Agenda

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Date: 30 June 2023
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A meeting of the

Joint Scrutiny Committee

will be held on Monday, 10 July 2023 at 6.30 pm
Abbey House, Abbey Close, Abingdon OX14 3JE

The meeting will be streamed live here:
https://www.youtube.com/c/SouthandValeCommitteeMeetings

Members of the Committee:

Councillors

South	**Vale**
Stefan Gawrysiak (co chair in the chair)	Katherine Foxhall (co chair)
Alexandrine Kantor	Andy Cooke
Jo Robb	Lucy Edwards
Leigh Rawlins	Judy Roberts
Ed Sadler	Andrew Skinner

Alternative formats of this publication are available on request. These include large print, Braille, audio, email and easy read. For this or any other special requirements (such as access facilities) please contact the officer named on this agenda. Please give as much notice as possible before the meeting.

Patrick Arran
Head of Legal and Democratic

Agenda

Open to the Public including the Press

1. Apologies for absence

To record apologies for absence and the attendance of substitute members.

2. Urgent business and chair's announcements

To receive notification of any matters which the chair determines should be considered as urgent business and the special circumstances which have made the matters urgent, and to receive any announcements from the chair.

3. Declaration of interests

To receive declarations of disclosable pecuniary interests, other registrable interests and non-registrable interests or any conflicts of interest in respect of items on the agenda for this meeting.

4. Minutes

(Pages 4 - 5)

To adopt and sign as a correct record the Joint Scrutiny Committee minutes of the meeting held on 27 February 2023.

5. Public participation

To receive any questions or statements from members of the public that have registered to speak.

REPORTS AND OTHER ITEMS BROUGHT BEFORE JOINT SCRUTINY COMMITTEE FOR ITS CONSIDERATION

6. Integrated Care Strategy

(Pages 6 - 66)

The Integrated Care Strategy has been created by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Partnership. Joint Scrutiny Committee is invited to consider the report of the Head of Policy and Programmes and to ask questions about the strategy attached.

7. Exclusion of the public

To consider whether to exclude members of the press and public from the meeting for the following items of business under Section 100A and 100I of the Local Government Act 1972 on the grounds that:

(i) It is likely that there will be disclosure of exempt information as defined in paragraph 3 of Schedule 12A, and

(ii) the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

8. Exempt minutes

(Pages 67 - 71)

To consider exempt minutes from the meeting of 27 February 2023

Minutes

of a meeting of the

Joint Scrutiny Committee

held on Monday, 27 February 2023 at 6.30 pm
at Meeting room 1, Abbey House, Abbey Close, Abingdon OX14 3JE

Open to the public, including the press

Present in the meeting room:
Members:
South Oxfordshire District Councillors: Ian White (Co-chair), Jo Robb, Stefan Gawrysiak and Leigh Rawlins
Vale of White Horse District Councillors: Nathan Boyd (Co-chair in the chair), Andy Cooke and Max Thompson (substitute)

Officers: Candida Basilio (Democratic Services) and Adrianna Partridge (Deputy Chief Executive for Operations and Transformation)

Cabinet Members for Environment: Councillors Sally Povolotsky (Vale) and Sue Cooper (South)

Present remotely:
Officers: Paul Fielding (Head of Housing and Environment), Simon Hewings (Head of Finance), Suzanne Malcolm (Deputy Chief Executive – Place)

Councillors: Emily Smith and Bethia Thomas

Sc.12 Apologies for absence

Apologies received from Councillor David Grant, with Councillor Max Thompson in attendance as substitute.

Sc.13 Declaration of interests

None.

Sc.14 Minutes

The minutes of the last meeting on 7 November 2022 were agreed as a correct record and the chair will sign them as such.

Sc.15 Work schedule and dates for all South, Vale and Joint scrutiny meetings

The committee noted the work programme.

Sc.16 Public participation

None.

Sc.17 Exclusion of the public

Resolved:
The committee voted in favour of excluding the public to consider exempt reports.

Sc.18 Delivery of waste services

Committee considered a report on waste services and provided comments to the relevant Cabinet members.

Sc.19 Delivery of waste services - procurement of new vehicles

Committee considered a report on waste vehicle procurement and provided comments to the relevant Cabinet members.

The meeting closed at 20:41

South Oxfordshire District Council

Listening Learning Leading

Cabinet Report

Report of Head of Policy and Programmes

Reporting Officer: Tim Oruye

Telephone: 07849701774

Author: Jayne Bolton, Community Wellbeing Manager

Telephone: 07717 355143

E-mail: tim.oruye@southandvale.gov.uk

Wards affected: District wide

Cabinet member responsible: Cllr. Maggie Filipova-Rivers

Tel: 07850 141623

E-mail: maggie.filipova-rivers@southoxon.gov.uk

To: CABINET

Date: 22 June 2023

Integrated Care Strategy

Recommendation

(a) That Cabinet endorses the Integrated Care Strategy attached at appendix one.

Purpose of Report

1. To update Cabinet on the progress of the Integrated Care Strategy (ICS) drafted by Health and Care partners in Buckinghamshire, Oxfordshire, and Berkshire West (BOB) on a set of proposed priorities to support improved health and wellbeing across the area and consider it for endorsement.

2. To update Cabinet on the progress of the Community Hub Team's involvement to ensure the voice of our local communities, especially those in deprived areas and where health inequalities exist, are represented, and responded to particularly within the consultation on the ICS.

Corporate Objectives

3. The ICS supports many of the council's priorities and aims as set out in the Corporate Plan and the Climate Action Plan.

Background

4. The BOB Integrated Care Partnership (ICP) (formally established on 1 July 2022), is a collaboration of organisations, which plan and provide health and care services for two million people who live and work in the local authority areas of Buckinghamshire Oxfordshire, West Berkshire, Reading and Wokingham (the latter three authorities under the umbrella of 'Berkshire West'). Members include local authorities, Local NHS organisations and GPs, public health, Healthwatch, care providers, the voluntary sector, the Oxford Academic Health Science Network and other research partners.

5. The Integrated Care Board ("the ICB") is the new NHS body that receives funds from NHS England and plans and buys services for Berkshire, Oxfordshire, Buckinghamshire ("BOB"). The Health and Care Act 2022 documented new statutory requirements for the ICB, one of which is to produce an Integrated Care Strategy at ("BOB") level, as explained in guidance published by the DHSC in July 2022.

6. The BOB Integrated Care Partnership's (ICP) vision for the two million people who live in the area is to have the best possible start in life, to live happier, healthier lives for longer, and to get the right support when they need it. To achieve its vision, the ICP has developed a strategy, which proposes a common set of priorities that partners will work on together.

7. Oxfordshire Health Improvement Board considered the proposed ICS on 17 November 2022 as did the Oxfordshire Health and Wellbeing Board on 1 December 2022 both of which includes our members.

8. Representatives from across the health and care systems have collaborated widely with partner organisations, the voluntary sector, and other stakeholders to understand their ambitions as a foundation for the ICS, working with local people and communities to refine the proposals and agree a common set of priorities for the health and care system, through various public engagement exercises.

9. The Future Oxfordshire Partnership received a report on 23 January 2023 from the ICP on a Place-based Partnership model, setting out the Vision for residents to be healthier and happier, a guiding principle of improved wellbeing and reduction in inequalities and how the ICB will approach partnership working and a place-based approach to health care.

10. The first step of the Vision is to agree an ICS with clear principles and priorities to take forward across the Partnership. These are based on a commitment from the partners to work together to improve people's health and wellbeing and reduce the inequalities in health experienced by people across our populations. The ICS builds on current joint local health and wellbeing strategies and outlines the areas where it is expected partners can do more together, locally and across the health and care system, to improve health and wellbeing in a manner that is fair and inclusive.

11. Daniel Leveson is the Place Director for Oxfordshire and responsible for convening leaders from across the health and care system to develop a thriving partnership to

create conditions that enable the ICB to delegate some of its functions and budgets to place.

12. The Oxfordshire Place based Partnership Leadership team is detailed below:

Name	Job Title	Organisation
Daniel Leveson	Place Director	BOB ICB
Stephen Chandler	Interim Executive Director: People, Transformation and Performance	Oxfordshire County Council
Mark Stone	Chief Executive	Representative for City and District Councils
Dr Nick Broughton	Chief Executive	Oxford Health NHS FT
Professor Meghana Pandit	Chief Executive	Oxford University Hospitals NHS FT
Ansaf Azhar	Director of Public Health	Oxfordshire County Council
Veronica Barry	Executive Director	Healthwatch
Laura Price	Chief Executive	Oxfordshire Community and Voluntary Action
Dr Toby Quartley	GP Lead	North PCNs
Dr Michelle Brennan	GP Lead	South PCNs
Dr Joe McManners	GP Lead	City PCNs

The Strategy

13. Following initial feedback through Future Oxfordshire Partnership, Oxfordshire Health Improvement Board and Oxfordshire Health and Wellbeing Board formal consultation on the ICS commenced in December 2022 and closed on 29 January 2023. This consultation invited local people and communities to refine the proposals to agree a common set of priorities for the health and care system.

14. The ICS strategy seeks to provide a clear direction for our health and care system and the people who live in the BOB area and proposes the following sets of principles and five priority areas.

ICS Principles:

- **Preventing Ill-Health** – help people to stay well and independent, enjoying better health for longer. We will help develop healthy places and thriving communities to protect and improve people's health.

- **Tackling Health Inequalities** – we will see to improve the physical and mental health of those at risk of the poorest health. This will include making sure people can access health and care services, whatever their background.

- **Providing Person Centred Care** - we will work together to provide help in a way that meets people's needs and helps them to make informed decisions and be involved in their own health and care.

- **Supporting Local Delivery** – we will plan and design support and services with local people and provide support as close as possible to where people live, learn and work.

- **Improving the Join Up Between our Services** - we will improve the way our services work together to ensure people get support when they need it and residents have a better experience of health and care services.

ICS Priorities:

- **Promoting and protecting health** – keeping people healthy and well
- **Start Well** – helping all children and young people achieve the best start in life
- **Live Well** – supporting people and communities to live healthy and happier lives
- **Age Well** – staying healthy and independent for longer
- **Improving quality and access –** accessing the right care in the best place

15. Each of the Priorities have a number of areas of focus and proposals for measurable achievements/targets which are detailed in the ICS attached at appendix one to this report.

Consultation

16. As indicated above much discussion has already been undertaken with partners to develop the draft ICS and a formal public consultation carried out. In addition, a workshop for members and officers was organised by Oxfordshire County Council's Public Health team working closely with the ICB/P officers. It was held on 19 January 2023 to discuss the ICS in more depth, feedback more detailed local comments and identify anything that was felt to be missing from the priorities presented. This was attended by our Community Wellbeing Manager.

17. Officers from planning, planning policy, infrastructure and wellbeing teams fed back the bullet point comments below either at the workshop or through a formal consultation response agreed by the cabinet member for community wellbeing.

- stronger integration with local authority planning matters especially integration with Local Plans is required to ensure service provision is projected alongside housing developments

- physical assets such as expansion of or new GP surgeries/health centres should be much stronger – especially in areas of housing growth where developer contributions can be obtained

- the importance of improving the housing conditions that people live in and addressing the wider social, economic, and environmental issues that affect our health should be much stronger and could include local authority disabled facility grants to support residents to stay in their homes longer

- links to housing provision for staff resources to ensure appropriate workforce should be included and joint working with local authorities and affordable housing teams

- the importance of preventative work already being undertaken at a local level to offer support to residents through working with local social prescribers, our community hub support teams and active communities officers

- the advantage of local information hubs connecting all our services could be developed to offer a one stop shop advice and information service

- more investment in community and voluntary sector services should be included as they provide valuable local services

- inequalities in rural areas is a problem and needs to be addressed through a wide range of options such as retention of local resources, digital access to services and/or transport initiatives

- mental health priority should include loneliness and isolation

- support for the priority to reduce alcohol consumption and this has a wide impact on whole family's mental health and wellbeing.

