NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOB ICB BOARD MEETING

Title	Buckinghamshire Place Update		
Paper Date:	04 January 2024	**Meeting Date:**	16 January 2024
Purpose:	Discussion	**Agenda Item:**	08
Author:	Philippa Baker, Buckinghamshire Place Director	**Exec Lead/ Senior Responsible Officer:**	Matthew Tait, Chief Delivery Officer

Executive Summary

This presentation covers:

- An overview of the context for health and care in Buckinghamshire and how partners are working together to address the collective challenges we face.
- The progress we are making in relation to the three priorities identified by the Buckinghamshire Executive Partnership at the start of the year: tackling health inequalities, joining up care, and transforming Special Educational Needs and Disability (SEND) services.
- Our intentions and ambitions for our future place-based strategy in Buckinghamshire.

Action Required

The board are asked to discuss the content and consider the impact and role of the parternship.

Conflicts of Interest:	Conflict noted: conflicted party can participate in discussion and decision

Two of our partner members work within Buckinghamshire. This paper is not for decision and the perspective of these members will be valuable to the Board in understanding how the partnership is developing.

Date/Name of Committee/ Meeting, Where Last Reviewed:	N/A

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Buckinghamshire Update

BOB ICB Board

January 2024

Philippa Baker – ICB Place Director for Buckinghamshire

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CONTENTS

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2. Key Challenges across Buckinghamshire

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The below provides a summary of key challenges being faced by health and care organisations in Buckinghamshire

With a growing and ageing population, Buckinghamshire Council is experiencing significant demand increases in the following 4 areas:

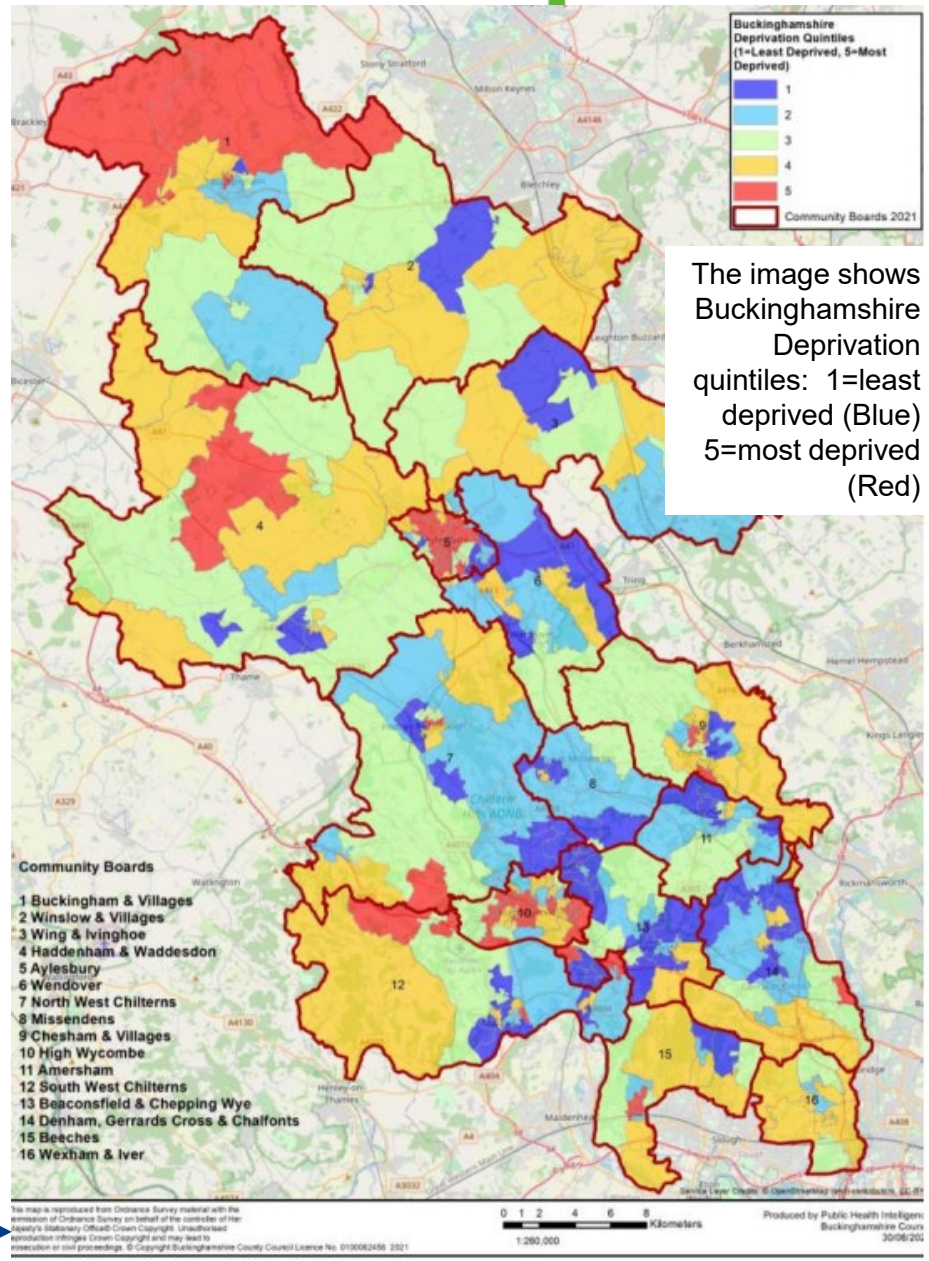
- **Adult Social Care:** Increases in client numbers, complexity and increased cost of care packages.
- **Childrens Social Care:** Rise in spend to support looked after children due to decrease in foster carers and increased care costs.
- **Homelessness**: Increasing cost due to increased demand for temporary accommodation.
- **Home to School Transport:** Due to the increased volume of and cost to support children with Education and Health Care Plans (EHCP) to get to school.

