunocompromised individual	179	0.99%
Household contact of Shielded Patient	166	0.92%
Immunosuppression	321	1.78%
Learning disability	45	0.25%
Morbid obesity	55	0.31%
Person in long-stay residential care home/care facility	11	0.06%
Pregnant woman	139	0.77%
Social care workers	175	0.97%

VACCINE SUPPLY

Both GP surgeries and Community Pharmacies have to order the flu vaccinations late 2019 early 2020 ready for September 2020. Obviously this was pre-Covid so in most cases the new flu orders reflected the take up in the previous year, 2019/2020. Both GP and Community Pharmacies had exhausted all the placed order stock within few weeks of receipt of stock. There continues to be slow but continuous

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supply of vaccine stock to meet pre-booked appointments with both GP surgeries and community pharmacies.

We have been re-assured by NHSE&I that flu vaccine stock is not an issue and that it is an distribution and delivery issue. The terms for GP surgeries to access the DHSC National Stock have been published and we await an announcement of how community pharmacy will access that stock.

Community pharmacies have been prioritizing NHS patients over the private patients due to the pandemic.

Please click on the link below to see the latest news for community pharmacy

https://www.buckslpc.org/public/flu-2020-21/

PARTNERSHIP WORKING

COVID-19 has benefited us all to work closely within our local and regional partners. Community Pharmacy is now included in all System level discussions. We have the perfect ingredients in Buckinghamshire of 1 CCG, 1 BHT, 1 County Council, 1 STP, 1 NHS SE, 1 PHE regional team to enable local collaborative working. We have regular scheduled meetings.

COVID has enabled us to communicate closely with all Local Authorities in the county. We have had good working relationship with HealthWatch Bucks and we need to re-focus our efforts with engagement with patient groups.

We have been less successful with our engagement with local MP's and the LPC would appreciate support in linking us with the MPs.

Please click on the link below to see who the LPC works with

https://www.buckslpc.org/about/who-we-work-with/

The partnerships have widened through the Network DES to meet local health needs via the Primary Care Networks (PCN). We have 12 PCNs in Bucks and we have 12 community pharmacy leads. Early engagement was great in Bucks facilitated by the CCG but with COVID it faded but has re-emerged in the last few weeks. The PCNs are maturing at different levels but there are PCN lead pharmacists who are actively engaging with community pharmacy leads.

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Please click on the link below to our Primary Care Networks page

https://www.buckslpc.org/professional/primary-care-networks-pcn/

CHALLENGES FOR COMMUNITY PHARMACY

Community Pharmacy has never shy'd of providing free health advice as part of the service they provide to their patients and this has worked to their detriment as the system expects them to continue to provide the free advice. The purse holders take this for granted and it makes it very difficult to agree for paid services. We have to be recognized as a frontline provider in remuneration for the services we provide. Services have to be outcome focused, with fair contracts, transparent and fair payment for doing the work.

Patient education is essential as to what to expect from their community pharmacy. COVID has taken its toll on the community pharmacy workforce, many struggling to survive in business and more importantly major concerns re the health and wellbeing of pharmacy staff. The pharmacy experience in the latest lockdown measures, in particular up North, we are hearing stories of patients being abusive, aggressive and demanding.

The latest Medicines Optimisation strategy (October 2020) expects:-

- Community pharmacy as the first port of call for self-care, prevention and minor illness consultation, working closely with general practices and within primary care networks, and always working to reduce health inequalities, including in people from Black, Asian and minority ethnic communities.
- Develop cross-system leadership teams (e.g. senior managers network comprising of community services, community pharmacy, secondary and primary care).
- Provide professional leadership for the pharmacy quality scheme and clinical services delivered through the Community Pharmacy Contractual Framework 2019 to 2024 (e.g. NHS Community Pharmacist Consultation Service and the New Medicines Service).

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Health and Adult Social Care Select Committee (Chairman: Jane MacBean, Scrutiny officer: Liz Wheaton)

Date	Topic	Description & Purpose	Lead Presenters	Contributors
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.	Mayank Patel, Chief Officer, Local Pharmaceutical Committee Jane Butterworth, Clinical Commissioning Group	Representatives from local pharmacists
	Support for Carers and key workers*** (this item to be rescheduled)	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

	Proposed closure of New Chapel Surgery, Long Crendon	There is currently a public consultation running on the proposed closure of the GP surgery in Long Crendon. This item will provide Committee Members with an opportunity to hear more about the proposal and the issues raised so far.	Representatives from Unity Health, the Clinical Commissioning Group and local Action Group	
	County-wide engagement exercise	For Members to receive an update on the current county-wide engagement exercise around future health provision. A more detailed discussion will take place in January following the analysis of the survey results and other engagement exercises.	David Williams, Director of Strategy and Business Development, Buckinghamshire Healthcare NHS Trust	
	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
	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)

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
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.	Angela Macpherson, Cabinet Member for Adult Social Care Gareth Williams, Cabinet Member for Communities and Public Health (Chairman of Health & Wellbeing Board) Neil Macdonald, Buckinghamshire Healthcare NHS Trust James Kent, Accountable Officer, BOB ICS	Gill Quinton, Corporate Director for Housing and Adult Social Care Jane O'Grady, Director for Public Health David Williams, Director of Strategy and Business Development, Buckinghamshire Healthcare NHS Trust Robert Majilton, Deputy Chief Officer, CCG

4 March 2021	Healthcare provision	Item to be developed	TBC	TBC
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)

*** This item may be deferred to a meeting in 2021 to allow for an item on the proposed closure of New Chapel Surgery, Long Crendon in November.

Report to Health & Adult Social Care Select Committee

Date:	**5 November 2020**
Title:	**Director of Public Health Annual Report**
Relevant councillor(s):	**Gareth Williams**
Author and/or contact officer:	Dr Jane O'Grady
Ward(s) affected:	All Wards
Recommendations:	**Committee Members are requested to note the Director of Public Health Annual Report.**

Recommendations within the Director of Public Health Annual Report for Buckinghamshire Council

a) The council to consider adopting a 'health in all polices' approach whereby relevant policies and decisions consider how residents health could be improved and poor health prevented as part of business as usual, e.g. when planning new developments or considering transport policies.

b) The council to consider opportunities to develop its role as an anchor organisation[1].

c) The council to continue to roll out training to front line staff to encourage residents to make simple changes that could improve their health, wellbeing and independence and ensure staff can signpost people to community assets that can support this.

[1] Anchor organisations are typically large organisations that are embedded in communities and unlikely to move due to their long term commitment to a community (for example hospitals, universities and local councils). They have large resources in terms of purchasing power and employment and as such can have a key role in building successful local economies and communities by their actions

d) The Buckinghamshire Council public health and prevention team should support Community Boards to consider the health needs of their population and what simple practical steps they could take to improve health in their local area.

e) To continue to promote the health of the council workforce with good workplace health policies.

Recommendations for Community Boards

a) Community Boards should work with local communities, public health and wider partners to identify the health and wellbeing issues in their local area and take effective action to address them. Community boards should use their pump-priming wellbeing fund to help improve health and wellbeing in their area.

Recommendations for the NHS and primary care networks
The NHS should:

a) Increase their focus on preventing ill health and tackling inequalities and ensure this is built into every care pathway.

b) Consider how to build a health in all policies approach and opportunities to act as an anchor organisation.

c) Consider how the NHS can best support effective place-based working and community-centred approaches.

d) Ensure front line staff are trained to support people to make simple changes to improve their health and wellbeing and to signpost people to community assets that support this.

e) Continue to promote and protect the health of their workforce through effective workplace policies.

Primary care networks:

a) Should work with their local communities, Buckinghamshire Council public health, Community Boards and other partners to understand and improve the health in their local area.

b) Ensure front line staff are trained to support people to make simple changes to improve their health and wellbeing and signpost people to community assets that can support their health.

c) Continue to promote and protect the health of their workforce.

Reason for decision: The report aims to provide a baseline overview of the health of Buckinghamshire residents for the new unitary council to inform their plans. It highlights the multiple ways the council and members can improve the health and wellbeing of residents. It helps meet the council's responsibility for improving and protecting residents health and supports the councils strategic plan. An early draft of an action plan is included which will be completed with input from partners, community boards and members.

1. Executive summary

1.2 Each year the Director of Public Health produces an annual report on the health of their population.

1.3 In light of the creation of the new Buckinghamshire Council and its 16 Community Boards, this year's report focuses on the overall health and wellbeing of Buckinghamshire's population. It serves as a baseline against which progress in improving the health and wellbeing of our population can be measured. It highlights the many opportunities that the new unitary council and members have to improve the health of our residents through the council's actions on community engagement and leadership, transport, planning, the environment, the economy, education and other services.

1.4 The aim is to support a strategic approach in the new council and partners to address the health of our population.

1.5 The report also analyses the health of residents at a more local level both at a community board level and at the level of primary care networks. This will enable the new Community Boards to understand some of the health and wellbeing issues in their local area. The DPH annual report provides further detail on the factors that drive health and should be read in conjunction with the Community Board profiles.

1.6 By identifying the health issues and geographical mapping of the Community Boards and Primary Care Networks it is hoped that this will support joint working at a local level between health and local authority partners, other public and private sector partners, residents and communities and the voluntary sector.

1.7 The report highlights trends in our health from 100 years ago to more recent trends and also reviews what the future might hold for our health. The report was being

finalised as the COVID pandemic struck and therefore does not cover the impact of COVID. There will be a later report on COVID.

1.8 A healthy population is vital for the economic and social success of Buckinghamshire. Adopting the recommendations of this report will contribute to improving the health and life chances of our residents and will help reduce the growth in demand on council services and other public sector services

1.9 If the recommendations of this report are adopted by the council and partners the outcomes we would expect are:

a) An understanding of the current health and wellbeing across Buckinghamshire and for specific communities.

b) A clear focus on health and wellbeing for Community Boards and their respective priorities and plans.

c) Tailored health and wellbeing initiatives driven by Community Boards and funded through the health and wellbeing grant from Public Health.

d) Health and wellbeing to be a key consideration for all decisions and policies for the new Buckinghamshire Council.

e) The Council to further consider its role as a key anchor organisation in Buckinghamshire and how it can use its resources to further health and wellbeing for residents.

f) If these recommendations are adopted we would see improved health and a levelling up of health outcomes across Buckinghamshire specific to particular initiatives e.g. increased safe active travel would reduce long term conditions, improve air quality and air quality related health, improve employee productivity and contribute to educational attainment.

2. Content of report

2.1 Our health is influenced by a wide range of factors including our social circumstances, the places and communities in which we live, the health behaviours we adopt and the health and care we receive. Factors such as income, housing, education and transport play a central role in our health and wellbeing throughout the course of our lives. The community we live in is one of the most important factors for our physical and mental health. All of these factors are interlinked – for example, the places and communities we live in influence our behaviour in a range of ways, the quality of the air we breathe, how well we know our neighbours and our physical and mental health.

2.2 The four main health behaviours – smoking, physical inactivity, unhealthy diet and alcohol misuse account for 40% of all years lived with ill health and disability. These

behaviours are major risk factors driving the development of long-term conditions that account for 70% of all NHS and social care spend.

2.3 Much of our behaviour is strongly shaped by our environment and communities, often without us realising. The cues that shape much of our behaviour can be found in the physical, economic, digital, social and commercial environments we inhabit. Interventions that alter our environment to improve our health see the largest health gains and are more likely to reach groups at risk of poorer health than individual based approaches. A combination of individual and population based approaches will deliver the best results.

2.4 Buckinghamshire residents generally enjoy better health and wellbeing than the England average. In terms of factors that influence health, our residents have generally higher levels of educational attainment, income, employment and better living conditions than the England average. Over one third of our residents live in the 10% least deprived wards in England. Only 0.3% of Buckinghamshire residents live in the 20% most deprived areas in England.

2.5 The over 65 population in Buckinghamshire has a longer life expectancy than the England average, and they spend more of their life in good health compared to this age group elsewhere.

2.6 The recorded prevalence of diabetes, heart disease, chronic obstructive lung disease and severe mental illness are all lower than England. Likewise, rates of smoking, drug use, physical inactivity and suicide are also lower in Buckinghamshire when compared to England. However, many residents experience potentially avoidable ill health and disability. The major causes of disease, disability and death among adults are long-term conditions, many of which are potentially preventable.

2.7 Despite our overall better health, important health inequalities still exist in Buckinghamshire which means that these benefits are not evenly distributed throughout our local population. People living in the more deprived areas of Buckinghamshire experience poorer health from birth through to old age. Almost 1 in 10 children and young people, and 1 in 13 people aged over 65 years live in poverty, which will increase their risk of poorer health. Differences in life expectancy across the County are related to levels of deprivation. Nationally the impact of the COVID-19 pandemic has replicated existing health inequalities, and in some cases, has increased them.

3. Outcomes from last year's Director of Public Health report

3.1 Last year's annual report focused on alcohol and the impact it has on our health and wellbeing in Buckinghamshire.

3.2 As a result of that report, much work has taken place across the county by many partners to further support residents to get the alcohol misuse advice and care they need at the right time in the right place.

3.3 The following is just some of the work that has taken place following the 2018/19 report:

a) A programme of face to face training on screening and initial brief advice for alcohol has been delivered. Additional training is being organised following the COVID-19 pandemic to further support our residents.

b) Additional engagement with key groups of residents who may be at increased risk from alcohol misuse has been delivered. This has resulted in the number of alcohol referrals increasing over the last year. Following lockdown for COVID-19, a sharp increase in referrals has been seen.

c) A pilot online web-based alcohol intervention programme was developed by our alcohol service provider to support individuals with alcohol issues who are unlikely to attend local treatment Hubs. The intervention is currently at the testing stage. Recovery workers have been trained and are currently working through the programme to assess its effectiveness.

d) The 'Co-existing common mental health problems and substance/alcohol misuse clinical pathway' has been agreed with Healthy Minds. This pathway between Healthy Minds (Improving Access to Psychological Therapies service in Bucks) and One Recovery Bucks (our alcohol service provider) improves the referral process and the relationships between the two services, which in turn benefits clients of both services. It ensures residents can receive the right treatment at the right time.

e) The Council and the NHS have agreed the process for shared care for individuals taking alcohol relapse prevention medications. Shared care allows for service users who are successful in achieving abstinence to be supported by their GP in Primary Care. To date 12 GP surgeries have signed up to this initiative and service users are being support in primary care.

f) Work to include alcohol misuse assessment in acute care more widely at Buckinghamshire Healthcare NHS Foundation Trust has progressed over the last year. Due to COVID, progress has been paused but will be picked up once regular acute care services resume.

4. Other options considered

4.1 The recommendations in this report aim to capitalise on the opportunities afforded by the formation of a new unitary council, community boards and primary care networks to help maintain or improve the health of the population. If the

recommendations are not supported and implemented there is potential that valuable opportunities to improve the health and wellbeing of our residents is missed. The COVID pandemic has had a profound impact on our society. The people who have had the most serious outcomes from COVID include those with often preventable long term conditions including diabetes, heart disease, high blood pressure and obesity so it is important that we redouble our efforts to help prevent these conditions for the benefit of our residents and to help keep them safe from COVID. Nationally COVID has also had a more serious impact on certain groups including people from Black Asian and other minority ethnic communities and those living in more deprived areas. COVID has also had an impact on wider determinants that affect our health such as income, employment and education so it is also very important we focus efforts on the broader determinants of health too.

5. Legal and financial implications

5.1 This is a report setting out the high level summary of the health and wellbeing of Buckinghamshire's residents. There are no direct financial implications of adopting this report.

5.2 No direct legal implications for this report.

6. Corporate implications

6.1 Value for Money: This is a high level report covering a diverse range of areas and therefore cannot be covered by a single value for money assessment. Individual policy decisions may flow from the report which will have individual value for money assessments.

6.2 Other Consideration: This report is for partners as well as Buckinghamshire Council and will be disseminated and presented after approval by Cabinet in a variety of forums.

7. Consultation and communication

7.1 The Public Health Profiles for Community Boards were distributed in July 2020. These profiles are part of the overall suite of information produced as part of this year's Director of Public Health Annual Report. All Community Boards have received their profiles and discussed the information and implications.

7.2 The Cabinet Member for Communities and Public Health has reviewed and approved the report. The report has also been shared with the following Cabinet members at the Adults and Health Business Unit Board:

a) Cllr Gareth Williams – Cabinet Member Communities & Public Health

b) Cllr Angela Macpherson – Deputy Leader & Cabinet Member Adult Social Care

7.3 Local Members will be sent copies of the report after Cabinet Decision and the report is also being presented at the Health and Adult Social Care Select Committee and the Health and Wellbeing Board.

7.4 Beyond the above, normal communication channels will be used to disseminate the report to partners and residents.

8. Next steps and review

8.1 Partners and the council can use the report to inform the health impact of a wide range of their own plans including the regeneration of town centres and development of Aylesbury Garden Town, transport planning and housing development or local health and wellbeing plans. The report will also inform the Health and Wellbeing Strategy and the place based Buckinghamshire COVID recovery plan across all workstreams. A joint high level action plan to implement the recommendations of the DPHAR will be developed and monitored through the Health and Wellbeing Board.

9. Background papers

9.1 The full Director of Public Health Annual Report is included as an appendix to this report.

9.2 The action plan for the Director of Public Health Annual Report is also included as an appendix to this report (Appendix 2).

Appendix 2: Director of Public Health Annual Report DRAFT Action Plan (version 2)							
Action plan timescale: July 2020 to July 2021							
	Detail of action	**Lead Team/Directorate**	**Timescale**		**Key milestones**	**Outputs**	**Outcomes**
			From	**Completed by**			
Recommendation 1: The council to consider adopting a 'health in all policies' approach whereby relevant policies and decisions consider how residents health could be improved and poor health prevented as part of business as usual, e.g. when planning new developments or considering transport policies.							
1.1 NEW	**A framework for how each directorate can adopt a 'health in all policies' approach to be drafted and signed up to by the council.**	**Public Health & Policy Team**	**August 2020**	**March 2021**	• Agree council's vision for utilising the Health in All Policies approach • Engagement with directorates on how this can work and how best to influence decisions for better health and wellbeing • Agree the governance of the framework and its principles • Draft framework to be agreed by CMT/Cabinet • Final framework to be ratified as a key consideration for all decisions and policies by the council	Health in All Policies framework specific to Buckinghamshire Council in place	Decisions that include the county's health and wellbeing at their core become standard practice for Buckinghamshire Council
1.2 NEW	**Every directorate to reference this framework when**	**Policy Team/CMT**	**January 2021**	**ongoing**	Governance in place for ensuring the framework is applied for all decisions at all levels	Inclusion of health and wellbeing as a key consideration of CMT papers Inclusion of health and	All policies and decisions taken by the council will be working to improve health and wellbeing for residents.

	determining and agreeing policies and decisions.					wellbeing in officer and member decisions	
Some example of council work that will include a Health in All Policies approach							
1.3 NEW	**Air quality monitoring and air quality action plans: - consideration to be given by housing officers when placing residents with confirmed cardiovascular issues, asthma or other respiratory illness.**	**Environmental Health**	**November 2020**	**March 2022**	This approach can be trialled and implemented between Nov 2020 and March 2021. Single strategy to be developed in 2021, must be in place by March 31st 2022. Review of progress with Buckinghamshire's Action Plans by Public Health Consultants, as umbrella Air Quality Strategy for Buckinghamshire is developed.	Protocol and advisory note developed for housing officers. Workshop for PH consultants to review and discuss proposed Air Quality Strategy.	Pre-existing medical conditions are not exacerbated unnecessarily.
1.4	**Homelessness Strategy and Allocations Policy. These documents are both to be consulted on and developed for the new Council, between Aug 2020 and April 2021.**	**Housing**	**Aug 2020**	**April 2021**	Single Allocations Policy to be implemented by April 2021, subject to governance. Single Homelessness Strategy and various partnership arrangements and operating groups with partners to be implemented after March 2021. Public Health team input to be invited in development work to ensure health is considered fully. Future funding bids to be assessed from a health perspective	Policy draft developed and consulted on with stakeholders prior to seeking political approval in early 2021.	Dependent on how policies and strategies are developed - to be updated as work progresses and metrics to be identified.

					to identfiy opportunities - e.g. health interventions and advice in rough sleeper initiative locations.		
1.5 NEW	**Library service delivery plan 2020/21 to include work to support health and the new libraries strategy will include health and wellbeing as a key priority, particularly around how libraries can support wellbeing of residents given the pressures created by COVID-19.**	**David Jones / Communities**	**September 2020**	**April 2022**	Development of new well-being resources in new Marlow library by December 2020 Creation of partnership with Making Marlow Dementia Friendly by March 2021 Engagement on new strategy with residents and key stakeholders Gap analysis of current versus desired provision Draft strategy by September 2021 Final Strategy by April 2022 Additional key milestones to be identified once project begins	Increased usage health and wellbeing resources especially dementia and reminiscence collections	Residents with dementia and their carers/family are better able to utilise library resources. Residents better able to identify and borrow high quality wellbeing resources. Also aim to reduce some stigma around self -help groups
1.6	**Showcase health and well-being for residents as part of the transformation of Marlow Library.**	**Libraries/ Communities**	**July 2020**	**December 2020**	Development of new well-being resources. Create partnership with Making Marlow Dementia Friendly group Deliver new dementia friendly resources for residents.	Well-being section of resources for residents to use and borrow from the library. Dementia friendly design for the library	Residents with dementia and their carers/family are better able to utilise library resources. Residents better able to identify and borrow high quality well-being resources. Also aim to reduce some stigma around self-help resources.