- links to Oxfordshire Food Strategy to address the issues of food insecurity and allowing residents to equal opportunities to access healthy food will help to address the overweight and obese priority

- dentists need to be included in strategy

- a joined-up approach to healthy activity schemes using tried and tested systems to measure usage and impacts on health prevention across Oxfordshire.

18. The full engagement report on the BOB ICP Strategic priorities is now available to read.

Links to other strategies

19. The council has recently approved a new active communities strategy and, following endorsement of the Oxfordshire Food Strategy, is just commencing work on a local area food action plan to address the issues of food insecurity, education and these strategies will help to encourage residents to be more active and eat more healthily, already supporting some of the priorities in the ICS.

20. Our consultation response also highlights the importance of linking health into our Local Plans and our housing strategies.

Community Hub

21. The council's community hub team supports initiatives to address health inequalities and works with Oxfordshire local authorities and other partners on programmes and initiatives across the BOB area. The team directly supports our residents who are most in need by securing and redirecting funding to them, advising on policy issues regarding benefits and council tax reduction schemes, working directly with advice services and local food banks. They will lead on the local food strategy action plans and can steer resources and finance to the areas identified in the ICS as being in most need now and in the future.

22. The team will be the key contact on the next stages of the implementation of the ICS and work closely with partners across the BOB area to ensure our areas are given due consideration as part of the wider health agenda. We particularly want to ensure closer working with our planning policy and planning development management teams to ensure appropriate health provision and funding is secured through new developments and to ensure healthy living and appropriate green spaces are provided particularly on key strategic sites and where we have garden communities.

Options

23. There is no legal obligation to endorse the ICS. However, not supporting the strategy and not participating in its implementation may see the Council being unable to influence related work for the benefit of our residents and miss out on partnership schemes and funding that supports the improvement of the health and wellbeing of our residents.

Climate and ecological impact implications

24. There are no direct climate or ecological impacts in relation to endorsement of the ICS.

Equalities and Diversity implications

25. A commitment is required from all the partner organisations of the ICP/ICB, including the district councils, to work together to improve people's health and wellbeing and to reduce the inequalities in health experienced by people in the district.

26. We do have concerns about the number of GP surgeries available for our growing population and the impact this may have causing patients to travel long distances to access services. This has a particular impact on our most vulnerable residents.

Financial Implications

27. There are no direct financial implications relating to the endorsement of this strategy.

28. The community hub core team currently funded until March 2026 can offer some resources to support the work on this health agenda. It will be regularly monitored to understand the level of resource required to have meaningful input into the ICS.

29. There are also financial benefits where funding is already being provided by the ICB for locally led health initiatives such as the Move Together and You Move programmes. It is possible, due to the success of these programmes that similar funding will come forward where specific areas of need are identified.

30. It should also be noted that the council currently allocates 20 per cent of its Community Infrastructure Levy (CIL) proportion to health care infrastructure, balances as of 31 March 2023 are over £7 million. We also secure Section 106 contributions for health purposes from strategic housing development sites.

31. Any council decision that has financial implications must be made with the knowledge of the council's overarching financial position. For South, the position reflected in the council's medium-term financial plan (MTFP) as reported to full Council in February 2023 showed that it is due to receive £644,000 less in revenue funding than it plans to spend in 2023/24 (with the balance coming from reserves), with this budget gap expected to continue in future years. However, there is great uncertainty over this caused by a lack of clarity from government.

32. The future funding gap is predicted to increase to over £8.5 million by 2027/28, based on current cautious officer estimates of future funding levels. Whilst it is anticipated that overall funding for the council will remain relatively unchanged in 2024/25, the lack of certainty on future local government funding from 2025/26 onwards means the level of funding, and the resulting estimated funding gap, could be significantly different from current officer estimates in either a positive or negative way. Every financial decision, particularly those involving long-term funding commitments (i.e. those beyond 2024/25), needs to be cognisant of the potential for significant funding gaps in future years.

Legal Implications

33. Supporting principles of the Integrated Care Strategy neither imposes nor infers any additional obligations on the council and it is therefore considered that there are no legal implications in adopting the strategy.

Risks

34. Lack of support for this strategy could result in a reputational risk that is that the council may not be seen as not having a seat at the table to ensure that strategic decisions are made in the best interests of our residents, as well as damaging potential working relationships with local partners, which we are working hard to retain post pandemic.

Other implications

35. There are not considered to be any other implications beyond those set out above.

Conclusion

36. The ICS and its strategic priorities take the first step in this new partnership approach. It requires a commitment from the partner organisations, including the district councils, to work together to improve people's health and wellbeing and reduce the inequalities in health experienced by people across BOB.

37. The ICS builds on our current Oxfordshire local health and wellbeing strategies, which are currently being updated and will shape the future of health and social care in response to local needs.

38. The ICP reviewed all consultation comments received and considered some minor changes before approving the ICS on 1 March 2023.

39. Officers therefore recommend that Cabinet endorses the ICS attached at appendix one of this report.

Next Steps

40. The ICB and NHS Trusts have a joint statutory responsibility to provide a Joint Forward Plan (JFP) and to engage across the system on its content with various partners including local authorities. This needs to describe how the ICB and its partner trusts intend to arrange and/or provide NHS services including the delivery of the universal NHS commitments. It is envisaged it will be a five-year plan. Formal publication of the JFP is required by 30 June 2023.

41. The JFP is due to be considered at the next meeting of the Oxfordshire Health and Wellbeing Board on 29 June 2023, which our Cabinet Member for Community Wellbeing will attend. The Board will be asked to give a formal opinion 'on whether the draft takes proper account of local health and wellbeing strategy' and this opinion will be published with the JFP. In future years, the ICB and their partner trusts will have a duty to update their JFP before the start of each financial year.

42. An Oxfordshire Place based Partnership will be created, arrangements are being formalised to co-ordinate and leverage collective resources to meet the health needs of the people of Oxfordshire. The Joint Strategic Needs Assessment and Oxfordshire Health and Wellbeing Strategy will inform and guide the plans to:

- identify people/populations that will benefit from more local joined-up services
- ensure joined-up services are simple, seamless and innovative
- reduce health inequalities, focussing on people living in deprived areas, minority groups and populations where life expectancy and healthy life years are worst
- create a sustainable system by designing new models of care that make the best use of our collective resources.

Background papers

Oxfordshire Health and Wellbeing Board Report of 16 March 2023

Cabinet Report

Report of Head of Policy and Programmes

Reporting Officer: Tim Oruye

Telephone: 07849701774

Author: Jayne Bolton, Community Wellbeing Manager

Telephone: 07717 355143

E-mail: tim.oruye@southandvale.gov.uk

Wards affected: District wide

Cabinet member responsible: Cllr. Helen Pighills

Tel: 07850 141623

E-mail: helen.pighills@whitehorse.gov.uk

To: CABINET

Date: 23 June 2023

Integrated Care Strategy

Recommendation

(a) That Cabinet endorses the Integrated Care Strategy attached at appendix one.

Purpose of Report

1. To update Cabinet on the progress of the Integrated Care Strategy (ICS) drafted by Health and Care partners in Buckinghamshire, Oxfordshire, and Berkshire West (BOB) on a set of proposed priorities to support improved health and wellbeing across the area and consider it for endorsement.

2. To update Cabinet on the progress of the Community Hub Team's involvement to ensure the voice of our local communities, especially those in deprived areas and where health inequalities exist, are represented and responded to particularly within the consultation on the ICS.

Corporate Objectives

3. The ICS supports many of the council's priorities and aims as set out in the Corporate Plan and the Climate Action Plan.

Background

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5. The Integrated Care Board ("the ICB") is the new NHS body that receives funds from NHS England and plans and buys services for Berkshire, Oxfordshire, Buckinghamshire ("BOB"). The Health and Care Act 2022 documented new statutory requirements for the ICB, one of which is to produce an Integrated Care Strategy at ("BOB") level, as explained in guidance published by the DHSC in July 2022.

6. The BOB Integrated Care Partnership's (ICP) vision for the two million people who live in the area is to have the best possible start in life, to live happier, healthier lives for longer, and to get the right support when they need it. To achieve its vision, the ICP has developed a strategy, which proposes a common set of priorities that partners will work on together.

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10. The first step of the Vision is to agree an ICS with clear principles and priorities to take forward across the Partnership. These are based on a commitment from the partners to work together to improve people's health and wellbeing and reduce the inequalities in health experienced by people across our populations. The ICS builds on current joint local health and wellbeing strategies and outlines the areas where it is expected partners can do more together, locally and across the health and care system, to improve health and wellbeing in a manner that is fair and inclusive.

11. Daniel Leveson is the Place Director for Oxfordshire and responsible for convening leaders from across the health and care system to develop a thriving partnership to create conditions that enable the ICB to delegate some of its functions and budgets to place.

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The Strategy

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17. Officers from planning, planning policy, infrastructure and wellbeing teams fed back the bullet point comments below either at the workshop or through a formal consultation response agreed by the cabinet member for community wellbeing.

- stronger integration with local authority planning matters especially integration with Local Plans is required to ensure service provision is projected alongside housing developments

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- dentists need to be included in strategy

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18. The full engagement report on the BOB ICP Strategic priorities is available.

Links to other strategies

19. The council has recently approved a new active communities strategy and, following endorsement of the Oxfordshire Food Strategy, is just commencing work on a local area food action plan to address the issues of food insecurity, education and these strategies will help to encourage residents to be more active and eat more healthily, already supporting some of the priorities in the ICS.

20. Our consultation response also highlights the importance of linking health into our Local Plans and our housing strategies.

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21. The council's community hub team supports initiatives to address health inequalities and works with Oxfordshire local authorities and other partners on programmes and initiatives across the BOB area. The team directly supports our residents who are most in need by securing and redirecting funding to them, advising on policy issues regarding benefits and council tax reduction schemes, working directly with advice services and local food banks. They will lead on the local food strategy action plans and can steer resources and finance to the areas identified in the ICS as being in most need now and in the future.

22. The team will be the key contact on the next stages of the implementation of the ICS and work closely with partners across the BOB area to ensure our areas are given due consideration as part of the wider health agenda. We particularly want to ensure closer working with our planning policy and planning development management teams to ensure appropriate health provision and funding is secured through new developments and to ensure healthy living and appropriate green spaces are provided particularly on key strategic sites and where we have garden communities.

Options

23. There is no legal obligation to endorse the ICS. However, not supporting the strategy and not participating in its implementation may see the Council being unable to influence related work for the benefit of our residents and miss out on partnership schemes and funding that supports the improvement of the health and wellbeing of our residents.

Climate and ecological impact implications

24. There are no direct climate or ecological impacts in relation to endorsement of the ICS.

Equalities and Diversity implications

25. A commitment is required from all the partner organisations of the ICP/ICB, including the district councils, to work together to improve people's health and wellbeing and to reduce the inequalities in health experienced by people in the district.

26. We do have concerns about the number of GP surgeries available for our growing population and the impact this may have causing patients to travel long distances to access services. This has a particular impact on our most vulnerable residents.

Financial Implications

27. There are no direct financial implications relating to the endorsement of this strategy.

28. The community hub core team currently funded until March 2026 can offer some resources to support the work on this health agenda. It will be regularly monitored to understand the level of resource required to have meaningful input into the ICS.

29. There are also financial benefits where funding is already being provided by the ICB for locally led health initiatives such as the Move Together and You Move programmes. It is possible, due to the success of these programmes that similar funding will come forward where specific areas of need are identified.

30. It should be noted that the council currently allocates 20 per cent of its Community Infrastructure Levy (CIL) proportion to health care infrastructure, balances as of 31 March 2023 are £2,441,248. We also secure Section 106 contributions for health purposes from strategic housing development sites.

31. Any council decision that has financial implications must be made with the knowledge of the council's overarching financial position. For Vale, the position reflected in the council's medium-term financial plan (MTFP) as reported to full Council in February 2023 showed that the council was able to set a balanced budget for 2023/24, but that there is expected to be a budget gap in future years. However, there is great uncertainty over this caused by a lack of clarity from government.

