NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 14 March 2024 at 2.00 pm

Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND

Martin Reeves
Chief Executive

6 March 2024

Contact Officer: ***Democratic Services***
Email: committees.democraticservices@oxfordshire.gov.uk

Membership

Chairman – Councillor Liz Leffman (Leader, Oxfordshire County Council)
Vice Chairman - Sam Hart (Buckinghamshire Oxfordshire Berkshire West ICB)

Board Members:

Councillor Joy Aitman	West Oxfordshire District Council
Ansaf Azhar	Corporate Director of Public Health & Community Safety, Oxfordshire County Council
Councillor Tim Bearder	Cabinet Member for Adult Social Care, Oxfordshire County Council
Michelle Brennan	GP Representative
Stephen Chandler	Executive Director, People, Oxfordshire County Council
Councillor Phil Chapman	Cherwell District Council
Lisa Lyons	Director of Childrens Services
Councillor Maggie Filipova-Rivers	South Oxfordshire District Council
Karen Fuller	Corporate Director of Adult Social Care, Oxfordshire County Council
Caroline Green	Chief Executive, Oxford City Council (District Representative)
Councillor John Howson	Cabinet Member for Children, Education & Young People's Services, Oxfordshire County Council
Dan Leveson	Place Director for Oxfordshire, Buckinghamshire Oxfordshire Berkshire West Integrated Care Board
Councillor Nathan Ley	Cabinet Member for Public Health, Inequalities & Community Safety, Oxfordshire County Council

Grant MacDonald	Interim Chief Executive, Oxford Health NHS Foundation Trust
Professor Sir Jonathan Montgomery	Chair, Oxford University Hospitals NHS Foundation Trust
Don O'Neal	Chair, Healthwatch Oxfordshire
Councillor Helen Pighills	Vale of White Horse District Council
David Radbourne	Regional Director Strategy and Transformation, NHS England
Councillor Louise Upton	Oxford City Council

Notes:

- ***Date of next meeting: 4 July 2024***

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned….."*.

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or email democracy@oxfordshire.gov.uk for a hard copy of the document.

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 below

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 8 March 2024. Requests to speak should be sent to shilpa.manek@oxfordshire.gov.uk

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that 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 Last Meeting (Pages 1 - 12)

To approve the Note of Decisions of the meeting held on 7 December 2023 (**HBW5**) and to receive information arising from them.

6. DPH Annual Report (Pages 13 - 18)

This paper informs the Health & Wellbeing Board on the structure and overview of content, including key messages, of the upcoming Oxfordshire County Council Director of Public Health Annual Report (2023/24) focussed on climate and health.

Directors of Public Health are required to establish an annual report highlighting key public health priorities for their area.

This work is timely and closely aligned with the UK Health Security Agency's first Health Effects of Climate Change report (published December 2023), the Lancet Countdown on health and climate change report (published December 2023) and the British Medical Journal's editorial on treating the climate and nature crisis as one indivisible global health emergency, co-signed by 200 major health journals (published October 2023).

The Board is RECOMMENDED to endorse the:

Call to action for system partners to ensure that every health action, policy and strategy should mitigate for and prevent negative health impacts of our changing climate, and similarly every climate action, policy and strategy should identify the impacts and maximise the benefit for our health and wellbeing.

7. Health and Wellbeing Strategy Outcomes Framework & Delivery Plan (Pages 19 - 48)

Organisations across the Health and Wellbeing Board (HWB) have developed a new Oxfordshire Health and Wellbeing Strategy for (2024-2030). This requires an Outcomes Framework to ensure the strategy moves into delivery and makes a positive difference to the health and wellbeing of local residents.

The task and finish group has continued to work together since the strategy itself was finalised in December 2023 to develop this Outcomes Framework. Initially the group undertook a comprehensive review of current strategies and performance measures across relevant organisations, ensuring a nuanced understanding of the existing landscape. After that several shared outcomes and indicators were agreed upon to support delivery of specific elements of each of the 10 priorities. Subject matter experts in each priority area have been drawn into the task and finish group to support this work.

The Outcomes Framework is structured as follows for each of the 10 priorities;

- 3-5 Shared Outcomes- that break-down the priority into specific areas of delivery.
- Outcome Indicators- high level metrics that will be updated annually and determine whether the progress is being made to achieve the desired outcomes or not.
- Supporting Indicators- more specific metrics that will usually be updated more frequently and support achievement of the Outcome Indicator
- Primary Partnership- the existing group(s) that will have oversight of delivery against a specific priority area and update the HWB Board annually on progress.
- Key partnerships that bring partners together to deliver action relevant to the specific priority.
- Key strategies and activity already happening in the specific priority area that will support delivery of the outcomes.

The full Outcomes Framework is available in annex 1 for all 10 of the strategy priorities.

As the strategy has 4 domains- Start Well, Live Well, Age Well and Building Blocks- and the HWB Board has 4 meetings per year, it is proposed that at each board meeting an update on progress against 1 of the domains is presented, thus ensuring progress against all parts of the strategy is reviewed on an annual basis.

The Health and Wellbeing Board is RECOMMENDED to

- *Agree the Health and Wellbeing Strategy Outcomes Framework (Annex 1) which contains the Shared Outcomes under each of the Strategy's priorities as well as the Outcome Indicators and key programmes/ partnerships relevant to each*
- *Agree the reporting arrangements of relevant partnership forums into the Health and Wellbeing Board, with one strategy domain per quarterly meeting, so that over the course of a 1-year period the board reviews progress against the whole strategy*
- *Comment on the draft performance report (Annex 2) as the proposed way of visualising data against specific priorities.*

8. Community Profiles Update (Pages 49 - 58)

To be presented to the Board by Kate Austin, Public Health Principal, Fiona Ruck, Health Improvement Practitioner and

- May Elamin – Community Health Development Officer – Oxford City Council
- Jon Hyslop – Community Glue
- Tom McCulloch – Community First Oxfordshire
- Tony Eaude – Littlemore Resident
- Alexa Bailey - Community Health Development Officer – Oxford City Council

The Oxfordshire Health and Wellbeing Board is RECOMMENDED to

1.1 Note the findings and rich insight contained within the Community Profiles for Littlemore and Central Oxford.

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.

9. Place based Research Collaboration in Oxfordshire (Pages 59 - 62)

The report would be presented to the Board by Adam Briggs, Deputy Director of Public Health.

This paper summarises why research is crucial to the work of local government to improve health and tackle inequalities in Oxfordshire. The paper asks for to HWB comment on the development of a place-based approach to research across the county.

The Health and Wellbeing Board is RECOMMENDED:

To DISCUSS and COMMENT on the development of a place-based approach to

research across Oxfordshire, including how to best involve and work with HWB members and to support the delivery of the Health and Wellbeing Strategy.

10. Primary Care Strategy (Pages 63 - 138)

The report will be presented by Louise Smith, Deputy Director Primary Care BOB ICB.

The BOB ICB draft Primary Care Strategy is presented to the Oxfordshire Health & Wellbeing Board as part of the ICB's commitment to ensuring the contribution and engagement of system partners and the public in the development of its Primary Care Strategy.

The Oxfordshire Health & Wellbeing Board are asked to:

- Note the work undertaken by the ICB and Partners to develop the Primary Care Strategy
- Discuss the content themes and any further points for consideration and/or of concern.

11. Planning for next JSNA & PNA (Pages 139 - 144)

The report will be presented by Steven Bow, Consultant in Public Health.

The Health and Wellbeing Board is RECOMMENDED to

1. Agree to transition the Joint Strategic Needs Assessment (JSNA) publication from 2025 onwards to an interactive digital format.
2. Approve the approach to 2024 JSNA publication to be focused on key thematic areas agreed by the Board.
3. Agree to the establishment of a JSNA steering group made up of partners represented on the Board to take forward the work.
4. Note the requirement to update the Oxfordshire Pharmaceutical Needs Assessment (PNA) by April 2025.
5. Agree to the establishment of a PNA Task and Finish group made up of partners represented on the Board to take forward the work.
6. Agree to the proposed timescale to undertake the work- including public consultation and for approval at the Health and Wellbeing Board in March 2025.

12. Report from Healthwatch Oxfordshire (Pages 145 - 154)

To report on views of health care gathered by Healthwatch Oxfordshire by Dr. Veronica Barry, Executive Director.

13. Reports from Partnership Boards (Pages 155 - 158)

To receive updates from Partnership Boards. Reports from –

- Place-base Partnership (To Follow)
- Health Improvement Board; and
- Children's Trust Board (Verbal Update)

14. **Forward Work Programme** (Pages 159 - 160)

Members to note the items on the Forward Work Programme.

15. AOB

OXFORDSHIRE HEALTH & WELLBEING BOARD

Minutes of the meeting held on Thursday, 7 December 2023 commencing at 2.00 pm and finishing at 4.35 pm

Present:

Board Members:	Councillor Liz Leffman (Chair) Sam Hart (Vice-Chair) Councillor Joy Aitman Ansaf Azhar Stephen Chandler Karen Fuller Caroline Green Dan Leveson Councillor John Howson Councillor Dr Nathan Ley Grant MacDonald Kerrin Masterman Don O'Neal District Councillor Helen Pighills Councillor Louise Upton Councillor David Rouane District Councillor Andrew McHugh
Other Members in Attendance:	Councillor Kate Gregory
Other Persons in Attendance:	Veronica Barry (Healthwatch Oxfordshire), Mish Tullar, David Lunt and Clare Keen,
By Invitation:	
Officers:	

Agenda Item	**Officer Attending**
Item 6	Lily O'Connor
Item 7	Imogen Coningsby
Item 7	Tamanna Rahimi
Item 7	Jamie Slagel
Item 8	Anne Lankester
Item 9	Laura Gajdus
Item 9	Senay Nidai
Item 11	Steven Bow

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 (Email: committees.democraticservices@oxfordshire.gov.uk)

	ACTION
44 Welcome by Chair (Agenda No. 1)	
The Chair welcomed attendees to the meeting and in particular Councillor Dr Nathan Ley, who was attending his first meeting as Cabinet Member for Public Health, Inequalities and Community Safety.	
45 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
Apologies were received from Councillor Tim Bearder (Oxfordshire County Council), Councillor Maggie Filipova-Rivers (South Oxfordshire District Council) and Councillor David Rouane was substituting and Councillor Phil Chapman (Cherwell District Council) and Councillor Andrew McHugh was substituting.	
46 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest received.	
47 Petitions and Public Address (Agenda No. 4)	
There were no petitions or requests for public address received.	
48 Note of Decisions of Last Meeting (Agenda No. 5)	
It was agreed that the Note of Decisions of the previous meeting held on 5 October 2023 would be approved. **RESOLVED: that the Board APPROVED the notes of the last meeting held on 5 October 2023 and the Chair be authorised to sign them as a correct record.**	
49 Update on the Oxfordshire Winter Plan and Vaccinations	

(Agenda No. 6)	
The report and tables were introduced by Dan Leveson, Place Director for Oxfordshire, Buckinghamshire Oxfordshire Berkshire West ICB, before he handed over to Lily O'Connor, Programme Director Urgent and Emergency Care for Oxfordshire, to go into the detail. It was reported that the dashboard provided the statistics for the performance overview. Members commented that: • It was great to see the performance against the targets. It would have been good to see them against the national performance. The Committee were informed that the national context would be shown in the next version of the report, there was a comparative but no like for like context. • It was commented that outcomes are better for people have been assessed and cared in their own home than in hospital. According to national work it is a saving of at least £2000 per person. • The definition of 'homes' was clarified as meaning the persons 'own bed' this could be in their own home or in a care home. • It was important to raise that when there was reference to 105 people in inappropriate out of area inpatient beds referred to bed days so that would be maybe four or five people. • Good progress was being made. • A request was that urgent care centres be added to the next version of the dashboard. The Officer commented that data had only been received for two of the three urgent care centres, so data was incomplete hence had not been involved. The dashboard would be developed further going forward. • It was highlighted that the situation was improving and reducing year on year if the middle of winter was compared for primary, secondary, and acute care which was an encouraging place to be. The Team was thanked by the Board. The Corporate Director of Public Health and Community Safety updated the Board on the infections and vaccinations. There was a current increase in respiratory infections and covid cases. In terms of vaccinations, across Oxfordshire, in all age groups, this was above average and doing well regionally. For the over 65s for flu vaccinations, it was over 80% but Oxfordshire was currently lagging for the under 65 age group. Further outreach work needed to be done with groups such as pregnant women, asylum seekers, people with learning difficulties and the elderly, which had been commissioned by the ICB. Oxfordshire was	

above average for 2–3-year-olds. Caroline Green, Chief Executive of Oxford City Council asked if there was variation of uptake in different areas of Oxfordshire and was informed that the under 65's had dropped and that there was a lower uptake in areas of deprivation and within certain communities such as the Pakistani community and the BAME community. It was asked if there was an evaluation on how the vaccine champion schemes were being effective in the areas. It was reported that it was too early to evaluate this, but a significant piece of work was being evaluated on how networking was done in the community. This would give useful insight to use for targeting vaccinations. Councillor Howson suggested targeting the under 65's at the school gates where young mums could be reached. This could be investigated. The Chair thanked all for their updates.	
50 Health and Wellbeing Strategy (Agenda No. 7)	
David Munday, Deputy Director of Public Health, OCC, thanked all Members of the Health and Wellbeing Board (HWB) for their attendance at the workshop and the really helpful engagement and time to steer the task and finish group. The engagement for the Strategy had been really positive. The Board were reminded that the new Health and Wellbeing Strategy had been structured around four areas. The principles of prevention, tackling inequalities and working in closer collaboration. Secondly, there were priorities across the life course, thirdly, there were the fundamental building blocks of health that everyone needed to have in place to lead healthy and happy lives and finally, the three enablers listed that helped to move from the Strategy to delivery. The Strategy had been heavily influenced by the Joint Strategic Needs Assessment (JSNA), this was the assessment of residents needs in Oxfordshire and the early engagement and public consultation in this strategy work. This then connected into the Integrated Care System Strategy and the NHS 5-year forward plan and Primary Care Strategy. This was the Primary Place Strategy for Oxfordshire. The two main reflections had been a real desire and willingness to joined up working to have a new Strategy and good collaboration to improve health and wellbeing locally and a real appetite to move this from a Strategy to delivery and making a difference. The Board was introduced to Imogen Coningsby, Health Improvement Practitioner and Tamanna Rahimi, Paediatric Public Health Fellow.	

Imogen Coningsby reported on the consultation. From mid-October to mid-November, the draft Health and Wellbeing Strategy went out for consultation, parts of the consultation had been informed by the engagement work carried out by Healthwatch and Public Health with over 1000 residents over summer. The aim of the public consultation was to gather further insights from residents and stakeholders on the final draft version of the Strategy to ensure that the voices of the residents and stakeholders were incorporated into the Strategy. The consultation had been conducted through an online survey that had been conducted through an online survey that had been developed and agreed by the Health and Wellbeing Strategy Task and Finish Group. An easy read survey was also carried out with the sector organisations and community groups. A variety of different channels were used to engage respondents including key networks and partnerships, social media, staff communications, E newsletters, councillors, parish councils and other council teams such as housing social care and children's services. In order to capture people that could not access the online survey, Healthwatch hosted a webinar that 68 people attended. The online survey received 435 responses, many of which were from organisations that represented many people. There was high support for the priorities and the enablers in the draft, the three principles in the draft received high support at 93%, overall people thought the Strategy was well written, well structured and easy to read. Tamanna Rahimi added that there were some cross-cutting themes included how the Strategy would be delivered including what kind of workforce would be required to deliver the ambitions, concern around access to health services and respondents felt that by improving access to healthcare was vital to improving health and wellbeing. Mental Health had been through integrating the concerns in every life course section of the Strategy highlighting the building blocks of health on mental health. Residents felt that parental wellbeing, bettering home environment, family relationships and their importance had not been addressed before school readiness and mental resilience in children and young people. This had been reflected in the ambitions. David Munday informed the Board that the next steps after the meeting were to create a final, attractive version that would be published in January 2024 with extensive comms and promotion, including some easy read versions. Then this would move into the delivery and action plan which would be presented to the Board at the March 2024 meeting along with the outcome's framework. The Chair thanked the Officers and the Board Members for all the	

hard work that had gone into producing the Strategy. The Board highlighted the following points: • It was interesting to see the support in the education phase in a child's life and recognise change going forward. • It was good to be involved and to see the immediate actions in the report. It had been noted that many responses had commented on the difficulties in getting GP and dentist appointments and this had been a barrier for residents. • It was a good Strategy, but it was important to see how it was important to see how it would be delivered in such difficult financial times, asking if the activity was necessary. • It was asked if the Strategy and Delivery Plan would be better launched together in March 2024. • It was a good to have a single Place-based approach and direction that everybody had been involved in with so much positive collaboration. • The Board were reminded of the agreed principles of tackling inequalities, prevention of ill health and working in collaboration. • The point was raised that it was mainly women who had responded to the survey and if this needed to be addressed. Approach was an important point and where the consultations were carried out. • There was a link to the Drug Combat Partnership, and this would be included in the delivery plan. **RESOLVED: that the Board noted the content of the public consultation report, approved the content of the full final Strategy as a final version of the Board's Health and Wellbeing Strategy for 2024-2030, supported plans to publicise the Strategy in January 2024 when it was fully launched and noted that Officers would bring a delivery plan and outcomes framework to support Strategy implementation to the March 2024 meeting.**	
51 Adults Safeguarding Annual Report (Agenda No. 8)	
Karen Fuller, Corporate Director of Adult and Housing and Anne Lankester, Head of Adult Safeguarding, presented the report to the Board. The key highlights from the report were presented. Further information was given to the Board on the Multi-Agency Risk management (MARM) process which was designed to support anyone working with an adult where there was a high level of risk and the circumstances sat outside the statutory adult safeguarding framework, but where a MARM process would be	

helpful.

The Leader process was highlighted to the Board. This is a nationally set process to review the deaths of anyone with a learning disability in Oxfordshire. This review is carried out to understand what processes could have supported the individual more and to make improvements for others.

Councillor McHugh requested that the District Councils continued to be included in the professional relationship's reviews. And with respect to learning disability health checks with the GP partners, the statistics did not look impressive at 24% when the target was 75%, could something further be done? There were different and better ways of doing this. David Munday informed the Board that there was an established work stream to improve this and that the figures reported are cumulative over the 23-24 year so by the end of the year (March 24), the annual check uptake would be much higher.

RESOLVED: that the Board noted the contents of the report and its conclusions.

52 Children's Safeguarding Annual Report
(Agenda No. 9)

Laura Gajdus, Business Manager, Oxfordshire Safeguarding Children Board (OSCB) presented the report to the Board. The report in the pack was reporting from April 2022 to March 2023. The Head of Safeguarding and QA for Oxfordshire Childrens Services, Senay Nidai was also in attendance at the meeting. The Business Manager shared a couple of slides with the Board explaining the Vision, the aims and the Safeguarding Partners including the Council, the ICB and Thames Valley Police. The three safeguarding issues that the partnership continue to review were the neglect of children in the family home, minimising the risks to children outside the home and that children were often safer in school. The audit of these issues was very important, and this was carried out by system-wide views on safeguarding work, assessments, audits, views from practitioners, families and children and through the data. The Board were informed about the ongoing training and how successful and useful it was.

Councillor Pighills asked how closely the team worked with the Community Safety Partnership and was informed that they worked closely, they frequently did learn from the domestic homicide reviews in relation to a child and the impact for the child. There was also a subgroup that looked at exploitation but was always looking for new opportunities to connect. The Serious

Incident Notifications were clarified to the Board, and they were carried out. **RESOLVED: that the Board noted the annual report of the Oxfordshire Safeguarding Children Board, senior safeguarding partners and considered the key messages.**	
53 Report from Healthwatch Oxfordshire (Agenda No. 10)	
Don O'Neal, Chair of Healthwatch Oxfordshire, presented the report to the Board. The main point to highlight was that the Community Research in Oxfordshire report had found that communities were tired of research 'on them' and not 'with them' and that this needed to change. From the work carried out, four key principles had been identified, these were that nothing about us, without us, commit to action, value the lived experience and time, and to be open, transparent and accountable. All of the Healthwatch Reports could be found on the website. Veronica Barry, Executive Director of Heathwatch Oxfordshire, informed the Board of the other reports including what people understood by joined up care and patient experience on discharge pathways. Dan Leveson added that the commitment as a system was to invest in the actions that were community driven and built from grassroots communities to make a difference to their health and wellbeing based on the assets from those communities. Ansaf Anwar added that if any Member of the Board was doing any community research, to engage with him so that the research was not repetitive. Councillor Upton added she had attended an event exploring how to be tapping into the Universities research students - an initiative called "policy lab" being developed between OCC and OU- that were looking at making people healthier and happier and it was essential to check with Public Health and Healthwatch to ensure that the same questions were not being asked. The Chair reiterated that people were happy to engage but also wanted feedback. **RESOLVED: that the Board noted the report from Healthwatch Oxfordshire.**	
54 Performance Report (Agenda No. 11)	

Steven Bow, Consultant in Public Health, presented the performance report to the Board. The main points to highlight included:

- Measures 1.13 and 1.14 were showing modest increases in MMR vaccination coverage but were still short of the 95% target.
- Measures 1.15 and 1.16 showed the updated data was now available for data on reducing the levels of children overweight in reception class and Year 6 as per the National Child Measurement Program.
- Measure 2.17 showed that the number of smoker quitters had decreased and was now amber. This indicator was under review as the smoking prevalence had gone up.
- Measure 2.21 and 2.22, increased in the level of cervical screening had increased and was heading in the right direction but was still short of the target and this was similar for breast screening.

Members raised the following points:

- Councillor Upton asked how the estimated diagnosis rate for people with dementia was obtained and was informed that the national model was used which was linked to GP registrations, it was a national estimate which was subject to caveats.
- Councillor Howson raised a point on the two education indicators for children in care which were green, a current concern was that of unaccompanied young asylum seekers, currently there were 100 under the transfer scheme. Councillor Howson thanked the Interim Corporate Director for Childrens Services, Anne Coyle, who would be leaving at the end of 2023.
- Councillor McHugh commented that there were no targets for CAMHS, there was also no data for a year and yet the notes revealed that there had been a cyber-attack in July 2022, Councillor McHugh asked if there was any back up. He was not satisfied that there were no targets and no data for a year, it was not acceptable. The Chair agreed that there was a huge backlog. David Munday commented that this was one of the priorities of the Health and Wellbeing Strategy looking more at early intervention and then the provision. Grant MacDonald, Interim Chief Executive of Oxford Health NHS Foundation Trust, confirmed that there had been a cyber-attack and a whole new system had been put in, external reassurance had been taken and this was being done as quickly as possible, the data was available as this was being completed manually and emergency cases were being seen within 24 hours and urgent cases within a week. It

was the routine care that took months to be seen for an assessment. There was a solid CAMHS service in place. Councillor Howson was concerned that no data was available and was reassured that trend data could be given. Dan Leveson confirmed that the metrics were being looked at as the regulator and commissioner.	
55 Reports from Partnership Boards (Agenda No. 12)	
A) Place Based Dan Leveson presented his report to the Board and stated that this was a consultative forum where leadership from health and social care come to identify priority populations that can be joined up. The biggest success was actually coming together as a leadership team overseeing the work. Over the next couple of years, it was going to be crucial, with the financial pressures to continue to agree to do the right things. As a system, we were really standing out in some areas. B) Health Improvement Board Councillor Pighills presented the report to the Board and commented that the Board had received a presentation on the new Oxonair webpage and its functionality about the air quality of Oxfordshire. The second part of the meeting was on tobacco control, presented in three parts, smoke-free pathways in NHS provider organisations, tobacco control Alliance action plan update and Stop for life targeted community outreach. C) Childrens Trust Board Councillor Howson commented on the recently held workshop that reflected on the impact the Board was having on the outcomes of children and young people and what was working well and what could be improved. There would be revised governance that would be introduced in January 2024. David Munday commented that going forward with the three standing regular updates and moving to the delivery of the Strategy, it was worth looking at mapping across the different actions and the different priorities and what sat within the different subgroups of the Health and Wellbeing Board. It would be good to see reports from the subgroups and how they were contributing to the Strategy delivery.	
56 Forward Work Programme (Agenda No. 13)	

RESOLVED: The Board noted the Forward Work Programme.	
57 AOB (Agenda No. 14)	
None	

..... in the Chair

Date of signing .....

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Oxfordshire Health & Wellbeing Board Briefing Paper

Author: Rosie Rowe

Telephone number: N/A

Email: Rosie.Rowe@oxfordshire.gov.uk

28 February 2024

Director of Public Health Annual Report: Climate and Health

1. Recommendation

1.1 The Board is RECOMMENDED to endorse the:

Call to action for system partners to ensure that every health action, policy and strategy should mitigate for and prevent negative health impacts of our changing climate, and similarly every climate action, policy and strategy should identify the impacts and maximise the benefit for our health and wellbeing.

2. Summary and purpose

2.1 This paper informs the Health & Wellbeing Board on the structure and overview of content, including key messages, of the upcoming Oxfordshire County Council Director of Public Health Annual Report (2023/24) focussed on climate and health.

2.2 Directors of Public Health are required to establish an annual report highlighting key public health priorities for their area.

2.3 This work is timely and closely aligned with the UK Health Security Agency's first Health Effects of Climate Change report (published December 2023), the Lancet Countdown on health and climate change report (published December 2023) and the British Medical Journal's editorial on treating the climate and nature crisis as one indivisible global health emergency, co-signed by 200 major health journals (published October 2023).

3. Background

3.1 Health is the untold story in the climate emergency. This is staggering given the immediate and positive health benefits for individuals, families and communities which can be delivered through climate action. Climate action means better health for everyone – whether we are talking about newborn babies, children, teenagers, working age adults or older people. Amidst mounting pressure in our NHS, tackling

the impacts of the changing climate across Oxfordshire will save lives and money, and conserve resources for those most in need. It will also benefit the building blocks of our health: providing homes which can be heated and cooled affordably, infrastructure for people to walk and cycle to keep communities active, connected, and healthy, and green spaces to boost mental health and store carbon. It will also support delivery of a range of plans that seek to support climate action in Oxfordshire, including Building a Greener Oxford University Hospitals 2022 – 2027, Oxford Health Trust Strategy Sustainability Strategic Objectives 2021 – 2026 , SCAS People Strategy Sustainability Plans 2023-2026, and nationally in Delivering a 'Net Zero' National Health Service – July 2022 and Royal College of GP's Decarbonising General Practice Guide.

3.2 Despite progress to reduce fossil fuel use and polluting greenhouse gas emissions, climate change is happening now in Oxfordshire, posing a real and current threat to health and wellbeing. We are all experiencing the effects of the climate emergency with increased frequency and severity of adverse weather events. Since 2007, there have been 18 severe flood events, 10 named storms, 8 severe cold snaps, 4 major heatwaves and 3 periods of drought. These events are having direct and harmful impacts on our health and wellbeing, and will continue to lead to premature deaths and preventable suffering unless necessary climate action is taken.

3.3 Of real concern, many infectious diseases are sensitive to the climate, and with warmer temperatures we can expect a greater risk of new and emerging infectious diseases on our doorstep. The impact of climate change on individuals will vary, with the worst effects on disadvantaged and more vulnerable populations, and without necessary action this will further widen health inequalities.

4. Content

4.1 This report has been developed and refined by an interdisciplinary steering group, with collaboration between colleagues in public health, the NHS, data intelligence, climate action, transport, emergency planning and food policy. The primary audience of this report are system partners in health, care and local government.

4.2 The report is structured as follows:

Section Title	Main Content
Executive Summary	Executive summary provided by Ansaf Azhar (Director of Public Health)
Introduction	This section sets out the need for this timely report on climate and health. We present that health is the untold story in the climate emergency, and that immediate and positive health benefits can be delivered through climate action. This means better health throughout the life course. We set the context in terms of current NHS pressures and cost-of-living crisis.
Section 1: Why the focus on the impacts of climate change on health now?	This section explains why we all need to take urgent climate action in Oxfordshire to protect and improve our health. We discuss five key areas of the climate emergency and their implications for our health: temperature, air, water, food, and nature. We present a body of current evidence describing the local health impacts of our changing climate across these five areas in Oxfordshire.
Section 2: What are we doing now?	This section explains what Oxfordshire County Council, local anchor institutions, system partners and community action groups are currently doing to address our changing climate – with immediate and longer-term

	positive benefits for health and wellbeing. We will discuss five areas of climate initiatives with positive health benefits including: - Energy efficient healthy homes and buildings - Sustainable travel and clean air - Green health and social care - Healthy and sustainable diets - Accessible green spaces, clean water, and nature
Section 3: Call to Action	This section sets out a call to action on climate and health across Oxfordshire – this includes: system actions, national policy and funding, and individual actions (see below).

5. Call to action

5.1 The final section of the report consists of a call to action which consists of:

5.1.1 System Actions

a. Work together for cleaner indoor and outdoor air by promoting active, sustainable travel and adopting low-carbon energy and supply chains
b. Increase and improve access for all to safe, inclusive green and blue spaces with positive impacts on wildlife, biodiversity and adaptation
c. Adapt and upgrade buildings, estates and facilities to ensure high-quality services can be delivered now and in the future
d. Work with suppliers and the supply chain to reduce carbon emissions, ensure decisions consider carbon impacts, and encourage suppliers to develop more sustainable practices, including maximising social value
e. Ensure partnership working through existing forums and networks to accelerate action on climate mitigation and adaptation, whilst maximising benefits for health and wellbeing, with a particular
f. focus on delivery of system wide action to address the risks of extreme weather eventsBuild and continuously bolster community resilience to meet the needs of our changing climate

5.1.2 National Policy and Funding

a. Reduce air pollution by investing in low-carbon and climate-resilient infrastructure including public transport, renewable energy, and electric vehicle charging
b. Create good, secure employment and reduce inequalities by supporting reskilling, retraining, remote working and research to accelerate the move to a net-zero economy
c. Improve our resident's health and wellbeing by upgrading our homes, healthcare facilities and schools to ensure they are fit for the future
d. Boost our physical and mental health by making it easy for people to walk, cycle, and use active, sustainable transport

e. Improve our mental and physical health, capacity for natural cooling, and air quality by ensuring access for all to green spaces and other green infrastructure

5.1.3 Individual Actions

Last, but not least, there are many practical things that each of us can do, with very little time and effort. Some of these are free, and many save money. Almost all improve our own health and the health of others. These small changes can add up to big action.

Take a look at Climate Action Oxfordshire or Community Action Group Oxfordshire where there are plenty of suggestions to get started.

There are also resources and support available if you are experiencing the effects of climate anxiety, or eco anxiety (often defined as a longer-term fear of environmental doom, and worries about what might happen if we do not take action to avert disaster due to the climate emergency). There is also tailored support available for young people.

6. **Delivery of the DPHAR Recommendations**

The recommendations for system action on climate and health have informed the development of the Health & Wellbeing Board strategy. Climate change is a key priority of the strategy and its recommendations are included in its outcomes framework and delivery plan.

All system partners are asked to consider how they can contribute to delivery of the recommendations.

7. Communications

7.1 The report has been tabled at meetings of the Environment Action Group of the Future Oxfordshire Partnership and Oxfordshire's Health Overview and Scrutiny Committee where its recommendations have been supported.

7.2 The report will be the focus of an All Member's Briefing of the County Council on 18 April and will then go to full Council for adoption on 16 April 2024.

7.3. An engagement plan is being finalised to support awareness of and action to support its recommendations by system partners.

8. Conclusion

8.1 The 2023/24 annual Director of Public Health report is aligned with local, national, and international priorities of addressing both the climate emergency and health. At the recent COP28, over 120 countries backed the Climate and Health Declaration. Endorsed by 123 countries, the Declaration marks a world first in governments

acknowledging the growing health impacts of climate change on communities and countries. It also acknowledges the large benefits to people's health from stronger climate action, including by reducing air pollution and lowering health care costs.

7.2 The 2023/24 annual Director of Public Health report mandates accelerated and stronger action on many of the objectives set out in local 'green' plans. These actions have the potential to improve the health and wellbeing of residents in Oxfordshire immediately, and for future generations.

9. **The Board is RECOMMENDED to endorse the:**

Call to action for system partners to ensure that every health action, policy and strategy should mitigate for and prevent negative health impacts of our changing climate, and similarly every climate action, policy and strategy should identify the impacts and maximise the benefit for our health and wellbeing.

