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, 26 September 2024 at 2.00 pm

Room 2&3 - County Hall, New Road, Oxford OX1 1ND

Martin Reeves
Chief Executive

September 2024

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

Membership

Chairman – Councillor Liz Leffman
Vice Chairman - Sam Hart

Board Members:

Councillor Rizvana Poole	West Oxfordshire District Council
Ansaf Azhar	Corporate Director of Public Health, 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 Rob Pattenden	Cherwell District Council
Lisa Lyons	Director of Children's 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 Cheke Munkonge	Oxford City Council

Notes:

- ***Date of next meeting: 5 December 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. Requests to speak should be sent to democratic.services@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 14th March 2024 (**HBW5**) and to receive information arising from them.

6. ICB Update (Verbal Report)

The Board to receive a verbal update.

7. Marmot Place (Pages 13 - 22)

Report by Corporate Director of Public Health.

Oxfordshire faces significant inequality despite being a county of relative high affluence. A range of work programmes exist that see to address these inequalities, but there is not a unifying umbrella or methodology that guides these activities, and it is difficult to know how effective the range of action is.

This paper summarises an opportunity to partner with Professor Michael Marmot's Institute of Health Equity (IHE) who are the leading international experts in approaches to addressing social determinants of health to review our current activity and support more effective action going forward.

The strategic aims of this partnership would be to:

a. Provide a high-quality evidence based external review of the range of activities happening in Oxfordshire to tackle health inequality and inform potential gaps.
b. Act as a glue to bring together all activities to tackle health and social inequalities across Oxfordshire.
c. Provide a corporate evaluative framework for above initiatives across Oxfordshire.
d. Enable to measure rural inequality and take effective actions.
e. Mobilise our policy research to find innovative solution to tackle health inequality and help secure external funding for future work.

This approach supports the implementation of the Oxfordshire Health and Wellbeing Strategy agreed by the Board in December 2023.

RECOMMENDATION

The Health and Wellbeing Board is RECOMMENDED to

Endorse the proposed partnership with the Institute of Health Equity to develop Oxfordshire as a Marmot Place to advance our local programmes of work to tackle health inequalities in Oxfordshire, noting the rationale for this work and its connection into the new Oxfordshire Health and Wellbeing Strategy.

Agree to act as the existing system partnership board that has oversight of the developing Marmot Place work programme, and receive updates on progress at future Board meetings.

8. Prevention of Homelessness Directors Group (Pages 23 - 64)

Report by Director of Adult Social Care

This report provides a progress update on the work that has been undertaken in relation to homelessness services in Oxfordshire to improve support following the Safeguarding Adults Review in 2020, specifically “The Alliance”, which is overseen by the Prevention of Homelessness Directors’ Group. The report provides an update on progress made, a summary of current activity and an overview of current and future challenges.

RECOMMENDATION

a) The Health and Wellbeing Board is RECOMMENDED to note the report.

b) The Health and Wellbeing Board is RECOMMENDED to consider the frequency of further updates.

9. Oxfordshire JSNA Update (Pages 65 - 78)

Report by Corporate Director of Public Health.

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

RECOMMENDATION:

The Health and Wellbeing Board is RECOMMENDED to:

1. **Approve the content of the Joint Strategic Needs Assessment for 2024 and encourage widespread use of this information in planning, developing and evaluating services across the county.**

2. **Contribute information and intelligence to the JSNA Steering Group to further the development of the JSNA in future years, and to participate in making information more accessible to everyone.**

3. **Note requirements and plans for publishing the update of the Pharmaceutical Needs Assessment.**

4. Agree to the proposed approach and plan to align PNA workplan and steering group with ICS partners. Including a PNA publication date of 1st October 2025.

10. Oxfordshire Better Care Fund 2023-25 Update (Pages 79 - 156)

Director of Adult Social Services.

This report sets out the background and summary of the Better Care Fund Plan for 2024-25 for the Health and Wellbeing Board. It follows the same structure as the briefing given to the Health and Wellbeing Board Chair before submission of the Plan in July – see paragraph 5.

BCF Plans are owned and approved by the Health & Wellbeing Board on behalf of the Council and Integrated Care Board and other partners. As such, the Board approves the Plan each year.

Our 2-year BCF plan for 2023-2025 was assured and approved by the Health and Wellbeing Board in June 2023. The 2024-25 plan is intended to be an interim update.

This year, the July meeting of the Board was suspended due to the General Election. The Health and Wellbeing Board Chair therefore approved the Plan in a separate briefing meeting held on 2 July and attended by BCF leads and the Corporate Director for Adult Social Care. During the meeting, the Chair was asked:

a. To note the system-wide development and planning process for the 24/25 BCF plan.
b. To note and approve the recommended schemes for BCF funding 24/25.
c. To note the trajectories for BCF metrics & demand and capacity plan per the above schemes as agreed by the Urgent and Emergency Care board on 23 May.
d. To note and approve the plan to manage the implementation, spend, impact and long-term funding and efficiency approach proposals relating to approved schemes in a monthly BCF steering group which will report quarterly to UEC board and Place Based Partnership.
e. To approve submission of the final BCF 24/25 plan to NHS England
f. To support delegation to Adult Social Care Lead Karen Fuller to submit routine reports to NHS England and escalate any performance issues to HWB by exception.

RECOMMENDATION

The Oxfordshire Health and Wellbeing Board is RECOMMENDED to

Note the Oxfordshire Better Care Fund Plan for 2024-25, as approved by the Health and Wellbeing Board Chair via delegated authority on 2 July 2024 and NHS England on 23 August 2024.

11. Outcomes Framework (Pages 157 - 184)

Report by Director of Adult Social Services.

The Health and Wellbeing Board approved a new strategy in December 2023, with the priorities split between 4 thematic areas of Start Well, Live Well, Age Well and Building Blocks of Health. Delivery against the ambitions within the strategy is the responsibility of all organisations represented on the Board and is supported by an Outcomes Framework agreed by the Board in March 2024 .
The Board has agreed to receive a rotating update on delivery of 1 of the 4 strategy themes at its quarterly meetings, meaning that over the course of a 12-month period an update on each theme would be presented once. This report is the first annual report of the thematic domain of Age Well covering:

- **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.

- **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.

The performance report in Annex 2 presents the data for our Key Outcome and Supporting Indicators selected for these two priorities. As this is the first year of the current Health and Wellbeing Strategy, many of the measures we will use to monitor its

success have not had targets for the previous year. For each measure we have therefore produced trend data and where possible compared Oxfordshire's performance with the national performance. The performance annex includes actions for any measures where the direction of travel is of poorer performance or any measures with targets where the measure is not on target.

RECOMMENDATION

The Health and Wellbeing Board is RECOMMENDED to note the progress on the delivery of priorities 5 & 6 under the thematic domain of Age Well within the Health and Wellbeing Strategy.

12. Update on Unpaid Carers Strategy (Pages 185 - 196)

Report by Director of Adult Social Care.

Following the decision of the Health and Wellbeing Board on 16th March 2023, Oxfordshire's All-age Unpaid Carers Strategy was co-produced with carers and published in Autumn 2023, based on the priorities expressed by carers and strategic review of supporting carers in Oxfordshire.

Following the approval of the Strategy, an Action Plan was developed bringing together all the activities and commitments from all organisations in line with their own remit under each priority of the Strategy.

The Carers Strategy Oversight Group was established with representatives from all statutory and voluntary organisations and carers to oversee the implementation of the Strategy.

This report summarises the progress as reported by the organisations on the activities they carried out in the first three quarters of the implementation.

RECOMMENDATION

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

- **Note the progress achieved in the first three quarters of the implementation of the All-age Unpaid Carers Strategy and the Action Plan.**
- **Approve the mechanisms established to monitor the progress against the Strategy's agreed priorities and reporting progress to the Health and Wellbeing Board.**
- **Comment on the progress achieved to date and make recommendations for ensuring faster progress in the coming months.**
- **Note that the Place Based Partnership will be accountable for progress and ensuring all health partners are meeting their commitments under the Strategy.**

13. **Report from Healthwatch Oxfordshire** (Pages 197 - 202)

To report on views of health care gathered by Healthwatch Oxfordshire.

14. **Reports from Partnership Boards** (Pages 203 - 230)

To receive updates from Partnership Boards. Reports from –

- Place Base Partnerships
- Health Improvement Board; and
- Children's Trust Board

15. **Forward Work Programme** (To Follow)

Members to note the items on the Forward Work Programme.

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OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 14 March 2024 commencing at 2.00 pm and finishing at 4.30 pm

Present:

Board Members:	Councillor Liz Leffman – in the Chair Sam Hart (Vice-Chair) Councillor Joy Aitman Ansaf Azhar Michelle Brennan Stephen Chandler Councillor Phil Chapman Councillor Maggie Filipova-Rivers Karen Fuller Councillor John Howson Dan Leveson Councillor Dr Nathan Ley Lisa Lyons Ben Riley (In place of Grant MacDonald) District Councillor Helen Pighills Councillor Louise Upton Veronica Barry (In place of Don O'Neal) Clare Keen (In place of Caroline Green)
Officers:	
Whole of meeting	Louisa Chencier Louise Smith Lily O'Connor Rosie Rowe Adam Briggs Tamanna Rahimi Fiona Ruck

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
58 Welcome by Chair (Agenda No. 1)	
The Chair welcomed all to the meeting and requested that introductions took place around the room.	
59 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
Apologies for absence were received from Don O'Neal, Chair of Healthwatch Oxfordshire and Veronica Barry, Executive Director, would be substituting. Apologies were also received from Caroline Green and Clare Keen was substituting, Grant MacDonald and Ben Riley was substituting and Professor Jonathan Montgomery.	
60 Declarations of Interest - see guidance note below (Agenda No. 3)	
There were no declarations of interest received.	
61 Petitions and Public Address (Agenda No. 4)	
There were no petitions or requests for public address received.	
62 Note of Decisions of Last Meeting (Agenda No. 5)	
It was agreed that the Note of Decisions of the previous meeting held on 7 December 2023 would be approved. **RESOLVED: that the Board APPROVED the notes of the last meeting held on 7 December 2023 and the Chair be authorise to sign them as a correct record.**	
63 DPH Annual Report (Agenda No. 6)	
The report informed the Health & Wellbeing Board on the structure and overview of content, including key messages, of the upcoming Oxfordshire County Council Director of Public Health's	

Annual Report (2023/24) focussed on climate and health. The Corporate Director of Public Health & Community Safety, Ansaf Azhar, highlighted that health was forgotten when it came to climate change, considering the immediate and positive health benefits for individuals., families and communities which could be delivered through climate action. Amidst mounting pressure in our NHS, tackling the impacts of the changing climate across Oxfordshire would save lives and money, and conserve resources for those most in need. It would 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 would also support delivery of a range of plans that seek to support climate action in Oxfordshire. Ansaf Azhar thanked everyone that had been involved. 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. Rosie Rowe, Head of Healthy Place Shaping, gave a presentation to the Board on why there was an increased focus on climate and health. It was reported that there was a full day dedicated to health at the COP2023. The five key areas were Temperature, Air, Water, Food and Nature. There were many reasons for focussing on the impacts now such as higher temperatures, bettering air quality in Oxfordshire has improved health, increasing flood events, disruption to supply chains resulting in shortages, increased prices and increased food insecurity and greener neighbourhoods and more exposure to green space correspond to better general and mental health, reduced cardiovascular mortality, reduced stress, reduced incidence of low birth rate and maintaining a healthier weight. Plenty of action was being undertaken such as supporting residents to increase the energy efficiency of their homes, the introduction of zero emission buses, reducing emissions of supply chains and reducing food waste. There was a call for everyone to do more. The three key messages from the presentation were that health impacts of climate action were immediate, actions taken to improve climate health, also immediately improve our health and the health of others and every climate action, policy and strategy should identify the impacts and maximise the benefit for our	

health and wellbeing and by the same token, every health action, policy and strategy should mitigate for and prevent negative health impacts of the changing climate. Points discussed by the Board included: • Organisations working in silo with separate agendas and the need to work together. • Birth rate decline in Oxfordshire and closure of small village community schools. • The Director of Public Health had already looked at inequalities and then healthy weight and both had been very successful. • Collaborative working with anchor organisations. • Focussing on what could be done now that showed results to show people results and then engage. • It was a great time for joined up working. • The Community would be engaged by appropriate comms, inclusion of lived experiences and by reaching out to residents and stakeholders. **RESOLVED: that the Board endorsed 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.**	
64 Health and Wellbeing Strategy Outcomes Framework & Delivery Plan (Agenda No. 7)	
The Board were introduced to the Health and Wellbeing Strategy update by David Munday, Consultant in Public Health OCC. The update included the following points: • The Joint Health and Wellbeing Strategy for Oxfordshire was published in January 2024 after it had been approved by the Board. • The Outcomes Framework would show the Strategy in actions showing impacts and local results. This would be a strategic view of all the actions across the new strategy and the shared ambitions. • The Strategy has three principles: Preventing ill health, Tackling health inequalities and Closer collaboration. There are two priorities per each life course and then four building blocks of health. • The idea was not to create new meetings and new boards as these structures were already in place such as the	

Health Improvement Board, the Children's Trust Board and many others, already in place. These would oversee the activity of the work taking place.

Tamanna Rahimi, Paediatric Public Health Fellow, gave some examples of how the Outcomes Frames was constructed and the key features. The indicators were explained by Tamanna too.

David Munday added that the Board would see on a quarterly basis, each life course, Start Well, Live Well, Age Well and Building Blocks, ensuring that the Board sees the overall view over a year and looking at things at the right timeline.

The Board Members made the following comments:

- Some of the measures in the healthy homes area were not measurable such as household incomes, social housing as it meant different things to different people.
- It was suggested that any moving targets were recorded with reasons as the scope for targets could change depending on external circumstances.
- The children's area seemed to be very focussed on physical side and not much on mental side. It would be interesting to see more about younger children, before school.

Resolved: That the Health and Wellbeing Board:

- **Agreed the Health and Wellbeing Strategy Outcomes Framework (Annex 1) which contained the Shared Outcomes under each of the Strategy's priorities as well as the Outcome Indicators and key programmes/ partnerships relevant to each.**
- **Agreed 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.**
- **Commented on the draft performance report (Annex 2) as the proposed way of visualising data against specific priorities.**

65 Community Profiles Update
(Agenda No. 8)

The report was presented to the Board by Fiona Ruck, Health Improvement Practitioner. It was highlighted that The Director of Public Health Annual Report in 2019 had highlighted ten wards in Oxfordshire that had 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 were most likely to experience inequalities in health. Community profiles for Littlemore and Central Oxford (Phase 3) were published in December 2023 which completed the creation of community profiles for all ten areas. These profiles provided an in-depth understanding of the enablers and challengers to the health and wellbeing of communities. The profiles linked to the Joint Strategic Needs Assessment (JSNA) and contributed to the local evidence base to inform service delivery, as well as being a resource for local communities to support their work. The Board received brief summaries from the Community Officers as below: Jon Hyslop, Community Glue, Engagement process in City Centre reported the following points: • There were high pockets of deprivation with mainly blue-collar area within a working-class area. There is a high concentration of social housing. The project started in July 2023 with many wanting to be a part of it from local organisations and partner organisations. This was an important area for local homelessness services. The information gathering took place through individual and group contact and through an online survey. Reaching the homeless and people in social hosing was good but it was poor in terms of access to young adults and local minority ethnic communities. • The findings included that people had good access to primary and secondary healthcare although transport was sometimes an issue. And there was a lack of physical and social spaces. May Elamin, Community Health Development Officer, Oxford City Council reported the following points: • Since the publication of the Central Oxfordshire Inside Gathering Report in December 2023, focus had been given to making meaningful connections to meet the recommendations. The connections were vital for a coordinated effort to deliver the actions. An action plan had been developed with identified improvements and activities to improve the health and wellbeing in the area. Connections had been made with partners to improve activities for residents. The information was shared with residents using the community notice boards, local primary schools and medical centres to try and get the information to as many people as possible. • Looking into transport, funding and other initiatives. Tom McCulloch, Community First Oxfordshire, reported the following points:	

- Looking at the Littlemore area. Reached out to 200 people using different methods such as focus groups, one to one interviews and a community survey. This was over a 10-week period between September and November 2023. This allowed engagement with many groups and reached a good number of children and young people, 60% females were consulted and 80% British and other ethnicities. Additional research would be useful as many assets were available but some of these could be improved such as improving communications and the youth council. The challenges identified included the lack of local available healthcare services and facilities and access to healthcare causing an isolation in the community. There was a lack of public transport and a lack of safe walking connections. There was lots of excellent community support, but the volunteers were very stretched in time, funds, facilities and resource.

Tony Eaude, Littlemore Resident, reported the following points:

- Littlemore had for many years been overlooked for its primary care services. There is no GP surgery, no dentist, no pharmacy and had many elderly and disabled residents have to travel distances to services. The access to public transport was not good, especially from certain areas. The population in Littlemore and surrounding areas had risen significantly and would continue to do so due to the substantial development in the area. The study's had shown that Littlemore was an area of derivation that was not recognised.

David Munday thanked all for attending and for all the work carried out. The Community Profiles were all complete now but there was still work to complete. From the profiles that had been generated, it was now time to move from insight to actions on the recommendations. There were community health development officers in each area to take the work forward. The engagement to see how the health and wellbeing was improving was still in place. Phase 4 work was ongoing to see how the community profile work could be replicated. The Board would be kept updated.

Councillor Howson commented that he had lived in and around Oxford for over 40 years and had noticed that the large number of people that had moved into the area were still using the GPs from other areas causing the transport issues.

Ben Riley, Oxford Health, thanked the speakers and commented that their comments were very helpful to evolve and for the planning and local engagement. In the City Centre area, an important asset highlighted, the medical centre that specially

provided primary care for the homeless. It was good to hear that the level of service was very good, but the building was not in a good state. There was refurbishment work ongoing on the entire reception and waiting area at the site. It was the fifth year of the five-year contract, so these comments were helpful to start conversations to develop the service going forward. In the Littlemore area, the Trust have a large premises in the Littlemore Health Centre and hospital but agreed with the comments that there was very little access to primary care in the area and that public transport was a challenge, especially at the weekends for people to get to the service. Councillor Louise Upton commented that it was very important to have positive interactions between children and their care givers and to have social and community spaces and youth councils. The Chair would take away the public transport point raised by many. The Council had no direct responsibility for public transport but had good links with bus companies. Others from the Board agreed that the transport issues had been raised previously and in other work being carried out and reassurance was given that work was being done for access to primary care sites. **Resolved: That the Oxfordshire Health and Wellbeing Board** **Noted the findings and rich insight contained within the Community Profiles for Littlemore and Central Oxford.** **Support the promotion and sharing of the community profiles with partners and colleagues across the system.** **Use the insight from the community profiles to inform service delivery plans of partner organisations on the Board.**	
66 Place based Research Collaboration in Oxfordshire (Agenda No. 9)	
The Board received a presentation from Adam Briggs, Deputy Director of Public Health. This paper and presentation summarised why research was crucial to the work of local government to improve health and tackle inequalities in Oxfordshire. The paper asked for the HWB to comment on the development of a place-based approach to research across the county. The comments from the Board included:	

• This was welcomed by the Place-Base Partnership Director. Lots of conversations were taking place and it was important to engage all NHS primary, secondary and commissioners, especially as the resources were being used differently in the county to engage all NHS areas. • The Local Policy Lab was a win-win situation for the County. **Resolved: That the Health and Wellbeing Board discussed and commented 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. The item would be added to a future agenda for an update to the Board.**	
67 Primary Care Strategy (Agenda No. 10)	
Louise Smith, Deputy Director Primary Care BOB ICB, commented that it was very interesting to attend the Board and to note that sustainability had not been included in the Primary Care Strategy but after listening to the discussions, it would now be included. The Health and Wellbeing Strategy and the Primary Care Strategy had to work alongside each other, the access was an issue that was queried lots but that was being addressed and the research element was very important in healthcare. The consultation had ended on 29 February 2024, but any further feedback would still be welcome. Louise Smith presented the presentation to the Board. Some of the points raised included: • Where in the county would this be run, would the districts and parishes be included. The best aspects from each county would be taken and that best practice would be shared with other areas. • The primary care estates sat under the wider care estates strategy that was being formulated. The S106 was used in different ways and the aim was to build on existing practices and work alongside the local plans and people moving into the areas using the GP data. • The prevention and CVD prevention would reduce the demand on primary care but also improve the outcomes. • It was important to know that prevention alone did not reduce the GP workload, so the workforce was still required.	

• GPs were working 60-70 hours a week, and this was not sustainable. • There seemed to be a real confusion between the GPs, general practice and primary care and understanding of what primary care meant and the difference was important and very necessary. • The roll-out of this would be very interesting to see and it was worth noting that different areas of Oxfordshire would differ from each other too. **Resolved: that the Oxfordshire Health & Wellbeing Board:** - **Noted the work undertaken by the ICB and Partners to develop the Primary Care Strategy and** - **Discussed the content themes and any further points for consideration and/or of concern.**	
68 Planning for next JSNA & PNA (Agenda No. 11)	
The Board were presented with a report on the Planning for the next JSNA and PNA by Steven Bow, Consultant in Public Health. 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. In response to the evolving landscape of demographic, health and social care data dissemination and accessibility, a novel approach was being proposed for the development of the JSNA. This proposal aimed to transition the traditional static JSNA into a dynamic and interactive digital format. This transformation could be undertaken during 2024/2025, and was envisioned to enhance usability, accessibility, and data visualisation for stakeholders involved in public health planning and decision-making processes. The publication of a Pharmaceutical Needs Assessment (PNA) is a legal duty of the Oxfordshire Health and Wellbeing Board. It was a comprehensive assessment of the current and future pharmaceutical needs of the local population, and the extent to which current service provision meets these. There had been many changes in the pharmacy landscape since 2022, when the previous PNA was published. A number of recommendations were being suggested for the	

Board to agree. The Board agreed that Climate be added to sections to be updated in the JSNA during the summer as part of the "lighter touch" 2024 update. **Resolved: that the Board:** **1. Agreed to transition the Joint Strategic Needs Assessment (JSNA) publication from 2025 onwards to an interactive digital format.** **2. Approved the approach to 2024 JSNA publication to be focused on key thematic areas agreed by the Board.** **3. Agreed to the establishment of a JSNA steering group made up of partners represented on the Board to take forward the work.** **4. Noted the requirement to update the Oxfordshire Pharmaceutical Needs Assessment (PNA) by April 2025.** **5. Agreed to the establishment of a PNA Task and Finish group made up of partners represented on the Board to take forward the work.** **6. Agreed to the proposed timescale to undertake the work- including public consultation and for approval at the Health and Wellbeing Board in March 2025.**	
69 Report from Healthwatch Oxfordshire (Agenda No. 12)	
Veronica Barry, Executive Director of Healthwatch Oxfordshire, informed the Board that Healthwatch Oxfordshire had been involved and represented throughout the agenda items including the Health and Wellbeing Strategy, the Primary Care Strategy and the Community research work too. It was reported that the oral health needs were being looked into as well as the oral health needs of children with special education needs. These would be reported on in April 2024. The rural health and deprivation were also being looked into. **RESOLVED: that the Board noted the report from Healthwatch Oxfordshire.**	
70 Reports from Partnership Boards (Agenda No. 13)	
A) Place Based Dan Leveson presented his report to the Board and stated that the focus was largely around the financial planning for the next	

years emerging care system. It was to support the urgent care centres, support the virtual wards, hospitals and homes, support the integrated neighbourhood teams, integrate the transfer of care team and the dischargeable access and to work with all the increase in demand of out of hours primary care. There was also an ICB consultation for revamping the structures. B) Health Improvement Board David Munday presented the report to the Board. The Board were informed about a received report on Healthy Weight Services and the importance of these in Oxfordshire. C) Children's Trust Board Lisa Lyons, Executive Director, Childrens Services, reported that she had just come into the post and was in the process of relaunching the children's trust arrangements. There had been a huge change in regulations which had completely changed the focus for the statutory services for partners in education and health. This was currently being worked on and something would be in place by late spring and reported at the next Board meeting.	
71 Forward Work Programme (Agenda No. 14)	
RESOLVED: The Board noted the Forward Work Programme and recommended to add the update to the Primary Care Strategy, later in the year.	

..... in the Chair

Date of signing .....

Divisions Affected - All

OXFORDSHIRE HEALTH AND WELLBEING BOARD

26th September 2024

MARMOT PLACE - GOING FURTHER AND FASTER ON ADDRESSING HEALTH INEQUALITIES IN OXFORDSHIRE

Report by Ansaf Azhar

RECOMMENDATION

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

   Endorse the proposed partnership with the Institute of Health Equity to develop Oxfordshire as a Marmot Place to advance our local programmes of work to tackle health inequalities in Oxfordshire, noting the rationale for this work and its connection into the new Oxfordshire Health and Wellbeing Strategy

   Agree to act as the existing system partnership board that has oversight of the developing Marmot Place work programme, and receive updates on progress at future Board meetings.

Executive Summary

1. Oxfordshire faces significant inequality despite being a county of relative high affluence. A range of work programmes exist that see to address these inequalities, but there is not a unifying umbrella or methodology that guides these activities, and it is difficult to know how effective the range of action is.

2. This paper summarises an opportunity to partner with Professor Michael Marmot's Institute of Health Equity (IHE) who are the leading international experts in approaches to addressing social determinants of health to review our current activity and support more effective action going forward.

3. The strategic aims of this partnership would be to:

   a. Provide a high-quality evidence based external review of the range of activities happening in Oxfordshire to tackle health inequality and inform potential gaps
   b. Act as a glue to bring together all activities to tackle health and social inequalities across Oxfordshire
   c. Provide a corporate evaluative framework for above initiatives across Oxfordshire
   d. Enable to measure rural inequality and take effective actions.
   e. Mobilise our policy research to find innovative solution to tackle health inequality and help secure external funding for future work.

4. This approach supports the implementation of the Oxfordshire Health and Wellbeing Strategy agreed by the Board in December 2023.

Background

5. Oxfordshire experiences persistent inequalities in health outcomes between different areas of the county. As reported by the Director of Public Health Annual Report 2019, there are 10 wards in Oxfordshire which include areas ranked in the 20% most deprived in England. These areas tend to have worser health outcomes than their more affluent counterparts.

6. We understand that inequalities also exist within rural settings, but to date there has been limited work to explore this issue and work with local communities to find solutions. Our work on non-geographically bound health inequalities, for example those experienced by "inclusion groups" or minority ethnic groups could still be strengthened.

7. The main drivers of health inequality are the wider determinants of health or what we increasingly refer to as the "building blocks" of health.

8. Professor Michael Marmot and his Institute of Health Equity (IHE) are the international experts on evidence-based action to address inequality and based on their research. More than 10 years on now since the first Marmot report, the team and IHE are now focused on developing and implementing the following 8 "Marmot Principles" to guide effective action.

Marmot Principles

i. Give every child the best start in life.
ii. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
iii. Create fair employment and good work for all.
iv. Ensure a healthy standard of living for all.
v. Create and develop healthy and sustainable places and communities.
vi. Strengthen the role and impact of ill health prevention.
vii. Tackle racism, discrimination and their outcomes.
viii. Pursue environmental sustainability and health equity together.

9. Some local areas such as Coventry, Manchester, Gwent, Luton, Lancashire & Cumbria have partnered with Marmot's team to adopt these principles or methodology to their work on inequality and are referred to as Marmot Places.

10. An independent evaluation of this work in Coventry demonstrated positive impact after 6 years and showed

    a. A 20% reduction in the number of neighbourhood areas listed as the most deprived according the ONS Index of Multiple Deprivation

b. Stabilising of different in life expectancy between women in the most and least deprived areas, despite a national increase in this gap
c. A 6-month reduction in the gap in male life expectancy, again against a national increase

Oxfordshire as a Marmot Place

11. System partners in Oxfordshire are already active in running a range of projects and programmes that seek to address inequalities in Oxfordshire. Some of these programmes address a particular building block of health (such as housing or employment) or a particular health behaviour (such as physical inactivity or tobacco use) whilst others are broader taking an asset-based community development approach (including the Community Profiles, Brighter futures in Banbury, Well Together Programme, Oxfordshire Food Strategy and the Oxfordshire Way prevention programme)

12. The aim of the Marmot Place partnership is not to duplicate any of these existing programmes but to provide an overall strategic and evidence-based framework that brings these different strands of work together. It aims to ensure there is a common methodology- underpinned by the Marmot Principles- that exists across all programmes of work

13. The proposed Marmot Place partnership builds on the new Oxfordshire Health and Wellbeing Strategy which identified action on health inequalities as one of the 3 cross cutting principles that spans across all priority areas for action. The Strategy's 10x priorities span across four thematic areas- the first 3 being stages of the life course- with the fourth the Building Blocks of Health. This final theme aligns closely with the action on what the Marmot team describes as the social determinants of health that are the structural drivers of much of the inequality we see locally.

14. Various areas in the country have now partnered with the Marmot team to become a Marmot Place. Oxfordshire has some specific features which will be of interest to the Marmot team and make Oxfordshire as a Marmot Place different to others. These include the increasingly close working with the Universities in Oxford to take place-based approaches to research and wellbeing and the more rural than inner-city nature of the County.

15. The Marmot Principles listed above are the key pillars that Marmot Place work is built around. The team at IHE recommend that, at least initially, Places prioritise 2 principles to focus the work on. This ensures that the work-programme can be focused and provide some tangible impact and is not spread out to thinly.

16. To select the right principles for Oxfordshire, one of the first tasks to work on- with the input from IHE colleagues- is to use the following criteria to map out where our initial focus should be. The suggested criteria include;
    a. How does the principle align with the HWB Strategy?
    b. Are the principles reflected within other existing strategies in the County

c. What existing projects or activity is already in place against each principles
d. What does the data within the JSNA tell us about the local need in Oxfordshire regarding each principle
e. What is the evidence of positive impact further action might make

17. In initial discussions with the Marmot team a high-level draft work programme has been developed with an aim to start the partnership this autumn. **A copy of this work-programme is included as annex 1.** It is anticipated that this work-programme will iterate over the 2-year partnership to ensure it meets the specific ask in Oxfordshire.

18. To build momentum with this work and to draw in wider partners, including community groups and community leaders, to this project, it is proposed that a launch event is held in November. This would include hearing directly from Michael Marmot and his team on the national picture regarding health inequalities and the positive impact that Marmot Place work has had in other areas. It will also provide opportunity to hear directly from residents most impacted by the inequalities we see and ensure opportunity for meaningful conversation and dialogue between attendees.

19. It is suggested that regular updates on the progress of the Marmot Place work programme will be provided to the Health and Wellbeing Board. In addition, board members and officers from represented organisations will be asked to engage in relevant specific meetings and workshops to progress the work.

Corporate Policies and Priorities

20. As identified earlier in the report this proposal aligns closely with the Health and Wellbeing Board's new Health and Wellbeing Strategy as well as other strategies held in partnership or by single organisations that include a focus on health inequality

Financial Implications

21. The cost of engaging the Institute of Health Equity for 2 years is £150,000 and funding has been identified from the Public Health grant to enable the system to benefit from this work

Legal Implications

22. There are no legal implications associated with this report and the Marmot Place initiative should support the requirement that when using public health grants, local authorities must consider reducing inequalities in health between people in their area.

Staff Implications

23. There are no staffing implications associated with this report

Equality & Inclusion Implications

24. This project will actively seek to improve healthy equity and the health and wellbeing of inclusion groups. A formal Equity Impact Assessment is not required

Sustainability Implications

25. There are no direct sustainability implications relate to this report. One of the Marmot Principles relates to environmental sustainability and therefore it is anticipated that the

Risk Management

26. A detailed risk assessment is not required for this work. Oversight and input on the work programme will be provided by the Health and Wellbeing Board.

Consultations

27. Public Consultation is not required for this proposal, however meaningful engagement and joint work between organisations on the Health and Wellbeing Board and communities themselves lies at the heart of what will make this work successful.

ANSAF AZHAR, DIRECTOR OF PUBLIC HEALTH AND COMMUNITIES

Annex: Annex 1- Oxfordshire Marmot Place Proposed Work Programme

Background papers: Nil

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September 2024

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Oxfordshire Marmot Place
Draft Proposal

Introduction

This proposal suggests a proactive approach to health inequalities using the Marmot principles and resulting in a long-term plan for sustained change in Oxfordshire. This approach is being employed by a growing number of areas in England and Wales that are declaring themselves 'Marmot Places' to lend traction to their aims.

The Marmot Principles
Give every child the best start in life
Enable all children, young people, and adults to maximise their capabilities and have control over their lives
Create fair employment and good work for all
Ensure a healthy standard of living for all
Create and develop healthy and sustainable places and communities
Strengthen the role and impact of ill health prevention
Tackle racism, discrimination, and their outcomes
Pursue environmental sustainability and health equity together

Oxfordshire County Council Public Health will commission the UCL Institute of Health Equity (IHE) over a period of two years to conduct a review to highlight inequalities and their underlying causes, engage with health and individual partner organisations, identify plans and actions already in place to tackle inequalities, identifying gaps and recommending ways to achieve positive change.

There is no additional funding as part of this approach but the joint focus, detailed understanding of underlying factors and shared commitment will galvanise and maintain local actions.

Strategic Aim

Oxfordshire becoming a Marmot Place aims to improve the lives of residents and reducing health inequalities. The Marmot approach will act as a catalyst for joint-up action and sustained change, driven by local communities and organisations. There are five strategic aims:

a. Provide a high-quality evidence based **external review of the range of activities** happening in Oxfordshire to tackle health inequality and inform potential gaps
b. Act as a **glue to bring together** all activities to tackle health and social inequalities across Oxfordshire
c. Provide a **corporate evaluative framework** for above initiatives across Oxfordshire
1. Enable to **measure rural inequality** and take effective actions.
e. **Mobilise our policy research** to find innovative solution to tackle health inequality and help secure external funding for future work.