Recommendation 2: The council to consider opportunities to develop its role as an anchor organisation.							
2.1 **NEW**	**A clear understanding of what an anchor organisation is and how it impacts communities to be shared with all directorates and members.**	**Policy Team and Public Health**	**September 2020**	**December 2020**	Define what Buckinghamshire Council means by 'anchor organisation' Share the definition and examples of projects with all directorates	Clear definition of what the Council means by anchor organisation Council actions take into consideration its role as an anchor organisation	Decisions about utilising the council's influence and assets have health and wellbeing as a key consideration
2.2 **new**	**A framework for how each directorate is and will contribute to the Council's role as a key anchor organisation in the county.**	**Policy Team and Public Health**	**December 2020**	**July 2021**	• Determine key areas for the council to utilise its anchor organisation status • Engagement with residents on how this can work • Agree the governance of the framework and its principles • Draft framework to be agreed by CMT/Cabinet	Final framework to be ratified as a key consideration for all decisions and policies by the council	
Some Examples of Anchor Organisation Projects for Directorates							
2.3 **new**	**Integrated Commissioning to ensure contracts awarded by the council consider the health and wellbeing of provider organisations.**	**Integrated Commissioning Team**	**September 2020**	**ongoing**	Develop the integrated commissioning approach to including health and wellbeing into tendering and procurement processes	Agreed approach to ensuring contracts promote health and wellbeing of provider organisations Delivering this approach consistently and robustly	

2.4	**The council will continue to explore how the Tatling End model for affordable housing can be replicated for additional affordable key worker housing**	**Property and Assets**	**Ongoing**	**ongoing**	Survey key stakeholders to determine what are the key factors for where key workers work and live. Financial modelling to explore viable options.	Report of recommendations once background work and studies are conducted.	Tatling End residential development available for let. Potential future developments would be let on an affordable basis and focus on key workers.
2.5	**Continue to develop work and proposals on potential country park.**	**Property and Assets**	**Ongoing**	**ongoing**	Further scoping of the requirements to develop existing assets into 2 country parks in the south of the county	Scheme and site evolution and master planning	Additional country park locations available for physical activity, socialising and enjoying nature in the south of the county.
2.6 NEW	**Work experience, training and apprenticeships to be provided to help support less advantaged groups, e.g. care leavers, people with disabilities, young people**	**Human Resources/ Integrated Commissioning/ Children's.**	**September 2020**	**Ongoing**	10 new start apprenticeships by end January 2020.	Establish more Work Experience for disadvantaged groups in our local place	Disadvantaged groups gain skills and experience to help them access employment/higher education
2.7	**Adult Social Care will continue to develop and deliver the Health and Social Care Academy in conjunction with Bucks New Uni, University of Bedford, the LEP and NHS partners to**	**Adult Social Care / Wider Partners in HEI's, BHT, LEP**	**September 2020**	**March 2021 - and beyond for delivery**	Autumn 2020 - Inter Agency Agreement prepared by BC ASC and Legal and to be agreed across all agencies; Next stage develop Articles for new Organisation; Work alongside to end March 2021 on first phase for establishing faculty structure	Enhanced learning and development to benefit of Adult Social Care sector	Phase One: Establishing faculty structure including Social Care faculty

	continue growing and developing local talent.						
Recommendation 3: The council to continue to roll out training to front line staff to encourage residents to make simple changes that could improve their health, wellbeing and independence and ensure staff can signpost people to community assets that can support this.							
3.1 **NEW**	**Explore options for continuing to deliver Making Every Contact Count training to front line staff - particularly in light of COVID-19 guidance and social distancing.**	**Public Health**	**August 2020**	**October 2020**	PH reserve funding outcome 19th Aug 2020 Develop delivery plan in response to PH reserve funding outcome mid Sept. 2020	Delivery plan and training model developed	Sustainable training available for front line staff to access
3.2 **NEW**	**Service directors to identify key frontline staff to be trained in Making Every Contact Count and ensure they receive appropriate training.**	**All BC Directorates**	**October 2020**	**Ongoing**	List of front line staff identified for training produced October 2020 Training model developed to provide training, based on demand and capacity Oct 2020)	Key staffing groups identified Key groups actively participate in training	Culture of prevention is developed with the council MECC is imbedded across the organisation Staff are skilled and knowledge in MECC and actively use it

3.3 NEW	**Deliver a programme of training on Making Every Contact Count to front line council staff.**	**Public Health**	**October 2020**	**Ongoing**	Update training package (Oct 2020) Set training dates (Oct 2020)	Existing MECC training package updated to support covid-19 Accessible training is available Training figures will be subject to the staff identified for training by service directors (action 3.2)	Staff are skilled and knowledge in MECC and actively use it Residents are supported to improve their own health and wellbeing
3.4 NEW	**All new employees will have the principles of every contact counts explained at induction and will be signposted to further training provided by PH. HR will signpost but content and delivery will be delivered by PH. Reference to ECC training will also be made in the employee essentials workbook.**	**Human Resources/'Public Health**	**October 2020**	**ongoing**	Update induction course October 2020	PH to define	PH to define
Recommendation 4: The Buckinghamshire Council public health and prevention team should support Community Boards to consider the health needs of their population and what simple practical steps they could take to improve health in their local area.							
4.1	**Create profiles of key health and wellbeing**	**Public Health**	**January 2020**	**July 2020**			

	indicators for each Community Board						
4.2	**Share the profiles with Community Boards to support their priority setting work for the year.**	**Public Health**	**June 2020**	**July 2020**			
4.3	**Community Boards will use Community Board Profiles to inform their action plans and work with partners to develop place based approaches to address their local needs and issues.**	**Localism Managers/Community Coordinators**	**July 2020**	**ongoing**	CB will develop their action plans - to include health and wellbeing actions		
4.3.1	**Community Boards to address health and wellbeing priorities, including COVID-19, using the information from the CB profiles as well as local intelligence on the needs of local communities.**	**Localism Managers/Community Coordinators**	**July 2020**	**ongoing**	CBs drive partnership approaches to address priorities. Identify local initiatives tailored to priorities. Initiatives agreed and funded initiatives delivered.	action plans will include initiatives to address health and wellbeing priorities	

4.4	**Community boards should use their pump-priming wellbeing fund to help improve health and wellbeing in their area.**	**Localism Managers/Community Coordinators**	**July 2020**	**TBD**	CBs work in partnership to identify good projects relevant to local communities. Projects for funding identified to address action plan priorities. Health and wellbeing funding earmarked in line with corporate timescales (given COVID situation) - March 2021 Projects funded and initiated. TBD	50% allocated through councillor crisis emergency fund to support local communities and groups during the COVID-19 pandemic.	Communities support process in place. Vulnerable residents supported through the emergency period by VCS organisations. VCS were able to further deliver health and wellbeing services during COVID-19. Health and Wellbeing Priorities addressed/supported through locally funded projects/initiatives.
Recommendation 5: To continue to promote the health of the council workforce with good workplace health policies.							
5.1	**Public health to inform and influence HRs Health and Wellbeing Champions work programme, ensuring the programme of work is evidence based and links with national public health campaigns and guidance.**	**Public Health**	**July 2020**	**July 2021**	Communications team work to be developed in partnership with task and finish groups as per agreed timetable.	PH act as Health and Wellbeing Champions within relevant subgroups (e.g. Physical activity)	The Health and Wellbeing Champions work is evidence based and fully supports behaviour change Staff health and wellbeing improves

5.2	**Human resources to consider current and potential workforce policies are health promoting.**	**Human Resources**	**May 2020**	**March 2020**	Health & Wellbeing is embedded within the "Employee attachment and engagement" section of BC's Organisational Development Strategy. You and your wellbeing is a component of BC Council's employee proposition. BC is committed to promoting the health, attendance and well-being of its employees though our Health & Attendance Policy	Training will be available on supporting employee health & wellbeing and managing attendance as part of the Being a Bucks Manager (BABM) framework.	Managers understand their responsibilities under the policies and that supporting employee wellbeing is a key part of their job
5.3	**Human resources to consider current and future health and wellbeing programmes, events and initiatives for council staff.**	**Human Resources**	**May 2020**	**March 2020**	The Council's Health & Wellbeing Action Plan describes the activities which will be put in place to support employee health and wellbeing. Events and initiatives are identified by the H&W Champions group. Employees can access support and advice, counselling and on-line resources via the PAM Assist, the EAP HR provide a number of Covid 19 related interventions including H&W tips; webinars; team reflective sessions	H&W outputs e.g. Information available via Together Newsletter, The Source, team reflective sessions, webinars etc.	Employees are well informed about health & Wellbeing and able to make informed decisions and access the appropriate support when needed.

					The Council have Mental Health First Aiders/Allies who are available to have supportive conversations with employees as required.		
5.4	**BC has signed the Time to Change Pledge**	**Entire Council**	**May 20**	**May 21**	Rachael Shimmin and Gareth Williams signed the Time to Change Pledge in May 2020. A Time to Change Action Plan has been developed to support BC in meeting the requirements of the standard.	Time to Change Action Plan and associated actions	Increased openness about and reduced stigma associated with poor mental health. People sharing their stories
5.5	**All directorates to ensure quarterly Health, Safety and Wellbeing meetings are held.**	**Directorates**	**April 2020**	**ongoing**	Directorates hold quarterly engagement meetings (Directorate Workforce Matters) where health, safety and wellbeing is discussed and champions are invited	Outputs and interventions from meetings	Employees are able to engage with their directorates about health, safety and wellbeing and access information and support needed.

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2020
DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT




A Picture of Health?
Buckinghamshire - Past, Present and Future

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Executive Summary

What influences our health?

Our health is influenced by a wide range of factors including our social circumstances, the places and communities in which we live, the health behaviours we adopt and the health and care we receive. Factors such as income, housing, education and transport play a central role in our health and wellbeing throughout the course of our lives. However, all of these factors are interlinked – for example, the places and communities we live in influence our behaviour in a range of subtle and not so subtle ways, our exposure to air pollution and traffic noise. Our income affects the food we can afford, the ability to heat our homes and live in good quality housing, all of which affect our health. The differences in health we see across Buckinghamshire often reflect the different circumstances of people's lives.

The four main health behaviours – smoking, physical inactivity, unhealthy diet and alcohol misuse account for 40% of all years lived with ill health and disability. These behaviours are major risk factors driving the development of long-term conditions that account for 70% of all NHS and social care spend. Addressing these four behaviours could lead to a reduction of up to 80% of new cases of heart disease, stroke and type-2 diabetes and a reduction of 40% of new cases of cancer.

Much of our behaviour is strongly shaped by our environment and communities, often without us realising. The cues that shape much of our behaviour can be found in the physical, economic, digital, social and commercial environments we inhabit. For example, price, advertising and availability influence our consumption of cigarettes, unhealthy food and alcohol. Safe and attractive places to play and safe cycling and walking routes to school and work influence people's physical activity levels.

Evidence shows that interventions that alter our environments and communities to promote health, such as structural changes, see the largest population health gains and also gains in the most vulnerable communities compared to individual-based approaches.

Interventions that seek to change individual behaviour without addressing the wider environment are likely to have less impact. For example, more than 50% of the population are overweight or obese. A strategy that focuses only on changing the behaviour of individuals one at a time cannot reverse this epidemic. A whole system approach at population level is required that addresses a wide range of factors such as food formulation, pricing, advertising, availability and social norms.

Our health at a glance

Buckinghamshire residents generally enjoy better health and wellbeing than the England average. In terms of factors that influence health, our residents have generally higher levels of educational attainment, income, employment and better living conditions than the England average. This reflects Buckinghamshire's position as one of the least deprived authorities in England. Over one third of our residents live in the 10% least deprived wards in England. 0.3% of Buckinghamshire residents live in the 20% most deprived areas in England. The over 65 population in Buckinghamshire has a longer life expectancy than the England average, and spend more of their life in good health compared to this age group elsewhere. The prevalence of diabetes, heart disease, COPD and severe mental illness are all lower than England. Likewise, rates of smoking, drug use, physical inactivity and suicide are also lower in Buckinghamshire when compared to England. However, many residents experience potentially avoidable ill health and disability. The major causes of disease, disability and death among adults are long-term conditions, many of which are potentially preventable.

Despite our overall better health, important health inequalities still exist in Buckinghamshire. People living in the more deprived areas of Buckinghamshire experience poorer health from birth through to old age. Almost 1 in 10 children and young people, and 1 in 13 people aged over 65 years live in poverty, which increases their risk of poorer health. Differences in life expectancy across the County are closely related to levels of deprivation. The impact of the COVID-19 pandemic has been greater on those with long term conditions, older people and people from Black Asian and minority ethnic groups and people living in deprived areas. The pandemic also affects the broader determinants of health such as income, employment and education. COVID has replicated existing health inequalities, and in some cases, has increased them, reinforcing the need to prevent the development of long term conditions and reduce health inequalities by acting on all the determinants of health at an individual and population level.

Recommendations

We need action across the four pillars influencing health: the socioeconomic determinants, strong communities, healthy behaviours, and effective, proactive preventive health and social care. The formation of the new Community Boards and the Primary Care Networks offers exciting opportunities to work with local communities at a neighbourhood level, gaining insight into what the key wellbeing issues are for their area and what would work to address them.

Emphasis should be placed on reducing existing health inequalities within our local population. Buckinghamshire Council's strong focus on empowering communities and developing community assets will support this work. Strong communities will be a key driver for recovery from the impact of the COVID-19 pandemic.
The Council and local NHS organisations should consider adopting a 'health in all policies' approach whereby relevant policies and decisions consider how residents' health could be improved and poor health prevented as part of business as usual e.g. when planning new developments or considering transport policies. Both organisations should also continue to develop their crucial roles as 'anchor organisations', and positively influencing multiple factors that can help to improve the health and wellbeing of the local population.

Recommendations for Buckinghamshire Council

- The council to consider adopting a 'health in all polices' approach whereby relevant policies and decisions consider how residents health could be improved and poor health prevented as part of business as usual, e.g. when planning new developments or considering transport policies.
- The council to consider opportunities to develop its role as an anchor organisation.
- The council to continue to roll out training to front line staff to encourage residents to make simple changes that could improve their health, wellbeing and independence and ensure staff can signpost people to community assets that can support this.
- The Buckinghamshire Council public health and prevention team should support Community Boards to consider the health needs of their population and what simple practical steps they could take to improve health in their local area.
- To continue to promote the health of the council workforce with good workplace health policies.

Recommendations for Community Boards

Community Boards should work with local communities, public health and wider partners to identify the health and wellbeing issues in their local area and take effective action to address them. Community boards should use their pump-priming wellbeing fund to help improve health and wellbeing in their area.

Recommendations for the NHS and primary care networks

The NHS should:

- Increase their focus on preventing ill health and tackling inequalities and ensure this is built into every care pathway.
- Consider how to build a health in all policies approach and opportunities to act as an anchor organisation.
- Consider how the NHS can best support effective place-based working and community-centred approaches.
- Ensure front line staff are trained to support people to make simple changes to improve their health and wellbeing and to signpost people to community assets that support this.
- Continue to promote and protect the health of their workforce through effective workplace policies.

Primary care networks

- Should work with their local communities, Buckinghamshire Council public health, Community Boards and other partners to understand and improve the health in their local area.
- Ensure front line staff are trained to support people to make simple changes to improve their health and wellbeing and signpost people to community assets that can support their health.
- Continue to promote and protect the health of their workforce.

1. Introduction

This year's Director of Public Health annual report was designed to give an overview of the health of our residents to the new unitary council for Buckinghamshire, the new Community Boards, the local Primary Care Networks and our Integrated Care Partnership and local residents. It reviews our current health and what factors influence it, recent health trends and some glimpses of what the future might hold. It highlights how the broad range of responsibilities of the new council can be used to positively influence residents health and the importance of working at a local level with communities and partners to benefit all.

The report also identifies the way in which our residents health varies significantly between different areas in Buckinghamshire and includes some headlines from the local health profiles being produced for Community Boards and Primary Care Networks.

I was just finalising this report when the UK was hit by the first wave of the Coronavirus (COVID-19) pandemic and all our efforts were refocussed on responding to this. We are now slowly emerging from the national lockdown. As we continue to learn more about this very new disease we can see that the virus has had more impact on some communities than others. This echoes some of the variations we see locally in peoples health. Some residents have sadly lost their lives and others will be making a slow recovery from COVID. The indirect health effects potentially include an impact on peoples mental health, employment, income and on childrens education – all of which affect health.

Overall, so far, the virus has had a more severe impact on the elderly and those with certain long term conditions, those living in more deprived areas and certain ethnic groups. This gives us added impetus to redouble our emphasis on prevention including preventing key conditions such as obesity and diabetes and addressing the health and wellbeing of different groups.

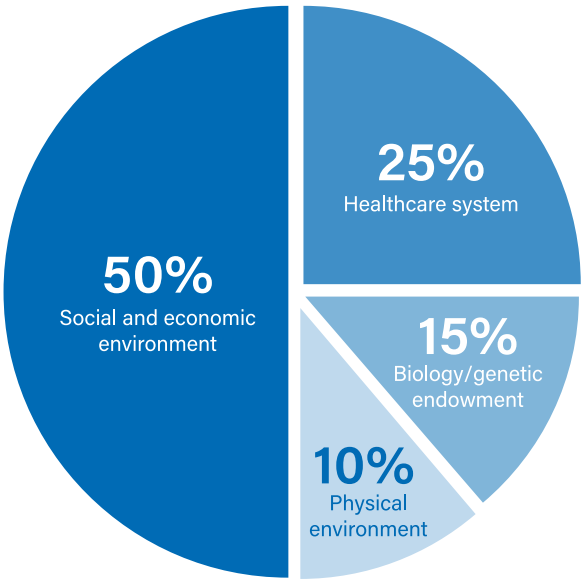
We will be producing a report looking at the health impact of COVID in Buckinghamshire as we gather information from residents, partners and statistics to help us work together on a successful recovery for Buckinghamshire and reduce the impacts of further waves of COVID-19.

During the pandemic we saw a fantastic response from communities helping out their neighbours in times of need and unparalleled co-operation between all partners in Buckinghamshire, including local government, the NHS, businesses, schools, police, fire and voluntary organisations. This has demonstrated our incredible ability in Buckinghamshire to work together to improve things with our communities and I am confident this will help us achieve better health and wellbeing for our residents and a successful recovery from the pandemic.

Dr Jane O'Grady
Director of Public Health
June 2020

2. What influences our health?

Our health is influenced by a wide range of factors including our social circumstances, the places and communities in which we live, the health behaviours we adopt and the health and care we receive. However, all these factors are interlinked – for example, the places and communities we live in influence our behaviour in a range of subtle and not so subtle ways. Health related behaviours, particularly smoking, being physically inactive, drinking too much alcohol and an unhealthy diet contribute to the development of a wide range of diseases, but these choices are not made in a vacuum and are heavily influenced by the social, economic and physical environments in which people live. Researchers have tried to estimate the relative contribution of the various factors to an individual's health as highlighted to the right.



Source: Canadian Institute for Advanced Research, Health Canada, Population and Public Health Branch AB/NWR 2002

Our health is influenced by a wide range of factors The image below highlights some of the main influences on our health which are addressed in the following chapter.

Income

Income impacts our health in many ways. It is stressful to be on a low income, and this affects people's physical and mental health. People's ability to heat their homes, buy healthy food and participate in activities is limited when on a low income. Due to the circumstances in which many people on low incomes may live, unhealthier behaviours are more common. People on low incomes are more likely to live in poorer quality housing and may be less able to afford to keep their homes warm.

Children growing up in poverty have worse cognitive, social, behavioural and health outcomes. Poverty and poor health in childhood can impact our educational attainment and future employment and income as an adult thus perpetuating the cycle of poverty between generations.

Conversely, poor health can also lead to poverty due to loss of employment opportunities and earning.

Work

Good-quality work is good for our health. It provides a regular income, security and a sense of purpose and satisfaction. It also helps afford a basic standard of living and participate in community and social life. Meanwhile, 'poor-quality' work (for example, work that involves adverse physical conditions, exposure to hazards, a lack of control and unwanted insecurity) is bad for our health. Being unemployed is linked to poorer mental health and psychological wellbeing and a higher rate of death.

Housing

Where we live can promote our health if it is affordable, safe, in good condition and connected to the community, services and employment. A lack of affordable housing can lead to financial hardship and stress, overcrowding and, in the most severe cases homelessness.

Families living in overcrowded conditions experience a range of health-related problems such as poor and irregular sleep patterns, depression and anxiety, strained family relationships and break-ups. Children who live in crowded homes are more likely to have emotional problems, do less well at school and have worse physical health.

Damp and cold housing increases the risk of respiratory conditions, mental health problems and death.

Homelessness

Being homeless also has a profound effect on physical and mental health. To be legally defined as homeless people must either lack a secure place to live or not reasonably be able to stay in their current home. Local authorities may provide temporary accommodation to households who meet these criteria.

People become homeless for many different reasons, including lack of affordable housing, poverty and unemployment, and life events.

People who have experienced homelessness are twice as likely to have poor physical and mental health than the general population. Poor mental and physical health is both a cause and consequence of homelessness. Chronic and multiple health needs are common and often go untreated.

Rough sleeping

Rough sleeping is the most visible form of homelessness. Rough sleeping is a stressful, lonely and often traumatic experience that has a major impact on mental health. Serious mental health issues such as schizophrenia, bipolar disorder and post traumatic stress disorder (PTSD) are far more common amongst rough sleepers. Suicide rates are nine times higher for this group of people.

People sleeping on the street are almost 17 times more likely to have been victims of violence. Rough sleepers are also more vulnerable to issues relating to alcohol and drug use and some homeless people use drugs and alcohol to cope with their mental health problems. Multiple health needs alongside drug and alcohol use can also act as a barrier to accessing mainstream health services.

At the ages of 16-24 years old, people sleeping rough are twice as likely to die as their housed peers. For 25-34 year olds the ratio increases to four to five times, and at ages 35-44 years old to five to six times higher than people of the same age living in houses.

Environment

The environments in which we live affect our physical and mental health directly and indirectly in the way these promote or hinder healthy behaviours. Being in contact with the natural environment is vital for our mental wellbeing and physical health at all ages. People with access to good quality green space have better mental and physical health, and every 10% increase in green space is associated with a reduction in disease equivalent to a gain of five years of life. The impact of income inequalities on health is reduced in areas with more accessible green space. A fuller description of these issues can be found in the previous Director of Public Health annual report, Healthy Places, Healthy Futures: Growing Great Communities.

Air pollution is one of the most significant environmental risk factors for poor health and contributes to over 150 early deaths in Buckinghamshire each year. Air pollution contributes to a range of poor health outcomes including dementia, low birth weight babies, stroke, lung disease and heart disease, amongst other conditions. Older people, children and people with cardiovascular or respiratory diseases are particularly vulnerable to the effects of air pollution. Exposure to air pollution is also unevenly distributed across our population, with deprived communities more likely to be living near busy polluting roads.

Communities

The communities in which we grow up, play, work and live profoundly affect our happiness, physical and mental health and our chances of success in life. We thrive in communities where there are strong social ties, a feeling of community and a sense of belonging and where everyone has the opportunity to participate fully in community life. Having a voice in local decisions also makes a vital and positive contribution to our health and wellbeing.

People with strong social connections and support from family, friends or their community are happier and live longer, have healthier lives with fewer physical and mental health problems than those who are less well connected. Supportive social relationships aid recovery from ill health and reduce the risk of early death after retirement.

Taking part in local communities (for example, membership of community, resident, religious or other voluntary groups) is also associated with a substantially higher quality of life. Access to culture and leisure opportunities is good for our physical and mental health.

Participation in the arts can contribute to community cohesion, reduce social exclusion and isolation, and make communities feel safer and stronger. For example, arts participation can increase physical activity, contributing to a reduction in childhood obesity. Engagement with the arts and cultural activities can reduce anxiety, depression and stress, and increase self-esteem, confidence and purpose.

People who experience social isolation and loneliness are more likely to experience depression and anxiety, be physically inactive, smoke and drink alcohol. They also have an increased risk of heart disease and dementia and die prematurely. They are more likely to visit their GP, use accident and emergency services, be admitted to hospital and enter local authority funded residential care. However, arts and cultural intervention can have a positive impact on health conditions such as dementia and depression.

Education

A good education is good for health. Education supports making health promoting choices, builds good social skills that support people making strong social connections and helps them gain satisfying employment. Four more years of education reduces death rates by 16% and reduces the risk of heart disease and diabetes.

When compared to people with the highest life expectancy, people with the lowest life expectancy are three times more like to have no qualifications. People with lower educational attainment are more likely to report being in poorer health, smoke, be obese and suffer alcohol-related harm.

Transport

We travel for work and play, to get to school, shops and other services. How we travel, how far and for how long, has significant implications for our health, the health of others and society as a whole. A healthy transport system can help our communities access key services, learning opportunities and jobs.

Active travel (such as walking and cycling) improves our health through physical activity and by reducing air and noise pollution, increasing social connections and making communities safer. It improves our mood, reduces stress and the risk of developing long term conditions or dying early. It is also the lowest carbon, cheapest and most reliable and sustainable form of transport. It reduces congestion, absenteeism and boosts economic productivity.

Compared to commuters travelling by car, cyclists have a 46% lower risk of developing heart disease, 52% lower risk of dying from heart disease, a 45% lower risk of developing cancer and a 40% lower risk of death from cancer. Long commutes are increasingly being recognised as having a detrimental effect on our health and wellbeing. Long commutes have been linked with higher levels of stress and anxiety and higher blood pressure. When we use public transport we are likely to do an extra 12–15 minutes physical activity each day.

Each year in the UK, traffic accidents cause around 250,000 casualties and kill almost 3,000 people. People living in the most-deprived areas have a 50% greater risk of dying from a road accident compared with those living in the least deprived areas.

3. Healthy behaviours

Healthy behaviours are important at every age. These behaviours start early in life and are heavily influenced by the people around us and the places we live. For example, children who grow up in homes where adults smoke or drink harmful levels of alcohol are more likely to adopt these behaviours themselves.

The four main health behaviours – smoking, physical inactivity, unhealthy diet and alcohol misuse account for 40% of all years lived with ill health and disability. These behaviours are major risk factors driving the development of long-term conditions that account for 70% of all NHS and social care spend. Addressing these four behaviours could lead to a reduction of up to 80% of new cases of heart disease, stroke and type 2 diabetes and a reduction of 40% of new cases of cancer.