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Divisions Affected - All

Oxfordshire Health and Wellbeing Board

14th March 2024

OXFORDSHIRE'S HEALTH AND WELLBEING STRATEGY OUTCOMES FRAMEWORK AND DELIVERY PLANNING

Report by Ansaf Azhar, Corporate Director of Public Health and Community Safety

RECOMMENDATION

The Health and Wellbeing Board is RECOMMENDED to

- *Agree the Health and Wellbeing Strategy Outcomes Framework (Annex 1) which contains the Shared Outcomes under each of the Strategy's priorities as well as the Outcome Indicators and key programmes/ partnerships relevant to each*
- *Agree the reporting arrangements of relevant partnership forums into the Health and Wellbeing Board, with one strategy domain per quarterly meeting, so that over the course of a 1-year period the board reviews progress against the whole strategy*
- *Comment on the draft performance report (Annex 2) as the proposed way of visualising data against specific priorities.*

1. Executive Summary

1.1. Organisations across the Health and Wellbeing Board (HWB) have developed a new Oxfordshire Health and Wellbeing Strategy for (2024-2030). This requires an Outcomes Framework to ensure the strategy moves into delivery and makes a positive difference to the health and wellbeing of local residents

1.2. The task and finish group has continued to work together since the strategy itself was finalised in December 2023 to develop this Outcomes Framework. Initially the group undertook a comprehensive review of current strategies and performance measures across relevant organisations, ensuring a nuanced understanding of the existing landscape. After that several shared outcomes and indicators were agreed upon to support delivery of specific elements of each of the 10 priorities. Subject matter experts in each priority area have been drawn into the task and finish group to support this work

1.3. The Outcomes Framework is structured as follows for each of the 10 priorities;

- 3-5 Shared Outcomes- that break-down the priority into specific areas of delivery
- Outcome Indicators- high level metrics that will be updated annually and determine whether the progress is being made to achieve the desired outcomes or not
- Supporting Indicators- more specific metrics that will usually be updated more frequently and support achievement of the Outcome Indicator
- Primary Partnership- the existing group(s) that will have oversight of delivery against a specific priority area and update the HWB Board annually on progress
- Key partnerships that bring partners together to deliver action relevant to the specific priority
- Key strategies and activity already happening in the specific priority area that will support delivery of the outcomes

The full Outcomes Framework is available in annex 1 for all 10 of the strategy priorities

1.4 As the strategy has 4 domains- Start Well, Live Well, Age Well and Building Blocks- and the HWB Board has 4 meetings per year, it is proposed that at each board meeting an update on progress against 1 of the domains is presented, thus ensuring progress against all parts of the strategy is reviewed on an annual basis.

2. Background

2.1. **Strategy formulation:** On 6 March 2023, the HWB approved plans to update Oxfordshire's Joint Health and Wellbeing Strategy (JHWS) and form a cross-organisational Task and Finish group to drive progress between meetings. The Task and Finish Group has overseen the publication of the Oxfordshire Joint Strategic Needs Assessment (JSNA) 2023, refined a longlist of priorities through workshop with HWB, completed extensive early engagement work with Oxfordshire residents and used its findings to inform themes for the JHWS, also informed by the ICS Strategy published in March 2023.The draft strategy was reviewed and approved for a full public consultation in October 2023. The findings and recommendations from the consultation and relevant scrutiny committees were incorporated into the final strategy that was approved by the HWB on 8th December. Further details of this process can be found in the report to HWB: 231207_HWB_Item_7_Health_and_Wellbeing_Strategy_Coversheet.pdf (oxfordshire.gov.uk). The strategy was then published and launched on 24th January 2024: New strategy aims to improve health outcomes for all (oxfordshire.gov.uk).

2.2. **Strategy Priorities**: The Health and Wellbeing Strategy offers a strong, unified vision for improved health and wellbeing and will act as the primary *place*

strategy for health and wellbeing in Oxfordshire. It focuses on health and wellbeing in a broad sense, moving beyond a clinical or service-oriented view, towards a community-oriented view. It focuses on the things people need to stay healthy such as stable employment, warm homes, environments that allow healthier living and communities that are well connected and supportive. It also focuses on what we can do jointly across health and social care in Oxfordshire to prevent people being at risk of poor health, from birth to older age, and thereby both improve health and reduce the need for healthcare services. The strategy does not focus on access to healthcare services as this is covered by partner strategies across the ICS.

2.3. **Strategy Structure:** The strategy is structured on the three principles (figure 1) - health inequalities, preventing ill-health, and closer collaboration that will underpin and be the lens through which the strategy will be implemented. There are then 10 priorities in total, the first 6 follow the life course approach to wellbeing, divided into Start Well, Live Well and Age Well and then 4 priorities centred around the building blocks of health: Financial Wellbeing and Healthy Jobs, Climate action and Health, Healthy Homes, and Thriving Communities. Helping to ensure Oxfordshire's health and care system is inclusive, compassionate, data-informed, rooted in communities, and sustainable are key enablers of the strategy; Oxfordshire's digital infrastructure, the health and care system joint workforce, and anchor institutions. For an overview of these components of the strategy see a summary document here: [Health and wellbeing strategy (oxfordshire.gov.uk)]

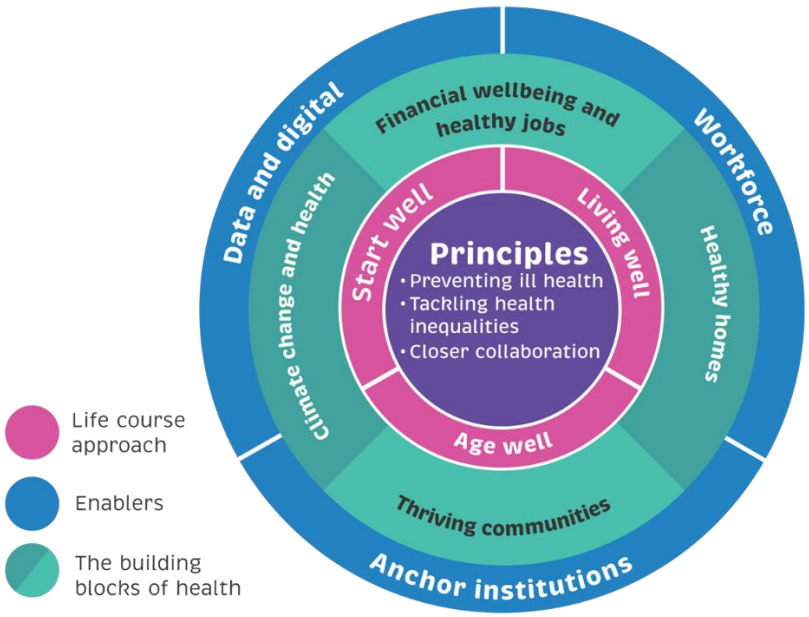

Figure 1. Summary of Health and Wellbeing Strategy 2024-2030

The full strategy can be read here: Health and wellbeing strategy - 2024-2030 (oxfordshire.gov.uk).

3. Outcomes Framework Approach

3.1. An outcomes framework is an integral component of a robust health and well-being strategy, serving as guiding pillars to ensure the efficacy and success of the initiative. By establishing clear outcomes, the outcomes framework defines specific, measurable goals, providing a structured approach to track progress and evaluate impact. This framework enables stakeholders to align their efforts toward common objectives, fostering collaboration and resource optimisation.

3.2. The Oxfordshire Joint Health and Wellbeing Strategy is broader in its scope than ever before, and it is therefore important the primary focus of the framework is on overarching principles of implementation and high-level outcomes that span these diverse domains. This outcomes framework provides a focus on the desired outcomes without prescribing or defining every action that could be undertaken to achieve this. This should ensure flexibility and adaptability, allowing stakeholders to navigate evolving circumstances without constraining the strategy's responsiveness to changing needs, ensuring the strategy remains relevant and effective over time.

3.3. **Principles of a shared outcomes framework:** The outcomes framework has taken into account the following principles

Principles of a shared outcomes framework: Shared outcomes toolkit for integrated care systems - GOV.UK (www.gov.uk)

1. Focused on the population at place level
2. Creates a shared vision and brings organisations together.
3. Supports relationships and cultural change.
4. Minimises burden to organisations within the place.
5. Focused on local outcomes, not organisational processes or outputs.
6. Complements existing responsibilities and regulatory frameworks.
7. Embeds organisational mutual accountability for delivery and progress.

4. Process

4.1. **Overview:** Since the completion of the Health and Wellbeing Strategy in December, the Task and Finish Group has developed a outcomes framework to support implementation of the strategy. This is presented in Annex 1

4.2. **Stakeholder Engagement:** In the development of the Health and Wellbeing Strategy diverse stakeholders, including community members, healthcare professionals, policymakers, and advocacy groups have been consulted to ensure a comprehensive understanding and reflection of the varied perspectives and needs of Oxfordshire. Those voices through the early engagement work and public consultation have continued to be incorporated into the outcomes framework. Further subject matter expertise has been drawn into thematic action groups – Start Well, Live Well, Age Well and Building Blocks - that have driven the development work. This has included representatives from all organisations on the Health and Wellbeing Board.

4.3. **Mapping current strategies**: Early in the process, mapping of current areas of work relating to the priorities of the strategy was undertaken. This process has helped prevent the duplication of efforts, optimise resource allocation, and ensures that the new framework complements, rather than conflicts with, ongoing strategies. Mapping current approaches aims to foster collaboration by acknowledging and integrating successful elements from existing initiatives. It also means any gaps in activity to deliver the ambition in the strategy can be identified and addressed.

4.4. **Logic Model Approach:** A logic model approach was used to provides a systematic and visual representation of the strategy's components, illustrating the logical connections between inputs, activities, outputs, and outcomes. This has helped to articulate the cause-and-effect relationships, making explicit how specific activities contribute to desired outcomes. Additionally, a logic model approach offered a structured foundation for selecting performance indicators, ensuring that outcomes are not only well-defined but also measurable.

4.5. **Development of shared outcomes:** Following the logic model approach an Outcomes Framework for the JHWS has been developed with support of the action groups involved. The shared outcomes within each priority reflect existing county wide outcomes in those areas. Where action groups identified dimensions of strategic priorities that are not currently being addressed, these have been framed as opportunities for potential development over the course of the strategy. It is also important to note that the breadth and scope of the strategy has provided challenges and opportunities; the comprehensive approach to health and wellbeing the strategy takes allows for inclusive and holistic solutions however this can lead to a lack of specificity due to the multitude of interconnected elements. Action groups have attempted to focus on areas of intersection in partners' strategic goals and actions where the HWB could make a significant difference to outcomes or reflect areas of particular policy interest.

4.6. **Monitoring Outcomes:** The outcomes framework aims to describe the key measures needed to evaluate the impact of the action to achieve the shared outcomes and encourages shared accountability across partner organisations – all working to the same measure of success. The metrics selected reflect those being used in existing plans to align with and accurately portray the efforts already carried out in delivery and prioritisation. They also reflect the major areas of inequality of outcome and cover a broad a range of inequalities dimensions where data allows. Both quantitative indicators, such as changes in key health metrics and qualitative indicators such as improvements in community wellbeing surveys will provide valuable insights into the strategy's effectiveness and relevance. Regular evaluation and narrative reporting is used where it is difficult to obtain indictors that sufficiently target the shared outcome or where more nuanced feedback is required. Indicators have been separated into Key Outcome Indicators, which reflect the high level measures of success related to shared outcomes and are usually an overview but can be a proxy measure, and Supporting Indicators which are measures of success that address different aspects and provide insight of the work required to meet the shared outcome.

4.7. **Assessment of indicators**: The assessment and selection of indicators has been divided into Phase 1 and Phase 2. Phase 1 identifies key indicators aligning with shared outcomes, that are well established and currently reported across different formats, have readily available data or have readily feasible data collection. Phase 1 indicators have been agreed on by action groups and task and finish group members and are included in the outcomes framework. There is continuing work in Phase 2 which seeks to review and refine indicator selection, particularly those supporting indicators, work with partners to address gaps in measurement, feasibility of data collection and ensuring continued relevance of the metrics used over the term of the strategy.

4.8. It is also anticipated that where data is available, the Outcome Indicators and Supporting Indicators will provide data at both a county level and at smaller geographical footprints so that the impact on reducing health inequalities within the 10 wards can be monitored. There are also 3 over-arching indicators that cut across the strategy that will be updated annually and reported to the board

4.8.1. Inequalities in life expectancy

4.8.2. Healthy life expectancy

4.8.3. Preventable mortality

5. Reporting and Delivery Plans

5.1 **Reporting Structure**: The delivery of the health and wellbeing strategy requires monitoring that will be undertaken at various levels of detail and frequency. At the

core, the HWB will have a high -level overview of the progress being undertaken in the 10 priorities of the strategy through reports to HWB on an annual basis from 4 thematic domains - Start Well, Live Well, Age Well, Building Blocks, each reporting once a year to HWB quarterly meetings. Primary Partnerships responsible for oversight of delivery of each priority (mostly grouped into the thematic domains) have been identified within the outcomes framework (see annex 1). Primary Partnerships have been engaged with and selected due to their existing activity in the targeted health and wellbeing strategy area. By leveraging partnerships already operational in each thematic domain, the proposed reporting structure (see figure 2) optimises efficiency and minimises burden to organisations, embedding the reporting on the 10 priorities into the current system

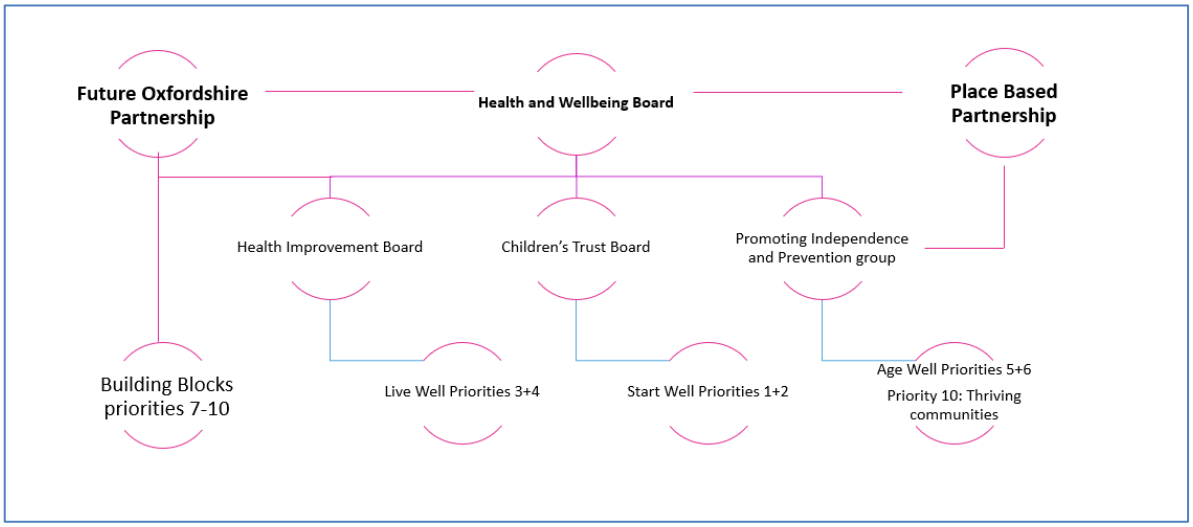

Figure 2: Proposed reporting structure for Health and Being Strategy

5.2 It should be noted that 2 building blocks priorities 9 (Healthy Homes) and 10 (Thriving Communities), both have 2 partnership bodies contributing to oversight of delivery. For priority 9 this is the Future Oxfordshire Partnership and the HWB itself. For priority 10 a combination of the Safer Oxfordshire Partnership and Promoting Independence and Prevention group (PIP) will lead on delivery.

5.3 **Performance report formats**: Primary Partnerships will monitor progress within the priorities they are responsible for. Progress report formats can be tailored to the unique dynamics of the partnership and its goals and to capture the nuances and detail of actions within the priority. However all updates will answer the following questions at annual reports of performance, as well as providing data on the Outcome Indicators and Supporting Indicators relevant to their priority:

1. What progress has been made since last update?
2. What are the current outstanding actions that still need to be taken?

3. What challenges are there and can the HWB support resolution of the issue?

5.4 **Example of performance report:** The Health Improvement Board (HIB) has been identified as the primary partnership for priorities 3 and 4- the Live Well domain. There are well established programmes of work and data sets within these priorities that provide a robust foundation for compiling a comprehensive performance report, therefore a prototype performance report is included in annex 2 that will be used by the HIB for future reporting**.** It is expected that the same approach to annual performance reporting will be provided for each of the other 8 priority/ 3 domains when providing their annual update to the board

5.5 **Delivery plans:** The outcomes framework outlines how the priorities are grouped into thematic domains and overseen by primary partnerships. Also outlined are details of the multiple strategies, action plans and programmes of work that are currently in place working towards the shared outcomes. Where a delivery plan is developed for a single priority, it is the consolidation of these existing actions and outlines in detail plans for delivery, as well as identifying gaps and opportunities for the HWB to ensure partnership working to the priority goal.

5.6 An example delivery plan (for the Live Well priorities 3 + 4) has been developed with partners part of the Health Improvement Board (see Health Improvement Board in supporting delivery of HWB strategy- Feb 24.pdf (oxfordshire.gov.uk) . This delivery plan brings together county wide partnership plans, such as the Whole Systems Approach (WSA) to obesity and the Tobacco Control Alliance action plan. It will be determined by the Primary Partnerships for each priority whether to develop a single delivery plan for the HWB strategy priority it owns or not. However, either way, they will still update the HWB Board on action taken to address the priority on the proposed an annual reporting cycle.

5.7 **Coordination of delivery planning**: The consolidation of existing actions and identification of opportunities for development for each priority requires multiagency coordination and cooperation. While these partnerships exist, there is a clear need for a role in coordination of this delivery that links to the HWB. A Health and Wellbeing Representative is proposed for each priority or thematic domain within the strategy, thereby constituting a group of 7- 10 officers to provide a unified voice influencing the work within each thematic domain by advocating for the strategy. The key credentials for the role include knowledge of the priority area and how it relates to the strategic priorities of the JHWS, excellent communication skills and partnership working. The role of a HWBR is flexible and can evolve over time but primarily ensures:

1. Clear communication channel : central point of contact for all partners facilitating open and effective communication
2. Coordination and Collaboration: Ensuring partners are continuing to work on the agenda(s) relevant to the priority and strategy - through existing partnerships and programmes
3. Identification of gaps or areas in need of greater focus: flagging these to the Board and helping convene action to address gaps
4. Monitoring and Evaluation: Collaborating on refinement of monitoring and evaluation processes based on feedback, evaluation results, and changing circumstances for the duration of the strategy timescale. Co-ordinating updates (annually) back to the board on progress against the priority

6. Financial and Staff Implications

6.1 There are no direct financial implications associated with this report. The Officer resource required to develop the work has required and continues to require contribution from partners of the Health and Wellbeing Board, as agreed by the Health and Wellbeing Board on 16th March 2023. All partners on the HWB Board will need to use organisational resource to support delivery of this strategy.

7. Legal Implications

7.1 The publication of Oxfordshire's Health and Wellbeing Strategy has met the Health and Wellbeing Board's statutory duty to publish a strategy to address health needs of the local population. The publication of the JSNA 2023 enabled the Board to meet its duty that its strategy addresses resident needs as outlined in the JSNA. The HWB's legal duty to consult residents has been met with publication of the consultation report in December 2023.

8. Equality and Inclusion Implications

8.1 Tackling health inequalities plays a key role in the outcomes framework for the Health and Wellbeing Strategy. The strategy places front and centre the need to tackle avoidable and unfair inequalities in health outcomes, experiences, and access to health and care services. This guiding principle is driven by insights from JSNA 2023.

8.2 Staff across organisations have all emphasised that people from disadvantaged groups should have a chance to help shape the Health and Wellbeing Strategy. As outlined in previous reports, officers have engaged with residents from disadvantaged groups across Oxfordshire during the process of updating the strategy, especially those whose health has been adversely impacted by their respective disadvantage.

9. Sustainability Implications

9.1 The process of updating the strategy itself has no direct sustainability implications. However, the strategy includes a priority regarding the impact of climate change on health, including air quality, access to nature, and the built environment, which is emphasised through the outcomes and key metrics in the outcomes framework. The final strategy builds on and affirms existing partnership-wide climate action commitments, recognising the impact this has on residents' health and wellbeing.

10. Risk Management

10.1 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	DAVID MUNDAY, DEPUTY DIRECTOR OF PUBLIC HEALTH
Annexed papers:	1. Annex 1- Oxfordshire Health and Wellbeing Strategy (2024-2030) Outcomes Framework 2. Annex 2- Draft Metrics for Live Well Priorities
Contact Officer:	DAVID MUNDAY, CONSULTANT IN PUBLIC HEALTH david.munday@oxfordshire.gov.uk 07922 849652

29th February 2024

Oxfordshire Joint Health and Wellbeing Strategy 2024-2030 Outcomes Framework

Strategy Cross-cutting Outcome Indicators:	Healthy Life Expectancy
	Inequalities in Life Expectancy
	Preventable Mortality

Priority 1: Best Start in Life

All children in Oxfordshire should experience a healthy start to life and be ready for school, especially in our most deprived neighbourhoods.

Shared outcomes	Key strategies and activities delivering on priority	Key Outcome Indicators	Supporting Indicators
1.1 Improved parental physical and mental health during pregnancy, birth and after birth	Buckinghamshire, Oxfordshire Berkshire West Local Maternity Neonatal Service Equity and Equality Action Plan NHS England: Saving Babies Lives 2 Care Bundle NHS England: Core20PLUS5 Oxfordshire Start for Life offer Healthy Start Scheme Oxfordshire's Tobacco Control Strategy and action plan	Levels of smoking in pregnancy - smoking status at time of booking and delivery Number of mothers who had a Mother's (mental health) Assessment Proportion of births with low birth weight Levels of maternal overweight/obesity	Proportion of New Birth Visits (NBVs) completed within 14 days Number of children/families supported with alcohol and drug use through Family Solutions Plus New parents support/parenting confidence – TBC
1.2 Children with good health, feeling safe and secure, living in nurturing environments.	Oxfordshire's Whole System Approach to Obesity Action Plan Oxfordshire Food Strategy Oxfordshire Start for Life offer HM Government: The Best Start for Life – A vision for the 1001 critical days Department of Education: Statutory framework for the early years foundation stage Department of Health: The Healthy Child programme – two year review	Increase breastfeeding rates at initiation, 6-8 weeks, 6 months Reduce levels of children obese in reception (4-5 years old) and year 6 (10-11 years old) Reduce proportion of 5 year olds with decayed, missing or filled teeth Increase immunisation rates – percentage of children with up to date immunisations (focus on children in care) Decrease A+E attendances and hospital admissions for unintentional injuries in children (ages <14 years and 14+ years)	Supporting families framework: Reporting on parents/carers that require support with physical health needs of child are being well-managed, and family have sufficient / the right support in place/ necessary adaptations have been made/in place - TBC Number of families in need engaging with, and benefitting from, appropriate support, plan in place to manage on-going health needs - TBC
1.3 Children have opportunities for learning from birth and families	Oxfordshire School Readiness and Lifelong Learning Strategic Plan June 2020 Children & Young People's Plan 2023/2024	Increase percentage of children achieving a good level of development at 2 to 2 and a half years and at age 4 years, particularly in most deprived communities	Attendance at 2-year Universal Health Visitor Review development check Take up of 2-year-old or 3–4-year-old government-funded early education and childcare entitlement

	supported with childhood development	Oxfordshire SEND Local Area Partnership Priority Action Plan Department of Education: Statutory framework for the early years foundation stage	Increase percentage of children achieving a good level of development at the end of Reception Increase percentage of children with free school meal status achieving a good level of development at the end of Reception	
1.4	**Early identification and support for children and families where there is emerging need**	Children & Young People's Plan 2023/2024 Oxfordshire Early Help Strategy Update June 2022 Early Help and the Locality Community Support Service Drug and Alcohol Partnership Strategy Oxfordshire Domestic Abuse Strategy and action plan Commissioning Strategy for Looked After Children Placements 2020-2025 Oxfordshire SEND Local Area Partnership Priority Action Plan	Number of children cared for (age under 5) Percentage of looked after children whose emotional wellbeing is a cause for concern Number of referral and re-referrals in 12 months (requests for services to be provided by children's social care regarding a child who is not currently in need)	Number and key referral criteria of Early Help Strength and Needs Assessments, improvement in outcomes evidenced through EHA - TBC Number and rate of police-recorded domestic incidents affecting children EYFS progress check at 2 years of age

Primary partnership for priority	**Key Partnerships**
Children's Trust Board/ TBC	BOB ICB's Integrated CYP Delivery Network/Programme Oxfordshire Safeguarding Children Board Oxfordshire Food Strategy Network Oxfordshire Tobacco Control Alliance Alcohol Partnership, Oxfordshire Maternal Mental Health Alliance (MMHA) Oxfordshire Mental Health Prevention Concordat Partnership Group School Readiness and Lifelong Learning group SEND Improvement Board

Priority 2: Children and Young People's Mental Health and Emotional Wellbeing

More children and young people in Oxfordshire should experience good mental health and emotional wellbeing

Shared outcomes	Key strategies and activities delivering on priority	Key Outcome Indicators	Supporting Indicators
2. 1 Improved emotional wellbeing and mental health of children and young people, with positive transitions to adulthood.	Oxfordshire's Better Wellbeing and Mental Health Strategy for Children and Young People 2022 to 2025 Suicide and Self-Harm Prevention Strategy 2020-24 Oxfordshire Mental Health Prevention Framework 2020-2023	Levels of self reported wellbeing and measures of loneliness, anxiety and depression, worry/stress Estimated populations and prevalence of children and young people with a probable mental disorder, 5 to 16 year olds and 17 to 22 year olds in Oxfordshire	Rates of child inpatient admissions for mental health conditions Rates of child hospital admissions as a result of self-harm
2.2 A prevention first approach with meaningful measures to tackle drivers of poor mental wellbeing in childhood	Oxfordshire's Whole System Approach to Obesity Action Plan Oxfordshire on the Move, You Move programme Holiday Activities and Food programme Early Help Strategy and action plan Oxfordshire School Readiness and Lifelong Learning Strategic Plan June 2020	Percentage of 16-17 year olds not in education, employment or training (NEET) Pupil absence – increased rates of school attendance and participation Rates of children in need due to abuse or neglect	Average Attainment 8 (GCSE) score, and score of children in care Percentage of children taking part in 6 hours of physical activity a week Compliance with statutory timelines in co-production of Education Health Care Plans for CYP with Special Educational Needs and Disability Improved family relationships – TBC Under 18s conception rate/Percentage of delivery episodes where the mother is aged less than 18 Admission episodes for alcohol-specific conditions – Under 18s Hospital admissions due to substance misuse (15 to 24 years)
2.3 Increased and diversified capability to support CYP with their emotional and mental health needs at earliest opportunity	Oxfordshire's Better Wellbeing and Mental Health Strategy for Children and Young People 2022 to 2025 Early Help Strategy and action plan Oxfordshire Mental Health Prevention Framework 2020-2023 Suicide and Self-Harm Prevention Strategy 2020-24 Oxfordshire Social Prescribing Oxfordshire Community & Voluntary Action (OCVA) and Community First Oxfordshire (CFO) Well Together Programme	Support for children and family mental health – meeting evidence requirements for Supporting Families framework	Evaluation of development of new roles such as Social Prescribers to support families to reach out to alternative help where appropriate Improved provision of Safe spaces for CYP+Trusted adults Evaluation of the increased range of mental health support and counselling services, including face to-face, telephone, and digital support, as well as availability of educational resources and toolkits. Evaluation of the provision of mental health and suicide prevention training for professionals and volunteers and developing a confident workforce
2.4 Closer partner collaboration to align and improve our system approach to accessing help	Children & Young People's Plan 2023/2024 Oxfordshire Early Help Strategy Update June 2022 Oxfordshire SEND Local Area Partnership Priority Action Plan	Monitoring overall outcomes of CYP with mental health needs - TBC	Progress measures being met in implementation of joint initiatives Regular evaluation of progress on achievement of shared outcomes

Primary partnership for priority	Key Partnerships
TBC/ Children's Trust Board	Active Oxfordshire/Oxfordshire on the Move Safer Oxfordshire Partnership Community Safety Partnerships Oxfordshire Stronger Communities Alliance Oxfordshire Mental Health Prevention Concordat Partnership Group Oxfordshire Safeguarding Children Board Oxfordshire's Children and Young People's Emotional Wellbeing and Mental Health Board SEND Improvement Board Suicide and Self Harm Multi- Agency Group Oxfordshire CAMHS partnership VCS Children and Young People Mental Health Partnership Thames Valley Violence Reduction Unit

Priority 3: Healthy People, Healthy Places

The length and quality of people's lives in Oxfordshire should not be negatively impacted by exposure to tobacco, alcohol, or unhealthy weight. People in Oxfordshire should live in healthy environments where they can thrive free from these harms.

Shared outcomes	Key strategies and activities delivering on priority	Key Outcome Indicators	Supporting Indicators
3.1 More residents living with healthy weight and reduced harm from unhealthy weight, with focus on priority groups. Using Whole Systems Approach: **i. System Leadership** **ii. Prevention** **iii. Support** **iv. Healthy weight environments**	Oxfordshire's Whole System Approach to Obesity Action Plan Oxfordshire Food Strategy and actions plans Oxfordshire's Healthy Place Shaping Action Plan NHS Joint Forward Plan BOB ICB Action Plan NHS Health Check Programme Making Every Contact Count /Here for Health programmes Healthy Start programme	Percentage of adults (aged 18 plus) classified as overweight or obese Year 6 prevalence of overweight (including obesity) Reception prevalence of overweight (including obesity) Achievement of county wide Gold Sustainable Food Award	Percentage of adults aged 16 and over meeting the '5-a-day' fruit and vegetable consumption recommendations Percentage of the eligible population aged 40-74 years receiving a NHS Health Check Healthy Start Voucher uptake Deaths from circulatory disease (under 75 years)

3.2 Oxfordshire to become smoke free **i. Less people taking up smoking** **ii. Smokefree environments** **iii. Effective regulation and enforcement of illicit tobacco** **iv. More smokers supported to quit, targeting those populations where smoking rates remain high**	Oxfordshire's Tobacco Control Strategy and action plan Stop for Life Oxon	Smoking Prevalence in adults (18+) - current smokers Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers	People smoking with mental health condition Smoking prevalence in pregnancy
3.3 Reduced alcohol related harm **i. Address unmet need for alcohol support and treatment.** **ii. Improve earlier identification and prevention of alcohol harm**	Drug and Alcohol Partnership Strategy and action plan	Alcohol treatment progress and completion Admission episodes for alcohol-related conditions	Alcohol only numbers in structured treatment Restrict clusters of premises licenced to sell alcohol- TBC

Primary partnership for priority	**Key Partnerships**
Health Improvement Board	Oxfordshire food strategy network and food action working groups Oxfordshire Tobacco Control Alliance Alcohol Partnership, Oxfordshire Oxfordshire Anchor Network

Priority 4: Physical activity and Active Travel

Residents of Oxfordshire should be able to be and stay physically active, for example by walking and cycling, especially in our most deprived areas.

Shared outcomes	Key activities delivering on priority	Key Outcome Indicators	Supporting Indicators
4.1 A system wide approach to physical activity, incorporating key physical activity programmes	Oxfordshire on the Move Move Together programme You Move programme Oxfordshire's Whole System Approach to Obesity Action Plan	Percentage of physically active adults Percentage of physically active children	Uptake of Move together/You move programmes Number of schools participating in Schools Active Programme -TBC
4.2 Whole system approach to improving access and uptake of active travel options	Oxfordshire Healthy Place Shaping Action Plan Oxfordshire Infrastructure Strategy 2021-2040 Local Plans/Neighbourhood plans Net Zero Route Map and Action Plan Local Transport and Connectivity Plan	Active travel - percentage of adults walking/cycling for travel at least three days per week (age 16+)	Number of Cycling and Walking Activation initiatives that promote inclusion - TBC By 2030 the Route Map ambition is for a: 20% reduction in vehicle miles from personal trips. 10% mode shift of personal trips (private vehicles to sustainable modes)
4.3 Recognition and action on the critical importance of being active for mental health and wellbeing	Oxfordshire Mental Health Prevention Framework Oxfordshire Mental Health Partnership partner programmes Oxfordshire Social Prescribing NHS Health Check Programme Making Every Contact Count programme	Self reported wellbeing: people with a low happiness score or ONS wellbeing measures of anxiety, happiness, satisfaction and worthwhile Percentage of people using outdoor space for exercise/health reasons - TBC	Adult patients recorded with a diagnosis of depression Emergency hospital admissions for intentional self-harm in all ages

Primary partnership for priority	Key Partnerships
Health Improvement Board	Active Oxfordshire Safer Oxfordshire Partnership Community Safety Partnerships Oxfordshire Stronger Communities Alliance Oxfordshire Mental Health Prevention Concordat Partnership Group Zero Carbon Oxford Partnership (ZCOP)

Priority 5: Maintaining Independence

We will support more older residents to remain independent and healthy for longer. We will ensure they are always treated with dignity and are fully valued

Shared outcomes	Key activities delivering on priority	Key Outcome Indicators	Supporting Indicators
5.1 More older residents to remain well, safe and independent in their home for longer	Oxfordshire Way Oxfordshire on the Move You Move programme Oxfordshire's All-Age Unpaid Carers' Strategy for Oxfordshire and action plan Oxfordshire Better Care Fund (BCF) Plan	Proportion of physically inactive adults (age groups of 55-74 and 75+) Emergency hospital admissions due to falls in people aged 65 and over* Unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions)* -	Hip fractures in people aged 65 and over Carer quality of life/satisfaction with adult social care service (aged 65+) – TBC
5.2 Enable older people who have lost a degree independence to regain independence or support their health and wellbeing in their chosen setting	Oxfordshire Way Oxfordshire Mental Health Prevention Framework 2020-2023 Oxfordshire Social Prescribing	Percentage of people who are discharged from acute hospital to their normal place of residence* Proportion of people discharged who are still at home after 91 days into reablement / rehabilitation services*	Estimated diagnosis rate for people with dementia Rate of admission to permanent residential care home funded by adult social care *
5.3 More older people empowered to take part in decision making about their own health and wellbeing	Oxfordshire Way Oxfordshire Mental Health Prevention Framework 2020-2023 Oxfordshire Mental Health Partnership partner programmes Oxfordshire Social Prescribing NHS Health Check Programme Making Every Contact Count programme Oxford Health's Family, Friends and Carers Strategy 2021	Self reported wellbeing: people with a low happiness score or ONS wellbeing measures of anxiety, happiness, satisfaction and worthwhile Percentage of people using outdoor space for exercise/health reasons - TBC Proportion of carers receiving direct payments for support direct to carer	Difficulties in activities of daily living Income Deprivation Affecting Older People Index (age 60+) Percentage of people aged 65+ receiving winter fuel payments Uptake proportion of residents eligible for pension credit Volunteering rates (65+) Adult social care user feelings of choice over care and support services

Primary partnership for priority	Key Partnerships
Promoting Independence and Prevention Group **Joint Commissioning Executive**	Prevention and Health Inequalities Forum Place Based Partnership Active Oxfordshire Safer Oxfordshire Partnership Community Safety Partnerships Oxfordshire Stronger Communities Alliance Oxfordshire Mental Health Prevention Concordat Partnership Group Carers Oxfordshire, partnership between the charities Action for Carers and Rethink Mental Illness

*Indicator included in Better Care Fund Plan

Priority 6: Strong social relationships

Everyone in Oxfordshire should be able to flourish by building, maintaining, and re-establishing strong social relationships. We want to reduce levels of loneliness and social isolation, especially among rural areas.

