BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

This is Annex 1 to the Board papers.

This is a separate compiled Annex in support of Item 12.

These provide further information and detail, and are not part of the formal Board papers.

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Annex 1 to the Board Papers

Joint Forward Plan

BOB ICB Board, May 2023

DRAFT – WORK IN PROGRESS

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Welcome and Foreword

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

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

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

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

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

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

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

Working in partnership and listening and responding to our communities are fundamental to how we will work. We want to know what people think of the services they experience, what their ambitions and hopes are and how we can support them. We want to understand and reflect the diversity of our populations and ensure our services are responsive to changing lifestyles and different communities' needs.

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

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

01
Introduction

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1.1 Purpose of the Joint Forward Plan

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

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

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

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

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

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

Delivering our Integrated Care Strategy

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

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

2023/24 Operational Planning Requirements

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

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

Delivering the JFP within our 2023/24 financial allocation

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

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

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

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1.2 Our System Landscape

Our health and care landscape

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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

Our unitary / upper tier councils

Reading Borough Council – Working better with you; West Berkshire Council; Oxfordshire County Council; Buckinghamshire Council; Wokingham Borough Council

Population of nearly 2 million

Approx. 68,000 staff in health and care

50+ primary care networks

Thames Valley Cancer Alliance

NHS Oxford Health NHS Foundation Trust

NHS Berkshire Healthcare NHS Foundation Trust

2 Community and mental health trusts

NHS Royal Berkshire NHS Foundation Trust

NHS Buckinghamshire Healthcare NHS Trust

NHS Oxford University Hospitals NHS Foundation Trust

3 Acute / integrated hospital trusts

NHS South Central Ambulance Service NHS Foundation Trust

1.3 Our Place Based Partnerships

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

Our Place Based Partnerships (PBPs)

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

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

The role of PBPs in delivering local priorities

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

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

PBPs will focus on the following populations:

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

Developing our PBPs

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

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

Health and Wellbeing Boards

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

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

1.4 Our Provider Collaboratives

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

BOB Acute Provider Collaborative

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

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

Our Acute Provider Collaborative is committed to:

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

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

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

BOB Mental Health Provider Collaborative

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

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

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

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

Developing our Provider Collaboratives

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

1.5 Our Wider Partnerships

Our Clinical Networks

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

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

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

Voluntary, Community and Social Enterprise

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

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

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

Our communities

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

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

We need to form a genuine partnership between the public and our broad community of providers. It is the people who live and work in our communities who can provide us with the best insight into what needs to change and the best ways to deliver those changes. Most of our engagement will be at ‘place’ level. – leveraging the value of our Place Based Partnerships. Local areas will use and develop their own methodologies for embedding the voice of residents in their decision making.

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

We also need to empower individuals and communities to manage and promote their own health and wellbeing. Therefore, we have a critical focus on prevention throughout our Joint Forward Plan, as well as specific plans on personalised care.

In co-designing our services with our communities, we need to ensure that everyone is included. We are committed to finding new and creative ways to engage with, and empower, people from every part of our community so that no group or individual is left out.

Our broader social and economic contribution

We recognise that health and care organisations can play a vital role in improving the health and wellbeing of their local communities through their role as “anchor institutions”. As we develop our plans and our ways of working in partnership, we will more proactively design and plan how we can maximise the broader social and economic contribution we make to our local area. This may include:

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

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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Addressing Our Biggest System Challenges

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.1 Understanding Our Population's Health Needs

Understanding our population, their health needs and recognising inequalities

Our population's health needs are increasing

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

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

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

Our Demographics

Our overall population size is anticipated to grow by 5% by 2042, over the same period the number of **people aged over 65 is expected to increase by 37%**

People **tend to live in good health above the national average** across BOB. Apart from in Reading where women spend fewer years in good health

People in more deprived areas **develop poor health 10-15 years earlier** than people living in less deprived areas

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

Our Population Health

Start Well

Around **1 in 5 children** in Reception and **1 in 3 children in Year 6** are **overweight or obese**.

Around **50% of children** are **not meeting the recommended levels of physical activity** across BOB.

Numbers of mental health referrals for young people are increasing. **24% of secondary children** have **reported previously deliberately self-harming.**

Live Well

13% of residents in our area smoke according to GP data but this varies significantly between our least and most deprived areas.

Across BOB, **3 in 5 adults are overweight or obese**. 68% of adults with a learning disability are overweight.

Around **12% of adults have a recorded diagnosis of depression** and 0.8% have a severe mental illness.

Age Well

Estimated **60% of people over 60 have one or more long term conditions**.

Nearly **1 in 15 people aged over 75 say they always or often feel lonely**

A **person's risk of developing dementia** rises from one in 14 over the age of 65, to **one in six over the age of 80.**

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.2 Understanding Our Population's Experience

Citizen Experience Research

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

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

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

Public Engagement on the Integrated Care Strategy

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

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

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

Core Services are not easy to access

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

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

Memorable wait times are defining citizen experiences

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

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

National Themes for the NHS

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

2.3 Understanding Our Performance

Recovering Performance from the impact of Covid-19

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

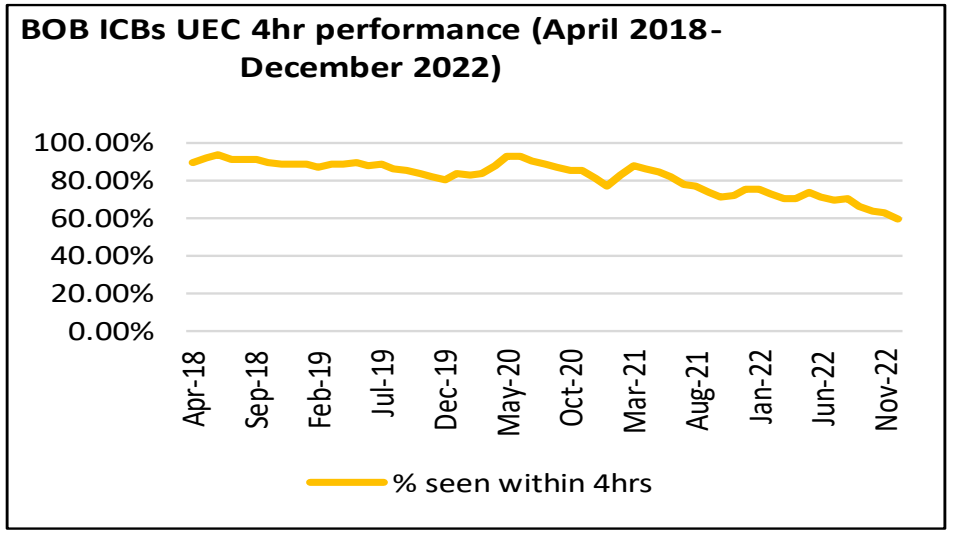
In the context of this focus on recovery, it is important we fully recognise the current challenges we face. This section outlines some of our key performance challenges across Urgent and Emergency Care, Planned Care, Primary Care and Mental Health services, alongside some of our critical workforce and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

Urgent and Emergency Care

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

Accident and Emergency 4 hour Performance

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



Ambulance Handovers delays:

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

No Criteria To Reside

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

Urgent Care Centres

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

Virtual Wards:

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

Urgent Community Response

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

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

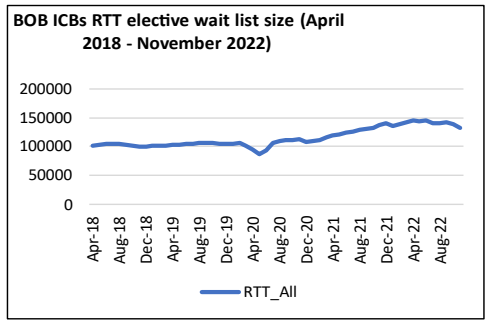
2.3 Understanding Our Performance

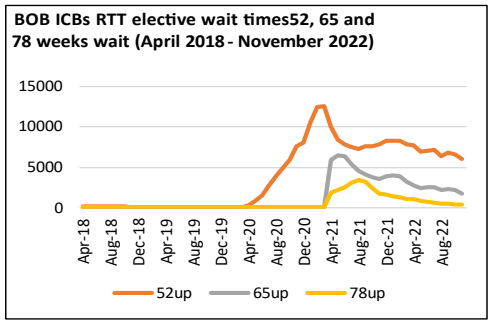
Planned Care

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

Waiting times for planned treatment

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





Cancer

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

Productivity

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

Diagnostics

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

Primary Care

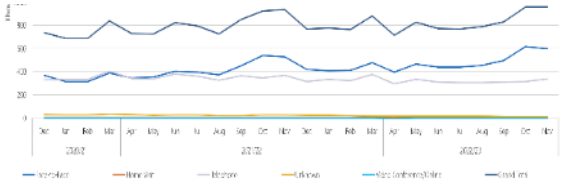
It is important for people in BOB to be able to see their GP quickly, and access other primary care services such as dentists and pharmacists, when they need to. We know that when people cannot access these services promptly, they are more likely to rely on other services that are already under significant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

Demand for primary care services remains extremely high, notably during winter 2022.

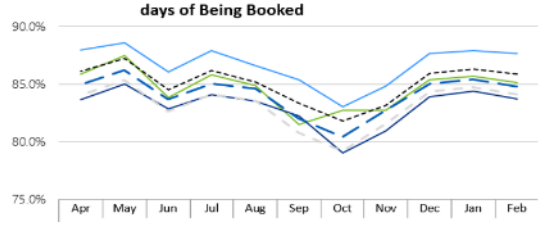
The ICB has been working to increase capacity in general practice, including an additional 2000 sessions of clinical time and additional capacity in acute respiratory infection 'hubs'.

Whilst we have seen a steady increase in the number of appointments we offer, we have struggled to keep pace with increasing demand and therefore make a sustained improvement in the percentage of GP appointments seen within 14 days of being booked.

A steady increase in GP appointments across BOB



Percentage of General Practice Appointments seen within 14 days of Being Booked



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

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

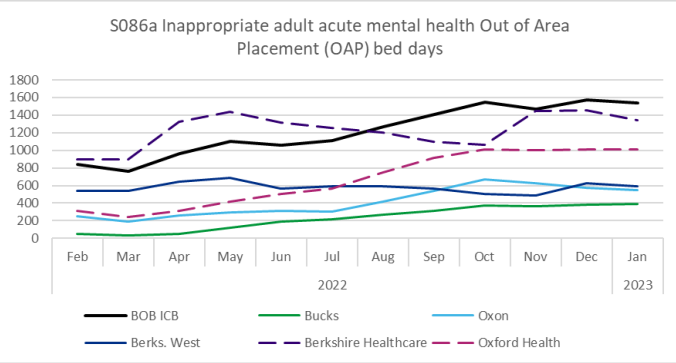
2.3 Understanding Our Performance

Mental Health

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

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

Out of Area placements
The number of inappropriate out of area bed days increased over the 12 months to Dec 22.
This is a direct indication of capacity Constraints in the system.



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

Health checks for people with severe mental illness (SMI)
Across BOB an improved position has been observed (Dec 22) but remains under the national standard

2.4 Understanding our Sustainability – Finance

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

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

Pre-Covid identified drivers of underlying deficit

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

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

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

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

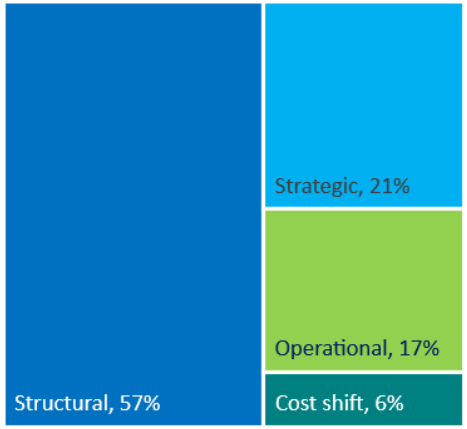
Strategic (21% of underlying ICS deficit pre-Covid)

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

Cost shifts

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

Pre-Covid drivers of deficit by theme



Post-Covid drivers of underlying deficit

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

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

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

Addressing the underlying deficit

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

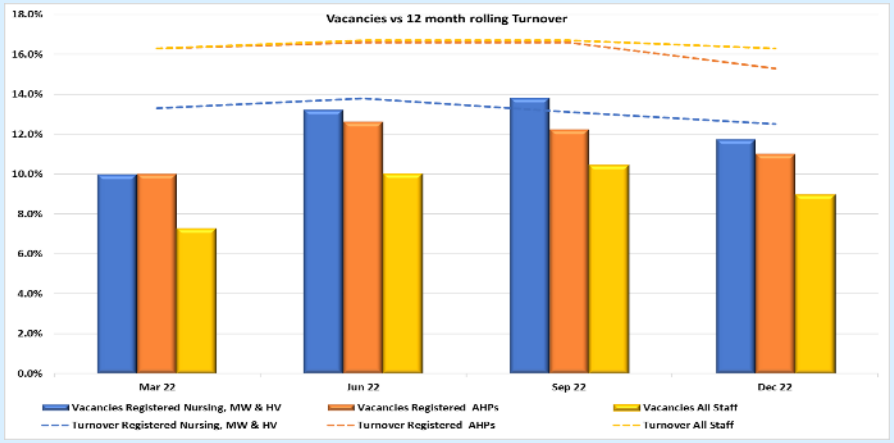
2.4 Understanding our Sustainability – Workforce and Environmental

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

Our Workforce

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

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



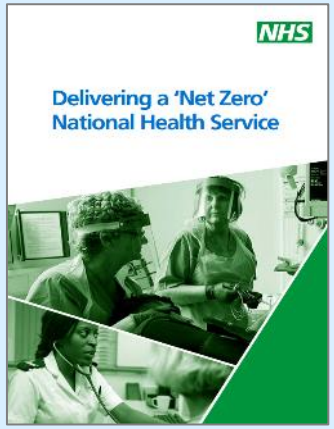
Our Net Zero Commitments

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

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

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

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



Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.5 Our Biggest System Challenges

As a system, we have a comprehensive understanding of:

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

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

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

These challenges will require us to work in new and different ways to address them effectively. They will require greater collaboration across system partners, a long-term focus and will need us to be innovative and ambitious in how we respond.

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

2.6 Developing Our System Response

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

Steve McManus
Stephen Chandler
24 March 2023

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

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

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

1/ A commitment to doing things differently

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

2/ System coordination with local delivery

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

3/ Prioritising our resources to communities with greatest need

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

4/ Clarity on what success looks like – in the short and longer term

We have identified high level outcome measures for each of our biggest challenges – but as we develop more detailed plans it will be necessary to confirm specific outcomes to be achieved for each intervention proposed.

5/ Utilising existing governance structures to make it happen

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

6/ The importance of working together

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.7. Addressing our Inequalities Challenge

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

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

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

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

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

Service Plans Reference:

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

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

Our longer term transformation approach – Unlocking population health management

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

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

2023/24 Priority Transformation Milestones

Q1
- Form an ICS Data Leadership and Governance Group with clinician and patient input.
- Completed stock-take of data sets, collection and reporting

Q2
- Define and establish Centre of Excellence for Data including learning and community of practise.
- ICS Data Charter established.

Q3
- Build a team that can work with local teams and produce proof of value analysis.
- Agree shared responsibility between ICS and local system functions

Q4
- Finalise development of a common ICS data architecture.
- Embed culture of data driven transformation is embedded as part of PHM approach.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.8. Addressing our Model of Care Challenge

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

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

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

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

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

Service Plans Reference:

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

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

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

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

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

2023/24 Priority Transformation Milestones

Q1
- Current state analysis, highlighting underlying gaps in data, technology and service provision for Primary Care.
- Identify & accelerate opportunities for integrated neighbourhood team rollout (incl. piloting models for different communities)

Q2
- Stakeholder engagement to agree Primary Care vision
- Co-design ways of working for Primary Care in BOB – looking at challenges of workforce, digital, and opportunities for strengthening partnerships.

Q3
- Commence detailed planning and implementation of new ways of working - focusing on the core areas of focus from the Fuller Stocktake – Access, Continuity and Prevention.

Q4
- Publish a Primary Care Strategy with a 5-year roadmap, incl costs and implementation plan
- Confirm timetable for change and start to implement the action plan

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.9. Addressing our Experience Challenge

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

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

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

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

Service Plans Reference:

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

Our longer term transformation approach

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

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

2023/24 Priority Transformation Milestones

Q1
- Define demand and capacity problem statement
- Agree with clinical and pathway leads priority areas for analysis and focus
- Understand existing data landscape across system partners

Q2
- Baselining current capacity levels across BOB
- Assessment of available resources and how to deploy
- Evaluation and decision on tools, methodology.

Q3
- Refinement of model to ensure comprehensive capture of system level capacity

Q4
- Analysis of system interventions to determine likely impact
- Utilisation of strategic planning tool to inform flexible use of system capacity, plan development and prioritisation

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.10. Addressing our Sustainability Challenge - Workforce

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

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

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

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

Service Plans Reference:

- Workforce

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

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

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

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

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

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

2023/24 Priority Transformation Milestones

Q1

- Build comprehensive understanding across system partners to understand key workforce issues- e.g. through hosting a Q1 Education Summit
- Develop comprehensive workforce intelligence to support appropriate targeting of interventions.

Q2

- Undertake a deep dive into the barriers for successful recruitment campaigns
- Build volunteer and reserve capacity.
- Develop and expand apprenticeships.
- Focus on our flexible working offer with the aim of increasing availability

Q3

- Develop our full People Plan collaboratively with leaders and people across BOB's health and care system.
- Deep dive into the differences of terms and conditions across the BOB health and care sector, developing alignment proposals

Q4

- Finalise our People Plan for publication on 1st April 2024.
- Undertake a full review of all recruitment and retention programmes, developing targeted action plans.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.10. Addressing our Sustainability Challenge - Financial

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

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

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

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

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

Service Plans Reference:

- Finance

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

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

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

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

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

2023/24 Priority Transformation Milestones

Q1

- Finalise Operating Plan for 2023/24
- Review actions required in year to achieve position.
- Launch IECG and improvement targets
- Commence build of long term financial model to include system and individual organisation level detail

Q2

- Build on our understanding across our system partners of the key long term pressures within our current financial position.
- Develop comprehensive intelligence to support appropriate targeting of interventions

Q3

- Develop our full Finance Strategy collaboratively with leaders and people across BOB's health and care system.
- Deliver initial quick wins and opportunities from the efficiency group that can support the 24/25 system plan and beyond

Q4

- Finalise our Finance Strategy for publication on 1st April 2024.
- Undertake the Operating Plan process for financial year 24/25 and a full review of associated impact on the Long Term Finance Model.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

2.11. 2023/24 Delivery Architecture

Oversight of delivery

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

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

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

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

2023/24 Building the foundations for change

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

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

03

Delivering Our Strategy

Our Five-Year Joint Forward Plan:

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

DRAFT

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.1 Promoting and protecting health

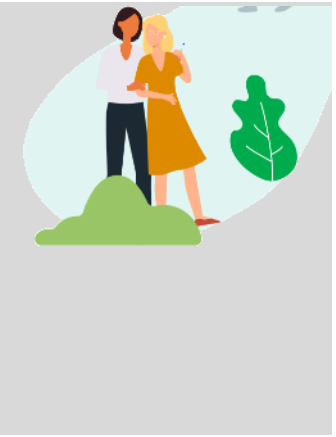
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.1 Promoting and Protecting Health

Keeping people healthy and well

Promoting and Protecting Health

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



The importance of prevention

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

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

Our focus areas

1. **Inequalities**
2. **Prevention**
3. **Vaccinations**

3.1 Promoting and Protecting Health – Our Summary Plan

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

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.2 Start well

3.2 Our Joint Forward Plan: Start Well

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

Starting Well in BOB

- In BOB, we want every child and young person to get the best possible start in life. There are 425,200 people aged 0-19 in BOB, which is 24% of the total population (Census 2021). Higher proportions of children and young people (CYP) aged 0-15 are concentrated in Reading, High Wycombe, Aylesbury and Banbury in the BOB area.
- To achieve this, we need to focus right at the beginning, by supporting mothers during and after their pregnancy and then work to ensure each child achieves their early development milestones in a timely fashion to give them the best start to life, their education and future opportunities.
- Our local communities and environments should help support all children and young people to make healthier choices which will lead to healthier outcomes in their life.

Supporting children and young people

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

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

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

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

Our focus areas

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.2 Start Well – Our Summary Plan

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

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Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.3 Live Well

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.3 Our Joint Forward Plan: Live Well

Supporting people and communities to live healthier and happier lives

Living Well in BOB

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

Supporting people to manage Long-Term Conditions

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

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

Our focus areas

1. Adults Mental Health
2. Adults Neurodiversity
3. Cancer

Long Term Conditions

4. Integrated Cardiac Delivery Network
5. Integrated Respiratory Delivery Network
6. Integrated Stroke Delivery Network
7. Integrated Diabetes Delivery Network

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.3 Delivering Our Strategy – Live Well

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

3.3 Delivering Our Strategy – Live Well

Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
Long Term Conditions - Introduction	• Improve outcomes in population health and healthcare. • Act sooner to help those with LTCs • Support people with LTCs to stay well & independent. • Provide quality care for those with multiple needs as population ages. • Co-produce consistent pathways across ICS to reduce unwarranted variation. • Integrate service models to delivered joined up care wrapped around patients' needs.	• Assess the population needs, increase preventative interventions, diagnose earlier, reduce inequalities and improve health outcomes. • Take a collaborative approach with our partners and stakeholders through the LTC BOB Integrated Delivery Networks (IDNs) to develop integrated care models to better manage patients with LTCs. • Develop a proactive approach to improve outcomes for patients with multiple LTCs.	• All LTC service areas reporting into the *ICB Clinical Programme Board* • ICB Exec Lead – Chief Medical Officer
4 Integrated Cardiac Delivery Network	Reduce the number of CVD events by having a strong focus on prevention and reduce the health inequality gap by using PHM approach. We aim to **co-design consistent and integrated pathways and empower patients to live well with CVD** and other co-morbidities.	• CVD Prevention – better blood pressure and lipid management, increase NHS Health checks, lifestyle interventions and targeted smoking cessation. • Heart Failure – earlier detection and a reduction in hospital admissions and re-admissions. • Enhanced Cardiac Rehabilitation.	
5 Integrated Respiratory Delivery Network	**Patient-centred, integrated clinical pathways delivering high quality respiratory care that is accessible** to all across BOB ICS Supporting people with respiratory disease to live longer.	• PHM to identify and support people at most risk. • Deliver earlier diagnosis, education and care planning in community • Integration of respiratory services, enabling the right support to people closer to home. • Optimising medicines to improve health outcomes and reduce carbon emissions. • Leveraging innovation and research to improve outcomes in respiratory care.	
6 Integrated Stroke Delivery Network	We will bring key stakeholders together to facilitate a **collaborative approach to service improvement of the whole stroke pathway**, including prevention, ensuring a patient centred, evidence-based approach to delivering transformational change.	• Implementing consistent pathways of care for stroke. • Maximising stroke prevention opportunities. • Reducing variation in access to stroke rehabilitation services.	
7 Integrated Diabetes Delivery Network	• We will support **education and training** of our workforce • we will **reduce clinical variation** and health inequalities • We will adopt **new diabetes care technologies** and improve access to services, • We will improve primary and secondary **prevention** • Supported **personalised self-care** will enable people with diabetes to manage their health so they can live the life they want to live.	• Reach and exceed pre-pandemic attainment of the eight diabetes care processes (8CPs) and the three treatment targets (TTTs). • Innovation and service development focusing on digital technologies to improve outcomes and reduce inequalities. • Deliver a high-quality integrated care approach, promoting self-care for primary and secondary prevention so people with diabetes experience fewer preventable complications	

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3.4 Age Well

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3.4 Our Joint Forward Plan: Age Well

Staying healthy and independent for longer

Aging Well in BOB

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

Supporting older people to remain healthy

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

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

Our focus areas

1 Age Well Services

3.4 Delivering Our Strategy – Age Well

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

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.5 Improving quality and access

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

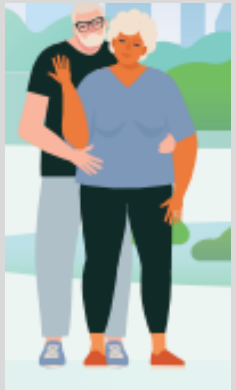
3.5 Our Joint Forward Plan: Improving Quality & Access to Services

Accessing the right care in the best place

Better access to quality services

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

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



Supporting people to access our quality services

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

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

Our focus areas

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

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.5 Delivering Our Strategy – Improving Quality and Access

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.5 Delivering Our Strategy – Improving Quality and Access

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

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Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

3.6 Supporting and Enabling Delivery

3.6 Supporting and Enabling Delivery

Building and growing the foundations of successful delivery

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

Our Enabling Plans

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

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

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

- Workforce
- Digital and data
- Finance
- Estates

Our Supporting Plans

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

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

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

3.6 Delivering Our Strategy – Key Enablers for Delivery

Enabled Through

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

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix A – Service Delivery Plans

May 2023

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BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Delivering Our Strategy

Strategic Theme	Page references
1. Promoting and protecting health	Pg. 4 – 18
2. Start well	Pg. 19 – 33
3. Live well	Pg. 34 – 69
4. Age well	Pg. 70 – 77
5. Improving Quality & Access	Pg. 78 – 106
6. Supporting and Enabling Delivery	Pg. 107 - 151

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Joint Forward Plan on a Page

Our System Vision and Partnerships 01	Everyone who lives in our area has the best possible start in life, lives happier, healthier lives for longer, and can access the right support when it is needed				
	Place based partnerships, Provider Collaboratives, Clinical Networks, VCSE, Communities				
Addressing Our Biggest System Challenges 02	1. A reduction in inequalities in outcomes and experience 2. People are better supported in their communities to live healthier lives 3. Improved accessibility of our services and elimination of long waits 4. A sustainable model of delivery across the BOB system				
Delivering Our Strategy – Our Service Delivery Plans 03	**Promote and protect health:** Keeping people healthy and well	**Start Well:** Help all children achieve the best start in life	**Live Well:** Support people and communities live healthy and happier lives	**Age Well**: Stay healthy, independent lives for longer	**Quality and access:** Accessing the right care in the best place
	1. Prevention 2. Inequalities 3. Vaccination and Immunisations	1. Maternity 2. Children and Adolescent Mental Health Services 3. Learning Disabilities 4. Children's Neurodiversity 5. Children with Long Term Conditions	1. Long Term Conditions (stroke, cardiovascular disease, diabetes, respiratory) 2. Adult Mental Health 3. Adult Neurodiversity 4. Cancer	1. Ageing well services (e.g., frailty – community multidisciplinary teams)	1. Primary care 2. Urgent and Emergency Care 3. Planned care 4. Palliative and End of Life Care
Supporting and Enabling Delivery 04	Workforce, Finance, Digital, Estates, Research & Innovation, Net Zero, Quality, Personalised Care, Continuing Healthcare				

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Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

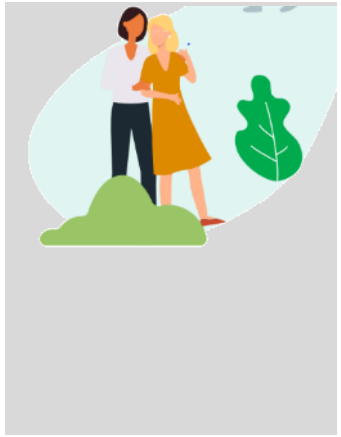
1. Promoting and protecting health

Promoting and Protecting Health

Keeping people healthy and well

Promoting and Protecting Health

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



The importance of prevention

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

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

Our focus areas

1. **Inequalities**
2. **Prevention**
3. **Vaccinations**

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Promoting and Protecting Health – Our Summary Plan

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

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Inequalities and Prevention

Context: Inequalities

- People living in more deprived circumstances tend to:
  - Be more likely to smoke and consume a less healthy diet
  - Have worse physical or mental health
  - Develop more long-term conditions and at an earlier age
  - Achieve poorer health outcomes from available health services
- People from ethnic groups are often more likely to be living in more deprived communities but also can be at a higher risk of developing some diseases. For example, people from Black and South Asian ethnic groups are at a higher risk of diabetes and CVD.
- People from Health Inclusion Groups i.e., the Homeless, Asylum Seekers & Refugees, Carers, Victims of Domestic Violence, those with Drug & Alcohol Dependency, as well as those with SMI/LD experience significant health inequality in access, experience and health outcomes.

Context: Prevention

- Many people have long term conditions (e.g., Diabetes/ COPD/Cardiovascular Disease/ Cancer/ Stroke) that could have been prevented, delayed or mitigated with early interventions, diagnosis and the optimal support and management
- Approx. 1 in 5 adults do less than 30 mins of moderate exercise per week.
- It's estimated that 3 in 5 people over 60 years old have at least one long-term condition and many long-term conditions are preventable
- Primary Prevention—intervening before health effects occur, e.g., vaccinations, altering risky behaviours (poor eating habits, tobacco use), and restricting things known to be linked with a disease or health condition.
- Secondary Prevention— detecting the early stages of disease and intervening before the onset of signs and symptoms in the earliest stages, through measures such as regular blood pressure testing.
- Tertiary Prevention—managing disease post-diagnosis to slow or stop disease progression (e.g., chemotherapy, rehabilitation, and screening for complications).

Our Ambition…

We will increase our primary and secondary prevention work, keeping people healthy for as long as possible and delaying a deterioration into poor health. To enable this, we will focus on the key areas of smoking, obesity & diet, alcohol & drugs, self-care, physical activity and early interventions, diagnosis and optimal management.

To Deliver Our Ambition, We Will:

INEQUALITIES

1. Governance – Develop an embedded and mature system-wide governance structure, approach and multi-agency partnership supporting decision making and delivery
2. Population Health Management – (PHM) Develop a comprehensive and effective population health management approach
3. Workforce – Develop an integrated workforce that is supported and capable to work differently to address inequality in the BOB system
4. Resourced Actions - Develop a system wide prioritised, resourced, coordinated and focused approach to Health Inequalities and improving outcomes
5. Community Engagement & Insight - To enhance engagement, understanding and service provision for Inclusion Health Groups and populations / areas of inequality

PREVENTION

6. Smoking – Reduce smoking prevalence (and increase access to tobacco dependency services)
7. Weight Management – Work to reduce obesity prevalence (and increase weight management services)
8. Physical Activity – Work to increase Physical Activity rates for people in BOB
9. Drug and Alcohol – To reduce harmful drinking, drug behaviours and drug use (and increase referrals to Drug & Alcohol services)

What We Need For Success:

A shared ambition

- Engagement with delivery key partners & communities, inc. Health Providers and Organisations, Local Authorities inc. Social Care, Housing, Public Health, Voluntary & Community Sector & local populations
- A culture of sharing learning, shared responsibility, collaboration and a recognition of need to work differently across all system partners
- A cohesive partnership with shared ambitions across inequalities & prevention agenda

Clarity on resourcing

- Sufficient resource is invested to enable additional activity required across key areas
- Agreed resource prioritisation to enable improvements and change in delivery
- An integrated workforce that is supported, ambitious, capable and invested in prioritising prevention, addressing inequalities and improving patient outcomes

The infrastructure to work together

- Partnership agreements and support for an integrated PHM service, including across organisation and service/ portfolio areas boundaries
- Systematic data collection on protected characteristics and deprivation captured and reported across ICS services.

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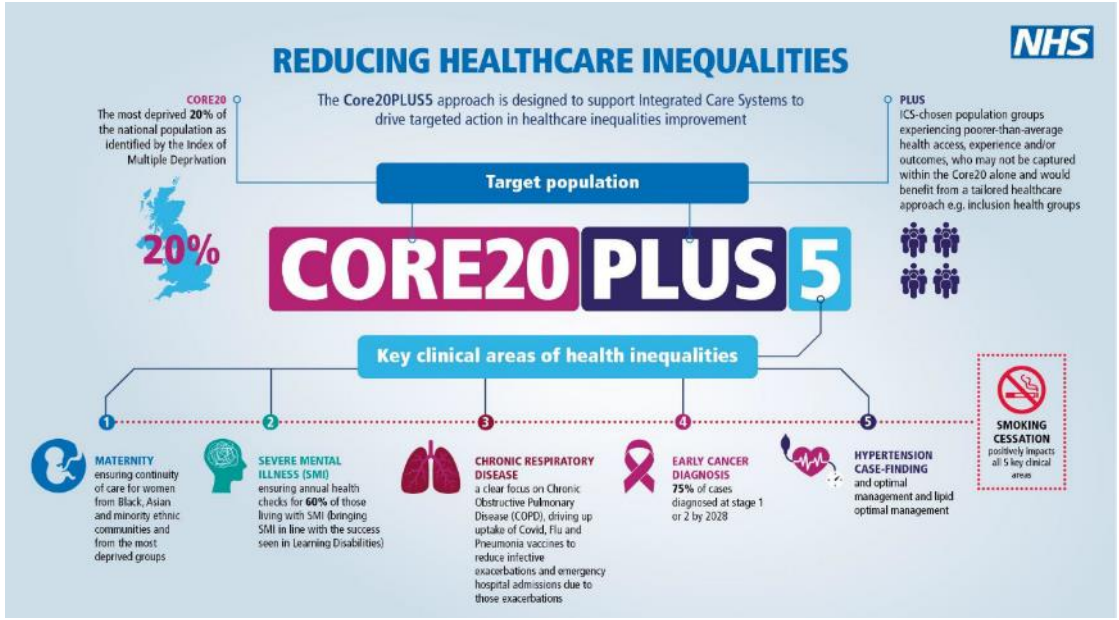
Our targeted approach to Inequalities

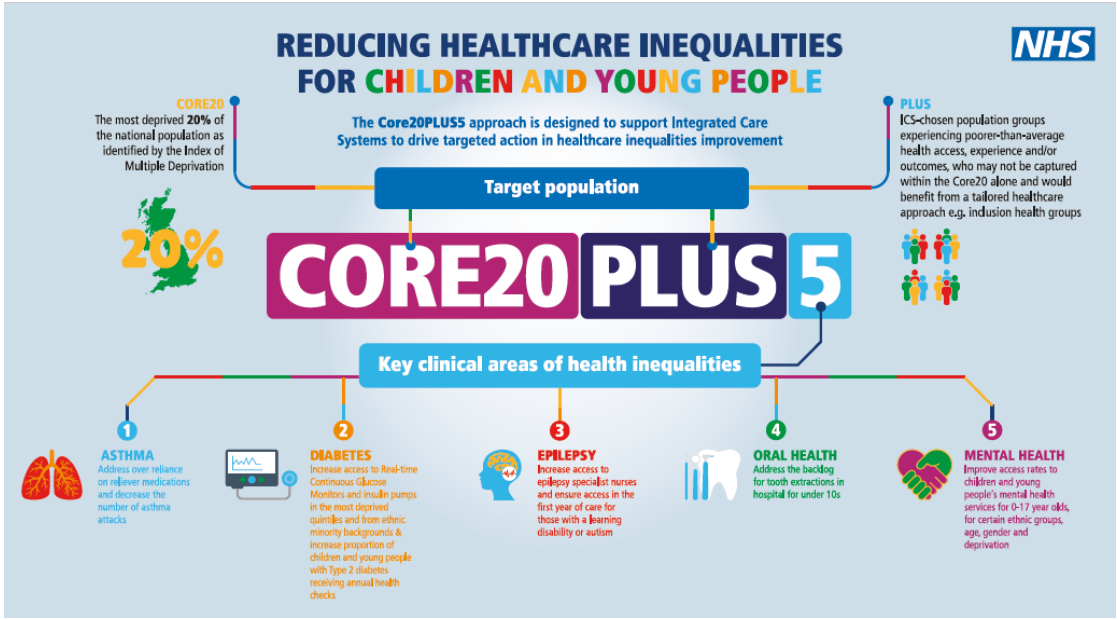
A universal approach to policy and delivery of services is not sufficient and risks improvements in the average population not being realised for the most deprived and at worst, may exacerbate and widen the inequalities between the least and most deprived residents.

We are committed to working together with partners across BOB to identify and tackle inequalities. This commitment will require new ways of working and planning for services. This is particularly relevant to how we restore services inclusively across following the COVID 19 pandemic:

- Using data we will identify populations and communities where there are inequalities of access, experience and outcomes or individuals and communities at higher risk of developing a disease.
- Detailed and tailored approaches will be developed to support people and their communities in a way that is culturally relevant and competent.
- This approach will take time to develop and mature, supported by funding decisions that may benefit some communities more than others.

We must do more to support all people to access the care and support they need and improve the lives of those who are often the most disadvantaged across our area. While this approach matures we will continue to align our priorities to the Core20plus5 approach, targeting specific communities and diseases or conditions as priorities for both adults and children (see below). Over time we will continue to review and assess these priorities to ensure they are the right areas of focus for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.





Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Inequalities and Prevention

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Governance – Develop an embedded and mature system-wide governance structure, approach and multi-agency partnership supporting decision making and delivery and ensure meaningful Equality impact assessments are an integral part of decision-making processes	• Ensure there are named individuals with leadership and accountability roles for inequality & prevention across BOB provider partnership. • Ensure transparent collective decision-making guides how resources are used, and assets are developed to target inclusive outcomes. • Implement policies that address inequalities and promote prevention.	• Ensure all providers have a named lead for inequalities. • Develop and publish inequalities and prevention priorities for 23/24 and beyond (in addition to Core20plus5). • Make resource commitments against priorities to support successful delivery of Inequality & Prevention activity within Places. • Publish regular performance data reports against stated priorities.	• Review 23/24 performance of activities invested in against priorities. • Review 23/24 priorities and consider additional for 24/25 and beyond. • Refresh resource commitments for this year and beyond. • Review and refresh performance data for this year and beyond.	• Review 24/25 priorities and consider additional for 25/26 and beyond. • Review and refresh resource commitments for this year and beyond. • Review/ refresh performance data for this year and beyond.
02 Population Health Management – Develop a comprehensive and effective population health management approach	• Ensure services are restored inclusively following the COVID 19 pandemic. • Target our investments and evaluate outcomes using population health data. • Evaluate the success of our programmes based on our ability to meet end user needs and improve experience.	• Ensure data sets are collated and adequate to identify inequality challenges and to track performance in key priority areas. • Promote and improve data capture recording for protected characteristics and Inclusion health Groups such military veteran/ homeless etc. • Work with PHM colleagues to ensure capacity and capability for PHM work is available to support Inequalities & prevention priorities. • Work to support and enable the delivery of the ICS Digital and Data Strategy.	• Continue to ensure health inequalities are driven by an increasingly robust Population Health Management approach. • Continue to refine processes to monitor and evaluate outcomes, evidenced from data sources. • Ensure appropriate / ongoing evaluation / shared learning and further development of the projects to build upon service provision.	• Review 24/25 priorities and consider additional for 25/26 and beyond. • Review/ refresh performance data for year and beyond.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Inequalities and Prevention

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Workforce – Develop an integrated workforce that is supported and capable to work differently to address inequality in the BOB system	• We will have an integrated workforce who are proactively working to reduce inequalities and have the skills set and confidence to make an impact.	• Develop a workforce strategy to reduce inequalities & promote prevention. • Launch the strategy – focus on training and securing expertise / knowledge and retaining staff.	• Continue to deliver workforce strategy. • Provide access to training that supports personalisation, prevention and tackling inequalities. • Fund workforce initiatives that target inequalities and promote Prevention. • Engage staff regarding their expectations, support and satisfaction of prevention and health inequality work .	• Continue to deliver workforce strategy. • Continue to provide access to training that supports personalisation, prevention and tackling inequalities.
04 Resourced Actions – Develop a system wide prioritised, resourced, coordinated and focused approach to Health Inequalities and improving outcomes	• We will reduce inequalities within the Core20Plus5 priority areas and accelerate lifestyle and primary prevention activities across BOB.	• We will invest £4 million across BOB to prioritise delivery of inequalities and prevention activity. • We will publish an Inequalities & Prevention Action Plan for year and beyond. • Implement action plan for the delivery of Core20Plus5 initiatives. • We will put in place clear steps to improve data quality and performance monitoring (including Ethnicity).	• Invest £4 million across BOB to prioritise delivery of inequalities and prevention activity. • Report on inequality and prevention activities from previous year. • Refresh, publish and implement action plan for year and beyond.	• Invest £4 million across BOB to prioritise delivery of inequalities and prevention activity. Additional BOB funding is dependent on national funding settlements.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Inequalities and Prevention

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
05 Community Engagement and Actions – To enhance engagement, understanding and service provision for Inclusion Health Groups and populations / areas of inequality.	• Services are designed/ implemented to reduce barriers and maximise benefits for service users. • Barriers to service are reduced and service outcomes improved in targeted health groups. • Identify and monitor appropriate measures to assess Access, Experience and Outcomes for populations of concern.	• Invest in the recruitment of an ICB Prevention & Inequalities Team. • Review capacity and capability of engagement/coproduction resource. • Develop our patient and community engagement capacity. • Run two coproduction/ engagement events with public / patients in two priority pathway areas.	• Set up Pathway Transformation with agreed evaluation of outcomes in the two priority areas explored in year 1. • Undertake coproduction and engagement of public / patients in defining interventions / service delivery transformation in two priority pathway areas.	• Evaluation of the results and shared learning for further priority areas. • Set up Pathway Transformation with agreed evaluation of outcomes in two further priority areas.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Inequalities and Prevention

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
06 Smoking – Reduce smoking prevalence (and increase access to tobacco dependency services)	• Reduction in the numbers of smokers across BOB to <5% by 2024. • A reduction in current smokers at age 15 to <3% by 2024 • A reduction in the percentage of women who smoke at time of delivery to <6% by 2024*. • A reduction in smoking prevalence for adults in routine and manual occupations to <11.6% by 2024* • More people will stop smoking, especially those in deprived areas, inclusion health groups and those with LTCs. • A reduction in health conditions made worse by smoking, and fewer people developing cancer and lung disease. *These figures are based on achieving the national targets.	• Increase capacity of smoking cessation services across BOB and increase numbers of referrals to Smoking Cessation Services from Acute Hospitals. 1. Embed the inpatient Tobacco Advisory Service in all Acute Hospitals incl. MH and Maternity services to ensure people admitted to hospital (Acute & MH) who smoke will be offered NHS funded tobacco treatment services. 2. Ensure all pregnant women, or partners, who smoke are identified and encouraged down the 'smoke free' pathway. 3. Ensure all MH inpatients who smoke are identified and encouraged down the 'smoke free' pathway. 4. Develop the Community Pharmacy Smoking Cessation offer targeting the most deprived areas in each Place across BOB. 5. Increase referral from all practices across BOB to smoking cessation services. • Target activity where prevalence is highest and ensure more people in deprived areas / cohorts are referred to smoking cessation services. • Implement a whole system approach in order to reach out to the large number of smokers engaged with care and support services on a daily basis. • Work to ensure that local NHS Trusts are smoke free and encourage smokers using, visiting or working in the NHS to quit, including comprehensive smoke free policies. • Provide personalised care and support training to healthcare professionals so as to use every 'teachable moment' to deliver 'very brief advice' on quitting. • Promote use of Make Every Contact Count through training and awareness programmes. • Benchmark and collate data / evidence and performance. • Increase numbers of Adult Health Checks.	• Evaluation of year 1 and re-targeting of priorities and actions for years 2-3. • Continue to increase capacity of smoking cessation services across BOB and increase numbers of referrals to Smoking Cessation Services from Acute Hospitals.	• Evaluation of year 2 and re-targeting of priorities and actions for years 3-5. • Continue to increase capacity of smoking cessation services across BOB and increase numbers of referrals to Smoking Cessation Services from Acute Hospitals.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Inequalities and Prevention

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
07 Weight Management - Work to reduce obesity prevalence (and increase weight management services)	• A reduction in the proportion of people who are overweight or obese including Children and Young People. • A reduction in the proportion of people who have type 2 diabetes. • Increased understanding within population about management of weight. • Improved knowledge / confidence of staff in weight management. • People make food choices that are better for their health. • Health care professionals across the system are equipped with the knowledge of local services and latest guidance around weight management. • Workforce has the confidence and skill to talk to patients about their weight. • An increase in opportunities for service users to be signposted to weight management services. • An increase in the recorded number of shared decision-making conversations. • Increase in patients' ability to self-manage at the start of the pathway. • Consistent and equitable access to Tier 3 and Tier 4 weight management services across BOB – including access to services where required. • Services include appropriate multi-disciplinary input. • A reduction in associated morbidity and mortality related to obesity.	• Target activity where prevalence is highest and ensure more people in deprived areas / cohorts are referred to weight management services. • Increase referral from all PCNs to weight management and associated services including National Digital Weight Management Programme • Offer personalised care and support training to health workforces in Making Every Contact Count, Shared Decision Making and Motivational interviewing to aid the conversation around healthy weight and use every 'teachable moment' to deliver 'very brief advice' on diet and weight loss. • Provide training to improve knowledge / confidence of staff of weight management pathway and services. • Work with system partners in interdependent areas such as physical activity and public health to integrate approaches and priorities. • Increase referral to NHS Diabetes Prevention Program in line with programme targets and with a particular focus in areas on inequality/communities of highest prevalence. • Conduct stocktake of current weight management provision across the 3 places and identify challenges. • Embed very low-calorie diet (VLCD) pathway (pilot).	• Evaluation of year 1 planned activities. • Re-targeting priorities and actions for years 2-3, based on evaluation. • Deliver a systematic campaign to promote weight management services for children and young people. • Expand weight management and personalised care training to further workforces across patient pathways. • Develop business case to support the commissioning of services to address gaps in Tier 3 provision to ensure consistent service offer across BOB. • Review Tier 4 services, and develop action plan to ensure access is consistent across BOB. • Explore provision of Tier 4 service within BOB footprint.	• Evaluation of year 2 planned activities. • Re-targeting priorities and actions for year 2-3, based on evaluation. • Expand weight management and personalised care training to further workforces across patient pathways. • Assess capacity and demand across services to ensure timely provision of interventions. • Ensure all places have tier 2-4 service offers supporting a preventative model and with sufficient capacity to meet demand.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Inequalities and Prevention

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
08 Physical Activity – Work to increase Physical Activity rates for people in BOB	• More adults are physically active. • More children and young people will be physically active, especially in our most deprived areas. • Improved knowledge / confidence of staff in benefits of Physical Activity. • Physical activity embedded in long-term condition and other relevant health pathways.	• Target activity to the areas of BOB and where prevalence is highest and ensure more people in deprived areas / cohorts are supported to meet physically activity recommendations. • Support BOB and place based multi-agency partnerships to improve physical activity levels and reduce obesity. • Ensure physical activity is routinely embedded in long-term condition pathways and other relevant health pathways. • Provide training to health and social care staff and the voluntary sector to deliver effective brief physical activity advice. • Review and develop opportunities for key stakeholders to engage in physical activity development through relevant meetings and networking events. • Provide personalised care & support training to healthcare professionals so as to use every 'teachable moment' to deliver 'very brief advice' on Physical Activity. • Promote use of MECC through training and awareness programmes. • Develop data collection criteria for 23/24.	• Evaluation of year 1 activities. • Re-targeting of priorities and actions for year 2-3, based on evaluation.	• Evaluation of year 1 activities. • Re-targeting of priorities and actions for year 2-3, based on evaluation.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Inequalities and Prevention

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
09 Drug and Alcohol – To reduce harmful drinking, drug behaviours and drug use (and increase referrals to Drug & Alcohol services)	• A reduction in the proportion of people drinking alcohol at levels that are harmful to their health and wellbeing. • An increase in the number of people receiving support to tackle their alcohol & drug misuse. • More people are identified and supported to reduce their harmful drinking particularly in higher risk groups such as people living in more deprived areas, people with mental health conditions, veterans of our armed forces, and ex-offenders.	• Target activity where prevalence is highest and ensure more people in deprived areas / cohorts are referred to specialist alcohol services by their primary care team. • Increase data collection and understanding re alcohol consumption (AUDIT-C, progressing to full AUDIT where indicated and provide advice / referral). • Provide personalised care & support training to healthcare professionals so as to use every 'teachable moment' to deliver 'very brief advice' on harmful Alcohol & Drug use. • Promote use of MECC through training and awareness programmes. • Review the provision of alcohol care teams (ACT) to improve care across BOB. • Ensure that the integrated workforce is aware of alcohol pathways of care so as to increase referrals, rather than signposting, to specialist drugs and alcohol treatment services. • Seek to increase the provision of hepatitis B vaccination to injecting drug users and their household and close family contacts. • Develop data collection criteria 23/24. • Clarify policy re dual diagnosis.	• Increase awareness, understanding and support a change in lifestyle and attitudes in order to empower and enable individuals to make more positive choices about the role of alcohol and drugs in their lives. • Increase awareness and identification of substance misuse in parents, to reduce the impact on children and parents. • Improve earlier identification and prevention of alcohol harm. • Support the vulnerable and complex needs population to address substance misuse and associated harms, with particular focus on: 1. Those with dual diagnosis (mental health and substance misuse). 2. Homeless people and those vulnerably housed. 3. Those in deprived areas.	• Evaluation of year 2 and re-targeting of priorities and actions for years 3-5. • Continue to increase awareness and identification of substance misuse in parents, to reduce the impact on children and parents. • Continue to support the vulnerable and complex needs population to address substance misuse and associated harms.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Immunisations and Vaccinations

Context: Our challenge in BOB

National vaccination programmes are well established in the UK and remain one of the most essential and cost-effective tools available to ensure population health and wellbeing. Preventative healthcare including vaccinations is highlighted in the NHS long term plan as a priority to improve public health. BOB has a successful immunisation program delivering 18 routine vaccination pathways, alongside travel vaccinations, post exposure vaccinations and supporting outbreak management.