Each unhealthy behaviour alone increases the risk of many long term conditions but in combination these risk factors have a multiplicative effect. Unfortunately, the majority of people have more than one unhealthy behaviour - 70% of people have two or more, 25% have three or more and 5% have all four unhealthy behaviours. Engaging in four unhealthy behaviours makes individuals four times more likely to die prematurely than someone who has no unhealthy risk factors. Men, younger age groups, those in lower socio economic groups and people with lower levels of education are more likely to exhibit multiple unhealthy behaviour risks. Tackling multiple unhealthy risk factors is a key component in actions to reduce health inequalities.

The impact of the four main health behaviours is highlighted below.

Smoking

Smoking is the biggest cause of preventable illness and premature death in England. It increases the risk of developing more than 50 serious health conditions, including cancer, heart attack, stroke and chronic respiratory disease. One in 10 adults smoke in Buckinghamshire, equating to more than 42,000 adult smokers, and there are more than 600 early deaths each year due to smoking. These deaths cost the Buckinghamshire economy £24.8m due to lost economic activity.

The average smoker will lose 10 years of their life compared to a non-smoker. Within a year of stopping smoking the risk of heart attack falls to about half that of a continuing smoker, and within 10 years the risk of lung cancer falls to half that of a smoker.

Smoking is the largest single cause of inequalities in health and accounts for half the difference in life expectancy between the lowest and highest income groups. Smoking is more common in people with routine and manual jobs where 21% of adults smoke, twice the Buckinghamshire rate.

Young people are more likely to take up smoking if those around them smoke. In poorer communities young people are more exposed to smoking behaviour, more likely to try smoking and find it harder to quit.

Second-hand smoking

Second-hand smoke is the smoke a smoker breathes out. In the case of an unborn baby, it is the chemicals that reach the baby in the mother's womb. Second-hand smoke contains about 4,000 chemicals, more than 50 of which are known to cause cancer.

For women who smoke or are exposed to second-hand smoke when pregnant, their babies may develop serious health problems, including miscarriage, being born too early or with a low birthweight. Infants exposed to second-hand smoke are also more likely to die from sudden infant death syndrome.

Children exposed to second-hand smoke have more ear infections, respiratory problems (e.g. bronchitis and pneumonia) and tooth decay. Children with asthma are especially sensitive to second-hand smoke. Children who grow up with parents who smoke are themselves more likely to smoke.

Non-smoking adults who are exposed to second-hand smoke at home or at work, have an increased risk of developing lung cancer by 20 to

30%. Non-smokers exposed to second-hand smoking in the home have a 25% increased risk of heart disease.

Costs of smoking to the NHS

The cost of smoking to the NHS in Buckinghamshire is £23m per year with £7.7m spent on hospital admissions and £9m spent in primary care.

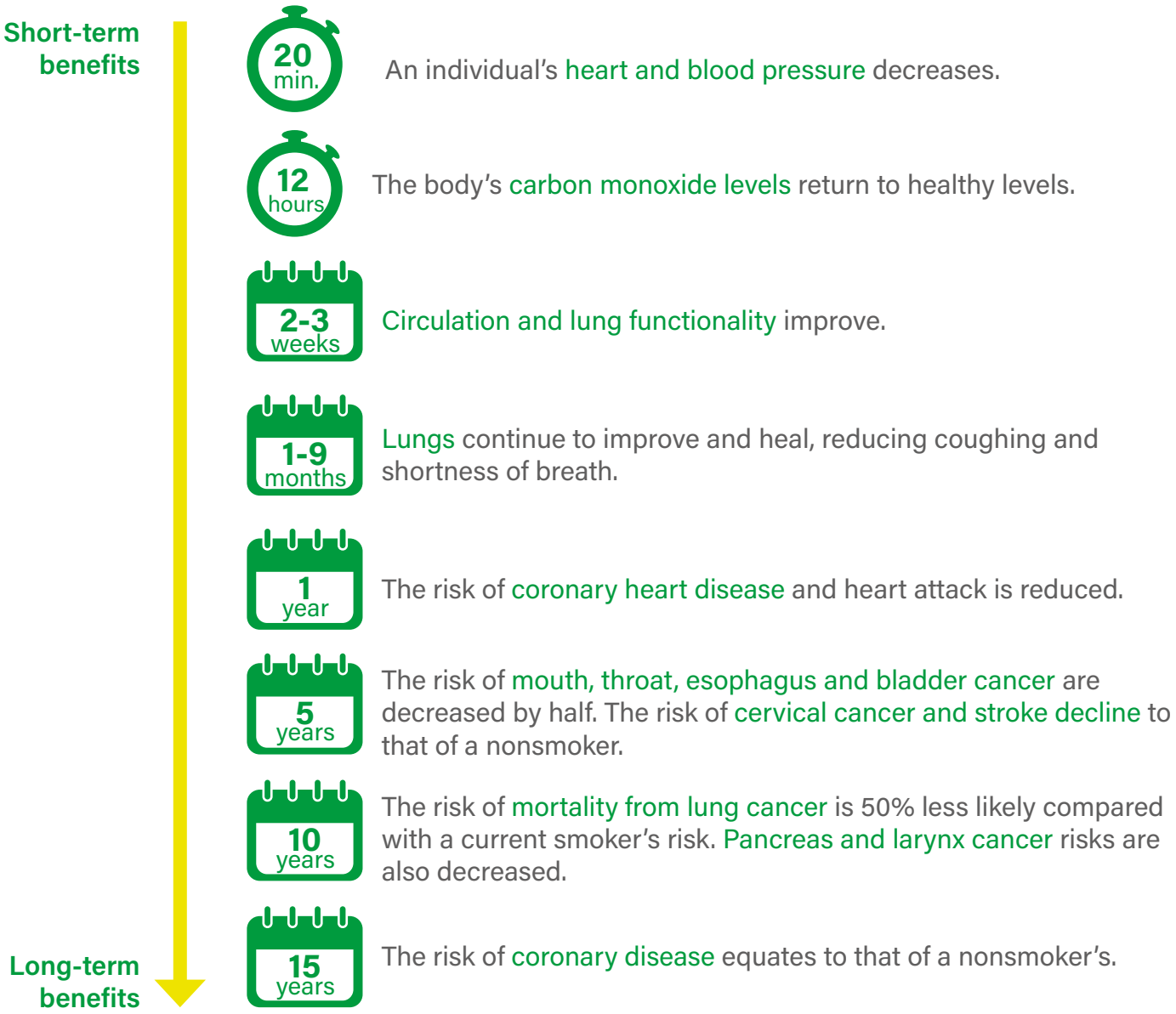
An audit in Buckinghamshire found one in four emergency hospital admissions and 13% of all elective admissions were for people who smoke. Almost half of patients admitted with respiratory conditions were smokers. Emergency respiratory admissions are the highest emergency spend for Buckinghamshire at approximately £19m per year.

Smoking and social care

Social care needs occur 10 years earlier in current smokers compared to people who have never smoked. The Buckinghamshire social care costs due to smoking are estimated to be £6 million per year; £5 million of these costs are estimated to be met by the local authority.

Stopping smoking

There are many health benefits to stopping smoking at any age, some of which are realised immediately as shown below.



Smoking cessation treatment is a highly effective and cost effective intervention. The Ottawa model is an effective hospital-based model. It identifies patients admitted to hospital who smoke and gives them support to quit. People who receive the intervention are more likely to stop smoking, less likely to be readmitted to hospital or visit A&E within 30 days and 26% less likely to be hospitalised over two years. There is a 48% reduction in death over two years compared to patients who receive usual care.

Alcohol

Alcohol contributes to more than 200 health conditions and injuries, including cancer, heart disease, stroke, mental health and memory problems. In England, alcohol misuse is the biggest risk factor contributing to early death, poor health and disability for people aged 15 to 49 years old.

More than 100,000 people (one in four adults) in Buckinghamshire are drinking above the recommended levels and risking their health, often without realising it. Further statistics are in the 2019 Director of Public Health Annual Report which focuses on alcohol.

Alcohol misuse does not just affect the individual who is drinking too much but also impacts on the people around them, including their children and families and the wider community.

Children of parents who are alcohol dependent are more likely to experience difficulties at school, to consider suicide and to become dependent drinkers themselves. These children are also more likely to go into the care of the local authority. Alcohol also plays a significant role in domestic violence, crime and road traffic accidents.

England's Chief Medical Officer advises that to keep harm from alcohol to a low level, people should not drink more than 14 units across a week on a regular basis. This advice is the same for men and women

Alcohol misuse treatment in hospitals

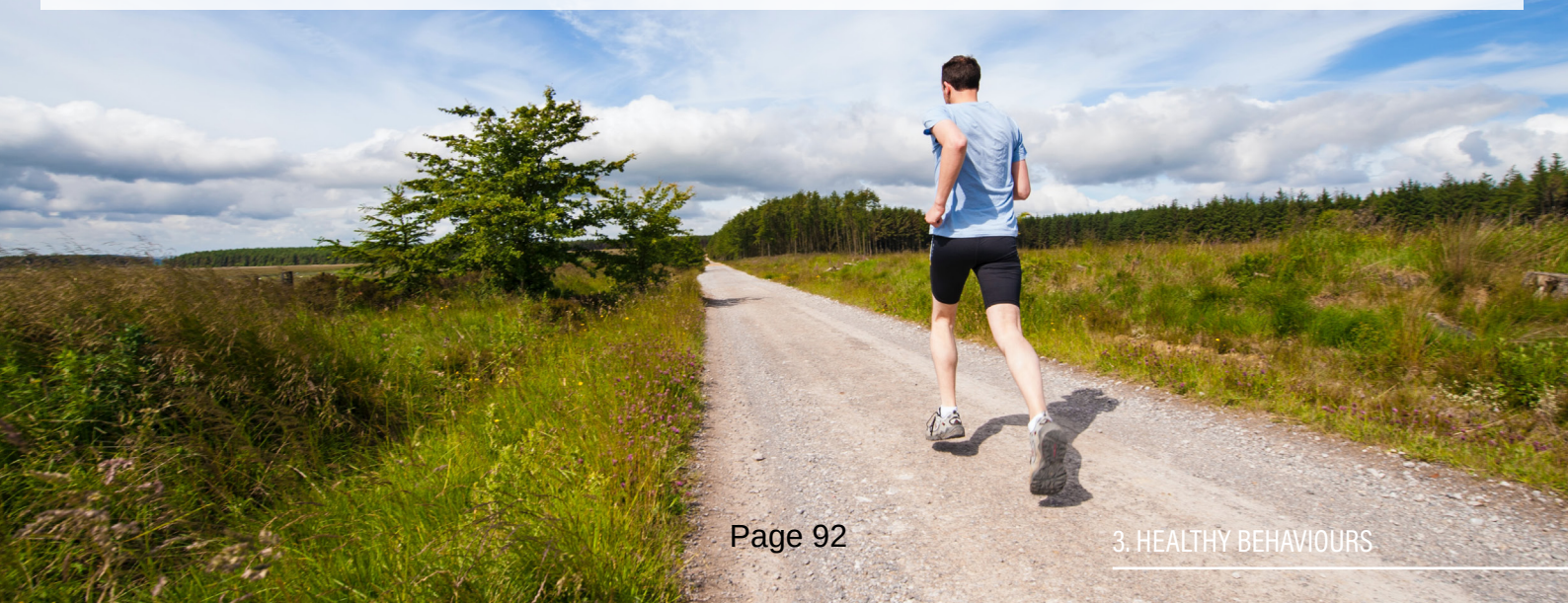
Nationally, 13-20% of all hospital admissions are alcohol-related. Consultant-led alcohol care teams have been shown to both improve the care for patients who misuse alcohol, and to reduce impact on the health care system. Patients benefit from these teams by having their needs addressed more quickly and appropriately. Alcohol care teams can also deliver a reduction in the number of days patients with alcohol-misuse are in hospital. They produce savings to the NHS of £286,000 per 100,000 population.

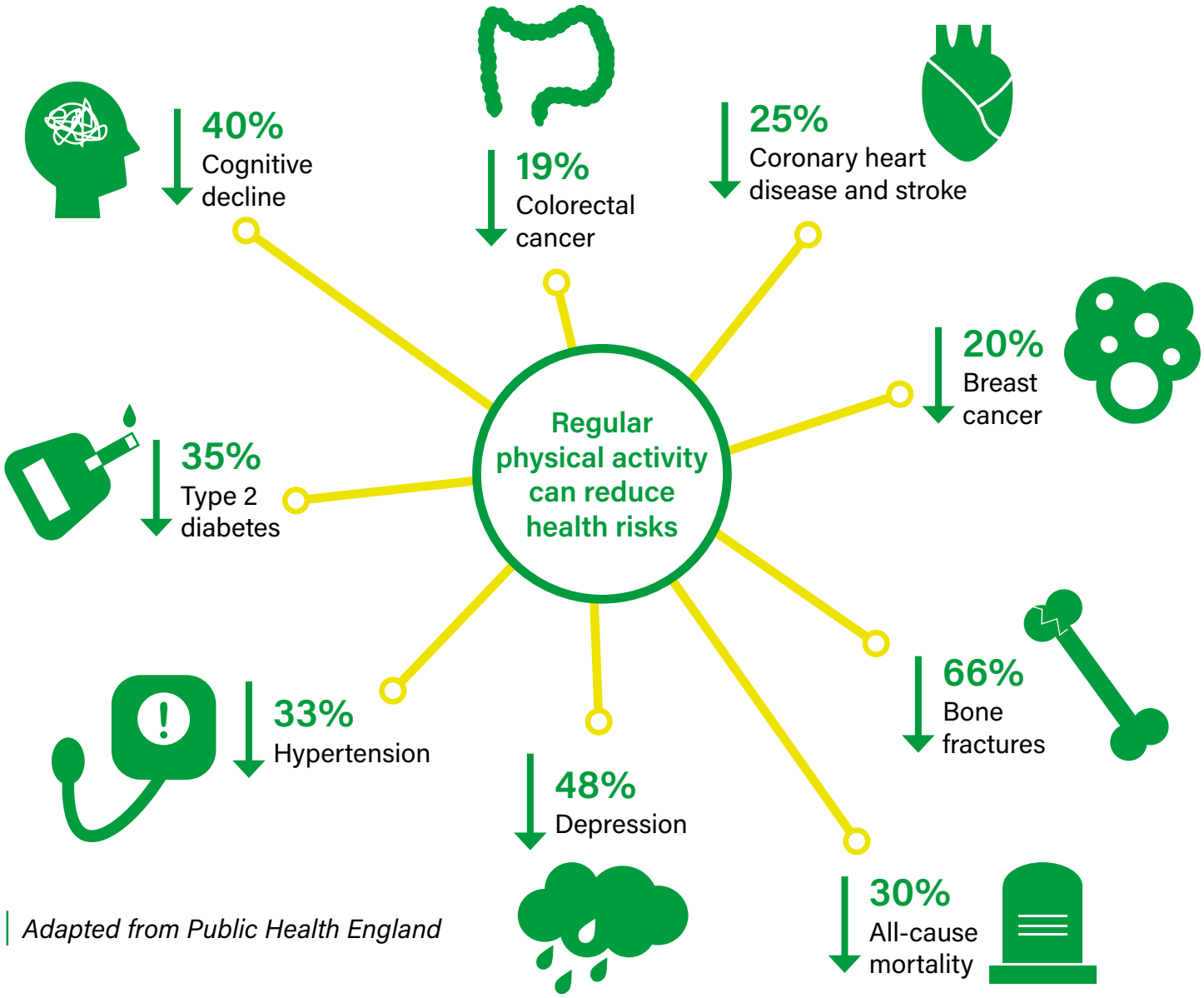
Physical activity

Physical activity has major health and social benefits. It increases physical and mental wellbeing, educational attainment and social interaction. It also reduces and delays the onset of many long-term health conditions. The benefits to health start at just 30 minutes of physical activity a week, but more than a quarter of UK adults fail to achieve this.

For adults the recommended level of physical activity is 150 minutes of moderate intensity physical activity per week. This is the level that makes you breathe a little harder and feel a little warmer. People can talk but not sing while doing moderate intensity physical activity. For further information on physical activity see the Director of Public Health Annual Report on Physical Activity.

Physical activity reduces the risk of a wide range of health conditions as shown overleaf.





Adapted from Public Health England

Meanwhile, inactivity contributes to as many deaths in the UK as smoking and is the fourth leading risk factor for mortality worldwide. Physical inactivity costs the UK economy £7.4 billion a year.

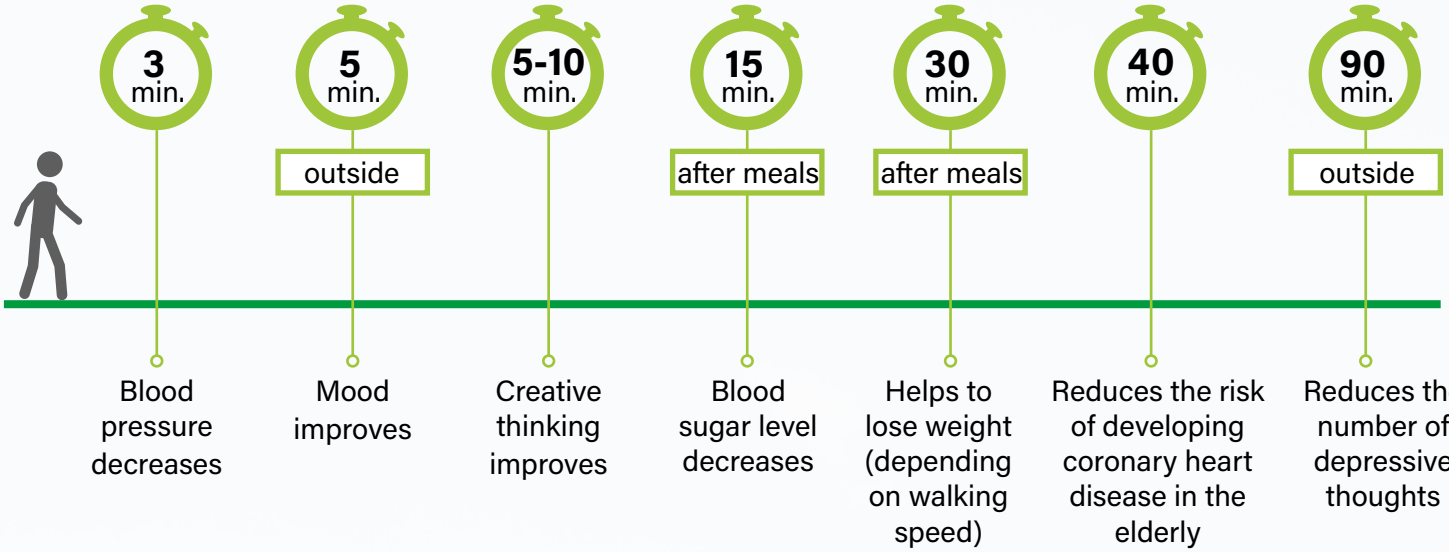
How to increase physical activity

Building physical activity into everyday life is one of the easiest ways to increase physical activity, for example. using active travel such as walking or cycling as part of the daily life. However the environments in which we live also affect people's desire and ability to be physically active, for example the availability of safe, attractive environments in which to play, walk or cycle.

The NHS can help advise people about the benefits of physical activity and this has been shown to be very effective. 'Moving Medicine' promotes healthy conversations between healthcare professionals and members of the public. One in four people would be more active if they were advised by a GP or a nurse; however, almost three quarters of GPs say they do not discuss the benefits of physical activity with their patients.

Walking is a safe and sustainable form of physical activity and has instant benefits as shown overleaf.

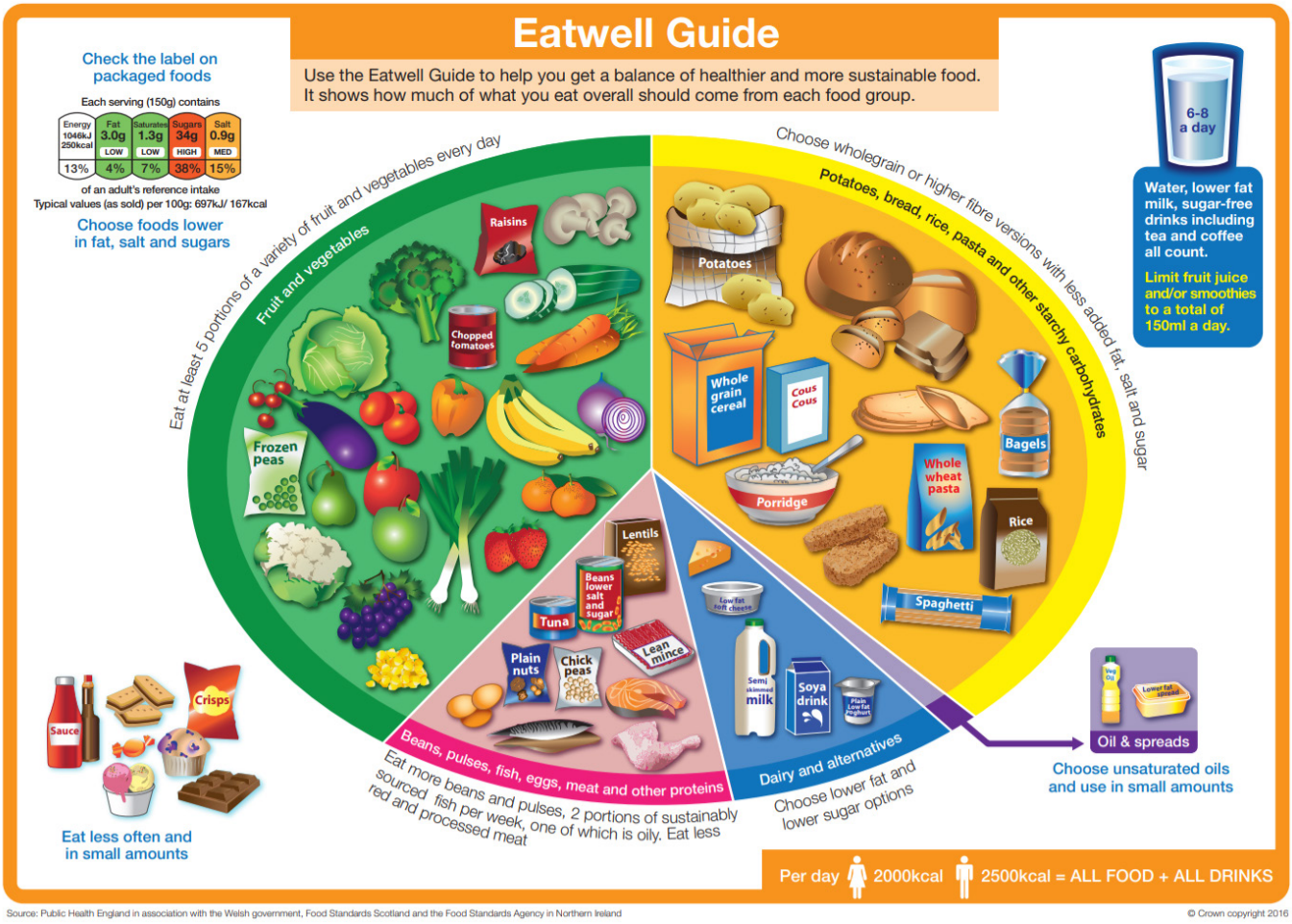
How walking affects the body



Healthy eating and obesity

Healthy eating

A balanced diet is essential for health. An unhealthy diet is one of the leading risk factors for a wide range of conditions, including cancer and dementia. A healthy diet includes a variety of different foods that include the wide range of nutrients our bodies need, as illustrated by the Eatwell Guide.



It is three times more expensive to get the energy we need from healthy foods than unhealthy foods. The food and drink we consume is heavily influenced by the environment around us. In 2017, over £300 million was spent on advertising soft drinks, confectionary and sweet and savoury snacks, compared to £16 million spent on advertising fruit and vegetables.

Overweight and obesity

Overweight and obesity are the result of an imbalance of calorie intake and physical activity. More than 50% of adults in Buckinghamshire are overweight or obese. The gap between the most and the least deprived groups has widened over the past 10 years, with the most deprived groups having higher levels of obesity. Projections suggest that if this trend continues as many as one in three children in the most deprived areas will be obese by 2030.

The amount we eat is very important as the chart overleaf shows, with today's high energy density foods it is very hard to outrun an unhealthy diet.

