Public Document Pack

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 6 October 2022 at 2.00 pm
Council Chamber - County Hall, New Road, Oxford OX1 1ND

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

Stephen Chandler
Interim Chief Executive

September 2022

Contact Officer: ***Colm Ó Caomhánaigh, Committee Officer***
Tel: 07393 001096 Email: colm.ocaomhanaigh@oxfordshire.gov.uk

Membership

Chair – Cllr Liz Leffman (Leader, Oxfordshire County Council)
Vice Chair – Dr David Chapman (GP and former Clinical Chair, Oxfordshire Clinical Commissioning Group)

Board Members:

Ansaf Azhar	Corporate Director of Public Health & Wellbeing, Oxfordshire Co Co
Councillor Tim Bearder	Cabinet Member for Adult Social Care, Oxfordshire Co Co
Councillor Liz Brighouse OBE	Deputy Leader and Cabinet Member for Children, Education & Young People's Services, Oxfordshire Co Co
Dr Nick Broughton	Chief Executive, Oxford Health Foundation Trust
Sylvia Buckingham	Chair, Healthwatch Oxfordshire
Stephen Chandler	Interim Chief Executive, Oxfordshire Co Co
Councillor Maggie Filipova-Rivers	Vice-Chair, Health Improvement Partnership Board
Karen Fuller	Interim Corporate Director of Adult and Housing Services, Oxfordshire Co Co
Kevin Gordon	Corporate Director for Children's Services, Oxfordshire Co Co
Dr James Kent	Chief Executive, Integrated Care Board
Councillor Mark Lygo	Cabinet Member for Public Health & Equality, Oxfordshire Co Co
Kerrin Masterman	GP Representative
Professor Sir Jonathan Montgomery	Chair, Oxford University Hospitals NHS Foundation Trust
David Radbourne	Regional Director Strategy and Transformation, NHS England
Yvonne Rees	Chief Executive, Cherwell District Council (District Representative)
Councillor Louise Upton	Chair, Health Improvement Partnership Board

Notes:• Date of next meeting: 1 December 2022

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 contact Democratic Services 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 the Chair, Councillor Liz Leffman

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

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

Requests to speak must be submitted by no later than 9am four working days before the meeting i.e. 9 am on Friday 30 September 2022. Requests to speak should be sent to colm.ocaomhanaigh@oxfordshire.gov.uk .

If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that if the technology fails, then your views can still be taken into account. A written copy of your statement can be provided no later than 9 am 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 - 10)

To approve the Note of Decisions of the meeting held on 7 July 2022 (**HBW5**) and to receive information arising from them.

6. Covid-19 / Health Protection Update (Verbal Report)

2:05pm

A verbal update on the latest situation from the system partners.

7. Terms of Reference of the Board and of the Integrated Care Partnership (Pages 11 - 40)

2:15pm

To update the Terms of Reference of the Oxfordshire Health & Wellbeing Board reflecting NHS changes and the Terms of Reference of the Integrated Care Partnership.

Health and Wellbeing Board is RECOMMENDED to

a) APPROVE the updated Terms of Reference for the Oxfordshire Health and Wellbeing Board (See Annex 1)

b) NOTE the draft Terms of Reference for the newly establishment Integrated Care Partnership (See Annex 2)

8. Integrated Care Partnership Strategy Development and Engagement Strategy (Pages 41 - 54)

2:30pm

A paper including updates on the following:

- ICP/ICB Governance
- ICP interim strategy development
- ICB engagement strategy

9. Joint Strategic Needs Assessment 2022 (Pages 55 - 60)

2:50pm

There are two statutory duties of the Health and Wellbeing Board – the publication of a Joint Health and Wellbeing Strategy and the publication of a Joint Strategic Needs Assessment (JSNA). The JSNA enables local authorities and the NHS to assess the current and future health, care and wellbeing needs of the local community to inform local decision making.

The Health and Wellbeing Board is RECOMMENDED to

a) Note the content of the Joint Strategic Needs Assessment for 2022 and encourage widespread use of this information in planning, developing and evaluating services across the county.

b) 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.

10. Community Profiles: The Leys and Abingdon Caldecott (Pages 61 - 66)

3:00pm

As part of the prioritisation of health inequalities in the Board's Strategy, Community Profiles are being produced for the 10 most deprived divisions in Oxfordshire. These are the second and third Community Profiles to be produced.

The Oxfordshire Health and Wellbeing Board is RECOMMENDED to

a) Note the findings and rich insight contained within the Community Profiles

b) Support the promotion and sharing of the Abingdon Caldecott and 'The Leys' community profiles with partners and colleagues across the system.

c) Use the insight from the Abingdon Caldecott and 'The Leys' profiles to inform service delivery plans of partner organisations on the Board.

11. Better Care Fund Plan 2022/23 (Pages 67 - 118)

3:20pm

The Better Care Fund planning round for 2022/23.

The Health & Wellbeing Board is RECOMMENDED to

(a) Approve the Oxfordshire Better Care Fund Plan for 2022/23

(b) Approve the planned investment and schemes designed to deliver the metrics within the Plan

(c) Approve the proposed trajectories for the metrics as set out in the Plan

12. Social prescribing In Oxfordshire (Pages 119 - 126)

3:30pm

This paper updates Health & Wellbeing Board on the development and implementation of Social Prescribing in Oxfordshire.

The Health & Wellbeing Board is RECOMMENDED to

(a) Note this report which sets out

- **the current landscape of Social Prescribing in Oxfordshire**
- **the opportunities to develop and extend reach and impact across public health, health, social care, and community priorities**
- **next steps and a potential governance route to assure delivery**

(b) Approve the recommended approach to develop an implementation plan for Social Prescribing in Oxfordshire

(c) Note the proposed governance approach for this work

13. Report from Healthwatch Oxfordshire (Pages 127 - 132)

3:45pm

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

14. Performance Report (Pages 133 - 136)

3:55pm

To monitor progress on agreed outcome measures.

15. Reports from Partnership Boards (Pages 137 - 144)

4:05pm

To receive updates from partnership boards including details of performance issues rated red or amber in the performance report.

- Health Improvement Board (Verbal Update)
- Children's Trust

OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 7 July 2022 commencing at 10.00 am and finishing at 12.40 pm

Present:

Board Members:	Councillor Liz Leffman (Chair) Dr David Chapman (Vice-Chair) Ansaf Azhar Councillor Liz Brighouse OBE Sylvia Buckingham Karen Fuller Dr James Kent Councillor Mark Lygo Councillor Louise Upton Stephen Chandler (virtually) Dr Nick Broughton (virtually)
Other Members in Attendance:	Councillor Nick Leverton
Officers:	
Whole of meeting	David Munday, Consultant in Public Health; Colm Ó Caomhánaigh, Committee Officer.

Part of meeting

Agenda Item	**Officer Attending**
7	Amanda Lyons, Interim Director of Strategic Delivery and Partnerships BOB ICS
8	Helen Shute, Programme Director, Community Services Strategy, Oxford Health; Lily O'Connor, Oxford University Hospitals
9	Hayley Good, Deputy Director for Education, Oxfordshire County Council
10	Jack Gooding, Senior Public Health Principal, Oxfordshire County Council
13	Rosie Rowe, Head of Healthy Place Shaping, Oxfordshire County Council
14	Kate Austin, Health Improvement Principal, Oxfordshire County Council

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 Colm Ó Caomhánaigh, Tel 07393 001096 (colm.ocaomhanaigh@oxfordshire.gov.uk)

	ACTION
1 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
Apologies were received from Kevin Gordon, Jonathan Montgomery and Yvonne Rees.	
2 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest.	
3 Note of Decisions of Last Meeting (Agenda No. 5)	
The notes of the meeting held on 17 March 2022 were agreed as an accurate record.	
4 Health Protection Update (Agenda No. 6)	
Ansaf Azhar, Corporate Director of Public Health & Wellbeing, gave a verbal update. Regarding Covid, case rates had been rising significantly since April but it was still not at the winter peak levels. We were likely to continue to see such fluctuations for a few years as new variants and sub-variants arise. There were unlikely to be mandated measures as before because of the disruption that they cause. It will need to become part of business contingency planning. Vaccination remains the most effective form of protection. It was never too late to get vaccinated. There will be a new campaign in the autumn. The surveillance unit remained in place and will continue to monitor Covid and other infectious diseases.	
5 Bucks, Oxfordshire, Berkshire West Integrated Care System (BOB ICS) Establishment (Agenda No. 7)	

A presentation on the establishment of BOB ICS had been included in the agenda pack. Amanda Lyons, Interim Director of Strategic Delivery and Partnerships BOB ICS, focussed on the slides around the preparatory phase.

Members raised a number of issues which James Kent and Amanda Lyons responded to as follows:

- They were working closely with Jane O'Grady, Director of Public Health with Buckinghamshire Council, in developing the approach.
- The Health and Wellbeing Board's strategy included Start Well which together with the involvement of Kevin Gordon, OCC Corporate Director for Children's Services, will ensure that needs of children will be a core component. They have not met with the Chairs of the Children's Trust Boards yet but will take that on board.
- The Integrated Care Board was about one third of the way through the appointments to the Executive. Javid Khan as Chair of the Board was overseeing appointments to it. Stephen Chandler was partner representative for local government.
- The Integrated Care Partnership (ICP) was being designed and that needed to conclude soon as there was likely to be a complex governance aspect to it.
- Many of the staff transferring from the dissolved Oxfordshire Clinical Commissioning Group were clinicians. The OCCG was weighted towards primary care whereas the ICB would be expected to expand into the broader clinical community including paediatricians.
- The ICB was not starting with a blank canvass. There were strategies such as those of the Health & Wellbeing Boards in place. The question now was if the new structures provided opportunities to go further or if any course correction was needed.

Members also made the following points:

- The design of the ICP needed to take into account that Oxfordshire was the only non-unitary council involved, with city and district councils that had to be taken into consideration.
- A philosophical change was involved here as all needed to act like one organisation.
- Prevention, early intervention and education would be key aspects of the partnership.
- The whole needed to be greater than the sum of the parts. Bringing the public health budget into the pool for the optimum benefit of the public would be an important part.

6 Oxfordshire Integrated Improvement Programme - Update (Agenda No. 8)	
Board members were asked to consider the opportunities this work presented to improve the health and wellbeing of people across Oxfordshire; how they might communicate this shared vision within their organisations; and to commit their organisation's support and an appropriate amount of staff time and resource to the work. Helen Shute, Programme Director, Community Services Strategy, Oxford Health, gave a presentation. Karen Fuller added that there had been a real shift in whole system working with much greater trust and transparency. The challenge now was to get on with the work. James Kent cautioned that the challenge would be in delivery capacity and constraints such as management bandwidth. There will be a need to align ambition with resources. Members raised a number of issues that Helen Shute, Karen Fuller and Lily O'Connor, Oxford University Hospitals, responded to: • The principles developed for the Community Services Strategy were all embedded all the projects they were working on. • Aggregating the needs will be the next step and following that will be a workforce strategy across the system, not just the clinical areas. How the existing workforce was deployed will be part of the discussion. It was too early to say when people will see a difference on the ground. • Hospice at home was part of the Intensive Community Care project even though it was not mentioned in the paper. • There were opportunities to use online tools to get wider public feedback in addition to in-person events.	
7 Update on the Local Area SEND Strategy (Agenda No. 9)	
Board members were asked to note the Local Area SEND strategy, particularly in relation to its support on delivering the Board's Joint Health and Wellbeing Strategy and to support the implementation of the SEND strategy within the work-programmes of their respective organisations. Hayley Good, Deputy Director for Education, Oxfordshire County Council, highlighted the connections with the work of the Board. She added that, following the Monitoring Visit on 6 June, formal monitoring was no longer required. This had been taking place	

every six months since 2017. **Action:** **Hayley Good will circulate the feedback letter from the Monitoring Visit.** Councillor Liz Brighouse emphasised the importance of having local provision for special schools rather than using private provision, much of it out of county and very costly. She also advocated more special support for schools to allow more children with SEND to attend their local school. Members raised issues and Hayley Good and Councillor Brighouse responded as follows: • The number of responses to the consultation was disappointingly low, particularly from health and social care colleagues. It had been widely advertised and a number of children did take part in two roadshow events specifically for them. • There had been a lot of discussion in advance of the formal consultation and broad agreement on the principles, which may account for the lack of feedback later in the process. • The implementation plan be co-produced and will come to Cabinet and it was hoped there will be more engagement with that. • The Equality and Climate Impact Assessment for the strategy was certainly available whether or not it was part of the Cabinet papers. • There were some delays in annual assessments due to the increase in the number of plans and staffing pressures. The Council volunteered to be part of a pilot for a new inspection process and timeliness of assessments will be part of what they look at. **Action:** **It was agreed that the Board should receive regular updates on progress on implementing the strategy.**	Hayley Good David Munday
8 Children & Young People's Emotional Well-Being: Promotion & Mental Ill Health Prevention Draft Strategy (Agenda No. 10)	
The Board was asked to approve the Children and Young People's Emotional Wellbeing Promotion and Mental Ill Health Prevention Strategy, subject to any feedback from the Board and after fulfilling consultation requirements. Ansaf Azhar introduced the report. They had started looking at a CAMHS Strategy (Child and Adolescent Mental Health Service)	

but realised that what was needed was more intervention 'upstream'. It was a holistic strategy, the result of collaborative work across the system, designed to reduce the need for specialist intervention. Jack Gooding, Senior Public Health Principal, Oxfordshire County Council, described the processes followed in developing the partnership strategy. Demand had already been increasing and was exacerbated by the pandemic. The next step was to develop an action plan. The implementation of that will be overseen by the Children & Young People's Wellbeing & Mental Health Board. Members commented as follows: • Research had shown that reducing the gap in educational attainment had benefits for mental health outcomes. • It was important that equity was built into the system – for example, eliminating differences in the way professionals sometimes deal with people with low educational attainment. • There was significant evidence of increases in substance misuse among young people since the pandemic. • There appeared to be nothing in the strategy about support for mothers during pregnancy and after. • KPIs should be as simple and flexible as possible. • When looking at costs of services, we should also look at the costs of not providing them. • The term "anti-social behaviour" should not be used in relation to those with mental health issues. Ansaf Azhar added that there was a sense of urgency around this but the strategy would evolve over time and as we learned from experience. It was agreed to move forward with the strategy.	
9 Report from Healthwatch (Agenda No. 11)	
The Board had received an overview of Healthwatch activity and outcomes January – March 2022 for noting. There were hardcopies of their Annual Impact Report available too. Members thanked Healthwatch for their attendance at all the health-related bodies and for the work they do in reaching all sectors of the community. The report was noted.	
10 Update on Publication of Joint Strategic Needs Assessment (JSNA) (Agenda No. 12)	

The Board had earlier this year agreed to delay the publication of the JSNA until October in order to be able to include data from the 2021 Census. David Munday, Consultant in Public Health, reported that the Office for National Statistics' timetable had slipped and it was now proposed to publish the JSNA in October without that census data which will instead be included in the 2023 report. The recommendations of the report were agreed. **RESOLVED to:** **a) Note that the JSNA 2022 report will be provided to the Health and Wellbeing Board as planned in early October 2022, but (other than total population counts by district) will <u>not</u> include Census 2021 results. This is a result of the delay in the publication of Census data by the Office for National Statistics.** **b) Approve the plan for future JSNA updates to be provided to the June H&WBB meeting (moved from the regular report to the March meeting).** **c) Note that there has been a "call out" for evidence for the 2022 JSNA report, publicised by Healthwatch, and partners are asked to continue to support this work with information and data and make use of this shared evidence base.**	
11 FOP (Future Oxfordshire Partnership) and H&WB workshops (Agenda No. 13)	
Rosie Rowe, Head of Healthy Place Shaping, Oxfordshire County Council, summarised the report on the workshop. These joint workshops were held twice annually to build on opportunities for joint working. Some examples were working with the Local Nature Partnership on providing access to green spaces, working in the Integrated Care System, development of a sustainability strategy on climate change involving local authorities and work by the Oxfordshire Inclusive Economy Partnership (OEIP) on reducing inequalities associated with employment. **Action: It was planned to have an autumn workshop and any ideas on the topics to cover would be very welcome.** Asked about the proposed Oxfordshire Inclusive Economy Charter from the OIEP, Rosie Rowe responded that the initial work was focused on measures that employers could take in recruitment to look in communities that would not normally seek jobs in particular sectors. There was also a Skills & Education	All

Subgroup that was working with information provided by education colleagues to increase the aspirations of young people. **Action: Rosie Rowe will ensure that the Council's education services will be connected to these discussions.** With regard to the social prescribing strategy, there was a clear desire to have one common strategy covering not just social prescribers in the NHS but also those in the community. There was agreement that there needed to be a flexible model that allowed for a range of roles. An existing strategy was being broadened to include the community element. David Chapman raised the issue of where such a strategy should sit in terms of governance. He believed that it could be translatable to BOB-ICS (Bucks, Oxon, Berkshire West – Integrated Care Strategy). Rosie Rowe responded that it will be an Oxfordshire strategy even if elements were also relevant to the BOB or national level. **Action: It was agreed to take social prescribing as an item at the next Board meeting.** It was agreed to note the report's recommendations.	Rosie Rowe David Munday
12 Implementation of MECC Work Programme (Agenda No. 14)	
Following a paper to the Health and Wellbeing Board in December 2021 and a subsequent MECC (Make Every Contact Count) workshop session in March 2022, the Board received a report outlining the approach being taken to develop a more strategic approach to MECC. Kate Austin, Health Improvement Principal, Oxfordshire County Council, highlighted the creation of a post to lead on the wider roll out of MECC in Oxfordshire to ensure there was a more targeted approach to help address health inequalities. It was hoped to fill the fixed-term post in the autumn. There will be an operating budget and reports will go to the Health Improvement Board. The recommendation in the report was agreed. **RESOLVED to support the approach being taken to expand the Making Every Contact Count (MECC) work programme in Oxfordshire as an enabler for delivery of the Joint Health and Wellbeing Strategy and to address local health inequalities.**	
13 Performance Report (Agenda No. 15)	

David Munday, Consultant in Public Health, Oxfordshire County Council, highlighted a number of performance indicators under the three life course stages "Start Well", "Live Well" and "Age Well" from the strategy. Asked about the unusually large increase in the numbers of Looked After Children, Councillor Liz Brighouse responded that she discussed the situation every week with Kevin Gordon, the Corporate Director for Children's Services. There was a problem with getting court dates which was causing a backlog in the system. A lot of work was being done through Family Solutions Plus to support families and help to avoid children being taken into care. David Munday explained that the mean and median figures were used for waiting times for CAMHS because the median figure eliminated the most extreme data at both ends and can give a more accurate picture of the typical wait. The targets were "to be confirmed" and would be decided as part of the implementation plan for the strategy. The Board noted the performance report.	
14 Reports from Partnership Boards (Agenda No. 16)	
Councillor Louise Upton reported that the most recent meeting of the Health Improvement Partnership Board focussed on Healthy Place Shaping which included, for example, 20-minute neighbourhoods, the access to nature programme and Active Oxfordshire's physical activity strategy. Councillor Liz Brighouse noted that most of the issues discussed at the Children's Trust Board meeting had also been discussed at this meeting which indicated agreement on what the issues were. They had discussed CAMHS, unaccompanied asylum seekers and child refugees coming from Ukraine. She also drew attention to a 'deep dive' being conducted into the use of Tier 4 beds i.e. in-patient CAMHS services.	

..... in the Chair

Date of signing .....

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Divisions Affected - All

OXFORDSHIRE HEALTH AND WELLBEING BOARD
6 October 2022

UPDATE TO TERMS OF REFERENCE FOR HEALTH AND WELLBEING BOARD AND DRAFT TERMS OF REFERENCE FOR INTEGRATED CARE PARTNERSHIP

Report by Corporate Director of Public Health & Community Safety

RECOMMENDATION

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

   a) APPROVE the updated Terms of Reference for the Oxfordshire Health and Wellbeing Board (See Annex 1)

   b) NOTE the draft Terms of Reference for the newly establishment Integrated Care Partnership (See Annex 2)

Executive Summary

2. The Health and care Act 2022 established Integrated Care Systems (ICSs) as legal entities and created new NHS bodies called Integrated Care Boards (ICBs). Within this legislation all ICSs are required to establish new partnership forums called Integrated Care Partnerships (ICPs). These bring together ICBs and Local Authorities (LAs) with responsibility for Social Care and Public Health in order to integrate the services they plan, purchase, and provide for local residents.

3. Health and Wellbeing Boards continue to be a crucial partnership forum at a Place footprint (ie Oxfordshire) to bring partners together to improve health and wellbeing of local residents. This has not changed with the passing of the new Health and Care Act, however the Board does need to review and update its own terms of reference to reflect this changing landscape and different partnership organisations

Exempt Information

4. No information in this report is exempt

Background- Change to Health Landscape from 1st July 2022

5. **Integrated care systems (ICSs)** are geographically based arrangements that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. They gained formal legal status on 1st July 2022

6. The aim of ICSs is 4-fold.

   6.1. To improve population health and healthcare
   6.2. Tackle inequalities in outcome, experience and access
   6.3. Enhance productivity and value for money
   6.4. Help the NHS to support broader social and economic development

7. **The Integrated Care Partnerships (ICP)** are formed in accordance with Section 116ZA of the Local Government and Public Involvement in Health Act 2007 as introduced by Section 26 of the Health and Care Act 2022. The ICP is a statutory joint committee of the BOB Integrated Care Board (ICB) and the local authorities in the ICS who are responsible for adult social care: Buckinghamshire Council, Oxfordshire County Council, Reading Borough Council, West Berkshire Council, Wokingham Borough Council. In addition to these Founding Members listed above, it is proposed with the BOB ICP Terms of Reference that wider health and social care partners are also included with the membership of the ICP. Full details are within the proposed ToR in annex 2.

8. Additionally, the ICP is required to develop and publish an Integrated Care Strategy. This is initially due to be published by Dec 2022 and will inform the plans and work programmes of organisations of partners within the ICP.

9. **Integrated Care Boards** are the NHS body that plans and commissions services for local residents. Locally, there is one ICB that covers the BOB area. There is work in progress for ICBs to take on greater commissioning responsibilities than CCGs have historically delivered as responsibilities move to ICBs from NHS England's regional teams. ICBs have the ability to delegate decision making to a Place level (ie Oxfordshire level) via new Place Based Partnerships.

Health and Wellbeing Board Changes to Terms of Reference

10. The creation of ICPs is not intended to duplicate existing arrangements such as Health and Wellbeing Boards but provide opportunity to establish greater integration at a larger system footprint. The principal of subsidiarity is critical to the establishment of ICPs, meaning that where decisions and planning can happen at an Oxfordshire level it will.

11. The Health and Wellbeing Board for Oxfordshire has been in place since 2013 and is required to publish an annual Joint Strategic Needs Assessment (JSNA), develop a (Local) Joint Health and Wellbeing Strategy to meet the needs identified in the JSNA and ratify plans to utilise the Better Care Fund to improve outcomes for local residents. It also is required to publish a Pharmaceutical Needs Assessment every 3 years. None of these requirements have changed.

12. However, there is clearly a need for collaboration and interaction between the ICP and the HWB Board. When the ICP Strategy is completed the HWB Board will need to consider it when preparing its own strategy- now called a Joint **Local** Health and Wellbeing Strategy (JLHWBS)- to ensure that they are complementary. Conversely, HWBs should be active participants in the development of the integrated care strategy as guidance on the content of the integrated care strategy may also be useful for HWBs to consider in the development of their JLHWS.

13. To reflect the changing landscape with the creation of ICSs and the Local Government arrangements in Oxfordshire, the following changes to the Health and Wellbeing Board's Terms of Reference are proposed. The updated ToR are included in annex 1.

    13.1. Two members from NHS Oxfordshire CCG (Chief Executive and the Clinical Chair) are replaced by ICB Clinical Lead with Oxfordshire responsibilities and the Place Director for Oxfordshire from the ICB. Once appointments are made, one of these 2 posts will take the role of vice chair

    13.2. The two City/ District representatives (Chair and Vice-Chair of the Health Improvement Board) are replaced by one representative from each of the 5x Oxfordshire City/ District Authorities.

    13.3. The role of a Chief Executive representative from City & District Councils is included in the Terms of Reference- in practice this is already in place, but has not been formalised before in the Terms of Reference

    13.4. The TORs continue to give the Health and Wellbeing Board the power to establish sub-groups, tasks and finish groups and similar. Currently the HWB has 2 formal sub-groups- the Children's Trust and the Health Improvement Board. No changes to sub-groups are proposed in these amended ToR.