Buckinghamshire Council is also required to achieve £75.4m savings in its first 4 Years as a Unitary Local Authority, equating to 17.1% of the net 2020/21 budget.

A summary of key health challenges being experienced in Buckinghamshire:

- **Estate:** Significant capital and estate challenges across acute, community and primary care.
- **Urgent Emergency Care:** Continued rising demand across both primary and secondary care.
- **Mental Health:** Sustained levels of demand and complexity across community mental health and in-patient services with ability to maintain consistent and timely patient flow challenging across acute wards.
- **Elective Care:** Continued challenges around COVID elective backlog, cancer performance and need for increased diagnostic capacity.
- **SEND:** Increasing demand, for example the average waiting time for a neuro development assessment is currently 102 weeks.

Buckinghamshire also has significant pockets of rural and urban deprivation, particularly in former district council areas



The image shows Buckinghamshire Deprivation quintiles: 1=least deprived (Blue) 5=most deprived (Red)

2. Overview of Buckinghamshire health and care landscape

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Buckinghamshire has strong foundations for partnership working:

- An integrated acute and community Trust.
- A coterminous unitary local authority.
- An embedded primary care Federation (FedBucks).
- A local levelling up programme - 'Opportunity Bucks' - focussed on addressing inequalities across Buckinghamshire.
- A unique academic partner supporting training and workforce, the Buckinghamshire Health and Social Care Academy.

Buckinghamshire Place within BOB ICB

Buckinghamshire Population

The people in Buckinghamshire also access services outside the Buckinghamshire boundaries, most significantly into Frimley ICB, for example approx. 30% of people in our discharge pathways were discharged from Wexham Hospital. People living in the north also access services of Bedford, Luton and Milton Keynes ICB.

Buckinghamshire Healthcare NHS Trust (BHT)

BHT Provides Acute and Community health services across Buckinghamshire with acute sites in Aylesbury and Wycombe, Community Hospitals in Amersham and Buckingham and a range of community sites.

Buckinghamshire Primary Care

Buckinghamshire has a Federation (FedBucks) working in partnership with GP Practices and BHT to support a range of services, particularly Urgent Care Access. The are 47 Practices, 13 PCNs who have formed the GP Provider Alliance (GPPA).

Oxford Health NHS Foundation Trust (Oxford Health)

Provides Mental Health Services to the Buckinghamshire Population.

Buckinghamshire Council

Buckinghamshire Council is a unitary local authority, the boundary is largely but not entirely coterminous with Buckinghamshire health population.