10 calorie-dense food and drinks and their activity equivalence

FOOD TYPE	CALORIES APPROX.	WALK OFF K/CAL (medium walk 3-5mph)	RUN OFF K/CAL (slow running 5mph)
Sugary soft drink (330ml can)	138	26 min	13 min
Standard chocolate bar	229	42 min	22 min
Sandwich (chicken and bacon)	445	1 hr 22 min	42 min
Large pizza (1/4 pizza)	449	1 hr 23 min	43 min
Medium mocha coffee	290	53 min	28 min
Packet of crisps	171	31 min	16 min

Overweight and obesity increase the risk of developing a wide range of conditions. Obese adults are more likely to develop diabetes, certain cancers and dementia. We now know that people who are overweight or obese who contract coronavirus (COVID-19) are more likely to fall seriously ill and be admitted to intensive care unit. Obese adults aged 65 and older are up to twice as likely to require social care support as older adults with a healthy weight.

Obesity costs the UK 3% of its GDP (£60 billion in 2018) through direct medical costs and its impact on productivity. The NHS spends an estimated £6.1 billion each year on the impacts of obesity and the costs of treating obesity.

Tackling unhealthy behaviours

While we cherish the idea of free choice, much of our behaviour is also strongly shaped by our environment, often without us realising. The cues that shape much of our behaviour can be found in the physical, economic, digital, social and commercial environments we inhabit. For example, price, advertising and availability influence our consumption of cigarettes, unhealthy food and alcohol. Safe and attractive places to play or safe cycling and walking routes to school and work influence people's physical activity levels.

Evidence shows that interventions that alter our environments to promote health, such as structural changes, require little or no action from individuals, see the largest population health gains and also gains in the most vulnerable communities compared to individual-based approaches.

Interventions that seek to change individual behaviour without addressing the wider environment are likely to have less impact. For example, more than 50% of the population are overweight or obese. A strategy that focuses solely on changing the behaviour of individuals one person at a time cannot reverse this epidemic. A whole system approach at population level is required that addresses a wide range of factors such as food formulation, pricing, advertising, availability and social norms.

4. Our health at a glance

Further detailed information about the health of Buckinghamshire residents can be found in the Data Compendium that accompanies this report but a high level summary is provided below.

There are approximately 540,000 people living in Buckinghamshire. Our population's age profile is similar to the England average but with a lower proportion of people aged 20-34 years and a slightly higher proportion of people over 85 years old.

One in seven people are from a black, asian or minority ethnic group, which is lower than the England average but this rises to one in three for school age children.

Buckinghamshire residents generally enjoy better health and wellbeing than the England average. This reflects Buckinghamshire's position as one of the least deprived authorities in England and the favourable conditions in which our residents live. Over one third of our residents live in the 10% least deprived wards in England. 0.3% of the Buckinghamshire live in the 20% most deprived areas in England.

In terms of the factors that influence health, our residents have generally higher levels of educational attainment, income, employment and better living conditions than the England average. This affects their health as well as their opportunity to adopt healthy behaviours. However, although we are an affluent county almost one in 10 children and young people and 7.7% of people aged over 65 years live in poverty in Buckinghamshire, which will increase their risk of poorer health.

Life expectancy at birth and the years lived in good health are both higher than the England average. Life expectancy at birth is 85.1 years for females (83.1 for England) and 81.8 years for males (79.6 England) in Buckinghamshire. Healthy life expectancy at birth is 70.3 for female (63.8 England) and 68.8 for male (63.4 in England)

Outcomes for Buckinghamshire children and young people are generally better than the England average. The proportion of women smoking in pregnancy and babies born at low birthweight are lower than the England average. Smoking rates among young people are lower

than the England average but teenage alcohol consumption is similar to the England average. Young people achieve well at school and better than the England average but the proportion of 16-17 year olds not in education or training is similar to the England average. England data shows an increase in the proportion of young people with mental health problems. There has been an observed increase in the number of mental health admissions and admissions for self-harm in young people locally although rates remain lower than the England average.

Adults in Buckinghamshire are also generally healthier than the England average. Although rates of smoking are lower than the England average, one in 10 adults (more than 42,000) people still smoke. A higher percentage of Buckinghamshire adults drink more alcohol than the recommended limit and more than half of adults in Buckinghamshire are an unhealthy weight amounting to approximately 208,000 adults. Physical activity levels are similar to the England average.

Despite our better health many residents experience potentially avoidable ill health and disability. The major causes of disease, disability and death in Buckinghamshire among adults are long-term conditions, many of which are potentially preventable. Long-term conditions include diseases such as heart disease, cancer and diabetes and account for 70% of spend on health and social care. Half of our residents have at least one long-term condition and three in 10 have two or more long-term conditions. People with multiple long-term conditions (multi-morbidity) tend to have lower quality of life, more problems with co-ordinating their care and greater use of healthcare services. The prevalence of multiple long-term conditions tends to increase with age but this is not inevitable if people have healthy behaviours. The onset of multiple conditions often occurs 10-15 years earlier in more deprived communities.

The top risk factors in Buckinghamshire that increase the risk of disease and death are behavioural risk factors (diet, smoking, alcohol and physical inactivity) and so called metabolic risk factors (high blood pressure, high cholesterol and overweight/obesity).The three metabolic risk factors are influenced to a very large extent by diet and levels of physical inactivity as well as other factors like alcohol consumption.

The prevalence of many long-term conditions is lower than the England average. This is the case for diabetes, heart disease, chronic lung disease and serious mental illness. The recorded rates of asthma, high blood pressure, depression and dementia are similar to the England average. The rates of many cancers are lower than the England average but rates of breast cancer and malignant melanoma (a form of skin cancer) are higher than the England average.

The top four causes of death in Buckinghamshire are cancer and cardiovascular diseases accounting for 58% of all deaths followed by respiratory disease and neurological disorders such as dementia.

Although overall our health is good, this varies across Buckinghamshire between different communities. People living in the more deprived areas of Buckinghamshire experience poorer health from birth through to old age.

Premature death rates (for people under 75 years) have fallen overall. Life expectancy has increased for men and women in Buckinghamshire since 2001, although life expectancy for women started to plateau in 2011 in line with England trends. People living in the more deprived areas of Buckinghamshire have lower life expectancy than those living in the least deprived areas and this gap has widened in line with England trends.

The years people can expect to live in good health (healthy life expectancy) in Buckinghamshire has increased and shows a similar pattern of longer healthy life expectancy in less deprived areas.

The incidence of different illnesses also varies between communities for example there are higher rates of diabetes, heart disease and high blood pressure in some black and asian communities. Other groups in Buckinghamshire also often have poorer health than the Buckinghamshire average – this includes carers, people with mental health problems or learning disability and homeless people.

The next section highlights the variations in health at a local level in Buckinghamshire.

Patterns of health

Within Buckinghamshire there are considerable differences in health and wellbeing between different population groups and communities. Understanding these differences and what is driving them presents a great opportunity to work with communities to help improve health and wellbeing and quality of life for residents. This section presents a high-level view of health from our existing statistics at a local geographical level. What it cannot capture is the views of communities themselves about the key issues from their perspective and what the solutions might be. Gaining insight from communities is a vital part of the jigsaw.

Local patterns

The variations in health that exist reflect a variety of factors, including the conditions in which people are born, grow, learn, work and age. The index of multiple deprivation is an England measure combining information on a range of indicators, including income, housing, employment and education, many of which influence people's health.

Locally we can analyse the impact of relative deprivation on health by dividing the population of Buckinghamshire into fifths (called quintiles) based on the deprivation score of the area in which they live. Each quintile contains approximately 100,000 people. Map 1 (overleaf) shows the deprivation quintiles within Buckinghamshire relative to Buckinghamshire. The most deprived areas are shaded red. The least deprived are purple.

The analysis shows that starting from birth and continuing throughout life, people living in the most deprived areas tend to have poorer health across a wide range of areas. These health outcomes often show a stepwise gradient with people living in the most deprived areas having the worst outcomes, followed by those living in the second most deprived areas. The best outcomes are experienced by those in the least deprived areas.

So for children and young people - comparing the most deprived quintile 5 (Q5) and least deprived quintile 1 (Q1):

Babies and children in the most deprived quintile (DQ5) are:

- Almost twice as likely to be born low birth weight babies at full term.
- 30% more likely to die before their first birthday.
- More than twice as likely not to reach the 'school readiness' developmental milestone at end of school reception year (35% vs. 16%).
- More than twice as likely to be obese by end of primary school compared with children in DQ1 (22% vs. 9%).
- 34% more likely to have an emergency admission to hospital.
- More than five times more likely to be 'looked after' children.

And for people of all ages comparing the most deprived quintile 5 (Q5) and least deprived quintile 1 (Q1):

People in the most deprived quintile (DQ5) are:

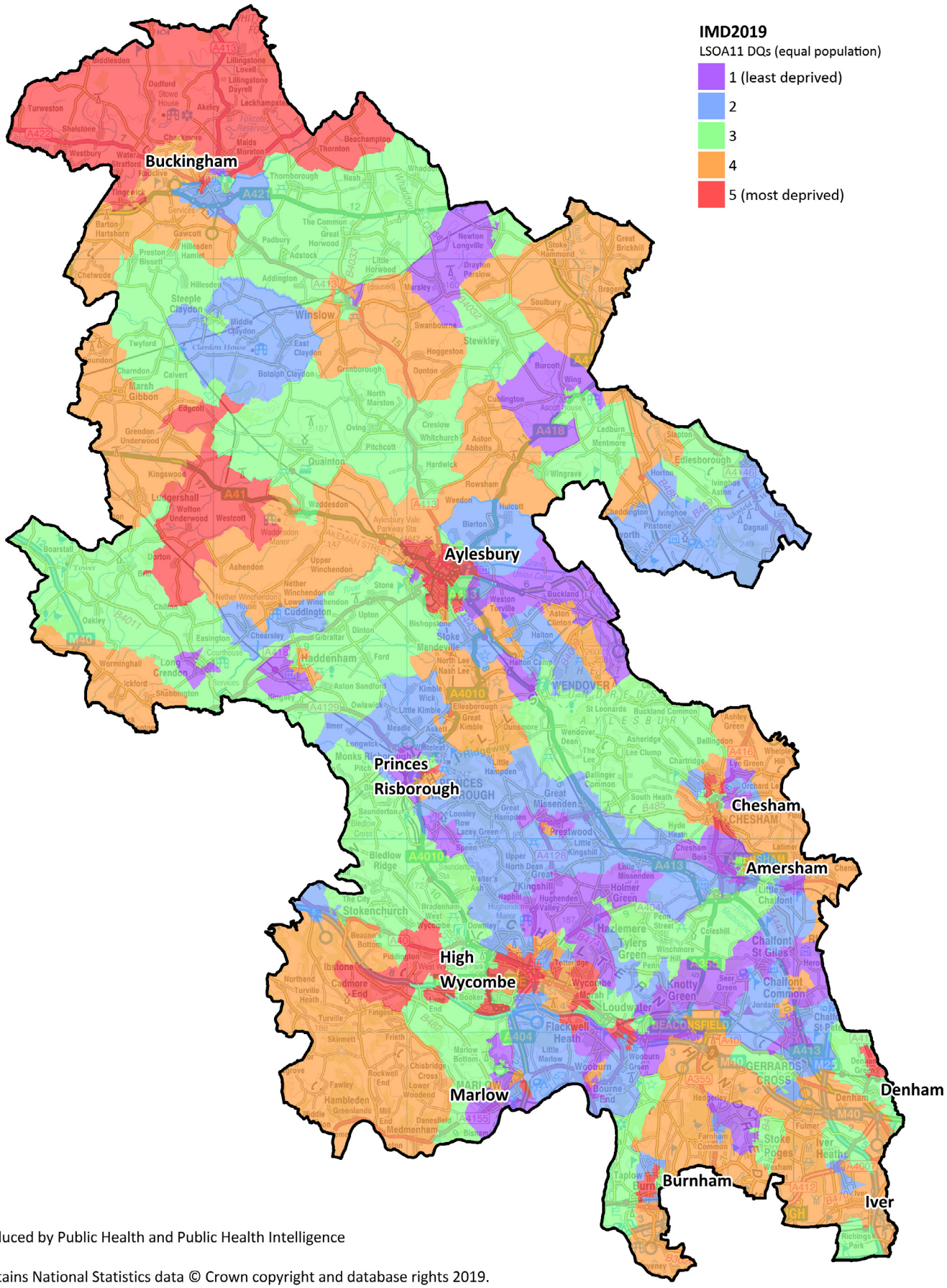
- More than 2.5 times more likely to smoke than people in DQ1 (22.8% vs 8.9%).
- More than twice as likely to be in treatment for alcohol use and four times more likely to be in treatment for drug use.
- More likely to have a long-term condition and multiple long-term conditions. People living in more deprived areas develop multiple long-term conditions 10 years earlier than people living in less deprived areas.
- More than 60% more likely to have an emergency admission to hospital.
- More than 60% more likely to have an emergency admission for conditions like heart disease and stroke, 71% more likely to have emergency admissions for cancer, more than twice as likely to have an emergency admission for mental health or self-harm, and three times more likely to have admissions for chronic obstructive pulmonary disease(COPD).
- Have a premature death rate (deaths under 75 years) twice as high as those in the least deprived quintile.
- Women living in the most deprived quintile in Buckinghamshire can expect to live for 4.8 years less than women living in the least deprived areas. Men living in the most deprived quintile in Buckinghamshire can expect to live 6.1 years less than men living in the least deprived areas. The gap in life expectancy has widened since 2001 as life expectancy has grown faster in the least deprived quintile than the most deprived quintile.

Patterns in healthy life expectancy

Healthy life expectancy (HLE) varies across Buckinghamshire. In Oakridge and Castlefield (Wycombe), male HLE is 56.6 years, compared with Chesham Bois and Weedon Hill where male HLE is 76.2 years. In Southcourt (Aylesbury) female HLE is 57.5 years, compared to Chesham Bois and Weedon Hill where female HLE is 79.1 years.

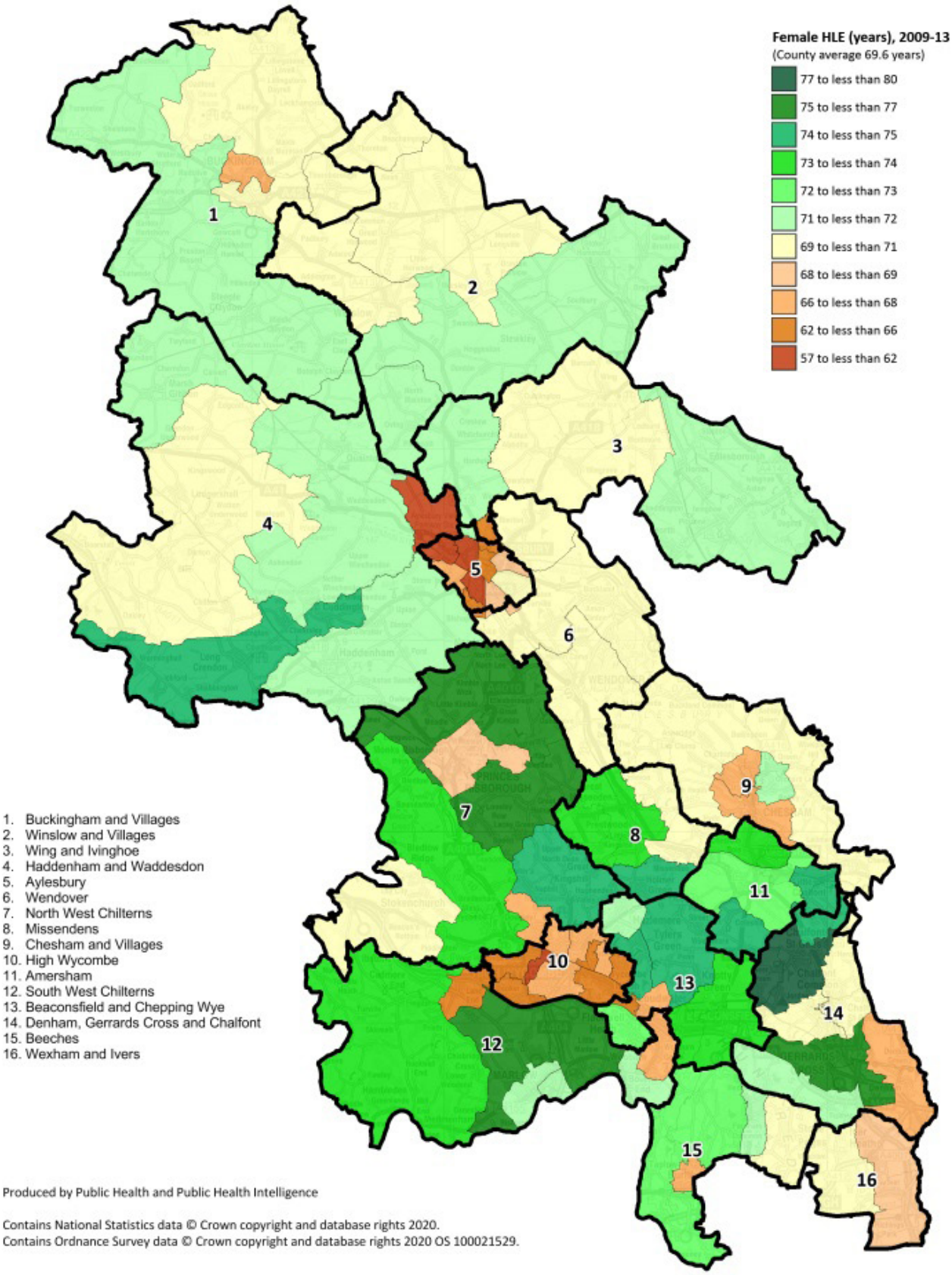
Map 2 shows the variation in healthy life expectancy across Buckinghamshire for women and Map 3 for men. Healthy life expectancy is shown by graded colours – dark green represents areas with the longest average healthy life expectancy and dark red indicates areas with the shortest healthy life expectancy.

Map 1: Map showing deprivation quintiles of areas in Buckinghamshire compared with the rest of the county, Index of Multiple Deprivation 2019.

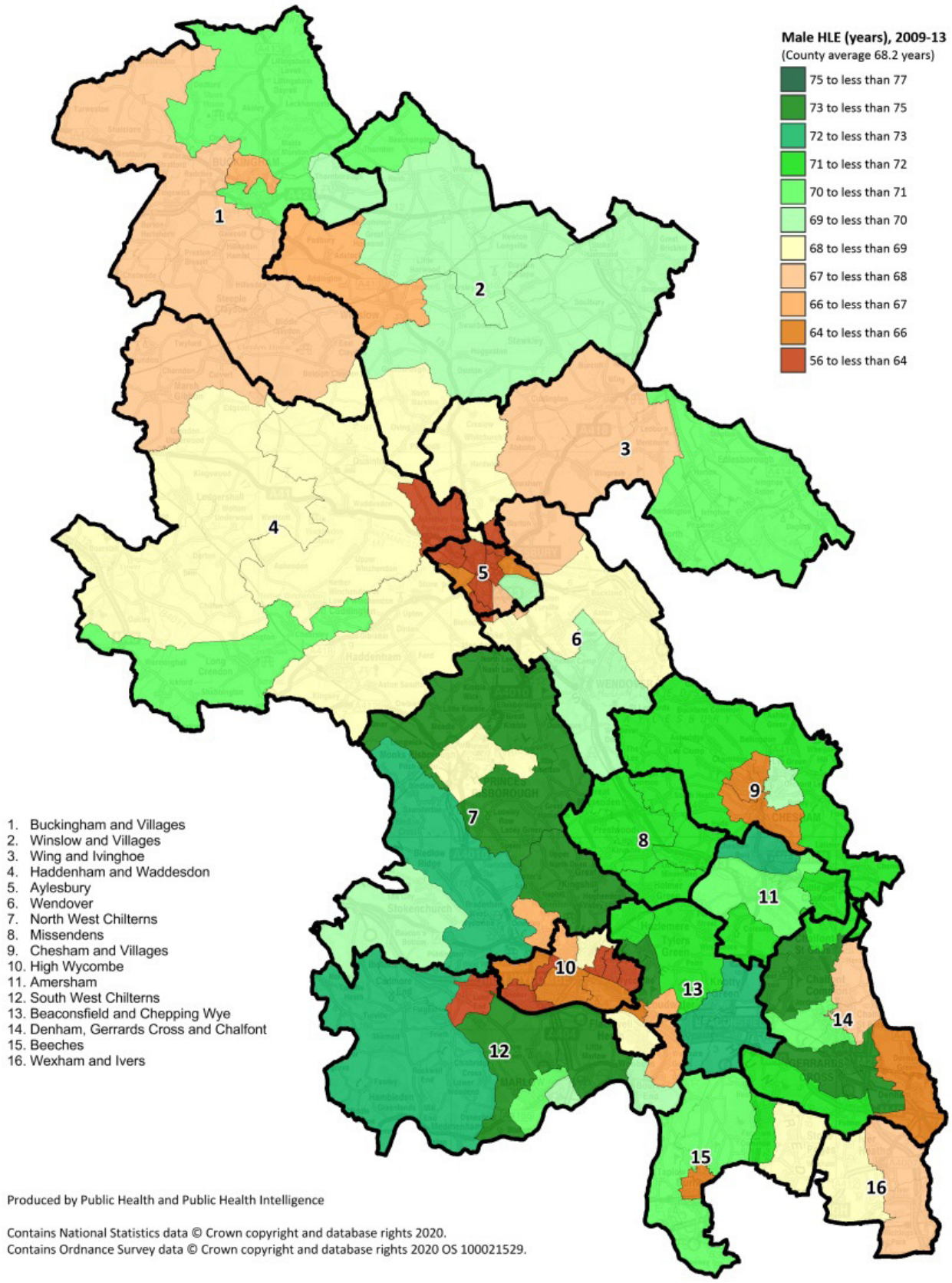


Produced by Public Health and Public Health Intelligence

Map 2: showing the variation in healthy life expectancy across Buckinghamshire for women.



Map 3: showing the variation in healthy life expectancy across Buckinghamshire for men.



The gap in healthy life expectancy in Buckinghamshire

On average residents in more deprived areas spend a greater proportion of their shorter lives in poor health.

For example, in Gerrards Cross, women on average spend less than 12 years of their life (13% of their life) not in good health, compared to Oakridge and Castlefield in High Wycombe where women can expect to spend over 25 years (over 30% of their life) in not good health.

In Gerrards Cross, men on average spend around nine years (11% of their life) not in good health, compared to Oakridge and Castlefield in High Wycombe where men can expect to spend over 21 years (27% of their life) in not good health.

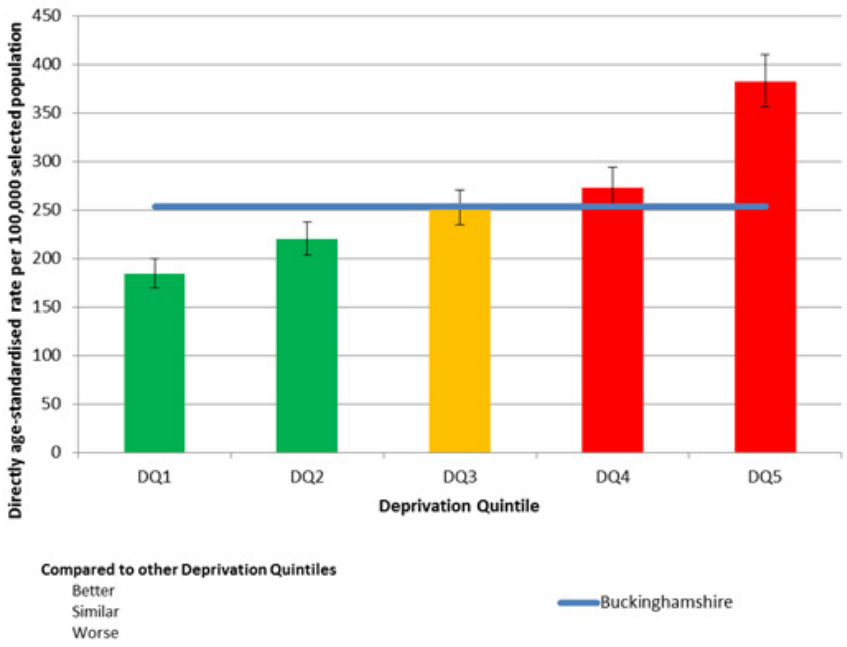
Premature deaths

The rate of premature death (death under the age of 75 years) is twice as high for the most deprived quintile in Buckinghamshire as it is for the least deprived quintile (2018-19).