Delivery and Outcomes

PHASE 1. October 2024-October 2025

1. Launch October 2024
    i. Presentation by Michael Marmot
2. Assessment of current activity to address health inequality
    i. Mapping of existing work programmes across different organisations/ parts of the Oxfordshire system that is addressing inequalities/ building blocks of health in different ways. This could be mapped against the 8x Marmot principles and/or mapped geographically to the different areas of Oxfordshire
    ii. An assessment of the overall effectiveness of above programmes in improving health equity
    iii. Review of our system wide working and maturity of our local system for health equity

Outputs:

1. IHE attend advisory and steering group meetings
2. Workshops and meeting with relevant stakeholders and community groups to identify opportunities for action.
3. Review of Oxfordshire health inequalities system: mapping and overview of programmes and approaches from range of partners on the SDH and identification of gaps
4. Two deep dives into agreed areas of activity

Time Commitment

Deputy Director	15 days
Senior Researcher	20 days
Researcher	30 days
Michael Marmot	2 days
Senior advisor	3 days

3. Insight into nature of health inequality in Oxfordshire beyond our 10 wards with LSOA in quintile 5 of IMD
    i. Understand the nature of rural health inequalities in Oxfordshire- often smaller than/at a lower level than LSOA level. What are its key features and how is it different to urban Oxford/Banbury
    ii. Understand the prevalence and health needs of inclusion health groups in the County

Outputs

1. Mapping of approaches to address rural health inequalities and identification of gaps
2. Workshop and meeting with relevant stakeholders and community groups to identify gaps in knowledge and understanding.
3. Report and recommendations for action developed in collaboration with partners

Time Commitment

Deputy Director	10 days
Senior Researcher	25 days
Researcher	15 days
Michael Marmot	1 days
Senior advisor	6 days

PHASE 2. October 2025 - October 2026

4. Evidence-based actions for health equity
    i. Based on insight from Phase 1
        - What should we stop, what should start, what should carry on- focused on 2 or 3 priority Marmot Principles for Oxfordshire?
        - What action is required to address any identified inequality?
5. Research and evaluation
    i. Develop a framework for the evaluation of new or existing programmes that aim to improve health equity
    ii. Work with the Oxfordshire "Policy Lab" and local research partnership to develop an approach to researching new and innovative ways to address the building blocks of work and reduce health inequality
6. Monitoring & implementation
    i. Development of monitoring tool that can be used to track progress against improving health equity in Oxfordshire
    ii. In doing i) ensure interaction/ compliments existing outcomes framework of the local Health and Wellbeing Strategy
    iii. System support for implementation/ oversight of action to improve health equity, including approach to governance

Outputs

1. IHE activities across Oxfordshire to make the case and disseminate the findings from Phase 1
2. Work in partnership with the Policy Lab to develop health equity framework for evaluation and other accountability tools
3. Develop monitoring tool
4. Continuing meetings with steering and advisory groups and partners

Time Commitment

Deputy Director	20 days
Senior Researcher	20 days
Researcher	30 days
Michael Marmot	1 days
Senior Advisor	3 days

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Divisions Affected – All

HEALTH AND WELLBEING BOARD

26 September 2024

HOMELESSNESS AND ROUGH SLEEPING IN OXFORDSHIRE

Report by Director of Adult Social Care

RECOMMENDATION

a) The Health and Wellbeing Board is RECOMMENDED to note the report.

b) The Health and Wellbeing Board is RECOMMENDED to consider the frequency of further updates.

Executive Summary

1. This report provides a progress update on the work that has been undertaken in relation to homelessness services in Oxfordshire to improve support following the Safeguarding Adults Review in 2020, specifically "The Alliance", which is overseen by the Prevention of Homelessness Directors' Group. The report provides an update on progress made, a summary of current activity and an overview of current and future challenges.

Background

2. Across the Districts, City and County, there is a joint commitment to people who experience homelessness and rough sleeping is derived from the aim to create thriving communities for everyone in Oxfordshire where people live safe, healthy lives and play an active part in their community, providing services that enhance the quality of life in our communities.

3. Homelessness is a national issue and is a growing trend. National rough sleeping statistics show that is rouse 27% to nearly 4000 rough sleepers at the end of last year. This is only known rough sleepers, so the actual number will be higher still. Councils have seen a 14% rise in homelessness presentations over the same period. It is estimated that 1 in every 182 people in England are homeless.

4. The need for a system-wide response was also identified in the Safeguarding Adults Review (SAR) published in 2020 which reviewed the deaths of nine homeless people in Oxfordshire in 2018 & 2019. One of the key findings from the SAR was that the approach to working with people experiencing multiple-exclusion homelessness (where they had mental ill-health, substance abuse

issues and/or were experiencing domestic abuse) was fragmented and required a coordinated, system-wide response. Following this review, the Alliance of homelessness services, the review process for scrutinising all deaths of people who were homeless, and the Prevention of Homelessness Directors' Group (PHDG) were all created. The PHDG comprises of senior colleagues from all the commissioning partners as well as other statutory agencies involved within the system, such as Health, Probation and The Police.

5. Homelessness support services are commissioned in partnership between the Districts and City Council's, which have statutory responsibilities to provide homelessness and housing advice services, Oxfordshire and West Berkshire Integrated Care Board along with the County Council through a pooled fund. This commissioning partnership oversees a delivery partnership between agencies working across the County and City to provide the support services. This delivery partnership is referred to as The Alliance. The providers that make up the Alliance are listed below.

    i. A2Dominon
    ii. Aspire Oxfordshire
    iii. Connection Support
    iv. Elmore Community Services
    v. Homeless Oxfordshire
    vi. St Mungo's

    Services that are provided through the Alliance include;

    Prevention

6. Aspire and Connection Support services work to prevent homelessness and rough sleeping. They work with around 1000 cases across a year.

    The prevention Service provides:

    - Support and empower people at risk of homelessness to manage debts & housing arrears.
    - Access to benefits
    - Access to mental health services and drug and Alcohol services
    - Access to long term housing and support with advocacy when working with statutory and other services.
    - Support people to link them to the right community services.

    Outreach

7. St Mungo's and Connection Support provide support to those rough sleeping to access emergency housing, access to benefits and health services as well as connecting with other local authorities to refer for those with no local connection to Oxfordshire.

8. Rough sleeping statistics are reported to central government as part of mandatory local authority returns. The identification, monitoring and outcomes for rough sleepers are therefore closely monitored by local authorities and The

Alliance in turn. On any one night and as an average across Oxford and Oxfordshire, there are between 55 and 65 people sleeping rough. This is lower at times of severe weather, when additional services are offered through local authorities.

Supported Accommodation

9. There are around 230 properties across the County. Access to supported accommodation is through an Access Panel. There is a high demand for this accommodation, with an average of 22 referrals per month and the waiting list is around or in excess of 100. 30% of referrals are for the accommodation with the higher support levels where 24/7 support is available, at O'Hanlon House, Matilda House (both Oxford) and Mawle Court (Banbury). Around 25% of people have lived in supported accommodation for two years or longer, which demonstrates issues relating to move on and supply.

   (This is a different pathway to those who require Temporary Accommodation, who are homeless and in Priority Need, such as families facing eviction. The responsibility for assisting these households would sit with the City and District Council's and be managed outside the Alliance contract.)

   Some additional services are also provided, such as

   - Women's Project (Oxford City)
   - Survivors of childhood exploitation (New Beginnings)
   - Embedded Housing workers
   - Stepdown beds
   - Housing First supported accommodation

10. The value of the contract is £3.8million per year, split between the partners. The contract has run for three years. There is a break clause for years four and five. In addition, there is the opportunity to renegotiate costs at year four which start on 01 April 2025. However, it has been made clear to the Alliance that there is no available funding to increase the budget.

11. Oxford City Council are the largest sole contributor, with 50% contribution, followed by Oxfordshire County Council at 24.6%. The contribution percentages and values are within the contract and are shown in the table below. See section 14 "Future Funding Challenges" below.

Party	2022/27Contributions
Oxford City Council	£1,911,399
Cherwell District Council	£353,930
South Oxfordshire District Council	£69,370
Vale Of White Horse District Council	£69,370
West Oxfordshire District Council	£53,700
Oxfordshire Clinical Commissioning Group	£150,000
Oxfordshire County Council and Oxfordshire Clinical Commissioning Group (from Better Care Fund)	£273,117
Oxfordshire County Council	£940,000
Total	**£3,820,886**

12. With collaboration from all the District, City and County Council's, the ICB (Integrated Care Board), Oxford Health and University Hospitals, Probation, Lived Experience Forum and Thames Valley Police, a Strategy and Action Plan was produced. The Oxfordshire Homelessness and Rough Sleeping Action Plan (2023-2026) has seven key strands. The Strategy and an operational version of the Action Plan are **Appendix 1 and 2 of the report.**

    i. Accountability
- Accommodation & commissioning
- Proactively prevent homelessness.
- Timely move-on
- The right home in the right place
- Delivery of Service - Rapid response to rough sleeping
- Focus on the person not the problem

13. The PHDG oversees the work of the Countywide Housing Steering Group (CHSG), who are a multi-agency group that comprises colleagues from all the involved agencies and that has responsibility for delivering all actions within the action plan.

14. It is to be noted that this model of service delivery is one of the only known models for service delivery of this kind in the Country.

Progress

Action Plan Progress

15. Work has commenced in delivering the action plan and its priorities outlined above. There are 9 “priority” actions for delivery this year. These identified priorities are summarised below

    i. Delivery of an effective case management system
    ii. Improving the holistic support provided to vulnerable people that is appropriate for them
    iii. Reviewing services to ensure they are housing led and where gaps in service may exist
    iv. Ensuring consistency in approach on homelessness prevention and client experience across the City and Districts
    v. Developing a range of options to address Countywide supply into the homelessness system
    vi. Continuing rollout and development of the Housing First model
    vii. Review and explore enhancement in services provided through outreach
    viii. Transformation of supported accommodation schemes within the Alliance to be Housing Led.

    Upon delivery of these priority actions, a new set of priority actions will be set for following years.

Governance

16. Strong and effective governance and reporting has been a challenge since the start of the Alliance. It has taken some time for the providers to establish some commonalities and fully understand and embrace the delivery partnership. This has however shown some improvement as the contract has progressed. There is an established Alliance Leadership Team (ALT), which makes the day-to-day decisions regarding the contract delivery. The lead commissioner (Oxfordshire County Council) and Oxford City Council have officers that attend this meeting.

17. On the commissioning side, an overwhelming positive of the Alliance process has been the cooperation between commissioning partners. The Commissioning partners meet monthly at the Joint Management Group (JMG) to discuss contract progress.

18. There has been a further meeting introduced between volunteered representatives of each group (ALT and JMG) to try to align and expedite certain evolving challenges as they arise.

19. ALT are seeking an Independent Chair, which is within the original contractual arrangement but has never been filled, to help provide independent governance. Recruitment is ongoing.

20. Another governance challenge that work has been ongoing to overcome has been the inconsistencies and integrity of data within the Alliance services. Improvements have been made with the inputs of commissioning officers at the County and City. A County wide data solution, potentially a database, has been agreed between partners, and is in the process of being delivered.

21. A new resource, working particularly on the commissioning side, has been agreed and commissioned jointly to provide greater delivery of the action plan and drive some of the changes and transformation required. This post holder is due to start in the Autumn and is being hosted by the City Council.

Cost control and adherence to the contract

22. The contract funding for the Alliance operates on a fixed fee model. During the last financial year, costs rose for suppliers, generally due to employee terms and conditions changes. These costs were met by efficiencies within the service areas rather than reduction in commissioned services. Significant and excellent work by colleagues at Oxfordshire County Council and Oxford City Council ensured that a balanced budget was presented for this year.

23. However, there has been a general agreement that this process was challenging for commissioned services and led to strain in relationships between some ALT partners and with JMG partners in turn. It is an ALT responsibility to present a balanced budget, but they were unable to reach this without significant input from commissioners. Further challenges are expected in this area and are outlined in following sections.

24. Following the budget setting process concluding at the beginning of this financial year, a service transformation process began in the 3 key service areas, outreach support for rough sleepers, homelessness prevention services and supported accommodation as well as a group looking at cross cutting themes like costs and control. These 4 small subgroups that contain different ALT and JMG members are currently reaching a conclusion and are due to present their findings and recommendations to JMG in October 2024. Transformation of services is a part of the Alliance contract.

25. Despite some progress being made on the functioning of the Alliance partnership, demand on services within the homelessness system has grown since the start of the contract. This is a national picture as outlined in the previous section of the report. An area of particularly acute demand is around access to supported accommodation that the Alliance manages. This accommodation is accessed through a Panel and is significantly oversubscribed. The current waiting list is in excess of 100 people. This does inevitably lead to delays for vulnerable people accessing the support they need. The City and District Councils are all experiencing an increase in households that require temporary accommodation because they are homeless and in Priority Need, where the temporary accommodation duties on Councils are activated. This accommodation comes with no or little support, and the people housed are vulnerable. This is a potentially growing gap in service provision.

Despite these pressures, commissioning partners are positive with the delivery of services and are positive about the potential transformation process.

Future Challenges

Future Funding Uncertainty

26. Additionally, funding for the Alliance comes from the Rough Sleeping Initiative (RSI). The future of this money beyond this year is yet to become clear. This in part is due to the change in Government at Westminster and thus reviews of departmental spending. If RSI grant is not continued, or another funding mechanism identified or offered, future funding beyond this year is unclear. This may lead to a service reduction which in turn could lead to non-delivery of the contractual objectives. Alliance partners are aware of the commissioning position on this and have been requested to make contingencies on this basis.

Service Pressures within Business as Usual

27. Should funding be in place to continue with the contract as it is currently into next year and future years, it is likely that services will remain under pressure. The rising costs that providers are incurring, particularly on staffing, have currently been met by finding efficiencies within operating models. It is believed that this will not be possible in future years as all possible efficiencies have been explored. JMG will be advising that there is no additional funding available (if the funding from government remains as it has been) and thus the JMG, with Alliance partners will need to examine the services being delivered carefully to ensure that the contractual obligations are met. Although the Alliance is a partnership, some partners could be disproportionately affected

Requirements of services to change, transform or act flexibly

28. Taking account of the aforementioned challenges, the situation within homelessness and rough sleeping services has changed since the beginning of the contract. The demands of single vulnerable people on services, the rise in rough sleeping, the rise in homelessness presentations to Councils and the associated rise in temporary accommodation usage have changed what is required from services. Following the transformation work, it may be necessary for some services to change of be flexible to meet the emerging needs of those requiring homelessness services within Oxfordshire. The ability of ALT to manage this change is not tested.

Demand and Housing Supply

29. As mentioned in earlier sections of the report, the demand on services is increasing. A key challenge for the system is housing supply and move-on opportunities for those in pathway accommodation. This is a common challenge among several pathways across the Housing and Social Care system. The

demand for social housing across the City and Districts is unlikely to decrease, and therefore this will remain a challenge. There are actions within the Countywide Action Plan that are underway to approach these strategic discussions, but this is a key challenge across the system.

Financial Implications

30. The delivery of the action plan is dependent on the funding being available from all partners.

    Comments checked by:

    Stephen Rowles
    Strategic Finance Business Partner.
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Legal Implications

31. The report provides a progress report on the work being undertaken to address homelessness across Oxfordshire and as such there are no specific legal implications arising from the same.

32. Nonetheless it is worth noting that, as stated above, District and City Councils have statutory responsibilities to provide homelessness and housing advice services and it is not permissible to circumvent the statutory framework for the provision of such services. It is possible however to utilise the authority's wider powers to support those with particular vulnerabilities or needs, and to support and promote the general well-being of the local population: for example, the prevention powers of S2 Care Act 2014, the powers as to improvement of public health of s2B (1) NHS Act 1996 and the general power of S1 Localism Act 2011.

    Comments checked by:

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Karen Fuller
Director of Adult Social Care

Annex: Appendix 1 Homelessness and Rough Sleeping Strategy.

Appendix 2 Countywide Homelessness and Rough Sleeping Action Plan

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September 2024

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Appendix 1

Oxfordshire's Homelessness and Rough Sleeping Strategy 2021-26

Introduction

This is the first county wide Oxfordshire Homelessness and Rough Sleeping Strategy and marks a commitment to an inter-agency cross sector partnership approach. Significant innovations include a Housing Led / Housing First approach, so that people are supported in tenancies rather than proving they are tenancy ready, and use of a By Name List to ensure real time data informs decisions and developments.

The Covid-19 response has shown things can be done differently when normal rules no longer apply. Councils, under the government's 'Everyone In' scheme were required to provide self-contained emergency accommodation to people sleeping rough during the lockdown. This took a public health approach, overriding existing legal tests of who might qualify for assistance. Services in 2020 are working to ensure those accommodated do not return to rough sleeping, in part funded by the Next Steps Accommodation Programme (NSAP), which has now become the Rough Sleeper Accommodation Programme (RSAP).

However, we collectively face challenges in coming months and years. The ongoing health threats of the Covid-19 pandemic put those who are homeless, or who live or work in shared housing and support services at increased risk and make the provision of services more challenging. The economic impacts have the potential to significantly increase financial hardship and put more people at risk of homelessness. Voluntary and community sector organisations that provide an important safety net are also experiencing financial and operational impacts.

This strategy draws on the year-long Housing-led Feasibility Study, undertaken by Crisis during 2019-2020, which engaged with people with lived experience of homelessness and rough sleeping in Oxford and countywide. A housing-led, or 'rapid rehousing', approach seeks to end a person's homelessness by moving them into their own home as soon as possible, before addressing any other issues they may need support with. This would be a significant change from the current provision which is heavily focussed on placements within supported accommodation, including hostel provision. Prevention of homelessness by working upstream is also fundamental to the strategy.

The strategy is informed by the recommendations of the Oxfordshire Safeguarding Adults Boards' Thematic Review (SAR) of Homelessness 2019, which explored the circumstances surrounding the deaths of 9 individuals who had all experienced what the report terms multiple exclusion homelessness leading up to, and at the time of, their deaths in 2018/19.

The strategy is also informed by the recommendations from the Homelessness Health Needs Assessment published in 2019.

The Oxfordshire councils, Oxfordshire County Council; Oxford City Council; Cherwell, South Oxfordshire, Vale of White Horse and West Oxfordshire District Councils; the Oxfordshire Clinical Commissioning Group (CCG) and Oxford Health NHFT currently resource around £12.5 million worth of supported housing[1], targeted at people in housing need and those who sleep rough. In addition, Oxfordshire benefits from a great deal of community-based support. However, this strategy is needed because:

- Over the course of a year around 600-700 people sleep rough in Oxfordshire
- 64 people were sleeping rough in Oxfordshire on a 'typical' night in November 2019
- Life expectancy for people who sleep rough, is on average 30 years less than the rest of the population. People who sleep rough die, on average, between the ages of 43 and47 years
- People who sleep rough are 17 times more likely[1] to be victims of violence than those who do not
- Nationally, 14% of those who sleep rough are women. A quarter of women sleeping rough have been sexually assaulted while on the streets
- Three quarters of people who are street homeless experience mental ill health.
- Two thirds of people who are street homeless report using drugs and/or alcohol to cope
- In Oxfordshire, our housing, social care and health systems are fragmented. Access to housing is linked to location and can be dependent on district or city connection
- Those currently using housing and support services have very little choice over or input to these**.**

The Ministry of Housing, Communities and Local Government (MHCLG) is supporting Oxfordshire councils to work in a more coordinated and consistent way to tackle rough sleeping and homelessness by resourcing the partnership to deliver a 'one system' approach in Oxfordshire.

This multi-agency strategy will underpin a transformation in the way housing, social care and health services work together and work with people in need of housing and support. It will inform future commissioning of services within Oxfordshire. It will be subject to annual review with partners.

The focus of this strategy is on rough sleeping and single homelessness including couples without dependants. There will be close working and connection across to the work on families, young people, people with mental health issues and people experiencing domestic abuse.

There is a separate Action Plan setting out 1) actions, 2) by whom and 3) Outcomes/measures for each of the "We will" bullet points within the 5 priorities set out below. This plan will be kept under review.

[1] This figure includes Mental Health supported accommodation

Vision

To prevent and resolve homelessness, so that no one sleeps rough in Oxfordshire and that sustainable housing solutions are found so that the impact of homelessness on people's lives is reduced.

Principles

- We treat people in need of our services with respect
- We acknowledge people as individuals and work with their strengths
- We work in a 'psychologically informed way', understanding how past trauma and adverse childhood experiences affect people who experience homelessness
- We actively involve people affected by homelessness in identifying solutions and offer choice wherever possible
- We avoid 'gatekeeping' in the delivery of services
- There is a human face to our services so that the person who is homeless has a named person they can contact
- We focus on the health, wellbeing and quality of life of people who experience homeless, addressing the whole person, not just housing needs
- We co-operate to deliver a co-ordinated and consistent service across the county
- Take action to maximise the resources available to deliver the vision
- We will engage positively with the voluntary sector and faith-based groups
- Senior leaders across the system will seek to influence and lobby national policy and longer-term funding developments across MHCLG, Dept of Health, MOJ etc

Purpose/ Mission: transform the way we respond

Developing a whole system approach is at the heart of this strategy. We need to coordinate the way services work together to prevent people from being passed between agencies without clarity as to who retains responsibility or who to contact; or from becoming lost in the gaps between services. We need to ensure we respond to the wider needs of individuals, not just their presenting or urgent issue. We will:

- Hold relevant organisations and system leaders to account for delivering strategic objectives and service improvement, through clearer countywide governance, in relation to the prevention of and effective response to 'multiple exclusion' homelessness.

- Ensure greater choice and flexibility in provision of housing and support and greater collaboration to deliver better outcomes.

- Prevent people in need of housing and support from being passed between agencies Establish system-wide performance indicators, focusing on

performance at the 'joins' between services and overall outcomes of the individual, not just the project

We need to transform the way our services understand and respond to the hopes, needs and experiences of individuals. We will:

- Ensure our services understand and adjust for the impact of past trauma and adverse childhood experiences, particularly on those experiencing 'multiple exclusion homelessness'. This means workforce transformation across the statutory and voluntary sectors.

- Ensure that our services are culturally competent and able to respond to the diversity and individuality of the people we work with, including the importance of informal networks to people's lives.

Priorities:

1. **Proactively prevent homelessness**

The Homelessness Prevention Act 2017 extended the period in which a household is defined as 'threatened with homelessness' from 28 to 56 days. It also placed a new 'prevention' duty on local authorities to 'take reasonable steps' to prevent the threatened homelessness of anyone who is eligible.

The City and district councils have implemented the new legislation and practices. However, research shows that the prevention rate can be further improved where intervention occurs before the 56 day timescale in the Act. Good practice initiatives need to be developed further, to ensure a coherent countywide prevention approach, informed by direct evaluation from those with lived experience. Crisis's research found Oxfordshire councils are more than five times more likely to give financial assistance to someone owed a prevention duty to secure alternative accommodation than to help them to secure the accommodation they were already occupying.

A significant focus on prevention will be essential over the coming months and years, as we recover from the impact of the COVID-19 pandemic. Between March - May 2020, the number of claimants of unemployment benefits in Oxfordshire increased from 6,655 to 17,500, an increase of 10,845 or 163%. This was above the increases across England (+114%) and the South East as a whole (+150%)[2]. The government put a hold on eviction processes following lockdown, but these recommenced in October 2020. Local authorities need to overcome any concerns that engaging with people at an early stage of housing need will increase caseloads. The Homelessness Code of Guidance for Local Authorities states that advice and information should aim to assist people as early as possible to maximise the chance

[2] https://oxfordshire.org/covid-19-economic-impact-showing-in-data-new-reports-added-to-ocf-insight-website/

of preventing homelessness, as well as encouraging them to contact the Authority as soon as possible rather than waiting until crisis point.

Statutory service cannot do this alone and will need to support a wide range of partners to ensure availability of accurate, accessible and timely help and advice.

We will:

- Implement effective, evidence-based prevention services with strong links to specialist services e.g. mental health, drug and alcohol misuse.

- Improve access to timely, accurate information and advice on all elements of homelessness prevention

- Ensure there are effective links and "wrap around care" between services, so an individual is supported to access all the services they require.

- Go beyond the homelessness legislation to intervene early and prevent homelessness whether there is a statutory duty or not

- Deliver consistent tenancy sustainment support across the whole county and all housing providers and tenures including in the Private Rented Sector (PRS), and supported housing including pre-eviction protocols where appropriate

- Use a data-led approach to proactively identify those who may be at risk of losing accommodation or of being discharged without accommodation

- Ensure housing options services are accessible and responsive to all who need them, including a strong PRS offer such as deposits and rent in advance.

2. **Rapid response to rough sleeping**

Current outreach services tend to focus on verification and the 'processing' of people who sleep rough, with limited opportunity for individuals concerns to influence what happens to them. The default option is often a referral to whichever supported housing project has a bedspace available. It is evident that many people with lived experience avoid or disengage from statutory services because of restricted options or placements that do not fit their wider needs.
These include concerns about physical and psychological safety and the opportunity to either abstain from or safely use alcohol and other substances.

The SAR highlighted concerns that in some cases people experiencing multiple exclusion homelessness are required to sleep rough before they can access necessary help, support and care services. Records show that 20% of those accommodated within county under ***Everyone In*** had No Recourse to Public Funds (NRPF) or were EEA workers who had lost their Worker Status. These are people

who are prevented by law from accessing mainstream housing, welfare benefits and employment.

We will:

- Ensure that people experiencing multiple exclusion homelessness are not required to sleep rough in order to be offered help

- Ensure rapid access for all those who are sleeping rough or at immediate risk of rough sleeping to a 'psychologically informed' assessment of their specific needs

- Wherever possible keep people in their local area, where long term housing solutions can be found, rather than having to travel to the City for accommodation and support services

- Provide access to advocacy and informal support from peer mentors

- Provide a range of safe, dignified provision for people coming directly from the streets

- Provide a range of flexible accommodation, which can be adapted for single people or couples and create safe spaces for women and LGBTQ+ rough sleepers

- Identify appropriate housing and support solutions by working jointly with individuals in housing need, using a strengths-based approach

- Ensure that people experiencing multiple exclusion homelessness benefit from an integrated approach to their care and support, mental health, physical health, drug and alcohol misuse and accommodation needs

- Identify appropriate safety nets for people with No Recourse to Public Funds (NRPF) including EEA Nationals having problems with Worker Status.

3. **Focus on the person, not the problem**

Many individuals remain involved in the homelessness 'system' for years, sometimes decades, unable to move forward despite the involvement of multiple professionals. There is concern that some individuals are not on any authority's housing register; they continue to be affected by past incidents and are dealt with in a 'deficit-based' way. A lack of collective responsibility too often allows individuals to drop between services, effectively 'ceasing to exist' until the re-present.

There is need for an oversight mechanism; shared responsibility for a list of those who need a multi-agency case-management approach to end their homelessness.

This needs to be based on a plan, co-produced with the individual, centred on their specific needs and aspirations.

Supported housing placements are often the 'default position', regardless of an individual's needs, concerns or aspirations. Most people who sleep rough are offered no other option. Much supported housing is of relatively low physical standard which is difficult to change when those living there have little incentive to maintain it, having been given no choice to live there and it being transitory in nature. It may be difficult for specific placements to accommodate couples or pets, which prevents the formation or sustainment of relationships and connections.

The Crisis research highlights inherent conflicts in the current 'staircase model' which requires people to remain in supported housing for around 12 months to demonstrate 'tenancy readiness'. The nature of supported housing prevents those accommodated from treating it as their home and forming any kind of connection. Concentrating people with a range of 'behavioural problems' in one location is challenging for individuals. It also means that staff must try and balance the need to enforce necessary rules with the development of positive relationships that those placed need in order to achieve positive change.

Crisis acknowledge that a minority of people in housing need may benefit from congregate models of supported housing, mainly where:

- their needs for assistance to sustain independence is based around health needs that may benefit from therapeutic group work, rather than behavioural challenges
- their health and wellbeing require a significant degree of constant active monitoring to ensure their safety
- an important element of assistance is the provision of mutual support from those with shared experiences or a shared commitment to behavioural change.

Ultimately, supported housing can be an expensive way of delivering housing support because of the staff time involved in managing interactions between people with different but complex behavioural problems.

We will:

- Adopt a 'Housing-led' approach to providing the level and type of support agreed with those at risk of rough sleeping or experiencing multi- exclusion homelessness

- Improve the multi-agency case management of people who have been sleeping rough long term, by implementing the 'By Name' approach

- Improve wider wellbeing and improve quality of life of those in housing need, including those experiencing multiple-exclusion homelessness. This will include timely intervention from specialist services e.g. mental health, drug and alcohol misuse, physical health and Safeguarding including neglect as well as implementing the learning from the Mortality Review Panel which investigates the deaths of all homeless people in Oxfordshire.

- Ensure rents are such that people are able to work, and are supported to maintain / return to work.

4. **Timely move on**

Over 1000 bedspaces are currently commissioned across the county, plus a significant amount of floating support, outreach, advice and day provision. Investment in the total resource, including mental health provision, was estimated at £12.5 million. Crisis found that most people moved into supported housing do not go through the Housing Options process and only 13% of those placed in supported housing gained access to settled housing during 2018/19.

Significantly, the difficulty in finding move-on accommodation means many individuals stay far longer in what is intended as transitory, supported housing than intended. The frustration this causes can undo positive changes made by the individual in conjunction with the support staff. The SAR highlights that a bedspace in supported accommodation is not a 'solution' to people's needs or aspirations. Delayed move on can impact negatively on people in a similar way to delayed discharge from hospital

Funding arrangements in supported housing impact on individuals often not being able to afford to move on if they gain employment. This is not the case where support is provided separately to housing.

We will:

- Ensure those accommodated in supported temporary housing have clearly identified and regularly reviewed routes to settled accommodation

- Improve access to social housing by single households experiencing or at risk of homelessness by ensuring a strong focus in the work of the Housing Needs teams and necessary changes in relevant policies.

5. **The right home in the right place**

In Oxford the average house price of £513,754 is around 17 times the UK average yearly household income of £29,600. The lack of supply of affordable one bed properties remains a problem countywide. However, research found examples of quotas for move-on allocations not being filled, and of registered providers (RPs) letting their accommodation via Right Move because they have not been let though Choice Based Lettings schemes. The level of social housing lettings per 1000 households in Oxfordshire is currently above the national average. However, the numbers of those social housing registers in Oxfordshire have fallen faster than the national average. A significantly lower proportion of lettings to those in

'reasonable preference' categories are made to those who are homeless, within the county. The proportion of lettings going to the most vulnerable single homeless applicants in Oxfordshire is half the national average. There is evidence of overly restrictive practices in the way local authorities manage access to their housing registers for those who have had problems in past tenancies, although there is a lack of data as to the numbers affected.

During ***Everyone In***, researchers identified many individuals who were not on a housing register despite having been homeless in a locality for many years. Mental health service providers gave evidence that people with a diagnosis of mental health issues are frequently denied access to housing registers.

Local authorities are not using their powers to create their own additional preference categories. The only example of this is at CDC, for people experiencing domestic abuse. A much higher proportion of social housing allocations in Oxfordshire go to households nominated by local authorities to RPs than is the case nationally.

There is anecdotal evidence that some RPs are risk adverse in relation to housing more vulnerable residents, but this is not adequately monitored or evidenced. Policies relating to move on from supported housing focus on demonstrating 'tenancy-readiness' when this could be achieved by being 'tenancy-supported'.

There is good work being undertaken by councils and voluntary and community sector organisations to secure access to the private rented sector (PRS) for those experiencing homelessness, but this is patchy and not consistent across the county. Some council schemes do not focus on single households and tenancy sustainment provision is not consistent.

All opportunities need to be explored to widen the range of housing options for single people, to better respond to individual needs and choices.

We will:

Minimise all barriers to allocating social housing to single homeless households in greatest housing need, monitoring, reviewing and developing allocation policies, working positively with Social Landlords to understand and mitigate concerns, ensure excellent and persistent delivery of support, which can be long term when needed

- Work with Registered Providers to ensure applicants with support needs are 'tenancy supported', not 'tenancy ready'.

- Promote access to and sustainment of good quality tenancies in the private rented sector

- Increase the supply and range of housing options for single households by: setting targets for allocations to Housing First, measure results and hold system leaders to account; influencing developers, Planning policies and

registered providers, including considering new build options; considering retention of some shared housing as low or no support.

Appendix A Strategic Context

Housing Act 1996 as amended/ Homelessness Reduction Act 2017
Our District and City housing authorities have a statutory responsibility for publishing an homelessness and rough sleeping strategy every five years and must prevent homelessness and offer assistance.

The Care Act 2014
Places a duty of the County Council, explicitly referencing housing as key to promoting the integrations of health and care

The County strategy, **Oxfordshire 2030** set out the overarching strategic plan for the future of Oxfordshire, including the priorities:

- Healthy and thriving communities
- Reducing inequalities and breaking the cycle of deprivation

The strategy is to be achieved through a partnership approach.

NHS Long Term Plan

Appendix B Resources

Local housing authorities
Oxford City, Cherwell, South Oxfordshire, Vale of Oxfordshire and West Oxfordshire District Councils

- Housing options teams
- Housing allocations teams
- Strategic Housing Teams
- Revenues and Benefits teams
- Economic growth teams

Health, Education and Social Care (HESC) Commissioning, Oxfordshire Clinical Commissioning Group (OCCG)/Oxfordshire County Council

- Financial resources: commissioning
- Staff resources in relevant teams – Adult social care/ mental health/ Childrens Services/ education
- Public Health

NHS Health Trusts

- Oxford Health for mental health and Community Services Directorate where Luther Street and District Nursing sit and links for Out Of Hospital project
- OUH linked in re the Out Of Hospital project and have significant role re health and wellbeing of homeless population including a community safety and safeguarding agenda around homelessness. Homeless people are

invariably high demand users of healthcare, in particular urgent / emergency care services

MHCLG funding

- Rough Sleepers Accommodation Programme formally called Next Steps
- Rough Sleepers Initiative
- Cold Weather Fund
- Extra help for rough sleepers with drug and alcohol dependency - GOV.UK (www.gov.uk)

Voluntary and community sector organisations and the general public who want to see an end to rough sleeping. This includes Oxfordshire Homeless Movement and the Lived Experience Advisory Forum. Also the current providers of homelessness services: Connection Support, Homeless Oxfordshire, Mayday Trust and St. Mungo's. But also the many locally based community groups and charities who offer important help and support to people affected by homelessness.