32. The future funding gap is predicted to increase to over £7.8 million by 2027/28, based on current cautious officer estimates of future funding levels. Whilst it is anticipated that overall funding for the council will remain relatively unchanged in 2024/25, the lack of certainty on future local government funding from 2025/26 onwards means the level of funding, and the resulting estimated funding gap, could be significantly different from current officer estimates in either a positive or negative way. Every financial decision, particularly those involving medium-term funding commitments (i.e. those beyond 2024/25), needs to be cognisant of the potential for significant funding gaps in future years.

Legal Implications

33. Supporting principles of the Integrated Care Strategy neither imposes nor infers any additional obligations on the council and it is therefore considered that there are no legal implications in adopting the strategy.

Risks

34. Lack of support for this strategy could result in a reputational risk that is that the council may not be seen as not having a seat at the table to ensure that strategic decisions are made in the best interests of our residents, as well as damaging potential working relationships with local partners, which we are working hard to retain post pandemic.

Other implications

35. There are not considered to be any other implications beyond those set out above.

Conclusion

36. The ICS and its strategic priorities take the first step in this new partnership approach. It requires a commitment from the partner organisations, including the district councils, to work together to improve people's health and wellbeing and reduce the inequalities in health experienced by people across BOB.

37. The ICS builds on our current Oxfordshire local health and wellbeing strategies, which are currently being updated and will shape the future of health and social care in response to local needs.

38. The ICP reviewed all consultation comments received and considered some minor changes before approving the ICS on 1 March 2023.

39. Officers therefore recommend that Cabinet endorses the ICS attached at appendix one of this report.

Next Steps

40. The ICB and NHS Trusts have a joint statutory responsibility to provide a Joint Forward Plan (JFP) and to engage across the system on its content with various partners including local authorities. This needs to describe how the ICB and its partner trusts intend to arrange and/or provide NHS services including the delivery of the universal NHS commitments. It is envisaged it will be a five-year plan. Formal publication of the JFP is required by 30 June 2023.

41. The JFP is due to be considered at the next meeting of the Oxfordshire Health and Wellbeing Board on 29 June 2023, which our Cabinet Member for Community Wellbeing will attend. The Board will be asked to give a formal opinion 'on whether the draft takes proper account of local health and wellbeing strategy' and this opinion will be published with the JFP. In future years, the ICB and their partner trusts will have a duty to update their JFP before the start of each financial year.

42. An Oxfordshire Place based Partnership will be created, arrangements are being formalised to co-ordinate and leverage collective resources to meet the health needs of the people of Oxfordshire. The Joint Strategic Needs Assessment and Oxfordshire Health and Wellbeing Strategy will inform and guide the plans to:

    - identify people/populations that will benefit from more local joined-up services
    - ensure joined-up services are simple, seamless and innovative
    - reduce health inequalities, focussing on people living in deprived areas, minority groups and populations where life expectancy and healthy life years are worst
    - create a sustainable system by designing new models of care that make the best use of our collective resources.

Background papers

Oxfordshire Health and Wellbeing Board Report of 16 March 2023

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Partnership

Integrated Care Strategy

March 2023

Contents

Welcome

There is little doubt we are living through a time where pre-existing assumptions about health outcomes are being challenged. From the shock of the pandemic, to a cost of living crisis likely to widen health inequalities rather than reduce them, the task of setting a course for the years ahead is not easy.

We already know that the places and circumstances where people are born, grow up, live, and learn influence how happy and healthy they are, which makes it particularly difficult to set a strategy for a catchment area as large as ours. Many strategies cross over county boundaries, others do not.

The pandemic shone a bright light on the health inequalities in our societies. We always knew they existed, but we maybe don't talk about them enough. As always, the biggest impact was felt by less well-off communities and the same will apply to the economic conditions in the year ahead.

My own patch of Reading ranks as the third most unequal town or city nationally for wealth distribution. Looking at the wider area of Buckinghamshire, Oxfordshire and Berkshire West – which covers nearly 2 million individuals – life expectancy can vary between areas by up to a decade. And people in less affluent areas experience poor health 10-15 years earlier than their more affluent neighbours (the so-called 'healthy life expectancy gap').

The pandemic also taught us the importance of partnership. The work of one organisation can be quickly undermined if other bodies are pulling in a different direction. By identifying our shared priorities, and the actions that can support them, this strategy helps us work together towards a common goal – to give people the best possible start in life, for people to be happier and healthier and to ensure they have access to support when they need it.

Partner organisations and local communities know best what the challenges are in their own areas. It's why we have consulted widely on our proposed priorities and why we intend to continue this dialogue with people and organisations across our area. This strategy is the start of a journey which aims to ensure that the NHS and all partners direct limited resources so as to have the biggest positive impact on people's lives.

JN Brock

Cllr Jason Brock

Chair, Integrated Care Partnership
and Leader of Reading Borough Council

Our Integrated Care Partnership

Our Integrated Care Partnership (ICP) is a group of organisations who plan and provide health and care services for the people who live and work in the local authority areas of Buckinghamshire, Oxfordshire and Berkshire's three westerly local authority areas of West Berkshire, Reading and Wokingham (known as 'Berkshire West').

Members include local NHS organisations and GPs, local authorities, public health, Healthwatch, care providers, voluntary and community groups, as well as academic and research partners.

The purpose of this Strategy

As a Partnership we are committed to working together to improve health and wellbeing across our area. We want to ensure that children and young people have the best possible start in life and that everyone can live a happy and healthy life for a long as possible. We also want to ensure that people who live and work in Buckinghamshire, Oxfordshire and Berkshire West are able to access the right support when they need it.

This ambition applies to everyone in our area. However, we recognise that this is a bigger challenge for some people and we are committed to working together to reduce the inequalities in health experienced by many people in our area.

What are health inequalities?

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience, and the care that is available to them.

Many different things lead to health inequalities. The conditions in which we are born, grow, live, work and age all impact on our health and wellbeing. People living in geographic areas where there are high levels of deprivation often have much poorer health and lower life expectancy than those living in wealthier areas.

Some groups and communities are also more likely to experience poorer health than the general population. The individuals in these groups often share specific characteristics including those protected by law such as sex, ethnicity or disability. For example, those from Black, Asian and minority ethnic communities and people who are neurodivergent or have a learning disability frequently suffer from significant health inequalities.

Other individuals experience challenges in accessing care, often because they are from socially excluded groups. For example, those experiencing homelessness or people with drug and alcohol dependencies.

Our Integrated Care Partnership

Improving services for everyone, preventing ill health and reducing health inequalities will require us to work together better and to work differently. We need to consider how resources are used, how we assess the impact of the decisions we make and look at new ways in which everyone can have equal access to appropriate services. We need to work more closely with our communities, listening to what they tell us and using their lived experience to guide our actions.

To do this we have agreed five areas of strategic priority where we expect to do more together, locally and across the health and care system, to improve health and wellbeing in a manner that is fair and inclusive. This strategy outlines these priorities and sets the direction for our health and care system.

This strategy builds on our current joint local health and wellbeing strategies. These have been developed between NHS, local authority and other partners at local authority level. We have worked with members of our partner organisations, the voluntary sector, and others to understand their areas of focus and ambitions.

We also asked local people and partner organisations to share their views on our draft priorities and we have used their feedback to shape this strategy. This is just the start of a dialogue which will continue as our work develops. Together we are confident we can make a real difference in Buckinghamshire, Oxfordshire and Berkshire West.

Our area

Situated in the heart of the Thames Valley, much of our area is rural with more densely populated areas around our towns and cities including, High Wycombe, Oxford and Reading.

Beyond our boundaries we have a mix of rural areas and large urban centres. Our location offers relatively quick access to London and strong transport links to other parts of England.

Our health and care system

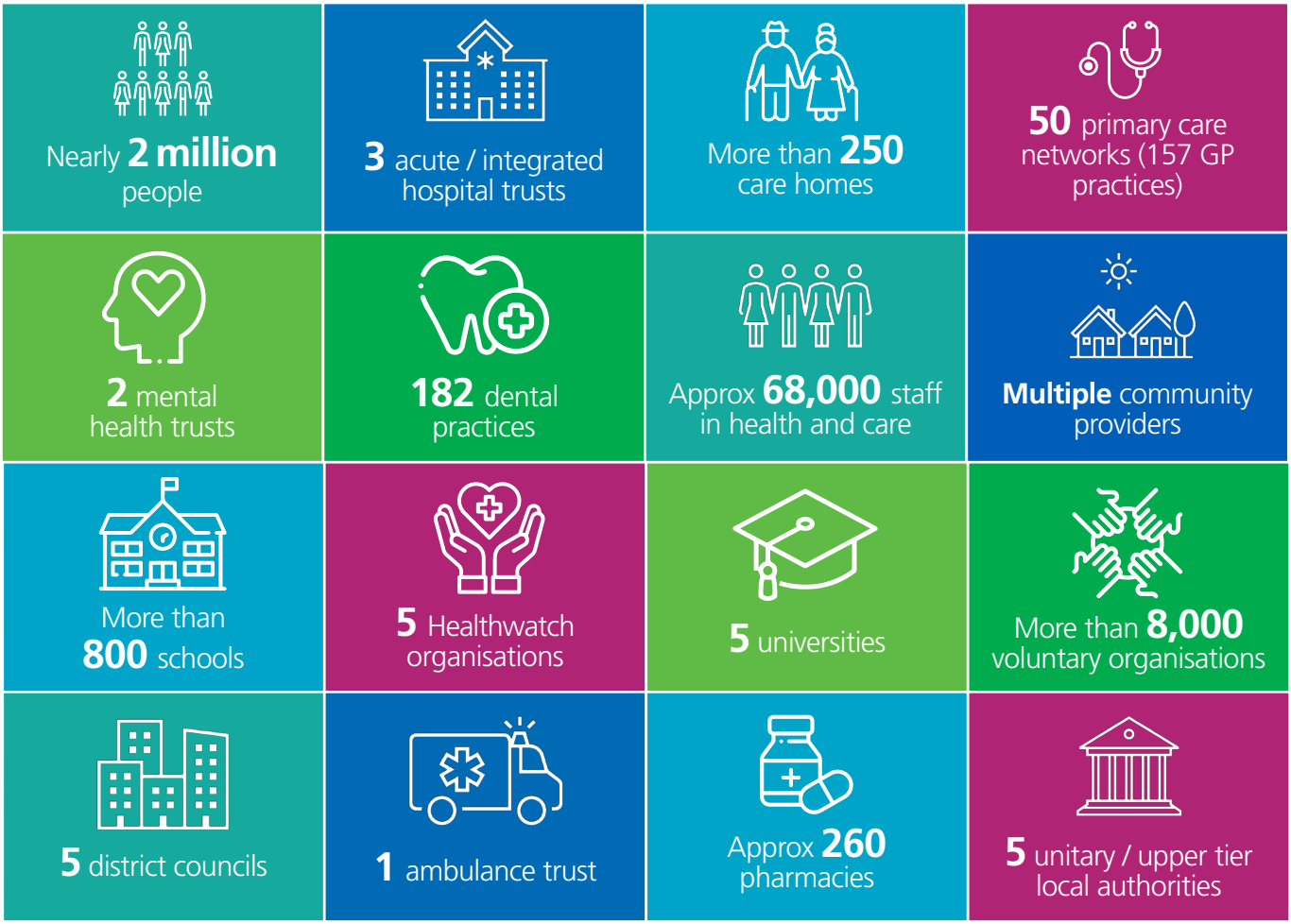
Our health and care system is made up of many organisations who all play a part in helping people to be as healthy as possible, for as much of their lives as possible. These include local councils, social care support, hospitals, emergency services, GP practices, dentists, mental health providers, care homes, and many voluntary, community and social enterprise organisations.

In addition to these organisations who directly provide health and care services, we have links with schools, universities, businesses and research partners working in health or care in our area.

There are well over 8,000 registered charities in our geography and there may be as many as 5,000 more informal community groups.