The graph to the right shows death rates from all causes for people under the age of 75 in Buckinghamshire by deprivation quintile. Premature mortality has a clear social gradient, and shows a stepwise increase in the rates of early death increase with increasing deprivation.

It is estimated that 3,444 premature deaths in Buckinghamshire between 2003 and 2018 can be attributed to poorer socioeconomic conditions[1].

Premature mortality rates (under 75 years old) by deprivation quintile 2016-18



In Buckinghamshire when compared to DQ1 people in DQ5 are:

59% more likely to die prematurely from cancer.

2.3 x more likely to die prematurely from cardiovascular disease.

3.4 x more likely to die prematurely from frespiratory disease.

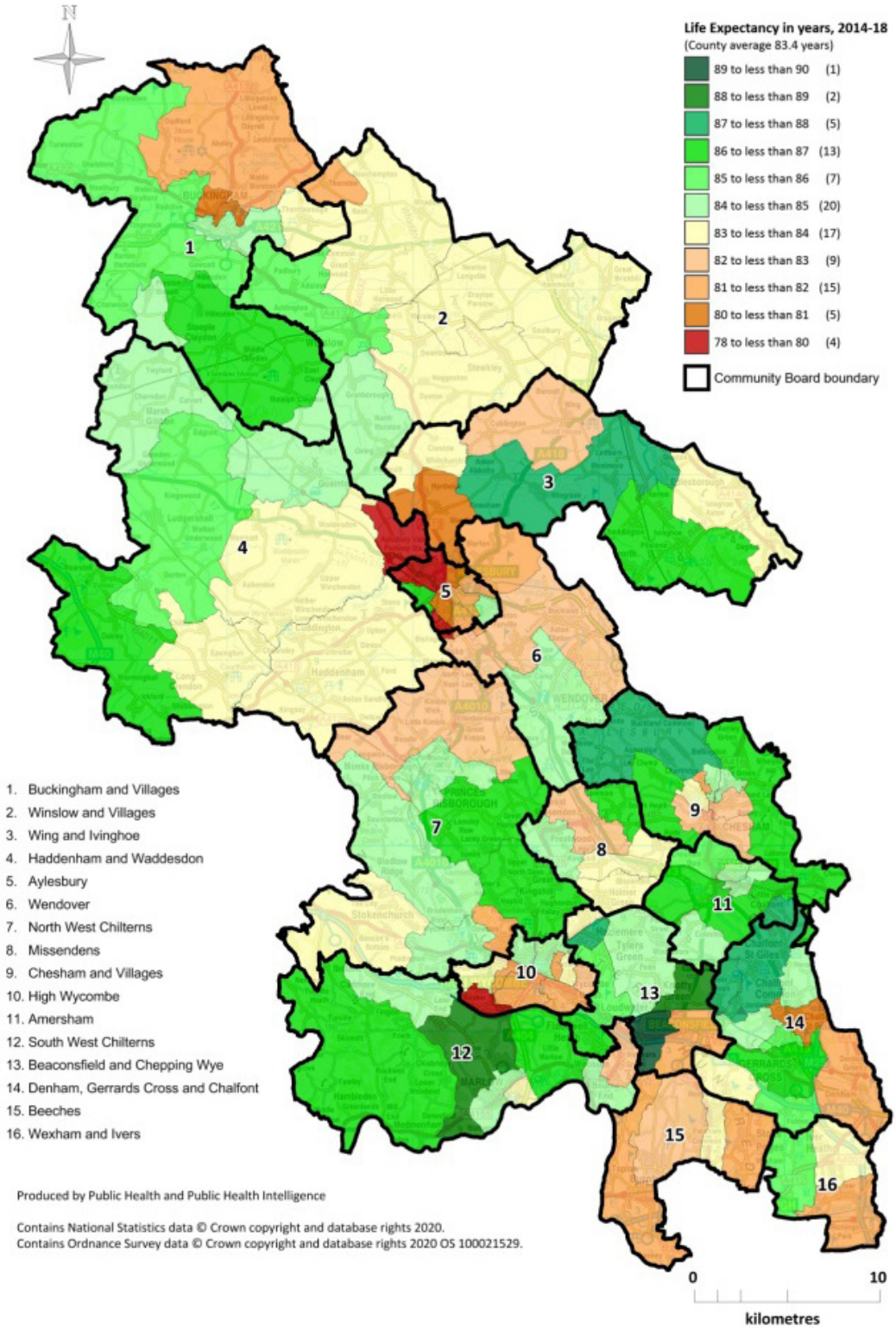
[1]*If the rates of premature deaths (under age 75) in the least deprived decile are applied to other deciles, we can compare what the expected death rate would be with the actual death rate and estimate how many early deaths can be attributed to socioeconomic inequalities. SOURCE: https://public.tableau.com/profile/rob.aldridge#!/vizhome/MATI_19_11_25/MATI_dashboard*

Life expectancy across Buckinghamshire

Life expectancy varies across Buckinghamshire from 76.6 years (Riverside) to 87.5 years (Grendon Underwood and Brill) for men and 80.2 years (Riverside) to 94.3 (Beaconsfield North) for women. The variation in life expectancy across Buckinghamshire is shown in Map 4.

Public Health England uses a measure called the slope index of inequality to measure the gap in life expectancy across Buckinghamshire. On this measure the Buckinghamshire gap in life expectancy is narrower than the gap in England for men and women but wider than the gap in the neighbouring counties of Oxfordshire and West Berkshire.

Map 4: Life expectancy (persons), 2014-18, by ward

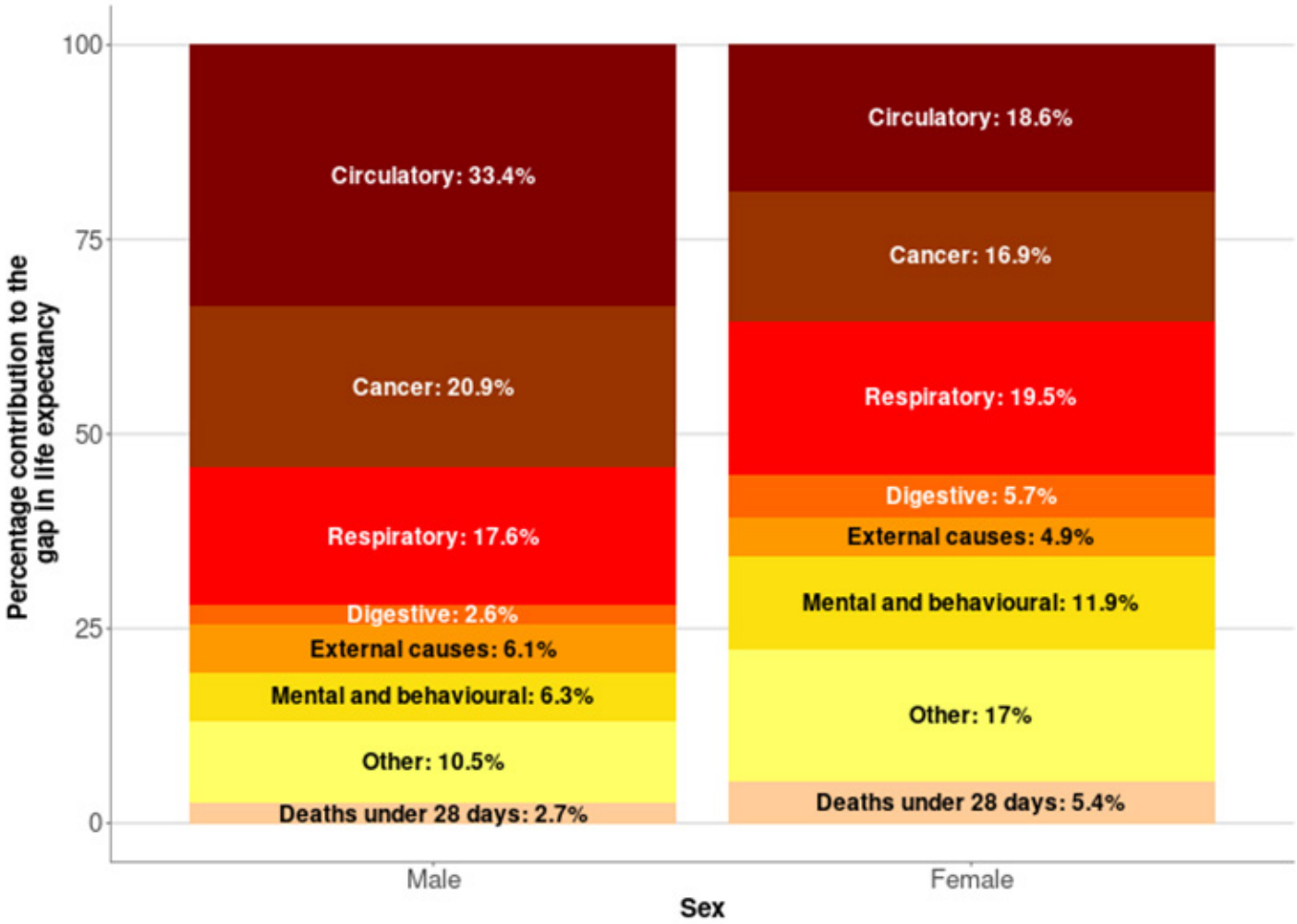


What are the main conditions responsible for the gap in life expectancy?

For men living in Buckinghamshire, 72% of the life expectancy gap is explained by more deaths from circulatory disease (such as stroke or coronary heart disease), cancer and respiratory disease which account for 33%, 21.9% and 18% of the gap respectively.

For women living in Buckinghamshire 55% of the life expectancy gap in women is explained by more deaths from respiratory disease, circulatory disease and cancer accounting for 19.5%, 18.6 and 16.9% respectively of the life expectancy gap between the most deprived quintile.

Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Buckinghamshire, by broad cause of death, 2015-17.



Source: Public Health England based on ONS death registration data and mid year population estimates, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation, 2015

Community Boards

Community Boards are the new partnership forums for local people, town and parish councils, community groups, police, healthcare organisations and residents to work with Buckinghamshire Council to understand and respond to local needs more effectively. There are 16 Community Boards across Buckinghamshire as shown on the map below.

Local profiles for each Community Board have been produced highlighting the opportunities community boards have to make a difference to local resident's health and wellbeing.

Some headlines describing the variations in health between community boards are described overleaf.

Buckinghamshire Community Boards

Demographics

Populations

The Community Boards vary in size from High Wycombe and Aylesbury, which are the two largest, with populations of 75,449 and 70,335, respectively to Wexham and Ivers with a population of 14,465 people.

The most ethnically diverse Community Boards are High Wycombe, Wexham and Ivers and Aylesbury having 36.3%, 20.7% and 20.6%, respectively, of their populations who are black, asian or a minority ethnicity group (BAME). This compares to Winslow and Villages for which only 2.9% of their population is BAME.

The most deprived Community Boards are High Wycombe and Aylesbury with an Index of Multiple Deprivation (IMD) 2019 score of 16.31 and 16.14, respectively, followed by Wexham and Ivers Community Board with a score of 12.05. The IMD score for Buckinghamshire is 10.05. Missendens is the least deprived Community Board with a score of 4.50. Child poverty[2] ranges from 4.96% in Missendens Community Board to 15.26% in High Wycombe and 13.21% in Aylesbury Community Board.

The age profiles of the Community Boards also vary. The Community Board with the highest proportion of under-5s is High Wycombe where 7.6% of its population is under 5 years old. 7.2% of Aylesbury's population is under-5 years old. Winslow and Villages Community Board has the lowest proportion of under-5s with 4.3%.

The Community Board with the highest proportion of people aged 85 years and older is Denham, Gerrards Cross and Chalfonts (4.2%). Missendens has 3.8% of its population aged 85 years and older. This compares to High Wycombe which has with the lowest proportion (1.7%) of people in this age group.

Births

In 2018 there were 5,988 births in Buckinghamshire. The Community Board with the highest number of births was High Wycombe (1,183 live births) followed by Aylesbury (932 live births). The Community Board with the lowest number of births was Missendens Community Board (117 live births).

The Community Board with the highest proportion of low birth weight babies was High Wycombe (8.2%) (2016/18). Buckingham and Villages Community Board had the lowest proportion of low birth weight babies (4.6%).

Early years

Early years foundation stage progress (EYFSP) is a measure of social, psychological and academic development at the age of five. Differences between the average score achieved in different community board areas can indicate differences in early schooling, economic or social factors.

Across Buckinghamshire the average EYFSP scores vary by community board, with the percentage of children being assessed as having achieved a good level of development ranging from the highest at 82.5% in Beaconsfield and Chepping Wye to the lowest at 64.2% in High Wycombe Community Board. Overall, 80% of community boards in Buckinghamshire achieve EYFSP scores above the England average of 72%.

Life expectancy and healthy life expectancy

Life expectancy is highest in the Amersham Community Board area at 85.8 years. The lowest is in the Aylesbury Community Board area at 81.5 years and High Wycombe at 81.9 years. The Community Boards for Aylesbury, Beeches, High Wycombe, Wendover and Wexham and Ivers all have life expectancies statistically significantly lower than Buckinghamshire.

The overall life expectancy at Community Board level masks significant variation in life expectancy at ward level. For example, in the High Wycombe Community Board life expectancy ranges from 79.5 (Booker and Cressex) to 84.2 (Terriers and Amersham Hill ward).

Across Buckinghamshire, the number of years people live in good health varies across the county. The number of years spent in good health varies within Community Board areas. For example, within the Beaconsfield and Chepping Wye Community Board area, the healthy life expectancy for women ranges from 65.6 years to 74.1 years living in good health. For men living in the Denham, Gerrards Cross and Chalfont Community Board area, healthy life expectancy

[2] Child poverty is reported as the proportion of children aged 0-15 years living in income deprived families.

ranges from 65.3 years to 74.8 years depending on where the man lives.

Healthy behaviours

Health related behaviours account for a very significant burden of ill health in our population and behaviours vary across and within Community Boards. Smoking, alcohol, childhood healthy weight are the indicators for healthy behaviours included in Community Board profiles.

Smoking

General Practice records show there are high levels of smoking in some Community Board areas. 20.4% of adults aged 15 and older smoke in Aylesbury Community Board and 19.9% in High Wycombe. This compares to 10% of adults aged over 15 in Amersham Community Board area.

Substance misuse

The number of people using the county's substance misuse service varies across the Community Boards. Aylesbury has 116 individuals currently receiving support for alcohol addiction and 62 for alcohol and non-opiate drugs combined. Wycombe has 99 individuals receiving support for alcohol addiction and 53 for alcohol and non-opiate drugs combined. Wexham and Ivers Community Board has only 21 residents receiving any substance misuse services.

Childhood healthy weight

Almost 40% of Year 6 pupils who live in the Wexham and Ivers Community Board area are overweight or obese which is the highest proportion in Buckinghamshire. This compares to 20.6% of Year 6 pupils in Denham, Gerrards Cross and Chalfonts.

Emergency hospital admissions

All causes for all ages

The rate of emergency hospital admissions for all causes for people of all ages for 2018/19 was highest for Aylesbury Community Board followed by High Wycombe Community Board. The rate was lowest for Amersham Community Board.

Other Community Boards where admissions were statistically significantly higher than Buckinghamshire and England are Beeches and Wexham and Ivers.

All causes for under-5s

For all Buckinghamshire Community Boards the rate of emergency admissions for children under five is statistically significantly higher compared to England.

Missendens Community Board had the highest rate for emergency hospital admissions for under-5s. North West Chilterns, Aylesbury and High Wycombe were all statistically significantly higher than the Buckinghamshire average.

The rate was lowest for Beaconsfield and Chepping Wye Community Board.

Long-term conditions

The majority of people in Buckinghamshire have at least one long-term condition. Two of the commonest long-term conditions in Buckinghamshire are diabetes and depression.

There are over 27,000 people (6.1% of people 17 and older) in Buckinghamshire with diabetes. The prevalence for diabetes for each Community Board ranges from 3.3% in Missendens to 7.6% in High Wycombe. Aylesbury and Wexham and Ivers each have 7.0% of their adult populations with diabetes.

Over 10.7% of all adults in Buckinghamshire have been recorded on GP registers as having depression amounting to 47,251 people. The highest recorded prevalence of recorded depression is found in Aylesbury where 14.7% of adults are recorded as having depression. Wing and Ivinghoe has 13.8% (1,940) of adults recorded as having depression. The lowest prevalence is in Missendens where 6.9% (875) of adults are recorded with depression.

Dementia

According to GP records, there are 4,475 people (0.8% of the population) in Buckinghamshire with dementia. Community Boards with the highest recorded prevalence of dementia is Denham, Gerrards Cross and Chalfonts Community Board at 1.1% of the population (437 people). The community boards with the largest numbers of people with dementia are Aylesbury (449) and High Wycombe (447).

Other Community Boards with relatively higher prevalences of dementia are Beeches (0.9%) and

North West Chilterns (0.9%). Winslow and Villages has the lowest reported dementia at 0.5% of the population (80 people).

Dementia-friendly communities are vital for helping people live with dementia and remain a part of their community. Dementia-friendly initiatives are currently in the following Community Board areas:

- Aylesbury, Buckingham and Villages, South West Chilterns, Wendover, and High Wycombe

Preventable deaths

Preventable deaths rates are for causes of death which are considered preventable in people under 75 years old. The community board with the highest rate of preventable deaths is Aylesbury Community Board followed by Wexham and Ivers and High Wycombe Community Boards. The Community Board with the lowest rate is Haddenham and Waddesdon Community Board.

Primary care networks

Since July 2019 primary care has been organised into 12 primary care networks (PCNs). Each of these covers a population of approximately 30,000 to 50,000 patients and includes several general practices. PCNs will help deliver the NHS Long-Term Plan and provide a wider range of services to patients. PCNs will take a proactive a holistic approach to improving their population's health

The table and maps below show the alignment of the primary care networks and the Community Boards.

Over the next few years the plan is for the networks to have expanded neighbourhood teams. These teams will include a range of health and social care professionals to ensure communities get the care and support they need.

Profiles for each of the 12 Buckinghamshire PCNs have been produced highlighting opportunities to improve the health of their population and some headlines are reproduced here.

Primary Care Networks (PCN) and 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

Primary Care Networks in Buckinghamshire CCG

Demographics

Populations

The primary care networks vary in size from Arc with 84,009 to Westongrove with 29,285 people.

The most deprived primary care networks are B.M.W. (Aylesbury) and Maple (Aylesbury) with Index of Multiple Deprivation (IMD) scores of 17.61 and 15.77, respectively. Other PCNs above the Buckinghamshire average deprivation are South Bucks, Cygnet (High Wycombe) and Dashwood (High Wycombe). The IMD score for Buckinghamshire is 10.05. The Chalfonts is the least deprived primary care network with a score of 4.95.

Across the PCNs there is variation in the age structure of each community. The PCN with the highest proportion of under-5s is BMW PCN (Aylesbury) where 9.0% of its patients are under five years old. The PCN with second highest proportion of under-5s is Cygnet (High Wycombe) with 6.6%. The Chalfonts PCN has the lowest proportion of under-5s with 4.3%.

The PCN with the highest proportion of people aged 85 years and older is The Chalfonts (3.7%) followed by Mid Chiltern (3.3%). The PCN with the lowest proportion of people in this age group is B.M.W (1.1%).

Births

The PCN with the highest proportion of low birth weight babies was B.M.W. in Aylesbury (8.5%) followed by Maple in Aylesbury (8.4%). Westongrove PCN had the lowest proportion of low birth weight babies (5.9%).

Life Expectancy

The PCNs with the lowest life expectancy in Buckinghamshire are BMW (80.5 years) and Maple (80.7 years) where life expectancy is statistically significantly lower than Buckinghamshire. Mid Chiltern PCN has the highest life expectancy with 85.2 years followed by Arc PCN with 85.1 years.

Healthy behaviours

Smoking

General Practice records show there are higher levels of smoking in some PCNs compared to the Buckinghamshire average. According to GP records there are 58,297 current smokers in Buckinghamshire. GP records report that 14.7% of patients aged 15 years and older smoke. This is higher than the England survey estimate of 10.3% for Buckinghamshire.

21.1% of adults aged 15 and older in BMW PCN (Aylesbury) smoke. For Maple PCN (Aylesbury), 19.0% of its adults aged 15 and older smoke. This compares to The Chalfonts PCN which has the lowest smoking prevalence of 9.8% for 15+ year olds.

Substance misuse

The number of people using the county's substance misuse service varies across the primary care networks. Arc PCN has 120 individuals receiving support for alcohol addiction or alcohol and non-opiate drugs combined. Dashwood PCN (High Wycombe) has 115 individuals receiving care for alcohol addiction or alcohol and non-opiated drugs combined. This compares to The Chalfonts PCN which has 20 patients receiving support.

Emergency hospital admissions

All cause emergency admissions for all ages

The rate of emergency hospital admissions for all causes for people of all ages for 2018/19 was highest for BMW PCN followed by Dashwood, Maple and South Bucks PCNs. These four PCNs were significantly higher compared to Buckinghamshire and England.

The PCNs with the lowest emergency admission rates were Arc and Mid Chiltern PCNs.

All cause emergency admissions for under-5s

For all Buckinghamshire primary care networks, the rate of emergency admissions for children under five is statistically significantly higher compared to England.

Maple PCN had the highest rate for emergency hospital admissions for under-5s. Dashwood and BMW were also both statistically significantly higher than the Buckinghamshire average.

The rate was lowest for The Chalfonts PCN, but the rate for this PCN is still higher than England.

Long-term conditions

The majority of people in Buckinghamshire have at least one long-term condition. Two of the commonest long-term conditions in Buckinghamshire are diabetes and depression.

The prevalence for diabetes in Buckinghamshire is 6.1% of adults aged 17 and over. The diabetes prevalence for each PCN ranges from 3.4% in Mid Chilterns PCN (1,130 people) to 9.4% in Dashwood PCN (3,324 people). Maple PCN has 6.9% of its adult population with diabetes.

Over 10.7% of all adults in Buckinghamshire have been recorded on GP registers as having depression amounting to 47,251 people. The highest recorded prevalence of recorded depression is found in BMW PCN where 15.8% (4,537) of adults are recorded as having depression. Dashwood PCN has 15.2% (5,356) of adults recorded as having depression. The lowest prevalence is in Mid Chilterns PCN where 6.8% (2,264) of adults are recorded with depression.

Dementia

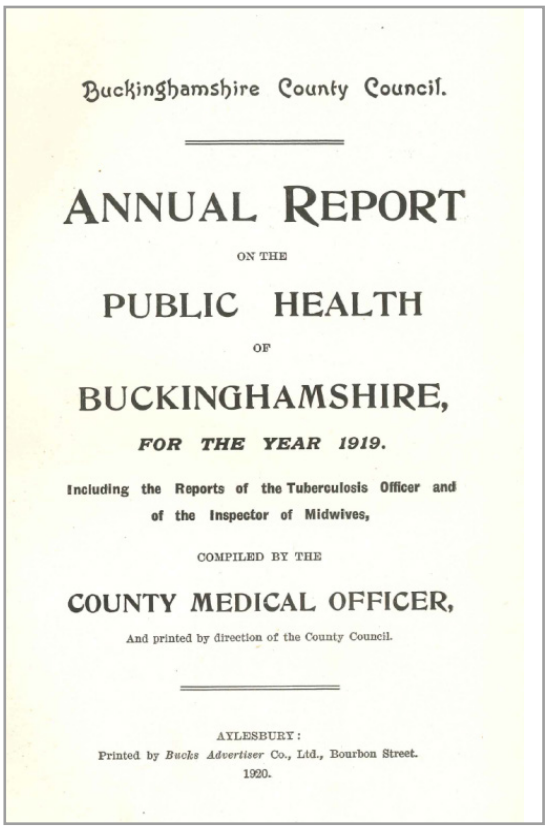
According to GP records, there are 4,475 people (0.8% of the population) in Buckinghamshire with dementia. The primary care networks with the highest recorded prevalence of dementia are Westongrove (1.2%, 342 people) and The Chalfonts PCN (1.1%, 354 people). The PCNs with the largest numbers of people with dementia are Arc PCN (651), South Buckinghamshire (413) and North Buckinghamshire (413).