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Oxfordshire Countywide Homelessness and Rough Sleeping Strategy Action Plan

Accountability				
Item	**Action**	**Owner**	**Timescale (Red are Priority Actions)**	**Progress**
	Terms of Reference for HDG, CHSG, Aligned with ALT. Establish reporting mechanisms for HDG.	Chair HDG & CHSG		Completed
1	Improvements to collective risk management process, including: Create a statement of purpose that organisations will avoid passing people between agencies. Establish a single multi-agency risk assessment and management process – Process to include the lines of escalation, and commitments to flexible service. Create a risk management map to understand processes to reduce/monitor risk. (Done)	ALT Workforce Development Workstream (WFD) Leads Helen Denyer and Benn Kiley	2024/2025	Completed

1.1	Establish system-wide performance indicators, focusing performance at the 'joins' between services and overall outcomes of the individual.	All CWSG Leads	2024/25	
1.2	Deliver new countywide data base, based on by names approach, from procurement through to operational delivery. Develop effective multi-agency case management throughout the system (not just the Alliance), with Personal Housing Plans at the prevention stage, and the By Name List approach to case management for those experiencing homelessness. Develop a new countywide Assessment Hub model to coordinate the By Name List approach and provide an accessible and inclusive gateway into services for those who are homeless.	Ossi Mosley, Samia Shibli Actions within Alliance led by ALT's WFD work stream leads (Helen Denyer and Simon Hewett-Avison)	Database commissioned by summer 2024	There was a meeting in November of the development subgroup. A paper to be submitted to the Countywide Homelessness Steering Group (CHSG) in Jan. Summary paper circulated to ALT and JMG. Verbal update to be given in July at CHSG.
1.3	Deliver a strength-based approach to working with individuals, offering holistic support Including: •Developing our assessment hub, and ensuring aligned to the objectives of the strategy (i.e. multi agency etc)	Andy Chequers, Richard Wood, Samia Shibli and Ossi Mosley	Future developments to the assessment hub determined by April 2024	This is very challenging in light of DLUHC's position on shared spaces. More to be said in Jan

	•And, ensuring there are feedback loops for those accessing services to evaluate their accessibility, their effectiveness •Build upon existing OOHC team to develop an outreach model which can get services to where they are needed, when they are needed.			
1.4	Development of later life and end-of-life pathway for people who are homeless	Commissioners, Simon Hewett-Avison	2025	• These may need splitting out. I have started to progress the end of life/palliative care discussions with the team based at Sobel House. There is a workshop coming up **In-person event at Sobell House Hospice on Monday, 15 July from 12-3**
1.5	Requesting partners review strategies & services to ensure they do not exclude those in housing need. Request HDG members identify relevant strategies that need a dedicated section on those with a housing need	Chair of CWSG and Chair of HDG	2025	

Accommodation and Commissioning

Item	Action	Owner	Timescale (Red are Priority Actions)	Progress
2	Take steps to develop our understanding of "greater choice" and then take steps to implement it, including: •Providers and commissioners review current client choice in system, and opportunities for more choice, identifying changes that can be made across system. •Informed by this view on choice: then review commissioning and contract management of support services •Transparency of offer negotiation with person and mapping of what is available. •As part of being flexible, review the use of Excluded Licence Agreements within the Alliance services. This will include trying to avoid a person having no other option than rough sleeping	Commissioners (Ossi, Samia, health commissioners), Chris Keating and Paul Roberts	2024-25	Part of workstream reviews/service transformation taking place in 2024. Review of eviction processes are being reviewed across the Alliance supported accommodation pathways
2.1	Carry out a review of current buildings held by Alliance, to see if	Lead -Chair of ALT (Helen	April 2024 to feedback to JMG and then HDG, on	Work is currently happening in AMT (led by Toby Blake) to create a shared

	they meet needs of a Housing-led system. Work with Psychologists to ensure commissioned services / accommodation aligns with principals of PIE and is driven by what the people who might actually use it are telling us. Identify gaps in services. and create specifications which define the group of people for each scheme and the type of support they need Pull in other research, such as OHMs report	Denyer) and Ossi Mosley, Chris Keating and Paul Roberts (both as ALT Housing Supply Leads) Peter Moore, supported by all ALT members and LAs	draft plans and recommendations	definition of Housing Led, expected to be at decision point in late November. Mapping exercise to follow this. However, worth noting that it is unlikely that shared housing which comprises much of the current accommodation provision would fall under the definition of Housing Led. We have recently (6th Nov) met with a researcher at Oxford University (psychology) recently with potential to do some research work. Model, specification and costings for alternative accommodation service for people with complex needs who require a different offer to existing services has been developed alongside the City Council (often referred to as 'Garden House 2'). There have been discussions about additional need for women's only provision. Also noting reduction over last 2 years in prevention services has created a deficit in support reducing availability to pick up referrals from 80%+ to 53%.
2.2	Ensure a focus on employment where relevant and within services that rents are as affordable as	Commissioners, ALT and Housing		

	possible for people to be able to work	Authorities (*Lead to be determined later, as not action for this year)*		
2.3	Work across providers and support sector to develop thinking and plans in order to better support NRPF people	Commissioners, ALT and Housing Authorities (*Lead to be determined later, as not action for this year)*	2025	

Proactively Prevent Homelessness				
Item	**Action**	**Owner**	**Timescale (Red are Priority Actions)**	**Progress**
3	Benchmarking exercise to be carried out of all housing authorities, collecting information on prevention offer across the City and Districts, which will allow comparison and inform recommendations/ decisions on a common and minimum offer	Richard Wood lead (Oxford City), Phil Ealey, Caroline Clissold, Richard Smith.	Delivery of benchmarking report in June 2024	

	across the county, that can be then agreed and shared as a framework.	Support from Peter Moore		
3.1	Work with health partners to mainstream homeless.	Healthy Place Shaping Team, alongside NHS colleagues/ primary care/ MH (Peter Moore, Kate Holborn, Andy Chequers	2024-25	
3.2	Conduct research into people newly arrived on the streets to find out to what extent they had previously presented for assistance elsewhere in the homelessness system, and why this had not prevented them from homeless.	MEAL Workstream Leads (Helen Denyer and Ossi Mosley), with/ Crisis (Kate Cocker), and St Mungo's and Connections involved	2024-25	Outreach services are part of the service reviews that are underway as part of the alliance transformation and workstream review. Part of this review is a greater understanding of collective data in the key areas to help inform service provision.
3.3	Identify and analyse patterns as to why cases are closed without any outcome through the statutory duty system.	Cherwell (Sharon Burden), with support from other Districts	Complete	It was clear that all districts seem to be working in the same way i.e. extending Prevention duties for court orders for those cases over 56 days. All districts are closing Prevention cases at 56 days where there is no further action from landlords to progress the eviction process

				or family members are still accommodating. There are few instances where cases are closed without any outcome and if they are this is usually due to lost contact or not being eligible for homeless services. S&V figures are much higher than the other districts. It would appear that we all report using the same mechanisms and S&V advised that the reason their figures may be higher is that they are very successful in discharging prevention duties though social lets. The group consensus was that we are all seeing a shrinking PRS and increase in approaches from singles, but all seem to be working in the same way which is encouraging. I have asked if all districts can share some information regarding TA so we can compare figures across Oxfordshire. It was agreed that we would continue to meet up on a quarterly/half yearly basis to continue to share ideas, pressures, good working practices and see what everyone else is doing.

3.4	To develop case and secure funding and service model for a dual diagnosis/ complex needs service.	Samia Shibli/ Health (Andy to confirm with County colleagues) and Catherine Sage (Mental health)	Develop business case by summer 24	
3.5	ALT define what strengths based looks like, and ensure progress to meet	ALTs WFD workstream leads, Helen Denyer and Benn Kiley, and Peter Moore from OOHC	2025	
3.6	Consult with people with lived experience as to the type and form of information they need and can access, in order to inform future advice.	MEAL workstream leads (Helen Denyer and Ossi Mosley		Lived experience event has taken place. Some recommendations within the below document LEAF Festival of feedback
3.7	Agree new discharge protocol / charter for both health and probation	Peter Moore (health) Lou Everett, Greg Yard (probation)	2025	
3.8	Review access pathways into Alliance services to ensure people do not have to sleep rough to be	Helen Denyer, and Chris Keating and	Summer 24	

	offered help, including the review of the access panel	Phil Ealey, Tany (MEAM), supported by all LAs		

Timely Move-On				
Item	**Action**	**Owner**	**Timescale (Red are Priority Actions)**	**Progress**
4	Local housing authorities have Personal Housing Plans in place and work actively with people to find accommodation solutions, and support continue following end of Relief Duty.	Richard Wood lead, Phil Ealey, Caroline Clissold, Richard Smith	April 2022 onwards	Completed. Regular reviews should be undertaken as part of regular engagement between Districts and City.
4.1	Benchmarking exercise to be carried out of all housing authorities (See prevention priority), collecting information on practice on move on planning and PHP use across the City and Districts, which will allow comparison and inform recommendations/ decisions on a common and minimum offer across the county, that can be then agreed and shared as a framework (also see above under Priority 3).	Richard Wood lead, Phil Ealey, Caroline Clissold, Richard Smith	Delivery of benchmarking report in June 2024	To undertake a bench marking exercise to build comparisons with a 6-month timescale. A virtual team meeting is due in Dec.

4.2	Review of current practise in relation to identified routes to move on from supported accommodation and into more stable accommodation	Paul Roberts, Chris Keating, Ossi Mosley and Samia Shibli, plus Mental Health pathway (Catherine Sage); other provides of interim/supported accommodation	Sep-24	Supported accommodation is one of the areas for workstream review and service transformation currently underway.
4.3	Develop a Countywide report on how to increase the supply of a range of affordable housing options for single homeless households across the county, with a range of recommendations. This will include how to support RPs to deliver more affordable and social housing that suitable for our clients; ensure developers include percentages of single households in developments; monitor that all Local Authorities are setting Local Plans compliant with the Countywide strategy, that council use all their housing enabling tools to support the supply of suitable affordable housing, and recommend shorter term steps to	Housing Supply group, with Richard Wood leading (working group established, including Richard S, Phil E, SOHA rep)	Initial report delivered to HDG in March/April 2024, to go on to Council Chief Executives.	Supply subgroup is meeting, with a working group being formed to drive through developments. Supply event was held in spring 2024 Further engagement planned with senior staff across the system to provide a collective approach to supply of housing that is required for those customers that are within this pathway. Further engagement events and subsequent action planning to take place in 2024.

	bring on more affordable one bedroom accommodation now.			

The Right Home in the Right Place				
Item	**Action**	**Owner**	**Timescale (Red are Priority Actions)**	**Progress**
5	Benchmarking exercise to be carried out of all housing authorities (as in above priorities), collecting information on processes and procedures across the City and Districts, which will allow comparison and inform future recommended changes to bring in more alignment and common approach. Benchmarking and recommendation to be mindful of local need, local supply and local priorities will mean differences in allocation policies will need to continue	Richard Wood lead, Phil Ealey, Caroline Clissold, Richard Smith & RP representation	Delivery of benchmarking report in June 2024	Informed by supply work as above
5.1	Close engagement between RPs/ ALT and local housing authorities to build common understand and culture of a “tenancy supported” approach	CW Housing Supply sub-group (lead to be assigned after initial	2025	Part of prevention workstreams and alliance transformation groups

	Including agreed definition of "tenancy supported", setting provider expectations Ongoing monitoring of compliance with definition Learning from Housing First and MH Housing First on level of support required and what worked/ didn't work.	actions completed)		
5.2	Benchmarking exercise (as above) to consider offer of PRS access schemes across the County and ALT to ensure that services and staff are promoting and supporting PRS access.	Richard Wood, Phil Ealey, Caroline Clissold, Richard Smith, Paul Roberts and Chris Keating.	Delivery of benchmarking report in June 2024	
5.3	Review the designation of 1-bed properties for older people; consider within or alongside this the feasibility of creating a scheme of long-term but 'own front door' supported housing for those whose needs are currently not well-met by either homelessness or adult social care services.	Housing Supply sub-group of the CWSG to consider designation, Ossi Mosley and City leading on SHAP bid for new accommodation	2023/24 for SHAP bid 2024-2025 for designation, following groups paper	Part of supply workstream as outlined above

5.4	Work with housing and support providers to roll out and develop a consistent and high fidelity model of Housing First across the county; Continued deliver of Housing First across RPs, learning through doing.	ALT Housing Supply Lead Paul Roberts and Chris Keating, alongside HF support providers Simon Hewett-Avison, Benn Kiley, Helen Denyer, with support from LAs and RPs	6 monthly reviews of numbers delivered (need to benchmark numbers in Sep 23)	Work underway. Best placed providers for each district confirmed. Support capacity in each district confirmed. RP liaison regarding their commitment to pledging properties to be picked up by Richard Wood as part of Countywide group.
5.5	Continue to bid for and access central government funding to acquire more Housing First units.	LA leads, and members of the Housing Supply sub-group of the CWSG	6 month reports to CWSG on progress and opportunities	
5.6	Bring together and explore ways to scale up and/or replicate the wide range of options and activities to promote housing supply within the community, faith and voluntary sectors.	Andy Chequers, Richard Smith, Richard Wood, OHM	2024/25	Supply work underway as above

Delivery of Service – Rapid Response

Item	Action	Owner	Timescale (Red are Priority Actions)	Progress
6	Establish and further develop a psychologically informed assessment in Oxford City, consideration if Districts needs similar services. Respond to changing support from DLUHC on current assessment centre and SSTS at Floyds Row. Explore options, including outreach, surgeries and digital methods for extending an assessment hub service countywide. Co-locate clinical and professional specialists to ensure assessment covers full range of needs.	Ossi Mosley and Helen Denyer	Response to DLUHC funding position by April 2024	This is in progress, a proposal has been developed which covers top two actions in this section, though requires sign off from various parties including DLUHC to enable model to be in place from April 2024. Progress is being made towards sign off which will be in place by Jan 2024 latest.
6.1	Provide access to support and advocacy from peer mentors	ALTs WFD workstream leads Helen Denyer and Benn Kiley	2024/25	
6.2	Development of a clear referral and escalation framework for organisations in the Homelessness Alliance, and other willing partners, who are working with adults with complex care and support needs.	HDG, CHSG, OSAB (Leads to be determined)	2024/25	

	This framework should include a clear route for seeking professional support advice in complex cases.			

Focus on the Person not the Problem				
Item	**Action**	**Owner**	**Timescale (Red are Priority Actions)**	**Progress**
7	Take steps to ensure services understand and adjust for the past impact of trauma, across statutory and voluntary sectors. Including • Organisations to audit their practices (assessment, appointment, eviction, etc) against the Government definition of working in a trauma-informed approach. This should include the training of staff in trauma-informed working (length of course, etc) • Create a skills matrix that each commissioned provider be required to train staff to this level and participate in	All organisations reporting to CHSG. Led by Chair of ALT, LA reps and Crisis (Kate)	2024/25	

	communities of practice to share and further develop good practice. • Ensure understanding of a trauma informed approach is present in leaders of the system, through training of members of HDG and CWSG • Embed (targeted) joint working, shadowing, shared inductions etc…with trauma-informed, strengths-based, PIE experts • Embed shared reflective practice across all services • Survey people on whether they feel services are working with them in a way that's sympathetic to anything that's happened in their past and what would make them feel safe and was and has it been met – KINGS COLLEGE ASSESSMENT. Make routine in future			
7.1	Ensure services delivered are able to respond to the diversity and individuality of the people they work with.	Erin Booth, Public Health & new complex cases	Summer 24 for new database	

	Including: • Deliver services with a strong focus on Equality, Diversity and Inclusion Embedding an integrated approach to meeting their care and support needs (mental health, physical health, etc) regardless of diversity and acknowledging the complexity of intersectionality. • Deliver new database that will capture EDI information. • Ensure that data then informs clear actions to target at risk groups, in order to improve their service, experience and outcomes. • Map current service provision for adults who self-neglect and/or have complex needs.	commissioning post holder ALTs Monitoring, Evaluation, Assessment and Learning (MEAL) workstream		
7.2	Ensure the development of supported housing in line with Housing Led principles. Continued progress of the Alliances transformation of their accommodation. (Linked to priority	Lead - Chair of ALT (Helen Denyer) and Ossi Mosley, Chris Keating and Paul Roberts	April 2024 to feedback to JMG and then HDG, on draft plans and recommendations	Housing led joint definition being worked up. Client property need mapping exercise under way with aim to engage at least 60% of currently accommodated clients. Mapping exercise should determine how much housing led accommodation is

	action in 2nd section – report to be produced). Encourage other supported housing commissioners to oversee similar transformations.			required and we will then need to define the housing providers – RP, private, Alliance for instance. Supported housing is a theme within the workstream reviews and alliance transformation.
7.3	Undertake a study of the people who have benefitted from a time in supported housing, to see if there is a clear pattern that supports the notion of the circumstances under which congregate supported housing may be appropriate, and then collect information about people currently using supported housing, using an agreed framework adapted from the first part of the research	Chris Keating and Paul Roberts	2024/25	

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Oxfordshire Health and Wellbeing Board

26th September 2024

Oxfordshire Joint Strategic Needs Assessment 2024 & Pharmaceutical Needs Assessment 2025 update

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

RECOMMENDATION

The Health and Wellbeing Board is RECOMMENDED to

1. Approve the content of the Joint Strategic Needs Assessment for 2024 and encourage widespread use of this information in planning, developing and evaluating services across the county.
2. Contribute information and intelligence to the JSNA Steering Group to further the development of the JSNA in future years, and to participate in making information more accessible to everyone.
3. Note requirements and plans for publishing the update of the Pharmaceutical Needs Assessment.
4. Agree to the proposed approach and plan to align PNA workplan and steering group with ICS partners. Including a PNA publication date of 1st October 2025.

Joint Strategic Needs Assessment (JSNA)

Introduction

1. The Joint Strategic Needs Assessment (JSNA) is a statutory annual report provided to the Health and Wellbeing Board and published in full on Oxfordshire Insight. It provides an evidence base for the Health and Wellbeing Strategy and is an opportunity for an annual discussion about the key issues and trends from a review of a very wide range of health-related information about Oxfordshire.
2. Producing the JSNA is a collaborative project with contributions from many analysts and sector specialists from Oxfordshire's Local Authorities, NHS, Thames Valley Police, Healthwatch Oxfordshire and Voluntary Sector organisations.
3. In addition to local datasets, the report makes use of data from NHS Digital, the Office for National Statistics, commissioned reports, and information from a range of central government departments. Datasets can take time to process, which means that this 2024 JSNA update includes data from 2021 through to 2024.

4. The JSNA is a contemporary assessment of the health and wellbeing needs of the population. However, information about services needed to address population needs is beyond the scope of the JSNA. In some cases, the data may not be recent enough to reflect changes in services.

5. Whilst work is ongoing to transition the JSNA to a dynamic and interactive digital format for 2025, this paper highlights key findings from the 'lighter touch' 2024 Oxfordshire JSNA, as agreed previously by the Health and Wellbeing Board. JSNA 2024 update reports are available, subject to the Board's approval. Please see Oxfordshire Insight.

6. Plans for the continued development of digital JSNA 2025 are also detailed in this paper.

Key findings from the 2024 update of the JSNA

7. A one-page summary of the facts and figures from across the life course in the JSNA 2024 is provided in Annex 1.

8. The Board's attention is also drawn to the following key findings from the JSNA 2024 update reports.

Inclusion Health Groups

9. "Inclusion health" is a term used to describe people who are socially excluded, often underserved and who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. People belonging to inclusion groups tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities.

10. **Homelessness -** There has been an increasing trend in households owed a homelessness duty in Oxfordshire, and a 39% increase from 2022 to 2023. The numbers of people sleeping rough continues to increase (sampled on a single night each year), with increasing numbers of people from European Union countries. Among Oxfordshire districts, Oxford city has the highest rates of people owed a homeless duty.

11. **Drug and alcohol misuse -** Comparing the pre-pandemic 5-year average (2015/16 to 2019/20) with the 2022/23 count shows a slight decline in those in treatment for opiates and an increase in other substance categories. As of 2022/23 the rate for alcohol-related admissions in Oxfordshire was lower than (better) the national average (347 per 100,000 compared to 475 per 100,000 in England). At county level, admissions for alcohol-specific conditions are falling steadily in under 18-year-olds. However, deaths due to alcohol (all age) are increasing.

12. **Vulnerable migrants -** Although many migrants come to the UK to work or study and are young and/or healthy, some may have increased health needs associated with their experiences either before, during or after migration. At the end of 2023, there were 3,556 people counted in more vulnerable migrant population groups in Oxfordshire. The number of unaccompanied asylum-seeking children in Oxfordshire in 2023 was almost double that seen in each of the previous four years (104 children in 2023). Of the Oxfordshire districts, West Oxfordshire has the highest number of people belonging to specified immigration groups (Homes for Ukraine, Afghan resettlement, supported asylum seekers) per 1,000 population.

13. **Gypsy, Roma and Traveller communities -** This population faces significant discrimination and stigma and are among the most disadvantaged minority groups in the UK. At the time of the 2021 Census, Oxfordshire had a total Gypsy, Roma and Traveller population of 1,880 people. This was 0.26% of the total population, just below the England average (0.29%).

14. **Other vulnerable populations -** Local data for the prevalence and health needs of sex workers in Oxfordshire is lacking, therefore limiting our knowledge of needs for this vulnerable population group. For other vulnerable populations we have prevalence data but need to look to national data or research findings for specific health needs. As of March 2024, the total prison population in

Oxfordshire was 1,391. We have 2,405 children (age 10-17 years) cautioned or sentenced (2022/23), with rates slightly above the regional average. Recorded victims of modern slavery continue to increase, with the highest numbers in Oxford (97 in 2023). In 2023 there were 8,375 police recorded victim survivors of domestic abuse in the County. We have 486 young care leavers (aged 17-21 years) (2023).

15. **Unpaid carers -** Oxfordshire has more than fifty-two thousand residents providing unpaid care, 43% of whom provide more than 20 hours a week of unpaid care (2021). Many carers themselves suffer with long-term health condition(s).

Mental Health and Wellbeing

16. **Children and young people –** Extrapolating from national survey data suggests around 35,700 children and young people in Oxfordshire are suffering with a probable mental disorder. Children with a probable mental disorder are also more likely to live in lower income households and may be less able to afford activities outside of school. They are also less likely to be physically active or spend time in green space.

17. The proportion of primary and secondary school age children who are identified as having social, emotional and mental health need as their primary need, as a percentage of all school pupils, is increasing year on year. This is consistently significantly above the national average. Currently 3,691 pupils in Oxfordshire are supported with a primary need of social, emotional and mental health.

18. The latest data shows the post-pandemic rise in secondary pupils recorded as persistent absentees remains very high at 26.9% (up from 13.5% in 2020/21).

19. **Adults –** Active lives survey data estimates that 6% of people aged 16+ in Oxfordshire feel lonely often or always. Rates of depression continue to increase, with 86,662 currently recorded on GP practice registers (2022/23), including 9,416 newly diagnosed. The cost of living, rising unemployment and high housing costs in Oxfordshire may contribute to poorer mental wellbeing.

20. The population of Oxfordshire is aging and there has been a gradual upwards trend in the prevalence of dementia over the past ten years.

21. There has been a long-term steady decline in unpaid carers reporting enough social contact, although the pattern is in-line with national trends.

22. The prevalence of serious mental illness (schizophrenia, bipolar affective disorder and other psychoses) is 0.88% of patients. This is below the national average.

23. Emergency admissions due to self-harm is falling in recent years.

24. Positively, rates of volunteering in Oxfordshire appear to be higher than the national average and are increasing over time. Volunteering has been shown to have positive benefits for improved mental health and wellbeing.

Special Educational Needs and Disabilities (SEND)

25. Following the 2023 inspection, there has been considerable progress to build a more seamless and robust local area partnership focused on delivering the highest quality services for our children and young people.

26. Alongside the establishment of the SEND Improvement Board and Partnership Development Group, work is focused on three transformation themes: 1. Right Support, Right Time; 2. Right plan Right First Time, Every Time; 3. Right provision, Right Time, Looking to Independence – include representation from all areas of the partnership (including parent/carers).

27. The review of data and the development of data dashboards/key performance indicators is a cross-cutting theme for this transformation work. It is in the final stages of development.

28. There are 15,019 pupils with SEND support in Oxfordshire. The proportion of pupils with Special Educational Needs support in Oxfordshire is above average and increasing. However, the proportion of pupils in Oxfordshire schools with Education Health and Care Plans has remained below the national average. The greatest increase in number of pupils with an Education and Health Care Plan (EHCP) in Oxfordshire has been in primary aged boys and there is a strong link between pupils with EHCP and adversity. Neglect is the most presenting need for children with an EHCP.

29. The primary need in Oxfordshire for SEND support is speech, language and communications followed by social, emotional and mental health. These are higher than the national average and are predicted to continue to increase further locally by 2031.

Healthy Weight

30. Excess weight can lead to serious health consequences such as cardiovascular disease, type 2 diabetes, musculoskeletal disorders, and some cancers. The risk of health problems starts when someone is only very slightly overweight and increases as weight gain increases. Many of these conditions cause long-term suffering for individuals and families, in addition to high costs for the health care system.

31. **Children** - The latest child measurement data shows an improvement (a decrease) in the proportion of children measured as overweight or obese in Oxfordshire, similar to the national trend. At district level, reception-aged children (4-5 years) in Cherwell and Vale of White Horse did not improve as much as the England average and are now similar to the national average (previously better than). At year 6 (aged 10-11 years): Oxford remains the only district similar to (rather than better than) the national average. At smaller geographies, four areas currently have significantly worse proportions of year 6 children with excess weight, corresponding with areas of higher deprivation: Banbury Ruscote (Cherwell), Banbury Grimsbury (Cherwell), and Littlemore & Rose Hill (Oxford) and Blackbird Leys (Oxford).

32. **Adults** - The latest data shows that the prevalence of adults classified as overweight or obese has improved (decreased) in Oxfordshire, in contrast to the national average where the prevalence increased. However, the change (60% in 2021/22 to 57.8% in 2022/23) is not statistically significant. More than two thirds (68%) of adults on Oxfordshire GP practice Learning Disabilities registers were measured as overweight or obese, 10 percentage points above the total adult population.

Gambling Harms

33. Britain has one of the most accessible gambling markets in the world. Concerns regarding the harms associated with gambling have been increasing in the UK in recent years.

34. **Adults** - Estimates for Oxfordshire suggest that just over 18,000 (or 31 per 1,000) adults may benefit from some type of treatment or support for harmful gambling. This is similar to the national figure of 35 people per 1,000 of the adult population.

35. Gambling offline may be more common in populations living in low-income areas of the County, whereas gambling online may be more common in higher-income areas.

36. The levels of support that people with problem gambling may require ranges from brief advice and self-help to psychologist-led cognitive behaviour therapy.

37. **Impacts on children -** It is estimated that more than 10,400 children in Oxfordshire are living in households with an adult who may require treatment and support for gambling.

Local Research

38. Whilst local research approaches, ethos and methodologies vary, insights can help bring the statistical data included in the JSNA to life. It can bring added 'qualitative' depth and, more importantly, highlight the lived experiences and voices of local communities.

39. **Community research** - Recent local research activity in the County includes the establishment of Oxfordshire Community Research Network. This is a network of community groups and organisations, together with local authority, academic and NHS representatives. The network seeks to support more community-led research, to identify research priorities and to facilitate better coordination of public and community involvement in research.

40. Examples of community-led or community involvement in research in 2023 includes work around food insecurity; healthy eating; reducing inequalities in maternal and early years health, including maternal mental health; housing and health; and active travel and use of green space. Healthwatch Oxfordshire have produced several reports related to community experiences of health care services, in addition to their work with community researchers.

41. **Academic research** – Local authority engaged academic research has included work on school children's mental health and wellbeing (Oxwell school survey), and an evaluation of Oxfordshire's new approach to family

safeguarding in children's social care. Oxfordshire County Council is also working more closely with the University of Oxford and Oxford Brookes University through the establishment of a Local Policy Lab (Est.2024) – an initiative to harness the research capabilities and capacity within these universities, to progress work on policy relevant research questions for Oxfordshire.

42. **Needs assessments** - In addition to the JSNA, specific needs assessments on oral health, gambling harms and healthy weight, have been carried out over the past year.

Climate and Health

This section on Climate and Health is new to the JSNA and builds on work related to 2023/24's Director for Public Health Annual Report.

43. **Temperature -** Average annual temperatures continue to rise in Oxfordshire. Against a baseline of annual average temperatures from 1851-1900, the difference has exceeded two degrees Celsius on three occasions, two of which were in the last two years (2006 (+2.00°C), 2022 (+2.43°C), and 2023 (+2.14°C)). Across Oxfordshire, most healthcare facilities are in areas of medium or high heat risk. Oxford City's facilities are the most at risk, with almost all (84%) being in areas of high risk.

44. With increasing concerns around fuel and heating costs, some residents may be more vulnerable to cold winter temperatures. Between 2021 and 2022, the proportion of households in Oxfordshire classified as "fuel poor" increased from 7.9% to 9%, now a total of 26,700 households. This is lower than the south-east (9.7%) and national (13.1%) proportions.

45. **Flooding -** Across Oxfordshire, just one healthcare facility is in a lower risk area for flooding, with the remaining in either medium- or high-risk areas.

46. According to data from The Rivers Trust, comparing 2021 to 2023 there were 1,105 more sewer storm overflow spills counted, an increase of 36%. This amounts to a 15,667-hour increase for the time that untreated sewage flows directly into the environment.

47. **Access to green space -** Public Health evidence shows that that greener neighbourhoods and more exposure to green space correspond to better physical and mental health and wellbeing. A recent report showed that Oxfordshire's accessible greenspace is not evenly distributed, and over 50% of land area in the county (51% to 66%) does not meet any of the Accessible Greenspace Standards (2024).

48. **Air quality -** there are 11 designated Air Quality Management Areas (AQMAs) in Oxfordshire. 2022 monitoring showed that 3 areas (Banbury, Botley and The Plain in Oxford) exceeded the national target for NO2 of 40 µg/m3. In 2023 The Plain in Oxford was within the legal limit. It is estimated that fine particulate air pollution's effect on mortality in Oxfordshire was equivalent to 354 deaths in 2022. Note that this is not an estimate of deaths directly caused by air pollution but a total representing the contribution of air pollution to all deaths.

49. **Food insecurity -** Across the UK, the number of people in 'food insecure' households rose to 7.2 million in 2022/23, an increase of 2.5 million people since 2021/22. The main reason for an increase in food insecurity was a sharp increase in food prices in 2022/23. The Priority Places for Food Index (PPFI) was initially developed in response to the 2022 cost of living crisis which has put many communities under severe financial pressure and at an increased risk of food insecurity. Cherwell contains the greatest number of highest priority areas (7) while Oxford has the highest percentage of the total in the district (7%). Both Cherwell and Oxford contain both the greatest number and proportion of high priority areas. Of the 34 areas that are ranked as priority 3 or higher, 30 of these are in Cherwell (12) or Oxford (18).

50. **Greenhouse gas emissions -** Between 2008 and 2021, domestic greenhouse gas emissions in Oxfordshire fell by 35%. Per dwelling emissions have reduced by 42%, from 6.0 to 3.5 tCO2e per dwelling. The district with the lowest domestic emissions per dwelling was Oxford followed by Cherwell. This difference by district will be influenced by the differing profiles of type of dwelling.

Republishing the 2023 JSNA in individual Chapters

51. This is a cosmetic change rather than a content update. Previously, the JSNA was only available as a large PDF document. This document had in-built functionality to navigate its many (300+) pages, however we wanted to provide users a different way to access the JSNA in more convenient, theme-specific documents.

52. To this end, alongside the original document, the JSNA has now been separated into smaller documents. The JSNA website page has also been restructured to make this subdivision of themes more obvious to users accessing the site.

How the findings will be used

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

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

- Oxfordshire Local Area Inequalities dashboard
- Oxfordshire Population Dashboard
- Interactive Early Years JSNA dashboard
- Interactive healthy weight story maps
- Index of Multiple Deprivation 2019 dashboard
- Oxfordshire Local Skills dashboard

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

56. The 2024 JSNA was used to inform the new Health and Wellbeing Strategy 2024-2030 and will be reviewed as part of the work on the Health and Wellbeing Strategy outcomes reporting.

57. The JSNA report and related resources are used widely as part of service planning. Recent examples include providing population projections for commissioning strategies, use of carers data for the Unpaid Carers Strategy and Action Plan, data on protected characteristics as part of service reviews and contextual data as part of the development of The Oxfordshire Way in Adult Social Care.

Planning the 2025 update to the JSNA

58. Following the March 2024 Health and Wellbeing Board meeting, it was proposed that 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. This will ensure that it involves and reflects the needs of residents, patients and partners across Oxfordshire. Steering group members continue to be sought, with invitations extended to colleagues and partners when sharing the recent updates to the 2024 JSNA. Please see Annex 2 for a planned roadmap for the development of the Digital JSNA.

59. A proposal, outlining a change to the Oxfordshire Insight microsite was submitted to IT Programme Board on 8th August 2024. This project is twofold – firstly the development and publication of a new site in Autumn 2024, alongside the second strand of moving current content onto the new platform by end January 2025. The new digital approach to the JSNA will be a flagship project as part of this second and ongoing phase – and will also be linked into the Business Intelligence Strategic Transformation Programme.

60. The next progress update of the Digital JSNA will be presented to the December 2024 meeting of the Health and Wellbeing Board.

Pharmaceutical Needs Assessment

61. The publication of the Pharmaceutical Needs Assessment (PNA) is a legal duty of the Oxfordshire Health and Wellbeing Board.[1] It is a comprehensive assessment of the current and future pharmaceutical needs of the local population, and the extent to which the current service provision meets these needs.[2] An updated map of pharmacy provision within the County can be found on the PNA section of Oxfordshire Insight.

62. The previous Oxfordshire PNA was published on 1 April 2022 and is due to be updated by 31 March 2025.

63. As with many parts of the health and care system, there have been changes in the pharmacy landscape since the publication of the last PNA in 2022. The ICS has been established with the commissioning of pharmacies now delegated to ICBs from NHS England.

64. Key members of the PNA steering group are representatives from NHS pharmacy and primary care, previously working within the Oxfordshire Clinical Commissioning Group, and now incorporated within the BOB ICB, and Community Pharmacy Thames Valley.

65. Due to allowances made during the COVID-19 pandemic, most Health and Wellbeing Boards in England published their last PNA on 1 October 2022, including the four other boards within the BOB ICS area.

66. To allow one PNA steering group across BOB ICS, it is proposed that the development and publication of the Oxfordshire PNA be aligned with the other HWBB PNA publications, and to post-pone publication until 1 October 2025. As planned, there would be no change to the agreed approach, and an Oxfordshire specific PNA would be produced with consultation with Oxfordshire residents, however, alignment across BOB ICS would allow a more coordinated approach from NHS colleagues and the Local Pharmacy Committee. Additionally, this approach would allow better assessment of needs at the County boundaries. It is proposed that an interim or draft PNA would be used to highlight any gaps in need during the period March-October 2025.

