Meeting: Trust Board Meeting in Public

Date: 28 May 2025

Approval Report

Agenda item	BHT Strategy
Board Lead	Duncan Dewhurst – Chief Digital and Transformation Officer
Author	Gemma Thomas – Director of Strategic Delivery
Appendices	BHT Strategy
Onward governance	N/A

Report overview

Buckinghamshire Healthcare NHS Trust (BHT), we strive to deliver **outstanding care**, create **healthy communities** and be a **great place to work**. Together with other health and care organisations in Buckinghamshire we aim to **help people live healthier and more independent lives** through:

- reducing health inequalities,
- improve the health of our local population,
- ensure our services are value for money.

This strategy outlines how BHT will deliver care to achieve these goals over the next 10 years.

Previously considered	The strategy was recommended for approval at EMC on 20 May 2025
Decision	The Board is requested to approve the adoption of the Trust Strategy.

Relevant strategic priority

Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☐

Relevant breakthrough objective – 2025/26

☒ Reduction in emergency admissions ☒ Reduction in elective waiting times	☒ Supporting people to live healthier lives	☒ Zero tolerance to bullying	☐ Governance / Statutory Requirement

Implications / Impact

Quality	The strategy aims to improve quality of the care and service BHT provide
People (BHT colleagues)	A key section of the strategy is how we support our colleagues to develop and be healthy.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	The strategy aims to mitigate against all 8 of the principal risks set out in the BAF.
Financial	A key aim of the strategy is to ensure our organisation is financially sustainable for the future. In budget
Compliance	Good governance

Partnership: consultation / communication	The strategy sets out how BHT will support delivery of the joint health and wellbeing strategy which was developed in conjunction with partners across Buckinghamshire. Significant engagement has taken place in the development of the strategy including multiple workshops with care group invites, sessions with colleague networks, freedom to speak up guardians, education colleagues, care group boards, SDU away day/strategy sessions, Senior Leadership Forum, Strategy Development Group. Public and patient feedback from July 2023 to July 2024 to BHT and Healthwatch has also been reviewed and an engagement session with General Practice Patient Participation Groups was held, to understand views of the patients and public. This feedback has all support the development of this strategy.
Equality	A key aim of this strategy is to reduce health inequalities for our population and to improve equality for our colleagues.
Equality Quality Impact Assessment [EQIA] completion required?	Stage 1 went to the EQIA panel on 20/05/25, the positive impact of the strategy and the significant opportunity for our colleagues and population to increase equality was noted. The EQIA was approved and did not need to go to stage 2.

1. Executive Summary

At Buckinghamshire Healthcare NHS Trust (BHT), we strive to deliver **outstanding care**, create **healthy communities** and be a **great place to work**. Together with other health and care organisations in Buckinghamshire we aim to **help people live healthier and more independent lives** through:

- reducing health inequalities,
- improving the health of our local population,
- ensuring our services are value for money.

To achieve these aims we need to significantly change how we deliver care for people in Buckinghamshire. This strategy marks a clear shift in focus: tackling health inequalities is now our top priority. We know that when everyone has a fair chance to be healthy, the whole community benefits, people live longer, stay well, and rely less on overstretched services. That means better care for everyone, and a system we can sustain for the future.

This strategy is not set in stone, it will develop and change as health and care needs and services evolve. It is meant to be a guide for our teams as they develop and improve services, and to help us explain and involve the public in shaping what care will look like in the future.

2. Proposal

The vision and the aims of this strategy were developed as part of the Joint Local Buckinghamshire Health and Wellbeing Strategy 2025-2035, which sets out how health, social care, voluntary and community organisations and our communities will work together to improve the health and wellbeing for people living in Buckinghamshire.

The priorities for the strategy though:

- Listening to feedback from our colleagues and partners including workshops with colleagues across all partner organisations starting in December 2023
- Analysing the health or our local population including how our residents use and access services
- Undertaking an exercise to understand all the public and patient feedback that had been provided over the previous 12 months, including everything from BHT, the responses to the Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board (BOB ICB) primary care consultation and everything from Healthwatch Bucks.

After developing the priorities further engagement sessions and workshops were held with colleagues, partners and the public to understand how we could best deliver on these priorities.

