

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 14 May 2026 at 1.00 pm
Room 2&3 - County Hall, New Road, Oxford OX1 1ND

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Martin Reeves
Chief Executive

May 2026

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

Membership

Chair – Cllr Liz Leffman (Leader, Oxfordshire County Council)

Board Members:

Ansaf Azhar	Director of Public Health & Communities, Oxfordshire County Council
Councillor Tim Bearder	Cabinet Member for Adults, Oxfordshire County Council
Michelle Brennan	GP Representative
Councillor Rachel Crouch	West Oxfordshire District Council
Councillor Rob Pattenden	Cherwell District Council
Councillor Georgina Heritage	South Oxfordshire District Council
Karen Fuller	Director of Adult Social Care, Oxfordshire County Council
Councillor Sean Gaul	Cabinet Member for Children and Young People, Oxfordshire County Council
Caroline Green	Chief Executive, Oxford City Council (District Representative)
Councillor Kate Gregory	Cabinet Member for Public Health and Inequalities, Oxfordshire County Council
Lisa Lyons	Director of Children's Services, Oxfordshire County Council
Grant MacDonald	Interim Chief Executive, Oxford Health NHS Foundation Trust
Councillor Helen Pighills	Vale of White Horse District Council
David Radbourne	Regional Director Strategy and Transformation, NHS England
Councillor Chewe Munkonge	Oxford City Council

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Barbara Shaw	Chair, Healthwatch Oxfordshire
Matthew Tait	Chief Delivery Officer, BOB ICB

Notes:• *Date of next meeting: 9 July 2026*

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AGENDA

1. **Welcome by Chair**
2. **Apologies for Absence and Temporary Appointments**
3. **Declarations of Interest - see guidance note below**
4. **Petitions and Public Address**

Members of the public who wish to speak on an item on the agenda at this meeting, or present a petition, can attend the meeting in person or 'virtually' through an online connection.

Requests to present a petition must be submitted no later than 9am ten working days before the meeting.

Requests to speak must be submitted no later than 9am three working days before the meeting (ie: 9AM Monday 11th May 2026)

Requests should be submitted to omid.nouri@oxfordshire.gov.uk AND committeesdemocraticservices@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 9am on the day of the meeting. Written submissions should be no longer than 1 A4 sheet."

5. **Note of Decisions/Minutes of Last Meeting (Pages 9 - 26)**

To approve the Note of Decisions/Minutes of the meeting held on 12 March 2026 and to receive information arising from them.

6. **Community Research- Community Health Development Officer & Well Together Programme Evaluation (Pages 27 - 34)**

The Health and Wellbeing Board is **RECOMMENDED** to:

1. Support the promotion and sharing of the findings from the evaluation of the Oxfordshire County Council-funded Community Health Development Officer (CHDO) programme and the Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)-funded Well Together programme, with partners and colleagues across the system.

7. Oxfordshire Joint Strategic Needs Assessment 2026 (Pages 35 - 38)

The Health and Wellbeing Board is **RECOMMENDED** to:

1. Provide feedback on the proposed design of the 2026 Joint Strategic Needs Assessment (JSNA).
2. Advise on the content of the 2026 JSNA, approach, and to highlight any additional topics and themes of research and intelligence interest that they would like to see included.
3. Via relevant officers in their organisations, contribute information and intelligence to the JSNA to further its development and participate in making information more accessible to everyone.

8. Health & Wellbeing Strategy Update- Start Well (Pages 39 - 74)

The Health and Wellbeing Board is **RECOMMENDED** to:

1. **NOTE** the progress of the delivery of priorities 1 and 2 under the thematic domain of Start Well within the Health and Wellbeing Strategy along with key challenges.
2. **NOTE** the Best Start in Life plan, attached as an appendix to this report, and:
 - a. **DELEGATE** responsibility for regular monitoring of progress on outcomes relevant to the Best Start in Life Plan to the Children's Trust Board;
 - b. **NOTE** that those outcomes will include the inequality of Good Level of Development (GLD) outcomes for children eligible for free school meals; and
 - c. **NOTE** that the Children's Trust Board will report to the Health and Wellbeing Board on this matter as part of these annual Start Well updates and as required for escalation.

9. Oxfordshire Better Care Fund Plan (2026-27) (Pages 75 - 114)

The Health and Wellbeing Board is **RECOMMENDED** to:

1. **NOTE** and **APPROVE** the direction of travel set out in this report for the Oxfordshire Better Care Fund Plan for 2026/27 and the decision-making process set out at paragraph 14.
2. **APPROVE** the Oxfordshire Better Care Fund Plan for 2026/27 and decision on the assurance statements set out at paragraph 19 (of the main report for this item) for submission by 19th May 2026.

10. **Oxfordshire Combating Drugs Partnership Annual Report** (Pages 115 - 128)

The Health and Wellbeing Board is **RECOMMENDED** to:

1. **NOTE** the activities and outcomes of the Oxfordshire Combating Drugs Partnership, reflected in the Annual Progress Report in Annex 1.

11. **Health & Wellbeing Strategy Indicator Review (Verbal Update)**

The Health and Wellbeing Board is recommended to **NOTE** the verbal update on the Health and Wellbeing Strategy Indicator Review.

12. **Marmot Place Update (Verbal)**

The Health and Wellbeing Board is recommended to **NOTE** the Marmot Place Update.

13. **Neighbourhood Health Plan Update (Verbal)**

The Health and Wellbeing Board is recommended to **NOTE** the Neighbourhood Health Plan Update.

14. **Report from Healthwatch Oxfordshire** (Pages 129 - 140)

To receive and **NOTE** the Healthwatch Oxfordshire Report on patient views and experiences of Oxfordshire health and care services.

15. **Reports from Partnership Boards**

To receive updates from Partnership Boards:

1. Place-Based Partnership (Verbal Update).
2. Health Improvement Board (Verbal Update).
3. Children's Trust Board (Verbal Update).

16. **Forward Work Plan** (Pages 141 - 142)

The Board is asked to **NOTE** the forward work programme.

Councillors declaring interests

General duty

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

What is a disclosable pecuniary interest?

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

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

Declaring an interest

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

Members' Code of Conduct and public perception

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

Members Code – Other registrable interests

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

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

Other registrable interests include:

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

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

Members Code – Non-registrable interests

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

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

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

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

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

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

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OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 12 March 2026 commencing at 1.00 pm and finishing at 4.05 pm

Present:

Board Members:

Councillor Liz Leffman (Chair)

Professor Sir Jonathan Montgomery (Vice-Chair)

Councillor Sean Gaul

Michelle Brennan

Councillor Kate Gregory

Ansaf Azhar

Caroline Green

District Councillor Georgina Heritage

Barbara Shaw

Karen Fuller

Lisa Lyons

City Councillor Chewe Edgar Munkonge

Officers:

Isabel Rockingham (Head of Joint Commissioning-Age Well).

Rob MacDougall (Director of Community Safety and Chief Fire Officer).

Serena Abel (Public Health Principal).

Kate Austin (Public Health Principal).

Fiona Ruck (Health Improvement Practitioner).

Tom Gubbins (Wellbeing Manager, Cherwell District Council).

Dr Jessica Allen (Deputy Director at Institute of Health Equity).

Kate Holburn (Deputy Director of Public Health).

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.)

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	ACTION
<p>171 Welcome by Chair (Agenda No. 1)</p>	
<p>The Chair opened the meeting and welcomed Members, officers and partner representatives attending both in person and remotely.</p> <p>The All-Age Autism Strategy had again been postponed until the July Health and Wellbeing Board (HWB) meeting, and this was to allow the strategy to be discussed at the Joint Health Overview Scrutiny Committee (JHOSC) prior to its formal sign off by the HWB.</p> <p>The Chair also explained that the Neighbourhood Health Plan item was to be held at this meeting, although this would again be for the HWB to note the ongoing work to develop the plan, as opposed to signing off a final version of the plan.</p> <p>Reference was also made to a motion from Council which asked the HWB to request the JHOSC to undertake scrutiny of children’s and adults mental health services. There was a very brief report in the agenda which outlined this request to the HWB. It was highlighted that the understanding was that HOSC had engaged in scrutiny of children’s mental health services in its November 2025 meeting, and that it would conduct a deep dive into adults mental health services in its April meeting. The JHOSC would then report its findings on children’s and adults mental health services directly to Council in its annual report.</p> <p>The Board NOTED the Chair’s Introduction.</p>	
<p>172 Apologies for Absence and Temporary Appointments (Agenda No. 2)</p>	
<p>Apologies were received from Grant Macdonald, and Rob Bale was substituting for Grant.</p> <p>Apologies had also been received from Cllr Helen Pighills and Cllr Rob Pattenden.</p> <p>Apologies were received from Matthew Tait, and Chris Wright was substituting for Matthew.</p>	

<p>173 Declarations of Interest - see guidance note below (Agenda No. 3)</p>	
<p>No declarations of interest were made.</p>	
<p>174 Petitions and Public Address (Agenda No. 4)</p>	
<p>There were no requests to speak from members of the public. Cllr Jane Hanna wished to make a statement in relation to the mental health motion, and she was invited to speak at item 6 on the mental health motion as opposed to at this point.</p>	
<p>175 Note of Decisions/Minutes of Last Meeting (Agenda No. 5)</p>	
<p>The Board APPROVED the minutes of the meeting on 4 December 2025 as an accurate record.</p>	
<p>176 Update on Mental Health Motion (Agenda No. 6)</p>	
<p>Councillor Jane Hanna, Chair of the JHOSC, presented an update on recent scrutiny work relating to children’s mental health and SEND services.</p> <p>Councillor Hanna explained that the Committee had undertaken an in-depth examination of SEND provision and children’s mental health, prompted by sustained increases in demand and complexity across the system. She described how scrutiny had focused not only on service performance but on how partners were working together, and whether the system as a whole was structured to respond effectively to children and families.</p> <p>She reported that evidence presented to the JHOSC demonstrated a more unified and deliberate focus by partners on SEND children than had previously been evident. This had been particularly important given that SEND pressures were a significant driver of escalating demand across education, health and social care. The Committee had welcomed this increased alignment but remained concerned about the scale of unmet need.</p> <p>Councillor Hanna referred to the 2025 Ofsted inspection, which had concluded that effective action had been taken since 2023. However, she stressed that Ofsted’s findings should not be interpreted as indicating that the system was “fixed”. The</p>	

Committee's view was that progress had been made in the right direction, but that the pace of improvement remained constrained by structural and systemic barriers.

She outlined the key challenges identified during scrutiny. These included limitations in time and workforce capacity across all partners, the cumulative impact of organisational change, and the complexity introduced by the formation of the Thames Valley Integrated Care Board, which covered a much larger geography than Oxfordshire alone. Councillor Hanna explained that partners were subject to different national policy requirements, performance regimes and delivery timelines, which were not always aligned and made joint working more difficult.

A recurring theme during scrutiny had been the lack of clarity about local flexibility at place level. Councillor Hanna explained that partners were often uncertain about where discretion existed and how far they could adapt national requirements to meet local need. The Committee had concluded that greater clarity and confidence around local decision-making was essential if improvement was to accelerate.

She reported that the Cabinet Member for Children had attended the scrutiny session and had spoken candidly about the long-term sustainability challenge facing children's services. Funding pressures, reductions in preventative services, and increasing statutory demand were affecting all partners, not just the local authority. Councillor Hanna reminded the Board that the JHOSC had repeatedly highlighted, since 2023, the need for a stronger focus on securing sustainable, long-term funding for children's services rather than relying on short-term mitigation.

Councillor Hanna also highlighted the prominence of children's and young people's voice during scrutiny. The Committee had discussed how feedback from children and families was often fragmented across the system and had explored ways in which those voices could be brought together more coherently. This had led to discussion about the role of Healthwatch and other local voice mechanisms, and how they could be strengthened.

She concluded by emphasising that the update provided to the Board was necessarily a summary, and that a much more detailed scrutiny report would follow. She stressed that the Committee's work was intended to support system improvement rather than laying blame.

In discussion, Members of the Board reflected on the scale and depth of the JHOSC's scrutiny work. The Board acknowledged that health scrutiny of this nature was time-intensive and often underestimated, and commended the Committee for its evidence-based and constructive approach.

<p>The Chair thanked Councillor Hanna for the update and noted the strong alignment between the JHOSC's findings and the Board's own responsibilities for strategic leadership, integration and prevention.</p> <p>The Board RESOLVED to:</p> <ol style="list-style-type: none"> 1. AGREE to request the Health Overview and Scrutiny Committee to investigate mental health services and follow up. 	
<p>177 Oxfordshire Neighbourhood Health Plan (Agenda No. 7)</p>	
<p>Michelle Brennan (Oxfordshire GP representative) introduced the draft Oxfordshire Neighbourhood Health and Care Plan. She set out the national policy context, explaining that although NHS England guidance had been delayed, systems were still expected to progress neighbourhood-based models of care.</p> <p>Michelle Brennan explained that Oxfordshire had identified 15 proposed neighbourhoods, largely aligned with existing Primary Care Network footprints. She emphasised that these geographies were intended as a starting point, not a final model, and would be tested and refined over a 12-month period.</p> <p>She outlined the proposed priorities for Oxfordshire: proactive care for people with frailty and complex needs; improved management of multiple long-term conditions; and better integrated support for children and young people aligned with Family Hubs. She also described how population health management data and neighbourhood-level data packs would support local prioritisation.</p> <p>The Board then explored the tension between neighbourhoods as organisational units for service delivery and neighbourhoods as places recognised by residents. Concerns were raised about rural geography, transport links, and whether proposed neighbourhoods reflected how people actually moved through their communities.</p> <p>It was emphasised that neighbourhoods should not create new barriers or restrict access to services. Others highlighted the need for clarity about accountability and governance, questioning who would be responsible for decisions and outcomes at neighbourhood level.</p> <p>There was discussion about the relationship between</p>	

<p>neighbourhood health and prevention, with Members stressing that the model should not become overly clinical or hospital-focused. Contributions highlighted the importance of community assets, housing, loneliness, mental health and transport as integral to neighbourhood health.</p> <p>The Chair summarised that while there was broad support for the direction of travel, the discussion had highlighted the need for further refinement, engagement and clarity as national guidance emerged.</p> <p>The Board RESOLVED to:</p> <ol style="list-style-type: none"> 1. Consider and support the following to progress with implementation of Oxfordshire’s neighbourhood health and care approach for 26/27: <ol style="list-style-type: none"> a) The Objectives and guiding design principles. b) The Neighbourhood geographies (working drafts for 26/27). c) The Priorities. d) The Foundations. e) The Population health management approach. 	
<p>178 Health & Wellbeing Strategy Update - Building Blocks priority 4-5 - Age well (Agenda No. 8)</p>	
<p>Karen Fuller (Director of Adult Social Care and Izzy Rockingham (Head of Joint Commissioning-Age Well) presented the Health and Wellbeing Strategy Update on priorities 5-6.</p> <p>Karen Fuller introduced the item, explaining that the paper provided a comprehensive update on progress against Priorities 5 and 6 of the Health and Wellbeing Strategy, which focused on maintaining independence for older people and strengthening social relationships. She noted that the report also proposed amendments to the shared outcomes and metrics used to track delivery, reflecting changes in the wider policy and data landscape.</p> <p>Karen Fuller emphasised that the report illustrated the value of system-wide working under the “Oxfordshire Way”, particularly where health, social care, voluntary sector and district partners had aligned their activity. She highlighted that the agenda item linked closely with earlier discussion on neighbourhood health and care, and that the Age Well work was expected to increasingly align with neighbourhood-based models over time.</p>	

The Head of Joint Commissioning-Age Well then presented the detailed content of the report. She explained that Priority 5 centred on maintaining independence and had three core shared outcomes. The first was ensuring that older people remained safe, well and independent in their own homes for longer. She described how the system was supporting more people at home, including increases in care hours delivered through adult social care and greater use of extra care housing. She stressed that this was not solely a social care issue, but depended heavily on community-based support and voluntary sector involvement. She highlighted the role of voluntary sector partners in improving health and wellbeing and reducing reliance on statutory services. She drew attention to the Move Together programme, noting that while it targeted people with long-term conditions, 45% of participants were over 65, meaning that a majority were being reached earlier in life. This was described as a positive shift towards prevention, reducing frailty before it became entrenched.

In relation to hospital activity, the Head of Joint Commissioning-Age Well reported that Oxfordshire remained on target for emergency admissions relating to long-term conditions. However, she acknowledged that falls-related admissions remained above target. She explained that a system-wide falls action group had been established and was developing a coordinated response involving health, social care and voluntary partners.

The second shared outcome related to supporting people who had lost a degree of independence. The Head of Joint Commissioning-Age Well described consistently strong reablement outcomes, with around 80% of people achieving independence or reduced care needs following reablement. She explained how this aligned with the Home First approach and a continued commitment to treating care home admission as a last resort. Oxfordshire's performance in this area compared favourably with other local authorities nationally.

The Head of Joint Commissioning-Age Well also highlighted an area of concern: dementia diagnosis rates. She explained that Oxfordshire remained below target, and outlined work underway through a BOB Integrated Care Board-wide group and local clinical groups within Oxford Health NHS Foundation Trust to address this.

The third shared outcome focused on empowering older people to make decisions about their own health and wellbeing. There was an increasing use of Live Well Oxfordshire as a directory of community support, and it was highlighted that the impact of the specialist advice service, which had supported nearly 3,000 people in its first year, had secured significant financial benefits for residents.

Turning to Priority 6, the Head of Joint Commissioning-Age Well explained that social isolation remained a major challenge. She noted that while Oxfordshire performed better than the England average, over a third of older people still reported not having as much social contact as they would like. She described work to strengthen community connections through community capacity grants, partnerships with organisations such as Age UK, and local area coordination.

There were also particular challenges faced by older people in rural areas, including isolation, transport barriers and digital exclusion. It was explained that this work was closely linked to the Marmot programme and that public health colleagues were supporting further analysis and targeted responses.

The Board expressed surprise that discharge to usual place of residence was no longer a required national metric, noting its importance in supporting independence. It was explained that while the national requirement had been removed, local measurement could still be retained.

The Board also sought clarification on falls prevention, questioning whether the issue was a lack of provision or a lack of awareness and coordination. It was responded that there was a breadth of existing services, but that navigation and awareness were challenges. It was explained that a public-facing and professional awareness campaign had been launched, alongside practical measures such as a dedicated advice line for care homes.

Further discussion explored the role of environment in falls prevention, including pavements, housing and public spaces. The importance of avoiding over-medicalisation and instead addressing wider determinants through neighbourhood planning and highways collaboration was also emphasised.

The Board also discussed satisfaction metrics, noting that Oxfordshire was slightly below the national average. It was explained that there were limitations of national surveys and how local feedback mechanisms, including Healthwatch intelligence and provider engagement, were being used to gain a more nuanced understanding.

The Board **RESOLVED** to:

1. **NOTE** the progress on the delivery of priorities 5 & 6 for Age Well within the Health and Wellbeing Strategy.
2. **NOTE** and **AGREE** the proposed amendments to the Health and Wellbeing Board Shared Outcome metrics.

<p>179 Safer Oxfordshire Partnership Annual Report, including Domestic Abuse Strategic Board Annual Report (Agenda No. 9)</p>	
<p>Rob MacDougall (Director of Community Safety and Chair of the Safer Oxfordshire Partnership) presented the Community Safety Partnership (CSP) Agreement.</p> <p>The Director of Community Safety began by setting out the statutory basis of Community Safety Partnerships under the Crime and Disorder Act 1998. He explained that CSPs were responsible for reducing crime, tackling anti-social behaviour, addressing re-offending, substance misuse and exploitation, and protecting vulnerable people. He emphasised that these objectives were inseparable from health and wellbeing outcomes.</p> <p>It was described how CSP priorities were developed using local intelligence, Police and Crime Commissioner priorities, and county-wide strategic intelligence assessments. These assessments identified the most significant risks and harms at district and county level. It was explained that while local CSPs responded to local contexts, the Safer Oxfordshire Partnership provided a county-wide strategic framework to ensure alignment, avoid duplication and support escalation where required.</p> <p>The practical work of the Partnership was also outlined, including coordinated prevention activity on serious violence, modern slavery, domestic abuse, exploitation and anti-social behaviour. It was explained how governance arrangements ensured accountability across agencies and supported joint responses to safeguarding and public health concerns.</p> <p>The Director of Community Safety placed particular emphasis on the intersection between community safety and health, explaining that many CSP priorities addressed the wider determinants of health. Domestic abuse, substance misuse, unsafe environments and repeat victimisation were all drivers of health inequality and high demand on health and care services. It was explained that effective community safety interventions could reduce pressure on emergency departments, mental health services, ambulance services and social care by preventing crises and repeat harm.</p> <p>The Director of Community Safety also highlighted the role of CSPs in convening partners beyond the traditional health system, including housing, policing, safeguarding, fire and rescue, youth services and the voluntary sector. He stressed that this breadth of partnership was critical to addressing complex, cross-cutting issues.</p> <p>In discussion, Board Members reflected on the strong alignment</p>	

between CSP priorities and the Health and Wellbeing Strategy. Members noted the importance of prevention-focused approaches and welcomed the emphasis on reducing inequalities. There was recognition that community safety work often prevented demand that would otherwise fall on health and social care services.

Ansaf Azhar introduced the Domestic Abuse Partnership Strategic Board Annual Report for 2024–25. He explained that the report formed part of the Partnership’s accountability to both the Safer Oxfordshire Partnership and the Health and Wellbeing Board.

Ansaf Azhar outlined the evolution of the Domestic Abuse Partnership since the implementation of the Domestic Abuse Act in 2021. He explained that Oxfordshire had developed a holistic domestic abuse strategy alongside a safe accommodation strategy, structured around a four-P framework: prevention, provision, pursuing perpetrators, and partnership. He emphasised that lived experience was embedded throughout governance, strategy and delivery.

Serena Abel (Public Health Principal) was invited to expand on key areas of progress. She described the domestic abuse training needs assessment commissioned following a multi-agency conference in January 2025, which had focused on seldom-heard voices. Feedback from the conference had highlighted the need for more coherent and accessible training across the system.

It was explained that while Oxfordshire had a strong overall training offer, it was fragmented. There was duplication in some areas, gaps in others, and inconsistency in access and quality. The needs assessment had involved surveys, interviews and workshops, and had identified opportunities to develop a central training directory, clearer graduated pathways for professionals, stronger quality assurance, greater involvement of people with lived experience, and more flexible training formats to meet the needs of frontline staff.

There was also a description of the progress on reviewing pathways for children and young people affected by domestic abuse. This work had been driven by safeguarding learning, national inspection findings and local intelligence. A proposal for a full pathway review had been approved in December 2025, enabling additional officer capacity to begin structured engagement with children, young people, parents, carers and professionals. It was explained that the aim was to develop a pathway that was trauma-informed, grounded in lived experience, and practical for professionals to use.

The Public Health Principal outlined how the wider domestic

<p>abuse needs assessment was feeding into a refresh of the overarching strategy and a review of governance arrangements, including the structure and focus of sub-groups.</p> <p>Questions were raised by the Board about how success could be measured without relying solely on reported incident numbers, and how the system dealt with perpetrators who did not engage with training or support. In response, Ansaf Azhar explained that increased reporting was often a positive indicator of improved awareness, trust and access to support. He stressed that cultural change took time and required a whole-system approach, including education, mental health support, substance misuse services and work with schools.</p> <p>The Public Health Principal added that the Strategic Board reviewed a quarterly multi-agency surveillance pack bringing together data from MARAC, high-risk services, safe accommodation, children’s social care and health settings. While acknowledging data limitations, she explained that this provided a more nuanced and timely picture than annual reports alone.</p> <p>There was further discussion about the need to join up safeguarding, community safety and domestic abuse narratives more clearly, both internally and externally, to avoid fragmentation and duplication.</p> <p>The Board RESOLVED to:</p> <ol style="list-style-type: none"> 1. NOTE the activities and outcomes of the Safer Oxfordshire & Oxfordshire Domestic Abuse Strategic Board, reflected in Annex 1 & 2. 	
<p>180 Director of Public Health Annual Report (Agenda No. 10)</p>	
<p>Ansaf Azhar (Director of Public Health), Fiona Ruck (Health Improvement Practitioner), and Kate Austin (Public Health Principal) introduced the Director of Public Health Annual Report. Ansaf Azhar explained that it marked five years since his first report, which had shone a spotlight on inequality in Oxfordshire. He described this year’s report as both reflective and forward-looking.</p> <p>Ansaf Azhar explained that the most recent Index of Multiple Deprivation data, published at the end of 2025, showed that Oxfordshire had become relatively less deprived overall compared with 2019, and that several of the previously most deprived wards had improved. He was careful not to attribute</p>	

causality directly to individual interventions, but argued that sustained, partnership-led effort had made a meaningful difference.

Ansaf Azhar described the Community Insight Profile approach as foundational to this progress. By combining data, lived experience and asset mapping, partners had been able to develop solutions tailored to specific communities rather than applying generic interventions. He highlighted the role of community health development officers in mobilising community assets and bridging statutory and voluntary sectors.

Ansaf Azhar described how this work had led to the formation of the Prevention and Health Inequality Forum, which initially operated without dedicated funding but brought partners together around a shared commitment. Subsequent pooled funding had enabled over £1.5 million of investment in tackling inequality, including physical activity programmes and voluntary sector support, some of which had gained national recognition. He stressed, however, that the report was not an invitation to relax. He warned that financial pressures, NHS reform and local government reorganisation risked undermining progress if prevention and inequality work were deprioritised. He argued that inequalities remained significant, particularly in rural areas, and that now was the moment to scale up rather than retreat.

Ansaf Azhar then introduced the new format of the report, explaining that it had moved away from a traditional written document to an interactive, web-based format designed to be accessible, engaging and updatable.

The Public Health Principal and Health Improvement Practitioner then demonstrated the website, explaining how it allowed users to explore content non-linearly, engage with videos and case studies, and access up-to-date data. They described how the format enabled new content to be added over time and made the report more usable for partners and communities.

Discussion focused on accessibility and digital exclusion. Members asked how the report would reach people without internet access. It was explained that the report would be taken out into communities through local area partnerships and that work was underway with communications teams and community organisations to ensure accessibility.