Other primary care networks with relatively higher prevalences of dementia are AV South PCN (0.9%), Arc (0.8%) and South Buckinghamshire (0.8%). Maple PCN and Chesham and Little Chalfont PCN have the lowest reported dementia at 0.5% of the population (213 and 178 people, respectively).

5. Health trends

100 years ago

The *Annual Report on the Public Health of Buckinghamshire,* published by the County Council's Medical Officer in 1920 identified the health issues of the day.



Buckinghamshire County Council.

ANNUAL REPORT

ON THE

PUBLIC HEALTH

OF

BUCKINGHAMSHIRE,

FOR THE YEAR 1919.

Including the Reports of the Tuberculosis Officer and of the Inspector of Midwives,

COMPILED BY THE

COUNTY MEDICAL OFFICER,

And printed by direction of the County Council.

AYLESBURY:
Printed by *Bucks Advertiser* Co., Ltd., Bourbon Street.
1920.

At this time life expectancy was approximately 55 years for men and 60 years for women. Infectious diseases took a huge toll on the population and the report included lists of the numbers of children who had died from diphtheria, measles, whooping cough, influenza, scarlet fever and polio. Smallpox had just reappeared in Buckinghamshire after eight years without any cases, and spread very rapidly before cases could be isolated in special hospitals. The report also makes passing reference to the First World War and the 'Spanish Flu' pandemic, both of which had taken a massive toll on public health in previous years.

As there were no plumbed toilets or sewerage systems in the rural areas contamination of drinking water also caused a great deal of sickness in Buckinghamshire.

The medical officer mentions an 'appreciable decrease in infantile mortality' in 1919, and pays tribute to the work of volunteers in newly established 'Infant Welfare Centres' for their part in achieving it. Many things have changed for the better since then. The Infant Mortality Rate for Buckinghamshire that was being celebrated 100 years ago was 62 deaths under the age of one year for every thousand live births, whereas today's rate is 3.4 deaths per 1,000 live births

Life expectancy has also improved dramatically and the introduction of vaccines and other measures has reduced the incidence of many infectious diseases. Tuberculosis rates have fallen from 9.1 cases per 10,000 people living in the county to 0.9 cases 10,000 population. The main causes of disease and death are now long term conditions such as heart disease and cancer.

Infectious diseases can still re-emerge as a significant threat. Since this report was written the world has suffered from the Coronavirus pandemic which has severely affected people's lives and livelihoods and will have very far reaching impacts on society. This highlights the ongoing threat of newly emerging infectious diseases and their ability to cause global pandemics and the importance of good communicable disease surveillance and response. Other important issues include the growing resistance of bacteria to antibiotics which threatens to increase the risk of untreatable infections and deaths from infectious diseases. Finally, if immunisation rates fall then we would see a return of many infectious diseases.

The NHS did not come into existence until after the Second World War, and the consequences of people's need to pay for treatment recurs several times in the report. This delayed people seeking treatment until it was too late for treatment to be effective.

Other things have not changed. There is mention of the importance of working with GPs to prevent illness, of trying to improve vaccination coverage and of the crucial importance of the voluntary sector in supporting health and wellbeing.

More recent trends

Trends in healthy behaviours

Smoking rates have fallen in both teenagers and adults. 5% of 15 year old were current smokers in 2014/15 and 10% of adults are current smokers. Although smoking rates in routine and manual occupations have also fallen they remain double the county average at 21%. Despite this good progress there are more than 42,000 current smokers in Buckinghamshire. There has been less progress on women smoking in pregnancy and levels have remained fairly constant fluctuating between 7.5-8.8% of women smoking at the time of delivery

Nationally regular E-cigarette use is rising but among young people remains low at 4.9% of 11-18 year olds reporting they currently vape in 2018 and this figure falls to 0.8% among those who have never smoked.

70% of Buckinghamshire adults are estimated to be physically active with no significant change over recent times. However this is likely to be an overestimate as this is self-reported data which consistently overestimates objectively measured activity levels

The percentage of overweight or obese children in Reception (age 4-5) has not changed significantly since 2007/08, but the percentage of children in Year 6 (age 9-10), who are overweight or obese has increased by 9% slightly faster than the England increase of 5%.

The percentage of adults who are overweight or obese is estimated to have fallen by 10% over the last 5 years but remains at 53.8% of the population

Overall rates of alcohol-related hospital admission rose by 26% between 2008/09 to 2017/18 but the rate of alcohol related admissions in under-18s fell. The rise in admissions due to legal and illegal drugs in 15-24 year olds has more than doubled over the same period. Although this represents only 105 admissions between 2015-2018 it is a trend that will be closely monitored and work is ongoing to reduce substance misuse in all age groups.

The teenage conception rate for under-18s in Buckinghamshire has halved since 2011 and is currently less than half the England rate. The rate of new sexually transmitted infections in under-25s has remained relatively constant since 2012 and is 25% lower than the England rate.

Health trends

The percentage of babies born at term with low birthweight has remained relatively constant over the last 10 years and is similar to the England average. The infant mortality rate fluctuates year on year due to the small number of infant deaths with no clear improvement.

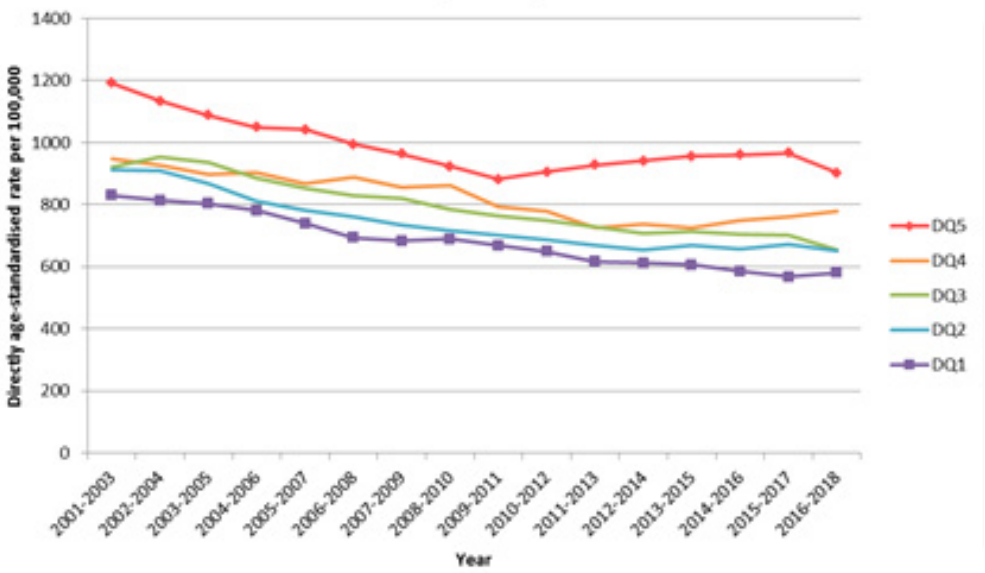
In Buckinghamshire within the last decade the prevalence of some long-term conditions, including depression, diabetes and cancer, recorded on GP registers has increased significantly by 50%, 25% and 90% respectively. The prevalence of recorded dementia, serious mental illness and chronic obstructive pulmonary disease has also increased but from a much lower base. The prevalence of diagnosed high blood pressure, heart disease and asthma has remained fairly constant.

The commonest cancers in Buckinghamshire are breast, prostate, colorectal cancer, skin and lung cancer. Breast cancer incidence in Buckinghamshire has increased by 18.7% compared to the England rise of 9.7% between 2001 and 2017 and the incidence of breast cancer in Buckinghamshire is 15% higher than England rate. The incidence of prostate cancer in Buckinghamshire has fallen by 22% since 2001, and is currently 8.5% lower than the England rate. The incidence of lung cancer in Buckinghamshire has increased by 2.8% but remains lower than the England rate. The incidence of bowel cancer has increased by 1.3% since 2001 and is similar to the England rate. Suspected skin cancer referrals in Buckinghamshire have increased by 79% since 2012/13, although England referral rates have more than doubled over this period. Although numbers are relatively small (141 cases diagnosed in 2018) the incidence of malignant melanoma (a type of skin cancer related to sun exposure) has increased by 65%.

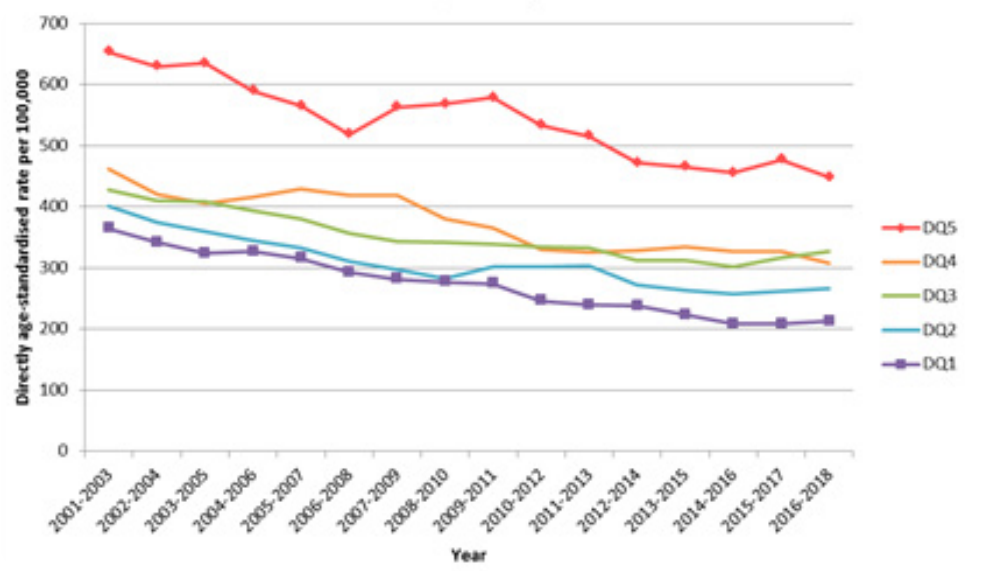
Trends in premature deaths

The all-cause premature death rate (deaths under the age of 75) has fallen by 30% in Buckinghamshire between 2001-2017 and is currently 22.6% lower than the England average. The rates have fallen across all deprivation quintiles but fastest in the least deprived (36.8% reduction). Progress in the more deprived areas has been more uneven and prone to greater fluctuations with increases in death rates in some years. The most notable is the increase in premature mortality rates for women in the most deprived quintile between years 2012 and 2017.

Mortality rates for females by deprivation quintile (all causes, under 75 years old)



Mortality rates for males by deprivation quintile (all causes, under 75 years old)



Premature mortality for some of the main causes of death have fallen. Cardiovascular disease in Buckinghamshire has halved since 2000 and is currently 27% lower than the England rate. The trend has been similar across all deprivation quintiles. For cancer, premature mortality in Buckinghamshire has fallen by 21% since 2001, and is 14% lower than the England average. Premature mortality for respiratory diseases has shown a slight decrease, both locally and nationally, falling by 10.5% in Buckinghamshire.

Life expectancy

Between 2001-03 and 2016-18 overall male life expectancy in Buckinghamshire increased by 3.8 years and female life expectancy increased by 3.2 years. Female life expectancy in Buckinghamshire appears to have slowed since 2011-13, in parallel with the England trend for women.

Although all deprivation quintiles have seen increases in life expectancy, the gains are slowest in the most deprived quintile (DQ5). Men in DQ5 have gained an extra 3.3 years of life compared to men in DQ1 who have gained 4.7 years between 2001 and 2018.

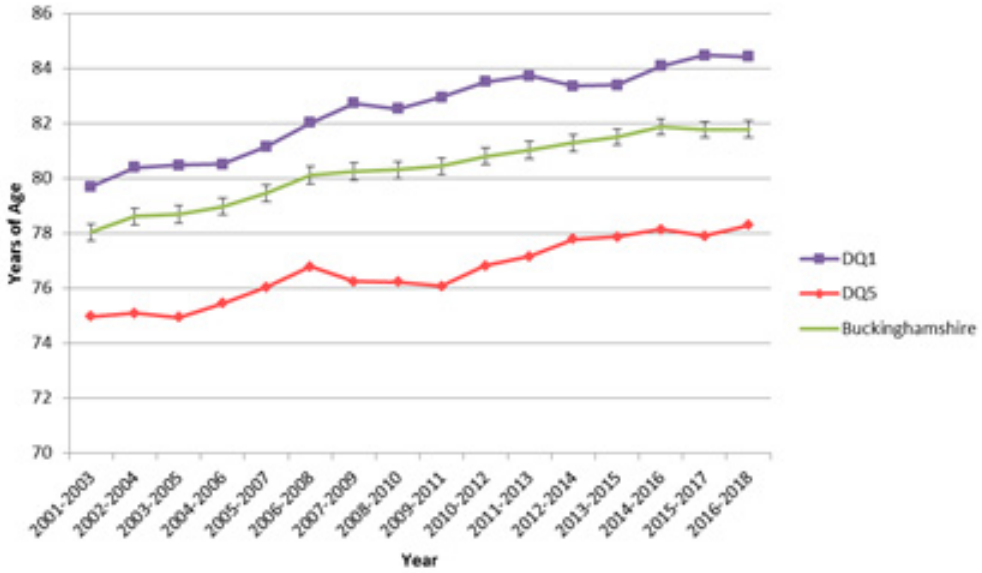
Female life expectancy in Buckinghamshire increased approximately equally for all quintiles until 2010 when female life expectancy for DQs 4 and 5 started to plateau while other quintiles have continued to rise. As a result, women in DQ4 and 5 have gained an extra 2.4 and three years of life expectancy, respectively, between 2001 and 2018, while those in DQ1 and 2 have gained 3.4 and 3.6 years over the same period.

The overall impact is that the gap in life expectancy between residents living in the least deprived (DQ1) and most deprived areas (DQ5) has grown over time for both men (from 4.7 to 6.1 years) and women (from 4.4 years to 4.8 years).

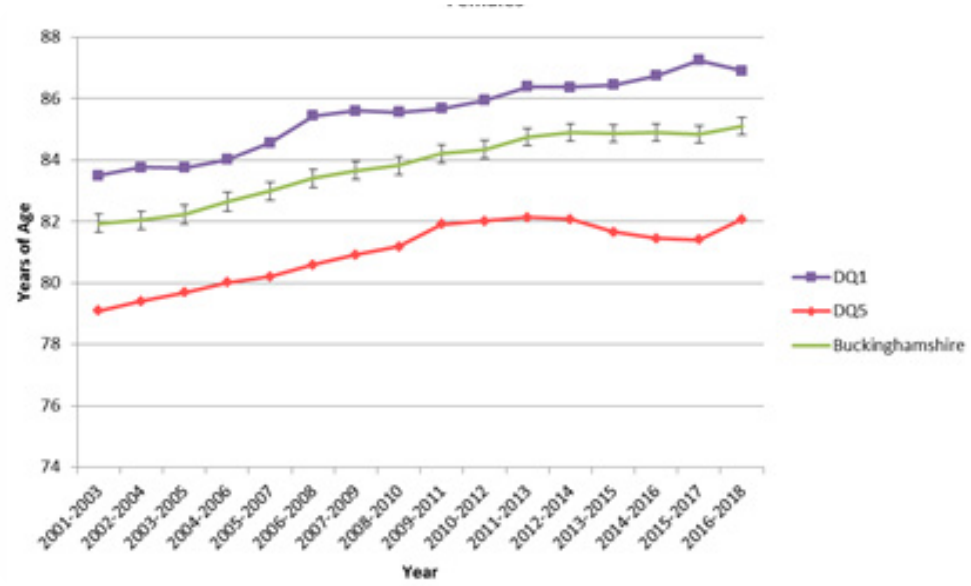
Healthy life expectancy

Healthy life expectancy in Buckinghamshire rose from 68.6 years in 2009-11 to 70.3 years in 2015-17 for women, and from 67.6 years to 68.8 years over the same period for men. In both cases the England HLE has remained approximately 4-5 years less than Buckinghamshire.

Male life expectancy at birth by deprivation quintile



Female life expectancy at birth by deprivation quintile



6. What does the future hold?

To improve the health of our population we need to understand current and future health needs. This means we need to try to predict trends that will affect our residents health, including the age profile and ethnic mix of our communities, trends in health behaviours, wider social and economic trends and changes to the built and natural environment in which they live. We can do this partly by extrapolating from the recent trends highlighted in the previous section but also drawing on future predictions.

An ageing population

The good news is that people are living longer. A consequence of this is that our population is ageing. The population of Buckinghamshire aged over 65 years and over 85 years is set to increase by 23% and 43%, respectively between 2020 and 2030. As life expectancy increases we want to ensure that those extra years are lived in as good health as possible.

On current trends the ageing of our population will increase the numbers of people with multiple long term conditions and disability. Long term conditions such as cancer, heart disease, stroke and dementia already pose considerable health challenges locally and nationally and already account for approximately 70% of health and social care spending.

The chances of someone ageing well are affected by their health behaviours in mid-life. We know that adopting healthy behaviours with respect to the four main health behaviours (smoking, physical activity, alcohol, healthy eating) reduces the chances of developing disability, disease and dementia in older age. Maintaining these behaviours in later life is also vital for health and independence. Ageing well also depends on a variety of other factors, including people's social health, whether they have supportive relationships or are socially isolated. Other key factors include having sufficient income, living in good quality housing and health promoting age-friendly social and physical environments.

Health behaviours

It is estimated that 40% of the disease burden in England is due to four health behaviours – smoking, physical inactivity, poor diet and harmful alcohol consumption.

The prevalence of these four behaviours and the consequent levels of obesity in the future will have a critical impact on the future health of the whole population and inequalities in health.

For smoking and alcohol, current trends appear positive. Ipsos MORI analysed smoking, alcohol and obesity for the two youngest generations in Britain – Millennials (those born between 1980 and 1995) and Generation Z (born 1996 onwards). This revealed a continued decline in the prevalence of smoking and alcohol consumption in these groups.

However, there was a worrying generational trend for obesity: in each successive generation adults are less likely to be a healthy weight. Millennials are the first generation where less than half are at a healthy weight in their twenties. The likelihood of being overweight increases with rising age and based on population trends, more than seven in every 10 Millennials[3] will be overweight or obese by the time they reach middle age.

There is also emerging evidence that Generation Z is two to three times more likely to become obese or overweight compared with older generations in England. Therefore Buckinghamshire's recent decrease in obesity and overweight is unlikely to maintained longer term.

Previous England estimates have predicted that the UK may reach obesity levels of 38%, which would lead to an extra 544,000–668,000 people with diabetes, 331,000–461,000 people with coronary heart disease and strokes, and 87,000–130,000 people with cancer in the UK.

[3] *Those born between 1981 and 1996.*

Other health trends

Mental health problems have been rising in young people and adults.

Improvements in life expectancy have slowed and in some parts of the UK life expectancy has been falling. The slowing down in the growth rate of life expectancy is spread across all age groups but is mostly seen in older people. In Buckinghamshire we can see that life expectancy started to plateau for women in 2011. For men life expectancy began to plateau in 2014.

Local data show that the life expectancy gap in Buckinghamshire between people living in the most deprived areas (DQ5) and least deprived areas (DQ1) increased between 2001 and 2018 for both and women which mirrors England trends.

The physical, social and economic environment

Changes that adversely impact social, economic and environmental conditions will have a detrimental effect on health but some, especially economic conditions, are hard to predict.

Social health

The Academy of Medical Sciences report *Improving the Health of the Public by 2040* predicts that the current nationally observed changes to household structures, including higher separation rates, more single parents, more same-sex partnerships and more cohabitation, will continue. The number of one-person households is expected to grow along with a rise in sole-parent households and the proportion of couples without children. If replicated in Buckinghamshire this could have an impact on the mental and physical health of residents if this leads to more people becoming socially isolated or lonely and having less informal support including when they are ill.

Climate change

The 2015 Lancet Commission on Health and Climate Change identified numerous health impacts as a result of increased floods and intense storms, heat stress, air pollution, the spread of infectious diseases, food insecurity and migration. This includes poorer mental health due to the impact of extreme weather events and a wide range of physical health problems and even death from a range of causes including heat stress and infectious diseases.

Emerging infectious diseases

Although we cannot predict when new infectious diseases will emerge, we know that new diseases will continue to affect the world's population. It is predicted that this may become more frequent as the global population expands encroaching on the natural habitat and brings us into closer contact with diseases in animals. The world has recently seen outbreaks of new diseases such as swine flu, SARS, MERS and most recently COVID-19, all since 2003.

Housing and infrastructure growth

Housing and infrastructure growth in Buckinghamshire could affect the health of our residents. More affordable, well designed housing and neighbourhoods with plenty of green and blue natural spaces, places to meet and cultural and leisure opportunities could improve health. Poor design could result in a wide range of adverse impacts, including neighbourhoods without adequate community spaces, increased reliance on the car and increased air and noise pollution, insufficient mitigation of the impacts of climate change and housing unsuitable for an ageing population. Further details on the impact of our physical and social environment on health can be found in the 2018 Director of Public Health Report Healthy Places, Healthy Futures: Growing Great Communities.

7. What should we do?

We are already experiencing the impact of many of the factors highlighted above and the challenge is predicted to grow. So the actions we need to take to secure a healthy and prosperous future are the same ones we need to take now to address our current health problems.

Health and wellbeing priorities

Based on knowledge of what influences our health, current and future trends in health and the determinants of health the priorities for focus should be:

- Ensuring every child gets the best start in life.
- Promoting mental wellbeing for all.
- Addressing the big four health behaviours and obesity at all ages.
- Preventing and delaying the development of long-term conditions.
- Promoting safe, strong, empowered, supportive communities.
- Improving the health of those with poorest health so the health gap between communities narrows.
- Planning for population growth, climate change and an age-friendly society.

There is no single solution or magic bullet to tackle these complex public health issues. We need action across the four pillars influencing health: the socioeconomic determinants, strong communities, healthy behaviours and effective, proactive, preventive health and social care.

We need to take action at a strategic level and a very local neighbourhood level and put communities and individuals at the heart of what we do, engaging them at every stage.

This means delivering a whole systems approach to prevention across all partners in Buckinghamshire to promote good health. This should include supporting effective, co-ordinated place based working with local communities across partners to avoid duplication and maximise our impact. We also need to develop our workforce to build skills in community-centred approaches and help support a thriving voluntary, community and social enterprise sector.

Taking action

Much good work is already underway across a range of partners in many of these areas. We are adopting a whole systems approach to scale up prevention initiatives. Local government, the NHS, and partners in Department for Work and Pensions, Police and Fire services in Buckinghamshire have signed up to the Buckinghamshire Shared Approach to prevention. These organisations have agreed to work together on key prevention priorities to maximise the impact of our collective efforts. They will take a holistic approach to prevention across the four pillars of social determinants, communities, health behaviours and health and social care. Social isolation has been chosen as the first priority for shared action.

Each organisation will have different opportunities to influence the health of residents and the Buckinghamshire Council Public Health team is working with each organisation to identify and plan their contributions.

The formation of the new Community Boards and the primary care networks offers exciting opportunities to work with local communities at a neighbourhood level, gaining insight into what the key wellbeing issues are for their area and what would work to address them. Buckinghamshire council's strong focus on empowering communities and developing community assets will support this work.

There are a wide range of ways for all organisations in Buckinghamshire to make a difference. I have highlighted below some important opportunities for the NHS and Buckinghamshire Council as the size of these organisations and scope of their responsibilities means they have a significant impact on resident's health.