    13.5. The Health and Wellbeing Board is able to approve changes to its own ToR and future changes can be made if needed as ICSs and associated structures develop and mature.

Corporate Policies and Priorities

14. The establishment of Integrated Care Boards within the new ICS structures provides even greater opportunity to integrate health and care services for residents in Oxfordshire than has happened to date. It is anticipated this will have a positive impact on health and wellbeing across the life-course. It will also provide further opportunity to support the improvement of the health of those with the greatest need the fastest. It will therefore contribute the following strategic priorities of Oxfordshire County Council;

    14.1. Tackle inequalities in Oxfordshire
    14.2. Prioritise the health and wellbeing of residents

14.3. Support carers and the social care system
14.4. Create opportunities for children and young people to reach their full potential

Financial Implications

15. There are no direct financial implications arising from this report. More broadly, the establishment of the ICS and its associated structures aims to allow greater integration of services. This may include changes to the current arrangements where Oxfordshire County Council and the local NHS commissioning body (now the ICB) pool some of their budgets through Section 75 arrangements. Any such changes will be subject to separate approval processes.

Comments checked by:

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

Legal Implications

16. As described in paragraph 7, Oxfordshire County Council has a statutory responsibility to form an Integrated Care Partnership with other founding partners. This report seeks the approval of the Terms of Reference for this new forum to support this statutory duty.

Comments checked by:

Anita Bradley, Monitoring Officer, anita.bradley@oxfordshire.gov.uk

Staff Implications

17. There are no direct staffing implications associated with this report. It is anticipated the Member and Officer time taken to participate in this new partnership forum will drive efficiencies of working for a range of teams in the council and therefore have a positive impact on staff capacity.

Equality & Inclusion Implications

18. One of the 4 aims of Integrated Care Systems is to tackle inequalities in outcomes, experience and access. These inequalities in health can be experience by a range of population groups, including those with protected characteristics. It is therefore anticipated that supporting the establishment of the new ICP will have a positive impact on equality and inclusion.

Sustainability Implications

19. This paper does not have any direct sustainability implications. Where any new or amended services are established because of greater integration, they will be individually assessed for their sustainability implications. Any potential travel and printing implications for Oxfordshire County Council staff joining a new partnership forum will be managed via existing policies to mitigate such impacts

Risk Management

20. A detailed risk assessment is not required for this report. There are opportunities and risks to Oxfordshire County Council from the formation of ICSs and this is managed via the council's usual risk management processes.

Consultations

21. Public consultation is not required for the agreement of these Terms of Reference

ANSAF AZHAR, CORPORATE DIRECTOR OF PUBLIC HEALTH & COMMUNITY SAFETY

Annex:	Annex 1- Proposed new ToR - Oxfordshire Health Wellbeing Board_6th Oct FINAL Annex 2 - ICP Draft Terms of Reference Working Draft FINAL.
Background papers:	Health and Care Act 2022 https://www.legislation.gov.uk/en/ukpga/2022/31/section/25/enacted#section-25-4 https://www.gov.uk/government/publications/health-and-wellbeing-boards-draft-guidance-for-engagement/health-and-wellbeing-boards-draft-guidance-for-engagement#summary
Contact Officer:	David Munday, Consultant in Public Health, david.munday@oxfordshire.gov.uk 07922 849652

October 2022

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Oxfordshire Health & Wellbeing Board Terms of Reference

1. Health & Wellbeing Board

The Oxfordshire County Council and NHS have a duty to establish a Health & Wellbeing Board[1]. The Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county.

2. Role and Function

The Health & Wellbeing Board will have the following responsibilities:

(1) Create and own a single unifying vision for the improvement of the Health and Wellbeing of Oxfordshire residents;

(2) Create, own and monitor a comprehensive high-level Joint Local Health and Wellbeing Strategy[2] for the improvement of the Health and Wellbeing of Oxfordshire residents;

(3) Agree a suite of strategies which will be created and monitored by its sub-committees and sub-groups. These will flow from the overarching Joint Local Health and Wellbeing Strategy;

(4) Monitor the implementation of its strategies and the member organisations will hold one another to account for delivery. The Board will receive regular reports from its sub-committees and sub-groups based on outcome measures set by each;

(5) Prepare a Joint Strategic Needs Assessment,[3] to describe the health needs of the population and help to determine the priorities and objectives for health and social care services across Oxfordshire, and a Pharmaceutical Needs Assessment[4] to assess and set out how the provision of pharmaceutical services can meet the health needs of the population for a period of up to three years, linking closely to the Joint Strategic Needs Assessment;

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[1] The Board is a committee of the Council by virtue of the Health & Social Care Act 2012 and the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013

[2] In accordance with sections 116 and 116A of the Local Government and Public Involvement of Health Act 2007

[3] In accordance with sections 116 and 116A of the Local Government and Public Involvement of Health Act 2007

[4] National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

(6) Oversee the joint commissioning arrangements for health & social care across the county and be the accountable body for the Better Care Fund;

(7) Maintain oversight of the commissioning intentions of both the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) and the Council;

(8) Generally exercise the functions of the Council and its partner ICB under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007 ("the 2007 Act");

(9) Exercise any other functions of the Council which may be delegated to the Board (other than the functions of the authority by virtue of section 244 of the National Health Service Act 2006);

(10) Encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in its area;

(11) Provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services;

(12) Establish and monitor Partnership Boards as required to help deliver required service change and improved outcomes.

Additionally, the Board may:

(13) Encourage persons who arrange for the provision of any health-related services in its area to work closely with the Health & Wellbeing Board;

(14) Encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together;

(15) Give the Council its opinion on whether the authority is discharging its duty under section 116B of the 2007 Act;

(16) Receive annual reports from Adult Safeguarding Board(s) and Children Safeguarding Board(s).

3. **Membership**

The rules on political proportionality do not apply to the Health & Wellbeing Board nor to any sub-committees set up by it. The Health and Wellbeing Board will involve Integrated Care System and wider partners. The membership[5] of the Health & Wellbeing Board will be:

[5] *The membership is to be interpreted as the membership specified by Section 194 of the Health and Social Care Act 2012*.

(1) Leader of the County Council – Chair;

(2) ICB Clinical Lead with Oxfordshire responsibilities;

(3) One representative from each of the District and City Councils within Oxfordshire County Council's area;

(4) Cabinet Members of the County Council with responsibility for Adult Social Care, Children & Family Services and Public Health;

(5) Place Director Oxfordshire ICB;

(6) Chief Executive Oxford University Hospitals NHS Foundation Trust;

(7) Chief Executive Oxford Health NHS Foundation Trust;

(8) Chief Executive Oxfordshire County Council;

(9) One Chief Executive representative from City & District Councils;

(10) A Healthwatch representative;

(11) The Director for Children's Services;

(12) The Director for Adult Social Care;

(13) The Director of Public Health;

(14) An NHS England representative;

(15) One Primary Care provider representative;

(16) Such other persons, or representatives of such other persons, as the local authority thinks appropriate with the proviso that once the Board is established, the Board will be consulted before such appointments are made;

(17) Such additional persons as the Health & Wellbeing Board may determine.

Note: Vice-Chair to be nominated by ICB between their two Board representatives.

4. Chairing of Meetings

Meetings of the Board will be chaired by the Leader of the County Council and the Vice-Chair will be the Clinical Lead in ICB for Oxfordshire Place as notified to the Monitoring Officer. In the absence of either of these persons, the Board will elect a chairman for the duration of the meeting unless or until the Chairman or Vice-Chairman arrive, in which case the Chairman or Vice-Chairman will preside as appropriate.

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5. Voting Rights

All members of the Board or of any sub-committee or sub-group (or of any joint sub-committee of two or more such boards) shall be treated as voting members of the Board or sub-committee or sub-group, unless the Council decides otherwise in any particular circumstance. In which case, before making such a direction, the Council must consult the Board.

Decisions will be taken by the majority of those present and voting and the Chairman of the Board (or sub-committee or sub-group) will have a second or casting vote.

Notwithstanding the voting rights of members of the Board (or any sub-committee or sub-group), the meeting will reach its decisions by consensus where possible.

Virtual attendance

Board Members are required to attend formal Board meetings in person. Guest speakers and report authors may use hybrid/virtual meeting arrangements to participate at the meeting.

Public statements

Members of the public can make their statements in person or via hybrid/virtual meeting arrangements.

6. Validity of Proceedings

The Health & Wellbeing Board (and any sub-committees or sub groups) will operate according to the Council's Constitution and also according to the Terms of Reference for the Board itself.

As a committee of the Council, except where set out in these Terms of Reference the convening and conduct of meetings will be in accordance with the Council Procedure Rules approved by the Council.

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7. Cabinet and Scrutiny

The Cabinet may delegate functions to the Health & Wellbeing Boards and may receive recommendations from the Board.

The Health & Wellbeing Board is subject to scrutiny (but not to call-in except in respect of any functions delegated by the Cabinet) by the Council's Joint Health Overview & Scrutiny Committee and, as appropriate, the People Overview and Scrutiny Committee.

The Board may also ask a Scrutiny Committee or, with the relevant Portfolio Holder's permission, a Cabinet Advisory Group, to investigate issues relevant to both the Board and the committee or group.

The Board will make an annual report on its work to both the Council, to

Cabinet and to the Joint Health Overview & Scrutiny Committee.

8. Code of Conduct

All voting members of the Board (and its sub-committees or sub-groups) are subject to the County Council's Members' Code of Conduct. This includes the requirement to register Disclosable or Registerable Interests and to declare them, as appropriate at meetings. Should a member have a Disclosable Pecuniary Interest in a matter before the Board (or sub-committee or sub-group), then the member (unless a dispensation has been received) should declare it and withdraw from the meeting, taking no part in the discussion or voting upon that item.

9. Substitution

Members of the Board may arrange for a substitute to attend on their behalf. However, any substitutes should reflect the seniority and status of the member making the substitution. Substitutions should be communicated to the Chair of the Board in advance of the meeting.

Quorum

Decisions should not be taken other than by the properly constituted Board; this means that at least a quarter of the original voting membership of the Board should be present when decisions are made.

10. Transparency and Openness

The Health & Wellbeing Board will meet in public at least four times a year. The Board may meet informally, and not in public, at other times e.g. for purposes of informal group discussion, board learning & development and workshops.

The public's rights of access to the Board's public meetings will be subject to the Access to Information Procedure Rules (Part 8.1 of the Council's Constitution). These make provisions for the giving of public notice of meetings, access to agendas, reports and minutes, the supply of copies of such papers, the inspection and purchase of background papers and the circumstances in which the public may be excluded from meetings by virtue of the consideration of confidential or exempt information.

In addition, the Freedom of Information Act 2000 gives a general right of access to information held by public authorities and will extend to information generated by, or for, the Board and held by any public authority.

11. Sub-Committees and Sub-Groups

The Health & Wellbeing Board will be mindful of its powers to appoint one or more sub - groups or sub-committees to discharge of any of its functions, with certain conditions. The Board may also appoint advisory groups, working groups or informal 'task and finish groups' to make recommendations to it on any of its functions.

Annex 1 sets out the provisions relating to the appointment of sub-committees and informal working groups and therefore to the appointment of any Partnership Boards and a Reference Group.

Annex1

Appointment of Sub-Committees and Sub-Groups

The Health & Wellbeing Board may appoint sub-committees or sub-groups. The Board may appoint one or more sub-committees or sub-groups to discharge of any of its functions, with the following conditions:

(1) Where any functions may be discharged by the Board under 3(2) above, by virtue of section 196(2) of the Health & Social Care Act 2012, (i.e. functions that are exercisable by the authority), then unless the Council otherwise directs, the Board may arrange for the discharge of those functions by a sub-committee of the Board, or an officer, or both.

(2) Where the Board discharges functions by virtue of any other enactment that section 196(2) of the 2012 Act, then unless the Council directs otherwise, the Board may arrange for the functions to be discharged by a sub-committee of the Board.

In addition, the Board may appoint one or more sub-committees or sub-groups to advise the Board with respect to any matter relating to the discharge of the Board's functions.

The membership of any sub-committees or sub-groups will be for the Board to determine. The sub-committees and sub-groups will operate according to this Constitution and also according to their Terms of Reference as established by the Board.

A meeting of the any sub-committee or sub-group shall not be quorate unless at least a quarter of its voting members are present for the duration of the meeting.

As a sub-committee of the Council, the convening and conduct of meetings will be in accordance with the Council Procedure Rules approved by Council.

Sub-Groups may include advisory or working groups and other such informal task and finish groups, to assist with any of the Board's functions.

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Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Partnership (ICP) Terms of Reference

Table of Contents

1. Establishment

1.1 Statutory joint committee: The Buckinghamshire, Oxfordshire and Berkshire West (each a "Place") ("BOB") Integrated Care Partnership ("ICP"), is formed in accordance with s.116ZA, Local Government and Public Involvement in Health Act 2007 ("LGPIHA") (introduced by s.26, Health and Care Act 2022).

The 'responsible local authorities' (s.103, LGPIHA) within the BOB Integrated Care System ("ICS") area are Buckinghamshire Council, Oxfordshire County Council, Reading Borough Council, West Berkshire Council, Wokingham Borough Council (each an "LA", and together "the LAs").

The ICP is a statutory joint committee of the BOB Integrated Care Board ("ICB") and the LAs.

1.1. Terms of Reference:

1.1.1. Definition: The Terms of Reference (ToRs) for the ICP are defined by the ICB and the constituent councils and may be amended by them at any time.

1.1.2. Review: The Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the Terms of Reference will be submitted to the Board and councils for approval.

2. Aims, authority, accountability, reporting and authority to act

2.1 The overall aim of the ICP is to deliver the expectation set out in the joint declaration between NHS England and the Local Government Association (March 2022) that it shall 'drive the direction and policies of the Integrated Care System (ICS)' for BOB.

2.1. Specifically, the ICP will also help deliver the four ICS aims:

ICS aims	Description
Improve outcomes	Improve outcomes in population health and healthcare
Reduce inequalities	Tackle inequalities in outcomes, experience and access
Provide value	Enhance productivity and value for money
Support the local area	Help the NHS support broader social and economic development.

2.2. Accountability and reporting: The Committee is accountable to:

2.2.1. ICB

2.2.2. Local authorities, who are responsible for social care and shall report to them on a regular basis on how it discharges its responsibilities.

2.3. Authority to act: The Integrated Care Partnership has authority under the Health and Care Act to exercise its function as a statutory joint committee of the ICB and local authorities.

The Committee is authorised to:

Authorised activity	Description
Create ICP committees and groups	Create committees and task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and Terms of Reference of any such committees and groups task
Seek information	The ICB and each local authority shall consider any requests by the Committee for disclosure of information that reasonably relates to any item of business considered by the Committee. Such disclosure shall have regard to the normal FOI exceptions and commercial or political sensitivity.
Commission reports	Commission reports it deems necessary to help fulfil its obligations.
Obtain advice	The ICP may use independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the ICB for obtaining legal or professional advice.
Investigate activity	**Investigate** activity within its Terms of Reference.

3. Principles

In everything it does, the ICP will uphold the ICS principles:

Theme	ICS partnership principles from the ICS design framework
Improved outcomes focus	• **Improved outcomes:** Focus on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives, and reduced health inequalities.
Subsidiarity	• **Triple aim, cooperation and subsidiarity:** Support the triple aim (better health for everyone, better care for all and efficient use of NHS resources), the legal duties on statutory bodies to co-operate and the principle of subsidiarity (that decision-making should happen at the most local appropriate level). • **Support for place:** Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
Distributed leadership	• **Distributed leadership:** Come together under a distributed leadership model and commit to working together equally. • **Professional, clinical, political and community leadership:** Draw on the experience and expertise of professional, clinical, political and community leaders and promote strong clinical and professional system leadership.
Collective accountability	• **Collective challenge:** In discussion, operate collective challenge, for shared and individual/organisational contributions to joint objectives. • **Risk/ benefit sharing:** Enable sharing of risks, benefits and support. • **Transparency:** Agree arrangements for transparency and local accountability, including meeting in public with minutes and papers available online. • **Consensus:** Partners will use their reasonable endeavours to seek a consensus between partners, including working through difficult issues where appropriate. .
Innovation and continuous learning	• **Transformation**: Contribute to the transformation of health and care services. • **Innovation:** Enable opportunities to innovate, share best practice and maximise sharing of resources across organisations (additional) • **Continuous learning:** Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries.

4. Duties

The ICP's duties are to:

Duties	Description
Develop the ICP strategy:	Develop an integrated care strategy for BOB ICS, with the agreement of all partners Submit the integrated care strategy it develops to the ICB, local authorities and NHS England. The Strategy will take account of the three Place Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).
Use data	Base the strategy on the best available evidence and data, covering health and social care (both children's and adult social care) and addressing the wider determinants of health and wellbeing including for example, employment, environment and housing issues.
Engage stakeholders	Agree a plan for consulting and engaging the public and communicate to stakeholders in the development of the strategy.
Enhance relationships	Work with the structures in Place (eg Health and Wellbeing Boards, Place Based Partnerships) to enhance relationships between leaders across the health and care system in order to consider best arrangement for its local area. The ICP will seek to complement, but not duplicate, the work of the HWBs and to provide an opportunity to strengthen the alignment of the ICS and HWBs.
Review progress	Monitor the ICBs performance against the strategy. Challenge all partners to demonstrate progress in reducing inequalities and improving outcomes.
Seek assurance	Seek assurance that the integrated care strategy has been developed in an inclusive and transparent way and elements of the strategy have been co-produced with people with lived experience and expertise from professional, clinical, social, political and community leadership.

5. Chair, membership, attendees, sub-groups

The ICP has the following arrangements:

Arrangement	Description
Chair	The Chair will be elected by the six founding ICP members. This would be for a 1-year term which could be renewed once (maximum of 2 years). References to Chair in these ToRs are to the Chair of the ICP or to the Chair of a Meeting (if different) as the context requires.
Deputy Chair	A Deputy Chair will be elected by the six founding ICP members. The Deputy Chair shall be from a different founding member body or Place to the elected Chair. This would be for a 1-year term which could be renewed once (maximum of 2 years).
Membership	**Statutory founding members:** • An identified representative of the ICB • Elected member from Buckinghamshire Council • Elected member from Oxfordshire County Council • Elected member from Reading Borough Council • Elected member from West Berkshire Council • Elected member from Wokingham Borough Council **Other members:** • Two elected members from Buckinghamshire Council • Two elected members from Oxfordshire councils (to include at least one elected member from City/District councils) • One member from an Acute NHS Provider* • One member from a Mental Health NHS Foundation Trusts* • One member from South Central Ambulance Service NHS Foundation Trust • Two members from primary care; one to be a GP * • Three Directors of Public Health • One member from Healthwatch • One member from the BOB VCSE Alliance • One member from the Oxford Academic Health Sciences Network (AHSN) • One member representing care sector providers (with no direct financial interest)

- One member representing child and adolescent mental health

(These four members from NHS providers must between them cover the three Places)

In attendance/non-voting

- ICB Chief Executive Officer
- One Director of Adult Social Care (DASS) **
- One Director of Children's Services (DCS) **–

**Each to be from different Place

Attendees	Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff and individuals to attend the meeting (for all or part of a meeting) as necessary in accordance with the business of the Committee. Such attendees will not be eligible to vote. Opportunities will be created for members of the public to attend and be given opportunity to speak at selected meetings.
ICP sub-groups	It is expected that sub-groups operating on a task and finish basis alongside dedicated workshops, dedicated public meetings and other methods to be used for broader stakeholder participation and to include views and needs of patients, carers, the social care sector.
ICP Assembly	The ICP proposes to develop an inclusive Assembly that meets twice a year; approach TBD
Stakeholder Participation	It is anticipated that Task and Finish Groups - alongside dedicated workshops, dedicated public meetings and other methods – will be used for broader stakeholder participation and to include views and needs of patients, carers, and the social care sector.

Each ICP member ("Member") shall identify a named Substitute to attend a Meeting if they are unable to. Where relevant, references in these ToR to "Member" include a Substitute attending in place of that Member.

6. ICP meetings

This section on ICP meetings describes the requirements for:

- Frequency of meetings, chair role and procedure in chair absence
- Attendance, conflicts of interest and quoracy
- Voting, EDI and transparency

6.1 Frequency, chair role, procedure in chair absence

	Description
Meeting frequency	The ICP will meet at least three times a year and at each Meeting will agree/review the ICP Strategy and review performance and progress.
Virtual meetings, extra-ordinary meetings and notice of meetings	(i) • **Virtual meetings:** The Committee may meet virtually (to include any method agreed by the Chair) and members attending using electronic means will be counted towards the quorum. • **Extraordinary meetings** may be held at the discretion of the Chair. • **Notice** A minimum of five working days' notice should be given when calling any meeting, unless the Chair authorises otherwise in exceptional circumstances.
Chair role	The Chair is responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.
Procedure in chair absence	In the absence of the Chair and Deputy Chair,, or if the Chair and Deputy Chair has a precluding interest, the remaining members present shall elect one of their number to Chair the meeting.

6.1. Attendance, conflicts of interest, and quoracy

	Description
Attendance record and procedure for absence	**6.1.1. Attendance record:** Committee members are expected to make every effort to attend meetings and come prepared. **6.1.2. Procedure for absence:** If unable to attend, members must send their apologies to the Chair and Secretary prior to the meeting and may be represented by their named substitute. In the case of members the deputy may speak and vote on their behalf and will count towards the quorum where necessary.

Conflicts of interest: All Members shall behave in a manner complying with the Principles of Public Life (the "Nolan Principles").

Declarations: All members and those in attendance must at the start of the meeting, declare any conflicts of actual or potential conflicts of interest (even if such a declaration has previously been made) pertaining to the agenda. This will be recorded in the minutes and on the register of interests. See ICB conflicts of interest policy.

Exclusions: The involvement of anyone with a conflict will be managed in line with the conflicts of interest policy by the Chair including exclusion from the discussion if necessary.

Disqualifications: If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

Quoracy and procedure for non-quoracy	**6.1.3. Quoracy:** The quorum of the Committee is a minimum of twelve (50%) members, including at least one representative from the statutory partners, i.e. at least one from the ICB and one from each of the five founding councils. **6.1.4. Procedure for non-quoracy:** If the Committee is not quorate then the meeting may proceed if those attending agree, but no decisions may be taken, or the meeting may be postponed at the discretion of the Chair.

6.2. Voting, Equality, Diversity and Inclusion (EDI) and transparency

Meetings will be transparent, with clear decision-making, which demonstrates equality, diversity and inclusion.

Description

6.2.1. Voting Eligibility: Only members of the Committee may vote. Each member is allowed one vote.

6.2.2. Decisions: Decisions will be guided by national policy and best practice. Decisions will be taken by consensus. When this is not possible the Chair may call a vote. A decision would require a majority of ICP members and a majority of the six founder members. Where the founder member majority is not achieved, the proposal to be resubmitted at a further meeting, having worked to address the key concerns of founder members wherever possible. The chair may have a casting vote, if members are equally divided on an issue.

6.2.3. Recording of votes: The result of the vote will be recorded in the minutes.

6.2.4. Virtual voting: If a decision is needed which cannot wait for the next scheduled meeting and it is not appropriate to call an extraordinary meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email, or other electronic communication. LEGAL NOTE: TBC if suitable arrangement

Equality, Diversity and Inclusion	Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

Meeting transparency: All Meetings will be held in public, and papers made available online unless an exemption provision applies to any item of business (in which case the determination of 'exempt information' will be guided by the definitions contained in the Local Government Act 1972 Schedule 12A, for example personal data and the financial or business affairs of any person).

Where minutes and reports identify individuals, they will not be made public.

7. Working arrangements

The ICP working arrangements will:

	Description
Complement Health and Wellbeing Boards	The ICP will complement, not duplicate, the work of the Health and Wellbeing Boards and provide an opportunity to strengthen the alignment of the ICS and Health and Wellbeing Boards. The ICP strategy will take account of the Health and Wellbeing Boards' Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS).
Evolve	Working arrangements are likely to evolve in line with the scope and nature of the ICP activities.
Be jointly resourced	All ICP members and partners are expected to contribute to the needs of the ICP. Where the Committee's requirements involve the partners in incurring unreasonable and/or unfunded expenditure (such as research or the resourcing of the Secretariate) then such costs will be met by the ICB in line with the 'new burdens' policy.
Be agreed and documented	Working arrangements will be agreed, documented and continually updated - the full detail of the ICP's working arrangements can be seen in Appendix I.