BOB is currently achieving above national average uptake for childhood immunisations in general. Seasonal vaccination programs, Covid & Flu also follow this trend. (see data on the right side of this page). However significant variation is seen across the BOB footprint which is linked to avoidable differences in coverage between population groups, such as by ethnicity or deprivation. Covid19 has impacted on the delivery and uptake of routine immunisations, and there in a need to ensure services return to pre-pandemic levels of activity.

Our Ambition: By March 2028 we aim to protect our population from vaccine preventable diseases through the implementation of the national immunisation strategy. We will maximise uptake across all vaccination programs, reduce the occurrence of outbreaks while focusing on addressing local vaccine inequalities.

To Deliver Our Ambition, We Will:

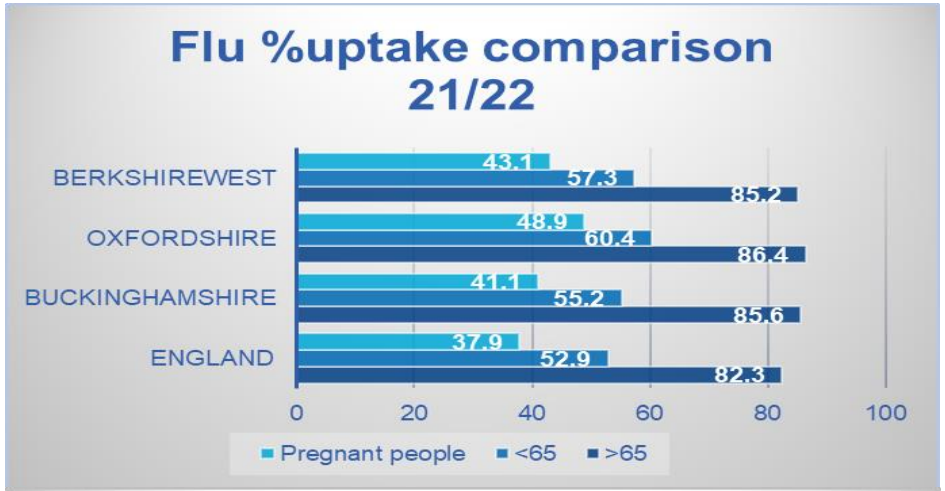
1. Develop and deliver a successful population health strategy that supports the reduction in variation of immunisation uptake across our population.

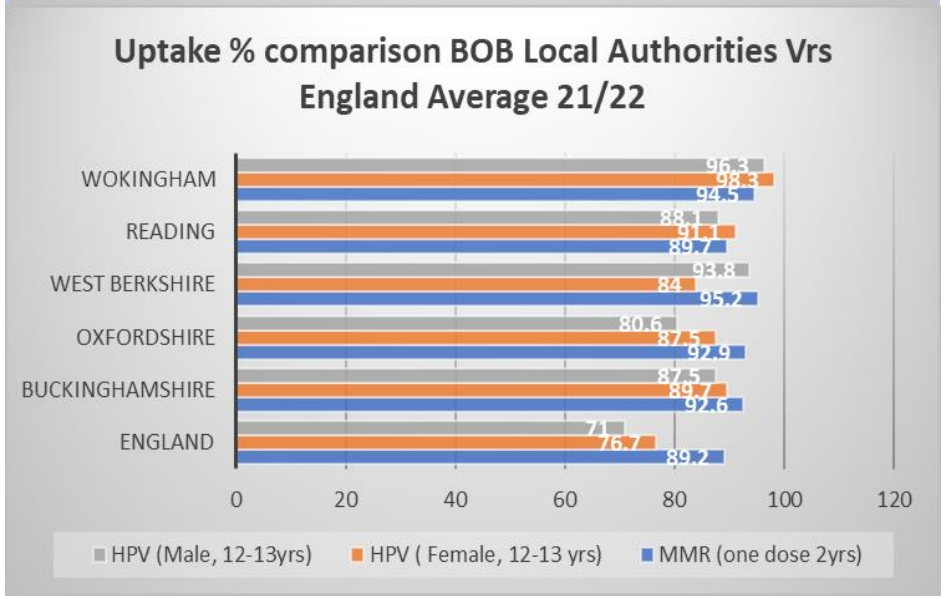
2. Provide an integrated service that promotes flexibility across providers, meeting the needs of the population, and resulting in an increased uptake of all immunisation programs.

3. Develop and maintain a resilient and highly skilled immunisation workforce

What We Need For Success:

- Strong clinical leadership to support collaboration and partnership working with between health, LA, PH and third sector
- Community engagement in developing future delivery models that fit around their diverse needs
- Access to accurate real time reporting and data to measure outcomes, including key population characteristics
- Continued funding to support targeted interventions in areas of high deprivation and low uptake
- Recurrent funding, at system level, to ensure retention of workforce and expansion of innovative delivery models





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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Immunisations and Vaccinations

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Develop and deliver a successful population health strategy that supports the reduction in variation of immunisation uptake across our population.	• By the end of 2028 our aim is that: 1. no community or group has an uptake that is more than 5% lower than highest uptake group, or 2. no community or group has an uptake level below 90%. • A BOB wide strategy to support a reduction in the impact of health inequalities on vaccination uptake. • An established population engagement team to reduce vaccine hesitancy. • Improved access to vaccination within communities. • Targeted support to PCNs identified with below average uptake. • Strengthened understanding of and wider accessibility of all routine immunisations for those with protected characteristics and inclusion health groups. • A multi-stakeholder approach to promote and improve uptake of key maternity immunisations – pertussis, covid and flu, and targeted neonatal BCG.	• Implement vaccination dashboard. • Review outcomes of access and inequality projects delivered in 22/23. • Develop sustainable long-term communication and engagement plan. • Use community engagement approaches, learning from evaluation of the covid vaccination campaigns, for those groups identified as having lower uptake of immunisations, with a particular focus on the MMR and 4-in-1 pre-school booster, alongside covid and flu. • Work collaboratively to improve access to immunisations in primary care, including through enhanced access and cross-PCN working. • Increase the ongoing offer and uptake of immunisations in primary care for those who leave school without completing their immunisation. An estimated 8-25% of year 11 have not completed adolescent immunisations in BOB (data are subject to limitations) - these are immunisations protecting against HPV, meningococcal disease, tetanus, diphtheria and polio. • Review the national immunisation strategy, once published.	• Develop the network of community engagement. • Use a multi-stakeholder approach to promote and improve uptake of key maternity immunisations – pertussis, covid and flu, and targeted neonatal BCG. • Pilot targeted interventions, informed from the review of previous interventions. • Develop the BOB immunisation strategy in line with the National guidelines.	• Increase the scale of targeted work. • Review the impact of interventions on vaccination uptake. • Embed immunisations into the broader health prevention pathways.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Immunisations and Vaccinations

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Provide an integrated service that promotes flexibility across providers, meeting the needs of the population and resulting in an increase uptake of all immunisation programs.	• An increase in the flexibility of delivery models. • An increase in the levels of co-administration where clinically feasible • An increased uptake ensuring all vaccination programs reach the national targets.	• Undertake an internal review of current vaccine governance arrangements across BOB. • Review the National immunisation strategy, once published. • Develop a network for shared learning across vaccination programs within BOB • Undertake stakeholder engagement activity prior to the winter vaccinations focused on increased flexibility.	• Pilot a series of evidenced based interventions to increase uptake. • Create an action plan to ensure the new national immunisation strategy is fully implemented. • Review the impact on the flexible approach, identify which aspects have had a positive impact on our population.	• Implement and scale up interventions that have been identified as the most effective. • Embed the identified beneficial flexibility into future programs.
03 Develop and maintain a resilient and highly skilled immunisation workforce	• Workforce developments that enhance immunisation promotion, ensure standards are met, increase capacity and resilience for delivering programmes. • A workforce that is upskilled in wider public health approaches such as wider health promotion activity. • A workforce that is resilient to changing demands and can respond to significant outbreaks / surge requirements. • Reduction of vaccination related incidents.	• Develop a multi stakeholder learning platform. • Work alongside our emergency response specialists to review our outbreak response. • Review and identify specific health promotion activities that can be delivered alongside immunisations.	• Increase the level of MECC training among the immunisation workforce.	• Review the impact of the interventions and update action plan.

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Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

2. Start well

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan: Start Well

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

Starting Well in BOB

- In BOB, we want every child and young person to get the best possible start in life. There are 425,200 people aged 0-19 in BOB, which is 24% of the total population (Census 2021). Higher proportions of children and young people (CYP) aged 0-15 are concentrated in Reading, High Wycombe, Aylesbury and Banbury in the BOB area.
- To achieve this, we need to focus right at the beginning, by supporting mothers during and after their pregnancy and then work to ensure each child achieves their early development milestones in a timely fashion to give them the best start to life, their education and future opportunities.
- Our local communities and environments should help support all children and young people to make healthier choices which will lead to healthier outcomes in their life.

Supporting children and young people

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

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

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

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

Our focus areas

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

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

1.2 Start Well – Our Summary Plan

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

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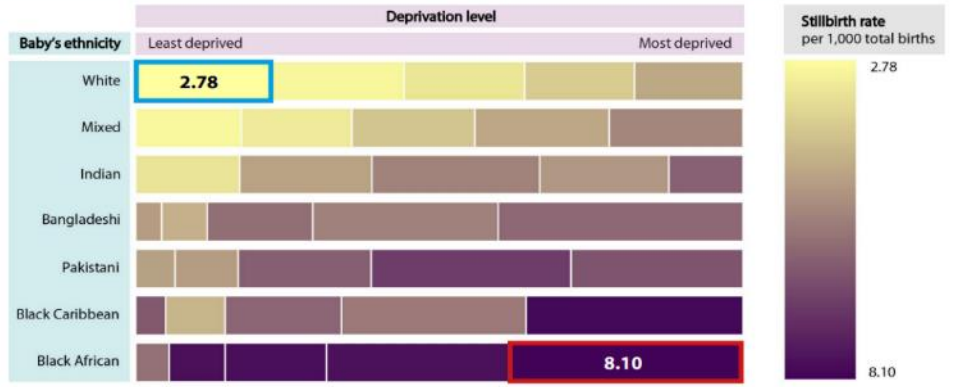
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Women's, Maternity and Neonatal

Context: Our challenge in BOB

- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) data shows that women and birthing people's outcomes are not equitable, with a clear correlation between women from ethnic and deprived communities experiencing higher rates of maternal and neonatal morbidity and mortality. (MBRRACE 2022)
- Black women are 3.7 times, and Asian 1.8 times, more likely to die during the perinatal period, whilst 1 in 9 women who died had severe and multiple disadvantage. These figures have increased since the previous report.
- Independent investigations nationally have concluded that there must be a focus on safety first, including staffing numbers and skill mix, as well as addressing culture of behaviour in practise between multi-disciplinary teams.
- Personalised care, which represents the needs and wishes of each individual service user, must be included in the planning and delivery of perinatal care and women's services.
- Supporting women's health throughout the life course to improve these outcomes and target women-specific health issues, including support for miscarriage, fertility, menstrual health and menopause as well as the health impact of violence against women and girls, as promoted in the first Women's Health Strategy (2022).

3 **Combining the two charts shows how some ethnic groups are much more affected by the higher rates of stillbirth associated with deprivation**



Our Ambition: By 2028, our maternity and neonatal services in BOB will prioritise and provide care which is safer, equitable, personalised, kinder and sustainable and ensuring positive work cultures and behaviours. We will ensure close alignment with women's health needs across the life course, to support preventative health initiatives that are realistic, and provide timely and responsive health services when they are needed.

To Deliver Our Ambition, We Will:

1. Make our services safer, using the Single Delivery Plan (March 2023) to focus on the coming 3 years.
2. Address staffing deficit, ensuring a mixture of skills, and also opportunities for development (Workforce Strategy).
3. Listen to and engage our service users, including those from minority communities.
4. Implement the BOB Maternity Equity Strategy.
5. Improve accuracy and reliability of data (ICB Digital Strategy).

What We Need For Success:

- **Strong, visible leadership** within BOB and the Local Maternity and Neonatal System (LMNS).
- **Funding** to support all workstreams in the long term.
- **Workforce ambitions and strategies** to make BOB an attractive place to work, with career opportunities and excellent training/education.
- **LMNS Workstream Leads** to push this work across not only BOB, but regionally and nationally transformation programme.
- **Diverse Maternity Voices partnership (MVP) and service user groups** to capture broad experiences across communities, representative of the diversity in BOB, to influence and steer workstreams.
- **A clear schedule of safety and quality assurance measures,** which align with Maternity Incentive Scheme (MIS) and the ambitions of the Women's Health Strategy.
- **Collaboration with all partners** that straddle women's and perinatal, to allow a focus on prevention across the life course.
- **Digital information systems and platforms** to enable wider system participation and knowledge sharing. Use of data intelligence that can be used to configure services which improve outcomes. Simple, reliable data package that self-populates and synergises with other dashboards e.g., NHS National and Regional Maternity Dashboards.
- **Ensure maternity representation at all ICB meetings** where relevant (where maternity has an underlying interdependency), for example digital, mental health, CYP, women's health etc.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Women's, Maternity and Neonatal

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Safety	• Implementing PSIRF across maternity, neonatal and women's services. • Implementing safety actions for SBLCBv3 and subsequent versions. • Implementing Ockenden and East Kent actions to support improved patient safety. • Implement MIS. • Continue with national safety ambition of improving stillbirths, brain injury and neonatal deaths.	• Implement human factors training to support initiatives with improving safety based on historic Serious Incident data. • Implement actions from the final Ockenden Report. • Implement actions from the East Kent Report. • Continuing compliance with MIS. • Continue with national safety ambition of improving stillbirths, brain injury and neonatal deaths. • Continue with the system side safety huddle and widen the attendance base with neighbouring LMNS. • Initiate principles of PSIRF with the Patient Safety Incident Panel. • Build on the relationship with the Oxford AHSN and Clinical Networks to ensure alignment of guidelines across the system. • Implement safety actions from Single Delivery Plan • Begin to map the alignment of workstreams to include women's health strategy across the life course.	• Continue with national safety ambition of improving stillbirths, brain injury and neonatal deaths. • Support trusts to implement Quality Improvements related to Safety, e.g.: Each Baby Counts Learn and Support. • Continue to embed learning following Patient Safety Incidents, by looking back at incidents and themes and looking forward. • Continue to support trusts to embed the principles of the Human Factors training throughout each training opportunity and interaction with service users and colleagues. • Develop the work around women's health and synergise where there is overlap.	• To continue with the ongoing national drivers related to assurance, compliance and safety. • Develop guidance, and services that are more aligned across the system, to ensure ease of movement for service users, either through choice or mutual aid. • Ensure the shared mental model is embedded across the system in all quality and safety initiatives in the perinatal, neonatal and women's services.
02 Workforce	• Supporting initiatives to improve safe staffing. • Improving supply of midwives e.g., return and retire, international recruitment, attracting school leavers/university students, placement expansion, focused support packages etc. • Up skilling/creating new roles in maternity and women's services • New ways of working i.e., Continuity of Carer (CoC). • Improving leadership and culture of working practises.	• Lead on placement expansion initiatives to improve the number of student placements at different trusts. • Continue with international midwifery recruitment. • Continue with implementation of CoC building blocks. • Producing website page to act as an education hub for Multi-Disciplinary Team staff in maternity. • Lead on return to practice initiatives. • Lead on projects related to retaining midwives at the beginning of their careers. • Lead on safe staffing initiatives in line with NICE guidelines, the core competency framework and Ockenden. • Establish a maternity workforce forum. • Implement workforce-based actions from Single Delivery Plan.	• Continue with sustainable CoC models implementation (assuming safe staffing). • Continue with all workforce initiatives which recruit and retain midwives to staff staffing levels. • Finalise the training hubs for the LMNS with a range of different courses which can be accessed by clinicians for their development. • Support initiatives for apprenticeships to support Maternity Support Workers development. • Align with the general NHS workforce plan.	• Continue with all workforce initiatives to improve retention and recruitment. • Continue with sustainable CoC models implementation (assuming safe staffing). • Continue to implement all workforce deliverables in relation to the long-term plan. • Improve trust culture and leadership (for example human factors will be embedded) and staff feel supported and psychologically safe.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Women's, Maternity and Neonatal

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One – (aligned to Operational Plan)	Year Two	Years Three – Five
03 Personalisation and co-production	• Implement Personalised Care and Support Plan's (PCSPs) to improve choice and individualized planning of care.	• Ensure PSCP conversations are culturally competent, and plans are available in the key languages per trust. • Ensure PSCP conversations and plans itself are accessible (easy to read). • Produce a paper PSCP copy. • Rollout out of PSCP copy. • Source, test and implement a digital solution for PSCPs. • Ensure specialist referral services continue to be operational as per their service specification for women and pregnant patients (such as the Maternal Medicines Network (MMN) and Maternal Mental Health Services (MMHS).	• Rollout out digital PSCP solution. • Training regarding motivational interviewing, making every contact count, conversations regarding shared decision making with all staff groups. • Empowering the service user regarding their maternity care and provide places to find information about their maternity care (for example on a website).	• Restoring services inclusively to work towards universal proportionalism (in context of equity strategy) personalising services for ethnic diverse and deprived communities to achieve equitable outcomes (for example lowering threshold for referrals). • Customised foetal surveillance charts to inform clinical decisions.
04 Prevention and equity	• Support initiatives for reducing health inequalities for the ethnically diverse and deprived populations. • Lead on a range of public health initiatives for maternity, neonatal and women's health as per the Long-Term Plan (LTP) and ICB objectives. • Plan, implement and evaluate various pilots related to community projects (Community connections and co-production).	• Widen focus and support initiatives for all health inclusion groups including perinatal mental health. • Explore and implement campaigns for vaccination against COVID and flu and other vaccinations pregnancy. • Start the implementation of the maternal and neonatal equity strategy. • Lead on social prescribing and health justice partnership initiatives. • Supporting coproduction training for all staff to lead to a more collaborative way of working between service users, commissioners and staff and other key stakeholders.	• Continue to listen to women and families on the sort of investments in maternity and women's health which will make care more personalised for their needs with emphasis on seldom heard groups (informed choice). • Evaluate the impact of community connectors projects piloted in 23/24 to decide their extension. • Leading on preconceptual health initiatives and life course approaches building relationships with primary care, local authority, voluntary sector.	• Look at data to see the effectiveness of alternative choices to smoking. • Continue on LTP ambitions in relation to equity and prevention as well as continuing the implementation of the equity plan.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Women's, Maternity and Neonatal

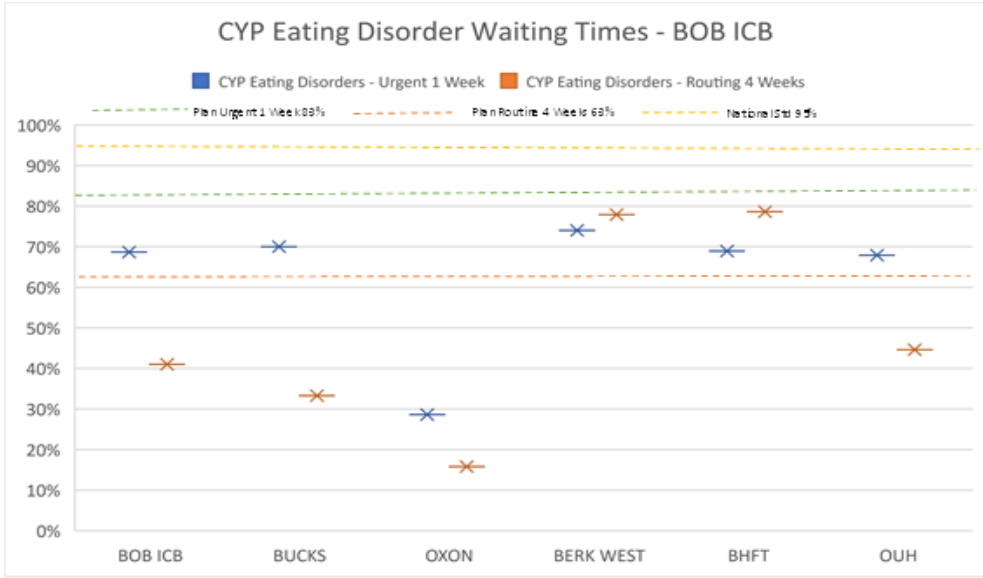
What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One – (aligned to Operational Plan)	Year Two	Years Three – Five
05 Digital and data	• Produce a LMNS maternity dashboard lead by a system analyst to be able to monitor programme deliverables. • Continue with support projects and programmes with improving digital maturity for each trust according to the wider ICB digital strategy working in collaboration with the ICB digital teams.	• Recruit LMNS analyst. • Display LMNS dashboards at key meetings to monitor deliverables and pick out outliers/areas of good practice. • Implement elements of the ICB strategy in line with trust timelines.	• Improve the accuracy of data capture and fill in gaps to ensure data is reported consistency to board. • Bring together larger sets of data from multiple sources to further inform LMNS decision making and investment into services. • Account for digital exclusion when digitally transforming services.	• The LMNS will inform their decisions and investment and service configuration based on data from an experienced analyst. • LMNS to triangulate different data sets to improve quality improvement projects • Data to be processed on a timely basis.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: CYP Mental Health

Context: Our challenge in BOB

- NHS England Survey 2021 showed rates of mental health disorders increased since 2017:
- 6-16 year olds: 11.6% to 17.4%
- 17-19 year olds: 10.1% to 17.4%
- CYP population in BOB has grown at rate of 0.83% (slightly above national average of 0.66%). However, growth in demand for CYP MH has been growing at a significantly higher rate (32%).
- There has been a significant increase in acuity and complexity of need in young people requiring support from CYP MH services. This includes complex eating disorders, autism and adverse life events resulting in demand in acute hospital settings, inpatient settings and/or social care.
- Service performance has not recovered to pre-pandemic levels and there is a rise in unmet demand and complexity.
- There is a need to meet the Long-Term Plan and Operational Guidance for 23/24 requirements to:
- Make it easier and quicker for people of all ages to receive mental health crisis care 24/7.
- Increased access to services for CYP including through school and college-based Mental Health Support Teams.
- Continued investment into eating disorders services .



Note the ongoing cyber-attack incident has meant that data for CYP ED cannot be considered an accurate reflection of activity.

Our Ambition: By March 2028, we will have delivered improved mental health and wellbeing outcomes for children and young people (ages 0 – 25), living learning and working in BOB. To achieve this, we will take a needs led and person-centred approach (in line with the THRiVE framework) to implementation, transformational change and delivery.

To Deliver Our Ambition, We Will:

1. Improve timely access and early intervention in universal care and support across our system.

2. Develop a population health approach to identify and support CYP most at risk of mental-ill health focussing on early intervention, early support and prevention.

3. Enhance support for CYP when they experience a mental health crises, developing needs-led models that maximise sustainable community-based solutions.

What We Need For Success:

- All system partners will require a shared understanding of the THRiVE framework and an agreement of their role in helping young people to thrive and to access the right information and support, at the right place and at the right time.
- Gaps in provision and adaptations in order to reach vulnerable groups will need clarification and review in order for the framework to be fully inclusive.
- Targeted workforce development across CYP MH.
- Digital: development of a BOB-wide digital support offer with project and procurement support. Population health management analytics.
- Governance structure to facilitate collaborative working across providers, partners and stakeholders to develop services needed to embed prevention, early intervention and a focus on inequalities.
- System leaders work jointly to reduce barriers to appropriate care for young people in crisis, adhering to core principles of joint working.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For CYP Mental Health

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Improve timely access and early intervention in universal care and support across our system	By March 2028 there will be: • Reduced waiting times for first and second contact with CYP-MH services. • Expanded services, including through school and college-based Mental Health Support Teams, so that more CYP aged 0-25 can get the support they need. • Defined and improved mental health and wellbeing outcomes for children and young people. • System wide understanding of the THRiVE Framework. • Clear pathways for accessing help.	• Scope current service models and approaches across the ICS informed by the THRiVE assessment tool. • Define what 'good' would look like. • Detail existing gaps, variations and inconsistencies in provision. • Engage with participation groups to co-produce and prioritise improvements. • Review current transition processes across the system, working with service users to co-produce proposed improvements.	• Finalise action plan to 1) reduce gaps, weaknesses and inconsistencies identified by THRiVE assessment tool and 2). build on existing projects and good practice identified. • Identify vulnerable groups and variations in provision required to make access to support equitable. • Agree outcome measures. • Implement and monitor transition pathway improvements.	• Deliver changes and improvements identified and agreed in year 1 and 2. • Work with all system partners to embed early intervention and support using the THRiVE Framework. • Monitor agreed outcome measures to identify progress against action plan. • Repeat the THRiVE assessment tool at year 5 to identify improvements.
02 Develop a population health (PHM) approach to identify and support CYP most at risk of mental-ill health focusing on early intervention, support and prevention	By March 2028 there will be: • A defined and agreed approach to PHM to support the implementation of anticipatory, preventative and personalised care models for CYP and their families. • A map of the variations in need and outcomes across the system and at place. • Agreed metrics informing service design, transformation, commissioning and delivery, driven by PHM data.	• Review existing national and place-based population health data to identify known gaps in provision. • Agree data road map. • Identify population health lead/project support for CYP. • Work with CSU and key stakeholders, to provide oversight of data improvement and combined population health approach. • Agree strategic, population health-based approach to developing services.	• Embed governance and structures to facilitate working collaboratively with providers, partners and stakeholders. • Agree and initiate systems for monitoring progress and change.	• Population health management will be at the core of commissioning and design of CYP-MH services, in line with the THRiVE framework. • There will be an agreed process for intelligent commissioning and service design, informed by current health data and anticipated population needs across the system and for identified groups.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For CYP Mental Health

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Enhance support for CYP when they experience a mental health crises, developing needs-led models that maximise sustainable community-based solutions	• Reduced rates of hospital admissions for self-harm among people aged 10-24 years. • An agreed model for crisis care, acute liaison and alternatives to T4 inpatient provision with an increased offer of Hospital at Home and day hospital provisions. • Agreement and adherence to core principles for collaborative joint working for children in crisis and requiring complex social and mental health support packages.	• Share data regarding access to crisis services, T4 inpatient beds and T4 hospital at home or day hospital services. • Identify challenges and improvements in demand, capacity and flow for CYP requiring T4 inpatient beds. • Identify system partners to work collaboratively on alternative models of care, including increase in social care placements for CYP with complex health and social care needs.	• Share learning from good practice and pilots (e.g., hospital navigators, acute liaison pilot). • Informed by co-production, a model for health support required for social care placements for children and young people with complex care and mental health needs will be agreed. • Expand/continue alternatives to T4 inpatient provision (hospital at home, Day hospital).	• Continue with provision of alternatives to T4 inpatient admission. • Collate and review admission data and outcome measures, including clinical outcomes. • Review data to identify efficacy and benefits of hospital at home, day hospital as alternatives to T4 inpatient. • Deliver changes and interventions identified and agreed for supported social care placements.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: CYP Neurodiversity

Context: Our challenge in BOB

- Across BOB, there are a number of children and young people with Autism and ADHD.
- We know that these groups have poor health and life outcomes when compared with our neuro-typical population. They are more likely to experience major illnesses, including poor mental health and/or other co-morbid physical health conditions, face shorter healthy life expectancy and die earlier.
- Neurodivergent people are less likely to access screening, checks or treatment, and face significant barriers to accessing the services, information, and reasonable adjustments they need.
- The NHS LTP & Operational plan focus on:
- Improved community-based support, reducing reliance on inpatient care
- Increase NHS staff awareness of the needs of people with an LD or neurodiversity (ND)
- Equitable access to healthcare – 75% of CYP with LD / ND to access an annual health check by March 2024

Our Ambition: By March 2028, we will ensure that all neuro-divergent children and young people will receive the right support, at the right time and in the right place dependant on their needs and not dependant on a diagnosis.

To Deliver Our Ambition, We Will:

1. System review of referrals, pre-assessment / assessment & feedback of outcome. Learning and processes are aligned across BOB to improve efficiencies and service user experience.

2. Deliver parity of care across BOB, regardless of a diagnosis

3. Access to timely assessment and diagnosis using alternative models of support for CYP and their families

What We Need For Success:

- Active engagement with our Neurodiverse population and VCSE to co-produce and co-deliver required changes to our services, pathways and develop community – based supports
- Active engagement with clinicians and commissioners to redesign our assessment pathways for understanding Neurodiversity
- Implementation of projects with strong project management oversight to ensure that initiatives are delivered to budget and time

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For CYP Neurodiversity

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 System review of referrals, pre-assessment / assessment & feedback of outcome. Learning and processes are aligned across BOB to improve efficiencies and service user experience.	By March 2028: • All children and young people identified as potentially neurodivergent will receive a profile of needs assessment to inform their support needs which will not need to wait or for, or be dependent on, a formal diagnosis from a clinician.# • Neurodiversity will not be a barrier to children and young people who need to access mental health services and support (link with CYP-MH JFP ambition number 2).	• Consolidate project team. • Undertake a demand & capacity review to baseline current state & identify areas for improvement. • Scope existing needs led support models and profiling tools (e.g., Portsmouth model or Autistica). • Engage key stakeholder, especially education partners, in a commitment to move to a needs led model.	• Complete benefits analysis of existing models. • Design proposal. • Stakeholder engagement events (parents/carers and professionals). • Adapt proposal according to stakeholder feedback. • Develop operational action plan.	• Deliver changes and improvements identified and agreed in year 1 and year 2. • Monitor agreed outcome measures to identify progress against action plan.
02 Deliver parity of care across BOB, regardless of a diagnosis	• All CYP and their families accessing ND services will have access to equal support. • Neurodiversity assessments will be of the same standard and content regardless of where in the system they take place.	• Establishment of the BOB-wide SHaRON Jupiter platform including agreed governance and safeguarding processes. • Assessment, triage and report workstreams established.	• Implementation of BOB triage, assessment and report approach. • Outcome measures to be agreed.	• Changes and improvements will be reviewed using PDSA approach. • Benefits of SHaRON BOB platform to be reviewed using outcome measures.
03 Access to timely assessment and diagnosis using alternative models of support for CYP and their families	• Assessment processes will be streamlined including truncated and complex assessment models. • ND profiling tools will be in place and reduce lengthy assessment models. • Capacity and demand data will be clear and inform commissioning of provider and third-party provider assessments. • Artificial Intelligence / Intelligence Automation (AI/IA) will be utilised for triage and to reduce time taken for assessment processes.	• Workstream 1 and 2 will initiate needs led and improved assessment modelling work. • Capacity and demand for ND pathways will be collated and will identify disparities in capacity and demand. • System for ongoing capacity and demand modelling will be agreed. • Ai/IA project initiated.	• Workstream 1 and 2 will continue. • A system for ongoing review of capacity and demand will be embedded. • AI/IA project team will test prototypes for triage and assessment models using automation/artificial intelligence.	• Changes and improvements identified in workstream 1 and 2 will be delivered. • AI/IA model will be implemented. • Capacity and demand will be transparent and accessible for commissioners, system partners and providers.

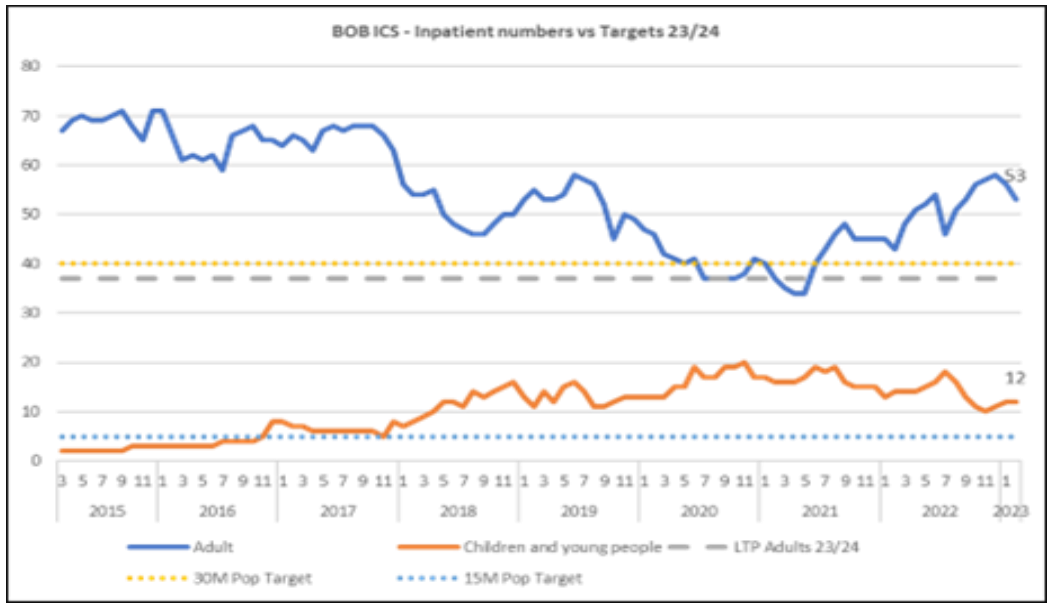
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Learning Disabilities

Context: Our challenge in BOB

- Across BOB, there are 43,000 adults and 50,000 children with a learning disability.
- People with a learning disability (LD) have on average, 2.45 long-term conditions and higher rates of death from avoidable causes than for the general population (49% vs 22%).
- Challenges: workforce, service provision and accommodation to meet the needs of people with significant complexity and acuity, higher number of patient admissions, lower number of Annual Health Checks (AHCs), access to universal services, access to paid employment, improvement required in transition to adult services, single approach to the Dynamic Support Register (DSR) requiring further development, and lack of forensic services.
- LTP and Operational Planning 23/24 focuses on the need to increase access to Annual Health Checks (AHC), reduce reliance on inpatient care, harness the knowledge of people who are experts by experience to inform future service development.

In line with NHSE targets for 23/24 BOB aim is for learning disability inpatients is to reach 37 for adults and 5 for CYP



Our Ambition: By March 2028, we will have delivered improved physical, mental health and wellbeing outcomes for children, young people and adults with a learning disability and their families/carers.

To Deliver Our Ambition, We Will:

1. Reduce health inequalities and ensure that our health and care commissioned services are providing good quality health, care and treatment to people with a learning disability and their families.

2. Improve community-based support.

3. Champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability.

4. Make sure across BOB health and care providers have an awareness of the needs of people with a learning disability.

What We Need For Success:

- Digital capability.
- Funding.
- Collaboration and integration.
- Comms and engagement resource – support with communication and coordinating feedback from service users.
- Public health data and a single approach to data reporting.
- Recruit and retain experts by experience.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Learning Disabilities

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Reduce health inequalities and ensure that our health and care commissioned services are providing good quality health, care and treatment to people with a learning disability and their families	• By March 2024 improve the percentage of people with a learning disability aged 14+ receiving an AHC and health action plan from the 22/23 baseline of 38.5% to 75%. • There will be evidence of co-design and co-production in all initiatives • Embed people with a learning disability as an inequalities cohort in action to improve weight management.	• Ongoing monitoring & reporting of AHC and Health Action plan delivery. • Create BAU process to achieve the LTP prevention of over-medication objectives. Decision taken whether to fund STOMP (Stopping The Over-Medication of children and young People with LD, autism or both) and STAMP (Supporting Treatment and Appropriate Medication in Paediatric).	• Ongoing monitoring & reporting of AHC delivery. • Dependent on STOMP / STAMP 23/24 outcomes.	• Delivery of AHCs is BAU.
02 Improve community-based support	• By March 2024 no more than 37 adults with a learning disability and/or who are autistic are cared for in an inpatient unit. • There will be a Dynamic System Register (DSR) in place that supports the planning of admission avoidance.	• Review NHSE DSR & CTR (Care Treatment Review) policy guidance for implementation. • Review CTR training and management providers against policy guidance and value for money, working with SE ICS teams to agree future provision. • Procure a BOB wide DSR model. • Ongoing management of inpatient activity.	• Review CTR performance against national requirements. • Ongoing monitoring for improvement of CTR provider performance. • Ongoing monitoring against 22/23 performance emanating from DSR procurement.	• Continued management and improvement cycles for management of inpatient numbers and supporting processes.
03 Champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability	• There will be evidence of co-design and co-production in all initiatives. • There will be a 23/24 baseline of roles and WTE numbers filled by people with LD and by 31/3/24 a target for increase to Year 5.	• Identify with partner organisations roles that can be filled by people with LD and develop an implementation plan to increase employment within HESC organisations. • Develop guidance to be available to BOB communities that support organisations to employ people with LD.	• Develop resources that are co-designed and produced by people with LD to identify the opportunities and benefits to all organisations of employing people with LD. • Develop and implement a communication plan that showcases the successes of employing people with LD.	• Ongoing monitoring of increasing employment of people with LD in BOB HESC organisations.

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Our Joint Forward Plan For Learning Disabilities

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Make sure across BOB health and care providers have an awareness of the needs of people with a learning disability	• There will be an implemented training plan that meets the needs of BOB HESC employees. • There will be a database that captures the number of people who have attended training with monitoring across the period to manage uptake.	• Develop and agree with partner organisations a roll out plan for LDA awareness training. • Implement the roll out plan for Oliver McGowan (OMMT) training. • Develop with national team or SE ICS, options for web-based alternatives to OMMT.	• Ongoing delivery of mandatory training requirements in line with roll out plan. • Evaluation of training materials and user feedback. • Map the physical health and co-morbidities for people with LD and develop a communication plan for dissemination to healthcare professionals.	• Scope training needs of people working who support people with LD – develop plan using coproduction and design.