The strategy is for 10 years as this is a huge cultural shift and it will take time to impact against health inequalities and outcome measures. The strategy sets out a clear plan for what we aim to achieve over the next five years which will evolve throughout the 10 years of this strategy. The strategy will be delivered through our strategic transformation

programmes, the delivery of our breakthrough objectives and implementing the Improvement Management System.

3. Next Steps

Following approval at the board the next steps will be to develop implementation plans through the strategic transformation programmes by September 2025 and undertake an engagement process with our colleagues and the public to:

- Raise awareness and understanding of the Trust's strategic direction
- Enable all colleagues to see how their work contributes to the strategy
- Co-produce local implementation plans
- Foster ownership, alignment, and accountability across team
- Encourage feedback, innovation, and continuous improvement

The conversation with the public should be aligned with the Health and Wellbeing Strategy engagement. This is to ensure alignment with our partners and many of the key patient facing initiatives are part of the wider health and wellbeing strategy including the development of integrated neighbourhood teams and a greater focus on prevention.

Our benchmark for meaningful engagement is:

- Have conversations which support teams to understand their role in the delivering the strategy and allow feedback on how can deliver the strategy with the aim of reaching the whole organisation.
- Informing communities about the work we're doing and how they can get engaged (circa 5% of the population).
- Carry out roadshows across Buckinghamshire with partners within an aim to engage with circa 1,000 people across 12 months. This should include ensuring the people providing feedback are representative of our community including people living in Opportunity Bucks wards.
- Developing our co-production approach, which we will measure through reporting co-production projects twice a year.
- Established engagement forums in neighbourhood teams in 2026/27.

4. Conclusion and recommendations

Board is requested to recommend the adoption of the BHT Strategy.

Helping people live healthier and more independent lives

Buckinghamshire Healthcare NHS Trust Strategy 2025-2035

1. Introduction

At Buckinghamshire Healthcare NHS Trust (BHT), we strive to deliver **outstanding care**, create **healthy communities** and be a **great place to work**. Together with other health and care organisations in Buckinghamshire we aim to **help people live healthier and more independent lives** through:

- reducing health inequalities,
- improving the health of our local population,
- ensuring our services are value for money.

To achieve these aims we need to significantly change how we deliver care for people in Buckinghamshire. This strategy marks a clear shift in focus, tackling health inequalities is now our top priority. We know that when everyone has a fair chance to be healthy, the whole community benefits, people live longer, stay well, and rely less on overstretched services. That means better care for everyone, and a system we can sustain for the future.

Right now, too many people face unfair barriers to good health because of where they live, how much they earn, or other factors outside of their control. These gaps lead to preventable illness and pressure on services. By closing them, we improve lives and reduce the demand on services.

This is not about small improvements. It is about working in a new way, together with partners and our communities to focus on prevention and make sure no one is left behind. Our main measure of success will be reducing the gap in deaths under 75 between people living in the most and least deprived areas of Buckinghamshire. This strategy sets out how we will do this, over the next ten years.

This strategy is not set in stone, it will develop and change as health and care needs and services evolve. It is meant to be a guide for our teams as they develop and improve services, and to help us explain and involve the public in shaping what care will look like in the future

2. About us

BHT is an integrated acute and community trust, employing over 7,000 colleagues. We provide services in hospitals and community settings including health centres, schools, GP practices and people's own homes.

BHT is in a strong position to improve how care is delivered and reduce health inequalities because we provide both hospital and community services. This helps our teams work more closely together, so patients experience fewer delays, don't have to repeat their story and receive more consistent care. We also have a track record of working with local GPs, Buckinghamshire Council, mental health services, voluntary services and community groups to design services that better meet local needs. In recent years, we have focused more on preventing illness and offering early support, using new care approaches and digital tools. Together, these strengths put us in a good place to make lasting improvements to people's health and the care we provide.

3. Why do we need to change the way we work?

3.1 Buckinghamshire Context

Buckinghamshire's population is ageing rapidly, in 2043 there will be 34,305 more people aged over 65 and there will be fewer people aged 16-64. There will also be an increase in people living with multiple long-term conditions. The number of people living with major illness in England is projected to increase by 2.5 million people (37% increase) by 2040. This will mean that demand for health and care services increases as the working age population decreases.