8. Secretariat and administration

The ICP will be normally provided with a Secretariat by the body that holds the Chair for the duration of such Chairing. The Chair may however request other founding members to contribute personnel to the Secretariat at his/her discretion. All reasonable costs for the Secretariate will be met by the ICB.

The role of the Secretariate will include the following functions:

Functions	Description
Distribute papers	Prepare the agenda and papers and distribute them in good time before meetings (and not less than five working days) after agreement by the Chair and the relevant lead officer.
Monitor attendance	Monitor the attendance of those invited to each meeting and highlight to the Chair those that do not meet the minimum requirements.
Maintain records	For example, conflicts of interest and members' appointments and renewal dates.
Take minutes	Take good quality minutes and agree them with the chair. Keep a record of matters arising, action points and issues to be carried forward.
Provide updates	Update the Committee on pertinent issues/ areas of interest/ policy developments.

Appendices

I. Document management
II. Working arrangements

Appendix I: Document management

Revision History

Version	Date	Summary of Changes

Approved by

This document must be approved by the following:

Name	Title	Signature	Version	Date

Document control

The controlled copy of this document is maintained by BOB ICP. Any copies of this document held outside of that area, in whatever format (e.g., paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

Appendix II: Detailed ICP working arrangements

TBD

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS

ICB and ICP Update

Oxfordshire Health & Wellbeing Board

October 2022

Agenda Item 8

Update Topics

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

- ICP/ICB Governance
- ICP interim strategy development update on progress
- ICB engagement strategy update

ICP/ICB governance update

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Key definitions

Integrated care system (ICS)
A partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area

Integrated care partnership (ICP)
A statutory committee jointly formed between the NHS integrated care board and all local authorities with public health and social care responsibilities in the ICS area

Integrated Care Board (ICB)
A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area

ICP/ICB governance update

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- ICP founder members agreed ICP Committee membership and first meeting of ICP planned for October
- Founder member roles for ICP strategy development and ICP secretariat being confirmed.
- ICB Establishment Board 1 July, next meeting in public 27 September 2022
- ICB Board Assurance Sub-Committees first meetings in August- October
- Place Based Partnerships

ICB Establishment 1 July 2022

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Board meeting held
  - Governance arrangements agreed
  - 2022/23 Operational and Finance Plan, BOB Green Plan and System Delivery Plan received
- Papers for the ICB meeting on 27 September will be available here
- Website for the ICB (www.bucksoxonberksw.icb.nhs.uk) in development, currently contains core information including
  - Information about the Board and board members
  - Board members
  - Governance documents/arrangements
  - Contact information

ICB Board Members

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Role	Post holder
Chair	Javed Khan OBE
Chief Executive	Dr James Kent
Partner Member – NHS Trusts	Steve McManus
Partner Member – Primary Care	Dr Shaheen Jinah
Partner Member – Local Authorities	Stephen Chandler
Non-executives	Saqhib Ali Margaret Batty Tim Nolan Aidan Rave Sim Scavazza
Chief Finance Officer (interim)	Richard Eley
Chief Medical Officer	Dr Rachael De Caux
Chief Nursing Officer	Rachael Corser
Member for Mental Health	Dr Nick Broughton
Associate NED (Digital)	Haider Hussain

Development of Place Based Partnerships

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- ICS made up of three smaller areas known as places
- Place arrangements will evolve over time, with all three Place Directors starting early October
- Place strategies guided by health and wellbeing board plans and NHS Long Term Plan
- Councils and Trusts asked to devolve decision making to their representatives on Place-Based Partnerships
- Update paper presented to ICB Board on 27 September
- Place role in operational oversight and strategic development for:
  - Reduce health inequalities
  - Address wider determinants of health and prevent major illnesses (CVD, Cancer, Mental Health)
  - Urgent and Emergency Care
  - Primary medical care and community services integration
  - Adult mental health, learning disability and autism
  - Child and adolescent mental health, learning disability and autism
- Pooled funding arrangements incorporated and/or continued where appropriate

Working with people and communities approach

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- ICB wants effective engagement and partnership at the heart of its thinking, planning and delivery
- First draft developed in consultation with range of groups
- Draft submitted to NHSE and presented to ICB Board on 1 July
- ICB worked with partners to create proposed framework for practical actions and update to ICB Board on 27 September

Interim ICP strategy development update

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Strategy working group continues to meet with a broad executive representation from across BOB
- Guidance issued on ICP strategy content by Department of Health and Social Care in late July
- Thematic review completed and agreed Task and Finish groups
- Task and Finish Groups to identify a smaller number of areas which would benefit from all ICP partners working together to achieve better outcomes for our population.
- Project plan developed so ICP strategy can go to NHS England, the ICB and Local Authorities no later than 31 December 2022

ICP strategy – Dept of Health & Social Care Guidance

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

- Recognises a year of transition so allows for initial strategy in December 2022 to be updated in 2023

- ICP to consider population joint strategic needs assessment, Health and Wellbeing Board strategies and NHS Mandate, and to involve Healthwatch to prepare ICP strategy

- ICP to consider whether needs can be met more effectively under s75 arrangements and a statement on better integration

ICP Strategy working groups

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Review of HWB strategies and NHS Long Term Plan identified 6 thematic ICS working groups

1. start well
2. live well
3. age well
4. promoting healthy lifestyles
5. health protection
6. demand management

The working groups will recommend priorities to the ICP Board and describe how these priorities can be driven forward taking into consideration:

- Research and innovation
- Health inequalities
- Workforce
- Data and information sharing
- Opportunities for s75 pooled budgets and further integration

Proposed strategy working groups and proposed leads

The working groups will be chaired with executives from across the ICS and the initial themes for consideration have been arrived at from the review of the HWB strategies, NHS local strategies and the NHS mandate as required in the national guidance.

1.Start Well Chair: Kevin Gordon	Maternity & Neonatal
	Early years development
	Children and Young People Mental Well being (inc CAMHS)
	Enhancing healthy lifestyles (e.g. Nutrition and healthy weight)
2. Live Well Chair: Ansaf Azhar	Cancer
	Screening
	Adult Mental Health & Loneliness
	Cardiovascular Disease
3. Age Well Chair: DASS to be confirmed	Long term conditions (inc. carers, out of hospital care & frailty)
	Adult Mental Health, Dementia & Loneliness
	End of Life care
4. Promoting Healthy Lifestyles Chair: Ingrid Slade	Tobacco control and smoking
	Drugs & Alcohol
	Healthy eating, healthy weight
	Physical activity
5. Health Protection Chair: Tracy Daszkiewicz	Pandemic preparedness
	Immunisation, infection prevention and control
	Health hazard preparedness
6. Demand Management Chair: Matthew Tait	Elective & Diagnostics (inc. cancer)
	Urgent & Emergency care (inc. ambulance & discharge)
	Primary Care (incl. Dentistry and pharmacy)

Our approach to outlining the system-wide opportunities

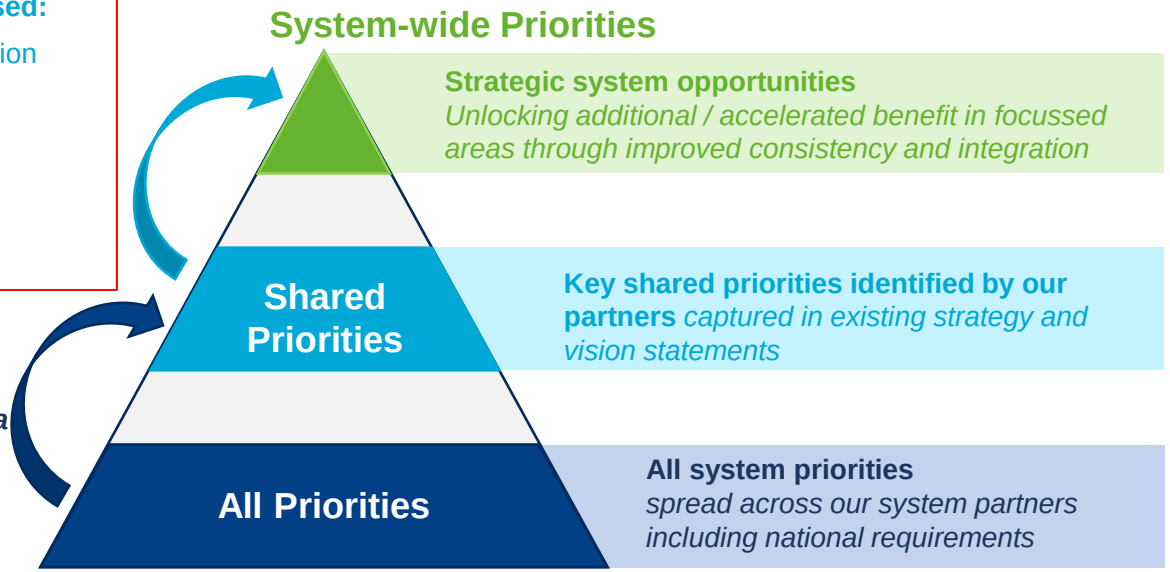
We are not starting from a blank sheet - the opportunities have been derived from strategy documentation and priorities (national and local) and thinking that currently exists across the system (see Phase1).

Phase 2: Cross system working groups mobilised:

- Current state - What are the challenges, population needs, inequalities
- Future demand and target outcomes
- What are the opportunities - How can integrated working accelerate or improve outcomes
- Propose system-wide priorities

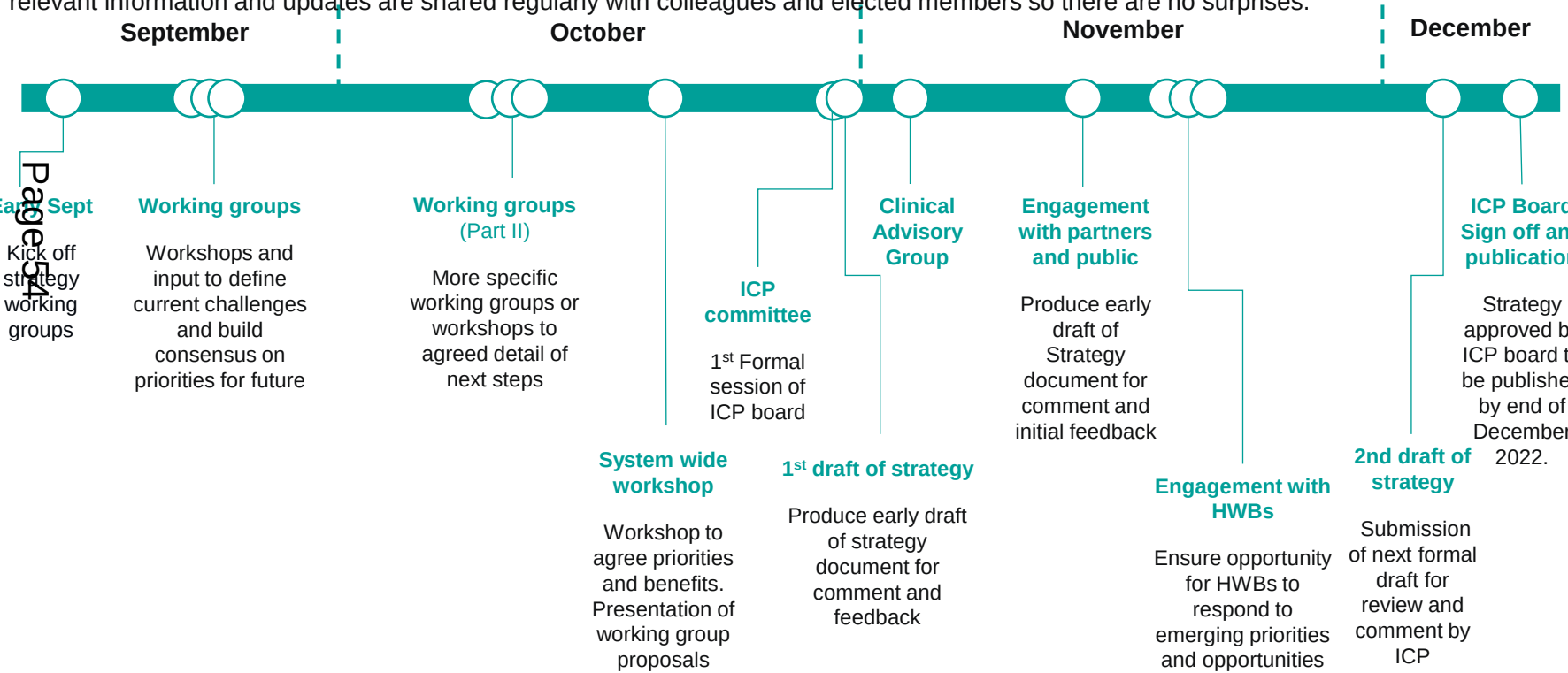
Phase 1: Identifying shared priorities *(complete)*

- ✓ *Review of **input documentation** and **base data***
- ✓ *Working with **Strategy Steering Group & stakeholders***
- ✓ *Creation of "**starter for 10" of the opportunities for the system***



Proposed timelines and approach – to be confirmed by ICP

The 2022 Health & Care Act requires the ICP to prepare an ICP strategy. The DHSC guidance issued in July sets out further details on requirements including publication dates. Steering group members have been tasked with working closely with their organisations to ensure relevant information and updates are shared regularly with colleagues and elected members so there are no surprises.



Oxfordshire Health and Wellbeing Board
6 October 2022

Oxfordshire Joint Strategic Needs Assessment 2022 update

Report by Corporate Director of Public Health & Community Safety, Oxfordshire County Council

RECOMMENDATION

The Health and Wellbeing Board is RECOMMENDED to

a) Note the content of the Joint Strategic Needs Assessment for 2022 and encourage widespread use of this information in planning, developing and evaluating services across the county.

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

Introduction

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

2. Producing the JSNA is a collaborative project with contributions from many analysts and sector specialists from Oxfordshire's Local Authorities, NHS, Thames Valley Police, Healthwatch Oxfordshire and Voluntary Sector organisations.

3. In addition to local datasets, the report makes use of data from NHS Digital, the Office for National Statistics and the Office for Health Improvement & Disparities. Datasets can take time to process, which means that this 2022 JSNA update includes information from 2020 as well as more recent data from 2021 and 2022. Only limited data is available at this stage from Census 2021 due to the release timings from the ONS.

4. It is important to note that the JSNA does not include information about services needed to support the health and wellbeing of the population and, in some cases, the data may not be recent enough to reflect changes in services.

5. This paper gives an overview of the key findings from the 2022 Oxfordshire JSNA and plans for the continued development of JSNA resources.

Key findings from the 2022 update of the JSNA

6. A one-page summary of the facts and figures from across the life course in the JSNA 2022 are provided in Annex 1.

7. The Board's attention is also drawn to the following key findings from the JSNA 2022

8. **Overall, Oxfordshire has a growing and ageing population. The number of young children aged under 5 has declined, most significantly in Oxford City.**

   - The first Census 2021 results show that, over the 10-year period, 2011 to 2021, Oxfordshire's population increased from 653,800 to 725,300, up by 10.9% (+71,500). This was above the growth across England of 6.6%.
   - The number of older people aged 65 and over in Oxfordshire increased by 25% (+25,900).
   - The number of young children aged under 5 declined by 8% (-3,100).

9. **The COVID-19 pandemic has had both direct and indirect impacts on health and wellbeing. Often these impacts are felt more acutely by those already experiencing poorer health outcomes or health inequalities.**

   - **Direct** - as a result of COVID-19 infection:
     - Between March 2020 and March 2022 in Oxfordshire, there was a total of 211,588 confirmed cases of COVID-19 and 1,273 deaths with COVID-19 on the death certificate.
   - **Indirect** - including:
     - **Mental health** - services have seen growing numbers of mental health referrals, especially for young people, and increasing numbers of children with social, emotional and mental health needs. The latest ONS measures of personal wellbeing (2020-21) for Oxfordshire show a decline in reported happiness and an increase in anxiety. The average level of anxiety in Oxfordshire has remained above the England average.
     - **Physical activity** - in trends likely to be affected by a change in the number of people working from home, adults walking and cycling for travel (rather than leisure) has decreased in all areas of Oxfordshire over the past 3 years (2018 vs 2021).
     - **Unemployment** - the number of people claiming unemployment benefits in Oxfordshire has reduced significantly since the peak in May 2020 but remain around 85% above pre-pandemic levels.
     - **Domestic abuse** – the number of police-recorded victims of domestic abuse increased in 2020 and again in 2021 with the greatest increases in Cherwell and Vale of White Horse districts.
     - **Volunteering** - nationally, the proportion of people participating in formal volunteering has dropped significantly. Oxfordshire

projects have reported a reduction in the number of older people volunteering.

- Ofcom research indicates that the pandemic has created an even greater **digital divide**.
- The **dementia** diagnosis rate has not yet recovered to pre-pandemic levels and the number of dementia referrals has increased significantly.

10. **Non- communicable diseases such as Cancer and Cardiovascular Disease remain the leading causes of death. For the three years 2019 to 2021, COVID-19 accounted for 5% of deaths in Oxfordshire. Excess deaths from causes other than COVID-19 were above average in Cherwell and Vale of White Horse.**

- Oxfordshire's leading cause of death (2019 to 2021) was *Cancer*, followed by *Heart Disease* for males and *Dementia & Alzheimer disease* for females. COVID-19 accounted for 5% of deaths in this period.
- From March 2020 to December 2021, Oxfordshire had a total of 1,138 excess deaths (11.5% of total deaths). The districts with the highest rates of excess deaths were Cherwell and Vale of White Horse which were each above the national average. In each of these districts there was a higher proportion of excess deaths due to causes other than COVID-19.

11. **On most county-wide indicators of health and wellbeing, Oxfordshire is rated as better than or similar to average. Exceptions, i.e. where Oxfordshire was worse than average, include hospital admissions due to falls, rates of loneliness and GP-recorded rates of cancer and depression.**

- In 2020-21 the rate of hospital admissions due to falls in Oxfordshire was above (worse than) the national average. Oxford City has had a consistently high rate of admissions due to falls, the rate in Cherwell has seen a recent and significant increase.
- Adults in Oxfordshire were significantly more likely to feel lonely than average, with the highest rates in Oxford City and Cherwell. The large-scale GP patient survey shows Oxfordshire as above-average on people feeling "isolated from others".
- GP-recorded rates of cancer and depression were each above average in 2019-20 and again in 2020-21.

12. **Although ranked as healthy overall, Oxfordshire has areas with poorer health outcomes, many of which are also ranked as deprived. National data shows that lower income households are being disproportionately affected by rising prices.**

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

- In Oxfordshire's most deprived areas, just over a third (36%) of pupils were eligible for Free School Meals. In the least deprived areas of Oxfordshire the rate was 7%.
- ONS data from mid-2022, shows that rising prices are having a disproportionate effect on lower income households.

13. **The provision of a wide range of Health and Care services was impacted by the pandemic and the commissioning of services was reorganised in mid-2022.**

- **COVID-19 vaccination** - from December 2020 Oxfordshire operated a major COVID-19 vaccination programme.
- **Preventative services** – many preventative services were reduced or halted by the pandemic including (for example) the NHS Health Check programme. Interventions by School Health Nurses were affected by COVID-19 as the majority of children and young people were not in school from March to June 2020 and staff were redeployed.
- **Primary care** - telephone appointments were higher than face-to-face in early 2020 and remain high. GP Patient Survey 2022 data shows a drop in overall experience of GP practices in Oxfordshire and nationally. Oxfordshire has remained above (better than) average. Fewer respondents have found it 'easy' to get through to their GP by phone.
- **Secondary care** - compared with 2019-20 (pre-pandemic) there has been a significant increase in 111 calls and in outpatient attendances. The rate of A&E attendances is relatively unchanged.
- **Reorganisation** - in July 2022, Oxfordshire Clinical Commissioning Group was dissolved. The new Buckinghamshire, Oxfordshire, Berkshire West Integrated Care Board was established in its place and is now the local NHS commissioning body.

How the findings will be used

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

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

16. 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.

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

18. The JSNA will inform both the developing Integrated Care Partnership Strategy as well future versions of the Health and Wellbeing Board's Joint Local Health and Wellbeing Strategy

Planning the 2023 update to the JSNA

19. The next update to the JSNA will be presented to the June 2023 meeting of the Health and Wellbeing Board.

20. The main development work will start in April 2023 and by that time we expect to have further data available from the ONS Census 2021 survey. This will enable the inclusion of in-depth multi-variate analysis such as: differences in health by age, sex, rurality, disability and ethnicity; the demographic and health profile of carers, armed forces and other groups; the type and size of housing.

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

Financial Implications

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

Legal Implications

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

ANSAF AZHAR CORPORATE DIRECTOR FOR PUBLIC HEALTH

Contact Officer: David Munday
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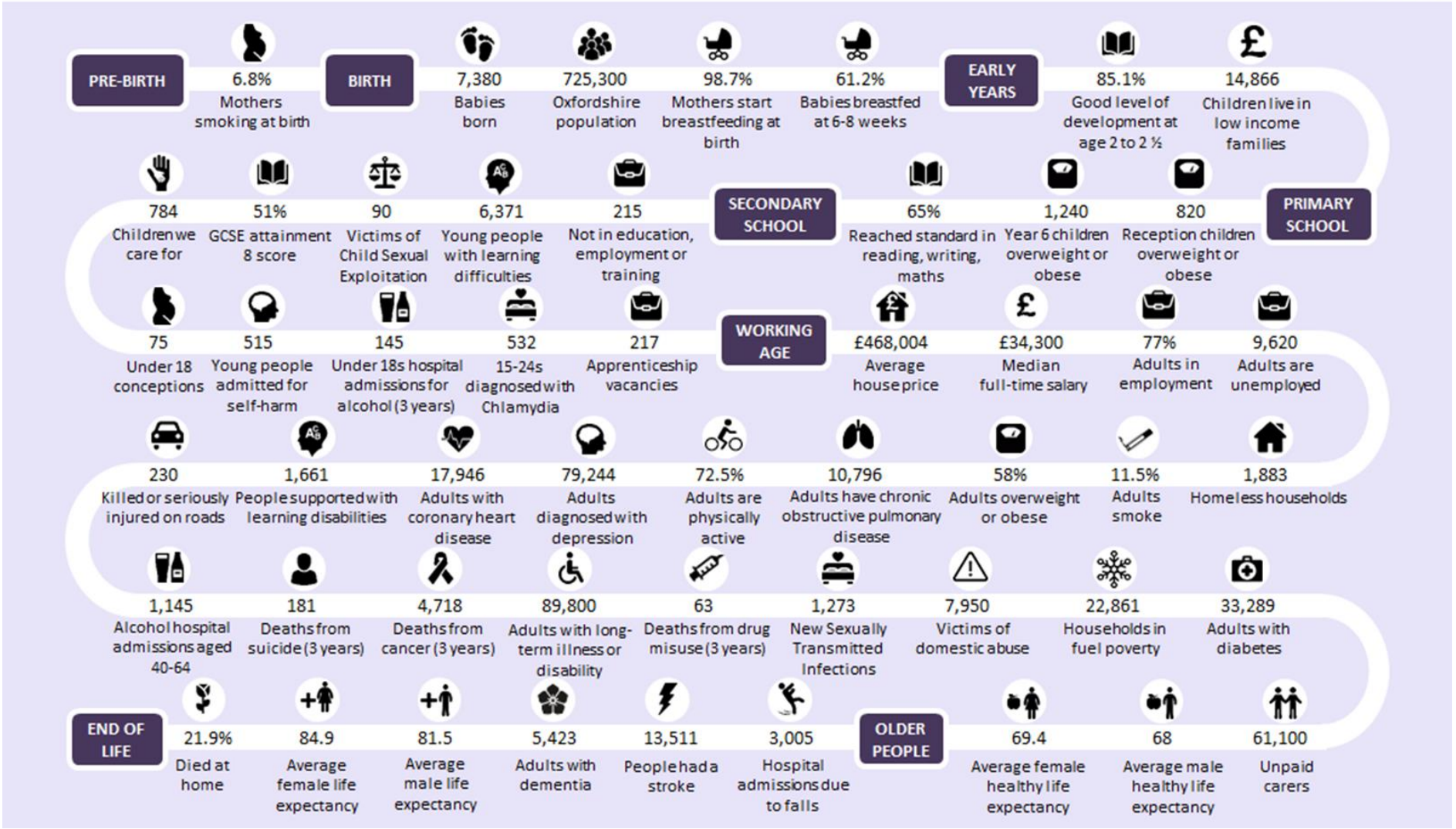
October 2022

Annex 1- Oxfordshire JSNA health and wellbeing facts and figures 2022

Oxfordshire JSNA, health and wellbeing facts and figures 2022



Divisions Affected - ALL

OXFORDSHIRE HEALTH AND WELLBEING BOARD
6 October 2022

Community Profiles for Abingdon Caldecott and 'The Leys'

Report by Corporate Director of Public Health & Community Safety, Oxfordshire County Council

RECOMMENDATION

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

   a) Note the findings and rich insight contained within the Community Profiles

   b) Support the promotion and sharing of the Abingdon Caldecott and 'The Leys' community profiles with partners and colleagues across the system.

   c) Use the insight from the Abingdon Caldecott and 'The Leys' profiles to inform service delivery plans of partner organisations on the Board.