Shared outcomes	Key activities delivering on priority	Key Outcome Indicators	Supporting Indicators
6.1 More connected communities and closer links between health, social care, and community-centred interventions, ensuring no age exclusions	Oxfordshire Way Oxfordshire Healthy Place Shaping Action Plan District and City Local Plans/Oxfordshire Neighbourhood plans	Percentage over older residents reporting "often, always or some of the time" feeling lonely Proportion of adult social care users who have as much social contact as they would like Improve Self-reported wellbeing: happiness, worthwhile, satisfaction	Number of social care users accessing community-based support for health and care needs Volunteering rates (65+) People supported by social prescribing
6. 2 Better understanding of the unique strengths and challenges of living in Oxfordshire's rural areas	Housing and Homelessness Strategies Oxfordshire Well Together programme Oxfordshire County Council Voluntary and Community Sector Strategy 2022 – 2027 Oxfordshire Social Prescribing programme Community Capacity Grant programme	Narrative reporting from community insight surveys and interviews	Measures of community engagement through residents survey– TBC Measures of access to transportation infrastructure/economic opportunities/health and social care services/cultural and recreational – TBC

6..3 Digital support for virtual connection & improved digital skills	Digital Inclusion Strategy	Number of embedded Digital Champions within GPs, PCNs and community organisations who are championing digital health	Assessment of availability and uptake of training opportunities in digital literacy, measure presence/effectiveness of initiatives focussed on enhancing digital skills in the community

Primary partnership for priority	**Key Partnerships**
Promoting Independence and Prevention Group	Prevention and Health Inequalities Forum Place Based Partnership Active Oxfordshire Safer Oxfordshire Partnership Community Safety Partnerships Oxfordshire Stronger Communities Alliance Oxfordshire Mental Health Prevention Concordat Partnership Group

Priority 7: Financial Wellbeing and Healthy Jobs

All of Oxfordshire's people should have good basic standard of living and financial wellbeing. Our local economy should be inclusive, equitable, and fair and everyone should be able to contribute through life-long learning and good quality stable work.

Shared outcomes	Key activities delivering on priority	Key Outcome Indicators	Supporting Indicators
7.1 Residents in poverty or struggling with cost of living pressures have access to targeted financial wellbeing support	Oxfordshire Food Strategy Oxfordshire Strategic Economic Plan (2024) Resident Support Scheme (24/25) Council tax reduction match funding Holiday Activities and Food programme Education Commission Report 2019/20 Director of Public Health Annual Report: hidden inequalities in a prospering Oxfordshire Oxfordshire Way	Percentage of emergency cost of living funding to residents in need funding spent	Uptake of eligible benefits and estimated underclaiming with a focus on: Pension credit and Council tax reduction

7. 2 Preventing financial crises by supporting residents to feel in control of their finances.	Oxfordshire Mental Health Prevention Framework 2020-2023 UK Strategy for Financial Wellbeing 2020-2030 Oxfordshire County Council Voluntary and Community Sector Strategy 2022 – 2027	Number of residents in Oxfordshire engaging with local credit union	Number of residents accessing low-interest loans and saving with the credit union Average household income before housing costs for residents in areas of higher deprivation Social prescribing levels to financial wellbeing services Number of contacts to new joint advice service (starting November 2024)
7.3 Supporting inclusive economy approaches that provide pathways to well-paid and stable employment that supports residents' wellbeing.	Oxfordshire Strategic Economic Plan (2024) Oxfordshire Skills Strategy	Children under 16 living in relative low-income families Number of residents claiming in-work benefits Number of people with mental illness in employment	Apprenticeship completion rate Lower quartile monthly gross pay vs lower quartile monthly rent (percentage) - TBC
7.4 The health and care system contributes to a resilient and fair local economy	Oxfordshire Strategic Economic Plan (2024) Circular Economy Plan 2050 Anchor network strategy	Health and care system are more able to fill vacancies locally (lower agency spend) - TBC	TBC after Oxfordshire Anchor ambitions forum 8th April 2024

Primary partnership for priority	**Key Partnerships**
Future Oxfordshire Partnership	Oxfordshire Inclusive Economy Partnership (OIEP) + Anchor Network Prevention and Health Inequalities Forum (PHIF) Food Action Working Groups (FAWGs – one for each district + steering group) Oxfordshire Local Enterprise Partnership (OxLEP) Board Oxfordshire Skills Board Joint Communities Hub Officer Group Transformation Group (ASC) Co-Production Oxfordshire Advisory Board Oxfordshire Stronger Communities Alliance Community Insight Profile ward groups Oxfordshire Mental Health Prevention Concordat

Priority 8: Climate Action and Health

The health and care system in Oxfordshire should take action to reduce climate change and the impacts of climate change on people's health

Shared outcomes	Key activities delivering on priority	Key Outcome Indicators	Supporting Indicators
8.1 Partners working together for cleaner indoor and outdoor air by promoting active, sustainable travel and adopting low-carbon energy and supply chains	Director of Public Health Annual Report (2023 – 2024) and related communications and engagement plan Oxfordshire County Council Air Quality Strategy Route Map 2023 – 2026 District and City Council Air Quality Plans Cycling & walking Activation programme Oxfordshire Local Transport and Connectivity Plan Oxfordshire's Healthy Place Shaping Delivery Plan Oxfordshire Net Zero Route Map and Action Plan Pathways to Zero Carbon Oxfordshire Vision & Strategy 2022 – 2027 Future Oxfordshire Partnership: The Oxfordshire Strategic Vision	Ambient air pollution (including CO_2, NO_2, and particulate matter) Annual change in average nitrogen dioxide concentrations in Oxfordshire's Air Quality Management Areas (AQMAs) compared to the 2019 average, as reporting in district councils' Annual Status Reports (ASRs). (Target 10% annual reduction)	Reporting of organisational contributions to air pollution and their demonstrated, sustained shifts to less polluting alternatives Routine measurement and evaluation of ambient air pollution (including CO_2, NO_2, and particulate matter-PM), including analysis of data at intervention and control sites as part of the School Sensor project Annual frequency of summer fires, and specifically wild fires. (Fire smoke includes both gases and PM which can adversely impact on a range of health conditions) An indicator to measure concentrations of total PM2.5 locally is in development
8. 2 Increase and improve access for all to safe, inclusive, and connected green and blue spaces, which are rich in biodiversity, support nature connection and wellbeing, and are climate resilient.	Local Nature Recovery Strategy Making the case for investment in Green Infrastructure in Oxfordshire	Indicators to measure connectedness with nature, access to and/or quality of green space are in development	
8. 3 Adapted and upgraded buildings, estates and facilities to ensure high-quality services can be delivered now and in the future as resources are made available	Better Housing Better Health service Building a Greener OUH 2022 – 2027 Oxford Health Green Plan 2022 – 2025 Greener Practice Oxfordshire ICS Green Plan OCC Carbon Management Plan OCC Climate Action Framework OXLEP County wide Energy Strategy	Rates of fuel poverty across OxfordshirePercentage of fuel poor homes receiving support from the Better Housing Better Health service	Reporting of whether local health system Green Plans include adaptation measures Hospital overheating incidents
8.4 Partners working together to support net zero targets and climate adaptation measures	Oxfordshire Net Zero Route Map and Action Plan Pathways to Zero Carbon Oxfordshire (PAZCO) Vision & Strategy 2022 – 2027 Oxfordshire County Council Carbon Management Plan 2022 – 2025 Building a Greener OUH 2022 – 2027	Delivery of PAZCO 2050 routemap priorities as reported into the Future Oxfordshire Partnership	

	Oxford Health Green Plan 2022 – 2025 Greener Practice Oxfordshire ICS Green Plan South Central Ambulance Service, Our Future Action on Carbon and Energy in Schools Initiative Nationally: Greener NHS Centre for Climate and Health Security, UKHSA Greener Practice Delivering a Net Zero Health Service		
8.5 Building and continuously bolstering community resilience by adapting our built environment and improving green infrastructure to meet the needs of our changing climate.	Winter Warmth and Extreme Heat Campaigns Oxfordshire County Council Climate Action Framework Oxfordshire Local Flood Risk Management Strategy	Proportion of completed community emergency planning forms with embedded heat-health and flooding guidance	Annual frequency of flooding incidents Annual heat-related excess deaths, and illness Community Action Groups Annual Report Narrative reporting of system engagement to build and bolster community resilience to meet the needs of our changing climate

Primary partnership for priority	**Key Partnerships**
Future Oxfordshire Partnership	Zero Carbon Oxfordshire Partnership (ZCOP) Local Nature Partnership (LNP), including the Nature & Health Working Group Community Action Groups (CAG) Oxfordshire Oxfordshire Inclusive Economy Partnership (OIEP) Oxfordshire Anchor Network

Priority 9: Healthy Homes

Everyone should have access to quality, affordable, and energy efficient homes which support their health and wellbeing. Social, private rented, and new build homes should be of a good material standard and maintained to prevent health issues.

Shared outcomes	Key activities delivering on priority	Key Outcome Indicators	Supporting Indicators
9.1 More healthy, safe, secure homes	Oxfordshire's Healthy Place Shaping Delivery Plan Better Housing Better Health Oxfordshire District and City Local Plans/Oxfordshire Neighbourhood plans Oxfordshire Infrastructure Strategy Oxfordshire Strategic Economic Plan (2024)	Proportion of houses with Category 1 or 2 hazard under the Housing Health and Safety Rating System (HHSRS) * Percentage of households living in a home with a damp problem.* Percentage of households living in a home with an energy efficiency rating (EER) of A - C+D or E to G	Percentage of fuel poor homes receiving support from the Better Housing Better Health service Percentage of homes fail the Decent Homes Standard – TBC * Completion of Health Impact Assessments
9. 2 More affordable homes	District and City Local Plans Oxford City Housing, Homelessness and Rough Sleeping Strategy 2023 to 2028 Cherwell District Council Housing Strategy 2019-2024 South Oxfordshire and Vale of White Horse Housing Delivery Strategy 2022 – 2024 and Action Plan West Oxfordshire District Council Affordable Housing Supplementary Planning Document (SPD) Oxfordshire Countywide Action Plan Homelessness & Rough Sleeping 2023 -2026	Mortgage or rent as a proportion of household income (including and excluding housing support), by tenure Rent as a proportion of household income (including and excluding housing support), by tenure - TBC Proportion of private/social renters currently in arrears or had been in the last 12 months	Number of affordable homes delivered * Completion of benchmarking exercise on prevention offer across the City and Districts, to inform decisions on a common and minimum offer across the county.
9..3 Increase availability of housing to meet the needs of specific groups	Oxfordshire Countywide Action Plan Homelessness & Rough Sleeping 2023 -2026 District and City Local Plans Anchor network strategy	People with long-term limiting disability in unsuitable accommodation (all ages) - Indicator to be informed by Supported Housing Needs assessment (due March 2024)	Mean life satisfaction score, by tenure (EHS)

9.4 Prevention and reduction of rough sleeping and homelessness	Oxford City Housing, Homelessness and Rough Sleeping Strategy 2023 to 2028	Reduce Homelessness -number of households owed a duty under the Homelessness Reduction Act Rough sleeping numbers as per 5 core indicators in Ending Rough Sleeping Data Framework, December 2023	Reduce numbers living in temporary/insecure accommodation – TBC Number of repeat homelessness applications No of households presenting as homeless per 1000 of population
Primary partnership for priority		**Key Partnerships**	
Health and Wellbeing Board		Oxfordshire Inclusive Economy Partnership (OIEP) Anchor Network Future Oxfordshire Partnership The Oxfordshire Homelessness Alliance	

* Indicator definition or data may vary across Oxfordshire city and district councils.

Priority 10: Thriving Communities

We will support and enable all communities to play their key role delivering better health and wellbeing for people across Oxfordshire

Shared outcomes	Key activities delivering on priority	Key Outcome Indicators	Supporting Indicators
10.1 Thriving, safe communities where all people of all ages feel a sense of belonging.	Oxfordshire Way District and City Local Plans/Oxfordshire Neighbourhood plans Safeguarding Board Plans County and District Community Safety Plans Housing and Homelessness Strategies Thames Valley's Police and Crime Plan Thames Valley Police Violence Against Women and Girls Strategy Oxfordshire Well Together programme	Improve perceived sense of belonging, % of people reporting "great place to live"	Self reported wellbeing: people with a low happiness score or ONS wellbeing measures of anxiety, happiness, satisfaction and worthwhile Measures of crime/perceived safety – TBC when Community Safety Partnership agreement is finalised in July 2024 Drug related deaths and harm/treatment completion and treatment progress measures Number of people being case managed by Oxfordshire Domestic Abuse service

	Oxfordshire Overarching Domestic Abuse Strategy 2022 – 2025 and Action Plan Oxfordshire Combating Drugs Partnership Action Plan		
10. 2 Inclusive, cohesive and connected communities	Oxfordshire Healthy Place Shaping Action Plan District and City Local Plans Local Cycling and Walking Infrastructure Plans Oxfordshire Way	Loneliness: Percentage of adults who feel lonely often / always or some of the time Measure the utilization and accessibility of shared spaces, parks, and community facilities that encourage interaction among residents.- TBC	Proportion of adult social care users who have as much social contact as they would like Development of Local Cycling and Walking Infrastructure Plans Number of Cycling and Walking Activation initiatives that promote inclusion - TBC Number of Local Plans that include a specific Healthy Place Shaping policy- TBC Percentage of people using outdoor space for exercise/health reasons- TBC
10.3 Empowered communities playing a key role promoting health and wellbeing	Oxfordshire County Council Voluntary and Community Sector Strategy 2022 – 2027 Oxfordshire Social Prescribing programme	Number of people with any volunteering or community participation in the last 12 months Number of people supported by social prescribing	Number of social care users accessing community-based support for health and care needs - TBC
10.4 Resilient and sustainable voluntary and community sector across Oxfordshire	Oxfordshire County Council Voluntary and Community Sector Strategy 2022 – 2027 Community Capacity Grant programme Well Together Programme Anchor network strategy	Outcomes from Well Together Programme (TBC)	Measures of VSCO sustainability - TBC Organisational Impact reports Programme case study reports

Primary partnership for priority	**Key Partnerships**
Promoting Independence and Prevention Group **Safer Oxfordshire Partnership**	Community Safety Partnerships Oxfordshire Combatting Drugs Partnership Oxfordshire Stronger Communities Alliance Oxfordshire Domestic Abuse Strategic Board (ODASB) Oxfordshire Neighbourhood Plans Alliance (ONPA) Thames Valley Violence Reduction Unit (incl Community & Voluntary Sector Board)

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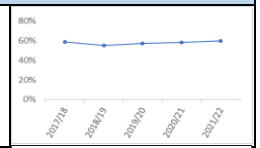
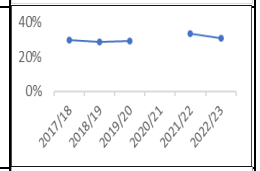
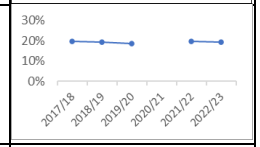
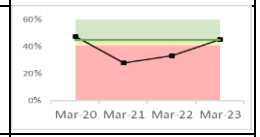
Live Well Priorties

Key

Supporting

* available at MSOA level

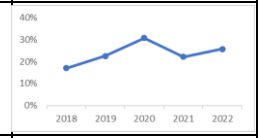
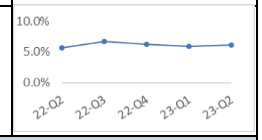
		NEW	Frequency	Region	Target TBC	Reporting Period	Value	Commentary	Trend Chart
3	**Healthy People, Healthy places**								
	Healthy Weight								
3.101	Percentage of adults (aged 18 plus) classified as overweight or obese	Y	Annual	Oxfordshire	*57%*	21/22	60%		
3.102	Year 6 prevalence of overweight (including obesity)	Y	Annual	Oxfordshire*	*31%*	22/23	31%		
3.103	Reception prevalence of overweight (including obesity)	Y	Annual	Oxfordshire*	*18%*	22/23	19%		
3.104	Achievement of county wide Gold Sustainable Food Award	Y	Annual	Oxfordshire	*Gold*	2023	Silver		
3.105	Percentage of adults aged 16 and over meeting the '5-a-day' fruit and vegetable consumption recommendations	Y	Annual	Oxfordshire		21/23	40%		
3.106	% Of those residents invited for a NHS Health check, the % who accept and complete the offer.	Y	Annual	Oxfordshire	*45%*	22/23	45%		
3.107	Healthy Start Voucher uptake	Y	Monthy	Oxfordshire	*65%*	Feb-24	75%		
3.108	Deaths from circulatory disease (under 75 years) Indirectly standardised ratio - per 100	Y	Unknown	Oxfordshire		2016-20	72		

Live Well Priorties

Key

Supporting

* available at MSOA level

		NEW	Frequency	Region	Target TBC	Reporting Period	Value	Commentary	Trend Chart
	Smoke Free								
3.201	Smoking Prevalence in adults (18+) - current smokers	Y	Annual	Oxfordshire	*9%*	2022	11%		
3.202	Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers	Y	Annual	Oxfordshire	*16%*	2022	26%		
3.203	Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS)	Y	Annual	Oxfordshire		21/22	20%		
3.204	Smoking prevalence in pregnancy	Y	Quarterly	Oxfordshire	*6%*	Q2 23/24	6%		
	Alcohol related harm								
3.301	Alcohol only successful treatment completion	Y	Quarterly	Oxfordshire	*42%*	Nov-23	53%		
3.302	Alcohol treatment Progress	Y	Quarterly	Oxfordshire		Dec-23	76%		
3.303	Alcohol only numbers in structured treatment	Y	Quarterly	Oxfordshire	*743*	Nov-23	916		

Live Well Priorties

Key

Supporting

* available at MSOA level

		NEW	Frequency	Region	Target TBC	Reporting Period	Value	Commentary	Trend Chart
4	**Physical activity and Active Travel**								
	Physical Activity								
4.101	Percentage of physically active adults	Y	Annual	Oxfordshire		Nov21-Nov22	12%		
4.102	Percentage of physically active children	Y	Annual	Oxfordshire		Academic Yr 22-23	25%		
4.103	Uptake of Move together								
4.104	You move programmes								
	Active Travel								
4.201	Active travel - percentage of adults walking/cycling for travel at least three days per week (age 16+)	Y	Annual	Oxfordshire	*6%*	2022	44%		
	Mental Health								
4.301	Self reported wellbeing: people with a high anxiety score	Y	Annual	Oxfordshire		22/23	18%		
4.302	Adult patients recorded with a diagnosis of depression	Y	Annual	Oxfordshire		22/23	31%		
4.303	Emergency hospital admissions for intentional self-harm in all ages (Rate / 100k)	Y	Annual	Oxfordshire*		21/22	141.8		

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Divisions Affected – ALL

OXFORDSHIRE HEALTH AND WELLBEING BOARD
14 March 2024

Community Profiles for Littlemore and Central Oxford

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 Community Profiles for Littlemore and Central Oxford.

   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 in 2019 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. Community profiles for Littlemore and Central Oxford (Phase 3) were published in December 2023 which completes the creation of community profiles for all ten areas. These profiles provide an in-depth understanding of the enablers and challengers to the health and wellbeing of communities.

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. Annexes 1 and 2 contain direct links to the recently published Phase 3 community profile reports.

6. Across all 10 areas, the community profiles form part of a spectrum of work and provide a platform for more in depth work with communities. Local action planning, a grant scheme to take forward the profile recommendations and a Community Health Development Officer programme to support this, develops a sustainable onward legacy.

7. The community profile work programme aligns closely to the Well Together programme to increase capacity in areas that need it the most. Plans are in place to develop an interactive dashboard to make finding information from the profiles more accessible for local communities as well as strategic partners.

Background

8. 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.

9. 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 (2019) 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.

10. 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.

11. 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 6 October 2022. Phase 2 included Banbury Grimsbury and Hightown, Banbury Cross and Neithrop and Ruscote (a refreshed profile for Ruscote from the original proof of concept - combined with the Neithrop profile) as well as profiles for Barton and Rose Hill in Oxford City. These were taken to the Health and Wellbeing Board on 29 June 2023.

Phase 3 Profiles

12. Since then, the final two profiles (out of the 10 areas) have been completed for the areas listed below in Oxford City (Phase 3) which form the main focus of this report.

- **Littlemore** - We worked closely with the local Littlemore partnership group from the outset to identify opportunities for joint working and to develop the project. The findings from the Community Insight profile are now being used for the development of the health and wellbeing elements of the Local Neighbourhood Plan.

- **Central Oxford** – The ward boundary for the Carfax area that was in the original 10 areas in scope has changed since 2019 and so this profile covers selected areas of St. Thomas, St. Ebbe's, Friars Wharf and Grandpont. The areas were selected after discussion with the profile steering group and were based on the local data indicating high rates of social housing and comparative higher levels of household deprivation.

13. Similarly, to the previous 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.

14. The Littlemore community engagement and insight was led by Community First Oxfordshire and in Central Oxford this was led by Community Glue. The steering groups varied in their make up in each area but included key stakeholders such as representatives from local community groups, health organisations, Councillors, Local Authorities etc. In these Phase 3 profiles, Oxford City Council has been supporting with project management.

15. The profiles are helping to 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.

Findings from the Phase 3 Profiles

16. A selection of the key findings and recommendations have been detailed for each area in the table below.

Littlemore	**Selection of key findings** **<u>Key assets and strengths</u>** • Community feeling and neighbourliness • Green, open spaces and playparks • Community groups and organisations • Schools • Local shops and services • Location of Littlemore – proximity to the countryside and Oxford City **<u>Challenges</u>** • Access to health care services

	• Mental Health/ Long term impacts from the COVID-19 pandemic • Transport and Roads • Housing • Cost of Living **<u>Recommendations from the community insight report</u>** **1. Public Realm and Services** • Primary and secondary healthcare provision: discussions to explore improvements to local services. • Local environment/streetscape improvement discussion • Anti-social Behaviour initiatives • A 'local infrastructure campaign' • Public transport improvement discussions **2. Community cohesion and integration** • Develop a holistic, community-wide communication strategy • Develop a programme of whole-community events • Develop a Youth Council • Extend community development worker support • A Warm Spaces publicity campaign **3. Community action: innovation and resilience** • Improve joint-working and networking • Explore innovation in community building usage and/or development of a community hub • Explore funding avenues for community innovation • Launch a Littlemore Volunteer Drive **4. Community action: meeting locally- identified needs** • Additional support for young people • Community-based mental health initiatives • Develop new or extend existing community activities and sessions • Develop community-based Life Skills sessions • Develop new or extend existing environment-based community activities, sessions and innovations • Support group for parents of children with Special Educational Needs and groups for • children/ young people • Develop a community transport scheme/ Good Neighbours Scheme to facilitate better • access to community activity • Explore intergenerational innovation
City Centre	**Selection of key findings** **<u>Strengths/ Assets</u>** • Access to employment and work-related training • A range of services for healthcare available

	• Access to nearby amenities • Feelings of safety and a strong sense of community **<u>Challenges</u>** • Money and Poverty • Access to drug and alcohol and mental health support • Affordable housing • Diminishing number of venues • Access to other parts of the city **Recommendations from the community insight** **1. Community Advocacy** • Increased provision of health and social care services • Improving affordability of and access to housing • Better transport infrastructure and public transport • Re-establishing liaison between agencies responsible for public safety • Provision of Speech and Language Therapy locally • Repairs to pavements and bridges that connect the area to West Oxfordshire • Reviewing refuse collection arrangements **2. Coordination** • Improving coordination and sharing of resources between local groups and organisations around schemes timings, promotion and publicity, outreach of activities and volunteering • Improved grant funding for development work • Improvements to local enterprise support • Availability of local and low-cost activities for people unable to work because of age or disability • Improved money and welfare advice • Coordination of the many projects aimed at reducing food poverty and food waste in the area • Improved provision of leisure and outdoor pursuits for children and young people • Use of volunteering to increase capacity for existing projects and as a strategy for improving accessibility of projects by diverse communities • Using Local Area Coordination and Social prescribing to link people to informal support sources **3. New initiatives and development** • Bringing social housing tenants together to unite different elements of the community and to surface common issues • Development of social spaces and recreation areas on the sites of some blocks of social housing • Developing a community space for residents own use

	• Support for local organisations to increase outreach and satellite projects • Exploration of the availability of vacant spaces owned by Oxford University for community use

Next Steps and Sustainability

Action Planning

17. An action plan is being developed for each area that is linked to the outcomes from the insight in each profile. The steering groups are working together to take these forward recommendations with support from the Community Health Development Officer in Littlemore and in Central Oxford.

Community Health Development Officers

18. Community Health Development Officers, funded by Oxfordshire County Council, and hosted by relevant City and District Councils are working with local partners and residents to develop and support initiatives to improve the health and wellbeing of the communities that they are working within. These posts help to develop community resilience and bring sustainability to this in-depth community work.

Grant Funding

19. 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 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 Oxford City Council 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.

20. We are working closely with colleagues in the Well Together Programme which is also disbursing grant funding in these areas through a community capacity building approach. We are aiming to ensure that there is a joined-up approach between our activities, to build on and complement each other's programmes, and establishing a coordinated process for local organisations putting in bids for funding.

Evaluation

21. A joint evaluation of the Community Health Development Officer programme and the Well Together Programme is underway, led by researchers from Oxford University. The evaluation report, expected in December 2024 will

capture successes, challenges and learning from both programmes. It has been jointly funded by Oxfordshire County Council and the NHS Integrated Care Board, to understand more about the effectiveness of both programmes in addressing inequalities, as well as to explore how both programmes link with the wider prevention system.

Community Profile Interactive Dashboard

22. We have started to develop a web based interactive community insight profile dashboard covering all the areas where community profiles have been developed. The aim of dashboard is to improve accessibility by providing easy to find information to influence the work of partner agencies and to support with the data requirements for local grant applications by groups in the community. It will increase the impact of community profile resources, and improve efficiency by offering automatically updated quantitative data on the areas where profiles have been developed.

Phase 4

23. We have now started Phase 4 of the community profiles which take the learning from the above work, but moves us beyond the 10 initial areas to other geographical areas where health inequalities exist, including some more rural areas. This will include a selection of areas across the county that have areas that are ranked in the 30-40% most deprived nationally and may be at risk of poorer health outcomes. The areas include:

- Berinsfield (South Oxfordshire) – due for completion spring 2024
- Wood Farm (Oxford City) – due for completion by March 2025
- An area in Witney to be confirmed (West Oxfordshire) due for completion by March 2025
- Bicester West (Cherwell) – due for completion by June 2025

Corporate Policies and Priorities

24. 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

25. The funding for these two profiles and associated grant schemes in Phase 3 originally came from within the Public Health grant (Wider Determinants cost centre) and were paid over to the City Council to manage in March 2023 for Littlemore and June 2023 for Central Oxford. Details are shown within the table below.

Littlemore Profile FY 2022-23	

Community insight	£5000
Project management	£5000
£25,000 for community grants	£25,000
	TOTAL £35,000
Central Oxford FY 2023-24	
Community insight	£7500
Project management	£4999
£25,000 for community grants	£25000
	TOTAL £37,499
Overall funds transferred for the Phase 3 profiles and associated grant schemes	**TOTAL £72,499**

Comments checked by:
Stephen Rowles – Strategic Finance Business Partner

Legal Implications

26. There are no legal implications associated with this report.

Equality & Inclusion Implications

27. 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

28. There are no sustainability implications to note with this report.

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

Annex 1: Littlemore Community Profile
Littlemore Community Profile Summary of findings:
Littlemore_CommunityProfile_Summary.pdf (oxfordshire.gov.uk)

Littlemore Community Insight Report:
Littlemore_CommunityProfile_Insight.pdf (oxfordshire.gov.uk)

Data for Littlemore:
Littlemore_CommunityProfile_Data.pdf (oxfordshire.gov.uk)

Annex 2: Central Oxford Community Profile
Central Oxford Community Profile Summary of findings:
CentralOxford_CommunityProfile_Summary.pdf (oxfordshire.gov.uk)

Central Oxford Community Insight Report:
CentralOxford_CommunityProfile_Insight.pdf (oxfordshire.gov.uk)

Data for Central Oxford:
CentralOxford_CommunityProfile_Data.pdf (oxfordshire.gov.uk)

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March 2024

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Health and Wellbeing Board
14 MAR 2024

Developing a place-based approach to research across Oxfordshire

Report by Adam Briggs, Deputy Director of Public Health

RECOMMENDATION

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

To DISCUSS and COMMENT on the development of a place-based approach to research across Oxfordshire, including how to best involve and work with HWB members and to support the delivery of the Health and Wellbeing Strategy.

Executive Summary

2. This paper summarises why research is crucial to the work of local government to improve health and tackle inequalities in Oxfordshire. The paper asks for to HWB comment on the development of a place-based approach to research across the county.

Background

3. At times of resource constraint, the use of research and evidence becomes increasingly important to prioritise scare funds. By using high-quality, systematic research to unpick why different approaches work for different populations and in different settings, local government can make better use of limited resources to deliver improved health outcomes for everyone in Oxfordshire.

4. Oxfordshire's communities and residents are critical to the development of a place-based approach to research. To help develop this, Oxfordshire Community Research Network (OCRN) was launched in March 2023 and is funded by UK Research and Innovation (OCRN was one of 25 successful collaborations out of 291 applications)
    a. The OCRN is made up of local community and volunteer groups, as well as council representatives and public involvement leads from across the universities and hospital trusts. The OCRN has agreed it's three key objectives: delivering community-led research; supporting research prioritisation; coordinating public and community involvement in research.
    b. HealthWatch Oxfordshire have completed an extensive review of community research activity across Oxfordshire, making recommendations for improving community research in the county.
    c. The network is starting the development of its community research strategy and designing its staffing requirements. The network has also recently identified an evaluation partner to help identify what's working and how things could be done better.
    d. OCRN has recently received a six-month £25k funding extension to support community research workshops and an external evaluation of the network's

development and related activities. Following this, the Network will apply to UKRI for up to £1m over five-years to further develop its work.

e. OCC has also successfully been awarded an Oxford Policy Engagement Network Fellowship in partnership with Nuffield Department of Primary Care, University of Oxford to help with network's design and expansion.

5. Oxfordshire has two internationally recognised universities and two major academic NHS trusts. Oxford Brookes University and the University of Oxford both have strategic ambitions to work more closely with local communities and local councils to support wellbeing and tackle inequalities in Oxfordshire.
    a. OCC has been working closely with central administration teams at Oxford Brookes University and University of Oxford to support a place-based approach to research in Oxfordshire.
    b. As part of this commitment, OCC is partnering with University of Oxford and with Oxford Brookes University to create a Local Policy Lab. The Local Policy Lab will support an annual cohort of graduate students to spend 6-8 weeks tackling policy-relevant research questions based in or with local government (OCC or district councils). The Local Policy Lab initiative is being launched on 18th March, 2024 with projects starting from late April. Projects will focus on climate policy and on the wider determinants of health and tackling inequalities. Students will be supported by university staff working in partnership with council staff. Research topics will be proposed and prioritised by local authorities working in partnership with the CRN to ensure that policy labs focus on policy-relevant research that matters to residents (annex 1).

6. Oxfordshire County Council is embarking on the development of a cross-council research strategy, to be led by a new OCC Head of Research (figure 1). The strategy will develop a programme of research to allow OCC to work with colleagues across community, academic, health, governmental and business organisations locally, regionally, and nationally to make better use of our unique assets. These include our community relationships, data, services and staff. Work to embed research across OCC includes implementing a new Research Strategy Board, putting in place the necessary governance and assurance processes, and creating a range of training and professional development opportunities.

