To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 29 June 2023 at 2.00 pm
Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND

If you wish to view proceedings online, please click on the Live Stream Link on the website.

Martin Reeves
Chief Executive

21 June 2023

Contact Officer: ***Jonathan Deacon, Interim* Democratic Services Officer, *Democratic Services***
Email: committees.democraticservices@oxfordshire.gov.uk

Membership

Chair – Cllr Liz Leffman (Leader, Oxfordshire County Council)
Vice Chair – Sam Hart, Buckinghamshire Oxfordshire Berkshire West Integrated Care Board

Board Members:

Councillor Joy Aitman	West Oxfordshire District Council
Ansaf Azhar	Corporate Director of Public Health & Wellbeing, Oxfordshire Co Co
Councillor Tim Bearder	Cabinet Member for Adult Social Care, Oxfordshire Co Co
Councillor Liz Brighouse OBE	Deputy Leader and Cabinet Member for Children, Education & Young People's Services, Oxfordshire Co Co
Dr Nick Broughton	Chief Executive, Oxford Health Foundation Trust
Sylvia Buckingham	Chair, Healthwatch Oxfordshire
Councillor Phil Chapman	Cherwell District Council
Councillor Maggie Filipova-Rivers	South Oxfordshire District Council
Karen Fuller	Interim Corporate Director of Adult and Housing Services, Oxfordshire Co Co
Dr James Kent	Chief Executive, Integrated Care Board
Dan Leveson	Place Director for Oxfordshire, Buckinghamshire Oxfordshire Berkshire West Integrated Care Board
Kerrin Masterman	GP Representative

Professor Sir Jonathan Montgomery	Chair, Oxford University Hospitals NHS Foundation Trust
Councillor Michael O'Connor	Cabinet Member for Public Health & Inequalities, Oxfordshire County Council
Councillor Helen Pighills	Vale of White Horse District Council
David Radbourne	Regional Director Strategy and Transformation, NHS England
Yvonne Rees	Chief Executive, Cherwell District Council (District Representative)
Martin Reeves	Chief Executive, Oxfordshire County Council
Councillor Louise Upton	Oxford City Council

Date of next meeting: 5 October 2023

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chair

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

Members of the public who wish to speak at this meeting can attend the meeting in person or 'virtually' through an online connection.

To facilitate 'hybrid' meetings we are asking that requests to speak or present a petition are submitted by no later than 9am four working days before the meeting i.e., 9am on Friday 23 June 2023. Requests to speak should be sent to jonathan.deacon@oxfordshire.gov.uk.

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure your views are taken into account. A written copy of your statement can be provided no later than 9am 2 working days before the meeting. Written submissions should be no longer than 1 A4 sheet.

5. Note of Decisions of Previous Meeting (Pages 1 - 10)

To approve the Note of Decisions of the previous meeting held on 16 March 2023 and to receive any information arising from them.

6. Buckinghamshire, Oxfordshire and Berkshire West Joint Forward Plan (Pages 11 - 72)

2.05pm

Report by Robert Bowen, Acting Director Strategy and Partnerships, BOB ICB

Buckinghamshire, Oxfordshire and Berkshire West (BOB) Joint Forward Plan describes how the Integrated Care Board (ICB) and partner NHS trusts are required to develop an annual, five year Joint forward Plan. This plan intends to balance delivery of the BOB Integrated Care Strategy ambitions with delivery of the other NHS commitments.

The Board is RECOMMENDED to agree the wording in Appendix A as its formal opinion on whether the Joint Forward Plan takes 'proper account of the joint local health and wellbeing strategy'.

7. Oxfordshire Joint Strategic Needs Assessment 2023 update (Pages 73 - 80)

2.20pm

Report by Ansaf Azhar, Corporate Director of Public Health & Wellbeing, Oxfordshire County Council.

The Joint Strategic Needs Assessment (JSNA) is a statutory annual report provided to the Health and Wellbeing Board and published in full on Oxfordshire Insight. It provides an evidence-base for the Health and Wellbeing Strategy and is an opportunity for an annual discussion about the key issues and trends from a review of a very wide range of health-related information about Oxfordshire.

The Board is RECOMMENDED to

1. Note the content of the Joint Strategic Needs Assessment for 2023 and encourage widespread use of this information in planning, developing and evaluating services across the county.
2. Contribute information and intelligence to the JSNA Steering Group to further the development of the JSNA in future years, and to participate in making information more accessible to everyone.

8. Updating the Health and Wellbeing Strategy (Pages 81 - 108)

2.35pm

Report by Ansaf Azhar, Corporate Director of Public Health & Wellbeing, Oxfordshire County Council.

Oxfordshire's Health and Wellbeing Board last published a Joint Local Health and Wellbeing Strategy in 2019. The Board has a statutory responsibility to publish this Strategy. Officers have now begun the process of updating it as agreed by the Board at their previous meeting on 16 March 2023.

The Health and Wellbeing Board is RECOMMENDED to

- Note the formation and activity of the cross-organisational Task and Finish group, with representation from all organisations on the Health and Wellbeing Board;
- Note ongoing progress towards updating the Health and Wellbeing Strategy;
- Approve plans to communicate and engage with residents;
- Approve proposed structure for the Health and Wellbeing Strategy;
- Consider and determine the timeframe for the updated Health and Wellbeing Strategy;
- Discuss emerging themes, principles, and priorities and offer guidance to officers regarding content of the strategy;
- Approve a workshop of the HWB to take place in September so that board members and officers on the Task and Finish group can work together on further content development.

9. Better Care Fund Plan 2023-25 (Pages 109 - 176)

3.05pm

Report by Karen Fuller, Interim Corporate Director of Adult Services, Oxfordshire County Council.

The Better Care Fund is the main statutory vehicle for the County Council and the NHS to integrate funding within a system wide plan to improve the health and care outcomes for our population and improve the resilience of the health and care system mainly in relation to the flow into and out of hospital. The Plan must be approved by the Health & Wellbeing Board on behalf of the Council and Integrated Care Board and other partners.

The Oxfordshire Health and Wellbeing Board is RECOMMENDED to

- Approve the Oxfordshire Better Care Fund Plan Priorities for 2023-25
- Approve the trajectories for the Better Care Fund Metrics
- Approve the Better Care Fund Income and Expenditure Plan.

10. Oxfordshire Combating Drugs Partnership (Pages 177 - 182)

3.25pm

Report by Ansaf Azhar Corporate Director of Public Health & Wellbeing, Oxfordshire County Council

Oxfordshire have established a Combating Drugs Partnership with a range of partners from health, local authority, criminal justice and the voluntary sector, and have agreed a strategic action plan to address local need.

The Health And Wellbeing Board is RECOMMENDED to note the progress with the Oxfordshire Combating Drugs Partnership.

11. Community Profiles (Pages 183 - 192)

3.40pm

Report by Ansaf Azhar, Director of Public Health and Community Safety, Oxfordshire County Council

The Director of Public Health Annual Report highlighted ten wards in Oxfordshire which have small areas (Lower Super Output Areas) that were listed in the 20% most deprived in England in the Index of Multiple Deprivation update (published November 2019) and are most likely to experience inequalities in health. To better understand the needs and priorities of these communities, the County Council has been working with local partners to create community profiles.

The Oxfordshire Health and Wellbeing Board is RECOMMENDED to:

a) Note the findings and rich insight contained within the Phase 2 Community Profiles for Barton, Banbury Neithrop and Ruscote, Banbury Grimsbury and Rose Hill.
b) Support the promotion and sharing of the community profiles with partners and colleagues across the system.
c) Use the insight from the community profiles to inform service delivery plans of partner organisations on the Board.

12. Pharmaceutical Needs Assessment Update (Pages 193 - 202)

4.00pm

Report by David Munday. Deputy Director of Public Health, Oxfordshire County Council.

The Pharmaceutical Needs Assessment (PNA) assesses the number of pharmacies and access for residents (measured by distance to travel). It does not assess quality or convenience issues. The criteria for general access used in the PNA is for all parts of the urban population to be within 20 minutes' walk or 20 minutes' public transport time of a pharmacy and all parts of the rural population to be within 20 minutes' drive-time or a five mile radius of a pharmacy.

The Health and Wellbeing Board is RECOMMENDED to

a) Note the intention of Lloyds Pharmacy Ltd to withdraw all 237 Lloyds pharmacies inside Sainsbury's stores nationwide in 2023, affecting 6 pharmacies in Oxfordshire.
b) Issue a Supplementary Statement, further to the Oxfordshire Pharmaceutical Needs Assessment 2022, that records the closure of the Lloyds Pharmacy in Sainsbury's store, Heyford Hill, Littlemore, Oxford on 22 April 2023.
c) Issue a Supplementary Statement, further to the Oxfordshire Pharmaceutical Needs Assessment 2022, that records the consolidation of the Lloyds Pharmacy in Sainsbury's store, Bure Place, Bicester, with Lloyds Pharmacy, Old Barn Coker Close, Bicester and the closure of the Lloyds Pharmacy in Sainsbury's on 10th June 2023.
d) Issue a Supplementary Statement, further to the Oxfordshire Pharmaceutical Needs Assessment 2022, that records the consolidation of the Lloyds Pharmacy in Sainsbury's store, Witan Way Witney, with Lloyds Pharmacy, Windrush Health Centre, Welch Way, Witney and the closure of the Lloyds Pharmacy in Sainsbury's on 13th June 2023.
e) Note that the further three closures of Lloyds Pharmacies in Sainsbury's stores in Banbury, Kidlington and Didcot do not require a Supplementary Statement.

13. Report from Healthwatch Oxfordshire (Pages 203 - 210)

4.10pm

To receive an update from Healthwatch Oxfordshire.

14. **Performance Report** (Pages 211 - 214)

4.20pm

To monitor progress on agreed outcome measures.

15. **Reports from Partnership Boards** (Pages 215 - 230)

4.25pm

To receive updates from Partnership Boards. Reports from –

- Oxfordshire Place-base Partnership
- Health Improvement Partnership Board; and
- Children's Trust

Councillors declaring interests

General duty

You must declare any disclosable pecuniary interests when the meeting reaches the item on the agenda headed 'Declarations of Interest' or as soon as it becomes apparent to you.

What is a disclosable pecuniary interest?

Disclosable pecuniary interests relate to your employment; sponsorship (i.e. payment for expenses incurred by you in carrying out your duties as a councillor or towards your election expenses); contracts; land in the Council's area; licenses for land in the Council's area; corporate tenancies; and securities. These declarations must be recorded in each councillor's Register of Interests which is publicly available on the Council's website.

Disclosable pecuniary interests that must be declared are not only those of the member her or himself but also those member's spouse, civil partner or person they are living with as husband or wife or as if they were civil partners.

Declaring an interest

Where any matter disclosed in your Register of Interests is being considered at a meeting, you must declare that you have an interest. You should also disclose the nature as well as the existence of the interest. If you have a disclosable pecuniary interest, after having declared it at the meeting you must not participate in discussion or voting on the item and must withdraw from the meeting whilst the matter is discussed.

Members' Code of Conduct and public perception

Even if you do not have a disclosable pecuniary interest in a matter, the Members' Code of Conduct says that a member 'must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself' and that 'you must not place yourself in situations where your honesty and integrity may be questioned'.

Members Code – Other registrable interests

Where a matter arises at a meeting which directly relates to the financial interest or wellbeing of one of your other registerable interests then you must declare an interest. You must not participate in discussion or voting on the item and you must withdraw from the meeting whilst the matter is discussed.

Wellbeing can be described as a condition of contentedness, healthiness and happiness; anything that could be said to affect a person's quality of life, either positively or negatively, is likely to affect their wellbeing.

Other registrable interests include:

a) Any unpaid directorships
b) Any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority.

c) Any body (i) exercising functions of a public nature (ii) directed to charitable purposes or (iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management.

Members Code – Non-registrable interests

Where a matter arises at a meeting which directly relates to your financial interest or wellbeing (and does not fall under disclosable pecuniary interests), or the financial interest or wellbeing of a relative or close associate, you must declare the interest.

Where a matter arises at a meeting which affects your own financial interest or wellbeing, a financial interest or wellbeing of a relative or close associate or a financial interest or wellbeing of a body included under other registrable interests, then you must declare the interest.

In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied:

Where a matter affects the financial interest or well-being:

a) to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
b) a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest.

You may speak on the matter only if members of the public are also allowed to speak at the meeting. Otherwise you must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation.

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OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 16 March 2023 commencing at 2.00 pm and finishing at 4.14 pm

Present:

Board Members:	Councillor Liz Leffman (Chair)
	Dr Sam Hart (Vice-Chair) Councillor Joy Aitman Ansaf Azhar Councillor Tim Bearder Councillor Liz Brighouse OBE Dr Nick Broughton Sylvia Buckingham Karen Fuller Hayley Good (for Kevin Gordon) Dan Leveson Councillor Mark Lygo Councillor Helen Pighills Martin Reeves Councillor Louise Upton
	Councillor Maggie Filipova-Rivers (virtually).
Other Members in Attendance:	Michelle Brennan (virtually)
Officers:	
Whole of meeting	David Munday, Consultant in Public Health; Jonathan Deacon, Interim Democratic Services Officer

Part of meeting

Agenda Item	**Officer Attending**
8	Rob Bowen (virtually)
10	John Pearce
11	Adam Briggs (virtually)

These notes indicate the outcomes of this meeting and those responsible for taking the agreed action. For background documentation please refer to the agenda and supporting papers available on the Council's web site (www.oxfordshire.gov.uk.)

If you have a query please contact Democratic Services, Oxfordshire County Council (Email: committees.democraticservices@oxfordshire.gov.uk)

	ACTION
1 Welcome by Chair (Agenda No. 1)	
The Chair welcomed attendees to the meeting and in particular, the recently appointed Vice-Chair of the Board, Dr Sam Hart and Chief Executive of Oxfordshire County Council, Martin Reeves.	
2 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
Apologies were received from Kevin Gordon, Kerrin Masterman, Professor Sir Jonathan Montgomery, David Radbourne, Yvonne Rees and Cllr Barry Wood. Hayley Good attended for Kevin Gordon.	
3 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest.	
4 Petitions and Public Address (Agenda No. 4)	
There were none.	
5 Note of Decisions of Last Meeting (Agenda No. 5)	
RESOLVED: That the Board **APPROVED** the notes of the last meeting and to authorise the Chair to sign them as a correct record**.**	
6 Health Protection Update (Agenda No. 6)	
Ansaf Azhar, Director of Public Health & Wellbeing, Oxfordshire County Council (OCC) gave a verbal update. He stated that the position in relation to infectious diseases had	

improved. Cases of Covid had significantly stabilised as had excess mortality. Cases of Strep A and flu had reduced. There was, however, still significant pressure on the health and care system. The COVID vaccination programme this spring for the extremely vulnerable and the autumn COVID / Flu booster programme remain fundamental to achieving on-going control of these viruses. He also advised that there was not currently a need for the Health Protection Update briefings to be a standing agenda item, due to the reduction in cases of infectious diseases. Should any specific health protection issues arise in the future they would be reflected in the agenda. It was noted that there were indirect impacts from Covid and as there was an emergence from the pandemic, there was a requirement to focus on long term disease management as well as urgent care. **The update was noted.**	
7 Report from the Board's Workshop on the Integrated Care System Strategy (Agenda No. 7)	
The Board was advised by David Munday, Consultant in Public Health, OCC that items 7, 8 and 9 all involved strategy development in relation to the Integrated Care System (ICS) and Oxfordshire. The ICS Strategy had been developed across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) area. The paper set out what had taken place in relation to the Strategy since the previous Board meeting in December including, most notably during the formal consultation period as it was being formed, the themes and priorities considered by Board members at the Workshop held in January. Some of the key discussions at the Workshop included the wider determinants of health being reflected in the strategic work for the ICS and having true integration of services experienced by residents, moving from the strategy to delivery phases. It was noted that the Strategy Team had reviewed the feedback from the Workshop, the public consultation and other Health and Wellbeing Boards. The ICS strategy had now been approved by the Integrated Care Partnership (ICP) and it had subsequently been published. It was agreed by Board members that the Workshop had achieved a positive impact and that public engagement by the organisations involved needed to be ongoing. **RESOLVED:** that the Board **NOTED** the output from the	

workshop on 19th January 2023 regarding the new ICS Strategy and that this strategy has now been finalised and published.	
8 Development of ICB 5 year Joint Forward Plan (Agenda No. 8)	
The Board received a set of slides in the papers which provided a summary position on the Joint Forward Plan. Rob Bowen, Acting Director of Strategy and Partnerships, ICB, stated that the document set out an ambition for how the NHS will deliver services in partnership with organisations in the BOB system. It was seeking to articulate how collectively the aims of the ICS and some local NHS commitments would be delivered. The engagement process with partner organisations was currently taking place. Mr Bowen outlined the timetable with a draft of the Joint Forward Plan being completed by the end of March. There was still an opportunity to comment and have input after March. It was intended to sign off the document by the end of June. Each of the Health and Wellbeing Boards across the BOB system would have the opportunity to comment on how well the Plan aligned to the joint health and wellbeing strategies. It was currently intended to run a series of community related focus groups in April and May. The Board noted that it was expected that the Joint Forward Plan would be formally considered at the next meeting on 29 June. It was also noted that there would be an ongoing process of public engagement in relation to the document and it would be refreshed on an annual basis. **RESOLVED:** that the Board **NOTED** the presentation and the timetable for the ICB 5 year Joint Forward Plan.	
9 Developments of "Place" Working in Oxfordshire - Joint Local Health and Wellbeing Strategy, Joint Strategic Needs Assessment and Place – Based Partnership (Agenda No. 9)	
The report was presented by David Munday and Dan Leveson, Oxfordshire Executive Director of Place, ICB. The Board was advised that the Joint Strategic Needs Assessment (JSNA) continued to be the bedrock of understanding the health needs of residents and informed organisational strategy and plans. It was proposed to bring the 2023 updated JSNA at the next Board meeting in June incorporating the latest data available, which it was anticipated would include the 2021 Census data. It was also intended that given the current Joint Local Health and Wellbeing Strategy (JHLWS)had been published in 2018 and ran	

until 2023, a revised version would be developed over the course of the year with the final version being published by the HWB Board in December. It would be the principal strategy document for Oxfordshire based work. Progressing the Strategy would involve a steering group made up from the Board's representative organisations. The progress would be reported at future Board meetings. The Board agreed the proposals. It was noted that the engagement plan for consultation on the JLHWS was being worked up and input from partner organisations on this was welcome. It was confirmed that the consultation process would not be online only. Members discussed local residents' experiences of accessing primary care services and sufficiency of future provision in light of demographic growth. This issue was noted and agreed that it need further exploration and solution at a system level. **RESOLVED:** that the Board: (a) Agreed the timelines and process for the development of the Oxfordshire Joint Strategic Needs Assessment and the Joint Local Health and Wellbeing Strategy in order to meet the Board's statutory duty to publish these documents; (b) Agreed the oversight for this work to be undertaken by steering group(s) made up of relevant officers and staff from organisations that form the Oxfordshire Health and Wellbeing Board; and, (c) Noted the development of the Oxfordshire Place-Based-Partnership, its overall aim and the main areas of focus for the partnership.	
10 Review of Support to Unpaid Carers (Agenda No. 10)	
The report was presented by Councillor Bearder, Cabinet Member for Adult Social Care and Karen Fuller, Corporate Director of Adult and Housing, at OCC. There had been a Survey of Adult Carers in England 2021/22 which showed that, nationally and in Oxfordshire, unpaid carers' satisfaction levels against all measures had fallen. In response a new All-age Unpaid Carers Strategy for Oxfordshire across Children's and Adults' Services was being developed. The Board welcomed the 'Live Well Oxfordshire' brochure, copies of which had been made available at the meeting. It was noted that this brochure and a separate Carers' brochure had been sent to GP practices. It was recommended that social prescribing	OCC councillors receive the 'Live Well Oxfordshire' and separate carers' brochures and that the Board receive a digital link to the brochures (Karen Fuller, Corporate

teams in Primary Care Networks also received the brochures so that frontline primary care was more aware of the work being taken forward. It was appreciated that Children's and Adults' Services were liaising with the PCNs. Actions were agreed that OCC councillors received the brochures and that the Board received a digital link to the brochures. The Board was advised that there would be more consultation with key partners. The final strategy and consultation outcomes were scheduled to be published in August/September. **RESOLVED:** that the Board: (a) Supports the development and publishing of a new All-age Unpaid Carers Strategy for Oxfordshire, based on priorities expressed by carers of all ages; (b) Supports the aligning of workplans across Health, Education and Social Care to the refreshed All-age Unpaid Carers Strategy for Oxfordshire so that all services have procedures in place to identify and support unpaid carers, regularly review procedures, and seek ways to support and include carers; (c) Supports the development and updating of a central public repository of information for carers so that carers and those supporting/advising them can easily find support; and, (d) Supports the establishment of the overview arrangements necessary to ensure improvements are achieved across the system.	Director of Adult and Housing, at OCC).
11 Developing community research capacity and partnerships across Oxfordshire (Agenda No. 11)	
The report was introduced by Adam Briggs, Deputy Director of Public Health. He stated that the paper set out the development of a more co-ordinated approach to the community research ambitions across Oxfordshire. He explained that there were three aspects to this, NIHR Health Determinants Research Collaboration (HDRC), Community Research Networks (CRNs) and data integration. HDRCs are local government-led partnerships funded for £5m over five years to develop local authorities' capacity and capabilities to deliver research focused on the wider determinants of health and inequalities. It was proposed to submit an expression of interest and full application to follow in the event of being shortlisted. Some funding had been provided by UK Research and Innovation (UKRI) in order to set up a CRN.	

Funding recipients were invited to submit applications for full implementation of CRNs (funding up to £600k over three years) from around July 2023. In relation to data integration, it was proposed to take forward two pieces of work in partnership with people working in data and intelligence across OCC as set out in the report. It was noted that the funding was competitive on a national level and Dr Briggs was asked what the feedback/lessons learnt had been from not securing the funding to be an HIDR HDRC in 2022 in order to seek to achieve this in 2023. He advised that these were to make the bid a broader one with research leads across Council directorates, greater collaboration with higher education institutes and also, how the roles of the county and district councils and their partnership working can be best communicated. The Board welcomed the proposals. It was agreed that updates would be given at future meetings whether the funding bids were successful or not. **RESOLVED:** that the Board supported proposed funding bids to the National Institute for Health Research and to UK Research and Innovation.	
12 Report from Healthwatch (Agenda No. 12)	
The Board considered a report by Healthwatch Oxfordshire setting out its activities since its last report to the Board. Sylvia Buckingham, Chair Healthwatch Oxfordshire, presented the report. Ms Buckingham referred to Ros Pierce having left the post of Executive Director at Healthwatch after 6 years of service. Dr Veronica Berry was the new Executive Director. She also drew Board Members' attention to the mention in the report of the Men's Health video which had been made by Healthwatch in 2018. In October 2022 Public Health Oxfordshire commissioned a new and supplementary NHS Health Checks service. They had acknowledged "that [the video] was part of the research that led us to change this contract to offer NHS checks in the community". The update was **NOTED**.	
13 Performance Report (Agenda No. 13)	
David Munday highlighted a number of performance indicators under the three life course stages "Start Well", "Live Well" and	

"Age Well" from the Strategy. He explained that it would be necessary to update the Performance Report to ensure that what was being tracked tied in with the priorities of the new Health and Wellbeing Strategy for Oxfordshire. The key points relating to the performance indicators included: • "Start Well" – there was an improving picture in reducing the level of smoking in pregnancy. Also, the metric had changed to the reduction target of both overweight and obese children in Year 6. There would be increased activity system wide to achieve this target as highlighted in the annual report being published shortly. Finally, there was an improved position in increasing the number of early help assessments. • "Live Well" – it was known that there had been good engagement with the flu immunisation programme for under 65s, buth that the final 22/23 flu season vaccination data was awaited. For the children's programme, there was a higher uptake than had been seen the previous year. It was welcomed that the number of those quitting smoking had increased. The four red indicators, including NHS Healthcheck programme and cervical screening, had been impacted by capacity challenges due to Covid. Recovery programmes were in place to improve performance and uptake. • "Age Well" – there was a metric of 93% of people discharged to their normal place of residence. There was discharge pathway work taking place to improve performance and reach the target. The target was being exceeded in terms of increasing the percentage of over 65s who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. It was recognised that the size of the Performance Report spreadsheet needed to be bigger in future to make it easier to read. The Board **NOTED** the Performance Report.	
14 Reports from Partnership Boards (Agenda No. 14)	
The Chair thanked Councillor Louise Upton for her contribution as Chair of the Health Improvement Board (HIB) as it was noted that she was stepping down from the role. She would continue to attend Oxfordshire Health & Wellbeing Board meetings as a representative of the City Council. **HIB**	

Councillor Upton presented the report of the 23rd February HIB meeting. The meeting had specifically focused on the theme of healthy weight and physical activity. It had reviewed a summary of the Director of Public Health Annual Report which had been presented in Final Draft form before publication later in March. There had been consideration of the Whole Systems Approach to healthy weight. There would be a more detailed workshop scheduled in the Spring to look at the role of local authorities in creating environments that are more conducive to healthy weight, including in relation to food and exercise. Councillor Upton also referred to Active Oxfordshire presenting the new Oxfordshire on the Move physical activity framework that they have developed with the support of a significant number of organisations. They welcomed the ambitions of Active Oxfordshire and agreed they would receive regular updates from them. **Children's Trust Board (CTB)** Councillor Liz Brighouse presented the report of the Children's Trust Board. Matters she highlighted included the Children's Services Strapline having now been developed and circulated to all board partners and OSCB, for all to use and reach out more widely with other agencies. This would involve partners working together to help children, young people and families to thrive. She also stated that significant training had been put in place for multi-agency staff in the use of Strength & Needs forms and Early Help. Also, a pilot had been undertaken with health visitors in order to encourage them to engage with Early Help matters / Strengths and Needs Assessments. The Board **NOTED** the reports and the presentations at the meeting.	

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Date of signing .....

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Divisions Affected - All

Oxfordshire Health and Wellbeing Board
29th June 2023

Buckinghamshire, Oxfordshire and Berkshire West (BOB) Joint Forward Plan (JFP)

Report by Robert Bowen, Acting Director Strategy and Partnerships, BOB ICB

RECOMMENDATION

1. **The Health and Wellbeing Board is RECOMMENDED to**

   Agree the wording in Appendix A as its formal opinion on whether the Joint Forward Plan takes 'proper account of the joint local health and wellbeing strategy'

Executive Summary

2. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Joint Forward Plan (JFP) describes how the Integrated Care Board (ICB) and partner NHS trusts are required to develop an annual, five year Joint forward Plan. This plan intends to balance delivery of the BOB Integrated Care Strategy ambitions with delivery of the other NHS commitments.

3. The plans have been developed jointly with BOB Integrated Care System (ICS) partners with input and feedback from wider system and public engagement, including input from local authority partners, which has informed the development of the JFP.

4. ICBs and their partner trusts must involve relevant HWBs in preparing or revising the JFP. This includes sharing a draft with each relevant HWB, and consulting on whether the JFP takes proper account of each relevant joint local health and wellbeing strategy (JLHWS).

5. Health and Wellbeing Boards are required to provide comment on the JFP's alignment to current health and wellbeing strategies through June 2023 – specifically whether the draft Joint Forward Plan takes proper account of each joint health and wellbeing strategy.

6. The JFP will be formally published by the end of June 2023.

Introducing the Joint Forward Plan

7. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB) and its partner trusts are required to publish the first Joint Forward Plan (JFP) by 30 June 2023.

8. **National Guidance** sets out that at a minimum the JFP needs to describe how the ICB and partner NHS trusts "intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments". Additionally, systems are encouraged to use the JFP to develop a shared delivery plan for the Integrated Care Strategy and the Joint Local Health and Wellbeing Strategies (JLHWS).

9. The Buckinghamshire, Oxfordshire and Berkshire West JFP addresses these ambitions across our organisations and also recognises the value and importance of our partnerships with local authorities in the ongoing development and delivery of services for the benefit of the people and communities who live and work in our areas.

10. The JFP sets a rolling five-year ambition and will be updated annually before the beginning of each subsequent financial year.

11. There are four supporting documents with this paper:

- Appendix A - Proposed HWB Response to JFP
- Appendix B - Joint Forward Plan Summary
- Appendix C - JFP Feedback Themes and Responses
- Joint Forward Plan – **All documents and appendices**

Aligning to joint health and wellbeing strategies

12. As described in previous meetings with the health and wellbeing board, the Joint Forward Plan has been developed specifically in response to the ambitions of the Integrated Care Strategy, signed off by the ICP in March 2023. The strategy was developed jointly by system partners, including local authority representatives, to reflect the needs of local populations as described in the local health and wellbeing strategies.

13. The Joint Forward Plan has subsequently been developed with further input from system partners to ensure these ambitions are reflected and local needs are taken into account.

14. The ICB and partner NHS trusts are required to consult with Health and Wellbeing Boards on "whether the draft takes proper account of each JLHWS [Joint health and wellbeing strategy] published by the health and wellbeing board that relates to any part of the period to which the JFP relates". The Health and Wellbeing Board must respond with its opinion and may also send

that opinion to NHS England, telling the ICB and its partner trusts it has done so - see page 7 of national guidance (paragraph 8) on developing the Joint Forward Plan.

15. Our JFP, guided by the vision set out in the Integrated Care Strategy, aligns with and builds on the strategies, approaches and targets set out by our three local health and wellbeing strategies developed by the five Health and Wellbeing Boards across BOB. We recognise that Oxfordshire have set out key priorities in the joint local health and wellbeing strategy:

- Agreeing a coordinated approach to prevention and "healthy place shaping"
- Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan)
- Agreeing an approach to working with the public so as to re-shape and transform services locality by locality
- Agreeing plans to tackle critical workforce shortages.

16. The Oxfordshire HWB Board is in the process of updating and reviewing its Strategy as the current one runs until 2023. Staff from the Integrated Care Board and the Oxfordshire based NHS provider organisations are part of the Task and Finish Group for that work. As this new strategy emerges there will be continued alignment between this and the Joint Forward Plan. The JFP will be updated on an annual rolling basis and HWBs will be consulted on any significant changes made each year and within year. Progess will be reported to the ICB Board twice yearly.

17. We are confident that the BOB Joint Forward Plan takes into account the HWS strategic priorities and are reflected in the service delivery plans aligned to the five themes of the Integrated Care Strategy – Promoting and Protecting Health, Start Well, Live Well, Age Well and Improving Quality and Access to services.

18. We also know we need to do more as a system to address the wider determinants of health and our social and economic improvement responsibilities and we will be developing our plans with system partners for how we can do this over the coming months.

19. The table below sets out the alignment (based on the current 2019-2023 strategy).

Oxfordshire Health and Wellbeing Priorities	Mapping to the BOB Joint Forward Plan
Agreeing a coordinated approach to prevention and "healthy place shaping"	A greater focus on prevention and keeping people well in their communities is a fundamental principle of the Integrated Care Strategy and the Joint Forward Plan. Our ambition to move to a more prevention and community - based model of care can be seen throughout the service delivery plans in the Joint Forward Plan (see JFP Appendix A: Service Delivery Plans). Our overall approach to prevention is described in the first of the five strategic themes within the JFP: Promoting and Protecting Health. This focuses on our approach to tackling inequalities in access, experience and outcomes and prevention and working to keep people healthier for longer through increased primary and secondary prevention activities. Our JFP outlines plans to work together to reduce demand for reactive services and shift the focus to preventative care. This can also be evidenced in the 'Live Well' strategic theme where there are specific plans to address Long Term Conditions such as Cardiovascular disease. These plans aim to increase preventative interventions for those with or at risk of developing Long Term Conditions and to improve health outcomes for those living in BOB. This section also outlines plans to empower individuals to manage their own health supported in their communities. Additionally, the Promoting and Protecting Health section of the JFP outlines our plans for supporting people to stay healthy – for example through weight management and increasing physical activity in the community. Specific outcomes we are trying to achieve

Oxfordshire Health and Wellbeing Priorities	Mapping to the BOB Joint Forward Plan
	are to reduce the proportion of people who are overweight or obese in BOB including children and young people.
Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan)	Our Joint Forward Plan recognises the challenge that people living in BOB face in the health and care system. The ambition to tackle accessibility and user experience challenges are addressed across two of our four key challenge areas. The Model of Care challenge aims to create an integrated approach to primary care, accelerating opportunities for integrated neighbourhood teams. This aims to help with the issues citizens have with their journey through the BOB care system and move care closer to home to avoid unnecessary touchpoints in the health and social care system. Additionally, this is recognised in the user experience challenge where access and waiting times are addressed and transformational plans have been put in place to improve the journey for patients. The 'Improving Quality & Access' strategic theme in the JFP outlines specific service delivery plans to improve and transform services across Primary Care, Planned Care, Urgent & Emergency Care and Palliative and End of Life Care. These plans have extensive detail regarding our ambition to ensure services are effective, efficient and joined up across the system. Our enabling Digital Strategy will support the transition to the new system of care through digitising, connecting and then transforming our digital, data and technology capabilities

Oxfordshire Health and Wellbeing Priorities	Mapping to the BOB Joint Forward Plan
	to help improve the way people move through our health and care services.
Agreeing an approach to working with the public so as to re-shape and transform services locality by locality	The public have been directly involved in shaping the BOB Integrated Care Strategy and have had the opportunity to comment on the draft version of the JFP. We have taken their feedback into account and addressed them, where appropriate. The Joint Forward Plan will be delivered in partnership with leaders and staff working closely with our populations at every level across the system, through our Place Based Partnerships, as integrated locality teams, or extending beyond our ICS borders when that is what is needed. Our main JFP document outlines the role of Place Based Partnerships in delivering local arrangements and bringing together system partners to deliver the outcomes that matter to each 'Place'. We recognise that decisions about the delivery of services can best be taken close to the people who use those services. This is especially true when designing services to reduce inequalities experienced by our most vulnerable residents and those in the most deprived communities. Our ambition to deliver personalised care can been seen across many service delivery plans through the JFP. For example, within the 'Start Well' strategic theme, the service delivery plan for Maternity and Neonatal services has a focus on personalisation to transform the way care is provided, by listening and engaging with women and families to improve service user experience. In our 'Improving Quality & Access' strategic theme, the service delivery plans for

Oxfordshire Health and Wellbeing Priorities	Mapping to the BOB Joint Forward Plan
	Palliative and End of Life Care are focused on co-designing PEoLC through provider collaboratives and in partnership with the people who have lived experience of these services. We recognise the importance of working with the public to transform and improve services in each local area.
Agreeing plans to tackle critical workforce shortages	The workforce challenges we face as a system in BOB, and our plans to address them, are referenced throughout the JFP. We know that workforce shortages can affect all front line service areas and others such as digital capabilities. To support our workforce plans we are also developing our enabling estates strategy. In the Supporting and Enabling Delivery (last section of Appendix A) section of the JFP, there is a specific service delivery plan focused on Workforce. This outlines our collective ambition through system collaboration to ensure we have an integrated workforce that is looked after, feels valued and respected and is reflective of our communities. We are focusing on improving recruitment and retention through a collaborative focus on strategic workforce planning and developing innovative attraction action plans to support key areas of workforce shortages. The JFP recognises the scale of the workforce challenge we face in BOB, and that a stable and resilient workforce is critical in ensuring we can deliver health and care services sustainably. The JFP therefore identifies system sustainability, including a specific focus on workforce, as one of our biggest system challenges where we will develop a long-term transformational

Oxfordshire Health and Wellbeing Priorities	Mapping to the BOB Joint Forward Plan
	approach and where greater collaboration and system working is required. It is recognised that there is already much work underway to address workforce challenges and we will continue to work with system partners to agree a way forward on building workforce stability and mobility. Within the service delivery plans, workforce is a consistent cross-cutting theme and recognised as a key enabler to delivering on our plans and ambitions. Service areas have developed specific workforce-focused plans where appropriate to ensure we have the right capability and capacity to deliver. For example, the primary care service delivery plan outlined a key focus on building GP led, integrated neighbourhood teams which will be supported by a sustainable workforce plan.

20. Additional information on how the Joint Forward Plan aligns to the ambition of the Integrated Care Strategy can be found in the JFP supporting documents.

21. There are four supporting documents with this paper:
- Appendix A – Proposed HWB Response to JFP
- Appendix B- Joint Forward Plan Summary
- Appendix C – JFP Feedback Themes and Responses
- Joint Forward Plan – **All documents and appendices**.

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Oxfordshire Health and Wellbeing Board
29th June 2023

Appendix A – Proposed Oxfordshire Health & Wellbeing Board (HWB) Response to Joint Forward Plan (JFP)

Dear Mr Bowen

I am writing on behalf of the Oxfordshire Health and Wellbeing Board to provide our formal response to the Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board's Draft Joint Forward Plan. I note we are required to comment as to "whether the draft takes proper account of the Joint health and wellbeing strategy published by the health and wellbeing board that relates to any part of the period to which the JFP relates".

Firstly, we have welcomed your regular updates at our HWB in regard to the development of the JFP and also the formation of the overarching Integrated Care System Strategy. I know that in addition to these discussions, senior Officers from the Local Authorities and our other partners organisations have worked with yourself and NHS colleagues in the formation of these documents.

Our current JHWBS states the following priority areas which we see alignment to within some specific parts of the JFP.

- Agreeing a coordinated approach to prevention and "healthy place shaping"
- Improving the resident's journey through the health and social care system (as set out in the Care Quality Commission action plan)
- Agreeing an approach to working with the public so as to re-shape and transform services locality by locality
- Agreeing plans to tackle critical workforce shortages.

We should note that our current JHWB Strategy is in the process of being updated and therefore our key priorities will be updated. We are committed to the JHWB Strategy to be the primary strategy at Place that drives our collective effort to improve residents' health and wellbeing in Oxfordshire. This will have more of a focus on the wider determinants of health - that we know drive so much of the health status of local residents - than there is within the JFP. We know action at Place can only be done in partnership and look forward to working with NHS colleagues in developing and implementing this strategy.

Councillor Liz Leffman, Chair, Oxfordshire Health and Wellbeing Board.

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Joint Forward Plan

June 2023

DRAFT – WORK IN PROGRESS

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Welcome and Foreword

We are delighted to introduce our first five-year Joint Forward Plan which details how the NHS collaboratively aims to deliver and improve our services to meet the health and wellbeing needs of people in our area.

Together, our organisations exist to improve the health and wellbeing of the people they serve. We fund, plan and deliver NHS services for the people of BOB. We want everyone who lives in our area to have the best possible start in life, live happier, healthier lives for longer, and to be able to access the right support when it is needed

Our ambition and hopes for Buckinghamshire, Oxfordshire and Berkshire West (BOB) communities were first set out in our Integrated Care Strategy, published in March 2023, based on what local organisations and communities told us was important to them.

In this Joint Forward Plan we set out our aim to further develop and improve our services to better meet the needs of our people and communities. We know that we can only do this successfully by working together, listening to our people and communities, to deliver change. However, this is not a plan just about the NHS, it is about how the NHS working with councils, charities, education, science and the voluntary sectors will combine the skills and resources to jointly improve the lives and communities of the people we serve.

This integrated approach is about recognising that all our organisations deploy different skills, expertise and resources which if used collaboratively, in a jointly planned and delivered way, will have a much greater impact on improving people's lives and community wellbeing.

In developing our Joint Forward Plan we have identified a small number of key challenges that, if addressed, we believe will have the greatest impact on ensuring our services more effectively meet the needs of people in BOB. Meeting these challenges will require long term change, working in new ways – with greater collaboration across system partners and with our communities - and will require a fundamental change in focus, from a system based on treating illness to one that prioritises prevention and keeping people healthy in their communities.

Alongside our focus on key challenge areas, we have also developed detailed service plans, setting out our ambition and plans for how we intend to develop and deliver our NHS services in BOB over the next five years, in line with our Integrated Care Strategy.

As a collective of NHS providers in BOB we will work in together and in partnership with other organisations to listen and respond to our communities. We want to know what people think of the services they experience, what their ambitions and hopes are and how we can support them. We want to understand and reflect the diversity of our populations and ensure our services are responsive to changing lifestyles and different communities' needs.

We will update our Joint Forward Plan on an annual basis, continuously reflecting on feedback from our partners and communities and developing our plans in line with the resources available to us, as we make progress in improving our services and delivering in a sustainable way for the population we serve.

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Addressing Our Biggest System Challenges 02	1. An **inequalities** challenge 2. A **model of care** challenge 3. An **experience** challenge 4. A **sustainability** challenge	A reduction in inequalities in outcomes and experience People are better supported in their communities to live healthier lives Improved accessibility of our services and elimination of long waits A sustainable model of delivery across the BOB system			
Delivering Our Strategy – Our Service Delivery Plans 03	**Promote and protect health:** Keeping people healthy and well	**Start Well:** Help all children achieve the best start in life	**Live Well:** Support people and communities live healthy and happier lives	**Age Well:** Stay healthy, independent lives for longer	**Quality and access:** Accessing the right care in the best place
	1. Inequalities 2. Prevention 3. Vaccination and Immunisations	1. Women's, maternity and neonatal services 2. Children and Adolescent Mental Health Services 3. Learning Disabilities 4. Children's Neurodiversity	1. Long Term Conditions (stroke, cardiovascular disease, diabetes, respiratory) 2. Adult Mental Health 3. Adult Neurodiversity 4. Cancer	1. Ageing well services (e.g., frailty – community multidisciplinary teams)	1. Primary care 2. Urgent and Emergency Care 3. Planned care 4. Palliative and End of Life Care
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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

01 Introduction

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1.1 Purpose of the Joint Forward Plan

What is our Joint Forward Plan and what is it for?

The **Buckinghamshire, Oxfordshire and Berkshire West (BOB)** Joint Forward Plan (JFP) describes how we intend to balance delivery of the BOB Integrated Care Strategy ambition with the national NHS commitments and recommendations, including the requirements of the 2023/24 operational plans.

This is our first JFP since the BOB Integrated Care Board (ICB) was formally established on 1 July 2022. It is an opportunity for the ICB and its partner trusts to set out how we will arrange and/or provide NHS services to meet our population's physical and mental health needs. This JFP therefore sets out our five-year comprehensive plan to improve and transform our services, whilst also recognising our most immediate priorities for the year ahead.

This plan will be updated annually before the start of each financial year. Assuring delivery of the Joint forward plan will be picked up formally through the ICB Board and relevant Board assurance committees.

This plan focuses on actions that will be delivered by the NHS in BOB (ICB, NHS Trusts, primary care, etc). As we develop as a system it is expected that future joint forward plans may reflect more fully our wider partnership activities including the role of social care, public health, voluntary and community groups.

We have worked with our partners to develop this plan, including a consultation with our five Health and Wellbeing Boards, whose opinion can be found in Appendix C.

Delivering our Integrated Care Strategy

Our vision is that ***everyone who lives in our area has the best possible start in life, lives happier, healthier lives for longer, and can access the right support when it is needed***. We are focusing on five Strategic Themes to help us achieve that vision.

In the JFP, we have considered how our services align to these themes and developed detailed plans for how we should jointly improve and transform these services over the next five years in order to deliver on our strategy.

2023/24 Operational Planning Requirements

In common with health and care services across the country, our system continues to experience a period of sustained pressure. In line with the priorities and requirements of the Operational Planning Guidance issued by NHS England, a detailed operational and financial plan has been submitted for BOB that demonstrates how we will deliver on specific priorities. It also indicates the financial pressure we continue to operate within.

Our plans for the first year of our JFP are aligned to our 23/24 Operational Plan, whilst also identifying our longer term transformation ambitions.

Delivering the JFP within our 2023/24 financial allocation

Our JFP sets a five year ambition across multiple service areas. Although our annual financial envelope across this period will be significant, we do not have clarity on our financial allocations beyond 2023/24.

The commitments included in this plan for 2023/24 are to be delivered within the constraints of the 2023/24 financial envelope. The 2023/24 JFP delivery plans and BOB operational plan ambitions have been developed together to maximise alignment.

The JFP commitments for subsequent years remain subject to our allocation being confirmed. It is recognised that these ambitions will need to be balanced with operational planning requirements yet to be specified. However, this plan is clear on the ambition to move towards a model more focused on prevention and keeping people well in their communities. We anticipate our long term financial planning to support this shift.

1.2 Our System Landscape

Our health and care landscape

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- 157 GP practices
- Over 250 care homes
- 182 dental practices
- Approx. 260 pharmacies
- 5 Healthwatch organisations
- More than 800 schools
- 5 universities
- 5 unitary / upper tier local authorities
- 5 District Councils
- 8,000 registered social enterprise organisations and estimated that there are over 5,000 informal social enterprise organisations

Our unitary / upper tier councils: Reading Borough Council; West Berkshire Council; Oxfordshire County Council; Buckinghamshire Council; Wokingham Borough Council

Population of nearly **2 million**

Approx. **68,000 staff** in health and care

50+ primary care networks

Thames Valley Cancer Alliance

NHS Oxford Health NHS Foundation Trust

NHS Berkshire Healthcare NHS Foundation Trust

2 Community and mental health trusts

NHS Royal Berkshire NHS Foundation Trust

NHS Buckinghamshire Healthcare NHS Trust

NHS Oxford University Hospitals NHS Foundation Trust

3 Acute / integrated hospital trusts

NHS South Central Ambulance Service NHS Foundation Trust

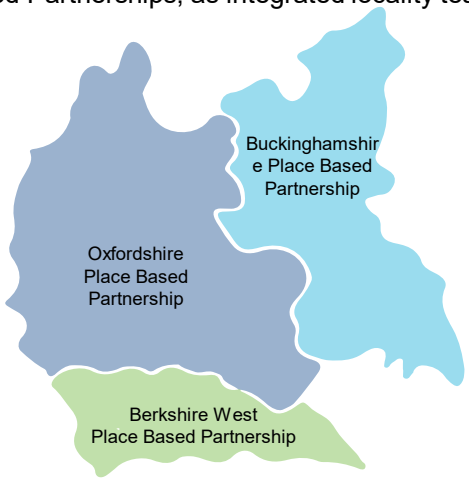
1.3 Our Place Based Partnerships

Our model for system working has thriving places at its heart. Across our ICS we want to empower, support and challenge our places to deliver for the people they serve. Decisions about the delivery of services are normally best taken close to the people who use those services. If we are to succeed in supporting people to live healthier and more independent lives, we need a nuanced understanding of the issues facing different people and communities. This Joint Forward Plan will be delivered in partnership with leaders and staff working closely with our populations at every level across the system – wide, through our Place Based Partnerships, as integrated locality teams, or extending beyond our ICS borders when that is what is needed.

Our Place Based Partnerships (PBPs)

Within BOB we have three strong and distinct Places – Buckinghamshire, Oxfordshire, and Berkshire West – that are broadly co-terminus with local authorities and the catchment for district general hospital services.

Each place is establishing a place-based partnership which will be leading delivery at a local level, driving transformation and integration, and ensuring the plan delivers improvements in outcomes and experiences for the people living in each place.



The role of PBPs in delivering local priorities

Our PBPs and their wider local arrangements can bring together system partners to deliver the outcomes that really matter to each “Place”, in support of the Joint Local Health & Wellbeing Strategies (JLHWSs).

Each place will design its own partnership, which may include local government, primary care and VCSE organisations. In BOB, we see the role of our PBPs as critical to shaping how services are delivered locally, and a maturing partnership approach across BOB will be important in how we best shape services that meet the needs of local populations. We already have a strong history of working at place-level across the BOB system, and will build on this existing strength through our new formal partnerships to ensure local priorities are delivered. We also see our PBPs as vital in driving the integration of services “on the ground”, which make a genuine difference to quality and accessibility for local people.