Executive Summary

2. Life expectancy and health outcomes across Oxfordshire are not equal and in our areas with the lowest socioeconomic status, people are experiencing poorer mental and physical health. Inequalities in life expectancy and health are long standing issues but listening to local communities and acting on their insight can help us to change this.

3. The community profiles shine a spotlight on the health enabling assets that can be built on in the Abingdon Caldecott and Leys (Blackbird Leys and Northfield Brook) areas and what needs to change to help address challenges faced by communities. The insight shared about what matters to people has been used to inform a set of high-level recommendations to take forward. A follow up action plan will be produced which will need system wide engagement to enable these changes to be made.

Background

4. The purpose of creating a community profile is to ensure we understand as fully as possible the health outcomes and factors that influence these

outcomes within wards in Oxfordshire where residents are most at risk of poor health, or experience health inequalities. A proof of concept for ward profiles, focussing on the Banbury Ruscote ward was taken to the Oxfordshire Health and Wellbeing Board in June 2020. More details can be found through this link. (from page 47 onwards).

5. We are now working with communities to produce profiles to cover the other 9 wards identified in the Oxfordshire Director of Public Health Annual Report which have the greatest number of small areas ("Super Output Areas") that were listed in the 20% most deprived in England in the Index of Multiple Deprivation update (published November 2019) and are most likely to experience inequalities in health.

6. The Abingdon Caldecott and Leys profiles cover the first 3 of these 9 priority wards and are the areas where this work is currently the most advanced. They have taken the approach of setting up locally based steering groups to help shape the direction of the profiles along with an external organisation capturing the community insight. As noted in the community profile reports, there are limitations to the data, and although the numbers of participants means that insight is not representative of all residents in those areas, they provide valuable insight by enabling the community's voices to be heard.

7. Further profiles will be produced for:

Banbury

- Grimsbury and Hightown
- Banbury Cross and Neithrop
- Ruscote (a refreshed profile jointly with Neithrop)

Oxford City

- Barton and Sandhills
- Rose Hill and Iffley
- Littlemore
- Carfax

The Abingdon Caldecott and The Leys Community Profiles

8. A link to access both full profiles can be found here: Community Insight Profiles | Oxfordshire Insight

8.1 Some of the findings from the community insight report for **Abingdon Caldecott** included:

- 'Local residents noted a range of local groups, services and organisations that are particularly helpful or useful to health and wellbeing.'

- 'The rising cost of living was a commonly expressed concern, with the lack of affordable housing available locally also referred to. People stated that they were

cutting back on certain activities (e.g., leisure activities for children) because of rising prices.'

- 'The need to better understand lived experience was felt to be very important in project design, asking questions such as where are the challenges, where are the blockages: *'am I likely to access the community larder from Caldecott if I have to walk to town with a toddler and then get back to the school in time to pick my kids up?'.'*

- 'There was generally expressed opinion that there is lingering anxiety in the community as a result of the pandemic, and that it had exacerbated isolation and had a negative impact on mental health problems.'

- Recommendations included improving project design and partnership working by building on the strengths of the South Abingdon Partnership, and taking forward a range of potential community action projects such as community food projects, family fun activities and pavement health routes.

8.2 Some of the findings from **The Leys** community insight report included:

- 'Two major themes that came out of the insight gathering was a sense that many people feel there aren't many activities or opportunities that suit them, and a lack of spaces where these could happen.'

- 'There were also issues about how people access the activities that are currently available, in terms of physically getting there, affording any costs, feeling welcome, digital access, or the surrounding support (e.g. childcare) to attend classes or sessions.'

- 'Many responses seemed to contradict each other: for some, it's easy to access healthcare, whereas for others it's very difficult; some people feel very safe, while others don't. This seemed to depend on various factors, including where in the Leys people live, relative to services and transport routes; their socio-economic status, gender, age, ethnicity and position in community (e.g. feeling safe when 'people know me'), and their mobility (e.g. access to a car or buses and/or disability).'

- 'Many Leys residents are frustrated by participating in research and engagement work and seeing no impact as a result. This had contributed to a feeling of being ignored by authorities, and a sense that the Community Profile would be no different. Some participants challenged us on the methods and the overall concept of the insight gathering, and some expressed an urgent need for things to really change as a result of this work.'

- Recommendations included taking forward potential opportunities for healthy food, green spaces, getting active, community spaces and communication and publicity initiatives.

How the profiles will be used

9. The profiles will link to the Joint Strategic Needs Assessment and will be a useful mechanism to pull together all the data and insight available at a local level. This then informs future action planning and the development of key strategies such as the Joint Local Health and Wellbeing Strategy and the Integrated Care Partnership Strategy. It will be shared with relevant partnerships and boards across the local system including the Oxfordshire Health and Wellbeing Board. We anticipate the profile will also be useful for local partners to help with data needed for funding applications, developing local initiatives and communities within those wards.

10. The community insight has highlighted that there is fatigue with community engagement and so it is important that these community profiles influence visible change for local residents. As well as the anticipated longer term strategic action arising from the profiles, it will be important that communities also see some more immediate action. A process will be agreed with the steering groups for each community profile to best utilise a pot of grant funding of £25,000 per ward, to fund local community projects that help meet the recommendations set out in the profiles.

11. The process of producing the profiles was as important as the end product and we are pleased that the two organisations who carried out the community insight will be attending the meeting to talk about their work: Community First Oxfordshire and Oxford Hub.

Next steps

12. The profiles should be viewed as dynamic on-line documents that can be updated with any additional insight or research in the areas as it is produced, as well as national data updates such as from the 2021 Census.

13. The volume of valuable insight has meant that these are long documents to ensure that as much of the community insight as possible can be included. The next steps will include producing an easy read summary version for each profile that will be more accessible.

14. A detailed action plan based on the high-level recommendations from the profiles will also be produced to enable partners to help take forward the recommendations in a structured and collaborative way.

Financial Implications

15. The funding for these two profiles has been committed from within the Public Health grant. The agreed funding is deemed to be split as shown within the table below.

£5,000 per ward for community insight x 3 wards	TOTAL £15,000 (Actual spend)
£25,000 per ward x 3 wards allocated for follow up grant funding	TOTAL £75,000 (Committed spend)
Overall Budget	**TOTAL £90,000**

Comments checked by: Stephen Rowles
Assistant Finance Business Partner for Adult Social Care and Public Health
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Legal Implications

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

Equality & Inclusion Implications

17. These profiles seek to help to address inequalities by providing insight into communities experiencing inequality, to help inform service planning and to act as evidence for funding applications for activities in those areas. There is also £25,000 grant funding available per ward to support immediate projects that help to deliver the recommendations in the profile.

Sustainability Implications

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

Contact Officer: Kate Austin,
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October 2022

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Divisions Affected - All

Oxfordshire Health & Wellbeing Board
6 October 2022

Oxfordshire Better Care Fund Plan 2022/23

Report by Interim Corporate Director of Adult Social Care

RECOMMENDATION

1. **The Health & Wellbeing Board is RECOMMENDED to**
   (a) Approve the Oxfordshire Better Care Fund Plan for 2022/23
   (b) Approve the planned investment and schemes designed to deliver the metrics within the Plan
   (c) Approve the proposed trajectories for the metrics as set out in the Plan

Executive Summary

2. The national conditions for the Better Care Fund in 2022/23 are:
   (a) a jointly agreed plan between local health and social care commissioners, signed off by the Health & Wellbeing Board
   (b) NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
   (c) invest in NHS-commissioned out-of-hospital services
   (d) a plan for improving outcomes for people being discharged from hospital
   (e) additionally, the plan needs to include a demand and capacity template
3. The Better Care Fund planning round for 2022/23 national conditions allow for the plan to be submitted by the deadline of 26 September 2022 and ratified at the next available meeting of the Health & Wellbeing Board.
4. The Oxfordshire Better Care Fund plan meets the national conditions and reflects those strategic plans that have been agreed by the County Council, Integrated Care Board, and system partners in the Oxfordshire Improvement Leadership Board.
5. The Oxfordshire Better Care Fund plan meets the minimum investment criteria
6. The Better Care Fund is intended to support integration and our plan provides evidence of that both in respect of commissioning and operations. The Fund is designed to deliver improved performance against several metrics and these trajectories for these have been approved by the Oxfordshire Improvement Leadership Board who will monitor delivery during the year and are recommended here to Health & Wellbeing Board for approval.

Better Care Fund planning guidance 2022/23

7. The Better Care Fund planning guidance was published on 19 July 2022 and can be found at 2022 to 2023 Better Care Fund policy framework - GOV.UK (www.gov.uk)

8. The Better Care Fund [BCF] is designed to support integration of commissioning and operational delivery and specifically to support the management of demand in the urgent and emergency care system across health and social care. Plans for 2022/23 need to
   (a) Be agreed by ICBs and local authorities and be signed off by Health & Wellbeing Boards
   (b) Demonstrate how Better Care Fund funding streams will be spent to meet the planning requirements. The Better Care Fund consists of
      (1) The CCG mandatory minimum contribution (set nationally by area)
      (2) The improved Better Care Fund
      (3) The Disabled Facilities Grant which is distributed to district council housing teams
   (c) Reflect local health and social care plans and priorities
   (d) Set "stretching targets" for the BCF metrics (see para 17ff below)
   (e) And delivers the BCF policy objectives
      (1) enable people to stay well, safe and independent at home for longer
      (2) provide the right care in the right place at the right time

9. The guidance that has been issued from NHSEI re the scope and emphasis of the plan has emphasised that the plans need to be aligned to and support delivery of local winter/surge plans and that also they should continue to support recovery from the pandemic.
   (a) In 2022/23 there has been limited changes to the BCF policy and planning guidance to provide "continuity to systems during this transitional period"
   (b) NHS England has signalled that from 2023 BCF planning may move to a 2-year planning cycle
   (c) In 2022/23 there is an additional requirement for systems to complete a demand and capacity plan to support achievement of the policy objectives at (8e).

Oxfordshire Better Care plan 2022/23

10. The Better Care Fund Plan as submitted to NHS England is attached at Appendix A (main submission) and Appendix B (narrative). The main submission sets out
   (a) The income within the Plan
   (b) The expenditure on specific schemes funded through the Plan
   (c) The proposed trajectories for the metrics required for the Plan
   (d) Confirmation that we have met the national planning requirements

11. The narrative plan highlights the progress Oxfordshire has made and its future plans in respect of the key requirements in the Planning Guidance:
   (a) Prevention and enablement: supporting people in their own community to manage their own needs through information and advice, strengths-

based approaches and innovation. We are seeking to build on the strengths-based approach set out in the *Oxfordshire Way* and to align our ambition with the development of NHS Social Prescribing

(b) Avoidance: where people are at risk of increased ill-health and loss of independence, Home First approaches and services that will help them remain safely at home and avoid either unnecessary conveyance for assessment, or admission to hospital or escalation to long-term care

(c) Home First approaches to supporting discharge from acute hospital settings through an improved and extended intervention to support people get safely back home where their short and long terms needs can be assessed, and personalised plans developed for recovery and/or care

(d) A comprehensive model of assessment, and rehabilitation and reablement where people need to go home from hospital via a step-down bed in community hospital or nursing home.

(e) Support for the provider market at times of great pressure around workforce and increased costs

(f) Surge planning for winter and other risks

12. The Plan builds on the redesign and integration of commissioning across the County Council and ICB in 2020/21. During 2021/22 this integrated approach has been confirmed and consolidated by both parties and a new s75 NHS Act 2006 pooled budget agreement is due to replace the current version from December 2022 which consolidates these arrangements and provides the governance for the BCF plan and investment.

13. The Plan in 2022/23 includes a demand and capacity plan as set out at Appendix C. In 2022/23 the requirement is to "have completed a plan". It will not be performance-measured as part of assurance. The template is a "work in progress" in that a number of the fields that populate the plan cannot at this point easily be measured and/or the data cannot be extracted from systems in the way it has been prescribed in the planning guidance. NHS England are using this exercise in 2022/23 as a learning piece to improve the demand and capacity expectations from 2022/23 and in Oxfordshire we will continue to develop the plan over the course of Quarters 3 and 4. At present it tells us what we know: that we have significant pressures around supporting people in their own homes, and that we will continue to need to develop a range of different approaches to address these gaps. We have a technical issue in recording the number of referrals to step down beds from hospital that will be resolved in Q3.

14. The Plan is aligned to other key strategic initiatives such as the *Oxfordshire Way* and the development of NHS Social Prescribing and Anticipatory Care Planning in primary care. It complements the system Urgent Care Improvement Implementation Plan and is supported by aligned initiatives within Public Health and with District and City Councils, especially around homelessness and home improvement for people with disabilities. The development of the schemes within the plan has been a partnership exercise involving a wide range of stakeholders from social care, NHS, Public Health, independent care providers and the voluntary and community sector.

15. There will be an opportunity to further integrate our planning approaches in the next planning round from 2023, building on the partnership approach we have

taken in 2022/23, and working on a 2-year planning cycle which should increase scope for impact.

16. The 2022/23 plan is the first that has been developed within scope of the Integrated Care Board and we have worked with colleagues in the other Health & Wellbeing Board areas across Bucks and Berkshire West to understand the pressures and approaches in those systems. This may create further learning opportunities in 2023/24.

17. **Health & Wellbeing Board is asked to approve the Oxfordshire Better Care Fund Plan for 2021/22.**

Investment in Better Care Fund 2021/22

18. The Plan as submitted meets the requirements of the Planning Guidance:

Funding Sources	Income	Expenditure	Difference
DFG	£6,658,544	£6,658,544	£0
Minimum NHS Contribution	£46,696,469	£46,696,469	£0
iBCF	£10,705,289	£10,705,289	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£64,060,302**	**£64,060,302**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£13,267,002
Planned spend	£17,703,190

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£29,321,155
Planned spend	£36,010,693

19. The investment in schemes is set out in the template submission at tab 5a. There are 48 schemes designed to deliver the BCF priorities set out at para 8e above.
    (a) At the time of writing NHS England additional funding for winter capacity around beds that support our ability to move people out of hospital is awaiting confirmation
    (b) In line of this a sum of £945,093 has been set aside to cover this requirement. If the sum is not needed for this purpose it will be used elsewhere to assure resilience of the plan during winter

20. **Health & Wellbeing Board is asked to approve the investment plan for Oxfordshire Better Care Fund Plan for 2022/23.**

Trajectories against the national Better Care Fund metrics

21. The metrics in the Better Care Fund have been changed from 2022/23 and the former "length of stay in hospital" measure has been removed. There are 4 metrics, and our proposed targets are set out in para 22-25

22. **BCF metric 8.1**. The plan sets out a range of *preventative* and *avoidance* measures which will increase our capacity to manage the risk of non-elective admissions to hospital. A number of complementary measures also form part of the system urgent care Integrated Improvement Plan such as the use of virtual wards in the community, and a more integrated response between ambulance and community services to people who fall in their own home. The 2019/20 baseline for non-elective admissions was low owing to the impact of the pandemic response. There was a steep increase in 2021/22, and these pressures have continued. **In view of this we have set a target to reduce by 2% from the 2021/22 performance and achieve a rate of no more than 720 unplanned admissions per 100,000 population over the year.**

23. **BCF metric 8.3.** The current proportion of people discharged home from acute hospital stay in Oxfordshire is 91% against the national target of 95% and our 2021/22 target of 93%. As a system we have worked ceaselessly to create additional capacity in reablement and domiciliary care, and to increase our ability to divert people from formal care when they can in fact live at home with more informal preventative support as in the Oxfordshire Way. Our Home First approach, together with close working with our strategic reablement providers has created a lot of learning and as a system we believe we can improve the current performance through the plans that are in place. However, Oxfordshire retains a large bed base and so anticipate that we will not achieve the 95% national expectation in 2022/23. **We therefore plan to achieve 93% of people admitted to hospital returning directly home on discharge in 2022/23**.

24. **BCF metric 8.4.** Permanent council-funded residential admissions to nursing homes are driven both from the community and as part of hospital discharge. In 2021/22 we had considerable success in reducing early and unnecessary to residential care and improved on our BCF target. This is driven by a strengths-based approach in line with the *Oxfordshire Way* and our use of step-down beds from hospital when we cannot take people directly home: we don't malke the decision to admit too early. We are continuing to work with housing provider partners to make best use of Extra Care Housing as an alternative to long-term care as well as considering the role of equipment and assistive technology to support people in their own homes and communities. We will continue to drive these initiatives and are therefore looking to fund no more than 9 permanent admissions to care homes per week. **We plan for 351 admissions in 2022/23 per 100k of population over the age of 65**.

25. **BCF metric 8.5.** The impact of our Home First and strengths-based prevention work together with the performance of our reablement services in supporting people to independence means that we anticipate that this will mean an **improvement in the numbers of people still at home 90 days after reablement episode to 84%**.

26. **Health & Wellbeing Board is asked to approve the trajectories for the Better Care Fund metrics for 2021/22.**

Governance, assurance and engagement for Better Care Fund Plan

27. The development of the BCF plan has been led by officers from the Bucks, Oxfordshire and Berkshire West ICB and Oxfordshire County Council integrated commissioning team and has been agreed for submission on behalf of the Health & Wellbeing Board by the Corporate Director of Adult Services for the Council and the Chief Executive of the ICB.
28. The detail of the initiatives in for 2022/23 has been developed by the Oxfordshire Urgent Care Delivery Group delegated from the Oxfordshire Improvement Leadership Board. A partnership group of representatives from social care, primary care, Oxford Health NHS FT and Oxford University Hospitals NHS FT, public health, City and District Councils, independent care provider bodies and the voluntary and community sector has worked up the schemes. This work has been overseen by Senior Responsible Officers from NHS and Council.
29. The Better Care Fund plan builds out from a range of existing system wide plans and initiatives which have been developed through different levels of system working.
30. The target metrics in the plan have been reviewed and approved by the Oxfordshire Improvement Leadership Board.
31. The Disabled Facilities Grant narrative builds on the discussions held between District Councils and Oxfordshire County Council's therapy lead and integrated housing occupational therapists.

Financial Implications

32. The investment in the Better Care Fund is made up of agreed budgets contributed to the s75 NHS Act 2006 pooled commissioning budget by the County Council and Oxfordshire Clinical Commissioning Group. The spending plan have been agreed by the County Council and the CCG in the Joint Commissioning Executive. The winter funding element is agreed by the Corporate Director for Adult Services and the Chief Nurse Oxford University Hospitals NHS FT delegated from the Joint Commissioning Executive.

    Comments checked by:

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

Equality & Inclusion Implications

33. We have completed an Equality and Climate Impact Assessment to support the Better Care Fund Plan, and this will be reviewed in Q4 2022/23 to assess impact of the funded schemes.
34. The Oxfordshire JSNA has identified both geographical populations (in parts of Banbury and Oxford) and areas of need where Oxfordshire performs worse than baseline, especially in relation to younger people and older people, where prevalence of depression, loneliness and falls are above average and the dementia diagnosis rate is below national targets
35. These findings have informed the Better Care Fund Plan for 2022/23 with a range of specific schemes that are detailed in the template, and which include
    (a) Increased mental health capacity in emergency departments

(b) Extended dementia and carer support services, and a number of initiatives around the falls' pathway
(c) Increased support for homeless people
(d) The focus in the deployment of the Disabled Facilities Grant and Housing Improvement on supporting people with behaviours that challenge with emotionally sustainable building design which supports sensory needs
(e) A range of preventative services and community capacity delivered in partnership with community services that we are seeking to target in areas of greatest need as defined by the JSNA especially in relation to reducing isolation and increasing access to physical activity

Karen Fuller, Interim Corporate Director of Adult Social Care

Annexes: Annex 1 Oxfordshire HWB FINAL BCF 2022-23 Planning Template
Annex 2 Oxfordshire HWB Better Care Fund Plan 2022-23 Narrative
Annex 3 Oxfordshire HWB BCF Demand and Capacity Template

Contact Officer: Ian Bottomley Lead Commissioner Age Well 07532 132975
ian.bottomley@oxfordshire.gov.uk

October 2022

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Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Oxfordshire	
Completed by:	Ian Bottomley	
E-mail:	ian.bottomley@oxfordshire.gov.uk	
Contact number:	7952132975	
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Thu 06/10/2022	<< Please enter using the format, DD/MM/YYYY
If using a delegated authority, please state who is signing off the BCF plan:	Karen Fuller	

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Corporate Director of Adults and Housing
Name:	Karen Fuller

	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`	James	Kent	jameskent99@nhs.net
	Additional ICB(s) contacts if relevant		Matthew	Tait	m.tait@nhs.net
	Local Authority Chief Executive		Stephen	Chandler	stephen.chandler@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.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Oxfordshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£6,658,544	£6,658,544	£0
Minimum NHS Contribution	£46,696,469	£46,696,469	£0
iBCF	£10,705,289	£10,705,289	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£64,060,302**	**£64,060,302**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£13,267,002
Planned spend	£17,703,190

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£29,321,155
Planned spend	£36,726,693

Scheme Types

Assistive Technologies and Equipment	£5,859,721	(9.1%)
Care Act Implementation Related Duties	£5,113,867	(8.0%)
Carers Services	£126,305	(0.2%)
Community Based Schemes	£1,991,000	(3.1%)
DFG Related Schemes	£7,374,544	(11.5%)
Enablers for Integration	£184,000	(0.3%)
High Impact Change Model for Managing Transfer of (	£3,195,626	(5.0%)
Home Care or Domiciliary Care	£10,466,307	(16.3%)
Housing Related Schemes	£1,440,690	(2.2%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£11,790,191	(18.4%)
Reablement in a persons own home	£2,110,000	(3.3%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£1,570,580	(2.5%)
Residential Placements	£11,891,378	(18.6%)
Other	£946,093	(1.5%)
Total	**£64,060,302**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)			

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 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)	93.0%	93.0%	93.0%

Residential Admissions

		2020-21 Actual	2022-23 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	442	350

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Oxfordshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Oxfordshire	£6,658,544
DFG breakdown for two-tier areas only (where applicable)	
Cherwell	£1,239,940
Oxford	£1,421,433
South Oxfordshire	£1,550,448
Vale of White Horse	£1,638,973
West Oxfordshire	£807,750
Total Minimum LA Contribution (exc iBCF)	**£6,658,544**

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

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

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

NHS Minimum Contribution	Contribution
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	£446,005
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£46,250,464
Total NHS Minimum Contribution	**£46,696,469**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£46,696,469**	

	2021-22
Total BCF Pooled Budget	**£64,060,302**

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

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Oxfordshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£6,658,544	£6,658,544	£0
Minimum NHS Contribution	£46,696,469	£46,696,469	£0
iBCF	£10,705,289	£10,705,289	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	**£64,060,302**	**£64,060,302**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£13,267,002	£17,703,190	£0
Adult Social Care services spend from the minimum ICB allocations	£29,321,155	£36,726,693	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Care Homes	Long-term residential and nursing care for vulnerable people	Residential Placements	Care home		Social Care		LA			Private Sector	Minimum NHS Contribution	£11,822,015	Existing
2	Home Support	Support at home for help people live as independently as	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£7,675,307	Existing
3	Equipment	Integrated equipment service to enable people to live as independently	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	53.4%	46.6%	Private Sector	Minimum NHS Contribution	£4,797,721	Existing
4	Market resilience	Fee uplifts to support the independent provider market	Care Act Implementation Related Duties	Other	Fee uplifts	Social Care		LA			Private Sector	iBCF	£4,400,000	Existing
5	Home First MDT	Integrated therapy led P1 and community pathway MDT led by LA	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£656,000	Existing
6	Urgent Care leadership	LA funding for integrated system UEC leadership	Enablers for Integration	Programme management		Social Care		CCG			CCG	Minimum NHS Contribution	£54,000	Existing
7	Reablement/P1 capacity	Capacity to support P1 performance	Reablement in a persons own home	Reablement service accepting community and		Social Care		Joint	69.0%	31.0%	Private Sector	Minimum NHS Contribution	£2,110,000	Existing