Figure 1. Four pillars of an OCC research strategy

Corporate Policies and Priorities

7. This work in consistent with a range of OCC corporate priorities and the aims of the Health and Wellbeing Strategy, including improving health and wellbeing, and tackling inequalities.

Financial Implications

8. Progressing the plans in this report will include applying for external research funding – leveraging some of the £40bn+ invested in research in the UK each year. For example, OCC has recently secured funding from the NIHR Applied Research Collaboration Oxford and Thames Valley for a new two-year social care research post.

Legal Implications

9. N/A

Staff Implications

10. Development of a place-based approach to research will involve the development of training opportunities for staff, councillors, and residents, and the creation of new posts in local government, NHS trusts, and in universities.

Equality & Inclusion Implications

11. Equality and inclusion is being incorporated throughout this work, and forms a core part of the development and delivery of this programme of work.

Sustainability Implications

12. This work can support the county's wider sustainability agenda by helping understand the breadth of work on sustainability and health. This includes climate being one of the areas of focus for the Local Policy Lab.

Risk Management

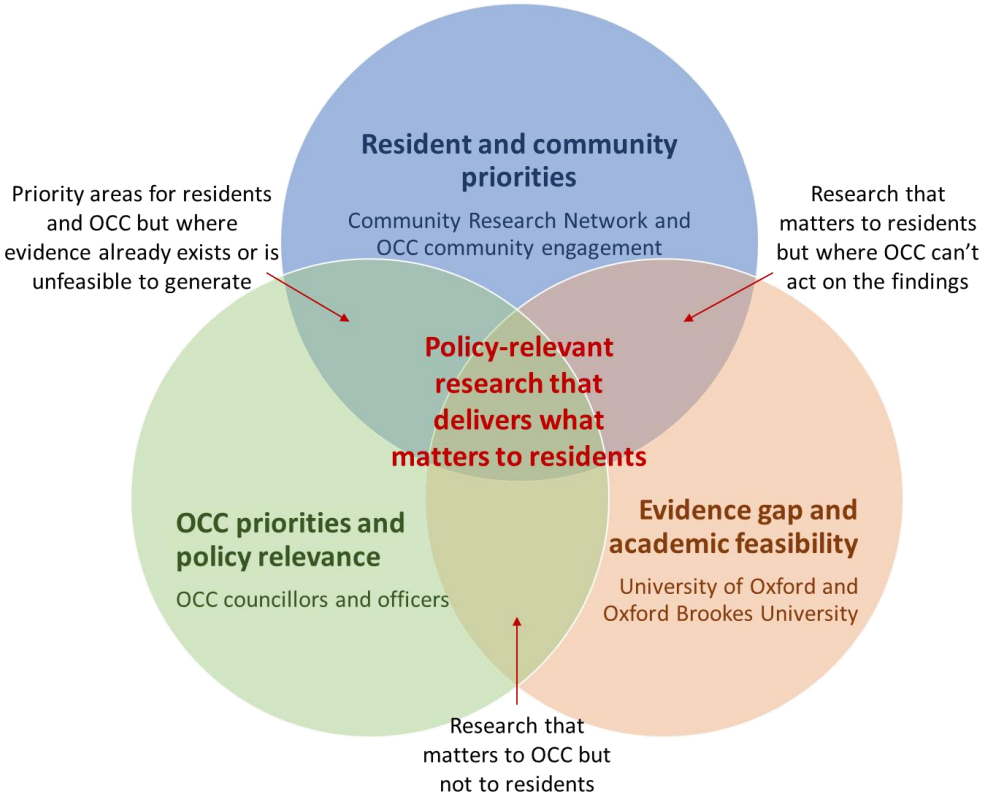
13. The Oxfordshire Community Research Network is currently funded through to Summer 2024 and without ongoing investment or successfully applying for external funding applications there is a reputational risk for OCC and reduce trust from community groups in research and academics.

14. There is a risk that research insights do not directly impact local decision making and improve health outcomes. This is mitigated by working across OCC and with communities to ensure that research is both policy relevant and matters to people in Oxfordshire.

15. Research funding applications are very competitive and have no guarantee of success. Closer partnership working between communities, councils, academics and NHS trusts will ensure that funding applications have the best possible chance of success, learning from the expertise available in the county.

Lead officer: Adam Briggs, Deputy Director of Public Health
adam.briggs@oxfordshire.gov.uk; 07917 534370
SLT member: Ansaf Azhar, Corporate Director of Public Health and Community Safety
March 2024

Annex. An illustration of how to identify policy-relevant research that matters to residents



Oxfordshire Health & Wellbeing Board

14 March 2024

Buckinghamshire Oxfordshire & Berkshire West Integrated Care Board (BOB ICB) Primary Care Strategy

Louise Smith, Deputy Director Primary Care BOB ICB

Action Required

The Oxfordshire Health & Wellbeing Board are asked to:

- Note the work undertaken by the ICB and Partners to develop the Primary Care Strategy
- Discuss the content themes and any further points for consideration and/or of concern.

Executive Summary

The BOB ICB draft Primary Care Strategy is presented to the Oxfordshire Health & Wellbeing Board as part of the ICB's commitment to ensuring the contribution and engagement of system partners and the public in the development of its Primary Care Strategy.

Since July 2023 BOB ICB has been developing its Primary Care Strategy informed by research, analysis and engagement. The document in draft form sets out details of the ambition for a new model of primary and community-based care also outlined in our Integrated Care Strategy (published in March 2023) and the Five Year Joint Forward Plan (published in July 2023). This is set in the context of a clear national and global direction of travel for Primary Care, including the Fuller Stocktake, which describes how primary care should streamline access, provide continuity of care and focus more on prevention.

Integration is at the heart of the model and the high-level priorities are below.

- Everyone who lives in BOB to be able to receive the right support when it is needed and with the right health and/or care professional. Our communities are finding it difficult to get an appointment in General Practice or with an NHS dentist, and this needs to change.
- Integrated Neighbourhood Teams to care for those people who would benefit most from proactive, personalised care from a holistic team of professionals, for example those at most risk of emergency hospital admissions.
- To help communities stay well with an initial targeted focus on our biggest killer and driver of inequalities, cardiovascular disease.

Moving towards a more community-based and preventative health and care system will require a fundamental shift of activity, resource and funding, and the changes in the strategy are intended to support that shift.

In developing our Primary Care strategy, we have engaged with many stakeholders across the system in a variety of ways including focus groups, surveys and workshops. The wealth of insights from this engagement as well as supporting documents such as the Current State Report and Good Practice Report have informed the current version of the Strategy that was published on the ICB engagement portal on 10 January 2024.

Following feedback that there had not been adequate time for engagement and for all voices to be accurately reflected, the ICB committed to a structured programme of further engagement that is now coming to an end. There will be a whole system workshop including actions to progress on 20 March followed by ICB Board final sign off in May 24.

Additional papers used to inform the strategy document (available on request or through the engagement portal):

BOB Current State Report

BOB Good Practice Report

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

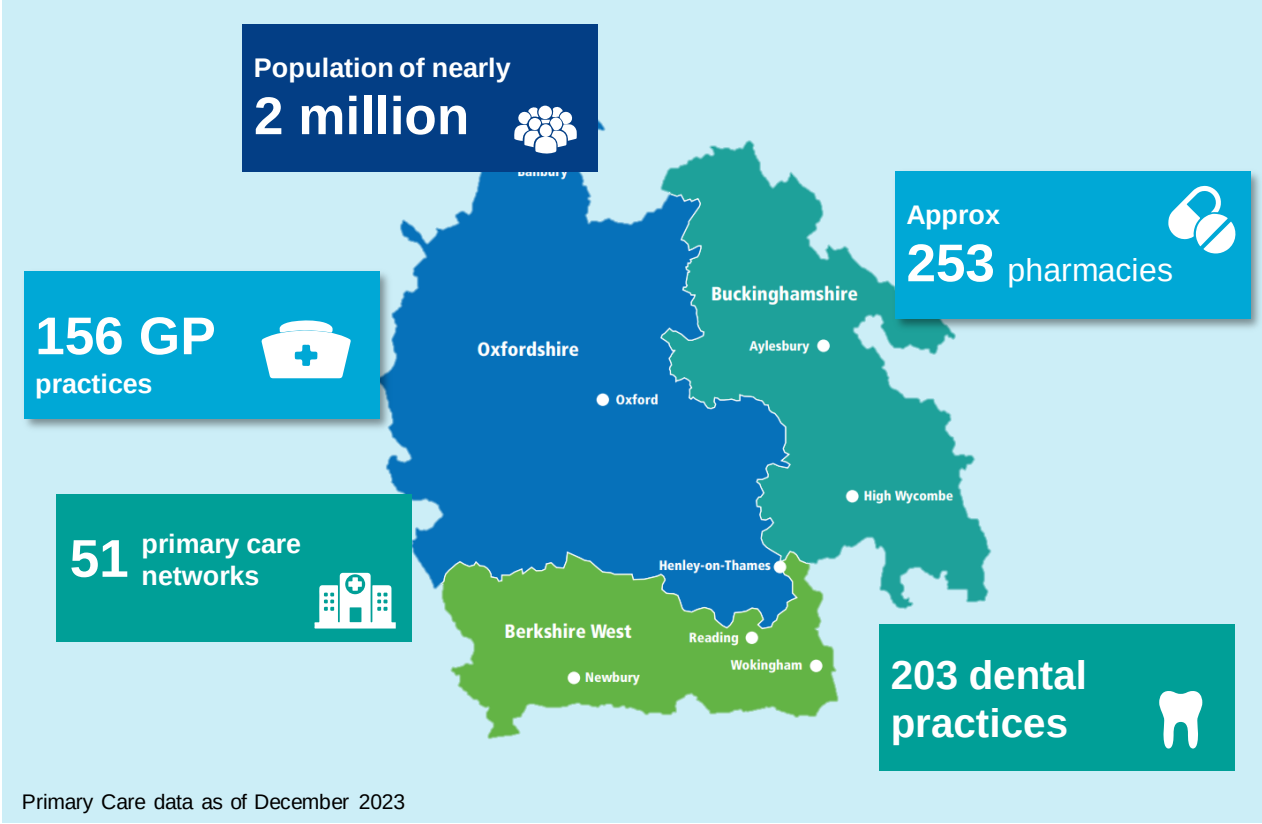
Transforming Primary Care – Executive Summary

General Practice, Community Pharmacy, Optometry and Dentistry

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Why we need a primary care strategy

Primary Care includes General Practice, Community Pharmacy, Optometry and Dentistry services. These services provide the first point of contact, have an ongoing connection with local communities, and lead on improving the 'whole person' health of our population.

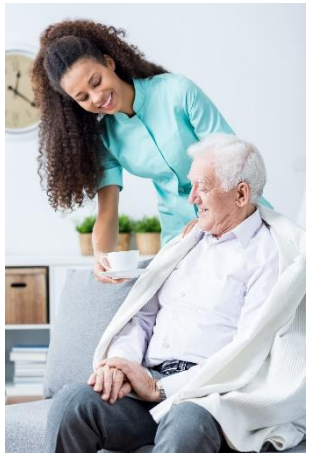


Primary Care data as of December 2023

- BOB ICS is putting primary care at the heart of our transformation, to deliver our vision set out in the Integrated Care Strategy:
- ***Everyone who lives in BOB should have the best possible start in life, live happier, healthier lives for longer and be able to access the right support when they need it.***
- We currently deliver some outstanding primary care, but services are under considerable pressure. We have inequalities in outcomes for our patients, workforce gaps and high workload.
- A national direction has been set to integrate Primary Care provision. We have developed this strategy to **address the challenges we are facing in Primary Care and improve integration between all of our pillars in Primary Care** and how they work together to deliver the new model of care. This strategy will also cover how Primary Care will work with system partners such as community services, to deliver our future vision. Therefore, this strategy is aimed at multiple different audiences – people who use Primary Care services, our staff who work in Primary Care as well as wider system partners, who will contribute to improving integration and collaboration to move to a more sustainable Primary Care system.

Approach to developing this draft strategy

This strategy builds from national guidance and our own local plans. We have carried out extensive engagement and analysis to inform the development of this draft primary care strategy, which we now want to refine through further engagement with system partners and those who live and work in BOB.



2022

National guidance such as The Fuller Stocktake

Spring 2023

BOB Integrated Care Strategy and Joint Forward Plan

Summer 2023

Focus Groups and Surveys

We carried out focus groups with key stakeholders - General Practice, Community Pharmacy, Optometry, and Dentistry and surveyed all pillars of Primary Care for their views.

Research on good practice

We researched global, national and local examples of good practice delivery of Primary Care services within other systems and within BOB.

Autumn 2023

System-wide workshop

Bringing together over 130 stakeholders from across the system to discuss the future vision and opportunities for Primary Care.

Data Analysis

We have analysed available data to understand how people in BOB are using services today as well as what our workforce looks like.

Winter 2023

Current State Report

Compiles documents, good practice, data analysis and views from engagement order to describe BOB's Primary Care Landscape.

Ongoing engagement

Feeding in all our research and engagement so far, we started to draft the strategy and continued to meet with key stakeholder groups to get their input and feedback.

January 2024

First draft of the Primary Care Strategy

This document summarises the key challenges facing Primary Care and how we plan to address these through a change in our model of care. We will continue engaging with system partners' and the public to hear their views.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our primary care system has many strengths

There is much outstanding practice across primary care in BOB, and unique capabilities across its Places. Below are five highlights where the system has particular strengths that can be built upon.

01

General Practice access and quality metrics in line with or above the national average

The proportion of GP appointments seen within 14 days is **higher** than the national and regional average. Most GP practices have either good or outstanding CQC ratings. Quality and Outcomes Framework scores are just above average.

02

High uptake of the Community Pharmacy Consultation Service

BOB has the **third highest** number of referrals (per population) to the Community Pharmacy Consultation Service across the Southeast region. 122 of the 156 GP practices are 'live' and referring their patients to community pharmacists, with a further 27 preparing to start using this service (as of December 2023).

03

Strong focus on inequalities, prevention, and wider determinants of health

All three Place-based Partnerships have focused on this. For example, 'Opportunity Bucks' targets the 10 most deprived areas in Buckinghamshire. Oxfordshire work focuses on specific communities such as people who are homeless. In Berkshire West community outreach is focused on reducing premature mortality.

04

Population Health Management Infrastructure

In parts of BOB, the Connected Care model has been developed with the addition of Population Health Management tools and is enabling people to be directed to the most appropriate health and care service, based on their needs. This supports better triage and navigation, identification of people who would benefit from intensive case management, and ability to design prevention interventions.

05

Flexible dentistry commissioning for our most vulnerable populations and extended commissioning for Minor Eye Conditions

BOB has started a pilot for flexible commissioning, where 10% of the contract can vary depending on local needs. This has enabled practitioners to service patients from under served communities who require dental care. Additionally, there has been great uptake of the referrals to the Minor Eye Conditions service and patient feedback has been positive.

06

Strength of existing at-scale delivery structures

Each Place has a Placed-Based-Partnership (including local authorities, VCSE and others) which can drive and deliver transformation and integration at a local level. There are evolving Federations of General Practices established in each Place – FedBucks, PML in parts of Oxfordshire and the Primary Care Alliance in parts of Berkshire West that can lead change and deliver services for a large part of the population.

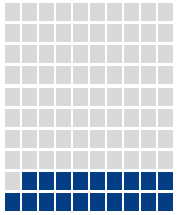
1: NHS Digital (2023); 2: Primary Care Access and Recovery Plan (2023); 3: Brookside Case study – Segmentation in Primary Care (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

There are challenges within primary care and within the wider system that require new ways of working

Demand for primary care outstrips current capacity and inefficiencies are created (for patients and staff) where the parts of the system do not work well together. The challenges require a system response, they cannot be solved by primary care alone.

01 People report a worsening experience of accessing primary care



Since 2021, there has been a 19% decrease in positive responses with regards to the overall experience of booking an appointment.[1]

19% said there were no dental appointments available or said that the dentist was not taking on any new patients.[2]

02 Many primary care staff feel they are under extreme pressure

BOB LMC data shows that GPs are responsible for more patients, and are spending a large proportion of time on administrative tasks relating to how patients move between parts of the system. [3]

Multiple respondents to the BOB dental survey said they are under extreme pressure due to demand much greater than capacity, lack of funding and recruitment and retention challenges.

03 This is driven by a mismatch between demand and capacity across the system

BOB's growing population and changing demographic profile is increasing demand for primary care services - more than one in four of the adult population live with more than two long term conditions.[5]

14 community pharmacies closed in 2023 and 16 out of 20 100hr pharmacies reduced their opening hours (mainly the 9pm-12am slot).[6]

04 Capacity is difficult to grow due to funding, recruitment, retention and estates challenges

In the Community Pharmacy workforce survey, 67% of respondents said it is very difficult to fill vacant roles for pharmacists.[7]

There are estates pressures across the system for example, in Bucks, approximately 570,000 patients are served by a primary care estate of approximately 24,121 m^2.

1: National GP survey results, 2023; 2: BOB GP Patient Survey Dental Statistics 2023; 3: BBOB LMC The Health of General Practice in BOB; 4: BOB Primary Care Assurance Report 2023/24 Quarter 2 (2023); 5: BOB Joint Forward Plan (2023); 6: Buckinghamshire Executive Partnership Report on Primary Care July 2023; 7: Community Pharmacy Workforce Survey 2022; 8: OCCG Primary Care Estates Strategy (2020)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our shared system vision for primary care

The challenges – and opportunities – facing primary care result from complex system-wide factors and a whole system response is required. BOB's Joint Forward Plan commits the system to developing new models of care and primary care is at the heart of that. This is our future vision for primary care, but it requires other system partners to also work differently to deliver it.

Our Shared Vision:

Everyone in BOB has the support they need from primary care, working within a coordinated and integrated health and care system that supports people to stay well.

Model of Care

Primary Care

General Practice	Pharmacy	Optometry	Dentistry
We ensure people get to the right support first time to meet their needs	We provide personalised, proactive care for people with complex needs, supported by Integrated Neighbourhood Teams	We design targeted support for everyone to stay well by understanding our population by a review of the information	

Enablers

Workforce – Multi-skilled extended primary care teams work in an integrated way, at the heart of the system, and as part of integrated neighbourhood teams; flexible working is maximised; and workforce wellbeing is prioritised

Digital and data – Shared patient records are being used across the system to aid safe and effective clinical decision making based on real-time information

Estates – We are making the best use of Public Estate and community assets to support primary care delivery.

Resourcing – Resources have shifted from hospital settings into community settings and our contracts are joined up and based on outcomes that integrated services deliver.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We ensure people get to the right support first time to meet their needs

Our vision is that people who contact the health system will be directed to the right health and care support to meet their needs first time – so that might not necessarily be a GP but the right health care professional and in the right place.

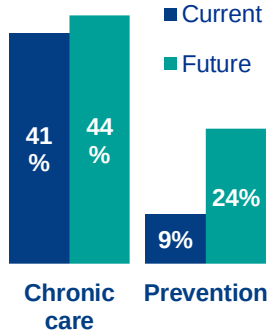
The challenge today – using General Practice as an example

People report a worsening experience getting to the primary care support they need and are frustrated when they feel they are 'bounced around the system'.

Across BOB, patients having a good experience of making a GP appointment has decreased by 19%

Staff feel under extreme pressure and some of the burden comes from a lack of smooth processes as people move between different parts of the system and can end up requiring multiple appointments before they get to the right place.

Staff in General Practice in BOB would like to spend more time on prevention and chronic disease management:



When people find it difficult to get a GP or dentist appointment, they report that they sometimes go to A&E.

In the BOB ICS GP National Survey, people said:

10% went to A&E when they couldn't get a GP appointment

30% visited A&E instead when the GP practice was closed

Our future vision

Self-management

Supporting all our communities to access the high-quality information available on the NHS website.

Signposting to this from community centres, health services, GP websites and apps, and through targeted outreach.

Triage & navigation

When people request support (e.g. through GP online form, by calling 111) care coordinators can triage the request – with clinical supervision – and direct it to the right place.

Supported by digital triage tools, some of which use Artificial Intelligence, and backed by Population Health data that helps teams understand the health needs of the person requesting care.

Initial contact

Initial contact is with the right professional / service, which could be a virtual or face to face appointment with a (for example):

- ✓ GP, Nurse, Physio or other staff member
- ✓ Community Pharmacist, Optometrist or Dentist
- ✓ Urgent Care/Treatment Centre for minor injuries
- ✓ Weight management, audiology, or podiatry service
- ✓ VCSE and mental health services

Supported by digitally-enabled communication between these different clinicians and services.

1:BOB GP National Survey (2023); 2: Survey shared with General Practices across BOB as part of Primary Care Strategy work

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We provide personalised, proactive care for people with complex needs, supported by Integrated Neighbourhood Teams

Our vision is to have Integrated Neighbourhood Teams (INTs) made up of professionals from a range of disciplines, operating at the appropriate scale, to support people with more complex needs to stay well in their communities.

The challenge today

People's health needs are changing and many live with multiple long term conditions where traditional disease-specific care is not the best model.

"More than one in four of the adult population live with more than two long term conditions"[1]

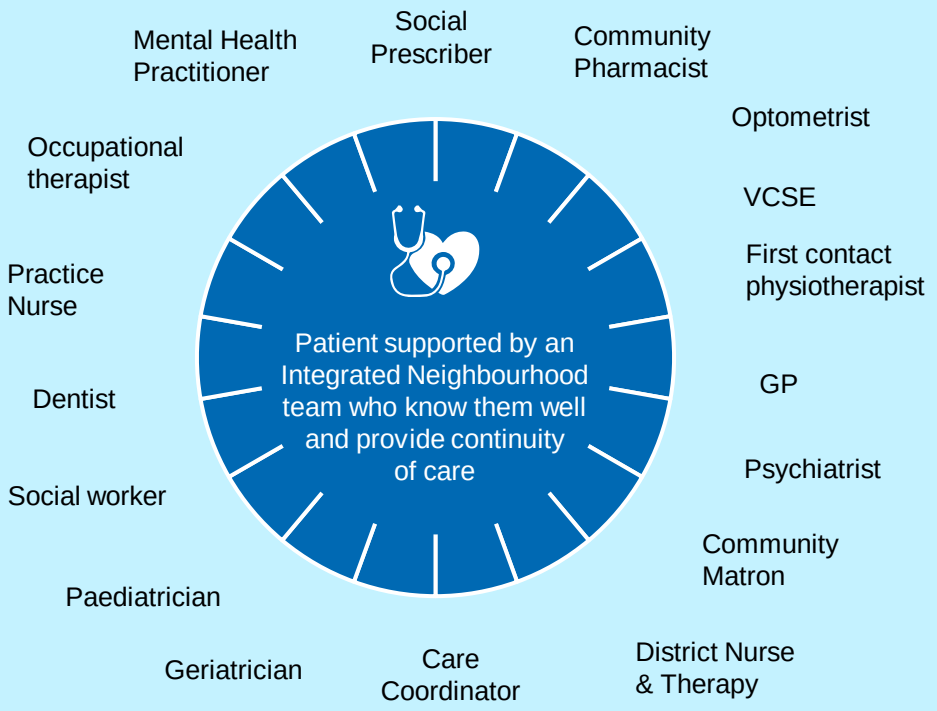
Many issues that affect people's health are not purely medical and require input from multiple parts of the public sector, for example housing, benefits.

"The Buckinghamshire population have higher levels of social isolation"[2]

Where people's needs are not well-managed, they often end up requiring more urgent and costly treatment, that doesn't provide a positive experience or improve longer term outcomes. Groups from more deprived areas tend to end up using the emergency care system more.

"Higher acuity patients now make up a greater proportion of A&E activity than 4 years ago"[3]

Our future vision



Team of colleagues from a range of contributing organisations

To manage the challenges on the left, we need to move towards a more community-based model. This will require the system to shift resource from secondary care into the community and will impact the way the whole system works, especially secondary care with Primary Care. INTs will be the delivery vehicle for this model and our specialist workforce e.g. secondary care consultants, mental health, social care providers, VCSE sector, primary and community care, will have a key role to play in the INT. We will need to ensure job plans are aligned and resources and time commitment are agreed upfront.

INTs will support a defined group in the population who have complex needs and are at risk of experiencing the poorest outcomes. They work together with the individual to develop and deliver a personalised care plan, making sure they can access the support (medical and non-medical) they need.

System partners work together to provide resources (staff, estates, funding) to these teams that come together regularly (daily or weekly), virtually and physically.

The footprint for these teams will be determined locally – with input from a range of system partners – using population health data to identify cohorts who will benefit the most.

1: BOB Joint Forward Plan (2023); 2: BOB fact pack and BOB Integrated Care Strategy (2023); 3: BOB ICB ECDS Data V2 (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We design targeted support for everyone to stay well by understanding our population by a review of the information

Our vision is to share and use data to inform targeted approaches to improve our population's health, working in partnership with our Local Authorities and making every primary care contact count.

The challenge today

- 60,000 living in a deprived area, who develop poor health 10-15 years earlier than those in less deprived areas.
- Approximately 11% of BOB's population are active smokers, with nearly 8% of pregnant women actively smoking.
- Across BOB, 3 in 5 adults are overweight or obese. 68% of adults with a learning disability are overweight.
- Nearly 18% of BOB's population undertake less than 30 minutes of physical activity per week.
- In BOB, there were 115k alcohol attributable admissions to hospitals between 2016/7 and 2020/21.

Our future vision

Primary Care supports people from the beginning to the end of life, and prevention and health promotion are key throughout. Whether it's stopping people becoming unwell in the first place, preventing ill health progressing, or minimising the impact of poor health.

All four Primary Care pillars – General Practice, Community Pharmacy, Optometry and Dentistry – have a critical role to play in prevention activities and the promotion of living a healthy life in local communities. With the right data being shared and discussed between all system partners, including Local Authorities, there is an opportunity to maximise preventative activities and deliver more personalised care. These include opportunistic activity – like blood pressure monitoring during eye checks, and proactive activity – like community pharmacy reaching out to those who may have undiagnosed high blood pressure, or dental checks in early years settings. There is also an opportunity to tackle the social, economic and environmental factors that affect health by supporting people to live healthier lives – like increasing access to tobacco dependency services and weight management services. However, we recognise the need to release capacity, before we can optimise our workforce's full potential to deliver more preventative activity. Our future integrated model of care should help overcome this barrier.

In order to make and sustain a shift towards a more preventative system, we will use data to drive our decision making. We will embed a strategic and system-wide Population Health Management (PHM) approach to allow us to understand the health needs across our system and identify our most vulnerable and at risk groups - those who experience the poorest outcomes and inequalities. With this understanding, we will work with communities to design the right support for the population group we are looking at. We'll evaluate and scale what works and stop or change what doesn't.

1: BOB Joint Forward Plan (2023); 2: Fingertips Public Health Data (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Four enablers are essential to delivering this vision

Focusing on the activities described over the next two pages should be a priority for the system, as workforce, digital and data, estates and resourcing are critical to deliver the future model of care.

Workforce

- Fully understand current and future workforce skills gaps and challenges around recruitment and retention particularly in rural areas
- Develop longer term local plans, building partnerships to develop a sustainable supply of locally recruited and trained staff.
- Maximising uptake of apprenticeship roles developing the workforce through the apprenticeship levy.
- Expansion of the coaching and mentoring and 'looking after you' programmes for all primary care staff and ensuring access to health and wellbeing support.
- A greater focus on continuous professional development and protected learning time across primary care. Specific learning being commissioned according to training needs analysis, local and national priorities.
- Enable staff to move seamlessly between provider organising using the 'BOB' staff passport' making shared and rotational roles much easier, which in turn results in an increase in staff retention as they have a better employment experience.
- Looking at Dentistry specifically, exploring different types of contract models to encourage recruitment, reviewing the skill mix model to align with new prevention priorities and the training required for this, and review of commissioning training courses to grow dental workforce.

Resource

- In common with the rest of the country, funding is constrained in BOB Integrated Care System, and we need to look at ways to use the existing resources we have differently. Where possible, will look at how we use funding to focus on areas of higher deprivation.
- We know that other systems globally that achieve excellent outcomes for their populations have health and care systems that spend a far greater proportion of their budgets on primary care activities than we do, and this is a shift we are committed to making in BOB.

We plan to do this in two ways:

- By changing the location and type of work our staff do, regardless of who they are employed by. For example, a respiratory consultant spending time each week with an Integrated Neighbourhood Team supporting people experiencing breathlessness.
- By changing the way we commission services so that we consolidate funding to support providers working together to deliver the best outcomes for a defined population – we will begin piloting this approach in 2024.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Four enablers are essential to delivering this vision

Digital & data and estates are key enablers to underpin the successful delivery of our future model of care.

Digital and data

Enhancing our digital capabilities across the system will enable us all to work differently, release capacity by minimising existing administrative pressures and ensure people have a more seamless journey through the system. Building on the ICB's Digital and Data Strategy we will:

Digitise Our Providers – deliver the minimum digital foundations across our providers

- Optimise digital triage tools within General Practice to free up time for staff from manual administrative tasks e.g. processing incoming requests for patients. This will include training for both clinical and administrative teams to ensure they get the full benefits out of digital tools.
- Carry out engagement on the requirements of GP principle clinical systems in readiness for the closure of the GP IT Futures framework that will support the ongoing development of our Electronic Patient Records.

Connect Our Care Settings – use digital, data and technology to connect our care settings

- Enable providers both within primary care e.g. GP, community pharmacy, optometry, dentistry and between primary and secondary care to digitally share patient records. This capability should support effective clinical decision making and enable smooth navigation of patients to the right part of the system.
- Sharing information in this way will reduce administrative burden e.g. for primary care teams, and empower secondary care providers to update medication changes on discharge from care automatically via the NHS Electronic Prescribing Service (ePS) and send a notification to the patient's pharmacy to dispense medication in the community.
- Unlocking interoperability and shared record capabilities will support other digital technologies such as remote monitoring tools to empower patients, and their carers, to play a greater role in their care.

Transform Our Data Foundations – deliver the data foundations to provide the insights required to transform our systems and better meet the needs of our population

- Continue to spread and scale the existing Population Health Management infrastructure that exists in BOB across the entire system.
- Advance our data sharing agreements so we continue to benefit from the capabilities within the Thames Valley and Surrey Shared Care Record, and continue to work with clinical system providers to enable data sharing features within the BOB system.

Estates

- Make greater use of virtual consultations and 'hub working' (with multiple professionals in same space) for non-complex same day care.
- As part of the ICB plans for a shared estates strategy, set a clear expectation that both same day access hubs and Integrated Neighbourhood Teams should make use of the best available public estate. For example, this could mean a same day access hub located at an Urgent Care Centre, or an INT located in a community health centre.
- Explore opportunities for partnership working between the ICB, Primary Care providers and wider local system partners, in particular local councils, to optimise use of public sector estate and community assets, and take opportunities to put health on the high street

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our approach to delivering this strategy

We are committed to ensuring this strategy turns into action and makes a difference to people living in BOB. The ICB will oversee delivery of the strategy at a local level, whilst empowering our staff working in primary care and system partners to make the required changes. These principles underpin our approach to delivering this strategy.

1 Create Focus

To achieve our vision, we need to prioritise a small number of high impact actions. Acknowledging our system is under pressure and capacity is limited, the actions we focus on must have the biggest impact on the challenges we are trying to address.

2 Delivery Programme Approach

Our delivery approach is underpinned by the continuous improvement principles outlined in NHS IMPACT. This approach will be bespoke for the three priorities and enable teams to:

- ✓ Understand the problem and biggest opportunities for improvement
- ✓ use data to drive decision-making
- ✓ test small incremental changes for our priority actions
- ✓ share learnings and learn from experience
- ✓ Create a 'bottom-up' culture of improvement

3 Local Design

Primary Care is a complex landscape of mostly independent contractors which means we cannot implement a "one size fits all" model. We need to ensure the detailed design of the model of care takes place at a neighbourhood level, where those working on the frontline of Primary Care are making the decisions, with their communities, about changes in the way we work.

4 ICB Support

We recognise the need for the ICB to lead delivery of the strategy and to support the changes in the way we work. The ICB will act as a "convenor", bringing together Primary Care with system partners to have meaningful discussions on how we deliver our priority actions and better meet the needs of our population. Further support will be given in enabling areas such as workforce, to ensure neighbourhoods are supported to drive the changes.

5 System partner Support

To deliver this strategy and enable a shift in the model of care, all system partners will be required to work in new and innovative ways. For example, acute providers will need to identify members of their workforce who can work in the community alongside primary care colleagues. All partners will need to identify opportunities to work more flexibly and share resources, including estates in new ways.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our priorities for delivery

We have identified three areas where we can make a real impact on improving people's health and wellbeing and reducing pressure on staff. Where possible, we will focus on working with communities that experience the most inequalities. In line with BOB's overall system strategy, we have focused on aligning the priorities with two of our system goals and introducing more joined-up ways of working between services – rather than discrete priorities with one area like dentistry or general practice. The priorities are described in more detail on later pages.

1 Non-complex same-day care

General Practice, Community Pharmacy, Optometry and Dentistry will work together, with 111 and Urgent Care, to **better manage those who require support that day, but whose need is not complex.**

Around 70% of population health need is low complexity, and this makes up approx. 50% of GP activity.

Impact:

- Improved patient experience as they get the urgent support they need.
- Release capacity in General Practice to focus those with more complex needs.