PBPs will focus on the following populations:

- **Children and young people** including improving school readiness, child and adolescent mental health (CAMHS), special educational needs and disability (SEND).
- **Adult mental health** and learning disability (LD) and neurodiversity (ND).
- **People with urgent care needs** including children, adults and older adults with multiple illnesses and frailty.
- **Health inequalities and prevention** including healthy lifestyles, wider determinants of health and our role as anchor institutes.

Developing our PBPs

To support the development of strong places, and based on learning and experiences from other Place-Based Partnerships, we will be reviewing progress against a number of common characteristics we want our places to have. These will be used as to help set an initial baseline and to support ongoing continuous improvement as Partnerships.

A priority for 2023/24 is to further develop our ways of working to will define how accountability and responsibly is shared between the ICB and our PBPs, supporting the principle of subsidiarity. Over the next five years we anticipate the level of delegated responsibility and budgets to our PCPs will grow as our partnership approach matures.

Health and Wellbeing Boards

Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. In BOB, we have five Health and Wellbeing Boards (HWBs) closely aligned with our Place Based Partnerships.

Each of our Health and Wellbeing Boards has developed a Joint Local Health and Wellbeing Strategy – with Wokingham, Reading and West Berkshire co-producing a single strategy covering “Berkshire West”.

1.4 Our Provider Collaboratives

Along with Place Based Partnerships, our emerging Provider Collaboratives will be central to delivery of the BOB ICS vision, recovering core services and productivity, and meeting operational planning requirements each year. These collaboratives are early in their development and we expect their roles to grow and evolve over the period of this plan.

BOB Acute Provider Collaborative

The Acute Provider Collaborative is a developing partnership between our three acute/integrated trusts: Buckinghamshire Healthcare NHS Trust, Oxford University Hospitals NHS Foundation Trust and Royal Berkshire NHS Foundation Trust.

The Collaborative is built on a set of principles that have been agreed in a Memorandum of Understanding between the three organisations.

Our Acute Provider Collaborative is committed to:

- Working openly and transparently, sharing knowledge and intelligence to inform aligned solutions where appropriate and possible to do so.
- Being informed by the health needs of the population of BOB ICS, work together where there is opportunity to reduce health inequalities and improve equity of access.
- Supporting the exploration and identification of mitigations to service or performance challenges, where working together will improve delivery outcomes.
- Reducing costs by doing things once across the three Parties where possible.
- Encouraging improved recruitment and retention within the system through the exploration, alignment and adoption of innovative staffing models.

In 2023/204, the Acute Provider Collaborative will deliver on the following priorities, aligned with the strategic themes and enablers of our Joint Forward Plan Base.

- Quality and access – Deliver the **Elective Care Recovery Programme** for 2023/24 and meet the target of **eliminating 65 week waits,** on the way to eliminating 52 week waits, and embedding the diagnostics strategy.
- Digital and data – Support **digitisation and alignment** between the three acute providers and the **procurement of an EPR system for Buckinghamshire Healthcare NHS Trust.**
- Finance – Work with the ICB **to identify and deliver efficiency opportunities for 2023/24.**

BOB Mental Health Provider Collaborative

The mental health provider collaborative is between Oxford Health NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust. Our aim is to improve the mental health of our population by leading a transformation approach of mental health services at scale, linking with and supporting the work of our Place-Based Partnerships. Our first areas of focus for transformation will be:

- Children and Adolescent Mental Health Services – where we can build on the collective work done to date to tackle system wide challenges.
- Addressing health inequalities, in line with the Advancing Mental Health Equalities Strategy. This includes improving the use of data and insights to strengthen our equalities strategy at scale and a focus on workforce transformation.
- Embedding a culture of quality improvement. We will use the Provider Collaborative as a way to learn from each other and scale best-practice across both of our trusts, engaging with the ICB to embed learnings from quality improvement work at system level.
- Engagement work with our clinicians, people with lived experience of mental health services and wider stakeholders will help us identify further priorities for our collaborative.

It is recognised that as individual organisations we may not be able to achieve our ambitions and the scale of transformation we require. Our BOB mental health provider collaborative will therefore enable us to systematise joint working for the benefit of our population.

Our collaborative has recently been selected as one of the national “Provider Collaborative Innovators” in recognition of the importance of developing our joint ways of working. Through this scheme, we will work closely with NHS England who will provide support to accelerate the benefits in the quality and efficiency of patient care across our populations.

Developing our Provider Collaboratives

Throughout 2023/24 we will continue to develop our approach to joint system working through the Provider Collaboratives, including the establishment of proportionate governance and agreement of our strategic priorities for the next five years.

1.5 Our Wider Partnerships

Our Clinical Networks

Across BOB we have many thriving and active networks that bring together clinicians and managers from across our system to collaborate around clinical areas and pathways, to deliver on priorities, identify and address variation, share best practice and enable integrated, high quality and patient-centred care.

Through our networks we deliver more consistent approaches to care, address health inequalities, plan for and address the increase in demand for services, and enable effective working across organisational boundaries.

Our Clinical Networks demonstrate some of the most effective models of partnership in BOB and are critical in implementing new ways of working, providing strong clinical leadership and supporting digital and innovative transformations.

Voluntary, Community and Social Enterprise

The Voluntary, Community and Social Enterprise (VCSE) sector is an important system partner made up of more than 8000 organisations and community groups anchored in counties, districts, towns, villages and neighbourhoods across Buckinghamshire, Oxfordshire and Berkshire West.

The BOB VCSE Health Alliance promotes the value of voluntary and community action and service provision in improving population health, tackling inequalities and advancing social and economic development.

The Alliance will enable the collective voice and experience of the VCSE continuously to shape the integrated care system as it is develops. BOB ICB and the Alliance are working towards a partnership agreement that will set our shared values and our practical expectations of one another as system partners.

Our communities

Our vision and priorities are focused on improving the health and wellbeing of everyone in our area. To do this, we know we need to work closely with the people who live and work in our area, listen to their voices and involve them in our planning.

In developing our Integrated Care Strategy, we asked people for their thoughts on our emerging priorities and used this feedback to shape our key areas of focus. However, we recognise this dialogue needs to continue and our engagement needs to move beyond simply asking people for their views.

We need to form a genuine partnership between the public and our broad community of providers. It is the people who live and work in our communities who can provide us with the best insight into what needs to change and the best ways to deliver those changes. Most of our engagement will be at 'place' level. – leveraging the value of our Place Based Partnerships. Local areas will use and develop their own methodologies for embedding the voice of residents in their decision making. We have shared the Joint Forward Plan with the BOB community and conducted some discussion groups to engage with individuals. Through these discussion groups, we have received feedback from the public on specific Service Delivery Plans, key JFP themes and how we can improve as a system.

At a system level we will be held to account by a Joint Health and Overview Scrutiny Committee representing the voices of people from across Buckinghamshire, Oxfordshire and Berkshire West.

We also need to empower individuals and communities to manage and promote their own health and wellbeing. Therefore, we have a critical focus on prevention throughout our Joint Forward Plan, as well as specific plans on personalised care. In co-designing our services with our communities, we need to ensure that everyone is included. We are committed to finding new and creative ways to engage with, and empower, people from every part of our community so that no group or individual is left out.

Our broader social and economic contribution

We recognise that health and care organisations can play a vital role in improving the health and wellbeing of their local communities through their role as "anchor institutions". Anchor institutions are large organisations that are unlikely to relocate and have a significant stake in their local area. Across the BOB area there are many public, private and voluntary sector organisations that hold a significant interest in the long-term development and health of their local areas (Kings Fund 2021).

As we develop our plans and our ways of working in partnership, we will more proactively design and plan how we can maximise the broader social and economic contribution we make to our local area. This may include:

- Considering where we locate our services and the impact this may have on other services – for example helping drive increased footfall to local high streets
- How we can better offer employment opportunities to marginalised groups – for example ex-offenders.

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

02

Addressing Our Biggest System Challenges

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2.1 Understanding Our Population's Health Needs

Understanding our population, their health needs and recognising inequalities

Our population's health needs are increasing

People living in our area are generally healthier and live longer lives in good health than the national average. However:

- **Our population experiences unacceptable variation** in access, experience of services and health outcomes. c.60,000 people in BOB live in an area that is in the bottom 20% of areas nationally as defined by deprivation. Other populations with other characteristics (including sex, ethnicity or disability), also experience inequalities
- **Our population is getting bigger:** The BOB population is expected to increase by 5% over the next 20 years through natural growth. Additionally, new housing developments planned across our area will further increase our population size.
- **Our population is getting older**: The number of people aged over 65 is expected to increase by 11% over the next 5 years and increase by 37% by 2042.
- **Our population is suffering with more long-term conditions:** more than one in four of the adult population live with more than two long term conditions. People with multiple conditions are more likely have poorer health.

Collectively this changing demand is putting increased pressure on all our services and resources. The challenges are complex and require a multi-faceted approach to address them.

Our Demographics	Our Population Health		
Our overall population size is anticipated to grow by 5% by 2042, over the same period the number of **people aged over 65 is expected to increase by 37%**	**Start Well**	Around **1 in 5 children** in Reception and **1 in 3 children in Year 6** are **overweight or obese**.	Around **50% of children** are **not meeting the recommended levels of physical activity** across BOB.	Numbers of mental health referrals for young people are increasing. **24% of secondary children** have **reported previously deliberately self-harming.**
People **tend to live in good health above the national average** across BOB. Apart from in Reading where women spend fewer years in good health	**Live Well**	**13% of residents in our area smoke** according to GP data but this varies significantly between our least and most deprived areas.	Across BOB, **3 in 5 adults are overweight or obese**. 68% of adults with a learning disability are overweight.	Around **12% of adults have a recorded diagnosis of depression** and 0.8% have a severe mental illness.
People in more deprived areas **develop poor health 10-15 years earlier** than people living in less deprived areas				
People who identify as white British make up **73% of residents**. Although this differs from 53% in Reading to 85% in West Berkshire.	**Age Well**	Estimated **60% of people over 60 have one or more long term conditions**.	Nearly **1 in 15 people aged over 75 say they always or often feel lonely**	A **person's risk of developing dementia** rises from one in 14 over the age of 65, to **one in six over the age of 80.**

2.2 Understanding Our Population's Experience

Citizen Experience Research

As well as understanding our population demographics and health needs, it is important for us to know what people in BOB think about their experience of our services. KPMG's UK Citizen Experience Excellence Research 2022 analysed the experience of services for over 10,000 people in the UK across multiple industries, which included 8,746 UK responses relating to people's experience of the NHS. This included 1,284 responses specific to the South-East region.

That research highlighted two areas in particular that influence people's experience of NHS services across the South-East:

- **Ease of accessibility of core services** – with feedback particularly relating to difficulties making GP appointments
- **Long and memorable wait times** – including how well people are communicated with and kept informed when they experience long waits for services.

Public Engagement on the Integrated Care Strategy

Correspondingly, as part of the public engagement on the BOB Integrated Care Strategy, the priority ranked as most important to the respondents was 'Improving quality and access to services'.

However, it is recognised that people using our services have other valued perspectives that go beyond access.

In developing our system JFP and designing our services for the future, it is critical that we recognise what matters most to people in BOB. Our plans must address and prioritise the issues that have the most significant impact on the experience of the population we serve.

Core Services are not easy to access

Citizens are finding it increasingly challenging to book GP appointments and access other core NHS services. There are clear issues with communications, in particular when phone lines are constantly busy, and citizens are unable to speak to the operator.

36% of people in the South East said that services were not easily accessible, which is **3%** above the national NHS average.

Memorable wait times are defining citizen experiences

Growing waiting lists for NHS treatments coupled with long waiting times to be seen and mismanagement of wait time expectations, are causing inconvenience and discomfort for citizens to such an extent, that the time spent waiting is more memorable than the health outcome of their appointment. In some circumstances, the citizen has been left with no option than to get private healthcare.

40% of people in the South East said they were not proactively informed and kept up to date, which is **4%** above the national NHS average.

National Themes for the NHS

- Digital service are not 'seamless' driving resistance to use
- Core services are not easy to access
- There is a frustration at the lack of continuity
- A shift in expectations and behaviours
- Outstanding frontline staff (and vaccine roll out)
- Memorable witing times are defining citizen experiences
- A lack of trust in 'under qualified' healthcare staff
- Virtual interactions are seen as inferior to face to face

2.3 Understanding Our Performance

Recovering Performance from the impact of Covid-19

In BOB, as in the rest of the country, we are still feeling the effects of the pandemic. We have seen waiting lists for planned care rise, increasing demand for both primary care and urgent and emergency care services, and the negative impact this is having on patient Length of Stay as well as on our workforce. Therefore, a core focus for the year-ahead remains on recovery – ensuring our services are at least getting back towards pre-Covid levels – whilst also recognising we need to continue transforming our health services to ensure they are fit for the future.

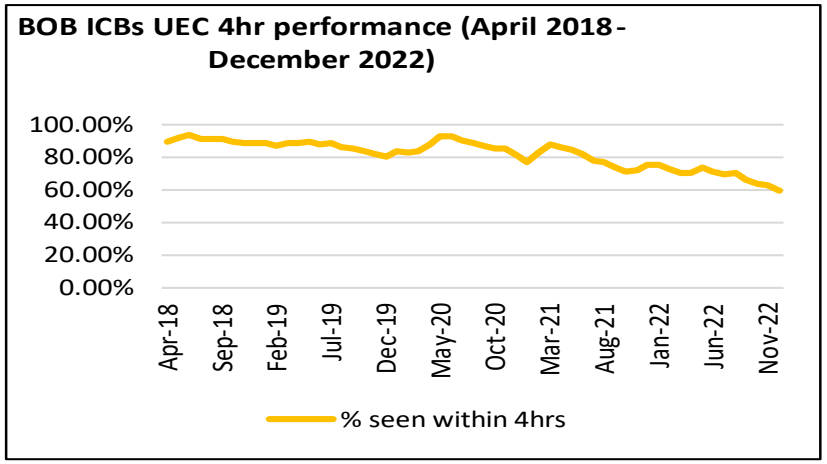
In the context of this focus on recovery, it is important we fully recognise the current challenges we face. This section outlines some of our key performance challenges across Urgent and Emergency Care, Planned Care, Primary Care and Mental Health services, alongside some of our critical workforce and financial sustainability issues.

Urgent and Emergency Care

Urgent and Emergency Care (UEC) continues to be under severe pressure nationally with record demand for NHS services.

Accident and Emergency 4 hour Performance

Although performance has seen an improvement from performance pressures in December and January, our system remain under pressure. BOB delivered 68.9% against the 4hr standard in M12. This is below the regional average of 75.9% and national average of 71.5%



Ambulance Handovers delays:

Throughout 2022/23 the number and length of handover delays has been a challenge with significant seasonal variation through the year. An improvement was seen in all providers in Q4.

No Criteria To Reside

Patients are staying in hospital longer than required. Once people no longer need hospital care, they should be discharged to their home or community setting more appropriate for their care needs – although delays can be experienced due to, for example, the availability of community support. Week commencing 16th April 2023 the BOB system had 394 people in acute beds who did not meet the criteria to reside – increasing cost and operational pressures

Urgent Care Centres

Through 2022/3, two new Urgent Care Centres opened across BOB in response to increasing demand. The number of patients using these services has increased as the centres have become more established.

Virtual Wards:

To help manage demand and support patients across BOB, an increasing number of virtual ward beds have been established over the course of 2022/23 – with approximately 300 beds available at the end of 2022/23. This growing capacity has been consistently utilised at over 80%

Urgent Community Response

Our UCR teams continue to perform well consistently achieving 2 hour response target. However the volumes of referrals, particularly from 111, primary care and care homes, remains very high.

We recognise the impact this pressure has on our patients and the population we serve, as people often have to wait longer for the support they need. This is clearly unsustainable and requires a system wide response to ensure improvements are made

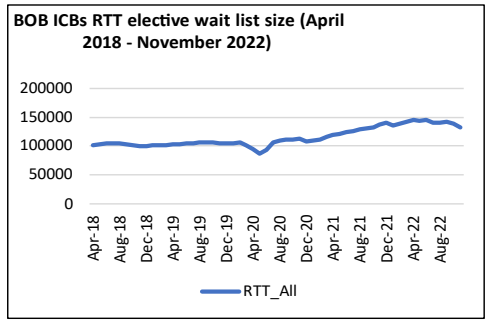
2.3 Understanding Our Performance (cont.)

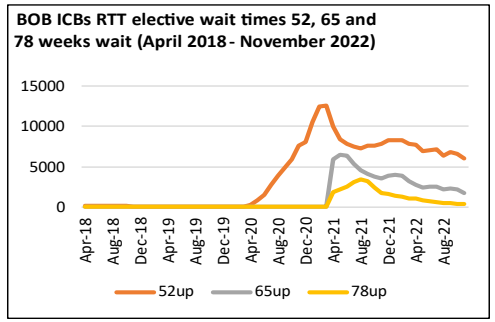
Planned Care

The COVID-19 pandemic has had a significant impact on the delivery of elective care. Our patients are now waiting longer for treatment than they were before the pandemic began.

Waiting times for planned treatment

The overall size of our waiting list across BOB increased significantly as a result of Covid. In April 2018, our overall elective waiting list was around 10,000, which grew to around 15,000 by April 2022 before starting to fall. Steady progress has been made to reduce the number of patients waiting the longest, but the overall waiting list remains significant.





Cancer

The number of patients waiting more than 62 days for treatment has increased in 22/23 across all providers in BOB. There is variation across the three sites and links to challenges with diagnostic capacity.

Productivity

The elective activity levels remain below the levels achieved in the 19/20 (pre-pandemic) position.

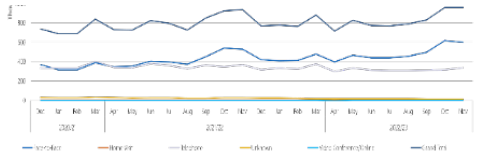
Diagnostics

Overall numbers of patients waiting for a diagnostic test increased in 22/23. Area of greatest pressure in Q4 related to endoscopy with notable variation between providers. Pressures resulted from a shortage of diagnostic resources (e.g., equipment and facilities).

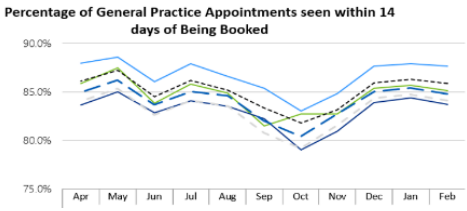
Primary Care

It is important for people in BOB to be able to see their GP quickly, and access other primary care services such as dentists and pharmacists, when they need to. We know that when people cannot access these services promptly, they are more likely to rely on other services that are already under significant pressure.

A steady increase in GP appointments across BOB



Demand for primary care services remains extremely high, notably during winter 2022.
The ICB has been working to increase capacity in general practice, including an additional 2000 sessions of clinical time and additional capacity in acute respiratory infection 'hubs'.
Whilst we have seen a steady increase in the number of appointments we offer, we have struggled to keep pace with increasing demand and therefore make a sustained improvement in the percentage of GP appointments seen within 14 days of being booked.



There remain a number of specific issues impacting Primary Care that show our current model in BOB is unsustainable:

- Patient satisfaction with Primary Care services is falling. Less than 6 in 10 people in BOB described the experience of making an appointment as good in the 2022 GP patient survey.
- NHS dental care across BOB is becoming increasingly difficult to access. We have seen an increase in unplanned closures of community pharmacies, meaning access to this vital enabler of self-care is reduced.
- GPs report it is harder to balance caring for people with non-urgent, long-term needs with the pressures from people who want urgent, same day support.
- Staff burnout and absences have added to capacity constraints across the whole primary care workforce in spite of the employment of additional, non-GP roles.
- Demand for care and associated expectations from the patient are rising. In BOB 3% of a practices population will typically call them each day, 69% in a month (January 2023).

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.3 Understanding Our Performance (cont.)

Mental Health

There are capacity challenges impacting the services we provide to our patient suffering mental ill health. These are a reflection of pressure across all our MH pathways, not just with the acute and community services delivered by our providers.

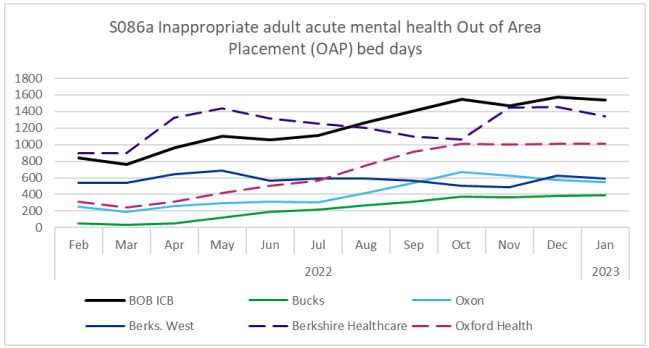
Talking therapies

Across BOB we perform at slightly below the national standard (6.5%) with some variation across our places and across population groups (including ethnicity).Waiting times for treatment are better than national targets

Out of Area placements

The number of inappropriate out of area bed days increased over the 12 months to Dec 22.

This is a direct indication of capacity Constraints in the system.



Children's eating disorder services

Although showing an improving trend the access times for eating disorders services remain below the national target level for both urgent and routine support

Health checks for people with severe mental illness (SMI)

Across BOB an improved position has been observed (Dec 22) but remains under the national standard

2.4 Understanding our Sustainability – Finance

The ability of our system to meet the biggest challenges we face relies on us having a sustainable delivery model. This means being on a sound financial footing that will allow us to invest in the things that deliver the greatest benefit to the experience, access and outcomes for our population. It also means having a stable and resilient workforce, with enough staff working in the right ways to deliver and improve our services.

We are currently forecasting a financial deficit position for 2023/24. Our underlying deficit was previously explored before the impact of Covid – a number of themes were identified which were deemed to represent the drivers of our system deficit. Whilst the impact of Covid has resulted in additional pressures, these original negative impactors remain valid and, combined with more recent influences upon our resources, represent areas of opportunity against which we are designing current and future productivity initiatives to address.

Pre-Covid identified drivers of underlying deficit

Structural (57% of underlying ICS deficit pre-Covid)

- Higher costs associated with PFI and LIFT contracts;
- Relative CCG underfunding (using distance from target)

Strategic (21% of underlying ICS deficit pre-Covid)

- Potential sub scale and services commissioned which are costly
- Higher than average primary care funding
- High Non-Elective activity impacting Elective activity
- Community/mental health costs higher than average

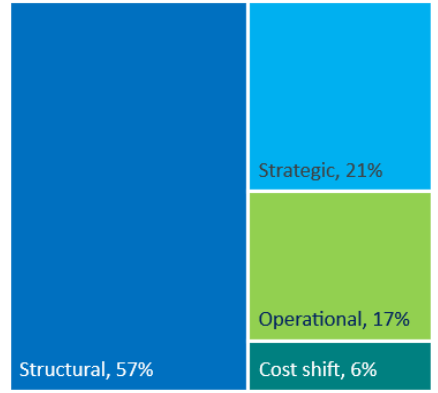
Strategic (21% of underlying ICS deficit pre-Covid)

- Higher relative costs than peers (NCCI)
- Loss making JV and contracts
- High temporary staffing costs
- Estate cost pressures (particularly backlog impact)
- Support function and procurement

Cost shifts

- Lower relative funding of acute services (Berks W CCG)

Pre-Covid drivers of deficit by theme



Post-Covid drivers of underlying deficit

Whilst the ICS has not yet updated the drivers of deficit analysis post-Covid (and post CCG merger into a single ICS), a number of new adverse drivers noted include the following:

- Increased costs of prescribing and CHC care at ICB level and out of area placements;
- Increased use of temporary staff needed to deliver increased activity despite increased sickness and turnover, further impacted by increased locum/agency rates;
- Planned system wide efficiency target of £22m not delivered; and
- Planned efficiencies across the system are behind plan (55% delivered against plan YTD @ M10).

The above is reflective of an increase in non-elective and urgent and emergency care demand across the ICS, an increasing acuity and challenges of discharging patients with no criteria to reside across our system pathways. Along with the requirement to deliver increased elective care and reduce waiting lists and pressures upon available staffing resource, costs have increased.

Addressing the underlying deficit

Recognising the need to retain exceptional care to our patients, whilst seeking to maximise our use of resources, the ICS is exploring ways to improve productivity across all providers, maximising the value of each pound spent and underpinning the ability to recover underlying financial position in pursuit of financial sustainability.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

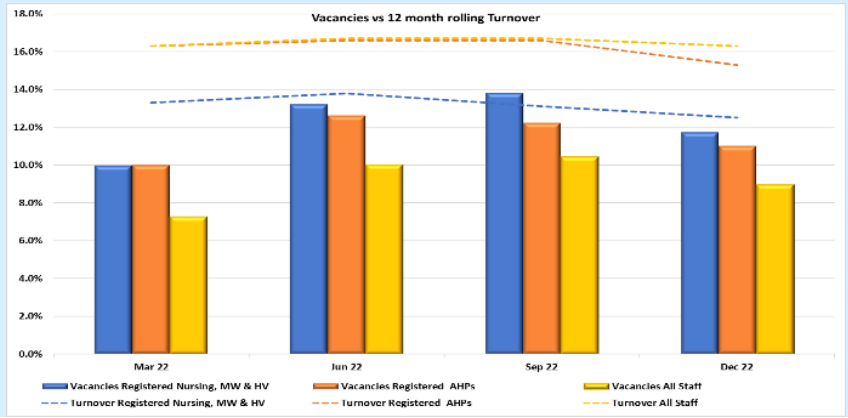
2.4 Understanding our Sustainability – Workforce and Environmental

Our sustainability as a system is not driven only by our financial position and performance. To operate as a sustainable system, we also need to have a resilient workforce with the right number of staff working in the right ways, and we need to ensure we can meet our environmental commitments.

Our Workforce

Our Health and Care landscape has changed significantly following the Covid-19 pandemic. 2 years on, our NHS Providers in BOB and their workforces are still navigating new ways of working, as well as needing to adapt to changing circumstances in their personal life. We are seeing burnout, low levels of job satisfaction and concern over health and wellbeing being cited as reasons why staff are leaving the NHS for other types of work.

Recruitment and retention challenges are being felt in many areas, including nursing and midwifery. Pressures are also being felt in many other areas across the health and care system, particularly in primary care and the ambulance service. In addition, a proportion of our current workforce either returned to practice or delayed retirement to support our response to the pandemic. There is a risk that many of these will now choose to leave our health and care system and with the increased pressure on our entire workforce there is a risk of further loss.



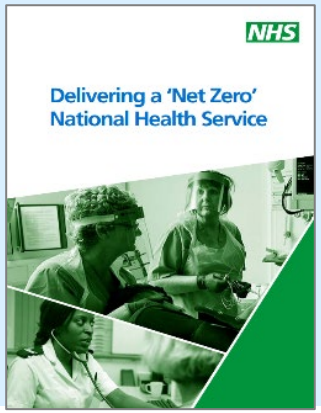
Our Net Zero Commitments

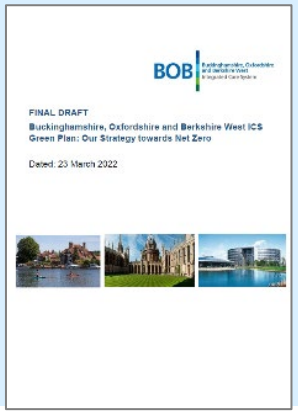
Identifying a route to net zero emissions for a complex system as large as the NHS is particularly challenging. To understand how and when the NHS can reach net zero, NHS England established an NHS Net Zero Expert Panel, reviewed nearly 600 pieces of evidence submitted to NHSE and they conducted extensive analysis and modelling.

Nationally, the aim is to be the world's first net zero national health service.

- For the emissions the NHS control directly (the NHS Carbon Footprint), the NHS will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions the NHS influence (our NHS Carbon Footprint Plus), the NHS will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

BOB is committed to playing its part in delivering on these national ambitions. In BOB each NHS organisation has an ambition to achieve Net Zero and a plan to deliver these changes.





Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Biggest System Challenges

As a system, we have a comprehensive understanding of:

- Our population demographics
- Our population health trends
- People's experience of our services, and
- How our services are currently performing

Through analysis of these areas, it is clear we have a number of key challenges that have a significant impact on people in BOB's access, experience and outcomes. In particular, we have identified

1. An **inequalities** challenge
2. A **model of care** challenge
3. An **experience** challenge
4. A **sustainability** challenge

These challenges will require us to work in new and different ways to address them effectively. They will require greater collaboration across the system, we can harness the knowledge and expertise of all our system partners and the academic research conducted in each partner organisation. The challenges will require a long-term focus and will need us to be innovative and ambitious in how we respond.

	Our Biggest System Challenges	The Outcomes We Want To Achieve	Aligning to the BOB Integrated Care Strategy
An inequalities challenge	1. People in certain communities and demographic groups in BOB have **much worse health outcomes and experience**	**Reduction in inequality of access, experience and outcomes** across our population and communities	**Promote and Protect health**
A **model of care** challenge	2. We have an **ageing population in BOB and more people living with long term conditions**, who will be increasingly poorly served by an acute-focused model of care	People are supported to **live healthier lives for longer in their communities**	**Start, Live and Age well**
An **experience** challenge	3. People in BOB tell us their **experience of using our services has deteriorated** – driven primarily by long waits and difficulty accessing services	**Improve accessibility of our services and eliminate long waits** to improve citizen experience.	**Improving quality and access to services**
A **sustainability** challenge	4. We have **a large forecast financial deficit** across our system with **significant workforce gaps**, which is likely to get worse without change	A sustainable model of care in BOB – achieving **financial balance** with a **stable, resilient workforce**	

2.6 Developing Our System Response

"This is your day to develop your JFP for the NHS …
and to look at how we can work together to provide better healthcare for all in BOB."

Steve McManus
Stephen Chandler
24 March 2023

Recognising the need to work differently to address our biggest challenges, **we brought a wide range of partners** from the NHS VCSE sector, local authorities, patient representatives and Academic Health Science Network on 24 March 2023 in a first-of-its-kind event for our system, **to agree our shared ambitions, consider the biggest challenges we face and how we should respond**. The event was co-sponsored by Steve McManus, Interim Chief Executive, BOB ICB, and Stephen Chandler, Director of People, Oxfordshire County Council, and Local Authority representative on the ICB Board.

Our work on the 24 March has allowed us to start to build consensus and develop new ideas about some of the big things we want to prioritise as a system to address our most significant challenges. While we recognise these won't answer everything, they have provided a foundation to help us shape more detailed plans and options for our "must do" actions for next year. Through the event relationships were strengthened across system partners to drive these forward. Further work is now needed with system partners to scope, evaluate and quantify the benefit of proposed interventions.

A number of key principles were identified through our work together to shape how we address some of our biggest system challenges:

1/ A commitment to doing things differently
Our biggest system challenges require a system response, and we recognise that doing "more of the same" will not deliver the transformational change to achieve the outcomes we want. We are therefore committed to being bold and innovative in delivering our goals.

2/ System coordination with local delivery
Critical programmes of work will be coordinated at system level but the actions needed to deliver will likely be delegated to Place Boards, Provider Collaborative forums and individual organisations to allow for local flexibility where that is noted as being of benefit.

3/ Prioritising our resources to communities with greatest need
We will use data and evidence to understand and evaluate the actions that will have significant impact in delivering our outcome goals – and we will focus our resources on those communities in greatest need.

4/ Clarity on what success looks like – in the short and longer term
We have identified high level outcome measures for each of our biggest challenges – but as we develop more detailed plans it will be necessary to confirm specific outcomes to be achieved for each intervention proposed.

5/ Utilising existing governance structures to make it happen
Where possible, we will maximise the opportunity to "plug in" to existing system governance arrangements to oversee and drive forward our proposed actions, ensuring we build on and enhance existing plans and we do not duplicate effort or add to any administrative burden.

6/ The importance of working together
The single most consistent feedback across partners from our system workshop on 24 March was simply: We must work more closely together and collaborate to deliver the best outcomes for the people of BOB.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.7. Addressing our Inequalities Challenge

Outcome goal: Reduction in inequality of access, experience and outcomes across our population and communities

Where are we now and what action are we already taking?

Across our BOB partnerships, there are already numerous examples of collaborations focussed on reducing inequalities in access, experience and outcomes. Reducing these inequalities is a central ambition of our partnership as set out in the BOB Integrated Care Strategy. In 2023/24 we have activity planned that will accelerate and grow our support to people and communities with greatest needs. These activities include:

- ***Increased investment for place based initiatives*** – A £4 million new annual investment for 23/24 & 24/25 will be directed towards populations who face the largest health inequalities in access, experience, and outcomes. The funding, devolved to Place, will focus on key ill health prevention reflecting local needs and includes:
  - ✓ Reducing premature mortality though **community outreach programmes** in Berkshire West with local, targeted actions including increasing health checks, BP monitoring and promoting 'active medicine'
  - ✓ Supporting Buckinghamshire's **Opportunity Bucks** programme targeting the 10 most deprived areas in Bucks – actions including health checks for people with severe mental illness, preconception and maternity support for highest risk ethnic communities,
  - ✓ In Oxfordshire supporting specific communities including people who are **homeless**, building partnerships and **increasing community capacity** with VCSE and local partners to deliver local core20plus5 initiatives.
- ***Core20Plus5*** – an ongoing focus on the priorities identified through our core20plus5 analysis. For example: smoking cessation – Further investment of £835,000 in Tobacco Advisory Services in acute in-patient, maternity and mental health inpatient

We have places where Population Health Management is working successfully already on a small scale (for example, in the Reading West PCN and Banbury Cross Health Centre). We are improving our understanding and outcomes in relation to people with diabetes in our Nepalese community and our most deprived housebound patients. Further detail on these plans are available in the relevant service delivery plans.

Service Plans Reference:

Tackling inequalities is a theme running through all delivery plans. Most actions included in:

- Inequalities & Prevention
- CYP and Adult Mental Health
- Maternity and Neonatal
- Long Term Conditions
- Personalised care

Our longer term transformation approach – Unlocking population health management

We recognise that a more consistent approach to identifying and addressing inequality challenges will be significantly strengthened through the development of a robust approach to **population health management**. Although we have examples across BOB where PHM is used to make decisions, this could be strengthened and spread across the system. We commit to progressing this in 23/24 through the following actions: :

- Create an **integrated data set** across our providers, with data available for analysis to identify opportunities for targeting support to communities and people in BOB
- Establish the right **analytical capability and decision making infrastructure** to clearly understand where the areas of greatest inequalities exist and analyse the causes
- Utilise the Population Health data and analysis to **target activity** in the areas which have the greatest need and where the most impact will be made, with initial rollout in targeted clinical areas.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Form an ICS Data Leadership and Governance Group with clinician and patient input. • Completed stock-take of data sets, collection and reporting	• Define and establish Centre of Excellence for Data including learning and community of practise. • ICS Data Charter established.	• Build a team that can work with local teams and produce proof of value analysis. • Agree shared responsibility between ICS and local system functions	• Finalise development of a common ICS data architecture. • Embed culture of data driven transformation is embedded as part of PHM approach.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.8. Addressing our Model of Care Challenge

Outcome goal: People are supported to live healthier lives for longer in their communities

Where are we now and what action are we already taking?

As a system, we recognise that we need to shift to a more **preventative and community-based approach** for health and care services, that better meets the needs of the different populations we serve. We have a range of initiatives already in place to change the way we deliver our care and services in BOB. In 2023/24 we will build on these programmes, setting the foundation for longer term transition. Our activity includes:

- ***Earlier identification for those with Long Term Conditions*** – we will empower individuals to manage their own health and wellbeing, in particular where they have Long Term Conditions (LTCs). For example – cardiovascular disease is one of the most common causes of deaths in BOB and a major contributor to the gap in life expectancy between people living in our most and least deprived areas. Our plans include some important actions for 2023/24, including:
  - ✓ Better identification and control of Blood Pressure and Cholesterol in primary care
  - ✓ CVD Champions in Primary Care Networks to help deliver CVD prevention and improve community links
  - ✓ Extend delivery of NHS health checks in settings outside of primary care such as places of work and non-health care settings
  - ✓ Deliver consistent messaging around lifestyle changes by increasing the number of staff confidently utilising "Making Every Contact Count
- ***Increase the ARRS roles*** across the whole of the BOB system – promoting multi-professional partnership working to support our people in our communities, building resilience to pressures and helping people navigate to the right care in the best place (incl. pharmacy, social prescribing, etc.)

People who live in BOB are critical partners in shaping the model of care that we need as a system and we will involve our communities in co-designing our strategies and services, ensuring no individual or group is left out.

Service Plans Reference:

- Live Well and Age Well Service Plans
- Inequalities & Prevention
- Primary Care
- Planned Care
- Urgent and Emergency Care

Our longer term transformation approach – An integrated approach to primary care

To support people better in their communities we need to materially change the way our primary and community care services operate across the system. In 2023/24 we are therefore committed to developing a **Primary Care Strategy** to confirm how we can develop our primary care services in particular to support a more community-focussed model of care that better meets the needs of our population, balancing continuity of care with same day access where needed.

Through the Primary Care Strategy, and in response to the Fuller review, we anticipate the focus of our delivery in 2023/24 to be:

- **Prevention** – in target areas identified through PHM approach (based on Core20PLUS5), focus on growing and fully utilising new roles like social prescribing link workers
- **Access** – begin to implement a new approach to delivering same-day primary care appointments, both virtual and face to face
- **Continuity –** pilot integrated neighbourhood teams, with a first priority focus on target areas identified through Core20PLUS5 PHM approach.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Current state analysis, highlighting underlying gaps in data, technology and service provision for Primary Care. • Identify & accelerate opportunities for integrated neighbourhood team rollout (incl. piloting models for different communities)	• Stakeholder engagement to agree Primary Care vision • Co-design ways of working for Primary Care in BOB – looking at challenges of workforce, digital, and opportunities for strengthening partnerships.	• Commence detailed planning and implementation of new ways of working – focusing on the core areas of focus from the Fuller Stocktake – Access, Continuity and Prevention.	• Publish a Primary Care Strategy with a 5-year roadmap, incl costs and implementation plan • Confirm timetable for change and start to implement the action plan

2.9. Addressing our Experience Challenge

Outcome goal: Ensuring people can access high quality care and support at the right time and in a place they can get to

Where are we now and what action are we already taking?

As a system we continue to experience significant issues with long waits and accessibility of services that negatively impacts the experience of people and communities in BOB. This is the case across many of our services including elective care, primary care and mental health. We do, however, already have a range of key initiatives in place aimed at delivering material improvements for the population we serve, and indeed in several areas have already started to see significant progress. Key interventions that will further develop over 2023/24, that are built into our service plans, include:

- **Achieving a maximum 65 week waits** – Although a very long wait this evidences an ongoing improvement in the BOB position. The system wide Elective Care Board will oversee the delivery of collaborative system working to improve patient experience, reduce waits and to deliver more sustainable for those specialties with the longest waits and highest volumes
- **Increase diagnostic capacity –** Further capacity will be developed in our **Community Diagnostics Centres**. In line with national guidance, we will increase activity levels by a minimum of 120% of pre-pandemic levels across 2023/24 and 2024/25 to support the recovery of performance to 95% of patients being treated within 6 weeks by March 2025
- Within Primary Care, we will introduce a new **demand and capacity tool in every practice** helping to understand appointment capacity and flexibility across the region and for each practice to make decision about required capacity.

Service Plans Reference:

- Urgent and Emergency Care
- Planned Care
- Primary Care
- CYP Mental Health
- Adult Mental Health
- Cancer
- Prevention and Inequalities

Our longer term transformation approach

Whilst we are already making some progress in improving the experience of people in BOB – for example by reducing the size of our waiting lists and eliminating some of our very long waits – we know we need a more transformational approach in the longer term to improve how people experience our services in BOB. To achieve our longer term ambitions, in 2023/24 we will focus on:

- Developing a better and more complete **understanding of demand and capacity** across the system – facilitated through development of the right tools and data
- Using this understanding to make targeted **pathway-specific improvements through the Elective Care Board and Acute Provider Collaborative**, where we know they will have the greatest impact on improving waiting times and accessibility (e.g. ENT, Urology, Outpatients, Theatres), to improve patient experience and outcomes, requiring collaborative work between providers.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Define demand and capacity problem statement • Agree with clinical and pathway leads priority areas for analysis and focus • Understand existing data landscape across system partners	• Baselining current capacity levels across BOB • Assessment of available resources and how to deploy • Evaluation and decision on tools, methodology.	• Refinement of analysis to ensure comprehensive capture of system level capacity	• Analysis of system interventions to determine likely impact • Utilisation of strategic planning tool to inform flexible use of system capacity, plan development and prioritisation

2.10. Addressing our Sustainability Challenge – Workforce

Outcome goal: A sustainable model of delivery in BOB – achieving financial balance with a stable and resilient workforce

Where are we now and what action are we already taking?

In response to the workforce challenges we face in BOB, we have a number of key activities already underway that will continue over 2023/24, including:

- Scoping of the potential benefits that may be delivered through a system-wide **recruitment and retention hub**
- Commissioning research on the **cost-of-living crisis**, how this is impacting our workforce, and the effect on recruitment and retention of our staff to confirm most effective support interventions for our staff
- Rollout of **Kindness, Civility and Respect** training for all staff across NHS partners to improve staff experience and wellbeing
- Established a **Temporary Staffing Programme Board** responsible for overseeing use of agency and bank staff and optimise use of temporary staffing across system partners
- **System Inclusion Group** set up to identify and share best practice and support across system partners on Equality, Diversity and Inclusion.

Service Plans Reference:

- Workforce

Our longer term transformation approach – Co-creating a BOB 5-year People Plan

We will develop a five-year People Plan for the Integrated Care System setting out our ambitions for our 'one workforce' which includes those working health, social care, the voluntary, community and social enterprise (VCSE) sector, and unpaid carers.

The plan development will be overseen by BOB ICB's People Committee.

The People Plan will define our system's transformational approach to addressing our workforce challenges – including key areas such as staff experience and wellbeing, use of voluntary and community workers, sharing best practice, career pathways, role design, and staff retention.

As part of our People Plan, in 2023/24 we anticipate the focus of delivery to be:

- Targeted work on the **cost-of-living crisis** – influenced by the research currently underway- and what we can do differently to attract, support and retain our workforce despite these challenges.
- Working with system partners to agree way forward on building workforce stability and mobility across the system through collaborative models of resourcing including establishing a **system-wide recruitment & retention hub**
- Strengthening **staff engagement, experience and wellbeing** (e.g. through flexible working project task and finish group, strengthening of staff networks) to build workforce resilience across the system and optimise collaborative delivery arrangements of occupational health and psychological support services between providers in the ICS.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Build comprehensive understanding across system partners to understand key workforce issues- e.g. through hosting a Q1 Education Summit • Develop comprehensive workforce intelligence to support appropriate targeting of interventions.	• Undertake a deep dive into the barriers for successful recruitment campaigns • Build volunteer and reserve capacity. • Develop and expand apprenticeships. • Focus on our flexible working offer with the aim of increasing availability	• Develop our full People Plan collaboratively with leaders and people across BOB's health and care system. • Deep dive into the differences of terms and conditions across the BOB health and care sector, developing alignment proposals	• Finalise our People Plan for publication on 1st April 2024. • Undertake a full review of all recruitment and retention programmes, developing targeted action plans.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.10. Addressing our Sustainability Challenge – Financial

Outcome goal: A sustainable model of delivery in BOB – achieving financial balance with a stable and resilient workforce

Where are we now and what action are we already taking?

Over the five-year period of this plan, the BOB system will spend approximately £15bn on the provision of NHS care and services. How this money is spent will be critical to the delivery of our ambitions for change across the system. We will need to make bold choices about how money can be used to support and facilitate the changes required. Our long-term financial planning must encourage the shift to a more preventive model that supports people to be healthy for as long as possible in the community.

However, as a NHS system at the end of the 2022/23 financial year we had an out turn deficit of £30.6m (subject to audit) and through our operational and financial planning for the 2023/24 year, we continue to forecast significant financial pressure across our system. Our ambition is to achieve financial balance in 2024/25.

In 2023/24 the ***ICS Efficiency Collaboration Group (IECG),*** established to bring together collective opportunities for change and transformation, will contribute to this goal as it seeks to develop a medium to longer term delivery programme improving patient services whilst generating financial savings. To this end the IECG is focused on productivity gains, underpinned by improvements in areas such as theatre utilisation, reduced follow-ups, delayed transfers of care and length of stay and continued medicines optimisation. This will be supported by robust and efficient support functions which continue to evolve as the ICS develops, within which efficiency initiatives are also being developed to maximise the value for money delivered by those services.

Service Plans Reference:

- Finance

Our longer term transformation approach – Co-developing a 5 Year Finance Strategy

We will develop **a five-year Finance Strategy** for the Integrated Care System setting out our ambitions for a sustainable future across the ICS. The plan development will be overseen by BOB ICS's Chief Finance Officers through the Senior Finance Group.

The Finance Strategy will define our system's financial approach to supporting changes that address our sustainability challenges – including in key areas such as optimisation of estates, effective use of workforce, sharing best practice, maximising productivity.

As part of our Finance Strategy, in 2023/24 we anticipate the focus of delivery to be:

- Targeted work on ensuring a **comprehensive understanding of the core cost base and drivers of deficit** position
- Working with system partners committed to a **system wide efficiency plan** that supports the route to a system breakeven position in 24/25 with the programme led by a Chief Finance Officer alongside a clinical executive partner
- To develop a **long-term approach our financial plans** that support system wide delivery of our wider strategic ambition through production of long term financial model that encompasses the whole system position supported by individual organisation detail.

2023/24 Priority Transformation Milestones

Q1	Q2	Q3	Q4
• Finalise Operating Plan for 2023/24 • Review actions required in year to achieve position. • Launch IECG and improvement targets • Commence build of long term financial model to include system and individual organisation level detail	• Build on our understanding across our system partners of the key long term pressures within our current financial position. • Develop comprehensive intelligence to support appropriate targeting of interventions	• Develop our full Finance Strategy collaboratively with leaders and people across BOB's health and care system. • Deliver initial quick wins and opportunities from the efficiency group that can support the 24/25 system plan and beyond	• Finalise our Finance Strategy for publication on 1st April 2024. • Undertake the Operating Plan process for financial year 24/25 and a full review of associated impact on the Long Term Finance Model.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.11. 2023/24 Delivery Architecture

Oversight of delivery

For the identified challenge areas, the following groups will be used to ensure progress is made with respect to the planned activities.

Challenge Area	Inequalities challenge	Model of Care challenge	Patient experience challenge	Sustainability challenge	
Action proposed to address challenges	Deliver a **population health management** at scale in BOB	Develop a sustainable **primary care strategy**	Target Improvements to **waiting times and access**	Develop a **Finance Strategy** to support change	Develop a 5 year **People Plan**
Governance Group to oversee progress	**BOB ICB Prevention, Pop. Health & Reducing Health Inequalities Group**	**TBC** **(multi-stakeholder group to co-design model)**	**Elective Care Board**	**CFOs in Senior Finance Group**	**ICB People Committee**

The governance for all the detailed delivery plans (appendix B), oversight of progress will be through existing governance channels. Each plan will have a named accountable ICB executive.

Progress on all delivery plans will be reported through to the ICB on a twice yearly basis (see governance details in appendix B).

2023/24 Building the foundations for change

- The actions proposed in previous pages are to address the challenge areas are explicitly and deliberately focused on 2023/24.
- These actions aim to balance activity that will impact people, communities and staff in BOB and the short term with setting a foundation for future change.
- However, longer term action plans are required for each of these areas. These need to be developed jointly between BOB ICB, NHS Partner Trusts, and wider system partners. It is proposed these action plans will be co-developed over the course of 2023/24.
- A **System Transformation Group** will be established to lead this planning.
- The System Transformation Group will:
  - ✓ Receive updates on the 2023/24 challenge areas actions, both short and long term (see pages 21-25) – providing support and challenge as necessary
  - ✓ Meet at least quarterly
  - ✓ Ensure wider engagement in development of longer term plans –both from their representative organisations and from wider stakeholders
  - ✓ Agree, define and scope system priorities that will support the transition to a sustainable BOB Integrated Care System, with a model more focused on prevention and supporting people to be healthy in their communities for as long as possible
  - ✓ Consider future governance arrangements to support long term transformation in BOB.