8	Homelessness Alliance	Contribution from BCF towards mutli-agency Homelessness MDT	Housing Related Schemes			Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£273,000	New
9	Workforce	Recruitment and retention support to independent care sector	Enablers for Integration	Workforce development		Social Care		LA			Private Sector	iBCF	£130,000	Existing
10	Dom care expansion	Additional homecare capacity to support people to live	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£300,000	Existing
11	Community capacity	Development of micro-provider capacity that supports independence	Community Based Schemes	Other	Capacity to support self-care and	Social Care		LA			Charity / Voluntary Sector	iBCF	£250,000	Existing
12	Hospital discharge teams	Hospital social work capacity working into Home First and P2 MDT	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	iBCF	£1,200,000	Existing
13	P2 D2A beds	Contribution to additional P2 capacity	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£360,000	Existing
14	Growth in Home Support	Demographic growth in home care capacity	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£2,310,000	Existing
15	DFG	Assessment capacity and modifications to accommodation to	DFG Related Schemes	Adaptations, including statutory DFG grants		Other	District councils	LA			Local Authority	DFG	£6,658,544	Existing
16	Carers	Integrated Carers advice and support and grants	Care Act Implementation Related Duties	Carer advice and support		Social Care		Joint	47.5%	52.5%	Charity / Voluntary Sector	Minimum NHS Contribution	£713,867	Existing
17	Telecare	Remote monitoring and response services to enable people to live	Assistive Technologies and Equipment	Telecare		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,062,000	Existing
18	Urgent response	Emergency domiciliary care provision that prevents escalation to	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£120,000	Existing
19	Extra Care Housing	Supported housing that provides alternatives to long-term residential	Housing Related Schemes			Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£1,042,690	Existing
20	Home Improvement Agency	Implementation service for Disabled facilitiies grants (partnership with	DFG Related Schemes	Adaptations, including statutory DFG grants	Home improvement agency	Social Care		LA			Local Authority	Minimum NHS Contribution	£716,000	Existing
21	Community capacity	Communuty capacity to support people to live independently in their	Prevention / Early Intervention	Social Prescribing	Capacity to support self-care	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£450,000	Existing
22	Information, advice, community development and	Information, advice and strengths-based support to people in their own	Prevention / Early Intervention	Social Prescribing	Capacity to support self-care	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£855,000	Existing
24	Night sitting to support EOL packages of care	Support to people to enable them to die at home	Home Care or Domiciliary Care	Domiciliary care packages	Specialist EOL support to dom care	Social Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£61,000	Existing
25	Active Aging Exercise support	Strength and balance classes to support falls prevention	Prevention / Early Intervention	Other	Capacity to support self-care	Social Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£207,000	Existing
26	NHS hospital at home-virtual ward support	Hospital at Home services working into PCN MDT to prevent	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£1,204,000	Existing

27	Independent hospital at home virtual ward	Hospital at Home services working into PCN MDT to prevent	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Private Sector	Minimum NHS Contribution	£537,000	Existing
28	Virtual ward escalation	Community-based emergency medical unit to prevent conveyance	Bed based intermediate Care Services	Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£3,274,000	Existing
29	Discharge to assess beds	P2 capacity in independent settings (BCF contribution to	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		CCG			Private Sector	Minimum NHS Contribution	£3,165,000	Existing
30	D2A bed team	Integrated therapy, nursing and social work MDT to support P2 flow	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£975,000	Existing
31	D2A beds community hospital	P2 capacity in community hospitals	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£3,800,000	Existing
32	Surge: repurposed bed capacity	Designated beds provision for covid and P2-P3 pathway	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£200,191	New
33	Surge: increased medical capacity in community	Increased GP cover to manage flow	Bed based intermediate Care Services	Step up		Community Health		CCG			NHS Community Provider	iBCF	£16,000	new
34	Surge: enhanced discharge capacity	Expansion of discharge MDT to support 7 day flow	High Impact Change Model for Managing Transfer	Early Discharge Planning		Acute		CCG			NHS Acute Provider	Minimum NHS Contribution	£110,413	New
35	Pilot: avoiding conveyance from care homes	Expansion of MH and SALT support to manage complex residents	Residential Placements	Discharge from hospital (with reablement) to		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£69,363	New
36	Enhanced UCR	Extended UCR to assure 0800 pick ups and 7 day resilience	High Impact Change Model for Managing Transfer	Flexible working patterns (including 7 day working)		Community Health		CCG			NHS Community Provider	iBCF	£200,000	new
37	Pilot: supporting people with MS	IV service to avoid long hospital stays and free up team for community	High Impact Change Model for Managing Transfer	Early Discharge Planning		Acute		CCG			NHS Community Provider	iBCF	£37,713	new
38	VCSE support into Pathway 0	VCSE integrated into discharge teams	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Charity / Voluntary Sector	iBCF	£450,000	Existing
39	Pilot: supporting homeless people who attend ED	Step up bed and support as alternative to ED and admission	Housing Related Schemes			Social Care		LA			Charity / Voluntary Sector	iBCF	£125,000	New
40	Increased MH support into ED	Extended ED Psychiatric service to support discharge planning	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Mental Health Provider	iBCF	£60,000	new
41	Inceasing morning discharge from ED	7 day transport and settling in service for people ready to leave ED	High Impact Change Model for Managing Transfer	Early Discharge Planning		Community Health		CCG			NHS Community Provider	iBCF	£63,000	new
42	Trusted assessor	new 7 day model of Trusted assessor to support discharge to	High Impact Change Model for Managing Transfer	Trusted Assessment		Social Care		LA			Private Sector	iBCF	£70,000	new
43	Pilot: step down housing for people on P1	Deployment of ECH with intgerated reablement to support complex	High Impact Change Model for Managing Transfer	Housing and related services		Social Care		LA			Charity / Voluntary Sector	iBCF	£70,000	new
44	Improving P2 discharges	Increased therapy and assistive tech inputs to support discharge home	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Private Sector	iBCF	£197,000	new

45	Improving response to homeless people	Integrated care development for homeless people	High Impact Change Model for Managing Transfer	Housing and related services		Social Care		LA			Charity / Voluntary Sector	iBCF	£81,500	New
46	Expanded dementia offer	New service to work with people with MCI and increased capacity for	Prevention / Early Intervention	Other	Dementia support	Social Care		LA			Charity / Voluntary Sector	iBCF	£58,580	new
47	Improved response to carers	Mapping gaps and developing practical support to carers	Carers Services	Respite services		Social Care		LA			Charity / Voluntary Sector	iBCF	£126,305	New
48	14/9 funding still to be allocated	Surge capacity (interim beds)	Other		TBC surge and development projects	Social Care		LA			Private Sector	Minimum NHS Contribution	£946,093	new

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Oxfordshire

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population	Indicator value	172.3	161.7	177.3	157.5	The actual for 21/22 was actually 734.4 Plan assumes 2% improvement; 6% weighting to last 6 months for winter. M4 performance showed a significant reduction in NEL and this is under review	See narrative plan pp 9-16
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value	175	175	185	185		

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

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	91.7%	91.5%	90.8%	90.1%	Proposed trajectory is carried forward from 2021/22. Actions in place to improve allocation to discharge pathways; diversion from P1 to P0; and from P2 to P1 within a Home First ethos and practice.	see narrative plan pp 9-16
	Numerator	11,696	11,714	11,244	10,805		
	Denominator	12,755	12,801	12,384	11,992		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	93.0%	93.0%	93.0%	93.0%		
	Numerator	11,313	11,260	11,260	11,260		
	Denominator	12,165	12,109	12,109	12,109		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	441.7	429.5	369.9	350.2	This is consistent both with Oxfordshire's trend performance and in our preventative programme to avoid admission to long term care	see narrative plan pp 9-16
	Numerator	575	570	491	474		
	Denominator	130,189	132,728	132,728	135,361		

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

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	62.0%	77.0%	81.0%	84.0%	The 21/22 performance was 81%. This trajectory is in line with performance and reflects outcome data for people supported by reablement in Oxfordshire	see narrative plan pp 9-16
	Numerator	302	308	324	336		
	Denominator	487	400	400	400		

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

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Oxfordshire

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
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 ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? 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? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	See narrative plan page 1		
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	See narrative plan (throughout)		
	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? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • 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?	Narrative plan Confirmation sheet	Yes	See narrative plan page 15		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes	See narrative plan pp9-16		

Agreed expenditure plan for all elements of the BCF	**PR7**	**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? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • 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?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes	See narrative plan pp 15		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes	See narrative plan pp 9-16		

Oxfordshire Better Care Fund Plan 2022/23: narrative plan

Health & Wellbeing Board: Oxfordshire

Introduction: development of the Plan

1. Partners involved in the development of this Plan:
    a. Bucks, Oxfordshire and Berkshire West ICB, including GP reps from Primary Care Networks [ICB]
    b. Oxford University Hospitals NHSFT [OUH]
    c. Oxford Health NHSFT [OH]
    d. South Central Ambulance Service [SCAS]
    e. Oxfordshire County Council (integrated commissioning, operations and Public Health) [the Council]
    f. West Oxfordshire DC [WODC]
    g. Oxford City Council [the City]
    h. South Oxfordshire DC/Vale of White Horse DC [S&VDC]
    i. Cherwell DC [CDC]
    j. Oxfordshire Association of Care Providers [OACP]
    k. Oxfordshire Care Homes Association [OCHA]
    l. Age UK Oxfordshire [AUK]
    m. Order of St John Care Trust [OSJ]
2. A wider group of stakeholders have been involved in the development of specific schemes including independent providers (eg nursing homes providing pathway 2 discharge beds, GPs providing in-reach medical support to those beds) and a wider cross section of the voluntary and community sector in relation to the development of social prescribing and prevention (including Oxfordshire Mind, CAB).
3. The development of the BCF plan has been led by officers from the Oxfordshire Integrated Commissioning team hosted by Oxfordshire County Council. For 2022-23 the Council determined that we should extend the planning process to include a wider group of stakeholders in both the planning as well as consultative stages. A workshop of interested parties was held in March which led to a fortnightly planning group that has developed the schemes and plan that are set out below. This has included DFG and housing leads from the Districts.
4. In 2022-23 the BCF plan for Oxfordshire forms part of and complements the system Integrated Improvement Plan. These plans have been developed and overseen by the system-wide Urgent Care Delivery Group [UCDG] reporting to the Oxfordshire Improvement Leadership Board [OILB]. OILB is the reformed AEDB for Oxfordshire. Co-ordination of this activity has been overseen by a senior leaders' group from the Council, the ICB, OUH, OH and SCAS.
5. The demand and capacity plan and target metrics in the BCF plan have been reviewed by UCDG and agreed by OILB. OILB will monitor, assure and implement remedial plans associated with the BCF metrics as part of its wider remit for system performance.

Executive Summary: Oxfordshire's key priorities for 2022/23

6. Oxfordshire's key priorities for 2022/23 are
    a. **Winter/surge capacity**: keeping social care and the hospital flow going through winter
    b. **Conveyance/admission avoidance**: stopping people needing to go to hospital to get the care that they need-*right care, right place, right time*
    c. **Improving discharge pathways**: helping people get Home First as soon as they no longer need a hospital bed-*right care, right place, right time* and *safe and well at home*
    d. **Addressing health inequalities, including in hospital pathways**: making our pathways work for everyone, including younger people, people with mental health needs, people with dementia; people with learning disability and/or autism; homeless people
    e. **Integrating care and support around people in their own home**: building on existing links with district councils and developing our offer around equipment, the use of technology, and the use of extra care housing to keep people *safe and well at home*
    f. **Unpaid carers and prevention**: further development and implementation of the Oxfordshire Way; creating the community capacity and the social prescribing to link people to it; and responding to unpaid carers' concerns re dementia support and practical help that supports them as carers and so help people keep people *safe and well at home*
7. We will develop our approach to demand and capacity planning through a focus on asset- and strengths-based approaches in care assessment and delivery as described in the *Oxfordshire way*, and continue to develop deployable community assets outside of standard care settings and approaches.
8. We will align the Better Care Fund plan with the system urgent care Integrated Improvement Plan. The Better Care Fund *investment* plan is focussed on those areas that are not covered by external funding; but overall the Plan is aligned to the system Integrated Improvement Plan.
9. The 2022/23 Plan is different from that in 2021/22 in that
    a. It has been developed with a much wider group of stakeholders who are involved in co-producing the specific schemes
    b. It has a greater focus on prevention and on Carers
    c. It is informed by an approach to demand and capacity that will be developed further during 2022/23
    d. It is realistic but ambitious regarding the opportunities to improve outcomes for our population and support more people at the right place at the right time, and in a way that support their ongoing independence in their own community

Better Care Fund Priorities for 2022/23

10. Oxfordshire has consolidated changes rolled out in the 2021/22 plan and expanded them as set out below. The key challenges that have faced the Oxfordshire system are as follows.

11. Our experience of winter 2021/22 and the evidence of the developing demand and capacity plan is that
    a. We have insufficient capacity in key areas (mainly reablement/domiciliary care/P1) to meet demand in the traditional way.
    b. This is driven by workforce constraints which are common to NHS and social care providers
    c. Therefore, we need to work differently to manage that demand, both in terms of admission avoidance and in terms of discharge from hospital
    d. We need to focus particularly on the opportunities to work in a preventative and strengths- and asset-focussed way to help people make the most of what they have within their own communities
    e. We will continue to develop our ability to understand demand and map and develop the capacity that makes a difference as set out below. We have reviewed the High Impact Change model as set out below at para in support of this.

12. The withdrawal of Hospital Discharge Policy funding after March 2022 means that our surge planning for winter 2022/23 needs to be funded through alternative routes. At the time of writing this Plan funding for additional beds and for other initiatives to support flow may be available from other NHS sources. However, we have left a contingency in the BCF plan for 2022/23 which will be deployed on further developmental projects if not needed for this extra capacity.

13. The demand and capacity planning exercise within the BCF has highlighted a number of key issues for Oxfordshire
    a. Our reliance on bed-based pathways to support discharge
    b. Our lack of Pathway 1 capacity driven by workforce challenges
    c. Our need to understand better the relationship between the needs of the individual and where s/he is placed in terms of the discharge pathways. The pathway prescription may be driven by availability rather than needs
    d. Our need to move to a more anticipatory model to avoid unmanageable pressures on the discharge pathway
    e. And the need to quantify and then deploy a wider set of resources within the community.

14. To develop our use of demand and capacity modelling we intend to
    a. Use the BCF funding 2022/23 to engage a specialist agency that will support models that identify and deploy capacity
    b. Use Urgent Care funding to employ a dedicated urgent care data analyst to work with organisational Business Intelligence leads to improve the flow and system view of key data

15. The Plan has been approved by the Oxfordshire Improvement Leadership Board (the successor to the A&E Delivery Board) which has agreed the following system priorities:

a. **Winter/surge capacity**: keeping social care and the hospital flow going through winter
b. **Conveyance/admission avoidance**: stopping people needing to go to hospital to get the care that they need-*right care, right place, right time*
c. **Improving discharge pathways**: helping people get Home First as soon as they no longer need a hospital bed-*right care, right place, right time* and *safe and well at home*
d. **Addressing health inequalities, including in hospital pathways**: making our pathways work for everyone, including younger people, people with mental health needs, people with dementia; people with learning disability and/or autism; homeless people
e. **Integrating care and support around people in their own home**: building on existing links with district councils and developing our offer around equipment, the use of technology, and the use of extra care housing to keep people *safe and well at home*
f. **Unpaid carers and prevention**: further development and implementation of the Oxfordshire Way; creating the community capacity and the social prescribing to link people to it; and responding to unpaid carers' concerns re dementia support and practical help that supports them as carers and so help people keep people *safe and well at home*

Key changes and developments from the 2021/22 Plan

16. During 2021/22 Oxfordshire implemented key system initiatives to support the delivery of the BCF which we will continue to develop to meet those priorities identified above in 2022/23:
    a. An integrated commissioning team across Health, Social Care (children and adults) and Public Health and hosted by the Council. **All commissioning of activity funded from the Oxfordshire BCF is now delivered by a team of jointly funded commissioners acting on behalf of the ICB and Council.** The s75 agreement between the Council and the ICB is broader than the BCF and covers all age mental health, adult learning disability and/or autism, all adult social care (except community operational teams), NHS continuing healthcare and a range of preventative and community health services which support deliver of the BCF metrics. The current s75 will be replaced by a new version from 1 November 2022 which consolidates and extends the commitment to integrated commissioning in line with our ambition to create a life stage, tiers of need approach to service delivery.
    b. A joint funded System Director of Urgent Care (funded from BCF). **Oversight and assurance of Oxfordshire's system performance sits with this post reporting to OILB. The post is part-funded from the BCF.** This post has developed the system Integrated Improvement Plan which is designed to implement NHS mandated changes in urgent and emergency care especially in relation to admission avoidance through the model of Virtual Wards and the implementation of Urgent Community Response. The BCF Plan has been aligned to this urgent care approach and from 2023 will be fully integrated.
    c. A Home First MDT (**funded from BCF**) to support discharge home from hospital and management of people at risk in the community. The new team went live on 1 October 2021. **The integrated team comprises Council staff working with OH community therapists and voluntary sector**.

d. The Home First MDT is working in partnership with new strategic providers of reablement and domiciliary care commissioned by the County Council and CCG under Live Well at Home contracts. Live Well at Home also went live on 1 October 2021. **During 2022/23 the providers have worked into daily MDT huddles designed to assure reablement plans and map capacity against demand**. **These contracts are funded in part from the BCF**

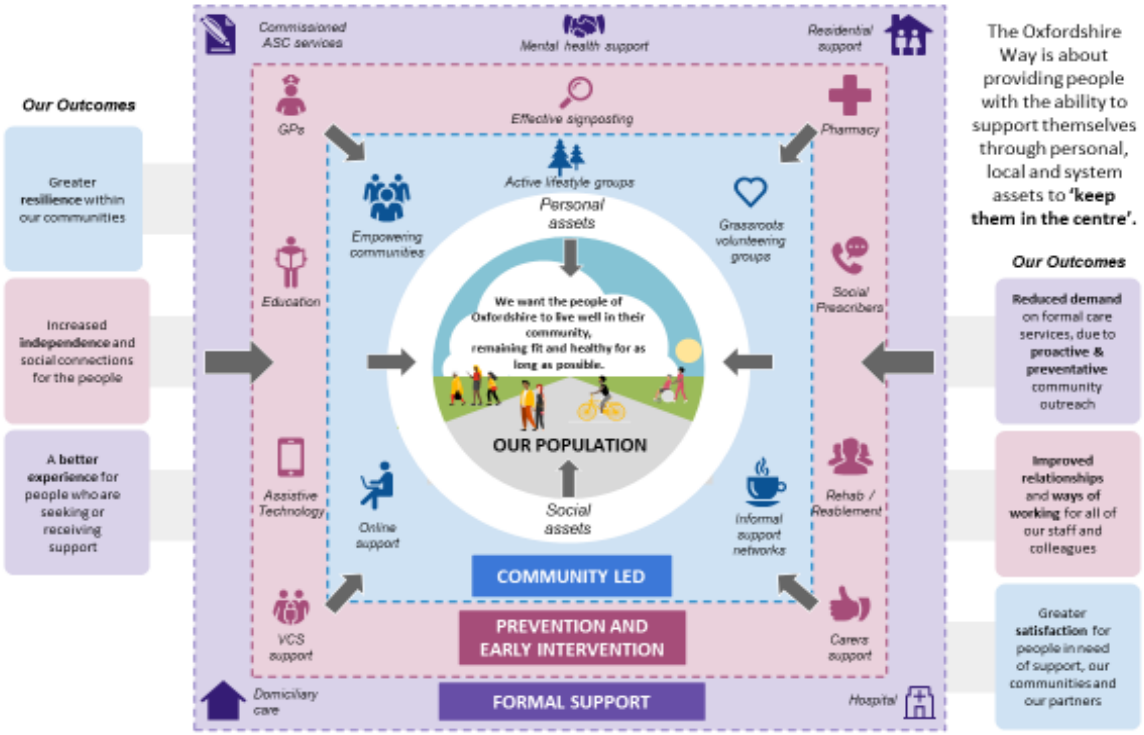
e. The Home First MDT works closely with existing AUK support into the hospital discharge pathways to complement people on Pathway 1 and support people on Pathway 0. **This is funded from the BCF**

f. Oxfordshire began delivery of the Ageing Well Urgent Community Response from 1 October 2021. **This is funded outside of the BCF but closely aligned to it; and in 2022/23 we are investing from the BCF to extend the reach of the service during winter.**

g. The Council has developed with partners a Transformation Programme called *The Oxfordshire Way* in 2021 to develop strengths-based approaches to assessing and planning support for people in the community within adult social care teams. **During 2022/23 we have worked with the voluntary and community sector to expand this work. In 2022-23 we are working with the voluntary sector and primary care to align the Oxfordshire Way with the implementation of NHS Social Prescribing in Oxfordshire**. We are working with the ICB and local primary care networks to map the inputs from Social Prescribing and community capacity into the implementation of Anticipatory Care Planning from April 2023.

h. **The BCF funds Community Capacity grants, community development, advice information and support and the development of micro-enterprises that act as an alternative to formal care and support people's independence within their own community**. This capacity underpins the implementation of the Oxfordshire Way and NHS Social Prescribing. It is aligned to Public Health funding (e.g., in relation to healthy place-shaping, targeted interventions around high needs localities and preventative programmes around falls). It will constitute an "offer" to primary care networks to develop an integrated approach to social prescribing in the County.

We have developed a compelling future narrative and roadmap for the transformation of Adult Social Care and the role it will play within our communities - The Oxfordshire Way



17. A review of performance within Pathway 2 against a discharge to assess approach has identified changes that will increase the proportion of people who return home and within a shorter timeframe. **We have developed a model with additional therapy input, greater co-ordination capacity in care home providers and will implement increased use of assistive technology in 2022/23, funded from BCF**

Governance of the Better Care Fund in Oxfordshire

18. The Oxfordshire Health and Well-Being Board has overall responsibility for the Better Care Fund Plan and will review and approve the plan at its meeting on 6 October 2022. The HWB has delegated responsibility to the Council Corporate Director for Adult Services who briefed the Chair of HWB and the Cabinet Lead for Adult Social Care prior to submission of this plan.
19. Oxfordshire has developed a new s75 NHS Act 2006 agreement that incorporates the Better Care Fund. This new agreement has been approved by Cabinet at the Council and will be approved by the Bucks, Oxfordshire, and Berks West Integrated Care Board at its meeting in November 2022. The new agreement which incorporates the funding deployed within this Plan will commence on 1 December 2022.
20. The development of this Plan and proposed trajectories for the BCF metrics; the allocation of funding against the schemes in the Plan; and the demand and capacity plan has been overseen by the system Urgent Care Delivery Group and approved by the system wide Oxfordshire Improvement Leadership Board (the

successor to the A&E Delivery Board). The OILB will in due course report to the Oxfordshire Place Based Partnership Board when established.

21. Commissioning oversight of the Plan and pooled budgets in the s75 NHS Act 2006 is delegated by the Council and the ICB to the Joint Commissioning Executive. The Deputy Director, Integrated Commissioning is the Pooled Budget Manager for the s75 agreement (including the Better Care Fund) and accountable to the Joint Commissioning Executive. Within the s75 agreement, the commissioning of Better Care Fund Plan services is delegated by the ICB to the Council via the Health, Education and Social Care integrated commissioning team. This team is led by the Deputy Director and hosted by the Council.
22. Proposals in respect of the Disabled Facilities Grant and Home Improvement Agency are developed by the County Housing Forum, a joint meeting of District Council leads and the Lead Occupational Therapist Oxfordshire County Council and the integrated housing OTs and lead commissioners.