Financial Implications

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

[1] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (legislation.gov.uk)
[2] National Health Service Act 2006 (legislation.gov.uk)

Legal Implications

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

ANSAF AZHAR CORPORATE DIRECTOR FOR PUBLIC HEALTH

Contact Officer: Bethan McDonald
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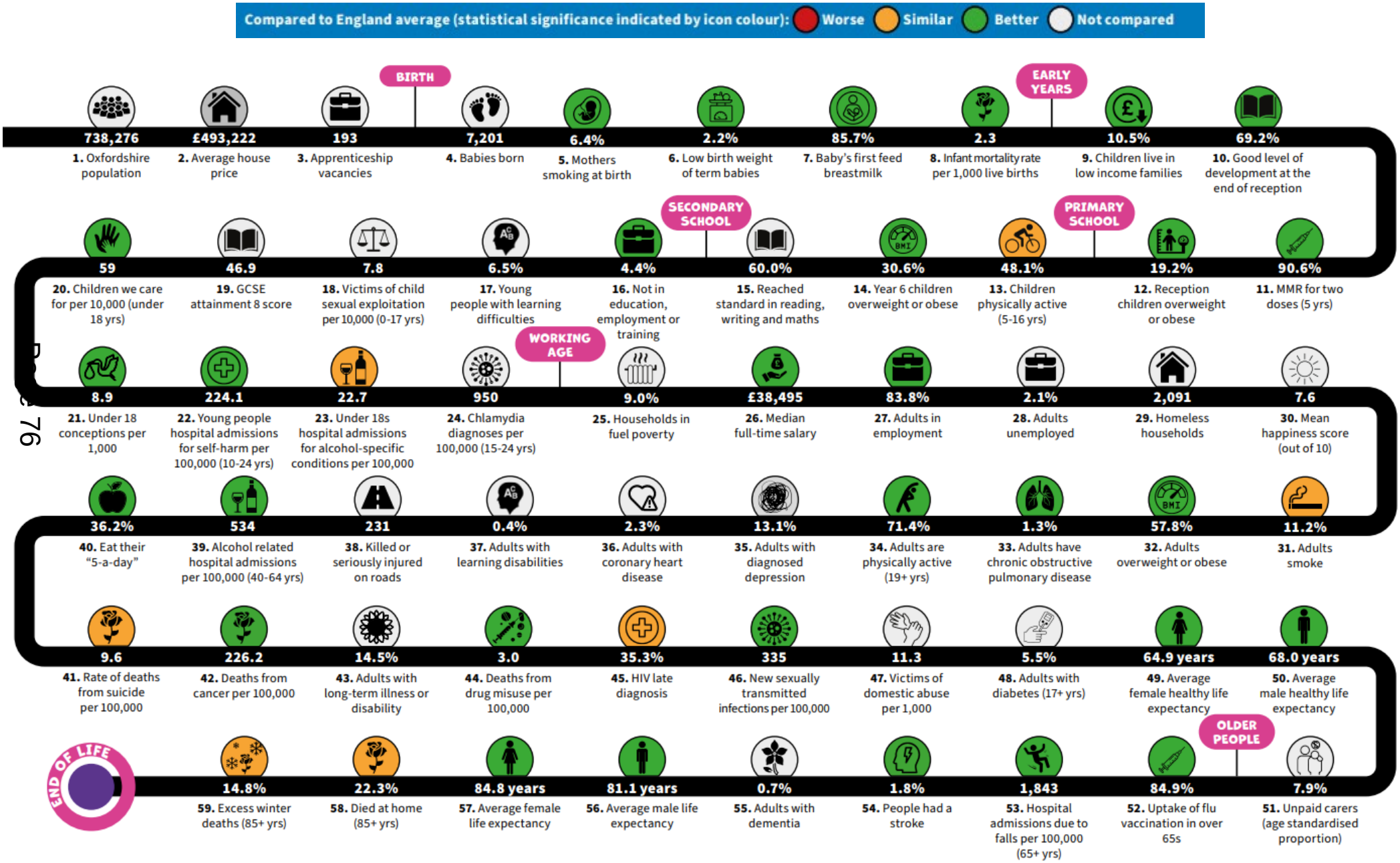
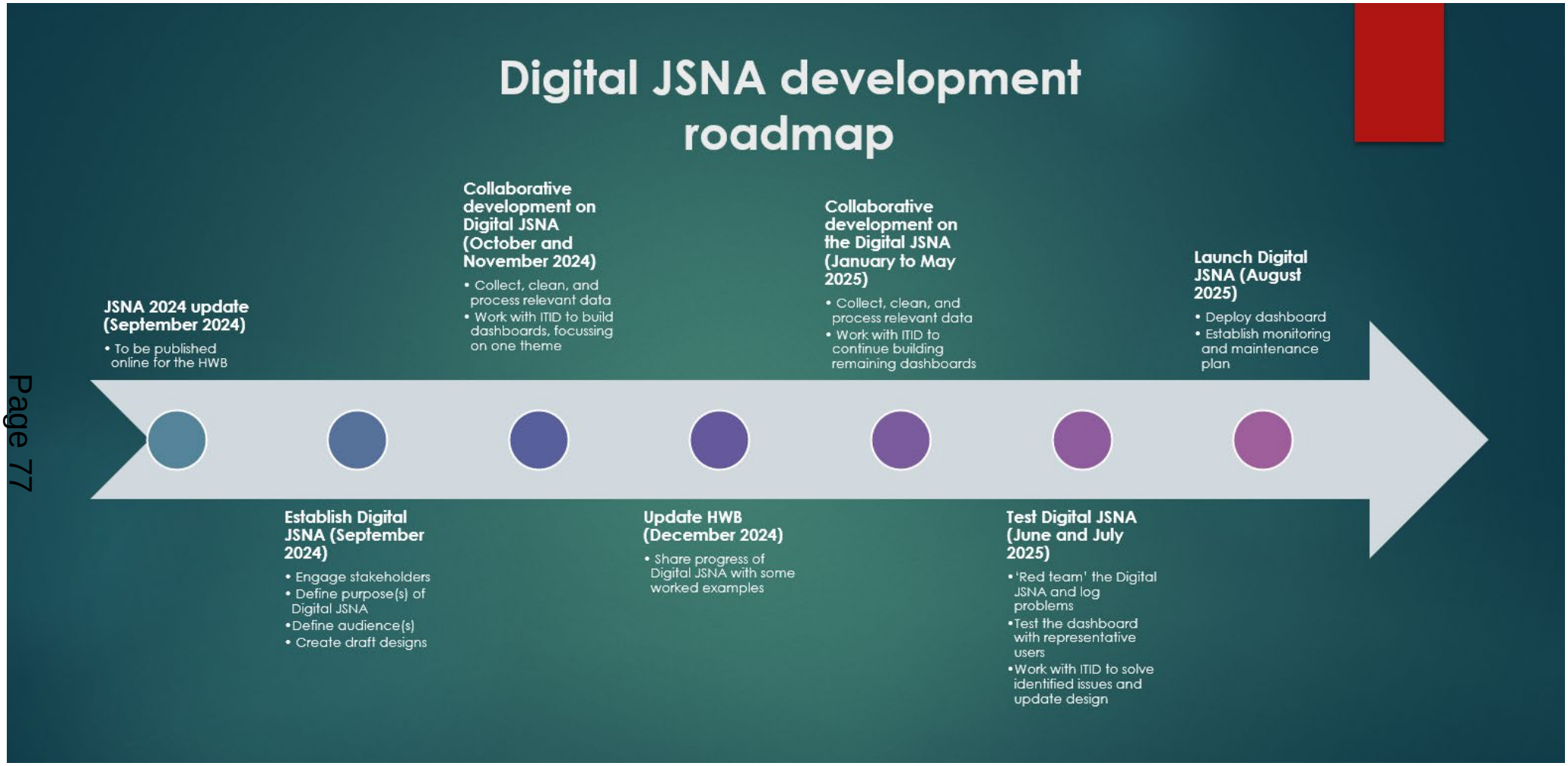
September 2024

Annex 1 - Oxfordshire JSNA health and wellbeing facts and figures 2024
Annex 2 - Digital JSNA development roadmap

Annex 1 - Oxfordshire JSNA health and wellbeing facts and figures 2024



Annex 2 – Digital JSNA development roadmap



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Divisions Affected -

OXFORDSHIRE HEALTH AND WELLBEING BOARD – 26th September 2024

Oxfordshire Better Care Fund (BCF) 2024-25

Report by Karen Fuller

RECOMMENDATION

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

   - Note the Oxfordshire Better Care Fund Plan for 2024-25, as approved by the Health and Wellbeing Board Chair via delegated authority on 2 July 2024 and NHS England on 23 August 2024.

Executive Summary

2. This report sets out the background and summary of the Better Care Fund Plan for 2024-25 for the Health and Wellbeing Board. It follows the same structure as the briefing given to the Health and Wellbeing Board Chair before submission of the Plan in July – see paragraph 5.

3. BCF Plans are owned and approved by the Health & Wellbeing Board on behalf of the Council and Integrated Care Board and other partners. As such, the Board approves the Plan each year.

4. Our 2-year BCF plan for 2023-2025 was assured and approved by the Health and Wellbeing Board in June 2023. The 2024-25 plan is intended to be an interim update.

5. This year, the July meeting of the Board was suspended due to the General Election. The Health and Wellbeing Board Chair therefore approved the Plan in a separate briefing meeting held on 2 July and attended by BCF leads and the Corporate Director for Adult Social Care. During the meeting, the Chair was asked:

   (a) To note the system-wide development and planning process for the 24/25 BCF plan
   (b) To note and approve the recommended schemes for BCF funding 24/25
   (c) To note the trajectories for BCF metrics & demand and capacity plan per the above schemes as agreed by the Urgent and Emergency Care board on 23 May

(d) To note and approve the plan to manage the implementation, spend, impact and long-term funding and efficiency approach proposals relating to approved schemes in a monthly BCF steering group which will report quarterly to UEC board and Place Based Partnership
(e) To approve submission of the final BCF 24/25 plan to NHS England
(f) To support delegation to Adult Social Care Lead Karen Fuller to submit routine reports to NHS England and escalate any performance issues to HWB by exception

Better Care Fund Plan 2024-25: main changes

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

7. The Better Care Fund is designed to improve integration to achieve these goals and is required to evidence how it brings together the range of commissioners, health and care providers, the voluntary sector and our population to develop and deliver the plan. The Better Care Fund particularly is a vehicle for extensive and imaginative integration to align services and to address health inequalities.

8. Although the 2024/25 plan is an update to our 2023-25 plan, there were some key changes in this year's submission:

(a) Introduction of a new metric based on the proportion of people discharged from hospital who are still at home after 91 days.
(b) Changes to the demand and capacity mapping, including an ask to include estimates around spot purchasing and merging reablement and rehabilitation pathways to improve accuracy of reporting

9. These changes have been captured in our Better Care Fund Plan and reflected in the annexes to this report.

Development of this Plan

10. Following feedback from last year, we have endeavoured to make this year's BCF planning process more transparent and collaborative. In January, we set up a fortnightly BCF steering group meeting with membership from across the Oxfordshire system, including:

- Health – acute, community, primary care and the Integrated Care Board
- Oxfordshire County Council – Adult Social Care, Age Well, Live Well, Public Health, Housing
- City and District Councils
- Oxfordshire Association of Care Providers
- Age UK Oxfordshire

11. This group has shared responsibility for determining how to spend the unallocated BCF funding for 24/25 and the Additional Discharge (ADF) funding.

12. BCF Leads have attended several system-wide meetings to provide regular updates on the development of the BCF plan and build system understanding of how the BCF works. This includes the Urgent Care Delivery Group, the Urgent and Emergency Care Board, the Oxfordshire Place Based Partnership and the Joint Commissioning Executive.

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

14. BCF Leads have also attended meetings with key stakeholders to build awareness of the BCF and its aims. Forums attended include the Promoting Independence & Prevention group, the Primary Care Clinical Directors' meeting, the Oxfordshire Association of Care Providers meeting, the Mental Health and Learning Disability and Autism Board, the Accommodation Programme Board, the Oxford University Hospitals Trust-wide Urgent Emergency Care Group and the Oxford Health Same-day Urgent Care Group.

15. The Oxfordshire system has acknowledged that this year's planning approach has been engaging and transparent. We intend to build on this for next year's planning process and continue to work in partnership for the benefit of Oxfordshire residents.

Better Care Fund Plan 2024-25: Key priorities for Oxfordshire

16. The plan supports Oxfordshire's continued roll out of Discharge to Assess (D2A) to take people home. This service has significantly reduced delays to discharge in Oxfordshire on all pathways. Medically Optimised For Discharge (MOFD) Length of Stay (LoS) for people on P1 pathways during 23/24 almost halved, reducing from a mean of 11 days to 5.8. We plan to further this improvement 24/25 through the continued embedding of D2A and the implementation of more trusted assessor approaches across our pathways. D2A has also confirmed that in many cases people who were listed for long-term care can move quickly to full independence if we can get them back to their own community and resources.

17. The D2A model has enabled Oxfordshire to build capacity for discharge and improve flow. However, we are seeing increased discharge activity year on year due to an increase in admissions to hospital. Once in hospital, complexity is one of the key barriers to timely discharge in the Oxfordshire system. Many of our longer LoS are complex patients i.e. with mental health, homelessness, learning disability/autism and/or frailty who get 'stuck' in hospital and cannot be discharged.

18. This year's plan is an opportunity to build our capability to support this patient cohort and improve their experience and outcomes, through adopting integrated, system-focused approaches to discharge support.

19. For this reason, there is substantial investment in schemes to support more complex and frail people to remain in the community rather than be admitted to hospital and, where admitted, to provide wraparound support to enable quicker discharge and reduce the risk of readmission.

20. This approach closely aligns with the Oxfordshire Way to support people to remain independent at home and complements the ICB Urgent and Emergency Care Funding plan for 2024-25 to reduce pressure on emergency care.

21. The plan supports people who interact with acute and mental health pathways. It also supports admission avoidance and complex discharges, particularly for people with presentations relating to mental health and homelessness, including alcohol issues. This has been developed in partnership across health, District Councils and Public Health and is supported by Public Heath grant.

22. The BCF plan supports the development of out of hospital and targeted support for people living with learning disability and or autism; both in improving discharge planning from acute and specialist settings, and in providing alternatives to admission and increased housing options.

23. To deliver this, the BCF plan builds on community and Voluntary, Community & Social Enterprise capacity to support people at home in their own communities. This is aligned to Adult Social Care community capacity funding and the ICB Health Inequalities Fund.

Demand and Capacity Plan

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

25. We have worked with Business Intelligence leads across health and social care to develop our demand and capacity plan. We believe we have mapped the known demand and have plans to meet it during 24/25. This will be monitored monthly by the system Urgent and Emergency Care Board.

Metrics

26. There are 5 areas for which Oxfordshire must give trajectories for 2024-25. These are measured quarterly by NHS England and monthly by the Council and Integrated Care Board's Joint Commissioning Executive with recommendations from the system Urgent and Emergency Care Board.

Non-elective (NEL) admissions to hospital

27. Our approach in 2023-24 has reduced non-elective admissions to hospital. During 2023-24 we have confirmed that NEL under this metric include 0 Length of Stay attendances in our acute Same Day Emergency Care (SDEC). We have therefore set a target that:
    - Increases the number of people seen in SDEC along the same trajectory as 2023/24 (14.85%) and
    - Reduces the number of NEL admissions to inpatients to 95% of the 2021/22 outturn

    This leaves a net position of a reduction of 0.9%. The quarterly weighting reflects annual performance.

8.1 Avoidable admissions		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	191.8	179.7	176.0	176.0
	Number of Admissions	1,491	1,397	-	-
	Population	726,530	726,530	-	-
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Adults over the age of 18 with specified long-term conditions	Indicator value	172	160	182	176

Admissions to hospital due to falls

28. Oxfordshire has been an outlier for falls-related admissions for several years. However, in 2023-24 the performance improved, and we have assumed that plans developed in 23/24 will continue to deliver in 24/25.

29. Oxfordshire has a range of services that support people at risk of falls and admission or conveyance. The BCF also funds falls and preventative strengths-based services and our Care Home Support service. We aim to make further improvements within our existing falls provision, which involves working at a system level to improve the effectiveness of the falls pathway.

8.2 Falls		2023-24 Plan	2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,802.0	2,027.0	1,802.0
	Count	1,802	2779	2480
	Population	2,480	130,843	130,843

Discharge to Usual Place of Residence

30. We have set a reduction on non-elective admission for both long term care and for falls to mitigate the risk of creating avoidable demand for discharge services. In 2023/24 we have reduced the MOFD LoS for P1 and have sufficient capacity to meet existing P1 demand including the use of live-in and waking nights provision to avoid use of a bed.

31. However, we need to divert 35-40 people a week from P2/P3 to P1 to deliver the BCF plan in year. This diversion has been built into the trajectory towards 95%, which is supported by:

    (a) Establishment of the TOC Hub which now directs discharge from all bed bases,
    (b) Expansion of Discharge to Assess including live-in and waking nights support to reablement and short-term care and assessment,
    (c) Provision to increase the community rehab pathway during 24/25. This work will commence in Q2 and inform plans for 25/26.

32. A change to the coding approach, as indicated by NHS England, will reclassify discharges back to care homes in line with this metric and also support improvements in our performance.

8.3 Discharge to usual place of residence		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan
	Quarter (%)	91.0%	91.7%	92.5%	93.0%
	Numerator	11,511	11,977	11,840	11,625
	Denominator	12,644	13,060	12,800	12,500
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.0%	92.0%	93.5%	95.0%
	Numerator	11,510	11,921	12,138	12,661
	Denominator	12,511	12,958	12,982	13,327

Permanent Admission to residential care

33. Oxfordshire is focused on Home First and strengths-based approaches to care assessment and planning and will continue to reduce the length of time in which older people live away from their own communities wherever possible. We have set a further reduction for 2024/25.

8.4 Residential Admissions		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan
	Annual Rate	357.7	325.8	296.9	283.8
	Numerator	468	450	410	400
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Denominator	130,843	138,108	138,108	140,953

Income and Expenditure Plan

Income plan

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

Expenditure plan

35. The minimum NHS contribution and the Improved Better Care Fund allocations are committed in full in line with the schemes set out in the template that support

the plan. The Disabled Facilities Grant is passed through in full to the District and City Councils.

Additional Discharge Funding

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

Summary of income and expenditure

	2024-25		
Running Balances	Income	Expenditure	Balance
DFG	£7,262,808	£7,262,808	£0
Minimum NHS Contribution	£52,132,104	£52,132,104	£0
iBCF	£10,705,289	£10,705,289	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Local Authority Discharge Funding	£2,501,441	£2,501,441	£0
ICB Discharge Funding	£5,718,165	£5,718,165	£0
Total	**£78,319,807**	**£78,319,807**	**£0**

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

Financial Implications

38. The plan as drafted sets out the income and expenditure for the Better Care Fund in 2024-25.

39. The final plan as submitted was approved by the Council's S151 officer.

40. Since submission of the plan, the phasing of some schemes has been reconfigured. This has resulted in the reallocation of some funds within the BCF. This was decided through system consultation and is a common occurrence in BCF planning and delivery. The changes made have been developed in partnership with the Urgent and Emergency Care Board.

Comments checked by:

Stephen Rowles, Strategic Finance Business Partner,
Stephen.rowles@oxfordshire.gov.uk

Inequalities

41. The Additional Discharge Funding is deployed extensively to support the most vulnerable people on discharge and prevent them entering hospital settings in the first place.

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

43. Per our 23-25 plan, we will improve access to longer-term housing for people with complex needs in our discharge pathways: we will fund specialist development capacity to identify housing options for people living with learning disability/autism settings; and we will work with district councils to integrate housing options for people in step down pathways who have no home.

Implementation and Review for 2024-25

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

45. We will also utilise our BCF Steering Group to monitor implementation of the schemes and create a separate BCF Strategy Group, attended by key representatives from Business Intelligence, Finance and Urgent and Emergency care to report on the impact and value of the plan.

46. There will be a formal review concluded in Q3 to confirm any in-year amendments to the plan and inform the proposals for 2025/26.

Karen Fuller, Corporate Director of Adult Social Care
[SLT Member]

Annex: Oxfordshire HWB 2425 BCF Plan

Background papers: Nil.

Contact Officer: Ian Bottomley, Lead Commissioner Age Well
ian.bottomley@oxfordshire.gov.uk

September 2024

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BCF Planning Template 2024-25

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

6. Please ensure that al boxes on the checklist are green before submission.

7. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

4. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

4.2 Hospital Discharge

A new text field has been added this year, asking for a description of the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation. Please answer this briefly, in a couple of sentences.

The capacity section of this template remains largely the same as in previous years, asking for estimates of available capacity for each month of the year for each pathway. An additional ask has now also been included, for the estimated average time between referral and commencement of service. Further information about this is available in the capacity and demand guidance and q&a documents.

The demand section of this sheet is unchanged from last year, requesting expected discharges per pathway for each month, broken down by referral source.

To the right of the summary table, there is another new requirement for areas to include estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways. Please estimate this as an average across the whole year.

4.3 Community

Please enter estimated capacity and demand per month for each service type.

The community sheet also requires areas to enter estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2024-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations, DFG allocations and allocations of ASC Discharge Fund grant to local authorities for 2024-25. The iBCF grant in 2024-25 remains at the same value nationally as in 2023-24.

2. The sheet will be largely auto-populated from either 2023-25 plans or confirmed allocations. You will be able to update the value of the following income types locally:

- ICB element of Additional Discharge Funding
- Additional Contributions (LA and ICB)

If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

3. The sheet will pre populate the amount from the ICB allocation of Additional Discharge Funding that was entered in your original BCF plan. Areas will need to confirm and enter the final agreed amount that will be allocated to the HWB's BCF pool in 2024-25. As set out in the Addendum to the Policy Framework and Planning Requirements; the amount of funding allocated locally to HWBs should be agreed between the ICB and councils. These will be checked against a separate ICB return to ensure they reconcile.

4. The additional contributions from ICBs and councils that were entered in original plans will pre-populate. Please confirm the contributions for 2024-25. If there is a change to these figures agreed in the final plan for 2024-25, please select 'Yes' in answer to the Question 'Do you wish to update your Additional (LA/ICB) Contributions for 2024-25?'. You will then be able to enter the revised amount. These new figures will appear as funding sources in sheet 6a when you are reviewing planned expenditure.

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

6. If you are pooling any funding carried over from 2023-24 (i.e. underspends from BCF mandatory contributions) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field at the bottom of the sheet to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

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

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

6. Expenditure

This sheet has been auto-populated with spending plans for 2024-25 from your original 2023-25 BCF plans. You should update any 2024-25 schemes that have changed from the original plan. The default expectation is that plans agreed in the original plan will be taken forward, but where changes to schemes have been made (or where a lower level of discharge fund allocation was assumed in your original plan), the amount of expenditure and expected outputs can be amended. There is also space to add new schemes, where applicable.

If you need to make changes to a scheme, you should select yes from the drop down in column X. When 'yes' is selected in this column, the 'updated outputs for 2024-25' and 'updated spend for 2024-25' cells turn yellow and become editable for this scheme. If you would like to remove a scheme type please select yes in column X and enter zeros in the editable columns. The columns with yellow headings will become editable once yes is selected in column X - if you wish to make further changes to a scheme, please enter zeros into the editable boxes and use the process outlined below to re-enter the scheme.

If you need to add any new schemes, you can click the link at the top of the sheet that reads 'to add new schemes' to travel quickly to this section of the table.

For new schemes, as with 2023-25 plans, the table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet. olease enter the followine information:

1. Scheme ID:

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

2. Scheme Name:

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

3. Brief Description of Scheme

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

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.

- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn ""yellow"". Please select the Sub Type from the dropdown list that best describes the scheme being planned.

- Please note that the dropdown list has a scroll bar to scroll through the list and all the options may not appear in one view.

- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.

- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.

- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.

- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

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

- A change has been made to the standard units for residential placements. The units will now read as 'Beds' only, rather than 'Beds/placements'

6. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.

- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.

7. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.

- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.

- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:

- Please select the type of provider commissioned to provide the scheme from the drop-down list.

- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

Better Care Fund 2024-25 Update Template

2. Cover

Version 1.3.0

Please Note:

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

Health and Wellbeing Board:	Oxfordshire	
Completed by:	Ian Bottomley	
E-mail:	ian.bottomley@oxfordshire.gov.uk	
Contact number:	07532 132975	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Thu 04/07/2024	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Liz	Leffman	liz.leffman@oxfordshire.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Dr	Nick	Broughton	nick.broughton1@nhs.net
	Additional ICB(s) contacts if relevant		Dan	Leveson	daniel.leveson@nhs.net
	Local Authority Chief Executive		Martin	Reeves	martin.reeves@oxfordshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Karen	Fuller	karen.fuller@oxfordshire.gov.uk
	Better Care Fund Lead Official		Pippa	Corner	pippa.corner@oxfordshire.gov.uk
	LA Section 151 Officer		Lorna	Baxter	lorna.baxter@oxfordshire.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

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

#REF!

	Complete:
2. Cover	Yes
4.2 C&D Hospital Discharge	Yes
4.3 C&D Community	Yes
5. Income	Yes
6a. Expenditure	#REF!
7. Narrative updates	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2024-25 Update Template

3. Summary

Selected Health and Wellbeing Board: Oxfordshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£7,262,808	£7,262,808	£0
Minimum NHS Contribution	£52,132,104	£52,132,104	£0
iBCF	£10,705,289	£10,705,289	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Local Authority Discharge Funding	£2,501,441	£2,501,441	£0
ICB Discharge Funding	£5,718,165	£5,718,165	£0
Total	**£78,319,807**	**£78,319,807**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	2024-25
Minimum required spend	£14,811,329
Planned spend	£20,602,315

Adult Social Care services spend from the minimum ICB allocations

	2024-25
Minimum required spend	£32,734,242
Planned spend	£34,900,303

Metrics >>

Avoidable admissions

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	171.5	159.7	181.9	176.2

Falls

		2023-24 estimated	2024-25 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,027.0	1,802.0
	Count	2779	2480
	Population	130843	130843

Discharge to normal place of residence

	2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.0%	92.0%	93.5%	95.0%

Residential Admissions

		2022-23 Actual	2024-25 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	358	284

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	No
	PR2	0
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	0
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: Oxfordshire

Checklist
Complete:

Hospital Discharge

Capacity - Demand (positive is Surplus)	Capacity surplus. Not including spot purchasing: Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Capacity surplus (including spot purchasing): Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1
Short term domiciliary care (pathway 1)	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1
Reablement & Rehabilitation in a bedded setting (pathway 2)	21	-18	7	12	11	13	-6	6	39	-1	6	26	21	-18	7	12	11	13	-6	6	39	-1	6	26
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-12	-6	-10	-10	-13	-20	-30	-19	-9	-15	-9	-23	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-2

Average LoS/Contact Hours per episode of care: Full Year	Units
40	Contact Hours per package
33	Contact Hours per package
28	Average LoS (days)
34	Average LoS (days)
28	Average LoS (days)

Please briefly describe the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation – e.g. social support from the voluntary sector, blitz cleans. You should also include an estimate of the number of people who will receive this type of service during the year.

Oxfordshire commissions Age UK Oxfordshire to provide step down support on a social prescribing model. This focuses on supporting patients and families where people are within P0 but also compliments P1 where the discharge would benefit from access to non-care community services. This service works across all bed bases. In 2023/24 2244 people were supported in or on their return home from hospital. 1450 were followed up post discharge.

Capacity - Hospital Discharge

Service Area	Metric	Refreshed planned capacity (not including spot purchased capacity): Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Capacity that you expect to secure through spot purchasing: Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	253	260	265	265	265	270	275	280	280	280	275	280	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased)	5.8	5.5	5.2	4.9	4.6	4.6	4.3	4	4	4	3.7	3.2												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	91	100	105	105	105	110	115	115	115	115	110	115	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	5.8	5.5	5.2	4.9	4.6	4.6	4.3	4	4	4	3.7	3.2												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	164	170	175	188	177	170	185	165	180	158	148	168	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	8.2	8.2	8	8	8	7.5	7.5	6	6	6	5.5	5.5												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												
Short term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	11	5	9	9	12	19	19	18	8	14	8	22
Short term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0												

Demand - Hospital Discharge

Please enter refreshed expected no. of referrals:

Pathway	Trust Referral Source	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Expected Discharges:	Total Discharges	505	560	552	562	555	565	613	579	551	575	542	568
Reablement & Rehabilitation at home (pathway 1)	Total	256	263	268	268	268	273	278	283	283	283	278	283
	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	253	260	265	265	265	270	275	280	280	280	275	280
	OTHER	3	3	3	3	3	3	3	3	3	3	3	3
	(blank)												
Short term domiciliary care (pathway 1)	Total	94	103	108	108	108	113	118	118	118	118	113	118
	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	91	100	105	105	105	110	115	115	115	115	110	115
	OTHER	3	3	3	3	3	3	3	3	3	3	3	3
	(blank)												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	143	188	166	176	166	159	187	159	141	159	142	142
	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	141	186	164	174	164	157	185	157	139	157	140	140
	OTHER	2	2	2	2	2	2	2	2	2	2	2	2
	(blank)												
Other short term bedded care (pathway 2)	Total	0	0	0	0	0	0	0	0	0	0	0	0
	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
	(blank)	0	0										
Short term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	12	6	10	10	13	20	30	19	9	15	9	23
	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	11	5	9	9	12	19	19	18	8	14	8	22
	OTHER	1	1	1	1	1	1	11	1	1	1	1	1
	(blank)												

Better Care Fund 2024-25 Update Template

4. Capacity & Demand

Selected Health and Wellbeing Board: Oxfordshire

Community — **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Social support (including VCS)	39	70	80	70	64	52	55	51	157	14	12	39
Urgent Community Response	53	55	60	60	49	45	0	-20	-20	-35	0	-10
Reablement & Rehabilitation at home	4	1	4	1	1	4	1	4	1	1	10	1
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours

Full Year	Units	Checklist (Complete:)
1	Contact Hours	Yes
24	Contact Hours	Yes
40	Contact Hours	Yes
0	Average LoS	Yes
0	Contact Hours	Yes

Capacity - Community

Please enter refreshed expected capacity:

Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Checklist
Social support (including VCS)	Monthly capacity. Number of new clients.	420	420	420	420	420	420	420	420	420	420	420	420	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	430	430	430	430	430	430	430	430	430	430	430	430	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	70	70	70	70	70	70	70	70	70	70	70	70	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Demand - Community

Please enter refreshed expected no. of referrals:

Service Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Checklist
Social support (including VCS)	381	350	340	350	356	368	365	369	263	406	408	381	Yes
Urgent Community Response	377	375	370	370	381	385	430	450	450	465	430	440	Yes
Reablement & Rehabilitation at home	66	69	66	69	69	66	69	66	69	69	60	69	Yes
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0	Yes

Better Care Fund 2024-25 Update Template

5. Income

Selected Health and Wellbeing Board: Oxfordshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Oxfordshire	£7,262,808
DFG breakdown for two-tier areas only (where applicable)	
Cherwell	£1,352,465
Oxford	£1,550,428
South Oxfordshire	£1,691,152
Vale of White Horse	£1,787,710
West Oxfordshire	£881,053
Total Minimum LA Contribution (exc iBCF)	**£7,262,808**

Local Authority Discharge Funding	Contribution
Oxfordshire	£2,501,441

ICB Discharge Funding	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	£55,139	£0	It has been confirmed that ADF will not be available from
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£5,718,000	£5,718,165	
Total ICB Discharge Fund Contribution	£5,773,139	£5,718,165	

iBCF Contribution	Contribution
Oxfordshire	£10,705,289
Total iBCF Contribution	**£10,705,289**

Local Authority Additional Contribution	Previously entered	Updated	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	£497,921
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£51,634,183
Total NHS Minimum Contribution	**£52,132,104**

Additional ICB Contribution	Previously entered	Updated	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£52,132,104**	**£52,132,104**	

	2024-25
Total BCF Pooled Budget	**£78,319,807**

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

Better Care Fund 2024-25 Update Template

6. Expenditure

To Add New Schemes

Selected Health and Wellbeing Board: Oxfordshire

<< Link to summary sheet

	2024-25		
Running Balances	Income	Expenditure	Balance
DFG	£7,262,808	£7,262,808	£0
Minimum NHS Contribution	£52,132,104	£52,132,104	£0
iBCF	£10,705,289	£10,705,289	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Local Authority Discharge Funding	£2,501,441	£2,501,441	£0
ICB Discharge Funding	£5,718,165	£5,718,165	£0
Total	**£78,319,807**	**£78,319,807**	**£0**

Required Spend

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

	2024-25		
	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£14,811,329	£20,602,315	£0
Adult Social Care services spend from the minimum ICB allocations	£32,734,242	£34,900,303	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

!!! Critical errors detected !!!