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

03 Delivering Our Strategy

Our Five-Year Joint Forward Plan:

3.1 Promoting and protecting health
3.2 Start well
3.3 Live well
3.4 Age well
3.5 Better access to quality services
3.6 Supporting and Enabling Delivery

DRAFT

3.1 Promoting and protecting health

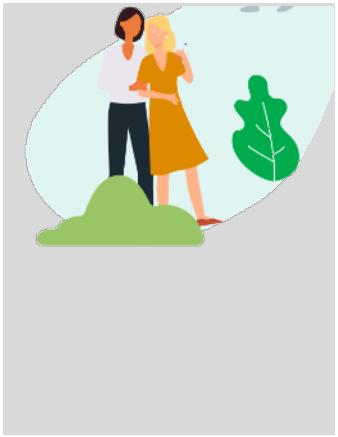
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.1 Promoting and Protecting Health

Keeping people healthy and well

Promoting and Protecting Health

- People living in Buckinghamshire, Oxfordshire and Berkshire West are generally healthier and live longer lives in good health than the national average. However, this can mask variation in access, experience and outcomes of services for certain populations and communities.
- We need to support people to live healthier lives by improving the circumstances in which people live, by taking action to tackle the social, economic and environmental factors that affect health.
- We need to ensure that the services people access to support their health are accessible and provide the best outcomes for all.



The importance of prevention

- It is estimated that between 20-25% of people's health is determined by the access to and quality of formal health or care services. The circumstances in which people live (e.g. housing, environment, employment, education) have a far greater impact on people's health and the choices they make.
- Nearly 60,000 people in BOB live in an area that is in the 20% of most deprived areas in England.
- 70% of heart disease, 50% of type 2 diabetes, and 38% of cancers could be prevented. Smoking, physical inactivity, an unhealthy diet and alcohol misuse account for 40% of all years lived with ill health.
- We can be a part of shaping the decisions of our local communities and helping them to live healthier lives.

Our Joint Forward Plan recognises the importance of prevention and addressing inequalities in BOB. Our five-year ambition is to reduce health inequalities for our population ensuring that everyone has equal access to appropriate care and support. We want to keep people healthier for longer through increased primary and secondary prevention activities.

Our focus areas

1. Inequalities
2. Prevention
3. Vaccinations

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.1 Promoting and Protecting Health – Our Summary Plan

Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
1 Inequalities	**Reduce health inequalities (access and experience of services & health outcomes) for our population** so that everyone has equal access to appropriate services and support. To enable this, we will provide tailored support to defined populations or groups, particularly those living in deprived areas, certain ethnic groups, LGBTQ+ communities, people with special educational needs and disabilities, people with long-term mental health problems, carers and groups who often are or feel socially excluded.	• Develop an embedded and mature system-wide governance structure, approach and multi-agency partnership supporting decision-making and delivery • Develop a comprehensive and effective population health management approach • Develop an integrated workforce that is supported and capable to work differently to address inequality in the BOB system • Develop a system-wide prioritised, resourced, coordinated and focused approach to Health Inequalities and improving outcomes • To enhance engagement, understanding and service provision outcomes for Inclusion Health Groups and populations / areas of inequality	• Inequalities & Prevention will be reporting into *Prevention, Population health and Reducing health inequalities* • ICB Exec Lead – Chief Medical Officer
2 Prevention	**Increase primary and secondary prevention work year-on-year**, keeping people healthy for as long as possible and delaying a deterioration into poor health.	• Reduce smoking prevalence (and increase access to tobacco dependency services) • Reduce obesity prevalence (and increase weight management services) • Increase physical activity rates for people in BOB • Reduce levels of harmful drinking, drug behaviours and use (and increase referrals to Drug and Alcohol services)	
3 Vaccinations	**Protect our population from vaccine preventable diseases** through the implementation of the national immunisation strategy. We will maximise uptake across all vaccination programs, reduce the occurrence of outbreaks while focusing on addressing local vaccine inequalities.	• Develop and deliver a successful population health strategy that supports the reduction in variation of immunisation uptake across our population. • Provide an integrated service that promotes flexibility across providers, meeting the needs of the population and resulting in an increased uptake of all immunisation programs. • Develop and maintain a resilient and highly skilled immunisation workforce.	• Immunisation and Vaccinations will be reporting into the *Vaccine Oversight Board* • ICB Exec Lead – Chief Nursing Officer

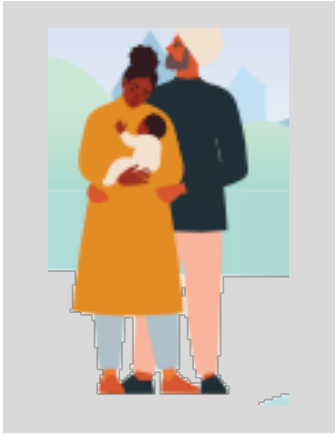
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.2 Start well

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.2 Our Joint Forward Plan: Start Well

Helping all children and young people achieve the best start in life



Starting Well in BOB and supporting early years development

- In BOB, we want every child and young person to get the best possible start in life. There are 425,200 people aged 0-19 in BOB, which is 24% of the total population (Census 2021). Higher proportions of children and young people (CYP) aged 0-15 are concentrated in Reading, High Wycombe, Aylesbury and Banbury in the BOB area.
- The foundations for a person's future health and wellbeing are set in the early years of life. This begins with supporting mothers during and after their pregnancy and then working together to ensure children achieve their early development milestones so they are ready to get the most out of life, their education and future opportunities. We recognise the recommendations of 'The Best Start for Life – a vision for the 1001 critical days' report and are committed to working collaboratively across the system to support implementation.
- We want to promote communities and environments that support all children and young people to make healthier choices, and which will allow them to thrive and achieve.
- This can only be achieved through cross-organisation working and our focus is to continue to develop partnerships across BOB that will support the delivery of the right care, support and services that will promote the healthy development of our children and young people.

Our five year ambition is to narrow the early years development and school readiness gap between the most and least deprived areas in each place ensuring that all children get the best start in life and are able to get the greatest benefit from their education.

Our approach will strengthen the partnerships between providers and services to identify and support children with different developmental needs.

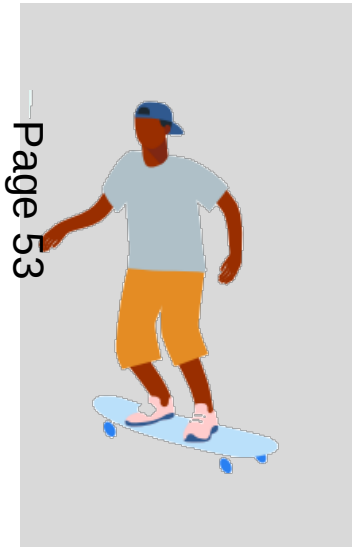
Our delivery focus

- Review the collection and sharing of data relating to early years development to support that the right information being available to identify areas of inequality where intervention may be needed.
- In collaboration with LA and other system partners, provide support offer for families living in the most deprived areas within each Place, maximising uptake of funded early education placements and availability of parenting programmes, family support services etc.
- Work with partners to establish a appropriate system-wide CYP oversight and assurance of services covering the 0-19 years

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.2 Our Joint Forward Plan: Start Well

Helping all children and young people achieve the best start in life



Supporting children and young people

To provide better care and support for CYP we will focus on:

- Developing BOB system leadership, governance, resourcing and cross-organisational coordination for CYP pathways and services
- Improving asthma and epilepsy pathways and care in line with national priorities
- Improving diabetes care, particularly for those transitioning from CYP to adult care. This will include improving access to continuous glucose monitoring (CGM) for CYP.
- Maintain Long Covid services and support, improve access and better integrate with other CYP services.
- Improving CYP Mental Health outcomes through earlier intervention and support and improving access, experience and outcomes for all Mental Health services
- Ensuring neurodiverse CYP have access to the right support at the right time according to their needs
- Improving physical, mental health and wellbeing outcomes for children and young people with a learning disability and their families/carers

In this way we aim to improve services, enhance access and people's experience, reduce health inequalities and deliver better health and wellbeing outcomes that will benefit CYP and their families and carers.

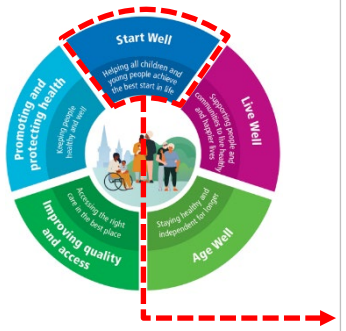
Our Joint Forward Plan therefore sets out our five-year ambition and the key actions we will take, working with Local Authorities, VCSE and other partners, to improve and transform maternity and neonatal, children and young people's mental health and learning disability services across BOB.

Our focus areas

1. Maternity and Neonatal
2. CYP Mental Health
3. Learning Disabilities
4. CYP Neurodiversity

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.2 Start Well – Our Summary Plan



Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
1 Maternity and Neonatal	Ensure our maternity and neonatal services in BOB prioritise and provide care which is **safer, equitable, personalised, kinder and sustainable** and ensuring positive work cultures and behaviours.	• **Safety** (learning from incidents and leading on quality improvement initiatives, complying to national maternity and neonatal reviews and schemes, ensuring we use an evidence based, evidence informed approach). • **Workforce** (bolstering supply, enriching roles with up skilling and training, new roles & succession planning, new ways of working, building staff resilience and culture & leadership). • **Personalisation** (improving service user experience of maternity and neonatal services by listening to women and families, engagement and participation, with focus on seldom heard voices from our ethnic diverse and deprived populations, providing personalised care and support plan solutions). • **Prevention and equity** (implementation of BOB maternity and neonatal equity strategy and planning and implementing prevention initiatives and reducing health inequalities for our ethnic diverse and deprived populations). • **Digital and data** (improving accuracy and reliability of data and its use in service and quality improvement, implementing ICB digital strategy).	• Maternity & Neonatal reporting into *LMNS Stakeholder & Assurance Group* • ICB Exec Lead – Chief Nursing Officer
2 CYP Mental Health	**Improved mental health and wellbeing outcomes for children and young people** (ages 0 – 25), living learning and working in BOB. To achieve this, we will take a needs-led and person-centred approach (in line with the thrive framework) to implementation, transformational change and delivery.	• Improve timely access and early intervention in universal care and support across our system. • Develop a population health approach to identify and support CYP most at risk of mental-ill health focussing on early intervention, early support and prevention. • Enhance support for CYP when they experience a mental health crises, developing needs-led models that maximise sustainable community-based solutions.	• CYP MH reporting into the *ICB MH Partnership Board* • ICB Exec Lead – Chief Nursing Officer
3 Learning Disabilities	By March 2028, we will have delivered **improved physical, mental health and wellbeing outcomes for children, young people and adults with a learning disability and their families/carers.**	• Reduce health inequalities and ensure that our health and care commissioned services are providing good quality health, care and treatment to people with a learning disability and their families. • Improve community-based support. • Champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability. • Make sure across BOB health and care providers have an awareness of the needs of people with a learning disability.	• Governance route in development. • ICB Exec Lead – Chief Nursing Officer
4 CYP Neurodiversity	By March 2028, we will ensure **that all neuro-divergent children and young people will receive the right support, at the right time and in the right place** dependant on their needs and not dependant on a diagnosis.	• System review of referrals, pre-assessment / assessment & feedback of outcome. Learning and processes are aligned across BOB to improve efficiencies and service user experience. • Deliver parity of care across BOB, regardless of a diagnosis of ADHD or autism. • Access to timely assessment and diagnosis using alternative models of support for CYP and their families.	• Governance route in development. • ICB Exec Lead – Chief Nursing Officer

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.3 Live Well

3.3 Our Joint Forward Plan: Live Well

Supporting people and communities to live healthier and happier lives

Living Well in BOB

- We want everyone in BOB to have the opportunity to live a healthy life. We need to tackle factors that influence people's health and how we can support individuals to make healthy changes to their lifestyle.
- To support individuals to make healthy changes to their lifestyle, we can take targeted preventative work around health conditions that affect large numbers of people across our area.
- Therefore, we want to focus on preventative interventions around cardiovascular disease, cancer, adults' mental health and other areas.

Supporting people to manage Long-Term Conditions

- While levels of long-term conditions such as heart disease or diabetes in BOB are generally lower than the national average, cardiovascular disease is still one of the most common causes of deaths in the local area and a major contributor to the gap in life expectancy between people living in our most and our least deprived area.
- Our focus is also on supporting people to manage long term conditions (LTCs) and delivering more joined up care for people with personalised care and support plans.
- This includes identifying those at risk of developing LTCs and providing support to address lifestyle factors and earlier detection of those with LTCs and provision of support to avoid unplanned care.

Our Joint Forward Plan therefore sets out our five-year ambition and the key actions we will take to improve and transform support and services for people living with long term conditions and those at risk of developing these conditions.

Our focus areas

1. Adults Mental Health

Long Term Conditions

2. Integrated Cardiac Delivery Network
3. Integrated Respiratory Delivery Network
4. Integrated Stroke Delivery Network
5. Integrated Diabetes Delivery Network

6. Adults Neurodiversity
7. Cancer

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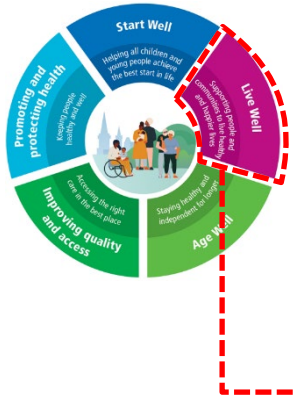
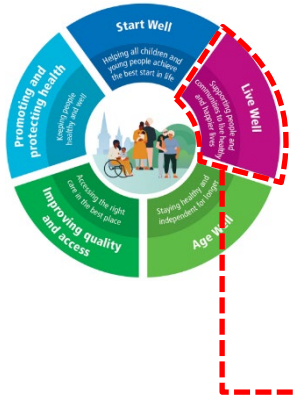
3.3 Delivering Our Strategy – Live Well



Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
1 Adults Mental Health	**Improved mental health and wellbeing outcomes for all adults and older people** living, learning and working in BOB.	• Promote a successful population health approach to prevent, identify and support individuals, groups and communities most at risk of developing mental ill health. • Tackle the social factors impacting mental health and wellbeing. • Improving timely access to support for mental health crises and develop alternative sustainable models. • Improving outcomes that are person centred, using asset-based approaches that builds resilient communities and promotes integration. • Address inequalities in physical health for people with a mental illness	• Adults MH reporting into the *ICB MH Partnership Board* • ICB Exec Lead – Chief Nursing Officer
2 Adults Neurodiversity	BOB will be an area where Neurodivergent people thrive, and their strengths are embraced.	• Improving access to assessing, understanding and supporting a person's neurodiversity. • Ensuring infrastructures are in place and are effective to reduce unnecessary admissions under the MHA. • Improving the experience for any neurodiverse people using our Mental Health Inpatient Services. • Improving equity of access through anticipatory and reasonable adjustments. • Ensuring that staff working across BOB have the skills and knowledge to identify Neurodiversity. Understand and meet the needs of this service user group. • Co-producing community-based assets that support the social and emotional needs of neurodivergent people.	• Governance route in development. • ICB Exec Lead – Chief Nursing Officer
3 Cancer	**Reduction of the cancer backlog and consistent delivery of the Faster Diagnosis Standard** by March 2024. Sustainably meet all Cancer Waiting Times by March 2028, and achieve the National Cancer Ambition of diagnosing 75% of cancers at Stage I & II.	• Delivery of Sustainable operational performance across the system. • Delivery of the 28-day Faster Diagnosis standards. • Achieve the Early Diagnosis standard. • Increase the Early Diagnosis Rates. • Improve the quality of treatment and care. • Implementation of the Teenage and Young Adult Cancer Care Service Specification. • Patient Engagement, Involvement and Experience. • Support, Training & Education for medical, nursing, allied health professionals and admin staff in cancer services and primary care.	• ICB Exec Lead –Chief Medical Officer

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

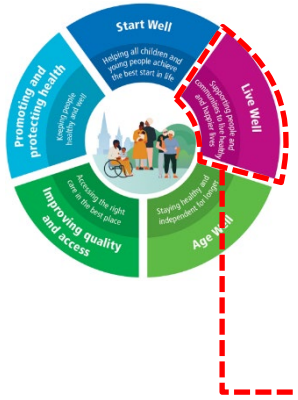
3.3 Delivering Our Strategy – Live Well



Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
Long Term Conditions – Introduction	• Improve outcomes in population health and healthcare. • Act sooner to help those with LTCs • Support people with LTCs to stay well & independent. • Provide quality care for those with multiple needs as population ages. • Co-produce consistent pathways across ICS to reduce unwarranted variation. • Integrate service models to delivered joined up care wrapped around patients' needs.	• Assess the population needs, increase preventative interventions, diagnose earlier, reduce inequalities and improve health outcomes. • Take a collaborative approach with our partners and stakeholders through the LTC BOB Integrated Delivery Networks (IDNs) to develop integrated care models to better manage patients with LTCs. • Develop a proactive approach to improve outcomes for patients with multiple LTCs.	• All LTC service areas reporting into the ICB Clinical Programme Board • ICB Exec Lead – Chief Medical Officer
4 Integrated Cardiac Delivery Network	Reduce the number of CVD events by having a strong focus on prevention and reduce the health inequality gap by using PHM approach. We aim to **co-design consistent and integrated pathways and empower patients to live well with CVD** and other co-morbidities.	• CVD Prevention – better blood pressure and lipid management, increase NHS Health checks, lifestyle interventions and targeted smoking cessation. • Heart Failure – earlier detection and a reduction in hospital admissions and re-admissions. • Enhanced Cardiac Rehabilitation.	

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.3 Delivering Our Strategy – Live Well



Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
5 Integrated Respiratory Delivery Network	**Patient-centred, integrated clinical pathways delivering high quality respiratory care that is accessible** to all across BOB ICS Supporting people with respiratory disease to live longer.	• PHM to identify and support people at most risk. • Deliver earlier diagnosis, education and care planning in community • Integration of respiratory services, enabling the right support to people closer to home. • Optimising medicines to improve health outcomes and reduce carbon emissions. • Leveraging innovation and research to improve outcomes in respiratory care.	• All LTC service areas reporting into the ICB Clinical Programme Board • ICB Exec Lead – Chief Medical Officer
6 Integrated Stroke Delivery Network	We will bring key stakeholders together to facilitate a **collaborative approach to service improvement of the whole stroke pathway**, including prevention, ensuring a patient centred, evidence-based approach to delivering transformational change.	• Implementing consistent pathways of care for stroke. • Maximising stroke prevention opportunities. • Reducing variation in access to stroke rehabilitation services.	
7 Integrated Diabetes Delivery Network	• We will support **education and training** of our workforce • we will **reduce clinical variation** and health inequalities • We will adopt **new diabetes care technologies** and improve access to services, • We will improve primary and secondary **prevention** • Supported **personalised self-care** will enable people with diabetes to manage their health so they can live the life they want to live.	• Reach and exceed pre-pandemic attainment of the eight diabetes care processes (8CPs) and the three treatment targets (TTTs). • Innovation and service development focusing on digital technologies to improve outcomes and reduce inequalities. • Deliver a high-quality integrated care approach, promoting self-care for primary and secondary prevention so people with diabetes experience fewer preventable complications	

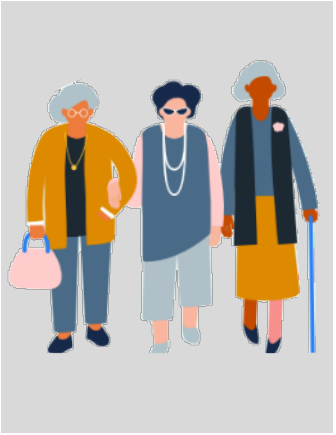
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.4 Age Well

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.4 Our Joint Forward Plan: Age Well

Staying healthy and independent for longer



Aging Well in BOB

- Similarly to many areas of the UK, we have a growing aging local population. As people get older, they generally need and expect more support in their communities and formal health and care services.
- Approximately a quarter of people in the local area are aged over 60 and this number will grow by around 11% in the next five years. People aged over 75 or those with a long-term illness/disability are more likely to say they feel lonely.

Supporting older people to remain healthy

- At BOB, we are committed to supporting older people remain healthy, independent and connected in their communities by ensuring community services are co-designed by those that are using the service.
- Some older people receive support from social care or voluntary and community groups, while friends and family also frequently act as essential carers.
- Working in partnership with the individual, their family and carers, we can ensure plans are personalised and maximise the person's independence.

Our Joint Forward Plan therefore sets out our five-year ambition and the key actions we will take to provide more joined up care for older people and supporting more people to remain healthy and independent for longer.

Our focus areas

1 Age Well Services

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.4 Delivering Our Strategy – Age Well

Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
1 Age Well Services	By March 2028, we will be: • Supporting more people to remain healthy and independent for longer. • Providing **proactive, personalised and coordinated care for more people who are becoming frail** and their health conditions more complex. • Supporting more unpaid carers.	• Support people to remain healthy, independent, and connected within their communities. • Offer proactive personalised care planning and identify early those who are likely to develop more complex needs and become frail. • Provide multi-disciplinary integrated care involving health care, social care and VCSE for people as their conditions become more complex and they become frail. Care is coordinated and delivered in the right place at the right time. • Provide rapid reablement and recovery support for people who have become acutely unwell to enable them to return home quickly and safely from hospital. • Identify and support unpaid carers to maintain their own health and wellbeing and their ability to care for their friends and relatives. Inform and empower patients and carers in relation to services and pathways across the system.	• Governance route in development. • ICB Exec Lead – Chief Nursing Officer/Chief Medical Officer

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.5 Improving quality and access

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

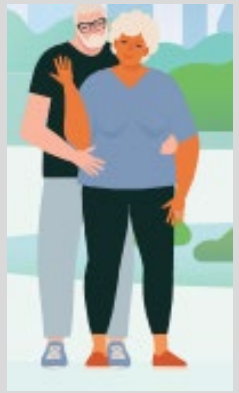
3.5 Our Joint Forward Plan: Improving Quality & Access to Services

Accessing the right care in the best place

Better access to quality services

- Within BOB, we are committed to adopt a pro-active and preventative approach to keep people healthy and preventing ill-health. We know we need to improve our current services and take action to make sure these services are accessible to everyone who needs them.
- In a national survey conducted in 2021, respondents said that the two most important priorities for the NHS were:
- Making it easier to get a GP appointment.

  1. Improving waiting times for planned operations.
- We also hear concerns about social care, dental and pharmacy services and the challenges of accessing services from rural areas.



Supporting people to access our quality services

- At BOB, we are focused on ensuring people can access high quality care and support, at the right time and in a place they can get to. During our public engagement we have heard how unfortunately, accessing support or services can sometimes be difficult or slow and through our JFP we are determined to make this experience better.
- We want to do more to improve the support we offer to people at all stages of life, right through to the support and care we provide for people who are dying. We aim to strengthen our partnership approach and provide the best support to meet people's different needs.
- We recognise there are some groups within our communities whose access to, and experience of, services and outcomes is worse than others e.g., minority ethnic groups. We are committed to addressing these disparities.

Our Joint Forward Plan therefore sets out our five-year ambition and focuses on services for people at every stage in life, both improving these services and ensuring everyone, irrespective of their personal characteristics/circumstances can access the support they need at the right time.

Our focus areas

1. **Urgent & Emergency Care**
2. **Planned Care**
3. **Primary Care**
4. **Palliative and End of Life Care**

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.5 Delivering Our Strategy – Improving Quality and Access

Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
1 Urgent & Emergency Care	By 2028, our ambition is to ensure we get patients the right access to **the right care when it's needed, improving the outcomes and the experience of patients, their families and friends and** consistently delivery against the operational standards determined by NHSE.	• Recover key performance indicators; reducing ambulance handover delays, securing a reduction in the percentage of patients waiting more than 12hrs in Emergency Departments to be seen, improving type 1 A&E performance and; reducing G&A bed occupancy. • Develop and implement a model of care that better supports and meets the needs of High Frequency Users, building on the anticipatory care models adopted in primary and community care services. • Deliver a consistent single Integrated Urgent Care model across the BOB footprint from September 2024. • Embed and increase the capacity and service offer of Urgent Community Response teams to provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently. • Increase adult and paediatric Virtual Ward capacity. • Ensure there is a clear route of access to same day services through a Single Point of Access supported by a directory of services that is available to healthcare professionals to inform the timely navigation of pathways. • Implementation of the top 10 high impact changes to improve hospital discharge, including from community and Mental Health inpatient services. • Secure a non-emergency patient transport service that provides a more consistently responsive service, fair access to service users, is sustainable and compliant with the national framework.	• Reporting into *BOB UEC Programme Board* • ICB Exec Lead – Interim Chief Delivery Officer
2 Planned Care	By March 2028 we will aim to **sustainably reduce and eliminate long waits for our elective services and address variation in access across the system**, recovering to at least pre-pandemic planned care performance levels against NHS Constitutional Standards by March 2028. We aim to improve access to services by enhancing pathways and coordinating approaches across the system, reducing variation and non value-added interventions.	• Increase health service capacity, through the expansion and separation of elective and diagnostic service capacity. • Prioritise diagnosis and treatment, including a return towards delivery of the six-week diagnostic standard and reducing the maximum length of time that patients wait for elective care and treatment. • Transform the way we provide elective care including reforming the way we deliver outpatient appointments, making it more flexible for patients and driven by a focus on clinical risk and need, and increasing activity through dedicated and protected surgical pathways. • Provide better information and support to patients, supported by better data and information to help inform patient decisions.	• *Reporting into the BOB Elective Care Board* • ICB Exec Lead – Interim Chief Delivery Officer

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.5 Delivering Our Strategy – Improving Quality and Access (cont.)

Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
3 Primary Care	To transform how primary care is delivered in each community/ neighbourhood, enabling integrated primary care provision which **improves the access, experience and outcomes for communities aligned to their needs**. Through the mobilisation of integrated neighbourhood health and care teams, primary care services will become more sustainable, and patients will get the support they need when they need it.	• Increase primary care resilience and provide the tools required to enable change including time and skills. • Create the infrastructure across BOB to implement the change (Estates, Workforce & digital). • Increase capacity and manage demand for primary care services by working differently so that we can deliver on nationally agreed access priorities and targets. • Build GP led, integrated neighbourhood teams, supported by a sustainable workforce plan. • Deliver more targeted activity to identify and support the prevention of ill-health and address inequalities.	• Reporting into *Primary Care Operational Meeting* • ICB Exec Lead – Deputy CEO & Chief Medical Officer
4 Palliative and End of Life Care	We will **deliver high quality, personalised, integrated 24/7 services shaped by those with lived experience for Palliative and End of Life Care** (PEoLC) for all ages, across the BOB ICS.	• A robust model of access to 24/7 Palliative and End of Life services for patients, their carers and relatives. • A successful population health approach to early identify people needing Palliative and End of Life services. • To co-design PEoLC through Provider Collaboratives and in partnership with people with lived experience.	• Reporting into the *ICB Palliative and End of Life Care Board* • ICB Exec Lead – Chief Nursing Officer

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.6 Supporting and Enabling Delivery

3.6 Supporting and Enabling Delivery

Building and growing the foundations of successful delivery

Meeting the ambitions of our Joint Forward Plan relies on the us having the right supporting and enabling plans in place as a system to ensure we can deliver effectively.

Our Enabling Plans

Our enabling plans set out how we will develop the most important elements we rely on in delivering our services such as having the right number of skilled staff and IT that effectively supports front-line care and a sustainable financial environment where we can invest in the right things.

In BOB, we start from a position of strength in some of these areas, for example we have recently completed our system Digital Strategy that will provide the basis for improving our services through better use of digital and data over the next five years, while on others we know we have a lot to do. For example, we don't yet have a system view of data flows, and our estates maintenance backlog is the worst in the South East region and among the worst nationally.

These enablers will be critical to ensuring we can deliver on the ambitions within our service plans, and ensuring our system is sustainable – on sound financial footing and with a resilience and stable workforce. Our enabling plans cover:

- Workforce
- Digital and data
- Finance
- Estates

Our Supporting Plans

As well as our enabling plans, we have a number of additional supporting plans that provide the foundation for delivery of our core services, meaning we can do so in a way that maintains and improves quality and patient safety, meets our environmental commitments, leverages high quality research and innovation, and ensures we are meeting the individual needs of our population.

We have developed five-year plans across the following key areas:

- Quality
- Safeguarding
- Infection prevention and control
- Research, innovation and quality improvement
- Personalised care
- Continuing Healthcare
- Delegated commissioning
- Net zero

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.6 Delivering Our Strategy – Key Enablers for Delivery

Enabled Through

Service Area	Five-year Ambition	Our Delivery Focus	Governance & Exec Lead
Workforce	By March 2028 we will have an **integrated workforce that is looked after, feels valued and respected, is reflective of our communities** and made up of the right people in the right roles at the right time delivering health and care services for our communities.	• Have an inclusive & diverse compassionate leadership reflecting the population we serve driving cultural change towards strong partnership working. • Improve recruitment and retention through a collaborative focus on strategic workforce planning and developing innovative attraction action plans to support key areas of workforce shortages. • Support a system focus on innovative job design for roles and teams that operate across organisational and professional boundaries, reducing reliance on costly agency workers, and fostering career development through developing meaningful and personalised career pathways. • Make BOB a great place to work in health and care. Ensure our people have rewarding jobs, work in a positive culture that embraces kindness, civility and respect and are supported with both their physical and mental health and wellbeing.	• *Reporting into the ICB People Committee* • *ICB Exec Lead – Interim Director of People*
Digital and Data	Improve the lives and experiences of those accessing and working in our Integrated Care System, through building collective digital and data maturity across our partners and providers. By 2025, we will have • **Enabled safe and informed care** by aligning our providers behind a single shared care record. • **Improved maturity of electronic patient records** by converging providers onto platforms which meet national data standards. • **Equipped our workforce** in exploiting the use of digital and data and develop DDaT professions across the ICS.	• Digitise our providers to reach the Minimum Digital Foundations for a core level of digitisation across our system. • Connect our care setting using digital, data and technology and improve citizen experience. • Transform our data foundations to provide the insights required to transform our system and better meet the needs of our population.	• *Reporting into the CIO Forum* • *ICB Exec Lead – Chief Information Officer*

3.6 Delivering Our Strategy – Key Enablers for Delivery (cont.)

Enabled Through

Service Area	Five-year Ambition	Our Delivery Focus	Governance & Exec Lead
Quality	**Each patient will receive timely, safe, effective care with a positive experience.** We will demonstrate this by delivering on our Quality Strategy and improving against comprehensive system metrics and our CQC and SOF ratings.	• Publish a Quality Strategy to support improvement which will incorporate the National Patient Safety Strategy. • Develop a system-wide quality assurance framework to underpin our improvement work, based on the NHSE early warning metrics for systems. • Ensure patient experience and co-design is fully embedded in our quality assurance/improvement work and our quality strategy.	• Reporting into the *System Quality Group* • ICB Exec Lead – Chief Nursing officer

BOB Joint Forward Plan – Feedback Themes and Responses

An Initial version of the Joint Forward Plan was produced for the end of March 2023, in line with the timescales specified by NHS England. This version was shared with multiple system partners – including each of our six NHS Providers and our five Health and Wellbeing Boards – to give partners an opportunity to review content and provide feedback ahead of finalisation by the end of June 2023. All feedback received has been considered and changes have made to the JFP in response. The significant themes are captured below with details on how the feedback has been considered in the latest version.

Themes	Feedback received	Our Response
Overall length of the Joint Forward Plan .	We received comments on the overall length of the JFP, and suggestions that a shorter more accessible version would be beneficial	We have made numerous amendments throughout the JFP to condense existing material and reduce page-count where possible. For example, we have reduced overall page count in sections 1 and 2 through refining content throughout these sections. We have also produced a short Executive Summary version of the document (c. 17 pages), which captures key background and contextual information, how we will respond to our key challenge areas, and provides a high-level summary of our five-year ambitions for each service area. This summary is deliberately more accessible and shareable version of the document. We are planning to publish four separate documents, allowing users to access the right level of detail as they require: • Summary of our JFP • Joint Forward Plan – main document • Appendix A – Service Delivery Plans • Appendix B – Supporting Information Plans are in action to deliver an easy read version of the Joint Forward Plan once the final version has ben confirmed.
Strategic focus and clarity .	We received comments that the focus on the key strategic challenge areas in the JFP was welcome but the JFP would benefit from additional longer term focus and prioritisation and less on short term operational challenges	The JFP identifies four key challenge areas that will be prioritised and worked on collaboratively as a system: shifting the focus of our model of care to keep more people healthy and well in the community, reducing inequalities, improving experience the experience of our services and delivering sustainably. We recognise we need to work differently as a system and have chosen to take a longer-term transformational approach to these four challenges. Updates to our plans for these key challenges have been made in response to feedback- this includes actions for the year-ahead and for the longer term. This includes: • Clarifying realistic transformational activity for 2023/24 for each of the challenge areas – balancing change with operational pressures. • Defining how we will oversee and influence progress across these challenge areas The JFP is also required to describe how the 'universal commitments of the NHS' will be delivered and is therefore deliberately aligned to the NHS operational requirements.
Governance	We received comments that the governance structures and processes were unclear	Updates to the JFP have been made that clarifies how our plans will be overseen, managed and monitored. For each Service Plan, we have specified:

	relating to how our plans would be overseen and monitored.	• An ICB Executive who has overall responsibility and accountability for delivery of the plan • The key governance forum and/or committee that will oversee the delivery of each Service Plan For our key challenge areas, we have included new content on how we propose shaping our future work in these areas through establishing a System Transformation Group
Finance	We received comments that the sections relating to financial implications of the plans and affordability could be stronger with greater clarity over the funding assumptions for future years	The relevant sections have been clarified. This confirms that the JFP has been developed in line with 2023/24 operational and financial planning and recognises that the certainty on the financial implications is reduced as plans reach further into future years. A key aim of 2023/24 is to develop a financial plan that will support and enable system change. We recognise the challenge associated with committing to longer term plans without clarity over funding arrangements. The JFP will be updated on an annual basis – and a key element of this will be revisiting plans to ensure they are realistic and affordable in light of any changes to funding availability.
Accessibility and communication	We received feedback from our public engagement focus groups that accessibility and communication in BOB needs to be improved, particularly with regards to primary care.	In response we have strengthened the ambition of two of our system challenges areas: • The Model of Care challenge aims to create an integrated approach to primary care, accelerating opportunities for integrated neighbourhood teams and moving care closer to home. This should help with the access issues people in BOB currently face. • The user experience challenge recognises the access and waiting times issues experiences by some people using our services. A number of issues are already underway with interventions in 23/24 planned to include a better understanding of demand and capacity in primary care and pathway reviews for a number of higher intensity specialties.
The need to promote a greater focus on care in the community	We received feedback that greater clarity could be provided in the primary care strategy ambition on intended/expected role of community services	The 2023/24 action to develop a primary care strategy now includes a more detailed description of a community- based model of care – with a particular focus on the implementation of integrated Neighbourhood teams, in line with the recommendations of the Fuller stocktake report.
Prevention and Inequalities	We received feedback that requested specific changes to Smoking, Weight Management and the Drug & Alcohol Service Plans to ensure more clarity on the outcomes that will be delivered	Feedback was taken into account and where appropriate, amends made to the Joint Forward Plan service delivery plans to reflect the comments received and clarify outcomes.

Oxfordshire Health and Wellbeing Board
29th June 2023

Oxfordshire Joint Strategic Needs Assessment 2023 update

Report by Ansaf Azhar Corporate Director of Public Health & Wellbeing, Oxfordshire County Council

RECOMMENDATION

The Health and Wellbeing Board is RECOMMENDED to

1. Note the content of the Joint Strategic Needs Assessment for 2023 and encourage widespread use of this information in planning, developing and evaluating services across the county.
2. Contribute information and intelligence to the JSNA Steering Group to further the development of the JSNA in future years, and to participate in making information more accessible to everyone.

Introduction

1. The Joint Strategic Needs Assessment (JSNA) is a statutory annual report provided to the Health and Wellbeing Board and published in full on Oxfordshire Insight. It provides an evidence-base for the Health and Wellbeing Strategy and is an opportunity for an annual discussion about the key issues and trends from a review of a very wide range of health-related information about Oxfordshire.
2. Producing the JSNA is a collaborative project with contributions from many analysts and sector specialists from Oxfordshire's Local Authorities, NHS, Thames Valley Police, Healthwatch Oxfordshire and Voluntary Sector organisations.
3. In addition to local datasets, the report makes use of data from NHS Digital, the Office for National Statistics and the Office for Health Improvement & Disparities. Datasets can take time to process, which means that this 2023 JSNA update includes information from 2021 as well as more recent data from 2022 and 2023. The JSNA will include data from the Census 2021.
4. It is important to note that the JSNA does not include information about services needed to support the health and wellbeing of the population and, in some cases, the data may not be recent enough to reflect changes in services.
5. This paper gives an overview of the key findings from the 2023 Oxfordshire JSNA and plans for the continued development of JSNA resources.

Key findings from the 2023 update of the JSNA

6. A one-page summary of the facts and figures from across the life course in the JSNA 2023 are provided in Annex 1.

7. The Board's attention is also drawn to the following key findings from the JSNA 2023.

8. **Population and demographics**

We have seen an increase in the population in Oxfordshire above the growth in England. We have also seen an increase in mixed or multiple ethnic groups. Population forecasting predicts a future rise in older people.

9. The first Census 2021 results show that, over the 10-year period, 2011 to 2021, Oxfordshire's population increased by 10.9% (+71,500). This was above the growth across England of 6.6%.

10. The number of older people aged 65 and over in Oxfordshire increased by 25% (+25,900). (Chapter 2 slide5). The oldest age group, those aged 85 and over, is predicted to increase by 2031 to 5,900 people (+31%).

11. The number of young children aged under 5 declined by 8% (-3,100).

12. According to the Census 2021, 0.6% of Oxfordshire residents aged 16+ identify with a gender which differs from their sex registered at birth, which is higher than the national average.

13. The population from mixed or multiple ethnic groups has increased by 71% (+ 9,378) over the past 10 years.

14. **Starting Well**

Many Oxfordshire children reach a good level of development by the time they start school, however those eligible for Free School Meals (FSM) had a lower than average (worse than) good level of development. This is also the case for children living in areas with higher income deprivation. Oxfordshire continues to have a higher than average proportion of pupils with Special Educational Needs (SEN) support, although the gap with England has narrowed. The number of mental health referrals for young people has increased significantly. There are clear inequalities for childhood obesity by deprivation, sex, and ethnic group.

15. Similar to the national trend (4.2% for boys), Oxfordshire has an increasing percentage of children with social, emotional, and mental health needs, with a higher prevalence in boys (4.8%).

16. **Education -** The GCSE average attainment 8 score[1] in Cherwell (48.6) was below (worse than) the England and South East average.

17. **Education and Special Educational Needs Support** - Oxfordshire continues to have a higher-than-average proportion of pupils with SEN support, although the gap with England has narrowed.

[1] A pupils Attainment 8 score is calculated by adding up the points for their 8 subjects and dividing by 10. A Local Authority Attainment 8 score is the average of all the eligible pupils' scores.

18. The proportion of pupils with autism was above the England average in Oxfordshire's state-funded secondary schools (2.7% compared with 1.8%), however, the total prevalence (all schools) is similar. (Chapter 3 slide 12)

19. The number of children looked after (CLA) in key stage 2 with SEN support and with Autistic Spectrum Disorder was 9 percentage points above the percentage for England (16% in Oxfordshire vs England 7.3%).

20. **Education, deprivation, and poverty -** Although Oxfordshire is below the national average for pupils eligible for FSM, there are areas where primary school pupils have a higher rate including Rose Hill and Iffley, Banbury Ruscote and Littlemore. Half the primary school pupils in these areas received a FSM on Census Day. These areas are also in the 20% most deprived nationally.

21. Outcomes also vary by levels of income deprivation. Using the Income Deprivation Affecting Children Index (IDACI), based on the child's residence, the percentage of children with a good level of development is higher for children who live in less deprived areas, and lower for children who live in more deprived areas.

22. South Oxfordshire (37.4%) had the lowest percentage of children (eligible for FSMs) who had a good level of development compared to the other Oxfordshire districts.

23. The percentage of children with FSM status achieving the expected level in the phonics screening check in Year 1 was 10 percentage points lower in Oxfordshire than the England value (51.9% compared to 62%).

24. The 2021/22 early years foundation stage results show Oxfordshire has a lower percentage of children eligible for FSMs who had a good level of development (43.1%), than the South East (47.4%) and England (49.1%) rate.

25. **Mental Health** - Between 2020-21 and 2022-23, the number of referrals of Oxfordshire patients to Oxford Health for mental health services increased by 23% for people aged 0-4.

26. **Disability** - Areas of Oxfordshire ranked as more deprived on child poverty also have higher rates of children and young people on the Oxfordshire disability register.

27. **Children cared for -** The proportion of Oxfordshire's cared for children who were placed more than 20 miles from their home and outside Oxfordshire remained at 36% as at March 2022. The Oxfordshire rate is above the regional and national rates.

28. **Living Well**

Despite Oxfordshire's relative affluence there are wide inequalities in health and wellbeing. The cost of living, including house/rental prices, energy prices, cost of food etc. are continuing to increase, and in many cases are above the England average. There are 13,636 people providing over 50 hours of unpaid care in Oxfordshire, many of whom are not in good health. Some health conditions are above the national average including cancer and osteoporosis.

29. **Carers** - Census 2021 shows 52,674 (7.7%) of residents in Oxfordshire were providing unpaid care, of which 13,636 (2%) were providing 50+ hours. In

England, the proportion of people who provided 50 or more hours of unpaid care a week was 2.8% in 2021. 23% of people providing unpaid care in Oxfordshire were not in good health (self-reported). This was below (better than) the national average of 28% of people proving unpaid care in England who were not in good health.

30. **Health Conditions** - The prevalence of cancer in Oxfordshire in 2021-22 was above the national average.

31. The prevalence of Cancer and Osteoporosis in Oxfordshire were above the England average.

32. Two of Oxfordshire's small areas, Banbury Ruscote and Banbury Neithrop had significantly higher rates of hospital admissions for coronary heart disease than England.

33. Six of Oxfordshire's small areas had significantly higher rates of hospital admissions for heart attacks than England.

34. People with learning disabilities (LD) are likely to have much higher rates of certain health conditions than the general population. Rates of Epilepsy are almost 30 times as high for people with LD.

35. Some small areas of Oxfordshire experience significantly higher standard mortality ratios than the average with the high rates of deaths from cancer, circulatory diseases and stroke for people aged under 75.

36. **Mental health** - The prevalence of depression in adults has further increased in Oxfordshire, however remained just below the England average

37. **Economic activity** - Data shows 82.2% of people aged 16-64 are economically active in Oxfordshire. This is above the England average (78.7%).

38. Oxfordshire has a greater proportion of those who are economically inactive due to being a student (33.0%) and retired (23.4%) than the England average. Of those that are economically inactive, 88.6% of people in Oxfordshire did not want a job, this is lower (worse) than the England average (82.1%).

39. The Census 2021 shows some of the small areas that have the highest levels of economic inactivity due to long term sickness or disability. These are Blackbird Leys (9%), Northfield Brook (9%) and Banbury Grimsbury (8%). This is above the South East (3.1%) and England (4.1%) average.

40. **Deprivation and poverty** - According to the Census 2021, there were areas of Oxfordshire that were classified as deprived on four dimensions including education, employment, health, and housing. Households were deprived if they met one or more of the four dimensions of deprivation. Parts of Blackbird Leys, Banbury Ruscote, Greater Leys, Littlemore, and Rose Hill were deprived in three or four dimensions.

41. Oxford City (10.0% of households) remains significantly worse than the regional average (8.4%) on fuel poverty[2].

[2] Fuel Poverty - Fuel poverty in England is measured using the Low Income Low Energy Efficiency (LILEE) indicator. A household is considered to be fuel poor if: they are living in a property with a fuel poverty energy efficiency rating of band D or below and when they spend the required amount to heat their home, they are left with a residual income below the official poverty line.

42. ONS (Office for National Statistics) data shows that rising prices of food are having a disproportionate effect on lower income households.

43. The cost of renting in Oxfordshire is 49% higher than England.

44. The cost of house-buying in Oxfordshire is 61% higher than England (based on lower quartile price paid).

45. **Loneliness** - Oxfordshire was ranked the loneliest county compared with its statistical neighbours. The districts ranked highest on the rate of adults who felt lonely always/often or some of the time were Oxford City and Cherwell, which were each significantly above the Oxfordshire (24%) and national (22%) averages.

46. **Crime** - In 2022 (Jan-Dec) Thames Valley Police recorded a total of 7,818 victims of domestic abuse in Oxfordshire. This was 2% above the 3-year average for the years 2019 to 2021, with the greatest increases in West Oxfordshire (+7%) and Cherwell (5%).

47. **Built and natural environment** - Twenty-two of Oxfordshire's small areas were rated as having the worst carbon footprint per person in the county. Some were rated in the worst 1% in England.

48. **Ageing Well**

Oxfordshire's population is ageing, with a substantial recent and predicted growth in the number of older people and decline in younger people. There are clear inequalities in life expectancy across Oxfordshire and the number of hospital admissions due to falls is above the national average. We have also seen an increase in the uptake of mental health services for older people and the dementia diagnosis rate is significantly worse than the England average.

49. **Life Expectancy** - The number of years spent in poor health in Oxfordshire has remained unchanged at 15.5 years for females and 13.6 years for males.

50. There are clear inequalities in Life Expectancy across Oxfordshire. Males living in the more affluent areas of the county are expected to live around 11 years longer than those in poorer areas. For females, the gap in life expectancy is around 12 years.

51. **Falls** - In 2021-22 the rate of hospital admissions due to falls in Oxfordshire was above the national average. Oxford City has had a consistently high rate of admissions due to falls, the rate in Cherwell has seen a significant increase and was statistically above (worse than) the England average.

52. **Mental Health** - Between 2020-21 and 2022-23, the number of referrals of Oxfordshire patients to Oxford Health for mental health services increased by 9% for people aged 80-84.

53. **Dementia** - The estimated dementia diagnosis rate (aged 65 and over) in Oxfordshire (60.7%) is significantly worse than the England (62%) average. The higher the percentage the better.

54. **Adult social care** - Older adult social care users (living at home) are more likely to be living in urban areas of Oxfordshire than the general older population.

Areas with higher rates of adult social care users living at home include the more deprived urban areas of Oxfordshire in Oxford, Banbury, and part of Abingdon.

55. **Prevention**

56. **Mortality** - The highest rates of preventable mortality found in males by district (2018-20) were in Oxford City and West Oxfordshire. The highest rates for females were in Cherwell and Oxford City.

57. In the five-year period, 2016 to 2020, Oxfordshire had a total of 3,230 deaths considered preventable in people aged under 75 years. Oxfordshire had the second lowest rate of deaths from causes considered preventable under 75 years (calendar years 2016 to 2020) in its group of statistical neighbours and was well below (better than) the national average.

58. **Tobacco** - Between 2017 and 2019 (combined 3 years), there was an estimated 1,698 tobacco-related deaths in Oxfordshire. The rate of deaths was below the England average. However, the ONS Annual Population Survey shows the prevalence of smoking in working age adults in routine and manual occupations in Oxfordshire was 30.7%. This was well above the England rate of 24.5%.