Members also discussed the importance of long-term funding stability for prevention programmes, with examples such as Move Together highlighting the challenge of annual funding cycles. Ansaf responded by emphasising the need for a system-wide, value-based approach to investment and a shift towards upstream funding.

<p>The Board RESOLVED to:</p> <ol style="list-style-type: none"> 1. NOTE and consider the 2025/26 Director of Public Health Annual Report and specifically note the progress made to address health inequalities in Oxfordshire following the publication of the Director of Public Health Annual Report in 2019/2020, which marked a pivotal moment in Oxfordshire. 2. SUPPORT the interactive format of the Director of Public Health Annual Report 2025/26 and note the insights that can be used for informing future service delivery plans. 	
<p>181 Community Insight Profile toolkit (Agenda No. 11)</p>	
<p>Ansaf Azhar (Director of Public Health), Fiona Ruck (Health Improvement Practitioner), and Kate Austin (Public Health Principal) presented the Community Insight Profile Development Framework, explaining that it captured learning from several years of place-based work and translated it into a practical, step-by-step toolkit.</p> <p>It was explained that the framework supported partners to identify appropriate geographies, engage meaningfully with communities, map assets, and turn insight into action. It was stressed that the toolkit was not just about data collection, but about building trust, shared understanding and collaborative decision-making.</p> <p>Tom Gubbins (Wellbeing Manager, Cherwell District Council) described Cherwell District Council's experience of using community insight profiles and piloting the toolkit. He explained how the approach had shifted organisational culture, sharpened focus, and led directly to over 50 projects in Banbury and Bicester, reaching around 11,000 attendances.</p> <p>He gave examples of how insight profiles had influenced wider place-shaping decisions, including investment in sports facilities and wayfinding schemes. He also described the pilot in Heyford Park, where over 300 residents and organisations had contributed to an insight profile that was already shaping priorities around inclusion, youth provision, skills and transport.</p> <p>Members discussed the importance of rolling the toolkit out beyond early adopters and ensuring that it was used by non-health partners. Ansaf Azhar stressed that the toolkit would only be effective if it informed real decision-making across the system.</p>	

<p>The Board RESOLVED to:</p> <ol style="list-style-type: none"> 1. NOTE the Community Insight Profile Development Framework (CIPs Toolkit) as a core legacy product of the Public Health led Community Insight Profiles (CIP) programme. 2. NOTE the alignment of the Toolkit with the Board’s prevention and inequalities priorities, the Marmot Place work and the Director of Public Health Annual Report (DPHAR) 2025/26. 3. SUPPORT dissemination and use of the CIPs Toolkit across partners and communities to enable locally led CIPs and action plans. 	
<p>182 Marmot Update (Agenda No. 12)</p>	
<p>Kate Holburn (Deputy Director of Public Health) introduced the Marmot programme update, outlining progress in working with the Institute of Health Equity. She explained that Oxfordshire had initially focused on a subset of the Marmot principles, including best start in life and fair employment, while also exploring rural inequalities.</p> <p>Dr Jessica Allen (Institute of Health Equity) then presented detailed analysis from the Institute of Health Equity. She highlighted stark inequalities in early years development, particularly for children eligible for free school meals in affluent and rural areas. She explained that growing up poor in a wealthy area appeared to be associated with worse outcomes, potentially linked to stigma, service access and social isolation. She also presented data on educational attainment, economic inactivity and employment outcomes for young people, highlighting significant variation across Oxfordshire and persistent disadvantage for children eligible for free school meals.</p> <p>Discussion focused on how this evidence was informing family hub development, transport planning and early years support. Members stressed the importance of granular data and community engagement, and asked about learning from other rural areas.</p> <p>It was explained that similar patterns were emerging in other rural counties and that while the numbers affected were smaller than in urban areas, this made the problem potentially more tractable if addressed systematically.</p>	

<p>The Board RESOLVED to:</p> <ol style="list-style-type: none"> 1. NOTE the progress made through the Marmot programme and the partnership with the Institute for Health Equity. 2. NOTE the need to embed accountability further to the publication of the following reports to address inequities (the IHE Maternity, Babies, Children and Young People deep dive; the Rural Inequalities review; and the IHE Fair Employment deep dive). 	
<p>183 Healthwatch Oxfordshire Update (Agenda No. 13)</p>	
<p>Barbara Shaw (Chair, Healthwatch Oxfordshire) provided an update on Healthwatch Oxfordshire’s recent activity. She described work undertaken with Community First Oxfordshire to gather insight from rural communities, particularly those that were seldom heard.</p> <p>Barbara Shaw also highlighted the completion of a “How To” community research toolkit, designed to enable grassroots groups to undertake their own research and feed insight into the system.</p> <p>The Board acknowledged the importance of Healthwatch intelligence in complementing formal data sources.</p> <p>The Board RESOLVED to:</p> <ol style="list-style-type: none"> 1. NOTE the Healthwatch Oxfordshire Report on patient views and experiences of Oxfordshire health and care services. 	
<p>184 Update on the future of an independent patient voice for Oxfordshire - working group report (Agenda No. 14)</p>	
<p>Omid Nouri (Health Scrutiny Officer) presented the working group report, and explained that the purpose of this item was to receive an update on the establishment and activities of the Health and Wellbeing Board Working Group on an Independent Patient Voice.</p> <p>The Health Scrutiny Officer outlined the rationale for the working group’s establishment as well as the activities it had engaged in</p>	

<p>thus far in exploring what a future independent patient voice function could look like subsequent to the passing of government legislation to abolish Healthwatch.</p> <p>The Health Scrutiny Officer also explained that the working group should convene another meeting in April 2026 to discuss both the material the would be utilised as part of a public engagement exercise to shape a future independent patient voice, as well as to discuss the prospect of launching a mapping exercise to determine which patient voice mechanisms already exist within the system and how to avoid duplication with this work.</p> <p>The Board RESOLVED to:</p> <ol style="list-style-type: none"> 1. AGREE to formally establish a working group on an independent patient voice. 2. AGREE that the working group will explore and evaluate models for a future independent patient voice function in Oxfordshire following the imminent abolition of Healthwatch by government legislation. 3. AGREE to the proposed membership of the working group outlined in this report below. 4. DELEGATE to the working group the power to oversee the commissioning of a public engagement exercise to explore the future of an independent patient voice. 5. AGREE to receive an update from the working group on a likely future independent voice function subsequent to the passing of government legislation to formally abolish Healthwatch. 	
<p>185 Reports from Partnership Boards (Agenda No. 15)</p>	
<p>District Cllr Georgina Heritage provided an update from the Health Improvement Board, highlighting recent discussions on healthy weight, physical activity and food strategy delivery. She described both successes and challenges, including reliance on short-term funding and volunteer capacity.</p> <p>Cllr Sean Gaul then presented an update from the Children’s Trust Board, seeking agreement for the Board to take the lead on overseeing the Best Start in Life plan and associated outcomes, including reducing inequalities in early years development for children eligible for free school meals. Members expressed</p>	

<p>support for this approach and discussed how reporting and oversight would be integrated with the Health and Wellbeing Board's agenda.</p> <p>It was acknowledged that Matthew Tait was not present to introduce the Place-Based Partnership Report, but that a written report was submitted by the Partnership and was in the agenda.</p> <p>The Board RESOLVED to:</p> <p>1. NOTE the Partnership Board updates.</p>	
<p>186 Forward Work Plan (Agenda No. 16)</p>	
<p>The Board AGREED the forward work plan.</p>	

..... in the Chair

Date of signing

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OXFORDSHIRE HEALTH AND WELLBEING BOARD

14 May 2026

Community Health Development Officer and Well Together programme Evaluation Report

Report by Ansaf Azhar– Director of Public Health and Communities, Oxfordshire
County Council

RECOMMENDATION

1. **The Oxfordshire Health and Wellbeing Board is RECOMMENDED to**
 - 1.1 Support the promotion and sharing of the findings from the evaluation of the Oxfordshire County Council-funded Community Health Development Officer (CHDO) programme and the Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)-funded Well Together programme, with partners and colleagues across the system.

Executive Summary

2. This report gives an overview of the Oxfordshire County Council-funded Community Health Development Officer (CHDO) programme and the Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)-funded Well Together programme. Both programmes build on the Community Insight Profiles (CIPs) work and aim to reduce health inequalities by supporting community-led action, small grants, and stronger local partnerships in areas facing the greatest disadvantage.
3. The evaluation found that CHDOs and Well Together Community Capacity Builders are a key strength. Their regular local presence helps to build trust, connect residents and organisations, and support the delivery of local priorities.
4. The final report of the evaluation highlights that these approaches work best when funding is multi-year, roles are stable, reporting is proportionate, and success is measured using realistic indicators such as reach, participation, trust, stronger networks, and long-term sustainability.

Background

5. Oxfordshire County Council Public Health has been working with partners to develop Community Insight Profiles (CIPs). This work began after the publication of the [Director of Public Health \(DPH\) Annual Report](#) for 2019/20, which highlighted ten wards in Oxfordshire that included small areas (Lower-layer Super Output Areas) in the 20% most deprived in England (Index of Multiple Deprivation (IMD), 2019) and are therefore more likely to experience health inequalities. Following this, a further four Community Insight Profiles

were developed for areas identified as falling within the 30–40% most deprived nationally (IMD 2019), and where local partners agreed there would be added benefit in developing a profile.

6. The profiles map local assets, capture community insight on enablers and challenges to health and wellbeing and set out a dataset of indicators for each area to help inform high-level recommendations.
7. Each profile includes locally led recommendations that set out objectives to strengthen community assets and development opportunities. An action plan is then developed for each area, based on those recommendations.
8. To support delivery of the actions arising from the Community Insight Profile recommendations, Community Health Development Officer posts have been funded in each area where a profile has been developed. This is supported by a small grants scheme to help community projects deliver the recommendations in the profiles.

The Community Health Development Officer (CHDO) programme and associated community grants programmes.

9. Oxfordshire County Council has funded nine Community Health Development Officer (CHDO) posts to cover the 14 areas where a Community Insight Profile (CIP) has been developed. The posts are hosted by the relevant city or district council. Posts have been recruited to by the city and district councils in different ways to reflect local need; for example, one full-time role may cover several areas, or part-time roles may focus on a single area.
10. CHDOs work with local partners and residents to turn CIP recommendations into action. Using an asset-based approach, they help to coordinate local activity, share health and wellbeing messages, and support projects that build community capacity, resilience, and connection.
11. CHDOs act as trusted connectors in the communities they work with. Their role includes:
 - (a) Supporting delivery of CIP recommendations through local action planning.
 - (b) Convening local partnerships and coordinating health promotion activity.
 - (c) Building capacity by connecting people, aligning activity and encouraging joint working.
 - (d) Supporting communities to access grant funding for local health and wellbeing initiatives.
 - (e) Raising awareness of public health services and local health and wellbeing opportunities.

Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) funded Well Together programme

12. Building on the CIPs programme, the Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) has funded a grants programme called 'Well Together'. This programme invests in community-led health and wellbeing projects and capacity building in the 10 wards that were included in phases 1–3 of the CIP programme.
13. [Well Together](#) is a place-based programme designed to bring individuals, communities, and organisations together to enhance wellbeing from the ground up. Community Capacity Builders are a key element of the programme. Taking an asset-based focus, they helped to identify health and wellbeing priorities that mattered to local residents. They connected with existing and new community groups and individuals wanting to do more in their community; building confidence, connections and mutual support and collaboration.
14. The programme is based on the principle that wellbeing is created collectively through engagement in activities, meaningful conversations, and relationships that are part of everyday life. Community Capacity Builders actively support access to Well Together funding and build relationships with the funded groups. This includes helping organisations to collect stories and data to evaluate the effectiveness and impact of their activities, as well as offering guidance on expanding outreach, promoting local collaboration, and connecting with wider networks and resources – making small steps in addressing the deeper roots of inequality.
15. The Well Together Community Capacity Builders and the Community Health Development Officers actively worked together to co-ordinate activities and support to maximise the benefit to communities.

Strategic links

Marmot

16. Both the CHDO and Well Together programmes support delivery of the Marmot Place approach by enabling direct engagement with partners and communities in areas most affected by health inequalities. This place-based, community-led approach aligns with the Marmot focus on addressing inequalities linked to the social determinants of health.

Director of Public Health Annual Report 2025/26

17. [The Director of Public Health Annual Report \(DPHAR\) 2025/26](#) recommends sustained, preventative action to reduce health inequalities. It highlights the importance of strengthening community assets, supporting local leadership, and embedding place-based approaches. The report includes examples of how CHDOs, grant schemes, and the Well Together programme have benefitted local communities, supported by case studies and videos.

Health Overview and Scrutiny Committee recommendations

18. The benefits of the CHDO and Well Together programmes are also reflected in recommendation 4 from the HOSC response to the Director of Public Health Annual Report, presented on [29 January 2026](#):

To move Community Health Development Officer, Well Together roles and community led programmes onto multiyear funding cycles, given that short funding cycles undermine sustainability. It is recommended that there is a best value review and prioritisation of funding continuity to avoid regression of gains in areas with improving Index of Multiple Deprivation deciles.

Development of Neighbourhood Health and Care

19. Community led development supports the foundations for neighbourhood health and care. Building on the work of the Community Insight Profiles and the further insights gained via the Well Together programme and the CHDOs can enable a more sophisticated and rounded approach to Population Health Management, combining qualitative and quantitative data. There is an opportunity to build on the trust and relationships developed to engage and involve residents in identifying what is most important to them. There is a need to provide holistic support and interventions in response to ill health, particularly for those experiencing the greatest health inequalities.

Evaluation of the Community Health Development Officer role and the Well Together Programme

20. The CHDO programme and the ICB-funded Well Together programme are being evaluated by the University of Oxford as part of the Oxfordshire Health Humanities Project. [The interim report \(January–December 2024\)](#) focused on the roles within each programme and the set-up of the grant schemes. The final report explores the impact of the funded activities and the benefits of longer-term investment. An executive summary of the findings from the final evaluation report can be found in annex 1 of this report.
21. The evaluation covers the first 10 areas where Community Insight Profiles were produced, which mirrors the 10 areas covered by the Well Together programme. However, the learning from the evaluation can be scaled and applied to all areas in Oxfordshire, and beyond.
22. An extract from the evaluation report is included below:

“Individual Community Health Development Officers and Well Together’s Community Capacity Builders are particular strengths of each programme, able to effectively engage with local communities through regular presence in community activities; excellent communication and networking skills; and active partnerships with existing organisations and networks.”

High level findings from the final report

23. The final report suggests several public health policy implications:
- a. Support long-term, relationship-based community infrastructure—not short-term “projects.” Trust, familiarity, and sustained networks are central. Policy should therefore prioritise multi-year funding, continuity of staff, and stable local partnerships.
 - b. Treat community capacity-building as a core prevention strategy (not an optional add-on). Both CHDO and Well Together are bottom-up prevention models that enable residents and local organisations to define needs, mobilise assets, and deliver activity. Policy should elevate these mechanisms alongside clinical services.
 - c. Design evaluation frameworks that match programme timescales and aims. As population-level outcomes will not shift quickly, policy should legitimise intermediate measures (participation, reach into underserved groups, network strength, resident engagement, trust, and sustainability) rather than relying only on morbidity/mortality changes.
 - d. Use flexible delivery models with clear roles and coordination across sectors with clarity on who does engagement, grant support, and coordination and look at ways of reducing administrative burden for community groups.

Next Steps

24. The next steps will be to complete a dissemination plan to ensure that the research findings are shared with a range of audiences, including policy makers, academics and communities.

Corporate Policies and Priorities

25. The CHDO and Well Together programmes align with Oxfordshire County Council’s corporate priorities for 2025–2028, which focus on making the county greener, fairer, and healthier.

Financial Implications

26. There are no direct funding implications from this report. The work described has been funded by the Public Health grant and the ICB Inequalities and Prevention fund.

Comments checked by:

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

Legal Implications

27. There are no specific legal implications arising from this report. The work described informs and supports the delivery of the local authority's public health functions.

Comments checked by:

Janice White, Principal Solicitor – ASC, SEND and Education

Equality & Inclusion Implications

28. The CHDO and Well Together programmes aim to help address inequalities by providing funding and support to communities experiencing the greatest inequality.

Sustainability Implications

29. There are no sustainability implications arising from this report.

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

Annex 1: Summary of the Evaluation of the Community Health Development Officer role and the Well Together programme

Annex 1 is provided as a separate document attached to this paper.

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May 2026

University of Oxford Health Humanities Evaluation of Oxfordshire CHDO and WT Programmes

Executive Summary

Community Health Development Officers (CHDO) and Well Together (WT) are two community health programmes aiming to reduce health inequalities in the ten Oxfordshire wards identified as priority wards in the Oxfordshire Director of Public Health Annual Report 2019/20. These are Abingdon Caldecott, Banbury Cross and Neithrop, Banbury Grimsbury and Hightown, Banbury Ruscote, Barton & Sandhills, Blackbird Leys, Littlemore, Northfield Brook, Osney & St Thomas, and Rose Hill & Iffley. Health inequalities are differences in health outcomes and access to healthcare. These can include differences in rates of illness, average life expectancy, or the availability of resources such as medical care, healthy and affordable food, or green space.

The CHDO and WT community health programmes draw on [Community Insight Profiles](#), detailed overviews of quantitative and qualitative evidence about which local health and wellbeing assets residents identify as important. They also record community views on what residents appreciate about their ward and which community issues they would like to see addressed, including challenges to health and wellbeing.

Methodology

As these two programmes were initiated in 2023 and our research was conducted from January 2024 to December 2025, their impact will not be demonstrable in population-level data. Instead, our evaluation uses empirical research to analyse the ways in which these programmes have been implemented, to what extent the programmes helped to develop and support community capacity for health and wellbeing, and the extent to which target communities engaged with the two programmes.

We used a mixed-methods approach, combining qualitative and quantitative evidence. This drew on methods from the humanities and social sciences, including history, anthropology, economics, and public health in order to understand the social and cultural contexts of community health. Our research analysed the health and social contexts of the ten priority wards; the funding and grant activities of the two programmes; and community engagement with the two programmes. This drew on statistical analysis; focus groups; semi-structured interviews; neighbourhood surveys; and extensive fieldwork and event participations. Lead researchers were Erica Charters (PI), Sally Frampton, Urvi Khaitan, and Yuxin Peng.

Findings

Our evaluation presents quantitative and qualitative data showing that the CHDO and WT programmes have demonstrably fulfilled their objectives. They were successful in taking a community-based approach to support health and wellbeing through effective communication, activities, and practices in the communities most likely to experience health inequalities. The two programmes also demonstrated substantial reach into underserved groups. This was accomplished by: implementing the recommendations of Community Insight Profiles; working with ‘anchor’ organisations, key partners, and stakeholders; and coordinating with grassroots and voluntary sector groups.

A key factor that enabled this collaboration was each programme's allocation of community activity funding. This supported over 100 community organizations to help deliver over 200 health and wellbeing activities distributed across the ten wards. In our survey of c. 1600 households in the target neighbourhoods, we found that two-thirds (73%) of residents had heard of, attended, or wished to attend these local community health activities; moreover, one-third (34%) of residents had participated in at least one CHDO- or WT-funded health and wellbeing activity in their ward. Both programmes therefore had a significant impact on households in the target neighbourhoods of the ten priority wards.

Collaboration and coordination with communities fundamentally relied on the programmes linking residents to existing medical and health provision and health and wellbeing activities in the wards, as well as ensuring that local health infrastructure is accessible and trusted. To accomplish this, we found that individual Community Health Development Officers and Well Together's Community Capacity Builders are particular strengths of each programme. They effectively engage with local communities through regular presence in community activities; excellent communication and networking skills; and active partnerships with existing organisations and networks.

Our research found that communities understand health through social relationships: through concerns over family and household health, rather than simply through individual health. Residents also prioritize people – neighbours, family, and social ties – in what is important to them in their communities. At the same time, each community is unique, requiring individuals and approaches that take account of local identity and culture, rather than simply implementing models. Above all, community health and wellbeing depend on communities themselves as active and engaged networks of social and cultural relationships.

Recommendations

The CHDO and WT programmes offer a model for long-term preventative and community health. By working with existing community organisations, supporting resident-identified priorities, and making use of trusted individuals who excel at working with local communities, these programmes provide effective bottom-up and relationship-based community health infrastructure.

Our research found that long-term approaches and sustained initiatives and engagement are crucial to the continued effectiveness of community health programmes. Rather than one-off projects, we recommend that such community-based and relationship approaches be categorized as key long-term strategies to achieve resilient community health, prioritizing sustainability over innovation.

Residents access and engage with health and wellbeing activities and with medical and health infrastructures through social relationships that require trust and familiarity, and – crucially – through social relationships that encourage aspirations and expectations of improved health and wellbeing. We recommend that methodologies for evaluating the effectiveness of community health programmes prioritize resident engagement and trust to achieve meaningful reporting while ensuring proportionate demands on the responsibilities of community organizers.

Oxfordshire Health and Wellbeing Board Thursday 14th May 2026

Oxfordshire Joint Strategic Needs Assessment 2026

Report by Director of Public Health and Communities

RECOMMENDATION

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

1. Provide feedback on the proposed design of the 2026 Joint Strategic Needs Assessment (JSNA).
2. Advise on the content of the 2026 JSNA, approach, and to highlight any additional topics and themes of research and intelligence interest that they would like to see included.
3. Via relevant officers in their organisations, contribute information and intelligence to the JSNA to further its development and participate in making information more accessible to everyone.

Executive Summary

4. The Joint Strategic Needs Assessment (JSNA) is a statutory annual report provided to the Health and Wellbeing Board and [published in full](#) on the [Oxfordshire Data Hub](#). 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. It should be used as a tool by all partners of the health and wellbeing board to ensure that services provided by their organisations are suitably tailored to the local needs in Oxfordshire identified by the JSNA. Neighbourhood health plans are expected to have due regard to the JSNA.
5. 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.
6. The JSNA is a contemporary assessment of the health and wellbeing needs of the population. However, information about services needed to address population needs is beyond the scope of the JSNA. In some cases, the data may not be recent enough to reflect changes in services.
7. Following last year's update, the JSNA is now presented across both interactive dashboards and written reports.

Help and Resources

8. Since the release of the JSNA, training sessions have been provided to services within Oxfordshire County Council. This has enabled officers to understand the new format of the JSNA and how to navigate the dashboards.
9. To meet the needs of users who are not Oxfordshire County Council employees, the council has created a range of documents and a [small collection of videos](#) that outline how best to use the JSNA to locate data and research.

User Feedback

10. Ahead of the commencement of work on the 2026 update, the council asked users to provide feedback of their use of the JSNA in its new form. 27 responses were submitted. The majority of these were council employees, with local authority officers and employees of voluntary and community organisations also represented.

Navigation and data sourcing

11. Overall, users feel positive about the JSNA. Most respondents feel confident navigating the JSNA (17), report that the data is easy to find (15), and prefer the new blended format (12).

Accessibility

12. Most respondents (22) report that the JSNA is accessible to them. 11 respondents claimed that the new dashboards are easier to use than PDF documents alone. 3 respondents recorded a negative sentiment for the ease of using the JSNA in its updated format. The council continues to work to ensure that the JSNA is compliant with accessibility legislation and guidance.

Training

13. Users had mixed feelings on whether training was sufficient to meet their needs. 11 respondents had no opinion on the training, with 7 reporting a negative sentiment. Following the release of the 2026 JSNA, a new training offer will be devised to better ensure that users feel confident when accessing the JSNA.

2026 JSNA

Update to the JSNA

14. The JSNA will continue to be presented via interactive Power BI dashboards alongside analysis and narrative reports for each chapter and its associated themes. The latter will be available in downloadable PDFs. This way, the council hope to leverage the benefits of digital tools while retaining the rich narrative that explains the findings of the JSNA.

Data and research due to be included in the 2026 JSNA

15. The council will seek input from the JSNA steering group to decide on the content of the 2026 edition. As a starting point, we will review the data and research that was included in the 2025 edition, a total of 435 indicators.
16. Additional requests that have been made since the publication of the 2025 JSNA include:
 - a. **Inclusion health groups.** This would constitute a complete update of the data and research that was included in the 2024 edition, and a more complete summary of the data and research therein.
 - b. Further data and research related to **homes and health**, using Hertfordshire's ['Health and Safe Places'](#) model as a starting point.
 - c. **Gambling harms.**
17. Additional requests will be prioritised based on their public health need, strategic alignment and developer capacity.

Marmot Place

18. Given Oxfordshire's status as a Marmot Place the JSNA has an important role in furthering an understanding of the health inequalities in Oxfordshire. The steering group will consider Marmot principles to highlight these inequalities in the development of the JSNA.

Future work

19. Throughout the coming months, the council will continue to work on the 2026 JSNA. It will be brought to the Health and Wellbeing Board for final approval ahead of its publication later in the year.
20. A steering group with representatives from partners of the Health and Wellbeing Board and other relevant stakeholders will be formed to provide guidance and feedback on the new digital format of the JSNA. This will ensure that it involves and reflects the needs of residents, patients and partners across Oxfordshire. Steering group members continue to be sought and the first meeting is planned for May 2026.
21. The council is open to modifying the structure and/or content of the JSNA to better meet the needs of colleagues and partners. For example, last year a new chapter titled 'Children and Young People' was introduced.
22. User testing of the digital JSNA 2026 will be undertaken upon completion of each chapter in the summer of 2026.
23. A communications plan for publication and dissemination of the key findings from the JSNA will be developed to support awareness and use of the JSNA across the council and partners

Financial Implications

24. 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.

Comments checked by:

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

Legal Implications

25. Local Authorities and Integrated Care Boards have equal and joint responsibility to prepare JSNAs through the Health and Wellbeing Board. The purpose is to provide assessments of the current and future health and social care needs of the local community.

26. To aid transparency and accountability, there is a requirement to publish the JSNA, showing what evidence has been considered and what priorities have been agreed and why, which will assist in demonstrating progress against objectives and focus on improving outcomes for everyone.

27. Local areas are however free to undertake the JSNA in the way that best suits the local community – there is no specific template or format that must be used and no mandatory data set to be included.