Overall approach to integration

23. **Joint priorities** for the BCF Plan have been agreed by the system at OILB as at para 15.
24. **Commissioning of services funded via the BCF is wholly integrated**, with 19 joint funded posts hosted by the Council and led by the Deputy Director, Integrated Commissioning who reports to the Executive Director of Place for the ICB and the Corporate Director of Adult Services for the Council. The integrated commissioning team is overseen by a Joint Commissioning Executive [JCE] made up by the Directors of Adults, Children and Public Health for the Council and the Directors of Place and Delivery for the ICB, together with Directors of Finance for both organizations.
25. The JCE is responsible to the Council and the ICB for the pooled budget spend which is in total £390m. This covers all age mental health, adult learning disability and/or autism, adult social care, and a range of health services for adults and older adults. **The ICB delegates strategic commissioning against this pooled fund to the Council within the new s75 agreement. The BCF pool funds the following joint initiatives that are managed by the Council on behalf of the partners**
    a. Live Well at Home reablement and domiciliary care services
    b. Pathway Way 2 step down beds (additionally joint funded by OUH)
    c. Pathway 2 discharge multi-disciplinary team
    d. Dedicated specialist dementia nursing home beds
    e. Community Equipment Services (additionally joint funded by OH and OUH)
    f. Dementia Support Services
    g. Carers support services (including direct grants)
    h. Falls pathway
26. The overall approach to integration is to develop multi-disciplinary teams around the needs of the individual and structures that work in an integrated way for case management and resource deployment across the system. Daily flow is managed by a multi-agency meeting led by the Deputy Director Operations for

the Council and the system Director of Urgent Care. Strategic planning and delivery of services is led from the OILB.

27. The BCF funds specific integrated services as follows
    a. Home First MDT bringing together reablement service providers, Council and NHS staff
    b. An integrated care planning approach for people in Pathway 2 bringing together acute hospital discharge teams, community therapy in-reach, social care in-reach, primary care, and nursing home staff. The BCF is funding an expanded therapy-led model in 2022/23.
    c. Homelessness step down services that bring together mental health, voluntary sector floating support, social care and health. The BCF is funding an expansion to this service to create an integrated case management system and to create a step-up facility to avoid admissions.
    d. Support to Care Homes: in reach services provided by OH Care Home Support Service which is aligned with primary care as part of the delivery of the NHS Enhanced Healthcare in Care Homes Direct Enhanced Service. In 2022-23 this is being expanded via the BCF in 2 pilots to extend Speech and Language Therapy and mental health support which will support admission avoidance and timely discharge home especially in cases related to delirium.
    e. Falls pathway. This is provided jointly by OH community therapy services and the voluntary sector led by Age UK. This is being expanded in 2022-23 as part of a review jointly between the BCF and Public Health to extend the preventative offer around screening and strength and balance classes and to deploy assistive technology for people who are at risk of falling. The falls pathway touches on many organisations and we will additionally be working with district councils and housing providers to improve our Falls response within the BCF plan.
    f. Community capacity: BCF funding is being used to bring together voluntary sector advice services delivering social prescribing, advice, and information with community-based services working to support social care and primary care in managing demand and increasing independence and resilience. This offers the opportunity to align BCF and NHS primary care ARRS funding to increase scope and impact
    g. Integrated occupational therapy support to District Council Home Improvement Agency and Disabled Facilities Grant functions

Aligned Plans

28. In 2022/23 the Oxfordshire System Urgent Care Director has led on an Integrated Improvement Plan to assure delivery of key NHS policy objectives (e.g. Virtual Ward) in the County. This work has been funded by national and local dedicated NHS funding. The BCF Plan has been designed to complement this Plan where it supports delivery, specifically where this impacts on the BCF metrics:

Improvement Plan theme	Programme	BCF aligned contribution
	Anticipatory Care	The Oxfordshire Way

Improvement Plan theme	Programme	BCF aligned contribution
Better support for people at home		Community capacity and capability
	Primary care virtual ward	Voluntary sector support to primary care MDT
Winter surge	Increased referrals to Urgent Community Response	Investment to expand service
	Acute virtual ward	Hospital at Home services
	Reduced Length of Stay in ED	Homelessness step-down beds Investment in Urgent Community Response Increased patient transport for early morning discharge and settling in at home
Aligning demand and capacity	Bed-based D2A	Increased therapy input in MDT Additional nursing home staff capacity Use of assistive technology to support journey home

29. The integrated deployment of the NHS national and local funding together with the BCF has increased the scope of the planned interventions in
30. Similarly, the BCF Plan has been developed with the support of Public Health and Primary Care and aligns funding from both to support delivery of the metrics especially in relation to prevention (NHS Social Prescribing and Falls).
31. From 2023/24 we intend to integrate these planning approaches further subject to any specific requirements from NHS England.

Implementing the BCF Policy Objectives (national condition four)

Enable people to stay well, safe and independent at home for longer

32. **Demand and capacity to support community interventions**. Development of the demand and capacity template has highlighted the following issues:
    a. **Voluntary sector support**. We have captured the commissioned capacity funded by the BCF, but this is a subset of a much wider potential offer that is being funded in part from the BCF (Community Capacity grants) and from NHS and other forms of social prescribing. We need to develop a better understanding of this capacity, whether it can be deployed to support admission avoidance and then how to count it. This work is being progressed through our prevention workstreams (see para 33a)
    b. **Urgent Community Response**. Demand on UCR has been increasing and now exceeds the national expectation of 13 pick ups per day. Within the BCF we plan to invest to increase those pick ups and provide greater out of hours resilience especially in the early mornings. It is likely that the service will need to be further expanded in 2022/23.
    c. There is a **shortfall of reablement** as discussed below at para 35c

d. **Step up bed provision** is provided via our emergency ambulatory assessment units. This capacity meets demand except when these beds have been redeployed into Pathway 2 and become unavailable

33. Oxfordshire will deliver right care, right place, right time through the following initiatives

a. **Prevention**. Supporting people to live independently in their own community.

i. Oxfordshire has developed the *Oxfordshire Way,* a strengths and asset-based approach to helping people live independently in their own community. This approach is delivered in partnership with Voluntary and Community Services and funded by the BCF. In 2022-23 we have reviewed and expanded a grants programme to increase community capacity and capability especially in areas of deprivation and amongst groups who are most at risk of isolation and decreasing physical activity. This approach grew out of the local response to covid, and in recognition that we needed to enable more people to live independently if we are going to manage the demand for social care at a time of constraint driven by workforce pressures. The Oxfordshire Way runs through our approach to care planning for people who have needs under the Care Act and we are looking for alternatives to long-term care until this is in the best interest of our population.

ii. This approach is being expanded in 2022/23 by aligning the development of the Oxfordshire Way with NHS Social Prescribing and similar initiatives led by District Councils and Public Health (especially around Healthy Place Shaping and Green Social prescribing). We have established a multi-agency Promoting Independence and Prevention Group that brings together these commissioners with primary care and the voluntary sector to develop alignments between what is already there and to identify gaps. Specifically, the group is developing an approach that integrates the community offer with the implementation of NHS Social Prescribing to assure that there is information and advice, resources that people can use, and support for those who need it to access those resources to support independent self-care. The group is also developing approaches that encourages the development of "bottom up" community capacity that improves individual, community and system resilience, by adopting the characteristics of community connectors and local area co-ordination.

iii. Within this preventative approach we have focussed on the needs of Carers in response to feedback in the 2021/22 national Carers survey. Working with Carers groups we are funding within the BCF an expansion of dementia support to include help and support for people with mild cognitive impairment and expanding our practical support and respite offer to Carers. Our ability to support carers both "makes the NHS and the care sector go further" but also recognises

that a key driver of long-term admission to residential settings is carer breakdown.

b. **Anticipatory Care Planning**. This is a key plank of the system Integrated Improvement Plan and is led in Primary Care Networks based on population health management risk stratification tools. The BCF is supporting this approach by funding the community services (above) that will help deliver effective Social Prescribing and the Community Information Network that delivers the Oxfordshire Way and advice and information to help people support themselves with informal support.
    i. We are reviewing our falls pathway in 2022-23. Oxfordshire is an outlier for falls that lead to fractures and we believe that our performance in relation to metric 8.1 is also impacted significantly by fallers at home where no fracture takes place. We are working with primary care to increase referrals into strength and balance classes funded by BCF and delivered in the voluntary sector.
    ii. We are working generally with our provider sector to increase capability around the management of people with acute long-term needs. As part of a refresh of our approach to contracting with care homes, we are redesigning the care bandings with them and developing standards and identifying gaps in managing the levels of need identified in the banding. This will inform how we deploy the BCF in 2023/24.
c. **Enhanced support to people at risk**. Within the Integrated Improvement Plan Oxfordshire is creating primary care virtual wards that bring together primary care, community health, social care and dedicated co-ordination to provide short-term management of people at risk of admission to hospital. These will be fully implemented across the County by March 2023. The BCF is funding voluntary sector input into these structures and they will draw on the community capacity set out above.
    i. The review of the falls pathway will also identify people at risk especially those people at risk in care homes and will develop classes that support residential settings in managing these risks
    ii. The BCF is funding additional inputs into care homes that support management of speech and language issues (compromised swallow) and complex dementia and mental health presentations. This approach is both about patient level intervention and working with care homes to increase their capability and confidence to manage these situations
d. **Virtual ward approaches to avoid conveyance and admission**. Within the Integrated Improvement Plan this is led by Urgent Community Response in partnership with the ambulance service and the BCF funded Hospital at Home services. We are using the BCF to extend the Urgent Community Response offer so that it can respond to early morning (pre-0800) referrals and to provide an extended transport service offer so that we can take people home and settle them in after an overnight attendance at the acute.

We are also extending for winter the capacity of our ambulatory assessment units in the community.

i. Within the Virtual ward the ambulance service and urgent community response have designed improved protocols to avoid conveyance where people have fallen. This will be incorporated within our revised falls pathway

ii. We have extended the deployment of our BCF funded equipment service to increase locality stores of key kit to avoid the need for conveyance

iii. We are introducing a homeless step-up response building on the learning and success of our discharge model. Funded by the BCF this will develop housing and support that particularly can support diversion from ED for homeless people where admission may otherwise happen owing to the need to manage a clinical need (e.g. dressings)

34. These approaches together will impact on BCF metrics 8.1, 8.4, and 8.5 as follows

a. **BCF Metric 8.1**. Oxfordshire is planning for a 2% reduction in activity in 2022/23. There was a significant reduction in non-elective activity in M4 2022/23, but we have adopted a prudent approach that assumes a 6% growth in projected activity against the current trajectory in Q4.

b. **BCF metric 8.4**. Oxfordshire has reduced long-term placements in residential settings for 2 years and we project a continued reduction for 2022/23 based on our approach to strengths-based assessment in line with the Oxfordshire Way, extra care housing as alternative settings and a low rate of pathway 3 discharges from hospital

c. **BCF Metric 8.5**. We have seen improved impact from reablement and expect that to continue based on current performance with delivery of recovery.

		19/20	20/21	21/22	22/23								
		Actual	Actual	Actual	**Annual Plan**	Q1		Q2		Q3		Q4	
						Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
1	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	745.1	622	734.4	**720**	175	185	350		535		720	
4	Long term support needs of older people met by admission to residential and nursing care homes per 100,000 population	597	442	370	**352**	85	67	170		261		352	
5	% of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	67.2%	62.0%	81.0%	**84%**	n/a						84%	

35. Oxfordshire Improvement Leadership Board approved these trajectories at its meeting on 13 September and will monitor delivery of these targets

Improving discharge

36. As part of the BCF planning round for 2022/23 we have reviewed our progress against the High Impact Change domains as follows

High Impact Domain	**Oxon self-assessment**	**Action in BCF plan**
Early discharge planning	Partly in place	Development of Transfer of Care function within system Integrated Improvement Plan
Monitoring and responding to demand and capacity	Partly in Place	Plan to engage external consultants to support a needs-based approach to demand modelling and capacity
MDT to support discharge	In place	MDT in place for HF and P2 discharge
Home First D2A	In place	Home First MDT in place for P0 and P1
7 day working	Partly in place	Additional capacity to support discharge and admission avoidance 7 days
Trusted assessment	Not in place	New service commencing Q3 22/23
Engagement & Choice	In place	
Improved discharge to care homes	Partly in place	BCF funding for mental health/SALT in addition to existing Care Home Support Service Supported by Trusted Assessment
Housing & related services	Partly in place	BCF pilot to deploy extra care housing i discharge pathway BCF funded activity in partnership with Districts re homelessness: step down Beds in place; step up beds start Q3

37. The Oxfordshire system is constrained by workforce pressures to support discharge into Pathway 1. We are working with our providers to improve this through a range of recruitment and retention initiatives funded by the BCF, but as in the example of the Oxfordshire Way we have challenges that have to be managed by alternative approaches to discharge

38. **Demand and capacity to support discharge**. Development of the capacity template has highlighted the following issues

a. The BCF funds **VCSE support to discharge in Pathway 0** (and it also supports Pathway 1). There is currently no waiting list for intervention and so capacity is judged to match demand. This will need to be reviewed as we seek to shift capacity from Pathway 1 to Pathway 0

b. **Urgent Community Response support to Pathway 0**. Currently there is a relatively small referral rate to UCR from ED. This should increase during 2022/23 with the development of the virtual ward model. The BCF is paying for additional capacity in UCR during 2022/23

c. **Reablement (Pathway 1).** Oxfordshire currently has insufficient capacity to meet demand largely due to workforce issues within our strategic providers. An action plan is in place to mitigate this which is in part reflected in this plan: review of Pathway 1 referrals by the Home First MDT to divert patients to Pathway 0 supported as in (a) above; increase in workforce from international and other recruitment plans; step down from reablement from review of plans and progress at the earliest opportunity; alternative use of extra care flats for "complex pathway 1". Our recovery to no long-term care rate is above the national target of 67% and we will work with providers to increase this in line with metric 8.5. There is provision in our BCF plan for additional P2 bed surge capacity as a mitigation to the Pathway 1 shortfall.

d. **Pathway 2**. In the BCF plan as set out below we are redesigning part of the step-down bed pathway to increase flow. At the time of writing this plan we have a technical gap in producing a demand profile for Pathway 2 beds which will be resolved during Q3.

e. **Pathway 3**. There is a surplus supply of residential and nursing home beds in Oxfordshire and capacity meets demand except for in complex needs relating to dementia. Within the BCF plan we are investing in mental health support to care homes to support discharge to beds for more complex patients and working with providers (via the BCF funded Care Home Support Service) to increase capability around this cohort.

39. These findings and the review of the High Impact Change Model have driven our approach to improving discharge pathways as part of the BCF plan

a. The hospital Care Team is working with physios, the voluntary sector and Urgent Community Response in ED to support discharge home rather than admission.

BCF is funding patient transport capacity and extended mental health capacity to support that.

b. We will implement the Homelessness step up beds as a discharge route from ED to avoid admission

c. The virtual ward teams at para 33d are managing people away from conveyance to remove the risk of admission and pressure on the discharge pathways

d. The Home First MDT looks at all points to divert people from Pathway 1 to 0 with voluntary sector support. Both inputs are funded from BCF.

e. We are piloting an approach where we use extra care housing pathway flats with integrated reablement to support people on “complex P1”. This may be because of housing issues, or because of specific social/family factors where there may be a risk of reducing independence from diverting to P2.

f. We have reviewed our Pathway 2 model via nursing home short stay hub beds: we are moving to reduce the LoS in these beds from 21 to 10-14 days to improve throughput and to get people home more quickly. Led by the Pathway 2 hub MDT, the new model will increase therapy leadership both in terms of capacity (7 day working) and intensity and will work with nursing home staff who will employ therapy assistants and with GP practices providing medical cover. We will also pilot the use of assistive technology to support this discharge, introducing the kit in P2 to improve confidence and therefore compliance on return home. These initiatives are funded by BCF.

g. The short stay hub beds also manage people who may be for long-term P3 (e.g., CHC discharge to assess). We will be developing our model for D2A for more complex care e.g. in cases of delirium where we need to manage the risk of a pre-emptive referral into P3

h. In developing our support to care homes we will also be seeking to use this resource to support the safe and timely discharge of people with mental health needs especially where they are returning to their usual place of residence. We will also use this input to support discharges from secure mental health settings of older adults with dementia and other presentations.

i. We continue to commission from the BCF pool in partnership with District councils a dedicated discharge pathway for homeless people.

j. We will fund additional discharge liaison capacity over winter especially to support discharge of children and young people; people in surgical wards who

may be able to discharge home on Pathway 0; discharge of people from outside of Oxfordshire.

k. We will implement a Trusted Assessor model jointly with partners from OACP and OCHA to enable care providers to safely and with confidence take referrals and returners in need of long-term care

40. These actions will support the delivery of metric 8.4 which was agreed by Oxfordshire Improvement Leadership Board at its meeting on 13 September 2022. OILB will monitor and assure delivery of this trajectory.

a. **Metric 8.3**. Oxfordshire is challenged around delivery of this metric as set out above, but we have retained our 21/22 target. The schemes set out above will support greater flow home and as a system we are committed to delivery.

b. **Metric 8.4**. As above para 31b.

		19/20	20/21	21/22	22/23								
		Actual	Actual	Actual	**Annual Plan**	Q1		Q2		Q3		Q4	
						Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
3	% of people who are discharged from acute hospital to their normal place of residence	91.3	90.3	91.5	**93%**	93%	90.5%	93%		93%		93%	
4	Long term support needs of older people met by admission to residential and nursing care homes per 100,000 population	597	442	370	**352**	85	67	170		261		352	

Supporting unpaid carers

41. The BCF funds the Oxfordshire Carers Support Service which provides advice, assistance, and practical support. This is commissioned by the Council on behalf of the ICB. The Service distributes grants on behalf of the Council and the NHS and is joint funded from the NHS minimum contribution.

42. In 2021/22 the national Carers Survey raised some significant concerns around our support for Carers, and we have co-produced a response which includes services funded additionally from the BCF from 2022-23:

a. An expansion of the existing Dementia Support Service

b. The development of a parallel service for people with mild cognitive impairment but whose needs are impacting on the unpaid carers ability to manage and support their loved one

c. Increased dementia education and information for carers

d. Increased practical support for carers across all domains: respite for shopping or social activities that reduce isolation and carer stress; practical support re travel, minor items of household and garden maintenance.

e. This increased practical support will be backed by a mapping exercise carried out with Carers groups to identify gaps and the extent of the need to inform our commissioning approach from the BCF from 2023/24

Disabled Facilities Grant (DFG) and wider services

43. The DFG is passed through to the District Councils for deployment. The BCF funds Home Improvement Agency to enable the implementation of the DFG and

support the continued independence of vulnerable people within their own communities.

44. Oxfordshire County Council has a Deputy Director, Housing function and dedicated team integrated within Adult Social Care. This team supports the interface with District Councils in terms of planning approaches and housing development (especially supported living and extra care housing) and manages the relationship with the Districts around homelessness. This capability has informed and facilitated the development of the various homelessness and extra care housing initiatives set out in this Plan

45. Spend of DFG and the implementation of Home Improvement Agency is overseen by the County Housing Group chaired by the Lead for Occupational Therapy (OT) at the County Council. 4 of the 5 district councils use part of their allocation to pay for dedicated housing OTs in the County working both with children and with adults. These OTs work alongside Home Improvement teams and housing officers to identify the best way forward in each case: whether there is an equipment alternative; whether the DFG represents the best use of resources and/or whether alternative accommodation may be more viable and in the longer-term interest.

46. During 2022/23 we will develop this work into a view of the inter-relation between care costs (health and social care), housing (tenancy) costs, equipment and adaptation costs to determine whether there is (for instance) the opportunity to create more bespoke and personalised packages but also how we can align the health and care needs identified in Oxfordshire Way strengths-based assessment or anticipatory care planning with housing and adaptation. We have identified several lines of enquiry

    a. Whether we can pool resources arising from high-cost care and equipment packages with adaptation costs to create a more personalised, effective and efficient package for people with complex needs. This may involve using BCF to fund additional specialist therapy assessment to support care planning
    b. The role of District Councils' and housing providers in identifying and managing falls risk
    c. Rethinking our approach to extra care housing in terms of allocation thresholds and in-reach support
    d. Ensuring that we have an equitable offer across the County between the different districts and using the BCF from 2023-24 to support that

Equality and health inequalities

47. We have completed an Equality and Climate Impact Assessment to support the Better Care Fund Plan, and this will be reviewed in Q4 2022/23 especially in relation to an improved understanding of the impact of our performance on BCF metrics in relation to protected characteristics.

48. The Oxfordshire JSNA has identified both geographical populations (in parts of Banbury and Oxford) and areas of need where Oxfordshire does worse than baseline, especially in relation to younger people and older people, where prevalence of depression, loneliness and admission to hospital owing to falls are

above average and the dementia diagnosis rate is below. These findings have led the BCF in terms of

a. The approach to implementing the Oxfordshire Way and in particular the priorities for the Community Capacity grants programme to support social prescribing and address health inequalities
b. Our focus on falls within this Plan where Oxfordshire is an outlier and within Oxfordshire where there are particular hot spots across the County

49. A review of performance across the BCF for 2021/22 identified key areas of inequality

a. The needs of people especially children and young people in acute hospital settings around mental health. We have invested additional resource from the BCF to support people in ED
b. The needs of carers as set out above at para 39
c. The needs of homeless people, especially in relation to attendance at ED as set out above
d. A gap in our pathways to support older people with delirium in our discharge pathways
e. The need to support people especially around physical activity which is reflected in the prevention elements of this Plan

50. In developing the BCF Plan for 2022-23 we have mapped in longer-term projects that will need to be built into the plan from 2023-24 in line with the intended BCF 2-year planning cycle. These areas include are key system challenges around equality

a. **Homelessness**: funding for the current range of services is due for review in 2023.
b. **Children and Young People**: development of dedicated accommodation and support to divert children on neuro-divergent pathways to avoid the need to admit to hospital, bring them back into County from out of area placement
c. **Learning disability and/or autism**: development of step up and down supported housing pathways that bring people back in County and reduce need for general or specialist hospital admissions or high cost out of area placement
d. **Housing**: funding for *Better Housing, Better Health* ends 2023 which is a Public Health and District council led initiative to support people with poor housing and in fuel poverty
e. **Housing support for people with complex needs**; need to increase accessibility, coverage, and impact of our use of adaptations and technology to enable people to live independently at home
f. **Prevention**: future funding of Move Together exercise model, and consolidation of social prescribing and community capacity in line with Oxfordshire Way around health inequalities

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

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, subject to sign-off	
If no, please indicate when the report is expected to be signed off:	Thu 06/10/2022	<< Please enter using the format, DD/MM/YYYY

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Corporate Director of Adult Services
Name:	Karen Fuller

How could this template be improved?	Creating a single view of demand and capacity for each category with a gap figure Further clarification on the numbers to be collected

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

[<< Link to the Guidance sheet]

[^^ Link back to top]

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Oxfordshire

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	372	372	372	372	372	372
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	160	160	180	180	180	180
2: Step down beds (D2A pathway 2)	0	0	0	0	0	0
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	75	75	80	80	80	80

Any assumptions made:	
	P0: currently we cannot map "supported referrals into P0". This is the total referrals to commissioned VCSE discharge team 21/22 at a flat monthly rate P1: Current referral level mapped against 2122 provision P2: TBC: awaiting resolution of a data reporting issue-we can report placements but not numbers added to P2

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

	Demand - Discharge						
Trust Referral Source (Select as many as you need)	Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRU	0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector	372	372	372	372	372	372
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRU	1: Reablement in a persons own home to support discharge (D2A Pathway 1)	160	160	180	160	160	160
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRU	2: Step down beds (D2A pathway 2)	TBC	TBC	TBC	TBC	TBC	TBC
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRU	3: Discharge from hospital (with reablement) to long term residential care (Discharge to	75	75	80	80	80	80

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Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Oxfordshire

3.2 Demand - Community

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

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	VCSE: taken as referrals into commissioned service; annual performance /12 UCR: 21/22 total number of referrals and trend uplifted for current performance. Trend is upwards and above national projection Reablement: June 22 extrapolated: note >100% increase in demand since April Step up beds: admissions to emergency multidisciplinary units-DATA TO BE CONFIRMED

Demand - Intermediate Care Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	204	204	204	204	204	204
Urgent community response	448	448	450	460	460	460
Reablement/support someone to remain at home	95	95	95	95	95	95
Bed based intermediate care (Step up)	14	16	16	16	16	16

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Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Oxfordshire

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	Commissioned VCS support to discharge: assumed that demand is matched by supply no waiting list UCR- ED referrals to UCR: this data is only available since June: projected to increase P1: reablement new starts: current (2223) reablement starts, includes referrals from P2 beds. Rehab capacity will follow reablement and so does not impact on capacity. Non reablement rehab referrals would be discharged on P0 but that data is not currently collected in that format

Capacity - Hospital Discharge							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
VCS services to support discharge	Monthly capacity. Number of new clients.	372	372	372	372	372	372
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	21	25	30	30	30	30
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	110	110	120	120	120	120
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	240	197	253	205	187	202
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	75	75	80	80	80	80

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Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: Oxfordshire

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	VCSE: assumed that commissioned capacity matches demand. This is not the total VCSE capacity but that cannot currently be counted UCR: OH target and staffing is for 13 referrals pd; impact of additional BCF investment will increase this in 2223 assumed by +1 pd Reablement: June new starts rolled forward to include provider expansion plans

Capacity - Community							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	204	204	204	204	204	204
Urgent Community Response	Monthly capacity. Number of new clients.	434	420	434	434	392	434
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	45	45	45	45	45	45
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	30	30	30	30	30	30

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Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board: Oxfordshire

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	£33,603,000
BCF related spend	£16,003,000
Comments if applicable	These figures need to be ratified. UCR and acute HaH still TBC BCF spend: P1 and reablement in community: £2.291m (ex uplifts); Hospital at Home £1.741m

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Divisions Affected - All

Oxfordshire Health & Wellbeing Board
6 October 2022

Social Prescribing in Oxfordshire

Report by Interim Corporate Director of Adult Social Care

RECOMMENDATION

1. **The Health & Wellbeing Board is RECOMMENDED to**
   (a) Note this report which sets out
   - the current landscape of Social Prescribing in Oxfordshire
   - the opportunities to develop and extend reach and impact across public health, health, social care, and community priorities
   - next steps and a potential governance route to assure delivery

   (b) Approve the recommended approach to develop an implementation plan for Social Prescribing in Oxfordshire
   (c) Note the proposed governance approach for this work

Executive Summary

2. This paper updates Health & Wellbeing Board on the development and implementation of Social Prescribing in Oxfordshire.
3. Social prescribing is a priority in local and national strategy.
   (a) At a national level the NHS has developed a model of Social Prescribing that will support people identified by GPs and others initially in primary care and then elsewhere in the NHS. This being rolled out nationally in line with a *Social Prescribing Maturity Matrix* which is currently out for consultation. This will provide a framework for good practice when adopted. Primary Care Networks are separately required to deliver Social Prescribing in line with the national Network Contract.
   (b) In Oxfordshire, the development of Social Prescribing is a priority in the Joint Health & Wellbeing Strategy as a means of *Improving Health by Tackling Wider Issues.* Specifically, it was one of the areas of focus for the Health Improvement Board to meet its aim to *Create healthy communities where people of all ages can maintain and improve their health as they live, learn, work, and socialise*
4. Oxfordshire has developed local initiatives that build on the broad model of Social Prescribing. These include the Council Led *Oxfordshire Way* and schemes that have grown out of our response to the Covid Pandemic such as *Move Together.*

5. There is considerable potential to develop these national and local programmes into a model that creates resilient and engaged communities which enable people to *maintain and improve their health.* Social Prescribing has a key part to play in this.