59. **Alcohol -** Under 18s admissions were higher in females than males. In the most recent data the rate per 100,000 in Oxfordshire was 22.2 in males (similar to England and South East) and 46.9 in females (significantly worse than England and South East).

60. **Obesity and physical exercise** - Cherwell had the highest (65.8%) percentage of adults classified as overweight or obese. This was above the England average of 63.5%. (Chapter 5 slide 27). Adults on the learning disabilities register had a higher rate (68%) of being classified as obese or overweight than those who were not on the register (58%).

61. There are clear inequalities for childhood obesity by deprivation, sex, and ethnic group. Combined 5-year data for 2016/17 to 2021/22 shows that children were more likely to be obese in the more deprived areas of Oxfordshire (a pattern observed nationally). In Oxfordshire primary schools, the prevalence of obesity was highest in boys than girls and in Black and Asian groups.

62. A slightly higher percentage of Oxfordshire adults meet the physical activity guideline than national and regional figures, but roughly 1 in 4 Oxfordshire adults do not. Recent figures show 46.6% of children and young people in Oxfordshire were achieving an average of 60 minutes of physical activity per day, similar to the national average of 47.2%.

63. **Oral Health** - Data collected during the 2021 to 2022 school year shows that 18.5% of 5-year-olds in Oxfordshire had experienced tooth decay, significantly lower (better) than the national average of 23.7%. However, Oxford was significantly worse than the Oxfordshire average. (Chapter 5 slide 46)

How the findings will be used

64. The main JSNA report is published in full on Oxfordshire Insight for use by organisations, local communities and residents.

65. The report is accompanied by interactive dashboards to allow users to explore and find data for topics and local communities.

66. As in previous years, the JSNA will be widely disseminated to partners represented on the HWBB. Further JSNA presentations are also planned for the Oxfordshire Analyst Network and will be provided to partners on request.

67. The JSNA report and related resources are used widely as part of service planning. Recent examples include providing benchmarking information on hospital admissions due to falls, data on the health and care workforce, supporting the review of care beds and the latest information on Mental Health and Wellbeing for the Commissioning team.

68. The JSNA will inform the future version of the Health and Wellbeing Board's Joint Local Health and Wellbeing Strategy

Planning the 2024 update to the JSNA

69. The next update to the JSNA board will be mid-2024 with date to be confirmed.

70. The format of the JSNA will be reviewed and work carried out to continue to improve accessibility and the scope of the JSNA's interactive resources.

Financial Implications

71. There are no financial implications relating to this report as the work on publishing an annual JSNA and producing population forecasts is already accounted for within business as usual service planning.

Legal Implications

72. There are no legal implications relating to this report.

ANSAF AZHAR, CORPORATE DIRECTOR FOR PUBLIC HEALTH AND WELLBEING

Contact Officer: Steven Bow
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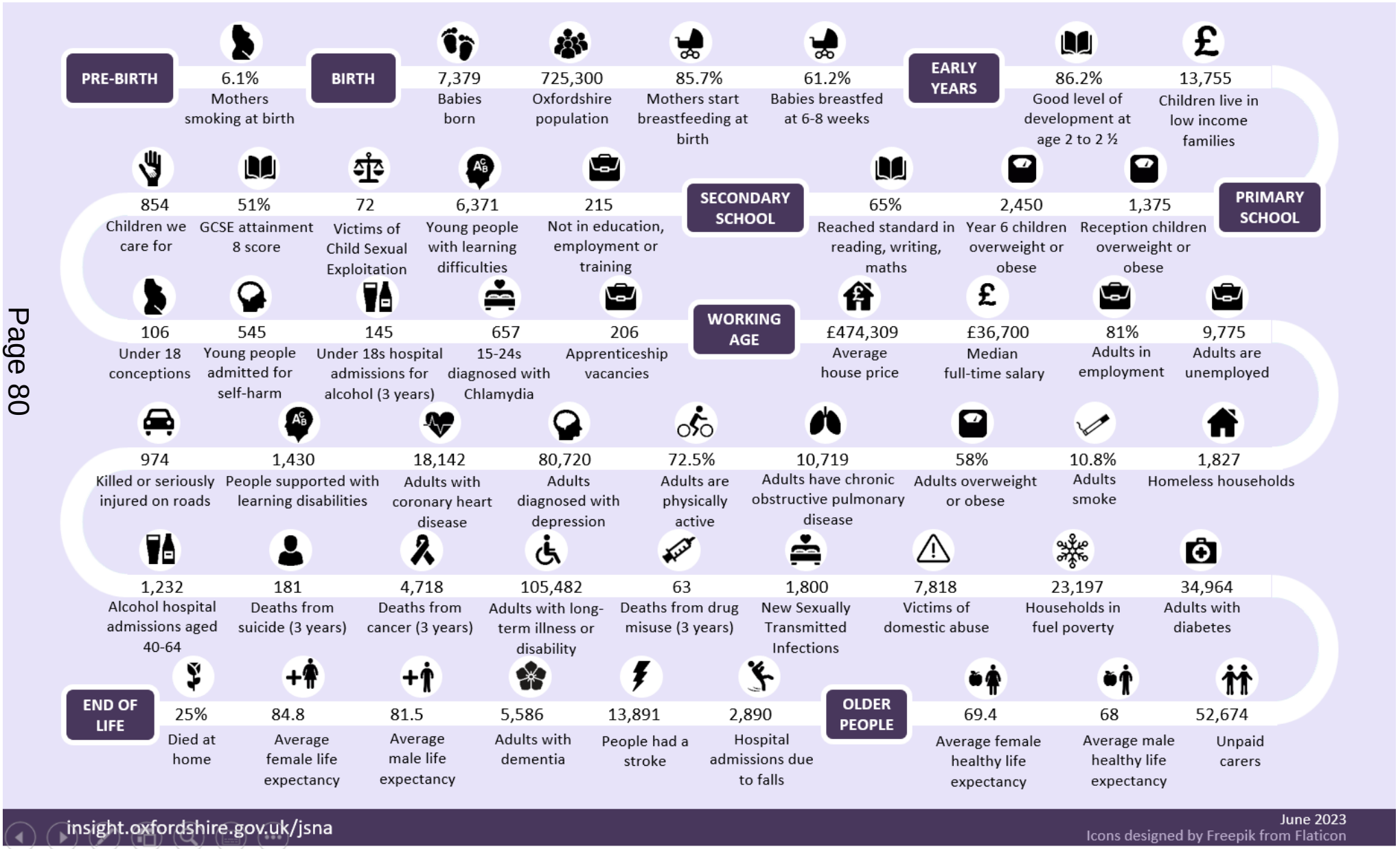
June 2023

Annex 1 - Oxfordshire JSNA health and wellbeing facts and figures 2023

Oxfordshire JSNA, health and wellbeing facts and figures 2023



June 2023
Icons designed by Freepik from Flaticon

Divisions Affected - All

Health and Wellbeing Board

29th JUNE 2023

Updating the Health and Wellbeing Strategy

Report by ANSAF AZHAR, Corporate Director of Public Health

RECOMMENDATION

1. **The Health and Wellbeing Board is RECOMMENDED to**

- Note the formation and activity of the cross-organisational Task and Finish group, with representation from all organisations on the Health and Wellbeing Board;
- Note ongoing progress towards updating the Health and Wellbeing Strategy;
- Approve plans to communicate and engage with residents;
- Approve proposed structure for the Health and Wellbeing Strategy;
- Consider and determine the timeframe for the updated Health and Wellbeing Strategy;
- Discuss emerging themes, principles, and priorities and offer guidance to officers regarding content of the strategy;
- Approve a workshop of the HWB to take place in September (date TBC) so that board members and officers on the Task and Finish group can work together on further content development.

Executive Summary

2. Officers have now begun the process of updating Oxfordshire's Health and Wellbeing Strategy as agreed by the Health and Wellbeing board on 16 March 2023. The strategy will offer a strong, unified vision for improved health and wellbeing at place and will act as the primary place strategy for health and wellbeing in Oxfordshire. A cross-organisational Task and Finish Group has been established to drive forward strategy development between board meetings, with representation from all organisations on the Health and Wellbeing Board. All organisations on the Task and Finish group have contributed to the proposed structure for the strategy and to ongoing discussions around high level themes, principles, and priorities. This report proposes an overarching structure for the Health and Wellbeing Strategy and summarises 'emerging themes' from these ongoing discussions. The Task and Finish Group has also contributed to and agreed an overall approach to communications and engagement, as summarised in this report and outlined in full in Annex 1.

Background

3. Oxfordshire's Health and Wellbeing Board (HWB) last published a Joint Local Health and Wellbeing Strategy in 2019. The Health and Wellbeing Board has a statutory responsibility to publish this strategy. The most recent strategy comes to a close in 2023.[1] Since 2019, the social, economic, and health context has changed very significantly: residents, local authorities, and the NHS have experienced Covid-19 and continue to be impacted by the cost of living crisis. Inequalities in health outcomes continue to widen—the most recent data shows that, on average, men in one of our poorest neighbourhoods (Blackbird Leys) live 14 years less than men from one of our wealthiest neighbourhoods (North Thame).[2] Moreover, since 2019, the organisation of health and social care has changed: the Health and Care Act 2022 created statutory Integrated Care Systems (ICSs), aiming to closer integrate health and social care.

4. Since the formation of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) in July 2022, partners have worked across the BOB area to create an overarching system wide ICS Strategy, published in March 2023. Nonetheless, the Health and Wellbeing Board has a statutory responsible to create and publish a health and wellbeing strategy.

5. On 16 March 2023, the Health and Wellbeing Board approved initial plans to update Oxfordshire's Joint Local Health and Wellbeing Strategy. The Board approved an indicative timeline as well as the establishment of a steering group comprised of senior officers from organisations sitting on the Health and Wellbeing Board.

6. The Health and Wellbeing Strategy must outline the Board's priorities to tackle the needs identified in Oxfordshire's Joint Strategic Needs Assessment (JSNA).[3] As such, the Health and Wellbeing Strategy must be closely informed by the JSNA, which is published annually to give data and intelligence on the health needs of local residents. The publication of the JSNA 2023 coincides with the publication of this paper and seeks final approval from today's Board meeting.

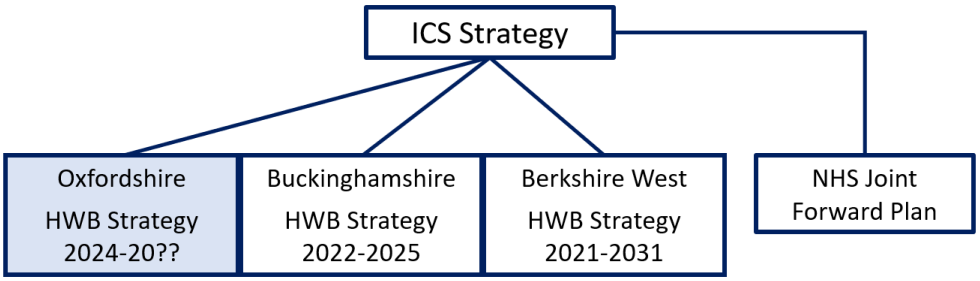
7. Updating Oxfordshire's Health and Wellbeing Strategy therefore offers a real opportunity for Oxfordshire to establish a strong local vision for improved health and wellbeing and to develop the strategic direction of Oxfordshire's Health and Care system.

[1] https://www.oxfordshire.gov.uk/sites/default/files/file/constitution/oxfordshirejointhwbstrategy.pdf
[2] Oxfordshire Local Area Inequalities Dashboard
[3] Statutory guidance on joint strategic needs assessments and joint health and wellbeing strategies (publishing.service.gov.uk), pp. 8-9

Footprint and Scope

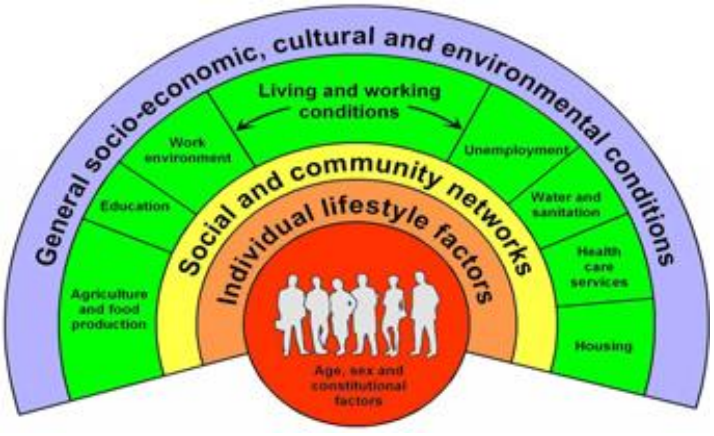
8. The Health and Wellbeing Strategy will act as the primary place strategy for health and wellbeing in Oxfordshire. Figure 1 below outlines how officers propose this strategy intersects with the ICS Strategy and the NHS Joint Forward Plan:

Figure 1: proposed intersection between ICS Strategy, NHS Forward Plan, and local Health and Wellbeing Strategy



9. The scope of the updated strategy will be quite broad. While NHS organisational strategies often have a clinical or bio-medical focus, the Health and Wellbeing Strategy needs to reflect the wider determinants of health which significantly influence local residents' health and wellbeing.

Figure 2: Dahlgren and Whitehead rainbow to illustrate wider determinants of health and scope of the health and wellbeing strategy



10. Given the broad scope of the Health and Wellbeing Strategy, it will need to build on a wide range of existing strategies, policies, and plans across different organisations. All organisations represented on the Health and Wellbeing Board have suggested, and can continue to suggest, existing strategies, plans, and policies which the updated Health and Wellbeing Strategy should account for. The Health and Wellbeing Strategy will need to provide the overarching focus and vision for improving health and wellbeing within these existing plans and work programmes.

Updated Process

11. The Task and Finish Group is operating to the below timeline for publishing an updated Health and Wellbeing Strategy.

Figure 3: *Timeline for updating the Health and Wellbeing Strategy*

12. Progress will be reported to the HWB at its quarterly meetings ahead of final sign-off and publication at the HWB meeting on 7th December 2023. Officers also propose to host a deep-dive workshop for the Health and Wellbeing Board in early September, to delve into the details of an early draft version of the strategy. Officers will present a draft strategy to the Joint Health Oversight and Scrutiny Committee on 21st September 2023.

13. The Task and Finish Group is responsible for ensuring the strategy follows this process and publishes a strategy in good time. The group is comprised of representatives from the different partners on the HWB and meets monthly. It is chaired by David Munday, Deputy Director of Public Health. Group members are of sufficient seniority to represent their organisational priorities and regularly communicate progress to their respective organisations. The group has agreed a Terms of Reference outlining its role, responsibilities, and membership (see Annex 2). Further details on the progress of this group to date can be found under “Progress to date” below.

Communications and Engagement

14. The Task and Finish Group, including Healthwatch Oxfordshire, have developed a Communications and Engagement Plan for the update to the Health and Wellbeing Strategy (see Annex 1). The plan outlines how officers will:

    i. Gather and listen to residents, board members, Councillors, and staff
    ii. Inform staff and residents that the Health and Wellbeing Strategy is being updated—and why that matters
    iii. Enable the smooth progress of strategy development by informing and engaging key decision-makers
    iv. Communicate how the final strategy helps residents and their loved ones

15. At the heart of communication with residents is the need to make this real. We must get beyond acronyms and complex data to tell stories: how does this affect real people living real lives? To make it real, we will use graphics, videos, and quotations from residents.

16. All Oxfordshire residents should have a say in what their Health and Wellbeing Plan looks like. Therefore, the Task and Finish group is keen that residents' voices help shape the strategy. Officers particularly want to hear from groups that are more impacted by or more at risk of poor health and groups we don't listen to often enough. So, officers are planning a 'golden thread' of engagement with residents throughout the development of this strategy:

    i. Between June and August, officers will collate existing reports and research which detail resident' thoughts and opinions.
    ii. Between June and August, officers will organise focus groups among residents we especially want to hear from, in partnership with existing community groups and voluntary organisations.
    iii. Between June and August, Healthwatch Oxfordshire plan to survey residents, speak to residents at pop up events and in market towns, and host online conversations.
    iv. In October and November, partners will jointly launch and promote a formal public and professional consultation. Public events will accompany this consultation exercise.

    This activity will all inform the eventual strategy.

17. Healthwatch Oxfordshire will play an important part of this partner-wide engagement with the public. This work forms part of the Board's shared approach to speaking to residents and collecting insight from them. They propose to:

- Speak to residents at in-person ‘pop-up’ events
- Ask residents for their views in a short online survey
- Continue discussions with residents about health and wellbeing
- Hold an online wellbeing webinar
- Contribute to the public engagement report

18. All the activity noted above will generate a consultation and engagement report which will be presented to the Health and Wellbeing Board.

Progress to date

19. The cross-organisational Task and Finish group has already met twice to drive forward the process of updating the Health and Wellbeing Strategy. During this time, it has:

    a. Overseen the publication of the JSNA and used its findings to inform emerging themes for the Health and Wellbeing Strategy
    b. Hosted conversations and/or workshops with colleagues in respective organisations about the Health and Wellbeing Strategy’s priorities and principles
    c. Developed a draft structure of the Health and Wellbeing Strategy and reviewed emerging themes, principles, and enablers
    d. Viewed and commented on an early draft of the Communications and Engagement plan

20. Officers are finalising logistics for resident focus groups. Officers plan to host these focus groups among existing community groups to avoid placing extraneous burden on residents and community leaders, many of whom are already overburdened. Officers will offer training, a facilitation pack, slides/activities, and vouchers for residents to support community leaders facilitating these focus groups. Community leaders will feed back to officers. Officers have also worked with Healthwatch to develop their parallel plan to speak to and engage with residents.

Timeframe

21. The question remains open as to what timeframe Oxfordshire’s updated Health and Wellbeing Strategy operates over. Oxfordshire’s previous Health and Wellbeing Strategy operated over a five year period from 2019-2023. However, Oxfordshire’s neighbouring authorities within the BOB area have opted for different timeframes: Buckinghamshire’s strategy runs from 2022-2025 (three to four years) while Berkshire West’s strategy runs from 2021-2031 (ten to eleven years).

22. The adopted timeframe must take into account the fact that, in many cases, improvement in health and wellbeing outcomes will take a reasonably long time to achieve. However, as the Covid-19 pandemic and the cost of living crisis have shown, significant events can occur which cannot be foreseen. Such events impact on health and wellbeing and require a new strategic approach to effectively address them. Taking this into account and building on feedback from the T&F group, setting the strategy for 2024-2030 represents a reasonable balance of organisational views on the overarching timeframe. It should be noted that, irrespective of the strategy's exact timeframe, it will contain some priorities that need to and can be delivered over a shorter time period (1 to 2 years) and others which are longer term in the nature.

23. **The Health and Wellbeing Board is requested to consider the above points and provide its opinion on the appropriate length of the strategy, which the Board will finalise after feedback from residents as part of the formal consultation.**

Proposed Structure & Emerging Themes

24. This section outlines a proposed structure for the strategy, as approved by the Task and Finish Group. It also offers high level themes emerging from substantial ongoing contributions from and discussion among the Task and Finish group.

25. It is worth emphasising that this section is far from final. The final themes, priorities, and principles must be informed by resident voices and data insight. Further, officers propose that the final strategy advocates a limited number of priorities, to ensure that Oxfordshire's local vision for health and wellbeing has real focus. The process of refining these themes, priorities, and principles must be determined by three factors: 1) what residents tell us during our engagement work; 2) data insight from JSNA and other key sources; and 3) which areas of focus can only be achieved by system-wide working.

Structure

26. The Task and Finish Group proposes that the strategy adopts the Life Course approach, with 'Start Well', 'Live Well', and 'Age Well' as key themes. This reflects the approach taken by the ICS Strategy. The Task and Finish group continues to consider the possibility of additional themes which span the entire life course. The Task and Finish group also proposes that the strategy is guided by various 'principles'—ways of working that guide everything we do over the next few years—and underpinned by various 'enablers', without which the system will not be able to improve residents' health and wellbeing. A visual

representation of this framework is provided below. **The Health and Wellbeing Board is requested to approve the overarching framework for the strategy.**

Figure 4. Proposed high level structure of Health and Wellbeing Strategy

27. Officers suggest that, for each life course theme e.g., "Start Well", there are roughly three priorities. This will ensure the Board has a clear focus over the next few years. Officers also suggest that the strategy includes immediate actions, outlining where the Board will drive change over the first 1-2 years. For each priority area, officers propose that the strategy implements change through various routes: providing quality, inclusive, and accessible services; enabling healthy behaviours; building community resilience; putting in place the building blocks of health; and creating a healthy built environment.

28. Officers also suggest that the strategy and its priorities are linked to an associated delivery plan and outcomes framework. The outcomes framework would outline key KPIs and outcomes for each priority area. The delivery plan would outline in depth how respective organisations will work together to deliver these priorities, KPIs, and outcomes, year-on-year. Both the delivery plan and outcomes framework would be monitored by existing or to-be-formed groups, which would report directly to the Health and Wellbeing Board. The Health and Wellbeing Board would receive annual reports about progress on the delivery plan and outcomes framework.

Content

29. All organisations have contributed, and continue to contribute, to discussion around the content of the Health and Wellbeing Strategy. **These discussions are early and ongoing.** All organisations have had the opportunity to submit written documentation outlining what they want to see in the updated Health and Wellbeing Strategy. All organisations have also contributed to ongoing discussions about what the updated Health and Wellbeing Strategy ought to include. This ongoing dialogue has allowed the group to propose principles and enablers to guide and support the strategy; priorities within each Life Course theme; possible additional themes/content; and strategies/plans/policies they wish to contribute to the Health and Wellbeing Strategy. The collation of submitted documents and ongoing dialogue has informed the 'emerging themes' outlined below:

Principles	Enablers	Themes spanning entire life course

• Tackling health inequalities
• Prevention & early intervention—whole system approach
• Collaboration & partnership between organisations
• Healthy place shaping
• Value-led & insight/evidence-informed
  ○ Led by values of residents
  ○ Informed by qualitative & quantitative data insight & evidence
• Empowering communities
  ○ Community resilience
  ○ Asset based community development (ABCD)
• Co-production, lived experience, & community engagement
• Person-centred care
• Daring to do differently
	• Data & digital
	  ○ Shared data & records
	  ○ Data insight & intelligence
	  ○ Accessible population health data
	  ○ Digital inclusion
	• Workforce
	  ○ Staff health wellbeing—without workforce wellbeing we cannot deliver better health & care
	  ○ Recruitment & retention
	• Vibrant communities
	  ○ Community resilience
	  ○ Opportunities & strengths among people & places
	• Anchor institutions, including 'One Public Estate'
	• Communication & language
	• Innovation and research
		• Prevention & inequalities
		  ○ Equality, diversity, and inclusion
		  ○ Health inclusion groups
		• Climate, nature, and clean air
		  ○ Climate related health risks e.g., heat
		  ○ Climate mitigation
		  ○ Biodiversity
		  ○ Protecting nature & increasing access to nature
		  ○ Green prescribing

Start Well	**Live Well**	**Age Well**
• Mental health & emotional wellbeing (including CAMHS) • Early years—first 1001 days & perinatal support • Food, nutrition, & FSM—tackling childhood obesity • Physical activity & active travel • 0-5 school readiness, especially among areas of deprivation and for children eligible for Free School Meals • Educational attainment • SEND (special education needs & disability)—community resilience • Lost opportunities due to Covid/cost of living crisis	• Adult mental health & wellbeing, including suicide & self-harm • Key behavioural determinants e.g., tobacco control, alcohol, healthy weight & food • Being active & active travel • Adults with learning disabilities, disabilities, & neurodivergent adults • Stronger links between health, housing and mental health • Accessible, affordable, quality housing • Poverty, deprivation, & financial resilience—foundational economy • Available, quality employment • Domestic abuse	• The Oxfordshire Way (helping residents to help themselves) • All ages carers, including unpaid carers • Preventing unnecessary hospital admissions & anticipatory care • Dementia & falls • Rurality and social isolation • Reducing preventable mortality • Local Area Coordinator programme & integrated neighbourhood teams around PCNs • Keeping active

Financial Implications

30. There are no direct financial implications associated with this report. The Officer resource required to develop the work will need contribution from partners of the Health and Wellbeing Board.

Legal Implications

31. The development of Oxfordshire Health and Wellbeing Strategy will meet the Health and Wellbeing Board's statutory duty to publish a strategy to address health needs of the local population, as described above. The publication of the JSNA 2023 will enable the Board to meet its duty that its strategy addresses resident needs as outlined in the JSNA.

Staff Implications

32. The Officer resource required to develop the work will need contribution from partners of the Health and Wellbeing Board, as agreed by the HWB on 16th March 2023.

Equality & Inclusion Implications

33. Tackling health inequalities will play a key role in the eventual Health and Wellbeing Strategy. This includes inequalities in health outcomes, experiences, and access to health and care services. This priority will be driven by insights from JSNA 2023.

34. It is important that residents from disadvantaged groups have a chance to help shape the Health and Wellbeing Strategy. As outlined above, officers will engage with residents from disadvantaged groups across Oxfordshire during the process of updating the strategy, especially those whose health is adversely impacted by their respective disadvantage. Officers will draw on existing networks and community groups to run targeted focus groups to ensure their voice is heard.

Sustainability Implications

35. The process of updating the strategy itself has no direct sustainability implications. However, it is anticipated that the strategy will also consider the impact of climate change on health, including air quality, access to nature, and the built environment. It is anticipated that the strategy will build on and affirm existing partnership-wide climate action commitments, recognising the impact this has on residents' health and wellbeing.

Risk Management

36. A detailed risk assessment is not required for this work. Regular oversight and input on the strategy development will be provided by the Health and Wellbeing Board and the Task and Finish group.

NAME	ANSAF AZHAR, CORPORATE DIRECTOR OF PUBLIC HEALTH
Annex:	Annex 1_Communications and Engagement Plan_HWS
	Annex 2_Terms of Reference_HWS Task & Finish group
Background papers:	Final ICS Strategy: Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Partnership | http://yourvoicebob-icb.uk.engagementhq.com
	Oxfordshire Joint Health and Wellbeing Strategy 2019-2023
	Joint Strategic Needs Assessment | Oxfordshire Insight
	Statutory guidance on joint strategic needs assessments and joint health and wellbeing strategies (publishing.service.gov.uk)
	Health and wellbeing boards – guidance - GOV.UK (www.gov.uk)
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June 2023

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Annex 1

Update to the Health and Wellbeing Strategy Communications and Engagement Plan

Project Lead: David Munday
Author: Jamie Slagel
Communications Lead: Rachel Fox
Date: June 2023

Introduction

Right now, lives are being cut short in Oxfordshire. People in our poorest neighbourhoods are dying over a decade earlier than people in the wealthiest areas. But we can change that by ensuring Oxfordshire's residents have stable jobs, quality housing & good education; shaping healthy physical environments for residents; enabling healthy behaviours; empowering communities and neighbourhoods; and providing quality, accessible, and inclusive health and care services.

The updated Health and Wellbeing Strategy will outline how we—Oxfordshire's local authorities and NHS organisations—are going to do this. Updating the health and wellbeing strategy represents an important opportunity to establish a strong local vision for improved health and wellbeing in Oxfordshire. After all, since 2019, when we last published our strategy, the social, economic, and health context has significantly changed: we have experienced Covid-19 and continue to experience the impact of the cost of living crisis. Inequalities in health outcomes continue to widen.[1] Our approach must change too.

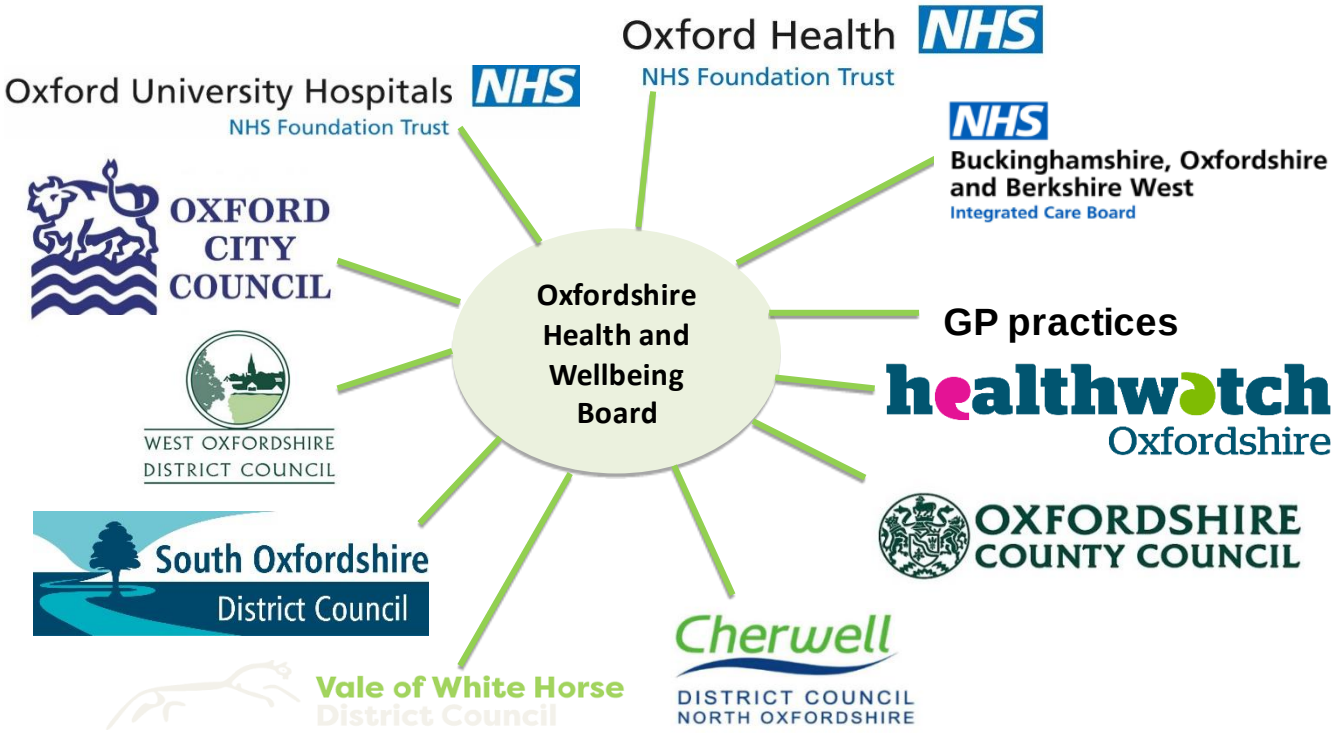
Partnership-led communication and engagement will be crucial to the development and publication of this important strategy. We want to hear what will make a difference to residents and communities. We want to co-ordinate effectively across local authorities, NHS organisations, and Healthwatch Oxfordshire. And we want to make sure that staff know what we're doing, and why we're doing it. This document outlines our partnership communication and engagement plans.

[1] https://public.tableau.com/views/OxfordshireLocalAreaInequalitiesDashboard/Home?embed=y:display_count=no&:showVizHome=no

Background

Who we are

Many organisations sit on and contribute to the Health and Wellbeing Board. This includes local authorities, NHS provider organisations, the Integrated Care Board, GP practices, and Healthwatch Oxfordshire, as you can see below:



N.B. Oxfordshire County Council is represented on the Health and Wellbeing Board by three directorates: Public Health, Adult Social Care, Children Education and Families.

Updating the Health and Wellbeing Strategy

Between now and December 2023, we are updating Oxfordshire's Joint Local Health and Wellbeing Strategy. The strategy will offer a unified local vision for improved health and wellbeing and will act as the primary place strategy for health and wellbeing in Oxfordshire.

Publication of the strategy is a statutory responsibility (Health and Social Care Act 2012) of the Health and Wellbeing Board. The strategy is informed by the annually published Oxfordshire Joint Strategic Needs Assessment. This ensures it is informed by data and intelligence on the health needs of local residents.

While NHS organisational strategies often have a clinical or bio-medical focus, the Health and Wellbeing Strategy will reflect wider factors that impact local residents' residents' health and wellbeing. This includes the building blocks of health: housing,

education, employment, access to green space, active travel, community resilience, and air quality.

The current process of updating the strategy must take into account recovery from Covid-19 and ongoing concerns regarding the cost of living crisis, the shift in governance from Clinical Commissioning Groups (CCGs) to Integrated Care Systems (ICSs), and growing health inequalities.

This document

We want this document to provide clear and accessible public information about our vision and plans for health and care in Oxfordshire. It is intended to be a working document, not a static one—we will continue to update and change this plan as we go along.

The communication and engagement approach outlined in this document is consistent with the County Council's recently published Consultation and engagement strategy. This approach also reflects LGA and NHS England's guidance on working with people and communities when building strong integrated systems. After all, this is Oxfordshire's primary health and wellbeing strategy at place-level.

Objectives

The process of publishing an updated Health and Wellbeing Strategy requires various communication and engagement objectives for different audiences. Our core objectives are:

1. **Inform** staff and residents that the Health and Wellbeing Strategy is being updated—and why that matters

2. **Engagement**: ensure that the updated strategy is informed by:
    i. Residents
    ii. Councillors/board members
    iii. Staff (across all partner organisations)

3. Enable the **smooth progress** of strategy development by informing and engaging key decision-makers

4. **Communicate** how the value and impact of residents' involvement, and how the (eventual) published strategy helps residents and their loved ones

Audiences

Our audiences can be split into three categories:

1. Public
2. Staff
3. Decision Makers

Our objectives are different for different audiences. Consequently, we will use different communication channels for different audiences.

Public

Ultimately, all Oxfordshire residents should have the opportunity to shape what their Health and Wellbeing Strategy looks like. We will listen to the views and experiences of residents and local communities to inform the development of the strategy—what are their priorities? What do they want to see?

Within this large cohort, there are specific groups we especially want to hear from, including:

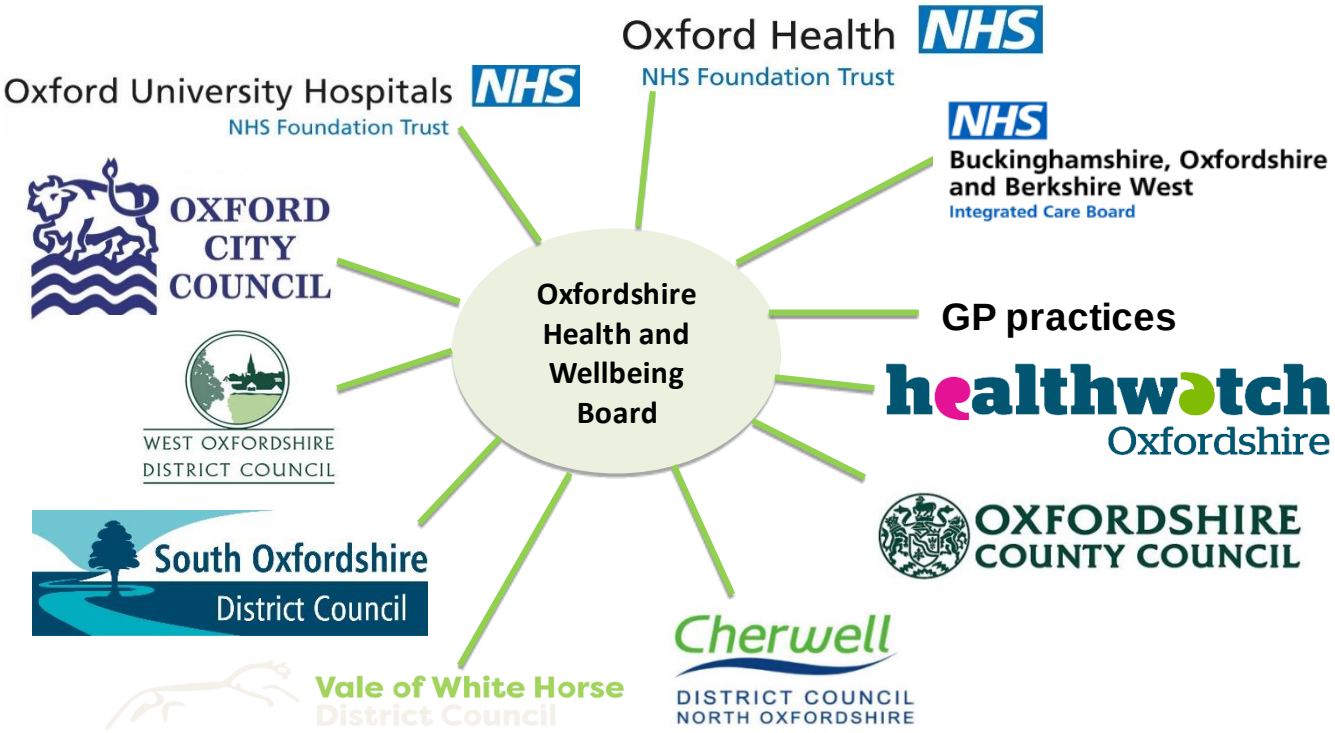
- Carers & residents in care
- Pregnant and new mums
- Children & young people
- Older people
- Residents with learning disabilities
- Neurodiverse residents
- Residents with long term health conditions
- LGBTQ+ residents
- Ethnic minorities
- Military populations
- Underreached residents
- Health inclusion groups
- Residents in areas of multiple deprivation

Staff

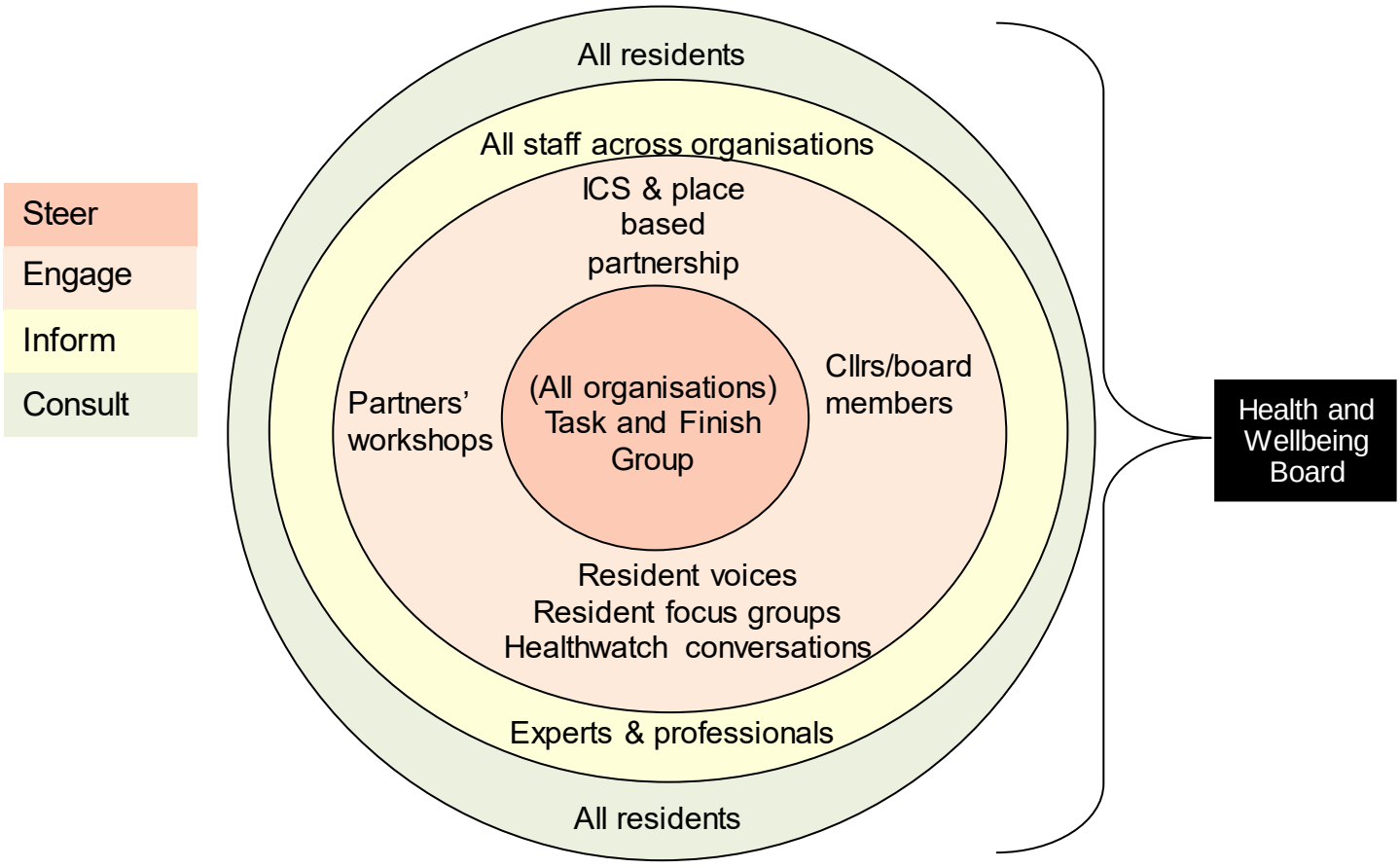
We will inform staff that this update is occurring and communicate what the published strategy contains and why that matters. This comprises all staff at all partner organisations on the Health and Wellbeing Board, including frontline staff.

Decision Makers

We will regularly engage key decision-makers and strategic employees across partner organisations—both to inform them of the process and to consult their views. This will enable smooth and timely publication of the updated strategy. This includes political and/or board members, corporate directors, and employees overseeing strategy or health and wellbeing. Below is a map of the relevant organisations:



Stakeholder Map



Strategy

Our strategy takes a three-pronged approach:

1. Regularly engage with and consult key decision makers
2. Inform staff across partners about the update
3. Engage, consult and communicate with the public

Stakeholder Engagement

Regularly engage with and consult key decision makers

To ensure we meet our goal of regularly engaging with and consulting key decision makers, we will attend key meetings as follows.

Health and Wellbeing Board. We will visit the Health and Wellbeing Board three times—firstly on 29 June 2023 to agree vision, scope, themes, and principles. Secondly on 5 October 2023 to agree a draft strategy for public consultation. Finally on 7 December 2023 to sign-off the final strategy. Furthermore, in the first week of September, we plan to engage the HWB members in a workshop session to enable them to take a deeper dive into an early draft version of the strategy.

Task and Finish Group. The Task and Finish group will have officer-level representation from all partners who sit on the Health and Wellbeing Board. They will meet monthly with a mandate to drive forward and provide oversight to the publication of the strategy. This group will lead the process and, as such, its members will often be responsible for communications and engagement in their respective organisation.

Chief Executives Meeting. We will go to the CEX meeting on Monday 19 June and again where necessary and appropriate.

Community Joint Working Group. We will regularly visit the Community Joint Working group in a more informal manner to help socialise the strategy and ensure that officers responsible for community and health across city/districts are engaged at all stages. We will also visit the Community Hub's more formal meeting to formally involve and engage key partners during the process.

Joint Health Overview and Scrutiny Committee. We will visit HOSC on 21 September 2023 for detailed scrutiny of an early draft strategy.

Place Based Partnership. We will visit on 7 July 2023 and again where necessary.

Further Officer Engagement. Officers who sit on the task and finish group have run a workshop and/or consulted with colleagues in their respective organisations so they

can formulate a vision of what they wish the Health and Wellbeing Strategy to look like. These conversations have been used to provide written responses which have been collated to inform the development of system-wide vision and priorities.

Staff will also engage with other meetings and forums as and where opportunities arise.

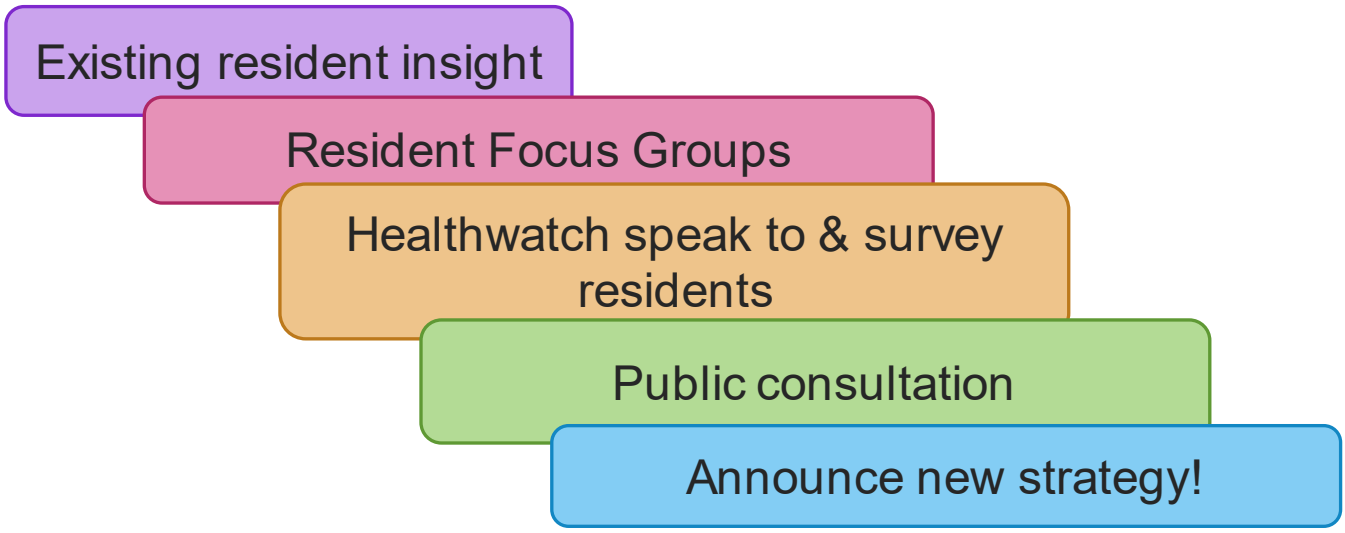
Engage with and consult residents and communities

All Oxfordshire residents should have a say in what their Health and Wellbeing Strategy looks like—we are all committed to this. Therefore, it is very important to us that our development of this strategy involves engagement with residents and communities across Oxfordshire. To do so, we will:

1. Learn from existing insight into the views of residents and communities
2. Engage existing resident groups to run focus groups among voices we don't listen to often enough
3. Work in partnership with Healthwatch to gather insight into residents' priorities
4. Run a four week public consultation in October 2023

We particularly want to hear from groups that are more impacted by or more at risk of poor health and groups we don't listen to often enough.

In addition to 'You Said, We Did' public feedback, each stage will generate a public report presented to the Health and Wellbeing Board to ensure transparency and accountability. This will create a 'golden thread of engagement and consultation':



Existing Resident Insight

It is crucial that our strategy is informed by residents and communities. At the same time, we wish to avoid increasing the burden on residents—especially vulnerable residents—and to avoid duplicating work. So, we will use existing insight into resident and community perspectives, where possible. This will be incorporated into our public engagement reports and will inform decision makers.

Resident Focus Groups

Health and Wellbeing Board members will engage existing community groups to gain insight and feedback from specific cohorts/groups of residents through focus groups. To maximise engagement and avoid extraneous burden, focus groups will take place among existing community groups. To support this work, officers will offer training, a facilitation pack, and slides/activities to support community leaders to facilitate these focus groups. Residents who take part will be compensated for their time.

Key Groups we wish to hear from:

- Carers & residents in care
- Pregnant and new mums
- Children & young people
- Older people
- Residents with learning disabilities
- Neurodiverse residents
- Residents with long term health conditions
- LGBTQ+ residents
- Ethnic minorities
- Military populations
- Underreached residents
- Health inclusion groups
- Residents in areas of multiple deprivation

We have a goal to talk to at least 100 residents in our resident focus groups across at least 8 groups.

All groups will be provided with the draft strategy (and narrative on how community engagement has shaped it) following sign off at the October HWB meeting, with an invitation to participate in the consultation on it.