Most of the registered charities are very small and volunteer-run. As well as making a difference to the health and wellbeing of our population, these voluntary and community groups provide us with a strong link into our communities and a valuable insight into local needs.

Some of the people and organisations playing a part in the health and wellbeing of our population include:



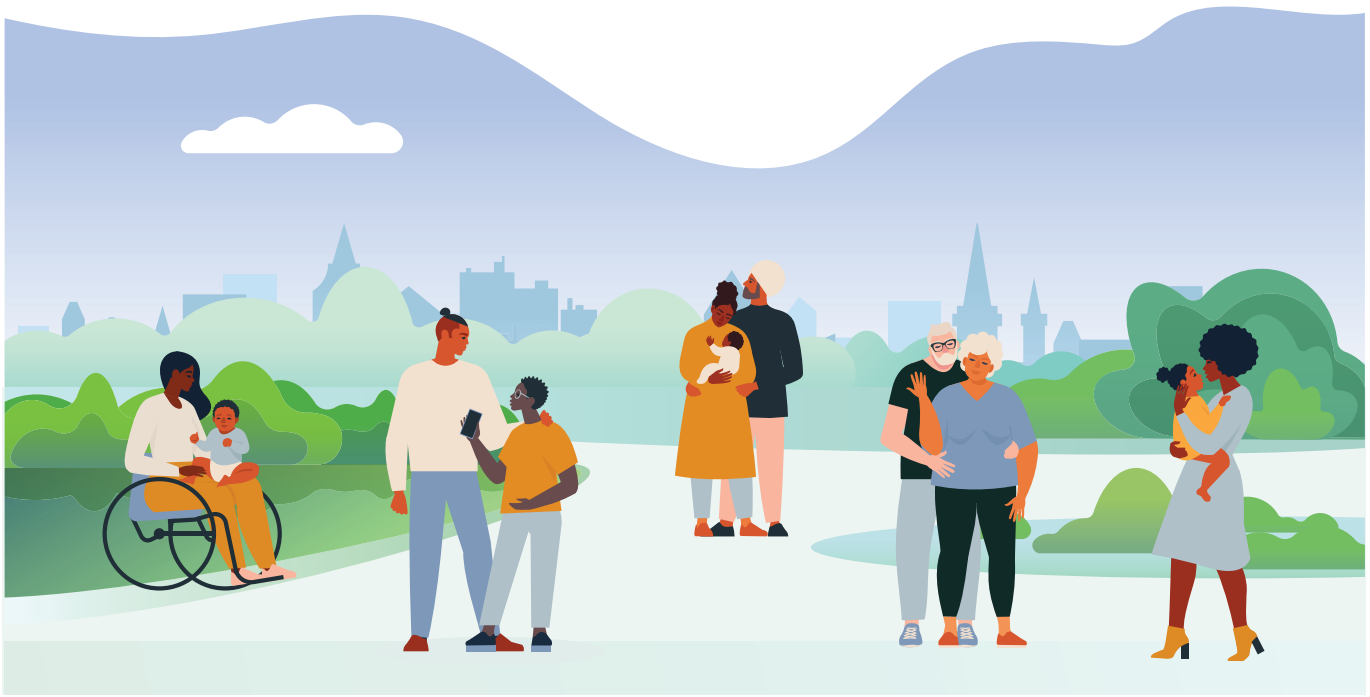
Our population

Nearly two million people live in Buckinghamshire, Oxfordshire and Berkshire West.

The overall age profile of people living in our area is similar to the national average, with a slightly higher proportion of people aged under 18 and a slightly lower proportion of people aged over 65 years. Just over 1 in 5 people are under 18 years and just under 1 in 5 people are over 65 years of age.

This profile is likely to change over time. We anticipate a 5% growth in the overall size of the population by 2042 (an extra 89,000 people). This figure, however, masks significant changes for different age groups. The number of people aged over 65 is predicted to increase by 37% (increasing by 122,000 people) while the number of children and young people (those aged under 18 years) will reduce by 7% (26,000 people) over the same 20 year period.

According to the 2021 census, the ethnic profile for our combined area is very similar to the national average. However this masks individual differences at local authority level. People who responded that they were White British make up 73% of residents overall which is similar to the national average but this ranges from 53% in Reading to 85% in West Berkshire. People from many different ethnic groups live in our area including 3.5% of the population who describe themselves as Indian, 3.1% as Pakistani, 1.6% as Black African and 0.8% as Black Caribbean. These relative proportions vary between local authorities and ethnic diversity tends to be higher in our major towns and cities.



Our health and wellbeing

Living long lives in good health

People living in our area are generally healthier and live longer lives in good health than the national average. This is true for all our local authorities except for Reading where women do not live as long as the national average and men live as long as the national average.

Within each local authority, how long people live varies between wards by up to 10 years, with people living shorter lives in more deprived wards.

Across our local authorities, both men and women spend more years in good health than the national average apart from women in Reading who spend fewer years in good health. The gap in years spent in good health is even wider than the gap in how long people live. People in more deprived areas develop poor health 10-15 years earlier than people living in less deprived areas.

A good start in life

The early years are a crucial time for the health and wellbeing of children and their development with far reaching impacts throughout their school years and adult life. A mother's physical and mental health during pregnancy can affect the health and development of her baby before it is born. Children undergo rapid physical, mental and emotional development in the first five years of life and the circumstances in which they live and early life experiences have a profound effect on their development and subsequent mental and physical health as teenagers and adults.

The proportion of babies born at term who were a low birthweight was similar to the national average of 2.9% except in Oxfordshire where 2.3% of babies born at term were low birthweight.

A higher percentage of children in our area achieve a good level of development compared to the national average, except in Reading which is slightly lower. However, this average overlooks the experience of some of our most vulnerable children. Children in receipt of free school meals have lower levels of good development, especially in Oxfordshire and West Berkshire.

Young people aged 16-17 who are not in education, employment or training (NEET) are at increased risk of poor physical and mental health. In 2020, Buckinghamshire had a higher proportion of 16-17 years who were NEET than the national average, Reading had a similar percentage to the national average, while rates were lower in other parts of our area.

Healthy behaviours

The four main health behaviours – smoking, physical inactivity, an unhealthy diet and alcohol misuse - account for 40% of all years lived with ill health and disability. These behaviours are major risk factors for long-term conditions such as heart disease and cancer. People with all four unhealthy behaviours are four times more likely to die prematurely than people with no unhealthy behaviours and the risk increases with each behaviour.

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

1 in 4 residents in Buckinghamshire and Oxfordshire and 1 in 5 residents in Berkshire West (Wokingham, Reading and West Berkshire) are estimated to drink alcohol at levels that increase their risk of health problems.

Around 3 in 10 children aged 10-11 years across our area are overweight or obese and around 6 in 10 adults are overweight or obese.

Around 1 in 5 adults do less than 30 minutes moderate intensity activity a week.

Our health and wellbeing

The circumstances in which people live affect their health behaviours and on average people living in more deprived circumstances tend to have lower levels of healthy behaviours.

Long term conditions

Levels of long term conditions such as heart disease or diabetes are generally lower than the national average. Long term conditions tend to increase with age and it is estimated that 3 in 5 people over 60 years have a long term condition. However, many long term conditions are preventable. For example, up to 70% of heart disease and stroke, up to 50% of type 2 diabetes and 38% of cancer cases could be prevented. Smoking causes 15% of all cancers and obesity and being overweight is the second most common cause of cancer in the UK.

People living in deprived areas develop more long-term conditions and at an earlier age than people living in less deprived areas.

Mental health and wellbeing

Good mental wellbeing supports people to get the most out of life. However mental health problems are common and can be worsened by adverse social and economic circumstances. Approximately 12% of adults across Buckinghamshire, Oxfordshire and Berkshire West have a recorded diagnosis of depression which is similar to the national average and 0.8% have a severe mental illness such as schizophrenia.

Factors that influence our health and wellbeing

The places and circumstances in which people are born, grow up, live learn and work profoundly influence their health. Although the health of the population across Buckinghamshire, Oxfordshire and Berkshire West is generally better than or similar to the national average this masks many differences between different groups of people. These differences are often the result of the different social, economic and environmental conditions in which they live.

Deprivation

From birth to old age people living in more deprived circumstances tend to have worse physical or mental health.

Buckinghamshire, Oxfordshire, West Berkshire and Wokingham are in the 10 least deprived local authorities in the country. Reading is slightly less deprived than the national average. However, within each local authority, levels of deprivation vary - 3% of our population (57,000 people) live in an area that is one of the 20% of the most deprived areas in England.

The percentage of children living in poverty, and the percentage of households living in fuel poverty are all below the national average and unemployment levels are lower than the national average, except in Reading.

The proportion of people who are defined as homeless is below the national average, apart from Reading where rates are higher.

Recorded rates of domestic abuse and hospital admission rates due to violence are lower than the national average. However, we know there is significant under reporting of domestic abuse.

Poorer health outcomes for some groups

We know that some people living in deprived areas tend to have poorer health. There are several other groups that also tend to have poorer health.

People from different ethnic groups are at higher risk of some diseases. For example, people from Black and South Asian ethnic groups are at a higher risk of diabetes and cardiovascular disease (which causes heart disease and stroke). Mothers from Black and South Asian ethnic groups are at greater risk of complications and death during pregnancy and child birth.

Other groups with poorer health include people with a physical or learning disability, people suffering severe mental illness and those who are homeless.

These differences in health are due to a complex mix of societal, economic, environmental and biological factors. However, health problems can also be compounded by people's knowledge of, or ability to access services. Services may not be accessible or acceptable or appear welcoming to some groups of people. Some groups of people also report having worse experiences or poorer outcomes from services.

Inequalities are often multiple and overlapping – for example, a study by the Race and Health Observatory (June 2021) highlighted that people from Black and Minority Ethnic (BME) groups are disproportionately affected by socioeconomic deprivation – a key determinant of health status.

Our vision and principles

Our vision is for everyone who lives in Buckinghamshire, Oxfordshire and the Berkshire West area, to have the best possible start in life, to live happier, healthier lives for longer, and to be able to access the right support when they need it.

Five principles will guide everything we do:

Preventing ill-health

We will help people stay well and independent, enjoying better health for longer. We will help develop healthy places and thriving communities to protect and improve people's health.

Tackling health inequalities

We will seek to improve the physical and mental health of those at risk of the poorest health. This will include making sure people can access health and care services, whatever their background.

Providing person centred care

We will work together to provide help in a way that meets people's needs and helps them to make informed decisions and be involved in their own health and care.

Supporting local delivery

We will plan and design support and services with local people and provide support as close as possible to where people live, learn and work.

Improving the join up between our services

We will improve the way our services work together to ensure people get support when they need it and residents have a better experience of health and care services.

Our priorities

We have identified five priority areas.

Supporting our delivery

While these priorities will be the central focus of our work, we recognise that the success of this strategy will depend on a number of factors including:

- The **people** who work across our health and care system. This includes people in paid employment and also the large number of volunteers and informal carers across Buckinghamshire, Oxfordshire and Berkshire West.
- The **digital solutions, data and insights** available to those who work or volunteer in our area as well as how we use digital technology to move care closer to people's homes and to support people to self-manage their health conditions.
- Our ability to **respond to change and learn from best practice** to embrace new and innovative ways of working.

We also need to ensure that we provide strong leadership across our area whilst also empowering partnerships at a local level to deliver in their communities. Most of all, we know we need to engage with the people who live and work in our area: we need to listen to their voices and involve them in the plans we develop to deliver this strategy.

In the following sections we explain why we have selected each priority, what our areas of focus will be, and what we hope to achieve. These priorities build on the local health and wellbeing strategies already in place and on existing work that is being led by individual organisations in our area. By selecting these priorities, we have the opportunity to develop this work at a wider system level and to support local plans. Our priorities don't name all the important statutory work that is being led through other multi-agency arrangements, such as adult and child safeguarding, but we recognise the importance of continuing to work closely together to deliver the best possible local services for our people and communities.