8. Recommendations

Buckinghamshire Council

The new Buckinghamshire Council can have a profound impact on the health of communities across all of the four domains described above. Firstly, through its wide ranging roles on the social determinants of health, including education, the built and natural environment, housing, transport and supporting a thriving economy. The council also has a key role in promoting safe, friendly and resilient communities and supporting sport, cultural and leisure opportunities. It commissions vital public health services and services for children and adults and therefore has the opportunity to improve health and wellbeing from the start to the end of life. It is also major employer which offers opportunities to promote the health of the workforce and beyond and has very significant purchasing power.

The diagram below illustrates the wide range of services that can have a positive impact on residents health. If Buckinghamshire Council were to build health considerations into all its policies and services that could have a very significant beneficial impact on the health of our residents.

Buckinghamshire Council can bring additional value to local communities and businesses by acting as an 'anchor organisation'. Anchor organisations are typically large organisations that are embedded in communities and unlikely to move due to their long term commitment to a community (for example hospitals, universities and local councils). They have large resources in terms of purchasing power and employment and as such can have a key role in building successful local economies and communities by their actions. They have large amount of influence as employers, purchasers and owners of land and buildings (see examples in box overleaf).

Examples of good practice

Guy's and St Thomas' NHS Foundation Trust offer apprenticeships, work experience and opportunities to local people, targeting those who are long-term unemployed, or who have disorders which have affected their employment, such as autism. More than 500 local people have benefited from this scheme since 2008, and many have ended up working for the trust.

Sandwell and West Birmingham Hospitals NHS Trust also offer 'live and work' apprenticeships to young people facing homelessness since 2014. They have worked with the local authority and a homelessness charity to convert unused hospital buildings into homes, and provide a vocational training programme with the possibility of a job in the Trust at the end. In the first two years of the project they trained 27 apprentices and recruited 22 of them.

Preston City Council has built wealth within the local community, by (among other things) breaking down large contracts into smaller contracts which smaller local businesses are then in a position to bid for. The amount of procurement spending retained within the city and county has dramatically increased as a result.

A consortium of anchor organisations in Leeds have worked together to shift procurement spending towards local suppliers. The Joseph Rowntree Foundation noted that even if they only succeed in transferring 10% of their combined total spend, this would be worth £168-196 million each year to the local economy.

Adapted from The King's Fund - 'Building healthier communities: the role of the NHS as an anchor institution.

Recommendations for Buckinghamshire Council

- The council to consider adopting a 'health in all polices' approach whereby relevant policies and decisions consider how residents health could be improved and poor health prevented as part of business as usual, e.g. when planning new developments or considering transport policies.
- The council to consider opportunities to develop its role as an anchor organisation.
- The council to continue to roll out training to front line staff to encourage residents to make simple changes that could improve their health, wellbeing and independence and ensure staff can signpost people to community assets that can support this.
- The Buckinghamshire Council public health and prevention team should support Community Boards to consider the health needs of their population and what simple practical steps they could take to improve health in their local area.
- To continue to promote the health of the council workforce with good workplace health policies.

Recommendations for Community Boards

Community Boards should work with local communities, public health and wider partners to identify the health and wellbeing issues in their local area and take effective action to address them. Community boards should use their pump-priming wellbeing fund to help improve health and wellbeing in their area.

Recommendations for the NHS and primary care networks

The NHS should:

- Increase their focus on preventing ill health and tackling inequalities and ensure this is built into every care pathway.
- Consider how to build a health in all policies approach and opportunities to act as an anchor organisation.
- Consider how the NHS can best support effective place-based working and community-centred approaches.
- Ensure front line staff are trained to support people to make simple changes to improve their health and wellbeing and to signpost people to community assets that support this.
- Continue to promote and protect the health of their workforce through effective workplace policies.

Primary care networks

- Should work with their local communities, Buckinghamshire Council public health, Community Boards and other partners to understand and improve the health in their local area.
- Ensure front line staff are trained to support people to make simple changes to improve their health and wellbeing and signpost people to community assets that can support their health.
- Continue to promote and protect the health of their workforce.

Appendix

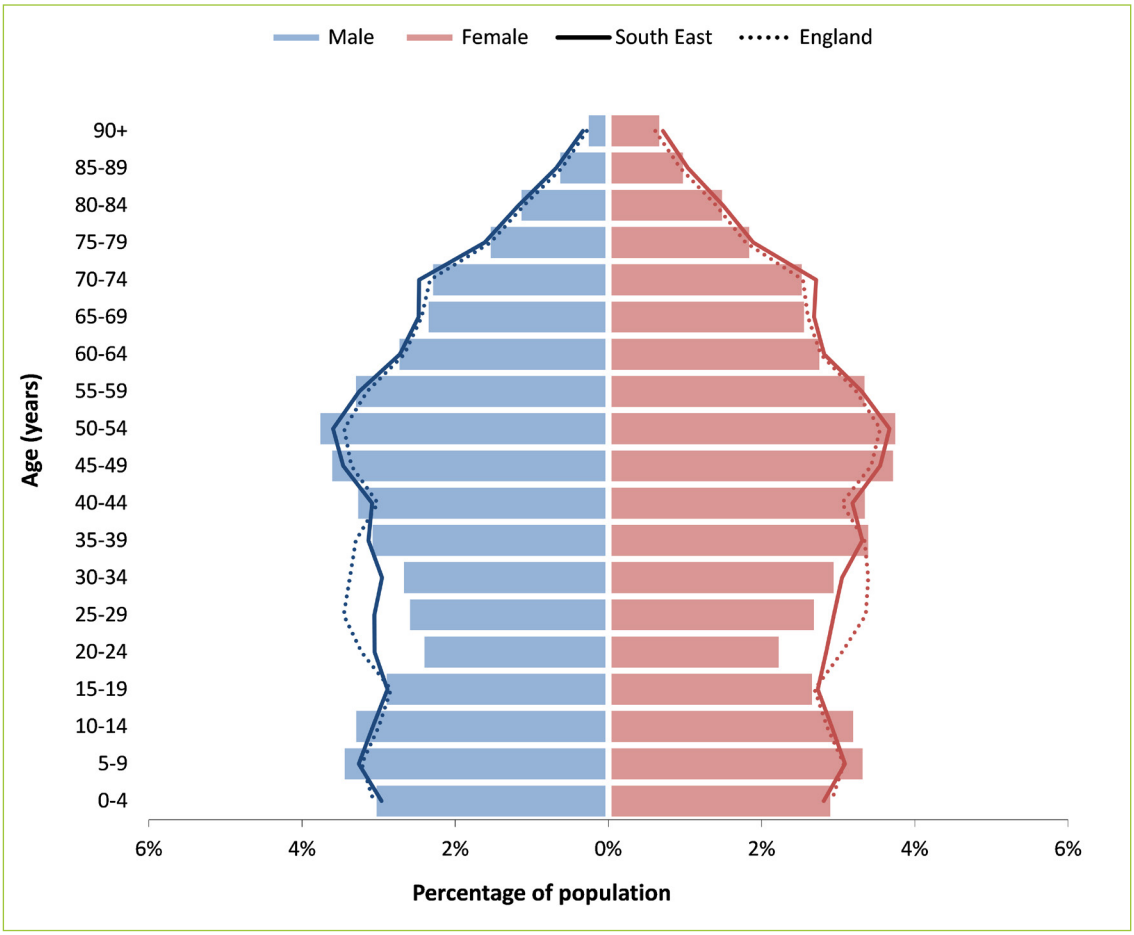
Key Facts in Buckinghamshire

People

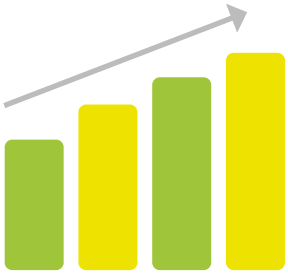
Population

540,059
residents (2018)

- **6%** Under 5 years (6% England)
- **19%** 5-19 years (17.7% England)
- **56.2%** 20-64 years (58.2% England)
- **9.9%** 65-74 years (9.9% England)
- **6.2%** 75-84 years (5.8% England)
- **2.7%** 85+ years (2.4% England)



Projections



There are projected to be

75,494

more people living in Buckinghamshire by 2030[1] (compared with 2018 this is a 14.4% increase to 618,117 people).

[1] This projection excludes housing projections.

Life expectancy and healthy life expectancy at birth

- Life expectancy at birth is **85.1 years** for females (83.1 for England) and **81.8 years** for males (79.6 England).
- Healthy life expectancy at birth is **70.3 years** for females (63.8 England) and **68.8 years** for males (63.4 in England).

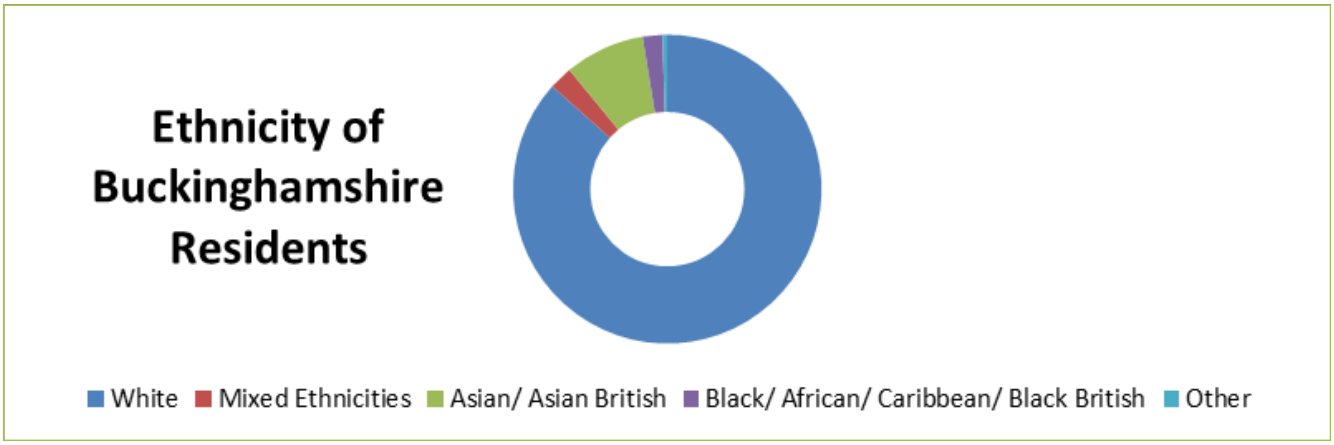
- Male life expectancy at birth has improved from **80.1 years** in 2006/08 to **81.8 years** in 2016/18.
- Male healthy life expectancy at birth has improved from **67.6 years** in 2009/11 to **68.8 years** in 2015/17.

- Female life expectancy at birth has improved from **83.4 years** in 2006/08 to **85.1 years** in 2016/18.
- Female healthy life expectancy at birth has improved from **68.6 years** in 2009/11 to **70.3 years** in 2015/17.

Population groups

1 in 7

people (13.6%) in Buckinghamshire are from a Black, Asian or Minority Ethnic Group (9.3% South East, 14.6% England).



65,295

Buckinghamshire residents were born outside the UK (12.9% of the county's population). (similar to South East 12.1%; lower than England 13.8%).

Place

Where we live influences our health and wellbeing.

Deprivation

Buckinghamshire is the seventh least deprived upper tier local authority in England (of 151) according to the 2019 Index of Multiple Deprivation (IMD).

0.3%

of Buckinghamshire residents live in the 20% most deprived areas in England (2019).

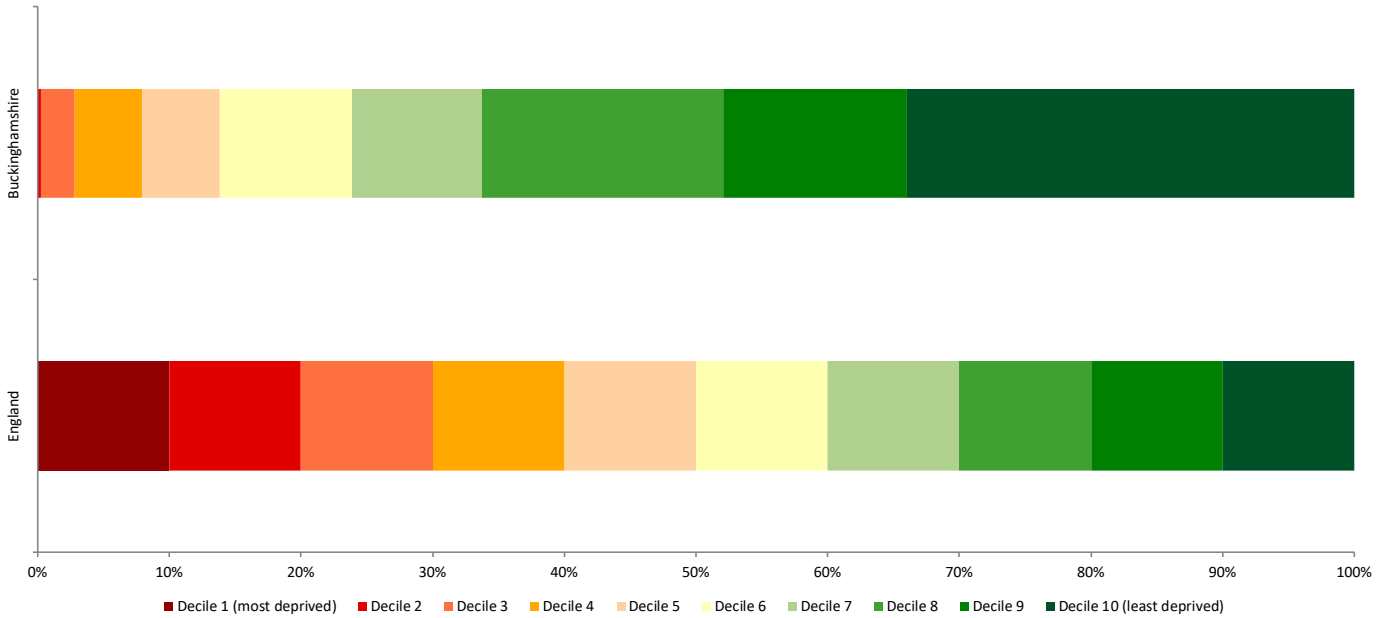
8%

of the Buckinghamshire population lived in the 40% most deprived areas in England (2019).

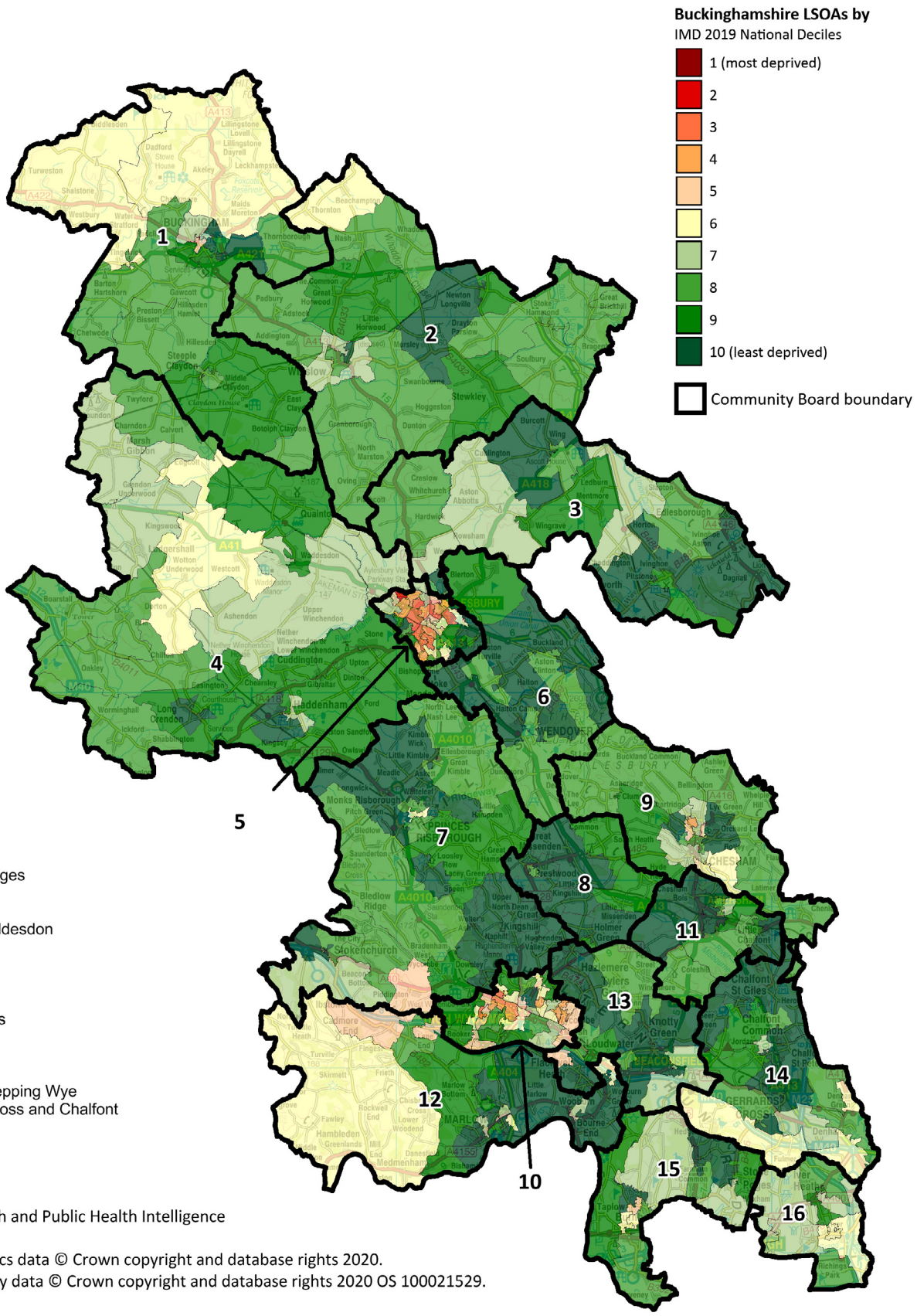
34.3%

of Buckinghamshire residents live in the 10% least deprived areas in England (2019).

England deprivation deciles, IMD 2019



England Deprivation Deciles for Buckinghamshire, 2019



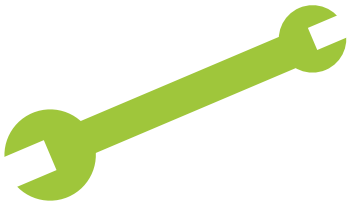
Community Boards:

1. Buckingham and Villages
2. Winslow and Villages
3. Wing and Ivinghoe
4. Haddenham and Waddesdon
5. Aylesbury
6. Wendover
7. North West Chilterns
8. Missendens
9. Chesham and Villages
10. High Wycombe
11. Amersham
12. South West Chilterns
13. Beaconsfield and Chepping Wye
14. Denham, Gerrards Cross and Chalfont
15. Beeches
16. Wexham and Ivers

Produced by Public Health and Public Health Intelligence

Employment and work

Getting people into work is a priority for good health and wellbeing.



24%
(6,800) of Buckinghamshire residents were unemployed in 2018/19. (3.1% South East, 4.1% England).

1.5%
(5,075) of Buckinghamshire residents aged 16 to 64 received out-of-work benefits through Universal Credit in December 2019. (2.9% England).

7.2%
(830) of 16-17 year olds were not in education, employment or training (Dec 2018 - Feb 2019).

Employment rates are lower for people with long-term health conditions, people with a learning disability and individuals in contact with secondary mental health services (2017/18).

11.1%
(6,300) of 16-64 year olds were out of work due to long-term sickness (Oct 2018-Sep 2019). (23.3% England).

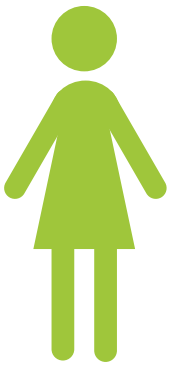
Median gross earnings

The median gross weekly earnings for full-time workers in Buckinghamshire is

£670.50
(2019). (£636 South East and £587 England).

The median gross weekly earnings in Buckinghamshire:

£728.5
for men (2019).



£622
for women (2019).

Housing and homelessness

8.2%
(17,437) people estimated to be in fuel poverty in Buckinghamshire. (11.1% in England). (2016)

The cost of buying a house in Buckinghamshire is high compared with the England average.

Average house prices, September 2019

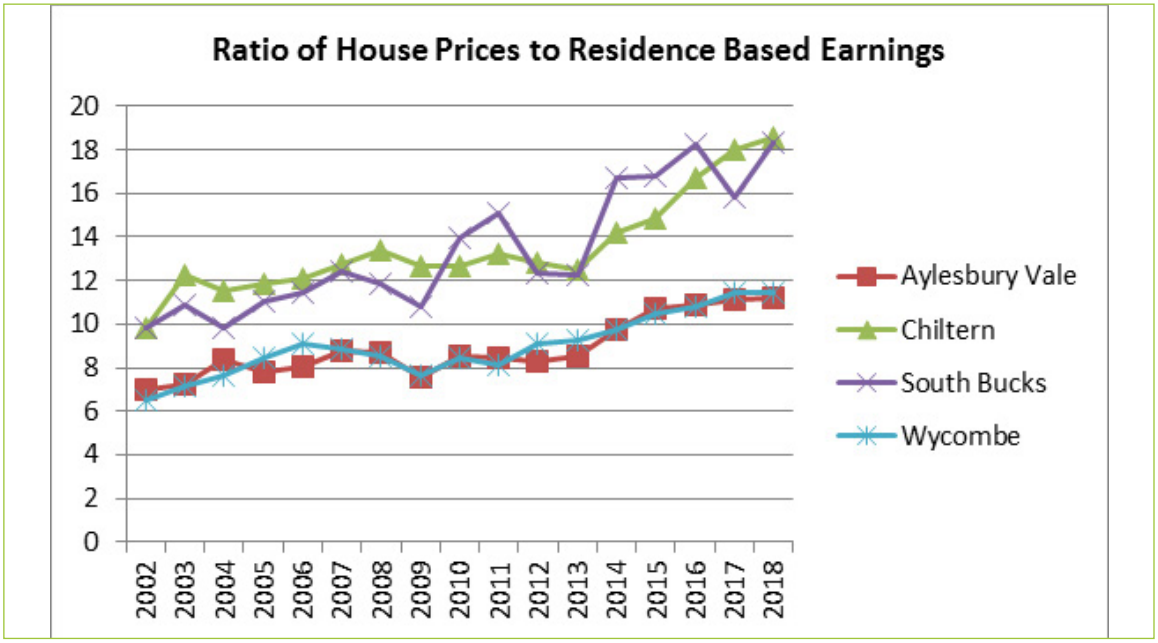
Area	Average house price (all)	Average house price for a semi-detached
Aylesbury Vale District Council	£327k	£331k
Chiltern District Council	£539k	£487k
South Bucks District Council	£609k	£534k
Wycombe	£398k	£405k
England	£251k	£235k

Data source: Housing Price Index

Average monthly rents (all sizes of accommodation), 2018/19

Aylesbury Vale District Council	£918
Chiltern District Council	£1,287
South Bucks District Council	£1,458
Wycombe	£1,093
Buckinghamshire	£1,113
England	£858

Data source: Private Rental Market Summary Statistics

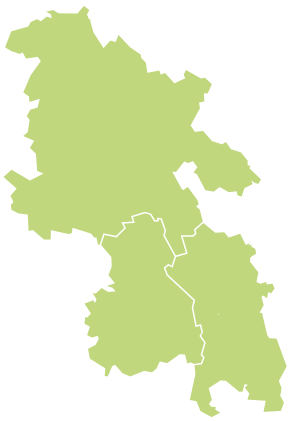


- House prices in Buckinghamshire range from **11.2 times higher to 18.6 times higher** than residence based earnings (2019).
- House prices in Buckinghamshire were **1.6 times higher** than the average house price for England (2019).

Rough sleeping

Rough sleeping is defined by the Government as 'people sleeping, or bedded down, in the open air (such as on the streets, or in doorways, parks or bus shelters); people in buildings or other places not designed for habitation (such as barns, sheds, car parks, cars, derelict boats, stations, or 'bashes')'[2].