Comments checked by:

Janice White, Principal Solicitor - ASC, SEND and Education

NAME

Ansaf Azhar, Corporate Director of Public Health and Communities

Background papers: Nil

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May 2026

OXFORDSHIRE HEALTH AND WELLBEING BOARD

14 MAY 2026

HEALTH AND WELLBEING STRATEGY UPDATE

PRIORITIES 1 and 2 – Start Well

Report by Director of Children, Education and Families

RECOMMENDATION

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

NOTE the progress of the delivery of priorities 1 and 2 under the thematic domain of Start Well within the Health and Wellbeing Strategy along with key challenges.

NOTE the Best Start in Life plan, attached as an appendix to this report, and:

- a) **DELEGATE** responsibility for regular monitoring of progress on outcomes relevant to the Best Start in Life Plan to the Children's Trust Board;
- b) **NOTE** that those outcomes will include the inequality of Good Level of Development (GLD) outcomes for children eligible for free school meals; and
- c) **NOTE** that the Children's Trust Board will report to the Health and Wellbeing Board on this matter as part of these annual Start Well updates and as required for escalation.

Executive Summary

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

Priority 1: The best start in life

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

Priority 2: Children and young people's emotional wellbeing and mental health

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

Introduction

4. This cover paper highlights some key successes and challenges in relation to Priorities 1 and 2 of the Health and Wellbeing Strategy.
5. It should be noted that these priorities require a whole systems approach to bring about change and the report does not include every piece of work that is happening across the system in each area but highlights key successes along with key challenges. It should also be noted that it may take some time for the interventions put in place to positively affect the outcome trajectory.
6. Performance information is provided in the attached annex 1 which gives an overview of key indicators as set out in the Health and Wellbeing Board Outcomes Framework.

Priority 1: The best start in life

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

- Improved parental physical and mental health during pregnancy, birth and after birth
 - Children with good health, feeling safe and secure, living in nurturing environments
 - Children have opportunities for learning from birth and families supported with childhood development
 - Early identification and support for children and families where there is emerging need.
7. We have worked in partnership through our Early Help and Prevention Board to progress our strategy. The implementation plan is now in place for delivery, and a full suite of KPIs has been developed. Education, health, police and voluntary/community sector organisations are working together well, including to develop our shared practice around Strengths & Needs assessment and team around the family work.
 8. Similarly, the Early Years Board has progressed its partnership strategy and implementation plan. This Board has played a key role in the development of our new Best Start in Life plan, which sets out how we will work together to achieve a good level of development for all children. We hosted a successful Baby Week in November 2025, focusing on 'Healthy Parent, Healthy Baby', with events held across Oxfordshire and positive feedback from participants, and we are planning to repeat in November 2026.
 9. The Oxfordshire Best Start in Life Plan sets out a shared ambition that every child in Oxfordshire has the best possible start in life, and that families receive the right support, at the right time, in the right place. The Plan focuses on the

period from pregnancy to school entry, when timely, coordinated support can make the greatest difference.

10. The Plan aligns national policy, local priorities and partner delivery into a single, outcome-focused approach. It strengthens joint working across the local authority, district councils, health, early years, education, early help and the voluntary and community sector, with a clear focus on prevention and reducing inequalities.
11. To meet the National ambition of 75% of 5-year-olds to achieve a good level of development, each local authority has been given a local target. However, in Oxfordshire we are more ambitious to achieve the best possible outcomes for children and young people. Our revised local targets are therefore:
 - (a) All eligible children: 79.8% (2% above Local Target)
 - (b) All free school meal eligible children: 59.8% (9% above Local Target)
12. The plan sets out four key priorities to achieving this vision:
 - (a) **Healthy beginnings** - We will focus awareness raising of the importance of pregnancy and early childhood across all organisations in Oxfordshire and ensure additional support for families where this is needed.
 - (b) **Strong foundations** - We will focus on working with partners to deliver coordinated support through Family Hubs and the wider Family Hub Network, including a range of parenting programmes, and resources to support home learning, supporting families to stay safe and nurturing positive early relationships and supporting babies and children to learn.
 - (c) **High-quality early years learning** - We will focus on ensuring that all children can fully participate, achieve, and feel supported in the environments where they grow and develop. To support children to thrive and learn, we will invest in a strong and well-trained workforce and champion inclusive practice across the early years system.
 - (d) **Strengthen our Best Start in Life Offer** - We will focus on working together across services and with families through our Family Hub Network and Family Hubs to continue to develop a wider Best Start in Life offer which is available when families need support local to where they live. We will share our data and use this to identify what families need and where they need it.
13. The Children's Trust Board will hold ongoing responsibility for monitoring the performance and impact of the Best Start in Life plan. To support this, a Best Start in Life Plan Steering Group will be responsible for prioritising the plan, tracking progress, and addressing any risks or issues. The steering group will also ensure oversight of the combined budget and make recommendations on funding allocation to the appropriate boards. The Children's Trust Board will provide regular updates to the Health and Wellbeing Board as outlined in the recommendations above.
14. We have worked to increase early years sufficiency and uptake of the funded childcare offer. Alongside this we have developed our early years SEND offer to strengthen identification and inclusion from the earliest stage. We have

delivered training and support to schools including Making a Difference in Reception, phonological awareness training and support on the Early Years Foundation Stage (EYFS) Profile.

15. Wellcomm, a speech, language and communication screening and intervention tool has been rolled out across over 400 early years settings and 45 primary schools – and expanding. Over 1000 children have been screened and we are seeing progress made with children on their second screening.
16. We have piloted Targeted Programs such as Tots Talking (36 providers involved) and Talk Boost from Speech and Language UK (12 providers), in areas with low levels of good level of development and high numbers of children eligible for free school meals. The '50 Things to do before you are 5' app for is available for parents to support learning in the home environment with an emphasis on early language and communication, and has been downloaded over 4000 times. We also offer Dad's Pad as digital support for fathers and we have set up a new fathers group with Oxford United.
17. We have progressed plans to develop a network of Family Hubs across Oxfordshire. Our first site in Blackbird Leys is now open with a developing offer and public launch event being planned for the Summer. We have scoped venues for the other primary Family Hubs as well as begun to develop with partners plans for pop-up and outreach venues. Work has begun to develop our digital Family Hub and to align relevant early help staff for Family Hubs delivery. We have also developed plans for our parenting programmes and home learning environment offer.
18. Earlier this year we received a Royal Visit from HRH The Princess of Wales to Rose Buds Stay and Play Group to meet volunteers and families and learn more about the work of Home Start and the support it provides to families and young children across Oxfordshire communities.
19. Oxfordshire's Oxford Parent-Infant Project (OXPIP) was one of the first charities to secure new funding from The 1001 Critical Days Foundation to expand Sapling antenatal and postnatal support to families in Oxfordshire in 2026. The expansion means OXPIP can help hundreds more families develop secure parent-infant relationships. Oxfordshire County Council Public Health team have also provided match funding until 2031.
20. Growing Minds has secured additional funding from Oxfordshire County Council Public Health. Growing Minds is a collaborative, evidence-based early years project based in Littlemore and Berinsfield, two areas of disadvantage in Oxfordshire. The project is delivered by Peep, Home-Start Oxford and The Berin Centre. Their mission is to narrow the early years attainment gap and improve school readiness by empowering families to create strong home learning environments from birth. Growing Minds will be expanding their project into Blackbird Leys. The project includes access to Dolly Parton's Imagination Library, Peep Learning Together Groups and one-to-one family support.

21. The number of babies being born to teenagers aged 16 years and under is increasing in line with national trends, and this has placed additional demand on the Family Nurse Partnership service. The Family Nurse Partnership is an intensive, targeted home-visiting programme for first-time young mothers, fathers and families. Public Health have commissioned additional capacity within the nursing team.
22. Our Low Income Family Tracker (LIFT) has been delivered in partnership with district councils. LIFT has identified over 1,100 households who are eligible for Free School Meals, who will therefore also qualify for YouMove (access to access low cost and free activities), and we have shared information with families about their entitlements. LIFT has also helped to identify households eligible for Household Support Fund and food vouchers, resulting in over 150 families redeeming vouchers to date. 225 households who are experiencing low financial resilience and debt have been identified, prompting targeted outreach through postcards, letters, and leaflet drops across specific wards.
23. As part of the Government's national supervised toothbrushing programme for 3-5 year olds, Colgate-Palmolive have been providing toothbrushes, fluoride toothpaste and educational materials targeted in key deprived areas. So far in Oxfordshire 385 packs have been delivered, with five early years settings actively participating and an additional four getting ready to launch their scheme. This is delivered in partnership with Oxfordshire Oral Health Promotion Service.
24. In line with Government reforms, we have begun to deliver Families First Partnership work in Oxfordshire. A test and learn pilot is now live in the South locality, trialling multi-agency child protection activities with initial positive results. We have also worked to co-design a single assessment to be used as part of the reforms. We have been working to scale up our family group decision making and family network meeting offer for more families, to find collaborative solutions to meet the child's needs.
25. We have been successful in securing Department for Culture, Media and Sport (DCMS) funding to develop our youth offer. We are working with district councils and voluntary and community sector partners to develop local youth partnerships to improve provision and access in all localities. A data dashboard, youth voice strategy and youth offer strategy are under development.
26. Our new Oxfordshire Education Partnership has agreed a strategy with five key priorities to improve education and inclusion, from early years to post-16. This work is now progressing in partnership, including to strengthen attendance, supporting curriculum review, ensure sufficiency of provision, and reduce travel to learn distances.

Priority 2: Children and young people's emotional wellbeing and mental health

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

- Improved emotional wellbeing and mental health of children and young people, with positive transitions to adulthood.
 - A prevention first approach with meaningful measures to tackle drivers of poor mental wellbeing in childhood
 - Increased and diversified capability to support CYP with their emotional and mental health needs at earliest opportunity
 - Closer partner collaboration to align and improve our system approach to accessing help
27. As part of Oxfordshire's role as a Marmot Place, we have worked with the Institute of Health Equity particularly around the Marmot principle 'Giving children the best start in life'. In-depth analysis and research has been carried out, drawing on national best practice and working with a wide range of local stakeholders, to prepare a series of recommendations which we are now planning to implement to supplement the existing work already in place.
28. Our emotional wellbeing and mental health strategy has progressed alongside CAMHS transformation, overseen by partnership boards and with the annual OxWell survey as well as KPIs helping us to measure progress. The roll out of mental health support teams is on track to cover all schools by 2029 and these teams have been supporting schools to develop a whole school approach to promoting good mental health, wellbeing and resilience. We are also participating in the national Well Schools programme.
29. Tellmi, our digital app to provide peer support and counselling for children aged 11-18, has supported over 500 young people, with positive feedback – 77% of users feel less alone since using Tellmi and for 32% Tellmi is their only form of mental health support. Tellmi have engaged with 60% of Oxfordshire secondary schools and received positive feedback from partners on their materials, resources and workshops, as well as the Tellmi directory which signposts to local and national resources. Outcomes from year one have included improved mood, decreased anxiety and increased school attendance.
30. The development of a new public health approach to mental health for primary schools in Oxfordshire began in July 2025 in response to the increasing need for a preventative approach for children, young people and schools. This will provide primary schools with the training, tools and resources to support good mental health and wellbeing as children transition to secondary school and beyond. We have also established new groups to support emotional literacy for young people aged 14+/under 14.
31. CAMHS have developed and implemented a new programme, Supportive Steps, which aims to support parents to be able to help their children who may have mental health difficulties. The team provides workshops covering the fundamentals of mental wellbeing, preparing for change, engaging with therapy and overall understanding the CAMHS pathway. The offer draws on

the power of parent peer support, social prescribing and evidence-based clinical care to ensure families are offered a robust service right from the very start of their journey with us. Self-help videos have been developed for parents and carers and the first cohorts have started.

32. Oxford Health Foundation Trust have worked in partnership with Oxford University to set up a research clinic within CAMHS called AnDY (Anxiety and Depression Clinic). The clinic offers high-quality treatments to young people with anxiety, depression, and/or obsessive compulsive behaviour. Through the clinic research is supported that improves our understanding of the development and maintenance of anxiety-related disorders and depression in young people, and that supports the development of targeted, effective and accessible treatment.
33. CAMHS are working with children's social care on a pilot to improve multi-agency working for high-risk complex families open to both agencies. This involves identifying, screening, consultation and assessing parents together, and delivering a therapeutic parenting group. Additionally, Oxford Health has delivered a programme to support children and young people with complex needs to thrive in the community and to access care in creative ways. This is designed to be integrated, trauma-informed and systemic, working in partnership with a third sector organisation 'RAW' who provide youth workers.
34. A project is underway to support a better transition to adulthood for young people open to CAMHS. The transition process has been mapped alongside learning from real case examples and feedback from young people and their families. Improvements have been made already, including a new Transitions Panel to discuss with adult mental health colleagues young people turning 18, and future focus areas include strengthened working with the voluntary and community sector and an ADHD medication review service for young people aged 18-25.
35. Additionally, we have two dedicated clinicians to work with Oxford University Hospitals and children's social care to support transitions when a young person presents to an acute hospital with mental health difficulties or having self-harmed.
36. We have awarded grants to community projects to support prevention of poor mental health, with three projects directly supporting young people and two supporting new mothers and families. Alongside this, Oxfordshire Mind have delivered Youth Mental Health First Aid and Suicide Awareness training to staff and volunteers working with young people allowing early intervention and support, and the Mental Health Prevention Concordat and Suicide Multi-Agency Group provide opportunities for partners to collaborate.
37. We have also delivered Making Every Contact County training to primary schools and early years settings, using evidence-based behaviour change techniques to help everyday conversations with people to improve their health and wellbeing. We are encouraging schools across the county to take up

Department for Education funding to train a senior mental health lead to develop and implement a whole school or college approach to mental health and wellbeing.

38. Work is underway to tackle some of the wider determinants of health and wellbeing to make a difference for children and young people. This includes Good Food Oxfordshire's work to tackle food poverty, including with a community food map and resources, and work to promote health eating choices, including in the vending machines at leisure centres in the county.
39. Our Sustainable School Streets Strategy has been adopted and a pilot launched looking at green infrastructure to reduce air pollution in school playgrounds and raise awareness of role school runs via car play. CAG Oxfordshire has been supporting the development of two community gardens in areas of deprivation, working with young families and children, to provide access to nature and wellbeing support. The Better Housing Better Health service continues to support families staying warm in the winter and cool in the summer. A project with Oxfordshire Community Rail Partnership has started to support confident travel to green spaces for wellbeing or jobs for employment for young people, focusing in the first instance on care experienced young people.

Next steps

40. We will continue to progress the activities outlined in this report. Many of our strategies and partnerships are now in a more mature and established position, giving us the infrastructure we need to work together and deliver the best possible life outcomes for children, young people and families.
41. A key challenge continues to be raising awareness of the offer available and making sure it reaches all children, young people and families. Joined-up partnership working, effective signposting, and the development of our digital Family Hub are crucial to success in this area.
42. There is significant national reform and change taking place that relates to Start Well services and partners. Reforms include the national roll-out of Family Hubs, Families First Partnership and the wider Children's Wellbeing & Schools Bill. Alongside this, there are changes in our health partners, including the development of neighbourhood models, and incoming local government reorganisation. This will require close partnership working and robust prioritisation to manage through change and to achieve compliance with new national expectations.
43. We will progress our Best Start in Life plan, focusing on improving support for parent and infant relationships and the home learning environment to improve good level of development. Additionally, we will host a Best Start in Life Summit in September 2026 in partnership with Oxfordshire Inclusive Economy Partnership and Oxford Brookes University.

44. We will develop our Family Hubs network, with a launch event 'open house' to raise awareness of the offer in our first Hub, and more sites coming soon. Libraries will be recruiting early years staff to work across Oxfordshire to engage families with expanded book gifting and events in local libraries for families.
45. We are rolling out a free school meals auto-enrolment scheme, where eligible children will be identified and enrolled without families needing to apply. This removes barriers to access and should contribute positively to tackling health inequalities, as more eligible children receive daily nutritious meals. We will continue to expand engagement with Tellmi, particularly through secondary schools and to develop its support offer for neurodiversity.
46. We will progress our neurodevelopmental conditions redesign project to review pathways and how we best support families. This includes the creation of a multi-disciplinary team of clinical and non-clinical staff to improve specialist knowledge and support.

Financial Implications

47. There are no financial implications that the Health and Wellbeing Board is asked to note in relation to this report. Existing budgets from across the system are being utilised to deliver against the above priorities.

Comments checked by:

Jane Billington, Strategic Finance Business Partner

Legal Implications

48. This report provides key updates to the Health and Wellbeing Board in relation to the Council's statutory duty under section 12 of the Health and Social Care Act 2012 to take such steps as it considers appropriate for improving the health of the people in its area.

Comments checked by: Craig Cochrane, Principal Solicitor, Child Care Legal Team

Lisa Lyons
Director of Children, Education and Families

Annex 1. Start Well performance indicators

Annex 2. Best Start in Life plan

Contact Officer: Anna Jennings, Head of Transformation (Children, Education and Families)

May 2026

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Annex: Health and Wellbeing Strategy – Start Well indicators

Indicator	Source	Period	Value	Trend	Compared to England	Period	Value	Trend	Compared to England
Children in need due to abuse or neglect (under 18 years, per 10,000)	Home Data to Insight	2024/25	55	Increase	Lower	2023/24	54	Higher	Lower
Admission episodes for alcohol-specific conditions (under 18 years, per 100,000)	DHSC Fingertips - https://fingertips.phe.org.uk/search/Admission%20episodes%20for%20alcohol%20specific%20conditions#page/1/gid/1/pat/15/ati/502/are/E10000025/iid/92904/age/173/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1	2021/22 - 23/24	18.29	Cannot be calculated	Similar	No updated data available			
Hospital admissions due to substance misuse (15 to 24 years, per 100,000)	DHSC Fingertips - https://fingertips.phe.org.uk/search/Hospital%20admissions%20due%20to%20substance%20misuse#page/1/gid/1/pat/15/ati/502/are/E10000025/iid/90808/age/156/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1	2021/22 - 23/24	26.89	Cannot be calculated	Better	No updated data available			
Low birth weight of term babies (proportion)	DHSC Fingertips - https://fingertips.phe.org.uk/search/Low%20birth%20weight%20of%20term%20babies#page/1/gid/1/pat/15/ati/502/are/E10000025/iid/20101/age/235/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1	2024	2.3	No significant change	Better	2022	2.22	No significant change	Worse
Average Attainment 8 score	Oxfordshire Data Hub – JSNA – Children and Young People	2024/25	46.4	Stable	Same	2023/24	46.2	No significant change	Same National benchmark: 46 Statistical neighbours: 48

Indicator	Source	Period	Value	Trend	Compared to England	Period	Value	Trend	Compared to England
Average Attainment 8 score of children in care	Oxfordshire Data Hub – JSNA – Children and Young People	2024	14	Worse	Not compared	2023	20	Not calculated	
Children in care (per 10,000)	Internal data sets	2025/26	50	No significant change	Better	2024/25	50	Stable	Better National benchmark: 70 Statistical neighbour benchmark: 51
Children in care immunisations (proportion)	Home Data to Insight	2025/26	79%	Decreased		2024/25	88%	Increased	Better: National 84% SN 82%
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years, per 10,000)	DHSC Fingertips - https://fingertips.phe.org.uk/search/Hospital%20admissions%20caused%20by%20unintentional%20and%20deliberate%20injuries%20in%20children#page/1/gid/1/pat/15/ati/502/are/E10000025/iid/90284/age/26/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1	2023/24	72.62	Decreasing and getting better	Similar	No updated data available			
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15 to 24 years, per 10,000)	DHSC Fingertips - https://fingertips.phe.org.uk/search/Hospital%20admissions%20caused%20by%20unintentional%20and%20deliberate%20injuries%20in%20young%20people#page/1/gid/1/pat/15/ati/502/are/E10000025/iid/90285/age/156/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1	2023/24	95.14	Decreasing and getting better	Worse	No updated data available			

Indicator	Source	Period	Value	Trend	Compared to England	Period	Value	Trend	Compared to England
Percentage of 5-year-olds with experience of visually obvious dental decay	DHSC Fingertips - https://fingertips.phe.org.uk/search/Percentage%20of%205%20year%20olds%20with%20experience%20of%20visually%20obvious%20dental%20decay#page/1/gid/1/pat/15/ati/502/are/E10000025/iid/93563/age/34/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1	2023/24	20.9	Cannot be calculated	Similar	No updated data available			
Percentage of looked after children whose emotional wellbeing is a cause for concern	Home Data to Insight	2025/26	42%	Decreased		2024/25	46%	Increased	Increased National 42% SN 44%
Percentage of physically active children and young people	DHSC Fingertips - https://fingertips.phe.org.uk/search/Percentage%20of%20physically%20active%20children%20and%20young%20people#page/1/gid/1/pat/15/par/E92000001/ati/502/are/E10000025/iid/93570/age/246/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1	2024/25	46.4	Increasing and getting better	Worse	2023/24	43.51	Cannot be calculated	Worse
Pupil absence (proportion)	Internal data sets	2025/26	6.7%	Better		2024/25	7.2%	Better	Worse National benchmark: 6.8% Statistical neighbours: 6.6%

Indicator	Source	Period	Value	Trend	Compared to England	Period	Value	Trend	Compared to England
Reception prevalence of obesity (including severe obesity)	DHSC Fingertips - https://fingertips.phe.org.uk/search/Reception%20prevalence%20of%20obesity%20including%20severe%20obesity#page/1/gid/1/pat/15/ati/502/are/E1000025/iid/90319/age/20/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1	2024/25	8.3	Increasing and getting worse	Better	2023/24	7.71	No significant change	Better
School readiness: percentage of children achieving a good level of development at the end of Reception	https://fingertips.phe.org.uk/search/percentage%20of%20children%20achieving%20a%20good%20level%20of%20development%20at%20the%20end%20of%20Reception#page/1/gid/1/pat/15/ati/502/are/E1000025/iid/90631/age/34/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1	2024/25	70	Better	Better	2023/24	68.8	Same	Better National: 68% SN: 70%
Year 6 prevalence of obesity (including severe obesity)	DHSC Fingertips - https://fingertips.phe.org.uk/search/Year%206%20prevalence%20of%20obesity#page/1/gid/1/pat/15/ati/502/are/E1000025/iid/20602/age/201/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1	2024/25	17.8	Decreasing and getting better	Better	2023/24	18.65	Increasing and getting worse	Better
Under 18s conception rate (per 1,000)	DHSC Fingertips - https://fingertips.phe.org.uk/search/Conception#page/1/gid/1/pat/15/ati/502/are/E1000025/iid/20401/age/173/sex/2/cat/-1/ctp/-1/yr/1/cid/4/tbm/1	2022	9.2	Increasing and getting worse	Better	2021	8.91	No significant change	Better
Smoking status at time of delivery (proportion)	DHSC Fingertips - https://fingertips.phe.org.uk/search/smoking#page/4/gid/1/pat/15/ati/502/are/E1000025/iid/93085/age/1/sex/2/cat/-1/ctp/-1/yr/1/cid/4/tbm/1	2024/25	5.5	No change	Better	2023/24	5.5	Decreasing and getting better	Better

Indicator	Source	Period	Value	Trend	Compared to England	Period	Value	Trend	Compared to England
	1/yr/1/cid/4/tbm/1								

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Oxfordshire's Best Start in Life Plan

Foreword

**Councillor Sean Gaul,
Lead Member for Children's Services**

“ We know that the early development of babies and children under 5 is crucial for long-term health and wellbeing, being ready for school and learning, and in shaping and unlocking children's potential, raising their aspirations as future citizens; so, they can be anything they want to be and this is why giving every child the best start in life is a priority for Oxfordshire.

We are ambitious for all our children but know that not every child is achieving their outcomes which will support their future lives.

Last year 7 out of 10 children reached their Good Level of Development but for children eligible for free school meals this was 4 out of 10, this is not good enough, we must close this gap and reduce this inequality, whilst improving outcomes

for all children, which is why we have set ourselves even more challenging targets than the Department of Education set Oxfordshire.

By 2028 we want 8 out of 10 children to achieve their Good Level of Development and be ready for school, and for those who are eligible for free school meals we will work tirelessly to close the gap so 6 out of 10 children are successful and thriving.

We know this is a challenging ambition, and we won't stop there, but it's a step in the right direction and we are committed and focussed to reducing this inequality and improving outcomes through this Best Start in Life Plan.”

**Lisa Lyons,
Director Children's Services**

“Oxfordshire's Best Start in Life Plan sets out our shared commitment to ensuring all children, whatever their background or circumstances, are supported to thrive from the beginning.

It reflects our determination to strengthen families and give every child the strong foundations they need to grow and learn.

I am proud that children are at the heart of everything we do and of the ambitions shown across partners in developing our offer, together we are creating the conditions for children to grow up safe, happy, healthy, learning and engaged.

**Ansaf Azhar,
Director of Public Health and Communities**

“Every child deserves the very best start in life. The experiences children have from pregnancy through their early years shape their health, wellbeing, learning and life chances far into the future.

When we get things right early on, we give children – and our communities – the strongest foundations to thrive.

Oxfordshire is a place where many children do well, but we know this is not the story for everyone. Some families face additional challenges, and too often these can affect children's development before they even start school. This Best Start in Life Plan sets out how we will work together to change that – by focusing on prevention, early help and making sure support is easy to find and access, when it is needed most.

This plan brings together partners across health, education, family support, early years settings and the voluntary, community and faith sector, alongside families themselves. By listening, learning and acting together, we can reduce inequalities and improve outcomes so that all babies and young children in Oxfordshire have the best possible start in life.

Every child's best start, together

Every baby and young child deserves the very best start in life. The experiences children have before they start school shape their health, learning and wellbeing for the rest of their lives. What happens in pregnancy and the early years has a lasting impact on children's physical health, emotional wellbeing, learning and relationships.

In Oxfordshire, many children do well. However, we know this is not the case for everyone. Some families face barriers linked to poverty, poor health, trauma, isolation or wider pressures, which can make it harder to access support or to give children the start they want for them.

This Best Start in Life Plan sets out, in clear and accessible language, what we want to achieve for babies, young children and families in Oxfordshire, and how services and partners will work together to make this happen. It focuses on the period from pregnancy through to starting school, when timely support can make the greatest difference.

Our ambition is straightforward: every child in Oxfordshire has the best possible start in life so every child can grow up safe, happy, healthy, learning and engaged and every family gets the support they need, at the right time, in the right place.