Promoting and protecting health

Keeping people healthy and well

Although people in Buckinghamshire, Oxfordshire and Berkshire West are generally healthier than the national average, many people suffer poor health from conditions that could be prevented or delayed. Behaviours such as smoking, drinking too much alcohol, having an unhealthy diet, not being physically active or being overweight can lead to a wide range of conditions including diabetes, cancer, heart disease, stroke, lung disease and dementia.

The choices we make are shaped by our circumstances – the people we see around us, the places we live, and other influences such as the availability and pricing of unhealthy foods, alcohol or cigarettes. These factors directly affect the opportunities people have to live healthy lives across our area, including shaping their decisions about smoking, what to eat and the amount of alcohol they drink. Indeed, our data shows stark differences in health outcomes for different population groups, including a variation in life expectancy of up to 10 years between the least and most deprived areas.

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 influence health. We also need to support people and communities to address behaviours that lead to many long term conditions. This includes training and supporting our staff to promote the adoption of healthier behaviours.

By working better together and focusing on prevention in everything we do, we can keep people healthy and well for longer.

Take action to address the factors that influence our health and wellbeing.

Why this matters:

The communities and environment we live in have a significant impact on our health and wellbeing. The world around us influences the choices we make and the quality and length of our lives. This includes decisions we make about how we live our lives from whether we smoke to what we eat or the amount of alcohol we drink.

For example, feeling safe in our local area, with safe places to play and exercise makes it easier to stay healthy and active. Similarly, safe travel routes to school, shops or work make it easier to build physical activity into our day for example, by choosing to walk or cycle.

Our social connection to other people shapes how happy or lonely we feel, while secure employment is also important to our health and wellbeing. The rising cost of living may damage people's health, especially those already experiencing financial hardship. National figures from 2020 found more than 1 in 7 households were affected by fuel poverty, with single parent households most likely to be fuel poor (1 in 4) and couples aged over 60 making the largest average reduction in fuel usage to avoid fuel poverty.

Promoting and protecting health

The price rises in 2022 and 2023 mean more households are struggling. It is harder to stay healthy and well if food and heating are unaffordable.

The quality of our housing and the air we breathe also has a direct impact on our health and wellbeing. Poor air quality, contaminated land and water pollution can lead to acute and chronic disease. Air pollution is responsible for a range of respiratory conditions, cardiovascular disease, cancers and birth defects.

We are committed to addressing the social, economic and environmental factors that influence our health, and to reducing inequalities. For this we need a place-based approach and coordinated action across local government, health care and voluntary sector organisations.

Organisations across Buckinghamshire, Oxfordshire and Berkshire West have also committed to reduce their carbon footprints. The NHS target is to achieve net zero by 2040. This will require significant changes to how we live and work but will ultimately improve and protect the health of the people who live or work across our area.

Our focus areas:

- Supporting the local economy and developing job opportunities and routes into employment for people who live in our area.
- Improving public and staff awareness of services tackling income, fuel and food insecurity, and helping staff to refer people to appropriate services.
- Helping our most vulnerable people and communities access information and local offers of help, including community food projects, benefits entitlements and debt advice.
- Ensuring safe and accessible options for exercise and active travel.
- Encouraging a public health approach to planning and development, to ensure our built environments support healthy lives.
- Ensuring schemes and services are in place so people are helped to live in warm homes.
- Working together to ensure people accessing social housing have safe, warm, damp and mould free homes.
- Ensuring that new housing developments adequately reflect the needs of older people and those with disabilities and are resilient to the impact of climate change.

What we want to achieve:

- The adoption of local planning principles that have health at the heart of the built environment.
- Greater community connectedness through a consideration of community in the structures and services we provide.
- A physical environment that supports people to live independently through thoughtful design.
- All our communities have access to green space within their locality.
- More sustainable road travel, particularly for staff members who use their cars often as part of their work.
- Reduced carbon emissions across all our providers to deliver the commitment each organisation has made to achieving net zero.

Reduce the proportion of people smoking across Buckinghamshire, Oxfordshire and Berkshire West.

Why this matters:

Smoking is one of the biggest causes of preventable disease and early death in our area, accounting for over 4,000 premature deaths each year. It is also the biggest factor behind the gap in life expectancy between people living in the most and least deprived areas, with decisions around smoking shaped by many of the factors considered in the previous section.

According to GP data, 13% of people in Buckinghamshire, Oxfordshire and Berkshire West smoke (154,000 people), but rates are higher in more deprived areas. An estimated 22% of people working in routine and manual occupations and 36% of people with a severe mental illness smoke.

Smoking and tobacco consumption rates are high in some ethnic minority communities and among immigrants from countries where tobacco regulations and cultural approaches to its use are different from UK.

1 in 6 Lesbian Gay Bisexual and Transgender people smoke every day, the prevalence being higher among younger LGBT people.

Smoking causes a very wide range of ill health from the earliest years to older age. For example, smoking while pregnant can harm the unborn baby and result in babies being born too early and having a low birthweight. Parental smoking harms children's health. Smoking also increases the risk of cancer, heart disease, stroke and lung disease and the need for social care occurs on average 10 years earlier in smokers.

Smoking is estimated to cost health and care organisations in Buckinghamshire, Oxfordshire and Berkshire West £94 million each year (£69 million for health and £25 million for social care).

Our focus areas:

- Working together in effective tobacco control partnerships at a place based/local authority level to help reduce the numbers of people smoking.
- Providing, or proactively referring, people to services to help them stop smoking.
- More people in deprived areas are referred to smoking cessation services by their primary care team.
- Co-producing culturally appropriate services, where necessary, to encourage people to give up smoking or tobacco consumption in other forms.
- Supporting more people in contact with the NHS to stop smoking. This includes helping people to stop smoking before planned operations to help their recovery, helping people admitted to hospital, pregnant women and their partners, and people with severe mental illness to stop smoking.

What we want to achieve:

- A reduction in the overall number of smokers in Buckinghamshire, Oxfordshire and Berkshire West, especially in our most deprived areas.
- Fewer young people will take up smoking.
- More people will stop smoking, especially in deprived areas.
- A reduction in conditions made worse by smoking, including fewer people developing cancer and lung disease.
- A reduction in the gap in life expectancy between the most and least deprived areas.

Increase the proportion of people who are a healthy weight and physically active, especially in our most deprived areas and in younger people.

Why this matters:

Across Buckinghamshire, Oxfordshire and Berkshire West, approximately 6 in 10 adults are overweight or obese and approximately 3 in 10 children aged 10-11 are overweight or obese.

Obesity increases the risk of many long-term conditions including cancer, diabetes, heart disease and dementia. Obese people die up to 10 years earlier than people with a healthy weight. Adults and children living in more deprived areas are more likely to be obese.

The risks of many illnesses could be reduced by increased physical activity. Indeed, 1 in 3 deaths are from illnesses where being physically active is an important protective factor against becoming ill. Approximately 1 in 5 adults are inactive.

Our focus areas:

- Working together in place based multi-agency partnerships to improve physical activity levels and support people to stay a healthy weight.
- Promoting active travel and increasing access to green spaces.
- Working together with school aged children to increase physical activity and promote healthy lives.
- Supporting changes that help people to eat healthily and improve access to affordable healthy food. This includes promoting healthy schools and hospitals, and healthy weight in hospital initiatives.
- Supporting more people to lose weight.

What we want to achieve:

- A reduction in the proportion of people who are overweight or obese.
- More children and young people will be physically active, especially in our most deprived areas.
- More children and young people will have access to healthy food and are a healthy weight, especially in our most deprived areas.
- More adults are physically active.
- More adults have access to healthy food and are a healthy weight.
- A reduction in the proportion of people who have type 2 diabetes.

Reduce the proportion of people drinking alcohol at levels that are harmful to their health and wellbeing.

Why this matters:

1 in 4 adults in Buckinghamshire and Oxfordshire and 1 in 5 adults in Reading, West Berkshire and Wokingham (Berkshire West) drink alcohol at levels that are harmful to their health and wellbeing. This is higher than the national average.

Alcohol is one of the most common causes of disability and of death in adults aged 15-49. Alcohol increases the risk of several cancers (including breast cancer), heart disease and stroke as well as liver damage.

Alcohol can lead to family breakdown and increases the risk of domestic violence and child abuse or neglect. It also increases the risk of accidents and violence.

7 out of 10 people with an alcohol disorder have mental health problems.

While drinking at levels that increase risk of harm is most common in the wealthiest fifth of the population, both alcohol-related admissions and alcohol-related deaths are most common in the most deprived areas nationally.

Our focus areas:

- Working together in effective multi-agency drug and alcohol partnerships at place level.
- Identifying and supporting more people 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.
- Hospitals and other care providers have clear pathways for identifying and supporting people who misuse alcohol.
- Developing more integrated help for people who have substance misuse and mental health problems.

What we want to achieve:

- 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 misuse.
- A reduction in conditions caused by alcohol including high blood pressure, cancer and liver disease.
- A reduction in the numbers of violent incidents, accidents and domestic violence triggered by alcohol and a reduction in children being taken into care because of parental alcohol abuse.
- A reduction in the number of people with mental illness who regularly drink at levels that increase the risks of harm.

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.

Why this matters:

The prevention of infectious disease requires an integrated effort across health and social care and direct action by the people and communities affected. It is only this collective effort that can stem or prevent the acceleration of transmissible infection.

We need a shared understanding of the threats and the possible and probable infections. We need to be able to take preventative measures and intervene early. This will require an understanding of the different requirements affecting the varying populations and settings in which we live, work and learn.

Vaccinations are important to protect against ill health. However, since 2013 there has been a decline in the uptake of childhood vaccines in England and this has declined further since the Covid-19 pandemic. In Buckinghamshire, Oxfordshire and Berkshire West, we estimate only 8-25% of 15-16 year-old children have had all the recommended adolescent immunisations. There are also noticeable differences in the uptake of immunisations across our area, leaving some communities vulnerable to infectious diseases.

Our focus areas:

- Protecting more people by immunising them against serious diseases.
- Raising the public's awareness of anti-microbial (antibiotic) resistance and continuing to work with professionals to reduce it.
- Ensuring robust infection control measures amongst our staff and in all health and care settings.
- Developing linked data that gives early indication of local outbreak risks through closer working with the UK Health Security Agency that means effective prevention and earlier intervention.
- Stimulating local action to prioritise tackling blood born virus and reducing transmission through earlier diagnosis and treatment.
- Continuing to work together across our area to prepare robust responses to future pandemics and other environmental or public health emergencies.
- Using local public health expertise to understand global health activities to protect our populations.

What we want to achieve:

- A reduced number of adults and children catching or becoming ill from serious infectious diseases.
- A reduction in the inequality of vaccine uptake across our communities.

Promoting and protecting health

- A reduced impact of outbreaks and spread of disease by achieving herd immunity thresholds for a range of diseases such as measles.
- Stronger protection for those whose immune systems are compromised, are too young, or otherwise unable to receive certain live vaccinations.
- A population that is free from Hepatitis B and C, HIV, Tuberculosis and a halt in the rise in sexually transmitted infections.
- An intelligence platform which provides the evidence to address infectious diseases linked to health inequalities.
- A robust Public Health led Health Protection and Resilience Partnership to establish a gold standard system to protect our populations.

Start well

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

The foundations for a person's future health and wellbeing are set in the early years of life. We need to give every child in Buckinghamshire, Oxfordshire and Berkshire West the best possible start. This begins with supporting mothers during and after their pregnancy and then working together to ensure children achieve their early development milestones so they are ready to get the most out of life, their education and future opportunities.

We want to promote communities and environments that support all children and young people to make healthier choices, and which will allow them to thrive and achieve. We want all children and young people to be able to access the care and support they need, when they need it, and we want that support to be available as early as possible, in places that make getting the support easy.

However, we know some of the circumstances children and families face make it less likely they will receive the support they need. We need to be ready to offer prompt support to those at greatest risk and to children and families who are starting to struggle. For example, we need to identify emerging mental health problems as early as possible and provide treatment before their condition worsens.

