BEP Annual Review 2023/24

Building on the strong partnerships already in place within Buckinghamshire, the Buckinghamshire Executive Partnership was formally established in April 2023.

Included within this paper is:

- A summary of the three BEP priorities agreed for 2023/2024.
- An overview of what has been achieved in each of the priorities.
- The Terms of Reference of the BEP for annual review.
- The draft Terms of Reference of the Delivery Group, formally established in April 2024, for review.

BEP is asked to:

- Reflect on the three priorities agreed for 2023/2024 and the achievements made to date, noting the 2024/25 priority proposals in Paper 2.
- Review the Terms of Reference for both the BEP and Delivery Group.
- Approve the new branding for the Buckinghamshire Executive Partnership.

Buckinghamshire Executive Partnership

BEP priority areas 2023/24

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

	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.**
By April 2024, we will have:	**Invested up to £6 million funding** to support early intervention for the "waiting well" enabling quicker diagnostics, a reduction in waiting times and improvements in people's experience of our SEND pathways.	**Transformed the way we discharge patients from hospital** with the right support where needed in Buckinghamshire, including by establishing • an integrated discharge team working across the NHS and local authority social work teams; • a new interim/complex bedded hub model (June); • A new intermediate care centre (Sep); • A new transfer of care hub to better co-ordinate people's discharges across multiple agencies (Oct).	**Buckinghamshire Health and Wellbeing Strategy** – Have delivered year 1 of our action plans for the workstreams in the strategy including **Invested £1.1m NHS funding and Opportunity Bucks funding in tackling health inequalities and engaging communities in the following ways:** **Early Years/Start well** - pilot focusing on pre-conception health and service awareness for women of childbearing age. **Mental Health** - action plan to address inequalities, including defined actions for MH inpatient services and CAMHs. **Healthy Lifestyles** – increasing referrals into lifestyle services; ensuring all staff are aware of services and how to make referrals. **CVD prevention** - Ensuring ECGs available for the hypertension pathway to be followed promptly; and implementing a 'Stop Before the Op' initiative.
Did we deliver ?	**Delivered in part:** Investment committed across SEND programme, with some underspend due to recruitment challenges. Waiting lists have stabilised across community paediatrics and integrated therapies but remain challenging for ND 5-18 pathway. DBV programme underway supporting early help and intervention.	**Delivered in full:** All key milestones achieved with new ambitions set for 2024/25	**Delivered in Part:** NHS investment made into 4 agreed areas set out above. More progress to be made in 2024/25 to co-ordinate health Inequalities work across Bucks and integrate tackling health inequalities into everything we do.

Buckinghamshire Executive Partnership

Priority 1: Transforming SEND

The Aim: Transforming the experience of care and support for children and young people with SEND and their families

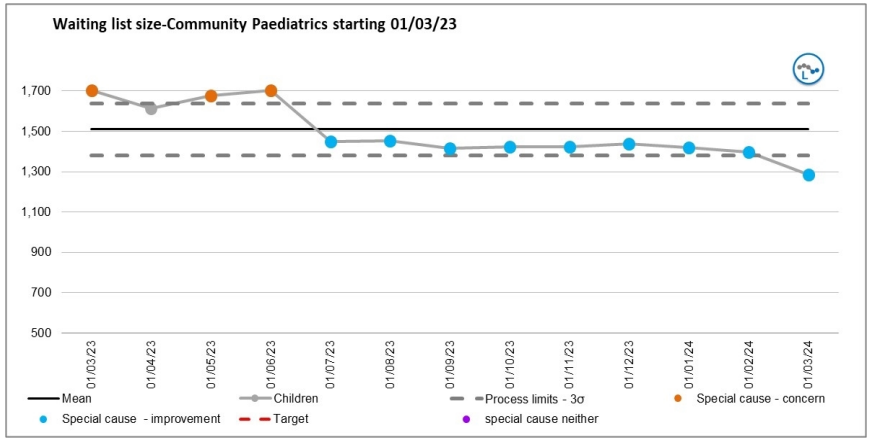
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