We believe that the NHS should be fair and access is equal for all. The reality however is that our current approach fails to address poor outcomes for many in our county – how we work in the future must ensure a move towards equal outcomes, through understand how inequality occurs and addressing it.

This increase is driven by the ageing population but many of these long-term conditions are avoidable through providing care and support proactively and changing lifestyle behaviours. For example, in Buckinghamshire:

- 1 in 4 adults are drinking alcohol at a level that negatively impacts their physical and mental health
- 11.2% of adults smoke
- 1 in 5 adults are physically inactive
- More than half of children do not meet the national guidelines of 60 minutes of activity per day
- More than 6 in 10 adults are overweight or obese
- 3 in 10 children in year 6 are overweight or obese
- 20% of residents reported feeling lonely often/always or sometimes

All these factors are amongst the biggest drivers of long-term conditions and premature mortality (dying before the age of 75).

Some of our communities' face health inequalities, which are unfair and avoidable. If you live in the most deprived ward in Buckinghamshire, you are more than three times likely to die before the age of 75 than the least deprived ward. These inequalities are caused by the environment in which we are born, grow, live, work and age. The differences in the outcomes for our population are stark for example:

- Women who live in the Berryfields and Hayden Hill (Aylesbury) live 12.6 years less than women who live in Marlow Bottom.
- Men who live in Quarrendon and Meadowcroft (Aylesbury) live 8.4 years less than men who live in Marlow Bottom.
- Diabetes is twice as common in the most deprived groups as is smoking – both factors which will drive worse health outcomes.
- Women living in the most deprived areas including parts of Booker Cressex and Castlefield can expect to spend 64.3 years in good health, which is 6.2 years more in poor health than those less than 5 miles away in Marlow who are amongst the least deprived in the county.
- Men living in the most deprived areas of Buckinghamshire can expect to live in good health 63.3 years, which is 4.9 years less that the least deprived areas.
- Mothers from the most deprived areas in Buckinghamshire are twice as likely to smoke at the time of giving birth, despite Buckinghamshire having the lowest rate of mothers smoking at the time of delivery.

Much of the difference between these groups is driven by lifestyle factors that are driven by living conditions, education, housing and the wider environment people live in. But many of these outcomes can be changed through changing lifestyle behaviours, for example losing weight can reduce risk of cancer and diabetes:

- Being overweight or obese is the second biggest cause of cancer in the UK – causing more than 1 in 20 cancers. Maintaining a healthy weight or losing weight reduces the risk of cancer.
- People living with obesity are 80 times more likely to develop diabetes than someone with a BMI (body mass index) under 22. Weight loss can put diabetes into remission.

3.2 National Context

Nationally Lord Darzi's review of the NHS identified that the current model of care is unsustainable. The review concluded that we must; re-empower patients, shift care closer to home and simplify and join up care delivery at a neighbourhood (local) level

In response to the Darzi review the government are developing the NHS 10-year plan (due to published in summer 2025) which the government and NHS England have set out will be based on three shifts: moving care into the community, making better use of technology and a focus on prevention.

4. How we developed this Strategy

The vision and the aims of this strategy were developed as part of the Joint Local Buckinghamshire Health and Wellbeing Strategy 2025-2035, which sets out how health, social care, voluntary and community organisations and our communities will work together to improve the health and wellbeing for people living in Buckinghamshire. The Health and Wellbeing strategy covers all ages and all aspects of health and wellbeing including physical, mental, social and the wider determinants that impact on our health (such as housing and work).

The Joint Local Buckinghamshire Health and Wellbeing Strategy 2025-2035 has been developed over 18 months and identified the key areas that we need to change to improve the health of people in Buckinghamshire. We developed the strategy though:

- Listening to feedback from our colleagues and partners including workshops with colleagues across all partner organisations starting in December 2023.
- Analysing the health or our local population including how our residents use and access services.
- Undertaking an exercise to understand all the public and patient feedback that had been provided over the previous 12 months, including everything from BHT, the responses to the Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board (BOB ICB) primary care consultation and everything from Healthwatch Bucks.

After developing the priorities further engagement sessions were held with colleagues, partners and the public to understand how we could best deliver on these priorities.