6. This paper
   (a) Sets out the current landscape of Social Prescribing in Oxfordshire
   (b) Identifies the opportunities to develop and extend reach and impact across public health, health, social care, and community priorities
   (c) sets out next steps and a potential governance route to assure delivery
   (d) Seeks approval from Health & Wellbeing Board for the direction of travel

What is Social Prescribing and what is the situation in Oxfordshire?

7. The King's Fund has defined Social Prescribing-in the NHS context-as follows:
   (a) Social prescribing, also sometimes known as community referral, is a means of enabling health professionals to refer people to a range of local, non-clinical services. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs or practice nurses[1].
   (b) Recognising that people's health and wellbeing are determined mostly by a range of social, economic, and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

8. The NHS Social Prescribing approach (as set out in the national Maturity Matrix-see below 20-25) is linked to Population Health Management approaches: identifying people at risk of poor health and/or health inequalities (either by screening, proactive case finding or when they approach with a health problem) and then working with them in a different way to create individual person-centred plans which look for different ways of managing their health needs better. This is the NHS model:

The Social Prescribing Link Worker sits in the Primary Care Network and works to create the "tailored plan" within a "common outcomes framework".

The model recognises that this is a new discipline, and that workforce and outcomes definition needs to be developed; and that delivery of the Social Prescribing outcomes will be contingent on somewhere to support people towards (community groups/capacity) and on strong partnership arrangements, especially where Social Prescribers identify unmet need and gaps in local community provision.

9. In Oxfordshire 19 out of 20 Primary Care Networks now employ Social Prescribing Link Workers either directly or via voluntary and community sector organizations. Overall referrals are increasing from 2020/21 to 2021/22 and a change in the age profile:

(a) In 2021/22 there was a total of 7,552 patients referred to Social Prescribing in Oxfordshire. Almost two thirds (62%) of patients referred were female and 38% were male.

(b) Between 2020/21 and 2021/22 there was an increase in the number of younger people and a decrease in the number of older people referred.

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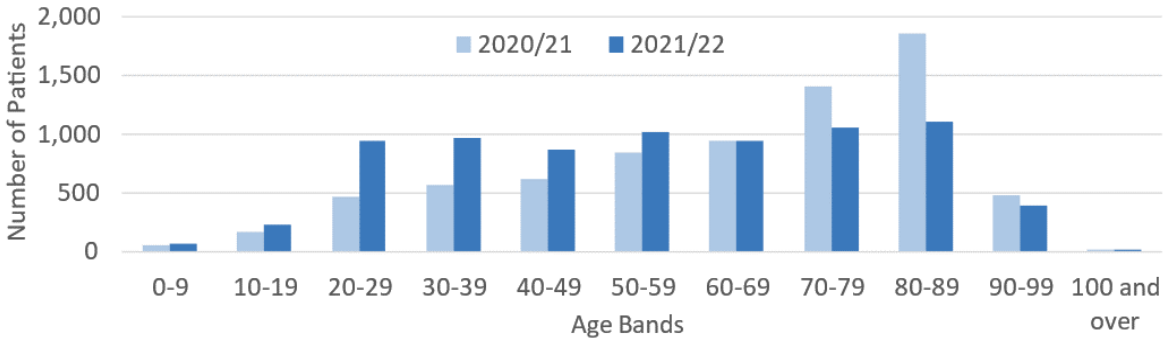

10. In the *Oxfordshire Way* the Council has developed a similar Social Prescribing approach in respect of people with an identified need for social care. Focussing on a strengths-based support model, staff employed by Age UK Oxfordshire help people identify what is important to them, identify what they can do or where they can go which will make a difference to their health and wellbeing, and "walk with them" when getting started or following up is difficult:

We have developed a compelling future narrative and roadmap for the transformation of Adult Social Care and the role it will play within our communities - The Oxfordshire Way

11. NHS Social Prescribing and the Oxfordshire Way are at this point mainly working with a "known" population: people already supported in primary or adult social care, or people identified via case-finding and/or population health management approaches. However, Oxfordshire also has Social Prescribing-like services that support a more preventative approach with people who are not "on the statutory radar". This broader approach to prevention can be described as
    (a) *Preventing people from becoming disconnected from their own resources, natural supports, and communities so that need fewer or no formal service interventions*
    (b) In 2021/22 the Council and the then Clinical Commissioning Group commissioned work to explore prevention within communities. This identified the key role played by *community connectors* who
        (1) Work with people who are "less connected than most"
        (2) Undertake activity that helps people think about their lives, strengths, and aspirations
        (3) Then use this insight to help people connect with other people, organizations, activities, services in their communities
        (4) And may help people to use and develop their skills and talents to better contribute to and have a positive impact on their community
    (c) This definition of community connectors" may cover the work undertaken by NHS Social Prescribers and the Oxfordshire Way, but may also cover a wider range of community organizations (see 12-13).
    (d) Community Connectors may also include unpaid community-based individuals and groups who may be in some ways better-placed to signpost, support and enable communities to respond to the needs of individuals. This represents an informal capacity with considerable potential to increase reach and impact of commissioned services.
12. An example of this approach is *Move Together.* This is a supportive pathway for people across Oxfordshire to become more active. Coordinated and delivered by Active Oxfordshire in partnership with Oxfordshire's District Councils, the pathway ensures that people get the right support to become active and improve their health (both physical and mental) and wellbeing. The initiative grew out of work that was previously focussed on diabetes management and was developed and has been funded short-term from the Covid Pandemic response. Move Together both works in a Social Prescribing model (developing personalised plans with individuals, identifying ways to get more active, walking with them on that journey) and additionally acts as a specialist resource for other Social Prescribers and other referrers.
13. The Council commissioned a snapshot survey of Social Prescribing in the County in July 2022 which confirmed that Oxfordshire has several examples of good practice and a significant amount of coverage
    (a) There are more than 125 full-time equivalent people working in community connector/social prescribing roles
    (b) This includes 45 staff working in Primary care 19 of the 20 primary care networks
    (c) There are social prescriber roles working in community and acute NHS settings as well as in primary care, including supporting people living with cancer and long-term conditions and around smoking cessation

(d) There are people working with specific client groups, e.g., adults with a learning disability and/or autism, people with mental health problems presenting to primary care, tenants of housing providers, victims (and potential perpetrators) of crime

(e) There are specifically focussed approaches: e.g., covid funding supported activities that help people get back into physical activity; debt and finance; citizenship and contribution

14. The commissioners of these services range across Council Public Health and Adult Social Care; NHS England (social prescribing); the NHS Integrated Care Board (additional social prescribing across City Primary Care Networks); District and City Councils; specific housing providers; Oxford University Hospital NHS FT; Oxford Health NHS FT. Many of these initiatives have grown out of the Oxfordshire response to supporting vulnerable and isolated people and communities during the pandemic.

15. The providers included in-house staff and a range of voluntary and community sector providers including Active Oxfordshire, Age UK, Citizens Advice North Oxfordshire, SOFEA, Oxfordshire Mind, Oxford Hub and District and City hubs

16. The common themes across these different Social Prescribing approaches are a focus on addressing key risks to long-term health and wellbeing outcomes

(a) Combating isolation and increasing the sense of connectedness

(b) Mental wellbeing

(c) Physical wellbeing, especially physical activity

(d) Practical resources that can address specific risk factors (eg debt advice, housing issues, fuel and other forms of poverty) which contribute to the wider determinants of ill-health

17. The range of different models for Social Prescribing in Oxfordshire are built around key inputs

(a) Need for good quality, accessible, information and advice that can support self-help and act as a touch point for professionals and other referrers

(b) Co-produced, person-centred approaches to planning: what is important to the individual and how do they meet their individual challenges

(c) Practical support and navigation to enable people to access community resources when they cannot do so themselves

(d) Community resources and social capital that people can use to help them develop and achieve their personal plans

Opportunities to develop Social Prescribing and community connectors

18. Social Prescribing is key in the delivery of a range of local plans and initiatives

(a) Delivering the Oxfordshire Health & Wellbeing Strategy and addressing those health inequalities identified in the Joint Strategic Needs Assessment. Focussed social prescribing and community development approaches help people manage risks arising from the wider determinants of health and support the development of community resources. By identifying what is important to individuals we can better engage them in managing their own health. Social Prescribing can help inform and deliver our approach to Healthy Place Shaping especially in terms of identifying gaps in localities and opportunities to develop community capacity.

(b) Delivery of key system initiatives that assure "right care, right place, right time" as set out in the Better Care Fund plan and the system urgent care Integrated Improvement Plan. This will help manage demand on our health and care services
    (1) Supporting primary care with at risk populations, especially in terms of physical activity and mental wellbeing
    (2) Providing person-centred alternative forms of support for people who are at risk of hospital admission, or who have recently been discharged from hospital and are being supported by health and care in "virtual wards". A strengths-based assessment has been shown to reduce the demand for care by identifying the things that are important to the person, and which may be provided outside of formal NHS or Council care
(c) Improving our response to Carers, to people with mental health problems, to people living with learning disability and/or autism; helping with practical issues as well as building up that individual resilience to deliver 16b above.
(d) Developing our information and advice offer Live Well Oxfordshire to increase the options and resources available to the public and to social prescribers
(e) Increasing community capacity, social capital and capability and the ability of our communities to "grow their own" in terms of the things that will help keep the local population connected and well. This forms a key part of the Oxfordshire Better Care Fund 2022/23 plan
(f) The NHS Maturity Matrix model for Social Prescribing (see below 20-25) highlights the need to create a feedback loop on gaps in community provision and to use that data to support the development of the model and community development

19. There are opportunities to extend the range of options in the community by working to build links between Social Prescribers and arts and cultural groups and organisations, and to groups and organisations helping people access and connect to green spaces. The resources that people might use to help them *maintain and improve their health* are often already there: Social Prescribing connects people and resources to unlock that potential.

NHS Social Prescribing Maturity Matrix

20. This sets out a good practice framework for primary care networks, places (here, Oxfordshire), and systems (here Bucks, Oxfordshire and Berkshire West Integrated Care System).
21. The Maturity Matrix is a good practice and developmental model. Currently, Primary Care Networks are required under the Network Contract to *provide the [PCN's] patients with access to a social prescribing service.* During 2022/23 Primary Care Networks are required to design and implement a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs.
22. Both the NHS Maturity Matrix and the requirements of the NHS Network Contract include various opportunities and risks for the wider development of Social Prescribing in Oxfordshire
23. The key risk is that NHS Social Prescribing and the wider Oxfordshire offer develop in parallel in a way that is inefficient and creates confusion. The NHS

model, the Oxfordshire Way and the other forms of community connectors all have

(a) A working relationship and may be working in some instances with the same people

(b) All rely on the continued development of community capacity and social capital

(c) All need an up to date and comprehensive information and advice resource

(d) And so, they **must** develop in a co-ordinated way

24. The key opportunities are that

(a) For the NHS model: that there are existing partnerships, pathways, and resources (especially around community capacity) that can be deployed to support patients of primary care; there is knowledge and resource on good practice and workforce development. There is an opportunity at both primary care network and ICB place level to do this once and drive greater value and impact by building on what is already there

(b) For the Oxfordshire approach to social prescribing: there are opportunities around building partnerships with primary care networks; building our understanding of unmet need; developing outcome measures and the means of capturing them; developing system data on impact.

25. The roll out of NHS Social Prescribing will be led by the ICB and there are some features that are specific (case finding, feedback into the patient's record) to that model. However, there are opportunities to work in partnership across this and the other initiatives to create a wider offer to our population if we work together across health and care and other partners to align our programmes and approaches.

26. The key features of the Maturity Matrix are set out below.

	Leadership & Governance	Workforce	Planning & Commissioning	Digital	Evidence & Impact
Neighbourhood (Primary Care Networks)	• Named SP lead in practice • Partnership working • Governance processes in place	• Access to high quality supervision • Access to IT • Population Health Management used to identify beneficiaries	• Unmet needs are identified routinely	• Access to GP IT systems • Use of prescribed codes identified & used in patient record	• ONS 4 evaluation tool used • Opportunities for feedback from individuals
Place (Oxon)	• Named SP lead in place • There is a co-produced SP plan • Governance in place	• Plan to develop the workforce • Cross sector working encouraged • Partnership working to ensure support services availability	• SP developed with partners • Unmet need shared across partners • SP built into clinical & care pathways	• Development of SP digital systems • Up to date service directories	• Leaders work with neighbourhood & system partner to capture ONS4 data
ICS (BOB)	• Senior Officer in place for SP • Links to & support for Voluntary sector • Senior Officer works across sectors & localities to produce a BOB SP strategy	• Frameworks used to inform recruitment & development for SP Link Workers • Peer support networks developed across • Focus on SP Link Worker retention	• Unmet need data gathered to inform planning • Population Health Management informs commissioning • SP- strategy includes long term investment plan for voluntary sector	• ICS has capability to link datasets between all health sectors • People can self-refer to SP using digital technology	• Benefits realisation model in place • Routine collection of data that shows impact of SP on health and social care services

Next steps

27. The Deputy Director, Integrated Commissioning has established a *Promoting Independence and Prevention* group that has brought together Public Health, District Councils, NHS, primary care, voluntary and community sector (including Social Prescribers), and Adult Social Care to develop ideas and practice around prevention and community capacity and capability. The PIP group is well-placed to link the development of NHS Social Prescribing and other strands and is leading the following initiatives
    (a) Development of Community Capacity, social capital and our information and advice offer
    (b) Development of pilots in Primary Care Networks that bring together local NHS and other Social Prescribers together with other services (such as Carers Oxfordshire, Dementia Support Service) to
        (1) Build local relationships and develop understanding of what is available within the local community
        (2) Improve approaches to referral and co-ordination
        (3) Identify gaps in local provision
        (4) Identify good practice and opportunities to increase impact and efficiency
        (5) Inform the local implementation of the NHS Social Prescribing Model in line with the Maturity Matrix framework
    (c) Further mapping that particularly considers the role of City and District Council hubs; the commissioning and resourcing routes for Social Prescribing and opportunities for alignment of these; wider opportunities around arts and culture, and access to green spaces
28. There is a need to bring the ambition, activity and plans set out in this paper into one place. This is endorsed by the partners within the PIP group. As local Place systems and structures develop it is proposed that
    (a) The PIP group led by the Deputy Director, Integrated Commissioning develop an approach to the implementation of Social Prescribing in Oxfordshire across health and care. This would include a review of the membership and scope of the group and should consider the opportunities for co-production with our wider community
    (b) The PIP group develop a plan and report into the most relevant Place forum. This will be confirmed when NHS and LA Place governance arrangements are more developed

Karen Fuller, Interim Corporate Director of Adult Social Care, Oxfordshire County Council

Annex: Nil

Background papers: Nil

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October 2022

Report to Oxfordshire Health and Wellbeing Board
October 2022

CONTENTS

Healthwatch Oxfordshire Reports to external bodies

During April to end September 2022 we published the following reports:

- Health and Wellbeing Board July 2022.
- Health Improvement Board May and September 2022
- Reports to the Oxfordshire Joint Health Overview Scrutiny Committee in May, June and September 2022.

All the above reports are available online at https://healthwatchoxfordshire.co.uk/our-reports/reports-to-other-bodies/

Buckinghamshire Oxfordshire Berkshire West Integrated Care Board's (BOB ICB) draft strategy for working with people and communities.

In May we published our response to Buckinghamshire Oxfordshire Berkshire West Integrated Care Board's (BOB ICB) draft strategy for working with people and communities. We welcomed the document noting that it is 'in plainer English than others we have seen'. We requested that 'A plain English and Easy Read version of the revised document should be produced to facilitate easy access and greater understanding in order to engage the whole population'.

We asked:

1. for a 'a strong commitment from BOB ICB that patients and service users are around the table when services are being designed, developed, and reviewed.'
2. what resources will be directed to ensure all communities have an equal chance to be involved in service change and development? And 'How will it be ensured that those who are seldom heard and those facing inequalities in health and outcomes are reached, heard, and able to feed into development of place-based priorities?'

We also responded to the document stating that:

- 'There is no clear indication of how flexible this strategy is to allow the place-based partnership to respond to their local needs or what resources will be made available at place to deliver the strategy. Without these there is a real danger that the strategy will fail.'

Our full response can be found on our website at https://healthwatchoxfordshire.co.uk/news-and-events/correspondence/

Informing and influencing

An update on outcomes from Healthwatch Oxfordshire research and reporting.

All our reports can be found on our website here: https://healthwatchoxfordshire.co.uk/reports

More detail is available in our Report to September Healthwatch Oxfordshire Board papers https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/

Community research

Following on from work by community researchers (Rolanda Vullnetari, Nagla Ahmed and Omotunde Coker) focusing on Albanian Sudanese communities, and black women's views on maternity services:

- Online presentation by community researchers of their work to Community Participatory Action Research Showcase event hosted by Health Education England in May, with over 170 attendees (nationally).

- Maternity film and continued conversations and meetings with maternity health professionals and Maternity Voices Partnership, and Buckinghamshire, Oxfordshire and Berkshire (Local Maternity and Neonatal System Equity group) led to links with service providers and continuing conversation about how to run listening events and anticipated development local community-based maternity services, with community involved
- Maternity film showed at inequalities in health workshop convened by Public Health Oxfordshire as example of community research approach
- Sudanese healthy lifestyle report shared with local health and wellbeing agencies including Active Oxfordshire, Achieve, City Council, Fusion Leisure, Mental Health Concordat, Press Red (whole systems obesity insight) and public health.
- Ongoing dialogue with Fusion Leisure and others to try and support establishment of culturally appropriate women's swimming sessions

Follow on from report: Contacting GP surgeries (March 2022)

Report raised at Oxfordshire Quality Committee and referenced in Oxfordshire Clinical Commissioning Group report to Health Overview Scrutiny Committee.

- Impact: Oxfordshire Clinical Commissioning Group implemented changes including investment in telephony solutions, procurement of online options for GPs, and promotion of NHS app to access patient records.
- Issue of GP access escalated to Buckinghamshire, Oxfordshire and Berkshire Quality Surveillance Group for action.

Follow on from report: Using interpreters to access health and social care (March 2022)

- Presented to Black, Asian and Ethnically Diverse Worlds Group (BAED)
- Follow on invited to attend Oxford University Hospital's Trust Quality Improvement meetings with focus on improving interpreting access and service across the trust, and within maternity services
- Cited in Oxford Health Quality report to Health Overview Scrutiny Committee, noting action to improve accessibility of both interpreting and translation on the Trust website

Progress from other reports

Chipping Norton (March 2022) report quoted and praised in 'Community and Prevention' report by Community Catalysts

Rural Isolation in Oxfordshire (March 2022), with Communities First Oxfordshire noted at Health Improvement Board as relevance to Healthy Place Shaping in the county. The report findings were presented to Health Overview Scrutiny Committee (HOSC) in September. The Committee called for more research reaching those who do not have access to or use internet, and to hear from young people.

Let's Talk about mental health (Sep 2020) referenced at workshop putting business case for mental health services in Oxfordshire attended by 54 representatives across commissioner and provider organisations

Boaters' experience of accessing health and social care (Feb 2020)

- Report shared to Northampton Council by Canal and River Trust as example of good practice
- Links to boating community provided to NHS South-East Commissioning Support Unit to support vaccine and health outreach and 'Health on the Move' bus planning

Work plan update

The Healthwatch England Grant to develop a resource for all Healthwatch on **'working with community researchers to achieve change for people'** is completed. Veronica Barry, Senior Community Involvement Officer gave a presentation to other Healthwatch engagement leads on this which was very well received. As part of this work we developed a theory of change model. Both documents are on the Healthwatch England website - https://network.healthwatch.co.uk/guidance/2022-09-05/working-community-researchers-to-achieve-change-people.

The Health Education England / Public Health England funded community research work is now completed. In May all projects were featured at a regional celebration of the work and very well received. The impact of this work continues in communities and the health system.

The 2022-23 work plan has been updated to reflect:

1. The loss of a member of staff – the main impact is on the listening to seldom heard community – working men in the county. We will revisit this in October with an option to engage with a voluntary or community organisation to deliver in partnership with Healthwatch Oxfordshire.
2. We are also exploring working in partnership with a local voluntary organisation to deliver research into the main concerns of young people. In the meantime we have a simple online survey to focus on their needs.
3. The Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) Core20Connectors project was unsuccessful in funding bid. We continue to discuss with BOB ICB about adopting the community research approach to engage with and listen to seldom heard communities.

We are holding two round table discussions in September:

1. 'What can be done to improve patient access to NHS Dentistry service in Oxfordshire, Buckinghamshire and Berkshire West?'. Follow up from what we are hearing – dentistry is still the most often reason for people to contact us.
2. 'Getting prescriptions from your pharmacy' – follow on from our report published in August 2022

Both sessions are to be attended by the relevant commissioners, representative organisations, and other Healthwatch (dentistry).

The **Patient Participation Group** support / Primary Care Network support is continuing at a pace with attendance at PPG meetings, meetings with practice managers and Primary Care Network leaders, sharing information, and webinars. The September webinar showcased CQC inspections (presented by a Primary Medical Care lead inspector from the CQC) and Healthwatch Enter & View visits to demonstrate the difference and involvement from patients and patient groups.

Healthwatch Oxfordshire 2022-23 Progress to date

Summary of Activity April – end June 2022

In total we heard from 832 people via different methods:

- **Face-to-face events** – attended Eid festival, pharmacy outreach, and spent the day at Templar Square Cowley. In total we spoke to 78 people and gave out 213 Healthwatch Oxfordshire bags.
- **Two research surveys closed** – Care home visiting post pandemic and pharmacy getting prescriptions. Across the two surveys 497 people responded.

- **90 signposting events**
    - 32 for Dentistry, 19 for GPs, and 8 regarding Community Pharmacy
    - 43 by telephone, 44 email, 3 outreach
- **2 Enter & View visits** we listened to 82 people and made 22 recommendations
- **Feedback Centre**
    - 85 reviews left covering 40 services; 11 provider responses posted

We also:

- **Engaged with 14 voluntary / community groups**
- **Published 4 Enter & View reports**
- **Responded to:**
    - Buckinghamshire Integrated Care Board draft strategy consultation

Communications

We continue to promote Healthwatch Oxfordshire, our surveys, and engage with the wider population via our website, social media – Facebook, twitter, LinkedIn, -and direct mailings to targeted groups including Patient Participation Groups, seldom heard groups, communities directly involved with Healthwatch Oxfordshire for example through community research projects and regular contacts. In summary more people are responding to Healthwatch Surveys quoting social media and direct mailings as their source.