John Hopkins ACG System

2 Integrated Neighbourhood Teams

General Practice, Community Pharmacy, Optometry and Dentistry will work together with community, mental health, acute and VCSE services to provide **proactive, personalised care to a defined population group with more complex needs**, for example, frail older people.

Around 70% of health and social care spending is on long term conditions.

Impact:

- People's health conditions are better managed reducing their need for unplanned hospital care.
- System capacity better coordinated and directed at need leading to greater staff satisfaction

Long-term conditions and multi-morbidity | The King's Fund (kingsfund.org.uk)

3 Cardiovascular Disease (CVD) prevention

General Practice, Community Pharmacy, Optometry and Dentistry will work together with Local Authorities, VCSE and the wider health system to **reduce the risk factors for Cardiovascular Disease (CVD)** including smoking, obesity and high blood pressure.

CVD is one of the most common causes of ongoing ill-health and deaths in BOB.

Impact:

- Reduce 797 heart attacks and 290 strokes (CVD events) in the next 4 years.
- Reduce demand on General Practice and Secondary Care and reduce the overall societal cost.

BOB Size of Prize 2023

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We will continue to focus on other improvements in addition

Our three priorities focus on those areas where we need a system-wide focus to tackle the biggest challenges. There are other areas where work has been and will continue to be undertaken to make improvements to realise our vision. These align with our priorities in the BOB Joint Forward Plan and the Integrated Care Strategy, and we have highlighted a number of areas below.

General Practice

- Support the public to **optimise use of the NHS app** so that they can see their medical records, order repeat prescriptions, manage routine appointments and see messages from their practice.
- **Improve the ways in which patients contact and interact with their GP and navigate care**, including the 111 service - support provided to GPs through national and local improvement programmes.
- Continue to **strengthen the primary care workforce** including recruitment, retention, supporting staff practice to the top of their license.
- **Improve the interface between primary and secondary care –** to streamline processes and touchpoints for patients.

Community Pharmacy

- Roll out of the **Pharmacy First initiative in 2024** so that patients can access prescription-only medicine without needing to visit a GP e.g. for UTI treatment.
- Upskilling of community pharmacists in line with upcoming new policy so that more **pharmacists are able to provide assessments of patients and make prescribing decisions** without patients having seen their GP first.
- Continue to expand vaccination service e.g. flu and covid
- **Expand GP Connect** to enable GP practices and authorised clinical staff (e.g. pharmacy professionals) to **share and view electronic health records information and appointments information.**

Optometry

- **Implementation of an electronic referral platform** which will allow community optometrists to send routine referrals directly to the patients' chosen hospital or single point of access**.**
- **National intent to extend and roll out 'in school' eye testing** in all schools from April 2024, with certain schools given priority for the rollout.
- **National minor eye condition service to be expanded in early 2024** which aims to improve equity and accessibility for patients with most eye conditions seen at eye units and by GPs.

Dentistry

- Further expansion of the Flexible Commissioning scheme which provides **care for patients from underserved communities.**
- Continuing to undertake oral **health assessments and increase dental hygiene in children and young people -** targeting prevention interventions.
- Exploring implementation of **mobile dental units**.
- Building dental clinical workforce resilience
- **Proactive management approach** to dentistry though better oversight of access, quality and performance challenges.

Community

- **Expanding hospital at home approach and redesigning hospital discharge** model - integrating with local councils so more services and care can be moved into the community.
- **Enabling patients to have direct access to community services** such as musculosketal, audiology, weight management and community podiatry without needing to go to the GP first.
- **Improve community-based support for those suffering with Mental Health** e.g. The Thames Valley Link Programme (TVLP) has been established to provide extra support to children and young people who are often described as having 'complex needs' .

ICB and Place support for local delivery

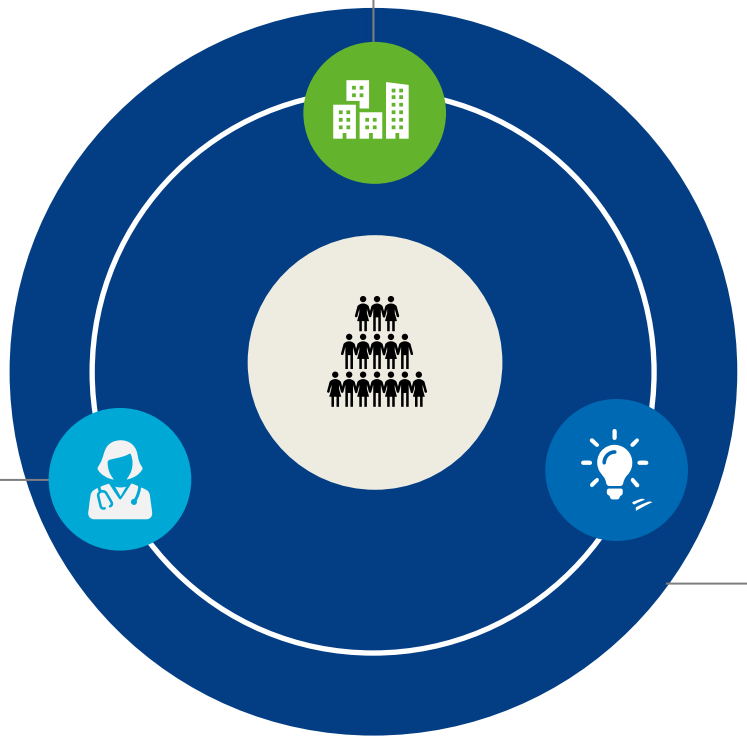
Clinical and operational teams, working with their communities, will be the ones who drive new ways of working. The ICB and Place teams will provide dedicated support to focused Local Action Teams working on our three priorities within an overall Primary Care Delivery Programme.

Place-level

- Place-based Partnerships are **accountable** for delivery of the priorities
- Place Delivery Teams will be established to be **responsible** for delivery and first line of support for Local Action Teams

Local Action Teams

- Clinical and operational teams working with communities
- **Footprint** determined locally as appropriate – could be PCN, Local Authority, other
- **Members** determined and may differ for each priority but include all pillars of primary care and wider system partners
- **Leadership** of teams must be clearly agreed for each priority



The delivery structure will need to align to the overall BOB ICB Operating Model that is being developed.

ICB-level

- The BOB ICB Primary and Community Care Strategic Transformation Coordination Group is **accountable** for delivery of the priorities
- The Primary Care Team is **responsible** for delivery of the priorities, working closely with ICB leads for Workforce, Digital & Data, Estates and Resourcing.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

A phased approach working with cohorts across the three priorities

The Primary Care Delivery Programme will bring together multidisciplinary teams from across Neighbourhood, Place and ICB levels to deliver our three high impact actions, across a three year period. Our Placed-Based-Partnerships will be key to supporting delivery of this approach and driving improvement. Two of our priority workstreams are aligned with our wider system goals on CVD Prevention and Integrated Neighbourhood teams.

Priority workstreams	2024	2025	2026
1 Non-complex same-day care	Cohort 1: March – August 2024, Three sites in each Place	Cohort 2: September 2024 – February 2025, Up to six sites in each Place Cohort 3: March – August 2025, Up to nine sites in each Place	
2 Integrated Neighbourhood Teams	Mobilisation Co-design blueprint of INTs in each Place	Cohort 1: September 2024 – February 2025, Three sites in each Place Cohort 2: March - August 2025, Up to six sites in each Place	Cohort 3: September 2025 – February 2026, Up to nine sites in each Place
3 CVD Prevention		Cohort 1: March - August 2025, Three sites in each Place	Cohort 2: September 2025 – February 2026, Up to six sites in each Place Cohort 3: March – August 2026, Up to nine sites in each Place

'Site' = Neighbourhood level team e.g. Primary Care Network (PCN), or multiple PCNs working together or any appropriate scale at a local level.

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Thank you for reading this draft strategy (summary version).

We are grateful to all those in the BOB Integrated Care System who have helped to shape this draft strategy.

We need your views and feedback to help agree our final strategy, so please do share your thoughts via **engagement.bobics@nhs.net**

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Transforming Primary Care

General Practice, Community Pharmacy, Optometry and Dentistry

We want to hear your views on this draft strategy

This draft strategy is based on research, analysis and engagement carried out in the second half of 2023. We are publishing it in draft form to seek feedback from people living and working in BOB. We would like to hear thoughts on the questions below or any aspect of the strategy.

Challenges	Do these reflect your understanding and/or experience of Primary Care?
Vision	Do you understand the vision and why it is important?
Priorities	Do you think that these priorities will start to address the challenges that have been identified?
Delivery approach	Is there anything additional you would like to see included to enhance the outlined delivery approach?

Foreword

BOB ICS has put the four pillars of Primary Care – General Practice, Community Pharmacy, Optometry and Dentistry at the heart of transformation to deliver a shared ambition and vision for a new model of care and a more integrated way of working across the system.

We are delighted to introduce our draft Primary Care Strategy, setting out how we plan to move towards a more preventative and community-based model of providing health and care services and helping people to stay well in the community. We want to thank our workforce and the public for all the input and feedback that you have given so far.

Our ambition for a new model of primary and community-based care was first outlined in our Integrated Care Strategy (published in March 2023) and then in our Five Year Joint Forward Plan (published in July 2023). Nationally and globally, a direction of travel has been set for Primary Care, including the Fuller Stocktake, which describes how primary care should streamline access, provide continuity of care and focus more on prevention.

We want to improve these areas by better integrating all pillars of Primary Care within our wider system. As a first priority, we want everyone who lives in BOB to be able to **receive the right support** when it is needed and with the right health and/or care professional. We have heard how our communities are finding it more difficult to get an appointment in General Practice or with an NHS dentist, and we are determined to make this better. Alongside this, we will continue to bring together Integrated Neighbourhood Teams to care for those people who would benefit most from **proactive, personalised care** from a holistic team of professionals, for example those at most risk of emergency hospital admissions. We want to help communities stay well and so we will also have a targeted focus on our biggest killer and driver of inequalities – Cardiovascular Disease. All pillars of primary care can make a huge contribution to supporting people to **reduce the risk factors** like high blood pressure.

So far, in developing our Primary Care strategy, we have engaged with many stakeholders across the system including those who work at the frontline of primary care. We understand the pressure on staff, and as we adopt the new ways of working outlined in this strategy, we will track the impact on staff satisfaction. Moving towards a more community-based and preventative health and care system will require a fundamental shift of activity, resource and funding, and the changes in this strategy are intended to support that shift.

Thank you for taking the time to read this strategy, your feedback is essential to help us get this right, so we can produce a final strategy that sets out an agreed shared vision for our system, with the commitment from all partners to the changes needed to get there.

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

Contents

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

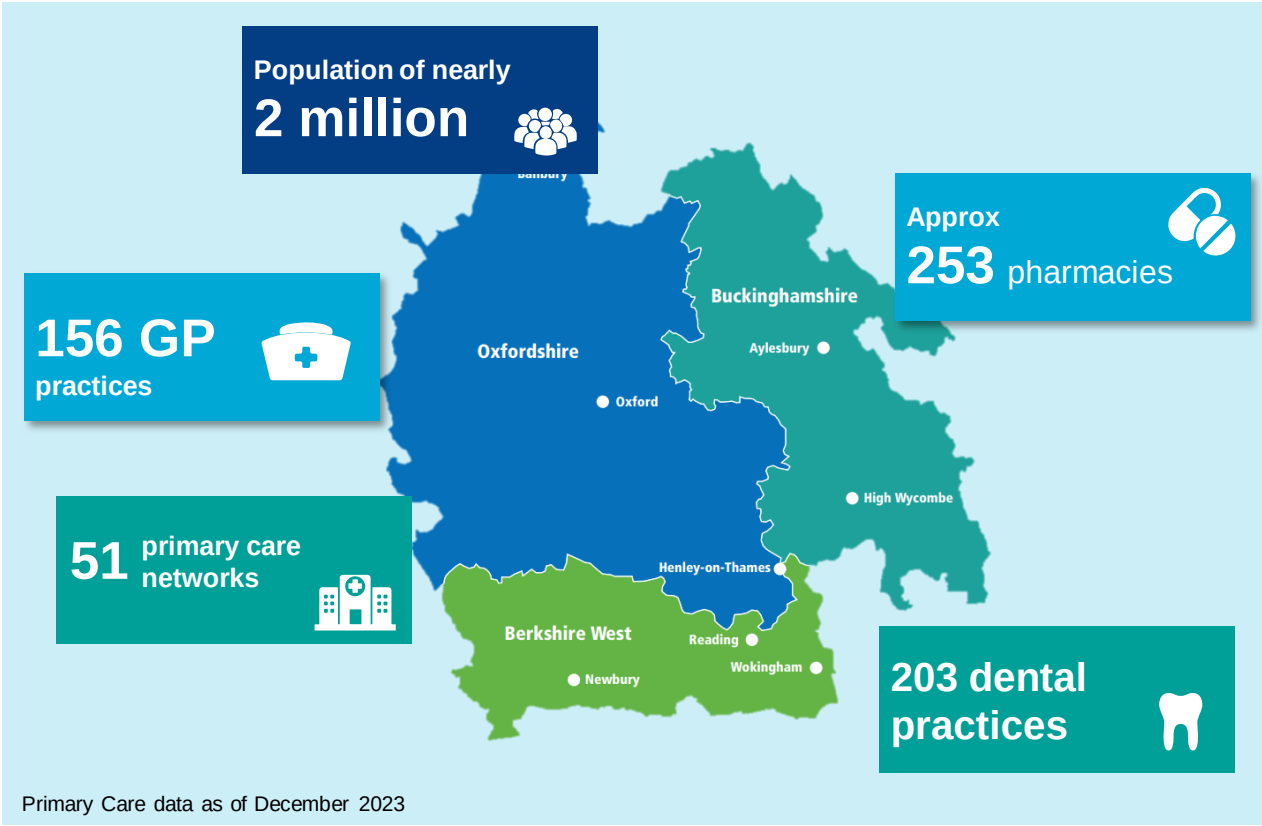
Introduction

This section outlines the work that has been done to date to develop this draft strategy. It describes research and analysis that has been carried out, and engagement that has been undertaken across all system partners and with the public – although this is just the beginning. This draft strategy is being published and shared widely to hear further feedback from people who live and work in BOB.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Why we need a primary care strategy

Primary Care includes General Practice, Community Pharmacy, Optometry and Dentistry services. These services provide the first point of contact, have an ongoing connection with local communities, and lead on improving the 'whole person' health of our population.



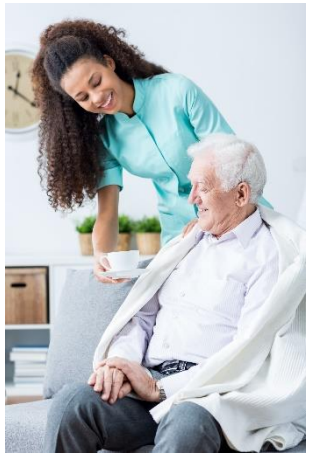
Primary Care data as of December 2023

- BOB ICS is putting primary care at the heart of our transformation, to deliver our vision set out in the Integrated Care Strategy:
- ***Everyone who lives in BOB should have the best possible start in life, live happier, healthier lives for longer and be able to access the right support when they need it.***
- We currently deliver some outstanding primary care, but services are under considerable pressure. We have inequalities in outcomes for our patients, workforce gaps and high workload.
- A national direction has been set to integrate Primary Care provision. We have developed this strategy to **address the challenges we are facing in Primary Care and improve integration between all of our pillars in Primary Care** and how they work together to deliver the new model of care. This strategy will also cover how Primary Care will work with system partners such as community services, to deliver our future vision. Therefore, this strategy is aimed at multiple different audiences – people who use Primary Care services, our staff who work in Primary Care as well as wider system partners, who will contribute to improving integration and collaboration to move to a more sustainable Primary Care system.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Approach to developing this draft strategy

This strategy builds from national guidance and our own local plans. We have carried out extensive engagement and analysis to inform the development of this draft primary care strategy, which we now want to refine through further engagement with system partners and those who live and work in BOB.



2022

National guidance such as The Fuller Stocktake

Spring 2023

BOB Integrated Care Strategy and Joint Forward Plan

Summer 2023

Focus Groups and Surveys

We carried out focus groups with key stakeholders - General Practice, Community Pharmacy, Optometry, and Dentistry and surveyed all pillars of Primary Care for their views.

Research on good practice

We researched global, national and local examples of good practice delivery of Primary Care services within other systems and within BOB.

Autumn 2023

System-wide workshop

Bringing together over 130 stakeholders from across the system to discuss the future vision and opportunities for Primary Care.

Data Analysis

We have analysed available data to understand how people in BOB are using services today as well as what our workforce looks like.

Winter 2023

Current State Report

Compiles documents, good practice, data analysis and views from engagement order to describe BOB's Primary Care Landscape.

Ongoing engagement

Feeding in all our research and engagement so far, we started to draft the strategy and continued to meet with key stakeholder groups to get their input and feedback.

January 2024

First draft of the Primary Care Strategy

This document summarises the key challenges facing Primary Care and how we plan to address these through a change in our model of care. We will continue engaging with system partners' and the public to hear their views.

Engagement so far

Broad engagement across the primary care system has been undertaken to understand the current landscape and test the future vision (stakeholders shown on the right). We look forward to engaging further with BOB residents to refine the strategy.

Since July 2023, we've heard from **approximately 150 stakeholders across BOB** to deepen our understanding of the challenges facing Primary Care and to discuss what the future model of care should look like.

We have been seeking the views of the public through our website. We will analyse all comments when they are received but based on what people have told us so far, some trends are emerging:

- Some patients report finding it extremely challenging to get an appointment with their GP and / or NHS dentist
- Many have positive experiences with their community pharmacy but note that at times pharmacists can be very busy
- Generally, patients have reported being happy with services provided by optometry.

We have listened and understand the immense pressure that the workforce is facing. We have heard what matters most to our staff and most importantly, to our patients. We know we can do more as a system to meet the needs of our population and to keep people healthy in their communities. Therefore, we are **making a commitment to do things differently and work more closely with partners** to deliver the best outcomes for people living in BOB.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Patient and public groups
- General Practice
- Dentistry
- Health and Wellbeing Boards
- Social Care
- Healthwatch
- Clinical Networks
- Acute providers
- Place Directors
- Voluntary & Community Sector (VCSE)
- Representative Bodies e.g. LMC, LPC & LDC
- Community Pharmacy
- Optometry
- Local Authorities
- Public Health
- Community trusts
- Mental Health Providers
- ICB Leads
- NHS SE Regional Leads
- Health Innovation Oxford & Thames Valley

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Primary Care in BOB today

In this section we describe the current state of primary care services in BOB. This is based on the engagement activities described on page 8 and an analysis of data showing how our population currently uses the primary care and the urgent and emergency care system.

The section describes the landscape of primary care services, highlights some of the strengths of our system in BOB, and then summarises the challenges we face. The following section then outlines how we need to work differently to address these challenges.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Primary care supports our communities

Primary care supports our unique and varied communities with a wide range of needs and helps to tackle the health inequalities some communities experience

Our population

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%.

Within BOB, Oxfordshire and Buckinghamshire will continue to have the highest proportion of over 75 year olds.

People who identify as white British make up 73% of residents. Although this varies from 53% in Reading to 85% in West Berkshire.

Health needs and inequalities

- c.60,000 people in BOB live in an area that is in the bottom 20% of areas nationally as defined by deprivation.
- 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.
- Estimated 60% of people over 60 have one or more long term conditions.
- People in our more deprived areas develop poor health 10-15 years earlier than those in less.
- BOB has 8.8 care home beds per 100 people 75+ in comparison to the national average of 10.8 as well as a slightly smaller 16+ population with a caring responsibility.
- There is a disproportionate reliance on acute services e.g. A&E from populations living in areas of higher deprivation.

1: BOB fact pack (2022); 2: BOB Joint Forward Plan (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Primary care is at the heart of our system

Not only is primary care the typical 'front door' for our population to access the health system, it also carries out 90% of all patient contacts. Below is a selection of facts about primary care activity.

01 Primary care supports a **registered population** of around 584,000- people in Berkshire West, 587,000 people in Buckinghamshire, and 816,000 people in Oxfordshire.

02 In Berkshire West, approximately **73% of the population are 'generally well'**, 19% have moderate need and 2.4% have higher need (based on Population Health Management data from Brookside Group Practice, 2023).

03 The equivalent of **19% of the population in BOB contact their practice every working week.** General practice activity levels in BOB are higher than pre-pandemic levels with **825,000 appointments** each month.

04 There are approximately **1,100 GPs, 430 nurses** and over **900 staff in the Additional Roles Reimbursement Scheme (ARRS) across BOB**, including Social Prescribers, Clinical Pharmacists, Nursing Associates and Mental Health Practitioners.

05 Across BOB, there are on average **63 dentists per 100,000 of the population** compared to a national average of 43 NHS dentists per 100,000.

06 There are **253 community pharmacies offering a range of clinical services** e.g. flu and COVID-19 vaccines, blood pressure checks, oral contraception.

1: Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14 (2016); 2: NHS Digital (2023); 3: Brookside Case study – Segmentation in Primary Care (2023); 4: BBOB LMC The Health of General Practice in BOB (2023); 5: NHS Dental Workforce statistics and NHS Digital (2023); NHS dentistry - Health and Social Care Committee (parliament.uk) 6,7: Primary Care Access and Recovery Plan (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our primary care system has many strengths

There is much outstanding practice across primary care in BOB, and unique capabilities across its Places. Below are five highlights where the system has particular strengths that can be built upon.

01

General Practice access and quality metrics in line with or above the national average

The proportion of GP appointments seen within 14 days is **higher** than the national and regional average. Most GP practices have either good or outstanding CQC ratings. Quality and Outcomes Framework scores are just above average.

02

High uptake of the Community Pharmacy Consultation Service

BOB has the **third highest** number of referrals (per population) to the Community Pharmacy Consultation Service across the Southeast region. 122 of the 156 GP practices are 'live' and referring their patients to community pharmacists, with a further 27 preparing to start using this service (as of December 2023).

03

Strong focus on inequalities, prevention, and wider determinants of health

All three Place-based Partnerships have focused on this. For example, 'Opportunity Bucks' targets the 10 most deprived areas in Buckinghamshire. Oxfordshire work focuses on specific communities such as people who are homeless. In Berkshire West community outreach is focused on reducing premature mortality.

04

Population Health Management Infrastructure

In parts of BOB, the Connected Care model has been developed with the addition of Population Health Management tools and is enabling people to be directed to the most appropriate health and care service, based on their needs. This supports better triage and navigation, identification of people who would benefit from intensive case management, and ability to design prevention interventions.

05

Flexible dentistry commissioning for our most vulnerable populations and extended commissioning for Minor Eye Conditions

BOB has started a pilot for flexible commissioning, where 10% of the contract can vary depending on local needs. This has enabled practitioners to service patients from under served communities who require dental care. Additionally, there has been great uptake of the referrals to the Minor Eye Conditions service and patient feedback has been positive.

06

Strength of existing at-scale delivery structures

Each Place has a Placed-Based-Partnership (including local authorities, VCSE and others) which can drive and deliver transformation and integration at a local level. There are evolving Federations of General Practices established in each Place – FedBucks, PML in parts of Oxfordshire and the Primary Care Alliance in parts of Berkshire West that can lead change and deliver services for a large part of the population.

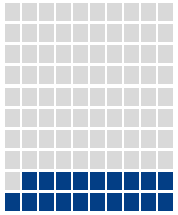
1: NHS Digital (2023); 2: Primary Care Access and Recovery Plan (2023); 3: Brookside Case study – Segmentation in Primary Care (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

There are challenges within primary care and within the wider system that require new ways of working

Demand for primary care outstrips current capacity and inefficiencies are created (for patients and staff) where the parts of the system do not work well together. The challenges require a system response, they cannot be solved by primary care alone.

01 People report a worsening experience of accessing primary care



Since 2021, there has been a 19% decrease in positive responses with regards to the overall experience of booking an appointment.[1]

19% said there were no dental appointments available or said that the dentist was not taking on any new patients.[2]

02 Many primary care staff feel they are under extreme pressure

BOB LMC data shows that GPs are responsible for more patients, and are spending a large proportion of time on administrative tasks relating to how patients move between parts of the system. [3]

Multiple respondents to the BOB dental survey said they are under extreme pressure due to demand much greater than capacity, lack of funding and recruitment and retention challenges.

03 This is driven by a mismatch between demand and capacity across the system

BOB's growing population and changing demographic profile is increasing demand for primary care services - more than one in four of the adult population live with more than two long term conditions.[5]

14 community pharmacies closed in 2023 and 16 out of 20 100hr pharmacies reduced their opening hours (mainly the 9pm-12am slot).[6]

04 Capacity is difficult to grow due to funding, recruitment, retention and estates challenges

In the Community Pharmacy workforce survey, 67% of respondents said it is very difficult to fill vacant roles for pharmacists.[7]

There are estates pressures across the system for example, in Bucks, approximately 570,000 patients are served by a primary care estate of approximately 24,121 $m^{2.}$

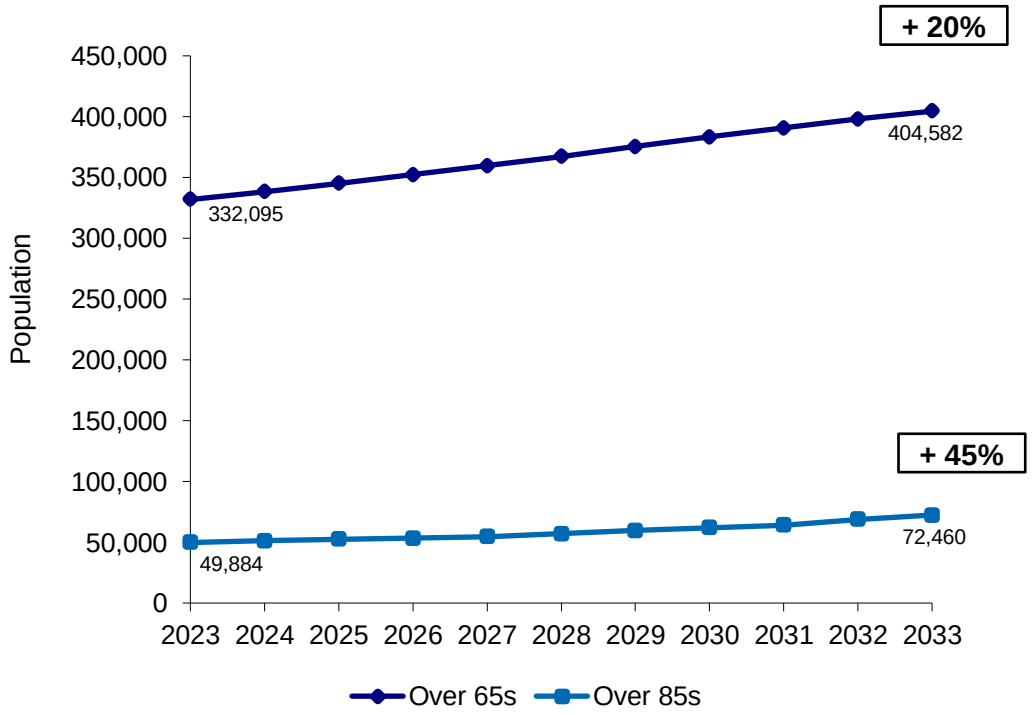
1: National GP survey results, 2023; 2: BOB GP Patient Survey Dental Statistics 2023; 3: BBOB LMC The Health of General Practice in BOB; 4: BOB Primary Care Assurance Report 2023/24 Quarter 2 (2023); 5: BOB Joint Forward Plan (2023); 6: Buckinghamshire Executive Partnership Report on Primary Care July 2023; 7: Community Pharmacy Workforce Survey 2022; 8: OCCG Primary Care Estates Strategy (2020)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

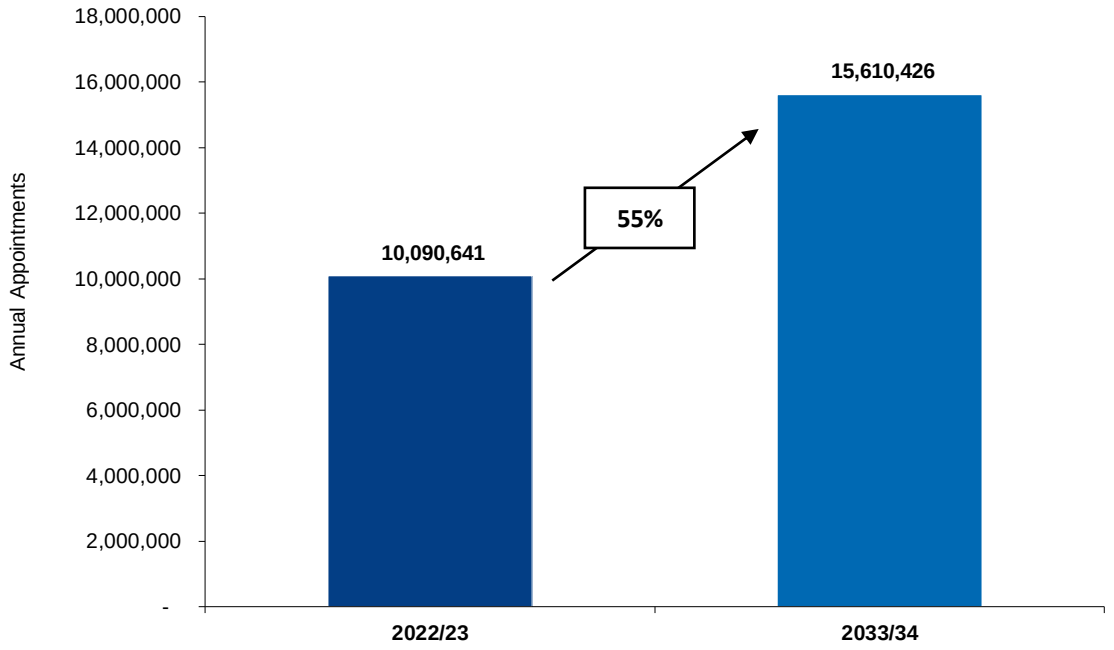
If we do nothing, the mismatch between demand and capacity will continue to grow

Over the next 10 years the population of BOB will increase, particularly the older population who make the greatest use of healthcare services. If there is no change to the model of care, based on historic trends in primary care activity and population forecasts, GP appointments would need to increase by 55%. This would represent an unsustainable level of growth in terms of available funding and workforce, and Primary Care cannot manage this demand alone. This requires a system-wide response to work in new ways and coordinate care and services differently.

BOB Forecast Population Growth to 2034 for Over 65s and Over 85s



BOB ICB General Practice Appointments (All Types – 2022/23 vs 2033/34)



KPMG analysis, based on ONS population projections

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Snapshot of what we have heard from the public so far

We listen to what patients say about primary care through a wide variety of forums including our local Healthwatch organisations. Below are the high-level themes that have emerged from early analysis of comments received via BOB ICB's public engagement website during November and December 2023.

Lots of patients mentioned they struggle to access an NHS Dentist.

Some patients said they are opting to go private or not attend a dentist due to being unable to access NHS provision.

Some patients said they are unable to get a GP appointment or have to wait for long periods of time, or are only able to call at certain times.

Patients reported a high turnover of staff in General Practice and said they are often unable to see the same doctor for treatments. This makes them feel it is hard to build relationships and results in a lack of trust.

Some patients felt like they were being blocked from accessing a GP by the receptionist or triage booking system. Some Patients stated they felt it was unnecessary or embarrassing having to explain symptoms on the phone and in person.

Overall feedback for optometry from patients who have accessed services was good.

Patients reported a lack of awareness of NHS provision for optometry (eye health).

There was positive feedback on the use of the NHS App to communicate with GP surgeries and for prescriptions.

Patients often stated long queues and wait times at their Pharmacy.

Patients stated that online GP booking is not always accessible for certain demographics of patients.

> *I have had a lot of experience accessing PC on behalf of my elderly mother. There is a lack of joined up services following hospital discharge and provision of care at home for a 97 year old.*

> *Getting to see a nurse at the surgery is adequate but GPs are still difficult to see in person. More needs to be done at surgery level so those of us not living in Oxford don't have to do a five hour round trip on buses to get to the "local" hospital.*

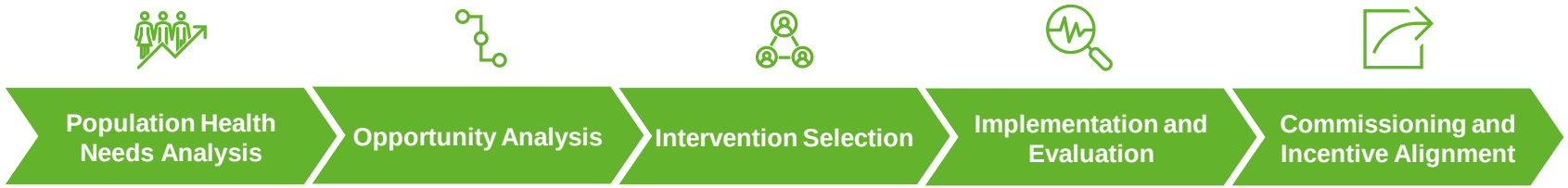
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We are learning from other systems who have tackled these challenges

We have reviewed good practice from other systems globally, nationally, and locally to understand the key features that have enabled them to tackle the same challenges we face. These features are summarised here, and the next page shines a spotlight on one particular example.