Oxfordshire's Best Start in Life vision

The vision and intended outcomes mean that children in Oxfordshire are happy and loved, safe and protected, healthy in body and mind, curious and learning, and ready for school and for life.

Parents and carers feel confident and supported, listened to and respected, and able to ask for help early without fear of judgement or stigma and every family gets the support they need, at the right time, in the right place.

We want families to experience support that feels welcoming, practical and joined up, with professionals working alongside them and building on their strengths.

★ **Every child has the best start in life, and parents, parents-to-be, babies and young children have what they need to thrive.** ★

Through achieving this vision, it will mean that all babies, children and families are:

Safe

Learning

Happy

Healthy

Engaged

Why the early years matter

The first years of life, starting in pregnancy, are a period of rapid brain development. Babies and young children learn through relationships, play, communication and everyday experiences. Warm, responsive relationships with parents and carers help children feel safe and secure and support the development of language, emotional regulation and social skills.

When families experience challenges such as poverty, poor mental health, domestic abuse or trauma, these can affect children very early on. Without support, difficulties can become more complex over time. Acting early – and working with the whole family – gives children the best chance to thrive and reduces the need for more intensive intervention later.

Working together around families

Best Start in Life is not a single service or programme. It is a shared way of working across Oxfordshire, with services and partners working together around families.

This means listening to families, valuing lived experience, sharing information appropriately, and working collaboratively across health, education, early years, Family Help, libraries, the voluntary and community sector and wider partners.

Our shared ways of working include:

- **Putting families and children at the centre**
- **Acting early and preventing problems from escalating**
- **Working with the whole family and wider support networks**
- **Building strong, trusting relationships**
- **Using evidence and learning to improve practice**
- **Focusing effort where inequalities and need are greatest**

Oxfordshire is proud to have partnered with Marmot and is a Marmot County, this means we are committed to addressing and reducing inequalities for all residents of Oxfordshire

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Current outcomes

As part of the development of the Best Start in Life Plan, analysis of a range of data was completed, including research undertaken by the Institute of Health Equity through our Marmot County status. Overall Oxfordshire is characterised by high-quality childcare provision, low levels of deprivation and positive child development outcomes, however not all children are achieving strong outcomes, and not all families are able to access the support they need, when they need it.

Families have told us that it can be hard to find out what support is available, where it is available and whether they are able to take up the current offers of support and services and partners should work more closely together.

We understand that each child and family is unique and may have different needs and require different support at different times and are committed to ensuring that support is available locally and when families need it.

Most children in Oxfordshire have positive outcomes in healthy beginnings, with lower rates of parental smoking at delivery, higher breastfeeding rates, and a reduced incidence of low birth weight compared to regional and national averages. However, nearly 21% of children by age five have visible dental decay and 8.3% prevalence of obesity at age 4-5 years, which can impact children's health as they grow.

Most babies and children in Oxfordshire live in stable and safe families, however we know that some families have additional challenges and needs which can impact upon babies and children's outcomes. We will support families who need additional support where they may be experiencing domestic abuse, struggling with mental health, or needing support with parenting.

Seven out of ten children in Oxfordshire are achieving their expected Good Level of Development outcomes, which is higher than the national average. For children who are eligible for free school meals this is just four out of ten and there has been a 10% decline in the number of 2-year-olds accessing early years settings where families are in receipt of additional support. 97% of eligible working parents with two-year-olds have accessed childcare and 95% of eligible parents of 3 and 4-year-olds are accessing childcare.

The majority of Early Years Providers are judged good or better by Ofsted in Oxfordshire (96%), which is higher than National giving confidence that practice and provision is good in most of our early years education settings.



0-4 population at a glance

37,800
children aged
0-4 years-old

8.3%
Reception
prevalence of
obesity at age 4-5

87.5%
of Oxfordshire
children were
achieving a
Good Level of
Development at
age 2 to 2 and a
half years

70%
of children achieved
a Good Level of
Development in 2025

43%
of children eligible for free school meals
achieved a Good Level of Development

**Greatest
population
increases in
the south and
northeast of
the county**

Oxfordshire's Best Start in Life priorities

Healthy beginnings

We will focus awareness raising of the importance of pregnancy and early childhood across all organisations in Oxfordshire and ensure additional support for families where this is needed.

Strong foundations

We will focus on working with partners to deliver coordinated support through Family Hubs and the wider Family Hub Network, including a range of parenting programmes, and resources to support home learning, supporting families to stay safe and nurturing positive early relationships and supporting babies and children to learn.

High-quality early years learning

We will focus on ensuring that all children can fully participate, achieve, and feel supported in the environments where they grow and develop. To support children to thrive and learn, we will invest in a strong and well-trained workforce and champion inclusive practice across the early years system.

Strengthen our Best Start in Life offer

We will focus on working together across services and with families through our Family Hub Network and Family Hubs to continue to develop a wider Best Start in Life offer which is available when families need support local to where they live. We will share our data and use this to identify what families need and where they need it.

Our Best Start in Life offer in Oxfordshire

Families in Oxfordshire can access a wide range of support, from universal services available to everyone, through to more targeted and intensive help for families who need additional support. We open our first Family Hub in Blackbird Leys in April and four further Family Hubs are planned.

Our focus is on making this offer easy to understand, easy to access and well joined up. Families should not have to navigate multiple systems or repeat their story. Instead, support should feel coordinated, relationship-based and shaped around what matters most to them.

This offer brings together health services, early years education and childcare, Family Hubs, Family Help, libraries, community spaces, and voluntary and community organisations working together around families.

The vision for Family Hubs in Oxfordshire is a network of provision across Oxfordshire for children and families through a Family Hub Network with partners, including the voluntary, community and faith sector to provide a range of services and a primary hub in each locality including continued delivery of existing support and developing new co-delivered support, developing outreach and 'pop up' sites in existing community locations so that all families can access support in their local neighbourhood.

The 0–19 Public Health Nursing Service

Oxfordshire’s integrated 0–19 Public Health Nursing Service brings together health visiting, school health nursing and the Family Nurse Partnership into a single pathway with one point of access. Eleven locality teams operate across the county, providing coordinated support as children grow.

Families are offered the Healthy Child Programme contacts from pregnancy through to age five. These include antenatal support, new birth visits, reviews at 6–8 weeks, 1 year and 2–2½ years, and a new universal 4 year review to support health, development and school readiness.

Health visiting teams also provide targeted and specialist support where vulnerabilities are identified and run group-based support such as infant feeding groups, baby drop-ins and ‘Marvellous Me’ sessions to promote confidence, emotional wellbeing and early relationships.

The Family Nurse Partnership provides intensive, evidence-based support for eligible young parents from early pregnancy until their child’s second birthday. This is complemented by an integrated young parent pathway, with family nurses offering specialist leadership and support for families with more complex or multiple needs.

The service works closely with Home Start, a national charity providing volunteer-led, nonjudgemental peer support for families with children under five. This partnership strengthens early help and prevention by offering practical and emotional support alongside statutory health services.

Through the Best Start in Life Plan we are committed to increasing the uptake of health visitor checks for all families and supporting families to know and use the services available in our Family Hubs and through the Family Hub Network.

Family Help through our Family Hub Network and Family Hubs

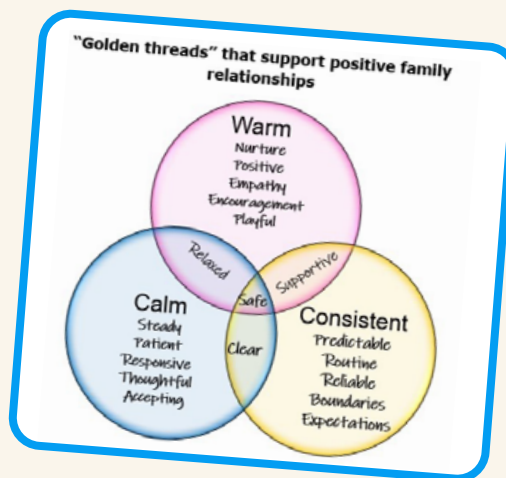
Family Help is a key part of Oxfordshire’s Best Start in Life approach, providing whole family, strengths-based support when children or parents are experiencing difficulties.

Family Help works alongside families where children may be affected by issues such as poverty, parental mental health needs, trauma, domestic abuse or other pressures.



Family Help practitioners work in a relational, trauma-informed and restorative way. Support is consent-based and focuses on building on family strengths, improving day-to-day family life.

Support may include purposeful home visiting, direct work with children, coordination of plans through a lead professional role, and helping families connect with local community support. Family Help teams also deliver group-based parenting programmes that support parents to build confidence, skills and positive relationships and can



signpost parents for additional support through partnerships with voluntary support groups such as Home Start.

These include evidence-based programmes focused on nurturing parenting, understanding children’s development and behaviour, strengthening parent-child relationships, supporting parents of teenagers, and helping parents affected by conflict or trauma.

Through the Best Start in Life Plan we are committed to increasing our offer of family support by working more closely with voluntary agencies local to where families live, offering additional parenting support programmes and offering a range of home learning resources to support families build on their strengths and support each child to achieve a Good Level of Development.

Libraries and early learning

Oxfordshire's network of 45 libraries is a core part of the Best Start in Life offer. Libraries are welcoming, inclusive community spaces that support families from birth onwards and play an important role in early language, literacy and social connection.

Through local libraries, families can access early years programme development and the expansion of Dolly Parton's Imagination Library in key locations, helping children develop a love of books and reading from an early age. Book Start book packs for babies, weekly rhyme time and story time sessions that support language development, Stay and Play activities in targeted areas, and milestone events such as World Book Day, Baby Week and the Summer Reading Challenge.

Libraries also host a wide range of creative and cultural activities for children and families, including Lego clubs, chess clubs, coding clubs, author events and creative workshops.



These activities support learning, confidence, social skills and community connection, libraries support literacy, learning and wellbeing, with benefits that can last throughout a child's life.

As part of the Best Start in Life Plan, we are committed to expanding access to books and early reading events with partners through access to libraries and through the Family Hubs and Family Hubs Network to all babies and children.



Voluntary, community and faith sector groups

Oxfordshire works in partnership with voluntary, community, and faith groups who offer a range of different services and support to families. This includes information and advice, guiding people to appropriate resources, running stay-and-play sessions, and offering more specialised support like one-on-one help

Through the Best Start in Life Plan we are committed to strengthening our working with the VCFS sector to develop and enhance the offer to babies, children and families.

Family Information Service (website)

The Family Information Service website offers comprehensive resources and support for children, young people, and families residing in Oxfordshire. This freely accessible platform provides detailed information regarding local services available within the community.

Through the Best Start in Life Plan we are committed to improving our digital information offer for families and partners to deliver Family Hubs information directly to families in an accessible format.

Parks and open spaces

Oxfordshire parks and play areas offer a mix of quiet areas and high energy spaces for babies and children with their families to enjoy being outside together in nature and for meeting spaces with friends, with some being fully inclusive and with sensory specific equipment. Open spaces and play areas support babies and children with their physical development and health, with social skills, cognitive development and learning through creative imaginative play. For families they provide opportunities for bonding and having fun and are good for everyone's mental well-being.

As part of the Best Start in Life Plan, we are committed to ensuring more parks and play areas are accessible for children and families, whatever their needs.

Leisure centres

Children thrive when they can be active, whether involved in specific sports or in joining in with their families and care givers. Being active supports physical health and also promotes language, social and emotional development. There are a range of leisure centres delivered by district council partners, which provide access to families to engage in a range of different play and recreational activities.

As well as leisure centres, Active Oxfordshire delivers YouMove, free and low-cost activities for eligible children and their families, including those on benefits related free school meals or Universal Credit, refugee children, and children supported by early help services in Oxfordshire, enabling babies and children to stay active and have fun along the way.

As part of the Best Start in Life Plan we are committed to working with the leisure centres as part of our Family Hubs Network to support babies and children, with their families to access and enjoy leisure facilities.

Oxfordshire County Music Service

We recognise the importance of music in the holistic development of babies and children in supporting their development of speech, language and communication, emotional, social and physical skills and in supporting strong attachments with parents and care givers, which contribute to children achieving a Good Level of Development. Music is fun and Oxfordshire County Music Service has an early years music strategy and offers whole-class music lessons for early years as part of the wider curriculum support offer to schools and delivers one-off, bespoke music workshops in schools. Children and families have benefitted from community music projects in schools and settings.

Through the Best Start in Life Plan we are committed to expanding music into all Family Hubs and through the Family Hub Network and extend the current offer to settings and schools to ensure every child has an opportunity to take part in sessions so music can support improved outcomes.

Access to childcare

From September 2025, working families who meet the eligibility criteria have been able to access up to 30 funded hours per week for children from nine months. 97% of eligible working parents of two year olds have accessed this offer and just over 95% of eligible parents of three and four year olds are accessing childcare.

However there remain some geographic areas within the county who have limited childcare options. The Family Information Service supports families with finding appropriate childcare and accessing the eligible childcare entitlements.

Through the Best Start in Life Plan we are committed to securing childcare for all children and families and improving access for those children whose families are receiving additional support or through our Family Hub Networks.

Early Years SEND service

The Early Years SEND is a countywide Special Educational Needs and Disability advisory support service for children with special educational needs under 5 years. The service works with children under 5 years, either known to or waiting to be seen by a community paediatrician, who need additional support with their development and learning. Specialist teachers offer individual support and advice to parents, carers and family, and work with the child's setting on to support the child's individual needs and unique circumstances.

Through the Best Start in Life Plan we are committed to ensuring access to specialist support is available to all families and settings to ensure children's needs are identified early and to support settings and families to work together to support those needs.

Quality Early Years Education

96% of Early Years Providers are judged good or better by Ofsted compared to 91% nationally, giving confidence that practice and provision is good in most of our early years education settings (Ofsted statistics: 1 September 2024 to 31 March 2025).

The early years quality team provide support and guidance to all early years providers (childminders, preschools, day nurseries, nursery schools and all other schools) through quality improvement visits which support leadership, teaching and access to high quality training and resources. Additional targeted support is offered where identified following Ofsted and to settings with low Good Level of Development outcomes.

Through the Best Start in Life Plan we are committed to working to increase all Early Years Providers are meeting expected standards and that Good Level of Development outcomes in line with our ambitious local revised target.

Delivering on our vision

The following section outlines how the system will be coordinated to deliver on the Best Start in Life Plan.

Voice of families

In the Best Start in Life Plan, we will make sure the voices of babies, children and families are at the heart of how we design, deliver and improve our work. We will build their perspectives into our governance structures, create regular and accessible ways for families to share their experiences, and ensure their feedback directly shapes decisions.

Using a mix of approaches, including working with the voluntary, community and faith sectors, we will hear from a wide range of families and communities. Most importantly, we will act on what they tell us, so that services feel relevant, responsive and built around their needs, driving continuous improvement across the whole early years system.

Governance

The Best Start in Life Plan will report to the **Children's Trust Board**, which will hold overall responsibility for monitoring the performance and impact of the plan. Updates will be provided quarterly.

To support this, a **Best Start in Life Plan Steering Group** will be responsible for prioritising the plan, tracking progress, and addressing any risks or issues. The steering group will also ensure oversight of the combined budget and make recommendations on funding allocation to the appropriate boards.

Delivery of the Best Start in Life Plan will take place through the **Oxfordshire Education Partnership, Early Years Board, and Early Help and Prevention Board**, with progress and outcomes ultimately reported back to the steering group and Children's Trust Board and to the **Health and Wellbeing Board**.

Shared commissioning of services

We ensure a clear core offer in all Family Hubs and to provide local targeted Best Start in Life offer for family support and for those children who are identified as not achieving their Good Level of Development. We will jointly commission with partners where additional services are identified by need.

Our key measure of success will be the Good Level of Development

A Good Level of Development (GLD) is the Statutory Assessment at the end of the Early Years Foundation Stage (EYFS) when children are in Reception classes¹.

Impact measures by 2028

% of children with a Good Level of Development at 5-years-old

Local revised Target 79.8%
DfE local target - 77.8%

% difference between the proportion of children eligible or not eligible for Free School Meals achieving a Good Level of Development

Local Revised target 59.8%
DfE target – 50.8%

¹ Children are assessed against the Early Learning Goals (ELGs) which are part of the Early Years Curriculum and support teachers to make a holistic, best fit judgement about a child's development and their readiness for year 1.

High level Best Start in Life Plan, March 2026 to March 2027

For all babies, children and families to have:

■ **Healthy beginnings:**

1. Work with partners to ensure that we have a clear offer to identify and support parental wellbeing, as well as parent-infant relationships
2. Work with partners to increase up the uptake of the health visitor checks, for 2-2.5 years and Oxfordshire's 4-year-old check
3. Improve our offer of information of support for dads and male carers
4. Ensure young parents can access the support they need

■ **Strong foundations:**

5. Open five primary Family Hubs across Oxfordshire
6. Develop and publish a clear offer for each Family Hub locality

7. Offer proven, high-quality parenting and home learning programmes that help children and families learn and develop well

8. Ensure that we have an effective system in place, in line with national guidance, to keep families safe

■ **Access to high-quality early years learning:**

9. Increase Free School Meal entitlement take-up, by developing auto-enrolment
10. Increase uptake of 15-hour childcare entitlement for families receiving additional or universal support
11. Increase childcare sufficiency for 9 months to 23 months and for under 3 places in identified areas of need
12. Support those schools with low Good Level of Development scores or where additional need is identified
13. To continue enhancing inclusivity within Early Years Settings for all children, building upon the existing work and progress already underway

■ **To strengthen our Best Start in Life offer:**

14. Strengthen partnerships and networks across health, education, social care and the voluntary, community and faith sector
15. Develop of a Best Start in Life workforce training offer
16. Develop our digital information offer
17. Use our data to better inform our understanding on Good Level of Development
18. Use our Oxfordshire Marmot County status to engage wider partners including research partners and local businesses to raise the awareness of the importance of the Best Start in Life

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OXFORDSHIRE HEALTH AND WELLBEING BOARD 14TH MAY 2026

OXFORDSHIRE BETTER CARE FUND (BCF) PLAN 2026-27

Report by Karen Fuller

RECOMMENDATION

1. **The Board is RECOMMENDED to**
 - a) **NOTE** and **APPROVE** the direction of travel set out in this report for the Oxfordshire Better Care Fund Plan for 2026/27 and the decision-making process set out at paragraph 14.
 - b) **APPROVE** the Oxfordshire Better Care Fund Plan for 2026/27 and decision on the assurance statements set out at paragraph 19 for submission by 19th May 2026.

Executive Summary

2. The Better Care Fund (BCF) Plan is owned and approved by the Oxfordshire Health and Wellbeing Board (HWB) on behalf of Oxfordshire County Council (OCC) and the Thames Valley Integrated Care Board (TV ICB) – previously known as Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board and other system partners. The HWB is required to approve the BCF Plan each year and to provide assurance that it meets the national conditions set by NHS England – see paragraph 18.
3. This report sets out the local context for the Oxfordshire BCF Plan 2026/27, including the approach to joint governance, planned priorities and the proposed decision-making and sign-off route, in advance of submission to NHS England by 17.00 on 19 May 2026.
4. The BCF planning guidance was published on 17 February 2026. It outlines the investment, expenditure and metrics to be delivered by the BCF Plan. The guidance positions 26/7 as a transition year, laying the foundations for future reform and stronger alignment with neighbourhood-level planning, and also the policy shift from “acute to community” and “sickness to prevention” as stipulated in the NHS 10 Year Plan. This approach to supporting people proactively and in their own communities is aligned with Oxfordshire’s ambitions in the *Oxfordshire Way* and the Health and Wellbeing Strategy 2024-2030.
5. Oxfordshire’s 26/7 BCF Plan will further improve the ability to divert and prevent admissions, particularly for people with complex needs and/or frailty,

retain discharge capacity but improve discharge processes, and improve outcomes to independence in the community. Ultimately, the aim is to ensure that people are supported to stay at home and live independently for as long as possible.

6. The development of the BCF Plan builds on the system approach to planning and engagement developed over the last few years and overseen closely by the Oxfordshire Place Based Partnership Board.

Background and national context – key changes for 2026-27

7. The Better Care Fund (BCF) is the main statutory vehicle for Oxfordshire County Council (OCC) and the Integrated Care Board (ICB) to integrate funding within a system-wide Plan to improve health and care outcomes for the population and improve the resilience of the health and care system, particularly in relation to the flow of Oxfordshire residents into and out of hospital (including Oxford University Hospitals NHS Foundation Trust, and also Royal Berkshire NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust).
8. The BCF enables ICBs and local authorities to plan and deliver more joined-up, preventative care, particularly for people with complex health and social care needs, supporting independence for longer. The BCF Plan must describe how commissioners, providers, voluntary and community sector (VCS) partners and local communities will work together to develop and deliver the BCP Plan. It provides a shared framework to align services, reduce health inequalities and support timely discharge, intermediate care, rehabilitation and reablement.
9. National BCF planning guidance for 2026/27 sets out the conditions and reporting requirements for local areas, including maintaining the NHS minimum contribution and the minimum contribution to adult social care (ASC). BCF Plans must also set out how partners will deliver against the national performance metrics, aligned to wider system planning.
10. The guidance positions 2026/27 relate to the transition year, laying the foundations for future reform and stronger alignment with neighbourhood-level planning. This means that there are no immediate funding changes for 26/7 and any further changes will be made no earlier than 27/8 subject to consultation.
11. The 26/7 BCF planning framework includes:

Finance – The 3 key funding lines established last year remain:

- (a) Disabled Facilities Grant (as in previous years)

- (b) The NHS Minimum Contribution, including the minimum contribution to adult social care
- (c) The Local Authority Better Care Grant

Metrics - The national metric set for 2026/27 remains focused on admissions, discharge/flow, long-term care and independence outcomes, with a requirement for partners to agree (with the HWB) local goals for:

- d) Non-elective emergency admissions to hospital for people over 65 [existing]
- e) Average length of discharge delay for all adult patients [existing]
- f) Permanent admissions to care homes for people over 65 [existing]
- g) Percentage of people over 65 still at home 12 weeks following reablement [new metric]

12. The 26/7 BCF Plan submission requires that systems:

- a. Set out the rationale for using BCF funding to deliver integrated and preventative care
- b. Set specific goals for metrics a & b, detail plans to drive progress against metrics c & d, and provide detail on the methodology informing the goals
- c. Explain the planned impact of the funding on the system goals
- d. Outline how systems have confidence that the service funded through BCF represent value for money and how they will seek to raise the productivity of services
- e. Outline joint governance structures for managing expenditure, assessment of impact, value for money and continuous improvement

Development of the 2026/7 Plan and route to Decision

13. Since 2022/23, Oxfordshire has adopted an increasingly transparent, system-wide approach to annual BCF planning. The development of the BCF Plan is overseen by the Oxfordshire Place-Based Partnership. There is also a system-wide BCF Oversight Group, established in 2024/5, to review the impact of BCF funded schemes and develop the BCF Plan.

14. The decision-making approach sits with system forums as follows:

Role in BCF planning	Responsibility
System endorsement of BCF Plan – including guidance around narrative and strategic direction and alignment with Oxfordshire priorities	Place Based Partnership
<i>New for 26/7</i> - Assurance that the BCF Plan is developed in alignment with Oxfordshire’s approach to Neighbourhoods, and reflect the	Primary & Community Care Board

national ambition for BCF funding streams to be used to progress this approach	
Alignment of BCF investment and system Urgent and Emergency Care (UEC) Funding, and setting robust, system-owned targets and trajectories that deliver the BCF metrics in relation to hospital avoidance and discharge	Urgent and Emergency Care Board
Approval of investment and expenditure plans, and assurance to Council, Cabinet and ICB Board for the wider BCF Plan	ICB/OCC Joint Commissioning Executive (JCE)
Final sign off for 26/7 BCF Plan	<ul style="list-style-type: none"> a) Chief Executive and s151 Officer for the Council b) Chief Executive TV ICB c) Chief Executive NHS Bath, North-East Somerset, Swindon and Wiltshire Integrated Care Board (see paragraph 59) d) Chair, Oxfordshire Health & Wellbeing Board

15. The national planning guidance was issued on 17 February. A draft BCF Plan was submitted to NHS England for review and feedback and returned with comments during the week-commencing 27 April, ahead of the HWB paper submission deadline of 29 April.
16. In previous years, planning timelines have meant the HWB has delegated approval of the Plan to the Chair of the Board for approval outside the HWB meeting, with the final plan shared to the HWB for information after BCF Plan submission.
17. This year, longer planning timelines have enabled sharing the BCF Plan with the Board prior to the final submission date of 1700 on 19 May 2026. The Board is asked to:
 - (a) Note and approve the direction of travel set out in this report for the Oxfordshire Better Care Fund Plan for 2026/7 and the decision-making process set out at paragraph 13
 - (b) Approve the Oxfordshire Better Care Fund Plan for 2026/7 for submission by 19 May 2026.
18. If the Board proposes any amendments to the BCF Plan, shared as an appendix to this paper, an additional final version will be shared for information ahead of the next HWB meeting in June.