Voluntary and Academic Partners

Key partners include: Healthwatch and Buckinghamshire Health and Social Care Academy. Across the voluntary sector in Bucks there are 2,400 registered organisations, 11,000 paid staff and 47,000 regular volunteers

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Our key priorities:

- Working in Partnership
- Tackling Health Inequalities
- Transforming SEND
- Joining Up Care

Working in Partnership across health and care

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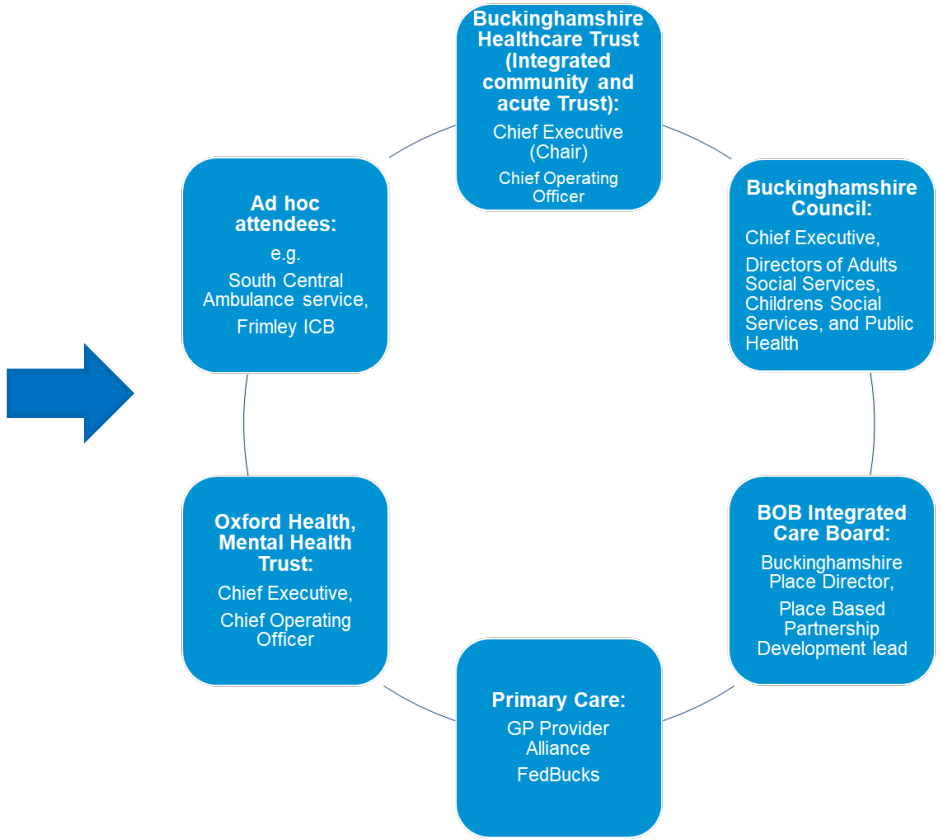
The Buckinghamshire Executive Partnership (BEP) was established in April 2023, building on the existing joint working between partners in Buckinghamshire.
The BEP supports the delivery and transformation of health and care services in Bucks.



For 2023/2024 the BEP identified 3 priority areas to focus on as a partnership: Health Inequalities, Special Educational Needs and Disabilities (SEND) and Joining up Care:

Transforming SEND	Joining up Care	Tackling Health inequalities
The aim: Transforming the experience of care and support for young people with SEND and their families	The aim: Bringing partners together across health and care, to deliver person-centred care, in the community that helps people stay healthy and independent for longer.	The aim: Tackling health inequalities experienced by those from socially deprived areas and ethnic minority groups in: • Early years; • mental health (access to services and experience); • healthy lifestyles (weight losing, smoking cessation and reducing harmful alcohol consumption); • CVD prevention.

PRIORITY 1 - Tackling Health Inequalities

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- **Buckinghamshire overall has relatively low levels of deprivation** as measured by the IMD compared to the country as a whole, ranking seventh least deprived out of 151 local authorities nationally. However, there are significant inequalities in levels of deprivation within the county, concentrated in **Aylesbury, High Wycombe, Burnham, Chesham, and Denham.**
- In response to this inequality, Buckinghamshire Council set up the '**Opportunity Bucks'** programme - designed to level up outcomes across Buckinghamshire across several domains including **education, employment, built environment and health and wellbeing.** It focusses on the 10 wards experiencing the poorest outcomes across multiple indicators of inequality in Buckinghamshire.
- **120,000 people live in Opportunity Bucks Wards, 21.7% of the Bucks population.**

Ward areas

1. Aylesbury North West
2. Aylesbury North
3. Aylesbury South West
4. Chesham
5. West Wycombe
6. Booker, Cressex and Castlefield
7. Abbey
8. Terriers and Amersham Hill
9. Ryemead and Micklefield
10. Totteridge and Bowerdean