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3. Live Well

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3.3 Our Joint Forward Plan: Live Well

Supporting people and communities to live healthier and happier lives

Living Well in BOB

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

Supporting people to manage Long-Term Conditions

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

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

Our focus areas

1. Adults Mental Health
2. Adults Neurodiversity
3. Cancer

Long Term Conditions

4. Integrated Cardiac Delivery Network
5. Integrated Respiratory Delivery Network
6. Integrated Stroke Delivery Network
7. Integrated Diabetes Delivery Network

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Delivering Our Strategy – Live Well

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

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Delivering Our Strategy – Live Well

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Service Area	Five-year Ambition	Our Delivery Focus	Governance & Reporting
Long Term Conditions – Introduction	• Improve outcomes in population health and healthcare. • Act sooner to help those with preventable long-term conditions. • Support people with LTCs to stay well & independent. • Provide quality care for those with multiple needs as population ages. • Co-produce consistent pathways across ICS to reduce unwarranted variation. • Integrate service models to delivered joined up care wrapped around patients' needs.	• Assess the population needs, increase preventative interventions, diagnose earlier, reduce inequalities and improve health outcomes. • Take a collaborative approach with our partners and stakeholders through the LTC BOB Integrated Delivery Networks (IDNs) to develop integrated care models to better manage patients with LTCs. • Develop a proactive approach to improve outcomes for patients with multiple LTCs.	• LTCs reporting into *the ICB Clinical Programme Board* • ICB Exec Lead – Deputy CEO & Chief Medical Officer
4 Integrated Cardiac Delivery Network	Reduce the number of CVD events by having a strong focus on prevention and reduce the health inequality gap by using PHM approach. We aim to **co-design consistent and integrated pathways and empower patients to live well with CVD** and other co-morbidities.	• CVD Prevention – better blood pressure and lipid management, increase NHS Health checks, lifestyle interventions and targeted smoking cessation. • Heart Failure – earlier detection and a reduction in hospital admissions and re-admissions. • Enhanced Cardiac Rehabilitation.	• All LTC service areas reporting into the *ICB Clinical Programme Board* • ICB Exec Lead – Deputy CEO & Chief Medical Officer
5 Integrated Respiratory Delivery Network	**Patient-centred, integrated clinical pathways delivering high quality respiratory care that is accessible** to all across BOB ICS Supporting people with respiratory disease to live longer.	• Population health management to identify and support people at most risk. • Delivering earlier diagnosis, education and care planning in the community. • Integration of respiratory services, enabling the right support to people closer to home. • Optimising medicines to improve health outcomes and reduce carbon emissions. • Leveraging innovation and research to improve outcomes in respiratory care.	
6 Integrated Stroke Delivery Network	We will bring key stakeholders together to facilitate a **collaborative approach to service improvement of the whole stroke pathway**, including prevention, ensuring a patient centred, evidence-based approach to delivering transformational change.	• Implementing consistent pathways of care for stroke. • Maximising stroke prevention opportunities. • Reducing variation in access to stroke rehabilitation services.	
7 Integrated Diabetes Delivery Network	We will support the education and training of our healthcare professional workforce we will reduce clinical variation and health inequalities. We will adopt new diabetes care technologies and improve access to services, as well as Improved primary and secondary prevention interventions and supported personalised self-care will enable people with diabetes to manage their health.	• Reach and exceed pre-pandemic attainment of the eight diabetes care processes (8CPs) and the three treatment targets (TTTs). • Innovation and service development focusing on digital technologies to improve outcomes and reduce inequalities. • Deliver a high-quality integrated care approach, promoting self-care for primary and secondary prevention.	

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Our Context and Ambition: Adults Mental Health

Context: Our challenge in BOB

- In BOB, there are a number of adults and older people who experience Mental Health issues that will be served by different providers across BOB.
- Our performance has not recovered to pre-pandemic levels and there is a rise in unmet demand and complexity of needs which cannot be met.
- Challenges include:
  - Workforce recruitment and retention across all services, linked with national shortage in specific roles. Level and length of funding is a driver around this challenge locally. Staff wellbeing across services is also a challenge.
  - Short-term contracts making long-term planning difficult
  - Different referral systems, increase in referrals and growing waiting lists
  - Adapting to digital models of delivery, sharing across services and interoperability
  - Need for reliable information that is easily accessible

Our Ambition: By March 2028, we will have delivered improved mental health and wellbeing outcomes for all adults and older people living, learning and working in BOB

To Deliver Our Ambition, We Will:

1. Promote a successful population health approach to prevent, identify and support individuals, groups and communities most at risk of developing mental ill health
2. Develop a sustainable workforce
3. Improve timely access to support for mental health crises and develop alternative models which offer sustainable solutions
4. Improve outcomes that are person centred, using asset based approaches that builds resilient communities and promotes integration
5. Address inequalities in physical health for people with a mental illness

What We Need For Success:

- Shared, reliable data and analysis
- Shared commitment to collaboration and integration
- Targeted interventions
- Reconfiguration of resources

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Adults Mental Health

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
01 Promote a successful population health approach to prevent, identify and support individuals, groups and communities most at risk of developing mental ill health	• Ensure services meet national standards for waiting times, standards of care and outcomes, including NHS talking therapies, Early Intervention for Psychosis and Community Mental Health Services • Provide better community-based support for adults and older adults with mental illness • Ensure that people living in our more deprived areas have better access to a wider range of support and information to improve their mental health at an early stage. • Provide services that are culturally sensitive that improve access, experience and outcomes for people from ethnic minorities at highest risk of deteriorating mental health	• Ensure NHS Talking Therapies meet national standards of care as an evidence based intervention to support people with common mental health problems, and address inequalities in access, experience and outcomes. • Increase the number of adults and older adults supported by community mental health services (5% increase each year) • Develop a Population Health Management programme to identify groups experiencing inequalities in access, experience and outcomes in services • Take action to improve data quality for inequalities groups to support action and monitoring, prioritising ethnicity recording • Continue progress to reduce the gap in access, experience and recovery of all ethnicity groups relative to White British • Develop/ Implement a plan to increase access to IAPT for older adults • Continue to mobilise the community mental health framework for Adults and Older People • Continue to fund and implement ARRS roles • Join up support for people with mental health problems including access to employment support, health care, psychological support and services led by the voluntary community and social enterprise sector. • Continue to recover progress to EIP quality standards	• Work with local authorities to understand current community approaches and identify opportunities to inform work to address inequalities through PHM • Ensure NHS Talking Therapies meet national standards of care as an evidence based intervention to support people with common mental health problems, and address inequalities in access, experience and outcomes. • Increase the number of adults and older adults supported by community mental health services (5% increase each year)	• Commission and increase access to IAPT Long Term Condition services including post-Covid syndrome (incl. co-location of therapists in primary care) • Map the location of our patients and complete analysis of length of stay and cost involved • Identify opportunities for further collaborative between LA and Health to commission specialist supported accommodation locally for people with Personality Disorder • Expand current provision to include support for all-ages (including 35+) and people experiencing At-Risk Mental State (ARMS), in line with EIP commissioning guidance

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Adults Mental Health

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
02 Develop a sustainable workforce	• Reduction in number of vacancies. • Retention of staff.	• Work collaboratively with the provider collaborative to develop a comprehensive workforce plan including primary care. • Explore with system partners how we can make BOB ICS an attractive place to work.	• Implement the workforce plan • Develop a skilled workforce to deliver an age appropriate, equitable service. • Develop/implement a training programme for clinicians to ensure the service provides appropriate intervention in caring for individual's specific needs e.g., evidence-based interventions for Older Adults presenting with PD.	• Review, evaluate and refresh workforce plan. • Develop a training plan that supports new roles and new models of care.
03 Improve timely access to support for mental health crises and develop alternative models which offer sustainable solutions	• 100% coverage of 24/7 age-appropriate crisis care, via NHS 111. • All general hospitals will have mental health liaison services, with 70% meeting the 'core 24' standard for adults and older adults.	• 24/7 Crisis Resolution Home Treatment functions (CRHT) for adults, operating in line with best practice by maintaining coverage to 2023/24. • Continue with the development of the Breathing Space and other A&E Avoidance services. • Deliver the programme for mental health and ambulances, including mental health transport vehicles, training for ambulance staff and the introduction of nurses and other mental health professionals in Integrated Urgent Care clinical assessment services. • Develop a range of complementary and alternative crisis services to A&E and admission (including in VCSE/Local Authority provided services) within all local mental health crisis pathways.	• Review crisis services, identify gaps and develop further crisis pathways. • Review/refine the programme for Integrated Urgent Care. • Review the alternative crisis services.	• Implement findings of reviews to ensure that a comprehensive integrated urgent care response is available 24/7.

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Our Joint Forward Plan For Adults Mental Health

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
04 Improve outcomes that are person centred, using asset-based approaches that builds resilient communities and promote integration	• Reduce the rate of adult acute mental health length of stay, Discharges followed up within 72 hours. • Recover the dementia diagnosis rate to 66.7%. • reduce the number of working age adults in acute care with a stay over 60 days and the number of older adults with a stay over 90 days. • Reduce Out of Area Placements (OAPs) to zero.	• Continue investment in improving the therapeutic offer to improve outcomes and experience from inpatient care, and work to decrease long lengths of hospital stay. • Continue delivering the 72-hour post discharge follow-up standard. • Work in partnership with LA and Health partners paying for people in Supported Accommodation & Care Homes to understand and identify issues and obstacles in ensuring timely move on / step down of patients in Rehab placements. • Support Community Mental Health services to improving the service users' physical health as well as mental health. • Improve access to this support through aligning and enabling local VCS organisations (e.g., Age Concern) and PCN social prescribers to advocate and take this offer to older adults. • Work with partners to keep older people well through utilising existing wellbeing services, identifying and filling gaps, particularly in areas of carer support, loneliness and bereavement support. • Provide services that are culturally sensitive that improve access, experience and outcomes for people from ethnic minorities at highest risk of deteriorating mental health. • Ensure people have access to Individual Placement and Support (IPS) services through delivery against ICS trajectories, in line with the fidelity model. • Deliver and maintain the ambition to eliminate all inappropriate adult acute OAPs. • Develop/implement a dementia recovery plan.	• Expanding the established peer worker training and posts, that will cover carer's perspective and lived experience. Working with our voluntary sector partners to develop a range of peer support options that are inclusive of / specific to the needs of older people. We have included peer support workers in the transformation budget (totalling £197k) and our MH trusts have 38 peer support workers already in place. • Enabling existing Older People's Mental Health (OPMH) Specialist Practitioners to provide training and consultation to other clinicians around OPMH issues. • To tackle the need for Physical Health checks for Older Adults with SMI the specialist service will support with engagement and advice on key older people issues differentiating between physical health root cause e.g., delirium vs. mental health presentation. • Strengthening the link and integration with local community hospital provision to provide holistic intervention that supports rehab and returning home.	• Strengthen integrated working with PCNs and stakeholders ensuring collaborative work with physical health colleagues to implement initiatives such as EHCH and Ageing Well.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Adults Mental Health

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
05 Address inequalities in physical health for people with a mental illness	Reduce the gap in life expectancy and cardiovascular outcomes for people with a Severe Mental Illness	Develop and implement plan to support Core20plus5 Increase the number of people with severe mental illness who stop smoking through referral to and provision of specialist support promoted in secondary and primary care. Increase the uptake of regular physical health checks, with appropriate advice and treatment to meet national target.	Review and refine Core20plus5 plan Increase the number of people with severe mental illness who stop smoking through referral to and provision of specialist support promoted in secondary and primary care. Increase the uptake of regular physical health checks, with appropriate advice and treatment to meet national target.	Continue to evaluate impact of Core20plu5 plan Increase the number of people with severe mental illness who stop smoking through referral to and provision of specialist support promoted in secondary and primary care. Increase the uptake of regular physical health checks, with appropriate advice and treatment to meet national target.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Adults Neurodiversity

Context: Our challenge in BOB

- Across BOB, there are 25,000 Autistic adults (1.76 %) and 35,000 people with ADHD (2.4%).
- We know that these groups of people have poor health and life outcomes when compared with our neuro-typical population. Often socially excluded and stigmatised neurodivergent people are at significantly greater risk of experiencing health inequalities than the neuro-typical population.
- They are more likely to experience major illnesses, including poor mental health and/or other co-morbid physical health conditions, face shorter healthy life expectancy and die earlier.
- Neurodivergent people are less likely to access screening, checks or treatment, and face significant barriers to accessing the services, information, and reasonable adjustments they need.
- A study across England in 2019 revealed that two in three autistic adults felt they were not getting the support they need and that only 8% of autistic adults and 5% of families thought that health and care services in their area had improved since the Autism Act. Considering the national and local attention on autism since 2009, this raised significant concerns as to the speed of change and the delivery of quality services.
- Challenges: poor access to assessment, diagnostic pathways and specialised support, inequitable access to services, healthcare workforce knowledge and skills when responding to this population, and absence of a National ADHD strategy.

Our Ambition: By March 2028, BOB will be an area where Neurodivergent people thrive, and their strengths are embraced.

To Deliver Our Ambition, We Will:

1. Improve access to assessing, understanding and supporting a person's neurodiversity
2. Ensure infrastructures are in place and are effective to reduce unnecessary admissions under the Mental Health Act
3. Improve the experience for any neurodiverse people using our Mental Health Inpatient Services
4. Improve equity of access to pathways of care and care settings through anticipatory and reasonable adjustments
5. Ensure that staff working across BOB have the skills and knowledge to identify Neurodiversity, understand and meet the needs of this service user group
6. Enable people to thrive by co-producing community-based assets that support the social and emotional needs of neurodivergent people

What We Need For Success:

- Active engagement with our Neurodiverse population and VCSE to co-produce and co-deliver required changes to our services, pathways and develop community – based supports
- Active engagement with clinicians and commissioners to redesign our assessment pathways for understanding Neurodiversity
- A training programme for staff working in BOB that supports their roles and function to meet the needs of ND service users and support adjusted approaches

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Adults Neurodiversity

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Improve access to assessing, understanding and supporting a person's neurodiversity	• Improve identification of neurodiverse service users accessing other mental health pathways of care. • 95% of people requiring assessment and diagnosis of autism or ADHD will be assessed within the three-month waiting time within NICE guidance. • There will be profiling pathways in use across BOB by 25/26.	• Engage with stakeholders to redesign current diagnostic pathways. • Review of skill set for staff delivering assessment pathways. • Design profiling pathway. • Develop & Implement profiling pathway pilot. • Produce and agree options paper for redesign of diagnostic pathways. • Develop business case to support redesign of diagnostic pathway. • Co-produce training programme to improve identification of neurodiversity within Mental Health Pathways of care.	• Engagement with ND population on redesign proposal. • Implement redesign of diagnostic pathway. • Develop training programme for staff working in diagnostic pathways. • Maintain implementation of profiling pathway pilot. • Deliver training programme to improve identification of neurodiversity in mental health pathways of care.	• Evaluation of profiling pathway pilot and decision on continued implementation. • Implement and evaluate impact of diagnostic pathway redesign. • Develop business case for sustainable pathway. • Implementation of pathway as business as usual. • Evaluation of training programme. • Training to improve identification of neurodiversity becomes business as usual.
02 Ensure infrastructures are in place and are effective to reduce unnecessary admissions under the Mental Health Act	• Reduce reliance on inpatient care, so that by March 2024 no more than 30 autistic adults per million are cared for in an inpatient unit. • There will be a Dynamic Support Register (DSR) for ND people across BOB and have system wide oversight of this. • Care and Treatment Reviews (CTR) meet national requirements for frequency and quality standards. • Admissions to inpatient units is reduced in line with national guidance and requirements. • There will be an enhanced reasonable adjustment service across BOB based on learning from current model in OHFT.	• DSR for Neurodiverse service users available in each county. • There is a BOB ICB process in place overseeing DSRs. • There is an improvement plan in place in line with published guidance for CETR / CTRs. • Develop process for review of admissions into inpatient services to identify factors leading to admission. • Staff and public know how to access DSR. • Project initiation for enhanced reasonable adjustment service across BOB initiated.	• Learning from Y1 DSR process implementation evaluated, and action plans developed. • Learning from CTR process review leads to action plan. • Implementation of reasonable adjustment service.	• Annual evaluation of DSR process and learnings in place. • Annual evaluation of CTR process in place. • Learnings from thematic reviews of admission identifies opportunities for wider service improvements. • Evaluation of impact of reasonable adjustment service.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Adults Neurodiversity

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Improve the experience for any neurodiverse people using our Mental Health Inpatient Services	• To ensure that there is an inpatient training programme in place to improve identification of ND service users, their needs are understood and met and supports implementation of reasonable adjustments. This is within Trust core competencies for inpatient staff by 2026 and 75% of inpatient staff have received this training by 2028. • All MH inpatient wards have completed a Green Light Toolkit by 2025 and action plans are implemented by 2026. Lived experience review to be undertaken in 2027 to measure impact of action plans and develop additional action plans as required. • All wards have access to support and consultation from reasonable adjustment services by 2026. • All wards have an admission process in place that includes sensory screening, communication screening and specific care planning templates for ND service users by 2025. • Implement and evaluate inpatient peer support worker pilot by 2027. • Implementation of host commissioner guidance and commissioner oversight visits. • Lengths of stay on Mental Health inpatient wards are reduced by 10% for this population of people by 2027.	• Implementation of recommendations arising from Lived Experience review of inpatient wards completed in 2022. • Co-production of resources to support reasonable adjustments on wards. • Green Light Toolkit audit programme is in place and being undertaken across BOB. • Develop admission process for inpatient services that include screening for autism and ADHD, sensory screening, communication profiling and ND specific care planning templates. • Develop training programme for inpatient staff. • Develop role for peer support workers within inpatient services as pilot. • Create and implement oversight board where intelligence from host commissioner and commissioner oversight visits are shared and action plans developed.	• Implementation and evaluation of reasonable adjustment resources. • Delivery and evaluation of inpatient training programme. • Implementation of admission process that includes sensory screening, communication profiling and ND specific care planning templates. • Green Light Tool Kit audits completed and wards working on action plans. • Co-produce post diagnostic support materials for inpatient services to support service users in understanding their Neurodiversity and relationship to their mental health. • Recruit and pilot peer support workers into inpatient service. • Implementation of commissioner oversight board and actions arising from this.	• Implement post diagnostic support package. • Reasonable adjustments as business as usual and auditing of implementation. • Evaluation of impact of peer support workers and consider widespread implementation. • Green Light Tool Kit re-audit across BOB supported by people with lived experience of ND. • Commissioner oversight board is business as usual.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Adults Neurodiversity

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Improve equity of access to pathways of care and care settings through anticipatory and reasonable adjustments	• There will be a definition of barriers with an action plan to reduce them. • There will be a toolkit of reasonable adjustments and a stakeholder engagement plan to roll it out. • There will be a directory of specialist interventions and communication to ensure that these are understood by stakeholders. • PEACE pathway for adapted eating disorder interventions will be in place across BOB. • Staff will be able to identify reasonable adjustments and implement these. • 75% of ND persons using our services will have a reasonable adjustment passport in place and adjustments are reported as being available to them by 2027.	• Review and make recommendations of service settings. • Co-produce and deliver training into services to promote changes to settings and processes. • Co-produce reasonable adjustment resources to support staff and service users. • Identify needs that cannot be met by adapted pathways and develop an action plan to make changes to pathway and inform stakeholders. • There will be published baseline metrics for assessing equity of access. • Co-produce training programme to support staff in identifying and providing reasonable adjustments.	• Review of Y1 service settings and processes to identify ongoing improvement needs and co-delivery of training into services. • Development of improvement metrics and Evaluation of reasonable adjustment resources and continue to develop resources. • Identify evidence base to meet needs that cannot be met by adapted pathways. • Develop options for delivery of specialised interventions to complement existing pathways. • HCP and service user experience surveys and questionnaires.	• Continue review of service settings and processes by EbE and co-delivery of training into services. • Reasonable adjustment resources widely available. • Commissioning and delivery of specialist interventions to complement existing pathways. • Audit of percentage of Neurodiverse service users with reasonable adjustment passport in place. • Audit of service user satisfaction of impact of reasonable adjustment passport.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Adults Neurodiversity

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
05 Ensure that staff working across BOB have the skills and knowledge to identify Neurodiversity, understand and meet the needs of this service user group	• ND mandatory training is embedded into staff induction programmes and 100% of newly appointed staff are attending this by 2027. • There will be a definition of the knowledge and skills required to identify and meet the needs of ND and their need for reasonable adjustments which is understood by all stakeholders and there is a training programme in place to meet this by 2026. This is reflected in provider trusts core competencies for staff for each area of service. By 2028 50% of staff have completed this service specific training. • All training provided to staff is evidenced to be co-created and co-delivered by people with lived experience by 2026.	• Deliver mandatory training in line with the requirements of the Health and Social Care Act. • Complete training needs analysis to inform training programme for specific service areas. • Commission EbE / VCSE to co-produce materials to meet training requirements.	• Ongoing delivery of mandatory training requirements in line with roll out plan. • Ongoing co-production of service specific training materials. • Co-delivery of training materials. • Evaluation of training materials. • Engagement with provider trusts for training to be added to core competencies for staff.	• Co-production, co-delivery and co-evaluation of training materials.
06 Enable people to thrive by co-producing community-based assets that support the social and emotional needs of neurodivergent people	• Peer support is available across BOB providing education, emotional support and practical strategies for successfully living with ND by 2027. • ND people have forums in place across BOB to engage with services to support services to understand existing barriers and co-producing solutions for making changes by 2025.	• Fully engage with our ND population and VCSE to understand the community-based supports that will support and empower them. • To co-create and co-deliver service user forums where this engagement can happen.	• Co-create a plan for developing peer led support and advocacy within each county. • To procure and commission services and organisations that can meet the requirements of the plan.	• Delivery of the plan and building the community-based supports.

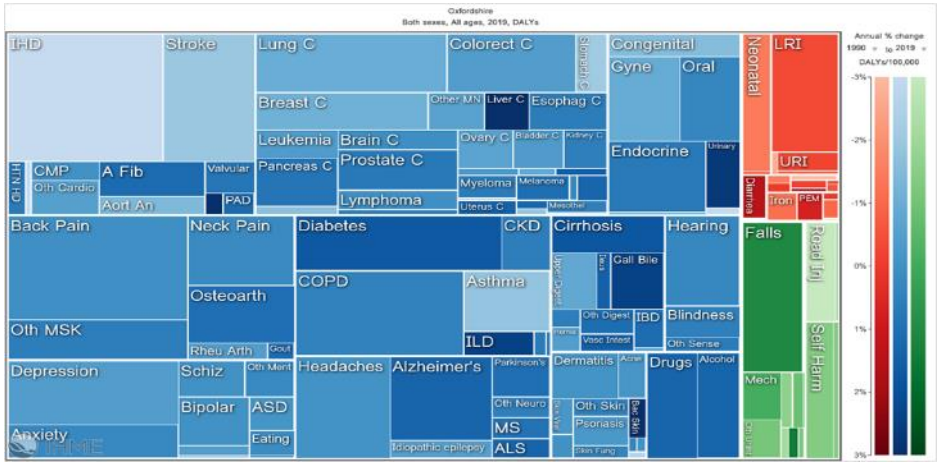
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Long Term Conditions

Context: Our challenge in BOB

- The Long-Term Plan (LTP) sets out clear and costed improvement priorities for the biggest killers and disablers of our population including Long Term Conditions (LTCs).
- The Global Burden of Disease study shows that the top five causes of early death for the people of England are: heart disease and stroke, cancer, respiratory conditions, dementias, and self-harm.
- People with LTCs account for 50% of all GP appointments, 64% of all outpatient appointments and over 70% of all inpatient bed days.
- Treatment and care for people with LTCs is estimated to take up around £7 in every £10 of total health and social care expenditure.
- Challenges: The growing incidence of long-term conditions that is part of an ageing population poses a number of serious challenges for health and social care systems.

Global Burden of Disease by condition in Oxfordshire



Our Ambition: By March 2028 we would

- Improve outcomes in population health and healthcare.
- Act sooner to help those with preventable long-term conditions.
- Support people with LTCs to stay well & independent.
- Provide quality care for those with multiple needs as population ages.
- Co produce consistent pathways across ICS to reduce unwarranted variation.
- Integrate service models to delivered joined up care wrapped around patients' needs

To Deliver Our Ambition, We Will:

1. Assess the population needs, increase preventative interventions, diagnose earlier, reduce inequalities and improve health outcomes.

2. Take a collaborative approach with our partners and stakeholders through the LTC BOB Integrated Delivery Networks (IDNs) to develop integrated care models to better manage patients with LTCs.

3. Develop a proactive approach to improve outcomes for patients with multiple LTCs.

What We Need For Success:

- A collaborative and consistent approach through the BOB IDNs to deliver on priorities, identify and address variation, share best practice and enable integrated care that is high quality and patient-centred, address health inequalities, plan for and address the increase in demand for services and enable effective working across organisational boundaries.
- Our BOB Clinical Programme approach brings together stroke, cardiac, diabetes and respiratory IDNs along with mental health, children and young people, end of life, maternity, personalised care and Place Directors to enable a joint approach to managing the population health.
- Strong Clinical Leadership from all care sectors through our LTCs IDNs using a clinical evidence-based approach.
- Data driven health actuary business intelligence and data dashboards to enable a proactive population health management approach for prioritisation, management and to monitor outcomes.
- Working closely with all our colleagues and partners that enable innovation and service delivery for LTCs for example providers, communications, health inequalities, public health, primary care, digital, diagnostics, personalised care, medicines optimisation.

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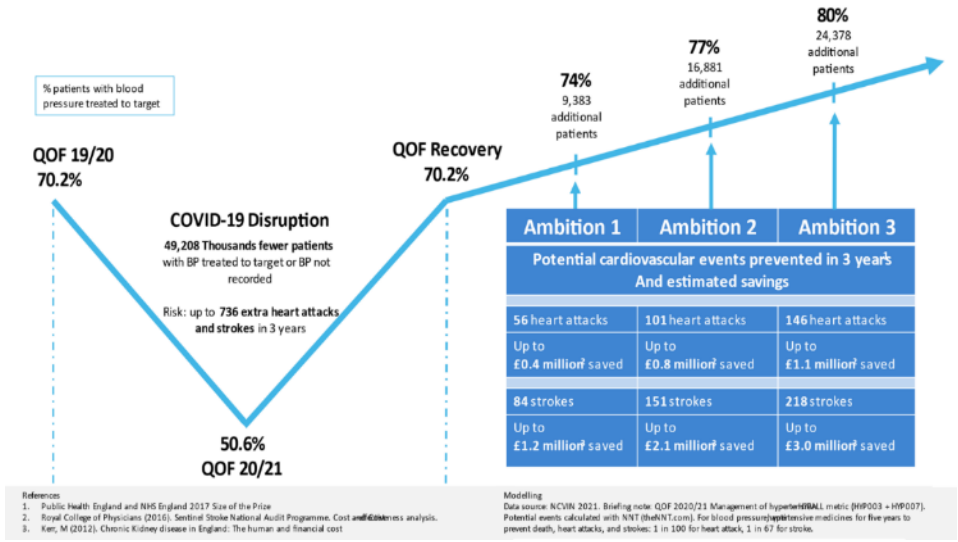
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Integrated Cardiac Delivery Network

Context: Our challenge in BOB

- The NHS Long Term Plan (LTP) identifies Cardiovascular Disease (CVD) as a clinical priority and the single biggest condition where lives can be saved over the next 10 years:
- CVD causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. Premature CVD mortality is four times higher in the most deprived communities.
- CVD is largely preventable, through lifestyle changes and a combination of public health and NHS action, and ongoing engagement with communities.
- Early detection and treatment of CVD can help patients live longer and healthier lives, therefore reducing pressure on the overall health and care system.
- CVD is contributing to the largest gap in life expectancy between the most and least deprived, accounting for up to 25% of the difference in deaths caused by CVD.
- Challenges: increased funding/resources to level-up services and support across BOB, specialist skilled workforce recruitment and retention, impact of COVID-19 on effective management of hypertension, delivering personalised care and support planning.

Blood pressure optimisation to prevent Heart Attacks and Strokes in BOB



Our Ambition: By March 2028, we aim to reduce the number of CVD events by having a strong focus on prevention, and reduce the health inequality gap by using PHM approach. We aim to co-design consistent and integrated pathways and empower patients to live well with CVD and other co-morbidities.

To Deliver Our Ambition, We Will:

1. CVD Prevention – better blood pressure and lipid management, increase NHS Health checks, lifestyle interventions and targeted smoking cessation.
2. Heart Failure – earlier detection and a reduction in hospital admissions and re-admissions.
3. Deliver enhanced Cardiac Rehabilitation.

What We Need For Success:

- Strong Clinical Leadership from all care sectors.
- Population health management approach to identify and support patient most at risk of developing CVD and supporting earlier intervention and self-management.
- Reduction of inequalities – with a focus on targeted work with PCNs, specifically in areas of known deprivation, and focus on people with learning disabilities and severe mental illness.
- Co-design of consistent and integrated pathways.
- Working in partnership with other teams and stakeholders, and interdependent workstreams and enablers.
- Digitally enabled approaches to enhance care, add value and transform pathways.
- Support our colleagues with the improvement of lifestyle changes.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Integrated Cardiac Delivery Network

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 CVD Prevention – better blood pressure and lipid management, increase NHS Health checks, lifestyle interventions and targeted smoking cessation.	• 77% of patients with Hypertension treated to target across BOB by March 2024. • Optimise Lipid for patients with known Cardiovascular disease. • Continue to address health inequalities and deliver on the Core20PLUS5 approach. • Support the improvement of lifestyle changes. • Working with our PH leads to deliver more NHS Health Checks to the most at risk communities and residents. • Build on community based approaches for mini health checks as an adjunct to support education and sign posting.	**Hypertension** • Increased case finding/improved numbers of patient treated to target through working with PCNs/practices. • Achieve QOF recovery (70%) across all PCNs. • Increased numbers of patients signposted to Community Pharmacy Hypertension Case Finding Service. • Working with partners to improve cardiovascular checks focused on inequalities such as people with known SMI and LD. • Scope feasibility of personalised care and support planning as part of multi-morbidity approach. **Cholesterol** • Mapping and developing a lipid pathway across BOB. • Address service gap in Familial Hypercholesterolaemia (FH) service across BOB. **Lifestyle Changes** • Work with our colleagues on lifestyle changes for people with CVD e.g. reduce the incidence of smoking, obesity and increase physical activity. • Deliver consistent messaging working with our Partners and Colleagues around lifestyle changes by increasing the number of staff confidently utilising MECC.	• Scope for further opportunities for Community targeted interventions, working with PH partners and Voluntary Care Sectors. • Scope expansion of Health Checks for NHS staff across NHS providers, based on initial work at RBFT. • Ongoing review of outcomes from increased case finding and community-based initiatives. • Scope provision of group consultation approaches to support sustainable and effective service models. • Continue to embed personalised care, including care and support planning for the multi-morbid patient.	• Continue to develop at scale alternative approaches to identify people at risk of hypertension, through community engagement and targeted approaches. • Reduction in number of new strokes and heart attacks. • Reduction reliance on primary care to identify hypertension. • Consistent and sustainable approaches to support lifestyle change – through education, timely intervention and working with broader partnerships, Public health, community groups to influence Joint HWB strategies for example and sustainable community approaches.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Integrated Cardiac Delivery Network

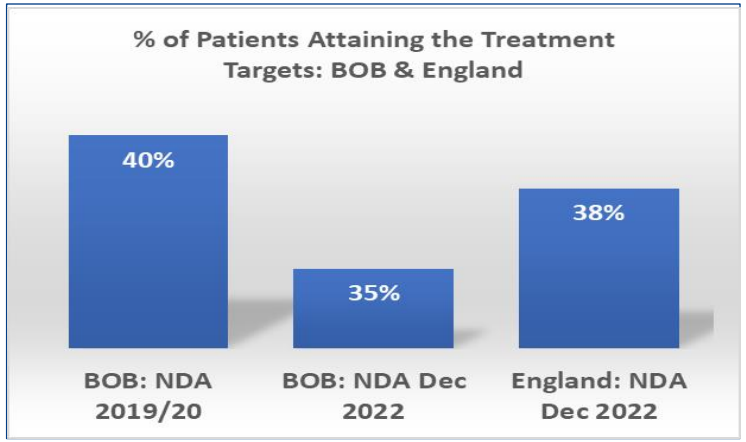
What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Heart Failure – earlier detection, diagnosis and a reduction in hospital admissions and re-admissions	• Earlier identification and more complete treatment of patients with Heart Failure in primary care, over next 2-5 years. • Reduced admissions and readmissions with Heart Failure to hospital over next 2 – 5 years.	• Review of Heart Failure pathways across BOB (identification of gaps and inequities, opportunities for improved efficiency). • Build on case finding mechanisms and additional support for primary care in optimal prescribing. • Review mechanisms for identification and prioritisation of those people most at risk from hospital admission. Data driven, focusing on area of highest impact. • Explore opportunities for virtual wards to support care closer to home.	• Pilot new integrated approaches. • Pilot virtual care and virtual ward care approaches. • Ongoing engagement with patients/carers to test and refine proposals. • Continue to embed personalised care, including care and support planning, shared decision making and Patient Initiated Follow ups as examples.	• Wider rollout of new approaches dependent upon results of pilots. Data driven, focusing on areas of highest impact.
03 Deliver enhanced Cardiac Rehabilitation	• Extended availability of cardiac rehabilitation to patients who are not currently able to access it and address gaps to ensure equitable access and address any inequalities.	• Implementation of digitally enabled approach to enhance CR service model. • Scope and identify potential options for service model across BOB, addressing gaps, inequalities, and inequities.	• Implementation of digital enabled approach as an adjunct to the CR service model. To pilot and evaluate impact. • Scope options for levelling up of service options across BOB, with robust options identified to address.	• Rollout sustainable approach to provision of cardiac rehabilitation. • Ensure sustainable increased access and uptake and improved outcomes for patients.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Integrated Diabetes Delivery Network

Context: Our challenge in BOB

- Covid19 has resulted in significant additional demand and mortality due to a combination of lifestyle factors, delayed presentation and inevitable disruption to routine care. In addition, restrictions and pressures of the pandemic resulted in a significant reduction in general practices' ability to monitor and care for people with type 2 diabetes. Across BOB, our position on the National Diabetes Audit (NDA) for attainment of the eight care processes (8CPs) in people with type 2 diabetes dropped from over 70% ICS average in 2018/19 to under 60% at the end of 2021/22. The average number of people with type 2 diabetes who have achieved all three Treatment Targets (TTTs) decreased from 40% in 2018/19 to 33% at the end of March 2022.
- BOB ICS was shown to be the lowest prescribers of Continuous Glucose Monitoring (CGM), creating an inequality of access for our patients. The successful submission of a business case approved the prescribing of CGM in primary care by FP10 (Group 1). These changes will bring the ICS in line with NICE guidance, reduce the inequality of access and improve outcomes for our patients however significant resources are needed to support general practice to implement CGM initiation and upskill healthcare professionals.
- Non-covid related excess mortality has primarily been driven by diabetes, cardiovascular disease and liver disease and the sustained period of high urgent and emergency care demand is understood to be driven primarily by respiratory disease and CVD of which diabetes is a major risk factor.
- There is a need for greater focus on identifying and supporting people with type 1 and type 2 diabetes who are not currently engaging with NHS services until they are in poor health.
- Clinical variation exists where providers have differing levels of confidence in treating patients with diabetes. There is variation in diabetes structured education delivery across the system with some areas having less access to the timely, quality education needed to enable them to manage their condition.



Our Ambition: By March 2028 we will meet the health needs of our population:

- Supporting the education and training of our healthcare professional workforce we will reduce clinical variation and health inequalities.
- Adoption of new diabetes care technologies and improved access to services will lead to fewer preventable complications and hospital admissions.
- Improved primary and secondary prevention interventions and supported personalised self-care will enable people with diabetes to manage their health so they can live the life they want to live.

To Deliver Our Ambition, We Will:

1. Reach and exceed pre-pandemic attainment of the eight diabetes care processes (8CPs) and the three treatment targets (TTTs).

2. Innovation and service development focusing on digital technologies to improve outcomes and reduce inequalities.

3. Deliver a high-quality integrated care approach, promoting self-care for primary and secondary prevention so people with diabetes experience fewer preventable complications.

What We Need For Success:

- Strong Clinical Leadership from all care sectors.
- Timely and accurate data and BI to support proof of success, monitoring and outcomes.
- Collaboration between primary, community and secondary care to ensure patients have equal access to the right education at the right time.
- Excellent project management and communication.
- Allowing patients access to the latest diabetes technologies for their long-term health and ensuring finance is not a barrier to this.
- Workforce support and modelling – targeted use of specialist skills.
- Access to the highest impact interventions and supportive resources relating to the primary and secondary prevention and management of diabetes.
- Support our colleagues with improving lifestyle changes.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Integrated Diabetes Delivery Network

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Reach and exceed pre-pandemic attainment of the eight diabetes care processes and three treatment targets for the population	• More people with diabetes (Type 1 and 2) receiving all eight care processes annually. • More people with diabetes (Types 1 and 2) achieving all 3 treatment targets. • General practice healthcare professionals utilising high quality education and a multidisciplinary team (MDT) approach to enable them to deliver excellent diabetes care, therefore reducing clinical variation and inequalities.	• Develop an enhanced service to financially incentivise general practice to: • achieve or exceed their pre-pandemic attainment of the eight care processes (8CPs) or achieve the BOB average of 68%. • Access HCP education and engage with MDTs. • Identify and tackle areas of inequality.	Through an enhanced service offer the IDDN will financially incentivise primary care to: • maintain and/or exceed their pre-pandemic attainment of the eight care processes (8CPs) or the BOB average of 68%, whichever is higher. • Achieve their pre-pandemic attainment of the number of patients who met all three treatment targets or reach the pre-pandemic BOB average of 41%.	• Continued review of effectiveness of diabetes LCS. Iterative adjustments where needed to improve outcomes. • Continue to increase attainment of the 8CPs and TTTs. • Targeted support of general practice to further address areas where inequality of access and care exists, including areas of increased deprivation.
02 Innovation and service development focusing on digital technologies to improve outcomes and reduce inequalities	• Improved glycaemic control for more people with Type 1 diabetes and eligible people with Type 2. • In line with NICE TA, increased uptake of hybrid closed loop systems for those eligible compared with national and/or regional uptake. • Reduction in hospital admissions for diabetes related emergencies and in the long term for diabetes related complications which will be informed via the ICB's diabetes dashboard.	• The IDDN will lead and support the role out of CGM prescribing in general practice with the provision of education and clear pathways. • Support HCPs to optimise medications in line with NICE Guidance. • Implementation of hybrid closed loop monitors and other NICE TAs or guidance as they emerge.	• Joint working with system partners, using business intelligence (BI) to increase uptake of CGM, ensuring equity of access for patients in areas of known inequalities. • Continue to improve access to hybrid closed loop monitors and implement NICE TA/ guidance as it emerges.	• Building on learning and improving access to diabetes technologies. • Continued interventions to support optimisation of diabetes therapies.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Integrated Diabetes Delivery Network

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
03 Deliver a high-quality integrated care approach, promoting personalised self-care for primary and secondary prevention so people with diabetes experience fewer complications	• More people identified with non-diabetic hyperglycaemia referred to lifestyle interventions. • More people to achieve remission of their type 2 diabetes by participation in the Type 2 Diabetes Path to Remission (T2DR) programme and lifestyle interventions. • Improved access to high quality type 2 diabetes structured education (DSE) delivery that meets the needs of the population. • Fewer hospital admissions for preventable complications of diabetes. • Support colleagues to improve lifestyle interventions.	• Through an enhanced service offer the ICB will financially incentivise primary care to: 1. Increase referrals to the NHS Diabetes Prevention Programme (NDPP). 2. Provide medication monitoring for patients attempting to achieve diabetes remission on the T2DR. • Service review and redesign of DSE and targeted place-based interventions that meet the needs of the population. • Work with our colleagues on lifestyle changes for people with diabetes e.g., reduce the incidence of smoking, obesity and increase physical activity.	• Continue to support uptake of T2DR and NDPP. • Continue role out of DSE service redesign. • Work with system partners to adopt a holistic approach to prevention through adoption of lifestyle interventions and supporting personalised self-care. • Focus on areas of inequality, deprivation and meeting the needs of local populations.	• Continue to support uptake of T2DR and NDPP. • Continue role out of DSE service redesign • Work with system partners to adopt a holistic approach to prevention through adoption of lifestyle interventions and supporting personalised self-care. • Continue to develop interventions at place.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

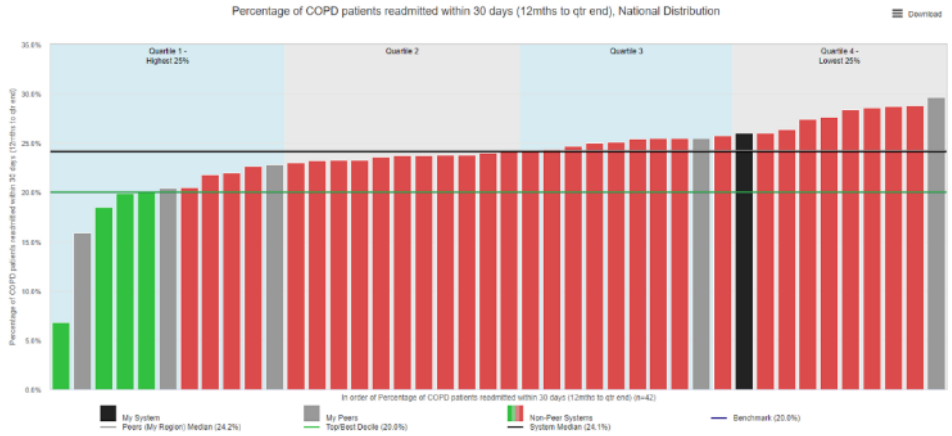
Our Context and Ambition: Integrated Respiratory Delivery Network

Context: Our challenge in BOB

- Nationally, respiratory disease affects one in five people in the UK. Lung diseases account for approx. 700k hospital admissions and over 6 million bed-days each year (BLF). Despite inclusion of lung health as a priority in the NHS Long Term Plan, outcomes continue to stagnate and there has been the impact of COVID-19.
- There are 114,312 people with Asthma (6.3% prevalence) and 24,881 people with COPD (1.3% prevalence) in BOB (QOF 2021-22). BOB prevalence is lower than the England average prevalence for both Asthma (6.5%) and COPD (1.9%).
- Respiratory outcomes across BOB are generally in line with national averages, however variation remains (Public Health Profiles).
- Respiratory admissions are a significant winter pressure, respiratory diagnostics and pulmonary rehabilitation capacity have been significantly impacted by COVID-19 and respiratory conditions are more prevalent in areas of higher inequality.
- Long Covid is a new condition requiring multi-disciplinary support.

Percentage of COPD patients readmitted within 30 days in BOB ICB compared to all other ICBs in England (Q2 2022/23).

NHS Model Health System (HES data)



Our Ambition: By March 2028 we will ensure patient-centred, integrated clinical pathways deliver high quality respiratory care that is accessible to all across BOB ICS supporting people with respiratory disease to live well for longer.

To Deliver Our Ambition, We Will:

1. Enable a population health management approach to identify and support people at most risk of respiratory disease and address health inequalities.
2. Deliver earlier diagnosis, education and care planning in the community.
3. Deliver an integrated respiratory service, enabling the right support to people closer to home.
4. Optimise medicines to improve health outcomes and reduce carbon emissions.
5. Leverage innovation and research to improve outcomes in respiratory care for the population.

What We Need For Success:

- Strong Clinical Leadership from all care sectors.
- Health actuary business intelligence and data dashboards to enable prioritisation and monitoring of outcomes.
- Digital integrated shared care records and care and support plans.
- Working closely with all our colleagues and partners that enable innovation and service delivery for LTCs for example communications, health inequalities, local authorities, public health, primary care, digital, diagnostic hubs, personalised care, medicines optimisation.
- Recruiting and retaining the required workforce in the right places. Education and training for healthcare professionals and patients.
- Commitment and resourcing of innovation and transformation to improve services and delivery patient-centred, integrated care.
- Define the responsibilities for specialist commissioning for LTCs as this is delegated to ICBs.
- Support our colleagues with improving lifestyle changes (in particular smoking cessation).