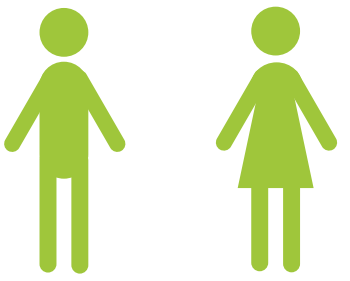
In August 2020, many individuals who would be rough sleeping were accommodated due to Coronavirus. Therefore, without this intervention the following numbers of individuals would have been rough sleeping:



38 Aylesbury Vale

46 Wycombe

7 Chiltern/ South Bucks



80% male

20% female

[2] The Office of the Deputy Prime Minister's definition of rough sleeping. A 'bash' is a makeshift shelter often comprised of cardboard boxes.

Air pollution

5.7%

of adult deaths (age 30+) in Buckinghamshire are attributable to particulate air pollution (2017). (5.1% in England).

Road safety

41.6 per 100,000

(665) people were killed or seriously injured on Buckinghamshire's roads (2015-2017) (40.8 for England = 67,654).

Car ownership

- **13.3%** of Buckinghamshire households have three or more cars/vans. This is almost double the England proportion of 7.4% (2019).
- **12.6%** of Buckinghamshire households do not own a car/ van. This is lower than England (25.8%) (2019).

Crime and domestic violence

- In 2018/19 the rate for 'all crime' was higher in Chiltern and South Bucks District Councils (**48.2/1000 population**) and lower in Aylesbury Vale (**41.4/1000**) compared with Buckinghamshire rate of **44.7/1000 population**.
- Rates for violent crime and for domestic violence are similar across all district councils and Buckinghamshire at around **17.7/1000 and 6.9/1000 population** respectively (2018/19).

Starting well

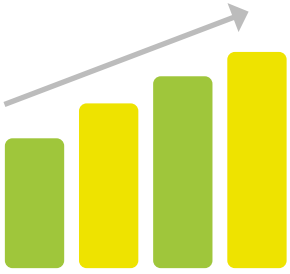
The health and wellbeing of children in the county is influenced by a wide range of social, economic and environmental factors.

Population

135,244

0-19 year olds in Buckinghamshire (2018). 25.0% of the population (compared to 23.7% of England).

The number of 0 to 19 year olds is projected to increase by 8% between 2015 and 2025 from 129,600 to 139,900 children and young people.



Child poverty

9.5%

of children live in poverty in Buckinghamshire (9,215 children). (17% in England) (2016).

Births

5,859

births in Buckinghamshire (2018).

The crude birth rate is 10.8 births per 1,000 people (2018).

Infant mortality

In 2018, there were **4.1** infant deaths per 1,000 live births (2016-18). (England, 3.9 per 1,000)

Children in need

3,338

Children in Need in Buckinghamshire in 2018/19. Almost 50% were in need due to abuse or neglect.

School readiness

73%

of reception-aged children achieved a good level of development by the end of reception in 2018/19. (72% for England).

Youth unemployment

6.4%

of 16-17 year olds (11,440 individuals) are not in education, employment or training in Buckinghamshire. 6% for England (2017)

Low birth weight babies

2.56%

of babies (139 in 2017) were born at full-term with low birth weight in Buckinghamshire. This compares to 2.82% in England (2017).

The total number of babies who were born at low weight in Buckinghamshire was **403** in 2017 (6.9% of total births). (England, 7.4%).

Children in care

515

children in Buckinghamshire were in the Local Authority's care in March 2019. The rate was 41 per 10,000 10-17 population compared to 65 per 10,000 for England (March 2019).

67%

of children in care were in foster care (March 2019).

Special educational needs (SEN)

- At the beginning of 2019 there were **5,482 children** in state-funded Buckinghamshire primary schools with special educational needs.
- The most common type of specific needs were speech, language and communication needs (35.4%), but:
  - 7% had an autistic spectrum disorder.
  - 3% had a physical disability.
  - 1.9% had hearing impairment.
  - 1.1% had visual impairment.
- **9.4%** of Buckinghamshire school students received SEN support in 2019 (England, 11.9%).

Maternal and infant health

82.1%
of new mothers initiate breastfeeding for their new babies in Buckinghamshire (2016/17) (England, 74.5%).

55.6%
of mothers in Buckinghamshire were continuing to breastfeed at 6-8 weeks. (England, 43.1%) (2017/18).

7.5%
(388) of women smoke at the time of delivery. (10.6% in England, 2018/19).

- Uptake for childhood immunisations in Buckinghamshire is higher than England for most immunisations. However, the uptake is **below the 95% target** to achieve good coverage for the population (2018/19).
- The rate of teenage pregnancies (under-18 conceptions) was **9.2 per 1,000 people** in 2018. (17.8/1,000 for England). This is equivalent to approximately 100 under-18 year olds becoming pregnant per year (2018).

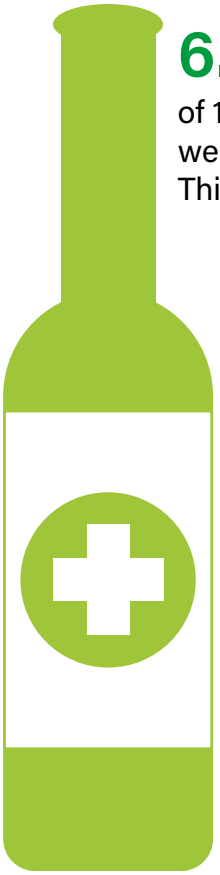
Young people

5.1%

of 15 year olds smoke in Buckinghamshire (8.2% in England) (2014/15).

4.9%
of teenagers are using e-cigarettes [ASH, 2018].

Although there is no Buckinghamshire data, e-cigarette use (vaping) among teenagers is rising nationally, with 4.9% classified as current users (ASH, 2018).



6.5%
of 15 year olds in Buckinghamshire were classified as 'regular' drinkers. This is higher than England (6.2%).

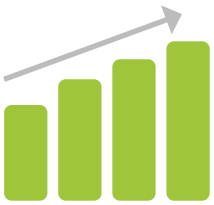
The rate of hospital admissions for under-18s for alcohol-specific conditions in Buckinghamshire was **22.9/100,000** in 2015-18, compared to 32.9/100,000 for England (2015-18).

Hospital admissions for alcohol-specific conditions in Buckinghamshire for people under 18 was **22.9 per 100,000** population. Compared to 32.9 per 100,000 population for England (2015-18).

Emotional wellbeing

375.9 per 100,000

10-24 year olds admitted to hospital as a result of self-harm in Buckinghamshire. 370.8 emergency admissions in total (2018/19). (England, 444.0)



The prevalence of mental disorders in children aged 5 to 15 years increased from 9.7% in 1999 to **11.2%** in 2017. (2017 Mental Health Survey of Children in England).

1 in 10 children had borderline mental health and emotional wellbeing difficulties (2017/18).

7.1% had 'cause for concern' difficulties according to a local survey on mental health and emotional wellbeing in young people (2017/18).

Physical health

7.2%
of 5 year olds in Buckinghamshire had one or more decayed, missing or filled teeth (England 23.3%) (2016/17).

29.3%
of children in Year 6 in Buckinghamshire are overweight or obese (2018/19). (England, 34.4%)

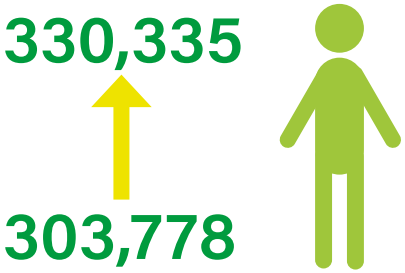
SUMMARY

Buckinghamshire outperforms England as a whole in terms of lower child poverty, higher breastfeeding initiation and higher childhood immunisation rates. Teenage pregnancy rates are significantly lower than the national average, as is the proportion of mothers in Buckinghamshire who smoke during their pregnancies. Almost all of the major indicators for child and maternal health and wellbeing are better than England, with the exceptions of teenage alcohol consumption and the proportion of 16-17 year olds not in education, employment or training (both higher than England).

Living well

Population

The number of 20-64 year olds in Buckinghamshire is 303,778 (2018). This is projected to increase by 8.2% to 330,335 by 2030.



Health behaviours

Some health behaviours can have a negative impact on our health and wellbeing.

10.3%
of adults (42,903) are current smokers according to the APS (2019).

9.2%
of adults abstain from drinking alcohol, which is lower than England (15.5%).

28.6%
of Buckinghamshire adults drink over the recommended 14 units per week (25.7% for England).

4.5%
of 15-64 year olds use opiates and/or crack cocaine. (6.2% for England, 2016/17).

71%
of adults are physically active (66% for England) (2017/18).

18%
of adults in Buckinghamshire are inactive (22% for England, 2017/18).

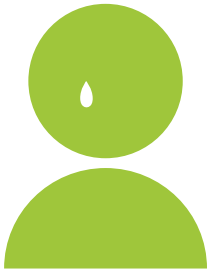
1.9%
of adults cycle for travel at least three days per week (2017) (3.3% for England).

57.8%
of Buckinghamshire residents meet the recommended '5-a-day' (54.8% for England) (2017/18).

Emotional health

10.7% of people in Buckinghamshire (47,251) have depression according to GP records. This is similar to England (10.7%). (2018/19)

0.79% of people in Buckinghamshire (4,486) have severe mental illness according to GP records. This is similar to England (0.96%). (2018/19). Severe mental illness registers include people with schizophrenia, bipolar affective disorder and other psychoses.



8 per 100,000 deaths due to suicides and undetermined injuries. (England, 9.6 per 100,000) (2016-18).

The numbers of suicides for the last three years were as follows:

2016	2017	2018
33	**33**	**45**

Long-term conditions

52.8%

of Buckinghamshire residents have at least one long-term health condition (March 2020).

The number and proportion of the population with the following long-term conditions (2018/19):

- Diabetes (**27,231**) (17+, 6.1%). 6.9% for England.
- Hypertension (**78,775**) (all ages, 13.9%). 14.0% for England.
- Coronary Heart Disease (**16,638**) (all ages 2.9%). 3.1% for England.
- Dementia (**4,475**) (all ages, 0.8%). 0.8% for England.
- Chronic Obstructive Pulmonary Disease (COPD) (**7,689**) (all ages, 1.4%). 1.9% for England.
- Asthma (**34,461**) (all ages 6.1%). 6.0% for England.
- Depression (**47,251**) (18+, 10.7%). 10.7% England.

Multi-morbidity

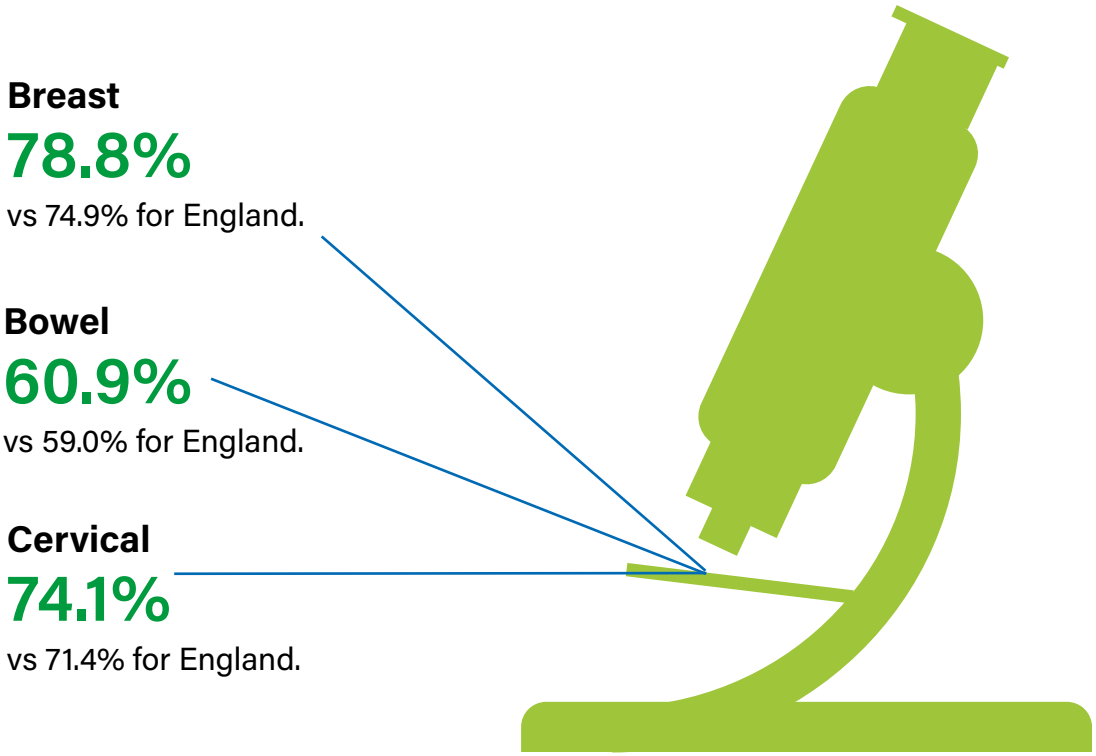
3 in 10

people have two or more long-term conditions; this is called multi-morbidity. It is more common for people to have more than one long-term condition (March 2020).

- **72.6%** of people aged 65+ years have two or more long-term conditions in Buckinghamshire (March 2020).
- Multi-morbidity is also associated with increased health and care costs. **More than half** of GP consultations and emergency hospital admissions are for people with two or more long-term conditions (2019).
- Patients who live in more deprived areas in Buckinghamshire develop multiple long-term conditions approximately **10 years earlier** than in less deprived areas (2019).
- **33.8%** have both a physical and a mental health condition (2020).

Cancer screening and diagnosis

The proportion of eligible people screened for breast, cervical and bowel cancers was higher in Buckinghamshire than England in 2018.



SUMMARY

The population of Buckinghamshire is, on average, healthier than the England population. The prevalences of diabetes, heart disease, COPD and severe mental illness are all lower than England. Likewise, rates of smoking, drug use, physical inactivity and suicide are also lower in Buckinghamshire, when compared to England. Health indicators for which Buckinghamshire is worse than England include breast cancer, abstaining from alcohol consumption and malignant melanoma diagnosis. Life expectancy for the county is generally high, although there are differences related to deprivation.

Aging well

Population

There are

101,700

people aged 65+ in Buckinghamshire (2018).

18.7%

of Buckinghamshire's population is aged 65+ years old (18.2% for England) (2018).

By 2030, there will be **27.7%** more people aged 65+ in Buckinghamshire (101,700 to 129,900). This equates to 28,200 more people in this age group.

By 2030, there will be **52.4%** more people aged 85+ in Buckinghamshire (14,500 to 22,100). This equates to 7,600 more people in this age group.

Life expectancy and healthy life expectancy at 65

- Life expectancy at 65 is **22.4 years** for females (21.1 for England) and **19.9 years** for males (18.8 for England).

- Male life expectancy at 65 has increased from 17.1 years in 2001-03 to 19.9 years in 2015-17.
- Men have **12.9 years** (10.4 years for England) of healthy life expectancy at the age of 65.

- Female life expectancy at 65 has increased from 20.0 years in 2001-03 to 22.4 years in 2015-17.
- Women have **14.9 years** (10.9 years for England) of healthy life expectancy at age 65.

Social isolation

11.8%

of households in Buckinghamshire were classified as pensioners living alone, compared to 12.4% in England (2011 Census).

It is estimated that **13,318** people aged 65-74 and **20,340** people aged 75 and over live alone in Buckinghamshire (2019), increasing to 16,777 and 30,404 people respectively by 2035.

Social care

45.5%

of adult (65+) social care users have had as much social contact as they would like (46% in England) (2018/19).

5.1%

of adult social care users feel socially isolated (5.8% in England) (2018/19).

61.2%

of adult social care users had good quality of life (62.6% in England) (2018/19).

Falls and hip fractures

27,800

people aged 65 and over were estimated to have had a fall in 2019 (POPPI). This number is predicted to increase to 35,808 by 2030.

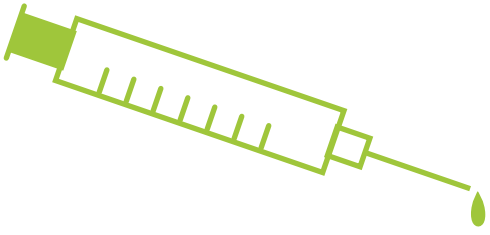
The rate of hospital admissions due to falls for people aged 65+ years was **1,990 per 100,000** people in Buckinghamshire. (England, 2,170 per 100,000; South East, 2,189 per 100,000) (2018/19).

The rate of hip fracture in people aged 65 and over is **496 per 100,000** population. (England, 578/100,000) (2018/19).

Flu vaccination

72.8%

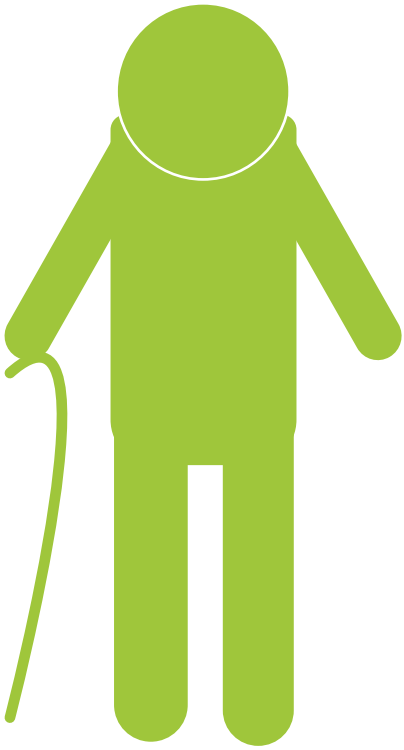
of people aged 65+ (73,106) received the flu vaccination, compared with 72.0% in England (2018/19).



Dementia

6,892 of people aged 65+ are estimated to have dementia in Buckinghamshire (2019).

7.11% of adults aged 65+ years are estimated to have dementia in Buckinghamshire (England 7.2%) (2019).



4.21 per 10,000

population had dementia recorded by their GP (England 3.41 per 10,000).

3,015 per 10,000

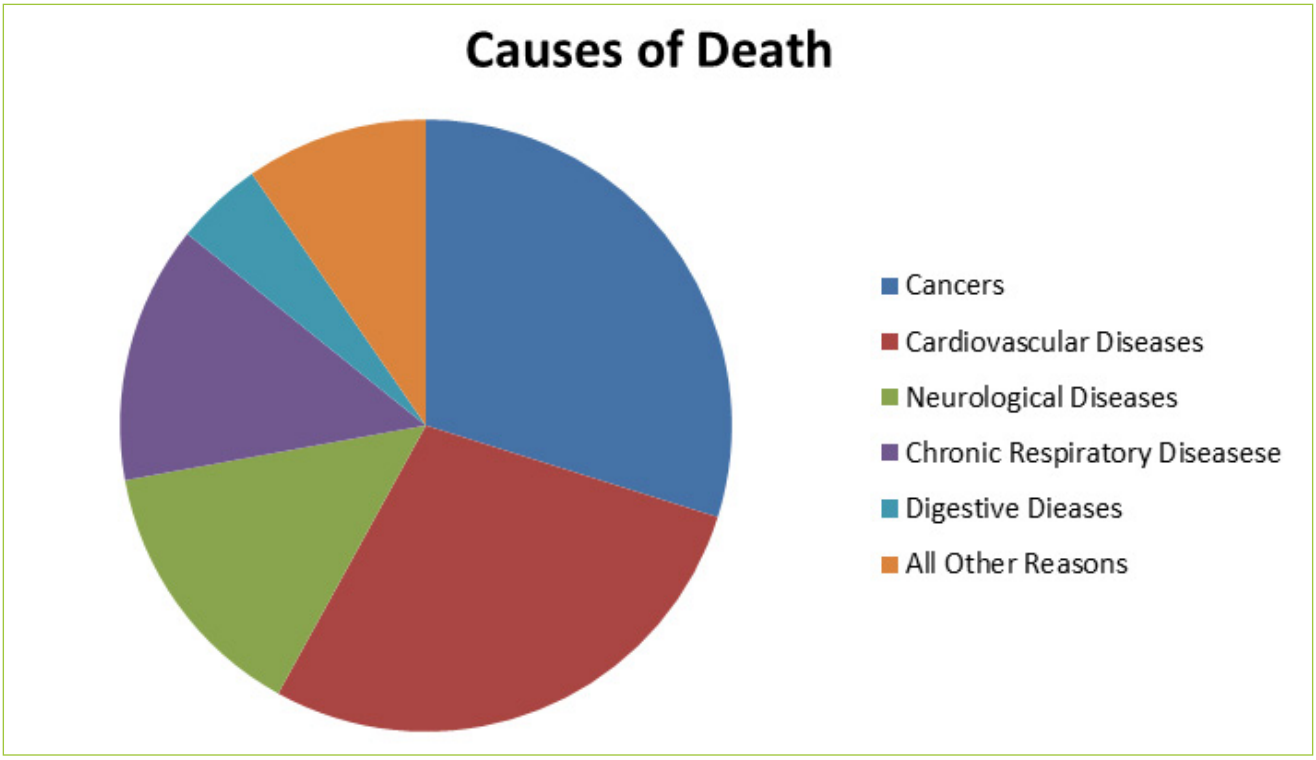
population aged 65+ had an emergency hospital admission for dementia in Buckinghamshire (England 3,609 per 100,000) (2018/19).

SUMMARY

The over 65 population in Buckinghamshire has a longer life expectancy than the England average and spend more of their life in good health compared to England. There is lower deprivation in this age group of the population compared to this age group elsewhere. The number of over 65s living alone in Buckinghamshire is set to increase over the next 10 years.

Death

The top causes of death in both males and females (all age) are cancers, cardiovascular diseases, respiratory diseases and neurological disorders.[3]



Death rates from causes considered preventable[4]

The deaths rates in Buckinghamshire for causes considered to be preventable are:

Overall premature death rate **255 per 100,000 population**
(330 per 100,000 for England) (2016-18).

Death rate for people under 75 for all cardiovascular diseases **31.3 per 100,000 population** (45.3 per 100,000 for England) (2016-18).

Death rate for people under 75 for all respiratory diseases **11.2 per 100,000 population** (19.2 per 100,000 for England) (2016-18).

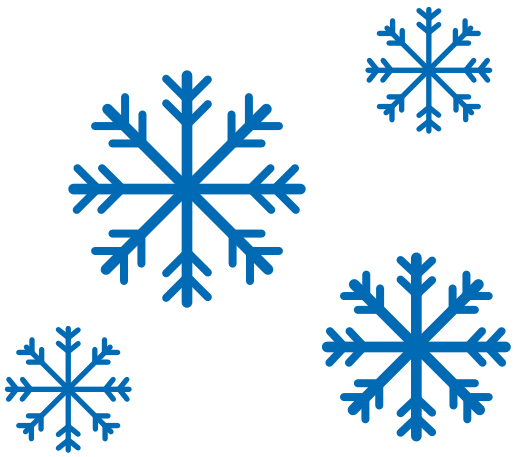
Death rate for people under 75 from liver disease **10.4 per 100,000 population** (16.3 per 100,000 for England) (2016-18).

Death rate from cancer **61.4 per 100,000 population** (76.3 per 100,000 for England) (2016-18).

[3] Neurological disorders includes dementia and Alzheimer's
[4] Preventable deaths are those that when considering the determinants of health at the time the person dies, the death could potentially have been avoided by public health interventions in the broadest sense.

Excess winter deaths

- Most excess winter deaths are due to circulatory and respiratory diseases in Buckinghamshire.
- The majority occur among the elderly population.
- The Excess Winter Deaths Index (EWD Index) provides the additional deaths that occurred during winter months (December to March) compared to non-winter months. In Buckinghamshire, there were **884** more deaths in the winter periods between 2014 and 2017 (**average of 281 deaths per year**). This is similar to England.



Dying at home

22.1%
of deaths (all age) occur at home compared with 23.6% in England (2019).

71.7%
of people with dementia die in their usual place of residence (England = 68.5%) (2019/19).

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