Health & Wellbeing Board Buckinghamshire

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

Date: 14th December 2023

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

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

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

☐ **Decision** ☐ **Endorsement**

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

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

1. Purpose of report

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

1.2. Included within this Report:

BOB ICB Board Meeting

BOB Joint Forward Plan and Integrated Care Strategy

BOB ICB Primary Strategy

Primary Care Access and Recovery Plan

BOB ICB Digital and Data Strategy

Covid and Flu vaccination programme Autumn 2023

Early Identification and Intervention to Better Support Children and Young People's Therapy Needs | Family Information Service (buckinghamshire.gov.uk)

2. ICB Board Meeting

1.1. The BOB ICB held its board meeting in public on 21 November; papers are available here: https://www.bucksoxonberksw.icb.nhs.uk/about-us/board-meetings/board-papers/

3. BOB Joint Forward plan and Integrated Care Strategy: shared system goals

1.1. In early 2023, following extensive engagement across the system, the BOB Integrated Care Partnership (ICP) published the Integrated Care Strategy and subsequently BOB NHS partners published the NHS Joint Forward Plan describing its approach to delivering the relevant ambitions of the strategy.

1.2. These documents continue to provide the framing and long-term direction for the wider ICS, including the relevant NHS organisations. Within this wider framing, we are proposing that this year we identify a smaller subset of goals that we wish to prioritise to drive forwards collective action across the BOB system. This will allow us to focus our energy and resources to deliver impact in a few targeted areas.

1.3. Our objectives as an ICS are to:

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

1.1. To identify a smaller number of goals to prioritise this year, we held an engagement session with system leaders from NHS, local government, voluntary sector and research partners on 30 October. Within this discussion, we considered our system vision for the next three to five years and the areas we think we should focus on over the next year to help us make progress towards achieving this.

1.2. A draft report on the BOB shared system goals can be found on the BOB ICB website. All NHS and partner organisations have been sent this paper and asked for comments and views during November / December 2023. Following this, we will finalise our system goals and move into organising ourselves to deliver on these during 2024/25.

2. BOB ICB Primary Care Strategy

2.1. The Fuller Stocktake, published in May 2022, set out a vision for Primary Care in England and an agenda to help manage these pressures. It emphasised the need for action in three key areas: Access, Continuity and Prevention. It aligns with BOB's local vision and ambitions and now there is a need for a localised strategy to take this forward.

2.2. BOB ICB is working with colleagues across the system to document understanding of the current state of primary and community care services, to identify good practice to build on (both locally and nationally), to design a new approach to primary and community care delivery, and to set a plan of how to deliver this together over the coming months and years.

2.3. More than 140 stakeholders and system partners gathered in High Wycombe for a Primary Care Strategy Day on 18 October. This was a successful engagement event where we started to develop the vision and guiding principles for the strategy. An excellent panel session featured representation from all disciplines, including our provider Trust partners and colleagues in public health, highlighting the current challenges across different sectors. The voluntary services, Healthwatch, patient participation groups and public health all provided vital contributions.

2.4. The challenges facing primary care across BOB:

- Increasing demand from an ageing population with multiple conditions. BOB's population is predicted to grow by five per cent by 2042 (37 per cent increase in those over 65)
- Patient dissatisfaction with access is growing
- Capacity is not keeping pace with demand. Average patient list size has increased from 2,500 per FTE in 2020 to 3,250 today
- General practice staff would like to spend more time on prevention and chronic care, from 50 per cent today to 68 percent
- BOB spends more on acute services than on primary care, community services and mental health combined
- Estates are a barrier to change, e.g. in Buckinghamshire, 70 per cent of practices have more patients per square metre of estate than recommended
- People in our more deprived areas develop poor health 10-15 years earlier than those in wealthier areas

2.5. The model for primary care services is expected to focus on:

- Access – people get to the right support first time to meet their needs
- Continuity – people receive personalised, joined up care from an integrated neighbourhood team
- Prevention – we use data to understand outcomes then deliver support that makes a difference

2.6. A draft strategy is expected to be available later in December.

2.7. As part of our programme of work to transform primary care, the ICB launched its public engagement exercise – the **'Primary Care Conversation'** at: **https://yourvoicebob-icb.uk.engagementhq.com/hub-page/primary-care** to gather the views of local communities through online events, focus groups and a survey which will help inform and shape the strategy.