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

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Previously entered Outputs for 2024-25**	Updated Outputs for 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Disabled Facilities Grant	Home adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		1050	1150	Number of adaptations funded/people	Other		LA			Local Authority	DFG
2	Home Improvement Agency	Home adaptation service and minor works to people's homes	DFG Related Schemes	Other	Delivery of DFG works	0	0	Number of adaptations funded/people	other	District housing authority	LA			Local Authority	Minimum NHS Contribution
3	Integrated Community Equipmnent	Equipment service	Assistive Technologies and Equipment	Community based equipment		21500	22000	Number of beneficiaries	Social Care		Joint	44.5%	55.5%	Private Sector	Minimum NHS Contribution
4	Telecare	telecare services	Assistive Technologies and Equipment	Assistive technologies including telecare		4750	5000	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution
5	Care homes	Nursing home placements	Residential Placements	Nursing home		226	226	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution
6	Home care	Support for people at home	Home Care or Domiciliary Care	Domiciliary care packages		295333	29533	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	Minimum NHS Contribution
8	Market resilience	Provider fee uplifts (in year and historic)	Care Act Implementation Related Duties						Social Care		LA			Private Sector	iBCF
9	Workforce	Care worker recruitment and retention initiatives	Workforce recruitment and retention					WTE's gained	Social Care		LA			Private Sector	iBCF

10	Extra Care Housing	Extra care housing as an alternative to residential care	Housing Related Schemes						Social Care		LA			Private Sector	Minimum NHS Contribution
11	Information, advice, community development and	Information, advice, advocacy and community development capacity	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	iBCF
12	Community Capacity	Grant funding to increase community capacity and alternatives to formal care	Prevention / Early Intervention	Other	Community grants caoacity				Social Care		LA			Charity / Voluntary Sector	iBCF
13	Homelessness Alliance	Support funding to homelessness MDT	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution
14	Carer support	Advice, support and grants programme for carers	Carers Services	Carer advice and support related to Care Act duties		42350		Beneficiaries	Social Care		Joint	32.5%	67.5%	Charity / Voluntary Sector	Minimum NHS Contribution
15	Falls prevention	Strength and balance classes for oeople at risk of falling	Prevention / Early Intervention	Other	Strenght and balance classes for at risk people				Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
16	Falls service	Assessment and tailored support for people at high risk of falls	Prevention / Early Intervention	Other	Clinical support to high risk fallers				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
17	Night sitting	Homecare capacity for people at end of life	Urgent Community Response						Continuing Care		NHS			Private Sector	Minimum NHS Contribution
18	Hospital at Home North Oxon	Community interventions to support UCR in supporting people at home	Urgent Community Response						Community Health		NHS			Private Sector	Minimum NHS Contribution
19	Hospital at Home South Oxon	Community inommunityu entions ty suppout UCR in suppouting people at home	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
20	Virtual ward escalation	Medical assessment and step up service in the community	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
21	Reablement	D2A provision to Home First approaches on discharge and in the community	Home-based intermediate care services	Reablement at home (to support discharge)		3000	3000	Packages	Social Care		Joint	43.0%	57.0%	Private Sector	Minimum NHS Contribution
22	Home First MDT	Clinical triage, assessment and case allocation to Home First providers	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
23	Hospital social work team	Clinical triage, assessment and case allocation to support social care discharge	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	iBCF
24	P2 Discharge to Assess beds	Reablement bed pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		1300	750	Number of placements	Community Health		Joint	67.9%	32.1%	Private Sector	Minimum NHS Contribution
25	P2 pathway MDT	Reablement bed pathway MDT	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
26	P2 Community Hospital beds	Bed-based intermediate care with rehabilitation (to support discharge) recovery	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		1244	1100	Number of placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
27	NHS ADF to be allocated	Further schemes to be finalsied in Q2 2324	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
28	LA ADF to be allocated	Further schemes to be finalsied in Q2 2324	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Private Sector	Local Authority Discharge
29	Trusted Assessment	Expanded TA service to cover P1 restarts and P3	High Impact Change Model for Managing Transfer of Care	Trusted Assessment					Social Care		LA			Private Sector	Local Authority Discharge
30	Interim expansion of P2 pathway	Additonal short-term therapy and provider support to P2 beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		0	0	Number of placements	Social Care		NHS	80.0%		Private Sector	ICB Discharge Funding
31	SALT care home pilot to support discharge	Specialist input to support complex discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	ICB Discharge Funding

32	Surge capacity	Provisiob for additional NH beds in winter	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		50	0	Number of placements	Social Care		LA			Private Sector	Local Authority Discharge
33	Delirium pathway beds	Specialist step down beds to support complex discharges	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		72	0	Number of placements	Social Care		LA			Private Sector	Local Authority Discharge
34	MH step down pathway	Beds and associated MDT to support discharge for people with severe mental illness	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		160		Number of placements	Other	VCSE	NHS			Charity / Voluntary Sector	ICB Discharge Funding
35	MH discharge funding	Grant resource to support complex MH discharges	Personalised Budgeting and Commissioning						Mental Health		LA			NHS Mental Health Provider	Local Authority Discharge
36	MH support to care homes	Complex in reach to residential to support discharge	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			NHS Community Provider	ICB Discharge Funding
37	Personality Disorder discharge	Dedciated discharge planning and navigation for people living with personality disorder	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
38	MH OT support	Dedicated OT support to increase flow home from MH acute beds	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
39	MH social work	Dedicated social work support to increase flow home from MH acute beds	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		LA			NHS Mental Health Provider	Local Authority Discharge
40	OP OOH discharge support	Extended hours service to support older people's MH acute discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
41	LDA intensive discharge support	Aditional case manager input to manage complex LDA discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Other	LDA community team	LA			NHS Community Provider	Local Authority Discharge
41	LDA housing capacity development	Development caoacity to support housing options on discharge for complex LDA service users	Housing Related Schemes						Other	LDA community team	LA			Local Authority	Local Authority Discharge
42	LD nurse discharg support	In-reach specialist LD nurses to complement acute in-patient specialist team to manage discharges from acute	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Other	LDA community team	NHS			NHS Community Provider	ICB Discharge Funding
43	Demand and capacity	IT and BI capacity to monitor and deploy resource management	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Other	Cross sector	NHS			Private Sector	ICB Discharge Funding
7	Home care2	Support for people at home	Home Care or Domiciliary Care	Domiciliary care packages		95012	95012	Hours of care (Unless short-term in which	Social Care		LA			Private Sector	iBCF

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Adding New Schemes:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'		Outputs for 2024-25	Units (auto-populate)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding
44	Integrated Neighbourhood teams	** Expansion of PCN led MDT to support admission avoidance of complex people into hospital, reducing LOS, enabling	Community Based Schemes	Integrated neighbourhood services			500 new patients		Primary Care		NHS			NHS Community Provider	ICB Discharge Funding
45	Virtual Ward capacity	** Hospital outreach service to support community capacity, UCR and INT and provides wraparound support to help	Community Based Schemes	Integrated neighbourhood services			4200 pick ups		Community Health		NHS			NHS Acute Provider	ICB Discharge Funding
46	High Intensity User Project	** MDT to support people with complex MH presentations and follow up in the community. The HIU service works in	Community Based Schemes	Integrated neighbourhood services			750 patients		Community Health		NHS			NHS	Local Authority Discharge
47	D2A expansion	D2A costs including live in and waking nights support to reablement	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs			180 live in packages		Social Care		LA			Private Sector	Local Authority Discharge
48	Redesign of P2 reablment and D2A	Development of MH and complex nursing beds for D2A P2 pathway	High Impact Change Model for Managing Transfer of Care	Other	P2 beds		40 complex discharges		Community Health		LA			Private Sector	Local Authority Discharge
49	Care worker capacity	**Training and new starter/retention grants for care workers to provide the workforce to deliver D2A and support	Care Act Implementation Related Duties	Other	Market sustainability				Social Care		LA			Charity / Voluntary Sector	Local Authority Discharge
50	Care Home resilience	**Training and MDT programme to increase care home resilience around NEL and sustainable, timely discharge at	Enablers for Integration	Integrated models of provision					Primary Care		NHS			NHS	Local Authority Discharge
51	Intermediate care model	Created P1 rehab capacity	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
52	CYP respiratory pilot	**Community intervention to support NEL avoidance and provide early supported discharge for children and	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as			50 CYP avoiding admission		Community Health		NHS			NHS Community Provider	ICB Discharge Funding
53	LDA admission avoidance	**Building on the previous adults community discharge grant, this scheme funds adjustments that avoid hospital	Housing Related Schemes						Social Care		LA			Charity / Voluntary Sector	Local Authority Discharge
54	LDA safe spaces	**Resourcing a new step up facility to provide people with learning disabilities and autism with safe interiors. This aims	Housing Related Schemes						Social Care		LA			Private Sector	Local Authority Discharge
55	MH Housing discharge pathway	Dedicated embedded housing workers to support discharge from acute MH beds	Housing Related Schemes				72 discharges		Social Care		NHS			Charity / Voluntary Sector	ICB Discharge Funding
56	CAMHS transition and discharge	Dedicated posts to supprot CYP into adults who are also using in-patient acute services	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
57	Weekend discharge MDT	Increasing P1 discharge capacity at weekends	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)			600 discharges		Acute		NHS			NHS Acute Provider	ICB Discharge Funding

58	Heart Failure outreach	**Heart failure patients present a clinical risk and so can be challenging to discharge and can have longer, often	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			112 NEL avoided		Community Health		NHS			NHS Acute Provider	ICB Discharge Funding
59	Alcohol support into ED	**Expansion of alcohol services to support people attending ED and follow up in community. Alcohol-related	Integrated Care Planning and Navigation	Assessment teams/joint assessment			100 NEL avoided		Acute		NHS			NHS Acute Provider	ICB Discharge Funding
60	Reablement bed pathway	Reprofiled P2 reablement bed capacity	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)			750 placements	Number of placements	Community Health		Joint	76.0%	24.0%	Private Sector	Minimum NHS Contribution
62	Virtiual Ward 2	Contribution to scheme 45	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
63	System integrated staffing	Commissioning and operaitonal integrated roles	Integrated Care Planning and Navigation	Care navigation and planning					Other	System posts	Joint	50.0%	50.0%	NHS	Minimum NHS Contribution
64	Communications Plan for D2A and winter	**Public engagement. There has been significant local opposition to SSHB closures which we've	Other		Communications				Social Care		NHS			Local Authority	ICB Discharge Funding
67	Paediatric discharge support	Pharmacy support to discharges	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			Reduced LoS		Acute		NHS			NHS Acute Provider	ICB Discharge Funding
68	Integrated Community Equipment	Equipment service	Assistive Technologies and Equipment	Community based equipment			22000	Number of beneficiaries	Social Care		Joint	53.0%	47.0%	Private Sector	Minimum NHS Contribution
69	Integrated single point of access	Single front door; technical system integration and scheduling tools; clinical back fill for development 2425	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
70a	Frailty assessment and discharge	Expanded SDEC capacity to support discharge flow for 0 day LoS and reduce NEL for winter 2425 (6MM)	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Acute		LA			NHS Acute Provider	Local Authority Discharge
70b	Frailty assessment and discharge	Expanded SDEC capacity to support discharge flow for 0 day LoS and reduce NEL for winter 2425 (6MM)	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Acute		NHS			NHS Acute Provider	ICB Discharge Funding
70c	Frailty assessment and discharge	Expanded SDEC capacity to support discharge flow for 0 day LoS and reduce NEL for winter 2425 (6MM)	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Acute		NHS			NHS Acute Provider	Minimum NHS Contribution

Further guidance for completing Expe

Schemes tagged with the following will count towards the
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribut

Schemes tagged with the below will count towards the pla
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, onl
- **Source of funding** selected as 'Minimum NHS Contribut

2023-25 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes

5	DFG Related Schemes
6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)
12	Home-based intermediate care services
13	Urgent Community Response

14	Personalised Budgeting and Commissioning
15	Personalised Care at Home
16	Prevention / Early Intervention
17	Residential Placements
18	Workforce recruitment and retention
19	Other

Scheme type
Assistive Technologies and Equipment
Home Care or Domiciliary Care
Bed based intermediate Care Services
Home-based intermediate care services
Residential Placements
DFG Related Schemes
Workforce Recruitment and Retention
Carers Services

nditure sheet

planned **Adult Social Care services spend** from the NHS min:

ion'

anned **Out of Hospital spend** from the NHS min:

ly the NHS % will contribute)
ion'

Sub type
1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other
1. Independent Mental Health Advocacy 2. Safeguarding 3. Other
1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other

1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other
1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

1. Bed-based intermediate care with rehabilitation (to support discharge)
2. Bed-based intermediate care with reablement (to support discharge)
3. Bed-based intermediate care with rehabilitation (to support admission avoidance)
4. Bed-based intermediate care with reablement (to support admissions avoidance)
5. Bed-based intermediate care with rehabilitation accepting step up and step down users
6. Bed-based intermediate care with reablement accepting step up and step down users
7. Other

1. Reablement at home (to support discharge)
2. Reablement at home (to prevent admission to hospital or residential care)
3. Reablement at home (accepting step up and step down users)
4. Rehabilitation at home (to support discharge)
5. Rehabilitation at home (to prevent admission to hospital or residential care)
6. Rehabilitation at home (accepting step up and step down users)
7. Joint reablement and rehabilitation service (to support discharge)
8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care)
9. Joint reablement and rehabilitation service (accepting step up and step down users)
10. Other

1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other
1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other
1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other

Units
Number of beneficiaries
Hours of care (Unless short-term in which case it is packages)
Number of placements
Packages
Number of beds
Number of adaptations funded/people supported
WTE's gained
Beneficiaries

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.

Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2024-25 Update Template

7. Narrative updates

Selected Health and Wellbeing Board: Oxfordshire

Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more t of enquiry clearly.

2024-25 capacity and demand plan

Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.

The capacity and demand plan is derived from performance in 2023-24 as recorded in the Oxfordshire UEC data return that is reviewed monthly by th DISCHARGE

The plan reflects Oxfordshire's continued roll out of Discharge to Assess to take people home. All people are now discharged to assess and the figures actuals which have been increased to reflect the need to divert more people from P2/P3 to P1 to achieve the 95% target (see metrics tab). Commissio any "spot" purchasing is carried out within our Live Well at Home framework as part of core D2A. Within D2A we will continue to purchase live-in and reablement at home.

This version of the demand and capacity template reflects our planned reduction of P2 reablement beds as part of the move to D2A. This version DOE P2 BEDS. We are still working on the operational opportunities to reduce LoS in both reablement and rehab beds and reduce the current wait to ente

Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations ar

In 2023/24 we increased our support to reablement pathways by rolling out D2A and building in live in and waking nights capacity and capability to m for rehab in a bedded setting. Within bedded settings we have reduced our P2 reablement capacity and are working with our remaining providers to complex nursing D2A and for people with resolving delirium and more complex dementias. These people may be on a CHC and/or long-term residenti intermediate care pathway to support more people with rehabilitation needs at home rather than in a community hospital bed. This project is still in alongside Home First D2A staff in care providers to assure that people can receive therapy plans at home wherever possible. We will also be explorin support into these programmes to extend and integrate rehab and exercise. We will also in 24/25 review the team that supports people in reablemer reablement plans in bedded settings.

What impacts do you anticipate as a result of these changes for:

i. Preventing admissions to hospital or long term residential care?

We plan to reduce the number of NEL as set out in the metrics by 5% for admitted in-patients and 5% for fallers. We will also increase the number of evaluate the opportunities to expand or target these approaches: >65 fallers and >18 admitted NEL inpatients only amount to 30-35% of the total NE risk that NEL activity with the BCF groups does not necessarily map onto the discharge population. This research will be reflected in the final submitte Failure readmissions and fallers in certain parts of the County and/or who are conveyed out of hours. These opportunities are still being evaluated as

ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?

We will continue with the implementation of Home First D2A and increase the number of people going home to 95%. D2A has confirmed that in man quickly to full independence if we can get them back to their own community and resources. We have reduced the MOFD LoS in all pathways during 2 D2A and the implementation of more trusted assessor approaches across our pathways. The TOC hub is moving into oversight of all hospital discharg LoS across these. We are changing the scope of some of our remaining P2 reablement beds to accept the more complex delirium, dementia and CHC- implemented and are expanding our MH step down pathway to avoid lengthy move on delays for complex patients (in acute as well as MH beds). We funded beds in July 24 that specifies care needs and inputs required to reduce the level of debate and delay for patients on P3. We are underpinning t care homes and community to improve care home resilience. We will expand the Care Homes discharge model commenced in 23/24 to add in psychi an admission for people with very complex dementia presentations.

Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICE

The BCF Working Group has developed these plans with AHP leads from Community and Acute trusts as well as the Local Authority fully engaged. This would otherwise have to go into P2 rehab beds and that forms part of our plans for 2425. The BCF plan has been developed in parallel to the system U and in consultation with the Place Based Partnership. This is a highly integrated system planning approach. We have system leads for UEC and Home I TOC manager

Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?

Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types
The data deployed in this plan has been derived to a large extent from the System UEC datapack that is reviewed by UEC Board every month. The pac developed by system BI leads from acute, community, mental health and social care. Data is complimented by Public Health data which has been use inequalities. There is a system BI group which we plan to expand further during 2425 using these funds to increase the system perspective on activity and identify developing our BI modelling for 2526. We are identifying KLOE (eg readmissions from P1 discharges; admission from deprived areas; LoS for people in in the development in this plan. We are looking across data sources especially in relation to falls and NEL: we have identified a spike in ambulance dis and performance data across a number of commissioners and services. A big focus is to improve analysis of community health and mental health data acute and social care.

Approach to using Additional Discharge Funding to improve

Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.
EDADF funds our Discharge to Assess service, which has significantly reduced delays to discharge in Oxfordshire. Over the last year, MOFD LoS for pe 11 days to 5.8. This is a considerable shift from our discharge performance previously. This year's plan will therefore continue to reduce MOFD LoS a taking people home first and carrying out assessments there instead of in hospital, we are removing the assessment and brokerage delay in sourcing the scope of care packages awarded post-assessment, meaning our population is receiving supportive care which is tailored to their independence ne capacity to reduce discharge delays, ADF is also paying for additional costs to providers of D2A (non chargeable assessment period of 72hrs) and for li The D2A model has enabled Oxfordshire to build capacity for discharge and improve flow. However with capacity increased, we are now finding that Oxfordshire system. We are seeing increased discharge activity year on year due to an increase in NEL. Many of our longer LoS are complex patients,
Please describe any changes to your Additional discharge fund plans, as a result from o **Local learning from 23-24** o **the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www**

The ADF spend for 24/25 has been reprofiled in several ways: there is a shift away from P2 spend to Home First D2A to reflect the impact of the latter discharge to usual place of residence. We have increased spend in non-elective avoidance to reflect the concern that we will not be able to keep pace door and, given the challenges with discharging more complex patients, it is better to support this cohort outside of a hospital setting. We have retair into care home resilience; and we have continued to invest in non-BCF metric pathways both to reflect pressures on beds in MH, LDA and CYP wards, complex groups and also to improve outcomes for these groups in line with health inequalities. Hospital social work teams have been reorganised arc and there are further moves towards integration of care assessment and delivery in the community. We are investing in infrastructure posts around c Home First lead) to improve system flow in and out of hospital, and in capacity around BI to ensure we can map the impact of our approach. We are a from the public, parts of our system and from our local Healthwatch and Health Scrutiny Committee is that we must do more to engage the public an

Ensuring that BCF funding achieves impact

What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with referenc

We have introduced a productivity test for all ADF schemes and other new schemes that are proposed or extended into 24/25. This has required proj days saved, admissions avoided and how these might be realised in 25/26. This approach has worked out from the BCF metrics and extended to inclu planning pathways. Additionally the approach to the allocation of funds in 24/25 from within the BCF has been to align these with other funding (eg U funding across ICB, Public Health and adult social care) to obtain best value for the funds available in terms of sustainability and impact. These decisio by both the UEC Board and the Place Based Partnership. The implementation, spend and impact will be monitored monthly in these fora during 24/25 planning for 2025/26. The PBP has also authorised the review of key areas of spend and activity where there are clearly system wide opprtunities to r support into care homes; support for complex people who are homeless within acute hospital and housing pathways.

han 250 words) and should address the questions and Key lines

e UEC Board. The plan in summary reflects: for "reablement" or "short-term care" are extraploated from oned capacity has been increased to reflect these numbers and l waking nights support so that more people can receive ES NOT INCLUDE ASSUMPTIONS RE REDUCING LENGTH OF STAY IN r these pathways from acute. These figures will be updated in the
e in place to address any gaps in capacity?
itigate the need for P2 beds where there is not a medical need reprofile a proportion of the remaining bed stock for more ial pathway. During 2024/25 we will be developing our development but will involve community OT and PT working g the opportunity to build in our existing VCSE delivered exercise nt/D2A beds to align the skill mix to support delivery of

Checklist Complete:	Linked KLOEs (
Yes	Does the HWB show that analysis of demand a considered when calculating their capacity and
Yes	Does the plan describe any changes to commis issues? Does the plan take account of the area's capaci levels of demand over the course of the year an services?

people seen in acute and community SDECs. We are continuing to L admitted to acute settings in Oxfordshire and there is significant d plan. We have identified specific challenges around Heart part of the implementation of this plan.	Yes	Has the plan (including narratives, expenditure template set out actions to ensure that services and well at home by avoiding admission to hosp discharged from hospital to an appropriate servi
y cases people who were listed for long-term care can move 23/24 and plan to further that in 24/25 through the embedding of e pathways (including MH) and we have opportunities to reduce level D2A patients to avoid delays in those settings. We have launch a new care homes framework for social care and CHC this work with support to develop MDT between primary care, atry support to increase flow especially back to care homes after	Yes	Has the plan (including narratives, expenditure template set out actions to ensure that services and well at home by avoiding admission to hosp discharged from hospital to an appropriate servi
3 and reflected in BCF and NHS capacity and demand plans. s work has highlighted the gap in a P1 alternative for rehab that UEC plan and both have been managed through the UEC Board First funded through this plan working with the system funded	Yes	Does the plan set out how demand and capacity authority, trusts and ICB and reflected these cha capacity and demand plans?
Yes	Yes	

of intermediate care.		
k is owned and led by the ICB Place System UEC Director and d to identify hotspots of NEL activity which reflect local health value. As part of the implementation of this plan we are specific rural geographies) to monitor key areas of risk identified positions from telecare responder services by comparing contract a which at present is not at a level of analysis or manipulation as	Yes	Has the area described how shared data has be
ople on P1 during 23/24 almost halved, reducing from a mean of nd focus on discharges to increase flow through P1 and P2. By packages from hospital beds. We are also seeing a reduction in eds. To continue supporting this service and build market ve in and waking nights support during reablement periods. complexity is one of the key barriers to timely discharge in the i.e with mental health, homelessness, learning disability/autism	Yes	Does this plan contribute to addressing local perfor Is the plan for spending the additional discharge gra
.gov.uk)		

r initiative and to increase our ability to deliver metric 8.3 - : with discharge demand without turning off the tap at the front ned a focus on infrastructure/system capability with more support to build system resilience and expertise in supporting these more ound a D2A "follow people out model" to enable faster discharge, coordination and deployment (System UEC director, TOC lead, also investing in a communications programme as key feedback d reduce levels of objection by families and communities to home	Yes	Does the plan take into account learning from th the national evaluation of 2022/23 funding?"
e to BCF objectives and metrics?		
ects to evidence the financial impact of initiaties in terms of bed de the impact on MH, LDA and CYP NEL avoidance and discharge JEC funding allocated from the ICB, prevention and inequalities ns have been developed within joint commissioning and ratified 5 to assure the delivery of BCF and other plans and to inform eprofile investment for efficiency and impact where indicated: eg	Yes	Does the BCF plan (covering all mandatory func being used in a way that supports the objectives against the fund's metric?

For information)

nd capacity secured during 2023-24 has been
demand assumptions?

ssioned intermediate care to address gaps and

ity and demand work to identify likely variation in
ıd build the capacity needed for additional

plan and intermediate care capacity and demand
are available to support people to remain safe
ital or long-term residential care and to be
ice?

plan and intermediate care capacity and demand
are available to support people to remain safe
ital or long-term residential care and to be
ice?

y assumptions have been agreed between local
anges in UEC activity templates and BCF

een used to understand demand and capacity for different types of inte

mance issues and gaps identified in the areas capacity and demand plan?

nt in line with grant conditions?

ıe impact of previous years of ADF funding and

1

dling streams) provide reassurance that funding is
s of the Fund and contributes to making progress

#REF!

Better Care Fund 2024-25 Update Template

7. Metrics for 2024-25

Selected Health and Wellbeing Board: Oxfordshire

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Plan	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	191.8	179.7	176.0	176.0	During 2324 we have confirmed that NEL under this metric include 0 LoS attendances in our acute SDECs and so we have set a target that 1. INCREASES the number of people seen in SDEC along the same trajectory as 2324 (14.85%) and 2. REDUCES the number of NEL admissions to inpatients to 95% of the 2021/22 out turn This leaves a net position of a reduction in 0.9%. The quarterly weighting reflects annual performance.	BCF is funding the extension of Integrated neighbourhood teams and Virtual Wards which together with UCR are increasingly supporting more complex people in the community. We are also funding targeted pieces of work in 2425 around Heart Failure readmissions and assessment capacity in acute settings.
	Number of Admissions	1,491	1,397	-	-		
	Population	726,530	726,530	-	-		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan		
	Indicator value	171.50596	159.71837	181.91489	176.19342		

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

8.2 Falls

		2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,802.0	2,027.0	1,802.0	We have assumed that plans for 2324 will deliver in 2425. Oxfordshire has been on a reducing trajectory until 2324 and we have reinstated our 2324 plan. Our performance in Q4 was in line with the plan.	The BCF funds falls and preventative services and also our Care Home Support Service. We are still in this version evaluating the system wide or tactical approaches to further improvements within existing service alignments. We know that certain PCN geographies do less well and also there are issues re out of hours services esclating to acute rather than using available services.
	Count	2,480	2779	2480		
	Population	130,843	130,843	130,843		

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2023-24 Q1 Actual	2023-24 Q2 Actual	2023-24 Q3 Actual	2023-24 Q4 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	91.0%	91.7%	92.5%	93.0%	Firstly we have set a reduction on NEL for both LTC and for falls to mitigate the risk of creating avoidable demand for discharge services. In 2023/24 we have reduced the MOFD LoS for P1 and have sufficient capacity to meet existing P1 demand including the use of live-in and waking nights provision to avoid use of a bed. However we need to divert 35-40 people a week from P2/P3 to P1 to deliver the plan in year. This diversion has been built into the trajectory towards 95%.	Establishment of the TOC Hub which now directs discharge from all of the bed bases. Expansion of D2A including live-in and waking nights support to reablement and short-term care and assessment. To support the diversion from P2 rehab we have made provision to increase the community rehab pathway during 24/25. This work will commence in Q2 and inform plans for 25/26
	Numerator	11,511	11,977	11,840	11,625		
	Denominator	12,644	13,060	12,800	12,500		
		2024-25 Q1 Plan	2024-25 Q2 Plan	2024-25 Q3 Plan	2024-25 Q4 Plan		
	Quarter (%)	92.0%	92.0%	93.5%	95.0%		
	Numerator	11,510	11,921	12,138	12,661		
	Denominator	12,511	12,958	12,982	13,327		

8.4 Residential Admissions

		2022-23 Actual	2023-24 Plan	2023-24 estimated	2024-25 Plan	Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Please describe your plan for achieving the ambition you have set, and how BCF funded services support this.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	357.7	325.8	296.9	283.8	Oxfordshire is focussed on Home First and strengths-based approaches to care assessment and planning and will continue to reduce the length of time in which older people live away from their own communities wherever possible. We have set a further modest reduction for 24/25.	30% of people who fall within this measure are self-funders who have depleted their own capital and become the Council's own responsibility. We are exploring how we can make more use of extra care and domiciliary options to support people within existing BCF funded provision and will develop support to self-funders who are considering moving to residential care.
	Numerator	468	450	410	400		
	Denominator	130,843	138,108	138,108	140,953		

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

Please note, actuals for Cumberland and Westmorland and Furness are using the Cumbria combined figure for the Residential Admissions metrics since a split was not available; Please use comments box to advise.

	Code	2023-25 Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) to be confirmed for 2024-25 plan updates	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated (in line with the Health and Wellbeing Board's formal governance arrangements) approval? **Paragraph 11 as stated in BCF Planning Requirements 2023-25* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Have all elements of the Planning template been completed? *Paragraph 11*	Cover sheet Cover sheet Cover sheet Cover sheet
	Not covered in plan update - please do not use	**A clear narrative for the integration of health, social care and housing**	Not covered in plan update	
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Cover sheet Planning Requirements

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4 & PR6**	**A demonstration of how the services the area commissions will support the BCF policy objectives to:** **- Support people to remain independent for longer, and where possible support them to remain in their own home** **- Deliver the right care in the right place at the right time?**	Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service? Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care? Have gaps and issues in current provision been identified? Does the plan describe any changes to commissioned intermediate care to address these gaps and issues? Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC demand, capacity and flow estimates in NHS activity operational plans and BCF capacity and demand plans? Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?	
Additional discharge funding	**PR5**	**A strategic, joined up plan for use of the Additional Discharge Fund**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan? Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?	
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	PR 4 and PR6 are dealt with together (see above)	
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services and NHS commissioned out of hospital services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? Does the total spend from the NHS minimum contribution on NHS commissioned out of hospital services match or exceed the minimum required contribution?	

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? Where there have been significant changes to planned expenditure, does the plan continue to support the BCF objectives? Has the area included estimated amounts of activity that will be delivered/funded through BCF funded schemes? (where applicable) Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? Is there confirmation that the use of grant funding is in line with the relevant grant conditions? Has the Integrated Care Board confirmed distribution of its allocation of Additional Discharge Fund to individual HWBs in its area? Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? Paragraph 12	
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric setting out: - supporting rationales that describes how these ambitions are stretching in the context of current performance? - plans for achieving these ambitions, and - how BCF funded services will support this?	

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Divisions Affected – All

HEALTH AND WELLBEING BOARD

26 September 2024

HEALTH AND WELLBEING STRATEGY UPDATE - PRIORITIES 5 and 6

AGE WELL

Report by Karen Fuller

RECOMMENDATION

1. **The Health and Wellbeing Board is RECOMMENDED to note the progress on the delivery of priorities 5 & 6 under the thematic domain of Age Well within the Health and Wellbeing Strategy.**

Executive Summary

2. The Health and Wellbeing Board approved a new strategy in December 2023, with the priorities split between 4 thematic areas of Start Well, Live Well, Age Well and Building Blocks of Health. Delivery against the ambitions within the strategy is the responsibility of all organisations represented on the Board and is supported by an Outcomes Framework agreed by the Board in March 2024 .

3. The Board has agreed to receive a rotating update on delivery of 1 of the 4 strategy themes at its quarterly meetings, meaning that over the course of a 12-month period an update on each theme would be presented once. This report is the first annual report of the thematic domain of Age Well covering:

   - **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.

   - **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.

4. The performance report in Annex 2 presents the data for our Key Outcome and Supporting Indicators selected for these two priorities. As this is the first

year of the current Health and Wellbeing Strategy, many of the measures we will use to monitor its success have not had targets for the previous year. For each measure we have therefore produced trend data and where possible compared Oxfordshire's performance with the national performance. The performance annex includes actions for any measures where the direction of travel is of poorer performance or any measures with targets where the measure is not on target.

Introduction

5. The Health and Wellbeing Strategy sets out a strong, unified vision to improve health and wellbeing for local people of Oxfordshire between 2024-2030. The strategy defines our high-level principles and priorities. We are working with partners and communities to track our activities and monitor our progress, ensuring there is good governance, meaningful evaluation and transparent accountability.

6. Everyone should have access to the health and care services they need which are delivered in the right place, at the right time, to ensure the best outcomes. Across Oxfordshire, we face challenges, including an ageing population and increased demand for services. There are also opportunities and strengths in the work we are doing with our communities. This report focuses on the progress of people ageing well in Oxfordshire, and supporting people to stay comfortable and live independently in their own homes and among their communities for as long as possible.

7. Oxfordshire's population is ageing. Between 2011 and 2021, Oxfordshire saw an increase in 25% of the older people population aged 65 plus. This trend is forecast to continue. Services continue to improve and meet demand for our growing population of older people across Oxfordshire.

8. This cover paper highlights some key successes and challenges and should be read in conjunction with the attached report which covers in more detail each of the outcomes in relation to Priorities 5 and 6 of the Health and Wellbeing Strategy. It provides updates on activities delivering on the priorities, challenges to progress and plans for the year ahead, including a RAG rating. There is also a data annex which provides a quantitative report against the Key Outcome and Supporting Indicators, including a summary of planned action if performance is below our shared ambition.

Key successes and challenges

9. **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 outcome 5.1: More older residents to remain well, safe and independent in their home for longer

We want people to live healthy for longer and be supported within their own community. Where people need support from social care we want to provide high quality social care services. Appropriate community and preventive services should keep people out of hospital.

We are seeing reduced hip fractures, emergency hospital admissions this year (24/25) and reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions, though the latter is not yet at target. Actions are in place within the Better Care Fund plan to provide increased support to care homes, which will reduce the need for emergency admissions, improving the use of Disabled Facilities Grants to ensure housing is appropriate to people's needs and that equipment is in place to support independence and we continue to identify and reduce the reasons people are falling.

Satisfaction levels
Where people require social care, satisfaction is increasing and has done consistently for older people since Covid. Performance is above the national average with 70% saying they are very satisfied and 92% satisfied.

Physical activity
34% of older people are physically inactive. This is lower than the national average but has increased in the last year. Our jointly funded programme Move Together includes support for older people with long term conditions to increase their activity levels. Moving Medicine initiative /Physical Activity Clinical Champion training is upskilling clinicians to have conversations with patients about the benefits of physical activity & signposting/referring to Move Together.

10. **Shared outcome 5.2**: Enable older people who have lost a degree of independence to regain independence or support their health and wellbeing in their chosen setting.

We want to support people to remain independent. When people are admitted to hospital we want to support them to return home and stay there. We are continuing to develop community services so that when people need support they can stay in their own home as long as possible.

The number of people discharged home from acute hospitals continue to rise and is now in line with the national average and the Better Care Fund target; where people are supported home with reablement (a short-term service to return people to their previous level of functioning following illness) a growing number remain at home 3 months later and now performance is better than the national position. Relatively few people are needing a permanent residential or nursing care placement as we continue to develop alternatives to care homes such as home care (27% increase since 2023) and extra care housing.

Dementia diagnosis rate
We remain below target on diagnosing people with dementia. There is a detailed action plan to improve this which includes implementing DiADeM – a

diagnostic tool in care homes; projects to improve coding and to improve and standardise hospital pathway; dementia advisors are being embedded into the system; dementia Oxfordshire contract extended to December 2025 and workstream in place to developing support to informal carers; providing appropriate care in care homes and whilst in hospital and provide appropriate support to people with complex dementia.

Community Links Oxfordshire (Age UK Oxfordshire)
Community Connectors work with residents across Oxfordshire, having strengths-based conversations with people to enable them to live independently and confidently for longer in the community by bridging the gap between the local community and the statutory and voluntary organisations that are able to offer support. As at July 2024, 73% of referrals made by Adult Social Care to Community Links no longer required intervention from Adult Social Care after connecting support from Community Links.

Urgent Community Links (Age UK Oxfordshire)
Community Connectors work with people within the acute and community hospitals who are medically fit to return home, assisting with support arrangements necessary to enable the person's discharge and to avoid readmission. The service successfully supported 2,244 in hospital in 2023-24. It also supported 354 people jointly with the Ageing Well health teams with a focus on the early, multifaceted support to the most frail people who are most at risk of an episode leading to institutional care, so that they can stay happily and actively in their community for as long as possible.

11. **Shared outcome 5.3**: More older people empowered to take part in decision-making about their own health and wellbeing

Where people need care, we want them to have as much control over this as possible. A higher number of older people in Oxfordshire use a direct payment to purchase their own care – though in line with the rest of the country this figure is dropping in part as the increased vibrancy of the home care market means people have more choice where care is commissioned for them. The proportion of people saying they have choice and control over their care is in line with the national position

We have a specialist Direct Payment Advice team which supports current and potential direct payment users, representatives and colleagues across the county to work through what type of direct payment people would prefer and can assist with employed/self-employed personal assistants and signpost to other third-party suitable options.

Some people find the responsibility of a direct payment daunting. The council has a list of approved direct payment support services that provides support. As part of their service, they will:

- Process payroll and pay your employee(s).
- Issue payslips for your employee(s).
- Liaise with Her Majesty's Revenue and Customs (HMRC) to make sure you have paid the appropriate tax.

- Submit all HMRC monthly and annual returns.
- Act as your agent and register you and your employee's with HMRC and make payments via a PAYE system.
- Administrate any pension scheme contributions and communicate as your agent with the Pension Regulator.

The Direct Payments Advice team is responsible for sharing good practice on direct payments across the county by linking in with other organisations such as Think Local Act Personal, Skills for Care and many others.

Live Well Oxfordshire

In 2022 there were 68,524 visits to the Live Well Oxfordshire online directory. This increased to 141,497 in 2023. Included in this were 182,219 page views in 2022 which rose to 347,447 in 2023. There are plans to introduce Care Finder to Live Well Oxfordshire which will assist people to find care solutions using the online directory through answering a series of questions and filtering results accordingly. This development will provide choice and control and support people to source their own care in Oxfordshire.

Advice service (Age UK Oxfordshire and partners)

There are many Oxfordshire residents experiencing financial difficulties relating to benefits and not everyone is claiming what they are entitled to. The recently commissioned advice service commences on 1 October 2024 and will have a particular focus on ensuring it is promoted to and accessible to people living in the Lower Super Output Areas (LSOAs) in the county which are classified within the 20% most deprived nationally and most likely to experience inequalities, and to people with protected characteristics. The service will include preventative training for people in communities before they reach a crisis point. This may include training on money management, budgeting and awareness raising for sources of support. This will be an empowering service supporting people to take responsibility for themselves and to develop skills.

12. **Shared outcome 6.2**: Better understanding of the unique strengths and challenges of living in Oxfordshire's rural areas

There is no significant difference in social care satisfaction by whether people live in urban or rural areas. However, people in rural areas report more likely to be lonely and less able to get out of their house. The Local Area Coordination service and the Community Capacity Grants are initially focused on supporting people in less urban populations.

Locally older people are more likely to regularly volunteer than younger people.

91% of people 55+ use the internet compared with 96% of younger adults. The rate of use drops off with age with 1 in 4 people over 75 not using the internet. We remain committed to producing hard copies of publications, for example, the Live Well Oxfordshire Care and Support Guide 2024-25 and the Services Handbook for unpaid carers.

Local Area Coordination

Oxfordshire has introduced preventative approaches that reduce or delay the need for social care. Local Area Coordinators provide a means by which people can be introduced or introduce themselves with no thresholds or time limits and on their own terms. Evidence suggests this can meet people's needs before they go into crisis. They can then build a relationship at their own pace and work through what matters to them and what they need to live the life they wish to. The LAC helps people connect with their community and gather support from there. The LACs have a dynamic role which includes cultivating strong partnerships with community members, groups, agencies and services to support local community capacity building and closer collaboration.