Healthwatch activity

Healthwatch Oxfordshire will play an important part of this partner-wide engagement with the public. This work forms part of the Board's shared approach to speaking to residents and collecting insight from them. They propose to:

- Speak to residents at in-person 'pop-up' events
- Ask residents for their views in a short online survey

- Continue discussions with residents about health and wellbeing
- Hold an online wellbeing webinar
- Contribute to the public engagement report

This activity will be carried out independent of local authorities or health services but will occur parallel to the other resident insight work we are undertaking.

Public Consultation

After the Health and Wellbeing Board signs off the draft strategy on 5 October, we plan to go to public consultation between 5 October and 5 November. We will promote this consultation across the full range of our partners' platforms.

Targets

1. Talk to at least 100 residents in events during the consultation process.
2. Receive at least 500 responses to the consultation.

Communication

At the heart of our consultation—from members to residents—is the need to make this real. We must get beyond acronyms and complex data to tell **stories**: how does this affect real people living real lives? To this end, we propose to use graphics, videos, and quotes from residents.

Balancing different stakeholder perspectives

Inevitably, conflicting views will arise from our work talking and listening to residents. We think it's important to hear the full range of perspectives and our public engagement report will reflect this.

Nevertheless, the final strategy will have to manage these conflicts in a fair and transparent manner. To do so, when deciding what to include in our strategy, we will consider:

1. What the most recent Joint Strategic Needs Assessment (JSNA) tells us about resident needs across Oxfordshire
2. Whether the priorities are achievable within the timeframe
3. The shared priorities of all members of the Health and Wellbeing Board

Communications

- **Communications assets for resident focus groups**
  - Consistent messaging that makes this strategy real, following this guidance
  - Graphics of key statistics, with accompanying narrative

- Resident quotations
- Resident stories
- Simplified papers
- Simplified 'what we already know': JSNA statistics + narrative + graphics
- Resident focus group facilitation packs, slides/activities

- **Resident-targeted communications** (public consultation & publication of strategy)
  - Press release
  - Social media posts, including graphics
  - Template copy for partner organisation newsletters
  - Internal communications
  - Video from OCC's Director of Public Health—why it matters

We will adopt this framework: How to talk about the building blocks of health - The Health Foundation

Key Milestones

April-May 2023	OCC - planning work
May-June 2023	All partners - developing scope, priorities, vision
29 June 2023	Health and Wellbeing Board
June-September 2023	All partners - strategy development & writing
June-August 2023	Healthwatch - speak to & survey residents
June-July 2023	OCC - Resident focus groups
September 2023	HWB Workshop (one-off)
21 September 2023	HOSC
5 October 2023	Health and Wellbeing Board
6 October – 5 November 2023	OCC - Public Consultation
7 December 2023	Health and Wellbeing Board

Risks & Mitigation

Each event will be individually risk assessed as is standard practice for any engagement (either digital or physically in-person).

Implementation

Date	Activity	Details/channel	Owner	Status
Overall				
Comms & Engagement Plan	Comms strategy and plan plus sign-off	Includes narrative, key messages and timeframes	Jamie Slagel	Ongoing
Stakeholder / internal engagement				
Monthly between May and December	Task and Finish Group	Responsible for driving forward process of updating strategy.	Jamie Slagel	Ongoing
June 29 Oct 5 Dec 7	Health and Wellbeing Board	Responsible for publishing strategy.	David Munday	/
23 May Summer November	Community Hub Group	*See above*	Jamie Slagel	Done / /
Early September	HWB Workshop	Detailed discussion of draft strategy.	David Munday	/
21 Sep	HOSC	Scrutiny of draft strategy.	Ansaf Azhar	/
Sep (tbc)	All member briefing	*See above*	Jamie Slagel	/
19 June *Again tbc*	CEX meeting	*See above*	Ansaf Azhar	/
September	Storytelling toolkit for engagement with members and residents	Graphics and stories that make this work real— why does this matter to you and your loved ones?	Charlotte Knowles	/
September	Video for engagement with members and residents	Video that makes this work real—why does this matter to you and your loved ones?	Charlotte Knowles	/
October December	Communications toolkit i.e., messages all partners can use	Toolkit all partners can use to align messages and brand.	Jamie Slagel	/
October December	Internal email/newsletter content for staff	Informing staff what is happening and why it matters.	Jamie Slagel	/
October December	Member newsletter content	Informing members what is happening and why it matters.	Jamie Slagel	/
October December	Intranet news story or page	Informing staff what is happening and why it matters.	Jamie Slagel	/
Consultation and engagement				
June-July	Pre-consultation engagement events ('focus groups')	*See above*	Jamie Slagel	

October 6	Consultation document and pack for online publication		Rachel Fox	
October 6	Digital engagement / consultation platform content		Rachel Fox	
June-August	Surveys for residents (tbc)		Veronica Barry	
June-August	Speaking to residents at pop up events and market towns (tbc)		Veronica Barry	
June-August	Online events with residents (tbc)		Veronica Barry	
Marketing/publicity				
October	Webpage content and short URL	Communicating that we're updating/have updated the strategy and why that matters.	Jamie Slagel	
October - November	Social media content plan and messages	Communicating that we're updating/have updated the strategy and why that matters.	Charlotte Knowles	
October	Social media assets	Communicating that we're updating/have updated the strategy and why that matters.	Charlotte Knowles	
October	Digital ad van and localised digital ads	Communicating that we're updating/have updated the strategy and why that matters.	Charlotte Knowles	
October December	Video explainer	Communicating that we're updating/have updated the strategy and why that matters.	Charlotte Knowles	
October December	External newsletters/bulletins content	Your Oxfordshire, Pulse	Jamie Slagel	
Media				
October 6	Press statement/release	Communicating that we're updating/have updated the strategy and why that matters.	tbc	
December 8	Press release – end of programme	Communicating that we're updating/have updated the strategy and why that matters.	tbc	

Oxfordshire HWS Task and Finish Group
Terms of Reference

Purpose

The Oxfordshire Health and Wellbeing Strategy Task and Finish Group will meet monthly between April and December 2023 to oversee the update of the Oxfordshire's Health and Wellbeing Strategy. This document defines the Terms of Reference for the group.

1. Background

1.1. The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWBs) and required them to publish a Joint Local Health and Wellbeing Strategy (JLHWBS). HWBs and their strategies are a key component in driving forward integration of initiatives and services locally to improve health and wellbeing. The JLHWBS is informed by the Oxfordshire Joint Strategic Needs Assessment, published annually.

1.2. Oxfordshire's Health and Wellbeing Board last published its JLHWBS in March 2019, setting out the vision for 2018-2023 and requires updating. Oxfordshire must also review its local strategy in light of developments since 2019, including: the establishment of Integrated Care Systems (see below); the publication of the BOB ICS Strategy (see below); recovery from COVID-19.

1.3. Integrated Care Systems

1.3.1. The Health and Care Act 2022 created statutory Integrated Care Systems (ICSs). Oxfordshire is part of the Buckingham, Oxfordshire, and Berkshire (BOB) ICS. Since the formation of the BOB ICS in July 2022, partners across BOB worked together to publish a systems-wide BOB ICS Strategy in March 2023.

1.3.2. While these changes have occurred, the Health and Wellbeing Board retains its statutory duty to create and publish a JLHWBS. Indeed, one of

the ICS's foundational principles is 'subsidiarity': while some work will be system wide, there remains the importance of Place (i.e., Oxfordshire) to drive forward the health and wellbeing agenda. Furthermore, the HWB and partners in the NHS Integrated Care Board have agreed that the JLHWBS will act as the overall place strategy for Oxfordshire.

1.4. At its meeting on 16th March 2023**,** the Health and Wellbeing Board agreed to the formation of a task and finish group which will have a more detailed involvement in the strategy development between board meetings.

2. Aims and Objectives

2.1. The overall aim of this group is to **establish a strong local vision for improved health and wellbeing in Oxfordshire**.

2.2. The group will have two core responsibilities:

2.2.1. The group will provide oversight to the production of Oxfordshire's Joint Strategic Needs Assessment for 2023, due for publication in June 2023.

2.2.2. The group will drive forward the update of Oxfordshire's Joint Local Health and Wellbeing Strategy, due for publication in December 2023.

2.3. The objectives of the group are:

- Formulate an overarching health and wellbeing vision for Oxfordshire, taking into account existing strategies/plans across organisations in Oxfordshire.
- Develop the priorities, themes, and principles for the updated Health and Wellbeing Strategy.
- Analyse data from the JSNA 2023 to ensure that priorities, themes, and principles are evidence-based.
- Ensure the updated health and wellbeing strategy integrates with the ICS Strategy and includes those aspects of the ICS Strategy which are best applied at place.

- Refine the strategy during the course of its development.
- Champion the inclusion of diverse voices and the experience of the whole community in the development of the revised strategy.
- Support and promote public consultation on the draft strategy in Autumn 2023.
- Track progress towards publishing a signed off updated Health and Wellbeing Strategy.

2.4. Members of the group will represent their organisation or directorate. They will:

- Represent their organisation's vision and priorities for improved health and wellbeing in Oxfordshire.
- Regularly brief, feedback, and discuss with relevant stakeholders within their organisation. This will include briefing relevant portfolio holders and other elected members, and board members.
- Work with their organisation to facilitate sign-off of the updated strategy, noting that the strategy is formally signed off by the HWB itself.

2.5. Responsibility for approval of the updated Health and Wellbeing strategy does **not** fall to this group, but rather to the Health and Wellbeing Board.

3. Membership

The membership of the group will comprise:

Organisation	Name	Group Role
Oxfordshire County Council, Public Health	David Munday	Chair
Oxfordshire County Council, Public Health	Jamie Slagel	Secretariat
Oxfordshire County Council, Partnerships	Robin Rogers	Member
Oxfordshire County Council, Health Place Shaping	Rosie Rowe	Member
Oxford City Council	Mish Tullar	Member
Cherwell District Council	Nicola Riley	Member
West Oxfordshire District Council	Heather McCullogh	Member

South Oxfordshire District Council, Vale of White Horse District Council	Jayne Bolton	Member
BOB ICB	Dan Leveson	Member
Oxford University Hospitals	Sam Shepherd	Member
Oxford Health	Priya Thompson	Member
Healthwatch Oxfordshire	Dr Veronica Barry	Member
GP Clinical Lead	Dr Sam Hart	Member
Oxfordshire County Council, JSNA	Daisy Hickman	Member
Oxfordshire County Council, Public Health Consultant	Steven Bow	Member

If the named members are unable to attend, they may invite appropriate substitutes to attend and represent their organisation in their stead.

4. Ways of Working

4.1. Openness

The group commits to openness, transparency, and a 'no surprises' approach to working together to ensure all parties remain informed and engaged throughout.

4.2. Timeframe: April 2023 – December 2023

The current timeline requires that, in December 2023, the Health and Wellbeing Board publish the refreshed Health and Wellbeing Strategy. Consequently, the Task and Finish Group will meet for a finite period, between April 2023 and December 2023.

4.3. Regularity & length

The Task and Finish Group will meet regularly, once a month. Meetings will last 1.5hrs in length.

4.4. Administration

- The Secretariat will circulate the agenda and relevant papers 5 working days in advance of the meeting.
- The Secretariat will record action notes and will note the responsible individual for each action.
- At each meeting, the group will receive progress updates for actions.

Divisions Affected -

OXFORDSHIRE HEALTH AND WELLBEING BOARD
29th JUNE 2023

Oxfordshire Better Care Fund 2023-25

Report by Karen Fuller

RECOMMENDATION

1. **The Oxfordshire Health and Wellbeing Board is RECOMMENDED to**

   - Approve the Oxfordshire Better Care Fund Plan Priorities for 2023-25
   - Approve the trajectories for the Better Care Fund Metrics
   - Approve the Better Care Fund Income and Expenditure Plan

Executive Summary

2. This report sets out the background and key decisions for the Health & Wellbeing Board. The Better Care fund must be approved on behalf of the system by the Health & Wellbeing Board. In summary the Board is asked to
   (a) Note the background and the key changes to the planning guidance for 2023-25
   (b) Approve the Better Care Fund priorities which are described in detail in Annex 2
   (c) Approve the trajectories for the Better Care Fund metrics as set in Annex 1 and explained in the narrative in Annex 2
   (d) Approve the Income & Expenditure Plan as set out in Annex 1.
   (e) Note the implementation approach and the plan formally to review the Plan in Quarter

Better Care Fund Plan 2023-25: main changes

3. The Better Care Fund is the main statutory vehicle for the Council and the NHS to integrate funding within a system wide plan to improve the health and care outcomes for our population and improve the resilience of the health and care system mainly in relation to the flow into and out of hospital.

4. The Better Care Fund is designed to improve integration to achieve these goals and is required to evidence how it brings together the range of commissioners, health and care providers, the voluntary sector and our population to develop

and deliver the plan. The Better Care Fund particularly is a vehicle for extensive and imaginative integration to align services and to address health inequalities.

5. The Plan must be owned and approved by the Health & Wellbeing Board on behalf of the Council and Integrated Care Board and other partners. As such the Board approves the Better Care Plan each year.

6. In 2023 there have been key changes to the scope and focus of the Better Care Fund.
   (a) The plan is for 2 years rather than one and the planning guidance was issued in April which means we can plan and invest to achieve transformational change
   (b) The plan includes a new Additional Discharge Fund which will replace the winter funding added most years. This must be spent on new and/or additional capacity and only on things that will support flow out of hospital bases. It should be used to support flow out of mental health as well as acute settings
   (c) There is a new measure relating to admissions to hospital after a fall. Historically Oxfordshire has been an outlier for falls and so this is a significant measure for us.
   (d) There will be new measures: in quarter 3 there will be a measure relating to length of stay in hospital beds; and in 2024/25 the current reablement measure will be replaced by another one to speak to recovery after a community or hospital intervention

7. These changes have been captured in our Better Care Fund plan and reflected in the Annexes to this report.

Development of this Plan

8. The timescale for the delivery of the Plan in 2023/24 has foreshortened some of the usual engagement processes. The plan has mainly been developed with the support of the system multi-agency Urgent Care Delivery Group and the Mental Health and Learning Disability and Autism Delivery Board. There have been briefings to the Promoting Independence and Prevention Group and the Carers Strategy Group amongst others.

9. The metrics were reviewed and endorsed by the system Urgent and Emergency Care Board. The proposals for the deployment of the Additional Discharge Funding by the Place Based Partnership.

Better Care Fund Plan 2023-25: key priorities for Oxfordshire

10. The expansion and embedding of the *Oxfordshire Way*. This brings together BCF funding and planning with Public Health and Integrated Care Board funding into a programme to address health inequalities in Oxfordshire through a focus on loneliness, exercise, and connectivity. The programme supports people to live independently within their own community. It builds community capacity and strengths-based assessment and support to enable people to access what works for them. We will work with the voluntary and community organisations who co-ordinate and provide this support to create

metrics that evidence impact, and which we can map back to the Better Care Fund measures.

11. The development of a more integrated approach to supporting people to live as independently as possible in their own home across housing (including extra care housing), adaptations, assistive technology, and equipment. This will involve the development of a shared approach across Health, Social Care and District and City Councils and housing providers. This will build on existing relationships to improve our response to helping people in their own home.

12. Supporting the implementation of the Oxfordshire Integrated Care Plan to improve the assessment and care planning for at risk populations and the implementation of responses linked to Urgent Community Response, Same Day Emergency Care and Enhanced Healthcare in Care Homes. This approach includes mental health and learning disability and/or autism pathways integrated into neighbourhood teams. As part of this model, we will build on and develop our existing falls response to prevent people falling and needing to be admitted to hospital.

13. The implementation of a Home First Discharge to Assess model for people who are admitted to hospital. We have created a Transfer of Care hub that now manages all discharges from Oxfordshire acute and community bed bases and will seek to expand to neighbouring trusts. We will increase the number of people going home; we will assess people in their own home; and when people need to go into bed-based reablement services we will increase the throughput to get them home as soon as they are ready.

14. Further develop our demand and capacity planning capability across health and social care including around community capacity that keeps people at home and in mental health and learning disability and autism discharge pathways.

15. A renewed and continued focus on inequalities throughout all the above priorities.

16. Health and Wellbeing Board is asked to approve these priorities for the 2023-25 Better Care Fund Plan

Demand and Capacity Plan

17. As part of the Plan for 2023-25 NHS England has asked all systems to create demand and capacity plans against which expenditure plans should be prioritised. The plans are for *intermediate care* (defined as for support for up to 60 days) in both the community and on hospital discharge (from all acute and mental health bed settings).

18. This has proved a challenge for Oxfordshire as for other systems: the data required is not necessarily recorded in the way that we have been required to submit it; and in some cases, we have had to “shoe-horn” our local approach

into the planning requirements. As a minimum we will need to develop a monitoring approach to check our monthly progress and then formally review at the end of quarter 2 ahead of the winter.

19. There are some local issues. In 2022 Oxford Health NHS FT experienced a major data failure linked to a national system which continues to create challenges in reporting and analysing data. There are currently some gaps in the plan in relation to community intermediate care and mental health discharges which will be resolved prior to submission. As we have committed significant resources from the Additional Discharge Funding in respect of mental health discharge from hospital, we have anticipated the finalisation of the data.

20. The demand and capacity profile for acute hospital discharge reflects planned changes to the pathways as we move to more Home First discharges in Q3 and Q4. We believe that we have mapped the known demand and have plans to meet it during 2023/24. This will be monitored monthly by the system Urgent and Emergency Care Board

21. Health & Wellbeing Board is asked to note the demand and capacity plan. A verbal update will be given on progress with the plan at the meeting.

Metrics

22. There are 5 areas for which Oxfordshire must give trajectories for 2023-24. These will be measured quarterly by NHS England and monthly by the Council and Integrated Care Board's Joint Commissioning Executive with recommendations from the system Urgent and Emergency Care Board.

Non-elective admissions to hospital

23. Our approach in the Oxfordshire Integrated Care Plan has reduced non-elective admissions to hospital in Q3 and Q4 of 2022-23. There are now established *Virtual Wards* in the City and Bicester and the plan is to roll these out during 2023-24 beginning with Banbury. We anticipate that the continued development of these approaches will lead to an ongoing improvement in our trajectory to reduce non-elective admissions in 2023-24. The evidence is that the key factor is in the management of frailty where there are multiple long-term conditions.

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	169.1	146.6	190.5	185.0
	Number of Admissions	1,315	1,140	1,481	-
	Population	691,667	691,667	691,667	691,667

		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Indicator value	172	140	176	176

Admissions to hospital due to falls

24. Oxfordshire has been an outlier for falls-related admissions for several years. In 2022-23 the performance improved. We believe that in significant part this was due to work in the Integrated Care Plan above. There has been a reduction of 10% in attendees after a suspected fall and the assumption is that by identifying fallers at risk of further falls but prior to an injury requiring admission we are able to divert people into community services that avoided that later episode.

		2021-22 Actual	2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,102.6	1,897.0	1,802.0
	Count	2,890	2610	2480
	Population	130,843	130843	130843

Discharge to Usual Place of Residence

25. The Home First Discharge to Assess approach will support the development and delivery of improved performance against this measure. However, there is a level of risk relating to the amount of pathway change and improvement in 2023-24 and we are therefore profiling an improvement where we achieve 95% in 2024-25. We have retained as part of the Additional Discharge Funding a provision to purchase short-term interim P2 beds over the winter 2023-24 and this may-if deployed-offset the delivery of the metric, but we plan to reduce this provision in 2024-25 and to remove it entirely as soon as capacity permits.

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	369.5	350.2	346.5	325.8
	Numerator	481	474	469	450
	Denominator	130,189	135,361	135,361	138,108

Permanent Admission to residential care

26. Oxfordshire has delivered on its plan to redirect resources away from long-term residential and nursing care. This is linked to the Oxfordshire Way and the Home First framework set out elsewhere in this plan. In summary we aim through a range of plans to support people at home and with access to community assets to help people maintain independence for longer and to reduce the length of stay in residential care through delayed entry to these services. We will maintain this plan in 2023-24.

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	90.7%	91.3%	90.6%	93.0%
	Numerator	11,143	11,499	11,670	11,260
	Denominator	12,282	12,588	12,882	12,109
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Quarter (%)	91.0%	92.0%	92.5%	93.0%
	Numerator	11,193	11,500	11,840	11,625
	Denominator	12,300	12,500	12,800	12,500

Recovery: still at home 90 days after reablement

27. This measure will be discontinued after 2023/24. We believe that the adoption of a Home First D2A approach with clinical and community support into reablement and the escalation route into Urgent Community Response to support short-term issues and avoid escalation to hospital will deliver continued performance against this measure.

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.5%	84.0%	84.8%	88.0%
	Numerator	243	336	262	264
	Denominator	298	400	309	300

Income and Expenditure Plan

Income plan

28. The income into the plan is prescribed. Neither the Council nor the Integrated Care Board plan to add further sums at this time but note that we are making full use of aligned expenditure particularly from Public Health and the Integrated Care Board's Inequalities Funding.

29. The contribution of the neighbouring Swindon ICB to the Oxfordshire Plan is not yet known at the point of submission of this paper. This will be updated at the meeting and prior to the final submission.

Expenditure Plan

30. The minimum NHS contribution and the Improved Better Care Fund allocations are committed in full in line with the schemes set out in the template that support the plan. The Disabled Facilities Grant is passed through in full to the District and City Councils.

31. The plan will need to be uprated when the contribution at para 24 is known. This will be added to the contribution that the Better Care Fund makes to out of acute hospital care.

Additional Discharge Funding

32. The plans for this fund have been reviewed in the system Urgent & Emergency Care Board and the Place Based Partnership and endorsed as supporting the demand and capacity gap and delivery of the trajectories set out for the Better Care Fund metrics.

33. Currently there is a total of £1.26m still to be allocated against this fund in 2023/24 and a larger sum for 2024/25 (the final allocations are not yet known). This will be allocated by the Joint Commissioning Executive on recommendations from system partners in by quarter 3, based on the understanding of likely winter pressures and the impact of the new Home First Discharge to Assess models.

Summary of income and expenditure

	2023-24			2024-25		
Running Balances	Income	Expenditure	Balance	Income	Expenditure	Balance
DFG	£6,658,545	£6,658,545	£0	£6,658,545	£6,658,545	£0
Minimum NHS Contribution	£49,339,489	£49,339,488	£1	£52,132,104	£52,132,103	£1
iBCF	£10,705,289	£10,705,289	£0	£10,705,289	£10,705,289	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,500,865	£1,500,865	£0	£2,491,436	£2,491,436	£0
ICB Discharge Funding	£3,236,000	£3,231,538		£5,718,000	£5,718,000	£0
Total	**£71,440,187**	**£71,435,725**	**£4,462**	**£77,705,373**	**£77,705,373**	**£0**

34. The investment in Adult Social Care and NHS Out of Hospital Discharge Funding are met.

35. Health and Wellbeing Board is asked to approve the income and expenditure plan

Financial Implications

36. The plan as drafted sets out the income and expenditure for the Better Care Fund in 2023/24 and the draft position for 2024/25. As noted above the final income figure needs to be confirmed by the Integrated Care Board prior to submission and that additional income accounted for in the expenditure plan.

37. The final plan as submitted will be approved by the Council's s151 officer.

Comments checked by:

Thomas James, Finance Business Partner
Thomas.james@oxfordshire.gov.uk

Inequalities

38. The Additional Discharge Funding is deployed extensively to support the most vulnerable people on discharge from specialist as well as general acute settings. Oxfordshire has purchased specialist step down beds for people living with severe mental illness. The in-reach staff that support these beds work to engage people in health services.

39. We are investing in specialist mental health support to enable older people with complex needs be discharged to nursing homes where their needs can be managed in the least restrictive setting.

40. We are investing in integrated capacity across health, therapy, social work for people both in mental health units and learning disability/autism settings. These MDT approaches recognise the additional complexity facing these groups beyond the Home First model in successful discharges into the community.

41. We will improve access to longer-term housing for people with complex needs in our discharge pathways: we will fund specialist development capacity to identify housing options for people living with learning disability/autism settings; and we will work with district councils to integrate housing options for people in step down pathways who have no home.

42. The BCF through the Oxfordshire Way and Community Capacity grants are supporting the Public Health priority to improve health outcomes in the 10 most deprived wards overseen by the joint Health Inequalities Forum.

43. We will be working with our providers across a range of fields (support for unpaid carers, demand and capacity for community intermediate care, profiles of fallers, community capacity) to develop outcome metrics that can be

mapped back to health inequalities and to the BCF metrics. This will be overseen by the Oxfordshire Health Inequalities Forum.

Implementation and Review for 2024-25

44. Responsibility for the implementation of the Plan is delegated to the Council and Integrated Care Board's Joint Commissioning Executive. That body will in turn be advised by the system Urgent and Emergency Care Board and the Mental Health and Learning Disability and Autism Delivery Board in respect to the metrics and the impact of the Additional Discharge Funding.

45. Given the various dependencies relating to the demand and capacity processes, the several change programmes relating to discharge to assess and the need to confirm the deployment of the Additional Discharge Funding there will be a formal review concluded in Q3 to confirm any in-year amendments to the plan and the proposals for 2024/25.

46. Guidance on the approach to 2024/25 planning has not yet been released by NHS England. We can anticipate this through the Q3 review.

Karen Fuller, Interim Corporate Director of Adult Services
[SLT Member]

Annex: Better Care Fund Final Draft Template for Submission

Better Care Fund Final Draft Narrative Plan for Submission

Background papers: Nil

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
  - emergency admissions due to falls for the year for people aged 65 and over (count)
  - estimated local population (people aged 65 and over)
  - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Oxfordshire
Completed by:	Ian Bottomley
E-mail:	ian.bottomley@oxfordshire.gov.uk
Contact number:	07532 132975
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No
If no please indicate when the HWB is expected to sign off the plan:	Thu 29/06/2023 << Please enter using the format, DD/MM/YYYY

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Liz	Leffman	liz.leffman@oxfordshire.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Steve	McManus	steve.mcmanus4@nhs.net
	Additional ICB(s) contacts if relevant		Dan	Leveson	daniel.leveson@nhs.net
	Local Authority Chief Executive		Martin	Reeves	martin.reeves@oxfordshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Karen	Fuller	karen.fuller@oxfordshire.gov.uk
	Better Care Fund Lead Official		Pippa	Corner	pippa.corner@oxfordshire.gov.uk
	LA Section 151 Officer		Lorna	Baxter	lorna.baxter@oxfordshire.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

#REF!

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	No
6a. Expenditure	#REF!
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Oxfordshire

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£6,658,545	£6,658,545	£6,658,545	£6,658,545	£0
Minimum NHS Contribution	£49,339,489	£52,132,104	£49,339,488	£52,132,103	£1
iBCF	£10,705,289	£10,705,289	£10,705,289	£10,705,289	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,500,865	£2,491,436	£1,500,865	£2,491,436	£0
ICB Discharge Funding	£3,236,000	£5,718,000	£3,231,538	£5,718,000	£4,462
Total	**£71,440,187**	**£77,705,373**	**£71,435,725**	**£77,705,373**	**£4,462**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£14,017,915	£14,811,329
Planned spend	£17,600,804	£18,584,314

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£30,980,733	£32,734,242
Planned spend	£34,266,820	£36,220,029

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	172.0	140.0	176.0	176.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,897.0	1,802.0
	Count	2610	2480
	Population	130843	130843

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.0%	92.0%	92.5%	93.0%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	369	326

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	88.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	No
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Oxfordshire

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month.
The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabilitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.		Complete:
	We have assumed a 5% increase in demand across all services in 2324. We have mapped monthly profile demand and capacity against 2223 performance.	3.1 Yes
	For Pathway 1 we have grouped together reablement, rehab and short-term dom care as this will all be delivered via our D2A service on referral directly from the Transfer of Care hub.	3.2 Yes
	During 2023-24 capacity in both P1 and P2 reablement will increase in line with planned changes to the pathways.	3.3 Yes
	We do not use step up bed-based reablement from the community in Oxfordshire.	3.4 Yes
	Short term community social care support is delivered as part of our ICB pathways and not measured	

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
(Please select Trust/s.....)	Social support (including VCS) (pathway 0)												
OXFORD HEALTH NHS FOUNDATION TRUST													
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		225	232.5	225	232.5	232.5	225	232.5	225	232.5	232.5	210	232.5
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
(Please select Trust/s.....)	Reablement at home (pathway 1)												
OXFORD HEALTH NHS FOUNDATION TRUST													
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		255.2	263.5	253.1	261.5	261.5	253.1	294.5	286.1	294.5	294.5	269.3	294.5
OTHER		8	8	8	8	8	8	8	8	8	8	8	8
(Please select Trust/s.....)	Rehabilitation at home (pathway 1)												
OXFORD HEALTH NHS FOUNDATION TRUST													
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST													
OTHER													
(Please select Trust/s.....)	Short term domiciliary care (pathway 1)												
OXFORD HEALTH NHS FOUNDATION TRUST													
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST													
OTHER													
(Please select Trust/s.....)	Reablement in a bedded setting (pathway 2)												
OXFORD HEALTH NHS FOUNDATION TRUST													
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		116	83	112.4	110.3	100.85	102.95	75.2	73.8	75.2	75.2	68.4	75.2
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)												
OXFORD HEALTH NHS FOUNDATION TRUST													
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		140.4	140.8	111.4	102.0	125.1	107.2	113.5	113.5	71.5	92.6	86.3	123.8
OTHER		8	8	8	8	8	8	8	8	8	8	8	8
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
OXFORD HEALTH NHS FOUNDATION TRUST													
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		36	49	35	37	42	40	45	43	44	28	22	38
OTHER		10	10	10	10	10	10	13	13	14	14	12	14
Totals	**Total:**	1484	1499.1	1453.7	1464.1	1496.3	1431.5	1487.6	1467.5	1416.2	1434.95	1311.25	1595.9

3.2 Demand - Community

Demand - Intermediate Care

Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	171	176.7	171	176.7	176.7	171	176.7	171	176.7	176.7	159.6	176.7
Urgent Community Response	417.9	451.5	467.25	471.45	486.15	310.8	349.65	290.85	480.9	395.85	345.45	395.85
Reablement at home	51.45	64.05	68.25	109.2	92.4	31.5	25.2	31.5	44.1	76.65	55.65	59.85
Rehabilitation at home												
Reablement in a bedded settine	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting												
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)		214.3	221.4	214.3	221.4	221.4	214.3	221.4	214.3	221.4	221.4	200.0	221.4
Reablement at Home	Monthly capacity. Number of new clients.	163.9	147.6	162.9	153.5	153.5	161.4	211.6	205.9	211.6	211.6	194.3	211.6
Rehabilitation at home	Monthly capacity. Number of new clients.	14.3	14.8	14.3	16.2	16.2	18.6	23.8	22.9	23.8	23.8	21.3	23.8
Short term domiciliary care	Monthly capacity. Number of new clients.	61.3	63.3	61.3	63.3	63.3	61.3	63.3	61.3	63.3	63.3	57.2	63.3
Reablement in a bedded setting	Monthly capacity. Number of new clients.	83.7	86.5	83.7	86.5	86.5	83.7	73.1	70.7	73.1	73.1	66.0	73.1
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	102.2	105.6	102.2	105.6	105.6	102.2	105.6	102.2	105.6	105.6	95.4	105.6
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	36	49	35	37	42	40	45	43	44	28	22	38

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly

ICB	LA	Joint
	100%	
		100%
		100%
	100%	
		100%
100%		
	100%	

3.4 Capacity - Community

Capacity - Community

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	150	155	150	155	155	150	155	150	155	155	140	155
Urgent Community Response	Monthly capacity. Number of new clients.	400.0	413.3	400.0	413.3	413.3	400.0	413.3	400.0	413.3	413.3	373.3	413.3
Reablement at Home	Monthly capacity. Number of new clients.	27	27.9	27	27.9	27.9	27	27.9	27	27.9	27.9	25.2	27.9
Rehabilitation at home	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.												
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly

ICB	LA	Joint

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Oxfordshire

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Oxfordshire	£6,658,545	£6,658,545
DFG breakdown for two-tier areas only (where applicable)		
Cherwell		
Oxford		
South Oxfordshire		
Vale of White Horse		
West Oxfordshire		
Total Minimum LA Contribution (exc iBCF)	**£6,658,545**	**£6,658,545**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Oxfordshire	£1,500,865	£2,491,436

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Bath and North East Somerset, Swindon and Wiltshire ICB		
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	3236000	£5,718,000
Total ICB Discharge Fund Contribution	£3,236,000	£5,718,000

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Oxfordshire	£10,705,289	£10,705,289
Total iBCF Contribution	**£10,705,289**	**£10,705,289**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	£471,248	£497,921
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£48,868,241	£51,634,183
Total NHS Minimum Contribution	**£49,339,489**	**£52,132,104**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	

Total NHS Contribution	**£49,339,489**	**£52,132,104**

	2023-24	2024-25
Total BCF Pooled Budget	**£71,440,187**	**£77,705,373**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Oxfordshire

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£6,658,545	£6,658,545	£0	£6,658,545	£6,658,545	£0
Minimum NHS Contribution	£49,339,489	£49,339,488	£1	£52,132,104	£52,132,103	£1
iBCF	£10,705,289	£10,705,289	£0	£10,705,289	£10,705,289	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,500,865	£1,500,865	£0	£2,491,436	£2,491,436	£0
ICB Discharge Funding	£3,236,000	£3,231,538		£5,718,000	£5,718,000	£0
Total	**£71,440,187**	**£71,435,725**	**£4,462**	**£77,705,373**	**£77,705,373**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£14,017,915	£17,600,804	£0	£14,811,329	£18,584,314	£0
Adult Social Care services spend from the minimum ICB allocations	£30,980,733	£34,266,820	£0	£32,734,242	£36,220,029	£0

Checklist

Column complete:

#REF!	#REF!	#REF!	#REF!	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

!!! Critical errors detected !!!

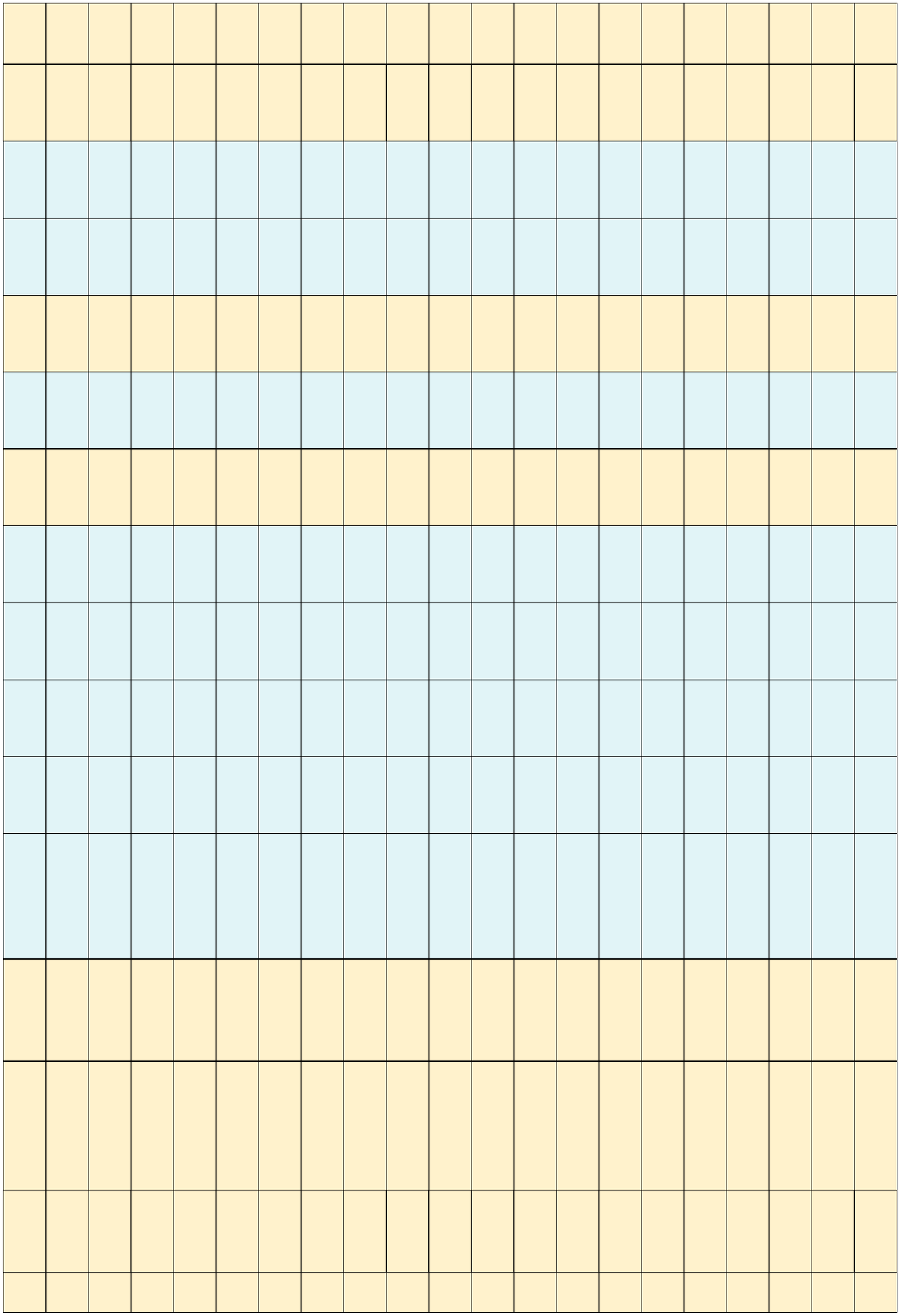
This is usually due to cutting and pasting into cells - Please start over from the last working copy of this template or contact the BCF Team for support: england.bettercarefundteam@nhs.net

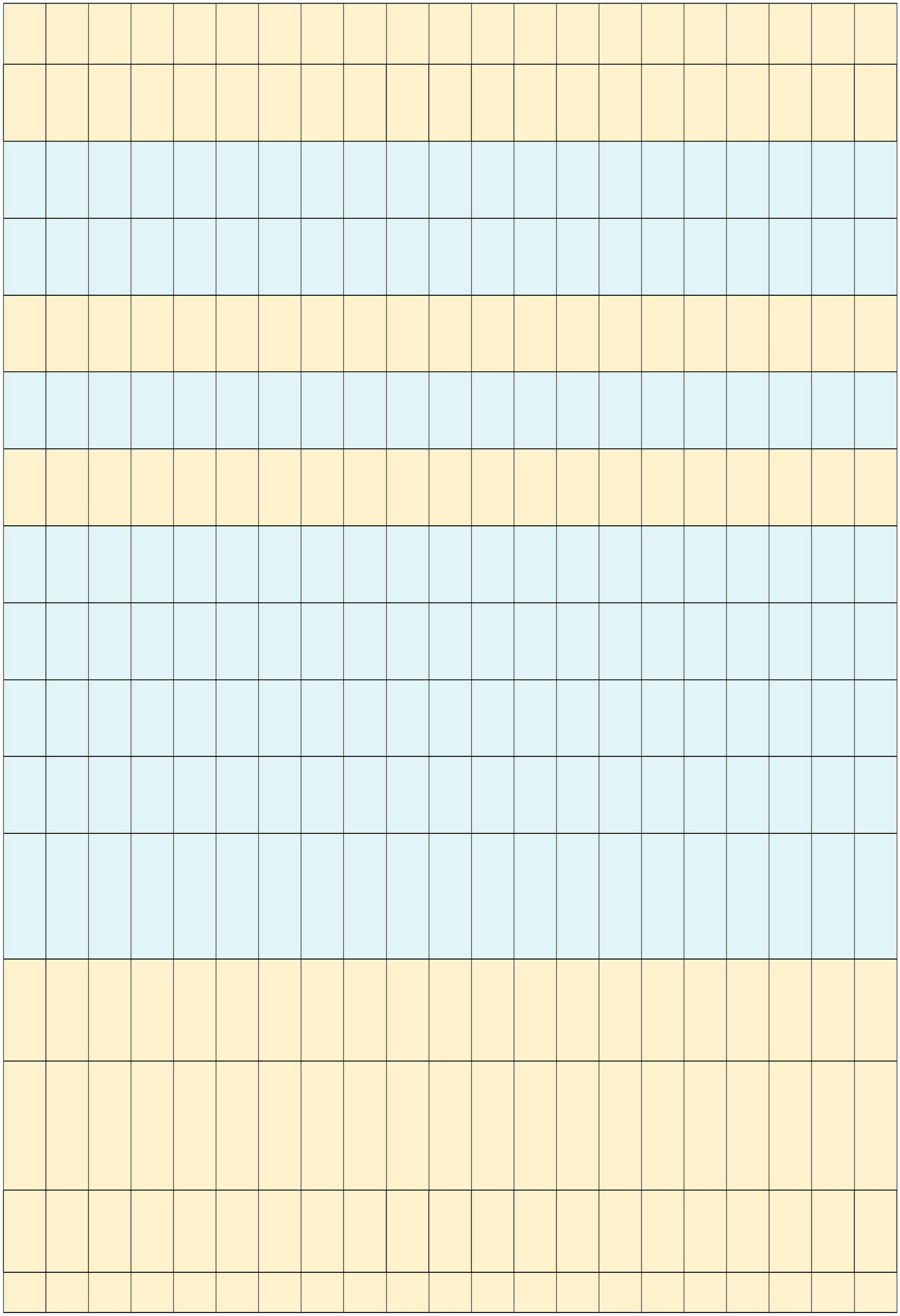
									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding

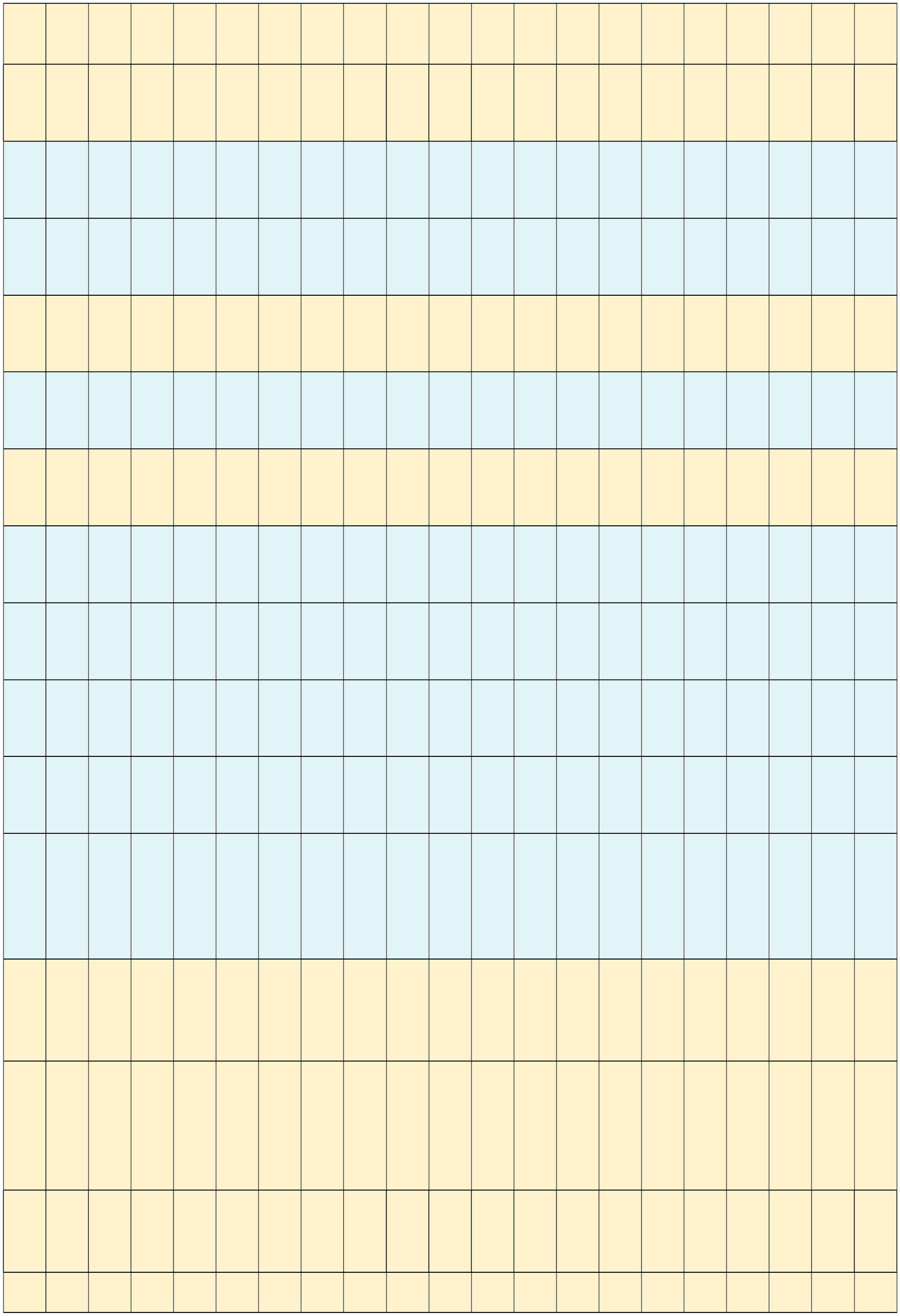
1	Disabled Facilities Grant	Home adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		950	1050	Number of adaptations funded/people	Other	District housing authority	LA			Local Authority	DFG
2	Home Improvement Agency	Home adaptation service and minor works to people's homes	DFG Related Schemes	Other	Delivery of DFG works	0	0	Number of adaptations funded/people	other	District housing authority	LA			Local Authority	Minimum NHS Contribution
3	Integrated Community Equipmnent	Equipment service	Assistive Technologies and Equipment	Community based equipment		21000	21500	Number of beneficiaries	Social Care		Joint	44.5%	55.5%	Private Sector	Minimum NHS Contribution
4	Telecare	telecare services	Assistive Technologies and Equipment	Assistive technologies including telecare		4500	4750	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution
5	Care homes	Nursing home placements	Residential Placements	Nursing home		214	226	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
6	Home care	Support for people at home	Home Care or Domiciliary Care	Domiciliary care packages		279406	295333	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution
7	Home care 2	Expansion to support for people at home	Home Care or Domiciliary Care	Domiciliary care packages		95012	95012		Social Care		LA			Private Sector	iBCF
8	Market resilience	Provider fee uplifts (in year and historic)	Care Act Implementation Related Duties						Social Care		LA			Private Sector	iBCF
9	Workforce	Care worker recruitment and retention initiatives	Workforce recruitment and retention						Social Care		LA			Private Sector	iBCF
10	Extra Care Housing	Extra care housing as an alternative to residential care	Housing Related Schemes						Social Care		LA			Private Sector	Minimum NHS Contribution
11	Information, advice, community	Information, advice, advocacy and community development capacity	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	iBCF
12	Community Capacity	Grant funding to increase community capacity and alternatives to formal care	Prevention / Early Intervention	Other	Community grants caoacity				Social Care		LA			Charity / Voluntary Sector	iBCF
13	Homelessness Alliance	Support funding to homelessness MDT	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution
14	Carer support	Advice, support and grants programme for carers	Carers Services	Carer advice and support related to Care Act duties		38500	42350	Beneficiaries	Social Care		Joint	32.5%	67.5%	Charity / Voluntary Sector	Minimum NHS Contribution
15	Falls prevention	Strength and balance classes for oeople at risk of falling	Prevention / Early Intervention	Other	Strenght and balance classes for at risk people				Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
16	Falls service	Assessment and tailored support for people at high risk of falls	Prevention / Early Intervention	Other	Clinical support to high risk fallers				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
17	Night sitting	Homecare capacity for people at end of life	Urgent Community Response						Continuing Care		NHS			Private Sector	Minimum NHS Contribution
18	Hospital at Home North Oxon	Community interventions to support UCR in supporting people at home	Urgent Community Response						Community Health		NHS			Private Sector	Minimum NHS Contribution
19	Hospital at Home South Oxon	Community inommunityu entions ty suppout UCR in suppouting people at home	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
20	Virtual ward escalation	Medical assessment and step up service in the community	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
21	Reablement	D2A provision to Home First approaches on discharge and in the community	Home-based intermediate care services	Reablement at home (to support discharge)		2544	3000	Packages	Social Care		Joint	43.0%	57.0%	Private Sector	Minimum NHS Contribution