Systems tended to emphasise high-quality trusted information and digital tools to support people to self-care. People can access services in many ways but are triaged to ensure they reach the right part of the system, and their initial contact can be with a broad range of multi-skilled professionals. Pathways are standardised across system and supported by digital tools.

Systems tended to have a standardised approach to identify patients with or at risk of medical or social complexity, provide regular holistic assessments, co-develop personalised care plans and regularly evaluate outcomes and experience for this cohort.



Systems tended to have a strategic and data-driven approach to prevention that identifies population groups with similar risks, identifies and selects interventions to improve the outcomes of all groups, evaluates to see what has worked, and aligns financial and other incentives to help scale successful interventions.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Learning from the Clalit System

Within BOB we have taken particular inspiration from the Clalit system in Israel, which has produced impressive outcomes by taking a primary care led approach. Some of the key features of the system are described here, and as a system we must take the learnings and coordinate a system-wide approach.

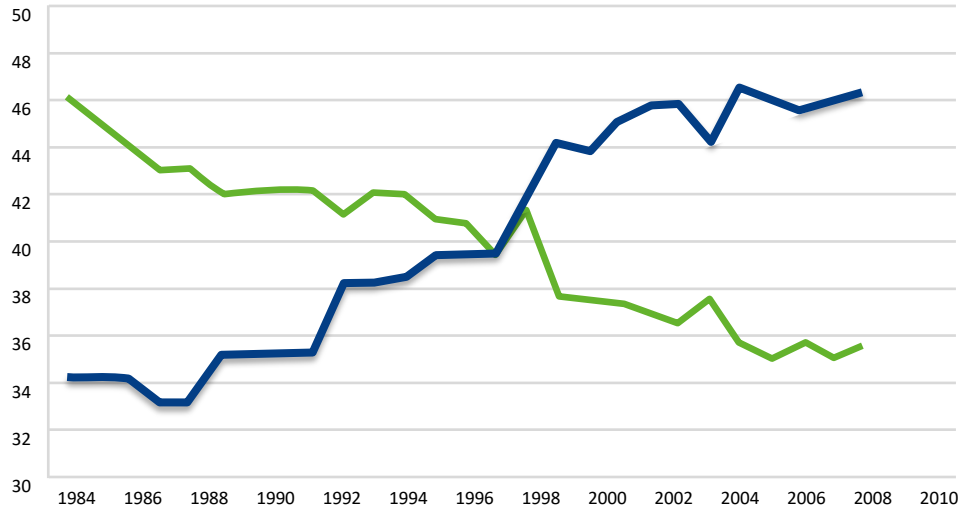
Israel's life expectancy is 0.9 years higher than in the UK, while national health expenditure is 7.8% of Gross Domestic Product (GDP), compared to 9.8% in the UK (2019 figures). The Israeli model is primary care led, and accounts for a greater proportion of expenditure than hospital care.

The Israeli healthcare system provides universal coverage through four not-for-profit Health Maintenance Organisations (HMOs), which can be compared to the UK's Integrated Care Systems. The largest HMO is Clalit.

Key features of the Clalit system:

- Integrated GP community clinics, including all professionals in one setting
- Direct hospital-to-community communication, enabled by fully interoperable data sharing system including online health records and results
- Proactive nurse-led health and wellness activities informed by health data
- Use of population health metrics to determine health policy decision making
- Payment is on a salaried or capitated basis, to incentivise the management of the population's health as effectively as possible in the lowest cost setting.
- Clinicians are paid more to work in rural or areas, which typically in Israel are home to more vulnerable groups.

Hospital vs. community care, percentage total health expenditure



Israel Central Bureau of Statistics

Professor Ran Balicer, MD, PhD, MPH, Director, Health Policy Planning, Clalit Health Services

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Shared Vision for Primary Care

This section sets out the way in which we need to change our model of care and work differently to address the challenges described. It is based on reviewing how those systems that deliver the best outcomes for their populations work, and engaging with those working and using services in BOB.

We describe both the components of the new model of care and the enablers that need to be in place to deliver these. The new model of care aims to achieve specific outcomes and we have developed a scorecard (section 5) to track our performance against these outcomes.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our shared system vision for primary care

The challenges – and opportunities – facing primary care result from complex system-wide factors and a whole system response is required. BOB's Joint Forward Plan commits the system to developing new models of care and primary care is at the heart of that. This is our future vision for primary care, but it requires other system partners to also work differently to deliver it.

Our Shared Vision:

Everyone in BOB has the support they need from primary care, working within a coordinated and integrated health and care system that supports people to stay well.

Model of Care

Primary Care

General Practice	Pharmacy	Optometry	Dentistry
We ensure people get to the right support first time to meet their needs	We provide personalised, proactive care for people with complex needs, supported by Integrated Neighbourhood Teams	We design targeted support for everyone to stay well by understanding our population by a review of the information	

Enablers

Workforce – Multi-skilled extended primary care teams work in an integrated way, at the heart of the system, and as part of integrated neighbourhood teams; flexible working is maximised; and workforce wellbeing is prioritised

Digital and data – Shared patient records are being used across the system to aid safe and effective clinical decision making based on real-time information

Estates – We are making the best use of Public Estate and community assets to support primary care delivery.

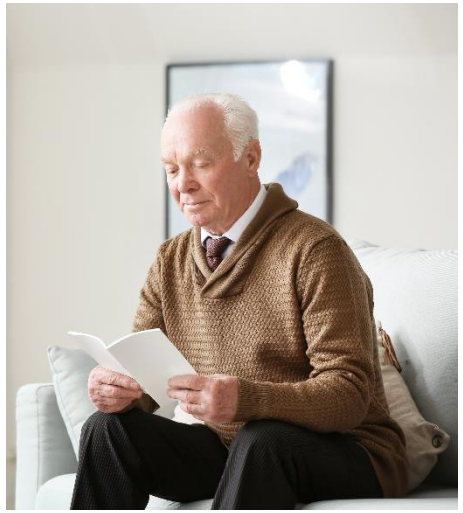
Resourcing – Resources have shifted from hospital settings into community settings and our contracts are joined up and based on outcomes that integrated services deliver.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

How will it feel for primary care staff?

Consultants in general practice

- I have had a mixed week with a higher level of complexity overall but no more than 12 consultations per session.
- My patients are appropriately and efficiently triaged. This is increasingly via digital triage although phone and walk in are also available.
- I have experienced a large reduction in interface work as all providers can complete their bloods/requests/investigations.
- I am supervising a team of allied health professionals regularly each week, to manage risk and support their development.
- Administrative tasks are now completed by non-clinicians who work as part of a dedicated team to answer patient queries.
- I have the option to subspecialise and work in the same day access hub covering a larger geography.
- Some other GP colleagues are part of an Integrated Neighborhood Team, managing patients with complexity. Overall there is much greater access to secondary care consultants in line with the neighbourhood way of working.
- I have greater influence over the community around us. I see the development of community infrastructure as the first line response for more issues, rather than general practice or another acute setting.

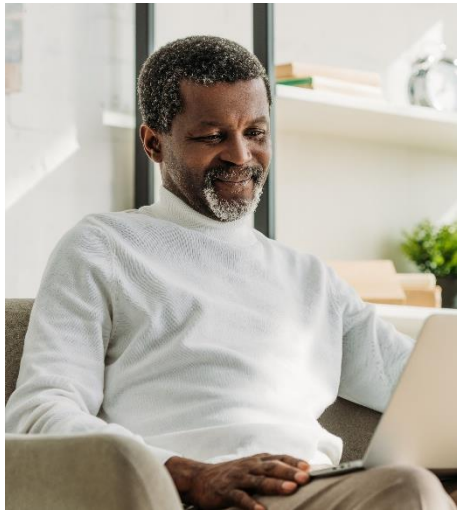


Community Pharmacist

- I feel so much more empowered when patients come to me with health issues.
- I can use my health care knowledge to assess their condition.
- I am now able to prescribe them with medication such as oral contraception.
- I also now carry out hypertension management of many more patients as part of a local cardiovascular prevention scheme with my system colleagues.
- As part of this, I have the resources for health promotion to help educate those I see. I can even point them in the direction of local services like weight loss management in the community.
- The system I use is so much more simple now. I can view the patient notes and update their record – if a patient I see appears to be high risk, I can easily refer them to the GP.
- I also sit as part of an INT weekly meeting where I build personalised care plans for a local frail population cohort who we are managing closely to prevent them going to hospital.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

How will it feel for primary care staff?



Optometrist

- A patient comes to my practice for a routine sight test.
- They tell me that they are diabetic now and that their medication has changed - they can't remember what the exact changes are.
- I have a view of their patient record and can see their diabetic status is accurate and can see what medication they are now on for diabetes and blood pressure.
- I can update my records accurately and be on the look out for diabetic retinopathy or hypertensive changes.
- I can notify the GP easily through the shared record interface of any retinopathy or ocular side effects of their medication.
- I can also highlight if the patient is overdue a diabetic check.
- It is so much easier having access to a digital patient record. Without it you have to go by what people remember and what they feel is relevant.
- Communicating directly with the GP digitally improves the accuracy of information and therefore patient care.

Dentist

- As part of my role, and as part of the wider prevention agenda, I support CVD/Diabetes screening, deliver dentistry in care homes, and also provide prevention advice for young children.
- I have educational resources to provide my patients and can point them in the direction of activities going on in the community such as Local Stop Smoking Services to support with their broader health and wellbeing.
- The system I use has been updated and I can update my patients' notes and view their drug histories. There are also easier referral pathways into secondary care.

Community District Nurse

- I provide nursing assessments and care for housebound patients with a physical healthcare need. We see patients at home and in residential care settings.
- I work with colleagues across the system on a day to day basis to manage patients with complexity, as part of an Integrated Neighbourhood Team
- I regularly communicate with the clinical lead when I have a complex case.
- I enjoy being part of MDT meetings as we proactively manage care for patients and also provide more personalised care.
- I can access, update and share my patients' notes with the other team members I am working with.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

How will it feel for patients?

- My husband has dementia and has recently become very ill with more symptoms - he is completely dependent on me and struggles to communicate.
- Over the past month, I have been supported by a team to care for my husband.
- I now have a direct line to the Care Coordinator and we have regular calls so I can share any of my concerns or let the care coordinator know if anything has changed.
- The Care Coordinator liaises closely with my usual GP and Proactive Care Nurse and arranges visits as necessary This team regularly updates my husband's care plan, using any information I have shared with them.
- It has been a really difficult time with my husband becoming very unwell, but to some extent my worries are eased knowing I have direct contact with the same team on a regular basis who know my husband well and can consider any personal factors in his care.
- Additionally, just the other day, a volunteer from a local charity visited to chat with me and has connected me to other people living as a carer / have family members with dementia locally.

Susan, aged 82

Danielle, aged 25

- I have a UTI and am experiencing painful symptoms. I contact my GP via an app downloaded to my mobile phone.
- I have requested to see my GP as I think I might need antibiotics after experiencing symptoms for a couple days .
- The app has told me I can go straight to my local pharmacy which is convenient for me as I can walk there during my lunchbreak.
- I visited my local pharmacy and they gave me antibiotics.
- My patient record is automatically updated so my GP knows I have received this treatment.

Sonny, aged 8

- My child has high needs and is at a specialist educational needs setting.
- Healthcare professionals are carrying out preventative health checks at the school.
- A mobile dental unit has visited the school to provide dental and oral health services which is convenient.
- A Community development worker recently visited my family at home to provide additional information, advice and guidance.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We ensure people get to the right support first time to meet their needs

Our vision is that people who contact the health system will be directed to the right health and care support to meet their needs first time – so that might not necessarily be a GP but the right health care professional and in the right place.

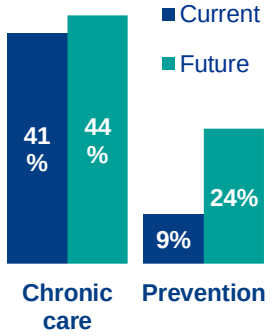
The challenge today – using General Practice as an example

People report a worsening experience getting to the primary care support they need and are frustrated when they feel they are 'bounced around the system'.

Across BOB, patients having a good experience of making a GP appointment has decreased by 19%

Staff feel under extreme pressure and some of the burden comes from a lack of smooth processes as people move between different parts of the system and can end up requiring multiple appointments before they get to the right place.

Staff in General Practice in BOB would like to spend more time on prevention and chronic disease management:



When people find it difficult to get a GP or dentist appointment, they report that they sometimes go to A&E.

In the BOB ICS GP National Survey, people said:

10% went to A&E when they couldn't get a GP appointment

30% visited A&E instead when the GP practice was closed

Our future vision

Self-management

Supporting all our communities to access the high-quality information available on the NHS website.

Signposting to this from community centres, health services, GP websites and apps, and through targeted outreach.

Triage & navigation

When people request support (e.g. through GP online form, by calling 111) care coordinators can triage the request – with clinical supervision – and direct it to the right place.

Supported by digital triage tools, some of which use Artificial Intelligence, and backed by Population Health data that helps teams understand the health needs of the person requesting care.

Initial contact

Initial contact is with the right professional / service, which could be a virtual or face to face appointment with a (for example):

- ✓ GP, Nurse, Physio or other staff member
- ✓ Community Pharmacist, Optometrist or Dentist
- ✓ Urgent Care/Treatment Centre for minor injuries
- ✓ Weight management, audiology, or podiatry service
- ✓ VCSE and mental health services

Supported by digitally-enabled communication between these different clinicians and services.

1:BOB GP National Survey (2023); 2: Survey shared with General Practices across BOB as part of Primary Care Strategy work

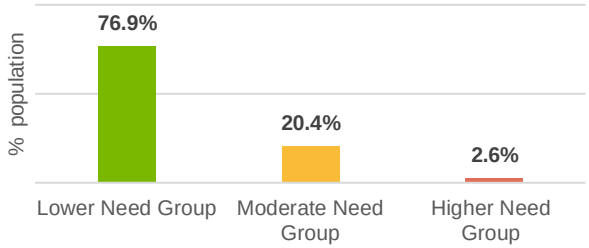
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Changing how we work so people get the right support first time

There are lots of examples in BOB that demonstrate how we better navigate people to the right support. Below, we have described two initiatives already in place that help to ensure people get to the right care and support, first time.

Using data to get patients the right support in Brookside

- Brookside Group Practice use data to understand the needs of their population.
- As shown below, 77% of Brookside's population has generally low needs – these people tend to have a non-complex requirement when they contact their GP, for example, a Urinary Tract Infection (UTI).
- Brookside call this group 'green' patients and support them through an urgent care team or by directing them to community pharmacy.
- Shifting 'green' activity to other places has allowed General Practice to spend more time seeing people with more complex needs. This reduces demand for primary care and A&E because their health is better managed.
- This approach has increased staff satisfaction as skills and interests can be matched with particular work, and they have the option to rotate between teams for more variety.



Population proportion by patient need group

Directing patients to Community Pharmacy

- The NHS Community Pharmacist Consultation Service (CPCS) supports patients to access a same day appointment at their community pharmacist for minor illness or with urgent requests for routine medicine. The service also enables pharmacists to refer patients to an alternative service should it be required.
- This approach is well-utilised in BOB, which has the second highest number of referrals in the South East, relative to population, with over three-quarters of practices using this scheme to refer their patients to Community Pharmacists. There was a 5% increase in the number of referrals that were made in September 2023, with BOB the only ICB to see an increase.
- This service has multiple benefits for the system:
  - Increases patient access to primary care services;
  - Is more convenient where community pharmacies are often closer to patients' homes;
  - Helps to ease pressure on GPs and emergency departments; and
  - Contributes to improving staff satisfaction where the service utilises the skills and medicines knowledge of pharmacists.

Brookside Case study – Segmentation in Primary Care (2023); NHS Community Pharmacist Consultation Service (CPCS) – integrating pharmacy into urgent care; BOB Primary Care Assurance Report 2023/24 Quarter 2 (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We provide personalised, proactive care for people with complex needs, supported by Integrated Neighbourhood Teams

Our vision is to have Integrated Neighbourhood Teams (INTs) made up of professionals from a range of disciplines, operating at the appropriate scale, to support people with more complex needs to stay well in their communities.

The challenge today

People's health needs are changing and many live with multiple long term conditions where traditional disease-specific care is not the best model.

"More than one in four of the adult population live with more than two long term conditions"[1]

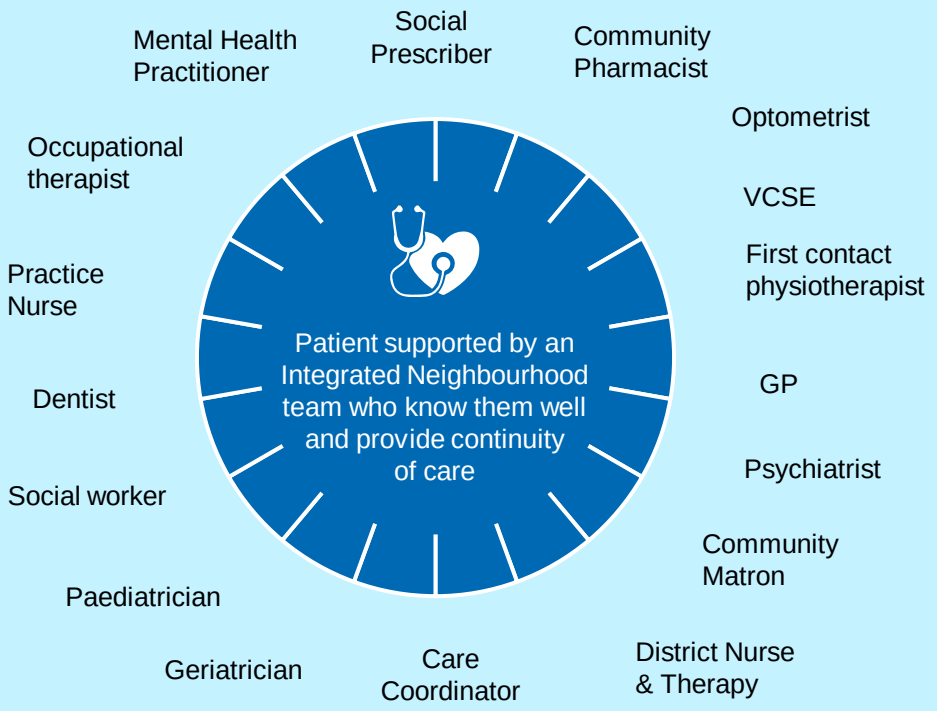
Many issues that affect people's health are not purely medical and require input from multiple parts of the public sector, for example housing, benefits.

"The Buckinghamshire population have higher levels of social isolation"[2]

Where people's needs are not well-managed, they often end up requiring more urgent and costly treatment, that doesn't provide a positive experience or improve longer term outcomes. Groups from more deprived areas tend to end up using the emergency care system more.

"Higher acuity patients now make up a greater proportion of A&E activity than 4 years ago"[3]

Our future vision



Team of colleagues from a range of contributing organisations

To manage the challenges on the left, we need to move towards a more community-based model. This will require the system to shift resource from secondary care into the community and will impact the way the whole system works, especially secondary care with Primary Care. INTs will be the delivery vehicle for this model and our specialist workforce e.g. secondary care consultants, mental health, social care providers, VCSE sector, primary and community care, will have a key role to play in the INT. We will need to ensure job plans are aligned and resources and time commitment are agreed upfront.

INTs will support a defined group in the population who have complex needs and are at risk of experiencing the poorest outcomes. They work together with the individual to develop and deliver a personalised care plan, making sure they can access the support (medical and non-medical) they need.

System partners work together to provide resources (staff, estates, funding) to these teams that come together regularly (daily or weekly), virtually and physically.

The footprint for these teams will be determined locally – with input from a range of system partners – using population health data to identify cohorts who will benefit the most.

1: BOB Joint Forward Plan (2023); 2: BOB fact pack and BOB Integrated Care Strategy (2023); 3: BOB ICB ECDS Data V2 (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Changing how we work so people with complex needs receive personalised, proactive care

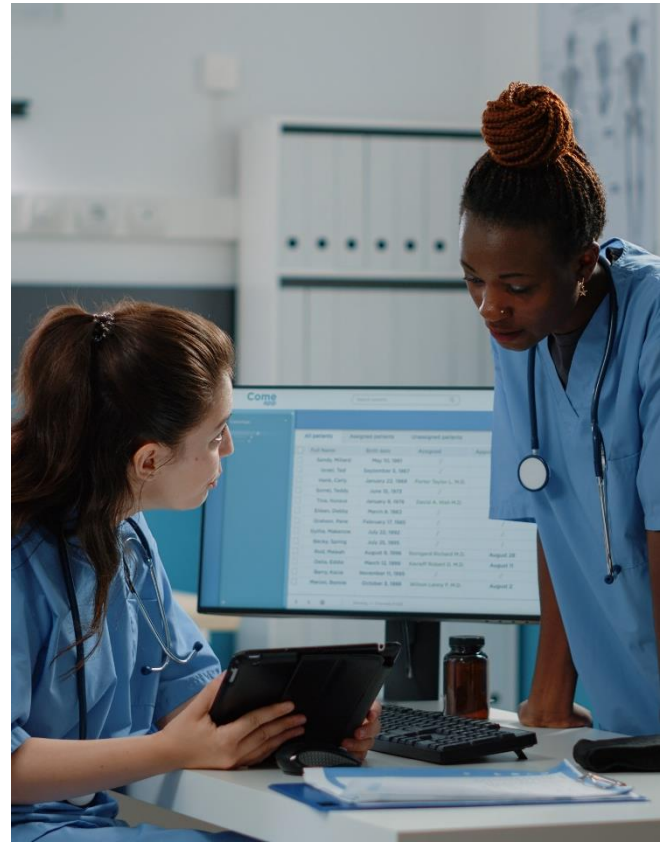
Below, we have described two initiatives already in place that are providing integrated holistic support to people with complex needs.

Bicester Integrated Neighbourhood Team

- The INT has been in development since October 2021 and consists of 2 funded GPs who cover 7 sessions a week.
- The team is comprised of staff members from Oxford Health, social services, community services, community therapies and others
- The INT provides two streams of care: 1) enhanced care for patients who have been discharged from hospital and require care to avoid readmission and 2) proactive care to improve access to patients who can't access services easily e.g. frail patients with acute illness.
- The team conduct a daily ward round to understand who has been seen the previous day and who needs support. Staff are able to call Oxford University Hospital if they have any patient cases with medical complexity and need expert advice and guidance.

Frimley's Integrated Care Model

- To improve seamless access to care and support, Frimley Health and Care introduced an integrated care model. The integrated team is proactive, providing in-reach into hospitals to enable people to return to the community as soon as they're ready.
- The INT model has a single point of access with a joint triage and assessment mechanism.
- INT meetings are focused on supporting people at high risk of hospital admission and with complex needs.
- The team consists of key roles such as GPs, mental health workers, social workers, nurses and rehab practitioners. Input is included from the voluntary sector, ambulance service, pharmacists and psychology.
- Outcomes that have been achieved so far are: care home admissions have been reduced by 12%, GP referrals into hospitals reduced by 13% and elective admissions to hospital reduced by 5%.



1: Future of General Practice, Oxfordshire event slides; 2: frimley-case-study.pdf (nice.org.uk)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We design targeted support for everyone to stay well by understanding our population by a review of the information

Our vision is to share and use data to inform targeted approaches to improve our population's health, working in partnership with our Local Authorities and making every primary care contact count.

The challenge today

- 60,000 living in a deprived area, who develop poor health 10-15 years earlier than those in less deprived areas.
- Approximately 11% of BOB's population are active smokers, with nearly 8% of pregnant women actively smoking.
- Across BOB, 3 in 5 adults are overweight or obese. 68% of adults with a learning disability are overweight.
- Nearly 18% of BOB's population undertake less than 30 minutes of physical activity per week.
- In BOB, there were 115k alcohol attributable admissions to hospitals between 2016/7 and 2020/21.

Our future vision

Primary Care supports people from the beginning to the end of life, and prevention and health promotion are key throughout. Whether it's stopping people becoming unwell in the first place, preventing ill health progressing, or minimising the impact of poor health.

All four Primary Care pillars – General Practice, Community Pharmacy, Optometry and Dentistry – have a critical role to play in prevention activities and the promotion of living a healthy life in local communities. With the right data being shared and discussed between all system partners, including Local Authorities, there is an opportunity to maximise preventative activities and deliver more personalised care. These include opportunistic activity – like blood pressure monitoring during eye checks, and proactive activity – like community pharmacy reaching out to those who may have undiagnosed high blood pressure, or dental checks in early years settings. There is also an opportunity to tackle the social, economic and environmental factors that affect health by supporting people to live healthier lives – like increasing access to tobacco dependency services and weight management services. However, we recognise the need to release capacity, before we can optimise our workforce's full potential to deliver more preventative activity. Our future integrated model of care should help overcome this barrier.

In order to make and sustain a shift towards a more preventative system, we will use data to drive our decision making. We will embed a strategic and system-wide Population Health Management (PHM) approach to allow us to understand the health needs across our system and identify our most vulnerable and at risk groups - those who experience the poorest outcomes and inequalities. With this understanding, we will work with communities to design the right support for the population group we are looking at. We'll evaluate and scale what works and stop or change what doesn't.

1: BOB Joint Forward Plan (2023); 2: Fingertips Public Health Data (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Changing how we work so we can use data to understand our population, and to design targeted support for everyone to stay well

There are lots of examples in BOB that demonstrate how we can use data to drive prevention activity. Below, we have described two initiatives already in place where system partners are working together to make a difference to specific communities and tackle inequalities.

Nepalese community prevention activity

Population health data analysis of people with Type 2 diabetes pinpointed poorer outcomes for some patients in South Reading in the Nepalese community who had a lower uptake of the standard NHS diabetes education offer.

Working with the Greater Reading Nepalese Community Association, a programme was created that:

- Provides group consultations and education, delivered in Nepalese
- Hosted a Pressure Station at a football tournament to encourage visitors to get a blood pressure check and further support - the GPs, along with their surgery staff and local volunteers conducted 90 mini health checks over the course of the tournament, measuring BMI, blood glucose and blood pressure.
- Has promoted health and preventative healthcare advice and identified new cases of possible hypertension and diabetes.

A specialist nurse, who is Nepalese and understands some of the cultural variants within that community, delivers the programme.

Oral health outreach in Oxfordshire

The Community Dental Services team in Oxfordshire take a proactive approach to offering services, particularly in the ten most deprived wards.

They have visited parent sessions at primary schools, Banbury Mosque, Health walks, Dementia support group (online), Community Hubs, food banks, children's classes, weight management groups, clinics in the John Radcliffe, and the Health on the Move Bus.

They have developed their online presence and promotion of national campaigns linked to oral health including National Smile Month and Mouth Cancer Action Month.

The messages, advice and resources that they shared between April 2022 and March 2023 have been used, seen and accessed over two and half million times.

The team also produce a free monthly newsletter which contains social media content around oral health to encourage partners to also share their content – this has 157 subscribers.

1: Reading Football Festival Supports “Know Your Numbers Week” (2023); 2: Oxfordshire Oral Health Needs Assessment (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Four enablers are essential to delivering this vision

Focusing on the activities described over the next two pages should be a priority for the system, as workforce, digital and data, estates and resourcing are critical to deliver the future model of care.

Workforce

- Fully understand current and future workforce skills gaps and challenges around recruitment and retention particularly in rural areas
- Develop longer term local plans, building partnerships to develop a sustainable supply of locally recruited and trained staff.
- Maximising uptake of apprenticeship roles developing the workforce through the apprenticeship levy.
- Expansion of the coaching and mentoring and 'looking after you' programmes for all primary care staff and ensuring access to health and wellbeing support.
- A greater focus on continuous professional development and protected learning time across primary care. Specific learning being commissioned according to training needs analysis, local and national priorities.
- Enable staff to move seamlessly between provider organising using the 'BOB' staff passport' making shared and rotational roles much easier, which in turn results in an increase in staff retention as they have a better employment experience.
- Looking at Dentistry specifically, exploring different types of contract models to encourage recruitment, reviewing the skill mix model to align with new prevention priorities and the training required for this, and review of commissioning training courses to grow dental workforce.

Resource

- In common with the rest of the country, funding is constrained in BOB Integrated Care System, and we need to look at ways to use the existing resources we have differently. Where possible, will look at how we use funding to focus on areas of higher deprivation.
- We know that other systems globally that achieve excellent outcomes for their populations have health and care systems that spend a far greater proportion of their budgets on primary care activities than we do, and this is a shift we are committed to making in BOB.

We plan to do this in two ways:

- By changing the location and type of work our staff do, regardless of who they are employed by. For example, a respiratory consultant spending time each week with an Integrated Neighbourhood Team supporting people experiencing breathlessness.
- By changing the way we commission services so that we consolidate funding to support providers working together to deliver the best outcomes for a defined population – we will begin piloting this approach in 2024.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Four enablers are essential to delivering this vision

Digital & data and estates are key enablers to underpin the successful delivery of our future model of care.

Digital and data

Enhancing our digital capabilities across the system will enable us all to work differently, release capacity by minimising existing administrative pressures and ensure people have a more seamless journey through the system. Building on the ICB's Digital and Data Strategy we will:

Digitise Our Providers – deliver the minimum digital foundations across our providers

- Optimise digital triage tools within General Practice to free up time for staff from manual administrative tasks e.g. processing incoming requests for patients. This will include training for both clinical and administrative teams to ensure they get the full benefits out of digital tools.
- Carry out engagement on the requirements of GP principle clinical systems in readiness for the closure of the GP IT Futures framework that will support the ongoing development of our Electronic Patient Records.

Connect Our Care Settings – use digital, data and technology to connect our care settings

- Enable providers both within primary care e.g. GP, community pharmacy, optometry, dentistry and between primary and secondary care to digitally share patient records. This capability should support effective clinical decision making and enable smooth navigation of patients to the right part of the system.
- Sharing information in this way will reduce administrative burden e.g. for primary care teams, and empower secondary care providers to update medication changes on discharge from care automatically via the NHS Electronic Prescribing Service (ePS) and send a notification to the patient's pharmacy to dispense medication in the community.
- Unlocking interoperability and shared record capabilities will support other digital technologies such as remote monitoring tools to empower patients, and their carers, to play a greater role in their care.

Transform Our Data Foundations – deliver the data foundations to provide the insights required to transform our systems and better meet the needs of our population

- Continue to spread and scale the existing Population Health Management infrastructure that exists in BOB across the entire system.
- Advance our data sharing agreements so we continue to benefit from the capabilities within the Thames Valley and Surrey Shared Care Record, and continue to work with clinical system providers to enable data sharing features within the BOB system.

Estates

- Make greater use of virtual consultations and 'hub working' (with multiple professionals in same space) for non-complex same day care.
- As part of the ICB plans for a shared estates strategy, set a clear expectation that both same day access hubs and Integrated Neighbourhood Teams should make use of the best available public estate. For example, this could mean a same day access hub located at an Urgent Care Centre, or an INT located in a community health centre.
- Explore opportunities for partnership working between the ICB, Primary Care providers and wider local system partners, in particular local councils, to optimise use of public sector estate and community assets, and take opportunities to put health on the high street

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Approach to Delivery

In this section we set out our plans to deliver our shared vision. We have proposed a delivery approach based on the principles of Quality Improvement that we know can drive change. Given the pressure and limited capacity in the system, we have set out three priorities that as a system we commit to delivering.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our approach to delivering this strategy

We are committed to ensuring this strategy turns into action and makes a difference to people living in BOB. The ICB will oversee delivery of the strategy at a local level, whilst empowering our staff working in primary care and system partners to make the required changes. These principles underpin our approach to delivering this strategy.

1 Create Focus

To achieve our vision, we need to prioritise a small number of high impact actions. Acknowledging our system is under pressure and capacity is limited, the actions we focus on must have the biggest impact on the challenges we are trying to address.

2 Delivery Programme Approach

Our delivery approach is underpinned by the continuous improvement principles outlined in NHS IMPACT. This approach will be bespoke for the three priorities and enable teams to:

- ✓ Understand the problem and biggest opportunities for improvement
- ✓ use data to drive decision-making
- ✓ test small incremental changes for our priority actions
- ✓ share learnings and learn from experience
- ✓ Create a 'bottom-up' culture of improvement

3 Local Design

Primary Care is a complex landscape of mostly independent contractors which means we cannot implement a "one size fits all" model. We need to ensure the detailed design of the model of care takes place at a neighbourhood level, where those working on the frontline of Primary Care are making the decisions, with their communities, about changes in the way we work.

4 ICB Support

We recognise the need for the ICB to lead delivery of the strategy and to support the changes in the way we work. The ICB will act as a "convenor", bringing together Primary Care with system partners to have meaningful discussions on how we deliver our priority actions and better meet the needs of our population. Further support will be given in enabling areas such as workforce, to ensure neighbourhoods are supported to drive the changes.

5 System partner Support

To deliver this strategy and enable a shift in the model of care, all system partners will be required to work in new and innovative ways. For example, acute providers will need to identify members of their workforce who can work in the community alongside primary care colleagues. All partners will need to identify opportunities to work more flexibly and share resources, including estates in new ways.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our priorities for delivery

We have identified three areas where we can make a real impact on improving people's health and wellbeing and reducing pressure on staff. Where possible, we will focus on working with communities that experience the most inequalities. In line with BOB's overall system strategy, we have focused on aligning the priorities with two of our system goals and introducing more joined-up ways of working between services – rather than discrete priorities with one area like dentistry or general practice. The priorities are described in more detail on later pages.