LACs are currently in Chipping Norton and Bicester East, and work is ongoing for a further two areas in Didcot and Kidlington.

Plans for the year ahead

13. There are detailed plans for the year ahead in the attached report for each shared outcome.

14. The Oxfordshire Way Prevention Strategy (Priority 10: Thriving Communities) will be published shortly with a delivery plan by December 2024.

Financial Implications

15. There are no financial implications that the Health and Wellbeing Board is asked to note in relation to this report. As detailed within this update, the pooled budget, BCF and other existing budgets are being utilised to deliver against the above priorities.

Comments checked by: Stephen Rowles, Strategic Finance Business Partner, stephen.rowles@oxfordshire.gov.uk

Legal Implications

16. This report provides key updates to the Health and Wellbeing Board in relation to the Council's statutory functions to improve the health and wellbeing of the Oxfordshire population. The Council's statutory functions derive from a variety of legislation including Part III of the National Assistance Act 1948, the National Health Service and Community Care Act 1990, the Care Act 2014 and the Health and Social Care Act 2012.

Comments checked by: Jayne Pringle, Head of Law and Legal Business Partner (Contracts & Conveyancing), Jayne.Pringle@oxfordshire.gov.uk

Karen Fuller
Corporate Director of Adult & Housing

Annex: Annex 1: Age Well report

Annex 2: Performance report

Background papers: Nil

Contact Officer: John Pearce, Commissioning Manager (Age Well), John.Pearce@oxfordshire.gov.uk 07775 824765

September 2024

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Priority 5: Maintaining Independence				Age Well
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	**Updates on activities delivering on priority**	**Challenges to progress**	**Plan for the year ahead**	**RAG Rating**
5.1 More older residents to remain well, safe and independent in their home for longer	• **Physical activity programme** • Active Oxfordshire -Participants recorded 36% fewer GP appointments in the 4 weeks prior to their 3-month review following being part of Move Together, compared to the 4 weeks before their initial assessment. This can be translated into a saving of 4 GP appointments per participant per annum. -There was a 28% reduction in 111/out-of-hours demand in the 4 weeks prior to the 3-month review compared to IA, and participants reported 12% fewer falls -60% of those having a 3-month review had increased the amount of activity they were doing between the initial assessment and 3-month review. Of those who achieved an increase in activity, the average weekly increase was 316 minutes per week or 45 extra minutes a day. This is the equivalent of an extra 4,500 steps per day at a moderate pace. • Age UK Oxfordshire -944 people have taken part in a community class in the last year. -% of participants who have tripped or fallen has decreased from 41% prior to 34% during the 12 week stay strong and steady classes. -% of people that had to attend A&E after a fall decreased from 11% prior to 1% during the 12 week stay strong and steady classes	Both these contracts have now been formalised but are due to end March 25. Both these contracts included short term investments that have not been confirmed going forward (from April 25). Full procurement exercise will need to be undertaken as there is no option to extend beyond March 25.	Oxfordshire falls pathway is currently being reviewed with key stakeholders from the system being involved. One of the main aims of these contracts, when initially set up, was to be aligned and fully supporting the health and social care service provision in the prevention and management of falls in Oxfordshire. This alignment was made possible with the improvements implemented as part of the new contract as of 1.4.23. More work is being done now to map out all of the services involved in the falls pathway to further identify gaps and improvement opportunities. More focus is being added on prevention as well. This contract is within the scope of this review and any recommendations can then be taken forward in time and within procurement requirements.	Green

	Review of Falls pathway and reduction in >65 admissions in Q1 2425
	
	• Oxfordshire falls pathway is currently being reviewed with key stakeholders from the system being involved. One of the main areas we are focusing on is the interface between services. Mapping exercise has shown that in theory we have all the services we need in the system, and it is the interface between them that needs to be further improved.
		Sustainability is the main challenge we are focusing on at present. The number of falls related admissions has been going down and the main focus of the group is to maintain and sustain that performance. The actions in the plan for the year ahead have been identified to support this challenge.	• Deep dive into 20 acute admissions and analysis of the opportunity to have prevented admission
			• Deep dive into GP practices with significant falls admissions increases
			• Explore why 14% of falls admissions from November 23 deep dive don't relate to falls: data recording or referral issues?
			• Identify the opportunity to avoid high % of admission rate (64) for frailty score of less than 6
			• MIL (Medication Information Leaflet) implementation
			• Development of out of hours support options across UCR/SCAS
			• Expansion of Call before convey 24/7: for October 24
			• Information and preventative support
			  ○ AUKO leaflet
			  ○ AUKO/Falls service interface and joint working
			
			Isle of Wight model to be further explored
				Green

	Our Better Care Fund (BCF) Plan for 2024-25 includes plans for schemes specifically to reduce non-elective admissions for long-term conditions – see 'Plans for Year ahead column At the time of writing, actual admissions have reduced by 1% year on year since 2021-22 and admissions to Same Day Emergency Care (SDEC) settings have increased by 5%. Note that the increase in SDEC admissions includes a planned increase in people who are seen in same day emergency care and then returned home without admission to a bed.	Some specific avoidable admission projects for BCF have not yet commenced i.e. Heart failure readmissions	Our Better Care Fund plan for 24/25 forecasts a net reduction of 0.9% for avoidable admissions. Our plan contains several schemes that support this, including: • Expansion of Integrated Neighbourhood Teams and Virtual Wards. Working with UCR and BCF funded community SDEC this capacity increases Oxfordshire's ability to support more complex people in the community • Targeted schemes around Heart Failure readmissions and admission avoidance from ED • Step up capacity to avoid admission from ED and SDEC for high intensity users, including people with mental health and alcohol-related conditions.	Amber

	Hip fractures: 23/24 has seen a reduction in hip fractures after the post covid increase we saw in 21/22 and 22/23. Numbers in 23/24 are lower than pre covid period of 2019/20 as well	Still working on reducing numbers. reduce the number of emergency hospital admissions due to falls in people aged 65 and over as measured by BCF metrics. Plan trajectory needs to be <7 per day. We need to reduce falls by one per day for target.	Data is still being reviewed at present to understand these numbers i.e. GP practice performance, care homes vs homes, male vs females. Falls information leaflet and resource is being developed that will provide advice and information to people at risk of falls and their families around: importance of environment (clutter etc), vit D supplements, exercises they can do on their own and other risk factors and things they can do to mitigate them.	Amber
5.2 Enable older people who have lost a degree of independence to regain independence or support their health and wellbeing in their chosen setting	**Expansion of discharge to assess (D2A)** The D2A model was rolled out across Oxfordshire from January 2024 and has seen an average of 425 referrals per month since. The model has significantly improved flow through reducing the number of pathway 2 beds.	There have been issues with payments processes and internal infrastructure in the Council. A new payments process is being developed to address this. Sometimes D2A packages are not picked up during the morning huddles with providers. As a workaround, they are being sourced via e-Brokerage under D2A mitigation and picked up by Zonal Providers The shift to home assessments can be difficult for patients and their families. The Social Connections public engagement programme with BOB ICB has helped us address the public's concerns. Additionally, Healthwatch are conducting a review on people's experience of being discharged from hospital. The final report will be published in the Autumn and will be used to improve the framework.	We are developing our internal infrastructure, including payments and data collection to better support the D2A model. The 2 year extension of our Live Well at Home Framework for all reablement and home care providers will support this. We launched a Trusted Assessor pilot in June which has shown promising impact on the flow of cases through D2A. The pilot intends to promote safe and timely discharges from hospital to Adult Social Care by using assessments carried out in hospital. This avoids the need for an assessment at 72 hours by OCC staff and supports the provider in deployment of staff.	Green
	Q1 2425 performance on discharge home • At month 3 we are at 92.4% of discharges to usual place of residence. This is slightly ahead of our 92% for this point in the year. This progress has been supported by the reclassification of returns to care homes as P0s (from P3) and will continue to rise as our data quality improves.	There have been challenges around implementing our Live Well at Home Framework to support fast discharge. Where providers cannot pick up care quickly, the care is distributed via our e-brokerage systems which lengthens the process for discharge. We are addressing this as part of the extension for the contract.	Our BCF plan for 24/25 projects that we will reach 95% discharges to usual place of residence. Our plan to achieve this is as follows: - Continue with the implementation of D2A and Trusted Assessor approach - The Transfer of Care hub is moving into oversight of all hospital discharge	Amber

	• We have reduced the Length of Stay for those who are Medically Optimised for Discharge in all pathways during 23/24 and plan to further that in 24/25 through the embedding of D2A and the implementation of more trusted assessor approaches across our pathways.		pathways (including Mental Health) and we have opportunities to reduce the Length of Stay across these. - Our BCF plan supports more complex people who interact with acute and mental health pathways. It supports admission avoidance and complex discharges, particularly for people with presentations relating to mental health and homelessness, including alcohol issues. - The BCF plan also supports the development of out of hospital and targeted support for people living with learning disability and or autism; both in improving discharge planning from acute and specialist settings, and in providing alternatives to admission and increased housing options - In July we launched a new care homes framework for social care that specifies care needs and inputs required to reduce the level of debate and delay for patients on P3 pathways.	
	Reablement performance on back to independence • The Live Well at Home Framework is delivering on its aim to support Oxfordshire residents to live independently at home. Aligned with the intentions of the Framework, the majority of reablement cases achieve independence or a reduction in care needs. At the time of writing, across all 5 zones, an average of 76.3% of reablement cases are discharged independent, exceeding the 65% KPI target. For independence and reduced care needs combined across all 5 zones, the average is 88.76%, exceeding the 75% KPI target. • The majority of people who are identified as requiring long-term care after a Reablement episode have a reduction in their care needs. Since September 2022, there has been an average of a 60% reduction in the average number of care hours following reablement across all 5 zones.	**Length of Stay in Reablement** • LoS has reduced over time but there is opportunity for further reduction. The average LOS for reablement across all 5 zones is 31.5 days. This exceeds the KPI for 21 days	We are aiming to further reduce the Length of Stay in reablement through further developing the efficiency of the LWAH framework. Our developing Technology Enabled Care Strategy also has the potential to support independence outcomes.	Green

	Community reablement • We have seen a steady increase in community reablement starts since January 2024. This aligns with our aim of working proactively to support people in their own homes and prevent admission to hospital. **Short Stay Hub Beds (SSHB)** The SSHB service enables quicker discharges from the acute hospitals for individuals that require a bed service for rehabilitation or if they require a period of care/assessment and cannot return home and do not require a hospital bed. These beds have direct therapy input which enables more individuals to go home.	As expected, referrals into D2A from community reablement remain significantly lower than referrals from hospitals. There is opportunity to further increase these. We have reduced SSHB upon introduction of the D2A programme. The SSHB now seem to have more referrals for complex needs.	An increased focus on community-based services as outlined in the rest of this document should result in an increase in proactive reablement referrals. The SSHB contract will end in March 2024. Along with system partners we are drawing up a new model of care for these beds that is in line with the current level of needs. We expect to go out to procurement early next year to secure this service and for continuation of this vital provision. These beds help to reduce the LOF in hospital and are well used with low voids.	Amber
	Dementia diagnosis rate Previous OH memory clinics demand and capacity analysis completed showing a shortfall of 310 diagnostic episodes to achieve 66.7% by March 25. With current activity DDR is expected to be 64.3% by March 25. CMHT and OUH data not yet received, but activity is expected to be lower. Approximately 600 people on the waiting list.	Capacity in memory assessment services (MAS) is the main challenge because: • Dementia prevalence rates increase every year and therefore more diagnostic activity is required just to maintain the DDR • Higher mortality rates increase the number of dementia diagnoses needed each month to replace those going off the dementia register which further exacerbates the commissioning gap.	Some of the other mitigating actions include diagnosing people in care homes via DiADem tool and data cleansing exercise in primary care.	Red

		There are also a number of contributing factors which are impacting on the capacity and efficiency of memory assessment services: • Post-Covid backlogs put high demand on services (ie. resources required to triage and manage a waiting list). Unless we address the capacity issue in memory clinics, we are not going to see much improvement to the DDR. With the current capacity and mitigating actions, we are only able to maintain current performance.		
	Care homes admissions: use of Care bands Where an individual requires a care home bed, this is sought in a timely manner	In July 2024 a new integrated Care Home Framework (CHF) was introduced to purchase care home beds for those with eligible needs under the Care Act 2014 and those meeting the eligibility criteria for 100% CHC (NHS Continuing Health care) funding. A care bands model has been applied to the CHF which is understood by operational staff and by providers. This model defines the care needs of the individual and care delivery inputs. There was extensive engagement during 2023 with the Council and Health staff, care home providers and residents of care homes and their families. The CHF aims to standardise the quality of care within the care homes. This is in the early stages and in time will be able to show our spend under the different care bands. Automated E-Brokerage is being used to send and allocate referrals thereby saving valuable time for the providers and the Council staff and enabling quicker admissions to care homes.	We have a good level of care home providers on the CHF; however, we noted more providers showed interest hence the Council has decided to re-open the CHF in Sept 2024. By December this should increase the number of care homes available on the CHF and thereby increasing the choice available to meet the needs of individuals requiring a care home placement. By Nove/Dec we will be able to view reports showing our placing behaviour and spend across the different care bands; helping us budget for future placements. It should also highlight any gaps in our services. We aim to seek any future block bed arrangements through the CHF which guarantees a set of terms and conditions including quality criterion.	

	Care homes admissions: use of ECH • All requests for residential care home placements are now scrutinised by senior ops managers at the ASC managers forum, all requests need to demonstrate they have considered ECH before being approved • We have asked ops managers to ask the question *how could this person be supported in ECH instead of a residential care home?* Commissioners could consider options for additional service requirements to support while ensuring ECH doesn't become a quasi-residential care home. • Ongoing marketing and education, raising awareness of ECH amongst social care & stakeholders especially around routes to appeal.	We believe it's possible to achieve a diversion of approx. 15% of care home placements into ECH measured by our soon to be published specialist housing needs analysis, but this is reliant on: 1. Allocations panels for each extra care housing schemes that meet regularly and have up to date data about vacancies in and applicants for extra care housing (for each scheme). 2. Allocations panels that are chaired by a representative from the local authority Adult Social care team. 3. An extra care housing allocations policy with eligibility criteria that prioritises applicants with local authority social care eligible care needs (over applicants with no care needs). 4. A local authority front line social care staff team that is focussed exclusively on assessing applicants for extra care housing schemes and being fully aware of the balance of care needs in existing extra care schemes, to ensure vacancies are filled by people with the most appropriate eligible care needs from the local authority's perspective (and to reflect the mix of care needs agreed for a scheme). Elements 1 – 3 are in progress and require part adjustment. Full realisation of the ambition is reliant on dedicated operational resourcing in 4 above.	• Refine the allocations panel process • Produce an Extra Care Housing strategy/market position statement supplement that factors in the outcome of the needs analysis. • Continue to seek additional commissioning and dedicated ECH operational resource.	Amber
	Oxfordshire Way and supporting people at home <u>Community Links & Social Prescribing</u> As at July 2024, 73% of referrals made by Adult Social Care to the Community Links Service by Age UK Oxfordshire no longer require intervention from Adult	The service is fully staffed but working over capacity due to demand.	Outcomes impact analysis, and analysing feedback from one to one community connecting support.	Green

	Social Care after connecting support from Community Links. <u>Urgent Community Links & Oxford Health Age Well team work</u> Works with people within the acute and community hospitals who are medically fit to return home, assisting with support arrangements necessary to enable the person's discharge and to avoid readmission. Successfully supported 2244 in hospital in 2023-24. Also supported 354 people jointly with the Ageing Well health teams with a focus on the early, multifaceted support to the most frail people who are most at risk of an episode leading to institutional care, so that they can stay happily and actively in their community for as long as possible.	Challenge is managing the significant increase in referrals.	Continue to support timely and safe discharges from hospital and avoiding admissions or readmissions.	
5.3 More older people empowered to take part in decision making about their own health and wellbeing	**Live Well Oxfordshire** Live Well Oxfordshire care and support guide 2024-25 published in July 2024 brochure for people that are digitally excluded. Live Well Oxfordshire online directory is promoted via Champions and at various groups on a rolling programme. In 2022 there were 68,524 visits to the Live Well Oxfordshire online directory. This increased to 141,497 in 2023. Included in this were 182,219 page views in 2022 which rose to 347,447 in 2023.	It has been a challenge working with the developer to ensure enhancements are able to be completed on our timeline.	Funding has been received to develop Live Well Oxfordshire to include guided searches and Care finder which will assist people in finding care solutions. Plans for a marketing campaign for Live Well Oxfordshire aligned with the Oxfordshire Way	Amber

	Specialist advice service There are many Oxfordshire residents experiencing financial difficulties relating to benefits and not everyone is claiming what they are entitled to. The recently commissioned **advice service** will have a particular focus on ensuring it is promoted to and accessible to people living in the Lower Super Output Areas (LSOAs) in the county which are classified within the 20% most deprived nationally and most likely to experience inequalities, and to people with protected characteristics. The service will include preventative training for people in communities before they reach a crisis point. This may include training on money management, budgeting and awareness raising for sources of support. This will be an empowering service supporting people to take responsibility for themselves and to develop skills.	A challenge is ensuring that people are claiming benefits they are entitled to which can impact on health, housing etc. Working stigma. Health inequalities.	New contract starts 1 October 2024. Combined with health inequalities work. Prevention offer – community based education. Citizens Advice services have joined up, and therefore should be easier for people to find the right door.	Green
	Co-production Advisory Board The Board is made up of experts by experience. The members look at the work of the Council and collectively offer advice on how co-production may be applied to projects. We have recruited members from existing informal networks of citizens who have drawn on our services in Oxfordshire. We are currently co-producing a recruitment campaign that will attract other citizens who have been persistently under-represented or excluded from most forms of participatory work with local authorities. Our current membership includes those who have experienced service provision of domestic abuse, homelessness, Mental Health and unpaid carer support.	Ensuring awareness of co-production processes and opportunities are well known and developed. Ensuring the voice of people who draw on care and support is in all commissioning/operational activity. Cultural change is a challenge.	Creating a consultation group of older people to help us to co-produce future commissioning requirements with the support of Age UK Oxfordshire. Foster active community participation through events, regular forums for open dialogue, and collaborative decision-making processes on initiatives that promote unity.	Amber
	Dementia Oxfordshire Service designed to reach all people living with dementia in the community. Co-designing training and leaflets to support the dementia community with people who draw on care and support. co-produced support and education sessions that have been created with the help of people who are	Contingency planning requires support and promotion for the person living with dementia and their carers/families.	Mild Cognitive Impairment included in the contract with Age UK Oxfordshire will be developed further. Dementia Plan ongoing. Support the promotion of the training for carers and people living with dementia, and professionals.	Green

	living with the condition themselves, for people living with dementia and their unpaid carers. These include post diagnosis sessions and Understanding dementia for informal care givers.			
	Health inequalities Tackling health inequalities is a priority in the operational plans of our partners and stakeholders. For example, supporting Age UK Oxfordshire as it works with LGBTQI+ older adults in including their voice in services.	Challenge is reaching people to enable their voices to be heard, and to ensure all commissioning activity reflects all aspects of the community.	Strengthen the recruitment of staff from all communities. Support the community groups across Oxfordshire that can offer a range of support, and which address the increased barriers that exclude groups experience, to help increase resilience	Amber

Priority 6: Strong social relationships — Age Well

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	Updates on activities delivering on priority	Challenges to progress	Plan for the year ahead	RAG Rating
6.1 More connected communities and closer links between health, social care, and community-centred interventions, ensuring no age exclusions	**Oxfordshire Way Prevention strategy** Draft strategy to be completed by September 2024. Delivery plan to be drafted by December 2024.	Ensuring the plans as they develop best describe the activities that are taken forward. Ensuing communities with least assets are prioritised in delivery plans. Identifying activities that make a measurable difference to supporting older people's inclusion and have continued social care investment.	Identify measurable outcomes that demonstrate impact. Engagement process to be agreed over autumn. Review progress quarterly at PHIF forum.	Green

	Oxfordshire way • <u>Mapping</u> Mapping community link workers and social prescribers • <u>Increasing access to arts and nature through social prescribing.</u> Testing the use of micropayments to providers for supporting equitable access to community arts and nature based social prescribing opportunities. Referrals will be made through the Live Well Oxfordshire directory of groups, services and information.	IT system integration may require more time to develop.	We plan to integrate EMIS with Live Well Oxfordshire so that social prescribing referrals to organisations can be more efficient.	Amber
	Consortiums We are supporting the VCS to consider working in partnership with each other to ensure the sector is in a position to collaborate for improved joint delivery of future provision.	Cultural change is a challenge when there is competition as this requires greater levels of trust and transparency. Making some of the changes to the restrictions due to procurement requirements to enable partners of choice to work together.	Creating further opportunities to explore collaborative working, making use of sub-contracting, alliances and joint commissioning.	Amber
	Well Together A grant programme providing substantial prevention funding directly to existing and new social infrastructure organisations and groups in the 10 priority areas in Oxfordshire to address health inequalities and support prevention. Funding from ICB.	Uncertainty of funding after 2025.	Review impact of grants and prioritising health inequalities funding.	Green

	Community capacity grants *(applies also to shared outcome 6.2)* The purpose of the grants is to build up and strengthen grass roots organisations in their own local areas, especially where we know there are gaps or insufficient development of local resources. The aim is to ensure residents have access to community services to support being independent and reduce reliance on formal statutory services. Funded by the council and administered by Oxfordshire Community & Voluntary Action.	Ensuring interventions are both targeted and impactful.	Bring all impact assessments from VCS together to form local picture and establish mechanisms to measure and communicate the impact and value of community grants and initiatives, demonstrating the value of the sector and attracting continued support.	Green
	Communities of practice Brings together practitioners, charities and volunteers involved in Adult Social Care to share experiences and solve problems in order to provide better visibility of/and access to available support, and a more joined-up experience for adults with social care needs within the community.	Multiple stakeholders working on a wide variety of issues and concerns requires continued support.	Explore the potential of hub models in supporting VCS organisations, for instance with central based training.	Green
	Carers *(applies also to shared outcome 5.3)* <u>Carer groups:</u> Held across the county for unpaid carers to come together and talk to other carers who understand their situation. They can also bring their cared for person. Some carer support groups are for unpaid carers in general while others are aimed at carers of people with specific conditions such as dementia, autism, mental health illness or addictions. There are also groups for specific communities for example Veterans. <u>Short breaks for carers:</u> Action for Carers Oxfordshire working with local businesses to provide services which give unpaid carers a short break and help them to continue in their caring	Identifying more unpaid carers to combat social isolation. Joining up the carer system so carers only need to tell their story once. Respite/short breaks oversubscribed.	Improve the provision of respite care to support unpaid carers to meet the needs of those with more complex conditions. With Carers Oxfordshire we are generating opportunities to support carers back to work and employment if they choose through short breaks and support this will be evaluated to see the impact it has. Support community-led projects that bring together residents, local businesses and organisations to work towards common goals such as more short breaks offers.	Green

	role. Examples are Laundry service and Feet up Friday (a hot, nutritious meal delivered to the door on a Friday).		Delivery of All age carer strategy action plan ensuring improved carer identification, respite offers and support outside of caring.	
	Place shaping Completed mapping of community connectors and social prescribers across Oxfordshire and held a network meeting to support connection.	Current demand for primary care services has limited the capacity of GP practices to engage with place based work focused on prevention. We need to ensure that various place based initiatives to promote better connection between communities and health and social care do not duplicate each other and that community connectors work with each other to add greatest value to their communities.	Refine mapping of community connectors and social prescribers and publish on the Live Well website. Work with the Integrated Neighbourhood Teams to ensure that this work links to community activities and draws on community assets.	Green
	Good Neighbour Schemes Volunteers who help older people, or people with disabilities with shopping, dog-walking, lawn-mowing, form-filling, collecting prescriptions, befriending. There are 49 GNS working across the county and many smaller voluntary groups offering local transport etc. Start-up funding is available to support the setup of new Good Neighbour Schemes and other community assets.	Finding and supporting volunteers can be a challenge.	Measure the level and impact of community involvement through volunteer activities, participation in civic events, and engagement in local initiatives.	Green
	Shared Lives Scheme Operates across Oxfordshire and offers short breaks, long term accommodation or daytime support to adults who have support needs and want to have an ordinary living experience by staying with a household approved with the Scheme. The Scheme is registered and inspected by the CQC and Shared Lives Carers are fully trained and supported by the Scheme and share their home and community life with people who stay with them.	Having sufficient shared lives carers. Dementia strand: condition can be progressed so that shared lives can't meet their needs. Referral systems are currently at a later stage than required.	Funding received to develop the service for people leaving care, and a strand for people with dementia.	Amber

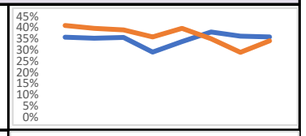
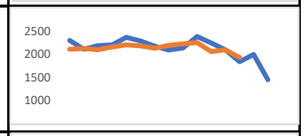
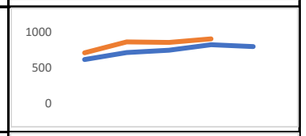
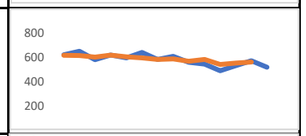
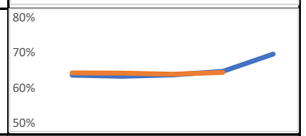
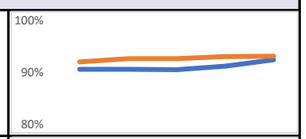
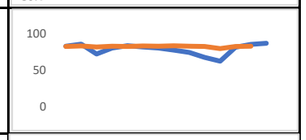
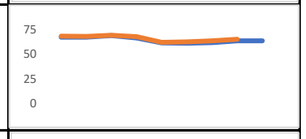
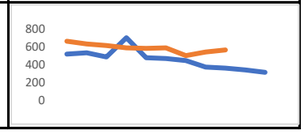
	Homeshare service – Age UK Oxfordshire Safely matches an older person, or couple, who would benefit from practical help or companionship at home, with another person who can lend a hand and who needs affordable accommodation. In return for the accommodation in a welcoming home, the Sharer offers the Householder 10 hours of their time each week as a combination of companionship and practical help.	A challenge can be finding appropriate matches. Recruitment of staff to work on the homeshare project took longer than expected.	Receiving funding via Accelerated Reform Fund. Age UK Oxfordshire has successfully recruited and has a marketing plan to help expand the existing service.	Green
	Community Micro Enterprises Helping people and communities across the country to use their talents to start and run small enterprises and community businesses that support and care for other local people. They create good local jobs and keep local money local. There are currently 94 CMEs in Oxfordshire helping people remain independent, connected with and contributing to their community. These people are taken through the 'doing it right' standards with Community Catalysts to ensure micro-enterprises are viable, sustainable and provide safe, high-quality, person-centred services.	Challenge is attracting new providers and promoting their availability.	Using Care Finder and Guided Searches on Live Well Oxfordshire to assist people in finding care solutions through CMEs. Focus on encouraging activities particularly for people with learning disabilities.	Green
6. 2 Better understanding of the unique strengths and challenges of living in Oxfordshire's rural areas	**Local Area Coordination (LAC)** Oxfordshire has introduced Local Area Coordinators to provide a means by which people can be introduced or introduce themselves with no thresholds or time limits	Developing a new model in restricted financial circumstances means the provision can only be made available in four communities (to date). Developing robust outcome measures is a challenge.	LACS are currently in two areas of the county and work is ongoing for a further two areas in Didcot and Kidlington.	Green

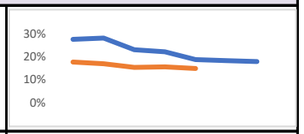
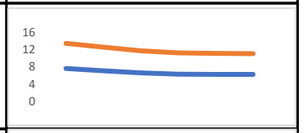
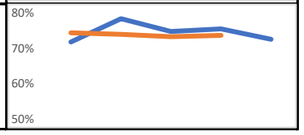
	and on their own terms. They can then build a relationship at their own pace and work through what matters to them and what they need to live the life they wish to. The LAC helps people connect with their community and gather support from there. The LACs have a dynamic role which includes cultivating strong partnerships with community members, groups, agencies and services to support local community capacity building and closer collaboration.			
	Place shaping Healthwatch and OCF have completed a study looking at the needs of Ambroseden and surrounding villages. These findings have been shared with District colleagues so that it can inform planning policy and community development	Dispersed population with smaller pockets of often hidden health inequalities means that improving health and wellbeing in rural areas is costly. It has not been a primary priority compared with reducing health inequalities in urban areas where there is a larger population experiencing inequality	Work with partners to gather data to better understand the health and wellbeing issues facing rural communities and the assets they have available to support health improvement. Ensure that rural communities are included as part of the Marmot work to address health inequalities in Oxfordshire.	Green
6.3 Digital support for virtual connection & improved digital skills	**Digital inclusion strategy** Digital inclusion strategy underpinned by annual action plan: Action: Research, identify and promote support around digital literacy for carers, including young carers: Response: Accelerated Reform Fund secured to improve online digital access to the carer's assessment Age UK Oxfordshire has a digital inclusion workstream. This includes managing a team of volunteers that provide digital support in the community to help older people get online and learn more about the digital world. There is also a small tablet loan scheme and access to a limited number of free data SIMS.	Tackling the digital divide It remains a challenge for carers without digital access. Securing funding for this area of work has been challenging for Age UK Oxfordshire. This is not funded by OCC or ICB.	Continue to ensure we maintain a telephone and outreach service for carers to access. We will continue with paper-based information. Digital Inclusion campaign October 2024. Continue to support the action plan for the Digital Inclusion Strategy.	

Age Well HWBB measures

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

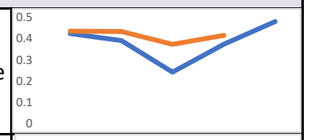
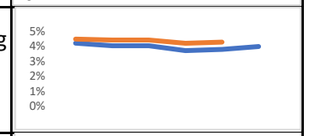
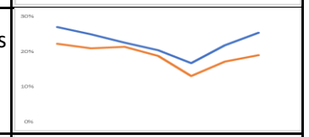
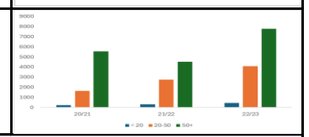
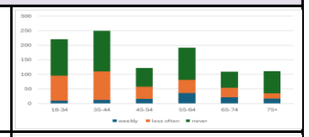
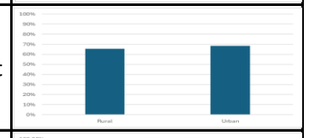
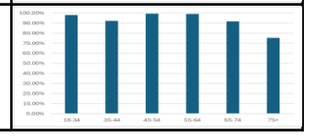
	Indicator	Frequency	Target	Reporting period	Value	RAG	Direction of travel	Commentary	Trend chart Oxon blue; Eng Orange
5.1 More older residents to remain well, safe and independent in their home for longer									
5.10	Proportion of older people who are inactive	Annual		Nov-23	34.0%		R	Proportion of inactive older people (65+) has increased by 5% points in the year but remains just below the national average. **ACTIONS: Move Together programme supports older people to increase their activity levels. Includes training of clinicians & signposting.**	
5.11	Emergency hospital admissions due to falls in people 65+ *	Quarterly	2480	Jun-24	2228	G	G	Latest national data, 22/23. Performance better than national average. Admissions rose by 6% in 23/24. In first quarter of 24/25 admissions due to falls fell with 557 admissions in the quarter against a target of 620.	
5.12	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions) *	Quarterly	5359	Jun-24	5784	A	G	Increasing admissions, but better than national. Apr-Jun 24/25 1466 admissions - target 1340, improved on 23/24. **ACTIONS: Managed via BCF plan, & include improving support to care homes; access to equipment and technology in homes & reducing falls**	
5.13	Hip fractures in Over 65s	Annual		Mar-24	741		G	In line with national position the number of people over 65 with a hip fracture is reducing. Number fell by 76 (9%) from 817 to 741 in last year and is currently 8% below the national rate	
5.14	Overall satisfaction of people who use social care services with their care and support (65+ only)	Annual		Mar-24	69.6%		G	69.6% very/extremely satisfied; 92% satisfied, 2% dissatisfied. Performance fell till 2020 and has risen subsequently. Performance above the national average of 61.9%	
5.2 Enable older people who have lost a degree independence to regain independence or support their health and wellbeing in their chosen setting									
5.20	Percentage of people who are discharged from acute hospital to their normal place of residence *	Quarterly	92%	Jun-24	92.4%	G	G	Historically below target. Target set to increase in year to 95%. Target for first quarter 92%. Performance 92.4%	
5.21	% of people still at home 91 days after reablement	Annual		Mar-24	86.3%		G	Performance has improved in the last 3 years (after falling in the previous 7 years). Figure now better than the national average	
5.22	Estimated Dementia Diagnosis rate	Quarterly	66.7%	Jun-24	63.2%	R	G	Pre-covid at target level. In line with England fell in 2021 and is now rising slowly, but remains below target & England level. **ACTIONS: Need to improve capacity in OH memory clinics and using new tool to diagnose people in care homes**	
5.23	Permanent care home admissions for people aged 65+ *	Quarterly	400	Jun-24	408	A	G	Performance better than England & improving. Latest national data 16th out of 151 authorities. **ACTIONS: Continuing to develop community based alternative to care homes such as home care (27% increase since 2023) and extra care housing**	

5.3 More older people empowered to take part in decision making about their own health and wellbeing									
5.30	% of older people using social care who receive a direct payment	Quarterly		Jun-24	17.8%	G	R	Performing better than England (by 4% pts). **ACTIONS: DP Advice Team supports users - undertaking technical tasks if requested. The increased stability and vitality of the home care market has meant more people are choosing home care.**	
5.31	People in receipt of pension credit	Quarterly		Feb-24	8178			8178 pensions in recipt of pension credit - 6.3% of pensioners in Oxfrodshire. This compares to 11.0% of pensioners in England. 7039 are onguaranteed pension credit	
5.32	% of older people using social services who have control over their lives	Annual		Mar-24	72.6%		R	Performance dropped in year but better than national average: **ACTIONS: Continuing to improve our information offer; developing additional service capacity in key services such as home care and ECH. Supporting people via DP advice team**	

Age Well HWBB measures

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.