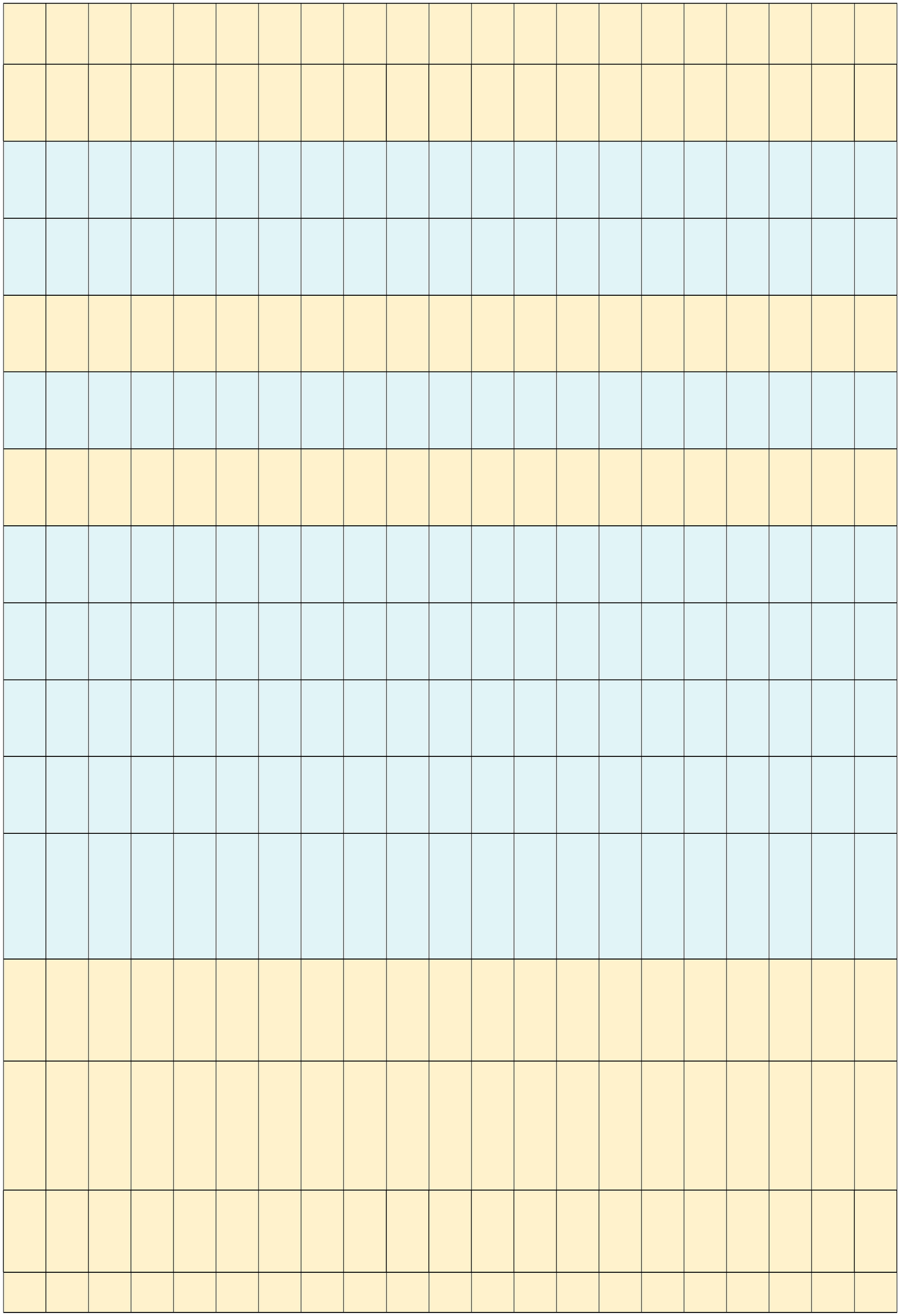
22	Home First MDT	Clinical triage, assessment and case allocation to Home First providers	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
23	Hospital social work team	Clinical triage, assessment and case allocation to support social care discharge	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	iBCF
24	P2 Discharge to Assess beds	Reablement bed pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		1185	1300	Number of Placements	Community Health		Joint	67.9%	32.1%	Private Sector	Minimum NHS Contribution
25	P2 pathway MDT	Reablement bed pathway MDT	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
26	P2 Community Hospital beds	Bed-based intermediate care with rehabilitation (to support discharge) recovery	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		1244	1244	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
27	NHS ADF to be allocated								Community Health		NHS			NHS Community Provider	ICB Discharge Funding
28	LA ADF to be allocated								Social Care		LA			Private Sector	Local Authority Discharge
29	Trusted Assessment	Expanded TA service to cover P1 restarts and P3	High Impact Change Model for Managing Transfer of Care	Trusted Assessment					Social Care		LA			Private Sector	Local Authority Discharge
30	Interim expansion of P2 pathway	Additonal short-term therapy and provider support to P2 beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)				Number of Placements	Social Care		NHS	80.0%		Private Sector	ICB Discharge Funding
31	SALT care home pilot to support discharge	Specialist input to support complex discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
32	Surge capacity	Provisiob for additional NH beds in winter	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		100	50	Number of Placements	Social Care		LA			Private Sector	Local Authority Discharge
33	Delirium pathway beds	Specialist step down beds to support complex discharges	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		36	72	Number of Placements	Social Care		LA			Private Sector	Local Authority Discharge
34	MH step down pathway	Beds and associated MDT to support discharge for people with severe mental illness	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)				Number of Placements	Other	VCSE	NHS			Charity / Voluntary Sector	ICB Discharge Funding
35	MH discharge funding	Grant resource to support complex MH discharges	Personalised Budgeting and Commissioning						Mental Health		LA			NHS Mental Health Provider	Local Authority Discharge
36	MH support to care homes	Complex in reach to residential to support discharge	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			NHS Community Provider	ICB Discharge Funding
37	Personality Disorder discharge	Dedciated discharge planning and navigation for people living with	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
38	MH OT support	Dedicated OT support to increase flow home from MH acute beds	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
39	MH social work	Dedicated social work support to increase flow home from MH acute beds	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		LA			NHS Mental Health Provider	Local Authority Discharge
40	OP OOH discharge support	Extended hours service to support older people's MH acute discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
41	LDA intensive discharge support	Aditional case manager input to manage complex LDA discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Other	LDA community team	LA			NHS Community Provider	Local Authority Discharge
41	LDA housing capacity development	Development caoacity to support housing options on discharge for complex LDA							Other	LDA community team	LA			Local Authority	Local Authority Discharge

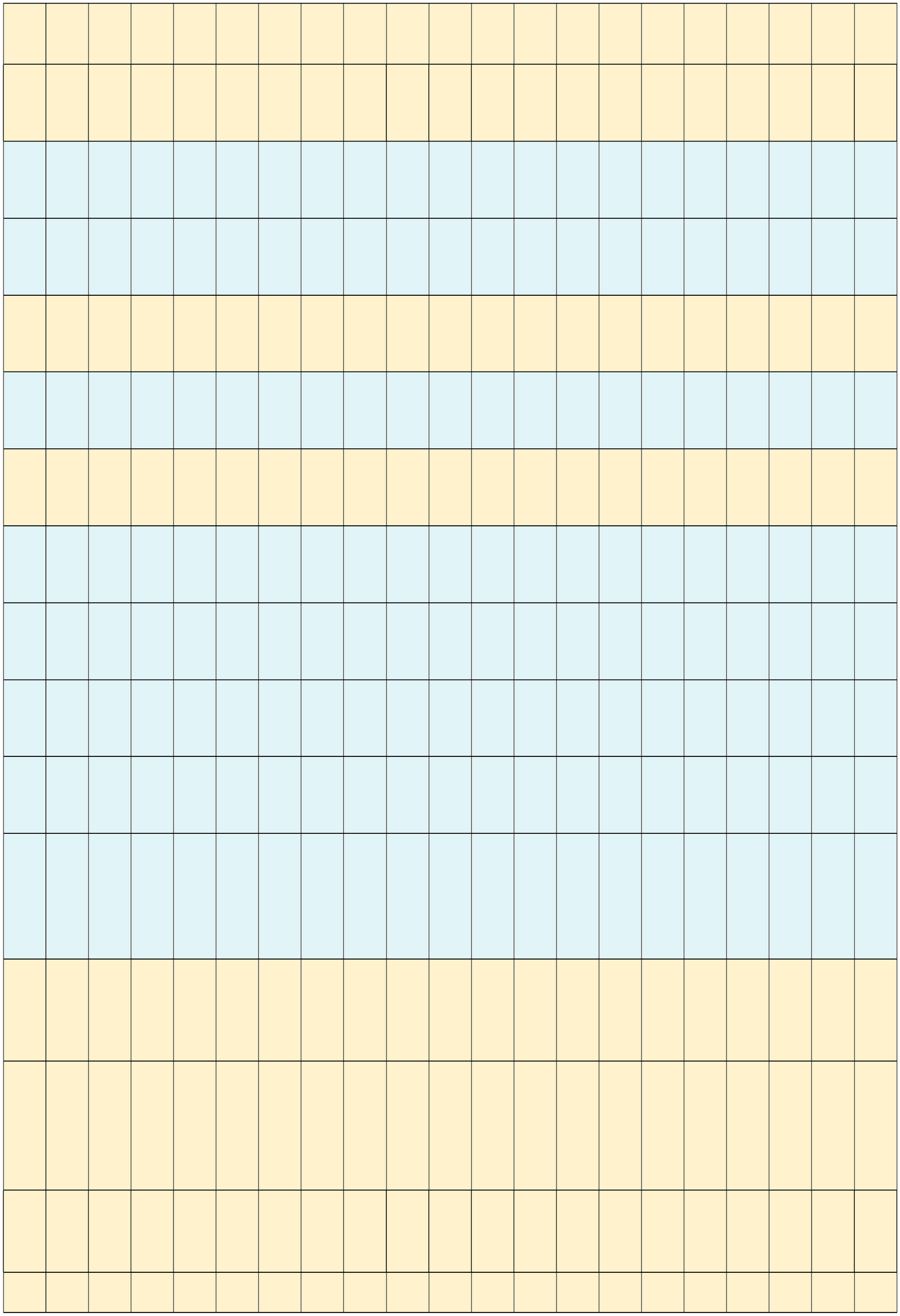
42	LD nurse discharg support	In-reach specialist LD nurses to complement acute in-patient specialist team to	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Other	LDA community team	NHS			NHS Community Provider	ICB Discharge Funding
43	Demand and capacity	IT and BI capacity to monitor and deploy resource management	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Other	Cross sector	NHS			Private Sector	ICB Discharge Funding

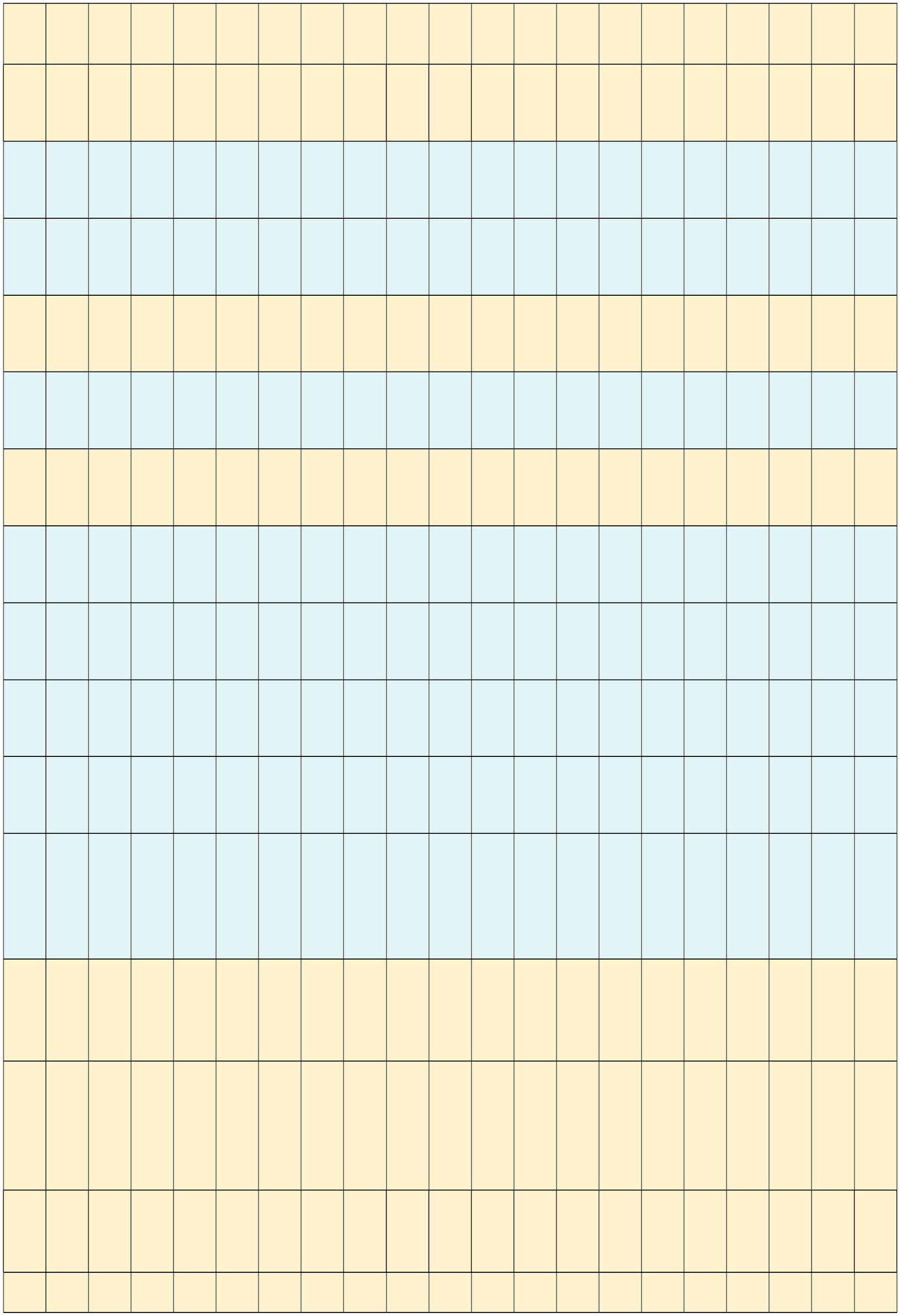


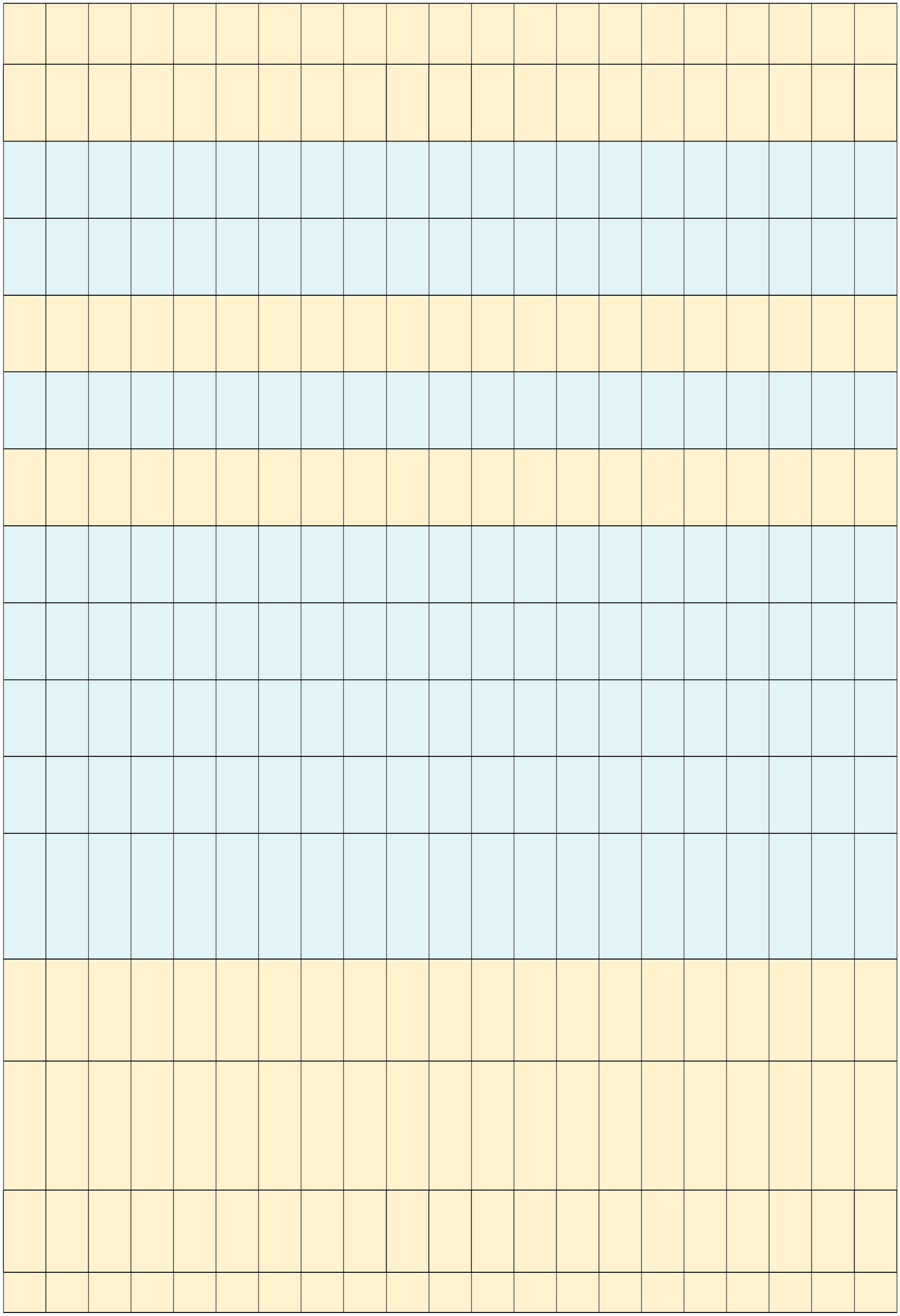


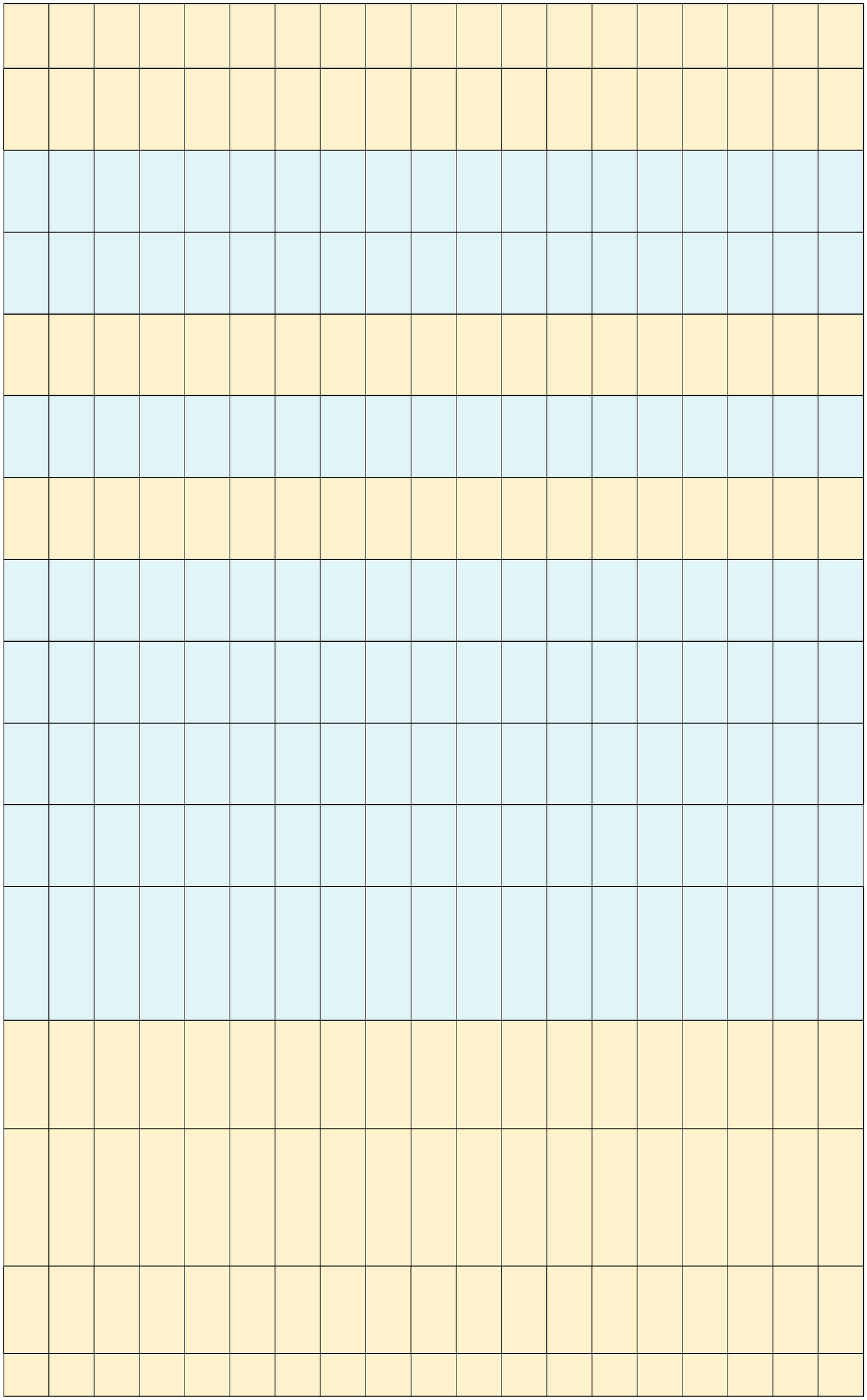












Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Oxfordshire

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	169.1	146.6	190.5	185.0	We have set a trajectory to reduce NEL by 5% in 2023/24. We anticipate a seasonal reduction in Q2 and then an increase in demand in Q3 and Q4	Management of NEL is being driven by the work of the UCR aligned to development of local wards. This response is being rolled out through Oxon. The BCF funds hospital at home, out of acute emergency medical assessment units, reablement/dom care and VCSE support to help manage people within community settings
	Number of Admissions	1,315	1,140	1,481	-		
	Population	691,667	691,667	691,667	691,667		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	172	140	176	176		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,102.6	1,897.0	1,802.0	The Oxon 5 year rate is 2126.6 (average). 2223 performance shows a 5% improvement and this trajectory has been mapped through to 2324	Oxon has invested via the BCF in VCSE preventative and specialist community falls provision. However, the improved performance in 2223 has been mapped to the work in UCR and virtual wards, especially where non-admitted fallers can be diverted to anticipatory care prior to a further fall requiring admission. In 2324 we are expanding the prevention offer in an
	Count	2,890	2610	2480		
	Population	130,843	130843	130843		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal	Quarter (%)	90.7%	91.3%	90.6%	93.0%	Q3 2022-23 performance was 90.1%. Ambition is to achieve 95% in Q1 2024-25	Oxon has introduced a Transfer of Care approach in 2223 which has seen an increase in the number of people discharged via P0 and P1. In 2324 a TOC
	Numerator	11,143	11,499	11,670	11,260		
	Denominator	12,282	12,588	12,882	12,109		

discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		team funded by BCF will work with our Home First team and providers (both BCF) in a revised D2A model that will be rolled out regionally from Q2. At the same time we are reducing our P2 capacity in terms of beds and increasing the throughput to get
	Quarter (%)	91.0%	92.0%	92.5%	93.0%		
	Numerator	11,193	11,500	11,840	11,625		
	Denominator	12,300	12,500	12,800	12,500		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	369.5	350.2	346.5	325.8	Oxfordshire has a reducing trajectory for use of long-term residential care. This reduction will increase in 2324	Oxfordshire has plans to reduce the use of care homes through greater deployment of equipment and technology and support to unpaid carers to keep people well at home; use of extra care housing as an alternative to residential; and longer-term increased
	Numerator	481	474	469	450		
	Denominator	130,189	135,361	135,361	138,108		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.5%	84.0%	84.8%	88.0%	This figure relates to the improved performance of our providers agaisnt the national target of reablement leading to no long-term care	Adoption of a Home First D2A approach with clinical and community support into reablement. Escalation route into UCR to support short-term issues and avoid escalation to hospital
	Numerator	243	336	262	264		
	Denominator	298	400	309	300		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan

HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Oxfordshire

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

a. Bucks, Oxfordshire and Berkshire West ICB, including GP reps from Primary Care Networks [ICB]
b. Oxford University Hospitals NHSFT [OUH]
c. Oxford Health NHSFT [OH]
d. South Central Ambulance Service [SCAS]
e. Oxfordshire County Council (integrated commissioning, operations and Public Health) [the Council]
f. West Oxfordshire DC [WODC]
g. Oxford City Council [the City]
h. South Oxfordshire DC/Vale of White Horse DC [S&VDC]
i. Cherwell DC [CDC]
j. Oxfordshire Association of Care Providers [OACP]
k. Oxfordshire Care Homes Association [OCHA]
l. Age UK Oxfordshire [AUK]
m. Order of St John Care Trust [OSJ]
n. Oxfordshire Promoting Independence and Prevention Group (PIP)

How have you gone about involving these stakeholders?

Briefings to Oxfordshire Urgent Care Delivery Group [UCDG], Urgent and Emergency Care Board [UEC], Mental Health & Learning Disability/Autism Delivery Board and Promoting Independence and Prevention Groups. The metrics and demand and capacity projections were reviewed in UCDG and UEC and recommended to the Joint Commissioning Executive (JCE) of the Council and ICB for adoption. The deployment of the Additional Discharge Funding was reviewed by the Place Based Partnership (PBP) Committee and approved for deployment by the JCE. UCDG, UEC, PIP and PBP are multiagency groups with membership including District Councils, PBP and Healthwatch.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

1. The Oxfordshire Health and Well-Being Board has overall responsibility for the Better Care Fund Plan and will review and approve the plan at its meeting on 29 June 2023. The HWB has delegated responsibility to the Council Corporate Director for Adult Services who briefed the Chair of HWB and the Cabinet Lead for Adult Social Care prior to submission of this plan. The Place Director for the ICB obtained approval for the Plan from the ICB Executive on 26 June 2023 Oxfordshire has developed a new s75 NHS Act 2006 agreement between the Council and BOB ICB that incorporates the Better Care Fund. This new agreement came into force on 1 April 2023.

2. The development of this Plan and proposed trajectories for the BCF metrics; the allocation of funding against the schemes in the Plan, including for the Additional Discharge Funding; and the demand and capacity plan has been overseen by the system Urgent Care Delivery Group and approved by the system wide Urgent & Emergency Care Board. The demand and capacity, BCF metrics and proposed deployment of the Additional Discharge Funding was reviewed by the system wide Place Based Partnership.
3. Commissioning oversight of the Plan and pooled budgets in the s75 NHS Act 2006 is delegated by the Council and the ICB to the Joint Commissioning Executive. The Deputy Director, Joint Commissioning is the Pooled Budget Manager for the s75 agreement (including the Better Care Fund) and accountable to the Joint Commissioning Executive. Within the s75 agreement, the commissioning of Better Care Fund Plan services is delegated by the ICB to the Council via the Health, Education and Social Care integrated commissioning team. This team is led by the Deputy Director and hosted by the Council.
4. Proposals in respect of the Disabled Facilities Grant and Home Improvement Agency are developed by the County Housing Forum, a joint meeting of District Council leads and the Lead Occupational Therapist Oxfordshire County Council and the integrated housing OTs and lead commissioners.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

Oxfordshire's key priorities for the BCF in 2023-25 are

1. The expansion and embedding of the Oxfordshire Way. This brings together BCF funding and planning with Public Health and ICB funding into a programme to address health inequalities in Oxfordshire through a focus on loneliness, exercise and connectivity. The programme builds community capacity and strengths-based assessment and support to enable people to access what works for them.

2. The development of a more integrated approach to supporting people to live as independently as possible in their own home across housing (including extra care housing), adaptations, assistive technology and equipment.

3. Supporting the implementation of the system Integrated Care Plan to improve the assessment and care planning for at risk populations and the implementation of responses linked to Urgent Community Response, Same Day Emergency Care and Enhanced Healthcare in Care Homes. This approach includes mental health and learning disability and/or autism pathways integrated into neighbourhood teams. As part of this model we will build on and develop our existing falls response.

4. Home First Discharge to Assess for people who are admitted to hospital. We have created a Transfer of Care hub that now manages all discharges from Oxfordshire acute and community bed bases and will seek to expand to neighbouring trusts. We will increase the number of people going home; we will assess people at home; and when people need to go into bed-based reablement we will increase the throughput to get them home.

5. Further develop our demand and capacity planning capability including around community capacity and in mental health and learning disability and autism discharge pathways.

6. A continued focus on inequalities throughout all of these priorities.

The key changes in the 2023-25 BCF Plan are

The expanded focus on prevention and community capacity to underpin all of our plans to keep people well, living independently and in their own communities

The development of a new Carers Strategy

The development of a Home First approach both in terms of expanding community services and enabling people to return home after a hospital stay

The focus on people living with mental health, learning disability and/or autism

A focus on health inequalities across all of our other plans

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Oxfordshire's key priorities for the BCF in 2023-25 are

1. The expansion and embedding of the Oxfordshire Way. This brings together BCF funding and planning with Public Health and ICB funding into a programme to address health inequalities in Oxfordshire through a focus on loneliness, exercise and connectivity. We aim to create the conditions where people can live independently in their own home within resilient communities. This approach underpins all other aspects of this plan around admission avoidance, falls prevention, home first on discharge and reducing long-term care in residential settings. The programme builds community capacity, area coordination and strengths-based assessment and support to enable people to access what works for them.

2. Developing a more integrated approach to supporting people to live as independently as possible in their own home across housing (including extra care housing), adaptations, assistive technology and equipment.

3. Supporting the implementation of the system Integrated Care Plan to improve the assessment and care planning for at risk populations and the implementation of responses linked to Urgent Community Response, Same Day Emergency Care and Enhanced Healthcare in Care Homes. This approach includes mental health and learning disability and/or autism pathways integrated into neighbourhood teams. It will also include a review that builds on our current falls response and associated services.

4. Home First Discharge to Assess for people who are admitted to hospital. We have created a Transfer of Care hub that now manages all discharges from Oxfordshire acute and community bed bases and will seek to expand to neighbouring trusts. We will increase the number of people going home; we will assess people at home; and when people need to go into bed-based reablement we will increase the throughput to get them home. We will review the capacity of our bed based rehabilitation services in 2023-24 to explore options to redeploy resources into Home First wherever possible in 2024-25

5. Further develop our demand and capacity planning capability including around community capacity and in mental health and learning disability and autism discharge pathways.

6. A continued focus on inequalities and the needs of unpaid carers throughout all of these priorities.

The planning and deployment of the Better Care Fund is led by the Health, Education and Social Care Integrated Commissioning Team. This is joint funded by the Council and the ICB

and hosted in the local authority. Our s75 NHS Act 2006 pooled commissioning budget is much larger than the BCF at £400m. We will continue to review during 2023-25 the opportunities to increase the scope of the Pooled Budget especially in relation to prevention and children's services.

In 2023-25 the BCF expenditure plan has been expanded to include a greater emphasis on prevention and to deliver via the Additional Discharge Funding our ambitions for Home First Discharge to Assess from acute bed bases, and a range of initiatives to support the timely and effective discharge for people living with mental health, learning disability and/or autism and in particular those who are homeless.

The BCF investment and this plan is designed to support system-wide initiatives:

- the development of a Health Inequalities programme bringing together Public Health and ICB Inequalities funding with the BCF to create community capacity and localised support to enable people to stay well and independent in their own communities and
- the system wide Integrated Care Plan to expand community services and avoid hospital conveyance and admission led by the Place Director for Urgent Care. This programme is funded partly by BCF and partly from other ICB funding streams.

The BCF plan for 2023-25 has been built on learning from the winter-funding round in 2022-23 and on the development of demand and capacity approaches. There are areas both of uncertainty (especially in relation to community intermediate care capacity) and development (implementation of a range of new initiatives) that mean that this plan will need to reviewed and reprofiled during 2023-24. At the point of submission, the plan does not fully deploy the Additional Discharge Funding as we anticipate that some of the new initiatives may need implementation or other funding and may also lead to changes in demand across pathways that may need to funded. The plan will be reviewed in Q2 2023-24 to confirm this further ADF investment and to confirm any changes to the plan for 2024-25.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Oxfordshire has a 6 part approach to enabling people to stay well, safe and independent at home for longer

1. We are developing community capacity that underpins all of our asset-based approaches. The BCF investment plan includes a grants programme to support neighbouhood and community groups to meet the needs of their communities with a focus on combatting isolation and supporting exercise. Within the BCF Plan we commission Age UK to provider information and advice (Live Well Oxfordshire) and support through the Community Links service to enable people to identify what is important to them and access resources to enable them to retain their independence. This BCF funded service works alongside Public Health and ICB funded programmes that work in the 10 most deprived Wards in Oxfordshire, provide exercise support (Move Together) delivered by the voluntary sector, seek to develop Healthy Place Shaping and map into NHS Social Prescribing and District Council community support.

During 2023-24 we are mapping this range of services and inputs under the Oxfordshire Health Inequalities programme. We will identify opportunities to consolidate the approach and increase impact. Particularly we are working with voluntary and community sector partners to develop approaches to measuring impact and mapping those successes back to the BCF metrics in relation to avoidable admissions, admissions to long-term care and discharge to usual place of residence. It is likely that this capacity and capability will in turn support the delivery of the future BCF recovery measure.

2. Adult Social Care has developed the model of strengths-based assessment and asset-based planning known as the Oxfordshire Way. This approach now underpins the Home First Discharge to Assess models funded from the BCF. The Oxfordshire Way builds upon the development of Community Capacity above.

3. The BCF funds a range of services that support a more integrated approach to keeping people well in the community. The BCF funds extra care housing, the integrated community

equipment service jointly commissioned and managed across the Council and NHS; use of telecare and assistive technology. These services are under review during 2023-24 as part of the development of a new Assistive Technology strategy for Oxfordshire.

4. The BCF also funds a range of services that are being developed into new Integrated Neighbourhood teams in 2023-24 as part of the Oxfordshire Integrated Care Plan. This will bring together PCNs, social care, community health and the Voluntary sector working with the community capacity as set out above.

5. In 2022-23 Oxfordshire undertook a review of our support for carers co-produced with carers and organisations that work with them. In Q2 we will conclude an engagement on the future model for supporting carers across health and care settings and a common outcomes framework so that unpaid carers know what to expect and we can measure impact across different providers. The BCF funds Carers Oxfordshire and personal budgets for carers. This has been expanded for 2023-24 to increase the capacity of the service. We will carry out a review of the different forms of respite available to carers in Q2 2023-24. We have also expanded our BCF funded offer through Dementia Oxfordshire to support more carers earlier in the diagnosis journey of the cared-for in response to findings in our survey.

6. Oxfordshire will develop a more integrated approach to supporting independence through housing adaptations in 2023-24 in a major review of the opportunities to co-ordinate, integrate and increase impact. There is already strong operational co-working around housing adaptations: the DFG pays for Housing Occupational Therapy teams around the County that work closely with housing teams and all of our Home Improvement Agency services are now either delivered directly by District Councils in a partnership or a directly commissioned service. There are also a range of district housing-BCF interfaces eg the role of Community Safety approaches in supporting integrated strengths-based assessment and care planning, and local district-led initiatives around community support as part of tenancy sustainment or around falls risk. There is an opportunity for the BCF to deepen and extend the joint working across these and other related areas (e.g. extra care housing allocation, development of move on accommodation for people in step down pathways). This work will be led by the Council and will include two aspects: the opportunities to develop assistive technology, community equipment and adaptations into a range of options to support people to stay at home led by the Council's Principal OT together with housing leads and commissioners; and a review of the wider interface of the BCF with housing to identify opportunities to increase options to deliver more integrated approaches.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Oxfordshire was adversely affected by a major data outage in 2022-23 which impacted on our Community Health provider and that situation is not yet fully resolved. This has significantly impacted on our ability to map demand and capacity in this area and forms part of the plan for 2023-24: we will undertake a full review of demand and capacity in Q2 to inform the plans including investment for 2024-25.

We have assumed a 5% increase in demand where we can assess that in the light of the data outage.

In terms of demand for community social support and for reablement we understand the demand and have commissioned responses to meet that. We have commissioned the

Community Links service from Age UK and although the forecast demand exceeds the contracted service we are confident that the range of other services funded by the BCF and elsewhere as part of our community capacity building will meet these needs. In terms of community reablement, the projected demand from our new Home First Discharge to Assess service will mean that overall services will need to expand. All referrals for reablement come into the Home First team. The provider contracts are designed to flex according to demand and we have strong capacity in our market in terms both of reablement and domiciliary care after significant recruitment to our Live Well at Home Framework in 2022-23 (currently over 90 accredited providers).

We do not use reablement in a bedded setting in Oxfordshire and there is no evidence that it is needed in our Home First model. In terms of short-term social care, most of this will be routed through to Home First in the first instance which provides both reablement and domiciliary care and is not counted separately for demand or capacity purposes. As noted above we have strong capacity to support people at home and if a bed is needed short-term we have planned respite capacity within our main residential and nursing home block contracts. This demand is not currently measured separately but performance will be reviewed in Q2.

The Urgent Community Response service is funded to meet the planned demand for 2023-24. Our challenge is two fold and this will form part of the review in Q2:

> The UCR is being developed as a single front door for all community intermediate health care. Therefore any therapy assessment for rehab and the initial response is within the UCR figures. However, the impact of this deployment on planned care in the community is still being evaluated, and the extent of any gap in capacity to meet intermediate care demands is not yet fully understood
>
> As noted above this is compromised further by the data outage. We anticipate being able to address this gap during Q2

As with reablement, we do not routinely use bed-based rehabilitation as step up from the community. The commissioned step up beds are generally used for assessment and short-term care for frailty to avoid conveyance to acute settings. Again, we cannot currently assess the flow from these step up beds into bed-based rehabilitation and this will be reviewed during Q2

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Oxfordshire has been rolling out a programme of initiatives as part of the system Integrated Care Plan in 2022-23 and this will continue in 2023-24. The range of services include

Support for on the day demand from primary care: Urgent Care Centres will triage 95% of all NHS 111 referrals

Single point of access via UCR for all clinicians

Development of integrated neighbourhood teams with support from Urgent Community Response and health professionals MDT

These plans have had some success in the reduction of non elective admissions in Q3 and Q4 of 2022-23. There are now established virtual wards in the City and Bicester and the plan is to roll these out during 2023-24 beginning with Banbury. Analysis of the demand data and from audit in Emergency Departments has emphasised that a key factor in the decision to attend is often linked to proximity rather than the presenting condition and risks. Therefore a key focus is on the City and Banbury.

The BCF funds Hospital at Home and Emergency Multi-disciplinary Assessment units which are being developed into the integrated neighbourhood model together with Urgent Community Response and the Primary Care Network based teams including for Enhanced Healthcare in Care Homes.

We anticipate that the continued development of these approaches will lead to an ongoing improvement in our trajectory to reduce non-elective admissions in 2023-24. The evidence is

that the key factor is in the management of frailty where there are multiple long-term conditions.

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	169.1	146.6	190.5	185.0
	Number of Admissions	1,315	1,140	1,481	-
	Population	691,667	691,667	691,667	691,667
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Indicator value	172	140	176	176

Oxfordshire has been an outlier for falls-related admssions for a number of years with several hotspots within the County. In 2022-23 the performance improved. We believe that in significant part this was due to work in the Integrated Care Plan above. There was a call before convey pilot between UCR and ambulance services and a review of fallers in Emergency Department where there was no case for admission. There has been a reduction of 10% in attendees after a suspected fall and the assumption is that by identifying fallers at risk of further falls but prior to an injury requiring admission we are able to divert people into community services that avoided that later episode.

The BCF already funds both a preventative strength and balance class approach delivered by Age UK which is being extended into a further “upstream” service via Public Health funding in 2023-25. The BCF also funds the community Falls Service which works with people identified at serious risk of falling in a planned care model. There are several other initiatives both to mitigate the risk of falls and to assess and divert people into community and other services that could help improve strength and balance, as well as the clinical pathway interventions. Oxfordshire is applying for funds via the ICB for a digital pilot to manage falls risk in Care Homes; Raiser chairs are deployed in extra care and some care home settings and available to support UCR in peripheral stores; there are faller initiatives being run in the wider community by the City Council and by the Fire Service home risk assessment service. And there is the review of assistive tech, equipment and home adaptation as set out above. Oxfordshire has the opportunity to make a big impact on falls building on and aligning current and planned initiatives and we will develop this plan in 2023-24 for roll out from Q3 and throughout the lifetime of this plan. The review of the BCF plan in Q3 will determine if this areas needs further investment in 2425. We are confident we will maintain the reduction in falls achieved in 2223

		2021-22 Actual	2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,102.6	1,897.0	1,802.0
	Count	2,890	2610	2480
	Population	130,843	130843	130843

Oxfordshire has delivered on its plan to redirect resources away from long-term residential and nursing care. This is linked to the Oxfordshire Way and the Home First framework set out elsewhere in this plan. In summary we aim through a range of plans to support people at home and with access to community assets to help people maintain independence for longer and to reduce the length of stay in residential care through delayed entry to these services. We will maintain this plan in 2023-24

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	369.5	350.2	346.5	325.8
	Numerator	481	474	469	450
	Denominator	130,189	135,361	135,361	138,108

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Oxfordshire will make a step change in the delivery of Home First in 2023-25. During winter 2022-23 we have established a multi-agency Transfer of Care Hub and appointed a system lead to manage the development and implementation of the model during this period. The new model has already improved decision-making regarding choice of discharge pathways and will be extended as follows:

1. Our pathway 1 model will be transformed into a fully discharge to assess model where people will be supported at home for up to 72 hours whilst assessed for reablement, rehabilitation or domiciliary care and a plan is put in place. This involves a redesign of current services which we are developing in partnership with our independent strategic care and reablement providers. The model will be implemented in phases from July to Oct 2023 and be fully operational before the winter. In the same phase the Hospital Social Work and Home First teams will be redesigned to support the new model, with the aim that they follow people home and assess them there. Additional Discharge Funding is supporting the implementation and will be used to fund any elements that cannot be redeployed from our current model. There is a proportion of the Additional Discharge Fund which is not yet allocated and the deployment of this will be assessed as part of the learning from the phased roll out.

The new model will increase the amount of people discharged to Pathway 1 and will require increased investment in reablement and care packages and this increased capacity will be funded from the Additional Discharge Funding. Our long-term domiciliary care Live Well at Home framework has expanded significantly and delivering significantly increased capacity. During winter 2022-23 we have expanded the number of providers working into our Home

First reablement model and we will be seeking to integrate this new capacity and capability into this new D2A model.

2. We are similarly redesigning our Pathway 2 provision in 2 phases

a) in phase 1 we are recommissioning our current “short stay hub beds”. These beds commissioned from nursing homes and flow through them is managed by a multi-disciplinary team led by the acute hospital discharge team. For reablement we will firstly seek to divert more people into Home First Discharge to Assess as above. Where people need a reablement bed we will move to a 7 day therapy led model of in-reach into the homes which will reduce LoS from 21-25 to 10-14 days. This increased throughput will allow us to reduce the number of beds and support the development of our Home First Discharge to Assess ethos and practice.

As part of the recommissioning of the nursing home provision we will also continue to commission discharge to assess for beds who would benefit from a nursing home stay to confirm their long-term care needs

b) the work of the transfer of care team has established “clear water” between people needing bed-based reablement and bed-based rehabilitation. In 2023-24 we will continue to assess the level of demand for rehabilitation and the specific requirements that we may need where rehab at home is not an option on discharge from acute (complex medical needs and frailty; non-weight bearing; bariatric pathway). In Q3 we will reset our ambition and plan for P2 rehab provision during 2024-25 and develop proposals for the use of that estate in step down and alternative community-based provision

3. Additionally we have identified a continuing unmet need for delirium-related support. In the short-term we have identified the opportunity to deploy the Additional Discharge Funding to purchase specialist provision from local nursing homes. However, our plan is to develop a mixed model of beds and in-reach support to people’s homes. We will finalise this model during Q2 2023-24 and then proceed to implementation.

4. Additional Discharge Funding is also being used to support flow through specialist Mental Health and/or Learning Disability beds and to enable these user groups to flow more effectively through acute settings. This includes

Step down beds for people with severe mental illness

A personality disorder discharge support service

Enhanced discharge support to care homes for older people with complex presentations

Expanded MDT approaches to supporting complex discharges with more upstream planning

Housing options development for people with complex learning disability and/or autism presentations

In-reach service to support the specialist learning disability team in acute settings with effective discharge planning

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Our understanding of the demand for intermediate care, and across acute and mental health pathways, has developed both from the implementation of the Transfer of Care hub in the acute, and focussed work on delays to discharge in mental health pathways.

All acute discharges other than P0 are now routed through the Transfer of Care hub. This has radically reduced the use of bed-based and/or inappropriate pathways owing to pressure to discharge patients and has led to the development of the Home First D2A model (see previous section) and the review of our P2 reablement and social care pathways.

We have assumed a 5% increase in demand.

We have commissioned from BCF an Urgent Care Community Links service from Age UK to support people needing help on P0. The service also supports other discharges where indicated especially carers and other family members. Although the demand and capacity profile shows a slight shortfall the service can flex above contracted levels and will draw on the community resources developed as part of the Oxfordshire Way.

We have reprofiled P1 capacity across reablement, rehabilitation and social care as these are all routed by the TOC hub to Home First for deployment to our Live Well at Home strategic providers. We are stepping up the capacity within this service both to meet the expanded demand from October and to meet the redirected demand from P2 reablement beds.

We are reducing the P2 reablement capacity in line with Home First and increasing the throughput via a shorter length of stay 7 day therapy model. This change in demand profile has been mapped into P1.

We have discharge data into P2 rehabilitation from the Transfer of Care hub and LoS data in the community hospital beds. In 2023-24 we have assumed a “standstill” profile of beds and length of stay but this will be reviewed in Q3 as there may be a case to reduce demand assumptions as the Transfer of Care team continues to divert people to Home First and/or bed based reablement rather than rehabilitation.

We have mapped short-term social care capacity to demand. There is surplus capacity in terms of our Live Well at Home domiciliary care framework and residential and nursing home beds. The barriers to discharge and lengths of stay tend to be for other reasons (equipment, complex discharges and so on) than simple capacity. We will review this in Q3 and reprofile as necessary for winter and for 2425. We do anticipate in 2324 the need to buy additional nursing home capacity until we have fully implemented Home First D2A.