19. In the BCF template the HWB is asked to confirm several assurance statements on behalf of the Oxfordshire HWB in respect of the BCF National Conditions as follows:

National funding condition	Key planning and assurance requirements	Oxfordshire position
1. Deliver integrated, preventative care aligned to neighbourhood health and social care priorities	<p>Jointly agreed BCF Plan showing how pooled funding supports integrated and preventative services, particularly intermediate care and reablement.</p> <p>Clear local goals for reducing non-elective admissions (65+), discharge delays, improving reablement outcomes and preventing avoidable long-term care, with evidence of value for money.</p>	<p>Oxfordshire has an agreed joint BCF Plan aligned to neighbourhood health priorities, with a focus on intermediate care, reablement, frailty and discharge.</p> <p>Local goals, metrics and governance arrangements are in place, with a clear narrative on impact and value for money.</p>
2. Comply with national funding, pooling and grant conditions	<p>Confirmation that the NHS minimum contribution to adult social care is maintained and that required BCF funding streams (including DFG) are pooled and spent in line with grant conditions and approved BCF Plans.</p>	<p>Oxfordshire has pooled the required NHS and local authority funding in line with national conditions, including the NHS minimum contribution to adult social care.</p> <p>Planned spend is set out clearly by funding source and category.</p>
3. Maintain effective joint governance, oversight and assurance arrangements	<p>Clear joint governance between the NHS, local authority and Health & Wellbeing Board to oversee delivery, performance, value for money and improvement, and engagement with national and regional assurance processes.</p>	<p>Oxfordshire has established joint governance arrangements with oversight through partnership structures and the Health & Wellbeing Board.</p> <p>Performance and delivery are monitored regularly, and the system is engaged with national and regional BCF assurance processes.</p>

Oxfordshire Better Care Fund Plan 2026/7 – Key priorities and approach

20. Oxfordshire's 25/6 BCF Plan focused on reducing non-elective admissions to support system flow. The Oxfordshire system achieved a 3% reduction in NELs against a zero-growth target, while also reducing conveyances to A&E by 4%. However, the Oxfordshire system's previously improving trajectory for discharge delays has slowed.
21. In 26/7 the Oxfordshire system will further improve ability to divert and prevent admissions to hospital, particularly for people with complex needs and/or frailty, retain discharge capacity and improve discharge processes, and improve outcomes to independence in the community. Ultimately, the aim is to ensure that support for people to stay at home and living independently for as long as possible. This approach is aligned with the local strategy – *The Oxfordshire Way* – and national guidance, including the NHS strategic commissioning and neighbourhood health frameworks.
22. As 2026/7 is a transition year ahead of significant reform from 2027/28, most services funded by the BCF in 2025/6 will also be funded in 2026/7. However, the BCF Plan has increased investment in existing BCF-funded services and also funded some new schemes for 2026/7 which will progress the Oxfordshire system towards its goals.
23. **Integrated planning** - A core objective of BCF planning is to support integrated approaches across health, care and the wider system. In Oxfordshire this is demonstrated through:
 - (a) **Alignment with wider system funding and priorities**
 - i. Alignment of BCF funding with ICB urgent and emergency care investment to support system resilience and delivery of BCF metrics.
 - ii. Alignment with Adult Social Care community capacity funding, and Public Health funding to support the wider prevention agenda under as part of the *Oxfordshire Way*.
 - iii. Close working alongside wider system initiatives, including homelessness and mental health
 - iv. Ongoing funding of system posts, including business intelligence and analytics support, and integrated commissioning roles to enable joint planning, and delivery. New for 2026/7, the BCF Plan also includes funding for posts dedicated to developing Oxfordshire's approach to Neighbourhood health and care.
 - (b) **Jointly commissioned prevention activity**
 - i. Joint funding with Public Health for targeted schemes, including falls prevention and reducing alcohol-related admissions.
 - (c) **Enabling system-wide partnership working**

- i. Support for partnership approaches, including the development of the Disabled Facilities Grant and Home Improvement Agency offer across the County Council and City and District councils.

24. **Preventing admission to hospital –**

- (a) Oxfordshire's 25/6 BCF Plan focused on reducing non-elective admissions to support system flow. The Oxfordshire system has achieved a 3% reduction in NELs against 25/6's zero-growth target, while also reducing conveyances to A&E by 4%. To deliver this, the Oxfordshire system invested in services that improve the coordination capacity, capability and deployment of services that stop people being conveyed to hospital.
- (b) Delivered by Oxford Health NHSFT, Single Point of Access - front door for urgent community support, used by GPs, ambulance crews, care homes and hospital teams - and ambulance call (999/111) stack expansion – additional clinical decision support for ambulance staff to avoid unnecessary trips to A&E – have been key in delivering improved performance against this BCF metric. This year's BCF Plan includes increased investment in both services, which has enabled the expansion of the stack provision to operate from 8am – 8pm Monday - Friday. This will reduce the need for ambulance conveyance at “the end of the working day” and the risk of people being admitted to hospital overnight where their needs can be met in the community.
- (c) Continued investment in mobile visiting, hospital at home services and Integrated Neighbourhood Teams also enables support for people in the right place at the right time. This is also aligned with the Oxfordshire system's developing approach to Neighbourhoods and shifting care away from acute settings to communities.

25. **Maintaining independence –** this includes building community capacity, supporting unpaid carers and both home and bed-based intermediate care models.

(a) **Community capacity, information and support –**

The Oxfordshire system has an extensive community information and support offer which enables Oxfordshire residents to access advice, guidance and support to proactively manage their health and wellbeing. Services aligned to this approach both within and outside the BCF include the Local Area Coordination programme, Community Capacity Grants and falls prevention services delivered with health, public health and voluntary sector partners

c) **Intermediate care -**

There is continued investment in therapy-led approaches to supporting people in their own homes. This includes reablement following discharge and proactive community reablement. In 2025/26 the Oxfordshire system recommissioned the Short Stay Hub Bed model.

for people who require more support following discharge from hospital. During the year the system agreed to scale up the number of beds to reflect the increasing needs of people that were otherwise being supported under a Home First approach. This has proved more effective, and the increase has been consolidated in the 2026/7 BCF Plan. The BCF Plan also funds community equipment and technology enabled care services which support people to remain in their own homes.

26. **Home First approach –**

- (a) The Oxfordshire system has responded to significantly increased demand for discharge over the last couple of years. This has involved joint working between the Transfer of Care Hub in hospitals and Home First Discharge to Assess teams in the community and our care market of over 130 providers. However, in 25/6 the previously improving trajectory for reducing delays to hospital discharges has slowed. This is due to increased demand exceeding staffing capacity in Home First and increasing complexity of people coming into hospital.
- (b) With the improvements in NEL performance, discharge demand has since stabilised. This means that in 26/7 the Oxfordshire system can 'right-size' the approach to discharge through increasing staffing capacity in the Home First MDT to reduce delays for assessment following discharge.
- (c) The Oxfordshire system have also identified process improvements across all care pathways which should enable a reduction in discharge delays. This includes further utilising the Trusted Assessment model delivered by care providers and funding technological solutions such as OPTICA software which enable tracking of tasks relating to discharge across health and care partners.

27. **Unpaid carers** – There is continued investment in supporting unpaid carers to enable the Oxfordshire system to support people in their own homes and communities. This includes projects delivered jointly with health partners such as carer's IDs and passports to support identification of carers. In 26/7 the Oxfordshire system will be refreshing the system-wide All-Age Unpaid Carers Strategy which will involve input from people drawing on care and support, carers, and local health and VCSE partners. This aligns with the development of a *carer's strain index* to enable identification of carers at the highest risk of crisis. This will enable proactive responses and prevent carer breakdown and subsequent social admissions to hospital.

28. **Health Inequalities** – Support for people experiencing specific health inequalities is reflected in the BCF Plan as follows:

- a) Additional funding to develop Integrated Neighbourhood Teams in areas of deprivation, with high and/or complex needs and health inequalities

- b) A small amount of funding has been reallocated from pilot mental health schemes into the Oxfordshire Health and Homelessness Integration team. This reflects the Oxfordshire system ongoing commitment to supporting some of the most complex people and diverting them away from ED and ensuring that discharge from acute and mental health in-patient beds supports them to more sustainable support in the community
 - c) Continued funding for the alcohol support team joint funded by the BCF and public health
 - d) Oxford Health mental health inpatient schemes continue to reduce discharge delays and reduce the number of people placed out of county due to a lack of suitable local beds
 - e) Support for people living with a learning disability and/or autism to avoid admission to secure beds
 - f) The Oxfordshire system has allocated resource to develop data analysis capability to enable a population health approach towards the Oxfordshire system's developing Neighbourhoods model.
29. **Housing** – Housing is a key part of supporting people's independence in their own communities.
- a) The BCF continues to support the Health and Homelessness Intervention Team and contributes to the Homelessness Alliance partnership.
 - b) The BCF funds the care in Extra Care Housing developments. In 2025/6 we opened a new ECH scheme – [Fern Meadows](#) – in Faringdon.
 - c) The Oxfordshire system works closely with colleagues in the City & District Councils in the Home Improvement Agency/Disabled Facilities Grant group, attended by Therapy and Housing leads across the Oxfordshire system. This group has been developing shared performance indicators and is exploring the opportunities to develop the interface between housing adaptations, extra care and supported housing, and community equipment
 - d) The Disabled Facilities Grant element of the BCF remains but, following a national review of the funding formula, The Oxfordshire system is preparing for a 2.5% reduction in funding across the county over the next 2 years. The Oxfordshire system is exploring options to deploy these funds creatively to support people to remain at home.
30. **Permanent admissions to care homes** - Oxfordshire has a recurring challenge with self-funders entering care homes earlier than may be necessary to meet their care needs. The County Council is developing projects to support self-funders to provide them with the information and advice needed to make informed decisions about their care provision. This includes steering people to other alternative support funded by the BCF, such as Extra Care Housing. The County Council is also undertaking work to further analyse length of stay in care homes to ensure they are used as a last resort.

Metrics

31. In 2025/6 there was a requirement to submit a system Demand and Capacity plan as part of the BCF Plan submission. This is not required in 2026/7, but the system Urgent Care Delivery Group has undertaken demand and capacity modelling and analysis to inform the system targets for performance against the BCF metrics.
32. There are 3 metrics for which Oxfordshire must submit trajectories for 2026/7. These are measured quarterly by NHS England and monthly by the County Council and ICB's Joint Commissioning Executive with recommendations from the system Urgent and Emergency Care Board.
33. In addition to the 3-headline metrics, Oxfordshire sets local system trajectories and targets agreed through the Urgent and Emergency Care Board.

Non-elective (NEL) admissions to hospital for people aged 65 and above

34. This metric is continued from 2025/6. Supporting indicators previously measured in conjunction with admissions metrics – including admissions for people with long term conditions and falls-related admissions for people over 65 – have been removed from the national reporting requirements but will continue to be measured locally.
35. The BCF planning template sets out the current performance against this metric:

5.1 Non-Elective admissions

		Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
Non elective admissions to hospital for people aged 65 and over per 100,000 population	Rate	1,364	1,393	1,314	1,421	1,368	1,271	1,468					
	Number of admissions 65+	1910	1,950	1,840	1,990	1,915	1,780	2,055					
	Population of 65+*	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999				
		Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
	Rate	1,357	1,384	1,302	1,376	1,328	1,185	1,399	1,291	1,356	1,358	1,357	1,357
	Number of admissions 65+	1900	1938	1823	1926	1859	1589	1959	1808	1899	1901	1900	1900
	Population of 65+	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999

36. Admission avoidance is a key metric for both individual outcomes and for the ability to manage hospital performance and system cost pressures.
37. The aim of the 2026/7 BCF Plan is to hold a zero-growth position for 25/6 levels. In 2025/6 Oxfordshire achieved a 3% reduction in NELs against the target of zero growth on 24/5 performance. This equates to approximately 753 fewer admissions over the year.
38. The Oxfordshire system has also developed local trajectories for admissions specifically relating to people who are frail. This is aligned with national targets to reduce admissions and bed days for this cohort by 10% by 2029. The

Oxfordshire system has completed modelling to achieve this over the next 3 years and in 26/7 aims to achieve a 2% overall reduction for people in this cohort in 26/7.

Average length of discharge delay for all adults discharged from acute hospitals

39. This metric is continued from 2025/6. It measures both the proportion of people discharged on the day they were ready for discharge, and the length of discharge delay for those people who do not leave on that day. The below table shows Oxfordshire's performance against the metrics and our target for 2026/7.

5.2 Discharge delays												
	Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.68	0.70	0.63	0.73	0.69	0.71	0.67	0.68				
Proportion of adult patients discharged from acute hospitals on their discharge ready date	85.7%	86.8%	87.4%	87.0%	87.3%	86.8%	86.7%	86.6%				
For those adult patients not discharged on DRD, average number of days from DRD to discharge	4.7	5.3	5.0	5.6	5.4	5.4	5.1	5.1				
	Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
Average length of discharge delay for all acute adult patients	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60
Proportion of adult patients discharged from acute hospitals on their discharge ready date	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00

Source: <https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/>

40. The Oxfordshire system will retain the same targets as 25/6 but with increased investment in Home First MDT staffing and process improvements. In addition, the reduction in non-elective admissions should in turn reduce supported discharge demand and enable the reduction of the average discharge delay across all pathways to 5 days.
41. Internal audits have been completed to understand the reasons for delayed discharges across pathways 1 and 3. One of the key drivers for delays in pathway 1 was double handed care packages. The Oxfordshire system have worked with the provider market to develop the pricing model and ensure providers are incentivised to reduce the length of delay for more complex people in pathway 1 and plan to monitor delays specifically for this cohort. For pathway 3, our care homes framework and banded care rates has already reduced the administrative burden both for the County Council and care home providers, and the Oxfordshire system have also identified opportunities to further develop the trusted assessment provision to reduce delays at the point of assessment.

42. The Oxfordshire system has also set local targets for each pathway and targets in the acute and community trusts for the number of patients who are medically optimised for discharge each day. Performance against these targets will be monitored in UEC Board.

Permanent admissions to care homes

43. The Oxfordshire system’s continued focus on Home First and strengths-based approaches to care means that the number of people admitted to care homes each year has remained broadly stable over the last decade. Oxfordshire continues to perform well nationally for low care home admissions, ranking 41 of 152 local authorities in 25/6.

44. The target for 25/6 was to maintain an ongoing downward trajectory for care home admissions. However, the population supported is becoming increasingly frail and as noted above, a significant proportion of people who are captured by this metric were already resident in a Care Home prior to coming within the cohort.

45. The below table shows national data for care home admissions in 2025/6 and the proposed trajectories for 26/7. The care home admissions figures for 25/6 submitted nationally differ to local data and are under-reported.

46. In 26/7 is zero growth on care home admissions, equating to 800 over the year.

5.3 Admissions to residential and nursing care homes		Rolling 12 month total until end of quarter date indicated							
		Actual Ending 31-12-2024	Actual Ending 31-03-2025	Actual Ending 30-06-2025	Actual Ending 30-09-2025	2026-27 Plan Ending 30-06-2026	2026-27 Plan Ending 30-09-2026	2026-27 Plan Ending 31-12-2026	2026-27 Plan Ending 31-03-2027
Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population	Rate	519.3	490.0	481.4	474.3	571.4	571.4	571.4	571.4
	Number of admissions	727	686	674	664	800	800	800	800
	Population of 65+*	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999

*Population of people aged 65 and above are based on the latest available mid-year estimates from the ONS

Outcomes from reablement - % of people remaining in the community within 12 weeks following reablement post discharge

47. This metric has been developed to monitor the outcomes of people undergoing reablement following a hospital stay. It is intended to support systems to measure the quality of community and reablement support. People are counted in the figures if they are readmitted to hospital, admitted to a care home or if they died at any point within the 12-week period.

- 48. As this metric is new for 26/7, there is no requirement for HWB to submit trajectories. However, the Oxfordshire system has reviewed current reablement outcomes to baseline performance against this new metric.
- 49. Over the last 12 months, 1669 people in Oxfordshire were reabled post-discharge and 72% remained in the community after 12 weeks. This is a positive indicator for how the Oxfordshire system is supporting people to remain independent.
- 50. The Oxfordshire system is completing further analysis of the remaining 28% of this cohort who did not remain at home. A high percentage of these people died during the 12-week period. This suggests that these people may have been approaching their last months of life and indicates that they could be supported in an alternative way to reablement. Further analysis to ensure tailored approaches to meet the needs of this cohort is aligned with the national NHSE target to reduce the number of admissions and bed days for people approaching the end of their lives by 10% in 2029.

Income and Expenditure Plan

Income

- 51. The income into the BCF Plan is prescribed by NHS England. Neither the County Council nor the Integrated Care Board plan to add further sums currently but note that the Oxfordshire system is making full use of aligned expenditure particularly from Public Health and the Integrated Care Board's Urgent and Emergency Care Funding. The income into the BCF plan will be recorded as a variation to the Council and the ICB's s75 Act 2006 pooled budget agreement.
- 52. The income to the BCF Plan for 2026/7 is as follows:

Running Balances	2026-27		
	Income	Expenditure	Balance
DFG	£8,262,172	£8,262,172	£0
NHS Minimum Contribution	£61,172,312	£61,172,312	£0
Local Authority Better Care Grant	£13,206,730	£13,206,730	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	£82,641,214	£82,641,215	-£1

- 53. The total Disabled Facilities Grant allocation remains the same as in 2025/6. It is passed through directly to the City and Districts in line with the grant conditions.
- 54. For 2026 to 2027, the NHS minimum contribution to adult social care has been uplifted by 4.4%, with the remaining ICB contribution uplifted by 2.1%. The NHS minimum contribution has been uprated by 2%. For Oxfordshire, this has equated to an additional £2m. As part of the guidance publication NHSE also provided indicative NHS minimum contributions for 27/8 and 28/9.

55. The Local Authority Better Care Grant has not been updated for 2026/7.

Expenditure plan

56. The minimum NHS contribution and Local Authority Better Care Grant allocation expenditure commitments are confirmed as follows:

Required spend on adult social care from NHS minimum allocations	
2026-27	
	Planned Spend
Adult Social Care services spend from the NHS minimum allocations	£38,673,699
	Minimum required spend
	£35,531,804

- 57. In 26/7 Oxfordshire has committed to exceed this minimum commitment.
- 58. The income and expenditure plan sign off has been signed off by the County Council and ICB JCE leads.
- 59. The NHS minimum contribution includes an amount which is expected to come as a contribution from NHS Bath, North-east Somerset, Swindon and Wiltshire [BaNESSW] ICB. This is valued at £584,265. The ICB has confirmed that it will resolve this question outside of the BCF sign-off process and the funding should be treated as income in this plan.

Corporate Policies and Priorities

60. The Oxfordshire BCF Plan 2026/27 supports the County Council’s Corporate Plan outcomes by enabling residents to live well and independently for longer, improving access to timely support and strengthening prevention. It aligns with the Oxfordshire Way approach to strengths-based, community-focused support and contributes to delivery of the Oxfordshire Health and Wellbeing Strategy 2024–30, including the shift from “sickness to prevention” and supporting people living independently at home through joined-up health, social care, housing and voluntary and community sector (VCS) provision. The BCF Plan also supports system priorities for urgent and emergency care (UEC) and neighbourhood development by investing in admission avoidance, intermediate care, rehabilitation and reablement, and services that reduce health inequalities.

Financial Implications

- 61. The planning guidance sets out the income and expenditure for the Better Care Fund in 2026-27.
- 62. The final BCF Plan will be approved by the County Council’s S151 officer.

63. The final BCF Plan as submitted will be varied into the s75 NHS Act 2006 Pooled Commissioning Budget agreement between the County Council and the ICB as required by the Planning Guidance.
64. The Local Authority Better Care Grant (LABCG) forms part of the County Council's Fair Funding allocations. The DFG is received by the County Council and is paid over to the districts as stated within the grant conditions and the funding for the NHS minimum contributions is paid directly to the ICB forming part of the pooled budget for 2026/27 covering both health and social care costs as per the agreed BCF Plan.

Comments checked by:

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

Legal Implications

65. Part 1 of the Care Act 2014 places a statutory duty on councils to promote individual well-being and to develop and maintain strategies and services to prevent the need for care and support arising in the future. The Care Act also requires councils to work co-operatively with health services to meet the needs of the local population. The Oxfordshire Better Care Fund Plan for 2026/27 forms part of the preventive measures being developed to meet the needs of local communities.

Comments checked by:

Jay Akbar
Head of Legal & Governance

Staff Implications

66. The BCF Plan 26/7 continues to fund several cross system 'integrator' posts, including the system UEC lead, Transfer of Care and Home First leads and joint commissioning and data analytical resource. It also includes new investment for posts dedicated to developing and delivering Oxfordshire's approach to neighbourhood health and care.

Equality & Inclusion Implications

67. The BCF Plan continues to fund schemes which address health inequalities experienced by people in Oxfordshire. This includes targeting areas of deprivation through the provision of Integrated Neighbourhood Teams and

supporting vulnerable people experiencing homelessness, learning disabilities and/or mental health challenges.

68. The BCF Plan 26/7 also brings opportunities for to consider more broadly how BCF funding is used to support people under 65, including people experiencing specific long term conditions and children and young people.

Risk Management

69. As part of 26/7 planning, the Oxfordshire system has mapped several system risks and interdependencies which could impact on delivery of the BCF Plan and performance against the proposed trajectories. This includes national risks, such as Local Government Reorganisation and the ongoing Industrial Action by resident doctors, and local risks relating specifically to Oxfordshire organisations and services.
70. The Oxfordshire system's approach to these risks and how they impact delivery of the 26/7 BCF Plan will be managed as a system through the Urgent and Emergency Care Board and Oxfordshire Place Based Partnership Forums.

Engagement

71. The BCF Plan has been developed through involvement with already established system groups rather than specific engagement activities relating to individual schemes. However the key messages in *the Oxfordshire Way* around supporting people to live at homes and in their communities remain the same.
72. Building on engagement work already completed with system partners, the Oxfordshire system also undertaking a significant engagement programme to inform Oxfordshire's Neighbourhood development approach, with BCF funding earmarked to support this work.
73. As part of planning for 27/8 the Oxfordshire system will explore opportunities to increase engagement and feedback on the schemes funded by BCF and build this into an evaluation exercise planned for Q2.

Implementation and Review for 2026/7

74. Responsibility for the implementation of the BCF Plan has been delegated to the County Council and ICB's Joint Commissioning Executive. That body will in turn be advised by the system Urgent and Emergency Care Board in respect to system performance against metrics and the impact and value of committed funds. Performance will also be reported and reviewed in the Place Based Partnership.
75. The existing BCF Oversight Group will be deployed to monitor implementation of new and existing schemes for 26/7 to inform planning for 27/8.

Karen Fuller, Corporate Director of Adult Social Care

Annex 1: BCF narrative return template

Annex 2: BCF numerical return template

Background papers: Nil.

Other Documents: Better Care Fund Plan 2026/27 submission (numerical and narrative returns)

Contact Officer: Isabel Rockingham, Head of Joint Commissioning – Age Well, Oxfordshire County Council/Thames Valley Integrated Care Board

May 2026

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Better Care Fund 2026-27

Narrative return

Introduction and guidance

This return has been designed to enable ICBs and local authorities, working with Health and Wellbeing Boards (HWBs), to submit information which demonstrates how their plans for the Better Care Fund (BCF) meet the national conditions and planning requirements for 2026-27. Completing and submitting the BCF narrative return is a required part of the overall BCF submission process. Planning leads should ensure that all questions within this narrative return are fully addressed.

This year, the length of the narrative return has been reduced. This reflects feedback on the benefits of a more focused BCF assurance process. In completing the return, HWBs, ICBs and local authorities may wish to develop more detailed joint plans for BCF expenditure for their own use and/or draw on other joint plans.

Each question in the return has a suggested length of around a page (around 500 words) and we would generally expect the overall submission to be around 2500 words. These act as a guide to support a more focused assurance process rather than strict limits.

The narrative provided in this return should align with the expenditure plans and the ambitions for the national metrics set out in your BCF excel numerical return.

When completing the narrative return, please use the following documents for guidance and support, these can be found on the [BCF Exchange](#):

- 1) **Planning Principles:** outlines what good practice looks like in relation to each narrative question and aligns with the relevant national conditions.
- 2) **Metrics Handbook:** provides the formal technical specifications for the national metrics within the framework, including the rationale, methodology, required data inputs and worked examples.

Submission Requirements:

- Each HWB area must have its own BCF excel numerical return, but a single narrative BCF return covering multiple HWBs may be submitted where this reflects local integrated working arrangements.
- Each HWB area included in a combined narrative return should provide clarity and state any specific details relevant to the separate HWBs within the narrative questions (and more words may be required for this than a single HWB return). Local authorities, ICBs and HWBs for each area should formally sign off the shared narrative return and their individual numerical excel BCF return.

- The deadline for completing this narrative return is **19 May 2026**.
- Please submit this return to both: england.bettercarefundteam@nhs.net and your regional better care manager(s).

Submission details

Mandatory to complete, please do not submit a return without completing the details below:

<i>Adapt as necessary</i>	HWB area 1	HWB area 2
HWB	Oxfordshire	N/A
ICB	Thames Valley	N/A
ICB	Bath, North-East Somerset, Swindon and Wiltshire	N/A

1. Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative care linked to the relevant areas of neighbourhood health and social care services.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Priorities for 26/7

Oxfordshire's 25/6 plan focused on reducing non-elective admissions to support system flow. We achieved a 3% reduction in NELs against a zero-growth target, while also reducing conveyances to ED by 4%. However, we saw an increase in delay bed day consumption and our previously improving trajectory for discharge delays has slowed. In 26/7 we will further improve our ability to divert and prevent admissions, particularly for people with complex needs and/or frailty, and also retain discharge capacity but improve discharge processes, and improve outcomes to independence in the community. Ultimately, we aim to ensure that we can support people to stay at home and living independently for as long as possible. This approach is aligned with our local strategy – *The Oxfordshire Way* – and national guidance, including the NHS strategic commissioning and neighbourhood health frameworks.

Integration

Partners across health, social care and the voluntary sector in Oxfordshire work together to design and deliver services which prevent health crisis, reduce conveyances and hospital admissions and support more efficient discharge. We continue to fund several cross system 'integrator' posts, including our system UEC lead, Transfer of Care and Home First leads and joint commissioning and data analytical resource. These posts are also key in developing Oxfordshire's approach to delivering neighbourhood health and care.

Home First, Discharge and Intermediate Care

We will further develop our established 'Home First' approach by 'right-sizing' our capacity to respond more effectively and efficiently to system and user demand. We have sufficient capacity through our care market, with over 130 providers on our Live Well at Home Framework, which enables continued delivery of reablement. However growing discharge demand in 25/6 meant demand exceeded Home First staffing capacity which led to D2A assessment delays. With the improvements in NEL performance discharge demand has since stabilised, meaning this year we have increased Home First MDT staffing capacity aligned to system need. We have also reviewed our bedded intermediate care capacity and funded 10 additional Short Stay Hub Beds in Pathway 2 to address the needs of more complex and frail patients who were previously supported through enhanced care packages via D2A. A review of outcomes for this cohort showed 40% were admitted to care homes – this has since lowered since we reviewed bedded capacity. We are committed to achieving high outcomes to independence following reablement and maintaining low rates of permanent admissions to care homes .