We also recognise that some children, young people and their families need additional support and we are committed to working together to provide joined up services to enable these children and young people to reach their full potential.

Improve early years outcomes for all children, particularly working with communities experiencing the poorest outcomes.

Why this matters:

The first five years of a child's life are crucial to their healthy development and these years can have a lasting impact on the rest of their life.

The best start for a child begins with a healthy pregnancy. The mental and physical wellbeing of the mother and their home environment is important for the baby's healthy development. Proactively supporting mothers during and after pregnancy, therefore, improves outcomes for both mothers and their children.

Some mothers and babies have a higher risk of complications during pregnancy and this includes women living in more deprived circumstances and those from Black and Asian ethnic groups. This can result in poorer outcomes, including babies being born too early or with low birthweight. Although deaths in pregnancy are rare, national research has found that mothers from some minority ethnic groups are more likely to die during pregnancy than their White British counterparts.

The Covid-19 pandemic lockdowns have impacted on the development of many younger children, who lost time in school and nursery and missed out on many social and developmental opportunities. This has led to more children who are not as ready to learn at two years old and not ready for school at five years old.

Families have also told us that they sometimes experience difficulty finding the services they need and have to 're-tell their story' to different services and professionals. This is most often the case for disadvantaged and vulnerable families.

Our focus areas:

- Offering support to women to ensure a healthy pregnancy with targeted actions focused on women from deprived communities and from minority ethnic groups who have historically experienced more problems during pregnancy and poorer outcomes.
- Supporting women experiencing mental health difficulties during pregnancy and after their baby is born.
- Improving the help we offer to pregnant women and their partners to stop smoking.
- Strengthening and simplifying the links between services for under-fives and making it easier for families to find and access the support they need without stigma.
- Working together to provide support to children under five to enable them to fulfil their full potential.

What we want to achieve:

- An increased proportion of mothers will have a healthy pregnancy, including those living in more deprived areas and those from targeted minority ethnic groups.
- Fewer babies will be born prematurely or with a low birthweight.
- Fewer mothers will smoke during pregnancy.
- The number of women who receive effective support for their mental health during pregnancy and after their baby is born will increase.
- The number of children achieving their early development milestones on the way to school readiness will increase, especially in our most deprived communities, so that they can get the greatest benefit from their education.

Improve emotional, mental health and wellbeing for children and young people.

Why this matters:

Mental health problems are a leading cause of disability in children and young people. Problems experienced as a child can have long-lasting effects. Indeed, half of those with lifelong mental illness experience symptoms by age 14.

The number of children suffering from mental health problems in our area has increased over the past five years with more children admitted to hospital for mental health conditions, including more cases of self-harm.

Measures of positive mental wellbeing have also reduced. The pressures children have faced as a result of the Covid-19 pandemic have made this situation worse.

We need to help our children by identifying mental health problems as early as possible and providing treatment before their condition worsens. At the moment it takes too long for children and young people to access mental health and wellbeing services in our area.

We need to do more. We will work with the many active voluntary, community and social enterprise organisations who tell us that they could do more to help us support our children and young people.

Our focus areas:

- At every opportunity across our system (health, care and education), supporting children to get the right mental health and wellbeing advice at the right time at a place near to where they live and learn.
- Improving access to mental health support teams for more pupils, prioritising schools with higher numbers of students eligible for free school meals, a higher proportion of students with special education needs or high proportion of students who live in the most deprived neighbourhoods.
- Reducing the waiting times and improving the experience for children and young people accessing mental health services, particularly NHS Child and Adolescent Mental Health Services (CAMHS).

What we want to achieve:

- Better mental health for children living and learning in Buckinghamshire, Oxfordshire and Berkshire West, through earlier intervention and support.
- More children will have easier access to support when they need it, including reduced waiting times for formal mental health services.
- Reduced rates of hospital admissions for self-harm among people aged 10-24.

Improve the support for children and young people with special educational needs and disabilities, and for their families and carers.

Why this matters:

The number of children and young people who have special educational needs or disability (known as SEND) has been increasing since 2016 and there are currently 1.5 million in England. This includes children and young people with speech, language and communication needs, social emotional and mental health needs, moderate learning difficulties, autism spectrum disorder and other neurodevelopmental disorders or specific learning difficulties.

In Buckinghamshire, Oxfordshire and Berkshire West, we need to improve the identification of children and young people with SEND and ensure they get appropriate and timely support. This will help them to take as full and active part in their daily lives as they can and enable them to reach their full potential.

Effective support at the right time and in the right place can improve educational attainment, employment, social mobility and mental health, which in turn impacts on longer-term health and wellbeing. Timely support for the child or young person also helps to support the broader resilience of the family.

Our focus areas:

- Identifying children and young people with special educational needs and disability at the earliest opportunity and ensuring they, and their families, are able to access the right level of support.
- Providing support for these groups in a broad range of settings based on their presenting needs rather than whether they have a diagnosis.
- Giving children and young people with special educational needs and disabilities, and their families, opportunities to shape their support with their clinical and professional teams.

What we want to achieve:

- Children, young people and their families report that they know where and how to access available support and services and report positively on their experience.

Support young adults to move from child centred to adult services.

Why this matters:

Services designed for children are not appropriate for young adults as they get older. There comes a point where the young person's care needs to move from a team focused on supporting children to professionals who provide services for adults. This varies from individual to individual and usually happens between the ages of 16 and 25.

Young adults, particularly those with more complex needs, can find this change difficult. It is important the process is as clear and supportive as possible, meeting the young person's needs while building their resilience to look after their own health as much as possible.

We can work better together to support young adults through this transition, understanding the needs and wishes of the individual and their carer(s) to ensure the right support remains available.

Our focus areas:

- Building the confidence of young adults, their independence and resilience as they transition so that they and their families and carers are actively involved in the changes to their support.
- Working together across our services to provide more holistic support, recognising the needs of the individual and supporting them through the move to adult services.

What we want to achieve:

- An increased number of young adults contribute to the development of a personalised plan that addresses their specific needs as they move to adult health or social care services.
- An increased number of young adults meet and actively engage with the adult services team that will be working with them after their transition.
- Sustained and personalised support for individuals in preparation for, during and after the transition phase to adult services.

Supporting people and communities to live healthy and happier lives

We want every adult in Buckinghamshire, Oxfordshire and Berkshire West to have the opportunity to live a healthy life. Under our priority of promoting and protecting health we have already explained how we will tackle factors that influence people's health and how we will support individuals to make healthy changes to their lifestyle.

To support people to live healthier and happier lives we plan to supplement this with targeted preventative work around health conditions that affect large numbers of people across our area. In this strategy we are prioritising cancer, cardiovascular disease and all aspects of adult mental health. We want to do more to support those who are at greatest risk of developing these or most likely to suffer inequality in access, experience or outcomes.

While supporting those most at risk of developing these conditions, we also need to offer extra support to the people in our communities who we know currently have poorer health outcomes overall, including people with learning or physical disabilities.

We also want to help people to understand how they can stay healthy and support them to look after themselves.

Improve mental health by improving access to and experience of relevant services, especially for those at higher risk of poor mental health.

Why this matters:

Mental illness is common – every week around 1 in 6 adults will experience a common mental health disorder such as anxiety.

Mental health problems are the biggest single cause of disability in the UK, and suicide is one of the leading causes of death in England in people aged between 20 and 64 in England.

People with a severe mental illness (schizophrenia, bipolar disorder, and major depressive disorder) have more than a 50% higher risk of having cardiovascular disease and an 85% higher chance of dying from cardiovascular disease.

Mental health problems can affect anyone, but some groups are at higher risk of poor mental health than others due to social and environmental factors. People living in the most deprived areas in England are twice as likely to be in contact with mental health services as those in the least deprived. Emergency mental health admissions are also higher in our more deprived areas.

People from some groups in society find it harder to access mental health services and have a poorer experience of services when they do. This includes people from certain ethnic minority groups.

We expect the cost-of-living increase to have a significant impact on the mental wellbeing of people who live in our area and we know the risk of deaths by suicide increases in times of economic crisis. People living in the most deprived areas, and with known risk factors for poorer mental health, are most likely to be most vulnerable to the health consequences of the cost-of-living crisis.

To effectively improve mental health we recognise that we need to consider all the factors that influence an individual's wellbeing rather than trying to focus on just one aspect of their life.

Our focus areas:

- Joining 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.
- Listening to ethnic minority groups on how to best provide mental health support relevant for their communities.
- Providing services that are culturally sensitive that improve access, experience and outcomes for people from ethnic minorities at highest risk of deteriorating mental health.
- Ensuring 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.
- Improving the physical health of people with severe mental illness by increasing the number of people with severe mental illness who stop smoking and increasing the uptake of regular physical health checks, with appropriate advice and treatment.
- Ensuring mental health treatment and support is tailored to individuals' needs to ensure improved accessibility for all people, including people who are neuro diverse.
- Providing better community-based support for adults and older adults with mental illness.

What we want to achieve:

- Improved mental health of everyone who lives in Buckinghamshire, Oxfordshire and Berkshire West, with particular improvements for those at highest risk of poor mental health.
- Improved mental health of people from ethnic minorities and those living in our more deprived areas.
- Improved access to, experience of and outcomes from services that support mental health.

Reduce the number of people developing cardiovascular disease (heart disease and stroke) by reducing the risk factors, particularly for groups at higher risk.

Why this matters:

Cardiovascular disease is one of the most common causes of death in Buckinghamshire, Oxfordshire and Berkshire West and a major contributor to the gap in life expectancy between people living in our most and our least deprived areas.

Certain groups of people are more likely to develop and die from cardiovascular disease. This includes people living in more deprived areas, people from Black and South Asian communities and people with serious mental illnesses such as schizophrenia.

Other groups, particularly women, are less likely to get cardiovascular disease but their signs and symptoms are sometimes different to men. This means their symptoms are often overlooked. For example, research has found that communication campaigns tend to focus on men and, as a result, women are less likely to recognise symptoms and may be slower getting help.

Up to 70% - 80% of cardiovascular disease is preventable and we know what works to help prevent it, including behaviours we can change. These behaviours include smoking, drinking too much alcohol, lack of physical activity, unhealthy eating and being overweight, having high blood pressure, diabetes or high cholesterol. We need to ensure that people at higher risk can access the support they need to reduce their risks.

Many people who have diabetes or high blood pressure have not yet been identified and so people are not receiving the support and treatment they need to prevent cardiovascular disease.

Our focus areas:

- Identifying more people with risk factors and supporting them to take action.
- Increasing the number of people receiving NHS Health Checks that detect cardiovascular risk factors, especially in deprived areas and in people at higher risk of heart disease and stroke.
- Increasing the number of people with high blood pressure we detect and supporting them to keep this under control.
- Increasing the numbers of people helped to stop smoking.
- Targeting communications campaigns to those who may not understand their specific signs and symptoms of cardiovascular disease, including women.
- Undertaking community engagement, using a tailored approach to improve people's health in communities at higher risk of heart disease with a particular focus on Black and South Asian groups.
- Increasing our capacity and infrastructure for cardiovascular support in the most deprived areas to improve access to, and experience of, services and to improve health outcomes.

- Ensuring people are supported to increase their physical activity and achieve a healthy weight and diet, as these are key factors in cardiovascular health.
- Helping people understand how to stay healthy and know where to access the support to do it.
- Increasing our capacity and infrastructure for cardiovascular support in the most deprived areas to improve access to, and experience of, services and to improve health outcomes
- Ensuring people are supported to increase their physical activity and achieve a healthy weight and diet, as these are key factors in cardiovascular health.
- Helping people understand how to stay healthy and know where to access the support to do it.