The demand and capacity plan for mental health discharges has been impacted by the same data outage that has impacted community intermediate care. The data also needs to be mapped onto the pathways used in acute hospital discharge and there are both language and technical differences in the resources used and destinations achieved. The data as presented is the capacity achieved in 2223 inflated by 5% and allocated pro-rata to a judgement of the mental health leads on how to map existing pathways onto the BCF definitions. There is not a way at this point of understanding how this capacity relates specifically to demand. There are delays and the plans for the deployment of the Additional Discharge Funding set out how this capacity will be improved. However at this stage the

demand and capacity are netted off. This will be reviewed during Q2 as data becomes available and the plans will be reviewed for Q3/Q4 and 202425.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

The measures set out above will support the development and delivery of improved performance against Metric 8.3. However, there is a level of risk relating to the amount of pathway change and improvement in 2023-24 and we are therefore profiling an improvement where we achieve 95% in 2024-25. We have retained as part of the Additional Discharge Funding a provision to purchase short-term interim P2 beds over the winter 2023-24 and this may-if deployed-offset the delivery of the metric, but we plan to reduce this provision in 2024-25 and to remove it entirely as soon as capacity permits.

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute	Quarter (%)	90.7%	91.3%	90.6%	93.0%
	Numerator	11,143	11,499	11,670	11,260

hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Denominator	12,282	12,588	12,882	12,109
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
	Quarter (%)	91.0%	92.0%	92.5%	93.0%
	Numerator	11,193	11,500	11,840	11,625
	Denominator	12,300	12,500	12,800	12,500

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Oxfordshire is moving towards full maturity against the HICM with the implementation of Home First MDT, the transfer of care hub and the integrated interface between assessment and provision across NHS, social care and independent providers:

Early Discharge Planning: achieved through the Transfer of Care hub

System demand and capacity: partly achieved for discharge less so for community intermediate care demand. We have made provision in the deployment of the Additional Discharge Funding for both the IT that may improve monitoring, planning and deployment and the business intelligence that will map dependent capacity (eg where dedicated therapy might be needed to support a provider led discharge)

Multidisciplinary Discharge team working: achieved via Transfer of Care TOC hub, Home First D2A MDT and the Hub team managing flow through P2 reablement beds

Home First D2A: achieved-roll out July-Oct 2023

Flexible working patterns: partly achieved. A review of the deployment of dedicated staff teams and/or moving discharge functions to business as usual for existing teams across 7 day working is under way in Q1 and Q2 of 2324

Trusted assessment: partly achieved. We have had considerable success with an interim model in 2223 which has been welcomed by independent care providers. In the new models of care all P1 and P2 referrals will now be on a trusted assessor basis using common assessment tools and templates. The space for a dedicated trusted assessor service will be in restarts, some complex social care packages and in supporting providers working into the new pathways. This expanded service will be funded from Additional Discharge Funding and operational prior to Q3 2324

Improved Discharge to Care homes: partly achieved. We will be expanding our Care Home Support Service to deploy specialist mental health support in 2324 to improve discharge form acute and older adult mental health beds. This will be funded by Additional Discharge Funding

Housing and related pathways. Achieved for homeless people in both mental health and acute settings where we are investing in step down bed provision and the associated teams to enable people to move on to more settled accommodation and engage with health and other services. Other issues relating to housing will form part of the development of the more integrated approach across housing, technology and equipment

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

BCF funding is supporting

Information and advice on options and self care

Assessment and care planning in the Home First Discharge to Assess and the other discharge pathways

Support for carers in terms of advice and information and also personal budgets

Support for the most complex needs including for people in crisis

Market development through the Live Well at Home Framework to deliver Home First Discharge to Assess and the recommissioning of short-term discharge to assess beds

Market Sustainability through funding of fee uplifts

Trusted Assessor to support independent providers including in self-funded arrangements

Support for workforce development and funding for the care provider body

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

In 2022/23 we have been listening to carers through workshops, surveys, storytelling and carers' voices events in shaping a new strategy. This has told us that although caring can be rewarding, carers are frequently tired, cannot easily find information that they need, have to keep retelling their story, and do not feel valued.

We have developed a strategy that is currently out for consultation. This strategy has been co-produced with 1,600 adult and young carers along with stakeholders from the County Council, Carers Oxfordshire, Rethink Mental Illness, Oxfordshire Family Support Network, Be Free Young Carers, Oxfordshire Parent Carer Forum, Age UK Oxfordshire, Dementia Oxfordshire, Oxford Health, Oxford University Hospitals, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board and Oxford City Primary Care Networks Social Prescribers.

The action plan within this strategy proposes practical steps to recognise, involve, empower and support carers of all ages. We will continue to listen to carers throughout the lifetime of the strategy and build this into our annual review of the BCF plan

The BCF funds

- Carers Oxfordshire, a partnership between the charities Action for Carers (Oxfordshire) and Rethink Mental Illness, has been commissioned by the Council to be the primary Adult Social Care service for unpaid carers 18 years and older
- Personal budgets that are available for unpaid carers to support their wellbeing

Subject to the result of the engagement our key actions in the lifetime of the BCF plan will be

Improve recording & reporting data re unpaid carers

Ensure support to carers is effective at improving their wellbeing and providing opportunities from breaks from their caring role (including access to those community services developed as part of the Oxfordshire Way)

safeguard the most vulnerable carers who need more support to look after themselves, particularly during times of change and transition

encourage and enable carers to have an active life outside their caring role, including fulfilling their education, employment, and training potential

All health providers are signed up this plan and to developing common metrics that enable us to measure impact of the strategy as well as in the BCF funded services.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

There is strong operational co-working around housing adaptations: the DFG pays for Housing Occupational Therapy teams around the County that work closely with housing teams and all of our Home Improvement Agency services are now either delivered directly by District Councils in a partnership or a directly commissioned service. There are also a range of district housing-BCF interfaces eg the role of Community Safety approaches in supporting integrated strengths-based assessment and care planning, and local district-led initiatives around community support as part of tenancy sustainment or around falls risk. There is an opportunity for the BCF to deepen and extend the joint working across these and other related areas (e.g. extra care housing allocation, development of move on accommodation for people in step down pathways). This work will be led by the Council and will include two aspects: the opportunities to develop assistive technology, community equipment and adaptations into a range of options to support people to stay at home led by the Council's Principal OT together with housing leads and commissioners; and a review of the wider interface of the BCF with housing to identify opportunities to increase options to deliver more integrated approaches.

This development is a key priority for 2023-24 and an acknowledgement that there is scope to improve aspects of this work. We will also seek to identify how this work might be informed by the Public Health Better Housing Better Health.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

No

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Not applicable

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

The current BCF plan expands Oxfordshire's focus on health inequalities in 3 key ways:

1. The Additional Discharge Funding is deployed extensively to support the most vulnerable people on discharge from specialist as well as general acute settings. Oxfordshire has purchased specialist step down beds for people living with severe mental illness where either they would benefit from bed-based reablement with specialist support during transition, and/or where they have no home to which they can return. These beds also provide a step up capacity for some people who typically will have attended ED and are not plugged into primary and community health services. The in-reach staff that support these beds work both to engage people in health services. This funding is supporting the wider homelessness pathway in 2023-24 and will form part of a wider system conversation around the role of the BCF and other plans and partners in meeting these needs from 2024-25. The BCF additionally already invests in the current homelessness MDT

We are investing in specialist mental health support to enable older people with complex needs be discharged to nursing homes where there needs can be managed in the least restrictive setting. This will support people in both mental health and acute beds.

We are investing in support for people with personality disorders who typically can get delayed in specialist mental health units In-reach service to support the specialist learning disability team in acute settings with effective discharge planning.

We are investing in integrated capacity across health, therapy, social work for people both in mental health units and learning disability/autism settings. These MDT approaches recognise the additional complexity facing these groups beyond the Home First model in successful discharges into the community.

We will improve access to longer-term housing for people with complex needs in our discharge pathways: we will fund specialist development capacity to identify housing options for people living with learning disability/autism settings; and we will work with district councils to integrate housing options for people in step down pathways who have no home.

2. The BCF through the Oxfordshire Way and Community Capacity grants are supporting the Public Health priority to improve health outcomes in the 10 most deprived wards overseen by the join Health Inequalities Forum. As noted at various points in this plan there are opportunities to map, align and integrate services and funding to improve health outcomes and the delivery of the BCF metrics for our population.

The principle focus of this work is on addressing isolation and increasing exercise to address our key challenges around mental ill-health and cardiovascular disease in our most vulnerable populations.

3. We will be working with our providers across a range of fields (support for unpaid carers, demand and capacity for community intermediate care, profiles of fallers, community capacity) to develop outcome metrics that can be mapped back to health inequalities and to the BCF metrics. This will be overseen by the Oxfordshire Health Inequalities Forum that brings together Public Health, ICB, social care, Districts and the Community providers to assure progress with plans and support decision-making on deployment of resources including BCF and ICB Inequalities Funding.

Divisions Affected - All

OXFORDSHIRE HEALTH AND WELLBEING BOARD
29th JUNE 2023

Oxfordshire Combating Drugs Partnership

Report by Ansaf Azhar

RECOMMENDATION

1. **The Health And Wellbeing Board is RECOMMENDED to note the progress with the Oxfordshire Combating Drugs Partnership**

Executive Summary

Illegal drug use is linked to crime, poor health outcomes, and brings fear to communities, disproportionately affecting disadvantaged populations. In 2019, the government launched a drug strategy, From Harm to Hope: A 10 year plan to cut crime and save lives[1] which set out an ambitious target to combat illegal drug use, and improve services for people who use drugs. This introduced the need for local Combating Drugs Partnership, bringing together local partners to ensure there is a coordinated approach to addressing the local challenges of drug use. Together key local partners jointly agree, own and deliver a strategic action plan to

- reduce overall drug use,
- reduce drug-related crime,
- reduce drug-related deaths and other harms.

Oxfordshire have established a Combating Drugs Partnership with a range of partners from health, local authority, criminal justice and the voluntary sector, and have agreed a strategic action plan to address local need.

Background

The impact of the illegal drug market is felt across society, fuelled by organised criminal activity to ensure supply can be achieved, and threatens both the neighbourhoods they operate in and individuals drawn in. People who use drugs suffer poorer health outcomes and are at risk of a higher mortality rate. Drug consumption is linked to other social determinants of health, and disproportionality affects disadvantaged populations.

[1] From harm to hope: a 10-year drugs plan to cut crime and save lives (publishing.service.gov.uk)

In 2019, the government launched a drug strategy, From Harm to Hope: A 10 year plan to cut crime and save lives[2] which set out an ambitious target to combat illegal drug use, and improve services for people who use drugs. This was underpinned by a government investment of over £1000 million to enable local areas to achieve the targets. The strategy addresses the recommendations of the Dame Carol Black[3] report, which highlighted the complexity of factors which drive the illegal drugs market, and the lack of investment in addressing these.

The aims of the Harm to Hope strategy are to break the cycle of illegal drug use by co-ordinating actions to reduce both supply and demand of illegal drugs, whilst providing effective services to support and treat people who use drugs.

The Combating Drugs Partnership brings together local partners to ensure there is a coordinated approach to addressing the local challenges of drug use. Together key local partners must jointly agree, own and deliver a strategic action plan to

- reduce overall drug use,
- reduce drug-related crime,
- reduce drug-related deaths and other harms.

Combating Drugs Partnership guidance was published in June 2022[4], stating the partnership should have a Senior Responsible Officer occupying a senior role in one of the core membership organisations, and membership should include:

- elected members (in two-tier authority areas it would be appropriate to have multiple representatives to ensure that different tiers and responsibilities are adequately represented, notably housing)
- local authority officials (including expertise in relevant areas such as substance misuse, housing, employment, education, social care and safeguarding)
- NHS (including strategic and mental health provider representation)
- Jobcentre Plus
- substance misuse treatment providers
- police
- PCC
- National Probation Service
- people affected by drug-related harm
- the secure estate, such as prisons, young offender institutions (YOIs)

Other partners can also be included by local agreement.

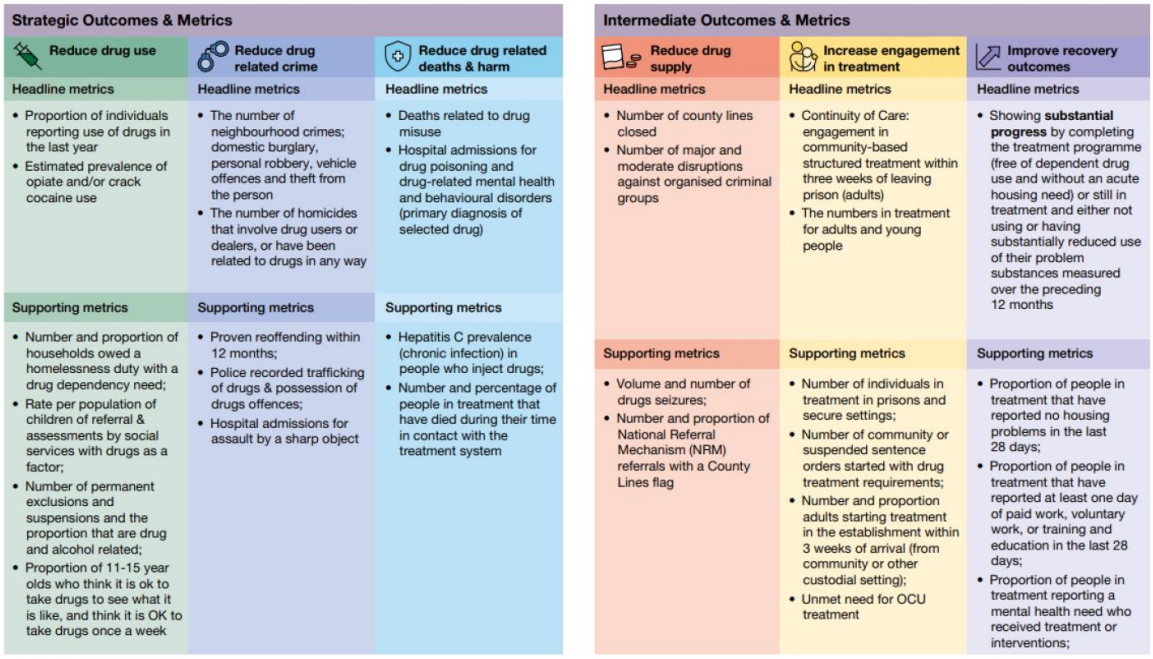
CDPs were required to produce a local needs assessment looking at drug supply, use and treatment. Based on the findings, the partnerships must agree a strategic action plan to address local challenges.

Local progress is being monitored against a National Outcomes Framework, which focuses on the three aims of the strategy. The national monitoring and reporting for

[2] From harm to hope: a 10-year drugs plan to cut crime and save lives (publishing.service.gov.uk)
[3] Review of drugs: phase two report - GOV.UK (www.gov.uk)
[4] Drugs strategy guidance for local delivery partners - GOV.UK (www.gov.uk)

this framework is still being developed, and will ultimately support local delivery of the strategic priorities.

Full national Combating Drugs Outcome Framework[5]



Strategic Outcomes & Metrics

Reduce drug use	Reduce drug related crime	Reduce drug related deaths & harm
Headline metrics	**Headline metrics**	**Headline metrics**
• Proportion of individuals reporting use of drugs in the last year • Estimated prevalence of opiate and/or crack cocaine use	• The number of neighbourhood crimes; domestic burglary, personal robbery, vehicle offences and theft from the person • The number of homicides that involve drug users or dealers, or have been related to drugs in any way	• Deaths related to drug misuse • Hospital admissions for drug poisoning and drug-related mental health and behavioural disorders (primary diagnosis of selected drug)
Supporting metrics	**Supporting metrics**	**Supporting metrics**
• Number and proportion of households owed a homelessness duty with a drug dependency need; • Rate per population of children of referral & assessments by social services with drugs as a factor; • Number of permanent exclusions and suspensions and the proportion that are drug and alcohol related; • Proportion of 11-15 year olds who think it is ok to take drugs to see what it is like, and think it is OK to take drugs once a week	• Proven reoffending within 12 months; • Police recorded trafficking of drugs & possession of drugs offences; • Hospital admissions for assault by a sharp object	• Hepatitis C prevalence (chronic infection) in people who inject drugs; • Number and percentage of people in treatment that have died during their time in contact with the treatment system

Intermediate Outcomes & Metrics

Reduce drug supply	Increase engagement in treatment	Improve recovery outcomes
Headline metrics	**Headline metrics**	**Headline metrics**
• Number of county lines closed • Number of major and moderate disruptions against organised criminal groups	• Continuity of Care: engagement in community-based structured treatment within three weeks of leaving prison (adults) • The numbers in treatment for adults and young people	• Showing **substantial progress** by completing the treatment programme (free of dependent drug use and without an acute housing need) or still in treatment and either not using or having substantially reduced use of their problem substances measured over the preceding 12 months
Supporting metrics	**Supporting metrics**	**Supporting metrics**
• Volume and number of drugs seizures; • Number and proportion of National Referral Mechanism (NRM) referrals with a County Lines flag	• Number of individuals in treatment in prisons and secure settings; • Number of community or suspended sentence orders started with drug treatment requirements; • Number and proportion adults starting treatment in the establishment within 3 weeks of arrival (from community or other custodial setting); • Unmet need for OCU treatment	• Proportion of people in treatment that have reported no housing problems in the last 28 days; • Proportion of people in treatment that have reported at least one day of paid work, voluntary work, or training and education in the last 28 days; • Proportion of people in treatment reporting a mental health need who received treatment or interventions;

Oxfordshire Combating Drugs Partnership

All Combating Drugs Partnerships (CDP) in the Thames Valley areas have adopted the local authority footprint. The SRO in Oxfordshire is the Director of Public Health, which is in line with most other areas in South East.

The Oxfordshire CDP has been successfully operating since October 2022, engaging a wide range of partners including Thames Valley Police, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, Turning Point, Oxford Health NHS Foundation Trust and Oxfordshire County Council amongst others.

The CDP have received valuable input from people with lived experience, supported by Turning Point, to ensure the partnership have an understanding of the impact of drugs on people's lives, and the benefits that supportive services can bring.

Some partners, such as Thames Valley Police and the Police and Crime Commissioner's Office (PCC), are members of several CDPs. This has enabled the PCC analysts to provide a common dataset to all CDPs in Thames valley to support the needs assessment and ongoing data monitoring. However, the time commitment to attend many partnerships has been a challenge for these organisations.

A rapid needs assessment was produced in December 2022. There was already an existing Drug and Partnership strategy in Oxfordshire, which was reviewed and adopted as the basis for agreeing a strategic delivery plan.

[5] Drugs strategy national outcomes framework - GOV.UK (www.gov.uk)

The delivery plan has now been agreed, and covers the following areas:

- Early Intervention for Children and Young People

Focus on prevention campaigns, increasing numbers in treatment, and focusing on vulnerable young people.

- Reduce Drug Related Homicides and Violent Crime

Ensuring effective pathways from prison to community services, improve early identification of those at risk of exploitation, increased focus on complex cases

- Preventing Drug Deaths

Rolling out harm reduction interventions such as naloxone, ensuring pathways to drugs services are effective, learning from lived experience of those who lost friends and family to drug use

- Reduce County Lines and Local Organised Crime Groups

Partnership working and Coordinate intelligence of county line closures and cuckooing, police form a consistent approach around county lines, supporting adults with drug and alcohol services in the criminal justice system.

- Increase Treatment Places and Recovery Support Families at Risk for Substance Use

Promotion of all drug and alcohol services and pathways between them, specific support for some cohorts such as parents or sex workers, and known unmet need.

Corporate Policies and Priorities

The Combating Drugs Partnership supports the Corporate plan in the following priorities:

- Tackle inequalities in Oxfordshire
- Prioritize the health and wellbeing of residents

Financial Implications

The Combating Drugs Partnership have oversight of the grants provided from OHID to support the delivery of the harm to hope ambitions. In Oxfordshire these include:

	Rough Sleeping Drug and Alcohol Treatment Grant*	Supplementary Substance Misuse Treatment and Recovery Grant	Supplementary Substance Misuse Treatment and Recovery Housing Support Grant

Start	November 2020	April 2022	January 2023
End	April 2025	April 2025	April 2025
Value 2023-2024	£1,140,605	Main Grant: £634,600 Inpatient Detoxification: £96,612	£621,708
Aims	To improve treatment and recovery outcomes for those who are rough sleeping.	To improve outcomes for drug and alcohol users generally, reduce drug and alcohol related deaths, and increase the number of those in treatment.	To improve treatment and recovery outcomes for those with a housing need.
Delivery	Additional interventions of assertive outreach, community treatment, residential rehabilitation and inpatient detoxification.	A range of intervention including harm reduction provision, additional staffing to expand reach of treatment services, and criminal justice support.	A range housing related support for people in treatment through a specialist floating support team and Recovery Living support service, along with training, peer mentoring and personalised budgets for sustaining tenancies, first month rent and rental deposits.

*The Rough Sleeping Drug and Alcohol Treatment Grant was introduced before the Harm to Hope strategy, and is not part of the funding provided to deliver that strategy. However, as Oxfordshire Drug and Alcohol services benefit from this grant to improve services for a specific treatment population, oversight of this at a local level is included with other grants.

Staff Implications

The Combating Drugs Partnership is led by the Public Health and Community Safety Directorate. This support is mainly funded from the Public Health grant.

Equality & Inclusion Implications

The needs assessment investigated treatment needs for all sectors of the populational including ethnic minorities and those with protected characteristics. The strategic action plan has reflected any gaps identified where necessary.

An Equality and Climate Impact Assessment was completed for the recently commissioned Supplementary Substance Misuse Service, provided by Turning Point.

Risk Management

Risk	Mitigation
In the first year of the CDP there have been extremely tight timescales for delivery of actions, such as delivery of needs assessment and action plan	CDP meeting monthly to progress actions and move forward at pace, with a clear focus.
As this is a new partnership, there is a risk that the CDP strategic action plan does not align with partners' strategic delivery.	A workshop has taken place for partners to work on the action plan, to ensure understanding and a robust partnership approach. This should ensure alignment with partners' strategic direction.
Difficult to achieve a comprehensive and partnership reviewed assessment of need within the required timescales.	Following initial needs assessment review, certain areas have been agreed as needing further investigation in the coming year through review of new datasets and the latest commissioning packs as they become available.

NAME Ansaf Azhar, Director of Public Health

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19th June 2023

Divisions Affected – ALL

OXFORDSHIRE HEALTH AND WELLBEING BOARD
29th JUNE 2023

Community Profiles for Barton, Banbury Neithrop and Ruscote, Banbury Grimsbury and Rose Hill

Report by Ansaf Azhar – Director of Public Health and Community Safety, Oxfordshire County Council

RECOMMENDATION

1. **The Oxfordshire Health and Wellbeing Board is RECOMMENDED to**

   1.1 Note the findings and rich insight contained within the Phase 2 Community Profiles for Barton, Banbury Neithrop and Ruscote, Banbury Grimsbury and Rose Hill.

   1.2 Support the promotion and sharing of the community profiles with partners and colleagues across the system.

   1.3 Use the insight from the community profiles to inform service delivery plans of partner organisations on the Board.

Executive Summary

2. The Director of Public Health Annual Report highlighted ten wards in Oxfordshire which have small areas (Lower Super Output Areas) that were listed in the 20% most deprived in England in the Index of Multiple Deprivation update (published November 2019) and are most likely to experience inequalities in health.

3. To better understand the needs and priorities of these communities, we have been working with local partners to create community profiles, providing an in-depth understanding of the enablers and challengers to the health and wellbeing of communities and have now completed four profiles that cover five more areas (Phase 2 of the programme).

4. The profiles link to the Joint Strategic Needs Assessment (JSNA) and contribute to the local evidence base to inform service delivery, as well as being a resource for local communities to support their work.

5. Annex 1-4 contain direct links to the recently published Phase 2 community profile reports.

Background

6. The purpose of creating a community profile is to ensure we understand as fully as possible the health outcomes and factors that influence these outcomes within areas in Oxfordshire where residents are most at risk of poor health, or experience health inequalities. A proof of concept for ward profiles, focussing on the Banbury Ruscote ward was taken to the Oxfordshire Health and Wellbeing Board in June 2020. More details can be found through this link. (from page 47 onwards).

7. Since then, we have been working with communities to produce profiles to cover the other areas identified in the Oxfordshire Director of Public Health Annual Report which have the greatest number of small areas (Lower Super Output Areas) that were listed in the 20% most deprived in England in the Index of Multiple Deprivation update (published November 2019) and are most likely to experience inequalities in health.

8. The profiles map the assets in each area, capture community insight around enablers and challenges to health and wellbeing and detail a data set of indicators for each area to help inform high level recommendations. The methodology of the community insight capture and asset mapping are explained in each of the individual community insight reports.

9. After the proof of concept, the initial areas of focus (Phase 1) were Abingdon Caldecott and The Leys (Blackbird Leys and Northfield Brook combined) and a report outlining the key findings from these profiles was taken to the Oxfordshire Health and Wellbeing Board on 6th October 2022.

Phase 2 Profiles

10. Since then, four further profiles have been completed for the five areas listed below (Phase 2) which form the main focus of this report.

Banbury

- Grimsbury and Hightown
- Banbury Cross and Neithrop
- Ruscote (a refreshed profile for Ruscote from the original proof of concept -combined with the Neithrop profile)

Oxford City

- Barton
- Rose Hill

11. Similarly, to the Leys and Abingdon Caldecott profiles, we have taken the approach of setting up locally based steering groups to help shape the direction of the profiles along with an external organisation capturing the community insight, in all the areas except Barton. In Barton, the Community Health Development Officer, employed by Oxford City Council lead on the insight gathering. The Banbury community insight was led by Community First Oxfordshire and Rose Hill by Oxford Hub. The steering groups vary in their make up in each area but may include representatives from local community groups, health organisations, Councillors, Local Authorities etc. In these Phase 2 profiles, the relevant district or city council has been supporting with project management.

12. As noted in the community profile reports, there are limitations to the data, and although the numbers of participants means that insight is not representative of all residents in those areas, they provide valuable insight by enabling the community's voices to be heard.

13. The profiles will help influence action for developing community assets and addressing health inequalities experienced by the residents of the profiled communities. A series of locally led recommendations have been included in the profiles, which set out objectives to build on the assets identified in these communities, to strengthen the opportunities available for development. An action plan is in development for each area where a profile has been produced, based on each profile's recommendations.

Key Findings from Phase 2 Profiles

14. **A summary of the findings, recommendations and next steps have been detailed for each area in the table below.**

Banbury Grimsbury and Banbury Ruscote and Neithrop	**Selection of key findings** Findings and recommendations for the three areas overlapped and are summarised below. • Green spaces and parks were highly valued assets and the proximity to the town centre and shops and services was frequently mentioned although issues with accessing healthcare was reported as causing some anxiety. • Locally available activities and the community venues where these are held are highly valued • Local community networks are well developed and there is a sense of a commitment to improvement across the long term although gaps were found in the lack of awareness in the wider community about what is available locally • Mental health was raised as a common concern with the pandemic being reported as having contributed negatively to this as well as the cost of living • Locally based groups and organisations are struggling with resourcing, funding, and a lack of volunteers

	Recommendations These were arranged under the following themes and a selection of recommendations are listed alongside them: • Public realm – improving of lighting and the local environment • Community, communication, and integration – development of a community- wide communication strategy, development of a programme of whole -community events • Community action – funding and bid writing support and improved joint working, additional support for young people, community based mental health initiatives, and additional peer-to-peer support **Next steps** • An action plan has been developed that is linked to the recommendations emerging from the insight • The steering group are working together to take forward actions from the recommendations in the report with support from the Community Health Development Officer • The community grants scheme is being set up and is likely to be based on a modified version of an existing Cherwell community grant scheme (Spark funding)
Barton	**Selection of key findings** • Seventy-six percent (76%) of participants felt satisfied, more than satisfied or very satisfied with their housing situation with green spaces and this was most commonly mentioned as a reason they liked living in Barton • The location of Barton and its accessibility to the city and local amenities including hospitals and transport links was reported several times as highly valued by respondents • Walking was the most preferred typical mode of transport followed by cars and buses • Worries about safety were linked to groups congregating outside shops and respondents reported feeling more unsafe at night, while others felt that feelings of insecurity were due to perception rather than actual threat • A larger proportion of respondents from Barton felt that they are part of the local community while others reported a stigma attached to living in Barton which affected their willingness to attend community events • Thirty-eight percent of respondents stated feeling lonely sometimes and less than 5% reported feeling lonely all the time • A high proportion of respondents from both Barton and Barton Park (66% and 77%) reported feeling they have the skills and/or qualifications to find employment

	• Over 80% of respondents reported that they consider themselves healthy and themes amongst respondents related to supporting self-care include strong social support networks and relationships, physical activity and movement and spending time outdoors in nature. **Recommendations** A selection of the recommendations derived from the findings of the community insight are below: • More resourcing to support social prescribers in Barton • Long term funding for community programmes that engage the community with their surrounding environment • Nurturing relationships between diverse groups to address perceptions of crime • Reinstating the community newsletter • Fully involve residents in programme design • Initiatives to further support active travel **Next steps** • An action plan was developed and a multi sectoral and community workshop was held following the publication of the report to discuss how the recommendations could be taken forward. A follow up session is scheduled to assign specific tasks from the action plan to relevant parties and to plan the grant funding process
Rose Hill	**Selection of key findings** • Forty-eight percent (48%) of respondents reported being 'quite satisfied' with Rose Hill as a place to live and a further 25% reported being 'very satisfied' • The community centre was identified as a key asset although concerns were raised that cost of some activities provided there were prohibitive to residents • Residents reported challenges related to housing including poor build quality, over-crowding, low levels of ownership and difficulties consulting with housing associations and property owners • Insight gathering suggested that some residents may experience challenges around self- motivation and aspirations which can become a barrier to accessing jobs or education • The cost of living was a major concern for residents cited as a barrier impacting housing, exercise, healthy eating, travel, and access to local facilities. • Most respondents reported feeling 'very' or 'quite safe' in Rose Hill and those that did not cited poor lighting and fast-moving traffic as reasons for this. • Forty-six percent (46%) of respondents reported feeling they had good health. Among the barriers to good health reported

	were workload, cost, childcare or a long-term condition. Also reported were challenges faced in accessing healthcare service due to a lack of provision in the area **Recommendations** The emerging recommendations are grouped into themes with a selection of these shown below • Quick wins – brightening up of the oval with a gardening project, establishing a health walk for Rose Hill, strengthening the Rose Hill News • Longer term – Improving access and uptake of education and training opportunities, improving residents access to healthcare including mental health support, mentoring schemes to change perceptions of Rose Hill, community ownership of initiatives taken forward from the community insight **Next steps** • An action plan has been developed and a panel consisting of a selection of members of the community as well as existing members of the steering group is being established to look at developing a grant process for the distribution of small grants to take forward actions from the recommendations

Grant Funding and Next Steps

Grant Funding

15. As well as the anticipated longer term strategic action arising from the profiles, it will be important that communities also see some more immediate action. To follow on from each profile a grant fund of £25,000 has been allocated for each area and a process has/will be agreed with each of the steering groups in profiled areas, for how best to utilise the money to fund local community projects, that help meet the recommendations set out in the profiles. The grants will be disbursed by an external organisation with oversight from Public Health. Outcomes and monitoring data will be reported back to the steering groups from the organisations receiving the grant funding. Any funding not spent in the 2023-24 financial year may be carried over into 2024-25.

16. In the case of Phase 1, Abingdon Caldecott and The Leys, which are the areas most advanced, we have taken two different approaches to the disbursement of grants.

17. **Abingdon Caldecott** – Community First Oxfordshire (CFO) are holding the grant funds and are working closely with members of the community profile steering group to co-produce the grant scheme. CFO will provide support to applicants, undertake governance checks, and will then present eligible

applications to a group of selected members of the steering group who will form a panel to decide on the grant awards. CFO completed the community insight aspect of the profile in this area and so are well placed to understand how proposed projects may help meet the recommendations identified.

18. **The Leys (Blackbird Leys and Northfield Brook)** – Oxford Hub completed the community insight aspect of the profile in this area and were already planning a second round of Participatory Grant Making (PGM) with some funding they had received another organisation. This provided a good opportunity for us to explore a different approach to the more traditional grant making processes. An exciting aspect of the PGM approach is that the decision-making panel is formed from local residents. This means that the community are enabled to make decisions about how funding should be used in their own area rather than council officers.

19. **Barton, Banbury Neithrop and Ruscote, Banbury Grimsbury and Rose Hill -** We are currently in the planning stages for how the grant scheme will work for the Phase 2 profiles. However, it is likely that a selection of members of the steering group will be part of each of the grant award assessment panels. More details are in the table below. The relevant district or city council that has been supporting with project management will lead on disbursing the grants.

Next Steps

20. We are progressing work for Phase 3 to complete profiles for all 10 of the areas which will include Littlemore and an area in the city centre covering parts of Osney St Thomas and Hinksey park. These are expected to be completed by 31st December 2023.

21. We are scoping out a Phase 4 of community profiles which take the learning from the above work but moves us beyond the 10 wards themselves to other geographical areas where health inequalities exist, including some more rural areas.

Community Health Development Officers

22. For longer term sustainability of this in-depth community work, we have been working with the city and district councils to fund a Community Health Development Officer (CHDO) programme to cover the 10 areas. Where a profile has already been produced, they will be supporting the delivery of the recommendations identified and, in the areas, where the profile is yet to be completed they are supporting with community engagement in the creation of the profile, and will then support the recommendations to be delivered once completed. All areas now have a postholder in place except Abingdon Caldecott which we anticipate will be recruited to later this year.

Corporate Policies and Priorities

23. The creation of community profiles links to the strategic priorities in the Oxfordshire County Council Corporate Plan of tackling inequalities in Oxfordshire and prioritising the health and wellbeing of residents.

Financial Implications

24. The funding for these four profiles (5 areas) in Phase 2 came from within the Public Health grant (Wider Determinants cost centre) in the 2022-23 financial year as a one-off cost. Details are shown within the table below.

£5,000 per area for community insight x 5 areas	TOTAL £25,000
£5,000 per area for project management x 5 areas	TOTAL £25,000
£25,000 per area for community grants x 5 areas	TOTAL £125,000
Overall Budget for Phase 2 profiles	**TOTAL £175,000**

Comments checked by: Stephen Rowles
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Legal Implications

25. There are no legal implications associated with this report.

Equality & Inclusion Implications

26. These profiles seek to help to address inequalities by providing insight into communities experiencing inequality, to help inform service planning and to act as evidence for funding applications for activities in those areas.

Sustainability Implications

27. There are no sustainability implications to note with this report.

Ansaf Azhar
Director of Public Health and Community Safety
Oxfordshire County Council

Annex 1: Barton Community Profile
Barton Community Profile Summary of findings:
Barton_CommunityProfile_Summary.pdf (oxfordshire.gov.uk)

Barton Community Insight Report:
Barton_CommunityProfile_Insight.pdf (oxfordshire.gov.uk)

Data for Barton:
Barton_CommunityProfile_Data.pdf (oxfordshire.gov.uk)

Annex 2: Banbury Grimsbury Community Profile
Grimsbury Community Profile Summary of findings:
BanburyGrimsburyandHightown_CommunityProfile_Summary.pdf (oxfordshire.gov.uk)

Banbury Grimsbury Community Insight Report:
BanburyGrimsburyandHightown_CommunityProfile_Insight.pdf (oxfordshire.gov.uk)

Data for Banbury Grimsbury:
BanburyGrimsburyandHightown_CommunityProfile_Data.pdf (oxfordshire.gov.uk)

Annex 3: Banbury Ruscote and Neithrop Community Profile
Banbury Ruscote and Neithrop Community Profile Summary of findings:
BanburyNeithropRuscote_CommunityProfile_Summary.pdf (oxfordshire.gov.uk)

Banbury Ruscote and Neithrop Community Insight Report:
BanburyRuscoteandNeithrop_CommunityProfile_Insight.pdf (oxfordshire.gov.uk)

Data for Banbury Ruscote and Neithrop:
BanburyGrimsburyandHightown_CommunityProfile_Data.pdf (oxfordshire.gov.uk)

Annex 4: Rose Hill Community Profile
Rose Hill Community Profile Summary of findings:
RoseHill_CommunityProfile_Summary.pdf (oxfordshire.gov.uk)

Rose Hill Community Insight Report:
RoseHill_CommunityProfile_Insight.pdf (oxfordshire.gov.uk)

Data for Rose Hill:
RoseHill_CommunityProfile_Data.pdf (oxfordshire.gov.uk)

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June 2023

Divisions Affected - Banbury Calthorpe, Bicester Town, Didcot West, Kidlington South, Rose Hill and Littlemore, Witney South and Central and the wider areas of Banbury, Bicester, Didcot, Oxford and Witney

Oxfordshire Health and Wellbeing Board

29th June 2023

Pharmaceutical Needs Assessment Update

Report by David Munday. Deputy Director of Public Health

RECOMMENDATIONS

The Health and Wellbeing Board is RECOMMENDED to

a) Note the intention of Lloyds Pharmacy Ltd to withdraw all 237 Lloyds pharmacies inside Sainsbury's stores nationwide in 2023, affecting 6 pharmacies in Oxfordshire.

b) Issue a Supplementary Statement, further to the Oxfordshire Pharmaceutical Needs Assessment 2022, that records the **closure of the Lloyds Pharmacy in Sainsbury's store, Heyford Hill, Littlemore**, Oxford on 22 April 2023.

c) Issue a Supplementary Statement, further to the Oxfordshire Pharmaceutical Needs Assessment 2022, that records the **consolidation of the Lloyds Pharmacy in Sainsbury's store, Bure Place, Bicester, with Lloyds Pharmacy, Old Barn Coker Close, Bicester** and the closure of the Lloyds Pharmacy in Sainsbury's on 10th June 2023.

d) Issue a Supplementary Statement, further to the Oxfordshire Pharmaceutical Needs Assessment 2022, that records the **consolidation of the Lloyds Pharmacy in Sainsbury's store, Witan Way Witney, with Lloyds Pharmacy, Windrush Health Centre, Welch Way, Witney** and the closure of the Lloyds Pharmacy in Sainsbury's on 13th June 2023.

e) Note that the further three closures of Lloyds Pharmacies in Sainsbury's stores in Banbury, Kidlington and Didcot do not require a Supplementary Statement.

Introduction

1. The Pharmaceutical Needs Assessment (PNA) assesses the number of pharmacies and access for residents (measured by distance to travel). It does not assess quality or convenience issues.

2. The criteria for general access used in the PNA is for all parts of the urban population to be within 20 minutes' walk or 20 minutes' public transport time of a pharmacy and all parts of the rural population to be within 20 minutes' drive-time or a five mile radius of a pharmacy.

3. The PNA informs the commissioning of essential, enhanced and advanced services from community pharmacies by NHS England and the Integrated Care Board, and the commissioning of services from pharmacies by the Public Health department of the local authority and by other local commissioners.

4. NHS England and the Integrated Care Board exercise the responsibility for using PNAs as the basis for determining 'market-entry' to the local pharmaceutical list.

5. The current Oxfordshire PNA was produced by a partnership-based PNA Steering Group[1] and was approved by the Health and Well Being Board in March 2022. It was published in April 2022 on Oxfordshire Insight at Pharmaceutical Needs Assessment | Oxfordshire Insight

6. If a significant change takes place in the provision of pharmaceutical services, following the publication of a PNA, this can be noted by the issuing of a 'Supplementary Statement'.

7. Supplementary Statements are factual in nature and do not include comments on the changes which have taken place. However, a Supplementary Statement on a closure can be taken to imply that a gap in the provision of community pharmaceutical services may occur due to the change. A Supplementary Statement on a consolidation can be taken to imply that no gap in the provision of community pharmaceutical services has been identified due to the change.

Background

8. In January 2023, Lloyds Pharmacy Ltd announced the withdrawal of all 237 pharmacies inside Sainsbury's stores in 2023[2].

9. This change affects 6 pharmacies in Oxfordshire, at Sainsbury's stores in Littlemore (Oxford), Bicester (Cherwell), Witney (West Oxfordshire), Banbury (Cherwell), Kidlington (Cherwell) and Didcot (South Oxfordshire).

Supplementary Statements further to the Oxfordshire PNA

10. In early 2023, the Oxfordshire PNA steering group reformed and assessed the areas affected by these changes, including the presence of other pharmacies using the 20 minute travel time rule. It concluded that three of the six closures in Oxfordshire require a Supplementary Statement to the PNA: Littlemore, Bicester and Witney.

11. **Supplementary Statement on the closure of the Lloyds Pharmacy in Sainsbury's store, Heyford Hill, Littlemore, Oxford.**

- The PNA Steering Group agreed that the closure of this pharmacy may result in a reduce access to pharmaceutical services for local residents
- There are alternative pharmacies in neighbouring areas which met the criteria for general access as laid out in the PNA 2022 including a pharmacy in Kennington. However, car ownership is lower than average in

[1] The Oxfordshire PNA Steering group includes representatives from NHS England, Oxfordshire County Council, Pharmacy Thames Valley and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

[2] LloydsPharmacy to close Sainsbury's pharmacies with up to 2,500 job losses - The Pharmacist

the area and the geography of the area (including the major roads and the river) means that public transport and walking connections to alternative pharmacies are limited.

- The number of prescriptions issued at the Heyford Hill pharmacy (2,000 prescriptions per week) was relatively low volume, but the area is known to experience poorer health outcomes which may be compounded by this change.
- Closure took effect on 22nd April 2023.

12. **Supplementary Statement on the consolidation of the Lloyds Pharmacy in Sainsbury's store, Bure Place, Bicester, with Lloyds Pharmacy, Old Barn Coker Close, Bicester.**

- The PNA Steering Group agreed that general access to pharmacies in Bicester after the consolidation would be at a satisfactory level (within 20 minutes walk or public transport time). The second Lloyds pharmacy (which will remain) is close to the GP health centre. Residents will still have a good choice of alternative pharmacies in Bicester.
- The application for this consolidation was granted at the Integrated Care Board Pharmaceutical Services Regulations Committee meeting held 29th March 2023.
- The closure of the Lloyds Pharmacy in Sainsbury's store Bure Place Bicester took effect on 10th June 2023.

13. **Supplementary Statement on the consolidation of the Lloyds Pharmacy in Sainsbury's store, Witan Way Witney, with Lloyds Pharmacy, Windrush Health Centre, Welch Way, Witney.**

- The PNA Steering Group agreed that general access to pharmacies in Witney after the consolidation would be at a satisfactory level.
- Lloyds intends to sell the consolidated business (the regulations allow this to take place during or after the consolidation) to another party who already runs other pharmacies in Oxfordshire. The remaining pharmacy is near to the health centre and community hospital which is an appropriate location.
- The application for this consolidation was granted at the Integrated Care Board Pharmaceutical Services Regulations Committee meeting held 26th April 2023.
- The closure of the Lloyds Pharmacy in Sainsbury's Witan Way Witney took effect on 13th June 2023.

Changes to pharmacy provision where a Supplementary Statement is not required.

14. There are three closures of Lloyds Pharmacies in Sainsbury's stores where a Supplementary Statement is not required: Banbury, Kidlington and Didcot. In each of these cases the closure is considered to leave good or satisfactory pharmacy cover in the local area.

15. **Banbury:** Lloyds Pharmacy in Sainsbury's Oxford Road Banbury is due to close on 3rd August 2023.

- The PNA Steering Group agreed that general access to pharmacies in Banbury after the closure would be at a good level. Peak Pharmacy in South Bar Street is relatively close and has a car park. Housing developments to the south of Banbury however could increase the workload of this pharmacy and the Steering Group may have to give this further consideration in the future.

16. **Kidlington:** Lloyds Pharmacy in Sainsbury's Oxford Road Kidlington closed on 1st June 2023.

    - The PNA Steering Group agreed that general access to pharmacies in Kidlington after the closure would be at a satisfactory level with two other pharmacies in the local area and a further pharmacy in nearby Yarnton.

17. **Didcot:** Lloyds Pharmacy in Sainsbury's Central Drive, Didcot closed on 31st May 2023.

    - There was general agreement in the PNA Steering Group that general access to pharmacies in Didcot would be at a satisfactory level after the closure, and after the new pharmacy had opened in the north of the town.
    - The closure would leave one pharmacy in the centre of Didcot (Boots), but there were pharmacies in the south east of the town (Tesco), in the south west (Lloyds, Woodlands Medical Centre), and one in the expanding area to the west. A further pharmacy would open in the north of Didcot later in 2023 and this would also be able to serve the new estate being built nearby at Ladygrove.
    - The PNA 2022 had noted that further discussions might be required about the service needs of the western and southern expansion of the town in the future, but this issue was not directly relevant to the question of provision in the centre of Didcot.

Corporate Policies and Priorities

18. The recommendations are intended to promote the health and well-being of residents of the county and the issue of health inequalities have been borne in mind.

Financial Implications

19. There are no financial implications for Oxfordshire County Council arising from this paper.

Legal Implications

20. There are no legal implications for Oxfordshire County Council arising from this paper. In issuing the Supplementary Statements the NHS's regulatory framework for pharmaceutical services is being adhered to. This framework is overseen by the ICB and NHS England.

Staff Implications

21. There are no staff implications for Oxfordshire County Council arising from this paper.

Equality & Inclusion Implications

22. Perspectives of health inequalities and of social deprivation have been taken into account in the formulation of these recommendations.

Sustainability Implications

23. There are no implications for climate-related issues arising from this paper.

Risk Management

24. There are no elevated risks associated with this paper. The Council is required to fulfil its public health responsibilities in facilitating PNA processes and providing analysis of the health needs of the population.

Consultations

25. The Oxfordshire PNA 2022 was published after a full public and professional consultation. The results of this have been taken into consideration.

NAME

David Munday, Deputy Director of Public Health, Oxfordshire County Council

Annex:	Three Supplementary Statements included as an annex to this report.
Other Documents:	The Oxfordshire Pharmaceutical Needs Assessment 2022 is available on the Oxfordshire Insight webpages: https://insight.oxfordshire.gov.uk/cms/PNA
Contact Officer:	David Munday, Deputy Director of Public Health, david.munday@oxfordshire.gov.uk.

June 2023

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County Hall
1 New Road
Oxford
OX1 2ND

Supplementary statement to Oxfordshire Health & Well-being Board's Pharmaceutical Needs Assessment

Pharmaceutical needs assessment published April 2022

Supplementary statement issued 29th June 2023

The following pharmacy has now closed:

Lloyds Pharmacy in Sainsbury's store, Heyford Hill, Littlemore, Oxford OX4 4XR

With effect from 22nd April 2023.

Supplementary statement issued by:

David Munday
Deputy Director of Public Health.
29.06.23

County Hall
1 New Road
Oxford
OX1 2ND

Supplementary statement to Oxfordshire Health & Well-being Board's Pharmaceutical Needs Assessment

Pharmaceutical needs assessment published April 2022

Supplementary statement issued 29th June 2023

The following pharmacies have now consolidated, with the second named pharmacy providing ongoing services:

Lloyds Pharmacy in Sainsbury's store, Bure Place, Bicester OX26 6FA

Lloyds Pharmacy, Old Barn Coker Close, Bicester OX26 6AE

With effect from: 10th June 2023.

Supplementary statement issued by:

David Munday
Deputy Director of Public Health.
29.06.23.

County Hall
1 New Road
Oxford
OX1 2ND

Supplementary statement to Oxfordshire Health & Well-being Board's Pharmaceutical Needs Assessment

Pharmaceutical needs assessment published April 2022

Supplementary statement issued 29th June 2023

The following pharmacies have now consolidated, with the second named pharmacy providing ongoing services:

Lloyds Pharmacy in Sainsbury's store, Witan Way Witney, OX28 4FF

Lloyds Pharmacy, Windrush Health Centre, Welch Way, Witney OX28 6JS

With effect from: 13th June 2023.

Supplementary statement issued by:

David Munday
Deputy Director of Public Health.
29.06.23.

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Healthwatch Oxfordshire- report to Health and Wellbeing Board. June 2023.

Healthwatch Oxfordshire's Annual Impact Report

Our **Annual Impact Report** for the year 2022-23 will be published at the end of June 2023, along with an online presentation event open to the public on **July 4th 2-3 pm. https://healthwatchoxfordshire.co.uk/event/healthwatch-oxfordshire-a-celebration-of-our-work-over-the-past-year/** The report will be available online on the 4th July. Members of the Health and Wellbeing Board have been invited.