Prevention: supporting people in their own homes in their own communities

Admission avoidance

We will further develop our admission avoidance capability through continued funding for urgent community response, including community same day emergency care, hospital @ home (adults and children's), community therapy and specialist mental health and support. We will also increase our capability to coordinate and direct these resources via Single Point of Access – our front door for urgent community support, used by GPs, ambulance crews, care homes and hospital teams - and ambulance call (999/111) stack expansion – additional clinical decision support for ambulance staff to avoid unnecessary trips to A&E. Since it was first developed in 24/5, SPA has enabled us to improve coordination of community response to support people in their own homes, prevent the need for conveyance and risk of admission. To complement this, we have also funded the expansion of stack diversion (8am – 8pm), adding additional medical, administrative and visiting capacity support to reduce unnecessary conveyances to ED. Our community equipment and telecare contracts will further support this by helping people stay safe at home (e.g., rapid provision of equipment and alarms/sensors) and reducing avoidable escalation to 999 and ED.

Community capacity, information and support

We have an extensive community information and support offer which enables Oxfordshire residents to access advice, guidance and support to proactively manage their health and wellbeing. Services aligned to this

approach both within and outside the BCF include our Local Area Coordination programme, Community Capacity Grants and falls prevention services. Also, key for 26/7 is developing our approach to measuring the impact of prevention – see response to question 3.

Unpaid Carers

We have continued investment in supporting unpaid carers to enable us to support people in their own homes and communities. This includes projects delivered jointly with health partners such as carer's IDs and passports to support identification of carers. In 26/7 we will be refreshing our system-wide All-Age Unpaid Carers Strategy which will involve input from people we support, carers, and local health and VCSE partners. We are also developing a carer's strain index to enable identification of carers at the highest risk of crisis. This will enable us to respond proactively and prevent carer breakdown and subsequent social admissions to hospital.

Disabled Facilities Grant (DFG)

The County and District Councils work in partnership through occupational therapy and BCF-funded Home Improvement Agencies to deliver DFGs. This includes adaptations such as level access showers, ramps and stairlifts, and working with our community equipment provider to deliver equipment to support people to live independently at home. We have developed joint KPIs to measure funding impact and we are exploring opportunities to use DFG funding more innovatively, such as developing joint plans for shared extra care temporary accommodation to support people while they are waiting for major adaptations on discharge from hospital

Changes in planned spend

As 26/7 is a transition year ahead of BCF reform, the majority of core schemes are being maintained, with targeted additional investment focused on front door diversion, discharge processes and neighbourhood enablement. To reflect the priorities outlined above, key changes in planned spend for 26/7 include:

- Additional investment in urgent response and front door diversion through SPA and expanding stack capability
- Additional funding to develop Integrated Neighbourhood Teams in areas of deprivation, with high and/or complex needs and health inequalities
- Investment in technological infrastructure (OPTICA) to reduce discharge delays relating to process issues
- Home First D2A & reablement budgets include provision for additional staffing and bedded intermediate care capacity
- A small amount of funding has been reallocated from pilot mental health schemes into the Oxfordshire Health and Homelessness Integration team. This reflects our ongoing commitment to supporting some of our most complex people and diverting them away from ED and ensuring that discharge from acute and mental health in-patient beds supports them to more sustainable support in the community
- Support for the development of Neighbourhood Health and Care, including resourcing for coordination, comms, business intelligence, engagement and training

- 2. Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.**

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Oxfordshire agreed system trajectories 26/7

Oxfordshire has used a combination of local and national data to set trajectories against BCF core metrics and interrelated local metrics which impact system flow. According to national data, our current performance for NELs and discharge delays remains better than our peer averages. The trajectories for 26/7 are as follows:

Priority area	Performance metric	25/6 target	25/6 actual / position	Agreed system targets	Data underpinning performance
1. Non-elective admissions (NELs)	a) All non-elective admissions aged 65+ [BCF core]	Zero growth vs 24/5	2.5% reduction vs 24/5	Zero growth compared with 2025/26	System
	b) General Medicine & Geriatric Medicine admissions at OUH (local frailty subset aligned with national target)	Zero growth vs 24/5	2.5% reduction vs 24/5	2% reduction on 2025/26 levels • 4 fewer admissions per week (progression towards 10% reduction by 2029)	System
	c) Conveyances to ED (local stretch)	No formal target	3% reduction vs 24/5	3% reduction on 2025/26 levels • (3 fewer conveyances per day)	System, inc. OH (stack) & SCAS
2. Discharge delays and flow	a) Average delay per discharge [BCF core]	0.6 days	0.74 days	0.6 days	System
	b) % discharged on Discharge Ready Date [BCF core]	88%	86.4%	88%	System
	c) Average delay for those not discharged on DRD [BCF core]	5 days	5.4 days	5 days	System
	d) Length of stay MOFD	Pathway 1: 4.4 days Pathway 2: 3 days Pathway 3: 9 days	Pathway 1: 5 days Pathway 2: 3.9 days Pathway 3: 14.7 days	Pathway 1: 4.4 days Pathway 2: 3 days Pathway 3: 14.7 days (zero growth)	System
	e) MOFD patients per day (OUH)	80 per day	108 per day	80 per day	System, inc. OUH, OH
	f) MOFD patients per day (OH)	15 per day	23 per day	15 per day	
3. Outcomes after discharge	a) % of people in the community 12 weeks after reablement (new BCF metric) - End of life cohort outcomes (national target)	N/A (new metric for 26/7)	Baseline established: 72%	Indicative baseline - 72% • 8% died within 12 weeks – audit ongoing	OCC
4. Long-term care home admissions	a) Admissions to residential and nursing care aged 65+ [BCF core]	760	-800	Zero growth on 2025/26 • (~800 admissions per year)	OCC

Non-elective admissions

As in 25/6, we have modelled NEL demand on >65 admissions to General Medicine and Geratology (GMG). NEL bed days currently average at 5.9 days per admission. In 25/6 Oxfordshire outperformed our zero-growth BCF target and achieved a 2.5% reduction in admissions for this cohort. This equated to 284 fewer admissions and a 3.66% reduction in bed days lost compared to 24/5.

The GMG cohort is the frailty cohort for whom systems must achieve a 10% reduction in admissions and bed days by 2029, as stipulated in the NHS Neighbourhood Framework. We have modelled the 10% reduction to 2029 and our 26/7 BCF target is a 2% reduction on 25/6 performance. To deliver this, we must divert 4 additional patients per week against the 2025/6 baseline.

Following expansion of the stack to 12 hours per day Monday – Friday, we have also set a local stretch target to achieve a 3% reduction in all conveyances for people 16+, equating to 3 people diverted per day. The BCF schemes will impact on people above and below 65 and so we will map locally the impact in both groups, and how this impacts people in the GMG frailty cohort. This includes monitoring trends across our acute sites in Banbury and Oxford City and overlaying with our developing neighbourhood geographies and underpinning population analysis.

Delayed discharges

Throughout 25/6 we have maintained high numbers of discharges and overall Length of Stay for GMG emergency admissions remains stable at 8 days. However, we have not been able to control bed day consumption from delayed discharges in line with 25/6 NEL performance. In broad terms we have seen an upwards trajectory for bed days lost to discharge delay across all pathways in 25/6. The average length of delay has increased from 5.6 days in 24/5 to 5.8 days in 25/6, meaning we did not achieve our 5-day 25/6 target.

In 26/7 we will aim to reduce the average length of delay days to our 25/6 target of 5 days. Internal audits for delays in pathways 1 & 3 have identified that delays are driven by process issues, particularly for more complex cases, rather than provider capacity. Schemes such as OPTICA will support improve efficiency of processes. We have also increased staffing in Home First to respond to discharge demand. Progress will be monitored against local targets set for each pathway.

We do not anticipate significant changes to the percentage of people discharged on discharge ready day where predominantly the population in this instance is people on Pathway 0. The system view is that the focus for Oxfordshire needs to continue shifting to front door rather than discharge to maintain flow.

Long-term care home admissions

In 25/6 Oxfordshire has not been able to maintain our downwards trajectory for care home admissions due to increased levels of frailty. At year end we had 800 admissions to care homes against our target of 760. Despite this, admissions to care homes remain broadly stable over the last decade, and Oxfordshire continues to perform well nationally, ranking 41 of 152 local authorities in 25/6.

In 26/7 Oxfordshire will aim for zero-growth on 25/6 figures, equating to 800 admissions across the year.

Of the 40 additional admissions this year, almost a quarter were self-funders who have depleted capital and now quality for LA support. At the point that they hit the metric there are limited opportunities to divert people into community-based support. We have continued to invest in resources to support self-funders, such as our Live Well Oxfordshire directory, and ensure they have the information they need to consider alternatives to residential care. Overall, nursing client numbers continue to be on a downward trajectory and residential client numbers have been falling since December 25 which attests to the reduction in permanent admissions over time.

Improving outcomes from reablement

Oxfordshire has reviewed our reablement outcomes to baseline our performance against this new metric. Over the last 12 months, 1669 people in Oxfordshire were reabled post-discharge and 72% remained in the community after 12 weeks. Of the remaining 28%, the majority were readmitted. 8% of the total number of people who underwent reablement died. We are completing further analysis of this cohort to determine if we can develop more tailored approaches towards people leaving hospital via D2A who are approaching their last months of life. This will involve working closely with palliative community services and aligns with national targets to increase identification and reduce admissions for people who are EoL.

All system trajectories have been endorsed by our cross-system Urgent Care Delivery Group and approved by our Urgent and Emergency Care Board on 23 April 2026. We are committed to continually improving data quality and monitoring via these forums.

3. Please provide a short explanation of the planned impact of BCF funding on achievement of goals.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Non-elective admissions

Our targets for NELs are informed by the impact achieved in 25/6 following ongoing significant investment in urgent care services and SPA. Our 26/7 plan will build on this achievement to further reduce non elective admissions by 4 per week, saving 1905 additional bed days compared to 25/6, and reduce conveyance to ED by 3 people per day.

- The stack expansion will increase from 4 hour to 12-hour operation from 8am-8pm Monday to Friday. This is informed by local analysis which identified a direct correlation between ED attendance in the evenings and increased emergency admissions, with 4-8pm highlighted as a key pressure point for ambulance arrivals in ED. We have modelled that SPA & stack can divert 3 conveyances per day to progress us towards our 26/7 target. Longer term we may also expand this provision to cover weekends.
- Investment in SPA has enabled us to better utilise and coordinate our resources to prevent admission. While NELs have reduced, there has been 41% increase in community same day emergency care attendances since February last year. We have also seen an increase in referrals to our adults and

children's hospital at home provision and we are on track to reach our upwards trajectory of 450 H@H admissions per month. Following an increase in emergency admissions from care homes, we also introduced an advice line specifically for care home staff and expanded our existing Care Home Support Service. Analysis of South Central Ambulance Service data in September 25 showed Oxfordshire has the lowest conveyance rate for care homes in the South East at 45.9%. Emergency admissions from care homes have also stabilised. We will continue to work with our care home market to further improve this and achieve our target of 4 additional diversions per week.

- We are continuing targeted interventions to avoid admission for specific cohorts of more complex people that are at an increased risk of admission to hospital and/or likely to be more complex to discharge once admitted. This includes children with respiratory conditions, people with learning disabilities, people at risk of falls, people with dementia in care homes and people with complex mental health and/or experiencing homelessness. Impact thus far has been reductions in mental health bed occupancy for older adults, and a reduction in ED attendances for people 65+ who have fallen. However, 40-50% of ED attendances relating to falls are walk-ins rather than conveyances. Developing knowledge about SPA and other community resources, in addition to funded falls prevention services, should reduce this figure.
- Integrated Neighbourhood Teams also impact conversion rate into admission. We have developed INTs in areas of deprivation in Bicester, 2 in Banbury and Blackbird Leys in the City and invested further in 26/7. The combined caseload has been on an upward trajectory, averaging at approximately 700 people per month.

Delayed discharges

The reduction in non-elective admissions should in turn reduce supported discharge demand and enable us to reduce the average discharge delay to 5 days across all pathways. As identified already, we have invested into more Home First MDT staffing to support flow, as well as completing internal audits to understand the reasons for delayed discharges. One of the key drivers for delays in P1 was double handed (DH) care packages. We conducted an audit on DH cases and concluded that prescriptions were proportionate to care needs. We have worked with our provider market to develop our pricing model and ensure providers are incentivised to reduce the length of delay for more complex people in P1 and plan to monitor delays specifically for this cohort. For P3, our care homes framework and banded care rates has already reduced the administrative burden both for the Council and our care home providers, and we have also identified opportunities to further develop our trusted assessment provision to reduce delays at the point of assessment. Our MOFD LoS targets across each pathway are:

- Pathway 1: 4.4 days
- Pathway 2: 3 days (generic community hospital)
- Pathway 3: 14.7 days from point of discharge notice

We have also set targets for daily MOFD patients in the acute and community trusts. For the acute, following an average of 108 patients per day against an 80 per day target in 25/6, we are proposing that the above interventions will achieve the same target – c.8% of the current open bed base. For our community trust, we intend to reduce daily MOFD from an average of 25 people per day to 10. Achievement of this target will be supported through conveyance reduction, as well as investment in technology like OPTICA.

Improving outcomes from reablement

Well-timed, early reablement can reduce the risk of first admission to hospital or the risk of deterioration after discharge and prevent future admissions. Improvement in delays in P1 discharges and reducing assessment timeframes will ensure reablement starts as soon as possible. We will also complete further modelling of readmission rates following reablement to better understand the root causes for delays. As mentioned previously, we anticipate further work is needed with community palliative care teams to develop more tailored approaches to people in their final months of life. 25/6 also saw an increase in community reablement referrals compared to previous years, meaning we are proactively supporting more people to remain independent at home.

BCF also funds our community equipment and telecare provision, both of which support people to remain independent in their homes. Over 25/6 we have also worked with District council colleagues to identify shared

KPIs for DFG funding so that we can monitor impact, reduce inequity in terms of wait times for assessments and installations, and identify opportunities for improvement.

As part of our Prevention Strategy, in 26/7 we are also developing our capability to measure the impact of preventative schemes and services which support independence, reduce social isolation, prevent health decline and enable people to remain in their communities. This work involves mapping existing grants, projects and services at county and neighbourhood level, and working with university, public health and health partners to robustly evaluate impact, overlaps and gaps. This work will feed into the development of Oxfordshire's neighbourhood health and care structure.

Long-term care home admissions

We have a recurring challenge with self-funders entering care homes earlier than may be necessary to meet their care needs. We are developing projects to support self-funders to provide them with the information and advice needed to make informed decisions about their care provision. This includes steering people to other alternative support funded by the BCF, such as Extra Care Housing. We are also undertaking work to further analyse length of stay in care homes to ensure they are used as a last resort.

4. Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.

Please provide a concise statement of around one page (e.g. around 500 words) please provide your response below:

Oxfordshire's BCF planning process centres on achieving best value for the *Oxfordshire pound*, rather than solely savings made by individual organisations. As a continuation from 25/6, we have aligned the BCF plan with other 'system' funding streams, such as Urgent and Emergency Care funding, to ensure we plan in relation to system context and ensure best value and use of resources. This year we also aligned BCF plan development with Community Growth and Mental Health Investment Standard funding.

We have allocated the additional funding uplift for 26/7 to 5 core schemes – SPA, stack expansion, INTs, OPTICA and Neighbourhood development – all of which closely align to our system trajectories and national targets to increase productivity by 2%. We will improve productivity through digitisation - OPTICA – which will improve our ability to track and monitor tasks relating to discharge in real time. We have also undertaken work to review staffing requirements and ensure we optimise Home First staff time and capacity – see below.

Progress to increase the impact of the *Oxfordshire pound* will be aligned to the development of neighbourhood health and care models. To inform BCF planning for 27/8 the system will review funded contracts and identify opportunities to further transform how we deliver services. We are developing our understanding of the value and impact of preventative services and mapping the interaction of our population across mental health, homelessness and acute care pathways. BCF funds joint schemes with system partners, such as our complex alcohol team funded jointly with Public Health and is directly aligned to spend in other areas such as mental health and City and District homelessness spend.

Our plan includes ongoing investment in Business Intelligence expertise and as a result we have developed a comprehensive UEC sit-rep, collating data from across health and social care, to enable robust monthly monitoring of our performance against our trajectories. Our longer-term ambition is to develop a live dashboard enabling us to monitor performance in real time. In addition, we have developed the capability to monitor the productivity of each of our services – mapping activity and cost against system bed day savings. This enables system oversight of performance, expenditure and impact as well as comparison between commissioned services to ensure value for money. Both resources inform evaluation of system performance and are monitored in both our System Urgent Care Delivery Group and System Urgent and Emergency Care Board.

Ongoing monitoring enables us to proactively review outcomes and continuously improve. Home First D2A was one of our biggest cost drivers in 25/6. We completed in-year analysis the reasons for increasing costs and identified that this was broadly due to mitigation payments to providers resulting from inadequate Home First staffing capacity and high cost enhanced D2A care packages. Analysis of the outcomes of the latter cohort showed a high care home admission rate, which led us to recommission additional bedded intermediate care capacity to deliver improved outcomes in a more cost-effective way. This has released funding to further

support Home First staffing capacity and productivity, and these changes can now be delivered within existing budget envelopes in 26/7. The additional process improvements required to meet our discharge delay targets will also be delivered with minimal additional funding.

Newly funded schemes for 26/7 are developing service specifications with metrics specifically aligned to our system trajectories to enable ongoing monitoring and ensure value for money.

5. Please outline your robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Oxfordshire’s BCF plan is developed by a system-wide BCF Oversight Group which is attended by operational, clinical and commissioning leads together with the voluntary and community sector. Organisations represented include:

- Oxford University Hospital NHS FT
- Oxford Health NHS FT (Community and Mental Health)
- Oxford City Council (Homelessness and Home Improvement Agency)
- West Oxfordshire, South & Vale and Cherwell District Councils (Home Improvement Agency)
- Oxfordshire County Council (Public Health, Adult Social Care);
- OCC/ICB integrated commissioning team;
- Oxfordshire Association of Care Providers;
- Age UK;
- Healthwatch

To meet the requirements of National Condition 1, this group will continue to meet regularly to review expenditure and progress of the 26/7 plan against our system trajectories. The data to inform this will be collected through quarterly returns from each of the BCF scheme leads. Schemes that received new or significantly increased investment in 26/7, such as STACK diversion and SPA, will develop service specifications and targets aligned to the system and BCF trajectories. This will enable us to closely monitor impact and spend. More broadly, this group will also capture and share lessons learned and adjust spending plans over time. In Q1, we will also work with the ICB to review block contracts that the BCF contributes to and increase visibility of the Oxfordshire funding landscape. This insight will inform planning for 27/8.

The BCF Oversight group reports into several other system-wide forums and will continue to do so throughout 26/7. The decision-making process and responsibilities in Oxfordshire are as follows:

Role in BCF planning	Responsibility
System endorsement of BCF Plan – including guidance around narrative and strategic direction and alignment with Oxfordshire priorities	Place Based Partnership
<i>New for 26/7</i> - Assurance that the BCF Plan is developed in alignment with Oxfordshire’s approach to Neighbourhoods, and reflect the national ambition for BCF funding streams to be used to progress this approach	Primary & Community Care Board

Alignment of BCF investment and system Urgent and Emergency Care (UEC) Funding, and setting robust, system-owned targets and trajectories that deliver the BCF metrics in relation to hospital avoidance and discharge, and is responsible for coordinating course correction should performance against the trajectories go off track	Urgent and Emergency Care Board
Approval of investment and expenditure plans, and assurance to Council, Cabinet and ICB Board for the wider BCF Plan - Including variations and in-year allocations	ICB/OCC Joint Commissioning Executive (JCE)
Final sign off for 26/7 BCF Plan	<ul style="list-style-type: none"> a) Chief Executive and s151 Officer for the Council b) Chief Executive TV ICB c) Chief Executive NHS Bath, North-East Somerset, Swindon and Wiltshire Integrated Care Board d) Chair, Oxfordshire Health & Wellbeing Board

The BCF Oversight Group reports to all of the above groups. The responsibility for the delivery of this plan similarly will be governed by these bodies with Joint Commissioning Executive retaining the responsibility to report to HWB.

Better Care Fund (BCF) 2026-27 Numerical Template

1. Guidance

Overview

The numerical return is designed to capture planned BCF spend, goals and assurance statements. Together with the narrative return these will enable local areas to demonstrate how they meet the national funding conditions, in line with the published BCF 2026-27: <https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027>.

Completed numerical returns are due by Tuesday 19 May 2026 (noon)

Submissions should be sent to the national BCF team at england.bettercarefundteam@nhs.net, as well as to regional Better Care Managers.

This guidance provides an overview of how to complete this numerical return. Further guidance is provided in the BCF Planning Principles guidance and and supporting documents which can be found on the Better Care Exchange - <https://future.nhs.uk/bettercareexchange/view?objectID=70716560>

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.

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

Data needs inputting in the cell

Pre-populated cells

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

2. Cover

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

Governance and sign-off

National condition one (refer to tab 6) outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. Please enter date of expected sign off if not yet signed off. **This accountability must not be delegated.**

Data completeness and data quality:

- Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the BCF team: england.bettercarefundteam@nhs.net (please also copy in your better care manager).
- The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission. Please contact your regional BCF team if you have any issues.

3. Income

This sheet should be used to specify all funding contributions to the HWBs BCF plan and pooled budget for 2026-27. This section will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant (DFG) and Local Authority Better Care Grant (LABCG). For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your better care manager).

Additional Contributions

This sheet also allows local areas to add in additional contributions from both the NHS and local authority. You will be able to update the value of any additional contributions (local authority and NHS) income types locally. If you need to make an update to any of the funding streams, select 'Yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information as this will ensure section is marked as complete.

Unallocated funds

Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

4. Expenditure

Please see tab '4a. Expenditure guidance' for further information.

5. Metrics

For 2026-27, local authorities, integrated care boards (ICBs) and HWBs will be expected to monitor performance and improvement for the four metrics listed in the Metrics Handbook <https://future.nhs.uk/bettercareexchange/view?objectID=277641413>, available on the Better Care Exchange:

It is a national requirement for partners to set local goals in relation to the following two metrics:

- Non elective admissions to hospital for people aged 65 and over per 100,000 population
- Average length of discharge delay for all acute adult patients

HWBs are also encouraged to set goals for the metric on long-term admissions to residential and nursing homes for people aged 65 and over per 100, 000 population.

We also expect HWBs to monitor and drive improvements for the metric on the proportion of people aged 65 and over discharged from hospital with reablement provided partly or solely by local authorities who remained in the community within 12 weeks of discharge.

Further details on the metrics, can be found below:

1. Non-elective admissions to hospital for people aged 65 and over per 100,000 population. (monthly)

- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions. The population figure is pre-populated using the latest available mid-year estimates.
- This will then auto populate the rate per 100,000 population for each month

Source statistics: <https://digital.nhs.uk/supplementary-information/2026/non-elective-inpatient-spells-at-english-hospitals-occurring-between-1-april-2020-and-30-november-2025-for-patients-aged-18-and-65>

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)

- This is calculated as the sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients discharged in that month.

In completing the table for 2026-27 we ask areas to set out these two components and sheet automatically calculates the average figure:

- In a given month, the total number of patients discharged on the same day as their Discharge Ready Date, divided by the total number of patients discharged in that month.
- The sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients delayed by at least 1 day and discharged in that month.

Source statistics: <https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/>

3. Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population

- Admissions data is taken from the Client Level Data (CLD) source published on a quarterly basis and presents admissions as a rolling 12-month total, calculated to the end of each quarter and reported as a rate per 100,000 population.
- Population are based on a calendar year using the latest available mid-year estimates.

Any improvement planned in reablement can be noted in the narrative template but does not need to be included in this numerical template.

For missing pre-populated actuals data from November 2025 to date, please check the BCF dashboard on the DHeXchange which will have more recent data as it becomes available.

6. National conditions

This section requires local authorities, ICBs and HWBs to confirm whether the three BCF national conditions and planning requirements detailed in the published BCF 2026-27 guidance will be met. The assurance statements in this section refer to specific planning requirements, supplementing the information provided in the narrative template and this numerical template.

This sheet requires the local authorities, ICBs and HWBs to confirm 'Yes' or 'No' to the assurance statements. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.

In summary, the national conditions are as below:

- **National condition 1:** ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding, to deliver more integrated and preventative care, linked to the wider development of neighbourhood health and social care services.
- **National condition 2:** ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.
- **National condition 3:** ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.

Better Care Fund 2026-27 Numerical Template

2. Cover

Version 1.0

Please Note

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

Governance and Sign off

Health and Wellbeing Board:	Oxfordshire
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	Yes
If no indicate the reasons for the delay.	
If no please indicate when the HWB is expected to sign off the plan:	

Complete:

Yes

Yes

Yes

Yes

Submitted by:	Isabel Rockingham
Role and organisation:	Head of Joint Commissioning - Age Well
E-mail:	isabel.rockingham@oxfordshire.gov.uk
Contact number:	07576 326 872
Documents submitted (please select from drop down)	
In addition to this template the HWB are submitting the following:	Narrative

Yes

Yes

Yes

Yes

Yes

	Role:	Professional title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation
Health and wellbeing board chair(s) sign off	Health and wellbeing board chair	Cllr	Liz	Leffman	liz.leffman@oxfordshire.gov.uk	
	Health and wellbeing board chair					
Named accountable person	Local authority chief executive	Mr	Martin	Reeves	martin.reeves@oxfordshire.gov.uk	
	ICB chief executive 1	Mr	Nick	Broughton	nick.broughton1@nhs.net	Thames Valley ICB
	ICB chief executive 2 (where required)	Mr	Matthew	Hawkins	matthew.hawkins1@nhs.net	NHS Bath and North East Somerset, Swindon and Wiltshire ICB
	ICB chief executive 3 (where required)					
Finance sign off	LA section 151 officer	Ms	Lorna	Baxter	lorna.baxter@oxfordshire.gov.uk	
	ICB finance director 1	Mr	Richard	Chapman	richard.chapman@nhs.net	Thames Valley ICB
	ICB finance director 2 (where required)					
	ICB finance director 3 (where required)					

Yes

Yes

Yes

Yes

Yes

Area assurance contacts <i>Please add any additional key contacts who have been responsible for completing the plan</i>	Local authority director of adult social services	Ms	Karen	Fuller	karen.fuller@oxfordshire.gov.uk	
	DFG lead	Ms	Isabel	Rockingham	isabel.rockingham@oxfordshire.gov.uk	
	ICB place lead 1	Mr	Daniel	Leveson	daniel.leveson@nhs.net	Thames Valley ICB
	ICB place lead 2 (where required)					
	ICB place lead 3 (where required)					

Yes
Yes
Yes

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(s).