What we want to achieve:

- Fewer people will develop heart disease, stroke and vascular dementia particularly in the communities at higher risk.
- More people will know their blood pressure and be supported to manage it effectively, via lifestyle changes or clinical treatment.
- The gap in life expectancy between people living in deprived areas and the rest of the population will narrow as cardiovascular disease is a major driver of that gap.
- The gap in life expectancy between people living with severe mental illness and the rest of the population will narrow as cardiovascular disease is a major driver of that gap.
- The death rates from cardiovascular disease in Black and South Asian groups will reduce towards the levels experienced in the rest of the population.

Increase cancer screening and early diagnosis rates with a particular focus on addressing inequalities in access and outcomes

Why this matters:

The number of people being diagnosed with cancer is increasing. However, only half of these cancers are diagnosed in the early stages when there is a greater chance of successful treatment. Although there is variation across different types of cancer, early detection rates are lower in more deprived areas.

There are three national screening programmes which are important in detecting cancer early and starting treatment sooner.

These are for breast, bowel and cervical cancer.

Screening rates across Buckinghamshire, Oxfordshire and Berkshire West vary depending on the area, the GP practice people are registered with, and population characteristics such as ethnicity and level of deprivation. There is lower uptake amongst people with severe mental illness and those with a learning disability.

Cervical and breast screening uptake has declined over the last five years. National data shows some ethnic minority groups are less likely to attend cervical screening. We are currently analysing our data to understand the uptake of cervical screening from ethnic minorities in Buckinghamshire, Oxfordshire and Berkshire West.

Overall cancer screening uptake is also lower in people with learning disabilities compared to those without a learning disability. Nationally, it is recognised that cancer screening rates are also lower in people with severe mental illness and among Trans people.

We already have projects that target work with specific communities to increase screening and early detection rates but we know we need to do more. We plan to support community-based teams, who know and understand their local communities best, to spread the importance of cancer awareness and screening and to increase uptake rates.

Our focus areas:

- Improving understanding of, and accessibility to, all screening services for those from diverse communities and backgrounds through better community engagement and ensuring services are culturally competent.
- Using the data we have available to improve identification and support for communities that have low uptake of screening and detection services.
- Increasing uptake of screening where rates are low. This includes:
  - increasing uptake of cervical screening in younger women and people with a cervix
  - increasing the uptake of cervical screening in women from ethnic minority groups who are less likely to attend cervical screening compared to White British women
  - ensuring discussion of screening is embedded into the health check for those with learning disabilities and severe mental illness
  - recognising the screening needs of different people will vary and therefore make reasonable adjustments to ensure screening and detection services are tailored and accessible to all people.

What we want to achieve:

- Deliver the national ambition of ensuring 75% of cancers are diagnosed early (at stage 1 or stage 2) by 2028.
- Reduce the variation and inequality in cancer screening, access and uptake.

Age well

Staying healthy and independent for longer

People often require more support as they move through life and their health and care needs become more complex. We know there is more we can do to improve the services these people receive. Although we don't see this as age specific, most people who fall into this category will be older. This matters because our population is ageing. For example, approximately a quarter of people who live in Buckinghamshire, Oxfordshire and Berkshire West are aged over 60, and this number will grow by around 11% over the next five years.

As people get older, they generally need more support both in their communities and from health and care services. Some receive support from social care or voluntary and community groups, while friends and family also frequently act as essential carers. Environmental adaptations and physical aids can also be used to provide invaluable assistance to enable people to remain independent.

It is often possible to anticipate changes in a person's needs as they age or move through life and there are advantages in making proactive plans about potential care and support needs. This is something we need to do more. Working in partnership with the individual, their family and carers, we can ensure plans are personalised and maximise the person's independence.

By working more effectively together we can enable people to stay healthy and independent in their homes and communities for as long as possible.

Support people to remain healthy, independent, and connected within their communities.

Why this matters:

Positive relationships and social interactions contribute to our quality of life and wellbeing in many ways. Staying physically active enables people to get out and about to meet friends, enjoy a wide range of activities and access services and shops as well as maintaining health and independence.

Isolation and loneliness increase the risk of poor health, including increasing the risk of anxiety and depression. Six per cent of people aged 75 and over say they often or always feel lonely. People with a limiting long-term illness or disability are more likely to say they often feel lonely.

Other social and environmental factors can also directly affect people's resilience. These can include help from informal support networks such as family and communities, appropriate housing, the ability to eat well and stay warm. A rapid change in social situation can lead to poorer health and the need for more formal care. This deterioration could often be avoided if the right support is available.

Working together to help people to stay active and connected within their communities, will help them be healthier and independent for longer and reduce social isolation and loneliness.

Age well

Our focus areas:

- Working with our communities and residents to co-design support and services to encourage activity and positive community connections.
- GPs, community connector/social prescribers, community services, social care and the voluntary community social enterprise sector will work together to increase opportunities for people to connect socially with others and remain physically active.
- Ensuring health and care staff are more aware of opportunities available in the local community so they can direct people to appropriate activities.
- Considering opportunities for assistive technology and telecare to help more people stay independent for longer.
- Supporting people to access relevant technologies and increase their digital skills and confidence so they can remain virtually connected.

What we want to achieve:

- People will be supported to maintain social contact and will be more aware of opportunities to connect with others in the community.
- Older people will be empowered to manage their health, making healthy life choices and remaining physically active.

Provide personalised and joined up care for people as their care needs increase and become more complex.

Why this matters:

We want people to remain as healthy and independent for as long as possible and be able to access the right support to manage their health and care needs when they need it. However, some people will require more support as they age or their care needs become more complex.

An increasing number of people are developing long-term health conditions such as arthritis, heart disease, mental illness or dementia and may recover less quickly from illness or health and social setbacks.

We want to ensure that everyone's care and support is well planned and is developed in partnership with the person, their family and carers. This means joining up the work of health, social care and the voluntary and community sector. This will be underpinned by personalised care and support plans that are visible to all professionals involved in the person's care.

Our focus areas:

- Helping people learn about their condition(s), providing advice and support so they are empowered to better manage their condition(s) and improve their wellbeing.
- Identifying people who are likely to need care and support earlier, irrespective of whether that support is likely to come from health or social care or their own unpaid carers.

- Ensuring that more people have personalised care and support plans, with appropriate support from multi-disciplinary teams.
- Ensuring people's care plans are accessible to all relevant health and social care professionals so they can provide effective and coordinated care.

What we want to achieve:

- Earlier identification and support for people with more complex, long term care and support needs.
- People with complex health and care needs, including long term conditions, are less impacted by poor mental health.
- A reduction in the number of people admitted to hospital or care home placements who could have stayed at home with more appropriate support.

Improve support for carers.

Why this matters:

Around 3 in 5 people will be unpaid carers at some point in their lives. In 2011, there were nearly 27,000 unpaid carers across the Buckinghamshire, Oxfordshire and Berkshire West area and this number is likely to have increased since then.

Unpaid carers perform vital work to keep people safe and well. In doing this they also significantly reduce the demand for formal health and care services. However, many carers do not get the support they need to help them with their caring role and to help them look after their own health and wellbeing. Indeed, carers have reported that they are finding it harder to access adequate advice and support, and satisfaction with carer support services is declining.

Being a carer can have a significant impact on an individual's physical and mental health.

Many carers are juggling employment, education and other commitments alongside their caring responsibilities, with some facing significant financial difficulties.

People of all ages fulfil the role of carers, including children and young people of school age. Nationally nearly half of carers are more than 55 years old and nearly a third of carers are disabled themselves. In 2018, Carers UK reported that people providing high levels of care are twice as likely to be permanently sick or disabled. 7 out of 10 carers said they had suffered mental ill health as a result of caring, and 6 out of 10 said they had suffered physical ill health as a result of caring. 8 in 10 people say they have felt lonely or socially isolated.

We need to do more to ensure that carers of all ages can access relevant support and advice to allow them to continue in their caring role whilst looking after their own health and wellbeing.

Age well

Our focus areas:

- Identifying all carers in our area and sharing this information appropriately between health, social care and other professionals.
- Improving the support available to carers of all ages, recognising that the support offered to young carers may be different to support for adults.
- Helping carers access support, including ways to look after their own health and wellbeing, so they can continue to provide care in the way that they wish to.
- Changing the way we work to empower carers to be an active participant in shaping the personalised care and support plans that are developed for the people they care for.
- Working across our system to share best practice and promote a consistent level of support for all carers.

What we want to achieve:

- Carers experience a consistent level of seamless support, including better access to support in a crisis.
- The health and wellbeing of all carers is improved.

Improving quality and access to services

Accessing the right care in the best place

As a Partnership we are committed to adopting a proactive and preventative approach with a strong emphasis on keeping people healthy and preventing ill-health. However, we know this shift towards prevention must sit alongside an equally important focus on improving our current services and taking action to make sure these services are accessible to everyone who needs them.

Across the country, accessing support and services is sometimes difficult or slow. 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 and improving waiting times for planned operations. These priorities are echoed across Buckinghamshire, Oxfordshire and Berkshire West. We also hear concerns about access to social care, dental, pharmacy and optometry services and about the challenges of accessing services from rural areas, particularly given the limited public transport in many parts of our area.

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. An increasing number of people are using our services, including more people in need of support at the end of life. We aim to strengthen our partnership approach and provide the best support to meet people's different needs.

We are committed to providing the highest quality support to everyone. There are some groups within our communities whose access to, and experience of, services and outcomes is worse than others. This includes some minority ethnic groups, people with learning or physical disabilities and people who are often excluded (e.g. sex workers, people who are homeless or part of the gypsy, Roma and traveller communities). We are committed to addressing these disparities.

Our final strategic priority therefore focuses on services for people at every stage in life - both improving these services and making sure that everyone, irrespective of their personal characteristics or their personal circumstances, can access the support they need at the right time.

Develop strong integrated neighbourhood teams so that people's needs can be met in local communities.

Why this matters:

Primary care, as the first point of contact into health and care services, has an essential role to play in preventing ill health and tackling health inequalities. However, many of these services in our area are struggling.

Public satisfaction with GP services is falling.

GPs are reporting it is harder to balance caring for people with non-urgent, longer term care needs with the increasing pressure from more people who want urgent, same day support. Although more people are living with long term conditions, pressures on our teams mean it is harder for people to build relationships and understanding with those involved in their care.

Improving quality and access to services

All our GP practices have joined a Primary Care Network with other practices. These networks are bringing together a wider range of professionals to work collaboratively to provide high quality support to people when they need it.

GPs often see patients who could be seen by another member of the locally based team such as community, district and practice nurses, pharmacists, social workers, dentists, opticians, and health coaches. We are committed to helping more people access these services and professionals, to be supported to manage their health where possible and get faster support from a more appropriate professional when needed, reducing the burden on GPs.

In some parts of the country there are examples of non-health and care services, such as Citizens Advice, employment advisors, or money and debt specialists sharing space with clinical teams to provide support for people in other aspects of their lives that can directly impact their health or wellbeing. This is something we want to explore for our area.

Our focus areas:

- Ensuring people understand the alternative options to care and support in their community and are supported to use them.
- Integrating health, care and voluntary services at neighbourhood level.
- Strengthening the networks and joint working between professionals in our communities so people find it easier to get the right support when they need it.
- Ensuring there is greater continuity of care for those that need it, particularly those with long term conditions.

What we want to achieve:

- More people access the right support and care when they need it.
- People are more satisfied with the care they receive from primary care professionals in the community.
- Inequalities in access to GP services are reduced across Buckinghamshire, Oxfordshire and Berkshire West.

Improving quality and access to services

Reduce and eliminate long waits for our planned services, and address variation in access across the system.

Why this matters:

Faster treatment generally results in more positive outcomes while delays can lead to worse outcomes. Unfortunately, there are long waits to access some of our services.

Waiting times for some diagnostic and specialist services are particularly high, with some people waiting more than a year and a half. Many of these waiting times increased during the Covid-19 pandemic and continue to increase as the number of referrals is still growing.

Waiting times vary across Buckinghamshire, Oxfordshire and Berkshire West because the demand for services and the capacity of our specialist services is different. By working better together across our entire system we plan to make better use of capacity and provide a faster service to patients. We will further improve services by involving people in decisions about their care.