3. Primary Care Access and Recovery Plan

3.1. NHSE published the national Delivery Plan for Recovering Access to Primary Care on 9 May 2023 in response to the growing demand and pressures in primary care and their impact on the ability of patients to access services.

3.2. The BOB ICB Primary Care Access and Recovery Plan (PCARP) has been written in the context of the BOB ICB Joint Forward Plan and the developing primary care strategy (see above).

3.3. The components of the BOB ICP plan are:

- Empowering patients through self-referral pathways; improving NHS App functionality; expanding community pharmacy services
- Modern General Practice including cloud-based telephony and digital pathways
- Building capacity by growing multi-disciplinary teams and expanding training and retention of workforce
- Reducing bureaucracy by improving the interaction between primary and secondary care

3.4. All ICBs were asked to report on progress against the Primary Care Access & Recovery Plan (PCARP) at public boards in November 2023.

3.5. Among the progress highlights across BOB are:

- Patient self-referral pathways in musculoskeletal; audiology; weight management; community podiatry; and wheelchair services.
- All GP practices in the BOB area have enabled the NHS App with more than six out of ten patients aged 13 and over now registered to use it.

- Eight out of ten BOB residents live within a twenty minute walk of a pharmacy and there are twice as many pharmacies in areas of deprivation than in affluent areas. Across BOB we have 253 community pharmacies offering a range of clinical services. More than 7,760 referrals have been made from GP practices into community pharmacies since April 2023, which equates to approximately 1,295 hours of saved practice appointment time.
- Nearly nine out of ten BOB GP practices are live with digital telephony and the remaining practices are signed up to make the change by March 2024.
- Initiatives in place to support the recruitment and retention of GP practice staff including a coaching and mentoring service and a return to practice programme for all Allied Health Professionals and nurses returning to primary care.

3.6. The full BOB Board report can be found on the ICB website.

4. BOB ICB Digital and Data Strategy

1.1. The ICB Board approved the Digital and Data Strategy in May 2023. The strategy sets out a range of outcomes and priorities under three strategic themes of Digitise, Connect and Transform, a delivery programme and a costed (but not fully funded) plan.

1.2. The first BOB Integrated Care System digital summit was held in September in Reading. We believe this may be the first ICS-wide summit of its kind nationally, with more than 200 colleagues in attendance from across the NHS, local authorities, VCSE, Health Innovation Network, patient groups and social care.

1.3. The summit provided an excellent foundation to showcase the outstanding work underway across BOB and provided an opportunity for people to connect and learn how they can contribute to, share and use the capabilities being developed across the system.

1.4. Good progress has been made on digitising social care records, falls prevention, digital diagnostics and virtual wards/hospital at home.

1.5. The full Board report on progress can be seen on the BOB ICB website

2. Covid and Flu Vaccination Programme Autumn 2023

2.1. The BOB autumn/winter vaccination programme is benchmarking well against regional and national counterparts for Covid vaccination uptake. BOB has delivered nearly 370,000 Covid top-up vaccinations since the programmed launched in September, which is above both the national and regional average.

2.2. BOB continues to perform well with flu vaccination with early indications showing we are ahead of rates delivered at this point in previous years, with nearly 470,000 vaccinations delivered.

2.3. Outreach and inequality work will continue to ensure all those who wish to access a Covid vaccination are able to before the end of the programme. There are currently 26 access and inequality projects running across BOB for this Autumn/Winter campaign which are all targeting Covid-19 vaccine hesitancy and uptake through understanding barriers and dispelling myths across different populations, particularly those from ethnic minority/low uptake areas. This includes community champions projects, where champions are engaging with communities/populations where hesitancy is high.