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Integrated Respiratory Delivery Network

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
01 Enable a population health management approach to identify and support people at most risk of respiratory disease and address health inequalities	• Improved COVID, Flu and Pneumonia vaccination rate for people with chronic respiratory disease. • Reduction in risk factors driving respiratory disease and acuity – smoking, lack of physical activity, cold and unsafe housing: (1) Smoking status of patients with certain conditions recorded in the last 12 months (QOF) and (2) Smoking cessation support and treatment offered to patients with certain conditions. (QOF). Analyse by COPD and Asthma patients specifically where possible.	• Implementation of digital shared care record and respiratory population health informatics dashboard. • Work with immunisation team to improve COPD uptake of vaccinations in time for winter 2023/24, with focus on areas of inequality. • Continue and embed the work on better housing for better health – incl. further promotion of the cold and unsafe homes referral pathway.	• Embed use of population health analytics and a population health management approach to respiratory disease and healthcare. • Lung Health Checks incorporated with in the Health Check programme. • Work on improved identification, prevention and mitigation with system partners – particular focus on smoking and physical activity • Work with lung screening programmes to ensure any respiratory diagnoses are followed up with support and care plan put in place.	• Maturing population health management approach is enabling the direction of resources to where they are most needed in the population and at optimal points in the pathway. Enables consistent tracking of healthcare outcomes, variation in care and identification and addressing of health inequalities. • Patients are identified and diagnosed quickly through a proactive population health management approach. • 'Lung Health Checks' recorded in IHD clinics, diabetes clinics, etc when patients are seen who have a smoking history.
02 Deliver earlier diagnosis, education and care planning in the community	• More COPD and Asthma diagnoses confirmed with appropriate diagnostic tests. Track spirometry activity in primary care and Community Diagnostic Centres (CDCs). • Monitor and increase COPD and Asthma registered prevalence: COPD 2021/22: 1.3% and Asthma 6.3% (QOF 2021/22). • Increase in percentage of COPD and Asthma patients reviewed in the last 12 months: COPD: 58.4% and Asthma: 50.1% (QOF 2021/22).	• Continuation of the BOB Spirometry SNS. • Diagnostic spirometry access restored to 100% of BOB population post-pandemic. • 14 PCNs in areas of higher inequality will have a FeNO machine with HCPs trained to do testing. • Develop and agree the BOB Breathlessness pathway and a plan for its implementation.	• Implement the BOB Breathlessness pathway. • Optimise high quality, sustainable, accessible respiratory diagnostics. • Sustainable programme of respiratory education for patients and training for healthcare professionals delivered across BOB. • Embedding personalised care and support planning for people with respiratory disease – with a focus on asthma action plans.	• Breathlessness pathway and support services go live and then become fully operational and established. • All patients are receiving proactive and personalised care, that is well coordinated around them by the BOB Integrated Respiratory Service.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Integrated Respiratory Delivery Network

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
03 Deliver an integrated respiratory service, enabling the right support to people closer to home	• Maintain rate (per 100,000) of Asthma emergency hospital admissions (19 years and over) and COPD emergency hospital admissions from 2019/20 baseline (pre-COVID). • Reduce percentage of COPD and Asthma patients readmitted to hospital within 30 days. • Monitor and optimise hospital length of stay for COPD and Asthma admissions. • Reduce Emergency Bed Days for COPD and Asthma. • Monitor respiratory referrals from primary care to secondary care outpatients (non 2WW). • Pulmonary Rehabilitation: (1) Patients with COPD with a MRC dyspnoea score >=3 in last 12 months, who have had an offer of referral to PR: 46.9% (QOF 2021/22). (2) Reduce PR waiting list: 1,623 patient waiting Q3 2022/23. (3) Aim to achieve 85% patients starting PR within 90 days of referral. • Aim for more Long Covid patients to receive initial assessment within 6 weeks and for no one to wait more than 15 weeks: 4th Dec 2022 bi-weekly reporting period 82% patients waited >15 weeks.	• Continue Pulmonary Rehab capacity expansion. • Complete the Community Respiratory Services review to inform integrated respiratory care in the community going forward. • Complete the Integrated Severe Asthma Care (ISAC) project and for the evaluation to inform severe asthma specialised commissioning and integrated respiratory care going forward. • Review Long Covid services/pathways in context of funding allocation, activity and latest commissioning guidance.	• Approval for specification and resourcing of BOB integrated respiratory care – incorporating learning from Community Respiratory Services review and ISAC project. Planning and recruiting for implementation. • Develop effective governance across provider collaborative to facilitate integrated respiratory care. • Specialised respiratory commissioning embedded into the system. • All Trusts in BOB consistently submitting to the national COPD and Asthma audits.	• BOB Integrated Respiratory Service goes live and then becomes fully operational and established. Contributes effectively to breathlessness pathway with the cardiac and diagnostic services. • Respiratory patients are well supported to maintain a good quality of life for as long as possible by the BOB Integrated Respiratory Service and other key partners in the system and their community. • Long Covid service has become business as usual with baselined funding – but is integrated with other appropriate services/pathways possibly such as Chronic Fatigue Syndrome, Breathlessness, Pain Management.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Integrated Respiratory Delivery Network

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Optimise medicines to improve health outcomes and reduce carbon emissions	Improved medication adherence and self-management by patients: • Monitoring inhaled steroid prevention (including ICS LABA) across BOB – defined as identifying the proportion of patients receiving 5 or fewer steroid inhalers including ICS LABA products (in a rolling 12 months). • Monitoring excess SABA prescribing across BOB – defined as identifying the proportion of patients prescribed preventer inhalers without antimuscarinics who were also prescribed 6 or more SABA inhalers (rolling 12-month period). Reduction in carbon emissions from respiratory medicine prescriptions: • Monitoring MDIs prescribed as a proportion of all inhalers, excluding salbutamol. • Monitoring mean carbon impact (kg CO2e) per salbutamol inhaler prescribed.	• Agreement of BOB wide COPD prescribing guidance as first priority • Review expected NICE Asthma guidance when published near end of 2023.	• Continued focus on low carbon, cost effective devices where possible and build into updated local guidance. • Ensure consistent respiratory medication and prescribing guidelines across BOB.	• Continued focus on low carbon, cost effective devices where possible and build into updated local guidance. • Ensure consistent respiratory medication and prescribing guidelines across BOB.
05 Leverage innovation and research to improve outcomes in respiratory care for the population	• BOB ICS will aim to support two respiratory innovation projects per year approved via the IRDN.	• Innovation Review Panels commence, reviewing first potential innovation projects. • Work with academic researchers in the system working on early identification and diagnosis projects for COPD and asthma.	• Innovation Review Panels embedding, and two innovation projects tested.	• Innovation and research developments are routinely tested and cycled into improving respiratory care in BOB.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

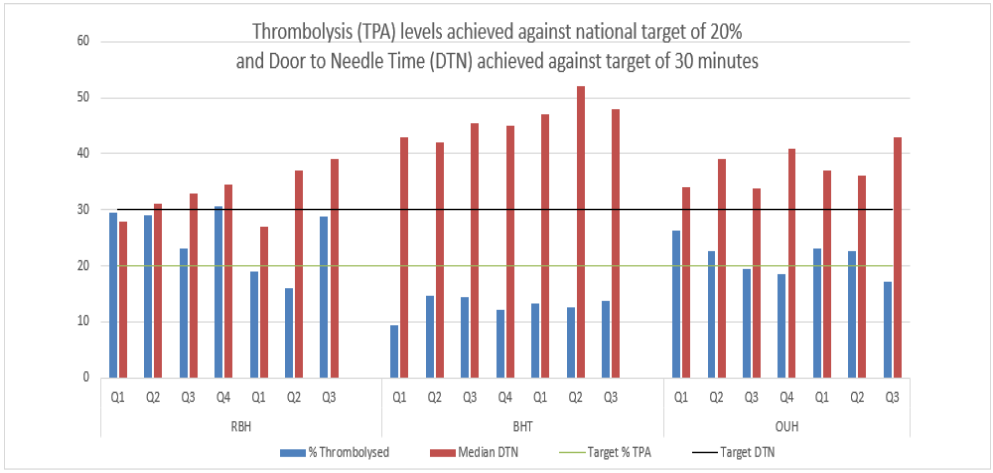
Our Context and Ambition: Integrated Stroke Delivery Network

Context: Our challenge in BOB

- Nationally, the incidence rate of strokes in the most deprived quintile is roughly double that of the least deprived quintile.
- A reduction in AF detection and hypertension/lipid management during the pandemic could have a significant clinical impact if not addressed, with an estimated 441 additional strokes occurring in BOB over the next three-year period.
- Stroke priorities are guided by the National Stroke Service Model, the National Service Model for an Integrated Community Stroke Service (ICSS) and GIRFT for Stroke.
- Mechanical Thrombectomy (MT) is currently commissioned by Specialised Commissioning but is likely to become the responsibility of BOB ICB in coming years.
- Overall BOB performance compares well to national stroke data, but we have significant variation in some key performance indicators such as admission to a stroke unit within 4 hours and 6-month assessments
- There is good collaborative working across the BOB system, including Public Health and VCSE.

Challenges:

- Workforce is an issue across both the acute and community sectors.
- Transformation funding is short-term – longer term funding is required to sustain improvements.



Our Ambition: By March 2028, we will bring key stakeholders together to facilitate a collaborative approach to service improvement of the whole stroke pathway, including prevention, ensuring a patient centred, evidence-based approach to delivering transformational change. The BOB ISDN will develop and agree a work plan which is informed by national, regional and local priorities, supporting, monitoring and maintaining consistent, high quality stroke care across the BOB ICS.

To Deliver Our Ambition, We Will:

1. Ensure we have consistent pathways of care for stroke.

2. Maximise stroke prevention opportunities (Focusing on AF, hypertension and lipid management working in collaboration with the Integrated Cardiac Delivery Network).

3. Reduce variation in access to stroke rehabilitation services.

What We Need For Success:

- Strong Clinical Leadership from all care sectors.
- Longer term funding to sustain improvements.
- Continued collaboration with key stakeholders, particularly Primary Care, Public Health, Oxford AHSN and SCAS.
- Improved patient flow in hospitals and to enable admission of stroke patients and to be transferred to rehab units when required.
- Access to timely data about detection rates for Atrial Fibrillation (AF). Development of an overall stroke dashboard to provide easy access to performance data.
- All rehabilitation teams actively participating in research and learning from other Stroke Networks nationally.
- Support our colleagues with improving lifestyle changes.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Integrated Stroke Delivery Network

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
01 Ensure we have consistent pathways of care for stroke	• Improve access to thrombolysis and MT. • Offer 24/7 MT service in Oxfordshire with support from London. • Fewer stroke mimic admissions.	• Improve achievement of targets. • Agree MT support from London OOH. • Monitor LOS for stroke across BOB. • Deliver pre-hospital video triage project.	• Improve achievement of targets. • Provide 24/7MT service in Oxford. • Take on Spec comm for MT.	• Achieve and sustain national targets.
02 Maximise stroke prevention opportunities	• Reduction in the number of strokes across BOB. • Improved management of hypertension with greater proportion of people with controlled BP. • Improve lipid management coordinating with both primary and secondary care as well as Public Health with a greater proportion of patients with previous CV event achieving non-HDL target <2.5 mmol/l. • Support the improvement of lifestyle changes.	• Improve AF detection rates through education event and working with primary care. • Extend health check project for staff at RBH to include an AF. • Work with Stroke Association on roll out of 6-month reviews and stroke recovery services in Oxfordshire as both services include future stroke prevention for stroke survivors. • Support education re lipid management in primary and secondary care. • Work with our colleagues on lifestyle changes for people with CVD e.g., reduce the incidence of smoking, obesity and increase physical activity.	• Work with stroke services to improve sign posting to smoking cessation services. • Scope for further opportunities for community targeted interventions, working with PH partners and Voluntary Care Sectors. • Scope expansion of Health Checks for NHS staff across NHS providers, based on initial work at RBH. • Support secondary prevention of stroke with increased uptake of 6-month reviews across BOB.	• Continue to develop at scale alternative approaches to identify people at risk of hypertension, through community engagement and targeted approaches. • Reduction in number of new strokes. • Consistent and sustainable approaches to support lifestyle change- through education, timely intervention and working with broader partnerships, Public health, community groups etc.
03 Reduce variation in access to stroke rehabilitation services	• Ensure access to rehab services is available to all stroke patients regardless of where they live in BOB.	• Deliver Oxfordshire 6-month review and Bucks psychology projects and sustain funding. • Complete detailed review of existing community rehab pathway provision. • Formulate priorities to align with national ICSS model. • Complete project plan for priorities.	• Support move towards 7 day working with increased number of assessments and discharges at weekends. • Support move towards needs based rehab services with an increased number of service specs reflecting needs-based access rather than time -based constraints. • Support services across BOB to increase uptake of 6-month review process.	• Evaluation of vocational rehab provisions to develop pathway to ensure equitable access across BOB. • Continue supporting teams to achieve 7 day working and needs led delivery as per ICSS model. • Improved integration with Social Care and reablement services. • Integrated model for community rehab services.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

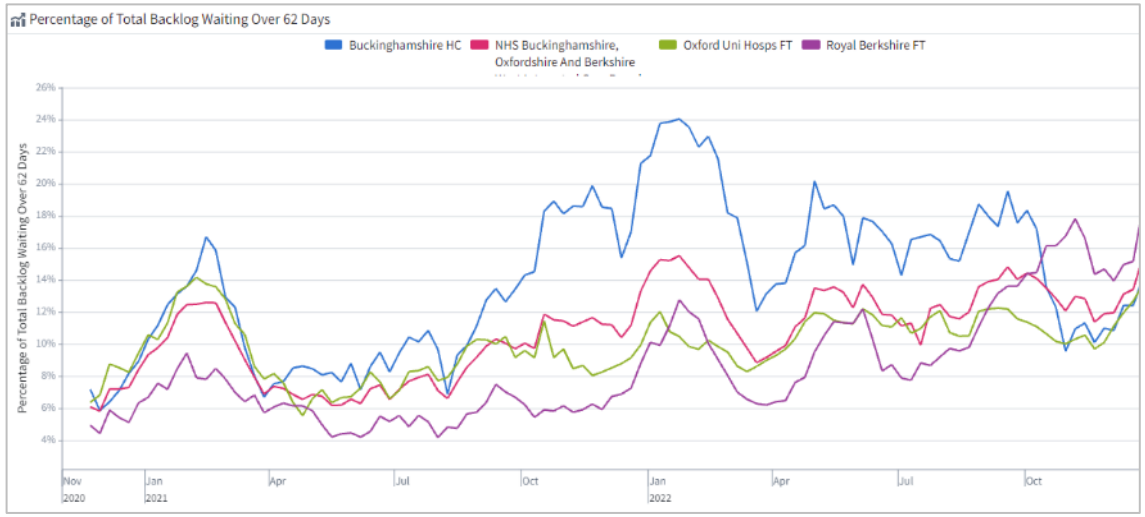
Our Context and Ambition: Cancer Services

Context: Our challenge in BOB

The overall NHS National Cancer Programme ambition is to save thousands more lives each year by dramatically improving how we diagnose and treat cancer – our ambition is that by 2028, an extra 55,000 people each year will survive for five years or more following their cancer diagnosis.
Cancer Services in BOB fall under the remit of Thames Valley Cancer Alliance, which includes BOB as well as Great Western Hospital in Swindon.

Most recent Cancer Waiting Times from January 2023 across BOB show a sustained increase in number of cancer referrals overall with 6379 patient being seen on a suspected cancer pathway. The current standards show BOB performance at 69.4% for the 28 day faster diagnosis standard against a target of 75%, a 31 day first treatment performance standard of 81.3% against a target of 94% and a 62 day urgent referral to first treatment performance of 59.9% against a target of 85%:

The increase in referrals has been met with an increase in the number of first overall cancer treatments, but not at the same rate and therefore the backlog across BOB has grown, although the system has been working to address this. The latest data from March 23 suggests that the number of patients still on a cancer PTL post 62 days as a percentage of the overall waiting list in BOB is 9.2% against an ideal of 6.4%



Our Ambition: Reduction of the cancer backlog and consistent delivery of the Faster Diagnosis Standard by March 2024. Sustainably meet all Cancer Waiting Times by March 2028, and achieve the National Cancer Ambition of diagnosing 75% of cancers at Stage I & II

To Deliver Our Ambition, We Will:

01	Delivery of Sustainable operational performance across the system	02	Delivery of the 28 day Faster Diagnosis standards	03	Achieve the Early Diagnosis standard
04	Increase the Early Diagnosis Rates	05	Improve the quality of treatment and care	06	Implementation of the Teenage and Young Adult Cancer Care Service Specification
07	Patient Engagement, Involvement and Experience	08	Support, Training & Education for medical, nursing, allied health professionals and admin staff in cancer services and primary care		

What We Need For Success:

- Clear, up to date data through the TVCA dashboard in conjunction with Trust and Primary Care data teams
- A sustainable cancer workforce working in collaboration across the system
- Clinical Advisory Groups for each tumour site with representation from all organisations across the system
- Patient participation on all workstreams to allow for co-production
- Embedding of the Health Inequalities agenda into all workstreams

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Strategy – TVCA Cancer Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
01 Delivery of sustainable operational performance across the system	• Improve cancer performance by supporting Trusts to: 1. Reduce long waits. 2. Meet Cancer Waiting Times standards. 3. Embed key pathway improvements. 4. Deliver improved data oversight. 5. One version of system capacity by single system PTL.	• Achievement of the Faster Diagnosis Standard across TVCA and all Trusts to have a submitted backlog position which is met for March 2024. 1. ensure appropriate diagnostic and treatment capacity available. 2. specific TVCA programmes will be embedded to contribute to backlog reduction (e.g., Best Practice Timed Pathways /FIT work / Teledermatology/ Timely referrals). • Mutual Aid across BOB ICS and TVCA will be facilitated via ICS pathways to reduce waiting times and support patients. This process will be refreshed. • Staff will be trained to support improvements to pathway management across the whole pathway including both tracking and MDT coordinators. Training will support improved knowledge of the updated CWT V11.1. • Monitoring and assurance will be carried out via TVCA and Trust forums. • Improvements in automation and depth of data collection will support trust and TVCA dashboards – Providing ability for timely intervention within pathways to improve CWT's.	• Formal evaluation of year one progress with a view to adapting and improving the operational performance – specifically reducing the backlog. • Project future growth on the pathways in order to maintain the required diagnostic and treatment capacity. • Continue to adapt the existing programmes to ensure successful delivery of improvements. • Annual review of pathways to ensure improvements made are sustainable and where required review further improvement requirements. • Implement a TVCA wide PTL to support oversight of capacity and activity to drive achievement of CWT via system level working/capacity utilisation.	• Achievement of all Cancer Waiting Time Standards on a sustainable basis. • Actions required will depend on progress across years one and two and will include consistent review of demand and capacity across the system.

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Our Strategy – TVCA Cancer Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
02 Delivery of the 28-day Faster Diagnosis standards	Compliance with the 28-day faster diagnosis standard through 2 main routes: • Best Practice Times Pathways – the majority of patients from the indicative tumour sites should follow these pathways. • Non-site specific pathways (NSS) – improved usage and uptake in the number of referrals.	To deliver the 28-day standard we will: Consistently implement best practice pathways across our Trusts, monitored through TVCA Quarterly Assurance: • Four locally identified pathways – prostate, lower GI, skin and breast. • The nationally commissioned pathways. • There also pathways for head and neck and gynae cancer which are also being implemented but lie outside of national cancer team 23/24 planning. Improve all NSS pathways (currently live in all trusts): • referral numbers are different in the different Trusts. Work this year will include a workshop for Trusts and an audit of all live pathways in April 23. • Engagement with primary care to ensure understanding and awareness of the pathways. • Update pathways to include ability to redirect from emergency care and standard 2ww pathways.	Best Practice Pathways: • Transition all pathways to 'business as usual' within trusts. • Trusts will be monitored to ensure compliance with regular reporting. Non-site specific pathways: • Expected to move to business as usual. • Joint working with commissioners to ensure sustainable funding is in place. • GRAIL project go live in 24/25 (see later), this will increase referrals on this pathway. • Ensure appropriate capacity is available to facilitate this.	• Continued monitoring of Cancer Waiting Times standards with interventions as required.

Our Strategy – TVCA Cancer Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
03 Achieve the Early Diagnosis Standard	Improve access and timely presentations to cancer diagnosis services in order to diagnose 75% of cancers at stage I&II by 2028. Currently 57.8% of cancers were diagnosed at stages 1&2 and 42.3% at stages 3&4. • increased screening uptake. • increased appropriate 2ww referrals. • supporting the health inequalities agenda. • Increasing public awareness of cancer symptoms. Primary Care pathways: • Delivery of the PCN DES requirement to remove variability across the system by putting in place a more standardised and better understood offer for patients. • Improved quality of referrals to ensure the correct patient is referred at the correct time to the correct place. • Specifically by reviewing and monitoring activity in LGI, NSSP and Dermatology pathways. • GP Direct Access to cancer pathways to speed up referrals.	• Work with Public Health and other key stakeholders to increase screening rates: 1. The use of Ardens searches to target direct contact with people with protected characteristics. 2. Encourage the use of practice endorsed letters for non-responders. 3. Provide and encourage the use of text/AccuRx messaging. 4. Increase awareness of cancer symptoms and signs through local and national initiatives incl. 'Help Us Help You' campaigns. • Work with populations identified using Core20plus5 in the Cancer Allies programme to improve overall access including collaboration with the BOB inequalities team. • Ensure PCN DES and QOF contractual requirements for 23/24 are completed. • Review the referral practice across the TVCA footprint against the NG12 guidelines to decrease the number of inappropriate referrals. • Follow BSG/NICE guidance using FIT in LGI cancer referrals. • Ensure all practices are using Clinical Decision Tools consistently across the TVCA footprint. • Review existing direct access pathway. Create further direct access opportunities for specific pathways. Confirm guidelines including strong governance and capacity across the system.	• Continue to support delivery of cancer awareness, including 'Help Us Help You' Campaigns. • Build on success and increasing our reach with our Cancer Allies programme. • Refine the metrics and understanding of health inequalities across the system to improve targeting of messages. • Monitoring stage of cancer diagnosis and ability to achieve the stated early diagnosis aim. • Review of progress and support requirements for implementation of future PCN DES and QOF requirements. • Assessment of quality of referrals across all pathways and reflection of learning from the LGI, NSS and dermatology pathways. • Link with local, regional and national teams to assess outcome of GP direct access implementation including appropriateness of referrals and capacity required across the system.	• Continued cancer awareness and Help Us Help You campaigns and work on the health inequalities agenda. • Monitoring against the stated aim of diagnosing 75% of cancers at stage I&II.

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Our Strategy – TVCA Cancer Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
04 Increase early Diagnosis rates	• Increase numbers of patients diagnosed at stage I&II to 75% by 2028.	• Community Pharmacy pilot project – National pilot to allow community pharmacists to make suspected cancer referral (Improve health inequalities and access to primary care) – 2 tumour sites initially – lower GI and Lung. • Targeted Lung Health Checks (case finding for lung cancer) – roll out to at 2 locations in BOB. Target specific patient groups to diagnose lung cancer at an earlier, treatable stage aiming for 50% population coverage. • Colon Capsule Endoscopy – improve access and reduce waiting time (lower GI pathway). Roll out beyond current single TVCA location to BOB. • Increase Lynch Syndrome testing on the colorectal and endometrial pathways – Create and roll out clinical pathway. • Roll out GRAIL project (subject to successful reporting from the NHS-Galleri trial expected March 2024 – Prepare the infrastructure for roll out of the test (led by the national cancer team – expected Q3).	• Evaluate and learn from pilot both locally and nationally. Roll out to other sites if successful. • Roll out of this pathway to all appropriate BOB sites and utilisation of place-based capital funding to support. • Embed as an alternative to colonoscopy across the system • Extend clinical pathway to provide care and advice for family members. • Roll out of GRAIL test with monitoring of outcomes.	• Roll out of this pathway to all appropriate BOB sites to achieve 100% population coverage. • Monitoring of compliance and transition to BAU. • Roll out of GRAIL test with monitoring of outcomes.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Strategy – TVCA Cancer Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
05 Improve the quality of treatment and care	• Reduce the level of treatment variation across cancer treatment. • Personalised Care – deliver the personalised care agenda for cancer. • Personalised Care with an emphasis on children, teenage and young adult survivors of cancer.	• Focus on the outcome of the Lung Cancer GIRFT project – Each system choosing 3 metrics to concentrate on. • Focus on one metric each from the breast, prostate and bowel audits. • TVCA will work with the CAGs and the Trust GIRFT and audit leads. • Ensure that all patients on targeted pathways (prostate, colorectal, breast, endometrial) have personalised care interventions (HNA, Personalised Care and Support Planning, End of Treatment Summary and Cancer Care Review). • Scope project to identify the obstacles and gaps in delivering this service. • Co-develop (staff and service users) and implement an action plan to deliver service improvements.	• Support, resource and embed any changes. • Roll out to other sites. • Priorities and recommendations from the national team to be reviewed annually. • PSFU to become BAU across Trusts with continued delivery of personalised care and support planning to meet the needs of the patient population whilst addressing and health inequalities. Required appropriate workforce in primary and secondary care to facilitate. • Develop a plan for late effects follow up, work with ICS to commission appropriate services.	• Support, resource and embed any changes. • Roll out to other sites. • Priorities and recommendations from the national team to be reviewed annually. • Embed all changes as BAU. • Monitor and evaluate impact of the projects with all TVCA Trusts. • Review with service users any further opportunities for improvements. • All Trusts to have access.

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Our Strategy – TVCA Cancer Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
06 Implementation of the Teenage and Young Adult Cancer Service Specification	• These Cancer Services are used by teenagers and young people aged between 16-24. • The service should provide all cancer chemotherapy and radiotherapy, specialist palliative care services, survivorship, long term follow-up and specialist therapies and rehabilitation. • A new service spec was published in November 2021 which details specifications for a principal treatment centre as well as shared care policies for the network. • Requires combined working with Providers, ICB, TVCA and the TYA ODN.	• Establish a task force funded by TVCA to baseline current services and complete a gap analysis against the new service specification. • Agree as a Cancer Alliance and ICB a roadmap of how the service specification should be delivered. • Identify what funding will be required to deliver all aspects of the service specification and explore avenues of sourcing funding. • Begin implementation of the areas identified in the gap analysis.	• Have clear pathways and protocols in place across the network including details on shared care and appropriate COSD data collection.	• By the end of year 5, to have full implementation of the service specification including full development of a designated Principal Treatment Centre.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Strategy – TVCA Cancer Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
07 Patient Engagement, Involvement and Experience	• Increased diversity on our Patient Partnership Group (PPG), to ensure that the patient voice is represented inclusively, within the Thames Valley population, across all protected characteristics and minority groups. • Increase of service user representatives, as a pooled resource for supporting our Clinical Advisory Groups (CAGs) and other project work across the Alliance. • Better experience of care.	• Increasing engagement with local stakeholders, BOB VCSE Health Alliance and other charitable partners, to promote involvement/recruitment of service users. • Host a public & stakeholder engagement event, to promote diversity inclusion within the Alliance and our aims for addressing health inequalities. • Regular comms activities across all social media platforms (including campaigns within the cancer allies programme) to promote patient involvement/drive recruitment. • Systems will be encouraged to review patient experience data and collaboratively support quality improvements, across Primary & Secondary care settings. This will include analysis of the Under 16s survey results, the National Cancer Patient Experience Survey (NCPES) results, as well as other Trust insight.	• Building upon the previous year's activities collaborate to bring our patient groups together when required (ICB & TVCA with BOB Trusts). • Align work with national transformation guidance using quality improvement projects to improve experience of care in primary and secondary care including patient voice.	• Ensuring we have intersectional representation (including those from underrepresented/seldom heard communities) actively contributing within specific workstreams – i.e,. focus group discussions to align with national priorities. • Monitor experience of care within all workstream projects.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Strategy – TVCA Cancer Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan - How We Will Do It		
		Year One	Year Two	Years Three- Five
08 Support, Training & Education for medical, nursing, allied health professionals and administrative staff in cancer services and primary care	• Skilled and competent workforce. • Valued workforce. • Improved patient experience. • Improved staff retention and job satisfaction.	• Scope workforce requirements for FD and BPTP programmes considering review of complete tumour specific pathway with consideration of alternate roles to support service delivery. • Support HEE with Trusts engaging in Diagnostic workforce training plans e.g., endoscopy, screening. • Work with GMSA for delivery of Genomics training particularly for Lynch Services. • Support SACT & Cancer CNS to access further cancer specific. training utilising HEE funding e.g., SACT training, tumour specific training, Master's modules for advanced practice supporting ACCEND framework. • Scope and share opportunities for Coaching/Mentoring, Leadership & Management training for aspiring nursing and AHPs (ACCEND). • Implement ACCEND framework for all cancer nursing and AHP staff in TVCA. • SACT Nurse retention project – reviewing the requirements of SACT nurses to improve retention. • Commission communication skills – advanced, intermediate and refresher courses for all clinical staff. • Commission Compassion Fatigue training for cancer staff supporting staff in resilience and feeling valued. • Cancer awareness training for Cancer Support Workers, Patient Navigators, MDT Co-ordinators and CNS. L2 Improving patient experience in Health and Social Care for administrative staff in cancer services. • Monthly lunch and learn training sessions for primary and secondary care to support early diagnosis, faster diagnosis and personalised care. • Deliver ARRS Cancer Services Training in primary care. • Further develop Communities and Practice/Networks. for AHPs, ACP & AOS staff, and nurses working to promote personalised care and extend to cancer support workers, MDTCs, pathway navigators. • Scope and deliver ethical international oncology recruitment – consultants and specialty doctors TVCA wide as requested by all secondary care Trusts.	• Workplan to align with national priorities as per NHS workforce plan and Operational guidance with focus on supporting alternative roles to support delivery of cancer services. • Work with GMSA for delivery of Genomics training for tumour sites aligning with national delivery plan. • Support continued HEE funded training for cancer diagnostic workforce, nursing & AHPs. • Continue with the delivery of ethical international recruitment for Oncologists and specialty doctors.	• Workplan to align with national priorities as per NHS workforce plan and Operational guidance with focus on supporting alternative roles to support delivery of cancer services. • Work with GMSA for delivery of Genomics training for tumour sites aligning with national delivery plan. • Support continued HEE funded training for cancer diagnostic workforce, nursing & AHPs.

Buckinghamshire, Oxfordshire and Berkshire West
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4. Age Well

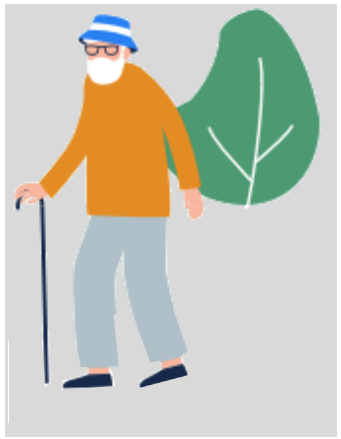
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan: Age Well

Staying healthy and independent for longer

Aging Well in BOB

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



Supporting older people to remain healthy

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

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

Our focus areas

1 Age Well Services

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Delivering Our Strategy – Age Well

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

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Age Well Services

Context: Our challenge in BOB

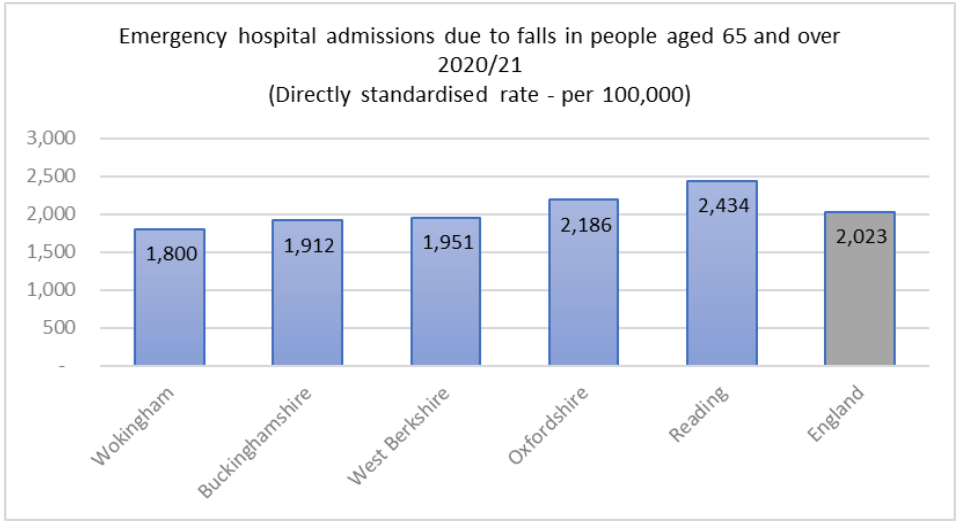
- Ageing in this context relates to the experience of ageing in the overall life course with its physical and mental health impacts upon people's health and wellbeing, and not simply based on a particular chronological age. The ageing process has a direct impact on a person's ability to remain resilient and independent in their own community. Not everyone relevant for Age Well initiatives will be old, but most will be older.
- A strong indicator for the population relevant to Age Well are those coming to the end of their healthy life expectancy (HLE) – the number of years of their life someone is expected to live in good health. In England, for people in the most deprived areas this HLE is 52.3 years for males and 51.4 years for females, compared to life expectancies of 74.1 years (males) and 78.7 years (females), whereas for those in the least deprived areas HLE is 70.7 years for males and 71.2 years for females compared to life expectancies of 83.5 years (males) and 86.4 years (females). Approximately a quarter of the BOB population are aged over 60 and this is projected to grow by 11% over the next five years. However, we will need to plan for Age Well pathways and services to provide care and support for some people aged 50 and over, particularly in our more deprived areas.
- The aims of BOB health and care services delivering on our Age Well ambition are to:

a) Extend the healthy life period for those who are ageing for as long as possible to remain fit and well in their own communities

b) Provide multi-disciplinary and cross-organisational support in a compassionate, effective and person-centred way when they become frail and their health conditions multiple and/or complex, in order to maintain their health and wellbeing as best as possible. This will include prevention of and recovery from acute episodes of illness, including ambulatory care sensitive conditions (ACSC).

c) Supporting unpaid carers to maintain their own health and wellbeing and their ability to care for their friends and relatives.

- To achieve these aims will require NHS, Local Authority and Voluntary Community and Social Enterprise sector (VCSE) partners working effectively together to deliver efficient, integrated and multi-disciplinary services to support our population as they age. A personalised care and support planning approach enabled by digital technology will be a key enabler to proactive and effective care and cross-organisational working. Compassionate and effective planning, care and support is required at the end of life and this is set out in the Palliative and End of Life section of this document.



Our Ambition: By March 2028, we will be:

- supporting more people to remain healthy and independent for longer
- providing proactive, personalised and coordinated care for more people who are becoming frail and their health conditions more complex
- supporting more unpaid carers

To Deliver Our Ambition, We Will:

1. Support people to remain healthy, independent, and connected within their communities.
2. Offer proactive personalised care planning and identify early those who are likely to develop more complex needs and become frail.
3. Provide multi-disciplinary integrated care involving health care, social care and VCSE for people as their conditions become more complex and they become frail. Care is coordinated and delivered in the right place at the right time.
4. Provide rapid reablement and recovery support for people who have become acutely unwell to enable them to return home quickly and safely from hospital.
5. Identify and support unpaid carers to maintain their own health and wellbeing and their ability to care for their friends and relatives. Inform and empower patients and carers in relation to services and pathways across the system.

What We Need For Success:

- Cross-system and Place-based governance arrangements to enable leadership, focus and coordination to achieve Age Well aims and ambition
- Workforce trained in recognising stages of the Age Well pathway and an ability to optimise health and resilience of the person appropriately
- Develop MDT working across systems to enable integrated care and for the person to remain in their usual place of residence and avoid preventable admissions
- A shared electronic care record to allow read/write access to individualised care plans by care professionals and to drive a data dashboard.
- Identify those in the different stages or the Age Well course using data stored in health and social care.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Age Well Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Support people to remain healthy, independent, and connected within their communities.	• Increase in older people who are physically active. • Reduction in older people who feel lonely/isolated. • Decrease inequality relating to physically active older people. • Decrease inequality relating to loneliness and isolation of older people.	• Review VCSE funding and service arrangements across BOB to enable consistency and resilience. • Develop an approach for systematically identifying isolation / loneliness in our populations – working with PCNs, Local authorities, urgent care teams, community teams and VCSE, sharing learning from COVID. • Promote and support the five steps to mental wellbeing to older people: connect with other people, be physically active, learn new skills, give to others and pay attention to the present moment (mindfulness). • Primary care social prescribers and health coaches, personalised care team and community services work with social care and the voluntary community social enterprise (VCSE) sector to develop a plan to enhance social connection and physical activity opportunities for older people. • Identify and address barriers to people taking up social and physical activities such as mobility and transport issues. • Communication and engagement with healthcare staff to build awareness of the need to reduce loneliness and increase physical activity and of the opportunities in the local community for activities, social engagement and physical activity. • Public health campaign about frailty and planning for later life.	• Implement the developed approach for identifying and tackling loneliness/isolation across the system. • Maintain the commitment to training BOB health and social care staff in the Active Medicine programme to support older people understand the benefits of physical activity and to become more physically active. • Identify older people who are malnourished in the community and ensure they receive the necessary support to achieve a balanced and healthy diet. • Exploration and assessment of assistive technology and telecare to help people remain healthy and independent at home – virtual care technologies.	• Healthcare staff in the community are consistently aware of the community, social engagement, physical activity opportunities relevant to their patients and are including this in personalised care planning. All partners are working together across health, social care and VCSE to reduce loneliness and improve social engagement and physical activity. • Confirmation and deployment of appropriate assistive virtual care technologies to help people remain healthy and independent at home. • Development of rollout of an education programme for patients to use the virtual care technologies alongside the deployment of the technologies.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Age Well Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Offer proactive personalised care planning and identify early those who are likely to develop more complex needs and become frail.	• People are educated, informed and empowered to enable self-care and better manage their long-term condition and improve their wellbeing. • Improved identification of people who have multiple long-term conditions, are frail and are approaching end of life. Registered on primary care systems that link to an integrated care record. Linked to LTC and Palliative and EOL sections of JFP. • Personalised care and support plans are in place, reviewed and updated for all older people with physical and mental health long-term conditions. Care plans are accessible to all health and social care professionals needing to access them to enable effective and coordinated care. Clinical Frailty Scoring is embedded and recorded.	• Early identification and diagnosis of long-term conditions and mental health issues, leading to timely care planning, education and support in the community to give patients, families and carers the best chance of managing health conditions effectively. • Personalised care and support planning is training for health and care staff for all stages of an individual's life course which is comprehensive across health and social care including mental health. This should include shared decision-making to enable informed and empowering conversation with patients and carers. • Move to a consistent approach to risk stratifying our populations and taking more opportunities to deliver pre-emptive support, including personalised car planning, effective community therapy and rehabilitation. • Implement consistent use of the Clinical Frailty Score (Rockwood) across the BOB healthcare providers. Frailty score to be recorded in the patient's care record. • Develop effective approaches for planning and supporting people with multiple long-term conditions.	• Raising all models of Continuing Health Care assessment and delivery to the best standards across BOB so that citizens have prompt consistent assessments to allow them to develop their own personalised care pathway. • Personalised care and support planning is happening consistently at all stages of an individual's life course across health and social care. This should include shared decision-making to enable informed and empowering conversation with patients and carers. • Appropriate engagement of Voluntary and Community Sector (VCSE) across BOB to deliver aspects of the person's personalised care plan which may involve community connectors/ social prescribing. • Linked to workstream 3 implement effective MDT planning and support for people with multiple long-term conditions. • Consistent polypharmacy review of all patients becoming frailer and more complex to ensure medicines regime remains appropriate. This should include a shared decision-making approach and conversation with the patient.	• Embedded and reviewed model of care for people with multiple long-term conditions that is proactive, personalised and coordinated. Linked to workstream 3. • Personalised care and support planning is embedded and happening consistently at all stages of an individual's life course across health and social care. This should include shared decision-making to enable informed and empowering conversation with patients and carers. • Personalised care and support plans are recorded in the patient's integrated shared record available and editable across all health and social care staff/organisations involved in their care. It includes Clinical Frailty Score and polypharmacy review.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Age Well Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Provide multi-disciplinary integrated care involving health care, social care and VCSE for people as their conditions become more complex and they become frail. Care is coordinated and delivered in the right place at the right time.	• Population health management and MDT working in the context of a significant long term condition population and increasing multi-morbidity, will optimise healthcare resources and improve workforce satisfaction. • Better control and management of people's long-term conditions will result in reduced complications and people remaining well for longer. This will lead to a reduction in healthcare utilisation and unplanned care. Example outcomes could include: • Reduction in emergency admissions of people aged 65+. • Reduction in falls. • Reduction in emergency admissions for people with long term conditions. • Reduction in heart attacks and strokes. • Reduction in diabetic foot amputations. • Improved mental health of people with long-term conditions. • Improved morbidity and mortality of people with long-term conditions. • More people supported to remain in the community through UCR, virtual wards, virtual care and multi-disciplinary health and social care teams (link to UEC plan).	• Review best practice across Places in BOB. Share best practice across providers, form MDTs and develop the use of the virtual ward approach to make sure integrated and pre-emptive care can be delivered where possible, particularly for the most complex patients. This should inform the development of community-based MDT model of care. • Develop cross-system and Place-based governance arrangements to enable leadership, focus and coordination to achieve Age Well aims and ambition. • Develop a plan for effective use of the Better Care Fund (BCF) to support service developments. • Development of MDT models to consider different types of MDT to be required at particular stage of the patient's life course and complexity/acuity of their condition. • Trusted Assessor role incorporated into workforce development and MDT working. • Awareness of the increased likelihood of mental health issues in those with long term conditions and engagement with local IAPT services for these patients. • Integrated and personalised care in the community as a priority for people with dementia. This will require working across health and social care, and the voluntary and community sector.	• Governance arrangements to enable leadership, focus and coordination to achieve Age Well aims and ambition are embedded. • Integrate community and secondary care so that the patient is not aware of boundaries of care. • Full development of community services including primary care to deliver most care near the patient's home. This should be informed by the development of the MDT model of care for Age Well that addresses complexity, frailty and multiple long-term conditions. Trusted Assessor workforce model incorporated within MDT working. • Focus on person remaining at their usual place of residence where possible, as long as appropriate care can be delivered there and if displaced to another setting the aim should be that they are discharged home as a matter of priority acknowledging the therapeutic benefits of home settings, particularly to aid recovery and reduce confusion. • Development of fully operational patient shared care record available across health and social care providers that is reviewable and editable by all. • Optimise in-reach support into care homes.	• Integrated MDT model of care in the community for Age Well that addresses complexity, frailty and multiple long-term conditions is embedded, reviewed and refined to enable optimal coordinated care. This includes development of different appropriate MDTs for the different stages of complexity and acuity, linking with virtual wards. Trusted Assessor MD working is embedded. • Patient shared record is fully operational and embedded within MDT working. • Places are informing and adjusting delivery and targeting the MDT model as required to address health inequalities.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Age Well Services

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Provide rapid reablement and recovery support for people who have become acutely unwell to enable them to return home quickly and safely from hospital	• Reduction in delayed discharges from hospital. • Reduction in re-admissions within 30 days to hospital	• .Review of reablement and rehabilitation services across BOB to ensure service models and capacity are optimised and consistent, with consideration of Place based needs as well as BOB system. • Benchmark provision in BOB against best practice regionally and nationally. • Develop an improvement plan for reablement and rehabilitation services as required determined by the outcome of the review. • Engage with national work scoping the need for upskilling of community staff to support patient flow between hospital and community.	• Implement the improvement plan for reablement and rehabilitation services. • Scope and introduce new roles, for example advanced practitioner in frailty, allied health professional roles in primary care. • Commission and support BOB wide training informed by the national upskilling scoping project. • Develop outcomes focussed data modelling system to inform longer-term monitoring.	• Service model embedded with appropriate workforce in each Place in BOB with robust links across BOB and overarching system-wide service principles and metrics. • Monitor reablement and rehabilitation services performance and continuously improve.
05 Identify and support unpaid carers to maintain their own health and wellbeing and their ability to care for their friends and relatives. Inform and empower patients and carers in relation to services and pathways across the system.	• Improved health and wellbeing of carers. • Improved experience for citizens and staff alike such that care is seamless and consistent. This will include a focus on better access to support in a crisis. • Improved patient and carer satisfaction with care, support, coordination and personalisation. • Improvement in patients and carers seeing the right person at the right time, thereby improving efficiency and effectiveness to improve capacity.	• Cross-system review of carer support and respite care. • Health and social care services/pathways are clearly understandable and communicated effectively to staff, patients, families and carers. This will include ensuring information is easily available and accessible, in both digital and non-digital forms considering a significant number of carers are digitally excluded. • Many older carers do not self-identify and register as carers, which limits access to support such as attendance allowance. Programme of communication and awareness raising combined with training for the workforce to aid in identification of carers and their registration to enable access to the full range of support and entitlements. • Share understanding on the challenges older people face accessing care, working with our populations understanding where digital abilities are limited, and access can be made easier.	• Carers will be systematically identified, and a register of carers maintained. Carers assessments need to reviewed and updated annually, with support needs identified. • NHS and Local Authorities develop and agree a consistent offer of support to unpaid carers, working across BOB geographies, linked with existing BOB programmes. This will include the provision of a consistent offer of respite care.	• NHS and Local Authorities implement agreed consistent offer of carer support and respite care across BOB. This should include: 1. Understand and provide appropriate supply and type of respite care to help aid carers in their work looking after individuals. Respite care need to be easily accessible and bookable both online and offline. 2. Offer of proactive support for those who are suffering due to their caring roles.