5. What are we going to do differently

To help people live healthier and more independent lives and reduce health inequalities we will:

- Work more closely with our partners to make it easier for people to access our services, improve the experience of care such as providing more continuity of care and improve health outcomes.
- Focus on preventing illness and early support.
- Reduce health inequalities including focusing on issues which impact on health, such as poor housing.
- Use data to make things better for our patients and communities.
- Involve communities in designing how we deliver care and empower them to live healthy lives.

6. What are we going to deliver

6.1 Excellence in Core Services

One of our core goals is to deliver coordinated, safe and people centred care in a sustainable way. To deliver this, the work of this strategy will be underpinned by continual improvement in the quality of clinical services already offered by the Trust aiming to drive up standards of care across planned and emergency settings whilst improving the experience of patients and carers.

For some of our services this improvement will come from working closer with community teams and for others particularly in the acute hospital closer working with colleagues from neighbouring Trusts to strengthen networks of care.

6.2 Integrating Care

We will set up Integrated Neighbourhood Teams (INTs), which we know from national guidance and international research improves people's health and reduces unnecessary overlap in services. These teams bring together colleagues from hospitals, community care, mental health, GP practices, the council, local charities and community groups to work in specific areas. By working closely together they can provide support that focuses on prevention and meeting the needs of local people.

They are not new teams, but the existing teams working more closely together.

The focus will be on preventing problems before they start, stepping in early when help is needed, and looking at all aspects of a person's life, not just their medical needs. For BHT, this means being more proactive and helping the whole Buckinghamshire population, not just those already using our services. This includes:

- Bringing hospital, community, primary and social care teams together in the same location to build better relationships, and offer advice, support, and training to each other.
- Sharing information between services to spot people who may need help early, for example, noticing when someone's diabetes is not well controlled and working with them to manage it before it causes bigger problems.
- Making sure there is no wrong front door, wherever someone first asks for help, they will be guided to the right service, without being passed around.
- Supporting the whole person, not just one health issue. This could mean connecting them with things like food banks, carers' breaks, or local classes like Tai Chi, through social prescribing.

By offering help earlier, in different ways, and in the right places, we can reduce avoidable pressure on services. For example, giving someone a health coach to support them with managing a long-term condition. Neighbourhood teams will also cut down on wasted time and effort caused by services not working together.

Case Study: Nadia was a palliative care patient living with her young family in a home which was unsuitable for her changing needs, but it was important to her to spend her final months at home with her children and husband. Through integrated working professionals were able to facilitate a move to a home that met Nadia's needs. Nadia passed away with peace of mind, knowing her family was supported and her wish to remain with them was honoured. Her family expressed deep gratitude for the compassionate care provided.

Case Study: Elsie was the main carer for her husband with dementia, when she was admitted to hospital, temporary carers provided support to her husband, however they had no specialist training to support people living with dementia and were unable to meet his needs. On returning home, Elsie found her house untidy, her husband's personal care neglected and all the care for her husband stopped. Elsie tried to find, but could not access, a few hours of respite care which she desperately needed. This led to her own deterioration, and she returned to hospital. During Elsie's second stay in hospital, carers without training again moved into her house and when she returned her husband had been moved to a care home for respite and her house was dirtier. Elsie was too embarrassed to ask for help cleaning but struggled to do it herself and asked for her husband to come home after two days saying that 'The care home will do more harm than good, and I'll end up with more work to so when he comes home'.

Elsie's story provides an example of where the care provided has fallen short of what we would want for our patients and identifies the need for organisations to work in a coordinated way and support people as a whole person.

6.3 Focus on prevention

Our goal for our communities is everyone will have the opportunity to live a healthy-life and every child will have the best start in life. Healthy behaviours impact about 30% of a person's overall health and are a significant driver poor health. Therefore, we will be focusing more on preventing illness and loss of independence, so people can get the right information, advice and support to stay well, this will include:

- Helping patients live healthier lives by using every opportunity to talk about things like stopping smoking, eating well, being more active, and drinking less alcohol. We'll also connect people to support services like Be Healthy Bucks, health coaching, and local groups through the Joy App.
- Expanding health checks like screening and early support, especially for cardiovascular disease and diabetes, two of the biggest causes of early death. This includes finding and treating more people with high blood pressure and growing our service to help people manage their cholesterol.
- Identify illness and needs early to enable support to be put in place before it causes bigger issues. For example, identifying and treating osteoporosis to prevent hip fractures.
- Developing an alcohol care team to spot harmful levels of drinking and offer the right support.
- Work with communities and partners to increase the number of people getting vaccinations.
- Offer more health coaching and personalised care plans to help people stay well.
- Work with local organisations to tackle the root causes of poor health such as loneliness.
- Helping our own colleagues stay healthy. More than a quarter of our team lives in the most deprived parts of Buckinghamshire, so we want to support their wellbeing too. We will we do this through increasing the number of people who access health and wellbeing services.
- Giving children the best start in life for example by supporting pregnant women to stay healthy and increasing uptake of childhood vaccinations.