	Complete:
2. Cover	Yes
3. Income	Yes
4. Expenditure	Yes
5. Metrics	Yes
6. National Conditions	Yes

Better Care Fund 2026-27 Numerical Template

3. Income

Selected HWB:

Local authority contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Oxfordshire	£8,262,172
DFG breakdown for two-tier areas only (where applicable)	
Cherwell	£1,538,565
Oxford	£1,763,767
South Oxfordshire	£1,923,855
Vale of White Horse	£2,033,699
West Oxfordshire	£1,002,286
Total Minimum local authority contribution (exc local auth	£8,262,172

Complete:

Local authority better care grant (LABCG)	Contribution
Oxfordshire	£13,206,730
Total Local authority better care grant	£13,206,730

Are any additional local authority contributions being made in 2026-27? If yes, please detail below

Yes

Local authority additional contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Total additional local authority contribution	£0	

Yes

NHS minimum contribution	
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	£584,265
NHS Thames Valley ICB	£60,588,047
Total NHS minimum contribution	£61,172,312

Are any additional NHS contributions being made in 2026-27? If yes, please detail below	No
---	----

Yes

Additional NHS contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Total additional NHS contribution	£0	
Total NHS contribution	£61,172,312	

Yes

	2026-27
Total BCF pooled budget	£82,641,214

Funding contributions comments
For any useful details please use the text box below (for no additional comments, insert 'NA')

NA

Yes

Better Care Fund 2026-27 Numerical Template

4. Expenditure

Selected Health and Wellbeing Board:

Running Balances	2026-27		
	Income	Expenditure	Balance
DFG	£8,262,172	£8,262,172	£0
NHS Minimum Contribution	£61,172,312	£61,172,312	£0
Local Authority Better Care Grant	£13,206,730	£13,206,730	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	£82,641,214	£82,641,215	-£1

Required spend on adult social care from NHS minimum allocations

	2026-27	
	Minimum required spend	Planned Spend
Adult Social Care services spend from the NHS minimum allocations	£35,531,804	£38,673,699

Checklist

Column complete:

	Yes	Yes	Yes	Yes	Yes
Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27 (£)
1	Disabled Facilities Grant related schemes	DFG allocation	DFG	Yes	£8,262,172
2	Disabled Facilities Grant related schemes	Home Improvement Agency	Local Authority Better Care Grant	Yes	£758,954
3	Assistive technologies and equipment	Technology Enabled Care	Local Authority Better Care Grant	Yes	£847,541
4	Assistive technologies and equipment	Integrated community equipment (social care)	Local Authority Better Care Grant	Yes	£3,458,031
5	Assistive technologies and equipment	Integrated community equipment (community health)	NHS Minimum Contribution	No	£3,300,000
6	Wider local support to promote prevention and independence	Community information, advice, care navigation and social prescribing	Local Authority Better Care Grant	Yes	£1,771,000
7	Support to carers, including unpaid carers	Community information, advice, care navigation and social prescribing	Local Authority Better Care Grant	Yes	£555,242

8	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Home First community and discharge reablement	NHS Minimum Contribution	Yes	£4,031,378
9	Short-term home-based social care (excluding rehabilitation, reablement or recovery	Home First Discharge to Assess	NHS Minimum Contribution	Yes	£2,100,185
10	Discharge support and infrastructure	Home First MDT capacity (ASC discharge teams)	Local Authority Better Care Grant	Yes	£2,894,300
11	Discharge support and infrastructure	Pathway 2 MDT capacity (HUB team)	NHS Minimum Contribution	Yes	£1,062,678
12	Urgent community response	Hospital at Home (City) OUH Acute Virtual ward	NHS Minimum Contribution	No	£1,430,529
13	Urgent community response	Hospital at Home (South) - CYP (c.£500k & adults)	NHS Minimum Contribution	No	£1,314,043
14	Urgent community response	Hospital at Home (North) (PML)	NHS Minimum Contribution	No	£559,950
15	Urgent community response	Integrated Neighbourhood Teams	NHS Minimum Contribution	No	£1,600,000
16	Urgent community response	Community Same Day Emergency Care (SDEC)	NHS Minimum Contribution	No	£3,314,740

17	Long-term home-based social care services	Home Care	NHS Minimum Contribution	Yes	£13,256,983
18	Long-term residential/nursing home care	Residential and nursing homes	NHS Minimum Contribution	Yes	£13,339,473
19	Evaluation and enabling integration	System joint posts: UEC Leadership; TOC Manager; HF Lead; BI support: Integrated commissioning	NHS Minimum Contribution	No	£267,547
20	Evaluation and enabling integration	System joint posts: UEC Leadership; TOC Manager; HF Lead; BI support: Integrated commissioning	NHS Minimum Contribution	Yes	£267,547
21	Home-based intermediate care (short-term home-based	Care sector workforce	Local Authority Better Care Grant	Yes	£225,000
22	Housing related schemes	Extra Care housing	NHS Minimum Contribution	Yes	£1,612,000
23	Housing related schemes	Contribution to Oxfordshire Homelessness Alliance	Local Authority Better Care Grant	Yes	£273,000
24	Housing related schemes	Health & Homelessness Integration team	NHS Minimum Contribution	No	£1,996,366
25	Discharge support and infrastructure	grants; PD support (120k)	Local Authority Better Care Grant	No	£165,000
26	Wider local support to promote prevention and independence	Learning Disability and Autism intensive community support	Local Authority Better Care Grant	No	£312,000
27	Bed-based intermediate care (short-term bed-based	Short stay hub bed model-P2 reablement-ICB contribution	NHS Minimum Contribution	Yes	£2,621,697
28	Bed-based intermediate care (short-term bed-based	Short stay hub bed model-P2 reablement-OCC contribution	Local Authority Better Care Grant	Yes	£827,904
29	Discharge support and infrastructure	Complex dementia mental health support to care homes (CSS expansion)	Local Authority Better Care Grant	Yes	£272,000
30	Discharge support and	Trusted Assessor service	Local Authority Better	Yes	£125,000

31	Wider local support to promote prevention and independence	High Intensity User support	NHS Minimum Contribution	No	£179,000
32	Wider local support to promote prevention and independence	Alcohol complex care support	NHS Minimum Contribution	No	£83,430
34	Home-based intermediate care (short-term home-based)	CYP respiratory support to prevent admissions	NHS Minimum Contribution	No	£60,000
35	Wider local support to promote prevention and independence	Stay strong and steady falls prevention service	NHS Minimum Contribution	No	£201,236
36	Home-based intermediate care (short-term home-based)	Falls prevention service	NHS Minimum Contribution	No	£446,529
38	Bed-based intermediate care (short-term bed-based)	Contribution to P2 rehab bed pathway costs (CH beds (inc stroke)	NHS Minimum Contribution	No	£5,386,712
39	Urgent community response	Community resource to divert patients from 999/111 to UCR (SPA)	NHS Minimum Contribution	No	£720,429
40	Discharge support and infrastructure	Same day emergency discharge (MDT ORU)	NHS Minimum Contribution	No	£200,000
42	Support to carers, including unpaid carers	Community information, advice, care navigation and social prescribing - (Care Act)	NHS Minimum Contribution	Yes	£381,758
43	Short-term home-based social care (excluding rehabilitation,	Home First Discharge to Assess	Local Authority Better Care Grant	Yes	£304,525
45	Urgent community response	STACK EXPANSION 8-8	NHS Minimum Contribution	No	£815,000
46	Discharge support and infrastructure	OPTICA	NHS Minimum Contribution	No	£160,000
47	Wider local support to promote prevention and independence	NEIGHBOURHOOD DEVELOPMENT	NHS Minimum Contribution	No	£463,103
48	Home-based intermediate care	Home First community and discharge reablement	Local Authority Better	Yes	£417,233

Guidance for completing expenditure sheet

1. Please enter spend information in the bottom table starting cell B30 including the category of spend which is a dropdown containing the categories listed in the table below. You must also enter scheme-level detail for the line of spend in 'Description of Scheme' with the appropriate level of information keeping this relatively succinct, for example 'Community Health Rehabilitation' or 'MSK services' or 'Integrated Crisis and Rapid Response' would be sufficient. Please also enter source of funding which determines the total spend appearing in the source of funding table at the top. Ensure a 'Number' is entered in the 'Expenditure for 2026-27 (£)' so that the validation boxes can be marked as complete.

2. Please ensure 'Adult Social Care Spend' is marked 'Yes' when the money is spent on Adult Social Care across any funding source.

Scheme Types

Number	Category of scheme	Description
1	Assistive technologies and equipment	Using technology in care processes to support self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Housing related schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.
4	Wider support to promote prevention and independence	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and wellbeing.
5	Short-term home-based intermediate care (rehabilitation, reablement and recovery services)	Short-term (up to 6 weeks), therapy-led services in the person's usual residence (home or care home), following the 'Home First' principle. For adults 18+ to regain independence post-illness/injury/discharge (step-down) or prevent admissions/long-term care (step-up). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus support from unregistered workers and other professionals (nurses, doctors, social workers). Outcomes: better function, confidence, wellbeing; less carer reliance and long-term care demand. Domiciliary social care (personal care, domestic help) included only within a rehab/reablement-focused package.
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Short-term domiciliary social care (e.g. personal care, help with domestic tasks, voluntary sector support), except where it is provided as part of a package that also includes rehabilitation, reablement and/or recovery services.
7	Long-term home-based social care services	Ongoing social care services (e.g. personal care, help with domestic tasks), helping people continue to live at home and maintain independence.
8	Long-term home-based community health services	Ongoing health services provided in people's own homes or in other non-residential community-based settings.
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Short-term (up to 6 weeks), therapy-led services in a community bed-based setting (e.g. community hospital, care home bed or designated facility). For adults 18+ to regain independence post-hospital stay (step-down) or prevent avoidable admission/long-term residential care (step-up from community). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus multi-disciplinary support (unregistered workers, nurses, doctors, others as needed). Where safe and appropriate, transition to home-based intermediate care is required to continue recovery at usual residence. Outcomes: improved function, confidence, wellbeing; reduced acute admissions, readmissions and long-term social care demand. May include mixed health and social care interventions.
10	Long-term residential or nursing home care	Ongoing care provided in a residential care home or nursing home for people who need more intensive or specialised support than can be provided at home.
11	Discharge support and infrastructure	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Schemes specifically designed to provide care and support for people nearing the end of life.
13	Support to carers, including unpaid carers	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.

14	Evaluation and enabling integration	Schemes that monitor or evaluate the impact of integrated care schemes. Schemes or services that enable integrated care, such as (but not necessarily limited to): - Joint commissioning arrangements - Integrated care planning - Helping people navigate services - Workforce development or recruitment and retention
15	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2026-27 Numerical Template

5. Metrics for 2026-27

Selected Health and Wellbeing Board:

5.1 Non-Elective admissions

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
		Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
Non elective admissions to hospital for people aged 65 and over per 100,000 population	Rate	1,364	1,393	1,314	1,421	1,368	1,271	1,468					
	Number of admissions 65+	1910	1,950	1,840	1,990	1,915	1,780	2,055					
	Population of 65+*	139,999	139,999	139,999	139,999	139,999	139,999	139,999					
		Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
		Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	Rate	1,357	1,384	1,302	1,376	1,328	1,135	1,399	1,291	1,356	1,358	1,357	1,357
Number of admissions 65+	1900	1938	1823	1926	1859	1589	1959	1808	1899	1901	1900	1900	
Population of 65+	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999

Complete:

Yes

Source: <https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65>

5.2 Discharge delays

		Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
		Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)		0.68	0.70	0.63	0.73	0.69	0.71	0.67	0.68				
Proportion of adult patients discharged from acute hospitals on their discharge ready date		85.7%	86.8%	87.4%	87.0%	87.3%	86.8%	86.7%	86.6%				
For those adult patients not discharged on DRD, average number of days from DRD to discharge		4.7	5.3	5.0	5.6	5.4	5.4	5.1	5.1				
		Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
		Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
Average length of discharge delay for all acute adult patients		0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60
Proportion of adult patients discharged from acute hospitals on their discharge ready date		88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge		5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00

*Dec Actual onwards are not available at time of publication

Yes

Yes

Source: <https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/>

5.3 Admissions to residential and nursing care homes

		Rolling 12 month total until end of quarter date indicated							
		Actual Ending 31-12-2024	Actual Ending 31-03-2025	Actual Ending 30-06-2025	Actual Ending 30-09-2025	2026-27 Plan Ending 30-06-2026	2026-27 Plan Ending 30-09-2026	2026-27 Plan Ending 31-12-2026	2026-27 Plan Ending 31-03-2027
Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population	Rate	519.3	490.0	481.4	474.3	571.4	571.4	571.4	571.4
	Number of admissions	727	686	674	664	800	800	800	800
	Population of 65+*	139,999	139,999	139,999	139,999	139,999	139,999	139,999	139,999

Yes

*Population of people aged 65 and above are based on the latest available mid-year estimates from the ONS

Better Care Fund 2026-27 Numerical Template

6: National Condition Planning Requirements

Health and wellbeing board



National Condition	Planning requirement	Assurance statement	Yes/No to assurance statement	Where the planning requirement or assurance statement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution
National Condition 1: effectively support the delivery of integrated and preventative care ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.	ICBs and local authorities must have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care.	Named ICB and local authority chief executives and named HWB chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care.	Yes		
	ICBs and local authorities must set out plans that: - show reasonable progress in the metrics of non-elective admissions (for people aged 65 and over) and delayed discharges - show how they will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement - include the specific contribution of BCF-funded services.				

Complete:

Yes

<p>National Condition 2: comply with expenditure and grant conditions</p> <p>ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.</p>	<p>ICBs and local authorities must pool their designated minimum contribution (in the case of ICB partners) and the Local Authority Better Care Grant and DFG (in the case of local authority partners). ICBs and local authorities are able to voluntarily pool additional funding through the BCF where they consider this is likely to lead to an improvement in the services being funded.</p>					
	<p>The NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each health and wellbeing board area.</p> <p>Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the DFG, including the pooling of funding.</p>	<p>ICBs and local authorities confirm compliance with BCF national grant and funding conditions, and that they will deliver in accordance with approved spend and BCF numerical return, including maintaining the NHS minimum contribution to adult social care.</p>	Yes			Yes
		<p>ICBs and local authorities confirm they will pool funds through Section 75 agreements by 30th September 2026.</p>	Yes			Yes
<p>National Condition 3: - effective governance, reporting and engagement</p> <p>ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.</p>	<p>ICBs and local authorities must have effective joint governance in place to ensure local accountability for delivery of outcomes, including reviewing performance against plan objectives and local goals, and taking action if necessary to bring delivery back on track.</p>					
	<p>ICBs, local authorities and health and wellbeing boards are required to engage with BCF reporting, oversight and support processes</p>	<p>ICBs and local authorities confirm full compliance with BCF planning and reporting requirements and will adhere to the BCF oversight and support processes.</p>	Yes			Yes

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Oxfordshire Health and Wellbeing Board
14 May 2026
Oxfordshire Combatting Drugs Partnership –
Annual Progress Report (2024-2026)

Report by Ansaf Azhar, Director of Public Health and Communities

RECOMMENDATION

The Health and Wellbeing Board is **RECOMMENDED** to note the activities and outcomes of the Oxfordshire Combatting Drugs Partnership, reflected in the Annual Progress Report in Annex 1.

Executive Summary

1. The Oxfordshire Combatting Drugs Partnership (CDP) brings together Local Authority, NHS, criminal justice and voluntary sector partners to reduce the harms from alcohol and drugs.

Overall Oxfordshire continues to perform strongly against national benchmarks, particularly in relation to treatment access, continuity of care following release from prison and drug-related deaths. Key achievements over the reporting period include:

- Increase in the number of adults accessing drug and alcohol treatment
- Strong performance against national continuity of care targets
- Significant expansion of naloxone availability
- Strengthened system response to emerging drug threats through the local drug information system.

However, challenges remain in particular:

- Declining numbers of children and young people accessing specialist substance use support
- Persistent inequalities in drug and alcohol related harm.

This report provides the Health and Wellbeing Board with assurance on progress to date and outlines priority areas for system focus.

Corporate Policies and Priorities

2. The activity of the Oxfordshire Combatting Drugs Partnership supports the vision, values, objectives and strategic priorities in the County Council's corporate plan by tackling inequalities through ensuring that services are

accessible to all and demonstrates our commitment to prioritising the health and wellbeing of our residents.

Financial Implications

3. No direct funding implications from this report. The work described has been funded by the PH grant and associated OHID grants.

Comments checked by:

Silvia Sousa, Business Partnering Accountant for Public Health and Communities, silvia.sousa@oxfordshire.gov.uk

Legal Implications

4. The annual progress report of the Oxfordshire Combatting Drugs Partnership (CDP) at Annex 1, sets out and updates on the local area's response to the Government's 2021 Strategy *From harm to hope: A 10-year drugs plan to cut crime and save lives*.
5. The Government Strategy requires a strong local partnership response, that brings together all relevant organisations and key individuals, to take a proactive approach to implementing the Government's priorities and work together to jointly agree local provision and identify areas for improvement.
6. The Strategy further requires the partnership to provide a single point of contact for central government and a nominated chair to be the responsible owner. The report confirms that the Oxfordshire CDP is chaired by the Director of Public Health at Oxfordshire County Council, Ansaf Azhar, who is also the Senior Responsible Owner for the CDP.

Comments checked by:

Janice White,
Principal Solicitor – ASC, Send and Education

Staff Implications

7. There is no staffing implications linked to this report.

Equality & Inclusion Implications

8. Any Equality and Inclusion implications for activities are assessed when services are commissioned. There are no Equality and Inclusion implications specifically linked to this report.

Sustainability Implications

9. There are no sustainability implications specifically linked to this report.

Risk Management

10. This report covers the emerging threat of Synthetic Opioids. Details of mitigating actions taken under the “Reducing Drug Related Death” workstream are detailed in the report.

Consultations

11. There are no consultations as this is retrospective review of activity in the Combatting Drugs Partnership.

Ansaf Azhar
Director of Public Health and Communities

Annex: Annex 1 Oxfordshire Combatting Drugs Partnership
Annual Progress Report 2024-2026

Background papers: NIL

Other Documents: NIL

Contact Officer: Tom Addey, Public Health Registrar

May 2026

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Annual Progress Report 2024-2026

Executive Summary

The Oxfordshire Combatting Drugs Partnership (CDP) brings together Local Authority, NHS, criminal justice and voluntary sector partners to reduce the harms from alcohol and drugs. Overall Oxfordshire continues to perform strongly against national benchmarks, particularly in relation to treatment access, continuity of care following release from prison and drug-related deaths. Key achievements over the reporting period include:

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This report provides the Health and Wellbeing Board with assurance on progress to date and outlines priority areas for system focus.

1. Introduction and Context

The Oxfordshire Combatting Drugs Partnership (CDP) was established in October 2022. Its purpose is to ensure clear strategic direction, and implementation of the aims and objectives set out in the Government's 2021 drug strategy, From Harm to Hope¹ through delivery of a local strategy and action plan.

The partnership brings together agencies from across Oxfordshire to work collaboratively to reduce drug use, drug related deaths and harm, drug related crime and increase engagement in treatment.

While the national strategy focuses primarily on illicit drugs, the Oxfordshire CDP takes a whole system approach to substance related harm, recognising that alcohol continues to be a significant driver of ill health, health inequalities, demand on health and care services, and wider social harm.

The CDP provides a forum to collectively address local issues and challenges relating to substance use related harm.

¹ [From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK](#)

Oxfordshire Combatting Drugs Partnership

1.1 About the Oxfordshire CDP

The Oxfordshire Combating Drugs Partnership is chaired by the Director of Public Health at Oxfordshire County Council, Ansaf Azhar. Ansaf is the Senior Responsible Owner for the CDP. This partnership covers the county of Oxfordshire.

1.2 Membership

Membership of the Oxfordshire Combatting Drugs Partnership is shown below:



Oxfordshire Combatting Drugs Partnership

Oxfordshire Combatting Drugs Partnership

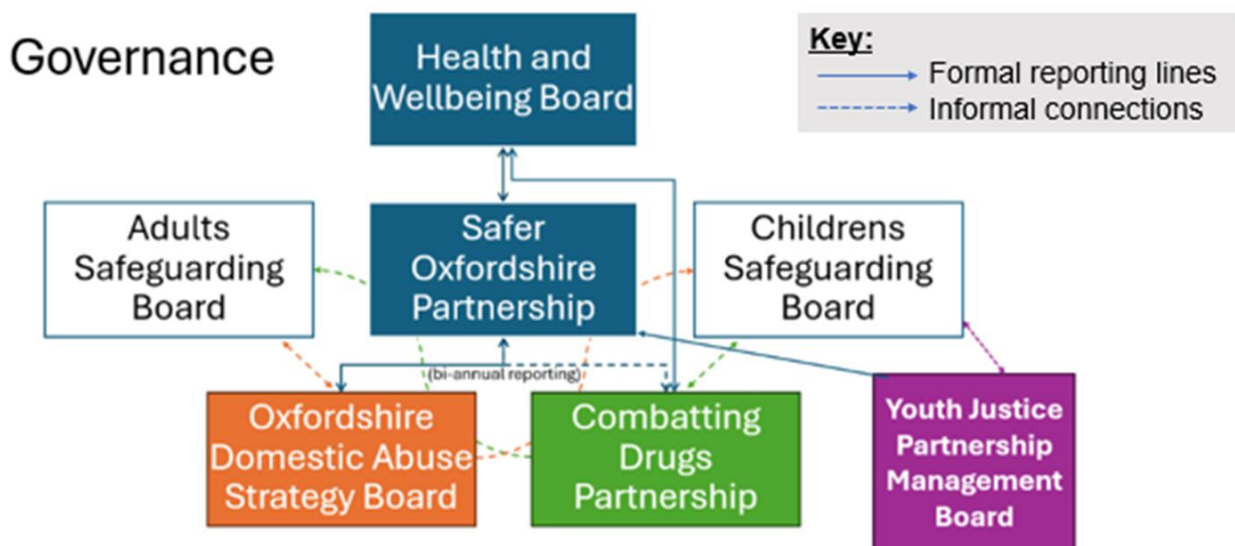
1.3 Scope of the Oxfordshire Combatting Drugs Partnership

The Oxfordshire Combatting Drugs Partnership is responsible for:

- Monitoring data, including intelligence from those with lived experience, to ensure we have a current view of the needs and challenges in relation to drug and alcohol use.
- Overseeing delivery of the local combatting drugs plan and other related substance use plans. This includes overseeing the activities funded by external grants provided to support the implementation of the national Harm to Hope strategy.
- Identifying and communicating themes and emerging issues and developing a response which draws on the strength of the systemwide partnership.
- Providing visibility and accountability for issues related to drug and alcohol use and providing a forum for discussion between partners.
- Reviewing challenges in more detail where required and monitoring related actions.
- Sharing intelligence and current activities / developments with other partnership boards where relevant.

1.4 Governance

The Oxfordshire Combatting Drugs Partnership reports to the Health and Wellbeing Board and maintains links with Safeguarding Boards, the Domestic Abuse Strategic Board and Safer Oxfordshire Partnership to ensure each group has overview and awareness of any cross-board priorities.



2. Summary of the drugs and alcohol landscape in Oxfordshire

In 2025 the Partnership carried out a Health Needs Assessment (HNA). This systematic review brought together quantitative and qualitative evidence to identify population health needs, gaps in services, and inform recommendations for future action. The HNA executive summary was published on the [CDP website](#) in January 2026.

The following is a summary of what key data from the HNA is telling us:

- Overall rates of opiate and/or crack cocaine use are lower in Oxfordshire than the England average, however there is significant variation within the county
- Overall rates of alcohol dependency are lower in Oxfordshire than the England average however there is significant variation within the county
- The proportion of people with an identified alcohol treatment need who are not engaged in services (unmet need) has declined substantially in Oxfordshire since 2015/16, falling below national levels
- The level of unmet need for opiate and/or crack cocaine use treatment remained relatively steady in Oxfordshire, consistently below the England average
- The number of adults accessing treatment for alcohol and/or drug use in Oxfordshire has increased significantly since 2020
- The number of adults in treatment for opiate use increased over the period to March 2025, but remains the hardest group to identify and bring into services
- The number of children and young people in treatment for substance use has declined over the last three years; work to identify and engage them remains a priority for the CDP
- Overall, deaths and hospital admissions for adults related to drug use are substantially lower than national averages, with rates remaining steady, compared with increasing rates nationally. However, parts of Oxfordshire have rates in line with national averages
- Overall alcohol related deaths and hospital admissions have seen a slight increase but remain substantially below the national average
- Areas within Oxfordshire with higher rates of deprivation show higher rates of alcohol related hospital admissions, showing inequality within the county
- Rates of alcohol related unintentional injuries, and intentional self-poisonings have reduced and remain similar to national averages
- The number of adults with a substance use treatment need who successfully engage in community-based structured treatment following release from prison has increased substantially since 2020 exceeding the national ambition.

Oxfordshire achieved or exceeded all local and national targets for increasing the number of adults starting and progressing in treatment over the initial three years of the drug strategy implementation.

3. How is the Oxfordshire CDP addressing drug and alcohol harms

Following a review of the local Drug and Alcohol 2020-2024 strategy and national drug strategy, the CDP developed and agreed a comprehensive action plan, mapped to the strategic priorities, using national and local data to inform the requirements of each group.