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

5. Improving quality and access

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan: Improving Quality & Access to Services

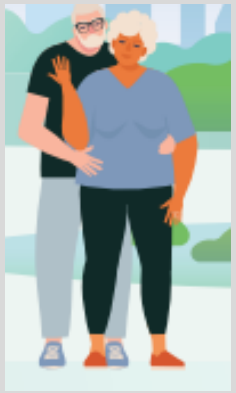
Accessing the right care in the best place

Better access to quality services

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

1. Making it easier to get a GP appointment.
2. Improving waiting times for planned operations.

- We also hear concerns about social care, dental and pharmacy services and the challenges of accessing services from rural areas.



Supporting people to access our quality services

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

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

Our focus areas

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

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Delivering Our Strategy – Improving Quality and Access

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

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Delivering Our Strategy – Improving Quality and Access

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

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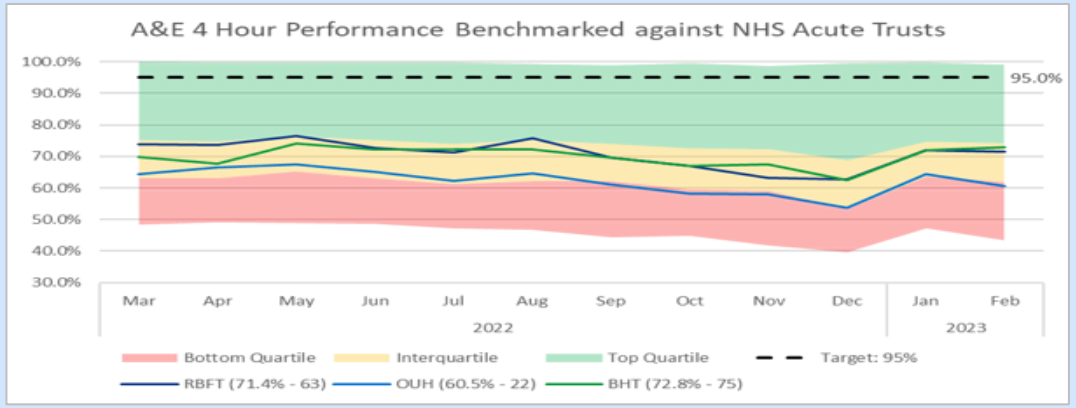
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

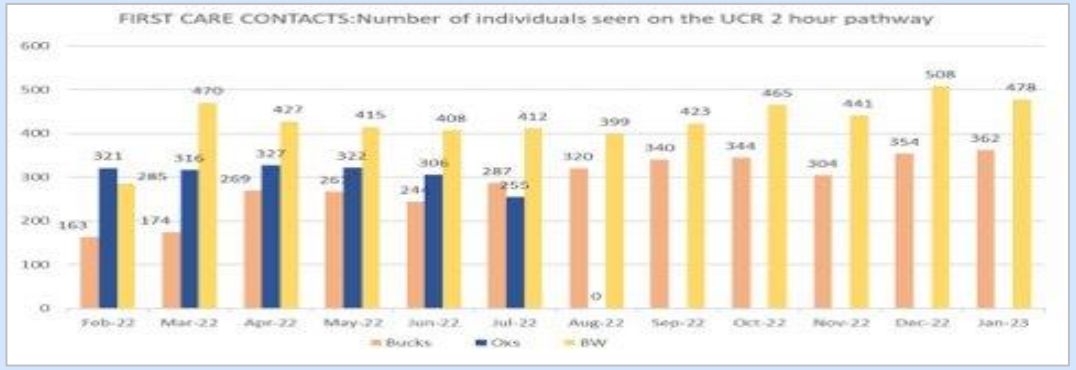
Our Context and Ambition: Urgent and Emergency Care

Context: Our challenge in BOB

- There has been increasing and sustained pressure across all health and care since the Covid 19-pandemic. UEC continues to be under severe pressure with an increasing volume of attendances in A&E and the number and length of ambulance handover delays has been a challenge.
- Pressure remains significant in A&E with Trusts achieving on average between 61% and 72% of patients seen within the 4 hour target. See below:

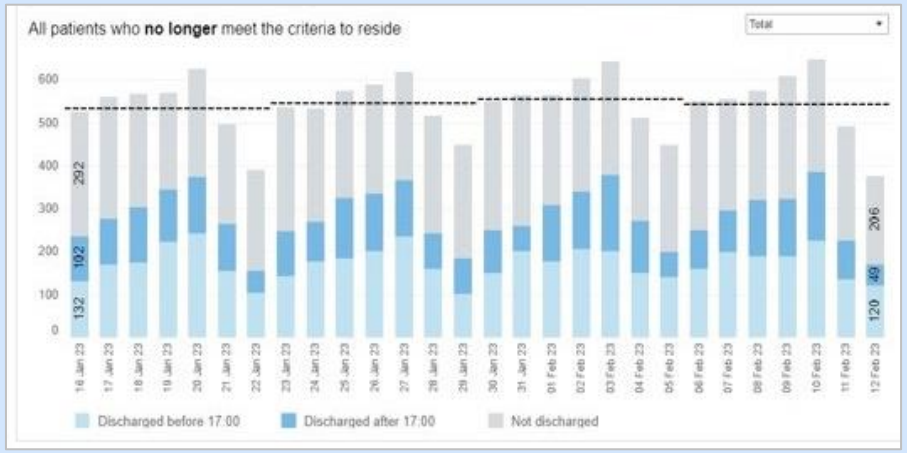


- The provision of UCR remains critical to the UEC pathways and show a gradual increases in the number of people using the service over the last 12 months. Reporting for Oxfordshire has been disrupted following the Advance outage from August '22.

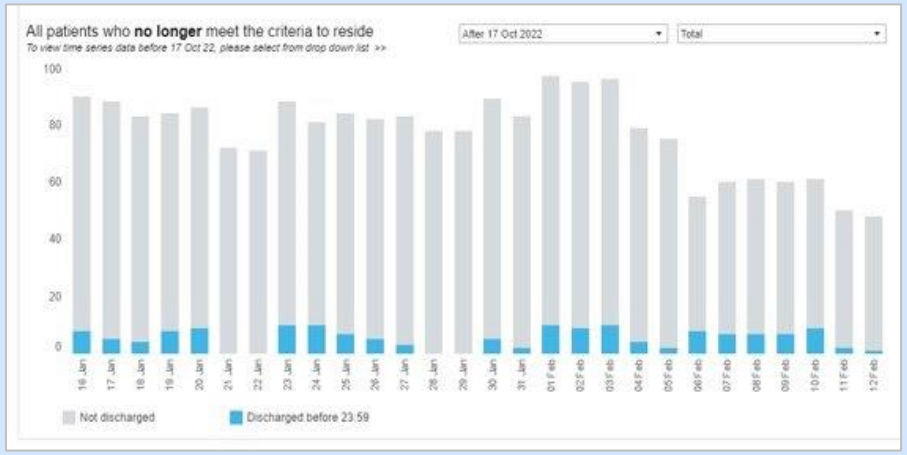


- Discharge and flow remain a challenge across our sites, with variation between organisations. The data below shows further improvements for those not meeting the Criteria to Reside and as a system BOB compares well in the length of stay of those patients.

Acute patients



Community



Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Urgent and Emergency Care

Our Ambition: By 2028, our ambition is to ensure patients access the right care when it's needed, improving the outcomes and the experience of patients, their families and friends and consistently delivering against the operational standards determined by NHSE.

To Deliver Our Ambition, We Will:

1. Recover key performance indicators; reducing ambulance handover delays, securing a reduction in the percentage of patients waiting more than 12hrs in Emergency Departments to be seen, improving type 1 A&E performance and; reducing G&A bed occupancy. (Data captured within slide 15).

2. Develop and implement a model of care that better supports and meets the needs of High Frequency Users, building on the anticipatory care models adopted in primary and community care services.

3. Deliver a consistent single Integrated Urgent Care model across the BOB footprint from September 2024 that is compliant with the national service specification and that makes best use of our urgent care resources interfacing with local place-based urgent care service delivery.

4. Embed and increase the capacity and service offer of Urgent Community Response teams to provide urgent care to people in their homes which helps to avoid hospital admissions and enables people to live independently for longer by providing fast access to a range of health and social care professionals within two hours, including access to physiotherapy and occupational therapy, medication prescribing and reviews.

5. Increase adult and paediatric Virtual Ward capacity to support patients across 9 conditions, who would otherwise be in hospital, to receive the acute care, remote monitoring and treatment they need in their own home or usual place of residence for up to 14 days as an alternative to care in hospital.

6. To ensure there is a clear route of access to same day services through a Single Point of Access supported by a directory of services that is available to healthcare professionals to inform the timely navigation of pathways and suitable onward referral to meet urgent care needs.

7. Deliver a programme of work that supports the implementation of the top 10 high impact changes to improve hospital discharge, including from community and Mental Health inpatient services.

8. Secure a non-emergency patient transport service that provides a more consistently responsive service, fair access to service users, is sustainable and compliant with the national framework.

What We Need For Success:

- System partners need to work together in delivering a more co-ordinated approach to an agreed cohort of High Frequency Users.
- Optimise the use of electronic shared records across care providers to minimise duplication and support pathway navigation seamlessly.
- Establish a workforce strategy that supports delivery of the UEC ambition, including the promotion of new enhanced practitioner roles with appropriate supervision.
- Optimise the use of digital enablers in the provision of community care, including virtual monitoring devices and mobile diagnostic kit which is interoperable with provider IT systems.
- Recurrent investment in services that reduce ED attendances, ambulance conveyances and hospital admissions.
- Funding, changed workforce model, reconfiguration of resources and workforce, shared commitment to collaboration / integration / reconfiguration.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Urgent and Emergency Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Recover the performance of key UEC indicators	• A reduction in ambulance handover delays. • Improve Type 1 A&E performance by March 2025 and secure 95% by the end of year 5. • Reduce G&A bed occupancy • Ensure less than 1% of patients wait more than 12hrs in Emergency Departments to be seen.	• Deliver 0 >60min handover delays by the end of year one. • Deliver 76% A&E type 1 performance by March 2024. • Reduce G&A bed occupancy to 92% by the end of year one through a reduction in the number of patients not meeting Criteria to Reside. • Ensure Trusts have recovery plans in place to minimise delays to be seen in ED and that suitable alternatives to ED are promoted to patients to minimise inappropriate ED attendances.	• Deliver 0 >30mins handover delays by the end of year two. • Deliver 80% A&E type 1 performance by March 2025. • Maintain G&A occupancy at 92% through the deployment of best practice discharge planning and provision.	• To reduce the overall number of hours lost to handovers by more than 50% by the end of year 5. • Deliver 95% A&E type 1 performance by March 2025. • Maintain G&A occupancy at 92% and reduce the number of medical beds required as a result of improved community provision and admission avoidance, including Urgent Community Response and Virtual Wards. • Less that 0.5% of patients wait more that 12hrs in ED to be seen.
02 Develop and implement a model of care that better supports and meets the needs of High Frequency Users, building on the anticipatory care models adopted in primary and community care services	• A model of care that better supports and meets the needs of High Frequency Users, building on the anticipatory care models adopted in primary and community care services.	• Secure a 50% reduction in HFU interactions with urgent and emergency care services by the end of year 5.	• Review existing support and service models for HFUs and high intensity services. • Engage providers in the identification and case management of HFUs. • Build on best practice to develop an improved support package for high frequency users.	• Test and evaluate impact of high frequency user support and service models. • Implement learning further to evaluation/impact tracking and revaluate.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Urgent and Emergency Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Deliver a consistent single Integrated Urgent Care model across the BOB footprint from September 2024 that is compliant with the national service specification and that makes best use of our urgent care resources and interfacing with local place-based urgent care delivery.	• Deliver a consistent single Integrated Urgent Care model across the BOB footprint from September 2024 that is compliant with the national service specification and that makes best use of our urgent care resources interfacing local place-based urgent care services. • Provide a service development structure to the IUC environment allowing for proactive management of pathway issues and emerging themes within IUC. • Making it easier to access the right urgent care services at place closer to home ensuring integrated urgent care services works more effectively for the public, so people can more easily access the care they need, when they need it.	• IUC recommissioning process set up and agreed at executive level. • Baseline of current activity and recommendations for future service model and the scope of procurement. • Procurement process in line with latest guidance. • Full-service specification development for all elements of IUC including aligned Directory of Service across BOB. • Contract award to preferred provider (s) • Place-based Assessment of Urgent Treatment / Care services and Clinical Assessment Service provision and procurement processes where applicable. • Service Development Group embedded into commissioning of IUC • Identification of themes for development with service development plan in place.	• Full Contract Mobilisation for new IUC service for BOB and place. • Urgent Treatment / Care Services and Clinical Assessment services mobilisation at place. • Contract management processes in place across BOB and place. • Continued function of Service Development Group and plan refresh.	• Maintain Service Development Group and plan. • Maintain contract review process.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Urgent and Emergency Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Embed and increase the capacity and service offer of Urgent Community Response teams to provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer by providing fast access to a range of health and social care professionals within two hours, including access to physiotherapy and occupational therapy, medication prescribing and reviews.	• UCR teams receiving a minimum of 30% more referrals over the next 5 years compared to 22/23. • UCR equally accessible by all • All appropriate category 3 and 4 referrals redirected to UCR prior to ambulance dispatch. • All patients eligible for UCR support to be redirected to UCR before ambulance called – at IUC/111 stage. • Consistent Point of Care testing offer.	• Increase UCR 2-hour referrals by 10% pre crisis (i.e., pre ambulance). • Implement process and protocols for ensuring appropriate category 3 and 4 ambulance referrals are redirected to UCR pre-ambulance dispatch. • Review and ensure access to UCR 2-hour pathways for those with mental health, learning disabilities and autism. • Implement consistent core Point of Care testing offer across BOB ICS UCR teams.	• Increase UCR 2-hour referrals by 10%. • Introduce live capacity tracker. • Develop demand and capacity tools. • Develop and link with proactive care offer including completion. • Review equity of access in line with BOB ICS health inequalities strategy.	• Increase UCR 2-hour referrals by 10%. • 24-hour provision, staffed in line with demand and capacity models, by year 3. • All patients who may be eligible for UCR to have this noted in their care plan.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Urgent and Emergency Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
05 Increase adult and paediatric Virtual Ward capacity to support patients across 9 conditions, who would otherwise be in hospital, to receive the acute care, remote monitoring and treatment they need in their own home or usual place of residence for up to 14 days as an alternative to care in hospital.	• 50 beds per 100,000 adult population by year 5. • Virtual wards/hospital at home available as a discharge route for all relevant specialties by year 5. • Minimum agreed virtual ward offer in all places to prevent postcode lottery. • Beds 80% utilised on average in years 1 and 2 and 90% utilised on average in year 3. • Patients for whom their needs can be met adequately by a virtual wards/hospital at home service to avoid an admission will receive this service.	• BOB ICB summit to confirm virtual ward/hospital at home vision and aims and minimum offer for BOB ICB. • Provide development support for all places to achieve 29 beds per 100,000 population. • Bed utilisation at 80% for all providers. • BOB ICS wide pathways developed where possible. • Evaluation to explore costs and benefits of different virtual ward/hospital at home models delivered, to inform case for further investment developed.	• BOB implements further VW/Hospital at home beds totalling 40 per 100,000 population. • Further BOB wide ICS pathways developed in line with vision and minimum offer. • Virtual ward/hospital at home pathways built into all relevant SOPS including but not limited to IUC, SPA, hospital discharge protocols.	• BOB implements further VW/Hospital at home beds totalling 50 beds per 100,000 population in place. • 90% utilisation achieved. • All patients who may be eligible for virtual ward to have this noted within their care plan.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Urgent and Emergency Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
06 To ensure there is a clear route of access to same day services through a Single Point of Access supported by a directory of services that is available to healthcare professionals to inform the timely navigation of pathways and suitable onward referral to meet urgent care needs	• By April 2024, ensure consistent and rapid access to clinical advice and alternative services, and to reduce unnecessary attendance to Emergency Department. • From April 2023, at Place level, develop existing services to ensure there is a coordinated acute and community approach to deliver a single point of access for care homes, primary care, paramedics and patients, staffed by qualified clinicians, able to ensure patients get referred to the most appropriate service for their needs as laid out in the Department of Health & Social Care – NHS England – Delivery Plan for Recovery, Urgent and Emergency Care Services.	• Further development of Placed based Directory of Services aligning this with population demand for integration within Single Point of Access. • Reduce Single Point of Access service variation within BOB. • Work towards the development of a 24/7 SPA.	• Develop a true Single Point of access 24/7 for BOB, linked to the development and rollout of the IUC.	• By April 2024, ensure consistent and rapid access to clinical advice and alternative services, and to reduce unnecessary attendance to Emergency Department. • From April 2023, at Place level, develop existing services to ensure there is a coordinated acute and community approach to deliver a single point of access for care homes, primary care, paramedics and patients, staffed by qualified clinicians, able to ensure patients get referred to the most appropriate service for their needs as laid out in the Department of Health & Social Care – NHS England – Delivery Plan for Recovery, Urgent and Emergency Care Services.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Urgent and Emergency Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
07 Deliver a programme of work that supports the implementation of the top 10 high impact changes to improve hospital discharge, including from community and Mental Health inpatient services	• Increase the volume of Pathway 0 discharges. • Minimise delays across discharge pathways for all care settings (community and MH included). • Establish 7day working that reduces the disparity between Monday-Friday and weekend discharge profiles. • Ensure the majority of discharges are secured in the morning. • Drive down the volume of patients that don't meet the Criteria to Reside (CTR) across all settings.	• Secure a 10% reduction in both acutes and community Trusts of the number of patients no longer meeting the CTR by the end of the year. • Establish a baseline and improvement trajectory to improve MH discharges in-year. • Increase the number of discharges achieved on Saturdays and Sundays by 15% against the average 21/22 baseline. • Agree and mobilise Trust level improvement plans to support more than 75% of discharges being completed in the morning.	• Secure a 30% reduction in both acutes and community Trusts of the number of patients no longer meeting the CTR by the end of the year. • Deliver a 10% improvement of MH discharges against the 22/23 baseline.	• Eradicate the differential in weekday/weekend discharge profiles • Achieve 95% of all discharges being enacted in the morning. • Patients not meeting the CTR <5% across all care settings.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Urgent and Emergency Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
08 Secure a non-emergency patient transport service that provides a more consistently responsive service, fair access to service users, is sustainable and compliant with the national framework	• Procure a new operating model for non-emergency patient transport that reflects the new national patient transport model for April 2025. • Deliver a dynamic, sustainable and responsive patient transport service that improves stakeholder and patient experience. • Increase use of voluntary sector services to support patients. • Support the NHS in achieving a reduction in CO2 emissions.	• Wide engagement with all stakeholders (Patient groups, Commissioners, acute and community Trusts, voluntary sector, primary care) to support developing a new service specification and model for non-emergency patient transport. • Quality and KPIs developed alongside, financial and activity model. • Draft contract with schedules completed • Further market engagement with Providers. • The above to be completed to enable issuing an Invitation to Tender (ITT) documents by 31st Oct 23. • Stakeholder panel to evaluate tenders and recommend preferred bidder for the Board. • Governance sign off and award of contract by April 24 to enable a go live for April 25.	• Following award of the contract work with the Provider on a 12-month mobilisation plan for delivery of the contract and ensure wide stakeholder engagement in readiness for April 25 go live. • Ensure expected benefits are realised as part of mobilisation.	• Delivery of new contract and non-emergency patient transport service from 1st April 2025. • Support the Provider in ensuring safe delivery of operational services • Monitor contract and service delivery closely. • Review lessons learnt from procurement.

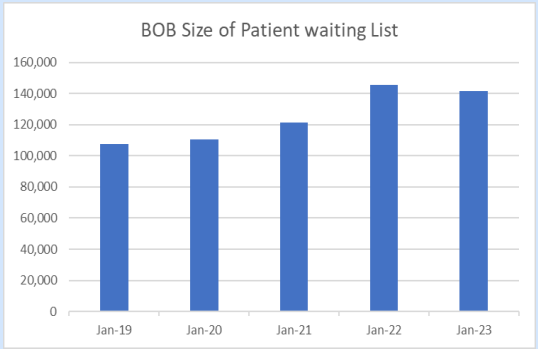
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

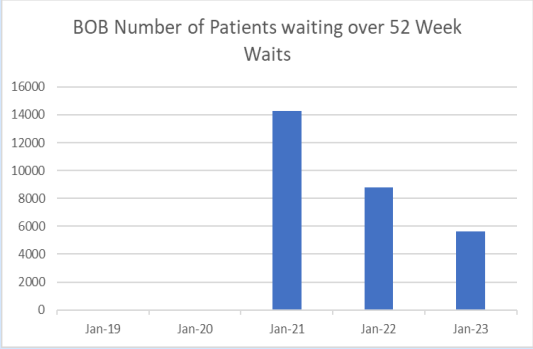
Our Context and Ambition: Planned Care

Context: Our challenge in BOB

The COVID-19 pandemic has had a significant impact on the delivery of elective care. Our patients are now waiting longer for treatment than they were before the pandemic began. Furthermore, it is recognised that faster treatment generally results in more positive outcomes whilst delays can lead to poorer outcomes.
Although progress has already been made in reducing the volume of very long waiting patients i.e., those waiting over two years for treatment, waiting times for some diagnostic and specialist services remain particularly high, with some people still waiting more than a year and a half for treatment. These waiting times increased during the pandemic and in some services, continue to increase as the number of referrals is growing following a reduction in demand experienced during the pandemic.
There is variation in the overall waiting times across BOB. The demand for services and the capacity of our specialist services is different across the providers. We aim to make better use of capacity, provide a faster service to patients involving them in care decisions.

Context: Our challenge in BOB





Our Ambition: By March 2028 we will aim to sustainably reduce and eliminate long waits for our elective services and address variation in access across the system, recovering to at least pre-pandemic planned care performance levels against NHS Constitutional Standards (18 weeks) by March 2028. We aim to improve access to services by enhancing pathways and coordinating approaches across the system, reducing variation and non value-added interventions.

To Deliver Our Ambition, We Will:

1. Increase health service capacity, through the expansion and separation of elective and diagnostic service capacity.
2. Prioritise diagnosis and treatment, including a return towards delivery of the six-week diagnostic standard and reducing the maximum length of time that patients wait for elective care and treatment.
3. Transform the way we provide elective care including reforming the way we deliver outpatient appointments, making it more flexible for patients and driven by a focus on clinical risk and need, and increasing activity through dedicated and protected surgical pathways.
4. Provide better information and support to patients, supported by better data and information to help inform patient decisions.

What We Need For Success:

- There needs to be a more co-ordinated approach where service, financial and workforce planning are better aligned. This will be central to recovering planned elective services.
- We will need to target actions to narrow supply gaps in priority pathways, specialties and roles across the system to meet the challenges of elective recovery and increase permanent workforce capacity.
- Investment is needed in digital technology to assist healthcare workers in completing non-clinical tasks which increases the time they can spend caring for patients, as well as improving communication and information available to patients while they wait for treatment.
- Implementation of strategies to make more effective use of Independent Sector capacity that compliments services delivered through NHS facilities.
- Investment in our NHS estate to create capacity and meet modern standards of service delivery now and in the future.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Planned Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Increase health service capacity	Increased elective capacity over the planning period, to meet the national target of delivering and sustaining 30% more activity vs 2019/20 by 2024/25 (tbc)	• Planned activity of 95.7% of 2019/20 baseline activity levels through a mix of increased capacity and initiatives to improve productivity and throughput • Through the system wide Elective Care Board, oversee the delivery of collaborative system working to improve patient experience, reduce waits and to deliver more sustainable care in the initial cohort of High Volume Low Complexity specialty work programmes for those specialties with the longest waits and highest volumes of patients waiting • The Theatre Steering Group will continue to produce 'Specialty Deep-Dives', identifying areas of opportunity to improve theatre productivity and performance aiming for at least 85% utilisation in all areas • Continue to develop business cases for additional elective capacity through proposed elective hubs and surgical; pathways • Further additional diagnostic capacity will become available through the Community Diagnostic Centres as part of planned increases for year 2 of the three-year programme, with an increase in diagnostic equipment and workforce which will increase the availability of diagnostic tests to 110% of 2019/20 activity levels • Work on building more effective relationships with Independent Healthcare Providers to develop a coordinated use of resource and capacity • Begin full demand and capacity analysis for elective services to highlight where demand outstrips capacity	• Continue to expand initiatives from year one with an aim to increase elective activity to 130% (tbc) of 2019/20 activity levels. • As improvements are made, embed a continuous review process to identify and expand the range of specialties targeted under the work of the Elective Care Board to increase capacity through targeted improvement programmes • Subject to approvals, begin to build and plan to commission elective capacity and pathways through elective hubs and protected surgical pathways • Continue to increase diagnostic capacity through year-three of the Community Diagnostic Centres programme with additional equipment and workforce becoming available • Following the demand and capacity analysis and through provider collaboration, start the process of designing a system-wide clinical strategy to level up on equity of access to services • Aim for top decile performance on theatre and clinic productivity and utilisation through the targeted work of the system-wide Theatre and Outpatients Steering Groups	• Sustain at least 130% of 2019/20 activity levels (tbc) • Continue process of reviewing and identifying specialties to benefit from targeted work programmes under the remit of the Elective Care Board • Commission additional capacity made available through elective hubs and new/improved estate • Identify longer term coordination and collaboration with Independent Healthcare Providers that utilises capacity within available resources as effectively as possible • Commence revision of commissioning arrangements across the system to align on e.g. MSK services • Commence process of reconfiguration following outcome of system-wide clinical strategy

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Planned Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Prioritising diagnosis and treatment	A return towards delivery and sustainability of the six-week diagnostic standard so that 95% of patients needing a diagnostic test receive it within six weeks by March 2025 and reducing the maximum length of time that patients wait for elective care and treatment, initially treating all patients who will have waited more than 65 weeks by March 2024 and then all patients waiting over 52 weeks by April 2025. Aim to recover to at least pre-pandemic planned care performance levels against NHS Constitutional Standards (18 weeks) by March 2028.	• Achieve a maximum of 65 week waits from referral to treatment by 31st March 2024. • Maintain validation of waiting lists to a minimum of 52 weeks reducing in line with performance targets to ensure each patient has had their waiting status validated within the last 12 weeks to ensure timely and orderly access to diagnosis and treatment. • Embed a process for clinical prioritisation that takes into account inequity of access to services resulting from Health Inequalities – also ensuring the order of being seen reflects patient need as well as length of wait. • Develop elective strategy for addressing inequalities in access to elective diagnostics and treatment. • Continue to prioritise those patients waiting the longest in accordance with performance targets through effective waiting list management using an updated system-wide Access Policy. • Ensure patients are offered the choice of having their diagnosis and treatment sooner where other providers have shorter waits through the continued use of inter-provider mutual aid including the use of the independent sector. • Ensure through targeted commissioning of independent sector capacity that there is focus on the priority specialties where waits for diagnostics and treatment are the greatest. • Continue process of redesigning clinical pathways focusing on the High-Volume Low Complexity priority specialty and diagnostic work programmes as part of the remit of the Elective Care Board.	• Achieve a maximum of 52 week waits from referral to treatment by 31st March 2025. • Continue to prioritise those patients waiting the longest in accordance with performance targets through effective waiting list management. • Building from the demand and capacity analysis and system-wide clinical strategy to level up on equity of access to services, focus levelling up reconfiguration efforts on those specialties with the largest inequities in access to diagnosis and treatments. • Continue process of redesigning clinical pathways focusing on the pathways that have the longest waits for diagnosis and treatment.	• Continue to incrementally reduce the maximum wait from referral to treatment for planned care against the 18-week NHS Constitutional Standard by 31st March 2028.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Planned Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Transforming the way we provide elective care.	Transformation in the way we provide elective care; for example, by reforming the way we deliver outpatient appointments, making it more flexible for patients and driven by a focus on clinical risk and need, and increasing activity through dedicated and protected surgical hubs and pathways. Key Outcomes: 1. Deliver reductions in the volume of unnecessary out-patient follow up attendances in line with the national ambition to reduce by 25%. 2. Increase in flexible Patient Initiated Follow Up appointments (PIFU) Year 1: 8%, Year 2: 10%, Years 3 to 5: 20%. 3. Advice and Guidance (A&G) target of 90% response/plan within 48hrs and issue A&G. Pre referral: Year 1 65%, Year 2 75%. Post referral: Year 1 10%, Year 2 20%, Years 3 to 5 25%.	• Through the system wide Elective Care Board, continue to drive transformation of elective care focusing initially on those specialties with the longest waits and highest volumes of patients waiting as well as through the guidance provided by the system-wide Theatres, Perioperative and Outpatients Steering Groups. • Begin process of delivering Right Procedure Right Place in targeted specialties as guided by the Theatre Steering Group. • The system will deliver appropriate reductions in the volume of unnecessary out-patient follow up attendances in line with the national ambition to reduce by 25%; using the capacity that will be released to increase the availability of new outpatient appointment slots where we will aim to hold 'one-stop' outpatients in 25% of clinics by aligning diagnostics, consultation and treatment in one visit. • Continue roll out of Advice and Guidance (A&G) to 65% pre-referral diversion rates and post referral to 10% as an alternative to direct referral into secondary care with a target of 90% response/plan in 48hrs. • Reduce the likelihood of patients that Do Not Attend (DNAs) or who cancel and do not rebook. • Maximise efficiency and productivity and continue to use 'Getting It Right First Time (GIRFT) methodologies. • Continue to develop scope for additional elective capacity through elective hubs and protected surgical pathways.	• Increase the proportion of 'one-stop' outpatient clinics to 30%. • Embed Advice and Guidance where it adds value to be route for 50% of patients referred into secondary care. • Complete ICS wide evaluation of value of Advice and Guidance focusing on where there is the greatest benefit. • Develop model for centrally delivered Advice and Guidance for pre-referral across initial 2-3 specialities. • Referrals to secondary care will be made digitally using standardised referral forms where available including referrers out of area. • Development of space and plans to move Outpatients delivered in new models from secondary care to new sites that offer diagnostics where possible on the day e.g., Community Diagnostic Centres and Community Hospitals.	• Increase the proportion of 'one-stop' outpatient clinics incrementally to 40%. • Embed Advice and Guidance incrementally where it adds value, for 60% of patients referred into secondary care. • Reduce maximum wait for first Outpatient Attendance to 6 weeks.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Planned Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Providing better information and support to patients.	We will provide better information and support to patients, supported by better data and information to help inform patient decisions, and make greater use of available technologies to better manage appointments, bookings and the sharing of information. We will ensure patients have choice at the point of referral, and that this is enhanced for long-waiting patients. Key Outcome - With enabling support from data/digital, Patients with a Long-Term Condition to be managed remotely: • Year 1: 30% of total patients. • Year 2: 40% of total patients. • Years 3 to 5: 50-70% of total patients.	• The use of the MY Planned care app, linked to Trusts patient portals, will make key information available to patients. • Patients will be able to access accurate waiting times data for all major specialities across the system. • Signposting to all information pre-attendance and while waiting (Waiting Well) for next step in their care e.g., surgery. • Appointments will be able to be cancelled and rebooked electronically by all patients. • Regular testing e.g., blood tests will be able to be managed by the patient and results communicated via the patient portal. • Use of Digital First will facilitate pathways education and standardised approaches across providers with digital referral, proformas, senior triage, photos, workforce working to top of licence, standardised statutory and mandatory training and single contracts. • All patients with a Long-Term Condition will have access to education and can make choices about their care management with 30% of patients managed remotely. • Identify patients that want to use group consultation and look at local delivery as a trial of personalised OP care. • Utilise the shared data through Graphnet to focus care and management around Primary Care Networks and neighbourhoods with a particular focus on inequalities and access to healthcare.	• Enable patient inputting information re change of health status, concerns, issues etc speeding up the communication process. • Research opportunities for use of artificial intelligence as a developing technology. • Coordination of appointments for patients and delivery of virtual appointments where patents attend for multiple conditions and are carers. • Collection and use of information to understand patient's individual needs and health status while waiting and ensure they are supported through social prescribing, volunteer services. • Develop patient information to support good experience of outpatients and facilitation of choice of site, clinician and times. • Investigate and embed new technologies to enhance patient pathways and experience at both an operational and clinical level.	• 95% of patients will be able to cancel book and rebook appointments. • Ensure that we are digitally connected to our patients in order to allow flexibility in how and where they access diagnostics. • Enable 50-70% of patients with Long Term Conditions to manage their own care with remote monitoring and education. • Deploy emerging technologies such as AI to support image analysis and reporting • Use effective data collection to capture machine level utilisation and efficiency. • Investigate areas that may benefit from the use of Artificial Intelligence (AI), Robotic Processing Automation (RPA) or other emerging technologies to increase capacity. • Work with early adopters to bring in Artificial Intelligence to support areas such as Stroke AI imaging.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

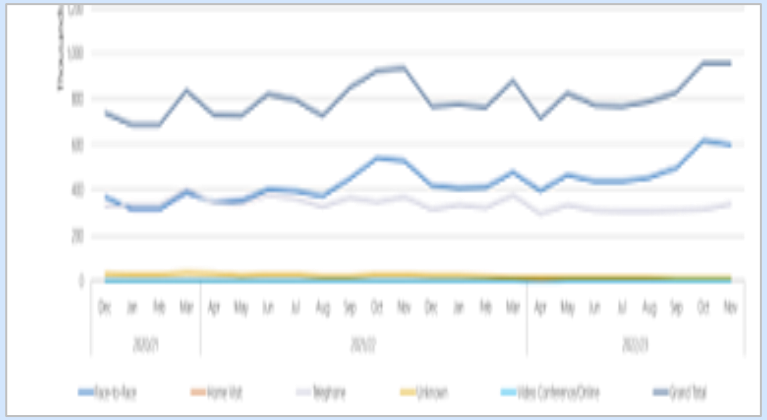
Our Context and Ambition: Primary Care

Context: Our challenge in BOB

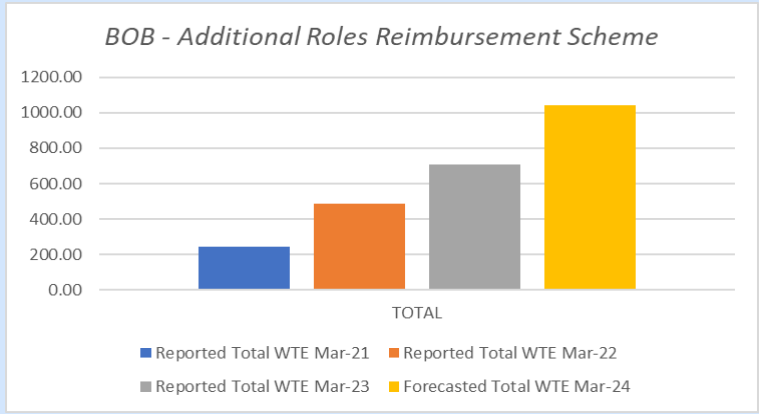
Primary Care across the UK remains under significant pressure. This position is reflected across BOB. Numerous reports published in recent years describe the challenges facing primary care, a model for the future. It is the Fuller Report (2022) *Next steps for integrating primary care*, which will however shape the ambition for primary care and the plan for the next five years. In BOB a number of specific factors continue to drive a need for change.

- **Patient satisfaction** with Primary Care services is falling. Less than 6 in 10 people in BOB described the experience of making an appointment to see their GP as good in the 2022 GP patient survey.
- The **complexity of post covid backlogs and provider dissatisfaction with the NHS dental contract** means dental care is becoming increasingly difficult to access. A 30% reduction in access is expected by March 2022/23.
- **Community pharmacy increases in 'unplanned' closures**, meaning this vital enabler of self-care is absent.
- GPs report it is harder to **balance caring for people with non-urgent, long-term needs with the pressures from people who want urgent, same day support.** Clinicians and patients value continuity of care.
- Staff burnout and absences have added to capacity constraints across the whole **primary care workforce** in spite of the Additional Roles Reimbursement Scheme. In the next year, we are aiming for our additional roles (clinical non-GP roles) to increase from 705 WTE to 1.042 WTE – see next page for reference.
- **Demand for care** and associated expectations from the patient are rising. In BOB 3% of a practice's population will ring them each day, 69% in a month (BBOLMC Report, January 2023).
- Covid-19 has highlighted **healthcare inequalities in BOB**, and positive innovations such as digital technologies has exacerbated this.
- The current estate and **infrastructure** needs to be modernised to support better join up with partner organisations and our rapidly expended populations.
- Although BOB can compare favourably with the average national picture our true challenge is **reducing variation** so that we level up the care a patient should expect to receive and reduce inequity in access, experience and outcomes.

The graph below shows a gradual increase in GP appointments in BOB since December 2020. **POOR RESOLUTION IMAGE NEEDS REPLACE**



In BOB, we have progressively increased our investment in ARRS (clinical non-GP roles). The below graph represents in March 2021 where WTE was 242, which is expected to rise to a forecasted 1,042 WTE by March 2024.



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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Primary Care

Our Ambition: To transform how primary care is delivered in each community/neighbourhood, enabling integrated primary care provision which improves the access, experience and outcomes for communities aligned to their needs. Through the mobilisation of integrated neighbourhood health and care teams, primary care services will become more sustainable, and patients will get the support they need when they need it.

To Deliver Our Ambition, We Will:

1. Increase primary care resilience and provide the tools required to enable change including time and skills.
2. Create the infrastructure across BOB to implement the change (Estates, Workforce & digital).
3. Increase capacity and manage demand for primary care services by working differently so that we can deliver on nationally agreed access priorities and targets.
4. Build GP led, integrated neighbourhood teams, supported by a sustainable workforce plan.
5. Deliver more targeted activity to identify and support the prevention of ill-health and address inequalities.

What We Need For Success:

- A system leadership culture that promotes an enabling and psychologically safe environment, and the capacity, time and skills for people to learn and experiment.
- Optimise the potential of delegated pharmacy, optometry and dentistry (POD) commissioning to enable sustainable models of integrated delivery with other services.
- Workforce – System support to develop a comprehensive people plan which is able to deliver a more stable and resilient multidisciplinary workforce.
- Digital & Data – System digital and data team support to help with roll-out of a more informed and digitally aware primary care aligned to the service model. This will include the provision of population health data (information), electronic shared care record (connectivity) and patient centred innovations (self-care support).
- Estates – System and local support through local authorities and ‘one public estate’ strategies to maximise opportunities to modernise and integrate estate.
- Place-based provider and local authority support for neighbourhood community engagement and participation in the GP lead Integrated Neighbourhood Team Model.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Primary Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Increase primary care resilience and provide the tools required to enable change, including time and skills	• Improvement in primary care staff satisfaction rating. • Staff retention. • Strive towards100% of practices in BOB to be CQC rated good.	Strategy & Set Direction • Development of a BOB wide integrated primary care strategy, using a series of engagement events and seeking to embed POD as appropriate by Sept 23. • Identify & optimise opportunities of POD delegation to improve capacity in PMS by October 2023. • Continued refinement of the longer term JFP actions. • Resourcing of PCN/neighbourhood level leadership to maintain viable engagement and leadership until April 28. • Supporting resilience. • Develop & implement a practice-based resilience reporting tool with LMC by Sept 23. • Implement the Bureaucracy busting concordat, Aug 22) by April 24. • Influence national programmes to establish plans and mechanisms for resilience by April 24 – particular POD focus.	• New National GP contract expected April 24 – this may influence further actions. • Continued action from year one as we support 150 practices as prioritised. • Place based leadership of some elements of primary care with system wide sharing and learning between Places. • Place based collaboration on POD with support and leadership from a single shared ICB function.	• Devolvement of budgets to place • Review implications of new National GP contract and further planning. • Continue to review place-based leadership, elements of primary care with system wide sharing and learning between Places. • Continue to support place-based collaboration on POD with support and leadership from a single shared ICB function.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Primary Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Create the infrastructure across BOB to implement the change (Estates, Workforce & digital)	• 100% of PCNs to complete the Estates toolkit by June 23. • Maximise access to and use of Local Authority section 106 and CIL funding opportunities by working with LAs. • Participation in work public estate initiatives. • 100% use of ARRS allocation by April 24. • 5% increase in GP WTE by 2028. • Increased staff satisfaction. • Primary care providers have access to the digital equipment necessary. • Increased use of digital tools by the population e.g., NHS 111 app / online services. • PHM tool at neighbourhood level. • Multidisciplinary teams with read and write access to shared care record (interoperability).	• Develop BOB primary care strategies for estates and workforce linked to system, place and neighbourhood. • Complete roll out of the PCN Estates toolkit. • Build on the PCN Estates toolkit working with HEE to layer in all provider community workforce. • Embed workforce planning at system and place using available data sets. • Work with PCNs and providers to ensure ARRS funding is allocated, recruitment is maximised, and training is provided to embed and retain roles. • Continue the BOB primary care workforce retention programme bringing POD into that forum and establish system level POD workforce baseline. • Develop local workforce resilience plan, to optimise skill mix and extend capability of professions and support wider training and development. • Encourage the GP partnership model with trainees. • Commission health & wellbeing services for primary care. • Finalise proof of concept for automation of non-clinical tasks (Observations). • Review IT equipment and replacement plan, support services (fit for purpose). • Undertake baseline assessment of digital status (POD), identify and agree priority areas for interoperability focus (Community Pharmacy). • Complete roll out of advanced telephony.	• Review and invest in robotic process automation (RPA) technology to allow for the automation of non-clinical tasks (Observations). • Continue to develop BOB primary care strategies for estates and workforce linked to system, place and neighbourhood. • Continue to encourage the GP partnership model with trainees.	• We will monitor and evaluate our work during year two and use the outcomes to inform further work to be undertaken in years three to five.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Primary Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Increase capacity and manage demand for primary care services by working differently so that we can deliver on nationally agreed access priorities and targets	• Increase total number of appointments provided at general practice by 5% April 24. • Increase in units of dental activity to pre-pandemic levels by April 25. • 90% general practice same day access for urgent care by April 25. • 90% access to general practice routine care within 2 weeks by April 25. • Increase in number of completed referrals to community pharmacy consultation service (CPCS) 111, GP & UEC by April 24. • Implementation of direct access community to secondary care pathway by October 2023. • 100% of BOB Practices to have implemented and be using Capacity and Management tool by March 2024.	• Introduction of capacity & demand tool to help with oversight of GP practice management, helping to understand appointment capacity and flexibility across the region. • Develop model and implementation plan for same day access. • Implement direct/self-referral pathways (weight management/audiology etc). • Full implementation and roll out of the Clinical Advice Service (CAS) with links to primary care. • Review locally commissioned services & redesign to support priority areas. • Primary care communication plan designed to support confidence in alternative service providers and messages on access, services, interventions and realistic expectations. • Investigate the potential of e-hubs. • Proactively plan for winter 23 with a predetermined financial envelop. • Use of Pharmacy Needs Assessments (PNA), and transformation programme to inform community pharmacy capacity. • Complete CPCS roll out and maximise use • Implement Community Pharmacy liaison resources to further develop integrated working with general practice. • Review current dental service capacity and requirement. • Commence procurement programme. • Implement National dental contract reform using local Flexible Commissioning schemes improving access. • Develop and implement Local Eye Network with a focus on relieving pressures on GP and acute service providers.	• Potential for new contract – this may influence further actions. • Continued identification and roll out of direct access pathways. • Continuation of the dental procurement programme. • Identification of additional services required of CP.	• We will monitor and evaluate our work during year two and use the outcomes to inform further work to be undertaken in years three to five.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Primary Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Build GP led, integrated neighbourhood teams	• Integrated neighbourhood teams capable of safe and evidenced based patient care. To be prioritised in areas of known deprivation first. • PHM tool in place. • Service offers appropriate to the population health needs. • MDTs in place. • Joined up patient pathways that can easily move through primary, mental, community and secondary healthcare. • Continuity of patient care (Improvements in patient satisfaction).	Dependant on primary care resilience: • Establish an aligned leadership model at place. • Stocktake of previous initiatives and working at place to establish baseline. • Define our neighbourhoods, including population and care needs. • Understand resource flows including staff, finance, estates etc. • Community / neighbourhood engagement events. • Define the model including level of integration / collaboration and skills required.	• Mobilisation of implementation team at place / neighbourhood, as a pilot for a selected deprivation area. • Work with providers to consider options around integration and embedding of community and mental health resource aligned to PCNs / neighbourhoods. • Develop the MDT ways of working. • Consider the following as service offers – Chronic disease management, Frailty, Personalised care.	• Start to see results – services develop, and patient outcomes improve.