1 Non-complex same-day care

General Practice, Community Pharmacy, Optometry and Dentistry will work together, with 111 and Urgent Care, to **better manage those who require support that day, but whose need is not complex.**

Around 70% of population health need is low complexity, and this makes up approx. 50% of GP activity.

Impact:

- Improved patient experience as they get the urgent support they need.
- Release capacity in General Practice to focus those with more complex needs.

John Hopkins ACG System

2 Integrated Neighbourhood Teams

General Practice, Community Pharmacy, Optometry and Dentistry will work together with community, mental health, acute and VCSE services to provide **proactive, personalised care to a defined population group with more complex needs**, for example, frail older people.

Around 70% of health and social care spending is on long term conditions.

Impact:

- People's health conditions are better managed reducing their need for unplanned hospital care.
- System capacity better coordinated and directed at need leading to greater staff satisfaction.

Long-term conditions and multi-morbidity | The King's Fund (kingsfund.org.uk)

3 Cardiovascular Disease (CVD) prevention

General Practice, Community Pharmacy, Optometry and Dentistry will work together with Local Authorities, VCSE and the wider health system to **reduce the risk factors for Cardiovascular Disease (CVD)** including smoking, obesity and high blood pressure.

CVD is one of the most common causes of ongoing ill-health and deaths in BOB.

Impact:

- Reduce 797 heart attacks and 290 strokes (CVD events) in the next 4 years.
- Reduce demand on General Practice and Secondary Care and reduce the overall societal cost.

BOB Size of Prize 2023

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We will continue to focus on other improvements in addition

Our three priorities focus on those areas where we need a system-wide focus to tackle the biggest challenges. There are other areas where work has been and will continue to be undertaken to make improvements to realise our vision. These align with our priorities in the BOB Joint Forward Plan and the Integrated Care Strategy, and we have highlighted a number of areas below.

General Practice

- Support the public to **optimise use of the NHS app** so that they can see their medical records, order repeat prescriptions, manage routine appointments and see messages from their practice.
- **Improve the ways in which patients contact and interact with their GP and navigate care**, including the 111 service - support provided to GPs through national and local improvement programmes.
- Continue to **strengthen the primary care workforce** including recruitment, retention, supporting staff practice to the top of their license.
- **Improve the interface between primary and secondary care –** to streamline processes and touchpoints for patients.

Community Pharmacy

- Roll out of the **Pharmacy First initiative in 2024** so that patients can access prescription-only medicine without needing to visit a GP e.g. for UTI treatment.
- Upskilling of community pharmacists in line with upcoming new policy so that more **pharmacists are able to provide assessments of patients and make prescribing decisions** without patients having seen their GP first.
- Continue to expand vaccination service e.g. flu and covid
- **Expand GP Connect** to enable GP practices and authorised clinical staff (e.g. pharmacy professionals) to **share and view electronic health records information and appointments information.**

Optometry

- **Implementation of an electronic referral platform** which will allow community optometrists to send routine referrals directly to the patients' chosen hospital or single point of access**.**
- **National intent to extend and roll out 'in school' eye testing** in all schools from April 2024, with certain schools given priority for the rollout.
- **National minor eye condition service to be expanded in early 2024** which aims to improve equity and accessibility for patients with most eye conditions seen at eye units and by GPs.

Dentistry

- Further expansion of the Flexible Commissioning scheme which provides **care for patients from underserved communities.**
- Continuing to undertake oral **health assessments and increase dental hygiene in children and young people -** targeting prevention interventions.
- Exploring implementation of **mobile dental units**.
- Building dental clinical workforce resilience
- **Proactive management approach** to dentistry though better oversight of access, quality and performance challenges.

Community

- **Expanding hospital at home approach and redesigning hospital discharge** model - integrating with local councils so more services and care can be moved into the community.
- **Enabling patients to have direct access to community services** such as musculosketal, audiology, weight management and community podiatry without needing to go to the GP first.
- **Improve community-based support for those suffering with Mental Health** e.g. The Thames Valley Link Programme (TVLP) has been established to provide extra support to children and young people who are often described as having 'complex needs' .

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

ICB and Place support for local delivery

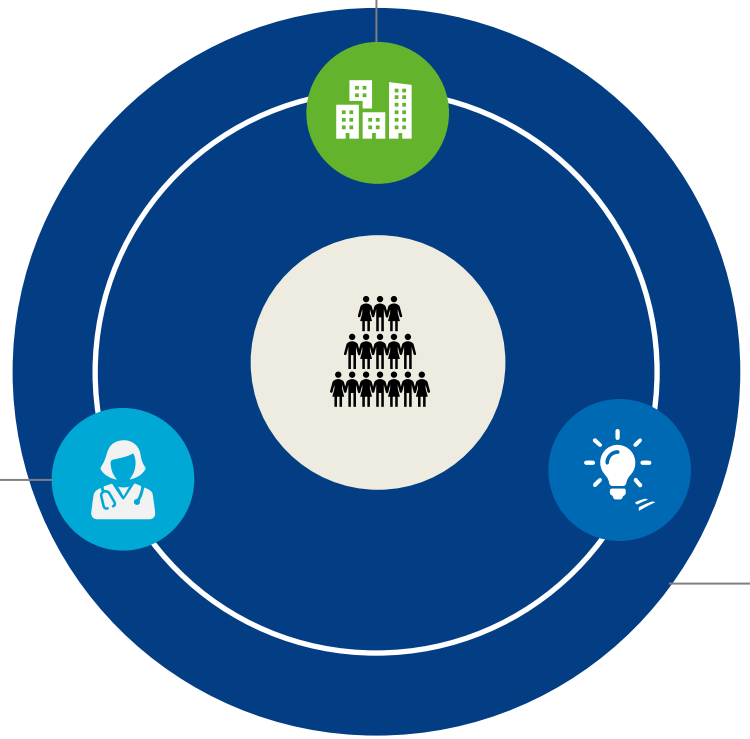
Clinical and operational teams, working with their communities, will be the ones who drive new ways of working. The ICB and Place teams will provide dedicated support to focused Local Action Teams working on our three priorities within an overall Primary Care Delivery Programme.

Place-level

- Place-based Partnerships are **accountable** for delivery of the priorities
- Place Delivery Teams will be established to be **responsible** for delivery and first line of support for Local Action Teams

Local Action Teams

- Clinical and operational teams working with communities
- **Footprint** determined locally as appropriate – could be PCN, Local Authority, other
- **Members** determined and may differ for each priority but include all pillars of primary care and wider system partners
- **Leadership** of teams must be clearly agreed for each priority



The delivery structure will need to align to the overall BOB ICB Operating Model that is being developed.

ICB-level

- The BOB ICB Primary and Community Care Strategic Transformation Coordination Group is **accountable** for delivery of the priorities
- The Primary Care Team is **responsible** for delivery of the priorities, working closely with ICB leads for Workforce, Digital & Data, Estates and Resourcing.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

A phased approach working with cohorts across the three priorities

The Primary Care Delivery Programme will bring together multidisciplinary teams from across Neighbourhood, Place and ICB levels to deliver our three high impact actions, across a three year period. Our Placed-Based-Partnerships will be key to supporting delivery of this approach and driving improvement. Two of our priority workstreams are aligned with our wider system goals on CVD Prevention and Integrated Neighbourhood teams.

Priority workstreams	2024	2025	2026
1 Non-complex same-day care	Cohort 1: March – August 2024, Three sites in each Place	Cohort 2: September 2024 – February 2025, Up to six sites in each Place Cohort 3: March – August 2025, Up to nine sites in each Place	
2 Integrated Neighbourhood Teams	Mobilisation Co-design blueprint of INTs in each Place	Cohort 1: September 2024 – February 2025, Three sites in each Place Cohort 2: March - August 2025, Up to six sites in each Place	Cohort 3: September 2025 – February 2026, Up to nine sites in each Place
3 CVD Prevention		Cohort 1: March - August 2025, Three sites in each Place	Cohort 2: September 2025 – February 2026, Up to six sites in each Place Cohort 3: March – August 2026, Up to nine sites in each Place

'Site' = Neighbourhood level team e.g. Primary Care Network (PCN), or multiple PCNs working together or any appropriate scale at a local level.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Action plan to establish the Primary Care Delivery Programme

We want to work with all partners in primary care in a new way, utilising the continuous Quality Improvement approaches that we know can drive change and make an impact.

1
- Establish **Place Delivery Teams** to lead this work from March 2024.
- Place Delivery Teams membership to be determined, but for example: GP Chairs, other clinical leadership as determined from primary care pillars, Place Directors and ICB primary care team

2
- Establish the Governance structure, reporting up to the **Primary & Community Transformation Board**.
- Performance and outcomes for each of the priorities to be monitored through the **Primary Care Strategy Scorecard.**

3
- Determine local footprints for this work in each Place – these will be the **'Local Action Teams'** taking part in the Delivery Programme.
- Footprints will need to be determined for each of the 3 priorities: 1) same day- access, 2) Integrated Neighbourhood teams and 3) CVD Prevention

4
- Place Delivery team and Placed-based Partnership to hold launch event of the **Primary Care Delivery Programme** - to explain programme objectives, timeline and rollout.
- **All neighbourhoods** will be required to participate in this programme of work, but it will be tailored to their circumstances.

5
- Undertake **baseline assessment** to understand starting point and specific needs of the Local Action Teams – like current state of triage and navigation functions across Primary Care and whether they have already adopted a multidisciplinary way of working with system partners.

6
- Support access and use of **population health management (PHM)** data to understand which population cohorts experience the poorest outcomes and are from the most deprived areas – to inform selection of neighbourhoods for each cohort.

7
- Use the baseline assessment to identify three Local Action Teams in each Place to take part in the **first cohort** of the Delivery Programme, (same-day access) – the teams should be a mix of those already working in new ways and those who are yet to begin.
- Use the assessment and PHM data to identify 3 teams in each Place to take part in the **second cohort** (INTs). Majority of the teams should be from deprived areas.

8
- Place Delivery Team to hold introductory **mobilisation calls** with the Local Action Teams in each cohort, to agree team members and ensure their time has been allocated to participating in the programme .

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Priority 1

Non-complex same-day care

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

1

Our first priority is to expand at-scale triage and navigation to appropriately direct same-day non-complex need

This is the first priority as it will directly address the biggest concern of our population – access to care – and can also rapidly reduce pressure on staff by reducing people needing multiple appointments before they get to the right place.

Approximately half of General Practice activity is same-day care and a large proportion of this is for non-complex needs, like Urinary Tract Infections. In these cases, speed of access is generally more important than continuity of care.

Non-complex needs can often be directed to other primary care services such as community pharmacy or virtual/physical access hubs (where practices collaborate to triage and treat same-day need).

This way of working is emerging in parts of BOB and is in line with national direction of travel around at-scale working. Working at-scale (e.g. through same-day access hubs) can help to improve access as it involves a multidisciplinary way of working, utilising a varied workforce to deliver a wide range of services e.g. a hub could have pharmacists, physician associates, dentists and specialist nurses. This can help manage demand more effectively in a local area.

What impact will this way of working have?

- **Improve patient experience** by making it easier to navigate to the support they need.
- **Release capacity for GPs** to see people who have medium to high complex needs
- **Enhanced staff satisfaction and retention** due to at-scale supervision models that make it easier to provide appropriate oversight and support to ARRS roles, and possibility to rotate in and out of hub roles providing more variety
- **Make better use of current estate** through hub working and an increase in virtual consultations.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

1

An example of a future same-day access pathway

Self management | **Triage & navigation** | **Initial Contact**

Same Day Access Hub Front Door

Patient feeling unwell

Self Care / Management

If appropriate the patient tries to resolve through publicly available, regulated information, advice and guidance e.g. from NHS Website/App, or goes to the pharmacy

Patient requests support

The patient decides they need further support and requests through their preferred route (most often likely to be **their local GP** surgery):

- **Online**
- **Phone**
- **Walk-in**
- **111**
- **Community Pharmacy**

Patient is seeking **'same day'** which they can request via **cloud telephony**, **online consultation,** or **speaking with staff member**.

This redirects them or their online form directly to the hub.

Triage & Navigation

Patient is triaged based on need - by the Same Day Access Hub Care Coordinator (who has support from a clinician when needed). Patient segmentation RAG rating pops up on screen to assist triage. Information will be captured by a **consistent digital tool** whether on the phone or online. If a same day appt is required this will be scheduled in to the Same Day Access Hub.

Same day appointment not needed

If a same day appointment is not needed, the hub care coordinator will either:

a) Book the patient in for a routine appointment in the coming days at their home practice by accessing the local GP **EPR system**, or

b) Direct them elsewhere e.g. 111, Community Pharmacy, dentist, community service, mental health service etc.

c) If the care coordinator feels they need to speak directly to their home practice reception, they can divert them back through cloud telephony

Initial Contact

A patient is seen in either:

- ✓ A same-day face to face or virtual appt with a GP
- ✓ A same-day face to face or virtual appt with another member of extended general practice/ primary care network team
- ✓ Redirected to Community Pharmacy, Optometry, Dentistry or UTC
- ✓ Redirected to community services such as audiology or mental health services
- ✓ Redirected to VCSE

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

1

Triage and navigation will be designed locally but with common features

The specifics of the model of care must be determined at local level to reflect the differing needs of populations, existing workforce and estate, and configurations of partner providers. However, patients and staff will benefit from consistent features.

01

Patients continue to request same-day care in a range of ways that suit them – on their GP website/app, NHS app, by phoning their GP, walking into their community pharmacy, or calling 111.

02

Data is collected to support triage through an online form – filled in by the patient or receptionist/care coordinator – that is consistent across the neighbourhoods. Online tools are used to support clinical decision-making.

03

Triage is undertaken only once – either by the practice, 111 or, ideally and over time, by the same day access hub.

04

Over time, triage can be backed by prior patient need and risk stratification to support clinical decision-making.

05

Where triage determines that the patient should be seen by their home practice, either due to complexity or because routine appointment is more appropriate, they are ideally booked directly or transferred back to the practice (i.e. they do not need to make a new request).

06

Where triage determines the patient should be seen outside of General Practice – e.g. Urgent Care/Treatment Centre, community pharmacy, dentist or optometrist, agreed clinical pathways will enable this. Patients will be booked in to the right service e.g. into urgent dental slots, transferred by phone, or clearly directed, ideally with accompanying clinical communication.

07

The same day access hub is resourced by multi-skilled staff from practices and the wider system, who will contribute staff by agreement, likely based on list size. The hub should offer face to face as well as virtual appointments – this could be in existing estate by rotating around practices, or in an existing dedicated space if available.

08

The hub will use Standard Operating Procedures agreed with all practices and partners, and will have documented approach to Clinical Governance.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

1

Action Plan for same-day non-complex care

Primary care is at different stages of adopting this way of working, and the detailed design of same-day access pathways must build from where neighbourhoods are starting from. Place Teams will support a Quality Improvement approach to delivery.

The **ICB and Place Teams will**:

- ✓ Bring teams together for focused sessions to progress activities on the right – enabling them to **share learning**, do things once where **consistency** makes sense, and support each other to **overcome blockers**
- ✓ Provide **resources** based on national, global and local good practice on same day access
- ✓ Work to enable **patient records to be shared** across all of Primary Care and broader system and improve ability to **communicate and refer** between all primary care professionals (digitally).
- ✓ Make available the ICB Expert teams responsible for **key enabling areas** like workforce, digital, data and estates to provide updates, help unblock issues, escalate where needed and provide extra support, as required.
- ✓ Support the setting of **clear outcome metrics** and the tracking and collation of these to demonstrate impact
- ✓ Ensure **involvement of system partners** in co-designing pathways, and promote visibility of new ways of working across their Place
- ✓ Roll out **Population Health Management tools** to help segment our population into groups based on their needs and identify those most likely suitable for same-day non-complex care.

Local Action Teams will be supported to:

Existing pathways

- ✓ **Map current access pathways** that exist e.g. across GP, Pharmacy, Mental Health etc.
- ✓ Identify where the **biggest improvements** can be made and set measurable outcomes.
- ✓ **Agree and test a small number of changes** to the pathways on a small scale, discuss how all system partners could support these changes.
- ✓ Capture and **analyse impact** of the change, collecting data and tracking the impact against the outcome measure.
- ✓ If the changes demonstrate sustainable improvement, agree plans for **implementation of changes at a wider-scale.**

New pathways

- ✓ For new pathways e.g. **same-day access hub, Minor Eye Conditions** etc, map future state, set outcome metrics and conduct small-scale test of change.
- ✓ Capture and analyse impact of the change, spread scale if improvement is demonstrated.

Supporting discussions:

- ✓ Identify **enablers required** to support best use of pathways – Standard Operating Protocols, digital interoperability of patient records and appointment booking systems
- ✓ Estimate impact of **increased referrals to Community Pharmacy** and build into plans for Pharmacy First – look to increase referrals from A&E and UCC using EMIS.
- ✓ Review **demand and capacity modelling**, agreeing capacity required in same day access hub and workforce contributions from each practice.
- ✓ Identify enablers required to support at-scale working – rotational or dedicated use of existing estate, interoperability of systems (cloud telephony, EPRs, triage tools etc).

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Priority 2

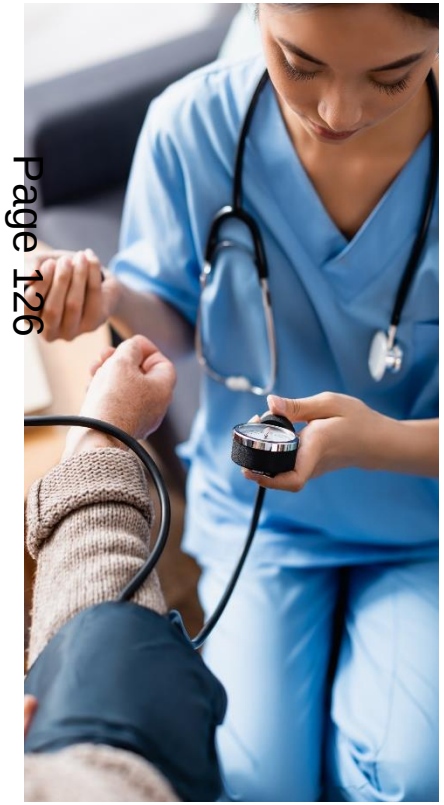
Integrated Neighbourhood Teams

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2

Our second priority is to create Integrated Neighbourhood Teams to coordinate care and support for at least one population cohort

As a system, we're committed to making a reality of integrated neighbourhood working, and this priority means we will begin that work by establishing Integrated Neighbourhood Teams in all areas beginning with a focus on one defined population cohort.



An integrated community-based model can make the biggest difference for those who have (or are at risk of having) complex medical or social issues. Often this is associated with multiple long term conditions, and inequalities in access, experience and outcomes.

We want to put primary care at the core of this model, with Integrated Neighbourhood Teams as the delivery mechanism to implement this way of working. All neighbourhoods will work to design and develop an INT to bring professionals from across the system to work together in the community (virtually and physically) to provide holistic support to **at least one population cohort** e.g. frail older people, children with health conditions.

There are already some Integrated Neighborhood Teams operating in BOB and lots of plans underway. Developing relationships and building trust amongst system partners will be key to the success of this approach.

What impact will this way of working have?

- Improve **patient experience** by providing continuity of care from a named professional, who can coordinate a holistic approach to meeting needs, combining expertise from different teams.
- Improve **outcomes** especially in the management of long-term conditions and reduce inequalities in outcomes.
- Reduce **demand for GP appointments** as continuity is provided by a multi-skilled team working together to manage needs, releasing capacity for GPs to focus on the most complex needs and prevention.
- Reduce **Emergency Department attendance and emergency admissions** as issues (medical and social) are addressed before they escalate.
- Improve **staff wellbeing** through development of a collaborative culture that puts patients needs first and supports flexible working in different teams.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2

Defining an Integrated Neighbourhood Team for BOB

We recognise that INTs are not a new concept, but rather an evolution and extension of Multi-disciplinary Teams that have already been operating. Each INT will look different, based on the population it is focused on and the partners involved. As a system, we have developed core principles to guide how we build INTs that will make it easier for us to explain INTs to our population and staff, and learn from each other as we develop new ways of working.

Who

INTs are the delivery vehicle for a community based model. They will:

- Be a multidisciplinary team of generalist and specialist skilled health and social care professionals.
- Work with other partners in the neighbourhood – e.g. police, mental health services and local housing associations.
- Actively involve and engage the local community in planning and decision-making to ensure services align with actual population needs.
- Have a designated GP clinical lead with protected time.
- Have secondary care consultants aligned to support and deliver services to the population cohort.
- Be established from existing resources and infrastructure.
- Integrate into service and community development in neighbourhoods, with all pillars of Primary Care part of the offer.

What

Teams will develop their own standard working practices that may include:

- A daily call 'huddle' - where patient notes are reviewed, next steps for priority patients discussed and plans for home-visits agreed.
- A weekly INT meeting is scheduled to discuss high risk patients in more detail and create personalised care plans
- Any community-based care that is required for patients should be allocated to the most appropriate team e.g. district nursing.
- The secondary care consultant will provide specialist advice to the team and help resolve complex cases.
- Community teams will have regular contact with the clinical lead/ GP in the INT to ensure any complex issues are resolved.
- Across some teams, senior GPs may serve as the 'consultant in General Practice', providing holistic expert care to a population cohort.

Where

- Determine a local footprint for the INTs in each Place, which may be based on PCN or multiple PCNs.
- Teams do not have to be co-located in the same premises to work successfully but opportunities to engage in person, alongside virtual meetings are preferable

Supported by:

- PHM tools to identify, understand and define a cohort to focus on
- High degree of trust and a culture of collaboration between health and care teams and professionals
- Virtual and physical space to come together
- Ability to share patient records among system partners

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2

Action Plan for Integrated Neighbourhood Teams

Primary care is at different stages of adopting this approach to delivering care, and the detailed design of INTs must build from the Local Action Teams that are developing this team, alongside their system partners. Place Teams will support a Quality Improvement approach to delivery.

The **ICB and Place Teams will**:

- ✓ Support the determination of a **local footprint** for INTs, based on PCN or neighbourhood.
- ✓ Identify the **Local Action Teams** to take part in each cohort of the Delivery Programme, ensuring an early focus on deprived areas.
- ✓ Bring teams together for focused sessions – enabling them to **share learning**, do things once where **consistency** makes sense, and support each other to **overcome blockers**
- ✓ Make available ICB teams responsible for **key enabling areas** like workforce, digital, data and estates to provide updates, help unblock issues, escalate where needed
- ✓ Support the setting of **clear outcome metrics** and the tracking and collation of these to demonstrate impact
- ✓ Ensure **involvement of system partners** in the Integrated Neighbourhood Team approach e.g. ensuring specialist secondary care consultants job plans are aligned with this way of working, and promoting visibility of new ways of working across their Place.
- ✓ Roll out **Population Health Management tools** and support use of these to identify initial population cohort that each INT decides to focus on
- ✓ Continue to **expand shared care record** to enable patient records to be shared across all of Primary Care and broader system

Local Action Teams will be supported to:

- ✓ Review population health data to **agree a population cohort to focus on** based on the principles of tackling inequalities and reducing system pressure.
- ✓ Lead conversations with system partners (including primary, secondary care, community services, VCSE, social care and others) to **agree roles in the INT**, securing the required capacity and commitment.
- ✓ Work with providers to ensure Pharmacy, Optometry, Dentistry and others are appropriately involved and aligned to the team, **maximising the capacity of the whole system** to meet the needs of the population cohort.
- ✓ Define the **core capabilities of the INT and interactions** between all providers.
- ✓ Agree **ways of working** with INT core members e.g. daily huddles, weekly MDT meetings to review patients and care plans.
- ✓ Identify appropriate **virtual and physical space**
- ✓ Establish **Standard Operating Procedures** for referrals into and out of INT, clinical governance etc.
- ✓ **Test new way of working** with small segment of the population cohort - conduct daily and weekly calls, review patients and actions required.
- ✓ **Track and evaluate benefits**, share learnings and tweak processes (where required).
- ✓ **Scale** approach to whole population cohort once improvements are demonstrated.

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Priority 3

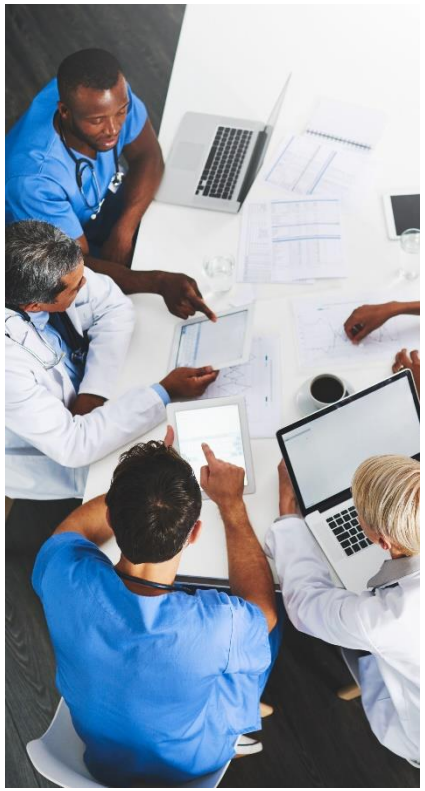
CVD Prevention

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3

Our third priority is to align primary care to support a system-wide focus on preventing Cardiovascular Disease

Cardiovascular disease (CVD) is a major cause of death in BOB and is a key driver of the life expectancy gap between people living in our most and least deprived areas. To reduce the number of heart attacks and strokes, we need a system-wide focus on intervening to reduce the major risk factors, and tackle inequalities.



All four pillars of primary care are already leading the fight against CVD, by targeting the high risk conditions (high blood pressure, Atrial Fibrillation (AF), high cholesterol and heart failure). This includes encouraging healthy lifestyles, identification of those at risk, and effective clinical management of those with high risk conditions.

We want to build on that work and take the opportunity to target those efforts strategically where they will have most impact – by using data about our population's health to focus on those communities at highest risk, including deprived areas, some ethnic minority groups, and those with severe mental illness, learning disabilities or neurodiversity.

With CVD prevention as a system priority across BOB, primary care's efforts will be enhanced by working in an integrated way with system partners – like public health teams and local councils. This should reduce duplication, maximise value for our population and enable us to deliver more proactive and personalised care.

What impact will this way of working have?

- Reduce the number of people developing CVD, and prevent people from having a heart attack or stroke (CVD events).
- Reduce Emergency Department attendances and emergency admissions for heart attacks and strokes.
- Reduce the gap in life expectancy between the most and least deprived communities.
- Support people with high-risk CVD conditions such as atrial fibrillation, high blood pressure and raised cholesterol to better manage their health with convenient, community-based support.
- Make it easier for staff in all parts of the system to direct people to information, resources, support and services that can help them to adopt healthy lifestyles.

BOB Joint Forward Plan (2023)

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3

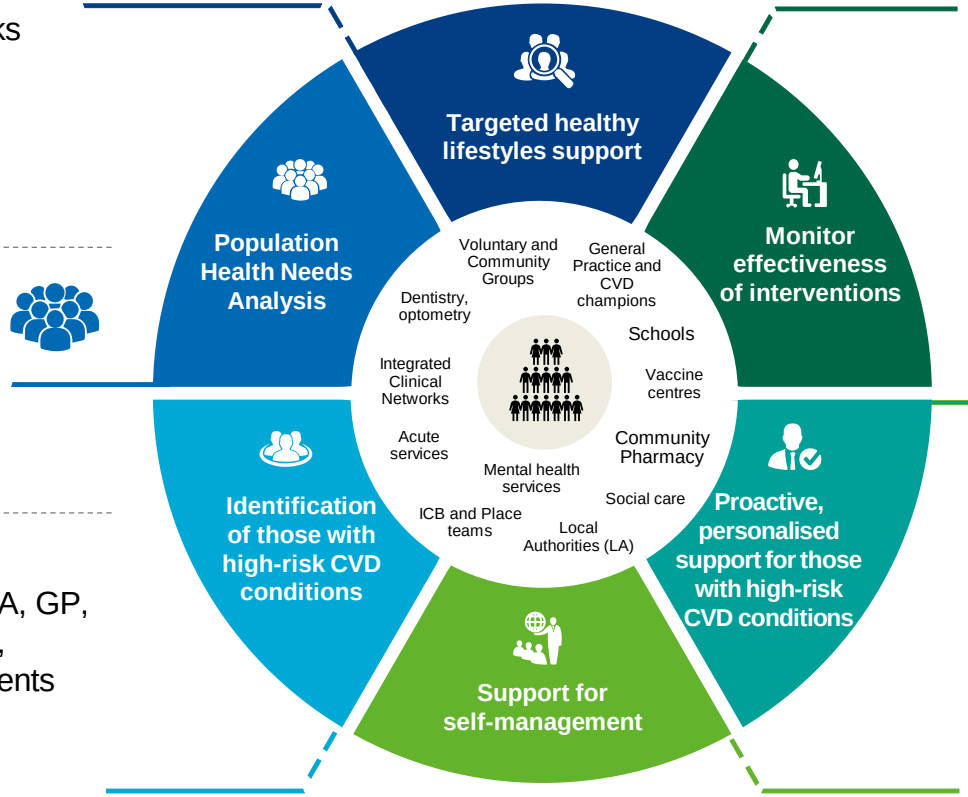
Example future integrated local approach to CVD prevention

This slide shows an example of how all parts of the system come together at a local level to take a data-driven approach to CVD prevention, supported by system-wide shared training.

Produce and share population risks for CVD at system, Place, LA and PCN level. Do community engagement for a deeper understanding.

Agree local plans with all partners e.g. signposting to smoking services. Others include obesity, physical inactivity, healthy diet and alcohol use.

Health checks undertaken by LA, GP, pharmacy, dentistry, optometry, vaccine centres, community events



Based on agreed outcome metrics, evaluate success or otherwise of intervention, share findings, and build into future planning

From primary to secondary care, integrated clinical pathways for proactive management hypertension, AF, high cholesterol

Information provided for self-management of e.g. simple hypertension, in partnership with community pharmacy, automated blood pressure stratification.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3

Action plan for Cardiovascular Disease prevention

Whilst all aspects of primary care already undertake CVD prevention activity, ICB and Place Teams will support this focus, working with cohorts of Local Action Teams through a Delivery Programme approach.

The **ICB and Place Teams will:**

- ✓ Support access to **PHM data** where not yet available, support all to use the data to draw out actionable insights.
- ✓ Put in place 'one ICS' **education and training** on CVD prevention so multidisciplinary teams attend together to drive collaboration.
- ✓ Provide **educational resources** based on national, global and local good practice on CVD prevention, working with Integrated Clinical Networks
- ✓ Bring teams together for focused sessions to progress activities on the right – enabling them to **share learning**, do things once where **consistency** makes sense, and support each other to **overcome blockers.**
- ✓ Support the setting of clear **outcome metrics** and the tracking and collation of these to demonstrate impact.
- ✓ Ensure **involvement of system partners** in co-designing pathways, and promote visibility of new ways of working across their Place.

Local Action Teams will be supported to:

- ✓ Map CVD prevention activity **already planned or being implemented** across the site by all partners, including Public Health.
- ✓ Explore and debate the **population health information** shared and use this to prioritise and shape three local actions, that all partners will work on with the community to reduce risk factors for CVD
- ✓ Use data to identify where the **biggest improvements** can be made and set measurable outcomes.
- ✓ Actions might include for example, targeted smoking cessation interventions, increase in NHS health checks, expansion of hypertension case finding by community pharmacies.
- ✓ Agree and test interventions on a small-scale, collecting data and **tracking the impact** against the outcome measure.
- ✓ If the changes demonstrate **sustainable improvement**, agree plans for implementation of changes at a wider-scale.
- ✓ Identify key enablers such as **workforce and estates** requirements, including how to strengthen **CVD champion** roles and make use of opportunities at community events.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Oversight of Progress

In this section we set out our plans to build a strong delivery structure based on Quality Improvement principles to ensure accountability is clear and we make progress on delivering our vision. We also include a scorecard that we will use to track measurable progress for our population and our staff.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We will ensure accountability for delivery is clear, based on quality improvement principles

We will build a strong delivery infrastructure that empowers frontline teams to design and deliver changes to their models of care, and enables the ICB to mobilise resources and unblock issues

Level	Accountable	Responsible
ICB	**Primary and Community Care Transformation Board** • Set overall plan as per this strategy • Monitor delivery against outcome metrics • Allocate resource appropriately • Troubleshoot when issues are escalated **Digital and Data Oversight Group** • Set overall primary care digital and data plan as per digital and data strategy • Monitors progress being made against the digital and data plan that will interlink this strategic	**Primary care team** • Delivery of overall plan: - With Place-based Delivery Teams for Model of Care - With ICB leads for Enablers • Track progress and report to P&C Transformation Board • Allocate team members to each Place-based Delivery Team
Place	**Place-based-Partnerships** • Monitor delivery in their Place • Allocate resources • Troubleshoot when issues are escalated • Ensure learning is widely shared	**Place Delivery Teams** (including alliance / federation staff as appropriate, ICB primary care team members, others to be determined) • Agree sequencing of Local Action Teams to join programme • First line of support for Local Action Teams • Track progress and escalate issues to ICB level for resolution
Neighbourhood	**Local Providers** • Corporate and clinical accountability rests with established providers / groups of providers working together e.g. in alliance or federation structures • Appropriate memoranda of understanding or other constructs put in place to enable contribution to Local Action Teams	**Local Action Teams** (Clinical and operational teams working with their communities) • Design new local models of care to deliver the priorities in the strategy, supported by Place Delivery Team • Engage with Primary Care Delivery Programme at the appropriate time, take advantage of the resources and peer learning available • Escalate issues to Place Delivery Team

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We will develop a scorecard to track progress

Whilst the whole system embarks on this transformation journey, we need a way to regularly monitor progress against our outcomes. We have developed this scorecard to translate the strategy into operational terms and focus on a set of key measurements. The scorecard will provide a quick, but comprehensive snapshot of the Primary Care system.