Oxfordshire Combatting Drugs Partnership

The following were agreed as priority areas:

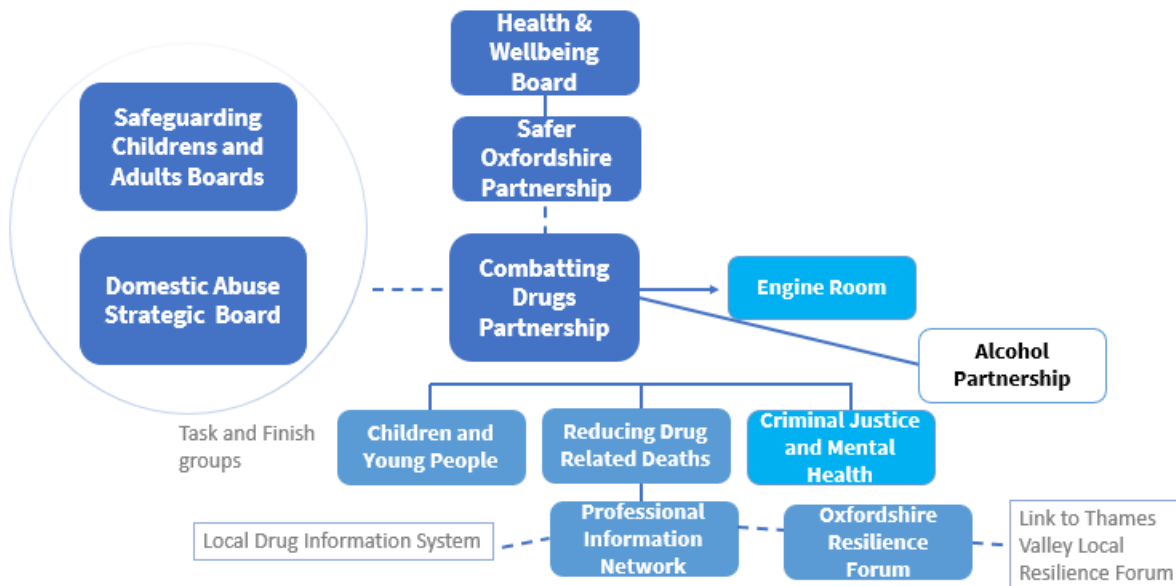
- Reduce drug use
- Reduce drug related crime
- Reduce drug related death and harm
- Increase treatment and recovery

Alcohol related harm is addressed across all priority areas.

The diagram below shows the structure of the CDP and related task and finish delivery groups which were mobilised in 2024 and report to the Combatting Drugs Partnership on a quarterly basis.

The groups are responsible for progressing actions to support the priority areas outlined above and reporting progress to the CDP.

Combatting Drugs Partnership Structure



The 2025 Drug and Alcohol Health Needs Assessment will inform the strategic development of priorities for the Combatting Drugs Partnership and its task and finish groups for 2026 and beyond, which may include changes to the current partnership structure.

In 2023 the CDP agreed that a focus on increasing the numbers of people in treatment should be a key priority across all partners. Each task and finish delivery group reports any opportunities and actions to increase treatment numbers and improve recovery outcomes to the CDP. Moving forward into 2026 and beyond this focus is changing to one of sustaining treatment capacity and improving treatment engagement and outcomes with key groups.

4. Task and Finish Group delivery and progress

A summary of the delivery of the groups and progress made is set out below.

4.1 Children and Young People Task and Finish Group

Over the past 18 months the primary focus for this group has continued to be improving the effectiveness of referral pathways to the children and young people's substance use service provided by Cranstoun Here4YOUth, to increase the number of children and young people who receive support and specialist treatment.

Links have been strengthened with a range of partner agencies, including:

- Children's services run by Oxfordshire County Council
- VCSE organisations such as Oxfordshire Youth and SOFEA
- Thames Valley Police, particularly its Harm Reduction Unit
- The School Health Nursing service
- Children and young people's mental health services
- Adult community alcohol and drug service provided by Turning Point

Health care, education and Children's Services are key sectors that require further partnership work to enhance awareness of the Here4YOUth service's offer, alongside more joined up working.

Whilst awareness of the Here4YOUth service has increased across partner services, over the last year, the number of under-18s being referred and/or engaging in structured treatment for their drug and alcohol use has not yet increased. Thus, increasing awareness of the service offer and facilitating referrals to the service, from a wide range of agencies across the whole Oxfordshire system, remain primary objectives for the group. It is anticipated that recent efforts to strengthen collaborative links will result in increased engagement by young people into specialist interventions.

4.2 Reducing Drug Related Deaths and Harm Task and Finish Group

Synthetic Opioids are man-made drugs that mimic the effects of natural opioids (such as morphine) but can often be significantly more toxic and carry a higher risk of accidental overdose. They include fentanyl and nitazenes and present a significant risk to people who consume illegal drugs. The UK government have set up a task force to mitigate this threat, and we are working locally to respond.

A reducing drug related death and harm group was set up under the CDP in Oxfordshire in June 2024 and actions that have been taken forward by the group include:

- Increasing carriage and distribution of take-home naloxone in CDP agencies and organisations
- Establishing a Professional Intelligence Network to coordinate intelligence and system response

4.2.1 Naloxone

Naloxone is a prescription-only medication that rapidly reverses the effects of an opioid overdose. In December 2024, [The Human Medicines Regulations 2024 was amended](#) to enable a wider range of people to supply naloxone without a prescription, including people working for the police, probation and youth justice services, as well as named registered healthcare professionals, provided these individuals have undergone appropriate training.

In December 2024, **Thames Valley Police (TVP)** launched the roll-out of naloxone for carriage by front-line officers. This project was supported by the Oxfordshire adult community alcohol and drug service provided by Turning Point, who trained front-line TVP officers and provided the initial supply of naloxone. As of February 2026, there have been 361 kits issued to TVP officers, including uniformed officers, response and neighbourhood policing teams, and some specialist departments. Since the start of the roll-out, there have been 25 recorded cases of emergency usage of naloxone by TVP officers, with successful resuscitation of the people involved.

The **Oxfordshire Community Pharmacy Take Home Naloxone (THN) service** commenced in February 2025 and as of February 2026, 29 pharmacies across Oxfordshire have signed up to deliver the service. As of February 2026, 141 THN supplies have been made by pharmacies, including 90 supplies made to 'first-time recipients' of naloxone. Further work is underway to raise awareness of the service and support more pharmacies to participate.

A naloxone mapping exercise to identify potential gaps in training and access was conducted in February 2025; results indicated that further work may be required to raise awareness of the importance of naloxone and how to access/use it. Public Health in collaboration with Turning Point delivered naloxone learning events for pharmacy professionals, GPs and CDP members in February, March and April 2025.

Further work is underway to raise awareness of naloxone locally, including via promotional posters and waiting room digital screens, and to widen access to take-home naloxone via other settings where feasible.

Turning Point continue to deliver bespoke naloxone training to local services, which alongside Police Officers, has included probation and ambulance service staff as needed. In April 2025, Cranstoun Here4YOUth Oxfordshire commenced the delivery of enhanced overdose management training, targeted to services that work with young people.

4.2.2 Local Drug Information System (LDIS)

The CDP monitors and addresses emerging threats from synthetic opioids and other dangerous substances through the LDIS (also referred to as the *drug alerts* or *early warning* system). This is done by:

YOU CAN SAVE A LIFE WITH A SPRAY!

Knowing and recognising the signs of an opioid overdose and carrying naloxone can help save a life.

Naloxone saves lives by temporarily reversing the effects of an opioid overdose, helping the person to breathe normally until an ambulance arrives.

oxfordshire.gov.uk/
Take-Home-Naloxone

You can now get a naloxone pack and training on its use free of charge at select local pharmacies.

For information about the **Take Home Naloxone service** and where you can get a free naloxone pack scan the QR code or visit [oxfordshire.gov.uk](https://www.oxfordshire.gov.uk) and search for 'naloxone'.

OXFORDSHIRE COUNTY COUNCIL

Oxfordshire Combatting Drugs Partnership

- Risk-assessment and ongoing monitoring of emerging threats based on intelligence received and proactive surveillance of local and national data
- Communicating potential threats, using agreed communications strategies and messages, to rapidly inform relevant services and people who use drugs as appropriate
- Taking actions to prepare for and mitigate imminent or potential threats through enhanced and targeted multi-agency harm reduction interventions.

4.2.3 Professional Information Network (PIN)

The Oxfordshire PIN, a subgroup of LDIS, was established in September 2024 in response to the increasing risk of death and harms locally and nationally linked to illicit potent synthetic opioids, specifically Nitazenes.

The PIN group meets three times a year to share knowledge, intelligence and resources about current drug-related concerns. Further 'reactive' meetings are also scheduled as needed to address urgent drug-related threats. The PIN reports to the Combating Drugs Partnership via the "reducing drug related deaths subgroup".

In December 2024, a local Response Plan was codeveloped and agreed by the PIN group. This Plan details an agreed stepped local approach to (rapidly) mitigate risk and harms from synthetic opioids and emerging drug threats.

Throughout the past year, there have been continued local and national reports of overdoses and acute health harms confirmed or suspected to be linked to synthetic opioids such as Nitazenes and Orphines, and/or other high-risk non-opioid substances such as Ketamine, Xylazine, Medetomidine, and new psychoactive substances.

The PIN group have worked collaboratively to ensure that reliable intelligence about drug threats is communicated effectively, via the LDIS, to relevant local and national agencies and to people who use drugs, to prompt local action. Based on the evaluated risk and impact of the drug threat, local services implement enhanced harm reduction interventions as part of the overall response.

4.3 Criminal Justice and Mental Health Task and Finish Group

This task and finish group has monitored performance against the continuity of care from prison to community treatment services metric. The number of adults with a substance use treatment need who successfully engage in community-based structured treatment following release from prison, within 3 weeks, has increased substantially since 2020 and continues to increase, exceeding the national ambition of 75% and regional and national averages.

The task and finish group has also overseen pathway and service developments to ensure comprehensive delivery of Probation orders including mental health and drug and alcohol treatment requirements (MHTRs, DRRs and ATRs).

Probation have reported changes to the structure of their staff teams to include the creation of a specialist Integrated Offender Management (IOM) Substance Use Team to manage offenders with substance use issues. This ensures a more joined-up approach with partners

including Turning Point and a workforce with greater expertise and skills in managing complex substance use cases

The group continues to monitor the impact of measures to reduce the prison population on community services, as the number of offenders managed in the community continues to rise.

4.4 Reducing Drug Related Crime and Supply

Thames Valley Police (TVP) have shared their approach to reducing harm and the supply of illicit drugs, set out in their Drug Strategy, which is built on four key pillars: Prevent, Prepare, Protect and Pursue.

The CDP and Thames Valley Police are working together to ensure cross-agency representation at partnership meetings, with attendance of CDP members at TVP Prevent and Protect meetings, and TVP attendance at CPD meetings. This collaboration is vital for reducing work duplication, facilitating cross organisational data sharing, and enabling better problem-solving capabilities.

4.5 Data

Data is reviewed annually against the Local Outcomes Framework at a partnership level, using locally available data including National Drug Treatment Monitoring System, health and social care and criminal justice data from across the partnership.

Specific metrics for task and finish groups relate to delivery of key actions, such as increasing the number of Naloxone distributors, and increasing the number of children and young people and adults in treatment and are reviewed on a quarterly basis.

5. How our local community can get involved in the Oxfordshire CDP

People with lived experience, supported by local services, periodically attend CDP and contribute to discussions.

They have shared their own stories to explain the importance of services, and how service accessibility and engagement can be improved. Turning Point have supported people who have previously accessed treatment to attend meetings and provide feedback to the group.

The Oxfordshire CDP plan to expand how we involve people with lived experience, their families and the local recovery community, recognising their essential contribution to improving outcomes. In 2025 Public Health undertook a scoping exercise to explore how to bring the voice of lived experience and the local community into the CDP beyond the current model. An options appraisal and business case was developed and approved in November 2025, and in 2026-2027 we will be moving at pace to procure a Lived Experience Advisory Group to further embed the voice of those with lived experience and their families.

6. Next steps

The Combatting Drugs Partnership is convening a multi-agency workshop to review the findings of the needs assessment, reflect achievements and challenges and agree future strategic direction. This work will inform the development of a renewed partnership strategy and action plan.

DRAFT

Healthwatch Oxfordshire Report to Health and Wellbeing Board – May 2026

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Since the last Health and Wellbeing Board (HWBB) meeting 12 March 2026

Healthwatch Oxfordshire reports to external bodies

Since the last Health and Wellbeing Board (HWBB) March meeting we attended:

- Health Improvement Board
- Oxfordshire Joint Health Overview Scrutiny Board (April 2026)
- Oxfordshire Safeguarding Adults Board and Oxfordshire Children's Trust Board
- Oxfordshire Military and Civilian Partnership.

Any reports to external bodies we attend can be found online at <https://healthwatchoxfordshire.co.uk/reports-to-committees>

We attend Oxfordshire Place Based Partnership monthly, and attended the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) Quality Committee.

We attend Primary and Community Board, Neighbourhood Health working groups, and Oxfordshire Health Inequalities Forum and Oxfordshire Marmot Place meetings.

We published our priorities and focus for the coming year 2026-27 here: <https://healthwatchoxfordshire.co.uk/our-priorities>

We have published Healthwatch Oxfordshire responses to Oxford Health draft strategic framework, and to government consultation on proposals for Local Government Reorganisation here: <https://healthwatchoxfordshire.co.uk/correspondence>

Hearing from residents – Healthwatch Oxfordshire research and insight reports

Our research reports focus on making sure the voice of people who use services is directly linked to recommendations of improvement or change. Hearing from people is carried out using a variety of methods, including online, face to face, and

targeted work, linking to community groups, and on the streets. All our reports and written responses to our recommendations from commissioners and providers can be seen here: <https://healthwatchoxfordshire.co.uk/reports> All reports are available in summary and Easy Read. Due to local pre-election restrictions we delayed publication of reports during this period. To see more about the **impact** of our reports and how we ensure people's voice makes a difference see here: <https://healthwatchoxfordshire.co.uk/impact/impact-of-our-research/> We follow up on recommendations and action with providers or commissioners at six months.

- We completed our engagement on End of Life Care, and will be publishing a report at the end of May
- We finished the outreach and engagement in early April across **14 rural settlements** along with Community First Oxfordshire as part of the **Marmot focus on health inequalities**. This work, was commissioned by Oxfordshire County Council (OCC) for the Marmot insight). We are currently analysing data and will have a final draft report for OCC at the end of May.



Since the last meeting in March we published the following reports based on what we've heard from the public. Insights give lived experience perspectives, and valuable indicators for health and social care services as they navigate the shift to Neighbourhood Health.

- **Your feedback about Cora Health** (provider of musculoskeletal services) (January 2025 - January 2026 feedback from 90 people). We heard some positive feedback about timely and effective care. However, unfortunately most people told us about challenges experienced in getting support from Cora Health, including poor communication, unclear information, trouble making convenient appointments, long waits, cancelled appointments and problems with referrals. Our recommendations, and provider and commissioner responses can be seen with the report.
- **What we heard about GP services in Oxfordshire** (April 2025 - March 2026 feedback from 786 people). We presented to Health Overview Scrutiny Committee (HOSC) working group on GP services in April. (Published this week)



Snapshot reports:

- What you told us about mental health services

What you told us about using mental health services



In 2025 we heard from more than 100 people about their experiences of seeking support for their mental health. People contacted us by phone, email, our online Feedback Centre, and spoke to us when we were out and about.

We also visited the Keystone Hubs across the county, and carried out two Enter and View visits to Littlemore and Warneford Hospitals. People we spoke to had experience of a range of services, including Talking Therapies, CAMHS, Adult Mental Health Teams, Keystone Hubs and voluntary sector support like MIND, Restore and the Samaritans.

We will publish a longer report about what people told us, but here is a summary of some of the themes we heard, which include:

Helpful and compassionate help when people found the right support for them...

There should be more understanding about mental health services - to really understand what the patient is going through. I was passed around in adult mental services which made me very ill as they could not understand my mental health needs. Keystone Hub in Banbury were fantastic and offered the support and care I needed to make my mental health better.

Used a bereavement service in Talking Therapies, a six-week course which was online and was really helpful.

People who listened and validated my experiences... Making friends who understand mental health issues.

I really enjoy coming to the art class at the Keystone Hub. It gives me something to look forward to. It's just nice to know that I have someone with and to receive good advice.

Challenges and long waiting times in finding support...

Very difficult to get mental health support for one of my cared for family.

Mental health services are overwhelmed and unable to respond affectively to anything but the most severe cases.

Waiting lists for treatment after mental health diagnosis is far too long.

CAMHS support while waiting - it's hard to get the right provision at the right time.

Some told us about the things that support mental wellbeing, including exercise, being with friends and family, hobbies and connecting with nature...



We also heard about things that cause stress and affect people's mental wellbeing, including accessing a GP as first point, impact of poor health, loneliness and isolation, rural access challenges, money and work worries, and wider national and global uncertainty...

Some people told us about the need for more culturally appropriate, accessible and tailored support:

More Asian agencies to help people who struggle with mental health.

Better access to mental health services for teenagers and young people.

Nothing for men... especially around mental health, trying to find things for my generation, especially when retired, is difficult, especially mental health.

For information and support

- See the **Live Well Oxfordshire** website <https://livewell.oxfordshire.gov.uk> for details of organisations and activities to help you stay healthy and well
- See the **Oxford Health** website <https://oxfordhealth.nhs.uk/support-advice/what-to-do-in-an-emergency> for details of mental health support in an emergency, including contacting **NHS 111** to access the 24/7 Mental Health Helpline
- The **Oxfordshire Mind** website www.oxfordshiremind.org.uk also gives details of local support and services, including the Oxfordshire Mind Guide



Please get in touch with us if you have a question about local health services or would like to tell us about your experience of using a service.

You can call us on **01865 520520** or email hello@healthwatchoxfordshire.co.uk



Community research

Healthwatch Oxfordshire continues to bring our expertise in supporting **community and participatory research** and working with communities to explore issues and voice issues of importance to them. As noted above, we have been working with Sunrise Multicultural Project, looking at barriers to cancer care, working with a member of the Chinese Community to hear from this group, and with OX4 Food Crew to hear from families in temporary accommodation, as well as the Black Women in Maternity Group.

- ✓ See our website for links to all community research supported by Healthwatch Oxfordshire, as well as resources, and local links to other community research <https://healthwatchoxfordshire.co.uk/community-research>
- ✓ We attended a celebration event of Community Participatory Action Research (CPAR) at Reading University on 23rd April, showcasing work by community researchers across the Thames Valley, including Oxfordshire, with keynote speaker Dr Priya Singh, Chair of Thames Valley Integrated Care Board.
- ✓ Healthwatch Oxfordshire shared insights on our journey, case studies and experience of community research with the Thames Valley Research Engagement Network (REN) in an interview piece here: <https://researchengagementnetwork.notion.site/Stories-and-updates-272f5d0ad77d8051a753da07454ce6a1>)
- ✓ We are an active member of **Oxfordshire Community Research Network** and continue to contribute to its development.

Participatory research is supported by Healthwatch Oxfordshire working alongside community members. Since the last meeting we have published the following reports:

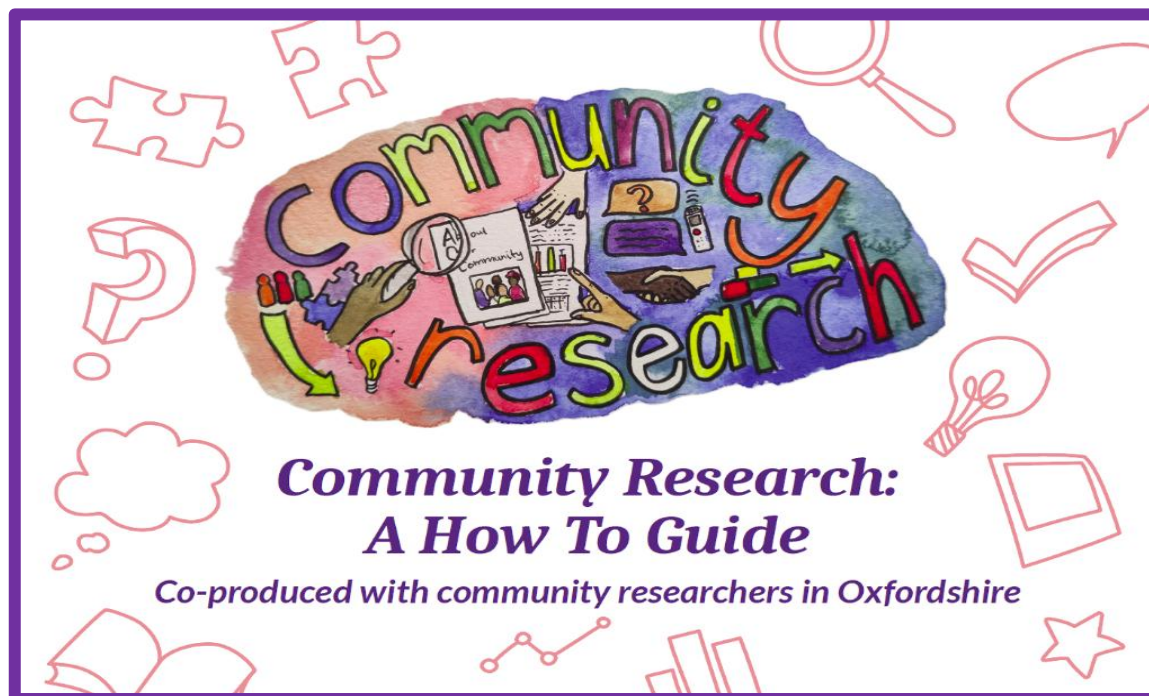
- **What we heard about cancer and access to healthcare** – community research with Sunrise Multicultural Project who wanted to understand the experiences of some of the communities they support in Banbury Neithrop and Ruscote, especially South Asian women – including what barriers people face to getting a timely diagnosis and what would support people to find and get help for cancer early on. As a result of this work, breast nurse, Sam Evans visited the women to listen and share information, and a translated leaflet has been made.

- **I do not know what to do or who to see when I am ill – hearing from older Chinese people** – We supported a community researcher who carried out interviews with 20 older Cantonese-speaking people from Oxfordshire. We heard that older Chinese people had both positive and negative experiences of using health and care services. We heard about barriers to care, particularly:
 - Language barriers and patchy access to interpreting support
 - Difficulty making GP appointments
 - Long waits for care.

We also heard how these challenges, particularly a lack of tailored communication or proper interpreting support, can compound each other, meaning that some people were waiting for an initial appointment over months rather than weeks. We heard that in several instances people chose not to contact health services when they were unwell, or had to go without care despite having tried to seek help.

- **Black women in Maternity** – research led by this group hearing from women from African Caribbean heritage and their experiences of maternity care. This fed into Amos Review of Maternity care, and will continue to build a dialogue with maternity services in the county. Healthwatch Oxfordshire supported the group with the research process.
- **Publication of a 'How to guide' for community researchers** – co-produced with community researchers in Oxfordshire (see below).

We are pleased to launch this week a 'Community Research a How to Guide', co-produced with community researchers in Oxfordshire



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See here for online version <https://healthwatchoxfordshire.co.uk/community-research-how-to-guide> which can be used by anyone in Oxfordshire and is free for others to promote and use.

This is the culmination of work in Sept-Dec 2025 when we held a series of participatory workshops with local grassroots groups, including Oxford Community Action, AFIUK, Transition Lighthouse, Sudanese and Nepali community among others, building on the insights and learning from community members skills and knowledge. (Funding for us to convene and run workshops by

Oxford University, via Oxfordshire County Council) to develop the Oxford Community Research Network. Healthwatch Oxfordshire then resourced it to fruition, editing and designing the guide with local designer, getting it printed, and developing it in an online format. We shared this printed report with the community members on 13th May at Rose Hill, and together looked at next steps for supporting groups to use the guide, continue skills development and working with members of Oxfordshire Community Research Network.

The development of this resource took has relevance and potential to wider community development, resident voice and asset-based capacity building approaches, including Neighbourhood Health and Marmot Place, and wider health inequalities work in Oxfordshire and Thames Valley ICB.

Enter and View visits and reports:

Staff and lay representatives make Enter and View visits to healthcare settings to collect evidence of what works well and what could be improved to make people's experiences better. Based on the feedback of patients and members of staff, we highlight areas of good practice and suggest improvements. See <https://healthwatchoxfordshire.co.uk/enter-and-view-reports>

Since the last meeting we have published the following Enter and View reports:

- St Leonard's Ward, Wallingford Community Hospital
- Ashurst Ward at Littlemore Mental Health Centre

The impact of our Enter and View visits



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Other activity summary

- See here: <https://healthwatchoxfordshire.co.uk/our-impact/> with examples of how our work has had an impact, including our **Q4 Jan-Mar (2025-26)** activity summary
- Recordings to watch and slides, and joining details for our **public webinars** can be seen here <https://healthwatchoxfordshire.co.uk/our-webinars>

Since the last meeting we held a webinars for the public on:

- ✓ **Putting Marmot Principles into Practice in Oxfordshire.**
- ✓ **Oxford Health Strategy** which we convened with Healthwatch Bucks.



- **We publish bi-monthly news bulletins** to bring up to date health and care information to the public (to read previous issues and to sign up to receive a copy see <https://healthwatchoxfordshire.co.uk/our-newsletter>), as well as active social media platforms, website and sharing communications via local news and community networks.
- We carry out active listening, engagement and **ongoing outreach** to community groups, at events and on the street and other settings across the county, and gain insights into experiences and views on health and care along with via phone and our online feedback centre. We have a rolling programme of hospital visits to speak to the public. Outreach in the last quarter (Jan-Mar 2026) included:
 - Focus groups and talking to people on the street to hear from rural towns and villages as part of Marmot engagement work – in Watchfield, Stanford in the Vale, Faringdon, Deddington, Shrivenham, Chalgrove and Sonning Common
 - Outreach to parent groups to hear about maternity services, including in Rose Hill, Banbury, Witney
 - Eid Extravaganza in Blackbird Leys

- In Jan-Mar 2026 Healthwatch Oxfordshire was contacted by **97 people** looking for information and advice about a wide range of services. The **top three services** people contacted us about this quarter were GP services (26), hospital outpatients services (16) and maternity care (12)
- We received **94 reviews from the public** of **51** health and care services via our Feedback centre. We received **29 responses** to reviews from service providers. To leave a review here: <https://healthwatchoxfordshire.co.uk/feedback-on-a-local-service>
- We continue actively working with **Patient Participation Groups** (PPGs) across the county, attended PPG meetings and sending news updates, and supporting involvement in development of Neighbourhood Health.

Health and Wellbeing Board **Forward Work Plan:**

9th July 2026 meeting:

1. All-Age Autism Strategy.
2. Marmot Place Extended Update.
3. Health & Wellbeing Strategy Indicator Review.
4. Prevention of Homelessness Directors Group Update.
5. Neighbourhood Health Plan Update.
6. Climate Impact on Health.

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