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Our Joint Forward Plan For Primary Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
05 Deliver more targeted activity to identify and support the prevention of ill-health and address inequalities	Data driven care – Use of PHM tools to identify 'at risk' populations and provide proactive care and support. **Prevention & early intervention** • Achievement of 90% Quality and outcome framework targets across all practices in the Core20PLUS5 groups including hypertension case finding. • Increase in numbers of Annual Health Checks for those with SMI to greater than 60% and/or in line with LD, whichever is the greatest. • Anticipatory Care Planning. • COPD identification and management. • Targeting community pharmacy provision in those areas of highest deprivation". • Vaccination take up rates. • Early cancer diagnosis (cervical screening). • Increase online access to primary care services for those who are in digital poverty. • Reduce number of children under 10 accessing acute care for tooth extraction **Identification of and referral to Lifestyle and Specialist Services for** • Obesity. • Smoking. • Alcohol consumption.	• System wide review of the impact of deprivation on access. • Prioritisation of integrated neighbourhood teams in areas of deprivation. • Agree and develop the PCN population health approach incl. tool and training. • Encourage general practice to target QoF public health interventions on Core20PLUS5. • Increase health checks targeting based on PHM data and risk. • Support general practice to engage with their communities on lifestyle and behaviour choices, reduce disparities in access, experience and outcomes. • Provide the tools and pathways for practice social prescribers to sign post and refer to interventions. • Support practices to adapt a MECC approach. • Increase capacity of CP hypertension case finding. • Work with system partners to optimise local partnership focus and resource to establish integrated smoking cessation services. • Establish referral processes from hospital to CP smoking cessation services to support our populations to continue programmes started whilst having an inpatient stay identifying clear local targets. • Develop collaborative system partnership public health approach to oral health prevention. • Address backlog tooth extraction in hospitals for under 10s. • Providing education, skills and equipment to the general public to support online access targeted at Core20PLUS5. • Develop and use Oral Health profiles to increase and target focus on dental prevention and early intervention March 2024. • Develop aligned/integrated partnership working arrangements to optimise prevention agenda for dental services.	• Planning service delivery to support year one deprivation on access review. • Continue to support practices to adapt a MECC approach. • Continue to provide education, skills and equipment to the general public to support online access targeted at Core20PLUS5. • Progress integrated partnership working arrangements to optimise prevention agenda for dental services.	• We will monitor and evaluate our work during year two and use the outcomes to inform further work to be undertaken in years three to five.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

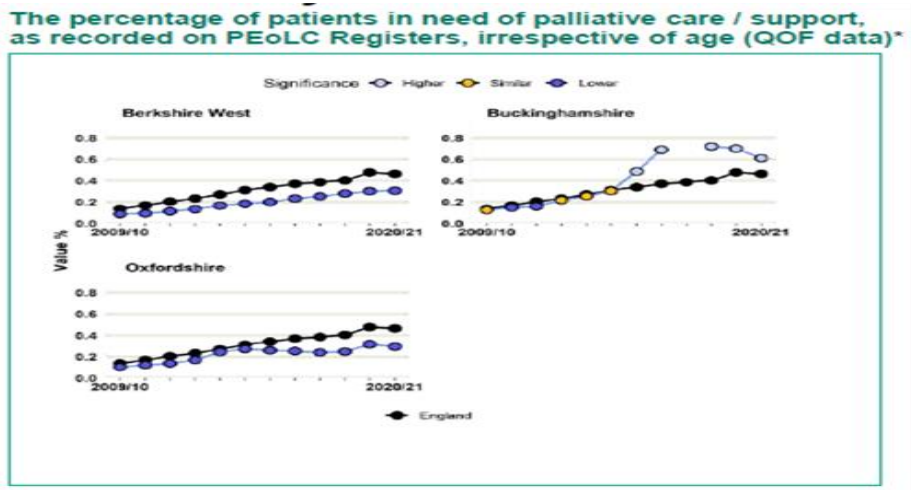
Our Context and Ambition: Palliative and End of Life Care

POOR RESOLUTION IMAGE NEEDS REPLACE

Context: Our challenge in BOB

- Palliative and End of life care (PEoLC) affects us all, at all ages of life. Palliative and End of Life is a thread through all services delivered whether that is Planned Care or Urgent and Emergency Care, with access to services affecting the living, the dying and the bereaved. BOB has a population with increasingly complex co-morbidities and lifelong conditions, resulting in an increase in need for PEoLC services delivered by both generalists and specialists.
- This requires well-commissioned, sustainable 24/7 PEoLC services. Across BOB, there are different models of services, working to a range of service specifications interfacing with multiple providers. An opportunity exists to improve co-ordination and cross-provider collaboration to achieve rapid hospital discharge, admission avoidance, enhanced community support and overall improved patient experience.
- The Long-Term Plan sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. The Clause 21 of the Health and Care Act 2022 states that ICBs have a legal responsibility to commission palliative care services that meet their population needs.
- Challenges: sustainable and collaborative commissioning across health and social care, digital interoperability between NHS and non-NHS providers, workforce issue (recruitment and retention across all providers), and proactive care planning for patient at end of life – shaped by people and families with lived experience.

What our data shows



Our Ambition: By March 2028, we will deliver high quality, personalised, integrated 24/7 services shaped by those with lived experience for Palliative and End of Life Care (PEoLC) for all ages, across the BOB ICS.

To Deliver Our Ambition, We Will:

1. A robust model of access to 24/7 Palliative and End of Life services for patients, their carers and relatives.
2. A successful population health approach to early identify people needing Palliative and End of Life services.
3. To co-design PEoLC through Provider Collaboratives and in partnership with people with lived experience.

What We Need For Success:

- Funding.
- Digital shared data platform requirement to develop shared patient records and advance care plans.
- Changed workforce model to increase resilience.
- Reconfiguration of resources and workforce.
- Shared system commitment to collaboration, integration and reconfiguration.
- Good links with Health and Wellbeing Boards.
- Support from Communications and Engagement to help with communication around PEoLC issues.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Palliative and End of Life Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 A robust model of access to 24/7 Palliative and End of Life services for patients, their carers, and relatives. (All age)	• To ensure the ICBs fulfils the legal duty to commission PEoLC under s3 NHS Act 2006 as amended in the Heath and Care Act amendment in July 2022, through workstreams 1, 2 and 3. • Improved accessed for Patient's, their Carers and Relatives to Health Care Professionals in and out of hours in Year 1 and 2. • To improve Patient, their Carers and Relatives experience Year 1 and 2. • Reduce the percentage of deaths with three or more emergency admissions in the last three months of life (Public Health Profile data). • Reduce unwarranted Palliative and End of life care (PEoLC) South Central Ambulance Service (SCAS) call outs year 3-5. • To align to NHSE PEoLC Strategic Clinical Network Core metrics and technical guidance for PEoLC of improving access, quality and sustainability. • To deliver packages of services set out against the NHS National Ambitions Framework .	• To ensure the BOB PEoLC service directory is up to date, with associated communications to raise awareness of PEoLC services. • Liaise with NHSE regional and national teams to update the central NHS service directory for BOB PEoLC services. • To implement a PEoLC virtual ward. • Review existing service offer between operating hours 8am – 8pm, 7 days a week, with a view to pilot extended service offer. • Review existing Night Care provision BOB wide (including those services provided by the non-commissioned sector) with a view to building on existing well supported provisions. • Scope the preferred 24/7 service model, focusing on increasing accessibility to Patients, their Relatives and carers. • Create options appraisal for 24/7 model, agree costings and measures for success. • Launch and implement a 2-year pilot 24/7 service. • To complete an Equalities and Health inequalities impact assessment to ensure fair accessibility to services 24/7 (taking into account potential accessibility issues i.e,. literacy, digitally poor and language barriers) and complete an action plan focused to address over the 5 years. • To work closely with our regional leads and ICS' to share best practice, including digital access.	• Evaluate 24/7 access model against 6,12,18-month reviews incorporating lived experience feedback to inform a business case for longer term funding of the preferred model. • Ensure fair and equitable access to 24/7 services for everyone, by reducing inequalities. • To continue to work closely with our regional leads and neighbouring ICS to share best practice. • Increase of Night Care provision to cover current unmet needs across BOB building on pilots currently in place. • Work with pharmacy teams to understand PEoLC just in case medication stock availability and accessibility to medication. • Review and update PEoLC directory of services yearly. • Partial implementation of digital shared care record (digital care) to enable a Electronic Palliative Care Coordination System (EPaCCs).	• 24/7 service pilot close report with successful model moving to business as usual, reflected through improved experience for Patients, their Families and Carers both in and out of hours. • To continue to work closely with our regional leads and neighbouring leads to share best practice. • To continue to review and update PEoLC directory of services yearly. • Continue roll out of digital shared care records to an Electronic Palliative Care Coordination System (EPaCCs).

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Palliative and End of Life Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 A successful population health approach to early identify people needing Palliative and End of Life services.** (All age)	• To deliver personalised care to improve end of life care (Long Term Plan) • Increase the number of patient's offered an Advance Care Plan (ACP) and holding an ACP by March 2024. • Increased number of clinicians trained to be ReSPECT/DNACPR independent signatories by April 2025. (Baseline yet to be confirmed across BOB). • Increased numbers of patients on palliative care registers in BOB through early identification and ensure they are offered the opportunity for personalised care and support planning conversation. • Incremental year on year increase of PEoLC Quality Outcomes Framework (QOF) prevalence in BOB to the national average 0.5% with further work to continue to rate of circa 0.8% of the BOB population. (Public Health Profile data). • Fewer avoidable emergency admissions through identification of a person being in their last year of life. (Baseline yet to be confirmed across BOB) . • Improved ICS staff confidence, knowledge and skills in PEoLC, focusing on personalised care. • Improved quality of care planning documentation across BOB by year 3. • Improved accessibility to a care plan for all providers to reduce duplication.	• Continue ACP and early identification training offer across BOB until April 2025. • Work with available providers to deliver ongoing bespoke training and workshops to GP/Hospice and Community teams to reiterate and develop further understanding of the importance of early identification and Care Planning. • Map out current advance care plan usage across BOB and identify gaps in provision/training needs. • Understand local variation in methods for collecting this information and to develop a local trajectory on number of care plans offered and completed. This will be working with digital colleagues to understand what is needed for digital copy of ACPs in patient records with associated alerts across BOB. • Review and amend community templates such as the frailty documentation to encompass care planning element. • Enhance training of ReSPECT modules in all clinical settings where it has been implemented. • Work with Neonatal Intensive Care Unit (NICU), Paediatric Intensive Unit (PICU) and Maternity and other specialist Services on early ID for Children and Young People (CYP).	• Liaise with NHSE to add ACP to the NHS patient app and promote pilot completion of this within BOB, whilst recognising this may not be appropriate for all patients. • Refine care planning documentation across BOB, with implementation of ReSPECT and ensure that all system organisations. understand the importance of ReSPECT and offer the opportunity to attend associated training. • Embed personalised care and support planning for people who are end of life. • Work with other specialist services to improve early identification within a cohort of patients.	• Fully implement ReSPECT as the standardised document in BOB which is accessible to all health providers to reduce duplication. • Review, standardise and implement BOB wide advance care planning document. • Review and implement a BOB wide PEoLC identification tool. • Continue to provide training and support to all clinical staff across BOB to support with difficult conversations around ReSPECT, ACP completion, and PEoLC care provisions.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Palliative and End of Life Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 To co-design PEoLC through Provider Collaboratives and in partnership with people with lived experience. (all age)	• More patients feel informed and empowered with a sense of control over their end-of-life care needs. • More people are able to die in their preferred place of death. • Better engagement from all providers inclusive of Voluntary, Community and Social Enterprise (VCSE), NHS and non-NHS services in each place-based group. • Consistent specification across all providers. • Our PEoLC services are in line with the national PEoLC ambitions framework. • Sustainable PEoLC pathways in context of funding allocations, collaboration, activity and commissioning. • Fair access to care for palliative and end of life patients across BOB. • Ensure PEoLC patients of all ages are supported to live and die well.	• Establish a baseline across the region of available services for PEoLC (all ages). • Complete a demand and capacity model to support redesign based on needs of different groups. • Self-assess against the frameworks including the national ambitions, GSF and CQC key lines of enquiry (KLOE). • Continue “Getting to Outstanding” Programme, BOB-wide forum cutting across all providers and places. • Develop a provider collaboration to support PEoLC as a whole system approach through pilot initiatives for collaboration, such as multi-disciplinary teams (i.e.,Transition CYP to Adults). • Define, agree and set up lived experience groups across each Place. • Ensure lived experience representatives are invited and are an active partner in system-wide meetings. • Review and update PEoLC provider service specifications to the new adult and CYP PEoLC specifications. • Explore new models of integrated health and social care to support redesign of integrated service models. • Work with health and wellbeing boards to understand the development of population-based needs assessment for end of life. • Review and scope the current offer of pre and post bereavement services to establish unmet need.	• Develop an approach to better understand and anticipate population needs, future financial analysis, infrastructure and sustainability PEoLC services. • Commission at scale across all providers to ensure consistency. • Develop further relationships with VCSE. • Map and scope the use of personalised health budgets for PEoLC. • Review PEoLC pathways with a view to identify service gaps to address to inequalities. • Ensure a person’s preferred place of death is a viable option. • Review and update self-assessments against framework.	• Develop further relationships with neighbouring ICS to ensure service accessibility and consistency for those who live on borderlines. • Continue to review and address inequalities through enhanced models of care. • Review and monitor any redesign changes align to population health needs. • Consider further demand and capacity modelling to ensure proactive planning for PEoLC services. • Review and update self-assessments against framework.

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

06

Supporting and Enabling Delivery

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Supporting and Enabling Delivery

Building and growing the foundations for successful delivery

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

Our Enabling Plans

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

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

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

- Workforce
- Digital and data
- Finance
- Estates

Our Supporting Plans

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

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

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

Delivering Our Strategy – Key Enablers for Delivery

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Enabled Through

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

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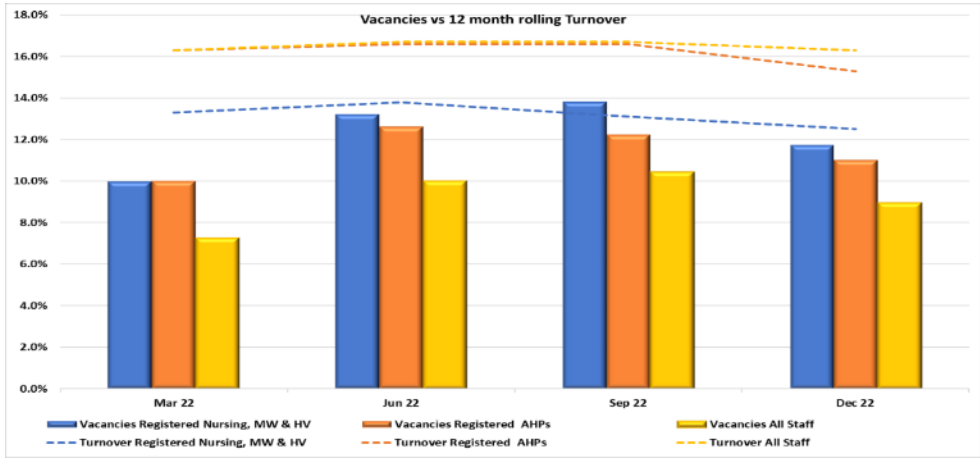
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Workforce

Context: Our challenge in BOB

- It has become increasingly difficult within the NHS to permanently recruit and retain the people needed to deliver our services. Rising living costs and BOB's close proximity to London, where salaries for comparable roles are higher and attract area supplements, pose further localised challenges. Combined, these difficulties result in a heavy and increasing reliance on costly temporary staffing which further destabilises the workforce during this time of national pressure.
- Gaps in workforce supply mean that a continued focus on education and widening entry level opportunities to the NHS are needed. The transformation of existing roles and organisational design is also critical to both the sustainability of services and improving our employee experience.

In Ambition 2 below, we aim to improve retention of our nurses, midwives and AHPs and reduce vacancies within BOB.



Our Ambition: By March 2028 we will have an integrated workforce that is looked after, feels valued and respected, is reflective of our communities and made up of the right people in the right roles at the right time delivering health and care services for our communities.

To Deliver Our Ambition, We Will:

1. Have an inclusive and diverse compassionate leadership reflecting the population we serve, and driving cultural change towards strong partnership working. across organisational and sector boundaries.

2. Improve recruitment and retention through a collaborative programme developing innovative attraction action plans to support key areas of workforce shortages and seek out truly integrated solutions planning ahead for future workforce challenges.

3. Have roles and teams that operate across organisational and professional boundaries for the greater benefit of our communities, reducing reliance on costly agency workers, whilst fostering career development and supporting meaningful and personalised career pathways. We'll make the most of people's skills and use technology and innovation to drive efficiency and improve outcomes for our communities.

4. We will make Buckinghamshire, Oxfordshire and Berkshire a great place to work in health and care. We will ensure our people have rewarding jobs, work in a positive culture that embraces kindness, civility and respect, with opportunities to grow and are supported with both their physical and mental health and wellbeing.

What We Need For Success:

- Dedicated resources, including leadership and subject matter expertise to lead and shape workforce programmes, analytical support and project co-ordination.
- Funding might be required depending on the types of interventions that are developed.
- Support from national teams depending on the types of support that are available.
- Engagement from system partners and a willingness to embrace collaborative working.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Workforce

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 We will have an inclusive and diverse compassionate leadership reflecting the population we serve driving cultural change towards strong partnership working across organisational and sector boundaries	• Leaders, and line managers, that positively interact with the diversity around them, building trust and psychological safety within their teams and fostering a culture where all individuals can bring their authentic self to work and feel safe to speak out and contribute. • Strengthened relationships with our partners leading to improved engagement and collaboration. • Partners learning from each other, sharing challenges and best practice. • Increased sense of belonging among employees. • Boosted retention and reduced turnover and absence rates. • Increased group cohesion, mutual support and cooperation. • Effective embedding of the NHS 6 high impact EDI Actions.	The projects below are examples of the work that could be done in **years one and two:** • Work with regional leadership and lifelong learning teams to develop a leadership strategy for all leaders, clinical and non-clinical. • Support employers to deliver the Workforce Race Equality Standard's (WRES) model employer goals to increase representation at senior levels across the system. • Facilitate peer-to peer learning and sharing of good practice on promoting equality, equity, diversity and inclusion. • Collaborate to build shared actions plans around inclusivity and sharing challenges and best practice across Trusts. • Collaborate on development and education plans focused on equality, diversity and inclusion, compassionate leadership and partnership working. • Develop specific and measurable EDI objectives for Chief Executives, chairs and board members across the ICS to which they will be individually and collectively accountable.	• Due to the size and scope of the challenge and work in year one, activities may flow into year two.	• Monitor and evaluate our work during year two and use the outcomes to inform further work to be undertaken in years three to five.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Workforce

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Improve recruitment and retention through a collaborative programme developing innovative attraction action plans to support key areas of workforce shortages and seek out truly integrated solutions planning ahead for future workforce challenges	• Reduction in overall vacancies with a focus on 'difficult to recruit' roles and occupations where there are high vacancies and/or high turnover. • Reduction in organisational turnover. • Reduction in time to hire and cost to hire. • Improved number of suitable candidates per vacancies, with a larger, more experienced candidate pool. • More effective recruitment channels and increased overseas recruitment activities. • Improved onboarding experience for all new starters. • Increased number of clinical professionals that remain in their profession. • Streamlined recruitment and onboarding processes. • More nurses, midwives and AHPs. • Workforce attracted from the communities we serve as well as workers looking to live and work in the area.	The projects below are examples of the work that could be done in **years one and two**: • Undertake cross system coaching and mentoring programme. • Focus on CPD, education and development. • Undertake a deep dive into social and economic barriers to work for highlighted posts and support collaborative action plans. • Make training more accessible through collaborative training programmes. • Expand recruitment and international recruitment channels. • Develop and deliver an aligned comprehensive induction, onboarding and development programme for internationally recruited staff. • Build anchor institutions and networks. • Introduce a single ICS onboarding / induction / digital passport. • Develop, promote and expand apprenticeships. • Build volunteer and reserve capacity. • Explore BOB-wide recruitment campaign for the NHS, promoting careers and the NHS as a great place to work. • Embed fair and inclusive recruitment processes and talent management strategies that targets under-representation and lack of diversity. • Develop a comprehensive bank of workforce intelligence to support and identify key areas of focus and appropriate targeting of interventions for all system partners.	• Due to the size and scope of the challenge and work in year one, activities may flow into year two.	• Monitor and evaluate our work during year two and use the outcomes to inform further work to be undertaken in years three to five.

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care System

Our Joint Forward Plan For Workforce

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 We will have roles and teams that operate across organizational a nd professional boundaries for the greater benefit of our communities, reducing reliance on costly agency workers, whilst fostering career development and supporting meaningful and personalised care er pathways. We'll make the most of people's skills and use technology and innovation to drive efficiency and improve outcomes for our communities	• Reduced agency costs. • Spread and adoption of new roles and new ways of working. • Equality and consistency across the system in. terms of agency fees and bank rates. • Increased employment mobility across Trusts with reduction in leavers exiting BOB and increased skills, knowledge and experience retention within our Trusts. • Increased information and skills sharing across Trusts, learning from each others' experiences and sharing challenges and best practice. • Greater efficiency and effectiveness.	The projects below are examples of the work that could be done in **years one and two**: • Establish a collaborative system for managing temporary staffing. • Focus on flexible, hybrid and remote working. • Build a career development and progression framework lined to social and education pathways. • Broaden our existing workforce planning and modelling to encompass all health and care disciplines. • Agree consistent bank rates across the system. • Explore and develop collaborative workforce sharing arrangements such as system-wide secondments, digital staff passports, rotational roles. • Develop collaborative networks, utilising existing networks and supporting with action plans. • Explore use of digital technology to aid productivity and availability to adopt more flexible working practices.	• Due to the size and scope of the challenge and work in year one, activities may flow into year two.	• Monitor and evaluate our work during year two and use the outcomes to inform further work to be undertaken in years three to five.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Workforce

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 We will make Buckinghamshire, Oxfordshire and Berkshire a great place to work in health and care. We will ensure our people have rewarding jobs, work in a positive culture that embraces kindness, civility and respect, with opportunities to grow and are supported with both their physical and mental health and wellbeing	• Our people know where and how to access support with their physical and mental health and wellbeing. • Improved Staff Survey results. • Improved employee experience for our people throughout the life of their work • Improved retention. • Reduction in absence and turnover rates. • Reduction in number of people reporting harassment, bullying or abuse from colleagues.	The projects below are examples of the work that could be done in **years one and two**: • Use training hubs to support lifelong learning for primary care staff, as well as train and embed new roles in primary care. • Align training programmes across the system. • Establish collaborative programme and cross-system networks to focus on results of NHS Staff Survey. • Establish collaborative programme focused on Civility and Respect, using NHSE diagnostic tools, HEE Workforce Behaviour Toolkit and supporting Trusts with shared, aligned development and action to eliminate the conditions in which bullying, discrimination, harassment and physical violence at work occurs. • Support partners to develop and deliver an improvement plan to eliminate pay gaps.	• Due to the size and scope of the challenge and work in year one, activities may flow into year two.	• Monitor and evaluate our work during year two and use the outcomes to inform further work to be undertaken in years three to five.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Digital and Data

Context: Our challenge in BOB

Utilisation of Digital and Data provides an opportunity to enable transformation and achieve the triple aim of better health, better care and lower cost. We seek to demonstrate the potential value from delivering products, services and platforms in a coordinated approach across our providers. Our intent goes beyond digitisation of processes and pathways to delivering true transformation of our Health and Care System, enabled by digital, data and technology.

The National ICS Design Framework sets out the digital and data requirements for ICSs and the What Good Looks Like (WGLL) framework domains, in particular Well Led, Empower Citizens, Improve Care and Healthy Populations, have been extensively used to guide our Digital and Data Strategy, including defining the desired capabilities for our systems and providers.

Our current challenges include:

- Data and decision-making priorities in BOB are handled within individual trust and provider strategies, there is an opportunity to align these across the system.
- The need for a common ICS control of data feeds that flow between providers to enable a single view of a citizen.
- Infrastructure and systems are varied across the ICS, there are opportunities to improve collaboration between partners and ensure value for money.
- The need to responding to rising citizen expectations of public services and digital demands.
- Citizens are more digitally literate compared to national average, but capability varies across the ICB significantly.

We will need to change our ways of working to realise the benefits of being unified as a system, by exploiting and building upon collaboration opportunities already existent within the ICS. The role of the Integrated Care Board will be to bring together our collective strengths and facilitate delivery of the strategy, aligned to the ICS development aims.

BOB ICS Digital & Data Strategy, Vision and Ambition Objectives:

Our Vision

Improve the lives and experiences of those accessing and working in our ICS, through building collective digital and data maturity across our partners and providers.

Our Objectives

Digitise	Connect	Transform
We will deliver the Minimum Digital Foundations across our providers to reach a core level of digitisation across the system.	We will use digital, data and technology to connect our care settings and improve experience for citizens.	We will deliver the data foundations to provide the insights required to transform our system and better meet the needs of our population

Our Ambition: Our ambition is to improve the lives and experiences of those accessing and working in our Integrated Care System, through building collective digital and data maturity across our partners and providers. By 2025, we will have:

- Enabled safe and informed care by aligning our providers behind a single shared care record.
- Improved maturity of electronic patient records by converging providers onto platforms which meet national data standards.
- Equipped our workforce in exploiting the use of digital and data and develop DDaT professions across the ICS.
- Empowered citizens achieving common digital experiences to enable self-management of care and reduce administrative burdens.
- Enabled access and care at home by delivering capabilities such as virtual wards, virtual consultations and remote monitoring.
- Provided common infrastructure enabling staff mobility, and optimise performance, resilience and security of systems, while delivering VfM.
- Delivered our data foundations to improve data flows across the ICS enabling more informed decisions on improvements to health and wellbeing.

To Deliver Our Ambition, We Will:

1. Digitise our providers to reach the Minimum Digital Foundations for a core level of digitisation across our system.

2. Connect our care setting using digital, data and technology to improve citizen experience.

3. Transform our data foundations to provide the insights required to transform our system and better meet the needs of our population.

What We Need For Success:

- Strong digital leadership across all partners with a desire to work collaboratively, share assets and improve collective digital maturity.
- ICS digital governance to monitor delivery, challenge and assure delivery and relevancy of the strategy during its lifespan, and to evidence outcomes.
- Common standards to develop system-wide benchmarks and ensure equitable value across the system.
- Development and retention of a skilled digital workforce to deliver successfully, support transformation, and realise outcomes.
- Commercial leverage to deliver single solutions and drive value for money.
- An understanding of end-user needs (patients, citizens and workforce) to enable us to judge the success of our strategy.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Digital and Data

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Digitising our providers EPR maturity, digital adult social care, common infrastructure and equipping our workforce	**Acute electronic patient records (EPR):** Converge to a single instance of Cerner across acute providers.	• Develop convergence plan and requirement specification. • Consult on ICS stakeholders on specification.	• Procure Acute EPR.	• Implement Buckinghamshire Healthcare Trust EPR to core minimum digital foundations. • Start Convergence journey with Acutes.
	Community & mental health EPR: Converge to RiO and establish centre of expertise at Berkshire Healthcare Foundation Trust.	• Implement Oxford Health Foundation Trust EPRs (RiO/EMIS).	• Establish RiO centre of excellence at Berkshire Healthcare Foundation Trust.	• All community and mental health providers meet minimum digital foundations.
	Digitising Adult Social Care: 80% of CQC-registered providers with Digital Care Records. Falls detection technologies delivered for 10% of residents most at risk.	• Develop funding formula to determine devolution of funds to providers. • Identify first tranche providers. • Establish and implement community of interest group among providers and ICS partners.	• 80% of social care providers with digital care records. • Deployment of falls prevention technologies.	• Deliver Social Care Skills Passport.
	Common Infrastructure: Rationalise and drive value through common infrastructure where the opportunity arises.	• Establish ICS Cyber Security Strategy. • Complete ICS infrastructure discovery.	• Establish ICS infrastructure standards.	• Establish ICS cloud strategy.
	Workforce digital skills: Work with providers and education institutions to build digital curriculum.	• Assess baseline skills.	• Develop workforce curriculum.	• Social Care Skills Passport.
	Digital Data and Technology professional talent: Continue to expand graduate schemes and support apprenticeships through established NHS schemes. Establish cross-ICS shared DDaT capability.	• Undertake DDaT skills stocktake.	• Establish cross-ICS DDaT Talent Pool Development & Apprenticeship Programme.	• Establish ICS analytics centre of excellence.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Digital and Data

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Connecting our care settings Shared care record, virtual care, digital patient engagement	**Shared Care Record:** Single cross-ICS Shared Care Record based on TVS Graphnet and Oxford University Hospitals Health Information Exchange for integration.	• Implement cross-ICS Shared Care Record.	• Enable inter-ICS data sharing. • Enable intra-ICS feeds to Shared Care Record.	• Full-scale adoption.
	Support Virtual Care: Deliver 430 Virtual Ward beds across BOB by April 2024. UEC Service Delivery Plan has described the use of virtual wards and care in more detail.	• Implement 344 virtual ward beds.	• Increase virtual ward capacity to 430 beds.	• Explore virtual ward pathways for heart failure and end of life.
	Citizen Access: Converge to NHS App for patient digital access, where needs cannot be addressed an existing Patient Portal will be utilised.	• Develop ICS digital patient engagement strategy.		• Consolidate patient portals. • Converge to NHS App and NHS login.
	Diagnostics & Imaging: Digital plan is to be developed and will seek regional contributions where available while prioritising existing resources where possible.	• Develop regional strategy & proof-of-concepts.	• Transform regional diagnostics.	• Transform regional diagnostics.
03 Transforming our data foundations Insights required to transform our system and better meet the needs of our population	**Population Health Management:** Build PHM maturity aligned to ICS priorities.	• Undertake PHM maturity baseline assessment and develop strategy.	• Build PHM maturity.	• Build PHM maturity.
	Secure Data Environment: Position Thames Valley and Surrey HIE SDE as regional SDE and implement new research use cases.	• Design and implement SDE.	• Pending confirmation from Oxford University Hospitals.	• Pending confirmation from Oxford University Hospitals.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Estates

Context: Our challenge in BOB

- The BOB Estate provides over 760,000 sqm of occupied space. This includes clinical inpatient, outpatient and ancillary buildings held over a number of ownership models including FH,LH and PFI, costing £328m per annum. The Estate is managed by NHS Provider Trusts, NHS Property Cos, Commissioning Bodies, Primary Care and 3rd Party Providers.
- The Estate is regulated in the main through HTM/HBNs, H&S Legislation and policies such as Carter et al. Similarly, the NZC standards will play a major role in the future development of the Estates practices and provision.
- The overarching requirement for the Estates Group is to take the BOB Clinical Services Strategy and produce an **Estates Infrastructure Strategy** to align priorities, ensure synergy and allow flexibility for the changing demands of the NHS.

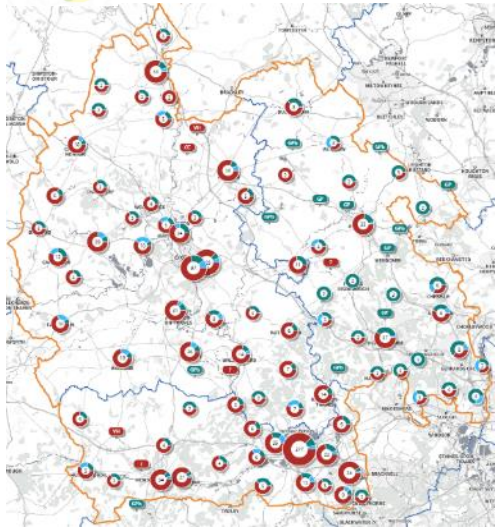
Key focus areas for the Estates Infrastructure Strategy are:

1. Backlog Maintenance – A number of condition and functional challenges are evident in the Estate, including £408m (£238m critical) Backlog Maintenance (8th highest ICB Nationally and 1st ICB SE Region). A number of Primary Care and Acute sites require repair and improvement work in line with planned maintenance programmes. We plan to address the declining nature of the Estate with an aim to reduce Critical Backlog Maintenance by 2028, of 5% per annum, dependent on funding provisions.
2. Non-clinical space – Our clinical space usage is below the national average, and our strategy plan will be focused on making the most of our sites to deliver clinical care for our people, making the best use of our estate.
3. Collaboration between partners – There are shoots of joined up working that are starting to develop across organisations, but limited resources and time are a blocker to success. We will review the availability of resource through the ICB Estates structure and the System Estates Teams to deliver potential change opportunities and to help meet changing clinical and operational demands.

Model Health System

SHAPE place

Primary & NHS Trust Estate



Map contains coloured circles representing estates split by Primary Care (Green), Secondary Care (Red), NHS Property Co (Blue)

Total backlog maintenance costs (£)

System value

£408.71m

Estates & Facilities cost (£ per m2)

System value

£429.78/m2

Amount of non-clinical space (%)

System value

37.36%

Energy costs per m2 (£/m2)

System value

£32.13

Coloured boxes beside above stats; Red/Green – BOB stats are adverse/favourable against national average

Our Ambition: By March 2028 we will have developed and adopted a System Infrastructure Strategy in conjunction with Clinical Service Strategy which has improved usage, efficiencies and reduced wastage throughout the estate.

To Deliver Our Ambition, We Will:

1. Deliver the ICS Infrastructure Strategy, which is expected to prioritise, integrate stakeholders and improve upon the procurement of Estates Contracts, development of a Workforce Plan, improvement of Space Management and production of a system wide Capital Investment Plan for the BOB Estate.

2. Implement an ICB Estates Structure capable of delivering the Strategy for all key Stakeholders.

What We Need For Success:

- The overarching requirements of the Clinical Services Strategy to inform Estates direction of travel.
- A shared commitment to collaboration / integration / reconfiguration from all Infrastructure Stakeholders.
- A structure in place to deliver the Strategy once completed.
- Suitable and sufficient capital and revenue allocations to arrest infrastructure issues and drive improvement.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Estates

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 System Infrastructure Strategy	• An Infrastructure Strategy and Delivery Plan aligned closely to the needs of the overarching Clinical Services Strategy for BOB. • Common Estates objectives between all Stakeholders within BOB. • Improved environment and conditions for Clinical teams to work. • Enhanced Patient experience. • NHS Carbon ambitions.	• Publish an Infrastructure Strategy for BOB developed by the Estates Group and supported by colleagues in IT and Equipment. • Undertake workshops along with data gathering exercises to inform the Strategy. • Source external resources to produce the document. • Develop a Delivery Plan to support the Strategy, focusing on key areas such as Procurement, Portfolio Optimisation, Workforce and Capital Projects.	• Refresh the Strategy following Spending Review outcomes to ensure alignment with allocation. • Implement and further develop the Delivery Plan. • Joint Procurement contract awards (Pilots FM management systems and soft service contracts). • Reduce Non-Clinical space to 30% • Reduce Workforce Vacancies.	• Complete performance reviews • Reduce Critical Backlog Maintenance by 5% per annum (dependent on funding). • Develop support for Primary Care Estates.
02 ICB Estates Delivery Team	• An Estates Structure to support the System and Partner needs. • A dedicated Team capable of developing and delivering the Estates Strategy and Delivery Plan. • Shared specialist knowledge capacity for Partners.	• Develop and agree an Estates Structure, which supports the wider infrastructure requirements of the Estate. • Recruit into the structure, prioritising specialist knowledge positions.	• Deliver the System Strategy and Delivery Plan. • Engage all System Stakeholders and provide accountable leadership of the ICB. • Work with wider community partners to design Estates solutions for both health and care needs.	• Deliver and update the System Strategy and Delivery Plan to ensure relevance to the Clinical Services Strategy.

 DRAFT

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Finance

Context: Our challenge in BOB

The BOB system is impacted by a challenging National economic environment which includes in particular:

- **Increases in demand for services, both non-elective and emergency care and elective (including reduction of backlog); and**
- **Inflationary pressures, particularly in energy prices and agency and locum rate increases.**

This above has resulted in significant health and care financial pressures which perpetuate a significant underlying financial deficit. Acknowledging our commitment to ensuring that taxpayer money is spent most effectively we are working to ensure that funding is directed to providers as appropriate to underpin best value, care and support for local people.

The delivery of care to our population is varied from prevention and early diagnosis to care in the home through to community, mental health and social care, all playing a significant part in ensuring our patients receive the best care in the most effective manner. The significance of care in these settings upon resultant levels of demand and acuity of need in the acute sector cannot be underestimated and it is right therefore that our partners are working together in understanding the totality of our funding envelope and exploring opportunities of working together to make the best use of collective funding, sharing of ideas and resources available.

A drivers of deficit analysis undertaken in 2019 and 2020 indicated that lower than peer funding was a significant contributor to our underlying financial position. This issue remains and BOB is the only ICB below the funding target in the South-East Region. Furthermore, BOB is funded at 24% less than the best funded ICB in the SE Region and 13% less than the regional average, resulting in an allocation that is 2.9% below target. The rate at which progress is made to target funding for 2023/24 is 0.2% and if this rate remains the same BOB will still be 2.1% below target by the end of the five years. Therefore, the need for significant system wide efficiencies and internal productivity has never been more if we are to achieve recurrent financial balance within 5 years (2028).

The BOB system is working on developing two layers of efficiency to underpin financial recovery which will be locally-led and to this end an ICB Efficiencies Collaboration Group (IECG) has been established with the aim of identifying, developing and supporting delivery of system-wide interventions and changes that will benefit patients and maximise value for money (reflected in increased productivity). The IECG will be supported as necessary by Finance teams.

Our Ambition: Up to March 2028 we aim to achieve recurrent financial balance (break even position) across the system on an underlying basis. We are committed to developing a financial strategy that supports a shared vision of healthcare delivery for the whole population of BOB. We will promote a culture of shared financial responsibility, accountability and risk management and work to develop and embed a partnership approach to working with colleagues, supporting productivity and transformation initiatives. Our key enablers to achieving this are summarised below:

To Deliver Our Ambition, We Will:	**1.** Deliver with our financial allocation for next 5 years	**2.** Develop productive and effective finance function	**3.** Work in a collaborative / integrated way across the system	**4.** Prioritise effectively to make decisions on future capital investment

What We Need For Success:

- Consistent and transparent processes and reporting tools which we can rely upon for making timely and informed decisions, relating to ways of working and capital investments goals;
- Executive support from ICB/partners in prioritising such development, possibly supported by external resource
- Staff development/training and close working across partners

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Finance

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Deliver within our financial allocation for next 5 years *Note –* *For this ambition, outcomes and activities continue on to the next page*	• Recurrent financial balance (break even position) across the system.	• Commercial and proactive approach will support the formation of a centrally managed ICS Efficiencies Collaboration Group (IECG) proposed by the System Productivity Committee which will contribute towards the identification, development and delivery of initiatives which will underpin recovery of our core services and productivity. • Financial support will be provided to the IECG which will gather and create initial hypotheses and insights into areas of opportunity, working with existing delivery groups (which would take ownership for developing further and delivering benefits) then monitor and report the status of programmes of work designed to improve support functions and clinical and operational productivity and outcomes. • Finance will support development of original 8 priority efficiency workstreams for 2023/24 are suggested to be initial schemes to develop given that these have been approved previously at Executive level. These are as follows: • Single rate card. • Procurement. • Estates. • Commercial. • Clinical standardisation. • Discharge to assess. • Theatre productivity. • Medicines management.	• Networks and forums will provide access to insight into what other Trusts and systems have planned and implemented to improve productivity and reduce costs. These ideas will be gathered and included in the ideas portfolio for prioritisation. • Model Hospital/productivity toolkit SE Region benchmarking identifies clinical areas of opportunity to improve productivity and cost, supporting clinical standardisation. Areas of opportunity will be gathered, and clinical engagement actioned to develop.	• Insights created from data and benchmarking will identify where opportunities are available to improve productivity and in so doing reduce costs relative to activity.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Finance

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Deliver within our financial allocation for next 5 years	• A finance function that is internally effective and productive and externally effective • 2023/24 planning guidance aims: Recovering core services and productivity; 2. Making progress in delivering the key ambitions in the Long-Term Plan (LTP); 3. Continuing transforming the NHS for the future.	• Maximise the commercial opportunities across the system. • Obtain information, engineer and present in a logical and transparent manner in respect of priority schemes and initiatives. • Produce timely, transparent and concise financial reporting, creation of insights enabling reporting of drivers to management and regulators. • Measure cost effectiveness of finance function benchmarked against other systems.	• Networks and forums will provide access to insight into what other Trusts and systems have planned and implemented to improve productivity and reduce costs. These ideas will be gathered and included in the ideas portfolio for prioritisation. • Model Hospital/productivity toolkit SE Region benchmarking identifies clinical areas of opportunity to improve productivity and cost, supporting clinical standardisation.	• Insights created from data and benchmarking will identify where opportunities are available to improve productivity and in so doing reduce costs relative to activity.
02 Develop productive and effective finance function	• A central approach to system level development by integrating with system Trusts partners. Evidenced through development of: 1. Central financial reporting processes and documentation providing transparency and drivers of financial performance; and 2. Centrally driven horizon scanning and efficiency identification using NHS tools available covering clinical, operational and support functions.	• Redesign our finance function to provide staff opportunity and align resources in the most effective manner to deliver our business-as-usual reporting function. • Control may cover agency controls, rostering, stock levels and usage, provisions and approach to inclusion of assets and liabilities on the balance sheet. Managing this in a consistently agreed manner will likely result in cost savings, albeit not all cash releasing and not all recurrent.	• Review of current opportunity portfolios and ideas arising (from workshops and workstreams, for example) with a view to assessing suitability for scalable system opportunity.	
03 Work in a collaborative, integrated way across the system	• A portfolio of ideas for review and prioritisation and potential further development, collected and collated by the IECG from a variety of sources, both internal and external.	• Previously approved priority efficiency workstreams for delivery across BOB ICS, not yet developed and delivered in 2022/23. This list was the result of a longer list from a brainstorming workshop and therefore the longer list of opportunities should be reviewed again for scalable system opportunity.	• Opportunities will be identified by those working within our ICS and therefore a mechanism by which submission of ideas to the IECG should be created.	