Outcomes	Success metric*	Frequency of measure
Improve patient experience	1. GP Patient Survey for overall satisfaction 2. % of positive responses on Friends and Family test	Annual Monthly
Improve outcomes for Long Term Conditions	1. QOF indicators – for diabetes, respiratory, cardiac (hypertension) 2. Hypertension 18+ managed to target 3. 18+ Q risk score of 20+ and need lipid therapy 4. Proportion of people with long term conditions with care and support plans 5. Reduction in emergency admissions for chronic ambulatory care sensitive conditions	Monthly data from CSU
Improve staff wellbeing	1. Sickness absence rates 2. Leaver rates among newly qualified staff 3. Retirement rates 4. NHS Staff survey (when introduced for primary care)	Monthly Annual
More sustainable system	1. Average number of EMIS entry types – clinical vs administrative 2. Community Pharmacy Consultation Scheme uptake and outcomes	Monthly

*Please note that this data is an example only and we will do more work to define the metrics as an ICB and identify where we have data that we could measure each of these.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Glossary of terms

Term	Definition
A&E	Accident and Emergency
AF	Atrial Fibrillation
ARRS	Additional Roles Reimbursement Scheme
BOB	Buckinghamshire Oxfordshire and Berkshire West
CAS	Clinical Assessment Services
CVD	Cardiovascular disease
CPCS	Community Pharmacy Consultation Service Scheme
EMIS	Education Management Information Systems
EPR	Electronic Patient Records
EPS	Electronic Prescription Service
ED	Emergency Department
F2F	Face-to-face
FTE	Full-time Equivalent
GP	General Practitioner
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
INT	Integrated Neighbourhood Team

Term	Definition
JFP	Joint Forward Plan
KPI	Key Performance Indicator
LA	Local Authority
LDC	Local Dental Committee
LPC	Local Pharmacy Committee
LMC	Local Medical Committee
LTC	Long Term Condition
MECS	Minor Eye Condition Service
MDT	Multidisciplinary team
PBP	Place Based Partnerships
PROMS	Patient Reported Outcome Measures
POD	Pharmacy Optometry Dentistry
PHM	Population Health Management
PCN	Primary Care Network
QI	Quality Improvement
QOF	Quality and Outcomes Framework
UCC	Urgent Care Centre
UDA	Unit of Dental Actvity
UTC	Urgent Treatment Centre
VCSE	Voluntary, community or social enterprise

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Thank you for reading this draft strategy.

We are grateful to all those in the BOB Integrated Care System who have helped to shape this draft strategy.

We need your views and feedback to help agree our final strategy, so please do share your thoughts via **engagement.bobics@nhs.net**

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HEALTH AND WELLBEING BOARD – 14 MARCH 2024

PLANNING FOR THE NEXT JOINT STRATEGIC NEEDS ASSESSMENT & PHARMACEUTICAL NEEDS ASSESSMENT

Report by Ansaf Azhar, Corporate Director of Public Health & Community Safety

RECOMMENDATION

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

    1. Agree to transition the Joint Strategic Needs Assessment (JSNA) publication from 2025 onwards to an interactive digital format
    2. Approve the approach to 2024 JSNA publication to be focused on key thematic areas agreed by the Board
    3. Agree to the establishment of a JSNA steering group made up of partners represented on the Board to take forward the work
    4. Note the requirement to update the Oxfordshire Pharmaceutical Needs Assessment (PNA) by April 2025
    5. Agree to the establishment of a PNA Task and Finish group made up of partners represented on the Board to take forward the work
    6. Agree to the proposed timescale to undertake the work- including public consultation and for approval at the Health and Wellbeing Board in March 2025

Joint Strategic Needs Assessment (JSNA)

The publication of a Joint Strategic Needs Assessment (JSNA) is a statutory duty of the Oxfordshire Health and Wellbeing Board. The JSNA is an assessment of the health and wellbeing needs of Oxfordshire residents which could be met jointly by the Health and Wellbeing Board (HWB) partners.[1]

The current JSNA was agreed by the HWB and published on Oxfordshire Insight in June 2023, and has been shared widely with local partners, informing strategies across health and care services, most especially the Joint Local Health and Wellbeing Strategy.

In response to the evolving landscape of demographic, health and social care data dissemination and accessibility, a novel approach is being proposed for the

[1] Local Government and Public Involvement in Health Act 2007

development of the JSNA. This proposal aims to transition the traditional static JSNA into a dynamic and interactive digital format. This transformation could be undertaken during 2024/2025, and is envisioned to enhance usability, accessibility, and data visualisation for stakeholders involved in public health planning and decision-making processes.

In the meantime, it is proposed to undertake an update of selected sections of the JSNA during summer 2024 in order to maintain the relevance and accuracy of the JSNA. However, in order to be able to dedicate resources to focus on development of the digital JSNA, a full update would not be undertaken. Key components of this "lighter touch" 2024 update include:

- Life course summary "snake" infographic
- Special Educational Needs and Disabilities (SEND)
- Mental health local data
- Gambling harms
- Inclusion health groups (including homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and traveller communities, sex workers, people in contact with the justice system and victims of modern slavery)
- Local research

This list is not meant to be exhaustive and if partners on the Health and Wellbeing Board have specific requests of the 2024 JSNA that are important for the delivery of their 2024-25 business plans, there remains flexibility to amend this list. On reviewing the relevant legislation this proposed "lighter touch" approach for 2024 remains compliant with statutory requirements.[2]

It is proposed that both the 2024 JSNA update, and the transition to a digital product in 2025, will be directed by a steering group with representatives from partners of the Health and Wellbeing Board and any other relevant stakeholders, in order to ensure that it involves and reflects the needs of residents, patients and partners across Oxfordshire.

The main steps in developing the new Oxfordshire JSNA will be to:

- Establish JSNA steering group – April 2024
- Draft JSNA chapters peer reviewed - May 2024
- HWB approval and publication of JSNA - July 2024
- Initiation of collaborative development of the digital JSNA - July 2024
- Progress update to HWB - December 2024
- HWB approval and publication of digital JSNA (summer 2025)

[2] Local Government and Public Involvement in Health Act 2007; Health and Social Care Act 2012; Health and Care Act 2022

Pharmaceutical Needs Assessment (PNA)

What is the Pharmaceutical Needs Assessment

The publication of a Pharmaceutical Needs Assessment (PNA) is a legal duty of the Oxfordshire Health and Wellbeing Board.[3] It is a comprehensive assessment of the current and future pharmaceutical needs of the local population, and the extent to which current service provision meets these.[4]

The PNA covers:

- Community pharmacies (including distance selling pharmacies),
- Dispensing appliance contractors[5], and
- Dispensing GPs.

The PNA is used by the Pharmaceutical Services Regulations Committee (PSRC) in considering pharmacy applications. The PSRC is managed by the South East Pharmacy Optometry and Dentistry Commissioning Hub on behalf of all South East Integrated Care Boards. Decision-making membership includes ICB representative/s, a lay member and the Head of Primary Care (pharmacy lead).

The scope of the PNA is set out in national guidance/ legislation and is intentionally limited. The primary assessment is whether local residents are within 20 mins travel time (by car if in a rural area/ by foot or public transport if in an urban area) of a pharmacy service. It does not make a detailed assessment of every premises opening hours, waiting times for dispending a prescription or other quality indicators, as these are the responsibility of the NHS commissioning body

The previous Oxfordshire PNA was published on 1 April 2022 and must be updated within three years (or sooner), i.e. by 31 March 2025.

Pharmacy provision in Oxfordshire and changes since the last PNA

As with many parts of the health and care system, there have been changes in the pharmacy landscape since 2022. The ICS has been established with the commissioning of pharmacies now delegated to ICBs from NHS England. Many pharmacies continue to offer additional services such as vaccination, smoking cessation support, oral contraception and the Pharmacy First scheme launched in Feb 2024.

Since the completion of the previous PNA in March 2022, there have been a number of changes in pharmacy provision including:

- Closure of Lloyds pharmacies based in Sainsbury's supermarkets, this affected 6 pharmacies in Oxfordshire.
- Closure of a pharmacy in Bicester town centre.

[3] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013
[4] National Health Service Act 2006
[5] Dispensing Appliance Contractors dispense specified appliances such as stoma, catheter or incontinence appliances and are required to provide home delivery services, reasonable supplies of supplementary items such as disposable wipes, and access to expert clinical advice. DACs provide services nationally and serve large geographical areas. They may choose whether to offer an appliance usage review (AUR) service. Oxfordshire HWB area has one appliance contractor at present.

- Notification that two pharmacies are due to close at the end of March 2024, Cowley Pharmacy in Oxford and Boots Pharmacy in Thame.
- Change of ownership of 11 Lloyds pharmacies and 5 others.
- Opening of 2 new pharmacies, one each in Didcot and Bicester.
- Opening of a new distance selling pharmacy in Witney.
- Recent approval granted for a further 2 new pharmacies in Littlemore, Oxford and south of Banbury, each in response to the closure of a Lloyds in Sainsbury's in those areas.
- Approval given to a new pharmacy to open in central Oxford.

In June 2023, the Health and Wellbeing Board approved the publication of three Supplementary Statements to the PNA related to the closure of Lloyds pharmacies in Sainsbury's supermarkets in Littlemore, Oxford, Bicester and Witney.

We know that both population need and service provision are not static but continue to evolve. For example, market factors have led Boots to announce a national plan to reduce the number of premises in UK and housing growth or population changes can impact on the demand for services. The new PNA will capture these changes and will be kept under review during its 3-year life span.

Any proposed changes in pharmacies including closures, will continue to require advance notice of between 3 and 6 months (depending on opening hours).

Plan

The main steps in developing the new Oxfordshire PNA will be to:

1. Reconvene the **PNA Steering Group** including representatives of NHS England, BOB ICB, Pharmacy Thames Valley and Oxfordshire Public Health and discuss with other partners on the Health and Wellbeing Board, such as Healthwatch Oxfordshire and district councils, what input they could bring to this work.
2. **Collate data and carry out a gap analysis** (assessing the need for pharmacy services) which will evaluate access to physical community pharmacies in urban and rural areas and will include the prospective needs of new build areas.
3. Carry out a **public consultation**, which is expected to take place from November 2024 to January 2025. The PNA consultation documents will be circulated to the Health and Wellbeing Board for comment before the draft is published.
4. **Sign-off and publication of the final PNA:** presenting the post-consultation version of the PNA to the Oxfordshire Health and Wellbeing Board for approval in March 2025.

NAME
Ansaf Azhar, Corporate Director of Public Health & Community Safety

Annex: Nil.

Background papers: Nil.

[Other Documents:] Nil.

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March 2024

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Your voice on health and care services

Healthwatch Oxfordshire Report to Health and Wellbeing Board -March 2023

Healthwatch Oxfordshire Board

- We held an **Open Forum** on February 27th for people to meet our Board of Trustees, ask questions and hear about our work and activities, including our Q3 activity summary report. https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/

Healthwatch Oxfordshire reports to external bodies

Since the last Health and Wellbeing Board meeting in December 2023 we attended: Health Improvement Board (Nov 2023, Feb 2024 with lay ambassador), Oxfordshire Joint Health Overview Scrutiny Board (HOSC Nov 2023, Jan, Feb 2024), Oxfordshire Place Quality Committee (monthly) and Oxfordshire Safeguarding Adults Board. External bodies we attend and any reports can be found online at: https://healthwatchoxfordshire.co.uk/our-reports/reports-to-other-bodies/. We also attend Oxfordshire Place Based Partnership (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board - BOB ICB) among other BOB ICB committees including the Health Overview Scrutiny.

Healthwatch Oxfordshire and Healthwatch Bucks published a joint response to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board Primary Care Strategy consultation here: https://healthwatchoxfordshire.co.uk/news-and-events/correspondence/

Healthwatch Oxfordshire research and insight reports

All our reports can be seen here: https://healthwatchoxfordshire.co.uk/reports All reports are available in summary and Easy Read. Since the last meeting we published the following reports:

Maternal Mental Health in Oxfordshire (December 2023) based on anonymous data provided by Healthwatch England from 45 Oxfordshire women, about experiences of mental health support in the county during and after pregnancy. Highlighted

some of the gaps in support for mental health experienced by women going through pregnancy and childbirth, and with insights with direct relevance to Health and Wellbeing priorities.

Continuing our community research approach -

- Healthwatch Oxfordshire continues to develop its focus on hearing from people with lived experience using community research approaches, building on our previous models, work and reports with community research, and community researchers including videos: https://healthwatchoxfordshire.co.uk/our-work/community-research/
- Healthwatch Oxfordshire is again acting as host organisation to two community researchers during May 2023 -May 2024 within NHS South-East **Community Participatory Action Research** (CPAR2) Programme Phase 2. Two researchers from Oxford Community Action are focused over the year on learning research skills and exploring challenges of the impact of the cost of living and impact on black and minority ethnic communities. Training has been given with Reading University and Scottish Community Development Centre, alongside Healthwatch Oxfordshire bringing practical and day to day support and hands on training. Their research has focused on food poverty and working with other food groups in OX4 Food Crew (Oxford Mutual Aid and Waste2Taste). A survey has heard from 160 people, and we have also created a film together. This will be published in April and encourage conversation with the system about food insecurity, and contributing to wider Oxfordshire food strategy work and insights. We will also be attending a CPAR2 Showcase Event with the researchers in London in June, where all the researchers across the South-East showcase what they have heard.

- We continue to contribute insight and our learning about community research to others and to the development of the Oxfordshire Community Research network. November we published – '***Community Research in Oxfordshire***' with a full long read report, shorter and easy read versions, of a report summarising views we heard from community members, a two-sided summary of this work and an Easy Read report of this work are available at https://healthwatchoxfordshire.co.uk/report/community-research-in-oxfordshire-november-2023/ We will be sharing our learning alongside community researchers at a forthcoming Oxford University Policy Lab on 18th March. Wider exploration of this model is also taking place at BOB ICB level.

- One example of continued focus and impact stems from our work with community researcher Omotunde Coker and the film made on Black Women's Views of **Maternity services** (under CPAR1) https://healthwatchoxfordshire.co.uk/our-work/our-videos/ Women who made this film with us presented their experiences in conversation with 39 midwifery students at Oxford Brookes university in November 2023. Insights from this film also influenced the establishment of the Early Lives, Equal start project at Flo's in Oxford.

We continue **Enter and View** visits to health and care settings and have published **reports** https://healthwatchoxfordshire.co.uk/our-work/enter-and-view/ from visits as follows:

- Podiatry Service at Wallingford Community Hospital (Dec 2023)
- Inpatient Ward Bicester Hospital (Feb 2024)
- The Close Care Home (March 2024)
- Day Lewis Pharmacy, Didcot (March 2024)
- Inpatient Ward Didcot Community Hospital (Jan 2024)

- We received funding from **NHS Core 20 Plus 5** via the BOB ICB to support us to reach community connectors to hear about challenges in **oral health** for under 10's. We have been working with five community connectors in Banbury Ruscote and Neithrop areas to listen to people's experiences of supporting children with oral health. Connectors received training in basic research skills and have been building on local links and networks. To supplement this, we have also held a survey on oral health for parents and carers of children with SEND, as well as accessing hotel accommodation for asylum seekers in Banbury. A report will be published shortly, along with a small community-based event for connectors to share their learning with oral health professionals and bring learning to service design.
- We are working with user led charity **My Life My Choice** to support establishment of a Health Voices forum. The first session brought meeting and discussion between champions and learning disability nurse from Oxford University Hospitals NHS Foundation Trust- to learn about hospital services and to share experiences. Sessions with other health professionals.

- We hosted two **webinars on** 1 December and 28 February (76 members of the public in total) for the public to hear from members of Buckinghamshire, Oxfordshire and Berkshire West integrated Care Board (Dan Leveson, and Primary Care leads) about the Primary Care draft strategy and to give their views. This webinar can be seen here: https://healthwatchoxfordshire.co.uk/news-and-events/patient-webinars/

HWO goals, priorities and operational plan for 2024-25 year will be published shortly here : https://healthwatchoxfordshire.co.uk/about-us/our-priorities/. These are developed taking into account information from the following sources, including resident views: -

- Analysis of what we hear from members of the public across the county via our signposting service, Feedback Centre, projects and outreach activity -October to December 2023
- We had an online call-out (with additional outreach) asking the public for their views on what priorities Healthwatch Oxfordshire should consider for the coming year. We had 125 responses and what people told us will help inform our plans
- Review of planned policy and operational changes in health and social care services – both nationally and locally - Taking note of issues raised in our population that are seldom heard by the health and care system or Healthwatch Oxfordshire are not hearing from.

Other activity summary Oct - Dec 2023 (Q3)

A summary of our Q3 activity can be found here: https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/

Between October and December 2023:

- **62** people contacted us for help or information about local health and care services. The top four services we heard about were GP services, dentistry, Covid vaccine access, and adult social care. We signpost people on to relevant services if needed, and all staff are trained in Making Every Contact Count (MECC)

- Received **87** reviews for **40 health and care** services via our online Feedback Centre (https://healthwatchoxfordshire.co.uk/services) and received **51 direct** responses to reviews from service providers. In this way people can see how their comments and feedback are taken seriously and can help to improve services for all. It can also be an opportunity for providers to highlight and clarify pathways to access and information.
  Example of Feedback Centre provider response to a comment on GP access: *"Thank you for your feedback. I would be happy to discuss this with you if you could contact the Practice. We have been using online forms since 2018. The form has now been updated to be simpler. All medical needs are triaged by a GP rather than untrained staff except for acute illness which are booked directly into our shared acute hub (where patients speak to/see highly trained paramedics and advanced nurse practitioners). The GP triages into the appropriate appointment based upon the information given by the patient. We have a wide variety of staff:- paramedics, pharmacists, nurses, physiotherapists who are able to provide the necessary support to patients, our service is no longer purely a GP service but the clinician who can deal with your issue".*

- We made **4 Enter and View** visits where we heard from 51 members of the public and staff about their experiences of specific services. The Enter & View visits are supported by our team of Enter and View lay volunteers. As above reports are published with recommendations and service provider responses. Information about Enter and View is available on our website, along with Easy Read format https://healthwatchoxfordshire.co.uk/wp-content/uploads/2024/01/Enter-and-View-easy-read-information.pdf
- In addition, we visited the Horton Hospital, John Radcliffe Hospital as part of our regular **hospital visits**, speaking to **136** people during these two visits hearing about experiences of health care.
- We have an active social media presence, and links to local community groups and networks. We also reach people through community networks, parish and other news, voluntary sector, through ongoing communications including fortnightly news bulletin. Our website has resource and information on health and care.
- Building on our outreach work to hear from working men in Carterton, we supported a campaign by Oxfordshire Men's Health Partnership to reach out to men in West Oxfordshire, attending events at RAF Brize Norton, Carterton Town Hall and Carterton Leisure Centre for further focused work on men's health.

- We continued outreach visits to speak to people about their experiences of using health and social care services, attending in this time for example, Oxford Older People's Day, Communities of Practice, and a range of community-based groups.
- Our support for **Patient Participation Groups (PPGs)** continues with bi-monthly newsletters, regular emails and attendance at PPG meetings. In January 2024 we distributed a survey to all PPGs and GP Practices to gain an updated understanding of the status and activity of PPGs and support needs- as with changes in health service structures, this will enable identification of what their support needs are and where best placed.

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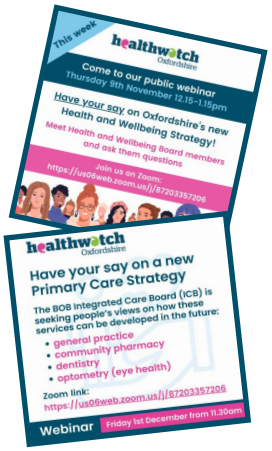
healthwatch Oxfordshire

October to December 2023

Your voice on health and care services

Activity and achievements

Outcomes and impact of our work



Helping people have their say on key new health strategies

We hosted a webinar in November for people to hear about and comment on a draft **Health and Wellbeing Board Strategy** for the county. **69** members of the public attended. We also held a webinar in December for people to hear from Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) about work to create a new **Primary Care Strategy**. **39** people attended this event. We also contributed reports and insights to help ensure people's voices were fed into the development of both these strategies.

Vaccine clinic victory for Didcot

We raised what we were hearing from Didcot residents about lack of access to **COVID booster vaccines** with the Health Wellbeing Board and BOB ICB – leading to the provision of a 'pop-up' clinic in the town.

Sharing views of maternity care with trainee midwives

We supported seven women featured in a film highlighting Black women's experiences of maternity services to continue to share their voices by speaking at an Oxford Brookes University teaching session attended by **39** student midwives.

We also:

- ✓ Published reports highlighting women's experiences of mental health support in the county during and after pregnancy, and of people's experiences of joined-up care in Oxfordshire.
- ✓ Published a series of reports capturing views on community research in Oxfordshire to help shape the county's emerging community research network.
- ✓ Continued to support two community researchers from Oxford Community Action who are focusing on food poverty and the impact of the cost of living on Black and minority ethnic communities.
- ✓ Carried out targeted outreach work with schools and community groups and organisations in Banbury to hear about the challenges parents and carers face helping children under ten years old to look after their oral health.
- ✓ Worked with My Life My Choice to support a new Health Voices Group to ensure the voices of adults with learning disabilities are heard and acted on by health commissioners and providers.

healthwatch Oxfordshire

October to December 2023

Your voice on health and care services

Activity and achievements

Hearing from you

→ **62** people contacted us for help or information about local health and care services. The top four services we heard about were GP services, dentistry, COVID vaccine boosters and adult social care.

→ We received **87** reviews for **40** health and care services via our Feedback Centre. We received **51** responses to reviews from service providers.

→ **125** people completed our survey sharing their views on what our priorities should be for 2024-25. What we heard has been used to help form our plans for the coming year.

Our Enter and View work

We made **4** Enter and View visits - to the Podiatry Service at Wallingford Community Hospital, the Inpatient Ward at Didcot Community Hospital, the Inpatient Ward at Bicester Community Hospital and Day Lewis Pharmacy in Didcot, hearing from **51** members of the public and staff.

Reports on our visits, which set out our recommendations for improvements, together with a response from the provider about what changes they will make, can be read at **www.healthwatchoxfordshire.co.uk/reports**

Out and about

We continued our programme of outreach visits across the county to speak to people about their experiences of using health and social care services, attending events including Oxford Older People's Day and RAF Brize Norton Health and Wellbeing Day. We supported a campaign by Oxfordshire Men's Health Partnership to reach out to men in West Oxfordshire, attending events at Carterton Town Hall and Carterton Leisure Centre. We also spent an afternoon as a team speaking to **30** working men in Witney town centre.

In addition, we visited the Horton General Hospital in Banbury and the John Radcliffe in Oxford as part of our regular hospital visits, speaking to **136** people during these visits.

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Divisions Affected - All

HEALTH AND WELLBEING BOARD

14th March 2024

CHAIR'S REPORT OF THE HEALTH IMPROVEMENT PARTNERSHIP BOARD 29th FEBRUARY 2024

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 29th February 2024 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;
   2.1. Tobacco Control
   2.2. Mental Wellbeing
   2.3. 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 29th February 2024. The thematic focus of the meeting was on Healthy Weight and Physical Activity, the latter including a full update on implementation of the Oxfordshire Food Strategy. There was also an important item on the role of HIB in delivery of the new Oxfordshire Joint Local Health and Wellbeing Strategy. A summary of the meeting is provided below and full reports are available at: https://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=899&MId=7689&Ver=4

Key Reports

5. **Health and Wellbeing strategy delivery-** The HIB noted the newly published Oxfordshire Joint Local Health and Wellbeing Strategy which all HIB members and representative organisations had contributed to the development of. It was agreed that priorities 3 and 4- that both sit in the "Live Well" part of the strategy

aligned very closely with the existing priorities of the HIB listed above in paragraph 2, and it was agreed that the HIB should take on the responsibility for ensuring delivery of this part of the strategy. An indicative summary of the overlapping themes for HIB going forward is summarised in the diagram below, but it is acknowledged that the detail of the Boards work programme will evolve and adapt as work progresses over the life of the strategy

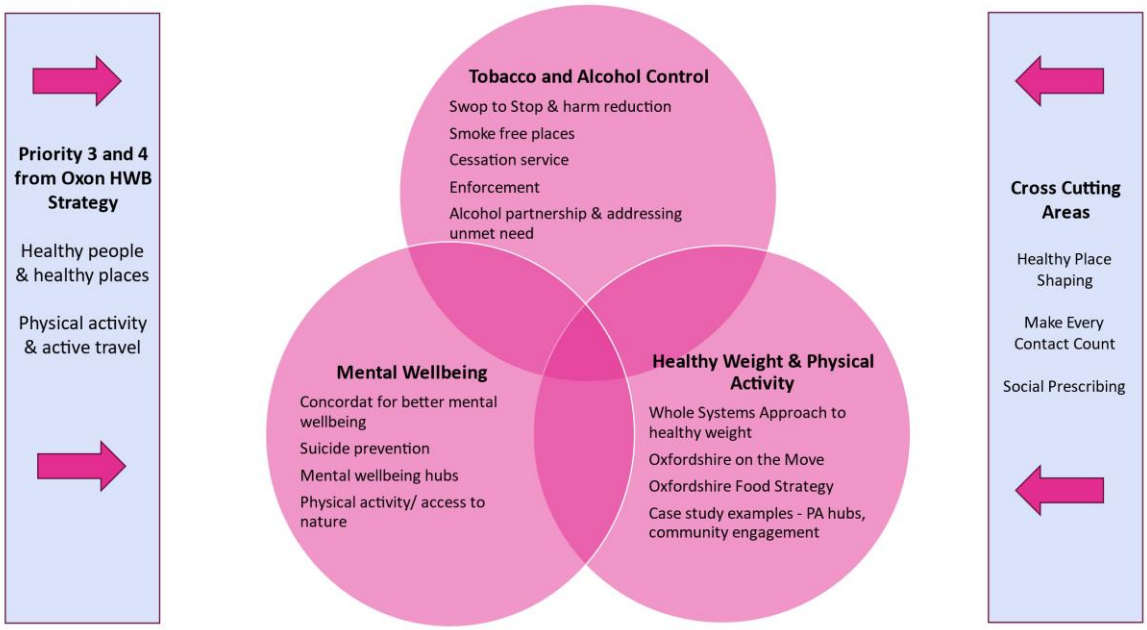

Figure 1- Proposed priorities for the Health Improvement Board

6. **Healthy weight services**- The HIB received and update of the provision of healthy weight services in Oxfordshire. These are split into 4 tiers with responsibility for commissioning in tier 1 and 2 sitting with Oxfordshire County Council, whilst tier 3 & 4 sits with the Integrated Care Board. These tiers are summarised in Figure 2 below.

   The Tier 2 services locally includes behavioural change programmes such as a 12 week face to face and group programmes and other specific target programmes. It performs well both in terms of completion of the courses and sustained weight loss and 6 and 12 months. A pilot programme for children and their families has also been running in Oxfordshire for the last 18 months and these 2 programmes will be brought together into 1 combined service from August of 2024 which will have a life course approach to service delivery. There is currently high levels of availability for places in tier 2 programmes in Oxfordshire.

   An outline of tier 3 and tier 4 weight management provision was provided by the ICB. It was noted that services in this space are challenged at present in terms of waiting times and provision across the ICS footprint. It is the tier 3 service that includes provision of the new NICE approved injectable medication to support weight loss, although it was noted that it is only a very small portion of the local population that are eligible for or would benefit from this medication.

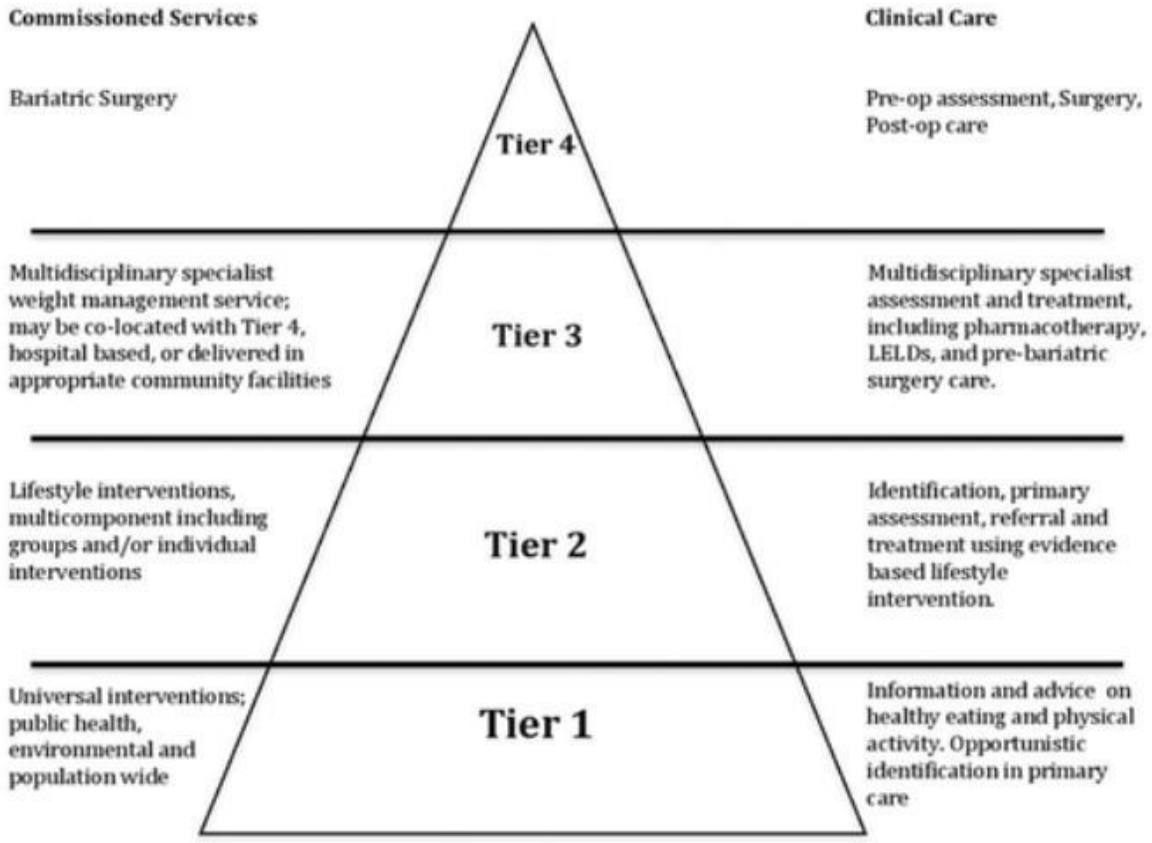

Figure 2- Outline of Tiered Healthy Weight Commissioned Services in England

7. **Oxfordshire food strategy-** The progress against implementation of this strategy was presented and included some county wide initiatives as well as case study examples of specific local action.

   The Board welcomed the county wide work which included Oxfordshire being awarded a Sustainable Food Places Silver Award, the Talking About Sustainable Eating Toolkit and Priority Places Food Index. An excellent initiative in the Didcot area, call "Nourish and Flourish", was also presented to the Board. The innovative approach taken by the local Primary Care Network to part fund the project and embed a healthy eating clinic within one of the PCN Practice sites was agreed to be a novel but effective way of supporting local residents. The sustainability of food action working groups and programmes of work happening needs to be kept under review.

8. **Oxfordshire On The Move-** An update on this physical activity movement was presented by Active Oxfordshire. The progress, increased numbers, reach and outcomes for those participating in the YouMove and Move Together programmes was encouraging to see. Active Oxfordshire presented evidence on how successful engagement in these programmes reduce demand on primary care

services and therefore offers a more cost-effective pathway with better outcomes for residents too.

Future meetings of HIB

9. As described above the HIB will continue to focus on its priority areas and ensure this aligns with the Live Well section of the new Health and Wellbeing Strategy. The performance report it receives on a quarterly basis will be updated to reflect the Key Outcome Indicators and Supporting Indicators specific to this priority.

10. The next meeting of the HIB will take place in June 2024

DAVID MUNDAY
DEPUTY DIRECTOR FOR PUBLIC HEALTH

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February 2024

Forward Work Programme

Future Meetings

Better Care Fund 2023-25 Update
Oxfordshire JSNA 2024 Update
Oxfordshire Community Safety/Combating Drugs Partnership Update
Annual Safeguarding Reports Adults & Children (Dec 2024)

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