The evidence demonstrating the correlation between deprivation and health access, outcomes and experience in Buckinghamshire is clear. In the 10 most deprived wards :

- Smoking rates are 50% higher
- Women are more likely to experience poor perinatal mental health – 30% of perinatal mental health referrals are from the most deprived Wards.
- The rate of emergency admissions for Cardiovascular Disease is 35% higher than the rate for the non Opportunity Bucks wards.
- There is generally a higher rate of emergency admission due to Mental Health.
- People report lower patient experience scores with their GP Practices in areas of highest inequality.
- People from Opportunity Bucks wards are accessing unplanned care services more frequently than people from other areas and planned care services less frequently

Tackling Health Inequalities - the actions we are taking

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Summary of actions being taken to address health inequalities, including the projects enabled through the NHS Health Inequalities Funding. All align to the four priority areas of the Bucks Health and Well Being Strategy.

Partners aim to align our actions with the Joint Local Health and Wellbeing Strategy and to target investment in Opportunity Bucks areas where this will maximise impact.

Maternity and Early Years

- Increase in uptake of health development reviews
- Reduce smoking rates during pregnancy
- Targeted vaccination support
- Healthy Start Promotion
- Increase community support for pregnant women
- Improve early years development

Cardiovascular Disease

- Increase blood pressure checks
- Roll out of targeted lipid management service in BHT
- Long term condition management in primary care
- Data led approach to CVD prevention & management

Healthy Behaviours

- Increase referrals to drug & alcohol services
- Roll out of inpatient smoking cessation services
- Address environmental factors e.g. smoke free parks, healthy food
- Developing Health on the High Street Model – Unit 33

Mental Health

- Partners to help address factors that lead to poor mental health (see DPH annual report 2023)
- Engage communities in improving access to mental health support
- VCSE approach to improving outcomes for groups who experience health inequalities
- Targeted talking therapies

NHS Health Inequalities funding to support improvement in priority areas

- **Preconception Project to better understand the factors that impact pre-conception health in specific population groups and so help to shape services for better outcomes**
- **Pre-habilitation Pilot: This pilot focusses on proactive outreach to people on a BHT waiting list, who have identified risk factors. The pilot supports people to have better outcomes following surgery and continue with a healthier lifestyle and where relevant better management of their long term condition.**
- **Increasing uptake of physical health checks of people with severe mental illness or SMI**