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Finance

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Prioritise effectively decisions on future capital investment	• Processes that enable us to make informed decisions in respect of our investment choices.	• Develop and agree with partners on prioritisation mechanisms for investments (regulatory, health and safety, quality, productivity, staff welfare, case for need etc). • Distinguish between capital and revenue and also recurrent and non-recurrent implications for induvial organisations and wider system.	• Review year one activities and refine processes and key tasks.	• Review year one and year two activities and refine processes and key tasks.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Quality

Context: Our challenge in BOB

Organisations within our system are facing significant challenges relating to capacity, workforce and population health management. System collaboration with all partner organisations is required to maintain and improve quality and safety and deliver a better patient experience.

Our ambition is to build a system in which we deliver continuous quality improvement and an effective early warning system to enable us to rapidly identify and address areas where quality fall below expected standards with a particular focus on pathways and links within systems.

Learning across our system and from others will be central to our ambition to drive improvement in quality and reduce inequalities in access and outcomes.

National policies and drivers – Quality workstreams are driven by national recommendations including the NHS Patient Safety Strategy, Kirkup inquiry and the Patient Experience Improvement Framework.

Requirements identified from other sources: Further workstreams are developed from other national sources e.g., planning and operational guidance. Timely and accurate qualitative and quantitative data and a strong quality assurance framework is required to support meaningful benchmarking both regionally and nationally. The draft NHSE guidance on early warning signs of quality issues provides a comprehensive dataset to inform our view of an organisation's quality.

The new Patient Safety Incident Response Framework (PSIRF), which is part of the National Patient Safety Strategy, represents a significant change in the way we respond to, investigate and learn from patient safety incidents. The new framework supports a move towards understanding the underlying causes of patient safety incidents and has a focus on organisational culture. It gives organisations and systems the freedom to identify their patient safety challenges and opportunities with a clear focus on Quality Improvement.

What our data shows

Provider Trust	Overall CQC Rating	SOF Rating
Berkshire Healthcare Foundation Trust	Outstanding	1
Royal Berkshire Foundation Trust	Good	2
South Central Ambulance Service	Inadequate	4
Buckinghamshire Healthcare Trust	Good	3
Oxford Health Foundation Trust	Good	2
Oxford University Hospitals Foundation Trust	Requires Improvement	2
BOB Primary Care: 157 GP Practices	**Overall CQC Rating**	
153 Practices (97%)	Outstanding or Good	
4 Practices (3%)	Inadequate or Requires Improvement	

*CQC = Care Quality Commission / SOF = System Oversight Framework

Our Ambition:

It is our ambition that “Each patient will receive timely, safe, effective care with a positive experience.” We will demonstrate this by delivering on our Quality Strategy and improving against comprehensive system metrics and our CQC and SOF ratings.

To Deliver Our Ambition, We Will:

1. Publish a Quality Strategy to support improvement which will incorporate the National Patient Safety Strategy.
2. Develop a system-wide quality assurance framework to underpin our improvement work based on the NHSE early warning metrics for systems.
3. Ensure patient experience and co-design is fully embedded in our quality assurance/improvement work and our quality strategy.

What We Need For Success:

- Leadership across the system that is committed to quality and safety, for example in leading the culture shift required for the new Patient Safety Strategy.
- Clear and effective methods for quality assurance, improvement and governance being developed in our framework.
- Co-designed quality strategy with agreed quality objectives, underpinned by programme delivery board.
- Cultural shifts to support effective inter-organisational relationships and improvements.
- Patient involvement and co-design is key to delivering personalised care and improving services in a patient centred way.
- The NHS estate, digital and data are key aspects of quality care. Estates and digital challenges are a frequent underlying cause of quality issues.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Quality

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Publish a Quality Strategy to support improvement which will incorporate the National Patient Safety Strategy	• Co design and agreement of quality priorities across the system. • Identified cross organisational/pathways improvement opportunities.	• Engagement, co design and publication of the quality strategy. • Programme delivery board established. • Sign up and commitment throughout organisation. Executive leadership and clear oversight of progress.	• Review effectiveness of delivery of the strategy to date. • Resource and support for quality objectives. • Review of data/impact from year 1. • Robust inequalities data in place.	• Marked improvement in qualitative and quantitative measures of patient safety. • Measurable culture shift. • Robust inequalities data tracks implementation.
02 Develop a system-wide quality assurance framework to underpin our improvement work, based on the NHSE early warning metrics for systems	• Established clear, embedded data set across system which enables benchmarking and the early identification of issues. • Published framework describing process, governance and culture. • Clear links to objectives, strategy and ambitions. • Systematised Quality Assurance (QA) with stronger focus on Quality Improvement (QI).	• Engagement, co design and publication of the quality assurance framework. • Review of committees, Terms of Reference, and governance to support framework completion. • The system will have effective ways of identifying quality and safety challenges requiring improvement including the systematic use of the system quality metrics.	• Review effectiveness of delivery of framework to date. • Maturity actions in framework achieved e.g., system peer reviews and workforce flexibility. • The system will have a plan for developing the QI knowledge and skills in the workforce and the resources to support QI projects. • The system will have an established network for sharing QI.	• Demonstrable improvements in quality especially focused across pathways/organisations. These will be measurable via our established set of quality metrics. • Adaptation of framework beyond 3 year maturity actions. • Transformation/integration of services based on QA/QI and patient voice.
03 Ensure patient experience and co-design is fully embedded in our quality assurance/improvement work and our quality strategy	• Population is meaningfully and demonstrably involved in quality assurance, planning and improvement. • The BOB system will harness the potential of patient led and personalised care.	• Review of current provision undertaken across system learning from partner organisations. • Develop plan for harnessing patient feedback at all system levels. • Ensure patient feedback mechanisms established and heard at provider level. • Consult on patient partner approach for ICB and provider committees/governance.	• Experts by experience are developed for specialist input. • QI partners/patients' role developed and embedded working with Oxford AHSN.	• Patient led improvements can be demonstrated. • Patient voice routinely involved throughout the commissioning cycle and in quality assurance processes. • An established network of patients, carers and experts by experience supported by ICB team. • Further ambitions related to pooling resources and expertise explored.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Safeguarding and CIC/LAC

Context: Our challenge in BOB

Challenges: Overall the quality of safeguarding and CIC/LAC provided in BOB is good. Three 'PLACE' Safeguarding Teams have established partnerships, networks, assurance systems and processes. During and since the C19 pandemic there has been a significant increase in complexity and intensity of cases from a clinical, safeguarding and a psycho-social context from vulnerable groups. We have a key role in preventing and responding to harm, neglect and abuse of adults and children. Our ambition is to create a culture across the ICS that has at it's heart the welfare of our most vulnerable citizens and ensures a strong safeguarding voice, promotes system learning, development, quality improvement and an effective early warning system to enable us to rapidly identify and address areas where safeguarding falls below expected standards. Organisations within our system are facing significant challenges from capacity, workforce and population health management. System collaboration with all partner organisations is required to maintain and improve safeguarding and deliver a better outcomes for the vulnerable.

National policies and drivers - Safeguarding workstreams are driven by the NHS Safeguarding accountability and assurance framework (SAAF) and enquiries e.g. National Review of Children's Social Care following the deaths of Arthur Labinjo-Hughes and Star Hobson and The Independent Inquiry into Child Sexual Abuse.

Requirements identified from other sources: Further workstreams are developed from the safeguarding priorities identified in partnership through the safeguarding child/adult partnerships/boards across BOB ICS.

Our Ambition:

It is our ambition that "Each child or adult in need of our services is supported to stay healthy, keep their independence and live their lives free from abuse and neglect."

By March 2028 we will have developed a strategy and framework and will have demonstrated quality improvements to support provision of safeguarding that is equitable and meets the needs of the BOB population. All providers in BOB will be rated good or outstanding.

To Deliver Our Ambition, We Will:

1. Work across ICB Directorates and with ICS partners to assess demand and capacity – standardise and identify new ways of working for priority workstreams. Engage with vulnerable adults, children and young people and their representative groups to improve their experience and to develop our services.

2. Work to align and standardise our safeguarding Quality Assurance Framework (QAF) and processes.

3. Developing an improvement programme which promotes preparation for new legislation and duties. As an initial priority is to align with the Community Safety Partnership and Thames Valley Police priorities (all age) to meet the statutory violence duty.

What We Need For Success:

- The quality of safeguarding is interrelated with poor performance which inevitably has an impact on early recognition, prevention, response and outcomes. Addressing the system challenges and improving safeguarding are inextricably related.
- Leadership across system which is committed to safeguarding and understands that 'safeguarding is everyone's business'.
- Work to ensure the patient voice is heard and acted on – make safeguarding personal and using experts by experience and include all family
- The NHS estate, including digital, is a key aspect of good safeguarding, digital challenges are a frequent underlying cause of poor information sharing and recognition of vulnerability and risk. Development of a dashboard to allow for more transparency e.g. number of children on CP plans, CIC/LAC data, MASH referrals child and adults, number of DoLS, training compliance.
- A highly skilled, supported and motivated workforce is essential to delivering high quality safeguarding.
- Resources will need to be made available to support safeguarding and LAC teams in organisations to have the capacity as well as the capability to manage increased complexity and demand.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Safeguarding and CIC/LAC

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 **Work across ICB Directorates and with ICS partners to assess demand and capacity – standardise and identify new ways of working for priority workstreams. Engage with vulnerable adults, children and young people and their representative groups to improve their experience and to develop our services.** • Children in Care /Looked After Children (CIC/LAC) – Initial Health IHA/RHA clinical capacity • Multi Agency Safeguarding Hub (MASH) child and adult clinical capacity • Health Visitor/School Nurse HV/SC capacity • Quality Assurance Framework (QAF) capacity/prioritisation	• To have sufficient capacity and capability within key early help and safeguarding services to be able to work effectively and QA our commissioned services. • This will lead to an improved safeguarding culture and a better experience for patients and staff involved in safeguarding processes. • This will provide us with assurance concerning the quality of safeguarding and CIC/LAC services	• Assess demand and capacity for IHA/RHA and MASH child and adult services and develop business cases for increased clinical input • Review, identify new ways of working and renegotiate contracts with health providers of IHA/RHA and MASH services, to include KPIs • Participate in NHSE Pilot Looked After Children Integrated Dataset • Explore provision of annual pre-payment certificates, free dental care and ophthalmology for Care Leavers, 18- 25 not entitled to free prescriptions. • Work with the public health commissioners in local authorities concerning assessment of demand and capacity in HV/SN services • Assess demand and capacity to provide safeguarding supervision and QA commissioned placements e.g. Sec 117 and develop standardised BOB safeguarding QAF. • Review the impact of inequalities seen in safeguarding cases e.g. poverty, access to physical/ & mental health services, LD/A & neurodivergent, asylum seekers & travelling communities	• Increase MASH clinical capacity for children based on demand • Work with partners to consider the feasibility of developing adult MASHs in BOB • Clear link between QI programme based on learning from patient safety incidents	• Demonstrable improvement in qualitative and quantitative measures of safeguarding and CIC/LAC in priority work streams • Consistently achieve statutory standards, including time standards for IHA/RHA • Identify priority work streams based on year two review

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Safeguarding and CIC/LAC

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 **Work to align and standardise our safeguarding Quality Assurance Framework (QAF) and processes**: • Effective information sharing - new national Multi-Agency Safeguarding Partner Performance Board (MASPP) • Legal literacy MCA/DoLS/ - linked to preparedness for LPS and including inherent jurisdiction – Deprivation of Liberty Orders for CYP • Implementation of Multiagency Risk Management (MARM) Frameworks • CPIS 2 – introduction of next stage Child Protection Information Sharing system	• Implementation in practice of recommendations from national inquiries • Implementation in practice of learning from Safeguarding Adult Reviews and Child Safeguarding Practice Reviews in BOB • Effective information sharing systems and processes • Practioners who are legally literate as part of the preparation for the implementation of LPS	• Stock take/audit of multiagency work already underway via child and adult safeguarding boards and partnerships concerning effective information sharing to provide a better understanding of challenges and gaps – there is a relationship between this work and MASH clinical capacity • Design and roll out a programme of legal literacy training • Promote awareness and use of MARM designed to support partners to achieve successful outcomes when working with individuals who remain at high risk of harm despite interventions under S9, 11 or 42 of the Care Act • Participate in national consultation, introduction of CPIS 2	• Agree and develop a multiagency framework for effective information sharing, including real time evaluation and early warning indicators of failure. • Monitor legal literacy – audit and evaluation of impact of training on confidence/competence of practioners • Monitor use of MARM – audit and evaluation of practioners knowledge and confidence • Develop CPIS2 roll out plan in line with national recommendations	• Embed year one workstreams – business as usual • Identify risk based priority work streams based on national drivers and BOB ICS safeguarding board/partnership priorities

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Safeguarding and CIC/LAC

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 **Developing an improvement programme which promotes preparation for new legislation and duties. As an initial priority is to align with the Community Safety Partnership and Thames Valley Police priorities (all age) to meet the statutory violence duty.** Workstreams will include: - Criminal Exploitation - Child Sexual Exploitation - Contextual Safeguarding - Vulnerable and seldom heard groups e.g. LD and Neurodivergent, people with mental health needs - Domestic abuse - Violence against women - Modern Day Slavery - Transition to adulthood – links to SEND	A system working together to support the 5 national/Thames Valley Violence Reduction Unit work streams: 1. Data & Targeting 2. County Lines and Misuse of Drugs 3. Early Prevention and Intervention 4. Communities & Partnerships 5. Law enforcement and criminal justice	• Establish consistent ICB attendance and participation at the Thames Valley Violence Reduction Strategic Board • Ensure appropriate ICB representation at 5 Community Safety Partnerships • Arrange for the Office of the Police and Crime Commissioner – Thames Valley and Thames Valley Violence Reduction Unit to present to an appropriate ICB group • Establish that all acute providers are providing emergency department core violence data set to Thames Valley Together Project and Community Safety Partnerships and that this includes domestic abuse data • Arrange a BOB ICB/ICS event/work shop to raise awareness of Serious Violence Duty, understand work already underway in provider organisations and systems at PLACE, understand gaps and develop a phased plan to address. • Support Emergency Department Navigator projects – mentoring for young people funded by TV VRU	• The system will have an established network for understanding and implementing the Serious Violence Duty • Patient and public involvement and engagement will be integrated in violence reduction strategies • Develop a collaborative plan to implement the Serous Violence Duty at Place to address locality issues and on a BOB wide footprint as necessary. • Co-commission/fund early intervention prevention schemes pump primed by HO money via VRU that will taper off during 2023-25 2 e.g. ED Navigator schemes.	• Cultural shift concerning the understanding of trauma, early intervention and violence prevention as a public health issue • Implementation and evaluation of impact of collaborative plan

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Infection Prevention and Control

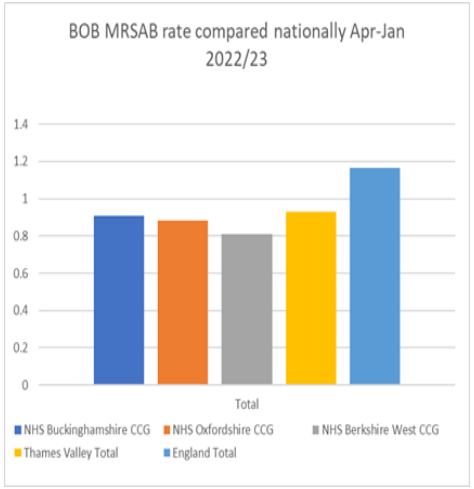
Context: Our challenge in BOB

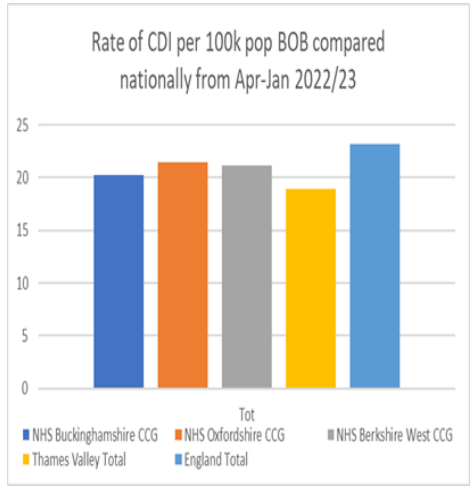
Population health needs: Our vision is to ensure that all healthcare services are providing clean, safe, effective care. Nationally the acquisition of a healthcare-associated infection (HCAI) remains a major cause of avoidable patient harm and has been shown to pose a serious risk to patients, clients, staff and visitors in a health and social care setting.

Current performance: The previous 4 years, since 2018/19, BOB has been placed below national average for C.difficile rates although above Thames Valley and on par with national average MRSA and Ecoli rates. Gram negative bloodstream infections (GNBSI) have shown a year-on-year increase nationally until the Covid pandemic. Although nationally and locally significant progress has been made year on year in the number of patients developing severe infections such as Meticillin Resistant Staphylococcus aureus (MRSA) and Clostridioides difficile (CDI), the reduction of HCAIs remains a key priority for the NHS.

Our Ambition: To establish a system wide infection prevention and control service and network that provides quality advice to services and service users to reduce preventable infection across the system.

MRSA and CDI infections rates are low for BOB against national levels





To Deliver Our Ambition, We Will:

1. Fostering integration, partnership and alliances among the newly formed Integrated Care Partnership (ICP).
2. Reduce BOB ICS reportable Clostridioides difficile infections (CDI) and Gram-Negative Bloodstream infections (GNBSI).
3. Antimicrobial Stewardship to within targets set.

What We Need For Success:

- Buy in at every level of the ICS that IPC is a top priority and essential to improving health for all.
- Funding and work planning for IPC Service (administrator, sessions for microbiology and pharmacy, data analyst).
- Communication and collaboration across ICS – digital infrastructure implementation across primary and secondary care to monitor infection risks and cases.
- Infrastructure for IPC governance and board assurance at system level.
- Access to Behavioural change expertise to support change of practice.
- Link practitioners in every care home, GP practice, dentist who are competent and updated through an established program.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Infection Prevention and Control

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Fostering integration, partnership and alliances among the newly formed Integrated Care System Stakeholders include: • Chief Executives • Chief Nurse • CMO • IP&C Leads from all settings • Primary Care Leads • Care Home leads • Finance • IT support • HR	• Transition from PLACE based to system wide IPC – establish BOB IPC Team. • Establish BOB ICB IP&C team complimented by a network of IP&C leads within providers. • Established IPC projects and workstreams informing policy and practice led by BOB IPCT. • IPC network that includes residential and care homes, primary care, dental • Working towards with ICS IPC board assurance framework. • Established IPC within system governance. • Competent and skilled link practitioners across settings. • System wide policies, guidelines and service user information. • Digital infrastructure to support delivery of infection prevention across settings. • Research and innovation network to improve IPC and patient outcomes and experience. • Recognition of specific place-based needs towards IP&C quality improvement.	• Establish BOB IPC Team with clear workstreams and projects that are system wide. • Inform wider IPC MDT in BOB workforce planning (pharmacy, data analysts, microbiology, epidemiology, behaviour change scientists). • Develop IPC 3-year plan built on Board Assurance Framework, report as part of quarterly report to ICS Board (to include AMS, GNSBI and CDI). • Understand existing IPC network across system and map future at local and system level. Plan study day to share plans and this JFP – aim of working towards IPC compliance across settings. • Develop competencies for link practitioners across system. • Business case presentation for digital systems (for HCAI surveillance and monitoring, IPC audit system for standard infection control precautions and outbreak). • Policy review and implementation.	• IPC BOB Team delivering workstream objectives and informing future planning. • Program of audit and education for link practitioners. • Build and implement digital infrastructure to support IPC across settings. • Create research and innovation network of IPC across settings to improve experience of service users. • Identify areas for standardisation, i.e., policies, implementation of Health and Social Care Act. • Review of journey so far to inform further planning.	• Reflect and consult on future with service users and build on research and innovation across settings to inform patient experience. • Review and update policies as part of review cycle. • Implement standardisation of previously identified workstreams.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Infection Prevention and Control

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Reduce BOB ICS reportable Clostridioides difficile infections (CDI) and Gram-Negative Bloodstream infections (GNBSI Stakeholders include: • IP&C Leads from all HC settings (DIPC's) • ICB • Meds Op teams • Primary Care Leads • IT support • NHS England • UKHSA	• Maintain HCAI rates within the annual set thresholds of NHS England year on year. • The national ambition is to halve GNBSI's by 2024/25 from 2016 baseline.	• Review internal collective resources e.g., IPC nurses, admins staff and IPC funding and address demands (current and future) and potential service gaps, to allow for succession planning and sustainability. • Develop a business case for an IPC surveillance eSystem e.g., ICNet • Assurance of IPC practice in all healthcare settings to reduce risk of transmission of HCAI, (shared learning and cross-organisational links to be able to effect change). • Seek assurance on National Standards of Healthcare cleanliness to reduce environmental transmission in acute and community trusts. • Review prevention and control strategy for CDI in primary and secondary care and monitor of themes and trends to ensure awareness of local risks for CDI & GNBSIs. • Continue plans to put Hydration Project in place across BOB in the community. • Review benefits catheter passport in Berks West, with view to launch BOB wide as appropriate. • Learn from PSIRF and agree practice improvements where required.	• On the basis of eSystems in place across BOB from year 1, analysis of all E coli) BSI across BOB (pre and post 48hr cases). • Explore point of care diagnostics to support more prudent prescribing. • Developing and implementing effective antimicrobial stewardship quality measures. • Review and collate SSI audits from acute trusts to identify gaps and improve practice to reduce GNBSI. • Produce action plan, following the results of the hydration project. • Survey public attitudes to and awareness of AMR and self-reported behaviours through new technologies, including social media; and use these to assess the impact of national public health campaigns and local awareness-raising activities. • Review of all quality improvement projects e.g., DRIPP to determine BOB standard action plans. • Explore IPC in the built environment specialists within the ICB to provide advice. • Aim for alignment with IPC Manual (England) by 2024 – including polices.	• Analysis existing data and guidelines to improve our understanding of HCAI reduction successes and draft action plan accordingly.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Infection Prevention and Control

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Antimicrobial Stewardship to within targets set. Stakeholders include: • IP&C Leads from all HC settings (DIPC's) • ICB • Meds Op teams • Antimicrobial Pharmacists (NHS trusts) • Primary Care Leads • IT support • NHS England • UKHSA	UK's five-year national action plan to achieve UK's 2019–2024 national vision to tackle AMR: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1070263/UK_AMR_5_year_national_action_plan.pdf • reducing need for, and unintentional exposure to antimicrobials. • Optimising prescribing practice to drive down inappropriate and indiscriminate use of antimicrobials in order to conserve the use of available antibiotics. • investing in innovation, supply and access.	• Continue to monitor and promote use of antibiotic guidelines in acute and primary care with a BOB wide standardised approach of Microguide and SCAN guidelines to ensure best practice prescribing. (Meds Op team). • Progress the establishment of an antimicrobial stewardship programme in all healthcare settings. • Collect the learning from practice audits on UTI prescribing and put a summary of learning points into the BOB Medicines Optimisation newsletter (May 2023). • Antimicrobial audit to be included in 23/24 prescribing quality scheme for primary care. • Consider the use of IC-Net across BOB secondary care to monitor prescribing and identify themes that increase risk of HCAI. • Launch webinar to include details of antibiotic prescribing dashboard, with an update on CDI rates pre and post pandemic. • Reviewing and addressing current IPC capability within the Antimicrobial Stewardship (AMS) and Health Protection (HP) Workforce. • Identify non pharmaceutical intervention & prevention and include as education.	• Improve professional education, raising wider awareness on the basis of audit findings. • Support the education of patients and the public around AMR , prevention and self-help messages. • Explore point of care diagnostics to support more prudent prescribing.	• Continue to developing and implementing effective antimicrobial stewardship quality measures.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Context & Ambition: Personalised Care

Context: Our challenge in BOB

Personalised care is the key to quality interactions between patient and professional. It means engaging people in decision making about their care, how it is planned, delivered and how we address disease before it occurs, taking into account individual health risks, lifestyle and health goals. Over 45% of people nationally want to be more involved in decisions about their care. Those people who feel confident in managing their health have 18% fewer primary care contacts and 38% fewer emergency admissions than their peers. It is recognised in the NHS Long Term Plan as a key change in NHS provision.

Across BOB we recognise that our local population needs are becoming increasingly complex and a *one-size-fits-all* health and care system does not match our individual requirements. Personalised care supports the reduction of health inequalities by looking at system equitability, accessibility and adaptation to needs. Whilst recognising that prevention is an essential element of personalised care, meaning people can enjoy their best possible health and well-being by positive lifestyle change and supported self – management. We want people using our services to be empowered to ask questions and tell us what is important to them, and we need those involved in their care to listen and then tailor their care, support and treatment. In many areas of the system personalised care approaches are well established in a number of clinical pathways with trained and skilled workforce. However, there is variation across the ICB and we need to embed a personalised care culture across our system partners and develop these broad principles.

Challenges: Integration and maturation of ICB. Limited coproduction and design with our population and local partners. Lack of joined up governance, structures, clear communication and sustainability of existing resources including funding, staffing, training, workforce capacity and competing priorities.

Personalised Care Enabler	Delivered Q1-Q3 22/23
Personalised Care and Support Plans	59,108
Personal Health Budgets	2,702
Social Prescribing Referrals	37,979
Number PCN Social Prescribing Link Workers	90
Workforce trained in PC skills	904

Our Ambition: By March 2028 , personalised care interventions will be fully embedded in to key clinical pathways (Maternity, End of Life, Cancer and Diabetes) across the BOB wide system. With our health workforce upskilled to deliver a personalised care approach based on 'what matters' to people and 'their individual strengths and needs'. The shift from reactive medicalised approach to proactive partnership approach requires us to work with peer leaders to shape our strategy. Our seniors and executives in the ICB acknowledge and commit to personalised care as essential to provision of our system wide vision. A golden thread essential driver in service development and improvement.

To Deliver Our Ambition, We Will:

01 Increase the Personal Health Budgets offer to the BOB ICB population.

02 Upskill our health and social care workforce to deliver a personalised care approach.

03 Embedding a person centric approach in practice and clinical pathways.

04 Increase awareness of social prescribing to the population and increase the number of Social prescribing link workers in primary care.

05 Recognising personalised care approach transcends all workstreams across the ICS.

What We Need For Success:

- Commitment from ICB executives to a personalised care approach in everything we do. A shift in culture and behaviours to support adaptation and delivery across the system. Have Personalised Care considered with any service review.
- Funding to sustain current workforce, Clinical and Senior leadership to influence and leaders the health and social workforce.
- Funding to expand capacity and develop new services. Collaboration with system partners to develop and integrate pathways.
- Joint working with interdependent teams e.g. inequalities, End of Life, Maternity, Cancer, Frailty, Urgent and Elective Care.
- Digital strategy to prioritise personalised care as a key enabler of change with @home, Virtual Wards, digitising care planning, shared care records.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan for Personalised Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Increase the number of Personal Health Budgets offered to the ICB population	Personal health budgets can be offered to those on the continuing health care pathway, those with a section 117 under the mental health act and those referred to local wheelchair service. In 22/23 the ICB are 50% below expected target for patients issued with a personal health budget. This means that 2000 patients are missing out on choice, flexibility and control over their health care. We need to ensure that everyone who is eligible for a PHB is offered one.	• Work with partners to ensure that every person eligible for a Personal Health Budget is offered one. • Ensure that the health and social care workforce have an awareness of the PHB offer and are skilled in how to discuss PHBs with those eligible. • Ensure that the PHB offer, and approach is consistent across the ICB to prevent inequalities. • Scope trajectories for delivery of PHBs.	• Explore areas to expand the offer of PHBs e.g., for those discharged from hospital or in areas where greater choice could benefit patient outcomes. • Develop a network of lived experience to lend expertise to, Getting it right first time. • Scope areas of health inequalities and challenges to access for PHBs. • Set PHB delivery trajectories.	• PHBs are offered to other cohorts e.g., discharge, neuro diverse. • PHBs are well embedded in the three main areas of eligibility, and also selected areas where value and impact is evidenced. • Awareness of PHBs is extensive amongst health and social care workforces. • Review position against PHB delivery trajectories.
02 Upskill our health and social care workforce to deliver a personalised care approach	BOB ICB has the benefit of an in-house training team who are working with our primary, secondary and community care workforce to provide the skills needed to deliver a personalised care approach. We aim to provide training to over 1000 members of the workforce per year. This training includes: • Motivational Interviewing • Making Every Contact Count • Shared Decision Making • Personalised Care and Support Planning The team also work to raise the awareness of personalised care operating model including awareness of social prescribing and personal health budgets	• Work with teams across ICB providers to extend our offer of sustainable, training and build personalised care capacity and capability in our workforce, to optimise outcomes for people and populations. • With a 'whole team' approach we will train teams throughout patient pathways to ensure the patient has a consistent person-centred approach throughout all their interaction within health services. • Target key areas to train staff in personalised care skills: Elective waiting list, Diabetes, Respiratory, CVD, Maternity, Cancer, Palliative and End of Life Care and Frailty. • ICB Delivery Leads to take ownership of PC for their portfolio.	• Personalised care training offer is expanded to further pathways e/g mental health, weight management, and multi morbidity care and support planning rolled out across PCNs. Aim to impact on non-elective admissions and winter pressures highlighted from the urgent care teams. • Identify patient outcome measures. • Embed and expand offer of PCSP multimorbidity training across PCNs.	• Personalised Care training workforce is expanded to meet demand and provide ongoing mentorship to workforce. • Personalised care training expanded to include social care and the Voluntary sector. • Develop PC all age offer (pathways for children and young people).

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Our Joint Forward Plan for Personalised Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Embedding a person centric approach in practice and clinical pathways	Embed personalised care into clinical pathways. We will take a whole team approach meaning that the patient will receive the same personalised care approach from all the different professionals and organisations on their care pathway. Key areas of focus will be: • Long term conditions – CVD Diabetes, Respiratory Pathways. • Frailty. • Palliative Care and End of Life. • Cancer. • Maternity. • Weight Management. • Urgent and Emergency Care. • Dementia.	• Develop a clear vocabulary and explanation of all the multi-professional workers our population may come in contact with in their multi-disciplinary team. • Working with system partners, in particular our long-term condition, planned care and urgent care colleagues to ensure that personalised care is considered for non-elective presentations, frail, multi-morbid, virtual wards and ambulatory pathways. • Develop a framework to engage with local partners and VCO about how we proactively engage with our local population. • Work with our digital team to enable digital innovation to support PC e.g., digitised care planning.	• Drive the conversation around transition from paediatric to adult services with a personalised approach to reduce those lost in the system, DNA rates, disease progression. • Implement framework to engage with local partners and VCO about how we proactively engage with our local population. • Work alongside our Public Health colleagues to educate the system partners on the use of population health measurement tools to help identify pockets of health inequalities and to help local and system teams address their needs.	• Personalised Care is business as usual within all health services and is supported and sustained by the ICB training team. • Personalised care is part of the ICB quality framework, and all recruitment of staff requires knowledge and training. • Ensure personalised care is a key corner stone of education and training of future health and social care workers by collaborating with our local training schemes, colleges and universities.
04 Increase the number of Social prescribing link workers in primary care and increase awareness of social prescribing to the population	PCNs across the ICB currently provide social prescribing services in GP practices to support the wider determinants of health of our patients. PCNs currently employ approximately 200 personalised care ARRS staff, (social prescribing link workers, care coordinators or health coaches), who work together to contribute to the social prescribing offer in primary care. We will work to sustain this valuable workforce by proving the value of their work and encouraging a growth in the workforce. We aim to increase the number of social prescribing referrals for our patients across BOB.	• Work with PCNs to support social prescribing staff, to recruit, embed and retain their teams. • Together with patient peer leaders and partners across the ICS to develop a social prescribing strategy to enable a thriving social prescribing landscape working closely with the voluntary sector. • We will expand the awareness of social prescribing • Work with social prescribing workforce to proactively support areas of health inequality. • Prepare winter pressures mitigation strategy utilising ARRS staff to identify vulnerable patients and provide proactive support to minimise risk of need for health resources over winter.	• Social prescribing outcome data is captured in a consistent way with a minimum data set and supported by patient case studies. • Social prescribing link workers can access digital tools to support and evaluate referrals. • External agencies can directly refer to PCN link workers.	• Introducing specialist roles where possible (e.g., children and young people) to meet the needs of the local population. • Social prescribing link workers enabled to deliver within secondary care. • Social Prescribing is available in all PCNs across BOB with self-referral and specialist link workers as part of the offer.

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Our Joint Forward Plan for Personalised Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
05 Recognising personalised care approach transcends all workstreams across the ICS	• We will work to make personalised care an essential driver in health and social care service improvement across all services. • ICB and Executives are asked to acknowledge and accept PC as vital to the successful provision of system-wide high quality personalised care. • Personalised care should be embedded across our transformation plans, new services and existing services. • We will work together as a system to bring a culture of personalised care. • PC is seen as vital to improve outcomes in population health, tackle inequalities in outcomes and enhance productivity and value for money and help the NHS support broader and social economic development.	• Develop and embed ICB personalised care and governance including clinical leadership and patient peer leaders to enable and assure workstream at Executive Board. • Establish and grow a network of PCI ambassadors for personalised care across BOB ICS. • Identify PC champions across secondary, primary and community care to drive the PC agenda. • Develop stakeholder map and identify key influencers. • Develop communications strategy to socialise PC agenda and raise awareness.	• Develop personalised care assessment template to be used within all service design. • PC training is embedded in all new starter inductions for ICB Staff.	• Expand network of key stakeholders and influencers. • PC training is embedded in new starter inductions across the wider health system.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Research, Innovation and Quality Improvement

Context: Our challenge in BOB

Our Opportunity: BOB is home to world leading research capability in addition to a significant portion of the UK's life sciences, AI and digital innovators base in the UK.
There is significant potential to work more closely with our research and innovation partners to directly address the identified priorities of our population.

Our Challenge: To work more closely with our partners to identify key common research priorities which demonstrably meet the health and care needs of our population
There is a need to increase our awareness of the currently existing relationships across the ICS research and innovation ecosystem, to strengthen our engagement and relationships within it and work towards identifying key shared goals

Our Ambition: By March 2028, we will have a densify golden thread of research, innovation and quality improvement running through our services and our decision-making.
This should lead to better access, experience and outcomes for patients, a more professionally rewarding and engaging environment for staff, as well as better deployment of our available resources for care.
This will require delivery against the 4 goals stated below to embed a system of working throughout the ICS and in close collaboration with our partners,
This will enable us to tailor and target research and innovation more closely to our population's needs and by extension to our strategic priorities.

To Deliver Our Ambition, We Will:

1. Build a strong partnership of research and innovation partners, with a common aim of improving support for patients and improved ways of working. identifying and agreeing research and innovation priorities for our population.
2. Develop a process for identifying and agreeing research and innovation priorities for our population.
3. Build a culture and capability for research, innovation, and implementation across the BOB system.
4. Agree and implement an approach to evaluating the impact of innovation and adoption.

What We Need For Success:

Require executive support from ICB/partners (including AHSN) in developing a coordinated set of relationship and alliances that are aligned to the BOB ICS ambitions and agreement of priority areas.
Patient and Public Engagement – Strengthen public, patient and service user involvement in research and its design
Staff Engagement and cultural development – benefits of research and innovation to patient outcomes explicit and clear to all. Celebrate positive change for patients
More intelligent use of data held within the system to drive research and innovation initiatives.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Research, Innovation and Quality Improvement

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Build strong partnership of research and innovation partners, with a common aim of improving support for patients and improved ways of working. identifying and agreeing research and innovation priorities for our population	By Q2 2023/4, BOB ICB will have: • Established clear and strong relationships with all major research and innovation partners within the BOB Geography and with Frimley ICB. • Have clear links and relationships with all research and innovation teams and key individuals within our member organisations. • Strengthened public, patient and service user involvement in research and its design.	• Validate the list of organisations involved in research and innovation spread across BOB. • Map the current regular meetings, groups and alliances that facilitate working between partner organisations. • Collaborate across the organisations to develop a coordinated set of relationship and alliances that are aligned to the BOB ICS ambitions. • Promoting engagement with patients and the public from all communities, ensuring they can access information about opportunities to get involved in research: 1. have equitable access to register their interest and take part in research. 2. are supported to get involved in identifying research needs and shaping research plans.	• Strengthen relationships with partners in order to develop some key shared prioritisation and planning of research, innovation implantation and evaluation of impact. • Continue to align the BOB member organisation research and innovation priorities with those of the wider population. • Develop scale and scope of patient and public participation in research and innovation. • Seek to further strengthen relationships with Life Science business, AI and digital innovators.	

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Our Joint Forward Plan For Research, Innovation and Quality Improvement

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Developing a process for identifying and agreeing research and innovation priorities for our population.	By Q3 2023/4 BOB ICB will have • Agreed and shared its research and innovation priorities for 2023/24 with all major research and innovation partners within the BOB Geography. • Contributed to and influenced the research and innovation priorities for 2023/24 of its major research and innovation partners including notably the AHSN and the ARC. By Year 2: • There should be a process in place by which the research and innovation priorities for member and partner organisations are agreed. From Year 3 onwards: • There should be a cycle in which research and innovation priorities are: 1. Agreed 2. Implemented 3. Reviewed	• Agree a process to agree our research and innovation priorities with member and partner organisations. • Agree and resource the architecture needed to drive and assure this process. • Review and better utilise our quality processes to drive innovation. • Work with research partners to identify emerging transformational technologies and translate outputs from horizon scanning.	• Strengthen relationships with partners and increase levels of common prioritisation and planning of research, innovation implantation and evaluation of impact. • Review and assure the processes established in year 1. • Work with research partners to identify emerging transformational technologies and translate outputs from horizon scanning.	

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Research, Innovation and Quality Improvement

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Build a culture and capability for research, innovation, and implementation across the BOB system	Starting Q1 2023/4 there should be increased visibility of the benefits and potential of research and innovation to our workforce. By Q3 2023/4 BOB ICB will have shared its research and innovation priorities across the BOB system. By Q4 2023 The ICB will have dedicated resource and infrastructure to support a culture and densify capability for research, innovation, and implementation across the BOB system. By year 3 The workforce and teams in the ICS should be better supported in developing their research , Innovation and quality improvement skills. By Years 3-5 A culture of permission for innovation and quality Improvement with the aim of establishing a vibrant QI Community of Practice.	• Q1 2023/4 To map the assets currently available within BOB to support the culture and capability for research and innovation. • Q1 2023/4 To agree any additional resource and infrastructure needed to build and support this culture and capability. • Q3 2023/24 To identify methods of making the benefits of research and innovation to patient outcomes explicit and clear to all. • Work with the AHSN and the ARC more closely to better understand their potential in building the desired culture and capability and to learn from their experience. • Work with the AHSN Patient Safety Collaborative to identifying and spread safer care initiatives from within the NHS and industry.	• To establish a development programme available for all staff and teams to increase their confidence and capability in the areas of research, innovation and quality improvement. • To review and refine the way in which we disseminate and socialise the impact of innovation and the adoption of new technologies on patient access, experience and outcomes as well as on staff and organisations.	• To review and refine the development programme available for all staff and teams. • To evaluate the success of the measures taken to promote a culture and capability for research and innovation within BOB. This may be measured by: 1. Levels of staff engagement in research and innovation. 2. Levels of awareness of innovations undertaken. 3. Levels of awareness of impact on patient care. 4. Staff Development. 5. Staff satisfaction and retention.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Research, Innovation and Quality Improvement

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Establish methodology to evaluate impact of innovation and implementation	By years 3-5: • To establish a virtuous loop of evaluation to better understand the impact of innovations made to better inform potential for dissemination or to trigger further cycles of change.	• Work with the AHSN and the ARC to develop and agree a process to evaluate the impact of research and innovation on the people who live and work in the BOB area. • Use national networks and resources such as the Future NHS Integrated Care Learning Network to learn from others. • Work with known local experts in BOB with a particular expertise in real world evaluation.	• Review the success of the methodologies used in 23/24. • Review the impact of the projects undertaken in 23/24. • Consider new or updated methodologies, seeking to learn from others.	• Review the success of the methodologies used in previous year. • Review the impact of the projects undertaken in previous year. • Consider new or updated methodologies, seeking to learn from others. • Seek to collate and demonstrate to impact of innovations undertake to patients, the public and the workforce.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: All Age Continuing Care

Context: Our challenge in BOB
ICBs have a statutory responsibility for securing, to a reasonable extent, the health care which an individual needs. For adults, this includes implementation of the legislatively mandated National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care; for children and young people a similar arrangement is delivered through the Children and Young People's National Framework.

All Age Continuing Care (AACC) has had a variety of delivery mechanisms at place across BOB. The Buckinghamshire and Oxfordshire teams have been outsourced since 2012 with Berkshire West in-house which has created some variation in process and outcomes both for the population we serve, and the staff involved.

The aims of BOB health and care services delivering on our AACC ambition are to:
a) Reducing unwarranted variation across BOB by implementing a transformation programme that considers overall delivery functions.
b) Enabling patients to have better choice and control through a consistent offer of Personal Health Budgets.
c) Improving quality of care by actively seeking views on, and reviewing the service as a result of, the experiences that individuals and their families have throughout their AACC journey within BOB.

To achieve these aims will require NHS, Local Authority and Voluntary Community and Social Enterprise sector (VCSE) partners working effectively together to deliver efficient, integrated and multi-disciplinary services to support the most vulnerable people in our population. A personalised approach will ensure patients are assisted to develop a care plan, based on 'what matters to me', with a trusted and skilled advisor towards activities that will help support their physical and mental health needs. Engagement with people with lived experience is key to improving services in order to support people and communities live healthy and happier lives.

Our Ambition…
By 2028, our ambition is to ensure the AACC service in BOB is delivered through a more consistent, equitable, personalised and sustainable approach that ensures positive work cultures and behaviours in order to provide a better experience for our population.

To Deliver Our Ambition, We Will:

1. Identify system level service development opportunities and efficiencies to inform the future AACC strategy.

2. Provide a 'Framework' compliant multi-disciplinary integrated approach for those people who require consideration for AACC.

3. Offer proactive personalised care planning to those individuals with more complex needs who are eligible for AACC.

4. Work closely with other BOB workstreams that interlink with AACC e.g., safeguarding, palliative and end of life care.

What We Need For Success:

- Cross-system and Place-based governance arrangements to enable leadership, focus and coordination to achieve the AACC aims and ambition.
- Workforce trained in high quality AACC delivery from referral to decision and onward through review and case management with an ability to apply a person-centred approach.
- Develop cross system relationships to enable integrated care and for the person to be supported to have choice and control in the way their care is delivered.
- Funding allocations that reflect a growing population need for AACC in order to support workforce ambitions and strategies.
- Digital information systems and platforms to enable wider system understanding. Business intelligence resource that can interrogate and present the data in order to improve outcomes.