Case Study: The Buckinghamshire Lipid Optimisation Programme is a collaborative programme working with Novartis Pharmaceuticals UK Ltd.

It utilises an innovative population healthcare tool to proactively identify patients with a history of cardiovascular disease and elevated cholesterol levels. Using the shared care record to bridge the gap between primary and secondary care, offering NICE-approved therapies to reduce patients' overall cardiovascular risk.

Once identified, patients are reviewed in virtual telephone appointments with specially trained BHT doctors. The programme prioritised the review of patients living in the most deprived parts of Buckinghamshire (Opportunity Bucks wards). Using a simplified protocol, the programme reviews patients at a pace and scale that would not be possible in traditional consultant clinics. In the first year of the programme, over 1,500 patients have been reviewed, at almost 14 times the pace of standard Consultant-led clinics.

1,014 (62%) patients had their medicine up-titrated based on NICE guidance, including over 500 patients referred for injectable lipid-lowering therapies. A population health model developed alongside Health Innovation Oxford suggests that the overall programme will prevent over 91 cardiovascular events and save over £940,000 in direct NHS costs within three years.

Case Study: Fracture Liaison Service

A unified team has been set up across Buckinghamshire, Oxfordshire & Berkshire giving clinical nurse specialists access to expert medical support to deliver care for patients with osteoporosis and improve the identification of osteoporosis in people who sustain fractures. This will be supported by integrated data allowing cross-cover and flexible working across hospital and community settings and artificial intelligence (AI) technologies which will help identify fractures seen on CT scans.

This service will, over the next 10 years, increase the number of people on bone strengthening medication to reduce fractures. This will deliver over 300 fewer hip fractures a year and 1,500 fewer bed days through providing appropriate care, equally to all patients across the three counties.

6.4 Reducing health inequalities

Our top priority as an organisation is to reduce health inequalities and making sure everyone has fair access to care, a good experience, and the best possible outcomes, no matter who they are or where they live. Focusing our efforts where they are most needed to make the biggest difference will be a core part of how we work every day.

However, healthcare only contributes to around 20% of a person's overall health. The other 80% is impacted by socio-economic factors (such as income and education attainment) the physical environment (for example air quality, lack of green spaces) and health behaviours (exercise, diet, smoking, drinking alcohol etc.). Therefore, if we are serious about reducing health inequalities, we need to reduce the inequalities in the care we provide and these wider factors that impact people's health. We will**:**

- Build on our role as a local employer and community partner by:

    - Creating jobs and training opportunities for people in the most disadvantaged areas of Buckinghamshire (Opportunity Bucks wards) including apprenticeships, school outreach, healthcare assistant training and helping volunteers move into paid roles.
    - Making sure our spending benefits the wider community through prioritising social value in our contracts.
    - Work with the public, voluntary and community groups to share buildings and space.
    - Provide community spaces through initiatives such as health on the high street.

- Use data to understand the health of our population and differences in outcomes between groups and make this information available at a service level.
- Build trust and stronger connections with communities who face worse health, making sure our services are easier for them to access. This includes working with these communities to shape the services they need.

- Make sure we consider inequalities in everything we do, by tracking differences in access, experience and outcomes and regularly reporting this to our Board and ensuring we listen to people from all parts of our community.
- Support our own colleagues by offering health checks to all colleagues living in Opportunity Bucks wards and improving access to health and wellbeing services.

Case Study

The Buckinghamshire School Aged Immunisation team identified that a diverse school in a deprived part of Buckinghamshire, had a poor history of immunisation uptake.