	Indicator	Frequency	Target	Reporting period	Value	RAG	Direction of travel	Commentary	Trend chart
6.1 More connected communities and closer links between health, social care, and community-centred interventions, ensuring no age exclusions									
6.10	% of adult social care service users who get as much social contact as they would like (over 65 only)	Annual		Mar-24	48.0%		G	Improvement in year. Age standardised data shows performance previously below the national average but improvement of 8% points in the year	
6.11	Number of social care users accessing community-based support for health and care needs in the year	Annual		Mar-24	5314			4.7% increase in the number of people aged 65 and over who accessed long term social care support in the year. 3.97% of peopple over 65 received long term support in the year compared to 4.27% nationally	
6.12	Volunteering rates (65+)	Annual		Nov-23	25.4%		G	Proportion of older people (65+) volunteering has increased by 3.6 % points in the year and is 8.7% points better Nov 21. The figure is consistently better than the national average	
6.13	People supported by social prescribing	Annual		Mar-23	7752		G	No national data: Locally 7752 people aged 50+ were referred to social prescribing in 22/23. This was up from 4505 in 21/22. Table shows people supported by age group (<20; 20-50 and 50+)	
6. 2 Better understanding of the unique strengths and challenges of living in Oxfordshire's rural areas									
6.21	Proportion of people who volunteer regularly or occasionally	Annual		Mar-24	13%			No national data: Older people more likely to regularly volunteer than younger people. 13% over 55s volunteering every week. Younger people more likely to volunteer occasionally. Chart shows frequency of volunteering by age group	
6.22	Impact of rurality on access to services and satisfaction	Annual		Mar-24				No significant difference in social care satisfaction by urban/rural areas. People in rural areas report more likely to be lonely and less able to get out of their house	
6.23	Proportion of older people using the internet	Annual		Mar-24	91%			91% of people 55+ use the internet compared with 96% of younger adults. The rate of use drops off with age with 1 in 4 people over 75 not using the internet	

* these indicators are reported as part of the better care fund

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Divisions Affected - All

Oxfordshire Health and Wellbeing Board
26th September 2024

ALL-AGE UNPAID CARERS' STRATEGY UPDATE

Report by Karen Fuller, Director of Adult Social Care

RECOMMENDATION

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

   - Note the progress achieved in the first three quarters of the implementation of the All-age Unpaid Carers Strategy and the Action Plan
   - Approve the mechanisms established to monitor the progress against the Strategy's agreed priorities and reporting progress to the Health and Wellbeing Board
   - Comment on the progress achieved to date and make recommendations for ensuring faster progress in the coming months
   - Note that the Place Based Partnership will be accountable for progress and ensuring all health partners are meeting their commitments under the Strategy

Executive Summary

2. Following the decision of the Health and Wellbeing Board on 16th March 2023, Oxfordshire's All-age Unpaid Carers Strategy was co-produced with carers and published in Autumn 2023, based on the priorities expressed by carers and strategic review of supporting carers in Oxfordshire.

3. Following the approval of the Strategy, an Action Plan was developed bringing together all the activities and commitments from all organisations in line with their own remit under each priority of the Strategy.

4. The Carers Strategy Oversight Group was established with representatives from all statutory and voluntary organisations and carers to oversee the implementation of the Strategy.

5. This report summarises the progress as reported by the organisations on the activities they carried out in the first three quarters of the implementation.

Carers in the UK

6. Carers UK data[1] show that

- Women are more likely to become carers and to provide more hours of unpaid care than men,
- One in seven people in the workplace in the UK are juggling work and care,
- Between 2010 and 2020, people aged 45-65 were the largest age group to become unpaid carers,
- Carers are facing pressure on their finances: 25% of carers are cutting back on essentials, and 63% are extremely worried about managing their monthly costs,
- Black, Asian and ethnic minority carers are more likely to be struggling financially- 58% said they were worried about their finances compared to 37% of white carers,
- Carer's Allowance is the main carer's benefit and is £76.75 per week (2023/24) for a minimum of 35 hours. It is the lowest benefit of its kind.
- Caring can have a significant impact on carers' health and wellbeing: 60% of carers report a long-term health condition or disability compared to 50% non-carers.
- Over a quarter of carers feel lonely often or always, this increases to half of carers for LGBT carers.

7. Value of unpaid care in England and Wales is estimated to be £162 billion per year (£445 million every day), exceeding that of the entire NHS budget in England for health service spending (Petrillo and Bennett, 2023).[2]

Oxfordshire's Carers

8. According to Census 2021, 52,674 residents were providing unpaid care in Oxfordshire, and 26% of them said they provide more than 50 hours of care. There were 983 young carers in Oxfordshire.

9. Carer's Survey is one way we get insights into our carers. In the last survey we received 297 responses out of an eligible population of 3918 which gives a confidence error of 5.5%. Older carers were more likely to respond - so the results may be skewed to their views. The findings show that of the people who responded
    - They are typically a white (95%) older (66%) woman (67%) who lives with (80%) the person they care for.
    - A third of them care for a second person
    - More than half of them live with a condition themselves
    - 72% provide personal care, 40% have been caring for more than 10 years
    - The person they care for is typically an older partner, 45% have a physical disability, over a third have dementia, over a third have a sensory impairment

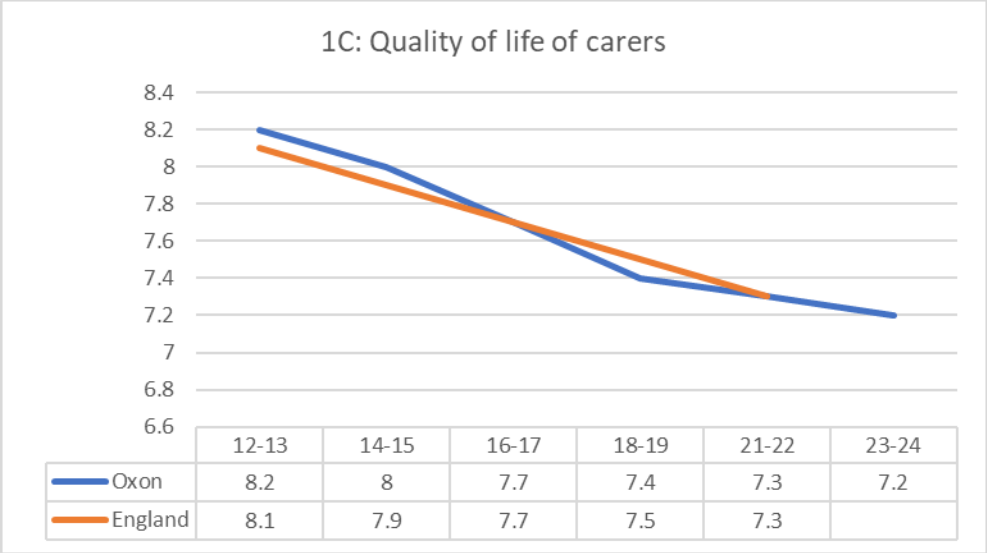
[1] Key facts and figures | Carers UK
[2] Value of unpaid care in England and Wales now exceeds that of NHS budget | the Centre for Care

- 25% receive home care

10. In terms of the support they receive,
    - 85% have had an assessment or review in the year
    - 50% have received direct payment, 46% information and advice only and 4% had other support
    - Over a third have had a support via a carers group
    - Employment support remains very limited

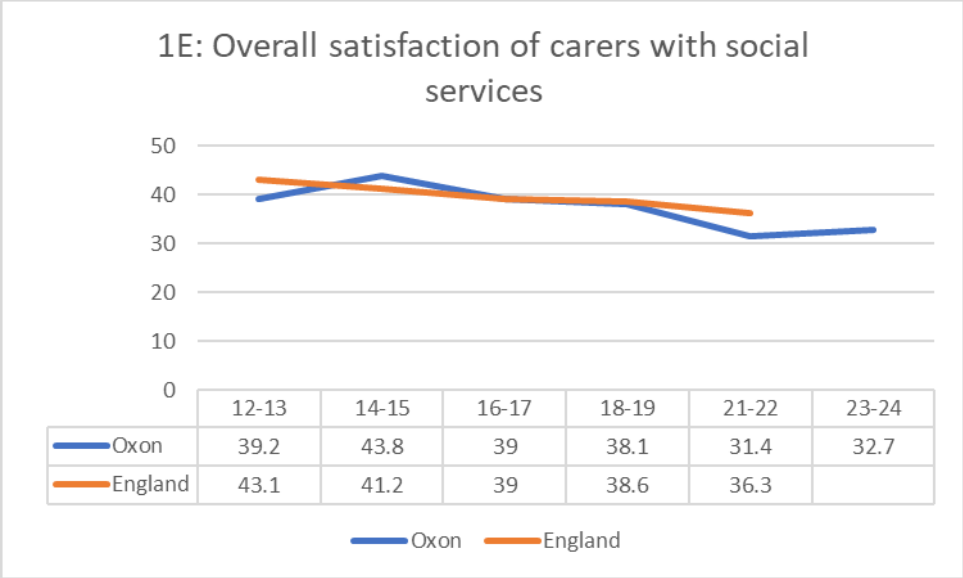
11. The impact of caring in Oxfordshire is parallel to the national picture:
    - 80% of our carers feel tired, 63% stressed and over a half become irritable and depressed
    - Nearly half feel lonely
    - Nearly a half experience financial difficulty

12. In terms of the Adult Social Care Outcomes Framework (ASCOF) measures

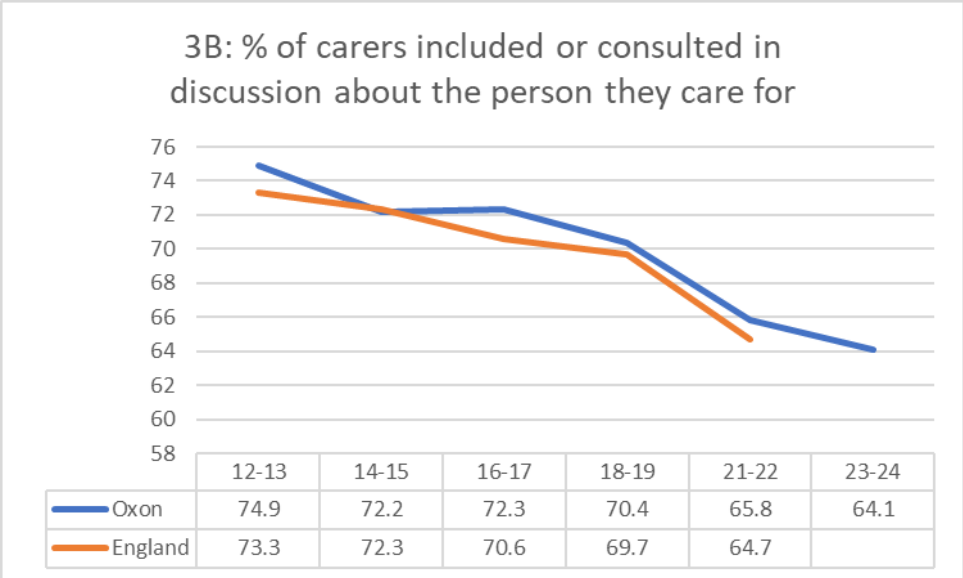


	12-13	14-15	16-17	18-19	21-22	23-24
Oxon	8.2	8	7.7	7.4	7.3	7.2
England	8.1	7.9	7.7	7.5	7.3	

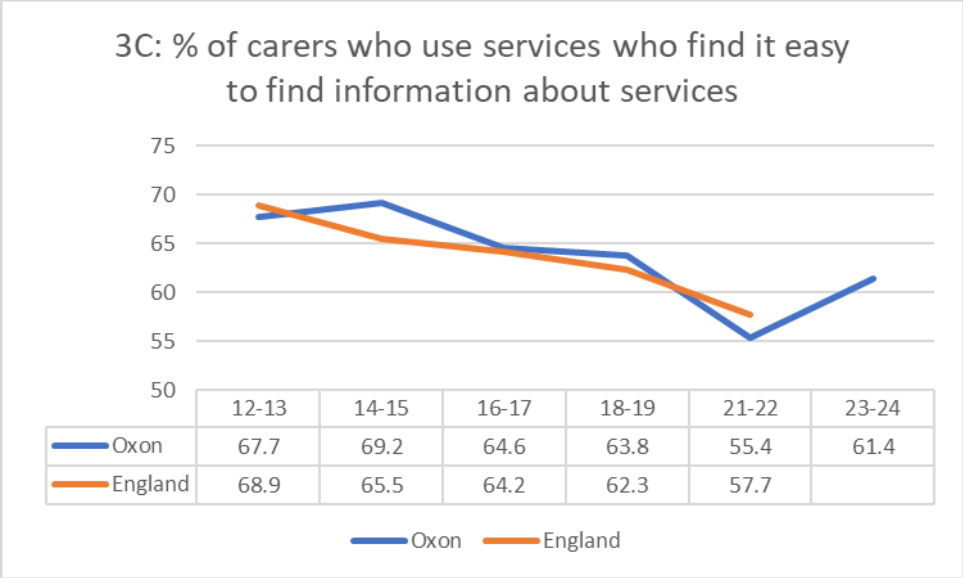
Quality of life is falling both locally and nationally. Nationally it is falling faster. Since 18-19 we have started to turn the curve



Again – nationally satisfaction is falling year on year. In Oxfordshire this last year satisfaction grew slightly though is still below the national average



People consulted again fell. This is in line with the national position



Both locally and nationally performance on access to information has been falling – however in the last survey (Nov 23) locally the figure rose

13. In Oxfordshire, our carers reported a higher level of satisfaction with social services, and ease in finding information about support, but they felt less consulted in discussions about the person they care for.

Oxfordshire's All-age Unpaid Carers Strategy and Action Plan

14. Following the decision of the Health and Wellbeing Board on 16th March 2023, Oxfordshire's All-age Unpaid Carers' Strategy was co-produced with carers and published in Autumn 2023, reflecting the priorities expressed by carers and findings of the strategic review of supporting carers in Oxfordshire.

15. One of the main issues raised by carers was their confusion with the health and social care system and limited joined up working among organisations supporting carers. This fragmented system not only limited the effectiveness of support carers receive, but also meant carers needed to understand and work with various systems of support, for themselves and the person they care for.

16. In response, the new Carers' Strategy was developed as a system strategy to enable all organisations to work towards a common mission, establish connections, join up efforts and achieve better outcomes for carers.

17. Oxfordshire's All-age Unpaid Carers' Strategy 2023-2026 has three broad priorities covering all aspects of supporting our carers:

Priority 1: **To identify carers and effectively support them**, improving their health and wellbeing and providing opportunities for a break from their caring role.

Priority 2: **To safeguard adult and young carers at risk** who need more

support to look after themselves, particularly during times of change and transition.

Priority 3: To encourage and enable carers **to have an active life outside their caring role**, including fulfilling their education, employment, and training potential.

18. The priorities of the Strategy are in line with Oxfordshire's Health and Wellbeing Strategy 2024-2030, specifically

- risk of poor mental health and wellbeing being higher among young carers
- large number of unpaid carers providing support for people with dementia and how valuable the support provided by Dementia Oxfordshire is in supporting them,
- importance of carers continuing to do activities they love for longer

19. Priority 1 of the Carers' Strategy regarding identification and recording of carers allows us to more effectively target support across health and social care systems and help deliver Priorities 2 and 3. This aligns with the Health and Wellbeing Strategy's ambition to improve the extent, quality and accessibility of digital infrastructure.

20. Each organisation's commitments under each of the three priorities of the Strategy are detailed in the Strategy Action Plan with tasks and outcomes.

21. As the Strategy covers three years, the Action Plan will be updated annually reflecting the progress achieved in the implementation and identifying areas of focus.

22. Current high-level Action Plan (Annex 1) was adopted by the Carers' Strategy Oversight Group to oversee the implementation of short- and medium-term priorities.

23. The Oversight Group oversees the implementation of the Strategy with members from across all partners and carers. This Group meets quarterly to receive progress reports shared by all partners.

Progress to date

24. A snapshot of some key successes from our contracted provider, Carers Oxfordshire, since the launch of the Strategy:

Strategy development Number of carers who contributed to strategy development	374	
Referrals into Carers Oxfordshire	**Number**	**% increase**
July 22- June 23	2845	
July 23- June 24 (post strategy)	3408	20%

Carers ID Cards		
Jul- Sept 2023	0	
Oct- Dec 23	103	
Jan- March 24	135	31%
Apr- June 24	190	41%
Short Breaks Number of carers accessing short breaks since strategy launch	662	
Max Cards Number of Max cards issued to families, giving discounts on activities and holidays UK wide.	553	

25. In the first quarter of the implementation all organisations met to strength joint working practices. This included agreeing governance arrangements for the life of the Strategy. We built on joint initiatives already in development, for example, the launch of the Carers' ID card, between Carers Oxfordshire and Oxford University Hospitals. Also, the collaboration between Carers Oxfordshire and ICB colleagues to produce standardised local GP surgery information to assist carers to self-identify.

26. Carers are integral to the success of the Strategy and action plan and attend and co-chair the quarterly oversight meetings. This is an opportunity for carers to review progress, ask questions and have their voice heard.

27. As anticipated, progress has been made at different rates for each priority. Connections are made at the quarterly meeting between organisations with clear actions to follow up opportunities they identified for more collaboration.

28. Highlights of the Strategy's achievements to date include

- Identifying carers - OCC extracted the data from the PHI database for the first time and analysed this to identify key demographics of carers known to health partners.
- Review of information shared by GP practices online and links to Carers Oxfordshire webpage is underway.
- Work is under way to link carers' contingency plans to their NHS shared care records. Early results demonstrate an increased number of contingency plans have been created.
- Launch of Carers ID which help carers to show that they are an unpaid carer and ensure they and their cared for get the support they need. IDs are used in Oxford University Hospitals as well, and carers shared very positive feedback about this initiative which helped them when they are in hospitals.
- Established an OCC Carers Support Group for staff with caring responsibilities. Positive feedback from staff
- Developed a protocol and training for professionals in Children's Social Care supporting Young Carers
- Oxford Health published a new Carers Handbook for Mental Health carers, which is for anyone who cares for or supports someone receiving care and treatment from our adult and older adult mental health services

- New Carers Leave Act 2023 provisions were promoted to all local employers.
- The Oversight Group meetings additionally provide opportunities for research into best practice and BOB-wide collaboration.

29. We remain committed to our principles of co-production and value working alongside our carers and receiving their feedback on the progress made and actions to be taken. We continue to include and encourage carers representing different caring experiences within the Oversight Group.

30. Accelerated Reform Fund (ARF) – national one-off funding in 2024-5. Carers Oxfordshire and OCC are working together to deliver ARF projects.
    - reviewing the carers assessment to ensure it is strengths-based and meets carers' needs, by looking at best practice from other local authorities and gathering carer views
    - reviewing and mapping the carers short breaks offer to co-produce and redesign the offer
    - work to improve BOB-wide communication to carers around self-identification is underway

Financial Implications

31. There are no direct financial implications associated with this report. However:
    - A 2018 National Audit office report estimated the value of care the public purse would have to replace if not provided by informal care as £58.6bn
    - In England, the average amount an informal carer saves the state annually is £12,500. For Oxfordshire's 26% of carers providing 50+ hours per week, this equates to £1.7m+ annual savings to the state

Legal Implications

32. Supporting carers is a statutory responsibility as defined in the Care Act 2014. Our strategy supports us meeting the statutory duties although publishing a strategy itself is not a legal requirement.

Staff Implications

33. The implementation of the Strategy has been overseen by Health, Education and Social Care Service within Adult Social Care, requiring each partner organisation to identify officers responsible for coordinating the delivery of activities and reporting progress to OCC quarterly. This requires every organisation to utilise their resource to support delivery of this strategy. Beyond this, there are no new or additional staff implications.

Sustainability Implications

34. The process of developing and implementing the strategy itself has no direct sustainability implications.

NAME	Karen Fuller, Director of Adult Social Care
Annex:	1. Carers Strategy Action Plan: Link to action plan on public facing webpage: All-age Unpaid Carers' Strategy
Background papers:	None
Contact Officer:	John Pearce, Commissioning Manager John.pearce@oxfordhire.gov.uk; 07775 824765

August 2024

Annex 1: Carers Strategy High Level Action Plan (as of July 2024)

Actions		Owner	Target Completion Date	RAG Status
Priority 1: Identifying carers and effectively supporting them				
Improve carers identification and recording	Analyse existing carers data and identify gaps	OCC	14/03/2024	Completed
	Improve recording of carers on LAS	OCC- SCHT	27/06/2024	Completed
	Improve recording of carers on LAS (joint assessments)	OCC - ASC teams	15/10/2024	On Track
	Improve identification and recording of young carers, by staff training and system changes	OCC- Children's teams	15/09/2024	On Track
	Support carer identification by GPs	ICB BOB	15/09/2024	Risk of Delay
	Utilise Carers Champions in identifying and supporting carers	OCC and all partners	15/10/2024	On Track
	Increase referrals to Carers Oxfordshire by increasing identification and accurate recording of carers	All partners	01/03/2025	On Track
Expand and enhance support programmes for carers	Improve supporting carers by working with them, using existing and new channels (all partners have a range of support options for carers including 1:1 support, support groups, training, workshops, information and advice, training)	All partners in coordination with Carers Oxfordshire and OCC	15/10/2026	On Track
	Co-produce a Carers Handbook for Adult Mental Health Services	Oxford Health	12/03/2024	Completed
Ensure carers have opportunities for breaks from their caring role to	Analyse existing breaks/respite services available to carers	OCC	05/09/2024	Risk of Delay
	Simplify and improve carers short breaks and respite options	OCC	15/11/2024	Risk of Delay

support their wellbeing	Guide parent carers to relevant services and organisations	Oxfordshire Parent Carer Forum	15/10/2026	On Track
Priority 2: Safeguarding adult and young carers at risk, particularly during times of change and transition				
Refreshing/developing Carers training		All partners	15/10/2024	On Track
Review and increase identification and support of carers from seldom heard groups and families in Oxfordshire's most deprived wards		OCC and Carers Oxfordshire	15/02/2025	On Track
Review and simplify processes to ensure young carers receive support in line with their level of need		OCC-Children's teams	15/09/2024	On Track
Review and improve transition from being a young carer to adult carer		OCC	15/05/2024	Completed
Support carers in hospital using a Carers Passport		OUH and OH	01/05/2024	Completed
Support people and their carers during dementia diagnosis		Dementia Oxfordshire	01/11/2024	On Track
All partners to ensure effective signposting to Carers Oxfordshire		All partners	15/10/2025	On Track
Priority 3: Encouraging and enabling carers to have an active life outside their caring role				
Clarify what respite offer is available for carers		OCC	05/09/2024	Risk of Delay
Develop and communicate a referral process for respite		OCC	15/11/2024	Risk of Delay
Ensure effective identification of OCC staff with caring responsibilities		OCC	15/02/2025	On Track
Set up a Carers Network in OCC		OCC	15/03/2024	Completed
Improve developing support for carers by working with them, using existing and new channels (all partners to have a range of support options for carers including 1:1 support, support groups, training, workshops, information and advice, training)		All partners in coordination with Carers Oxfordshire and OCC	15/10/2026	On Track
Working in partnership with voluntary sector and schools, ensure young carers have opportunities for breaks		OCC-Children's teams	15/10/2026	On Track

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Healthwatch Oxfordshire Report to Health and Wellbeing Board -Sept 2024

Note: this report covers a brief overview of Healthwatch Oxfordshire activity since the last meeting of Oxfordshire Health and Wellbeing Board (HWBB) of March 2024 – a longer time period than usual. The July meeting of the HWBB was cancelled due to pre-election restrictions.

Healthwatch Oxfordshire Board

HWO Board continued to meet, although the June Public Open Forum was cancelled due to pre-election guidance from Healthwatch England. Notes from the public open forum meeting with the board on 24th September can be seen here: https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/

Healthwatch Oxfordshire Annual Impact Report 2023-4 was presented online on 16th July. You can read the full report, and watch a video of the public presentation here: https://healthwatchoxfordshire.co.uk/report/healthwatch-oxfordshire-annual-impact-report-2023-24/

Healthwatch Oxfordshire reports to external bodies

Since the last Health and Wellbeing Board meeting in March 2024 we attended:

- Health Improvement Board (lay ambassador)
- Oxfordshire Joint Health Overview Scrutiny Board (HOSC April, June, Aug and Sep 2024)
- Oxfordshire Place Quality Committee (monthly)
- Oxfordshire Safeguarding Adults Board.

Any reports to external bodies we attend 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 and Quality Committees. We work closely with HW Bucks, HW Reading, HW Wokingham and HW West Berks to bring insight into BOB ICB.

We published responses to organisational Quality Accounts, and to proposed BOB ICB operating changes 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:

- **Health and Wellbeing in Ambroseden, Arncott, Blackthorn and Piddington (May 2024)** Healthwatch Oxfordshire commissioned Community First Oxfordshire (CFO) to undertake community insight research in a rural area of Oxfordshire with focus on understanding health inequalities, and health and wellbeing – the views of 162 residents in total were heard. The report was presented to the Health and Planning Group and Prevention and Health Inequalities Forum for discussion and learning.
- **What community researchers heard about food and the cost-of-living impact on communities in OX4 (July 2024)** Culmination of work by two community researchers Hassan Sabrie and Mujahid Hamidi (from local group Oxford Community Action) between June 2023 and June 2024. They were hosted and supported by HWO as part of the NHS South-East Community Participatory Action Research (CPAR2) programme, with training from Reading University, and additional support from Healthwatch Oxfordshire and Scottish Community Development Centre. The report captures views of 166 people living in the OX4 area of East Oxford and using the food support services of Oxford Community Action, Oxford Mutual Aid, and Waste2 Taste, part of the OX4 Food Crew umbrella. The learning, final report and film (see https://youtu.be/5_P3MMGUirI) was shared by the community researchers at CPAR2 showcase event in London, as well as at the Policy Lab, and Oxfordshire Community Research Network. The report identified cost of living challenges, and next steps have already been initiated including provision of weekly advice sessions delivered by Agnes Smith Advice Centre, distribution of OCC leaflets on additional cost of living support grants, and pilot ideas for a 'social supermarket' and food growing initiatives. Together we are holding a feedback event in October to share the findings and identify further ways of bringing in support to people facing challenges of cost of living.
- **Patient Participation Groups in Oxfordshire (July 2024)** We heard from 78 people representing 35 Patient Participation Groups and GP Practices across Oxfordshire – hearing about a wide variety of experiences of PPGs in the county,

including the good work and support they give to their GP surgeries, as well as needs articulated for more communication with health and care system, and clearer guidance around remit and role.

- **Supporting children's oral health (July 2024)** Supplemented with additional funds (via NHS Core 20 Plus 5 via BOB ICB), this work focused on hearing from parents and carers of children under 10 about oral health. We worked with five 'Community Connectors' in Banbury Ruscote and Neithrop to reach those living in the area. We carried out an additional online survey to hear from parents and carers of children with Special Educational Needs and Disabilities (SEND). Final reports include setting out what we heard from 96 people in Oxfordshire about supporting oral health in children. We heard from a total of 45 people via conversations our Community Connectors had with families from two wards in Banbury. We also carried out a county-wide online survey hearing from 38 people and had 9 in-depth interviews with caregivers of children with SEND. We also spoke to families seeking asylum and in temporary hotel accommodation in Banbury. In April 2024, we hosted an event in Banbury, where our Community Connectors shared what they had learned from their conversations with the public and presented their findings to representatives from the health system.
- We also published an additional **overview report jointly with Healthwatch Bucks, Healthwatch Oxfordshire and Healthwatch Reading** and presented to BOB ICB highlighting views gathered by each under Core 20 project. We shared learning and good practice with NHSE on working with community connectors.
- **What we heard about eye care services in Oxfordshire** (Sept 2024) We heard from 141 people using primary and secondary eye care services in the county. People were generally positive about their experiences of appointments at eye care services: 68% responded 'good' or 'very good 'for 'availability of appointments', 64% for 'waiting time for an appointment', and 73% for 'convenience of appointment time'. People were slightly less positive about their experiences of travelling to appointments, costs of care, and referrals. We heard that availability of appointments at the Oxford Eye Hospital was generally good, although people also experienced cancelled appointments, difficulty with transport and attending early appointments, busy waiting areas, and long waits to be seen. Some were frustrated at not being able to receive outpatient eye care at their local health facility.

Patients rated aspects of service quality highly, citing excellent experiences of care at the Oxford Eye Hospital. Most staff were viewed as considerate, kind and caring, with some providing outstanding care. However, crowded outpatient waiting areas, delayed appointments, and a perception of inadequate staffing left some people dissatisfied and concerned about patient safety.

Enter and View visits and reports:

We make Enter and View visits to healthcare settings to collect evidence of what works well and what could be improved to make people's experiences better. Based on the feedback of patients and members of staff, we highlight areas of good practice and suggest improvements. https://healthwatchoxfordshire.co.uk/our-work/enter-and-view/ Since the last meeting we have published the following Enter and View reports:

- The Close Care Home, Burcot (March 2024)
- Day Lewis Pharmacy, Didcot (March 2024)
- Alma Barn Lodge Care Home, Didcot (May 2024)
- Health Visitor Services at The Bluebell Centre, Didcot (July 2024)
- The Surgical Emergency Unit, John Radcliffe (July 2024)

Current surveys:

We currently focusing on:

Women's Health Services: https://www.smartsurvey.co.uk/s/womenshealthservices/ hearing about experiences of women's health services. Online and paper survey, with supplementary outreach.

In November we will be carrying face to face outreach to hear from **working men** in the county.

Other activity summary to date:

- Healthwatch Oxfordshire **Annual Impact Report for the year 2023-4** was published and presented online on 16th July- report https://healthwatchoxfordshire.co.uk/report/healthwatch-oxfordshire-annual-impact-report-2023-24/ and recording of the event https://youtu.be/EJZWDHB0VqE can be found here.
- During 2023-4: 4,786 people shared their experiences of health and social care services with us. 396 people left a review of their experience of using health and social care services via the Feedback Centre on our website (https://healthwatchoxfordshire.co.uk/services). 284 people came to us for advice and information about local health services. We published 39 reports based on our research, setting out what we heard and what improvements people would like to see to local services. All our staff are trained in Making Every Contact Count (MECC). We provide up to date information and news on health and care topics via social media, fortnightly news bulletin and via local networks across the county.
- Summaries of **Healthwatch Oxfordshire's quarterly activities** and achievements since the last meeting – include for Q4 Jan-Mar 2024 (2023-4 year) and Q1 April-June 2024 (2024-5 year) activity and can be found here: https://healthwatchoxfordshire.co.uk/impact/ with quarterly report summaries of activity, and examples of how our work has had an impact and made a difference.
- Our **goals and priorities** for the year can be found here: https://healthwatchoxfordshire.co.uk/about-us/our-priorities/
- We continue to hold **public webinars** https://healthwatchoxfordshire.co.uk/news-and-events/patient-webinars/ on topics including Pharmacy First, BOB ICB Primary Care Strategy, and Health Closer to Home – enabling residents to hear from health and care providers and commissioners, and contribute views to strategy development, feedback and other insight. The next webinar on 19th November will focus on men's health.
- We are carrying out a community insight profile of **Wood Farm**, commissioned by Oxfordshire CC and Oxford City Council as part of the ongoing health profiling of parts of the county. This piece of work and our report will form part of the overall profile for public health on Wood Farm due in early 2025.

Oxfordshire Place-base Partnership: Health and Wellbeing Board Update September 2024

1.0 BOB ICB Board meetings

The most recent BOB ICB Board meeting took place on 16 July 2024. The papers can be found on then BOB ICB website . The next meeting will take place on 19 September. Please see the website for papers.

2.0 GP Collective Action

The British Medical Association's (BMA) GP Committee (GPC) held a ballot of GP partner members during June and July 2024 on taking 'collective action' over the 2024-25 GP contract terms.

The ballot voted in favour of action, which subsequently began across England on 1 August.

When the GP contract was announced earlier this year, there was a 1.9% increase in funding on a contract that has remained static for five years. The BMA argues this increase does not cover staff wage increases and claims GP practices are struggling to balance income and expenditure – financial instability being one of the main reasons that practices hand back their contracts.

Responsibility to deliver the contract is held by GP practice partner(s) who are not NHS employees, but independent contractors to the NHS. Unlike NHS employees, such as junior doctors and consultants, GP partners are not subject to the Trade Union and Labour Relations (Consolidation) Act. The decision to hold a ballot is not statutory but indicative and the action is termed 'collective action' rather than strike action as contracts are unlikely to be breached.

As part of any 'collective action', GP practices as independent businesses may pick and choose from a list of actions suggested by the BMA's GPC, flexing them over time which could increase their impact on health services. The actions are enduring with no end point until an agreement negotiated with the Government.

A BOB ICB Incident Management Team (IMT) has been established and we are working with partners and stakeholders locally to plan for any disruption and to mitigate this where possible to ensure services continue to be provided for patients. We are continuing to closely monitor any effects and to address issues as they arise.

During this time of collective action, the NHS is asking the public to come forward as usual for care. GP practices are still required to be open between 8am and 6.30pm Monday to Friday and it is vital that patients still attend their appointments unless they are told otherwise. Patients should continue to use 111 for urgent medical help when their GP practice is unavailable and to call 999 in a serious or life-threatening emergency. Our latest media release is available here.

The possible actions which GPs can take are:

- Limit daily patient contacts per clinician to the European Union of General Practitioners and BMA recommended safe maximum of 25. Divert patients to local urgent care settings once daily maximum capacity has been reached.
- Stop engaging with the e-Referral Advice & Guidance pathway - unless it is a timely and clinically helpful process for you in your professional role.

- Stop supporting the system at the expense of your business and staff - serve notice on any voluntary services currently undertaken that plug local commissioning gaps.
- Stop rationing referrals, investigations, and admissions
    - Refer, investigate or admit your patient for specialist care when it is clinically appropriate to do so.
    - Refer via eRS for two week wait (2WW) appointments, but outside of that write a professional referral letter where this is preferable.
- Switch off GPConnect functionality to permit the entry of coding into the GP clinical record by third-party providers.
- Withdraw permission for data sharing agreements which exclusively use data for secondary purposes (i.e. not direct care). Read our guidance on GP data sharing and GP data controllership.
- Freeze sign-up to any new data sharing agreements or local system data sharing platforms. Read our guidance on GP data sharing and GP data controllership.
- Switch off Medicines Optimisation Software embedded by the local ICB for the purposes of system financial savings and/or rationing, rather than the clinical benefit of your patients.
- Practices should defer signing declarations of completion for "better digital telephony" and 'simpler online requests' until further GPC England guidance.
    - Defer signing off 'Better digital telephony': do not agree yet to share your call volume data metrics with NHS England.
    - Defer signing off 'Simpler online requests': do not agree yet to keep your online triage tools on throughout core practice opening hours, even when you have reached your maximum safe capacity

Should initial collective action be unsuccessful in influencing national negotiations then further actions may be initiated.

3.0 BOB ICB Operating Model

In July, BOB ICB shared details with partners of its revised way of working ('operating model'). The new approach aims to clarify and strengthen the ICB's role within the local health and care system and focus on where it can uniquely add value within a changing NHS.

Feedback from ICB staff and system partners has been carefully considered and a final operating model will be presented to the ICB Board for approval on 25 September 2024.

4.0 Oxfordshire Place-based Partnership

These following sections provide an update from our Oxfordshire Place-based Partnership.

4.1 Children and Young People

In July our Local Area Partnership SEND Improvement Board met with the Department for Education and NHS England for a stocktake to discuss the progress we have made in the years since the inspection and areas of concern. A full summary of the meeting and what it covered can be found in Steve Crocker's blog (independent chair).

Two critical areas for NHS colleagues to address and improve are the Neurodevelopmental and Integrated Therapies pathways. During September's SEND Improvement Board there will be a deep dive into health provision that is typically accessed by young people with SEND to develop shared understanding of where we are now, where we are going and how we are going to get there.