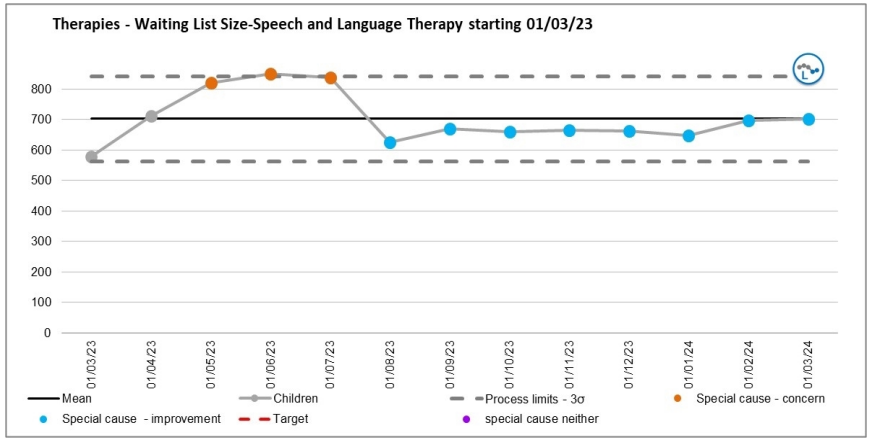
What BEP Partners delivered in 23-24:

- Investment in SEND across Integrated Therapies, Neurodevelopmental Pathway and Community Paediatrics;
- Investment in Delivering Better Value Programme;
- Early Help and Intervention projects, including review of the offer available;
- Transformation of Community Paediatrics Service using a multi-disciplinary team model;
- Recommissioning of Integrated therapies contract;
- Implementation of single provider pathway for Neurodevelopmental assessments (age 5+);
- Development of Balanced Scorecard approach to commissioner oversight;
- Development of data dashboard and key metrics;
- Review of governance architecture;
- Revision and development of SEND strategy.

Impact on Children and Young People:

- Stabilisation of waiting lists for community paediatric assessment and integrated therapies:





- Patient experience improvements due to new MDT model in the community paediatric service: families are seen as appropriate by therapists, psychologists and paediatric teams on same day, MDT review and assess collectively, enabling a holistic and swift assessment.
- The Community Paediatrics Service is now regularly providing health advice to Education Health Care Plans within the statutory 6 week timescale. All requests over the last 6 months have received a response within 6 weeks.

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Priority 2: Joining Up Care

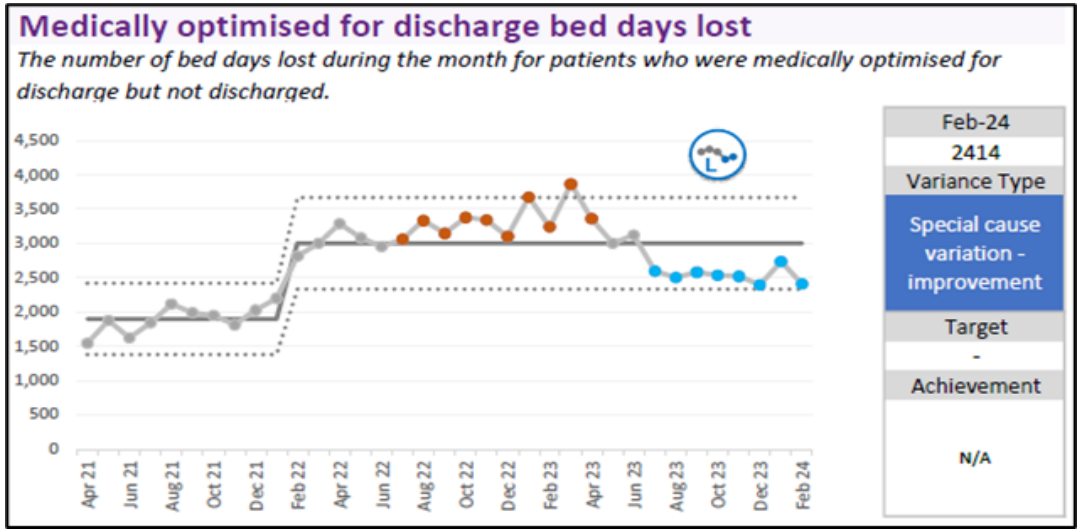
The Aim: bringing Partners together across health and care to deliver person centred care in the community that helps people stay healthy and independent for longer