It is widely recognised that inequalities linked with deprivation and certain personal characteristics can impact the length of time people wait for care. These inequalities will be targeted and addressed across our system.

Our focus areas:

- Working across the Buckinghamshire, Oxfordshire and Berkshire West system to make the best use of all capacity. This should lead to earlier diagnosis by specialities and a quicker start to treatment.
- Helping more people be actively involved in decision making about their care through the whole care pathway.
- Embracing the use of technology to develop innovative models of support.
- Helping people prepare to ensure they get the best outcomes from surgery or planned treatment and avoid complications. This could include support to stop smoking, optimising physical fitness by increasing physical activity or losing weight, preparing for life after surgery e.g. learning how to use walking aids before hip surgery to aid post-op recovery.

What we want to achieve:

- Reduced waiting times for patients to access diagnostic and specialist care services.
- More people have the specialist support and care at the right time, in line with national targets.
- Improved patient experience and confidence in their local health system.

Improving quality and access to services

Support the consistent development of our urgent care services to reduce demand and support timely access.

Why this matters:

Urgent and emergency care services are under pressure across England. We see this when we try to get same-day GP appointments, face long waits for an ambulance and when we wait in A&E. These delays result in a poor experience for people trying to access services and increase the risk of less positive outcomes.

Trends in Buckinghamshire, Oxfordshire and Berkshire West mirror this national picture. More people are using urgent and emergency care services which means there are times when people do not get the support they want, when they need it. We are committed to improving this.

Our focus areas:

- Providing high quality urgent care services in community settings that complement our hospital services so only the people most in need go to hospital.
- Assessing people's needs and making it easier for them to get the right support in the right place.
- Providing people at highest risk of using unplanned, urgent or emergency care with the support to stay at home.
- When people are ready to leave hospital, our teams, including social care, will provide joined up support that meets their needs, closer to their home communities.

What we want to achieve:

- People's experience of accessing urgent or emergency care is improved and they find it easier to get the right support at the right time.
- Preventable unplanned emergency admissions are reduced in our hospitals.
- The time people spend in hospital is reduced.

Improve access and experience of palliative and end of life services to enable people of all ages to die well.

Why this matters:

Death and dying is inevitable and affects everyone – the living, the dying and the bereaved. It is not a response to a particular illness or condition and is not confined to a particular age, stage in life, group or section of society.

In Buckinghamshire, Oxfordshire and Berkshire West there is a rising need for palliative and end of life services. For many people care at the end of life is not coordinated well enough, which causes unnecessary distress. In our area, we have a significantly worse performance than the England national average for percentage of deaths with three or more emergency admissions in the last year of life.

Improving quality and access to services

To deliver support and meet the needs of people of all ages who are living with dying, death and bereavement, we must have cohesive partnerships from across the health and social care sector, including statutory and voluntary organisations. This has to be underpinned by people with personal and professional experience, who share a common vision to improve end of life care through collaborative action between organisations at local level.

Our focus areas:

- Viewing each person as an individual and supporting all people with palliative and end of life care needs to receive the personalised care they need irrespective of time of day, age of individual, background, and care setting.
- Ensuring there is fair access to care.
- Focusing and maximising comfort and wellbeing, including mental health needs, for everyone with palliative and end of life care needs.
- Coordinating and providing high quality care and support to patients and their families through trained and educated staff across all providers within our area and ensuring that all staff are prepared to care.
- Improving and raising community awareness of death and dying, to enable 'compassionate communities' to grow, and providing robust pre and post bereavement services for all.
- Updating our population-based needs assessment for palliative and end of life care services in partnership with Health and Wellbeing Boards.
- Identifying people with palliative and end of life care needs early to allow proactive planning, to minimise risk of crisis and unnecessary hospital admission.
- Ensuring the voice of people with lived experience is within everything we do.

What we want to achieve:

- A system which provides cross-organisational working to enable right care, right place, right time and support a person to die well in their preferred place of care and death.
- Improved access, experience and outcomes across Buckinghamshire, Oxfordshire and Berkshire West for all ages, recognising the importance of children's services and the transitional interface with adult palliative care services.
- Improved access to 24/7 advice and guidance for people with palliative and end of life care needs, their families and their carers.
- Patients with palliative and end of life care needs have access to the most appropriate funding stream tailored to their needs.
- Our communities support and empower people approaching dying, leading to a change in society's perception on death and dying.

Delivering on our priorities

Working in partnership across our system will provide significant opportunities to change the ways we think and work. However, we know that there are significant challenges ahead as we plan the delivery of this Integrated Care Strategy. There are well publicised pressures on our resources, both staff and money, and we need to be clear about how the ambitions of this strategy will be delivered and measured.

Our approach to delivery.

Strong leadership

The Integrated Care Partnership is new and we recognise it will take time to see some of the benefits of collaborative ways of working, including moving activity from being responsive to being proactive and focused on prevention.

Our Partnership is committed to providing the strong leadership that will support this change. Delivery of this strategy will be helped by the requirement that some partners – for example NHS organisations and local authorities – are required to 'have regard' for this strategy when drawing up their own organisational plans.

We will develop clear delivery plans which will build on the principle of prevention. We will work in partnership to understand more about how people need and use our services and the support available to them. Locally and across our system we will take actions that focus on proactively supporting people earlier and reducing demand.

Our delivery plans will include a small number of carefully considered measures. These plans will link with relevant funding – including opportunities to pool and share our resources – and will allow us to plan and phase our work to ensure our ambitions can be achieved. Clear measures for each priority will allow us to regularly monitor and evaluate the impact this strategy is having.

We will publish our delivery plans as they are developed and will share information on our progress.

Delivering on our priorities

Taking a 'place-based' approach

When drawing up our plans for delivery, we anticipate that many priorities in this strategy will be delivered through our three 'places' (Buckinghamshire, Oxfordshire and Berkshire West), and include collaboration with our Health and Wellbeing Boards, local networks and organisations, and local people. This will build on the huge amounts of work that is already happening at this level, and in local neighbourhoods and communities.

The development of the Integrated Care Partnership has also created an opportunity to take action 'at scale', joining up services and using limited resources more effectively. Some of our priorities will benefit from a system-wide approach, others will be most effectively implemented at a more local level.

Working with 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.

We started a process of engagement by asking people for their thoughts on our emerging priorities and on the first draft of this strategy. 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. 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.

In doing this, 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.

Supporting our delivery.

As well as rethinking our approach to delivery, we recognise that the success of this strategy will largely rely both on the people who provide support and care across our system and on adopting new and innovative ways of working, including how we use digital technology and data.

Our People

The people who provide care and support to our population are vital to the delivery of this strategy. This includes people in paid employment and also the large number of volunteers and informal carers across Buckinghamshire, Oxfordshire and Berkshire West. Every day these staff and volunteers provide excellent care, offer direct support to individuals, and take action to tackle the underlying causes of ill-health.

However, many are finding this increasingly difficult. Our growing and ageing population is placing more and more demands on health and care services at the same time we are battling unprecedented challenges from the Covid-19 pandemic and the cost of living crisis. Changes in our population and how we deliver services also means we need to rethink the staff roles we have and ensure we have the right people in the right jobs.

Over the last few years, our staff and volunteers have demonstrated exceptional resilience but we know we need to do more to support them. Across our area there are many good examples of initiatives to promote staff wellbeing and there is a lot we can do to spread this best practice across organisations. We also need to tackle the things that add pressure on our workforce. This includes recruiting people to fill all the roles we need across the whole health and social care system. It is also includes making sure people want to stay. We are committed to working together to ensure a positive working environment and to working collaboratively to offer more opportunities for personal and career development.

Our focus areas:

- Ensuring all the people working in our system, paid or voluntary, are supported and feel valued.
- Pooling our knowledge and our experience of how to make a positive difference to the working environment for our staff and volunteers.
- Continuing to offer a range of health and wellbeing at work initiatives, sharing best practice between organisations across our area.
- Developing collaborative programmes to improve recruitment and retention and to increase overall staff capacity.
- Joining up our education and training, and develop a shared approach to career development across health and care.
- Doing more to ensure our staff are representative of the communities they serve whilst promoting inclusion and ensuring a genuine sense of belonging.

Digital, data and technology

Providing useful digital, data and technology solutions will be essential to deliver our priorities.

We are already supporting organisations make the most of technology and data. We need to ensure the information and data held by these organisations is shared appropriately and safely. This will strengthen system-wide pathways, allow for a fuller integration of teams and will lead to a much better experience for staff and people receiving support or care.

For example, electronic records and our ongoing work to fully implement a single shared care record will improve the breadth and depth of the information available to our clinical and care teams.

Technology is already allowing us to move care closer to people's communities and homes. It is creating more opportunities for people to self-manage their conditions using apps and initiatives such as wearable monitoring devices.

Better use of the information and data we have will allow a shared understanding of need and allow us take proactive and targeted action where this data identifies people or population groups suffering health inequalities. It will also identify opportunities to tackle individual health conditions by focusing on those most at risk.

Strong systems and processes will, however, only be valuable if people can use them. Developing the right digital skills of staff, volunteers and service users is vital. We also recognise that many people in our communities, including some particularly vulnerable individuals and groups, will need support to use digital solutions or help to access digital technology.

Our focus areas:

- Supporting health and care providers in our system to reach a minimum level of digital maturity.
- Delivering a single Shared Care Record for care settings across the ICS area.
- Delivering technology solutions which enable our workforce to collaborate efficiently while supporting work/life balance, and which provide greater resilience and security around access to clinical and administrative data.
- Supporting people to receive virtual care in, or close to, their home whenever appropriate and providing more access to digital care.
- Supporting those working or volunteering in our area to feel confident in their use of digital solutions.
- Improving the digital literacy of our citizens, especially in deprived areas, whilst also tackling the other factors causing digital exclusion.
- Using population health data to drive decision making. This will include:
  - building a stronger community of analysts to improve our analytical functions
  - using data from across our providers to identify individuals or groups of people with similar characteristics and needs
  - moving from being reactive to proactive by empowering our staff to develop and implement targeted interventions
  - using data to identify health inequalities, and some of their possible causes, to tailor care towards a more person-centred, holistic approach.

Continuous Improvement

In this strategy we have described how we will work together to improve the health and wellbeing of our population. We have given detailed examples of the type of work we plan to do to deliver our five priorities. However, we recognise that we need to be prepared to change. We need to learn from what works and what doesn't work.

Learning from our service users and staff

We have committed to developing a culture of shared learning to ensure continuous improvement in the care and services we provide. Listening and acting on what our staff and the people who use our services tell us will be important to this. We need to embed this across all partner organisations, from leaders to the people delivering our frontline services.

Our focus areas:

- Sharing and implementing best practice across our area.
- Developing a culture of learning with a focus on improvement across all partner organisations and at all levels, from leaders to those delivering our frontline services.
- Working with people who have lived experience of health conditions and services to proactively identify the improvements we need to make and co-developing those improvements.
- Strengthening public, patient and service user involvement in identifying our priorities and designing service improvements.

Maximising local research and innovation activity

We also need to embrace new innovatinos and technologies so that our care and services are always evolving in line with evidence and best practice. We will do this by working more closely with the wealth of world class academic, research and innovation institutions on our doorstep.

The development of the Integrated Care Partnership provides us with an exciting opportunity to draw upon and shape the direction of these potential partners. By identifying need and agreeing clear shared priorities we can seek to coordinate and focus activity that can directly address the needs of our population.

Our focus areas:

- Aligning the focus areas for research and innovation with the needs of our populations and the services they access.
- Providing opportunities for our staff to develop the skills to be more involved in quality improvement, research, evaluation and innovation.
- Addressing inequity of access to innovation and improvement and poor outcomes by some of our communities.
- Better utilising data, intelligence and available evidence to support research and innovation and quality improvements to our care and services.
- Work collaboratively with research networks and institutions within the ICS to deliver research programmes for the benefit of our populations.

For more information on the integrated Care Strategy or the work of the Integrated Care Partnership please contact: engagement.bobics@nhs.net

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