PRIORITY 2 - Transforming SEND

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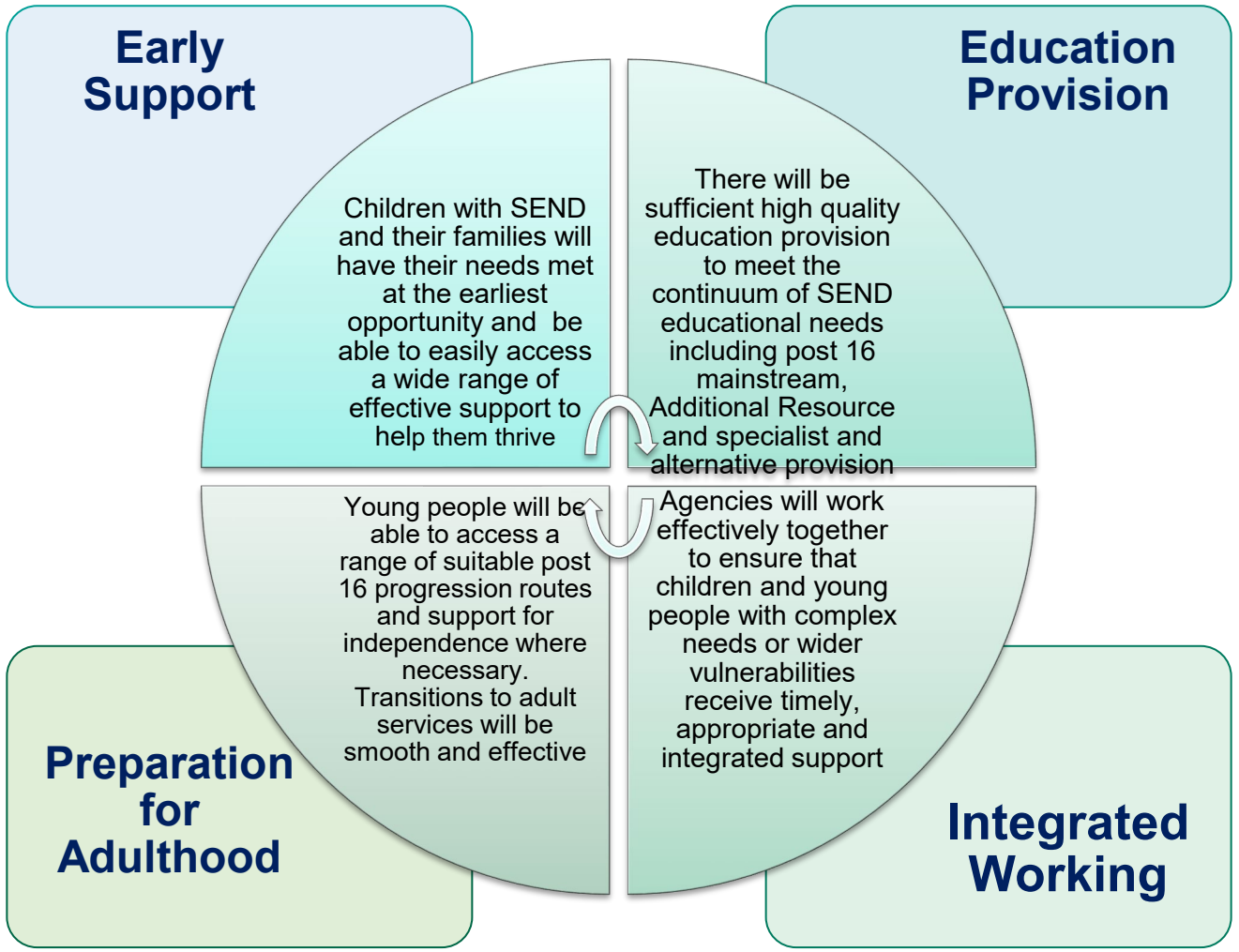
The key challenges we face around SEND reflect those being experienced in other parts of the country:

- Increasing demand for support and diagnosis for Neurodevelopmental conditions (Autism and ADHD)
- Increasing demand for statutory assessment and provision
- Increasing complexity of support required
- Leading to longer waiting lists for assessment and support.

To meet this demand we are working with partners to refocus our approach, continuing to drive down waiting times but simultaneously focussing on ensuring children and young people get the right early help and intervention support, and that we target our resources appropriately.

Emerging strategic ambitions and priorities:



Transforming SEND – the opportunity

A Case Study: Community Paediatrics

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The issue:

- Community paediatrics covers a range of services including Neurodevelopmental assessments for children from 0-5 and medication reviews for children on ADHD medication.
- The waiting list had been steadily increasing and transformative intervention was needed to turn the dial on access and ensure children, young people and their families were getting the support they needed.

The action:

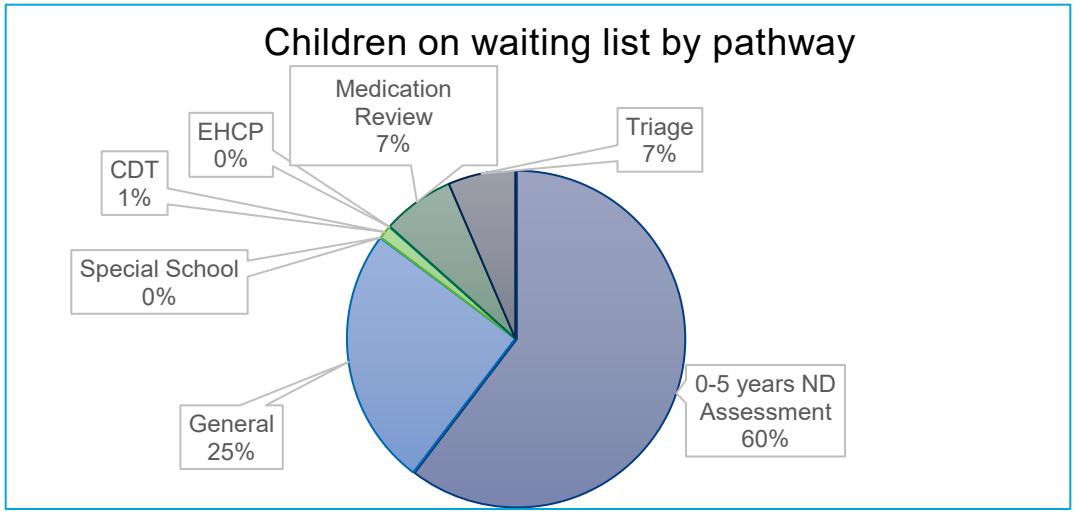
Utilising the additional funding provided by the ICB, the service has looked at innovative ways of working:

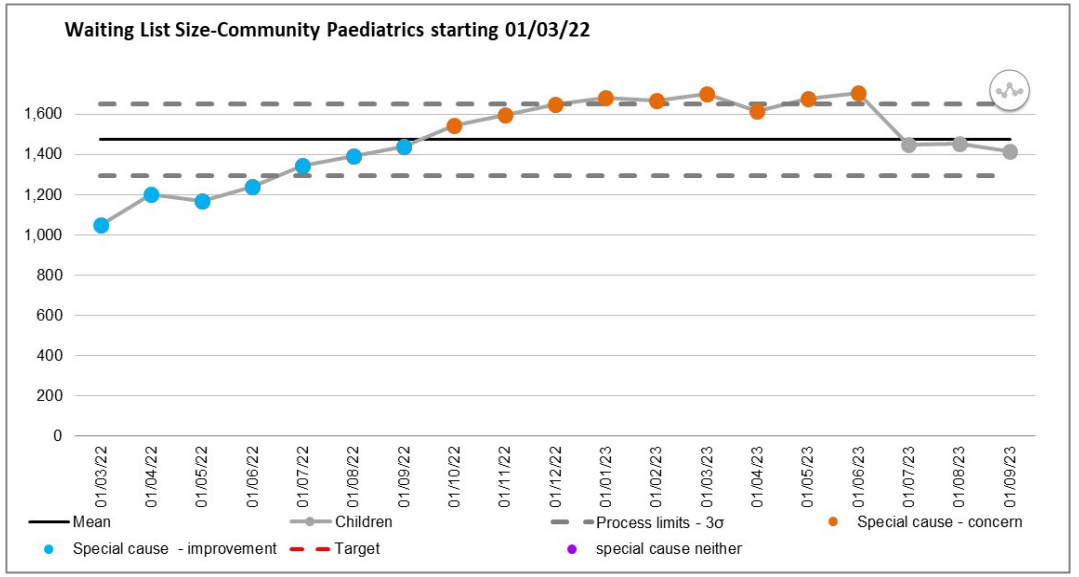
- Waiting list initiatives such as the use of social prescribers is supporting CYP and families while waiting.
- Improvements in recording to allow better understanding of the make-up of the waiting list.
- Developed a multi-disciplinary team (MDT) including a SEND Health Coordinator, Clinical Pharmacists and GP with Special Interest and nurses (to be recruited). Implementation of first multidisciplinary clinic has progressed well.

The impact:

- Reduced assessment time and time spent across disciplines reviewing the same child/young person
- Reduced individual waits for support from different services
- Second MDT clinic expected to start in Jan/Feb 2024.

The outcome: we are starting to see improvements in waiting times alongside improvements in the support provided to children and young people.