2.4. BOB ICB is working with local authorities to run this (through community insight) as part of a wider health promotion/protection approach to health and wellbeing. Cohorts being targeted as part of this include BAME populations; pregnant women; people with learning disabilities and serious mental illness; homeless and asylum seekers/refugees as well as areas of high deprivation.

2.5. Maternity champions are working with hospital trusts across BOB targeting hesitancy in pregnant women and aiming to raise vaccine uptake. We are running engagement projects where our providers contact eligible, often vulnerable, patients to encourage them to book a vaccination. Pop-up clinics target geographical gaps where patients have little access to vaccinations, and this has allowed us to increase uptake in these areas.

2.6. Providers are working in hotels for asylum seekers to administer vaccinations to eligible people, who would otherwise not have access to a vaccination.

2.7. In addition, a pilot workforce project offers attendees training in vaccine hesitancy conversations with eligible groups. Attendees have reported an increase in confidence, knowledge and skill when talking to patients about having a vaccine. Work with care home staff has allowed our provider to promote consistent, non-judgemental messaging to staff and in turn, increase vaccination uptake.

2.8. The programme is underpinned by a wide-ranging campaign communications plan through all digital and traditional media channels, with emphasis on targeted advertising to those communities which maybe vaccine hesitant or face other challenges.

2.9. Among the resources used this season:

- In-house materials for Black African and Pakistani communities (with translated materials to Place)
- Banners, posters, and pullups vaccine packs to for partner use

- Social ad sets to key groups and pharmacy bags to 75 pharmacies
- Maildrop to all fixed budget households.

3. Buckinghamshire-focussed Update

3.1. The Buckinghamshire Executive Partnership has identified three priority areas for 2023/24. These are SEND (Special Educational Needs and Disabilities), Joining Up Care and Health Inequalities. The Partnership has worked together to drive improvement and transformation in each of these areas.

4. SEND

4.1. Partners across Buckinghamshire and the ICB are continuing to work together to improve the care and support received by children and their families in Buckinghamshire. Progress has been made in some areas (for example in relation to community paediatrics)but demand continues to rise.

4.2. To support children and young people with SEND, the Local Area Therapies Strategy: Early Identification and Intervention to Better Support Children and Young People's Therapy Needs (2023-2026) was published in November.

Early Identification and Intervention to Better Support Children and Young People's Therapy Needs | Family Information Service (buckinghamshire.gov.uk)

4.3. It aims:

- to identify CYPs needs and provide them with therapy support at the earliest opportunity
- to reduce demand and dependency on limited specialist support. This support is then available for children with more complex needs

Joining Up Care

4.4. The Joining Up Care programme in 2023/2024 has predominantly focussed on transforming pathways for people being discharged from hospital. Positive progress has been made with reduced delays for people waiting to leave hospital being consistently reported.

4.5. On October 22nd 2023, the Transfer of Care Hub was launched. The Transfer of Care Hub brings together teams from health, care and the voluntary sector to ensure that people are discharged to the most appropriate place, with the right support and in a timely way.

4.6. In addition to this Olympic Lodge was opened at the end of October 2023 to provide additional bedded capacity for people who are ready to leave hospital. Olympic Lodge was

successful in supporting more timely discharge from hospital during the winter of 2022/23 and has been stood up to do the same during this winter.

Health Inequalities

4.7. The BEP agreed specific projects which have been funded through the ICB to support health inequalities in key areas, aligned to the Health and Wellbeing Strategy. Partners across Buckinghamshire, including the voluntary sector have worked together to develop and progress these projects during 2023/24.

Pre-conception Pilot

4.8. This pilot will support research to better understand the factors that impact pre-conception health in specific population groups and so help to shape services for better outcomes. The research has been carried out by Healthwatch Bucks and is close to completion. A paper outlining findings and potential recommendations for engagement and outreach is due at the March Health and Wellbeing Board.

Pre-habilitation Pilot

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

Physical Health Checks for people with Severe Mental Illness

4.10. This pilot is focussed on increasing the number of eligible people with a severe mental illness having a physical health check and on understanding why people do not attend health checks in this population group. The funding has supported the recruitment of three key posts including a nurse lead and health care assistant, and recruitment for a clinical lead is underway.