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

What BEP Partners delivered in 23-24:

- Implementation of the Integrated Discharge Team model, ensuring that patients are discharged appropriately, whether back home, into interim beds or home with a package of support.
- Operational deployment of the Transfer Of Care Hub (TOCH);
- Creation of four GP-led care home hubs to support discharge from hospital for those not yet able to go home or to their long term place of care;
- Redirection initiatives including: frailty line, consultant connect the expansion of urgent community response and hospital at home services;
- Primary Care Clinical Assessment Service taking 120 primary care dispositions from 111 into a central triage Clinical Assessment Service, diverting over 60% of calls away from Primary Care.

Impact on joining up care:



Metric (In Buckinghamshire Healthcare Trust)	Dec 2022	Dec 2023	Improvement Value
No of Medically Optimised for Discharge (MOfD) patients	99	60	39.4%
No of MOfD bed days lost	3,017	2,339	22.4%
Chartridge Ward Length of Stay	23	19	17.3%
No of admissions to Chartridge Ward	30	48	37.5%
No of discharges from Chartridge Ward	26	43	39.5%
% of General & Acute beds occupied across BHT	111.1%	100.4%	9.6%
No of patients within escalation areas.	246	55	77.6%

Measures taken by partners to join up care, particularly supporting discharge from hospital, have contributed to a drop in 'lost bed days'.
This in turn supports 'flow' through the hospital, freeing up beds for those who need to be admitted. Reducing length of stay avoids deconditioning and contributes to health and independence.

Patient experience has also been enhanced: we have improved the medical oversight, care and therapeutic offer for those discharged into care home beds temporarily, providing a more holistic offer designed to get people home or to their long term place of care quicker. Hospital@home enables people to receive care and support in a more familiar environment.

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Priority 3: Tackling health inequalities

Tackling health inequalities experienced by those from socially deprived areas and ethnic groups in early years, mental health (access and experience), CVD and healthy lifestyles.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

What BEP Partners delivered in 23-24:

- Support for Buckinghamshire Council's **Opportunity Bucks** programme Health and Wellbeing Workstrand. The Opportunity Bucks programme targets the ten most deprived wards in Buckinghamshire.
- Investment planning and oversight of expenditure under the **NHS health inequalities investment,** designed to support 'CORE20Plus5' initiatives, targeting the most deprived areas, which defines a target population – the most deprived communities – and identifies '5' focus clinical areas requiring accelerated improvement.
- Support for wider action plans under the **Joint Local Health and Wellbeing Strategy.**

Impact on Health Inequalities

Achieved in 2023/24	Next Steps in 2024/25
Completion of initial insight project to understand needs and interests of key population groups who experience higher maternal risk factors to improve preconception health.	In 2024/25 insights to be used to design and deliver integrated service plans to improve pre-conception health.
Nurse-Led Outreach Serious Mental Illness Health Check team recruited to and outreach initiated with 2 PCNs.	In 2024/25 system wide approach to be developed informed by population health management analysis and outreach team to engage with all PCNs.
Design of pre-habilitation pilot to support people from the most deprived communities in 2 PCNs who are identified as likely to benefit from early intervention whilst awaiting surgery. 59% of BHT staff have completed 'Very Brief Advice' smoking cessation training.	In 2024/25 the pre-habilitation programme will be fully implemented, with 3 Health Coaches in place to improve access, experience and outcomes

Project Planning for 24/25:

- Set up a **Deep End Network** to support GPs in our most deprived communities.
- Set up 3 **Communities of Practice** for frontline works in Opportunities Bucks areas.
- Develop **Community Research capacity.**
- Support the training of 60 **Health Coaches** to making every contact count across services.
- Implementation of the **Joy App** across Buckinghamshire to improve referrals into preventative services.