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Our Joint Forward Plan For All Age Continuing Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Identify system level service development opportunities and efficiencies to inform the future AACC strategy.	• Identify key workstreams. • Develop an options appraisal of the All Age CHC Operating Model. • Develop an options appraisal to outline potential models for All Age CHC commissioning across the ICS. • Scope the potential delivery of 'Quick Wins' including timeframes.	• Using the NHSE service improvement programme CHC Maturity Matrix undertake an analysis of AACC services including Personal Health Budgets across the three CCG / Places and identify areas of risk and opportunity whilst considering the immerging ICS configuration and aspiration. This would include the review of background documentation (strategy and planning documents), governance documents, data, and performance. • Undertake a workforce capacity and resource analysis. • Review commissioning and contracting arrangements across the ICS and analyse the key findings, identifying risks and opportunities in relation to QIPP and Quality Assurance. • To undertake a budgetary analysis of the AACC service across BOB. • Agree standardised quality, performance and finance metrics and processes. • Engagement with Key Health and Social Care Stakeholders. • Engagement with Patients and Carers for example Healthwatch, patient and carers groups.	• Maintain a proactive approach to recruitment and retention including robust induction processes and seeking stay and leaver interviews. • Implement and embed efficient commissioning and contracting arrangements across the ICB. • Embed monitoring and reviewing of performance delivery against national and local KPIs; developing improvement plans where required. • Maintain integrated working arrangements at system level.	• Assessments occur at the right time and place, meeting all nationally mandated KPIs. • Reduced variation in patient/carer experience of AACC assessments and eligibility across BOB. • Establishment of appropriate ICB oversight of AACC and related services performance, developing locally appropriate KPIs. • Standardised and enhanced corporate support services for AACC and related services, improve service resilience and efficiency. • Commissioning of services at scale where appropriate whilst retaining local flexibility and responsiveness.

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Our Joint Forward Plan For All Age Continuing Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
02 Provide a 'Framework' compliant multi-disciplinary integrated approach for those people who require consideration for AACC.	• Develop a workforce structure within AACC that is fit for purpose. • Ensure strong leadership is in place for the AACC workforce at both ICB and at place. • Develop relationships with system partners to ensure an integrated and consistent approach. • Create a Training and Development role that ensures delivery plans are in place, all staff maintain up to date training (both in terms of Statutory and Mandatory training and role specific training), policies and procedures are regularly reviewed etc. • Ensure all staff have access to relevant training opportunities. • To ensure that the ICB has relevant policies and procedures to govern PHBs that are publicly accessible.	• Ensure smooth in-housing of AACC workforce into the ICB. • Begin HR and recruitment process for implementation of the workforce structure. • Prioritise review and implementation of BOB-wide policies and procedures where feasible noting some place level requirements may be necessary.	• Maintain a proactive approach to recruitment and retention including robust induction processes and seeking stay and leaver interviews. • Embed the Training and Development role and integrate this at the wider system level with Local Authorities and providers.	• AACC is delivered consistently across BOB with reduced levels of unwarranted variation. • The BOB AACC workforce feel valued and vacancy levels/reliance upon agency is reduced. • Patients report a high level of satisfaction with their overall AACC experience.

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For All Age Continuing Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
03 Offer proactive personalised care planning to those individuals with more complex needs who are eligible for AACC.	• To ensure all people who are eligible for AACC are offered a Personal Health Budget (PHB). • To ensure that PHBs are delivered according to the principles of personalisation and offer individuals choice and control over care delivered with a focus on outcomes to improve health and wellbeing. • To ensure that the ICB has relevant policies and procedures to govern PHBs that are publicly accessible. • To ensure that direct payments are offered and delivered in line with the direct payment guidance (2014) and that safe care is delivered by personal assistants. • To ensure financial governance and audit is supported through clear contractual arrangements between the ICB and individuals. • To ensure individuals are supported in PHBs with advice, guidance and technological support being available to assist in managing and operating direct payments. • To ensure staff are trained in all aspects of PHBs, personalised care and support planning of people with PHBs.	• Baseline assessment. • Identification of areas of good practice. • Gap analysis. • Policy development. • Staff training. • Pilot of digital solution.	• Implementation of digital solution. • Maintenance of staff training. • Increasing numbers of PHB across BOB at all places.	• PHB and personalisation becomes business as usual across BOB at all places and cohorts within AACC. • Patients report a high level of satisfaction with their overall care planning and support within AACC.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For All Age Continuing Care

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
04 Work closely with other BOB workstreams that interlink with AACC e.g. safeguarding, palliative and end of life care	• To actively seek out opportunities with other BOB workstreams that interlink with AACC to improve efficiency by reducing duplication. • To recognise workstreams that overlap with AACC and build trust and relationships with staff within those workstreams.	• Review overall AACC functions. • Review existing BOB workstream leads for other areas of work and consider linkage.	• Develop workplans for areas of mutual involvement.	• Continuous review of potential opportunities.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Delegated Commissioning

Context: Our challenge in BOB

The Health and Care Act 2022 makes provision to allow the delegation of national commissioning responsibilities from NHS England to Integrated Care Boards (ICBs). It is anticipated that the national policy ambition to give systems responsibility for managing local population health needs, tackle inequalities and address fragmented pathways of care, will be enabled by the delegation of Direct Commissioning responsibilities to ICBs. In ICBs taking responsibility for a broader range of functions, we have an opportunity to better design services and pathways of care to meet local priorities, and have greater flexibility to integrate services across care pathways, ensuring continuity for patients and improved health outcomes for our local population.

In BOB, this means the ICB having either already taken commissioning responsibility or planning to take responsibility for the following services:

- **Pharmacy, Optometry and Dental (POD) –** There is an aligned approach across the ICBs in the South East region as early adopters of taking responsibility for Direct Commissioned services of Pharmacy, Optometry and Dental (POD services). BOB ICB assumed full responsibility and accountability for commissioning of POD services from 1 July 2022.
- **Specialised Services –** There are currently 154 specialised services commissioned by NHS England. Of these, there are 59 services which have been identified by NHS England as a ready for delegation to ICBs. During '23/24 ICBs will have joint decision making with NHSE via the establishment of a Partnership Board, with an aim to accept full delegation of the 57 services by April 2024.
- **Health and Justice, Sexual Assault and Abuse Services (SAAS)** – Responsibility for commissioning these services will continue to be retained by NHS England through 2023/24, with a longer-term aim to delegate responsibility to ICBs. It is anticipated that BOB ICB will not take full delegated responsibility until April 2025 at the earliest.
- **Section 7a NHS Public Health –** In 2023/24 we will work through the process to take delegated commissioning responsibility for the s7a Public Health immunisation portfolio by 1st April 2024. Public health screening services will be reviewed during 2023/24 to identify where the most benefit would be delivered through delegation of commissioning to the ICB.

National policy will remain critical in determining which services are delegated to the ICB and the associated timing, although there is an opportunity for BOB to be an active participant in influencing and shaping how national policy and regional model develops and how that is then translated into delivery of local benefits to optimise the health of our local population.

Our Ambition: Our key aim is to reduce inequality of access and outcomes for delegated services in BOB, as measured through indicators such as travel distance to services, waiting times and clinical outcomes. By March 2028, the ICB will, where identified as beneficial and/or directed by national policy, have safely assumed delegated commissioning responsibility for multiple services and used these new responsibilities to transform and integrate care in line with system strategic priorities. This will provide an opportunity to work as an integrated care system to focus on population health improvement, implementing integrated care pathways, prioritising prevention and early intervention to reduce inequalities across services and drive compliance with national service specifications.

To Deliver Our Ambition, We Will:

01 Develop a Delegated Commissioning strategy, supported by robust governance and operating model.

02 Where mandated by national policy and/or identified as beneficial to local outcomes, optimise services locally through taking full delegated responsibility for the commissioning of:

a. Pharmacy, Optometry and Dental
b. Specialised Services
c. Health and Justice and SAAS
d. Section 7a NHS Public Health

What We Need For Success:

- Clear system level Executive ownership.
- Close working with system partners to make measurable impact on prevention.
- Partnerships with acute providers to provider clinical leadership across delegated commissioning.
- Established formal delegation programme to develop vision and strategy for maximising delegation opportunity – with appropriate, resourcing and funding.
- Close working with NHSE national and regional teams as equal partners to influence and shape the programme of delegated commissioning.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan For Delegated Commissioning

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It	
		Year One	Years Two – Five
Develop a Delegated Commissioning strategy, associated governance and operating model at BOB system level	A clear vision and strategic direction for services delegated to the ICB Effective governance and ways of working embedded at an ICB-level that allow us to maximise the opportunities presented through the delegated commissioning process.	• Clarify system Executive ownership of delegated services at the ICB/system level, confirming representation and aligned regional/system governance • Develop a vision, strategy and operating model for delegated services focused on how to maximise opportunities to reduce inequality of access and improve health outcomes through more localised commissioning • Establish the programme clinical leadership framework	• Fully implement and embed new strategy and operating model • Mature new integrated ways of working across system • Continued development of an iterative qualitative outcome evaluation and improvement framework
Pharmacy, Optometry and Dental	Mobilise and align regional/system operating model Maximise opportunities to improve access at a local level with a focus on reducing inequalities improving quality and outcomes. Develop service transformation and primary care integration strategy.	• Implementation of revised regional model of 1 ICB system host, & NHSE workforce employment model. • System transition to new operating model and ways of working, ensuring assurance of delegated service responsibility • Delivery of Y1 objectives (as per PC template	• Fully embed new operating model and ways of working • Iterative improvement through delivery of transformation, and more localised commissioning to optimise services in line with local needs • Achieve milestones defined to achieve integrated primary care neighbourhood teams
Specialised Services	Executive representation & active participation and influence in Specialised Commissioning Partnership Board from 1st April ’23 Increase system level knowledge and understanding of service portfolio in preparation for transfer of commissioning responsibility. Identification of 3-4 services to pilot an effective model of integration and outcome improvement	• From 1 April – joint decision-making authority established for first 59 services identified as ready to delegate to ICB • Pre-delegation assessment framework (PDAF) anticipated Autumn 2023 to assess ICB readiness to assume full delegated responsibility by April 2024 • Development & implementation of system level governance and operating model • Continued development of service & pathway integration.	• Subject to results of PDAF in 2023/24, transfer of full delegated commissioning responsibilities for 59 services from 1 April 2024. • Operating model implementation and iterative optimisation of services • Continued development of an iterative qualitative outcome evaluation and improvement framework
Health and Justice and SAAS	Safe transfer of delegated responsibility for Health and Justice and SAAS to ICB in line with national timescales (TBC). Reduction in inequalities of access and outcomes following delegation	• Developed closer and shared ways of working between the ICB and NHS England • Continue to use the existing joint governance structures to continue collaborative working arrangement with NHSE.	• To be determined by national policy – potentially transition delegated commissioning responsibilities by April 2025 (tbc) • Operating model implementation and iterative optimisation of services
Section 7a NHS Public Health	Safe transfer of delegated responsibility for s7a immunisation services to the ICB by April 2024. Identification of s7a screening services that would benefit from delegation by April 2024. Reduction in inequalities of access and outcomes following delegation	• Work through process for transfer of s7a immunisation services by April 2024. Likely require PDAF in autumn 2023 – delegation contingent on results of assessment. • Work with NHS England to support identification of which s7a screening services that would benefit from delegation • PDAF for certain screening services may also be required in autumn 2023.	• To be determined by national policy – potentially transition delegated responsibilities for s7a immunisations by April 2024 • Transition of delegation of those screening services identified to be better managed locally • Operating model implementation and iterative optimisation of services

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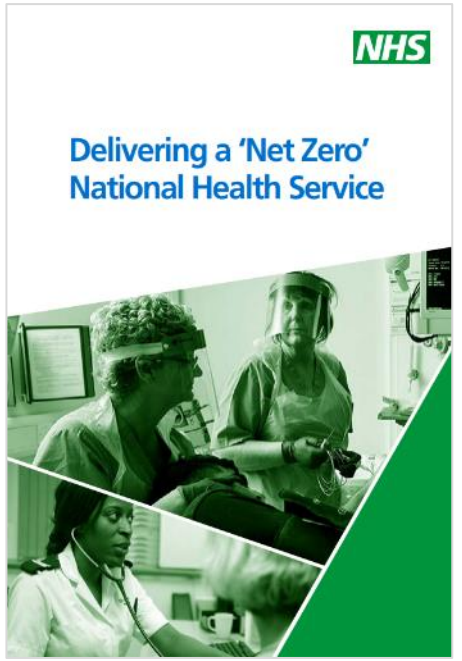
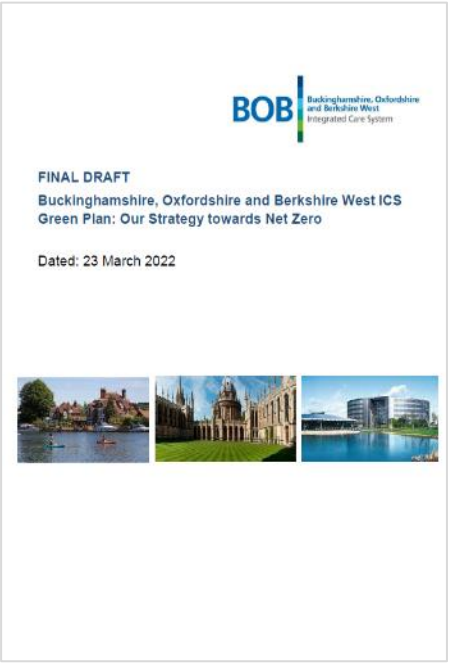
Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Context and Ambition: Delivering Net Zero

Context: Our challenge in BOB

- The NHS Vision for 'Net Zero' is – ***To deliver the world's first net zero health service and respond to climate change, improving health now and for future generations.***
- In order to achieve this target two milestones have been set out. They are:
  - The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040
  - The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.
- There is an interim target to achieve an 80% reduction in carbon emissions between 2028-2032.
- In BOB each NHS organisation has an ambition to achieve Net Zero and a plan to deliver these changes. These plans were mostly published in to 2021/22.
- Although the plans are specific to each organisation there are similarities and common themes presented setting out how the carbon reduction will be achieved. Activity to date has been led at the organisation level With limited facilitation provided by the ICB and NHS E colleagues.
- A green plan was published on behalf of the BOB system, coordinated by the ICB team, that set out a high-level action plan. Through an active programme Board, developing through 22/23 plans have been further clarified providing greater focus to system level priorities and areas for joint working and collaboration
- There is also a need to adapt to immediate consequences of environmental and climate change. In most situations these relate to severe weather events. Across BOB we need to ensure our resilience to these events is coordinate and does not impact on our longer-term net zero ambitions





Our Ambition: To define a clear path to achieving a net zero system by 2040 and be delivering on an agreed trajectory to an 80% reduction in carbon emissions by 2032.

To Deliver Our Ambition, We Will:

1. Develop and maintain a coordinated system wide plan that supports BOB organisations to deliver reduced carbon emissions and adapt to future environmental challenges.

2.Build a system wide commitment with visible leadership, partnership and governance to reduce the BOB carbon footprint.

. Build an ambitious culture across the ICS that aligns the net Zero ambition with high quality service provision.

What We Need For Success:

- Partnership working – Aligning with our respective Organisations will allow us to coordinate our efforts for the most significant, effective approach to getting Net Zero across BOB, which is our shared goal.
- Expert input – Work with the dedicated Net Zero team at NHS England to provide ongoing support regarding upcoming funding and collaborative opportunities and their further promoting of collaborative working by coordinating inter-ICS collaboration by facilitating meetings with Net Zero Managers across the region.
- Aligned prioritisation – meaningful incentivisation, policy support and funding support through NHS Policy to make Net Zero a primary issue for NHS organisations.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Our Joint Forward Plan for achieving Net Zero

What We Will Do	Planned Outcomes – What Are We Trying to Achieve?	Our Delivery Plan – How We Will Do It		
		Year One	Year Two	Years Three – Five
01 Develop and maintain a coordinated system wide plan that supports BOB organisations to deliver reduced carbon emissions and adapt to future environmental challenges	• A comprehensive plan for delivering a net zero health and care System by 2040 with a 80% reduction in carbon emissions by 2032.	• Confirm Areas of Focus across our NHS organisations – Common themes (e.g., Procurement, Meds Mngt, Transport and Estates). • Develop quantifiable actions plans for each area of focus. • 100% of suppliers to have a Net Zero plan. • 100% removal of Desflurane. • EPC ratings completed for all NHS buildings. • XX% of OP appointments to be virtual. • Climate adaption plans to be included in all Trust plans (e.g., in EPRR planning). • Full refresh of the ICB published Net Zero Plan (July 2024).	• Deliver a quantified trajectory for BOB achieving Net Zero, incorporating all Trust trajectories. • Full plan for electrification of NHS Fleet to be developed. • Refresh the overall BOB plan to take account of new priority areas or developments.	• Build delivery capability and capacity across the ICB team and within each provider organisation. • Ensure quantified performance progress is monitored against plan. • Carbon emissions reduced by at least 50% by 2028.
02 Build a system wide commitment with visible leadership and partnership to reduce the BOB carbon footprint	• Visible and committed leaders across BOB who are driving the Net Zero agenda across our system.	• Develop the Net Zero Programme Board to focus on facilitating and monitoring delivery of plans and promoting change. • Develop focus area groups to lead on areas of expertise, shaping specific content. • Use plan refresh to build leadership cadre across BOB at organisation or focus area level. • Support from NHS E green team to build leadership capabilities in Net Zero agenda.	• Build the leadership capacity and capability across the system on Net Zero – continue to link with NHS England team. • Clarify role and expectation of Board representative. • Develop a pan system leadership on Net Zero to support partnership working on common areas. • Develop a network of champions who are contributing across our organisations to reduce emissions.	• Have mature, well established areas where there are collaborative groups that are working together to move the Net Zero agenda forward, including LA etc. • Have a regular and robust open forum where all members of the ICS are able to contribute ideas and support/receive ideas and support.
03 Build an ambitious culture across the ICS that aligns the net Zero ambition with high quality service provision	• A culture where Net Zero ambition is embedded through all our service delivery and decision making.	• System events to share best practice and build profile of progress. • Re-establish the net Zero system Forum as place to share ideas and enthusiasm. • Develop plans for each focus area and organisation as inclusively as possible to foster spirit of ownership. • Link with AHSN experts to ensure innovation is shared widely across system.	• Build strong partnership of local providers who are able to support delivery of Net Zero in BOB. • Training available for staff across the BOB system to increase capabilities and contribution to Net Zero.	• To ensure Net Zero principles are embedded within all areas of NHS working. • To encourage patients to adopt more 'green thinking' into their treatment (traveling to appointments switched to online, being informed over meds choices and prescription behaviours).

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix B – F
Supporting Information

A. Joint Local Health and Wellbeing Strategies Summary
B. Mapping JFP to ICP Integrated Care Strategy
C. Health and Wellbeing Board Opinion
D. Critical Risks to delivery
E. Meeting legislative requirements
F. Assuring progress of our core delivery plans

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix A: Joint Local Health and Wellbeing Strategies

Our JFP, guided by the vision set out in our ICP Strategy, aligns with and builds on the strategies, approaches and targets set out by our three local health and wellbeing strategies developed by the five Health and Wellbeing Boards across BOB.

	Berkshire West	Oxfordshire	Buckinghamshire
Promoting and Protecting Health: Creating services which build trust and collaboration across diverse and hard to reach communities	• Reduce the differences in health between different groups of people. • Use data to understand local community need.	• Protect vulnerable people from risk of homelessness, threat of violence and the reality of cold homes. • Work together to reduce demand for reactive services and shift the focus to prevention.	• Improve mental health support for adults, particularly for those at greater risk of poor mental health. • Reducing social isolation.
Start well: Easily accessible services that support healthy children and happy families across diverse communities	• Promote good mental health and wellbeing for all children and young people by early identification, improving the equality of access and school engagement. • Improve process for transition to adult services.	• Deliver responsive services that place children, young people and families at the heart of what we do. • Support the most vulnerable children to have equal opportunity to become everything that want to be.	• Improve maternity and early years and helping children be ready for school. • Improve mental health support for children and young people and address social barriers. • Reduce prevalence of obesity.
Live well: Facilitating health decisions so communities can stay healthier for longer through prevention and early diagnosis	• Promote good mental health and wellbeing for all adults.	• Identify disease early and help people to manage their long-term conditions. • Ensure all people are involved in the design and evaluation of services.	• Reduce rates of cardiovascular disease by expanding tobacco dependency and NHS Health Checks. Reduce prevalence of obesity. • Improve mental health support particularly for ethnic minorities, students, men and LGBTQ.
Age well: Helping residents maintain their independence with effective services and accessible alongside opportunities for community engagement	• Continue to recognise the importance of social connection, green spaces and understanding of different cultural contexts. • Promote wellbeing activity and physical activities.	• Identify conditions early and ensure services are effective, efficient and joined up. • Focus on prevention, reducing the need for treatment and supporting residents to manage long term conditions.	• Improve mental health support by creating social opportunities in communities as well as improving early detection and diagnosis of dementia. • Increase the physical activity of older people.

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Sources: Buckinghamshire JHWBS, Oxfordshire JHWBS & Berkshire West JHWBS

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Promoting and protecting health	A reduction in the overall number of smokers in Buckinghamshire, Oxfordshire and Berkshire West, especially in our most deprived areas.	One of the ambitions in the JFP Service Delivery Plan of Inequalities, Prevention, Promoting and Protecting Health is to focus on reducing smoking prevalence and increasing tobacco dependency services in BOB. Some key initiatives: • Increase capacity of smoking cessation services across BOB and increase number of referral to those services from hospitals, embed tobaccos advisory service in all acute hospitals including mental health and maternity services, develop community pharmacy smoking cessation, and increase referrals to smoking cessation from primary care. • Smoking cessation support for those people with respiratory conditions, reducing smoking as a risk factor. • Activity will be targeted in more deprived areas and where smoking prevalence is highest.	Hyperlink to JFP – Prevention – Slide 12 Hyperlink to Respiratory – Slide 55
	Increase the proportion of people who are a healthy weight and physically active, especially in our most deprived areas and in younger people.	One of the ambitions in the JFP Service Delivery Plan of Inequalities, Prevention, Promoting and Protecting Health is to focus on reducing obesity prevalence and increase weight management services. Some key initiatives: • Target activity where prevalence is highest and ensure more people in deprived areas / cohorts are referred to weight management services. • Provide personalised care & support training to healthcare professionals so as to use every 'teachable moment' to deliver 'very brief advice' on diet and weight loss. • Increase referrals from primary care to weight management services including the National Digital Weight Management programme • Increase referrals to NHS Diabetes Prevention Programme and embed very low calorie diet pathway	Hyperlink to JFP – ambition 7 for Prevention and Adult Weight Management – Slide 13
	Reduce the proportion of people drinking alcohol at levels that are harmful to their health and wellbeing.	One of the ambitions in the JFP Service Delivery Plan of Inequalities, Prevention, Promoting and Protecting Health is to focus on reducing harmful drinking and drug behaviours and drug use. Some key initiatives: • Target activity where prevalence is highest and ensure more people in deprived areas / cohorts are referred to specialist alcohol services by their primary care team. • We will increase data collection and understanding re. alcohol consumption (AUDIT-C, progressing to full AUDIT where indicated and provide advice / referral). • Review provision of the alcohol care team (ACT) to improve care across BOB • Improve awareness and referral to alcohol pathways by integrated care teams	Hyperlink to ambition 9 of Prevention – Slide 15

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Promoting and protecting health	Protect people from infectious disease by preventing infections in all our health and care settings and delivering national and local immunisation programmes.	One of the ambitions in the JFP Service Delivery Plan of Inequalities, Prevention, Promoting and Protecting Health is to protect our population from vaccine preventable diseases through the implementation of a national immunisation strategy by 2028. Some key initiatives: • Implementation of vaccination dashboard. • Use community engagement approaches, learning from evaluation of the covid vaccination campaigns, for those groups identified as having lower uptake of immunisations, with a particular focus on the MMR and 4-in-1 pre-school booster, alongside covid and flu. • Work collaboratively to improve access to immunisations in primary care, including through enhanced access and cross-PCN working. • Effective integration and learning across organisations to deliver effective and flexible vaccination programme across BOB One of the ambitions in the JFP Service Delivery Plan of Infection Prevention and Control is to establish a system wide infection prevention and control service and network that provides quality advice to services and service users to reduce preventable infection across the system. Some key initiatives: • Fostering integration, partnership and alliances among the newly formed Integrated Care Partnership (ICP). • Reduce BOB ICS reportable Clostridioides difficile infections (CDI) and Gram-Negative Bloodstream infections (GNBSI). • Antimicrobial Stewardship to within targets set.	Hyperlink to delivery plan for Immunisations/Vaccinations - Slide 16 Hyperlink to delivery plan for Infection Prevention and Control – Slide 130

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Start Well	Improve early years outcomes for all children, particularly working with communities experiencing the poorest outcomes	The Joint Forward Plan for Start Well includes service delivery plans for different areas (Maternity and Neonatal, CYP Mental Health, CYP General, CYP Neurodiversity and Learning Disabilities). These service plans have a focus in embedding early interventions for children to improve outcomes and implementing prevention initiatives to reduce health inequalities within the most deprived groups. Some key initiatives: • Focus on personalisation and co-production in improving maternity services • Implement the maternal and neonatal equity strategy, listen and co-produce services to better support minorities and health inclusion groups. • Better support for pregnant women and their partners to stop smoking – reducing percentage of women smoking at delivery	Hyperlink to Start Well – Slide 20 Hyperlink to Inequalities and Prevention – Slide 12
	Improve emotional, mental health and wellbeing for children and young people.	The Joint Forward Plan for Start Well includes service delivery plans for CYP Mental Health. The ambition is to deliver improved mental health and wellbeing outcomes for children and young people, living, learning and working in BOB. Some key initiatives: • Scoping current service models and approaches across the ICS informed by the THRIVE assessment tool, details existing variations and gaps, and deliver the necessary changes and improvements. • Engagement with participation groups to co-produce and prioritise improvements and achieve more equitable access • Develop a population health management approach to support those most at risk of mental ill health focussing on early identification, support and prevention	Hyperlink to JFP for CYP Mental Health – Slide 27
	Improve the support for children and young people with special educational needs and disabilities, and for their families and carers	The Joint Forward Plan for Start Well includes service delivery plans for CYP Neurodiversity and Learning Disabilities. The ambitions are to : • Ensure that all neuro-divergent children and young people will receive the right support, at the right time and in the right place dependant on their needs and not dependant on a diagnosis. • Deliver improved physical, mental health and wellbeing outcomes for children, young people and adults with a learning disability and their families and carers. Some key initiatives: • System review of ND referral, pre-assessment / assessment and feedback of outcome – learning to improve processes and efficiency. Deliver parity of ND care across BOB. Alternative models of support to improve access. • Focus on reducing health inequalities and improvement in quality of care for LD, improve community-based support, champion those with lived experience, ensure greater awareness of needs of people with LD in health and care services.	Hyperlink to JFP for CYP Neurodiversity – Slide 29 Hyperlink to JFP for Learning Disabilities – Slide 31
	Support young adults to move from child centred to adult services.	The Joint Forward Plan for Children's and Young People's Mental Health covers young adults and supports the shift from child centred to adult services with a specific initiative to review current transition processes across the system, working with service users to co-produce proposed improvements.	Hyperlink to JFP for CYP Mental Health – Slide 27

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Live well	Improve mental health by improving access to and experience of relevant services, especially for those at higher risk of poor mental health.	The Joint Forward Plan for Live Well includes a service delivery plan for Adults Mental Health which aims to deliver improved mental health and wellbeing outcomes for all adults and older people living, learning and working in BOB. Some key initiatives: • Develop and implement plan to increase access to IAPT for older adults • 24/7 Crisis Resolution Home Treatment functions (CRHT) for adults, operating in line with best practice by maintaining coverage to 2023/24. • Join up support for people with mental health problems including access to employment support, health care, psychological support and services led by the voluntary community and social enterprise sector.	Hyperlink to JFP for Adults Mental Health – Slide 40
	Reduce the number of people developing cardiovascular disease (heart disease and stroke) by reducing the risk factors, particularly for groups at higher risk.	The Joint Forward Plan for Live Well includes a service delivery plan for Cardiovascular services and Stroke which includes ambitions and initiatives to address the ICP aim. Some key initiatives: • Increase case finding and number of patients treated to target working with primary care and Community Pharmacy Hypertension Case Finding Service. • Working with partners to improve cardiovascular checks focused on inequalities such as people with known SMI and LD. • Support education on lipid management in primary and secondary care. • Work with system colleagues to support people with lifestyle changes - reduce smoking and obesity and increase physical activity	Hyperlink for JFP Integrated Cardiac Delivery Network plan - Slide 49 Hyperlink for JFP Integrated Stroke Delivery Network plan – Slide 59
	Increase cancer screening and early diagnosis rates with a particular focus on addressing inequalities in access and outcomes.	The Joint Forward Plan for Live Well includes a service delivery plan for Cancer which includes ambitions and initiatives to address the ICP aim. Some key initiatives: • Achieve the Faster Diagnosis Standard across all Trusts – ensuring appropriate diagnostic and treatment capacity and specific programmes on backlog reduction. • Achieve the Early Diagnosis Standard working with Public Health and other stakeholders to increase screening rates. Community Pharmacy pilot to enable suspected cancer referrals and roll our Targeted Lung Health Checks in BOB. • Work with populations identified using Core20plus5 in the Cancer Allies programme to improve overall access including collaboration with the BOB inequalities team.	Hyperlink for the JFP Cancer plan – Slide 60

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Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Appendix B: Mapping JFP to ICP Strategy Aims

ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Age Well	Support people to remain healthy, independent, and connected within their communities.	The Joint Forward Plan for Age well includes a service plan for Age Well Services which has an ambition and initiatives to address this aim. Some key initiatives: • Develop an approach for systematically identifying isolation / loneliness in our populations – working with PCNs, Local authorities, urgent care teams, community teams and VCSE, sharing learning from COVID. • Promote and support the five steps to mental wellbeing to older people: connect with other people, be physically active, learn new skills, give to others and pay attention to the present moment (mindfulness). • Identify and address barriers to people taking up social and physical activities such as mobility and transport issues.	Hyperlink to JFP Age Well services – Slide 73
	Provide personalised and joined up care for people as their care needs increase and become more complex.	The Joint Forward Plan for Age well includes a service plan for Age Well Services which has an ambition and initiatives to address this aim. Some key initiatives: • Early identification and diagnosis of long-term conditions and mental health issues, leading to timely care planning, education and support in the community to give patients, families and carers the best chance of managing health conditions effectively. • Personalised care and support planning is training for health and care staff for all stages of an individual's life course which is comprehensive across health and social care including mental health. This should include shared decision-making to enable informed and empowering conversation with patients and carers. • Development of a community-based MDT model of care integrating community and secondary care that addresses complexity, frailty and multiple long term conditions.	Hyperlink to JFP Age Well services - Slide 75
	Improve support for carers.	The Joint Forward Plan for Age well includes a service plan for Age Well Services which has an ambition and initiatives to address this aim. Some key initiatives: • Health and social care services to be clearly understandable and communicated effectively to staff, patients, families and carers. • Many older carers do not self-identify and register as carers, which limits access to support such as attendance allowance. Programme of communication and awareness raising combined with training for the workforce to aid in identification of carers and their registration to enable access to the full range of support and entitlements. • Cross-system review of carer support and respite care. NHS and Local Authorities develop and agree a consistent offer of support to unpaid carers, working across BOB geographies, linked with existing BOB programmes. This will include the provision of a consistent offer of respite care.	Hyperlink to JFP Age Well services - Slide 76

Appendix B: Mapping JFP to ICP Strategy Aims

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ICP Strategic Theme	ICP strategy aims	Mapping of ICP aim in the JFP	Link To Delivery Plan
Improving quality and access to services	Develop strong integrated neighbourhood teams so that people's needs can be met in local communities.	The Joint Forward Plan for Improving Quality and Access to Services includes a service delivery plan for Primary care which has an ambition and initiatives to address this aim. Some key interventions: • Conduct community/neighbourhood engagement events. • Define our neighbourhoods, including population and care needs. • Define the model including level of integration / collaboration and skills required. Work with providers to develop MDT ways of working and integration/embedding of community and mental health resource.	Hyperlink to JFP for Primary care – Slide 101
	Reduce and eliminate long waits for our planned services, and address variation in access across the system.	The Joint Forward Plan for Improving Quality and Access to Services includes a service delivery plan for Planned Care which has ambitions and initiatives to address this aim. Some key initiatives: • Further additional diagnostic capacity will become available through the Community Diagnostic Centres • Through the system wide Elective Care Board, continue to drive the transformation of elective care focusing initially on those specialties with the longest waits and highest volumes of patients waiting as well as through the guidance provided by the system-wide Theatres, Perioperative and Outpatients Steering Groups. • Develop elective strategy for addressing inequalities in access to elective diagnostics and treatment. Embed a process for clinical prioritisation that takes into account inequity of access to services resulting from Health Inequalities – also ensuring the order of being seen reflects patient need as well as length of wait.	Hyperlink to JFP for Planned Care – Slide 92
	Support the consistent development of our urgent care services to reduce demand and support timely access.	The Joint Forward Plan for Improving Quality and Access to Services includes a service delivery plan for Urgent and Emergency Care which has ambitions and initiatives to address this aim. Some key initiatives: • Increase Urgent Community Response (UCR) 2-hour referrals by 10% pre crisis. • Develop virtual ward/hospital at home vision – achieving 50 virtual ward beds per 100,000 population by Year 5. • Ensure Trusts have recovery plans in place to minimise delays to be seen in ED and that suitable alternatives to ED are promoted to patients to minimise inappropriate ED attendances. • Development of 24/7 Single Point of Access for BOB to ensure consistent and rapid access to clinical advice and alternative services.	Hyperlink to JFP for Urgent and Emergency Care – Slide 81
	Improve access and experience of palliative and end of life services to enable people of all ages to die well.	The Joint Forward Plan for Improving Quality and Access to Services includes a service delivery plan for Palliative and End of Life Care (PEoLC) which aims to deliver high quality, personalised, integrated 24/7 services shaped by those with lived experience of PEoLC for all ages, across the BOB ICS. Some key initiatives: • Implement a PEoLC virtual ward and a 2-year 24/7 PEoLC service model. • Work with providers and HCPs across the system to train and promote early identification and advance care planning. • Complete demand and capacity model to support redesign to integrated service models based on needs of different groups. Ensure lived experience representatives are an active partner in system-wide meetings.	Hyperlink to JFP For Palliative and End of Life Care – Slide 103

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Appendix C: Health and Wellbeing Board Opinion

HWB feedback

During the development of this JFP, we worked alongside local HWBs to share ideas and hear their feedback on our progress. We have consulted with each of the relevant HWB's on our draft JFP and sought their views on the extent to which this plan takes proper account of priorities and focus areas outlined in each JLHWB strategy.

We have included a summary of their views below.

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Appendix D – Critical risks to delivery

This JFP articulates our ambition and plans to improve and transform our services over the next five years. It is important for our system to recognise, however, that there are a number of key risks that may impact our ability to deliver our plans. Our ability to deliver on our plans is dependent on the extent to which these risks materialise, and our ability as a system to appropriately manage and mitigate these risks.

Risk	Mitigation(s)
Operations	
Our system in BOB, as is the case nationally, remains under very significant operational pressure, with record demand for our services and a large backlog. We continue to experience a number of critical performance challenges particularly across urgent and emergency care, planned care and primary care, and we expect a continued focus on recovering performance in these areas nationally. **There is a significant risk that our system's time and resources are consumed primarily in trying to manage these more immediate performance issues which will limit our ability to deliver our longer term transformation ambitions.**	• Planning over the long term through the JFP and alignment to Operational Planning process, including focus on short-term recovery • Implementation in full of key recovery plans in relation to key areas – Urgent and Emergency Care, Elective Care etc. • Establishing the right governance and delivery infrastructure at ICB level to monitor progress against longer-term goals
Workforce	
Our ability to deliver our plans relies upon having a resilient workforce, with enough staff working in the right ways. It has become increasingly difficult within the NHS to permanently recruit and retain the people needed to deliver our services and we have seen an increasing reliance on costly temporary staffing which further destabilises the workforce during this time of national pressure. National strike action has also increased our workforce shortages at certain times. **There is therefore a significant risk that workforce shortages (in both capacity and capability) limit our ability to deliver on our plans.**	• Our workforce plans as part of the JFP include a key focus on recruitment and retention of staff • Where critical workforce gaps persist, we will continue to have a flexible approach to addressing them within our financial parameters. • We have established a system-level People Committee to oversee and drive forward the workforce improvements we require,
Finance	
The delivery of our JFP is dependent on sufficient investment in improving and transforming our services. Our system is currently under significant financial pressure, with a material deficit forecast for 2023/23, and a greater understanding is needed of the drivers of this deficit. **There is a significant risk that addressing this deficit may require a reduction in spending in certain areas which may impact our ability to deliver on some of our plans**. Due to the way NHS finances are managed, it is often difficult to make firm spending commitments over a long-term timeframe, so **there is also a risk that changes to our financial position over the planning period materially impact on our plans in later years.**	• Our plans for 2023/24 are designed, as far as possible, around availability of funding for the year ahead • Our Finance plan as part of the JFP outlines some of the key areas of focus to address our financial challenges • The JFP will be revised on an annual basis to reflect changes to our plans as they develop – and this will include the impact any changes to the financial resources available to us

Appendix E – JFP legislative requirements

Legislative requirements	Our response
The plan should set out how the ICB will meet its population's health needs.	Section 2.1 sets out the unique characteristics of BOB's population and our understanding of their health needs. BOB's population demographics have been central to the development of the ICP's strategy and strategic priorities set out in the strategy. Section 2.1 also provides an overview of our population health management approach and how this will be developed alongside partners. Each of the service plans included in this document provides an overview of key context on the population's health needs for example our service plan for Inequalities and Immunisations/Vaccinations.
Duty to promote integration across health services, social care and health-related services.	See sections 1.4, 1.5 and 1.6 which provide an overview of progress so far by the system to promote integration of services alongside plans for how future ICS architecture will continue to promote and facilitate integration. Our Place Based Partnerships are a delivery mechanism at a local level, driving transformation and integration. This is also reflected across our service plans such as in Age Well Services.
Duty to give due regard to wider effects of decisions, for example how the triple aim was considered its development.	The 'triple aim' was considered in various parts of the JFP. Aim 1) health and wellbeing of the people of England is reflected in section 2.1, aim 2) quality of healthcare services can be referenced in service plans for Inequalities and the plan for Quality as an enabling service and aim 3) sustainability and efficient use of resources has been considered in the plans for Finance and Workforce in Section 4 – Supporting and Enabling Delivery.
The JFP must describe how financial duties will be addressed (including ensuring that the expenditure of the ICB and its partner trusts does not exceed the aggregate of any sums received by them in a year).	See section 4 – Supporting and Enabling Delivery – Plan for Finance.
The JFP must set out the steps taken to deliver on relevant JLHWBSs, including identified local target outcomes, approaches and priorities.	See section 1.2 for an overview of each JLHWB strategy. The ICP Strategy aligns and builds on the outcomes, approaches and priorities set out in each local strategy. The Integrated Care Strategy has been built to align with the JLHWB strategy as shown in appendix A. There is also a detailed mapping of the JFP to the ICP strategy as seen in Appendix B. Appendix C reflects the Health and Wellbeing Board Opinion.
Duty to improve the quality of services (including clearly aligned metrics, outcomes and should be aligned with National Quality Board principles.	See section 4 – Supporting and Enabling Delivery – Plan for Quality. Additionally, quality has been referenced across service plans for example in Start Well – plans for Women's, Maternity and Neonatal and Learning Disabilities.
Duty to reduce inequalities.	Our ICP strategy outlines our commitment to working with partner organisations to improve people's health and wellbeing and reduce the inequalities in health experienced by people across our populations. Each service plan has a specific focus area on reducing inequalities as part of their 5-year plan for example in Live well – Adult's Mental Health and the service plan for Planned Care.

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Appendix E – JFP legislative requirements

Legislative requirements	Our response
Duty to promote involvement of each patient.	See section 1.4, 1.5 and 1.6 which explains how we will promote involvement of each patient through our partnerships.
Duty to involve the public (including how the public and communities have been engaged in the development of this plan and how future partnerships will be built with people and communities, particularly those who face greatest health inequalities).	See section 1.4, 1.5 and 1.6. The development of the JFP included Healthwatch representatives and we also conducted some citizen experience research which reflects what people in BOB think about their experience of our services.
Duty to patient choice and how patient choice has been considered when developing and implementing commissioning plans and contracting arrangements.	See section 4 – Supporting and Enabling Delivery – Personalised Care. The principle of patient choice is reflected across service plans for example CYP Mental Health and the plan for Cardiovascular services.
Duty to obtain appropriate advice.	Through the development of the JFP we have sought expert advice when necessary, through liaising with our system partnerships and collaborations. Service plans have been led and developed by the Subject Matter Expert in the area and working across system networks for example our focus on prevention plans were informed by our work with Public Health.
Duty to promote innovation.	See section 4 – Supporting and Enabling Delivery – Research, Innovation and Quality Improvement. This is also reflected in service plans for example the plan for Respiratory Services.
Duty to promote research.	See section 4 – Supporting and Enabling Delivery – Research, Innovation and Quality Improvement. This is also reflected within service plans for example in the plan for Planned Care in Improving Quality and Access.
Duty to promote education and training.	See section 4 – Supporting and Enabling Delivery – Workforce plan.
Duty as to climate change and how the ICB and its partners will deliver against the targets and actions in ‘Delivery a Net Zero’ NHS.	See section 4 – Supporting and Enabling Delivery – Net Zero plan.
Addressing the particular needs of children and young persons.	See section 3 and strategic theme titled ‘Start Well’.
Addressing the particular needs of victims of abuse.	See section 4 – Supporting and Enabling Delivery – Safeguarding.

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Appendix F - Assuring progress of our core delivery plans

1 Delivery plans will be regularly monitored through existing system / ICB groups

The detailed service delivery plans (appendix A) set out the 5 year ambition and supporting plans for BOB-wide services. In almost all cases these plans build on current activity that is already managed and assured through existing System or ICB level governance groups.

It is therefore proposed that relevant delivery plans will monitored and assured through these existing governance groups.

In many of these groups there will be system wide representation to allow for transparency of progress.

2 All delivery plans have a named accountable ICB executive

To ensure clear accountability for delivery and to provide oversight, each of the delivery plans will have a named accountable ICB executive, responsible for delivery. The identified executive lead role will align with existing responsibilities and accountabilities

3 Accountable ICB executive will provide assurance report to the ICB Board

In addition to the local reporting, it will be necessary to provide the ICB Board with necessary assurance of delivery progress.

- The Director of Strategy and Partnerships will coordinate a progress reports for the ICB via the relevant accountable executives.
- ICB Exec Leads will be accountable for producing a short highlight summary for each of their services.
- Suite of progress reports will be shared and single progress paper twice a year at ICB Public Board.

Example high level Board summary – Report details TBC:

[Service Area Name e.g. Integrated Respiratory Delivery Network]				Delivery Risk / Issue
Qualitative Update	*(Refer to delivery plan for proposed commitments)* *Describe:* • *Progress made since previous report* • *Progress against plan*			*There is a risk that… (Describe risk)*
Quantitative update	*Metric description*	*Baseline (YE 22/23)*	*Current performance*	*Delivery Risk / Issue*
1				
2				
3				

Example governance arrangements:

Service Delivery Plan(s)	Governance
Integrated Cardiac Delivery Network	• ICB Executive Lead: **Chief Medical Officer** • All integrated Delivery Networks report into the ***ICB Clinical Programme Board***
Integrated Respiratory Delivery Network	
Integrated Stroke Delivery Network	
Integrated Diabetes Delivery Network	

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