PRIORITY 3 - Joining Up Care: discharge case study

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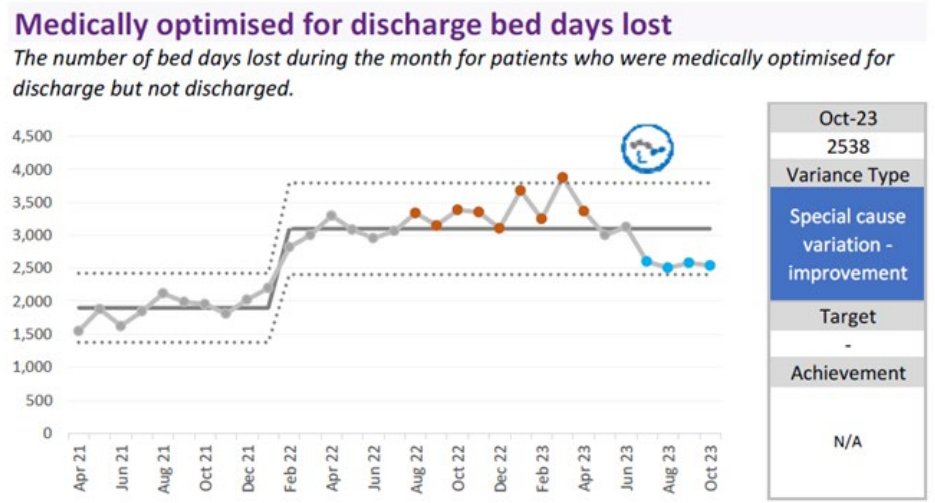
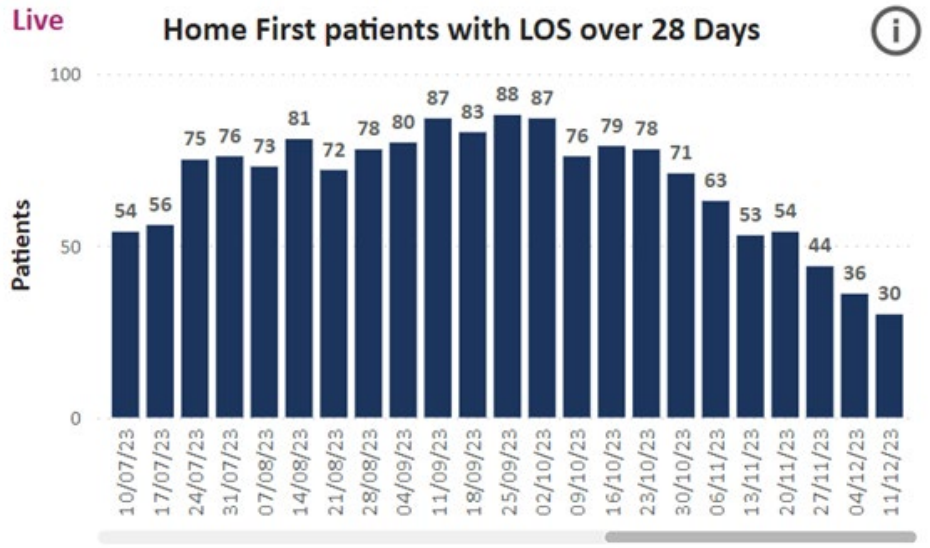
Joining Up Care

- The Joining Up Care programme has brought partners across health, care and the voluntary sector together to achieve a significant improvement in both performance and patient experience around discharge from hospital.
- Some of the key achievements in 2023/24 are:
  - **35% reduction in the number of lost beds** for people medically ready to leave hospitals in Buckinghamshire Healthcare Trust from March to October 2023
  - **Opening of discharge bedded hubs in four Care Homes** to facilitate the discharge of people who are not able to return immediately home. These are supported by a multi-disciplinary team and length of stay (LOS) has reduced from an average of over **3 months in previous discharge to assess beds to currently 39 Days**
  - The **Transfer of Care Hub launched** in October to facilitate timely discharge to the most appropriate discharge pathway.
  - **A focus on pathway one services (home with support)** to achieve more effective utilisation of capacity and more timely interventions from partners.
- **External partners such as Frimley are closely involved in this work the next steps in transformation are being planned.**

There has been a 35% reduction in lost beds per month for patients medically ready to leave hospital in BHT from March – Oct 23



Partners are working together to improve flow through our out of hospital discharge pathways, ensuring timely support and assessment with a person centred approach.



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Developing Buckinghamshire into the Future

Partners across the Buckinghamshire place identified the need to build healthier communities, improve population health and reduce health inequalities. Recognising the collaborative nature of this work Buckinghamshire partners have agreed to develop a place wide strategy.

The first strategy development session was held on 4 December 2023. The key outputs were:

1) The need for **prevention and proactive care** to feature more strongly in Buckinghamshire's service offer (including citizens as assets and a systematic approach to working with the VCSE sector).
2) Further develop an effective approach to providing care earlier in the pathway, in **out of hospital settings.**
3) The need to **add value** in those services where patients are receiving care in the appropriate setting.
4) The need to review **governance and accountability arrangements** to ensure accountability is shared and aligned.

The next steps will be to complete data collation and analysis as raised on 4 December and reconvene key partners in February to agree data analysis and confirm a focused set of key priority areas for integrated health and care in Buckinghamshire to then share and develop with wider partners.

Key enablers to this work will also need to develop alongside the strategy i.e. Data and Population Health Management approach (i.e. using connected care), Leadership development, Workforce inc: Health and Social Care Academy, digital (i.e. automation and remote monitoring).