The immunisation team collaborated with the school to increase uptake of immunisations. Two assemblies were held with the students to share the importance of immunisations, with one assembly dedicated to allowing students to ask questions in a group or individually. Resources were provided in different languages for students to take home and telephone conversations were made to parents prior to the day of vaccination and then again on the day with the student present.

This led to a compliance of 98.7% compared to 72% the year before.

6.5 Planned Care and Diagnostic Transformation

We will improve how we deliver planned care and diagnostic services to get better outcomes for patients, reduce waiting times and make the best use of our resources. This will include:

- Working with local hospitals in Oxford, Berkshire and Frimley through the Acute Provide Collaborative. By sharing skills and resources we can improve care, reduce waiting times and get more consistent results, such as introducing a shared Fracture Liaison Service based on the award-winning service in Oxford.
- Fully embed our GIRFT (Get it Right First Time) accredited elective surgical hub at Wycombe Hospital including making better use of our theatres and clinics, reducing length of stay in hospital and offering new procedures to meet the needs of local patients.
- Improve outpatient care by:
  - Making the most of our capacity including through reducing ‘did not attend rates’, improving administrative processes and embedding making every contact count
  - Redesigning pathways including advice and guidance, giving patients more control over their follow up and one stop models
  - Using digital tools like the patient portal to make communication easier for patients.
  - Bringing together health professions in joint clinics to provide more complete care (multidisciplinary teams) including working with general practice.
- Using our resources in a smarter way to give more well-rounded care by:
  - Helping people prepare for surgery by supporting healthy lifestyle changes.
  - Considering a person’s overall health and goals especially for frail patients and those with complex needs.
  - Working more closely with general practice and community services so that care starts earlier and close to home for example a community pain pathway.
- Improving access to diagnostic test by:
  - Using new technology like point of care testing and artificial intelligence (AI)
  - Making it easier to get the right test at the right time, including by training colleagues and changing how care is organised.
  - Focusing more on screening (early testing), especially for people who need it most.
  - Making sure we have the right equipment such as MRI and CT scanners to meet demand.

- Expanding community diagnostic services so people can get test quickly and close to where they live.

Case Study – Geoff was waiting for surgery and was struggling with:

- Chronic pain from multiple fractures
- Low appetite and BMI (body mass index)
- Difficulty breathing and sleeping
- Depression and low mood and feeling like he had nothing to be grateful for

The Getting Ready for Surgery team provided health coaching to support him to be fit for surgery and reduce the chances of surgical complications. The coach helped him, shift his mindset – from not wanting to live to finding ways to improve his health. Geoff set a daily goal of spending 15 minutes counting his blessing and he tracked his progress through using a diary. This resulted in Geoff saying he 'felt happy for the first time in years' and reporting a significant improvement in his mental health, he was also making healthier lifestyle choices which resulted in reduce risk of surgical complications.

6.6 Children, young people and maternity

We are committed to helping children, young people and families to live healthier lives by focusing more on prevention and early support. By working together with schools, health services, local charities and community groups, we aim to give children the right help at the right time, so they can thrive. We will:

- Make prevention a priority from the start, for example by supporting women to stay healthy during pregnancy, increasing access to childhood vaccinations, and using screening to catch health and development needs early.
- Integrating services to make it easier for children and families to get the support they need. This includes improving links between mental health services, GPs, and community teams and working with services like the Family Hubs to offer a single place to get advice and support from birth to age 19. We will also give more joined-up support for children with complex needs or disabilities, and help young people move smoothly into adult care.
- Support families and communities by increasing awareness of mental health needs during and after pregnancy and offering more education on key health issues such as asthma management, maintaining a healthy weight and emotional wellbeing.
- Set up women's health hubs to bring together health professionals and community groups to meet women's health needs throughout their lives.

By focusing on prevention and early help we can help children, young people and families stay healthy, avoid crises and give children a better start in life.

Case study - Beth, a young mother with learning disabilities received personalised support from the Family Nurse Partnership (FNP) to support her throughout her pregnancy and early parenthood journey. The support included consistent appointment scheduling with the same professional to build a routine and trust, accessible information, using a health passport to amplify Beth's voice and coordination of professionals.

Beth gave birth to a healthy baby at full term, and they are both thriving. Beth quit smoking during pregnancy, is breastfeeding and is planning a return to college.