We continue to experience across most of our services, higher levels of demand than capacity. We are developing new clinical models, utilising a wide range of practitioners and professionals, as well as working with parents, carers and young people to develop offers that will help while people wait for some of our diagnostic services.

Finally, with the leadership of Lisa Lyons (Director for Children's Services) we are contributing to the development of core strategies aligned with existing strategies (such as the Health and Wellbeing Board) and refreshing governance arrangements such as the Children's Trust Board.

4.2 Adult and Older Adult Mental Health and Wellbeing

Key partners are collaborating to design, commission and deliver a new and improved mental health model of care in Oxfordshire for adults and older adults. We are exploring how the Provider Selection Regime (PSR) can be applied to enable the development of a partnership led by Oxford Health, as the NHS mental health prime provider. Our aim is to develop an integrated model of care and deliver the best outcomes and experiences with the funding available. We hope to learn lessons from the existing outcomes-based contract to take into our future model.

Leadership development amongst partners has been highlighted as an area of great importance to maximise the potential of this process. We have begun an organisational development programme to support and further enhance collaboration, partnership, system leadership and trust between all stakeholders involved. Our aim is to have a clear vision and principles for transformation of mental health services and an integrated contract that provides certainty and enables transformation.

September's Joint Health Overview and Scrutiny Committee (JHOSC) will focus on current commissioned services and plans for the future in adult and older adult mental health.

4.3 Urgent and Emergency Care

Alongside our ICB Urgent and Emergency Care(UEC) funding a key component and enabler of delivering UEC for Oxfordshire residents is the Better Care Fund (BCF). We have been able to run a systemwide planning process with representation and contributions from a diverse range of organisations and sectors within Oxfordshire. Membership of the Steering Group includes representatives from NHS provider Trusts, local government, VCSEs, Healthwatch and Primary Care. The Place Based Partnership is well connected to this process and senior leaders have helped shape priorities and principles to date.

Our integrated UEC work is a central feature of our success in Oxfordshire. We continue to focus on reducing the delays for people medically optimised for discharge from hospitals. We have seen recent improvements in the 4-hour waiting standard in Emergency Departments and high levels of care provided in people's homes. The initiatives we have in-place like the Transfer of Care Team, Discharge to Assess and Home First, Integrated Neighbourhood Teams, Hospital at Home and Urgent Care Centres are all fundamental to our ongoing UEC programme. As we head into winter we are beginning to consider how we can continue to deliver the best possible care when the demand for services inevitably increases. Our plans will be scrutinised at JHOSC in September.

4.4 Prevention and Health Inequalities

Finally, some exciting news. We have demonstrated our commitment to prevention and reducing health inequalities through our Prevention and Health Inequalities Forum (PHIF)

chaired by Ansaf Azhar (Director of Public Health). Two of our flagship system projects have been shortlisted for prestigious Health Services Journal (HSJ) Awards in the category of Place-based Partnership and Integrated Care Award:

- Working in partnership to create a whole system approach for physical activity in Oxfordshire which has brought together BOB ICB, Public Health, Oxfordshire's district and city councils, Oxfordshire Active Partnership and the voluntary sector to jointly commission and deliver activity programmes which now reach more than 12,000 residents at highest risk of physical inactivity and health inequality.

- Oxfordshire Health and Homelessness Inclusion Team which has brought together housing, health, care and voluntary organisations to support planned, safe discharges from hospital for people experiencing or at risk of homelessness - avoiding discharges to the street; increasing access to mainstream services in community settings - avoiding unnecessary hospital (re)admissions and reducing inequalities; preventing rough sleeping and homelessness.

5.0 Conclusion

Despite upcoming periods of uncertainty and a requirement to review the operating model of the ICB, the strong spirit of place and the the progress made by the Place Based Partnership is encouraging. We remain committed to increasing our investment in communities and prevention, addressing the building blocks of health (jobs, housing, social activity, education) and reducing health inequalities in Oxfordshire.

Annual planning procceses for public sector organisations can often be viewed as being burdensome and complex, but in Oxfordshire we are working in a more trusting and transparent manner to ensure that realistsic plans and commitments are made to better improve access, oiutcomes and experience for our residents. To support this, OCC, BOB ICB and provider partners have emabrked upon a series of Health and Social Care Connections. So far, system leaders have visited 14 community events and held seven stakeholder meetings across Oxfordshire, connecting with 550 people. The purpose of these events has been to:

- Listen to feedback from the public about their recent experiences of health and social care.
- Connect senior leaders with the public for a two way conversation.
- Share complex messages about changes to health and social care around delivering support and services closer to home.
- Share a united 'Team Oxfordshire' approach.

Further events are planned for September and October to ensure countywide coverage. An evaluation of the connections roadshow will take place in November.

Daniel Leveson
Oxfordshire Place Director
September 2024

Divisions Affected – N/A

Health and Wellbeing Board –26 September 2024

Update of the Children's Trust Arrangements and Board.

Report by Director of Children's Services

RECOMMENDATION

The Health and Wellbeing Board is RECOMMENDED to

a) **To review the progress on the reestablishment and reset of the Children's Trust Arrangements (CTA) in Oxfordshire and to note the information contained within the report.**

Executive Summary

1. The Children's Trust Arrangements are the strategic partnership mechanism for identifying and monitoring the progress of improvements, in key high-level health and wellbeing outcomes for all children within the County of Oxfordshire. The Children's Trust Arrangements are the child and young people's focused branch of the Health and Wellbeing Board and therefore works closely with and reports to the Health and Wellbeing board.

2. The Children's Trust Arrangement are delivered through the Children's Trust Board, which is a small number of strategic leaders across the children's partnership who have authority, responsibility, accountability and decision-making powers. The Children's Trust Board is chaired by the Cabinet Member for Children's Services.

3. During a period of systems change and changes in leadership within the partnership, the Children's Trust Arrangements continued to operate some meetings and workshops in 2023, however these arrangements needed to be re-evaluated and to refine its strategic intent.

4. The first meeting of the Children's Trust Board and arrangements is planned for 24 October 2024 and will meet four times per year. Development is underway to consider whether one of these meetings should expand to include a whole children's partnership conference for wider partners in the children's system. A review of the progress against the Strategic objectives will occur annually.

Development of the Children's Trust Arrangements and Board: principles of Strategic Intent.

5. The terms of reference of the Children's Trust arrangements have been refreshed. It is not the role of the Children's Trust Arrangements to directly deliver operational work, but instead as a focus for the progress and delivery of the many other and already existing statutory and strategic boards and duties. For Instance, the priorities for the safeguarding of children are the strategic and statutory duty of the Children's Strategic Safeguarding Partnership under Working Together 2023, currently known as the Oxfordshire Safeguarding Children's Board.

6. A range of statutory and strategic Boards already exist within the Council and across the Children's partnership in Oxfordshire. Each board has a range of legal duties, and each board has a focus around a medium-term strategy, typically three to five years of planning and delivery. It is the role of the Children's Trust Arrangements and board to seek assurance and progress against each board's strategic objectives and review evidence of progress in improving outcomes for children and young people in Oxfordshire.

7. The Children's Trust Arrangements has a requirement to develop a high-level strategy or plan which identifies improvements in key areas impacting all children and young people in Oxfordshire. This strategic intention is based upon already established evidence such as the Joint Strategic Needs Analysis, and upon the existing priorities and strategies of a range of other statutory boards, legal frameworks and data. It is for the Children's Trust Arrangements to gain assurance of change and improvements against the strategic intent and intended outcomes for children.

8. In developing the Children and Young People's strategic Plan, the existing ambitions and priorities of existing strategies, data and improvement needs, have been accepted as the basis for the key high-level changes that the Children's Trust Arrangements would champion and adopt. The existing priorities and ambitions can be found in a range of plans and operational delivery for example:

   - The Council's Strategic Plan priorities and Plan 2023-2025, strategic plan 2022 - 2025 (pdf format, 3.6Mb)
   - The existing priorities for the current Health and Wellbeing Strategy in respect of children's outcomes, under Start Well.
   - The Youth Justice plan 2024
   - The outcomes and recommendations of the Education Commission 2023.

9. There are four broad areas of the Children and Young People's strategic plan:

   - Start Well and Early Help
   - Live Well: Young Lives

- Achieve Well
- The voices of children and Young People.

Corporate Policies and Priorities

10. As the Children and Young People's focussed branch of Health and Wellbeing Board, the Children's Trust Arrangements and the Children and Young Peoples Strategic Plan meets the vision, values and strategic priorities of the Council's corporate plan.(see Corporate Plan), with an obvious and direct link to priority 7, *Create opportunities for children and young people to reach their full potential.*

    There are other clear links to priority 2: *tackle inequalities in Oxfordshire;* priority 3: *prioritise the health and wellbeing of residents,* and working with the 'Future Generations' commitment, priority 8: *Play our part in a vibrant and participatory local democracy,* by recognising that children and young people are residents and that their outcomes and wellbeing should be influenced by listening to young residents about what matters to them in Oxfordshire.

Financial Implications

11. There are no direct financial implications of this report

    Comments checked by:

    Thomas James, Head of Finance Business Partnering,
    thomas.james@oxfordshire.gov.uk

Legal Implications

12. There are no legal implications of this report

    Comments checked by:

    Naomi Bentley-Walls, Head of Law (Childcare)
    naomi.bentleylawson@oxfordshire.gov.uk

Staff Implications

13. There are no staff implications in this report

Equality & Inclusion Implications

14. This report outlines the strategic vision and mechanism for improving outcomes for all children and young people in Oxfordshire. This report shows the focus and mechanism for tackling a range of disadvantage and differential outcomes.

Sustainability Implications

15. There are no sustainability implications in this report

Lisa Lyons
Director of Children's Services

Annex: Children and Young People's Strategic Plan

Contact Officer: Lisa Lyons, lisa.lyons@oxfordshire.gov.uk

September 2024

Oxfordshire Children's Trust Arrangements and Board

Terms of Reference (2024-26)

FINAL

		Date
Prepared by:	Lisa Lyons	July 2024
Reviewed by:	Children's Trust Board	
Review Date	Children's Trust Board	March 2021
Review Date	Children's Trust Board	July 2024

THE CHILDREN'S TRUST BOARD

TERMS OF REFERENCE 2024

1. Introduction

1.1 The Children's Trust Board brings together the public, private and voluntary sectors to improve outcomes and life experiences for all children and young people who live in the county. The Board focuses its actions on four priorities from the Children and Young People's Plan:

- Start Well: Early Help and Early Years
- Live Well: Young Lives; outcomes for Young People
- Achieve Well: outcomes for education and inclusion
- Children's and Young People's Voices and their influence over the services that shape their lives

1.2 The purpose of the Trust is to:

1. Oversee the strategic intent of Oxfordshire multi-agency partners based upon the desired outcomes of Health and Wellbeing Board with a focus upon outcomes and implications for Children and Young People. Along with a focus on effective partnership working across Oxfordshire to best support Children and Young People
2. Drive a long-term Children and Young People's strategy and plan, designed to improve outcomes for children in Oxfordshire in relation to the agreed priority areas of 'Start Well, Live Well, Achieve Well'
3. To receive assurance in relation to the impact and progress of the strategic priorities and to review the impact of other strategic boards and committees in supporting those priorities and progression
4. Champion the involvement of Children, Young People, Parents and Carers in partnership, working with senior managers and politicians
5. Ensure the Health and Wellbeing Board and other partnerships are sighted on the key challenges and outcomes facing Children and Young People in Oxfordshire

This term of reference sets out the strategic, decision making and operational structure of the Children's Trust Board. This document will be reviewed in line with the Health and Wellbeing Strategy, the strategic priorities of the Council and any refresh of the Children and Young People's Plan.

2. Responsibilities

2.1 The responsibilities of the Trust are to:

1. Report and inform the Health and Wellbeing Board (this does not preclude consultation and reporting to other committees and boards focused upon outcomes for Children and Young People)
2. Produce an overarching strategy focused upon key high-level outcomes using the delivery work of other strategic boards and committees to drive outcomes
3. Lead on the production, development and updates the Children and Young People's Plan
4. Review performance via the Children's Trust dataset which is overseen by the Performance, Audit and Quality Assurance Subgroup of both the Trust and Strategic

Safeguarding Arrangements for Children and Young People in Oxfordshire

5. Encourage and promote integrated working between children's services, health and social care and other local services including voluntary and public sector services

3. Structure

3.1 Membership:

3.1.1 Members of the Trust are required to be of sufficient seniority to be able to:

- Speak for their organisation and make decisions
- Commit their organisation on policy and practice matters
- Hold their organisation to account and lead dissemination of communication into and out from their organisation/agency

3.1.2 The Trust membership is drawn from each of the agencies or organisations set out below:

1. Cabinet Member for Children and Families (OCC)
2. Children Education and Family Services (CEF: DCS and Deputy Directors)
3. Director of Public Health
4. Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (2 representatives)
5. The City and District Councils: one mandated representative from the Districted and City Council on behalf of the others
6. Thames Valley Police
7. Oxfordshire Children's Strategic Safeguarding Arrangements: Scrutineer
8. Oxford Health NHS Foundation Trust
9. Safer Oxfordshire Partnership
10. Oxford University Hospitals NHS Trust
11. Representation from schools and colleges'
12. Members of the Children and Young People's Forum will represent the Third Sector
13. Healthwatch ambassador

3.1.3 Membership will be reviewed in line with CYP strategy updates. Associated colleagues may be invited to attend for specific information and assurance items.

Time limited task and finish groups or specific Invitees:

3.1.4 The Trust may, from time to time, establish working groups to pursue particular projects. These groups will be set up on a "task and finish" basis and will be dissolved once the project has been completed.

3.2 The Chair:

The Trust will be chaired by the Cabinet Member for Children and Family Services, Oxfordshire County Council.

3.3 Vice Chair:

The Vice Chair will be a representative from any of the organisations represented at the Board. The role of the Vice Chair involves chairing and preparing meetings, approving minutes and reports to the Health and Wellbeing Board in the absence of the Chair and leading on agreed specific pieces of work. The duration of the role can be negotiated but continuity is expected given that the Board only meets four times a year.

4. Administration

4.1 Forward Plan:

The Trust will produce an annual Forward Plan to ensure clearer oversight of key risks

and issues across the system. The Forward Plan will support the overall strategic direction of service delivery with a focus of assurance and escalation of issues as appropriate.

4.2 Meetings:

4.2.1 The Trust will meet four times a year and publish an annual plan for its meetings.

4.2.2 The agenda for three of the meetings will include a focus on at least one of the priorities listed above and include time to consider emerging and core business.

4.2.3 Core business includes:

1. Performance monitoring and assurance
2. Updates from other statutory boards across the partnership
3. New and emerging national, regional and local developments which impact on the business of the Trust.

4.2.4 Agendas will be published in advance of the meeting.

4.2.5 Strategy and Plan review:

The Trust will review the programme of assurance in line with the strategies and direction of Health and Wellbeing.

5. Communication, Consultation and Engagement

5.1 The Trust is responsible via a range of mechanisms across the partnership for engaging and involving Children, Young People, their Families, Carers and other local stakeholders to influence partnership plans that deliver outcomes for Children and Young People.

5.2 To achieve this, the Trust will work with specific partners and agency/partnership mechanisms on a range of participation, engagement, feedback and the output of coproduction activity, to ensure that the voice of Children, Young People and Families influence and inform the priorities and assurance of the Trust.

APPENDIX 1

Confidentiality and Information Sharing

1.1 Information used by the Children's Trust Board and provided to external bodies will be accurate, timely and fit for purpose.

1.2 Members of the Trust are encouraged to share information as required for the purpose of planning, developing and monitoring partnership projects and services by ensuring all data is in line with the Data Protection Act 1998.

1.3 All members of the Trust are responsible for communicating any relevant information to their organisation unless that information is deemed confidential to a particular meeting.

APPENDIX 2

Values

The Children's Trust Board will be:

1. Strategic - members of the Trust can take a strategic overview, to implement system change and thinking and to influence decision making and delivery within their organisation
2. Inclusive – the Trust will be a partnership of equals, actively involving all the key players in the public, private, voluntary and community sectors and children and young people
3. Outcome focused – The Trust will establish common priorities together with agreed actions and milestones that lead to demonstrable improvements against measurable baselines
4. A body that promotes equality – the Trust will serve the needs of all children and young people regardless of age, sex, disability, race, religion, belief or sexual orientation

2024-2028

Oxfordshire's

Children and Young People's Plan

A child first county: improving positive life experiences for Oxfordshire's children and young people

OXFORDSHIRE COUNTY COUNCIL

Councillor John Howson,

Cabinet Member for Children, Education and Young People's Services

"The Oxfordshire Children and Young People's Plan 2024 - 2028 outlines a partnership vision for improving the wellbeing and outcomes for all children and young people in Oxfordshire.

"Every child and young person will have the best possible start in life, the county will be a great place to grow up in and children and young people will have opportunities to become everything they want to be. These life chances will be reflected equally across our rural and urban communities.

"The Children's Trust will oversee and monitor the delivery of the plan ensuring that partners – county, city and district councils, police, health, education, the voluntary and community sector – all work together effectively across children's services.

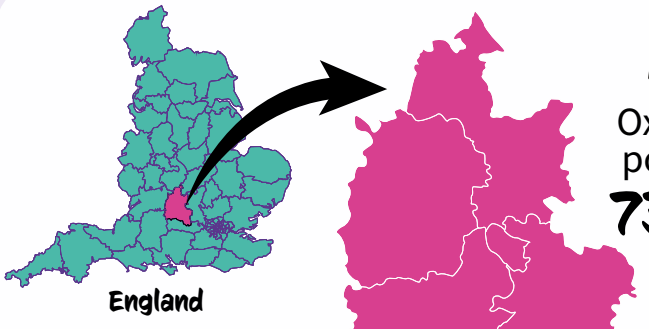
"Our plan sets out a range of priorities and outcomes for children in their early years and as they grow into young people. We will listen to and involve children and young people so we understand what matters to them and use this to shape future services. Putting the voices of children and young people at the heart of our collective work is crucial to delivering our ambitions.

"This plan provides the foundation to support children and young people, along with their families, to thrive. Together, we can build brighter futures for every child in Oxfordshire!"

Councillor John Howson

Sig needed...

Oxfordshire's numbers



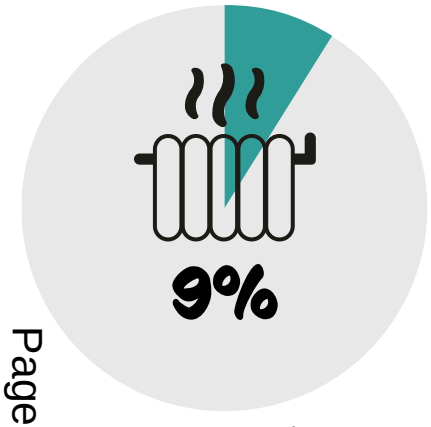
Oxfordshire population
738,276

7,201
Babies born

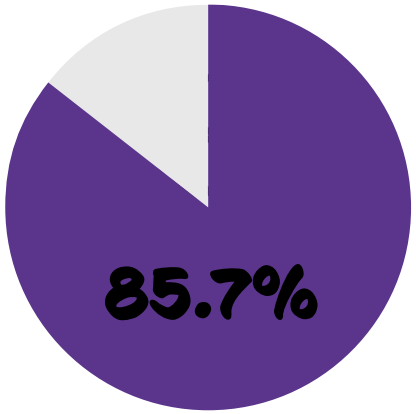
0.72%
(2,091)
Homeless households

59
Children we care for per 10,000 (under 18 yrs)

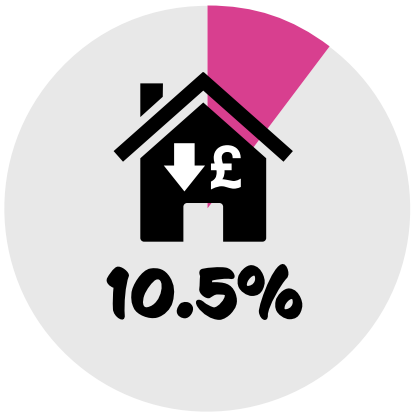
46.9/90
GCSE attainment 8 score



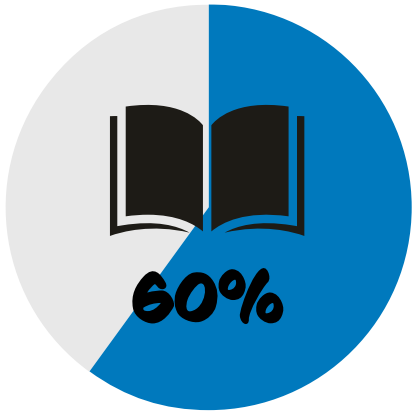
Households in fuel poverty



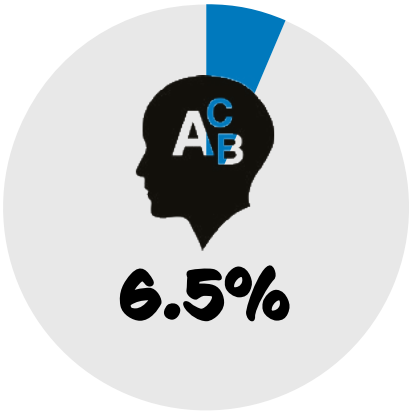
Baby's first feed breastmilk



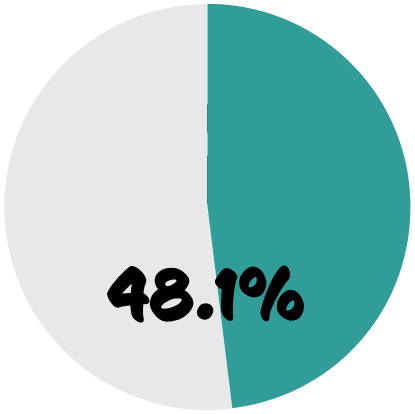
Children live in low income families



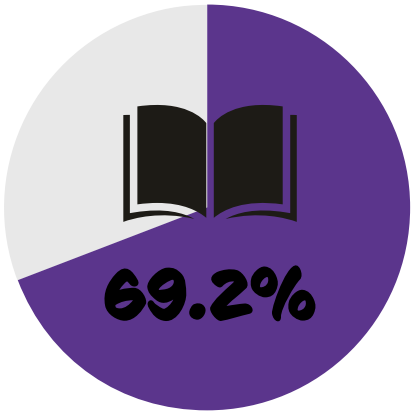
Reached standard in reading, writing and maths



Young people with learning difficulties



Children physically active (5–16 yrs)



Good level of development at the end of reception

Context and ambition

- The Oxfordshire Children and Young People's Plan is the high-level strategic ambition for all children and young people in Oxfordshire.
- This is a partnership and stakeholder plan that aims to improve the wellbeing and outcomes for all children and young people in Oxfordshire.

  The priorities in the plan are underpinned by data, intelligence and analysis of outcomes for children and young people, and are informed by feedback received from ongoing engagement and consultation with children, young people and their families.
- The direction, delivery and assurance of the plan is overseen by the Oxfordshire Children's Trust arrangements, which is the 'child focused' function of the Health and Wellbeing Board.

Start well and early help

Priorities

- All children should have the best start in life.
- All children should be ready for school and additional support is given in our most deprived neighbourhoods and disadvantaged groups.
- More children and their families take up the opportunity of early years education and childcare, especially those with additional needs.

Outcomes

- Our children in their earliest years have their health and development checks, and support is given to enhance their wellbeing and potential.
- Our rising fives (children aged four or five) are ready for school and are at their optimum health, physical and social development.
- Early years children access opportunities for play, learning and development through provision.
- Children in need of additional support are identified, including those entitled to free school meals and those with special educational needs and disabilities (SEND).
- More children are assessed and identified for speech, language and communication development in early years.

Live well: young lives

Priorities

- Keeping children and young people safe from harm.
- Providing help and support across the system at the earliest opportunity.
- Improving the experience of good mental health and emotional wellbeing of children and young people.
- Supporting children and young people with caring responsibilities.

Outcomes

- More children are safe at home and in their communities.
- Universal and early help is available to children and young people and their families at an earlier stage.
- More children and young people report a more ‘contented’ view of their lives and where they live. They increasingly know where to get advice and support when they have worries.
- Young carers are increasingly recognised and the partnership system provides greater opportunities to support them.

Achieve well

Priorities

- Improve school experience.
- Improve school attendance.
- Narrow the disadvantage gap across all key stages, while continuing to support positive outcomes for all.
- Ensure preparedness and support for all young people on their journey to meaningful employment, education and training.
- Where young people continue to draw on care and support in adulthood, we work together to ensure they are encouraged to live as independently as possible and are confident moving into adulthood.

Outcomes

- Children routinely have a school place, have high attendance and can access learning.
- More children have better educational outcomes and fulfil their potential.
- More young people from an earlier age are helped to prepare for their futures as young adults.
- Early help and prevention reduces the number of young people at risk of youth violence, harm outside the home and entering the criminal justice system.

Voices of children and young people

Priorities

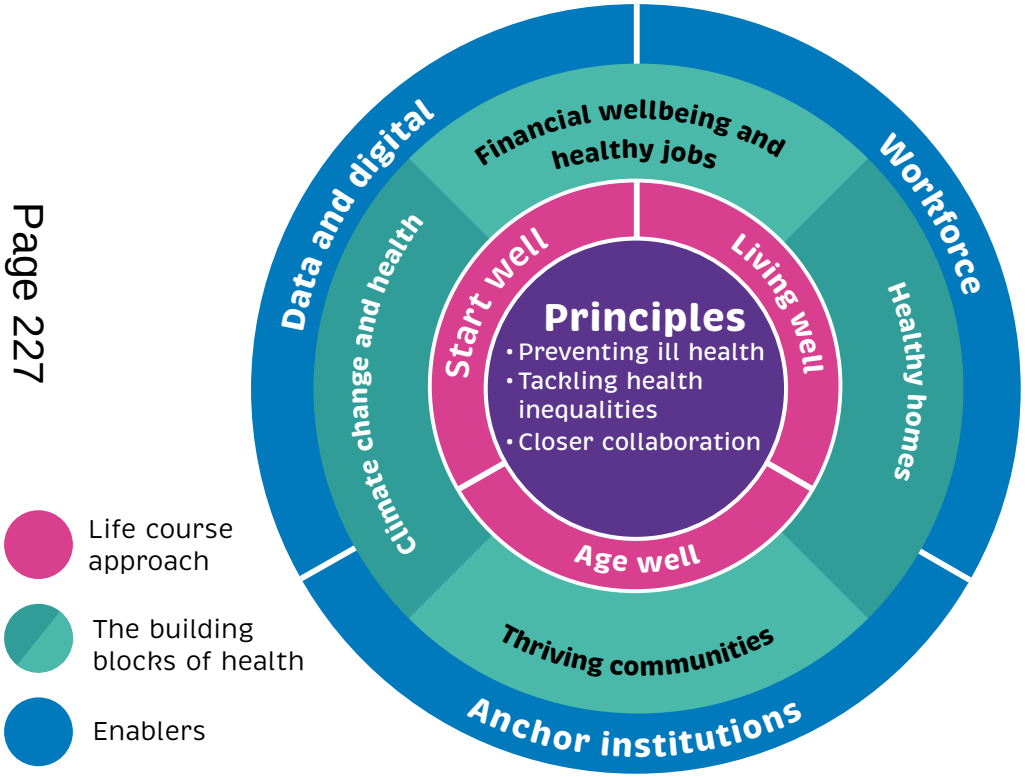
- Children are young residents, and Oxfordshire is a place that caters for their needs.
- Services across Oxfordshire are designed to meet the needs of young residents and respond to what matters to them.
- Decisions are taken and services commissioned that take into account the wellbeing of future generations.

Outcomes

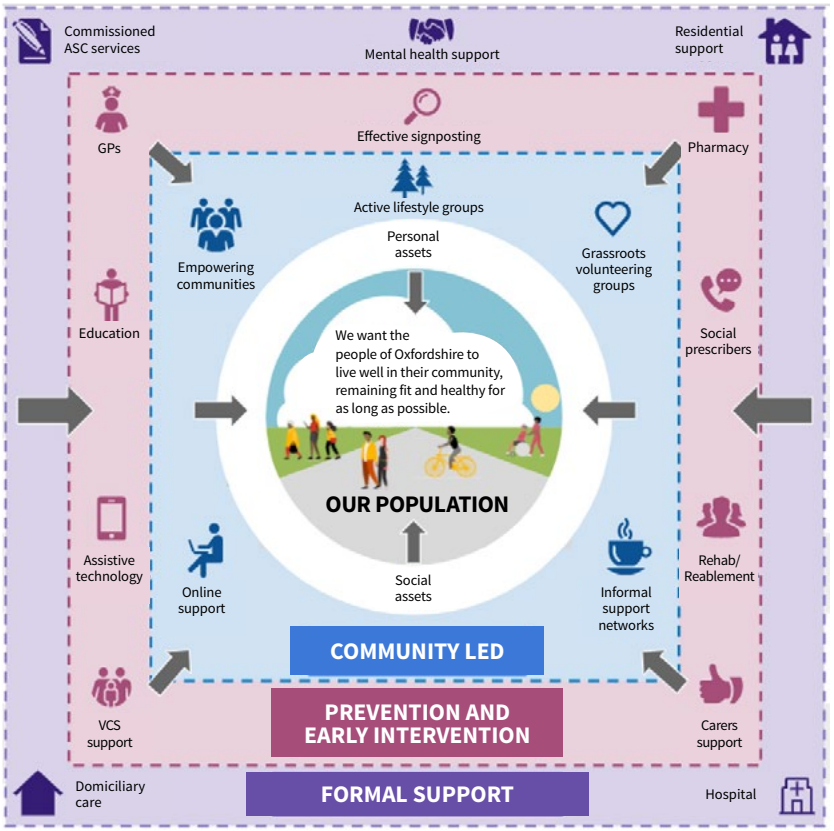
- The views of a wide range of children and young people help shape the strategic plans of the council and partnerships.
- Children and young people are able to let decision makers know what matters to them through a wide variety of channels.
- Intergenerational fairness is put at the heart of the council's decision-making.

Overarching strategies

All commissioning strategies and activity are guided by our joint Health and Wellbeing Strategy and the Oxfordshire Way strategic approach. Strategies are informed by analysis of our Joint Strategic Needs Assessment through co-production and public engagement.



Summary of Oxfordshire's Health and Wellbeing Strategy.



A diagram depicting Oxfordshire Way strategic approach.

Further information

Statutory boards responsible for oversight and delivery

- Health and Wellbeing Board
- Children's Trust arrangements
- Oxfordshire Place-Based Partnership
- Public Health Board
- Education and Inclusion Partnership
- Children and Young People Emotional Health and Wellbeing Board
- SEND Improvement and Assurance Board
- Oxfordshire Safeguarding Children Board and other strategic safeguarding arrangements
- Youth Offending Management Board
- Serious youth violence statutory function
- Oxfordshire Community Safety Partnership
- Oxfordshire Domestic Abuse Strategic Board
- Drug and Alcohol Partnership

Related strategies

- Health and Wellbeing Strategy, 2024-2030
- Health and wellbeing outcomes framework, 2024–2028
- Early help and prevention
- Local Area SEND Strategy
- SEND Sufficiency Delivery Strategy, 2022/23–2026/27
- Our commitment to future generations
- The Oxfordshire Way in adult social care
- All-age Unpaid Carers Strategy for Oxfordshire
- Commissioning Strategy for Children We Care For Placements 2020–2025
- Oxfordshire's Overarching Domestic Abuse Strategy, 2022–2025

Data and insight

- Oxfordshire Joint Strategic Needs Assessment
- Education Commission report, October 2023

Oxfordshire JSNA, health and wellbeing facts and figures 2024

Compared to England average (statistical significance indicated by icon colour): Worse | Similar | Better | Not compared

BIRTH

1. 738,276 — Oxfordshire population

2. £493,222 — Average house price

3. 193 — Apprenticeship vacancies

4. 7,201 — Babies born

5. 6.4% — Mothers smoking at birth

6. 2.2% — Low birth weight of term babies

7. 85.7% — Baby's first feed breastmilk

8. 2.3 — Infant mortality rate per 1,000 live births

EARLY YEARS

9. 10.5% — Children live in low income families

10. 69.2% — Good level of development at the end of reception

11. 90.6% — MMR for two doses (5 yrs)

12. 19.2% — Reception children overweight or obese

PRIMARY SCHOOL

13. 48.1% — Children physically active (5-16 yrs)

14. 30.6% — Year 6 children overweight or obese

15. 60.0% — Reached standard in reading, writing and maths

SECONDARY SCHOOL

16. 4.4% — Not in education, employment or training

17. 6.5% — Young people with learning difficulties

18. 7.8 — Victims of child sexual exploitation per 10,000 (0-17 yrs)

19. 46.9 — GCSE attainment 8 score

20. 59 — Children we care for per 10,000 (under 18 yrs)

WORKING AGE

21. 8.9 — Under 18 conceptions per 1,000

22. 224.1 — Young people hospital admissions for self-harm per 100,000 (10-24 yrs)

23. 22.7 — Under 18s hospital admissions for alcohol-specific conditions per 100,000

24. 950 — Chlamydia diagnoses per 100,000 (15-24 yrs)

25. 9.0% — Households in fuel poverty

26. £38,495 — Median full-time salary

27. 83.8% — Adults in employment

28. 2.1% — Adults unemployed

29. 2,091 — Homeless households

30. 7.6 — Mean happiness score (out of 10)

31. 11.2% — Adults smoke

32. 57.8% — Adults overweight or obese

33. 1.3% — Adults have chronic obstructive pulmonary disease

34. 71.4% — Adults are physically active (19+ yrs)

35. 13.1% — Adults with diagnosed depression

36. 2.3% — Adults with coronary heart disease

37. 0.4% — Adults with learning disabilities

38. 231 — Killed or seriously injured on roads

39. 534 — Alcohol related hospital admissions per 100,000 (40-64 yrs)

40. 36.2% — Eat their "5-a-day"

41. 9.6 — Rate of deaths from suicide per 100,000

42. 226.2 — Deaths from cancer per 100,000

43. 14.5% — Adults with long-term illness or disability

44. 3.0 — Deaths from drug misuse per 100,000

45. 35.3% — HIV late diagnosis

46. 335 — New sexually transmitted infections per 100,000

47. 11.3 — Victims of domestic abuse per 1,000

48. 5.5% — Adults with diabetes (17+ yrs)

49. 64.9 years — Average female healthy life expectancy

50. 68.0 years — Average male healthy life expectancy

OLDER PEOPLE

51. 7.9% — Unpaid carers (age standardised proportion)

52. 84.9% — Uptake of flu vaccination in over 65s

53. 1,843 — Hospital admissions due to falls per 100,000 (65+ yrs)

54. 1.8% — People had a stroke

55. 0.7% — Adults with dementia

56. 81.1 years — Average male life expectancy

57. 84.8 years — Average female life expectancy

58. 22.3% — Died at home (85+ yrs)

59. 14.8% — Excess winter deaths (85+ yrs)

END OF LIFE

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