Media

Over the past few months Healthwatch Oxfordshire has been contacted by the media – radio, and newspapers – to comment on current relevant issues or in response to our research reports. Press releases issued by Healthwatch Oxfordshire continue to result in media interest:

In April the Banbury Guardian ran our press release on the Chipping Norton Report, and the Witney Gazette ran an article on our getting prescription survey based on our press release. In June Healthwatch Oxfordshire Executive Director was interviewed live on BBC Radio Oxford regarding the pressures on Primary Care in Didcot.

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Health & Wellbeing Performance Framework: 2022/23
Quarter 1 Performance report

A good start in life

Measure	Target	Update	Q1 21/22		Q2 21/22		Q3 21/22		Q4 21/22		Q1 22/23		Notes
			No.	RAG	No.	RAG	No.	RAG	No.	RAG			
1.1a Reduce the number of children who are cared for who are not unaccompanied young people to 750	750	Q1 2022/23									**801**	**R**	Measure changed to exclude unaccompanied children. Trajectories in place to reduce to the level of similar authorities
1.2 Maintain the number of children who are the subject of a child protection plan	550	Q1 2022/23	510	A	548	R	530	A	559	R	558	A	Target reset to 550. Marginally above target, but still 200 below high spot of June 2019 (758)
1.3.1 Mean waiting days for CAMHS	tbc	Q1 2022/23	106		132		110		86		114		Mean waiting time is 6% up on same time last year
1.3.2 Median waiting days for CAMHS	tbc	Q1 2022/23	99		97		106		48		89		Median waiting time is 2% down on same time last year
1.5 Reduce the number of hospital admissions as a result of self-harm (15-19 year) to the national average (rate: 617 actual admissions 260 or fewer)	260	Q1 2022/23	85	R	146	R	202	A	280	A	43	G	43 admissions in first quarter. 172 pro rata for year
1.12 Reduce the level of smoking in pregnancy	6.5%	Q4 2021/22	6.9%	G	6.9%	G	5.7%	G	5.8%	G	7.0%	A	Figures ranged from 5.4 (Q1) and 7.0 (Q4) across the 4 quarters of 2021-22. Reaching 6.1 across all 4 quarters (391 women) a reduction since last year. This year maternity services across the ICP will be launching a bespoke targeted Stop Smoking Service
1.13 Increase the levels of Measles, Mumps and Rubella immunisations dose 1	95%	Q4 2021/22	93.1%	A	93.7%	A	92.6%	A	93.6%	A	93.7%	A	A national campaign to increase childhood MMR vaccination is ongoing since Feb 2022.
1.14 Increase the levels of Measles, Mumps and Rubella immunisations dose 2	95%	Q4 2020/21	92.5%	A	92.4%	A	91.6%	A	91.9%	A	91.6%	A	A national campaign to increase childhood MMR vaccination is ongoing since Feb 2022.
1.15 Reduce the levels of children obese in reception class	7%	Q4 2020/21	6.7%	A	6.7%	A	6.7%	A	6.7%	A			21/22 data not report as COVID resulted in unreportable sample size. However, the data we do have suggests an increase in obesity levels reporting on smaller proportion of cohort: Cherwell 7.1%; Oxford 6.5%; South 7.9%; Vale 5.5%; West Oxfordshire 7.4%
1.16 Reduce the levels of children obese in year 6	16%	Q4 2020/21	16.2%	A	16.2%	A	16.2%	A	16.2%	A			21/22 data not report as COVID resulted in unreportable sample size. However, the data we do have suggests that, as is the case nationally, there has been an increase in obesity
Increase the number of early help assessments to 2000 in 2020/21	5000	Q1 2022/23	801	G	1352	G	2188	G	2938	G	**849**	**R**	Target of 5000 for year. 849 in the first quarter, so just under 3400 in year. All local partners are identifying their pledges to early help via the children's trust
1.18 Monitor the number of children missing from home	Monitor only	Q1 2022/23	260		513		741		982		264		Last 12 months: 19% increase compared with last year; 5% increase on 2 years ago; 15% decrease on 3 years ago
1.19 Monitor the number of Domestic incidents involving children reported to the police.	Monitor only	Q1 2022/23	1782		3577		5166		6742				Last 12 months: 19% increase compared with last year; 5% increase on 2 years ago; 15% decrease on 3 years ago

Living well

	Target	Update	Q1 21/22		Q2 21/22		Q3 21/22		Q4 22/23		Q1 22/23		Notes
			No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	
2.2 Proportion of all providers described as outstanding or good by CQC remains above the national average	86%	Q1 2022/23	94%	G	93%	G	95%	G	95%	G	95%	G	Routine inspection on hold, inspecting only where a concern is raised. National average 86%
2.11 Increase the number of people with learning disability having annual health checks in primary care to 75% of all registered patients by March 2020	75%	Q1 2022/23	8%		20%		39%		71%	G	9%		Action plan in place. Checks tend to happen at the end of the year. Above the same point last year when target was met. Target increased to 75%
2.12 The number of people with severe mental illness in employment	18%	Q1 2022/23	20%	G	21%	G	22%	G	22%	G	22%	G	975/4340
2.13 Number of new permanent care home admissions for people aged 18-64	< 39	Q1 2022/23	6	G	10	G	20	G	33	G	10	A	10 people permanently admitted to care homes in the quarter (pro rate 40), marginally above target, still top quartile nationally
2.14 The number of people with learning disabilities and/or autism admitted to specialist in-patient beds by March 2022	10	Q1 2022/23	5	G	10	A	10	A	8	G	7	G	
2.16 Reduce the Percentage of the population aged 16+ who are inactive (less than 30 mins / week moderate intensity activity)	18.6%	Nov-21	21.3%	R	22.4%	R	22.4%	R	21.0%	R	21%	A	Decreased nationally (covid affect). New projects (Move together & You move) expected to improve figures. Cherwell 24.4%; Oxford; 15.1%; South Oxon 21.4%; VoWH 23.7%; West Oxon 20.7%
2.17 Increase the number of smoking quitters per 100,000 smokers in the adult population	> 1146 per 100,000*	Q4 2020/21			678	R	1042	A	1306	G	1384	G	The new smoking cessation provider has made excellent efforts to achieve their target 4 week quit rates by delivering the service remotely and continuing to engage with clients through the Covid pandemic.
2.18 Increase the level of flu immunisation for at risk groups under 65 years	85%	Sep 21 to Feb 22	58.9%	R	58.9%	R	58.9%	R	60.4%	R	60.4%	R	The 2021/22 flu programme offered the flu vaccine to the largest number of people in the history of the programme and was offered alongside the national COVID-19 vaccine programme. Uptake within the under 65 year 'at risk' cohort remained stable with an increase seen in the over 65 years cohort and the 50 – 64 years cohort.
2.19 % of the eligible population aged 40-74 years invited for an NHS Health Check (Q1 2015/16 to Q4 2019/20)	70%	Q1 2022/23	67.0%		69.6%		69.6%		72.6%		62.6%	A	NHS Health Check Programme, commissioned via GP Practices, improved performance back to pre-pandemic levels for Q1 2022/23. A few practices are still paused in their delivery of the NHS Health Checks as they restore services during this recovery phase.
2.20 % of the eligible population aged 40-74 years receiving a NHS Health Check (Q1 2015/16 to Q4 2019/20)	42%	Q1 2022/23	31.7%		32.6%		32.6%		33.5%		32.7%	A	Currently commissioning a new extra service for health checks via third-party to provide targeted outreach due to start 1/1/23. Programme paused nationally (COVID). A few GP Practices are still paused .
2.21 Increase the level of Cervical Screening (Percentage of the eligible population women aged 25-49) screened in the last 3.5)	80%	Q3 2021/22	65.9%	R	67.1%	R	67.6%	R	67.1%	R	66.5%	R	Below England (68.1%) & South (70.8%). Lower coverage in LSOAs with a higher percentage non-white population. NHSE Screening team working with BOB ICS to improve uptake, for younger, non-white women. This includes ensuring ceasing records are up to date and accurate in line with the National ceasing audit.
2.21 Increase the level of cervical Screening (Percentage of the eligible population women aged 25-64) screened in the last 5.5 years	80%	Q3 2021/22	75.7%	R	75.3%	R	75.4%	R	75.3%	R	75.0%	R	Comparable to England (74.8%) and the South (75.5%).

Aging Well

Measure	Target	Update	Q1 21/22		Q2 21/22		Q3 21/22		Q4 22/23		Q1 22/23		Notes
			No.	RAG	No.	RAG	No.	RAG	No.	RAG	No.	RAG	
3.4 Increase the proportion of discharges (following emergency admissions) which occur at the weekend	>18.8%	Q1 2022/23	20%	G	20%	G	20%	G	20%	G	20%	G	
3.5 Ensure the proportion of people who use social care services who feel safe remains above the national average	> 69.9%	Feb-22	72%	G	72%	G	72%	G	73.7	G	73.7	G	National social care user survey run each February
3.6 Maintain the number of home care hours purchased per week	21,779	Q1 2022/23	26,333	G	25,643	G	25,128	G	24,509	G	25,395	G	
3.7 Reduce the rate of Emergency Admissions (65+) per 100,000 of the 65+ population	24,550 or fewer	Q1 2022/23	21,822	G	22,949	G	22,061	G	20,798	G	22,476	G	
3.8 90th percentile of length of stay for emergency admissions (65+)	18 or below	Q1 2022/23	13	G	14	G	14	G	15	G	16	G	
3.19 (New measure): unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population	720	Q1 2022/23	769.6	R	745	R	749.5	R	732.0	R	740	A	185 for the quarter - pro rata for the year
3.21 (New measure) % of people discharged to their normal place of residence	93.0%	Q1 2022/23	91.0%	R	90.9%	R	90.6%	R	90.6%	R	90.5%	R	Actions in place to improve allocation to discharge pathways; diversion from home with care to home with no care; and from short term bed to home with care within a Home First ethos and practice.
3.12 Reduce unnecessary care home admissions such that the number of older people placed in a care home each week (BCF measure)	8.8	Q1 2022/23	9.4	G	8.1	G	9	G	9.2	G	8.6	G	112 admissions in the first 3 months
3.13 Increase the % of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (BCF measure)	77%	Oct - Dec 2022	62	R	62	R	62	R	84	G	84	G	Figure fell in year, possibly as people with higher needs were supported. Targeted amended in line with BCF
3.14 Increase the Proportion of older people (65+) who are discharged from hospital who receive reablement / rehabilitation services	3.3% or more	Oct - Dec 2021	2.85%	A	2.85%	A	2.85%	A	2.20%	A	2.20%	A	Figure dropped in year - measured at time of contract change which may have impacted performance
3.15 Increase the estimated diagnosis rate for people with dementia	67.8%	Q4 2021/22	63.0%	R	63.0%	R	61.0%	R	60.9%	R	61.0%	R	Below target, but above BoB and SE average
3.16 Maintain the level of flu immunisations for the over 65s	85%	Sep 21-Feb 22	84.4%	G	84.4%	G	84.4%	G	86.4%	G	86.4%	G	The 2021/22 flu programme offered the flu vaccine to the largest number of people in the history of the programme and was offered alongside the national COVID-19 vaccine programme.
3.17 Increase the percentage of those sent bowel screening packs who will complete and return them (aged 60-74 years)	60% (Acceptable 52%)	Q3 2021/22	70.3%	G	70.3%	G	70.9%	G	71.7	G	69.0%	G	The service is currently inviting at 129% of their pre-COVID-19 rate. Service is fully restored, recovered its backlog in July 2021 and performs within the invite target threshold of inviting within +/- 6 weeks. National average = 68.8%.
3.18 increase the level of Breast screening - Percentage of eligible population (women aged 50-70) screened in the last three years (coverage)	80% (Acceptable 70%)	Q3 2021/22	55.4%	R	55.4%	R	76.9%	R	66.6%	R	69.6%	R	COVID-19 restrictions impacted on programme as did workforce sickness/self-isolation. Fewer women presented potentially related to Covid. Additional capacity now in place and provider expects to be back to a sustained round from the Autumn 2022.

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Report to Health and Wellbeing Board

Report from: Children's Trust Board Chair – Cllr Liz Brighouse
Report Date: 6th October 2022
Dates of meetings held since the last report: 7th September 2022 – Virtual meeting
HWB Priorities addressed in this report – A Healthy Start in Life
Link to any published notes or reports: Children & Young People's Plan 2018 - 2023
Priorities for 2022-23 – Focus on Early Help To ensure all partners on the board dedicate senior leaders to the Early Help (EH) agenda and review their agency's current resource.

Priority focus for 2022/23:

- **Early Help & Mental Health & Well-Being**
- **Early Help & 0–5-year old's**
- **Early Help & SEND (Special Educational Needs & Disabilities) Early Intervention**

Objectives

- To identify issues and concerns for children and families early so that they can be addressed promptly and without the need for statutory interventions if that is not necessary or appropriate.
- To ensure that Early Help support is at the least intrusive level and designed to support families continue to develop and thrive.
- To use an Early Help Assessment to develop a holistic, coordinated multi-agency intervention where an organization alone cannot fully support the problems a family is facing.

Actions

- Each agency to review their senior leadership and resource levels to early help and report to Children's Trust Board and report on targets for their agency Early Help Assessments.
- To increase the number of Early Help Assessments (EHAs) to 10,000 by 2024/25.
- To identify resource to ensure front-line staff/designated staff across all our services are trained in the early identification and support that can be offered in relation to mental health and well-being, attachment, trauma informed and whole family working by:
  - scoping what is in place
  - adapting existing resources and designing training
  - planning delivery of training and/or train the trainers

Outcomes

- Senior strategic leadership and increased resourcing in place for early help so that fewer children are supported by statutory services.

- Pooled resource for Early Help
- Increase in EHAs (Early Help Assessments) to 5,000 by April 2023; 250 more staff trained to deliver EHAs.
- Reduction in children needing assessments for Education Health Care Needs, Child & Adolescent Mental Health Service (CAMHS) or Children's Social Care statutory support and improvement in Good Level of Development because their needs have been addressed at the earliest opportunity.
- Staff are confident to deliver mental health and well-being interventions, promote whole family working, signpost on as appropriate.

Priority focus for 2022/23: Be Supported

- To ensure the partnership listens to and learns from the views and feedback from children and young people, aged 8-18yrs and up to 25yrs with additional needs, about how supported they feel by the services they access in Oxfordshire.

1. Progress reports on priority work to deliver the Joint HWB Strategy

Priority Focus	Early Help & Mental Health & Well-being
	Early Help & 0–5-year old's
	Early Help & SEND Early Intervention
Deliverable	See updated Children and Young People Plan for list of deliverables
Progress report	TBC

Priority	**Be Supported**
Focus	Listen to the feedback from young people in Oxfordshire
Deliverable	This deliverable is measured by ensuring the voice of children and young people is included in our agenda items, via VOXY and the "Be Supported Survey."
Progress report	Be Supported Survey 2022 was launched on the 14th of March and ran for 6 weeks – 4 weeks of school time and then extending into the Easter holidays giving 6 weeks in total to complete the survey and to boost engagement. The full report is now available here after provided for info at the September meeting. Some key messages from this report of children and young people's views are: • Even though the sample size has been smaller in 2022 there hasn't been a significant change in their views and opinions in relation to how supported they feel. • Most of those surveyed do feel supported by the services they use, but it was slightly less compared to 2021. • There were positive responses for them knowing who to speak to when in need of support. • There were fewer positive responses, with regards to feeling listened to and believed and when they speak to staff, they are experienced and caring.

	• As with previous years most respondents commented again on schools, followed by health services which were mostly positive, but references made to the CAMHS waiting times being unacceptable. • There were some comments from transgender young people who felt unsupported and not understood by their school and trans healthcare services. • A general note is that responses have been slightly less positive overall in 2022 compared to 2021.

2. Note on what is being done in areas rated Red or Amber in the Performance Framework

The data and information below are for Performance Report Quarter 1 2022/23.

Be successful

- To term 4 (Easter) nearly 1 in 4 pupils were persistently absent. Absence is highest for vulnerable groups; Children with a child protection plan (57.0%), child in need plan (53.5%) and Children with an EHCP (41.9%).
- However there has been significant success in reducing exclusions which fell from 66 in 2020 to 19 in 2022 and suspensions fell from 1741 to 846 in the same period.
- Although the number of electively home educated children rose between Easter 2020 and Easter 2022 from 789 to 1021 those who were the subject of a child in need of child protection pan fell from 18 to 15

Be healthy

- The average (mean) waiting time for core CAMHS services is 10% lower than 12 months ago, and the median is 19% lower
- To April, A&E attendances for self-harm are 28% higher than last year and 52% more than 2019, though hospital admissions have remained stable
- The children's trust agreed a target of 5,000 early help assessments this year and 10,000 in 23/24. However, in the first 2 months of this year the number of early help assessments are lower than the corresponding period last year and under half the target rate.
- The number of under-age conceptions is falling, but the pregnant women scored with a risk of 3 or 4 continue to rise.

Be Safe

- The rate of growth of MASH contacts is beginning to slow down but remains over 60% higher than pre pandemic levels. Despite this increase the timeliness of red (most urgent) contacts was above target for every month of the year
- 535 children were the subject of a child protection plan at the end of May. This is below the revised target (550) and below that of similar authorities and is 200 less than the highpoint of June 2019 (769)
- The number of children we care for continues to rise but remains below the national rate. This puts pressure on workloads across the system and on placements.
- Recorded domestic incidents involving children were 3% lower than 20/21 figures but 5% higher than 2 years' ago. Recorded incidents of domestic crimes involving children were in line with last year's numbers, but 11% higher than 2019/20.

Indicator Number	RAG	What is being done to improve performance?
1.3a Mean wait for Core CAMHS (days)	N/A	In April 2022 the number was 114 – 10% lower than April 2021.
1.3b Median wait for Core CAMHS (days)	N/A	In April 2022 the number was 80 – 19% lower than April 2021.
1.11 Reduce the persistent absence of children subject to a Child Protection Plan	N/A	Data available annually only. This is for 2018/19 academic year.
1.1 Reduce the number of children we care for to 750 by March 2022	R	The number in May 2022 was 805 – the number of children we care for continues to rise but remains below the national rate (excluding unaccompanied young people).

3. Summary of other items discussed by the board

3.1 Update on Statement of Intent/Vision Statement for Children

Following on from the last Children's Trust meeting in May, it was agreed for members to send ideas and examples of how the Statement of Intent has been put into practice, by 10th October, then this will be on the agenda for the 27th of October meeting.
The link for the poll was recommended to be shared with other interest groups and to be completed and submitted by mid-October. The results of the survey will be launched at the Oxfordshire Safeguarding Children's Board (OSCB) Conference in November.

3.2 Responding to the Cost-of-Living Crisis

Along with a proposal on emerging insights being put together to take to Cabinet in a few weeks, there is a listening event on 6th of October which will involve partners from districts and localities. There is a Partnership Protocols Framework on 23rd of September that will involve strategic partnership work, following the COVID-19 pandemic.
This item will be covered again in the next Board meeting.

3.3 Feedback from OSCB on emerging issues

The OSCB annual report sets out the safeguarding challenges and where we need to improve practice. The key messages from the 2021/22 report are ensuring organisations are doing everything they can to support safeguarding priorities of neglect, child exploitation and keeping children safe in school. We require a collective focus to ensure early help is led and resourced at a senior level; capacity issues and demand in organisations are known across the partnership and the issues surrounding recruitment and retention of our highly valued workforce.

The Child Safeguarding Practice Review Annual report sets out what the safeguarding partnership can learn from the most serious and complex reviews. The current data from the 2021/22 report shows that 3 reviews were undertaken, 6 Rapid Reviews completed, and the Serious Case Review for Child R was published. The strategic messages from these reviews are:

- make sure that vulnerable children are seen.

- embed the culture of early help work across everyone working with children.
- develop a clear understanding of trauma informed practice across your services and adopt that approach to working with children.
- develop and invest in plans to keep children close to home by expanding local residential and foster care provision to meet children's needs.
- ensure rigorous commissioning and quality assurance of placements for the children we care for.
- maintain oversight of how we record and share information about children.
- ensure greater understanding of the range of mental health and mental wellbeing support opportunities for adolescents.

3.4 Children & Young People's Plan Priorities 22-23: Focus on Early Help

The Board agreed the Children & Young People's Plan (CYPP) 2022-23 at the May meeting, which includes 3 priorities around Early Help.

Oxfordshire Children and Young People's Plan 2018-2023

The CTB (Children's Trust Board) has requested that each organization formally responds by 16th September with their commitment to working together to deliver the plan.

The key actions are:

- Identify senior leaders within organisations who are responsible for Early Help (EH)
- Reviewing resources allocation to support EH
- Identify key metrics to evidence increase in EH delivery
- Ensuring that staff are trained to identify certain aspects of early identification and support.

CEDR Item (available upon request)

The above document is a well-advanced draft that will be developed further before being taken through Children, Education & Families (CEF) governance. The Senior Leadership Team will then take this through the required Oxfordshire County Council governance arrangements to ensure full sign up from the council to deliver the EH aspects of the CYPP, prior to it being submitted to the CTB. Below is a useful presentation for CTB members to discuss with senior leaders in their organisations.

CYPP – Organisational sign up (available upon request)

The strategic leads identified for EH would then form a multi-agency 'early help' partnership board.

3.5 Voice of Oxfordshire's Youth (VOXY)

A VOXY representative, Chloe Sharman-Moss, who observed the last CTB meeting in May and has been a nursery teaching assistant, highlighted some points from children and young people's voices at this meeting that link to the boards 3 early help priorities. These

are some of the points from her observations, with more detail in the paper inserted below:

- Children would have much more successful academic careers if they have early help in their lives and reach their milestones
- Young people mentioned having positive relationships and exercise to keep their body and mind healthy
- Need for more specialist schools, learning bases and support systems
- Improving the transition from primary to secondary school
- Children increasingly facing cyberbullying on social media mainly from people they know

Chloe's Observation (available upon request)

Here are her own experiences from being a nursey teaching assistant:

Chloe's Experiences (available upon request)

3.6 Update from parent representatives – Healthwatch Oxfordshire

Key points raised were:

- Child & Adolescent Mental Health Services (CAMHS) waiting lists
- Accident & Emergency self-harm admissions statistics
- Special Educational Needs & Disabilities (SEND) strategy
- Clinical systems outage – parents would welcome more clarity and updated information – Oxford Health fed back that there may be months of disruption
- Cost of living crisis – increasing gap between needs and funding

3.7 Update from the Children and Young People Forum - Voluntary Sector

Key points raised were:
Children and Young People Forum are to elect new representatives week commencing 12th September
A request for Kevin Gordon and Maria Godfrey to discuss the Early Help concept to the charity sector in terms of extra support and provision
There is an initiative from Oxford Hub to put together a presentation focusing on early support for families

3.8 Presentation on SEND Reform including the Green Paper

A SEND update and presentation was provided on the following:

- SEND and Alternative Provision (AP) Green Paper
- Local Area SEND Consultation
- Co-Production of implementation plans
- Accelerated Progress Plan (APP) Monitoring visit
- Local Area SEND Inspection methodology Testing

SEND update (available upon request)

The feedback from the Local Area SEND consultation was that parents find it difficult to comment without detailed implementation plans and that they are not given the detail around high-level statements.
The board partners would be happy to be involved in the co-production group and information on this would be provided at the next board meeting.

3.9 Youth Offer

There was an update of the Targeted Youth Support Service which has been set up to empower and support children and young people to improve their life opportunities and reduce disruption through adolescence leading to a more successful pathway into adulthood. Below is the strategy and presentation:

Target Youth Support Service Strategy and Update (available upon request)

The aims of this service are to:

- Improve outcomes for young people related to their personal and social development
- Improve the health and wellbeing in young people
- Identify opportunities for prevention and early intervention
- Prevent escalation of negative outcomes and sustained reduction of future long-term risk of harm

3.10 Forward plan for the next meeting

The following items are due to be considered in forthcoming meetings:

- Partner responses to the request for senior response to the Focus on Early Help in the Children & Young People's Plan
- Partner responses to how the Statement of Intent is being implemented in each organisation
- SEND update
- Cost of Living Crisis update

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