6.7 Frailty and multiple long-term condition

As more people live longer with frailty and multiple long-term conditions demand for care is increasing. We are committed to improving the care and support available by focusing on early identification and action, and coordinated, person-centred care to help individuals stay independent for as long as possible. Our aim is to improve quality of life and reduce avoidable hospital visits. We will:

- Spot frailty early by making sure people get a full health assessment in all care settings and using data to find those who may be frail, so we can offer support before their health gets worse.
- Introduce clear care plans for people with frailty or multiple long-term conditions, led by local neighbourhood teams. These plans will record what care people want, especially during a crisis, and be shared with everyone involved in their care.
- Implement a Buckinghamshire frailty model, which will include working with partners, using virtual support and hospital at home services, quicker access to short term help at home and planning care around the individual.
- Look at the whole person, not just one illness, considering their physical, mental and social needs. For example:
  - Making sure people understand their realistic treatment options and that the choices reflect what matters most to them.
  - Reviewing whether surgery will actually help someone feel better or live longer and offering alternatives where possible.
- Start conversations about end-of-life earlier, so people can have a say in where and how they are cared for. We will use a shared care form (ReSPECT) across all service, so people's wishes are known and respected.

By taking a personalised and proactive approach to support people with frailty and multiple long-term conditions, we can help people stay healthier for longer, improve their experience of care and reduce the need for hospital visits.

Case Study

An elderly gentleman was admitted to Wycombe Hospital for treatment following a cardiac event. He had been living independently at home with his wife prior to admission, but his wife very sadly passed away whilst he was in hospital, leaving the gentleman deeply worried about returning home. Although he retained decision-making capacity, he struggled to make choices due to psychological distress. Beyond requiring some rehabilitation, his primary needs centred on emotional and psychological support.

The discharge team coordinated a tailored plan, with ward staff arranging the logistics of his transition home. Onward Care provided food parcels and remote monitoring to ensure his wellbeing and Age UK provided a befriending service to combat isolation, whilst Home First implemented a care package to address daily needs. This collaborative approach ensured the gentleman received comprehensive support and was able to return home safely.

6.8 Looking after our colleagues

Our people are our greatest strength, having a skilled and motivated workforce is key to delivering high-quality care. We employ over 7,000 people in over 240 different roles delivering acute, community, specialist, health and care services to the population of Buckinghamshire and beyond. Most of our people (79%) live in Buckinghamshire. How we support them to live healthier lives is a key to ensuring we have a healthy workforce and community. As such we are:

- Offering health checks for all colleagues through self-booking and personally inviting colleagues who live in Opportunity Bucks wards (this is 27% of our colleagues) as they are at greater risk of experiencing health inequalities. This will enable us to pick up potential issues and risks for their health early. Results are sent to their GP to action where necessary, and signposting to further support is also provided.
- Building on our progress of improving work-life balance and creating a culture of recognition and support.
- Looking to the workforce of the future, we are engaging with all schools in Opportunity Bucks areas or those who have an intake of more than 40% of students from these areas, attending careers events and ensuring we prioritise our work experience placements for students living in Opportunity Bucks wards.

Our goal for our teams is that everyone will be able to make a difference, working together. This will be achieved through:

- Workforce planning to ensure we have the right people with the right skills in the right place at the right time.
- Continuing to focus on learning, development, and career progression for example apprenticeships, career progression opportunities, talent mapping and developing leaders of the future.
- Fostering an inclusive workforce where everyone feels valued and respected.

Case study: Julian joined BHT as a healthcare assistant in November 2014 and completed his NVQ in health and social care during the first 18 months of his employment. In 2017 he was in the first cohort of nursing associate trainee at BHT following the apprenticeship pathway and completing his foundation degree. On qualifying he took up a Registered Nursing Associate role. He was keen to gain his full registration and with the support of his line manager commenced his Registered Nurse Degree Apprenticeship and on completion took up a registered nurse position on the respiratory unit. Since then, Julian has continued to demonstrate his clinical and leadership skills and was promoted into a secondment role as junior ward manager in January 2025. His long-term plan is to remain in respiratory care and to look to develop his practice as a community respiratory nurse.

6.9 Key enablers

Key enablers are the support and services that our colleagues need to be able to deliver the goals set out in this strategy.