Healthwatch Oxfordshire reports to external bodies

Since the last Health and Wellbeing Board meeting in March 2023 we published our reports to the Health Improvement Board (Feb and June 2023) Oxfordshire Health and Wellbeing Board (March 2023) and Oxfordshire Joint Health Overview Scrutiny Board (HOSC in February and April 2023) and Oxfordshire Place Quality Committee. External bodies that we attend and these reports can be found online at: https://healthwatchoxfordshire.co.uk/our-reports/reports-to-other-bodies/ . We also attend Oxfordshire Place Based Committee (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board).

Healthwatch Oxfordshire reports to date

https://healthwatchoxfordshire.co.uk/reports Since the last meeting in March we have published the following reports:

- Healthwatch Oxfordshire outreach at Oxford University Hospitals 2022-3 (March 2023)
- Healthwatch Oxfordshire community outreach visits 2022-3 (April 2023)
- **Long COVID** (May 2023)
- **What you told us about hospitals** April 2022- May 2023 summary of online feedback

We also produced:

- A '**mystery shopper**' report on access to NHS dentistry in Oxfordshire https://healthwatchoxfordshire.co.uk/news/accessing-nhs-dentists-in-oxfordshire/ a spot check to assess NHS dentists accepting adult and child patients during one week in April. Presented at HOSC in April.
- **Three podcasts** have been released following work with **Oxfordshire Youth** to hear young people's views on health and care https://healthwatchoxfordshire.co.uk/our-work/our-podcasts/.

We published three **Enter and View** reports on visits to different services:

- Renal Dialysis Unit, Churchill Hospital (March 2023)
- Oxford Children's Hospital (April 2023)
- Accident and Emergency at John Radcliffe (April 2023)
- Langford View Care Centre Bicester (May 2023)

https://healthwatchoxfordshire.co.uk/our-work/enter-and-view/

Our support for **Patient Participation Groups** and Primary Care Networks, funded by Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB), continues. We attended 6 PPG/PCN meetings and events Jan-Mar. We held two patient webinars including one at the end of March focusing on '*How is your health and care changing*?' with presentation by Dan Leveson, Oxfordshire Place Based Director for BOB ICB and attended by 42 people. On 26th May we heard about the work of South Central Ambulance Service. Webinar recordings available https://healthwatchoxfordshire.co.uk/ppgs/patient-webinars/

Our work in numbers January - March 2023 (Q4)

Between January and March 2023 we:

→ Heard from or engaged with **3,606** people
→ Gave advice and information about local services to **92** people
→ Received **66** reviews for **35** services via our Feedback Centre
→ Had **3,013** people actively engage with our social media channels
→ Reported on **3** Enter and View visits where we heard from **43** people
→ Engaged with **15** voluntary or community groups reaching **76** people

Social media reach We have active social media presence, and links to local community groups and networks.

- Facebook – **17,393** reach
- Twitter – **9,784** impressions
- LinkedIn –**67** page views, **1614** impressions
- Instagram – **1,098** reach

Total social media followers – **3,013**

Our priorities for 2023-24

Healthwatch Oxfordshire published its priorities and work plan for 2023-24 https://healthwatchoxfordshire.co.uk/about-us/our-priorities/. These were developed from a number of sources, including what we hear from the public via face to face, feedback, and an online priorities survey in December 2022 - January 2023 (253 responses. See here for summary https://healthwatchoxfordshire.co.uk/wp-content/uploads/2023/03/Priorities-survey-summary.pdf), as well as review of health and social care policy developments, and reflections from our research projects.

Our priorities for 2023-24, to help us achieve our goals and strategy statement, are to:

1. Continue to raise with commissioners and individual providers issues regarding access to all services.
2. Challenge commissioners to involve patients and communities in the review, development and delivery of all services with a focus on NHS dentistry, GP services, Adult and Children's Continuing Care services, adult and child mental health services.
3. Design and deliver a project on rural isolation focusing on digitally excluded individuals/communities alongside a third sector organisation/s.
4. Explore with seldom heard communities how Healthwatch Oxfordshire can increase its profile within these communities and identify main concerns about accessing and experiences of health and care services.

Outreach activity January – March 2023:

'On the streets' outreach to listen to the public took place at Thame Market outreach with Rycote Patient Participation Group, Wallingford Health Fair, Carterton Warm Spaces and out on the street, Barton Health and Wellbeing Network café, Better Together Event for SEND (hosted by Oxfordshire Parent Carers' Forum). We attended Oxford Community Champions events, and supported learning about how to comment and complain about health and care, and other health service information. We were at the Nuffield Orthopaedic Hospital as part of our regular hospital visits and spoke to 112 people. In all we heard from or contacted 257 people at these events.

Healthwatch Oxfordshire linked into this and supported its #30 Chats in 30 Days campaign by having 30 conversations with working men in Carterton. During January we completed this outreach and spoke to a further 18 men in Carterton and published the report on this in February, with a total of 32 men engaged, now available on our website. https://healthwatchoxfordshire.co.uk/summarised-reports/men-in-carterton-summary-report/ The report was shared with Oxfordshire Men's Health Partnership.

Key issues we are hearing from the public:

We continue to hear about NHS dentistry, GP waiting times and access, and SEND.

Signposting January to end March 2023

During this period **92 people** contacted us to tell us their experience of using services and to give their feedback. People contacted us about a range of services including NHS dentistry, GP services, mental health services and physiotherapy.

The **top three issues** people contacted us about were dental services, GPs and hospitals.

27 people got in touch to give us feedback on **dental services -** 26 people wanted help to **find** an **NHS dentist.**

GP services - 24 people contacted us to give us feedback on GP services, 10 of these needed help in registering with a GP. We signposted people to BOB ICB.

Healthwatch Oxfordshire KPIs 2022-23 – Quarter 4 January to end March 2023

A more detailed report on impact and outcomes for Quarter 4 Jan- March 2023 can be seen in our reports presented at our public open forum in May https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/

- We closed one survey on Long COVID during this period. (The report is now on our website, published May 2023). We published four reports during this period Q4: Leaving Hospital with Medicines, Men in Carterton, Outreach activity report 2022-23 and Hospital Stands Outreach report 2022-23.
- January - March 2023 we engaged with 15 voluntary / community groups reaching 76 people. We have exceeded the target number of voluntary groups engaged.
- We carried out eleven Enter and View visits during the year and published three Enter and View visit reports in Q4. Eight reports have been published over the year and the remaining three reports will be published in Q1 of the next year (Ap-Jun 2023).
- We were slightly below our online feedback on services target for the year. Previous years' feedback had been higher due to COVID-19 vaccination reviews.

Appendix: Reports published in Q4 Jan-March 2023.

Where reports contain recommendations, we will follow up progress with commissioner or service provider at six and twelve months. Note: reports below do not include Enter and View reports.

Report	Recommendations	Response to recommendations	Impact/ outcomes
Leaving Hospital With Medicine January 2023	• Review communication and promotion of the Medicines Helpline • Seek patient input into the written communication and instructions for patients about medicines taken home • Review and improve discharge process within hospital • Review and ensure patients have clear communication about follow up prescriptions and	Oxford University Hospitals NHS Trust (OUH) responded to each recommendation in turn. Responses can be seen in the report on https://healthwatchoxfordshire.co.uk/our-work/research-reports/	Found very few patients aware of Medicines Helpline- commitment by OUH to promote better and to make messaging more patient focused

	where to turn once left hospital		
Men in Carterton – March 2023	No recommendations but key insights into barriers faced by men in accessing support, and language used to communicate	Shared with Men's Health Partnership and service commissioners	Planned focused activity in development in partnership for 2023-4 with Men's Health Partnership for coming year
Outreach at Oxford University Hospitals (OUHT) 2022-3 – March 2023	Themes: Parking, waiting times, interpreting services, waiting times, excellent care by clinical staff	Presented at Oxfordshire Place Based partnership, and used in OUHT to inform and understand patient views	Spoke to 354 people about their views on health and care services during four visits to OUHT Hospitals, and fed back to provider.
Healthwatch Oxfordshire community outreach visits 2022-3	Themes: Access to GP, access to NHS dentistry, Rural and social isolation, access to mental health services, earwax removal, digital exclusion.	Shared with health and social care commissioners	Spoke to 663 people during outreach visits across the county, and fed back to health and care commissioners.

Update on current work (June 2023)

- We will be supporting the Health and Wellbeing Board in hearing from the public to feed into the refreshed Health and Wellbeing Strategy over the coming months.

- We were successful in our application to Health Education England/ NHS England South East to act as host to support two community researchers from Oxford Community Action, taking part in the Community Participatory Action Research programme phase 2 across the South East region. Researchers will be developing projects over the coming year focused on impact of cost of living.

Health & Wellbeing Performance Framework: 2022/23
Quarter 4 Performance report

A good start in life

Measure	Target	Update	Q1 21/22		Q2 21/22		Q3 21/22		Q4 21/22		Q1 22/23		Q2 22/23		Q3 22/23		Q4 22/23		Notes
			No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	
1.1a Reduce the number of children who are cared for who are not unaccompanied young people to 750	750	Q4 2022/23									**801**	**R**	**817**	**R**	**805**	**R**	777	A	Figures continue to fall from high point in mid summer last year
1.2 Maintain the number of children who are the subject of a child protection plan	550	Q4 2022/23	510	A	548	R	530	A	559	R	558	A	**637**	**R**	**648**	**R**	560	A	Figure rose by 1 in the year. Rate similar to that of statistical neighbours. Figure over 200 less than the highpoint of June 2019 (769).
1.3.1 Mean waiting days for CAMHS	tbc	Jul 22 2022/23	106		132		110		86		114		124						Mean waiting time is 16% up on same time last year. Figures not updated since July because of the cyber-attack on the trust.
1.3.2 Median waiting days for CAMHS	tbc	Jul 22 2022/23	99		97		106		48		89		70						Median waiting time is 20% down on same time last year. Figures not updated since July because of the cyber-attack on the trust.
1.5 Reduce the number of hospital admissions as a result of self-harm (15-19 year) to the national average (rate: 617 actual admissions 260 or fewer)	260	Q4 2022/23	85	R	146	R	202	A	280	A	43	G	68	G	119	G	154	G	
1.12 Reduce the level of smoking in pregnancy	6.5%	Q3 2022/23	6.9%	G	6.9%	G	5.7%	G	5.8%	G	7.0%	A	7.0%	A	5.7%	G	6.7%	G	The Local Stop Smoking Service has supported pregnant women to quit and a new maternity Tobacco Dependency Service funded by ICB/NHSE is launching early in 2023 to support pregnant women to quit. The FNP incentivised quit scheme also continues.
1.13 Increase the levels of Measles, Mumps and Rubella immunisations dose 1	95%	Q3 2022/23	93.1%	A	93.7%	A	92.6%	A	93.6%	A	93.7%	A	95.3%	G	93.6%	A	92.7%	A	The NHSE Improving Immunisation Uptake (IIU) initiative supports GP practices to improved uptake. SE pre-school campaign, NHS contacts parents of pre school children to encourage vaccination.
1.14 Increase the levels of Measles, Mumps and Rubella immunisations dose 2	95%	Q3 2022/23	92.5%	A	92.4%	A	91.6%	A	91.9%	A	91.6%	A	96.4%	G	89.5%	A	91.5%	A	The NHSE Improving Immunisation Uptake (IIU) initiative continues to provide support to GP practices; ensuring improved uptake and reducing variation in uptake between practices.
1.15 Reduce the levels of children overweight (including obese) in reception class (NCMP data) – Annual. Note definition of indicator changed in Q1 22/23	7%	2021/22	6.7%	A	6.7%	A	6.7%	A	6.7%	A	19.9%	G	19.9%	G	19.9%	G	19.9%	G	Small increase in reception overweight and obesity since pre- pandemic levels in 2018/2019. Work continuing to address this through whole systems approach & specific programmes such as You Move and the child healthy weight service, Gloji Energy.
1.16 Reduce the levels of children overweight (including obese) in Year 6 (NCMP data) - Annual. . Note definition of indicator changed in Q1 22/23	16%	2021/22	16.2%	A	16.2%	A	16.2%	A	16.2%	A	33.4%	G	33.4%	G	33.4%	G	33.4%	G	Significant increase in Y6 overweight & obesity levels since (pre-pandemic. Work continuing to address this through the whole systems approach & specific programmes such as You Move and the child healthy weight service, Gloji Energy.
Increase the number of early help assessments to 2000 in 2020/21	5000	Q4 2022/23	801	G	1352	G	2188	G	2938	G	**865**	**R**	**1629**	**R**	2640	A	3559	A	Target reset to rise to 5000 per year. Figure excludes 289 completed as part of the Health visitor pilot
1.18 Monitor the number of children missing from home	Monitor only	Q4 2022/23	260		513		741		982		264		525		756		1007		3% increase compared to last year; 36% increase compared to 2 years ago; 50% decrease compared to 3 years ago
1.19 Monitor the number of Domestic incidents involving children reported to the police.	Monitor only	Q4 2022/23	1782		3577		5166		6742		1834		3660		5363		7006		5% increase compared to last year; 1% increase compared to 2 years ago; 10% increase compared to 3 years ago

Living well

	Target	Update	Q1 21/22		Q2 21/22		Q3 21/22		Q4 22/23		Q1 22/23		Q2 22/23		Q3 22/23		Q4 22/23		Notes
			No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	
2.2 Proportion of all providers described as outstanding or good by CQC remains above the national average	86%	Q4 2022/23	94%	G	93%	G	95%	G	95%	G	95%	G	95%	G	91%	G	92%	G	Routine inspection on hold, inspecting only where a concern is raised. National average 86%
2.11 Increase the number of people with learning disability having annual health checks in primary care to 75% of all registered patients by March 2020	75%	Q4 2022/23	8%		20%		39%		71%	G	9%		20%		44%		82%	G	Performance improvement on last year and on target
2.12 The number of people with severe mental illness in employment	18%	Q1 2022/23	20%	G	21%	G	22%	G	22%	G	22%	G							975/4340. Latest figures June. Figures not updated since June because of the cyber-attack on the trust.
2.13 Number of new permanent care home admissions for people aged 18-64	< 31	Q4 2022/23	6	G	10	G	20	G	33	G	10	A	18	G	25	A	33	A	33 people admitted in the year - above (worse than) target, but still top quartile nationally
2.14 The number of people with learning disabilities and/or autism admitted to specialist in-patient beds by March 2022	10	Q4 2022/23	5	G	10	A	10	A	8	G	7	G	8	G	7	G	5	G	
2.16 Reduce the Percentage of the population aged 16+ who are inactive (less than 30 mins / week moderate intensity activity)	18.6%	Nov-21	**21.3%**	R	**22.4%**	R	**22.4%**	R	**21.0%**	R	21%	A	21%	A	21%	A	19%	G	Inactivity levels worsened in Covid.New projects e.g. Move Together (July 2021) & You Move (June 2022) should improve performance. Local physical activity framework, Oxfordshire on the Move launched Apr 2023.
2.17 Increase the number of smoking quitters per 100,000 smokers in the adult population	> 1146 per 100,000*	Q3 2022/23			**678**	R	1042	A	1306	G	1384	G	1154	G	1242	G	1246	G	Oxon Local Stop Smoking Service targeting priority groups via workplace & and pop-up events. It is single point of access referral route. System wide work with Tobacco Control Alliance to support the Oxon to become Smoke Free through initiatives such as SF side-lines, parks, school gates and signposts smokers to the LSSS. 23/24 priorities social housing p& debt management providers.
2.18 Increase the level of flu immunisation for at risk groups under 65 years	85%	Sep 22-Feb 23	**58.9%**	R	**58.9%**	R	**58.9%**	R	**60.4%**	R	**60.4%**	R	**60.4%**	R	60.4%		**56.5%**	R	Improvement on 17/18 baseline, but below 21/22 (mirroring regional data). Public may be less sensitised to the need for vaccinations compared to height of COVID. NHS England Thames Valley Public Health Commissioning Teams are completing a review of the 22/23 flu vaccination programme with a view to maximising uptake and reducing inequalities in 23/24.
2.19 % of the eligible population aged 40-74 years invited for an NHS Health Check	70%	Q4 2022/23	67.0%		69.6%		69.6%		72.6%		62.6%	A	63.5%	A	68.4%	A	72.4%	G	66/67 GP Practices inviting patients to attend their NHS Health Check. Q4 2022/23 saw the highest number of invitations in Q4 since before the pandemic.
2.20 % of the eligible population aged 40-74 years receiving a NHS Health Check	42%	Q4 2022/23	31.7%		32.6%		32.6%		33.5%		32.7%	A	28.3%	A	**30.2%**	R	**32.8%**	R	GP Practices actively invite eligible patients; a countywide marketing campaign. Newly commissioned supplementary NHS Health Check Services Implementation Phase between October - December 2022 & delivery from 1st February 2023. Oxon service continues to benchmark higher than regional and national averages
2.21 Increase the level of Cervical Screening (Percentage of the eligible population women aged 25-49) screened in the last 3.5)	80%	Q3 2022/23	**65.9%**	R	**67.1%**	R	**67.6%**	R	**67.1%**	R	**66.5%**	R	**66.5%**	R	**67.0%**	R	**64.7%**	R	Below England (68.6%) & South (70.2%). Lower coverage in LSOAs with a higher percentage non-white population. NHSE Screening team working with BOB ICS to improve uptake, for younger, non-white women. This includes ensuring ceasing records are up to date and accurate in line with the National ceasing audit.
2.21 Increase the level of cervical Screening (Percentage of the eligible population women aged 25-64) screened in the last 5.5 years	80%	Q3 2022/23	**75.7%**	R	**75.3%**	R	**75.4%**	R	**75.3%**	R	**75.0%**	R	**75.0%**	R	**75.3%**	R	**74.7%**	R	Comparable to England (74.8%) and the SE (75%). NHSE SIT developing multi-agency plan to address inequalities across screening programmes which include a combination of programme level initiatives & targeted approach in some areas.

Aging Well

Measure	Target	Update	Q1 21/22		Q2 21/22		Q3 21/22		Q4 22/23		Q1 22/23		Q2 22/23		Q3 22/23		Q4 22/23		Notes
			No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	
3.4 Increase the proportion of discharges (following emergency admissions) which occur at the weekend	>18.8%	Q4 2022/23	20%	G	20%	G	20%	G	20%	G	20%	G	21%	G	21%	G	20%	G	
3.5 Ensure the proportion of people who use social care services who feel safe remains above the national average	> 69.9%	Feb 2023	72%	G	72%	G	72%	G	73.7	G	73.7	G	73.7	G	73.7	G	72.6	G	Data from Feb 23 survey. Slight drop but still above the national average
3.6 Maintain the number of home care hours purchased per week	21,779	Q4 2022/23	26,333	G	25,643	G	25,128	G	24,509	G	25,395	G	25,786	G	26,808	G	29,668	G	21% increase in year
3.7 Reduce the rate of Emergency Admissions (65+) per 100,000 of the 65+ population	24,550 or fewer	Q4 2022/23	21,822	G	22,949	G	22,061	G	20,798	G	22,476	G	23,673	G	23,183	G	23,998	G	
3.8 90th percentile of length of stay for emergency admissions (65+)	18 or below	Q4 2022/23	13	G	14	G	14	G	15	G	16	G	18	G	15	G	16	G	
3.19 (New measure): unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population	720	Q4 2022/23	**769.6**	**R**	**745**	**R**	**749.5**	**R**	**732.0**	**R**	740	A	689	G	745	A	699	G	
3.21 (New measure) % of people discharged to their normal place of residence	93.0%	Q4 2022/23	**91.0%**	**R**	**90.9%**	**R**	**90.6%**	**R**	**90.6%**	**R**	**90.5%**	**R**	**90.8%**	**R**	**90.6%**	**R**	**90.5%**	**R**	Actions in place to improve allocation to discharge pathways; diversion from home with care to home with no care; and from short term bed to home with care within a Home First ethos and practice.
3.12 Reduce unnecessary care home admissions such that the number of older people placed in a care home each week (BCF measure)	8.8	Q4 2022/23	9.4	G	8.1	G	9	G	9.2	G	8.6	G	8.2	G	8.2	G	9.2	A	481 admissions. Although target missed eprformance remains in top quintile nationally
3.13 Increase the % of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (BCF measure)	84%	Oct - Dec 2022	**62**	**R**	**62**	**R**	**62**	**R**	82	G	82	G	82	G	82	G	85	G	Targeted amended in line with BCF. Improvement in the year
3.14 Increase the Proportion of older people (65+) who are discharged from hospital who receive reablement / rehabilitation services	3.3% or more	Oct - Dec 2022	2.85%	A	2.85%	A	2.85%	A	2.20%	A	2.20%	A	2.20%	A	2.20%	A	2.28%	A	Small improvement in year.
3.15 Increase the estimated diagnosis rate for people with dementia	67.8%	Feb 2023	**63.0%**	**R**	**63.0%**	**R**	**61.0%**	**R**	**60.9%**	**R**	**61.0%**	**R**	**61.7%**	**R**	**62.0%**	**R**	**61.2%**	**R**	Below target, but above BoB and SE average
3.16 Maintain the level of flu immunisations for the over 65s	86%	Sep 22 - Feb 23	84.4%	G	84.4%	G	84.4%	G	86.4%	G	86.4%	G	86.4%	G	86.4%	G	**84.9%**	**R**	Improvement on 17/18 baseline, but below 21/22 (mirroring regional data). Public may be less sensitised to the need for vaccinations compared to height of COVID. NHS England Thames Valley Public Health Commissioning Teams are completing a review of the 22/23 flu vaccination programme with a view to maximising uptake and reducing inequalities in 23/24.
3.17 Increase the percentage of those sent bowel screening packs who will complete and return them (aged 60-74 years)	60% (Acceptable 52%)	Q2 2022/23	70.3%	G	70.3%	G	70.9%	G	71.7	G	69.0%	G	68.3%	G	68.3%	G	68.6%	G	The programme is meeting the achievable standard for uptake. Age-extension for the bowel screening programme is taking place, with age-extension to 54 year olds in 2023.
3.18 increase the level of Breast screening - Percentage of eligible population (women aged 50-70) screened in the last three years (coverage)	80% (Acceptable 70%)	Q2 2022/23	**55.4%**	**R**	**55.4%**	**R**	76.9%	R	**66.6%**	**R**	**69.6%**	**R**	71.5%	G	71.5%	G	**68.6%**	**R**	Programme impacted by pandemic. Local performance above SE (63.8%) & England (56.7%). NHS England Thames Valley Screening & Immunisation Team working with partners to address known inequalities across programmes. NHS England South East regional teams are working collaboratively to develop a breast screening workforce plan.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Oxfordshire Place-base Partnership: Update June 2023

1.0 Introduction

In March 2023 Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Partnership (BOB ICP[1]) published its Integrated Care System Strategy. It is aligned with local Health and Wellbeing Strategies and sets the direction for integrated care over the next 5 years.

There is also an expectation in national policy that systems will work through sub-system geographies called 'Places' and deliver services through Provider Collaboratives.

These Places will lead and deliver much of the operational detail to make integration a reality through Place-based Partnerships. The integration white paper (February 2022) and the statutory guidance on arrangements for delegation and joint exercise for statutory functions aim to accelerate the development of Place.

This paper is a brief update about Oxfordshire's place-based partnership (PBP). It provides an update on some of our achievements and an indication of our priorities.

2.0 Oxfordshire Place-based Partnership

Oxfordshire's PBP is building on a firm foundation and history of collaboration. Oxfordshire County Council (OCC) and the former CCG (now the ICB) has had a Section 75 agreement in place since 2013. It consists of two pooled budgets Live Well and Age Well (Better Care Fund) which totals almost £400m. In 2021 the then CCG and OCC developed the health, education and social care (HESC) to improve joint commissioning arrangements.

Furthermore, Oxford Health NHS FT (OHFT) has extensive experience leading collaboratives for adult mental health (with voluntary sector partners) and was one of the first wave specialist mental health collaboratives. More recently it has formed a local collaborative with Oxford University Hospitals Foundation Trust (OUHFT) at place and an ICS mental health collaborative with Berkshire Healthcare Foundation Trust (BHFT).

The PBP is a consultative forum representative of our health and care system. It offers a unique opportunity for executive leaders from health, local authorities and communities to come together, accelerate integration and find new ways to use our collective resources and improve outcomes for the residents we serve. It can make choices about how to leverage resources and prioritise actions and interventions that reduce health inequalities and increase our investment in prevention.

Since the previous update the membership of the place-based partnership has changed. Veronica Barry has replaced Rosalind Pearce as Chief Executive (CEO) of Healthwatch. Caroline Green has replaced Mark Stone to represent City and District Councils. Dr Toby Quartley has replaced Dr Mark Gray to represent General Practice (GPs) in the North of the county. Details of the membership can be found in appendix 1.

The partnership has met monthly since December. We initially focussed on our relationships and ways of working needed to be a thriving partnership working within a complex system. This will be measured over-time by a partnership maturity matrix (appendix 2).

[1] Group of organisations which plan and provide health and care services for nearly two million people who live and work in the local authority areas of Buckinghamshire, Oxfordshire and Berkshire West.

More recently the agenda has focussed on priority areas including urgent and emergency care and prevention and reducing health inequalities. We reviewed and supported new Section 75 agreement between OCC and ICB and have overseen the development of the Better Care Fund. In June we are focussing on the development of the ICS mental health collaborative and Oxfordshire's adult mental health model of care.

3.0 Key Achievements

3.1 OCC and ICB Section 75

At the end of March OCC and ICB signalled its ongoing commitment to joint working by renewing the Section 75 agreement which pools approximately £400m of NHS and local authority funds. It underpins the development of joint commissioning, the better care fund and how we deliver more joined up care for adults and older adults.

3.2 Adult Mental Health

In March 2023, the joint commissioning team agreed to award a two-year contract extension for the Oxfordshire Outcomes-based mental health contract. This is a pioneering collaboration between OCC, ICB, Oxford Health NHS FT (OHFT) and voluntary sector partners.

Stakeholders from across the system are participating in a system leadership programme (delivered in collaboration with NHS England and Health Education England) to develop skills and behaviours needed to work in a complex system. Under the leadership of OHFT, supported by the joint commissioning team, we aim develop a sustainable model of care for mental health. The programme will develop within the context of the emerging ICS Mental Health Collaborative. It will involve people that access mental health services and partners from across Oxfordshire to develop new, high value services.

3.3 Urgent and Emergency Care

Oxfordshire opened two Urgent Care Centres (UCC). The first, run by Principle Medical Limited at the Horton General Hospital (HGH) opened in February 2022. The second opened on the John Radcliffe site in February 2023 and is run by Oxford City Primary Care Network (PCN). Both UCCs receive on-the-day referrals from Primary Care and redirections from Emergency Departments.

In December 2022 Oxfordshire established a Transfer of Care Hub (TOC). This is a local coordinating centre linking all relevant services across health and social care to aid discharge and recovery and admission avoidance. It has increased the number of people returning to their own home and reduced the number of days people spent away from their places of residence.

Primary care in Oxford City and Bicester have led the development of 2 neighbourhood teams. These are multi-disciplinary teams to support people with complex needs that need continuity of care. They reduce on the day demand for GP practices and reduce the number of frail people attending emergency departments.

South Central Ambulance Services (SCAS) and OHFT's Urgent Community Response (UCR) service have worked together to deliver a 'call before you convey' pathway for people following a fall. It has increased the number of people being treated in their homes and reduced hospital conveyances by 12%.

Oxfordshire's Hospital at Home teams care for approximately 100 people a day in virtual wards in people's own homes. This is a safe and effective alternative to NHS inpatient care and prevents avoidable admissions as well as supporting early discharges.

3.4 Prevention and Health Inequalities

Active Oxfordshire in partnership with Districts, Public Health and multiple sectors (VCS, leisure, education and business) coordinate Move Together and You Move. These are projects aimed at supporting people across the county to be more active.

You Move targets families and children living in deprived areas or classed as 'otherwise vulnerable' (e.g. refugees, children in/on edge of care system) to access low cost and free activities. In its first year over 6,000 people have signed up. Move Together focusses on people with long-term conditions (including mental health) or at high risk of falls and supports them to move more. In total over 1,700 people were referred which is double the number compared to the previous year. A snapshot of the impact of this programme is in appendix 3.

4.0 Next Steps

4.1 Health and Wellbeing Strategy

Key stakeholders are working alongside Public Health to update the joint strategic needs assessment by July 2023. Concurrently, Oxfordshire's Health and Wellbeing strategy is being renewed with an aim to have a final version in December 2023. This will be a central document that sets out priorities to improve the emotional and physical wellbeing for the people of Oxfordshire set within the context of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Strategy (agreed by the Integrated Care Partnership in April 2023).

4.2 Better Care Fund

The Age Well team of HESC have led the development of Oxfordshire Better Care Fund (BCF). The aim is for Oxfordshire Health and Wellbeing Board to support the proposal for submission to NHS England in July 2023. The two-year plan has been developed with stakeholders from across health and social care including NHS providers, independent care providers and voluntary sector. Crucially, it includes our plans for meeting the health and care needs over winter.

4.3 Children and Young People

Partners involved in health and social care are focussed on improving outcomes for 0 to 5-year-olds (school readiness), families affected by special education needs and disability and child and adolescent mental health (including children transitioning to adult mental health services). HESC is supporting place to map the different parts of our system and identify opportunities to integrate services for people and populations that will benefit from more joined-up care.

4.4 Urgent and Emergency Care

Under the Urgent Care Board, chaired by Oxford University Hospitals NHS FT, we will continue to find ways of supporting people to stay well in their communities, avoid unnecessary ED attendances and hospital admissions and increase the time people spend at home.

The programme will focus on the following key areas in preparation for winter:

- Developing our 24/7 urgent primary care offer to deliver seamless same day care for people (without complex needs) via UCCs and out of hours care.
- Spreading neighbourhood teams across Primary Care Networks with access to a range of health and social care expertise to support people with complex needs, people over-75 and frail and people at the end of life.
- Improve the support for children and adults that require urgent mental health support on the same day.
- Build on the success of the Transfer of Care Hub and increase the number of people we support in their own homes.

4.5 Prevention and Health Inequalities

Place Director for Oxfordshire and Director of Public Health are working together to reinvigorate the Health Inequalities Forum. This will be a key part of place governance to oversee the development and delivery of system-wide plans to reduce health inequalities and increase our efforts in prevention. It is broadly focussed on the following areas:

- Healthy Behaviours (e.g. smoking, activity, diet and alcohol).
- Working with Communities (including VCS and city/districts).
- Health protection (e.g. vaccination, immunisation, blood pressure monitoring etc.)
- Anchor Institutes and major employers.

Initially the group has supported the proposed investment of ICB inequalities funding in the following areas:

- Homelessness (approx. £30k) to jointly fund a post to identify opportunities to join-up efforts countywide. This may expand to support the delivery of step-up/step-down services for the remainder of FY2324.
- Well Together – a programme coordinated by OCVA[2] and CFO to support grassroots organisations in the 10 most deprived wards in Oxfordshire. The programme will support activities that designed in communities to improve emotional and physical wellbeing of the population. It will also support clinical themes to reduce health inequalities and PCNs. By the end of FY2425 we intend to have invested £1m in grassroots organisations in the most deprived wards in Oxfordshire.
- Move Together is a programme coordinated by Active Oxfordshire. It is a joint programme with Public Health, Local Authorities (city and district councils) and the ICB. It supports people living in with long-term conditions and from inclusion groups to increase activity in a sustainable way. The ICB will contribute £500k over the next 2 years for this programme alongside Public Health and City and District Councils.
- Furthermore, the HI Forum will investment in thorough monitoring and evaluation of our efforts in prevention and reducing health inequalities.

5.0 Conclusion

'The whole is greater than the sum of its parts' (Aristotle).

Oxfordshire Place-based Partnership has made a good start. The PBP aims to be a thriving partnership, delivering high value care by working beyond organisational boundaries to make the best use of the collective resources we have in the system. The so-called 'soft' skills of building relationships built on trust and transparency are key to our success.

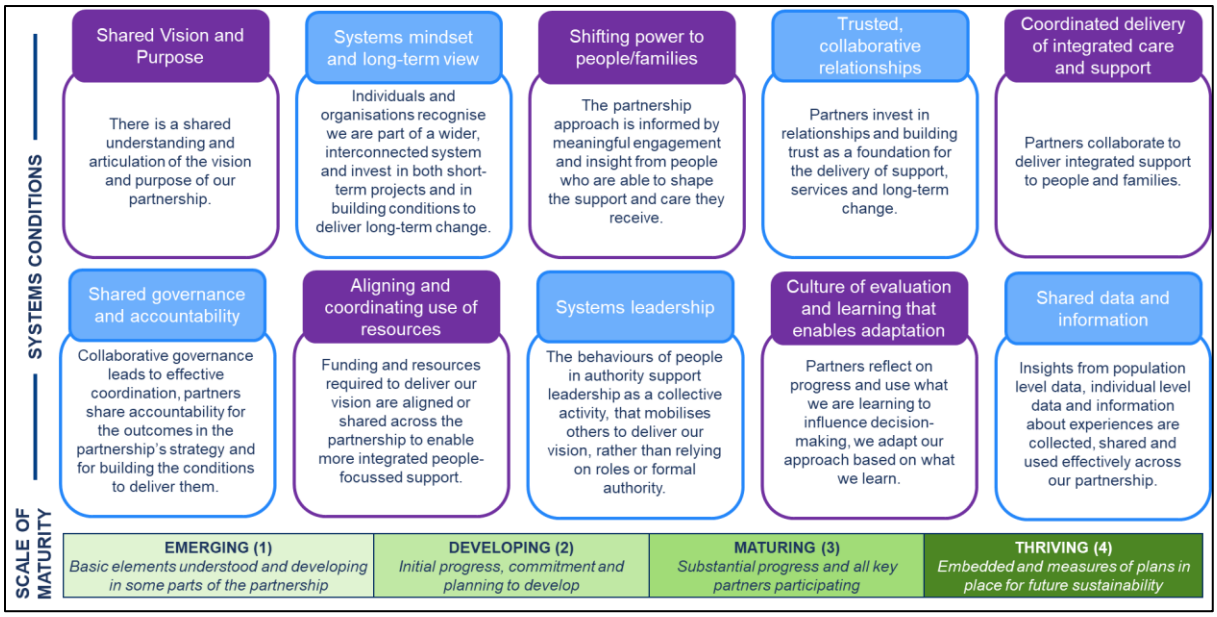
[2] Oxfordshire Voluntary Care Alliance and Community First Oxfordshire

We are committed to finding ways of investing more in prevention, addressing the building blocks of health (jobs, housing, social activity, education) and reducing health inequalities in Oxfordshire. The legacy system we are emerging from encouraged competition and in some instances increased fragmentation. We have an opportunity to collaborate and create seamless services and improve outcomes and experiences for people in Oxfordshire.

Appendix 1

Name	Job Title	Organisation
Daniel Leveson	Place Director	BOB ICB
Stephen Chandler	Executive Director	Oxfordshire County Council
Caroline Green	Chief Executive	Rep for City and District Councils
Dr Nick Broughton	Chief Executive	Oxford Health NHS FT
Professor Meghana Pandit	Chief Executive	Oxford University Hospitals NHS FT
Ansaf Azhar	Director of Public Health	Oxfordshire County Council
Veronica Barry	Executive Director	Healthwatch
Laura Price	Chief Executive	Oxfordshire Community & Voluntary Action
Dr Toby Quartley	GP Lead	North PCNs
Dr Michelle Brennan	GP Lead	South PCNs
Dr Joe McManners	GP Lead	City PCNs

Appendix 2



Appendix 3

Daniel Leveson
Oxfordshire Place Director
June 2023

Divisions Affected - All

HEALTH AND WELLBEING BOARD

29th June 2023

CHAIR'S REPORT OF THE HEALTH IMPROVEMENT PARTNERSHIP BOARD 15th June 2023

Report by David Munday, Deputy Director of Public Health, Oxfordshire County Council

RECOMMENDATION

1. The Health and Wellbeing Board are asked to note the content of the most recent Health Improvement Partnership Board meeting on the 15th June 2023 and the Board's contribution to the implementation of Oxfordshire's Joint Health and Wellbeing Strategy.

Background

2. The Health Improvement Partnership Board (HIB) has identified 3 priority thematic areas to focus on;
   (a) Tobacco Control
   (b) Mental Wellbeing
   (c) Healthy Weight and Physical Activity

3. Action on these priority areas is supported by an approach which is focused at addressing health inequalities and taking a preventative approach in all we do.

4. The most recent meeting of the HIB was on 15th June 2023. The Board received updates on Domestic Abuse (DA), Make Every Contact Count (MECC), and Social Prescribing. A summary is provided below and full reports are available at: https://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=899&MId=7298&Ver=4

Key Reports

5. **Domestic Abuse-** The update focused on the overarching DA strategy for Oxfordshire and the specific Safer Accommodation strategy that sits within it. Information was received on how the Lived Experienced Advisory Group function and feeds its valuable insight into how services are shaped and delivered. The LEAG group is small and would welcome new members to diversify it. The Board was pleased to learn that both female and male victims

of DA are supported and the process for assuring the quality of commissioned services is rigorous.

6. **Make Every Contact Count**- The HIB welcomed the local mapping of MECC activity to date and the formative implementation plan. It was noted that the OUH has embedded this approach within the "Here for Health" service and all member organisations were asked to consider what further opportunities there are within their services and teams to expand the work further, including within commissioned services. The MECC partnership for Oxfordshire is in the process of inviting funding bids from partnership members for small grants to support the rollout of MECC. The value of monitoring and evaluation was also agreed to be key, while acknowledging that it is difficult to quantify.

7. **Social Prescribing-** Partners from the Integrated Care Board presented an overview of how social prescribing is organised and funded in Oxfordshire, the types of issues that are supported and the number/ demographics of residents being referred. Funding for the link workers that underpin social prescribing ends next year. It is expected to be renewed but its effectiveness needs to be evaluated using data from the local programme. It was noted that more needed to be done to ensure social prescribing is accessed from those from more socioeconomically disadvantaged communities and those from some minority ethnic groups. The plan for development was noted and the Board was keen to understand more in future regarding high impact users, and uptake of services people are signed-posted to or that are prescribed.

8. **Healthwatch-** The quarterly update from Healthwatch was received from Robert Majilton Healthwatch Ambassador. The specific reports in this update were on visits to OUH hospital and long COVID. The 4th July annual impact report launch event was also noted and HIB members invited to attend.

Future meetings and Chair of HIB

9. As planned, the board undertook a workshop in March 2023 to develop a forward plan of agenda items for the 2023/24 year that address the priorities of the board and the Oxfordshire Health and Wellbeing Startegy. The HIB will continue to focus on the priority areas listed in paragraph 2 and has specific work programmes or initatives under each which will be a focused on at forthcoming meetings.

10. The Chair of HIB for the next 2 year cycle has been agreed to be Cllr Helen Pighills from Vale of White Horse Council. There has not been any changes to City or District representatives as a result of elections in May 2023, but Cllr O'Connor is now the County Council Cllr representative as the new portfolio holder for Public Health and Equalities. The HIB recorded its thanks to Cllr Lygo who had previously held this role and was a strong champion of so much of the Board's work.

11. The next meeting of the HIB will take place in September 2023

DAVID MUNDAY
DEPUTY DIRECTOR FOR PUBLIC HEALTH

Contact Officer: David Munday
Deputy Director of Public Health/Public Health Consultant
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June 2023

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OXFORDSHIRE HEALTH AND WELLBEING BOARD
29th JUNE 2023

Children's Trust Board Report

Report by Stephen Chandler/Anne Coyle

RECOMMENDATION

The Health and Wellbeing Board are asked to note the report.

Executive Summary

The Children's Trust ensures that the Health and Wellbeing Board are sighted on the key challenges facing children and young people in Oxfordshire. This report provides updates from the Children's Trust Board including details of performance issues rated red or amber in the performance report.

Main Report

1. Children & Young People's Plan 2023/2024 and Early Help update from partners

It was agreed at the last Children's Trust Board meeting in February that early help should be the overarching theme for the 2023/2024 Children & Young People's Plan and that partners would take a more inclusive approach developing the plan. The Strategic Transformation Leads across the partnership were involved to review early help priorities and agree key priorities and metrics to enable us to measure progress. Children's Trust members will attend a workshop on 14th June to agree the Children & Young People's Plan (CYPP), identify and commit to actions that are needed across the partnership to deliver on the plan, over the next 12 months. The Board will also discuss how to effectively communicate the plan through the partnership and with the public.

Presentation slides (Paper 1 available upon request)

Following the workshop, all partners will incorporate actions and measures into their business plan, work plans, projects, and programmes of work. Updates will be provided at the September meeting and future meetings by all partners, on how actions have been incorporated into their workplans and the progress made.

Early Help 'Ask' responses from partners

Partners were asked to provide feedback on the form in advance, and then to discuss further at the meeting on the progress being made within their organisations, and any challenges they are faced with, on their early help plans for 2023/2024.

Focus on Early Help 'Ask' Form (Paper 2 available upon request)

Early Help Data Update

The Early Help Strengths & Needs (S&Ns) Assessments is improving as the numbers increased from approximately 500 in 2016-2017 to 4000 in 2022 and figures also show that there is greater engagement with the process. However, there is a concern that the younger age group are less likely to get S&Ns assessments, although the learning from the Health Visitor pilot will be helpful and how we move forward with this. For those children and young people who are on a social care plan, a child in need or a child protection plan, more work needs to be done on ensuring consistency in having that S&Ns assessment, earlier.

Early Help Data to March 2023 (Paper 3 available upon request)

It was recommended that partner agencies should consider individual targets for number of early help assessments to undertake in 2023/2024.

Review of CYPP Outcomes for 2022/2023

The 2022/2023 plan has been updated and was provided to the Board for any comments, before its publication.

Children and Young People's Plan Year 5 Progress Plan 2022-23 (oxfordshire.gov.uk)

2. SEND (Special Educational Needs & Disabilities) Update

The paper provides 3 areas of updates, firstly on the SEND Employment Forum grant that has been established and is exploring how it can strengthen our model to plan meaningful outcomes and measure impact.

Secondly, Oxfordshire has been successful in securing an Early Intervention fund of £3.3m. Therefore, a strategic group has been established to focus on 3 broad workstreams of which updates will be provided to partners on a monthly basis.

The last area is the Education Health Care Needs Assessments (EHCNAs), where there continues to be an increase in demand each month. There is continued focus by Health and Social Care colleagues to carry out the EHCNAs within the 20-week statutory timeframe and data provided monthly improvements. However, the challenge is keeping this improved timeliness performance with the high demand and limited staff capacity across services.

SEND Update (Paper 4 available upon request)

3. Partnership Protocol

Based on the existing partnership protocol introduced in 2016 and following the learning from Operation Bullfinch and the Child Safeguarding Practice Review

concerning Jacob, this led to a request of a review of the Safeguarding and Community Safety system in 2022. The report is to be shared with the safeguarding boards, the Safer Oxfordshire Partnership, the Community Safety Partnerships and the Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care Partnership (ICP), for their support to implement some or all the recommendations.

Safeguarding & Community Safety Report & Presentation (Paper 5a & 5b available upon request)

It was agreed that The Children's Trust Board would be kept informed of how the protocol develops and to be engaged in those arrangements.

4. Feedback from OSCB on emerging issues

The Safeguarding Practice Review on child sexual abuse will be published in May and will also be available on the Oxfordshire Safeguarding Children's Board (OSCB). There is joint working to commence monthly from June, with colleagues of the Adults Safeguarding Board, to improve communication and prevent duplication of work. There is continued focus on safeguarding concerns and issues around Elective Home Education, permanent exclusions, in particular vulnerable children, children with an attendance plan and Children Missing Education (CME).
An Interim Board Manager is in post, until a permanent position will be in place from August.

OSCB Update (Paper 6 available upon request)

5. <u>Forward plan for the September 2023 meeting</u>

The following items are due to be considered in forthcoming meetings:

- Agreed 2023/24 Children and Young People's Plan by partners
- Focus and progress on Early Help - partner responses and feedback
- Progress of Early Help Board
- SEND update.

Paper prepared by Indra Gill and request documents via email from:
indra.gill@oxfordshire.gov.uk

<u>APPENDIX A</u>

What is being done in areas rated Red or Amber in the Performance Framework

The data and information below are for Performance Report to February 2023.

<u>Be successful</u>

- The number of children expelled continues to be a third of the 18/19 level, but the number of children suspended, which had been dropping is now rising
- 43% of primary school pupils and 22% of secondary school pupils who were suspended last year had special educational needs.
- Persistent absence (over 90%) has risen across the last 4 years – with 1 in 4 primary school children and 1 in 3 secondary school children persistently absent.

- 1.1% of primary school children (596 children) and 4.3% of secondary school children (1733 children) have severe absence.
- The number of electively home educated children is 64% higher than pre pandemic levels but only 8 children who are electively home educated are the subject of a social care plan

Be healthy

- Data on waiting times for CAMHS has not been updated since July 22 because of the cyber-attack on the trust. Concerns about access to eating disorder services have been raised by the ICB. Performance in Oxfordshire below standard and other areas in BOB. Updates on performance has been affected by the cyber-attack on Oxford Health.
- There has been a 16% decrease in A&E attendances for self-harm compared to last year, but figures are still 19% more than 2020 when we were in lockdown. Hospital admissions are 20% lower than the last 2 years.
- The number of early help assessments in the last 12 months is 24% higher than the previous 12 months but remains 19% below target. 88% of MASH contacts do not have a preceding strength and needs document and 2 out of 3 MASH contacts end up in no further action
- After 4 quarters when under-age conceptions fell it increased in the last two quarters. 14 children under 18 and some under 16 (number supressed under 5) presented at the OUH

Be Safe

- MASH contacts for the first 11 months of the year are 4% higher than last year and more than 60% higher than pre pandemic levels. Despite this increase the timeliness of red (most urgent) contacts remains better than target. Local benchmarking data suggests contact levels are similar to other areas in the southeast.
- Child protection numbers remain above target and those of similar authorities (605 compared to 550 target) but have decreased by 50 in the last quarter. The Child Protection Quality and Tracking Meeting is focusing on children the subject of repeat plans currently stands at 29% against a national average of 23% and children on a plan for over 18 months.
- There are currently 894 cared for children (compared to 413 in 2013). Numbers have dropped in the last 3 months by 20. The growth is driven by unaccompanied young people. Just 9% of initial health assessments have been completed on time and 5 children are in unregistered placements.
- In 2022 domestic incidents involving children were 9% higher than 2019 (pre Covid) and domestic crimes 28% higher. In the last year domestic incidents fell by 1% in the year whilst domestic crimes rose by 7%.
- In 2022 the number of children going missing was 12% lower than 2019(pre Covid) and the number of occurrences was 16% lower. However, compared to last year 9% more children went missing and there were 11% more missing incidents
- At the end of quarter 3, 8 out of 10 taxi drivers across county had up-to-date safeguarding training. City (75%) and South & Vale (73%) are below 90%

Indicator Number	RAG	What is being done to improve performance?
1.3a Mean wait for Core CAMHS (days)	N/A	In July 2022 the number was 124 – 16% higher than July 2021. Figure not updated since cyber-attack.
1.3b Median wait for Core CAMHS (days)	N/A	In July 2022 the number was 70 – 20% lower than July 2021.
1.11 Reduce the persistent absence of children subject to a Child Protection Plan	N/A	As of Term 4 22/23, the figure is 8.5% lower than this time last year.
1.1 Reduce the number of children we care for to 750 by March 2022	A	As of March 2023, the number was 770 - the number of children we care for is beginning to fall. It remains below the national rate, but above similar authorities.

May 2023

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