6.9.1 Improving Together

Improvement will be part of all our colleagues' jobs every day, and everyone will be able to make a difference, working together as a team. We know that teams delivering care and services are best placed to make improvements to increase the value of care we provide, improving outcomes and making the best use of our resources.

Through our 'Improving Together' approach:

- Colleagues will know our priorities and their role in achieving these.
- We will set ambitious goals and leaders will coach colleagues to achieve these.
- We will have a common way of making improvements using data and tools for structured problem-solving.

To enable this, we will implement our Improvement Management System (an evidence-based approach to continually improve services) in all teams to help them make the changes required to

deliver our vision and strategic priorities. This will include developing leadership skills and behaviours to implement this approach.

6.9.2 Digital transformation

Digital innovation and transformation are central to delivering high-quality, efficient, and person-centred care. We will improve safety and outcomes for patients through:

- Developing IT infrastructure including upgrading laptops and updating systems to reduce data security risks.
- Implementing electronic prescribing and an Electronic Patient Record (EPR).
- Implementing Artificial Intelligence (AI) and Automation technology to improve services.
- Developing population health management (using data to understand the health of our local populations) so we can use data to plan and transform services with our partners.
- Developing our colleagues' digital and data skills.

6.9.3 Estates development

We will continue to invest in our estate to support colleagues in delivering outstanding care including:

- Delivery of acute hospital redevelopment, initially focusing on the redevelopment of Wycombe General Hospital AND developing an estates plan for the Stoke Mandeville site.
- Developing community hubs to support working together with partners, prioritising areas that need it most.
- Ensure the estate and equipment is functioning to enable clinicians to deliver patient care such as servicing theatre and ultrasound equipment in house and out of hours.
- Supporting our colleague's health and wellbeing for example the provision of new breastfeeding facilities.
- Delivery of a refreshed Green Plan to include working with system partners on Net Zero initiatives such as joint procurement for a new waste contract, promoting active travel, delivery of community garden projects.

7. Outcomes and delivery

This strategy aims to change how we deliver care for people in Buckinghamshire, with tackling health inequalities being our top priority. We recognise that this is not a small change, but a significant shift in how we work. Reducing health inequalities will be our top priority over the next 10 years and our main measure of success will be reducing the gap in deaths under 75 between people living in the most and least deprived areas of Buckinghamshire.

We will deliver the changes to how we work through our Improvement Management System, strategic transformation programmes and delivery of our breakthrough objectives (specific annual objectives the organisation sets to focus on for one year to support achievement of our strategic goals).

The strategy sets out a clear plan for what we aim to achieve over the next five years which will evolve throughout the 10 years of this strategy. The strategic goals and outcomes we will use to measure the success of this strategy for the first five years are tabled below with the 2025/26 breakthrough objectives which will be updated annually.

	Outstanding Care	Healthy Communities	Great Place to Work
Strategic goals 2030	We will deliver **joined up, safe** and **people centred care** in a **sustainable way**	Everyone will have the **opportunity to live a healthy-life** and **every child will have the best start in life**	**Everyone** will be able **to make a difference** working together as part of a team
Outcomes 2030	We will support people to remain well and at home, so fewer people need a bed in an emergency We will have more time to care by reducing waste and unnecessary demand	More children will be ready for school Fewer people will die under the age of 75 Fewer people will feel lonely	People will be engaged and able to make improvements People will work together as part of teams – with colleagues across the Trust and with partners People will have the right tools and surroundings to deliver outstanding care, particularly digital tools and estates
Outcome measures 2030	Reduce growth in hospital admissions to 1% or less per year Reduce planned admissions and outpatient appointments Increase productivity	Increase the percentage of children with free school meal status achieving a good level of development at the end of Reception Reduce under 75 mortality rate from all causes (1 year range) Fewer people will feel lonely – develop specific measure for people receiving community or long-term care	Increase engagement and involvement scores in NHS staff survey Increase in people who feel able work in a team in NHS staff survey Increase in staff activation from 2025 baseline for those working in neighbourhoods. Achieve 3.4 on the What Good Looks Like (WGLL) Digital Capability Framework by 2030 Plan for Wycombe redevelopment and community estates model approved and started
Focus for 2025/26	Fewer people will need a bed in an emergency See people earlier	Support people to live healthier lives	Fewer people will experience bullying and harassment